INVESTIGATING THE IMPACT OF THE HIV/AIDS EPIDEMIC ON NURSES IN 4 PRIMARY HEALTH CARE SETTINGS IN CAPE TOWN.

Research Report on Study Funded by the Organization for Social Science Research in Eastern and Southern Africa

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Abstract

This research report presents the outcomes of an investigation of the impact of the HIV/AIDS epidemic on nurses in four primary health care settings in Cape Town.

Based on extensive interviews with nursing staff and health service managers, the authors present findings which illustrate severe strains placed on nurses by the epidemic in a context where health sector transformation is already taxing the health system considerably. There is an indication of a wide range of pressures on nurses, with few initiatives in place to alleviate stress and provide support. Nurses report a widening scope of activities as community resource persons, lack of skills, and vastly increased stress levels because of feelings of helplessness and guilt. Existing support mechanisms and training provision are considered insufficient.

The results are worryingly high levels of low morale and burnout, which impact on the quality of service delivery and contribute to nurses decision to leave public health services.

The need for expanded training programmes and systematic accessible and timely support emerge as key priorities
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>Ante-natal care</td>
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<td>ARV</td>
<td>Anti-Retrovirals</td>
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<tr>
<td>CHC</td>
<td>Community Health Centre</td>
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<td>CPN</td>
<td>Clinical nurse practitioner</td>
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<td>DoH</td>
<td>Department of Health</td>
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<td>HCW</td>
<td>Health care worker</td>
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<td>HIV</td>
<td>Human Immune Virus</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<td>LA</td>
<td>Local Authority</td>
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<td>LGHC</td>
<td>Local Government and Health Consortium</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
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<td>OSSREA</td>
<td>Organisation for Social Science Research in Eastern and Southern Africa</td>
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<tr>
<td>PAWC</td>
<td>Provincial Administration of the Western Cape</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>PWHA</td>
<td>People with HIV/AIDS</td>
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<td>SANC</td>
<td>South African Nursing Council</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Programme on HIV/AIDS</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Acknowledgements

We would like to acknowledge with gratitude the support from the Organization for Social Science Research in Eastern and Southern Africa (OSSREA) who made this study possible.

We also want to thank the Cape Town local authority and the Provincial Government of the Western Cape for permission to conduct this study and all those nurses who gave freely and generously of their time to share their experiences and insights with us.
1 Introduction

1.1 HIV/AIDS in South and Southern Africa

According to estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), 37.2 million adults and 2.2 million children were living with HIV at the end of 2003 (AVERT, 2004). Of these 39.4 million, 25.4 million are estimated to be living in Sub-Saharan Africa, making Africa by far the worst affected continent.

In 2004, an estimated 640,000 children aged 15 or younger became infected with HIV. Over 90% were babies born to HIV-positive women, who acquired the virus at birth or through their mother's breast milk. Of these, almost nine-tenths were in sub-Saharan Africa making Africa the leader in mother-to-child transmission.

South Africa has one of the fastest growing HIV/AIDS epidemics in the world (Avert 2003). It is currently estimated that over 5 million of the 42 million people living in South Africa were HIV infected at the end of 2002 (Doherty & Colvin, 2004) and those worst affected are women (Avert 2003; Karim et al 2002; Lovelife 2001). The Department of Health's latest antenatal survey (2002) estimated that pregnant women in their late twenties showed the highest infection rate at 31.4%, and that 83,581 babies had become infected with HIV through mother-to-child transmission in 2001 (cited in Avert 2003). South Africa's rural areas and urban township areas are particularly vulnerable due to a number of factors, among them poverty, unemployment, high levels of male migrancy to the industrial centres, the position of women in society and poor education (Grimwood et al, 2000). Furthermore, women are particularly heavily affected by the epidemic. They are at greater risk of infection and more vulnerable to impacts as women headed households in South Africa tend to be poorer than those headed by men and therefore have fewer reserves (Steinberg et al, 2000).

Evidence of the profound impact HIV/AIDS is having on the health sector and on its human resources is increasingly emerging. Tawfik and Kinoti (2001) summarise the impact in two ways. The first is “by reducing the supply of service providers through attrition due to death, departure from service and reduced performance” (World Bank 1999 and Bollinger and Stover cited in Tawfik & Kinoti 2001). Health workers and their families are directly affected and infected by the HIV virus. While there is a still a lack of hard data, anecdotal evidence suggests
that, in Africa, the health systems may lose one-fifth of their employees to HIV/AIDS over the next several years (Tawfik & Kinoti, 2001). A recent HSRC study found that “an estimated 15.7% of health workers employed in public and private health facilities located in the Free State, Mpumalanga, Kwazulu-Natal and North West, were living with HIV/AIDS in 2002. Among younger health workers, the prevalence was much higher. This group (aged 18 – 35 years) had an estimated HIV prevalence of 20%” (Shisana et al., 2002). As in many other sectors, the health sector is experiencing increased rates of absenteeism, as health workers have to care for sick family members and attend numerous funerals (ibid.). Patterns of high attrition and absenteeism due to HIV related illness and death, attendance at funerals and care of dependants is beginning to cause considerable strain on the health sector in several African countries (Tawfik & Kinoti 2001).

At the same time health workers bear the brunt of an increased disease burden and are expected to implement new initiatives and policies, often without additional staffing. A study conducted by the Centre for Health Policy (Modiba et al., 2002) found that TB patient load, a good indicator of the changing clinical load related to HIV, had increased by 27% over a 7-month period, between July 2000 and January 2001. The Interim Findings of the National PMTCT Pilot Sites recently found that in some sites the additional workload generated by the PMTCT programme "has not been compensated for by any additional staff", while in other sites lay counsellors had been appointed, but "nurse and medical staffing levels have been mostly unchanged" (McCoy et al., 2002).

The same studies point out that training and support for health workers is uneven. The PMTCT study found that, while "training and human capacity development is critical for the development of adequate staff competencies, morale and motivation", "many staff do not have a strong foundation of knowledge and skills in HIV and PHC". The report highlighted that the Programme engaged in very substantial training efforts, yet did not reach all staff involved in the programme. It stressed that "the sheer volume of training required at the pilot sites points to a major challenge should provinces expand the programme to new sites".

In facilities beyond the PMTCT sites the availability of knowledge and skills, as well as access to information, appears to be even more uneven. Modiba et al.
found that of a sample of 215 providers in PHC facilities in Gauteng more than half had received some training in HIV/AIDS, 40% had been trained in counselling, but only 10% had received training in the clinical aspects of HIV/AIDS and management. The study also found that "provider knowledge of the clinical illness associated with various stages of HIV was generally poor". A Rapid appraisal of primary level health services for HIV-positive children at public sector clinics in South Africa (Giese & Hussey, 2002) found that only 20% of a sample of 383 clinics had heard of the DOH guidelines for "Managing HIV in Children", and only 10% reported using them. In the same study, 21% of clinics reported that they were assisting clients with accessing social assistance grants, pointing to further increases in workload not directly linked to clinical load.

While at present the knowledge and skills base for managing different aspects of HIV is clearly uneven and the training needs are enormous, counselling and debriefing of staff are equally important, but sometimes undervalued. Giese and Hussey quote the desperate comment of one clinic manager that: "People are dying like flies". The psychological and emotional trauma reflected in this comment is frequently repeated in conversations with health workers, who state that they were trained to heal people, that they cannot cope with the fact that people around them are dying and that there is nothing they can do about it. Yet organised support and supervision to counter stress and burnout are only available to a minority of providers. Modiba et al reported that only 36% of the providers in their sample from 3 regions in Gauteng recorded that they had participated in formal group meetings for clinical or counselling debriefing. The figures are likely to be considerably lower in other provinces, and particularly in rural areas, although support and supervision of health workers in the context of the HIV pandemic is a topic that requires urgent research and intervention. As McCoy et al point out: "Support and supervision, as well as organising peer support groups, is required to help prevent staff burn-out. Providing effective and appropriate support and supervision for frontline staff is a highly skilled job that should also be part of a human resource development plan".

In addition to the training and support of existing staff, in particular the roll-out of ARVs will place a considerable extra burden on the system, requiring fairly large numbers of additional staff. The Operational plan for comprehensive HIV/AIDS
The **Operational plan for comprehensive HIV/AIDS care, management and treatment plan**, (DoH, 2003) stipulates recruitment requirements as follows:

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<tr>
<td>Medical officers</td>
<td>76</td>
<td>271</td>
<td>628</td>
</tr>
<tr>
<td>Prof. Nurses</td>
<td>228</td>
<td>813</td>
<td>1,883</td>
</tr>
<tr>
<td>Enrolled nurses</td>
<td>152</td>
<td>542</td>
<td>1,225</td>
</tr>
<tr>
<td>Assistant nurses</td>
<td>152</td>
<td>542</td>
<td>1,225</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>76</td>
<td>271</td>
<td>314</td>
</tr>
<tr>
<td>Ass. Pharmacists</td>
<td>76</td>
<td>271</td>
<td>314</td>
</tr>
<tr>
<td>Dieticians/Nutritionists</td>
<td>76</td>
<td>136</td>
<td>314</td>
</tr>
<tr>
<td>Social workers</td>
<td>38</td>
<td>136</td>
<td>314</td>
</tr>
<tr>
<td>Lay counsellors/CHWs</td>
<td>760</td>
<td>2,710</td>
<td>6,275</td>
</tr>
<tr>
<td>Admin. Clerks</td>
<td>152</td>
<td>542</td>
<td>1,255</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,786</strong></td>
<td><strong>6,233</strong></td>
<td><strong>13,805</strong></td>
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Source: Operational plan for comprehensive HIV/AIDS care, management and treatment plan, 2003

These recruitment requirements must be seen in the light of 53,000 vacant positions in the public health sector.

