MANAGING OCCUPATIONAL STRESS AND FEAR OF HIV/AIDS AMONG NURSES AND MIDWIVES IN NAMIBIA: A SUPPORTIVE POLICY APPROACH FOR WINDHOEK CENTRAL AND KATUTURA STATE HOSPITALS

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF MASTER OF PUBLIC ADMINISTRATION

OF

UNIVERSITY OF NAMIBIA
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DEPARTMENT OF POLITICAL AND ADMINISTRATIVE STUDIES

BY

CORNELIUS VATALENI WEYULU

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ABSTRACT.

Occupational stress and fear of contagion are common among nurses/midwives dealing with HIV/AIDS patients, and the psycho-social impact become more acute when death occurs, because the loss of a young patient, the suffering and self identification with the patient cause acute sadness and grief. Therefore a need rises to address the problem of occupational stress and fear among nurses and midwives caring for victims of HIV/AIDS. The Government of the Republic of Namibia has taken a policy decision as part of the Medium Term Plan III (MTP III), that all sectors should develop and implement sectoral workplace HIV/AIDS programmes geared toward addressing challenges facing their human resources. The Ministry of Health and Social Services (MOHSS) has launched its national HIV/AIDS sectoral committee to fulfill its sectoral obligation.

In the absence of well researched data on what kind of support staff members require at institutional level, the researcher undertook a study to explore how occupational stress and fear among nurses/midwives providing care to HIV/AIDS patients in the two Windhoek State Hospitals can be managed. The objectives of the study are: to explore strategies used by nurses/midwives to cope with occupational stress and fear, to identify ways in which occupational stress and fear can be alleviated and managed, to identify the nature of support nurses/midwives expect from their employer in dealing with stress and fear associated with care giving role regarding HIV/AIDS and lastly, to recommend possible strategies to assist in the management of occupational stress and fear.

The results of interviews and a focus group indicate that nurses/midwives are experiencing sadness, fear, stress, anger or happiness after nursing HIV/AIDS patients. These emotions however are influenced by various factors such as the condition of the patient, workload, knowledge deficiency, shortage of staff and high risk working conditions.

The study found that there is no sectoral HIV/AIDS policy or guidelines addressing the impact of HIV/AIDS on health care providers. This resulted in each nurse/midwife having to cope in his or her own way. The study further found that the two hospitals have no staff support programmes in place due to the absence of a policy framework.

The researcher suggests that future research should investigate the impact of HIV/AIDS on the workforce of the Ministry of Health and Social Services and the service delivery. Secondly, how home based care can be integrated in the training of health workers and the general delivery of nursing care to HIV/AIDS patients must be investigated. Thirdly, how the community feels about establishing hospice centres for terminally ill HIV/AIDS patients should also be explored.

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ABBREVIATION AND ACRONYMS

AIDS	=	Acquired Immunodeficiency Syndrome
CDC	=	Centre for Disease Control
GDP	=	Gross Domestic Product
HIV	=	Human Immunodeficiency Virus
MOHSS	=	Ministry of Health and Social Services
MTP	=	Medium Term Plan
NDHS	=	Namibia Demographic Health Survey
NDP	=	National Development Plan
NNHA	=	Namibia National Health Accounts
NPC	=	National Planning Commission
PHC	=	Primary Health Care
RMT	=	Regional Management Team
SADC	=	Southern Africa Development Community
SAFAIDS	=	Southern African HIV/AIDS Information Dissemination Services
TB	=	Tuberculosis
WHO	=	World Health Organization

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Last but not least, I wish to thank my dearest friend, partner and fiancée Selma, for constant encouragement and loyal support. Had it not been for her, I would not have come this far.

In the final analysis, however, the ideas, strengths and weakness contained in this study remain my own.

DEDICATION

This work is dedicated to the loving memory of my late parents, Esar and Tusnelde Weyulu who could not witness this accomplishment.

DECLARATION

This research paper is the candidate's original work and has not been submitted before for a degree in other institutions of higher learning in Namibia or somewhere else in the world.

Weyulu C.V.

CHAPTER ONE

1.1 INTRODUCTION AND BACKGROUND INFORMATION

The Ministry of Health and Social Services in the Republic of Namibia has the constitutional obligation to ensure that the Namibian Nation's health is attained. However, this Ministry faces many challenges in its attempts to attain the population's health status. One of these challenges is HIV/AIDS with its impact not only on the health of the entire population, but also on the Ministry's work force. Although no research has been conducted so far to assess the impact of HIV/AIDS in this sector, there are indications that HIV/AIDS is negatively affecting this Ministry's workforce. This is especially true for nurses and midwives who often have, to operate under stressful situations and encounter difficulties to manage their feelings of fear and stress related to working with AIDS (Haoses and Katjire, 2001).

The Ministry has been making significant efforts to meet its obligation toward the entire Namibian nation. This includes the prevention and reduction of HIV infection, the provision of treatment, care and counselling services to the citizens affected and infected by HIV/AIDS. However, despite the fact that educational and counselling services are made available to the public at all health facilities, it has been noted that staff members of the Ministry do not make use of these services.

It is stipulated in the newly launched Medium Term Plan III (MTP III, 2004) that all sectors in Namibia have the obligations toward the implementation of HIV/AIDS activities at workplace.

The Ministry of Health and Social Services as an employer has this obligation towards its employees, who are expected to provide health care services to the entire population. This is more crucial because health care services are currently overburdened by HIV/AIDS patients. Consequently, the Ministry looked into the aspects of the establishment of the work-based employee support programme by appointing the ministerial workplace HIV/AIDS Committee in September 2003. This committee has to plan and spearhead the implementation of the work-based support programme at all levels (MOHSS, 2004. Ministerial work place HIV/AIDS committee terms of reference).

In order to establish an effective work based support programme, it is imperative that studies are carried out within the Public Administration Context to explore the views and opinions of the employees who might be infected and affected by HIV/AIDS, hence this study. This is a case study of Nurses/Midwives rendering care to HIV/AIDS patients, however, is not about nursing as a profession.

1.2 THE ORGANIZATION OF HEALTH SERVICES IN NAMIBIA

The Ministry of Health and Social Services has adopted a Primary Health Care (PHC) strategy in the delivery of health services to the Namibian population. It also maintained and further strengthened the strong secondary and curative care services which were present at independence, to provide an integral national system of referral support for PHC services.

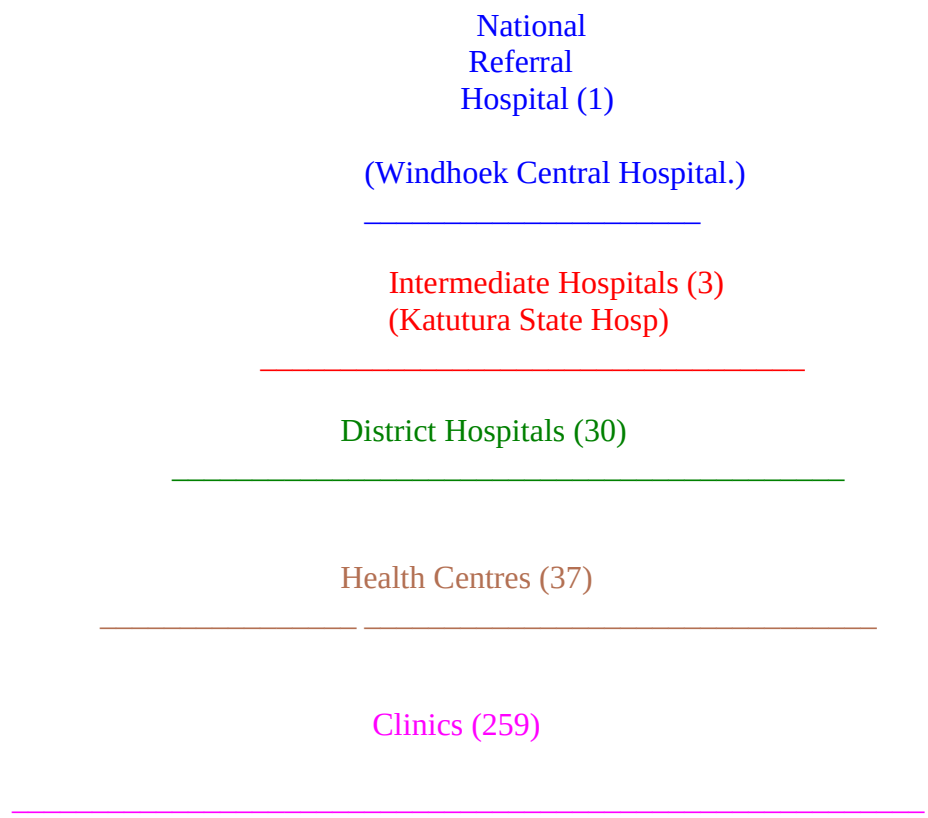
The central level of the Ministry of Health and Social Services plays a stewardship role through policy formulation, strategic planning and resource mobilization and allocation. As part of the health sector reform, in order to make the system responsive to the health needs of the Namibian people, restructuring has meant that authority is decentralized to the 13 Regional Management Teams (RMTs) that oversee service delivery in a total of 34 health districts. RMTs are responsible for the planning, organizing, implementation and evaluation of regional health plans and for other management activities (MOHSS, 2000).

There are three intermediate/referral hospitals i.e. Oshakati Hospital in Oshana Region, Rundu Hospital in Kavango Region and Katutura Hospital in Khomas Region, while Windhoek Central Hospital serves as the overall national referral hospital.

The hospital hierarchy is based on the principles of a cost-effective referral chain and specific health need. Fixed clinics are the entry points in the delivery of health services complimented by outreach services/mobile clinics. For a better understanding, the following figure depicts the organization of service delivery.

Figure, 1

Organization of Health Service delivery in Namibia



Source: MOHSS, Namibia National Health Accounts Report (NNHA, 2003).

As can be seen from figure 1, clinics which are the entry points in the delivery of health service are more than health centers and the number decreases further upward to the top of the hierarchy. In recognition of intersectoral collaboration as an integral aspect in health and social care delivery, Private and Mission facilities continue to make important contributions. Mission facilities are 100 percent subsidized by government, while private hospitals and clinics are mainly profit making entities. The latter mainly cater for the urban population, doctors' surgeries and nursing homes.

There are about 12 private hospitals with a bed capacity of 640, comprising about 9% of the total hospital beds in the country. It is estimated that about 80% of the population lives within 10 km distance from public health facilities (MOHSS, 2003).

1.3 THE EPIDEMIOLOGICAL PROFILE OF THE COUNTRY

The greatest proportion of the disease burden is mainly accounted for by communicable diseases, more especially HIV/AIDS, tuberculosis and malaria. Namibia is one of those countries in Sub-Saharan Africa that are hard hit by the HIV pandemic. Likewise, tuberculosis is on the increase, due partly to its close association with HIV/AIDS. In 2001, the incidence rate of tuberculosis was estimated at 680 per 100,000 population. Malaria is also posing a major problem especially in the Northern parts of the country.

The annual incident rate of malaria is estimated at about 248 per 1000 population (MOHSS 2002, Annual Malaria Control Programme). Non-communicable diseases such as cancer and cardiovascular problems are also among the top causes of death in state health facilities. This is reflected in Table 1.

Table 1. Main causes of Death in Government/Mission Health facilities in Namibia 2001.

Deaths: 2001	Number of Rate/1000 deaths	
AIDS	3013	(225)
Diarrhoea	2124	(158)
Pulmonary Tuberculosis	1959	(146)
Malaria	1728	(129)
Pneumonia	1392	(104)
Anemias	557	(43)
Cancer	556	(42)
Heart failure	449	(33)

Source: MOHSS (2004; Health Information Report 1999 - 2001).

1.4 HIV/AIDS PREVALENCE IN NAMIBIA

HIV/AIDS has posed the most serious development challenge for Namibia since the first case was diagnosed in 1986. The pandemic has since then escalated, to become the most significant public health problem in the country. Its negative impact on all sectors of the Namibian economy is already being felt, and is expected to increase over the next decade (MOHSS 2002:7).

By December 2003, a cumulative number of 136,068 HIV/AIDS cases had been recorded by the Ministry of Health and Social Services as the beginning of the epidemic. Despite some recent studies suggesting that HIV epidemic in Namibia may

be beginning to stabilize, the result of the 2002 sentinel sero-survey, revealed that the prevalence ratio is still alarmingly high. According to the survey, the HIV prevalence among pregnant women ranged from a high 43% in Katima Mulilo to a low 9% in Opuwo. In 2003, AIDS was responsible for 5.8% of all reported admissions, and for 20.8% of all reported deaths in public health facilities. The Ministry estimated that in some parts of the country between 50-70% of hospital admissions are HIV/AIDS related (MOHSS, 2004:3-5). Figure 2 shows relevant Ministry of Health and Social Services hospital in-patient data since 1995.

Figure 2: In-patient statistics related to HIV/AIDS in state health facilities

Year	Total admissions from all causes	HIV related Admissions	Total deaths from all causes	Aids Related deaths
1995	150017	1826 (1.2%)	6405	628 (9.8%)
1996	163279	2620 (1.6%)	7473	1125 (15.1%)
1997	169311	3908 (2.3%)	8283	1539 (18.6%)
1998	157045	5155 (3.3%)	9810	2179 (22.2%)
1999	153645	6878 (4.4%)	10670	2823 (26.0%)
2000	164295	7376 (4.0%)	12370	3304 (26.7%)
2001	186985	6881 (3.6%)	13482	3020 (22.4%)
2002	170168	9248 (5.4%)	12625	2788 (22.1%)
2003	166746	9654 (5.8%)	13508	2804 (20.8%)

Source: MTP III 2004-2009: National Strategic Plan on HIV/AIDS (2004).

1.5 STATEMENT OF THE RESEARCH PROBLEM

The above data on HIV/AIDS related deaths and hospitalization remain significant indicators for the burden the disease has on the entire health system, but more especially on nurses and midwives, who are at the center of HIV/AIDS by being in direct contact with HIV/AIDS patients on a daily basis. It appears that the nurses and midwives working directly with HIV/AIDS patients are experiencing fear of being infected with HIV/AIDS and therefore are affected by occupational stress. A case study conducted by Haoses and Katjire (2001) regarding workplace stress and fear among nurses and midwives in the Windhoek Central and Katutura State Hospitals, found that more than 90% of nurses and midwives have experienced major stress factors, which are fear and anxiety when giving care to HIV/AIDS patients.

