NURSES’ PERCEPTIONS OF SUPPORT IN CARING FOR PEOPLE LIVING WITH HIV AND AIDS (PLWHA) IN VHEMBE DISTRICT, LIMPOPO PROVINCE

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ABSTRACT

The purpose of this study was to explore and describe experiences of nurses regarding social support in caring for people living with HIV and AIDS (PLWHA) in Vhembe district, Limpopo Province. A qualitative research design which was exploratory, descriptive and contextual was used, with a purposive and theoretical sample of nurses who provided care in a regional hospital in Vhembe district of Limpopo Province. Data saturation occurred after in-depth interviews with fifteen participants, field notes were also used during data collection. The findings revealed that nurses caring for PLWHA experienced lack of social support from colleagues and managers and needed to be assisted to cope with care. Recommendations that are described focused on supporting nurses to cope in caring through provision of work-based support programmes.

Keywords: Caregivers, caring, HIV and AIDS, nurses, support

Introduction and background

Caregiving for chronically ill is often an emotionally intense and physically demanding experience which is characterised by persistent stressful demands (Land & Hudson, 2002:147). These tasks may be more burdensome because of the complexity of illness as PLWHA often require multiple services to promote disease management. The concept burden draws attention to the caregivers’ appraisal of the disruptions caused by the caregiving activities, and the effects of these disruptions on her or his life.

Nurses caring for PLWHA are subject to unique sources of caregiving stress such as physical and psychological issues, including stigma related to the disease, fear of contagion, unpredictable illness trajectories brings about additional challenges in the work environment. Furthermore, nurses experience shortages of staff, shortages of resources, emotional exhaustion and fatigue as they work under great pressure, meeting death and misery on a daily basis without receiving encouragement, compensation or on-going training and supervision (Mavhandu-Mudzusi, Netshandama & Davhana-Maselesele 2007:256; Davhana-Maselesele & Igumbor, 2008:70). In this light nurses might not be able to cope successfully or find meaning in their work situations. They face the risk of burnout.

The burdens experienced by caregivers are of concern globally; much has been written about the increased demand for the health services created by the AIDS pandemic, and the cost of providing medical care to HIV-infected persons (O’Neill & McKinney, 2003:3). The health profession has historically focused on nurse-patient relationships, with little attention being paid to the impact of HIV/AIDS on the caregivers/nurses who are responsible for maintaining the functioning of overburdened public health services. When caregivers/nurses are under stress they exhibit a wide range of signs and symptoms that are influenced by their personalities, belief systems, health, energy levels and coping skills. The multiple demands of Aids caregiving coupled with limited resources may result in role strain and a powerful stress process that predictably pushes the boundaries of human and
emotional capabilities (Land & Hudson, 2002:148). Nurses react differently to the caregiving role because of their varying life circumstances or capacities, as others find meaning and satisfaction in their caring role. Different responses arise because caregivers are exposed to constellations of the disease burden as well as their personal resources, such as self-esteem, coping efforts and their capacity to mobilise other resources such as social support or other support services. According to (Pallangyo and Mayers, 2009:491) reported that spirituality and psychological adaptation helped caregivers to reappraise their situations and gained greater control, thus aiding psychological adaptation. Spirituality and faith-based activities have also been found to be important coping mechanisms for caregivers and PLWHA. Ramathuba & Davhana-Maselesele (2011:80) also observed similar findings where the participants indicated that they work with their utmost ability even when conditions are not satisfactory because their blessings will come from heaven. Furthermore caregiver network also ease the pain as they are able to ventilate among their colleagues. This is also supported by Akintola (2004) that caregivers have developed informal networks through which they share their experiences and coping strategies.