Thus pressures on primary care services, which, in South Africa, are overwhelmingly nurse driven, are increasing dramatically. The need to implement increasingly complex services, coupled with the strain of the growing demand on STD and HIV services (due to a sharply rising disease burden) are contributing to high levels of stress and low morale amongst staff. Kober and van Damme (2004) commented recently that "in such a situation it is not surprising that many health workers decide to leave their country of origin. (...) South African statistics show that more than 82,000 health workers left the country between 1989 and 1997".
The double impact of HIV in impacting on human resources whilst simultaneously requiring a scaled up response from the health sector will be one of the defining challenges for health systems across Sub-Saharan Africa. If there is to be a more equitable and efficient use of health resources then how the scale up of HIV services occurs in the context of general health service delivery and the impact on human resources will be crucial.

1.2 South African health sector transformation

Concurrent with the changing and expansion of services to meet the prevention and treatment needs of a growing HIV infected population, the health system has been undergoing structural transformation towards a district health system based on the PHC approach for several years.

The South African health system prior to 1994 was characterised by fragmentation along racial, gender and class lines and a hospital-based, biomedical approach to health service delivery. Until 1994, 14 separate national departments were responsible for rendering health care to the South African population.

Racial inequalities in the health sector reflected those of society as a whole. As Pick pointed out (1995), “the development of human resources for health in South Africa needs to be seen more broadly in the context of the development of human resources capacity of the nation. Inequality in the human resource situation in South Africa is extreme”.

Furthermore, the 20th Century saw what van Rensburg (2004) calls “the systematic professionalisation of Western, allopathic medicine”. Curative, hospital-based approaches to health came to dominate the health system, increasingly marginalizing (until very recently) alternative and indigenous health care provision.

Lastly, historically “the organisational arrangements for the education and training of health personnel (...) established an unequal system of institutional and resource hierarchies in the health personnel education system” (van Rensburg, 2004), thus perpetuating an inappropriate emphasis in health service orientation. In their submission to the National Commission on Higher Education in 1996 the
Health Sciences Working and Reference Group elaborated how bio-medical and curative paradigms, student selection based on maths and science achievements, the location of training in tertiary hospitals and the lack of continuing education have contributed to not only inequitable, but also to inappropriate health care provision.

So, the historical picture of health human resources in South Africa has the following features:

The distribution of health professionals is highly inequitable in terms of access and availability.

Access to educational opportunity to train as health professionals is equally inequitable.

Education and training are inadequate and often inappropriate.

The African National Congress' Reconstruction and Development Programme, developed in the early 1990s as a blueprint for the post-apartheid period, called for “the complete transformation of the entire delivery system”, and argued for the introduction of “district health authorities”. It argued that “the whole NHS [National Health System] must be driven by the Primary Health Care (PHC) approach. This emphasises community participation and empowerment, inter-sectoral collaboration and cost-effective care, as well as integration of preventive, promotive, curative and rehabilitation services.”

The RDP summarised the key HR strategies to address the challenges facing the new system, albeit in broad terms. These are echoed in Pick’s HR chapter of the first South African Health Review of 1995, “the major issues to be considered in developing a coherent plan for the provision of human resources to meet the health care needs of South Africa include correcting the maldistribution of health personnel, integrating the fragmented health care system, improving efficiency and effectiveness of the health services, providing compassionate care for all South Africans, developing institutional capacity for the planning and management of human resources for health care, reorienting the education and training system for health science students, and corrective action”.

After the 1994 election the Department of Health (DoH) was quick to initiate major transformations within the health sector. “A major restructuring process was
embarked upon, particularly at national and provincial levels to service the objectives of a single, national Department of Health oriented to the Primary Health Care approach, and with district health systems as a major vehicle of service delivery” (SAHR 1995, chpt. 5).

Comprehensiveness and integration, availability, affordability and access were key words which characterised the envisaged system.

For human resource development the transformation has had far-reaching implications.

Decentralisation through the introduction of the DHS and the shifting of resources from tertiary and secondary to primary level has been a key feature of South African health sector transformation. Decentralisation can take many forms, from *deconcentration* – the shifting of authority to regional or district offices within the structure of the Ministry of Health, to *devolution* – the shift to local government, and *delegation* – the shift of power to semi-autonomous agencies (Mills, 1994). Whatever form is takes, decentralisation is bound to have a major impact on the way in which human resources are planned for and managed.

Two recent studies have addressed the impact of decentralisation, one of them a case study of health human resources in the Eastern Cape (Martineau et al., 2003), the other one a study by the *Local Government and Health Consortium (LGHC)* (2004). The Eastern Cape study found that, while certain minor HR functions had been devolved to districts, many measures were temporary, as demarcation of districts and devolution remained incomplete. The LGHC concluded that “management within the SA health sector remains quite centralised at national/provincial levels. The implementation of political devolution is, therefore, limited by managerial centralisation”. This, the study found, is also the experience of those working within the health system. “People at every level, but particularly front line managers and providers, feel that they work in isolation from others at their own level, and face a top heavy and rigid management hierarchy that imposes multiple and often conflicting demands” (LGHC, 2004). Reflecting this, they usefully depict the system as a series of inverted pyramids.
One effect of the above mentioned perception by frontline managers and providers is a certain degree of ‘transformation fatigue’ which several studies have by now made reference to. The *Voices of Facility and District Managers* in the *South African Health Review 2001* reflected this.

In research conducted into the implementation of the *Integrated Nutrition Programme* in Cape Town, staff complained about management’s inability to coordinate communication and activities between different departments and to prepare the ground for policy implementation. Staff voiced frustration with the fact that they bear the brunt of having to implement the new Nutrition policy, without practical support or acknowledgment. They furthermore feel that policies are often not well thought through or they get abandoned halfway through the implementation process. This eventually leads to general disenchantment with the transformation process, transformation fatigue. This is well articulated in a quote by a facility manager interviewed by Leon et al (2001):

*Source: LGHC, 2004*
“Because of all the change I am tired of change. Since 1994 these consistent changes. First it was the health policy they changed that, we had to get this primary health care, we are since then still in a changing phase because then it is this programme then it is that programme that’s changing”.

The LGHC study (2004) concludes that so far health system transformation has focussed on “hardware” rather than “software” issues, i.e. legal frameworks, structures, organograms, and technical skills development.

“A key casualty of the hardware focus has been the limited attention given to human resource management. Personnel shortages require urgent action. Training more staff or offering financial or other material incentives are seldom enough by themselves to tackle either migration or the problem of poor staff morale. Other software needs include building trusting personal relationships and developing the associated skills of communication, negotiation, and people management. (...) Finally, a focus on hardware over software has left little room for innovation and creativity. It has reinforced top-down and hierarchical decision-making procedures. These have crowded out local-level problem solving and bottom-up approaches to service delivery”.

“With the move towards decentralised health systems, many health workers, particularly at district level, now require, in addition to clinical skills, substantial public health skills in planning, advocacy, programme design, programme implementation and monitoring and evaluation which are fundamental to the successful implementation of the Primary Health Care Approach” (Sanders et al., 2001). These are skills in which few of the newly appointed district, sub-district and programme managers have received training, resulting in a yawning gap between existing and required job competencies (Edelstein et al., 1998).

Additionally, there is increasing evidence that many of the skills required for HIV/AIDS clinical treatment and management are still lacking amongst frontline health workers, yet urgently required and needing massive training inputs and continuous support (McCoy et al., 2002; Giese & Hussey, 2002).

The latest PHC facility survey points in the same direction. It found that large numbers of facility personnel were unable to correctly diagnose and manage common HIV related problems (Reagon et al., 2003). “In Mpumalanga and
Northwest none of the professional nurses could correctly diagnose fungal oesophagitis, while in the Northwest and in the Western Cape none of the respondents could correctly treat the condition”. This despite the fact that all three provinces had a good coverage of available protocols. This finding seems to indicate a worrying discrepancy between policy and implementation, in particular, of the weakness or absence of mentorship and supportive supervision.

It can be said, therefore, that the HIV epidemic is aggravating the situation in the SA health sector, putting further strain on all aspects of the system.

1.3 The nursing profession in South Africa

Nursing training in South Africa is rendered by Universities, as well as public and private training colleges. Training and nursing practice are controlled and regulated by the South African Nursing Council (SANC), which is also the professional registering body.

Three nursing categories are distinguished:

- Auxilliary nurses or *Enrolled Nursing Assistants*, who receive one year of training;
- *Enrolled Staff Nurses*, who receive two years of training and practice under the direct supervision of a registered nurse;
- Diploma- and degree-level *Registered Nurses* who receive four years of training, with qualifications in General nursing, Midwifery, Community Health nursing and Psychiatric Nursing.

In addition, nurses can gain post-basic qualifications in nursing education and administration. In the 1990s a number of additional courses were introduced to better prepare nurses for extended and specialised practice at primary care level. Nurses trained at this level are known as *Clinical Nurse Practitioners* (CPNs). As a rule, these nurses make up the most qualified staff in clinics in the South African context, as medical doctors are not on clinics’ staff establishment.
1.4 Structure of health services in Cape Town

Health services in Cape Town are rendered by local authorities (paediatric, promotive, preventive and curative services such as contraceptive services, and treat sexually transmitted infections and Tuberculosis) in clinics and by provincial authorities (adult curative services) in so-called community health centres (CHCs). The reasons for this division are largely historical (see chapter 1.2). The functional and organisational integration of services has been of the key challenges of the South African health system ever since, and the described division of services can be described as a remnant of history.