The same study (Haoses et al 2001) also revealed that 83% of nurses and midwives indicated that fear of HIV/AIDS negatively affected the manner in which they render care to the patient.

Despite the above evidence, there has been no significant effort from the concerned health institutions i.e. Windhoek Central and Katutura State Hospitals, toward addressing the identified occupational stress and fear among the nursing workforce. The situation is worsened by the absence of the Health Sector policy on HIV/AIDS at workplace to guide the provision of support services to nurses and midwives rendering care to those infected and affected by HIV/AIDS.

This problem identification was therefore used to explore strategies to manage

occupational stress and fear in giving nursing care to HIV/AIDS patients, which could further provide essential policy inputs to the establishment of workplace HIV/AIDS programme in the two Windhoek State Hospitals. This problem identification and definition is the first step of the public policy making process. It is only when a problem is explicitly defined that a policy can be formulated to deal with it.

1.6 JUSTIFICATION OF THE STUDY

As it was indicated earlier, the AIDS epidemic in Namibia escalated at an alarming rate since the first case was diagnosed in 1986, to become the leading cause of deaths and hospitalization in the public health facilities. The epidemic brings an increasing demand for nursing care which drains the nurses and midwives psychologically, emotionally and physically. In many instances nurses and midwives have to provide care to HIV/AIDS patients under difficult conditions, characterized by shortage of staff, limited resources, etc.

Despite all the above physical and psychological challenges, nurses and midwives are not expected by the wider public to pity themselves for the arduous circumstances they find themselves in by caring for HIV/AIDS patients. They are rather expected to continue to provide care and support to these patients and to provide comfort and reassurance to patient's relatives in times of health crisis and impending death.

The questions are they prepared to manage occupational stress and fear resulting from their day to day dealings with HIV/AIDS patients? This study is therefore an attempt to find appropriate policy inputs which can be used to help nurses and midwives to

manage occupational stress and fear. Furthermore, it is hoped that the outcome of this study will have a positive impact on nurses/midwives behaviour and attitudes toward caring for HIV/AISD patients and the quality of nursing care in general.

Occupational stress and fear are rooted from so many different factors and conditions that to eliminate them from the nursing environment is almost impossible. However, there is a need to find strategies to reduce their intensity on nurses and midwives and thereby minimize their harmful effects. This is what this study endeavors to explore.

1.7 RESEARCH OBJECTIVES

The objectives of the study are:

* To explore the coping strategies nurses and midwives use in the face of occupational stress and fear of HIV/AIDS.
* To identify how the occupational stress and fear of rendering care to HIV/AIDS patients can be managed and alleviated.
* To identify the nature of support nurses and midwives expect from their employer in dealing with occupational stress and fear associated with care giving roles regarding HIV/AIDS.
* To recommend policy strategies to assist and empower nurses and midwives to manage stress and fear related to the provision of care to HIV/AIDS patients.

1.8 RESEARCH QUESTIONS

The study is attempting to answer the following questions.

1. What strategies do nurses use to cope with occupational stress and fear of HIV/AIDS?
2. How can occupational stress and fear of HIV/AIDS be alleviated?
3. What kind of support do nurses and midwives expect from their employer in dealing with occupational stress and fear associated with care the giving role regarding HIV/AIDS?

1.9 STUDY LIMITATIONS

The study is generally focused on managing occupational stress and fear associated with giving nursing care to HIV/AIDS patients. While this study drew on the experience and outcome of a survey conducted by Haoses et al (2001) regarding workplace stress among nurses and midwives in the same two health institutions targeted, the focus of this study is different.

The primary focus of this study is to research further on coping and support strategies which could assist in managing occupational stress and fear identified in the survey by Haoses et al (2001). Hence, this study will be more complementary rather than comparative to the preceding survey.

The study is also limited to Katutura and Windhoek Central Hospitals. Despite the fact that, the two state health facilities share similar geographical location, Windhoek, they represent different levels of health care delivery in Namibia (See figure 1, Pg 4).

Katutura Hospital is categorized as "Class B" hospital and also an intermediate/referral hospital. On the other hand, Windhoek Central Hospital is a "Class A" hospital and the only National Referral Hospital providing for more specialized medical services than Katutura Hospital. Although the two hospitals complement each other in many respects due to their shared history and closer proximity, patient admission criteria of the two hospitals also differ along with the services each hospital provides.

1.10 DEFINITIONS OF TECHNICAL TERMS

The following concepts and terms will be defined as follows:

Epidemic = The occurrence in a community or region of cases of an illness, specific health-related behaviour or other health-related events clearly in excess of normal expectancy. The community or region, and the period in which the cases occur, are specified precisely (MOHSS: 2002).

Epidemiology = The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to control health problems (MOHSS, 2002).

Fear = Cognitive response to the anticipation of physical harm or painful emotional state.

Fertility Rate = Number of live births produced by women of reproductive age (15-49 years) during the year (MOHSS, 2000).

Infant Mortality Rate = Number of deaths of children under 1 year of Age during the year (MOHSS, 2000).

Midwife = A practitioner of the midwifery science who is registered or enrolled as such in terms of the Nursing Profession Act No. 30 of 1993.

Nurse = A practitioner of the nursing profession, enrolled or registered In terms of the Nursing Professional Acts No.30 of 1993.

Post-Exposure Prophylaxis = The use of therapeutic agents to prevent infection following exposure to pathogen (MOHSS, 2004).

Stress = Emotional and psychological reactions to both external and internal demands, which are perceived to be above an individual's ability to cope (Kotze, 1994).

1.11 SUMMARY

This chapter presented a brief introduction and background information about the health and social services in Namibia as well as the challenges the Ministry is facing due to HIV/AIDS. These challenges are stated as the justification of this research study. This chapter also outlined the objectives which are to explore the coping strategies nurses and midwives use to deal with occupational stress and fear, to identify ways of alleviating and managing these problems and the support these health care providers expect from their employer. This will then shed more light on what can be recommended to assist and empower nurses/midwives providing care to HIV/AIDS patients. The next chapter will focus on broader literature review which will set the theoretical framework for the study and guide its empirical process.

CHAPTER TWO

2. THEORETICAL AND CONCEPTUAL FRAMEWORK

2.1 INTRODUCTION.

This chapter presents the literature review on the concept occupational stress and fear and its prevalence the in health care profession. It also introduces the opinion of other researchers on how occupational stress and fear can be managed. In conclusion, the chapter discusses the Sectoral HIV/AIDS Strategies and legislation in Namibia.

2.2 THE CONCEPT OCCUPATIONAL STRESS AND FEAR

Stressors are any demands, be they physical or psychological in nature that people encounter during the course of living. If such stressors persist, the body's ability to cope may become depleted resulting in stress. Scientists defined stress as an emotional state and psychological reactions to both external and internal demands (Baron and Greenberg 2003). This reaction or condition as Kotze (1994) put it develops when the demands made of the individual exceed his/her adaptive (coping) abilities. It is already clear from the above definitions that, stress is a complex phenomenon which could result from different demands and manifest itself in different reactions.

According to Kotze (1994), occupational stress is often equated with particular physical circumstances at work, for example lack of occupational safety, risk of occupational disease, working hours, physical exhaustions, shortage of staff, sustained concentration etc. These circumstances suggest that stress is rooted in so many

different factors and conditions that to eliminate it from our live is virtually impossible.

People react differently to different stressors, with some individuals being tougher in dealing with stress than others. However, according to Haoses, et. al, (2001), the people involved normally perceives that the situation is threatening them and they are unable to cope with its demands. Their reactions normally take the form of physical ailment, emotional problems and poor job performance.

The effect of stress on an individual can be different in its intensity. Some effects may be classified a slight e.g. physical exhaustion, moderate e.g. feeling of anxiety and pain or it can be serious e.g. stomach ulcer or even death. In addition reaction to stress can be purely physical, psychological or psychosocial (Kotze 1994:203). Stress can also manifest itself in coping behaviour in the form of physical flight, attack, withdrawal or compromise. These are reactions common in situations which create a state of tension in the individual, for example pressure of work. According to Marren Tardivelle (1982), Symptoms of stress are frustration, aggression, frequent absence, tiredness and feeling of powerlessness.

Haoses et al (2001) further stated that one of the major stress factors is fear, and like stress, fear is rooted in different factors. It can be defined as an unpleasant emotion caused by exposure to danger, expected pain or apprehension about a specific condition. According to Kotze (1994) stress and fear are inseparable as they both

represent an important axiological factor in physical and psychological decompensation.

From the psychosocial point of view, work is generally regarded as essential for healthy development and people are normally influenced by their parents or friends to have a positive attitude towards work and to a career, however Kotze (1994) cited that, there are individuals and groups who do not wish to be associated with their work because of the stress and fear it generates.

According to Bennett, Muller and Ross (1995) occupational stress is regarded as a normal human emotional reaction to stressors on the job, which no doubt adversely affect many aspects of task performance. The same sentiment was shared by Baron et al (2003) who identified nurses and midwives as being among those who do jobs associated with high stress and fear, as their requires making decisions and working in unpleasant physical conditions.

2.3 OCCUPATIONAL STRESS AND FEAR IN THE HEALTH CARE PROFESSION

Occupational stress and fear are becoming more real in the health profession, especially on those caring for people infected with HIV/AIDS. AIDS presented unique stressors to health care providers, because the risk of contracting HIV is an issue that creates fear among those who care for HIV/AIDS patients. These stress and fear are often worsened by the fact that a negative HIV test does not necessarily mean that the patient has not come into contact with HIV (Bennett et al, 1995).

Caring for a sick person can no doubt be very stressful and demanding, and as the HIV/AIDS epidemic matures, the existence of occupational stress and fear in the health profession is not in dispute. Much of the burden of HIV/AIDS epidemic falls on the shoulders of nurses and midwives, who are responsible for the care of the majority of patients admitted to hospitals. There are however some significant emotional experiences linked to the care giving between the nurse/midwife and patient. Some of these experiences were described by Bennett et al (1995:2) as enormously rewarding and uplifting, on one hand, especially when a patient recovers because of the health worker's effort. On the other hand, other experiences can be emotionally stressful for the health workers, for example experiences associated with having to give bad news or dealing with patient's death.

The same view was shared by other writers like Mc Cann and Sharkey (1998) and Uwake (2000) who stated that Nurses/Midwives have the greatest direct contact with the patients and they continue to have fear of the disease and prejudicial attitude toward patients with HIV/AIDS.

Van Dyk (1993) stated that what is more stressful is the fact that the wonders of medical science and technology, which cure almost all health problems and made people feel secure, became a false sense of security as it has been shattered by HIV/AIDS. To this end, nurses and midwives have now realized that they do not have much to offer to HIV/AIDS patients. This sense of helplessness has also contributed to occupational stress and fear among nurses and midwives.

The stress and fear of HIV/AIDS among health professionals in Africa is further worsened by the fact that, in the already hard-hit African countries, with fragile health systems, skilled nurses and midwives are also dying just at the moment when they are most needed. Unfortunately, most African countries do not have a tested and proven HIV/AIDS nursing intervention (Ngcongco, 1998).

The study released in August 2003 at South African's first National AIDS Conference, involving 2,000 health workers and 2,000 patients from 222 clinics and hospitals, revealed that nurses accounted for the majority of those infected (UNAIDS, 2003:16).

In Zambia, mortality among nurses increased more than five fold from 1980 to 1991 and this was largely attributed to HIV. Absenteeism because of illness among staff themselves, their friends and relatives for whom they had responsibility, also contributed to the impact of the HIV epidemic on the provision of health care. The reduced number of staff members at work contributed to a high workload which is stressful (Charles et al, 2003).

AIDS affects the health sector by increasing ill health and death among service providers at all levels and also by increasing demand on service provision as people become sick and hence the work load on health staff increases.

Jackson (2002) reports that the health service has become a stressful place of work with the advent of AIDS. Staff often feel helpless and demoralized in the face of the

epidemic and may protect themselves by distancing themselves from their patients.

Haoses et al (2001) found evidence of this fact in Namibia, where some nurses indicated that they develop negative feelings toward patients, ignore them sometimes and even don't want to touch them.

There is fear for HIV/AIDS related stigma among health workers and the stigma can constitute one of the greatest barriers to the provision of adequate care and support. This leaves those seeking care prone to rejection by the very people that should care for them.

A survey conducted in 2002 among 1,000 physicians, nurses and midwives in four Nigerian states, revealed some disturbing findings. According to the study, one in ten doctors and nurses/midwives admitted having refused to care for an HIV/AIDS patient or even denied such patients admission to a hospital (UNAIDS, 2003:31).

It is evident from the result of the Nigerian survey that perceptions of stress and fear of occupational exposure to HIV can have a broad impact to nursing professional practice and the care delivery system in general. This is so, because it influences the nurse/midwife's willingness to treat infected patients, but the question is to what extent are nurses/midwives exposed to work-related risks of infection?

There are numerous studies that document the risks that health workers perceive as a consequence of caring for persons with HIV disease. Examples by Bennett et al,

(1995) are like Epstein (1993) and Greenberg (1992) reporting on perceptions. On the other hand, a similar number of writers attest to the low risk of occupational transmission, here examples are Bell (1991) and CDC (1992) as quoted by Bennett et al (1995:51).

A study by Marcus et al (1990) on the transmission of HIV in health care settings as cited by Bennett (1995), found that the transmission of HIV does indeed occur. However, there have been no documented cases of HIV transmission from the nurse to a patient. But, transmission from the patient to nurse does exist. However this is less than 1% risk of HIV transmission.

A study by the Center for Disease Control (CDC) in United States of America (1987) found that of 1,201 health workers who have previous history of needle stick injuries or cuts with sharp objects only four tested positive for HIV. The study attested these positive results to the possibility of exposure outside the workplace.

A similar study in San Francisco (1988) involving 358 health workers who had suffered 483 exposures indicated that only one health worker who had received a needle stick injury, presented a positive result (Bennett,1995).

Jackson (2002) also supported the findings by CDC as she points out that, to a small extent, nurses/midwives are exposed to work-related risk of HIV infection, but the great majority of infections will be sexually acquired.

