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UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

DEPARTMENT OF SOCIAL DEVELOPMENT

**CARING FOR HIV POSITIVE INFANTS:
COTLANDS HOSPICE STAFFS' PERCEPTIONS OF CHALLENGES AND
STRESSORS WHICH THEY EXPERIENCE IN THE WORKPLACE**

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A dissertation submitted in partial fulfilment of the requirements
for the award of the degree of
Master of Social Sciences specialising in Clinical Social Work Practice.

Faculty of Humanities
University of Cape Town
Supervisor: Fatima Williams
September 2011

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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PERCEPTIONS OF CHALLENGES AND STRESSORS, WHICH THEY
EXPERIENCE IN THE WORKPLACE**

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DATE

ACKNOWLEDGEMENTS

This dissertation would not have been possible without the unconditional support, encouragement, and contributions made by the following people:

Cotlands Baby Sanctuary, Somerset West, Cape Town for granting permission for me to enter into their unique organisation as research for this study and for the support during the duration of the interviewing process.

The staff at Cotlands Baby Sanctuary in Somerset West, Cape Town for their consent to participate and be interviewed for this study.

Special thanks to my supervisor, Fatima Williams for supervising this dissertation. Your unconditional encouragement, support and positivity you have shown throughout the duration of this process is invaluable. You have enabled me to grow in many ways as a more competent researcher.

Thank you to the Department of Social Development at the University of Cape Town for the ongoing support throughout this dissertation.

To my parents, Jonathan and Bonita Shifrin and my brother, Justin, thank you for always having faith in me throughout this journey and for the unconditional support.

To my friends for the ongoing encouragement and guidance during this time.

DEDICATION

This dissertation is dedicated to my loving parents
Jonathan and Bonita Shifrin.

For all the support and encouragement, they have shown me
throughout the development of my academic career.

University of Cape Town

ABSTRACT

This study explored Cotlands Hospice staff's perceptions of challenges and stressors which they experience in the workplace, in caring for HIV infants. This aim of this study was to highlight some of the key struggles that healthcare workers are faced with in the HIV workplace in caring for HIV positive infants. The study also explored the participants' current coping strategies used to cope with stressors from within the workplace and supportive resources available to aid the participants were identified. Lastly unmet needs identified by the participants were explored and discussed

The research was conducted at Cotlands Baby Sanctuary, Somerset West Cape Town in the hospice wing of the organisation. Permission for conducting this study was granted by the manager of Cotlands Cape Town. A qualitative research design was used to carry out the research and purposive sampling was utilised in selecting the sample group for this study. The sample group was comprised of Cotlands staff members who were directly involved in the care of the HIV positive infants. The sample was ultimately comprised of registered nurses or carers by profession. A pilot study was conducted with three participants from Cotlands. The pilot study enabled the researcher to improve and enhance the data collection instrument. Fourteen Cotlands' staff members were interviewed using a semi-structured interview schedule and a digital voice recorder was used to record each interview accurately. In order to establish themes and categories of the data, a qualitative data analysis was conducted.

Findings from the study indicate that the main stressors or challenges faced are work stressors and personal stressors. Work stressors encompass low salaries, working conditions, conflict among staff, fear of contagion, death and dying of infants and administering of Antiretroviral Treatment. Personal stressors faced were stress in the home, awareness of human vulnerability and lack of family time. The study revealed that the participants are faced with numerous stressors, and are equipped with current coping strategies such as faith and detachment from patients. Supportive resources available to the participants were identified both internally and externally of the workplace. Finally, the unmet needs such as the need for counselling, improved communication, additional training and additional recognition were most commonly identified.

GLOSSARY

AIDS	Acquired immune deficiency syndrome
HIV	Human Immunodeficiency Virus
PTSD	Post-Traumatic Stress Disorder
ARV	Antiretroviral Treatment
UNAIDS	United Nations Programme on HIV and AIDS
WHO	World Health Organization

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CHAPTER ONE

PROBLEM FORMULATION

1.1 Introduction

This chapter introduces the problems that nursing staff and carers experience in caring for infants with the Human Immunodeficiency Virus (HIV). The background to the study is discussed and the rationale follows. The research questions, research objectives and clarification of concepts are examined as well as ethical considerations and reflexivity discussed. Lastly, the structure of this dissertation as well as a conclusion is provided.

1.2 Background to the Problem

In 2008 33.4 million people were reported globally to be living with Human Immunodeficiency Virus (HIV). Out of the 33.4 million globally infected people, 2.1 million were children under the age of 15 years. It is disturbing that 280 000 deaths out of 2 million were those of children under 15 years of age. South Africa has been described as having the lowest below 5 years of age, live-birth rate in Sub Saharan Africa and in 2008 held the statistic of 71% of all new HIV infections. In sub Saharan Africa in 2008 it was reported that 22.4 million people were living with HIV and of those, 340 000 were newly infected children (WHO UNAIDS, 2009: 21).

With the high rates of adults and children infected by HIV/Acquired Immune Deficiency Syndrome (AIDS), the role of nurses and carers has become much more demanding and stressful. The researcher identified through extensive research that both nurses and caregivers caring for HIV infants experience the same stresses and challenges so throughout this dissertation the terms nurses and carers is used inter-changeably. Common struggles experienced by nurses caring for HIV positive infants, include the stressors of caring for terminally ill infants and the absence of emotional support at work in this regard. These stressors consequently have an emotional impact on their family life (Smit, 2005). Pakenham, Dadds and Terry (1995) introduce the notion of caregiver burden, which is essentially the psychological, emotional and social issues that are experienced by carers, and they investigated the nature of burden experienced by carers of HIV sufferers. The outcome of this study revealed a reciprocal relationship between both carer and patient. In this way, the

patient's illness has effects on the carer and the carer's manner impacts on the patient in return. Similarly, patient and carer coping strategies seemed to correlate and both patient and carer tended to share in their preferred coping manner.

Hansel, Hughes, Caliandro, Russo, Budin, Hartman and Hernandez (1999) researched the notion of boosting social support in the carers of children with HIV/AIDS and identified the difficulty in caring for children with HIV/AIDS and how these challenges affect the individuals providing this care. This study found that it is imperative for carers of HIV positive children to receive adequate social support in order for their needs to feel authenticated and to support them in the workplace.

In the same light, Miller (2000) cited in Govender, Rochat, Richter and Rollins (2006) found that with nurses already overworked and highly stressed by numerous factors, the long-term effects of this on a daily basis and increasing numbers of patients dying, could only prove detrimental to these nurses and possibly result in burnout. Kabbash, El-Gueneidy and Sharaf (2007) in a similar study explored burden, strain and coping strategies among caregivers of people living with HIV. These researchers found that carers suffered from a great deal of care burden and strain and concluded that these carers were in desperate need of support and aid because of the psychosocial impacts of their work. Through the investigation of carer's burden and adjustment to HIV, it was found that the carers' primarily struggled with distressing emotions, relationship difficulties, somatic symptoms and grief in caring for HIV patients. Extensive research has been conducted around the high stress levels and many stressors experienced by nursing staff and carers in HIV positive wards in numerous hospitals; however not enough research has been done on how to improve the circumstances for those working with HIV patients, and infants in particular (Pakenham et al, 1995).

Some reports of nurses concerns in caring for HIV patients and their fears around this date back to the early 1990's (Damrosch, Abbey and Warner, 1990 cited in Sherman, 2000). The estimated needs of such patients are often recurrent and prolonged hospitalisation. In the hospital setting, HIV positive patients require the necessary medications, usually antiretroviral therapy, and good nutrition, amongst other forms of care. This care is provided by nursing staff and carers trained in HIV care and it is not surprising to find that these staff

members experience a great deal of stress and feel overwhelmed (Smit, 2005). High rates of psychological distress were found in a study, which explored psychological adjustment in carers of school age children infected with HIV and carers whose personal stressors were poverty, family struggles or tension related had heightened psychological distress (Bachnas, Kullgren, Suzman Schwartz, Mc Daniel, Smith and Nesheim, 2001).

It is important that nurses are recognised as being major role players in the face of the HIV/AIDS pandemic and it has been said that “it must also be realised that nurses are the lifeblood of healthcare systems in developing countries, and are the key in delivery of interventions in the fight against HIV/AIDS” (Govender, et al, 2006: 254). Working conditions for staff members caring for HIV infants must be addressed sooner rather than later, as well as the implementation of the necessary resources and intervention strategies to promote a more conducive working environment for them in order for them in order to provide the best care to HIV/AIDS patients. Hansel, et al (1999)’s study to assess the impact of social support boosting intervention on carer stress, coping and social support among carers of children with HIV/AIDS revealed that improved social support was imperative due to the current lack thereof .

1.3 Rationale

According to Colvin (2005), HIV has created an additional burden on health care systems that are already in dire straits with pediatric HIV having a profound effect on Sub Saharan African health care systems. The high rates of the effects of pediatric HIV on health care services as a result of the increase in infant mortality, can be accounted for by the following: high rates of mother to child transmission, amplified and unpredictable risk due to environmental factors, poor nourishment, restricted access to standard and specialised medical and social care, sickness of the mother as well as prospective carers and lastly the stigmatisation of ill or presumably ill infants. Colvin (2005) also found that HIV positive children remained in hospital for an average of two days longer than HIV negative children that are hospitalised. It was found that HIV positive children generally have more dealings with the health care system than other paediatric patients with 48 % of HIV positive paediatric patients having undergone hospitalisation in comparison to that of 20% of HIV negative patients with hospital admissions. The increasing number of HIV positive paediatric patients which is placing an increased strain on the health care system, will negatively impact

on the care of these children due to increased burden through patient load and short staffing. Ultimately, this results in untimely death and HIV negative patients being sidelined and discharged prematurely in an attempt for the health care system to cope. The working conditions in hospitals, as a result of HIV positive sufferers, is clearly overwhelming the nursing staff. This is due to HIV/AIDS nursing requiring more time and commitment from nursing staff in comparison to nursing patients with treatable illnesses (Smit, 2005).

Carers have been accused of having lost their passion for nursing and not working hard enough, yet these carers provide the antiretroviral treatment to these infants and begin to care for and become attached to these infants, only for these infants to die on a daily basis. Anyone that experiences loss as frequently as carers do undoubtedly needs a great deal of support to cope with the HIV pandemic. In addition, working conditions and home conditions of nurses should also be taken into consideration when assessing nursing staff's working conditions. The researcher views this as a vicious cycle in that numerous HIV positive infants are hospitalised daily to receive antiretroviral treatment and the care provided by these staff members yet their home and working conditions remain stressful (Smit, 2005).

The problem that was researched was Cotlands Hospice staff's perceptions of challenges and stressors which they experience in the work place. The researcher views this as a valuable study as the impact of caring for HIV positive infants requires more research from the perspectives of those caring for these infants. It also appears that the challenges and stresses that manifest as a result of stress at work can have detrimental effects on nursing staff and this in turn affects their working ability.

This study allowed these staff members the opportunity to express their feelings with regard to caring for HIV positive infants and the stresses it brings as well as the psychological, emotional and physical impact at work and at home. In this way, carers' suggestions of what they feel is needed for them to be able to cope and persevere in this area of nursing were expressed. The findings from this research will be able to provide carers, nurses, nursing management and hospital superiors with possible intervention strategies in assisting the staff in this demanding area of work. Lehmann and Zulu (2005) cited in van Dyk (2007:64) reinforce the relevance of this study by stating, "If we expect our caregivers to continue to shoulder this disproportionate piece of the fight against the HIV epidemic, we have to hear

their urgent call for help and support and take seriously that we have to care for our caregivers”.

1.4 Cotlands Residential Facility

This study was conducted at Cotlands residential care facility in the hospice wing. Cotlands is a twenty-four hour residential care facility providing paediatric care and palliative care facility for children directly impacted by HIV/AIDS. Cotlands provides the full continuum of care to vulnerable children, with services ranging from home based care of HIV positive children through to end stage palliative care for children with AIDS. Cotlands residential services are used in emergencies for acute, chronic and terminally ill children who cannot be cared for at home or children who have been abandoned or orphaned. The residential facility at Cotlands is made up of the hospice and the sanctuary. The hospice wing cares for between 26 and 30 children between the ages of birth to six years old who are either HIV positive and cannot be cared for by their biological families or who have been abandoned as a result of their condition or children suffering from other illnesses, like malnutrition, Tuberculosis, Foetal Alcohol Syndrome and neglect as a result of poverty. In the case of children whereby a cure is not possible, effective palliative care is provided which focuses on the enhancement of quality of life for the child as well as the support of the family. Palliative care also includes managing distressing symptoms, provision of respite and care through death and bereavement (Cotlands, 2010).

The sanctuary wing provides care for up to 20 children between the ages of 2 and 6 years old. The children in the sanctuary have been abandoned, abused and or orphaned and children on anti retroviral treatment until they can be reunited with their families or until alternative suitable community placements can be arranged. Only the hospice wing of this organisation was selected for this study. The reasons for this are that this study was exploring the perceptions of those staff members that are caring for HIV infants specifically, in addition, the hospice staff are exposed to more sickly children who are very ill and who are potentially dying (Cotlands, 2010)

The composition of staff members in the hospice wing is as follows: 1 nursing sister, 3 staff nurses, 2 auxiliary nurses, 12 carers (permanently employed carers) and 9 relief staff (contract carers). The staff shifts are divided into day shifts and night shifts, with each shift

being 12 hours. The role of the nurses and carers are to put the children to sleep, wash, feed and change them, provide stimulation for the children and assist with the provision of anti-retroviral medication. The nurses and carers also provide comfort, care and love for the infants in an attempt to provide them with a homely and nurturing environment (Cotlands, 2010). The findings of the study will be made available to the Cotlands baby sanctuary and to the Department of Health in the hope that the findings will aid in improving working conditions and enhancing supportive resources for HIV/AIDS nursing staff in other hospitals. In this way this study can serve as a platform for further research.