2 Problem Statement

There have been a few studies in South Africa projecting morbidity and mortality, absenteeism and turnover rates among health workers due to HIV and Aids (Shisana, 2003). However, little or no work has been done to investigate the qualitative impact of the epidemic on health workers, particularly at PHC level. Anecdotal evidence suggests that particularly clinic staff in rural areas are stressed, burnt out and demotivated and that the HIV/AIDS epidemic contributes significantly to this situation: nurses report that large percentages of their patients are sick with AIDS, that migrant workers return home to die, that they suffer from the fact that they cannot help their communities any more, that they have to make daily decisions as to who should and who should not receive treatment, given resource constraints. They furthermore report that this is a primary reason for nurses to leave the health service or to move to better resourced, better supported areas. Nurses at PHC level, if not elsewhere, seem to be saying that they cannot cope anymore.

Yet a scan of national and international policy and strategy papers indicates that, while the pivotal role of health care staff in fighting the epidemic is taken for granted, little is said about the support, training and infrastructure required for staff to fulfill this role.

Human resource planning, production and management issues do not feature prominently in policy and strategy development, despite a growing understanding
that close attention to human resources is a prerequisite, if interventions and reforms are to succeed (see, for example, the recent Commonwealth Planning Workshop on *Reducing the impact of HIV/AIDS on human resources in the public sector*). This project wants to contribute to the filling of this gap.

### 3 Objectives

**General Objectives**

1. To gain a better understanding of the impact of HIV and AIDS and its intervention programmes on staff delivering primary level services in rural areas.
2. To gain a better understanding of existing support infrastructure for staff in rural areas.

**Specific Objectives**

1. To describe and quantify the impact of the HIV epidemic on the health workforce in selected PHC sites in two rural districts in terms of
   - morbidity
   - mortality
   - turnover/attrition
   - absenteeism
   - stress, burnout, motivation and morale.
2. To describe coping mechanisms of staff in rural facilities in dealing with the multiple impacts of the HIV and AIDS epidemic.
3. To identify existing and required management and training support.

It has to be pointed out that general objective two and specific objective two had to be dropped and rewritten respectively, after it became apparent that the implementation of the project in a rural site within the available time frame was not possible. Permission to switch the study site to a more accessible location was requested from OSSREA and was not denied.
4 Literature Review

The question of how HIV/AIDS impacts on health workers in general and nurses more specifically has sparked the interest of a small but substantial number of researchers, mostly from the Western world, since the early 1990s. Of particular interest have been issues of attitudes and knowledge of health workers; issues of health workers’ fear of infection, the role and treatment of HIV-positive health workers and stress and burnout among health workers.

4.1 Knowledge and attitudes

Levels of knowledge about HIV/AIDS unsurprisingly are reported to vary considerably among HCWs (Horsman and Sheeran, 1995), although Horsman and Sheeran point out that "since researchers use widely different instruments to assess knowledge, results are not strictly comparable across studies". Studies conducted in European countries and the US in the late 1980s and early 1990s found associations between younger age and increased knowledge of HIV as well as higher levels of formal education and greater knowledge. Literature exploring knowledge among health workers in Africa is only now beginning to emerge. A study conducted in Cameroon in 2001 (Mbanya et al., 2001) found that "most of the well-trained nurses (higher grade) were more knowledgeable and had better practices than poorly trained staff", and a negative correlation existed between advanced age and knowledge”. Brou et al. (2003) conducted a study in Cote d'Ivoire which surveyed the knowledge of health workers of just one commonly used medication used to prevent opportunistic infection. They found knowledge levels to be poor, and that levels of information were related to the level of HIV-related activities in the health centre.

The early literature dealing with attitudes of health workers to HIV+ focussed primarily on attitudes of HCWs to HIV/AIDS as a "gay" disease, although "several studies seem to suggest that HCWs appear to have negative attitudes, or at least problems confronting, issues of sexuality generally" (Horsman & Sheeran, 1995).

More recent studies conducted in several African countries "demonstrate a correlation between high levels of knowledge and positive attitudes" (Walusimbi and Okonsky, 2004). A study conducted by Walusimbi and Okonsky in Uganda found that the more knowledgeable nurses in a regional hospital were about the disease, the less likely they were to express fear of contagion or negative
attitudes towards patients. However, Mbanya et al. (2001) found that "the overall knowledge did not necessarily influence the attitudes and practices of staff".

4.2 Fear of contagion

Fear of contagion is closely related to both attitudes and knowledge. A number of studies have identified fear of contagion as a major stressor among health workers, which contributes to negative attitudes to patients. In the Cape Coast municipality in Ghana health workers expressed great fear of contagion due to the working environment and lack of basic supplies. "There was also a lack of consensus among them on the issues of confidentiality. The main arguments were those of the general debate between safeguarding individual rights and protecting the common good" (Awusabo-Asare & Marfo, 1997).

Horsman and Sheeran (1995) review a large number of studies dealing with a variety of aspects of perceptions of AIDS-related risks among health workers. Despite overwhelming evidence that risk of infection to health workers is actually low, they point out, quoting Gerber, that "characterising the risk to HCWs as 'low' is unhelpful because they [health workers] are likely to perceive the situation as one of 'risk' or 'no risk' and when exposed to possibly infected blood are not going to consider gradations of risk". Bennett (1998), building on work conducted by Meisenhelder in the late 1980s, similarly argues that "since the albeit small but nevertheless real risk may not soon be eliminated, it may be inappropriate to aim research efforts at reducing either risk perception or the fear associated with it. Instead, she suggests, strategies should aim at nurses' "comfort zone with risk-taking". She argues that where work is highly valued by individuals and society, it has "meaning beyond its potential harm, which can alter the perspective on one's vulnerability". While this suggestion that nurses might be less concerned about risk, if they themselves and society perceived the benefit of their work, may be controversial, it nevertheless strengthens the argument for strategies to look after carers better.

An important concern raised by health workers in numerous studies is that of social contagion or stigmatisation. A number of studies report results that indicate health workers being shunned by friends and neighbours and exposure to PWHAs affecting family relations (Horsman & Sheeran, 1995). When read in
conjunction with research results which suggest a strong correlation between coping and informal support from family and friends (Hayter, 1999), a serious stressor emerges.

4.3 Quality of care

Horsman and Sheeran also discuss how attitudes and fears of health workers impact on the quality of care they render. They found an uneven picture emerging, with some studies reporting that AIDS patients would receive less and below-standard levels of care, while the results of other studies reported a large degree of patient satisfaction with levels of care. Unfortunately, studies appear to almost exclusively deal with hospital-based care, rather than primary care, no doubt a reflection of where HIV/AIDS care was seen to be located in the late 1980s and early 1990s in many western countries.

4.4 Stress and burnout

A considerable volume of literature investigates the effect on health workers of caring for people with HIV/AIDS, in particular issues of stress and burnout (eg. Visintine & Campanini, 1996; Bellani et al., 1996; Hayter, 1999; Gueritault-Chalvin et al., 2000). There is overwhelming evidence that caring for patients with HIV/AIDS accelerates burnout among health workers and particularly nurses. We mentioned the concern with physical and social contagion, which accompanies nurses' working day. Other factors reported are role expansion into areas such as advocacy (Miller, 1991) and emotional exhaustion because preventive and promotive care is increasingly being replaced by curative care and because health workers identify with their patients (Gueritault-Chalvin et al., 2000; Hayter, 1999). Gueritault-Chalvin et al. further explored the impact different coping styles have on burnout. They found that external coping styles such as fatalistic attitudes, negative expectations and reliance of faith led to much faster burnout, compared to internal coping strategies such as expression of feelings and emotions, patience and time-out, as well as amount of time spent with HIV/AIDS patients. They concluded that “what would seem more important is to teach people how to determine the appropriate coping strategies they could use when
dealing with specific stressors”. “Another important implication is the finding that individuals who have a low internal locus of control maybe more inclined to seek external coping. Consequently, burnout prevention interventions should take individual differences into consideration by tailoring programmes to individual needs. Because age and perceived workload also predict burnout, young nurses who are found to have low internal locus of control and perceive their workload as heavy may be at particular risk of burnout and may require specific attention and training” before entering HIV/AIDS care (Gueritault-Chalvin et al, 2000). The importance of specific and systematic strategies to support health workers and train them to cope with stress is emphasised by all authors, as is the positive effect of perceived capacity, benefit and appreciation.

In summary, there is overwhelming agreement in the literature that care for HIV/AIDS patients places severe strains on health workers and nurses as frontline carers in particular. These strains are caused by a number of factors, prominent among them fear of infection, social stigma, emotional exhaustion and lack of appropriate skills. The literature is furthermore unanimous that systematic and context-sensitive strategies to provide support and development opportunities for carers can go a long way to ameliorate these strains.

5 Study Significance and Scope

The study presented here is a small-scale and initial contribution to a better understanding of the impact of HIV and AIDS on health workers. It has been conducted against the background of an accelerating brain drain of nurses from South Africa, research finding pointing to decreasing productivity and lack of skills, and overwhelming anecdotal evidence of burnout and low morale amongst nursing staff. A context-sensitive assessment was initiated the results of which are aimed at contributing to the development of strategies to ameliorate this situation.

