THE EXPERIENCE OF NURSES WORKED AT THE COVID-19 UNIT IN INTERMEDIATE HOSPITAL OSHAKATI, OSHANA REGION, NAMIBIA

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LYDIA K. DAVID

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MAIN SUPERVISOR: DR. H. IITA

CO-SUPERVISOR: MR M. NAMIDI

ABSTRACT

The Coronavirus Disease (COVID-19) is the world's most significant public health emergency. Nurses, essential members of the COVID-19 patient care team, are facing the majority of the problems brought on by the disease. To enhance the quality of care provided to COVID-19 patients, this study explored the experience of nurses who worked at the COVID-19 unit in Intermediate Hospital Oshakati, Oshana Region, Namibia. The study employed an exploratory and descriptive research design with a qualitative approach to the population of thirty-five nurses who worked at the COVID-19 unit in Intermediate Hospital Oshakati during the COVID-19 pandemic. Purposive sampling was used to select eight participants for data saturation. A semi-structured interview was used for data collection, and a tape recorder was utilized to capture the data. Thematic analysis was used for data analysis using the six steps proposed by Creswell (2014). Findings were presented in themes and subthemes for better comprehension. Ethical considerations were observed, such as approval, the principle of justice, confidentiality, privacy, beneficence, and non-maleficence. The analysis of the data revealed four themes and fourteen subthemes: A) positive experiences (learning, patient treatment and recovery, and patient management); B) negative experiences (worry and fear of death of patients, trauma development, and socialization experiences); C) lack of equipment, staff shortage, and challenges with communication with family; and D) psychological support, increase in supply of equipment, and increase in staff members. The study concludes that nurses who participated in this study had both negative and positive experiences and faced challenges. Recommendations include that health officials and hospital management should pay special attention to the challenges and needs of the nurses. They should act as advocates, ensuring that government and healthcare administrators provide nurses who provided care such as favorable working conditions, sufficient funding, and the motivation to carry out their duties skillfully and effectively.

Keywords: COVID-19, COVID-19 unit, experiences, nurse, nursing care, pandemic.

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DEDICATION

This thesis is dedicated to the living memory of my late father, Alfeus Dawid. Sadly, he did not live to see this successful accomplishment of his daughter.

"***Dad, your daughter has made it. I hope you are proud of me whenever you look down on Earth***."

DECLARATION

I, Lydia Kaalina David, hereby declare that this study is my own work and is a true reflection of my research and that this work, or any part thereof, has not been submitted for a degree at any other institution.

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ACRONYMS

2019-nCoV	2019 Novel coronavirus
COVID-19	Coronavirus Disease-2019
HCWs	Health Care Workers
ICU	Intensive Care Unit
MoHSS	Ministry of Health and Social Services
NGO	Non-Governmental organisation
PPE	Personal Protective Equipment
WHO	World Health Organisation
IHO	Intermediate Hospital Oshakati

CHAPTER 1

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Introduction

As frontline caregivers, nurses work hard to provide their patients with adequate care. During the COVID-19 pandemic, they gained valuable experiences that advanced the nursing field. Studies on the COVID-19 pandemic have been widely published since the disease outbreak. However, few qualitative studies in Namibia have explored and illuminated frontline nurses' experiences and difficulties in providing care for patients with COVID-19. This study explored the experiences of nurses who worked at the COVID-19 Unit in the Intermediate Hospital, Oshakati, Oshana Region, Namibia. The study's background, problem statement, research objectives, and significance are all presented in this chapter. Additionally, the chapter provides the limitations and delimitations of the research and finally offers a conclusion of the study.

1.2 Background of the study

The first case of Coronavirus-19 (COVID-19) was reported in November 2019, with a 55-year-old male from Wahun, Hubei Province, China, being the first to contract the virus (1). COVID-19 was labelled a pandemic by the World Health Organization (WHO) in March 2020, citing the virus's rapid spread to adjacent countries (2). The COVID-19 pandemic resulted in 435 million confirmed cases and 5.95 million confirmed fatalities by February 29th, 2022 (2). There have been 11,443,000 confirmed cases and 294,000 deaths in Africa so far (2).

Namibia recorded the first case in March 2020, after which a state of emergency was established, fundamental rights were curtailed, and the entire population was subjected to lockdown restrictions (3). As of February 28, 2022, an estimated 157 210 confirmed cases, 4007 confirmed fatalities, and 152 697 confirmed recoveries had been reported in this country of 2.451 million people (3). Meanwhile a total of 814,463 had received vaccine doses (3). As a result, the Namibian government, through the Ministry of

Health and Social Services (MoHSS), responded to the outbreak to lessen the impact of the COVID-19 pandemic.

In all nations with a high frequency of infections, health workers, including nurses, have been among the most afflicted groups by COVID-19 (4). Of the total confirmed cases in Namibia, 4.1% of the Health Care Workers (HCWs) tested positive for COVID-19, of which 64.7% were from state hospitals, 34.8% from private hospitals, and 0.6% from NGOs, with 54.4% recoveries and 0.6% deaths, according to the Namibia COVID-19 Situation Report No. 220 of 2020. As of June 7, 2021, 2,623 healthcare workers had contracted COVID-19 in Namibia, and six of them had passed away (5). Twenty-three (23) of the HCWs who contracted COVID-19 died while hospitalized in Intensive Care Units (ICUs).

On May 14th, 2021, 54 COVID patients were admitted to Intermediate Hospital Oshakati's ICUs among the general population, out of a total of 200 persons hospitalized countrywide (6). This put additional pressure on hospitals, particularly ICUs, and increased the demand for human and material resources. In the Intermediate Hospital Oshakati, 120 beds were made available, 40 of which were added and designated for COVID-19 patients, compared to the usual 80 ICU beds (7). These patients were under the nursing care of the nurses, which made them face different experiences in taking care of the COVID-19 patients at the hospital. COVID-19 unit caters for ICU and high care COVID-19 patients.

Moral distress occurs when a person recognizes the ethically correct course of action, but internal and external constraints make it challenging to follow through (8). It is most common among nurses whose identities are linked to altruism and compassion principles (9). Healthcare workers in COVID-19 ICUs are at risk of experiencing moral distress due to their empathic commitment, limited access to PPE, poor perception of organizational support, and uncertainty about disease containment strategies (9). Nurses during the COVID-19 epidemic also faced shortages of PPE, leading to increased demand and pricing of medical goods (10). Nurses in ICUs are affected by the COVID-19 pandemic, leading to anxiety disorders, depression, and post-traumatic stress disorder. Rationalization methods are essential to ensure wellness and a healthy workforce.

1.3 Problem statement

The Namibian government, through the MoHSS**,** is responding to the outbreak to mitigate the impact of the COVID-19 pandemic. The government increased bed capacity at major health facilities to accommodate the growing number of COVID-19 patients. For example, at Intermediate Hospital Oshakati, there were 80 beds before, but an additional 40 beds were made available in the ICU to accommodate the increasing number of patients that required hospitalization (7).

The most crucial role in treating patients during an outbreak of an infectious disease is always played by medical personnel, endangering their lives or putting their health in danger (7). Nurses, who make up the largest group of healthcare professionals, also treat patients directly and at the front lines of the healthcare system (8). They may experience psychological distress and exhaustion as a result of their long work hours and heavy workload due to their shortage, exposure to the virus, frequent and close contact with COVID-19-positive patients, a lack of personal protective equipment (PPE), stigmatization as COVID-19-vectors, pressure from the media, and an increase in fatalities, ad and facing with clinical complications (8,9,10, 19). Additional physical strain on nurses during the COVID-19 pandemic may result from nonstandard PPE, excessive sweating and dehydration, wounds from prolonged mask use, a suffocating sensation, and a lack of conducive eating and drinking environments (15) These elements lower the quantity and caliber of patient care and make nurses feel helpless and hopeless (11, 21).

Organizational coping strategies such as improving human resources policies, designing targeted psychological interventions, and having ethical guidelines for difficult decisions in ICUs are needed to address ethical dilemmas in COVID-19 Unit (4). Despite the fact that previous studies have highlighted some of COVID-19's experiences and consequences and offered measures to assist nurses, they were limited in their capacity to deal with the particular situation they were confronted with. Notwithstanding the fact that Namibia is one of the countries most hit by the pandemic, little is known about the experiences of nurses fighting COVID-19. There have been few research studies on nurses' experiences around the world. Yet, there is no one done at Intermediate Hospital Oshakati. As a result of this, there is a knowledge gap. It is thought that understanding the experiences and challenges faced by nurses at

Intermediate Hospital Oshakati in the COVID-19 Unit may aid in the creation of solutions to these issues. The goal of this study was to explore the experiences and obstacles of nurses working at the COVID-19 unit in Intermediate Hospital Oshakati, Oshana Region, Namibia.

1.4 Purpose of the study

The purpose of the study was to explore the experiences and coping mechanisms of nurses who worked at COVID-19 Unit in Intermediate Hospital Oshakati, Oshana Region, Namibia.

1.5 Objectives of the Study

The objectives of the study were;

- To explore the experiences of nurses working with COVID-19 patients in Intermediate Hospital Oshakati.
- To determine the coping mechanisms for the nurses' negative experience in caring for COVID-19 patients at Intermediate Hospital Oshakati

1.6 Significance of the study

From a theoretical and practical perspective, exploring the experiences of nurses working in the ICU and COVID-19 units at the Intermediate Hospital Oshakati could be of considerable value. Theoretically, researchers in the field of nurse's experiences with COVID-19 are expected to apply the benefits of their theoretical findings. Writers, publishers, policymakers, and text analysts may also consider the findings of this study. In fact, it would help the Ministry of Health and Social Services (MoHSS) and COVID-19 operational management, especially at the Intermediate Hospital Oshakati, to understand the experiences of nurses and help them overcome common difficulties in the area. Moreover, this pandemic would not be the last; others are still coming, and the MoHSS could use this finding to better care for and equip its staff in the future, given similar circumstances.

Exploring nurses' experiences caring for COVID-19 patients may be beneficial in improving and encouraging patient health. As qualitative research is frequently

used to investigate phenomena in depth, performing a qualitative study would help researchers better understand nurses' experiences in caring for patients with COVID-19 disease. In addition, as there have been few studies on nurses' experiences working in COVID-19 wards in Namibia, the current study would provide a clear picture of Namibian nurses' care experiences during the COVID-19 outbreak. Nurses could also use the findings of this study to practice excellent self-care methods.

Exploring the challenges that nurses experience when caring for COVID-19 patients would help nurses and hospitals to be more resilient in the face of the crisis, as well as improve preparedness and recovery. Furthermore, by informing leaders and decision-makers about these concerns and providing ideas and implications, nurses would be better supported.

In addition, the objective of nursing is to serve as a contributor to the enhancement of practical assistance. Understanding the life events of a patient is essential to providing quality nursing care; as a result, this understanding could lead to the revelation of nursing knowledge and produce results for nursing care and guidance in Namibia.

1.7 Limitations of the study

The limitations of this study are the same as those of all phenomenological research, according to Van Manen (24). He states that phenomenological findings may lack evidence of accuracy, generalizability, and objective validity. Despite the study's credibility, generalization is avoided due to the small sample size, thereby rendering the data unsuitable for forecasting (4). Moreover, the nurses involved in the study were privy to personal details about the participants, which impacted their perspectives, actions, and mindsets. As a result, the findings may not be representative of all nurses in Namibia.

The fact that this study's population was restricted to nurses who only cared for patients with COVID-19 diagnoses was a limitation of the study. Therefore, doctors and other frontline healthcare providers who provided direct care to

COVID-19 patients were not included, thus hampering the study's findings. In order to have a more thorough understanding of the experiences and challenges of frontline healthcare workers during the COVID-19 pandemic, the researcher suggests conducting additional studies to explore the experiences and challenges of other frontline healthcare workers who provided care during the pandemic across all treatment centers. Despite these drawbacks, this study offered a thorough understanding of the experiences of nurses who treated COVID-19 patients at IHO during the pandemic.

1.8 Delimitations

The sample for this study was only nurses working in the COVID 19 Unit at Intermediate Hospital Oshakati. The study purposively explored the experiences of nurses working in the COVID-19 pandemic Unit at Intermediate Hospital Oshakati, Oshana Region, Namibia.

1.8 Outline of the study

Five chapters made up this study as follows.

Chapter 1: Study's introduction and background information. The study's background, problem statement, aim and objectives, research questions, chapter summary, and chapter conclusion are all covered in this chapter's introduction.

Chapter 2: Theoretical and literature review. This chapter presents the theoretical review and the related literature review.

Chapter 3: Methodology: This chapter focuses on the researcher's efforts to address the research questions in order to achieve the goals and objectives of the study. It focuses on data research design, population, sample and sample size, data collection instrument, procedure and trustworthiness. The study further presents the data analysis procedure and, finally, ethical considerations.