1.5 Topic

Caring for HIV positive infants: Cotlands Hospice staff's perceptions of challenges and stressors, which they experience in the workplace.

1.6 Research Questions

- What are the stressors or challenges that Cotlands hospice staff experience in caring for HIV positive infants?
- What are the current coping strategies employed by Cotlands hospice staff?
- What are the supportive resources currently available to these staff members?
- What do these nurses and carers feel they need in order to effectively care for HIV positive infants?

1.7 Research Objectives

- To explore the challenges or stressors cotlands hospice staff experience in caring for HIV positive infants.
- To examine the current coping strategies utilised by hospice staff.
- To identify resources available to these staff members.
- To ascertain any unmet needs in the workplace identified by the staff.

1.8 Clarification of Concepts

Perceptions

An individuals' view of or about something (Oxford English Minidictionary, 2004).

Challenges

Challenges are defined as demanding tasks or situations (Oxford English Minidictionary, 2004).

Stressors

Psychological or emotional strains (Oxford English Minidictionary, 2004).

Nurse(s)

A person(s) qualified to care for ill patients (Oxford English Minidictionary, 2004).

Carer

A person who cares for ill, elderly or disabled people (Oxford English Minidictionary, 2004).

HIV

Human Immunodeficiency Virus, which is the virus that has been deemed as the cause of the Acquired Immune Deficiency Syndrome (Whiteside and Sunter, 2001 cited in Becker, 2005).

AIDS

Acquired Immune Deficiency Syndrome which is a disease caused by the HIV virus, which breaks down defences against infection (Oxford English Minidictionary, 2004).

Infant

A baby under 24 months of age (Oxford English Minidictionary, 2004).

HIV positive infants

Infants that have contracted HIV.

Cotlands Hospice staff

Registered nurses and carers employed by Cotlands Baby Sanctuary, working in the Hospice ward, caring for, feeding, changing, medicating and stimulating the infants.

1.9 Ethical Considerations

De Vos, Strydom, Fouche and Delpont (2005) identifies several ethical issues which researchers need to consider. These are:

1.9.1 Avoidance of harm

It is important that participants are not harmed physically or emotionally during the course of the study. It is more difficult to prevent the emotional harm of the participants more so than the physical harm of them. Participants should be made aware of this and if they are uncomfortable with this they could leave the study (de Vos, et al 2005). The participants in this study were assured that they would not encounter any physical or emotional harm due to the nature of the research; however if the participants were not satisfied with this they were able to withdraw from participating in the study.

1.9.2 Informed consent

According to de Vos et al (2005) informed consent allows for participants to give voluntary, legal consent to participate in the study once they have an understanding of the details of the research as well as what the study would entail. The nurses and carers from the hospice wing of Cotlands were all briefed on the nature of the study and on the details of how it was to be conducted. Once this was done, the staff were able to make an informed decision regarding their consent to participate in the research.

1.9.3 Deception of subjects and/or participants

The participants cannot be intentionally 'misinformed' or deceived by the researcher in anyway. This is seen as unethical and using the participants under false pretences (de Vos, et al, 2005). The participants were not deceived in any way by the researcher or the study in that they were informed both verbally and in writing regarding the purpose of the study as well as their role within the research. The written consent was signed by each respondent in agreement that they had been clearly informed in order to ensure the prevention of subject deception.

1.9.4 Violation of privacy/anonymity/confidentiality

Participants have the right to convey or not to convey respective information. The privacy of participants is to be respected at all times. It is the researchers' responsibility to ensure that the identity of participants is kept anonymous as is the information given by the participants to remain confidential (de Vos, 2005). The names of the participants used in the study remained anonymous at all times. The participants were only asked to provide information that they felt comfortable with revealing. During the transcribing of the interviews, the anonymity of the participants remained fully respected, as no identifying information was required. In this way, their privacy was fully respected. Confidentiality was adhered to at all times in relation to the participants and their contribution to the study.

1.9.5 Actions and competence of researchers

Actions and competence of researchers entails that researchers are adequately skilled and experienced in conducting the research. This includes conducting the research, collecting the data, analysing the data and reporting on it, all which must be done adequately and ethically (de Vos, et al, 2005). This researcher has developed her interviewing skills and knowledge of research through practical experiences in undergraduate and post-graduate Social Work studies and was confident in her abilities to conduct this research.

1.9.6 Release of publications of the findings

According to de Vos et al (2005) it is the researchers' duty to ensure that the research report is compiled clearly and correctly in order for it to be published and to aid other researchers in the expansion of one's own research. Researcher bias and plagiarism are unethical and are unacceptable. The data and outcomes of this study were ethically compiled and any limitations of the research were disclosed. The participants from this study were informed of the outcomes via a document that was provided to Cotlands containing the findings and recommendations that emerged through the study. Appreciation was also conveyed in this document to thank the participants for taking part in the study.

1.9.7 Debriefing of participants

Debriefing the participants allows the participants to reflect on their experiences of being in the study and express to the researcher any concerns or questions that participants might have. This is done to minimise any emotional distress that participants can encounter;

especially when qualitative research designs are being used. The researcher is then able to work through any issues that participants have (de Vos, et al, 2005). Once each interview had been conducted, the researcher spoke to each respondent off record and enquired how he or she was feeling after the interview. The researcher offered the participants the opportunity of debriefing.

1.10 Reflexivity

Reflexivity is the researcher's expression of personal views or issues in relation to the research being conducted (de Vos, et al, 2005). The researcher, as a Social Worker, identified with carers working in this field, feeling overwhelmed and unable to cope with demands in the workplace. The researcher identified with these staff members as she has experienced feeling incapable of helping terminally ill clients in the past even with the support of supervisors and colleagues. The researcher was aware of the impact that subjectivity could have had in influencing the outcome of the study in terms of researcher bias and her own feelings were contained when dealing with issues that she identified with on personal level. The researcher felt that this research is important in order to bring about awareness in the field of HIV nursing in order for staff to be understood, supported and appreciated in order for them to be able to cope better under their respective circumstances. Living in South Africa where the rate of HIV positive infants is one of the highest in the world, the researcher felt a responsibility in clarifying the circumstances that nurses find themselves in daily. After conducting this research, the researcher felt a greater sense of understanding and appreciation for the participants.

1.11 Structure of the Research Report

This research report will follow the following structure:

Chapter One

Problem formulation explores the nature of the problem that this study aims to investigate.

Chapter Two

The literature review compares and contrasts studies that have been conducted in this area of work.

Chapter Three

The methodology chapter closely analyses the types of research methods and practices used in executing the data gathering for this study.

Chapter Four

The findings chapter identifies, analyses and discusses the findings from this study

Chapter Five

Conclusions and recommendations are put forward based on the findings from chapter four.

1.12 Conclusion

This chapter discussed the background to the problem of nurses and carers in caring for HIV infants, the rationale for choosing this topic, the main research questions and main research objectives. Clarification of concepts, explanations of the ethical considerations of this study, reflexivity as well as the structure of this dissertation was discussed. The following chapter presents the literature review.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents literature relevant to the study. The literature reviewed here examines the stressors that carers experience in the field of HIV/AIDS, coping strategies that have been utilised by various carers as a means to coping with the nature of this work, supportive resources that have been available to these persons both within the working environment as well as in the home environment. Finally, the needs of carers that have been overlooked or not attended to are also discussed. This first part of this chapter provides the theoretical frameworks underpinning this study.

2.2 Theoretical Frameworks

The theoretical frameworks that underpin this study are compassion fatigue and occupational stress.

2.2.1 Compassion fatigue

Compassion fatigue has been defined as a form of burnout experienced by caregivers (Figley, 2002). Compassion fatigue is the direct outcome of the impact in caring for individuals who are suffering as a result of traumatisation and or pain (Sabo, 2006). It arises due to behaviours and feelings that are experienced in an attempt to help others. The 'others' usually refers to patients that have experienced or are experiencing a traumatic event or illness. Compassion fatigue is caused by the stress of attempting to help or cure these patients (Miller, Stiff and Ellis, 1988 cited in Sabo, 2006).

Boyle (2011) emphasises the importance of supporting staff in the workplace in an attempt to prevent the development of compassion fatigue as carers are exposed to tragedy and death within their line of work and are more vulnerable as a result of this. It is essential that compassion fatigue is dealt with early on in its development otherwise its effects can hinder caregivers from providing compassionate care to their patients (Boyle, 2011).

The symptoms of compassion fatigue can be emotional, intellectual, physical or social (Boyle, 2011). Some examples of symptoms of compassion fatigue are insomnia, irritability, anxiety, emotional distancing, the evasion of performing particular duties, behavioural distancing, feeling powerless and meagre, as well as sometimes experiencing flashbacks. The symptoms of compassion fatigue often coincide with the symptoms of Post-Traumatic Stress Disorder (PTSD) (Joslyn, 2002). Although the symptoms of compassion fatigue and PTSD appear similar, the difference between them is that PTSD results due to the exposure of a traumatic event, where as compassion fatigue can result due to the exposure to a person who is traumatised and or suffering (Leiter, Harvie and Frizzell, 1999 cited in Sabo, 2006).

There are factors which have been helpful in the prevention of the development of compassion fatigue. These factors are effective support systems, verbalisation of emotions, assistance from other organisations or persons outside of the workplace for guidance and support, and lastly, caring for oneself. Support systems and verbalisation of emotions both encourage the expression of thoughts and feelings that need to be resolved and supported. In this way, the thoughts and feelings are prevented from escalating and aiding the development of compassion fatigue. It has been found to be useful for organisations to share their knowledge and experience in improving working conditions for staff in a further attempt to prevent the development of compassion fatigue. Caring for oneself involves knowing what ones strengths and weaknesses are and being kind to oneself in the midst of stress (Joslyn, 2002). Additional preventative factors of compassion fatigue are creating a healthy balance between work and life and educating one self and others on these factors. Education of the causes and symptoms of compassion fatigue are also recommended (Boyle, 2011).

2.2.2 Occupational Stress

Occupational stress and burnout is described as being “the end stage of a chronic process of deterioration and frustration in the individual worker, due to chronic emotional and interpersonal stressors in the work situation” (Miller, 2000 cited in Van Dyk, 2007: 51). Occupational stress has also been identified whereby the responsibilities and requirements placed upon a person exceed the tools available to them in managing the work. The nature of stress in health care workers has been termed chronic stress. The reason for this is that these professionals are not able to really come to terms with and healthily move forward from the daily stressful experiences of their work (Cox, Kuk and Leiter, 1993 cited in van Dyk, 2007).

The causal factors of occupational stress may be due to the individual in the workplace, the work itself or additional stressors outside of the workplace. Common causal factors within the workplace have been identified as linked to unmanageable workloads, unclear responsibilities and experiences of trauma and loss by the staff (Bergh and Theron, 2003).

The symptoms of workplace stress may be physical, emotional, cognitive and behavioural in nature. Some physical symptoms of workplace stress manifest in the form of headaches, muscle discomforts, nausea, insomnia, increased pulse rate, recurrent cold or bouts of flu. Fluctuating moods, feelings of being overwhelmed, loneliness, isolation or depression are some emotional symptoms that persons experiencing workplace stress may present through cognitive symptoms, seen as difficulty concentrating, negative mindsets, preoccupation with fear or concern. Extreme changes in eating and sleeping patterns, using substances to settle down and overreacting to situations are some of the behavioural symptoms that may be exhibited during the experience and struggle of workplace stress (Lambert and Lambert, 2008).

It has been estimated that stress linked to occupation accounts for between 50 and 80% of psychosomatic or stress-type illnesses (Dollar and Winefield, 1996; Daley and Parfitt, 1996 cited in Jamal and Baba, 2000). Caring for ill patients is a very demanding profession emotionally, psychologically and physically and as a result, stress within the health care workplace cannot be evaded (Albar Marin and Garcia-Ramirez, 2005; Schaefer and Moos, 1993; and Gray-Toft and Anderson, 1981 cited in Hamaideh, Mrayyan, Mudallal, Faouri and Khasawneh, 2008). Persons caring for HIV individuals experienced a high level of care burden and over all negative psychosocial effects in assessing the burden, strain and coping mechanisms of HIV carers (Kabbash et al, 2007).

Working in the nursing profession brings with it not only conventional occupational stressors; but working with HIV positive and dying patients, infants in particular, exposes them to an array of other stresses in the workplace as well as in home life (Lambert and Lambert, 2001). Unmanageable demands and overwhelming exposure to death and dying are but some of the stressors that these individuals are faced with which will be discussed below.

2.3 Stressors faced by health care staff

The number of daily stressors faced by nurses/carers working in hospitals, caring for HIV/AIDS patients, is vast. The following stressors can be concluded as being the most prominent stressors for persons caring in this field of work (Smit, 2005).

2.3.1 Work Stressors

2.3.1.1 Fear of contagion

Safety practices in caring for HIV patients and the fear of accidental infection have been characterised as one of the major stressors in the study of work related stress and occupational burnout in AIDS caregivers. Fears of contracting HIV inadvertently echoes this concern whereby nurses are claiming that they have little or no access to protective medical items such as gloves and aprons to name a few (Gueritault-Chalvin, Kalichman, Demi and Peterson, 2000). Without these materials, health professionals who are in contact with HIV/AIDS patients, are at a higher risk of accidentally contracting HIV/AIDS (Smit, 2005 cited in van Dyk, 2007). The constant fear of exposure to the virus may accelerate the rate of occupational burnout (Gueritault-Chalvin, Kalichman, Demi and Peterson, 2000 cited in Smit, 2005).