The researchers believe that by helping caregivers define the meaningful and valued aspects of their care-giving roles they will be able to encourage positive feelings that can enhance both their physical and psychological well-being. The research described in this article sought to bridge the gap and to document the perceptions of support by caregivers/nurses of people living with HIV and AIDS (PLWHA)

**Problem statement**

Caring for PLWHA was found to be the source of stress and burnout among nurses, especially as historically the health profession has focused on the health or work-related outcomes of caring. It seems as if the effects of the relationship between organisational support and work outcomes such as organisational commitment, job satisfaction, reduced turnover, job performance and organisational citizenship behaviour has not been examined at an institutional level (Chen, Aryee & Lee, 2005: 458). HIV/AIDS care-giving creates the emotional strain of dealing with an unpredictable and currently incurable disease, and care-givers are burdened by fears of contracting the disease. Nurses experience a lack of support from their professional colleagues brought about by the stigma-by-association and stigma surrounding HIV. In fact, some caregivers try to conceal their status by withdrawing and this leads to high levels of chronic stress characterised by emotional exhaustion, de-personalisation and reduced personal accomplishment (Dieleman, Biemba, Mphuka, Sichinga-Sichali, Sissolak, van der Kwaak & van der Wilt, 2007:1; O’Neill and McKinney, 2003:4). As a result of their study carried out in Limpopo Province, Maselesele and Igumbor (2008:70) reported that 89% of nurses indicated that they had difficulty in coping with the number of deaths in their units and this made them feel powerless, they experienced compassionate fatigue, stress and burnout related to their work over load. They reported that there was a lack of support services that allowed them to deal with their stressful environments. For this reason the present research addressed the following question:

What support do nurses/carers experience while they care for PLWHA?

**Objectives**

The objectives of this study were to:

1. Explore and describe the support nurses receive while caring for PLWHA
2. Make recommendations that can facilitate the provision of support for nurses caring for PLWHA.

**Research design and method**

A qualitative, explorative, descriptive and contextual research design (Creswell, 2009:177) was used to explore and describe the experiences of nurses caring for PLWHA. The population of this study comprised of all nurse cadres rendering care at a regional hospital in Vhembe district, Limpopo Province. Purposive and theoretical sampling was used (Polit & Hungler, 1999:285) to select the hospital and convenience sampling was used to select participants because the researcher was knowledgeable about the setting and the staff complements that were necessary to meet the information needs of the study. Fifteen nurses participated; their ages ranged between 28 and
50 years, 12 were females and three were males, nine were professional nurses, four were enrolled nurses and two were enrolled nursing auxiliaries. All the nurses had nursing experience of more than 10 years. In-depth individual interviews were used to gather information. The interviews lasted for 45 to 60 minutes and the researcher maintained a climate that allowed the participants to express their feeling and to respond freely (Henning, Van Rensburg & Smit, 2004:75). Based on the research objectives, the broad research question enabled the researcher to gain a better understanding: “What are your experiences of support when caring for PLWHA?”. Follow-up questions were asked to allow for deeper and more thoughtful responses from the participants (Rubin & Rubin, 2005:159).

- What kind of support do you receive in caring for PLWHA?
- What should be done to enhance nurses’ support?

An audio-tape recorder was used to record the interviews and the data was transcribed verbatim for analysis purposes (Henning, Van Rensburg & Smit 2004:75). Field notes were taken in the presence of the participants to record the non-verbal cues that were observed during the interviews. The interviews were conducted mainly in Tshivenda as some were more comfortable communicating in their first language, and English or a mixture the two languages. The researcher translated all the interviews into English.

Data analysis

Qualitative data was analysed using an open coding method in accordance with Tesch’s steps mentioned in Creswell (1996:155). The researcher read all the transcripts carefully to obtain a sense of the whole. Thoughts were written down as they occurred. The topics were abbreviated as codes, and the codes written on the side of the transcript. The appropriate descriptive wording for the topics was identified and turned into categories and data belonging to each category were grouped together to form themes (Cresswell,2009:156; De Vos et.al, 2001:345). After the analysis of data the researcher consulted the supervisor to validate the emerged themes and supporting categories.

