

**FACTORS INFLUENCING SUBMISSION OF PORTFOLIOS OF  
EVIDENCE AMONGST NURSES TRAINED IN NURSE  
INITIATION AND MANAGEMENT OF ANTIRETROVIRAL THERAPY  
IN NORTH WEST**

**Martha N. Motlokoa**

A research report submitted to the Faculty of Health Sciences,  
University of the Witwatersrand, in partial fulfilment of the requirements for the  
degree of Master of Science in Nursing.

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## **DEDICATION**

This dissertation is dedicated to my supportive husband, T. P. A. Motlokoa, and children.

## **ACKNOWLEDGEMENTS**

I am grateful to my supervisor, Rita Maboko, for her guidance, patience and support. I am also thankful to Goitse Manthata for her assistance and contribution to the development of this report.

## **DECLARATION OF OWN WORK**

I, Martha N. Motlokoa, declare that this research report is my own work. It is being submitted for the degree of Master of Science in Nursing in the University of the Witwatersrand, Johannesburg. This report has never been submitted before for any degree or examination at this or any other university.

Signature

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Date

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## ABSTRACT

In response to the high number of patients needing ART treatment in South Africa, the National Department of Health introduced a programme termed nurse initiation and management of ART (NIMART). NIMART- trained nurses are mandated to submit a portfolio of evidence (POE) to measure their clinical knowledge and competency for accreditation. However, the POE submission rate is low.

The study objective was to identify barriers and facilitating factors affecting the submission of POEs by NIMART-trained nurses in the North West Province. A qualitative approach was followed using three focus group discussions to collect data from NIMART-trained nurses in the North West Province. Data was analysed thematically.

Six key themes were identified, including three barriers (disorganisation; NIMART prerequisites and lack of human resources) and three facilitating factors (support and team work; effective placement and motivation). Recommendations were made to improve POE submission and NIMART accreditation rate in future training efforts.

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## DEFINITION OF TERMS

- i. AIDS – acquired immune deficiency syndrome
- ii. ART – antiretroviral therapy
- iii. ARVs – antiretrovirals
- iv. Barriers – obstacles or circumstances interfering with submission of the portfolio of evidence
- v. DoH – Department of Health
- vi. Facilitating factors – factors promoting the submission of the portfolio of evidence
- vii. HIV or HI-virus – human immunodeficiency virus
- viii. ILGA – international lesbian, gay, bisexual, transgender and intersex association
- ix. IMCI – integrated management of childhood illnesses
- x. NDoH – National Department of Health
- xi. NGOs – non-governmental organisations
- xii. NIMART – nurse initiation and management of antiretroviral therapy training for registered nurses
- xiii. North West Province (NWP) – a province in the north of South Africa on the Botswana border, fringed by the Kalahari Desert in the west, Gauteng Province to the east, and the Free State Province to the south (Southafrica.info, 2002).
- xiv. PALSA PLUS – Practical Approach to Lung Health in South Africa
- xv. PEPFAR – the United States President’s Emergency Plan for AIDS Relief; a government initiative to address the global HIV/AIDS epidemic, primarily in Africa
- xvi. PMTCT – prevention of mother-to-child transmission
- xvii. POE – compilation of documents designed by the NDoH, which provide evidence of the management of 80 cases, including adult, paediatric, pregnant, HIV-TB co-infected, baseline and follow-up patients. The POE is used to measure clinical knowledge and competency and its approval is required for accreditation.
- xviii. RTC – regional training centre

xix. STIs – sexually transmitted infections

xx. TB – tuberculosis

# CHAPTER 1

## 1. INTRODUCTION TO THE STUDY

### 1.1 Introduction and Background

South Africa has improved remarkably in initiating HIV-infected people on antiretroviral therapy (ART), with the highest number of people (more than 2 million) initiated on antiretrovirals (ARVs) worldwide. The implementation of nurse initiation and management of ART (NIMART) training by the National Department of Health (NDoH) has been a key component of South Africa's national plan to increase ART enrolment. More people are being infected with HIV, which increases the demand for ARVs, and places more pressure on the public health sector (Nyasulu, Muchiri, Mazwai, & Ratshefola, 2013).

As the scale of the HIV epidemic became known, it was clear that there was an insufficient number of public sector doctors to provide HIV/AIDS care in South Africa (Georgeu, Colvin, Lewin, Fairall, Bachmann, Uebel, Zwareinstein, Draper, & Bateman, 2012). Initially HIV/AIDS care was mainly provided by doctors. As stated by Cameron, Gerber, Mbatha, Mutyabule, & Swart (2012), there were only 69 medical practitioners and 388 professional nurses per 100 000 people in South Africa. Considering that there were not enough medical practitioners to combat the increasing demand for ART, a Presidential mandate was called in 2010 for such treatment to be made available at all 5 500 public health facilities across the country, and for nurses to be trained in its prescription and management. In order for medical practitioners to be able to hand over their routine HIV management chores – monitoring, prescribing and dispensing of ARVs, and monitoring patient adherence – professional nurses needed to be trained in NIMART (Georgeu, et al., 2012).

Assigning ART management to professional nurses is of tremendous benefit to people living with HIV as such patients can now be managed at primary health care (PHC) level. As there is no need to refer uncomplicated cases to referral hospitals, patient compliance to treatment is improved (Cameron, et al., 2012; Nyasulu, et al., 2013). Furthermore, this saves transport costs for people living with HIV, with hospitals located far from residential areas in most cases, in contrast to conveniently

situated PHC clinics. Studies have found that NIMART is cost-effective and not inferior to doctor-managed ART (Nyasulu, et al., 2013). Nevertheless, Davies, Homfray & Venables (2013) warn that NIMART has to be implemented effectively, irrespective of its complexity, to ensure that a greater number of people have access to ARVs. Many countries have increased ARV access for those living with HIV, resulting in a 19% global decline in mortality and a longer life expectancy among this population between 2004 and 2009 (UNAIDS, 2010). NIMART promotes comprehensive and efficient patient management, whereby patients can be pre-counselled, tested for HIV and initiated on ART by the same nurse (Anova Health Institute, 2014). A patient can access other PHC services besides HIV services – tuberculosis (TB) services for instance – from the same nurse, which ultimately saves time and improves compliance, as there is no need to consult other nurses.

NGOs mandated to train nurses IN MIMART have developed training guided by NDoH guidelines and policies. NIMART training consists of a 5-day theoretical component that incorporates the following topics: a basic HIV/AIDS overview; opportunistic infections in adults and children; appropriate investigations; and the diagnosis and treatment of HIV, TB and sexually transmitted infections (STIs). The theoretical component also consists of case studies and role-play exercises. After training, a written examination is administered; if unsuccessful, trainees are allowed two more opportunities for assessment (Cameron, et al., 2012).

During training, nurses are allocated to a clinical mentor for 6 months for assistance in completion of a portfolio of evidence (POE) at the facility where they work. A POE comprises a number of collated documents demonstrating acquired skills, knowledge and work done. The documents are used as a tool to assess an individual's competency (Simmons & Lumsden, 2009). The POE developed for NIMART was developed by the NDoH using different clinical mentorship documents and tools from partners involved in NIMART training, as well as from policies and guidelines from the NDoH (NDoH, 2011). The POE is used during the NIMART programme by NIMART trainees to document cases that they have consulted under the supervision of a clinical mentor. Each POE must comprise 80 cases spanning paediatric, adult, pregnant, TB/HIV co-infected, baseline and follow-up patients. A patient may be representative of more than one case where there is overlap in these categories. After 6 months, the trainees are required to submit a completed POE for

accreditation purposes; this is reviewed by one mentor and accreditation is performed by the NDoH. A competency certificate is awarded to the trainee upon successful completion of a POE that meets all NDoH-stipulated certification requirements.

According to the District Health Information System of the North West Province, 1 500 nurses were trained in NIMART in the province between September 2013 and September 2014; however, only 190 trainees submitted a POE within the 6 months allocated for the accreditation process, despite being allocated clinical mentors (North West Province DoH, 2014). The Department of Health (DoH) has expressed concern at the limited number of accredited nurses as opposed to number of NIMART-trained nurses, and it is recognised that non-accreditation may interfere with provision of proper HIV management.

The North West Province DoH requested assistance from the Southern African HIV Clinicians Society (hereinafter referred to as “the Society”), in capacitating the province’s NIMART-trainee nurses in HIV/AIDS care. The researcher is employed by the Society – an NGO concerned with the promotion of evidence-based, quality HIV/AIDS health care in Southern Africa. The organisation provides information, resources and continuing professional development (CPD)-accredited education to health professionals on HIV/AIDS management. Accordingly, commencing in October 2014, the Society undertook to facilitate clinical case study workshops. The workshops are interactive sessions designed to strengthen participants’ competence and problem-solving skills through group review and discussion of common HIV/TB cases in PHC. The objectives of these workshops are to equip participants with the necessary skills to complete the POE for accreditation and to be able to confidently prescribe and manage ART. The researcher is the facilitator of these clinical case study workshops.

To increase the POE submission rate among NIMART-trained nurses in the North West Province, it is imperative that the Society gains an understanding of the barriers and facilitating factors which affect POE submission.

The problem of non-submission of POEs by NIMART-trained nurses is not unique to the North West Province, but is a problem faced in most provinces in South Africa. In

2013, Health-e News carried an article about the graduation of NIMART-trained nurses in Mpumalanga Province, reporting that between 2010 and 2013, 1 234 nurses were trained in a NIMART programme in the province, with only 225 declared competent and confident. According to the report, 1 009 NIMART-trained nurses did not submit their POEs, representing a very low accreditation rate of 5%. This information was verified in a formal announcement by the Mpumalanga MEC of Health and Social Development.

## 1.2 Problem Statement

A significant number of NIMART-trained nurses in North West Province are not submitting a Portfolio of Evidence (POE) within the 6-month timeframe stipulated by the NDoH for accreditation. The province therefore has very few nurses accredited in relation to the number who have received NIMART training. This has a direct impact on ART service delivery for patients. The barriers and facilitating factors affecting POE submission are not known; accordingly, this study sought to identify these in order to devise strategies to support nurses in attaining NIMART accreditation.

## 1.3 Research Purpose

To explore and describe the factors affecting the submission of POEs for accreditation by NIMART-trained nurses in the North West Province, in order to contribute to the improvement of the POE submission rate.

## 1.4 Research Objectives

To explore and describe (i) the barriers and (ii) the facilitating factors affecting POE submission by NIMART-trained nurses in the NIMART accreditation process in the North West Province.

## 1.5 Research Questions

- What are the barriers that interfere with POE submission by NIMART-trained nurses for NIMART accreditation in the North West Province?
- What are the facilitators promoting POE submission by NIMART-trained nurses for NIMART accreditation in the North West Province?

## 1.6 Research Significance

The effectiveness of NIMART training is currently measured by the accreditation rate. It is thought that non-accreditation may have an impact on the way HIV-positive individuals are managed and offered care. This study is intended to contribute towards the development of more effective strategies and see the introduction of support structures to allow NIMART-trained nurses to overcome potential barriers and promote facilitating factors that affect POE submission for NIMART accreditation. An improved POE submission rate and consequent improvement in the number of accredited nurses will positively influence the management and care offered to HIV-infected people.

## 1.7 Philosophical perspective/Study Paradigm

According to Brink, van der Walt, & van Rensburg, (2013a) qualitative research study doesn't have to be explained in terms of a theoretical or conceptual framework, instead a philosophical rationale may be presented, which is what has been done in this study.

A paradigm is a way of looking at natural phenomena that encompasses a set of philosophical assumptions and that guides one's approach to enquiry (Polit & Beck 2008). Laudén (1995) in Polit and Beck (2008) defines a paradigm a set of assumptions about the basic kinds of entities in the world, about how these entities interact, and about the proper methods to use for constructing and testing theories of these entities.

The Phenomenological paradigm was followed in this study. Phenomenological inquiry is used by qualitative researchers using naturalistic approaches to inductively and holistically understand human experience in context-specific settings. Phenomenological inquiry's main focus according to van Manen (2011) is to "borrow" other people's experiences to become more experienced as a researcher. Traditionally, techniques used to obtain "data" from participants are by way of interviewing, eliciting written responses, and participant observation in order to reflect on the meanings and experiences that they have (van Manen, 2011).

The transcendental type of the phenomenological approach was used in this study. During this enquiry process, the researcher should bracket any preconceived

beliefs and opinions that he/she might have about the phenomenon under investigation and data should be analysed in such a way that patterns or themes emerge to identify the essence of the phenomenon (Brink et al, 2013). In this type of study a theoretical framework cannot be used as this would influence the researcher's beliefs about the phenomenon under study. This is another reason a theoretical framework was not used in this study.

In this study the assumption made was that exploring the shared experiences from NIMART trained nurses would contribute toward formulating recommendations to improve the POE submission rate and consequent accreditation of NIMART trained nurses. An empirical study was conducted to achieve the study objective. According to van Manen (2011), empirical methods are used to explore examples and varieties of lived experiences especially in the form of anecdotes, narratives, stories, and other lived experience accounts. In this study the researcher used semi-structured interviews through FGD's to collect data.

#### 1.8 Conclusion

This chapter provided an introduction to the study, including an overview of the progress and history of HIV/AIDS programmes in South Africa, and the reasons why and how NIMART was introduced. Emphasis was placed on the problem facing the North West Province DoH regarding the low POE submission rate among NIMART-trained nurses. The problem statement, research questions and objectives, study significance and study assumptions were also defined.

Chapter 2 provides a literature review conducted relevant to the research.

## CHAPTER 2

### 2. LITERATURE REVIEW

#### 2.1 Introduction

According to Burns & Grove (2005), a literature review is a way of presenting a specific topic published by scholars, in an organised written format. The purpose of the literature review is to paint a picture in terms of what is currently known in a particular field, highlight the knowledge gaps that exist therein, and paint a way forward to seeking answers to a research question. In this study, policy documents, reports and peer-reviewed journal articles were reviewed to gain a greater understanding of the information pertaining to the barriers and facilitating factors affecting POE submission by NIMART-trained nurses for accreditation. Topics discussed in this literature review include the following: HIV/AIDS globally; NIMART programmes in South Africa and other countries; factors affecting South Africa's HIV prevalence, expanding access to ART, NIMART acceptability and effectiveness, NIMART accreditation in South Africa and task-shifting within the HIV/AIDS context in South Africa and other countries.

In this study, the researcher endeavoured to contribute new information in order to close the existing knowledge gaps related to the factors that affect completion of the NIMART accreditation process. Previous studies have probed NIMART training itself, and the significance thereof, but there is a dearth of research in terms of barriers or facilitators that could respectively interfere with, or promote the accreditation status of NIMART-trained nurses in South Africa.

#### 2.2 HIV/AIDS overview globally

The HIV/AIDS pandemic is still leading in causing deaths among human beings globally. AIDS is still one of the most destructive epidemics the world has ever witnessed. Globally, there are 35 million people infected with the HI-virus, with 2.1 million newly infected, although this represents a decline of 38% from the period 2001 - 2013 when there were 3.4 million new infections. The sub-Saharan countries take the global lead in terms of HIV prevalence, with an estimate of 22.5 million in 2013, accounting for nearly 71% of the global HIV prevalence. Within sub-Saharan

Africa, South Africa is leading with an HIV prevalence of 6.5 million (UNAIDS, 2013). Within the same period (2013), Statistics South Africa reported a contradictory HIV prevalence of 5.26 million (Statistics South Africa, 2013). Regardless of this discrepancy in prevalence rates, HIV/AIDS in South Africa is an important health concern, and the number of people living with HIV is rising as a consequence of prolonged life expectancy in HIV-positive individuals due to ART. These statistics mean that South Africa is leading globally with the number of people infected with the HI-virus. In sub-Saharan Africa, women are disproportionately affected: more women are HIV-positive than men, accounting for 58% of the entire HIV prevalence. In 2006, of the estimated 1.8 million people infected with HIV globally, 1.5 million were from sub-Saharan Africa and affected by conflict, displacement or disaster (UNAIDS, 2013). It is thought that this number has since grown, owing to the significant increase in number of people displaced.

Moving abroad, certain countries appear to have a very low HIV prevalence, although this is often justified by a small total population size. In Cuba, for instance, with a population of 11 million inhabitants, only 0.05% of the population is living with HIV according to the WHO (2004). In contrast, India accounts for 6%, United States of America 4%, Brazil 2%, China 2%, and the Russian Federation 2% of the global HIV prevalence.