Chapter 4: Findings. This chapter presented and interpreted the findings of the study.

Chapter 5: Discussion, Summary, Conclusions and recommendations. This was the last chapter of the study that provided literature control and made a summary of the findings, conclusions, and recommendations of the study.

1.9 Conclusion

The background information and research issue driving this study were presented to the reader in this chapter, as were the objectives and goals. Additionally, a chapter outline for the study and an explanation of its importance were provided. In Chapter 2, the literature was reviewed in relation to the subject of the study.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

A literature review is a search and evaluation of the available literature on a chosen topic or subject, and it documents the current state of the art in the area (25). According to Creswell, the term “literature review” refers to the entire academic paper or a particular section of an academic work, such as a book or article (26). It is a summary of the prior works that have been published on a subject. The goal of a literature review is to provide the researcher/author and readership with a comprehensive overview of the body of knowledge currently available on the topic under study (26). It aims to gather current, pertinent research on the subject of choice and synthesize it into a comprehensive overview of the body of knowledge in the area (27). This equips the researcher to present their own argument or conduct original research on the subject. Similarly, Baker (29) and Granello (30) contend that a literature review is useful in academic writing as it evaluates the current state of research on a topic, identifies subject matter experts, important questions that require additional research, and the methodologies employed in prior studies of the same or related topics. Therefore, a researcher should have a strong foundation of knowledge in the field and a good sense of the direction any new research should take after completing the literature review.

This chapter looks at what different authors have said about the evidence in the existing literature about nurses who worked during the COVID-19 pandemic. The literature review starts with an explanation of why human experiences should be studied using qualitative research methods. In addition to this, it is structured according to the general outline of the COVID-19 epidemic. Selected research studies relevant to the experiences of nurses are discussed.

2.2 Overview of COVID-19 endemic

The Huanan Seafood Wholesale Market in Wuhan, Hubei, China, experienced an outbreak of a strange pneumonia characterized by fever, dry cough, lethargy, and

sometimes gastrointestinal symptoms in late December 2019 (13). The first outbreak was detected in the market in December 2019, affecting roughly 66% of the employees. After the local health authority issued an epidemiologic notice on December 31, 2019, the market was closed on January 1, 2020. Thousands of people in China, including numerous provinces (such as Hubei, Zhejiang, Guangdong, Henan, Hunan, and others) and cities (Beijing and Shanghai), were affected by the disease's rapid spread in the next month (January) (31). In addition, the disease spread to Thailand, Japan, the Republic of Korea, Vietnam, Germany, the United States, and Singapore.

The first COVID-19 case in Africa was registered on February 14, 2020 in Egypt (26). COVID-19 instances were afterwards recorded in all other African countries. On January 13, 2020, a couple from Romania visited Namibia and reported the first occurrence in our country (Namibia). On March 17, 2020, the Namibian Head of State announced a state of emergency. In the last 24 hours, a total of 3,564 deaths (CFR 2.8%) have been reported, with zero (0) deaths. WHO had identified a total of 28,276 confirmed cases with 565 deaths worldwide as of February 6, 2020, including at least 25 countries (32).The outbreak's pathogen was later discovered as a novel beta-coronavirus known as 2019 novel coronavirus (2019-nCoV), which brought back memories of the 17-year-old severe acute respiratory syndrome (SARS-2003, caused by another beta-coronavirus).

2.3 Theoretical framework

This study will be guided by three theories of Dorothea Orem Theory of Nursing Self-Care Deficit, Nursing Systems Theory and Relationship based care.

2.3.1 Dorothea Orem Theory of Nursing Self-Care Deficit

This study was mainly based on the Dorothea Orem Theory of Nursing Self-Care Deficit. The Orem Model of nursing is another name for this paradigm. This theory was created by Dorothea Elizabeth Orem an American nursing theorist, between 1951 and 2001(33). According to the theory's definition, helping people manage their own self-care is the act of maintaining or enhancing an individual's functioning at an effective level at home (33). Thus, self-management, which is described as the practice of acts initiated and undertaken by the individual to protect life, health, and well-being

is the center of this strategy. In addition, the theory emphasizes each person's ability to practice self-care, which is described as the practice of actions that individuals start and undertake on their own behalf in order to maintain life, health, and well-being.

The relevance of this theory in this study is that it provides the ability to maintain the quantity and quality of care that is therapeutic in sustaining life and health, in recovering from disease or injury, or in managing patients' repercussions support which the existence of a nurse requires (33). In addition, Orem's Self-Care Deficit Theory highlights the significance of preserving autonomy in self-care processes, such as Covid-19 patient health and well-being, and assists nurses in determining which parts of Covid-19 patient care they should concentrate on in a certain circumstance.

2.3.2 Nursing Systems Theory

The Nursing Systems Theory was initially conceived of and put forward as a general system theory by Ludwig von Bertalanffy between the years 1901 and 1972 (35). According to the Nursing Systems Theory, nursing acts can be classified into three categories based on the needs of the patient: The Totally Compensatory System is used when the patient is completely reliant on the nurse's actions; the Partially Compensatory System is used when the patient is partially reliant on the nurse's actions but has some ability to develop some self-care actions; and the Support-Education System is used when the patient can carry out self-care but the nurse's role in terms of the guidelines is paramount.

In terms of nursing care in the face of the Coronavirus pandemic, the nurses are presented in a variety of scenarios, ranging from community preventative guidelines to COVID-19 to high complexity help in cases where the disease worsens. When evaluating the theory's self-care perspective, the nurses' attitudes promote the patient's autonomy, which is a critical component for their empowerment when faced with health decisions. Furthermore, through the Support-Education System, health education highlights a tool that enables the patients and collectivities to develop knowledge by themselves (7).

In this viewpoint, nurses are able to guide on some of the types of care like when sneezing or coughing, covering the mouth and nose with tissue paper or the inner side

of the arm; avoid touching the face, especially the eyes, nose, and mouth; and keep at least two meters away from people who cough or sneeze (33).

While the person is unconcerned with self-care, he or she may become ill, which may manifest itself softly or seriously. If it progresses slowly, it necessitates intervention under the Partially Compensatory System, in which the nurse supports the patient while the patient also does some tasks that demonstrate independence and self-care. As a result, the nurses provide guidance that goes beyond the basic and includes the management of home isolation, which includes the separation of personal use objects such as silverware, glasses, plates, and even a face towel; the importance of confining the patient to a single room in the house and, if this is not possible, ensuring that the patient wears a surgical mask at all times; and when dealing with tetanus.

According to Orem's nursing philosophy, self-care is defined as behaviors that people engage in to maintain, restore, or improve their health. Patients are not seen by nurses as passive users of health services; rather, they are seen as strong, dependable, responsible, and capable decision-makers who can properly care for their health. Orem identified three types of nursing systems: totally compensating, moderately compensatory, and supportive-educative. When the patient is ready to learn something but needs assistance and supervision, the nurse's position in the supportive educational system is adopted (36).

2.3.3 Relationship-based care model

The understanding of the the Relationship-Based Care (RBC) model. RBC is a paradigm shift in culture and operational structure that enhances all relationships within an organization and enhances safety, quality, patient satisfaction, and employee happiness. It is the method by which nurses treat patients, their families, and one another. The RBC model offers the theoretical foundations as well as the operational framework of the hospital system, encompassing doctor's offices, emergency care, and home care (37). The RBC culture is patient and family-centered and commits to three key relationships (self, coworkers/colleagues, and patient/family), as well as six aspects that are crucial to RBC implementation, including leadership, teamwork, professional nursing practice, patient care, resources based on practice, and outcomes measurement.

RBC is carried out by specialized administration for nurses to provide nursing care to COVID-19 patients seeking medical attention at Oshakati Intermediate Hospital (IHO). Accordingly, nurses' regulators at IHO permit a leadership structure for nurses that enables them to engage constructively and influence choices that have an impact on their practice. Thus, such professional governance gives IHO a framework for coordinating nursing care with the hospital's overarching objectives and enables all nurses to contribute significantly to those objectives. Each nurse is expected to work as a team member under the professional direction of nurses at IHO to battle the COVID-19 epidemic.

2.4 Selected studies relevant to nurse's' experience that worked with COVID patients.

This section historically reviews selected studies related to the experiences of nurses working with or caring for COVID-19 patients. These experiences are viewed from a psychological, physical and social perspective. It also provides some qualitative phenomenological studies on nurses' experiences in combating the COVID-19 pandemic.

2.4.1 Psychological issues

Providing care for COVID-19 patients cannot be seen as taking care of other diseases. A number of researchers have documented feelings of fear, worry and anxiety by nurses in taking care of COVID19 patients (38, 39, 40). Qian, Luo & Haase explored the experiences of healthcare providers during the COVID-19 crisis in China among 56 nurses caring for COVID-19 patients. Results showed that all nurses who participated in the study experienced feelings of fear related to death and dying or being contracted by the virus. The mentioned feelings of fear were perceived as a key stressor for nurses in providing care to patients (38). In another study by Taylor et al. (40), nurses' fear and anxiety about the risks of COVID-19 infection were experienced. The results demonstrated that nurses feared, were anxious and worried about transmitting the infection to their family members after work due to the sudden worsening and increasing number of COVID-19 patients in the health facilities, patients' condition and increased mortality rates. In another study, the results showed

nurses' worries with low engagement or not making enough efforts to save COVID-19 patients and limited skills and knowledge to help critically ill COVID-19 patients (40).

Previous quantitative and qualitative investigations have found experiences of COVID-19 infection-related ambiguity. Ulrich et al. created a work environment for critical care nurses and discovered sentiments of uneasiness among those caring for COVID-19 patients at medical facilities (41). The findings demonstrated that uncertainty-related feelings were a real source of worry, particularly at the beginning of COVID-19 patients' admission. According to a study by Qureshi et al., nurses caring for COVID-19 patients felt uneasy. They reported being unable to foresee when people would become unwell or feel better, as well as how long the epidemic would endure (17).

2.4.2 Physical issues

Physical issues caused by COVID-19 infection may or may not exhibit the early-stage symptoms of the disease and are not always signs of COVID-19. When the infection affects the human immune system, numerous symptoms emerge and impair human function, as in the case of opportunistic infections (42). O'Brien and Pheifer carried out a year-long investigation to compile information on the psychological and physical problems that affected 133 nurses who had COVID-19 infections (43). The writers employed both structured and open-ended questions as instruments for both quantitative and qualitative study. Pre-deployment physical stress was reported by 55% of the sample before being sent to COVID-19 clinics or units, according to the research. Patients' symptoms, which included flu-like symptoms, upper respiratory tract infections, mouth infections, and pneumonia, led to the physical stress of nurses. The authors also noted that the most typical issues that restricted the subjects' capacity to engage in various activities and impacted what these people could or were expected to do were weariness, decreased mobility, and dietary disturbances.

2.4.3 Social perspective issues

Nurses caring for patients with COVID-19 have been reported to have some side effects. In addition to negative social relationships with family and partners, nurses

caring for patients with COVID-19 developed several psychological problems, such as depression, awareness of the risk of illness, and loss of respect for themselves and others due to exhaustion (38). Koren, Alam, Koneru, DeVito, Abdallah, and Liu investigated nurses' perceptions of exposure to COVID-19 (44). One of the key findings is that social stigma is associated with social responses to people with COVID-19, including fear of contracting COVID-19. Nurses' fear of contracting the disease (Covid-19) is a stigma that causes sudden death for many nurses (2). Due to the public's fear of contracting COVID-19, the agreed view was that nurses should be screened forCOVID-19 to protect the public and patients in the hospital.
For nurses, the fear of contamination ranged from a rational concern to an irrational concern (38).

2.4.4 Copying mechanism

A number of researchers such as O'Brien et al., Koren et al., Sunet al. and Chen et al. (44, 45,43, 12) have reported on copping strategies utilized to reduce the psychological distress related to nursing COVID-19 patients. The provided strategies help nurses to cope with the stress of working in increasing mortality and busy wards. The coping strategies include employing a support network from friends, social workers, fellow workers and family members, comparing nurses' experiences with others from their own self-protection, staying health, controlling negative thoughts and maintaining positive ideas on the pandemic.

A study by Ahmadidarrehsima, Salari and Dastyar(42) reported using problem-solving strategies and stress mitigation strategies for copping with the negative experiences of nurses in taking care of Covid 19 patients. According to WHO, social support affects the quality of life of nurses (2). Further, the effect of quality of life among nurses was reported in a study by Chen and colleagues in which 56 nurses caring for people with COVID-19 participated in social support in China in their correlational design. Results indicated that social support and quality of life were substantially correlated with one another and that support was associated with good health status among nurses caring for COVID -19 patients. During this time, nurses learned coping mechanisms for dealing with their physical challenges. Many recalled spending as much time as

they could outside and developing a stronger spiritual connection with God, others, and themselves (46).

