

Running Head: PARISH NURSING

Nursing Interventions Utilized by Parish Nurses in Swaziland


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## Abstract

The area and culture most affected by AIDS is in sub-Saharan Africa, where 74 percent of the total number of people infected resides. In January 2005 data was collected through the nursing intervention classification (NIC) survey of twenty parish nurses in Swaziland, Africa. In May 2006 additional ranking surveys were completed and interviews were conducted. By ranking this data in comparison to data collected from United States parish nurses few similarities in the daily nursing interventions but many similarities in the core nursing interventions are found. From this comparison it is concluded that daily interventions are unique based on the population served such as in Swaziland where the majority of patients are affected by HIV/AIDS. The similarities in the core nursing interventions demonstrate that the fundamental practice of parish nursing is not defined by culture or population. By incorporating these daily and core nursing interventions into the current curriculum, future parish nurses in Swaziland can gain a better understanding of this important nursing practice.

### Dedication

This research project and thesis is dedicated to those individuals inflicted with HIV/AIDS. May this project become of use to those in poverty-stricken environments, who are in dire need of compassionate care.

### Acknowledgement

I would like to acknowledge my mother, who lovingly has always supported my dreams. I appreciate her encouragement in all of my endeavors throughout my life. I would also like to acknowledge my Uncle Brent and Aunt Belinda who have also showed undying support of my goals. Lastly, I would like to thank all of the incredible individuals I met in Africa who gave me the passion and inspiration to continue working towards all of my life's ambitions.

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## Chapter 1

### *Background*

Acquired immunodeficiency syndrome (AIDS) is a global emergency and one of the greatest threats to human life today. In 2005 alone there were between 3.4 million and 6.2 million people who were newly infected (Micromedex Health Care Services, 2007). The area and culture most affected by AIDS is in sub-Saharan Africa, where 74 percent of the total number of people infected resides. Worldwide there are approximately 33 million to 46 million people living with HIV. AIDS is caused by a progression of the human immunodeficiency virus (HIV) causing a depressed immune system. The HIV virus attacks the immune system by damaging the CD4, T-helper cells. The decrease in number of T-helper cells causes the immune system to not be able to fight off infection. Individuals infected with HIV/AIDS acquire opportunistic infections leading to diseases as a result of a depressed immune system (Micromedex Health Care Services, 2007).

*Diagnosis and transmission.* AIDS is usually diagnosed by a positive test for antibodies to HIV, and a T-cell count of less than 200 (500 is normal), or opportunistic infections that corresponds to a weakened immune system (Micromedex Health Care Services, 2007). AIDS is spread through the transmission of blood products or other bodily fluids (sperm, vaginal fluids, and breast milk). AIDS is primarily spread through sexual intercourse with an infected person or from mother to baby during or after birth. Infected mothers may pass on the disease to their infants through breast milk. The sharing of used needles with an AIDS infected person can also lead to transmission. The primary treatment given to slow the progression of AIDS is antiretroviral drugs. In conjunction

with these medications, patients are often prescribed prophylactic medications to aid in the prevention of acquired illnesses (Micromedex Health Care Services, 2007).

The risk for infection transmission is a very large problem related to the AIDS epidemic (Micromedex Health Care Services, 2007). There are multiple ways that this transmission can be addressed through teaching. Clients need to be taught how to reduce the risk of transmission, how to disinfect equipment at home (i.e. needles, syringes, and sex aids), provide facts to dispel myths, and initiate health teaching and referrals as indicated (Carpenito, 2006, p. 427). Even with the staggering number of newly infected people annually, the WHO reports that the rate of new infections is beginning to slow down. The World Health Organization states in “six of eleven African countries there were reported declines of 25% or more in HIV prevalence among 15-24 year-olds (2006, ¶16).” This trend downwards may be in part due to the increased education. In the 58 countries that reported, 74% of primary schools and 81% of secondary schools now provide AIDS education (World Health Organization, 2006).

### *Risk Factors*

The Centers for Disease Control and Prevention (CDC) identified specific circumstances for determining the risk a person has in the development of AIDS. These circumstances include the following: men who have sex with men, injection drug use, hemophilia/coagulation disorder, heterosexual contact with a high-risk or infected individual, blood, blood component, or transplant recipient, and combinations of these risk factors (Centers for Disease Control and Prevention, 2007).

### *Predisposition*

According to the AIDS support center, until there's a cure, there are 14 million AIDS orphans worldwide and by 2010 there will be 25 million (2007, ¶ 6). Obviously, this makes them a very large population affected by this disease. This center goes on to describe HIV/AIDS as a "disease of young people" and that "half of the 5 million new infections each year occur among people ages 15 to 24" (2007, ¶ 5).

Just as the worldwide statistics indicate, AIDS is more prevalent in the younger age group within the U.S. as well. Half of all new infections are reported in people 25 years of age or younger (Until There's A Cure Foundation, 2006). Worldwide over 19 million women are living with HIV/AIDS, which makes them a growing population, yet behind the rates of men. In the United States "70 percent of new infections occur in men and 30 percent occur in women (2006, ¶ 8)." By race, in the U.S., the African American population is the most frequently infected. They account for 54 percent of the new infections in men, and 64 percent of the new infections in women (Until There's A Cure Foundation, 2006, ¶ 9).

### *Impact on the Individual*

*Symptoms.* The impact of AIDS on a client is life-changing. Many factors including pain, low self-esteem, and medications influence the patient. According to *Medical-Surgical Nursing* (5<sup>th</sup> ed.) a person infected with HIV or AIDS often has pain from many causes (Ignatavicius & Workman, 2006). Reasons that commonly induce pain are joint and muscle pain, peripheral neuropathy-induced pain, pain from tumor invasion in bone or tissue, as well as pain from enlarged organs that compress nearby nerves (2006, p. 443-444).

*Self-esteem.* In addition to pain many patients with AIDS have dramatic changes in their self-esteem and self-concept. These transformations result from changes in appearance, alterations in relationships, and modifications in their day-to-day activities including productivity in the workplace (Ignatavicius & Workman, 2006, p. 445).

*Medication.* Adding to a client's change in lifestyle also includes the implementation of various medications. Though medications are individualized for each patient, there seem to be general difficulties that affect most clients. The cost of antiretroviral medications is astounding. The cost in the U.S. currently ranges from \$263.35 to \$2315.40 a month depending on the medication (Cichocki, 2006). Obviously, for a person that resides in a developing country these costs would make it impossible to receive medication. According to UNAIDS, the joint United Nations program for HIV/AIDS, "in sub-Saharan Africa where the epidemic is most severe—only a minute proportion of HIV-positive individuals have access to the drugs. Cost has been a major obstacle" ("Access to Treatment," n.d., ¶ 2). Another issue related to medication is the possible side effects. These can range from nausea and vomiting to a decrease in white blood cell counts. Though some of these side effects are manageable, others can lead to susceptibility to other pathogens (Ignatavicius & Workman, 2006, p. 444 & 449).

### *Psychosocial Impact*

The psychosocial impact on AIDS patients is one of the biggest concerns today. Due to the stigmatization, discrimination and self-concept changes, individuals with HIV/AIDS sometimes choose to either not get tested, or not tell their sexual partners.

*Stigma and discrimination.* The psychosocial impact on the individual becomes a greater problem than simply an individualized issue. The choices that patients make

based on the psychosocial changes can determine whether or not they pass on the disease to others as well. According to UNAIDS:

Together, stigma and discrimination constitute one of the greatest barriers to dealing effectively with the epidemic. They discourage governments from acknowledging or taking timely action against AIDS. They deter individuals from finding out about their HIV status. And they inhibit those who know they are infected from sharing their diagnosis and taking action to protect others and from seeking treatment and care for themselves (“Stigma and Discrimination,” n.d., ¶ 3 & 4).