6 Limitations of the Study

This has been a small-scale exploratory study the results of which are not easily generalisable.
Furthermore, as HIV/AIDS is an extremely sensitive issue in South African society to this day, carrying with it a great deal of stigmatisation and prejudice, which does not only include infected, but also affected people, not all nurses we approached felt free to participate in the study, although very few of them in the end refused to be interviewed. More importantly, the researcher repeatedly found herself in the role of counsellor, as interviewees used the interviews as debriefing sessions, and more than once came close to breakdown. While every effort was made not to let these experiences colour the results, particularly through debriefing of the researcher, it must be acknowledged that the nurses’ experiences did not leave the researchers untouched.

Lastly, as will be seen, HIV/AIDS does not occur in isolation in South Africa. Its impact on nursing staff has to be understood in the contexts of a period of far-reaching health sector transformation. There therefore are a number of confounding factors. However, because the focus of the study is on nurses’ perceptions and experiences of the epidemic on their professional and private lives, these confounding factors should not impact on the validity of the study.

7 Conceptual Framework

This was an in-depth study, aimed at providing a textured, context-sensitive view of two different PHC sites, which each already cope with a dramatic impact of HIV on service delivery and which will in future be expected to provide expanded services. The study has drawn on survey-type data and information, generated by UWC and outside projects (Equity Gauge, WHO study, HSRC study), but it explicitly focused on an in-depth, micro lens on service delivery. It worked from the assumption that the large-scale implementation of HIV programmes in African countries will have to take place at primary care level and that implementation in relatively fragile health systems such as can be found in all African countries, must be a process that strengthens the whole system. Consequently, primary care services and the personnel staffing these services are central to the delivery of HIV/AIDS services, and therefore need to be at the centre of systems strengthening. The study is based on the hypothesis that health services need to put in place measures to strengthen human resource in order to strengthen PHC (including HIV) services.
Figure 1 sets out a framework for analysing the way in which HIV particularly impacts on human resources.

**Figure 1: Conceptual framework: impact of HIV/AIDS on health human resources**

- Staff mortality/morbidity
- Absenteeism
- Turnover
- Stress, burnout
- Increasing workload
  - Leading to:
    - Low morale, low productivity
    - Decreasing quality of care
    - Increasing staff attrition
    - Increased burden on remaining staff

### 8 Methodology

To begin an assessment of the qualitative impact HIV/AIDS is having on health workers we conducted a small-scale study in 4 PHC sites in Cape-town Unicity.

Together with Local Authority and Provincial Administration of Western Cape in Cape-town we selected 4 primary health care settings with the following characteristics:

- Two facilities were jointly run by the Municipality and the Province (Facilities B and C\(^1\)) and two facilities were under the Municipality (Facilities A and D).
- All facilities were situated in historically under-serviced areas, which had been restricted to occupation by black Africans under the Apartheid regime.

\(^1\) For purposes of confidentiality we coded the four facilities A, B, C and D.
None of the facilities were involved in the administration of ARV treatment, but rendered other HIV related programmes, such as VCT, PMTCT, treatment of opportunistic infections, etc.

Focus group discussions with all nurses in all four primary health care facilities were audiotaped, transcribed and analysed.

In-depth interviews were conducted with 27 registered nurses, 3 enrolled staff nurses, and 6 auxiliary nurses in all selected four primary health care.

Furthermore, six managers were interviewed. Four of the district managers and the one area manager interviewed were employed by the local authority. The remaining district manager was employed by the province. Two of the district managers were male, all the rest were female. In order to protect the identities of those managers who participated, the selected sub-districts and PHC facilities will remain anonymous.

The interviews were taped and notes were made from the tapes. Following data analysis and before the final write-up, feedback sessions were held at all facilities.
9 Critical Interpretation and Analysis of Data

9.1 The Context

9.1.1 Health sector transformation

Health services in South Africa have undergone substantial transformation since 1994, with the aim to integrate a highly fragmented system into a newly developed district health system.

One of the legacies of the previous system is a separation at primary care level of preventive and promotive services and curative services for children rendered in municipal clinics and curative services for adults rendered in provincial community health centres (CHCs). The integration of these services has been underway since the late 1990s, but presently is still awaiting completion. Of the facilities that participated in this study two were jointly run by the Municipality and the Province (Facilities B and C) and two facilities were under the Municipality (Facilities A and D). In the latter two the local authority has instituted a mentorship programme with the explicit aim to render support such as counselling and debriefing for staff. We were asked to investigate how this programme had been received by staff in these facilities.

In some facilities, the integration process was felt to be causing pressure on the staff teams and bringing them into conflict. Staff employed by the province and local authority were forced to share the same physical space but did not feel themselves to belong to one integrated team. In reality they continued to function as two distinct teams, answering to separate line managers and employed under different conditions of service. As one manager put it:

“They see themselves as two authorities in one building - that’s your patients and this is our patients (...) it’s just a fight from morning to night, they just don’t work together”

2 For purposes of confidentiality we coded the four facilities A, B, C and D.
While all of the managers were supportive of integration, some felt that the change was not being managed properly. One view expressed was that any attempt to integrate services on the ground without devolving responsibility at management level was putting unnecessary strain on managers and frontline staff. It could, ultimately undermine any spirit of co-operation, thus jeopardising the whole process. One of the District Managers felt that, for this reason, the Provincial and Local authority staff should not work directly together until the policy direction on decentralisation and integration was resolved.

"let’s share, let’s communicate, but let’s not try and do things together, things that we know that they loaded with conflict and problems and, you know .. it’s just not going to work. One of them is just going to close up”

On the other hand, one manager felt that HIV/AIDS had forced “informal integration” and that, despite the delays in implementing “political integration”, people were at least talking and sharing resources.

**9.1.2 The legacies of apartheid and special segregation**

In order to understand the challenges facing health services in South Africa and in Cape Town (in fact, facing government in general), one needs to understand particularly the legacy of spacial segregation. Residential areas were segregated by population group for centuries, a segregation which was formalized with the Group Areas Act in the early 1950s. Under this Act living areas were strictly designated to different population groups, with so-called townships for “Africans” usually situated far outside the cities, under-serviced, under-developed and overcrowded. It is one of South Africa’s key challenges to reverse the resulting inequities, including health inequities. The graphs below, a result of equity gauge work done in our department, illustrate some of the inequities.
Inequity in Public Primary Care Expenditure (weighted for need): Zero line represents an average equitable expenditure

% Households below poverty line
The graphs show that the large township areas, Kayelitsha and Nyanga, not only consistently have the worst health outcomes, but that expenditure per capita weighted for need dramatically lags behind in these areas.

Although laws regulating the segregation of living space for different population groups were removed in the early 1990s, there remains severe de-facto segregation, now primarily along class lines. Townships remain relatively under-serviced, and because they are the areas in South African cities where living is somewhat less expensive, they are the first destination for the continuous flow of people from the rural areas into the cities. Although no precise figures are available, it is estimated that between 40,000 and 50,000 people enter Cape Town to live every year.

9.1.3 Overcrowding and space constraints

An important historical factor impacting on facilities in Cape Town is rapid urbanization through migration from rural areas. All facilities included in this study today cater for a very substantially larger population than they were built for. Even in cases where extra clinics were built to cope with the demand, the extra
services did not relieve the pressure on existing facilities as was hoped. This leads to conditions of overcrowding in the facilities and also to some staff shortages.

Furthermore, Primary Health facilities are finding that their buildings aren’t big enough to adequately provide new HIV related programmes such as VCT and PMTCT, nor to accommodate the numbers of people requiring treatment. The introduction of VCT services in all district health clinics requires a separate room for testing can be done in order to protect the confidentiality of clients, something most facilities cannot afford and were not designed to cope with.

"Even if there is enough time for health education but there is no space"

"The clinic was not designed to see what we are seeing now, there is no privacy, and we share rooms"

So, even if clinics were given more staff, as they so badly need, they may not have space to accommodate them.

"Even if a professional nurse dropped from heaven we couldn’t do anything with her because there’s no space for her"

9.2 Description of facilities

9.2.1 Facility A

Facility A is situated within a small township of an otherwise very wealthy Cape Town suburb. Historically this township was allowed to exist in close proximity to one of Cape Town’s wealthiest suburbs to facilitate easier access of domestic labour to the suburb. Since then the township has grown dramatically and now consists primarily of informal housing with very limited infrastructure.
Most houses will not have inside bathrooms or toilets, and even water taps are shared by several households.

Facility A is run by the local authority. The staff compliment is made up of 5 professional nurses, and one auxiliary nurse.

They render the following services:

- Well baby clinic,
- Paediatric curative care,
- Contraceptives,
- STI
- Anti-natal care
- Prevention of mother-to-child transmission (PMTCT), and
- T.B.

The facility serves people mainly from the surrounding informal settlements. It is full in the morning and relatively empty in the afternoon. Mostly young women and babies are seen at the clinic. Very few males visit the clinic. They mostly come for STI and TB treatment.

The clinic is implementing the “One stop shop service”, an innovation in South African primary care facilities whereby a client is seen and medicine is dispensed in the same consulting room.

The facility has two HIV lay counsellors.