2.5 Phenomenological studies on nurses' experiences in combating the Covid 19 pandemic.

Nine nurses and four doctors in China participated in a qualitative phenomenological study by Qian, Luo, and Haase (38) that examined the experience of battling COVID-19. Three themes came to light from the researchers' phone interviews with these subjects. The duty to care is described in the first theme, "being entirely responsible for a patient's well-being as their duty." The second theme was "challenges of working on COVID-19 wards" (38). The study's participants (nurses) talked about their struggles with managing their anxieties of getting ill or spreading illness to their family members, their helplessness when dealing with patients' failing health, and the depletion of PPE supplies (38). Regarding the third theme, "resilience amid adversities," nurses spoke about how they support one another and the coping mechanisms they employ (38).

Sun, Wei, and Shi (45) conducted a qualitative, phenomenological study that focused on the psychological experiences of nurses who cared for COVID-19 patients. Four themes emerged from the study interviews with 20 nurses: (i) a substantial quantity of negative emotions in the beginning; (ii) coping and self-care techniques; (iii) growth under pressure; and (iv) positive feelings happened concurrently with or progressively after negative emotions (45). The nurses admitted that virus their ignorance about virus brought on their uneasiness in the early stages and worried that they would spread it to their families (45). Additionally, they talked of the camaraderie they shared with their fellow nurses and how their appreciation of life and importance of professional duty at this period contributed to their growth and satisfying feelings about the experience (45).

Resilience is a nursing concept that has been thoroughly researched and examined about a variety of demographics, including nursing students, nurse shift workers, and critical care nurses (46). The ICU's high-stress atmosphere has been shown to hasten the onset of burnout symptoms like moral distress and compassion fatigue (47). Critical care nurses who report high levels of perceived burnout are associated with

demanding jobs, PTSD, and workplace bullying. In contrast, resilience is enhanced by social support, self-efficacy, and a sense of well-being (40). In critical care units, establishing and maintaining a healthy work environment aids in reducing burnout symptoms among nurses. Nurses should be encouraged to promote systemic change, innovate, work with other doctors who share their values, and be a change agent (41). Perfectionism, trouble setting boundaries, pessimism, competition, and mistaking self-interest with selfishness are some personality traits that critical care nurses have that contribute to an increase in burnout (22). Critical care nurses should engage in creative arts (music, art, dance, and writing programs) as recommended therapies to improve their wellbeing and resilience (45).

2.6 Significance to conduct a phenomenological study of the nurse that worked in COVID 19 pandemic.

It is evident that the physical, psychological, and social characteristics of the nurses who cared for patients at COVID-19 have changed. Since the World Health Organization (WHO) declared the COVID-19 epidemic a pandemic (2), it has continued to spread, causing panic, fear, anxiety, and social stigmatization of medical professionals. Research on the nurses who cared for COVID-19 patients has focused on the disease's cause, mode of transmission, and treatment. The various aspects of nurses' knowledge, practices, and attitudes towards caring for people with COVID-19 have been the subject of nursing research. However, according to (17), the objectives of nursing are to monitor, promote health, care for patients, and help patients take care of themselves.

To achieve these goals when caring for patients with COVID-19 infection, nurses must understand the fundamental nature of the infection. There are questions about how nurses are affected by the disease. For example, what is the purpose of life for nurses who care for COVID-19 patients? What emotions does a nurse experience after treating a COVID-19 infection? How does the infection affect nurses' day-to-day work and lifestyle?

Much research has been done on COVID-19, mainly in China, the United States of America (USA), and other European countries. Quantitative research methods

have been used to collect a lot of information. There has been very little qualitative research, specifically nursing research, reported in Namibia, where cultural differences in attitudes, lifestyles, and social context may exist.

It is thus essential to investigate the experiences of nurses who worked in COVID-19 units as they provided care for COVID-19 patients because the lived experiences of nurses who worked in COVID-19 in Namibia have never been fully documented in a phenomenological study. Because the samples were selected and the sample size was small, phenomenological studies have limitations that prevent the knowledge gained from being generalizable or predictable (30).

As a result, it is necessary to do a study of the experience of nurses who worked at the COVID-19 unit of the Intermediate Hospital in Oshakati, Oshana Region, Namibia. This study explored the experiences of nurses who worked at the COVID-19 unit of the Intermediate Hospital in Oshakati, Namibia's Oshana Region. In light of other completed studies pertaining to nurses who worked during COVID-19 periods, a global understanding of the experiences of nurses who worked at COVID-19 units will be considered.

2.7 Conclusion

The chapter presented a literature review supporting the study. It first unpacked the overview of the COVID-19 pandemic, followed by the theoretical framework limited to Dorothea Orem's Theory of Nursing Self-Care Deficit, Nursing Systems Theory, and the Relationship-Based Care model. The chapter further presented selected studies relevant to nurses' experiences working with COVID patients, emphasizing the psychological issues nurses faced, physical issues, social perspective issues, and coping mechanisms. In addition, the chapter discussed phenomenological studies on nurses' experiences in combating the COVID-19 pandemic and, finally, the significance of conducting a phenomenological study of the nurses who worked in the COVID-19 pandemic. The next chapter presents the research methodology used.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research methods used in this study, including the paradigm, research design, population and sample, sampling procedure, research instrument (the interview guide), data collection and analysis strategies, and ethical considerations.

3.2 Paradigm

A paradigm is defined as an entire repertoire of beliefs, values, laws, principles, theoretical methodologies, ways of application, and instrumentation (48). Historically, two paradigms have been used to determine all phenomena in the world: natural and human sciences. In natural sciences, the preferred method is quantitative, derived from a positivist perception that focuses on causal relationships of objects (49). The quantitative paradigm aims to study objects of nature, things, natural events, and how objects exist (50). Empirical scientists believe that if objective measurement cannot be assigned to a phenomenon, then the existence of the phenomenon may be in question. However, Oiler pointed out that a human being may not be seen to react in a prescribed manner after being stimulated like other subjects in scientific laboratory experiments (51). An individual is incomparable, unclassifiable, uncountable, and irreplaceable (52). Therefore, the quantitative paradigm is insufficient to explain humans' reality in their life events. Human sciences view the wholeness of human beings (53). The value of subjectivity, which refers to the meanings of how people make sense of their experiences and lives, is taken into account (54). Thus, the qualitative paradigm is used as it was used in this study.

Unlike the quantitative paradigm, the qualitative paradigm is based on human science and aims to understand human behaviour holistically and inductively from

an informant's perspective (54). It offers an opportunity to study and create meaning that enriches and describes human life in context (55). To understand the experiences of nurses working at the COVID-19 Unit in the Intermediate Hospital Oshakati, Oshana Region, Namibia, a qualitative methodology was deemed necessary, committed to seeing the phenomenon from an individual's experience of the COVID-19 pandemic from their point of view.

This study was based on the phenomenology paradigm, which focuses on the reality of human experiences from the perspective of human sciences (56). Phenomenology is a study of the human life-world which focuses on individual human experiences (53). A phenomenological method aims to uncover the meaning of lived experiences through analysis and intuition and to describe a phenomenon based on individual reports as they appear, without any preconceived notions (57). According to Clarke, in a phenomenology study, humanism and holism are both significant perspectives of human sciences (50). As a result, humanism focuses on understanding human beings on an individual level, whereas holism is concerned with viewing them as a whole. Phenomenology, as a way of thinking about what life experiences are like for people, is thus a paradigm that unfolds the meanings of human experiences taken from the human sciences perspective (53). Human beings can be understood in-depth by providing a holistic description of their experiences (50).

According to Spiegelberg, phenomenological investigations have six major elements: descriptive phenomenology, phenomenology of essences, phenomenology of appearances, constitutive phenomenology, reductive phenomenology, and hermeneutic phenomenology (58). Streubert and Carpenter summarise these elements as follows (58).

Descriptive phenomenology aims to research, analyse, and describe particular phenomena directly and freely, without unexamined presuppositions (53). The goal is to present these phenomena in the most intuitive way possible. *The phenomenology of essences focuses on the process of exploring data to search for and establish common themes and essences, thereby forming patterns of*

relationships shared by particular phenomena. Through this process, insights into essential structures and relationships can be obtained. *Phenomenology of appearance* involves giving attention to the phenomenon by dwelling on the data from different perspectives, resulting in a heightened sense of the inexhaustibility of the views. *Constitutive phenomenology* studies phenomena as they establish themselves, taking shape in one's consciousness and developing a reason for the dynamic adventure in one's relationship with the world. *Reductive phenomenology* occurs concurrently throughout a phenomenological investigation when personal bias, assumptions, and presuppositions are set aside, allowing for the purest descriptions of the phenomenon to be investigated. Finally, *hermeneutic phenomenology* is designed to reveal concealed meanings found in the phenomena, which are not immediately understandable but are achieved through an individual's self-interpretation of the phenomena.

Based on the six major elements of phenomenological investigations above, only descriptive phenomenology, phenomenology of essences, and reductive phenomenology were used in this study. Streubert and Carpenter (58) support that not all the steps must be adopted.

3.3 Research Design

Research design is the plan and procedure that involves steps of comprehensive assumption to detailed data collection procedures, analysis, and interpretation (58). This study employed descriptive and explanatory research designs that utilized a qualitative approach to data collection.

3.3.1 Qualitative approach.

Qualitative research is a type of research that explores and provides deeper insights into real-world problems (54). It collects non-numerical data such as words, images, and sounds to explore subjective experiences, opinions, and attitudes, often through observation and interviews. It aims to produce rich and detailed descriptions of the phenomenon being studied and to uncover new insights and meanings (55). A qualitative approach was used as there was a need to obtain an in-depth and interpretive

understanding of the experience of nurses who worked at the COVID-19 unit in Intermediate Hospital Oshakati, Oshana Region, Namibia.

3.3.2 Exploratory Research Design.

The need to explore the experiences of nurses working in a COVID-19 pandemic unit at Intermediate Hospital Oshakati required the use of an exploratory design. This design was helpful in answering questions such as ‘what’, ‘'why’, ‘where’, and ‘how’, toto shed light on the study problem and provide new information and insights (48). This research design was flexible and addressed research questions of all types, and thus was applied in this study. Exploratory research is generally used to investigate a situation, consider alternatives, develop tentative theories, and refine issues for a more systematic investigation.

3.3.3 Descriptive research design.

Descriptive research design involves a scientific technique for observing and interpreting behaviours without affecting the study (48). It is specifically designed to elicit participants’ responses accurately. According to Saunders et al., descriptive research design involves observing issues being studied by interviewing participants to obtain their views (48). Using this design allowed the researcher to assess the sample group comprehensively. Propositions and questions were posed concerning nurses' experience working in the COVID-19 pandemic unit at the Intermediate Hospital in Oshakati, Oshana Region, Namibia.

Given the nature of this study as articulated by the research questions, exploratory and descriptive research designs that employed a qualitative study approach were adopted.

3.4 Population

A population is defined as the total number of elements that interest the researcher (59). Polit and Hungler (60) opine that the population includes the people who have specific characteristics and are of interest to a researcher. In health, a population study is a study of a group of people taken from the general population who share

a common characteristic, such as age, sex, or health condition (60). This group may be studied for different reasons, such as their response to a drug, risk of getting a disease, or their experiences. A target population includes all cases the researcher would like to generalize. In contrast, the accessible population comprises all the instances that conform to the designated criteria and are accessible to the researcher as a pool of subjects for a study. In this study, the researcher targeted all 35 nurses who worked in the COVID-19 Unit at Intermediate Hospital Oshakati, Oshana Region, Namibia, during the COVID-19 pandemic.

3.5 Sample, procedure and size

3.5.1 Sample

Kassu defined a research sample as the elements of interest in the study (61). He added that sampling is the process of choosing a representative sample of the studied population. A defined plan for selecting the study sample is called the sampling strategy. For this study, the sample was nurses who worked in the COVID-19 unit at Intermediate Hospital Oshakati.

3.5.2 Sample procedure

Sample procedures are the techniques used to choose some members of the population to represent the entire population in the study (61). For qualitative studies, strategies include convenience, purposive, and snowball sampling, among others (61). Purposive sampling was used in this study to select participants, helping to focus on a particular characteristic of the population of interest to optimize the likelihood of participants accurately answering the research questions. Purposive sampling involved selecting units most relevant to the subject matter and studying those (62). It was important that the participants were familiar with and had enough knowledge of working with COVID-19 patients.

3.5.3 Sample size

Sample size refers to the total number of selected participants in the study. The sample size was determined by data saturation. The sample was drawn from the nurses in the COVID-19 Unit, who were responsible for nursing COVID-19 patients at IHO. Only eight participants were purposively sampled to participated in the study to data saturation.

