UNIVERSITY OF EDUCATION, WINNEBA

CARING FOR THE CARER: EXPLORING THE LIVED EXPERIENCES OF NURSES CARING FOR HIV/AIDS PATIENTS IN SELECTED HOSPITALS IN ACCRA, GHANA

CHRISTIAN KUMAH YEKPLE

DOCTOR OF PHILOSOPHY

2022

UNIVERSITY OF EDUCATION, WINNEBA

CARING FOR THE CARER: EXPLORING THE LIVED EXPERIENCES OF NURSES CARING FOR HIV/AIDS PATIENTS IN SELECTED HOSPITALS IN ACCRA, GHANA

CHRISTIAN KUMAH YEKPLE
(9170170002)

A thesis in the Department of Psychology and Education,
Faculty of Educational Studies, submitted to the School of
Graduate Studies in partial fulfilment
of the requirements for the award of the degree of
Doctor of Philosophy
(Guidance and Counselling)
in the University of Education, Winneba

DECEMBER 2022

DECLARATION

Student's Declaration

I, **Christian Kumah Yekple**, declare that this thesis, with the exception of quotations and references contained in published works which have all been identified and duly acknowledged, is entirely my own original work, and it has not been submitted, either in part or whole, for another degree elsewhere.

Signature: ………..……..…………………

Date: …………………………..………..……

Supervisors' Declaration

We hereby declare that the preparation and presentation of this work was supervised in accordance with the guidelines for supervision of thesis/dissertation/project as laid down by the University of Education, Winneba.

……………………..………………...……… (Principal Supervisor)

Signature: ………..……..…………………

Date: …………………………..………..……

………………………………………..……… (Co-Supervisor)

Signature: ………..……..…………………

Date: …………………………..………..……

DEDICATION

To my children, Elikem and Eyram, a motivation for you to exceed what I have done.

ACKNOWLEDGEMENTS

My sincere gratitude goes to my supervisors; Prof. Samuel Asare Amoah and Prof. Mathew Namale for their support, suggestions and corrections. I wish to acknowledge all the participants for their willingness to share their spare time with me to provide all the information needed for this study. I am grateful to the management of the 37 Military Hospital and the Korle Bu Teaching Hospital for allowing me to conduct the study in their institutions. I am equally grateful to the nurse managers of the Simango Ward of the 37 Military Hospital, and the Fevers Unit of the Korle Bu Teaching Hospital for the assistance they gave me during the process of recruiting participants for the study, and data collection. I am grateful to the following people who at various stages offered useful suggestions, advice and encouragement, or/and read through the draft report; Dr. Richardson Addai-Mununkum, Dr. E.Y. Yekple, Dr. Gideon Puplampu, Dr. Joana Agyeman Yeboah, Dr. Hannah Acquaye, and Pastor Alex Baah. I acknowledge the academic guidance of the Head of Department and the entire staff of the Department of Psychology and Education, University of Education, Winneba. I thank my colleague students for their useful suggestions and criticisms as well as their moral support during the conduct of this study. Finally, but not the least, I am most grateful to my wife and children for all the sacrifices they made to enable me go through school successfully.

TABLE OF CONTENTS

Contents **Page**

LIST OF TABLES

ABBREVIATIONS

AIDS:	Acquired Immunodeficiency Syndrome
ART:	Antiretroviral Therapy
CBOs:	Community Based Organizations
CD4:	Cluster of Differentiation 4
CDC:	Centers for Disease Control and Prevention
DDNS:	Deputy Director of Nursing Services
EAP:	Employee Assistance Programme
EAPA:	Employee Assistance Professionals Association
HAART:	Highly Active Antiretroviral Therapy
HBCG:	Home-Based Caregivers
HCWs:	Health Care Workers
HIV:	Human Immunodeficiency Virus
ICD-11:	International Classification of Diseases (11th Revision)
ICN:	International Council of Nurses
IRB:	Institutional Review Board
NGOs:	Non-Governmental Organizations
NMC:	Nursing and Midwifery Council of Ghana
PEP:	Post-Exposure Prophylaxis
PLWHA:	People Living with HIV and AIDS
UNAIDS:	United Nations Programme on HIV/AIDS
USA:	United States of America
WBCs:	White Blood Cells called
WHO:	World Health Organization

ABSTRACT

The study explored the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana. Objectives of the study included exploring the challenges encountered by nurses caring for HIV/AIDS patients, exploring how the work the nurses do affect their lives in the form of work place hazard, and exploring how the nurses cope with their work-related challenges. The study employed the phenomenological design. The population were nurses working in the isolation wards of the 37 Military and Korle Bu Teaching hospitals in Accra. These hospitals were selected because they have wards specifically designated for HIV/AIDS patients. The sample was purposively selected, and the sample size of 13 was determined by data saturation. Using a semi-structured interview guide, data were generated through in-depth face-to-face, audiotaped interviews. Data were analysed using thematic analysis. The findings revealed that the nurses experienced work-related challenges such as work-related stress, fear of infection, courtesy stigma, witnessing the suffering and death of patients, resource challenges, and lack of motivation. These challenges negatively affect the nurses physical and emotional wellbeing, and have the potential to compromise the quality of care they provide to the patients. The nurses adopted coping strategies such as rationing of care and PPEs, and religious coping, to deal with the work-related challenges. The study concluded that the nurses' work-related challenges need to be mitigated. This will help maintain the nurses physical and emotional wellbeing, and enable them continue providing the requisite care to the patients. Recommendations aimed at mitigating the work-related challenges were made. These include nurse managers providing adequate resources, and counselling services for the nurses when necessary. It was suggested that similar studies be conducted in other hospitals.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Human Immunodeficiency Virus (HIV) is a retrovirus that attacks the body's natural defense system (the immune system). The virus specifically attacks a type of White Blood Cells (WBCs) called Cluster of Differentiation 4 (CD4) cells, the cells which help the immune system to fight infections (WHO, 2019a). The normal range of CD4 cells in the blood is between 500 and 1500 cells/mm^3. This CD4 cell volume is progressively depleted by HIV infection (Okoye & Picker, 2013). If a person is infected with HIV, the virus remains in the human body for life, and progressively destroys the CD4 cells and impairs their functioning. Depletion of the CD4 cells weakens the immune system thus making the infected person prone to numerous opportunistic infections or HIV-related cancers (WHO, 2019a).

The most advanced stage of HIV infection is acquired immunodeficiency syndrome (AIDS), a group of symptoms and infections that result when the infected person's immune system has been so severely damaged that it can no longer effectively fight and prevent infections. At this stage, the CD4 cell count falls below 200 cells/mm^3 and the infected person acquires HIV related opportunistic infections or cancers (Wolbers et al., 2008). Depending on the individual, AIDS can develop between two to fifteen years after HIV infection (WHO, 2019a).

HIV was discovered, as the causative agent for AIDS, in 1983 by a group of French scientists led by Professor Luc Montagnier (Montagnier, 2002). There are two types of the virus: a) HIV type 1, which is responsible for most of the global AIDS pandemic, and b) HIV type 2, which was originally found in West Africa but has spread to other parts of Africa, Europe, India, and the United States (Campbell-Yesufu & Gandhi, 2011). Both types of the virus have the same modes of transmission and produce the same patterns of illness.

HIV can be transmitted from an infected person to another person through direct contact of body fluids such as blood, semen, vaginal secretions, or breast milk. The primary means of transmission of HIV worldwide are through: 1) unprotected sexual intercourse with an infected partner, 2) mother-to-child transmission during pregnancy, labour and delivery, or through breastfeeding, 3) transfusion of infected blood, or transplants of infected organs or tissues, and 4) sharing and use of contaminated needles, syringes and other skin-piercing instruments (International Labour Organization, 2015; Kapila et al., 2016; Kassa, 2018). In the healthcare setting, HIV could be transmitted from HIV infected patients to healthcare workers (HCWs) through accidental occupational exposures of the HCWs to the blood and body fluids of the HIV/AIDS patients (Auta et al., 2018; Mandić, Mandić-Rajčević, Marković-Denić, & Bulat, 2017; Tandi, Kim, Gilbert, & Choi, 2018).

AIDS was first recognized as a new disease in 1981 among five young gay men, in Los Angeles in the United States of America (USA), who succumbed to unusual opportunistic infections and rare cancers (Centers for Disease Control, 1981). The first Africans diagnosed with HIV/AIDS were two South African gay men identified in 1982 (Ras et al., 1983). In Ghana, the first case of AIDS was reported in 1986 (Neequaye et al., 1987). Since 1981, when it was first recognized as a new disease, HIV/AIDS has grown to pandemic proportions (Kumar et al., 2017; Piot & Quinn, 2013) and continues to be a major global public health issue. The number of people living with HIV/AIDS (PLWHA) globally continues to rise. The Joint United Nations

Programme on HIV/AIDS (UNAIDS) estimated that as at the end of 2020, there were 37.7 million people living with HIV (UNAIDS, 2021) with more than two-thirds of them living in sub-Saharan Africa. This makes the sub-Saharan Africa region the hardest hit by the HIV/AIDS pandemic. In Ghana, estimates of the Ghana AIDS Commission (2020) report revealed that there were about 346,120 PLWHA in the country as at 2020.

HIV/AIDS currently has neither a cure nor an effective vaccine. However, a combination of antiretroviral medications, known as "Highly Active Antiretroviral Therapy" (HAART), was introduced in 1996 for the treatment of HIV infections (Lacombe & Girard, 2004; Weston, Portsmouth, & Benzie, 2006b). In Ghana, the provision of HAART to PLWHA was started in 2003 (Addo et al., 2018). The combination of antiretroviral medications used in HAART are effective in suppressing the replication of the HIV, thus preventing the further destruction of the body's immune system, and hence halt the progress of the disease process (Weston et al., 2006a).

The introduction of HAART has significantly improved the prognosis of HIV infections as it decreases significantly the amount of the virus in the blood of the infected person, delays the progression of HIV infections to AIDS, prolongs the life span, and improves the quality of life of the PLWHA (Azia et al., 2016; Reda & Biadgilign, 2012; Bello et al., 2014; Bhatta et al., 2019; UNAIDS, 2014). The introduction of HAART has thus transformed HIV/AIDS from a hitherto rapidly terminal illness to a chronic, manageable disease (Broder, 2010; Colvin, 2011; Deeks et al., 2013). However, PLWHA could only realise these benefits of HAART if they adhered to the treatment regimen (Obirikorang, Selleh, Abledu, & Fofie, 2013; Yu et al., 2018).

If people infected with HIV are diagnosed early, before the infection progresses to AIDS, they could be managed on outpatient basis. However, studies have shown that many of the people infected with HIV seek healthcare very late, when their infections have progressed to the stage of AIDS and AIDS-related opportunistic infections and illnesses (Assen et al., 2016; Hu et al., 2019; Lakoh et al., 2019; Semakula & Deventer, 2013). These PLWHA therefore needed to be admitted to hospital for in-patient care (Guerro et al., 2014; Mkoko et al., 2017; Raberahona et al., 2018). The increase in life expectancy of those PLWHA on HAART is also accompanied with their being frequently admitted to hospital for the treatment of HIV-related opportunistic infections (Makhado & Davhana-Maselesele, 2016; Mammbona & Mavhandu-Mudzusi, 2019; Ramathuba & Davhana-Maselesele, 2013).

A retrospective patient admissions chart review by Kim et al. (2013) revealed that from 2004 to 2008, a total of 9, 101 HIV/AIDS patients were hospitalized in New York City, USA, whereas in Colombia, 901 such patients were admitted at six hospitals in Medellin, between August 2014 and July 2015 (Barreneche et al., 2017). A review of the case records of HIV-positive patients admitted to the medical and surgical Intensive Care Units (ICU) at Groote Schuur Hospital, Cape Town, South Africa, from 1st January to 31st December 2012 also revealed that 77 HIV-positive patients were admitted to the ICU (Mkoko & Raine, 2017). Similarly, a retrospective study performed on medical records in Madagascar revealed that from 2010 to 2016, 236 HIV positive patients were admitted to the Infectious Diseases Unit of the University Hospital at Antananarivo (Raberahona et al., 2018).

In Ghana, a retrospective review of the medical records revealed that 547 HIV-infected adults aged 18 years and above were admitted to the Korle Bu Teaching Hospital in Accra, between January 2012 and October 2013 (Saavedra et al., 2017). Similarly, a study by (Phillips et al., 2018) that involved a retrospective chart review to determine the common comorbidities and mortality rate of HIV-infected patients admitted over a six month period at the Komfo Anokye Teaching Hospital in Ghana, also revealed that 250 HIV-positive patients were admitted to the hospital within the six-month study period. At the 37 Military Hospital, records from the admissions and discharges book of the Simango (isolation) Ward revealed that 456 patients with HIV/AIDS and AIDS-related conditions were admitted to the ward between 2017 and 2019. These comprise 208 cases in the year 2017, 144 in 2018, and 104 in 2019.

Nurses are the frontline caregivers of HIV/AIDS patients while they are on admission (Dumitru et al., 2017; Mammbona & Mavhandu-Mudzusi, 2019; WHO, 2013). Depending on the stage of the illness at the time of admission to hospital, HIV/AIDS patients are often too frail and are unable to meet their own needs (Sinanaj et al., 2018) or independently perform their activities of daily living such; as eating and drinking, bathing, dressing, toileting, and movement (Shebi, 2006). Their total care therefore, depends on their caregivers, the nurses (Shebi, 2006; Sinanaj et al., 2018).

The nursing care for these patients includes helping them meet their physical, emotional, social and spiritual needs (Sinanaj et al., 2018). The nurses administer medications, and provide emotional support to the patients. They comfort, empathize with, provide encouragement to, provide counselling, as well as moral and spiritual support to the patients (Davhana-Maselesele & Igumbor, 2008; O’Neill & McKinney, 2003). Since most of these patients are weak and confined to bed, the nursing care to them also includes, helping them with their activities of daily living such as bathing, dressing, and feeding them, attending to their toileting needs; and regularly lifting, turning, and massaging them in order to prevent development of bedsores (O'Neill & McKinney, 2003). The nursing care also includes providing encouragement to the patients' family members, preparing the patients for peaceful death when necessary, and consoling grieving family members after the death of the patients (Davhana-Maselesele & Igumbor, 2008; Moshidi et al., 2021).

HIV/AIDS has become a chronic disease (Colvin, 2011; Moss, 2013), and like all chronic diseases, it affects not only the lives of those suffering from the disease, but also that of their close associates, including their caregivers (Lim & Zebrack, 2004). As is the case in caring for all patients with chronic diseases, caring for HIV/AIDS patients is a very stressful task that can have negative effects on the health of the caregivers (Simón et al., 2019; Valjee & van Dyk, 2014) and consequently, negatively affect the quality of care they provide to the patients (Valjee & van Dyk, 2014). The negative effects of caregiving on caregivers is described as "caregiver burden" (Adelman et al., 2014; Simón et al., 2019; Tazakori et al., 2017; Zarit et al., 1986). Caregiver burden is defined as; "the physical, psychological, emotional, social and financial stressors that individuals experience due to the provision of care" (Carretero et al., 2009; George & Gwyther, 1986). In the specific context of nurses in HIV/AIDS care, Tazakori et al (2017) described caregiver burden as the adverse effects on the emotional, social, and physical functioning of the nurses, and the challenges, problems and unpleasant experiences they face as they care for the HIV/AIDS patients. Simón, et al (2019) indicated that caregiver burden results from the dynamic interplay between the needs of the care recipient, the caregiving situation, the resources available for the caregiving role, and the weaknesses of the caregiver.

The challenges, problems, and unpleasant experiences that impose a burden of care on the nurses, and other caregivers of HIV/AIDS patients include: the fear and/or risk of being infected with HIV through occupational exposure to the blood and body fluids of the patients, increased workloads, increased physical and emotional stress, and burnout (Beyene & Tadesse, 2014; Esewe et al., 2017; Mammbona & Mavhandu-Mudzusi, 2019; Moshidi et al., 2021; Sanches et al., 2018; Mamukeyani, 2021; Tazakori et al., 2017; Tong et al., 2019; Valjee & van Dyk, 2014). Other such challenges and experiences include the nurses' over-involvement and identification with the HIV/AIDS patients witnessing the suffering and death of the patients as well as the emotional trauma of the patients' family members (Bam & Naidoo, 2014; Demmer, 2009; Koto & Maharaj, 2016; Valjee & van Dyk, 2014).

They also experience HIV/AIDS-related courtesy stigma and discrimination and lack of support (Mammbona & Mavhandu-Mudzusi, 2019; Ndou, 2017; Washington & Oberdorfer, 2013; Valjee & van Dyk, 2014). In Ghana, studies have revealed that family caregivers of HIV/AIDS patients or PLWHA experience work-related challenges such as HIV/AIDS-related courtesy stigma, and over-involvement and identification with the HIV/AIDS patients which impose a burden of care on the nurses (Afful et al., 2019; Mensah, 2018; Mwinituo & Mill, 2006; Puplampu, 2017; Mwinituo & Mill, 2006).

If left unmitigated, the caregiver burden experienced by the nurses could have detrimental effects on them, as well as the HIV/AIDS patients under their care (American Medical Association, 2018). Valjee and van Dyk (2014) found that un-mitigated caregiver burden could have serious consequences for nurses' psychosocial well-being resulting in high turnovers among them, and decrease their physical and psychological functioning. This situation could decrease this category of nurses' ability to provide the expected quality care to the patients. Un-mitigated caregiver burden could equally lead to compassion fatigue among the nurses, with the resultant reduction in the quality of care they could provide to the patients (Garcia et al., 2019; Gibson et al., 2017; Harrowing, 2011; West et al., 2018). Puplampu (2017) revealed that work-related challenges experienced by nurses have led to the unwillingness of some Ghanaian nurses to work in wards where HIV/AIDS patients are cared for, thus making it challenging for nurse managers to get nurses to accept transfers to these wards.

Cognizant of these lived experiences and their effects on the nurses caring for HIV/AIDS patients, Lekganyane and Alpaslan (2019), Ndou (2017), Tapsfield and Bates (2011), recognised the need for such nurses to be cared for and supported. Caring for and supporting nurses who care for HIV/AIDs patients comprises providing appropriate support systems for them to help lessen the effects of the caregiver burden on them, and help them cope effectively in their caregiving roles (Mammbona & Mavhandu-Mudzusi, 2019; Ndou, 2017; Tapsfield & Bates, 2011).

The nature of the nursing profession demands that nurses are given psychological and emotional support through counselling. The purpose of guidance and counselling in nursing cannot be overemphasized because it provides information and assistance, help individuals to make wise choices, improve the understanding of self, facilitate adjustment to new work environments and make them psychologically and emotionally prepared for activities of their work. Just as the school counsellor provides guidance and counselling for both students and teachers at the school setting (Namale, 2012), psychotherapists and counsellors can be of assistance to nurses who have psychological and emotional problems especially those who care for HIV/AIDS patients.

Having found that there are numerous work-related challenges and unpleasant experiences inherent in caring for HIV/AIDS patients, Van Dyk (2007) also recommended that hospital mangers should appoint professional counsellors to be responsible for the welfare of the caregivers, by providing professional therapeutic counselling, stress reduction and coping skills for the welfare of nurses taking care of PLWHA. Valjee and van Dyk (2014) recommended that hospital and nurse managers should appoint professionals tasked with the responsibility of attending to the emotional and psychological welfare of their staff by providing them counselling and debriefing services after stressful experiences.

In spite of the identified need to provide care and support for nurses caring for HIV/AIDS patients, it has been found out that, for most such nurses, these support programmes are often lacking (Ramathuba & Davhana-Maselesele, 2013; Moshidi, et al., 2021). The lack of care and support causes the nurses and other caregivers of HIV/AIDS patients to experience increased burnout, depression, stress related symptoms (Moshidi, et al., 2021), and other negative effects of caregiver burden and their attendant negative effects on the quality of care they provide to the patients.

The findings of many studies have revealed that nurses working in hospitals in Ghana experience numerous work-related challenges that impose a burden of care on them, affect their physical and emotional wellbeing, and impact negatively on the quality of care they provide to the patients under their care (Adzakpah et al., 2017; Dadson et al., 2018; Nukpezah et al., 2021; Odonkor & Adams, 2021; Odonkor & Frimpong, 2020; Tetteh et al., 2019). The studies therefore advocated for the formulation of policies to institutionalize unique care and support systems such as guidance and counselling systems, and other interventions in the hospitals to help the nurses and other HCWs deal effectively with their work-related challenges.

Most of these studies were focused on nurses caring for people with mental illnesses (Bonsu et al., 2020; Dadson et al., 2018; Tetteh et al., 2019). Since there are unique characteristics of HIV/AIDS care that make caring for HIV/AIDS patients unique with a unique caregiver burden (Asadullah et al., 2016; Grindel & Patsdaughter, 2000; Miller, 2005; Stavropoulou et al., 2011), there is the need to explore the lived experiences and challenges faced by nurses who care for HIV/AIDS patients. The findings will help in formulating policy necessary to provide the needed care and support for the nurses caring for HIV/AIDS patients.

1.2 Theoretical Framework

The theoretical framework reviews the theories that underpinned the study. It is reviewed under following sub-themes; the person-centered theory, the attachment theory, and the transactional theory of stress and coping.

1.2.1 The Person-Centered Theory

The person-centered theory is a counselling theory propounded by Carl Rogers (Rogers, 1957). It originated from Carl Rogers' earlier work, *Counselling and Psychotherapy* (Rogers, 1942). The development of this theory was influenced by Rogers's experiences as a therapist, his interaction with colleagues, and his research on the therapeutic process (Rogers, 1961; Sharf, 2012). It later evolved into client-centred counselling or client-centred psychotherapy, a counselling approach which is applicable to numerous types of counselling. The theory was developed from the concepts of humanistic psychology which views human beings as being capable and autonomous, with the ability to resolve their difficulties, realize their potentials, and change their lives in positive ways" (Corey, 2009). The person-centered theory is considered a phenomenological psychology because what the individual perceives as reality is accepted as reality for him/her.

The basic assumptions of the person-centered theory are that: individuals or clients are essentially trustworthy, that is they have the potential to understand themselves and the ability to resolve their own problems without direct intervention by the therapist. This explains why the person-centered therapy is also referred to as a non-directive approach. The purpose of person-centered approach therefore is to increase a person's feelings of self-worth, reduce the level of incongruence between the ideal and actual self, and help the client to become more fully functioning (Miller, 2012).

Rogers' strong belief in the positive nature of human beings, a belief that is based on his many years of practice as a counsellor, made him suggest that all clients, no matter what the problem they face, can improve and become fully functional (i.e. achieving a constructive or therapeutic personality change) without being taught anything specific by the therapist, once they accept and respect themselves. Rogers (1961) explained that in the person-centered approach, it is not the therapist who treats, cures, or changes the client. What the therapist does is to provide a therapeutic relationship in which the client will discover within him or herself the capacity to use that relationship for growth, and change and personal development will occur.

In order for this constructive psychological change and development to occur however, Rogers (1957) indicated that six necessary and sufficient conditions must be present. These conditions are that: 1) two persons are in psychological contact, 2) the first person, termed the client, is in a state of incongruence, being vulnerable or anxious, 3) the second person, the therapist, is congruent or integrated in the relationship, 4) the therapist experiences unconditional positive regard for the client, 5) the therapist experiences an empathic understanding of the client's internal frame of reference and endeavours to communicate this experience to the client, and 6) the communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

Rogers maintained that three of these conditions, namely, 1) congruence (genuineness, or realness), 2) unconditional positive regard (acceptance and caring), and 3) accurate empathic understanding (an ability to deeply grasp the subjective world of another person), which he termed core conditions or therapist attributes, create a growth-promoting climate in which individuals or clients can move forward and become what they are capable of becoming.

These attributes concern the conduct of the therapy itself and thus are the conditions that will make the client discover within him or herself the capacity to use the relationship for growth, change and personal development (Rogers, 1961). According to Rogers, if the therapist communicates these attitudes, the client will become less defensive and more open to him/herself, and will behave in prosocial and constructive ways. Rogers explained these three core conditions as follows.

1.2.1.1 Congruence

Congruence means that the therapist is genuine and authentic, and is in a stable and balanced state of self-experience and self-perception. The more the therapist is himself or herself in the relationship, putting up no professional front or personal facade, the greater is the likelihood that the client will change and grow in a constructive manner. This means that the therapist makes himself or herself transparent to the client, the client can see right through what the therapist is in the relationship, and the client experiences no holding back on the part of the therapist. Being genuine also involves the willingness of the therapist to express verbally and nonverbally the various feelings and attitudes existing in him (Rogers, 1961).

1.2.1.2 Unconditional positive regard

Unconditional positive regard involves basic acceptance and support of a person, regardless of what the person says or does. It means caring for the client, but not in a possessive way or in such a way as simply to satisfy the therapist's own needs. It means caring for the client as a unique individual with his/her own feelings and experiences. Acceptance, or caring is an important attitude in creating a climate for change in the client. The therapist must give no conditions for accepting the client. When the therapist accepts unconditionally whatever the client is at that moment, therapeutic movement or change is more likely to occur.

Rogers found that the more acceptance and liking the therapist feels toward the client, the more the therapist will be creating a therapeutic relationship which the client can use to self-develop. Unconditional positive regard implies the therapist is willing for the client to be whatever immediate feeling is going on - confusion, resentment, fear, anger, courage, love, pride etc. Such caring on the part of the therapist is non-possessive. The therapist prizes the client in a total rather than a conditional way (Rogers, 1957, 1961).

1.2.1.3 Empathy

Empathy means understanding accurately what the client is feeling. Empathic understanding means that the therapist senses accurately the feelings and personal meanings that the client is experiencing and communicates this understanding to the client. When functioning best, the therapist is so much inside the private world of the client that he or she can clarify not only the meanings of which the client is aware but even those just below the level of awareness (Rogers, 1957, 1961). Rogers (1980) however opined that this kind of sensitive, active listening is exceedingly rare in our lives. He is of the view that while we think and listen, very rarely do we listen with real understanding, and true empathy.

Expanding further on his belief about how people change in the person centered approach, Rogers (1980) explained that as people or clients are accepted and prized, they tend to develop a more caring attitude toward themselves. As they are empathetically heard, it becomes possible for them to listen more accurately to the flow of inner experiences. But as a person understands and prizes the self, the self becomes more congruent with the experiences. The person thus becomes more real and more genuine. These tendencies which are the reciprocal of the therapist's attitudes enable the person to be a more effective growth-enhancer for him or herself (Rogers, 1980).

1.2.1.4 Relevance of the person-centred theory to the current study

While discussing the relevance of the person-centred theory to this study, the client - therapist relationship can be looked at on two fronts. On one front is the HIV/AIDS patient -nurse relationship in which the nurse cares for the patient to recovery or to a peaceful death. The same relationship exists between the families of the patient and the nurse. On the other front is the nurse-hospital or nurse management relationship in which the nurse, having experienced work-related challenges and unpleasant experiences, or caregiver burden, is in a state of incongruence and needed to be cared for and supported to regain his or her functional state. In both instances, there are two persons who are in psychological contact, as indicated by Rogers (1957).

In the HIV/AIDS patient - nurse relationship, the patient (client), due to his/her condition, is anxious or incongruent and in contact with the nurse (therapist). As posited by Rogers, the nurse must be genuine, such that his/her words, non-verbal behaviour, and feelings agree with each other. The nurse must also accept, and care unconditionally for the patient (client). This is particularly important since HIV/AIDS evokes stigma and discrimination (Idemudia, Olasupo, & Modibo, 2018; Senzanje, 2011; Tsai et al., 2017), and the nurse also faces courtesy or secondary stigma and discrimination (Lekganyane & Alpaslan, 2019; Washington & Oberdorfer, 2013; Wu et al., 2016), as well as the risk of being infected with HIV through occupational exposure (Beyene & Tadesse, 2014; Esewe et al., 2017). Furthermore, the nurse must understand the patient's thoughts, ideas, experiences, and feelings and communicate this to the patient with empathic understanding. If the patient is able to perceive these conditions as offered by the nurse, the patient will feel satisfied with the care.

On the other hand, nurses who care for HIV/AIDS patients experience work-related stress and burnout (Kim et al., 2018; Koto & Maharaj, 2016; Mangal, 2015; Mohangi & Pretorius, 2017; Wright, 2016), they witness and had to cope with human suffering and the death of patients on regular basis (Bam & Naidoo, 2014; Demmer, 2009; Ramathuba & Davhana-Maselesele, 2013; Valjee & van Dyk, 2014) which makes them feel frustrated and helpless (Piculell & Wikander, 2012; Valjee & van Dyk, 2014). They (nurses) are also therefore in a state of anxiety and incongruity, and in contact with their employers, conditions that make them amenable to the person-centred approach. In this state therefore, the hospital or nursing management must understand the challenges faced by the nurses, and assist them physically, emotionally and socially so that they regain their state of normal functionality and hence provide the requisite care to the patients.

As was explained by Rogers (1961), in the person-centred approach, it is not the therapist who treats, cures, or changes the client. What the therapist does is to provide a therapeutic relationship in which the client will discover within him or herself the capacity to use that relationship for growth, and change and personal development will occur.

In order for this constructive psychological change and development to occur however, Rogers (1957) indicated that six necessary and sufficient conditions must be present. Therefore, all that the nurses need is the provision of the necessary human and material sources as well as a conducive environment, to make their work less cumbersome, as well as putting in place policies they can rely on in times of need to seek support and care to enable them overcome the challenges associated with their caregiving roles. Exploring the lived experiences of the nurses caring for HIV/AIDS patients will therefore bring to the fore all these challenges the nurses face as caregivers of HIV/AIDS patients, and thus provide the empirical basis for caring for them, and supporting them in their work.

1.2.2 Attachment theory

The attachment theory is a theory of interpersonal behaviour and is thought to affect how a person thinks, feels and behaves in close relationships (Bowlby, 1973). The theory originated as a psychoanalytic theory with the aim of explaining how children develop intimate relationships with their mothers and caregivers (Ainsworth, 1979; Bowlby, 1973). Although it is said to have originated from the joint work of John

Bowlby and Mary Ainsworth, John Bowlby is regarded as father of the attachment theory (Graham, 2015) because he formulated the core tenets of the theory in his ground-breaking works, Attachment, Separation, and Loss (Bowlby, 1973, 1980), in which he emphasized that all human beings have an innate biological drive to bond and socialize with others.

John Bowlby, a psychoanalyst and a pioneer into child psychology, who closely followed the works of Sigmund Freud, believed that the most important years in a person's life are the first few years. He suggested that children develop mental representations of their first attachment with their primary caregivers (mothers or other adults) which will then profoundly affect all future relationships and their own success as parents. According to Maunder and Hunter (2016), the attachment theory describes the development of close bonds between infants and parents in which a parent serves to regulate the infant's sense of safety and security by providing protective and soothing contact at times of distress and by providing a 'secure base' from which the infants can explore their environment. The attachment theory explains why people have different behavioural tendencies or patterns towards approaching others and in building relationships (Bartholomew, 1990).

Attachment is an enduring emotional tie to a special person, characterized by a tendency to seek and maintain closeness, especially during times of stress (Bowlby, 1969). van IJzendoorn (2012) described attachment as a pattern of emotional and behavioural interactions that develop over time, especially in contexts where infants express a need for attention, comfort, support or security. Parents or primary caregivers' ability to perceive, interpret and react promptly to their infants' needs and attention, influence the quality of their attachment relationships. Based on John

Bowlby's attachment theory, the relationship developed with primary caregivers is the most influential in children's lives. A secure relationship fosters not only positive developmental outcomes over time, but also influences the quality of future relationships with peers and partners (van IJzendoorn, 2012). Bowlby (1977) conceptualized that attachment is basically a process of human beings seeking to make affectionate bonds with significant people who will give them care and protection. He explained that an unwilling separation or breaking of this bond will lead to several forms of emotional distress such as anxiety, anger, depression and emotional detachment.

Though the attachment theory originated from studies on infants' and children's relationships with their parents, particularly mothers, it could be applicable to adults (Sable, 1992; Mikulincer & Shaver, 2016) where the focus of attachment shifts from parents to romantic partners or close friends (Waters, Hamilton & Weinfield, 2000; Crowell, Treboux & Waters, 2002). As indicated by Maunder & Hunter (2016), adult partners can act for each other as attachment figures who increase feelings of security by providing safe haven and secure base functions. The goal of attachment is to maintain an affectionate bond. Situations that compromise the maintenance of this bond bring loss and grief. A separation from the attachment figure, according to Bowlby (1973), evokes intense distress referred to as separation anxiety or distress.

In times of illness, the attachment shifts to healthcare professionals and other caregivers whom the sick person regards as having the expertise and power to provide the safety they require (Cassel, Leon & Kaufman, 2001; Maunder & Hunter, 2016). Some authors have consequently discussed the usefulness of the attachment theory in the helping professions, for example in medicine (Frederiksen, Kragstrup &

Dehlholm-Lambertsen, 2010), nursing (Miles, 2011), mental health (Bucci, Roberts, Danquah, & Berry, 2015; Godwin, 2003) and counselling (Hill, 2001). Researchers in mental health, clinicians and clinical psychologists have for a long time considered good health care provider-patient relationships to be an important factor for positive treatment outcomes in a range of therapeutic settings (Hooper, Tomek, & Newman, 2011). Hooper et al. (2011) also proffered the attachment theory and proposed attachment styles as a framework to better understand patient behaviours, patient communication styles with physicians and the physician-patient relationship in medical settings.

1.2.2.1 Relevance of attachment theory to the study

The current study sought to explore the lived experiences, and challenges faced by nurses who care for HIV/AIDS patients. The literature revealed that the caregivers often become over-involved with the HIV/AIDS patients and thus become emotionally attached to them because they spend a lot of their working time interacting closely with these patients (Davhana-Maselesele & Igumbor, 2008; Koto & Maharaj, 2016; Shirinda-Mthombeni, 2014; Tsheboeng, 2015). The over-involvement and attachment results in expressions of hopelessness and helplesness, and feelings of sadness if the patients die. Some of the nurses do grieve over the death of their patients (Davhana-Maselesele & Igumbor, 2008; Koto & Maharaj, 2016; Tsheboeng, 2015).

The attachment theory is of relevance to this study as it provides the understanding that the nurses' expressions of hopelessness and helplesness, feelings of sadness, and grief that results when the HIV/AIDS patients' conditions deteriorate and/or when they die, is as a result of the caregiver-patient attachment that results during the caregiving process. This confirms the separation anxiety and distress that results when there is a loss or threat of loss as described by Bowlby (1973) in the attachment theory. It is because of this that Tsheboeng (2015) suggested that grief counselling be used to assist these nurses and caregivers to help them overcome the loss, in order to avoid depression and breaking down and hence be able to provide the necessary care to the patients.

1.2.3 Transactional theory of stress and coping

The Transactional Theory of Stress and Coping (TTSC), originated by Richard Lazarus and Susan Folkman, is concerned with analysing the various procedures people experiencing stress go through to cope with such stressful experiences. It defined stress as “a particular relationship between the person and the environment that is appraised by a person as taxing or exceeding his or her resources and endangering his or her well-being” (Lazarus & Folkman, 1984). Since its first presentation as a comprehensive theory by Lazarus (1966), the TTSC has undergone several essential revisions (Lazarus, 1991; Lazarus & Folkman, 1984; Lazarus & Launier, 1978). In the latest version (Lazarus, 1991), stress is regarded as a relational concept, and viewed as a relationship or transaction between individuals and their environment.

In this transactional model of stress and coping, neither the environmental event nor the persons’ response defines stress, but rather the individual’s perception of the psychological situation is the critical factor. The effect that stress has on a person therefore is based more on that person’s feeling of threat, vulnerability and ability to cope than on the stressful event itself. Psychological stress therefore refers to a relationship with the environment that the person appraises as significant for his or her wellbeing and in which the demands are taxing or exceeding available coping resources (Lazarus & Folkman, 1984).

Two concepts are central to this theory, namely; cognitive appraisal, and coping. According to the TTSC, individuals are constantly appraising or evaluating stimuli within their environment. This appraisal process generates emotions, and when stimuli are appraised as threatening, challenging, or harmful, the resultant distress initiates coping strategies to manage emotions or attempt to directly address the stressor itself (Biggs, Brough, & Drummond, 2017).

1.2.3.1 The concept of cognitive appraisal

Cognitive appraisal is the process of categorizing an encounter, and its various facets, with respect to its significance for well-being (Lazarus & Folkman, 1984). It is the process through which individuals interpret and respond to potentially stressful situations. It is further defined by Folkman, Lazarus, Dunkel-Scheter, Delongis, & Gruen (1986) as "a process through which the person evaluates whether a particular encounter with the environment is relevant to his or her wellbeing, and if so, in what ways". During cognitive appraisal, a person considers two major factors that mainly contribute to his or her response to stress; 1) the threatening tendency of the stress to the individual, and 2) the assessment of resources required to minimize, tolerate or eradicate the stressor and the stress it produces. There are two main types of cognitive appraisal, namely; primary appraisal and secondary appraisal (Lazarus & Folkman, 1984).

1.2.3.1.1 Primary Appraisal

Primary appraisal assigns meaning to a specific individual-environmental transaction, and determines the significance of that transaction to the individual's well-being (Folkman, 1984; Lazarus & Folkman, 1984). In the stage of primary appraisal therefore, the individual experiencing stress, evaluates the nature of the stressor and/or the situation and how it can affect him or her. Lazarus and Folkman distinguished three kinds of primary appraisal: 1) irrelevant, 2) benign-positive, and 3) stressful.

When an encounter with the environment carries no implication for a person's well-being, it falls within the category of irrelevant. This implies the transaction is of no significance to one's well-being. It is highly adaptive for humans to distinguish between relevant and irrelevant cues so that they will mobilize for action only when it is desirable or necessary (Lazarus & Folkman, 1984). On the other hand, benign-positive appraisals occur if the outcome of an encounter is interpreted as positive, that is, if it preserves or enhances well-being or promises to do so. In other words, the encounter is exerting a positive effect on one's well-being. Benign-positive appraisals are characterized by pleasurable emotions such as joy, love, happiness, exhilaration, or peacefulness (Lazarus & Folkman, 1984). In the HIV/AIDS caregiving setting, benign-positive appraisals could occur when the HIV/AIDS patients' conditions improve and they are discharged from the hospital. This brings pleasurable emotions to the nurses or caregivers.

Stressful appraisals imply that the event could signify harm/loss, threat, or challenge (Lazarus & Folkman, 1984). In harm/loss stressful appraisals, some damage to the person has already been sustained, as in an incapacitating injury or illness, recognition of some damage to self-or social esteem, or loss of a loved or valued person. The most damaging life events are those in which central and extensive commitments are lost. Threat stressful appraisals concern harms or losses that have not yet taken place but are anticipated. Even when a harm/loss has occurred, it is always fused with threat because every loss also has a potential for negative implications for the future. For example, in the HIV/AIDS care setting, the fear of being infected with HIV through occupational exposure could be a threat stressful appraisal situation. The nurses caring for these patients need the knowledge, skills, and resources to protect themselves against the potential harm of occupational exposure.

The third kind of stress appraisal, challenge, has much in common with threat in that it also calls for the mobilization of coping efforts. The main difference is that challenge appraisals focus on the potential for gain or growth inherent in an encounter and they are characterized by pleasurable emotions such as eagerness, excitement, and exhilaration, whereas threat centres on the potential harms and is characterized by negative emotions such as fear, anxiety, and anger.

1.2.3.1.2 Secondary appraisal

Unlike primary appraisal which determines the meaning and significance of a transaction to the wellbeing of an individual, secondary appraisal determines what can be done to manage the stressor and its resultant distress (Dewe & Cooper, 2007). Secondary appraisal is enacted when a specific transaction is deemed to be stressful, and involves a cognitive process through which the individual identifies and evaluates his or her coping resources (Dewe & Cooper, 2007; Folkman, 1984). Secondary appraisal is a crucial feature of every stressful encounter because the outcome depends on what, if anything, can be done, as well as on what is at stake. It is a complex evaluative process that takes into account which coping options are available, the likelihood that a given coping option will accomplish what it is supposed to, and the likelihood that one can apply a particular strategy or set of strategies effectively (Lazarus & Folkman, 1984).

1.2.3.2 The Concept of Coping

Coping has been defined by Lazarus and Folkman (1984) as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person". The concept has earlier been described by Folkman and Lazarus (1980) as the cognitive and behavioural efforts of people to master, reduce, or tolerate situations that they perceive as dangerous or threatening to their wellbeing. Coping strategies refer to the specific efforts, both behavioural and psychological, that people employ to master, tolerate, reduce, or minimize stressful events. There are two types of coping: problem-focused coping, and emotion-focused coping (Folkman & Lazarus, 1980; Lazarus & Folkman, 1984).

1.2.3.2.1 Problem-focused coping

Problem-focused coping, which is more likely to be used when cognitive appraisal revealed that the stressful situation could be changed (Folkman & Lazarus, 1980), is directed at managing or altering the problem that is causing the distress. The individual makes efforts to change the stressful situations through problem solving, decision-making and/or direct action. The strategies adopted in problem-focused coping are similar to those used for problem solving and as such are often directed at defining the problem, generating alternative solutions, weighting the alternatives in terms of their costs and benefits, choosing among them, and acting. Problem-solving strategies are efforts to do something active to alleviate stressful circumstances.

Lazarus and Folkman identified the following strategies used in problem-focused coping; confrontative coping, seeking social support, and plan full problem-solving. Other strategies include active coping, planning, suppression of competing activities, restraint coping, seeking social support for instrumental reasons, and behavioural disengagement (Baqutayan, 2015; Carver, Scheier, & Weintraub, 1989).

1.2.3.2.2 Emotion-focused coping

Emotion-focused coping is directed at regulating the consequences of the stressful or potentially stressful events (Folkman & Lazarus, 1980). It is used when individuals feel they cannot manage the source of the problem. It involves using strategies such as avoiding, distancing oneself from the stressful situation, acceptance, seeking medical support, and use of alcohol. Other emotion-focused coping strategies, according to Baqutayan (2015) and Carver et al. (1989), include seeking social support for emotional reasons, positive reinterpretation and growth, acceptance, denial, turning to religion, focus on and venting of emotions, mental disengagement, humour, alcohol and drug use, and positive reinforcement and growth.

1.2.3.3 Relevance of the transactional theory of stress and coping to the study

The purpose of this study was to explore the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana. The available literature indicates that while caring for HIV/AIDS patients, the nurses experience unique physical, emotional, and psychosocial challenges and problems which are sources of stress for them (Haoses-Gorases, Katjire, & Goraseb, 2013; Ramathuba & Davhana-Maselesele, 2013; Tazakori et al., 2017).

The nurses need to deal with their work-related stress in order to remain healthy to provide the required standard care to the patients. They may have to apply the concept of cognitive appraisal and coping to determine whether the stressful situations they encounter while caring for the HIV/ADS patients are threats to their well-being or not, and determine whether they have the resources to deal with them in order to remain healthy enough to provide the needed care to the patients. The transactional theory of stress and coping is therefore of relevance to the study as it will help illuminate the experiences of the caregivers, the stress they encounter at work and the effective coping strategies they can adopt.

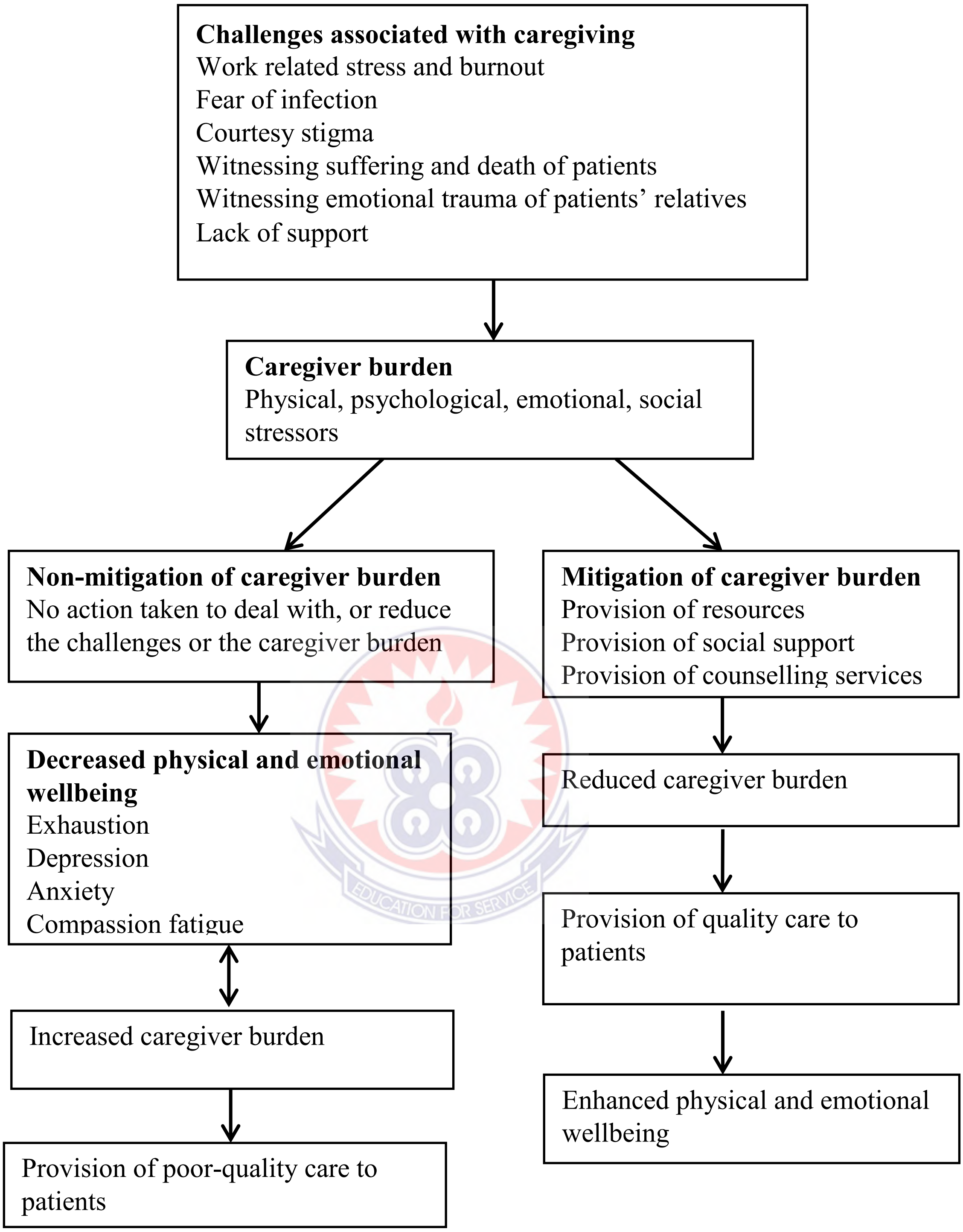
In conclusion, the person-centred theory, the attachment theory, and the transactional theory of stress and coping provided a holistic framework that underpinned the study. The study revealed that the nurses who care for HIV/AIDS patients experience work-related challenges, and that these challenges affect negatively the nurses' physical and emotional wellbeing, as well as their willingness to provide care to the patients. Th nurses called on management of the hospitals to provide them adequate staff, material resources, and counselling services. These would enable them deal with the challenges, so they could maintain their physical and emotional wellbeing and be able to provide the required nursing care to the patients.

This is in line with the basic assumptions of the person-centered theory that individuals or clients have the potential to understand themselves and the ability to resolve their own problems without direct intervention by the therapist. If management provide the necessary resources and support to them, the nurses would be able to deal with the work-related challenges they encounter while caring for the HIV/AIDS patients.

The attachment theory was relevance in providing the understanding that the nurses' expressions of hopelessness and helplessness, feelings of sadness, and grief that results when the HIV/AIDS patients' conditions deteriorate and/or when they die, is as a result of the caregiver-patient attachment that results during the caregiving process. This confirms the separation anxiety and distress that results when there is a loss or threat of loss as described in the attachment theory by Bowlby (1973). The transactional theory of stress and coping helped illuminated the experiences of the caregivers, and the work-related challenges they encounter while caring for the HIV/AIDS patients. It thus provided the basis for adopting effective coping strategies in dealing with their work-related challenges.

1.3 Conceptual Framework

The framework is in three broad categories namely: 1) challenges associated with caregiving which impose a caregiver burden on the nurses caring for HIV/AIDS patients, 2) consequences of non-mitigation of the caregiver burden on the nurses, and 3) consequences of mitigation of the caregiver burden imposed on the nurses.



Key:

1. Single head arrows: these indicate that there is a direct influence of one variable on the other.
2. Double head arrow: this indicates the relationship between two independent variables.

The figure represents the researcher's perception, based on the available literature on the lived experiences of caregivers of HIV/AIDS patients. Whilst caring for the HIV/AIDS patients, nurses encounter challenges such as work-related stress and burnout, fear of infection, over involvement /identification with the patients, witnessing suffering and death of patients, witnessing the emotional trauma of patients' and their relatives, courtesy stigma, and lack of support. These experiences impose caregiver burden on the nurses.

If no mitigative measures, such as provision of care and support for the nurses, are put in place by nurse manages, the caregiver burden could lead to effects such as the decreased physical and psychosocial wellbeing of the nurses, depression, anxiety frustration, exhaustion, compassion fatigue, reluctance to care, and high turnovers among the nurses. These effects further increase the caregiver burden experienced by the nurses, and could result in the provision of poor-quality care to the HIV/AIDS patients. On the other hand, if management of the hospital, nurse managers, and other stakeholders provide support to the nurses in the form of provision of adequate resources, social support, and counselling services, it will help reduce the caregiver burden experienced by the nurses and will enable them provide the expected quality care to the patients.

1.4 Statement of the Problem

Nurses are front line caregivers of hospitalized HIV/AIDS patients (Dumitru et al., 2017; Mammbona & Mavhandu-Mudzusi, 2019). They have more contact hours with the patients, and are the largest group of HCWs who provide intimate and personalized care for the hospitalized HIV/AIDS patients than any other groups of health workers (Mammbona & Mavhandu-Mudzusi, 2019; Wright, 2016). They play crucial roles in caring for HIV/AIDS patients by providing comfort, symptom management, and often palliative care for those in their terminal stages of the disease. Nurses who provide care to hospitalized HIV/AIDS patients experience work-related physical, social, and psychological challenges that impose a caregiver burden on them (Haoses-Gorases et al., 2013; Ramathuba & Davhana-Maselesele, 2013; Song et al., 2022; Tazakori et al., 2017). The caregiver burden experienced by caregivers of persons with chronic illnesses, including HIV/AIDS, usually manifests as physical, psychological, and behavioural symptoms such as: backaches, headaches, fatigue, insomnia (sleeplessness), anger and frustration, loss of interest in and commitment to work, feelings of restlessness, depression, anxiety, emotional outbursts, alienation from friends and family, lateness to work and neglect of duty, decrease in judgmental ability, inability to focus on tasks, and impaired work performance (Brodaty & Donkin, 2009; Khan, Pai, Kulkarni, & Ramapuram, 2018; Kim et al., 2018; Lee, Heo et al., 2014; O'Neill & McKinney, 2003; Simón et al., 2019; Strojek & Kolodziejczyk, 2018).

Further, the caregiver burden experienced by nurses caring for HIV/AIDS patients can, in the long term, affect adversely the quality of life of the nurses, their physical and psychological well-being, and compromise the quality of care they provide to the HIV/AIDS patients, if they are not cared for and supported to help mitigate their work-related challenges or experiences (American Medical Association, 2018; Ndou et al., 2015; Oyeyimika et al., 2020;Valjee & van Dyk, 2014). It is in this regard that Liang et al. (2018) described nurses caring for HIV/AIDS patients as "invisible patients" who also needed to be cared for.

It will however be impossible to provide the appropriate care and support for the nurses if their work-related experiences and challenges, that impose the burden of care on them, are not identified (Valjee & van Dyk, 2014). Studies that explored the lived experiences of nurses caring for HIV/AIDS patients were conducted in countries such as the USA, China, South Africa, and Nigeria, among others (Asuquo et al., 2013; Bam & Naidoo, 2014; Bejane et al., 2013; Qiao et al., 2016; Wright, 2016). The findings of these studies revealed that the nurses experience caregiver burden whilst providing care to the HIV/AIDS patients. The authors of these studies therefore recommended that supportive measures be put in place to help mitigate the work-related challenges the nurses face while caring for the HIV/AIDS patients.

Whereas studies in other countries investigated the lived experiences of nurses caring for HIV/AIDS patients with a view to identifying their challenges, finding means of mitigating their challenges, and providing the requisite support systems for them so that they could work in a conducive environment in order to function effectively (Ndou, 2017; Tapsfield & Bates, 2011), same cannot be said of the Ghanaian context where previous research on the lived experiences of caregivers of HIV/AIDS patients has focused mainly on the population of family caregivers of PLWHA (Afful et al., 2019; Mwinituo & Mill, 2006). There is a dearth of literature on the lived experiences of Ghanaian nurses who provide care to hospitalised HIV/AIDS patients, though, based on anecdotal evidence from some nurses caring for HIV/AIDS patients, it is possible that Ghanaian nurses caring for HIV/AIDS patients might be experiencing work-related challenges that impose a burden of care on them. The population and contextual gap identified needed to be explored.

1.5 Purpose of the Study

The purpose of the study was to explore the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana, and what care and support they receive from management of the hospitals. The study was intended to aid the researcher to make recommendations and suggestions that could be used to formulate policies for providing care and support to nurses caring for HIV/AIDS patients.

1.5 Objectives of the Study

The objectives of the study were:

1. To explore the care nurses provide to the HIV/AIDS patients.
2. To explore the challenges encountered by the nurses while caring for the HIV/AIDS patients.
3. To understand how the work-related challenges affect the nurses and their caregiving functions.
4. To find out what support systems are available for the nurses caring for HIV/AIDS patients to help them deal with their work-related challenges.
5. To explore how nurses caring for HIV/AIDS patients cope with their work-related challenges.

1.6 Research Questions

The following research questions were raised to guide the study:

1. What care do the nurses provide to the HIV/AIDS patients?
2. What challenges do the nurses encounter while caring for the HIV/AIDS patients?
3. How does the work-related challenges encountered by the nurses affect them and their caregiving functions?

4. What support systems are available to help the nurses caring for HIV/AIDS patients to deal with their work-related challenges?
5. How do nurses caring for HIV/AIDS patients cope with their work-related challenges?

1.7 Significance of the Study

The study is significant in providing empirical data on theory, practice, and policy on the phenomenon of nursing care for hospitalised HIV/AIDS patients, challenges encountered by the nurses while caring for the HIV/AIDS patients, how these challenges affect the nurses and their caregiving functions, support systems available for these nurses, and how the nurses cope with their work-related challenges.

The findings of the study would add up to the existing literature on the subject under investigation. The study would thus be significant in filling the knowledge gap created as a result of the dearth of literature on the lived experiences of Ghanaian nurses caring for hospitalised HIV/AIDS patients in the Ghanaian context, specifically in the Accra Metropolis.

For practice, the findings would be significant in providing the basis for the hospital management to plan with counsellors to help explore counselling interventions necessary to help the nurses deal with the challenges they encounter while caring for HIV/AIDS patients. Such interventions would help mitigate the caregiver burden imposed on the nurses by the challenges associated with their caregiving functions. In addition, the results of the study would help hospital authorities in finding out what support systems are available to help nurses caring for HIV/AIDS patients to deal with their work-related challenges, determine the adequacy of such support systems, and help provide the necessary augmentations. It would also be significant for counsellors to identify the necessary support systems the nurses need to deal with their work-related challenges. Further, the findings would also enable the hospital authorities plan with counsellors in identifying the appropriate coping strategies the nurses could use in dealing with the caregiver burden imposed on them by the challenges associated with their caregiving functions.

The findings of the study would be significant for hospital management in formulating policy on providing counselling services and stress reduction training to the nurses prior to being posted to the isolation wards. Further, the findings would provide empirical data to be used for instituting protocols for regular counselling and debriefing sessions for the nurses to help provide psychosocial support for them. The findings of this study may inform the formulation of policy on providing counselling and debriefing for all nurses to help them deal with their work-related challenges.

1.8 Delimitations of the Study

The study was delimited to the Korle Bu Teaching Hospital and the 37 Military Hospital in the Accra Metropolis, Ghana. Although nurses provide care to HIV/AIDS patients in other hospitals in the Accra Metropolis, these two hospitals were chosen because they have separate wards, known as isolation wards, solely designated for the care of HIV/AIDS patients and other infectious diseases. The nurses working in these isolation wards will therefore be in constant contact with HIV/AIDS patients and will thus experiences the unique challenges associated with caring for HIV/AIDS patients. These will impose on them the unique caregiver burden associated with caring for HIV/AIDS patients.

The study was also delimited to only nurses because, though other categories of healthcare workers provide care to hospitalised HIV/AIDS patients, nurses are the caregivers who spend the most time with these patients while caring for them. They are therefore most vulnerable to experiencing the work-related challenges that impose a burden of care on such caregivers. Recommended policies and practices on counselling will help mitigate the caregiver burden imposed on them by their work-related challenges.

Methodologically, the study is delimited to the qualitative approach because the researcher was interested in exploring the lived experiences of nurses caring for HIV/AIDS patients. The nurses' experiences as they provide care for HIV/AIDS patient, the meanings they have constructed from these experiences and how they cope with such experiences cannot be measured empirically, but is best explained by the participants from their own perspectives.

1.9 Operational Definition of Terms

For the avoidance of doubts, the following terms used are defined as they should be understood in the context of this study:

Care: - all the attention and the physical, psychosocial and emotional assistance provided by nurses to HIV/AIDS patients on admission such that they live in comfort or die a peaceful death.

Caring: – the physical, psychosocial, and emotional assistance or support provided by hospital and nurse managers, the government and other stakeholders, to the nurses caring for HIV/AIDS patients to ensure their mental and physical well-being and hence provide optimal care to the patients.

Carer or caregiver: - a nurse who provides care to HIV/AIDS patients on admission at the hospital.

Caregiver burden: - The adverse effects on the emotional, social, and physical functioning of the nurses, as a result of the work-related challenges they experience while caring for HIV/AIDS patients.

Courtesy stigma: - The stigma a person faces by virtue of his or her being associated with HIV/AIDS patients.

Emotional venting: - The act of a person expressing his or her concerns and frustrations as a way of releasing pent-up emotions or stress, and seeking support from others.

Experience: - The challenges, problems, and unpleasant situations faced by nurses caring for HIV/AIDS patients in the hospital, and their emotional reactions to such challenges.

Family caregiver: - A person who provides, usually unpaid, care or support to family members suffering from chronic diseases.

Frontline caregiver: - Healthcare workers who are directly involved in provision of care to patients.

Invisible patients: - Caregivers who are impacted negatively by the diseases or the conditions of the people they care for, but who normally do not receive any care or attention.

Mitigation of caregiver burden: - Reducing the severity of caregiver burden on the nurses.

Occupational exposure: - Coming into direct contact with the blood and other body fluids of patient while caring for the patient.

Psychosocial support: - Form of support provided to the nurses to help relieve them of issues of anxiety and other emotional challenges.

Social support: - Assistance provided to the nurses by other people around them.

Nurses: – all categories of professional nurses licensed by the Nursing and Midwifery Council (NMC) of Ghana, and who are practicing at the Korle Bu Teaching Hospital, and the 37 Military Hospital in Accra, Ghana.

1.10 Organization of the Study

The study is organized into five chapters. Chapter One provides an overview of the study and discusses the following; the background to the study, the theoretical framework and conceptual framework, statement of the problem, the purpose, and objectives of the study. The chapter also includes the objectives of the study, research questions, significance of the study, delimitations, and operational definition of terms used in the context of the study. It ends with a description of the organization of the study.

Literature relevant to the study is reviewed in chapter Two, while chapter Three deals with the methodology. This includes descriptions of the philosophical worldview or paradigm, research design, research setting, the study population, sampling technique and sample size. The instrument for data collection, procedure for data collection, data analysis and data management as well as measures for ensuring the methodological rigour or trustworthiness of the study and ethical issues are also discussed under chapter three. Chapter Four presents the results obtained after analysis of the data generated and the discussion of the findings in relation to existing literature. The summary and conclusions of the study, and recommendations made by the researcher, based on the findings of the study, were presented in chapter Five.

1.11 Summary of the Chapter

This chapter provides an introduction to the study. It began with a discussion of the background to the study, which included basic information on HIV infection and AIDS, treatment currently available for HIV/AIDS, nursing care provided to hospitalised HIV/AIDS patients, effects of caregiving on the nurses who provide care to HIV/AIDS patients, the work-related experiences and challenges of nurses caring for HIV/AIDS patients, and the need to provide care and support for nurses caring for HIV/AIDS patients.

It continued with a description of the theoretical framework that underpins the study and provides an explanation of the relevance of the theories to the study. The chapter also includes a description of the conceptual framework of the study, statement of the problem, purpose of the study, objectives of the study, research questions, and significance of the study, delimitations, and operational definition of terms used in the context of the study. The chapter concludes with a description of the organization and structure of the study. In the next chapter, chapter two, literature relevant to the study will be reviewed.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents a review of literature relevant to the study. Literature review, defined by Polit and Beck (2017) as a written summary of the state of evidence on a research problem, is very significant in the conduct of any new research. It is essential to understanding the accumulated knowledge about the research problem being studied (Garrard, 2017). The literature review serves various purposes such as: helping to summarize the available information about what is already known and what is unknown about the subject being studied (Polit & Beck, 2017), providing a framework for establishing the importance of, as well as a standard for comparing the findings of the study with the results of other studies (Creswell, 2014).

The study sought to explore the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana. The literature was reviewed under following sub-themes: nursing care for hospitalised HIV/AIDS patients, challenges encountered by nurses caring for HIV/AIDS patients, effects of work-related challenges on nurses and their work, support systems available to the nurses, coping strategies adopted by caregivers of HIV/AIDS.

2.1 Nursing Care for Hospitalised HIV/AIDS Patients

Since 1981 when HIV/AIDS was recognized as a new disease, it has grown to pandemic proportions (Kumar et al., 2017; Piot & Quinn, 2013), and the number of PLWHA globally continues to rise. The UNAIDS (2021) report estimated that there were about 37.7 million PLWHA globally as at the end of 2020. The introduction of HAART as treatment for HIV infections has led to an increase in the life span of

PLWHA thereby increasing the prevalence of PLWHA (Bello et al., 2014; Bhatta et al., 2019; Deeks et al., 2013; Lacombe & Girard, 2004; Weston et al., 2006b). The increase in their life span is also accompanied with the frequent hospitalizations of the PLWHA for the treatment of HIV-related opportunistic infections (Makhado & Davhana-Maselesele, 2016; Mammbona & Mavhandu-Mudzusi, 2019; Ramathuba & Davhana-Maselesele, 2013). Studies have revealed high incidences of frequent hospitalizations of PLWHA as a result of HIV/AIDS-related opportunistic infections in New York City, USA, (Kim et al., 2013), Colombia, (Barreneche et al., 2017), South Africa, (Mkoko & Raine, 2017) Madagascar (Raberahona et al., 2018), and Ghana, (Saavedra et al., 2017; Phillips et al., 2018).

Nurses are front line caregivers of hospitalized HIV/AIDS patients (Dumitru et al., 2017; Mammbona & Mavhandu-Mudzusi, 2019). Because most of these PLWHA are admitted to hospital at a time when they are often too frail and are unable to perform any of their activities of daily living, they had to depend on their caregivers, the nurses, for their total care (Shebi, 2006; Sinanaj et al., 2018). Considering the fact that HIV/AIDS has numerous physical, psychological, and economic effects on PLWHA (Bodkin, 2003; Cianelli et al., 2020; Kovach, 2008), it is apt that the caregivers of HIV/AIDS patients take these illness-related effects into consideration when providing care to the patients (Bodkin, 2003; Kovach, 2008).