Interwoven with the stigma of AIDS is the loss of self-esteem that infected individuals encounter. Many face discrimination, rejection or isolation from society.

*Grief.* Georgina Kenyon states that on a personal level those infected with HIV/AIDS may “feel grief, depression, hopelessness, anger, shock and betrayal” (n.d., ¶ 14). Furthermore, many of these people are thrown out of their jobs and homes and are rejected by their family and friends. All of these factors make it easy to see why these clients are at a high risk for decreased self-esteem. Of course, psychological needs vary from one person to the next depending on the stage of the disease, level of support, and prognosis (“Psychological Support,” n.d., ¶ 4).

*Cultural factors.* Another factor to consider is the degree of stigmatization associated with different countries and cultures. Discrimination may be less for individuals in the United States who have access to medication than for an individual in Africa who has no access to treatment. UNAIDS states that this may be a crucial point as “where there is hope, people are less afraid of AIDS; they are more willing to be tested

for HIV, to disclose their status, and to seek care if necessary” (“Stigma and Discrimination,” n.d., ¶ 6).

#### *Ethical Decisions and Traditional Treatments*

*Lack of care.* In many countries, where health care treatments and health care providers are scarce, treatment options for HIV/AIDS may be non-existent. According to UNAIDS the number of health care workers in developing countries, especially Sub-Saharan Africa, is dropping due to higher wages and better working conditions in western countries. The WHO estimates that “the shortage of health workers has reached 1 million and an additional 20,000 health workers are lost each year because of emigration” (Kenyon, 2006, ¶ 10).

*Death rates.* Another possible reason for the decline in health professionals is due to their increasing death rates related to AIDS. UNAIDS estimates that death rates of health workers in the worst-affected countries in Africa have increased “five or six-fold as a result of AIDS related illness” (Kenyon, 2006, ¶ 9 ). Thus, the hospitals are becoming overwhelmed with patients. This makes it more difficult for them to care for other patients with life-threatening illnesses. UNAIDS adds that “other obstacles to access include inadequate health infrastructure and lack of people with the relevant skills and training to provide the treatment” (“Access to Treatment,” n.d., ¶ 3).

*Lack of resources.* Due to the lack of resources and access to modern health care practices, those infected with HIV/AIDS in developing countries are turning to the traditional healers. UNAIDS states that “traditional healers outnumber modern health practitioners by more than 100 to one in many developing countries” (“Psychological Support,” n.d., ¶ 1).

*Traditional healers.* Traditional medicine and its practices are becoming more of an interest in developed countries. For many individuals inflicted with AIDS, traditional healers play a vital role in their treatment. UNAIDS states that

The appeal of traditional healers is that they provide client-centered, personalized health care that is culturally appropriate, holistic, and tailored to the needs and expectations of patients. The fact that they are trusted and respected within their communities is especially important with sensitive issues like sexually transmitted infections, including AIDS ("Traditional/Alternative Medicine," n.d., ¶ 2).

In addition, traditional healers are known for their use of herbs to treat symptoms, including those associated with AIDS.

The ethical decisions associated with AIDS are well known throughout the world. In addition to the unethical discrimination of those inflicted with HIV/AIDS, many of these individuals have little or no access to health care. Questions such as who should support these individuals psychosocially, medically, and spiritually need to be addressed in an ethical manner. With additional resources including medicine, medical professionals, and education being provided, we could be one step closer to stopping the spread of this pandemic.

This thesis will review the research related to HIV/AIDS transmission and identify how nurses can be educated to decrease the risk for transmission. The focus of this diagnosis will be on AIDS prevention through nursing teaching and implementation strategies.

## Chapter 2

*Review of Literature**Etiology*

The pathophysiology of HIV/AIDS is a complicated process that involves the replication of a virus and the subsequent destruction of the human immune system. In addition, the clinical manifestations that follow the proliferation of the virus are quite extensive. The pathophysiology of this disease is a process that starts with the introduction of the virus and comes to cessation with the eventual demise of the individual.

The human immunodeficiency virus causes a person to acquire HIV/AIDS. The virus invades an individual's cells, takes them over, and forces the cell to replicate the virus. The new viruses that are formed go on to infect additional healthy cells and the process repeats itself continually until the proliferation of viruses is too great for the body to handle (Ignatavicius & Workman, 2006).

*Pathogenesis*

*Entering the body.* The virus is equipped with an envelope that contains proteins for docking with these host cells. These proteins are able to distinguish the host's CD4+ lymphocyte cells. If they successfully dock with the CD4+ cells, they are able to enter the cell and create more virus particles (Ignatavicius & Workman, 2006).

*Virus replication.* After entering the host cell the virus must incorporate its genetic material into the hosts DNA (Ignatavicius & Workman, 2006). The virus's original genetic material is RNA. Therefore, in order to replicate itself it must turn its RNA into double stranded DNA. This transformation is accomplished by a viral enzyme,

reverse transcriptase. The HIV must then integrate this new double stranded DNA into the cells DNA. This is also accomplished by a viral enzyme, integrase, within the virus. The viral DNA that is made within the host cell is produced as one long strand. Therefore, prior to its release from the cell it must be cut into several smaller particles. This step is accomplished by the use of HIV protease. These smaller pieces are then packaged into a capsid or placed in sections of the CD4+ membrane. The virus is assembled (protein coat and RNA genome) and released from the host cell (Ignatavicius & Workman, 2006).

*Overwhelming the immune system.* Cells infected by HIV can be thought of as HIV factories. The subjugation of CD4+ cells to making HIV instead of carrying out normal immune system function damages the immune system. In the early stages of infection the immune system can fight off most of the HIV cells. However, as the virus continues to replicate at a rate of 10 billion new virus particles a day, the weakened immune system eventually allows for opportunistic infections and cancer to take hold (Ignatavicius & Workman, 2006).

#### *Opportunistic Infections*

Due to loss or impairment the immune system function encounters, a person with HIV/AIDS is at a very high risk for opportunistic infections. These opportunistic infections are typically caused by bacteria or viruses that do not normally generate illness in people with healthy immune systems. Once a person's CD4+ cells drop to a count of less than 200 cells/mm<sup>3</sup>, or they acquire an opportunistic infection he or she is considered to have AIDS rather than HIV (Ignatavicius and Workman, 2006). Opportunistic infections and their degree of impact on the individual depend on the area in which the

person lives, and the resources that he or she has available to fight off the infection.

According to the global AIDS program (GAP), in all resource-poor areas, tuberculosis is the most common opportunistic infection for adults (2007, ¶ 2). Other common infections are “pneumonia, diarrhea, encephalitis, [and] meningitis” (Global Aids Program, 2007, ¶ 2). Pneumonia is the most common among infected children in these same areas (Global Aids Program, 2007).

*Tuberculosis.* Tuberculosis (TB) often occurs earlier among individuals with HIV/AIDS than any other opportunistic infection (Avert, 2007). A diagnosis of TB for a person that is HIV+ officially moves his or her disease classification to that of AIDS. TB is a serious health threat to those with HIV/AIDS. This disease is spread by infected droplets in the air, and once inhaled it typically resides in the lungs. The bacterial proliferation of tuberculosis in the lungs is diagnosed as pulmonary tuberculosis. Signs and symptoms of pulmonary TB include “a bad cough that lasts longer than 2 weeks, pain in the chest and coughing up of blood or sputum. Other symptoms of TB disease include weakness or fatigue, weight loss, lack of appetite, chills, fever and night sweats” (Avert, 2007, ¶ 10). TB is harder to diagnose in clients with HIV and can be life threatening if undiagnosed or left untreated (Avert, 2007).