3.6 Research Instrument

Research instruments are measurement tools used to collect data from the sampled population (63). Primarily primary data was gathered, which is collected for the first time (63). Examples of research instruments that can be used to collect data from the sampled population include questionnaires, interviews, scales, and checklists (63). In this study, an interview guide written in English was utilised. In qualitative research, interviews are one of the most common data collection methods (63). They are semi-structured because, in addition to delivering high-quality responses, they usually provide the most collaboration and lowest refusal rate, and allow for interaction between the researcher and the subjects.

During data collection, the participants were asked the same questions in the same order. Interviews were performed by appointment once all selected participants gave their consent. The interview was a semi-structured interview guide to learn more about the interviewee's expertise, experiences, and perspectives on the study subject. The questions were more open-ended, allowing for a discussion with the participants rather than a standard question-and-answer approach.

The interview guide was divided into two sections: one for demographic information and the other for probing questions about the study area depending on the study's specific objectives.

A pilot study was conducted on two readily available nurses who did not participate in the final survey in order to pre-test the questions. This allowed the researchers to identify how long each interview would take during the data-gathering process. One question that was deemed to be confusing or ambiguous following the pilot study was removed from the interview questions.

3.7 Data collection procedure

After obtaining ethics approval from the University of Namibia (UNAM), the Postgraduate Research Committee, MoHSS, and Oshakati State Hospital, the policy study was launched. The COVID-19 unit at Oshakati State Hospital was the setting selected for the study. The researcher was introduced to the nurses who worked at COVID-19 unit by a senior staff member of the hospital and was allowed to participate in the activities of the healthcare facility, like having conversations with nurses who worked with COVID- 19 patients. Twelve (12) nurses who met the inclusion criteria were invited to participate in the study at different times. The time of invitation was considered in relation to their readiness. However, the busyness of these participants was a main concern, particularly their busy time. In the first instance, the researcher used telephone and individual contact to provide information related to the study. This included the purpose of the study, method of collecting information, estimated time of involvement, and benefits of the study. An individual meeting with each participant was then arranged and performed. The participant's willingness to take part in the study was confirmed before the consent form was signed. However, before arranging the interview, four nurses withdrew themselves from the study, owing to the participants' inability to cope with the emotional stress caused by the pandemic. A total of 8 nurses were the final number of participants included in this study. Once the consent form was signed, the first participant was individually interviewed for approximately 20 minutes without interruption. All interviewed Descriptions were recorded on audiotape. All participants chose to be interviewed at the healthcare facility where it was more convenient for them. Data collection took three working days from June 10–13, 2023. On the first day, only 4 participants were interviewed; on the second day, only two were interviewed; and the remaining two were interviewed on the third day, making a total of 8 participants.

3.8 Data analysis

Collected data was analysed using thematic analysis following Creswell's (2014) six steps of qualitative data analysis. The six steps involved when analysing and interpreting qualitative data are (i) organization and preparation of data for analysis and transcription of interviews; (ii) reading through all data to obtain a general sense of the information; (iii) coding by reviewing transcripts and field notes and

creating categories according to the responses; (iv) generating themes and descriptions with the use of codes for the themes or categories about data; (v) correlating the description and themes according to the commonality of the responses; and (vi) interpreting the meaning of themes/descriptions to make sense of the data by determining what lessons were learned - this, however, was the researcher's subjective interpretation. Only four key themes were obtained with twelve subthemes.

The nature of qualitative study makes it challenging, if not impossible, for the person analysing the data to remain completely objective. In this study, to maintain the objectivity of the study, bias was minimized by using two people to code the data to avoid inconsistency between the results of the researcher and another one.

3.9 Strategies employed to ensure the quality of data

The data quality in this study was determined according to the criteria for trustworthiness advocated by Lincoln and Guba in 1985 (65). The following criteria will be employed to ensure data quality in this qualitative study.

3.9.1 Credibility

This refers to the confidence one has in the truth of the results (66). Credibility can be achieved through triangulation, member checking, and negative case analysis. Shenton (2014) states that an investigator should seek to ensure that the study measures what it intends to. Research can be regarded as credible if the participants indicate in the interview that the views expressed are their own (66). To ensure the credibility of the instrument, the researcher's academic supervisors reviewed the study before data collection. Any valuable changes arising were incorporated into the final instrument for the final data collection.

3.9.2 Transferability

Transferability is how the study outcome can be employed in other ways (66). To achieve transferability, a broad overview and explanation of the study method, including how data were collected, interpreted, and analysed, should be provided

to enable easy understanding by other researchers. The participants reviewed a summary of the exhaustive description analysed and agreed that the report was suitable for the study phenomenon. This member check was suggested by Guba and Lincoln (65).

3.9.3 Conformability.

It is crucial in qualitative research to achieve conformity. Procedures must be followed to ensure that the findings and results are trustworthy and authentic and represent the respondents' opinions and not the researcher's knowledge on the topic (66). The researcher remained impartial throughout the study and did not influence the research results. During the coding, the researcher meticulously recorded the data to ensure the accuracy of recording the responses. The researcher clearly presented the findings as reported by the participants to ensure conformity (67) in exploring the experiences of nurses working in the COVID-19 pandemic unit at Intermediate Hospital Oshakati in Oshakati Region, Namibia.

3.9.4 Dependability

This was ensured by pre-testing the instrument and ensuring that the interview questions were aligned with the research's purpose and the study's specific objectives. Pretesting was done using two conveniently situated participants at the study site who did not form part of the final study.

3.10 Research ethics

Ethics searches for reasons for acting or refraining from acting, for approving or not approving conduct, and for believing or denying something about virtuous or vicious conduct or good or evil rules (54). In this study, the following ethical values were followed.

3.10.1 Approval letter

Clearance, approval, and permission for the study were obtained from the research committee of postgraduate studies at UNAM. MoHSS and administration of Intermediate Hospital Oshakati, Oshana Region Namibia**.**

3.10.2 Principle of justice

According to Adams, the principle of fair treatment/justice refers to the moral obligation to act based on fair adjudication linked to fairness, entitlement, and equality (55). The selection of participants in this study was fair and was carried out according to the eligibility criteria based on the research design. No financial rewards were given for participating in this research, and no penalty or fine was charged for declining participation.

3.10.3 Principles of Respect. Respect was potential and was enrolled in participants. It was a fundamental aspect that was instilled in all participants. It involved preserving their personal information confidentiality and upholding their right to privacy. Additionally, it included acknowledging their freedom to change their perspective, deciding that the research did not align with their interests, and being able to withdraw without incurring any fees.

3.10.4 Anonymity

This refers to the right of an individual to determine what activities they will or will not participate in. Providing anonymity of information collected from research respondents meant that the study did not collect identifying information of individual subjects (e.g., name, address, email address, etc.) or the study could not link individual responses with respondents' identities (55). Autonomy during the survey was ensured; no names of the participants were used for the completion of the research study, but they were given pseudonyms such as P1, P2, P3, ..,.P8. The researcher explained the aims and objectives of the survey to all respondents, and they were allowed to ask for clarification. A written informed consent was obtained.

3.10.5 Confidentiality.

The respondents were assured that no private information would be shared without their knowledge or against their will. The data collected was only used for the thesis, which would be stored in the university library. Additionally, the data were collected in a professional manner, and participants were allowed to ask for any information related to the study if there was anything, they did not feel comfortable with.

3.10.6 Privacy

Individuals have privacy interests about their bodies, personal information, expressed thoughts and opinions, personal communications with others, and the spaces they occupy (56). The researcher respected the individual participants and gave them the opportunity to exercise control over their personal information by consenting to, or withholding consent for, the collection, use, and disclosure of it.

3.10.7 Security

Security refers to measures used to protect information, including physical, administrative, and technical safeguards (56). The researcher fulfilled her confidentiality duties, in part, by adopting and enforcing appropriate security measures, such as physical security precautions. For example, the researcher locked up completed interview guides in a cabinet and the computer containing the research data in the same area with a password.

3.10.8 Beneficence.

Beneficence refers to the obligation on the part of the investigator to maximize the benefit to the individual respondent and/or society while minimizing the risk of harm to the individual (55). This study would help the Ministry of Health and Social Services (MOHSS) and COVID-19 operative management, especially at Oshakati State Hospital, to understand nurses' experiences and help them overcome common difficulties in the area. Moreover, this pandemic will not be the last;

others are still coming, and the MOHSS can use this finding to better care for and equip its staff in the future, given similar circumstances.

3.10.9 Non-maleficence

Non-maleficence ensures that what has been done is not harmful and that harm was not done by omitting care or treatment. The researcher assured respondents that they would not suffer any physical, psychological, financial, and/or emotional harm and ensured good practice throughout the study, making no false promises to participants.

3.11 Conclusion

The chapter presented the research methods used in the study, showing how qualitative data was collected from eight purposively selected nurses who work in COVID-19. The data was analysed thematically and findings were presented in themes and subthemes. The data collection process was done by international rules regarding research involving human beings. The next chapter presents the findings.

CHAPTER 4

DATA PRESENTATION

4.1 Introduction

The previous chapter presented the research methods used in data collection and analysis. In this chapter, collected data is presented thematically in themes and subthemes. Eight nurses who worked at the COVID-19 Unit in Intermediate Hospital Oshakati (IHO), Oshana Region, Namibia, during the COVID-19 pandemic participated in the study to achieve data saturation.

4.2 Demographic information of participants

The demographic information of participants included age, gender, and the number of people living with them. Eight participants participated in the study. The age of the participants ranged from 24 to 39 years, of which five are in their 30s and the remaining three are in their 20s. Five participants were females, and the remaining three were males, showing gender considerations in the study. Participants stayed with between one and six people at their homes. This is presented in Table 4.1 below.

Table 4.1: Demographic information of participants

Participant (P)	Age (years)	Gender	Number of people living with	Category of these nurses
P1	38	M	6	Registered nurses
P2	33	M	1	Registered nurses
P3	29	F	4	Registered nurses
P4	35	M	4	Enrolled nurses
P5	24	F	3	Enrolled nurses
P6	31	F	1	Registered nurses
P7	39	F	4	Registered nurses
P8	28	F	2	Registered nurses

Eight participants participated in the study. The participants ranged from 24 to 39 years, of which five are in their 30s, and the remaining three are in their 20s. Five participants were females, and the remaining three were males, showing gender considerations in the study. Participants stayed with between one and six people at their homes. Six participants were Registered nurses while the remaining 2 were Enrolled nurses

4.2 Experience working at COVID-19 unit

The verbatim transcription of the eight study participants' recorded interviews was completed, and meanings were formulated and determined for each theme. Through multiple readings of the transcripts, the researcher identified four significant or momentous themes of positive experiences, negative experiences, challenges, and coping mechanisms, which were then grouped into twelve subthemes (Table 4.2). These include learning, patient treatment and recovery, patient management, worry and fear of death of patients, trauma development, disclination, lack of equipment, shortage of staff, challenges with communication with family, psychological support, increase in the supply of equipment, and increase in staff members. Each participant's quote is followed by a numerical suffix that points the reader to the data distribution.

Table 4.2: Thematic table

Themes	**Subthemes**
4.2.1 Positive experiences	4.2.1.1 Learning
	4.2.1.2 Patient treatment and recovery
	4.2.1.3 Patient management
4.2.2 Negative experiences	4.2.2.1 Worry and fear of death of patients
	4.2.2.2 Trauma development
	4.2.2. 3 Disclimnation
4.2.3 Challenges	4.2.3.1 Lack of equipment
	4.2.3.2 Staff shortage
	4.2.3.3 Challenges with communication with family
4.2.4 Coping mechanisms	4.2.4.1 Psychological support
	4.2.4.2 Increase in supply of equipment

	4.2.4.3 Increase in staff members

4.2.1 Theme 1: Positive experiences

The participants had positive experiences learning how to deal with COVID-19 patients, patient treatment and recovery, and patient management.

4.2.1.1 Learning

Many participants gained positive experiences from learning how to deal with COVID-19 patients. These participants indicated that they learned how to cope in a very difficult situation, manage ventilated patients, and care for COVID-19 patients. These are evidenced in the following narratives:

> *"I learned more about COVID-19 and how to cope in a very difficult situation"* P1.

> *"I learned how to manage patients on ventilators"* P3.

> "*I learned more on how to manage Covid-19 patients"* P6.

This implies that they acquired knowledge on treating and managing COVID-19 patients. These findings are similar to one of Ahmadidarrehsima et al. (69) who found that nurses gained knowledge and experience in taking care of the COVID 19 patients.

In support of those above, a participant described how she learned and understood that COVID-19 is not a fatal disease.

> *"I learned and gained more knowledge and understanding that COVID is not a killing disease; it only needs psychological support and faith"* P4.

Many recalled spending as much time as they could outside and developing a stronger spiritual connection with God, others, and themselves (56). The above extracts show that participants learned to deal with COVID-19 patients when caring for or nursing them at the hospital.