According to the Ministry of Health and Social Services in Namibia (MOHSS, 2004:01), Health Care workers have a low risk of HIV infection after accidental exposure to infected blood or body fluids. Using the CDC guidelines, the Ministry further argued that, the overall risk for HIV transmission after a needle prick from an HIV positive source is estimated at 0.09-0.3%. Hence, the "HIV attributable to occupational exposure is uncommon" (MOHSS, 2004:01). Infection control measures are seen to be the mainstay of preventing occupational HIV infection.

From the various studies cited above, it is evident that literature on health care providers and occupational exposure to HIV presents a clear dichotomy. But, as long as institutions and experts cannot provide absolute assurance that the risks of occupational exposures to HIV are zero, nurses/midwives will continue to conclude that significant risk exists.

2.4 STRESS AND FEAR FACTORS ASSOCIATED WITH CARE GIVING ROLE

Reference has been made to the fact that stress and fear are rooted in different factors and conditions pertaining to a job. These factors and conditions can either be internal or external to an individual; they continually threaten the individual, reduce his/her effectiveness, adaptation and resistance. According to Kotze (1994), the external factors are stimuli to which an individual reacts. This reaction depends on the person's individual characteristics resulting from the biological development and the learning experiences which the individual brings along when she/he enters a job.

Bennett et al (1995) indicated that, responding to multiple severe disfiguring and often uncontrollable disease symptoms e.g. diarrhoea can be more stressful to a care provider.

The psychological symptoms of depression and AIDS related dementia create further treatment challenge, hence nurses/midwives with poor psychological skill preparation may feel that they are ill-equipped or lack necessary information to respond to the emotional needs of their patients.

The infectious nature of HIV is of understandable concern for many nurses/midwives and fear regarding possible exposure is wide spread. This is so despite protective and infection control guidelines available in many health institutions.

There is an increased fear of death and related anxiety among nurses/midwives caring for victims of HIV/AIDS. This fear is worsened by the extent to which these professionals can relate to or identify with patients as being similar to themselves. For HIV positive nurses/ midwives, watching the deteriorating health of their patients with AIDS could be a profoundly disturbing experience as it may be perceived as representing a preview of their own future (Bennett, 1995).

The individual's negative perception of the nurse/midwife's role in the Organization may also lead to intense feeling of dissatisfaction and stress, especially when they feel they are not appreciated and supported by the employer. According to the study by Haoses et al (2001) some nurses/midwives indicated that "they are only valued as

good nurses while healthy…, but if they became ill, the picture reverses" (18).

The same study identifies other stressful factors like heavy workload, seeing many people dying, shortage of staff, high need of care, lack of security and compensation, financial stress, long shifts, lack of in-service training, lack of support from employer, etc.

2.5 THE IMPACT OF OCCUPATIONAL STRESS AND FEAR ON NURSING CARE

As indicated in the definition of stress, sustained stress can exceed the individual capacity for physical and psychological adaptation, followed by serious symptoms like fear, anxiety, burnout, withdrawal, etc. In addition to the above internal reactions of an individual nurse/midwife, occupational stress and fear leads to specific work-related problems like, personnel turnover, absenteeism, occupational accidents, job dissatisfaction (Kotze 1994). This situation can constitute the greatest barriers to provision of adequate care and support of HIV/AIDS patients.

Some nurses in Namibia have already indicated that they can distance themselves from HIV/AIDS patients because of fear. Others tend to ignore patients or even get rebellious toward HIV/AIDS patients (Haoses et al 2001). On the other hand, some authors reported that in the early stages of the pandemic some patients gave accounts of their experiences of being shunned and not allowed to touch their own children (Blumenfield 1987 as cited by Bennett et al 1995).

2.6 DEALING WITH OCCUPATIONAL STRESS AND FEAR

Given the potential sources of stress and fear inherent in the role of providing care to people with AIDS, it is important that an appropriate support system for nurses and midwives is developed which could help in dealing with occupational stress and fear (Haoses et al 2001:25).

It is also apparent from various studies mentioned that minimizing the intensity of stress and fear of occupational exposure requires more than instituting infection control policies. It poses a challenge to the institutional environment and nursing personnel themselves to develop a remedial approach which could incorporate cognitive and emotional aspects of fear into stress and fear reduction efforts. To this, Baron et al (2003) suggested that to minimize the effects of such inevitable problems, strategies like employee assistance programmes, wellness interventions and stress management can be implemented in addition to what individual employees can do themselves.

The ideas of Sims and Moss's (1995) regarding dealing with occupational stress and fear, is that, in order to help employees, it is necessary to provide emotional support to staff in any setting. However they stressed that it is also recommendable to identify what it is that staff find helpful. This is so because some staff may find it helpful to speak to a Counselor on a one to one basis, while others may find support groups of more value. It could also be that peers and friends are more supportive.

Kotze's (1994) opinion regarding the management of stress and fear is that there

should be strategies which address the adaptive reactions or defence mechanisms of an individual. He singled out the most common ones which include talking things out, games, recreation, vacations, purposive relaxing techniques, reassessment of problems, imagining of problems and physical acting out feelings. He further argued that personal or self management strategies alone are not likely to be effective if not accompanied by organizational strategies addressing among others, therapeutic services, health education, team approaches, counseling approaches, support networking skills, corrective procedures, work standards (Kotze 1994).

Louw and Edward (1998) cautioned that not everyone has problems coping with stress as many people may handle stress very well. However, many believe their stress is under control but in fact display the signs of stress mismanagement. Therefore, they cautioned that "no one technique is likely to work for everybody" (647).

Despite the obvious need for fear and stress management among health care providers especially in Southern Africa, there have been few workplace interventions designed to reduce the problem and create support for workers who are HIV positive and / or caring for HIV/AIDS patients. According to Southern African HIV/AIDS Information Dissemination (SAFAIDS) efforts in that direction are blunted by fear of HIV/AIDS-related stigma among workers because the stigma may also prevent workers from seeking care, counseling and support (SAFAIDS 2003:09).

2.7 SECTORAL HIV/AIDS STRATEGIES IN NAMIBIA IN BRIEF

In Namibia, most private firms have introduced some workplace programmes as per the requirements of the Medium Term Plan II (MTP II); examples include Telecom Namibia and Namdeb. But, most Government Ministries and Agencies have not yet responded with similar workplace programmes (MOHSS 2003:05). This is with the exception the Ministries of Education which are already in a process of implementing the Education Sector policy on HIV/AIDS in Namibia. One of their focus areas is treatment, care and support of those infected/affected by HIV/AIDS (Republic of Namibia, Team Report on 15th International AIDS Conference, July 2004:02).

However it is encouraging to note that the establishment of workplace programmes remains one of the Sectoral obligations and commitments in the MTP III on HIV/AIDS. The Ministry of Health and Social Services is already in the process to accomplish this goal. It established a sectoral HIV/AIDS committee at National level in September 2003 which will facilitate the establishment of similar committees at Regional levels.

The main aims of the National Workplace HIV/AIDS Committee are among others to prevent and reduce HIV infection in the workplace as well as facilitate treatment, care and support to staff members who are infected and affected by HIV/AIDS (MOHSS 2004:119).

A ministerial workplace HIV/AIDS committee is thus a committee within the Ministry of Health and Social Services, with the responsibility for prevention of HIV/

AIDS, care and support for employees affected by HIV/AIDS within the Ministry. The committee proposed some strategies to provide care and support to staff members through: a wellness programme, social support and assistance to staff to plan for their future (MOHSS, 2004).

2.8 LEGISLATION IN PLACE IN NAMIBIA

Several policies and guidelines are in place addressing HIV/AIDS education, awareness, prevention and treatment among other occupational health problems. These include:

. Guidelines for implementation of National Code on HIV/AIDS in Employment (Ministry of Labour, March 1998).

. Guidelines for Anti-Retroviral Therapy (MOHSS, April 2003).

. National Guidelines on post-exposure prophylaxis at the work place (MOHSS, 2004).

. Draft Infection control guidelines (MOHSS, 2004).

. Regulations relating to the Health and Safety of Employees at work under the Labour Act 1992 (Act 6 of 1992).

. Policy on confidentiality, notification, reporting and surveillance (MOHSS, 2002).

. Guidelines for counseling of HIV/AIDS and Sexually Transmitted Diseases (MOHSS, 2001)

However, despite all these initiatives, the issue of support, counseling and holistic care of those affected by the stress and fear of HIV/AIDS resulting from the direct contact with blood and body fluids of other persons is not clearly articulated.

The National Guidelines on post-exposure prophylaxis at the workplace made some reference to counseling and education (MOHSS, 2004:26); however, this is in reference to those who are exposed already to the actual source of infection. The compliance with infection control recommendations in handling sharp objects and medical waste is the mainstay of prevention of occupational HIV infection. This is now complemented by the post-exposure prophylaxis with Antiretroviral therapy (MOHSS, 2004:01). Nevertheless, the need for psychological support and care still exist in a pre-exposure stage.

2.9 SUMMARY

In this chapter, the literature review concentrated on the aspects of occupational stress and fear and its prevalence in health care profession. The risk of occupational HIV transmission was briefly explored; thereafter the impact of fear and stress on the provision of nursing care was discussed. Attention was given to the nature and extent of support needed by health care givers in addition to the existing policies and legislations. Lastly, attention was also given to the sectoral responses in addressing the need for workplace strategies as required in NDP II. The next chapter will present a description on how the actual research was conducted. It will also deal with various measures taken to ensure the scientific and empirical value of the study.

CHAPTER THREE

3. RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter begins with a brief outline of the research design, which is primarily qualitative, descriptive, exploratory and contextual. This is followed by a discussion of population, sample size and sampling procedure, data collection and analysis. In conclusion, the chapter presents the ethical considerations and discusses the validity and reliability of the study.

3.2 RESEARCH DESIGN

Qualitative research forms the basis of this research design and method. Qualitative method was used because it allows exploration of human opinions, attitudes and behaviour by other humans in a way that acknowledges the value of evidence and the worth of subjectivity. In this study, there was a need to explore what nurses and midwives find helpful in managing occupational stress and fear in the two Windhoek State Hospitals. The method offers an opportunity to gain understanding of their context through a systematic approach. Descriptive results of the questionnaires are displayed quantitatively to facilitate the analysis.

The word explore implies scrutinizing unknown phenomenon for the purpose of discovery. This study is exploratory because it was conducted to enable the researcher to gain an insight and understanding into the occupational stress and fear of HIV/AIDS.

This would further enable the researcher to develop appropriate strategies to manage the problem of occupational stress and fear. The study was focused on individuals who were likely to have opinions on the phenomenon under investigation (Struwig and Stead, 2001:07). The researcher was interested in understanding the issue from the perspective of the research participant and interpreting the research data in the association with the participants (Struwig et al 2001:121).

The study was contextual in nature. Burns et al (1993) as quoted by Haoses et al (2001:04) stated that each person's concerns are qualitatively different, therefore the context (in this case a ward/unit) in which the nurse/midwife works shapes his/her behaviour. A contextual study was preferred because action related reactions can only be given and understood in a particular situation or context within which that person can be found.

It was also important to understand how previous exposure to occupational stress and fear played a role in individual nurse/midwife' thoughts, behaviour and action, as psychological and emotional responses are not static. Understanding coping skills in line with these dynamic aspects was also imperative.

3.3 POPULATION

The target population consisted of the two groups of nurses namely registered nurses/midwives and enrolled nurses/midwives. These nurses/midwives are working at Katutura and Windhoek Central Hospitals. The total population of nurses/midwives

in the two hospitals was about 1172. These nurses/midwives normally work in two shifts i.e. day and night.

3.4 SAMPLE SIZE

This study included only nurses/midwives who are in close contact with HIV/AIDS patients and rendering care to the infected and affected individuals in selected wards/units. The participants were therefore drawn from various medical, surgical, labour, paediatric wards, casualty, operating theatres and an, infectious disease clinic.

These wards/units were regarded as high risk areas because it is where most HIV/AIDS infected individuals are cared for and the chances of staff exposure to potentially infective body fluids are high.

The actual population from the selected wards/units was 317, which represents 27% of the target population (total number of all nurses/midwives in the two Windhoek State Hospitals). A final number of 80 nurses/midwives were purposively selected for interview. The sample size was thus 25% of the nurses/midwives population in the selected wards/units.

3.5 SAMPLING PROCEDURE

In this study a purposive/judgmental sampling method was used to select a sample of information-rich participants. This method was based on the judgment of a researcher regarding the characteristics of a representative sample (Bless and Higson-Smith, 1995). The method used was to select nurses and midwives in the wards/units

that was judged to be typical of the population under investigation. Thus, the sample was drawn from those nurses/midwives who have nursed HIV/AIDS patients at any point in their nursing career, as well as those who are in close contact with the infected/affected clients on daily basis. A monthly staff allocation list i.e. change list for the month of September and October 2004 was used to determine the sample size. This list gave an indication of how many nurses/midwives were allocated to each targeted ward/unit in both day and night shifts. Furthermore, the off-duty roster for each ward/unit was used to identify those who were on duty from time to time and thus assisted in selecting two nurses/midwives from each ward per shift i.e. day and night shifts.

Efforts were also made to interview those who were off duty on the day their ward/unit was visited, especially those who indicated their willingness to participate in the study. Those nurses/midwives who were on leave at the time of the study were excluded.

3.6 METHODS OF DATA COLLECTION

3.6.1 Pilot Study

A pilot study was done to test relevance and clarity of the research instrument before the commencement of the main study. Four nurses/midwives were involved in the pilot study and did not form part of the main study. This pilot study enabled proper modification of the instrument before the actual study was done. Any participant was free to withdraw from this study at any given time, participation remained voluntary.

3.6.2 Research Interview

The researcher made use of interviews, which were based on standardized questionnaires to acquire data from nurses and midwives who are care givers of HIV/AIDS patients. The questions were both closed and open-ended. The main questions were open ended to allow wider expression of opinions from the participants. The researcher was personally involved in interviews which were conducted at the Windhoek Central and Katutura State Hospitals. The participants selected the time they wished to be interviewed and the venue. All interviews took place within the hospital environment meeting the contextual nature of the study.

3.6.3 Focus group interviews

The researcher used focused group interviews to probe for further data and enable participants to provide more information not covered in the standardized interviews.

Semi-structured and open-ended questions were developed and used to initiate the focus group interviews. Questions started from more general and non-threatening to more specific ones. All participants were made to feel that their contributions were worthwhile and had the freedom to disagree with each other. A research assistant was used to assist the researcher in taking notes and observing how participants reacted to certain views. The questions and what was expected from the research assistant were already established prior to the interviews.