*Pneumonia.* Pneumocystis carinii pneumonia, or PCP, is the most common form of pneumonia associated with individuals who have HIV/AIDS (Cichocki, 2006). PCP is a widespread fungal organism in the environment and does not cause illness in the healthy person. However, PCP is the “most common serious infection among people with AIDS in the United States” (Cichocki, M., 2006, ¶ 1). This type of pneumonia usually develops slowly in those with HIV/AIDS. Signs and symptoms of PCP in a person

infected with AIDS include “several weeks of cough, fevers, and progressive shortness of breath, especially with exertion” (Gandhi, 2006, ¶ 6).

*Diarrhea.* Frequent, loose, and watery stools characterize diarrhea. For those infected with HIV/AIDS diarrhea is typically caused by bacteria and parasites. However, other causes can include “diet, infection, medication, or irritation or inflammation of the intestine” (AIDSinfo, n.d., ¶ 15). In persons with HIV/AIDS, diarrhea is more often more severe, and prolonged. (AIDSinfo, n.d.).

*Encephalitis.* Bacterial or viral organisms cause inflammation around the brain in this disease. In individuals with AIDS they can also acquire encephalitis from “parasites such as toxoplasmosis” (Gross, 2006, ¶ 7). Exposure to the virus or bacteria can be from insect bites, contaminated food or water, skin contact, inhaled respiratory droplets, lyme disease, tuberculosis, syphilis, and many viruses including the varacella virus. (Gross, 2006). More progressed signs and symptoms of encephalitis can include “loss of consciousness, poor responsiveness, stupor, coma, seizures, muscle weakness or paralysis” (Gross, 2006, ¶ 8). Though encephalitis is curable, brain damage and death can occur without treatment (Gross, 2006).

*Meningitis.* This disease is characterized by an infection of the meninges, which are “the membranes covering the brain and spinal cord” (Babcock, 2006, ¶ 2). Individuals with AIDS are at a high risk for the development of this infection related to their decreased immune function. This particular type of meningitis is caused by a fungus, “cryptococcus neoformans,” which is found in the soil around the world (Babcock, 2006, ¶ 3). Some and symptoms of meningitis include “headache, fever, nausea and vomiting, stiff neck, sensitivity to light, mental status change and hallucinations” (Babcock, 2006, ¶

4). Though complications can occur, this particular disease is curable. However, for individuals with AIDS, a long-term medication regimen must be followed to prevent the infection from coming back.

#### *HIV/AIDS Diagnosis*

The newest diagnostic HIV test is a rapid test, which produces results in five to thirty minutes. Like most HIV tests, this one measures a presence or absence of HIV antibodies in the blood (Cichocki, 2007). This rapid HIV test is considered to be as accurate as the traditional enzyme immunoassay (EIA) test, which takes one to two weeks to obtain results.

There are typically two parts to test for HIV. The first test, Elisa, detects HIV antibodies in the blood. If this test is positive the second portion of the test is completed. The second part, or the Western Blot, “detects specific protein bands that are present in an HIV infected individual” (Cichocki, 2007, ¶ 3). When the Elisa and Western Blot are used in combination the findings are 99.9% accurate. There is a third test, the PCR test, which is used to detect DNA and RNA pieces in the blood. These pieces indicate the presence of the HIV virus in the body (Cichocki, 2007, ¶ 4).

#### *Treatment and Therapy for HIV/AIDS*

*Visualization Therapy.* An individual’s well being can be enhanced when complementary therapies are used in conjunction with traditional therapies. Visualization, also referred to as guided imagery, is “technique of imagining positive [sic] images for promoting physical, mental and emotional health” (“Visualization Therapy,” n.d., ¶ 1). This technique has been used for centuries, but is currently gaining credibility due to scientific research that has proved its effectiveness. Visualization therapy offers a cost-

free way for patients to control their own self-healing. Individuals with HIV/AIDS can potentially increase their white blood cell counts, decrease their stress level, reduce their pain, stimulate the overall healing responses within the body, and aid in managing side effects of the disease. As the individual teaching required is very minimal, nurses can potentially enhance their patient's health outcomes by offering this complementary therapy in conjunction with traditional therapies.

#### *History and Origin of Visualization*

Visualization, or guided imagery, did not appear as a use in western medicine until the late 1960s (Bresler & Rossman, 2006). Healing rituals used visualization before this time, but primarily it was employed for religious events. The Native Americans, Hindus, Chinese, Tibetans, and Greeks all applied visualization methods in their culture far before its implication in the western medicine was recognized. These cultures recognized the mind/body connection and believed that they themselves, or their shamanistic healers, could communicate with the higher power through imagery (Bresler & Rossman, 2006).

More recently recognized visualization theories came from psychologists Sigmund Freud and Carl Jung. Freud was very interested in the unconscious mind and used it to create many of his well-known theories (Bresler & Rossman, 2006). Jung, also believed that imagery related to the unconscious mind, and that perhaps it was the closest an individual could come in connecting with it. Like Freud, Jung's theories and psychoanalysis were based on the theory of visualization (Bresler & Rossman, 2006).

Clinical research on visualization was not started until the late 1980s and is still limited today (Bresler & Rossman, 2006). The field of psychoneuroimmunology has

since been created to encourage researchers to study the effects of the mind on physiology and healing.

### *Psychoneuroimmunology*

There are many proven examples that the mind and body work together. The fight or flight phenomenon is a great example of how the psychological/emotional state of an individual can affect the endocrine system of the body. When a feeling of fear is present, the body releases adrenaline. A simple thought can cause a chemical reaction in the body (Mackenzie, 2007). In addition, thoughts can also cause an increase in peripheral blood flow to a certain area. A common example of this is the human sexual response to sexual thoughts that subsequently increase blood flow to the genitals (Donaldson, 2000).

The hypothalamus is at the center of this mind/body phenomenon. The hypothalamus is known to control the body's appetite, temperature, heart, lungs, adrenal and pituitary glands, and the digestive and circulatory systems (Mackenzie, 2007). The hypothalamus receives messages from neuropeptides, the chemical messenger hormones, which carry emotions back and forth between the mind and body. The messages received trigger the hypothalamus to act on its many systems (Mackenzie, 2007). Visualization should become easier for the individual over time as "gradually, through a reciprocal cyclic process of visualization and imagery, a bridge is built between conscious and unconscious processes" (Phillips & Morrow, 2005, p. 37-42).

The link between mind and body is very strong. It is shown that positive thoughts produce positive results and negative thoughts produce negative results. In fact, negative thoughts are actually shown to lower the immune system while positive thoughts can actually boost the immune system (Mackenzie, 2007).

*The Process of Visualization*

Visualization is the process by which individuals are directed to imagine themselves in some other physical, emotional, or spiritual state (“Visualization Therapy,” 2007). Through these images they are encouraged to see themselves in an optimal healthy state. When using visualization for medical reasons such as HIV/AIDS they may signal their immune systems to fight off the disease or virus.

The images that are imagined when using visualization techniques should help the individual to achieve a certain goal. Individuals implementing visualization should imagine what change needs to be made in their body and picture this change taking place (“Visualization Therapy,” 2007). The individual is free to choose his or her own images when practicing visualization techniques but the healthcare provider may want to provide examples. For instance, the nurse could encourage the individual to visualize that virus cells are shark bait and that the white blood cells are the sharks attacking the bait (Donaldson, 2000). They could also use a simple image of the virus cells being shrunken and dried while the rest of the cells are plump and flourishing (“Visualization Therapy,” 2007).

Initially the individual requiring visualization therapy may use the help of another individual to lead the person through a technique or script (Roffe, Schmidt, & Ernst, 2005). This can take place in a group or one on one setting. More often audiotapes are used by the individual so that they can practice the techniques in a location of their choosing. They can also choose to simply use the techniques without any guidance. In this case it may be recommended that they use gentle background music to help promote relaxation. While practicing visualization the individual should be in a comfortable,

relaxed position. Visualization techniques should be practiced for a minimum of fifteen minutes a day initially (“Visualization Therapy,” 2007). However, once the individual becomes more comfortable then the time may be diminished.