Fear of contagion can extend to the families of these staff members who are fearful of them contracting HIV from patients. Some staff have withheld incidences of needle stick injuries from their families to avoid their disapproval of them (van Dyk, 2007). It can be deduced that some health professionals work in fear that they will contract the HIV/AIDS virus due to the lack of provision of the necessary safety materials by hospitals.

The perceptions of HIV/AIDS explored in health care professionals in Singapore were found to be largely realistic and well understood by most of the health care professionals. Some of the misperceptions that were identified were the misperception of contracting HIV by means of 'casual' or 'social' contact and through kissing which is a most unlikely and uncommon means of contracting HIV/AIDS. The stigmas that have been attached to HIV/AIDS maintain an influence on people's misperceptions of this virus (Bishop, Oh and Swee, 2000).

Nurses that received in-depth and on-going HIV/AIDS education, which constituted the ways in which HIV could be contracted; understanding the virus itself, as well as management of these patients found that they were more comfortable in caring for HIV positive patients than

those nurses who did not receive HIV/AIDS education in such depth. Due the education received, the nurses were able to put in place all of the necessary precautionary measures to prevent HIV contagion and as a result reduced the fear of HIV contagion (McCann, Sharkey, and McCann, 1998). Further education on HIV/AIDS can be seen as an essential means to reduce the stigma around HIV/AIDS and to eradicate misperceptions.

2.3.1.2 Work conditions

Work overload is another major stressor in the daily lives of nurses caring for HIV patients (Foxall, Zimmerman, Standley, Bene, 1990 cited in Lambert and Lambert, 2001). Patient overload is not just the ratio of carers to patients but extends as far as health care staff not being able to provide the holistic care to patients as they are expected to do. Insufficient time, as a result of too many responsibilities that are to be completed during their shifts, which are on average twelve hours each, can be one cause of work stress. These responsibilities can include administering of medication, paperwork, taking patients' vital signs, feeding and washing if necessary. Van Dyk (2007) expands on these findings by adding that not only is there work overload in terms of patients; but also due to the high death rate of young HIV positive patients, grief and bereavement overload will result. In an average of patients admitted to hospital, one in every three to four patients is likely to be HIV positive (Smit, 2005). An estimation of the shortage of nurses in the USA by 2020 was identified as being 340,000. An increase of this nature will undoubtedly increase occupational stress, negatively impact on care provided to patients as well contribute to the number of nurses resigning (Auerbach, Buerhaus and Staiger, 2007 cited in Wieck, Dols and Northam, 2009).

A market shortage of nurses has been identified in sub-Saharan Africa. This shortage is due to the high frequency of nursing migration. This shortage of nursing professionals is a major crisis and concern for health care provision across sub-Saharan Africa (Ogilvie, Mill, Astle, Fanning and Opare, 2007). The shortage of nurses has been largely accredited to job dissatisfaction, being infected by HIV/AIDS and unmanageable case loads (Ncayiyana, 2004).

Many health care staff work an average of twelve hours per shift. It has been identified that working twelve hours or more decreases patient safety and the level of patient care. The impact of working long hours increases staff's risk for fatigue. A link between fatigue and an increasing workload, which is usually indicative in the health care field, escalates the risk for

mistakes made by staff, which directly impacts on patient care and safety. Staff that develop fatigue often experience increased absenteeism from work as well as feelings of discontent in the workplace (Rogers, Hwang, Scott, Aiken and Dinges, 2004).

2.3.1.3 Low salaries

In direct relation to work overload, arises the issue of low wages. Meeus and Sanders (2003) cited in Smit (2005) explain that nurses are very much underpaid whereby the starting salary of qualified nurses is low and as a result a number of nurses left the country in search of work in other countries in the hope to receive a higher paying salary. This loss of nurses would result in fewer staff, which would in turn worsen the problem of patient overload as a direct result of understaffing. Income and the working environment were revealed as being the most common issues resulting in job dissatisfaction in a study that explored job satisfaction of health care staff employed at healthcare centres in Turkey. The study did not find any correlation between job dissatisfaction and the age, gender or race of the healthcare staff (Bodur, 2002). Underpaid staff identified the need for their expertise and care within the health care field in caring for patients. It is because of this sense of responsibility to their patients that enables the staff to remain inspired within the workplace despite the issue of low salaries (Segall, 2000 cited in Van Lerberghe, Conceicao, Van Damme and Ferrinho, 2002).

An attempt to bridge the gap between nurses' low salaries and job dissatisfaction is that of benefits. Benefits are changeable and implementable across occupations and can be used as enticements to health care workers in an attempt to retain them in their particular jobs. The inclusion of benefits that staff qualify for has positively influenced job contentment and has resulted in more staff remaining in their current workplaces (Young, Albert, Puschke and Meyer, 2007 cited in Wieck et al, 2009).

2.3.1.4 Exposure to death and dying

Some nurses expressed that they struggle to cope with the exposure to death and dying of HIV positive patients on a daily basis. The studies reflect that HIV/AIDS nurses are constantly admitting and caring for patients in the hospital, only for them to weaken and die as there is no curative treatment for HIV, however since the introduction of antiretroviral treatment it has aided in keeping the virus under control and relatively symptom free. In the face of this pandemic, the role of nursing supervisors and hospital managers should be providing the staff with support that anyone being exposed to a relatively frequent rate of

death and dying would require in order to cope (van Dyk, 2007; Mc Vicar, 2003 and Lambert and Lambert, 2001). The symptoms experienced by health care workers who are faced with the death and dying of patients in the workplace are the characteristics of compassion fatigue. These symptoms are a direct result of the effect of on-going to exposure to traumatic events, such as the death of a patient and the symptoms will persist until the health care worker receives support or counselling to assist in dealing with these traumas (Sabo, 2006).

Nurses are not receiving the necessary support that they require according to Decker (1997) cited in Lambert and Lambert (2001). In supporting the mentioned concerns Pakenham, et al (1995) conclude that HIV caregivers experience painful feelings, relationship complexities, somatic symptoms and grief. Nurses who experience the loss of a patient or patients, often is not able to work through their losses and come to terms with them, as well as having time to care for themselves. In circumstances such as this, nurses are not able to care for themselves and as a direct result will have difficulty in providing optimum care for patients too (Couden, 2002).

2.3.1.5 Lack of support from management

Nurses claim having a poor relationship with their hospital supervisors or managers and that they do not receive support from their superiors and this leaves health care workers feeling as though they are working in segregation with management which is experienced as being as unsupported and unacknowledged by their superiors (van Dyk, 2001 cited in Becker, 2005). The absence of support from supervisors and managers amongst other staff members is disturbing after discussing the effects of compassion fatigue. Mc Vicar (2003) cites several studies including (Hillhouse and Adler, 2007; Bratt, Broome, Kelber and Losocco, 2000; and Ball, Pike, Cuff, Mellor-Clarke and Connell, 2002) to explore this and states that the effects of common fatigues are directly caused from stressors such as the issue of lack of support from management

The lack of support for nurses/carers identified as a stressor suggests that support and assistance is needed to enable them to provide the best care for their patients (Kabbash, et al, 2007). The psychosocial impacts on caregivers of people living with HIV/AIDS were explored and the caregivers identified the need for continuous, suitable and valuable support as well as being recognised for the work they have done (Orner, 2006).

2.3.1.6 Conflict among staff

Interpersonal conflict refers to the existence of simultaneous, opposing and conflicting thoughts, feelings and activities between persons in the same environment. Negative feelings such as anger and a fear of rejection may be causes for interpersonal conflict. Some of the causes of organisational conflict in the workplace may be due to differences in individuals' values, views, working style and low resources. The most common conflict in the workplace is conflict of interest between employers and employees (Bergh and Theron, 2003). Relationship conflict and task conflict are two types of conflict that exist within the workplace. Relationship conflict results when there is discord among staff personalities or feelings. If relationship conflict is not dealt with early on it can negatively impact group cohesion and the value of the staff relationship. This negative impact on the staff group will likely affect the functioning of staff in the workplace and in turn affect the quality of patient care (Ross, 1989; Pelled, 1996 cited in Ayoko, Callan and Hartel, 2003). Unresolved conflict among staff has been identified as being one of the causes of anguish and non-attendance in the workplace. In order for this to be eradicated, the implementation of a leader figure may prove beneficial in mediating conflict and reducing tensions (McVicar, 2003).

Symptoms of relationship conflict may be identified through behaviours such as staff irritability, staff being suspicious of one another, as well as resentment of other colleagues (Deutsch, 1969 cited in Ayoko et al, 2003). Task conflict is another type of conflict which can arise in the workplace. Ayoko et al (2003) cite several studies including (Amason and Schweiger, 1994; Deutsch, 1969 and Tjsovold, 1991) and explain that task conflict enhances the nature of the working relationship as it facilitates the process of exploring challenges on a practical level within the workplace that staff are faced with.

2.3.1.7 Working in the area of HIV/AIDS

In December 2008, antiretroviral treatment was being distributed to 1,77,808 children globally for the treatment of HIV/AIDS (Haldar and Reddy, 2009). Originally, nurses were not trained to give antiretroviral treatment to patients and now that is the most part of their HIV treatment work. In this way, many nurses feel incompetent in caring for HIV patients as the AIDS specific training they have received is insufficient apart from the deliverance of ARV's (Smit, 2005). As a result of this, nurses feel hopeless when caring for these patients (Lehmann and Zulu, 2005). Health professionals have expressed difficulties in coping with the evolving world of HIV care. These health professionals have struggled having to acquire

new skills and take on additional roles in ensuring this changing context (Yallop, Lowth, Fitzgerald, Reid and Morelli, 2002).

The issue of patient non-compliance to ARV medications is another stressor for health care professionals working in the field of HIV/AIDS. It is essential that patients maintain to take their ARV medication regularly otherwise the treatment becomes ineffective and the patient's viral load, which carries the disease, becomes active again. This will cause symptoms to recur and the patient will once again be infectious (Smit, 2005). In Botswana, particular barriers to the compliance of ARV treatment were identified. These barriers were cost of treatment drugs, travel distance to obtain ARV's on a regular basis as well as the accessibility to additional treatments for side effects that may occur as a result of the ARV treatment. These barriers are often the cause of patients' non-compliance to treatment and may contribute to increased patient loads for nurses in the treatment of HIV/AIDS (Weiser, Wolfe, Bangsberg, Thior, Gilbert, Makhema, Kebaabetswe, Dickenson and others, 2003). It can therefore be seen that HIV/AIDS nurses experience numerous stressors in the workplace.

The above section looked at work stressors identified by carers in the health care workplace, providing an understanding of some of the challenges they face. The following section will discuss personal stressors carers experienced outside of the workplace.

2.3.2 Personal Stressors

2.3.2.1 Lack of family time

As a result of work overload nurses felt guilty leaving their own children at home whilst working long, demanding shifts at the hospital. In this way the nurses felt that they were missing out on time with their children at home which added to the stressors they encountered at work, especially pediatric nurses who are the sole providers at home (Govender et al, 2006). Perhaps nurses would not be expected to work exceptionally long hours if their workload was manageable which would allow them to spend that much more time at home with their families. Emotional stress and fatigue was identified as a common problem experienced by healthcare workers caring for people living with HIV/AIDS. The physical and psychological exhaustion experienced is an all day occurrence for these healthcare workers (Smit, 2005). As a result of the totality of this exhaustion, it is likely to greatly impact on families in the home environment and further hindering their time spent together.

2.3.2.2 Stress in the home

A study exploring how outside stressors shape families' everyday lives and the relationship between work and family revealed that work and family stressors and experiences have the potential to negatively influence one another. The weight and impact of stressful circumstances can continue to affect those involved long after the actual situation has taken place. The reason for this is that one's responses and feelings in relation to stressors do not cease immediately and one continues to be affected for some time after. The impact of responses and feelings in relation to stressors have the ability to negatively affect circumstances in the workplace or the home environment, depending on which environment the feelings are carried over in to (Repetti, Wang and Saxbe, 2009).

Health care workers who continuously experience stressors outside of the workplace are also at risk for negative impacts on health and welfare (Repetti et al, 2009). In looking at South Africa, the issue of poverty is a very common social problem facing people living in South Africa, as is violence. Unemployment and abuse, such as physical and sexual abuse, and the abuse of alcohol and drugs are but a few of the additional social challenges facing people living in South Africa (Seedat, Van Niekerk, Jewkes, Suffla and Ratele, 2009). It can be deduced that health care workers in South Africa experiencing social problems are in danger of jeopardising their physical and psychological health.

The impact of work stress and burnout on life satisfaction was found to have a profound influence. Life satisfaction encompasses an individual's requirements and aspirations, both physical and mental in nature. Positive or negative shifts to an individual's personality or their surroundings may occur as a direct result on the impact of occupational circumstances. An individual may begin to perceive their circumstances in different ways as a result of the impact of stress and potential burnout (Rice, 1984 cited in Demeroute, Bakker, Nachreiner and Schaufeli, 2000). One may change their perceptions of themselves in terms of the different functions and responsibilities they assume and fulfil in their lives depending on the nature of occupational stress and burnout have on the individual (Biddle, 1979 cited in Demeroute, et al, 2000).

Current coping mechanisms that nurses have found beneficial in dealing with some of these stressors will now be examined.