Very importantly, the facility has an active community health committee and receives various forms of support from the surrounding wealthy areas. It has a number of projects running like the support groups for the AIDS infected clients. Clients are coming to the support groups in large numbers. This is in stark contrast to other clinics where, according to nursing staff, clients associate such structures with AIDS clients and stigma. There are also some donations from the wealthy people residing in Houtbay, which are handed out to needy clients in the form of vouchers in return for odd jobs performed in the facility.
9.2.2 Facility B

Facility B is a facility run jointly by the provincial and local authorities. Built initially for a small, peri-urban population, it is now serving a rapidly growing population living primarily in informal housing.

The facility has a staff complement of two professional nurses employed by the provincial authority, eight professional nurses employed by the local authority, one auxiliary nurse and three lay counsellors.

The facility offers the full ambit of primary care services:

- Pediatric and adult curative
- Family planning
9.2.2 Facility B

Like facility A, facility B is primarily frequented by women and babies, with a small number of male clients coming for STI and TB treatment.

The facility has a dispensary, but the resident pharmacist works half day. During the second half of the day professional nurses render dispensary services. This arrangement leads to a fair amount of disruption as nurses shuttle between client consultations and the dispensary, more specifically because the one stop shop service is not practiced.

Facility B had a clinic committee, but the relations are not as productive as in facility A. While there is occasional communication with the facility manager, some nurses did not even know that they could and should attend the meeting with the clinic committee.

During our interaction with the facility it is full almost all day most days until just before closure at 16h00.

9.2.3 Facility C

Like facility B, facility C was built for a small township on the outskirts of Cape Town. Like the other facilities it has grown dramatically through migration into Cape Town. The facility now serves a population which would have possibly tripled since the facility was built.

Facility C is surrounded by a mix of formal brick structures and fast growing informal settlements.
The facility is run jointly by provincial and local authorities, but unlike in facility B services are strictly separated. Two professional nurses and one auxiliary nurse employed by the provincial authority render adult curative services, while five professional nurses, one enrolled nurse and one auxiliary nurse employed by the local authority render paediatric curative services, the well baby clinic, STI and TB treatment, PMTCT and VCT, which is provided by two lay counsellors. The clinic has a specialised health promoter, but it does not offer ante-natal care. Like facility B, the clinic is busy right through the day.
Local authority staff have organised their service delivery around the *one stop shop service* approach, but provincial staff practice the old system. Because the facility does not have a pharmacist, the facility manager works full time in the pharmacy.

Several years ago the facility had an extremely active community health committee, which now has virtually disappeared.

### 9.2.4 Facility D

Facility D is situated on the edge of one of the largest, most sprawling townships in Cape Town, which has large sections of formal township housing (houses built with cement blocks, and containing two bedrooms, a kitchen, lounge a bathroom and a toilet, which is either outside the building or inside) as well as large informal settlements consisting of shacks. The facility is surrounded by small formal township houses. There are also informal settlements near the clinic. The facility is under sole authority of the local government and renders the following services using the *one stop shop service*:

- Well baby clinic
- Family planning
- Paediatric curative care
- VCT
- HIV clinic every Friday
- PMTCT
- STI treatment
- T.B. treatment
The clinic has a staff contingent of eight professional nurses, one enrolled and two auxiliary nurses and two HIV lay counsellors.

The facility serves clients mainly from both the informal and formal settlements. The facility is busy right through the day, seeing mainly women and babies. In the afternoons the majority of clients are school girls from nearby schools, who come for contraceptive services.

The clinic has a functioning community health committee which works hand in hand with facility staff. Nevertheless, the facility has a serious problem with gangsterism and crime: on one occasion the researcher found staff severely traumatised on her arrival, as they had just been attacked by gangsters and threatened with rape.
9.3 The impact of HIV/AIDS on nurses

We spoke earlier about the fact that nurses are impacted by HIV/AIDS in many different ways, as they are infected and affected much like all other members of society and they carry the professional burden of having to care for communities with increasing disease burdens. In our research we focussed primarily on the professional aspect of the impact of HIV/AIDS. Within their professional life, nurses are primarily impacted in two ways: service delivery is changing with the changing disease burden and nurses have to cope with a range of psychological impacts which spread beyond their professional life.

9.3.1 Impact on service delivery

There was widespread agreement between managers and facility staff that the volume and character of services to be rendered has been changing with the advent of HIV/AIDS. A whole series of factors were perceived to be adding to nurse’s workload including undertaking additional, non-clinical tasks, attending to large numbers of opportunistic infections and other HIV related programs, increased patient numbers, staff shortages and longer consultation times.

9.3.1.1 Role expansion

A recurring theme in interviews and focus-group discussions was the fact that nurses increasingly find themselves engaged in extra-ordinary activities in the absence of other kinds of support services, a development reported in other parts of the world as well (Miller, 1991). Below are a few examples of such activities.

9.3.1.1.1 Post-mortem care

A number of nurses reported that a growing problem in communities is the unavailability of funds for funerals which is often brought to them for resolution. Negotiating with different funeral businesses is increasingly becoming part of their scope of activities.
“When they die some of their members come to the clinic to tell us that there is no money to do the funeral for the person and there is nothing we can do with the corpse in the trolley”.

“For the funerals we are trying by all means to look for cheaper undertakers because you can find out that there is no one working in that house altogether, sometimes the members of the family hide themselves because they do not want to take the responsibility”.

“This means that we now have to talk with those undertakers. (...)we also took money out of our pockets as well to assist there”.

“When they die some of their family members come to the clinic to tell us that there is no money to do the funeral for the deceased”.

“The family members will ask if there is nothing we can do may be to help for the funeral”.

9.3.1.1.2 Providing food

Nutrition support is an important activity in HIV/AIDS care. For nurses working in severely impoverished areas, nutrition support is taking on another meaning, as many find themselves giving up their lunches and providing small amounts of money out of their own pockets to alleviate hunger amongst clients.

“The patient will tell you that he’s hungry and the tablets are making him feel hungry and you don’t know what you are going to give him, sometimes I even took money out of my pocket and give him so that he will be able to go and buy bread”.

“One woman came to me in the dressing room she told me that she has nothing to eat at home, I gave her R10.00 she is my client, I knew her husband was my client too and he died”.

“Even when you refer a client to Tygerberg infection clinic, you end up giving her money from your own pocket, because you do not want the baby to miss the appointment”.

“We even bring clothes from home for the babies, we end up being social workers”.

Facility A again was the exception to the rule. Here donations are made by wealthy residents which are used to alleviate hunger: one resident, for example, occasionally donate R1000.00 in the form of R 100.00 vouchers, to the facility manager to give to AIDS clients that can not afford. The facility manager uses the vouchers by asking clients to perform some work and then pay them for an example cleaning of clinic windows.
9.3.1.1.3 Dealing with employers

Surprisingly frequently nurses reported a sharp increase in queries from employers who enquired why their employees were at the clinic. Nurses say they spend a lot of their time duplicating work. They write sick certificates to employers, then explain clients’ condition again on the phone. More importantly, however, nurses felt a ethical dilemma: while staff-client privilege would not allow the disclosure of information, often clients themselves felt under pressure to let employers have the desired information or face dismissal.

“Some of the patients said just tell the person what was I there for, otherwise she want to know if I was not there for HIV/positive status, so we can see that people are still afraid of the virus, they have got a fear that they will be infected, so if they discovered that the patient is HIV positive they are going to chase that person from work”

“When you answer the phone you are being asked, has such and such a person visited your clinic? And you say yes the next question what was wrong with her or him”.

Interestingly, the literature does not reflect similar concerns raised in other countries, although it is unlikely that such developments are not taking place in other resource-poor countries. The concern with expanding scopes of activities and workloads as described above is twofold: not only are nurses taking care of larger number of sicker patients, they also feel obliged to render services to them which do not usually fall within their ambit. However, much of these activities has to count as “invisible work”, as information used to calculate staffing requirements in most cases is either based on headcount or on clinical activities or a combination thereof (see Cape Town Equity Gauge work; also, Schiff ). Non-clinical activities are simply not taken into account. If then non-clinical activities (including counselling and other psychological support) take up increasing percentages of nurses’ time, they experience and invisible and creeping increase in workload which will not be attended to. We have argued elsewhere that workload assessment and calculations in resource-poor settings without elaborate support networks require new and creative solutions, as nurses evidently take on the role of community resource persons in the absence of other, easily accessible resources. An adaptation of Schiff’s Workload
indicators of staffing needs would be a possible, yet very complex approach. Undoubtedly the staff and skills mix in primary care facilities also warrants rethinking: an expansion of the one stop shop service concept to include social and other service might be an interesting option.

9.3.1.2 Changing workloads and quality of care

9.3.1.2.1 Crowding out services

The introduction of curative services for under 13 year olds at local authority clinics, coupled with increased workloads due to HIV/AIDS, is felt to have placed a significant extra load onto staff. Many of those managing comprehensive services felt that curative services were now taking precedence over preventive and promotive services (traditionally their core activities) to the point of crowding them out. As one manager put it:

“we are swamped by curative services.”

Managers felt that clinic staff were overwhelmed by the demand for curative services, and were reduced to firefighting, constantly trying to deal with the backlog of patients and unable to give sufficient attention to preventing illness and health promotion activities.

“We used to go out on a daily basis and visit people in their homes (... ) it’s much more of a sausage machine now, one client in, one client out, and the more you can do in a day the better, which is sad.”

Staff expressed similar frustrations. The feeling of being overwhelmed by demand on the services and hopelessness at being unable to clear the backlog of people in the waiting room left them feeling demotivated and burnt out.

Another aspects of the increase in curative services is the deterioration of other forms of patient care: promotive services and in particular health education as well as follow-up and support are being “crowded out” by the ever increasing volume of curative services.