#### *Visualization Benefit to the Client*

The major implication of visualization for an individual with HIV/AIDS is the potential increase in white blood cell counts and the overall boost in immune system function (Donaldson, 2000). In addition, the client could experience a reduction in stress level, alleviation from pain, stimulation of overall healing responses within the body, and better control of side effects related to the disease or treatment (“Visualization Therapy,” 2007; Mansky & Wallerstedt, 2006).

In a study conducted by Donaldson, all participants saw an increase in their white blood cell counts within 90 days. The average increase in white blood cell count during this time was from 4320/ $\mu$ L to 5935/ $\mu$ L (Donaldson, 2000). All individuals were immunocompromised and were not currently receiving any other treatments to affect the white cell count. Donaldson remarked that “in changing old images of the medical problem to new ones, the individual may be enhancing, in subtle ways, his/her immune/body repair system” (2000, p. 118).

A review of literature regarding the effects of guided imagery on individuals with cancer was completed and found the benefits outweigh the risk of not attempting the therapy. It was concluded that there were “benefits in the guided imagery intervention groups compared to standard care control groups [and] significant effects were found in emotional response” (Roffe, Schmidt, & Ernst, p. 615, 2005). Though this research was conducted on oncology patients, the affects may be correlated to HIV/AIDS patients as

issues with immunosuppression, and emotional reactions to a chronic disease are similar in both groups.

Guided imagery is also proven very successful in treating anxiety in individuals with HIV/AIDS (Phillips & Morrow, 2005). Research completed by Phillips and Morrow indicates that guided imagery "has been used with a high degree of success in the management of anxiety. It has been used to help patients control pain and relax during anxiety-provoking invasive and noninvasive medical tests" (p. 37-42).

#### *Recommendation of Therapy*

As this alternative therapy has proven beneficial for HIV/AIDS patients' nurses should continue to educate patients on its potential uses. Visualization therapy can offer an individual a non-cost relief for their illness. In addition, it can be practiced in any relaxing environment. The teaching required by the nurse is very simple and can be completed in a minimal amount of time. As there does not appear to be any complications reported with this therapy, and the potential benefits to the patient are vast, visualization therapy should be encouraged.

#### *Medications*

There is currently no cure for HIV/AIDS. However, medications offer the only traditional treatment option for HIV/AIDS. There are approximately thirty HIV/AIDS medications currently approved for use by the United States FDA. These drugs include Protease Inhibitors (PIs), Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs), Non-nucleoside Reverse Transcriptase Inhibitors (NNRTIs), and Entry Inhibitors. According to the National Institutes for Health (NIH) "the recommended

treatment for HIV is a combination of three or more medications in a regimen called Highly Active Antiretroviral Therapy (HAART)” (AIDS info, 2006, p 7).

*AZT.* AZT is a primary treatment option for those affected by HIV/AIDS and is used in both the U.S. and Africa. AZT, also known as Retrovir or Zidovudine, is a reverse Transcriptase Inhibitor (NRTI). Therefore, it blocks reverse transcriptase, a protein that HIV needs to make additional copies of itself. Though AZT is not a cure it “appears to slow disease progression and prolong life” (NIH, ¶ 1, 2003). AZT was also shown to reduce the frequency and severity of opportunistic infections (NIH, 2003). AZT is often combined with other medications in the treatment of HIV/AIDS.

A diagnosis of HIV can be devastating for any individual. Though there are options available to treat symptoms and to slow the progression, there is no cure. Therefore, an individual diagnosed with HIV is likely to be very anxious regarding the prognosis. It is the nurse’s responsibility to educate the individual on resources available.

#### *Experimental Treatments*

The CDC is currently testing the use of antiretrovirals as prophylactic therapy for those in high-risk areas, or participating in high-risk behaviors. The CDC states that “Theoretically, if HIV replication can be inhibited from the very first moment the virus enters the body, it may not be able to establish a permanent infection” (CDC Trials, 2007, ¶ 6). The CDC also states that providing antiretrovirals to HIV-infected women during delivery, and to their newborns after delivery, they can reduce the risk of transmission by almost 50% (CDC Trials, 2007). Another study by the CDC found an 80% reduction in HIV transmission from a needle stick when antiretroviral therapy was started immediately and continued for several weeks (CDC Trials).

### *Restrictions During Treatment*

There is no specific activity, diet, or environment restrictions for those infected with HIV/AIDS. However, all of these things may influence the individual's ability to stay on a treatment plan. For instance, if a person needs to take medications three times a day and the work schedule is very busy this may become a very daunting task. In addition, if a person is experiencing diet problems and needs to take medications with food, this may be an impossible regimen to keep. Therefore, it is important to assess the individual's daily activities for areas that have the potential to cause non-adherence with prescribed medications (Micromedex, 2007).

### *Acute Exacerbations and Recommendations*

Typical exacerbations associated with HIV/AIDS are those that are manifested from other opportunistic infections. According to Micromedex, "Acute treatment is individualized according to the patient's presenting illness and consists of supportive care and identification and treatment of HIV-related illnesses" (2007, ¶ 29). Standards for acute exacerbations of HIV/AIDS cannot be generalized, as the underlying condition must guide treatment.

### *Vaccinations*

Though ongoing research for a HIV vaccine has gone on since 1987, no vaccine is currently available for the prevention of this disease. However, the support for a HIV vaccine from governments has increased from 100 million in 1995 to an estimated 357 million in 2002 (Irwin, Millen, & Fallows, 2003). In addition an international vaccine research partnership has developed. The African AIDS Vaccine Programme (AAVP) is a "network of researchers from countries throughout Africa with the goal of accelerating

development of vaccines” (Irwin, Millen, & Fallows, 2003, p. 99). In 1999 South Africa formed the SAAVI, South African AIDS Vaccine Initiative and set a ten year timetable for the development of an “effective, affordable vaccine for the southern African region (Irwin, Millen, & Fallows, 2003, p. 99).

### *Client Care*

*Coordination of Health Care Services.* Though health care services may be available in developing countries, the care received is mediocre when health care providers are not able to coordinate their patient care. Developing countries are in need of more responsive and effective primary care (Foong, Ng, & Lee, 2005). Research was conducted through semi-structured interviews from a convenience sample of 99 patients attending one of the two HIV/AIDS clinics over an eight-week period in Malaysia.

It is evident that although care is available in Malaysia, it is not publicized or utilized by those in need. By exploring ways in which new patients could be reached, it became apparent that there is a lack of communication between health care recourses. Thus, a conclusion was made that there is a need for nurses to coordinate health care for patients as well as provide education (Foong et al., 2005).

Researchers concluded that “a key missing factor is that of a professional group to take on the key role of co-ordinating efforts and integrating the services. In that respect, it may be that nurses, with their diverse skills base could make a significant contribution” (Foong, et al., 2005, p. 135). In addition to playing a role in coordinating patients’ care, nurses are also needed to provide education. After having been infected with HIV/AIDS, “88% of the participants indicated an interest in learning more about the disease” (Foong et al., 2005, p. 137). Patients listed some of their learning needs as information on

medications, disease progression, the latest research, and treatment options (Foong et al., 2005).

*The Need for Palliative Care in South Africa.* In order for individuals with HIV/AIDS to maintain their dignity at the end of life they desire counseling, palliative care, and the right to die at home. Though these priorities were found among individuals with HIV/AIDS in South Africa, the resources to carry them out are lacking. A lack of training and stigma associated with the disease are contributing to the deficit of recourses in this area. Therefore, in order to increase palliative care for those with AIDS health care providers must be willing to help change the experience of illness and death (Uys, 2003).