4.2.1.2 Patient treatment and recovery

Participants had positive experiences with treating and recovering patients. They acknowledged making adjustments to better the health and wellbeing of their COVID-19 patients for them to live autonomous lives and realize their full potential.

> *"My wish was for the patients to recover quickly and for Covid-19 to end. I didn't want the patients to die every day, and I wanted life to return to normal again"* P1.

According to a study by Qureshi et al., nurses caring for Covid 19 patients felt uneasy. They reported being unable to foresee when people would become unwell or feel better and how long the epidemic would endure (17).

> *"My wish was for all Covid patients to recover fully and get well"* P4.
>
> *"I feel fulfilled when I see patients recovering"* P8.

The above exemptions show that participants experienced patient treatment and recovery. They always wanted the patients to recover and get back to their everyday lifestyles.

4.2.1.3 Patient management

Participants acknowledged having gained positive insights into patient management, using their activities as healthcare providers to manage and meet the growing expectations of COVID-19 patients. They stated that, rather than just treating the illness, they emphasise building strong patient relationships. One of the participants was quoted narrating how she gained more knowledge about COVID protocols, burials, personal protective equipment (PPE), management of COVID-19, and how to prevent the infection from spreading quickly or at all. This is evidenced in the following narrative.

> *"I gained more experience on COVID protocols, burials, PPE, and management of COVID-19 and how to prevent the infection from spreading fast or not spreading at all"* P4.

These findings are similar to one of Ahmadidarrehsima et al. (69) who found that nurses gained knowledge and experience in taking care of the COVID 19 patients.

The narration demonstrates how participants developed experience in patient management. Interviews revealed that patient care management involves providing comp rehensive medical services to help patients manage their health, ranging from short-term case management and chronic illness care management to primary care procedures such as appointment scheduling.

4.2.2 Theme 2: Negative experiences

Participants had negative experiences of worry and fear of death of patients, trauma development, and poor socialization experiences when working at the COVID-19 unit in Intermediate Hospital Oshakati, Oshana Region, Namibia.

4.2.2.1 Worry and fear of death of patients

The participants indicated that various things scared and worried them, both inside and outside of the workplace. This concern was so severe that in some cases, the participants became worried and feared when they heard that can extend the illness their family members and family and witnessed patients passing away from COVID-19. The nurses' fear and worry were mainly derived from the risk of contracting the virus themselves, the potential for family members to become infected, the sudden deterioration of some patients' conditions, the increasing patient hospitalisation and mortality rates, the possibility of not engaging enough to save patients, and their own knowledge and skill deficiencies to assist critically ill patients.

> *"I was worried COVID-19 would infect me, and I later counseled myself since I am a nurse, ...my biggest fear was to get infected with COVID-19, and if I get infected, will I make it, or am I going to die?"* P1.
>
> *"I'm anxious about spreading the illness to my family, so every time my phone rings, I hear a heartbeat. I'm always afraid they'll call to let me know they have the disease's symptoms"* P7.

In a study by Taylor, Landry, Rachor, Paluszek, and Asmundson, nurses' fear and anxiety about the risks of COVID-19 infection were experienced. The results demonstrated that nurses feared, were anxious and worried about transmitting the infection to their family members after work due to the sudden worsening and increasing number of COVID-19 patients in the health facilities, patients' condition and increased mortality rates (39).
In support, four participants talked about how they were fearful

> *"I was fearful; my biggest fear was to contract COVID-19 to the extent of severe illness"* P2.
> *"I was scared of getting infected by COVID-19; my biggest fear was to die due to Covid 19"* P4.
> *"I was shocked and scared at the same time. I was scared to get infected with COVID-19, and I had fear of infecting my family*" P5.
> "*I was scared to get infected with Covid-19; yes, the terrible experience is when a lot of people were dying one after the other*" P6.

The director general at the media briefing stated that nurses' fear of contracting the disease (COVID-19) is a stigma that causes sudden death for many nurses (2).

Participant 2 added that she was angry and her biggest fear was to test for COVID-19. She narrated as follows.

> *"I was so angry….my biggest fear was to get tested for COVID-19"* P3.

The excerpt above demonstrates that participants' fears and worries about contracting the pandemic heightened because they interacted directly with Covid 19 patients.

4.2.2.2 Trauma development

The nurses claimed that their exposure to anxiety, fear, suffering, family rejection, and patients dying alone had caused them to develop trauma. They said,

> "*The nurse's worst experience can be the moment one of the patients takes your hand and says they are choking or suddenly starts shivering or screaming in pain in the chest. I was very disturbed and uneasy by the scenes*" P7.

Another participant talked about how he experienced a terrible occurrence in the Ward and how it affected him. The participants agreed that they saw people dying like animals:

> "*Yes, death. It was so bad because people were dying like animals and so fast. Imagine you talk to a person now, then later, when you go back, the person is dead. "I was traumatized"* P3.
>
> *"This was when I went to collect a body, and to my surprise, it was a person that I know very close to me. I was terrified and traumatized"* P1.

The above extracts show how participants were traumatized after seeing patients they were nursing dying in the hospital. As stated in the Namibian that the country has seen almost 100 COVID-19 patients die in the last two weeks, and 24 deaths were recorded yesterday alone (77).

4.2.2. 3 Discrimination

Most nurses claimed to have felt fear of rejection by others or their families, describing it as a painful experience. In some cases, family dissatisfaction with their work in the COVID-19 ward and the lack of empathy from coworkers in other wards were also viewed as unpleasant social experiences. One nurse shared,

> "*When I left the ward, everyone was running away from me; even my relatives were staying away from me" (7*).

Another participant said,

"*My friends and family did not want to interact or socialize with me as they think I will give them Covid-19*" (P4).

Other participants indicated that they experienced everyday life but were always avoiding interacting with them to prevent infecting their family members. She said,

"It has just been normal to them, but I have been avoiding them, like not hugging them" (P1).

"It was good but not much as it has been because most of them fear contracting COVID-19 from me since I work with COVID-19 patients" (P2).

Previous research has suggested that nurses isolate themselves to prevent emotional distress by severing connections with others (38) and protecting their families (44).

4.2.3 Theme 3: Challenges

Participants indicated they faced challenges when working with Covid- 19 patients. These challenges include a lack of equipment, staff shortage and challenges with communication with family.

4.2.3.1 Lack of equipment

Participants indicated they faced challenges of lacking equipment to be used in the hospital while nursing COVID-19 patients. The participants in this study reported that among the most prevalent unmet professional needs were the following: lack of personal protection facilities and equipment, particularly at the beginning of the COVID-19 epidemic; lack of appropriate dressings for the treatment of pressure sores caused by constant mask wear; lack of nursing and service staff; lack of oxygen ventilators; and lack of proper ventilation in the ward.

The participants narrated as follows:

"Lack of consumables, such as oxygen, has caused the hospital to try and procure some and borrow from other facilities, wherever possible" P1.

"Poor oxygen supply and a lack of ventilators in the hospital has caused them to borrow more ventilators from district hospitals to equip the COVID-19 ICU" P2.

"The biggest challenge has been the lack of oxygen, a major problem" P3.

"When the hospital has run out of oxygen, the crisis has been resolved by the hospital building a compressed gas system" P5.

In support, the Health executive director confirmed that the ministry has been experiencing a low supply of oxygen in the hospitals and has engaged other suppliers (77).

One participant talked about how the lack of equipment, such as face masks, gloves, and ventilators, created emotions in his work as a nurse. He narrated:

"*I went through a range of emotions when I saw mostly youth dying, and there was a shortage of some equipment, such as face masks, gloves, and ventilators, due to the increasing number of patients*" P4.

The Namibian in June further stated that the country has seen almost 100 Covid-19 patients die in two weeks, and 24 deaths were recorded in one day alone (77).

4.2.3.2 Staff shortage

The participants indicated a a shortage of staff at the hospital that affected effective nursing care during the Covid-19 period. The study's participants mentioned the challenges of working in the COVID-19 unit. Some of the issues mentioned included an excessive workload and hard work due to limited staff. The participants claimed that these issues resulted in intense work pressure and fatigue. For instance, the participants said,

"*We could not rest even for a moment once we entered the ward at the*

beginning of the shift. It wasn't very good. I thought I was fighting and taking part in a war" P7.

"Shortage of staff, it never gets resolved" P5.

Similarly, Sun et al. (14) reported that nurses' workload increased as the number of COVID-19 patients increased (69). These results are consistent with those of authors (8, 9, and 19), who discovered that treating COVID-19 patients posed difficulties that could cause them to feel depressed and exhausted, including long work hours and a heavy workload.The accounts above extracts demonstrate that nurses had a very heavy workload during the COVID-19 outbreak due to staff shortages. Since then, the workload has increased further due to the high patient care load associated with the virus, as well as the increased psychological strain in their living and working environments.

4.2.3.3 Challenges with communication with family

Two of the participants indicated that they faced challenges communicating with the families of the COVID-19 patients who had died at their hands. One participant "*it was not easy to brief the family about the death of their beloved*." P5

4.2.4 Theme 4: Coping mechanisms

The participants in this study came up with three coping mechanisms to deal with the challenges of caring for COVID-19 patients. The tactics employed included seeking for psychological support, increased supply of equipment and increased staff members.

4.2.4.1 Psychological support

The participants revealed that they had occasionally employed various techniques to lessen the effects of stress and emotions. These tactics included walking, reading, practicing relaxation techniques, and relying on God. They also noted that keeping negative thoughts at bay had been helpful. Additionally, they had developed a rational attitude toward their work in the COVID-19 ward. They had

been able to lessen their worry by adopting a professional approach and feeling a sense of responsibility to help resolve the pandemic crisis. Participant 1 commented,

> "*I was extremely concerned that I might spread the illness to my family, but I put my trust in God and made an effort to block out those thoughts"* P1.

Many recalled spending as much time as they could outside and developing a stronger spiritual connection with God, others, and themselves (56). Each participant in the study sought out interpersonal and staff members' psychological support to give people in distress a sense of calm and support, enabling them to deal with their problems more effectively. This support helped the nurses manage their circumstances and come to wise decisions. The participants narrated.

> *"Psychological support for nurses working with COVID-19 patients"* P1.
>
> "*The hospital management needs to assist with psychological support for health care workers working with COVID-19 patients"* P4.

Supported by the study by Catton, It is essential that authorities and governments should be aware of the physical and mental toll that the COVID-19 epidemic has placed on nurses, and they should pay attention to their needs in these areas and take appropriate action (76).The above extracts indicate that the provision of psychological support was necessary as one of the coping mechanisms used by nurses during and after the period of nursing COVID-19 patients.

4.2.4.2 Increase in supply of equipment

All indicated a need to increase the supply of equipment used in nursing COVID-19 patients. The participants were most concerned with procuring more oxygen cylinders to be able to have enough oxygen to be given to patients who wanted it. The participants narrated as follows.

> *"To make sure Oxygen is available when possible"* P1.

"The hospital could procure more cylinders to have sufficient oxygen supply in the ward" P2.

"*To look on staff shortage and procure enough oxygen*" P6.

The above extracts indicate that increasing the equipment supply was an important strategy for reducing the negative experiences faced by the nurses while taking care of the COVID-19 patients, which is supported by Ross that all nations must prioritize the efforts to increase oxygen availability (78).

4.2.4.3 Increase in staff members

The study participants proposed increasing the nursing staff to meet the increasing demand for COVID-19 patients at the hospital. They further emphasized increasing the staff allotment tostaff to motivate them to work effectively. Participant 1 suggested that the staff should be given cash allowances to supplement their average salaries. Two of the participants added that the number of staff members needs to be increased. The participants narrated as follows:

"And to employ more staff to deliver quality patient care" P2.

"At least they should employ enough workers and be able to give risk allowance please for this kind of things as it was traumatizing" P3.

The above extracts showed that increasing nursing staff and motivating them is a compensatory mechanism for the negative experiences nurses face while nursing COVID-19 patients. Karami et al. also noted that forfor nurses working in COVID-19 wards to deliver effective and high-quality care services, they had to overcome unusual work challenges including addressing staff shortages (75).

4.2 Summary of the themes analysed

The experiences of nurses working at the COVID-19 unit in Intermediate Hospital Oshakati, Oshana Region, Namibia, were contemplated in terms of how COVID-19 affected the population and the nursing professionals. The nurses had positive experiences of learning, patient treatment and recovery, and patient management. They had negative experiences that included worry and fear of death of patients,

trauma development, and socialisation experiences. In addition, participants experienced challenges of lack of equipment, staff shortage, and difficulties with communication with family. Three strategies were used to deal with such issues that faced the nurses in caring for COVID-19 patients. Psychological support, increased supply of equipment, and increased staff members were the coping strategies revealed that ensured individual nurses' ability to nurse COVID-19 patients.