“We feel frustrated because we can’t take that task of health education, We can’t because we are busy with sick babies and adults, so that part of our duty has fallen off”
“We see a lot of sick people coming to us, we are supposed to be doing preventive and promotive health but we can’t”.

Staff saw clients defaulting because there was no capacity for sufficient follow-up:

“Even the counselling that is done we do not do any follow up, it’s just it then nothing follows”

“We see a lot of clients, we tell them they must come back. When they come we are not there for them, we are busy”.

“Some come to the clinic not because they are sick, but for support, we do not give them any time for that”.

“We make false promises, some clients prefer to disclose to us than their family members”.

They further said that once clients are told of their status, they do not come back to the facility anymore. They then lose follow up or support that they should offer continuously to the client. They end up in a dilemma because they were not sure whether it was right to tell the client of his/her HIV+ status or not.

“Most people are no longer coming, we don’t know whether they are still alive or they died, we have lost their whereabouts”.

“The other lady, her mother was always here but ever since we said she must be tested and she tested positive, she never came up”.

“Sometimes if they find they are positive, they run away and come back when they are very ill”.

The question arises whether, if facility staff are over-stretched by curative services, some of the promotive and preventive activities such as health education and follow-ups, could be carried out by other groups of people: lay counsellors, home-based carers, NGOs or community health committees. It is evident from available statistics that in most facilities lay counsellors are not working to full capacity, and we found that relations with community health committees are in most cases either tense or non-existent. The impact of good relations between facility and surrounding communities and organisations was demonstrated by facility A. In this facility a close relationship with support-groups and NGOs, nurtured by a dedicated nurse, meant that follow-up and support of clients was well organised. The difference this made to the job
satisfaction of staff and service delivery was tangible in our interaction with them.

While in many clinics preventive and promotive work appears to have come to a virtual standstill, in Community Health Centres (or ‘day hospitals’) the capacity to tend to chronically ill patients is shrinking as the numbers of terminally ill AIDS patients rises and puts increased demands on the services and on staff.

“At the end of the day it’s going to be a whole lot of AIDS, HIV patients accessing the day hospitals and then we lose all our other patients that come in with chronic diseases, coming in with STIs and you know, so I just see that we don’t have the capacity”

Most nurses were clear that under these circumstances quality of care was deteriorating. The following were some of the comments which summarised nurses’ concerns and expressed frustrations:

“We do not look at quality anymore its quantity, the managers want high statistics, so we rush numbers”.

“You get home exhausted, when you think back at the end of the day you end up frustrated because you did not give quality care you are just seeing numbers”.

The distribution of work among different staffing categories as well as the role of community participation is evidently an issue that needs careful consideration by management and stakeholder groups, if primary care facilities are to do justice to the full spectrum of services expected of them.

9.3.1.2.2 Reaction to ARV Roll-out

None of the facilities were involved in administering ARV treatment at the time of the study. However, we asked nurses how they thought the roll-out would affect their work. Interestingly, reactions were mixed. While some nurses said that implementation of antiretroviral treatment would decrease the number of sick clients they were seeing, others felt that it would increase workload.

“I think it will work well we have got an excellent community, with churches, NGO’s”

“It won’ be a problem if only they can bring skilled staff to deal with clients”
“Things will be better, the number of deaths will decrease as well”

“Oh my goodness, it will affect our work, everybody will come and demand drugs irrespective of his stage”.

“It will increase our workload, where will the staff come from not when we can not cope now then?”

“I’m sure our numbers will drop everyday if we can get treatment and we will breathe”.

9.3.1.2.3 Shortage of drugs

An additional problem impacting on quality of care is the fact that shortages of drugs are a new and increasingly virulent problem in Cape Town facilities and nurses expressed very passionately that shortages of drugs add to their frustrations when they have to tell the clients that there are no drugs.

“We are running short of all kinds of drugs”

“Many a times we do not have drugs, I mean we can’t function if we do not have drugs”

“It’s very depressing since I started working here, seeing what is happening because these people come to you with an expectation.”

While this study could not ascertain whether the nurses’ concern was justified, i.e. whether shortages of essential drugs are an increasing problem, it would seem that nurses’ perceptions would warrant a closer investigation of the size and character of the problem. Because if indeed drug shortages are occurring in a city with as excellent an infrastructures as Cape Town, action needs to be taken as a matter of urgency to analyse and remedy the underlying causes.

9.3.1.3 Staff-Client Relations

It is not surprising that, given the tensions around loads and quality of services described above, relations between staff and clients were reported to be suffering. Nurses were quite self-critical about their relations with staff, admitting that they are at times rude to clients because of stresses of the working environment.
“Like any human being, you get tired, and become aggressive, we are like any human being, faced with dying people that you can not help, it’s frustrating, and people say we are rude, that’s it”.

“If I feel I can’t cope anymore with the workload, I just withdraw myself”.

“It has changed, I am even down spiritually, you don’t feel nice too, if all clients tested on that day are positive, your attitude changes automatically, you become down it’s haunting you can’t be nice as you were before”.

In facility A, however, which has an active community health committee and generally good relations with the wider community, this situation was markedly different. There is obvious teamwork between the clerks, counsellors, cleaners and nurses, and clients had evidently good relations with staff, calling nurses by names, which is very rare in the health services in South Africa.

A number of staff mentioned that they have a problem with language. Unlike the managers, who saw it primarily impacting on consultation times, staff were concerned with the impact language barriers have on nurse/client relationships and trust: HIV/AIDS carries stigma, and it becomes worse when a client is to communicate with health worker that does not understand her/his language.

“Language is also a barrier it is difficult to explain what you want to explain not using the language understood by the client”.

“We are scared we are not getting across to the client”.

9.3.1.4 Lack of appropriate skills

Most nurses have an acute sense that they lack appropriate skills to deal effectively with HIV/AIDS clients. We found that within the participating facilities one or two out of ten nurses had attended management of HIV or counselling courses. Even fewer, one nurse per facility, had received training on PMTCT. This means that when the trained nurse is not on duty other nurses have to render services that they feel unable to perform, leaving them feeling insecure and frustrated.

“I never went for training on counselling, I question my ability, I need those counselling skills”.

“I think it should be the basic thing to start with in nursing, to go through HIV/AIDS counselling”.
“We need the counselling skills, clients think you know everything concerning this disease and you do not know a thing”.

‘Not all the staff went for counselling course’.

The frustration increases when the reasons for lack of training are logistical:

“No they do not have any transport; we end up not attending courses”.

It is clear that the training challenge is an enormous one. The literature provides substantial evidence that improved skills correlate with better practice and attitudes (Horsman and Sheeran, 1995; Walusimbi and Okonsky, 2004), although this view is not entirely uncontroversial (Mbanya, 2001). There can be little doubt, however, that appropriate breadth and depth of requisite skills contributes greatly to staff feeling confident in their role and coping better (Gueritault-Chalvin et al., 2000). The problem arises, of course, that once-off training courses, often of very short duration, do not suffice to impart the required knowledge and skills or to instil the desired confidence. When the first pilot PMTCT programmes were evaluated in South African rural areas, the evaluators drew urgent attention to the size of the challenge of providing adequate training for large-scale new programmes (McCoy et al., 2002), a challenge dramatically increased since then through the pending roll-out of ARV treatment. Other unpublished studies in other African countries have generated similar findings (personal communication, Mickey Chopra). The challenge is for the development of comprehensive training programme which include a number of elements: initial training; regular refresher training; on the job mentoring and coaching as well as systematic and regular supervision. Such programmes would allow for a guided acquisition of theory and practice as well as reflection of practice, all urgent requirements for capacity development, which are reflected in the following capacity development cycle:
9.3.2 Psychological impact

By far the most dominant theme in all our interactions with nursing staff related to the dramatic increase in various forms of stress and anxiety that had transformed their working life with the advent of HIV/AIDS. They spoke extensively about the fear of injury and disclosure, impact of stresses on their family life, feelings of hopelessness and feelings of guilt.

9.3.2.1 Fear of exposure and disclosure

In contrast to much of the literature, the nurses interviewed for this study did not raise fear of contagion as their primary concern. While the fear of infection lives with them, their greatest concern was with potential disclosure of their status. Most were clear that, if given a choice, they would not test, nor did they want to disclose their status. During our focus group discussions, we encouraged nurses to disclose their status to us anonymously in sealed envelopes. Three nurses out of a total of 36 disclosed their status, all positive, all emphasizing that they would not disclose to colleagues. Amongst the reasons given in the interviews and FGDs were the following:

“There was an accusation in one clinic that clients were injected by blood of a HIV+ nurse in the family planning room, it was a big issue that is why I am saying it will be a big risk to disclose.”
“I will tell my family but the staff, no”.

“If you are known they will tend to protect you, because your immune system is no longer strong you will be infected easily”.

“If I find out that I am HIV+, what’s going to happen to my family, they will say I got it from work, you know males do not accept the blame, I am better of not knowing”.

“You won’t be productive, that is what I do not like, I am on contract, and my boss will fire me”.

But not only was their fear of repercussions in the case of disclosure. The great majority of nurses were unwilling to find out their status, based on their own experience and helplessness in assisting their clients.

“I mean you know it’s not going to be cured, why disclose?”

“You know that thing of anti-retrovirus, how many tablets you have to take, for myself I cannot complete the course of antibiotics, how much more tablets for life, I can’t take two panado”.

