Published in final edited form as:

Int Q Community Health Educ. 2010 ; 31(2): 155–169. doi:10.2190/IQ.31.2.d.

“I HAVE LOST SEXUAL INTEREST ...”—CHALLENGES OF BALANCING PERSONAL AND PROFESSIONAL LIVES AMONG NURSES CARING FOR PEOPLE LIVING WITH HIV AND AIDS IN LIMPOPO, SOUTH AFRICA*

YEWANDE SOFOLAHAN, B.S.,

Penn State University, University Park, Pennsylvania

COLLINS AIRHIHENUWA, Ph.D., M.P.H.,

Penn State University, University Park, Pennsylvania

DAISY MAKOFANE, Ph.D., and

University of Limpopo, Turfloop Campus, South Africa

EPHRAIM MASHABA

University of Limpopo, Turfloop Campus, South Africa

Abstract

As part of a capacity-building research project, this study examined the extent to which caring for people living with HIV and AIDS (PLWHA) affects both professional and personal relationships of nurse caregivers. The data were collected using focus group interviews with 17 female nurses at two Limpopo hospitals. The PEN-3 cultural model was used as a theoretical framework for exploring how nurses balance job demands with family responsibilities. The results generated three themes: the multiple identities nurses experience within their family and professional lives; nurse attitudes related to patient gender; and stigma experienced by nurses who care for PLWHA. Caring for PLWHA influences nurses' personal and professional lives by interfering with their perceptions and emotions as they relate to spousal, parental, and gendered relationships. The findings offer insight into factors requiring consideration when designing interventions to help nurses cope with the stress associated with caring for PLWHA while simultaneously managing family responsibilities.

INTRODUCTION

Many researchers have studied nurses who care for people living with HIV and AIDS (PLWHA) as people who stigmatize and who also experience stigma within the professional healthcare context [1–5]. However, only few studies have attempted to fully explore the experiences of nurses who care for PLWHA and the personal impact it has on their family lives [5, 6]. Even fewer studies have addressed the negative psychological impact caring for PLWHA has on nurses and the resulting effect on their job performance. Within the few studies that have addressed this issue, the main focus has been on identifying occupational risks these nurses experience, such as work overload and fear of occupational exposure to the disease [4, 5].

*This research was supported by the U.S. National Institutes of Health; R24 MH068180.

© 2011, Baywood Publishing Co., Inc.

Direct reprint requests to: Yewande Sofolahan, Doctoral Candidate, Department of Biobehavioral Health, 315 Health and Human Development East, Penn State University, University Park, PA 16802, yas108@psu.edu.

There is little knowledge about how caring for PLWHA affects nurses, especially regarding their attitudes toward patient gender. The difficulties nurses experience in balancing their personal and professional lives also warrants further exploration. Emerging from a larger capacity-building study on developing a cultural index for HIV stigma, this article presents findings related to the professional and personal life experiences of nurses who care for PLWHA.

BACKGROUND

South Africa has approximately 5.7 million PLWHA, representing 10.9% of the country's population and constituting the largest number of PLWHA worldwide [7]. In Limpopo province, where this study was conducted, HIV prevalence was found to be about 8% and the annual incidence rate was estimated to be about 2.4% [7]. Limpopo is rural with a predominantly black population and is one of the poorest provinces in South Africa [8]. It constitutes about 10.6% of South Africa's population (5.2 million in July 2009) and it has the highest population growth rate in the country [9]. Among all of the provinces in the country, Limpopo ranks near the bottom in terms of quality of life indicators including life expectancy, unemployment rate, literacy rate, and health. People from the poorer provinces rely heavily on public healthcare services [7], and Limpopo is no exception; it has the most people (87%) using public healthcare services in the country [10].