Research was conducted at seven sites throughout Southern Africa in rural, metropolitan, periurban, and urban sites. Community members, health care workers, caretakers, and people infected with AIDS were all involved in the research. Data were collected through observation, interviews, and questionnaires. The individuals and their caregivers in all the sites studied “expressed the highest appreciation for the counseling they received” (Uys, 2003, p. 271). There is a need for nurses to provide palliative care and end of life counseling for those living with AIDS in South Africa (Uys, 2003).

*HIV/AIDS Support Groups.* Individuals in South Africa who were undereducated about HIV/AIDS gained knowledge of the disease and a better quality of life through support groups. By utilizing these support groups individuals diagnosed with HIV/AIDS were able to gain insight on disease transmission, the importance of accepting the disease and having a positive outlook on life, and examine the stigmas associated with the disease.

This qualitative, grounded theory study was completed with the aid of twenty-eight participants. Researchers were interested in the “themes related to HIV/AIDS knowledge among rural residents of the Limpopo Province,” and what the practices of the HIV-positive people in this area included (Mabunda, 2004, p. 301). Information was gathered through observations and in-depth interviews. The findings of this study were identified as four themes: support group meetings, acceptance and coping, positive attitudes toward life, and relationships with extended families.

Prior to participating in support groups all of the informants stated that they did not have sufficient knowledge regarding HIV/AIDS. One participant shared that, “We did not know that it takes a long time. We thought that after 2 days, you would die” (Mabunda, 2004, p. 302). These participants overcame a lack of knowledge, and many of them continue to share their new knowledge with others. Nearly all of the participants in this study volunteer to do home health care for others affected with HIV/AIDS. In addition to sharing knowledge about HIV/AIDS they encourage others to enjoy life, and accept that they have the disease. Since joining the support groups all of the participants “look forward to making the best of their lives” (Mabunda, 2004, p. 302).

*Nutrition Enhancement.* Individuals with HIV/AIDS should be educated on appropriate nutritional needs that are specific to their disease process (Ignatavicius et. al., 2006, p. 444). As HIV/AIDS often coexists with malabsorption “the use of a high energy, high protein liquid, nutrient rich liquid supplement can be beneficial” (Micromedix, 2007, ¶ 74). As HIV progresses the individual may experience starvation related to decreased calorie intake and greater calorie loss. As the starvation progresses a condition referred to as cachexia may result. This condition includes muscle wasting as well as the

loss of fat (DeTommaso, 2002, ¶ 3). Therefore, the use of high quality multivitamins and protein powders can also be beneficial to the patient. A patient may also consider being tested for food allergies as these can lead to further malabsorption or diarrhea (Micromedix, 2007). Recommended dietary changes for all individuals with HIV/AIDS include “less roughage; less fatty, spicy and sweet food; and no alcohol or caffeine” (Ignatavicius & Workman, 2006, p. 444). The elimination of dairy products, eating smaller portions, and drinking plenty of fluids between meals are also recommended. Nurses should include nutritional education to all individuals with HIV/AIDS and diligently record the nutritional status of their own clients. Weight loss can be a predictor of death in those with HIV/AIDS. Therefore, it is suggested that proper nutrition may slow the progression of the disease (“HIV, AIDS, and Nutrition,” n.d., ¶ 1). If the patient is not receiving appropriate nutritional requirements then underlying disease problems or opportunistic infections should be examined.

*Psychological Health Promotion.* Individuals with HIV/AIDS often experience decreased self-esteem and self-concept. Changes in body image, relationships, and other daily activities can all distort an individual’s self perception (Ignatavicius & Workman, 2006). To promote psychological health the nurse should encourage the patient to “express feelings and identify positive aspects of themselves” (Ignatavicius & Workman, 2006, p. 446). In order to accomplish any psychological interventions a trusting relationship should be obtained between the nurse and client. From there, the nurse should aid the client in setting short-term, attainable goals and offering praise. For the individual with HIV/AIDS these goals could focus on independence, self-care, and control (Ignatavicius & Workman, 2006).

Stigmas relating to HIV/AIDS can also play a significant role in decreasing a person's self-concept. Suggestions for nurses to aid in combating these stigmas include integrating HIV prevention into primary care, supporting prevention materials in the community, involving families and communities, and educating clinicians so that they are not reluctant to treat people with HIV/AIDS ("Stigma & HIV/AIDS," n.d., ¶ 13). By educating others and providing teaching materials, nurses have the potential to provide a non-threatening environment for their clients in which education and psychological well-being can be promoted.

#### *Theory of Culture Care*

Madeleine Leininger once said, "[H]uman care is what makes people human, gives dignity to humans, and inspires people to get well and to help others" (Leininger & McFarland, n.d., p.1). This thought was developed into the theory of culture care diversity and universality. This nursing theory places an "emphasis on nursing as a means to know and help cultures" (Leininger & McFarland, n.d., p.1).

*Culture.* Leininger's theory incorporates the basic nursing ideals of culture and care as being essential to determining the clients care needs. According to Leinger, culture is defined as "the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular culture that guides thinking, decisions, and actions in patterned ways and often intergenerationally" (Leininger & McFarland, n.d., p. 6). Culture is an important idea in this theory as it stresses the importance of understanding, and applying the knowledge of a culture, to the care of the individual. Leininger adds, "Culturally based care factors are recognized as major influences upon human expressions related to

health, illness, wellbeing, or to face death and disabilities” (Leininger & McFarland, n.d., p.1).

*Care.* In Leininger’s theory the idea of caring is described as being a duty of a nurse. She states that caring “refers to actions, attitudes and practices to assist or help others toward healing and wellbeing” (Leininger & McFarland, p. 5). This idea of caring would certainly surpass all cultural barriers. According to Leininger both the cultural and caring aspects of this theory “need to be understood to discover clients’ care needs” (Leininger & McFarland, n.d., p. 2).

#### *Personal Application of Theory*

Worldwide health care should be of more concern. In developing countries the majority of individuals cannot afford health care or do not have adequate access to health care. This theory encourages nurses to use a caring and culturally respectful disposition when providing health care. When providing care to individuals outside the United States, their cultural beliefs, especially regarding healthcare must be recognized. In the United States, perspectives on health care vary greatly from those of other countries. This is especially true when comparing medical practices between the United States and developing countries. Therefore, the nurse’s role in providing care must compensate for cultural differences in medical practice.

#### *Nursing Diagnosis: Risk for Disease Transmission*

The risk for disease transmission is an essential nursing diagnosis in the treatment of HIV/AIDS patients. Without the knowledge or resources to prevent transmission, developing countries will continue to see an increase in the numbers affected by this epidemic. The nursing theory of cultural care addresses the way in which nurses can help

to stop the epidemic. By providing culturally appropriate treatment the nurses have a better chance of increasing their patients' understanding of the risk they possess for transmission. Taking into consideration the social standards and stigmas associated with this disease is a critical part in caring for these individuals.

#### *Clinical Application of Theory*

This theory applies to the treatment of HIV/AIDS patients as the majority of those infected reside outside the United States. Therefore, nurses must apply the concepts in this theory of cultural care to provide the best health care possible for these clients. These clients' health care concerns and complications are imperative for the nurse to understand in giving the client the best chance for survival. The nurse's role is to not only understand the disease process, but also to assist the client understanding that process as well. In order to educate these clients, the nurse must utilize the ideas of culture and care set forth by this theory.

#### *Application of Theory to Clients and Families*

Leininger's statement that human care is what gives people dignity and inspires them to help others is full of truth. Conceivably the best application of this theory for the clients and families is that of inspiration. The individuals in Africa that are suffering from HIV/AIDS are probably in need of simple human care more than most other people. The families of these clients will probably be greatly affected as well when they see the care that their family member has received. Perhaps this will relieve some of their anxiety related to the suffering family member. Once a family member has been affected by the loss of a loved one to HIV/AIDS, ideally they will be inspired to help others using the cultural care theory as well.