Nurses therefore, while providing medical care, attend to the physical, psychological, social, and economic needs of the HIV/AIDS patients. This approach of nursing care is in line with the concept of holistic nursing care which was originated by Florence Nightingale, the founder of modern nursing. Holistic nursing care is defined as a system of comprehensive or total patient care that considers the physical, emotional, social, economic and spiritual needs of the person; his or her responses to illness, and the effect of the illness on their ability to meet selfcare needs (Tjale & Bruce, 2007). The American Holistic Nurses Association (1998) also defined holistic nursing as "all nursing practice that has healing the whole person as its goal". Holistic nursing is premised on the concept that, the whole is greater than the sum of its parts, and that mind and spirit have an effect on the body.

The nursing care for these patients comprises helping them with their physical, emotional, spiritual and social needs (Sinanaj et al., 2018). Since most of the HIV/AIDS patients are weak and confined to bed, the nursing care to them also includes, helping them with their activities of daily living such as feeding, bathing, dressing, and toileting; regular lifting and turning and massaging in order to prevent development of bedsores (O'Neill & McKinney, 2003).

Zikhathile and Atagana (2018) indicated that the nursing care required by people who are frail with moderate to severe functional disabilities, terminally ill persons, and HIV/AIDS patients or persons with any other chronic diseases includes assisting them to use toilets, feeding and bathing them, changing their diapers and their positions in bed, and helping them to exercise. The nursing care also includes providing encouragement to the patients' family members, preparing the patients for peaceful death when necessary, and consoling grieving family members after the death of the patients (Davhana-Maselesele & Igumbor, 2008; Moshidi et al., 2021). Robbins, Cooper, and Bender (1992) also stated that nursing care for HIV/AIDS patients involves providing extensive physical care and rendering emotional support to them. Studies have revealed that the diagnosis of HIV/AIDS has devastating impacts on the infected individual, his/her family and friends (Dejman et al., 2015; Ji et al., 2007;

Laryea & Gien, 1993; McCain & Gramling, 1992; WHO, 2005). Nurses who care for HIV/AIDS patients therefore have to provide nursing care to the infected persons, their families, and friends (Moshidi et al., 2021).

In summary, this section of the literature review reveals that the care provided by nurses is geared towards meeting their physical and psychosocial needs. The review also reveal the nurses provide emotional support to the family members of HIV/AIDS patients because they also experience the devastating effects of the disease and hence needs to be supported. The next section of the review is focused on extant literature on the challenges experienced by nurses and other caregivers of HIV/AIDS patients.

2.2 Challenges Encountered by Nurses Caring for HIV/AIDS Patients

The challenges encountered by nurses while caring for HIV/AIDS patients include: fear of infection, work-related stress and burnout, HIV/AIDS related stigma and discrimination, inadequate resources, and inadequacy of support.

2.2.1 The fear of being infected with HIV

The fear of being infected with HIV is a key concern to all HCWs worldwide, particularly nurses who care for HIV/AIDS patients (Manganye et al., 2013; Beyene & Tadesse, 2014; Esewe et al., 2017;). This fear is due to the fact that HCWs who care for HIV/AIDS patients frequently experience occupational exposures to the blood and other body fluids of the HIV/AIDS patients which put them at risk of being infected with HIV and other blood borne pathogens (Shivalli, 2014; Tandi, Kim, Gilbert & Choi, 2018; Akpuh et al., 2020).

Occupational exposure among HCWs is described as any contact of the HCWs with potentially infectious material during their working activities (Lee et al., 2017; Serdar et al., 2013). It could occur through percutaneous injuries (e.g. needle pricks or cuts with sharp objects), or contact with mucous membrane or non-intact skin (e.g. exposed skin that is chapped, abraded, or afflicted with dermatitis), contact with blood, tissue, or other body fluids that are potentially infectious occurring at the workplace (Mponela et al., 2015; Yasin et al., 2019). Occupational exposures are common occurrences in health care settings (Akpuh et al., 2020; Nmadu & Sabitu, 2016; Sharma, Tripura & Acharjee, 2018) and carry the potential risk of transmitting blood-borne infections such as HIV to the affected HCWs (Akpuh et al., 2020; Subramanian, Arip, & Subramanian, 2017; Yasin et al., 2019).

A World Health Organization report, cited by Auta et al. (2017), estimated that, worldwide, more than three million health care related percutaneous injuries occur annually. Whereas exposure to occupational hazards among HCWs is a global phenomenon, HCWS in sub-Saharan Africa have higher rates of occupational exposure to infectious diseases than their counterparts in developed countries (Mossburg, Agore, Nkimbeng, & Commodore-Mensah, 2019) indicating that they have a higher risk for contracting blood borne illnesses. Almost all HCWs are at risk for occupational exposure to blood borne pathogens, but nurses are the HCW group most affected (Makhado & Davhana-Maselesele, 2016; Rohde et al., 2013; Tesfay & Habtewold, 2014) because they form the majority of HCWs and spend the most time with patients (Shivalli, 2014; WHO, 2013).

Though the risk of transmission of HIV to HCWs after occupational exposure is considered to be low, between 0.3% and 0.09%, following percutaneous and mucocutaneous exposures respectively (Mosendane, Kew, Osih, & Mahomed, 2012; Tesfay & Habtewold, 2014), it is a potential risk of HIV infection to HCWs and is the reason for the fear of being infected with HIV expressed by nurses caring for

HIV/AIDS patients (Akpuh et al., 2020; Esewe et al., 2017). There is indeed empirical evidence of transmission of HIV from patients to HCWs through occupational exposure (Anonymous, 1984; Do, Ciesielski, Metler, & Hammett, 2003; Gebresilassie, Kumei, & Yemane, 2014; Ippolito et al., 1999; Rapparini, 2006). The first documented case of transmission of HIV from an HIV/AIDS patient to a HCW, through occupational exposure, was reported in the United Kingdom in 1983 (Anonymous, 1984; Ippolito et al., 1999) and since then many such transmissions have also been documented in countries such as the United States, Brazil and Italy (Argentero, et al., 2007; Hsieh, Chiu, Lee, & Huang, 2006; Palenik, 2017; Rapparini, 2006) among others.

The fear of being infected with HIV through occupational exposure has been identified to be of great concern among nurses caring for HIV/AIDS patients. Using a quantitative descriptive survey that explored the knowledge and attitude of nursing students, in a Nigerian tertiary health institution, towards the care of HIV/AIDS patients, Esewe et al (2017) found that being exposed to HIV infection was a major source of fear to all the 165 respondents who returned their questionnaires. Because of this expressed fear of the possibility of acquiring HIV/AIDS from patients during their clinical practice, 84.2% of the respondents were of the view that HIV/AIDS patients should not be admitted into the same ward with patients suffering from other disease conditions. A few (16.4%) of the respondents actually thought that HIV/AIDS patients should not be admitted into the hospital bed at all but should rather be sent home to be cared for by their relations. These expressions from the nurses suggested their unwillingness to care for HIV/AIDS patients because of the fear of being infected with HIV.

The fear of being infected with HIV through occupational exposure was also found to be a major concern among nurses in university Teaching Hospitals in Sicily, Italy, and Calabar, Nigeria (Marranzano et al., 2013; Asuquo et al., 2013). A quantitative study was conducted by Asuquo, Adejumo et al (2013) to determine the extent of fear of vulnerability to and perceived seriousness of the fear of HIV infection through occupational exposure among nurses caring for HIV/AIDS patients in the University of Calabar Teaching Hospital, Nigeria. The study also determined the relationship between the fear of susceptibility to infection and caregiver burden among the nurses. The researchers used a purposive sampling technique to select 210 participants. Structured questionnaires and relevant validated scales such as Zarit Burden Interview and abridged Champion Health Belief Model Scale were used to collect data. The results revealed that the majority, (41.0%) of the nurses harboured fear of vulnerability to infection, and perceived HIV as a serious and life-threatening infection.

The study by Marranzano et al. (2013) was aimed at ascertaining nurses' attitudes, perceptions and workplace practices in dealing with HIV positive patients, and investigating their HIV/AIDS related knowledge. Findings of the study revealed that the fear of being infected with HIV through occupational exposure was the nurses' main concern. Being quantitative studies, the studies by Asuquo, Adejumo et al (2013) and Marranzano et al. (2013) were not able to explore the lived experiences of the participants and how they coped with or managed their fears of being infected with HIV.

A qualitative study was also conducted by Mametja, Lekhuleni, & Kgole, (2013) to explore the perceived problems experienced by professional nurses providing health care to HIV/AIDS patients in the public hospitals of Polokwane Municipality, Limpopo Province, South Africa. The findings of the study revealed that the nurses expressed the fear of being infected with HIV through occupational exposure. The study further revealed that the nurses' fears are heightened when they are pricked by used needles during the process of caring for the patients. To address these heightened fears of being infected with HIV, there is the need for the nurses to be provided with the necessary protective devices they need to help protect themselves against occupational exposures during the process of caring for the patients.

A related study by Wright (2016) that explored the lived experiences of registered nurses caring for HIV/AIDS patients in Broward County, Florida in the USA, also revealed that nurses are always anxious, nervous, and fearful of getting infected with HIV through occupational exposure. The qualitative study employed a descriptive, interpretive paradigm underpinned by Max van Manen's phenomenological method. The researcher employed purposive and snow-ball sampling techniques to recruit a maximum of 12 participants for the study. Audiotaped, semi-structured face-to-face interviews were conducted to generate data. The study revealed that the nurses encountered many acts of impediments associated with HIV/AIDS such as "*dreading occupational exposure*" which caused them to feel afraid and scared about caring for the HIV/AIDS patients. The nurses were scared and afraid of being infected with HIV especially through needle-stick injuries. They described the *dreading occupational exposure a*s frightening and disabling and is the basis for some of them wanting to resist providing care to the HIV/AIDS patients. The researcher concluded that the nurses' experiences highlighted the numerous effects of HIV/AIDS on healthcare and nurses alike. The study indicated the need for a comprehensive approach to make it possible for caregivers to provide appropriate nursing care to the patients.

Similarly, a qualitative study was conducted by Bam and Naidoo (2014) to explore the lived experiences of nurses caring for terminally ill HIV/AIDS patients in selected wards in a level one district hospital in KwaZulu-Natal, South Africa. Based on the fact that caring for HIV/AIDS patients carry a burden of fear for the carers, Bam & Naidoo (2014) found that the nurses utilized reasonable precautions, such as the wearing of the appropriate protective clothing when handling the terminal patients under their care in order to minimize the risks of being infected with HIV or other devastating diseases such as tuberculosis. Despite taking precautions to protect themselves however, the nurses identified some circumstances that exposed them to the risk of infection. These were mainly related to the patients' attitudes, as those who were in denial of the diseases became offended when the nurses utilized precautionary measures such as wearing gloves and facemasks before attending to them. The study revealed that the nurses' fears were based on the reality of the diseases South Africa is battling with. Apart from HIV/AIDS, the nurses fear that they could also be exposed to other infectious diseases such as Swine Flu and the extremely drug resistant tuberculosis.

A qualitative study was also carried out by Alemie (2012) to examine the perceptions of HCWs on work place transmission of HIV and its effects on healthcare at the University of Gondar Hospital in Northwest Ethiopia. A total of seven respondents were purposively selected from the major service areas of the hospital potentially at a higher risk of work-related HIV transmission, namely the maternity ward, medical and surgical wards, and the hospital laboratory. The respondents included a clinical nurse, a midwife, a general practitioner engaged in obstetrics care, three intern doctors who cared for medical, surgical, gynaecologic, obstetric and paediatric patients, and a laboratory technician. Questionnaires with open ended questions were used as the tool for data collection. Data was analysed using thematic approach. The five major themes identified were; 1) work-related transmission of HIV infection, 2) experience of injuries at the workplace, 3) the need for protective materials, 4) reasons why HIV transmission is a common risk among health professionals, and 5) care to HIV patients. The study found that the participants believed that they had a great risk of acquiring HIV at the workplace because occupational exposures were frequent occurrences among them. The exposures occur through injuries with sharp materials and needles, exposure to body fluids, and contact with wounds during dressing. The participants also reported witnessing a number of their colleagues experiencing the exposure accidents. This indicates that occupational exposure was common in the healthcare setting.

Among the reasons why the exposure incidents are rampant in the study setting were 1) medical interventions were related with blood and other body fluids and the use of sharp materials, 2) the health professionals were generally less careful while caring for those patients thus compromising their own safety, and 3) poor team work among the HCWs. The participants were worried about the inadequacy of protective materials, such as gloves, gowns, goggles and aprons. These materials are essential in the prevention of occupational exposures. The participants perceived that the inadequacy of protective materials was the main reason for the high incidence of the occupational exposure among them. Despite all the associated risks however, the study revealed that the participants reported that they do not discriminate in the care they provide to the HIV/AIDS patients. This is in contrast to the finding of Esewe et al. (2017) which revealed that nurses caring for HIV/AIDS patients expressed unwillingness to care for the HIV/AID patients because of the fear of being infected with HIV through occupational exposures. It is imperative that nurse and hospital managers endeavour to provide adequacy protective materials to the nurses to enable them protect themselves against occupational exposures, and hence minimize their risk and fears of HIV infection.

A study by Tazakori et al. (2017) also revealed that nurses who care for HIV/AIDS patients in Ardabil, Iran, experience intractable challenges, fear of infection, and stress when caring for these patients. Similar findings were also made by Rahimi et al. (2017) in their study that described nurses' experiences about acceptance of HIV/AIDS patients in Ardabil, Iran, and by Koto and Maharaj (2016) in their study to explore the difficulties facing HCWs in Lesotho. Likewise, studies by Nanayakkara and Choi (2020), Huq, Moriyama, Harris, Shirin, & Rahman, (2019), and Leyva-Moral et al. (2016) revealed that nurses caring for HIV/AIDS patients in Sri Lanka, Spain, and Barbados respectively were anxious about the possibility of being infected with HIV while providing care to the patients.

2.2.2 Work-related stress and burnout

Work-related stress is described as the physical and emotional outcomes that occur when there is a discrepancy between the demands of an individual’s job and the amount of control the individual has in meeting those demands (Khamisa et al., 2015; Manabete et al., 2016; Ojekou & Dorothy, 2015). According to the WHO (2020a), work-related stress is “the response people may have when presented with work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope.” Work-related stress therefore occurs anytime the demands or pressures of work on an individual exceed the individual's physical, emotional, social or psychological capabilities in meeting those demands and/or in performing his or her functions.

Although work-related stress manifests in all jobs, it is of much concern among HCWs. HCWs who work in the hospital setting are deemed to be especially at risk of developing work-related stress due to the inherent characteristics of their work (Akbar et al., 2016; Gonçalves et al., 2019; Urooj, 2012). Among HCWs, nurses' caregiving roles expose them to work-related stress because of the physical labour, exposure to human suffering, long working hours, poor staffing, increased involvement with their patients and the patients' families and friends, over identification with the patients, and dealing with death and bereavement issues, that are central to their work (Ojekou & Dorothy, 2015; Urooj, 2012).

Prolonged exposure to stressful working environments leads to burnout. Burnout therefore, according to the (UNAIDS, 2000), is not an event but a process in which unmitigated, everyday stresses and anxieties gradually undermine the carer's mental and physical health, so that eventually, care-giving and personal relationships suffer. Whereas Khamisa et al. (2015) described burnout as a state of physical and emotional depletion, Koutsimani et al. (2019) explained that burnout a psychological syndrome characterized by emotional exhaustion, feelings of cynicism and reduced personal accomplishment. The 11th revision of the WHO's International Classification of Diseases (ICD-11), defined burnout as "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed" (WHO, 2019b). Burnout, according to WHO (2019b), is characterised by three dimensions -

exhaustion, reduced professional efficacy, and increased mental distance from one's job or feelings of cynicism or negativism about one's job.

Researchers have identified that work-related stress is a challenge for the nursing profession (Campbell et al., 2011; Faremi et al., 2019; Veda & Roy, 2020). The available literature is replete with empirical evidence that nurses who provide care to HIV/AIDS patients commonly experience work-related stress (Bhembe & Tsai, 2019; Mammbona & Mavhandu-Mudzusi, 2019; Mamukeyani, 2021; Mohangi & Pretorius, 2017; Pan et al., 2022). Although caregivers of people diagnosed with all terminally ill diseases face similar issues and stressors, unique characteristics of HIV/AIDS care such as the secondary stigma associated with working with a stigmatizing disease like HIV, identification and emotional involvement with the patients, absence of a cure for AIDS, the intensity of the epidemic worldwide and its high prevalence, the fear of infection through occupational exposure, exposure to death and dying of the clients and dealing with bereavement issues and the grieving family and friends of the patients, make the caregivers of HIV/AIDS patients more susceptible to work-related stress and burnout (Mangal, 2015; Qiao et al., 2016; Urooj, 2012). Studies into the provision of care for HIV/AIDS patients revealed that, the burden of providing such care is challenging and a source of stress and burnout to the caregivers (Kim et al., 2018; Koto & Maharaj, 2016; Mangal, 2015; Mohangi & Pretorius, 2017).

A phenomenological study conducted by Wright (2016) to explore the lived experiences of registered nurses caring for HIV/AIDS patients in the United States of America (USA), also revealed high levels of stress and burnout among the nurses. High levels of work related stress was also found among nurses caring for HIV/AIDS patients in Botswana (Fako et al., 2013). Similar findings were made among HCWs caring for HIV/AIDS patients in China, Lesotho, and South Africa (Qiao et al., 2016; Wu et al., 2013; Koto & Maharaj, 2016; Hlengwa, 2010; Malatji, 2010; Campbell et al., 2011) where the researchers found that nurses who care for HIV/AIDS patients experienced high levels of work-related stress. Mangal (2015) also found that nurses and other caregivers of HIV/AIDS patients are more prone to experiencing work-related stress and burnout, as well as compassion fatigue by virtue of being in regular direct contact with HIV/AIDS patients.

Akintola, Hlengwa, and Dageid (2013) also conducted a cross-sectional, exploratory survey to investigate the level of stress and factors contributing to stress and the predictors of burnout among volunteer caregivers working in AIDS care in South Africa. The results of the study revealed that most of the caregivers had moderate-to-high levels of stress. A related descriptive cross sectional study was conducted by Malatji (2010) to determine the prevalence of high stress levels among HCWs caring for HIV/AIDS patients in HIV clinics in the Polokwane Municipality in South Africa. The study involved 44 HCWs recruited from four different clinics in the study setting. A self-administered questionnaire consisting of demographic information, the Maslach Burnout Inventory, the AIDS Stress scale and the stressors and rewards of HIV/AIDS work was used to collect data. Majority (46%) of the participants were nurses, followed by lay counsellors (25%). The results of this study revealed that more than half (52%) of the respondents had high levels of emotional exhaustion and depersonalization. A total of 27% of HCWs had moderate to severe AIDS stress as measured by AIDS Stress Scale.

A qualitative study done in Tanzania by Mubekapi (2012) also revealed that nurses involved in caring for HIV/AIDS patients experience work-related stress. The aim of the study was to explore and describe nurses' workplace stressors and coping strategies with regards to HIV/AIDS caregiving in Geita District Hospital, Tanzania. Using a semi-structured interview guide, face-to-face interviews were conducted to collect data which were analysed using a thematic content analysis. The findings further revealed that the nurses struggle with issues of death and dying, they feared occupational exposure, and found it difficult to cope with nursing shortage, increased workload and inadequate training on HIV/AIDs care. The nurses were generally disturbed by lack of organisational support and the unavailability of resources such as basic medical supplies and protective equipment. A descriptive cross-sectional study by Oyeyimika et al. (2020) to assess the caregiver burden, quality of life and coping mechanisms among caregivers of children living with HIV/AIDS who attend ART clinics for children in Lagos State, Nigeria, also revealed severe psychological distress among the caregivers.

A survey conducted by Coetzee et al. (2013) involving 1,187 South African nurses, found that the levels of emotional exhaustion as measured by the Maslach Burnout Inventory (MBI) were high among nurses in both public and private hospitals. Similarly, high levels of stress and burnout were found among a sample of 126 volunteer caregivers to PLWHA in 13 semi-rural communities in Durban, South Africa (Akintola et al., 2013). Moderate to high levels of emotional exhaustion (75.8%) with correspondingly high levels of depersonalisation (71.5%) were also found among 165 registered nurses from an academic hospital in Johannesburg, South Africa (Bruce & Sangweni, 2012). Quantitative data for Bruce and Sangweni's (2012) study were collected from the randomly selected sample of

Registered Nurses using a Job Satisfaction Scale and the Maslach Burnout Inventory (MBI). Data were analysed using Chi-square and Fisher's exact tests to determine the significance (at 0.05) of associations between job satisfaction variables and the dimensions of burnout, viz., emotional exhaustion, depersonalisation and personal accomplishment. Caregivers of HIV/AIDS patients in Kenya were also found to experience work-related stress and burnout because of the challenges and difficulties they face while taking care of these patients (Marete, 2018).

A high level of work-related stress was also reported by Mwinga and Mugala (2015) among a group of Zambian nurses. The qualitative study was conducted with the purpose of determining the prevalence and causes of stress amongst nurses at Ndola Central Hospital, situated in Ndola District, on the Copperbelt province of Zambia. It was found that almost all (93.4%) of the 183 randomly selected nurses had experienced high levels of work-related stress which in many cases was accompanied by a number of emotional and physical symptoms such as sleep disturbances and recurring headaches.

A cross-sectional survey was conducted by van der Colff and Rothmann (2014) with the objective of identifying occupational stressors among professional nurses in South Africa. A stratified random sample of professional nurses (*n*=818; females = 97%) in hospitals in South Africa was used. The Nursing Stress Indicator (NSI) was administered together with a biographical questionnaire. Three internally consistent stress factors, namely lack of organisational support, job demands and nursing-specific demands, were identified. The most severe stressors for professional nurses included staff shortages, inadequate salaries and excessive administrative duties. Similarly, in a cross-sectional study that examined associations between occupational stress and burnout among 368 HCWs who cared for PLWHA in Eswatini (former Swaziland), Bhembe and Tsai (2019) found that the HCWs reported higher scores of work-related stress including effort, over commitment, and effort-reward ratio than HCWs in other developing countries.

Moshidi et al. (2021) also conducted a qualitative, descriptive and exploratory study with the purpose of developing a model for the care and support of professional nurses who provide health care to HIV/AIDS patients in the public hospitals of the Limpopo Province in South Africa. To develop the model however, the researcher had to first explore and describe the experiences of the professional nurses regarding the care and support they receive while caring for the HIV/AIDS. The study population were professional nurses in five public hospitals from each district of the Limpopo Province. These hospitals were selected because they all shared similar characteristics of having clinics where HIV and AIDS patients receive care. A sample size of 20, determined by data saturation, was purposively selected. Data were collected using audiotaped face-to-face interviews and were analysed using an open-coding method in accordance with Tech’s qualitative data analysis method.

The research findings revealed that the nurses experienced emotional and physical strain, exhaustion, fatigue, work-related illnesses, and increased levels of stress. The current study is similar to that of Moshidi et al. (2021) because it also used the qualitative, phenomenological, exploratory and descriptive approach to explore the lived experiences of the nurses caring for HIV/AIDs patients in selected hospitals in the Accra Metropolis of Ghana with a view of making recommendations aimed at developing support systems to help the nurses cope with challenges associated with the caregiving role. Again, like the study by Moshidi et al, the hospitals selected for the current study have the similar characteristics of having wards specifically designated for the care of HIV/AIDS patients.

A study by Mangal (2015), which explored the impacts of care giving on the wellbeing of caregivers of PLWHA in Canada, revealed that the caregivers were confronted with, and experienced stressors such as burnout, compassion fatigue, and secondary traumatic stress due to having direct and close relationships with the PLWHA in their care. Ndou (2017) also found that caring for patients in general, and HIV/AIDS patients in particular is very exhausting emotionally and physically. She opined that this situation is made worse by the lack of support and resources available to the caregivers, and the effects of the increased workloads on the caregivers. Similarly, Urooj (2012), found that nurses and other HCWs involved in caring for HIV/AIDS patients often end up being physically and emotionally exhausted, due to the numerous challenges they face while caring for the patients.

A qualitative study conducted in Zimbabwe to explore the psychosocial impact of caregiving on the family caregivers of chronically ill HIV/AIDS patients also revealed that the caregivers experience physical exhaustion (Deventer & Wright, 2017). This corroborates the findings of a previous study, also conducted in Zimbabwe, by Chikukwa (2012). The qualitative study which examined the experiences of caregivers of HIV/AIDS patients in the Masvingo urban area in Zimbabwe revealed that caring for the HIV/AIDS patients was emotionally, psychologically, physically, and socially exhausting during the period of caring as well as in grief and bereavement.

A related cross-country study by Hamama, Tartakovsky and Patrakov (2016), compared the attitudes of HCWs (physicians, nurses, and counsellors) from Israel, Russia and Kazakhstan toward PLWHA and their sense of burnout. The findings of the study revealed that the HCWs felt emotionally drained from their work as caregivers of the PLWHA. Similarly, a cross-sectional descriptive study conducted in a regional hospital in the Limpopo province of South Africa by Makhado and Davhana-Maselesele (2016) found that emotional exhaustion was common among all levels of nurses caring for HIV/AIDS patients. Feelings of frustration and other negative experiences such as resignation, inadequacy, helplessness and anger are part of the negative experiences of nurses caring for HIV/AIDS patients (Piculell & Wikander, 2012; Valjee & van Dyk, 2014).

A study that employed qualitative, descriptive, explorative and contextual designs was conducted by Ndou et al. (2014) to explore the challenges experienced by professional nurses caring for patients diagnosed with AIDS-related illnesses to hospital in the Tshwane District, Gauteng Province, of South Africa. The study involved all professional nurses working in units in the hospital where patients diagnosed with AIDS related illnesses are cared for. Data were collected through in-depth individual interviews conducted using semi-structured interview guide and analysed by means of Tesch's open coding method. The findings of the study revealed that the nurses experienced physical and psychological challenges whilst caring for patients diagnosed with AIDS-related illnesses. These experiences led to stress and burnout because the management of the hospital was unwilling to respond to the professional nurses’ challenges. Similarly, after conducting a study that sought to find out the psychosocial impact of HIVAIDS care giving among the primary care givers in Mombasa County, Kenya, Muthoni (2017) found that the caregivers suffered from stress and stigma that affected them psychologically and socially.

Similar findings were made by Ramathuba and Davhana-Maselesele (2013) whose study also revealed that nurses who provide care to HIV/AIDS patients are subjected to unique sources of care giving stress such as physical strains like developing back aches due to lifting the patients, and changing their position in bed. They also experience psychological stress as they fail to cope with witnessing the suffering and death of the patients. These stressful situations, according to Haoses-Gorases et al. (2013), and Campbell et al. (2011), have the potential to make the nurses feel overwhelmed or helpless and put them at increased risks for mental or physical illness.

From this review, it is obvious that there is high prevalence of work-related stress among nurses who provide care to HIV/AIDS patients. The work-related stress experienced by these nurses does not only have an impact on the physical and psychosocial wellbeing of the nurses but could also compromise the quality of care they provide to the HIV/AIDS patients (Mohangi & Pretorius, 2017; Pan et al., 2022). It is therefore imperative that, as posited by Vernekar and Shah (2018), Gheshlagh et al. (2017), Johan, Sarwar, & Majeed, (2017), and Mulaudzi, Pengpid, & Peltzer, (2011), nurse and hospital managers provide support systems for the nurses, and develop stress reduction programmes that will help build a stress-free work environment that could promote the wellbeing of the nurses and ensure that the patients receive adequate care.

The foregoing review focused on work-related stress and burnout among nurses and other caregivers of HIV/AIDS patients. The next sub-section is dedicated to a review of literature on the sources of the work-related stress and burnout experienced by the nurses and other caregivers of HIV/AIDS patients.

2.2.2.1 Sources of work-related stress and burnout

The work-related stress and burnout encountered by nurses caring for HIV/AIDS patients originate from varying sources. Some of these are: work overload, constantly witnessing the suffering and death of the patients, and over-involvement and identification with the patents.

2.2.2.1.1 Work overload

Tong et al. (2019) conducted a qualitative study to examine the sources of work-related stress experienced by HCWs who provide medical care for PLWHA in Guangxi, China, and the impact of the said stress on their well-being and the performance of their work. In-depth interviews were conducted with 46 participants. The interviews were audio-taped, transcribed, and imported into NVivo V.11 for data management and analysis using a thematic approach. The findings categorised the key sources of work-related stress experienced by the HCWs into general work-related sources and HIV/AIDS-related sources. The general work-related sources of stress identified by the study included heavy workload, working overtime, large patient volume, and unrealistic work demands A high level of work-related stress was also found among nurses caring for HIV/AIDS patients in the Vhembe district of the Limpopo Province in South Africa (Mammbona & Mavhandu-Mudzusi, 2019). This was attributed to factors such as; the demanding nature of nursing the HIV/AIDS patients, most of whom were admitted to the hospital bedridden and critically ill thus requiring constant observations.

A related descriptive qualitative study was conducted by Pan et al. (2022) among nurses working in the AIDS department of a public, general hospital, which has the largest HIV care department in the Hunan Province of China. The purpose of the study was to explore the work-related stress experienced by the nurses caring for HIV/AIDS patients, the source and impact of the stress, and the coping strategies the nurses employed to deal with the stress. Using a purposive sampling technique, 33 nurses working in the AIDS department were recruited through flyers posted in the wards and clinic of the department. Data were collected through a focus group (n = 8) followed by semi-structured individual in-depth interviews (n = 25). The audiotaped recordings of the focus group and in-depth interviews were transcribed verbatim and analysed with the aid of a qualitative data analysis software package, NVivo 8.0. The findings revealed that the nurses experienced high levels of work-related stress which was attributed to heavy workload, mental health problems and risk behaviours of the patients.

Other studies also identified work overload as one of the major sources of the work-related stress and burnout encountered by nurses carrying for HIV/AIDS patients (Koto & Maharaj, 2016; Mamukeyani, 2021; Valjee & van Dyk, 2014; van Dyk, 2007). In a study that investigated the predictors of three dimensions of burnout; namely, emotional exhaustion, depersonalisation and personal accomplishment, among South African nurses caring for HIV/AIDS patients, Roomaney, Steenkamp, and Kagee, (2017) revealed high levels of burnout among the participants. The study identified work overload, in addition to interpersonal conflicts at work, organisational constraints, job status and HIV/AIDS-related courtesy stigma, as the significant predictors of burnout among the participants. Similarly, a cross-sectional, exploratory survey by Akintola et al., (2013) to investigate the level of stress, factors contributing to stress, and the predictors of burnout among volunteer caregivers working in AIDS care in South Africa, also identified role or work overload, lack of support, and the overwhelming nature of HIV/AIDS as the factors contributing to the work-related stress and the predictors of burnout among the caregivers.

A related qualitative study was conducted by Faremi et al. (2019) among nurses in two selected hospitals in a city in south-western Nigeria, to assess the frequency of stressful events among the nurses and how stressful they perceived those events to be. The findings of the study revealed that the most frequently stressful aspects of the nurses' work included work overload, inadequate staff to cover the work load in the wards.

Similarly, a qualitative, descriptive, exploratory study was conducted by Moshidi et al. (2021) to explore and describe the experiences of professional nurses caring for HIV/AIDS patients in public hospitals of the Limpopo Province in South Africa. The findings of the study revealed that the nurses experienced emotional and physical strain, exhaustion, fatigue, work-related illnesses and increased levels of work-related stress. The study revealed that these experiences were due to shortage of staff, and heavy workload which was aggravated by staff turnover and high absenteeism. A similar study by Sanches et al. (2018) also found that stressors such as work overload, lack of resources, difficulty in meeting the patients' expectations, and need to deal with the death of patients, and the fear of infection are present in the daily lives of nurses caring for HIV/AIDS patients, and may result in the occurrence of work-related stress and burnout.

2.2.2.1.2 Constantly witnessing the suffering and death of the patients

Constantly witnessing the suffering and death of patients is another source of the work-related stress experienced by nurses caring for HIV/AIDS patients. It has been found that most often, the HIV/AIDS patients are admitted to the hospital when they are terminally ill and therefore, they die either immediately, or a few days on admission to the hospital (Moshidi et al., 2021). The nurses who care for these patients therefore, on a regular basis, go through the emotional trauma of witnessing the suffering and death of the patients, as well as the grieving of the bereaved family members of these patients (Bam & Naidoo, 2014; Demmer, 2009; Ramathuba & Davhana-Maselesele, 2013; Valjee & van Dyk, 2014). This constitutes a source of work-related stress to them.

In a study that explored the lived experiences of nurses caring for terminally ill patients with AIDS in selected hospitals in South Africa, Bam and Naidoo (2014) also found that constantly witnessing the suffering and death of the HIV/AIDS patients generated feelings of helplessness, frustration, and stress among the nurses. The researchers further indicated that the nurses caring for HIV/AIDS patients are not only exhausted by the demanding nature of their work but also by the emotional burdens they carry. These experiences, according to Campbell et al., (2011), can put the nurses at greater risks for mental or physical illness. Similar findings were made by Valjee and van Dyk (2014) whose qualitative study, to investigate the effects of providing palliative care for PLWHA on the psychosocial well-being of the caregivers, also found that stressors inherent in AIDS care, such as constantly witnessing the suffering and dying of the patients was one of the sources of work-related stress experienced by the nurses.

A related study by Mashau and Davhana-Maselesele (2009) also revealed that the caregivers of HIV/AIDS patients expressed the emotional distress of constantly witnessing the suffering and death of the patients under their care. Findings of the study further indicated that HIV and AIDS caregivers carry an immeasurable burden because when their patients suffer, they also suffer, and this suffering is characterised by feelings of helplessness and despair. Mammbona and Mavhandu-Mudzusi (2019) revealed that the work-related stress experienced by nurses caring for HIV/AIDS patients is worsened by the nurses witnessing the death of neighbours and relatives admitted to the wards where they are working. A similar finding was made by Anshasi et al. (2020). Similarly, Davhana-Maselesele and Igumbor (2008) revealed that nurses caring for HIV/AIDS patients felt frustrated by their inability to help the terminally ill AIDS patients and were subsequently affected by their death.

2.2.2.1.3 O*ver-Involvement and Identification with the* HIV/AIDS Patients

Nurse-patient intimacy, nursing care that involves psychological, emotional and/or physical closeness between the nurse and the patient, is considered vital to the well-being and recovery of the patient (Williams, 2001). There are however implications of such closeness for the nurses since it leads to the nurses' over-involvement with the patients (Stavropoulou et al., 2012). Over-involvement is a term often used in nursing practice to describe a nurse's excessive personal investment in a patient's fate (Collins, 2007; Dowling, 2006). The phenomenon of over-involvement relates to John Bowlby's attachment theory (Bowlby, 1973).

Over-involvement and identification with the HIV/AIDS patients occur because the caregivers spend a great deal of their working lives interacting closely with the HIV/AIDS patients on admission and thus become emotionally attached to them (Koto & Maharaj, 2016). Shirinda-Mthombeni (2014) found that caregivers of HIV/AIDS patients often over-identify with their patients and often could not make a clear distinction between their work and their private lives. They find it very difficult when their patients are very sick and thus end up thinking about them even when they are not on duty. Over-involvement can cause unrealistic expectations that are detrimental to the patient, the nurse and the healthcare institution. The phenomenon of nurses' over-involvement and identification with patients have been identified as one of the sources of the work-related stress and burnout experienced by nurses involved in caring for HIV/AIDS patients (Bam & Naidoo, 2014; Ramathuba & Davhana-Maselesele, 2013; Valjee & van Dyk, 2014).

In a study that investigated difficulties faced by HCWs in the era of AIDS treatment in Lesotho, Southern Africa, Koto and Maharaj (2016) also found that, because they over-identify with the patients, HCWs feel sad for their patients because there is no cure for AIDS even though treatment is available. Similar findings were made by Puplampu (2017) among nurses caring for HIV/AIDS patients in a Ghanaian hospital. Valjee and van Dyk (2014) also conducted a study to assess the impact of caring for PLWHA on the psychosocial well-being of palliative caregivers in KwaZulu-Natal, South Africa. The study revealed that the caregivers seemed to over-identify with patients of a similar age or those with children of a similar age to their own, or who had similar life experiences. The emotional impact on the caregivers is more when they lose very young patients because they also have children of the same age. Many caregivers also expect their involvement with the HIV/AIDS patients to have a positive effect on the health and happiness of the patient. The American Medical Association (2018) revealed that this may be an unrealistic expectation and could cause frustration to the caregivers.

Mubekapi (2012) conducted an exploratory-descriptive, qualitative study into the workplace stress and coping strategies among nurses in HIV/AIDS care in a Tanzanian district Hospital. She found that direct contact of the nurses with patients over long periods facilitated the development of a nurse-patient and family personal relationship, particularly the chronic ones that stay in hospital for a very long time. This emotional attachment made it difficult for some nurses to deal with patients' death. The study further found that the death of the patients evokes arrays of emotions such as hopelessness and helplessness among some of the nurses.

A mixed method research was conducted by Hatzipapas, Visser, & Rensberg, (2017) to understand the emotional experiences of community care workers taking care of HIV-affected families in the greater region of Soweto, South Africa. The findings of this study also revealed over-identification and involvement with the PLWHA as a source of stress for the caregivers. The researchers stated that the stress often generated unresolved emotional issues for the caregivers and results in sleepless nights and intense sadness. These emotional issues experienced by the caregivers, confirm the concept of separation anxiety described in the attachment theory by Bowlby (1973).

The over-identification and involvement with PLWHA and its attendant work-related stress often generates unresolved emotional issues for the caregivers, resulting in sleepless nights and intense sadness (Hatzipapas et al., 2017), affects their psychological well-being, and directly influencing their ability to provide effective services to the care recipients (Corey, 2009). It is therefore important, for the self-preservation of care workers and for their emotional survival, that they should take care of themselves (Van Dyk, 2013). To achieve this, it is imperative that the caregivers of HIV/AIDS patients endeavour to make a clear distinction between their work and their private lives, and hence limit their personal over -involvement and identification with the PLWHA.

In summary, the available literature revealed that work-related stress and burnout is one of the major challenges experienced by nurses and other caregivers of HIV/AIDS patients. Numerous factors, notably, the fear of being infected with HIV through occupational exposure, work overload, constantly witnessing the suffering and death of the patients, and the caregivers' over-involvement and identification with the HIV/AIDS patients have been identified in the literature as some of the major sources of the work-related stress and burnout experienced by the caregivers. The preceding section of the review is focused on the nurses' and other caregivers' experiences of HIV/AIDS-related stigma and discrimination.

2.2.3 HIV/AIDS-related stigma and discrimination

Goffman (1963), defined stigma as "an attribute that is deeply discrediting" and that reduces the discredited person "from a whole and usual person to a tainted, discounted one". Earnshaw and Chaudoir (2009) also defined stigma as a significantly discrediting attribute which serves to devalue people who possess it, resulting in status loss and social rejection (Phelan, Lucas, Ridgeway & Taylor, 2014). Discrimination on the other hand is the negative acts that result from stigma which serve to devalue and reduce the life chances of the stigmatized person (Famoroti, Fernandes & Chima, 2013). Stigma and discrimination are associated with many chronic health or infectious conditions; including leprosy, mental health, tuberculosis, and HIV/AIDS (Asampong et al., 2018; Knifton, 2012; Oleniuk, Duncan, & Tempier, 2013; Stangl et al., 2019), and lately, Covid-19 (van Daalen, Cobain, Franco, & Chowdhury, 2021). HIV/AIDS has however been identified as one of the most feared and stigmatized diseases in recent history (Des Jarlais, Galea, Tracy, Tross, & Vlahov, 2006; Idemudia et al., 2018; Tsai et al., 2017).

HIV-related stigma and discrimination, defined by the UNAIDS as the prejudice, negative attitudes and abuse directed at PLWHA (UNAIDS, 2015), has been present since the advent of the HIV/AIDS pandemic (Senzanje, 2011) and is among the greatest challenges faced by PLWHA globally (Fauk, Ward, Hawke, & Mwanri, 2021; Tran et al., 2019). It has been found to have numerous negative consequences for the PLWHA (Li, Morano, Khoshnood, Hsieh, & Sheng, 2018). Nurses and other caregivers of HIV/AIDS patients are also known to experience HIV-related stigma by virtue of their association with the HIV/AIDS patients (Hedge et al., 2021; Njau et al., 2015; Wu et al., 2016). This type of HIV-related stigma, experienced by nurses and other caregivers of HIV/AIDS patients by virtue of their association with these patients, and PLWHA in general, is referred to as courtesy stigma, secondary stigma, or stigma by association (Goffman, 1963; Florom-Smith & De Santis, 2012; Philip, Chadee, & Yearwood, 2014). Phillips, Benoit, Hallgrimsdottir, and Vallance (2012) described courtesy stigma as the public disapproval evoked as a consequence of associating with a stigmatised individual or group. It encompasses public negative judgment as a result of associating with a stigmatized individual or group (Mensah, 2018; Philip et al., 2014). Available literature revealed that HIV-related courtesy stigma is widespread among HCWS.

Studies conducted in the USA (Parks & Smallwood, 2021), United Kingdom (Hedge et al., 2021), China (Wu et al., 2016), Haiti (Surkana et al., 2010), and Thailand (Washington & Oberdorfer, 2013) revealed that caregivers of HIV/AIDS patients, including nurses, experience stigma and discrimination because of their association with the HIV/AIDS patients. Similar findings were made by other researchers. A cross-sectional survey involving 358 caregivers from five hospitals across KwaZulu-Natal, South Africa was conducted by (Singh et al., 2011). The findings revealed that 49 (13.7 %) of the caregivers personally experienced stigma and discrimination as a result of caring for HIV/AIDS patients.

In a related study, Haber, Roby, and High-George (2011) adopted the mixed method exploratory design to examine stigmatisation of HCWs in HIV/AIDS care based on their association with PLWHA. The researchers tested the hypotheses that HCWs caring for HIV/AIDS patients experience stigmatisation due to their association with PLWHA, and that the courtesy stigma they experience is correlated with thoughts of leaving the HIV/AIDS field. A sample of 100 participants who provided direct care to PLWHA was recruited from a variety of public and private HIV/AIDS care centres in the Eastern Cape province of South Africa. The participants attended one of 12 focus groups held between June and August, 2008. They completed a 17-item questionnaire and discussed each item. Findings of the study revealed the presence of an adverse differentiation and labelling of the HCWS caring for HIV/AIDS patients, leading to status loss and discrimination, creating a motivation for the HCWs to leave AIDS work altogether.

Lekganyane (2016) also conducted a qualitative study aimed at exploring and describing South African Home-Based Caregivers' (HBCGs') experiences of, and coping strategies with courtesy stigma as one of their work-related challenges. Twenty-five HBCGs who met the inclusion criteria were identified and recruited, through the purposive and snowball sampling technique, from the Gauteng, Limpopo and the North West provinces. The tool for data collection was a semi-structured interview guide with open-ended questions. In-depth, face-to-face individualised interviews conducted in indigenous languages (Setswana, Northern Sotho and Zulu) were used to generate data for the study. The interviews were transcribed and translated form the indigenous languages into English, and analysed using Tesch's eight steps of data analysis. Findings from the data analysis revealed that the participants indicated they were undermined, devalued, mocked and avoided by community members, labelled, and even insulted due to their association with the PLWHA.

A study by Hedge et al. (2021) also revealed that nurses caring for HIV/AIDS patients were shunned by their colleagues working in other departments of the hospital, and they did not want them in the hospital canteen. Studies by Parks and Smallwood (2021), and Lekganyane (2016) revealed that the HCWs reported experiencing courtesy stigma which is manifested in the negative treatment from the community members who perceived them (the HCWs) to be HIV positive. The available literature thus provided evidence that HCWs in general, and nurses in particular as well as other caregivers of HIV/AIDS patients and other PLWHA do experience HIV/AIDS-related courtesy stigma because of their association with the PLWHA.

In the Ghanaian setting, a descriptive qualitative study was conducted by Afful et al (2019) among family caregivers of children living with HIV who accessed healthcare at the Princess Marie Louise Hospital in Accra. The aim of the study was to explore the care related experiences of Ghanaian family caregivers of children living with HIV. The purposive sampling method was used to select 15 participants for the study. In-depth one-on-one interviews, conducted using an interview guide, was used to collect data which were analysed using the qualitative data analysis software, NVivo. The approach used was thematic content analysis. Among other findings, the study revealed that the participants' fear of HIV-related courtesy stigma had reportedly resulted in social isolation of some family caregivers. It was found that most of the caregivers consciously lived in secrecy and were unwilling to share information with family members concerning the condition of their HIV positive children. The findings of the study further revealed that the fear of courtesy stigma affected the life choices of some of the participants. For instance, some of them reported employing stringent measures such as relocating with their HIV-positive children in order to distance themselves from family members and friends because of the condition.

A related study done in the Ghanaian context was conducted by Mensah (2018) with the objective of exploring stigma among formal HIV care providers in the Tema Metropolitan Area. The study employed a qualitative design and used in-depth interviews to collect data from the healthcare providers caring for HIV patients in the health facilities. The results of the study revealed that the formal HIV care providers experience HIV- related courtesy stigma socially and institutionally mainly from their co-workers working in different units and departments of the hospital. The study further revealed that the stigma experienced by the caregivers originated from misconceptions, ignorance and the fear of being infected with HIV. The study also revealed that the health care providers experienced neglect and rejection which were exhibited as differential treatment, body gestures, avoidance and tagging or labelling. Unlike Mensah (2018) study which explored a specific domain of the lived experiences of nurses caring for HIV/AIDS patients, that is stigma among HIV care providers in health facilities at the Tema Metropolitan Area in Ghana, the current study did a holistic exploration of the lived experiences of nurses caring for HIV/AIDS patients in the Accra Metropolis in Ghana and this included an exploration of their experiences of courtesy stigma.

Similarly, Puplampu (2017), found that nurses who care for HIV/AIDS patients feel stigmatized by their family members, friends, and even their co-workers. These findings correspond to those of an earlier study by Mwinituo and Mill (2006) which also revealed that the caregivers of HIV/AIDS patients in Accra, Ghana, experienced extensive courtesy stigma and discrimination from their close family members and even HCWs.

2.2.4 Inadequate resources

Adequate healthcare resources, comprising human resources (adequate staff) and material resources (adequate physical resources) namely; adequate equipment and appropriate physical infrastructure, are key for the provision of quality nursing care to patients (Matakanye, Ramathuba, & Tugli, 2019; Rivaz, Momennasab, Yektatalab, & Ebadi, 2017). This view was shared by Kieft, de Brouwer, Francke, and Delnoij (2014) who also mentioned adequate staffing as one of the essential elements that would improve the quality of nursing care provided to patients. According to Mammbona and Mavhandu-Mudzusi (2019) however, nurses who care for HIV/AIDS patients often experience the challenge of working with inadequate human and material resources.

In a study that explored the experiences of enrolled nurses caring for HIV/AIDS patients at a public rural community hospital in the Vhembe district of the Limpopo Province, South Africa, Mammbona and Mavhandu-Mudzusi (2019) revealed that there were very few nurses compared to the large number of patients admitted to the wards with HIV/AIDS related illnesses. The study also revealed that there was shortage of protective materials such as goggles, aprons, gloves and face masks that the nurses need to protect themselves against the risk of HIV infection through occupational exposure to body fluids of the patients. Similar findings were also made by Moshidi et al. (2021) and Ndou (2017) whose studies, which explored the experiences of nurses caring for HIV/AIDS patients in public hospitals in the Limpopo Province, and the Tshwane District of Gauteng respectively, in South Africa, also revealed inadequate resources as one of the challenges experienced by the nurses.

The findings of the above studies also correspond to those of studies by Haoses-Gorases et al. (2013), Berg and Nilsson (2015), Erkki and Hedlund (2013), and Mutemwa et al. (2013) which also found that shortage of staff in the face of increasing numbers of patients admitted with HIV/AIDS-related conditions, and lack of materials such as PPES are challenges encountered by nurses caring for HIV/AIDS patients. The lack or inadequacy of these resources has been found to have adverse effects on the care provided by the nurses to the HIV/AIDS patients. Rivaz et al. (2017) stated that imbalanced workloads, inappropriate nurse-patient ratios, and inadequate physical resources negatively affect nurse’s perceptions of the quality of the nursing practice environment. This will invariably affect the quality of care. Mammbona and Mavhandu-Mudzusi (2019) therefore recommended that nurses caring for HIV/AIDS patients should be supported and equipped adequately to enable them provide quality care to the patients.

In a related study that analysed the burdens of caregivers providing care to people living with HIV/AIDS under the community home-based care (CHBC) programme in Botswana, Ama and Seloilwe (2011) found that the caregivers experience numerous physical, emotional, financial or social challenges during the caregiving process. In spite of these however, the researchers found that the caregivers challenges are hardly ever considered by the planners of CHBC programmes, and the caregivers receive very little support from organizers of the CHBC programme. Similarly, in a study conducted among nurses who provide treatment for HIV/AIDS and/or tuberculosis patients in a municipal hospital in Rio de Janeiro, Brazil, (dos Santos, Gomez, and de Oliveiraet (2014) identified lack of human and material resources as one of the challenges faced by the nurses. The study found that lack of adequate equipment, particularly PPEs weakens the nurses because it can increase their susceptibility to infections, whilst the lack of human resources also leads to interferences in the care they provide to the patients. Inadequate supply of material and human resources was also reported among Ugandan nurses, and this was found to be a hinderance to the practice of universal precautions by the nurses (Nderitu, Mill, & Ritcher, 2014).

A study by Koto and Maharaj (2016) among HCWs involved in HIV/AIDS care in Lesotho revealed that poor or inadequate infrastructure was one of the work-related difficulties faced by the nurses. A study by Matakanye et al. (2019) to determine the experiences of nurses caring for TB patients at a regional hospital in Limpopo

Province, South Africa also found that poor and aging infrastructure, which is in dire need of refurbishment, was a resource of challenge faced by the nurses. Similarly, Mamukeyani (2021) found that inadequacy of resources was one of the challenges experienced by caregivers of PLWHA in Raliphaswa village at Ndzhelele, Makhado municipality, within Vhembe District in Limpopo province, South Africa. These resources were needed by the caregivers to protect themselves against occupational exposure and hence minimise their risk and fears of being infected with HIV whilst caring for the PLWHA. The inadequacy of such resources therefore is a source of stress to the caregivers. A related study, also conducted in South Africa, by Mogakwe, Magobe and Ally (2020) also revealed that nurses were faced with challenges related to the resources they need to provide quality standard care to patients. The researchers therefore, as part of their recommendations, emphasised the need for the allocation of sufficient and appropriate human resources, and the provision of adequate medical supplies and equipment to the health facilities to enhance the provision of quality nursing care.

2.2.5 Inadequacy of support

It has been established that nurses and other caregivers of HIV/AIDS patients experience numerous challenges, related to their caregiving role, which impose a burden of care on them (Koto & Maharaj, 2016; Mammbona & Mavhandu-Mudzusi, 2019; Moshidi et al., 2021; Ndou, 2017). Because these experiences, if left unmitigated, could have detrimental effects on both the nurses, as caregivers; and the quality of care they provide to the HIV/AIDS patients under their care (American Medical Association, 2018; Garcia et al., 2019; Gibson, Costa & Sampson, 2017), it is imperative that the nurses are provided appropriate support systems to help lessen the effects of the work-related challenges on them.

Other researchers, such as Madi, Chandran, Chowta, and Ramapuram (2016), Chikukwa (2012), Pretorius (2013), and The American Medical Association (2018) also emphasised the need for hospital and nurse managers to provide support for nurses caring for HIV/AIDS patients, and called for the development of policies that can systematically address their needs in order to alleviate the negative consequences of the burden of caring for the HIV/AIDS patients. These support systems could be in the form of offering counselling services to the nurses, provision of debriefing sessions to give them the opportunity to verbalize their experiences, and the provision of adequate resources (Makhado & Davhana-Maselesele, 2016; Mammbona & Mavhandu-Mudzusi, 2019; Ramathuba & Davhana-Maselesele, 2013). In spite of these recommendations however, it has been indicated that the support for nurses caring for HIV/AIDS patients is often either totally lacking, inadequate, or done haphazardly (Mametja et al., 2013; Mammbona & Mavhandu-Mudzusi, 2019; Moshidi et al., 2021; Ndou, 2017).

In view of the fact that most public hospitals in African countries are taking care of a lot of patients with HIV/AIDS-related conditions which increase the burden of care on the HCWs, including nurses, Mammbona and Mavhandu-Mudzusi (2019) conducted a qualitative phenomenological study that explored enrolled nurses' experiences of caring for HIV/AIDS patients at a public rural community hospital in the Vhembe district of Limpopo Province, South Africa. The 11 participants, who met the inclusion criteria, were selected purposively, and data were collected through semi-structured individual face-to-face interviews using an interview guide. The data were analysed thematically following a framework for interpretative phenomenological analysis. The results revealed that, though the participants experienced negative circumstances during the process of caring for the HIV/AIDS patients; they received limited professional support from their supervisors and managers to equip them with adequate knowledge, they were not offered emotional support regardless of the daily trauma they experience by witnessing the death of patients, and their remuneration was not commensurate with the amount of work they do caring for the HIV/AIDS patients.

A related study was conducted at one of the academic hospitals of Tshwane District, Gauteng province in South Africa by Ndou et al. (2015) with the objective of exploring and describing the support provided by the hospital, nurse managers, and co-workers to professional nurses who provide care to HIV/AIDS patients. That particular setting was chosen because it was a hospital where professional nurses provided care to patients with AIDS related illnesses. The study was based on the background that professional nurses who provide nursing care to patients diagnosed with AIDS related illnesses are identified as a risk group in terms of being infected with HIV, and that they sometimes feel stressed when carrying out their caregiving functions. The researchers adopted the qualitative explorative and descriptive designs. Participants were recruited from a target population of professional nurses and nurse managers working in the hospital units where patients with HIV/AIDS related illnesses are cared for. The accessible population for the study were all professional nurses working in the hospital units where patients with AIDS related illnesses were admitted, and who gave consent to participate in the study.

A non-probability purposive sampling method was used to determine the sample of the study. Data were gathered through the use of in-depth individual interviews conducted using an un-structured interview guide. Tesch's open coding method of data analysis was used to analyse the data. The findings of the data analysis revealed that the professional nurses received ineffective support from the organisation, nurse managers and co-workers when they experienced challenges related to their caregiving functions to the patients. The researchers indicated that provision of an effective social and emotional support from the organization, nurse managers and co-workers to meet professional nurses' needs would have made them feel valued, cared for, and respected.

There are some similarities between the current study, and that of Ndou et al (2015). In the current study, the qualitative approach with phenomenological design was employed to explore the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana. It was based on the premise that nurses who provide care to hospitalised HIV/AIDS experience numerous challenges which, if left unmitigated, could impact negatively on the nurses physical and social wellbeing, as well as compromise the quality of care they provide to the patients. One of the specific objectives was to assess support systems available to help the nurses caring for HIV/AIDS patients to deal with their work-related challenges. The two hospitals selected were chosen because they have specific wards dedicated to the care of HIV/AIDS patients.

A related study conducted by Atukunda, Memiah, and Shumba (2013) also found that majority (67%) of health the facilities in Uganda did not have any polices or practices in place to recognize or relieve the work-related stress faced by staff caring for the HIV/AIDS patients. The study was conducted to assess and address issues associated with stress and burnout among HCWs providing HIV care in 18 HIV health facilities in Uganda. Similar findings were made by Mametja et al. (2013). Using the qualitative, descriptive and contextual method, Mametja et al. (2013) conducted a study aimed at describing the perceived problems experienced by professional nurses who provide health care to patients with HIV/AIDS in public hospitals of Polokwane municipality, Limpopo Province and to identify guidelines to support these professional nurses. Semi-structured, one-to-one interviews were conducted to generate the data which were analysed using Tesch's open-coding method. One of the major findings of the study was that the nurses caring for the HIV/AIDS patients do not receive any support from the hospital management; neither do the relatives of the patients show any appreciation to them for their efforts at caring for the patients. The study further revealed that there were no protocols in place to provide counselling services to the nurses who need counselling services so that they could develop better coping skills toward the work-related challenges they experience whilst caring for the patients.

In contrast to the above literature however, a study by Mabusela (2010) found that the management of an HIV/AIDS care centre in Mamelodi, South Africa, empathised with the caregivers at the centre and realised the need for providing adequate support for them. The management therefore engaged the services of a counsellor or psychologist to provide debriefing sessions for the caregivers every three months. The purpose of the debriefing sessions was to give the caregivers an opportunity to explore their emotions and frustrations in order to cope with their daily work-related challenges. The study revealed that the debriefing sessions assisted the caregivers in coping with their work-related challenges. It was further revealed that the debriefing sessions relieved the caregivers of the challenges they experienced whilst they provided care to the HIV/AIDS patients. Dartey (2016) in her study to develop an Employee Assistance Programme for midwives who experience maternal deaths in the Ashanti Region of Ghana, posited that there is hardly any known work-related assistance programme designed to support Ghanaian midwives when faced with work-related challenges likely to affect their work-output.

It is clear from the literature review in the preceding sections that the nurses and other caregivers of HIV/AIDS patients or PLWHA in general, experience numerous challenges during the process of caring for these patients or the PLWHA. These challenges and experiences identified in the literature included; the caregivers' fears of being infected with HIV through occupational exposure to the blood and body fluids of the patients, work-related stress and burnout, and HIV/AIDS-related courtesy stigma. The literature further revealed that the caregivers also face other work-related challenges and experiences such as inadequacy of human and material resources they need for their work, as well as the inadequacy of, and in some instances, a total lack of support for the caregivers. The review in the ensuing section focussed on the effects of the aforementioned challenges and experiences on the nurses, and their caregiving functions.

2.3 Effects of Work-Related Challenges on Nurses and their Work

The challenges encountered by nurses while caring for HIV/AIDS patients have negative effects on the nurses and their caregiving functions.

2.3.1 Effects of fear of HIV infection

The fear of being infected with HIV through occupational exposures to the blood and other body fluids of HIV/AIDS patients, is one of the major challenges experienced by nurses and other caregivers of HIV/AIDS patients (Akpuh et al., 2020; Beyene & Tadesse, 2014; Esewe et al., 2017). This fear has been found to have a number of negative effects on the lives of the nurses and the quality of care they provide to the patients. Mammbona and Mavhandu-Mudzusi (2019) found that the excessive fear of being infected with HIV, sometimes negatively affects the sexual lives of the nurses who provide care for HIV/AIDS patients. This, as reported by these researchers, leads to some of them resorting to giving excuses to their partners in order not to engage in sexual activities.

Similar to this, a study by van Dyk (2010) also revealed that the fear of HIV infection through occupational exposure has compelled the spouses of nurses caring for HIV/AIDS patients to urge their partners to quit their jobs so as to avoid spreading the infection to them and their children. Similar findings were also made by Ha, Chuc, Hien, Larson, & Pharis, (2013) among the family members of Vietnamese HCWs caring for HIV/AIDS patients. Other studies have also revealed that the fear of being infected with HIV through occupational exposure has even led to some nurses resigning from their jobs in order to avoid the infection (King & McInerney, 2006; Mammbona & Mavhandu-Mudzusi, 2019).

The fear of being infected with HIV through occupational exposure has also been found to increase the nurses' level of work-related exhaustion, and affect, negatively, their capacity to cope with human suffering (Strojek & Kolodziejczyk, 2018). Studies by Mammbona and Mavhandu-Mudzusi, 2019) among South African nurses, Hassan and Wahsheh (2011) among Jordanian nurses, and Feyissa, Abebe, Girma, and Woldie (2012) among Ethiopian nurses, revealed that some of the nurses caring for HIV/AIDS patients exhibit unethical or unprofessional attitudes towards the HIV/AIDS patients because of their fears of being infected with HIV. These unethical or unprofessional attitudes include; seeing the HIV/AIDS patients as a burden instead of seeing them as vulnerable people in need of care, reluctance to care for HIV/AIDS patients, avoiding the patients, or outright refusal to care for them, and discriminating against the HIV/AIDS patients. These unethical or unprofessional attitudes towards the patients because of the nurses' or caregivers' fears of being infected with HIV through occupational exposure, can compromise the quality of care the patients receive (Mabusela, 2010; Mametja et al., 2013; Mammbona & Mavhandu-Mudzusi, 2019).

2.3.2 Effects of work-related stress and burnout

Work-related stress and burnout among nurses caring for HIV/AIDS patients could have serious consequences for the nurses, as caregivers, the HIV/AIDS patients, as care recipients, and the health care institution (Strojek & Kolodziejczyk, 2018). It has been found that work-related stress and burnout could lead to the nurses' intentions to resign, or actual resignations from their jobs (Mammbona & Mavhandu-Mudzusi, 2019; Mosadeghrad, 2013; Vandenbroeck, Van Gerven, De Witte, Vanhaecht, & Godderis, 2017).

According to Ginossar et al. (2014), work-related stress and burnout has resulted in high turnovers among nurses. Mosadeghrad (2013), and Vandenbroeck et al. (2017) revealed that work-related stress and burnout also leads to lack of job satisfaction, a major reason for turnovers among nurses who care for HIV/AIDS patients. The high turnover of nurses in HIV/AIDS care could lead to a reduction in the number of nurses available to care for the increasing number of HIV/AIDS patients. A study by (Sanches et al., 2018) also found that work-related stress and burnout among caregivers of HIV/AIDS patients compromises the quality of care they provide to the patients. Similar findings were made by Tong et al. (2019) in their study which also revealed that work-related stress, among health care providers who provide medical care for PLWHA has a substantial impact on the care providers' individual well-being, family and social life, and quality of care they provided to the patients.

The results of a study by Strojek and Kolodziejczyk (2018) revealed that the caregivers of HIV/AIDS patients may develop physical, psychological, and behavioural symptoms such as: backaches, headaches, fatigue, insomnia (sleeplessness), anger and frustration, loss of interest in, and commitment to work, feelings of restlessness, depression, and anxiety about their future. Others may include emotional outbursts, withdrawal from friends and family, lateness to work and neglect of duty, decrease in judgmental ability, inability to focus on tasks, and impaired work performance. Kim et al. (2018) also identified decreased judgmental ability and difficulty focusing on tasks as symptoms of work-related stress and burnout manifested by nurses and other caregivers of HIV/AIDS patients. These are likely to have negatively affects the health of the caregivers as well as the quality of care they provide to the patients. Ramathuba and Davhana-Maselesele (2013) found that when nurses are stressed, they display diverse symptoms that affect their organisational efficiency and the effectiveness of their caregiving functions. A study by Asuquo, Etowa, and Adejumo (2013) among Nigerian HCWs caring for HIV/AIDS patients revealed that caring for these patients is very challenging to the caregivers and produces ill effects such as fatigue and exhaustion on their physical health.

In a study among Iranian nurses, Mosadeghrad (2013) explored the status of work-related stress, and also examined the relationship between the nurses' work-related stress and their intention to leave their jobs. The study found that, due to the high levels of work-related stress experienced by the nurses, more than 35% of them were considering leaving the hospital if they could find another job opportunity. A related study conducted by Vandenbroeck et al. (2017) among Belgian nurses also found that high levels of work-related stress and burnout; (1) correlates with the emotional exhaustion of the nurses, (2) is strongly related to the nurses' poor health and their intention to leave their jobs, (3) decrease the caregivers' level of job satisfaction as well as (4) increase their probability of leaving the job.

The findings of a study conducted by Mammbona and Mavhandu-Mudzusi (2019) also revealed that several Enrolled Nurses caring for HIV/AIDS patients in one of the rural hospitals in the Vhembe District of South Africa resigned from the hospital due to the increased workload and its attendant work-related-stress and burnout they had to endure while caring for these patients. These findings corroborated those of previous studies in Colombia by Moreno-Jiménez, Rodríguez-Carvajal, Furlong, Hernández, and Benadero (2006) and in Namibia by Pendukeni (2004).

In a study that examined the consequences of burnout syndrome among healthcare professionals in Spain and Spanish speaking Latin American countries, Suner-Solera et al. (2014) found that burnout leads to emotional exhaustion and absenteeism among the healthcare professionals, which compelled most of them to consider leaving the nursing profession. The high turnover of nurses caring for HIV/AIDS patients has serious consequences as it could lead to shortage of nurses, which will also lead to increased work overload for the remaining nurses and thus creating a vicious cycle. Similarly, burnout has been revealed as one of the reasons why key healthcare personnel, such as nurses caring for HIV/AIDS patients in the Western Cape, South Africa, left their profession, resulting in insufficient staff to attend to patients (Roomaney, Steenkamp & Kagee, 2017) which will obviously compromise the quality of care the patients will receive.

