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BARRIERS TO PHYSICAL FITNESS, HEALTHCARE AND FOOD SECURITY OF OLDER PERSONS AND COPING MECHANISMS TO DEAL WITH THE BARRIERS IN UGANDA

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Abstract

Introduction: This paper explores the barriers to older people's physical fitness,healthcare, food security and nutrition and the coping mechanisms devised to deal with the barriers.

Methods: This was a descriptive cross-sectional survey. The research was based on eight districts, which included: Pallisa, Kampala, Jinja, Lira, Nebbi, Ntungamo, Luwero and Mbarara district. These districts were representative of both the rural and urban areas of the four regions of Uganda, namely: Western, Northern, Eastern and Central region. The sample consisted of 165 older persons and 50 key infromants selected using purposive sampling. Data was collected using focus group discussions and in-depth interviews guided by focus-group discussion guide and interview guide, respectively. Additional data from the key informants was collected through interviews. Analysis was done using the thematic technique and the themes were developed according to the context and variables of the study. The themes were then coded and entered into SPSS software for analysis and frequency and percentage distributions were generated.

Results: Results indicate that bodily weaknesses constituted the barrier to the physical fitness of the majority (75.2%) of the older persons in Uganda. Other barriers included lack of space for physical exercises and money to pay to health clubs. In contrast, suffering from chronic illnesses prevented more (52.5%) of the rural-based older persons than to the urban-based older persons (29.7%). Regarding access to health services the barriers included Health workers' aloofness, lack of respect for older persons, long distances to health centers and unavailability of health workers at health centers. While the barrier to food security and nutrition desired by the overwhelming majority of older persons in both rural and urban areas was economic inability to afford a balanced diet. Concerning coping mechanism, most of the older persons in rural areas (97%) grew food to cope with food security and nutrition barriers, while most of those in urban areas (70.3%) bought the food from markets.

Conclusion: Findings included in this paper indicate that the coping mechanisms devised by older persons in Uganda needed policy action to be effective.

Keywords: Older Persons, Barriers, Coping Mechanisms, Physical Fitness, Food Security, Nutrition, Uganda

Introduction

The vulnerability of older persons has attracted relatively more scholarly attention than the manner in which they cope with it, particularly in Uganda (Najjumba-Mulindwa, 2004; Lwanga-Ntale & Kimberley, 2003). As a result, coping mechanisms used by these persons to deal with the barriers encountered in their daily living conditions have remained largely unexplored (Nankwanga & Phillips, 2009a). A number of national policy frameworks and development programmes pursued in Uganda recognize that information regarding the plight of older persons in Uganda is still lacking. Some of these policy frameworks include: the Poverty Eradication Action Plan (PEAP) (Ministry of Finance, Planning and Economic Development, 2007) developed in 1990; the Uganda Vision 2025 developed in 1999; Plan for Modernization of

Agriculture (PMA) developed in 2000; the National Agricultural Advisory Services (NAADS) formulated in 2001 (Ministry of Agriculture, Animal Industry and Fisheries, 2005); Policy for older persons(Ministry of Gender, Labour and Social Development, 2007). Draft Food and Nutrition Policy formulated in 2003 (MOH), the Health Sector Strategic Plan developed in 2007 (Ministry of Health Uganda, 2007); and the National AIDS Strategic Plan developed in 2008 (Ministry of Health, 2008); to mention but a few.

An older person according to the 1995 Constitution of the Republic of Uganda and the Uganda Bureau of Statistics [UBOS] (2007) is an individual of at least sixty years. For operational purposes, in this paper, an older person is defined as any male or female individual whose age is at least 55 years and this is the definition adopted in this paper. This definition falls short of the constitutional definition but it was arrived at based on a number of observations. For instance, the World Population Census (2002) report noted that the onus for survival put people living in most of the poor economies at a greater disadvantage than those living in rich countries, thereby causing them to age beforehand. This effectively implies that most people in economically disadvantaged countries like Uganda die before they clock the age of sixty years, which the Population Census (2002) report used to define an older person. Velkof and Kowal (2007) clarified it further by observing that using 60 years of age as a boundary for old age may not be suitable for Sub-Saharan Africa since over 80% of the countries in this region have a life expectancy of less than 55 years of age. In fact, life expectancy in Uganda is estimated at 50 years (UBOS, 2007), implying that the adopted age limit of 55 is still an exaggeration in statistical terms. This definition was appropriate because Uganda is a Sub Saharan country.

Based on the operational definition, the proportion of older persons was adjusted from 6.1% to 7.1% of Uganda's estimated 30 million people (UBOS, 2007). This implies that older persons are about 2.13 million in Uganda. Out of these 2.13 million older persons, 88.5% live in rural areas and only 11.5% live in urban areas (UBOS, 2007). According to UBOS (2002), older persons' population is growing at an annual rate of 3.2%, which implies that their number is likely to double in the next 25 years. The statistics suggest that older people constitute a significant proportion of Uganda's population, which is rising so fast that it can no longer be ignored, especially in terms of policies required to deal with their plight. This paper is therefore important in that it provides a basis for formulating and implementing some of the required policies.

The social protection policy intended to alleviate the economic distress faced by older persons in Uganda should it come into force after its ongoing piloting is inadequate to address the needs of older persons (Nankwanga, 2011). The review of this draft policy reveals that it is intended to guide only cash transfers to these people. The draft therefore addresses a narrow scope of these persons' plight. One of the explanations for the narrowness is that the formulation of the draft did not pay attention to the analysis of the barriers encountered by Uganda's older persons in their living conditions and the coping mechanisms they use to deal with the barriers (Nankwanga & Phillips, 2009b). This would have provided a good basis for understanding and developing a course of action that would have facilitated the mechanisms, thereby making them effective in dealing with the barriers (Nankwanga, 2011). Accordingly, exploring and analyzing the coping mechanisms used by older persons in Uganda to deal with barriers encountered in their daily life is still needed so as to determine the policy implications of these mechanisms and the way forward.

According to literature, barriers have been described as limitations that constrain the older persons from maintaining the health conditions needed to participate in society as effectively as desired (Diane & Aldwin, 2003). They practically occur as impediments to older persons' desired physical fitness, access to healthcare, economic capacity, food security and nutrition (Diane & Aldwin, 2003). This paper, however, focuses on those that hamper older persons' realization of desired physical fitness, healthcare, food security and nutrition. According to Deeg and Bath (2003), barriers to personal health include all hindrances to a person's physical fitness and access to healthcare needed to maintain personal health as desired. The barriers tend to include body weaknesses that set in as described by the wear-and-tear biological theory of old age explained by Stuart-Hamilton (2003), chronic illnesses, and poor and inadequate feeding.

Pertaining to healthcare, the barriers encountered by older persons in their efforts to access needed healthcare have been identified as poverty, illiteracy, lack of health information, and long distances to health centres. Others include disparaging behaviour of health workers, healthcare abuse, ill-equipped/stocked hospitals, and lack of special arrangements for delivering health services to older persons at health centres (Kanyamurwa, 2008a; Nankwanga & Phillips, 2008; Kanyemibwa, 2007).

On the other hand, coping mechanisms have been defined as the means which people use to try to maintain their life across different and usually difficult or stressful situations (FitzGibbon & Hennessy, 2003). According to Carmel et al. (2008), coping mechanisms entail adaptive behaviours in old age that allow for effective and successful engagement with life-related tasks, challenges, and problems. In this paper however, only coping mechanisms used by older persons to deal with barriers to their personal health, food security and nutrition are considered.

The preceding observations were based on studies outside Uganda. Although some observations were made based on samples drawn from Africa, the geographical scopes of the studies were confined to slum areas in mega cities. This implies that coping mechanisms used by the older persons in rural settings were not covered. It was therefore unclear how the older persons, particularly those in Uganda, cope with life. This explains why a study was conducted based on which this paper is developed. The study was conducted using the methodology discussed in the next section.

Methodology

This was a descriptive cross-sectional survey. The study's setting covered the rural and urban areas of eight districts selected randomly from each of the four regions of Uganda, namely: Central, Eastern, Northern and Western region. The selected districts included: Pallisa, Kampala, Jinja, Lira, Nebbi, Ntungamo, Luwero and Mbarara district. The population of the study consisted of rural and urban older persons of Uganda. These persons were targeted to provide primary data about barriers to physical fitness, needed healthcare services, food security and nutrition and coping mechanisms. There were other categories of respondents who were included to act as key informants providing complementary data about the fore-mentioned themes. These included goverment policy makers and implementers in the Ministries of Gender, Labour and Social Development; Agriculture; Health; Education and Public service. The study population also included the administrators, managers, and officials of NGOs and religious organisations linked to the older persons in Uganda. Policy makers and implementers were targeted as key informants.

The sample drawn from the above population consisted of 165 older persons and 50 key infromants. The 165 older persons were selected using purposive sampling from the eight above named districts in the four regions of the country. The female older respondents (54%) were proportionally more than their male counterparts (46%), but there was no significant difference resulting from numbers (Chi square = 1.124, Sig. = 0.289). This implies that the data obtained from these respondents did not significantly differ as a result of the proportional difference in their gender.

While the fifty key informants were purposively selected from each district to participate in the study. The largest proportion of key informants (48%) was selected from Kampala district. This was because the offices of these respondents were mostly located in this district. They were therefore more easily accessible in this district. However, for purposes of collecting representative data, at least one key informant was selected from the rest of the remaining seven districts.

Data was collected from the selected older persons using focus group discussions and in-depth interviews guided by focus-group discussion guide and interview guide, respectively. Data from the key informants was collected by administering an interview schedule. The collected data focused on all the themes of the study but this paper focuses on only barriers to Uganda's older persons' physical fitness, access to healthcare, food security and nutrition, and coping mechanisms used to deal with the barriers. Data was analysed using the thematic technique of the content method of qualitative analysis. The themes were developed according to the context and variables of the study. The themes were then coded and entered into the SPSS software for analysis. Frequency and percentage distributions were generated and the results are presented in the next section.

Results

Barriers to Physical fitness, Food Security and Nutrition

The barriers to Uganda's older persons' physical fitness were established by asking these people to give factors that prevented them from participating in physical exercises by which they would keep physically fit. Results are shown in Table 1.

Table 1: Percentage Distribution of Barriers to Physical Fitness of Older Persons in Uganda

Preventive factor (Barriers)	Frequency by settings					
	Urban (N = 64)		Rural (N = 101)		Total percent (N = 165)	
	f	%	f	%	f	%
Bodily weaknesses	35	54.7	89	88.1	124	75.2
Suffering from chronic illnesses	19	29.7	53	52.5	72	43.6
Loss of hope, just waiting to die	11	17.2	22	21.8	33	20.0
Social life is the youth not us the elderly	15	23.4	33	32.7	48	29.0
Remoteness (lack of access to leisure facilities)	0	0.0	76	75.2	76	46.1
Tension and fear of rebel attacks	0	0.0	55	54.5	55	33.3
Housework	9	14.1	19	18.8	28	16.9
Lack of space for doing physical exercises	15	23.4	0	0.0	15	9.0
Lack of money to pay to health clubs	19	29.7	0	0.0	19	11.5
Lack of time due to a demanding job	9	14.1	12	11.9	21	12.7

***Note**: Respondents were not restricted to one reason; each respondent was thus free to give as many reasons as he/she could.*

From Table 1, bodily weaknesses constituted the barrier to the physical fitness of the majority (75.2%) of the older persons in Uganda. Remoteness, tension and fear of rebel attacks hampered the physical fitness of 75.2% and 54.5% of rural-based older persons but did not prevent any urban-based older persons' physical fitness. The reverse was true of urban-based older persons in the case of lack of space for physical exercises and money to pay to health clubs. Even suffering from chronic illnesses prevented more (52.5%) of the rural-based older persons than to the urban-based older persons (29.7%). These results suggest that older persons whose physical fitness was hampered by the barriers were more rural than urban based. It is important to note that some of the cited barriers were not hindrances in practice as shall be discussed later.

Barriers to older persons' access to healthcare were established by asking these people to point out problems that they encountered in accessing healthcare services. Findings appear in Table 2.

Table 2: Percentage Distribution of Barriers to Uganda's Older Persons Access to Needed Healthcare Services

Barriers	Frequency by settings					
	Urban (N = 64)		Rural (N = 101)		Total (N = 165)	
	f	%	f	%	f	%
Health workers' aloofness and lack of respect for older persons	36	55.4	55	54.5	91	55.2
Lack of medicine and drugs at health centres	35	54.7	89	88.1	124	75.2
Inadequate hospital beds	36	55.4	55	54.5	91	55.2
Bribery/corruption	50	78.1	67	66.3	117	70.9
Over waiting in long lines	44	68.8	76	75.2	120	72.3
Unconvincing diagnosis from health workers	35	54.7	55	54.5	90	54.5
Unaffordable medical costs	59	92.2	99	98.0	158	95.8
Long distances to health centres	0	0.0	78	77.2	78	47.3
Unavailability of health workers at health centres	50	78.1	69	68.3	119	72.1
Inadequate health workers at health centres	35	54.7	89	88.1	124	75.2
Inadequate space for inpatients	36	55.4	55	54.5	91	55.2

Table 2 reveals that all the barriers hindered most of Uganda's older persons from accessing healthcare services that they needed to maintain their personal health as desired. The only exception was the long distances that impeded 77.2% of older persons in rural areas but none in urban areas of Uganda.

Barriers to older persons' food security and nutrition were ascertained by asking these people to mention factors that hindered them from having enough food for feeding. Results appear in Table 3.

Table 3: Percentage Distribution of Barriers to Uganda's Older Persons' Food Security and Nutrition

Barriers	Frequency by settings					
	Urban (N = 64)		Rural (N = 101)		Total (N = 165)	
	f	%	f	%	f	%
Loss of gardens due to illegal eviction from land	11	17.2	20	19.8	31	18.8
Lack of land for cultivation	55	85.9	12	11.9	67	40.6
Destruction of crops by pests	13	20.3	56	55.4	89	53.9
Prevention of food production by the war/rebellion	19	29.7	39	38.6	58	35.2
Economic inability to afford a balanced diet	60	93.8	99	98.0	159	96.4
Destruction of crops by floods	18	28.1	62	61.4	80	48.5

Table 3 shows that the barrier to food security and nutrition desired by the overwhelming majority of older persons (96.4%) in both rural and urban areas was economic inability to afford a balanced diet. Regarding other barriers, while most (85.9%) of the older persons in urban areas were constrained by food due to lack of land for cultivation (85.9%) and food shortages (57.8%), most of those in rural areas were hampered by destruction of crops by floods (61.4%) and pests (55.4%).

Coping Mechanisms used by Older Persons in Uganda

The coping mechanisms in this section include those used by older persons in Uganda to deal with barriers to physical fitness and those used to deal with barriers to accessing needed healthcare services. Mechanisms used to deal with barriers to physical fitness are summarized in Table 4.