Bearing this in mind, nurses are acknowledged as important caregivers in South Africa. The nurse to population ratio in South Africa is 1:443 compared to the World Health Organization's minimum standard for nurse to population ratio of 1:500 [11]. This ratio appears to be better than the WHO recommended ratio, but it is actually far worse since not all nurses enrolled with the South African Nursing Council (SANC) are currently working in South Africa. Given that Limpopo has one of the highest HIV rates and is among the least-resourced provinces with actual practicing nurse to population ratio of 1:606, the role of nurses in caring for PLWHA becomes even more critical [12].

Studies from other countries have explored the experiences of nurses in caring for PLWHA. In Taiwan, Juan and colleagues found that Taiwanese nurses have many concerns and fears regarding HIV and AIDS that impact their attitudes toward caring for PLWHA [13]. In Uganda, Walusimbi and Okonsky found that fear of contagion is common among nurses who cared for PLWHA [14]. Also, in Northern England, Hayter found that burnout is significant among HIV community clinical nurse specialists [15]. Some of the challenges that are commonly expressed by nurses include being overworked, feelings of helplessness, emotional stress and fatigue, fear of contagion from occupational exposure, stigma by association with PLWHA, and being unable to separate their personal lives from their professional lives, given the caring and nurturing roles these women have in their families.

In the public hospitals in South Africa, it is estimated that one in every three to four people admitted to the hospital is infected with HIV [4, 16]. The burden of HIV and AIDS is taxing on healthcare workers, especially on nurses who directly care for PLWHA. Complete care for PLWHA includes a variety of services, including voluntary counseling and testing (VCT), preventing mother to child transmission (PMTCT), sex education, nutrition classes, and many others. Often, nurses are primarily responsible for providing these services, playing the role of counselor and nutritionist in addition to the role of physical caregiver [17].

Some studies have suggested that equipping nurses with sufficient HIV and AIDS knowledge would significantly help reduce contagion fears and other challenges presented by caring for PLWHA [18, 19]. Reis, Heisler, Amowitz, et al. [20] concluded that healthcare

providers who reported receiving inadequate training on HIV treatment and ethics admitted to treating PLWHA negatively. However, these suggestions do not address how to cope with the negative psychological impact and emotional drain experienced by nurses, and the subsequent effects on their families and personal relationships. For example, Delobelle, Rawlinson, Ntuli, et al. [5] found that nurse relationships with partners, children, and other family members were affected by caring for PLWHA, and that nurses reported experiencing secondary stigma from community and family members. Lehmann and Zulu [6] reported that stress experienced in the family lives of the nurses they interviewed was a major theme that resulted from their study. Many nurses indicated that their sex lives and their relationships with their children were negatively affected [17].

Given that nurses are critical to the care of PLWHA, it is important to explore their attitudes and experiences within professional and personal contexts so that interventions can be designed to help them balance the demands of work and family.

THEORETICAL FRAMEWORK

The PEN-3 cultural model, a tool developed to aid in understanding the role of culture in the health behaviors and decisions made by people from African countries, was the organizing framework that guided the study [21–23]. Unlike other models and theories commonly used by social psychologists, this model moves the focus away from the individual by considering other contextual and collective factors that help to shape individual decisions [22].

PEN-3 has three domains and each domain has three dimensions. The three interconnected domains are Cultural Empowerment, Relationships and Expectations, and Cultural Identity. In the first domain of Cultural Empowerment, PEN stands for the *Positive* values that promote the health decisions or behaviors of the person, *Existential* values or those unique attributes specific to the culture that pose no health threat, and *Negative* values or those health decisions or behaviors rooted in cultural practices that may cause harm. The second domain of Relationships and Expectations includes the *Perceptions* held by people that may promote or hinder health behaviors and decisions, the *Enablers* who may encourage or discourage healthy behaviors and practices, and the *Nurturers* who support the reinforcement or discouragement of healthy behaviors. The third domain of Cultural Identity, which is usually the point of entry for the intervention, examines how identity plays a critical role in influencing decisions in the context of the *Person*, the *Extended Family*, and the *Neighborhood*. PEN-3 has been used in other publications related to this project to address the nature of overall stigma relative to culture and identity [24], the role of family [25], the role of disclosure within the context of motherhood [26] and the role of food [27].