Measures to ensure trustworthiness

The researcher was engaged in prolonged interaction with the participants in order to build trust and establish rapport. The researcher repeatedly listened to the audio tapes in order to internalise the content of the interviews. The researcher tentatively observed the nurses’ behaviour in their working environment in the different units. This enabled her to observe occurrences of the phenomena and the interaction of the nurses. A field journal was kept on all occasions to record the thoughts, feelings, ideas and other circumstances surrounding the study.

Applicability through the strategy of transferability was ensured by providing sufficient descriptive data of the findings. The researcher used the strategy of dependability to ensure consistency. Coding and recoding of the study findings were done. The strategy of confirmability was used to ensure neutrality. In this study confirmability was supported by the data, findings, interpretations and recommendations that attest to its coherence.

Ethical measures

Ethical clearance was received from the North West University Ethics Committee, Limpopo Provincial Ethical Research Committee, and the site hospital. Once a letter of permission had been received, the researcher informed the participants regarding the purpose, methods and procedure of the study. The participants made an informed choice, volunteered to participate freely and voluntarily, and were requested to sign a consent form. Codes instead of names were used to ensure anonymity and raw data was not exposed to anyone except the supervisor of the study. Participants were assured that the information they provided would not be used against them (Burns & Grove, 2003:172; LoBiondo-Wood & Harber, 2002:277).

Research findings

One theme was identified during data analysis in which Tesch’s descriptive method of analysis (Creswell, 1996:155) was used. These themes are:

- Nurses experienced lack of support from colleagues and managers in caring for PLWHA;

Discussion of the findings
1. THEME 1: NURSES EXPERIENCED LACK OF SUPPORT FROM COLLEAGUES AND MANAGERS IN CARING FOR PLWHA

Participants expressed dissatisfaction with the types of support provided in the workplace. Dissatisfaction with organisational support was identified as the first category to be discussed.

The categories that emerged from the first theme will be discussed and supported by quotes from the participants.

1.1. Poor Organisational Support

The role of a leader is to cultivate employee perceptions of organisational support and requires social intelligence of the nurse manager in order for him/her to influence behaviour effectively and motivate employees towards creating a supportive organisation that reflects a secure, positive and caring workplace. When employees believe that the organisation cares about their well-being, it will be reflected in the employees’ increased affective organisational commitment (Baranik, Roling, & Eby, 2010:368).

Some nurses emphasised the need for organisational support, which included the presence of a supportive manager and opportunities to contribute to policy decisions. “Ever since I started working in the department of HIV/AIDS there is no single support that I have seen coming from management. Even though management is failing to come to the units due to other work commitments, she can delegate her subordinates who will give her feedback, to come and see us, hear us out and our inputs as well as encourage and empower us because working with HIV/AIDS patients requires great support”.

Ramathuba and Davhana-Maselesele (2011:34) are of the opinion that a health care environment where one spends long hours giving care has numerous stressful incidents, and a support system is required. Moola, Ehlers and Hattingh (2008:81) concur that interaction between work environment and the individual results in stress and therefore a support system encompassing debriefing, supportive interrelationships, communication, assertiveness and teamwork should be made accessible. One participant indicated the lack of professional programmes in the following way, “Hai …, I am not sure if there is an HIV/AIDS policy, maybe at the occupational health nurse’ office it might be available. I just overheard it from one nurse who indicated that nurses who are HIV+ don’t want to come to the open, because she was willing to form a support group that will even help other workers who are seen to be sick but have not thought of taking an HIV test, since she is able to see that what this person is complaining about is similar to what she went through and one cannot approach them because they conceal their status, you only meet them when you collect treatment and they don’t want to talk about it”.