*Parish Nursing*

The key of Parish nursing is the connection of nursing practice and faith beliefs. Parish nursing, otherwise known as Faith Community nursing (FCN), can be seen in a variety of different nursing roles. Parish nursing is “limited only by the imagination of the parish nurse and congregation working together on health ministry – in essence, the sky is the limit” (Patterson, 2003, p. 93)!

Often one of the greatest duties of the parish nurse is to assess the health of communities, families, groups, and individuals. This may be done through individual health screenings as well as public health fairs. Health fairs provide an opportunity for public screenings such as blood pressure, cholesterol, vision, hearing, and mental health checks (Patterson, 2003, p. 93). Health education, health advocacy and development of support groups can also be within the duties of the Parish nurse.

As the role of the FCN focuses on the spiritual aspect of nursing they often use nursing interventions that include “education, counseling, advocacy, referral, utilizing resources available to the faith community, and training and supervising volunteers from the faith community” (ANA, 2005, p.1). Often times however, the exact role of the Parish nurse and their specific duties can be difficult to specify. Ministry duties often overlap nursing duties and visa versa.

Though it can be difficult, “Comprehending the distinctiveness of the role of the parish nurse is important to the maturation of the ministry of parish nursing practice” (Solari-Twadell, P. A. & McDermott, M. A., 2006, p.17). Therefore, P. Ann Solari-Twadell, Assistant Professor in the Marcella Niehoff School of Nursing at Loyola University Chicago, and former Director of the International Parish Nurse Resource

Center, attempted to discover the work of Parish nurses. Solari-Twadell used the Nursing Intervention Classification System, or NIC, as a standardized vocabulary of nursing interventions. Over two thousand surveys were then sent out to all practicing Parish nurses within the United States. They were asked to rank the 486 interventions based on how often they used each within their practice. The frequency of each intervention was ranked from "rarely, if at all" to "several times a day." Top ten interventions ranked under "several times a day, daily, or about once a day" were active listening, presence, touch, spiritual support, emotional support, health education, spiritual growth facilitation, documentation, humor, and hope instillation. Clarifying the role of the Parish nurse based on currently used interventions has the potential to establish and advance the Parish nurse practice.

#### *Parish Nursing in Africa*

Many of the Parish nurses throughout Africa work with individuals affected by HIV/AIDS. Many of these individuals are still in need of appropriate health centered teaching, promotion and prevention in regards to HIV/AIDS. The role of the Parish nurse could be easily utilized to provide education, treatment, and prevention of this disease. According to *Global AIDS: Myths and Facts*, "Ignorance breeds passivity, pessimism, resignation, or a sense that AIDS is someone else's problem. Accurate knowledge may awaken a sense of urgency about global AIDS and enable effective action" (Irwin, Millen, Fallows, 2003, p. xviii).

The top ten interventions identified above by Solari-Twadell as critical in the United States seem to focus on compassion and education. These areas can easily be utilized in clients with HIV/AIDS. Compassion for the client's with HIV/AIDS through

listening, touch, support, and hope not only increases the client's self esteem but also has the potential to decrease the stigmas surrounding HIV/AIDS.

*Nursing Intervention Classification System (NIC)*

The nursing intervention classification system, or NIC is used as a standard practice of nursing interventions. The NIC taxonomy is separated into seven domains including physiological basic, physiological complex, behavioral, safety, family, health system, and community. Each domain is then separated into classes. These classes are then further broken down into interventions. The interventions are then separated alphabetically creating the bulk of the book. A definition of the intervention and nursing actions are listed under individual nursing interventions.

Nurses can then use this classification system as a tool for identifying appropriate nursing interventions. In addition, it can be used to determine appropriate actions for a client's deficits. It can also be used as standardized vocabulary as Solari-Twadell did above, when conducting survey's.

## Chapter 3

### *Methodology*

#### *Purpose*

The purpose of this thesis project is to describe the interventions used by Parish nurses in Swaziland Africa using the nursing intervention classification (NIC) system. These results were then compared with the data compiled from the Parish nurse practice in the United States.

#### *Sample and Setting*

Twenty Parish nurses in Swaziland Africa completed surveys identifying most frequently used nursing interventions in their practice. These participants were all English speaking men and women native to Swaziland. Two participants were under 30 years of age, five were between the ages of 30 and 60 and thirteen were over 60 years of age. All of these Swaziland parish nurses have provided their services as volunteers since 2004. All participants over the age of 60, excluding one, work full time as parish nurses. All others work part time as parish nurses and part time in other paid positions.

#### *Data Collection*

Original data were collected by Carroll College students and Cynthia Gustafson in Swaziland, Africa during January 2005 and May 2006. In January data were collected through the NIC survey of twenty parish nurses. In May sixteen parish nurses completed additional ranking surveys and interviews were conducted.

#### *Survey Tool*

The survey was administered by student nurses under the guidance of Cynthia Gustafson, director of parish nurse program in Helena and facilitator of study abroad trip.

Initial nursing interventions were identified by the parish nurses in Swaziland in 2003 and then developed into a Likert type survey. The survey was then administered in 2005 and analyzed in 2007 as a part of this thesis. Student nurses from Carroll College also conducted interviews of the parish nurses in 2005. A structured interview guide was used for each survey. Interviews were transcribed by students and were approximately one page. This interview data contains both direct quotes from the parish nurses as well as interviewer comments.

#### *Data Analysis*

Survey data was analyzed through descriptive statistics, using rank priorities. Interview data was examined using a generic qualitative approach and the results were used to triangulate with the survey data to strengthen the results of the study. Steps for generic analysis included: a) read each transcript word for word, b) read second time identifying content that validated or did not validate rank order survey themes, c) compare and contrast similarities and differences between interview and survey results, and d) identified themes, e) strength of rank surveys adjusted based on interview themes

#### *Confidentiality*

The data are currently kept with Cynthia Gustafson in a locked file for security. No personal identification factors were associated with this data. The data collection was approved by the IRB from Loyola University. IRB approval was also obtained for this thesis. Currently the research analyst is certified in Protection of Human Subjects by the National Institute of Health.

*Limitations*

Several interventions on the rank survey were unusable due to the fact that they were flawed prior to distribution. Data was collected in a limited period of time and therefore some participants did not complete the survey. In addition, the surveys were distributed in English, which was not the primary language for all participants. Out of the total sixteen surveys four were unusable.

## Chapter 4

*Findings*

Parish nurses in Swaziland were asked to rank a list of interventions based on their daily frequency of use. They also ranked a separate list of interventions based on their perception of the intervention as fundamental, or core, to parish nursing. The top eleven interventions can be considered most significant as thereafter several interventions were ranked the same and there was a less significant ranking among interventions.

Table 4-1 *Top Daily Interventions Utilized by Swaziland Parish Nurses*

<u>Intervention</u>	<u>Rank</u>	<u>Domain</u>	<u>Class</u>
Pain Management	1	1: Physiologic Basic	E: Physical Comfort Promotion
Health Education	2	3: Behavioral	S: Patient Education
Nutritional Counseling	3	1: Physiologic Basic	D: Nutrition Support
Nutrition Management	4	1: Physiologic Basic	D: Nutrition Support
Active Listening	4	3: Behavioral	Q: Communication Enhancement
Diarrhea Management	5	1: Physiologic Basic	B: Elimination Management
Nutritional Management	6	1: Physiologic Basic	D: Nutrition Support
Medication Administration (Oral)	7	2: Physiological Complex	H: Drug management
Self Care Assistance	8	1: Physiologic Basic	F: Self Care Facilitation
Analgesic Administration	9	2: Physiological Complex	H: Drug management
Oral Health Maintenance	10	1: Physiologic Basic	F: Self Care Facilitation
Teaching Safe Sex	11	3: Behavioral	S: Patient Education

*Survey Rankings of Daily Interventions*

The daily interventions are a description of the most common ones utilized by Swaziland Parish Nurses according to the NIC classification system. The physiologic basic and behavioral domains are prominent. These domains can be considered as fundamental compared to other domains such as safety, family, and community. This is a reflection that the basic physiologic needs of these clients are not being met.