Table 4: Mechanisms used by Uganda's Older Persons to Cope with Barriers to Physical Fitness

	Frequency by settings					
	Urban (N = 64)		Rural (N = 101)		Total (N = 165)	
Mechanisms	f	%	f	%	f	%
Digging	15	23.4	30	29.7	45	27.7
Walking around	30	46.9	17	16.8	47	28.5
Cleaning the house	10	15.6	11	10.9	21	12.7
Cleaning the compound	14	21.9	15	14.9	29	17.6
Dancing	9	14.1	8	7.9	17	10.3
Running/jogging	5	7.8	0	0.0	5	3.0
Playing with grandchildren	6	9.4	18	17.8	24	14.5
Moving with cattle uphill every morning	0	0.0	19	18.8	19	11.5
Drumming	3	4.7	5	4.9	8	4.8
Playing guitar	2	3.1	7	6.9	9	5.4
Riding a bicycle	3	4.7	11	10.9	14	8.4
Going to health clubs	2	3.1	0	0.0	2	1.2
Picking food from the garden	3	4.7	17	16.8	20	12.1
Fetching water	6	9.4	15	14.9	21	12.7

Results in Table 4 indicate that relatively few older persons applied the coping mechanisms to deal with barriers to their physical fitness.

The mechanisms used by older persons to cope with healthcare barriers were established as shown in Table 5.

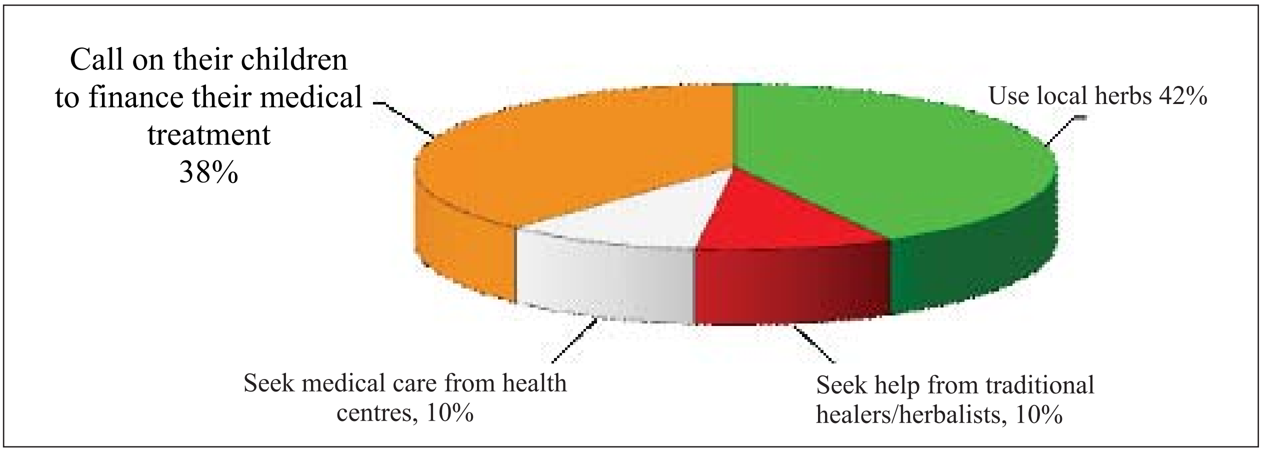
Table 5: Mechanisms Used by Older Persons in Uganda to Cope with Barriers to Personal Health care

	Frequency by settings					
	Urban (N = 64)		Rural (N = 101)		Total (N = 165)	
Mechanisms	f	%	f	%	f	%
Go to government hospital/health centre	13	20.3	14	13.8	27	16.4
Go to the nearest clinic/dispensary	60	93.8	0	0.0	60	36.4
Visit a traditional healer/herbalist	44	68.8	78	77.2	122	73.9
Buy medicine from pharmacy to treat myself	60	93.8	0	0.0	60	36.4
Look for herbs from bush or send a child to get them	60	93.8	98	97.0	158	95.8
I pray to God to heal me	60	93.8	33	32.7	93	56.4
Send for my doctor to come and treat me at home	2	3.1	0	0.0	2	1.2
Do physical exercises	13	20.3	14	13.8	27	16.4

Results in Table 5 indicate that the coping mechanisms that most of the older persons used to deal with barriers to their personal healthcare included: looking for herbs from bush or sending children to get the herbs (95.8%); visiting traditional healers (73.9%); and praying to God (56.4%). Key informants were also asked to describe the mechanisms that the elderly employed to deal with their personal health problems

Results are shown in Figure 1.

Figure 1: Mechanisms Used by Older Persons to Cope with Personal Health Problems, as Reported by Key Informants



From Figure1, most of the key informants (42%) reported that older persons in Uganda used local herbs to attend to their personal health problems. These results corroborate with the results obtained from older persons as shown in Table 5.

Mechanisms Used by older persons to cope with barriers to food security and nutrition were established as shown in Figure 2.

Figure 2: Mechanisms Used by Older Persons to Cope with Food security and Nutrition Barriers

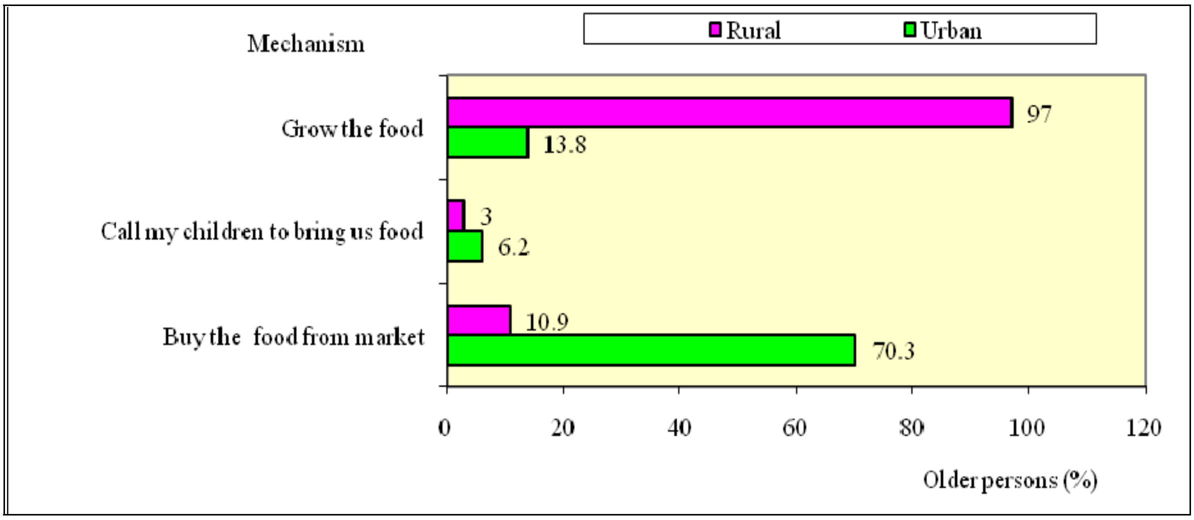


Figure 2 indicates that while most of the older persons in rural areas (97%) grew food to cope with food security and nutrition barriers, most of those in urban areas (70.3%) bought the food from markets.

Discussion

The results reveal a number of barriers that prevent older persons in Uganda from realizing desired physical fitness. Of all the barriers, one that prevents most of the older persons in Uganda face from realizing desired physical fitness was reported as bodily weaknesses. This barrier points to physical frailty that naturally sets in as a person grows old; and it is supported by the wear-and-tear theory of old age explained by Stuart-Hamilton (2003). It however, implies that most of the older persons in Uganda do not get involved in physical activity. Indeed, bodily weaknesses tend to be barriers when older persons are not involved in active ageing programs as Schutzer & Graves (2004) and Cooper, Bilbrew, Dubbert, Kerri, & Kirchner, (2001) point out. According to Help Age International (2002) and World Heath Organization (2002), being involved in physical activity regularly keeps the body muscles strong, with stable joints, improves cardiovascular and respiratory functioning, and strengthens the skeletal system thereby delaying the effects of frailty, falls and becoming tired all the time (Kanyoni & Phillips, 2009). Regular physical activity can also improve health and reduce the risk of premature death in many ways. For instance it can reduce the risk of heart disease, developing high blood pressure and developing type II diabetes and obesity. According to literature regular physical activity reduces the risk of developing colon cancer and possibly other cancers and lowers the blood cholesterol level and triglycerides which could harm the body when in high levels(Centre for Disease Control and Prevention, 2012).

The fact that most of the older persons were not involved in physical activity is clearly confirmed that it was a few of them who reported that they conducted physical exercises to cope with barriers to their physical fitness. Moreover, even the few who carried out the exercises did not do so regularly. Thus could not have some of the benefits that emanate from doing regular physical activity. Most of the older persons showed that they got involved in physical activities sometimes and sometimes not. This suggests that active ageing programs are inadequate in Uganda yet formulation of active ageing programmes was recommended in the WHO (2002) policy framework to all nations. Accordingly, the policy action implied by this suggestion involves promotion of active ageing in Uganda. This is particularly needed in the light of other factors such as nutrition and healthy behaviors.

Some of the reported barriers were actually not obstacles when viewed from the perspective of physical activity. In particular, remoteness, lack of space and lack of money were some of the reported barriers but each of these factors cannot prevent an individual from getting involved in regular physical activity. Physical activity involves activities such as walking, running, cycling or jogging around, doing domestic work like washing clothes, moping or indoor physical exercises with simple tools such as stools, stones, and objects with some weight. Clearly, any older person can carry out any of these physical exercises irrespective of whether he/she lives in a remote area, has money or space or not. Referring to each of these factors as barriers implies, however, that most of the older persons in Uganda are not aware of the many physical exercises that they can do in order to delay frailty. The policy issue implied by the findings is therefore about provision of information and promoting awareness of the benefits of physical activity, so that older persons can do in order to delay the onset of bodily weaknesses.

Results indicate further that most of the older persons were constrained from realizing desired personal healthcare by such barriers as health workers' aloofness and lack of respect for older persons. Unavailability of health workers and lack of drugs at health centres made the older people have a negative attitude towards accessing healthcare. As a result, most of them did not feel like going back for the services. Other barriers included bribery/corruption; over waiting in long lines; unconvincing diagnosis from health workers; unaffordable medical costs; and long distances to health centres. These barriers are consistent with those identified in the work of Kanyamurwa (2008a; 2008b), Nankwanga and Phillips (2008), and Kanyemibwa (2007). The barriers suggest that most of the older persons find it difficult to access desired healthcare services from government health centres.

This implication is reinforced by the mechanisms that older persons in Uganda reportedly used to cope with their personal health problems. Indeed, the overwhelming majority of these people resorted to looking for herbs from the bush or sending children to get the herbs; visiting traditional healers; and praying to God. Evidently, these coping mechanisms imply that most of the older persons did not look to the formal healthcare sector for solutions to their personal health problems yet use of herbs without prescription could have its own negative effect on the body. Besides these herbs do not usually have a specific known dosage and some are not even based on research. Hence older people end up wasting their money on herbs that may not even heal them. The results suggest therefore that there is need for policy action for encouraging older persons in Uganda to seek solutions to their personal health problems from the formal health sector as most of the traditional healers are not trained in what they do. The needed policy action can be derived from the barriers.

The results also suggest that most of the older persons avoided government health centres as a result of the centres' poor customer care, corruption, inaccessibility, and lack of healthcare facilities by which the needed healthcare services could be provided. The results suggest therefore that the needed policy action should focus on training health workers in gerontology and geriatrics to attain this speciality. There is need for government to weed out corruption from government health centres and hospitals, raise the commitment of health workers to their work; build accessible health centres and stock adequate healthcare facilities and drugs.

Optimal nutritional status is another important component of good health and requires particular attention (Kanyamurwa, 2008a; 2008b; Lee & Frongillo, 2001). Regarding food security and nutrition, results show that barriers included: loss of gardens due to illegal eviction from land; lack of land for cultivation; destruction of crops by pests and floods; prevention of food production by the war/rebellion; economic inability to afford a balanced diet due to high prices of food as a result they buy less and lack of capacity to grow food crops since most older people are weak and frail. These barriers suggest that most of the older persons in Uganda face food shortages as a result of natural disasters and lack of resources needed to acquire food. Certainly, food shortages imply that there is no adequate food security for older persons in Uganda. They also imply that older persons do not have enough food by which they can realise the desired nutrition levels and hence are forced to go through chronic hunger as many of them eat one meal instead of two meals a day. Food insecurity is a risk factor associated with poor nutritional and health status among older persons. Besides malnutrition can result in increased costs of care and also inflates national healthcare costs due to increased complication rates. Thus given the increasing ageing population in Uganda, if not addressed, demand for healthcare and social services by older persons will increase the national healthcare costs. Healthcare costs could be greatly reduced by improving the well being of older persons.

The barriers therefore, point to policy action that needs to focus on improving the food security and nutrition of older persons in Uganda. This action is particularly needed in view of the mechanisms that older persons used to deal with the barriers to their food security and nutrition. Indeed, the coping mechanisms showed that the overwhelming majority of older persons in rural areas were digging yet those in urban areas were buying the food from markets. These mechanisms are inadequate. Digging can only produce for subsistence. Secondly, buying the food is also difficult in view of the high poverty levels in Uganda. Coping mechanisms therefore need to be enhanced by better options such as encouraging large scale food production and improving the food storage facilities and provision of adequate information regarding food security and nutrition. While those who are very frail could be given handouts so as to boost their nutritional status and also in addition be encouraged to do physical activity alongside practicing healthy behaviours.

Conclusions

1. The coping mechanisms used by older persons to deal with barriers to their physical fitness are inadequate and point to the fact that physical activity programs are inadequate in Uganda. There is therefore need for policy action involving promotion of active ageing in the country.

2. The coping mechanisms used by most of the older persons suggest that these people do not look to the formal health sector for solutions to their personal health problems. There is need for policy action for encouraging older persons in Uganda to

seek solutions to their personal health problems from the formal health sector. The needed policy action needs to focus on training health workers in gerontology, weeding corruption out of government health workers, raising the commitment of health workers to their work; building easily accessible health centres and adequately stocking them with adequate healthcare facilities and drugs.

3. The coping mechanisms used by older persons to deal with barriers to their food security and nutrition are inadequate and the food security and nutrition barriers faced by older persons in Uganda imply that these people are faced with food shortages. This is aggravated by the fact that the mechanisms used to deal with the barriers are inadequate and therefore need to be enhanced by better options such as encouraging large scale food production and improving the food storage facilities.

In Summary, with an increasing population, ensuring that the older persons in Uganda have enough food to eat in order to meet their nutritional needs may be one important aspect to help our older people enjoy a healthy, active and successful quality of life. As Lee & Frongillo (2001) point out food insecure older persons require more attention because food insecurity is an unwanted occurrence, not only because of its relationship to poorer nutritional and health status, but it is also ethically unacceptable. In addition older persons need to be encouraged to do physical activity to remain physically active and fit for the proper functioning of their body. This could be enhanced through provision of the right information by physicians or medical personnel who regularly see them as they come to hospitals to seek for health care.

Recommendations

1. The government of Uganda, nongovernmental organizations, and agencies dealing with older persons should formulate a policy for promoting active ageing in Uganda through dissemination of information and rising the awareness of older persons of the physical fitness exercises that they can freely and easily conduct. Such policy strategies should include physical activity, health promotion of healthy lifestyles and nutritional programs

2. Institutions for training health workers should be encouraged to train health workers in gerontology and geriatrics and commitment of health workers to their work. The government of Uganda should also weed corruption out of health centres; build more health centres to improve accessibility; and adequately stock the centres with adequate healthcare facilities and medicines especially the essential drugs required by older people.