2.4 Current Coping Strategies

Nurses use a variety of coping strategies to manage stress in the workplace. Four commonly used coping strategies are discussed below.

2.4.1 Detachment from patients

Emotional distancing or detachment is a common coping mechanism and symptom of compassion fatigue described by Boyle (2011) whereby working in a close proximity to patients experiencing holistic pain, are impacted by the patient's circumstances and struggle with this. As a result, the participants emotionally distance themselves by restricting and concealing their feelings in an attempt to protect themselves from the painful emotions this work exposes them to. Behavioural distancing displayed in the form of decreased social interaction and heightened feelings of irritation can be indicators of greatly impacting stressors (Repetti et al, 2009).

According to Govender et al (2006) a number of pediatric nurses try to detach themselves from the dismal circumstances with ill patients as a means of coping with unmanageable situations. The notion of detachment or distancing serves as a means of separating from feelings or circumstances that are difficult to cope with (Lazarus and Folkman, 1984).

2.4.2 Support groups

Support groups have been suggested as a method of intervention in the prevention of compassion fatigue. Support groups provide support and guidance and allow for the expression of feelings and a space for the resolution of problems (Boyle, 2011). The aim of a support group is to create a safe, supporting space whereby people can experience a sense of belonging. The support group is utilised as a means for its members to share their feelings, troubles and allow for problem solving. A support group for healthcare workers could create a space where the challenges and stressors that the staff experience can be shared and worked through in the group (Becker, 2005).

The recommendation that HIV/AIDS healthcare workers have an available support provided by an individual outside of their workplace was found to be very beneficial in ensuring confidentiality (Miller, 2000 cited in Becker, 2005).

Research done on boosting social support in the caregivers of children with HIV/AIDS suggested that social support provides protection to the caregiver in terms of stress as well as aiding their coping abilities in this area of work (Hansel, et al, 1999). The benefits of a bereavement support group for pediatric HIV/AIDS case managers and social workers in New York were found to be that the members were able to share their common stresses and emotional strains in the workplace. In this way, the group provided a collective support system for the staff. The aim of this particular support group was to help its members to cope with dying children in the workplace (Strug and Podell, 2003).

2.4.3 Environmental-personal approaches and external-internal approaches

Personal or internal approaches involve nurses using introspective thinking in gaining control over their stressors as opposed to environmental or external methods, which involve altering work circumstances in order to reduce stress and increase coping abilities (Gueritault et al, 2000).

Mimura and Griffiths (2003) discovered some nurses use environmental or personal approaches when attempting to cope with stress. This is similar to Gueritault et al (2000)'s findings of nurses using internal or external coping methods to deal with HIV care giving stressors. Both studies revealed that personal or internal approaches were more successful in coping and to some extent reducing emotional and occupational stress. Medeiros and Prochaska (1998) cited in McCann and Pearlman (1990) suggest 'optimistic perseverance' as a way of coping with victims of traumatic experiences. In this way, medical professionals take on a positive attitude when working with terminally or very ill patients.

2.4.4 Faith based coping

Recent research has examined the positive relationship between religious faith and both physical and mental health. In a study exploring the association between the strength of religious faith and coping with daily stress did not find religious faith to be associated in positively coping with daily stress (Plante, Saucedo and Rice, 2001). A study conducted in South Africa exploring the protective role in religion among African women in townships found that prayer helped to create an understanding of problems experienced, as well as acting as a protective factor from the harmful effects of stress as a form of buffering (Copeland-Linder, 2006). A third study exploring spirituality as a coping source interviewed professional African women who did not differentiate between spirituality and religion, found

prayer, meditation and inspirational readings to be helpful in coping with stress. The findings of this study revealed that the participants experienced either responding in a more productive way to stress or they experienced the change in the stress itself (Bacchus and Holley, 2004). The outcomes from these three studies reveal different views on the relationship between faith and physical or mental health.

2.5 Supportive resources currently available to healthcare workers

2.5.1 HIV/AIDS Education

The HIV/AIDS education that nurses received through training was a current resource used by nurses to aid them in caring for HIV positive patients. Healthcare workers in this field of worked received training on how to care for people living with HIV/AIDS (Smit, 2005). Educational programs that were provided for the healthcare workers on how to adequately care for HIV/AIDS patients better equipped the staff and helped to shift some of the negative perceptions they held towards HIV/AIDS patients. The importance of on-going training of caregivers and nurses in the field of HIV/AIDS should be noted by all management staff within organisations working in the field of HIV/AIDS.

In exploring occupational stress experienced by caregivers in the context of HIV/AIDS, it was found that with ongoing training caregivers felt more competent and confident in the interaction between themselves as patients. It was also found that with ongoing training, the caregivers became more knowledgably equipped to deal with the stigma that comes with working in this field. The caregivers also learned basic counselling skills which was beneficial to them in their interactions with paediatric patients and their families (van Dyk, 2007).

2.5.2 Social supportive behaviours

General systems theory is comprised of systems within subsystems whereby each system affects and is impacted by the other systems. These systems can be comprised of groups, families, societies, communities and biological systems and cannot exist alone as they are essentially complete parts existing within a greater system (Payne, 1994 cited in Payne, 1997). Informal, formal and societal are some of the ways that systems are categorised (Pincus and Minham, 1973 cited inn Payne, 1997). The notion of community psychology acknowledges entire communities as 'the client'. In this way community psychology

highlights the relationship between individuals and communities and the power that exists within this relationship to enable effective functioning and resolution of problems on a greater level (Seedat, Duncan and Lazarus, 2001). In the same way, general systems theory includes communities as one of the many systems that influences individuals and families and provide security, belonging and support to its sub-systems (Toseland and Rivas, 2001 cited in Becker, 2005). It can be deduced that the role of greater systems and communities play a significant and supporting role for individuals within them.

According to Mashlach, Shaufeli and Leiter (2000) cited in Hamaideh, et al (2008), guidance, emotional support and tangible assistance were identified as social supportive behaviours. In their study, emotional support was found to be the most common form of social support received by these nurses in the workplace. The notion of emotional support and counselling was suggested as a means to caring for the carer in the workplace. It was proposed that counselling ought to be available to caregivers for two reasons. Counselling should be available to caregivers who are working in a field that exposes them to HIV/AIDS and the death and dying of patients that they will likely face, as well as to safe guard them from physical and psychological harm (van Dyk, 2007).

Spirituality can constitute a system within general systems that surround and influences beliefs, values and norms on a community and individual level. In illustrating this, the role of spirituality within a social work workplace was explored through the establishment of spiritual support within Jewish family service agencies. Due to increasing and unmanageable workplace stressors, the healing circle, a support program, was established in order to provide support to human service professionals as it was identified that persons providing spiritual support to others, in fact need spiritual support themselves too. Through respecting spirituality, whether it is religion affiliated or not, evidence suggests that incorporating the role of spirituality in the workplace could aid in job contentment and work performance. It was found that including spirituality in the workplace created a holistic approach to coping with workplace stress and the social workers greatly benefitted from this approach (Sokoll, 2007).

The lack of social support amongst family and friends was revealed in a study that explored occupational stress experienced by caregivers working in the HIV/AIDS field in South Africa. Some of the participants were unsupported by family and friends due to the work they

were doing. Their families and friends did not approve of them working with HIV/AIDS infected people and just below 50% of the participants stated that their family and friends could not acknowledge and understand their workplace experiences. Lack of support experienced by these caregivers puts them at high risk of experiencing symptoms related to compassion fatigue and may even cause burnout (van Dyk, 2007).

2.6 Unmet Needs

Many studies have revealed a large number of unmet needs identified by nurses/caregivers caring for HIV positive patients. Three major needs have been identified. These needs are: for competent and further education of HIV/AIDS as an illness and how it affects patients. The need for education is vital, particularly with regards to knowledge around providing support to patients and their families. The second unmet need is for social support for nurses/caregivers as a form of debriefing and support. The third unmet need is for improved communication among all staff and particularly from managerial staff. These needs were identified by the following authors: Smit (2005); Lehmann and Zulu (2005); and Govender et al (2006).

In a study exploring nurses' job satisfaction, stress, and recognition in a paediatric setting, recommendations to ensure work satisfaction included: comprehensive support and educational programs, increase staff recognition in the workplace, ensuring that there is adequate staffing, clear communication and cohesion among the staff (Ernst, Franco, Messmer and Gonzalez, 2004).

2.6.1. Comprehensive HIV/AIDS education and training

Smit (2005) and Lehmann and Zulu (2005) both reported the needs of HIV/AIDS education for nurses in their respective studies. Smit (2005) found that nurses reported needing more thorough knowledge with regard to medically caring for HIV positive patients through respective educational programmes. Nurses from Lehmann and Zulu (2005)'s study expressed their need for skills training programmes to improve their expertise in this area.

A large portion of nurses expressed the need for adequate training in caring for infected patients and their families. These nurses reported feeling incompetent in their ability to provide patient and their families with emotional support (Lehmann and Zulu, 2005).

Paediatric nurses specifically, reported needing more education in caring for suffering children, in addition to providing the necessary support for the children's respective families. In this way nurses expressed needing to expand and improve on their supportive and interactional skills more (Govender et al, 2006). Directly linked to this is the need for these health professionals to be trained in palliative care as this could assist nurses in caring for HIV positive dying children in a holistic manner (Santucci, 2007).

The aim of paediatric palliative care is to improve the overall quality of life for terminally ill children. Palliative care takes on a holistic approach to caring for these children by incorporating physical, psychological and spiritual approaches to make them as comfortable as possible during the last stages of their illnesses. Due to the nature of the HIV illness, nurses often feel hopeless at not being able to cure HIV positive patients; thus if nurses are trained in pediatric palliative care they could provide other forms of support to patients in place of a cure (Malloy, Ferrel, Virani, Wilson and Uman, 2006). Palliative care would therefore provide patients with the necessary emotional and spiritual support as well as bereavement support for the families of these children which are very much absent (Rushton and Caitlin, 2002).

2.6.2. Adequate social support

Numerous types of social support have been identified as unmet needs. Some of these unmet needs are: social supportive behaviours in the form of counselling and support groups, spiritual support, family support, community support and the need for support from managerial staff in the workplace. This section explores the extent of the need for social support in the health care field and the impact that social support has on health care workers.

Nurses are struggling as a result of them not receiving much, if any support within the work place. This refers mostly to the lack of support from supervisors and managers as well as the absence of adequate debriefing and counselling services available to these carers (Lehmann and Zulu, 2005). Social support, identified as an integral factor in providing holistic care to patients. Furthermore, to enable the provision of this service it is imperative that nurses'/carers' needs are recognized and that their involvement is acknowledged (Hansel, et al, 1999). A recommendation for mandatory bereavement support groups to be put in place as a means to fulfil nurses' needs for support in the workplace allows for the mutual support of

fellow nursing staff guided by trained counsellors would enable nurses to work through their traumatic experiences with dying patients (Strug and Podell, 2003).

2.6.3 Improved communication

Communication problems have been deemed one of the most common problems and sites for conflict within the workplace. Communication errors and conflicts can arise at many intervals whether too much communication has taken place or too little communication (Robin, 2001 cited in Bergh and Theron, 2003). Communication within groups is typically affected by the role of the leader and hierarchy within the group. The impact this has on the group may negatively affect the group and its potential from problem solving and team work as the leader of the group commonly takes charge of the group. In groups within the workplace the leader may be a superior staff member in which case the hierarchy is in place and this has the potential to disregard contributions from staff in lower positions. The result of this is communication disregard, it generates stress amongst the staff and implies that they are unworthy of contributing (Homans, 1951). Poor communication was found to be one of workplace stressors. It can be concluded that there is an extensive need for improved communication in the health care workplace (Omadahl and O'Donnell, 1999).

2.6.4 Recognition

The theme of health care professionals feeling unacknowledged is a common finding of studies that explore job satisfaction within the health care field. In exploring nurse's job satisfaction, stress and recognition in a paediatric setting, recognition of nurses was one of the highest unmet factors in the study (Ernst, Franco, Messmer and Gonzalez, 2004). A study conducted in the United Kingdom exploring workplace stress in nursing found that the participants expressed discontent at the lack of appreciation they experience within the workplace (McVicar, 2003). This concurs that lack of recognition is a rife problem experienced by health care workers. The impact of positive elements of HIV caregiving is often overlooked due to the many negative impacts this occupation has on its staff. The impact of recognition of staff in this area of work has the ability to reduce the risk of burnout. Recognition from patients and management in particular, provides staff with a sense of acknowledgement, fulfilment and satisfaction. In this way the staff are able to perceive their work in a more positive light as opposed to only focussing on the negative implications (Bennett, Ross and Sunderland, 1996).

2.7 Conclusion

This chapter presented the literature review and provided background information on the circumstances experienced by nurses/caregivers caring for HIV patients. The following chapter discusses the methodology used in this study.

CHAPTER THREE

METHODOLOGY

3.1. Introduction

This chapter examines the research methodology used in conducting this study. The research design, sampling, data collection, data analysis and limitations of the study are discussed within this chapter.

3.2. Research Design

The research design of a study is the method of research that is used by the researcher in an attempt to carry out the study (de Vos et al, 2005). This study used an exploratory qualitative research design approach. Babbie and Mouton (2001: 270) explain the key objective of qualitative research design as being that of “describing and understanding”. This is illustrated in this study whereby it explores the challenges and stressors experienced by Cotlands Hospice staff in caring for HIV infants. Babbie and Mouton (2001: 270-273) further outline a number of significant elements pertinent to qualitative research design, these are “naturalism, process, insider perspective, description and understanding, contextual interest, inductive approach and intersubjectivity”. A qualitative research design is conducted to produce more in-depth, comprehensive information from its participants using subjective information and participant observation to describe the context, or natural setting, of the variables under consideration, as well as the interactions of the different variables in the context to gain a wide understanding of the entire situation (de Vos et al, 2005).