METHODS

Aim

The aim of the study was to explore the impact of caring for PLWHA on nurses' personal and professional lives.

Design

A qualitative research design using focus group interviews was conducted with nurses who had experience caring for PLWHA.

Participants

Purposive sampling was used to identify and recruit registered nurses who care for PLWHA and speak English. Nurses were recruited by a trained graduate student from the Polokwane ($n = 9$) and Mankweng ($n = 8$) hospitals. The sample size was determined using data saturation. The graduate student conducted the focus group with the aid of a research assistant who served as co-facilitator. All of the recruited nurses were female, with variations in terms of age and number of years in the nursing profession.

Data Collection

The data was collected by a University of Limpopo graduate student during the third year of the larger stigma project in December 2007. Data was collected during one focus group session in each location and was conducted in English, with each session lasting between 60 and 75 minutes. All focus group interviews were recorded with permission from the participants, and later transcribed. Data collection techniques, such as the criteria used to determine the interview questions, research validity, and reliability, were the same as those described in an earlier study from the same project (see [24]).

The focus group interview guide included topics relating to the challenges HIV/AIDS nurses experience, current precautionary practices, gender differences in treatment of PLWHA, and the impact of caring for PLWHA on work performance and family relationships, especially those with spouses and children. Open-ended questions were posed to the nurses to elicit responses that generated themes on how caring for PLWHA influenced their personal and professional life encounters.

Ethical Considerations

The study protocol was reviewed and approved by the institutional review boards of Pennsylvania State University and the Human Sciences Research Council of South Africa. Participants were informed of the objectives of the study, the types of questions they would be asked, the duration of the interview, their rights to refuse to answer questions that made them uncomfortable, and the fact that their responses could not be linked to their identities. Each participant then read and signed the informed consent form. At the beginning of each interview, permission to record was obtained, and an identifying number was assigned to ensure anonymity.

Data Analysis

All focus group data were entered into NVivo 2.0, a qualitative software program designed by QSR International for organizing qualitative research data [28]. The software was used to organize transcripts and to code and manage the data. Thematic coding techniques consisting of open coding on a line-by-line basis were used to analyze content [29]. First, the underlying meanings of words or ideas in the text were identified. Each idea in the text that was relevant to the research topic (open code) was organized into a new meaningful word (category) through axial coding. Through data coding, three relevant themes emerged on how caring for PLWHA affects the professional and non-professional lives of nurse caregivers.

Following the recontextualization approaches of Morse and Field [30] and Cresswell [31], the themes were positioned to fit within an existing theoretical model. In this study, the 3×3 table of PEN-3 (see Figure 1) was used to position the results within the context of existing knowledge by further capturing the range of nurse experiences from positive to negative. Nine categories were generated by crossing the Relationships and Expectations domain with the Cultural Empowerment domain. The quotes in each category indicate positive, existential, and negative experiences rather than focusing only on the negative. It should be

noted that not all nine categories will be discussed, because they have been addressed previously by other scholars [4, 5, 32] or are not relevant to the current research.

Validity and Reliability

Credibility and trustworthiness were ensured through member checking. This entailed presenting emergent themes with participants at the end of each interview to verify that the researcher's interpretation truly reflected their views. In both sessions, we found the researcher's accounts to be consistent with those of the nurses. Peer checking was another test of qualitative reliability used to ensure credibility. An experienced colleague from South Africa reviewed the data and verified that what was written adequately reflected nurse experiences in Limpopo. After the transcription was complete, the graduate student who moderated the focus groups reviewed the data to ensure that it correctly captured all that was discussed.