3. The government of Uganda should take a policy action for encouraging large scale food production and improvement in food storage facilities in Uganda and also provide information regarding nutrition to the elderly.

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IMPACT OF DRUG ABUSE ON THE LIVES OF YOUTH IN A SEMI-URBAN COMMUNITY SETTING IN NIGERIA

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Abstract

Objective: This study examined involvement in drug abuse and its associated consequences among secondary school students in Nigeria.

Method: A structured questionnaire was used to collect data from 160 Secondary School students selected using a multi-stage sampling technique.

Result: Results showed that 85% of the respondents had a high level of awareness of drug abuse and 48.1% were involved in drug abuse. This study also revealed that friends, peer groups and involvement in social group were some of the factors influencing youths' participation in drug abuse. A significant relationship exists between respondents' involvement in drug abuse and health conditions ($X^2= 53.53$) and academic performance ($X^2= 6.727$).

Conclusion: This study concludes that involvements in drug abuse have a negative impact on the lives of the youth. Therefore, multidisciplinary actions should be put in place to end drug abuse among the youths in our community.

Keywords: Academic, drug abuse, health, violent, youth.

Introduction

Drug abuse is a rapidly growing worldwide problem (Lakhanpal & Agnihotri, 2007). It was identified as the number one national health problem, causing more deaths, illness and disability than any other health conditions (Kobiowu, 2006). It takes only a glance to see the enormous problems caused by drug abuse in society. Such problems include broken homes, youthful delinquencies and crime. Drug abuse and addiction has a universal phenomenon that extends across socioeconomic, age, cultural, religious and ethnic boundaries. The problem of drug abuse poses a significant threat to the health, social and economic fabric of families, communities and nations (Lakhanpal & Agnihotri, 2007). Literature review have shown that almost every country in the world is affected from drug abuse and the problem has now crossed national, ethnic, religious and gender lines (Lakhanpal & Agnihotri, 2007). The young ones are equally involved as well as the old. In fact, there is no age barrier to drug abuse.

The use of psychoactive substances among adolescents and young adults have become a subject of public concern worldwide, partly because of its potential to contribute to unintentional and intentional injury (Whichstrom, and Hegna, 2003). Despite the efforts of the various Nigerian tiers of government and the National Drug Law Enforcement Agency (NDLEA) to stem down the tide of drug abuse in the country, there has been a consistent rapid rise in the number of cases especially among the young adolescents (10-24 years) (Oshikoya & Alli, 2006). A number of authors Nestler and Malenka (2004); Skosnik, Spatz-Glenn and Park 2001; Hides, Dawe, Kavanagh and Young 2006), have reported that this increase in number of cases of drug abuse have resulted in an increase in the number of cases of cultism, violent disorders, as well as mental disorders among Nigerian youths.

The youths represent an estimated 15.8 % of the global population (World Population Prospects, 2006). Similarly, estimate has suggested that about a quarter of the Nigerian population are youth and recent statistics have shown that over 60 percent of this youths are involved in drug abuse, this include secondary school and university students (Odianose, 2009)

Several attempts by government-sponsored drug control policy to interdict drug supply and eliminate drug abuse have been largely unsuccessful (Wood, et al. 2003). Although, varieties of well-organised investigations of the fundamental problems associated with drug abuse have been done, there is a little doubt that drug abuse still remains one of the most challenging and unresolved public health problems in our society today. Most of the previous researchers in the field of drug abuse in Nigeria used hospital statistics, the few one that used survey methods were concentrated in the urban communities (Oshikoya and. Alli 2006). An area in which research is still limited is the impact of drug abuse on life of the youths in a semi-urban community setting. The aims of this research therefore are to (i) assess the awareness and knowledge of youth on drug abuse; (ii) identify their level of involvement, (iii) determine the impact of drug abuse on the youths, and (iv) identify various factors that predispose them to drug abuse.

RESEARCH METHODOLOGY

Study design and methods

A descriptive design was adopted, utilising a multi-stage sampling technique. One hundred and sixty students were selected from Ilesa. Ilesa, an ancient town, is regarded as the source and central focus of the Ijesa people. Permission to conduct the study was sought from the principals of the selected schools. Also, informed consent was gained from individual students that participated in the study. The instrument used for data collection was a Questionnaire developed from literature search and subjected to proper scrutiny by experts in the field of Nursing, Sociology, Education, Medicine and Psychology. The adapted version was tested for validity and reliability with a correlation coefficient of 0.82 before its final utilisation for the study. The questionnaires were randomly distributed to the student in the four randomly selected schools and they were given the opportunity to fill it without any interference. Data collected were coded and subjected to computer analysis using the Statistical Package for Social Sciences Programme (SPSS version 15.0). Statistical techniques used included descriptive and inferential procedures. Descriptive statistics employed were frequency count, percentages and while chi square was the inferential statistical techniques used.

RESULTS

Table 1 presents the socio-demographic characteristics of the respondents. The age of the respondents ranged from 10 to 21 years and more than half (57.5%) were between 16-20 years of age. The Table also revealed that 51.3% were male, and majority (80%) were Christians. A breakdown of the respondents based on the class reflected that 52.5% were in Senior Secondary School while 47.5% were in the Junior Secondary School.

Table 1: Socio-demographic characteristics of respondents.

Variables	**Frequency**	**Percent**
Age of respondents in years		
Less than 10	12	7.5
11-15	48	30
16-20	92	57.5
21 and above	8	5
Total	**160**	**100.0**
Sex		
Male	82	51.3
Female	78	48.7
Total	**160**	**100.0**
Religion		
Christianity	128	80
Islam	32	20
Total	**160**	**100.0**
Class		
JSS 1-3	74	47.5
SSS 1-3	84	52.5
Total	**160**	**100**

Table 2 shows that majority (85%) of the respondents had an awareness of drug abuse, and alcohol (26.3%) was the mostly identified substance of abuse while their major source of information was television (53.8%) and a large number (76.25%) believed that it is possible to quit involvement in drug.

Table 2: Awareness of respondents towards the danger of drug abuse

Variables	**Frequency**	**Percent**
Awareness towards drug abuse and its dangerous effect		
Good	136	85
Low	24	15
Total	**160**	**100**
Awareness of each drug		
Alcohol	42	26.3
Cigarette smoking	36	22.5
Cocaine	20	12.5
Marijuana	14	8.75
Indian hemp	18	11.3
Heroine	12	7.5
Valium	12	7.5
Not heard about	6	3.8
Total	**160**	**100**
Source of Information on the danger		
Friend	26	16.3
Poster	16	10
Television	86	53.8
Radio	32	20
Total	**160**	**100**
Quitting the Habit		
Yes	122	76.25
No	38	23.75
Total	**160**	**100**

Figure 1 presents the involvement of respondents in drug abuse. A total of 48.1% of the respondents were involved in various drug of abuse, with 22.5% involved in cigarette. Contained in Figure 2 were the responses of the students to the factors contributing to their involvement in drug abuse. They identified friends and peer group (62.5%), parental influence and involvement (78.8%) and social group (68.8%) as the major contributing factors.

Figure 1: Respondents involvement in drug abuse

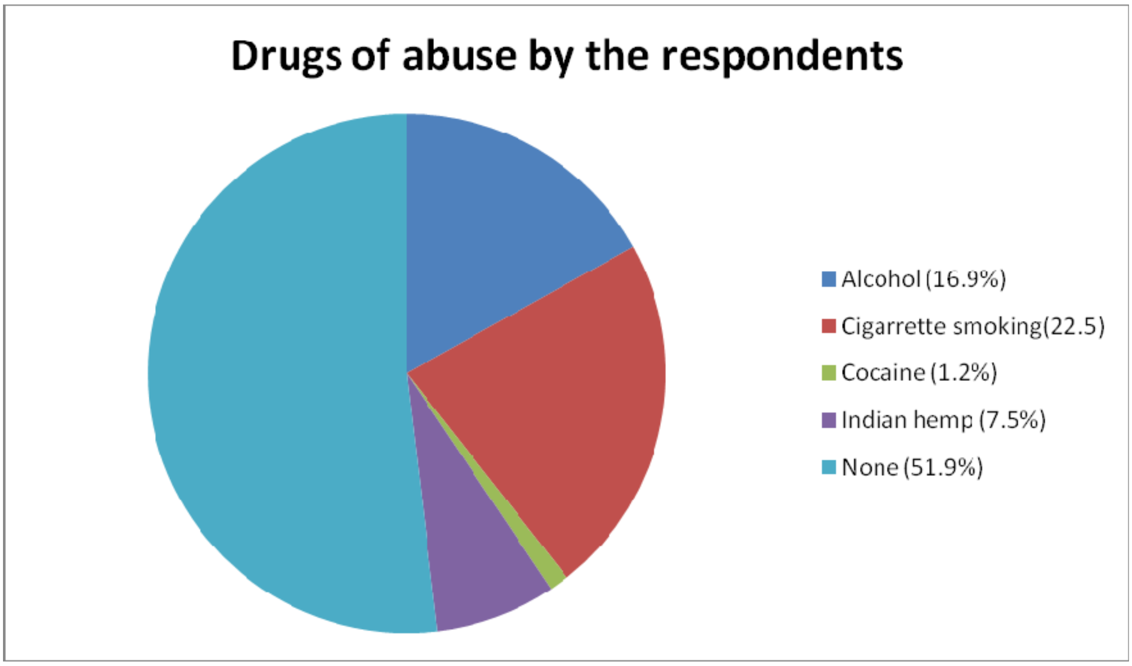
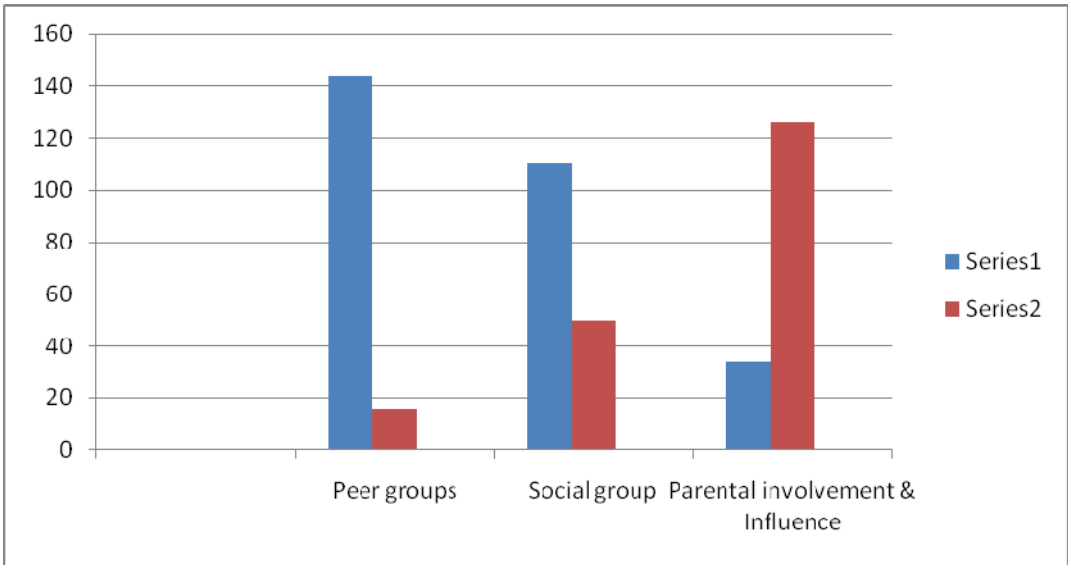


Figure 2 Factors influencing involvement in drug abuse



PRESENTATION OF DATA FOR THE TEST OF HYPOTHESES

Table 3 shows that a greater proportion of the drug abuser were having one health problem or the other while fewer people were having health problem among the non-abuser. Furthermore, there is a significant relationship between drug abuse and falling sick frequently (X^2= 53.53, df = 1, P = .000). The Table also shows that there is a significant relationship between drug abuse and academic performance among the respondents (X^2=6.727, df =1, p = 0.009). Furthermore, the Table revealed that there is no significant relationship between involvement in violent activities and drug abuse (X^2= 1.803, df = 1, p = 0.179).

Table 3: Relationship between respondents' involvement in drug abuse, health conditions, academic performance and involvement in violent activities.

Health	**Drug Abuse**		**Total**
	Abuser	**Non-abuser**	
Yes	68	26	94
No	9	57	66
Total	**77**	**83**	**160**
X^2= 53.53, df = 1. P = .000			
Academic performance	**Drug Abuse**		**Total**
	Abuser	**Non-abuser**	
Low	64	29	93
High	13	54	67
Total	**77**	**83**	**160**
X^2= 6.727 df =1, p = 0.009			
Involvement in Crime	**Drug Abuse**		**Total**
	Abuser	**Non-abuser**	
Yes	30	24	54
No	47	59	106
Total	**77**	**83**	**160**
X^2= 1.803, df = 1, p = 0.179			

DISCUSSION

The findings from this study provide an insight into drug abuse among secondary school students in a semi-urban community setting in Nigeria. The age of the students who participated in the study ranged between 10 and 21 years. In Nigeria, as in many other parts of the world, youth within this age group are expected to be in secondary school. Majority (57.5) of the students were aged 16-20 years i.e. the adolescents who are very vulnerable at experimenting and prone to drug abuse (Onojole and Bamgbala, 2004, NIDA, 2003, Lawoyin, 2005). This may be connected with the current trend of early enrolment of children in school which is very common nowadays. The male: female ratio of the respondents in this study showed no significant gender predominance. This agreed with the works of Wilke, et al. (2005) and Oshikoya and Alli (2006) that stated that drug abuse is a problem of both gender.

The greater percentage (80%) of the respondents that participated in this study are Christian while 20% are Moslem, this appears to reflect the pattern of religion in this locality. It may also mean that more

Christians send their children to conventional secondary school than the Moslem who are likely to send their own children to Koranic school. It is quite interesting to note that a large proportion of the respondents (28.1%) were from polygamous family. This may reveal the fact that polygamy is a common practice among the study population. This study also revealed that 58.1% of the respondents reside within the extended family setting. This may not be unconnected with the extended family practice which helps in strengthening the family ties among the Yorubas.

This study has also revealed that 85% of the respondents had a high level of awareness of drug abuse which is justified by their ability to classify and identify those drugs. This might have resulted from the regular and frequent campaign against drug abuse on the mass media, as well as in school. The respondents were able to identified most of the commonly abused drugs in society and the reason for this may be closely related to the fact that some of the students have been involved in the use of some of these drugs. Furthermore, this study has revealed that quite a large number (48.1%) of the youth were involved in drug abuse. The reason for this is not farfetched based on Yahya (2002) study which stated that Knowledge and use of drug are even handed over by the ancestors of the respondents to them, since a long tradition of its use for culinary, medicinal and ceremonial purposes in sub-Saharan African countries, has been documented. Another reason for this is likely to be due to the explorative and inquisitive nature of the youth. They are likely to practice whatever they see others doing. Since some of these drugs are being freely advertised on the media, of which youth are not shielded from, they may see it and subsequently want to practice it. Some of these drugs are recreational drug which are not sanctioned by society (Merck, 2008).