Qualitative research emphasises the importance of looking at variables in the natural setting in which they are found in order to describe and understand actions and or events being researched. The interaction between variables is important in this approach and detailed data is gathered through open ended questions that provide direct quotations where the interviewer is an integral part of the investigation. Qualitative data research is not designed to generalise its findings, but rather to contextualise the findings (Babbie and Mouton, 2001).

In the case of this study it was imperative that the data gathered is of a personal and detailed account of the experiences of the participants. The reason for this is that the aim of this study

was to explore the stressors and challenges experienced by nurses and carers at Cotlands; therefore a qualitative research approach was more preferable as opposed to using a quantitative approach in this case. The need for in-depth responses that could be explored further was imperative for the purposes of this study and a qualitative research design was the most appropriate design for this study as it encompasses all of the desired characteristics needed for this research. It is not imperative that the findings of this study are generalised as this research is only exploring nurses and carers within a particular context that is Cotlands, in caring for HIV infants (de Vos et al, 2005).

3.3. Sampling

Qualitative sampling was used in this study as the research design was qualitative in nature. Sarantakos (2000) cited in de Vos et al (2005) describes qualitative sampling as being unrepresentative of the general population, no particular sample size, lower in cost and somewhat restricted. Non-probability sampling is the most commonly used sampling technique. According to Babbie and Mouton (2001), non-probability sampling is a method of sampling that does not make use of random selection as the research has a particular purpose in mind. The most appropriate type of non-probability sampling for exploratory studies is purposive sampling.

Purposive sampling selects participants that are most representative of the respective group of people that will provide the most informative responses in relation to the area of interest of the study (deVos et al, 2005). The sample of this study was made up of both nurses and carers working in the hospice wing at Cotlands. Staff members from only the hospice wing were selected for the sample because these nurses and carers are the staff members that experience the most intimate contact with these infants. The sample consisted of 15 female staff members in total as qualitative research generally selects a relatively small sampling group (de Vos et al, 2005). All of the staff members caring for the infants were female as there were no male staff nurses or carers. These nurses and carers were informed of the aim, ethical considerations and procedure of this research. This was done verbally by the researcher explaining the above implications and the participants verbally consenting to participate in the study. Consent was also documented by the participants whereby they each signed an informed consent document. The verbal and documented consent confirms that the participants voluntarily agreed to participate in the study (Appendix B).

3.4. Pilot Study

According to de Vos et al (2005) the purpose of a pilot study is to conduct the research design for a probable study in an attempt to evaluate its feasibility. The pilot study enables the researcher to identify areas that may have previously been unclear or overlooked. A very small number of participants, characteristically similar to those that are used in a secondary study are selected for a pilot study. For this research a pilot study was conducted to evaluate the feasibility of this research. For the pilot study 2 participants, a nurse and a caregiver, were interviewed to test the semi-structured interview, the questionnaire, and the digital voice recorder.

3.5 Data Collection

3.5.1. Data Collection Method

De Vos et al (2005) expresses the use of interviewing as valuable data collection method in that it allows the respondent to express their experiences that engages both the participants and researcher as well as having the potential to open up interaction. The process of qualitative interviewing allows for the participants to mostly guide the interview, yet allowing the researcher to further explore relevant areas. In addition to this, the awareness of low levels of literacy in South Africa further motivates for the preferred use of interviewing in the case of this research study (Babbie and Mouton, 2001)

De Vos et al (2005) identifies semi-structured interviewing as being a beneficial data collection method when the research relies on personal accounts and or experiences as the main source of data. The nature of this research was dependent on the experiences of the nursing staff and carers at Cotlands. One-to-one semi-structured interviews focus on the respondent's perceptions and semi-structured interviews guide the direction of the interview, yet allow for flexibility of the semi-structured interview schedule. Semi-structured interviews allow for the participants to be seen as professionals as they predominantly guide the direction of the interview through their responses (Babbie and Mouton, 2001).

In this study the qualitative research design technique of one-to-one semi-structured interviewing was used to explore nurses and carers perceptions of stressors and challenges, current coping strategies, supportive resources and unmet needs. In-depth interviews are best used to explore these objectives as interviews allow participants the opportunity to relay their

detailed views, experiences and feelings around these issues. In this way the researcher obtains richer data which provides him or her with a better understanding of the problem (de Vos et al, 2005). The sequence of the semi-structured interview schedule questions is important as well as identifying the sensitive areas of the interview and the addition of the literature review aids the researcher in the direction the interview schedule should be taken (de Vos et al, 2005). Fourteen semi-structured interviews were conducted with both nurses and carers in the hospice wing at Cotlands. Each interview was between 30 to 40 minutes long as the nurses had limited time due to work constraints and responsibilities.

3.5.2. Data Collection Instrument

A semi-structured interview schedule was used to provide an outline of the areas underlying the topic of the research. Holstein and Gubrium (1995) in de Vos (2005) explain that the semi structured interview schedule provides the researcher with preset questions that allows for the respondent to expand on through providing more detailed accounts of subjective experiences. The semi-structured interview schedule explored respondent's perceptions with regard to resources available to them, their respective coping mechanisms as well as identified unmet needs. De Vos et al (2005) explains how it is useful for the researcher to become acquainted with the relevant literature around the topic that is being researched in order to assist them in asserting which areas or issues that arise during the interview are relevant to explore and that will ultimately aid in gaining clear, expansive data. In order to do this the researcher read journal articles, books and statistics in order to be able to gain sufficient background knowledge of this field.

From the researched literature the researcher was able to identify key areas essential to the research of this study. This enabled the development of the outline for the semi-structured interview schedule. These key areas were identified as being pertinent to the exploring and the understanding of the relevance of this study. These key areas were profiles of the participants, experienced stressors, coping with stressors and support systems. These four key issues outlined and guided the semi-structured-interview (See Appendix: A).

3.5.3. Data Collection Apparatus

A digital recording device was used to record these interviews. Smit (1995) in de Vos et al (2005) explains that a data recording device allows for a more detailed and accurate account

of recording interviews. This improves the reliability and validity of the data gathered. The digital recording device was chosen as the preferred method of data collection apparatus for this study. This type of data collection apparatus enabled the researcher to obtain all of the data from the interviews and to be able to replay them in an attempt to improve reliability of the transcriptions and furthermore provide adequate data analysis. The use of a recording device as opposed to writing notes during interviews allowed the researcher to maintain focus on the respondent and the content of the interview thus allowing for appropriate responses and pursuing of pertinent issues on the part of the researcher.

3.5. Data Analysis

According to de Vos et al (2005), data analysis is whereby obtained data is organised and restructured. Once all of the interviews had been conducted, the recorded interviews were transcribed and then analysed according to the steps for analysing qualitative data devised by Tesch (1990). Transcribing interviews involves converting spoken words (the recorded interview) into written words. The interviews were transcribed by the researcher and arranged into themes, categories and sub-categories according to Tesch (1990)'s eight steps for data analysis as follows:

- i. The researcher familiarised herself with the transcriptions and paid close attention to patterns and similarities across the interviews.
- ii. The researcher went through each transcription and made notes of the interview in relation to emerging themes.
- iii. The researcher then repeated steps i and ii for all of the transcripts. The researcher then listed the topics, themes, categories and sub-categories.
- iv. The listed topics were coded and divided up categorically. Additional categories that emerged were added into the existing structure.
- v. The researcher selected the most appropriate description for each theme, category and sub-category that most accurately described what each section contained.
- vi. The researcher made decisions regarding the categories and arranged them alphabetically.
- vii. All the data the applied to a particular category was collated and analysed. This was done for every category and ultimately created the initial analysis.
- viii. The researcher had to recode any existing data where it was necessary.

3.6. Limitations

The limitations of this study pertain to:

3.6.1. Research Design

A qualitative research design was chosen for this study as subjective experiences of the participants were necessary to explore of the problem being researched. According to de Vos et al (2005) a limitation of qualitative research is that the findings from that research cannot be generalised to the larger population. For this particular research the findings did not need to reflect that of the general population, but rather the subjective experiences of the participants.

3.6.2. Data Collection Approach

The data collection approach used here was that of one-to-one semi-structured interviews. De Vos et al (2005) describes how interviewing provides rich, in-depth data. The limitations of this data collection approach is that interviews are very time consuming, not only for the researcher, but also for the participants who agreed to participate in the interviews during their break time. Despite this limitation the participants were able to be present for the duration of the interview. Night shift staff were also interviewed to ensure an all round understanding of the nurses and carers involved. The night shift staff were only available late in the evenings to be interviewed once all of the infants were asleep. The researcher explained the confidentiality aspect of the study and best attempted to ensure that the participants felt as comfortable as possible. This was done to limit the participants feeling the need to respond untruthfully out of fear or uncertainty in relation to the study and the expectations of their participation and resulted in detailed, emotive responses.

3.6.3. Data Collection Instrument

According to de Vos et al (2005) the limitations of using a semi-structured interview schedule are related to the validity and reliability of this data collection instrument. In this way researchers may focus too rigidly on the semi-structured interview schedule thus over looking important issues or areas raised by the participants. The researcher followed the semi-structured interview schedule as a guide and remained flexible in exploring relevant topics raised by the participants.

3.6.4. Data Collection Apparatus

The researcher used a digital recording device to record all of the interviews. A limitation of a digital recording device is that some participants may feel uncomfortable being recorded and even participants that consent to being recorded may continue to feel uncomfortable thus impacting on their responses (de Vos et al, 2005). The researcher ensured that the recording device was placed close to the respondent without making the respondent feel uncomfortable. In addition the researcher reminded each respondent about continuing to adhere to confidentiality during the interview.

3.6.5. Data Analysis

De Vos et al (2005) explains the limitation of data analysis is that it is largely time consuming and needs to be done correctly to ensure the outcome of accurate results. The researcher began transcribing the interviews as soon as they had been completed and adhered to the appropriate steps of data analysis outlined by Tesch (1990).

3.6.6. Researcher

Researcher bias is a limitation on the part of the researcher within a conducted study which has the potential to alter the results and outcomes of the research being conducted (de Vos et al, 2005). The researcher of this study maintained an open-mind and non-judgmental attitude to the study as well as to the participants which controlled for researcher bias throughout this study.

3.7. Conclusion

This chapter discussed the components of the methodology of this study, comprising of the research design, sampling, data collection, data analysis and limitations. The penultimate chapter presents the findings of the study.

CHAPTER FOUR

RESEARCH FINDINGS

4.1 Introduction

The penultimate chapter presents the findings of the study. It firstly presents a profile of the participants in the form of a table. A framework for the findings provides the themes and categories of findings by using the research objectives provided in Chapter One. A discussion of the findings using the research objectives as headings is then provided. Some concluding remarks complete this chapter.

4.2 Profile of Participants

The following table presents a profile of the participants.

Table 1: Profile of the participants

Respondents	Gender	Marital status	Household members	Nature of the relationship of household members	Residing area	Training or working experience in the field of HIV	Length of time at Cotlands
1	Female	Married	Husband & 2 sons	Good	Grabouw	Basic HIV training	3 years
2	Female	Single	Interns from Germany	Good	Somerset West	Basic HIV training	9 weeks
3	Female	Divorced	2 children	Good	Macassar	HIV Counselling & basic training	2 years
4	Female	Married	Husband & 2 children	Complicated	Eersterivier	HIV Counselling & HIV medical training	4 months
5	Female	Married	Husband, 2 children & mother-in-law	Complicated	Eersterivier	Basic HIV training	7 years
6	Female	Married	Husband & 3 children	Good	Mascassar	Home based carer training & basic HIV training	1 & a half years
7	Female	Single	Sister	Good	Khayalitsha	None	2 years & 6 months
8	Female	Single	Mother, sister & 2 sons	Good	Macassar	Community care, palliative care & holistic care	2 years
9	Female	Married	Husband, daughter & grandchild	Good	Macassar	HIV medical training	7 years
10	Female	Single	Mother, uncle & 2 children	Good	Grabouw	HIV Palliative care training	3 years
11	Female	Married	Husband & 4 children	Good	Macassar	Basic HIV training	7 years
12	Female	Single	2 children	Good	Macassar	Basic HIV training	2 years
13	Female	Single	2 children	Good	Grabouw	College basic HIV training	3 years
14	Female	Married	Husband & 3 children	Good	Strand	Basic HIV training	5 years

4.3 Framework for discussing findings

The following table presents a framework for the discussion of findings.

Table 2: Framework of findings

THEMES	CATEGORIES	SUB-CATEGORIES
Nature Of Stressors Or Challenges Experienced	Work Stressors	Salary concerns Working conditions Conflict among staff Fear of contagion Death and dying of infants Administering of Antiretroviral Treatment
	Personal Stressors	Stress in the home Awareness of human vulnerability Lack of family time
Current Coping Strategies	Faith and prayer	Prayer
	Detachment from patients	Emotional distancing Behavioural distancing
AVAILABLE RESOURCES	Internal staff support	Managerial support Spiritual support and counselling
	External support structures	Family Community
UNMET NEEDS	Counselling	Group counselling
	Improved communication	
	Additional training	
	Additional recognition	

4.4 Discussion of Findings

The findings of this research will be presented in relation to the research objectives of this study.

4.4.1 Nature of Stressors or Challenges

The findings of the nature of challenges or stressors experienced by the participants reflect a wide range of concerns for the participants within the work environment as well as outside of the workplace. These stressors encompass areas such as financial, relational, familial, social and health challenges.