CHAPTER 5

DISCUSSION OF FINDINGS, SUMMARY, CONLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This is the last chapter of this entire study. It has four roles to attain. First, it makes a discussion of the findings; secondly, it summarises the study; thirdly, it presents conclusions of the study based on both the results and the discussions made; and finally, it makes the recommendations of the study.

5.2 DISCUSSION OF FINDINGS

There are two subsections in this section of the study. Exploring the experiences of the nurses who worked at the COVID-19 unit in the IHO, Namibia, is challenging yet rewarding. A second level of analysis about the nursing model is included to promote discussion further.

5.2.1 Positive experiences

Working under COVID-19 became a phenomenon with many different aspects and meanings. Under the themes of positive experiences, the various facets of nurses' experiences in the Covid 19 infection are covered: learning, patient treatment and recovery, and patient management.

5.2.1.1 Learning

The findings of the study suggested that nurses who worked in the COVID-19 unit had positive experiences of learning how to cope with a very difficult situation, managing patients on ventilation, and caring for COVID-19 patients. They learned how to take care of COVID-19 patients, as it was a new infection putting people at risk. They learned how always to use PPE, which was not common knowledge, and gained knowledge about caring for COVID-19 patients. These findings are

similar to one of Ahmadidarrehsima et al. (69), who found that nurses gained knowledge and experience in taking care of the COVID-19 patients. The learning of the nurses taking care of COVID-19 nurses is also congruent with a study by Zamanzadeh et al. (70). That nurses working in infection cases say COVID 19 learn new things and, as a result, gain more knowledge on nursing care and ways of preventing themselves from being infected by the infection and also how they can protect themselves from spreading the virus to their family members after their work hours.

5.2.1.2 Patient treatment and recovery

The participants of this study viewed working in the COVID-19 unit while treating COVID-19 patients as an essential nursing function. They perceived themselves as being able to provide treatment to patients and see them recover. Thus, the recovery of the patients makes it necessary to be part of a change process in which the patients improve their health and their wellness as they strive to reach their full potential. Other authors have also revealed similar findings (33, 7, and 8). The nurses experience the treatment and recovery of patients as it is their role, alongside other healthcare professionals, to treat patients directly and on the front lines of the healthcare system. In the same vein, MoHSS believes that the most crucial role in treating patients during an outbreak of an infectious disease is always played by medical personnel, endangering their lives or putting their health at risk (7). According to Orem, nurses have a crucial role in providing the ability to maintain the quantity and quality of therapeutic care in sustaining life and health, recovering from disease or injury, or managing patients' repercussions, which necessitates the presence of a nurse (33).

5.2.1.3 Patient management

Patient management involves several activities health practitioners use to meet patients' increasing expectations. Healthcare providers, including nurses, engage in various patient management activities. In managing patients, nurses treat illnesses and emphasize building strong patient relationships. This supports the fact that nurses had positive experiences managing patients while working at the

COVID-19 unit at the IHO. According to Onodera and Sengoku, patient management entails maintaining electronic health records, organizing treatment options, assisting with self-management, and other responsibilities ((71). They may even work with insurers to establish coverage for their patients. Without a patient care manager, nurses and social workers handle the duties above. The duties of a nurse in the care of patients include giving medication, performing routine medical examinations, documenting thorough medical histories, monitoring blood pressure and heart rate, performing diagnostic tests, operating medical equipment, drawing blood, and admitting and releasing patients by doctor's orders.

5.2.2 Negative experiences

The negative experiences of nurses worked at covid-19 unit in Intermediate Hospital Oshakati, Oshana region, Namibia were worry and fear of death of patients, trauma development and socialization experiences.

5.2.2.1 Worry and fear of death of patients

Many of the participants experienced worry and fear of the deaths of patients after seeing COVID-19 patients die. The participants in the study believed that nurses caring for COVID-19 patients were in and out of a cycle of emotional distress during that time. Concerns about death and dying were among the pain, along with worry, fear, and confusion. Several authors have reported experiencing similar, related emotional disturbances (38, 39, 40). The feelings of anxiety associated with death and dying were the emotional disturbances that the study participants most frequently expressed. They believed that being around COVID-19 patients put them at risk of contracting the pandemic, and as a result, they felt like they had been "sentenced to death." Nurses perceived the meaning of living with mortality fear as being similar to being "worry machines," which first started after witnessing patients pass away from COVID-19. These results are consistent with the World Health Organization's (2020) report. According to the report, the primary sources of stress for the employees of COVID-19 units were perceived to be feelings of fear related to death and dying.

According to Viney et al. (2019), the fear of dying can be explained as a typical human reaction to terminal illness, similar to responses to other fatal diseases such as HIV, cancer, and scleroderma. However, the results showed several factors that might trigger fear differently in some people than in others. For example, Participant 3 stated, "*"I was so angry,my biggest fear was to get tested for COVID-19."* The participants' feelings of fear and worry were also influenced by the experiences of COVID-19 patients with death. Other researchers (2, 38–40) reported similar outcomes.

5.2.2.2 Trauma development

Emotional and psychological trauma is caused by unexpected or highly stressful life events that result in a loss of psychological security and stability, leaving the individual with feelings of extreme fear and helplessness (72). Subjects who have experienced psychological trauma may feel emotionally numb, disconnected, and lose trust in others. Psychological trauma is usually associated with life-threatening situations, but an individual's reactions to anxiety triggers and depression stimuli can also result in trauma (72). For example, as their COVID-19 patients died in their care, the nurses experienced emotional and psychological trauma. Participants in this study experienced trauma after witnessing COVID-19 patients die, and their conditions deteriorate. Many people reported feeling fear, anxiety, depression, guilt, and symptoms of post-traumatic stress disorder (PTSD) in response to the situation. This highlights the wide range of nurse- and patient-specific traumas experienced by critical care nurses while treating patients during the pandemic. These findings comply with Foli et al. (73), who reported psychological distress in terms of depression, PTSD, anxiety, and guilt.

5.2.2.3 Socialization experiences

The findings show that the participants lacked socialisation opportunities, resulting in family dissatisfaction with the COVID-19 war's nursing staff and a perceived lack of empathy from their coworkers in other wards. This negative social experience seemed to be related to contextual elements, such as social rejection, which caused the participants to reduce their social engagement and become more

solitary, spending most of their time alone at home. Previous research has suggested that nurses isolate themselves to prevent emotional distress by severing connections with others (38) and protecting their families (44). This study lends credence to those conclusions, as the participants isolated themselves out of fear of rejection and to preserve their significant others from their emotional anguish. Furthermore, the study participants' sense of privacy and insecurity were found to play a role in hiding their COVID-19 status. Their fear of rejection, which impacted their socialization, was one of the main justifications offered for their need for self-defense.

5.2.3 Challenges

Nurses working at Covid-19 unit in IHO experienced challenges of lack of equipment, staff shortage and communication with family.

5.2.3.1 Lack of equipment

The participants reported that there was a lack of enough equipment available to care for the COVID-19 patients, raising concerns from nurses about the standard of care they delivered. They also mentioned having to care for patients with outdated equipment. According to nurses, the healthcare system was not ready for the pandemic, and the regulations were murky, lacking, and constantly changing. It was impossible to develop validated diagnostic protocols during a crisis such as COVID-19, so nurses' post-pandemic reflections may help manage crises in the future. These results are consistent with those of authors (8, 9, and 19), who discovered that treating COVID-19 patients posed difficulties that could cause them to feel depressed and exhausted, including long work hours and a heavy workload, exposure to the virus, frequent and close contact with infected patients, lack of personal protective equipment, limited oxygen cylinders, stigmatization as virus carriers, pressure from the media, and an increase in fatalities. Additionally, inappropriate PPE, excessive perspiration and dehydration, wounds from prolonged mask wear, a suffocating sensation, and an inability to eat or drink properly could increase the physical strain on nurses during the pandemic (20). These elements lower the quality and quantity of patient care and make nurses feel helpless and hopeless.

5.2.3.1 Staff shortage

When caring for COVID-19 patients, hospitals encountered various difficulties and challenging situations, including a nurse shortage that increased the nursing workload. This result is consistent with the findings of AACN (8), which stated that nurses experience psychological distress and exhaustion as a result of their lengthy workdays and demanding workload due to their shortage. Stimpfel also noted that difficulties with donning and doffing personal protective equipment, restrictions brought on by these clothes and equipment, fatigue, insomnia, headaches, and anorexia resulted in an excessive workload for nurses as well as physical and mental issues (74). Karami et al. also noted that forfor nurses working in COVID-19 wards to deliver effective and high-quality care services, they had to overcome unusual work challenges (75). Similarly, Sun et al. (14) reported that nurses' workload increased as the number of COVID-19 patients increased (69). Thus, for nurses to effectively care for patients, they should be protected from an excessive workload.

5.2.3.1 Challenges with communication with family

It became clear that there was a lack of open communication between the participants and the members of their families, which is essential for fostering mutual understanding and reducing hostility caused by patients' fear, anxiety, and misconceptions. Interestingly, this was also not particularly noticeable in the case of patients, a population that is expanding due to Namibia's status as an international hub. Recent reports of threats or acts of violence, including physical and verbal abuse, against healthcare workers during the COVID-19 pandemic have been made, though primarily by patients' relatives who were unhappy with hospital policies and lacked knowledge about COVID-19 and its treatment (25).

Poor communication contributed to Nurses' frustration and isolation due to their ignorance of the pandemic. A study by Qian, Luo & Haase indicated that although quarantining and social segregation decreased mortality and morbidity, they also led to social isolation and stigma (38). Nursing staff's performance and mental health were negatively impacted by social isolation and confinement (17).

Initiatives were taken to address this and raise the morale of healthcare workers. Nevertheless, some social groups still stigmatise healthcare professionals. Some studies suggest that the reactions of society made medical professionals feel guilty and yearn for a life of social isolation and little contact with the outside world (8,9). Even though they followed the isolation guidelines, some nurses were still classified as disease carriers. Out of fear of spreading the illness, they stayed away from their homes, families, and social settings (9). In a previous study, female nurses who participated reported struggling to balance the increasing demands of personal hygiene with the societal expectations of caring for the elderly and raising children (20). With no rules or guidelines, nurses had to get used to new routines and cope with the emotional toll of being away from their loved ones. They were left to manage their anxieties and apprehensions on their own. However, in addition to psychological resilience and intra- and extra-family social support, self-efficacy was one of the main protective factors preventing adverse psychological experiences during the COVID-19 pandemic (9).

5.2.4 Coping mechanisms

The nurses who participated in this study faced numerous challenges to survive. They employed various tactics to cope, such as increased staffing, equipment supply, and psychological support. Several studies (2, 44, 56) have mentioned the use of these tactics.

5.2.4.1 Psychological support

According to earlier research, psychosocial support is any aid that a person receives to maintain or improve their mental health and psychosocial wellbeing (43). A key component of psychosocial support is the treatment and prevention of mental illnesses such as post-traumatic stress disorder, anxiety, and depression. essentialshould authorities and governments must be aware of the physical and mental toll that the COVID-19 epidemic has placed on nurses, and they should pay attention to their needs in these areas and take appropriate action (76). The study's findings support these conclusions. The study's participants admitted to using different strategies occasionally to lessen the effects of stress and emotions. These

strategies included walking, reading, relaxing, and relying on God. Additionally, nurses observed that resisting pessimistic thoughts had been beneficial. They had also adopted a practical outlook on their work in the COVID-19 ward. They had been able to reduce their anxiety by doing so in a professional manner and feeling a sense of obligation to help address the pandemic crisis. Similar findings have also been reported by authors, who claim that psychological support is a tactic nurses can use to deal with the stress of working in busy wards with rising mortality (44, 45, 43, 12). Additionally, organizational coping mechanisms are required to deal with ethical problems in COVID 19 Units (4). These include improving human resources policies, creating targeted psychological interventions, and having ethical guidelines for difficult decisions in ICUs.

5.2.4.2 Increase in supply of equipment

All study participants noticed increased equipment available to aid in providing healthcare to COVID-19 patients. The results clearly showed that nobody was exempted from the problem of having little equipment to work with when nursing COVID-19 patients, which impacted their preparations to fight the virus. Lack of preparation could cause panic and anxiety among nurses, as they may not be aware of the scope of the COVID-19 pandemic's spread (13). Pandemic preparedness is crucial for disease control. Lack of equipment can impact employee motivation and teamwork at work (14). To protect staff members and patients, healthcare facilities must have long-term pandemic control tools and monitoring techniques (15). Nurses should follow these policies when dealing with a global pandemic like COVID-19. In addition, PPE is an essential factor to take into account when battling infections like COVID-19 (38). Numerous studies noted a lack of PPE in the workplace, particularly during the early COVID-19 pandemic that resulted in the condition of numerous nurses (15). The lack of PPE made nurses fearful and worried they might contract COVID-19 (15). All healthcare facilities should provide personal protective equipment (PPE) in accordance with a clear policy (8,9). This will guarantee sufficient PPE and security for all involved nurses. In addition, the national government should adopt PPE procurement policies for healthcare institutions (8). This will ensure complete PPE during epidemics. Good

communication is essential to maintain a secure work environment and to provide high-quality care.