Data from this study has established that the involvement of friends in drug abuse, influence of peer groups, being members of social group are some of the factors influencing youths' participation in drug abuse in Nigeria. This is related to the finding of Oshikoya and Alli (2006) who identified peer pressure as a predisposing factor to drug abuse. National Institute on Drug Abuse [NIDA] (2003); Oshikoya and Alli (2006), further said that experimentation with drugs during adolescence is common among the adolescent youths. At this age, they try so many new things. They use drugs for many reasons, including curiosity, to make them because it feel good, to reduce stress, or to feel 'grown up'. Using alcohol and tobacco at a young age increase the risk of using other drugs later. While some teens will experiment and stop, or continue to use occasionally without significant problems others will develop addiction, moving on to more dangerous drugs and causing significant harm to themselves and possibly others (NIDA, 2003).

This study has also shown that majority (87.5%) of the respondents were aware of the negative effect of drug abuse. Their major source of information is from television. This may be so because almost every household has television which even occupies the time of most of the youths. However, majority (76.25%) of the respondents were of the opinion that one can quit drug abuse and this likely means that the respondents are in the early stage of drug abuse and are of the opinion that the habit can be easily broken at an early stage. Health problem has been found to be related to involvement in drug abuse. Data from the study demonstrated a strong relationship between involvement in drug abuse and falling sick often ($p < 0.05$). The more one is involved in drug abuse, the more health problem one can have. This confirms the finding of Bartels, et al. (2005) that morphine and tranquilizers, analgesics and sedatives, may precipitate hepatic encephalopathy, possibly as a result of increased brain sensitivity to centrally acting drugs.

It was interestingly found from the study that there is a significant relationship between academic performance and drug abuse ($X^2 = 53.53$, df = 1. P = .000). This supports the finding of Monti, et al. (2005) that substance use itself may impair cognitive development which, in turn, reduces academic achievement and disrupts academic progression. Recent studies by King, *et al*. (2006) have shown that heavy adolescent substance use can lead to problems with working memory and attention due to changes in adolescent brain activity. Further research by NSDUH (2006) also suggests that there is a relationship between academic performance and adolescent substance use. Students who use alcohol or drugs have been shown to be at greater risk for performing poorly in school, and vice versa. However, our findings are in contrast with that of

Kobiowu (2006) who reported that there is no relationship between drug abuse and academic performance (X^2= 6.727 df =1, p = 0.009).

Finally, despite the popular belief that there exist a direct relationship between drug abuse and involvement in crime, which has also been established by a number of authors King, *et al* (2006), Weaver & Maddaleno (1999), World Bank (2003) and World Health Organization (2002), who argued that drug and alcohol use during adolescence leads to association with antisocial peer groups, which in turn diminishes school engagement and increases other behavioural and social problems. This study however, has shown otherwise.

CONCLUSION AND IMPLICATION OF THE FINDING

This study has vividly demonstrated that drug abuse is not restricted to the older youth and higher education students, it is also a common practice among the youths in secondary school and that this has an adverse effect on their heath and academics and has even been implicated as a cause for involvement in violent activities. The role of health care workers especially the nurses is paramount as they form the first line of defense against drug abuse. They can organise health education which should be targeted at the vulnerable segment of society, such as the older children, adolescent and young adults. Such educational measures should be carefully presented through methods that avoid threats and dramatisation. Another implication is that there is need for government agencies such as National Drug Law Enforcement Agency (NDLEA) to establish comprehensive and realistic policy on the control of drug among the youths. This should include establishing drug control centres, which will collate information on drug use, and liaise with similar smaller units in schools and institutions. This will enable them to intensify their anti-drug campaigns effort in order to have a drug –free society.

Also, parents and school authorities should carefully inform and counsel their children and wards against the destructive effects of these drugs. Any realistic attempt aimed at dealing with the issue of drug abuse must enjoy adequate multidisciplinary deliberation. Any law, which is designed to control drug abuse behaviour, must embrace suggestions from the country's relevant professional bodies such as nurses, psychologists, psychiatrists, sociologists, youth and welfare officers, counselors, educationists, Ministry of Health officials and law enforcement agents.

It is also important to suggest that youth friendly clinic should be established in all our hospitals, where youths will walk in freely and express their view about certain disturbing issues such as drug use and they will be counseled appropriately.

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CHALLENGES EXPERIENCED WHILE PROVIDING HOME BASED CARE: A COMMUNITY ORGANISATION'S EXPERIENCE

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Abstract

Introduction: The large and ever-growing number of people being infected with HIV/AIDS, led to health professionals being unable to cope with these increasing numbers. To combat this challenge, an alternative strategy such as home based care needed to be implemented. When attempting to attend to this need, a deeper understanding of the challenges facing community organizations when providing home based care is necessary in order to formulate these effective and relevant care services. The aim of the study was to explore the challenges faced by Umtha Welanga Community Organization in the provision of HIV/AIDS home based care.

Methods: A case study using a qualitative approach with in-depth interviews as the data collection method was used. The Umtha Welanga Community Organization constituted the total population therefore no sampling was applied. All the members of the management team and all the home-based caregivers were interviewed. Informed consent as well as consent for recording interview was obtained prior to data collection. Respondents were informed that participation is voluntary and that they can withdrew at any time. Data analysis began immediately after completion of all the interviews by transcribing and translating the audio-taped data. Thematic analysis was used in which data was coded and categorized.

Results: The main areas of concern were gender inequality, insufficient funding, lack of disclosure and trust, risk faced by caregivers and lack of recognition

Conclusion: Finances appear to be, both for the organization and the home based carers, a specifically influential obstacle in the implementation and maintenance of the services. Lack of recognition by the government and lack of trust and disclosure towards care workers; create difficult conditions for them to perform their tasks and duties. Care services also present risks and dangers to caregivers such as being susceptible to criminal activity, feeling unsafe and vulnerable.

Keywords: Challenges, Community organization, Home based care, HIV/AIDS.

Introduction

An overwhelming number of people infected with HIV/AIDS forced programmers and policy makers to consider shifting their focus of clinical care from only health services, to the community where patients are cared for with dignity by their own families and friends (Ogden, Esiman & Grown, 2004). Limited health care services highlighted the need for services rendered by home based caregivers (mostly family members & friends) (Campell, Nair, Maimane & Sibiya, 2008). These included a shortage of hospital beds, inadequate numbers of medical, nursing and allied health professionals in the public sector. Ankitola (2004) highlighted other factors such as a lack of resources for treatment and drugs, the often high cost of institutional care, crowded hospitals which are often unsuitable for managing patients with terminal or long term disease.

The involvement of community based, non-governmental and faith-based organizations has been promoted as a cost-effective strategy that can rapidly expand HIV care services (USAID, 2002).

Home Based Care (HBC) is viewed as a solution for caring and supporting people with HIV/AIDS and affected families (Sadler, Bahwere, Guerrero & Collins, 2005). It furthermore provides a supportive, familiar environment of home setting for care, and appears to be a cost effective option that enables the stabilization of individuals with chronic conditions (National Association for Home Care and Hospice, 2006).

The advantages of home based care are influenced by its relationship with the services offered by others, such as the government. In efforts to balance the delivery of services, and to reduce the amount of strain placed on either service provider, the aim of Community Based Organizations (CBO) is not to replace the work performed by the public health sector, but rather to support and working closely with the public sector so that the efforts of both parties are reinforced (UNAIDS, 2005). The resources, skills, time and energy of both government and community organizations, are required to meet the total requirements and challenges of home based care. The advantage of a mutually beneficial relationship between the private and public sectors is that effective and cheaper home based care can relieve the burden on hospitals and have additional social benefits for the clients and their families (Nsutebi, Walley, Mataka & Simon, 2001).

Supplementing the above reasoning of a mutually beneficial relationship, community/home based care and support should not be used as a replacement to the care and support provided by the formal health sectors, but should be viewed as one element in a co-coordinated and integrated continuum of care (Russell & Schneider, 2000). In a similar vein, community based organizations should not be expected to shoulder the majority or full responsibility for what is really an obligation of the state. CBO's must aim to develop partnerships with the government, private sector, schools, communities, families and individuals to ensure effective service delivery in the fight against HIV (UNAIDS, 2009). In addition, home-based care programs for resource-poor settings play a significant role in providing access to comprehensive palliative and supportive care for a large proportion of individuals and families affected by the HIV disease (US: Department of Health and Human Services, 2006). When communities are involved in the role of HBC, the more likely they will have a sense of ownership and responsibility (UNICEF, 2004).

It has been argued that in Southern Africa, home based care for HIV/AIDS clients is being promoted as a cheaper substitute to hospital care by the policy makers (Ankitola, 2008). The author further argued in contrast that cheaper forms of care can only be drawn by assessing all of costs, benefits and utility derived by all stakeholders in home based care. With respect to this, an important asset of the CBO is the volunteers who willingly offer their time and energy to care for the families that are infected and affected by HIV/AIDS. Focusing on the case of the Umtha Welanga Community Organisation (UWCO), this article seeks to reports on the challenges as experienced by this organisation.

Methodology

Research design

A qualitative approach using a case study design, with the Umtha Welanga Community Organization (UWCO) as constituting the case, was used.

Population and sampling

The population in this study consisted of all the employees of the UWCO.

Data collection methods and procedure:

In-depth interviews through an unstructured interview schedule were conducted with both management and home based care workers. Observation and field notes were administered during the data collection. An audio-recorder was used to capture the interview sessions. Data was collected at the UWCO office in Masiphulisane Centre in Khayelitsha. An appointment, for the interview, was scheduled with the employees of UWCO as well as the home based carers. All the interviews were conducted after informed consent was obtained from the interviewees. The interviews lasted between 40 to 60 minutes. Permission to audio-record the interview was requested and obtained from the participants before entry.

Data Analysis

Data analysis started with the transcription of the information from the audio taped recordings. The interviews were transcribed immediately after completion of data collection. Thematic analysis was employed to analyze or make sense of the data gathered. The transcripts were read thoroughly several times, broader categories were sorted into clusters and categories and from this, the themes emerged and relationships between them could be identified (Braun & Clarke, 2006).

Findings and Discussion

Demographic information

All employed caregivers were all black females living in the township of Khayelitsha. The participants' home language was reported as IsiXhosa. Their age ranged between 20 and 40 years. Fifty percent of the respondents were married and all have completed Grade 12. Christianity was the dominant religion practiced. The themes identified were education and training as provided by UWCO, finances, support systems and the benefit of care giving services.

The themes derived from the challenges experienced were gender equality, finances, voluntary service, overwhelming and demanding experience, risks faced by caregivers and lack of recognition.

Finances/funding

UWCO's greatest challenge, acknowledged by management, is the lack of funding which makes the operation of and the provision of services by the organization difficult. The organization experienced in particular negative responses with funding applications. They continuously and consistently apply for funding to different institutions and in most cases are turned down. The coordinator reiterated this challenge:

> “Actually, finance is the greatest challenge that we experience. Actually it is the biggest challenge to any organization, and those who can say we don't have the challenge I can say they are very lucky. But you have got to work very hard on that one. We keep on applying almost all the time, some gives us regrets. The solution is to keep on knocking until someone opens the door”

It has been reported that the stability of finances in a community home based care organization is very critical in creating a secure work environment for staff, most of who have families and other commitments (UNAIDS, 2008). Home based care is time and resource consuming and has difficulties such as travel costs and travel time (Campell & Foulis, 2004). Lack of funding jeopardizes the sustainability of community organizations, thus leading to a dependence on volunteer caregivers (Browning, 2008).

In addition to the organization having problems with funding the workers also indicated that they were not being paid enough. The majority of caregivers involved are largely women, and poverty and a high rate of unemployment were found to be the driving force behind women's involvement in home based care. Caregivers expressed dissatisfaction regarding the kind of payment offered and complained that it is insufficient to meet their basic needs. However, most of the care workers felt that if offered better salaries elsewhere, they would resign from their current position within the CBO:

> “The most challenging issue is only money or the salary. The salary is not sufficient to meet our basic needs but can only help you to survive” (Home Carer 2)

> “There is no money in this kind of job. Otherwise, I console myself by saying that things will become better one day. The other reason is that you have volunteered by yourself to offer care services without anyone forces you. Finance is a big problem when you are doing this kind of job.” (Home Carer 5)

Furthermore, it is also revealed that some organizations have fears that they can lose their staff for better employment opportunities (Kang'ethe, 2009). Besides committed and well trained volunteers, CBHC organizations also require effective support systems to provide adequate care to its clients and their families (UNAIDS, 2008). If home based care programs are to be sustainable in playing a vital role of caring and support of people with AIDS, proper remuneration arrangements and support structures must be put in place (Campell et al, 2008).

Gender inequality

Gender imbalance in people providing home base care services is reflected by the all-female component of home based carers of the UWCO organization, with two males involved in managerial positions. The coordinator confirmed this statistic:

> "Actually, most of our staff operating in this organization is female. The same with the client, it is the females who normally disclosed their status. We do have few men who are helping. You find that they are two or three. We have just started a program called gender health specifically focusing on the father to do HIV awareness campaign.
> We do door to door visit to ensure that men are involved in great numbers because the HIV/AIDS does not only concern women but affect us all regardless of whether you are male or female". (Coordinator)

Traditional gender norms result in more women and girls providing care and it also creates social barriers to men and boys becoming caregivers (UNAIDS, 2008). It has been demonstrated that the work of caring for people who have HIV/AIDS is primarily the responsibility of women and girls (Ogden et al, 2004) who spend active days and nights providing care to ill relatives, coupled with their general domestic chores (Opiyo, Yamaano & Jayne, 2008). Home based carers execute complex roles in adverse conditions (Campel & Foulis, 2004) and face challenges such as burn out and impoverishment, vulnerability to diseases and emotional and physical burden (Ogden et al, 2004). Furthermore, issues such as poor supervision, lack of appropriate incentives, and an unsupportive environment (Schneider, Hlope & van Rensburg, 2008) as well as poverty, social and cultural issues, inadequate health knowledge, lack of palliative services, transportation problems and feminization of the care giving have been challenges facing home based care (Odek & Odoo, 2007).

Overwhelming and demanding experience

The tasks and actions performed by care workers are found by them to be both physically and emotionally demanding, and for many it becomes an overwhelming profession. Some families that are being cared for live in extreme poverty. Home based care workers do not only suffer maltreatment and distress from the clients and family members, clients sometimes also refuse to disclose their status and insist that they are not sick due to lack of trust.

> "The most worrying thing is that when you visit people in their houses, you find that living conditions are very poor. This is one of the most troubling experiences you face". (Home Carer 3)

Caregivers are subsequently confronted with psychological and emotional challenges from both the client and family (Ankitola, 2008). Feelings of guilt and self blame are experienced by caregivers due to the overwhelming experiences they encountered.