RESULTS

The study participants were 17 female nurses working in the Polokwane Provincial Hospital in Polokwane City and Mankweng Hospital in Sovenga Township. All interviewed nurses had at least 1 year of experience caring for PLWHA and were hospital staff members. Six nurses acknowledged that their emotions often got in the way of being able to dispense their professional duties as caregivers, four nurses admitted to treating female PLWHA differently from their male counterparts, two nurses admitted to experiencing stigma by virtue of their role as caregivers of PLWHA, and three nurses reported that they treated all patients the same or did not respond at all. Data analysis revealed three main themes:

- setting boundaries between professional and non-professional life;
- nurse attitudes relative to PLWHA gender; and
- “stigma by association” due to caring for PLWHA.

Existential Role of Nurses: Setting Boundaries between Professional and Non-Professional Life

For nurses with family members or friends in the community living with HIV and AIDS, setting boundaries between their professional and non-professional lives is difficult due to their unique roles as caregivers. These nurses experience multiple identities at home and at work as they care for PLWHA in both settings. These nurses “don’t only teach, but also sit with them [PLWHA] and listen to their views and concerns about HIV/AIDS.” Close relationships with PLWHA in their personal lives is beneficial to nurses, as it strengthens their relationships with patients. However, such closeness also presents major emotional challenges to nurses in terms of their ability to set well-defined boundaries between their private and professional lives. Some nurses spoke about the emotional instability created by HIV and AIDS in their family roles as wives and mothers. When asked about her family life, one participant remarked:

Caring for HIV/AIDS patients affects me in my family. Presently, I have a problem of making love to my husband. I associate every man [to be a] carrier of the disease [HIV/AIDS]. I have lost sexual interest because of the fear of AIDS and other infection.

Sometimes encounters with PLWHA blurs some of those boundary lines nurses have drawn to separate their work from their personal lives. Often, these nurses can identify with patients at work when they test HIV positive. This induces empathy because each time a patient tests positive, “it reminds you of your own family members who died of AIDS or those who you care for because they are HIV positive.”

Perhaps the most revealing challenge occurs when a nurse feels her professional role is interfering with her role as a mother. The agency of motherhood in the African context is addressed in another paper [26]. Our findings reveal a similar agency on the part of nurses, who previously had only been studied in a professional context. Encounters with female PLWHA often cause nurses to question their roles as mothers, especially regarding the safety of their children. One participant remarked, “Our children are not safe because we are always out (attending workshops and trainings) leaving them without supervision which makes them vulnerable for infections.”

Beyond the challenges that caring for PLWHA presents to family roles, many nurses express frustration over HIV and AIDS workshops and training sessions aimed at helping them to become better nurses caring for PLWHA. Nurses believe that these programs should incorporate training sessions on how to deal with the complexities of PLWHA caregiving while balancing their non-professional roles with their professional roles. This is captured in the words of one participant: “Many HIV/AIDS programs take our family time in order to attend workshops and training so that we even fail to take care of our families as mothers.”

Positive Outcomes Related to Gender-Based Attitudes of Nurses toward PLWHA

In the positive category of PEN-3, caregiver empathy increases support for PLWHA. An important finding in this study was that some nurses reported being more sympathetic toward HIV-infected women than men. This empathetic feeling toward women was born out of the belief that “men are responsible for spreading HIV/AIDS,” and that “men are deliberate and purposeful carriers of the virus.” When asked if male PLWHA are treated differently from female PLWHA, one participant said:

My sympathy is always with female patients. Mostly black women are faithful in their relationship but men believe in multiple sexual relationships. I always protect women patients. Men with multiple partners come in the house with infections or virus and infect innocent women in the house.

Emotional empathy may be stronger when the patient is a woman with whom the nurses can identify with as wives, mothers, and caregivers in the family.

I can't treat them the same. With women I am very much emotionally touched because I think of the orphans she will leave behind after her death. Women are caregivers of children in the family, men always get nursing even from their families and relatives, but women will be in their homes without proper care.

When interacting with PLWHA, many of the nurses admit to being “emotionally affected” or “emotionally touched” and “feeling pity for them,” especially for female PLWHA, which poses a challenge to fulfilling job obligations. One participant explained:

I understand that I have to treat them [all patients] the same, but once I am faced with an HIV/AIDS patient, especially women, I get emotionally affected. I think of his/her family and community. I end up being more closely attached to the patient. I end up spending more time with HIV patient than those who are negative.