Kruger (in Struwig et al.,2001:99) cited that focus groups generally consist of four to eight participants who should participate voluntarily and who should also be

"homogenous in some respects". In this study five nurses/midwives were interviewed in one group. The participants in this group were homogenous in the sense that they work together to provide nursing care to HIV/AIDS patients. However their level of training differed with the enrolled nurses being the sub-professional category of nurses while the registered nurses/midwives constituted the professional category of nurses. This was necessary to obtain views from participants of different training and employment categories. However the research was not interested in making comparison between the two categories of nurses. These participants were obtained through a convenience sampling. Their selection was based on availability and their ability to express themselves during the group discussion. They took part voluntarily.

3.7 ETHICAL CONSIDERATION

Throughout the process of data collection the problem of persuading participants to co-operate with the researcher was always present. This was so because without such co-operation there would be non-response or incompletely filled out questionnaires. Participants had the right to refuse to participate and this was an ethical right which the researcher must respect (Bless et al, 1995).

3.7.1 Permission

When research is undertaken at a health service facility permission for such research should be obtained from the authority in charge of the service (Uysand Basson, 1991). In this case, written permission was obtained from the Permanent Secretary of the Ministry of Health and Social Services (See Appendix A). Permission was also

obtained from the Senior Medical Superintendents of the two Hospitals in which the interviews were conducted i.e. Windhoek Central and Katutura State Hospitals. (See Appendix B and C respectively).

3.7.2 Voluntary Participation

Each participant also participated on a voluntary basis and those who wished to withdraw their participation were permitted to do so at any given time of the study. The covering letter attached to each questionnaire was also an attempt to meet the ethical demand which requires that participants get involved after an informed consent. (See Appendix D).

3.7.3 Anonymity

Bless et al (1995) stated that anonymity is of great importance in studies where employees were asked to make statements about their working conditions etc. and this was the case in this study. Since anonymity was regarded as essential in this study, the names of participants were omitted and assurance was also given to them in a covering letter that their names would not be associated with the outcome of the study.

3.7.4 Confidentiality

In many studies confidentiality like anonymity cannot strictly be maintained, especially when data is collected by an interviewer who has direct contact with all participants (Bless et al, 1995). This was more crucial especially when the researcher was a colleague of the participants who was able to recognize each one of them.

This could have been the case in this study. In this case, it was important that participants were assured that the information given would only be used for the stated purpose of the research and no other person would have access to interview data. However, it was known that the outcome of the study would be shared with the employer i.e. Ministry of Health and Social Services.

3.8 VALIDITY AND RELIABILITY

The emphasis was put on the perspectives and language of the participants rather than on the interpretative terminology of the researcher. The interviews were also recorded verbatim. All these efforts were made to increase the interpretative validity.

At the end of each interview the researcher ensured that each participant agreed with what was recorded. Member-checks were used to examine the accuracy of the data. Interview reliability was ensured through a pilot study which was used to determine if the participants would understand the questions and find it useful in the main study. Results of both data collection methods were correlated to test consistency of the data.

3.9 SUMMARY

This chapter outlined some of the fundamental methodological issues on how the research was carried out. These included the research design, population, sample size and sampling procedure used. The methods of data collection, some ethical aspects and validity and reliability of the study were also given attention.

CHAPTER FOUR

4. DATA PRESENTATION AND ANALYSIS

4.1 INTRODUCTION

In the previous chapter the research methodology of this study was discussed. This is the penultimate chapter where the results obtained from the analysis of transcriptions of the views of nurses and midwives caring for HIV/AIDS patients in the two Windhoek State Hospitals are discussed.

4.2 PROCESS OF DATA ANALYSIS

In this study, data analysis was done simultaneously with data collection. The researcher commenced by reading the interview transcripts in order to make sense of the whole. After reading all interview transcripts, the researcher made a list of topics and clustered similar topics together and isolated the others that were contrary to the emerging themes. The researcher discarded irrelevant data to the topic and retained relevant data only.

The topics were assigned codes and then grouped into major categories. This was applied to open ended questions as opposed to close ended ones, which were more specific and straight forward. All material belonging to each category of data was assembled and the researcher started with preliminary analysis. In the process, new categories were developed which had not been previously identified.

The results were quantified on the basis of the number of participants in the case of closed ended questions, while for open-ended questions they were based on the number of responses that made reference to the same categories. This process was suggested by Tesch (in Creswell, 1994:155).

4.3 MEMBER-CHECKS

After each interview the researcher read what was recorded to the participant to verify the accuracy of the data. After the data analysis, theme categorizing, interpretation and conclusions were done. The researcher went back to the field and asked assistance of two participants from whom the data were originally collected in order to establish truth value of the research. Lincoln and Guba (1995:290, 314) indicate that from these member checks the researcher can make necessary amendments to the reports if needed. No amendments were done afterward.

4.4 DATA ANALYSIS AND INTERPRETATION

The analysis was done using the Statistical Progamme for Social Sciences (SPSS, 8.0 student version for Windows 95 or NT). Descriptive analyses were used to examine data from the standardized interview instruments as well as the focus group interviews. Data was first analyzed manually before being entered in the computer. The results are presented in descriptive form: percentages, frequencies, tables, graphs and charts.

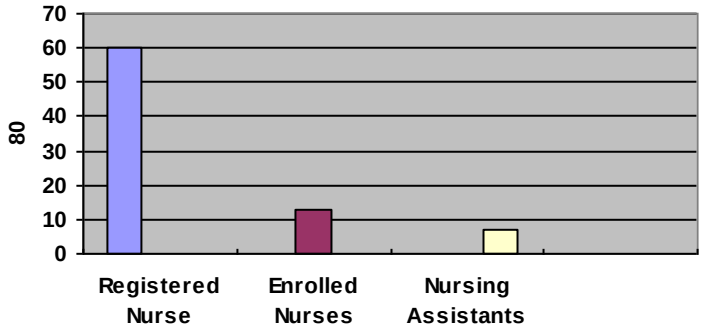
4.5 DISCUSSION OF FINDINGS

4.5.1 Profile of Participants

A. Employment Status (Rank)

As indicated in the previous chapter a total number of 80 participants were interviewed using a standardized questionnaire. This represents 25% of nurses/midwives working in the selected wards/units. Graph 1, shows the employment status of the research participants.

Graph 1: Employment Status of the Participants

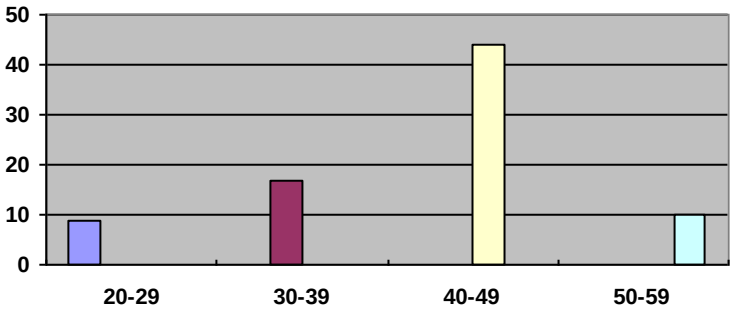


N = 80

As can be seen in Graph 1, registered nurses/midwives constituted 75% of the sample (N=60), followed by 16% (N=13) of the enrolled nurses and 9% (n=07) were nursing assistants. The smaller number of nursing assistants can be attributed to the fact that this category of nurses is being phased out by the Ministry of Health and Social Services through an upgrading process. Only a few of them are currently in the wards. The results further indicate high participation of registered nurses/midwives probably because this category of nurses is the one that plans the nursing care of HIV/AIDS patients.

B: Age Distribution of Participants

Graph 2: Age of Participants



N = 80

Most participants, 55% (N=44) are aged between 40-49 years. A significant number, 21%, are aged 30-39 (N=17), while 13% (N=10) represent the most senior age group of 50-59. The younger group of 20-29 years of age is represented by fewer participants. This result shows that nurses/midwives of different ages are providing care to HIV/AIDS patients. It also indicates that a significant number of these nurses/midwives are in their prime economically productive age.

C. Sections/Units

The participants worked in medical, surgical, paediatric, labour wards, theatres and casualty units as well as an Infectious Disease Clinic. See Table 2. Most participants, 23%, (N=18) were in the paediatric wards, followed by those in surgical wards and medical wards representing 21% (N=17) of the total sample respectively

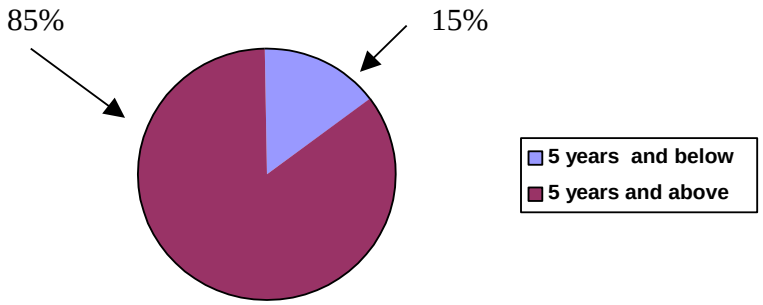
Table 2: Working area of the participants

WARDS/UNITS	NUMBER	PERCENTAGE (%)
Surgery	17	21%
Medicine	17	21%
Paediatric	18	23%
Labour (Maternity)	12	15%
Theatre	7	9%
Casualty	7	9%
Infections Disease clinic	2	3%
	N = 80	= 100%

D. Work Experience

The majority of participants, 85%, have work experience of five years or more (N=68), whereas 15% (N=12) had less than five years working experience. These results suggest that more than half of the participants have been in nursing long enough to have nursed more than one HIV/AIDS patient and their chances of having been exposed to occupational stress and fear related to HIV/AIDS care is high. Those who have been in nursing for less than five years are likely to be the few young ones (see Graph 2) who might have just graduated. Pie Chart 1, indicated the participant's years of work experience.

Pie Chart 1: Participants years of working experience

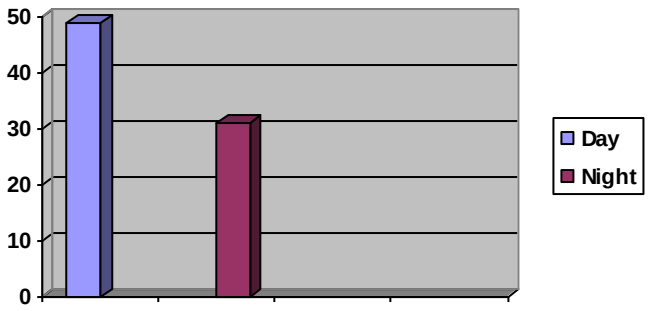


N = 80

E. Shifts

The participants were interviewed during day and night shifts. The nurses/midwives on day shifts were working in morning, afternoon and straight shifts, which are a full eleven (11) hour shift (07H00-19H00). Those who were on night shifts were working straight shifts starting at 19H00 until 07H00 the next day. The participants interviewed during the day shifts constituted 61% (N=49), while those interviewed during the night shifts represent 39% (N=31) of the sample. Graph 3 provides a simplified presentation of the shifts worked by participants as follows:

Graph 3. Shifts worked by participants

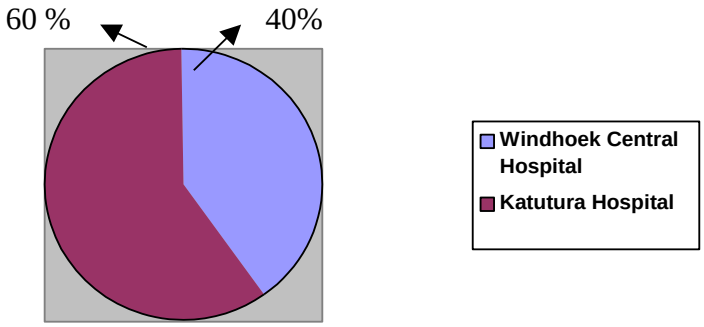


N = 80

F. Hospital at which participants interviewed

Participants (nurses/midwives) worked at Katutura and Windhoek Central Hospitals. The majority of participants 60% (N=48) worked at Katutura State Hospital while 40% (N=32) worked at Windhoek Central Hospital. More nurses/midwives were interviewed at Katutura Hospital than Windhoek Central Hospital. Because Windhoek Central Hospital, being a National Referral Hospital, has few wards in which HIV/AIDS patients are admitted as opposed to Katutura Hospital which is an Intermediate Referral Hospital. These results can be seen in Pie Chart 2 below.

Pie Chart 2: Hospitals where participants are work.



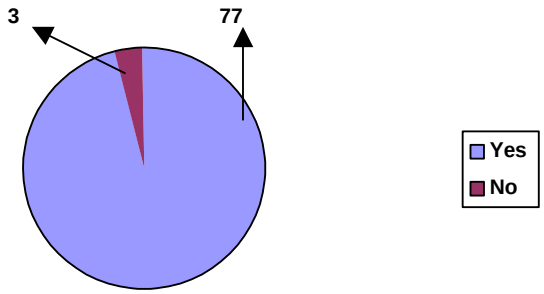
N = 80

G. Provision of Nursing Care to HIV/AIDS patients

Total annual admissions for the hospitals country wide were 166746 patients in 2003 out of which 9654 were HIV related admissions (MTP III 2004-2009). As expected most participants 96% (N=77) had provided care to patients who tested positive of HIV/AIDS. Four percent(4%) of the participants indicated that they were not sure whether they had nursed HIV/AIDS patients. This is because patients were not tested for HIV although they may have presented signs and symptoms similar to that of

HIV/AIDS (N=3). These nurses/midwives were mainly working at Casualty Units where patients do not stay long before getting admitted or discharged. Pie chart 3 provides a simplified illustration of these results.

Pie Chart 3: Number of Participants who had nursed an HIV/AIDS patient.



N=80

4.5.2 Feelings of nurses and midwives after nursing HIV/AIDS patients

How nurses/midwives have reacted to patients with HIV/AIDS varied, from the feelings of sadness, anger and fear to that of happiness and satisfaction (see Graph 4 below). There were however those who could not indicate their feelings, citing only that they "feel the same", which according to them means that all the patients are the same despite some being HIV positive. In this case participants were free to express as many feelings as possible. The results indicate that most participants (N = 58) experience sadness after having nursed an HIV/AIDS patient. It is also worth noting that out of this number twelve (N=12) participants indicated that they feel stressed after providing care to HIV/AIDS patients. The other themes indicated in this subcategory of sadness are hopelessness, hurt, bad, helpless, sorry, tired, empathy, pity, disturbed and wonder.