Our findings show that more must be done to ensure that PPE is available sufficiently to protect nurses and other healthcare workers from COVID-19 infection. To ensure that healthcare professionals and staff are prepared for any future pandemics, pandemic training should be provided at all healthcare institutions. To avoid a nursing shortage, nurse managers should also consider controlling nurses' work schedules and having adequate staff.

5.2.4.3 Increase in staff members

The results indicated that a small number of nurses caring for COVID-19 patients had increased their workload, and it was suggested that the number of nurses in the hospital, particularly at the COVID-19 unit, be increased. Prior research has shown that hospital nurses struggle with improving patient care responsibilities and exhaustion (18,20). A pandemic's potential to reach a critical stage could affect nurse recruitment. When working long hours, coworkers should support one another by providing quick breaks (22). As a result, healthcare facilities must be ready for the potential of insufficient medical personnel and have backup plans in place (22). The most recent research suggests that effective national hiring and significant sector financing are required to address this issue (23).

5.3 Relationship of the study findings with the nursing theories

Although none of the nursing models or theories were intended to serve as a framework for this study, the results were thought to somewhat accord with one. The research revealed that nurses' experiences at the COVID-19 Unit in IHO, Oshana Region, Namibia, illustrated how COVID-19 infection impacted their ability to care for patients with the same infection. Orem's Self-Care Deficit Theory appeared to apply to this study, and the findings were then subjected to a second level of analysis using these theories.

Self-care theory, supported by Orem's self-care deficit theory, is concerned with preserving and improving a person's functioning at home (33). It emphasizes the person's capacity to engage in self-care, which entails taking action for their benefit. According to the theory, which is related to nursing systems theory, self-care refers to the capacity to take care of one's own needs. In contrast, a self-care deficit occurs when demands exceed a person's ability and nursing assistance is necessary. This theory can be used to maintain therapeutic care, recover from illnesses or injuries, and handle patients' after-effects. Not only does it emphasize the value of preserving autonomy in self-care procedures, such as COVID-19 patient health and wellbeing, but it also highlights the need to do so and helps nurses decide which aspects of patient care to focus on.

5.4 SUMMARY

This phenomenological study aimed to explore the experiences of nurses who worked at the COVID-19 Unit in Intermediate Hospital Oshakati, Oshana Region, Namibia. The findings indicated that working under COVID-19 had effects on nurse's quality of life and service delivery. The meanings of working in the COVID unit for the participants in this study were captured into four major themes, including positive experience, negative experience, challenges, and coping strategies.

The participants had positive experiences, including learning how to deal with COVID-19 patients toa toughto cope in a tough situation, manage patients on ventilation, and care for COVID-19 patients. They further experienced favourable patient treatment and recovery, making adjustments to better the health and wellbeing of their COVID-19 patients so they could live autonomous lives and realise their full potential. Finally, they experienced patient management that helped them to manage and meet the growing expectations of COVID-19 patients.

The participants had positive experiences of worry and fear of death of patients, trauma development and socialisation experiences. The primary sources of participants' anxiety and fear included the possibility of contracting the virus themselves, the chance that their family members might catch it, the sudden deterioration of some patients' conditions, the rising hospitalisation and mortality

rates, the potential for not acting quickly enough to save patients, and their lack of knowledge and skills to help critically ill patients.

The participants developed trauma due to their exposure to anxiety, fear, suffering, family rejection, and patients dying. The findings further showed that emotional and psychological trauma arises from stressful life events, causing feelings of anxiety and helplessness. Nurses, particularly during the COVID-19 pandemic, experienced emotional and psychological trauma due to witnessing patients' deaths and deteriorating conditions. This highlights the diverse nurse- and patient-specific traumas experienced by critical care nurses, including depression, PTSD, anxiety, and guilt.

Findings showed that study participants had socialization experiences, which they described as painful experiences due to fear of rejection by others or their families. Additionally, participants had limited socialization opportunities, leading to family dissatisfaction with COVID-19 nursing staff and a perceived lack of empathy. This negative experience, coupled with the fear of rejection and insecurity, resulted in reduced engagement and a more solitary lifestyle, as well as hiding their COVID-19 status as a form of self-defence.

The findings of the study also told that participants were faced with challenges such as a lack of equipment, staff shortages, and difficulties communicating with family members. The most prevalent unmet professional needs included a lack of personal protection facilities and equipment, particularly at the beginning of the COVID-19 epidemic; lack of appropriate dressings for the treatment of pressure sores caused by constant mask wear; lack of nursing and service staff; lack of oxygen ventilators; and lack of proper ventilation in the COVID-19 unit.

Findings showed a shortage of nursing staff at the COVID-19 Unit. This challenge resulted in hard work, intense work pressure, and fatigue. Nursing staff shortage led to psychological distress, exhaustion, and physical and mental issues for nurses. To deliver effective care, nurses must overcome unusual work challenges and be protected from excessive workload.

Challenges with communication with family were experienced by the participants in one-to-one interviews. Findings showed that a lack of open communication between participants and families hindered mutual understanding and reduced hostility.

The study participants tried to deal with the difficulties, utilizing various strategies. Psychological support was used for wellbeing, treating and preventing emotional illnesses. Strategies like walking, reading, and relying on God reduce stress. Nurses find psychological support helpful in managing COVID-19 stress and ethical dilemmas.

The increase in equipment supplythe supply of equipment was significant as the COVID-19 Unit faced limited equipment. The rise in COVID-19 patient equipment impacted preparedness and morale. Lack of equipment can cause panic among nurses. Long-term pandemic control tools and monitoring techniques are crucial. Clear PPE procurement policies and good communication are essential for a secure work environment and high-quality care.

Several participants advocated for staff increases to reduce the nursing workload. A small number of COVID-19 nurses increased their workload, suggesting an increase in hospital nurses. The pandemic's potential to reach a critical stage could affect nurse recruitment. Healthcare facilities must be prepared for insufficient medical personnel and have backup plans. Effective national hiring and sector financing are needed to address this issue.

5.5 CONCLUSIONS

Participants had a positive experience of learning how to deal with COVID-19 patients, a toughcope in a tough situation, manage patients on ventilation, and care for COVID-19 patients. The study further concludes that participants had positive experiences of patient treatment and recovery to better the health and wellbeing of their COVID-19 patients in order to enable them to live autonomous lives and realize their full potential. Participants also had positive experiences with patient

management, using their activities as healthcare providers to manage and meet the growing expectations of COVID-19 patients.

Participants had negative experiences of worry and fear of death of patients when they heard that they could spread the illness to their family members and witnessed patients dying of COVID-19. Furthermore, participants had negative experiences of trauma development due to exposure to anxiety, fear, suffering, family rejection, and patients dying. The study also concludes that participants had negative socialisation experiences as they feared rejection by others or their families, describing it as a painful experience.

Participants faced challenges of lack of equipment, staff shortage, and communication with family. Nurses expressed concerns about COVID-19 care quality due to limited and outdated equipment, long work hours, and challenges such as stigmatisation, media pressure, and increased fatalities. These factors reduced patient care quality and quantity, making nurses feel helpless and hopeless. The study further concluded that the COVID-19 unit at IHO faced challenges, including nurse shortages and increased workloads. This led to psychological distress, exhaustion, and physical and mental issues for nurses. They faced difficulties with personal protective equipment. To deliver effective care, nurses must overcome unusual work challenges and be protected from excessive workloads. Finally, it is concluded that during the COVID-19 pandemic, nurses faced frustration and isolation due to a lack of open communication. COVID-19 nurses faced frustration, isolation, and emotional health issues due to quarantine, social segregation, and being in contact with disease carriers.

Findings showed coping strategies used by nurses who worked at the COVID-19 unit in IHO. These strategies included seeking psychological support, increasing the supply of equipment, and increasing staff members. Psychosocial support was crucial for mental health and well-being, treating and preventing emotional illnesses, and nurses found psychological support helpful in managing COVID-19 stress and ethical dilemmas.

In a nutshell, it is concluded that nurses had positive learning experiences, patient treatment and recovery, and patient management. They had negative experiences of worry and fear of death of patients, trauma development, and socialization experiences. In addition, nurses faced challenges of lack of equipment, staff shortage, and communication with family. They tried to deal with the difficulties by employing strategies of psychological support, increasing the supply of equipment, and increasing staff members.

Furthermore, the researcher was able to explain and discuss the full spectrum of human reactions to nurses who worked in a COVID-19 unit and with COVID-19 patients in this study, thanks to the application of Dorothea Orem's Theory of Nursing Self-Care Deficit, also known as the Orem Model of Nursing. According to the findings, the study participants responded to their nursing of the patients in both adaptive and ineffective ways. The knowledge gained will be helpful in testing the Orem Model of Nursing's ability to explain the phenomenon of nurses caring for COVID-19 patients in the future.

5.6 RECOMMENDATIONS

The study explored the experiences of nurses who worked at the COVID-19 Unit in Intermediate Hospital Oshakati, Oshana Region, Namibia. The study puts forward the following recommendations toto reduce the negative experiences faced by nurses who worked in the COVID 19 Unit.

5.6.1 General Recommendations

The study's findings showed that nurses caring for COVID-19 patients observed a lack of personal protective equipment (PPE), unstable emotional working conditions, and poor communication. To better prepare for upcoming pandemics, it is advised that the Ministry of Health and Social Services (MOHSS) and healthcare managers work together to develop a coordinated strategy for handling and controlling such outbreaks. It is crucial to emphasize the role of nurses in combating any pandemic.

When caring for patients with COVID-19, nurses have demonstrated extraordinary resilience and adaptation despite resource limitations and risks to their physical and emotional health. Nurses require the proper support from their colleagues, supervisors, policy makers, and the local community to plan for and manage such pandemics effectively. The findings of this study can inform future nursing practice, nursing education, and policy decisions, which could enhance and shape the response to global infectious disease epidemics.

The results of this study demonstrate that nurse managers and leaders must take a significant role in helping their nurses during and after the COVID-19 pandemic. Nurse managers are responsible for ensuring that nurses providing care to COVID-19 patients are well-trained and have the knowledge necessary to do so without running the risk of contracting the illness themselves or through their families.

This study also suggests that nurse managers should act as advocates, ensuring that government and healthcare administrators provide nurses who provided care during the pandemic with favorable working conditions, sufficient funding, and the motivation to carry out their duties skillfully and effectively.

The findings of this study demonstrated that the nursing administration must ensure that specialists offer nurses psychosocial support during epidemics. This will help lessen the stress and stigma of working as a nurse during the COVID-19 response. Healthcare and nursing managers can play a significant role in preventing nurses from having thoughts of leaving their profession by providing them with financial, psychological, and social support during epidemics like the COVID-19 pandemic. organisationalFuture organisational and governmental strategies and interventions are essential to improve the quality of services and the wellbeing of the nurses providing care during the pandemic.

5.6.2 Recommendations for further study

The study's nurses may not accurately reflect the larger group of nurses who cared for patients with COVID-19, so it is crucial to conduct more research to support the phenomenological viewpoint and facilitate human understanding. To better

understand the phenomena surrounding the use of COVID-19 units in healthcare facilities, research and compassionate relationships should be fostered rather than remaining silent.

This study aimed to look into the unique experiences of nurses who worked in the COVID-19 Unit. Due to the participants' heterogeneity, however, the data analysis did not allow the researcher to draw a firm conclusion. Factors such as risk behaviours and educational attainment were not considered. It is advised that researchers conduct studies on homogeneous groups to better understand the realities of the experiences of nurses who worked in the COVID-19 Unit and identify any associated constraints.

In this study, the Orem Model of Nursing was somewhat reflected in the analysis of nurses' experiences working in the COVID-19 unit. However, the Model might require additional scientific investigation for validation. It is advised that more research be conducted to test the Model's applicability with patients who had COVID-19. Once the Model has been validated, it can be widely used in all nursing-related fields, including research, practice, administration, and education.

5.7 CONCLUSION

The background, problem statement, aim, and objectives of the study have all been outlined in this research report. In the first chapter, this was done. Chapter 2 of the literature review probed significant facets of the investigational area. Chapter 3 broadly presented the design and execution of the research. The collected data were introduced, thematically analyzed, and presented in Chapter 4 in themes and subthemes for easier comprehension. Chapter 5 makes a summary, draws conclusions from the research and the discussion, and the research report ends with this chapter. The purpose is to offer responses that the researcher hopes will benefit nurses at Intermediate Hospital Oshakati, Oshana Region, Namibia.