Negative Consequence of PLWHA Care: Stigma by Association

Some of the participants report experiencing “stigma by associating with HIV positive patients.” This means they are stigmatized as nurses by the fact that they care for PLWHA. This “stigma by association” reportedly discourages PLWHA from freely disclosing their status to nurses, which prevents them from accessing much needed help. One nurse reported that, “Ever since the outbreak of this disease HIV and AIDS, we have been labeled.” This labeling poses as a challenge to effectively caring for PLWHA while simultaneously maintaining other relationships outside of their job.

This is especially true for nurses who provide in-home care to PLWHA. They have been negatively labeled as AIDS carriers, and such misperceptions result in unfriendly and unwelcoming attitudes from the patients' families whenever they visit. Even when patients who are visited at home have a disease other than HIV and AIDS, the nurses are still labeled and stigmatized since they also care for AIDS patients. As one nurse remarked that, "the patients we visit at home are regarded [by the community] as HIV-positive even though one does not have the truth about that. This makes it difficult for the patients' families to welcome us into their houses."

For the two nurses who reported experiencing stigma by associating with PLWHA, this negative attitude is a source of frustration, and discourages them from conducting future home visits. This problem of "stigma by association" is further compounded when family members refuse to give nurses entry into their homes to care for sick relatives. It seems as though the fear of what neighbors will say overwhelms the need for accessing treatment.

DISCUSSION

Study Limitations

The results of this study may not be transferrable to other areas, as what constitutes the experiences of nurses caring for PLWHA may vary depending on location. In addition, nurses who participated in the focus groups were purposively selected from two hospitals in Limpopo province, and as such their experiences with caring for PLWHA may not be the same as those of nurses based in other locations or clinical settings. Since there were no male nurses included in the sample, there could be gender differences in terms of how caring for PLWHA affects nurses. Finally, the experience of nurses caring for PLWHA could be considered sensitive information, thereby preventing the nurses from fully relating their experiences for fear of jeopardizing their jobs.

Study Outcomes

Qualitative data analysis reveals that examination of different work and family contexts is needed in order to understand the extent to which caring for PLWHA in South Africa impacts the lives of nurses. Given that nurses are critical to the level of care received by PLWHA, their attitudes and perceptions within the contexts of their familial and professional relationships were explored. Acknowledging the different roles nurses play, within both their family and community, and how the demands of these roles are sometimes in juxtaposition with the demands of caring for PLWHA sheds more light on the challenges nurses encounter. Rather than seeing them only as perpetrators of stigma, it is important to acknowledge how nurses themselves are impacted by caring for PLWHA.

Using the PEN-3 cultural model as our organizing framework, we were able to group the themes that emerged as: *positive* attitudes of nurses relative to PLWHA gender, the *existential* (unique) challenges nurses face in setting boundaries between professional and non-professional relationships, and the *negative* consequence of PLWHA care experienced as "stigma by association."

In the positive category (see Figure 1), the main theme that emerged was the attitude of nurses relative to patient gender, with the decision to support female PLWHA being prominent. Findings similar to this were reported in a study conducted in South Africa on nurse perceptions of HIV and AIDS, where it was noted that more than half of the nurses in their sample reported being compassionate and empathetic to PLWHA and their family members, especially if the nurses also had family members living with or dying from HIV and AIDS [4, 32]. However, to our knowledge, no previous studies revealed our finding of nurses being more sympathetic toward female PLWHA than male PLWHA.