The results further indicate that a significant number of participants (N=25) verbalise feelings of fear of nursing HIV/AIDS patients. This was evident from statements and words such as:

"I feel unsecured and unprotected"

" I feel very scared, worried and nervous"

"I feel my hands are becoming dirty"

" I feel very emotionally scared"

"I feel very disturbed emotionally and sometimes it is difficult to sleep at night"

Some references were made by 15 participants regarding their happiness in caring for HIV/AIDS. Examples are:

"I feel good when the patient is doing fine"

"I feel relieved when finished without injuring myself"

"It makes me appreciate the profession"

The results further suggest that few participants (N=4) verbalise their feelings of anger as evidenced by statements such as:

"I am angered by the fact that some patients cannot even eat or drink"

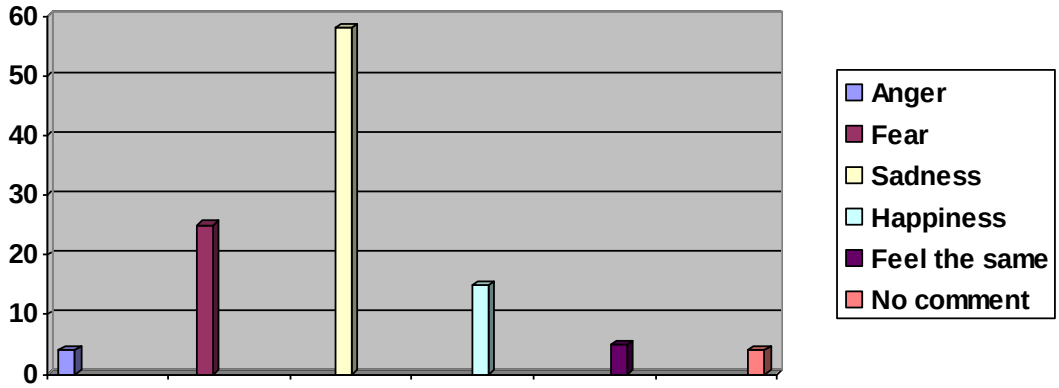
"I am angry because people do not want the change their sexual behaviour"

It was clear from these nurses/midwives that this anger was due to the incapacitating nature of disease, but also directed to patients, who were seen as being responsible for getting infected.

Few participants (N=4) indicated that they "feel the same". This statement which, upon further probing, was said to mean that these nurses regarded all patients as the same and no feeling of stress or fear was experienced after nursing them. However it was clear that this acceptance comes over time. These participants related to how it was difficult to nurse these patients in the beginning, but as time went on they became more resigned and accepting. It is more evident in the case of experienced nurses/midwives who have been nursing HIV/AIDS patients for many years. Over time those attitude changes occur, as indicated in statements such as:

"I got used, because almost every second patient in the ward is likely to be HIV positive and so do some of my colleagues"

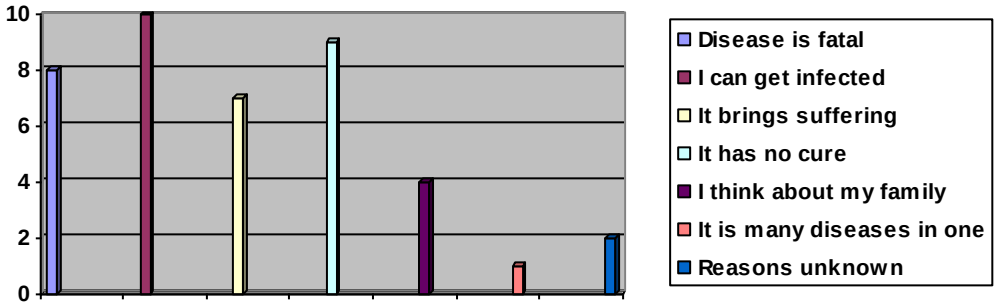
Graph 4: Feelings of participants (Nurses/Midwives) after nursing patients with HIV/AIDS



4.5.3 Justification of the Participants' feelings after nursing HIV/AIDS patients

A: Factors which contribute to feelings of fear

Graph 5: Reasons for feelings of fear



As can be seen in Graph 5, there are dynamics of fear on some participants' verbalizations, which indicate that nurses/midwives are often differently affected by various factors pertaining to the care of HIV/AIDS patients. Some of them are scared of getting infected in the process of rendering care (N=10).

"I am feeling sorry for the patients and fear that they might infect me..."

"Sometimes I feel already infected, keeping checking my fingers"

"I have fear for contamination, especially pricking myself or maybe I have unnoticed wound on my hands"

The fatality of the disease also contributed to the feelings of fear in some participants (N=08) as stated like: "The patient is definitely going to die". A bigger number (N=9) is scared by the fact that there is no cure for HIV/AIDS. Significant also were those who not only identify themselves with the patients, but who were also reminded of their family members, (N=14).

An example of this phenomenon is participant No. 19, who is an adult woman who stated:

> "The patient can be my family or my child, I have already buried one child and I have also one who is infected, it hurts deeply".
> "I am a mother and what I am seeing can happen to my children"

Young children and women who are raped were also identified as contributing to feelings of fear and sadness among nurses/midwives.

Some of them have fear of suffering (N=7).

> "HIV/AIDS is a long-term suffering disease"
> "It is a long illness which is expensive to treat"

Others fear the incapacitating nature of the disease (N=3) as one cited that:

> "It is dangerous and really bad as it makes patients weak and unable to eat or drink anything"

There are those who could not identify the cause of their fear (N=2). This is the fear of the unknown.

The results suggest that there are different factors that contribute to the same phenomenon, of which the major influencing factors here include fear of contagion associated with the uncertainties and feeling of futility in providing care for the patient with a potentially fatal disease, HIV/AIDS.

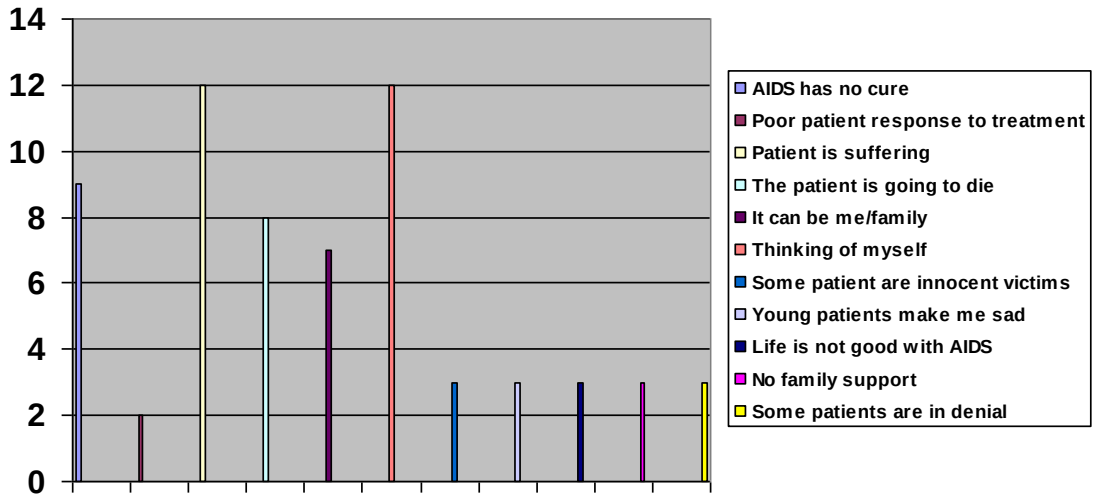
B: Factors that contribute to feelings of sadness

As indicated earlier, feelings of sadness appear explicitly on the verbalizations of 58 participants. Again the suffering of the patients was cited to be the major cause of sadness to many participants (N=12). However an equal number (N=12) of participants feel sad as they are thinking of themselves being in the same situation as their patients; examples here are statements such as:

"I might get the disease and be like them one day"
"It could happen to me"

These are clear and direct statements of self identification. Various factors were also identified as contributing to feelings of sadness. Those who saddened by the fact that there is no cure for HIV/AIDS are nine (N=9), while those who felt sad because their patients will eventually die are eight (N=8). Sadness was also caused by the disease's likelihood to infect/affect the participant's family members (N=7). The other factors that cause sadness among participants are: the innocence of some victims (N=3), the young age of most victims (N=3), lack of patient's family support (N=3), some patients are in denial (N=3), and the feeling that life is no longer good once infected (N=3). These results are reflected in graph 6 below.

Graph 6: Reasons for feelings of sadness

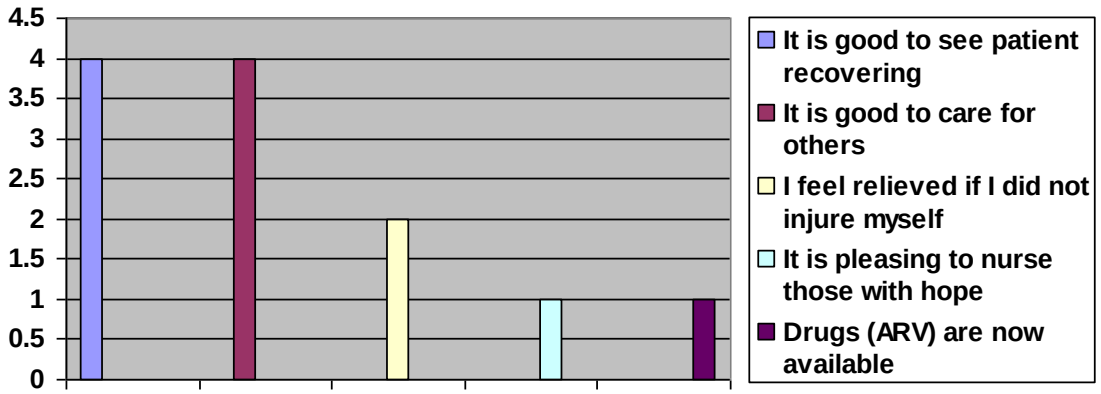


C: Factors associated with feelings of happiness

As it was stated earlier (graph 4), some participants (N=15) have experienced feelings of happiness after nursing HIV/AIDS patients. Participants cited various factors as the rationale behind such feelings. A significant number of the participants who verbalized feelings of happiness (N=4) indicated that "it is good to see patients recovering after they provided care to them". An equal number (N=4) also indicated that it was gratifying to care for others. Some participants feel relieved if they did not injure themselves after providing care to HIV/AIDS patients (N=2), while one participant indicated that she is pleased to nurse HIV/AIDS patients because the antiretroviral drugs are now available.

The results revealed some pleasant experiences in caring for the HIV/AIDS patients derived from the condition of the patients and a sense of altruism. Graph 7 presents the reasons for feelings of happiness.

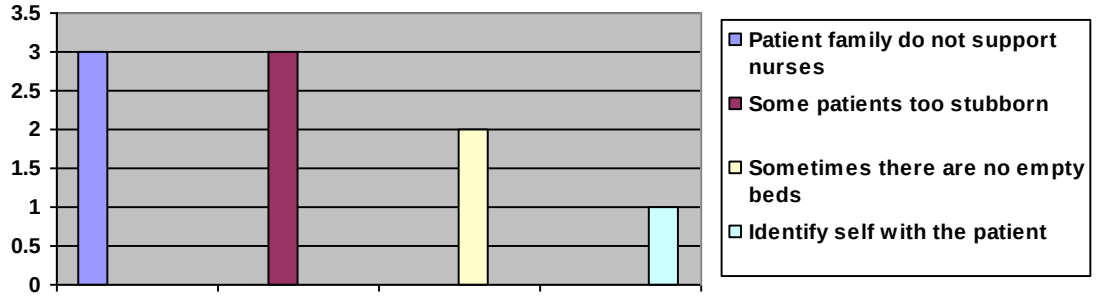
Graph 7: Reasons for feelings of happiness



D: Factors that contribute to feelings of anger

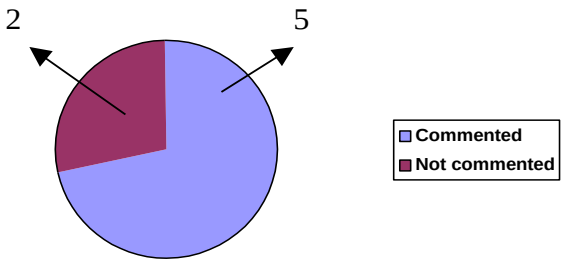
A smaller number of participants (N=4) who experienced the feelings of anger (graph 4,page 46), verbalized a number of factors, such as the patients' family not supporting nurses (N=3), an equal number of participants (N=3) stated that some patients are too stubborn, contributing to the feeling of anger in those caring for them. A few participants (N=2) are angered by lack of space for those patients who needed admission, while one participant indicated that it is annoying to imagine herself suffering as the patients do (see graph 8 below).

Graph 8: Reasons for feelings of anger



E: Number of participants provided additional comments

Pie Chart 4: Participants given additional comments



As it can be seen in Pie Chart 4, a small number of participants (N=5) commented by saying that they regard HIV/AIDS patients as similar to other patients. However, it was surprising to note that these participants could not state the feelings they experienced after nursing other patients who they claim to be similar to HIV/AIDS patients. A smaller number (N=2) of participants did not give reasons for their feelings.

4.5.4 Coping with stress and fear emanating from caring for HIV/AIDS patients

Results to the question, how participants manage their own fear and stress emanating from HIV/AIDS care giving role, are quantified on the basis of the number of participants who had reference to the same categories or themes. Data from interview transcripts was grouped into two main categories (emotionally focused coping behaviour and the problem focused coping behaviour) and subcategories and themes are grouped together as clusters of the participants' coping behaviour in order to make the discussion brief. Participants were allowed to state more than one management (coping) strategy. These may be found in Tables 3 and 4.