> "It is challenging out there in the community because you work with different people. The emotional experience that I once experience was after I have tried to help the client by washing him, the next thing he died. Emotionally, I was disturbed and started to feel guilty, for I did not understand how that person can pass away after washing him". (Home Carer 4)

Caregivers experienced feelings of emotional drain, being stressed, exhausted and overwhelmed (Dangeid, Sedumedi & Duckert, 2009). Home care is a process which has its ups and downs brought about by the condition of the patient and his/her functional level and it calls for the total dedication on these responsibilities (Ndaba-Mbata & Seloilwe, 2001).

On occasion, the case family is not welcoming toward the caregiver and they are even insulted by frustrated household members. At times clients also refuse to be assisted by care workers whom they are not familiar with. Evidence of this kind of behavior was documented by a caregiver through the following quote:

> "The client will refuse to be helped because the one she knows didn't come. She will tell you that I will only bath when that one comes. So it is a challenge really. You really need to be down until the client agrees. They will take advantage of us because they think we get paid for such services. We are only there to assist". Sometimes you are not welcomed and they will ask you many questions such: Who said we have got a sick person in this house? Who said we need your help? They can also close the door to show that you are not

> welcome". (Home Carer 5)

Lack of disclosure and trust

Lack of disclosure and trust from the family and clients toward the care workers, creates difficult conditions for them to perform their tasks and duties. Without being granted the permission or given the consent to perform care duties, care workers are unable to operate. The following quote demonstrates this:

> "Otherwise most of them don't disclose their status, and you can only get the \ information next door. Still you need to wait until they disclose and allow him/her for the permission to do home care. Other instance the client will be in denial. This is not easy at all. (Home Carer 5)

Openness and disclosure creates a significantly more comfortable atmosphere, and make work easier for the care workers. The appropriate disclosure of one's HIV status results in a sense of empowerment and leads to a decrease in stress (Tufts, Wessell & Kearney, 2010).

Risks faced by caregivers

It is mentioned that they feel unsafe, vulnerable and exposed to rape by the male clients who are staying without family members. Furthermore, care services present many risks and dangers to home based caregivers of UWCO who are females and had to conduct home visits mostly unaccompanied. Sexual harassment can be directed to both male and female; however, women are the most targeted. A home carer states her experiences regarding this risk:

> "There was one time when I visited the male client who was living on his own without family members or friends around. I was afraid of being raped". (Home Carer 3)

Preventive measure can be used such as sending two home based caregivers for a home visit instead of one caregiver to minimize the possibility of a woman becoming a target opportunity of rape and robbery, since the offender usually waits until the potential victim is vulnerable or isolated (UNAIDS, 2008).

Another participant also highlighted that it is not safe to walk in the location alone because there is a high rate of unemployment in the location which results in a high rate of crime and violence.

> "When we are doing visits, it is very risky sometime, because you are visiting the person for the first time and it is very risky and dangerous to ask people because of the crime rate around the location. The other thing is that it is not safe to walk around the location". (Home Carer 2)

The distance travelled by foot can be far and isolated without public transport. Caregivers sometimes even get lost while on their way to visit a client since they are afraid to ask people on the street for directions. As a result, caregivers become vulnerable to the crime in the location and their safety is therefore compromised. The following comment was voiced:

> "I think with home visit we do experience lots of challenges. We are in great risk because sometimes you don't know the address to that particular home. You will travel long distance asking people of the direction, trying to find the location. We even get lost sometimes and it is very dangerous because in the location it is not very safe, there is high rate of crime. Some places are very far and isolated" (Home Carer 5)

Home care workers are faced with considerable and huge tasks related to health and safety risks (UNAIDS, 2000). Care work is performed under threatening conditions and care workers are exposed to infections. The caregivers can contract HIV/AIDS while on duty if not properly covered and protected by gloves and therefore compromise their own safety and security for the sake of their clients; however, the organization ensures that they are using protective measures such as gloves and masks when performing client care. Health risks are created when caregivers come into close contact with client faeces, vomit and other bodily fluids and tuberculosis infection (UNAIDS, 2000).

Lack of recognition

The caregivers' principal concerns stem from a lack of recognition which is a prerequisite for the acknowledgement of another human being of one's emotions, knowledge or skills, all founding competencies in health and care work (Liveng, 2010). It is the service which is undervalued and they experience exploitation without normal rights or benefits such as leave, maternity benefits and a pension by healthcare authorities and communities (Schneider et al, 2008). The following citation supports the above comment:

> "My concern is that the government should start to recognize the services of home care seriously by ensuring that we are registered, recognized and paid well because this task drains a lot of energy".(Home Carer 2)

The roles and responsibilities assumed by caregivers are clearly unrecognized and undervalued (Pallangyo & Mayers, 2009). Ogden, et al (2004) supported that the home based care work is the kind of service usually taken for granted and undermined by the government and the NGO's because it is usually viewed as the activity or role to be performed by women to sustain their families, communities and nations. Therefore, when care work remains invisible to the society, even the care workers are taken for granted. Caregivers, whether doing formal or informal care work need to be acknowledged as part of the health care system to the response of epidemic requiring financial, medical and social support (UNAIDS, 2000).

Conclusion

The study concluded that there is gender imbalance in UWCO as the organization is predominantly constituted by women. The greatest challenge that the organization experience was the lack of sufficient funding for the smooth running of the operation and provision of services.

However, a lack of proper recognition and appropriate remuneration by the state exist. Lack of disclosure and trust from the family and clients toward the care workers, creates difficult conditions to perform their tasks and duties. Caregivers experienced negative treatment by clients and family members. Their safety and security is compromised as they are susceptible to contracting HIV/AIDS while on duty if not properly covered and protected by gloves, criminal activity and robbery and being raped, feeling unsafe and are vulnerable to gangsters in the community. This study highlights however, that the role of home based caregiver's will continue to be essential to the care of PLWHA in South Africa.

Recommendations

Following the afore-mentioned challenges experienced by home based carers, it is recommended that:

- The government should acknowledge care as a priority human need, encourage a gendered approach and ensure that home based care workers get recognition, credit and support for their valuable contribution, through various channels that address the issues surrounding the sustainability of such a profession.
- A system of registration and specific quality control measures are to be implemented in an effort to ensure both a sense of job security and better management of home based care schemes.

The security, safety, and subsequently too moral and, if needs be, financial support of volunteers should be properly facilitated, to ensure a sustainable volunteer culture in home based care.

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THE IMPACT OF CARE GIVING ON AFRICAN ELDERLY WOMEN CARE GIVERS OF THEIR ADULT CHILDREN WITH AIDS RELATED ILLNESS

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Abstract

Introduction: In South Africa, AIDS patients are increasingly cared for at home by women in their traditional role of family caregiver. The number of parents assuming care for their adult children infected with HIV and with AIDS related illness is increasing and this affects parents negatively. The purpose of this phenomenological study was to capture the lived experiences of African elderly women as caregivers in the challenging context of family members who are receiving antiretroviral therapy.

Objectives: The objective of this study is to describe the impact of care giving on elderly African women as caregivers of their adult children with AIDS related illness.

Methods: The study adopted the qualitative approach using Van Manen's method for hermeneutical phenomenological research to explore the lived experiences of 10 African elderly women who were the primary caregivers for their HIV-positive adult children were investigated. . Interviews were audio-taped, transcribed, and subjected to qualitative data analysis. Constant-comparative analysis was done, a process of constantly comparing the data for similarities and differences, guided data analysis, thus capturing all potentially relevant aspects of the data as soon as they were received. Transcription and analysis of the interviews began immediately following the first interview and was preceded by analyzing the transcribed interviews, line by line, highlighting important ideas and themes. Each theme was coded and recoded using Ethnographic computer program.

Results: Carers struggled with the physical impact of this disease; there was a clear nexus between the carer's coping capacity and the PLWHA's physical health. As the PLWHA's health declined carers' coping skills were put to the test and new boundaries set. While carers were often 'forced' into silence by the PLWHA, there was a demonstrated desire throughout the research process for these carers to 'debrief' and discuss their past or current care. Of the caregiving, personal care was most difficult and household tasks were most time consuming. Family life, with friends was areas most likely to be affected by caregiving.

Conclusion: While it may seem that the carers are coping with care of their children with AIDS, the outer façade is not always an accurate portrayal of the true situation. Health care workers should enquire as to the assistance these carers need from the social and health care services in order to continue to care for their children having AIDS related illness.

Keywords: Family; caregiver; person living with HIV/AIDS; experiences, Gugulethu.

Impact of HIV/AIDS on the caregiver

HIV/AIDS infections impact people on every continent in the world. It has generated phenomenal challenges to health care systems and to the caregivers who provide care to their loved ones with this disease within the home settings (Raveis & Siegel, 1991; Unger, Welz, & Haran, 2002). HIV/AIDS, like any fatal or chronic illness, imposes a stress, which may have long-term effects on family members. Becoming a caregiver is likely to introduce a profound impact on the individual's life and produce significant changes in his/her lifestyle (Wacharasin & Homchampa, 2008).

In this study, individuals became caregivers because they loved and cared for their ill family members, many of whom were disabled and/or chronically ill. Care giving or helping PLWAs to meet their physical and emotional needs can produce negative and positive impacts for the caregivers. The impact of care giving on the caregivers was discussed with the researcher.

Methods

Hermeneutic phenomenology is an appropriate method for this research, enabling the phenomena of life's experience to be structurally and systematically analysed, thereby allowing in-depth interpretation of these lived experiences. The aim is to '...construct an animating, evocative description in textual form of human actions, as we have met with them in the life-world' (van Manen, 1990, p. 19). The purpose of this form of research '...is to act as an advocate in progressing human life, by increasing its thoughtfulness and sensitivity to situations' (van Manen, 1990, p. 21).

On examining possible research methods, the main concern was to choose a methodology that would provide a framework within which the research question could be meaningfully addressed. The study adopted a qualitative research approach. Within this approach a phenomenological orientation was accepted since the objectives were to explore subjective meanings and experiences from the respondent's points of view.

Data collection

Data was collected by structured, in-depth, face-to-face interviews. The purpose of this approach was to elicit the participants' perspectives with as few probes as possible. This specificity assisted in (a) gaining further information, (b) testing preliminary findings, and (c) looking for commonalities and differences in the participants' stories (May, 1998). Interviews lasted from 45-90 minutes. Observational field notes (Lincoln and Cuba, 1985; Boyd, 1993) and theoretical memos and diagrams (Strauss and Corbin, 1990) were also used during data collection to ensure a more accurate and thorough recollection of the circumstances surrounding the interview and participants' experience.

Data analysis

A fear is expressed by phenomenological theorists and researchers that should analysis become too focused on specific steps, quality may be lost. Unlike other methodologies, phenomenology cannot be reduced to a "cookbook set of instructions; it is more an approach, an attitude, an investigation posture with a certain set of goals" (Keen, in Hycner, 1985: 279).

To analyse the rich wealth of data generated by the in-depth interviews, however, it was necessary that the researcher, being inexperienced in phenomenological analysis, follow a set of guidelines. These guidelines were provided by Hycner (1985) and Giorgi (2005) who felt a need existed to provide guidelines to researchers who did not have enough philosophical background to know what "being true to the phenomenon" meant in relation to concrete research methods (Hycner, 1985: 280).

A practical guideline from Allen (Personal communication, November, 2003) was also helpful. Interviews were audio-taped, transcribed, and subjected to qualitative data analysis. Constant-comparative analysis (Strauss and Corbin, 1990; Cherlin, 1983), a process of constantly comparing the data for similarities and differences, guided data analysis, thus capturing all potentially relevant aspects of the data as soon as they were received. Transcription and analysis of the interviews began immediately following the first interview and was preceded by analyzing the transcribed interviews, line by line, highlighting important ideas and themes. Each theme was coded and recoded using Ethnographic computer program (Siegel, Gluhoski, & Karus, 1997).

Ethical consideration

A study of people affected and infected with HIV/AIDS needs to be approached with great sensitivity. The stigma of HIV is such that HIV positive interviewees may fear discrimination, rejection or even violence if their HIV status is revealed. Research on HIV explores the most intimate sphere of a person's private, sexual and emotional life. An interview can become a difficult and emotional experience, regardless of how well a person seems to be coping. Morse and Richards (2002: 205) identify the following ethical principles regarding participants' rights:

- The right to be informed of the purpose of the study as well as what is expected during the research process. The amount of participation and time required. What information will be obtained and who will have access to it. Finally what the information will be used for.
- The right to confidentiality and anonymity.
- The right to ask questions of the researcher.
- The right to refuse to answer questions the researcher may ask, without negative

ramifications.
- The right to withdraw from the study at any time without negative ramifications.

The Impact of Care giving on the Caregivers

Results and Discussion

Negative Impact of Care giving

Providing care to PLWAs had negative consequences to caregivers. For example, their activities could extend over a 24-hour period. Caregivers fulfill the roles that could be described as parent, nurse, and housekeeper. These multiple roles can be demanding and at times come into conflict (Reynolds & Alonzo, 1998; O'Neill, & McKinney, 2003). The negative impacts of caregiving experienced by caregivers in this study included: 1) physical stress, 2) emotional stress, 3) financial burdens, 4) health problems, and 5) life style changes.

Physical stress.
The PLWAs required physical care such as hands-on assistance, or around-the-clock supervision. Caregivers who had never cared for their loved ones with HIV/AIDS experienced physical stress. Some caregivers had sleep disturbances that were related to the needs of the PLWAs that also included night-time assistance. Two caregivers explained their experiences.

A 71-year-old female caregiver who cared for her son (30 years old) had this to say.

> *"During the time he became very ill, I could not sleep because I monitored his symptoms all day. He had a high fever and night sweats. I had to tepid sponge his body to decrease his body temperature. About every 2 hours I would sponge him and then I would give him the pills. I held his hands all the time. When he moved and needed some help promptly, I felt exhausted but I did it. I understood him. At times I felt as sick as he was I felt just like him, but I continued to care for him."* (Case #8)

Here is another example from a 65 year-old female caregiver who cared for her daughter (27 years old).

> *"I took care of her all day and night…, only me. Other family members had to work. They had their own families. I was single, so I took the responsibility to care for my ill younger daughter. I did not sleep well. I was tired all of the time. When she had a high fever and a blurred state of conscious, I could not do much to help her. I felt worried about her. I lost weigh and I lost my appetite. During that time, I didn't want to eat anything because I felt fatigued most of the time. Sometimes, I felt like I didn't have enough energy to take care of her. " (case #10)*

In summary, these caregivers' narrations implied that they faced unavoidable tasks in caring for their family members with HIV/AIDS. These tasks can be interpreted as "physical stress or physical burdens," but because of their sense of responsibility, their cultural practices, and their religious beliefs, they continued to provide the care as best they could.

Emotional stress.
Half of the caregivers reported that they felt stressed and were anxious when caring for their loved ones with HIV/AIDS. This stress could be heightened by the uncertainty about the PLWAs' health status and prognosis, and the severity of the PLWAs' symptoms. Consider these experiences of the following caregivers.