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APPENDICES

Appendix 1: Ethical clearance certificate

UNAM
UNIVERSITY OF NAMIBIA

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: **DEC OSH 0050** **Date: 24/04/ 2023**

This Ethical Clearance Certificate is issued by the University of Namibia Ethics Committee (REC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the ethics committee.

Title of Project: THE EXPERIENCE OF NURSES WORKED AT COVID-19 UNIT IN INTERMEDIATE HOSPITAL OSHAKATI, OSHANA REGION, NAMIBIANAMIBIA

Principal researcher: LYDIA K. DAVID

Staff Number/ Student number: 200733273

Remarks: Low Risk Approved after re – submission

Centre for Research Services

Take note of the following:

1. Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the ethics committee. An application to make amendments may be necessary.
2. Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the ethics committee
3. The Principal Researcher must report issues of ethical compliance to the ethics committee (through the Chairperson) at the end of the Project or as may be requested by the ethics committee
4. The ethics committee retains the right to:
   i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
   ii) Request for an ethical compliance report at any point during the course of the research.

The ethics committee wishes you the best in your research.

Prof Hans J Amukugo (Oshakati Campus Chairperson Decentralized Ethics Committee)

Prof. Davis Mumbengegwi (Head, Multidisciplinary Research)

Appendix 2: Permission letter from MoHSS

REPUBLIC OF NAMIBIA

MINISTRY OF HEALTH AND SOCIAL SERVICES

Ministerial Building
Harvey Street
Private Bag 13198, Windhoek

OFFICE OF THE EXECUTIVE DIRECTOR

Tel: No: 061 -203 2507
Fax No: 061-222 558
Andreas.Shipanga@mhss.gov.na

Ref: 22/3/2/1
Enquiries: Mr. A. Shipanga

Date: 24 May 2023

Ms. Lydia K. David
PO Box 11442
Windhoek
Namibia

Dear Ms. David

Re: The experience of nurses worked at COVID-19 unit in Intermediate Hospital Oshakati, Oshana Region, Namibia

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
   - 3.1 The data to be collected must only be used for academic purpose;
   - 3.2 No other data should be collected other than the data stated in the proposal;
   - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
   - 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
   - 3.5 Preliminary findings to be submitted upon completion of the study;
   - 3.6 Final report to be submitted upon completion of the study;
   - 3.7 Separate permission should be sought from the Ministry for the publication of the findings.
4. All the cost implications that will result from this study will be the responsibility of the applicant and **not** of the MoHSS.

Yours sincerely,

EXECUTIVE DIRECTOR
MINISTRY OF HEALTH AND SOCIAL SERVICES

30/5/2023

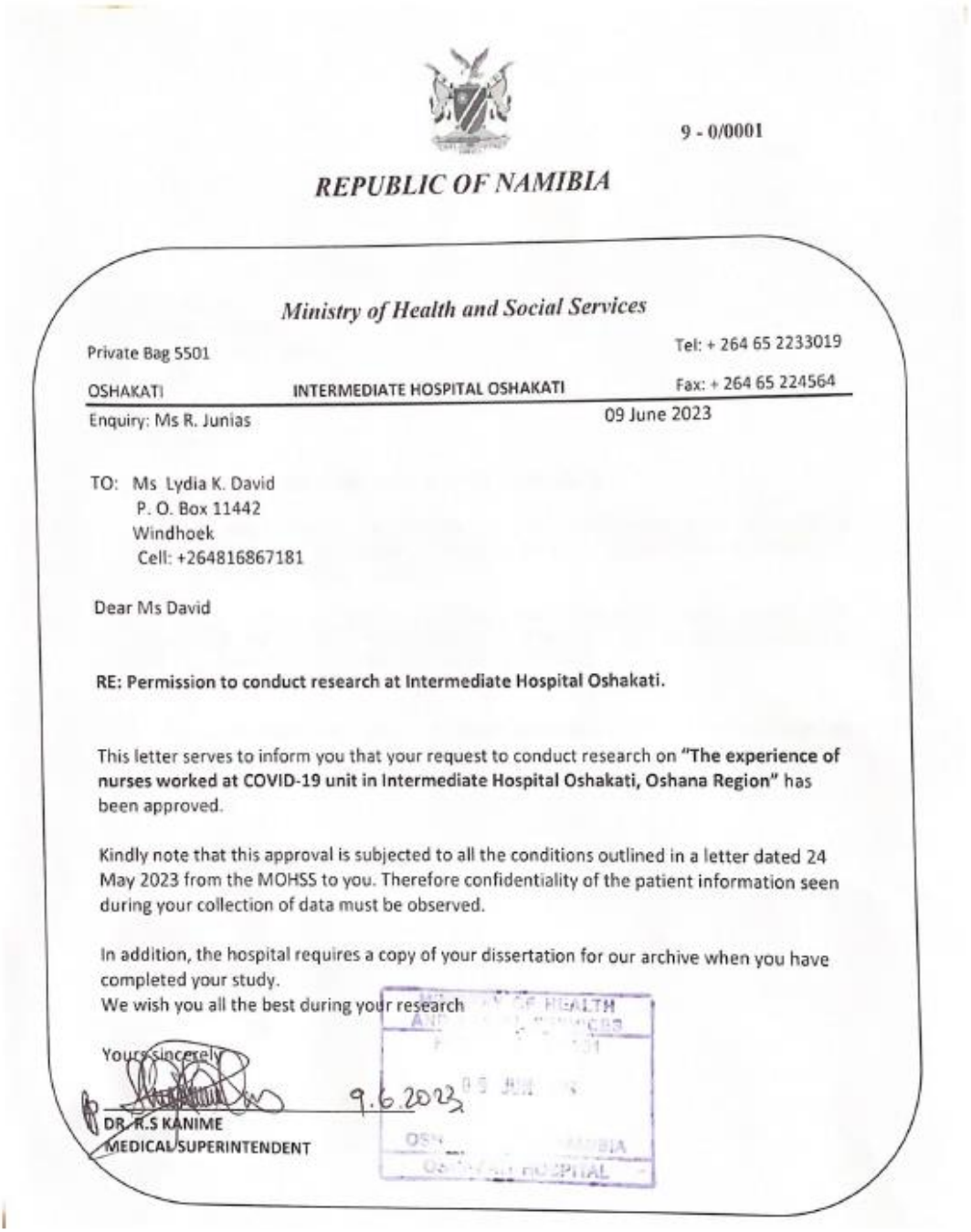
BEN NANGOMBE
EXECUTIVE DIRECTOR

All official correspondence must be addressed to the Executive Director.

My NAMIBIA MY COUNTRY, MY PRIDE

2763

Appendix 3: Permission letter from the setting - IHO



9 - 0/0001

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 5501
OSHAKATI
INTERMEDIATE HOSPITAL OSHAKATI
Tel: + 264 65 2233019
Fax: + 264 65 224564

Enquiry: Ms R. Junias
09 June 2023

TO: Ms Lydia K. David
P. O. Box 11442
Windhoek
Cell: +264816867181

Dear Ms David

RE: Permission to conduct research at Intermediate Hospital Oshakati.

This letter serves to inform you that your request to conduct research on **"The experience of nurses worked at COVID-19 unit in Intermediate Hospital Oshakati, Oshana Region"** has been approved.

Kindly note that this approval is subjected to all the conditions outlined in a letter dated 24 May 2023 from the MOHSS to you. Therefore confidentiality of the patient information seen during your collection of data must be observed.

In addition, the hospital requires a copy of your dissertation for our archive when you have completed your study.
We wish you all the best during your research

Yours sincerely

9.6.2023

DR. R.S KANIME
MEDICAL SUPERINTENDENT

Appendix 4: Informed consent form

UREC Annex 5F: Informed Consent for Qualitative Studies

INFORMED CONSENT FORM

Informed Consent for nurses worked at the COVID-19 unit at Intermediate Hospital Oshakati who I am inviting to participate in research titled "THE EXPERIENCE OF NURSES WORKED AT COVID-19 UNIT IN INTERMEDIATE HOSPITAL OSHAKATI, OSHANA REGION, NAMIBIA."

Name of Principal Investigator:	Lydia Kaalina David
Name of Sponsor:	N/A

This Informed Consent Form has two parts:

- **Information Sheet (this section, to share information about the study with you)**
- **Certificate of Consent (for signatures if you choose to participate)**

You will be given a copy of the full Informed Consent Form.

PART I: INFORMATION SHEET

Introduction

I am Lydia Kaalina David, pursuing a Master's degree in Public Health at the University of Namibia. I am doing research on the experience of nurses worked at the COVID-19 unit in Intermediate hospital Oshakati. I am going to give you information and invite you to be part of this research. Before you decide, you can

talk to anyone you feel comfortable with about the research. This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can always ask me.

Purpose of the Research

Exploring nurses' experiences caring for COVID-19 patients may be beneficial in improving and encouraging patient health. We believe that you can help us by telling us your experience working with COVID-19 patients, challenges that you may have confronted and how best they well resolved or how you think they could have been resolved. Describing the challenges that nurses experience when caring for COVID-19 patients will help nurses and hospitals be more resilient in the face of the crisis, as well as improve preparedness and recovery. Furthermore, by informing leaders and decision-makers about these concerns and providing ideas and implications, nurses will be better supported.

Type of Research Intervention

This research will involve your participation in an interview that will take about an hour.

Participant Selection

You are being invited to take part in this research because we feel that your experience as a nurse at COVID-19 unit can contribute to our understanding on the experience of nurses working with COVID-19 patients.

Voluntary Participation

Your participation in this research is entirely voluntary. The choice that you make will have no bearing on your job or on any work-related evaluations or reports. You may change your mind later and stop participating even if you agreed earlier.

Procedures

During the interview, I will sit down with you in a comfortable place at Intermediate hospital Oshakati. If it is better for you, the interview can take place

in your home or a friend's home. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but me the interviewer will be present unless you would like someone else to be there. The information recorded is confidential, and no one else will have access to the information documented during your interview. The entire interview will be recorded, but no-one will be identified by name in the recording. The recording will be kept in a locked file cabinet. The information recorded is confidential, and no one else will have access to the recordings. The recordings will be destroyed after 3 years.

Duration

I will have a once off interview with you and the interview will last for about one hour each.

Risks

There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen. You do not have to answer any question if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

Benefits

There will be no direct benefit to you, but your participation is likely to help us to understand the experiences of nurses and help them overcome common difficulties in the area. Besides, this pandemic will not be the last.

Reimbursements

You will not be provided any incentive to take part in the research.

Confidentiality

I will not be sharing information about you to anyone outside of the research team. The information that I collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the

researchers will know what your number is and I will lock that information up with a lock and key. It will not be shared with or given to anyone except the research supervisor.

Sharing the Results

Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. The knowledge that we get from this research will be shared with you before it is made widely available to the public. Each participant will receive a summary of the results.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job or job-related evaluations in any way. You may stop participating in the interview at any time that you wish. I will give you an opportunity at the end of the interview to review your remarks, and you can ask to modify or remove portions of those, if you do not agree with my notes or if I did not understand you correctly.

Who to Contact?

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact myself [Lydia K. David at 0816867181.

This research has been reviewed and approved by the relevant Ethics Review Committee at the University of Namibia, which is a committee whose task it is to make sure that research participants are protected from harm. The committee reports to the University's Centre for Research Services. If you wish to contact this Centre, please call +264 61 206 4673 or send an e-mail to research@unam.na.

You can ask me any questions about any part of the research study if you wish to. Do you have any questions?

PART II: CERTIFICATE OF CONSENT

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked, have been answered to my satisfaction. I consent voluntarily to be a participant in this study

…… ……..……

Name of Participant (print) Signature of Participant

…… ……

Date (day/month/year) Date (day/month/year)

Statement by the Researcher/Person taking Consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1. Interview

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

…… ……

Name of Researcher/Person taking Consent (print) Signature

……

Date (day/month/year)

Appendix 5: Research instrument – An interview guide

STUDENT NAME: LYDIA K. DAVID

TOPIC: The Experience of nurses Worked at COVID-19 unit in Intermediate Hospital Oshakati, Oshana Region, Namibia.

Section 1: Socio-demographic characteristics

1. How old are you?
2. Your gender?
3. How many people are you living with?

Section 2: The Experience of nurses at COVID-19 unit

4. What was your reaction when you were informed of your allocation to COVID-19 unit?
5. Since your allocation at COVID-19 ICU Ward:
    a) What has been your biggest fear?
    b) What has been your positive experience?
    c) What has been your utmost wish and why?
    d) Have you ever experienced a terrible occurrence in the Ward and how has it affected you?
    e) How has been the relationship between you and your family members and friends?
    f) What has made you feel fulfilled?
6. What challenges have you experienced and how were they resolved?
7. How best could the hospital management assist?

Name of researcher:

Date:

Signature:

Thank you very much