Not all participants were aware of any policy guidelines to support staff members living with HIV/AIDS. These findings were supported by Dieleman, et al. (2007:12) who found that none of the hospitals in their survey had a written policy to deal with HIV-positive staff, nurses continued working until they were too ill. When staff members are not disclosing their status they suffer, whereas staffs who were known to managers to be HIV positive received free anti-retroviral treatment, treatment of opportunistic infections and counselling. In addition, they were sometimes given lighter duties and private rooms in the hospital for admission. One participant in the present study reported, “I have heard about a nurse who doesn’t want to be seen when he goes to collect his ARV’s and even the food parcels that he collects he hides them somewhere and fetches them when he knocks off while going home, he doesn’t want to be seen, because of fear of discrimination”. This is a reflection of not having a clearly spelt out policy on HIV in the workplace, support programmes should be made available for nurses. Cloete (2008:134) suggests that the provision of workplace support programmes positively influences the self-concept of individuals, psychological contract and job performance. In addition workplace support programmes that contain environmental acceptance (e.g. non-discrimination, acceptance) have a greater influence on individuals living with HIV and AIDS.

Managers should be able to understand others at work effectively and to use such knowledge to influence employees to act in ways that enhance organisational objectives and effectively build the networks and social capital necessary to develop workplace support programmes that will elevate the organisational morale/climate. Workplace support programmes require an integrated approach, should be comprehensive, and should provide clear objectives and responsibilities while being concise enough to cater for key issues within an organisation.
Moreover it should include the benefits that are available.

Furthermore management structures of the institution was also judged as falling short with regard to assisting employees to deal with concomitant pressures arising from heavy workloads, they were not involved in the daily occurrences of the work settings, this is what one nurse said: “There is nothing that is being done, even if the staff that is sick and absent from work there is no means to replace them, once on sick leave, you will just have to bear the workload until her sick leave is over. Furthermore some participants indicated that “Mmm…, it’s very stressful, you just work because you are on duty and serving the community, when there are problems management is not supportive, like in Paeds Surgical there can be eight patients, instead of transferring the patients to medical wards and distributing the nurses to assist in medical wards, they will tell you, until then when change list is due, and nurses will be seated most of the time. In the real sense a person will be tired and worn out”. Booyens (1993:47) confirms that a schedule of staffing must give information on the number of staff available, the total number of beds and the maximum number of beds which can be staffed with the available staff complement should continuously be monitored, evaluated and controlled, since failure to do so can lead to discontent, demotivated staff and staff attrition. Shore and Shore (1995) in Treadway, Hochwarter, Ferris, Kacmar, Douglas, Ammeter & Buckley (2004:496) explain that Perceived Organisational Support (POS) relates to the perceived fairness in the attribution of organisational actions to be supportive, like fairness in resource distribution signals that the organisation is concerned for the welfare of its employees.

1.2. Poor Provisioning of Resources in Advocating Quality Care

Advocacy is an act of pleading or arguing in favour of something such as a cause, idea, or policy. Advocacy by those in managerial positions should aim at influencing public policy and resource allocation decisions within social systems and institutions, however most managers in public institutions cannot influence policy as they are not part and don’t even have the budget at their disposal. This is especially so in the health sector because health advocacy supports and promotes policy initiatives that focus on availability, safety and quality care. The South African Nursing care also maintains public safety and quality care at the interest of the community.

Another participant commented that support from management was not forthcoming, as nurses sometimes experienced difficulties when they were required to render quality nursing care “We are sometimes pushed to a state where you have to compromise quality of nursing care in order to push the routine, like giving oral and IVI treatments at the same time…. pushing two trolleys at once in order to curb the workload or shortage in the ward and one can make a mistake when you are busy”. Furthermore poor advocacy by management was described in this manner “if ever there can be a mistake or an incident they don’t consider how it happened, they only consider what you ought to have done, which is highly impossible to do that…mmmm… instead of standing by you they won’t”, and another one further commented “ I remember an incident where a colleague forgot to give a stat dose of TB treatment that was supposed to have been administered after the first sputum results and the laboratory people indicated that the results won’t be available until Monday, since it was on Friday and doctors don’t do rounds during weekends, the patient was not given and the matter was blown out of proportion”.