4.4.1.1 Work Stressors

This section will explore the work stressors experienced by the participants. The first work stressor to be explored is that of participants' salaries.

4.4.1.1.1 Salary Concerns

A large component contributing to work stress expressed by the participants is their concern around salaries. The finding indicates that participants feel frustrated and that they are being underpaid, particularly because sometimes they have to work longer hours than required. Participants also felt that their salaries did not take into account increasing costs of other basic needs.

Respondent 1: “ *mainly the money because we do a lot of work, okay it's our job but they don't recognise us...the work gets more and more and the money stays the same*”.

Respondent 13: “*you can imagine there's a lot of work for that little salary and it's not going to work, because if we are sad the children's also going to be sad because they feel all that stress. They want us to give them, they must give to us. Like last year we had a lot of stress, we were angry, talking about these people, there's a lot of work but they don't want to pay. The transport he's getting, he wants to get paid more and it's going up because he said the oil is going up and we don't get an increase...everything is getting expensive*”.

The participants felt very strongly that they are being underpaid for the work that they are doing and particularly the hours of work that they complete. The issues highlighted concur with findings that low salaries in South Africa have been the cause of nursing staff having gone in search of better paid work in the health sector in other countries (Meeus and Sanders, 2003 cited in Smit, 2005).

4.4.1.1.2 Working Conditions

The conditions that the participants work under are experienced as difficult due to various challenges they face in the workplace. The challenges they experience are an unmanageable workload due to staff required to be responsible for more infants than is realistic and understaffing which is directly linked to an unmanageable workload. In addition, working in the face of very ill children on a daily basis and at times being faced with death too has been deemed highly stressful. This can be seen through the following.

Respondent 6: *“It was a child who came here last week, wade is his name, he was abused, it was terrible to see that, the father abused him, he was 1 year, he was not really 2 yet but his father abused him maybe a long time, I don’t know exactly, but that thing oh I was sick after that”.*

Respondent 1: *“the workload...it’s a bit too much sometimes”.*

An unmanageable workload as well as the emotional nature of this work is what the participants expressed great difficulty with. Due to the disproportionate ratio of staff to children it was found that health care workers at times felt inadequate in their jobs. The issues highlighted concur with additional research which identified insufficient time as the difficulty in providing the holistic care these children need as a direct result of case overload (Foxall, Zimmerman, Standley, Bene, 1990 cited in Lambert and Lambert, 2001).

The working conditions described by the participants are undeniably the groundwork for the development of occupational stress as it is identified as the responsibilities and requirements placed upon an individual exceeding the tools provided for them to manage the given tasks (Cox, et al, 1993 cited in van Dyk, 2007).

4.4.1.1.3 Inter-staff Conflict

A number of the participants expressed their dissatisfaction with the high rate of conflict taking place between staff members. The main concern for the participants in relation to this stressor was the negative impact they felt that inter-staff conflict would have on the infants. It was the belief that the children would sense the unrest amongst staff which would in turn upset their temperament. This concerned the participants as it upsets them greatly if the children are upset. The following express these concerns.

Respondent 6: *“Sometimes we not getting along, everyone is not happy that day and they stress out again out of nothing”.*

Respondent 9: *“Sometimes there a lot of problems between the staff, amongst the staff, the complaints and whatsoever...because if we are not working you can see it immediately, and has an effect on the children. You can see that the children is not the same. They are stressed.*

They are irritable but then you can relate it to the staff because you know somewhere the staff is not”.

Organisational conflict in the workplace may arise due to differences in individuals’ values, views, working style and low resources and may present in the form of negative behaviours and feelings. Interpersonal conflict in the workplace, particularly among employers and employees, is one of the most common types of conflict (Bergh and Theron, 2003). The issues highlighted concur with the findings from the study in that interpersonal conflict among employees continues to be a major problem in the workplace. In such cases conflict among staff needs to be addressed urgently as it can negatively affect cohesion among colleagues which in turn could impact on the functioning of staff in the workplace as well as the quality of patient care (Ross, 1989; Pelled, 1996 cited in Ayoko, Callan and Hartel, 2003). Conflicts should not remain unresolved to prevent the development of anguish and non-attendance among staff (McVicar, 2003).

4.4.1.1.4 Fear of Contagion

Some of the participants expressed their fears around contracting HIV through their close work with the HIV positive infants. A number of the participants are very wary of the cautions that need to be put in place to prevent contraction of the virus. The findings also highlighted the participants’ knowledge of protecting oneself and the potential impact that contracting HIV could have within their respective families, which can be identified here.

Respondent 2: *“first of all of course being careful, you have to be careful. My mom took me to a doctor who told me in Austria before to be careful and what to do in a situation...”*

Respondent 6: *“Sometimes when the children bleed and they’re HIV positive and you’re afraid you can open and you can get...you must look after yourself and not take it home. If I got HIV positive my husband would be angry”.*

The findings reveal that the nurses are well educated on prevention of HIV contraction as opposed to findings in Smit (2005), whereby they found health professionals to be ill equipped with preventative materials. Thus we can see that the participants have perhaps been better educationally and practically prepared than other persons in this field of work

between the year 2005 and 2010. This improvement in knowledge and education can be seen to be major advancement in the evolving context of HIV and AIDS.

4.4.1.1.5 Exposure to the death and dying of Infants

Almost all of the participants expressed having been affected by the death and dying of infants in some way. Some of the participants spoke first hand of their experiences of the death of children due to HIV and how they have struggled to process the loss of these children. The death of infants has traumatised some of the participants, however; there was mention by some of the decrease in numbers of children dying from HIV since the availability of antiretroviral medication and that they experience fewer infant deaths.

Respondent 2: *“The sister told us when we came in please don’t believe people who say the medication doesn’t work. You see the pictures on the wall there, I said yes, and she said this year 2 children died. Before we had medication about 85 children died a year”.*

Respondent 5: *“In the beginning when I started here there was a lot of children, also a lot of children die when I was here because I came January but the previous year the place was open so most of the children I know. But it’s sad. You get used to the child. Because I remember I was working, it was night shift, so I didn’t know what was wrong with the baby so I pick up the baby and I took it to the staff nurse and I ask her what is happening to this child, and she said no the child is dying and the child died in my arms. It was just a small baby. But I wasn’t like shocked because that time I know that the child was sick”.*

The findings of this research indicate that health care staff has struggled over time to cope having experienced the death and dying of patients in the workplace. Evidence revealing that as a result of exposure to death and dying of infants, caregivers experience grief, sorrowful feelings and even present with somatic symptoms reinforces the reality of these experiences for the participants (Pakenham, et al, 1995). Compassion fatigue may be a direct outcome of the exposure to the death and dying, particularly where staff support is absent in the workplace (Boyle, 2011). Since the introduction and distribution of ARV’s findings by van Dyk (2007), Lambert and Lambert (2001) and Mc Vicar (2003) have supported the notion that there has been a decline in infant mortality as the findings of this study have revealed too.

4.4.1.1.6 Administering of Antiretroviral Treatment (ARV)

The participants expressed that they experience challenges in administering ARV's to those children who receive them. These infants refuse to take the medication and they dislike it, which becomes a time consuming process for staff to administer this medication. The children need to be comforted by the staff in order for them to take the ARV's. As tough a task as this is, it is crucial for these infants to take the medication in order to prevent the HIV infection from progressing.

Respondent 2: *“they get it with a syringe. The kids that get the medicine that tastes ok they drink it very fast it's not a problem for them, but the kids who get the HIV medication it seems to taste really, really terrible and its always a fight”.*

Since the introduction of ARV's, the administering of this medication has become a large part of the responsibility that health care workers working in the field of HIV/AIDS have had to take on. Smit (2005) found that some nurses felt out of their depth as many of them had not received ARV training as it was not yet a component of their original training; however the participants responsible for the administering of ARV's in this study at Cotlands, reported that their difficulty was rather getting the children to physically take the medication as opposed to not having the relevant training.

The stressors identified by the participants provides an understanding of the challenges they face in the workplace. The personal stressors experienced by the participants are explored below.

4.4.1.2 Personal Stressors

Personal stressors refer to those challenges that participants experience outside of the working environment and are usually affected by or impacts on family or home environments. Examples of these personal stressors are stress in the home, working circumstances affecting their personal life as well as insufficient family time.

4.4.1.2.1 Stress in the home

The participants expressed many feelings around stress in the home. Some participants' stressors were around finances and the concern about being the breadwinners at home. The participants' profiles reflect that half of the participants have a husband or partner living with

them. The other half of the participants are the sole providers of their household in supporting their children as well as other unemployed persons living with them. Family conflict, sometimes linked to unresolved family conflicts and substance abuse such as excessive alcohol consumption in families were some additional factors contributing to the participants' stress.

Respondent 6: *“sometimes my husband take a beertjie, but at the moment he didn't drink a lot anymore. But he was drink and I was worried when I finish here, I was a little bit stressed out, when he comes with a bakkie to fetch me. So when one of the staff members said there's a car then I can relax now, I'm not worried”.*

Respondent 12: *“sometimes it's financial problems because I must pay for everything. I don't get any support from anyone. I must suffer on my own...because my baby's going to high school next year and then I must pay all that money and I'm very stressed about that”.*

Reviewing the relationship between work and family, it is unavoidable that both work and family have the potential to negatively influence one another. Outside stressors shape families' everyday lives and the weight and impact of stressful circumstances can continue to affect people long after the actual situation. The reason for this is that people's response and feelings in relation to the stressor do not cease immediately (Repetti, Wang and Saxbe, 2009). In this way it can be understood how stressors in the home and personal lives of the participants are nearly impossible to disengage from within the workplace.

The high prevalence of social problems such as poverty and substance abuse have been highlighted as hugely problematic challenges facing people living in South Africa (Seedat, et al, 2009). Many of the participants are faced with multiple social problems and have expressed the immense strain it puts on them and their families.

4.4.1.2.2. Awareness of human vulnerability

A number of the participants mentioned that the work they do often forces them to think about their own children in the situations these ill infants are in. This echoes the reality of what they face in the workplace and makes them grateful for having healthy children. It also emphasises for them that life is precious; thus making them aware of the reality of the work they do.

Respondent 10: *“you just thinking you so glad your child is fine and so on. Now this one didn’t really get a real chance in life”.*

Respondent 11: *“I thought yesterday that could have been my child also but I must be strong because this is the work that I want to working with children”.*

The impact of stress and burnout has the ability to influence ones perceptions of themselves and their surroundings (Rice, 1984 cited in Demeroute et al, 2000). This can be done through critically assessing oneself in relation to the various functions and responsibilities we assume in our lives (Biddle, 1979 cited in Demeroute et al, 2000). Although Demeroute et al (2000) allude to work stress and burnout generally resulting in life dissatisfaction, the influence that health care staff experience as a result of work stress and observing the impacts that HIV/AIDS has on families may result in the perception that some of the participants have expressed in the form of positive life satisfaction. The participants described this as gratitude for the health and wellness of their own children.

4.4.1.2.3 Insufficient family time

Participants expressed having insufficient time to spend with their families due to the long working hours they experience. In particular the participants expressed concern around having minimal time available to spend with their children. As a result of this, the participants reported experiencing feelings of inadequacy in providing appropriate parenting and involvement in their children’s daily activities such as assisting with homework and spending quality time with them over weekends or in the evenings. In this way the participants are continuously worrying about their own children in addition to their concerns for the ill infants in the workplace.

Respondent 8: *“Sometimes I feel like I don’t have enough time to help him with his homework. I always have to ask my sister to help him, I don’t have time or my mom needs to help. Sometimes I just feel like I don’t do enough, and this year was the first year that he didn’t get a certificate or a diploma at school, and I feel like it was my fault because it was a very rough year we had”.*

Respondent 11: *“its exhausting. When I’m off for the 2 weeks i must take the child to school, fetch him at 13h00. Weekends it’s the same, its soccer watching. I must get some time off”.*

Long shifts and unmanageable workloads contributed to staff having insufficient time to spend with their families. Time missed out on with their own children was found to contribute to the stress that these staff members brought into the workplace (Govender et al, 2006). This echoes the participants' feelings of guilt for only being able to spend short amounts of time with their children which gives rise to feelings of inadequacy as mothers.

It can be seen that nurses and carers at Cotlands experience a multitude of stressors in relation to the workplace as well as personal stressors. It is essential to therefore explore the respondent's current coping strategies to ascertain how they cope with the above mentioned stressors.

4.4.2 Current Coping Strategies

This section explores the various types of coping strategies utilised by the participants as a means to coping with experienced stressors.

4.4.2.1. Faith and prayer

4.4.2.1.1. Prayer

Having faith in a higher power has provided participants with a great deal of comfort and support. Through this faith, prayer allows for the participants to share their feelings around the stresses and challenges they encounter and thus feel empowered to face these challenges more positively.

Respondent 1: *“just give my problem to the lord. Its all i can do.”*

Respondent 6: *“when I get stressed then I think to myself no one can help me. My lord is here. He really is...in our home we can't speak out.”*

The participants expressed that a lot of the time they can only pray in times of stress, particularly when expressing ones emotions is considered unacceptable either in the home environment or even in the workplace. These participants reported benefitting from prayer as well as having strong faith in that a higher power will protect them. A South African study found that prayer helped as a form of a coping mechanism in various ways. The finding of the study revealed that prayer helped to create an understanding of problems experienced, as well as acting as a protective factor from the harmful effects of stress (Copeland-Linder, 2006).

The findings of this research revealed that some of the Cotlands staff experience great comfort through prayer which concurs with the outcome of the South African study with women living in the townships.