A 64 year-old female caregiver who cared for his youngest daughter (25 years old):

> *"My family faced many problems since I knew that she had become addicted to drugs (injecting drug user). I felt so stressed when I knew that she was also infected with HIV/AIDS. When her symptoms appeared and got worse, I felt more anxious because I was afraid that she would die. I lived with an uncertainty about her life and death." (Case #3)*

Another family member, a 57 year-old female caregiver who cared for her daughter (34 years old):

> *"I felt so stressed. Nevertheless, I tried not to be stressed because it is not a good way to be when caring for my daughter. Caring for her was an emotionally intense and physically demanding experience. Um…sometimes, I*

> *cried because I thought about her illness that could not be cured." (Case #7)*

Financial burdens

A family member's illness with HIV/AIDS can adversely affect the economic well-being of caregivers and other family members. In this study, 10 caregivers reported that the course of the HIV/AIDS illness trajectory impacted the economic status of the PLWAs'caregivers badly. They reported a great deal of financial burden and stress. This fact helped to create the extra financial burdens that the family and caregivers had to confront.

A 60 year-old female caregiver who cared for her younger son (22 years old) told her story.

> *"The medication and treatment for the disease is expensive. I paid R600.00 per day during the first time he was admitted to the hospital. However, it gradually decreased to R200, 00/day. I did not tell anyone about this expense, not even my husband. I had to withdraw my money from my saving. I used the money for his treatment, food, and transportation. It was not enough, though." (Case #2)*

Another similar situation follows: A 60 year-old female caregiver and who cared for her son (32 years old) helps to highlight this concern.

> *"During his illness, he could not work. So he decided to quit his job. I continued to work for myself. I had to stop working some days when I felt sick. The loss of income made it difficult for us to live. My husband had to sell his property; a golden ring to get the money for living. I felt pity for my son. The money I had was not enough. I had to borrow money from my neighbour. I also had the interest on the money to be concerned about, too. I needed the money to pay for the food and milk for my kids. The rest of the money was used to pay for treatment, and so on...." (Case #4)*

Still, another story about finance: A 60 year-old female caregiver who cared for her 2nd son (26 years old) shared her thoughts about the financial burdens.

> *"His family neglected him. His wife ran away after knowing his positive HIV status. He didn't have enough money for care and he was in debt. When he returned home, I was the primary caregiver. I also paid for his daily living expenses and the expenses associated with treatment and care." (Case #5)*

HIV/AIDS related stigma

Because the stigmatization of persons with HIV/AIDS infection often extends to their caregivers, they, too, have to deal with the prejudice that exists because of the disease, the fear of infection, the loss of friendships, and the forced decision to live with secrets. Fear of social discrimination leads families to carefully consider what they might gain or lose from their disclosure to others about their ill family members' health status. These realities help to motivate the caregivers to keep secrets and protect the family's reputation and the PLWAs from hostilities and community gossip. The caregivers' reported experiences help to highlight their concerns and their struggles. A 67 year-old female caregiver who cared for her son (45 years old) described her predicament.

> *"I did not tell anyone about his HIV status. I avoided talking about it. However, my neighbours might have had some ideas about the type of illness that he had but I did not discuss it. They might know from his signs and symptoms. One neighbour said that she would not buy food that I had for sale because she was afraid of the possibility of becoming infected with the HIV/AIDS virus. She made me lose money from selling food." (Case #1)*

A 64 year-old female caregiver who cared for her youngest daughter (25 years old) added this remark.

> *"I did not consult with anyone about my daughter's illness except my family. I called my other daughter who was married and lived far away from my house. She gave me good advice and visited us very often." (Case #3)*

A 60 year-old female caregiver who cared for her 2nd son (26 years old) also experienced a similar situation.

> *"As AIDS was a stigmatizing disease, I concealed his HIV/AIDS infection from other people, so I could not ask for help from anyone.*

> *It made me frustrated and miserable." (Case #5)*

A 57 year-old female caregiver who cared for her daughter (34 years old) made this pronouncement.

> *"No one knew her HIV status. Only me I knew this secret. I was afraid that society would reject my children and that rejection would affect my children's education. When my neighbours asked about her illness, I told them that she had a lung infection." (Case #7)*

Some neighbours were afraid of the disease, and they tried to avoid dealing with family members who had ill relatives. For example, neighbours tried to avoid making contact with the ill members' family; the ill members' family used various avoidance strategies to minimize contact with their neighbours. Moreover, the PLWAs would try to confine themselves to their homes to avoid discrimination and prejudice from the neighbours and others in the community.

Positive Impact of Care giving

Knowledge gained.

Two caregivers reported that caring for PLWAs helped them learn more about how PLWAs suffered from the disease and the pain that they have to endure. They reported that it was a good experience for them to be aware of the disease and gain a better understanding of what the illness is like. Furthermore, it was beneficial for them to learn more about avoiding the risky sexual behaviours in their own personal lives. They refocused on how to take better care of themselves. Two caregivers explained: "To me, as a caregiver, I gained more knowledge and experience about how to take care of myself. Even though, caregiving was a difficult task and the ill family member needs close attention and care, I learned a lot. I learned how to live with my family member who has HIV/AIDS without any risk of infection. I learned to be more careful and to avoid getting infections." (Case #7)

> *"In the past, I knew little about AIDS because it was not of interest to me. Since my daughter had this disease, it became necessary for me to learn more about it. I searched for information about how to take care of myself, how to protect myself from the risk of infections, and how to take care of my daughter. I noticed that the persons who got the disease were younger persons such as my daughter. She was 27 years old. Then, I thought about myself. I had to use self care and protect myself and learn to stay far away from the disease. It is a frightful disease." (Case #10)*

Discussion

Assuming the caregiving responsibility for PLWAs affects caregivers both negatively and positively. Regarding the negative impact, the results of this study underline the assumption that the caregivers of PLWAs are physically, mentally, socially, and financially affected by the impact of HIV/AIDS. According to Pakenham and colleagues (1995), psychologists used the term "caregiver burden" to describe the physical, emotional, financial, and social problems associated with caregiving. The physical burden or physical stress of caregiving is documented in the literature and reported as having negative health effects on the caregivers (Aoun, Kristjanson, Currow, & Hudson 2005; Kipp et al., 2007, Prachakul & Grant, 2003; Thomas, 2006). Several researchers have discussed the types of negative outcomes that can occur when caregiving. Examples of some of these negative consequences are elucidated.

Emotional stress in family caregiving is defined as negative feelings or experiences of frustration, anxiety, and difficulties in dealing with the ill persons (Borijan et al., 1993). The caregivers in this study reported emotional distress. Much of the earlier research on the impact of caregiving for PLWAs revealed multiple caregiving problems. The most common problems were emotional distress, relationship difficulties, somatic symptoms, grief, fear of disclosure of the family members' HIV status, and confidentiality concerns (Engler et al., 2006; Holroyd, 2005; Orner, 2006; Shacham, Basta, & Reece, 2008; VanDevanter, Thacker, Bass, & Arnold, 1999).

The loss of family income through the disruption of wage earnings due to the demands for caregiving has been documented in the research literature, particularly in developing countries (Brouwer, Lok, Wolffers, & Sebagalls, 2000; Joseph & Bhatti, 2004; Knodel & Im-em, 2004; Mcgrath et al., 1993;

Oluwagbemiga, 2007; Rajaraman, Russell, & Heymann, 2006: Ssengonzi, 2007). These findings were consistent with previous studies (Irving et al., 1995; Joseph & Bhatti, 2004; Yun et al., 2005).

Conclusion

These findings lend support to prior research that suggested that caregiving for PLWAs can negatively affect the caregiver's health; however, caregiving can also provide positive experiences that are beneficial for personal growth and development and introspection. This research demonstrated that the stigma associated with HIV/AIDS is a barrier to caregivers' efforts to seek support from family, friends, and health professionals.

Furthermore, the results of this study have substantive implications for the understanding of the impact of caregiving upon family members providing assistance to PLWAs. The importance of the current findings as related to health care practice, social workers and nursing education, health policy, and future directions for research are also included.

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BARRIERS TO BACK CARE AMONG CLINICAL NURSES, TANZANIA

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Abstract

Understanding the barriers to back care techniques amongst nurses is important as it could assist hospital management and training institutions to design courses that could meet the needs of the nurses. The aim of this study was to explore the barriers to implementation of back care techniques among nurses in practice. Three focus group discussions were conducted with a group of nurse assistants, nurse midwives and nursing officers. A qualitative approach was used and data was analysed manually after taped interviews and field notes were transcribed. Barriers to effective back care included lack of training, work environment, poor facilities and attitudes. Participants emphasized the need for continuous training to improve knowledge as well as the need to address the poor working conditions. As nurse educators we may not be able to improve the working conditions but we can impact on the necessary knowledge that nurse practitioners should have to increase protection of their backs when working.

Keywords: attitudes, back care, barriers, knowledge,

Introduction

Among health professionals, nursing is the healthcare group recognized to have the highest rate of back injuries worldwide. The prevalence of low back pain among nurses is still reported to be high with a life time prevalence of 65% (Viera, Kumer, Coury & Narayan, 2006:82). This annual incidence rate of work-related back injuries among hospital nurses consistently exceeding 50% have been shown to occur in both developing and developed countries (Naidoo and Coopoo, 2007:68; Smith et al. 2003:187). The impact of work-related back injuries among nurses includes loss or impairment in physical function due to pain (Bener et al., 2006:262). Some low back pain sufferers experience disabling pain that negatively influences the quality of their life (van Nieuwenhuyse et al., 2006:50).

The reasons commonly highlighted for this high prevalence of low back pain among nurses, is their exposure to high physical demand tasks involving lifting and transferring of patients, and prolonged static postures (Vieira et al, 2006:86). This implies that nurses are required to be well informed of the back injury risk factors and the preventive measures for them to carry out their duties safely. Nestor (1988:.2) asserted that;

> *"Manual handling of patients is a skilled activity which requires time, practice, and application in order to be accomplished in a safe and comfortable manner."*

Various strategies to prevent low back pain have been attempted with contradictory results. The most commonly recognized approach to low back injury prevention was formerly the education and training programmes in biomechanics and lifting techniques. Researchers have also highlighted interventions such as exercise, back belts and multidisciplinary interventions (Tveito, Hysing & Eriksen 2004: 5). There is growing evidence in the literature suggesting that successful management of manual handling in health care organisations needs to incorporate more than one approach (Retsas & Pinikahana 2000: 881). Although various studies have highlighted the importance of back care techniques, translation of knowledge into practice still remains a challenge. The aim of the study was to explore the views of clinical nurses with regards to the barriers to the implementation of effective back care practices among nurses in Tanzania.

Method

The study utilized a qualitative approach with focus group discussions. Participants included purposively selected nurses that were stratified from three different groups namely nursing officers, enrolled nurses and nurse assistants at a local hospital in Tanzania. Permission was obtained from the hospital administration to conduct the focus group discussions in the conference room within the hospital. Written informed consent was obtained from participants. The aim of the focus group discussions was to explore their views on the barriers to implementing back care techniques. The focus group discussions consisted of 6-8 participants and were tape-recorded with permission from the participants. The discussions proceeded until saturation for about 40 minutes to 1hour. Focus group discussions were conducted by one of the authors. A probing technique was used to clarify the participants' responses and to obtain more information (Britten 1995:252). To ensure trustworthiness of the recorded data, the tape was replayed at the end of each focus group discussion for participants to verify that the records contained the discussion. The data was triangulated through the use of the field notes and transcripts. To ensure trustworthiness of the recorded data, a summary was presented at the end of each focus group discussion for participants to verify that the records contained the discussion. The tape recorded information and field notes were transcribed verbatim into a manuscript and the information was analysed into emergent clusters. The clusters were then coded and categorized into themes independently by both authors and consensus was reached in areas where there were discrepancies. Quotes are given that best support the theme identified.

Results and Discussion

Multidimensional factors were identified as barriers to effective back care amongst the nurses. The opening question that was posed to the nurses in order to facilitate the discussion was "Tell me the measures you take to protect your back during your nursing practice?". This question generated mixed responses and highlighted the multi- dimensional factors that could contribute to the barriers to back care.

> *"I would like to say that, even if preventive methods were available, it is difficult to apply them in preventing our backs from getting injuries"*
>
> *"Sometimes we do use body alignment and I also use it to protect my back but in some instances I can't use it because of shortage of "manpower", we have too much work to do"*

The results of the themes identified as barriers to implementation of back techniques are summarized below with relevant quotes. The main themes identified included lack of training, poor working conditions, attitudes of nursing staff and knowledge vs behavior

(Table 1).

Table 1 Barriers to implementation of back care techniques

Theme	Categories	Quote
Lack of training	Timing of knowledge obtained Type of lifting techniques Alternative techniques	**“***…….we came to know the techniques after we were injured, that’s why I tell you that we who are here are the ones who have already suffered back pain; hence what we are doing here is to prevent further injuries”.*
Work environment conditions	Poor facilities Shortage of staff Working hours Lack of assistive devices	*“……..but normally there is overcrowding of patients in the wards and there could be one lying on the floor (because beds are all occupied) who then has to be lifted and carried to theatre…..”* *“sometimes in the wards nurses are very busy, there can be a shortage of staff, and the patient has rung a bell… and there is no fellow nurse to assist with the task ……in such a situation you decide to do it alone with difficulty...”* *“…work shifts are too long for nurses as compared with work environments and nature of our work. Thus, if a nurse is able to care 50 patients from morning up to 1:00pm the mind becomes tired, so what will come next? She/he is tired and even the back is also tired”.*
Attitudes	Fear of being disabled Get the job done	*“A majority of us already have a back injury, and I suppose that most of us will retire with physical disability so we just do what we have to do.”* *“Another thing which is happening in us is that we work to finish the work e.g. the patient has asked you for help… so, getting them (colleagues) to assist you takes time, and at the same time you want the work to be done. We just do it then without considering the techniques”.*
Knowledge versus Behaviour		*“It is true that one should not apply force while bending, but it will take a long time to accomplish the task. If you have a patient in a situation like this (patients lying on the floor) it will be necessary for you to overlook those principles and suffer back pain”*

The results of the focus group discussions indicated that most of the participants had knowledge about the back injury prevention techniques, but the knowledge did not influence their behavior. Some of the respondents reported never having received training regarding back care techniques but were educated once they had sustained an injury. Some had received training during their basic nursing course but had forgotten about the techniques and thus could not implement them.

Participants highlighted the need for continuous refresher courses and more education.

> *"…the first year training was in 1979, while practicing on dolls and I never had any training after that…One might fail to implement what was taught from the class due to lack of understanding or forgetfulness…"*

These findings are in agreement with the study done by Kjellberg, Lagertrom, Hagberg (2003:474) who found a significant association between ages and work technique safety. The authors suggested that older nurses had poor techniques as they may have forgotten the techniques over time.

During the discussions, there was a trend of expression in all the FGD groups regarding work environments and conditions as an impeding factor to their effectiveness in applying back care techniques. This theme was categorized into poor facilities, shortage of staff, lack of equipment and working hours.

> *"…I try, but it is also difficult because of the working environments that are not conducive in relation to the measures of observing back care…You find that there are so many patients and not enough manpower, we also don't have the proper equipment to lift patients if we are short of staff"*

The results are comparable to the findings reported by Ando et al (2000:215) who stated that some working conditions compel nurses to assume incorrect postures when performing job related tasks. Smith et al (2003:187) also suggested that nurses exposed to unsuitable working conditions are at risk of getting musculoskeletal disorders including low back pain.