Caring for PLWHA sometimes created negative responses toward nurses. The main theme in the negative category was the stigma nurses experienced by caring for PLWHA, or “stigma by association.” This negative attitude often influenced some decisions by nurses on how to care for and support PLWHA. Similar findings were reported by Smit [32] that a source of anger and frustration from the nurses was due to being stigmatized for taking care of PLWHA. A study on nurse perceptions of stigma by Holzemer and colleagues [33] in five African countries was conducted to understand the effects of stigma on the quality of care given to PLWHA. In a similar study, they reported that AIDS stigma was found to negatively influence PLWHA and their healthcare providers in South Africa [34]. Similar to our findings, in another study nurses reported experiencing stigma by association from their families and patients’ families once they were associated with caring for PLWHA [5].

Understanding the existential (unique) role of nurses as caregivers both at home and at work have revealed some of the challenges they experience in setting boundaries between professional and non-professional relationships. HIV and AIDS prevalence in South Africa have made it almost impossible for nurses to separate their care-giving work from their family and social relationships, since many nurses also take care of family members with HIV/AIDS [4, 32]. The care-giving task has become especially daunting for nurses, since they get no respite; when they get to work they are tired, and when they leave work they are also tired [4, 32]. The author further suggested that perhaps some nurses stigmatize PLWHA because of the enormous amounts of stress they face both at home and at work in caring for PLWHA; the only stress relief outlet some of them may have is their patients [4, 32]. Holzemer and Uys [34] suggested that a thorough understanding of the attitudes of healthcare providers toward PLWHA can serve as a point of entry for interventions aimed at eliminating stigma among healthcare workers and, through them, eliminating stigma among the general populace.

CONCLUSION AND RECOMMENDATIONS

Given that nurses are critical to effective care for PLWHA, it is imperative to study the extent to which caring for PLWHA affects their professional and non-professional relationships, especially as wives and mothers. There needs to be a balance between the emotional investment inherent in caring for PLWHA and the detachment necessary for rejuvenation at home. If this balance is not managed properly, it may have negative impacts on the quality of patient care, family relationships, and most importantly, the mental and physical health of the nurses themselves. Since this study is an initial attempt at exploring the extent to which caring for PLWHA impacts the professional and non-professional lives of nurses, future studies will be required to develop interventions to help nurses effectively meet the emotional and psychological demands of caring for PLWHA.

Often, healthcare workers (particularly nurses) are overlooked as people who could potentially benefit from interventions. In order to better understand how HIV and AIDS influences the patient-healthcare worker relationship (especially in the context of eliminating stigma), interventions must be developed to help nurses deal with the emotional demands their job exerts on them. Hence, it is vital for the Department of Health (DOH) to identify existing support services available to nurses and to ensure that these are reviewed for their effectiveness. A starting point could be showcasing best practices in caring for PLWHA as a part of a training program focused not only on how nurses can be better at caring, but also on what they can do to cope with the stressful emotional and psychological demands of care-giving. Drawing on these existing support systems, nurse training programs should incorporate strategies and skills to help them balance all of their professional and non-professional roles: nurse, counselor, nutritionist, wife, mother, daughter, aunt, and community member, just to name a few. Finally, resources to support nurses such as

counseling and psychological support services should be made available and be easily accessible for use whenever the need arises.

Acknowledgments

The authors would like to thank the HIV and AIDS Stigma Project Team, especially Dr. Okokok for proofreading earlier paper drafts, Ms. Zungu for managing data collection in South Africa, and Ephraim Mashaba for collecting the data.