Table 3: Emotionally focused coping strategies

CLUSTERING OF PARTICIPANTS' STRESS AND FEAR MANGEMENT BEHAVIOURS	FREQUENCY
By putting God first and Pray (Religion).	11
By accepting the situation as stressful as it is.	9
By seeking psychological support e.g. counseling	7
By seeing HIV/AIDS patients as similar to others.	6
By doing what I wish for myself and my family.	6
"I just have to cope".	6
By trying to understand the patient and the disease.	8
By trying to remain calm despite circumstances.	5
Being mentally positive.	5
Through sharing ideas on HIV/AIDS care with colleagues.	5
Do relaxation after work.	5
By talking to my family about my work.	4
By trying to forget my experience at work.	3
By reading self help books.	3
"I got used" to the stress and fear.	2
"It is difficult"	2
"I cry"	1

Table 4: Problem focused coping strategies

CLUSTERING OF PARTICIPANTS' STRESS AND FEAR MANGEMENT BEHAVIOURS	FREQUENCY
By being cautious and use precaution measures	8
Provide treatment for the infection to be lowered.	3
Through team work stress and fear is low	2
ARV Drugs are not available.	1
"I use stress tablets"	1
Patient's family help with provision of care.	1

There are several significant conscious coping behaviours emerging from the quantification of the participants' statements as reflected in these tables. Some coping

behaviours are categorized as problem focused, because they are directed at eliminating or modifying the source of threats or as emotional focused, as they are about managing threats aroused by stress and fear. Some of these will be illustrated by quoted examples below.

A. Emotionally Focused Strategies

. Religion

In this theme participants (11) expressed the belief in God's control over their situation. This was expressed in various ways.

"I pray hard for myself. Ask God to give me courage".

"What helps to relieve my stress is my belief in God"

" If you protect yourself God will also protect you"

"By asking power and strength every morning and night from the Creator".

This is one of the passive stress and fear management behaviours in which participants ask God to solve their problems.

. Acceptance

It is significant that in 9 transcribed interviews, participants verbalized that acceptance of stressful and fearful situations helped them to manage occupational stress and fear. This acceptance was motivated by different factors. Some of them are motivated by the feeling of vulnerability:

"I accept because my turn will come."

Some of them are motivated by responsibility:

"I always find comfort by reminding myself that I am here by choice".

Some of them are motivated by the belief that they simply have to accept.

"Acceptance is the key to the management of stressful and fearful situation"

The statements above indicate that there are different motivations for the same coping behaviour.

* **Psychological Support**

There are those participants who are trained as counsellors for pre and post counselling of HIV/AIDS patients, (N=7). In this theme, an interesting trend emerged that those who are trained as counsellors use counselling as a strategy of managing their own stress and fear. This is evident from statements such as:

"I get help through counseling by other counsellors"

* Some emotionally focused coping strategies expressed in this study can be sub-categorized further as being either active or passive dependence management strategies as suggested by Uys (1994:28) in his study of mature defence mechanism strategies.

These statements are regarded as active stress and fear management strategies.

- Sharing ideas on HIV/AIDS care with their colleagues (N=5)
- Talking to their family about stressful and fearful situations (N=4)
- Reading books about self help (N=3)

The following are regarded as the passive stress and fear management strategies.

- "It is difficult but I just have to cope" (N=6)
- "I got used" (N=2)
- "Sometimes I cry" (N=2)
- "I try to forget my experience at work"

These results indicate that people do not need similar stress and fear management strategies but just good ones they find useful.

B. Problem focused stress/fear management strategies

Strategies in this category are more action oriented and preventative in nature. Most participants (N=8) reported the use of precautional measures and being more cautious as the way of relieving stress and fear.

The following statements are some of the methods verbalized by the participants.

"I learned to be calm in handling used instrument"

"I use method put up to protect myself"

"I wear gloves when handling blood, etc."

Some believe that having a patient put on treatment helps in lowering the transmission of the infections (N=3). Others manage their fear and stress through team work (N=2). This teamwork might even be extended to patient's family, who are encouraged to help nurses/midwives in the provision of care. One participant indicated that she is taking "stress tablets".

It is interesting to note that a relatively small number of participants cited problem focused strategies as opposed to emotional focused management strategies. It was also important to note that only one participant saw the introduction of antiretroviral drugs as a development that brought hope and comfort in dealing with HIV/AIDS.

C. Personal and work-related categories

The coping strategies can also be recombined into two categories namely, work-related and personal-related categories. The strategies falling into the personal category are:

- Putting God first and pray
- Remain calm
- Being mentally positive
- Relaxing after work
- Reading self help books
- Taking stress tablets, etc.

The following strategies are in the work related category:

- Accepting the situation as stressful as it is.
- Seeking psychological support.
- Regarding HIV/AIDS patients as similar to others.
- Trying to understand the patient and the disease.
- Being cautious and use of precautional measures.
- Provide treatment for the infection to be lowered.

These findings suggest that policy recommendation should be focused on empowering nurses and midwives to maximize the personal and work-related coping strategies they find useful individually or collectively.

4.5.5 Support needed in dealing with occupational stress and fear

On the question what should be done to help nurses/midwives experiencing fear and stress in caring for HIV/AIDS patients, the participants' responses are divided into six approaches with corresponding themes to substantiate them. They are:

(i) Emotional/Psychological approaches

(ii) Educational approaches

(iii) Physical/Environmental approaches

(iv) Religious approaches (Spiritual)

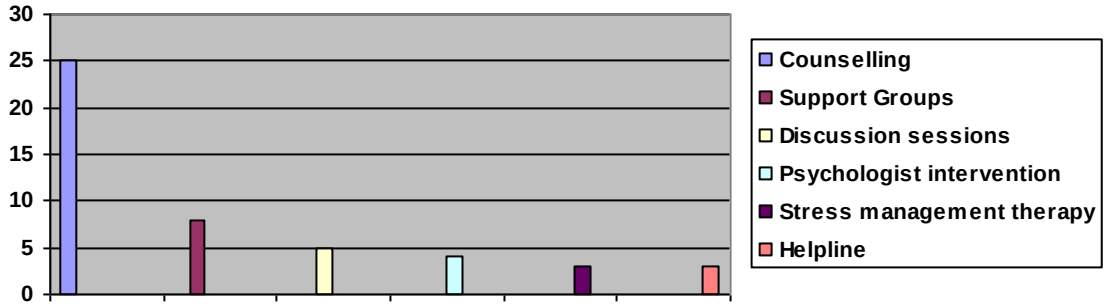
(v) Public focused approaches

(vi) Administrative approaches

Accordingly, these can be illustrated as follows:

(i) Emotional/Psychological Approaches to the Management of Stress and Fear

Graph 9: Emotional/Psychological Approaches



These results revealed a combination of primary prevention approaches like support groups, discussion sessions etc, which allow sharing of ideas with other members of a health team and the crisis interventions approaches such as help line and counselling interventions. This support should be available at all times as one participant put it:

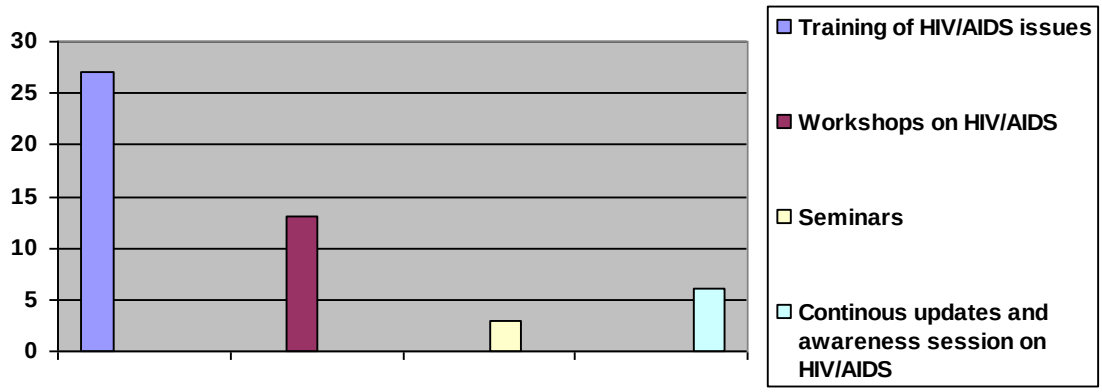
"There should be someone to talk to over 24 hours"

Significant to note is that most participants prefer counselling approach to the management of occupational stress and fear (N=25), as one participant indicated "There must be a counselling desk for nurses", while eight (N=8) proposed for group discussions and discussion sessions (N=5). These may be found in Graph 9 above.

(ii) Educational Approaches to the management of occupational stress and fear

Participants have indicated that attempts have to be made through educational and occupational training programmes to relieve stress and fear of HIV/AIDS care giving. These results are reflected in Graph 10 below.

Graph 10: Educational Approaches



In this theme, a number of participants (N=27) indicated that they need training on issues related to HIV/AIDS care. A further significant number (N=13) indicated the need for regular workshops on HIV/AIDS while some prefer seminars (N=3) and continuous updates and awareness on the new developments about HIV/AIDS (N=6).

These results suggest an acknowledgement of knowledge deficiency about HIV/AIDS transmission and care. These approaches, therefore, focused on addressing the lack of accurate and broad knowledge about HIV/AIDS, which some participants revealed in statements such as:

"I need training on how to handle used instruments"

"We need up to date information with the development of this disease"

"We need training on how to care for these patients"

"Who knows if the disease cannot be airborne?"

Participants indicated various areas in which they need training. These include:

- The basic information regarding protective measures.
- The safe handling of used instruments and prevention of needle prick injuries.
- The management of HIV/AIDS patients (care of HIV/AIDS patients).
- The reduction and management of occupational stress and fear.
- Up to date information/new development regarding what HIV/AIDS is, mode of spread, etc.

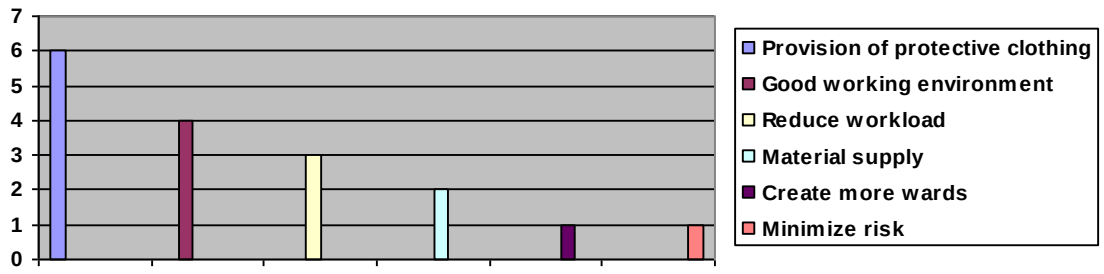
It is interesting to note that many participants acknowledge the feeling of uncertainties and lack knowledge on how to provide care to HIV/AIDS patients, as this can indeed promote the feeling of fear, stress and anxiety. This knowledge deficiency about HIV/AIDS care could logically affect outcomes of care for these patients. It has also been indicated that an accurate and broad knowledge about HIV/AIDS along with an in depth understanding of patient needs can help to alleviate much of the stress, fear associated with care of patient with HIV/AIDS (Walsimbi and Okonsky 2004). Less

fear was also found among participants who claim to be knowledgeable about the facts on HIV/AIDS (Uwakwe 2000).

(iii) Physical / Environmental Approaches

Participants also made suggestions focused on the improvement of their working environment, provision of protective clothing, material supplies, creating more space for patients and other means of minimizing HIV risks, (see Graph 11). These include the provision of protective clothing and other material supplies, items such as gloves, linen savers, goggles, gowns especially in theatres and sharp containers. Most of these resources were reported to be in short supply most of the time in the two Windhoek State Hospitals. Regarding the improvement of the working environment, participants suggested that their resting rooms are not comfortable at all and needed more attention. Furthermore, there is a need to create more space for HIV/AIDS patients by opening more wards. This is because the available space becomes overcrowded and not conducive to work in. The results are simplified in Graph 11 below.

Graph 11: Physical / Environmental Approaches



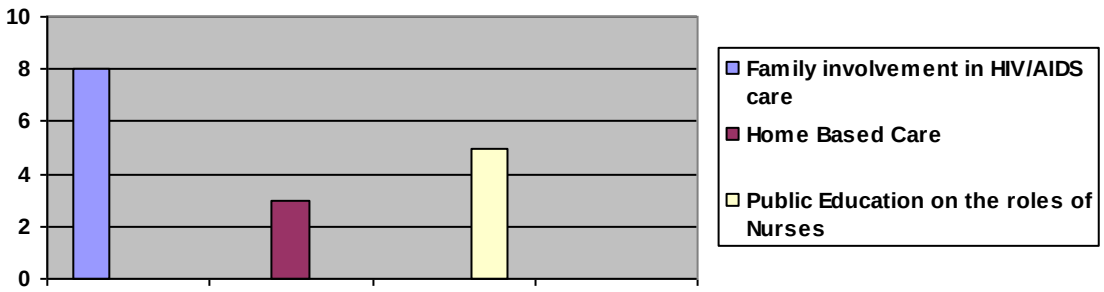
The wards identified by participants as being the most overcrowded are 4 East at the Windhoek Central Hospital and 5A at the Katutura State Hospital. Some participants suggested that something needs to be done to reduce the workload in these wards which made them more stressful to work in. Some felt that this can be achieved through strengthening the home based care approach to the care of HIV/AIDS patients, while others proposed that the risk of getting infected and its associated fear can be minimized through avoiding the drawing of many blood samples from patients and limit such procedures to the most essential tests.

(iv) Religious Approaches

In this theme, it is interesting to discover that although many participants use religion as their emotional focused strategy to manage occupational stress and fear (see Table 3, pg 53), only three (N=3) participants suggested that religious approaches can be used to manage the same phenomenon. The question is why is this case? This study did not attempt to seek answers to this question.