“It is so painful because you do not want to know your HIV status but when you have the needle prick injury, you have no alternative but to check your status as well”.

We heard a number of stories of nurses who had contracted needle prick injuries and had fought great inner battles over the question whether they should report the incident and be tested. Some had opted not to report, while others had gone for the first test, but not the three-months follow-up test.

Interestingly, this determination not to know their own status, which we came across in all facilities did not, in nurses' discourses, go hand in hand with negative attitudes towards patients. It appeared to be generally accepted that a large percentage of clients would be HIV positive, and that this was increasing exposure risk. However, nurses were as a rule not prepared to "own" and deal with this risk, preferring denial and ignorance of their status. If one discusses such behaviour as coping styles, Gueritault-Chalvin's work (2004) may provide lessons: clearly denial and ignorance would fall under what the author terms "external copying mechanisms", which lead to accelerated burnout as staff do not face their fear and concerns. Gueritault-Chalvin's suggestion that internal copying mechanisms such as expression of feelings and emotions, patience and time-out should be systematically taught to staff working within stressful
environments should receive consideration in the planning of training and support programmes for nurses.

9.3.2.2 Impact on family life

The issue social stigma and contagion, as discussed frequently in the literature, came up prominently in nurses’ statement. Occupational exposure contributes greatly to tensions within relationships, fuelled by fear and stigma. Staff reported that people shy away from them because they are known to be working with HIV positive clients.

Waiting during the window after needle prick injuries were said to be the most difficult time, where they received little support from employers and relationships with relatives, husbands or boy friend were disturbed.

“It once happened and my husband say please wash your hands before you touch us whilst I was in the process”.

“It’s very hard but, as it ended up being a bedroom problem. I starved in the bedroom as my husband because of shock and fear I assume, was afraid to involve with me in the sexual relationship until I finished the whole process”.

“When I told my daughter, she said again mama, you must stay away from the HIV+ people?”

“And now you’ll be asked now and again at home, have you tested again”

Another form of tension arises from projection. A number of nurses expressed that when they engaged with teenagers in facilities, they anticipated similar behaviour from their teenage children, thus creating conflict at home, with no access to debriefing at work.

“I shout and yell at my daughter, and say you are still going out with them, you do not use condoms”.

“It haunts me because I know she is not doing things differently from the other youth I see at the clinic”.

“Working with teenagers and then go home to your own teenagers this makes us to be so afraid that these kids are not taking it seriously, not just the clients your family life too”.
Generally, nurses felt helpless in these situations, not equipped to deal with the social fall-out of their working environment. They furthermore felt left alone in having to deal with these issues, with scant support from employers.

9.3.2.3 Confidentiality and stigma

The tension and helplessness is aggravated by feelings of guilt expressed by many nurses, which related to issues of confidentiality and stigma. They spoke about testing clients, but having to keep information from partners and close family members. They spoke about the pain they felt each time they met the unaware partner, of sitting at church, social functions and community meetings feeling intense guilt and pain because of their inability to share information.

"When you work in a place that you are living in, to see people that are being tested and they belong to your church, and results are positive, it’s not nice”.

"My sister’s boyfriend died of AIDS, here at the clinic, my sister is not aware, and I have to keep quiet, each time I see an AIDS client becoming thinner and thinner, I just say soon I’ll be seeing my mother’s child in this position”.

"I know the teacher close friend of mine, his girlfriend was positive, and as a person who knows that teacher and as a nurse, I can’t tell him, be careful use precautionary measures she is HIV+ and the girlfriend refused to tell him”.

"Another problem we have is the problem of teenagers who are unable to tell their parents that they are HIV positive, some will tell you that I can’t tell my mother, she has heart attack and my father is suffering from stroke so if I can tell them they will die, sometimes you know their parents”.

Obviously, an enormous stressor emerges here, as staff have to put their professional ethics and need for confidentiality before the urge to warn friend, family or even simply clients against a possible death sentence through infection. Again, little opportunity existed to work through these issues. In fact, many times nurses used the interviews with the researcher as debriefing sessions which rendered the first opportunity in a long time to unburden themselves and talk through concerns, as suggested by Gueritault-Chalvin's (2000) "internal copying mechanisms".
9.3.2.4 Feelings of hopelessness

In virtually all conversations, nurses spoke about an often overwhelming feeling of hopelessness in the face of the sheer size of the challenge in front of them. Many said that they had chosen the nursing profession to heal whereas now they had to watch clients die without being able to help or at least alleviate suffering.

“To start with the HIV/AIDS has increased the feeling of hopelessness, you find that you are unable to help the client thinking that there’s a lot of job to be done”.

“When thinking about the situation we are facing at work we just feel hopeless and helpless because we think that at the end of the day it may be you in that situation, and you’ll look like that client, and there is no cure for HIV/AIDS”

“You feel hopeless that you cannot do anything for them, you are fighting a loosing battle”.

“If you test more than three clients, and they all become positive same day, with the fourth one you are dead alive”.

Nurses also expressed desperate frustration at the lack of knowledge or willingness within communities to change their behaviour to prevent infection.

“So now that they take it as a joke, where as you as a nurses see people dying everyday, how does it make you feel, do you feel interested to continue preaching health education to them no”.

“To me even counselling doesn’t look effective, it is funny they keep on infecting each other”:

“I have noticed that the highest number of people that come for oral or injectable contraceptives are girls, it means they do not use condoms, and yet health education about condoms is all over, so”?

Again, nurses lack the skills and internal copying mechanisms to handle the enormous stresses of watching people suffer and die without being able to help. They respond either with anger at clients who engage in inappropriate behaviour or with desperation, both of them leading to aggravated burnout as well as deterioration in productivity and quality of care.

The feeling of helplessness is aggravated by a sense that other government support is not forthcoming or coming too late. Staff repeatedly spoke about the
ineffectiveness of the social grant and their unhappiness at not being able to refer clients to government support timeously.

9.3.3 Decision-Making and Support

Nurses speak with deep resentment of the fact that they are not involved in decision-making. A deep-seated and wide-spread perception is that health authorities do not want to hear their suggestions in matters pertaining to clients. Amongst other things, this causes conflicts between clients and nurses, as they are to convey messages decided upon for the clients by the management. For example, medication that is seen by nurses to be working well to boost the immune system for AIDS clients, is changed without any consultation.

“Instead they sometimes tell that certain tablets are no longer going to be available and only to find out that they were good for our patients in boosting their immune system”.

Furthermore, nurses feel that they are left alone at the coal face of service delivery, that they lack moral and practical support.

They feel neglected by management, with a powerful perception that management only cares about the community not about them.

“And like I said from management side, they look for petty things like you are off every Monday or Tuesday of the month, they call it a pattern, it is a problem to them”.

“They will listen easy to the community when there is a complaint, but when it’s us nurses who are complaining, nobody is listening to us”.

“Like the HIV rapid test, we have problems now, everyday we test about seven patients, five of them are positive, it takes from you.”

“We took it and then we come back because nobody listen we’ve asked for a debriefing session and nothing is happening so we are just carrying on until we drop there”.

“Why must you sign a leave, I mean if I need a psychologist because of my work or Don’t feel ok because of my work, now I must take a day’s leave going to see my own psychologist? Causing unnecessary shortage of staff why are we not provided with such services during working hours?”
Managers picked up on their staff’s unhappiness, but, not surprisingly, spoke about it quite differently. Two female managers felt that creating a supportive and nurturing environment was a crucial part of their role. One manager would purposefully invite the media to report on all her staff’s achievements and another felt it was important to display their progress in the clinic so that both staff and patients could appreciate their work. Regular communication with staff was also regarded as important to motivate and empower staff. For example, they felt that it helped staff to understand where they fit in by explaining why policies needed to be implemented, offer constructive criticism on their performance and recognising their contribution.

“Feedback from the staff is just ‘oh we just here to, we must just implement. People from the top just tells us we need just do this, and we just need to do do do do. So they do want to know that, you know, it will be appreciated.”

Most managers recognised that staff felt overwhelmed by the workload and that the stress they were under prevented them from identifying solutions. Staff in effect felt unable to see beyond the immediate pressures of an overcrowded waiting room and were locked into a cycle in which any change was perceived negatively.

“People get to a point where you can’t see the wood for the trees you become entrenched in something and it’s not often that you don’t want to do something differently, it never enters your head that there is another way to do it”.

While some managers believed that HIV/AIDS programmes were adding to the burden on staff, one manager took another view. She felt that the increasing numbers testing positive did not necessarily increase staff workload, but that VCT programs simply provide a diagnosis for patients who are already sick. Therefore the VCT program enables staff to identify the cause earlier and treat patients more effectively. She appreciated, however, that staff were often too overwhelmed to appraise the situation realistically and saw it as the role of managers to help staff to see things from a different perspective.
Several managers echoed the view that staff needed to gain distance from the problem and time away from the stresses of the clinic to identify solutions. Many recognised that increased resources were not the only solution, and that small changes could shift the perceived pressures considerably. The difference was in how much power managers felt they had to help staff to see beyond the full waiting room and recognise opportunities for change.

**9.3.4 The Mentorship Programme**

The Mentorship programme, established by the Cape Town municipality for staff several years ago, is one initiative aimed at providing support to staff, specifically in relation to HIV/AIDS related stresses. Although it fell out of the immediate brief of the project, we were asked by local authority management to include a brief assessment of the uptake and success of the programme.