References

1. Shisana, O.; Hall, E.; Maluleke, KR.; Stoker, DJ.; Schwabe, C.; Colvin, M., et al. The Impact of HIV/AIDS on the Health Sector: National Survey of Health Personnel, Ambulatory and Hospitalised Patients and Health Facilities, 2002, report prepared for the South African Department of Health. Cape Town, South Africa: HSRC Press; 2003.
2. Deetlefs E, Greeff M, Koen M. The Attitudes of Nurses towards HIV-Positive Patients. *Health SA Gesondheid*. 2003; 8(2):23–33.
3. Walusimbi M, Okonsky JG. Knowledge and Attitude of Nurses Caring for Patients with HIV/AIDS in Uganda. *Applied Nursing Research*. 2004; 17(2):92–99. [PubMed: 15154121]
4. Smit R. HIV/AIDS and the Workplace: Perceptions of Nurses in a Public Hospital in South Africa. *Journal of Advanced Nursing*. 2005; 51(1):22–29. [PubMed: 15941457]
5. Delobelle P, Rawlinson JL, Ntuli S, Malatsi I, Decock R, Depoorter AM. HIV/Knowledge AIDS Attitudes, Practices and Perceptions of Rural Nurses in South Africa. *Journal of Advanced Nursing*. 2009; 65(5):1061–1073. [PubMed: 19399982]
6. Lehmann, U.; Zulu, J. How Nurses in Cape Town Clinics Experience the HIV Epidemic. *Critical Health Perspectives*. 42005. Retrieved from http://www.phmovement.org/files/CHP_2005_No4-Nurses_Experiences_on_HIV1_1.pdf
7. Shisana, O., et al. South African National HIV Prevalence, Incidence, Behavior and Communication Survey, 2008: A Turning Tide among Teenagers. HSRC Press; Cape Town, South Africa: 2009.
8. Obi CL, Bessong PO. Diarrhoeagenic Bacterial Pathogens in Positive Patients with Diarrhoea in Rural Communities of Limpopo Province, HIV South Africa. *Journal of Health Population and Nutrition*. 2002; 20(3):230–234.
9. Statistics South Africa. Mid-Year Population Estimates 2009. Stats SA: Pretoria; Retrieved from <http://www.statssa.gov.za/PublicationsHTML/P03022009/html/P03022009.html>
10. Shisana, O., et al., editors. South African National HIV Prevalence, Incidence, Behavior and Communication Survey, 2005. HSRC Press; Cape Town, South Africa:
11. South African Nursing Council-SANC. Geographical Distribution of the Population of South Africa versus Nursing Manpower 2009. 2010. Retrieved from <http://www.sanc.co.za/stats/stat2009/Distribution%202009xls.htm>
12. Solidarity Research Institute. Nurse shortage in South Africa: Nurse/patient ratios. 2009. Retrieved from http://us-cdn.creamermedia.co.za/assets/articles/attachments/21373_solidarity.pdf
13. Juan C, Siebers R, Wu F, et al. The Attitudes Concerns, Gloving Practices and Knowledge of Nurses in a Taiwanese Hospital Regarding AIDS and HIV. *International Journal of Nursing Practice*. 2004; 10(1):32–38. [PubMed: 14764020]
14. Walusimbi M, Okonsky JG. Knowledge and Attitude of Nurses Caring for Patients with HIV/AIDS in Uganda. *Applied Nursing Research*. 2004; 17(2):92–99. [PubMed: 15154121]
15. Hayter M. Burnout and AIDS Care-Related Factors in HIV Community Clinical Nurse Specialists in the North of England. *Journal of Advanced Nursing*. 1999; 29(4):984–993. [PubMed: 10215992]
16. Crothers C. Social Factors and HIV/AIDS in South Africa: A Framework and Summary. *Society in Transition*. 2001; 32(1):5–21.
17. Lehmann, U.; Zulu, J. How Nurses in Cape Town Clinics Experience the HIV Epidemic. *Critical Health Perspectives*. 2005. Retrieved from http://www.phmovement.org/files/CHP_2005_No4-Nurses_Experiences_on_HIV1_1.pdf