The findings concur with De Villiers and Ndou (2008:13) who reported that managers blamed nurses if something happened to patients. Nursing practice standards are based on setting, promoting and controlling standards of nursing and midwifery. The Nursing Act, number 50 of 1978, regulations R2598 and R387 (RSA 1978) aim to protect the public from unsafe practices and incompetent practitioners since the quality of nursing care is an ethical issue. McIntosh and Stellenberg (2009:12) also indicated that employers were legally responsible for harmful or negligent acts of employees, implying that they had a legal liability to provide adequate facilities, staff and equipment for all of their clients.

1.3. Lack of Psychological/Emotional Support

Due to the scourge of HIV/AIDS, health workers have to cope with psychosocial stress of offering palliative care to increasing numbers of dying patients as well as caring for their own sick family
and relatives. These factors lead to increased low morale, burnout and absenteeism, and affect motivation and performance (Tawfik & Kinoti, 2006:10; Gueritault-Chalvin, Demi, Peterson & Kalichman 2000:153; Bellani, Furlani, Gnecchi, Pezzotta, Trotti & Bellotti, 1996:215).

The need for a supportive practice environment was expressed by most participants. “There is nowhere where we are getting support, Ee....e because we lack such kind of support as employees, to discuss with us issues relating to HIV/AIDS, for there is no support that we get”. Furthermore it was apparent that they perceived lack of emotional support and counselling in the workplace. “ Ee....e there is nowhere to relieve stress, you only can relieve stress by yourself, I don’t know how management chooses people who are supposed to be debriefed because you only hear people from Termination of Pregnancy(TOP) services saying they are going for debriefing but the rest of the wards not going”.

Mkhabela, Mavundla & Sukati (2008: 276) is also of the opinion that feelings of isolation and dissatisfaction were expressed by nurses working at VCT centres, they indicated that there were no structures in place to assist them, carers had to shoulder all the problems of their clients as well as of themselves; they had to sort them out, and after work go home with that burden.

1.4. Lack Appreciation and Recognition

Some participants complained that efforts and concerns went unnoticed by managers and that there was a lack of support from management. “I remember a professional nurse omitted to give a stat dose for TB patient in the ward, it was blown out of proportion, failing to understand that the workload is too much and carrying doctors’ orders whilst doing other routine because even when you take the matrons report and they see that you have 59pts in a 47 bed ward there’s nothing done.” Another participant indicated that, “We are working in a general ward that is not recognised as a specialty area, so......... , we are also trained like others working there, and we feel we are underpaid knowing that others get so much, so it does not give you that fight power, so we feel we are doing an extra job to have extra money”.

Ramathuba and Davhana-Maselesele (2011:34) reported that nurses needed more recognition to satisfy their needs for reputation, prestige and respect from others, factors that could lead to increased self-esteem and job satisfaction. However, the lack of satisfaction of esteem needs leads to feelings of inferiority and discouragement, affecting job satisfaction negatively. The authors further argue that if an organisation does not provide a culture of recognition and promotion, then nurses might leave their jobs. Selebi and Minnaar (2007:59) also support this finding that professional and subprofessional nurses expressed low satisfaction as a result of compliments or acknowledgement they received from doing their work, as this required no special resources but simply an oral acknowledgement such as “that was a job well done, keep it up”.

Longenecker and Pringle, (1984: 417 in Booyens, 1993:445), support the fact that hygiene factors and motivators affect the attitudes and behaviour of employees. The hygiene factors relate to aspects like satisfactory pay, adequate supervision, enlightened policies and administration, good working conditions and job satisfaction, while intrinsic motivation factors relate to aspects such as recognition and praise, autonomy in one’s work, opportunities for promotion and the individual experiences of a job well done. The motivating factors, if present, make individuals satisfied with their jobs, produce positive attitudes and help them to increase their productivity.

1.5. Poor Interpersonal Relations

When people work as a team they build good relationships, respect one another, become accountable to each other and share information. Thus they have a common vision that guides their actions and contributes to effective and efficient delivery of nursing care.

Some participants showed dissatisfaction with the management of the institution in relation to communication problems as a result of bureaucracy. “... It is just because we as nurses in the wards we don’t have access to the nursing service manager; we communicate unit manager .... to say we feel we are not coping but there is nothing being done except “let’s try our best.”