Managers reported that the programme enjoyed very low up-take: despite expressing a need for these kinds of support, there was routinely low turn out on days when counsellors were scheduled for debriefing and mentoring sessions with staff at facilities. They explained that low morale and high workload in themselves were thought to leave staff feeling too overburdened and overwhelmed to take advantage of the support on offer.

“We’re very short of staff on the ground, so, people even though they would like to go, when the time comes they say ‘oh my gosh I’ve got so much to do, no, I’m not going, it’s not worth my while, I can’t leave the rest of the people behind’”

We asked staff at the facilities where the programme was on offer whether and what they knew of the programme and whether they had made use of it. While at facilities A and D some staff had heard of the programme, it was not well known or well used. The predominant complaint was that assistance was not available when needed, but rather according to a schedule which may not suit the facility.
“It will come when you have forgotten what was your problem, so I do not know if it helps me”.

“No there is nothing for the nurses, only for the lay counsellors, nobody thinks for us”.

“We counsel ourselves as colleagues, there is nothing provided for us”.

“There might be one, but I am not aware of anyone, may be I must ask from the sister in-charge if there is anyone”.

“I do not know of any mentorship for nurses”.

“It's difficult because we do not have any qualified counsellors for nurses”.

“Luckily for me I have a mother and a husband, I know I am not supposed to divulge the information but what can I do, my husband is my good punching bag”.

So, while managers and staff agreed about the low utilisation of support services (in those cases where staff were aware of the availability of such services), the underlying reasons given differed: while managers believed that staff did not make support services a priority due to overload, staff were critical of the accessibility and availability, saying that such services would have to be available ad hoc and immediately on demand if they were to be successful.

10 Conclusions and Recommendations

The study presented here was small-scale and exploratory in character and focused on the qualitative aspects of how nurses perceive the impact of HIV/AIDS on their working lives. But despite its limited scope, it generated a number of interesting findings.

Firstly, it is very important to understand the impact of the HI/AIDS epidemic as occurring in particular contexts, whether these be social, economic and cultural contexts or health systems contexts. In relation to this study, the context of health sector transformation is crucial: when the impact of HIV/AIDS began to hit health services in South Africa in the late 1990s, South Africa had embarked on a path of health sector transformation which saw the introduction of a host of changes, all of them impacting fundamentally on health personnel. While there
is not question that these changes, which aim at redressing dramatic historical
imbalances and introducing equitable health care provision, were an urgent
necessity, they brought with them stresses on many parts of the health system,
most notably its human resources. Transformation fatigue, which has been
discussed elsewhere (Lehmann and Sanders, 2003; Leon et al., 2002) has
become a real phenomenon in the health sector. We found in our interviews
that in many cases staff struggled with the fact of increasing volumes and
changing scopes of work in the context of the insecurities of transformation. Any
solutions undoubtedly have to take account of and address this context.

But the epidemic also has its very specific impacts, as nurses staffing facilities
even in comparably well-resourced and well-prepared Cape Town feel both
overwhelmed and under-prepared to cope with or address its fall-out. The
frequently expressed sentiment is a combination of anger at not being able to
fulfil what they perceive to be their professional duties and anxiety about the
impact of the epidemic on their own lives. These feelings are aggravated by a
perceived lack of support and a tangible lack of appropriate skills.

We ignore their concerns and perceptions at our peril. It is evident that
particularly in developing country contexts with high prevalence rates, nurses
are the health professionals who fighting in the trenches, to use a militarist term.
Nurses (like lay counsellors) come face to face with the epidemic every single
day. Should we lose them (as we are), not only will we lose the battle against
HIV/AIDS, but primary care in general will collapse. This poses a serious
problem: we know from a recent WHO study that up to 70% of health personnel
may be contemplating leaving the public service and/or leaving the country
(WHO, 2003). We asked the nurses we interviewed at the end of each
interview, whether they would chose nursing as a profession again, if given a
choice, or whether they would encourage their children to take up nursing. Not
one answer came back affirmative, but many mentioned that they themselves
were thinking of leaving the profession, thus making their own contribution to
the brain drain.

There are those who want to dismiss the opinions expressed by staff as
subjective perceptions. These critics are right: these are subjective perceptions.
They may be objectively incorrect or exaggerated (and some of them are).
However, these perceptions shape discourses and decision-making about whether or not to joint the brain drain into the private sector or overseas, and how to position oneself in the face of great adversity.

Managers share these concerns. Many acknowledged that the frontline workers, if not themselves, were locked into a cycle of hopelessness and despair at the situation they were faced with. Facility staff feel they are up against insurmountable odds faced with increasing numbers of sick people due to HIV/AIDS, population growth and no extra staffing provision or space to meet the additional demand on services. Some mangers felt they were forced to sacrifice quality for quantity in their services as a result. Many of those managers who could see potential for change, felt constrained by factors outside of their control to effect it.

There clearly exists an action imperative. The study itself, in agreement with the published international literature, points to key intervention areas, at the core of which lies capacity development.

Training is one aspect of capacity development. However, as mentioned earlier, short or even longer courses on specific aspect of HIV management in themselves do not suffice. The challenge is for the development of comprehensive training programme which include a number of elements: initial training; regular refresher training; on the job mentoring and coaching as well as systematic and regular supervision. Such programmes would allow for a guided acquisition of theory and practice as well as reflection of practice, all urgent requirements for capacity development, which are reflected in the capacity development cycle.

Secondly, there is a need to strengthen management support, including supervision and prompt access to counselling and debriefing, and to strengthen strategies which make management support to be seen to be supportive rather than punitive. Key to this is the constructive and on-going engagement with front-line workers and their meaningful involvement in decision-making. This would also facilitate that new programmes, problems and their solutions are owned by all stakeholders, including frontline workers.

Thirdly, the role of community support cannot be overemphasized. Support from community structures and mutually respectful staff-client relations impact
dramatically on the environment within which staff operate (and clients access services).

In conclusion, the findings of this study do not stand in isolation. They support a growing body of knowledge which highlights the crucial role of nurses in providing health services to populations in developing countries, and their growing inability to render such services. While such findings give reason for grave concern, they should also be considered an opportunity. An opportunity to hear an urgent call for help and support, to take seriously that we have to “care for our carers”, if we expect them to shoulder a disproportionate piece of the fight against the HIV epidemic. To do this we have to understand better what kinds of support are effective and we have to put to requisite resources in place. This learning process should involve systematic operational research, monitoring and evaluation of programme planning and implementation. In the meantime, however, we should make use of what we do know about interventions which support and strengthen human resources. Amongst them are

- The involvement of staff in action research projects which will facilitate ownership and the development of reflective practice aimed at problem-solving and improving practice;
- The inclusion of internal copying skills into the curricula of health professions education to equip health personnel to cope with psychological stresses;
- Systematic and supportive supervision which will allow staff to engage with and air concerns with senior staff.
- The strengthening of community health committees and their relationships with facilities to facilitate mutual respect and collaboration.

There have been suggestions that in all its horror the HIV/AIDS crisis presents the South African health system (like many health systems in developing countries) with two options: it could either succumb to the crisis have implode under the severe additional strains presented by the epidemic. Or it could “rise to the occasion”, making use of the focus and the additional resources to strengthen the health system as a whole. The key to the second option lies to a
large extent in the system’s human resources: if we succeed in building a highly skilled and highly motivated health workforce, well linked to the communities they serve, our chances of success are great. If we fail to do so, we are undoubtedly bound to fail in our effort to strengthen the South African health system. Given what is at stake “failure is not an option”.
11 References


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12 Appendix: Interview Guide

- Can you explain to me how HIV and AIDS have changed your work as a nurse?
- Have the diseases that you see changed? If yes how?
- Have the clients changed, in terms of age, gender, severity of illness, frequency of illness?
- Has your workload changed? If yes, tell me about how it has changed.
- Has your relationship with clients changed?
- Describe how HIV/AIDS affects your work on daily basis?
- What HIV/AIDS related work do you do (VCT, PMTCT)?
- Have the staffing needs changed as a result of HIV/AIDS? If so how?
- What are your staffing needs, in terms of quantity, quality, and mix of categories?
- What training or other preparation did you receive to deal with HIV/AIDS, in terms of VCT and treatment, but also in terms of dealing with the dealing with HIV+ people on a daily basis?
- Is the staff adequately informed, skilled and educated to cope with the demands that are placed on them e.g. fear of contracting the disease?
- What skills do you need to deal with your present work? Do you feel you have these skills sufficiently? What would you like more of?
- Do you receive any other form of support, like counselling or debriefing?
- Alternatively, would you know how to access such support, if you felt you needed it?
- What coping mechanisms have you and staff developed to deal with the stresses of HIV and AIDS?
- Has excessive absence from work (excessive sick leave, for example) become a problem?
- Are you aware of any staff member/members that have been absent/sick or died due to HIV/AIDS related diseases?
- Are you aware of any staff members that resigned specifically because they cannot deal with the impact of HIV/AIDS? (Elaborate)
- Are there any policies existing for the care of immediate family members, relatives for staff members in cases where the staff member is affected or infected?
- The introduction of ART appears to be close to implementation now. How do you think this will affect your work?
- What in your view, has to be put in place to make ART treatment work in your facility?
- Is there any provision made to cope with workloads in the next three years?
- How have the changes you described impacted on you personally, and on how you feel about your job and your profession?
- If you could choose your profession again, would you choose nursing again? Explain you answer?
- If you could work in a different setting, would you do so? Why? Where would you go? Would this be just because of HIV or are there other reasons?
- What else do you still want to say about impact of HIV/AIDS on nurses?