A study that estimated the prevalence of staff stress and its correlates in a sample of palliative caregivers in HIV/AIDS in India revealed that the severity of stress experienced while caring for HIV/AIDS patients has compelled most of the staff to consider leaving HIV-related work (Chandra, Jairam, & Jacob, 2004). Similarly, in a study among caregivers of HIV/AIDS patients in South Africa, Akintola et al. (2013) found that high levels of stress and burnout impacts negatively on the health and well-being, and on the job performance of the caregivers. A related study by Khamisa, Oldenburg, Peltzer and Ilic (2015) also revealed that work-related stress and burnout is responsible for changes in the mental health of nurses, compromise the nurses' productivity and performance, as well as affect the quality of care they provide to the patients.

Work-related stress and burnout and the resultant fatigue and exhaustion experienced by HCWs caring for HIV/AIDS patients could also lead to reactions such as changing or leaving their jobs, neglecting the patients, role confusion, personal problems like family discords, and social discrimination, among others (Urooj, 2012). Work-related stress and burnout among the caregivers of HIV/AIDS patients constitute a threat to patients as the caregivers are more likely to subjectively rate patient safety lower and thus make mistakes or provide substandard care to the patients (Lyndon, 2016).

Symptoms of burnout such as decreased judgmental ability and difficulty focusing on tasks, may affect the nurses' ability to competently perform their professional caregiving functions. This may lead to an increased risk of the patient not receiving quality care. A cross-sectional study by Kim et al. (2018) examined the prevalence of burnout, and explored its relationship to the quality of care provided by Malawian HCWs caring for HIV/AIDS patients. The study concluded that burnout was common among the HCWs, and was associated with self-reported suboptimal patient care practices and attitudes. These findings reinforced those of an earlier study by Shirinda-Mthombeni (2014) which explored the experiences, challenges, and coping mechanisms of South African caregivers of PLWHA and revealed that challenges of work overload and its attendant stress sometimes become so overwhelming that it hinders the quality of care the HCWs provide to the patients.

Nurses, by virtue of their professional training, are expected to be empathetic to, and patient with their patients. However, as indicated by the American Medical Association (2018), unmitigated stress and burnout could cause nurses caring for HIV/AIDS patients to become less empathetic, impatient and even argumentative with the patients thus compromising the quality of care rendered to the patients. The findings of a study by Suner-Solera et al. (2014) revealed that burnout could lead to the HCWs making errors in the care they provide to patients. Making errors in healthcare provision is a very serious issue as it could culminate in the patient not receiving the best care, lead to deterioration in the patient's condition or even result in death. It is therefore imperative that measures be put in place to mitigate stress and burnout and /or its effects on nurses and other caregivers of HIV/AIDS patients. Khamisa et al. (2015), and Khamisa, Peltzer, Ilic, and Oldenburg (2016) therefore advocated for the development of strategies, intervention programmes, and evidence-based policies and practices towards improving nurse and patient related outcomes, improve job satisfaction, and reduce the impact of burnout on the general health of nurses.

Likewise, Roomaney et al. (2017) recommended the development and testing interventions that could reduce burnout among nurses caring for HIV/AIDS patients. The interventions recommended included reducing workloads and creating conditions for less interpersonal conflict at work. In this regard, the current study explored the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana with a view of finding means of developing support systems to help the nurses cope with challenges associated with their caregiving role.

Burnout among nurses caring for HIV/AIDS patients also has the potential for creating hostile relationships between the nurses and patients (Roomaney et al., 2017) which could compromise the quality of care provided to the patients. Work-related stress and burnout can also lead to detached feelings of HCWs toward patients, loss of caring, and lack of engagement, which can be harmful to the care environment and the outcome of the patient's health (Salloum, Kondrat, Johnco, & Olson, 2015). Burnout among HCWs can also result in the caregivers' reduced sense of personal accomplishment and satisfaction with job performance which could impact negatively on the quality of care provided to the patients, as well as lead to high turnover among the nurses (Smart et al., 2014).

In a study that explored the challenges experienced by professional nurses caring for patients diagnosed with AIDS-related illnesses at a hospital in the Tshwane District, Gauteng Province, of South Africa, Ndou et al. (2014) revealed that the nurses experienced stress and burnout due to the physical and psychological challenges they face whilst caring for the HIV/AIDS patients. The findings of the study further revealed that the challenges had a negative impact on the professional nurses' performance physically and psychologically. A related study by (Ndou, 2017) also found that public hospitals across South Africa are flooded by HIV/AIDS patients and this situation has completely changed the medical landscape and placed an excessive burden on the professional nurses caring for these patients. The challenges faced by the nurses while caring for the patients led to effects such as fatigue, ill health, resignations and provision of poor-quality care to the HIV/AIDS patients under their care.

Similarly, the findings of a quantitative study conducted by Chandra et al. (2004) to estimate the prevalence of staff stress and its correlates in a sample of palliative caregivers in HIV/AIDS in India also revealed that the staff considered leaving HIV-related work because of the severity of stress in dealing with the PLWHA. A correlational study was conducted among Greek nurses by Sarafis et al. (2016) to investigate and explore the correlation among occupational stress, caring behaviours and their quality of life in association to health. The study concluded that occupational stress affects the nurses' health-related quality of life negatively, while it can also be considered as an influence on patient outcomes. It has also been found that the stress associated with caring for HIV/AIDS patients often lead to strained interpersonal relationships between caregivers and their family members. A study conducted among Chinese healthcare professionals by Tong et al. (2019) revealed that most of the participants tended to release their negative emotions from work onto their spouses and children by shouting at them, criticising them, and even beating them.

The available literature provides evidence that the work-related stress and burnout, experienced by nurses and other caregivers of HIV/AIDS patients, has various negative effects on the caregivers, and the quality of they could provide to the patients under their care. The review also revealed that, in order to mitigate these negative effects, various researchers have recommended the development of policies and strategies to help reduce the work-related stress and burnout among nurses caring for HIV/AIDS patients.

2.3.3 Effects of over-involvement and over-identification with the patients

The American Medical Association (2018) revealed that though many caregivers expect their involvement with the HIV/AIDS patients to have a positive effect on the health and happiness of the patients, this may be an unrealistic expectation and could cause frustration to the caregivers. Mubekapi (2012) in her study that explored workplace stress and coping strategies among nurses in HIV/AIDS care in a Tanzanian district Hospital found that over-involvement and over-identification with the patients results in expressions of hopelessness and helplessness if the patients die. This corroborates the assertion of Bowlby (1973) in the attachment theory that, in situations where there is attachment, separation anxiety and distress results when there is a loss or threat of loss in the attachment.

In a study that explored the complexities of nurse-patient relationships, Turner (1999) revealed that many of the nurses who were over-involved with cancer patients found themselves feeling extremely upset when the patients die. Studies by Davhana-Maselesele and Igumbor (2008), Tsheboeng (2015), and Koto and Maharaj (2016) also found that HCWs who get over-involved or over-identify with HIV/AIDS patients, feel sad for their patients because there is no cure for AIDS even though treatment is available, and they grieve when the patients die. This also confirms the separation anxiety or distress that results when there is a loss or threat of loss, as described by Bowlby (1973) in his attachment theory.

2.3.4 Effects of courtesy stigma and discrimination

The findings of numerous studies have revealed that nurses and other caregivers of HIV/AIDS patients experience courtesy stigma because of their association with these patients (Hedge et al., 2021; Lekganyane, 2016; Mamukeyani, 2021; Parks & Smallwood, 2021). Studies by Afful et al. (2019), Mensah (2018), Puplampu (2017), and Mwinituo and Mill (2006) revealed that Ghanaian caregivers of HIV/AIDS patients also experience HIV/AIDS-related courtesy stigma.

HIV/AIDS-related courtesy stigma and discrimination have varying, usually negative, effects on caregivers of HIV/AIDS patients. For example, it led to the reluctance of many health professionals to care for HIV/AIDS patients (Bachleda & Menzhi, 2017; Haber et al., 2011; Hassan & Wahsheh, 2011). Bachleda and Menzhi (2017) further revealed that nurses who are involved in caring for HIV/AIDS patients are often shunned by their colleagues working in other departments. A qualitative, exploratory study was conducted by Haber et al., (2011) to examine courtesy stigma among HCWs because of their association with PLWHA. The study tested the hypotheses that HCWs caring for HIV/AIDS patients experience stigmatisation due to their association with PLWHA, and that such stigma is correlated with thoughts of leaving the HIV/AIDS field. A sample of 100 participants who provided direct care to PLWHA was recruited from a variety of public and private HIV/AIDS care centres in the Eastern Cape Province, South Africa. The participants attended one of 12 focus groups, and also completed a 17-item questionnaire and discussed each item. The findings of the study revealed the presence of an adverse differentiation and labelling of healthcare workers who care for HIV/AIDS patients. This led to status loss and discrimination, creating a motivation for the healthcare workers to leave AIDS work altogether.

Studies have revealed that due to HIV/AIDS-related courtesy stigma, family members of HCWs do not approve of them caring for HIV/AIDS patients. A qualitative study on HIV/AIDS-related stigma and discrimination among HCWs such as physicians and nurses attached to different hospitals in Bangladesh revealed that, due to courtesy stigma, the spouses of the physicians and nurses who take care of HIV/AIDS patients pressurise them to stop caring for the patients, or even quit their jobs (Ullah, 2011). Similar findings were made by Ha et al., (2013) in their study in which some staff members' families were concerned about the HCWs' daily interactions with HIV/AIDS patients in their work, and therefore impressed upon them to quit working in the HIV/AIDS care field and find other jobs. Lekganyane (2016) also revealed that caregivers of HIV/AIDS patients are undermined, devalued and even insulted due to their association with PLWHA.

Similarly, Majumdar and Mazaleni (2010) also found that courtesy stigma is extended to the associates of the HIV/AIDS patients, who also suffered victimisation and humiliation due to their association with them. Delobelle et al. (2009) indicated that the challenges of secondary or courtesy stigma discourages nurses from working in HIV/AIDS services. Courtesy stigma has also been found to contribute to emotional exhaustion, occupational stress, and burnout among nurses caring for HIV/AIDS patients (Van Dyk, 2007). These effects could affect the quality of care the nurses give to the patients.

2.3.5 Effects of inadequate resources, and lack of support

Several previous studies have revealed that among the numerous challenges experienced by nurses who provide care to HIV/AIDS patients are; inadequate human and material resources, and lack of support. These challenges have been found to have negative effects on the nurses and the quality of care they could provide to the HIV/AIDS patients.

A study conducted by Mammbona and Mavhandu-Mudzusi (2019) to explore enrolled nurses' experiences of caring for HIV/AIDS patients at a public rural community hospital in the Vhembe district of Limpopo Province, South Africa, found that caring for HIV/AIDS patients without adequate resources and support has negative effects on the nurses' physical health. The findings of the study also revealed that because most of the patients are admitted to the ward being critically ill, the nurses had to frequently lift these patients as part of their caregiving functions. This has led to backaches for some of the nurses. Additionally, because the nurses had to work without proper PPEs such as gloves, they face an increased risk of being infected with HIV. The study further revealed that inadequate resources compromise the quality of care the nurses could provide to the patients. Some of the participants in the study indicated that the physical and mental exhaustion inherent in caring for the HIV/AIDS patients affects their concentration leading to commission of errors while providing care to the patients, as well as engaging in unprofessional acts such as documenting procedures they have not carried out on the patents.

Similarly, a qualitative study by Moshidi et al. (2021) in five public hospitals in the Limpopo Province of South Africa revealed, among others, that the nurses caring for HIV/AIDS patients experienced inadequate resources and lack of support which led to physical and emotional strain, exhaustion, fatigue, and increased levels of stress among the nurses. The findings have shown that these experiences can impact negatively on the physical and psychological health of the nurses, which in turn contributes to job dissatisfaction. Some of the participants manifested job dissatisfaction through decreased performance or increased absenteeism. The increased workload encountered by the participants, which is aggravated by a shortage of staff, and increased absenteeism, also often compromised the quality of care provided to the patients.

The researchers recommended the need for policies, guidelines, and programmes to be developed as part of care and support for the caregivers, as well as development of strategies to halt staff turnovers to enable them to continue providing effective care to the HIV/AIDS patients. It was the considered view of the researchers that provision of care and support for nurses caring for HIV/AIDS patients is very vital because without such effective support for them, they will become demoralized and discouraged, and unable to provide the necessary quality care to the patients. In the current study, the researcher sought to explore the experiences of nurses caring for HIV/AIDS patients in selected hospitals in the Accra Metropolis, determine the effects of caring for caring for HIV/AIDS patients on the nurses, with a view to recommending appropriate care and supportive measures for them.

The findings of a study by Mamukeyani (2021) also indicated that the caregivers of PLWHA experience problems with regard to inadequacy of resources such as PPEs while caring for the PLWHA. The study found that the inadequacy of these necessary resources hinders the caregivers from providing the required care to the PLWHA. These findings correspond with those of Matakanye et al. (2019), Mosadeghrad (2013), Valjee and van Dyk (2014), and Ramathuba Davhana-Maselesele (2013), which also indicated that the inadequate resources and lack of support experienced by nurses when caring for patients impacts on their physical and psychological wellbeing, and also affects the quality of care they provide to the patients. A qualitative explorative study by Kangéthe (2009) to discuss the challenges influencing the state of caregiving in Botswana also revealed that though the caregivers of HIV/AIDS patients face occupational risks and challenges, they do not receive adequate psychosocial counselling to help them cope with the stress of care giving. This contributes to the caregivers rendering poor quality of care to the patients.

It is clear from the available literature that, the challenges associated with caring for HIV/AIDS patients have negative effects on the caregivers' physical and psychosocial wellbeing which could consequently hinder the quality of care they are expected to provide to the HIV/AIDS patients or the PLWHA. It is in order to mitigate the challenges associated with caring for HIV/AIDS patients, or their effects on the caregivers and their caregiving functions that recommendations have been made to hospital and ward managers to provide the necessary resources and support needed by the nurses and the other caregivers (Davhana-Maselesele & Igumbor, 2008; Matakanye et al., 2019; Moshidi et al., 2021; Ndou, 2017; Tapsfield & Bates, 2011). The ensuing sections of the literature review are focused on the coping strategies adopted by caregivers, and the support systems available to them in dealing with their work-related challenges and experiences.

2.4 Support Systems Available to the Nurses

2.4.1 Provision of resources to facilitate adherence to the standard precautions

In order to allay caregivers' fears of being infected with HIV through occupational exposure, it is imperative that they are provided the needed resources and support to enable them adhere to the standard precautions of infection prevention. The standard precautions are work practices that are necessary to provide a high level of protection to HCWs, patients and visitors to the healthcare facility (WHO, 2004a). They are the basic requirements in infection control measures to reduce healthcare-associated infections (Waramlah & Huda, 2019). They are a set of precautionary measures designed to reduce or prevent the occurrence of occupational exposures to HCWs (Centers for Disease Control, 1987). The components of the standard precautions include hand hygiene, wearing of personal protective equipment (PPEs), safe use and disposal of sharp instruments, and environmental cleanliness. Others are reprocessing of re-usable medical equipment and instruments, respiratory hygiene and cough etiquette, aseptic non-touch techniques, proper waste management, and appropriate handling of linen (Centers for Disease Control, 1987; Waramlah & Huda, 2019).

The standard precautions are based on the assumption that all patients are potentially infected with HIV and/or other blood-borne pathogens (Centers for Disease Control, 1987) that could be transmitted to the HCWs and the patients. It is therefore imperative that HCWs adhere to the standard precautions when providing care to all patients irrespective of the patient's disease condition or infection status (Asmr et al., 2019; Batran, Ayed, Salameh, Ayoub, & Fasfous, 2018; Centers for Disease Control, 1987; Gebresilassie et al., 2014; Zeb, Muhammad, & Khan, 2019). It behoves on the managers of healthcare facilities therefore to provide the needed protective materials, and proper training of their staff on the standard precautions and the need to adhere to them (Hamid, Aziz, Anita, & Norlijah, 2010; Hesse, Adu-Aryee, Entsua-Mensah, & Wu 2006).

The fear of being infected with HIV through occupational exposure to the blood and other body fluids of patients is one of the challenges faced by nurses who care for hospitalized HIV/AIDS patients (Beyene & Tadesse, 2014; Esewe et al., 2017; Manganye et al., 2013; Tandi et al., 2018). Adherence to the standard precautions protects nurses, and all HCWs against occupational exposure to blood and body fluids of patients, and hence reduces the risk of transmission of infections to them (Batran et al., 2018; Zeb et al., 2019). This will therefore help alleviate the fear of infection experienced by nurses caring for HIV/AIDS patients. Non-adherence to the standard precautions puts the HCWs and patients at risk of acquiring HIV and other infections through occupational exposure (Gebresilassie et al., 2014).

2.4.2 Adherence to guidelines on post-exposure prophylaxis

Post-exposure prophylaxis (PEP) is a WHO recommended guideline for preventing HIV infection after occupational exposure (Baggaley et al., 2015; Sultan etal., 2014; WHO, 2007, 2014). It refers to a set of comprehensive services to prevent HIV infection in individuals accidentally exposed to the blood and body fluids of HIV/AIDS patients. These services include, first aid care, counselling and risk assessment, HIV testing based on informed consent and the administration of short-term antiretroviral therapy (ART) with follow up and support (Baggaley et al., 2015; International Council of Nurses, 2000; Sultan et al., 2014).

Antiretroviral drugs have been used as PEP for HCWs following occupational exposure to HIV, since the early 1990s (WHO, 2014) and is backed by empirical evidence that suggest that their use following occupational and non-occupational exposure reduces the risk of acquiring HIV infection when it is administered as PEP within a short time following the exposure (Hoffmann et al., 2010). It is therefore recommended that PEP with a combination of antiretroviral drugs be initiated immediately, ideally within 72 hours, after the occupational exposure and continued for one month (Weston et al., 2006b). Effective post-exposure management will help ensure the safety of healthcare providers in the healthcare setting (Akinboro, Adejumo, Onibokun, & Olowokere, 2012).

The effectiveness of PEP in preventing HIV infection after occupational exposure, however, depends on the high level of adherence to the therapy (WHO, 2014). The exposure incidents must therefore be reported early so that the exposed health worker can benefit from the PEP. The International Council of Nurses (2000) therefore implored nurses and midwives to strictly adhere to the protocols and guidelines for reporting all occupational exposure incidents in the healthcare setting to ensure timely commencement of PEP. The International Council of Nurses further appealed to healthcare facilities to make the process of reporting occupational exposures flexible so as to facilitate compliance to it by nurses and midwives, and other HCWs as it helps minimize the risk of HIV infection through occupational exposure.

2.4.3 Psychosocial support

In the healthcare setting, psychosocial support or care is defined as the culturally sensitive provision of psychological, social, and spiritual care through therapeutic communication (Chen et al., 2017). It is the formal and informal services that address the psychosocial well-being of people facing challenging or stressful situations (Gilborn et al., 2006). According to (Kenny & Allenby, 2013), psychosocial support is an all-inclusive intervention that meets the physical, psychological and social needs of patients. It is aimed at increasing the self-esteem of the patients, strengthen their ability to cope with the disease, and to improve their physical, psychological and emotional well-being, social functioning and interpersonal relations (Legg, 2011; Watts, Botti, & Hunter, 2010).

Psychosocial support or care however is important not only to patients, but also to their caregivers (Arulappan, 2016; Legg, 2011) because caregivers of patients also face challenging situations and work-related stress and burnout that impair their psychosocial well-being (Orner, 2006; Ramathuba & Davhana-Maselesele, 2015). The caregivers also, therefore require psychosocial support (Orner, 2006; Ramathuba & Davhana-Maselesele, 2015) since the lack of care and support for them compromises the quality of care they could give to the care recipients (Ramathuba & Davhana-Maselesele, 2015).

In the context of HIV/AIDS, psychosocial support addresses the ongoing emotional, social, and spiritual concerns and needs of people living with HIV, their partners, and their caregivers. Kangéthe (2009) used the term psychological nourishment in place of psychosocial support, and described it as any process, factor, environment, treatment, or service that increases the HIV/AIDS caregivers' happiness, satisfaction, motivation, esteem, well-being, and their capacity to carry out care giving tasks. The findings of various studies have revealed that nurses who care for HIV/AIDS patients needed to be supported (American Medical Association, 2018; Chikukwa, 2012; Madi et al., 2016; Makhado & Davhana-Maselesele, 2016; Ndou, 2017). There are several types of psychosocial support available to nurses and other caregivers of HIV/AIDS patients. These support systems include: provision of counselling services, debriefings, formation of support groups, self-care, and employee assistance programmes.

2.4.3.1 Provision of counselling services

Counselling empowers the caregivers of HIV/AIDS patients to become capable of coping with their work-related challenges and stressors, and provide them a platform to share their challenges and develop the courage to continue caring for the patients (Lekganyane & Alpaslan, 2019). Mashau and Davhana-Maselesele (2009) recommended that counselling services should be provided as support for caregivers of HIV/AIDS patients.

The provision of counselling is relevant to nurses caring for HIV/AIDS patients because it helps in mitigating the work-related challenges associated with their caregiving roles (Chikukwa, 2012; Mabusela, 2010; Ndou et al., 2015; Tsheboeng, 2015). A qualitative study by Kangéthe (2009) revealed that counselling services from professional counsellors provide caregivers of HIV/AIDS patients the professional support to deal with work-related stress, burnout, and the overwhelming nature of caregiving.

2.4.3.2 Debriefing

Debriefing is found to be useful following a critical clinical incident to share emotions and ‘‘talk through’’ a stressful event (Papaspyros, Javangula, Adluri, & O'Regan, 2010), as well as encourage communication that enables individuals in a stressful event to discuss ways of improving future performance as well as to reflect on their emotions (Buykx et al., 2011). In the context of HIV/AIDS caregiving, Mashau and Davhana-Maselesele (2009), defined debriefing as a process through which caregivers of HIV/AIDS patients have the opportunity to verbalise their fears, pain and problems to a professional psychologist who will in turn help them to get treatment. Debriefings has thus been recommended as a form of psychosocial support for caregivers of

HIV/AIDS patients (Lekganyane & Alpaslan, 2019; Mashau & Davhana-Maselesele, 2009; Tsheboeng, 2015). Mashau and Davhana-Maselesele (2009) indicated that debriefing for caregivers of HIV/AIDS patients should be done by professionals such as psychologists, counsellors or social workers.

A qualitative study was conducted in South Africa by Lekganyane and Alpaslan (2019) to investigate the challenges experienced by caregivers of HIV/AIDS patients when performing their caregiving functions, and how they manage such challenges. The findings of the study identified debriefing as a means of providing psychosocial support to such caregivers. The authors suggested that quarterly debriefing sessions should be conducted to help the caregivers share their work-related challenges. The provision of counselling and debriefing sessions as support systems for nurses and other caregivers of HIV/AIDS patients to help mitigate their work-related challenges was also recommended by other researchers such as Ndou et al. (2015), Mabusela (2010), Madi et al (2016), Chikukwa (2012), and Tsheboeng (2015), because these caregivers are prone to suffer burnout or compassion fatigue (Mashau & Davhana-Maselesele, 2009). Kangéthe (2009) also posited that debriefing help caregivers to deal with situations surrounding especially death or very stressful events encountered during the caregiving role.

2.4.3.3 Formation of support groups

The WHO (2013) encouraged caregivers of HIV/AIDS patients to form support groups so that they can share experiences and ideas on coping and caring for the patients. Similarly, Mashau and Davhana-Maselesele (2009) has also recommended the formation of support groups because they found that by forming such groups, caregivers of HIV/AIDS patients would be able to share their experiences and advice each other on how to deal with the stress associated with their caregiving functions.

The idea of forming support groups was also suggested by Bester and Herbst (2010). They posited that caregivers should be trained on how to form the support groups amongst themselves. Support groups also help provide opportunities to caregivers of HIV/AIDS patients to exercise self-care (Lekganyane & Alpaslan, 2019). Williams (2014) regarded support groups as one of the enablers that keep the caregiver committed to the caregiving role. Casale and Wild (2012, 2013) also confirmed that social support may be an important resource for the mental and physical health of caregivers of HIV/AIDS patients.

2.4.3.4 Self-care

The concept of self-care, as a form of psychosocial support available to help nurses caring for HIV/AIDS patients in dealing with their work-related challenges, was described by Williams (2014) as the necessary measures taken by caregivers to maintain their health by cultivating healthy habits, while letting out the feelings and frustrations associated with caregiving, and getting away from the caregiving demands when necessary. The UNAIDS (2000) lays much emphasis on self-care for caregivers of HIV/AIDS patients, hence it impressed on the caregivers the importance of looking after themselves, and pointed out that if they allow themselves to get sick or burnout, they will be unable to help anyone. Self-care requires caregivers to remain healthy and fit physically, psychologically, socially and emotionally in order to fulfil their caregiving obligations and activities. It has four components, namely; 1) supportive physical environment, 2) cultivating healthy habits, 3) “letting it out”, and 4) “getting away from it”.

Supportive physical environment, according to, Williams (2014), refers to accommodation, food, and other amenities that are comfortable and convenient for the caregiver and the patient. Caregivers must therefore provide these amenities for themselves in order to remain healthy and fit physically, psychologically, socially and emotionally. It also implies that management of health facilities must endeavour to provide a conducive infrastructure that will facilitate good physical environment for the HCWs. Cultivating healthy habits means caregiver taking action to maintain or improve their health necessary for caregiving. Self-care for caregivers of HIV/AIDS patients also means caregivers eating a balanced diet, taking enough rest and keeping their bodies healthy through regular exercising (American Medical Association, 2018; Williams, 2014).

“Letting it out” implies caregivers finding means to express their feelings and frustrations associated with caregiving. It involves the caregiver communicating purposefully with others to share their feelings, or disclosing their thoughts and feelings through writing or other methods of expression that may not necessarily be shared with others. Letting it could thus be achieved through the methods of debriefing (Buykx et al., 2011; Papaspyros et al., 2010; Shinners et al., 2016).

The concept of “letting it out” encourages caregivers to form support groups within which they can share experiences and ideas on coping and caring for patients. Counsellors can also use these groups to provide group counselling to the caregivers. It further corroborates the suggestion of Ndou et al. (2015) that the co-workers of nurses caring for HIV/AIDS patients must, as a means of support, provide opportunity for interpersonal interactions during breaks and after work hours. Like the support groups that have been found to promote emotional support and give caregivers the opportunity to share their experiences and support one another on how to cope with stressful events (Bester & Herbst, 2010; Lekganyane & Alpaslan, 2019; Mashau & Davhana-Maselesele, 2009), letting it out can serve as a means of giving respite to the nurses from their work-related challenges and adverse experiences at work.

"Getting away from it" means finding physical or mental space to experience temporarily ordinary life, separate from the demands of illness and the caregiving role. Being away from the caregiving situation, either physically or mentally provides adequate respite for the caregiver (Williams, 2014). The concept of getting away could be said to have been envisioned by the American Medical Association (2018) when it indicated that support for caregivers should include provision for regular break times during the working shift. This idea is akin to respite support which was recommended by Lopez-Hartmann, Wens, Verhoeven, & Remmen (2012) for caregivers. Respite support is the provision of caregivers with a temporary break in their care giving activities in order to improve their well-being.

In summary, self-care as a support system available to help nurses caring for HIV/AIDS patients to deal with their work-related challenges involves actions and/or decisions the caregiver or the nurse must personally take in order to cope effectively with the challenges and experiences of caregiving and hence remain healthy to continue the caregiving work. It implies the individual caregiver or group of caregivers taking personal actions to resolve their work-related challenges. The concept of self-care thus agrees with the concept espoused by (Rogers, 1957) in the person-centred counselling theory, which is based on the assumption that human beings are essentially trustworthy and have the potential to understand themselves and the ability to resolve their own problems without direct intervention by the therapist.

Similarly, the concept was also emphasised by Bennett et al (1994) when they indicated that HCWs who care for HIV/AIDS patients must be prepared to care for themselves so as to remain healthy and able to continue providing the needed high quality care to the HIV/AIDS patients. Corey (2009) also revealed that caregivers sometimes identify so closely with care recipients that they lose their own sense of identity and assume the identity of the care recipients. This phenomenon, according to Corey makes it difficult for the caregivers to function effectively. As a way of self-help therefore, Corey (2009) recommended that caregivers need to learn how to "let clients go" and not carry around their problems.

2.4.3.5 Employee assistance programmes

Employee Assistance Programmes (EAPs) are workplace programmes designed to address work-related problems that negatively affect employees' well-being (Okemwa, Atambo, & Muturi, 2019). Nkanata, Muchangi, and Kiiru (2021) also defined EAPs as "mediation programmes at the work place that assist employees to resolve their personal problems". They are organized by work organizations to help employees in dealing with individual issues that might impact on their work performance. EAPs normally include counselling services, and programmes to ensure the physical, mental, emotional wellbeing of employees, as well as drug and substance abuse issues (Nkanata et al., 2021). In the specific case of nurses and other caregivers of HIV/AIDS patients, the goal of EAP will be to provide them the needed psychosocial support they require to deal with their work-related challenges which will ensure their psychosocial well-being and enable them provide the required effective and efficient care to the HIV/AIDS patients.

The concept of EAP originated in the United States of America (USA) in the early 1940s when, according to (Dickman & Challenger, 2009), an Occupational Alcoholism Program (OAP) was developed to assist employees who had alcohol-related problems such as absenteeism, deteriorating performance and associated labour force disability, trafficking of substances, and addiction. EAPs were thus originally designed as an occupational resource that provided assistance to employees with alcohol-related issues such as absenteeism, declining performance, and the associated impairment of the employees (Attridge, 2009; Daniels, Teems, & Carroll, 2005). This drug and alcohol abuse-based EAPs that originated in the USA have been transferred to other countries (Golan & Bamberger, 2009) such as the United Kingdom, Australia, Canada, Israel, Japan, South Korea, and South Africa among others (Csiernik, 2011), and Ghana (Dartey, 2016). EAPs have however evolved significantly from their origins as an American government-initiated alcohol intervention programme for employees, to its current state where it involves the provision of a wide range of services such as short-term counselling, critical incident debriefing and support, and management coaching, which can be used to manage a variety of personal and professional concerns among employees (Daniels et al., 2005).

The most essential function of a successful EAP is its ability to provide confidential counselling services, free of charge, to employees, management and their family members when needed on a daily basis (Attridge, 2009). Attridge (2009) categorised the services offered by EAPs into five kinds of activities that are performed to varying degrees by all EAPs, namely: services for individuals, services for managers and supervisors, services for the organization, liaison services to support other programmes and services, and administrative services. Dartey (2016) on the other hand, categorised the services offered under EAP into two main types of services namely, direct and indirect services. The direct services, which are services that deal with the individual workers either identified and referred or self-referred may include, but not limited to, the following; assessment, trauma debriefing, crisis intervention, counselling services, referral services, monitoring, and follow-up. The indirect services, on the other hand, are services that are provided to supervisors and all staff to help them identify colleagues with problems; behaviour changes, low outputs and others for early referral and treatment. They include training programmes and workshops for ward managers as well as all staff to help them identify any colleagues who have problems after experiencing work-related challenges. The indirect services serve as a means of preparing the staff on the actions to take when they experience work-related challenges on the wards.

Csiernik (2011) revealed that in work organizations where EAPs are implemented, they produce positive outcomes. Studies by Rena and Lekate (2021), Pace et al. (2019), and Nkanata et al. (2021), attest to the implementation of EAPs as a support system in the healthcare setting in general, and in nursing and midwifery. In Ghana, Dartey (2016) found that midwives were prone to challenges such as maternal deaths at the workplace. This makes the midwives more likely to experience stressful situations for failing to meet the general goal of their profession, which, among others, includes provision of adequate care for pregnant women until they safely deliver. These stressful conditions have negative effects on the midwives' health, behaviour and productivity. There was however a dearth of literature on how midwives in the Ashanti Region of Ghana are affected by maternal deaths and the coping mechanisms they employed to deal with the effects of maternal deaths, neither was there any known work-related assistance programmes designed to support Ghanaian midwives when they face with work-related challenges likely to affect their work-output. Dartey therefore conducted a qualitative study that developed an appropriate EAP for midwives dealing with maternal deaths in Ghana. The study recommended the need for EAP to be instituted in all hospitals in the Ashanti Region to assist midwives cope with challenges associated with maternal death. Apart from this study by Dartey (2016), there is hardly any mention of EAP in the literature in the Ghanaian setting.

Because nurses who care for HIV/AIDS patients face work related challenges such as work overloads, heightened work-related exposure to suffering, death and dying of patients, HIV/AIDS-related courtesy stigma, and fear of infection, amongst others, which could affect their wellbeing, thus making them troubled employees who need EAP services, Blum, Martin, and Roman (1992), and Moshidi et al. (2021) recommended the need for revisiting and re-enforcement of EAPs to facilitate the wellness of nurses caring for HIV/AIDS patients. The concept of EPA could equally be applied in providing support to all other categories of nurses and healthcare workers in general.

2.4.4 Provision of instrumental support

Instrumental or tangible support involves the provision of physical assistance in the form of material items or other forms of practical assistance to a person in need (Casale, Wild & Kuo, 2013; Khamarko & Myers, 2013). In the context of HIV/AIDS caregiving, instrumental or tangible support includes the things done physically, or the services provided to assist the caregivers of HIV/AIDS patients to mitigate their work-related challenges.

Ndou (2017) identified two types of tangible or instrumental support for the caregivers: support provided by the hospital managers, and support provided by the nurse managers. The support provided by the hospital managers include provision of adequate resources for protection against HIV transmission, supply of medical, cleaning and safety materials, and provision of adequate human resources. Support provided by the nurse managers include provision of mentoring and communication, management of role stressors, and provision of professional development and training. The resources for protection against HIV transmission include facilities for hand washing, safe disposal of sharp instruments, devices and contaminated materials; appropriate personal protective equipment (PPEs), as well as laid down protocols for post-exposure prophylaxis. As was indicated by Hamid, Aziz, Anita, & Norlijah (2010), and Hesse et al. (2006), it is the responsibility of managers of healthcare facilities to provide these needed resources and provide proper training of their staff to help them adhere to the standard precautions and hence protect themselves from occupational exposures.

Ndou et al. (2015) also described the specific support that management of the healthcare facility, nurse managers and co-workers must provide to nurses caring for HIV/AIDs patient. These, they indicated, include the provision of supervision, mentoring, counselling and debriefing services, and valued rewards by management of the healthcare facility to the nurses. The researchers also recommended that co-workers of the nurses should provide opportunities for interpersonal interactions during breaks and after working hours. This interaction between colleagues at work, according to Ndou et al (2015), forms the foundation for social and emotional support for the caregivers of HIV/AIDS patients. Ramathuba and Davhana-Maselesele (2015) posited that support from health care organizations to nurses caring for HIV/AIDS patients should include provision of resources, flexible working hours and supervisor support.

2.5 Coping Strategies Adopted by Caregivers of HIV/AIDS Patients

Coping, according to Lazarus and Folkman (1984), is the constantly changing cognitive and behavioural efforts used by a person to manage specific external and/or internal demands that are appraised as taxing or exceeding the person’s resources. Inherent in the work of nurses and other caregivers involved in caring for HIV/AIDS patients are unique physical, emotional, and psychosocial challenges and experiences (Akpuh et al., 2020; Bhembe & Tsai, 2019; Mammbona & Mavhandu-Mudzusi, 2019; Pan et al., 2022). It has been found that if these challenges and experiences are not appropriately dealt with, they could have negative effects on the nurses’ physical and emotional wellbeing as well as compromise the quality of care they provide to the patients. Studies have shown that nurses in general, and nurses who care for HIV/AIDS patients in particular, and other caregivers of PLWHA adopt coping strategies to help deal with (Kotrotsiou et al., 2021) or mitigate the effects of work-related challenges and experiences (Betke, Basinska, & Andruszkiewicz, 2021; Kangéthe, 2009; Kotrotsiou et al., 2021; Nala-Preusker, 2014; Pan et al., 2022).

To effectively cope with a stressful situation, the person experiencing the stressful situation must, as stipulated by Lazarus and Folkman (1984), engage in an assessment or appraisal of the stressful situation. The appraisal will enable him/her to adopt either or both of the two major types of coping; namely problem-focused coping, and emotion-focused coping (Folkman & Lazarus, 1980; Frydenberg, 2014; Lazarus & Folkman, 1984). The problem-focused coping refers to all the efforts that are made to change the stressful situations through problem solving. This approach is employed when the individual believes that a particular problem can be solved, and thus addresses it directly. It involves taking actions to address the stressor itself by managing its causes. As part of the coping effort, the individual draws from resources such as health, energy and positive beliefs which are part of his or her personality features and the problem-solving skills, social skills, social support and material resources from the environment (Lazarus & Folkman, 1984). The strategies used in problem-focused coping include; confrontative coping, seeking social support, and plan full problem-solving (Lazarus & Folkman, 1980).

Emotion-focused coping on the other hand refers to the attempts that are made to regulate distressing emotions, sometimes by changing the meaning of the stressful situation cognitively without actually changing the situation. The emotion-focused coping approach is utilised when a person feels that nothing can be done to solve the problem itself, and hence strategies are directed at regulating the emotional responses to the problem (Folkman, 1984; Frydenberg, 2014). This approach therefore involves modifying the meaning of the stressful event without dealing with the stressor itself. In this instance, the person will ignore or avoid the stressor and pretend it does not exist. Strategies employed in emotion-focused coping includes; avoiding the situation, distancing oneself from the stressful situation, acceptance, self-control, seeking social support, accepting responsibility, seeking medical support, and use of alcohol (Lazarus & Folkman, 1980).

How nurses caring for HIV/AIDS patients decide to cope with their caregiver burden is determined by the outcome of the appraisal process and available resources, problem solving skills, social skills, social support and material resources from their environment (Lazarus & Folkman, 1984). Available literature reveals that nurses caring for HIV/AIDS patients use these coping strategies in dealing with their work-related challenges.

A qualitative study conducted by Lekganyane (2016) to explore and describe the experiences and coping strategies of courtesy stigma as one of the work-related challenges of HBCGs of PLWHA in the Gauteng, Limpopo, and North West provinces of South Africa revealed that the HBCGs experience courtesy stigma which was manifested in ways such as; being undermined by nurses at the local clinics, being labelled and mocked by community members, being avoided by both community and family members. The study further revealed that the participants adopted a variety of emotion-focused coping strategies such as ignoring the negative treatments meted out to them, withdrawing from relatives and spending time with their nuclear family, receiving support from management and other professionals, educating the community on the importance of their work, as well as leaning on God.

A descriptive qualitative study was conducted by Afful et al. (2019) to explore the care related experiences of Ghanaian family caregivers of children living with HIV, who were accessing healthcare at the Princess Marie Louise Hospital in Accra. The study found that the caregivers experience HIV-related courtesy stigma manifested in social isolation. To deal with the situation, the participants adopted an emotion-focused coping strategy of relocating with their HIV-positive children to different locations in order to distance themselves from family members and friends, and thus avoid the courtesy stigma they experience.

A related study using the descriptive survey design was conducted in Kenya by Marete (2018) to 1) determine the effects of HIV/AIDS on the psychological wellbeing of elderly caregivers of persons infected and affected with HIV/AIDS in

Igembe South Sub- County, Kenya, and 2) find out the coping mechanisms used by these caregivers. The researcher used purposive sampling technique to select 220 elderly caregivers. Self-administered questionnaires, interview guides and focus group discussions were used to collect data. The qualitative data was analysed thematically while quantitative data was analysed using descriptive statistics. The findings of the study revealed that the caregivers adopted the following as coping strategies for the stressors encountered in their care giving roles: spiritual reliance through involvement in religious groups, attending guidance and counselling session, and receiving support from community-based organizations (CBOs) and non-governmental organizations (NGOs).

Similarly, a qualitative phenomenological study was conducted in South Africa by Guqa (2012) to investigate the psychological impact of caring on non-professional caregivers of HIV/AIDS orphans and children affected by HIV/AIDS. The lived experiences of eight participants were explored. The findings revealed that caring for HIV/AIDS orphans was emotionally, physically and mentally taxing for the caregivers. To help deal with their work-related stressors, the caregivers adopted different coping strategies such as; having optimistic and positive attitudes, being determined to achieve positive outcomes, relying on fate, religiosity, and dependency on others to help them cope. Some of the caregivers also indicated that prayer gave them the strength to deal with their work-related stressors and difficulties of their work.

In a qualitative study to ascertain the coping strategies adopted by elderly Ugandan women caring for PLWHA, and the support services available to them, Kyomuhendo (2018) found that the caregivers have adopted both problem-focused and emotion-focused coping strategies to cope with the challenges they experienced during the performance of their caregiving roles. The problem-focused coping strategies they adopted included seeking support from their family members, adjustment in time, dealing with negative reactions (confrontation), and dealing with fears of infection. They also used emotion-focused coping strategies such as acceptance of the caregiving role, positive re-appraisal, spirituality, isolation, and avoidance.

A related study was conducted by Kotrotsiou et al. (2021) to investigate the coping strategies of Greek nurses working in Greece and other European countries during the COVID-19 pandemic. The study found that the nurses adopted strategies such as avoidance, social support, faith-based practices, and wishful thinking to deal with their work-related challenges. Similar findings were made by Sehularo et al. (2021) when they conducted a narrative literature review to explore and describe the coping strategies used by nurses during the COVID-19 pandemic. Additionally, they also found that coping strategies such as use of COVID-19 protective measures, psychological support and management support were used by nurses who provided care for COVID-19 patients. The use of appropriate personal protective equipment (PPEs), and general adherence to the standard precautions of infection prevention, was also adopted by nurses and other HCWs as a strategy to protect themselves against occupational exposures and subsequent infection from pathogens such as HIV, Hepatitis and Covid-19 (Brown, Munro, & Rogers, 2019; Rai, El-Zaemey, Dorji, Rai, & Fritchi, 2021; Razu et al., 2021; Yasin et al., 2019).

Betke et al (2021) conducted a study to describe the specific relationship between the sense of coherence and strategies for coping with stress in a group of professionally active nurses in Poland. The findings revealed that; planning, seeking emotional social support, and seeking instrumental social support were the coping strategies adopted by the nurses to deal with the difficult situations and the stressors they experienced at work. Other studies have also found that nurses usually adopt the coping strategy of rationing nursing care; to deal with the challenge of inadequate nursing staff and its attendant work-related stress (Dhaini et al., 2019; Mandal & Rajendrababu, 2019; Rochefort, Rathwell, & Clarke, 2016; Witczak et al., 2021). Related studies have also found that, when faced with the work-related challenge of inadequate staff strength, nurses adopt the strategy of involving the patients' family members in providing care to the in-patients (Khosravan et al., 2014; Stavrianou et al., 2018). This is usually done after the nurses have taught the patients' family members some of the basic care procedures that they can perform for the patients.

Another coping strategy adopted by nurses and other caregivers is the religious coping strategy, or reliance on God. Religious coping was defined as "religiously framed cognitive, emotional, or behavioural responses to stress, encompassing multiple methods and purposes as well as positive and negative dimensions" (Wortmann, 2020). According to Pargament et al. 2005), religious coping is the use of religious beliefs or practices to cope with stressful life situations. Religious coping has been shown to be capable of helping people to cope with difficult situations such as physical illnesses, stress and depression (Koenig et al., 2001; Smith et a., Poll 2003). The use of this coping strategy has been reported by various other researchers such as Lamptey, Boateng, Hamenoo, & Agyemang (2018), Mohangi and Pretorius (2017), Mujjuzi et al. (2021), and Oyeyimika et al. (2020).

A mixed-method cross-sectional study was conducted by Mujjuzi et al. (2021) among 113 caregivers of paediatric HIV patients attending the Antiretroviral therapy (ART) clinic at a tertiary healthcare facility in Lira district, northern Uganda. The study assessed caregiver burden, and coping strategies among caregivers of the patients. The researchers used consecutive, and purposive sampling techniques respectively to recruit participants for the quantitative and qualitative data. A standard 22-item Zarit Burden Interview (ZBI) tool was used to collect the quantitative data while a semi-structured in-depth interview guide was used to collect the qualitative data. The quantitative data were analysed using SPSS version 23, and the qualitative data were analysed thematically. The findings revealed that majority of the caregivers experienced mild-to-moderate burden, and they adopted strategies such as; accepting social support, reframing, and seeking spiritual support as the three most commonly used strategies for coping.

A descriptive cross-sectional study was also conducted by Oyeyimika et al. (2020) among 246 caregivers of children living with HIV/AIDS who attend ART clinics for children in Lagos State, Nigeria. The purpose of the study was to assess the caregiver burden, quality of life and coping mechanisms of the caregivers. Interviewer-administered questionnaires were used to collect data. Psychological distress was measured using General Health Questionnaire 12 (GHQ-12), and caregivers' burden was assessed by Zarit Burden Interview 12 tool (ZBI). The data was analysed using Epi Info Statistical Package (version 7). The findings included severe psychological distress and high level of caregiver burden among the caregivers. The study further revealed that religious coping was the coping strategy mostly adopted by the participants, with substance abuse as the least. Other coping strategies used by the participants were; active coping, positive reframing, acceptance, venting, and denial.

The review in this section focused on coping strategies adopted by nurses and other caregivers to deal with their work-related challenges and experiences. It was revealed that the most common coping strategies adopted by the caregivers were; attending counselling sessions, seeking psychological support, social support, avoidance coping, rationing of nursing care to patients, and religious coping. One of the objectives of the current study is to explore the types of coping strategies used by the nurses caring for HIV/AIDS patients in the Korle Bu Teaching Hospital and the 37 Military Hospital in the Accra Metropolis in Ghana, to deal with the experiences related to their caregiving functions. The focus of the literature review in the next section is on support systems available to help nurses caring for HIV/AIDS patients, to deal with their work-related challenges.

2.6 Summary of the Literature Review

In this chapter, review of literature relevant to the study was presented. The review was done under the following thematic areas: 1) nursing care for hospitalised HIV/AIDS patients, 2) challenges experienced by nurses caring for HIV/AIDS patients, 3) effects of work-related challenges on nurses and their work, 4) coping strategies adopted by caregivers of HIV/AIDS patients to deal with their work-related challenges, and 5) support systems available to help nurses deal with their work-related challenges.

The review identified some gaps in the literature. It was revealed that the few Ghanaian studies related to the current study were limited in scope as they focused on just one aspect or the other of the experiences of nurses caring for HIV/AIDS patients such as experiences of HIV/AIDS-related courtesy stigma and discrimination, the perceived risk of HIV infection through occupational exposure, and psychological distress associated with caring for HIV/AIDS patients and the impact of same on the quality of life of the nurses caring for the patients

To the best of this researcher's knowledge therefore, there is a dearth of literature on studies that focused holistically on the lived experiences of Ghanaian nurses caring for HIV/AIDS patients, and that also investigated how the nurses cared for hospitalised HIV/AIDS patients. The current study therefore, sought to address this gap by exploring the lived experiences of Ghanaian nurses who care for HIV/AIDS patients since it will help unearth the nurses' work-related experiences, challenges and problems so that they could also be cared for and appropriate support systems could be provided for them. In doing so, the study will also add to literature on the subject in the Ghanaian setting. The methodology employed in conducting the study is discussed in the succeeding chapter.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter describes the research methodology the researcher used to conduct the study. The discussion focused on the following: research approach and design, study setting, population, sample, sampling techniques, instrumentation, procedure for data collection, data management and analysis, measures to ensure trustworthiness or rigor, and ethical considerations.

3.1 Research Approach

The purpose of this study was to explore the lived experiences of nurses caring for HIV/AIDS patients in two selected hospitals in Accra, Ghana. The study was underpinned by the constructivist or interpretive paradigm, with the assumptions of a relativist ontology, a subjectivist epistemology, a value-laden or balanced axiology, and a naturalist methodology (Denzin & Lincoln, 2018; Hussain, Elyas, & Naseef, 2013; Kivunja & Kuyini, 2017; Lincoln & Guba, 1985). The constructivist or interpretive paradigm seeks to understand the subjective world of human experience (Cohen, Manion & Morrison, 2018; Creswell & Creswell, 2018). The basic assumptions of this paradigm are that knowledge is socially constructed by people active in the research process, each individual holds different views, and the role of the researcher is to uncover these multiple views held by the individual participants in the research (Creswell, 2016).

In the constructivist paradigm, the ontological assumption of relativism means that there is no one ultimate reality or truth, but rather, there are multiple, subjective realities that vary from person to person. As explained by Okesina (2020), the relativist ontology implies that all knowledge about a phenomenon is relative to the knower and can be understood from the perspective of the individual who is directly involved in the subject being inquired into. The assumption of a subjectivist epistemology means that researchers make meaning of their data through their own thinking and cognitive processing of data informed by their interactions with participants (Kivunja & Kuyini, 2017). Knowledge is socially constructed from personal experiences of the real life within the natural settings in which the phenomenon is being investigated (Punch, 2005). The value-laden or balanced axiology assumed by the constructivist paradigm refers to the researcher making efforts to present a balanced report of the findings of the study based on the data gathered from the research participants (Goodwin, 2020; Kivunja & Kuyini, 2017; Nguyen, 2019). In assuming a naturalist methodology, the researcher studies the phenomenon of interest within its natural setting. In line with the constructivist or interpretive paradigm, which is typically seen as an approach to qualitative research (Creswell, 2014; Creswell & Creswell, 2018), the qualitative research approach was employed to conduct the study.

Qualitative research is a systematic, interactive, subjective approach used to describe life experiences and to give them meaning (Grove, Burns & Gray, 2013; Creswell, 2016). As stated by Lekganyane (2017), the systematic process followed by qualitative researchers enables them to gain an understanding of the subjective life experiences of the study participants. Authors such as Creswell and Creswell (2018), Creswell (2014), Denzin and Lincoln (2018), outlined some of the situations where it is appropriate to adopt the qualitative research approach. These situations include: when there is the need to study phenomena in the natural setting; attempting to make sense of, or interpret, the phenomena of interest from the perspectives of the people involved in the phenomena, and if a concept or phenomenon needs to be explored and understood because little research has been done on it. Such situations also include when there is a need for a complex, detailed understanding of the issue, and this can only be established by talking directly with the participants in their natural environment, and allowing them to tell their stories unhindered. Others are situations when the researcher wants to understand the contexts or settings in which the participants in a study address a problem or issue, and when exploring in order to understand the meaning individuals or groups ascribe to a social or human phenomenon or problem.

The qualitative approach was deemed appropriate for this study in which the researcher was interested in exploring the lived experiences of nurses caring for HIV/AIDS patients. The phenomenon of the lived experiences of nurses caring for HIV/AIDS patients needs to be explored and understood because there is a dearth of literature on the subject in the Ghanaian setting, though anecdotal evidence suggests that Ghanaian nurses caring for HIV/AIDS patients might be experiencing work-related challenges that impose a burden of care on them. The perceived challenges encountered by nurses caring for HIV/AIDS patients during the performance of their caregiving duties, and their coping strategies, therefore needs to be explored. The nurses' experiences as they provide care for HIV/AIDS patients, the meanings they have constructed from these experiences and how they cope with such experiences cannot be measured empirically. The experiences are unique to the nurses and could only be appropriately described by them (Creswell, 2014; Mcneil, 2015). To understand the nurses' experiences and the meanings they construct from such experiences therefore, the qualitative research approach is considered appropriate.

According to Brink (2006), the qualitative research method stresses the importance of people's interpretations of phenomena rather than the researcher's interpretation. In the current study, the qualitative research approach was selected to help provide a better understanding of the lived experiences of the nurses caring for HIV/AIDS patients. Furthermore, the researcher considered this study a typical qualitative study because it fitted well with the following basic characteristics of qualitative research: natural setting, researcher as key instrument, inductive and deductive data analysis, participants' meanings, and emergent design. These basic characteristics of qualitative research, and how they inform the choice of the qualitative research approach for the conduct of this study, are discussed in the following paragraphs.

In qualitative research, the researcher collects data in the field, i.e. the natural setting where the participants experience the phenomenon or problem under study (Creswell, 2014). This makes it possible for the researcher to directly observe or have face-to-face interactions with the participants while data is being gathered. In the current study, data was collected at the hospital wards where the nurses, as caregivers, care for the HIV/AIDS patients. Further, in qualitative research, as indicated by Creswell (2014), though the researcher may use protocols such as interview guides or checklists for observation; as tools for data generation, it is the researcher who personally collects the data by interviewing the participants, examining documents, observing the behaviour of participants etc. In this study, the researcher personally conducted and recorded the in-depth interviews himself, transcribed the interviews, read the transcripts carefully and coded them for analysis.

As stated by Creswell (2014), qualitative researchers use the inductive process as they work back and forth between the themes generated and the database until a comprehensive set of themes have been established. The researcher then deductively look back at the data from the themes to determine if more evidence can support each theme or whether there is the need to gather additional information. In this study, the researcher approached the data inductively to uncover experiences of the nurses as they provide care to the HIV/AIDS patients on admission on the wards. The focus of qualitative study is to understand, from the participants' perspective, the meaning of the phenomenon or problem being studied, not those of the researcher (Creswell, 2014; Merriam, 2009). The purpose of the current study was to explore the lived experiences of nurses who care for HIV/AIDS patients in the selected hospitals and the challenges they encounter while caring for the patients, from their own perspective.

Finally, emergent design means that the initial plan for qualitative research cannot be rigidly predetermined (Creswell, 2014; Creswell & Poth, 2018; Willis, 2007). This is because some or all phases of the research process may change or shift after the researcher enters the field to collect data. Upon entering the field, the research questions may change, the forms of data collection may shift, and the participants and the research setting may be modified. In this study, it became necessary for the researcher to review the original time lines because the Covid-19 epidemic in the country then, had caused a dramatic delay in securing ethical clearance for the study as the ethical review boards of the two hospitals could not meet as scheduled to review the proposal. Furthermore, in adherence to the Covid-19 protocols, some of the follow-up interviews were conducted via telephone in order to reduce the frequency of exposure to the isolation ward environment.

3.2 Research Design

The purpose of the study was to explore the lived experiences of nurses caring for HIV/AIDS patients, and what care and support they receive from management of the hospitals. The phenomenological research design, which is a method of investigating or inquiring into people's lived experiences of a phenomenon, and their meanings of such lived experiences (Atieno, 2009; Creswell & Poth, 2018; Pathak, 2017; Ravitch & Carl, 2016), was therefore considered the appropriate design for this study. The phenomenological research design is used to explore precise experiences obtained directly considering behaviours as determined by the phenomenon of experience and not by outside, objective, and physically described reality (Cohen, Manion & Morrison, 2018). The phenomenological research design was chosen because the study is aimed at understanding the nurses' burden of caring for HIV/AIDS patients. The phenomenological research design operates on the assumption that people are unique and they experience the same event differently, hence, to gain a better understanding of an individual's experiences, the person remains the best to describe it. This fits the constructivist paradigm adopted by the researcher.

Creswell (2007) explained that the type of problem best suited to be studied using the phenomenological design is one in which it is important to understand several individuals' common or shared experiences of a phenomenon, and that understanding these common experiences would be vital in order to develop practices or policies, or to develop a deeper understanding about the features of the phenomenon. In the current study, the researcher has identified the need to explore the lived experiences of nurses who provide care to HIV/AIDS patients at the Korle-Bu Teaching Hospital and the 37 Military Hospital in Accra, Ghana, identify the inherent challenges encountered by the nurses, understand how the challenges encountered by the nurses affect them and their caregiving roles, explore how the nurses cope with their work-related challenges and find out what support systems are available to help them deal with their work-related challenges. These are being done so that appropriate support systems could be provided for them. The phenomenological research design was therefore considered appropriate for this study.

3.3 Research Setting

The study was conducted in two hospitals in the Accra Metropolis, Ghana; namely the Korle-Bu Teaching Hospital and the 37 Military Hospital. Participants were recruited from the Fevers Unit of the Korle-Bu Teaching Hospital, and the Simango (Isolation) ward of the 37 Military Hospital. The Korle-Bu Teaching Hospital and the 37 Military Hospital were chosen for the study because they have separate wards, known as isolation wards, solely designated for the care of HIV/AIDS patients and patients with other infectious diseases. The nurses who work in these wards therefore are in direct contact with, and provide care to HIV/AIDS patients on a daily basis. They are therefore prone to experiencing the work-related challenges that constitute caregiver burden in caregivers of HIV/AIDS patients. Nurses who work in these settings will therefore be best qualified to provide the accurate information on the lived experiences of caring for HIV/AIDS patients. As indicated by Creswell and Creswell (2018), and Maxwell (2013), it is important that the qualitative researcher purposefully select research sites and participants that can provide the requisite information needed to understand the phenomenon being studied, and answer the research questions.

The Korle-Bu Teaching Hospital was established on October 9, 1923, as a general hospital to address the health needs of the indigenous people of the Gold Coast (Korle Bu Teaching Hospital, 2016). It was established under the administration of Sir Gordon Guggisberg, the then Governor of the Gold Coast. The Hospital is located in the Greater Accra Region, in the southern part of Ghana. It became a teaching hospital in 1962 when the University of Ghana Medical School (UGMS) was established for the training of medical doctors (Korle Bu Teaching Hospital, 2013, 2016).

According to the hospital's 2013 annual report (Korle Bu Teaching Hospital, 2013), the Hospital has evolved from a modest 192-bed capacity Hospital to become the national referral Centre in Ghana and the third largest hospital in Africa. The hospital currently has over 4,000 medical and paramedical staff with an average daily attendance of 1,500 patients, about 250 of which are admitted daily for further management (Korle Bu Teaching Hospital, 2016). The clinical and diagnostic departments of the hospital include Medicine, Child Health, Obstetrics and Gynaecology, Pathology, Laboratories, Radiology, Anaesthesia, Surgery, Polyclinic, Accident Centre, and the Surgical/Medical Emergency. The Fevers Unit is under the Medicine Department and caters for all patients with infectious diseases, including HIV/AIDS patients. It serves as the national referral centre for HIV infected patients, and has provided care and support to PLWHA since the first case of HIV was diagnosed in Ghana in 1986 (Lartey et al., 2015).

The 37 Military Hospital is a 500-bed facility located in Accra, the capital city of Ghana and situated about four kilometres from the Kotoka International Airport on the main Airport - Accra Central Road. The hospital was originally established and commissioned on 4th July 1941 by General George Giffard, the British Military

Officer who was the General Officer Commanding the West African Region then (Military Hospital Accra, n.d.). The aim of the hospital, then, was to provide treatment for Gold Coast soldiers injured in the Second World War. It gained the name 37 because it was the 37th Military Hospital to be built in the British Empire. The name was changed to the 37 Military Hospital of the Gold Coast in 1956 and later to 37 Military Hospital of Ghana when the country gained independence in 1957. Currently, the primary objective of the facility is to provide quality healthcare to service personnel and their families, civilian employees of the Ministry of Defence and their families, and ex-service personnel as well as the general public.

The hospital has a staff strength of over 2000 including both soldiers and civilians. The facility is a Teaching Hospital and is made up of several departments including Accident and Emergency, Medical, Surgical, and Paediatrics departments. The isolation ward, known as Simango ward, is under the Medical Division and caters for all patients with infectious diseases, including HIV/AIDS.

3.4 Research Population

The research population is the entire set of individuals or objects that have some common characteristics, or is the entire collection of cases in which a researcher is interested (Polit & Beck, 2017). The population for this study were nurses working in the Fevers Unit of the Korle Bu Teaching hospital, and the Simango (isolation) Ward of the 37 Military hospital. As at the time of conducting this study, there were a total of thirty-five (35) nurses working in the Fevers Unit of the Korle Bu Teaching hospital while the Simango Ward of the 37 Military Hospital had fifteen (15) nurses. The total population was therefore fifty (50) nurses.

3.4.1 Inclusion criteria

The inclusion criteria of a study are the list of requirements potential participants of the study must meet in order to qualify for participating in the study (Mcelroy & Ladner, 2014). As posited by Hornberger and Rangu (2020), an “effective inclusion and exclusion criteria create the ideal pool of participants to get the most beneficial data for the study”.

The purpose of this study was to explore the lived experiences of nurses caring for HIV/AIDS patients. The inclusion criteria were that the potential participants must: 1) be professional nurses, 2) have worked in either the Fevers unit of the Korle-Bu Teaching Hospital, or the Simango ward of the 37 Military hospital for at least one year, and 3) be willing to participate in the study. Equally, professional nurses who have worked in the two wards for at least one year but are now working in different departments or wards of the hospitals and who were willing to participate in the study, also met the inclusion criteria.

3.4.2 Exclusion criteria

The exclusion criteria are characteristics of members of the study population which should not be enrolled into the study (Mcelroy & Ladner, 2014). For this study, non-professional nurses, rotation/internship nurses, and student nurses working in the wards were excluded.

3.5 Sampling Procedure

The purposive sampling procedure, specifically criterion sampling, was adopted to select participants who met the inclusion criteria for the study (Creswell & Poth, 2018). Purposive sampling, a non-probability sampling technique, involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about, or experienced the phenomenon of interest (Creswell & Plano Clark, 2011; Creswell & Poth, 2018). This study was aimed at exploring the lived experiences of nurses caring for HIV/AIDs patients. The participants were nurses who had worked in the isolation wards for a minimum of one year and thus had experienced the burden of care associated with caring for HIV/AIDs patients.

The researcher went to the nurse managers of the two isolation wards and explained the purpose of the study to them. He then obtained the list, and telephone numbers of nurses who met the inclusion criteria, i.e., professional nurses who have worked in the isolation wards for at least one year. These nurses were eighter met physically on the ward, or contacted through phone calls, and the purpose of the study was explained to them. The nurses who were willing to participate in the study were identified. Convenient times to meet for data collection was arranged between each of these identified nurses and the researcher. These pre-arranged schedules were followed for interviewing the participants in their respective hospitals, until data saturation was reached.

3.6 Sample Size

In qualitative research, the sample size is rarely determined in advance (Neuman, 2006) because there is no specific answer to the question of what constitutes an adequate sample size for qualitative studies (Creswell & Creswell, 2018; Creswell & Poth, 2018; Hennink, Kaiser, & Weber, 2019). In determining the sample size for this study therefore, the researcher was guided by the principle of data saturation, the guiding principle most commonly employed for estimating sample sizes in qualitative research (Guest, Namey, & Chen, 2020; Mason, 2010; Saunders et al., 2018). This principle described saturation as the point at which data being gathered became redundant or when no new ideas or information were forthcoming from participants. To determine how many qualitative interviews are enough, Coenen et al. (2012) posited that saturation should be confirmed only after no new insights emerged in two or three consecutive interviews or focus groups.

In this study, when no new insights were emerging after the 11th interview, it was deemed that the data collection had reached a saturation point. However, in line with the position of Coenen et al. (2012), two more interviews were conducted to ensure and confirm that there are no new themes emerging. As a result, data collection was therefore stopped after the 13th interview.

3.7 Interview Guide

Qualitative research involves generating data about what the participants say and do in their natural settings to discover the world as they themselves see and experience it. Data collection instruments commonly used include interview guides, observation schedules, and focus group discussion schedules (Creswell, 2014). In this study, two separate semi-structured interview guides designed by the researcher, one for the nurses working in the isolation ward (Appendix H), and the other for the nurse managers of the isolation ward (Appendix I) were employed as the tools for data collection. The interview guides were developed to reflect the objectives of the study and the research questions.

The interview guide for nurses working in the isolation ward consisted of six sections, namely sections A to F. Section A comprised of participants' demographic data, section B contained questions on caring for HIV/AIDS patients, while section C contained the main questions on challenges faced by nurses while caring for the patients. Section D covered questions on impact of work-related challenges on nurses, while sections E and F contained questions on support systems for the nurses, and coping strategies, respectively.

The interview guide for nurse managers of the isolation ward has three sections; i.e., sections A, B, and C. Section A contained demographic information, section B contained questions on the work schedules of the nurse manager while section C covered questions on support systems for the nurses.