In addition to other barriers perceived by the participants in the study, their responses had also expressed attitudinal barriers towards implementation of back prevention techniques in their job practice. The attitudes articulated included the attitude of defeat. Participants claimed that even if they tried to protect their backs, the nature of their work will definitely lead to back injuries

> *"…nursing is a calling and thus there is no technique that can be used to avoid some of the tasks… when a patient is lying on the floor, you have to lift him cause you have accepted to be a nurse…"*

Zimerado and Ebbesen (1969:70) suggested that the environment causes behavior changes which in turn necessitate changes in attitude. When considering that there is also a relationship between knowledge and behavior, it is evident that the complexity of attitudes and their interdependence with knowledge, behavior and environment is highlighted. The views of the nurses need to be considered bearing all of these elements in mind if the desired outcomes are to be achieved.

Following the identification of the barriers, participants also made recommendations that could be considered. The participants clearly indicated the need for training seminars to refresh or improve their knowledge.

> *"I have never seen / heard a seminar being conducted or even being told that we shall be taught on how to prevent ourselves from getting back pain in our working environments…. we have never had such kind of seminars before, thus it becomes difficult to know even the basic rights of using your body especially the back…."*

Another recommendation from the group was that administrators of the hospital should create a more supportive working environment by addressing placement logistics as well as increasing the number of nurses employed.

> *"……..those who prepare duty rosters should consider balancing, for instance, if there are five people with back problems in that particular ward, they should not be placed in*

> *one shift or one day…."*

> *"My opinion is, if there could be a possibility to increase manpower ….and at the same time if the equipment were available, that would help us ... Also if we had more time to rest, say I work up to 1:00 o'clock and I go off…"*

The interview respondents also expressed their opinions that the employer(s) and probably the responsible ministry should consider risk allowance for nurses as they are working under high risk environments. The following quotations convey their feelings and opinions:

> *"……. I suggest there should be motivation in terms of payment of risk allowance which will assist in medical care".*
> *"……..payment of risk allowance will give us a sense that we are being cared for, just an incentive"*

One participant made a comment that nurses themselves need to be conscious of and adjust some of their lifestyles for instance diet. The following extract expresses her feelings and opinion:

> *"We are told that even eating and the type of food you eat can have an impact to our backs, because if you are overweight, it brings pressure on your back, thus makes it easier to experience back pain of which will also be difficult to recover very well..".*

Education was clearly indicated as a means to improve knowledge regarding back care techniques. Lindell (1994:214) suggests that behavior is "a practical expression of one's knowledge, skills and abilities'. This clearly implies that the effectiveness of one's knowledge has been manifested through one's behavior. However, the attainment of knowledge only, may not bring about the desired outcomes with regard to risk reduction (Nordin, Cedrashi, Balaque & Roux, 1992:699). Baker, Israel and Schurman (1996:178) indicated that behavior change is an essential part in the sustainability of injury prevention and in the maintaining of the well-being of workers in organizations. This can be achieved if motivation and role perception are considered as indispensible factors in connecting knowledge and behavior change (Lindell, 1994). Furthermore, for effective and sustainable individual behavior change, supportive policies and conducive work environmental conditions are essential (Crump, Earp, Kosma & Hertz-Picciotto, 1996:222).

Implications for practice

The current study provided an understanding of the barriers experienced by nurses to implementation of back care techniques in practice. The results of the current study clearly highlight that low back pain in nurses is influenced by multi-dimensional factors ranging from personal to occupational influences. The impact of personal attitudes, behaviours and knowledge in conjunction with occupational hazards impacted on the effective implementation of back care practices by nurses. It is also evident that there is a need to include back care techniques and theory as part of continuing professional development for nurses.

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CLINICAL MENTORING
THE VIEWS OF THE NURSING STUDENTS AND CLINICAL MENTORS

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Abstract

Introduction: In nursing, clinical learning is an important part of the curriculum and accounts for approximately 50% of the pre-registration nursing programme. Supporting students to learn in clinical settings is an important function for both educators and practitioners, however, there is little consensus in the literature on what constitutes appropriate learning support.

Purpose: This study was aimed at exploring the phenomenon of clinical mentoring as perceived by the nursing students and clinical mentors in a selected hospital in Durban.

Methodology: A qualitative descriptive approach was used in this study with a population of 48 registered nurses and 47 nursing students who were doing the four-year diploma in nursing. Sample size consisted of eight registered nurses and eight student nurses. Individual interviews were conducted to collect data.

Findings: The findings revealed that the assistance and guidance that the clinical mentors are offering to students are most crucial for growth and the development of students and gain of quality clinical skills. Challenges to the mentoring process included time constraints, shortages of human and material resources in the clinical facilities and lack of a system in place for the preparation of clinical mentors for this role.

Recommendations: This study suggests that the educational and clinical settings needs to work together to ensure that formalised mentorship programmes are put in place where clinical mentors will be trained for the role and formally appointed to the roles.

Keywords: mentoring, mentor, mentee, clinical learning, clinical teaching, clinical learning experiences

Introduction and Background

Mentorship is widely relied upon, not just as a support mechanism for students, but also as the main vehicle for the activities associated with learning, teaching and assessment of practice. Within nursing, mentorship is integral to students' clinical placement experiences and has attracted increasing interest among researchers (Myall, Levett-Jones & Lathlean, 2008). Gilmour, Kopeikin and Douche (2007) referred to mentoring as a key strategy for supporting nursing students and new practitioners in clinical settings. Gibbs, Brigden and Hellenberg (2007) asserted that mentoring is the most effective method to shape and develop professionalism, ethics, values and the art of a discipline because the mentors are role models of these critical attributes through their day to day involvement with the students.

Mentoring may be a formal structured process, but can also be informal, where clinical practitioners, by virtue of having students working under their supervision, serve as mentors. Whether formal or informal, Gibbs et al. (2007) state that mentoring is a protected relationship that encourages the holistic development of a person and it requires the development of bounded and purposeful relationships, which are underpinned by knowledge, experience and opportunities for reflection. In this relationship, according to Spouse (2001), learning and experimentation can occur, potential skills can be developed and results can be measured in terms of competencies and attainments.

Although mentorship is not a common practice in South African nursing, preceptors are frequently used in a variety of health care settings where student nurses undertake their clinical learning. Preceptors are customarily experienced nurses with clinical expertise, who act as role models as they guide, teach and assess the students, as directed by curriculum outcomes (Harris, 2007). Preceptors liaise with students and health service staff, and are accountable to the educational institution. This is usually a short-term engagement (Northcotte, 2001).

According to South African Nursing Council (SANC), clinical accompaniment is one of the strategies that are used to guide and support the student nurses in the correlation of theory to practice when they are placed in a clinical setting. This is done by the nurse educators. The students utilize the clinical learning opportunities in the health service under the supervision of registered nurses, midwives and other experts in the health service.

Problem Statement

In South Africa (SA), mentoring in the clinical settings for nursing students is not formalized, there are no guidelines from the regulatory body to serve as a guide to mentors in clinical settings and mentors do not undergo special preparation. Andrews and Roberts (2003) indicate that there remains little agreement on the role of the mentor and the most effective method for mentoring. Furthermore, there is confusion on the meaning of the term and the possible effect on its application in practice, thus making it difficult to evaluate the value of the phenomenon in nursing (Yonder, 2010). If students are to achieve a positive learning experience, it is vital that they receive adequate mentoring in their day to day clinical learning experiences.

Compounding the challenges related to mentoring is that student numbers are increasing while staff numbers, on the other hand, have been depleted in many hospitals. According to Ranse and Grealish (2009), clinical mentoring of students is becoming a burden as a result of the depleted pool of nurses that are expected to serve as mentors to student nurses, while at the same time providing quality care to their patients. It is against this background that this article explored the perceptions and views of the students and those expected to serve as mentors in the clinical settings on mentoring.

Collins, Price and Angrave (2006) highlighted that for effective learning to take place, it is critical that both mentors and mentees are thoroughly prepared for their roles. According to Mlambo (2006), clinical staff are not adequately prepared for their roles as mentors because the academic institutions do not communicate directly with them, but rather communicate with those in management positions in the clinical settings, and that the information normally do not filter down to those involved in the day to day dealings with the students.

Harrison, Lyons and Fisher (2009) point-out that a number of challenges related to mentoring of students in clinical settings including staff shortages, time constraints, students being used as part of the workforce, competing commitments and lack of resources and infrastructure to support the role of mentor. These challenges may render mentorship to be unfruitful and ineffective (Clutterbuck, 2005). Andrews and Roberts (2003) state that mentoring is usually done by nurses who have not been formally appointed, but who avail themselves and they noted that some of the clinical staff has no interest in the mentoring of students, as they feel it is additional work. This can lead to inappropriate staff being utilized as mentors.

Research Question and Objectives

The research question for this study was: What are the views of the student nurses and mentors on clinical mentoring? The objectives of this study were to: (a) describe the term clinical mentoring as perceived by the students and mentors; (b) explore the process of clinical mentoring in the clinical settings and (c) describe the benefits and challenges of clinical mentoring.

LITERATURE REVIEW

The reviewed literature shows that there is no agreed upon definition of the term mentoring (Bray & Nettleton, 2007). The term mentoring is sometimes used interchangeably with terms such as coaching and preceptorship (Gibbs et al., 2007; Harris, 2007).

Gibbs et al. (2007) explain that mentoring is a relationship rather than an activity and this is what clearly distinguishes mentoring from most other forms of learning and development. Coaching is often more specific and of a convergent purpose. A coach is a trainer, who is available to train the students on a particular skill and their relationship lasts for as long as the learning need exist (Gibbs et al., 2007).

Preceptorship on the other hand, is defined as a competent, confident and experienced nurse who assists another nurse or nursing student in giving quality nursing care by guiding, directing or training and states that the relationship that develops during preceptorship is for a short period of time (Gray & Smith, 2000). A mentor, on the other hand, is a guide, a facilitator and a support to the students and there is a special relationship that develops during the mentoring process. Mentoring relies heavily upon self-directed and student-centered learning, whereas coaching is much more didactic and teacher-centered (Robison & Boder, 2009; Gibbs, et al. 2007).

The regulatory bodies in countries such as UK, America and Australia have introduced formal mentoring programmes for student nurses and provided guidelines for these mentors in the clinical settings (Myall et al., 2008). It is mandatory in these countries that those students on training are assigned a formal mentor who will work with them through the duration of their training. These mentors undergo special preparation for their roles. This model of mentoring afforded supernumerary status to students and replaced the previous apprenticeship type model of 'learning on the job'. Lee (2007) reported that although mentors in these countries undergo training, research studies indicate that many mentors still feel ill-prepared to carry out their roles.

According to Harris (2007), in nursing, mentoring is of vital importance to the personal and professional growth and development of the students when they are in clinical settings. The students need to be guided and supported by well prepared clinical mentors to integrate theory to practice and become competent clinical practitioners with good judgment (Lee, 2007). This is in line with other studies (Webb, 2008; RCN, 2005; Northcotte, 2001) which assert that all students on approved programmes must be guided and supported by appropriately prepared mentors during their clinical placements in order to gain clinical learning experiences. Webb (2008) asserts that clinical learning amongst all professions enables the development of knowledge, skills and attitudes of an individual and grounded in practice through the use of reflection on actions. In the study conducted by Eby and Lockwood (2005) on a mentorship programme of final year students in Australia, the findings revealed that the students were well prepared for their transition from students to registered nurses. Eby and Lockwood suggested that the development of a year-long mentorship programme for final year nursing students was of value in preparing them for the workplace.

RESEARCH METHODOLOGY

Approach: A descriptive qualitative approach was used in this study. The study was done in a selected nursing college campus in Durban, KwaZulu-Natal (KZN) which has a hospital linked to it. The selected nursing college campus is one of the campuses of the KZN College of Nursing offering a four-year basic diploma nursing programme.

Population: This study population consisted of the first and second-year nursing students doing four-year basic diploma nursing programme and the registered nurses (RNs) who were working in the wards/units of the hospital where mentees were allocated for their clinical learning experiences. Only first and second year students were chosen to participate because at the selected nursing college campus, these groups of students are available in the hospital clinical setting. At third year level, students are placed in community health care centres and at fourth year level, at psychiatric hospitals sometimes outside Durban. The researcher then focused on the first and second year students who were available at the campus and placed in the selected hospital units. There were 25 first-year students, 22 second-year students and 48 RNs working in the wards/units of the selected hospital. Total population was 95 subjects.

Sampling: Non-probability purposive sampling was used to select the participants for the study. Four first-year students, four second-year students and eight RNs were requested to participate in the study making a total sample of 16 participants. The students who had spent more than six months in the clinical settings were selected and the RNs who had had the most working experience in this hospital were also selected to participate. Registered nurses at this selected hospital, are mainly exposed to the mentioned selected student nurses because of the fact that the third and fourth year students are not allocated in this hospital and therefore, the inclusion criteria for mentors was the exposure of the mentor to mentoring these specific groups of mentees.

Data Collection: Unstructured interviews were used to collect data followed by focus group discussions. The researcher firstly conducted individual interviews with the RNs and with the students. Then three separate focus group discussions were held for the group of first-year students, for the group of second-year students and for RNs' group. Data was collected in quiet, private office spaces at the college were used for the students and a vacant office in the hospital was provided by the nursing service manager to collect data from the RNs.

The researcher arranged a time schedule with the participants, taking into consideration their availability so as to avoid disturbing their class sessions. Data was collected during their lunch times when they were free. It took about 30 to 45 minutes to complete the individual interview with each participant. An audio-recorder was used to capture the interview sessions. Permission to conduct the study was obtained from the participants before using the audio-recorder.

Data Analysis: A six-staged Schweitzer (1998) model of analysing data was used. In stage 1, text was repeatedly read from each transcript, line-by-line, and compared the data to the notes which had been taken during the interview in order to get a holistic picture of the responses from the participants. In stage 2, a constituent profile was developed and the raw data summarized from each participant. The central themes were extracted as they repeatedly occurred in the transcripts. In stage 3: a thematic index was formulated which highlighted the major themes that emerged from participants. Referents were then extracted. The researcher searched the constituents for referents which were then isolated and listed separately.

The data was then examined and analyzed collectively. Stage 4 included searching for the thematic index. Referents, central themes and the constituent profile were compared to form interpretive themes. At stage 5, an extended description of interpretive themes was made. Interpretive themes were used to rigorously explicate meanings attributed to the phenomenon under study. Lastly, in stage 6, a synthesis of extended description of interpretive themes was done. This formed a summary of interpretive themes that produced an in-depth picture of participants' understanding and experiences of clinical mentoring in the selected hospital.

Ethical Considerations: Ethic approval was obtained from the Research Ethics Committee of the Faculty of Health Sciences at the University of KwaZulu-Natal (UKZN) and the Research Committee of the KZN Provincial Department of Health. Permission to carry out the study was also obtained from the Principal of the KZN College of Nursing and the Nursing Service Manager and Hospital Manager of the selected hospital. Written informed consent was obtained from the participants. All participants were assured that anonymity and confidentiality would be observed by not using their names as codes would be used when recording data. Codes were assigned to transcripts instead of the names of participants to ensure anonymity and confidentiality. Participants were informed that they had to the right to withdraw from the study at any point if they so wished.