(v) Public Focused Approaches

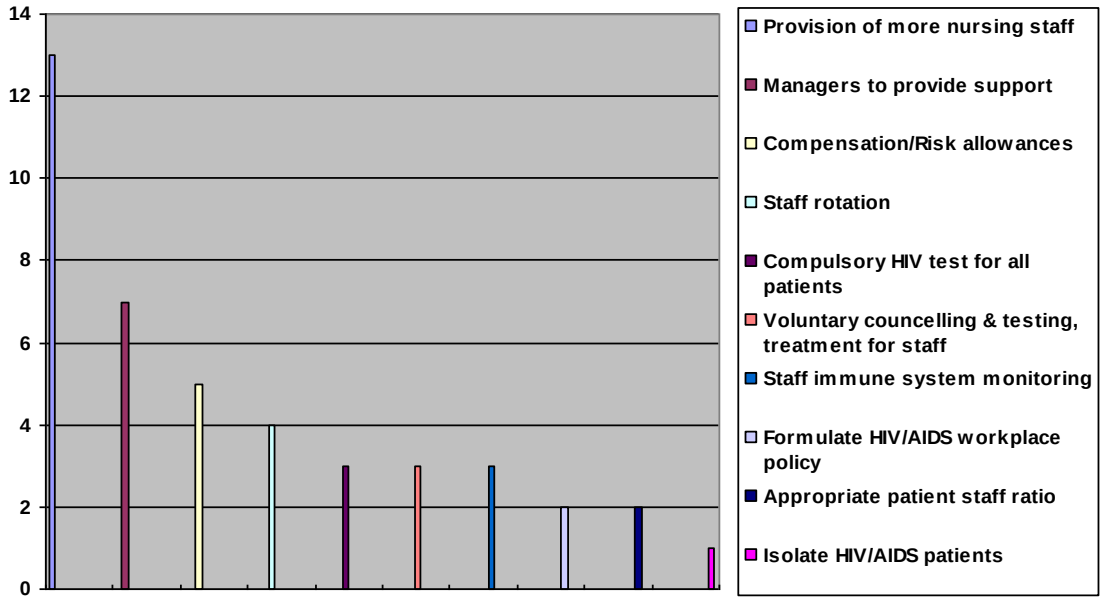
Graph 12: Public Focused Approaches



The other approaches the participants proposed are more focused on the general public and family members of the people infected and affected by HIV/AIDS. These approaches are aimed at addressing some factors which participants identified as promoting stress and fear among nurses and midwives nursing HIV/AIDS patients. These are: family members of patients making unnecessary demands on nurses/midwives and their unwillingness to assist and support nurses and patients. Thus, participants propose the involvement of family members of the patients in the provision of care (N=8), the home based care (N=3) and public education about the roles of nurses (N=6). Graph 12 above gives an illustration of these results.

(vi) Administrative Approaches to the Management of Occupational Stress and Fear

Graph 13: Administrative Approaches



A theme characterized by clear, direct statements from a significant number of participants (N=13) as a problem is that there is a shortage of staff in the wards. Thus, they suggested for the provision of more nursing staff in the affected wards/units. In the same vein, it is further proposed that there is a need to rotate staff in the wards accommodating HIV/AIDS patients. Some participants (N=4) indicated that staff rotations be done every second month to avoid some staff being overwhelmed by stress and fear related to AIDS care giving role. The other prominent suggestion is the development of an appropriate patient staff ratio, which most nurses indicated that it is not well addressed this time (N=2). Other participants indicated that it brings a lot of fear and uncertainty when a nurse does not know the HIV status of his/her patient. In the light of this, they suggested that HIV test be made compulsory for all patients being admitted (N=3). There are those, however, who felt that the same option be made available to staff members through voluntary counselling and testing (N=3). A relatively small number of nurses/midwives interviewed (N=3) felt also that there must be a regular monitoring of immune system for staff members. This is to be sure of one's status from time to time and avoids fear of the unknown.

Some participants (N=5) find comfort in the introduction of a risk allowance for those working with HIV/AIDS patients. Some referred to the same approach as "compensation". Managers are also called upon to be more supportive toward those working in fearful and stressful environment (N=7). One participant qualified this statement by indicating that "often managers blame nurses for being careless when they prick themselves on duty".

This causes more stress and fear in a particular staff member.

The absence of HIV/AIDS workplace policy was also identified by participants (N=2) as a deficiency that needs to be corrected, as it is expected to address occupational problem nurses/midwives have. These results are simplified in Graph 13.

4.5.6 Role players in the management of occupational stress and fear

On the question, who should be involved in the management of occupational stress and fear, participants had a choice among many options and they were allowed to indicate more than one choice. Consequently, the majority (N=46) indicated that occupational stress and fear should be managed by a multidisciplinary team. A significant number of participants (N=26) suggested that hospital managers should be the ones managing these problems, while other participants (N=17) made it clear that nurse supervisors should play a major role in managing occupational stress and fear of their subordinates caring for HIV/AIDS patients. However, many participants (nurses/midwives) do not feel that nurses/midwives themselves should be the ones managing the problems affecting them. This is reflected by a smaller number (N=8) of participants who indicated that nurses/midwives themselves should be the ones playing a role in dealing with occupational stress and fear. Nevertheless, judging from the number of participants who indicated a multidisciplinary approach, it is clear that the participants may prefer a team approach in which they might be included as opposed to individual approaches.

Table 5: Role players in the management of occupational stress and fear

Role players	Frequencies
Hospital Managers	26
Nurse Supervisors	17
Nurses/Midwives themselves	08
A multidisciplinary team	46

Participants were given the opportunity to identify any other role players to those listed in the questionnaires and their responses included the following:

Table 6: Other role players in the management of occupational stress and fear

Other role players	Frequencies
Social Workers	10
Church leaders	1
Community leaders	6
Non-Governmental organizations	6
Youth Groups	2

I interview participants indicated acceptance of social workers as role players in the management of occupational stress and fear, especially in the provision of counselling services to those in need. The results (Table 6) also attest to that, as most participants (N=10) identified social workers to top the list of other role players.

Community leaders and members of Non-Governmental Organizations were also listed (N=6). An addition to these choices, many participants identified organizations such as Namibia Red Cross Society, Catholic AIDS Action and AIDS Care Trust as being well experienced in HIV/AIDS related care and counselling services with the knowledge they think can be used to help nurses/midwives. It is again interesting to realize that despite the fact that most participants use religion as their emotional focused strategy to manage occupational stress and fear as indicated in Table 3, only one participant identified church leaders as possible role players in the management of the same problem.

These results suggest the composition of the multidisciplinary team which most participants suggested (see Table 5). They also indicate that role players in the management of stress and fear regarding HIV/AIDS care should not be restricted to the resources available within the Ministry of Health and Social Services, but also utilize the resources available in the community from which nurses/midwives originate.

4.5.7 Focus group discussion

A. Introduction

The researcher held a focus group interview as part of the sample of the participant's response. This method gave the participants more time with the researcher, and he was better able to understand what their responses were. The researcher had an opportunity to probe for further data and allowed participants to give more

information that was not well covered in the standardized interviews. This also serves as a means of validating the data collected during individualized interviews.

B. Participants

The group consisted of five nurses/midwives who care for HIV/AIDS patients in the targeted wards/units from which the main sample was taken. The group was comprised of three registered nurses/midwives and two enrolled nurses. At the time of the focus group interviews the participants had already been interviewed individually using the standardized questionnaire.

4.5.8 Results and Analysis of Focus Group Interview

A. Positive and negative experiences regarding nursing and HIV/AIDS patients

The group indicated that it is frightening to witness the death and the suffering of those who had not accepted their HIV/AIDS status. This is because, according to the group, those who did not accept die struggling and this is what is frightening. Those who had accepted their status are not in fear and die peacefully, hence they do not cause much feeling of fear in those caring for them. This experience however differs from nursing one patient to the other. The acceptance of the patient's family members is also identified as helping the nurses/midwives to cope with their work, especially in paediatric wards as opposed to adult wards.

The group also revealed the dilemma they experience in caring for patients, who prefer their HIV/AIDS status not to be known by relatives who are taking care of them

most of the time. It is said to be stressful when family members want to know the diagnosis of their loved ones from nurses, while the patient is against it.

Consequently, the group identified the issue of confidentiality as contributing to their stress. The other stressful experience the group stated is the fact that some HIV/AIDS patients are in denial and ignorant of their status. As a result, the group observed that these patients seek traditional treatment after having been discharged from the hospital. In most cases they get re-admitted to the hospital more tired than before. The group however experienced that this situation is not likely if both the patient and close relatives know the HIV/AIDS status of the patient, and they were all counseled.

C. The most serious problems facing nurses regarding the care of HIV/AIDS patients

The group indicated that nurses/midwives have fear of getting infected in the process of providing care to these patients, and this was identified as a serious problem. The other problem the group stated is staff shortage as opposed to increasing workload. These results also point to the issue of patient staff ratio which was indicated as a problem in the findings for the standardized interviews.

The other serious problem indicated by the group is that family members do not always assist the nurses/midwives in providing care to their loved ones. A similar problem was found during individualized interviews. This was related to fears which the families have. Upon probing further, the group revealed that most family members

know the signs and symptoms of HIV/AIDS or related illness such as diarrhoea, loss of weight etc., and most of them had past experience related to HIV/AIDS.

It was also revealed that most HIV/AIDS patients are confused and need continuous supervision and care. This requires that a nurse/midwife must sit at the bed-side to watch over this patient continuously. To them this is not practically possible as there are many patients in the ward who need attention, given the shortage of personnel being experienced. The group further verbalized that most HIV/AIDS patients stay longer in the hospital because of poor home-based care in the community. The same factor leads to re-admission of those previously discharged. According to participants, there are two reasons why home-based care is poor: one is that some patients would not allow their family members to help them, and two is that some patients are mostly left alone at home, helpless because family members do not know what to do anymore.

D. What is stressful and fearful in caring for HIV/AIDS patients

The group felt that occupational stress and fear results from lack of knowledge regarding the disease itself and available treatment. They reasoned that since most nurses/midwives have this knowledge deficiency, it is difficult for them to respond to the queries raised by patients' relatives about the disease and its care. "That brings guilty feelings", one participant confessed. Also, they felt that lack of knowledge makes them more scared, as they always think that there is a lot that they do not know about the disease. The group also agreed that lack of space in the wards to accommodate many patients in need of admission is stressful, as they have to search

for space in other wards, this is not always an easy task to do. It makes the patient feel unwanted and they also feel bad when they are not able to find space and give care the patients are seeking.

The other stressful factor the group deliberated on at length is poor pre-test counselling given to private patients by their private doctors. Sometimes patients are tested without counselling at all and not prepared to accept a positive test result. Consequently, these patients become confused upon receiving their results. This gives nurses/midwives a tough time and more stress. What is scaring about private patients admitted in state hospitals is that their medical history is not well documented. They have a tendency of changing doctors as their status becomes known and have their HIV test repeated many times, because the next doctor did not know whether such a test was already done. The nurses/midwives are always nursing these patients whose HIV status is "unknown", and a further HIV test is not always consented to by a patient who already knows his/her status. There is always an aspect of uncertainty, and if you are not certain fear will not go away.

E. Dealing with occupational stress and fear

The group reported that some of them got used to stress and fear, because patients with HIV/AIDS are so common. It does not help much to remain stressed and fearful, because even some of their colleagues with whom they have to share responsibilities are also HIV positive, the group related. The group also mentioned that adhering to infection control guidelines and taking precautionary measures bring a bit of relief, as

the chances of getting infected become minimal. Self protection is indicated as helping in overcoming extreme fear. The group suggested that putting "everything" in God's hands is also a way of coping with stress and fear. This is mostly achieved through prayers the group exemplified.

The group also cited what they regard as rare but helpful support nurses/midwives receive from the patients, in that very few patients tell them to be careful when nursing them, especially patients who are aware of their positive HIV status, while the nurse/midwife has no clue at all. The group concluded that one must be very lucky to nurse such patients. However, the group stressed that there are some nurses/midwives who cannot cope well with occupational stress and fear. This resulted in some of them getting scared of touching HIV/AIDS patients. Others try to avoid working with these patients at all costs. On a more positive but resigned confession, the group agreed that they just have to accept the situation they find themselves in citing this as being the key rationale of being a nurse.

F. Policy / Guidelines on HIV/AIDS for health workers

On the question whether the group has knowledge of any policy/guidelines on HIV/AIDS for health workers in the Ministry, the group stated that it has no knowledge of such policy/guidelines. The group felt that the problem was not given attention, because nurses/midwives did not complain about it. It is an unidentified issue because those affected remained suffering in silence. The group indicated that if there is any of such policy/guidelines it should be made known to them.

G. The existing help for those affected by occupational stress and fear

It was revealed that there is no formal arrangement or an appointed/identified person responsible for such service. The group observed that some staff makes use of their supervisors or social workers who are appointed to handle social problems for patients in the hospitals.

H. Support/Assistance the group would find helpful from the Employer

The group suggested that social workers be given the responsibility of helping nursing/ midwifery staff experiencing occupational problems. The group also proposed that regular seminars on HIV/AIDS issues for nurses would be enriching and empowering them not to be overwhelmed by stress and fear based on lack of knowledge.

The intervention of a psychologist to attend to those who need psychological therapy would also be appreciated. The group suggested that counselling services for staff members can be made available by extending the scope of the current nurse counsellors who are doing pre and post HIV test counselling for patients, to cater for nurses and midwives in need of counselling. It is felt that this can be achieved through empowering these counsellors to be able to attend to other nurses/midwives. In-service training would also help to fill the knowledge gap which contributes to occupational uncertainty, fear and stress. In addition, the Customer Care Desks already in existence in the two Windhoek state hospitals could also help nurses/midwives with problem solving when necessary.

I. Resources outside the Hospitals which can be used in managing occupational stress and fear

The group felt that nurses/midwives need to be trained in Home Based Care because this is the type of care AIDS patients require. It is only then that nurses/midwives could educate patients' family members on how to care for patients at home. Community organizations such as Catholic AIDS Action could be approached to give guidance to Hospitals on counselling and Home Based Care. There is also a need to strengthen community health and public education, which the group noted as being poor. This led to the lack of support discharged patients are getting at home. The group further stressed that people dealing with HIV/AIDS patients must be spiritually strong, because it is a battle to help HIV/AIDS patients. Religious support is required to strengthen the spiritual base of those who find comfort in this direction.

J. Staff support programme

The group indicated that there is a need to establish a committee made up of a multidisciplinary team. The professionals to be included in this committee are nurses/midwives, social workers, psychologists and trained counsellors. This committee should spearhead the establishment of a staff support programme in the Hospitals. It should be empowered to approach community organizations such as Namibia Red Cross Society to tap on the experience in its endeavour to establish an effective staff programme. The committee should be able to collect, listen to and discuss occupational problems brought to its attention. The group further required that there must be a focal person or persons such as social workers to whom nurses/midwives can go and relate the problems affecting their work. If that person

cannot solve such problems he/she would be able to refer it to the committee stated above. The group also felt that there should be a hotline open 24 hours to offer counselling services to those who are in need. One participant confessed that such services had worked for her, as she stated, "I personally phoned the one advertised in one of the local newspaper and it helped me".