3.8 Procedure for Data Collection

Prior to the commencement of data collection, introductory letters from the Department of Counselling Psychology of the University of Education, Winneba (Appendices A and B), were taken to the heads of the 37 Military Hospital, and the Korle Bu Teaching Hospital respectively seeking permission to conduct the study at the two health facilities. A separate introductory letter (Appendix C) was presented to the Institutional Review Board (IRB) of the 37 Military Hospital, while the same introductory letter (Appendix B) was presented to the IRB of the Korle Bu Teaching Hospital to seek ethical clearance for the study. To fulfil the requirement for obtaining the ethical clearance, the research proposal was submitted to the IRBs of the two hospitals for their review prior to granting of the ethical clearance.

After approval has been granted by the heads of the hospitals, and ethical clearance (Appendices D and E) has been obtained from the IRBs of the two hospitals, the researcher contacted the nurse managers of the two wards and the intention to conduct the study was made known to them, and the purpose of the study explained to them. The nurse managers' assistance was sought in identifying the nurses who met the inclusion criteria for the study. After these nurses were identified, the purpose of the study was explained to them using the information and informed consent form

(Appendix F), and their permission was sought for their participating in the study. The nurses who were willing to participate in the study were then recruited, each of them signed the volunteer agreement form (Appendix G) and agreements were reached between them and the researcher about the convenient date and time for the interviews. These agreements were followed in data collection. In view of the Covid - 19 pandemic and the preventive measures instituted to curb the spread of the disease, such as social distancing and the need to avoid physical contact as much as possible, most of the interactions with the nurse managers and the nurses, were done through telephone calls and WhatsApp messages. The actual interview sessions were done face-to-face while adhering to the Covid-19 protocols.

In-depth face- to- face, audio-taped interviews were conducted with each participant and their nonverbal cues in the form of facial expressions, and gestures as they narrate their experiences, were documented as field notes. The interviews, which lasted between 19 minutes and one hour, were conducted in English. The interviews were conducted at a time convenient to each respective participant, in either the staff rest room, a private room, or a secluded area in the ward in order to provide privacy to the participants and avoid interruptions so that they can feel free to express their views about the subject. Follow-up interviews were conducted with three of the participants, to help clarify certain gaps and misunderstandings that emerged after the first interviews were transcribed.

3.9 Data Analysis

This is a process of examining and interpreting the data gathered in order to elicit meaning, gain understanding, and develop empirical knowledge (Grove et al., 2013). In qualitative research, data analysis is done simultaneously with data collection, and occurs both in and out of the field (Merriam & Tisdell, 2016), and begins immediately after finishing the first interview or observation (Maxwell, 2013). Data analysis in qualitative research consists of preparing and organizing the data (i.e., text data as in transcripts, or image data as in photographs) for analysis; then reducing the data into themes through a process of coding and condensing the codes; and finally representing the data in figures, tables, or a discussion (Creswell & Poth, 2018). In this study, the data was analysed using the six-phase guide to doing thematic analysis recommended by Braun and Clarke (2006). The six phases of thematic analysis identified by Braun and Clarke are; familiarizing with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report.

Familiarizing with the data involves getting immersed in the data to the extent of becoming familiar with the depth and breadth of its content. This was done by first listening to the recorded interviews, and then transcribing them verbatim. The transcript was cross-checked for accuracy and completeness by replaying the audiotaped information and comparing it with the transcribed data while filling the missing links. After getting satisfied with their accuracy and completeness, each transcript was read repeatedly in an active way while searching for meanings and patterns, and taking notes or marking ideas for coding. Interesting features of the data were coded in a systematic fashion across the entire data set, collating data relevant to each code.

The codes were collated into potential themes and all data relevant to each potential theme were identified and highlighted. The themes were then checked and refined in relation to coded extracts. There was on-going analysis to refine the specifics of each theme and the experiences narrated by the participants as revealed by the analysis. This led to the generation of clear definitions and names for each theme. At the final phase of the process, rich and convincing extracts were selected as examples to buttress the themes. These were also further refined and analysed, leading to a selection of final extracts which were related to the research questions and objectives after which a report was produced as the findings of the study.

3.10 Data Management

Data management in the research process can be described as the effective handling of the data or information that is created during the course of conducting research. Data management is important because it ensures safekeeping of data during the research process, reduces the risk of data loss, increases accuracy and verifiability of the data (Given, 2008), as well as ensure confidentiality of the participants (Polit & Beck, 2017).

All the audio recordings of the interviews were saved on the researcher's personal computer, secured with a password known only to the researcher. The audio recordings were transcribed verbatim immediately after each interview. The soft copies of the transcripts were also saved in a folder on the researcher's personal computer and secured with a password known only to the researcher. The hard copies of each transcript, as well as the individual consent forms for each participant, were filed separately and labelled with a code number. After analysis of each transcript, the files containing the transcripts were kept under lock and key, and accessible to only the researcher and his supervisors. The audio recordings will be destroyed after the work has been submitted, while the transcribed data will be stored for a period of five (5) years and thereafter destroyed. According to section 1.08 of the Publication

Manual of the American Psychological Association, (APA, 2010), researchers are expected to retain their raw data for a minimum of five years after publication of the research.

3.11 Ensuring Trustworthiness or Rigor

The concept of trustworthiness or rigor in qualitative research, is the extent to which the findings are a true reflection or accuracy of the participants' personal or lived experiences of the phenomenon under investigation. According to Lincoln and Guba (1985), trustworthiness or rigor is established when findings of the study reflect, as closely as possible, the meanings as described by the research participants. Other authors defined the term as a measure of determining whether the research findings are accurate from the standpoint of the researcher, the participant, or the readers of the report (Creswell, 2014, 2016; Creswell & Miller, 2000; Lincoln, Lynham, & Guba, 2013; Polit & Beck, 2017).

Trustworthiness is an important consideration in evaluating the findings of qualitative research. It is an indicator of the extent to which the study was conducted meticulously, and hence, the value of a qualitative research is strengthened by its trustworthiness (Lincoln & Guba, 1985). Lietz, Langer, & Furman (2006) declared that trustworthiness involves engaging in efforts that increase the confidence that the findings of the study represent the meanings presented by the participants. This study explored the lived experiences of nurses caring for HIV/AIDS patients. To determine the trustworthiness of the findings of the study, the researcher adopted the four evaluation criteria suggested by Lincoln and Guba (1985) namely; credibility, transferability, dependability and confirmability, as described below.

3.11.1 Credibility

Credibility refers to confidence in the truth of the data and interpretations of such data (Polit & Beck, 2017). It is about establishing whether or not the research findings represent acceptable information drawn from the participants' original data and is a correct interpretation of the participants' original views (Lincoln & Guba, 1985). As was pointed out by Lincoln and Guba, credibility involves 1) carrying out the study in a way that enhances the believability of the findings, and 2) taking steps to demonstrate credibility in the research reports.

In addressing the issue of credibility, Shenton (2004) indicated that researchers attempt to establish that a true picture of the phenomenon under study is being presented. Strategies used to establish credibility include prolonged engagement with study participants, persistent observation (if appropriate to the study), peer-debriefing, member-checking, triangulation, and reflective journaling (Anney, 2014; Connelly, 2016; Creswell, 2014; Creswell & Creswell, 2018; Denzin & Lincoln, 2018; Lincoln & Guba, 1985). In the current study, the strategies adopted by the researcher to ensure credibility of the findings include: prolonged engagement in the research setting, peer debriefing, and member checking.

3.11.1.1 Prolonged engagement in the research setting

The researcher invested a lot of time in the data gathering process in order to have an in-depth understanding of the nurses' experiences as they care for the HIV/AIDS patients on the wards. Arrangements were made with the participants so that the researcher could return to them for follow up interviews to seek confirmation or clarification of issues discussed during previous interview sessions. In accordance to this prior arrangement, a second interview was conducted with three of the participants. This was after the first interviews were transcribed and it was realised that certain gaps and misunderstandings emerged that needed to be clarified. The second interview sessions helped cleared all doubts and inconsistencies in the participants' narrations and thus confirmed the information provided as credible.

The researcher, prior to conducting the interviews, visited the research settings more than once, and engaged the participants in conversations and discussions about the study. Similar engagements were made on phone and WhatsApp to discuss the dates for the interview. These engagements with the participants helped in the building of trust and establishment of rapport between the researcher and the participants. It was intended to make it more likely for a rich and detailed information to be obtained (Polit & Beck, 2017) as it helped minimize distortions of information that might arise if there were no familiarity between the researcher and participants. As was stressed by Anney (2014), prolonged engagement in the fieldwork helps the researcher to understand the core issues that might affect the quality of the data because it helps to develop trust with study participants.

3.11.1.2 Peer Debriefing

Peer debriefing is the process that involves a researcher locating a person, referred to as a peer debriefer, who critiques and asks questions about the study so that the account will resonate with people other than the researcher (Creswell & Creswell, 2018; Lincoln & Guba, 1985). This probing includes, but is not limited to, methodology, interpretation, and analysis of data. The process involves a researcher exposing himself/herself to searching questions from other people (Creswell, 2014). The purpose of peer debriefing is to ensure that aspects of the research that might otherwise remain only hidden in the researcher's mind are explored by neutral persons. Anney (2014) stressed that peer debriefings are vital because feedback from peers help the researcher to improve the quality of the study findings.

In this study therefore, the researcher discussed the topic and his ideas behind choosing the topic with his supervisors who provided useful guidance on the project. He also engaged his colleague students and other researchers, and sought their views about the suitability and feasibility of the topic. The researcher also did presentations during peer reviewed class seminars during which his course mates critiqued the topic and made useful suggestions.

During the process of undertaking this study, the researcher was in constant consultation with his supervisors and other lecturers, and opened up his work to be critiqued by his peers and others willing to provide scholarly guidance. During the process of data analysis, the researcher liaised with some of his colleagues to engage in consensual or intercoder coding. The draft study report was given to colleagues of the researcher and other researchers for their review. Finally, the draft report was reviewed by the researcher's supervisors before the final report was written.

3.11.1.3 Member Checking

Member checking involves taking the report or parts of it or specific descriptions or themes back to participants for them to confirm whether it is an accurate representation of their experiences (Creswell, 2014; Given, 2008; Polit & Beck, 2017). Lincoln and Guba (1985), and Onwuegbuzie and Leech, (2007) posited that member checking is a vital procedure that any qualitative researcher must undergo because it is the heart of credibility of the qualitative research findings. Member checking involves researchers asking participants to elaborate on, or clarify what they have said in interviews or done in observed scenes or when researchers sum up what they have heard at the end of an interview or seen following an observation session, and then ask participants to comment on the accuracy of these summaries (Given, 2008).

In this study, during and after data analysis, the researcher discussed the major findings and themes with some of the participants to seek their views on the authenticity of the report. This gave participants the opportunity to review the report and make comments on the themes and findings.

3.11.2 Transferability

The concept of transferability refers to the degree to which findings of the research can be transferred to or applied to other settings or contexts with other respondents (Anney, 2014; Bitsch, 2005; Polit & Beck, 2017). Bassey (1981) suggested that transferability could only be achieved if people in other settings or contexts believe their situations to be similar to those described in a particular study, and hence may relate the findings to their own positions. The strategies researchers can use to ensure transferability of qualitative research include; providing 'thick descriptions' of the research process, and the use of purposive sampling techniques (Anney, 2014). In this study, the strategies of 'thick descriptions', and use of purposive sampling, specifically the criterion sampling technique, to select participants for the study were applied to ensure transferability.

3.11.2.1 Thick description

The phrase "thick description" originally meant an "insider's account" (Maxwell, 2013), but has come to be used to refer to "a highly descriptive, detailed presentation of a study setting and in particular, the findings of a study" (Merriam & Tisdell, 2016). When thick description is used as a strategy to ensure transferability, it refers to a description of the setting and participants of the study, as well as a detailed description of the findings with adequate evidence presented in the form of quotes from participant interviews, field notes, and documents (Merriam & Tisdell, 2016). Polit and Beck (2017) described thick description as a rich, thorough, and vivid description of the research context, the study participants, and the experiences and processes observed during the inquiry.

Various authors have alluded to the fact that the researcher has a vital role to play in using thick description as a strategy to ensure transferability. For example Lincoln and Guba (1985) noted that it is the responsibility of the researcher to provide adequate descriptive data about the study to enable readers to evaluate the applicability of the data to other contexts. Amankwaa (2016) stated that researchers need to provide a rich picture of the research process that will inform and resonate with readers. Similarly, Shenton (2004) also stated that to allow for transferability, the researcher must provide sufficient detail of the context of the fieldwork for the readers to be able to decide whether the prevailing environment is similar to another situation, and whether the findings can justifiably be applied to the other setting.

In this study, a detailed description of the setting and the entire process of the study; that is rich and extensive details about the methodology from the setting, data collection procedure, data analysis to the production of the final study report were done in order to enhance transferability. Direct quotes from participants were used to support emerging themes. Providing a thick description that provides detailed information about the research process helps other researchers to replicate the study with similar conditions in other settings (Shenton, 2004) as it enables judgments to be made about how well the context of the study fits other contexts (Guba, 1981; Polit &

Beck, 2017). By providing thick description of the research process, and using direct quotes from participants to support emerging themes and findings of the study to ensure transferability of the study, the researcher had also demonstrated adherence to the subjectivist epistemology assumption of the constructivist paradigm that underpinned the study. The assumption of a subjectivist epistemology, as stated by Punch (2005), ensures that the knowledge generated from the research is socially constructed from personal experiences of the real life within the natural settings in which the phenomenon is being investigated, and the constructivist researcher makes meaning of the data through his or her own thinking and cognitive processing of data informed by their interactions with the study participants (Kivunja & Kuyini, 2017).

3.11.2.2 Purposive sampling

Purposive sampling is a non-probability sampling technique that involves identifying and selecting individuals or groups of individuals who are especially knowledgeable about, or experienced the phenomenon of interest to the researcher (Cohen et al., 2018; Creswell & Plano Clark, 2011; Creswell & Poth, 2018). In this study, purposive sampling, specifically the criterion sampling technique was adopted in recruiting participants. The criterion sampling technique seeks to select participants who meet some predetermined criterion (Creswell & Poth, 2018). The choice of this technique ensured that the participants recruited were nurses who have been caring for HIV/AIDS patients for at least one year, or who have provided care to HIV/AIDS patients for at least one year before been transferred to other wards or departments of the selected hospitals. Having worked in the isolation wards for at least one year would have made these nurses knowledgeable about the phenomena under investigation.

Using the purposive sampling method thus, as stated by Cohen et al. (2018), provides greater in-depth findings than other probability samplings methods. Using the purposive sampling method, for the reasons stated above, agrees with the relativist ontological assumption of the constructivist paradigm that underpinned this study, which implies that all knowledge about a phenomenon is relative to the knower and can be understood from the perspective of the individual who is directly involved in the subject being inquired into (Okesina, 2020). It ensured that the researcher had interactions with participants who are most qualified to provide their multiple realities that can be explored and interpreted in order to know the lived experiences of the nurses who provide care to hospitalised HIV/AIDS patients in the selected hospitals in the Accra Metropolis.

3.11.3 Dependability

The dependability criterion in the Lincoln & Guba's (1985) criteria for evaluating the trustworthiness of qualitative research refers to the consistency of data over time and conditions of the study (Polit & Beck, 2017). It is about determining whether the research findings could be consistently repeated if the research were replicated with the same or similar participants in the same or similar setting (Lincoln & Guba, 1985; Polit & Beck, 2017). It involves evaluating the research findings, interpretations and recommendations to confirm that they are accurate reflections of the data collected from the participants (Bitsch, 2005; Cohen et al., 2018). Researchers could use strategies such as use of audit trails, code-recode strategy, peer-debriefings, stepwise replication, triangulation and peer examination (Anney, 2014; Connelly, 2016; Korstjens & Moser, 2018) to establish dependability. In the current study, which explored the lived experiences of nurses caring for HIV/AIDS patients, the researcher used the following procedures to ensure dependability of the study; audit trail of the proceedings, the code-recode strategy, and peer-debriefings.

3.11.3.1 Audit Trail

According to Carcary (2020), the concept of audit trail in qualitative research was originally established by Halpern (1983), and subsequently adopted by Lincoln and Guba (1985) in response to quality issues associated with conducting qualitative research. It is a record of how the study was carried out and how conclusions were arrived at by the researcher (Carcary, 2020; Given, 2008). According to Carcary (2020) the audit trail enables readers to trace through a researcher's logic and determine whether the findings of the study may be relied upon as a platform for further enquiry. It provides a transparent description of the steps taken throughout a research project, supported by a thorough collection of relevant documentation. Audit trails are simply records kept of how qualitative studies are conducted. In this study, the researcher kept the following records as audit trail of the research process: 1) record of the raw data-including the audio recordings of all the interviews conducted, the soft and hard copies of the transcribed interviews, 2) drafts of the data reduction and analysis notes, 3) drafts of the codes and themes, 4) detailed and thick descriptions of the research methodology and measures taken to ensure trustworthiness of the study, 5) the research proposal, and 6) the study time lines and the interview guides.

3.11.3.2 The code-recode strategy

The code-recode strategy, also referred to as code agreement, involves the researcher coding the same data twice, giving one- or two-weeks' gestation period between each coding (Anney, 2014). The results from the two codings were compared to see if they are the same or different. Dependability of the study is enhanced if the multiple coding results are congruent (Anney, 2014). In this study, the researcher utilised the code-recode strategy to ensure dependability.

3.11.4 Confirmability

This is the degree to which the results of an inquiry could be confirmed or corroborated by other researchers (Lincoln & Guba, 1985; Polit & Beck, 2017). The confirmability criterion attempts to question the researcher's biases in the study. It is concerned with establishing that the research data is a true representation of the information provided by the research participants, and that the findings from, and the interpretations of the said data are not creations of the researcher's imagination, but are clearly derived from the data generated (Moon, Brewer, Januchowski-Hartley, Adams, & Blackman, 2016; Polit & Beck, 2017; Shenton, 2004; Tobin & Begley, 2004).

Procedures for ensuring confirmability include triangulation, and keeping of audit trail of the research process (Anney, 2014; Bowen, 2009; Connelly, 2016; Lincoln & Guba, 1985; Polit & Beck, 2017; Shenton, 2004). Confirmability of the current study was ensured by the researcher adopting data or information triangulation, and keeping an audit trail of the research process (as described above). Use of audit trails provided visible evidence that the research findings are real and truly originated from the research process (Bowen, 2009). The measures taken to ensure confirmability of the study are in line with the value-laden or balanced axiology assumed by the constructivist paradigm which dictates that the constructivist researcher makes conscious efforts to present a balanced report of the findings of the study based on the data gathered from the research participants on the field (Goodwin, 2020; Kivunja & Kuyini, 2017; Nguyen, 2019).

3.11.5 Reflexivity

The concept of reflexivity involves the researcher engaging in self-understanding about the biases, values, and experiences that he or she brings to a qualitative research study that could affect the research process and the findings (Creswell & Poth, 2018). It involves the researcher discussing his or her experiences with the phenomenon of interest under study, relaying past experiences through work, schooling, family dynamics, and so forth, and also discussing how these past experiences influence the researcher's interpretation of the phenomenon.

The researcher is a professional nurse in one of the research sites where he had once worked in the isolation ward where HIV/AIDS are cared for. Because the researcher is a key instrument in the process of collecting and analysing data in qualitative research, the researcher's positionality and his past experiences may affect the research process and the findings (Creswell, 2014). It was therefore imperative that the researcher acknowledges this fact and adopt strategies to avoid any biases and hence enhance the trustworthiness of the findings. Strategies adopted to maintaining reflexivity in the study include; peer debriefing, members checking, and keeping a reflexive journal.

Peer debriefing involves the researcher locating a person, referred to as a peer debriefer, who critiques and asks questions about the study so that the account will resonate with people other than the researcher (Creswell & Crewell, 2018; Lincoln & Guba, 1985). The researcher has discussed the topic and his ideas behind choosing the topic with his supervisors who provided useful guidance on the project. Colleagues of the researcher, as well as other academics were engaged and their views were sought about the suitability and feasibility of the topic. They critiqued the topic and made useful suggestions during peer reviewed class seminars. Peers were also engaged during the process of data analysis, and reading of the draft study. Finally, the draft report was reviewed by the researcher's supervisors before the final report was written.

Member checking involves taking the report or parts of it or specific descriptions or themes back to participants for them to confirm whether it is an accurate representation of their experiences (Creswell, 2014; Given, 2008; Polit & Beck, 2017). In this study, member checking was carried out during the data collection process by asking probing questions, and conducting follow-up interviews with three of the participants to help clear doubts about the information they provided. During and after data analysis, the researcher discussed the major findings and themes with some of the participants to seek their views on the authenticity of the report. This gave participants the opportunity to review the report and make comments on the themes and findings.

In keeping a reflexive journal, the researcher kept a personal record of his thoughts, feelings, observations, and reflections on interactions he had with research participants, decisions about the data collection and analysis, and interpretations of findings. The following records of the research process were also kept: the raw data- including the audio recordings of all the interviews conducted, the soft and hard copies of the transcribed interviews.

3.12 Positionality

The researcher is a professional nurse who has once worked in the isolation ward where HIV/AIDS and Tuberculosis patients were cared for. During this period, he has experienced courtesy stigma and other challenges associated with caring for patients with infectious diseases. The researcher also has regular interactions with nurses working in the isolation ward, some of whom narrated their work-related challenges such as stress, courtesy stigma, and risk of HIV infection through occupational exposure. These experiences were the researcher's motivation for conducting this study.

The researcher's professional background, his past experiences, and the fact that he is a staff at one of the research settings, made him an insider researcher in this study. Conditions that make one an insider researcher has been identified to be 1) when the researcher is involved as a professional who has worked with the research population, and 2) when the researcher has experiences similar to the lived experiences of the research participants (Chammas, 2020).

In order to deal with the challenges associated with insider research, a researcher must adopt strategies to establish the trustworthiness of findings of the study (Blythe, Wilkes, Jackson, & Halcomb, 2013; Creswell, 2016; Greene, 2014). In this study, the researcher adopted the evaluative criteria proposed by Lincoln and Guba (1985) for establishing trustworthiness in qualitative research namely; credibility, transferability, dependability, and confirmability. The specific strategies adopted were as discussed under "ensuring trustworthiness or rigor" above. In addition to these, strategies to ensure researcher reflexivity were adopted, as discussed above. These strategies ensured that the researcher conducted the study meticulously, and the findings represented the lived experiences of nurses caring for HIV/AIDS patients as narrated by the participants of the study, and devoid of researcher biases.

3.13 Ethical Issues

Ethical issues in research are concerned with the appropriateness of the researcher's behaviour in relation to the research participants or those who are affected by the research (Gray, 2004). Polit & Beck (2017) also defined the concept of research ethics as a system of moral values concerned with the degree to which research procedures adhere to professional, legal, and social obligations to study participants. It is about researchers making sure they treat both the research participants and the information they provide with honesty and respect (Dawson, 2009). The ethical principles of research involving human participants, such as respect for human dignity, anonymity, beneficence and justice (Polit & Beck, 2017), are designed to protect the rights and welfare of research participants, minimise the risk of causing physical and emotional discomfort, harm and/or danger from research procedures, and ensure the accuracy of the research findings, (APA, 2019).

Ethical issues can arise at any stage of the research process (Creswell, 2016; Creswell & Creswell, 2018; Gray, 2004) therefore researchers need to anticipate them and actively address them in their research plans in order to ensure that the ethical principles of conducting research are adhered to. In this study, the following measures were followed to ensure that the research was ethically conducted.

3.13.1 Permission to conduct the study

Prior to conducting research, the researcher needs to obtain permission from the relevant authorities and gatekeepers in charge of the research settings as well as obtain informed consent from the participants (Creswell, 2016; Creswell & Creswell, 2018; Creswell & Poth, 2018; Singh & Wassenaar, 2016). In this regard therefore, the proposal for this research was submitted to, and defended before a panel of assessors constituted by the Department of Psychology and Education, University of Education, Winneba. After obtaining approval from the panel to commence the study, introductory letters from the Department of Counselling Psychology, University of Education, Winneba, (Appendices A and B) were taken to the Commanding Officer of the 37 Military Hospital, and the Chief Executive Officer of the Korle Bu Teaching Hospital respectively, as well as the Institutional Review Boards (IRBs) of the two hospitals (Appendices B and C) to seek permission, and ethical clearance to conduct the study in the two hospitals.

After the permission and ethical clearance (Appendices D and E) were obtained from the two hospitals, the researcher contacted the nurse managers, of the Fevers' Unit of the Korle Bu Teaching Hospital, and the Simango Ward of the 37 Military Hospital to make the purpose of the study known to them. The assistance of the nurse managers was sought in identifying the nurses who meet the inclusion criteria for the study. After these nurses were identified, the purpose of the study was made known to them and their permission was sought for their participating in the study. The nurses who agreed to participate in the study were met and convenient dates and times for the interview were agreed on.

3.13.2 Informed consent

Obtaining informed consent involves, the researcher, informing the potential participants about their rights, the purpose of the study, procedures to be undertaken, potential risks and benefits of participation in the study, expected duration of study, extent of confidentiality of personal identification and demographic data, so that the participation of participants in the study is entirely voluntary (Polit & Beck, 2017). Informed consent seeks to incorporate the rights of autonomous individuals through self-determination. Individuals can make informed decisions of voluntarily participating in research only if they have information on the possible risks and benefits of the research (Ford & Reutter, 1990).

In this study, an information and informed consent form (Appendix F), prepared by the researcher, was used to recruit participants into the study. The informed consent form contained the necessary general information about the study, such as a brief background of the study, its purpose, procedures that would be followed during the research, possible risks and discomforts, and possible benefits. It also contained information about the confidentiality of participants, that is the fact that any information participants provided while participating in the study would be kept strictly confidential, and the fact that their participation in the study was voluntary, and that they were under no obligation to participate in the study, and had the right to withdraw at any time if they so wished. The consent form also included information on the fact that participants will be interviewed and the interviews will be audio taped.

After the participants had been identified, the informed consent form was reviewed with them individually, and each of them was given the opportunity to ask questions to seek clarification about the information contained on the consent form. The researcher thus provided accurate and complete information to the participants, so that they could understand the details of the study fully, to enable them make a voluntary and thoroughly reasoned decision about their possible participation. The participants who agreed to participate in the study signed a volunteer agreement (Appendix G) as evidence of their willingness to voluntarily participate in the study.

3.13.3 Confidentiality

Confidentiality in qualitative research is the ethical protection the researcher provides to research participants by holding whatever information they provide during the research data collection in confidence or keeping it secret from third parties or the public (Neuman, 2014; Saunders, Kitzinger, &, Kitzinger, 2015). Confidentiality is ensured when the researcher does not, either intentionally or inadvertently, disclose any information provided by the research participants to anyone, except members of the primary research team (Polit & Beck, 2017; Saunders, et al., 2015; Wiles, Crow, Heath, & Charles, 2008). Saunders et al. (2015), Polit and Beck (2017) indicated that researchers must take appropriate steps to ensure that there are no identifying information that links participants to the information they provided.

The following steps were taken to ensure participants' right to confidentiality in this study: 1) during recruitment, participants were assured that their identity and the data collected from them will be kept secret and confidential, 2) during data collection; for the sake of anonymity, participants were given pseudo names. For instance, P1 for participant 1, P2 for participant 2, up to P13 for participant 13. The interviews were conducted at a location out of the public view where nobody can see the participants, or hear whatever they say, 3) during the analysis of data, only the researcher or his supervisors had access to the data records, 4) during the reporting and presentation of the reports, participants were not described in any way that could reveal their true identities. Information from the data would not be released to any other person or persons apart from the researcher's supervisors. All audio recordings of the interviews and the soft copies of the transcribed data were saved on the researcher's personal computer with authorised access. The audio was destroyed after the work has been submitted. The transcripts of the audio recordings were securely stored to be finally destroyed after five years.

3.14 Chapter Summary

This chapter presented the research methodology used for the conduct of the study. It focused on the research paradigm that underpinned the study, the research design, the target population for the study, sample size and sampling techniques, instrumentation and procedure for data collection, and data analysis. It also described measures adopted by the researcher to achieve rigour or trustworthiness of the study. The specific measures the researcher adopted to ensure that the study adhered to ethical standards were also discussed in this chapter. The chapter ended with a description of the researcher’s position in the study. The preceding chapter, chapter four, is devoted to the presentation and discussion of the findings of the study.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF THE FINDINGS

4.0 Introduction

The study focused on exploring the lived experiences of nurses caring for HIV/AIDS patients at the Korle Bu Teaching Hospital and the 37 Military Hospital in Accra, Ghana. In the previous chapter, the methodology used for conducting the research was discussed. It included the research paradigm, research design, population, sample size, sampling techniques, instrumentation, procedure for data collection, and data analysis. This chapter presents the results and discussions of findings of the study. The data was analysed to conform to the objectives of the study, and the findings are presented according to the key themes and sub-themes that emerged during the processes of data analysis. The findings are supported by verbatim quotations of the expressions made by the participants to describe their lived experiences. The alphabet P, followed by a numeral, was at the end of each verbatim quotations as a code to identify the specific participant whose expressions were used to support the themes or the sub-themes for the study. The presentation starting with the demographic characteristics of participants, followed by the themes and sub-themes, and ended with discussion of the findings.

4.1 Demographic Characteristics of Participants

The demographic characteristics of the participants are presented in this section. The demographic characteristics covered are gender, age, marital status, educational level of the participants, their length of practice as nurses, and how long they had worked in the isolation ward providing care to HIV/AIDS patients. These characteristics are presented in Table 4.1 below.

Table 4.1: Demographic Characteristics of Participants

Participant Duration in	Gender Status	Age	Marital	Highest Education	Rank	Nursing Length of Practice	Isolation ward
P1 Years	Male	46	Married	Degree	PNO	19 Years	12
P2 Years	Female	38	Divorced	Degree	NO	12 Years	3
P3 Years	Female	42	Married	Degree	SNO	18 Years	8
P4 Years	Male	42	Married	Diploma	NO	15 Years	8
P5 Years	Female	38	Single	Degree	NO	14 Years	10
P6 Years	Female	37	Married	Degree	SNO	14 Years	13
P7 Years	Female	29	Single	Diploma	SSN	4 Years	3
P8 Years	Female	33	Married	Diploma	SNO	9 Years	5
P9 Years	Female	29	Single	Diploma	SSN	5 Years	5
P10 Years	Female	41	Married	Degree	SNO	17 Years	9
P11 Years	Female	42	Married	PhD	DNS	20 Years	5
P12 Years	Female	56	Married	Masters	DDNS	33 Years	6
P13 Years	Female	33	Single	Diploma	SSN	4 Years	4

Source: Field Data Collected

Key:

SSN: – Senior Staff Nurse
NO: – Nursing Officer
SNO: – Senior Nursing Officer
PNO: – Principal Nursing Officer
DDNS: – Deputy Director of Nursing Services
DNS: – Director of Nursing Services

As shown in Table 4.1, 13 participants comprising 11 females and two males participated in the study. The ages of the participants ranged between 29 and 56 years. Eight of the participants were married, four were single, and one was divorced. Out of the 13 participants, one had PhD in Nursing, one had a Master's degree in Administration, six had first degree in Nursing, and five had diploma in Nursing.

The participants had been practicing as nurses for between four and 33 years, and they had worked specifically in the isolation ward for between three and 13 years. Apart from two of the participants whose entire working life of between four and five years was spent at the isolation ward, the remaining 11 participants had worked in at least one other ward or department of the hospital prior to being posted to the isolation ward. The classification of the participants by their nursing ranks revealed that one was at the rank of a Director of Nursing, one was a Deputy Director of Nursing Services (DDNS), and one was a Principal Nursing Officer (PNO). The rest were; four Senior Nursing Officers (SNOs), three Nursing Officers (NOs), and three Senior Staff Nurses (SSNs). Two of the participants, both females, were ward managers.

4.2 Organization of Themes and Sub-themes

The data were analysed using Braun and Clarke's (2006) six-phase guide in doing thematic analysis. The themes from the data were: 1) description of the care nurses provide to HIV/AIDS patients, 2) challenges associated with caring for HIV/AIDS patients, 3) explanation of how work-related challenges affect the nurses and their caregiving functions, 4) support systems available to the nurses, and 5) coping strategies adopted by the nurses. These five main themes have been organised into 26 sub-themes. Details of the themes and sub-themes are provided in Table 4.2 below.

Table 4.2: Summary of Themes and Sub-themes

Themes	**Sub-Themes**
Description of the care nurses provide to HIV/AIDS patients	Provision of psychosocial support Provision of physical care Provision of financial support Provision of material support
Challenges associated with caring for HIV/AIDS patients	Fear of infection Work-related stress Courtesy stigma Abuse from patients and their relatives Challenges with staff Challenges with material resources Lack of motivation
Explanation of how work-related challenges affect the nurses and their caregiving functions	Physical exhaustion Feelings of anxiety Reluctance to provide care Reactions of family members
Support systems available to the nurses	Support from nurse managers Support from colleague nurses Support from family members Wish for further support
Coping strategies adopted by the nurses	Rationing of Care Rationing of PPEs Involving family members in patient care Self-protection against infection Engaging in CPD Religious Coping Social support

4.3 Theme 1: Description of the care nurses provide to HIV/AIDS Patients

In the interviews, the participants revealed the following as how they took care of the HIV/AIDS patients.

4.3.1 Provision of Psychosocial Support

Psychosocial care consists of attending to the social aspects of the patient’s life as well his or her emotional and psychological needs. Psychosocial care, otherwise known as holistic nursing care, is based on the principle that a patient's biological, social, psychological and spiritual aspects are interconnected. Participants’ responses revealed that the psychosocial care they provided to the HIV/AIDS patients included disclosure (breaking the news about the patients HIV status or HIV/AIDS diagnosis to them), providing counselling services to them, and showing empathy towards them as well as the provision of emotional support to grieving family members when patients die. Participants were therefore, of the view that provision of psychosocial support contributed significantly to the wellbeing of their patients and their family members.

To demonstrate that they provide psychosocial or holistic nursing care to the HIV/AIDS patients, Participant P1 stated that:

> *... I am talking of the totality of the care of the person, starting from the day the person comes to the ward until the person is discharged.*

Regarding the fact that the psychosocial care provided to the patients included provision of disclosure, Participant P10 stated that:

> *... I realized that if they come and we ask them why they are coming in, they don't know the reason they are coming in. So I have to sit the patient down and tell the patient what is happening. Then I reassure the patient that that is not the end of his or her life.*

Another participant, P11 also said:

> *Caring for them begins with breaking the news of their HIV status to them, helping them accept, preparing them for the initiation of the antiretroviral drugs.*

These comments suggested that some of the patients were not fully aware of their diagnosis as at the time of their admission to the ward and the nurses have to make the disclosure. P11 attested to this fact when she stated that:

> *...because at times the patient comes in, the test is done, they are diagnosed, the patient is not aware so the patient comes to the ward and I and the other staff at the ward have to break the news to the patient. So caring for them begins with breaking news of their HIV status news to them, helping them accept, preparing them for the initiation of the antiretroviral drugs.*

The comments also emphasise the importance the nurses attach to disclosure because of its relevance in ensuring that the patients adhere to the treatment regimen. Participants indicated that the provision of counselling services to the HIV/AIDS patients is a very important aspect of the nursing care they provide to the HIV/AIDS patients because it is very necessary in helping the patients understand their condition as HIV/AIDS patients, cope with the burden of living with an incurable disease for life, and adhere to the antiretroviral treatment. Participant 8 stated:

> *Okay, so when I talk about caring for the HIV/AIDS patients, counselling is the first and foremost. Counselling, and it is very, very important because people have a lot of perceptions about the disease.*

The interview data revealed that in providing psychosocial care to the patients, participants displayed empathy towards patients. A Participant revealed the following:

> *Mostly when they (the HIV/AIDS patients) come, they are confused, they are very confused, so I need to be there for them. We call something empathy; I need to be there for them to take them through the process so that they have to accept the condition. If they don't accept the condition and you force them to start the medication, they may not even come back (P1).*

Some participants stated that a way of expressing empathy towards the patients was to have quality time for them, and listen to them:

> *Caring for HIV patients entails a lot, but most importantly I have to be ready to listen to them, so I should have time for them. For them they need time, so if I want to care for them, I should be ready to give them my time, my attention, my love, and understanding. I mean everything, they need special care and dedication (P3)*
>
> *You know the people I am dealing with they are mostly fragile because of what the condition is about, and how society perceives the condition. So anything I am doing for the patient, it must be done with caution. They are already emotionally broken (P9).*

Oher participants also revealed that they empathised with the patients for having to take antiretroviral medications for the rest of their lives. Participant P3, a female who had worked in the isolation ward for eight years said that:

> *People living with HIV/AIDS have to take medications for the rest of their lives. It is not easy, I do feel for them, I think about it. That's why I have to continue giving them counselling while they are taking their medications, because swallowing pills every day. I think it is stressful for them.*

Participant P13, also a female who spent all her four years of practice as a nurse in the isolation ward, stated:

> *You see, taking medication in general is not easy. It's even now that we have them taking one a day. At a point they have to be taking (the medication) morning and evening. So, when they take medication to some point and they feel they are okay, then they've been cured. Some of them when they get to that stage, they get a bit tired taking the medication so they stop. So I need to counsel them, to let them know that for now HIV is incurable.*

According to the participants, the nurses' caring role also involves providing emotional support or comfort to the patients' relatives when patients die and the family members are grieving. Participants explained that while they feel sad about losing a patient, they still have to provide the needed emotional support to the bereaved family members of the patients, while dealing with their own emotions. Participant P3 explained that:

> *We just comfort ourselves and even try to comfort the family members. There are sometimes I get so attached so that I could just go, clean my eyes in the nurses' room, and then come back. I have to be strong to rather comfort the patient's family.*

Participant P4 is a male nurse who had practiced in the isolation ward for eight years. He stated:

> *... it's difficult, relatives come and breaking news (about death of a patient) to them is a whole lot. I remember one heavy woman when we were breaking the news to her, she nearly threw me away. It's difficult, I have to console her, comfort her, or provide emotional support to her.*

4.3.2 Provision of Physical Care

Most of the patients are admitted to hospital at a time when they are very weak and confined to bed, and hence unable to care for themselves. They are therefore dependent on the nurses who had to provide them total physical care. This involves helping them with their activities of daily living and administering their medications. The participants described the physical care they provided to the patients as follows:

> *…I make the beds, I treat pressure areas, I do wound dressings, and pass NG (nasogastric tube) to feed the patients. I have to do it because the patient needs to be fed (P1).*

Participant P11, a female who had worked in the isolation ward for five years said:

> *They come so physically weak and dependent that they need to be provided with total nursing care. They can come in a semiconscious state, and I have to nurse them to regain consciousness. So when I talk about total care, I am talking about helping the patient meet his or her activities of daily living. In the mornings I have to do bed baths, maintain oral hygiene, and then if the patient is bedridden, I have to treat the back and then give medications. If the person is unconscious, I have to feed through a nasogastric tube and then do continuous suctioning, and the monitoring of respiration and other vital signs. Then I do frequent turning of the patient to treat the back so that the patient does not develop bedsores. So it is a total nursing care.*

Other participants also said:

> *In caring for the HIV/AIDS patients, especially when the patients are very, very ill, I do almost everything for them. I care for their personal hygiene, I feed them, if they are not able to feed orally, I do tube feeding (P7).*

> *As a nurse, I have to do everything that the patient cannot do for him or herself. Like turning the patient in bed, bathing the patient, changing their diapers, treat their pressure areas. I have to feed them too, those whom I can't feed orally they will have to be fed through an NG tube. (P13).*

There are some of the patients however who are not totally dependent on the nurses. They only required assistance from the nurses to carry out their activities of daily living. As indicated by a female Participant, P13;

> *Some, I assist them. Like they can be doing part, but you have to be assisting them.*

4.3.3 Provision of Financial Support

Participants' responses revealed that caring for the HIV/AIDS patients include sometimes contributing money to purchase certain basic items needed by the patients. Typical responses from the participants in support of this included the following:

Participant P1, a male who spent 12 years working in the isolation ward said that:

> *... taking care of the HIV patients is not an easy task. Sometimes they prescribe medications, the patient cannot buy. Even some will come common water, they don't have money to buy water. Sometimes I and my colleagues have to contribute money to do the lab tests for some of them.*

Participant P3, a female who had worked for eight years in the isolation ward also explained that:

> *...most of them who come here, finances are a major problem for them. So sometimes you see my colleagues and I most often contributing money to make sure that they get their medications. Some of them, even after discharge, we have to call in the social worker to come to their aid.*

Participant P9 a female who had spent her entire five years period of working as a nurse, in the isolation ward also said:

> *I, personally, have constantly contributed money to buy food for some of our patients. Yes, when they come on admission, their relatives come around for the first two or three days, but when they realised this is the issue, they stop coming. So the patients become a burden on you the nurse. So sometimes my colleagues and I, out of sympathy for them, end up buying food, buying drinking water for them with your own pocket money.*

Participant P2 also said:

> *Some of them come and they are unable to afford their medications. Although the ARVs (HIV medications) are free, there are other tests, labs tests and other medications that they have to buy. You don't see their family members and it is quite frustrating. So, you see the staff contributing money to get those needs for them.*

4.3.4 Provision of Material Support

In the same vein, participants' responses revealed that some of the patients lack the necessary basic personal items needed for their care. The nurses therefore, had to provide these items in order to facilitate their care. Participant P9 stated that:

> *Some of them who come here, they don't even have clothes. So sometimes, my colleagues and I, when we are coming to work, we bring clothing to them from our homes. I buy toiletries for them, I buy towel, and sponge for them. ... they become a burden for on us the nurses. You are supposed to bath a patient, he doesn't have a towel, he doesn't have a sponge, will you leave the patient for the whole week? No, it makes you look irresponsible as a nurse, so you will be compelled to do something. Even if it means getting a pillow case to use as a towel to clean the patient, even if it means going to buy a small face towel to wipe the patient. That is what is happening on the ground.*

Participant P10, a female who had worked in the isolation ward for nine years, said that:

> *...even if you need items to bath the patient it is very difficult. At times we have to even contribute and buy items, some of us have to bring clothing from the house.*

It was revealed that the nurses sometimes serve as advocates for the patients. Participants revealed that they at times have to appeal to individuals and benevolent organizations to help support the patients. With regards to this, some participants stated:

> *There are sometimes the ward gets donations from churches that our DDNS sometimes contact to help. These churches also provide clothing, buckets, bath toiletries, and diapers for the patients who don't have. These also help but it isn't everything that they get (P9).*

> *...there are church members who at times come around to offer help. Maybe the patients need to run one or two labs or they need some things for wound dressing, diapers, they come to provide these things and then maybe at times they buy their medications for them (P13).*

It is clear that the participants were cognisant of the fact that HIV/AIDS affects the patients' and their relatives physically, emotionally, economically, and socially. In caring for these patients therefore, the participants provided holistic nursing care that met the patients' physical, emotional, economic, and social needs. They either assisted the patients to meet their activities of daily living, or provided those activities for them. In meeting the patients' psychological needs, the nurses provided counselling services to them and their family members to help them cope with the challenges associated with living with a chronic incurable disease for the rest of their lives. They also often contributed money to meet the patients' economic and material needs.

4.4 Theme 2: Challenges Associated with Caring for HIV/AIDS Patients

This theme was on the challenges participants encountered in caring for the HIV/AIDS patients. From the interview data, it was realised that the challenges encountered by participants in caring for HIV/AIDS patients were: fear of being infected with HIV through occupational exposure, work-related stresses, experiences of courtesy stigma, abuse from patients and their relatives, resource challenges, and lack of motivation.

4.4.1 Fear of Infection

Cognisant of the fact that occupational exposure to HIV through blood or body fluids of HIV/AIDS patients is a recognised risk factor of HIV infections among healthcare workers, participants revealed that, while caring for the HIV/AIDS patients, they live with a constant fear of being infected with HIV through occupational exposure. Participant P2, a female who had worked in the isolation ward for three years, described her experiences of fear of being infected with HIV through occupational as follows:

> *Sometimes it is scary, it is scary. So anytime I am going near a patient, I just put it at the back of my mind that there is the likelihood that I could get infected.*

Participant P11 also stated:

> *...anytime I am going to work, my heart misses a beat and I become afraid because, I am thinking about 'what if I get infected?' What if? And this what if runs through the minds of every staff every day, and anytime a staff starts showing signs of fever, cough, and other things, everybody's mind is like 'has she been infected?*

Occupational exposure is any skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of a healthcare employee's duties. Participants' responses revealed that they frequently experience occupational exposures to the blood and other body fluids of the patients. Two of the participants narrated the incidence of occupational exposure through needle pricks while caring for the HIV/AIDS patients.

> *There are workplace accidents. On one occasion I was actually pricked by the needle of an infected person. This was the very initial stages as I told you. I was scared, I was anxious, I couldn't believe it. I was taken aback I was like seriously; have I been pricked? (P3).*

> *Personally, I haven't had any, but I have colleagues who have had needle pricks and had to take the medication, the post-exposure prophylaxis. When you have needle pricks or you are exposed, there is postexposure prophylaxis that they give you (P8).*

4.4.2 Work-Related Stress

The participants' responses revealed that caring for HIV/AIDS patients is very stressful. Some of them explained that the demanding nature of the physical care they provide to the patients is what makes their work stressful. Participant P5, who spent 10 years in the isolation ward, described the stressful nature of the caregiving functions by stating:

> *Sometimes the critically ill patients that I encounter makes the work stressful because I have to be constantly monitoring the patients to be able to see the progression of their conditions.*

Participant P1 also said:

> *You see dealing with a patient who has HIV is a big task. It is stressful, very stressful. Sometime, I get traumatised psychologically and physically.*

Participant P7 also stated:

> *Yes, sometimes it is stressful. I remember there was this patient who had end stage HIV and was passing loose stools. So, I have to constantly stand by this patient. He is passing loose stools and I have to be changing the diaper every time, changing the bedsheet every. time so once I come for a shift, it's like I are constantly standing on that patient changing the diaper, changing the bedsheet, hydrating the patient.*

The participants also explained that the emotional stories they hear from the patients, coupled with the fact that they lack adequate resources to work makes their work stressful. A participant stated that:

> *We go through a lot of stress listening to people's stories. Some of the stories are so pathetic, at times I feel like crying with the patient. But I can't do that. As a caregiver, when you do that, your patient will break down. We go through a lot because of the things we hear from them. The patients are pouring their problems on you and your employer too is not giving you the adequate things to work with. All that come together, we go through a lot of stress (P3).*

The participants mentioned a number of factors that are responsible for the work-related stress they experience. Some of these factors include; work overload, constantly witnessing suffering and death of the patients, attachment to, and over-involvement with the patients, neglect of patients by their relatives, and lack of materials.

4.4.2.1 Work Overload

Participants' responses revealed that they often face the challenge of work overload. This, they explained is due to the fact that the nursing staff strength in the isolation wards is usually low, while the number of patients on admission is high. Some participants described the situation with the following words:

> *... going to that area, the staff strength is very, very low compared to the number of patients. There could be about 10 or 15 patients with only two nurses, or there could be only one qualified nurse with a non-professional nurse (P5).*
>
> *... the thing is that the ratio of staff to patients is a problem all-round the country, so it is also a problem in this ward. But we do try to manage (P7).*
>
> *The staff strength, ... at times I will be on night with three other colleagues, and we have 20 patients to care for. All of these patients can't bath, at times some of them you have to give assisted bath. So, for me, I will say in Ghana our staff strength to patients is not encouraging, it is not encouraging (P10).*

The participants' responses revealed that with few nurses caring for large numbers of the HIV/AIDS patients, most of whom are seriously ill, bedridden, and dependent on the nurses for total care, a lot of physical and emotional stress is exerted on the nurses. Some of the participants expressed their views on this issue in the various ways.

Participant P11 explained:

> *No, the staff strength was not enough, because the patient care was quite dependent on us. At times, I could be the only professional nurse on duty with one assistant, and if I have a lot of bed baths to do, before I come to the advanced nursing procedures as well as other basic procedures, you can imagine. So the nurses, we are always very tired.*

Participant P5 also remarked:

> *It is very tiring. Sometimes, I have to spend the whole day on the patients, at times I don't even have time for myself, time to even take my own breakfast or lunch. Sometimes I have to skip them for the sake of the patients" (P5).*

4.4.2.2 Constantly Witnessing Suffering and Death of Patients

Participants explained that most often the patients are admitted to the ward when they are in the terminally stages of the illness and hence end up dying shortly after being admitted to the ward. As they provide care to these patients, the nurses constantly watch these patients as their conditions deteriorate, they suffer and eventually die. Because of the emotional bond of attachment that develops between the nurses and the patients, participants mentioned feeling sad when the HIV and AIDS patients on their wards die. Witnessing the suffering and death of the patients constantly is very stressful as it affects the nurses psychologically. In support of this assertion, some of the participants made the following statements:

> *…most of our clients often come in when they are in their end stages. So, they might come in and then just pass on. When it happens like that you lose most of them. So, on the average I will say we do lose most of them to death. I wish they will recover so that we can sit and go down memory lane and laugh at certain things but at times it happens like that. Indeed, I feel sad about it (P3).*
>
> *There are feelings of sadness when the patients pass away. Yes, especially when they are young people who usually come and they pass on. I feel very sad. (P2)*
>
> *"Sometimes I feel it deep down myself that I have done a lot for the patients but they couldn't make it. It is not easy at all" (P1).*
>
> *... the feeling of losing a patient is really a sad thing and something that I sometimes find difficult to really overcome, especially when the patients are very young. (P7)*
>
> *Emotionally, I feel very down. It's like all my efforts have been wasted. It's like all I have done have been useless (P13).*

4.4.2.3 Attachment to, and Over-involvement with the Patients

During the process of caring for the HIV/AIDS patients, a bond of attachment often develops between the nurses as caregivers, and the HIV/AIDS patients as care recipients.

Participant P13 remarked that:

> *You see at times I take care of certain people for a certain period and then you become like a family.*

Consequent to this bond of attachment that develops between the nurses and patients, the nurses sometimes tend to get over-involved with the patients. This over-involvement often made some of them unable to detach themselves from the pain experienced by the patients, and their death. Some participants thus explained that because of the strong bonds of emotional attachment that usually develop between them and the patients, they at times are unable to detach themselves from the pain and death of the patients, and they virtually carry the pain and sadness from the hospital to their homes. Participant P2 stated that:

> *… there are times I get home and still continue thinking about my patients. When I think about their conditions and how they are suffering, I get home and I just get sad, I can't even sleep at night. Yes, it happens.*

P1 also said:

> *It is not easy at all. Sometimes I go to the house and when I remember all that I have done for this particular patient and yet he or she passes on, I feel like crying.*

4.4.2.4 Neglect of Patients by their Relatives

Another source of work-related stresses experienced by the nurses caring for HIV/AIDS patients is neglect of the patients by their relatives. Participants revealed that some of the patients admitted to the ward are often neglected by their relatives. This also put a lot of pressure on them as they, in addition to performing their caregiving roles, also have to perform all the obligations of these patients' relatives. Some of the participants stated that:

> *Some of them have been neglected by their families, rejected by their families (P1).*

> *Their relations bring them here and some of them when they finally realise what their relations are going through, they dump them here. They go and never come back. Medication becomes a problem. As to how laboratory investigations should get done becomes a problem. So they all become a burden on the nurse (P9).*

> *... at times they [relatives] will come and dump patients here. I don't know if it is because of the stigma. They will never come. Even if you need items to bath the patient, it is difficult (P10).*

> *Most of the patients were like a gift to the ward. ... their relatives bring them and they run away. You won't see them again. If you are lucky, then in the morning somebody will pass through (P11).*

> *... another aspect is we getting some of the relatives leaving the patients in our care, not providing the basic needs of these patients. Some of them come and they just leave the patients in our care. You need medications for the patient the relatives are not coming, some of them wouldn't even want the food provided by the hospital then it becomes an issue (P13).*

4.4.2.5 Lack of Materials

Participants also identified lack of materials the nurses need to care for the patients, as one of the causes of the work-related stress they experience while caring for the patients. P1, a male nurse who had worked in the isolation ward for 12 years remarked that:

> *...we feel stressful because what you want to do at that particular time, the things you need are not there so you feel stressed, you feel embarrassed, and at the end of the day you go to the house tired.*

P2, a female who had worked for three years in the isolation ward also explained that:

> *Most of the times they (the PPEs) come in short supply. So sometimes it makes it difficult doing the work.*

4.4.3 Courtesy Stigma

Stigma is being perceived in a negative way because of one's particular circumstances. Courtesy stigma, also referred to as 'stigma by association', is the type of stigma experienced by any person because of their close association with another person who has a stigmatizing condition. HIV/AIDS is a stigmatizing condition and people associated with HIV/AIDS patients such as their family members, friends, and even their caregivers are often stigmatized. Participants of the study narrated that they experience HIV-related courtesy stigma because of their association with the HIV/AIDS patients. Some participants commented that:

> *I feel very stigmatised, I feel very stigmatised (P11).*

> *At times people pass certain comments that make me feel like ahh! is it because I am on this ward? You know at times I meet my colleagues and they will be like [spoke in Twi] "Eeei muhwɛ HIV foɔ no" [Eeei look at the HIV people] (P3).*

Participants further indicated that the courtesy stigma and discrimination they experienced was often perpetrated against them by their professional colleagues. In support of this assertion, participants made statements such as:

> *Even sometimes I feel stigmatized by my own colleagues. Some see me and they are like … so you are still here, hmmm take care ohh. Sometimes these are the comments they pass even as my colleague nurses. That is the problem here. (P9)*

> *…I am talking about professional colleagues, yes. These are professionals, nurses, colleague nurses, some are doctors, and pharmacists (P3).*

Participants' responses revealed that they often experience stigmatizing attitudes such as being labelled with names that identified them as people associated with HIV/AIDS. Some participants stated the following:

Participant P6 said:

> *It is saddening that you meet colleagues and these colleagues are pointing fingers at you.*

Participant P2 also said:

> *It's funny. Some even think it's because I have also been infected that is why I was posted to go and work with HIV/AIDS patients. Some people have seen me and sympathised with me for working in the isolation unit.*

Participant P13 also explained that:

> *An example is, I heard this comment, somebody was like 'ohh the nurses here, some of them have it (HIV)'. They are like we have it (HIV) but we've being taking our medications well so we are looking nice and healthy. So you can imagine, because I am taking care of a retro patient, people are assuming I also have one (P13).*

Participants' responses also revealed that because of their association with the HI/AIDS patients, their colleagues in other wards or departments at times make conscious efforts to avoid them. Some participants explained that:

> *Ohh ... the colleagues that are outside, once they know that you are working in the isolation ward, it's like they don't want to come near you. They will say ... you are working in isolation ward? They don't want to converse with you (P7).*
>
> *Yes, it was that bad that I go for meetings and unconsciously or consciously people do not even want to sit close to me because I am coming from isolation ward. It was that bad. (P11).*
>
> *Most of the time, even if they are getting close and I want to greet them, or I meet them on the corridor, they don't even want to enter the ward so they make utterances like 'ohh isolation ward, let me draw back ohh'. In a funny way but the person has said it. It hurts sometimes (P5).*
>
> *... even sometimes, you are going and you want to shake hands with somebody and he will say no, you are in the isolation ward, I won't shake you (P1).*
>
> *...at times they want to visit me on the ward but they don't want to enter the ward. They want me to come outside and meet them because they also have this notion that it is a very infectious area (P3).*

Participants revealed that, not only do their colleagues and staff in other wards of the hospital tried to avoid them, they also avoided any object from the isolation ward. Participant P11 explained that:

> *Those of us working in the isolation ward, we are very stigmatised to the extent that if something leaves the ward, and goes to another ward, they reject it. Ahaa, they reject it. So that was the kind of thing that we were going through (P11).*

Participants' responses revealed that certain actions and behaviours by their colleagues and even nurse managers made them (participants) feel neglected and rejected because of their association with the HIV/AIDS patients. A participant made the following comments in support of this:

> *...the management of the hospital didn't frequent the ward because they felt they may be infected when they come to the ward. To the extent that if the Matron wanted to come to the ward, she will stand at the entrance of the ward and call out whoever she is looking for. So, it was kind of rejection from the staff, rejection from your own people you know, and if they happen to enter the ward, they would want to open doors with their legs so that their hands don't touch anywhere (P11).*

Participants of the study ascribe some reasons to why their own professional colleagues or even the nurse managers perpetrate acts of stigma against them. Some of them stated that:

Participant P3 stated:

> *At times they want to visit you on the ward but they don't want to enter the ward, they want you to come outside and meet them because they also have this notion that it is a very infectious area, when you enter you might get something you do not wish to get.*

Other participants believe the perpetrators of the stigma against them do so because of their ignorance or lack of adequate knowledge about the mode of transmission of the HIV. One such participant stated that:

> *I am sure the education has not gone down that is why. People have to know that getting HIV/AIDS, you don't get it through social contact. So, if I shake you, it doesn't mean that I am giving you HIV. Maybe they didn't understand the profession well otherwise they will not shun you. If they understand the profession well, they won't do that. The education did not go down with them that's why (P1)*

4.4.4 Abuse from Patients and their Relatives

Participants reported that they sometimes suffer verbal and physical abuse from the patients and their relatives. These were narrated by some participants who stated that:

> *…sometimes the patients will physically assault you. Yes, it happened to me. I even had a sprain of my thumb because a patient hit me (P1).*
>
> *Some are verbally abusive; others too are violent because most of them do not believe it when you break the news to them. Let me give you a typical example. There was one man, newly married for about six months, and then our in-charge then tried to break the news to him, …the man started insulting us. He started raining insults on all of us. So those are some of the things. As for the verbal insults is common. It is common" (P4).*
>
> *Some of them, they are verbally abusive, they even spit on you. They shout, they yell, some of them they try to push things on you and all that. If caution is not taken, you may even injure yourself or they may injure themselves as well or the people around you. For the verbal abuse we get it all the time (P9).*

4.4.5 Resource challenges

Resource challenges encountered by participants are categorised as human resource challenges, and material resource challenges.

4.4.5.1 Human Resource Challenges

These could be inadequate staff, non-rotation of staff, and lack of pre-deployment training.

4.4.5.1.1 Inadequate Staff

The participants' responses revealed that they face a challenge of inadequate nurses in the isolation wards compared to the number of HIV/AIDS patients they had to care for. Some of them stated that:

> *… the staff strength is very, very low compared to the number of patients. You could have about fifteen or ten patients with only two nurses, or you could have only one qualified nurse with someone who is not a professional nurse (P5).*

> *… hmmm, it's quite poor, the staff strength actually is a problem. Errrm, we manage though, but you can have as little as, or should I say as low as two nurses (P3).*
>
> *We were having two professionals and two assistants per shift. In the worst case you may have two professionals and one assistant. At times you have one professional and one assistant and if you have a lot of bed baths to do, you can imagine. So as for the patient-staff ratio, it was not enough at all (P11).*
>
> *Initially when I started working in this ward, I was mostly running the night duty and at that time we were two running the shift. As at that time, … we have in-patients like close to eighteen. Eighteen patients, most of whom were seriously ill and bedridden and we have to do virtually everything for them" (P9).*
>
> *… there are times the ward can be full, with that then the staff strength becomes low and then we become very stressed. Because taking care of a patient who is almost, I will say dependent on you, it's not easy, and there are certain nursing duties you can't do alone, you require assistance from your colleagues (P13).*

In view of this challenge, one of the participants expressed the need for more nurses to be employed to help address the situation. He therefore stated the following:

> *We don't have the staff, what do you do? So we need to employ more but you know, the resources are not there (P1).*

4.4.5.1.2 Non-rotation of Staff

Another issue of concern to the nurses was about how long they work in the isolation wards. The participants bemoaned the fact that there is no clear-cut policy on the rotation of nurses working in the isolation ward. This, they explained, leads to the nurses working in the isolation wards for long periods. The following comments by some of the participants confirm the nurses' concerns.

> *… for now, there is nothing put in place like that but I remember the former matron was saying that because it is an infectious ward, you should not stay here for more than five years. Because you are exposed, so at least after five years you should be moved to another ward so that when you go there and you are going to take care of different conditions altogether. But for now, nothing of that sort has happened (P1).*

> *Actually no. There are no laid down policies, but what we know is that from time to time, they do general changes (P9).*
>
> *There is no policy. Some people have been working here since they were recruited in this hospital. They've been here, they haven't been to any other department. So sometimes it's like when you don't even talk, when you don't opt for changes, you will just be here (P8).*
>
> *So far, I am not sure of the number of years that you are supposed to work here, because when it comes to our postings you don't really have any time to it. Once in a while the management just comes up with reshuffling. My former ward, I was there for quite a number of years, I think seven years or so before I was posted here (P2).*
>
> *Okay, for me, since I came to the ward, I have met people who have been there for several years like say five years, seven years, and I have also come to meet people who were there for two years and they were transferred out (P7)*
>
> *…there is nothing like that and even if you want to lobby to be moved from there, unless you have a strong connection [laughed], nobody would mind you, nobody will mind you. So, you are just there. I went there and I met people who have worked for more than five years there and I left them there and they are still there. Yes, and they are still there. But when we were there, we learnt that when people work there for about five years, they are supposed to be removed but they were not working with it and I never saw any document to even refer to, it was just a hear-say. So that is it, we were there for a long time nobody was saying anything to us" (P11).*

4.4.5.1.3 Lack of Pre-deployment Training

Participants considered the isolation ward a unique working environment. They therefore expected that prior to being posted there, they will be provided training specific to working in the isolation ward, and taking care of patients with infectious diseases. Such a special training, they hoped, will equip them with knowledge about the conditions they are going to care for, and what is entailed in caring for patients with HIV/AIDS as well as the inherent challenges they are likely to face while caring for the HIV/AIDS patients. Two of the participants stated that:

> *I would have loved that before coming to the ward, we would have had some specific training because this is a different area. Beginning work here without knowing anything you are like a novice, so you have to be*

> *ignorant about a whole lot of things for some period of time before you pick up. It is not a pleasant experience* (*P*8).