The nurses who participated in the study were dissatisfied with the management of the organisation as there was lack of openness between managers and nursing staff. Lephoko et al. (2006:34) reported that
staffs at selected hospitals in Mpumalanga were also not satisfied with the management approach of their hospitals. They illustrated their dissatisfaction as managers were not implementing participative management styles resulting in negative feelings towards the organisational goals and objectives. The approachability and open communication of a management team cultivates good interpersonal relationships.

One participant in the present study indicated the tensions that occur among nursing teams in the following way: “Is not always the case when nurses work well together, because some cannot handle work frustrations … Negative attitudes are always prevailing especially between the night and day staff, there is always no good relations because those on day duty put the blame at night staff, same with night staff, they blame those on day duty……, ja……, that how it is when people are working” (low tone).

These sentiments were also expressed by Selebi and Minnaar (2007:59) who reported that nurses were moderately satisfied (58, 6%) with the way in which they interacted with their co-workers. However, sub-professional nurses demonstrated low satisfaction (43, 64%) with the way that their co-workers interacted with one another.

Ackerman and Bezuidenhout (2007: 68) indicate that aspects such as inadequate working conditions and pay, ineffective company policies, poor interpersonal relationships and unsupportive supervisors can result in work being experienced as dissatisfying and can result in negative consequences.

1.6. Poor Educational Support and Monitoring

Most of the participants experienced a lack of educational support when caring for PLWHA. They further expressed the need for mentoring and empowerment, as there was no structure in place to educate them.

One participant indicated that, “We are not informed about these workshops, you only hear about them when the sisters in the wards give report back that they were attending a course, they can even attend several times, we only attend breastfeeding course….., this one you would be asked several times because it’s done locally”. Another participant said, “Only nurses trained as VCT counsellors are the ones that received updates occasionally, the majority being the professional nurses with less enrolled nurses undergoing VCT training and nursing auxiliaries are not trained but still there is nothing in place for this category of nurses and most of the basic nursing care are being rendered by them.” There is no proper structure in place to keep a data base on training or induction of nursing personnel, the findings concur with those of Mavhandu-Mudzusi et al. (2007:258) who indicated that there was nobody who coordinated VCT services and helped to mentor them, and that most VCT counsellors attended the workshops because they were run in hotels and needed certificates. Dijkstra, Kangawaza, Martens, Boer and Rasker (2007:637) found that 38% of participants in their study stated that the information on HIV/AIDS was not accessible to everyone. These findings imply that the current workplace education and counselling are insufficient. Development and up-skilling of staff are crucial to develop critical analytical thinking skills needed to improve patient care. Thus management should formulate a policy for in-service education and induction programmes and keep records to ensure that staff development is accessible to everyone.

1.6.1. Lack of in-service training

Some nurses felt that they lacked sufficient knowledge about the disease and the disease process “People don’t have relevant and complete information, you might think that people are informed by the media, like radios, but you still find that people are not well-informed, even nurses inclusive”.

One nurse said that the problem might be that people are perceived as having information on HIV/AIDS, but that the information is incomplete or inadequate. “I think the main problem is……..., information is there………ee……, or maybe not, you might think that people are having the information, and is not the case.”

In a study carried out in a South African state hospital Dijkstra, et al. (2007:637), found that 41% of their participants reported average or lower on perceived HIV/AIDS knowledge, 26% had incomplete basic HIV/AIDS knowledge, which was compatible with Shisana & Simbayi (2002) and Shisana; Rehle, Simbayi, Parker & Zama (2005). Moreover nurses around the world have repeatedly reported a knowledge deficit regarding HIV/AIDS. Booyens (1998:384) describes in-service training as
the training of employees while rendering service to clients in the institution and includes training, updating knowledge, educating, standardising procedures and keeping staff informed about policies and present requirements of the job. Norushe, Van Rooyen & Strumpher (2004:64) also reiterate that it is vital for any institution to base its training and development philosophy on job-content training, management and leadership training, with the intent that all employees should get job-content training throughout their careers in order to develop basic skills that were not acquired in previous training, but which are required in the execution of their current duties, thus exposing them to more functional areas.