The other suggestion the group indicated is the introduction of the risk allowance for those caring for HIV/AIDS patients, their reasons are that, such allowance gives one courage to continue working when he/she knows that the effort will be specifically rewarded. The same system is reported to be in use at some private health facilities such as Medi-Clinic in Windhoek.

K. Advice regarding the care of HIV/AIDS patients

The group was given opportunity to indicate issues on which it would advise the decision makers in the Ministry of Health and Social Services if given a chance to do so. The following issues were raised:

- That attention needs to be given on improving the staff allocation to the care of HIV/AIDS patients to offset the current shortage of nurses.
- That there is a need for additional space to accommodate patients with HIV/AIDS.
- It would also be interesting if the decision makers in the Ministry came to the wards/units from time to time and meet face to face with the patients and those taking care of them. This would enable them to realize how stressful it is to be in such a situation.
- Risk allowance be introduced for nurses/midwives handling HIV/AIDS patients. The group again tried to justify how a risk allowance can help in the management of stress and fear, by emphasizing that when one's work is rewarded in monetary terms, fear and stress would become less as one know that his/her sacrifice is not in vain. The group however agreed that stress and

fear cannot be eliminated completely from their work environment, but it can be relieved away.

The focus group was seen as a method which can be turned into a therapeutic discussion by some group members as one stated: "This type of discussion(s) can be therapeutic in themselves".

4.6 CONCLUSION ON THE DATA ANALYSIS OF TABLES, CHARTS, GRAPHS AND FOCUS GROUP INTERVIEWS

The tables, charts and graphs presented give the reader a better insight on the biographic data of the participants, their feelings after treating HIV/AIDS patients, the strategies they use in managing their individual stresses and fears, the approaches they would like to be used in helping those affected by these phenomena and the role players to be involved. The similarities and differences in the management approaches to occupational stress and fear from both standardized and focus group interviews, could probably be applied in any staff support programme.

CHAPTER FIVE

5. CONCLUSION AND RECOMMENDATIONS

5.1 GENERAL FINDINGS

The researcher makes the following general findings:

5.1.1 Four major emotions are being experienced by nurses/midwives that are caring for HIV/AIDS patients. These are sadness (which includes stress), fear, anger and happiness. This study therefore revealed that nurses/midwives are experiencing both pleasant and unpleasant emotions after having nursed HIV/AIDS patients.

5.1.2 There are different reasons behind these emotions and the most significant ones identified by nurses and midwives are:

. Shortage of staff, which contributes to an increased workload and stress.

. Exposure to high risk conditions which causes fear of contagion.

. Knowledge deficiency on HIV/AIDS related issues causing uncertainty, stress and fear of the unknown.

. The suffering patients are going through which makes nurses/midwives identify themselves with such patients, and this brings sadness and fear.

. The hope for recovery and appreciation some patients have for the care rendered to them by nurses/midwives brings a sense of happiness in health care providers.

. Poor family support to discharged patients and lack of home based care leads to frequent re-admissions of patients.

5.1.3 There is no sectoral policy on HIV/AIDS addressing the impact of HIV/AIDS on health care providers. Consequently, there is a lack of staff support

programmes in the two Windhoek State Hospitals helping staff to deal with the challenges emanating from the caring role to HIV/AIDS patients.

5.1.4 Identified stress and fear factors include the increased responsibility, care of incurable patients, shortage of supplies and human resources, fear of contagion and feeling of vulnerability and futility as well as the increased pressure from outside the hospital on nurses/midwives to be more caring.

5.2 RESTATEMENT OF OBJECTIVES AND ANSWERING THE RESEARCH QUESTIONS

In concluding this research, the researcher would like to re-state the objectives of the study. The following were the research objectives:

Firstly, to explore strategies used by nurses/midwives to cope with occupational stress and fear of HIV/AIDS.

Secondly, to identify ways in which occupational stress and fear of rendering care to HIV/AIDS patients can be alleviated and managed.

Thirdly, to identify the nature of support nurses/midwives expect from their employer in dealing with occupational stress and fear associated with care giving role regarding HIV/AIDS.

Lastly, to suggest possible strategies to assist and empower nurses/midwives in managing stress and fear related to the provision of care to HIV/AIDS patients.

5.2.1. Research Question One

What strategies do nurses/midwives use to cope with occupational stress and fear of HIV/AIDS?

The following coping strategies were indicated by nurses/midwives:

- Accepting and getting used to fearful and stressful situation.

- Using psychological support and counselling.
- Putting one's life in God's protection.
- Some nurses/midwives identify themselves with patients and provide care to them as they wish to be cared for should they become sick one day.
- Being mentally positive and trying to remain calm despite fear and stress.
- Sharing ideas on HIV/AIDS with colleagues and own family members.
- Trying to relax and forget about bad experiences at work.
- Reading self-help books.
- Crying

Despite such diverse coping behaviours, there are nurses/midwives who stated that, they find it difficult to cope with occupational stress, fear and other emotional problems related to HIV/AIDS care giving role. These nurses, however, did not reveal how they handle such problems. From these results it can be concluded that each nurse/midwife tries to cope in the way he/she finds helpful and useful. The results further suggest that most coping behaviour indicated by nurses/midwives seemed to have developed through trial and error and are of a dependant nature. These are talking to someone, having faith in God's protection, talking over things with someone e.g. colleague or a counsellor, etc. Some coping strategies can be regarded as passive because they do not involve active resilience behaviours. Examples are accepting and understanding the situation, crying and "just have to cope" as stated by some participants. The study also revealed that people (in this case nurses/midwives) do not need many coping strategies but just a few useful ones. This is evidenced by participants who indicated not more than three coping strategies they are using to manage occupational problems.

The above stated coping strategies are emotionally focused. There are also nurses/midwives who felt that the management of occupational stress and fear should be focused on eliminating or relieving the source of such problems through:

- Trying to be cautious and taking precautionary measures when working.
- Reducing stress and fear through teamwork.
- Involvement of patients' family members in the provision of care.
- The use of medicines e.g. stress tablets.

These strategies are more preventative so that the threat of stress and fear is averted. It is also evident from these results that there are no staff support programmes in place at the two Windhoek State Hospitals. This situation left individual nurses/midwives to deal with occupational problems related to HIV/AIDS care giving single handedly. The danger is that if their coping mechanisms fail, they would bounce back into crisis without help. It can therefore be concluded that this question has been answered.

5.2.2 Research Question Two

How can occupational stress and fear of rendering care to HIV/AIDS patients be alleviated and managed?

This question has also been answered. It was found that most nurses/midwives participated in this study, felt that there is a need for formal, specific and comprehensive approaches to deal with occupational stress and fear.

It can be concluded from the participants' responses that these approaches should target different needs of the participants, and these are:

- Emotional/psychological needs e.g. counselling and stress management
- Educational/Training needs e.g. knowledge on AIDS care giving
- Physical/environmental needs e.g. protective clothing
- Administrative needs/support e.g. risk allowance

It can thus be concluded that the required approaches should encompass various aspects of a person's psychodynamics. What should be in place is an administrative framework more especially in the form of a policy or guidelines, which the participants indicated that it is non-existent.

5.2.3 Research Question Three

What kind of support do nurses/midwives expect from their employer in dealing with occupational stress and fear associated with care giving role regarding HIV/AIDS?

The majority of nurses/midwives stated that there must be a support mechanism for nurses to enable them to cope with these challenges. The support programme should cater for diverse aspects as identified in the previous discussions under objective two. The nurses/midwives however felt that managers and supervisors should be more supportive toward those caring for HIV/AIDS patients. It is suggested that the support programme be managed by a multidisciplinary team to be effective. The diverse expertise of such a team should be able to cater for social, psychological, spiritual,

physical and administrative needs of the health care providers dealing with HIV/AIDS patients.

5.3 RECOMMENDATIONS

In conclusion of the report the following recommendations are made:

5.3.1 Recommendations related to emotional/psychological needs of nurses/midwives

Employee assistance programmes should be developed at the two Windhoek State Hospitals to provide the following services to nurses and midwives caring for HIV/AIDS patients:

. Peer intervention integrated with emotional support approaches such as one to one or group counselling, support groups and discussion sessions, etc.

. Stress management and wellness skills.

. Crisis intervention by means of hotlines and special crisis groups.

5.3.2 Recommendations related to educational needs of nurses/midwives

It is imperative that all nurses/midwives are given a firm foundation in HIV/AIDS knowledge to cope with the emerging challenges of HIV/AIDS. This will assist them to protect themselves while helping patients with HIV/AIDS. In-service education/training should be given to all nurses/midwives. It should include the prevention of needle prick injuries, the provision of care to terminally ill patients, home based care and basic information on the disease itself, its transmission and treatment available. Information on the new developments regarding HIV/AIDS should be given also, through meetings, workshops, seminars and leaflets and as part of the educational programme.

5.3.3 Recommendations related to the work environment

More wards should be opened to accommodate the increasing number of HIV/AIDS patients. This will reduce the problem of lack of space being experienced currently in the two Windhoek State Hospitals. The wards designated to accommodate those patients are mostly full and patients have to be admitted into other wards with unrelated cases. There should be comfortable resting rooms in wards/units for staff to relax when taking breaks from their work.

5.3.4 Recommendations related to material supplies

Nurses should be provided with adequate material supplies such as linen savers, gloves and beddings. Those in theatre and casualty department should be supplied with goggles to use at the operating tables. These materials will help to minimize occupational risks of infection.

5.3.5 Recommendations related to Human Resources

. A reasonable patient/staff ratio should be worked out to reduce the work overload on those currently working in the wards admitting HIV/AIDS patients. This will help in determining the staff requirements and address the staff shortage said to be a problem in the two hospitals.

. Staff allocations need to be improved to off set the current shortage of nurses/midwives as opposed to the increasing workload.

. Staff rotation should be done on a two monthly basis as this would prevent nurses/ midwives from being overwhelmed by stress and fear of rendering care to HIV/AIDS patients. This rotation should be done on a voluntary basis

especially for those who are already working in these wards, as this would allow those who enjoy working with HIV/AIDS patients to do so.

. New graduates should undergo an induction programme focused on preventative and anticipatory coping strategies to deal with the challenges of HIV/AIDS care giving.

. Managers and supervisors should be more supportive to their subordinates caring for HIV/AIDS patients. This will make them feel appreciated. They should also visit wards/units more regularly.

5.3.6 Recommendations that need policy decisions

. The Ministry of Health and Social Services should introduce risk allowance for staff members who are continuously providing care to HIV/AIDS patients in all state health facilities. This allowance will encourage staff to work in wards where many nurses/midwives are not prepared to work.

. Voluntary counselling and testing services should be made available to staff members within the health facilities. This will enable staff to know their status, seek treatment.

. All patients undergoing major operations should be tested for HIV/AIDS, and doctors should make the HIV status of their patients known to the nurses who are directly involved in the care of these patients. This will enable the nurse/midwife to be extra cautious and be free from fear of the unknown.

. Private Doctors using state health facilities should be compelled to ensure that their patients receive necessary pre and post test counselling and keep proper

medical records in their patients' files. This would prevent patients being tested without proper counselling, which makes them not ready to receive their results.

. The HIV/AIDS workplace policy should be formulated. This will describe the role of stakeholders and services that should be in place. It will lead to the establishment of institutional committees that will oversee the implementation of HIV/AIDS staff support programmes.

. Occupational Health Services should be strengthened and integrated with HIV/AIDS sectoral programmes. This will necessitate the proper screening of all health employees at the time of recruitment, which should also include voluntary counselling and testing for HIV/AIDS. It will further enable those who are willing to know their status to do so and those who want to have better knowledge of their immune system on a regular basis should be given that opportunity, at the employer's cost.

5.3.7 Recommendations related to public involvement

. Home based care for terminally ill HIV/AIDS patients should be strengthened. This will enable doctors to discharge patients who are not in need of nursing care and thus reduce the workload in the already overcrowded wards.

This will further reduce the number of HIV/AIDS patients being re-admitted in a worse condition shortly after being discharged from the hospital.

. The patients' family members have to be trained on home based care, while the patient is still in the hospital. This can be achieved through establishing

partnerships between the hospital and the community organizations such as Namibia Red Cross Society, Catholic AIDS Action etc. A proper referral system should be developed between the state health institutions and such organizations.

. The community should be encouraged to become involved with the hospital through the establishment of the Hospital Advisory Boards. These boards should be made up of prominent Community leaders such as Councilors, Governors, Traditional Leaders, Church Leaders, members of Non-Governmental Organizations, Associations, etc. Through these boards the hospitals will be able to share their problems regarding the care of HIV/AIDS patients, the roles of nurses/midwives and other health workers will be made clear to the public and what is expected of the public with regard to the care of HIV/AIDS patients will also be made clear. The public will have the opportunity to advise the hospital management through these representatives.

5.5 SUGGESTIONS FOR FUTURE RESEARCH

In conclusion of this report, recommendations are made for future research in the following areas:

. The impact of HIV/AIDS on the human and other resources of the Ministry of Health and Social Services should be assessed.

. The possibility to integrate home based care concept in the training of health care workers and the comprehensive delivery of care to HIV/AIDS at institutional levels should be explored.

. The possibility of introducing community hospice care for terminally ill HIV/AIDS patients needs to be looked at.

. To explore why religion is not regarded as one of the major approaches to manage occupational stress and fear related to HIV/AIDS care giving role within a hospital context.

5.6 CONCLUDING REMARKS

The results of this study reflect emotional problems and shortcomings to an extent that seriously influence the delivery of nursing care given to patients infected by HIV/AIDS in the two Windhoek State Hospitals.

This research has enlightened the dynamics of AIDS care giving in Namibia. It also serves as a basis to design different staff support programmes at the institutional level. It is hoped that the insight obtained will have a sobering effect on patient care and health workers dealing with the HIV/AIDS disease.

Furthermore, it is the vision and desire of the researcher that the results of this study are not seen and experienced as criticism but, as an indication of areas where our staff caring for HIV/AIDS patients need support and guidance to enable them to fulfill their professional obligations with minimum stress and fear.

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APPENDIX A

Permanent Secretary - Approval Letter

APPENDIX B

Approval Letter - Katutura State Hospital

Senior Medical Superintendent

APPENDIX C

Approval Letter - Windhoek Central Hospital

Senior Medical Superintendent

APPENDIX D

Letter to the Research Participants

APPENDIX E

Research Instrument for Standardized Interviews

APPENDIX F

Research Instrument for Focus Group Interviews