> *May be what I will say is that … people who are sent to the isolation wards should be properly prepared. (P11).*

All the participants however, revealed that they were not given any specific training about caring for the HIV/AIDS patients prior to being posted to the isolation ward. According to them, what they had was a sort of on-the-job training when they got onto the ward. Some of their comments on this issue included:

> *No there wasn't any special or initial training apart from the barrier nursing that we all learnt from our training colleges. That was what I had, but no official training, apart from you going there and being oriented on where to find what to work with (P6).*

> *No, I didn't receive any special training but what was done was that when I entered the ward, the ward in-charges and the administrators educated me on the ways and means of caring for the patients that we were going to encounter (P7).*

> *"I didn't have any special training but when I came here, they did a quick orientation for me. Like what working here entails, what they do here, they will tell you their routine services, and they will stress more on confidentiality" (P10).*

> *Actually here, all I had was, let's say on the job training. As I got to the ward I was shown round and when there is in-service training or something concerning conditions of our patients we are sometimes sent to go and learn about such, and get information about such conditions (P2).*

Another participant however was not bothered by the fact that she did not receive any specific training prior to being posted to the isolation ward because she believed that:

> *As a general nurse, I was expected to function anywhere you are assigned to (P13).*

4.4.5.2 Material resource challenges

The participants identified inadequacy of the material resources they need to enable them work effectively, and also protect themselves against occupational exposure to the blood and body fluids of the patients. The materials of major concern to them are the personal protective equipment (PPEs), and adequate infrastructure. Participants identified the material resources they need to facilitate their caregiving functions. Participant P9 stated that:

> *... the truth of the matter is that we need personal protective clothing. We need highly personal protective equipment like KN 95, surgical masks, gowns, haircaps and all others. You know with this is an isolation unit, we need a lot of functional sinks for handwashing. Water should flow freely, hand tissues, hand towels should be readily available for us to use to make the work somehow easier (P9).*

Participant P3 also said:

> *... basically, anything I will need to work as a nurse. That is PPEs, every one of them, like the gowns, masks, and sharps containers. Adequate supply of PPEs is very important. So, if there are enough them, I can comfortably work on the patients without the fear of being infected.*

In reality however, participants' responses revealed that these materials are not always readily available. Participant P9 indicated that:

> *The PPEs are not readily available; supply is poor but we are managing. Yes, we are managing.*

Participant P8 also said:

> *As for the resources, they are inadequate. They are really, really inadequate and then sometimes when you go and ask, they will just tell you there is none.*

Other participants also expressed their views as follows:

> *... some of the personal protective equipment are not available. The rubber aprons, haircap and all these things, from the time I have been here, sometimes if you are lucky you get at times you wouldn't get. Even during this Covid pandemic, it has been something else. We get but they are not always available as you are supposed to get (P9).*

> *You see in the hospital setup there is a lot of shortage you can mention. Sometimes you want the required PPEs, we are not getting it and the patient is there, you need to protect yourself and go in (P1).*
>
> *Most of the times they (the PPEs) come in short supply. So sometimes it makes it difficult doing the work (P2).*
>
> *I wouldn't say everything is hundred percent readily available. I will say at least the hospital management is trying it's (13).*

A ward manager explained that the inadequacy of PPEs puts a lot of stresses on them as the staff makes demands for the non-readily available PPEs. She stated the following:

> *... yes, it creates a lot of stress because everybody will run to you; 'matron, this is what we need, we are not getting this one', as if you are not performing that's why. But it is not like that, because we also work under somebody and if we need something, we have to call on the person and if the person is not helping, it is very difficult (P12).*

The participants' responses further revealed that the building housing the isolation wards are old with most of the equipment or gadgets malfunctioning. Some of them expressed their dissatisfaction with the poor infrastructure in the following way:

> *...to be frank with you this is an old building. Most of our things, especially our water closets got spoilt. Even we, the staff, when we come on night duty, our washroom where we bath is very bad, when you look at the building it is not conducive kuraa, it doesn't even stimulate you the staff to work here (P10).*
>
> *... the place is old, even if you enter our rest room and you see the chairs, it is so pathetic. The chairs in which we the nurses we rest is so, so pathetic that I couldn't even take you to our rest room for you to even come and sit down to do the interview (P8).*
>
> *... the environment was very, very appalling. It was a neglected ward actually, it was an old structure, and the hospital was not ready to do anything to the environment until we had a patient who came on admission and when the patient was discharged, the mother of the patient decided to adopt the ward. So she brought life to the ward, ahaa, other than that, it was a neglected old structure that you wouldn't even want to see and nobody was interested because they were not coming there. When you are even coming to work, you are*

> *sad because where you are going to be for the next six or eight hours is a neglected place (P11).*

The infrastructural challenges however, were being addressed. During the period of gathering data for the study, management of the two institutions began renovation works on the two isolation wards respectively. Two participants, one from each of the two institutions, who were interviewed after the commencement of the renovation works stated:

Participant P7 declared that:

> *...the building had been there for a long time so the public health division, in conjunction with our ward were trying to see how they can get us a new ward.*

Participant P12 also said:

> *There are a lot of challenges before the renovation. We have a lot of challenges. One is the infrastructure. The infrastructure was very old. We complained to the management and they solicitated for funds to renovate the place. So, the renovation is ongoing.*

4.4.6 Lack of motivation

The participants identified lack of motivation as one of the challenges they experience while caring for the HIV/AIDS patients. They mentioned that because of the stress and challenges inherent in caring for HIV/AIDS patients, they expected that management of the hospitals could provide them monetary incentives in the form of extra pay or insurance packages as a means of motivating them. This however, they explained, was lacking as they receive the same remuneration as their colleagues working in other wards and departments of the hospital. Participants' quotes in support of lack of motivation includes the following:

> *There is no motivation from the system that will give you some extra something making you feel like you are special, no. I think if they bring that one too, it will help. It will motivate the nurses. Uhuu, it will motivate the nurses. Like ……. something for the staff, or promotions or their salary, if they could look into it like add small amount to it, it will help (P5).*

> *… we are supposed to be given risk allowance which we've spoken about several times. Nobody is minding us because they claim that this ward is like any other ward (P8).*
>
> *I can talk of remuneration. You know that when you are working in an isolation ward, there is a particular percentage that is given to you, each staff. We raised it before but it didn't work. Working in isolation ward, there is a percentage that should be given to you. So, I can talk of remuneration, if it is there it can also be helpful (P1).*
>
> *I personally think that working here, since this place is an infectious diseases ward, there should be some form of insurance for the staff, the healthcare providers. Because as I indicated, I was pricked earlier on, you don't know the end result of occupational hazards here. Someone could acquire tuberculosis; someone could get infected with HIV, may be through negligence or may be not through negligence. So, I am thinking that if there could be some form of insurance for healthcare workers dealing directly with these patients, it will be very encouraging and motivating (P3).*

A ward manager, corroborated the concerns of the other participants regarding lack of motivation. She stated the following:

> *… they face stresses, and they are not motivated. You know staff, they need to motivate them, they need to give them risk allowances (P12).*

In summary, it is clear from participants' responses that they encounter numerous work-related challenges while caring for the HIV/AIDS patients. The main challenges they encounter include: fear of being infected with HIV through occupational exposure, work-related stresses, and HIV/AIDS related courtesy stigma. Others are abuse from patients and their relatives, human and material resource challenges, and lack of motivation. The next section discusses theme three, an explanation of how the work-related challenges affect the nurses and their caregiving functions.

4.5 Theme 3: Explanation of how work-related challenges affect the nurses and their caregiving functions

This theme summaries the participants' description of how the work-related challenges they encounter while caring for HIV/AIDS patients, affect them and their caregiving roles. The following sub-themes emerged under this theme. Physical exhaustion, feelings of anxiety, reluctance to care, interaction with family members.

4.5.1 Physical Exhaustion

Participants revealed that caring for HIV/AIDS patients is physically exhausting. Some participants narrated the following:

> *... sometimes I have to spend the whole day on the patient. At times I don't even have time for myself, time to even take my own breakfast or lunch. Sometimes I have to skip them for the sake of the patients. Sometimes I get back home and breakdown because of the workload (P5).*
>
> *... it can be hectic. It breaks your back because you wish you could do everything for your client, satisfy all of them, but you can't (P3).*
>
> *There are times you even have waist pains, back pains, because getting to turn a very big patient, you have pain. At times while you are bathing the patient in bed or maybe you are changing the patient's diaper so it's not easy you have backpains (P13).*

4.5.2 Feelings of anxiety

The participants expressed their feelings of anxiety when they were posted to the isolation ward. This is because of the stigma associated with caring for HIV/AIDS patients, as well as the fear of being infected with HIV while providing care to the patients. The participants' feelings of anxiety were expressed by some of them as follows:

> *I was anxious, I was anxious because of the fact that it was basically retroviral infections we take care of. It was an infectious unit on its own so any new infection that comes to Ghana would have to be taken care of here. So that anxiety was there, so I didn't really like the idea (P8).*
>
> *Hmmm, it wasn't an easy thing, I felt anxious and sad at a point, and you wonder why they chose you (P5).*

Participant P13 was however unperturbed about being posted to the isolation ward. She stated:

> *I knew where I was going, but I wasn't worried, because I believe wherever I am going to, I am going to work. Besides as a general nurse, I believe I could be placed anywhere and I should be able to function wherever I am being placed* (P13).

It could be inferred from participants' responses that; their feelings of anxiety seem to be more intense when they were initially posted to the isolation wards. So intense was their level of anxiety that some of them stated that they wept when they were posted to the isolation ward. In expressing her views on feelings of anxiety, Participant P3 had this to say:

> *Eight years ago, when I was posted here, I actually wept. I wept. I felt like, which ward is this, of all the wards in the hospital why here? Because the story about the ward was a very negative one. Infectious diseases ward, so I actually didn't like it when I was posted.*

Participant P11 also stated:

> *In fact, when I was asked to go to the isolation ward, I wept. Yes, I wept like a baby. Because the isolation ward was seen as a neglected ward where the staff that work there were highly stigmatised. I felt that it was a kind of a punishment. I saw it as a punishment, so I wept, I wept.*

Participant P4 said:

> *… anxiety set in when I was posted to the isolation ward.*

The nurses' level of anxiety, when posted to the isolation ward, seem to have waned as they got settled in the ward. These could be gleaned from the following expressions of the participants after they had worked in the isolation ward for a period of time.

After working in the ward for eight years, Participant P3 seemed to have overcome the initial anxiety and stated that:

> *… my employer posted me to the isolation ward initially but going forward, I didn't want to be moved anymore. I wanted to stay here.*

The reason for the waning of anxiety was that after working in the ward a period of time, participants had a better understanding of the situation in the isolation ward. Participant P3, after working in the isolation ward for eight years, explained that:

> *… along the way, I started understanding my clients, we were becoming friends. I put myself in their shoes and I also realised that they needed more care and love which I was willing to give. Also, I got to understand their sickness, I also got to learn about how to protect myself from getting infected. So, they were not scary to me anymore, because I now know that when I protect myself, I will not get infected with their disease. And they also needed more love and care from me.*

After working in the ward for eight years, P4 also said that:

> *… gradually, when I came here, with the training from the ward in-charge, and the way she talked to us, I got adjusted and started working.*

Participants indicated that the anxiety they felt and expressed when initially posted to the isolation ward was due to the fact that they did not receive any specific training prior to being posted to the ward. To buttress this assertion, Participant P4 said:

> *Well, initially, I did not have much knowledge about HIV, so I was afraid that maybe I was going to contract the disease when I start working here. So, anxiety set in when I was posted.*

Participants P11 said:

> *… not a training for basic people like myself who didn't know anything about management of cases at the isolation ward.*

Participant P2 also stated:

> *… all we did was on the job training. As I got to the ward, I was shown round and when there is in-service or something concerning conditions about our patients, I was sometimes sent to go and learn and get information about such conditions.*

Another participant said:

> *... before I was posted, no, no, no. All I knew was it was an infectious disease ward and people there have HIV, TB and others.* (P3)

These expressions are contrary to expectations of Participant P4 who wished that she had received some training specific to working in the isolation ward before being posted there. She stated:

> *... sure, I would you have wished that I had some prior training or orientation before going to the ward. So that at least I will acquaint yourself with basic knowledge of the care before resuming work.*

4.5.3 Self-blame

Some participants explained that because of the strong bonds of emotional attachment that usually develop between them and the patients, they at times are unable to detach themselves from the pain and death of the patients. Some of them often tend to even blame themselves for the death of the patients. Participant P1 explained:

> *... all that I have done for this patient, at the end of the day he has passed on. What happened? Are there any lapses? Is it that I didn't do my part well or something happened along the line. I feel a bit sad but what can I do?*

Other participants also stated that:

> *At times I start thinking, 'was there something I should have done'? What is it that I didn't do right? It's really sad when things like that happen (P3).*
>
> *When I came to the ward initially, every time a patient dies, I have to go for confession, and unfortunately or fortunately anytime it is the same priest that I meet. So it was like, do you always have to assume that, I mean, fault myself for the death of the patient? So, I go to the house and I am like you I have killed the patient (P6).*
>
> *... because for a patient you pay all the attention to, you come back and the patient dies, you wonder what did you do wrong? (P5).*

4.5.3 Missed nursing care

Participants revealed that the challenge of inadequate staff they experience, sometimes led to the patients missing the necessary nursing care they require. This happens because as a means of dealing with the inadequate staff situation, they often have to ration the care they provide to the patients, or that they were unable to respond to the patients' calls for assistance. While describing this situation, P3, a female nurse who had worked in the isolation ward for eight years stated that:

> *Sure, sure it affects it a lot so at times when we close and we are handing over, you see us apologising to a lot of patients because probably they had made a request or they had called and then we skipped them because we are not many so we did the major, major ones and probably somebody who was just calling for you to pick water or something and you are like ohh I'm just coming, let me just finish this and come and you forget.*

In a similar vein, P1, a male nurse who had worked in the isolation ward for 12 years, also explained that:

> *... they are not too sick so those ones I don't normally attend to them like those who are confined to bed.*

4.5.4 Reluctance to provide care

The challenges associated with caring for HIV/AIDS patients, particularly the risk and fear of HIV infection, led to some of the participants sometimes becoming reluctant to provide care to the patients. Comments made by sone participants in support of this were:

> *I feel reluctant to really, really open up to do the kind of work I am to do because if I end up infecting myself just because I came to nurse someone, then why do it? You get it? So, there are somethings that I feel reluctant (P8).*
>
> *The initial stages, if there are no PPEs, me I will not enter their room, I will not, I will not. If they (the patients) call, I will just say 'ohh I am coming, I am doing that, I am doing that' by the time you realise someone who has been there for long and has all these experience goes to do the thing, ahaa. Initially, I won't even venture when there are no PPEs (P3).*

Due to their reluctance to provide care to the HIV/AIDS patients, participants revealed that most nurses were not willing to accept postings to the isolation wards. They indicated that such nurses usually adopt different strategies to avoid or prevent being posted to the isolation ward. Some of the participants made the following comments:

> *Because we take care of infectious diseases, most nurses fear to come here and work. Like this Covid, HIV, most of the nurses are afraid to come here so sometimes it is difficult to even get the staff to work here. Even those who come here to work, it is like they are scared, most of them are afraid, they are scared so we have to counsel them, we have to talk to them before. So that's the problem that we have (P12).*
>
> *... when there are departmental changes or general changes and they are posted to come here, they do not want to come. They come with so many excuses like I have a child, I have a this. You see, they don't want to be here. When they change people, they say they won't go. They change staff and then the staff will go and bargain, cry roll on the floor because they were changed to come and work in this unit. They wouldn't come (P8).*
>
> *I heard of situations where they are doing some reshuffling or changes and then they have to bring some nurses to this ward but some of them will be like they don't want to be attached to the stigma, the risk of being infected and all that. We have instances where some people have been changed and they don't want to come. Some people end up coming but not because they actually readily wish they will be here (P13).*
>
> *I tried initially to have my ward changed which didn't work, so I psyched myself that well, if it won't work let me just come (*P3).

Participants' responses also revealed that at times, some of the nurses accept the postings to the ward but then shortly after, they go back to lobby to be posted out. A participant stated:

> *... they come, they orientate them and then after a week or two they are off. They come back and they make their own arrangements somewhere, they've been moved to another ward (P5).*

The nurses' unwillingness to accept postings to the isolation wards have led to some resigning from the hospital. One of the participants stated that:

> *I quite remember, I was posted to the ward with another colleague of mine and because of that alone, she has to stop employment here (P3).*

Participants' responses also revealed that, some of the nurses who have worked in the isolation ward for a while always yearn to leave the ward. Their requests to leave the ward are however not granted probably because their leaving will create a shortage in the ward since most staff are unwilling to work in the isolation ward. A participant who has worked in the isolation ward for over twelve years wished to be rotated to a different ward but his request was not granted. This participant had this to say:

> *I can say that, the ward is tagged and it is not everybody who wants to come. Yes, so those who are in, it will become difficult for them. So you are here, you try to do your best at least. So, when you ask them to move you, they say wait if we have staff, we will let you know then you move. Attempts have been made but it was not successful. I wish to leave but so far as there is no replacement, I don't have a choice. I wish I can move to another ward and get to take care of different conditions apart from HIV but there is no replacement for now* (P1).

A supervisor recounted that on some occasions, some of his subordinates come to him to express their desire to leave the isolation ward and he had to persuade them to stay. He stated:

> *Sometimes they will ask you … as for here, I don't want to work here again. 'Then I will say, ohh why do you want to leave?' They will say ohh because of the patients and the way things are going, I don't like it* (P1).

One participant also revealed that one of her colleagues whose request to leave the isolation ward was not granted has resigned from the hospital. She recalled that:

> *I was posted to the ward with another colleague of mine and because of that alone, she has to stop employment here. Yes, so she had to stop her employment here* (P3).

Participants' responses also revealed that their work-related challenges, and the reluctance of some nurses to care for the HIV/AIDS patients have the potential to compromise the quality of care they provide to the patients. Some of them stated that:

> *If you are nursing a patient and you are afraid that you can be infected, unconsciously it can, you know, affect the care you give* (P11).
>
> *... if you are not able to overcome it (the physical exhaustion), then you report to work the following morning, what you are supposed to do, you can't do it properly* (P1).
>
> *The inadequate staff strength affects the quality of care that we have to give to the patients. It does, it does. Considering our responsibilities and the care we are supposed to give* (P9).

4.5.5 Reactions of family members

Participants' responses revealed that their working in the isolation ward and caring for HIV/AIDS patients, evokes mixed feelings from their family members. Some of the participants explained that their family members were not in favour of them caring for HIV/AIDS patients and hence urged them to leave the isolation ward. Some participants made the following expressions:

> *When I started working here, I told my dad this is where I am. My dad had a friend in the hospital during those early days. That friend told my dad that to tell me that I should leave that ward because that place is not good. It is HIV people who are there. My dad came strongly telling me to move but I insisted that I want to work there* (P6).
>
> *Initially, family members also felt bad, just the way I was feeling bad initially. They were like ahh! where have they gone to put you? Everybody wants that I should do something about it and let them take me out from there* (P3).
>
> *... even though, I have educated them (my family members) on a few things, they still have their fears and then they wish, at least I have worked there for four years, they expect that there should be changes so that I will be moved to a different place* (P13).

Other participants also stated that their family members were supportive and urged them to take measures to protect themselves. The comments made by some of them were:

> *Ohh no, I have a lovely family, they come closer to me, and that makes me feel happy* (P1).
>
> *They don't have any problem. As in they will be anxious that I will get infected? Ohh no. So far let me say my husband really know, as for the*

> *others I don't really know if I told them that I work at the isolation ward. My husband is aware. He is the one I will say I am closest to, but he has not shown any form of anxiety* (P8).
>
> *Ohh, … they are just like I should be extremely careful anytime I am giving out my services. Uhuu, that I should be cautious, I should make sure that I do the right thing in whatever I am supposed to do. I should just make sure I do the right thing. Ahaa, that's mostly what they usually tell me* (P9).
>
> *Back at home, I think it is only my husband who knows exactly what I do when I come to work but for my children, they know nothing about it and my siblings too. Well, a couple of them know because I happen to be in the same working environment with a few of them so they know but I think it hasn't changed anything* (P4).

Some participants' responses also revealed that their work-related challenges tend to have negative effects on their interactions with their family members. It was revealed that some of them sometimes, using the defence mechanism of displacement, vent their anger and frustrations from work on their immediate family members at home. A participant stated the following:

> *… sometimes it is affecting you, your social life. You go to the house if you don't take care, your child is coming to you or your wife is coming to you and if you are not careful you shout at them. You shout 'no go, go, what do you want'? When they* have not done anything. You want to have a peaceful place to rest." (P1).

4.5.6 Explanations of satisfaction derived from caring for HIV/AIDS patients

In spite of these challenges and their effects on the nurses and their work life however, some participants revealed that they derive satisfaction from caring for the HIV/AIDs patients. They indicated that they felt satisfied and fulfilled when the patients they are caring for recover from the HIV/AIDS-related opportunistic infections that brought them to the hospital, and they are discharged. Some of the participants commented that:

> *… if I am able to nurse a patient and the patient gets better, I feel happy that the work done wasn't in vain* (P10)

> *... at the end of the day, the joy is feeling I have been able to do something for the patient. Especially when they get well and then they go and they come back for review and you are looking at them being healthy, that's one thing that gives us joy.* (P13)

Some of the participants explained that the satisfaction they derive from caring for the patients serves as an intrinsic motivation for them to do more for the patients despite the challenges associated with their work. Their comments in support of this assertion include:

> *So gradually that became my motivating factor. Just the joy that my patient is satisfied, feels happy, feels loved, and when they recover and go home, I get satisfied. It gives me satisfaction.* (P3)

> *When I look at how I saw the patient when he/she came in, and how the patient is now, it brings a lot of satisfaction so I will want to do more to help others.* (P11)

Contrary to the above however, one participant explained that she does not derive any satisfaction from caring for the patients. She stated that:

> *Hmmm, as for this environment, there is no way anybody will have that kind of job satisfaction here. For me, nothing really gives me satisfaction working here, nothing really gives me satisfaction working here* (P8).

This participant probably equates satisfaction at work to tangible of monetary rewards stated that:

> *... we are supposed to be given risk allowance which we've spoken about several times, nobody is minding us because they claim that this unit is like any other ward* (P8)

In summary, the interview data revealed that the work-related challenges encountered by the nurses affect them in various ways. These include; physical exhaustion due to excessive work load, feelings of anxiety, and reluctance to care for HIV/AIDS patients due to the fear of HIV infection and courtesy stigma.

4.6 Theme 4: Support Systems Available to the Nurses

Participants' description of the support systems available to help them deal with the challenges they encounter while caring for the HIV/AIDS patients emerged as the fourth theme. It was identified that the main support system available to the nurses was social support. Four sub-themes, namely, support from nurse managers, support from colleague nurses, support from family members, and wish for further support, emerged from this theme.

4.6.1 Support from nurse managers

The nurse managers explained that they offer social support to the nurses working under them in the isolation wards to help alleviate the challenges associated with their caregiving functions. One of the ward managers, who had worked in the isolation ward for six years, explained that:

> *I always encourage them, I always encourage them, I talk to them, I make them nice, I don't shout at them. When there is a problem, I always try to encourage them if there is an issue and they come to you, we find ways and means of solving the problem. If there is an issue between staff and they come to me, I call them and solve the problem. Sometimes I even call the senior officers if there is an issue with a junior officer, we all sit down and solve that problem. So, in the end everybody is happy* (P12).

Another ward manager, who had five years working experience in the isolation ward explained that her way of providing support to her staff was to be physically present with them while they work, and getting actively involved in the provision of the routine nursing care to the patients. This was meant to provide emotional support to the nurses working under her. She stated:

> *I was managing them but, I was playing direct supervisory role to them. So they have a lot of confidence because they realised that it was not just 'go and do it, but let's go and do it'. Ahaa, so I was passing NG tubes, I was passing urethral catheters, I was bathing patients, I was changing chest tubes, I was part of the rounds. Unless I am not around. Ahaa, so yes, I was the leader but I was with them. So, they*

> *were quite confident, so they talk freely, ahaa. They talk freely and we share ideas.* (P11).

4.6.2 Support from colleague nurses

The participants' responses also revealed that they mutually rely on, and receive emotional support from each other to help deal with the challenges they experience at work. P1, a male participant who had practiced as a nurse for 19 years, and had worked in the isolation ward for 12 years explained that:

> *You can talk to your colleague; he also tries to talk to you. He can talk to you in a way to calm you down, to bring you back to your normal self. Yes. We try to support each other.*

P2, a female participant who had worked in the isolation ward three years also stated that:

> *Sometimes with other staff members, probably the ward in-charge, we do sometimes talk about these things and we are able to talk through it and calm ourselves down. Yes, it does. I think talking about issues like this helps to bring down the burden (P2).*

Other participants also expressed the following comments:

> *So sometimes when it happens like that, we discuss it among ourselves. Probably within the people you are working with, ahaa. And then you get the relief. But sometimes even after that, as you are going home, the thought of it comes back and it's not easy, you have to try and then get back to your form. Yes, we helping each other, we helping our own selves, making ourselves happy. It's like we created our own something within (P5).*
>
> *… usually in the mornings we do have morning meetings, and so in the morning meetings if you have any challenges or any problems, they give you the floor for you to bring them out and we all discuss (P7).*

4.6.3 Support from family members

Participants also indicated that they often rely on their family members for emotional support. In support of this, P13, a female who's entire four years of practice as a nurse was spent at the isolation ward stated that:

> *At times I fall back to our family members and my loved ones at home, and at times my colleagues. We comfort ourselves* (P13).

P6 is a female who had practiced as a nurse for 14 years, and had worked in the isolation for 13 years. She remarked that:

> *For me, in the house, when I get depressed, it is just to air it out, speak to my husband, speak to my house help, speak to anybody around that this is it, then they will share and then it goes off (P6).*

4.6.4 Wish for further support

It could be concluded from the participants' responses that; they perceive the support available to them to be insufficient. For instance, in her response to the sufficiency of the support they receive from the ward managers, P4, a female nurse who had worked in the isolation ward for eight years remarked that:

> *… to some extent, but I won't say entirely. The ones that they need to tackle immediately, they do their best to assist, but the ones that are long term they will just reassure you that it will be rectified* (P4).

It is clear participants had expected that management of the hospital would engage the services of dedicated professionals whom they could consult for counselling and debriefing services when necessary. That is why P7 who had spent three years of her four years working period as a nurse in the isolation remarked that:

> *… you need someone to talk to you, to let you come out of that confusional state"* (P7).

Her comments were backed by others who also stated that:

> *If there were someone there who would call me and say, ohh, this morning I've seen that you are not okay, come, what is happening to you, I mean that will be okay (P4).*
>
> *… but nobody is there, so you try to swallow it yourself. But if there is someone, a group or someone I can approach, who can talk to me nicely, I think it will be helpful. You have been traumatised, right, psychologically and physically you are traumatized, so what do you do? You don't have anybody there* (P7).
>
> *You see, there is no one who will take care of us. If there were somebody or an office that if you feel you are not okay you can go and they will talk to you and you will be okay, or the person will observe and pass through the ward and see that ohh today you are not okay, what happened to you, then from there you find out the exact problem*

> *then you talk to the person. But we try to swallow it and you go with it* (P1).

> *There should be at least some psychologists for the staff so that if there is any problem we can go and talk to them and then at least it can ease some of the stress* (P2).

Participants also wished that management provide tangible support in the form of adequate staff to help alleviate the work overload they experience in the isolation ward.

> *We don't have enough staff, … We need to employ more staff* (P1).

It could thus be inferred that the nurses caring for HIV/AIDS patients in the two health facilities have a form of support available to help them deal with their work-related challenges. These support systems however are not sufficient to meet their needs.

4.7 Theme 5: Coping Strategies Adopted by the Nurses

This theme relates to the fifth objective of the study which is "to explore how nurses caring for HIV/AIDS patients cope with their work-related challenges". The theme describes the various coping strategies the nurses adopt to deal with the work-related challenges. It was discussed under following sub-themes: rationing of care, rationing of PPEs, involvement of patients' family members in their care, self-protection against infection, religious coping, and social support.

4.7.1 Rationing of care

This strategy was used by the participants to deal with the challenge of inadequate staff in the isolation wards. It involves rationing the available staff to provide care on priority basis. It involves devoting much time to patients whose care is more urgent or those who are critically ill. A participant explained this strategy as:

> *... those who are not too sick, those ones you don't normally attend to them like those who are confined to bed. So, I make sure that I see those who are confined to bed first before I go to those who are ambulatory and can do certain things for themselves (P1).*

4.7.2 Rationing of PPEs

This strategy ensures that the few PPEs available are rationed such that when a staff wears a PPEs such as the gowns and enters a particular room, the staff attends to all the patients in that room before coming out. A participant who is a supervisor in the ward explains this strategy by stating that:

> *If you have two or three patients in a room and the PPEs I have for the day is not enough, I will not assign many staff to go to that room. I can assign just two staff to work in that room. There is shortage all over but then what do you do? You make sure that you manage what you have properly (P1).*

This coping strategy ensures that the few PPEs available are judiciously used to achieve maximum results.

4.7.3 Involving Patients' Family Members in their Care

Participants' responses further revealed that, in order to ensure that the patients receive the needed care as much as possible, despite the inadequate staff strength, the nurses sometimes involve the patients' relatives in the provision of care to the patients. They explained that:

> *... we involve relatives in the care, like assisting us, especially in the night, to bath or feeding or anything that they can assist, because we are not many. Some of them are bedridden, the ones that are not bedridden, they do assist themselves but most at times, they are bed ridden* (P4).
>
> *So sometimes with the help of the relatives, when we teach them, they also help us care for the patients. So even though the staff strength is not enough, sometimes we do get help from the patients' relatives in caring for the patients* (P7).

4.7.4 Self-protection against infection

This strategy, which is aimed at reducing the risk of occupational exposure and hence the fear of fear of being infected with HIV, involves wearing of the appropriate PPEs and adhering to the infection prevention protocols. They explained that:

> *… we consciously protect ourselves with the required personal protective equipment. So, if you know you are protected, it helps you cope with the situation better and psychologically it doesn't give you a mental challenge, because you know you will not be infected. After all you are wearing the necessary protection, ahaa* (P11).

> *… we are in isolation ward. I have been trained on how to protect myself, how to wear the PPEs.* (P1).

> *I need to observe all the standard precautions. The hand washing, putting on my PPEs, segregation of waste, if I do all those things then I will be fine, I will be safe, there will be nothing to worry about. You don't try to cut corners with your standard precautions. When you do these, you are safe, your clients are safe, you are happy, your clients are happy and we are all good to go* (P3).

Since they face challenges with adequate supply of PPEs, some participants explained that they have resorted to purchasing their own PPEs to complement what the hospital supplies to them. P9, a female participant whose five years of practice as a nurse was served in the isolation ward explained that:

> *I buy my personal face masks because there are times you come, they don't even have, so if you condition your mind that from the house to work you are going to get masks to wear, you may be disappointed. So, I buy my masks, the KN95 and surgical masks. I buy in boxes, my headcap I get it, okay, I get my personal sanitizer so if the hospital provides, fine, if they don't provide fine* (P9).

4.7.5 Religious coping

Participants also use religious coping, specifically use of prayer and their religious faith and reliance on God as one of the strategies they used to cope with their work-related experiences. Some of them narrated the following:

> *… one of them is what I said, the trust that I have in God. I was taking consolation in God because every morning I have to really pray and commit myself and the ward into the hands of God and ask literally*

> *that God should protect us from infection. It was a daily prayer I was praying everyday before we start work* (P11).
>
> *When I went to the ward initially, every time a patient dies, I have to go for confession, and unfortunately or fortunately anytime, it is the same priest that I meet as a catholic. He will take you through bible discussions and try to let you know that you can't blame yourself for everything* (P6).
>
> *Here when I look around, I can see that things are not too attractive, it's not too conducive. There is a lot of stress, but with the help of God I think we are managing* (P9).
>
> *I don't have anybody to counsel me. Sometimes I swallow it and I have to pray to the almighty God to keep me alive, that's all* (P1).

4.7.7 Social support

Participants also indicated that they use social support strategies such as emotional venting, an act of expressing one's feelings and frustrations as a way of releasing pent up emotions or stress and seeking support from others. Some of the participants therefore explained that:

> *For me, in the house, when I get depressed, it is just to air it out, speak to my husband, speak to my house help, speak to anybody around, that is it*
>
> *You can talk to your colleague; he also tries to talk to you. He can talk to you in a way to calm you down, to bring you back to your normal self. Yes. We try to support each other* (P1).
>
> *Sometimes with other staff members, probably the ward in-charge, we do sometimes talk about these things and we are able to talk through it and calm ourselves down. Yes, it does. I think talking about issues like this helps to bring down the burden* (P2).
>
> *So sometimes when it happens like that, we discuss it among ourselves. Probably within the people you are working with, ahaa. And then you get the relief. But sometimes even after that, as you are going home, the thought of it comes back and it's not easy, you have to try and then get back to your form. Yes, we helping each other, we helping our own selves, making ourselves happy. It's like we created our own something within (P5).*
>
> *... usually in the mornings we do have morning meetings, and so in the morning meetings if you have any challenges or any problems, they give you the floor for you to bring them out and we all discuss* (P7).

> *At times I fall back to my family members and loved ones at home, and at times my colleagues* (P13).

In summary, this theme revealed that the participants adopted different strategies to cope with the challenges they experienced when caring for HIV/AIDS patients. The next section focused on the discussion of the findings of the study in relation to the existing relevant research literature.

4.8 Discussion of the Findings

This section presents the discussion of findings of the study. The purpose of the study was to explore the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana. The discussion is presented in line with the objectives of the study.

4.8.1 Description of the care nurses provide to HIV/AIDS patients

The first objective of the study was to explore the care nurses provide to the HIV/AIDS patients. The findings from the study revealed that the care provided by the nurses to the HIV/AIDS patients were classified under four domains involving psychosocial care, physical care, financial support, and material support.

4.8.1.1 Provision of psychosocial support

The results revealed that the nurses provided psychosocial support to the HIV/AIDS patients in the form of providing counselling services to them, being empathic towards them, and providing emotional support to grieving family members when patients die. The provision of psychosocial care contributes significantly to the wellbeing of the patients and their family members, as was indicated by Zongo et al. (2009) in their study that explored the psychosocial care of people living with HIV in Benin. The results of their study indicated that the psychosocial care of persons living with HIV/AIDS is a crucial factor for the improvement of their health. They stressed that the needs of PLWHA are not limited to accessing medicine and medical care hence they require other dimensions of care such as psychological, social and spiritual support. The provision of these other dimensions of care constitutes psychosocial care which the participants have provided to the patients in the current study.

This finding corroborates that of Zerfu et al. (2012), which also revealed that participants who were interviewed in a study that assessed home and community-based care programme for PLWHAs in Arba Minch, Southern Ethiopia received, psychological support in the form of counselling services from their caregivers. Similar findings were made by Wouters et al. (2012) and Zikhathile and Atagana (2018), whose studies revealed that PLWHA were provided psychosocial care in addition to the technical-medical care from nurses and doctors. A study by Asuquo, Etowa and Adejumo (2013), also found out that family caregivers of HIV/AIDS patients in Calabar, South East Nigeria, provided emotional support like keeping company especially when the patients are depressed.

A study by Figueiredo et al. (2014), to analyse the provision of health care actions and services for PLWHA receiving specialised care in Ribeirão Preto, Spain, also revealed that the provision of psychological support, including evaluation of the health status of family members, and the provision of support groups to the PLWHA as one of the domains of care provided. The participants, however regarded the psychosocial care provided to them as unsatisfactory. Similarly, in a study that investigated met and unmet palliative care needs of PLWHA in selected areas in Rwanda, Uwimana and Struthers (2007), identified psychosocial needs as one of the most common perceived palliative care needs of PLWHA. However, as was found by Figueiredo et al. (2014), the psychosocial care needs of the PLWHA were unmet. In the current study however, the nurses provided adequate psychosocial care for the HIV/AIDS patients under their care, and this contributed significantly to the wellbeing of the patients.

4.8.1.2 Provision of physical care

The findings from the data analysed revealed that most of the HIV/AIDS patients are usually admitted to the ward at a time when they are very weak and confined to bed and hence are unable to perform their activities of daily living. These patients were therefore, dependent on the nurses for their total physical care and performance of all their activities of daily living such as bathing them and making their beds, treating their pressure areas, dressings their wounds, and feeding them.

The finding on the provision of physical care to the HIV/AIDS patients is similar to those of a study by Zikhathile and Atagana (2018), in KwaZulu-Natal, South Africa, which also revealed that caregivers of HIV/AIDS patients provided physical care to the patients. The physical care provided includes bathing and feeding patients, assisting patients to use toilets, changing patients' position in bed, dressing the patients' wounds, administering medications, and helping patients to do simple physical exercises. The finding also corroborates that of Smit (2005), which found out that the nursing care provided to PLWHA in South Africa involves providing extensive physical care and emotional support. Similarly, the findings also corroborate that of Asuquo, Etowa and Adejumo (2013), which found out that the care provided by caregivers of HIV/AIDS patients in Calabar, South East Nigeria included bathing, dressing, and feeding the patients, attending to their toileting needs, assisting them with ambulation, as well as administering their medications.

4.8.1.3 Provision of financial support

Another finding of this study was that the participants' sometimes have to contribute money in order to provide financial support to the patients. This becomes necessary because most of the patients were poor, and were often neglected by their family members. The finding agrees with that of a study conducted by Asuquo, Etowa and Adejumo (2013), which assessed the relationship between caregivers' burden and availability of support for family caregivers of HIV/AIDS patients in Calabar, South East Nigeria, and found that the caregivers provided financial assistance to the patients for the purchase of food.

4.8.1.4 Provision of material support

Soboka and Feyissa (2015), described material support as the provision of food, clothes and financial support. The results of this study revealed that the nursing care provided by participants included providing the necessary basic personal items such as clothing, towel, sponge, buckets, bath toiletries, and diapers needed for the care of the patient, which most of the patients lacked because of their poor financial status, and the fact that most of them were neglected by their family members. These basic needs included clothing, towel, sponge, buckets, bath toiletries, and diapers.

The findings on how the nurses cared for the HIV/AIDS patients was supported by research literature, though there was a paucity of such literature, particularly literature regarding the provision of material support for the patients.

4.8.2 Challenges associated with caring for HIV/AIDS patients

The second objective was to explore the challenges encountered by the nurses while caring for the HIV/AIDS patients. The findings on this objective revealed that the nurses encounter various challenges encountered while performing their caregiving functions. These include fear of being infected with HIV through occupational exposure, work-related stress, courtesy stigma, abuse from patients and their relatives, resource challenges, and lack of motivation.

4.8.2.1 Fear of infection

The results of this study revealed that the nurses were often exposed to the blood and other body fluids of the patients they cared for. These exposures, which occur through needle pricks, and being splashed with body fluids such as vomitus, heightens the nurses' fears of being infected with HIV whiles they provide care to the patients. Studies done by Shivalli (2014), and Tandi et al. (2018) also revealed that health care professionals, including nurses, who care for HIV/AIDS patients, frequently experience occupational exposures to blood and other body fluids of the HIV/AIDS patients, which put them at risk of being infected with HIV and other blood borne pathogens. The findings on occupational exposure are also consistent with those of other previous studies which also revealed that frequent occupational exposures experienced by nurses and other HCWs increase their fears of being infected with HIV (Esewe et al., 2017; Koto & Maharaj, 2016; Rahimi et al., 2017; Tazakori et al., 2017; Wright, 2016).

Consequent to occupational exposure to blood and body fluids of HIV/AIDS patients, is its attendant risk of causing HIV infections among healthcare workers (Akpuh et al., 2020; Wyżgowski, Rosiek, Grzela, & Leksowski, 2016). This creates the fear of being infected with HIV among all health care workers, particularly those who specifically provide care for HIV/AIDS patients. In this study, the participants' responses revealed that caring for the HIV/AIDS patients was a daily dread for them as anytime they are going to work, or when they go near the HIV/AIDS patients, they do so conscious of the fact that there is the likelihood of being infected with HIV through occupational exposure.

This finding corroborates that of a study conducted in one of the district hospitals in Vhembe district of the Limpopo Province in South Africa by Mammbona and Mavhandu-Mudzusi (2019) which also revealed that increased risk of HIV infections resulted in enrolled nurses caring for HIV/AIDS patients living in extreme fear of being infected with HIV. Similarly, this finding also supports the findings of Wright (2016), Mametja, Lekhuleni, and Kgole, (2013), Tazakori et al.. (2017), Rahimi et al. (2017), Koto and Maharaj (2016), Esewe, Adeyemo, and Ikedimma (2017) which identified the fear of being infected with HIV, through occupational exposure, to be a an issue of great concern among nurses caring for HIV/AIDS patients.

Similar to the findings of these previous studies, the results of this study also revealed that the nurses' fear of being infected with HIV through occupational exposure is increased by the lack of appropriate or adequate PPEs. It is therefore imperative that as stated by Ramathuba and Makhado (2021), Mammbona (2017), Tesfay and Habtewold (2014), the nurses caring for HIV/AIDS patients are provided with the necessary PPEs and the other resources they need to protect themselves against occupational exposure while caring for the patients.

4.8.2.2 Work-related stress

The results of this study also revealed that work-related stress was one of the major challenges experienced by the nurses caring for HIV/AIDS patients. The participants described their caregiving functions to the HIV/AIDS patients as very stressful and traumatising, both psychologically and physically. This finding is in agreement with those of earlier studies (Bhembe & Tsai, 2019; Mammbona & Mavhandu-Mudzusi, 2019; Mamukeyani, 2021; Moshidi et al., 2021) in which the findings revealed that work-related stress was inherent in the work of nurses caring for HIV/AIDS patients. The causes of work-related stress are discussed under the following subthemes: (a) work overload, (b) constantly witnessing suffering and death of the patients, (c) attachment to, and over-involvement with patients, and (d) neglect of patients by their relatives.

4.8.2.2.1 Work overload

The responses from the participants in the study revealed that work overload, brought about by the combined effects of large numbers of patients on admission, and inadequate staff, was one of the major causes of the work-related stress they experienced while providing care for the HIV/AIDS patients in the isolation wards. This, the participants explained, makes them exhausted physically and emotionally. This finding confirms those of Mamukeyani (2021), Moshidi et al. (2021), Mammbona et al (2019), Tong et al. (2019) who also identified work-overload and its associated stress as one of the challenges faced by nurses caring for HIV/AIDS patients. These previous studies also revealed, as does the current study, that the increasing numbers of HIV/AIDS patients receiving hospitalised care was responsible for the increased workload for their caregivers, particularly nurses. Similarly, studies by Pan et al. (2022), Roomaney et al. (2017), and van der Colff and Rothmann (2014) also revealed that work overload was one of the sources of the work-related stress experienced by caregivers of HIV/AIDS patients. Because of the adverse effects of work-overload and its attendant work-related stress on the health of the nurses and the quality of care they provide to the patients, it is important that, as recommended by Tong et al. (2019), management improves the staff strength of the ward or improve the working conditions of the staff.

4.8.2.2.2 Constantly witnessing suffering and death of HIV/AIDS patients

Another cause of the work-related stress experienced by the nurses is witnessing the suffering and death of the HIV patients under their care. The participants explained that most often the patients are admitted to the ward when they are in the terminal stages of their illness and hence end up dying shortly after being admitted to the ward. As they provide care to these patients, the nurses constantly watch these patients as their conditions deteriorate, and they suffer and eventually die. Witnessing the suffering and death of the patients constantly is very stressful as it affects the caregivers psychologically.

The finding corroborates those of previous studies by Bam and Naidoo (2014), Ramathuba and Davhana-Maselesele (2013), and Valjee and van Dyk (2014), which also revealed that constantly witnessing the suffering and death of HIV/AIDS patients is a source of work-related stress experienced by caregivers of HIV/AIDS patients. The study by Valjee and van Dyk (2014) further revealed that if nurses witness how HIV/AIDS patients suffer and die, they feel it and that exerts negative emotional toll on them. Similar sentiments were expressed by participants in the current study. Similarly, in a study by Moshidi et al. (2021) that explored and described the experiences of professional nurses regarding care and support they receive while providing care to HIV and AIDS patients in the public hospitals of Limpopo Province, South Africa, the results revealed that some of the professional nurses were stressed because the patients were admitted to the wards when they were terminally ill and die soon after admission, or few days later. The finding further agrees with that of Mammbona and Mavhandu-Mudzusi (2019) which also revealed that the work-related stress experienced by nurses caring for HIV/AIDS patients is worsened when they constantly witness the death of the HIV/AIDS patients admitted to their wards.

Similar findings were made by Anshasi et al. (2020), Davhana-Maselesele and Igumbor (2008), and Mashau and Davhana-Maselesele (2009).

Since the participants in the current study indicated that most often the HIV/AIDS patients were admitted to the ward when they were in the terminal stages of their illness and hence end up dying shortly after being admitted, it is certain that the nurses are bound to have this experience often. It is in this regard that Melvin (2015), urged nurse managers to assist nurses, who are experiencing work-related stress as a result of constantly witnessing the suffering and death of patients, to deal with these adverse experiences. It was in the same vein that Kisorio and Langley (2016), also suggested that such nurses should be provided with resources for counselling and debriefing sessions that will help them deal with these challenges and experiences.

4.8.2.2.3 Attachment to, and over-involvement with the patients

The results of this study revealed that during the process of caring for the HIV/AIDS patients, a bond of attachment often develops between the nurses as caregivers, and the HIV/AIDS patients as care receivers. This bond of attachment often leads to some of the nurses becoming overly involved with the patients' situations. This over-involvement often made some of the nurses unable to detach themselves from the pain experienced by the patients. This experience also constitutes a source of the work-related stress experienced by the nurses. This finding of the study is consistent with the findings of other previous studies (Bam & Naidoo, 2014; Forson, 2020; Hatzipapas et al., 2017; Koto & Maharaj, 2016) which also revealed that attachment, over-identification and over-involvement with the PLWHA was a source of stress for the caregivers of HIV/AIDS patients.

4.8.2.2.4 Neglect of patients by their relatives

The findings of this study further revealed that some of the patients admitted to the ward are often neglected by their relatives. While the relatives' neglect is due to the stigma associated with HIV/AIDS, it puts a lot of pressure on the nurses as they, in addition to performing their caregiving roles, also have to perform the obligations of the relatives of these patients. Neglect of HIV/AIDS patients by their relatives has been documented by other researchers (Dejman et al., 2015; Uys, 2003). For example, in the study by Uys that explored the realization of counselling, palliative care, and terminal care for HIV/AIDS patients in seven settings in South Africa, the health workers in some wards reported that patients were neglected by their family members if they knew the diagnosis of the patients because of the fear that could also be infected with HIV if they got close to the patients. Similarly, Dejman et al. also found out that HIV/AIDS patients were rejected by their friends and family members because of fears of being infected with HIV.

4.8.2.3 Courtesy stigma

Another major finding of this study was that the participants experience HIV/AIDS-related courtesy stigma. This stigma, the participants revealed, was often perpetrated against them by their co-workers, and was mostly manifested in the form of labelling, avoidance, negative comments and behaviours, rejection, and neglect. These findings corroborated those of some previous studies in South Africa (Lekganyane, 2016; Mamukeyani, 2021), Kenya (Njau, et al., 2015), Thailand (Washington & Oberdorfer, 2013), and China (Wu et al., 2016) which also revealed that nurses and other caregivers of HIV/AIDS patients experience courtesy stigma because of their association with these patients.

Similarly, this finding is also consistent with the earlier studies in Ghana (Puplampu, 2017; Mensah, 2018; Mwinituo & Mill, 2006), which also found out that nurses and family caregivers of HIV/AIDS patients feel stigmatized by their co-workers, family members, and friends. Courtesy stigma is thus a common phenomenon experienced by nurses and other caregivers of HIV/AIDS patients. As was indicated by Bachleda and El Menzhi, 2017), all caregivers of HIV/AIDS patients are equally susceptible to courtesy stigma, regardless of their occupational status. The finding is also consistent with those of a study among caregivers of HIV/AIDS patients in Ghana by Mensah (2018) which revealed that health care providers experienced HIV/AIDS related courtesy stigma in the form of neglect and rejection, avoidance and tagging or labelling. Additionally, the results of a study by Lekganyane (2016), revealed that caregivers of PLWHA in South Africa were undermined, devalued and even insulted because of their association with the PLWHA.

Participants in this study stated that some of their colleagues had the perception that they were posted to the isolation ward because they were also HIV positive. This finding concurs with that of a study conducted among rural healthcare providers caring for HIV/AIDS patients in the USA by Parks and Smallwood (2021) which also revealed that the healthcare providers reported experiencing courtesy stigma manifested in the negative treatment from the community members who perceived them to be HIV positive. Similarly, a study by Lekganyane (2016), that explored the experiences of courtesy stigma and coping strategies among-home-based caregivers' of PLWHA in South Africa, also revealed that the caregivers experienced courtesy stigma in various forms including the community members perceiving them to be HIV positive, and hence avoiding them and the family members of the PLWHA.

The findings of this study further revealed that courtesy stigma experienced by the nurses caring for HIV/AIDS patients was due to their colleagues' ignorance and their fear of being infected with HIV. This explains why the nurses were shunned, neglected, and rejected. These findings confirm those of Hedge et al. (2021) which also noted that nurses in the United Kingdom experience HIV-related courtesy stigma and that the stigmatizing attitudes were linked to a lack of understanding, and fear of HIV infection. Similar findings were also made by Lohiniva et al. (2015), which revealed that the courtesy stigma toward physicians providing care for PLWH in Egypt was triggered by fear of being infected with HIV. It is clear that HIV/AIDS-related courtesy stigma is experienced by caregivers of HIV/AIDS patients in Africa, including Ghana (Lekganyane, 2016; Lohiniva et al., 2015; Mensah, 2018; Mwinituo & Mill, 2006; Puplampu, 2017), the United States of America (Parks & Smallwood, 2021), and the United Kingdom (Hedge et al., 2021).

Because courtesy stigma has been identified as a significant challenge to the well-being of HCWs caring for HIV/AIDS patients, it is important, as recommended by Parks and Smallwood (2021), to raise awareness of the dynamics of courtesy stigma and its potential negative impacts. In this vein, Brown, Trujillo and Macintyre (2001) suggested the adoption of a variety of intervention strategies such as information, counselling, coping skills acquisition, and contact to curb courtesy stigma. Similarly, Parks and Smallwood (2021), also recommended that openly naming and describing courtesy stigma might help to reduce feelings of isolation and anxiety among health professionals caring for HIV/AIDS patients.

4.8.2.4 Abuse from patients and their relatives

The participants involved in this study reported that they were sometimes abused verbally and physically by the patients and their relatives. This finding of the study corroborates the findings of previous studies which also revealed that nurses working in the paediatric wards in the US (Truman et al., 2013) and in Ontario, Canada (Pejic, 2005) as well as nurses working in various departments in 3 hospitals in Amman, Jordan (Ahmed, 2012), reported experiencing verbal and physical abuse perpetrated against them by patients and their family members. The finding of this study is also consistent with that of a study conducted by Stevenson et al. (2015) which revealed that Canadian registered nurses working in psychiatric units reported experiencing physical, emotional and verbal violence or abuse such as being chased, being hit, punched or grabbed, kicked, spit at, swearing, threats, intimidation or gestures relating to physical harm, from the inpatients.

Since these types of abuse experienced by nurses have been found to have adverse effects on their professional and personal activities (Ahmed, 2012; Pejic, 2005; Stevenson et al., 2015), it is imperative that, as indicated by Stevenson et al. nurse managers understand these negative experiences of the nurses and provide the needed support in the form of improved education, debriefing following an incident, and a supportive work environment to help alleviate the effect of these challenges on the nurses.

4.8.2.5 Resource challenges

Challenges with resources needed to provide effective care to the HIV/AIDS patients is another major finding of this study. Results from this study revealed that there was inadequate nursing staff compared to the number of patients on admission. This leads to increased workloads, and physical and emotional exhaustion among the nurses working in the isolation wards. This finding agrees with the findings of studies conducted in South Africa (Mammbona & Mavhandu-Mudzusi, 2019) and China (Tong et al., 2019) which also identified inadequate nursing staff as one of the challenges faced by nurses caring for HIV/AIDS patients.

The finding of inadequate staff in this study further corroborates with the findings of studies conducted by Haoses-Gorases et al. (2013), Berg and Nilsson (2015), Erkki and Hedlund (2013), Mutemwa et al. (2013), Moshidi et al. (2021) and Ndou (2017) which also found out that shortage of staff in the face of increasing numbers of patients admitted with HIV/AIDS-related conditions was a challenge faced by nurses caring for the HIV/AIDS patients. Kieft et al. (2014) posited that adequate staffing is one of the essential elements that would improve the quality of nursing care provided to patients. In view of the fact that inadequate nursing staff in the isolation wards leads to heavy workload, emotional and physical exhaustion, staff turnover, high absenteeism, and increased levels of stress among nurses caring for HIV/AIDS patients (Moshidi et al., 2021), it is imperative, as stated by Tong et al. (2019) that management of health facilities and the government takes measures to increase the number of nursing and other staff needed to work in the isolation wards.

Another challenge found in this study is the lack of a policy on the rotation of nurses working in the isolation wards. Staff or job rotation in nursing has been defined as the transfer of nursing personnel among departments with different functions or to different units/branches of the same hospital (Dinis & Fronteira, 2015; Erialdy et al., 2020; Ho et al., 2009; Jarvi & Uusitalo, 2004). There are a number of benefits to be derived from job rotation; namely reduction of boredom, reduction of work-related stress and risk of burnout, increased innovation, increased productivity, reduced absenteeism, and reduced turnover, renewal of staff enthusiasm and motivation among the staff (Dinis & Fronteira, 2015; Jaturanonda et al., 2006; Jorgensen et al., 2005; Lu et al., 2012). Job rotation has also been found to increase the levels of job satisfaction and job commitment, and also helps decrease the level of job conflict among nurses (Alfuqaha et al., 2021; Alfuqaha et al., 2022).

The results of this study revealed that there was no clear-cut policy on the rotation of nurses working in the isolation wards. The lack of a policy on rotation led to the participants claiming that they got stuck and working in the ward for long periods and therefore yearned for regular rotations to enable them have some respite from the caregiver burden inherent in caring for the HIV/AIDS patients. This finding is similar to that of Moshidi et al. (2021), who also found out that lack of job rotation was a challenge experienced by nurses caring for HIV/AIDS patients in five districts hospitals of the Limpopo Province of South Africa. This, the researchers revealed, has led to some of the nurses working in the designated wards for long periods, and has also made most nurses reluctant to work in wards where HIV/AIDS patients are cared for.

Because nursing as a humanistic career is prone to more levels of stressors compared to other professions, Alfuqaha and Alsharah (2018) recommended the job rotation approach as one of the solutions to tackle the problem of burnout among nurses. Similarly, Moshidi et al. (2021) posited that there is the need for a policy on job rotation for nurses working in the isolation wards to direct the nurses' mode of rotation, as well as regulate their length of stay in the isolation ward caring for the HIV/AIDS patients. It is in this regard that researchers such as Jarvi and Uusitalo

(2004), Pinhatti, Vannuchi, Sardinha and Haddad (2017), and Dinis and Fronteira (2015) also recommended that the rotation for nurses must be planned and done at regular intervals.

Another finding of the study was that, the participants expected to have some training prior to being posted to the isolation ward. They believed that such prior training would have equipped them with knowledge about what is entailed in caring for the HIV/AIDS patients, as well as the inherent challenges and experiences they are likely to encounter while caring for them. The findings of this study however revealed that, contrary to their expectations, none of the participants received any specific training about caring for the HIV/AIDS patients prior to being posted to the isolation ward. This finding concurs with those of Ramathuba and Davhana-Maselesele (2013), and Mulaudzi et al. (2011) in which nurses caring for HIV/AIDS patients expressed the sentiments that they wanted to be trained in matters related to HIV/AIDS to enable them provide adequate care to the HIV/AIDS patients, but they did not receive any such training. The importance of prior or initial training for caregivers of PLWHA was demonstrated in Zimbabwe when prior to engaging community health workers for HIV care, they were given a two-week fulltime training that covered counselling skills, content of the home visit sessions, and issues specific to HIV among children and adolescents (Busza et al., 2018).

Another resource challenge experienced by the participants was inadequate materials; namely, personal protective equipment (PPEs) and infrastructure. The results of this study revealed inadequate supply of PPEs such as gowns, aprons, goggles, masks, and gloves as material resource challenges faced by the nurses as they care for the HIV/AIDS patients. This phenomenon, as indicated by the participants, increases their risk of being exposed to the blood and body fluids of the patients, and thus increasing their fears of being infected with HIV and other pathogens during the caregiving process. This finding confirms those of studies conducted by Mamukeyani (2021), Mammbona and Mavhandu-Mudzusi (2019), Haoses-Gorases et al. (2013) which also identified shortage of PPEs such as gowns, aprons, goggles, masks, and gloves, needed by the nurses to protect themselves against occupational exposure and hence minimise their risk and fears of HIV infection, as one of the challenges experienced by nurses caring from HIV/AIDS patients. The finding further confirms that of Mutemwa et al. (2013) which also revealed that shortage of protective equipment needed by the nurses hinders the ability of the nurses to provide quality of care to patients. It is therefore, imperative that, as was recommended by Mammbona and Mavhandu-Mudzusi (2019), management of the institutions improve the supply of resources needed by the nurses for their work.

The results of this study also identified inadequate infrastructure as one of the major challenges faced by the nurses caring for HIV/AIDS patients. The participants indicated that the buildings were old with malfunctioning gadgets which makes their work environment unconducive. Unconducive work and stressful work environment, consequent to poor or inadequate infrastructure, was also found by Koto and Maharaj (2016), Mutemwa et al. (2013) as one of the difficulties facing HCWs involved in HIV/AIDS care in Lesotho and Kenya respectively, while a study by Matakanye et al. (2019), found out that poor, aging infrastructure which is in dire need of refurbishment was a resource challenge faced by nurses. Similar sentiments about poor infrastructure were made by participants in a study conducted in South Africa by Mammbona and Mavhandu-Mudzusi (2019), who therefore, recommended an improvement in the state of the infrastructure in the isolation wards.

4.8.2.6 Lack of motivation

The results of this study revealed lack of motivation as one of the challenges the nurses experience while caring for the HIV/AIDS patients. A study by Valjee and van Dyk (2014), which explored the impact of caring for PLWHA on the psychosocial well-being of palliative caregivers, also identified inadequate remuneration as one of the main concerns of caregivers of HIV/AIDS patients in South Africa. Similarly, this finding further agrees with that of a study conducted in the Tshwane District of Gauteng Province, South Africa, by Ndou et al. (2015) in which the participants revealed that nurses caring for patients diagnosed with AIDS related illnesses were not given any financial rewards such as occupational dispensation as motivation for caring for the HIV/AIDS patients.

Poor remuneration was also identified as a challenge facing community health workers involved in improving HIV treatment outcomes in children in Zimbabwe (Busza et al., 2018). Moshidi et al. (2021), indicated that appreciating the hard work and achievements of employees is essential in the workplace. They therefore, implored managers to implement compensatory measures such as effective awards ceremonies, appraisals, motivations or incentive packages in order to boost the morale of professional nurses caring for HIV/AIDS patients and improve productivity in the workplace.

4.8.3 Explanation of how work-related challenges affect nurses and their caregiving function

The findings on objective three, which sought to understand how the work-related challenges affect the nurses and their caregiving functions, revealed that the challenges affect the nurses’ physical and emotional wellbeing, as well as the willingness of some of them to care for the patients. The findings further revealed that the challenges affect the cohesion between some of the nurses and their nuclear family.

4.8.3.1 Physical exhaustion

The results of this study revealed that the challenge of inadequate staff experienced by the nurses leads to increased workloads for them leading to stress and physical exhaustion. In an earlier qualitative study by Tong et al. (2019) which explored the sources and impact of work-related stress among HIV/AIDS health care providers in Guangxi, China, the results revealed that most of the participants reported stress that was triggered by heavy workload, working overtime, staff shortage and other work-related factors. Work-related stress and physical exhaustion subsequent to increased workload, inadequacy of resources, and the demanding nature of caregiving work was also identified by Mamukeyani (2021) as some of the effects of the challenges experienced by caregivers of HIV/AIDS patients.

Similarly, the findings of a study conducted by Suner-Solera et al. (2014) to examine the consequences of burnout syndrome among healthcare professionals in Spain and Spanish speaking Latin American countries also found out that burnout leads to physical and emotional exhaustion, and absenteeism among the healthcare professionals. This, according to the researchers, has compelled most of the affected healthcare professionals to consider leaving the healthcare profession.

4.8.3.2 Feelings of anxiety

The participants' responses revealed that, because of the stigma associated with caring for HIV/AIDS patients, as well as the fear of being infected with HIV while providing care for the HIV/AIDS patients, some of the nurses expressed feelings of anxiety when they were posted to the isolation wards. So intense was their anxiety that some of the participants stated that they actually wept when they were asked to go and work in the isolation ward. A similar finding was made among Jordanian nurses when Hassan and Wahsheh (2011) revealed that because of the fear of infection and stigma associated with HIV/AIDS, caring for HIV/AIDS patients evokes high levels of anxiety among nurses.

The finding of this study also corroborates the findings of a study by Gueritault-Chalvin et al., (2000) which also revealed that anxiety over safety practices and fears of occupational exposure to HIV infection is a major stress-producing concern shared by many caregivers of HIV/AIDS patients. Studies by Zakeri et al. (2021), and Sun et al. (2020) also revealed that nurses in Iran and China respectively expressed feelings of anxiety in relation to caring for Covid-19 patients.

4.8.3.3 Missed nursing care

The findings of this study also revealed that the inadequate staff strength and its attendant work-related challenges experienced by the participants, while caring for the HIV/AIDS patients, sometimes led to the patients missing the necessary nursing care they require. The concept of missed nursing care, also referred to as compromised nursing care, or nursing care left undone, have been defined as: nursing interventions or the cares nurses have identified as necessary for their patients, but which for various reasons they are unable to provide, or are forced to delay (Dabney & Kalisch, 2015; Kalisch, 2006; Kalisch, Landstrom, & Hinshaw 2009; Palese et al., 2019). This finding of the study is similar to those of previous studies that have also identified that inadequate staffing, inadequate resources, and workload, among other work environment factors, were responsible for patients sometimes missing the nursing care they require (Dabney & Kalisch, 2015; Hessels et al., 2015; Kalisch, 2015; Papastavrou et al., 2014; Wakefield, 2014).

Missed nursing care has been found to have adverse effects on the quality of nursing care provided to patients (Ball et al., 2017; Fitzpatrick, 2018; Kalisch, 2015; Kalisch et al., 2009; Lake et al., 2016) as well as low nurses' job satisfaction and increase the likelihood of burnout and high turnover (Jones et al., 2015; Vryonides et al., 2014). Due to the negative effects of missed nursing care on patients and nurses, it is imperative that, as recommended by Gurková et al. (2021), Schubert et al. (2020), and Hessels et al. (2015), appropriate measures, such as the provision of adequate staff and sufficient resources be put in place to help curtail, if not eliminate, the phenomenon.

4.8.3.4 Reluctance to provide care

Another major finding of this study was that, due to the fear of being infected with HIV through occupational exposure, some of the participants sometimes display unprofessional attitudes toward the HIV/AIDS patients. Some of these unprofessional attitudes include feeling reluctant to care for the HIV/AIDS patients, and avoiding the patients. The study found out that in order to protect themselves against being infected with HIV through occupational exposure, some participants may try to avoid the patients, particularly if they do not have adequate PPEs. These findings of this study are in line with the findings of previous studies that also found out that because of the fear of being infected with HIV, nurses have been found to either avoid the patients, or refuse to care for them (Feyissa et al., 2012; Hassan & Wahshen, 2011; Mutemwa et al., 2013; Philip et al., 2014; Rosenburg et al., 2012; Shah et al., 2014). Similarly, these findings are also consistent with those of studies conducted by Pickles et al.

(2009), Wada et al., (2016), and Kok et al. (2018) which also found out that nurses and nursing students were reluctant to care for HIV/AIDS patients because of the fear of HIV infection.

The study by Pickles et al. (2009) was a literature review conducted to examine research studies into attitudes of nursing students towards caring for people with HIV/AIDS. The review revealed that due to the fear of contracting HIV/AIDS, there was reluctance on the part of some nursing students to provide care for people with HIV/AIDS. Similarly, the results of a study conducted among Turkish nursing students by Kok et al. (2018), revealed that the students' willingness to provide care decreases as negative attitudes toward AIDS increase. A related study among Japanese nurses by Wada et al. (2016), also revealed that the nurses were reluctant to care for a hypothetical HIV/AIDS patient and patients with other infectious diseases; and that the reluctance to care for patients with HIV and the other conditions was positively associated with prejudicial attitudes and negatively associated with confidence in personal safety precautions. Results of studies by Mammbona and Mavhandu-Mudzusi (2019), and Mutemwa et al. (2013), also revealed that lack of adequate PPEs make nurses reluctant to provide appropriate nursing care to the HIV/AIDS patients.

Similarly, nurses in Vietnam (Ishimaru et al., 2017), Japan (Wada et al., (2016), and physicians in the United States, Spain and Canada (Naidoo, 2006) also expressed unwillingness to provide care to HIV/AIDS patients. Nurses' unwillingness to provide care for HIV/AIDS patients was also reported among Nigerian nurses (Omisakin, 2001). The finding of this study further corroborates the findings of an earlier study conducted in Nigeria by Olley (2003) which revealed that the fear of being infected with HIV infection and its consequences may affect the willingness and capacity of HCWs to provide good quality care for people with HIV/AIDS.

Related to the reluctance to care for the patients was another revelation of this study that, due to the fear of being infected with HIV through occupational exposure, most of the nurses were not willing to accept postings to the isolation wards. The participants explained that such nurses usually adopt different strategies to avoid or prevent their being posted to the isolation ward. This finding is in line with the findings of an earlier study by Puplampu (2017), which found out that because of the fear of being infected with HIV through occupational exposure, some Ghanaian nurses were unwilling to work in wards where HIV/AIDS patients are cared for.