Academic Rigour: For credibility, students and mentors were requested to validate the correctness of data and data analysis. Transferability was done through detailed description of information obtained from the participants. To ensure dependability, the researcher conducted data quality checks or audits, peer review coding and also consulted with an expert in qualitative research who monitored the data collection process, the analysis and the interpretation of the data. Conformability was obtained by doing an audit of the data and by obtaining the participants' responses to the findings for cross checking and verification.

FINDINGS

The themes that were identified for this study included: (a) students' descriptions of clinical mentoring; (b) mentors' descriptions of clinical mentoring; (c) students' experiences of the process of clinical mentoring; (d) mentors' experiences of the process of clinical mentoring; (e) qualities of a good mentor; (f) benefits of clinical mentoring and; (g) challenges of clinical mentoring.

Figure 1: Data Presentation

Students views	Mentors' views
Description of clinical mentoring:	
• It is support and guidance to students when in clinical settings. • It's an opportunity for students to be exposed to new clinical learning opportunities and to practice nursing procedures within a safe clinical environment under the guidance of a mentor. • It is time of integrating theory learnt from college with practice in the clinical settings.	• It is a process of mothering, helping, supporting and guiding the students in their development, and acquisition of skills and knowledge when in a clinical setting. • It is a support strategy for assisting students to master clinical work through well structured learning experiences.
Views of the process of clinical mentoring:	
• For the mentoring process to be successful, students need to actively participate in clinical learning and be self directed. • Feedback received from clinical experiences form part of the mentoring process as it helped them to identify their shortcomings and understand where they went wrong. • It is viewed as an important role in promoting a positive learning environment for students to link theory to practice.	• Clinical and college staff should work together to make mentoring process more effective. • It should be done according to the students' needs; level of training and course learning outcomes. • Organisational factors play an important role to ensure that the environment is conducive for learning to takes place.
Benefits:	
• Grooming and nurturing students to become critical and mature professionals. • Students acquire good clinical skills and applied knowledge. • Helps to boost students' confidence and self-esteem and reduce feelings of isolation.	• Clinical mentors learn from the students during mentoring relationships.
Challenges:	
• The amount of time that the mentors had available to spend with them was limited. • Students were not properly mentored because of the heavy workload assigned to them in their professional capacity. • Students had not been informed about the mentoring process prior to their placement in the clinical settings.	• Mentors not adequately prepared for the process of mentoring which hampered their efforts. • Students assigned to the clinical setting for their practical training was increasing versus increased workload.

DISCUSSION

Descriptions of clinical mentoring

The phenomenon 'clinical mentoring' was understood according to individual experiences of students. Students described clinical mentoring as a form of support and guidance that was given to them by mentors as one participant stated:

> *The mentor is giving me a lot of support and guidance… always there to show me things and encourage me… she also made me realize what I actually do know and do not know.*

Mentors had a similar understanding that clinical mentoring is a strategy to guide and scaffold students in order to assist them to integrate theory to practice as indicated in the excerpt from the mentor:

> *Through mentoring, a student is groomed from a novice nurse to a fully grown-up grounded nurse who is able to face the challenges of the practice on her/his own and becoming an independent nurse practitioner... Enabling students to link theory to practice through practice and evaluation of their performances while undertaking a placement.*

According to Moll (2007) and Webb (2008), students need to be supported and guided when they are in clinical settings. Several researchers (Sean & Chow, 2008; Gilmour et al., 2007) pointed out that successful mentoring depends on the students' commitment to participate in the rendering of the nursing care in the wards, to ask questions when they are not sure and to be available for any activities that are done in the ward. Clinical mentoring depends heavily upon self-directed and student-centred learning (Gibbs et al., 2007). Pitney and Ehlers (2004) report that the students who actively participate in the learning process through clinical mentoring learn more than those who are not. It is therefore important that students take an initiative when working in the clinical settings so that supportive relationships of mentoring are developed.

Views on the process of clinical mentoring

Students reported that they had been made to feel welcome when they arrived at the clinical setting and had been orientated to their new surroundings.

Orientation helps to relieve anxiety and ease the students' transition from the classroom to the clinical setting. One of the mentors stated that:

> *Orientation of students in the unit is the actual kick-start of the mentoring process… I encourage them to ask some questions during the course of orientation if they have something they don't understand so that it is easy for me to explain it while they are still new.*

For the mentoring process to be successful, students need to actively participate in clinical learning and be self-directed. Ranse and Grealish (2009) are of the opinion that when students partake in clinical work and are mentored, they accept responsibility for work and valued this responsibility. Mc Call and Hughes (2010) described clinical involvement as important key factor for future practice as it provides hands on experiences and enhances communication and technical skills. The feedback that students receive from clinical learning experiences is viewed as part of the mentoring process because it helped to identify students' shortcomings and understand where they went wrong as stated in the abstracts below:

> *I enjoy working in this ward because the sister ensures that she corrects and give you feedback for each and everything I do, good or bad… it is important to get feedback immediately after demonstration of the procedure while a person still remembers the gap in my performance.*

McKimm (2009) suggests that a discussion of the student's performance after a procedure at different stages of training helps to increase the potential for learning as well as the professional development of the student, and also encourages the awareness of strengths and weaknesses by clarifying the areas for improvement and actions to be taken to improve performance. Mentors believed that the clinical and college staff should work in collaboration to make the mentoring process more effective as one mentor indicated that:

> *We have monthly nursing managers meetings with the college staff where the issues and problems pertaining to students learning in the wards are discussed…*

By working together, clinical and college staff can teach and prepare the students for proper placement and to work with confidence (Curtis, 2009).

According to Gibbs et al. (2007), the mentoring process incorporates a relationship that occurs between the clinical mentor and the educator that is characterised by trust and respect to ensure that learning and experimentation can occur and that potential skills can be developed in terms of competencies, attainment and confidence.

The majority of the mentors emphasised that teaching and clinical support of the students in the clinical setting should be done according to the students' needs, level of training and learning outcomes. It was indicated that the mentors followed the clinical learning outcomes in teaching and guiding students allocated in the clinical settings. One mentor stated that:

> *When the students come to the ward, I ask them about their learning objectives to ensure that they know their expectations in that ward... this will also inform me as to what I should cover in teaching them in accordance to their level.*

According to Hayes (2008), the training levels and learning outcomes are important when planning clinical learning and teaching so that theory and practice can complement each other. Learning outcomes act as evidence that teaching standards and curriculum have been maintained and covered. The mentors identified that organisational factors also played an important role in the mentoring of students to ensure that the environment is favourable for teaching and learning to take place in terms of clinical resources and requirements needed for clinical practice. According to Cherian (2007), in order to provide a quality mentoring process, training institutions must ensure that there are sufficient working resources and equipment available for the students. Healthcare organisations need to strive for the establishment of an environment that is acceptable for nurses and quality care so that proper mentoring takes place (Owen & Patton, 2003). Mlambo (2006) note, however, that the availability of equipment alone cannot guarantee the provision of quality care, but it may provide an important first step towards promoting it.

Qualities of a good mentor

Most students agreed that a good mentor must be approachable and always be available when students are in need of support as highlighted by one student that:

> *... Someone that I could always go up and ask a question… and feel like they can give me an answer without judging me... Someone that would talk to me on a personal basis… not make me feel intimidated… not indicating to me that she is smarter or something… demonstrates willingness to assist and support me.*

Pitney and Ehler (2004) indicated that accessibility, approachability and availability, when the need arises, are the key factors to the effective clinical mentoring of students. It is important that mentors are organised, friendly and approachable (RCN, 2005).

The students also felt that a good mentor needs to be a good role model for the students. This finding is underpinned in the results of the study by Gray and Smith (2000) which emphasised that clinical mentors need to lead by example to instil the sense of being professional, organised and self-confident. Students felt that a good mentor needs to have good communication skills, be knowledgeable with current clinical practices and not afraid to correct the students. One of the students stated that:

> *Open lines of communication and accessibility are important traits in a mentoring relationship… a student must be able to rely on this person for honest contribution in their growth and development with current knowledge... a wrong must be wrong and commend me for right actions.*

Myell et al. (2008) are of the view that mentors must always be up-to-date with current information and must also be experts in their own field of practice. Sherman (2005) indicates that mentors must be trained for this role so as to be able to display the 'necessary and expected' qualities. These qualities, according to Sherman, are good communication skills, ability to teach, openness, critical patience and a good attitude to others (2005).

Benefits of clinical mentoring

It was reported that clinical mentoring was essential for grooming and nurturing students to become critical and mature professionals as stated by one participant:

> *In the clinical settings, we exposed to the foundations of nursing for clinical growth … I can learn so much from her in a more relaxed and comfortable realistic setting in the ward... my clinical mentor is a clinical specialist with high clinical expertise.*

Some studies suggested that mentoring is important and effective in supporting the personal and professional development of trainees in the clinical area (Marable & Raimondi, 2007). The novice practitioners need to be mentored in order to develop professionally, acquire ethical standards, and learn about general nursing routines and responsibilities (Chapman & Orb, 2010).

Clinical mentoring benefited students to link theory to practice while in clinical placement. Brown, Birk, and Bernett (2008) are of the view that clinical mentors play an important role in supporting and assisting the students to apply theory into practice. This, according to Brown et al. (2008), is beneficial to the students because it links what was covered in the classroom to the realistic settings and, thereby, makes full sense to the learner.

Mentoring helps boost the students' confidence and self-esteem, and reduce feeling of isolation as they communicate with the mentor and other students during the exploration of information. Many studies (Bullough, 2008; Marable & Raimondi, 2007; RCN, 2005) point out that the provision of emotional and psychological support by mentors assist in boosting the students' confidence and enabling them to try some difficult experiences when in clinical practice. From the students' perspective, it was evident that mentoring was viewed as an integral part in the provision of an environment that is favourable for clinical learning to take place. Myal et al. (2008) indicated that a clinical mentor was responsible for increasing the students' learning chances.

The majority of mentors revealed that providing clinical support to the students encouraged them to keep up to date with their own clinical skills and knowledge to ensure that their practices were evidence-based so that they would be able to share them with the students. Some of the participants revealed that:

> *The students of today are very curious and critical, as a mentor, I need to be ahead of them and be as informative as they would expect me to be... be able to provide evidence-based clinical practice.*
>
> *Sometimes it is nice to work in a training hospital because you probably are compelled to read and explore more information at all the time in order to remain informative to be good source of information for the students... as a resource to students, I am needed to give updated information.*

Cahill (2006) highlighted that mentors' skills and knowledge increase during the mentoring process. Mentors played an important role in promoting a positive learning environment for students to link theory to practice. This is in line with the study by Myal et al. (2008) which suggests that the role of clinical mentor is important in helping the students to feel connected to their clinical placement.

Challenges to clinical mentoring

While students and mentors identified the benefits of mentoring, they also recognised some challenges that could have an impact on the process of mentoring. The amount of time that the mentors had available to spend with students was limited due to the staff shortages and other clinical commitment affected teaching and support. According to Harrison et al. (2009), mentors have no time to spend on teaching the students due to the pressure of their clinical work. Mentors experience conflict between patients care demands and fulfilling their mentoring roles. They also indicated that they were not adequately prepared for the process of mentoring which hampered their efforts as indicated in the following excerpt:

> *There are no guidelines for us as clinical mentors on how to go about with mentoring of the student in the clinical setting... I just help students in day-to-day activities in the ward and giving them direction in terms of expectations and decisions in their learning… transition … as they adapt to a new environment but there is no formal programme to support me playing this role.*

Supporting the findings of this study, several researchers (RCN, 2005; Orland-Barak, 2007; Bullough, 2008) state that mentors sometimes feel inadequately prepared for the mentoring role and are daunted by the prospect of giving lessons and also by the possibility that mentees might present new ideas. It was revealed that students were not properly mentored because of the heavy workload assigned to mentors in their professional capacity as stated below:

> *I don't have enough time for students... I am supporting too many students at a time and sometimes I feel under pressure… especially when there are staff shortages in our already under resourced clinical areas.*

This is consistent with the studies of Lee (2007) and Simpson, Hafler, Brown, Wilkerson (2004) which stated that clinical mentors experience increased and sometimes unmanageable workloads when the role of mentoring is added to their normal daily routine. One of the mentors reflected as follows:

> *We have huge workloads and mentoring becomes an issue, it waste time because if you are mentoring then you have to take students step by step, slowly, answering their questions and repeating one and the same thing, it just doesn't work… the workload that we have in the ward.*

Furthermore, apart from the difficulties mentors might experience in accommodating the students' needs as well as their normal duties, unmanageable workloads can have an impact on their work-life balance and cause stress. In this study, students indicated that they had not been informed about the mentoring process prior to their placement in the clinical settings and were unsure of the role of mentor, their role or what was expected of them. According to previous studies done (Aston & Molassion, 2003; Eby & Lockwood, 2005; Hopkins, 2005) it is indicated that students were not usually prepared for being mentored before the clinical placement whereas, it important for the person who is to be mentored to be introduced to the mentor before they are placed in the clinical settings, in order to have realistic expectations from the mentoring process.

The majority of clinical mentors felt that the number of students being assigned to the clinical setting for their practical training was increasing and that there were not enough trained nurses in place to mentor them, which had a negative impact on the quality of the mentoring process. Some of the mentors stated the following:

> *The wards are always full and the staff ratio to patients is terrible, we are always way too short-numbered, so we don't get time to teach and support the students the way we feel we need to, poor students I feel sorry for them… we just throw them in the deep end.*

> *We do not have staff, we have huge workloads and mentoring becomes an issue, it waste time because if you are mentoring then you have to take students step by step, slowly, answering their questions and repeating one and the same thing, it just doesn't work… the workload that we have in the ward.*

Myal et al. (2008) state that mentors who support too many students sometimes experienced pressure to accept more students, especially when they are short staffed.

Recommendations

This study suggests some recommendations for the improvement of clinical mentoring in basic nursing education specifically, as this relates to student mentoring in clinical settings as follows:

- Formalised mentorship programme need to be put in place where mentors will be properly trained for the role and formally appointed to the roles.
- The NEIs together with the clinical facilities should ensure that a system of mentorship preparation is put in place which will help clinical mentors to be aware of their role and know what is expected of them.
- Students need to be better informed about the mentoring process before they are placed in clinical settings so that they are aware of what is expected of them.

Conclusion

Mentoring is a dynamic and complex relationship that can support growth, increase synergy and develop ways for students to succeed as mature practitioners. Clinical mentorship in nursing remains an integral part of students clinical learning experiences and has a significant influence on the quality of the students' learning experiences when in clinical placements. The results reported that both mentors and mentees viewed clinical mentoring as a support and guidance strategy for students when in clinical settings, which needs to be formalised and well organised for effective results.

It is suggested that clinical mentoring should be a process where clinical and college staff work together in linking theory to practice towards ensuring that mentees acquire the best possible clinical skills, applied competence and knowledge that lead to professional and personal development. Through the process of mentoring, students are oriented to the clinical milieu and given guided opportunities to participate in the clinical activities in order to acquire skills they need, while at the same time being self-directed and independent learners.

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