4.4.2.2 Detachment from patients

Participants distance themselves as a way of coping with uncomfortable feelings and situations. Two types of distancing were identified through the participants' current coping strategies. The two types of distancing were emotional distancing and behavioural distancing.

4.4.2.2.1 Emotional distancing

The participants expressed the importance of not becoming emotionally attached to the babies which in turn results in them distancing themselves emotionally. Many of the participants referred to them cutting themselves off emotionally in their work. It appears the participants feel ill equipped to cope with and process their emotions effectively and as a result respond in this way.

Respondent 5: *"I give them attention but I just cut myself off. It's too difficult."*

Respondent 13: *"The biggest challenge is that you don't have to get attached that much. But all they want is love."*

This type of distancing has been found to be a common means of coping for health care workers. This is achieved through detaching oneself from the feelings that go along with various circumstances (Lazarus and Folkman, 1984). Emotional distancing or detachment is a prominent symptom of compassion fatigue described by Boyle (2011) whereby working in a close proximity to patients experiencing holistic, pain feel vicariously affected by the patient's circumstances and struggle with this. As a result, the participants emotionally distance themselves in an attempt to continue with their work and to protect themselves from the painful feelings this exposes them to.

The findings in conjunction with the profile of participants indicate that those participants who have been working at Cotlands for the longest period of time were those participants who expressed coping by means of distancing. Such is the case for respondent 5 and respondent 13 who have both been working at Cotlands in the field of infant HIV for seven

years and three years respectively. It can be concluded that particular participants are more prone to the development of compassion fatigue than others as distancing has been identified as a common symptom of compassion fatigue (Boyle, 2011).

4.4.2.2 Behavioural distancing

A number of the participants reported that they distance themselves by physically removing themselves from the presence of whomever or whatever the stressful situation is at the particular point in time. Most of these participants also reported smoking during these times as an attempt to 'de-stress'.

Respondent 8: *"I would go outside and sit on the couch and light a cigarette and just breathe...at home I would just go somewhere. Me I would just get dressed and go somewhere quiet."*

Respondent 12: *"Then I go outside. I say I'm coming and then i go outside...i go smoke. I take a smoke break and then I go sit and relax there."*

Changes in social behaviour such as a decreased social interaction, a sudden reluctance to expressing themselves and heightened feelings of irritation can be indicators of greatly impacting stressors (Repetti, Wang and Saxbe, 2009). The coping strategies described by some of the participants in an attempt to distance themselves from various stressors, concur with the findings of the study by Repetti, Wang and Saxbe (2009). The use of substances such as smoking cigarettes was described as a common behavioural symptom of workplace stress in an attempt to relax which is ultimately what the participants from this study have hoped to achieve through this behaviour (Lambert and Lambert, 2008).

The coping strategies identified as helping behaviours by the participants, provide insight into the methods of coping strategies they are currently using. The coping strategies used by the participants appear to be unable to diminish or resolve their stressors in the long term. This can be seen in that the stressors continue to resurface. Additional supportive resources that are available to assist the participants need to be explored. Further supportive resources available to the participants both inside and out of the workplace will now be reviewed.

4.4.3 Available supportive resources

The participants were able to identify supportive resources available to them both inside and out of the workplace. These resources offer support from various people and systems which assists these staff members in coping during stressful times.

4.4.3.1 Support in the workplace

Support in the workplace was identified as that of managerial support, co-worker support and various forms of counselling. The participants have highlighted these supportive resources as those they have found helpful in coping with stress.

4.4.3.1.1 Managerial support

The majority of participants felt they received a great deal of support from the staff nursing manager who they feel is approachable and understanding. Support provided by the facility manager and human resources was only mentioned by two participants who experienced them as an active support.

Respondent 14: *“The manager of us, the supervisor, Sister Lynette and Monica of course and the human resource lady, they provide help for us.”*

Respondent 10: *“The support is okay here. The staff nurses, and if you’ve got a problem you go to them and they listen and they will give you advice.”*

Respondent 11: *“Staff nurse does everything to see that we get support, and we work as a team.”*

The findings from this study revealed that a number of the participants felt comfortable to approach and reported having had approached managerial staff in an attempt to resolve any difficulties they experience. This would have a positive impact in that it allows for the expression of feeling and thoughts. The expression of feeling and thoughts, particularly negative in nature, is one way of preventing and counteracting compassion fatigue. This concurs with an attempt to reduce and eliminate the symptoms and effects of compassion fatigue, the establishment of support systems is a crucial element of this process. The element of encouraging staff to express their feelings and not to withhold them is an attempt at the prevention of compassion fatigue (Joslyn, 2002).

4.4.3.1.2. Spiritual support and counselling

Some of the participants made mention of spiritual support and counselling that is available to them in the workplace. These participants felt that this support was very beneficial to them. The emotional support of the social worker and the spiritual support of the spiritual volunteers have helped the participants to feel supported, particularly around issues of death and dying of patients.

Respondent 3: *“we do get spiritual attention...a volunteer and her husband they come and then they do spiritual work with the carers...and then we do have meetings that we can talk about things that are not right.”*

Respondent 5: *“...when one of the child’s is dying you know or died then the social worker comes to talk to us, and we go into the board room and they ask us how we are feeling, then we must talk about what happened and how did we feel about that child.”*

Respondent 9: *“...they give support to the staff, they give a lot of support to the staff like people that they bring in for death and dying or bereavement. Just for relaxation. They bring a lot...if I ask if there’s someone that I can talk to and I go to them and talk to them and say i want to talk to them then they organize....the only counselling is when there’s someone who’s dying or something particular is happening. Like when one of the staff has passed away then or something with the staff then you see they bring.”*

Literature exploring occupational stress has proposed that counselling is to be offered to carers in the context of caring for HIV/AIDS patients and that counselling will benefit carers in coping with the death and dying of infants, as well as the stressful nature this context of work exudes (van Dyk, 2007). The issues highlighted by the participants in how counselling has helped them to better cope, concurs with the findings that propose to implement counselling in the workplace for improved emotional support.

It has been identified that participants benefit from the spiritual support that is currently available to them in the workplace. The opinions expressed by the participants concur with the findings that persons in the caring profession can benefit greatly with the assistance of spiritual support. Spiritual support creates a holistic approach to coping with workplace stressors and it also has the potential to improve contentment and performance in the workplace (Stokoll, 2007).

4.4.3.2 External support structures

The two most prominent support structures identified by the participants were those of family and community. One can gauge to some extent what family relationships are like for these participants as well as what a prominent role the community plays in the lives of these women.

4.4.3.2.1 Family

It is interesting to note that despite some participants identifying a number of family stressors contributing to their already challenging jobs; some participants identified their entire family as being supportive of them and willing to listen to them. Other participants mentioned one particular person in their family who serves as their confidant. Many of these participants expressed how fortunate they are to have supportive people in their lives. Thus it can be seen that even though there are challenges in the home; some of the families still provide a great deal of support and comfort for the participants.

Respondent 3: *“I have a very close family. I have a brother who is reborn, and reborn, and reborn over and over. It’s the whole family and we’re very supportive.”*

Respondent 10: *“Like I will turn to my father because me and he we got a very good, a special relationship with each other, and if I got a problem I will go to him...”*

Many of the participants expressed that their families have been very supportive of them in their field of work. In a South African study it was revealed by caregivers working in the field of HIV/AIDS that a percentage of them were not supported by their families or friends, and they have felt as though no one understands them and the work that they do (van Dyk, 2007). The issues of the study just discussed, conflict with the findings of this research.

4.4.3.2.2 Community

The findings revealed the communities of the participants as an external source of support for many of them. Supportive structures within the community were provided by churches, supportive neighbours and friends, as well as support from schools in the area. These support structures provide a great deal of joy, hope and guidance to these women as well as providing them with a sense of belonging, reinforcing that they are not alone in their struggles.

Respondent 9: *“I have support from my church, I have support from the community.”*

Respondent 12: *“Sometimes my friends. I talk a lot with my friends and then she always gives me advice and then I feel again I can do something or whatever because she gives me sense that I must do this, I must do that...”*

The role of the community has been identified a supportive and influencing structure in relation to individuals (Seedat, et al, 2001). Communities provide individuals with a sense of belonging and security and from this identification, values, norms and beliefs can develop (Toseland and Rivas, 2001 cited in Becker, 2005). In viewing these understandings of community, the support the participants receive from their communities can be greatly valued.

Various supportive resources were identified as being available to the participants. These supportive resources, be them in the workplace or in their personal lives have enabled the participants to continue doing their jobs in spite of the many stressors they encounter. Needs that participants felt had not been met are discussed below.

4.4.4 Unmet needs

Four main needs that participants felt had been unmet in relation to their workplace and their nature of work. These needs were identified as being counselling, improved communication with managerial staff and colleagues, additional training/education and shown appreciation and adequate social support.

4.4.4.1 Counselling

A few participants suggested that counselling was not effectively provided to them. The majority of the participants identified group counselling as a potentially effective support within the workplace.

4.4.4.1.1 Group counselling

Many of the participants suggested group counselling. Elements of focus groups and support groups were felt to be the most helpful in terms of support that could be provided in the workplace. Through means of a group, the participants would be able to express their feelings

and concerns, and be able to support one another and problem solve together on a regular basis.

Respondent 5: *“They can give more like not training but, like a focus group where we can talk about our feelings and things like that. We can do it not like after two months but we can do it like every month.”*

Respondent 6: *“They can bring a support group in and then someone can stand up like in a union but like in the place.”*

A support group for paediatric staff caring for HIV/AIDS patients found a support group to be a positive means of providing a safe place for staff to express their emotions, frustrations and support for one another (Strug and Podell, 2003). Caregivers of HIV children experienced additional social support within the workplace to be greatly beneficial (Hansel et al, 1999). The additional support better equipped the caregivers in coping with stress in the workplace. Support groups have been identified as one form of prevention in tackling the development of compassion fatigue by providing emotional support for staff as well as an opportunity to express themselves within a confidential and supportive environment (Joslyn, 2002). Thus there is evidence that reaffirms the need and positivity in the outcome of support groups that participants in this study have requested for.

4.4.4.2 Communication

Some of the participants expressed feeling constantly uninformed within the workplace. Be it related to shift changes or new developments, these participants feel that they are not kept adequately informed and this breakdown in communication is causing conflict among staff as well as gaps within service delivery.

Participant 11: *“They must work on their attitudes (other staff members). They must be more open and communicate then it will be much better.”*

Participant 13: *“There isn’t very much on communication. This one says this and this one says that. They don’t know exactly what’s going on...we have to communicate more. If there’s a new development just let us know what’s going on.”*

The participants have expressed that communication is one of the many problems they experience within the workplace and have identified it as an unmet need at Cotlands. The issues highlighted by the participant concur with findings revealed from other studies which found poor communication to be one of the most prevalent workplace stressors among nurses (Omadahl and O'Donnell, 1999 cited in Lambert and Lambert, 2008). Due to the problems that arise out of ineffective communication, communication has been found to be a common cause of workplace conflict (Bergh and Theron, 2003).

4.4.4.3 Additional training

Quite a number of participants, as an outstanding need, raised additional training. Participants who are employed on a contract basis are not included in the training that is being provided to the permanent staff members and they feel disappointed at this. The motivation and eagerness of these participants to want to further and improve their skills and knowledge highlights the dedication of these participants to the children they work with.

Participant 1: *“Like for instance if you want to go and study further for auxiliary nurse if they can give that kind of training then you know for sure you can work in a hospital with HIV children and not just a carer.”*

Participant 12: *“They had training here for stress but we didn't go because it's not for us contract carers, and I think that's very wrong because it's for all the staff.”*

Participant 14: *“...especially the medication, there is a lot I want. I want to do the six-month course. So because there are many people that come in ask you about HIV and sometimes you can't answer them.”*

Additional research has revealed that having further training in the field of HIV/AIDS has improved health care worker's competence and confidence in caring for their patients (Smit, 2005). This finding coincides with the need for on-going training and education identified by many of the participants in this study.

4.4.4.4 Additional recognition

Half of the participants felt the need to be more appreciated in the workplace, particularly by the managerial staff. Although the participants feel supported by some of these staff

members, they also feel the need for verbal appreciation to be given more frequently in relation to the hard work and long hours they fulfil; as well as acknowledgement at times when they go beyond the call of duty. Some of these participants felt that if they were given a token gift, e.g. flowers, as a means of showing gratitude then staff would feel more appreciated than they do already.

Respondent 1: *"...sometimes we do extra for the children because its not our children, its our job. Sometimes we do extra and then I think they can sometimes give you a note or a letter to say thank you for caring for the children or a chocolate or something, or a bunch of flowers or something like that."*

Respondent 8: *"There is so much lacking but if I had to mention it now it would be that they do appreciate the staff but I think more needs to be done. It's not just thank you. I mean they have to do more because the staff here does so much above and beyond what they are supposed to do, and they know it. The management, all of them know it, and I just need for them to express it."*

Respondent 9: *"For me really my support here I think our HR is the person who's responsible for the staff. She's the one who's supposed to be responsible for everything for the staff but I don't think here the HR is here for the staff. What's actually happening, I don't think if you are happy they will start a union in the workplace, and if the HR was doing her job what she was supposed to do proper and her job, then there will be no union, but it seems to me she was not doing her job. You cannot go and ask her something because there's no answer actually."*

The notion of feeling unacknowledged is commonly expressed by health care workers in the field. In exploring nurse's job satisfaction, stress and recognition in a paediatric setting, recognition of nurses was one of the highest unmet factors in the study (Ernst, Franco, Messmer and Gonzalez, 2004). In this research, again the need to be recognised for the work that caregivers and nurses do has been highlighted as an unmet need. Ernst et al (2004) recommend for the implementation of nursing awards and recognition in any form to be implemented or enhanced as a means to addressing and rectifying job dissatisfaction among health care worker.