The findings from the study further revealed that whereas most nurses were not willing to accept postings to the isolation wards to care for HIV/AIDS patients, some of those who have worked in the isolation ward for a while always yearn to leave the isolation ward because of the challenges inherent in caring for the HIV/AIDS patients. A research finding similar to this was made by (Ginossar et al., 2014), which found out that work-related stress and burnout could result in high turnovers among nurses. This finding also corroborates those of earlier studies among Iranian nurses (Mosadeghrad, 2013), Belgian nurses (Vandenbroeck et al. 2017), Colombian nurses (Moreno-Jiménez et al., 2006), and South African nurses (Mammbona & Mavhandu-Mudzusi, 2019). The findings of the study revealed that a nurse from one of the study settings resigned when she was not able to influence management to reverse her posting to the isolation ward.

This finding is consistent with the findings of a study conducted by Pendukeni (2004) which revealed that some Namibian nurses caring for HIV/AIDS patients either considered leaving their jobs, expressed their intention of leaving their jobs, or actually resigned from their jobs due to the inherent experiences and challenges they had to endure while caring for the HIV/AIDS patients. A study conducted by Suner-Solera et al. (2014) to examine the consequences of burnout syndrome among healthcare professionals in Spain and Spanish speaking Latin American countries also found out that due to the physical and emotional exhaustion experienced by these healthcare professionals as a result of work-related stress and burnout, most of them were compelled to consider leaving the healthcare profession.

In view of the fact that nurses' reluctance or refusal to care for the HIV/AIDS patients can compromise the quality of care the patients receive (Mabusela, 2010; Mametja et al., 2013; Mammbona & Mavhandu-Mudzusi, 2019; Pendukeni, 2004), it is therefore, necessary that management of the hospital and nurse managers provide the necessary PPEs to nurses caring for HIV/AIDS patients to enable them feel protected in order to provide the appropriate care to the patients without hindrance.

4.8.3.5 Reactions of family members

Responses from participants revealed that their work of caring for HIV/AIDS patients evokes unfavourable reactions from their family members. Some participants indicated that their family members were not in favour of them caring for HIV/AIDS patients and therefore, out of concern for the safety of the nurses, urged them to leave the isolation ward. This finding reinforces those of the study conducted by Smit (2005) in which it was revealed that relatives of majority of the nurses caring for HIV/AIDS patients in a South African public hospital were very anxious about the nurses being exposed to HIV through occupational exposure. The findings of this study further agrees with the findings of studies conducted among nurses caring for HIV/AIDS patients in Bangladesh (Ullah, 2011), and Vietnam (Ha et al., 2013) which also revealed that the relatives of these nurses, concerned about the nurses' daily interactions with the HIV/AIDS patients impressed upon them to quit working in the HIV/AIDS care field and find other jobs.

Contrary to this finding of the study however, responses from the participants revealed that, the family members of some of the nurses were not worried about them working in the isolation ward. They revealed that the family members of such nurses rather supported them and always urged them to be cautious while performing their caregiving functions in order not to get infected through occupational exposures.

In order to offset the unfavourable reactions from the family members of the nurses caring for HIV/AIDS patients, Ha et al. (2013) recommended education to change the image of HIV work, which would thereby improve the status of those engaged in HIV/AIDS caregiving work. Furthermore, implementation of the joint WHO, ILO and UNAIDS (2011) policy guidelines on improving health workers' access to HIV and TB prevention, treatment, care and support services could also help health workers and their families feel less concerned about the risk of hospital-acquired infections through occupational exposure.

Participants revealed that the negative experiences and challenges tend to have negative effects on their interactions with their nuclear family members. They explained that at times these experiences and challenges get them so traumatised emotionally that after work, they virtually carry the emotional trauma and sadness home and, using the defence mechanism of displacement, vent their anger and frustrations from work on their immediate family members by shouting at them at no provocation. This finding is consistent with that of an earlier study conducted among Chinese healthcare professionals by Tong et al. (2019), which also revealed that most of the participants tended to release their negative emotions from work onto their spouses and children by shouting at them, criticising them, and even beating them.

The findings of the study also revealed that, in spite of the various negative experiences and the challenges inherent in caring for the HIV/AIDS patients, some of the participants indicated that they derive satisfaction and self-fulfilment from the caregiving functions. These participants expressed feeling satisfied and fulfilled when the patients recover from the HIV/AIDS-related opportunistic infections that brought them to the hospital. They also revealed that the patients' and their relatives' verbal expressions of appreciation about the care provided to them is also a source of satisfaction to them.

These findings support those of Valjee and van Dyk (2014), and Moreno-Jiménez et al. (2006) who also found that caregivers of HIV/AIDS patients derive satisfaction from their caregiving functions through feeling appreciated by the patients, as well as seeing improvements in the patients' conditions. Similarly, Smith et al. (2020) also found that caregivers of HIV/AIDS patients felt highly satisfied that their work was recognised and appreciated by the patients and their family members. In contrast to this finding of the study however, a study by Mametja (2013) that explored and described the perceived problems experienced by professional nurses who provide health care to patients living with HIV/AIDS in public hospitals of Polokwane municipality, Limpopo Province in South Africa found that the nurses were not appreciated by the patients and their relatives. These studies revealed that the patients' relatives rather blamed the nurses for everything that goes wrong at the hospital, and accused the nurses of rendering poor quality services to the patients even under circumstances beyond the nurses' control.

4.8.4 Support systems available to the nurses

The findings that emerged from the fourth objective revealed that the main support system available to the nurses caring for HIV/AIDS patients was social support from their nurse managers, colleague nurses, and family members. The nurse managers who participated in this study indicated that they provided support to the nurses in the form of encouraging them and finding means to solve their problems, if the solution for these problems is within their means. They stated that they also support the nurses by providing direct supervisory roles to them to help them develop self-confidence in their caregiving roles. This finding is consistent with recommendations made by Moshidi et al. (2021), and Zheng et al. (2018), that nurses caring for HIV/AIDS patients should be valued and given the necessary support they need to enable them provide the requisite care to the patients.

From the nurses' perspective however, the study revealed that the support provided by the nurse managers fell short of the nurses' expectations. This is because, as revealed by the study, the nurses expected support in the form of provision of adequate staff and special remuneration, regular interactions with the hospital management, and provision of dedicated psychologists whom they could consult for debriefing and counselling services when necessary. There seems to be a dichotomy between the nurses' expectations for support, and the actual support provided by their nurse managers. This situation could, as opined by Haoses-Gorases et al. (2013), Mulaudzi et al. (2011), and Ramathuba and Makhado (2021), contribute to the provision of sub-standard care by the nurses to the patients.

The perspective of the nurses is however similar to the findings of a study by Moshidi et al. (2021) which revealed that professional nurses caring for HIV/AIDS patients in the public hospitals of Limpopo Province, South Africa, experienced a lack of adequate support in their work because they were not provided with adequate human resources, which resulted in an increased workload. This finding is also consistent with that of a study conducted in the Tshwane district of Gauteng Province, South Africa, by Ndou et al. (2015) which revealed that professional nurses caring for HIV and AIDS patients received inadequate support despite the challenges they experienced while caring for the HIV and AIDS patients.

4.8.5 Coping strategies adopted by the nurses

The fifth objective of the study was to explore how nurses caring for HIV/AIDS patients cope with their work-related challenges. The findings of the study revealed that the participants adopted a number of coping strategies to help them deal with the challenges they encountered while caring for the HIV/AIDS patients. These coping strategies include; rationing of care, involving family members of the patients in their care, rationing of PPEs, self-protection against infection, religious coping, and social support

4.8.5.1 Rationing of care

One of the major findings of the study was resource challenges, namely; 1) inadequate nursing staff, leading to increased workloads, and physical and emotional exhaustion among the nurses, and 2) inadequate materials; namely, personal protective equipment (PPEs) and infrastructure. To cope with the challenge of inadequate nursing staff and its attendant increased workloads and work-related stress, the participants revealed that they adopt a strategy of rationing the nursing care rendered to the patients. Rationing of nursing care is a concept described by Mandal and Rajendrababu (2019) as nurses' inability to complete all nursing care activities for patients because of scarcity in time and resource. This strategy ensures that nursing care is provided on priority basis, and involves the nurses attending first to the patients who are confined to bed and unable to perform any of their own activities of daily living, before providing the care needs of the other patients.

Rationing of nursing care, as a strategy to deal with shortage of staff, was also utilised in the findings of other studies which also revealed that in situations of staff shortages, nurses were compelled to adopt the strategy of rationing nursing care by prioritizing their nursing interventions based on clinical judgment (Dhaini et al., 2019; Rochefort et al., 2016; Witczak et al., 2021). The concept of rationing of nursing care to patients has however, been found to have adverse effects. Rochefort et al. found out that rationing of nursing care may lead to the restriction or neglecting of planned nursing care to the patients, which may increase the risk of negative patient outcomes. Similarly, according to Mandal and Rajendrababu (2019), rationing of nursing care is opposed to the principles of holistic nursing, it threatens the occupational health and philosophical foundations of nursing practice, and adversely affects the quality of nursing care provided to patients (Mandal & Rajendrababu, 2019). It is therefore important that the nursing staff situation is improved to enable the nurses provide care without resorting to rationing of care.

4.8.5.2 Involving family members in patient care

Related to rationing of nursing care is the phenomenon of involving family members in patient care. Using this coping strategy, the participants revealed that they taught the patients' family members some of the basic care procedures that they can perform for the patients. While the family members perform these minor tasks, the nurses have time to attend to the more technical professional care required by the patients.

This finding corroborates that of a study conducted in Greece by Stavrianou et al. (2018), which also found out that due to understaffing and lack of nursing personnel, there have been an increase in patient : nurse ratios. This results in lower quality of care delivered to patients and it became necessary for family members of patients to be trained in basic nursing skills and interventions so that they could provide informal care during hospitalization of their sick relatives. Similar findings were made in Iran by Khosravan et al. (2014), who also found out that hospitalized patients had to receive unskilled and non- professional nursing care from their family members because there was shortage of nursing personnel.

It has been found out that involving family members in the care of patients in hospital has important benefits for the patients as well as the family members (Fateel & O'Neill, 2016; Kelley et al., 2019; Park et al., 2018). Fateel and O'Neill (2016) found out that the expressions of empathy and physical contact that develops when family members are involved in care, was therapeutic for both the family members and the patient during the stressful times of hospitalization as it instils a sense of security and reassurance. It is however, important that family members are taught and guided so that they understand the specific roles they can play in the care of the hospitalized patient.

4.8.5.3 Rationing of PPEs

The findings of the study also revealed that the participants experienced shortage of PPEs which puts them at risk of occupational exposure to the blood and body fluids of the patients, which heightens their risk and fear of being infected with HIV. To deal with this situation, the participants indicated that they have adopted a coping strategy of rationing the limited supply of PPEs in order to maximise their use. This strategy involves assigning just one or two of the staff to provide care to all the patients in each room. Once these staff, who are fully clothed in their PPEs, enter a particular room, they attend to all the patients in that room before coming out. This helps in maximizing the use of the scarce PPEs available. The use of this strategy is in line with the WHO (2020b) recommendations for the rational and optimal use of PPEs in health care settings when there are shortages of PPEs and other resources.

The WHO, (2020b) recommendations, among other strategies, advised healthcare providers to plan and bundle care at the health care facility to minimise the number of times service providers enter the patients' rooms, as well as using alternatives to face-to-face interactions where quality of care can be maintained. Bundling of nursing care is the process of grouping together a set of evidence-based practices that, when performed collectively and reliably, have been shown to improve the patient outcome (Prakash et al., 2017). Practicing this type of care involves grouping together key elements of nursing care for procedures to provide a systematic method to improve and monitor the delivery of clinical care processes. The aim of bundling care, as indicated by Prakash et al. (2017), is to ensure that all patients consistently receive the best care or treatment, all the time.

This approach of nursing care corresponds to the coping strategy adopted by participants in this study to maximise the use of scarce PPEs. Healthcare workers caring for patients with infectious diseases in other settings have also, when necessary, adopted unique coping strategies to deal with the shortage or inadequate supply of the PPEs they need to protect themselves. For instance, Hakim et al. (2021), found out that, during the COVID-19 pandemic, Pakistani healthcare workers experienced shortage of PPEs and to cope with this challenge, they adopted the strategy of re-using PPEs many times, especially N95 and N99 masks, and washed or chlorinated coverall suits and disposable gowns.

4.8.5.4 Self-protection against infection

In reaction to the risk and fear of being infected with HIV through occupational exposure, participants revealed that they adopted the strategy of self-protection against infection by adhering to the wearing of appropriate PPEs, and striving to adhere to the standard precautions of infection prevention when attending to the patients. To achieve this, some participants indicated that they had to sometimes purchase their own PPEs when there are inadequate supplies of PPEs. By adopting this strategy, the participants have taken appropriate actions against the source of stress they encounter, namely the fear of HIV infection, compounded by inadequate supply of the needed PPEs. Additionally, by adopting this strategy, they had taken proactive action against the risk and their fears of being infected with HIV while they provided care to the HIV/AIDS patients.

This finding is consistent with those of previous studies (Brown et al., 2019; Rai et al., 2021; Razu et al., 2021; Yasin et al., 2019), which also revealed that adequate wearing of the appropriate PPEs, and general adherence to the standard precautions of infection prevention are the necessary self-protective measures used by nurses and other healthcare workers to protect themselves against infection from pathogens such as HIV, Hepatitis and Covid-19. Adherence to the universal precautions of infection prevention is an effective means of preventing the spread of infection in the healthcare setting as it protects healthcare workers against occupational exposure (Brown et al., 2019; Yasin et al., 2019) and hence helps in reducing the nurses' fears of the risk of being infected with HIV through occupational exposure.

In the concept of coping, self-protection by adhering to the infection prevention measures could be classified as a problem-focused coping strategy (Lazarus & Folkman, 1984), since it involves the nurses making conscious efforts to avert the risk of occupational exposure to the blood and other body fluids of the HIV/AIDS patients they were caring for. These findings reinforce the fact that nurses caring for HIV/AIDS patients, and other healthcare professionals must be provided with the necessary and adequate resources they needed to protect themselves against occupational exposures at the healthcare setting. This recommendation was also made by Mokhtari et al. (2021), who urged managers and healthcare organizations to provide appropriate and adequate PPEs to nurses caring for patients with infectious diseases, and educate them on their proper use.

It emerged from the data that some of the participants adopted the strategy of self-help to deal with the work-related challenges they experienced while caring for the HIV/AIDS patients. Specific self-help strategies adopted by participants included talking about the depressing situations faced at work with their spouses and other members of their households. This strategy is in line with the concept of "letting out", a concept of self-help propounded by Williams (2014), in which caregivers find means to express their feelings and frustrations associated with caregiving. It involves caregivers communicating purposefully with others to share their feelings. It corroborates the findings of Lekganyane and Alpaslan (2019); Mashau and Davhana-Maselesele (2009); and Bester and Herbst (2010).

This finding however, contrasts with that of Rahman et al. (2020), which found out that several caregivers of stroke patients kept their emotions to themselves, and talked less with other people around them because when they shared the burdens inherent in their caregiving roles with others, they received unsupportive comments or feedback from them. These caregivers therefore choose to keep quiet and isolate themselves from people around them. This concern of caregivers underscores the need for them to be provided professional counsellors who will keep their concerns in confidence. The findings of this study further revealed that some participants also adopted the self-help strategy of self-encouragement, and self-motivation as a coping strategy to help them deal with the stressors at work. This is consistent with the finding of Lekganyane (2017) which also revealed that home-based caregivers caring for PLWHA also use self-help or self-motivation as one of the strategies that helped them to cope with their work-related challenges.

4.8.5.5 Religious coping

Religious coping, according to (Pargament, 1997), as cited by Abu-Raiya, Sasson, Pargament and Rosmarin (2020), is the application of religious beliefs, practices, experiences, emotions, or relationships in the effort to understand and deal with stressful life experiences. It comprises the various ways people use their religion and faith to manage stressful situations (Aflakseir & Coleman, 2011).

The findings of this study revealed that some of the participants adopted the religious coping or reliance on God as a strategy to deal with the work-related challenges they experienced while caring for the HIV/AIDS patients. Participants indicated that when faced with stressful situations while caring for the HIV/AIDS patients, particularly the risk of infection through occupational exposure, they take consolation in God's protective power, and prayed every morning committing themselves and the ward into the hands of God, asking for divine protection against HIV infection. This finding corroborates those of previous studies (Lamptey et al., 2018; Mohangi & Pretorius, 2017; Mujjuzi et al., 2021; Oyeyimika et al., 2020; Shirinda-Mthombeni, 2014) in which religious coping and reliance on God, manifested in praying and seeking the help of God for protection in dealing with the stressful situation, was utilised as a coping strategy by caregivers, including caregivers of HIV/AIDS patients.

Similarly, the finding is consistent with that of Zheng, Lee, & Bloomer, (2018) who found out that one of the resources nurses use to cope with the death of patients under their care was to adopt spiritual practices, including talking to or involving chaplains or ministers in their care, praying, and other faith-based activities, as their preferred coping strategies. In this study, a participant revealed that at the initial stages of working in the isolation ward, she consults a priest in her church every time a patient dies in the ward. By adopting this emotion-focused coping strategy, the participants have acknowledged the fact that the stressful work-related challenges they experience are beyond their control and thus, they needed the intervention of a superior being to manage their challenges (Smith et al., 2020).

The religious coping strategy was also adopted by healthcare workers and other caregivers of COVID-19 patients, cancer patients, , and stroke patients (Antony et al., 2018; Thune´-Boyle et al., 2011; Chow et al., 2021; Ofori et al., 2021; Razu et al., 2021;, Gholamzadeh et al., 2014; Kes & Yildirim, 2020; Kumar et al., 2015). The same coping strategy was also adopted by caregivers of diabetic patients, as well as the caregivers of persons diagnosed with other chronic diseases to deal with stressors and other challenges associated with their caregiving roles (Machadoa et al., 2018; Mamatsharaga, 2020). Due to its widespread use as a coping strategy, management of healthcare institutions could consider incorporating it into their formal support services for their staff to help them deal with their work-related challenges. This could be achieved through the introduction of chaplaincy units in the healthcare institutions.

4.8.5.6 Social support

Participants of this study revealed that they usually receive emotional support from each other to help deal with the work-related challenges they experience while caring for HIV/AIDS patients. They indicated that this social support takes the form of talking to each other in a way to calm each other down when faced with challenging and depressing situations. This support strategy is akin to the concept of "letting it out" described by Williams (2014), as caregivers finding means to express their feelings and frustrations associated with caregiving. It involves the caregiver communicating purposefully with others to share their feelings. These interactions provide the caregivers emotional support that help minimise the effects of their work-related challenges and thus helped in relieving the stressors they face at work. Blum, Brow & Silver (2012) opined that engaging one's social network during stressful periods is recognized as one of the most productive coping strategies. Social support provides a feeling of being cared for and valued, and having reliable people available to assist in times of need.

Similar to this finding of the current study are those of studies by Roca et al. (2021) and Savitsky, Radomislensky, & Hendel. (2021) which also found out that nursing students and auxiliary health workers, in Spain and Israel respectively, relied on each other as well as their friends and family members for support while they were caring for COVID-19 patients. This finding is also consistent with that of a study conducted among palliative care staff in South Africa by Smith et al. (2020), in which the participants revealed that they received support from their co-workers to deal with challenges they face in doing their work.

Another finding of this study was that the participants sometimes rely on their family members for emotional support when they feel depressed by the challenges related to their work. This finding corroborates those of studies conducted by other researchers (Amaugo, 2019; Amoateng, Kalule-Sabiti, & Oladipo, 2015; Kumar et al., 2015; Kyomuhendo, Boateng, & Agyemang, 2021; Roca et al., 2021; Savitsky et al., 2021; Smith et al., 2020) which also revealed that caregivers of PLWHA, as well as COVID-19 patients, received social support, as a coping strategy, from their co-workers, family members, and friends to help them deal with challenges inherent in caring for these patients.

It is clear that social support for caregivers of HIV/AIDS patients is very vital and has a positive effect on the ability of the caregivers to cope with the challenges related to their caregiving functions. As posited by Okeke (2016), social support is effective in enhancing the emotional well-being of caregivers of HIV/AIDS patients. He therefore recommended that serious efforts should be made to encourage the employment of the psychological management of caregivers of the HIV/AIDS patients. It is also essential that, as recommended by Zheng et al. (2018), nurses caring for HIV/AIDS patients should be provided with opportunities to share and discuss their work-related challenges and experiences with either their professional or non-professional colleagues thus allowing them to explore their feelings and emotions.

4.9 Chapter Summary

This chapter focused on the presentation and discussion of the findings of the study. The findings of this study revealed that the nurses provided a holistic nursing care, encompassing the provision of psychosocial support, physical care, financial support, and material support, to the HIV/AIDS patients. The findings also revealed the work-related challenges experienced by the nurses as they cared for the HIV/AIDS patients. These included; fear of being infected with HIV, work-related stress, HIV/AIDS-related courtesy stigma, abuse from patients and their relatives, resource challenges, lack of a policy on rotation of nurses, and lack of motivation. These experiences were found to have negative effects on the nurses' and their caregiving functions, namely; physical exhaustion, feelings of anxiety, missed nursing care, and reluctance to care for the patients. The participants indicated that they adopted coping strategies such as rationing of care and PPEs, self-protection, religious coping, and social support, to deal with these work-related challenges and their effects. In the next chapter, the summary, conclusions and recommendations of the study will be presented.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

In the preceding chapter (chapter four), the results and discussions of the findings of the study were presented. In this final chapter of the study, the summary, conclusions and recommendations of the study are presented.

5.1 Summary of the Study

The study was conducted to explore the lived experiences of nurses caring for HIV/AIDS patients in the isolation wards of the Korle Bu Teaching Hospital, and the 37 Military Hospital in Accra, Ghana. The objectives of the study were to: 1) explore the care nurses provide to the HIV/AIDS patients, 2) explore the challenges encountered by the nurses while caring for the HIV/AIDS patients, 3) understand how the work-related challenges affect the nurses and their caregiving functions, 4) find out what support systems are available for the nurses caring for HIV/AIDS patients to help them deal with their work-related challenges, and 5) explore how nurses caring for HIV/AIDS patients cope with their work-related challenges. This qualitative, phenomenological study, was underpinned by the constructivist or interpretive paradigm, with assumptions of a relativist ontology, a subjectivist epistemology, a value-laden or balanced axiology, and a naturalistic methodology.

The population for the study were a total of fifty (50) nurses working in the Fevers Unit of the Korle Bu Teaching hospital, and the Simango (isolation) Ward of the 37 Military hospital. Using the purposive sampling procedure, thirteen (13) professional nurses who have worked in the Fevers unit of the Korle-Bu Teaching hospital, and the

Simango ward of the 37 Military hospital for at least one year were selected to participate in the study.

Prior to data collection, the researcher obtained permission from the relevant authorities and gatekeepers in charge of the two health facilities used as the research setting. Ethical clearance was sought from the Institutional Review Boards (IRBs) of the two hospitals. Using an information sheet, the study procedure was explained to the participants and they were given opportunity to ask questions to seek clarification. Participants who voluntarily agreed to participate in the study were selected, and they signed the volunteer agreement form to participate in the study. A semi-structured interview guide was employed as a tool for data collection, and data was generated using in-depth face-to-face, audio-taped interviews conducted with each participant at the hospital wards. The data was analysed using Braun and Clarke's six-phase guide to thematic analysis.

5.2 Key Findings of the Study

The following were the key findings from the study:

1. The nurses provided holistic nursing care to the HIV/AIDS patients. This involves attending to the patients' physical, economic, and psychosocial needs.
2. The nurses who care for HIV/AIDS patients experience work-related challenges such as: a) fear of being infected with HIV through occupational exposure, b) work-related stress, c) HIV/AIDS-related courtesy stigma and discrimination, and d) resource challenges. Other challenges they encounter include; lack of a policy on the rotation of nurses working in the isolation wards, lack of specific training prior to being posted to the isolation ward, and lack of motivation.

3. The work-related challenges encountered by the nurses affects negatively their physical and emotional wellbeing, as well as their willingness to provide care to the patients. The challenges led to a) physical exhaustion, b) feelings of anxiety, and c) reluctance of some of them to provide care to the patients. It also led to some of them engaging in self-blame for the death of the patients. In spite of these challenges and their impact on the nurses, some of the participants indicated that they derive satisfaction and self-fulfilment from their caregiving functions.
4. The main support system available to the nurses was social support from the nurse managers, colleague nurses, and family members. Participants however perceived the available support system to be inadequate. They therefore wished that the management of the hospitals could provide further support for them in the form of; provision of adequate staff and PPEs, and making provisions for counselling services.
5. Participants usually adopt various coping strategies to help deal with their work-related challenges and experiences. These coping strategies include; rationing of nursing care, involving the patients' family members in the provision of care to the patients, rationing of the limited PPEs to ensure their maximal use, self-protection, religious coping, and social support, specifically emotional venting.

5.3 Implications of the Findings for Counselling, Nursing Practice and Administration, and Policy

5.3.1 Implications for Counselling

The findings of the study revealed that work-related challenges have negative effects such as physical and emotional exhaustion, feelings of anxiety, and even self-blame on the nurses. These affect the physical and psychosocial wellbeing of the participants. They also lead to the reluctance of some of them to care for the patients, their yearning to leave the isolation ward, and the unwillingness of others to accept postings to the isolation wards. These effects have the potential to compromise the quality of care the nurses could provide to the patients. There is the need for provision of necessary psychosocial care and support to the nurses.

It is imperative that counselling units, manned by professional counsellors be established in the hospitals for the provision of psychosocial care and support to nurses caring for HIV/AIDS patients. It is important that hospitals have such counselling units that are functional, and dedicated to the care and support of nurses caring for HIV/AIDS patients and all other healthcare workers in the hospital. This will ensure that the counselling and other psychosocial needs of the nurses are catered for to help mitigate the impact of work-related challenges they encounter while caring for the HIV/AIDS patients.

There is the need for providing counselling services, and stress reduction education to the nurses prior to being posted to the isolation wards. The findings make it imperative that management of the hospitals institute a protocol for regular counselling and debriefing sessions by professional counsellors and clinical psychologists for the nurses to help provide psychosocial support for them. This envisaged protocol could also include the provision of social support systems such as the formation of support groups where the nurses can meet and share their experiences and challenges associated with caring for HIV/AIDS patients.

The nurses should utilize the counselling services and other social support systems available to help safeguard their physical and emotional wellbeing. It is important that nurses who are traumatised by work-related experiences be encouraged to seek counselling and be helped to deal with their situation.

5.3.2 Implications for nursing practice and administration

The findings of the study raised issues that need to be addressed in order to help mitigate the work-related challenges encountered by the nurses caring for HIV/AIDS patients. Providing nursing care in an environment fraught with the challenges identified by the study, can have negative impacts on the caregivers' personal wellbeing and their caregiving functions. If the nurses continuously encounter these work-related challenges, and they do not receive sufficient support, it could negatively affect their personal wellbeing which could lead to compromising the quality of care they provide to the patients, as they may refrain from physical contact with the HIV/AIDS patients. The challenges and related experiences may also compel the nurses to quit the isolation wards, or leave the nursing profession thereby worsening the already inadequate staff situation in the isolation wards. This will adversely affect the provision of care to the HIV/AIDS patients, and hence worsen their condition.

Nurse managers and heads of the institutions must therefore help in providing adequate care and support to the nurses. The care and support should be in the form of provision of the requisite resources the nurses need to work and feel protected in the isolation wards, as well as motivating them to make them feel valued and accepted. Heads of the institutions also need to provide psychosocial support to the nurses to help them deal with the work-related challenges they encounter while caring for the patients. This could be done through engagement of professional counsellors and/or clinical psychologists to provide counselling services to the nurses whenever necessary. For the effective performance of their professional caregiving functions, nurse managers need to provide the nurses pre-deployment training. This training will equip the nurses with adequate requisite knowledge unique to caring for HIV/AIDS patients, and strategies for the management of work-related stress and other challenges associated with caring for the HIV/AIDS patients.

Findings of this study can thus be used to underscore the need for nurse managers to ensure that there is adequate supply of 1) the needed material resources like the PPEs that the nurses need to protect themselves against occupational exposures to blood and body fluids of the patients and hence minimise the risk and fear of infection, 2) human resources needed to reduce the burden of work overload on the nurses, as well as 3) conducive infrastructure. The nurses caring for HIV/AIDS patients should also employ social support systems and other self-help measures to protect themselves against the effects of the challenges associated with their caregiving functions.

5.3.3 Implications for policy

The findings also underscore the need for the nursing management to formulate policies on rotation of nursing staff in the isolation ward, as well as a policy on providing counselling and debriefing sessions for nurses caring for HIV/AIDS patients to help mitigate the psychosocial challenges they experience while caring for HIV/AIDS patients. The nurses caring for HIV/AIDS patients must be involved in the formulation of this policy and it should be communicated to all the staff to ensure it is adhered to.

The results of the finding indicated that the participants identified lack of motivation, commensurate with the challenges inherent in their caregiving functions, as one of the challenges they experience while caring for the HIV/AIDS patients. This finding calls for the adoption of a policy on providing a special incentives package for the nurses working in the isolation wards to help motivate them and make them feel appreciated and rewarded for the unique challenges they face while caring for the HIV/AIDS patients.

The findings of the study indicated the need for formulation of a policy on Employee Assistance Programme (EAP) designed to help the nurses deal with the challenges associated with their caregiving functions. The policy should include counselling and debriefing services for the nurses. These intended policies will help promote the physical and emotional well-being of nurses caring for HIV/AIDS patients.

5.4 Contributions of the Study to Knowledge

The study presents new knowledge to the field of counselling vis-à-vis nursing practice in particular, and healthcare practice in general. This knowledge could be used to provide care and support to the nurses and other healthcare workers.

The study revealed that the work-related challenges encountered by nurses while caring for HIV/AIDS patients have effects such as physical and emotional exhaustion, feelings of anxiety, and self-blame on them. The issues of self-blame, feelings of anxiety, and emotional exhaustion could lead to decreased productivity, absenteeism, increased turnover, increased medical errors, impairment of ability to think clearly, make sound judgements and act decisively among the nurses. It could also lead to decreased self-esteem, depression, and even suicidal ideation. The study therefore identified the need for introducing counselling interventions to help mitigate these challenges among the nurses.

The identification of counselling needs of nurses caring for HIV/AIDS patients as a means of mitigating the psychosocial challenges encountered by the nurses, is unique to this study. The findings of the study are unique in providing empirical basis for hospital administrators to liaise with professional counsellors to establish counselling units dedicated to providing counselling and debriefing services to nurses caring for HIV/AIDS patients. This will help mitigate the psychosocial challenges associated with their caregiving functions. It will also be useful in exploring the counselling needs of all healthcare workers in the hospitals.

To the best knowledge of the researcher, the clinical psychology units or wellness centres in the hospitals focus mainly on the needs of patients with psychological problems. Advocating the establishment of counselling units in the hospitals to cater for the nurses is thus unique for this study. It will contribute to the nurses receiving the necessary counselling and debriefing services needed to mitigate the caregiver burden imposed on them by their work-related challenges.

At the policy level, the findings would inform the Ministry of Health, the Ghanan Health Service, as well as the management of health facilities to consider the setting up counselling units, or identifying professional counsellors or clinical psychologists in the psychology units/wellness centres in the health facilities, who will be dedicated to the counselling needs of the nurses, and other healthcare staff in the hospitals.

5.5 Limitations of the Study

The research design was a limitation because the researcher used the qualitative research design. If the researcher used the quantitative or mixed methods, the findings could have been different.

The study was limited to nurses caring for HIV/AIDS patients in the isolation wards of only two hospitals in the country. This, coupled with the small sample size of thirteen (13) participants who participated in the study, and the fact that the participants were not randomly selected, made it impossible for the findings to be generalised to other hospitals in the country, or for all nurses caring for HIV/AIDS patients. However, the results may be transferable to other hospitals in the country where nurses provide in-patient care for HIV/AIDS patients. Whereas there are other categories of healthcare workers in the isolation wards, the study included only nurses. It is possible that if other workers were included, different data could have been obtained.

5.6 Conclusions

Nurses provide holistic nursing care to the HIV/AIDS patients. While doing so, they encounter physical, psychosocial, and resource challenges. These challenges affect the physical and emotional wellbeing of the nurses, and have the potential to compromise the quality of care they could provide to the patients. Though there are social support systems available to the nurses, the participants perceived them to be inadequate and hence called for them to be augmented.

There is the need for formulating policies and measures to mitigate the work-related challenges associated with caring for HIV/AIDS patients. Prominent among these policies and measures should be providing resources for counselling and debriefing sessions for the nurses, when necessary, and adequately resourcing them for their caregiving functions. These policies and measures will ensure that the nurses are physically and emotionally sound to provide the needed care to the patients.

5.7 Recommendations

Based on the findings of the study, the following recommendations were made with the anticipation that they could help in mitigating the work-related challenges experienced by the nurses caring for HIV/AIDS patients. The recommendations are made for counselling, and nursing practice.

5.7.1 Recommendations for Counselling

1. As a short-term measure, management should identify some of the clinical psychologists or counsellors of the hospitals who will be assigned the responsibility of providing professional counselling and debriefing services for the nurses caring for HIV/AIDS patients when necessary. This is intended to relieve the nurses of the psycho social impact consequent to the work-related challenges they encounter, and the caregiver burden this imposes on them.
2. As a long-term measure, management of the hospital should establish counselling units manned by professional counsellors solely for the provision of psychosocial care and support to nurses caring for HIV/AIDS patients. It is important that hospitals have such counselling units that are functional, and dedicated to the care and support of nurses caring for HIV/AIDS patients and all other healthcare workers in the hospital. This will ensure that the counselling and other psychosocial needs of the nurses are catered for to help mitigate the impact of work-related challenges they encounter while caring for the HIV/AIDS patients.
3. Management of the hospital should institute a protocol for the provision of regular counselling and debriefing sessions, by professional counsellors and clinical psychologists, for the nurses to help provide psychosocial support for them. This envisaged protocol could also include the provision of social support systems such as the formation of support groups where the nurses can meet and share their experiences and challenges associated with caring for HIV/AIDS patients.
4. Prior to being posted to the isolation ward, the nurses should be provided counselling and education and training tailored to equip them with knowledge on caring for HIV/AIDS patients, the challenges inherent in caring for such patients, and measures to take in dealing with such work-related challenges, including

training programmes on stress management. This is intended to make the nurses emotionally prepared to meet the challenges associated with their caregiving roles, and how they could deal with them.

5. Management should put in place measures for early identification of nurses who are traumatised by work-related experiences. These nurses should be encouraged to seek counselling and be helped to deal with their situation. This will help in early identification and management of work-related stress before it results in burnout.
6. It is further recommended that the nurses should form social support groups such as WhatsApp platforms through which they could voice out and share their experiences, and comfort each other. This will help prevent these challenges developing into burnout.

5.7.2 Recommendations for Nursing Practice

1. Management of the hospitals should advocate the recruitment of more staff to man the isolation wards. This is expected to help alleviate the work overload and the associated work-related stress experienced by the nurses.
2. Management of the hospitals should provide adequate supplies of PPEs for the nurses. Because, due to financial constraints, management may not be able to provide all the needed PPEs, it is further recommended that the nurses should also make the self-help effort of purchasing their own PPEs to supplement what is supplied by the hospital management. This is expected to help the nurses protect themselves against occupational exposures, and hence reduce, if not eliminate totally, their fears of being infected with HIV through occupational exposures.
3. The study revealed that the participants desired to have regular interactions with the hospital management to lay before them their concerns relating to the

challenges they experience while caring for HIV/AIDS patients. It is recommended that the nurse managers institute a protocol of organizing regular ward durbars with the nurses. During these durbars, management and staff could discuss the concerns of the staff and come to a mutual agreement on how to address them. It is also recommended that the nurse managers conduct regular needs-assessments to enable them identify the needs and challenges encountered by the nurses, and provide interventions to address them.

4. The study also revealed lack of rotation of staff as one of the challenges experienced by the participants of the study. To help deal with this challenge, it is recommended that the nurse managers devise a policy on rotation of staff postings to the isolation wards. This policy would indicate the duration stay would spend in the ward. This will ensure that every nurse practises in the isolation ward for a specific period of time. It is anticipated that when this is done, no group of nurses will remain in the isolation ward for very long periods. Such a policy may also help reduce the courtesy stigma associated with working in the isolation wards, as well as reduce the phenomenon of nurses being hesitant in accepting postings to the isolation ward.
5. The study revealed that participants experience courtesy stigma often perpetrated against them by their co-workers. It is recommended that, as indicated by participants, nurse managers should put in place a policy that ensures that every nurse in the hospital works in the isolation ward for a period of time. This, it is envisaged, could help curb the courtesy stigma perpetrated against nurses working in the isolation wards since every nurse would have experienced the challenges associated with caring for HIV/AIDS patients.

6. It is also recommended that management of the hospitals consider lobbying government for the institution of a policy on providing a special incentive package such as a risk allowance for the nurses working in the isolation wards. This will help motivate them and make them feel appreciated and rewarded for the unique challenges they face while caring for HIV/AIDS patients.
7. The Nurses could adopt the following self-help measures to help mitigate the challenges they experience while caring for the HIV/AIDS patients:
    a. Voicing out their feelings about the work-related challenges they experience while caring for HIV/AIDS patients.
    b. Taking intermittent respites respites during the working day, and regular annual leaves. These are expected to help them recuperate from the stressors associated with their caregiving roles
    c. Trying to avoid getting over-involved with the patients. This will help them separate their personal and family lives from their professional lives as caregivers.

5.8 Suggestions for Further Study

It is suggested that similar studies be conducted in other hospitals throughout the country where HIV/AIDS patients are cared for. The findings of such studies will help either confirm or reject the findings of the current study as well as help determine the level of the phenomenon of caregiver burden experienced by nurses caring for HIV/AIDS patients in the country. The findings of such studies will also help in formulating a national policy on providing care and support to caregivers of HIV/AIDS patients.

REFERENCES

Abokyi, L., Mahama, C., Sulemana, A., Adda, R., Amenga-Etego, S., Baiden, F., & Owusu-Agyei, S. (2014). Willingness to undergo HIV testing in the Kintampo districts of Ghana. *Ghana Medical Journal*, *48*(1), 43–46.

Abu-Raiya, H., Sasson, T., Pargament, K. I., & Rosmarin, D. H. (2020). Religious coping and health and well-being among Jews and Muslims in Israel. *International Journal for the Psychology of Religion*, *30*(3), 202–215. https://doi.org/10.1080/10508619.2020.1727692

Addo, S. A., Abdulai, M., Yawson, A., Baddoo, A. N., Zhao, J., Workneh, N., Okae, I., & Wiah, E. (2018). Availability of HIV services along the continuum of HIV testing, care and treatment in Ghana. *BMC Health Services Research*, *18*(739), 1–10. https://doi.org/https://doi.org/10.1186/s12913-018-3485-z

Adelman, R. D., Tmanova, L. L., Delgado, D., Dion, S., & Lachs, M. S. (2014). Caregiver burden: A clinical review. *Journal of American Medical Association*, *311*(10), 1052–1059. https://doi.org/10.1001/jama.2014.304

Adzakpah, G., Laar, A. S., & Fiadjoe, H. S. (2017). Occupational stress among nurses in a hospital setting in Ghana. *Clinical Case Reports and Reviews*, *2*(2), 333–338. https://doi.org/10.15761/CCRR.1000207

Afful, H., Hayfron-Benjamin, A., Asiedua, E., Donyeh, P. S., & Abraham, S. A. (2019). Caring for children living with HIV/AIDS: family caregivers experiences at the Princess Marie Louise Hospital, Ghana. *Journal of Tropical Medicine and Health*, *3*(1), 1–10. https://doi.org/10.29011/JTMH-143.000043

Aflakseir, A., & Coleman, P. G. (2011). Initial development of the Iranian religious coping scale. *Journal of Muslim Mental Health*, *6*(1), 44–61. https://doi.org/10.3998/jmmh.10381607.0006.104

Agyeman-Yeboah, J. (2017). *A best-practice guideline for facilitating adherence to antiretroiral therapy for persons attending public hospitals in Ghana*. PhD Thesis, Faculty of Health Sciences, The Nelson Mandela Metropolitan University, South Africa.

Agyemang, C. B., & Otoo, E. (2013). HIV/AIDS stigmatization on relatives and associates of people living with HIV/AIDS: A psychological study. *International Journal of Heath and Psychology Research*, *1*(2), 1–13.

Ahmed, A. S. (2012). Verbal and physical abuse against Jordanian nurses in the work environment. *Eastern Mediterranean Health Journal*, *18*(4), 318–324. https://doi.org/10.26719/2012.18.4.318

Ainsworth, M. D. S. (1979). Infant - mother attachment. *American Psychological Association*, *34*(10), 932–937.

Akbar, R. E., Elahi, N., Mohammadi, E., & Khoshknab, M. F. (2016). What strategies do the nurses apply to cope with job stress?: A qualitative study. *Global Journal of Health Science*, *8*(6), 55–64. https://doi.org/10.5539/gjhs.v8n6p55

Akinboro, A. A., Adejumo, O. P., Onibokun, C. A., & Olowokere, E. A. (2012). Community health care workers' risk perception of occupational exposure to HIV in ibadan, South-West Nigeria. *African Journal of Primary Health Care and Family Medicine*, *4*(1), 1–9. https://doi.org/10.4102/phcfm.v4i1.338

Akintola, O., Hlengwa, W., & Dageid, W. (2013). Perceived stress and burnout among volunteer caregivers working in AIDS care in South Africa. *Journal of Advanced Nursing*, *69*(12), 2738–2749. https://doi.org/10.1111/jan.12166

Akpuh, N., Ajayi, I. O., Adebowale, A., Idris Suleiman, H., Nguku, P., Dalhat, M., & Adedire, E. (2020). Occupational exposure to HIV among healthcare workers in PMTCT sites in Port Harcourt, Nigeria. *BMC Public Health*, *20*(451), 1–8. https://doi.org/10.1186/s12889-020-08528-5

Alemie, G. A. (2012). Exploration of healthcare workers' perceptions on occupational risk of HIV transmission at the University of Gondar Hospital, Northwest Ethiopia Getahun. *BMC Research Notes*, *5*(704). https://doi.org/10.1186/1756-0500-5-704.

Alfuqaha, O. A., Al-Hairy, S. S., Al-Hemsi, H. A., Sabbah, A. A., Faraj, K. N., & Assaf, E. M. (2021). Job rotation approach in nursing profession. *Scandinavian Journal of Caring Sciences*, *35*, 659–667. https://doi.org/10.1111/scs.12947

Alfuqaha, O. A., Al-Hiary, S. S., & Al-Hemsi, H. A. (2022). Job rotation approach among nurses: A comparative study. *Revista de Enfermagem*, *31*, e20200689. https://doi.org/https://doi.org/10.1590/1980-265X-TCE-2020-0689 1/12

Alfuqaha, O., & Alsharah, H. S. (2018). Burnout among nurses and teachers in Jordan: A comparative study. *Archives of Psychiatry and Psychotherapy*, *20*(2), 55–65. https://doi.org/10.12740/APP/80168

Ama, N. O., & Seloilwe, E. S. (2011). Analysis of the burdens of caregivers providing care to people living with HIV/AIDS in Botswana. *South African Family Practice*, *53*(1), 56–62. https://doi.org/10.1080/20786204.2011.10874061

Amankwaa, L. (2016). Creating protocols for trustworthiness in qualitative research. *Journal of Cultural Diversity*, *23*(3), 121–127.

Amaugo, L. G. (2019). *Loneliness and depression among informal caregivers of children with HIV/AIDS in Nigeria*. PhD Thesis, University of Bedfordshire.

American Holistic Nurses Association. Flagstaff, A. (1998). *Description of holistic nursing*. Flagstaff in Arizona, USA, AHNA.

American Medical Association. (2018). *Caring for the caregiver: A guide for physicians*. 1–3.

Amoateng, A. Y., Kalule-Sabiti, I., & Oladipo, S. E. (2015). Psycho-social experiences and coping among caregivers of people living with HIV/AIDS in the North-West province of South Africa. *South African Journal of Psychology*, *45*(1), 130–139. https://doi.org/10.1177/0081246314556566

Amofah, G. K. (1992). AIDS in Ghana: profile, strategies and challenges. *AIDS Analysis Africa*, *2*(5), 5. http://www.ncbi.nlm.nih.gov/pubmed/12317822

Anney, V. N. (2014). Ensuring the quality of the findings of qualitative research: Looking at trustworthiness criteria. *Journal of Emerging Trends in Educational Research and Policy Studies*, *5*(2), 272–281.

Anonymous. (1984). Needlestick transmission of HTLV-III from a patient infected in Africa. *The Lancet*, *324*(8416), 1376–1377. https://doi.org/10.1016/S0140-6736(84)92065-8

Anshasi, H. A., Fawaz, M., Alhalalmeh, S., Ahmad, W. Q., & Tassi, A. (2020). Nurses' stressors and their quality of life: A study on nurses caring for older patients. *Nursing Open*, (00) 1–9. https://doi.org/10.1002/nop2.553

Antony, L., George, L. S., & Jose, T. T. (2018). Stress, coping, and lived experiences among caregivers of cancer patients on palliative care: A mixed method research. *Indian Journal of Palliative Care*, *24*(3), 313–319.

APA. (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington DC, USA, American Psychological Association.

APA. (2019). *Publication Manual of the American Psychological Assosciation* (7th ed.). Washington DC, USA, American Psychological Association.

Appiah-Agyekum, N. N., & Suapim, R. H. (2013). Knowledge and awareness of HIV / AIDS among high school girls in Ghana. *HIV/AIDS - Research and Palliative Care*, *5*, 137–144.

Argentero, P. A., Zotti, C. M., Abbona, F., Mamo, C., Castella, A., Vallino, A., Luzzi, B., & De Carli, G. (2007). Regional surveillance of occupational percutaneous and mucocutaneous exposure to blood-borne pathogens in health care workers: Strategies for prevention. *La Medicina Del Lavoro*, *98*(2), 145–155.

Arulappan, J. (2016). Psycho social nursing care for better patient outcome. *Nursing & Care Open Access Journal*, *1*(1), 10–11.

Asadullah, M., Kamath, R., Pattanshetty, S., Andrews, T., & Nair, N. S. (2016). Psychological impact on caregivers of HIV-infected children in Udupi district, Karnataka. *AIDS Care*, *0*(0), 1–6.

Asamoah-Odei, E. J., Antwi, P. M., Ahmed, K., & Akar, G. K. (1990). AIDS in Ghana, 1986-1989 epidemiological aspects. *Ghana Medical Journal*, *24*(3), 191-200.

Asamoah-Odei, E. J., Antwi, P. M., Atiase, P. K., Osei, A., & Kafui, G. A. (1992). AIDS awareness amongst students of second cycle institutions in the Greater Accra Region. *Ghana Medical Journal*, *26*, 410–417.

Asampong, E., Gyeke, M. D., & Oduro, R. (2018). Caregivers' views on stigmatization and discrimination of people affected by leprosy in Ghana. *PLOS Neglected Tropical Diseases*, *12*(1), 1–12. https://doi.org/https://doi.org/10.1371/journal.pntd.0006219

Asmr, Y., Beza, L., Engida, H., Bekelcho, T., Tsegaye, N., & Aschale, Y. (2019). Assessment of knowledge and practices of standard precaution against blood borne pathogens among doctors and nurses at adult emergency room in Addis Ababa, Ethiopia. *Emergency Medicine International*, *2019*, 1–8. https://doi.org/10.1155/2019/2926415

Assen, A., Molla, F., Wondimu, A., Abrha, S., Melkam, W., Tadesse, E., Yilma, Z., Eticha, T., Abrha, H., & Workneh, B. D. (2016). Late presentation for diagnosis of HIV infection among HIV positive patients in South Tigray Zone, Ethiopia. *BMC Public Health*, *16*(558), 1–7. https://doi.org/10.1186/s12889-016-3263-y

Asuquo, E. F., Adejumo, P., Etowa, J., & Adejumo, A. (2013). Fear of HIV susceptibility influencing burden of care among nurses in South-East Nigeria. *World Journal of AIDS*, *3*, 231–238.

Asuquo, E. F., Etowa, J. B., & Adejumo, P. (2013). Assessing the relationship between caregivers burden and availability of support for family caregivers' of HIV/AIDS patients in Calabar, South East Nigeria. *World Journal of AIDS*, *3*, 335–344. https://doi.org/10.4236/wja.2013.34043

Atieno, O. P. (2009). An analysis of the strengths and limitation of qualitative and quantitative research paradigms. *Problems of Education in the 21st Century*, *13*, 13–18.

Attridge, M. (2009). Employee assistance programs: A research-based primer. In C. L. Cooper, J. C. Quick, & M. J. Schabracq (Eds.), *International Handbook of Work and Health Psychology* (3rd ed., p. 384). Wiley-Blackwell.

Atukunda, R., Memiah, P., & Shumba, C. S. (2013). Care for the caregiver: Stress relief and burnout among health workers in HIV care. *Global Journal of Medicine and Public Health*, *2*(1), 1-8.

Auta, A., Adewuyi, E. O., Tor-Anyiin, A., Aziz, D., Ogbole, E., Ogbonnae, B. O., & Adeloyef, D. (2017). Health - care workers' occupational exposures to body fluids in 21 countries in Africa: systematic review and meta-analysis. *Bulletin of the World Health Organization*, *95*, 831-841. doi.org/BLT.17.195735

Auta, A., Adewuyi, E. O., Tor-Anyiin, A., Edor, J. P., Kureh, G. T., Khanal, V., Oga, E., & Adeloye, D. (2018). Global prevalence of percutaneous injuries among healthcare workers: A systematic review and meta-analysis. *International Journal of Epidemiology*, *0*(0):1–9. https://doi.org/10.1093/ije/dyy208

Ayiworoh, F. U. (2016). *An Exploratory Case Study of HIV/AIDS Related Stigma in Rural Ghana*. MSc Thesis, University of Guelph, Ontario, Canada.

Azia, I. N., Mukumbang, F. C., & Wyk, B. Van. (2016). Barriers to adherence to antiretroviral treatment in a regional hospital in Vredenburg, Western Cape, South Africa. *Southern African Journal of HIV Medicine*, *17*(1), 1–8. doi.org/10.4102/sajhivmed. v17i1.476

Bachleda, C. L., & El Menzhi, L. (2017). Reducing susceptibility to courtesy stigma. *Health Communication*, *33*(6), 771–781. https://doi.org/10.1080/10410236.2017.1312203

Baggaley, R., Doherty, M., Ball, A., Ford, N., & Hirnschall, G. (2015). The strategic use of antiretrovirals to prevent HIV infection: A converging agenda. *Clinical Infectious Diseases*, *60*(Suppl 3), 159–160. https://doi.org/10.1093/cid/civ091

Ball, J. E., Bruyneel, L., Aiken, L. H., Sermeus, W., Sloane, D. M., Rafferty, A. M., Lindqvist, R., Tishelman, C., & Griffiths, P. (2017). Post-operative mortality, missed care and nurse staffing in nine countries: A cross-sectional study. *International Journal of Nursing Studies*, *78*, 10–15.

Bam, N. E., & Naidoo, J. R. (2014). Nurses experiences in palliative care of terminally-ill HIV in a level 1 district hospital. *Curationis*, *37*(1), 1238. https://doi.org/10.4102/curationis.v37i1.1238

Baqutayan, S. M. S. (2015). Stress and coping mechanisms: A historical overview. *Mediterranean Journal of Social Sciences*, *6*(2), 479–488.

Barreneche, M. F. Á., Andrés, C., Castro, R., Botero, A. H., Pablo, J., Franco, V., Mauricio, I., Romero, T., Carvajal, L. R., García, A. E., Mesa, A. O., María, L., Toro, E., Patricia, G., Fernández, P., Mauricio, J., Rivera, R., Andrés, C., & Restrepo, A. (2017). Hospitalization causes and outcomes in HIV patients in the late antiretroviral era in Colombia. *AIDS Research and Therapy*, *14*(60), 3–9. https://doi.org/10.1186/s12981-017-0186-3

Bartholomew, K. (1990). Avoidance of intimacy: An attachment perspective. *Journal of Social and Personal Relationships*, *7*(2), 147–178.

Bassey, M. (1981). Pedagogic research: On the relative merits of search for generalisation and study of single events. *Oxford Review of Education*, *7*(1), 73–94. https://doi.org/10.1080/0305498810070108

Batran, A., Ayed, A., Salameh, B., Ayoub, M., & Fasfous, A. (2018). Are standard precautions for hospital-acquired infection among nurses in public sector satisfactory? *Arch Med Health Sci 2018;6:223-7.*, *6*(2), 223–227. https://doi.org/10.4103/amhs.amhs

Bejane, S. M., Havenga, Y., & Aswegen, E. (2013). Primary caregivers ' challenges related to caring for children living with HIV in a semi-rural area in South Africa. *Africa Journal of Nursing and Midwifery*, *15*(1), 68–80.

Bello, S. I., Onunu, A. N., & Erah, P. O. (2014). Long-term effect of HAART on biochemical profiles of HIV/AIDS patients in a tertiary health facility in Benin City, Nigeria. *Tropical Journal of Pharmaceutical Research*, *13*(11), 1941–1946.

Bennett, L., Kelaher, M., & Ross, M. (1994). Quality of life in health care professionals: Burnout and its associated factors in HIV/AIDS related care. *Psychology & Health*, *9*(4), 273–283.

Berg, M., & Nilsson, L. (2015). Nurses experiences of caring for patients with HIV/AIDS in Dar es Salaam. A qualitative study at Muhimbili National Hospital and Buguruni Healthcare Center, Tanzania. *Nursing Science*, 1–31.

Bester, N., & Herbst, A. (2010). The role of hospice caregivers in caring for families infected with, or affected by, HIV/AIDS. *Social Work/Maatskaplike Werk*, *46*(4), 450–468.

Betke, K., Basińska, M. A., & Andruszkiewicz, A. (2021). Sense of coherence and strategies for coping with stress among nurses. *BMC Nursing*, *20*(107). https://doi.org/https://doi.org/10.1186/s12912-021-00631-1

Beyene, T., & Tadesse, S. (2014). Predictors of occupational exposure to HIV infection among healthcare workers in southern Ethiopia. *International Journal of Infection Control*, *10*(i3), 1–7.

Bhatta, D. N., Adhikari, R., Karki, S., Koirala, A. K., & Wasti, S. P. (2019). Life expectancy and disparities in survival among HIV-infected people receiving antiretroviral therapy: An observational cohort study in Kathmandu, Nepal. *BMJ Global Health*, *4*(e001319), 1–8. https://doi.org/10.1136/bmjgh-2018-001319

Bhembe, L. Q., & Tsai, F.-J. (2019). Occupational stress and burnout among health care workers caring for people living with HIV in Eswatini. *Journal of the Association of Nurses in AIDS Care*, *30*(6), 639–647.

Biggs, A., Brough, P., & Drummond, S. (2017). Lazarus and Folkman's psychological stress and coping theory. In C. L. Cooper & J. C. Quick (Eds.), *The Handbook of Stress and Health* (1st ed., pp. 351–364). West Sussex, UK, Wiley Blackwell. https://doi.org/10.1002/9781118993811.ch21

Bitsch, V. (2005). Qualitative research: A grounded theory example and evaluation criteria. *Journal of Agribusiness*, *23*(1 (Spring)), 75–91.

Blum, S., Brow, M., & Silver, R. C. (2012). Coping. In *Encyclopedia of human behavior,* Vol. 3 (2nd ed.). (2nd ed., pp. 596–601). London, UK, Academic Press.

Blum, T. C., Martin, T. K., & Roman, P. M. (1992). A research note on EAP prevalence, components and utilization. *Journal of Employee Assistance Research*, *1*(1), 209–229.

Blythe, S., Wilkes, L., Jackson, D., & Halcomb, E. (2013). The challenges of being an insider in storytelling research. *Nurse Researcher*, *21*(1), 8–13. https://doi.org/10.7748/nr2013.09.21.1.8.e333

Bodkin, C. (2003). Alternative therapies for the holistic care of the HIV/AIDS patient. *Health SA Gesondheid*, *8*(3), 37–46. https://doi.org/10.4102/hsag.v8i3.133

Bonsu, A. S., Yendork, J. S., & Teye-Kwadjo, E. (2020). The influence of caregiver stress and affiliate stigma in community-based mental health care on family caregiver wellbeing. *International Journal of Mental Health*. https://doi.org/10.1080/00207411.2020.1717053

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal*, *9*, 27–40.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment* (Vol. 1). New York, Basic Books.

Bowlby, J. (1973). *Attachment and loss volume II: Separation anxiety and anger*. New York, Basic Books.

Bowlby, J. (1977). The making and breaking of affectional bonds. I . Aetiology and psychopathology in the light of attachment theory. An expanded version of the Fiftieth Maudsley Lecture, delivered before the Royal College of Psychiatrists , 19 November 1976 . *The British Journal of Psychiatry*, *130*, 201–210.

Bowlby, J. (1980). *Attachment and loss Volume III: Loss and depression*. New York, Basic Books.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Brink, H. I. (2006). *Fundamentals of research methodology for health care professionals*. Lansdowne, India, Juta.

Brodaty, H., & Donkin, M. (2009). Family caregivers of people with dementia. *Dialogues in Clinical Neuroscience*, *11*(2), 217–228.

Broder, S. (2010). The development of antiretroviral therapy and its impact on the HIV-1/AIDS pandemic. *Antiviral Research 85 (2010) 1–18*, *85*, 1–18. https://doi.org/10.1016/j.antiviral.2009.10.002

Brown, L., Munro, J., & Rogers, S. (2019). Use of personal protective equipment in nursing practice. *Nursing Standard*, *34*(5), 59–66.

Brown, L., Trujillo, L., & Macintyre, K. (2001). *Interventions to reduce HIV/AIDS stigma: What have we learned?* Horizons Program, Tulane University, USA.

Bruce, J., & Sangweni, B. (2012). The relationship between burnout and job satisfaction among registered nurses at an academic hospital in Johannesburg, South Africa. *Africa Journal of Nursing and Midwifery*, *14*(1), 89–104.

Bucci, S., Roberts, N. H., Danquah, A. N., & Berry, K. (2015). Using attachment theory to inform the design and delivery of mental health services: A systematic review of the literature. *Psychology and Psychotherapy*, *88*, 1–20. https://doi.org/doi.org/10.1111/papt.12029

Busza, J., Dauya, E., Bandason, T., Simms, V., Chikwari, C. D., Makamba, M., Mchugh, G., Munyati, S., Chonzi, P., & Ferrand, R. A. (2018). The role of community health workers in improving HIV treatment outcomes in children: Lessons learned from the ZENITH trial in Zimbabwe. *Health Policy and Planning*, *33*, 328–334. https://doi.org/10.1093/heapol/czx187

Buykx, P., Kinsman, L., Cooper, S., Mcconnell-Henry, T., Cant, R., Endacott, R., & Scholes, J. (2011). FIRST2 ACT: Educating nurses to identify patient deterioration - A theory-based model for best practice simulation education. *Nurse Education Today*, *31*, 687–693.

Campbell-Yesufu, O. T., & Gandhi, R. T. (2011). Update on Human Immunodeficiency Virus (HIV) -2 Infection. *Clinical Infectious Diseases*, *52*(6), 780–787. https://doi.org/10.1093/cid/ciq248

Campbell, C. M., Scott, K. M. C., Nyamukapa, C., & Gregson, S. (2011). Sources of motivation and frustration among healthcare workers administering antiretroviral treatment for HIV in rural Zimbabwe. *AIDS Care*, *23*(7), 797–802.

Carcary, M. (2020). The research audit trail: Methodological guidance for application in practice. *The Electronic Journal of Business Research Methods*, *18*(2), 166–177. https://doi.org/10.34190/JBRM.18.2.008

Carretero, S., Garcés, J., Ródenas, F., & Sanjosé, V. (2009). The informal caregiver's burden of dependent people: Theory and empirical review. *Archives of Gerontology and Geriatrics*, *49*, 74–79. https://doi.org/10.1016/j.archger.2008.05.004

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, *56*(2), 267–283.

Casale, M., & Wild, L. (2012). The relationship between social support and the health of HIV-positive caregivers of children: A review of the empirical literature. *Vulnerable Children and Youth Studies: An International Interdisciplinary Journal for Research, Policy and Care*, *7*(3), 260–282. https://doi.org/10.1080/17450128.2012.668232

Casale, M., & Wild, L. (2013). Effects and processes linking social support to caregiver health among HIV/AIDS-affected carer-child dyads: A critical review of the empirical evidence. *AIDS and Behaviour*, *17*, 1591–1611. https://doi.org/10.1007/s10461-012-0275-1

Casale, M., Wild, L., & Kuo, C. (2013). They give us hope": HIV-positive caregivers' perspectives on the role of social support for health. *AIDS Care: Psychological and Socio-Medical Aspects of AIDS/HIV*, *25*(10), 1203–1209. https://doi.org/10.1080/09540121.2013.763893

Cassel, E. J., Leon, A. C., & Kaufman, S. G. (2001). Preliminary evidence of impaired thinking in sick patients. *Annals of Internal Medicine*, *134*, 1120–1123.

Centers for Disease Control. (1981). Pneumocystis pneumonia--Los Angeles. *MMWR Morbidity and Mortality Weekly Report*, *30*(21), 250–252.

Centers for Disease Control. (1987). Recommendations for prevention of HIV transmission in health-care setting. *Morbidity and Mortality Report 3*, *36*(6), 1s-18s. https://doi.org/10.1016/s0022-5347(17)41687-9

Chammas, G. (2020). The insider-researcher status: A challenge for social work practice research. *The Qualitative Report*, *25*(2), 537–552. https://doi.org/10.46743/2160-3715/2020.3928

Chandra, P. S., Jairam, K. R., & Jacob, A. (2004). Factors related to staff stress in HIV / AIDS related palliative care. *Indian Journal of Palliative Care*, *10*(2), 48–54.

Chen, C. S., Chan, S. W.-C., Chan, M. F., Yap, S. F., Wang, W., & Kowitlawakul, Y. (2017). Nurses ' perceptions of psychosocial care and barriers to its provision: A qualitative study. *The Journal of Nursing Research*, *00*(0), 1–8.

Chikukwa, H. T. (2012). *Experiences of family caregivers of HIV positive Zimbabweans in Masvingo urban: Highlighting the significance of caregiving work*. MPhil Thesis, Zimbabwe Open University.

Chow, S. K., Francis, B., Ng, Y. H., Naim, N., Beh, H. C., Ariffin, M. A. A., Yusuf, M. H. M., Lee, J. W., & Sulaiman, A. H. (2021). Religious coping, depression and anxiety among healthcare workers during the COVID-19 pandemic: A Malaysian perspective. *Healthcare*, *9*(79), 1–15. https://doi.org/https://doi.org/10.3390/ healthcare9010079

Cianelli, R., Villegas, N., Oliveira, G. De, Sailsman, S., Montano, N. P., Martinez, A. S., Toledo, C., Sandalaula, M., & Sanchez, H. (2020). Exploring the psychosocial impact of living with HIV on minority older women. *Journal of the American Psychiatric Nurses Association*, *00*(0), 1–9.

Coetzee, S. K., Klopper, H. C., Ellis, S. M., & Aiken, L. H. (2013). A tale of two systems - Nurses practice environment , well being , perceived quality of care and patient safety in private and public hospitals in South Africa: A questionnaire survey. *International Journal of Nursing Studies*, *50*(2), 162–173. https://doi.org/10.1016/j.ijnurstu.2012.11.002

Cohen, L., Manion, L., & Morrison, K. (2018). *Research Methods in Education* (8th ed.). Routledge, Taylor & Francis Group.

Collins, L. (2007). Seeking balance in relationships with patients: Understanding “over-involvement.” *British Journal of Neuroscience Nursing*, *3*(3), 117–122.

Colvin, C. J. (2011). HIV/AIDS, chronic diseases and globalisation. *Globalization and Health*, *7*(31), 1–6.

Connelly, L. M. (2016). Trustworthiness in qualitative research. *MedSurg Nursing*, *25*(6), 435–436.