Key interventions that appear to stand out are centered on pain, education, nutrition, and basic health assistance. These daily interventions could be expected as the majority of their the nurses' clients are living with HIV/AIDS. Areas of patient health care such as family, community and spiritual support can also be addressed within the context of these daily interventions.

*Validation from Interview Data*

In a review of the twelve interviews conducted with the parish nurses of Swaziland in 2006, health education stands out as a main nursing intervention. In nearly every interview the nurses specifically mentioned the importance of education within their practice. The following comments support this finding: "Education is the key to the end of the epidemic"; "I think the best thing we can do is educate"; and the interviewer stated "the level of care that was provided by the parish nurse gravitated more towards education for their clients."

Medication management, administration, and education are also highlighted as fundamental interventions. In nine of the twelve interviews, the nurses commented on the importance of medications given for pain, diarrhea, and nausea. One interviewer stated "the clients' needs are taught in a manner that allowed the client to administer their own care by providing guidance in taking medications." Many of the nurses spoke about the education that they had to provide about medications and the difference that made for their clients.

I talk to her, and tell her it is so important to go and take the ARVs so she can live. Her mother goes to the clinic for her and brings these back, and she takes the ARVs. She takes them at the times she should, and soon she walks, she can

take care of her children. Then she can get a job again, and can support her children. She tells the people how taking the drugs has helped her life and helped her children, and shows it is so important to be faithful, to take the ARVs and to live so she can be there for her family.

Table 4-2 *Top Core Interventions Utilized by Swaziland Parish Nurses*

<u>Intervention</u>	<u>Rank</u>	<u>Domain</u>	<u>Class</u>
Health Education	1	3: Behavioral	S: Patient Education
Diarrhea Management	2	1: Physiologic Basic	B: Elimination Management
Medication Administration	3	2: Physiological Complex	H: Drug Management
Counseling	4	3: Behavioral	R: Coping Assistance
Truth Telling	5	3: Behavioral	R: Coping Assistance
Emotional Support	6	3: Behavioral	R: Coping Assistance
Spiritual Growth Facilitation	7	3: Behavioral	R: Coping Assistance
Spiritual Support	8	3: Behavioral	R: Coping Assistance
Hope Instillation	9	3: Behavioral	R: Coping Assistance
Medication Management	9	2: Physiological Complex	H: Drug Management
Touch	10	3: Behavioral	R: Coping Assistance
Active Listening	10	3: Behavioral	Q: Communication Enhancement
Medication Prescribing	11	2: Physiological Complex	H: Drug Management

### *Survey Rankings of Core Interventions*

The core interventions create a picture of the overall importance of the parish nurse practice in Swaziland. Comparable to the daily interventions, the core interventions are also focused on the fundamental needs in life. In addition, the spiritual and emotional components of parish nursing become evident. Nearly all of the intervention classes are categorized under coping assistance. This includes interventions such as counseling, emotional support, spiritual support, and hope instillation. These interventions are especially important in the care of individuals with HIV/AIDS.

*Validation from Interview Data*

In every interview the parish nurses discussed issues related to coping. One interviewer stated, "Without the parish nurses, the people would have little support. The parish nurses have the time to spend with their patients and that is what the patients appreciate the most. They give a tremendous amount of love and support." The parish nurses frequently comment on how they are their clients' "only support system"; they provide "hope to the hopeless" as often they have been "stigmatized by their family and community." One parish nurse commented that she copes with the emotional demands because "I can always pray, because God can always hear. And I know that I can do a little, but that God can do everything else, so I do what He helps me to do and then I know that is all I can do so He can do the rest." An interviewer remarked, "The physical and emotional toll on these women could be tremendous, but they seem to have incredible fortitude and find the strength they need through their faith."

*Comparison to US Interventions*

The data compiled by P. Ann Solari-Twadell on the most frequently utilized interventions by the U.S. parish nurse provide an interesting comparison to the top interventions in Swaziland. The rankings of the U.S. interventions were obtained from chapter three of the book, *Parish Nursing: Development, Education, and Administration*, edited by Solari-Twadell.

Table 4-3 Daily Rank Comparison to U.S. Parish Nurses

<u>Intervention</u>	<u>Rank</u>	<u>Domain</u>	<u>Class</u>	<u>Rank of U.S.</u>
Pain Management	1	1: Physiologic Basic	E: Physical Comfort Promotion	Not in top 30
Health Education	2	3: Behavioral	S: Patient Education	6
Nutritional Counseling	3	1: Physiologic Basic	D: Nutrition Support	Not in top 30
Nutrition Monitoring	4	1: Physiologic Basic	D: Nutrition Support	Not in top 30
Active Listening	4	3: Behavioral	Q: Communication Enhancement	1
Diarrhea Management	5	1: Physiologic Basic	B: Elimination Management	Not in top 30
Nutritional Management	6	1: Physiologic Basic	D: Nutrition Support	Not in top 30
Medication Administration (Oral)	7	2: Physiological Complex	H: Drug management	Not in top 30
Self Care Assistance	8	1: Physiologic Basic	F: Self Care Facilitation	Not in top 30
Analgesic Administration	9	2: Physiological Complex	H: Drug management	Not in top 30
Oral Health Maintenance	10	1: Physiologic Basic	F: Self Care Facilitation	Not in top 30
Teaching Safe Sex	11	3: Behavioral	S: Patient Education	Not in top 30

Table 4-4 Core Rank Comparison to U.S. Parish Nurses

<u>Intervention</u>	<u>Rank</u>	<u>Domain</u>	<u>Class</u>	<u>Rank of U.S.</u>
Health Education	1	3: Behavioral	S: Patient Education	1
Diarrhea Management	2	1: Physiologic Basic	B: Elimination Management	Not in top 30
Medication Administration	3	2: Physiological Complex	H: Drug Management	Not in top 30
Counseling	4	3: Behavioral	R: Coping Assistance	10.5
Truth Telling	5	3: Behavioral	R: Coping Assistance	Not in top 30
Emotional Support	6	3: Behavioral	R: Coping Assistance	4
Spiritual Growth Facilitation	7	3: Behavioral	R: Coping Assistance	6
Spiritual Support	8	3: Behavioral	R: Coping Assistance	3
Hope Instillation	9	3: Behavioral	R: Coping Assistance	9
Medication Management	9	2: Physiological Complex	H: Drug Management	Not in top 30
Touch	10	3: Behavioral	R: Coping Assistance	15.5
Active Listening	10	3: Behavioral	Q: Communication Enhancement	2
Medication Prescribing	11	2: Physiological Complex	H: Drug Management	Not in top 30

### *Similarities*

The top daily intervention from the U.S. surveys, active listening, ranked as number five on the Swaziland surveys. Health education ranked as the top core intervention on both the U.S and Swaziland surveys. These similarities show that the interventions used by parish nurses are not defined by culture. Seven of the highest ranked U.S. interventions corresponded with the top eleven Swaziland interventions. This

similarity is perhaps the key to parish nursing. The core interventions focus on education, support, and interpersonal relationships. The focus on these qualities of nursing care is perhaps the difference between generalized nurses and parish nurses worldwide. Though available resources for parish nursing differ among countries, the underlying principle of client support and education requires no more than a compassionate parish nurse.