**Recommendations**

With reference to the analysed data and the Code of good practice on key aspects of HIV/AIDS and employment guideline (2000:3.1and 3.2), the Occupational Safety Act No 85 of 1993, Labour Relations Act No 66 of 1995 and International labour organisation code of practice on HIV/AIDS and the world of work The following recommendations were made:

**Implications for nursing practice**

This recommendation describes how the organisational culture and environment can be promoted.

- The workplace environment should be supportive, create environment that are non-discriminatory to enhance the individual’s positive self concept, commitment and utilisation of VCT services available or provided by the employer.

- Stigmatisation and discrimination need to be addressed and be included in work-based support programmes and policies.

- Despite these challenges nurses should receive regular debriefing to ease the emotional pain such as anger, grief, death and depression so as to cope with such challenges in the workplace.

- Support groups can also be beneficial as nurses can be able to ventilate their emotions.

- The promotion of professional practice of rewarding and acknowledging staff.

- Creation of career ladder to empower staff and enhance personal and professional growth.

- Staff allocation/roster are done with consideration of personal interest, knowledge and skills in a particular field.

**Implications for nurse education**

- Bridging the knowledge gap by having an institution based HIV/AIDS education policy document.

- Including HIV/AIDS within curricula for nurse training or health personnel, such inclusion or document will respond to personnel and staff needs to respond positively to PLWHA and members of the staff affected by the disease, and such document should not be restricted to the transmission of the virus and behaviours that reduce the risk of infection, it should be inclusive and comprehensive to deal with issues of human rights, rape, sexual assault and harassment, relating with and supporting PLWHA and occupational safety.

- Extra-curricular sessions with health professionals will improve knowledge and attitude on HIV/AIDS.

- Making HIV/AIDS information available to all personnel such as promoting awareness, disclosure and acceptance of HIV/AIDS through attendance of workshops, seminars and educational sessions by all nursing personnel

- Increasing multi-sectoral involvement in initiatives to combat the pandemic, to support workplace support programmes.

- Enforce legislation of employers’ obligation to implement workplace support programmes that could reduce or eradicate discrimination and promote individual quality of life.

**Implications for research**

Further research on making HIV and AIDS an issue of strategic importance in the institution, addressing the following areas:

- Provision and by implementation of comprehensive workplace support programmes.
• Availability of HIV/AIDS policy in institutions

• HIV/AIDS policy integrated into all organisational processes and other regulatory frameworks within the institution.

• Exploring the perceptions of nurses living with HIV/AIDS (NLWHA) as caregivers, to provide more insight into their feelings, reactions and job performance.

Limitations of the study
The study was conducted in Vhembe district of Limpopo Province and therefore does not intend to generalise the findings as the study was qualitative.

Conclusion
The support that nurses experienced in their course of performing their duties makes them vulnerable to varying degrees of psychological and emotional distress. The study highlighted that support from management and colleagues was lacking as managers did not listen to their plight and did not provide adequate staffing levels and resources. They did not appreciate and acknowledge the services provided by nurses and there was no formal structure in place to address HIV/AIDS issues in the workplace. From the perspective of most nurses it was revealed that the coping strategies used were mostly emotion-focused and negative psychological states were observed such as depersonalisation, emotional stress, and a lack of support among themselves that lead to them failing to work as teams or to complement one another. It is likely that care-giver burden is higher when nurses have lower levels of social support. Organisational support has an important influence on easing the burden of caring for PLWHA.

References


41. TREADWAY, DC; HOCHWARTER, WA; FERRIS, GR; KACMAR, CJ; DOUGLAS, C; AMMETER, AP & BUCKLEY, MR 2004: Leader political skill and employee reactions. The leadership Quarterly, 15:493-513.