Corey, G. (2009). *Theory and practice of counselling and psychotherapy* (8th ed.). Belmont, CA, Thomson Brooks/Cole.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, CA, USA, Sage Publications.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). California, USA, Sage Publications Inc.

Creswell, J. W. (2016). *30 Essential skills for the qualitative researcher*. California, USA, Sage Publications Inc.

Creswell, J. W., & Creswell, J. D. (2018). *Research design. Qualitative, quantitative, and mixed methods approaches* (5th ed.). California, USA, Sage Publications, Inc.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, *39*(3), 124–130.

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and Conducting Mixed Methods Research* (2nd ed.). Los Angeles, USA, Sage Publications.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design. Choosing among five approaches*. California, USA, Sage Publications, Inc.

Crowell, J. A., Treboux, D., & Waters, E. (2002). Stability of attachment representations: the transition to marriage. *Developmental Psychology*, *38*(4), 467–479.

Csiernik, R. (2011). The glass is filling: An examination of employee assistance program evaluations in the first decade of the new millennium. *Journal of Workplace Behavioral Health*, *26*, 334–355. https://doi.org/10.1080/15555240.2011.618438

Dabney, B. W., & Kalisch, B. J. (2015). Nurse staffing levels and patient-reported missed nursing care. *Journal of Nursing Care Quality*, *30*(4), 306–312. https://doi.org/10.1097/NCQ.0000000000000123

Dadson, D. A., Annor, F., & Yendork, J. S. (2018). The burden of care: Psychosocial experiences and coping strategies among caregivers of persons with mental illness in Ghana. *Issues in Mental Health Nursing*, *0*(0), 1–9. https://doi.org/10.1080/01612840.2018.1496208

Daniels, A., Teems, L., & Carroll, C. (2005). Transforming employee assistance programs by crossing the quality chasm. *International Journal of Mental Health*, *34*(1), 37–54. https://doi.org/10.1080/00207411.2005.11043395

Dartey, A. F. (2016). *Development of an employee assistance programme (EAP) for midwives dealing with maternal death cases in the Ashanti Region, Ghana*. PhD Thesis, Faculty of Community and Health Sciences School of Nursing, University of The Western Cape, South Africa.

Davhana-Maselesele, M., & Igumbor, J. O. (2008). The impact of caring for persons living with HIV and AIDS on the mental health of nurses in the Limpopo Province. *Curationis*, *31*(2), 67–73.

Dawson, C. (2009). *Introduction to research methods. A practical guide for anyone undertaking a research project*. Oxford, UK, Spring Hill.

Deeks, S. G., Lewin, S. R., & Havlir, D. V. (2013). The end of AIDS: HIV infection as a chronic disease. *Lancet*, *382*(9903), 1525–1533. https://doi.org/10.1016/S0140-6736(13)61809-7.

Dejman, M., Ardakani, H. M., Malekafzali, B., Moradi, G., Gouya, M. M., Shushtari, Z. J., Alinaghi, S. A. S., & Mohraz, M. (2015). Psychological, social, and familial problems of people living with HIV/AIDS in Iran: A qualitative study. *International Journal of Preventive Medicine*, *6*(126). https://doi.org/10.4103/2008-7802.172540

Delobelle, P., Rawlinson, J. L., Ntuli, S., Malatsi, I., Decock, R., & Depoorter, A. M. (2009). HIV/AIDS knowledge, attitudes, practices and perceptions of rural nurses in South Africa. *Journal of Advanced Nursing*, *65*(5), 1061–1073. https://doi.org/10.1111/j.1365-2648.2009.04973.x

Demmer, C. (2009). Confronting AIDS-related loss and grief : An exploratory study of professional caregivers in KwaZulu-Natal, South Africa. *African Journal of AIDS Research*, *5*(2), 97–107. https://doi.org/10.2989/16085900609490370

Denzin, N. K., & Lincoln, Y. S. (2018). *The Sage Handbook of Qualitative Research*. Los Angeles, USA, Sage Publications, Inc.

Des Jarlais, D. C., Galea, S., Tracy, M., Tross, S., & Vlahov, D. (2006). Stigmatization of newly emerging infectious diseases: AIDS and SARS. *American Journal of Public Health*, *96*(3), 561–567. https://doi.org/10.2105/AJPH.2004.054742

Deventer, C. Van, & Wright, A. (2017). The psychosocial impact of caregiving on the family caregivers of chronically ill AIDS and / or HIV patients in home-based care: A qualitative study in Zimbabwe. *Southern African Journal of HIV Medicine*, *18*(1), 1–7. https://doi.org/https://doi. org/10.4102/sajhivmed. v18i1.718

Dewe, P., & Cooper, C. (2007). Coping research and measurement in the context of work-related stress. In G. P. Hodgkinson & J. K. Ford (Eds.), *International Review of Industrial and Organizational Psychology* (Vol. 22, pp. 141–191). John Wiley & Sons.

Dhaini, S. R., Ausserhofer, D., Bajjani, M. El, Instructor, M., Dumit, N., Huda, A., Saad, A., Dean, F., & Simon, M. (2019). A longitudinal study on implicit rationing of nursing care among Lebanese patients – Study protocol. *Journal of Advance Nursing*, *75*, 1592–1599. https://doi.org/10.1111/jan.14012

Dickman, F., & Challenger, R. (2009). Employee essistance programmes: A historical sketch. In M. A. Richard, W. S. Hutchison, & W. G. Emener (Eds.), *Employee Assistance Programmes: Wellness / enhancement programming* (4th ed., p. 28). C C Thomas. https://doi.org/10.1038/132817a0

Dinis, L. I. C., & Fronteira, I. (2015). The influence of job rotation in the job satisfaction of nurses in a surgical service. *Journal of Nursing Referência*, *4*(5), 17–26. https://doi.org/http://dx.doi.org/10.12707/RIV14008

Do, A. N., Ciesielski, C. A., Metler, R. P., & Hammett, T. A. (2003). Occupationally acquired Occupationally acquired human immunodeficiency virus (HIV) infection: National case surveillance data during 20 years of the HIV epidemic in the United States. *Infection Control & Hospital Epidemiology*, *24*(2), 86–96.

dos Santos, É. I., Gomes, A. M. T., & de Oliveira, D. C. (2014). Representations of vulnerability and empowerment of nurses in the context of HIV/AIDS. *Florianópolis*, *23*(2), 408–416. https://doi.org/http://dx.doi.org/10.1590/0104-07072014000700013

Dowling, M. (2006). The sociology of intimacy in the nurse-patient relationship. *Nursing Standard*, *20*(23), 48–54.

Dumitru, G., Irwin, K., & Tailor, A. (2017). Updated federal recommendations for HIV Prevention with adults and Adolescents with HIV in the United States: The pivotal role of nurses. *Journal of Association Nurses in AIDS Care*, *28*(1), 8–18. https://doi.org/10.1016/j.jana.2016.09.011.

Earnshaw, V. A., & Chaudoir, Æ. S. R. (2009). From conceptualizing to measuring HIV Stigma: A review of HIV stigma mechanism measures. *AIDS Behaviour*, *13*, 1160–1177. https://doi.org/10.1007/s10461-009-9593-3

Erialdy, E., Sutarman, S., Mulyanto, A. I., & Prastowo, S. L. (2020). Implementation of work rotation model at the YPDR nursing academy Jakarta. *International Journal of Life Sciences & Earth Sciences*, *3*(1), 38–42. https://doi.org/https://doi.org/10.31295/ijle.v3n1.240

Erkki, L., & Hedlund, J. (2013). *Nurses' experiences and perceptions of caring for patients with HIV/AIDS in Uganda*. Thesis, Uppsala University, Sweden.

Esewe, R. E., Adeyemo, F. O., & Ikedimma, D. O. (2017). Knowledge and attitude of nursing students towards the care of patients living with HIV/AIDS: A case study. *International Research Journal of Public Health*, *1*(6), 1–13.

Fako, T. T., Wilson, D. R., & Linn, J. G. (2013). HIV/AIDS care , coping strategies and work environmental stress among nurses in Botswana. *International Journal of Nursing and Midwifery*, *5*(4), 57–64.

Famoroti, T. O., Fernandes, L., & Chima, S. C. (2013). Stigmatization of people living with HIV/AIDS by healthcare workers at a tertiary hospital in KwaZulu-Natal, South Africa: A cross-sectional descriptive study. *BMC Medical Ethics*, *14*(Suppl 1), 1–10.

Faremi, F. A., Olatubi, M. I., Adeniyi, K. G., & Salau, O. R. (2019). Assessment of occupational related stress among nurses in two selected hospitals in a city southwestern Nigeria. *International Journal of Africa Nursing Sciences*, *10*, 68–73. https://doi.org/10.1016/j.ijans.2019.01.008

Fateel, E. E., & O'Neill, C. S. (2016). Family members' involvement in the care of critically ill patients in two intensive care units in an acute hospital in Bahrain: The experiences and perspectives of family members' and nurses' - A qualitative study. *Clinical Nursing Studies*, *4*(1), 56–69.

Fauk, N. K., Ward, P. R., Hawke, K., & Mwanri, L. (2021). HIV Stigma and Discrimination: Perspectives and Personal Experiences of Healthcare Providers in Yogyakarta and Belu, Indonesia. *Frontiers in Medicine*, *8*(625787). https://doi.org/10.3389/fmed.2021.625787

Feyissa, G. T., Abebe, L., Girma, E., & Woldie, M. (2012). Stigma and discrimination against people living with HIV by healthcare providers, Southwest Ethiopia. *BMC Public Health*, *12*(5), 1–12.

Figueiredo, L. A., Lopes, L. M., Magnabosco, G. T., Andrade, R. L. de P., Faria, M. F., Goulart, V. C., Scatena, L. M., Nogueira, J. de A., Pinto, I. C., Arcencio, R. A., Palha, P. F., Villa, T. C. S., & Monroe, A. A. (2014). Provision of health care actions and services for the management of HIV/AIDS from the users' perspective. *Rev Esc Enferm USP*, *48*(6), 1024–1031. https://doi.org/10.1590/S0080-623420140000700010

Fitzpatrick, J. J. (2018). Missed nursing care: Research on interventions? *Applied Nursing Research*, *40*(163), 1. https://doi.org/10.1016/j.apnr.2018.02.003

Florom-Smith, A. L., & De Santis, J. P. (2012). Exploring the concept of HIV-related stigma. *Nursing Forum*, *47*(3), 153–165. https://doi.org/10.1111/j.1744-6198.2011.00235.x.Exploring

Folkman, S. (1984). Personal control and stress and coping processes: A theoretical analysis. *Journal of Personality and Social Psychology*, *46*(4), 839–852.

Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior*, *21*, 219–239.

Folkman, S., Lazarus, R. S., Dunkel-Schetter, C., Delongis, A., & Gruen, R. J. (1986). Dynamics of a stressful encounter: Cognitive appraisal, coping, and encounter outcomes. *Journal of Personality and Social Psychology*, *50*(5), 992–1003.

Ford, J. S., & Reutter, L. I. (1990). Ethical dilemmas associated with small samples. *Journal of Advanced Nursing*, *15*(2), 187–191.

Forson, D. K. (2020). *Psychological distress and social support on quality of life of nurses of HIV/AIDS patients in the Cape Coast Metropolis*. Unpublished MPhil Thesis in Clinical Health Psychology, University of Cape Coast, Ghana.

Frederiksen, H. Bøg., Kragstrup, J., & Dehlholm-Lambertsen, B. (2010). Attachment in the doctor – patient relationship in general practice: A qualitative study. *Scandinavian Journal of Primary Health Care*, *28*, 185–190. https://doi.org/10.3109/02813432.2010.505447

Frydenberg, E. (2014). Coping research: Historical background, links with emotion, and new research directions on adaptive processes. *Australian Journal of Psychology*, *66*, 82–92. https://doi.org/10.1111/ajpy.12051

Garcia, C. D. L., Abreu, L. C. De, Ramos, J. L. S., Castro, C. F. D. de, Smiderle, F. R. N., Santos, J. A. dos, & Bezerra, I. M. P. (2019). Influence of burnout on patient safety: Systematic review and meta-analysis. *Medicina*, *55*(553), 1–14. https://doi.org/10.3390/medicina55090553

Garrard, J. (2017). *Health sciences literature review made easy: The matrix method* (5th ed.). Jones & Bartlett Learning.

Gebresilassie, A., Kumei, A., & Yemane, D. (2014). Standard precautions practice among health care workers in public health facilities of Mekelle Special Zone, Northern Ethiopia. *Journal of Community Medicine & Health Education*, *04*(03), 1–15. https://doi.org/10.4172/2161-0711.1000286

George, L. K., & Gwyther, L. P. (1986). Caregiver well-being : A multidimensional examination of family caregivers of demented adults. *The Gerontologist*, *26*(3), 253–259.

Ghana AIDS Commission. (2020). *National and sub-national HIV and AIDS estimates and projections. 2020 Report.*

Gheshlagh, R. G., Naser Parizad, Dalvand, S., Zarei, M., Farajzadeh, M., Karami, M., & Sayehmiri, K. (2017). Job Stress among Iranian nurses: a systematic review and meta-analysis. *Scientific Journal of Nursing, Midwifery and Paramedical Faculty*, *2*(4), 68–75. https://doi.org/10.29252/sjnmp.2.4.68

Gholamzadeh, S., Hamid, T. A., Basri, H., Sharif, F., & Ibrahim, R. (2014). Religious coping and psychological well-being among Iranian stroke caregivers. *Iranian Journal of Nursing and Midwifery Research*, *19*(5), 478–484.

Gibson, K., Costa, B., & Sampson, A. (2017). Linking worker health and safety with patient outcomes: A systematic review. *Institute for Safety Compensation and Recovery Research (ISCRR)*, *190*, 1–32.

Gilborn, L., Apicella, L., Brakarsh, J., Dube, L., Jemison, K., Kluckow, M., Smith, T., & Snider, L. M. (2006). *Orphans and vulnerable youth in Bulawayo, Zimbabwe: An exploratory study of psychosocial well-being and psychosocial support. Horizons Final Report.* Washington, DC: Population Council.

Ginossar, T., Oetzel, J., Hill, R., Avila, M., Archiopoli, A., & Bryan Wilcox. (2014). HIV health-care providers' burnout: Can organizational culture make a difference? *AIDS Care: Psychological and Socio-Medical Aspects of AIDS/HIV*, *February 2015*. https://doi.org/10.1080/09540121.2014.936819

Given, L. M. (2008). *The SAGE Encyclopaedia of research methods, Volumes 1 & 2*. Sage Publications Inc.

Godwin, I. (2003). The relevance of attachment theory to the philosophy, organization, and practice of adult mental health care. *Clinical Psychology Review*, *23*(1), 35–56.

Goffman, E. (1963). *Stigma: Notes on management*. Prentice-Hall, Inc.

Golan, M., & Bamberger, P. (2009). The cross-cultural transferability of a peer-based employee assistance program (EAP): A case study. *Journal of Workplace Behavioral Health*, *24*(4), 399–418.

Gonçalves, A., Fontes, L., Simães, C., & Gomes, A. R. (2019). Stress and burnout in health professionals. In P. M. A. et Al. (Ed.), *Occupational and Environmental Safety and Health, Studies in Systems, Decision and Control 202,* (pp. 563–571). Springer Nature Switzerland AG. https://doi.org/10.1007/978-3-030-14730-3

Goodwin, D. (2020). Qualitative inquiry in adapted physical education. In D. R. S. Justin A Haegele, Samuel R Hodge (Ed.), *Routledge handbook of adapted physical education* (1st ed.). Londond and New York, Routledge, Taylor & Francis Group.

Graham, J. F. (2015). The history of attachment theory. *MA Thesis,The Faculty of the Adler Graduate School*.

Gray, D. E. (2004). *Doing research in the real world*. London, Sage Publications.

Greene, M. (2014). On the inside looking in: Methodological insights and challenges in conducting qualitative insider research. *The Qualitative Report*, *19*(29), 1–13. https://doi.org/10.46743/2160-3715/2014.1106

Grindel, C. G., & Patsdaughter, C. A. (2000). Coming full circle: Mentorship in HIV/AIDS care. *Journal of the Association of Nurses in AIDS Care*, *11*(6), 54–63.

Grove, S. K., Burns, N., & Gray, J. (2013). *The practice of nursing research: Appraisal, synthesis, and generation of evidence* (7th ed.). St. Louis, Missouri, Elsevier Inc.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Association for Educational Communications and Technology. ECTJ*, *29*(75). https://doi.org/10.1007/BF02766777

Gueritault-Chalvin, V., Kalichman, S. C., Demi, A., & Peterson, J. L. (2000). Sources of occupational stress and coping strategies a mong nurses working in AIDS care. *Journal of the Association of Nurses in AIDS Care*, *11*(3), 31–37. https://doi.org/10.1016/S1055-3290(06)60274-4

Guerro, A. C., Andretta, I. B., Bello, S. L., Trevisol, D. J., & Schuelter-Trevisol, F. (2014). Causes of hospital admission of AIDS patients in southern Brazil , 2007 to 2012. *Revista Da Sociedade Brasileira de Medicina Tropica*, *47*(5), 632–636.

Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PLoS ONE*, *15*(5), 1–17. https://doi.org/10.1371/journal.pone.0232076

Guqa, V. V. (2012). *The psychological impact of caregiving on carers of HIV/AIDS orphans*. Master of Arts Thesis in Clinical Psychology, University of South Africa.

Gurková, E., Mikšová, Z., & Šáteková, L. (2021). Missed nursing care in hospital environments during the COVID-19 pandemic. *International Nursing Review*. https://doi.org/10.1111/inr.12710

Ha, P. N., Chuc, N. T. K., Hien, H. T., Larsson, M., & Pharris, A. (2013). HIV-related stigma: Impact on healthcare workers in Vietnam. *Global Public Health: An International Journal for Research, Policy and Practice*, *8*(sup1), S61–S74. https://doi.org/10.1080/17441692.2013.799217

Haber, D. B., Roby, J. L., & High-George, L. D. (2011). Stigma by association: The effects of caring for HIV/AIDS patients in South Africa. *Health and Social Care in the Community*, *19*(5), 541–549.

Hakim, M., Khattak, F. A., Muhammad, S., Ismail, M., Ullah, N., Orakzai, M. A., Ulislam, S., & Ul-haq, Z. (2021). Access and use experience of personal protective equipment among frontline healthcare workers in Pakistan during the COVID-19 emergency: A cross-sectional study. *Health Security*, *19*(2), 140–150. https://doi.org/10.1089/hs.2020.0142

Halpern, E. S. (1983). Auditing naturalistic inquiries: The development and application of a model [PhD Thesis, School of Education, Indiana University]. In *Journal of Allergy and Clinical Immunology*.

Hamama, I., Tartakovsky, E., & Patrakov, E. (2016). Attitudes and burnout among health care professionals working with HIV/AIDS. *Вопросы Психологии*, *3*, 78–89.

Hamid, M. Z. A., Aziz, N. A., Anita, A. R., & Norlijah, O. (2010). Knowledge of blood-borne infectious diseases and the practice of universal precautions amongst health-care workers in a tertiary hospital in Malaysia. *Southeast Asian Journal of Tropical Medicine and Public Health*, *41*(5), 1192–1199.

Haoses-Gorases, L., Katjire, M., & Goraseb, M. (2013). HIV/AIDS related workplace stress and fear among nurses: Experiences in Windhoek (Namibia). *Online of Journal Medical Science Research*, *2*(8), 90–96.

Harrowing, J. N. (2011). Compassion practice by Ugandan Nurses who provide HIV care. *The Online Journal of Issues in Nursing*, *16*(1), 1–15. https://doi.org/10.3912/OJIN.Vol16No01Man05

Hassan, Z M, & Wahsheh, M. A. (2011). Knowledge and attitudes of Jordanian nurses towards patients with HIV/AIDS: Findings from a nationwide survey. *Issues in Mental Health Nursing*, 774–784. https://doi.org/10.3109/01612840.2011.610562

Hatzipapas, I., Visser, M. J., & Rensburg, E. J. Van. (2017). Laughter therapy as an intervention to promote psychological well-being of volunteer community care workers working with HIV-affected families. *SAHARA-J: Journal of Social Aspects of HIV/ AIDS*, *14*(1), 202–212. https://doi.org/10.1080/17290376.2017.1402696

Hedge, B., Devan, K., Catalan, J., Cheshire, A., & Ridge, D. (2021). HIV-related stigma in the UK then and now: to what extent are we on track to eliminate stigma? A qualitative investigation. *BMC Public Health*, *21*(1022), 1–10. https://doi.org/https://doi.org/10.1186/s12889-021-11000-7

Hennink, M. M., Kaiser, B. N., & Weber, M. B. (2019). What influences saturation? estimating sample sizes in focus group research. *Qualitative Health Research*, 1–14. https://doi.org/10.1177/1049732318821692

Hesse, A. A. J., Adu-Aryee, N. A., Entsua-Mensah, K., & Wu, L. (2006). Knowledge, attitude and practice of universal basic precautions by medical personnel in a Teaching Hospital. *Ghana Medical Journal*, *40*(2), 61–64. https://doi.org/10.4314/gmj.v40i2.36019

Hessels, A. J., Flynn, L., Cimiotti, J. P., Cadmus, E., & Gershon, R. R. M. (2015). The impact of the nursing practice environment on missed nursing care. *Clinical Nursing Studies*, *3*(4), 60–65. https://doi.org/10.5430/cns.v3n4p60.

Hill, E. W. (2001). A collaborative pastoral care and counselling supervisory model. *Journal of Pastoral Care*, *55*(1), 69–80.

Hlengwa, W. M. (2010). The burden of care: A study of perceived stress factors and social capital among volunteer caregivers of people living with HIV/AIDS in KwaZulu-Natal. *MA Theses, University of KwaZulu-Nata*, 1–95.

Ho, W.-H., Chang, C. S., Shih, Y.-L., & Liang, R.-D. (2009). Effects of job rotation and role stress among nurses on job satisfaction and organizational commitment. *BMC Health Services Research*, *9*(8). https://doi.org/10.1186/1472-6963-9-8

Hoffmann, C. J., Fielding, K. L., Charalambous, S., Innes, C., Chaisson, R. E., Grant, A. D., & Churchyard, G. J. (2010). Reducing mortality with co-trimoxazole preventive therapy at initiation of antiretroviral therapy in South Africa. *AIDS*, *24*(11), 1709–1716. https://doi.org/10.1097/QAD.0b013e32833ac6bc.Reducing

Hooper, L. M., Tomek, S., & Newman, C. R. (2011). Using attachment theory in medical settings: Implications for primary care physicians. *Journal of Mental Health*, *00*(0), 1–15.

Hornberger, B., & Rangu, S. (2020). *Designing inclusion and exclusion criteria*. https://repository.upenn.edu/crp/1

Hsieh, W. B., Chiu, N. C., Lee, C. M., & Huang, F. Y. (2006). Occupational blood and infectious body fluid exposures in a teaching hospital: A three-year review. *Journal of Microbiology, Immunology, and Infection*, *4*, 2006.

Hu, X., Liang, B., Zhou, C., Jiang, J., Huang, J., Ning, C., Liu, J., Zhou, B., Zang, N., Lai, J., Chen, R., Liao, Y., Pan, P., Liu, X., Lan, G., Pang, X., Ye, L., Shen, Z., & Liang, H. (2019). HIV late presentation and advanced HIV disease among patients with newly diagnosed HIV/AIDS in Southwestern China: A large-scale cross-sectional study. *AIDS Research and Therapy*, *16*(6), 1–10. https://doi.org/10.1186/s12981-019-0221-7

Huq, K. A. T. M. E., Moriyama, M., Harris, E. E., Shirin, H., & Rahman, M. (2019). Evaluation of Nurses ' Knowledge and Attitude toward HIV-Infected Patients in Barbados. *Journal of the International Association of Providers of AIDS Care*, *18*, 1–9. https://doi.org/10.1177/2325958219880592

Hussain, M. A., Elyas, T., & Nasseef, O. A. (2013). Research paradigms: A slippery slope for fresh researchers. *Life Science Journal*, *10*(4), 2374–2381.

Idemudia, E. S., Olasupo, M. O., & Modibo, M. W. (2018). Stigma and chronic illness: A comparative study of people living with HIV and/or AIDS and people living with hypertension in Limpopo Province, South Africa. *Curationis*, *41*(1), 1–5. https://doi.org/https://doi.org/10.4102/

International Council of Nurses. (2000). *Reducing the impact of HIV/AIDS on nursing and midwifery personnel*. Geneva, Switzerland, ICN.

International Labour Organization. (2015). *Handbook on HIV and AIDS for labour inspectors*. Geneva, ILO.

Ippolito, G., Puro, V., Heptonstall, J., Jagger, J., De Carli, G., Petrosillo, N., & Author. (1999). Occupational human immunodeficiency virus infection in health care workers: worldwide cases throughSeptember 1997. *Clinical Infectious Diseases*, *28*(2), 365–383. https://doi.org/10.1086/515101

Ishimaru, T., Wada, K., Hoang, H. T. X., Bui, A. T. M., Nguyen, H. D., Le, H., & Smith, D. R. (2017). Nurses' willingness to care for patients infected with HIV or Hepatitis B/C in Vietnam. *Environmental Health and Preventive Medicine*, *22*(9). https://doi.org/10.1186/s12199-017-0614-y

Jarvi, M., & Uusitalo, T. (2004). Job rotation in nursing: a study of job rotation among nursing personnel from the literature and via a questionnaire. *Journal of Nursing Management*, *12*, 337–347.

Jaturanonda, C., Nanthavanij, S., & Chongphaisal, P. (2006). A survey study on weights of decision criteria for job rotation in Thailand: Comparison between public and private sectors. *The International Journal of Human Resource Management*, *17*(10), 1834–1851.

Ji, G., Li, L., Lin, C., & Sun, S. (2007). The impact of HIV/AIDS on families and children - A study in China. *AIDS*, *21*(Suppl 8). https://doi.org/10.1097/01.aids.0000304712.87164.42

Johan, S., Sarwar, H., & Majeed, I. (2017). To identify the causes of stress among nurses working in intensive care unit of Ittefaq hospital, Lahore. *International Journal of Social Sciences and Management*, *4*(2), 96–109. https://doi.org/10.3126/ijssm.v4i2.17159

Jones, T. L., Hamilton, P., & Murry, N. (2015). Unfinished nursing care, missed care, and implicitly rationed care: State of the science review. *International Journal of Nursing Studies*, *52*, 1121–1137. https://doi.org/10.1016/j.ijnurstu.2015.02.012

Jorgensen, M., Davis, K., Kotowski, S., Aedla, P., & Dunning, K. (2005). Characteristics of job rotation in the Midwest US manufacturing sector. *Ergonomics*, *48*(15), 1721–1733. https://doi.org/10.1080/00140130500247545

Kalisch, B. (2015). Errors of omission: How missed nursing care imperils patients. *Journal of Nursing Regulation*, *7*(3), 64. https://doi.org/10.1016/S2155-8256(16)32323-7

Kalisch, B. J. (2006). *Missed nursing care: A qualitative study*. *21*(4), 306–313. https://doi.org/10.1097/00001786-200610000-00006

Kalisch, B. J., Landstrom, G. L., & Hinshaw, A. S. (2009). Missed nursing care: A concept analysis. *Journal of Advance Nursing*, *65*(7), 1509–1517. https://doi.org/10.1111/j.1365-2648.2009.05027.x

Kangéthe, S. M. (2009). Occupational risks and challenges faced by caregivers of persons living with HIV/AIDS in Kanye community home-based care programme, Botswana. *Occupational Health Southern Africa*, 22–25.

Kapila, A., Chaudhary, S., Sharma, R., Vashist, H., Sisodia, S., & Gupta, A. (2016). A review on: HIV AIDS. *Indian Journal of Pharmaceutical and Biological Research (IJPBR)*, *4*(3), 69–73.

Kassa, G. M. (2018). Mother-to-child transmission of HIV infection and its associated factors in Ethiopia : a systematic review and. *BMC Infectious Diseases*, *18*(216), 1–9. https://doi.org/https://doi.org/10.1186/s12879-018-3126-5

Kathuri-Ogola, L. N., Mugenda, O., & Kerre, F. P. (2014). Challenges faced and the coping strategies adopted by family caregivers in dealing with people living with HIV/AIDS in Thika District, Central Province, Kenya. *International Journal of Humanities and Social Science*, *4*(6), 184–193.

Kelley, R., Godfrey, M., & Young, J. (2019). The impacts of family involvement on general hospital care experiences for people living with dementia: An ethnographic study. *International Journal of Nursing Studies*, *96*, 72–81. https://doi.org/10.1016/j.ijnurstu.2019.04.004

Kenny, A., & Allenby, A. (2013). Barriers to nurses providing psychosocial care in the Australian rural context. *Nursing and Health Sciences*, *15*, 194–200. https://doi.org/10.1111/nhs.12014

Kenu, E., Obo-Akwa, A., Nuamah, G. B., Brefo, A., Sam, M., & Lartey, M. (2014). Knowledge and disclosure of HIV status among adolescents and young adults attending an adolescent HIV clinic in Accra , Ghana. *BMC Research Notes*, *7*(844), 1–6. https://doi.org/10.1186/1756-0500-7-844

Kes, D., & Yildirim, T. A. (2020). The relationship of religious coping strategies and family harmony with caregiver burden for family members of patients with stroke. *Brain Injury*. https://doi.org/10.1080/02699052.2020.1810317

Khamarko, K., & Myers, J. J. (2013). The influence of social support on the lives of HIV-infected individuals in low- and middle-income countries. *World Health Organization*, 1–40.

Khamisa, N., Oldenburg, B., Peltzer, K., & Ilic, D. (2015). Work related stress, burnout, job satisfaction and general health of nurses. *International Journal of Environmental Research and Public Health*, *12*, 652–666. https://doi.org/10.3390/ijerph120100652

Khamisa, N., Peltzer, K., Ilic, D., & Oldenburg, B. (2016). Effect of personal and work stress on burnout, job satisfaction and general health of hospital nurses in South Africa. *Health SA Gesondheid*, *22*, 252–258. https://doi.org/10.1016/j.hsag.2016.10.001

Khan, R., Pai, K., Kulkarni, V., & Ramapuram, J. (2018). Depression, anxiety, stress and stigma in informal caregivers of people living with HIV (PLHIV). *AIDS Care*, *30*(6), 722–726. https://doi.org/10.1080/09540121.2017.1418831

Khosravan, S., Mazlom, B., Abdollahzade, N., Jamali, Z., & Mansoorian, M. R. (2014). Family participation in the nursing care of the hospitalized patients. *Iran Red Crescent Medical Journal*, *16*(1). https://doi.org/10.5812/ircmj.11586

Kieft, R. A. M. M., de Brouwer, B. B. J. M., Francke, A. L., & Delnoij, D. M. J. (2014). How nurses and their work environment affect patient experiences of the quality of care: A qualitative study. *BMC Health Services Research*, *14*(249). https://doi.org/http://www.biomedcentral.com/1472-6963/14/249

Kim, J. H., Psevdos Jr., G., Singh, S., Kilayko, M. C., & Sharp, V. (2013). All-cause mortality in hospitalized HIV-infected patients at an acute tertiary care hospital with a comprehensive outpatient HIV care program in New York City in the era of highly active antiretroviral therapy (HAART). *Infection*, *41*, 545–551. https://doi.org/10.1007/s15010-012-0386-7

Kim, M. H., Mazenga, A. C., Simon, K., Yu, X., Ahmed, S., Nyasulu, P., Kazembe, P. N., Ngoma, S., & Abrams, E. J. (2018). Burnout and self-reported suboptimal patient care amongst health care workers providing HIV care in Malawi. *PLoS ONE*, *13*(2), 1–15.

King, L. A., & McInerney, P. A. (2006). Hospital workplace experiences of registered nurses that have contributed to their resignation in the Durban metropolitan area. *Curationis, 29*(4), 70–81.

Kisorio, L. C., & Langley, G. C. (2016). Intensive care nurses’ experiences of end-of-life care. *Intensive & Critical Care Nursing*, *33*, 30–38. https://doi.org/10.1016/j.iccn.2015.11.002

Kivunja, C., & Kuyini, A. B. (2017). Understanding and applying research paradigms in educational contexts. *International Journal of Higher Education*, *6*(5), 26–41. https://doi.org/10.5430/ijhe.v6n5p26

Knifton, L. (2012). Understanding and addressing the stigma of mental illness with ethnic minority communities. *Health Sociology Review*, *21*(3), 287–298. https://doi.org/10.5172/hesr.2012.21.3.287

Koenig, H. G., Mccullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health*. London, Oxford University Press.

Kok, G., Guvenc, G., & Kaplan, Z. (2018). Nursing students’ knowledge, attitudes, and willingness to care toward people with HIV/AIDS. *International Journal of Caring Sciences*, *11*(3), 1697–1706.

Korle Bu Teaching Hospital. (2013). *Korle Bu Teaching Hospital Annual Report*.

Korle Bu Teaching Hospital. (2016). *Research Policy Guidelines and Procedures*.

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120–124. https://doi.org/10.1080/13814788.2017.1375092

Koto, M. V., & Maharaj, P. (2016). Difficulties facing healthcare workers in the era of AIDS treatment in Lesotho. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*, *13*(1), 53–59. https://doi.org/10.1080/17290376.2016.1179588

Kotrotsiou, S., Theofanidis, D., Malliarou, M., Konstanti, Z., Sarafis, P., Tsioumanis, G., & Paralikas, T. (2021). Investigating nurses stress response strategies during the COVID-19 pandemic. *Mater Sociomed*, *33*(3), 168–173. https://doi.org/10.5455/msm.2021.33.168-173

Koutsimani, P., Montgomery, A., & Georganta, K. (2019). The relationship between burnout, depression, and anxiety: A systematic review and meta-analysis. *Frontiers in Psychology*, *10*(284), 1–19.

Kovach, D. A. (2008). Caring for the whole person with HIV: Mind, body, and spirit. *The Permanente Journal*, *12*(2), 69–71. https://doi.org/10.7812/tpp/07-137

Kumar, N., Unnikrishnan, B., Thapar, R., Mithra, P., Kulkarni, V., & Kumar, A. (2017). Stigmatization and discrimination toward people living with HIV/AIDS in a coastal city of South India. *Journal of the International Association of Providers of AIDS Care*, *16*(3), 226–232.

Kumar, R., Kaur, S., & Reddemma, K. (2015). Burden and coping strategies in caregivers of stroke survivors. *Journal of Neurology and Neuroscience, Special Issue*, 1–5. https://doi.org/10.21767/2171-6625.S10005

Kyomuhendo, C. (2018). *Experiences of elderly women caring for people with HIV/AIDS in Masindi District, Uganda*. MA Thesis, University of Ghana, Legon.

Kyomuhendo, C., Boateng, A., & Agyemang, F. A. (2021). Support services available for elderly women caring for people living with HIV and AIDS in Masindi District, Uganda. *Heliyon*, *7*, e07786. https://doi.org/10.1016/j.heliyon.2021.e07786

Laar, A., Manu, A., Laar, M., El-Adas, A., Amenyah, R., Atuahene, K., Quarshie, D., Adjei, A. A., & Quakyi, I. (2015). Coping strategies of HIV-affected households in Ghana. *BMC Public Health*, *15*(1), 1–9. https://doi.org/10.1186/s12889-015-1418-x

Lacombe, K., & Girard, P. (2004). A 2004 update on treatment and prophylaxis of opportunistic infections in the course of HIV disease. Part 1: Pneumocystosis and protozoiasis. *Médecine et Maladies Infectieuses*, *34*, 239–245. https://doi.org/10.1016/j.medmal.2004.03.005

Lake, E. T., Germack, H. D., & Viscardi, M. K. (2016). Missed nursing care is linked to patient satisfaction: A cross-sectional study of US hospitals. *BMJ Quality and Safety*, *25*, 535–543. https://doi.org/10.1136/bmjqs-2015-003961

Lakoh, S., Jiba, D. F., Kanu, J. E., Poveda, E., Salgado-Barreira, A., Sahr, F., Sesay, M., Deen, G. F., Sesay, T., Gashau, W., Salata, R. A., & Yendewa, G. A. (2019). Causes of hospitalization and predictors of HIV-associated mortality at the main referral hospital in Sierra Leone : a prospective study. *BMC Public Health*, *19*(1320), 1–9. https://doi.org/https://doi.org/10.1186/s12889-019-7614-3

Lamptey, I., Boateng, A., Hamenoo, E., & Agyemang, F. A. (2018). Exploring The Experiences Of Elderly Persons Cared For By Family Caregivers In Ghana. *International Journal of Innovative Research and Advanced Studies*, *5*(6), 199–208.

Lartey, M., Asante-Quashie, A., Essel, A., Kenu, E., Ganu, V., & Neequaye, A. (2015). Causes of Death in Hospitalized HIV Patients in the Early Anti-Retroviral Therapy Era. *Ghana Medical Journal*, *49*(1), 7–1.

Laryea, M., & Gien, L. (1993). The impact of HIV-positive diagnosis on the individual, Part 1: Stigma, rejection, and loneliness. *Clinical Nursing Research*, *2*(3), 245–266. https://doi.org/10.1177/105477389300200302

Lazarus, R. S. (1966). *Psychological stress and the coping process*. New York, McGraw-Hil.

Lazarus, R. S. (1991). *Emotion and adaptation*. New York, Oxford University Press.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, Springer Publishing Company.

Lazarus, R. S., & Launier, R. (1978). Stress-related transactions between person and environment. In L. Pervin & M. Lewis (Eds.), *Perspectives in Interactional Psychology* (pp. 287–327). New York, Plenum.

Lee, D., Heo, S. H., Yoon, S.-S., Chang, D.-I., Lee, S., Rhee, H.-Y., Ku, B. D., & Park, K.-C. (2014). Sleep disturbances and predictive factors in caregivers of patients with mild cognitive impairment and dementia. *Journal of Clinical Neurology*, *10*(4), 304–313.

Lee, J. H., Cho, J., Kim, Y. J., Im, S. H., Jang, E. S., Kim, J.-W., Kim, H. Bin, & Jeong, S.-H. (2017). Occupational blood exposures in health care workers: incidence , characteristics , and transmission of bloodborne pathogens in South Korea. *BMC Public Health*, *17*(827), 1–8. https://doi.org/10.1186/s12889-017-4844-0

Legg, M. J. (2011). What is psychosocial care and how can nurses better provide it to adult oncology patients. *Australian Journal of Advanced Nursing*, *28*(3), 61–67.

Lekganyane, M. R. (2016). HIV and AIDS-related courtesy stigma: South African caregivers' experiences and coping strategies. *Alternation*, *23*(2), 120–140.

Lekganyane, M. R. (2017). *Experiencing and managing work-related challenges by home-based caregivers caring for people living with HIV and AIDS: Guidelines for support from a social work perspective. A PhD Thesis in Social Work.* University of South Africa.

Lekganyane, M. R., & Alpaslan, N. (2019). Suggestions by home-based caregivers caring for people living with HIV and AIDS on how social workers could support them in managing their work-related challenges. *Social Work/Maatskaplike Werk*, *55*(1), 141–157.

Leyva-Moral, J. M., Terradas-Robledo, R., Feijoo-Cid, M., Dios-Sánchez, R. de, Mestres-Camps, L., Lluva-Casta-No, A., & Comas-Serrano, M. (2016). Attitudes to HIV and AIDS among students and faculty in a School of Nursing in Barcelona (Spain): a cross-sectional survey. *Collegian (.* https://doi.org/10.1016/j.colegn.2016.10.006

Li, Z., Morano, J. P., Khoshnood, K., Hsieh, E., & Sheng, Y. (2018). HIV-related stigma among people living with HIV/AIDS in rural Central China. *BMC Health Services Research*, *18*(453).

Liang, Y.-D., Wang, Y., Li, Z., He, L., Xu, Y., Zhang, Q., You, G., & Mi, X. (2018). Caregiving burden and depression in paid caregivers of hospitalized patients: A pilot study in China. *BMC Public Health*, *18*(53), 1–7. https://doi.org/10.1186/s12889-017-4563-6

Lietz, C. A., Langer, C. L., & Furman, R. (2006). Establishing trustworthiness in qualitative research in social work: Implications from a study regarding spirituality. *Qualitative Social Work*, *5*(441).

Lim, J.-W., & Zebrack, B. (2004). Caring for family members with chronic physical illness: A critical review of caregiver literature. *Health and Quality of Life Outcomes*, *2*(50), 1–9. https://doi.org/10.1186/1477-7525-2-50

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA, Sage Publications.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2013). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In Y. S. L. Norman K. Denzin (Ed.), *The landscape of qualitative research* (4th ed.). Los Angeles, Sage Publications.

Lohiniva, A.-L., Kamal, W., Benkirane, M., Numair, T., Abdelrahman, M., Saleh, H., Zahran, A., Talaat, M., & Kandeel, A. (2015). HIV stigma toward people living with HIV and health providers associated with their care: Qualitative interviews with community members in Egypt. *Journal of the Association of Nurses in AIDS Care*. https://doi.org/10.1016/j.jana.2015.11.007

Lopez-Hartmann, M., Wens, J., Verhoeven, V., & Remmen, R. (2012). The effect of caregiver support interventions for informal caregivers of community-dwelling frail elderly: A systematic review. *International Journal of Integrated Care*, *12*, 1–17. https://doi.org/10.5334/ijic.845

Lu, H., Barriball, K. L., Zhang, X., & While, A. E. (2012). International Journal of Nursing Studies Job satisfaction among hospital nurses revisited : A systematic review §. *International Journal of Nursing Studies*, *49*, 1017–1038. https://doi.org/10.1016/j.ijnurstu.2011.11.009

Lyndon, A. (2016). Burnout among health professionals and its effect on patient safety. *Agency of Healthcare . Research and Quality. Retrieved from: Https://Psnet.Ahrq.Gov/Perspectives/Perspective/190/Burnout-among-Health-Professionals-and-Its-Effect-on-Patient-Safety*.

Mabusela, M. D. (2010). An investigation of the challenges and coping mechanisms of home-based caregivers for patients living with HIV in Mamelodi. *MA Theses, University of South Africa*.

Machadoa, B. M., Dahdahb, D. F., & Kebbe, L. M. (2018). Caregivers of family members with chronic diseases: Coping strategies used in everyday life. *Cardenos Brasileiros de Terapia Occupational, São Carlos, 26*(2), 299–313. https://doi.org/https://doi.org/10.4322/2526-8910.ctoAO1188

Madi, D., Chandran, V., Chowta, N., & Ramapuram, J. (2016). Caregiver burden among adults caring for people living with HIV/AIDS (PLWHA) in South India. *International Journal of Infectious Diseases*, *45*(Supplement 1), 263. https://doi.org/https://doi.org/10.1016/j.ijid.2016.02.587

Majumdar, B., & Mazaleni, N. (2010). The experiences of people living with HIV / AIDS and of their direct informal caregivers in a resource-poor setting. *Journal of the International AIDS Society*, *13*(20), 1–9.

Makhado, L., & Davhana-Maselesele, M. (2016). Knowledge and psychosocial wellbeing of nurses caring for people living with HIV/AIDS (PLWH). *Health SA Gesondheid*, *21*, 1–10. https://doi.org/10.1016/j.hsag.2015.10.003

Malatji, T. (2010). Stress and healthcare workers caring for people living with HIV/AIDS in Polokwane Municipality Clinics. *MPhil Thesis, University of the Witwatersrand Johannesburg, South Africa*.

Mamatsharaga, I. P. (2020). *Challenges and coping strategies of caregivers caring for elderly people living with diabetes mellitus in a selected village of the Vhembe district, Limpopo province*. Unpublished MPH Dissertation, School of health sciences, University of Venda, South Africa.

Mametja, V. L., Lekhuleni, M. E., & Kgole, J. C. (2013). Problems experienced by professional nurses providing care for HIV/AIDS patients in public hospitals at Polokwane Municipality, Limpopo Province, South Africa. *African Journal for Physical, Health Education, Recreation and Dance (AJPHERD), Supplement*, 48–61.

Mammbona, A. A. (2017). *Experiences of enrolled nurses towards caring for people living with HIV and AIDS*. Unpublished MPhil thesis, University of South Africa.

Mammbona, A. A., & Mavhandu-Mudzusi, A. H. (2019). Enrolled nurses' experiences of caring for patients living with HIV in a South African rural hospital. *International Nursing Review*, *66*, 139–146. https://doi.org/10.1111/inr.12480

Mamukeyani, E. (2021). Difficulties experienced by caregivers of HIV/AIDS orphans: A qualitative study for rural based caregivers. *Open Access Library Journal*, *8*(e6721). https://doi.org/10.4236/oalib.1106721

Manabete, S. S., John, C. A., Makinde, A. A., & Duwa, S. T. (2016). Job stress among school administrators and teachers in Nigerian secondary schools and technical colleges. *International Journal of Education, Learning and Development*, *4*(2), 1–9.

Mandal, L., & Rajendrababu, A. (2019). Rationing of nursing care, a deviation from holistic nursing: A systematic review. *Nursing Philosophy*, *00*(e12257). https://doi.org/10.1111/nup.12257

Mandić, B., Mandić-Rajčević, S., Marković-Denić, L., & Bulat, P. (2017). Occupational exposure to blood and bodily fluids among healthcare workers in Serbian general hospitals. *Arh Hig Rada Toksikol*, *68*, 61–68.

Mangal, D. (2015). The impacts of care giving on the wellbeing of caregivers of people living with HIV/AIDS. *MSc Thesis, University of Manitoba, Winnipeg*.

Manganye, B. S., Maluleke, T. X., & Lebese, R. T. (2013). Professional nurses' views regarding stigma and discrimination in the care of HIV and AIDS patients in rural hospitals of the Limpopo province, South Africa. *African Journal of AIDS Research*, *12*(1), 33–40. https://doi.org/10.2989/16085906.2013.815411

Marete, J. G. (2018). Effects of HIV/AIDS on psychological well being of elderly caregivers and their coping mechanisms. *International Journal of Science and Research*, *7*(3), 1396–1402. https://doi.org/10.21275/ART2018838

Marranzano, M., Ragusa, R., Platania, M., Faro, G., & Coniglio, M. A. (2013). Knowledge , attitudes and practices towards patients with HIV/AIDS in staff nurses in one university hospital in Sicily. *Epidemiology Biostatistics and Public Health*, *10*(1), 1–6. https://doi.org/10.2427/8731

Mashau, N., & Davhana-Maselesele, M. (2009). Experiences of HIV/AIDS home-based caregivers in Vhembe district of the Limpopo Province. *Curationis*, *32*(4), 40–47. https://doi.org/10.4102/curationis.v32i4.985

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research*, *11*(3).

Matakanye, H., Ramathuba, D. U., & Tugli, A. K. (2019). Caring for tuberculosis patients: Understanding the plight of nurses at a regional hospital in Limpopo Province, South Africa. *International Journal of Environmental Research and Public Health*, *16*(4977). https://doi.org/10.3390/ijerph16244977

Maunder, R. G., & Hunter, J. J. (2016). Can patients be 'attached' to healthcare providers? An observational study to measure attachment phenomena in patient – provider relationships. *BMJ Open*, 1–11.

Maxwell, J. A. (2013). *Qualitative research design: An interactive approach* (3rd ed.). California, Sage Publications, Inc.

McCain, N. L., & Gramling, L. F. (1992). Living with dying: Coping with HIV disease. *Issues in Mental Health Nursing*, *13*(3), 271–284. https://doi.org/10.3109/01612849209078778

Mcelroy, L. M., & Ladner, D. P. (2014). Defining the study cohort: Inclusion and exclusion criteria. In T. M. Pawlik & J. A. Sosa (Eds.), *Success in Academic Surgery: Clinical Trials* (pp. 131–139). London, Springer.

Mcneil, B. (2015). *A phenomenological study exploring the leadership development experiences of academic research library leaders*. PhD Dissertation, University of Nebraska.

Melvin, C. S. (2015). Historical review in understanding burnout, professional compassion fatigue, and secondary traumatic stress disorder from a hospice and palliative nursing perspective. *Journal of Hospice & Palliative Nursing*, *17*(1), 66–72.

Mensah, M. (2018). *Stigma among HIV care providers in health facilities at the Tema Metropolitan Area*. Unpublished MPH Dissertation, School of Public Health, University of Ghana, Legon.

Merriam, S B. (2009). *Qualitative research: A guide to design and implementation* (3rd ed.). San Francisco, CA, Jossey-Bass.

Merriam, Sharan B, & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation*. San Francisco, CA, Jossey-Bass.

Mikulincer, M., & Shaver, P. R. (2016). Attachment Processes Emotion Regulation. In *Attachment in Adulthood: Structure, Dynamics, and Change* (2nd ed., pp. 187–225). New York, Guilford Publications.

Miles, K. (2011). Using attachment theory in mentoring. *Nursing Times*, *107*(38).

Military Hospital Accra. (n.d.). *37 Military Hospital Brochure*.

Miller, A. (2012). *Instructor's manual for Carl Rogers on Person-centered Therapy*. Psychotherapy.net.

Miller, D. (2005). *Dying to Care? Work, stress and burnout in HIV/AIDS*. Routledge.

Mkoko, P., & Raine, R. I. (2017). HIV-positive patients in the intensive care unit: A retrospective audit. *South African Medical Journal*, *107*(10), 877–881. https://doi.org/10.7196/SAMJ.2017.v107i10.12298

Mogakwe, L. J., Magobe, N. B. D., & Ally, H. (2020). Facilitating compliance with quality standards at primary health care clinics through adequate health care resources. *Africa Journal of Nursing and Midwifery*, *22*(1).

Mohangi, K., & Pretorius, C. (2017). On the periphery of HIV and AIDS: Reflections on stress as experienced by caregivers in a child residential care facility in South Africa. *Journal of Social Aspects of HIV/AIDS*, *14*(1), 153–161. https://doi.org/10.1080/17290376.2017.1389300

Mokhtari, R., Safdari, A., Hekmatpou, D., Sahebi, A., Moayedi, S., Torres, M., & Golitaleb, M. (2021). Investigating the effective factors of using personal protective equipment from the perspective of nurses caring for COVID-19 patients: A cross-sectional study. *International Journal of Environmental Research and Public Health*, *18*(7882). https://doi.org/https://doi.org/10.3390/ijerph1815788

Montagnier, L. (2002). A History of HIV Discovery. *Science*, *298*, 1727–1728.

Moon, K., Brewer, T. D., Januchowski-Hartley, S. R., Adams, V. M., & Blackman, D. A. (2016). A guideline to improve qualitative social science publishing in ecology and conservation journals. *Ecology and Society*, *21*(3), 17–36.

Moreno-Jiménez, B., Rodríguez-Carvajal, R., Furlong, L. V., Hernández, E. G., & Benadero, E. M. (2006). Burnout process and HIV/AIDS: Main implications for health care workers. *Revista Colombiana de Psicología*, *15*, 67–80.

Mosadeghrad, A. M. (2013). Occupational stress and turnover intention: Implications for nursing management. *International Journal of Health Policy and Management*, *1*(2), 169–176. https://doi.org/10.15171/ijhpm.2013.30

Mosendane, T., Kew, M. C., Osih, R., & Mahomed, A. (2012). Nurses at risk for occupationally acquired blood-borne virus infection at a South African academic hospital. *South African Medical Journal*, *102*(3), 153–156.

Moshidi, M. L., Malema, R. N., Muthelo, L., & Mothiba, T. M. (2021). Provision of care to the people with HIV: Voices of professional nurses in the public hospitals of Limpopo Province, South Africa. *International Journal of Environmental Research and Public Health*, *18*(3112). https://doi.org/https://doi.org/10.3390/ijerph18063112

Moss, J. A. (2013). HIV/AIDS review. *Radiologic Technology*, *84*(3), 268–270.

Mossburg, S., Agore, A., Nkimbeng, M., & Commodore-Mensah, Y. (2019). Occupational hazards among healthcare workers in Africa: A systematic review. *Annals of Global Health*, *85*(1;78), 1–13. https://doi.org/https://doi.org/10.5334/aogh.2434

Mponela, M. J., Oleribe, O. O., Abade, A., & Kwesigabo, G. (2015). Post exposure prophylaxis following occupational exposure to HIV: A survey of health care workers in Mbeya, Tanzania, 2009-2010. *Pan African Medical Journal*, *21*(32). https://doi.org/10.11604/pamj.2015.21.32.4996

Mubekapi, C. (2012). *Workplace stress and coping strategies among nurses in HIV/AIDS care: Geita District Hospital, Tanzania*. Doctoral Dissertation, University of the Western Cape, South Africa.

Mujjuzi, I., Mutegeki, P., Nabuwufu, S., Wosukira, A., Namata, F., Alayo, P., Amanya, S. B., & Nyeko, R. (2021). Care burden and coping strategies among caregivers of paediatric HIV/AIDS in Northern Uganda: A cross-sectional mixed-method study. *AIDS Research and Treatment*, *2021*, 1–14.

Mulaudzi, M. V., Pengpid, S., & Peltzer, K. (2011). Nurses' knowledge, attitudes, and coping related to HIV and AIDS in a rural hospital in South Africa. *Studies on Ethno-Medicine*, *5*(1), 25–32. https://doi.org/10.1080/09735070.2011.11886388

Mutemwa, R., Mayhew, S., Colombini, M., Busza, J., Kivunaga, J., & Ndwiga, C. (2013). Experiences of health care providers with integrated HIV and reproductive health services in Kenya: A qualitative study. *BMC Health Services Research*, *13*(18), 1–10. https://doi.org/10.1186/1472-6963-13-18

Muthoni, G. P. (2017). Psychosocial impact of HIV/AIDS caregiving among the primary caregivers in Mombasa County, Kenya. *MA Thesis in Counselling Psychology, Kenyatta University, Kenya*.

Mwinga, C., & Mugala, D. (2015). Prevalence and causes of stress among nurses at Ndola Central Hospital – A nurses ' perspective. *International Journal of Novel Research in Healthcare and Nursing*, *2*(3), 158–165.

Mwinituo, P. P., & Mill, J. E. (2006). Stigma associated with Ghanaian caregivers of AIDS patients. *Western Journal of Nursing Research*, *28*(4), 369–382. https://doi.org/10.1177/0193945906286602

Naidoo, P. (2006). Barriers to HIV care and treatment by doctors: A review of the literature. *South African Family Practice*, *48*(2), 55-16e. https://doi.org/10.1080/20786204.2006.10873343

Nala-Preusker, H.-P. M. (2014). *An investigation into older caregivers' lived experiences of adult AIDS-ill children in Umlazi Township, Kwazulu-Natal*. MA Thesis, University of South Africa.

Namale, M. (2012). *Guidance and Counselling in Education*. Accra, Ghana, Rich blank Publication.

Nanayakkara, G. N., & Choi, E. (2020). Knowledge gaps on HIV/AIDS among a group of nursing students in Sri Lanka. *Journal of Nursing Education and Practice*, *10*(6), 82–85. https://doi.org/10.5430/jnep.v10n6p82

Nderitu, E. W., Mill, J., & Richter, S. (2014). The experience of Ugandan nurses in the practice of universal precautions. *Journal of the Association of Nurses in AIDS Care*, 1–14. https://doi.org/10.1016/j.jana.2014.10.003

Ndou, N. D. (2017). Instrumental support for professional nurses caring for patients living with HIV/AIDS in the Tshwane District of Gauteng, South Africa. *Africa Journal of Nursing and Midwifery*, *19*(3), 1–13.

Ndou, N. D., Maputle, M. S., Lebese, R. T., & Khoza, L. B. (2014). "Challenges experienced by professional nurses caring for patients diagnosed with AIDS-related illnesses at the Hospital, Tshwane District, Gauteng Province, South Africa." •. *African Journal for Physical Health Education*, 255–165.

Ndou, N. D., Maputle, M. S., Lebese, R. T., & Khoza, L. B. (2015). Support of professional nurses caring for HIV/AIDS patients, Tshwane District of Gauteng Province, South Africa. *Journal of Human Ecology Ecol*, *51*(2), 187–192.

Neequaye, A. R., Mingle, J. A. A., Neequaye, J. E., Agadzi, V. K., Nettey, V., Osei-Kwasi, M., Hayami, M., Ishikawa, K., Ankra-Badu, G., Bentsi, C., Asamoah-Adu, A., Aggrey, S. E., Ampofo, W., Brandful, J. A., Grant, F., & Biggar, R. J. (1987). A report on Human Immuno- deficiency virus (HIV) infection in Ghana up to December 1986. *Ghana Medical Journal*, *21*(1), 7–11.

Neuman, W. L. (2006). *Social research methods: Qualitative and quantitative approaches* (6th ed.). Boston, USA, Pearson Education, Inc.

Neuman, W. L. (2014). *Basics of social research: Qualitative & quantitative approaches* (3rd ed.). Boston, USA, Pearson Education Inc.

Nguyen, T. T. L. (2019). Selection of research paradigms in English Language Teaching: Personal reflections and future directions. *The Second Annual International Conference on Language and Literature*, *2019*, 1–19. https://doi.org/10.18502/kss.v3i19.4826

Njau, P. W., Kariuki, M., & Wambu, C. K. (2015). Socio-Economic challenges and coping mechanisms of home based caregivers for people living with HIV/AIDS in Njoro Sub-County, Kenya. *Journal of Humanities and Social Science*, *20*(6), 70–77. https://doi.org/10.9790/0837-20637077

Nkanata, S. N., Muchangi, D., & Kiiru, G. (2021). Influence of employee assistance programs on employee retention in Kenyan public level five hospitals. *Journal of Business and Management (IOSR-JBM)*, *23*(9), 24–30. https://doi.org/10.9790/487X-2309012430

Nmadu, A. G., & Sabitu, K. (2016). Occupational exposure to blood and body fluids among primary health-care workers in Kaduna State, Nigeria. *Journal of Medicine in the Tropics*, *18*(2), 79–85. https://doi.org/10.4103/2276-7096.192223

Nukpezah, R. N., Fomani, F. K., Hasanpour, M., & Nasrabadi, A. N. (2021). A qualitative study of Ghanaian pediatric oncology nurses' care practice challenges. *BMC Nursing*, *20*(17), 1–10.

O'Neill, J. F., & McKinney, M. M. (2003). Care for the caregiver. In J. F. O'Neill, P. A. Selwyn, & H. Schietinger (Eds.), *A clinical guide to supportive and palliative care for HIV/AIDS* (2003 Ed, pp. 409–430). New York, Health Resources and Services Administration (HRSA).

Obirikorang, C., Selleh, P. K., Abledu, J. K., & Fofie, C. O. (2013). Predictors of Adherence to Antiretroviral Therapy among HIV/AIDS Patients in the Upper West Region of Ghana. *Isrn Aids*, *2013*, 1–7.

Odonkor, S. T., & Adams, S. (2021). Predictors of stress and associated factors among healthcare workers in Western Ghana. *Heliyon*, *7*, e07223. https://doi.org/10.1016/j.heliyon.2021.e07223

Odonkor, S. T., & Frimpong, K. (2020). Burnout among healthcare professionals in Ghana: A critical assessment. *BioMed Research International*. https://doi.org/https://doi.org/10.1155/2020/1614968

Ofori, A. A., Osarfo, J., Agbeno, E. K., Manu, D. O., & Amoah, E. (2021). Psychological impact of COVID-19 on health workers in Ghana: A multicentre, cross-sectional study. *SAGE Open Medicine*, *9*, 1–10.

Ojekou, G. P., & Dorothy, O. T. (2015). Effect of work environment on level of work stress and burnout among nurses in a teaching hospital in Nigeria. *Open Journal of Nursing*, *5*, 948–955.

Okeke, B. O. (2016). Social support seeking and self-efficacy-building strategies in enhancing the emotional well-being of informal HIV/AIDS caregivers in Ibadan, Oyo state, Nigeria. *Journal of Social Aspects of HIV/AIDS*, *13*(1), 35–40. https://doi.org/10.1080/17290376.2015.1126794

Okemwa, D. O., Atambo, W. N., & Muturi, W. M. (2019). Influence of employee assistance programs on commitment of nurses in public hospitals in Kenya. *International Journal of Academic Research in Business and Social Sciences*, *9*(1), 151–164. https://doi.org/10.6007/ijarbss/v9-i1/5376

Okesina, M. (2020). A critical review of the relationship between paradigm, methodology, design and method in research. *Journal of Research & Method in Education*, *10*(3), 57–68. https://doi.org/10.9790/7388-1003015768

Okoye, A. A., & Picker, L. J. (2013). CD4+ T-Cell Depletion in HIV Infection: Mechanisms of immunological failure. *Immunological Reviews*, *254*(1), 54–64. https://doi.org/10.1111/imr.12066

Oleniuk, A., Duncan, C. R., & Tempier, R. (2013). The impact of stigma of mental illness in a Canadian community: A survey of patients experiences. *Community Mental Health Journal*, *49*(1), 127–132.

Olley, B. O. (2003). Investigating attitudes towards caring for people with HIV/AIDS among hospital care workers in Ibadan, Nigeria: the role of self-efficacy. *African Journal of AIDS Research*, *2*(1), 57–61.

Omisakin, F. D. (2001). Nurses ' knowledge and skills about caring for patients with HIV / AIDS in Osun state. *Nigerian Journal of Medicine*, *10*(1), 30–33.

Onwuegbuzie, A. J., & Leech, N. L. (2007). Sampling designs in qualitative research: Making the sampling process more public. *The Qualitative Report*, *12*(2), 238–254.

Oppong-Asante, K. (2013). HIV/AIDS knowledge and uptake of HIV counselling and testing among undergraduate private university students in Accra, Ghana. *Reproductive Health*, *10*(1), 1. https://doi.org/10.1186/1742-4755-10-17

Orner, P. (2006). Psychosocial impacts on caregivers of people living with AIDS. *AIDS Care*, *18*(3), 236–240. https://doi.org/10.1080/09540120500456565

Oyeyemi, A, Oyeyemi, B., & Bello, I. (2006). Caring for patients living with AIDS: Knowledge, attitude and global level of comfort. *Journal of Advanced Nursing*, *53*(2), 196–204. https://doi.org/10.1111/j.1365-2648.2006.03715.x

Oyeyemi, Adetoyeje, Utti, V., Oyeyemi, L., & Onigbinde, T. (2007). Knowledge, attitude, and willingness of Nigerian physiotherapy students to provide care for patients living with Acquired Immunodeficiency Syndrome. *Physiotherapy Theory and Practice*, *23*(5), 281–290. https://doi.org/10.1080/09593980701209436

Oyeyimika, O. A., Muheezat, O. O., Adenike, O. F., & Ejiro, O. (2020). Caregiver burden, quality of life and coping mechanisms among caregivers of children living with HIV in Lagos, Nigeria. *African Journal of Health Sciences*, *33*(5), 68–77.

Pace, E. M., Kesterson, C., Garcia, K., Denious, J., Finnell, D. S., & Bayless, S. D. (2019). Experiences and outcomes of nurses referred to a peer health assistance program: Recommendations for nursing management. *Journal of Nursing Management*, *28*(1), 35–42. https://doi.org/10.1111/jonm.12874

Palenik, C. J. (2017). Occupational Acquisition of HIV Infection by Healthcare Workers in the United States. *Journal of HIV for Clinical and Scientifi c Research*, *4*(2), 15–17.

Palese, A., Bassi, E., Tommasini, C., Vesca, R., Di Falco, A., De Lucia, P., Mulloni, G., Paoletti, F., Rissolo, R., Sist, L., Sanson, G., Guardini, I., Bressan, V., Mesaglio, M., Papastavrou, E., & Blackman, I. (2019). Developing policies and actions in response to missed nursing care: A consensus process. *Journal of Nursing Management*, *27*(7), 1492–1504. https://doi.org/10.1111/jonm.12835

Pan, C., Wang, H., Chen, M., Cai, Y., Li, P., Xiao, C., Tang, Q., & Koniak-Griffin, D. (2022). Stress and coping in nurses taking care of people living with HIV in Hunan, China: A descriptive qualitative study. *Neuropsychiatric Disease and Treatment*, *18*, 303–315.