18. Li L, Wu Z, Wu S, et al. HIV-Related Stigma in Health Care Settings: A Survey of Service Providers in China. *AIDS Patient Care and STDs*. 2007; 21(10):753–762. [PubMed: 17949274]
19. Pisal H, Sutar S, Sastry J, et al. Nurses' Health Education Program in India Increases HIV Knowledge and Reduces Fear. *Journal of the Association of Nurses in AIDS Care*. 2007; 18(6): 32–43. [PubMed: 17991597]
20. Reis C, Heisler M, Amowitz L, Moreland S, Mafeni J, Anyamele C, et al. Discriminatory Attitudes and Practices by Health Workers toward Patients with HIV/AIDS in Nigeria. *PLOS Medicine*. 2005; 2(8):743–752.
21. Airhihenbuwa, CO. *Health and Culture: Beyond the Western Paradigm*. Sage; Thousand Oaks, California: 1995.
22. Airhihenbuwa, CO. *Healing Our Differences—The Crisis of Global Health and the Politics of Identity*. Rowman & Littlefield Publishers; Lanham, Maryland: 2007.
23. Airhihenbuwa CO, Webster D. Culture and Africa Contexts of HIV/AIDS Prevention Care and Support. *Journal of Social Aspects of HIV/AIDS Research Alliance*. 2004; 1(1):4–13. [PubMed: 17600995]
24. Airhihenbuwa CO, Okoror TA, Shefer TS, et al. Stigma Culture, HIV AIDS in the Western Cape, South Africa: An Application of the PEN-3 Cultural Model for Community Based Research. *Journal of Black Psychology*. 2009; 35(4):407–432.
25. Iwelunmor J, Airhihenbuwa CO, Okoror TA, Brown DC, Belue R. Family Systems and HIV/AIDS in South Africa. *International Quarterly of Community Health Education*. 2007; 27(4):321–325. [PubMed: 18573754]
26. Iwelunmor J, Zungu N, Airhihenbuwa CO. Rethinking HIV/AIDS Disclosure among Women within the Context of Motherhood in South Africa. *American Journal of Public Health*. 2010; 100(8):1393–1399. [PubMed: 20558809]
27. Okoror TA, Airhihenbuwa CO, Zungu M, et al. "My Mother Told Me Must Not Cook Anymore": Food, I Culture and the Context of HIV and AIDS Related Stigma in Three Communities in South Africa. *International Quarterly of Community Health Education*. 2008; 28(3):201–213. [PubMed: 19095587]
28. Qualitative Solutions and Research (QSR). NVivo 2.0: Using NVivo in Qualitative Research (Computer Software & Manual). QSR International; Melbourne, Australia: 2002.
29. Corbin, J.; Strauss, A. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Sage; Thousand Oaks, California: 1990.
30. Morse, JM.; Field, PA. *Qualitative Research Methods: Health Professional*. Sage; Thousand Oaks, California: 1995.
31. Creswell, JW. *Research Design: Qualitative, Quantitative and Mixed Methods Approach*. Sage; Thousand Oaks, California: 2003.
32. Smit R. Living in an Age of HIV and AIDS: Implications for Families in South Africa. *Nordic Journal of African Studies*. 2007; 16(2):161–178.
33. Holzemer W, Uys L, Makoe L, Stewart A, Phetlhu R, Dlamini P, et al. A Conceptual Model of HIV/AIDS Stigma from Five African Countries. *Journal of Advanced Nursing*. 2007; 58(6):541–551. [PubMed: 17484748]
34. Holzemer W, Uys L. Managing AIDS Stigma. *Journal of Social Aspects of HIV/AIDS*. 2004; 1(3): 165–174. [PubMed: 17601004]

Cultural Empowerment				
Relationships/ Expectations	Domains	Positive	Existential	Negative
	Perceptions	Nurses sympathize with PLWHA especially women*	HIV/AIDS has added more responsibilities to the workload of nurses and affected their job performance	Nurses are afraid of exposure to HIV through needle pricks
	Enablers	Community depends on nurses for help because they trust their services	Nurses belong to burial societies where they lose many of their members to HIV/AIDS	Stigma nurses experience by associating with and caring for PLWHA*
	Nurturers	Nurses have the responsibility to counsel a person on how to live positively with HIV	HIV/AIDS affects nurses both at home and at work.*	Family members wait till it's too late to bring their HIV+ members to the nurses until they are already worse and end up dying

Figure 1.

PEN-3 Table of Analysis showing examples of each domain.

*Represents main themes to be discussed that emerged in each category.