Neighbouring countries, such as Lesotho and Botswana, are better off than South Africa in terms of HIV prevalence, according to a report by UNAIDS, the WHO and UNICEF (2008). Lesotho recorded the third highest population of people living with HIV globally (23.2% of adults). The HIV prevalence rate in Lesotho is approximately 270 000, with 80 000 - 85 000 estimated to be eligible to be initiated on ARVs, and approximately 18 000 AIDS-related deaths annually, accounting for 1% of the population.

Although a middle-income country with a relatively well-developed health care system, Botswana also has a high HIV prevalence: in 2004, about 17.1% of the 1.7 million people in the country were diagnosed as HIV-positive, with a prevalence rate of more than 30% among women attending antenatal clinics. Botswana, with the advantages of a stable government and good leadership, was able to initiate ART in 74 000 eligible patients in 2006, with a goal to commence ART in 80% of eligible

HIV-positive citizens by 2009. The country is doing well in attaining its goal: in 2005 the African Comprehensive HIV/AIDS Partnership (ACHAP) reported that Botswana had more people receiving ART than its neighbouring countries in sub-Saharan Africa. During the same year that Botswana successfully initiated its citizens on ART, South Africa had not started initiating such treatment in its 900 000 citizens who required it (UNAIDS and WHO, 2005). Table 1 below summarises global HIV prevalence estimates by UNAIDS, (2013).

**TABLE 2.1 HIV prevalence globally**

<b>Countries</b>	<b>HIV prevalence estimates</b>
Sub-Saharan Africa	22.5 million
South Africa	6.5 million
Lesotho	270 000
Botswana	1.7 million
Middle East and North Africa	380 000
South and South East Asia	4 million
East Asia	800 000
Latin America	1.6 million
Caribbean	230 000
Eastern Europe and Central Asia	1.6 million
Western and Central Europe	760 000
North America	1.3 million
Globally	33.2 million

### 2.2.1 HIV/AIDS history in South Africa

South Africa has the largest HIV/AIDS programme in the world, proportionate to its HIV rate being the highest globally. As stated above, South Africa's HIV prevalence rate was approximated at 6.5 million in 2013. A UNAIDS GAP Report (2013) recorded 330 000 incidents of HIV infection and 200 000 deaths from HIV/AIDS and related illnesses in the same year. In 2013, Statistics South Africa estimated in their mid-year population estimates that there were 52.98 million people in South Africa, approximately 10% of whom were living with HIV. Life expectancy for an average South African was estimated to be 57.7 years for males and 61.4 years for females.

Government leadership in South Africa, specifically denialism that HIV causes AIDS, resulted in a delay in initiating eligible South African citizens on ART. This is supported by the opening speech made by then President Thabo Mbeki at the International AIDS Conference in Durban on 9 July 2000 that immune deficiency is a major problem in Africa but cannot be ascribed to one virus (Mbeki, 2011). Extreme poverty, rather than HIV and AIDS, was the central theme of President Thabo Mbeki's speech. There were international pharmaceutical and drug agencies willing to assist South Africa with free ART; however, the ministry of health resisted providing such treatment to the populace.

It was only in November 2003 that the South African government approved a plan to make ART publicly available (SANAC, 2011). As a consequence, a large number of people died from AIDS-related illnesses prior to 2003. However, once South Africa started issuing ARVs to those eligible for such treatment, new HIV infections were avoided – in particular, HIV infections among children, as a consequence of HIV-positive pregnant women receiving ART. There was an overall 51% decline in deaths due to AIDS-related illnesses in South Africa between 2009 and 2013 (UNAIDS GAP Report, 2013).

South Africa has progressed greatly in fighting the HIV epidemic in recent times, to become the country with the largest HIV management programme in the world. What is encouraging is that South Africa has largely funded its own resources for this programme (UNAIDS, 2013). Hopefully this financial security will last and the government, with support from research institute centres, will discover new ways of achieving further results in the battle against HIV. The government has implemented its policies strongly emphasising equity, social justice and forbidding discrimination of sexual groups. Resulting from the strict policy implementation, South Africa has the ability to provide HIV treatment tailored to men who have sex with men (MSM), in contrast to other sub-Saharan African countries (Rispel, Metcalf, Cloete, Moorman, & Reddy, 2011). South Africa is the only country in sub-Saharan Africa where gay rights are formally recognised (ILGA, 2013).

#### *2.2.1.1 Factors affecting South Africa's HIV prevalence*

The reasons for the high HIV prevalence in South Africa are varied and include: the high poverty rate; level of violence against women; traditional norms that encourage

intergenerational marriage and sexual intercourse; poor condom use; high mobility (particularly migrant labour); politically related issues; and obstacles that prevented an abrupt response to HIV; literacy problems; drug abuse; and a high prevalence of STIs (AIDS Foundation of South Africa, 2014). It would be difficult to correct some of these factors, because they would require longer term behavioural and societal changes.

South Africa has the highest number of people affected by poverty, with an estimated unemployment rate of 40% (Lopman, Lewis, Nyamukapa, Mushati, Chandiwana, & Gregson, 2007). Poverty has been linked with HIV prevalence, both at the individual and community level (Silveira, Santos, & Victora, 2008). Poorer individuals, due to the lack of alternative livelihoods, are prone to engage in sex work or what is termed “transactional sex”. Due to poverty, more women leave their homes looking for jobs in the cities, only to find out that employment is scarce, and end up using sex work as an alternative form of income.

Rape is also significant menace in the country: Muula (2008) posits that one woman is raped every second in South Africa. Compared to consensual sex, rape is likely to be unsafe due to tearing and the high probability of non-condom usage.

Sexual intercourse from different generations or age groups, (where young women have sex with men who are more than 5 years older than them) is another factor that contributes to HIV transmission in South Africa. This intergenerational sex is associated with unequal sharing of power and authority in decision-making, low condom usage, manipulation, poverty and the need for the woman to survive economically (Muula, 2008).

There is a positive correlation between socioeconomic background and the likelihood that an individual will consent to voluntary HIV counselling and testing; simply put, testing for HIV becomes less of a priority when faced with other challenges associated with being poor. On the contrary, those who are educated and employed are generally found to be more knowledgeable about their HIV status and HIV matters in general (Muula, 2008).

In a study about the impact of migration on HIV-1 transmission in South Africa, Lurie, Williams, Zuma, Mkaya-Mwamburi, Garnett, Sturm, Sweat, Gittelsohn, Abdool & Karim, (2003) argue that the system used in managing migrant labour camps is a contributing factor for the spread of HIV in South Africa. Male labourers are not allowed to have their spouses accompany them to the mines where they work; consequently, it is thought that this has created an opportunity for sex work to thrive. If the men are infected with HIV or other STIs, they will transmit those to their sexual partners when returning home.

A study on HIV/AIDS risk among men and women who drink at informal serving establishments (sheebens) was conducted in Cape Town, South Africa in 2008 by Kalichman, Simbayi, Vermaak and Jooste. The study revealed a link between consuming alcohol and the spread of HIV in the sheebens. The flourishing growth in the number of taverns and sheebens in poor, peri-urban South Africa, as a result of the outcomes of aggression, segregation and discrimination during the apartheid period, has contributed in the spread of HIV. Such environments promote sex work or irresponsible sexual behaviour; when individuals become intoxicated with alcohol, it may become challenging to negotiate condom usage.

### 2.2.2 Expanding access to ART

It is crucially important to increase access to ARVs for those who are eligible to receive such treatment. The initiation of ART improves quality of life and counters all the devastating effects brought on by the HIV/AIDS epidemic. Testament to this is the prevention of mother-to-child transmission during pregnancy, and the prevention of many children being orphaned as their HIV-positive mothers are being kept healthy by ARVs. Previously, the stress associated with pregnancy and its dramatic effects on the immune system, in the absence of ART, meant that some HIV-positive women would not survive the pregnancy.

In order for South Africa to be able to combat the HIV/AIDS epidemic, health personnel and communities need to be trained, there should be an improvement in infrastructure, and different stakeholder involvement has to be encouraged. To expand access to ART further, the NDoH wishes to initiate ART to 2 million eligible people over the next 2 years. In order to achieve this, it is crucial that South Africa embraces the adoption of a chronic diseases management model, continues with

extended task-shifting and decentralisation of ART services, and explores new and innovative ways of distributing ART (Gray, Conradie, Crowley, Gaede, Gils, Shroufi, Hwang, Kegakilwe, Nash, Pillay, Stender, Venter, & Matthews, 2015). It is necessary that South Africa stays abreast of new developments regarding HIV and adopts WHO recommendations timeously.

In 2007, the NDoH through its National Strategic Plan for HIV/AIDS, set out a goal to expand ART coverage to reach 80% of those who required treatment, by the year 2011. By October 2012 this goal was realised and even exceeded (IRIN, 2012). This was supported by a UNAIDS report (2012), which reiterated that South Africa had tremendous success in rolling out ARVs to those eligible, having achieved a 75% increase in ART rollout between 2009 and 2011. South Africa, as the country with the highest HIV rate globally, has demonstrated commendable achievements in expanding access to ARVs, especially to people in low socio-economic settings. As a result, greater benefits in terms of improved quality of life and survival have been realised.

Expanding ART to all pregnant women is one of the greatest strategies South Africa has implemented. The prevalence among children has declined and the mortality rate reduced by 20% (HSRC, 2014) through programmes like the prevention of mother-to-child transmission of HIV (PMTCT). UNAIDS (2013) praised the global community for its outstanding achievement in the preceding 5 years in fighting HIV/AIDS: globally by the end of 2013, 12.9 million people were receiving ARVs, of whom 5.6 million were initiated on the treatment since 2010; and the number of infected people who were not receiving ART was reduced by 27% between 2006 and 2013.

The increase in ART access has occurred rapidly, with only a few countries responsible for this sharp increase. South Africa was one of these countries, with a 33% increase, followed by India at 7%, and Nigeria, Mozambique, The United Republic of Tanzania, Zimbabwe and Uganda at 5% each. Sub-saharan Africa has avoided 4.8 million deaths since 1995 through ART expansion; placed in perspective, globally this figure is 7.6 million. In sub-Saharan Africa, 87% of HIV-infected people are aware of their HIV status and are receiving ARVs; and nearly 76% of these have achieved viral suppression. Viral suppression simply means that the HI-virus is

reduced to an undetectable level in a blood sample from someone who is HIV-positive and is compliant in taking his/her ARVs. The percentage of people living with HIV who are not receiving ART has been reduced from 90% in 2006 to 63% in 2013 (UNAIDS, 2013).

It is clear that increasing ART access was the best strategy implemented globally to combat the HIV epidemic. People are living longer, children born from HIV-infected mothers are being born HIV-free, and life expectancy has increased globally. However, no matter how much ART access the health system may have available, human resources remain fundamental in administering and managing treatment in eligible patients. With health worker shortages globally, ART programmes cannot be sustained without task-shifting.

### 2.2.3 Task-shifting globally

Task-shifting refers to the re-allocation of specific duties among health care professionals in an attempt to combat staff shortages and improve work flow. Specific duties from highly qualified health professionals are transferred to health professionals (or even non-professionals) with lesser training or qualifications, e.g. lay counsellors are trained to carry out HIV testing instead of nurses, or nurses are trained to prescribe ARVs instead of doctors. Distinct benefits through such re-allocation, specifically in the HIV/AIDS field, include improved access to treatment and a reduced effect of staff shortages on health care, through rapid expansion of the available human resources base (UNAIDS 2007). Importantly, the new roles shifted to the newly defined category of staff must be explained clearly, and as such, be defined by supporting documentation covering the scope of practice.

A shortage of health care personnel is experienced globally. According to a WHO (2007a) report, up to 57 countries, mostly sub-Saharan African countries, Bangladesh, India and Indonesia, face an extreme shortage of trained health care professionals. Globally, to fill the gap, 4 million health personnel are required. In further portrayal of this human resources crisis, health care personnel (doctors and nurses) per 100 000 rates were reported as follows: South Africa 69.2 doctors and 388.0 nurses, Botswana 28.7 doctors and 241 nurses, Ghana 9.0 doctors and 64.0 nurses, Zambia 6.9 doctors and 113 nurses, Tanzania 2.3 doctors and 36.6 nurses,

Malawi 1.1 doctors and 25.5 nurses, USA 230 doctors and 1 212 nurses, and the United Kingdom 256 doctors and 937 nurses.

Most countries are implementing task-shifting strategies in order to improve ART coverage. In Uganda, nurses have taken over doctors' tasks in managing patients on ARVs, in an attempt to address the serious health worker deficit (80%, with only one doctor per 22 000 patients) (WHO, 2007a). Other African countries are similarly not being left behind, with Malawi, Ethiopia, Namibia, Lesotho, Botswana, South Africa, Zambia and Rwanda having successfully implemented the approach of re-allocating duties in HIV management. This task-shifting is not restricted to the developing world: countries with high socio-economic rankings, such as the United Kingdom, United States of America and Australia, are similarly re-allocating duties to nurses and empowering them to prescribe routine medication (WHO, 2007a).

The re-allocation of duties expands clinical services and can even extend as far as transferring specific tasks from professionals to non-professionals. This happens when patients are trained to manage their own disease continuously – particularly in patients with chronic conditions such as asthma, diabetes and HIV infection. This may see improved patient outcomes in addition to reducing the requirement to travel often to a health facility, which is a known barrier to retention in care. This approach may thus increase adherence to treatment, particularly in the case of patients who are required to request permission from an employer to attend a clinic often. There is also evidence that a greater number of patients are more content consulting nurses than doctors, because nurses are perceived to have better interpersonal skills (WHO, 2007a).

Cautiously, the process of re-allocating duties has to be implemented correctly, such that quality of care is not compromised. Protocols and set standards must guide the recruitment and training of health workers to whom the responsibilities will shift. The development of these standards must be inclusive of: a definition of the training to be undertaken; ascertaining the level of expertise and experience that are prerequisite to enrolment for training; ascertaining how knowledge and competency will be assessed after training; appropriate mentoring processes; and ensuring opportunities for continuing education (UNAIDS, 2007).

#### 2.2.4 Task-shifting in South Africa

After the announcement from the South African president in December 2009 that ARV services would be offered by nurses, the country was finally in a position to expand its HIV programme. The mandate from the presidency focused on expanding ART to HIV-infected infants, pregnant women, and people co-infected with TB and HIV. This was a major victory for the HIV programme in South Africa. This task-shifting not only meant the expansion of the human resource base in HIV/AIDS management and consequently a greater ART coverage, but also other positive gains including: earlier, faster patient enrolment; improved treatment accessibility, especially in rural areas; lower incidental costs for the patients who previously had to travel to hospitals (as opposed to their PHC clinics) to access treatment; improved adherence; and longer retention of care in the HIV/AIDS programme (Davies, et al., 2013, NDoH, 2011).

Other motivations for implementing task-shifting in South Africa were: to lower the patient load on health professionals; to lower the child and maternal mortality rate; and to increase the life expectancy of HIV-infected individuals, as ART improves quality-of-life and delays death. Due to the task-shifting, expansion of the ART programme saw more than 2.6 million eligible patients initiated on ARVs by mid-2014 (National Consolidated Guidelines, 2015). Reports from the STRETCH study (Streamlining Tasks and Roles to Expand Treatment and Care for HIV) indicated that ART can be provided in a safe manner by nurses who are well trained, and lower ranked categories of health personnel such as lay counsellors can perform HIV test and counselling without compromising quality of care (Georgeu, et al., 2012). However, the process of transferring duties to lower-ranked categories of personnel is not the “quick fix” solution to rectifying the shortage of health personnel within sub-Saharan Africa, as many had hoped. As emphasised by Smart (2011), if the process of task-shifting is not well supported or is poorly implemented, it can place a significant degree of stress on implicated health personnel. Expanded task-shifting necessitates increased training, redefinition of nurses’ scope of practice, and a mentorship support structure whereby a nurse is able to refer back to an appropriately trained professional in the event that s/he is unsure of how to proceed clinically.

The NDoH needs to devise innovative ways to maintain the work done by NGOs in the HIV/AIDS management field in South Africa. Areas supported by PEPFAR grants (from the United States Presidency to address the global HIV/AIDS epidemic, primarily in Africa), are particularly vulnerable, because most such funding has been terminated in recent years. Task-shifting requires proper structures to be put in place and continuous support – especially the NIMART programme, since the majority of training has been conducted by NGOs and it is now the state’s responsibility to take over the reins. The NDoH has committed itself to the goal of having nurse-led ART initiation in 85% of eligible patients by 2016 (MSF, 2011).

#### 2.2.5 NIMART training programme

In 2010 the South African government mandated nurses to prescribe and initiate ART, as part of the strategy to increase access to ARVs at PHC level. To prescribe ART, nurses are required to have basic training in HIV care, PALS PLUS and IMCI training. PALS PLUS stands for Practical Approach to Lung Health in South Africa (Georgeu, et al., 2012), and IMCI stands for Integrated Management of Childhood Illnesses (Knowledge Translation Unit, 2013). PALS PLUS training draws on comprehensive, easy-to-use, evidenced-based guidelines that employ algorithms to enable the PHC nurse to manage lung diseases and HIV/AIDS clinically (Georgeu, et al., 2012). In 2005, the NDoH requested the incorporation of NIMART into its existing PALS PLUS guidelines and training. PALS PLUS has recently been implemented as the training and support model for accelerated implementation of HIV/AIDS and ARV care throughout South Africa.

After completion of the theoretical, coursework component of the NIMART training, which imparts knowledge on HIV/AIDS, the mentee is allocated a mentor to provide practical mentoring, in order to apply what was learnt during the coursework and enhance practical clinical competency.

#### 2.2.6 Clinical mentorship

Clinical mentorship is a system of practical training and consultation that promotes the continuing professional development (CPD) of mentees (in this case, professional nurses attending a NIMART course) to enable them to deliver clinical care that is sustainable and of a high quality. Clinical mentoring should be seen as part of the CPD required to create care providers who are competent. Its aim is to improve the

skills and knowledge of care providers (including nurses, doctors and pharmacists) in patient management.

Mentoring, driven by the learning needs of mentees, occurs via face-to-face consultations at the facility where a mentee is employed, or through continuous phone calls and email consultations (NDoH, 2011). The NDoH Clinical Mentorship Manual for Integrated Services (2011) further explains the mentoring process by stating that the face-to-face contact between the mentor (experienced, competent HIV clinician who has undergone clinical mentors' training), and the mentee should occur at least 1 - 4 times in the first 4 weeks. The mentoring support will differ depending on available resources; for example, in extreme cases, it may be more practical/efficient to have a nurse who works at a secluded PHC facility, travel to gain practical experience in an existing ART facility that is already providing the relevant health care services for 7 days – rather than having the clinical mentor travel to the remote PHC facility on separate occasions.

Clinical mentors must ensure that mentees perform a proper physical examination and treat patients broadly and holistically, with respect to various types of conditions irrespective of age, i.e. from infant to older adults. The mentees must acquire competency levels in all aspects of the specialty area in which they are being mentored. For example, in an HIV/AIDS, STI and TB mentorship programme, the mentee must be able to manage HIV-infected children and adults by providing pre-ART care, initiate ARVs, manage TB & HIV simultaneously, and manage pregnant women who are HIV-infected. Mentees must document (in the POE) all patients seen in consultation with the mentor and must maintain this record to ensure that all types of patients are included in the practical component of the NIMART training. The competency of a mentee is determined by the clinical mentor by evaluation of their ability to provide treatment and care of high quality standards. If the mentee requires additional support, it is recommended that mentoring sessions continue as required. According to MSF (2011), timelines for an individual NIMART-trained nurse to reach clinical competency vary – for example, based on prior experience in HIV/TB – but are expected not to extend beyond 3 months.

### 2.2.7 NIMART acceptability and effectiveness

Nurse-led models of ART management have proven to be very successful and have been implemented widely in poorly resourced African countries. Several studies have reported NIMART acceptability by nurses and patients: in a study by Davies, et al. (2013), NIMART-trained nurses in Gauteng Province, South Africa, expressed great optimism at the introduction of the NIMART course; particularly those who started prescribing and initiating ART. Another STRETCH (Streamlining Tasks and Roles to Expand Treatment and Care for HIV) study in 2011, reported that HIV-positive patients who were managed by nurses, as opposed to doctors, showed a comparative improvement in weight gain, and that nurses had a higher rate of detecting TB in patients that they manage. It has been proven that nurse-led ART programmes are as good as doctor-monitored ART (Nyasulu, et al., 2013). However, this very success is feeding the challenges. The number of patients on ART is growing, especially now that HIV-positive people can start ART at a threshold CD4 count of 500 cells/ $\mu$ l. HIV-infected people are required to attend nurse-managed clinics monthly or at least 3-monthly to obtain their medication whether or not they also need to attend for care. In some instances, large workloads have caused a “vicious tangle” of problems in clinics, including high staff stress, turnover, sickness and shortages, with a resultant poorer quality of care (Mutevedzi, Lessels, Heller, Barnighausen, Cooke, Newell, & Scale, 2010).

Numerous conflicting reports have been published regarding the effectiveness of NIMART. Bedelu, Ford, Hilderbrand & Reuter (2007) argued that PHC facilities are superior to hospital-based care when it comes to HIV/AIDS management; yet another study disagreed, stating that Bedelu, et al.’s results were not generalisable as they were based on one sub-district in Lusikisiki, South Africa. Furthermore, Massaquoi, Zacharian, & Manzi (2009) reported increased mortality rates among patients on ARVs attending PHC clinics in Malawi. Conversely, Fatti, Grimwood & Bock (2010) claimed that ART outcomes were better at PHC clinics, irrespective of PHC patients presenting with more advanced clinical stage diseases when commencing ARVs. This study was conducted in four South African provinces, thus the results are more likely to be generalisable, further supporting the notion that ART can be provided adequately in PHC settings in the country, and supporting the government’s call for the rapid up-scaling of ARVs at the primary level of care.

Other sub-Saharan African countries also endorse nurse-managed ART care; for instance, in Lesotho, nurse training for ART management involves intensive, in-service, theoretical and practical training in the management of HIV-related conditions and ART. This quarterly “out of service” clinical training, which lasts for one week, is adapted from the WHO’s guidelines for the integrated management of adolescent and adult illness (WHO, 2004).

#### 2.2.8 NIMART accreditation in South Africa

To ensure that patients are receiving quality care, health providers need to be both competent and knowledgeable; this can only be assessed through training and mentorship. Core criteria are used to evaluate the competency of NIMART-trained nurses, and such an evaluation has to be performed by a mentor. The mentee must complete the POE and submit it to the mentor, who submits it further to the district’s Department of Health, before accreditation can take place. The NIMART POE was developed by the NDoH using different clinical mentorship documents and tools from partners involved in NIMART training, and also from policies and guidelines developed by the NDoH (NDoH, 2011). The POE is used to record different cases consulted by the trainee under the guidance and supervision of a mentor.

There are barriers that interfere with POE submission, hence the need for this study, and it is recognised that this problem is nationwide in South Africa. According to a clinical mentoring concept paper published in 2011 by MSF, of the 7 492 nurses trained in NIMART nationally in 2010, only 1 745 (23%) were accredited to initiate ART. This corresponds with the poor results reported by Health-e News (2013) in Mpumalanga Province, as described in Chapter 1 (a 5% accreditation rate).

The NDoH has to put in great efforts to address the non-submission of POEs by NIMART-trained nurses, recognising that it is a national challenge. It was noted in this study that there is a knowledge gap regarding barriers interfering with POE submission, and that more research is needed in this regard, including other provinces, to devise ways to combat these barriers.

### 2.3 Conclusion

This chapter provided an overview of HIV/AIDS globally, highlighting HIV prevalence rates. HIV/AIDS was discussed in the context of sub-Saharan Africa, and focus was

placed specifically on the South African history. Expansion of ART access to people living with HIV was discussed, emphasising that ART access can be enhanced through re-allocation of duties among different categories of health personnel and the fact that many countries around the world practise this task-shifting. More emphasis was placed on task-shifting in South Africa. The NIMART training programme was discussed, with a focus on the current status quo in South Africa. NIMART acceptability among health care providers, specifically nurses, and NIMART effectiveness in South Africa and other African countries was also deliberated.

Chapter 3 encompasses the research design and methods.

## CHAPTER 3

### 3. RESEARCH DESIGN AND METHOD

#### 3.1 Introduction

Chapter 3 discusses the overall plan of how the answers to the research questions were obtained. The main focus of the study was to investigate the barriers and the facilitating factors regarding POE submission by NIMART-trained nurses in North West Province. Inclusive in the discussion were the following aspects: research design, population, sampling method and sample size, inclusion and exclusion criteria, study setting, data collection, data analysis, trustworthiness and ethical consideration.

#### 3.2 Research design

Research designs are the overall plan for obtaining answers to the research question being probed (Polit & Beck, 2008). The approach followed was a qualitative, exploratory descriptive design approach. According to Macnee (2004), a qualitative approach is used to gain knowledge to inform our practice broadly and holistically. As already explained in chapter one, van Manen (2011), states that empirical methods are used to explore examples and varieties of lived experiences especially in form of anecdotes, narratives, stories, and other lived experience accounts. Descriptive designs are concerned with gathering information from a representative sample of the population (Brink, et al., 2013). Burns and Grove (2005) further explain that a descriptive research design provides an accurate portrayal or account of characteristics of a particular individual, situation or group. It is a way of describing what exists, discovering new meaning, determining the frequency which with something occurs, and categorising information. Such an approach to research is usually conducted when little is known about a particular field or phenomenon.

#### 3.3 Research method

The purpose of research methodology is to inform the reader how the investigation was carried out or what the researcher did to solve the research problem or answer the research question (Brink, et al., 2013). This section should contain enough detail to enable another researcher to replicate the investigation, and is inclusive of the

following: population, sampling, sampling method and sampling size, inclusion and exclusion criteria, study setting, data collection, data analysis, trustworthiness and ethical consideration.

### 3.3.1 Population

According to Burns and Grove (2011), the population is the entire group of persons or objects of interest to the researcher, or those who meet the criteria that the researcher is interested in studying. The population accessible to the researcher is known as an accessible population (Burns & Grove 2011). In this study, the population comprised all NIMART-trained nurses in the North West Province, trained between September 2013 and September 2014, irrespective of whether they submitted a POE or not. The total population size was 1 500. For this study, the accessible population included all NIMART-trained nurses from two of the four North West Province districts.

### 3.3.2 Sampling method and sample size

A sample is a part or a fraction of a whole, or a subset of a larger set selected by the researcher to participate in a research study. Sampling refers to the researcher's process of selecting a representative group from a population in order to obtain information regarding a phenomenon (Brink, et al., 2013). For this study, purposive sampling was used to recruit participants. According to (Brink, et al., 2013), in purposive sampling participants are representative of the study phenomenon due to their knowledge of the phenomenon being studied.

In this study, NIMART-trained nurses were invited to participate, after they had attended clinical case study workshops catering for NIMART-trained nurses, facilitated by the researcher. The researcher's organisation supports the Department of Health in two North West Province districts; hence, only participants from those two districts were invited.

### 3.3.3 Inclusion and exclusion criteria

From the population, the researcher needs to further define and describe specifically which individuals will be included in the study (Brink, et al., 2013) and which individuals will be classified as irrelevant to the study. In this study, all willing, registered nurses who had undergone NIMART training were considered for

inclusion, irrespective of whether they had submitted a POE or not. This criterion was chosen to ensure that both barriers and facilitating factors interfering with the submission of POEs by NIMART-trained nurses were identified. All registered nurses who were not trained in NIMART were excluded from the study.

#### 3.3.4 Study setting and recruiting of study participants

The research setting is the specific place where data collection occurs (Polit & Beck 2008). In this study, the research setting was the regional training centre (RTC) of two North West Province districts. The researcher chose to conduct this study in this setting because the study participants were easily accessible to her. The researcher facilitated clinical case study workshops with NIMART-trained nurses from urban and rural PHC clinics in North West Province, hence the accessibility. After the facilitation of clinical case study workshops, the researcher invited the NIMART-trained nurses to be participants in this study. Only one training per day was booked at the RTC, so there were no any other people in the vicinity, the place was quite and there were no interruptions during FGDs. During the clinical case study workshops the chairs were arranged in a class room style, but for the FGD's chairs were re-arranged in a circular way to enhance effective communication. The participants seemed relaxed because they were used to communicating with the researcher and the note taker.

#### 3.3.5 Data collection

According to Burns and Grove (2005), data collection is the precise, systematic gathering of information relevant to the research question or hypotheses of the study. NIMART trained nurses were invited to participate in focus group discussions (FGDs). FGDs are interviews in which the opinions and experiences of groups of about 5 - 15 people are requested simultaneously (Brink, et al., 2013). A semi-structured guide (Appendix 8) was used to facilitate the FGDs. The guide had two main questions with probes focused on identifying barriers and facilitating factors regarding the submission of POEs by NIMART-trained nurses. The research questions were: "What are the barriers that interfere with NIMART-trained nurses submitting their POEs for accreditation in the North West?" and "What are the facilitating factors that promote the NIMART-trained nurses to submit their POEs for accreditation in the North West?" Participants were able to answer both questions with the help of probing questions during the FGDs; through these answers, the research questions were answered.

Informed consent was signed prior to the FGDs and the researcher used an information letter to explain the study to the participants, the letter was read and given to all the participants informing them about their responsibilities and rights as participants. An audio recorder was used during the FGDs to record the participants' voices, and the consent for the audio recorder was signed prior the commencement of the FGDs. All information, consent and guide documents are provided in the Appendices. Field notes in all three focus groups were taken by the researcher's colleague who was oriented as to how to take them. This colleague was a nurse mentor who is a co-facilitator of the clinical case study workshops. She's a professional nurse working for an NGO responsible in training nurses on NIMART in the North West Province and she is acquainted with qualitative data collection methods like focus groups. The NGO that the researcher is working for is working collaboratively with the note taker's NGO in capacitating NIMART trained nurses through case study workshops. The participants were not threatened by the note taker as they knew her from NIMART trainings.

Three focus group discussions were conducted, and data were collected over a period of six weeks. The dates for the focus groups were (2015/06/11, 2015/06/12, and 2015/07/23) for the respective focus groups. The DoH in the North West Province was responsible for booking all the workshops and it was totally out of the researcher's control.

The information about the group characteristics and dynamics are thoroughly explained on the field notes (Appendix 10). The total number of NIMART trained nurses participated in data collection was thirty. There were twenty six females and four males, the total number of participants who had submitted their portfolios were eighteen and those who had not were twelve. The FGDs continued until the data were saturated, after the third FGD similar issues were raised and no new data emerged, which signalled data saturation.

The main conclusions drawn from the field notes about the group dynamics are that in group 1 there were only female participants who were from urban areas and their participation was optimal, though two of the participants were not as active. Those who submitted their POE's were able to answer both research questions; out of nine participants six had submitted their POE's. In group 2 nine out of eleven participants

were not accredited and in this group participation was slow and questions were answered by the same people. Participants were from rural and urban areas and consisted of both female and male participants and the contribution was more on barriers than facilitators. Lastly, in group 3, participation was optimal and this group had all participants (only female participants) who submitted their POE's, they were all from urban areas. This group emphasised the fact that it is possible to complete and submit one's POE and most barriers can be defeated.

### 3.4 Data analysis

Data analysis entails categorising, ordering, manipulating and summarising the data and describing them in meaningful terms (Burns & Grove 2005, Brink, et al., 2013). To analyse the data the researcher used thematic analysis to analyse this study's data because it offers an accessible and theoretically flexible approach to analysing qualitative data (Braun & Clarke, 2006).

#### 3.4.1 Thematic analysis

According to Braun and Clarke (2006), thematic analysis is a method used for identifying, analysing and reporting patterns (themes) with data. All 4 steps of thematic analysis were followed (Henning, van Rensburg and Smit, 2004):

- I. Familiarising oneself with data
- II. Generating codes from the data
- III. Constructing categories
- IV. Constructing themes from categories

The researcher followed the steps in analysing the data by using an audio recorder to capture participant's voices. The researcher conducted the FGD's and transcribed the data verbatim herself, so that she can be fully familiar with the data. The researcher listened and re-listened to the audio recorder against the transcript for accuracy and to make sure that all that was said was captured and throughout this process the researcher was becoming familiar with the data. The researcher used field notes to describe participant's characteristics to supplement the transcripts. Analysis of data commenced only when all the three FGD's were completed, to ensure accuracy the researcher discussed the FGD data with the note taker.

Once all three transcripts were completed, the researcher together with a colleague from the same NGO that the researcher was working for started coding the transcript. The colleague was experienced in qualitative research. The researcher coded all the transcript alone manually without any use of software, and the colleague reviewed all the transcripts to check if the coding was done correctly. The researcher would sit down with the colleague who was helping her and discuss all the coded data in terms of why the coded section was seen as important. Once all the coding was completed, all relevant coded data was sorted into categories and relevant categories sorted into themes with relevant extracts selected to support the themes using a table with three headings (code, extracted data and themes). Using thematic analysis, the researcher extracted 6 key themes (3 facilitating factors and 3 barriers) from 48 codes (shown on Appendix 11) that were consolidated to form the themes, pointing out both barriers and facilitating factors affecting the submission of POEs for accreditation by NIMART-trained nurses in the North West Province.

The research supervisor also read the transcripts and assisted with finalising the themes. For the whole process of constructing codes, categories and themes, the researcher used different colour highlighters to highlight all interesting aspects of the data that was indicating to be potential codes, categories, and themes.

### 3.5 Trustworthiness

Trustworthiness refers to the employment of procedures to ensure the accuracy of findings (Brink, et al., 2013). According to Lincoln and Guba (1985), developing trustworthiness is a manner of ensuring data quality or rigour in qualitative research using a certain model. This model proposes four criteria for developing trustworthiness of a qualitative study, i.e. credibility, dependability, confirmability and transferability (Polit & Beck 2008).

#### 3.5.1 Credibility

According to Shenton (2004), credibility deals with the question of “How congruent are the findings with reality?” In order to ensure credibility, peer debriefing was conducted. The researcher discussed the study results with a colleague (the same colleague who helped during data analysis) who is familiar with the phenomenon in question and also continued with FGDs until the data were saturated. The results of

the study were also discussed with the research supervisor. Participants were comfortable with the researcher due to the fact that they were familiar with her from training facilitation; accordingly, they expressed themselves freely during FGDs.

### 3.5.2 Transferability

According to Lincoln and Guba's evaluation criteria (2006), transferability is when a study shows that the findings have applicability to a different group or in a different setting from where the data were collected. Shenton (2004) continues and stresses the fact that "it is important that sufficient thick description of the phenomenon under investigation is provided to allow readers to have proper understanding of it, thereby enabling them to compare the instances of the phenomenon described in the research report with those that have seen emerge in their situation". The other way to ensure transferability is by providing thick description, purposive sampling and data saturation (Brink, et al., 2013). The researcher ensured transferability by providing sufficient thick data; purposive sampling was used to recruit participants who were participative and knowledgeable regarding the phenomenon; and data were collected until saturation.

### 3.5.3 Dependability

According to Brink, et al. (2013), dependability refers to the provision of evidence such that if a study was to be repeated with the same or similar participants in the same or similar context, its findings would be similar.

To ensure dependability, the researcher reported in detail all processes and techniques related to methods used during the study, to enable future researchers to be able to build on or apply the study elsewhere. The group dynamics for all three groups were explained and information from the field notes helped in this regard.

### 3.5.4 Confirmability

Confirmability refers to the potential for congruency of data in terms of accuracy, relevance or meaning (Brink, et al., 2013). Confirmability is concerned with establishing whether the data represent the information provided by the participants and that the interpretations of the data are not fuelled by the researcher's imagination. The researcher ensured confirmability by reflecting the participant's voices during data analysis and the results were discussed with a colleague. The

audio recorder is kept at a safe location at the offices of the researcher's employment and they will be kept there for the next 2 years.

### 3.6 Ethical considerations

Ethics is a system of moral values concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants (Polit & Beck 2008). For any research, the research process – from identification of the study to publication of the findings – should adhere to ethical standards; this means that the participants' rights and the rights of the institution should be protected (Sendangala, 2010). In this study, ethical consideration included aspects such as approval from different institutions, signing of the informed consent, permission and consent to use audio-taping, confidentiality and anonymity, and the refusal to participate in the study.

#### 3.6.1 Ethical approval and request for permission

According to Brink, et al. (2013), researchers must submit their research proposal along with the necessary consent forms to the appropriate committee for review, before beginning the research project. In this study, the researcher submitted the proposal and permission was granted by different committees, including the Faculty of Health Science Postgraduate Committee, The University of the Witwatersrand Human Research Ethics Committee (Medical), and the North West Province Department of Health Policy, Planning Research, Monitoring and Evaluation Committee.

#### 3.6.2 Informed consent

To protect the right of the participants and to conduct ethical research, informed consent has to be signed by the participants. Thorough explanation of the study was given to the participants by the researcher, by reading the information letter to them, which contained all the relevant information that participants needed prior to signing consent and commencing with FGDs. Further consent obtained from the participants was the consent to be audio-taped. This consent was separate from informed consent for participation, as it informed participants that their voices were going to be recorded. Both consent forms were signed by all participants.

### 3.6.3 Confidentiality and anonymity

Confidentiality is defined as the management of private data such that participants' identities are not linked with their responses and are never publicly disclosed (Burns & Grove 2005). Anonymity is when the subjects' identities cannot be linked even by the researcher with individual responses (Burns & Grove 2005). Confidentiality and anonymity were maintained by the researcher by not using participants' names during the FGDs; instead, codes were used. Participants were requested not to share the content of the discussions outside the group. Though it was difficult to ensure the study participants were anonymous to colleagues who were attending clinical case study workshop with them because during recruitment, the researcher presented the study to all the nurses who attended the workshops. After the presentation, only those who were interested to be study participants stayed behind and the rest left the building but those who left knew who had stayed behind to be study participants. The researcher kept all the raw data, consent forms and audio-tape safely under lock and key.

### 3.6.4 Refusal to participate in the study

According to Burns and Grove (2005) and Polit and Beck (2008), prospective respondents in a study have a right to ask questions, refuse to give information, ask for clarification and discontinue participation or withdraw from a study at any time without penalty or loss of benefits. In this study the participants were informed of their right to withdraw or refuse to participate in the study without facing any negative consequences or penalties. They were also informed that they had the right not to answer questions if they felt uncomfortable doing so.

### 3.7 Conclusion

In this chapter, the research design and methodology were discussed. Data collection and trustworthiness to ensure study credibility were considered. A brief summary of issues relevant to the research ethics in the study were also discussed.

Chapter 4 discusses the data analysis and the study results.

## CHAPTER 4

### 4. DISCUSSION OF RESULTS

#### 4.1 Introduction

The purpose of this chapter is to present and discuss the results. Six themes emerged from analysing the data collected during FGDs. Each theme with relevant codes is shown in Table 4.1, with supporting extracts from study participants. The themes are divided into two categories, i.e. barriers and facilitating factors. The themes are also discussed and supported with literature.

**4.1.2 Table 4.1 Themes on facilitators of POE submission**

Themes	Codes	Participants Extracts
<b>FACILITATORS</b> 1. Support and Team work	-Support received from mentors and managers -Working as a team with colleagues -Asking other clinics for help	- "In the same facility, but like with people who are having both HIV and TB, it was a bit difficult, so I had to contact my friends from other facilities, so let's say you've got this kind of a client with HIV and TB, that I need to initiate, I would ask my friends to let me know so that I could negotiate with my operational manager to say on that particular day I need to go to that facility for one hour or so, so that I can get the cases".
2. Effective placement	-Placed in areas where there's ART -Working in accredited clinics -Working in an intergrated clinic	-"It was not much difficult because now of the integration, like you know in other CHC's there will be a specific set for PHC, maternity, and Antenatal care, so doing everything together, that helped me to quickly finish those cases"
3. Motivation	-Motivation from mentors -Self motivation -Knowing that you are not alone	-"I was not alone in filling in this POE, I was with a colleague, the mentor used to encouraged both of

		us, the motivation comes from the fact that you are not alone there's someone doing something similar like you"
<b>BARRIERS</b>		
4. NIMART prerequisite	-Requirements prior NIMART accreditation -Courses to be completed first before before POE submission	-"... we have a high number of nurses that are NIMART trained, but the whole lot of them don't have other requirements in order to complete the process, being certified NIMART competent, like they wouldn't have PALSAPLUS, we have moved on from that, now we are talking PC101, how long does PC101 takes at facility level? 12 sessions"
5. Lack of human resources	-Staff shortage -Seeing lots of patients	-"Another barrier that I am thinking of is the problem of the shortage of staff, yes. Because when we are at the facility we've got a lot of patients that you have to go through especially when you are working especially in a (an) 8 hour clinic"
6. Disorganisation	-Delaying in writing down patient's details in the POE -Writing patient's details in the scrap book -POE not issued	-"Sometimes you completed initiating that client, but you are lazy to put it into your POE, so it lapse, sometimes you forget even the name of the patient, the file, you have to retrieve that file, if you don't remember the name it will be impossible to retrieve it, then you lack behind"  -"No, I didn't receive the POE, I went back to the facilitator and I asked about it and the facilitator responded by saying she will get back to me"

## 4.2. Identified themes:

### **Facilitating factors**

1. Support and team work
2. Effective placement
3. Motivation

### **Barriers**

4. NIMART prerequisite
5. Lack of human resources
6. Disorganisation

## 4.3 Discussion of themes

### 4.3.1 Facilitating factors

#### *4.3.1.1 Support and team work*

The importance and benefits of support and team work was mentioned by many participants and the fact that the lack of support, poses as a barrier in filling in the POEs. There were different key players mentioned by participants that were seen to be supporting the NIMART programme. The most important key player mentioned was a mentor. After the theory part of NIMART training, trainees are allocated a mentor at facility level. According to the NDoH (2011), a mentor has to consult with the mentee and continuously develop the mentee professionally in a way that enables them to provide and maintain continuous clinical care of a high quality. The mentoring is seen as part of the CPD required to create health care providers who have the necessary knowledge and abilities to administer proper clinical health care. According to the NDoH Clinical Mentorship Manual for Integrated Services (2011), the mentoring should occur at the facility where the mentee works, through continuous phone calls and email consultations between the mentor and the mentee. Some participants shared the following:

-“I think I can just add that a mentor helps a lot, I just want to say that sometimes the managers do not understand that we need to fill in the POE nneh?(am I correct ), so if the mentor is there the manager allows us time to spend with the mentor and do our cases, so when you got, for an example, myself when I got the POE, I saw it as something difficult to fill in, and then I just threw it there, so the mentor kept on coming to see the progress as to how far I am”.

-“Ok, like the sister had said that the presence of the mentor and teaching us about how to fill in the ART stationery and something that I wasn’t quite sure of before, then when she came she showed me, explaining that this is how we do it, also saying, when you write the notes this is what is expected, learning and teaching occurred in different levels. The other thing is the support of the people that you are working with, they understood that they have to give you space and time to work on the POE.

Support goes with team work; mentorship involves team work with different kinds of team members. With any task where there is team work, positive outcomes are guaranteed. Even participants confirmed that through team work they were able to complete their POEs. Participants that were not placed effectively i.e. in facilities not offering intergrated services, for them to be able to complete all the different cases had to go to other facilities that had integrated services, so they would call a friend or a colleague from that clinic and arrange with them that they could be notified when there were relevant cases for them to consult. This was confirmed by a statement from one of the participants as follows:

“... for HIV/TB cases I contacted my friends to call me when there was a patient who was co-infected with HIV and TB who needed to be initiated on ART.”

There was a lot of feedback from participants regarding the importance of working as a team with their colleagues; team members motivate each other and motivate those falling behind. Motivation goes a long way, and most participants expressed that through motivation received from their mentors, colleagues and managers, they managed to complete their POEs on time.

More was said on teamwork:

“I also want to add to this point of team work, I had challenges getting the co-infected patients, the TB nurse managed to accommodate me to come and initiate those clients.”

As previously described, one client can account for different POE cases and can also be used by more than one trainee (NDoH, 2011). Some participants took advantage of this and worked in pairs, sharing cases among themselves. In support of this, one participant remarked:

“We were two in the facility who were NIMART-trained, so we would share a client, especially the under five-year-olds because they were scarce.”

Another participant added the following recommendation:

“... and the other thing that can work, is working as a team because you get to discuss cases with your colleagues and that makes your job lighter, because when you go to the book, you have discussed it already. It’s easy to fill in your POE, so team work is very important.”

As it was mentioned initially that there is more than one key player regarding support, the other important individual whose support is key, is the facility manager. It also came out during discussions that it is critical for the manager to also motivate the mentee, especially because s/he sees the mentee on a daily basis. The manager has to carry out the DoH’s goals and mandate to effectively contribute in implementing the NIMART programme (Davies et al., 2013).

The facility manager gives approval to the mentee to be able to see the mentor during working hours. The manager has to be knowledgeable about the entire process of mentorship, because s/he needs to know the mentor/mentee schedule so that other staff members can be organised in terms of time to fill in for the mentee during mentoring sessions. During mentoring, the process of consulting the patients becomes slow, so that slows down the queue; especially patients to be consulted by the mentee. That is where other colleagues are crucial in assisting. In this regard, some participants said the following:

“The manager is playing a role because she gives us time to go to the mentor, to travel from my clinic to go to other clinics to do other cases ...”

“...the other is support of the people you are working with. They understood that they have to give you space and time to work on the POE.”

Davies, et al., (2013), also stress the importance of managerial support by stating that facility managers need to be empowered and motivated to manage their staff complement effectively and delegate duties optimally so that all staff members perform appropriate duties. There has to be effective inter-facility communication,

mutual support, team work and a creative way to solve problems in the facility for the NIMART programme to be implemented successfully.

#### *4.3.1.2 Effective placement*

Effective placement is a major facilitator in promoting the completion of the POE. If a trainee is placed or working in a community health centre (CHC) that caters for different categories of patients s/he will be able to complete the POE faster. A participant had this to say in this regard:

“It was not much more difficult because of the integration of services, like you know in the CHC I work in, there’s PHC, maternity, antenatal care (ANC); so it was easy doing everything together. That helped me to quickly finish those cases.”

The other participant who was initially working in a mobile clinic and later transferred to a facility remarked:

“The person who was supposed to mentor me didn’t reach me, because at that time I was working at the mobile site ... after I was appointed to work in a fixed clinic that was the only time my mentor got to mentor me.”

#### *4.3.1.3 Motivation (increased self-esteem and empathy)*

Once the POE is complete, the trainee can be certified and accredited as a NIMART-trained nurse. Participants expressed a great relief and a sense of accomplishment after completing their POE. Certification and accreditation is one of the motivators which sees trainees endure the whole process and strive to complete and submit their POEs.

The participants were also motivated by the fact that once they complete their POEs, they were able to initiate eligible patients on ART and also manage them, according to participants that alone improved their self-esteem and confidence. They also raised the fact that continuous completion of the POEs slowly improved their level of knowledge, skills and competency. They could work independently without doctor supervision, some reiterated the fact that they were so competent that they were teaching or correcting the doctors with whom they were working with, showing them proper management of ART. In a study by Nyasulu, et al. (2013), it was emphasised that NIMART is not inferior to doctor-managed ART. This was confirmed by some of the participants by saying:

“We had this doctor who liked to change everything. Now that I am trained, I would sit down and say to him ‘No! According to the guidelines this is how it is supposed to be done’.”

According to the participants, mentors were also sometimes dishonest in motivating them, some of the participants reiterated that their mentors would sometimes tell them that their friends who are also on NIMART training programme had completed their POEs, only for them to discover later that those same people were also not yet done. To confirm this, a participant stated that her mentor said the following:

“... So-and-so is done and I know that you are also good. How come you are not finishing with this and I know you are initiating everyday?”

Friends and colleagues also extended their hand in motivating the mentees (participants). This was reported by one of the participants:

“I was motivated by the fact that it was just the two of us in the facility that had done the course; whenever I felt like giving up, my colleague would motivate me.”

As participants became more knowledgeable they reiterated that with their knowledge they were better equipped to advocate for proper procedures and to impart knowledge to colleagues. One of the participants shared with the group that:

“... you get that feeling of being a Guru because some doctors don’t have a clue about this HIV. So even doctors will come and ask you the regimen, saying: do you think this is a correct regimen? So all that makes you feel nice and competent”

Several studies have proven that NIMART is inexpensive and the care provided by NIMART-trained nurses is not of poor standard, relative to ART care offered by doctors (Nyasulu, et al., 2013). Studies like these support the abovementioned notions that nurses can be independent and manage ART as effectively as doctors. Another study done by Davies, et al. (2013), reported that despite a shortage of staff, attitudes from nurses towards NIMART remained optimistic. Some nurses were happy that they now have the ability to offer continuous care by initiating their own patients on ART, instead of referring them to ART management sites.

During the FGDs it emerged that some participants were motivated to pursue NIMART training because they reiterated that they felt sorry for their patients,

empathised with them. When ART was only initiated by doctors, it meant that patients had to report to care when doctors were available in the facility. Patients would be booked to see the doctor and arrive, only to discover that the doctor was not available that day and they would have to be turned back. In some cases, patients would come from very far, especially in rural areas. Having to turn sick patients away, and risking losing them, urged nurses to pursue the NIMART course to render the ART services accessible.

Some participants expressed that they felt guilt because they had completed the course but had not completed their POEs, and therefore could not yet initiate patients on ART. That motivated them to complete their POEs, in order to work independently. Testimonies from participants were as follows:

“I was motivated to finish the POE by the fact that in the facility I am working in, it was only doctors who were initiating clients on ART, and sometimes not all the patients would be seen because of the high volume of patients booked, or maybe on that day the doctors won’t be in, and the patients would be turned back. So, that motivated me to complete my POE so that I could help those patients.”

One of the participants from a rural area said:

“The clinic is too far, the village is too far so when we didn’t do this to initiate the people, they were suffering. They couldn’t go to the hospital to be initiated there because it is too far and that will require transport money that they don’t have.”

Others had this to say:

“... it was like all patients must wait for the doctor, when you are there and trained, but at the same time you are not going to do anything to help the patients.”

Through task-shifting (transferring the duty of initiating ART from doctors to nurses) the accessibility of ART to patients was increased. Davies, et al. (2013) list the positive outcomes thereof: patients are initiated on ART faster; patient outcomes are improved; doctors and nurses accept NIMART positively; the approach is considerably more cost-effective for patients (especially rural patients) because they do not have to travel to referral hospitals to access ART; and linked to the latter, there is an improvement in patient retention in care. Sub-Saharan Africa has been very successful in increasing accessibility of ART to those eligible, increasing ART

initiation and management from about 2% in 2003 to more than 40% in 2008 (Harries, Zacharian, Lawn, & Rosen, 2010).

#### 4.3.2 Barriers

##### *4.3.2.1 NIMART prerequisite*

Among other stumbling blocks mentioned by participants with regards to NIMART accreditation, are the prerequisites applicable to certification as a NIMART nurse. In order to prescribe ART, nurses are required to have basic training in HIV care, PALS PLUS and IMCI training. In 2005, the NDoH requested the incorporation of NIMART into its existing PALS PLUS guidelines and training (Georgeu, et al., 2012).

Participants expressed that these two courses mentioned above (PALS PLUS and IMCI), delayed their NIMART accreditation and certification. The POE could be completed, but without PALS PLUS and IMCI training, they wouldn't be able to be NIMART-certified. One of the participants confirmed:

"We have a high number of nurses that are NIMART-trained, but a whole lot of them don't have other requirements that would enable them to complete the process of being certified NIMART competent, like they wouldn't have PALS PLUS."

Another participant added:

"... some of us were told we had to do PALS PLUS first before we could submit the POEs."

According to literature, South Africa is not the only country that included other programmes within their NIMART training programmes. Lesotho adapted and incorporated similar guidelines into their HIV nurse training programme (WHO, 2004), notably PALS PLUS and IMAI (Integrated Management of Adolescent and Adult Illness). These guidelines were adopted from the World Health Organization (2004).

##### *4.3.2.2 Lack of Human resource (Nursing staff shortage & allocation/rotation)*

Some participants expressed concern regarding a shortage of staff, expressing that it becomes difficult to concentrate on completing the POE while the patient queues are long and there are too few nurses on duty to consult with all the patients. Sometimes

the staff shortage is within another department of programmes, such as immunisation for example. One of the participants confirmed:

“... when we are at the facility we’ve got a lot of patients that one has to consult through, so it is difficult for a person to focus. Like you have to do this and that, sometimes it’s difficult, with the shortage of staff that we are facing currently.”

Another participant remarked:

“When we are at the facility, we’ve got a lot of patients that one has to consult, especially when you have to work at the clinic ... So you don’t get enough time to fill in the POE.”

Literature has proven that it is important for action to be taken globally to alleviate the shortage of staff in the health sector, especially if the global commitment to the Millennium Development Goals and the demand for access to ART services are to be met (WHO HIV/AIDS Programmes, 2007b). It is also mentioned by Sanne, Orrell, Fox (2010) that there is shortage of 4.3 million health professionals (doctors, midwives, nurses and support workers) globally. SA is certainly not exempt from this problem of shortage of staff, it only has 17.4 doctors per 100 000 people. Moreover, this is mostly applicable to urban areas. Besides the shortage of staff, there are also other clinical commitments that affect completion of the POE:

“If the clinic is too busy, one gets allocated to other programmes besides ART ... So in a case like that, it is not possible to fill in your POE the whole day.”

#### *4.3.2.3 Disorganisation*

This disorganisation refers to both the Nimart trained nurses and the RTC. Some participants reported that they were not issued with a POE for up to 7 months post NIMART training. They stated that the RTC was supposed to issue the POE’s to them, but was delayed in doing so. Two of the participants stated the following:

“I ... was trained but I haven’t received the POE yet ... I went back to the facilitator and I asked about it and the facilitator responded by saying she will get back to me.”

“In my case, I didn’t get the POE and I completed the training in November 2014, 7 months ago.”

Participants reported that when they initiated patients on ART during mentorship and were supposed to enter the details in the POE, they often did not do so immediately. Instead they scribbled the patient's information on scrap paper and would transcribe the information to the POE at a later stage. Sometimes the scrap paper would be lost, and the mentee would be too lazy to transcribe the information and would end up not transcribing at all, and sometimes they would even forget the name of the patient they were consulting, which made it difficult for them to trace the patient on the ART register. According to those participants who completed their POE's, the proper procedure is to complete the POE while the trainee is still in the consulting room with the patient. If performed immediately, it would not take the trainees as long to complete their POEs.

To support the above statement some participants had this to say:

"... sometimes you completed initiating that client, but you are lazy to put it onto your POE, so it lapses. Sometimes you even forget the name of the patient and you have to retrieve that file. If you don't remember the name of the patient ... it will be impossible to retrieve it, then you stay behind."

Another participant added:

"You shouldn't wait till it's the last minute to fill in the POE, because it will be a lot of work to fill it in. It is better to do it on time, so that when the time for submission comes, you don't have much to do."

The other point that was raised is the fact that the POE itself is not well structured. The spaces between lines are limited and that interferes with documenting all the relevant information. The information of one client ends up overlapping onto the next line, and consequently looks disorganised and confusing. One participant had this to say regarding this point:

"The other challenge of completing your POE is the space. There would be thin lines which would not allow you to write, you know, the important stuff that needed to be recorded in the POE."

#### 4.4 Conclusion

Through FGD's with participants the researcher identified the barriers and the facilitators affecting NIMART trained nurses in North West Province in submitting their POE's for accreditation. The results of the study revealed that there are three barriers and three facilitating factors that affect POE submission by NIMART-trained nurses. Importantly, the numbers of barriers identified were equal to the number of facilitating factors identified, and once those barriers were combated with solutions, they could be turned into facilitating factors as indicated in the recommendations of some participants.

The barriers were: disorganisation, NIMART prerequisites and a lack of human resources and the facilitators mentioned were: support and teamwork, effective placement and motivation. However, on a positive note, the participants were able to provide recommendations to turn the barriers into facilitators. The participants were very positive and supportive of NIMART, irrespective of the barriers that they faced during completion of their POEs. Chapter 5 concludes the study, discusses limitations and provides further recommendations.

## CHAPTER 5

### 5. SUMMARY, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

#### 5.1 Introduction

This chapter discusses the summary of the research results, future recommendations, limitations and conclusions of the study. The recommendations made here could help the North West Province DoH design more effective strategies to support NIMART-trained nurses in overcoming the barriers and promoting the facilitating factors that affect POE submission. Overcoming barriers to POE submission could improve the NIMART accreditation rate among nurses and positively influence the standard of care offered to HIV-infected patients in PHC facilities in South Africa.

#### 5.2 Research objectives

The objectives of the study were to explore and describe (i) the barriers and (ii) facilitating factors affecting NIMART-trained nurses' submission of POEs for NIMART accreditation.

#### 5.3 Summary of research results

##### 5.3.1 Facilitating factors

###### *5.3.1.1 Support and team work*

In order for the NIMART programme to be successful, tremendous support and team work is required, especially from mentors. The mentorship programme is key in NIMART because it is seen as part of the continuing professional development needed to produce nurses who are knowledgeable and skilled to provide proper clinical health care (NDoH, 2011). Mentoring should involve abilities to motivate trainees. It was determined during this study that through motivation and support from the mentors, mentees were motivated to complete their POEs.

Team work was also identified as a facilitating factor. It was strongly evident from the participants of this study that team work and ongoing support from facility managers, colleagues, and friends allowed the nurses to achieve their goal of completing a POE for accreditation. In reference to Georgeu et al. (2012), the NIMART programme requires ongoing support and commitment from all involved stakeholders.

### *5.3.1.2 Effective placement*

Effective placement was identified as one of the major facilitators to submitting a POE for accreditation. Being placed in a CHC facility was identified as effective placement because it allowed access to the different categories of cases required by the POE. Furthermore, the process of completing the POE is enhanced when placed in such a facility.

### *5.3.1.3 Motivation*

The thought of being accredited, knowledgeable and competent motivated the trainees to complete their POEs. The ability to work independently and be knowledgeable boosted the NIMART-trained nurses' self-esteem and self-worth. Believing in themselves and gaining confidence motivated the nurses to do more and in the process complete their POEs. Being confident and competent motivated nurses to provide ongoing health care to their own patients by initiating them on ART instead of referring them to ART sites for initiation, as was done before NIMART was implemented (Davies, et al., 2013).

Motivation was one of the facilitating factors that kept NIMART-trained nurses focussed on completing a POE for NIMART accreditation. Empathising with patients was also noted as a motivator – wanting to change their patients' lives for the better, nurses were motivated to complete a POE so that they could help their patients without reliance on a doctor. With motivation, one is able to face any challenges interfering with the attainment of one's goal.

## **5.3.2 Barriers**

### *5.3.2.1 NIMART prerequisites*

NIMART prerequisites (IMCI and PALSA PLUS training) are found to be barriers interfering with the completion of POEs and accreditation of NIMART-trained nurses. More time to complete such training is required and that effectively means nurses would have to be away from clinical sites for extended time periods. This whole process of having to complete other courses before being NIMART-certified is necessary, but slows down the process of accreditation.

### *5.3.2.2 Lack of human resources*

According to Kober & Van Damme (2004), there are 32 000 vacant nursing positions in the South Africa public sector, partly as a result of a continuing “brain drain” to other countries. Irrespective of human resources shortages, there is still an increasing number of people being initiated on ARVs, and retained in the programme for patients requiring long-term support, resulting in an ever-increasing load of patients in the system (Ford, 2013). The majority of these patients are treated by NIMART-trained nurses, resulting in overburdening and even interference with mentorship schedules. Consequently, staff shortages were regarded as one of the obstacles hindering POE completion and submission among this study’s cohort.

### *5.3.2.3 Disorganisation*

For any programme to be a success, it needs some level of organisation from every key person involved. In the context of this study, disorganisation was described at the level of the RTC and the trainees. Processes stipulated by the NDoH Clinical Mentorship Manual for proper implementation of the NIMART programme are not always followed correctly by the RTC. It is vital that the resources crucial to the NIMART programme are mobilised. Another barrier identified was the fact that some trainees do not receive their POEs from the RTC immediately after training.

At the level of the trainee, a lack of planning and generally being disorganised was another barrier interfering with completion of the POE. Some trainees did not complete the POE immediately after or during consultation with relevant patients, leading to case data being lost and not entered into the POE.

## 5.4 Recommendations

Based on the aforementioned findings, the following recommendations are made for improving the POE submission rate and consequent accreditation of NIMART-trained nurses in the North West Province. These recommendations are intended for incorporation into the North West Province DoH’s strategies for improving the NIMART training programme, but may also be applicable elsewhere in South Africa. Such recommendations are important given the DoH’s current position of having to take the reins of the NIMART programme from previous implementing/supporting partners. As previously mentioned, in this handover, there have been teething

problems at the RTC level; for instance, inconsistent issuing of the POE documentation to trainees following NIMART training.

#### 5.4.1 Recommendations for nursing education and the NIMART training programme

- RTCs (each district has one RTC) should take the lead in the training of nurses in NIMART and should not rely on partners (such as NGOs that have partnered with the North West Province DoH in the training of nurses in HIV management)
- The trainee must be allocated a mentor before the theoretical training component ends, and the mentoring topic should be introduced to the mentee.
- Initially, there must be regular face-to-face mentoring to build the mentee's confidence.
- Mentees should avail themselves and commit to the mentoring programme.
- The RTC should issue POE booklets to all mentees on the last day of theoretical NIMART training.
- The POE documentation should be amended to increase the spacing between text lines, so that all important information may be recorded correctly.
- ART accessibility should be enhanced by incorporating HIV care with other clinical services in all facilities.
- The districts should offer prerequisite courses at a frequency greater than once per quarter, to increase uptake and ensure that such training does not impede further training and accreditation.
- A greater number of nurses should be trained and accredited in NIMART so that such tasks are not reliant on only a few nurses managing HIV in the facility. As such, patients should be treated holistically.

#### 5.4.2 Recommendations for nursing practice/facility-related recommendations

- The mentor should foster a good working relationship between her-/himself and the mentee.
- The facility manager should co-ordinate all clinical mentor activities as prescribed by the NDoH Clinical Mentorship Manual, and also provides support to mentees.
- The District Management Team is integral and must be involved in, and support the NIMART programme.
- The facility manager must be aware of mentoring schedules, to ensure that mentors and mentees are allowed to honour appointments.

- Mentees must be encouraged to document relevant cases immediately in their POEs.
- In a case where mentees are not issued a POE, they must be encouraged to document relevant cases in a dedicated notebook for transcription to a POE as soon as available.
- NIMART-trained nurses should be allocated to integrated facilities post training or rotated to other service points within a facility, to ensure coverage of the required cases for POE completion.
- Mentees should also be encouraged to arrange work in other facilities in their spare time, to ensure coverage of the required cases for POE completion.
- Where possible, mentees should be placed in pairs at facilities following theoretical training, in order to support each other.
- Mentees can motivate and inform each other of relevant information through social media, such as a WhatsApp group.
- Mentees should aim to submit a POE on time with the incentive of being competent and independent to treat patients.
- As staff shortages are a reality, mentees have to be committed and find time to slot in at least two cases per day; and this should be monitored by the facility manager.

#### 5.4.3 Recommendations for further research

Further research should be undertaken to:

- probe the barriers and facilitating factors affecting the submission of POEs by NIMART-trained nurses in other provinces in South Africa, because the problem addressed in this study occurs nationwide
- determine obstacles in the efficient running of the NIMART programme by RTCs in the North West Province
- perform a qualitative comparison of rural- versus urban-based nurses regarding barriers affecting NIMART accreditation
- Investigate mentor perception regarding factors affecting POE submission by NIMART-trained nurses.

## 5.5 Study limitations

The results of this study cannot be generalised to all NIMART trained nurses in South Africa because the study did not incorporate the entire population of NIMART-trained nurses and participants were sourced from only two of four North West Province districts. It was difficult to ensure that the study participants were anonymous to fellow colleagues who were not participants of the study because the recruitment of the study participants was done to the entire clinical case study workshop participants, after the recruitment only those who were interested were left behind and those who were not participating in the study left the building.

## 5.6 Conclusion

The results of this study identified barriers and facilitators regarding the submission of POEs in North West Province, participants who were not yet certified remained positive and enthusiastic about completing a POE and obtaining accreditation in the near future. Participants who were accredited felt positive and competent to manage HIV-infected people, and served to motivate and inspire those nurses who were not yet accredited. Identified barriers could be overcome and facilitators promoted through integration of the recommendations provided in this study.

An innovative strategy to combat barriers needs to be formulated and implemented by the North West Province DoH, especially now that supporting partners (NGOs) responsible for the training of nurses in NIMART in the province have to withdraw support for the DoH in some districts due to financial constraints on the partner's side. The RTCs must take charge of the NIMART training programme efficiently; if this is not achieved, it could threaten the long-term sustainability of NIMART. This requires support and commitment from senior management in the province.

Being NIMART-certified proved to be of great value to participants, imparting a sense of importance in that they could manage ART independently. As such, the DoH must ensure that the NIMART programme is always managed efficiently, considering that ART initiation is now performed mostly by nurses and that this is a mandate stipulated by the President.

According to the announcement made by the president of South Africa in 2009, citizens of the country were promised access to HIV counselling, testing and ARVs at any health facility (Cameron et al., 2012). Accordingly, all facilities are supposed to offer integrated HIV services, it is therefore unacceptable to have facilities that are not accredited to initiate ART. The goal is an 85% rate of NIMART by 2016 (MSF, 2011); facilities which are underachieving or not initiating ART in this manner may hold the country back in attaining this.

As a country, we need to ensure that ART is accessible to those who are eligible to receive it; barriers interfering with NIMART accreditation must be overcome; there must be proper training and education of communities and healthcare professionals, with improved infrastructure; and different stakeholders need to be encouraged to contribute in whichever capacity they can. Increasing ARV access to those eligible is still one of the challenges that the global community faces, and yet ARVs save lives and improve quality of life of HIV-infected people. Through the issuing of ARVs, pain and suffering caused by the progression of HIV is alleviated and the devastating impact of the epidemic is lessened. This stresses the point that it is imperative that all facilities offer HIV programmes, and that efficient HIV programmes are implemented nationwide (WHO, 2007b).

## **APPENDIX 1: PERMISSION LETTER: DEPARTMENT OF HEALTH**

11 Steenbras Street  
Ext. 1 Wilropark  
Roodepoort  
1724

Policy and Planning Department: North West Province Department of Health

Dear Madam/Sir

### **APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY**

I am registered for a Master of Science (MSc) in Nursing degree with the University of Witwatersrand, and conducting this research study is part of the requirements. I wish to request permission to conduct research in the North West Province among nurse initiation and management of antiretroviral therapy (NIMART)-trained nurses. The topic of my study is “Factors influencing submission of Portfolios of Evidence amongst nurses trained in Nurse Initiation and Management of Antiretroviral Therapy in North West.”

The research objectives are:

- to explore and describe the barriers affecting nurses submitting their POEs for accreditation
- to explore and describe the facilitating factors regarding submission of POEs for accreditation.

NIMART-trained nurses will be invited to participate in a focus group discussion (FGD). The FGD will take place after the clinical case study workshops that are offered to NIMART-trained nurses; therefore, service delivery will not be affected. The workshops are being facilitated by the researcher who is a partner to the department, working for the Southern African HIV Clinicians Society. The FGDs will last from 45 minutes to 1 hour. Data will be collected until data saturation is reached. A minimum number of 7 participants per FGD will be required. Confidentiality and anonymity will be maintained throughout data collection. Estimated data collection will commence in July 2015 after receiving permission from North West Department of Health and a clearance certificate from the Wits University Human Research Ethics Committee (Medical), and it will end in September 2015.

Yours Sincerely,

Nonhlanhla M. Motlokoa

(Tel: 083 975 2690 / 011 728 7365)

## **APPENDIX 2: INFORMATION LETTER FOR FOCUS GROUP DISCUSSIONS**

11 Steenbras Street  
Ext 1 Wilropark  
Roodepoort  
1724

Dear Madam/Sir

Hello, my name is Nonhlanhla Motlokoa. I am currently studying at the University of Witwatersrand for a Master of Science (MSc) in Nursing. Part of the requirement of my degree is that I conduct a research study and you are invited to be part of this study. The topic of my research study is “Factors influencing submission of Portfolios of Evidence amongst nurses trained in Nurse Initiation and Management of Antiretroviral Therapy in North West.” The aim of the study is to explore and describe the barriers and facilitating factors regarding submission of portfolios of evidence (POE) for accreditation by NIMART-trained nurses in the North West Province. You were selected to be part of this study because you are NIMART-trained and your views will be more relevant in answering the study question.

Participation will involve a focus group discussion to obtain your views on barriers and facilitating factors regarding submission of POEs. This FGD will be informal and will take more or less 45 minutes to 1 hour. I will also need your permission to record the FGD using a tape-recorder so that I can analyse the discussion from the FGD. These tapes will be kept under lock and key at the Southern African HIV Clinicians Society offices for 2 years if the study is published, or 6 years if the study is not published; after 6 years, they will be destroyed.

For the maintainance of confidentiality and anonymity, names will not be used when addressing each other; instead a code will be used to represent your name so that your identity can be protected. Total confidentiality cannot be guaranteed though as there will be other people present during the FGD. Confidentiality can also be protected by not discussing any content of the FGD outside the group. It is totally voluntary to participate in this study, and you will not face any negative

consequences if you decide not to participate in this study. You have the right not to answer questions if you feel uncomfortable doing so.

Your participation will be greatly appreciated. Should you have any questions or clarifications or wish to obtain the results of the study, you can contact me telephonically at 083 975 2690. The results of the study will be presented to the DoH during the research day. If you need to report or have any concerns regarding any aspect of this study, you can use the following contact details: HREC (Medical): Prof. P. Cleaton-Jones, HREC (Medical) Chairperson, Tel: 011 7171252; zanele.ndlovu@wits.ac.za.

Yours sincerely,  
N. M. Motlokoa

### **APPENDIX 3: CONSENT FORM FOR STUDY PARTICIPANTS**

I hereby confirm that I have been informed of the study by \_\_\_\_\_ including the nature, conduct, benefits and risks of her study \_\_\_\_\_ entitled \_\_\_\_\_ . I have also received, read and understood the above-written information (Participant Information Letter and Informed Consent) regarding the study.

In view of the requirements of research, I agree to participate in a focus group discussion and the data collected during this study can be processed in a computerised system or quoted directly in an anonymous manner. I have been informed that I am going to be tape-recorded during the focus group discussion.

I may, at any stage, without prejudice, withdraw my consent and participation in the study.

I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

#### **PARTICIPANT:**

---

**Printed Name, Signature, Date and Time**

I, \_\_\_\_\_, herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

#### **MSc Student:**

---

**Printed Name, Signature, Date and Time**

## **APPENDIX 4: PERMISSION TO PERFORM DIGITAL RECORDING DURING FOCUS GROUP DISCUSSIONS**

Dear participant

I would like to request your permission to tape/digitally record the focus group discussion that will be conducted with you. The reason for the recording is to ensure accuracy and reliability during the analysis of the research results. Your real name will not be used during the focus group and these records will not be given to anyone other than those involved in the study. The tapes will be kept under lock and key at the Southern African HIV Clinicians Society offices for 2 years if the study is published and 6 years if not published, and they will be destroyed after 6 years.

Thank you.

N. M. Motlokoa

---

MSc Student (Department of Nursing Education)  
University of the Witwatersrand

### **CONSENT TO TAPE/PERFORM DIGITAL RECORDING**

I \_\_\_\_\_ have been informed that I am going to be taped/digitally recorded by M. N. Motlokoa during this study's focus group, in which I consent to participate. I understand the reason for the tape-recording and I understand that the records will be kept under lock and key for the duration of 2 years. I hereby agree/consent to the focus group being taped/digitally recorded in this study.

---

Participant's signature

---

Date

## APPENDIX 5: PORTFOLIO OF EVIDENCE FOR NIMART TRAINING

### Appendix 5 Portfolio of evidence for NIMART training

#### Clinical Mentorship Manual for Integrated Services

##### Tool CM III

To be completed by: Mentee

Submitted to: Clinical Mentor

#### Mentee Logbook for Case Management of HIV/AIDS STIs and TB

##### General Objectives

The logbook is used to document cases that the mentee has reviewed with the clinical mentor. These cases must include patients across the lifespan. The mentor must ensure that the mentee has the opportunity to:

- Diagnose and manage opportunistic infections, including TB.
- Manage HIV positive clients not requiring ART.
- Interpret relevant laboratory investigations.
- Initiate ART, including clinical and psychosocial evaluation and develop a comprehensive treatment plan.
- Manage stable patients on ART.
- Manage side effects of ART.

##### Minimum Requirements

You are required to see a minimum number of patients in each of the categories listed below in consultation with the clinical mentor (in person or telephonically) throughout the duration of the clinical mentorship. If you are working at a clinic where there is not a high patient load, you could make arrangements to work 1 or 2 days at another ART clinic. Please discuss this with your supervisor and clinical mentor.

	Baseline Care <sup>1</sup>	ART Initiation	ART Follow-up	Initiate ART in TB	TB/HIV Follow-up	Total
Children 0-1 years	2	2	2	2	2	10
Children <3 years	2	2	2	2	2	10
Children >3 years	2	2	2	2	2	10
Pregnant Women	4	4	4	4	2	18
Adult Men	4	2	2	4	2	14
Women of Childbearing Age	4	2	2	4	2	14
TB/HIV Co-infected Patients	4					4
Total	22	14	14	18	12	80

<sup>1</sup> Baseline Care = WHO staging, CPT, CD4 count, screen for TB, health education, management of OIs, etc

**APPENDIX 6: ETHICAL CLEARANCE CERTIFICATE FROM THE UNIVERSITY OF THE WITWATERSRAND**



R14/49 Mrs Martha Nonhlanhla Motlokoa

**HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)  
CLEARANCE CERTIFICATE NO. M150417**

**NAME:** Mrs Martha Nonhlanhla Motlokoa  
**(Principal Investigator)**

**DEPARTMENT:** Nursing Education  
Regional Training Centres, Taung and Tshepong  
Hospitals, North West

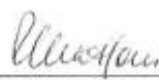
**PROJECT TITLE:** Barriers and Facilitators regarding Submission of Portfolios  
of Portfolio Evidence amongst Nurses Trained in Nurse  
Initiation and Management of Antiretroviral  
Therapy in North West Province

**DATE CONSIDERED:** 24/04/2015

**DECISION:** Approved unconditionally

**CONDITIONS:**

**SUPERVISOR:** Disebo Rita Maboko

**APPROVED BY:**   
\_\_\_\_\_  
Professor P Cleaton-Jones, Chairperson, HREC (Medical)

**DATE OF APPROVAL:** 17/07/2015  
This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

**DECLARATION OF INVESTIGATORS**

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report.**

Principal Investigator Signature \_\_\_\_\_

Date \_\_\_\_\_

**PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES**

# APPENDIX 7: RESEARCH APPROVAL LETTER FROM THE DEPARTMENT OF HEALTH, NORTH WEST PROVINCE



3801 First Street  
New Office Park  
MAHIKENG, 2735

Eng: Ketumetse Shogwe  
Tel: 018 391 4504  
kshogwe@nwpg.gov.za  
www.nwhealth.gov.za



## **POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION**

**Name of researcher :** Ms M.N Motlokoa  
University of the Witwatersrand

**Physical Address** \_\_\_\_\_  
**(Work/ Institution)** \_\_\_\_\_  
\_\_\_\_\_

**Subject :** **Research Approval Letter- Barriers and facilitators regarding submission of portfolios of evidence amongst nurses trained in nurse initiation and management of Antiretroviral Therapy in North West Province.**

This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities, and issue this letter as proof that permission has been granted by the Provincial office.

This letter of permission should be signed and a copy returned to the department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards

  
\_\_\_\_\_  
**Dr. FRM Reichel**  
Director: PPRM&E

10/06/2015  
Date

\_\_\_\_\_  
Researcher



  
Healthy Living for All

## **APPENDIX 8: SEMI-STRUCTURED INTERVIEW GUIDE FOR FOCUS GROUP DISCUSSIONS**

DATE: \_\_\_\_\_

**Title of Study:** Factors influencing submission of Portfolios of Evidence amongst nurses trained in Nurse Initiation and Management of Antiretroviral Therapy in North West.

Name of the Interviewer: Nonhlanhla M. Motlokoa

Name of the Note-taker: \_\_\_\_\_

Which year did you attend NIMART training:

Submitted POE: \_\_\_\_\_

Not submitted POE: \_\_\_\_\_

Gender: \_\_\_\_\_

Code: \_\_\_\_\_

Venue: \_\_\_\_\_

### **Introduction**

Hello, my name is Nonhlanhla Motlokoa, I will be facilitating this focus group discussion and my colleague will be taking notes during the discussion so that I can concentrate fully on our discussion. Thank you for taking your time to participate in this focus group discussion. The purpose of this study is to help me explore and describe barriers and facilitating factors affecting submission of portfolio of evidence among nurses trained in nurse initiation and management of antiretroviral therapy (NIMART). Your contributions will enable me to come up with recommendations to promote facilitators and overcome barriers, in the submission of the portfolio of evidence. Your participation is valued and I am requesting that whatever is discussed remains within the group and is not discussed outside of this group. However, I cannot guarantee that what is discussed in this room will be kept confidential. To ensure anonymity, names will not be mentioned; codes will be used instead. Please feel free to contribute your views; there are no right and wrong answers. The discussion will last from 45 minutes to one hour. As you know from the informed consent, this focus group discussion will be recorded; please verbally indicate that

you are aware that we are recording this session and that it is ok with you. Please be aware that you do not have to answer questions you are not comfortable answering.

## **Questions**

### **Identifying facilitating factors**

1. Would you like to share how you managed to complete and submit your POE?

### **Probes**

- In your opinion what is it that helped you complete your POE?
  - Tell me more about those facilitating factors?
  - What made it easy?
  - What motivated you to complete your POE?
  - How did you manage to keep yourself motivated?
  - How did it feel like to know that you have completed your POE?
2. What are the benefits of submitting your POE and becoming accredited?
3. Is there anything else you would like to share?
4. What advice would you give to someone who is struggling to complete his/her POE?

### **Identifying barriers**

5. Tell me about the barriers or challenges that you are facing or that you faced when completing the POE?
- What made it difficult?
  - Please explain the difficulties you encountered further.

## APPENDIX 9 Focus Group Discussion 2

No. of participants: 13

All the participants are trained and certified NIMART nurses (Numbers were used to address/refer to the participants to protect their identity)

Date 2015/07/23

**Researcher-:** “How did you manage to submit and complete your POE? What is it that helped you to complete your POE? Is there anyone who wants to start sharing with the group? Yes No. 7.

**No. 7-:** “What helped me a lot was the fact that there was (were) registers, all the clients that I have initiated, I have written them in the ART register. I was trained in 2011 and only completed my POE in 2013.

**Researcher-:** “Two years, so it took you two years to complete your .....” <<<No. 7 interjected>>, “No, I never was mentored, I went to the training....”

**Researcher-:** “yes” <<<prompting her to continue>>>.

**No. 7-:** “ In the training we were given a book, in a file form”-Researcher- “Ok”<<<prompting her to continue again>>>, No. 7-“ The POE, and then the facilitator or the person who was supposed to mentor me didn’t reach me because at that time I was working at the mobile site, it was difficult for her to reach me, but when I came to a fixed facility, I was appointed at this specific facility, it was the only time whereby she got time to mentor me and for me to fill in the POE, it was easy because I could go back to the facility where I was working, check in the register of the client that I have initiated and fill in the POE”.

**Researcher-:** “Ok, so it was more of a self-motivation?”

**No.7-:**“Yes”.

**Researcher-:** “Is there anyone else who would like to share with the group? Yes No. 3”

**No. 3-:** “Filling the POE initially from the course itself, I was a bit not confident, for initiating clients. Especially it was adults by then (Especially adult patients), but after the mentor came and mentored me with the POE, I was just following suit”.

**Researcher-:** “So if I get you correctly, having a mentor makes it easier to complete the POE?”

**No. 3-:** “Yes”

**No.2-:** “In my experience at the time I was doing Antenatal care, so the people that I managed to cover first were those people I was in contact with most of the time, so with the other categories I struggled, but with the categories I worked with, I managed to cover within a short period of time”.

**Researcher-:** “So how did you manage to cover other cases that were not Antenatal?”

**No. 2-:** “I just had to make time, when I was done with this, I had to find out, like ask a colleague if they have such and such a case, asked them to let me know if they have, so that I can do them because the colleague I was asking was done with her POE”.

**Researcher-:** “So tell me, was the colleague in the same facility or from another facility?”

**No. 2-:** “In the same facility, but like with people who are having both HIV and TB, it was a bit difficult so I had to contact my friends from other facilities, so, let’s say you’ve got this kind of a client with HIV and TB, that I need to initiate, I would ask my friends to let me know so that I could negotiate with my Operational manager, to say on that particular day I need to go to that facility for one hour or so, so that I can get the cases”.

**Researcher-:** “Ok” <<<No. 6 was raising her hand>>>, let’s hear No.6”

**No. 6-:** “With me it was only me who was trained on NIMART in that facility and it is a Community Health Centre, so it was easier for me, but the matter with me most of the time was that I had to attend to all those people, it went well, it took me 6 months to finish the POE”.

**Researcher-:** “So just to clarify issues, when you say to attend to all the cases, all the 80 cases you were able to get them in one facility and within 6 months?”

**No. 6-:** “Yes”

Researcher-“And the thing that helped you is the fact that it is a CHC (Community Health Clinic), whereby you see all the conditions that are included?”

**No. 6-:** “Yes”

**Researcher-:** “Just to summarise, it helps to be an initiator, someone who doesn’t wait for someone to push her or to push him to do the POE, you took it upon yourself to make sure that you get to the other facility, and the other point is that it helps to be an initiator, to be able to start things yourself, you managed to finish your POE. Coming to No. 6’s point, uhm.., having to work in a Community Health Clinic whereby all the cases are seen, is also one of the facilitating factors, oh ok. Is there anything else that everybody had said maybe that we did not touch on, that anyone would like to add? <<<No. 8 raises her hand>>>. Yes No. 8”

**No.8-:** “What helped me was (were) simulations, case studies and role play” (role plays)

**Researcher-:** “Simulation, case studies and role plays, would you like to elaborate a little bit on that?”

**No. 8-:** “Like in the case of Paediatrics, especially infants, infants if I may say, they were very scarce, so my mentor had to come up with case studies, simulations and role plays for us to finish all the 80 cases”

**Researcher-:** “Oh ok, did it happen like that with other people as well?” <<<The group answered simultaneously>>>- “Yes”

**Researcher-:** “Yes No. 10, would you like to elaborate?”

**No. 10-:** “I just wanted to add that, especially with adults it was easy to get the cases, the co-infected, pregnant ladies, but when it came to children category, it was a bit difficult, so maybe you will get 2 infants and you are expected to get 3, so that’s where the simulation helped”.

**Researcher-:** “Ok alright, thank you very much, so it is up to a mentor to know that such and such a case we are going to have difficulties obtaining it for the mentee, so he/she must be innovative and make sure that she can present other ways of making sure that you fill in that POE?” <<< group answered simultaneously>>> “Yes”.

**Researcher-:** “Ok let’s see the second question- Tell me more about these facilitating factors, we have explored that, and we discussed factors that made it easy for instance things like working in a CHC, having to phone your friend, what made it easy for any of you to fill in that POE? what other factors that you can think of and say that made it easy for me, if it wasn’t for ABCD, it was going to be a challenge for me to complete the POE?” <<<No 8. Raises her hand>>>, Yes No. 8

**No. 8-:** “The presence of the mentor”

Researcher- “The presence of the mentor made things easy for you?” <<<the whole group answered>>>, “Yes”

**Researcher-:** “Oh ok, <<<NO. 2 wanted to say something>>>, I’ll come back to you No. 2” I want No. 8 to elaborate, so when you say the presence of the mentor is there<<<Researcher remembered something>>> anyway she did explain that she didn’t have a mentor, hence it was a barrier for her to fill in your POE. Yes No. 2, I will come back to you No. 10<<<No. 10 wanted to say something, but I have noted No. 2 first>>>”.

**No. 2-:** “Ok, like the sister had said that the presence of the mentor and teaching us about how to fill in the ART stationery and something that I wasn’t quite sure of before, then when she came she showed me, explaining that this is how we do it, also saying, when you write the notes this is what is expected, learning and teaching occurred in different levels. The other thing is the support of the people that you are working with, they understood that they have to give you space and time to work on the POE.

**Researcher-:** “Ok, it still puts us back to having a mentor, <<<Researcher posed a question to No. 10>>>, was there anything that No.10 was supposed to say, before I interrupted you?”

**No. 10-:** “I think I can just add that a mentor helps a lot, I just want to say that sometimes the managers do not understand that we need to fill in the POE nneh (Ok)?, so if the mentor is there the manager allows us time to spend with the mentor and do our cases, so when you got, for an example, myself when I got the POE, I saw it as something difficult to fill in, and then I just threw it there, so the mentor kept on coming to see the progress as to how far I am (I was), so if it was not for the mentor motivating me to do the POE, I wouldn’t have completed, it helps to have a mentor”.

**Researcher-:** “Oh ok, correct me if I am wrong, you also saying besides mentors, if you have a manager who knew what’s happening, it helps as well to fill in your POE?” <<<the group answered simultaneously>>> “Yes, Yes”

**Researcher-:** “Oh, ok, so having a mentor and having an understanding manager that supports you also help with filling in of your POE, so is there anything else besides having a mentor and having a manager that understands. Have we missed anything<<<silence>>>, maybe as time goes by it will come back, so far we have just mentioned the manager and the mentor, maybe as we speak it will come out.

**No. 9-:** “If I may add, also if you have patients who are able to wait, because you can be mentored, your speed of consulting is going to be slow, so they were patient so that you can do the POE”.

**Researcher-:** “Oh ok, having patient patients<<<group laughs>>> having patient clients also helped you to complete your POE’s, ok, do you want to add or come with another point?”

**No. 6-:** “Yes I just want to add again with the help of team work, <<<Researcher added>>> “Team spirit,” No. 6 continued- “Yes, especially on the co-infected, the TB focal nurse managed to accommodate me to come and initiate those clients”.

**Researcher-:** “Oh ok, so team work with your colleagues, ya (yes) they are able to say, I’ve got someone who needs ART and he’s got TB”

**No. 6-:** “And also on the Antenatal clients”

**Researcher-:** “So it’s almost similar to that point that was mentioned by No. 2 to say she would phone whoever to say do you have cases, or if you have such and such cases, please call me, that’s still team work because they are also colleagues even though they are somewhere else. Anything else? <<< question posed to the participants, there was silence>>>”

**Researcher-:** “Second question, what motivated you to complete your POE? What is it that pushed you? It’s tiring but there was that thing that was giving you the spirit to say “complete me! complete me!” do you want to elaborate No. 6?”

**No. 6-:** “I think the way the mentor was motivating me when we were communicating, because she would say things like, you are going to be certified and then you will be recognised as a NIMART trained nurse, but if the POE is not completed and in future you are going to pay for the course, because currently you are aided financially to do this course, but if you fail to complete your POE then you have to pay back the department, then I was like Yo! Let me do it quickly<<<laughter from the group>>>, so because of that I didn’t fall behind, and she also liked to say “other people have completed it’s only you” you understand, that pushed me, but only to find out later that I was the first one to complete before those other people<<<more laughter from the group>>>”

**Researcher-:** “Ok, yes, let’s hear No. 2, then I will get back to you No. 4<<<No. 4 also wanted to say something>>>

**No. 2-:** “We were in the same class with No. 10, my mentor was aware of that, so she would always say to me “No. 10 is almost done, and I know that you are also good, how come you are not finishing with this, and I know you were initiating every day?”, because at first I would take the information and put it down there, I would write it on a photocopy paper instead of writing it on the POE, I was even using a pencil, because I was not sure of my story”

**Researcher-:** “Before you continue, I am a little bit confused, you were writing whatever was needed written on a POE, and you were writing it on a scrap paper, only to transcribe it later on your POE? <<<the group answered simultaneously>>> “Yes”.

**Researcher-:** “Oh, ok”.

**No. 2-:** <<<continues>>> “but as time goes on, when I was done I would write the information on to the POE, straight away, and the mentor kept on pushing me by saying No. 10 is done. She even once said “I was at such and such a meeting and your name was red flagged, wanting to find out why you were not done yet”, that pushed me<<<more laughter>>>”

**Researcher-:** “No. 4 were you going to add something?”

**No. 4-:** “I was motivated by the fact that it was just the two of us in the facility that had done the course, whenever I felt like giving up, the other one would motivate me and say “NO, No, No! You are almost there, don’t give up, you’ve got more cases than me, so do it!” I was also writing my cases on a scrap paper and I would also complain to her and say, I still need to transcribe these cases on the POE, and she would answer me by saying “but you are almost done because you have written it on a paper, all you need to do is to transcribe it on the POE”, that motivated me. The mentor also kept on motivating me by saying I am almost there”.

**Researcher-:** “Oh, ok, so it still takes us<<<No. 1 raises her hand>>>, I have noted you No. 1, <<<Researcher continued>>>, it still takes us to team work and working well with everybody in your space, because if you were a difficult person, maybe your colleague was not even going to bother motivating you, so team spirit, team spirit, it looks like it’s leading. <<<Researcher conversed back to No. 1>>>, yes No.1?”

**No. 1-:** “Ok me, the thing that made me work fast is because of my supervisor, not the mentor, the mentors were there, if I had any problem they would come and sometimes they would come unannounced, so I had to be ready at all times. My supervisor would be asking me now and then as to how far I am, and motivating me to do it often so that I can gain more knowledge and skill, she really supported me”.

**Researcher-:** “Ok, thank you. No.3 do you want to say something?”

**No. 3-:** “I was motivated to finish the POE by the fact that in the facility I am working in, it was only doctors who were initiating clients, and there would be more clients booked and some other days doctors won’t be coming in, so it motivated me to go and help those clients because they would be re-booked for the doctors again”

**Researcher-:** “mmh, ok, so in other words, hard work motivated you, because you had a choice of not initiating them, you would have easily said to them, come back when the doctor is here, so being a hard worker motivated you to go in there without anyone telling you, go and initiate and at the same time that also helped you to continue filling in your POE, am I right?”

**No.3-:** “Yes”

**Researcher-:** “Yes No.1”

**No. 1-:** “Just to add on what No. 3 was saying, it was like all the patients must wait for the doctor, when you are there and trained, but at the same time you are not going to do anything to help the patients, so it motivated me to finish my POE and be independent and start initiating. The patient would be saying, we are waiting for the doctor to fill in the ADR form, everything is waiting for the doctor, whereas you are there trained, so you have to just complete so you can be working like....”

**Researcher-:** “So in other words being independent motivated you to want to initiate and at the same time fill in your POE?” <<< group answered simultaneously>>>  
“Yes”.

**Researcher-:** “Ok, have we left anything regarding motivation?”

**No. 7-:** “Yes I can also add, for me it was more of the personal or professional gain, I wanted to know more about ARV’s, I wanted to know more about medication because I was lacking behind, so that also motivated me to finish my POE, so that I can also gain knowledge and also implement what I have been taught”.

**Researcher-:** “Oh ok, that’s good, just to summarise what you said, wanting to know more, being inquisitive, wanting to be knowledgeable and being able to practise what you have learnt from school, it’s what motivated you to complete your POE, ok”.

**Researcher-:** “Let’s see the next question, how did you manage to keep yourself motivated, is there anything we’ve left, we’ve spoken about motivation, but if there’s someone you want to add on it as to how did you manage to keep your self-motivated adding on whatever we have said, because we have touched on motivation already, is there anything maybe that we did not say or that anyone would like to add? <<<silence>>>”.

**Researcher-:** “Ok, we will leave motivation. <<<Researcher asked another question>>>, how did it felt like to know that you have completed your POE <<<laughter >>> <<<someone was mumbling something and the group laughed>>>, let’s hear, let’s hear.”

**Researcher-:** “Ok, would you like to express whatever you felt when you completed?”

**No. 8-:** “I was so happy, we were told that we were going to graduate in Mafikeng and the MEC would be there. During the graduation ceremony we were wearing white dresses and it reminded us from the days we used to wear white, on stage the MEC and the panel gave us certificates and a bag full of material to use when you initiate, when you refer, TB booklets, charts to guide us when we initiate clients”.

**Researcher-:** “So it felt good?”

**No. 8-:** “Very good”

**Researcher-:** “Is there anyone else, No. 6?”

**No. 6-:** “Especially that you are the only one who could initiate, it would be you and the doctor, doctor would be on the other room and you would be on the other room, clients would be waiting, it’s only you and the doctor and you feel like you are (a) guru, especially, that you are even prescribing, signing, and then they would go and come back and then you feel like yes!, and they would wait for you, if you are on lunch they would be saying “Eh No. 6 you’ve got 2 clients would you be able to see them ?” and then I would be saying, yes they can come, so they are referring to you, it felt like.....”

**Researcher-:** “So it’s a good feeling” <<<the group answered with enthusiasm >>>  
“yes”

**Researcher-:** “Yes No. 2 you wanted to add something?”

**No. 2-:** “I think what No. 6 has said, that answered the question of what motivated me”.

**Researcher-:** “Yes, yes”

**No. 2-:** <<<continues>>>, “just that nice feeling to say that if that question is being asked that who is NIMART trained? then you will be one of those people to say, I am NIMART trained, because it’s like sometimes this is very much in demand nowadays, so I was happy and relieved at the same time, because there was no one who was breathing down my neck to say did you complete the POE. So from now on I work at my own pace”.

**Researcher-:** “It’s a relief, ok, is there anything else? <<<silence>>>”

**No. 1-:** “Ok it was a relief because now you could sit down, we had this other doctor who would like to change everything (who liked to change everything), now that I am

trained, I would sit down and say to him No! according to the guidelines this is how it's supposed to be done, No! <<<laughter from the group>>>”

**Researcher-:** “Confidence, confidence, it boosted your confidence, and just for curiosity’s sake, how did the doctor took it, was he not feeling otherwise because you were now telling him what to do? He didn’t take it bad” <<<the group answered>>> “No”

**Researcher-:** “I like that, yes No. 10”

**No. 10-:** “Yes the feeling of being a guru is nice because other doctors don’t have a clue about this HIV, so even the doctor will come and ask you the regimen, saying do you think this is the correct regimen? So you feel competent and nice!”

**No. 6-:** “It also gave me confidence, there’s a time when a doctor had prescribed incorrectly, I then took the script together with the guidelines and showed him his mistake, he was a bit ashamed, but to hide his shame he tried defending himself by being defensive, but the following day he came back to me to say thank you Sister”.

**Researcher-:** “That’s good because doctors are also human, it doesn’t mean they know everything, especially HIV, some of them are not clued up as we often thought they are, ok. <<<asking the next question>>> , What are the benefits of submitting your POE and getting accredited?, we spoke about that, is there anything else you would like to share, anything else about facilitators<<<silence>>>, if none it’s fine, we will continue, it will come as we speak.”

**Researcher-:** <<<asking another question>>> “What advice would you give someone who is struggling to complete his or her own POE?” <<<silence>>> It’s mostly for those who are struggling, though we don’t have someone who hasn’t completed.... <<<Researcher remembered that there was this one participant who hasn’t completed, the Researcher asked her about it>>> Have you completed your POE? Would you like to explain your case, I am not 100% sure, are you trained? did you fill in your POE? Can you explain to us No. 11”?

**No. 11-:** “I was trained but not expected to fill in a POE because I am not practising”

**Researcher-:** “<<<asking one of the trainer who wasn’t part of the focus group, who was working on his laptop, though he wasn’t part of the FGD he knew that the discussion was confidential >>>, No. 12 please explain to me, No.11 is trained but she is not expected to fill in the POE, so would you say she is NIMART trained?”

**No. 12-:** “Yes, but competency, she’s not competent”

**Researcher-:** “So she’s NIMART trained but not competent?”

**No. 12-:** “She’s trained but not competent”

**Researcher-:** “And not accredited?”

**No. 12-:** “Yes”

**Researcher-:** “Oh, ok”

**No. 12-:** “That means we should get her..., there must be sessions you know, that are set aside for her, just to practise you know, to see those patients, to initiate a lot of them, as much as we know that she’s got that responsibility so that we can say she’s competent, so that she can get a certificate”

**No. 11-:** <<<interjected and said>>> “I do have a certificate”

**Researcher-:** “A certificate of what? <<< there was silence, No. 11 couldn’t answer, other group members started answering on her behalf, they were also not sure>>> certificate of accreditation, certificate for passing exams, <<< No. 11 wasn’t sure>>>”

**No. 11-:** “Maybe passing exams” <<<someone from the group said “Certificate of attendance” <<<the group started laughing>>>

**Researcher-:** “Anyway moving along, we are now going to talk about barriers, barriers, there’s not many questions on barriers” <<<No. 2 interrupted and said >>> “Before you continue you were asking something about how do you advise a person who is struggling to fill in a POE”

**Researcher-:** “Oh yes, thank you for bringing me back, it states: What advice would you give someone who is struggling to complete his/her POE?”

**No.2-:** “I would say she must jot down everyday”

**Researcher-:** “Yes, the cases? <<< the group answered>>> “Yes”

**No. 2-:** “Because if you say tomorrow, tomorrow, then a week later you say ag! Man let me forget about those one of last week, I will start afresh this week, and then time will be moving, and the other thing if you need help, just ask”

**Researcher-:** “Ok, any other advice for this struggling one?”

**No. 2-:** <<< continued>>>, the other thing she must have passion for what she is doing, she must love what she’s doing so that she can be motivated to finish what she has started”

**Researcher-:** “Oh ok so it is not mandatory for everyone to be NIMART trained? <<< the group answered simultaneously- “it is not mandatory”>>>

**Researcher-:** “So you just have to have love? <<< the group answered >>>“Yes”

**No. 3-:** “She must avail herself for the mentor, sometimes she will be struggling because she is dodging the mentor, then she’s not honouring the appointment, so she must be loyal and avail herself for the mentor to mentor you (her)”

**Researcher-:** “Avail yourself and stop being a dodgiest (someone who doesn’t commit to appointments), ok, any other advice for this lady or gentleman?”

**No. 12-:** “I was just saying, you know completing the POE, NIMART trained and all that, it’s like you went to school, it’s for your own good as a mentee, because you keep on initiating patients on a daily basis and no one is accrediting you, so it’s for your own benefit, it’s not the responsibility of the facility manager to see to it that you have completed. If you don’t complete, you don’t graduate, it’s your own down fall, you won’t be marketable you need to be competent and certificated”

**Researcher-:** “So in other words you have to do this for yourself, not doing it for the manager or whoever, so you doing it for yourself, ok, thank you No. 12, anything else ladies? <<<silence>>> before getting into the barriers, <<<silence>>>, ok let’s get into the barriers”

**Researcher-:** “Tell me about the barriers or challenges that you are facing or that you faced when completing the POE? I don’t think it was just a smooth ride to complete all those 80 cases, if you may recall back, what were the barriers that were interfering with you completing your POE<<< whispers from the group>>> No. 3 said something, we didn’t get that No. 3?”

**No. 3-:** “The time factor”

**Researcher-:** “What about the time factor?”

**No. 3-:** “Time factor, because we would start at 8 o’clock and there won’t be time to have lunch or tea, it was like we were being punished, she will keep on saying, you are not going for lunch or tea before you finish this”

**Researcher-:** “Was that the mentor who was saying that?”

**No. 3-:** “Yes”

**Researcher-:** “So time factor, uhm, was one of the barriers that made you not to be able to complete your POE, is that what you are saying?”

**No. 3-:** “Because in between you have to work at clinical setting, it’s not like you will be doing the POE the whole day.”

**Researcher-:** “Ok, is there anything else?”

**No. 7-:** “And also the availability of the mentor like I said, I took so long to complete because I was not mentored, I was not confident to fill in the POE, up until I was in a fixed clinic and the mentor could reach me, so if you don’t have a mentor, it makes it difficult for you to complete your POE”

**Researcher-:** “Ok, thank you No. 7, so time factor and the availability of a mentor it’s part of the barriers.

**No. 4-:** “The other thing is the shortage of staff”

**Researcher-:** “Shortage of staff”

**No. 1-:** “Yes, there will be this one client and there would be no one to do the other programmes, doctor will be initiating alone”

**Researcher-:** “It’s a problem to have shortage of staff”

**No. 6-:** “Sometimes you completed initiating that client, but you are lazy to put it into your POE, so it lapses, sometimes you forget even the name of the patient, the file, you have to retrieve that file, if you don’t remember the name it will be impossible to retrieve it, then you lack behind”

**Researcher-:** “So in other words, to turn that as a facilitator, it helps to write things down as soon as possible, before you forget, oh ok”

**No. 2-:** “If your mentor is not available and there is no one to apply that little pressure that you need, then you tend to relax”

**Researcher-:** “Then that becomes a barrier as well and then you become lazy, ok. No. 11, is there anything you would like to add that you think might be a barrier for filling in your POE? <<<silence>>>”

**No. 11-:** “uhm, I think, the categorization, if anyone who wanted to train could train, and not only certain people, I also heard you asking why is not every professional nurse that could be trained and be able to initiate, Like Primary Health Care, anybody can be a PHC nurse, with NIMART I think it’s only one group that graduate per year, is it not so? Trainings should be done regularly”

**Researcher-:** “Instead of one group per year.” Ok let me round up what you are saying, you are saying the number of trainings that takes place is too little, uhm

whereas the patients workload is increasing, so that also might be a barrier of people not completing their POE, because you don't have time to push the lines, it's only a few, maybe you will be the only one trained in the clinic, you have to push the queue, that's why you will not have time, someone was saying she would use a piece of paper to write down the patient's details, and at the end of the day the paper will be lost because there is no time of sitting in and filling it."

**Researcher-:** "Oh ok, thank you No. 11. The last question says please explain the difficulties you have encountered further, is there is anything that stopped you from completing your POE that we didn't mention?"

**No.6-:** "When we were completing those, there was sort of a sequence, it should be ANC, TB, whatever whatever (and the other programmes that I had forgotten right now), I forgot the other, so if you fill the cases incorrectly, maybe you start with Paeds, mixing them up, the mentor will send you back, you go back and re-write again".

**Researcher-:** "So you are saying previously they used to push people who are NIMART trained, to fill in their POE in sequence, like step by step, is that not happening currently? You can do any case anytime?"

**No. 6-:** "I am sure we didn't understand the process, she would be there as I was saying before you will be lazy to write them immediately and say to yourself I will go and write them later and only to find out that you will be mixing everything, not writing them according to those blocks and so then you will be sent back to start afresh"

**Researcher-:** "So just to be clear, it doesn't matter which patient you see today, tomorrow or next week, you can see ANC today, you can see TB/HIV tomorrow, you don't have to do just Paeds, just HIV/TB, oh ok the problem was writing them, it has to be TB, Paeds<<<someone said, according to the categories>>>. Oh ok, No. 3 you were going to say something"

**No. 3-:** “I was going to say, isn’t it when we were doing the POE we were with the patient and sometimes you have to prescribe medication, so sometimes there won’t be stock, some drugs will be out of stock, if you treat patient holistically you give treatment as well, and that makes you feel good. But sometimes due to drug shortage you will be doing half job because you would give the patient insufficient treatment”

**Researcher-:** “So that’s part of the barriers of completing your POE, because if you don’t fill in everything it’s not completed am I right? <<<silence>>>”

**No. 12-:** “The other challenge of completing your POE is the space, there would be thin lines which wouldn’t allow you to write, you know, the important stuff that you wanted to record in the POE. So the lines are too small for one case, so people ended up using maybe 2 to 3 lines for one patient to fill in the POE, so it came as a challenge because you are not sure what treatment you need to write on those lines, only ARV’s or maybe other drugs as well?”

**No. 5-:** “I just wanted to add to the fact that No. 6 has already raised because mostly we just added the women who are not eligible for that criteria and they are going to be subtracted then it’s a waste of time you have to re start again”

**Researcher-:** “Oh ok, thank you, anything else, we are almost done, anything else that someone would like to add, it doesn’t matter whether it’s facilitators or barriers, in closing<<<silence>>>”

**No. 7-:** “We feel competent with this NIMART because now our colleagues are seeking knowledge and skills from us, and then because now we are doing this on a daily basis, now it’s in our blood, you then sit with them, you become a mentor even though you are not a qualified mentor. But if you see that he/she is not good, you attend to that”

**Researcher-:** “So in other words, you mentor other nurses before you are even a mentor, a registered one, which is good, and that also keeps you up to scratch with the correct procedures of initiating”

**No. 3-:** “Having monthly HAST (HIV/AIDS, STI & TB) meetings also helps, during those meetings that’s where we getting updated information, updated guidelines are also discussed in these meeting, the discussions help with promoting clinics to work the same, use same guidelines. So when we talk HIV, we talk us <<<laughter from the group>>>, someone said we are Gurus.”

**Researcher-:** “Ok ladies thank you very much, thanks for your participation, we are done now, I am closing the recorder, not unless there’s anything else that anyone wants to add, before I switch off the recorder”

**No. 6-:** “No, it’s just that when it comes to HIV things change now and then, so it’s up to us to make sure that we keep on updating with new information. Like somebody comes up with something, and then you are a NIMART trained nurse, and now you question yourself how did they initiate this one, so you just need to be street wise and we need to subscribe”

**Researcher-:** “What do you mean when you said subscribe?” or you mean to the Societies, yes that’s true, you need to be updated and at par with whatever is happening around you because as she has said, HIV changes, guidelines change we always have to be up to standard with the knowledge that we give or the practice that we provide to our clients”

**No. 12-:** “Just to add with regard to filling in your POE, if as a group we know that we have POE’s for fill in, I think it will be encouraging to the group if a WhatsApp group is formulated, nneh (ok?) , whereby we update each other, e.g. letting the group know how far are you from finishing, so once you see that your peers are really pushing that side, it puts pressure on you. I mean I am studying now and that’s what

is happening, people will be saying I have already submitted my assignment that puts pressure on you, so if you can use that approach it will help you in future”

**Researcher-:** “So, social media can also help in pushing people, that can form part of the facilitators, mh ok, thank you No. 12<<<silence>>> Anything else, Ok, thank you very much ladies, I will be switching off the recorder now<<< No. 7 reminded me to thank No. 12 as well who is male, I only sad thank you ladies>>> sorry No. 12, thank you as well and thank you No. 7 for reminding me<<<laughter from the group>>>, <<<the tape recorder was switched off.

## **APPENDIX 10 FIELD NOTES**

### FIELD NOTES ON 3 FOCUS GROUP DISCUSSIONS

#### FIRST GROUP

DATE: 2015/06/11

VENUE: A Community Health Centre Boardroom in the North West

TIME: 12H45-13H30

NO. OF PARTICIPANTS: 9 (All from urban area)

GENDER OF PARTICIPANTS: females

NUMBER OF PARTICIPANTS WHO HAD SUBMITTED THEIR POEs: 6

NUMBER OF PARTICIPANTS WHO HAD NOT SUBMITTED THEIR POEs: 3

The first group had nine female participants, six members of the group were NIMART accredited and the remaining three members were not NIMART accredited. The study setting was a Community Health Centre, not far from nurses consulting rooms, being away from the main building the noise levels were very low. The environment was relaxed, since the setting is a boardroom, the participants were sitting around the table. The researcher offered participants juice and biscuits and re-assured them that the Focus Group Discussion (FGD) is not going to be a formal discussion, she encouraged the participants to be relaxed. The FGD happened immediately after the clinical case study workshop; the researcher recruited the participants just before ending the clinical case study workshop. The researcher presented her study briefly to all the clinical case study workshop participants and only those who were interested remained to be study participants and those who did not participate left the boardroom.

Participation from this group was optimal; though 2 participants were participating minimally, the researcher tried to involve them into the discussion but still their participation was minimal. Participants respected each other's views, giving each other a chance to speak. The researcher read the information letter and gave all the participants that letter as well; participants were given time to ask questions, they signed all the consent forms before the FGD started. Participants that have submitted their POEs were able to answer both questions regarding the barriers that they came across and also how they managed to overcome those barriers, they gave advice to those who haven't submitted. The FGD was conducted in English and lasted for 45 minutes; the researcher thanked the participants and switched off the audio recorder.

## SECOND GROUP

DATE: 2015/06/12

VENUE: Regional Training Centre in the North West

TIME: 13H45-14h30

NO. OF PARTICIPANTS: 11 (some from rural area and some from urban area)

GENDER OF PARTICIPANTS: 7 females

: 4 males

NUMBER OF PARTICIPANTS WHO HAD SUBMITTED THEIR POEs: 2 (1 male nurse & 1 female nurse)

NUMBER OF PARTICIPANTS WHO HAD NOT SUBMITTED THEIR POEs: 9 (3 males & 6 females)

The second focus group discussion had eleven participants comprising of four male nurses and seven female nurses, who were from semi-rural and urban areas, more nurses were not NIMART accredited only two out of eleven were accredited. Information letter was given to all the participants and the researcher read it to the participants and she gave them time to ask questions before commencing the study. Participants signed the consent forms before the study commenced.

Participation from this group was very slow, more questions were answered by the same people who were NIMART accredited, most of the participants contributed towards barriers. Participants had to be probed often due to silence after a question (that made the researcher feel uneasy), the atmosphere was relaxed though and participants didn't seem threatened. Participants were sitting around the table; chairs were rearranged that way, because for clinical case study workshop the chairs were arranged in a classroom style. Juice and biscuits were offered to the participants. The FGD was conducted in English and lasted for 45 minutes; the researcher thanked the participants and switched off the audio recorder.

### THIRD GROUP

DATE: 2016/07/23

VENUE: A Regional Training Centre in the Noth West

TIME: 14H00-14H55

NO. OF PARTICIPANTS: 10 (All from the urban area)

GENDER OF PARTICIPANTS: 10 females

NUMBER OF PARTICIPANTS WHO HAD SUBMITTED THEIR POEs: 10

NUMBER OF PARTICIPANTS WHO HAD NOT SUBMITTED THEIR POEs: 0

The third group had ten female participants, who were all from the urban areas. That day the clinical case study workshop was incorporated with mentor's training, so all participants were training to be NIMART mentors, which meant that they were all NIMART accredited. The mentor training started in the morning, followed by clinical case study workshop, at the end of the clinical case study workshop; nurses were recruited to be participants of this study then after the workshop data collection for the study commenced. Juice and biscuits were given to the participants by the researcher. Participants were sitting around the table; chairs were re-arranged from a classroom style setup to a round table setup. The researcher gave all the participants the information letter and read it to them as well; she gave them time to ask questions before commencing with FGD. All consent forms were signed by all the participants.

The group wanted to know how and when they can access the results of the study; the researcher reminded them that the information letter had her details, so they could phone her. This group was very participative and knowledgeable about the phenomenon, and no one was dominating the group, they were all giving each other a chance to speak. Even though all the participants had submitted their POEs, they were still able to come up with barriers that they faced before submitting their POEs.

Some of the participants were facility managers, and the FGD was conducted in English. The data from this group was rich and the discussion was flowing and lasted for almost an hour. The atmosphere was relaxed and full of laughter, participants were enthusiastic delighted to help the researcher because some of them admitted to be part time students so they were interested in seeing how the FGDs were conducted. Participants respected each other, none of the questions were too challenging for the participants to answer.

## **APPENDIX 11: 48 CODES USED FOR CONSTRUCTING THEMES**

### Support and teamwork:

1. Support received from mentors and managers
2. Working as a team with colleagues
3. Asking other facilities for help
4. Good relationship with your manager
5. Sharing a patient with colleagues
6. Contacting friends from other facilities
7. Presence of a mentor
8. An understanding manager that gives support
9. Team spirit

### Effective placement:

10. Placed in areas where ARV's are dispensed
11. Working in an accredited facility
12. Working in an intergrated facility
13. Working at other sections within the facility
14. Rotation every three months
15. Going to facilities where ARV initiation is done
16. Working in a Community Health Centre
17. Staff rotation to other ARV initiation facilities

### Motivation:

18. Motivation from mentors
19. Self motivation
20. Knowing that you are not alone
21. Eager to know more
22. Eager to handle difficult cases
23. Saving patient's life
24. Knowing that one would be accredited

### NIMART prerequisite:

25. Requirements prior NIMART
26. Courses to be completed first before POE submission
27. PC 101 training
28. Not trained on PALS PLUS
29. Can't submit POE without completing PALS PLUS

30. Prerequisite courses not offered regularly
31. Time required to complete PALS PLUS and PC 101

Lack of Human resources:

32. Staff shortage
33. Seeing lots of patients
34. Attending to all HIV+ patients alone
35. Patients turned back due to unavailability of doctors
36. Some days doctors doesn't come
37. Working with doctors alone
38. No one to do other programme
39. Doctors initiating alone
40. Few nurses trained on NIMART working in a Community Health Centre

Disorganisation:

41. Delaying in writing down patient's details in the POE
42. Writing patient's details in a scrap paper
43. POE not issued by RTC
44. Loosing patient's details/scrap paper
45. Not writing on the ART stationery immediately
46. Writing patient's details in a photocopy paper instead of a POE
47. Was never given a POE
48. Lazy to transcribe patient's information into a POE

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