Papaspyros, S. C., Javangula, K. C., Adluri, R. K. P., & O'Regan, D. J. (2010). Briefing and debriefing in the cardiac operating room. Analysis of impact on theatre team attitude and patient safety. *Interactive Cardiovascular and Thoracic Surgery*, *10*, 43–47. https://doi.org/10.1510/icvts.2009.217356

Papastavrou, E., Andreou, P., Tsangari, H., Schubert, M., & De Geest, S. (2014). Rationing of nursing care within professional environmental constraints: A correlational study. *Clinical Nursing Research*, *23*(3), 314–335. https://doi.org/10.1177/1054773812469543

Pargament, K. I., Magyar-Russell, G. M., & Murray-swank, N. A. (2005). The sacred and the search for significance: Religion as a unique process. *Journal OfSocial Issues*, *61*(4), 665–687.

Park, M., Giap, T. T. T., Lee, M., Jeong, H., Jeong, M., & Go, Y. (2018). Patient- and family-centered care interventions for improving the quality of health care: A review of systematic reviews. *International Journal of Nursing Studies*, *87*, 69–83. https://doi.org/10.1016/j.ijnurstu.2018.07.006

Parks, F. M., & Smallwood, S. W. (2021). Courtesy stigma and self-care practices among rural HIV/AIDS healthcare providers. *Journal of HIV/AIDS and Social Services*, *20*(2), 136–143. https://doi.org/10.1080/15381501.2021.1922116

Pathak, V. C. (2017). Phenomenological Research: A Study of Lived Experiences. *IJARIIE*, *3*(1), 1719–1722.

Pejic, A. R. (2005). Verbal abuse: A problem for pediatric nurses. *Pediatric Nursing*, *31*(4), 271.

Pendukeni, M. (2004). The impact of HIV/AIDS on health care provision: Perceptions of nurses currently working in one regional hospital in Namibia. *MA Thesis, University of the Western Cape, South Africa*.

Phelan, J. C., Lucas, J. W., Ridgeway, C. L., & Taylor, C. J. (2014). Stigma, status, and population health. *Social Science and Medicine*, *103*, 15–23. https://doi.org/10.1016/j.socscimed.2013.10.004

Philip, J., Chadee, D., & Yearwood, R. P. (2014). Health care students' reactions towards HIV patients: examining prejudice, emotions, attribution of blame and willingness to interact with HIV/AIDS patients. *AIDS Care*, *26*(10), 37–41. https://doi.org/10.1080/09540121.2014.896449

Phillips, R., Benoit, C., Hallgrimsdottir, H., & Vallance, K. (2012). Courtesy stigma: A hidden health concern among front-line service providers to sex workers. *Sociology of Health & Illness*, *34*(5), 681–696. https://doi.org/10.1111/j.1467-9566.2011.01410.x

Phillips, R. O., Steinmetz, A., Nichols, J., Adomako, E., Ofori, E., Antonio, E., Allihien, S.-M., Peprah-Addae, C., & Adams, W. (2018). Spectrum of disease in HIV-positive patients presenting to a tertiary care hospital: A retrospective, cross-sectional review in Kumasi, Ghana. *BMC Infectious Diseases*, *18*(419), 1–7. https://doi.org/https://doi.org/10.1186/s12879-018-3332-1

Pickles, D., King, L., & Belan, I. (2009). Attitudes of nursing students towards caring for people with HIV/AIDS: Thematic literature review. *Journal of Advanced Nursing*, *65*(11), 2265–2273. https://doi.org/10.1111/j.1365-2648.2009.05128.x

Piculell, E., & Wikander, M. (2012). *Experiences of registered professional nurseswhen caring for patients with HIV and AIDS at Polokwane hospital, Capricorn district, Limpopo Province, South Africa (SA)*. Nursing Thesis, University of Limpopo.

Pinhatti, E. D. G., Vannuchi, M. T. O., Sardinha, D. da S. S., & Haddad, M. do C. L. (2017). Job rotation of nursing professionals among the sectors of a hospital: A management tool in conflict resolution. *Texto & Contexto - Enfermagem*, *26*(2). https://doi.org/10.1590/0104-07072017001180015

Piot, P., & Quinn, T. C. (2013). Response to the AIDS pandemic - A global health model. *The New England Journal of Medicine*, *368*, 2210–2218. https://doi.org/10.1056/NEJMra1201533

Polit, D. F., & Beck, C. T. (2017). *Nursing research. Generating and assessing evidence for nursing practice* (10th ed.). Philadelphia, USA, Wolters Kluwer.

Prakash, S. S., Rajshekar, D., Cherian, A., & Sastry, A. S. (2017). Care bundle approach to reduce device-associated infections in a tertiary care teaching hospital, South India. *Journal of Laboratory Physicians*, *9*, 273–278.

Pretorius, C. A. (2013). Caregivers' experiences of stress while caring for orphaned and vulnerable children in an institution. *A Masters' Dissertation, Department of Educational Psychology, University of Pretoria, South Africa*.

Punch, K. (2005). *Introduction to social research: Quantitative and qualitative approaches*. London, Sage Publications.

Puplampu, G. L. (2017). *Understanding hope in HIV care: A narrative inquiry into the experiences of nurses in Ghana*. PhD Thesis, Faculty of Nursing, University of Alberta, Canada.

Qiao, Z., Chen, L., Chen, M., Guan, X., Wang, L., Jiao, Y., Yang, J., & Tang, Q. (2016). Prevalence and factors associated with occupational burnout among HIV/AIDS healthcare workers in China: A cross- sectional study. *BMC Public Health*, *16*(335), 1–7. https://doi.org/10.1186/s12889-016-2890-7

Raberahona, M., Razafinambinintsoa, T., Andriananja, V., Ravololomanana, N., Tongavelona, J., Rakotomalala, R., Andriamamonjisoa, J., Andrianasolo, R. L., Rakotoarivelo, A., Jean, M., & Randria, D. D. (2018). Hospitalization of HIV positive patients in a referral tertiary care hospital in Antananarivo Madagascar , 2010-2016 : Trends , causes and outcome. *PLoS Medicine*, *13*(8), e0203437.

Rahimi, G., Moshfeghi, S., Movahedpour, A., Tazakori, Z., Karimollahi, M., Mazaheri, E., Sadeghzadeh, S., & Vosogh, N. (2017). Nurses' experiences about acceptance of HIV/AIDS patients Ardabil, Iran. *Pharmacophore*, *8*((6S)), e-1173034.

Rahman M M, Putit Z B, Suut N B, Arif M T, Said A B, Suhaili R B, Fadzillah, M., Tambi, Z. B., & Kee, L. H. (2020). Coping strategies by stroke caregivers: Evidence from a qualitative study in Sarawak, Malaysia. *Malaysian Journal of Public Health Medicine*, *20*(1), 48–54.

Rai, R., El-Zaemey, S., Dorji, N., Rai, B. D., & Fritschi, L. (2021). Exposure to occupational hazards among health care workers in low-and middle-income countries: A scoping review. *International Journal of Environmental Research and Public Health*, *18*(5). https://doi.org/10.3390/ijerph18052603

Ramathuba, D U, & Davhana-Maselesele, M. (2013). Nurses' perceptions of support in caring for people living with HIV and AIDS (PLWHA) in Vhembe District, Limpopo Province. *International Journal of Research in Medical and Health Sciences*, *3*(2), 7–17.

Ramathuba, D U, & Makhado, L. (2021). Support model for nurses caring for people living with HIV and AIDS in the Limpopo province, South Africa. *Curationis*, *44*(1). https://doi.org/10.4102/curationis.v44i1.2092

Ramathuba, D U, & Davhana-Maselesele, M. (2015). Support in caring for people living with HIV and AIDS: A concept analysis. *Journal of Human Ecology*, *50*(1), 73–81.

Rapparini, C. (2006). Occupational HIV infection among health care workers exposed to blood and body fluids in Brazil. *American Journal of Infection Control*, *34*(4), 237–240.

Ras, G. J., Simson, I. W., Anderson, R., Prozesky, O. W., & Hamersma, T. (1983). Acquired immunodeficiency syndrome. A report of 2 South African cases. *South African Medical Journal*, *64*(4), 140–142.

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative Research. Bridging the conceptual, theoretical, and methodological*. London, Sage Publications Inc.

Razu, S. R., Yasmin, T., Arif, T. B., Islam, M. S., Islam, S. M. S., Gesesew, H. A., & Ward, P. (2021). Challenges faced by healthcare professionals during the COVID-19 pandemic: A qualitative inquiry from Bangladesh. *Frontiers in Public Health*, *9*(August). https://doi.org/10.3389/fpubh.2021.647315

Reda, A. A., & Biadgilign, S. (2012). Determinants of adherence to antiretroviral therapy among HIV-Infected patients in Africa. *AIDS Research and Treatment*, *2012*, 1–8. https://doi.org/10.1155/2012/574656

Rena, R., & Lekate, K. (2021). The implementation of employee assistance programmes amongst nurses in Mahikeng provincial hospital. *International Refereed Social Sciences Journal*, *12*(2), 12–25. https://doi.org/10.18843/rwjasc/v12i2/02

Rivaz, M., Momennasab, M., Yektatalab, S., & Ebadi, A. (2017). Adequate resources as essential component in the nursing practice environment: A qualitative study. *Journal of Clinical and Diagnostic Research*, *11*(6), IC01–IC04. https://doi.org/10.7860/JCDR/2017/25349.9986

Robbins, I., Cooper, A., & Bender, M. P. (1992). The relationship between knowledge, attitudes and degree of contact with AIDS and HIV. *Journal of Advanced Nursing*, *17*, 198–203.

Roca, J., Canet-Vélez, O., Cemeli, T., Lavedán, A., Masot, O., & Botigué, T. (2021). Experiences, emotional responses, and coping skills of nursing students as auxiliary health workers during the peak COVID-19 pandemic: A qualitative study. *International Journal of Mental Health Nursing*, *30*(5), 1080–1092. https://doi.org/10.1111/inm.12858

Rochefort, C. M., Rathwell, B. A., & Clarke, S. P. (2016). Rationing of nursing care interventions and its association with nurse-reported outcomes in the neonatal intensive care unit: A cross-sectional survey. *BMC Nursing*, *15*(46). https://doi.org/10.1186/s12912-016-0169-z

Rogers, C. R. (1942). *Counseling and psychotherapy: Newer concepts in practice*. Boston, USA. Houghton Mieelin Company.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*, 95–103.

Rogers, C. R. (1961). *On becoming a person. A therapist's view of psychotherapy*. Boston, USA. Houghton Mifflin Company.

Rogers, C. R. (1980). Growing old - or older and growing. *Journal of Humanistic Psychology*, *20*(4), 5–16. https://doi.org/https://doi.org/10.1177/002216788002000403

Rohde, K. A., Dupler, A. E., Postma, J., & Sanders, A. (2013). Minimizing nurses' risks for needlestick injuries in the hospital setting. *Workplace Health & Safety*, *61*(5), 197–202. https://doi.org/10.1177/216507991306100503

Röndahl, G., Innala, S., & Carlsson, M. (2003). Nursing staff and nursing students' attitudes towards HIV-infected and homosexual HIV-infected patients in Sweden and the wish to refrain from nursing. *Journal of Advanced Nursing*, *41*(5), 454–461.

Roomaney, R., Steenkamp, J., & Kagee, A. (2017). Predictors of burnout among HIV nurses in the Western Cape. *Curationis*, *40*(1), 1–9. https://doi.org/https://doi.org/10.4102/ curationis.v40i1.1695

Rosenburg, N., Taliaferro, D., & Ercole, P. (2012). HIV-Related Stigma Among Nursing Students in Cameroon. *Journal of the Association of Nurses in AIDS Care*, *23*(2), 170–176. https://doi.org/10.1016/j.jana.2011.09.003

Saavedra, A., Campinha-Bacote, N., Hajjar, M., Kenu, E., Gillani, F. S., Obo-Akwa, A., Lartey, M., & Kwara, A. (2017). Causes of death and factors associated with early mortality of HIV-infected adults admitted to Korle-Bu Teaching Hospital. *Pan African Medical Journal*, 1–7. https://doi.org/10.11604/pamj.2017.27.48.8917

Sable, P. (1992). Attachment theory: Application to clinical practice with adults. *Clinical Social Work Journal*, *20*(3), 271–272.

Salloum, A., Kondrat, D. C., Johnco, C., & Olson, K. R. (2015). The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers. *Children and Youth Services Review*, *49*, 54–61. https://doi.org/10.1016/j.childyouth.2014.12.023

Sanches, R. S., Souza, A. R., & Lima, E. S. (2018). Factors related to the development of stress and burnout among nursing professionals who work in the care of people living with HIV/AIDS. *Rev Fund Care Online*, *10*(1), 276–282. https://doi.org/10.9789/2175-5361.2018.v10i1.276-282

Sarafis, P., Rousaki, E., Tsounis, A., Malliarou, M., Lahana, L., Bamidis, P., Niakas, D., & Papastavrou, E. (2016). The impact of occupational stress on nurses' caring behaviors and their health related quality of life. *BMC Nursing*, *15*(56). https://doi.org/10.1186/s12912-016-0178-y

Saunders, B., Kitzinger, J., & Kitzinger, C. (2015). Anonymising interview data: Challenges and compromise in practice. *Qualitative Research*, *15*(5), 616–632. https://doi.org/10.1177/1468794114550439

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, *52*, 1893–1907.

Savitsky, B., Radomislensky, I., & Hendel, T. (2021). Nurses' occupational satisfaction during Covid-19 pandemic. *Applied Nursing Research*, *59*. https://doi.org/https://doi.org/10.1016/j.apnr.2021.151416

Schubert, M., Ausserhofer, D., Bragadóttir, H., Rochefort, C. M., Bruyneel, L., Stemmer, R., Andreou, P., Leppée, M., & Palese, A. (2020). Interventions to prevent or reduce rationing or missed nursing care: A scoping review. *Journal of Advanced Nursing*, *00*, 1–15. https://doi.org/10.1111/jan.14596

Sehularo, L. A., Molato, B. J., Mokgaola, I. O., & Gause, G. (2021). *Coping strategies used by nurses during the COVID-19 pandemic: A narrative literature review*. *26*(0).

Semakula, D., & Deventer, C. Van. (2013). Delays by people living with HIV/AIDS in accessing antiretroviral therapy. *South African Family Practice*, *55*(6), 574–578. https://doi.org/10.1080/20786204.2013.10874419

Senzanje, N. (2011). *Factors that contribute to HIV-related stigma and discrimination within the Christian faith community: a survey of the Christ Embassy Church in Windhoek*. MPhil Thesis, Stellenbosch University.

Serdar, T., Đerek, L., Unić, A., Marijančević, D., Marković, D., Primorac, A., & Petrovečki, M. (2013). Occupational exposures in healthcare workers in University hospital Dubrava – 10 year follow-up study. *Central European Journal of Public Health*, *21*(3), 150–154. https://doi.org/10.21101/cejph.a3803

Shah, S. M., Heylen, E., Srinivasan, K., Perumpil, S., & Ekstrand, M. L. (2014). Reducing HIV stigma among nursing students: A brief intervention. *Western Journal of Nursing Research*, 1–15. https://doi.org/10.1177/0193945914523685

Sharf, R. S. (2012). *Theories of psychotherapy and counseling concepts and cases* (5th ed.). Belmont, USA, Cengage Learning, Inc.

Sharma, A., Tripura, K., & Acharjee, A. (2018). A cross Sectional study on prevalence of needle stick injury and management practices among health workers working in a Teaching Hospital, Tripura. *IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)*, *17*(01), 5–7. https://doi.org/10.9790/0853-1701050507

Shebi, M. (2006). The experiences and coping strategies of HIV/AIDS primary caregivers within two disadvantaged communities in the Western Cape Metropole. *MA Thesis, Department of Psychology, Faculty of Community and Health Sciences, University of the Western Cape, South Africa*.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information 22 (2004) 63–75*, 63–75. https://doi.org/10.3233/EFI-2004-22201

Shinners, J., Africa, L., & Hawkes, B. (2016). Debriefing as a supportive component for registered nurses in transition. *Journal for Nurses in Professional Development*, *32*(4), 212–218. https://doi.org/10.1097/NND.0000000000000273

Shirinda-Mthombeni, K. (2014). The psychosocial challenges and coping mechanisms of palliative care volunteer caregivers for people living with HIV and AIDS. *MSc Thesis,University of South Africa*.

Shivalli, S. (2014). Occupational exposure to HIV: Perceptions and preventive practices of Indian nursing students. *Advances in Preventive Medicine*, *2014*, 1–6. https://doi.org/10.1155/2014/296148

Simón, M. A., Bueno, A. M., Otero, P., Blanco, V., & Vázquez, F. L. (2019). Caregiver burden and sleep quality in dependent people's family caregivers. *Journal of Clinical Medicine*, *8*(1072), 1–10.

Sinanaj, G., Harxhi, A., & Subashi, B. (2018). The role of nurses in the treatment and care of HIV/AIDS patients - based on the dimensions of health care. *International Journal for Innovation Education and Research*, *6*(01), 199–212.

Singh, D., Chaudoir, S. R., Escobar, M. C., & Seth Kalichman. (2011). Stigma, burden, social support, and willingness to care among caregivers of PLWHA in home based care South Africa. *AIDS Care*, *23*(7), 839–845. https://doi.org/10.1080/09540121.2010.542122.Stigma

Singh, S., & Wassenaar, D. R. (2016). Contextualising the role of the gatekeeper in social science research. *South African Journal of Bioethics and Law*, *9*(1), 42–46. https://doi.org/7196/SAJBL.465

Smart, D., English, A., James, J., Wilson, M., Daratha, K. B., Childers, B., & Magera, C. (2014). Compassion fatigue and satisfaction: A cross-sectional survey among US healthcare workers. *Nursing and Health Sciences*, *16*, 3–10. https://doi.org/10.1111/nhs.12068

Smit, R. (2005). HIV/AIDS and the workplace: Perceptions of nurses in a public hospital in South Africa. *Journal of Advanced Nursing*, *51*(1), 22–29.

Smith, P., Vasileiou, K., & Kagee, A. (2020). Experiences of work-related stress and coping among palliative care staff in South Africa: A qualitative study. *South African Journal of Psychology*, *00*(0). https://doi.org/10.1177/0081246320902300

Smith, T. B., Mccullough, M. E., & Poll, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin*, *116*, 614–636.

Soboka, M., & Feyissa, G. T. ol. (2015). The effectiveness of counseling, material support and/or nutritional supplementation on improving adherence to anti-retroviral therapy and clinical outcomes among HIV patients: A systematic review of quantitative evidence protocol. *JBI Database of Systematic Reviews and Implementation Reports*, *13*(7), 142–152. https://doi.org/10.11124/jbisrir-2015-2243

Song, Y., Wang, H., Yin, Y., Nie, A., Yang, H., Liu, Y., Tao, L., Zhong, H., Zhang, L., & Chen, H. (2022). Caregiver Burden Among Informal Caregivers of Persons Living with HIV / AIDS in Liangshan. *Patient Preference and Adherence*, *16*, 1027–1035.

Stangl, A. L., Earnshaw, V. A., Logie, C. H., Brakel, W. Van, Simbayi, L. C., Barré, I., & Dovidio, J. F. (2019). The health stigma and discrimination framework: A global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Medicine*, *17*(31), 18–23. https://doi.org/https://doi.org/10.1186/s12916-019-1271-3

Stavrianou, A., Kafkia, T., Mantoudi, A., Minasidou, E., Konstantinidou, A., SapountziKrepia, D., & Dimitriadou, A. (2018). Informal caregivers in Greek hospitals: A unique phenomenon of a health system in financial crisis. *Materia Socio-Medica*, *30*(2), 147. https://doi.org/10.5455/msm.2018.30.147-152

Stavropoulou, A., Kaba, E., Obamwonyi, V. A., Adeosun, I., Rovithis, M., & Zidianakis, Z. (2012). Defining nursing intimacy: Nurses' perceptions of intimacy. *Health Science Journal*, *6*(3), 479–495.

Stavropoulou1, A., Stroubouki, T., Lionaki, A., Lionaki, S., Bakogiorga, H., & Zacharias Zidianakis. (2011). Student nurses' perceptions on caring for people with HIV. *Health Science Journal*, *5*(4), 288–296.

Stevenson, K. N., Jack, S. M., O'Mara, L., & LeGris, J. (2015). Registered nurses' experiences of patient violence on acute care psychiatric inpatient units: An interpretive descriptive study. *BMC Nursing*, *14*(35). https://doi.org/10.1186/s12912-015-0079-5

Strojek, W. D., & Kolodziejczyk, I. (2018). 'Burnout syndrome' in health workers and caregivers and its impact on the performance in HIV/AIDS services: case study of the Rebiamul VCT and ART clinics of the Catholic Health Services of the Archdiocese of Mt Hagen. *Contemporary PNG Studies: DWU Research Journal Volume*, *28*, 1–21.

Subramanian, G. C., Arip, M., & Subramaniam, T. S. S. (2017). Knowledge and risk perceptions of occupational infections among health-care workers in Malaysia. *Safety and Health at Work*, *8*(3), 246–249. https://doi.org/10.1016/j.shaw.2016.12.007

Sultan, B., Benn, P., & Waters, L. (2014). Current perspectives in HIV post-exposure prophylaxis. *HIV/AIDS-Research and Palliative Care*, *6*, 147–158.

Sun, N., Wei, L., Shi, S., Jiao, D., Song, R., Ma, L., Wang, H., Wang, C., Wang, Z., You, Y., Liu, S., & Wang, H. (2020). A qualitative study on the psychological experience of caregivers of COVID-19 patients. *American Journal of Infection Control*, *48*, 592–598. https://doi.org/10.1016/j.ajic.2020.03.018

Suner-Solera, R., Grau-Martína, A., Flichtentrei, D., Prats, M., Braga, F., Font-Mayolas, S., & Gras, M. E. (2014). The consequences of burnout syndrome among healthcare professionals in Spain and Spanish speaking Latin American countries. *Burnout Research*, *1*, 82–89. https://doi.org/10.1016/j.burn.2014.07.004

Surkana, P. J., Mukherjee, J. S., Williams, D. R., Eustache, E., Louis, E., Jean-Paul, T., Lambert, W., Scanlanb, F. C., Oswald, C. M., & Fawzi, M. C. S. (2010). Perceived discrimination and stigma toward children affected by HIV/AIDS and their HIV-positive caregivers in central Haiti. *AIDS Care*, *22*(7), 803–815. https://doi.org/10.1080/09540120903443392.Perceived

Tandi, T. E., Kim, K., Gilbert, T. N., & Choi, J. (2018). Exposure and transmission risk of blood and body fluids among health care personnel at first level referral public hospitals in Meme division, Cameroon. *International Research Journal of Public Health*, *2*(22), 1–15.

Tapsfield, J. B., & Bates, M. J. (2011). Hospital based palliative care in sub-Saharan Africa; A six month review from Malawi. *BMC Palliative Care*, *10*(12), 8–13.

Tazakori, Z., Moshfeghi, S. H., & Karimollahi, M. (2017). Nurse's experiences of caring for patients with HIV/AIDS in Ardabil, Iran. *HIV : Current Research*, *2*(1), 1–4.

Tesfay, F. A., & Habtewold, T. D. (2014). Assessment of prevalence and determinants of occupational exposure to HIV infection among healthcare workers in selected health institutions in Debre Berhan town, North Shoa Zone, Amhara Region, Ethiopia, 2014. *AIDS Research and Treatment*, *2014*. https://doi.org/http://dx.doi.org/10.1155/2014/731848

Tetteh, D. D., Badu, E., Budu-Ainooson, A., Adusei-Nkrumah, J., Gyamfi, N., & Opoku, M. P. (2019). The burden of caregiving among mental health nurses providing services to consumers with depression in Ghana. *Perspectives of Psychiatric Care*, 1–9. https://doi.org/10.1111/ppc.12377

Thune´-Boyle, I. C. V, Stygall, J., Keshtgar, M. R. S., Davidson, T. I., & Newman, S. P. (2011). Religious coping strategies in patients diagnosed with breast cancer in the UK. *Psycho-Oncology*, *20*, 771–782.

Tjale, A. A., & Bruce, J. (2007). A concept analysis of holistic nursing care in paediatric nursing. *Curationis*, *30*(45–52).

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, *48*(4), 388–396.

Tong, H., Li, X., Qiao, S., Zhou, Y., Shen, Z., Yang, X., Zhang, Q., & Zeng, C. (2019). Sources and impact of work-related stress among HIV/AIDS health care providers in Guangxi, China. *Workplace HealtH & Safety*, *XX*(X), 1–11. https://doi.org/10.1177/2165079919857447

Tran, B. X., Phan, H. T., Latkin, C. A., Nguyen, H. L. T., Hoang, C. L., Ho, C. S. H., & Ho, R. C. M. (2019). Understanding global HIV stigma and discrimination: Are contextual factors sufficiently studied? (GAP RESEARCH). *International Journal of Environmental Research and Public Health*, *16*(1899).

Truman, A., Goldman, M., Lehna, C., Berger, J., & Topp, R. (2013). Verbal abuse of pediatric nurses by patients and families. *Kentucky Nurse*, *61*(1), 6–8.

Tsai, A. C., Hatcher, A. M., Bukusi, E. A., Weke, E., Hufstedlerd, L. L., Dworkin, S. L., Kodish, S., Cohen, C. R., & Weiser, S. D. (2017). A livelihood intervention to reduce the stigma of HIV in rural Kenya: Longitudinal qualitative study. *AIDS and Behaviour*, *21*(1), 248–260. https://doi.org/10.1007/s10461-015-1285-6.A

Tsheboeng, F. S. (2015). *The effects of home-based care of HIV/AIDS patients on caregivers: A case study of Mafikeng*. MA Dissertation, North-West University, (Mafikeng Campus), South Africa.

Turner, M. (1999). Involvement or over-involvement? Using grounded theory to explore the complexities of nurse-patient relationships. *European Joumal of Oncology Nursing*, *3*(3), 153–160.

Ullah, A. A. (2011). HIV/AIDS-related stigma and discrimination: A study of health care providers in Bangladesh. *Journal of the International Association of Physicians in AIDS Care (JIAPAC)*, *10*(2), 97–104. https://doi.org/10.1177/1545109710381926

UNAIDS. (2000). *Caring for carers: Managing stress in those who care for people with HIV and AIDS. UNAIDS case study*.

UNAIDS. (2014). *The gap report*.

UNAIDS. (2015). *UNAIDS Terminolog y Guidelines* (pp. 1–64).

UNAIDS. (2021). *Global AIDS update 2021*.

Urooj, S. (2012). Occupational stress and burnout in professional caregivers of people living with HIV/AIDS. *Social Work Chronicle*, *1*(1), 131–138.

Uwimana, J., & Struthers, P. (2007). Met and unmet palliative care needs of people living with HIV/AIDS in Rwanda. *SAHARA-J: Journal of Social Aspects of HIV/ AIDS*, *4*(1), 575–585. https://doi.org/10.1080/17290376.2007.9724819

Uys, L. R. (2003). Aspects of the care of people with HIV/AIDS in South Africa. *Public Health Nursing*, *20*(4), 271–280. https://doi.org/10.1046/j.1525-1446.2003.20404.x

Valjee, L., & van Dyk, A. C. (2014). Impact of caring for people living with HIV on the psychosocial well-being of palliative caregivers. *Curationis*, *37*(1), 1–13.

van Daalen, K. R., Cobain, M., Franco, O. H., & Chowdhury, R. (2021). Stigma: The social virus spreading faster than COVID-19. *Journal of Epidemiology and Community Health*, *75*(4), 313–314. https://doi.org/10.1136/jech-2020-214436 van der Colff, J. J., & Rothmann, S. (2014). Occupational stress of professional nurses in South Africa. *Journal of Psychology in Africa*, *24*(4), 375–384.

van Dyk, A C. (2010). *HIV/AIDS Care and counseling-A multidisciplinary approach* (4th ed.). Cape Town, South Africa, Pearson Education (Pty) Ltd.

van Dyk, A C. (2013). *HIV and AIDS education, care and counselling, a multidisciplinary approach* (5th ed.). Cape Town, South Africa, Pearson Education Pty Ltd.

van Dyk, Alta C. (2007). Occupational stress experienced by caregivers working in the HIV/AIDS field in South Africa. *African Journal of AIDS Research*, *6*(1), 49–66.

van IJzendoorn, M. H. (2012). Attachment-synthesis. In *Encyclopedia on early childhood development*. Montreal, Centre of excellence for early childhood development and strategic knowledge cluster on early child development. Retrieved from: http://www. child-encyclopedia. com/.

Vandenbroeck, S., Van Gerven, E., De Witte, H., Vanhaecht, K., & Godderis, L. (2017). Burnout in Belgian physicians and nurses. *Occupational Medicine (Oxford, England)*, *67*(7), 546–554.

Veda, A., & Roy, R. (2020). Occupational stress among nurses: A factorial study with special reference to Indore City. *Journal of Health Management*, *22*(1), 67–77.

Vernekar, S. P., & Shah, H. (2018). A study of work-related stress among nurses in a tertiary care hospital in Goa. *International Journal Of Community Medicine And Public Health*, *5*(2), 657–661.

Vryonides, S., Papastavrou, E., Charalambous, A., Andreou, P., & Merkouris, A. (2014). The ethical dimension of nursing care rationing: A thematic synthesis of qualitative studies. *Nursing Ethics*, *1*(20).

Wada, K., Smith, D. R., & Ishimaru, T. (2016). Reluctance to care for patients with HIV or hepatitis B/C in Japan. *BMC Pregnancy and Childbirth*.

Wakefield, B. J. (2014). Facing up to the reality of missed care. *BMJ Quality and Safety*, *23*, 92–94.

Waramlah, R., & Huda, B. Z. (2019). The interventions to improve standard precautions (SP) knowledge and practice among healthcare workers (HCWS): A systematic review. *International Journal of Public Health and Clinical Sciences*, 53–66.

Washington, C. H., & Oberdorfer, P. (2013). Perceived and experienced stigma and discrimination among caregivers of perinatally HIV-infected adolescents in Thailand. *Journal of Therapy and Management in HIV Infection*, *1*(2), 63–68.

Waters, E., Hamilton, C. E., & Weinfield, N. S. (2000). The Stability of Attachment Security from Infancy to Adolescence and Early Adulthood: General Introduction. *Child Development*, *71*(3), 678–683.

Watts, R., Botti, M., & Hunter, M. (2010). Nurses' perspectives on the care provided to cancer patients. *Cancer Nursing*, *33*(2), E1–E8.

West, C. P., Dyrbye, L. N., & Shanafelt, T. D. (2018). Physician burnout: contributors, consequences and solutions. *Journal of Internal Medicine*, *283*, 516–529. https://doi.org/10.1111/joim.12752

Weston, R., Portsmouth, S., & Benzie, A. (2006a). An update on HAART: part 1. *The Pharmaceutical Journal*, *276*, 631–634.

Weston, R., Portsmouth, S., & Benzie, A. (2006b). An update on HAART: part 2. *The Pharmaceutical Journal*, *276*, 693–696.

WHO. (2004a). *Practical guidelines for infection control in health care facilities*.

WHO. (2004b). The world health report 2004: Changing history. *World Health Report*, *95*(1), 96p. https://doi.org/10.2105/AJPH.2004.042002

WHO. (2005). *What is the impact of HIV on families?*

WHO. (2007). Standard precautions in health care. *Epidemic and Pandemic Alert and Response*, 268–268. https://doi.org/10.5005/jp/books/12675_65

WHO. (2013). *WHO nursing and midwifery progress report 2008-2012*.

WHO. (2014). *Guidelines on post exposure prophylaxis for HIV. Recommendations for a public health approach. Geneva, Switzerland* (Issue December Spplement).

WHO. (2019a). HIV/AIDS. Key facts. *Https://Www.Who.Int/News-Room/Fact-Sheets/Detail/Hiv- Aids, Accessed 1300 Hours, 16th August 2019*.

WHO. (2019b). WHO classifies burn-out as an "Occupational phenomenon." *Https://Www.Who.Int/Occupational_health/Topics/Stressatwp/En/ Retrieved 0930 Hours, 12th December 2019*.

WHO. (2020a). *Occupational health: Stress at the workplace.* Http://Www.Who.Int/Occupational_health/Topics/Stressatwp/En/ , Retrieved:2022-02-03.

WHO. (2020b). *Rational use of personal protective equipment for COVID-19 and considerations during severe shortages*.

WHO, ILO, & UNAIDS. (2011). *Improving health workers' access to HIV and TB prevention, treatment, care and support services: A guidance note*.

Wiles, R., Crow, G., Heath, S., & Charles, V. (2008). The management of confidentiality and anonymity in social research. *International Journal of Social Research Methodology*, *11*(5), 417–428.

Williams, A. (2001). A Study of practicing nurses' perceptions and experiences of intimacy within the Nurse-Patient relationship. 2001; 35: 188-196. *Journal of Advanced Nursing*, *35*, 188–196.

Williams, L. A. (2014). Theory of caregiving dynamics. In M. J. Smith & P. R. Liehr (Eds.), *Middle range theory for nursing* (3rd ed., pp. 309–327). New York, Springer Publishing Company, LLC.

Willis, J. W. (2007). *Foundations of Qualitative Research: Interpretive and Critical Approaches*. Thousand Oaks , CA, Sage Publications Inc.

Witczak, I., Rypicz, Ł., Karniej, P., Młynarska, A., Kubielas, G., & Uchmanowicz, I. (2021). Rationing of nursing care and patient safety. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.676970

Wolbers, M., Bucher, H. C., Furrer, H., Rickenbach, M., Cavassini, M., Weber, R., Schmid, P., Bernasconi, E., Hirschel, B., & Battegay, M. (2008). Delayed diagnosis of HIV infection and late initiation of antiretroviral therapy in the Swiss HIV cohort study. *HIV Medicine*, *9*, 397–405.

Wortmann, J. (2020). Religious coping. In *Encyclopedia of Behavioral Medicine* (2nd ed., pp. 1873–1875). Cham, Switzerland, Springer Nature.

Wouters, E., Van Damme, W., Van Rensburg, D., Masquillier, C., & Meulemans, H. (2012). Impact of community-based support services on antiretroviral treatment programme delivery and outcomes in resource-limited countries: A synthetic review. *BMC Health Services Research*, *12*(194).

Wright, A. A. (2016). *The lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida: A phenomenological inquiry*. PhD Dissertation in Nursing, Barry University, Miami, Florida, USA.

Wu, F., He, X., Guida, J., Xu, Y., & Liu, H. (2016). Network stigma towards people living with HIV/AIDS and their caregivers: An egocentric network study. *Global Public Health*, *10*(9), 1032–1045.

Wu, H., Liu, L., Wang, Y., Gao, F., Zhao, X., & Wang, L. (2013). Factors associated with burnout among Chinese hospital doctors: a cross-sectional study. *BMC Public Health*, *13*(1), 1. https://doi.org/10.1186/1471-2458-13-786

Wyżgowski, P., Rosiek, A., Grzela, T., & Leksowski, K. (2016). Occupational HIV risk for health care workers: risk factor and the risk of infection in the course of professional activities. *Therapeutics and Clinical Risk Management*, *12*, 989–994.

Yasin, J., Fisseha, R., Mekonnen, F., & Yirdaw, K. (2019). Occupational exposure to blood and body fluids and associated factors among health care workers at the University of Gondar Hospital, Northwest Ethiopia. *Environmental Health and Preventive Medicine*, *24*(18). https://doi.org/10.1186/s12199-019-0769-9

Yekple, C. K., Affram, C. K., & Donkor, E. S. (2014). Perceived risk of HIV infection among Midwives working in the labour wards. *Sci-Afric Journal of Scientific Issues, Research and Essays*, *2*(4), 141–146.

Yu, Y., Luo, D., Chen, X., Huang, Z., Wang, M., & Xiao, S. (2018). Medication adherence to antiretroviral therapy among newly treated people living with HIV. *BMC Public Health*, *18*(825), 1–8.

Zakeri, M. A., Rahiminezhad, E., Salehi, F., Ganjeh, H., & Dehghan, M. (2021). Burnout, anxiety, stress, and depression among Iranian nurses: Before and during the first wave of the COVID-19 pandemic. *Frontiers in Psychology*, *12*(789737), 1–9. https://doi.org/10.3389/fpsyg.2021.789737

Zarit, S., Todd, P., & Zarit, J. (1986). Subjective burdens of husbands and wives as caregivers: A longitudinal study. *Alzheimer Disease & Associated Disorders*, *1*(2), 109–110. https://doi.org/10.1097/00002093-198701020-00026

Zeb, A., Muhammad, D., & Khan, A. (2019). Factors affecting nurses' compliance to standard precautions in resource scarce settings. *American Journal of Biomedical Science & Research*, *4*(5), 384–389.

Zerfu, T. A., Yaya, Y., Dagne, S., Deribe, K., Ruisẽor-Escudero, H., & Biadgilign, S. (2012). Home and community based care program assessment for people living with HIV/AIDS in Arba Minch, Southern Ethiopia. *BMC Palliative Care*, *11*(8). https://doi.org/10.1186/1472-684X-11-8

Zheng, R., Lee, S. F., & Bloomer, M. J. (2018). How nurses cope with patient death: a systematic review and qualitative meta-synthesis. *Review Article*, 1–27. https://doi.org/10.1111/ijlh.12426

Zikhathile, T., & Atagana, H. (2018). Challenges facing home-based Caregivers in the management of health care risk waste. *International Journal of Environmental Research and Public Health*, *15*(2700).

Zongo, M., Capochichi, J., Gandaho, P., & Coppieters, Y. (2009). Psychosocial care of people living with HIV in Benin. *Sante Publique*, *21*(6), 631–639.

APPENDICES

Appendix A: Introductory Letter to 37 Military Hospital

UNIVERSITY OF EDUCATION, WINNEBA
FACULTY OF EDUCATIONAL STUDIES
DEPARTMENT OF PSYCHOLOGY AND EDUCATION
P. O. Box 25, Winneba, Ghana
psychology@uew.edu.gh
+233 (020) 2041070

20th August, 2019.

The Commander
37 Military Hospital
Neghelli Barracks
Accra.

Dear Sir/Madam,

LETTER OF INTRODUCTION

I write to introduce to you, CHRISTIAN KUMAH YEKPLE, the bearer of this letter who is a student in the Department of Psychology and Education of the University of Education, Winneba. He is reading Doctor of Philosophy in Guidance and Counselling with index number 9170170002

He is conducting a research on the topic: **CARING FOR THE CARER: EXPLORING THE LIVED EXPERIENCES OF NURSES CARING FOR HIV/AIDS PATIENTS IN SELECTED HOSPITALS IN ACCRA.** This is in partial fulfillment of the requirements for the award of the above mentioned degree.

He is required to administer questionnaire to help him gather data for the said research and he has chosen to do so in your outfit.

I shall be grateful if he is given permission to carry out this exercise.

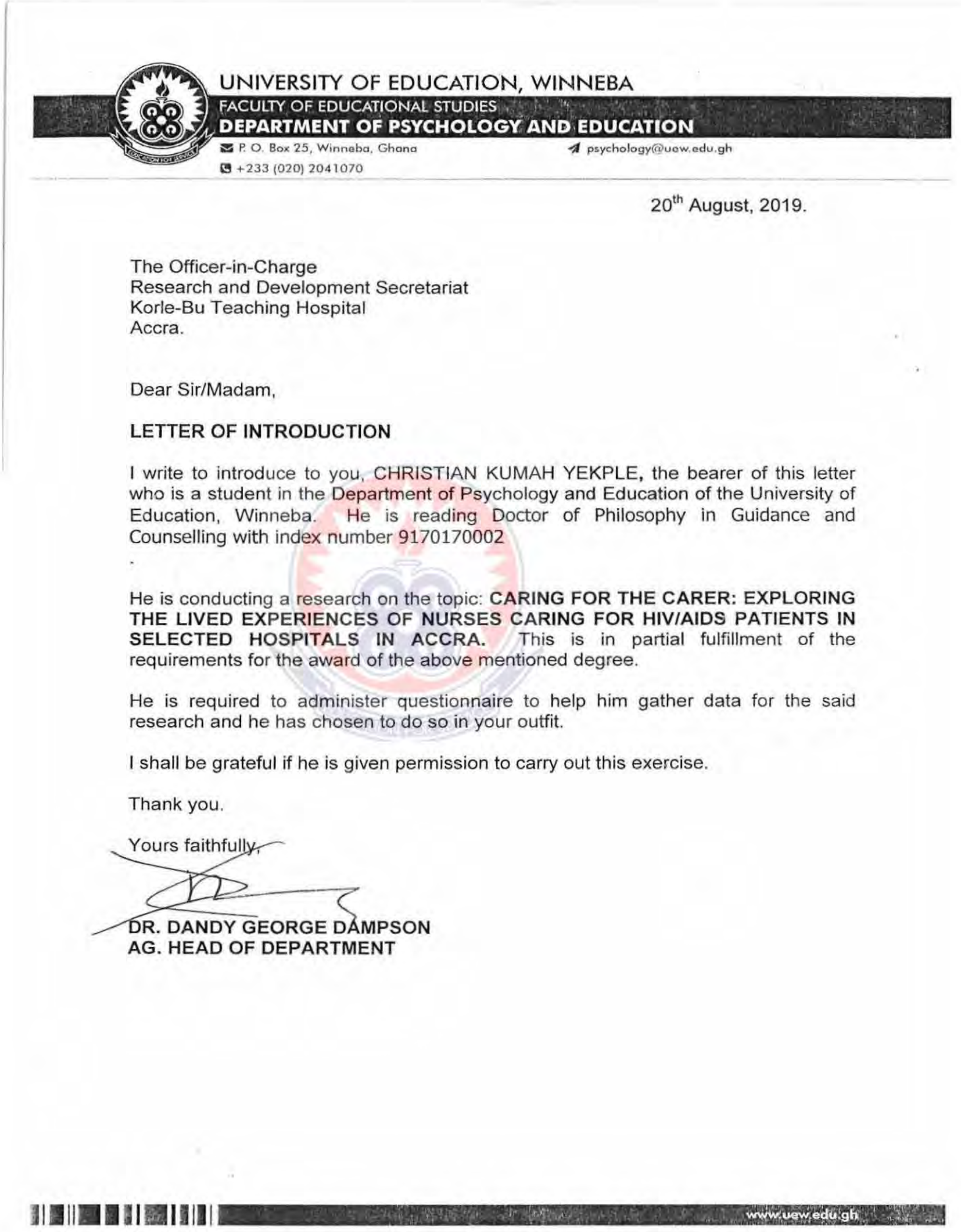
Thank you.

Yours faithfully,

DR. DANDY GEORGE DAMPSON
AG. HEAD OF DEPARTMENT

www.uew.edu.gh

Appendix B: Introductory Letter to Korle Bu Teaching Hospital, and the IRB



UNIVERSITY OF EDUCATION, WINNEBA
FACULTY OF EDUCATIONAL STUDIES
DEPARTMENT OF PSYCHOLOGY AND EDUCATION
✉ P. O. Box 25, Winneba, Ghana
psychology@uew.edu.gh
☎ +233 (020) 2041070

20th August, 2019.

The Officer-in-Charge
Research and Development Secretariat
Korle-Bu Teaching Hospital
Accra.

Dear Sir/Madam,

LETTER OF INTRODUCTION

I write to introduce to you, CHRISTIAN KUMAH YEKPLE, the bearer of this letter who is a student in the Department of Psychology and Education of the University of Education, Winneba. He is reading Doctor of Philosophy in Guidance and Counselling with index number 9170170002

.

He is conducting a research on the topic: **CARING FOR THE CARER: EXPLORING THE LIVED EXPERIENCES OF NURSES CARING FOR HIV/AIDS PATIENTS IN SELECTED HOSPITALS IN ACCRA.** This is in partial fulfillment of the requirements for the award of the above mentioned degree.

He is required to administer questionnaire to help him gather data for the said research and he has chosen to do so in your outfit.

I shall be grateful if he is given permission to carry out this exercise.

Thank you.

Yours faithfully,

DR. DANDY GEORGE DAMPSON
AG. HEAD OF DEPARTMENT

www.uew.edu.gh

Appendix C: Introductory Letter to the 37 Military Hospital IRB

UNIVERSITY OF EDUCATION, WINNEBA
FACULTY OF EDUCATIONAL STUDIES
DEPARTMENT OF PSYCHOLOGY AND EDUCATION
P. O. Box 25, Winneba, Ghana
psychology@uew.edu.gh
+233 (020) 2041070

8th November, 2019

The Chairman
Ethical Review Board
37 Military Hospital
Accra

Dear Sir,

LETTER OF INTRODUCTION

I write to introduce to you, **Christian Kumah Yekple**, the bearer of this letter who is a student in the Department of Psychology and Education of the University of Education, Winneba. He is pursuing a Doctor of Philosophy degree in Guidance and Counselling with index number 9170170002.

I write, in collaboration his supervisors, Dr Matthew K. Namale and Dr Samuel Asare Amoah, to confirm that approval has been given him to research on the topic "**Caring for the carer: Exploring the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra**".

I shall be grateful if he could be granted any assistance he may require from your outfit to enable him carry out this research.

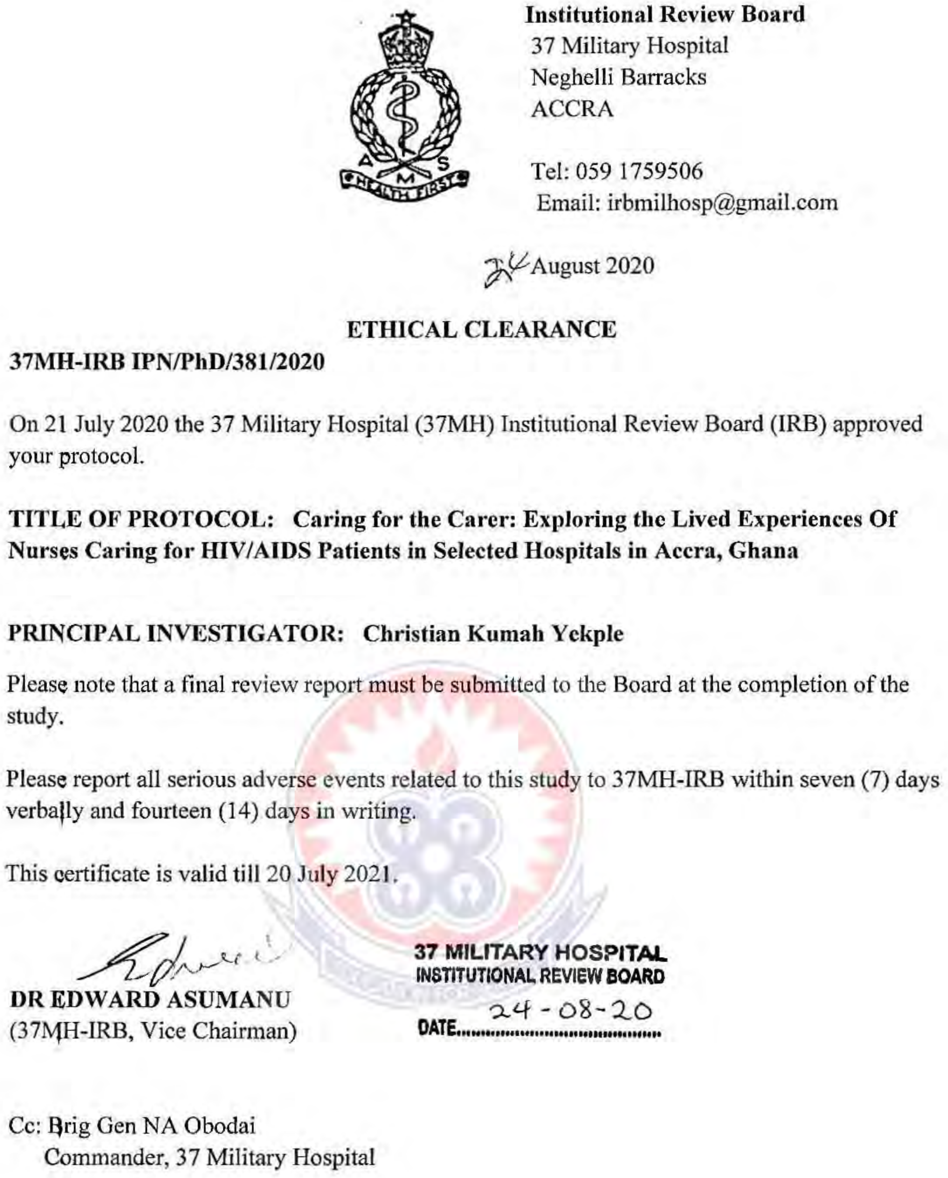
Thank you.

Yours faithfully,

Dr Richardson Addai-Mununkum
Departmental Graduate Coordinator

www.uew.edu.gh

Appendix D: Ethical Clearance from 37 Military Hospital IRB



Institutional Review Board
37 Military Hospital
Neghelli Barracks
ACCRA

Tel: 059 1759506
Email: irbmilhosp@gmail.com

24 August 2020

ETHICAL CLEARANCE

37MH-IRB IPN/PhD/381/2020

On 21 July 2020 the 37 Military Hospital (37MH) Institutional Review Board (IRB) approved your protocol.

TITLE OF PROTOCOL: Caring for the Carer: Exploring the Lived Experiences Of Nurses Caring for HIV/AIDS Patients in Selected Hospitals in Accra, Ghana

PRINCIPAL INVESTIGATOR: Christian Kumah Yekple

Please note that a final review report must be submitted to the Board at the completion of the study.

Please report all serious adverse events related to this study to 37MH-IRB within seven (7) days verbally and fourteen (14) days in writing.

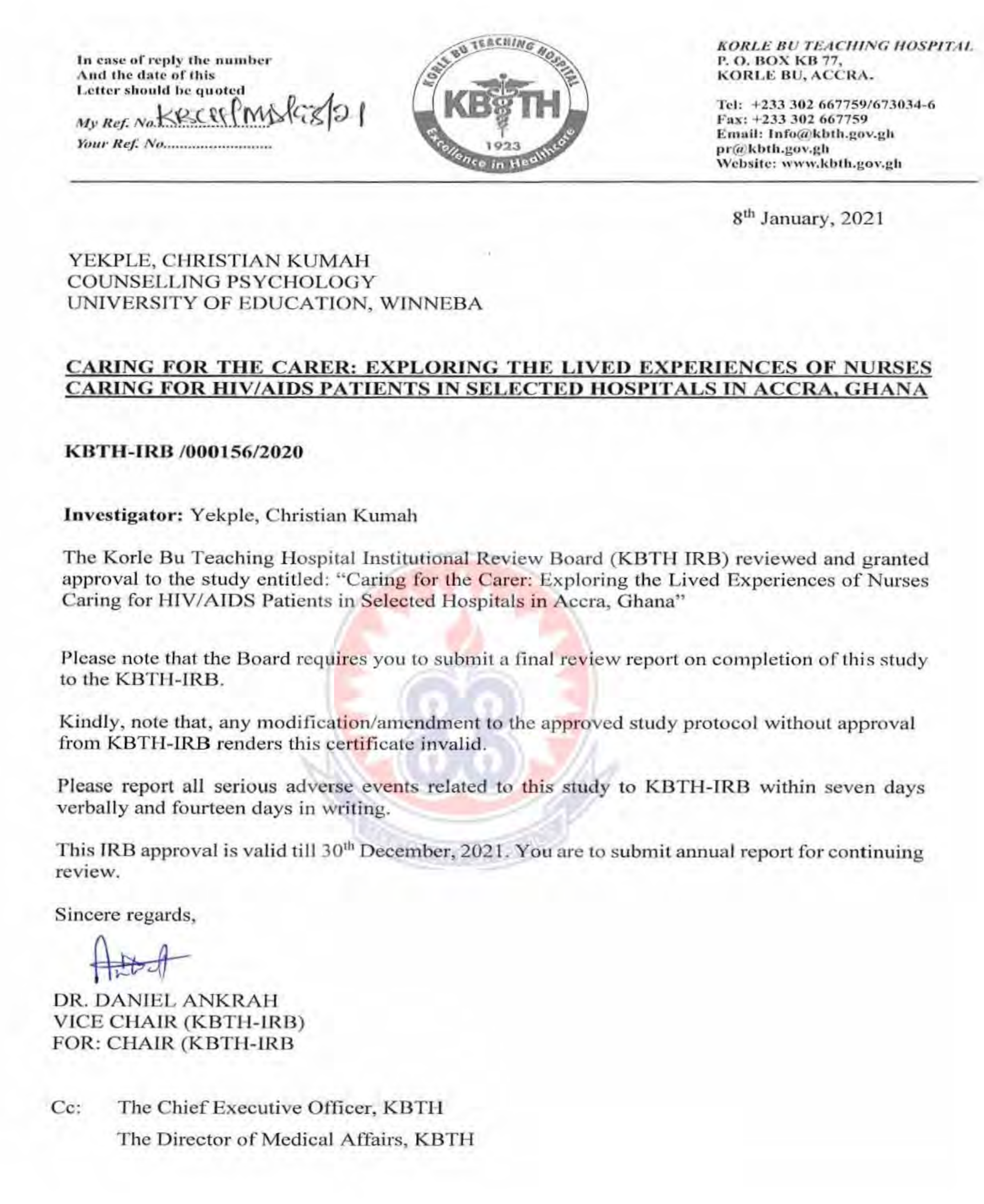
This certificate is valid till 20 July 2021.

DR EDWARD ASUMANU
(37MH-IRB, Vice Chairman)

37 MILITARY HOSPITAL
INSTITUTIONAL REVIEW BOARD
DATE 24-08-20

Cc: Brig Gen NA Obodai
Commander, 37 Military Hospital

Appendix E: Ethical Clearance from Korle Bu Teaching Hospital IRB



In case of reply the number
And the date of this
Letter should be quoted
My Ref. No. KBCEF/MSD/18/21
Your Ref. No...........................

KBTH
KORLE BU TEACHING HOSPITAL
1923
Excellence in Healthcare

KORLE BU TEACHING HOSPITAL
P. O. BOX KB 77,
KORLE BU, ACCRA.

Tel: +233 302 667759/673034-6
Fax: +233 302 667759
Email: Info@kbth.gov.gh
pr@kbth.gov.gh
Website: www.kbth.gov.gh

8th January, 2021

YEKPLE, CHRISTIAN KUMAH
COUNSELLING PSYCHOLOGY
UNIVERSITY OF EDUCATION, WINNEBA

CARING FOR THE CARER: EXPLORING THE LIVED EXPERIENCES OF NURSES CARING FOR HIV/AIDS PATIENTS IN SELECTED HOSPITALS IN ACCRA, GHANA

KBTH-IRB /000156/2020

Investigator: Yekple, Christian Kumah

The Korle Bu Teaching Hospital Institutional Review Board (KBTH IRB) reviewed and granted approval to the study entitled: "Caring for the Carer: Exploring the Lived Experiences of Nurses Caring for HIV/AIDS Patients in Selected Hospitals in Accra, Ghana"

Please note that the Board requires you to submit a final review report on completion of this study to the KBTH-IRB.

Kindly, note that, any modification/amendment to the approved study protocol without approval from KBTH-IRB renders this certificate invalid.

Please report all serious adverse events related to this study to KBTH-IRB within seven days verbally and fourteen days in writing.

This IRB approval is valid till 30th December, 2021. You are to submit annual report for continuing review.

Sincere regards,

DR. DANIEL ANKRAH
VICE CHAIR (KBTH-IRB)
FOR: CHAIR (KBTH-IRB

Cc: The Chief Executive Officer, KBTH
The Director of Medical Affairs, KBTH

Appendix F: Information and Informed Consent Form

My name is Mr Yekple Christian Kumah and I am a Doctor of Philosophy in Counselling Psychology student at the Department of Counselling Psychology, University of Education, Winneba. The research I wish to conduct for my Doctoral thesis is entitled: *Caring for the carer: Exploring the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana.* I, respectfully, wish to invite you to be a participant in the research. Please find below information about the research.

Title: Caring for the carer: Exploring the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana

Principal Investigator: Yekple Christian Kumah

Address: Department of Counselling Psychology, University of Education, Winneba,

P.O. Box 25, Winneba.

Tel: 0243156811

General Information about Research

Background**:** Nurses are the frontline personnel who provide care to HIV/AIDS patients who are admitted to hospitals. They have prolonged and regular contact with the patients. Researches have shown that caring for HIV/AIDS patients poses a great challenge to the nurses. They experience physical and psychological challenges which, if left unattended to, could adversely affect their personal health, and compromise the quality of care they render to the patients. If we are able to identify the work-related challenges, problems, and experiences of the nurses who care for HIV/AIDS patients on admission, then it could be possible to address them and provide the appropriate support systems that could help the nurses overcome these experiences and challenges or cope with them.

Purpose**:** The purpose of the study is to explore the lived experiences of nurses caring for HIV/AIDS patients with a view of finding means of developing support systems to help the nurses cope with challenges associated with the caregiving role.

Study Procedures**:** The study will involve face-to-face interview sessions which may last between 30 and 45 minutes. A second interview may be conducted, if necessary, for the purpose of clarification and verification of information collected during the first interview. With your permission, the interviews will be audiotaped and later transcribed to facilitate analysis. The interview will take place in a location and time mutually agreed upon by you and me.

The information that will be sought during the interview will be about your experiences and challenges as a nurse while caring for HIV/AIDS patients on admission in the ward. Direct observations will also be done in the ward to have first-hand information about your experiences and the challenges you face while caring for the patients.

Possible Risks and Discomforts

It is not anticipated that you will face any physical harm by participating in this study. However, if the interview sessions will cause any emotional distress to you, the researcher will liaise with his supervisors, who are professional counsellors, to assist you to overcome those distresses.

Possible Benefits

There is no direct personal benefit to you for participating in this study. You will however be provided with snacks and pastries during the interview period. Additionally, your participation will contribute to the documentation of experiences of and challenges faced by nurses who care for HIV/AIDS patients and help in finding means of developing support systems to help the nurses cope with challenges associated with the caregiving role.

Confidentiality

Any information you provide while participating in the study will be kept strictly confidential. Your name or personal data will not be mentioned in the records. You will only be identified by a Code number. No information that will link you in any way to the information you provided during your participation will be revealed to anyone. Any report published as a result of this study will not identify you by name.

Voluntary Participation and Right to Leave the Research

Your participation in this study is voluntary: you are under no obligation to participate and you have the right to withdraw at any time. Feel free to make any inquiries regarding the study at any point during or after the interview.

Contacts for Additional Information

If you need answers to any pertinent questions about the research, you may contact my supervisors as follows:

1. Professor Samuel Asare Amoah, Department of Psychology and Education, University of Education, Winneba.
Tel: 0208131469
2. Professor Matthew Namale, Department of Psychology and Education, University of Education, Winneba.
Tel: 0201665951

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of the 37 Military Hospital (37 MH-IRB), and the Institutional Review Board for Medical Research of the Korle Bu Teaching Hospital (KBTH-IRB). If you have any questions about your rights as a research participant you can contact either the 37 MH-IRB office between the hours of 7:30am-3:00pm through the landline 0302 769667 or IRB Administrator (Prince Yaw Ashitey – 024 300 4247) or email addresses: irbmilhosp@gmail.com **OR** the KBTH-IRB office between the hours of 8am-5pm through the landline 0302666766 or email addresses: rdo@kbth.gov.gh

Appendix G: Volunteer Agreement Form

The above document describing the benefits, risks and procedures for the research titled **"Caring for the carer: Exploring the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana"** has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

____

Name and signature or mark of participant

____

Date

Appendix H: Interview Guide for Nurses

INTRODUCTION: My name is Yekple Christian Kumah. I am a Doctor of Philosophy in Guidance and Counselling student at the Department of Counselling Psychology, University of Education, Winneba. I am conducting a study titled "Caring for the carer: Exploring the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana". The study seeks to explore the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana, with a view of recommending care and support systems that will help mitigate the challenges they encounter while caring for the patients. I respectfully invite you to participate in the study. Thank you very much for your co-operation.

SECTION A: DEMOGRAPHIC INFORMATION

1. Gender
2. Age
3. Marital Status
4. Educational Level
5. Your current nursing rank
6. Duration of practice as a nurse
7. How long have you been working in this ward?

SECTION B: CARING FOR HIV/AIDS PATIENTS

1. Did you choose to work in this ward?
2. Did you receive any special training on caring for HIV/AIDS before you were posted to the isolation ward?
3. Please can you share with me your reactions when you were first posted to the isolation ward?
4. Please share with me the daily caregiving activities you usually perform for the patients.
5. Apart from what you have just described, are there any other things you do for the patients?
6. Are there any of these activities that you consider more demanding?
7. Do you enjoy working in this ward?

8. Is there anything else you would like to share about your experiences as a caregiver to these patients?

SECTION C: CHALLENGES ASSOCIATED WITH CAREGIVING

1. How many nurses are usually on duty for a shift?
2. Would you say this staff strength is adequate?
3. What material resources do you usually require for your caregiving functions?
4. Are these materials usually available for you to work with?
5. What do you normally do if these materials are not readily available?
7. Kindly share with me your experiences or the challenges you encounter while caring for the patients.
8. Do you feel stressed by your work?
9. Are there any things about your work that make you feel stressed?
10. Do you normally report these challenges to any one?

SECTION D: IMPACT OF WORK-RELATED CHALLENGES

1. Do the work-related challenges/experiences affect you personally in any way?
2. Please share with me how they affect you.
3. Does your working in the isolation ward affect your relationship with your family members? (If yes, how?)
4. Do these challenges affect how you care for the patients?
5. Can you please share with me how these challenges or experiences affect your care giving functions?

SECTION E: SUPPORT SYSTEMS FOR THE NURSES

1. What support services or systems are available to help you deal with the challenges associated with your caregiving functions?
2. Are there any processes you need to follow in accessing these services?
3. Would you say that these support services are enough in helping deal with the challenges associated with your caregiving functions?
4. Can you think of any other services that could be of help in dealing with the challenges associated with your caregiving functions?

SECTION F: COPING STRATEGIES

1. Are there any policies in place to help you deal with the challenges you face while caring for the patients?
2. What should be done to help you cope with these challenges/ experiences?
3. What do you personally do to help you cope with these work-related challenges/experiences?
4. When you feel stressed due to challenges you encounter, what do you do?
5. Are there any other activities you engage in to reduce the challenges associate with your caregiving functions?
6. What do you do when faced with inadequate staff strength in the ward?
7. What do you do to cope with insufficient materials for your work?
8. Is there any other information you want to share with me about what you do to cope with your caregiving experiences?
9. Finally, is there anything else you will like to share with me about your work as caregiver to HIV/AIDS patients?

Thank you.

Appendix I: Interview Guide for Nurse Managers

INTRODUCTION: My name is Yekple Christian Kumah. I am a Doctor of Philosophy in Guidance and Counselling student at the Department of Counselling Psychology, University of Education, Winneba. I am conducting a study titled "Caring for the carer: Exploring the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana". The study seeks to explore the lived experiences of nurses caring for HIV/AIDS patients in selected hospitals in Accra, Ghana, with a view of recommending care and support systems that will help mitigate the challenges they encounter while caring for the patients. I respectfully invite you to participate in the study. Thank you very much for your co-operation.

SECTION A: DEMOGRAPHIC INFORMATION

1. Gender
2. Age
3. Marital Status
4. Educational Level
5. Your current nursing rank
6. Duration of practice as a nurse
7. How long have you worked in this ward as a nurse manager?

SECTION B: WORKING AS A WARD MANAGER

1. Did you choose to work in this ward?
2. Did you receive any special training on caring for HIV/AIDS before you were posted to the isolation ward?
3. What is involved in your job as the nurse manager in this ward?
4. What challenges do you face as the nurse manager?
5. What work-related challenges do your nurses report to you?
6. How do you help them deal with their challenges?

SECTION C: SUPPORT SYSTEMS FOR THE NURSES

1. Are there any support systems in place for helping the nurses deal with their work-related challenges or experiences?
2. Do the staff feel satisfied with the support systems in place for helping the nurses deal with their work-related challenges or experiences?
3. Are you happy working in this ward?
4. Would you say your staff are happy working in this ward?
5. Is there anything else you will like to share with me about your work as the manager of this ward?

Thank you.