### *Differences*

The differences seen in the daily interventions are likely related to the population served. In Swaziland much of the patient population consists of individuals affected by HIV/AIDS. The top daily interventions are a clear representation of this as the interventions consist of prevention, managing side effects, and emotional support for those affected by the disease. In addition, there is a clear distinction between the principal domains for Swaziland interventions compared to those in the U.S. The Swaziland daily interventions encompass several areas included within the physiologic basic domain and few interventions that relate to the behavioral domain. Conversely, the U.S. interventions are nearly all associated with the behavioral domain. This distinction shows that the Swaziland interventions are focused on care that supports physical functioning while the U.S. interventions are focused on care that supports psychosocial functioning. This is likely related to the fact that the population seen by the Swaziland nurses is individuals affected by HIV/AIDS, who are in greatest need of physical care.

## Chapter 5

*Implications**Current Swaziland Curriculum*

The parish nurse curriculum focuses on the “human capacity to do the good for another. As such, it asks that we reclaim what is being stolen by the AIDS crisis: human life and human dignity. Such an effort will entail not only that we bring forth the best of medical science, but also the best of the human spirit” (Mulcaire-Jones, G., 2006, p. 4).

The current curriculum, *Parish Nursing in South Africa* is an all encompassing resource and training manual. The current curriculum certainly meets their needs based on the data collected of the essential daily and core nursing interventions.

The general format of the manual presents a topic, allows time for reflection, and is then followed by a discussion. The manual is written for nurses and utilizes language appropriate for that base of knowledge.

The role of the parish nurse is based on the knowledge and utilization of science, art, and grace. These three roles reflect the essential interventions in both the daily and core categories. Science is the knowledge of human biology and pathology; art “relies on human skill and experience applied to the ends of beauty, truth and goodness” (Mulcaire-Jones, G., 2006, p. 16) and grace is the loving awareness in God.

The care and treatment of clients infected with HIV/AIDS creates a majority of the information provided in this manual. Examples of the sections include the biology and virology of the HIV/AIDS virus, opportunistic infections, risk avoidance, voluntary testing and counseling, principles of counseling, treatment, palliative care, and risks to the health care provider. African and Christian beliefs regarding HIV/AIDS are also

discussed. The focus on HIV/AIDS is essential to the practice of parish nurses in Swaziland. This is clearly identified in the top daily interventions as all of them are related to care of individuals with HIV/AIDS.

Overall the training and resource manual for the Swaziland parish nurses parallels the interventions that the nurses reported as essential to their practice. Therefore, the data collection from the parish nurses in Swaziland confirms that the current curriculum is appropriate for their practice.

#### *Future Preparation of Parish Nurses*

Though the current curriculum is sufficient for their practice, the surveys conducted with the Swaziland parish nurses provide great insight into their profession. The essential daily and core interventions noted by the current parish nurses should be incorporated into the present curriculum to better prepare future generations. In studying this emerging role of the parish nurse, education and support for this position can be developed. In addition, future parish nurses can be better prepared and more adequately trained for specific interventions that they will perform on a daily basis.

A section within the training manual should include the data results of this study. A table listing the top daily and core interventions would provide insight on day-to-day and key interventions to the newly trained parish nurse. Following the format of the manual, the section could begin with a story from a current parish nurse on her experiences carrying out a variety of interventions. The interventions could be listed and a brief description could be given explaining their collection. Critical thinking questions could then be presented that challenge the nurse to think of a clinical experience when these interventions were used, or make up a plan to address these interventions with a

client or the community. Current parish nurses would be a part of this session to help facilitate understanding of practical situations in which these interventions are used.

See Appendix A: Addition to Curriculum.

## Chapter 6

### *Conclusion*

AIDS is likely the greatest threat to human life that my generation will ever face. Its spread is inevitable as thousands die each day and even more are infected. The fact that HIV often is asymptomatic for years makes it a very difficult disease to end.

Sub-Saharan Africa is a region of the world with the greatest incidence of HIV/AIDS, and where resources for prevention and treatment are scarce. The social stigmas associated with acquiring HIV/AIDS are so negative that many choose to never get tested and therefore continue to pass the disease on to others. HIV/AIDS is a disease that affects so many in Africa, yet it seems so little is being done. As millions of individuals are newly infected with AIDS each year it should truly be a higher priority for everyone around the world. This epidemic will never end if we do not become passionately engaged in its elimination.

The parish nurses in Swaziland are a driving force in an important movement. They are working to aid those currently infected and to prevent others from infection. These nurses obtain no payment for their services yet put their lives in danger of acquiring HIV/AIDS every day. The interventions that they use in treatment of patients provide insight into the priorities of working with individuals affected by HIV/AIDS. In utilizing these important interventions we can all make a difference in the AIDS epidemic.

## Appendix A

*Addition to Curriculum*

Jabu, a Swaziland parish nurse, tells this true story of a woman and her struggles with AIDS:

She was a woman who was married to a man who worked in the mines in South Africa. He had three wives but they did not all stay together. She was the first to show symptoms of HIV/AIDS. The husband said she was making up and faking her symptoms in order to get attention because she was jealous. The other wives did not believe her in the beginning and then blamed her when she became very ill. I visited her throughout her illness and was her only support system. The other wives only started to see things differently toward the end of her life because they started to show symptoms as well.

*Application and Learning Exercise One*

In this story we see the challenge that a diagnosis of HIV/AIDS can cause. Though the disease itself can be very difficult to live with, the stigmas associated with such a diagnosis can cause many psychological complications as well. The denial associated with HIV/AIDS can create tremendous hardships in finding support systems. Think about how you would deal with a situation like the one presented above.

- What can you do as a parish nurse to help families overcome the anger and denial associated with a diagnosis of HIV/AIDS?
- In what ways do you feel you can help those affected with HIV/AIDS find support?

- If you were given the opportunity to speak to school aged children regarding HIV/AIDS, what education would you provide to them? How would you teach this age group about stigmas and discrimination?

*Application and Learning Exercise Two*

In May 2006 several Swaziland parish nurses were asked to rank lists of nursing interventions on how frequently they were used daily, and which were core to the parish nursing practice. The following charts represent the top ranked interventions and classes in these categories.

*Table 5-1 Top Daily Interventions and Classes*

Intervention	Class
Pain Management	E: Physical Comfort Promotion
Health Education	S: Patient Education
Nutritional Counseling	D: Nutrition Support
Nutrition Management	D: Nutrition Support
Active Listening	Q: Communication Enhancement
Diarrhea Management	B: Elimination Management
Nutritional Management	D: Nutrition Support
Medication Administration (Oral)	H: Drug management
Self Care Assistance	F: Self Care Facilitation
Analgesic Administration	H: Drug management
Oral Health Maintenance	F: Self Care Facilitation
Teaching Safe Sex	S: Patient Education

*Table 5-2 Top Core Interventions and Classes*

Intervention	Class
Health Education	S: Patient Education
Diarrhea Management	B: Elimination Management
Medication Administration	H: Drug Management
Counseling	R: Coping Assistance
Truth Telling	R: Coping Assistance
Emotional Support	R: Coping Assistance
Spiritual Growth Facilitation	R: Coping Assistance
Spiritual Support	R: Coping Assistance
Hope Instillation	R: Coping Assistance
Medication Management	H: Drug Management
Touch	R: Coping Assistance
Active Listening	Q: Communication Enhancement
Medication Prescribing	H: Drug Management

- Which interventions listed in the tables above do you believe could have been applied to the story told in exercise one?
- Why do you believe that health education ranks so highly in both categories? Do you know of any barriers that may prevent you from providing health education? Can you think of a plan for addressing these barriers?
- Can you think of a scenario when many of these interventions would be used for the same patient? What disease would you expect to be highly correlated with the use of these interventions?

### *Synthesis and Summary*

In this section we have worked to understand the issues that parish nurses must confront daily. As we see through the stories and tables, these issues can be broad and complex. Now that we have addressed the interventions that are necessary for the parish nurse to utilize in practice, we hope you will be more prepared for the daily challenges you may face. May your knowledge of the parish nursing practice, and the need for compassionate care, lead you to share your gifts with others.

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