4.5 Conclusion

This chapter presented the research findings. The findings were discussed using the research objectives as a framework. The final chapter presents conclusions and recommendations pertaining to the study and future research.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The final chapter discusses the main conclusions and recommendations from the research and the main conclusions are discussed using the headings of the research objectives. Recommendations are provided for Cotlands, other relevant organisations that work within the same field, as well as recommendations for future research.

5.2 Conclusions

The following conclusions can be made from the findings of the study:

5.2.1 Challenges or stressors Cotlands hospice staff experienced in caring for HIV positive infants

- It is evident that working in this field presents an array of challenges and stressors for those caring for HIV infants.
- The main challenges or stressors experienced by the participants were identified as being work stressors and personal stressors.
- Work stressors included issues such as salary, working conditions, fear of contagion, exposure to the death and dying of infants, understaffing and administering of antiretroviral treatment
- Salaries were a stressor as participants felt that they were being underpaid for the type of work they do as well as attempting to stay abreast of inflating costs of living expenses in the home.
- The emotional nature of the work and seemingly unmanageable workload in relation to number of staff was a difficult challenge faced by the participants.
- From the findings, one can conclude that conflict among staff is a prominent issue in this organisation. Discrepancies, gossiping and tension were identified as being most problematic among staff members as it created uneasiness within the working

environment and concern around the negative impact it may have on the infants the staff interact with.

- It can be concluded that many of the participants are well educated around protecting themselves from HIV contagion; however, they did express concern if they were to accidentally expose themselves to infection in caring for the infants.
- The exposure to death and dying has been a difficult and even traumatising experience for those participants who have encountered it. Fortunately, the findings reveal that the occurrence of the death and dying of infants is far less frequent due to ARV's.
- The giving of ARV's to the infants was found to be a stressful challenge for participants due to the children becoming distressed when they need to be given their ARV's.
- Personal stressors such as home stress, awareness of reality and insufficient family time were the most common personal stressors mentioned. Stress in the home was primarily due to the participants being the sole provider of the family as well as rife alcohol abuse in some families.
- The reflection of reality encompassed the realness of the trauma that an HIV diagnosis can have on children and their families. Participants became aware of how emotionally connected they are with the infants to the extent that it impacts on themselves psychologically that they are ill. This reality has made the participants grateful for having healthy children; yet as parents themselves, they are able to empathise with parents and families of ill infants.
- As a result of busy work schedules, participants are concerned about the minimal time available to them to spend with their families. As parents, participants feel that they are not able to adequately provide the essential care and support to their children due to time constraints.

5.2.2 Current coping strategies utilised by Cotlands staff

- The current coping strategies used by the participants were categorised as being faith based coping and coping through emotional and behavioural distancing in an attempt to avoid experiencing painful feelings or situations.

- Faith based coping comprised of prayer being the coping strategy utilised by some participants. It can be concluded that prayer positively enabled participants to truly and honestly express themselves to a higher power and in doing so ask for direction and strength to continue.
- The coping strategy of distancing of self was demonstrated in two ways, emotional distancing and behavioural distancing. Emotional distancing prevented participants from being in touch with the sad, painful and stressful feelings they encounter within the workplace. Behavioural distancing provided participants with a means to temporarily remove themselves from stressful and overwhelming circumstances.

5.2.3 Supportive resources available to these staff members.

- Various supportive resources both inside and outside of the workplace were expressed by the participants as available to them.
- Managerial support, support from colleagues and counselling were revealed as internal staff support. It can be concluded that within the work place these structures are what have sustained the staff emotionally and psychologically.
- Family and community support and encouragement by neighbours, churches and schools within local communities were the types of external support structures that participants have benefitted from. It can be concluded that the above mentioned types of support outside of the workplace have assisted in providing good support for the participants.

5.2.4 Unmet needs in the workplace identified by the staff

- It can be concluded that there are a number of unmet needs within the context of this workplace. These encompass the need for counselling, improved communication, enhanced training and increased shown appreciation.
- The need for counselling in the form of group counselling for staff to both support and be supported by one another was suggested. Improved communication and additional training were areas that if improved on would improve the service delivery of the organisation. The need for more shown appreciation to particular staff could boost staff morale and contentment.

- These outstanding needs were what the participants felt urgently needed be addressed by management in order to improve the working conditions for the nurses and carers, thus improving the overall working relationships and ambience among the Cotlands staff.

The recommendations emanating from the study will now be presented.

5.3 Recommendations

5.3.1 Recommendations by Cotlands staff

- Recommendations made by Cotlands staff were for there to be available, ongoing counselling for both permanent and contract working staff members. Suggestions were made for group counselling to be provided as it will provide the staff with an opportunity to discuss concerns and issues in the group sessions. The group sessions may also prove to be beneficial in providing support to one another within the group.
- The recommendation for improved communication in terms of more effective, clear and direct communication was strongly expressed by the staff as they feel uninformed when it comes to decision making and changes that affect them directly within the workplace. This could be achieved by holding regular staff meetings where information can be shared among the staff. This can also allow the staff to respond to or comment on the information shared. Alternatively, the regular distribution of a staff newsletter can serve as a means of maintaining regular communication between management and staff.
- These participants recommended that there be additional training available to them. It was expressed that training to address and provide additional insight into various topics relevant to their work would be the most beneficial training. The training could be in the form of sending staff on training courses if this is financially viable, alternatively it may prove more cost effective if professionals are brought in as guest speakers for this purpose.
- The most common recommendation was that of more frequently expressed appreciation from managerial staff to the nurses and carers in the organisation. Suggestions made by the staff around more frequent verbal appreciation and even at

times being presented with a token of gratitude from the organisation or management would serve as acknowledgment and additional motivation for them in the workplace.

5.3.2 The researcher's recommendations for Cotlands Baby Sanctuary Organisation

- The need for appreciation expressed by the participants can be improved on through more frequent expressions of appreciation in the workplace. It may prove helpful if gratitude is notably expressed to the respective individuals. This may be expressed by means of verbal communication or a letter of appreciation. An event held in honour of these staff members such as a staff breakfast or tea once or twice a year could also be effective in showing appreciation.
- The concept of organising an annual family day where staff can bring their families and enjoy a day of fun funded by the organisation is a way to show care and appreciation for the staff. In this way, the staff can enjoy leisure time with their families and time off from work. In order for this to be feasible, additional relief staff would be needed to care for the HIV infants for the duration of this day which would be a financial consideration for the organisation.
- It is imperative that counselling is available and provided to every member of staff that is involved in caring for HIV infants at Cotlands. More frequent and regular utilisation of the social worker that is affiliated with Cotlands would be recommended, as many of the staff members are familiar with her. However; if additional support is needed, the researcher recommends that a full time social worker could be employed at Cotlands to be available to the staff as their need for support arises. A monthly support group could be run too. Each shift team could have their own support group. This allows the groups to be relatively small and intimate. In light of these recommendations, it is nevertheless essential for available finances and the budgetary state of the organisation to be reviewed to determine the financial feasibility of these recommendations. Another consideration for management to look at in the provision of counselling is the issue of time constraints and setting aside time for the purposes of counselling and support.
- The problems that the participants encountered in administering ARV's may be better managed if staff took turns to administer ARV's and for this responsibility to rotated

more frequently than it currently is. This could prevent staff from becoming increasingly frustrated, as they would be fulfilling this responsibility less frequently.

5.3.3 The researcher's recommendations for other relevant organisations involved in paediatric HIV care

- It is recommended that organisations involved in paediatric HIV care should include in their budgeting that adequate, on-going support and counselling is made available and is accessible to every member of staff as a means of stress management and to prevent burn out.
- Due to the stressful and emotional nature of this work, it is recommended that management in these various organisations acknowledge and praise staff for exceptional and hard work in order to boost morale and improve the work ethic amongst the staff. This can be done by means of verbal recognition or by presenting staff with certificates or a token gift as rewards.
- It is recommended that staff involved in paediatric HIV care need to be educated about ARV's and the importance of compliance in taking this medication. In this way, these staff members are able to educate families of the children and the wider community. In doing so, the hope is that the stigma around ARV's diminishes and that over time, families become competent to care for these children at home.

5.3.4 Researcher's recommendations for future research

- As a continuation of research from this study, future research could explore the impact that antiretroviral treatment has had on infant survival and as a result, the impact therefore on the staff caring for these infants who have a much longer life expectancy than before.
- The researcher recommends that it may prove valuable to expand on the research yielded by this study and to investigate a comparison of stressors and coping strategies between organisations in urban areas compared to organisations in rural areas.
- The enhancement of on-going support for staff in the field of paediatric HIV has been identified as a crucial element in this area of work. The researcher recommends that

future research could explore the impact of on-going support within the context of HIV and the workplace.

5.4 Conclusion

The final chapter has presented the main conclusions from the research. The chapter has also highlighted recommendations to relevant organisations in the field of HIV infant care and future research.

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APPENDIX A

Interview schedule

Topic: Caring for HIV positive infants: Cotlands Hospice staff's perceptions of challenges and stressors which they experience in the workplace.

Information for the respondent:

- The respondent's identity will remain anonymous throughout the transcription and entire dissertation.
- The use of the digital voice recording device, used with the consent of the respondent, is to ensure optimum accuracy of the interviews.
- This research is being conducted under the auspices of the Department of Social Development, University of Cape Town, with the consent of Cotlands Baby Sanctuary, Somerset West, Cape Town.

Section A: Profile of the respondent

1. How long have you been working as a nurse?
2. How long have you been working here?
3. Where did you work before?
4. Why did you decide to work with HIV infants?
5. Where do you live?
6. How long do you have to travel to and from work?
7. What are your working hours?
8. Who do you live with?
9. Can you describe your relationship with them?

Section B: Perceived nature of challenges and stressors

1. How do you feel about your job?
2. What aspects of it do you enjoy and why?
3. What aspects of your job do you not enjoy? If so, why?
4. What has been your experience in caring for very ill or dying children?
5. How does working with sick and potentially dying infants affect you?
6. Have you had nursing training/attended workshops in working with HIV infants?

7. What are your responsibilities at home?
8. How much free time/personal time do you have for yourself at home in the week?
9. How do you feel in terms of whether this is sufficient?
10. Do you have time off on the weekend?

Section C: Current coping strategies

1. Do you feel appreciated and valued at work? Explain.
2. How stressful is your work?
3. What causes your job to be stressful?
4. How does feeling stressed affect your work?
5. How does feeling stressed affect your home life?
6. What do you do to cope when you are feeling stressed? Do you have any outlets or activities you enjoy doing that enable you to feel better or cope better?
7. How does that help you?
8. Do you know of any other ways nurses cope with these stresses?

Section D: Available supportive resources

1. What type of relationship do you have with your colleagues?
2. Do you have contact with any of your colleagues outside of work?
3. Do you turn to your colleagues during difficult times?
4. How available are your colleagues to you, if you need support?
5. How do they provide this?
6. Have your colleagues ever approached you when they are struggling caring for HIV infants?
7. Have you had any experiences whereby you have approached another colleague for support or a colleague has approached you for support? Explain
8. How frequently do you have contact or interact with your managers?
9. Are your managers attentive to your needs?
10. Would or have you ever approached your manager about stresses or difficulties you are having? Please explain
11. What types of support systems or structures are available to you in the workplace?
12. Is there any type of process for nurses to follow if they need emotional support?
13. Are there any forms of counselling offered or available to you at work?

14. Are there support groups open to nurses that have been provided through the workplace?
15. What is your family life like at home?
16. Do you confide in any person or people at home regarding work matters? Who?
17. How do they respond to you?
18. Do they provide you with the necessary support? How do they do this?
19. Is there any type of support that is lacking for you at home?
20. How involved are you in your community?
21. Do you have any types of support or support structures in the community? Please explain.

Section E: Perceived unmet needs

1. What do you feel is lacking in terms of support for you in the workplace to improve conditions?
2. How would this or these help you and other nursing staff to care for HIV infants?
3. What could colleagues do to help each other to cope better? How and Why?
4. What could managers provide nurses with to help them cope better? How and Why?
5. What could help within your home environment for you to cope that you aren't experiencing now?
6. Do you feel you have sufficient knowledge of your field of work or do you need to or want to learn more?
7. Are there any other outstanding needs or suggestions that you have not yet mentioned that you feel could be helpful nurses in the workplace if they were to be implemented or addressed?

APPENDIX B

Letter of Informed Consent

Research Topic: Caring for HIV positive infants: Cotlands staff perceptions of challenges which they experience in the workplace and possible intervention strategies in this regard.

As a volunteer participant in the above mentioned research, I understand that I will be asked to complete a survey that will ask questions related to my work experience as well as willingly participate in an interview. The interview may take up to 30-40 minutes. I also understand that I may consider some of the questions personal in nature but that the information I provide will be used exclusively for this project and will in no way be associated with my name, address, or any other identifiable information.

As a participant in this study I am aware that the questions on the research survey may cause anxiety or stress depending on my personal situation but that most find the experience harmless and even enjoyable. As a participant, I am aware that the responses I provide may assist future staff.

By signing below, I state that I have read this consent form in its entirety and that all of my questions have been answered. I understand that I may withdrawal from this study at any time and that my participation or lack of participation will in no way affect my status as a member of staff.

Subject signature

.....

Witness signature

.....

Date: