



**An exploration of the experiences of social workers and nurses
treating HIV/TB patients during the COVID-19 pandemic at King
Dinuzulu Hospital in Durban**

By

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Master of Social Science (Social Work) at the
University of KwaZulu-Natal

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DECLARATION – PLAGIARISM

I, **Thandiwe Thabethe** – Student no.: **217076258** – do hereby make the declaration that this thesis, except where indicated, is my original work. I further declare that it has never been submitted for any degree or examination at another university.

This thesis, unless where specifically acknowledged as being sourced from other researchers is entirely my own work. Where other sources have made use of word-for-word, as direct quotes or paraphrasing of their words, their information has been clearly acknowledged and referenced.

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DECLARATION OF ORIGINALITY

I, **Thandiwe Thabethe** (Student No.: 217076258) do hereby declare that this study, titled:

An exploration of the experiences of social workers and nurses treating HIV/TB patients during the COVID-19 pandemic at King Dinuzulu Hospital in Durban

is a product of my own research. There has been no falsification of source materials used or unacknowledged. I do make the declaration that this study represents my own research and it has never been in part or in full submitted to another University or for any other degree.



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February 2023

DECLARATION BY SUPERVISOR

With my approval, this thesis which I supervised is being submitted.



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February 2023

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DEDICATION

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Education is like trying to know or build your relationship with God through reading the Bible. The more you read it the more you realise that there is still a lot that you need to understand and appreciate about God. It is the same thing with education, the more you study the more you realise that "education is a lifelong journey whose destination expands as you travel" (Jim Stovall).

ACRONYMS AND ABBREVIATIONS

Abbreviation	Definition
AASW	Australian Association of Social Workers
AIDS	Acquired Immunodeficiency Syndrome
CDC	Centre for Disease Control and Prevention
COVID-19	Coronavirus Disease 19
DOH	Department of Health
DOL	Department of Labour
DOT	Directly Observed Treatment
DSD	Department of Social Development
DSD	Differentiated Service Delivery
EAP	Employee Assistant Program
HCWs	Healthcare Workers
HIV	Human Immunodeficiency Virus
HSSREC	Humanities Social Sciences Research Ethics Committee
ICT	Information and Communication Technology
ILO	International Labour Organisations
IPC	Inter-Professional Collaboration
KDH	King Dinuzulu Hospital
KZN	KwaZulu-Natal
MDR-TB	Multidrug-resistant Tuberculosis
MERS	Middle East Respiratory Syndrome
NGO	Non-governmental organization
PCC	Patient-Centred Care model
PH	Primary Healthcare
PLHIV	People Living with HIV
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Syndrome Disorder
PTSS	Post-Traumatic Stress Syndrome
SANAC	South African National AIDS Council
SARS	Severe Acute Respiratory Syndrome

SASSA	South African Social Security Agency
SCT	Social Constructionism Theory
SDA	Social Development Approach
SDH	Social Determinants of Health
TB	Tuberculosis
UKZN	University of KwaZulu-Natal
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organisation

ABSTRACT

The outbreak of COVID-19, a global health pandemic, created a tsunami of problems resulting in lockdowns as the world grappled to understand and contain its spread and save lives. For King Dinuzulu Hospital, a specialised healthcare centre for the treatment of TB, its designation as a COVID-19 health facility in the province of KwaZulu-Natal, turned it into a facility managing three epidemics, COVID-19, TB and HIV. The main aim of this study was to explore the experiences of public social workers and nurses caring for and treating TB/HIV patients during the COVID-19 pandemic at King Dinuzulu Hospital.

This study utilised a qualitative research methodology. Data were collected from 15 HCWs (seven public social workers and eight nurses) selected using a purposive sampling methodology. One-on-one in-depth interviews were conducted. These were guided by an interview guide with open-ended questions, and the collected data were analysed using thematic content analysis.

The study revealed that COVID-19 negatively affected the delivery of social work and nursing services at King Dinuzulu Hospital, and HCWs experienced psychological distress due to fear of being infected, infecting their family members and seeing some of their colleagues and patients at KDH die from COVID-19 pandemic.

The mitigation measures that were put in place to blunt the full impact of COVID-19 on HCWs providing services to TB/HIV patients, went some way in preventing a total disaster from happening. KDH needs to resolve the shortage of HCWs, provide sufficient PPEs, repair and provide access to telephones/ mobile phones, and provide adequate and conducive offices.

Keywords: COVID-19, Pandemic, Tuberculosis, Social Workers, Nurses

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CHAPTER ONE: INTRODUCTION

1. Introduction

This study explored the experiences of social workers and nurses treating human immunodeficiency virus (HIV) and tuberculosis (TB) patients during the corona virus disease 2019 (COVID-19) pandemic at King Dinuzulu Hospital in Durban. This chapter is an introduction section that provides the background, problem statement, aim, objectives, the questions it sets out to answer, the proposed study's assumptions; and the theoretical framework that was used to guide the study.

Most of the experiences shared by the study participants relate to the hard lockdown periods under level 5 from March to June 2020, and from June to July 2021 under adjusted level 4 (Ryan, Maclean, & Weideman, 2020; Ebhuoma, 2022). A time of great anxiety and stress due to the explosion of COVID-19 infections, deaths and sickness that almost overwhelmed the healthcare services.

1.1 Background

The novel coronavirus SARS-CoV-2 (COVID-19), HIV and TB pose the most unprecedented triple public health challenge the world and individual countries have ever faced in the 21st Century. About 37.6 million people were living with HIV, and about 690 000 people died from HIV-related deaths in 2020, globally (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2021). Among people living with HIV, Tuberculosis is the most common cause of death (Swaminathan & Narendran, 2008; Tamuzi *et al.*, 2020).

The COVID-19 pandemic, as feared by the World Health Organisation's Director-General, citing WHO modelling suggesting a 50% drop in TB case detection in countries with high TB burden, threatens to reverse the gains made in the fight against TB (World Health Organisation [WHO], 2020). People living with HIV/TB found in Sub-Saharan Africa, account for 70% of worldwide coinfection (Kanabus, 2021), making the fear of reversal of the gains made over the years in the fight against HIV/TB more acute in Sub-Saharan Africa.

Whereas HIV and TB pose a high risk of exposure to healthcare workers (HCWs), the novel coronavirus SARS-CoV-2 poses an even more significant threat to HCWs than any other infectious pathogens known in the history of humanity (Dramowski *et al.*, 2020). Despite the protection of healthcare workers from COVID-19 being a global priority, the World Health Organisation estimates a 14% of global COVID-19 infections among HCWs, of whom 7000 died from COVID-19 according to Amnesty International (World Health Organisation [WHO], 2020; Reese *et al.*, 2021; Amnesty International [AI], 2020). It is not an exaggeration that healthcare workers have endured the heaviest burden of occupational-related infection and death for being at the front of fighting COVID-19. According to WHO (2021c) estimates, the number of healthcare workers that died from COVID-19 between January 2020 to May 2021 was between 80 000 to 180 000 giving a medium of 115 500 deaths.

In the United States, about 19% of the occupational status COVID-19 infections cases were HCWs, while in South Africa, HCWs accounted for 7% of infections (CDC COVID-19 Response Team, 2020; Grobler, 2020). In South Africa, about 35 145 confirmed cases of COVID-19 were among public healthcare workers, of whom 339 died between March and November 2020 (Jordan, 2020). The number of healthcare workers who paid with their lives fighting COVID-19 in South Africa had exponentially increased to about 1300 by the end of 2021 (Heywood, 2021). Although there have been a few studies done concerning the experiences of HCWs during the COVID-19 pandemic (Adeniyi *et al.*, 2021, Reese *et al.*, 2021; Robertson *et al.*, 2020; Wiysonge *et al.*, 2022), there is no known study focusing on HCWs mainly working in a facility designated for COVID-19 and HIV/TB patients in South Africa.

Even though there are no known studies done at healthy facilities battling TB, HIV and COVID-19 epidemics, there are studies that have been conducted concerning individual epidemics comparable in some respects to COVID-19. Studies that have been conducted focusing on the experiences of HCWs during outbreaks of pandemics highlight several challenges they face. A study done in the Free State Province in South Africa at TB health facilities found that a significantly high number of HCWs who participated were afraid of occupationally contracting TB (Engelbrecht *et al.*, 2019). Similarly, HCWs have viewed the COVID-19 pandemic as an occupational health hazard that is severe exposure to death or a threat of death, thereby causing significant psychological consequences to them (Greenberg *et al.*, 2020).

Healthcare workers have also experienced discrimination and stigma for working or being at the front of the fight against pandemics such as Severe Acute Respiratory Syndrome (SARS), Middle East respiratory syndrome (MERS), TB, HIV and now COVID-19 (Cavalera, 2020; Maunder *et al.*, 2004; Ransing *et al.*, 2020). While people in communities need the services of HCWs, they also view them as a source of infection to these deadly killer diseases that make them feared and shunned. The discrimination, stigma and isolation they experience from their family members, community and colleagues such as during the SARS 2003 outbreak resulted in psychological trauma (Maunder *et al.*, 2004). SARS is a coronavirus disease from a SARS-CoV virus that broke out in Guangdong China and spread to 32 different countries and regions with a total death toll of 919 between 2002 and 2003 (Yang *et al.*, 2020).

1.1.2 Problem statement

Healthcare workers are an essential resource in the fight against the COVID-19 pandemic. Public health social workers and nurses are a part of the healthcare workforce, providing care, support and treatment to people affected and infected by COVID-19. Understanding their experiences during the COVID-19 pandemic would be insufficient without factoring in the other epidemics of HIV and TB. Public health social workers and nurses form part of the healthcare workforce that is on the frontline of the fight against COVID-19. They have borne the most occupationally-associated burden of infections, sickness, death, and psychological and mental health challenges due to the exposure of being at the frontline.

South Africa according to the World Health Organisation (2020) is one of the countries with the highest infectious disease burdens with overlapping (HIV) and tuberculosis (TB) epidemics and in the world has the highest number of people living with HIV (UNAIDS, 2021). HCWs were already dealing with the risks and challenges of TB and HIV in their places of work. COVID-19 compounds the already pre-existing occupational-related challenges and difficulties such as stress, and psychological problems borne of fear of this new deadly killer disease. The guilt they carry for infecting family members, and the stigma and discrimination from their communities and friends are afraid of being infected. All these experiences make their work more challenging (Ransing *et al.*, 2020; Bhanot *et al.*, 2021).

The healthcare industry due to the constant and complex exposure to a variety of health and safety hazards it presents to its employees during the course of their work makes it the most

hazardous to work in (Joseph & Joseph, 2016). King Dinuzulu Hospital as a specialized TB health facility exposes the HCWs not only to TB but HIV as well as they have close interaction (Sharma, Mohan, & Kadiravan, 2005).

The COVID-19 outbreak compounded the pre-existing HIV and TB occupational health hazard to healthcare workers, as they now had to contend with a third and even more dangerous pandemic. COVID-19 overwhelmed health facilities, services and the HCWs, especially during the hard lockdown periods. In the KZN province, hospitals were under severe strain as they were full to capacity with patients, mortuaries overflowing with dead bodies, nurses dying on a daily basis from COVID-19 infections acquired during their line of duty and some nurses being under quarantine and those available having to endure very heavy workloads without any plans of replacement (Sain, 2020).

Healthcare workers were rightly hailed as heroes for braving such traumatic, overwhelming and difficult occupational experiences. “Healthcare workers have been hailed as heroes but, for many, being a hero has come at a heavy price. Now, many are dealing with levels of trauma they have never previously experienced” (Nicolson, 2021).

Healthcare workers in this study face the unique challenge of working in a facility designated for treating COVID-19, HIV and TB patients. The study allowed them to share their experiences of working at the King Dinuzulu Hospital, a designated COVID-19 facility, given the psychological problems they have been subjected to due to work overload, the excessive number of deaths they witnessed during the hard lockdown periods, death, infections, quarantines and isolations.

1.1.3 The study location

This study took place at King Dinuzulu Hospital, formerly known as King George V hospital. It is situated in Ward 25 in Springfield, Durban Municipality District of KwaZulu-Natal Province. King Dinuzulu hospital is a centralised and specialist TB treatment district hospital where patients from all over KZN are referred. Following a 2020 March 15 declaration of National State of Disaster declaration by the President of the Republic of South Africa due to the outbreak

of COVID-19, King Dinuzulu Hospital was designated as one of the facilities in KZN admitting asymptomatic suspect cases for COVID-19 (KDN, 2020).

1.1.4 Aim

To explore the experiences of social workers and nurses treating HIV/TB patients during the COVID-19 pandemic at King Dinuzulu Hospital in Durban.

1.1.5 The objectives of the Study

1. To explore the workplace experiences of social workers and nurses caring for, supporting and treating people living with HIV/TB during the COVID-19 pandemic
2. To explore how COVID-19 has affected the delivery of social work services to HIV/TB patients.
3. To explore how COVID-19 has affected the provision of nursing services for HIV/TB patients.
4. To explore the unique challenges that are faced by social workers and nurses when attending to people living with HIV/TB that also have COVID-19.

1.1.6 Assumptions of the Proposed Study

- The designation of King Dinuzulu Hospital as a facility admitting symptomatic COVID-19 patients has increased psychological stress levels among public health social workers and nurses.
- Interactions between caregivers and clients (patients/ people living with TB/HIV); and between fellow workers have become frightening and difficult.
- The delivery of social work and nursing services to people living with TB/HIV has been negatively impacted due to COVID-19.
- The designation of King Dinuzulu Hospital as a facility admitting COVID-19 symptomatic patients has increased the occupational health hazard of social workers and nurses.

1.1.7 Research questions

1. What are the workplace experiences of social workers and nurses treating HIV/TB patients during the COVID-19 pandemic?
2. What is the impact of the COVID-19 pandemic on social work services for HIV and TB patients?
3. How has COVID-19 affected the healthcare services offered by nurses for HIV/TB patients?
4. What are the unique challenges that are faced by social workers and nurses when attending to HIV/TB patients that underlie the COVID-19 pandemic?

1.2.1 Theoretical framework

Two theories were used to guide this study. The social constructivism theory (SCT) and the patient-centred care model (PCC).

1.2.2 The Social Constructionism theory

The social constructionism theory originates in sociology, by Peter L. Berger and Thomas Luckman who first introduced it in their book, *The Social Construction of Reality*, published in 1966. While George Herbert Mead's symbolic interactionism theory suggests that the construction of identity is based on social interaction, they were also influenced by other thinkers such as Karl Marx and Emile Durkheim (Vinney, 2019). Conventional knowledge, according to social constructionists is not necessarily based upon objective, unbiased observations of the world.

The study used the social constructionism theory, which emphasises culture and context as important in understanding knowledge construction and society, is based on the following assumptions that reality is constructed through social invention (human activity); that knowledge is created through human interactions with each other and the environment; and that learning is a social process that results from social activities (McMahon, 1997; Derry, 1999; Ernest, 1999; Kim, 2001; Lombardo & Kantola, 2021). Through this theory, the study explored the healthcare

workers' reality, knowledge and learning through their own experiences with HIV/TB patients during the COVID-19 pandemic.

Social constructionism theory is relevant for this study as it is aligned with social work and health work practice in the generation of knowledge concerning patients and health care workers (HCWs). Knowledge about the experiences of HCWs treating HIV/TB patients during COVID-19 requires that HCWs be engaged and interact with patients for them to learn and appreciate the challenges they both face.

The most significant criticism of the social constructionism theory is the perception of how it conceptualises realism and relativism. Relativism holds that what we conceive to be true or false, right or wrong, good or bad, standards of reasoning and validation are all based on different agreements, and frameworks of assessments whose authority is confined to their context (Baghramian, 2004). There is a widespread and common critique of the social constructionism theory of not recognising anything as objective truth (Andrews, 2012; Craib 1997; Schwandt, 2003; Sismondo, 1993; Vinney, 2019); and that beyond language, there exists nothing (Bury 1986; Vinney, 2019).

1.2.3 Patient-Centred Care (PCC) model

This study also utilised the patient-centred care model in understanding the experiences of healthcare workers as they care for and treat HIV/TB patients during the COVID-19 pandemic. Patient-centred care models place patients at the centre of control for decisions, care and support they receive, and also focus on the structural processes and healthcare centre culture which affect patients and HCWs. According to the people-centred model, patients should be accorded the information and the opportunity necessary for control over healthcare decisions that affect them (Baker, 2001). Patient-centred care (PCC) model in healthcare is about treating a patient (persons receiving healthcare) with the dignity and respect they deserve as human beings by involving them in all the decisions made about their health. It is about empowering and making patients active participants in their healthcare and well-being, focusing on their particular needs (Reynolds, 2009).

Literature review shows that patients' participation in their own health care has been associated correlated with improved outcomes of treatment (Vahdat *et al.*, 2014)). It is therefore important for health facilities to create an environment that is supportive or facilitative of HCWs' ability to carry out their work in accordance with the values of the patient-centred care model. Nurses and social workers in particular that are working in health facilities play a part in making an environment where the PCC model is applicable. They avail patients with critical information concerning different treatment options and their pros and cons to make sure that they understand and are involved in the process. They also involve patients in finding and facilitating suitable support services, networks and systems at the family and community levels. In so doing, they help create an environment for patient-centredness which is considered, “an essential quality parameter of modern healthcare” (Birkeland *et al.*, 2022, p.86).

The patient-centred care model is also called people-centred care which “takes a holistic approach to patients, viewing them as individuals with multiple concerns, attributes and, often, conditions” (Odone *et al.*, 2018, p. 134). These concerns, attributes and conditions are beyond the confines of the illness of patients but constitute the social space or environment that provides for the wellness of an individual patient. The PCC model thus goes beyond what defines the individual patient to include the social, economic and cultural environment within which they come from in the form of families and communities (Odone *et al.*, 2018).

The cultural and ethnic variables that account for the specific and relevant circumstances of each patient are precisely what the PCC model is designed to consider in collaborative care. The successful delivery of collaborative care under the PCC model requires that HCWs should have cultural competence allowing them to deliver care that respects and considers the patients' values, beliefs, and behaviours including language (Renzaho *et al.*, 2013).

This model is suitable for this study as it aligns with the essence and professional identity of a social worker and good health work practice. A social worker is an instrument that advances the cause of human rights and social justice for the most disadvantaged in society through empowerment strategies, interventions, and sound relationships for the benefit of individuals, families, groups and communities (Engelbrecht, 1999). This requires adherence to professional ethics with which social workers must proactively or responsively meet and care for the needs of the vulnerable with empathy and commitment to building a more caring and humane society of interdependency (Engelbrecht, 1999; SACSSP, 2005).

1.3 Definition of keywords

COVID-19

Coronavirus disease 2019, is a disease caused by a virus called severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) which was first identified in Wuhan, China in December 2019 (Zhong et al., 2003; Tsang et al., 2020). It is a new strain of coronavirus that belongs to the family of viruses that cause severe acute respiratory syndrome (SARS) from a SARS-CoV virus (2003) and the Middle East respiratory syndrome (MERS), from a MERS-CoV virus (2012) (Zhong *et al.*, 2003; Tsang *et al.*, 2020). The SARS-Cov-2 virus is spread through aerosolised droplets through coughing, sneezing, speaking, talking, singing and breathing from an infected person's mouth or nose to another. Its common symptoms are cough, fever, tiredness and loss of taste or smell. The World Health Organisation (2020j) declared it a global emergence on March 11, 2020 (WHO, 2020j).

Tuberculosis

Tuberculosis (TB) is a communicable disease that is caused by a bacteria called *Mycobacterium tuberculosis* that mostly attacks the lungs. It spreads by the air through sneezing, coughing and spitting from a person with lung TB to another person (CDC, 1977; Chinenye, 2015). TB was a leading single infectious cause of death in the world before the COVID-19 epidemic; and despite being curable and preventable it still is the world's top infectious killer disease claiming the lives of about 1.5 million people per year with 10 million falling sick from it annually (Iacobino, Fattorini, & Giannoni, 2020; WHO, 2022a).

Pandemic

A pandemic is an outbreak of an infectious disease that occurs on a global scale and is widespread affecting all people across all international boundaries (Morens, Folkers, & Fauci, 2009; Porta, 2014). It also bears the hallmark of the explosiveness of its high rate of transmission within a short period of time and encounters minimal population immunity that results in high infection rates and severe fatalities (Morens, Folkers, & Fauci, 2009).

King Dinuzulu Hospital

King Dinuzulu Hospital is a health facility located in the Metropolis of Durban in the Province of KwaZulu Natal of the Republic of South Africa. It is a specialized hospital for the treatment of TB in KwaZulu Natal Province and was designated as a COVID-19 health facility after the declaration of the National State of Emergency, for the caring and treating of COVID-19 patients (KDN, 2020).

Nurses

Nurses are trained and qualified health professionals in nursing education and are authorized to practice nursing by the appropriate regulatory authority of their country (International Council of Nurses [ICN], 1987). Some of the functions they are authorised to perform, working as members of healthcare teams are the promotion of health, the prevention of illness, and care for the physically and mentally ill, in healthcare facilities and other community settings (ICN, 1987).

Social workers

Social workers are trained and skilled professionals who are devoted to helping vulnerable people such as children, older people, people with disabilities, women and the poor, as individuals, a group or a community. They help vulnerable people to reduce or eliminate the challenges they face in meeting their needs; maximise their abilities and strengths so that they can live life fully and make a full contribution to the well-being of society (Sheafor, Horejsi, and Horejsi, 2015). In their practice, the principles of human rights, social justice, respect for diversity and collective responsibility guide them; and they endeavour to enhance the well-being and address the people's life challenges in their diversity (IFSW, 2014).

1.4 Outline of the thesis

1.4.1 Chapter One

This chapter introduces the study and provides the background to the study. Specifically, this it lays out the aims and objectives of the study; the study's research problems and objectives. Key

questions the study seeks to answer are provided; the theoretical framework and the study outline are stated clearly.

1.4.2 Chapter Two

This chapter explores the literature on the topic under investigation that has been published. The literature review shows what is known and what has been written on HIV, TB and the COVID-19 pandemic. It also shows the role played by HCWs play in the fight against these deadly epidemics and the occupational-related challenges they encounter. It also presents the COVID-19 health protocols and the role they play in preventing and minimising infection and the spread of COVID-19.

1.4.3 Chapter Three

Chapter three presents the methodology of the study, that guided it. The study utilised a qualitative methodology. It used purposive sampling techniques to identify study participants. This chapter outlines the data collection process: observance of COVID-19 health protocols, administration and signing of informed consent forms, individual one-on-one interviews; and the utilisation of the thematic content data analysis method.

1.4.4 Chapter Four

Chapter four presents and analyses data from the study findings using thematic content analysis guided by the study objectives. Data is presented thematically through thick descriptions and verbatim quotations from the study participants. Further, relevant literature is used to analyse and interpret the findings in order to better understand them. This helps ensure that the findings are examined within the context of relevant literature and theoretical frameworks.

1.4.5 Chapter Five

A general conclusion to the study is given in this chapter. A summary of the study is provided in line with the aims and objectives of the study; and recommendations based on the findings and critical analysis are presented.

1.5 Conclusion

This introduction chapter provided a broad introduction, background, and theoretical framework for the study. It has also provided the outline of the thesis. The next chapter offers peer-reviewed literature in detail on what has been written about the subject matter.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter presents a literature review of essential themes on which the study is anchored. The review is thematically organised. The first section of the literature review is e on the COVID-19 pandemic's emergence in the world and South Africa. The second section will be on the theme of TB/HIV epidemics followed by the function public health social workers play in health institutions providing care and support to patients. The fourth section highlights the nurses' role in the providence of care and treatment to patients in health institutions. Lastly, the collaboration between public health social workers, nurses, and other health professionals in patient treatment, care and support.

2.2 The COVID-19 Pandemic

The disease caused by COVID-19 (SARS-CoV-2), which was first reported in China's Wuhan Province in December 2019, was named Coronavirus Disease 19 (COVID-19), by the world health organisation, classifying it as a global health emergency and pandemic (Huang *et al.*, 2020; Zhu *et al.*, 2020). COVID-19 belongs to the family of three major coronavirus epidemics reported worldwide caused by different agents, in 2002 severe acute respiratory syndrome coronavirus (SARS-CoV), in 2012 the Middle East Respiratory Syndrome Coronavirus (MERS-CoV) and in 2019 the severe acute respiratory syndrome coronavirus (SARS-CoV-2) known as COVID-19 (Soriano, & Barreiro, 2020; Tamuzi *et al.*, 2020).

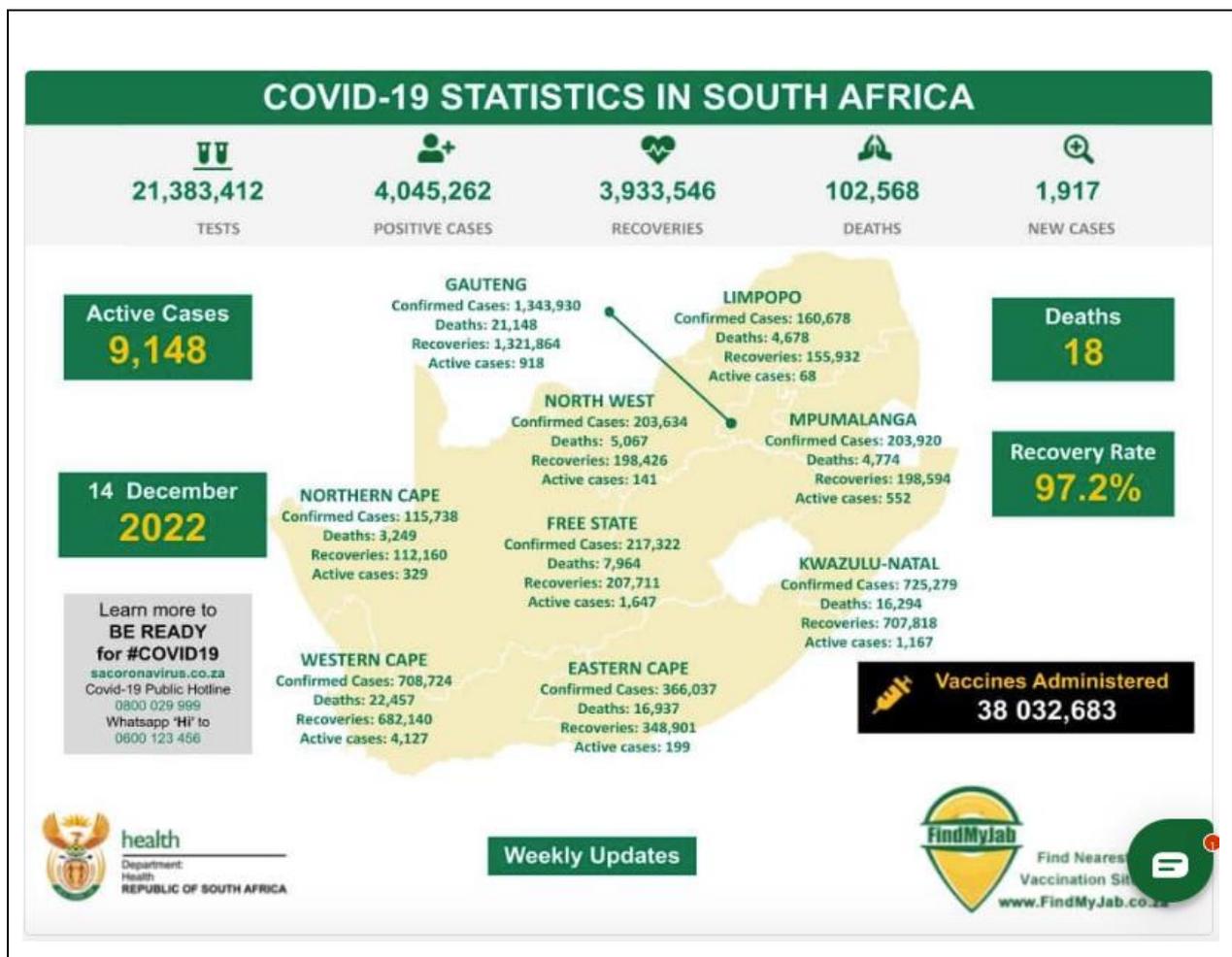
The SARS-CoV-2 virus spreads mainly between and among people through close contact between people. An infected person spreads the virus through their mouth or nose in tiny liquid droplets or "aerosols" through coughing, sneezing, heavy breathing, singing and talking, resulting in the inhalation or inoculation of the virus through the mouth, nose or eyes (World Health Organisation [WHO], 2020).

The virus has since then spread to all countries of the globe, and as of 9 August 2021, according to the World Health Organisation (COVID-19) Dashboard (WHO, 2021), there were about

202.296 million COVID-19 confirmed cases globally with about 4.288 million confirmed COVID-19 deaths. The latest global COVID-19 statistics as of 20 December 2022b, show that there were 649.753 million confirmed cases, and about 6.648 million deaths as per the World Health Organisation (COVID-19) Dashboard (WHO, 2022b).

South Africa, has not been spared by the COVID-19 pandemic. The first positive test case in the Republic of South Africa was confirmed and announced on 2020 March 5 (Mkhize, 2020). Since then, there have been 4.045 million confirmed COVID-19 cases with over 102,568 COVID-19 confirmed deaths (Department of Health, Republic of South Africa, 2022). The chart below presents and bears the most recent COVID-19 statistics in South Africa as of 15 December 2022.

Figure 1. COVID-19 Statistics in South Africa



Source: DoH RSA Update on COVID-19 (Sunday 15 December 2022)

2.2.1 COVID-19 health protocols – social distancing, masking, sanitising and PPE

One of the core mechanisms of containing the spread of disease, particularly one such as COVID-19, for which there was neither a vaccine nor treatment, was to reduce transmission of the disease through social distancing. The transmission of COVID-19 from person to person, is mainly through aerosolised respiratory droplets or particles therefore people are encouraged to physically distance, or "socially distance," themselves from one another is one of the main ways to reduce disease transmission. States have enacted several measures to encourage social distancing, including emergency declarations, school closures, non-essential business closures, mandating that people stay home, and mandating the use of face masks in public (Andersen, 2020; Gupta *et al.*, 2020; Raifman *et al.*, 2020).

In order to reduce the spread of COVID-19, governments have designed and implemented several social and physical distancing mandates (Gupta *et al.*, 2020). They implemented the social distancing policy mandates because it was theorised that it could effectively reduce the rate of transmission of COVID-19 a highly contagious disease (McCafferty & Ashley, 2021). Public health authorities recommended a distance of 2 m to be safe between people in public and further recommended other social distancing measures such as curfews and lockdowns meant to separate people (Abel & McQueen, 2020).

The other health measure per the WHO advice (WHO, 2020c) meant to minimise the spread of COVID-19, a respiratory viral disease, was the wearing of medical masks. Governments around the world issued mandates for masking in public. South Africa, through the Ministry of Health, made a recommendation to the public that, to help prevent the transmission of COVID-19, they were to put on masks when going out in public (Department of Health [DoH], 2020).

Studies by researchers, scientists and technologists have been undertaken on the efficacy of masking to minimise the spread of COVID-19. One such study by the National Institutes of Health showed that without a mask, saliva droplets spread the virus in the air (Anfinrud *et al.*, 2020; Rab *et al.*, 2020). This and other studies have demonstrated that without wearing a public mask, people can spread infectious COVID-19 without knowing that they are sick (Rab *et al.*, 2020), before, wearing public masks is important in minimising the transmission of COVID-19.

Precisely because the coronavirus, like other airborne viruses transmitted from one person to another, do so through ordinary breathing and speech that produce large aerosols that are potentially infectious, the use of masks limits the spread of viruses from one person to another (Duguid 1946; Papineni and Rosenthal 1997; Asadi *et al.* 2020). Apart from breathing and speech, other ordinary human exhalation flows of coughing and sneezing create a two-phase floating jet of droplets into the air through the nose and mouth (Tang *et al.* 2013; Mittal *et al.* 2020).

The combination of physical distancing enhances the effectiveness of masks in minimising the virus from spreading (Burger *et al.*, 2022; Eikenberry *et al.*, 2020; Li *et al.*, 2020). The mandated requirement of wearing masks in public social settings and its being visually observable make for high adherence potential and effectiveness in limiting the spread of the coronavirus.

It has been established that there are three routes through which COVID-19 is spread from one person to another: directly through contact with a person who is infected, indirectly by touch or contact with a contaminated surface and airborne by inhaling aerosols through close proximity to an infected person. The prevention or limiting of the spread of COVID-19 using a sanitisation mechanism to counter the three forms of infection, as illustrated below, require individual sanitisation (washing with soap or using hand alcohol-based sanitisers), surface treatment (sanitising surfaces like tables, chairs and floors), and ambience treatment (spraying in the air of a space like an office) (Khan & Yadav, 2020).

Sanitisation is another measure in the mix put in place to help limit the transmission of COVID-19 employed by governments in the world. The sanitisation of individual people, objects and spaces is meant to inhibit the life of viruses and break their spread. The sanitisation mechanism uses agents like alcohol and soap. "The overall sanitising action is to weaken the virus by depleting the lipid membrane using a disinfectant and remove it from the surface" (Khan & Yadav, 2020).

The Government of the Republic of South Africa, through the COVID-19 Environmental Health Guidelines under guideline 3.4.1 hand hygiene promotion, "encourages washing hands with soap and running water and the use of alcohol-based hand sanitisers" (DoH RSA, 2020, p.4). Workplaces (businesses, shopping malls and public spaces) under guideline 3.4.3 were mandated to provide hand rub sanitiser dispensers in prominent places to ensure that they are regularly

refilled; and to ensure that members of staff, contractors and customers have access to places with water and soap for washing (DoH RSA, 2020).

Healthcare workers fall in the category of essential workers with no exemption from working from home using online and other remote platforms during the time when COVID-19 infections were at their peak. Unlike other essential workers, theirs was a unique mission as they were required to be at the very front of the fight against COVID-19. This also meant that they faced extraordinary susceptibility to COVID-19 infection exposure and therefore needed extraordinary all-around protective measures to keep themselves, the patients and all those they would be in contact with safe.

As healthcare workers are an indispensable resource in the fight against the COVID-19 pandemic, their protection is of paramount importance, without which functioning healthcare systems would be at stake (Park, 2020). Personal protective equipment (PPE) is considered to be the last line of defence and a critical element of protection for HCWs during the COVID-19 pandemic. PPE includes gowns, face shields/goggles, gloves, surgical masks, respirators and aprons meant to reduce the risk for healthcare workers from getting infected or transmitting COVID-19 (WHO, 2020e). PPEs prevent contamination by protecting healthcare workers from contamination of COVID-19 on hands, eyes, shoes, clothes and hair (Park, 2020). HCWs gain confidence and feel prepared when provided with PPEs as well as guidance and training (Hoernke *et al.*, 2021; Houghton *et al.*, 2020).

2.3.1 The TB and HIV epidemics

The COVID-19 epidemic is not the only one that the world and South Africa are grappling with. Tuberculosis (TB) and the human immunodeficiency virus (HIV) are the two other epidemics with which the world and South Africa are still contending. According to the World Health Organisation (2020), TB is a major cause of ill-health, is among the top 10 leading worldwide cause of death, and ranks above HIV/AIDS as the lead cause of death from a single infectious agent. In 2019, as per World Health Organisation (WHO, 2020) statistics, there were about 360,000 active cases of TB, with a total death of about 58,000 people and, of these about 36,000 were HIV positive. These numbers bear testimony to the danger that the TB epidemic has on the

health and life of many in South Africa even as much focus has been turned towards the COVID-19 emergence.

There is a major concern about the impact of the COVID-19 pandemic on critical health services as previous experiences of humanitarian emergencies resulting from war or outbreaks of epidemics like Ebola, wiped away in a short period the significant health gains achieved in the past two decades (Delamou *et al.*, 2017; Kieny *et al.*, 2014; WHO, 2020f). This can be caused by the collapse of essential health services, demand and supply factors, the fear of catching COVID-19 making people stay away from health services, disruption in the supply of medicines, shifting of resources towards fighting the COVID-19 epidemic, and lockdowns leaving people without incomes to afford transport to health facilities (WHO, 2020f).

One of the essential health services that the COVID-19 pandemic has negatively impacted is TB health services, diagnosis, care and prevention, as they were severely disrupted due to the COVID-19 epidemic (Khan, *et al.*, 2021; McQuaid, *et al.*, 2021). According to McQuaid, *et al.* (2021, p. 439), "TB service providers across many high TB burden contexts have faced difficulties in service provision, due to lack of appropriate equipment and capacity, restrictions to movement and reallocation of resources." The impact of COVID-19 on TB health services of diagnosis, care and treatment is a global problem which is not consigned to a particular region or country (McQuaid, *et al.*, 2021).

South Africa has particularly been adversely affected by the TB and HIV epidemics. South Africa is one of the countries in the world with the highest number of people living with HIV (PLHIV) and with TB incidence. There are about "7.4 million (12.9% HIV prevalence) of People Living with HIV (PLHIV) - an estimated 90.5% of people have been tested and know their HIV status, of which 68% of those that know their HIV status are on ART and 88% of those on ART are virally suppressed" (South African National AIDS Council [SANAC] 2020, p. 9).

South Africa is the epicentre of HIV/TB that is resistant to drugs that in some cases spread in healthcare facilities. This puts the lives of healthcare workers playing a critical role in South Africa's public health providing care for people living with HIV/AIDS at risk as they work in settings with high HIV prevalence, challenging working environments and low staffing ratios. Drug-resistant TB, therefore, presents healthcare workers in South Africa as a serious

occupational health hazard (Gandhi *et al.*, 2006; Wells *et al.*, 2007; World Health Organization, 2011; Zelnick *et al.*, 2013).

2.4.1 Inter-professional collaboration (IPC) based healthcare

Inter-professional collaboration-based healthcare practice, according to the World Health Organisation (2010) "happens when multiple health workers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality of care across settings." The purpose of inter-professional collaboration-based healthcare practice in health facilities such as hospitals is for the quality and efficient care of patients.

New endeavours by healthcare systems are being centred on collaboration and interdisciplinary teams for a range of development and incorporation of care services (Dunevitz, 1997; Proenca, 2000). Healthcare systems in countries such as Canada, the United States of America, New Zealand and even here in South Africa have progressively been using the inter-professional based approach in the delivery of quality healthcare (Fouche *et al.*, 2013; Döbl *et al.*, 2015; Hawk *et al.*, 2015; Stanhope *et al.*, 2015; Ashcroft, 2018). In line with the inter-profession-based health care practice, social workers and nurses from two different professions serve side by side with each other and other health professionals in providing patients with health care services needed for effective and efficient treatment.

Different professionals working together as guided by the PCC model for quality care to patients face challenges that make interprofessional collaborative care difficult. While nothing can be taken away from the value of inter-professional collaboration-based healthcare in the delivery of high-quality care for patients across healthcare settings, it nonetheless presents challenges between HCWs across professions. In practice setting the lack of interprofessional communication skills by different professionals contributes towards many challenges that confront interpersonal collaboration between HCWs (Lindqvist, 2015). Some of the challenges include confusion in the understanding of roles and responsibilities, rank dynamics, respect and trust of abilities towards other professions, common language and interpretation of confidentiality, and dealing with conflicts and emotional stress arising thereof (Lindqvist, 2015).

2.4.2 Public Health Social Workers

Public health social workers in hospitals have not always been valued and considered vital in providing quality healthcare to patients. As a consequence, there has been an ongoing debate about the value and necessity of social work services in hospitals, often without supporting evidence, with some viewing social work services in hospitals as vital for social services assessments and speedy discharge plans for patients (Globerman *et al.*, 2002; Mizrahi & Berger, 2001; Auerbach *et al.*, 2007). Among those who do not view social work service as being vital in hospitals are some hospital administrators who hold the view that social workers are dispensable, especially under the need for the cost-cutting drive necessitated by the scarcity of resources in hospitals (Barth, 2003; Globerman *et al.*, 2002; Auerbach *et al.*, 2007).

Social workers have, however increasingly become vital assets to inter-professional or interdisciplinary teams with the change implemented in most healthcare settings from the traditional care model to the modern patient-centred care models (Zimmerman & Dabelko, 2007; Limon, 2018). Medical social workers are undoubtedly considered valuable by doctors and nurses in providing quality health care to patients in hospitals. Some studies have confirmed this, one of which was conducted by Keefe, Geron, and Enguidanos (2009), which found that medical social workers' involvement was considered by clinicians and nurses; and that they are seen as nurse "extenders" as they fill important gaps critical for better care for patients.

Social workers in South Africa working in health care facilities had to contend with segregation in service provision prior to 1990 (Petersen and Pretorius, 2022). The political developments which ended apartheid in 1990 enabled the transformation of social work as a specialist field that included health promotion and psychosocial strategies to help patients (Carbonatto, 2019; SACSSP, 2008; Petersen and Pretorius, 2022). In South Africa, social work in the health care industry before 1990 was considered a case of charity and voluntary work (Petersen and Pretorius, 2022).

The social development approach (SDA) in South Africa has been utilised by social workers who care for patients in health facilities. The SDA primarily uses principles of social justice, advocacy, empowerment, liaison with stakeholders and referral to communities (Petersen and Pretorius, 2022). While the SDA is in line with the PCC model and critical to the provision of quality care to patients in health facilities, it has brought with it some challenges to social workers

some of which include the removal of designated powers, failure in healthcare to consult social workers on matters affecting them and unanswered DSD referrals for long periods of time (Petersen and Pretorius, 2022). Such challenges, if not addressed would render the delivery of quality care to patients difficult to achieve as it requires and demands good inter-profession collaboration to succeed. The failure to fully give full respect and recognition to the social workers in healthcare settings as role players as declared by the WHO (2014), who are essential and not just playing a secondary role that is not important in the delivery of optimal and holistic care to patients as part of the multi-disciplinary team (MDT) (Petersen and Pretorius, 2022).

The social work profession also does not get as much respect as it should and deserve. In part, this is because it is considered a feminine profession as women constitute the biggest majority of social work professionals (Dahle, 2012). Despite the basic right of not being discriminated against in the workplace and in the workforce, the reality however is that discrimination on the basis of gender continues to be a problem even in developed countries (Curdová, 2005). “Historically, women have been barred from men’s privileged world, and the work they do is not recognized as professional, and thus devalued” (Dahle, 2012, p. 312). It is no surprise therefore that social workers working in hospitals as part of the MDT also suffer the same fate women face in workplaces, not because of the inferiority of their service and profession but because of the perception that they belong to a feminine profession.

The gaps that hospital social workers fill, if not attended could compromise the quality and effectiveness of the treatment, care, and support patients in healthcare facilities receive. Patients in hospitals are not the only ones who are beneficiaries of the work rendered by hospital social workers (Australian Association of Social Workers [AASW], 2020). Hospital social work professionals also provide services to patients' families as they face a whole range of different challenges as they accompany their loved ones. Through their targeted interventions, hospital social workers mobilise services and support for patients in their social environment and relationship contexts that consider the effects of familial, social, psychological, cultural and economic factors on health and wellbeing (AASW, 2020). They provide families and patients with counselling that helps them understand and deal with emotions associated with diagnosis, health conditions experienced, and decisions that need to be made (Whitaker, 2006; Limon, 2018).

In South Africa, social workers provide essential services in health care to the vulnerable population using SDA in order to address inequalities and uplift them so as to enable them to meet their needs (Petersen & Pretorius, 2022). In the same spirit, they also provide support, advocacy and management of cases for patients as part of the multi-disciplinary team (MDT) to uplift and enable patients weighed down by stress and sickness.

Public health social workers give supportive counselling to patients and their families and address social determinants of health (SDH) to enable and enhance patients' compliance with treatment (Moniz, 2010; Bywaters & Ungar, 2013; Renata, 2019; Petersen & Pretorius, 2022). In public healthcare provision, social workers are employed by the Department of Health (DoH) in health facilities, including those specialising in TB services to offer psychosocial assessments to patients. Medical staff refer patients to hospital social workers if non-adherence to treatment has been determined to be a factor in patient care caused by social factors (Zelnick *et al.*, 2018).

Social workers in hospitals also play the role of advocates. They act as advocates for patients ensuring that wishes and rights are known and respected by treatment teams and families. They ensure that treatment and accurate information about their care and treatment are provided to patients (Renata, 2019).

Another service social workers provide in healthcare facilities is case management and coordinating care for patients (Renata, 2019). They connect patients to social services they need such as shelter, food and financial support. They are involved in planning and coordinating the discharge of patients and their care at home, appointment follow-ups and treatment adherence (Renata, 2019).

2.4.3 Impact of COVID-19 on social work

In exploring the impact of COVID-19 on social work, it is equally relevant to give a brief impact of similar pandemics like SARS had on social work(ers). Available literature shows that social workers, expressed conflict between on one hand of living up to their professional duties and responsibilities; and on the other hand personal responsibilities of self preservation and of their families (Gearing, Saini, & McNeill, 2007; Mauder et al., 2003). Working under strict infection control measures, they experienced “fatigue, insomnia, irritability, decreased appetite, anxiety,

anger, frustration, fear, isolation, uncertainty, and stigma” (Gearing, Saini, & McNeill, 2007, p.19).

Social workers had to come up with coping measures among which was sharing of experiences to deal with the fear, stress and anxieties that gripped them (Gearing et al., 2007). Communication barrier due to the high transmissibility of SARS, disrupted physical interaction making social workers resort to interacting with patients and their families using telephones.

Emphasis during outbreak of pandemics is placed understandably placed on medical side. Just as important as attending to the medical emergence faced by the patients, the social needs of patients are brought into focus through the advocacy of social workers that bridges the medical and social needs of patients and their families. They also acted as a bridge between professions to help them understand that they each have an important complementarity role in the treatment and care of patients and their families (Gearing et al., 2007).

The COVID-19 pandemic has had a negative impact on the social work profession by deepening economic and social conditions on vulnerable populations requiring more social work interventions due to the loss of jobs and economic opportunities that have worsened poverty (Banks *et al.*, 2020; Schotte & Zizzamia, 2021). The COVID-19 emergence has deepened the social-economic conditions and vulnerability of people and communities making them more reliant on government support and care whose resources were stretched (Schotte, & Zizzamia, 2021).

The creation and maintenance of honest, trusting and empathetic relationships between social workers and their clients were challenging as the lack of physical interaction due to physical distancing and isolation was replaced by telephonic and internet platforms that could not guarantee privacy and confidentiality (Banks *et al.*, 2020). Even in cases where face-to-face meetings took place, the use of PPEs hindered communication with clients as they could not pick up non-verbal cues and could not show empathy with caring and reassuring gestures (Banks *et al.*, 2020).

The COVID-19 epidemic, like other epidemics such as TB and HIV/AIDS, is more than just a health issue. It has impacted people as individuals, families, communities and countries the world

over in different ways, making COVID-19 an economic, social, political, legal and religious issue as much as a health issue (Yoosefi Lebni *et al.*, 2021). It has worsened the prevailing social, economic and health conditions of people including that of patients.

2.4.4 Nurses

Nursing was historically understood to be a calling and vocation, but it has changed in modern and secular times to be known as a profession and, more recently, as a practice (Robb, 1900; Nelson, 2000). Each of these conceptualisations has been shaped by the historical and social factors leading to how nursing was understood in the past and how it is understood in the present (Liaschenko & Peter, 2004). The restoration and promotion of health, alleviation of illness and protection of patients are the main universal aims of the nursing profession to which their experience, skill and knowledge are expected to be applied (Liaschenko & Peter, 2004).

Nurses are the 'heartbeat' of the healthcare industry due to the vital role they play in the healthcare system which involves the promotion, prevention, restoration and maintenance of the health of individuals (Singh & Mathuray, 2018). The roles and functions played by nurses have changed as they increasingly are doing what previously was in the domain of physicians. "The nurse's responsibility has been increased to encompass the actual examination, diagnosis and treatment without direct supervision of a physician" (Singh & Mathuray, 2018).

In South Africa, nurses play an important role in health promotion and the provision of essential healthcare services. They constitute the largest single group among the healthcare providers in health facilities (DOH, 2013; Rispel, 2015). In the Republic of South Africa, there are three categories of nurses namely: professional nurses also called registered nurses who undergo a 4 years training program; enrolled nurses who go through a 2 years training program; and nursing assistants also called auxiliary nurses (Rispel, 2015)

South Africa as a country faces a 'nursing crisis' characterised by shortages (Rispel, 2015). Since 2010, the country has faced a shortage of about 44,700 nursing staff and has experienced about a 40% contraction in the supply of different categories of qualified nursing staff since 2013 with approximately 8 535 fewer nurses joining the workforce according to Welthagen cited in Brits (2019). Poor working conditions and positions not filled, an ageing workforce, inadequate

training and student output are some of the causes of shortages in nursing staff in South Africa (Brits, 2019).

Nurses working in South Africa's public health facilities experience excessive workloads, poor remuneration and staff shortages (Manyina & Van Aswegen 2017). The shortage of nurses undermines the country's ability to improve health outcomes and the health systems' performance. In South Africa, this has been made worse by a quadruple high burden disease in the country (WHO, 2018).

South Africa also has a shortage of doctors which is caused by among others, emigration of doctors to other countries due to push factors such as poor working conditions, inadequate supply of medicine and equipment, the risk of occupational exposure, crime and violence, and low salaries; restriction on the employment of foreign doctors; and limited training capacity (ECONEX, 2015). The shortage of doctors in South Africa has led to moving the country in 2010 to nurse-initiated antiretroviral treatment at Primary Healthcare (PH) facilities (Health Systems Trust, 2012; Singh & van Rensburg, 2017). The increase in the disease burden of HIV and TB in South Africa, the shortage of doctors and nurses resulting from their relocation to the private sector and abroad affect the success of nurse-initiated antiretroviral treatment at PH facilities have led to task shifting, making nurses have prominent roles in the treatment and management of DR-TB (Singh & van Rensburg, 2017).

This study will contribute towards narrowing the gap in the body of knowledge pertaining to the impact of COVID-19 on healthcare workers (social workers and nurses) in a centralised TB hospital. This knowledge will be of critical importance in the care and support of HIV and TB patients amid the COVID-19 pandemic. Understanding the experiences of public health social workers and nurses can lead to creating working conditions or interventions for them that would enable them to better care for and support HIV/TB patients during the COVID-19 pandemic.

2.4.4 Experiences of HCWs during epidemics

2.4.4.1 HCWs incurred the highest number of infections and deaths

The COVID-19 pandemic, unlike any other epidemic, placed demands on HCWs that are difficult to comprehend in its entirety. Evidence from studies conducted on experiences of HCWs

at the forefront of large-scale disease epidemics like EBOLA, MERS, SARS and COVID-19 show that HCWs bear the highest burden of fatalities compared to other populations of their countries. In the most recent outbreak of Ebola, for instance, in West Africa, between 2014 and 2016, by May 2015, about 1.45% of the population of doctors, nurses and midwives in Guinea had died compared to 0.02% of the national population. In Liberia, 0.11% of the national population compared to 8.07% of the population of HCWs died. In Sierra Leone, 0.06% of the national population compared with 6.85% of HCWs died (Evans, Goldstein, & Popova, 2015). In all these countries, the trends in terms of Ebola fatalities born by HCWs are consistently higher than that of ordinary national populations.

The same trends were observed with the outbreak of the Middle East Respiratory Syndrome (MERS) caused by the MERS-CoV virus and the Severe Acute Respiratory Syndrome (SARS) caused by the SARS-CoV virus. There was a disproportionately high percentage of HCWs infected by MERS and SARS compared to the rest of the national populations. The following two tables below show in stack terms just how overwhelmingly high the MERS and SARS infections among HCWs were compared to the rest of the national populations in different countries respectively:

Table 1: MERS infection status among HCWs in Saudi Arabia and South Korea

Country	Number of total cases	Number of HCW affected	Percent
Saudi Arabia	2121	405	19.1%
South Korea	186	25	13.44%
Global Total	2519	450 ^a	17.86% ^a

Source: Xiao et al., 2020.

Table 2: SARS Infection status among HCWs in different countries

Country	Number of total cases	Number of HCW affected	Percent
China	7429	1456	19.60
Canada	251	109	43.43
France	7	2	28.57
Germany	9	1	11.11
Philippines	14	4	28.57
Singapore	238	97	40.76
Thailand	9	1	11.11
Vietnam	63	36	57.14
Total	8020	1706	21.27

Source: Xiao et al., 2020

2.4.4.2 Psychological distress

Healthcare workers at the forefront of battling these deadly epidemics according to various studies done show that they suffered from common psychiatric disorders, depression and anxiety diagnosed as post-trauma stress syndrome (PTSS) and post-traumatic syndrome disorder (PTSD) (Cabarkapa *et al.*, 2020). These psychological problems they suffered from come from real-life experiences of their workplaces that expose them to life-threatening diseases they are called upon by their profession to fight. The experience of incurring the highest number of infections and deaths among their workmates associated with occupational health hazards instils a sense of fear as such an environment with the perceived and experienced threat goes against the basic human instincts of self-preservation, self-protection and survival (Khantzian, & Mack, 1983).

The fact that they have no choice, going by the obligations of their job, they suffer from psychological distress due to the anxiety, stress and fear of having to work in these workplaces that present a threat to their life. The reasons why HCWs around the world that were dealing with Ebola, MERS, and SARS experienced high levels of occupational stress associated with anxiety was, according to Ji *et al.*, (2017, p.), because they, “had to cope with the deaths of colleagues, threats to their lives, and working excessive hours in addition to their anxiety and fear of contamination, the breakdown of social support systems also increased psychological distress among them. A study by Lee *et al.* (2022) among HCWs during COVID-19 also obtained similar experiences of psychological distress due to occupational health-related stress, fear and anxiety.

There are common causes of psychiatric disorders among HCWs during the Ebola, MERS, SARS and COVID-19 epidemics. One of them is the fear of getting infected. Several studies suggest that the fear of being infected presenting a grave threat to the HCWs' mortality was of particular concern leading to psychological distress among them when working in workplace environments dealing with the stated epidemics Cabarkapa *et al.*, 2020; Hu *et al.*, 2020; Ji *et al.*, 2017; Maunder *et al.*, 2004; Tam *et al.*, 2004). The second reason upon which this fear is premised is the vulnerability of their family members and colleagues being hospitalized or being quarantined (Cabarkapa *et al.*, 2020; Rossi *et al.*, 2020).

2.4.4.3 Quarantine and isolation

Quarantine and isolation were some of the strategies introduced to minimize and prevent the spread of contagious diseases so as to protect the public from infection, sickness and death. These strategies imposed restrictions and limitations on personal contacts and the movement of the public (Low, & Knobler, 2004). Studies suggest that, the strategies of quarantine and isolation that are used for people who have been or are suspected to have been exposed to COVID-19 and are considered contagious respectively result in increased negative psychological problems such as anxiety and depression caused by isolation (Hossain, Sultana, & Purohit, 2020; Henssler, *et al.*, 2021). “Findings suggest that both containment strategies, quarantine and isolation, have negative impacts on psychological outcomes related to a broad spectrum of psychosocial stressors” (Henssler, *et al.*, 2021, p. 224).

Healthcare workers if and when infected with COVID-19 were also subjected to the same rules of quarantine or isolation. This public healthcare policy of 10 days isolation and contact trace posed a real threat to the care of patients in wards owing to the high number of HCWs, almost 20% of the entire South African healthcare workforce due to the Omikron variant (Bateman, 2021). At a personal level, HCWs experienced psychological distress due to isolation triggered by the public healthcare policy of isolation for those infected (Wu, Styra, & Gold, 2020).

2.4.4.4 Stigma and discrimination

The other experience HCWs have gone through during the outbreak of the epidemics is that of being stigmatized and discriminated against. Healthcare workers who work hard risking their lives at the forefront against the COVID-19 pandemic to save the lives of patients have found themselves to be victims of stigma and discrimination by society. HCWs were being avoided and in some instances ill-treated by their own family members, friends, neighbours, taxi drivers and landlords (Bhanot *et al.*, 2021). As a result of being shunned and not welcome by fearful family members and landlords, some HCWs ended up using their staff rooms and washrooms at the hospitals for sleeping (Ellis-Petersen, & Rahman, 2020; Bhanot *et al.*, 2021). They have been victims of harassment, abusive and vulgar comments, and attacks, and have been accused of spreading the virus and have in some cases been denied use of public transport by taxi drivers refusing to serve them (Ellis-Petersen, & Rahman, 2020; Bhanot *et al.*, 2021). This created a paradox and dilemma on one hand of the community’s need for HCWs in their struggle against

COVID-19 and on the other hand the community's fear of HCWs as spreaders of the COVID-19 disease.

As a consequence of the stigma and discrimination experienced at the hands of society, HCWs developed psychological problems such as stress and anxiety. They were anxious about the possibility of being infected knowing only too well how they would be perceived and treated by society, given that they experienced stigma and discrimination for the mere fact of being health workers. They were considered to be the source of the spread and infection thereby warranting isolation from friends, family and community members (Khee *et al.*, 2004). As a result of the isolation coming from the discrimination and stigmatisation experienced by HCWs, they have arguably developed long-term psychological distress that affects their well-being (Liu *et al.*, 2012; Robertson *et al.*, 2004).

2.5 Gaps in the literature

There is good published literature on TB/HIV and COVID-19 epidemics, and social workers and nurses serving in health facilities take care of patients. This particular study focuses on the experiences of social workers and nurses in a facility caring for and treating TB/HIV and COVID-19 patients. There is little to no known study on social workers and nurses providing care in a facility dealing with Trinitarian epidemics (TB, HIV and COVID-19).

2.6 Conclusion

This literature review chapter two has presented published literature on four constitutive sections of this study. Literature on the COVID-19 pandemic and the four prevention measures: social distancing, masking, sanitising and donning PPEs for healthcare workers. The second section of the literature is on the TB and HIV epidemics. The third section is on inter-profession healthcare workers: public health social workers. The fourth section is on the second part of the inter-profession healthcare workers: nurses. This chapter closes with a small section on the gap in the literature and a conclusion. The next chapter will cover the methodology that guided this research.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This section of the report is the methodology chapter. It lays out the scientific research methodology that guided this research. It presents the methodological approach, sampling, ethical considerations, data collection and analysis methods and procedures.

3.2 Methodological approach

The methodological research approach utilised by this study is the interpretivist/constructivist, which holds that reality is subjective, socially constructed, and a combination of multiple perspectives (Mackenzie & Knipe, 2006; Mertens, 2005). The interpretivist/constructivist paradigm originated in Edmund Husserl's phenomenology philosophy and the study of interpretive understanding called hermeneutics by Wilhelm Dilthey and other German philosophers (Eichelberger, 1989; Mackenzie & Knipe, 2006; Mertens, 2005). At its core, according to Cohen & Manion (1994, p.36), the understanding of the "world of human experience" is the interpretivist/constructivist's approach to research, relying on participants' views on the matter being investigated with due recognition to their background and experience (Creswell, 2003; Mackenzie & Knipe, 2006).

This study utilised the interpretivist-constructivist methodological approach as it found it to be more suitable, given that it is an open-ended exploration of experiences of participants which is inductive. It relies on individual experiences to draw general conclusions on a subject under study.

3.2.1 Study design

I conducted a qualitative study because it is designed to appreciate how individuals and communities make meaning of matters of concern to them and to understand their experiences. A qualitative design is appropriate for this study because it provides in-depth insights and conceptual comprehension of the data collected (Ulin *et al.*, 2002). It is an exploratory-descriptive design since it focuses on: a) social workers supporting TB/HIV patients and b) offering services during a COVID-19 pandemic.

Some of the benefits or advantages of using a qualitative study are that they produce a thick detailed description of the opinions, feelings and experiences of participants (Denzin, 1989). Therefore, the voice/s of the participants on a given topic or phenomenon under study are not lost and are abundantly tapped.

3.2.2 Participants

Data were collected from health care workers comprising seven public health social workers and eight nurses working at the King Dinuzulu Hospital (KDH) in the province of KwaZulu-Natal in South Africa. The proposed number of participants was sixteen (eight nurses and eight social workers), which is sufficient for a qualitative study as it seeks depth over numbers. According to Crouch and McKenzie (2006), participants fewer than 20 in a qualitative study are sufficient in providing better data as it allows for more natural conversations.

3.2.3 Sampling of participants

Sampling, according to Terre Blanche, Durrheim & Painter (2006, p.49) is “a process of selecting research participants from the whole population which involves a decision about people, settings, events, behaviours and social processes to observe” A population made up of and possesses the most distinctive characteristics and features a researcher is interested in is called a sample (De Vos *et al.*, 2005). In this study, the sample comprised 15 healthcare workers (eight nurses and seven social workers), all working at King Dinuzulu Hospital in Durban before the outbreak of the COVID-19 pandemic and during the COVID-19 pandemic, providing treatment, care and support services to TB/HIV patients.

This study used purposive sampling methods which allow the researcher to select participants with insights into the research questions. These participants were individuals with specific behaviours or characteristics sought by the researcher (Devers & Frankel, 2000). Participants who have experience working in a facility providing treatment and care for HIV/TB patients and have been working at King Dinuzulu Hospital for at least a year before the outbreak of the COVID-19 pandemic. The other criteria upon which they were selected was their provision of social work and nursing services to people living with HIV and TB.

The researcher approached the hospital manager for King Dinuzulu Hospital to help identify suitable study participants. The hospital manager contacted the heads of social workers and nurses to assist with inviting suitable participants for the study. I approached them individually and invited them to the study. For social workers who opted for physical interviews, their offices were used as venues, while others opted for telephonic interviews due to challenges caused by the severe floods in Durban during the data collection phase of my research and others due to COVID-19-related restrictions. The boardroom for nurses was used as the venue for the individual one-on-one interviews conducted with nurses that participated in the study.

The criteria for choosing public health social workers were first because this study is located within the discipline of social work at UKZN. Secondly, social workers provide psychosocial support and care to HIV/TB patients at the target, specialized TB health facility and designated COVID-19 facility, enabling them to provide relevant knowledge for the study. The nurses were selected on account of their provision of nursing services in this facility serving TB and HIV patients thereby providing relevant information for the study.

3.2.4 Data collection method and instruments

This research utilised semi-structured one-on-one in-depth interviews for the collection of data from participants, allowing them to express their opinions (Marshall & Rossman, 2006). Interviews are a two-way conversation between the interviewer and the interviewee in which the participant is asked questions by the researcher pertaining to the experiences and perceptions around the research problem (Mouton, 2001; Kumar, 2005). The interviews were conducted in English as participants were comfortable with this language. However, some participants occasionally mixed English and isiZulu when answering questions that were being asked.

I used an interview guide (Annexure IV) with open-ended questions that kept the interactions focused and allowed for probing (Britten, 1995). In-depth interviews create trust, and I was able to make the respondents comfortable enough to share openly and give insightful responses, which allowed for probes and follow-up questions. The interviews also provided access to the deeper insight gained from the observance of body language, changes in tone and word choice (Ritchie & Lewis, 2003; Zohrabi, 2013). However, the disadvantage was that this is a relatively

costly process, which can generate irrelevant data and is time-consuming (Zohrabi, 2013). Once-off contact also meant that some participants could not share fully.

3.2.5 Data collection procedure

On each pre-arranged day of the interview, I proceeded to the agreed venue at King Dinuzulu Hospital. In keeping with the COVID-19 health protocols for infection control, the participant was provided with sanitiser upon entry into the interview venue and thereafter was shown the chair. I then greeted and welcomed the participant to the interview. As these were individual one-on-one in-depth interviews, before starting the interview with a participant, the aim of the study, expectations and the length of the interview was explained, including the nature of the study and its purpose. Thereafter, the rights of a participant were explained, followed by the signing of the informed consent form after all clarifying questions had been answered. The participant's permission to record the interview with a digital recorder was sought before commencing the interviews. I thanked each participant for participating in the study at the end of each interview.

Telephonic interviews were conducted under conditions that ensured confidentiality. They were conducted from my apartment where I was alone and kept locked to avoid any type of intrusion and disturbance for the entire duration of the interviews to ensure privacy and confidentiality. The telephonic interviews tended to last slightly longer compared to physical ones due to internet issues such as lag and audibility. The actual interviews almost always never started on time as participants had to create room away from demands placed on them at work or from home. The WhatsApp platform for the interviews which were audio digital recorded with their permission. All the interviews, physical one-on-one and the telephonic ones lasted an average of 30 minutes.

3.2.6 COVID-19 health protocol considerations

This study was done in two months during the COVID-19 emergence, from April to May 2022. The data collection procedures had to consider regulations put in place by the government aimed at mitigating COVID-19 transmission and infection. Therefore, the researcher had to fully comply with the prescribed COVID-19 health protocols during the data collection period. In keeping with the COVID-19 health protocols, this study involved one-on-one individual interviews with all 15 participants. Five of the interviews were telephonic, while the majority

(10) were face-to-face. In conducting physical interviews, strict observance of sanitising, social distancing, masking, using well-ventilated venues and short interview periods of less than an hour were maintained to adhere to COVID-19 health protocols designed to minimize and prevent the spread of Coronavirus-2.

3.2.7 Ethical considerations

According to Babbie and Mouton (2001), when undertaking social scientific research, it is necessary to be aware of the general agreements among researchers about what is allowed in the conduct of the scientific enquiry and what is not. Among the protocols that needed to be observed was obtaining permission in the form of gatekeepers' letters from authorities that manage the institutional settings where data were collected; and Research Ethics Committee (RECs) only issues full ethical approval upon receipt of written permission (gatekeeper's letters) by authorised signatories (Denny *et al.*, 2015; Singh & Wassenaar, 2016).

An application to the University of KwaZulu-Natal Humanities and Social Sciences Research Ethics Committee (HSSREC) for ethical clearance was made on 19 November 2021 and received full approval on 18 March 2022 (Annexure I). The study sought permission from the Department of Health of KwaZulu-Natal, under whose jurisdiction the King Dinuzulu Hospital falls, and full approval was granted on 7 May 2022 (Annexure II). Thereafter, the management of King Dinuzulu Hospital Complex was approached for permission to conduct research at their facility, which is the location of the study; and was granted on 25 February 2022 (Annexure III).

Some of the ethical considerations included ensuring voluntary participation and no harm to the participants (Neuman, 2014). Bulmer (2008) observed that social ties bind information in today's modern industrial society. The commodification of information entails that, "keeping control of information about oneself and deciding what to release and to whom is often key means by which one's privacy is protected, and control is maintained over what others can learn about you" (Bulmer, 2008, p.152).

Confidentiality by which personal information would not lead to the identification of study participants in the data was modified to ensure respect for the participants' privacy in the study (Allen, 2017). Participants' confidentiality was ensured by conducting interviews in safe and conducive spaces in a manner that safeguarded their privacy.

To assure the participants of respect for ethical considerations to be adhered to, they were asked to sign informed consent forms. This was discussed verbally with the participants, who were told that they could stop the interview at any time if they did not wish to continue, without any negative consequences (Annexure VI). I also asked for permission to use the digital voice recorder and explained the reasons for data collection and analysis, and participants were assured of their anonymity through the use of pseudo-names and not their actual names in the write-up. Participants were also informed and assured that only the researcher and the supervisor would have access to the raw data kept in password-protected encrypted computer files.

Participants were informed that their participation in the study was completely voluntary and that they had the right to stop or withdraw from the study if they so wished at any time during the interview. They were also informed of their right to not answer questions that they did not want to or felt uncomfortable with.

3.2.8 Data analysis method

The study utilised the thematic content analysis method to analyse the data that was collected. It is a method of suitable for the analysis of qualitative data, after close examination and identification of common themes, ideas and meanings that repeatedly come up from the transcribed data (Caulfield, 2019). The thematic content analysis approach involves identification, analysis, organisation, description, and the reporting of themes generated from the data (Braun & Clarke, 2006; Nowell *et al.*, 2017).

In preparation for analysing all the data that were collected from all the fifteen participants in the study, all the audio-recorded interviews in the digital voice recorder were transcribed verbatim. The transcribed data were analysed through familiarization, coding, generating themes, reviewing themes, defining and naming themes, and writing up (Caulfield, 2019).

I was familiarized with the data generated from the study through the transcription process that allowed me to play and replay the digital audio-recorded files of the interviews. Secondly, I read and reread the transcribed data in tandem with listening to the audio files to correct mistakes and, most importantly, to understand what the participants were saying.

Having familiarised myself with the transcribed data, I highlighted relevant phrases and developed "codes" that identify common ideas. Each code describes the experiences, ideas or feelings expressed in each transcript. I then collated all the data into groups identified by codes that give an overview of the main points common across the data from different transcripts.

In the third stage, I generated themes from the identified patterns from the codes. I combined some codes and turned them into broader themes. I placed the generated themes under the study objectives that served as broader themes. Then I conducted a review of themes. I reviewed the themes to ensure that they were both accurate and useful representations of the data. Themes were refined, some were split, some combined, some discarded and some data were moved to more suitable themes.

After a review of the themes, I moved to defining and naming themes in stage five. I came up with a final list of themes, named concisely and defined each, formulating them in a manner that offers a better, clear and more accurate understanding of data.

In writing up, I transformed my analysed data in the form of themes into interpretable writing and used rich and persuasive quotes related to the themes, research questions, and literature in the write-up. This write-up was done to show and convince the reader of the merit and validity of the analysis of the findings; and that the questions the research set out to explore have been adequately answered.

3.2.9 Data Quality Control

A qualitative study can generate credible, trustworthy, and valid data provided qualitative scientific methodology is followed (Sekaran, 1999). This study used data collected from two groups of participants working in the same hospital - social workers and nurses. Two copies of the draft of findings were submitted, the first copy to the social work department and the second to the nurses working in the TB section for review, and comments from those who participated in the study checking for credibility and authenticity sought the confirmation of the participants that their responses, thoughts and attitudes as reflected in the report were accurate. My supervisor provided another layer of scrutiny.

3.2.9.1 Rigour

The study's trustworthiness entails the extent to which the data is credible, believable and trustworthy (Bashir, Afzal, & Azeem, 2008). In a qualitative study, the study's trustworthiness is ensured through the research findings' conformability, dependability, credibility and transferability. To achieve this, the study identified and accurately described the study participants' characteristics and the process followed throughout the research (Lincoln & Guba, 1985).

3.2.9.2 Dependability

A study cannot be deemed trustworthy if it is not dependable. The dependability of a study refers to whether or not the study findings would be consistent if the same study was to be done by other researchers with different participants with the same characteristics in a different place but with similar context/ setting (Lincoln & Guba, 1985; Babbie & Mouton, 2007). To establish dependability, a review and examination of the research process and the findings for consistency must be undertaken (Lincoln & Guba, 1985).

To ensure the dependability of this research, the nature of the study was clearly outlined and so were its aim, and objectives, and described the characteristics of the study participants; the study site and the context. The study design, processes and procedures before, during and after data collection and analysis were clearly outlined, and the presentation and discussions of findings were consistent with the study methodology and design.

Credibility

Credibility in a qualitative study is described to be the extent to which the findings are a true and accurate reflection of the views of the people under study, are believable and are of value (Lincoln & Guba, 1985). The value of a qualitative study has to be based on the experiences as per the perception of informants and not of the researcher.

The credibility of this study was also ensured by clearly stating and following the study, sampling and data analysis methodology. The study interviews were recorded using a digital voice recording to capture the exact words expressing the participants' views which were then

transcribed word for word. The researcher played back the recording during transcription for clarity when what was said was not clear enough.

The study used thick direct quotes from the collected data to present the accurate voice, minds and views of the participants so that the researcher's analysis is based on the participants' views. Further, the findings from the study participants are not presented and discussed as standalone but are analysed and triangulated with other participants' views on the same questions. The study findings are also contrasted with findings or literature from similar studies to establish credibility.

3.2.9.3 Transferability

The extent to which the researcher can demonstrate that the findings from the study can be applied to similar contexts, populations and phenomena. Transferability, according to Rodon and Sesé, (2008) “depends on the researcher delineating the characteristics of the setting under which her results hold, as well as on the reader determining if that setting is similar to the one where she wants to apply those results.” Similarly, Lincoln and Guba (1985) argue that transferability refers to the degree to which the applicability of research results depends on the similarity of research settings the findings are drawn from and those to which they are being transferable. This study, in chapter four, shows the interaction between findings from this study and other studies (literature) conducted on similar contexts, participants and phenomena with a lot of common findings/ results.

3.2.9.4 Confirmability

Confirmability, or the degree of neutrality in the research study's findings. This occurs when the findings are based on participants' responses and not any potential bias or personal motivations of the researcher. Researchers can provide an audit trail, which highlights every step of data analysis that was made in order to provide a rationale for the decisions made (Lincoln & Guba, 1985).

Confirmability implies objectivity of the study findings reflected as accurately as possible concerning the thoughts and voices of participants and not of the views and biases of the researcher by presenting unaltered direct quotes from the participants (Lincoln & Guba, 1985; Polit & Beck, 2012).

To ensure the confirmability of the findings of the study, I used many verbatim quotations from the study to present the original thoughts and experiences of participants to explain emerging themes from the study in chapter 4. All the discussions in chapter 4 were augmented with verbatim quotes and literature. While I wrote the data presentation and discussion chapter, it was guided by the thoughts and views of participants based on their experiences of working at King Dinuzulu Hospital during the COVID-19 pandemic and not my creation as the researcher (Elo *et al.*, 2014).

3.3 Conclusion

This chapter presented the qualitative methodological approach and design that guided this research. It has explained the sampling technique used and criteria for the selection of the participants, Further, it presented the ethical considerations, COVID-19 health protocols, and the data collection and analysis procedures followed in the research process. It has also explained the rigour that was applied during the study to ensure that the outcome of the study would have trustworthiness anchored on dependability, credibility, transferability and conformability. The study findings and discussion are presented in the next chapter.

CHAPTER FOUR: PRESENTATION OF THE FINDINGS

4.1 Introduction

The current chapter focuses on the presentation, analysis and discussion of the data that emanated from the fieldwork. Using a qualitative research design, data were analysed thematically from the themes that emerged in line with the study's objectives. Thick descriptions were used to add depth to the discussion. The presentation of data is divided into four main themes, with sub-themes as shown below in table 3.

4.1.1 Themes and sub-themes

Table 3: Themes emerging from the data

Main Theme	Sub-Themes
Workplace experiences of social workers and nurses during the COVID-19 pandemic	<ul style="list-style-type: none"> + Workplace changes introduced <ul style="list-style-type: none"> Controlled entry and mandatory screening Creation of new wards for TB/HIV patients Cancellation of hospital visitation + Health and safety challenges in the workplace <ul style="list-style-type: none"> Fear of occupational-related infections Socialisation restrictions
Effect of COVID-19 on the delivery of social work services to TB/HIV patients	<ul style="list-style-type: none"> + Social work service delivery challenges <ul style="list-style-type: none"> Counselling is made difficult due to social distancing Ten days delay before meeting patients Medication non-adherence + Social work services <ul style="list-style-type: none"> Psychosocial assessment Counselling support to patients Education to families for support to patients Provision of linkage to community social support structures
Effect of COVID-19 on the provision of nursing services for TB/HIV patients	<ul style="list-style-type: none"> + Some changes introduced to nursing services <ul style="list-style-type: none"> Dispensing of medicine Decentralisation of medicine collection + Some challenges to nursing service delivery <ul style="list-style-type: none"> The personal toll on nurses due to COVID-19 High non-adherence rates
Unique challenges faced by social workers and nurses when attending to people living with TB/HIV	<ul style="list-style-type: none"> + Challenges experienced by nurses and social workers <ul style="list-style-type: none"> Lack of sufficient and conducive workspace Lack of sufficient communication facilities Psychological distress Insufficient Personal Protective Equipment (PPEs) + Measures that helped mitigate COVID-19 challenges <ul style="list-style-type: none"> Provision of Personal Protective Equipment (PPEs) Provision of up-to-date COVID-19 information Availability of staff clinic Debriefing sessions

The study aimed to explore the experiences of social workers and nurses treating TB/HIV patients during the COVID-19 pandemic at King Dinuzulu Hospital in Durban. Four central themes and sub-themes emerged from the study:

Theme 1: Workplace experiences of social workers and nurses during the COVID-19 pandemic has two sub-themes: Workspace changes introduced; and Health and safety challenges in the workplace. Theme 2: Effect of COVID-19 on the delivery of social work services to TB/HIV patients, has two sub-themes: Social work service delivery challenges; and services provided by the social workers. Theme 3: Effect of the COVID-19 pandemic on the provision of nursing services for TB/HIV patients, has three themes: Some changes introduced, challenges to nursing service delivery, and the services provided by nurses. Theme 4: Unique challenges faced by social workers and nurses when attending to TB/HIV patients, has two sub-themes: Challenges experienced by nurses and social workers; and the measures that helped mitigate COVID-19 challenges.

4.1.2 Demographic data of participants

Table 4 Participants' demographic data

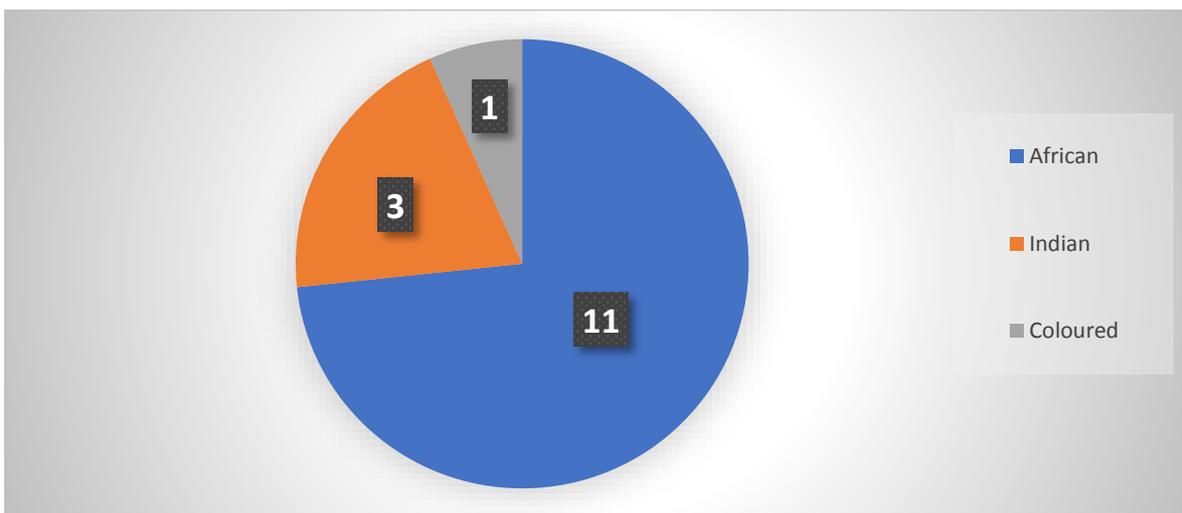
Name	Profession	Race	Age	Year started work at King Dinuzulu Hospital
NRS1	Nurse	African	50	2019
NRS2	Nurse	Indian	57	1997
NRS3	Nurse	Indian	45	2006
NRS4	Nurse	Indian	54	2006
NRS5	Nurse	Coloured	41	2005
NRS6	Nurse	African	57	1988
NRS7	Nurse	African	51	2011
NRS8	Nurse	African	47	2012
SWK1	Social Worker	African	31	2014
SWK2	Social Worker	African	48	2007
SWK3	Social Worker	African	43	2007
SWK4	Social Worker	African	52	2012
SWK5	Social Worker	African	33	2019
SWK6	Social Worker	African	52	2019
SWK7	Social Worker	African	38	2012

Figure 2 Participants by Profession



Of the 15 participants in this study, eight were nurses, and seven were social workers. The selection criterion for participation in the study included being a nurse or a social worker by profession. They were all offering treatment, care and support to TB/HIV patients at King Dinuzulu Hospital for at least one year before the outbreak of COVID-19, and willingness to participate voluntarily in the study.

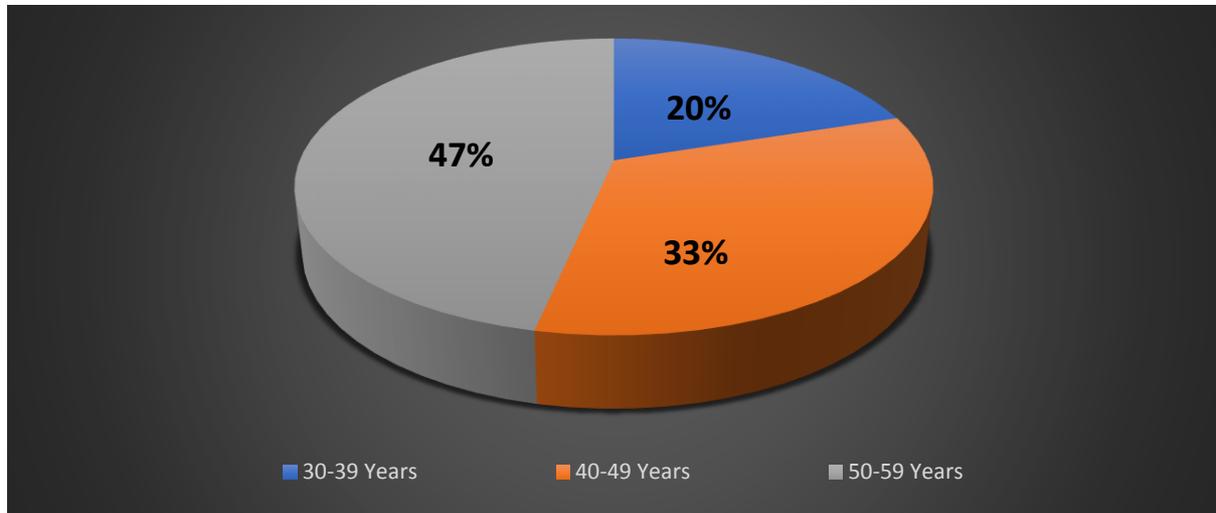
Figure 2: Participants by Race



The study participants that were selected were of mixed racial profiles. It was composed of eleven (11) participants who were African, three (3) participants who were Indian, and one (1) participant who was Coloured. Race, nonetheless, was not a criterion for the selection of participants but the profession i.e. social worker or nurse. They worked in the drug-resistant TB

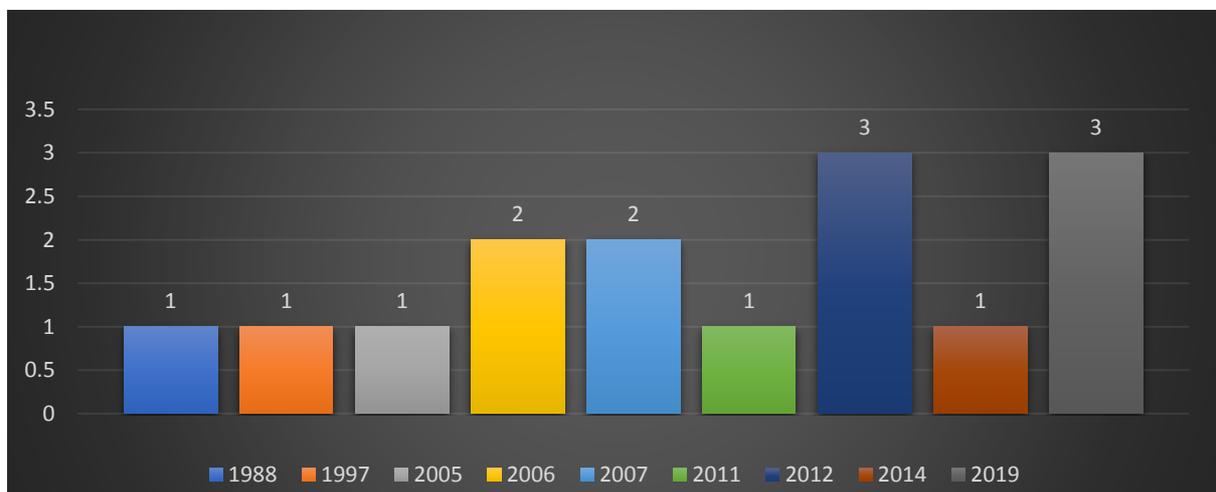
wards for at least a year before the outbreak of COVID-19 and willingness to participate voluntarily.

Figure 4: Participants by Age Group



The participants in this study comprised three age groups, those between 30 and 39 (3), between 40 and 49 (5), and between 50 and 59 (7). A majority of the participants were older and were nurses. While age was not a factor in determining who could participate in the study, the youngest participant in this study was 31 years old while the eldest was 57 years old. While the oldest sub-group constituted the majority of the participants by age (50 -59), this study does not ascribe nor rule out the fear of COVID-19 among the HCWs that participated due to age. Suffice it to say that studies suggest that older populations experienced higher anxiety levels because of their fear of COVID-19 (Agrawal., *et al.*, 2021; Şentürk, Yıldırım Keskin, & Sarızayım, 2021).

Figure 5: Year Participants first started working at KDH



The criterion for participation in this study was for one to have been working at KDH for at least a year before the COVID-19 pandemic. Figure 5 shows that the earliest participant in the study started working at this facility in 1988, for 44 years while the most recent people had been working with patients infected with TB for only three years.

4.2 Theme 1: Workplace experiences of social workers and nurses during the COVID-19 pandemic

The current study sought to explore the experiences of nurses and social workers caring for HIV and TB patients at King Dinuzulu Hospital in Durban during the COVID-19 pandemic. This section highlights the workplace experiences of participants and the impact of COVID-19 on the delivery of services to TB/HIV patients during the hard lockdown. The unique challenges faced by social workers and nurses when caring for people living with HIV and TB in this designated hospital showed a lack of sufficient and conducive workspaces, lack of sufficient telephones, fear, stress and trauma, a lack of sufficient PPEs and staff shortages.

4.2.1 Workplace changes introduced

4.2.1.1 Controlled entry and mandatory screening

The King Dinuzulu Hospital, following its designation as a COVID-19 health facility at which COVID-19 patients would be treated, had to make changes to the facility as part of the health protocols meant to minimise the spread of COVID-19. One of the protocols they introduced was controlling entry to the facility. Only one entry point, the main gate, was open, and the other gate was closed. This controlled entry access to the health facility is described as follows by two study participants:

The gate close to the TB section that is normally used by TB patients was closed. Everybody had to use the main gate of the hospital by the district hospital for screening, and walk all the way from the main gate to the TB section as there is no transport from the main gate to the TB section (SWKI).

We had a shuttle here at the hospital and it was cancelled due to COVID-19 to avoid infections from the patients to the staff members or from the staff members to the patients. The shuttle was coming from gate one to the district hospital because it is a long distance

so the patients had to walk. We had two gates the other one close to the TB department was closed so that everybody will go through screening when entering the hospital compound due to the COVID-19 virus (SWK3).

Mandatory screening procedures at the entry point for all persons entering the health facility were introduced. The mandatory screening that was required to minimise the spread of COVID-19 could not be possible without controlled entry access to the health facility. The entry screening procedures into the health facility were mandatory, meaning all staff members working at King Dinuzulu Hospital and patients had to undergo the same screening procedures without exception. These two participants stated that part of the screening procedures was to check for symptoms of COVID-19 saying:

The first thing they did was screening for all the staff, screening as soon as we come in the morning we had to check the temperature. We still do it every day. Then the questionnaire on that screening is if you have any symptoms like coughing or fever, you tick yes or no all the way down. That was one way of picking up if maybe you should go for the COVID test (NRS3).

We were also asked to do COVID-19 symptoms checkups whenever arriving at the hospital. We were provided with a thermometer to check the temperature, and there was a particular form that we were filling in (SWK4).

The screening for COVID-19 symptoms for members of staff was a daily routine. The first thing they did every time they came to the health facility for work was undergo screening procedures. Anybody showing symptoms of COVID-19 would then be subjected to COVID-19 tests.

None of those who participated in the study revealed that they were found to have been infected with COVID-19 as a result of the screening procedures introduced at entry points. That is not to say that it never happened. What is clear, however, is that the screening procedures missed some HCWs who had COVID-19 up until they had to take actual testing due to suspicions based on working in the same wards with colleagues who had tested positive. Even if the screening procedures missed some, the testing procedures still worked as they were able to detect COVID-19 in HCWs that were asymptomatic. One participant explained her asymptomatic status that was missed by the screening procedures, saying:

For the second time, it was just asymptomatic. It's just that there were some people who I worked with who were infected that I got worried about and did the testing even if no symptoms were detected at the screening stage; I tested positive even though I was feeling great. I tested positive but I was not sick. But I managed to infect my mom at home (NRS1).

The entry controls, compulsory screening and testing procedures worked as they were designed to minimise the spread of COVID-19 and enable those that tested positive to be isolated and treated so as not to infect others. While these procedures, were inconvenient as the staff were not used to being stopped in the past as members of staff working in this facility at entry points, it made them feel safe knowing that the hospital was taking these precautionary safety measures against the spread of COVID-19 seriously. The facilities created by the hospital to handle HCWs and patients by providing facilities for screening, testing and care/treatment were a relief during a life-threatening COVID-19 pandemic.

4.2.1.2 Creation of new wards for COVID-19 and TB/HIV patients

The compulsory screening procedures conducted at the main entry into King Dinuzulu Hospital required the creation of new wards for COVID-19 and TB/HIV patients. Data from the two participants cited below, show that specific wards were created to handle the quarantining and treatment of patients that tested positive:

The new wards in preparation for COVID-19 patients were divided into three. The first ward was a waiting ward while the patient is still waiting for COVID-19 test results. The second ward was a COVID-19-infected patients' ward. The third ward was a ward where the patients are admitted after being tested negative for the COVID-19 virus after the quarantine period to ensure that when they return to the normal ward they do not infect other patients by mistake (SWK2).

The hospital opened a place for screening everybody who was entering the compound of the hospital to minimise the spread of the COVID-19 virus. There was also a waiting ward that was having rooms inside where the patients were admitted while they are still waiting for COVID-19 test results (NRS3).

The creation of new wards was a positive development. It ensured that after proper screening and testing, patients who tested positive were not admitted to the same TB wards as those who did not have COVID-19. This protected TB/HIV patients some of whom could have succumbed to COVID-19 as a result of having a pre-existing condition/s that made them vulnerable.

The participants in the study never made a direct link between the creation of new wards to the shortage of staff. Their explanation of the reason for the shortage of staff was in relation to the retired and dead HCWs before and during the COVID-19 pandemic who were not replaced and those who got sick from their workplace and were in quarantine (isolation) and on treatment. It is my considered view that the creation of new wards without the employment of new staff compounded the pre-existing staff shortage and heavy workload. The unfilled vacancies left by those who retired or died before the outbreak of COVID-19 and those who died during the COVID-19 pandemic and the absence from work of those who got sick from COVID-19 were collectively a cause for both, the shortage of staff and heavy workload.

4.2.1.3 Cancellation of hospital visitation

Hospital visitations by loved ones play an important function in the recovery and wellness process of patients admitted to health facilities. But, hospital visitations during the COVID-19 pandemic were restricted. Although these restrictions were meant for the protection of patients and family members, restrictions put on hospital visitations to patients resulted in several negative physical consequences such as increased physical pain, and reduced nutrition intake; and mental health outcomes such as loneliness and depression (Hugelius, Harada, & Marutani, 2021).

Patients admitted to the hospital were not allowed to have family members and friends coming to visit them. This measure was designed to minimise the transmission of COVID-19 from the hospital to the homes of patients and vice versa. Two quotations from two of the participants in the study highlight the cancellation of hospital visitations:

And then visitors had to be restricted to the institution. In fact, we discouraged visitors at all costs from coming to the institution... Previously visitors were allowed to come to the institution (NRS4).

...we restricted the visitors, there were no visitors for our patients (SWKI).

The entry restrictions prevented patient visitations by family members and friends. This was a challenge to social workers and nurses as family participation in the healthcare of patients “improves outcomes across a broad spectrum of conditions” (Netzer & Iwashyna, 2017). This challenge made it difficult for social workers and nurses to get vital information about the patients that would allow them to provide timeous comprehensive care that would facilitate a quicker recovery process for their patients. This is because, mostly, it is the family members who know the patient better and therefore can provide critical information relating to their medical history, values and preferences. The presence of family members to patients through visitations is therapeutic, and re-assuring and helps in the restoration of their self-esteem (Babaei, & Abolhasani, 2020).

4.2.2 Health and safety challenges in the workplace

4.2.2.1 Fear of occupational-related infections

The COVID-19 pandemic had an impact on all people irrespective of their profession. Nurses' and social workers' health and safety were especially affected as frontline workers in the fight against the COVID-19 pandemic. Nurses and social workers working at King Dinuzulu Hospital were more exposed to COVID-19 than other healthcare workers in non-designated COVID-19 facilities. They were more exposed as they were working in the facility where COVID-19 patients were brought in for treatment, and they had to care for them by offering other required support services.

A study conducted by Engelbrecht *et al.* (2019) at eight health facilities in Free State Province, South Africa, found that a significant number of HCWs (67.2%) who participated in the study were afraid of occupationally contracting TB. Another study done in KZN by Zelnick *et al.* (2013), found that the biggest fear HCWs had, working in facilities treating TB was getting infected. As the COVID-19 pandemic implied exposure to death or threatened death it had psychological consequences that were significant at several levels (Greenberg *et al.*, 2020). It is no surprise therefore that the personal experience of the social workers and nurses in their

workspace at King Dinuzulu Hospital was that of apprehension, trauma, stress and fear. Two participants express the experience of feeling fearful working in such a facility:

It was very scary, because, at that time, (COVID-19) was seen as a life-threatening condition. If you encountered a patient that definitely made you think you might have contracted it as we didn't know what the pathophysiology of it was and how it was transmitted. It was really scary to all healthcare workers, including the management; and all of us. We were so scared because people were dying (NRS1).

It was scary! I was having that fear that I am working in a place that is admitting COVID-19 patients, and I was infected with the COVID-19 virus twice, and I had a family member who passed away due to COVID-19 and was admitted here at this hospital. There was too much fear for me, and to give counselling to the patients who are coming from outside the hospital or who are from home (outpatient) without knowing their condition or whether the person is having COVID-19 or not was very scary to me (SWK3).

HCWs have also experienced COVID-19-related stigma (COS) and discrimination for working in COVID-19 services leading to their decreased acceptability in their communities (Ransing *et al.*, 2020). Indeed, while communities recognise and appreciate the services rendered by HCWs, their proximity to the frontline made communities fear them as a source of infection.

The fear and trauma were not just based on what they experienced with the patients fighting for their lives and dying from COVID-19. It was also borne out of seeing their colleagues they knew and worked with getting infected, assuming it was from their workplace. The fear of infection in the place of work predates COVID-19. In a study conducted by Zelnick *et al.* (2013), HCWs expressed frustration due to the lack of adequate resources required to make workplaces safe from occupational health hazards.

There must have been a realisation among the HCWs that, as important as the measures that had been put in place for their protection from COVID-19, they were not fool proof. The fact that colleagues including some of the HCWs that participated in the study were infected was a source of concern and fear. The fear of being infected from their place of work was not just about their own health and safety. It was also about the health and safety concerns for their family members at home who would inevitably get infected if HCWs got infected with COVID-19 at their place

of work. Those fears were borne out by the findings from this study as in the case of the experience of one participant who explains her conviction of having been the source of COVID-19 which she eventually passed on to her mother saying:

I got COVID in the second wave but I wasn't really affected. I only got tested because my mother had it and my mother doesn't go out. So she would have definitely got it from me because we had about five or six staff members that had it in the ward (NRS5).

Some of these HCWs experienced trauma out of the guilt they felt for being responsible for infecting their beloved ones at home (Cavalera, 2020). The following quotes from the three participants speak to the fear experienced at the workplace due to the death of their family members, fellow staff members and their own experiences of getting infected with COVID-19:

It was scary, I was having that fear that I am working in a place that is admitting COVID-19 patients, and I was infected with the COVID-19 virus twice and I had a family member who passed away due to COVID-19 virus, and was admitted here at the hospital (SWK3).

I don't want to lie I was very scared, but as a nurse, I had to continue with my job to help those who can't help themselves. It was also very bad because some of our colleagues passed away. Some of us got infected with the COVID-19 virus, even myself was infected and my husband was infected as well and is working here at King Dinuzulu hospital, and my kids at home got infected as well. It was not easy (NRS8).

I've been anxious especially when the patient I need to assist is in the Covid-19 ward. Sometimes we have been dragging our feet in assisting the patients because we feared for our lives (SWK1).

The fear experienced at this workspace was real and felt in very personal terms by participants. They lived in fear of being infected, infecting their beloved ones at home and seeing patients and workmates battle and die from COVID-19 which also affected their morale though they persevered.

Mandatory screening protocols that were introduced were meant to minimize and prevent the spread of COVID-19 by screening for symptoms among all people including HCWs entering

King Dinuzulu Hospital, and those suspected of being infected were quarantined and subjected to testing. This was intended to assure and ensure their protection from being infected and not infecting others (fellow HCWs and patients) at their place of work. While the screening protocols were perceived by some to have been for their own good and a reassuring safety undertaking. One study participant said:

We were told that the screening was absolutely important. And if we picked up signs and symptoms, we needed to go straight to the staff clinic and get ourselves tested and receive treatment and care if found to be positive. This went some way in reassuring us (NRS8).

The mandatory screening protocols at the entry point into the hospital went some way in making some HCWs to have some degree feeling safe in their place of work. They understood that they were designed to prevent, minimise and stop COVID-19 infections in the hospital which is their workplace.

4.2.2.2 Socialisation restrictions

The way nurses and social workers interacted with each other and with other healthcare workers within the King Dinuzulu Hospital complex changed. Restrictions were put in place on socialisation between HCWs. Limitations were also put in place as to how many people were allowed to be in the same space at a given time. Here is how three study participants described the changes introduced to limit socialisation and ensure social distancing between and among healthcare workers at the King Dinuzulu Hospital complex:

We were not allowed to be crowded in one space. We were not visiting other wards to chat with friends we had to keep social distancing. Other staff members were infected with the virus and got sick. We were not even allowed to go to the offices of the management in trying to eliminate the infections (NRS7).

We were no longer sitting together during lunchtime and tea breaks. A person was eating alone; socialisation time was no longer there (SWK1).

We were not allowed to sit in the tea room as usual. We had to keep our distance and also not be there at the same time. We were taking turns, so we were no longer able to

socialise that much like before because at least we were supposed to be two at the tea room, when you are done you leave space for others. Our communication was now poor (NRS6).

This break from the usual routine that prohibited these healthcare workers from socialisation although necessary, was not easy as it was isolating and unsettling. This is consistent with studies done on healthcare workers showing that their isolation from colleagues during SARS 2003 outbreak, resulted in psychological trauma in some (Maunder *et al.*, 2004). It also made communication poor between and among HCWs as they could no longer be together and support each other at the time they needed each other the most.

The restrictions that were put on socialisation though intended for limiting and preventing the spread of COVID-19 had the unintended consequence of removing some measure of staff support. Socialisation among and between HCWs over tea or lunch breaks was more than just about food but was also about an opportunity for them to share about issues affecting their work, life and wellbeing. The COVID-19 pandemic created so much fear, anxiety and pain over which such tea and lunch break socialisation moments would have allowed HCWs to support each other through listening to and talking to each other about common and personal challenges. So, while being together through socialisation was good for support among HCWs, under the shadow of the COVID-19 pandemic circumstances, keeping away from each other through restrictions on socialisation was one way of not endangering and making worse the lives of fellow HCWs.

4.3 Theme 2: Effect of COVID-19 on the delivery of social work services to TB/HIV patients

4.3.1 Social work delivery challenges

4.3.1.1 Counselling made difficult due to social distancing

One health protocol to minimise the spread of COVID-19 is the social distancing of more than 1 metre (Ramaphosa, 2020). This health protocol while needed to stem the spread of the virus harmed human interactions such as the social work profession that among others relies on one-on-one interactions with clients in counselling sessions.

The provision of counselling to patients living with TB/HIV was negatively impacted by the outbreak of COVID-19. As the COVID-19 health protocols for in-door gatherings required maintaining social distance, it was scary for social workers to provide counselling sessions to TB and potentially COVID-19 patients who were considered to be a danger to them. What made them even more dangerous according to one participant was being in a confined small space without good ventilation with a patient who has dangerous multi-drug resistance tuberculosis and COVID-19, stating that:

Our offices are also small; there is no space while we are working with the people who are having TB and might be having Covid-19 as well. We are not just talking about TB but the people who are having a very dangerous TB who are no longer responding to the treatment. As a social worker, you have to confine yourself in the park home that is having only one small window with such a very dangerous patient. We feel unsafe as workers, we are at risk and scared (SWK3).

When there was a need, social workers went to the wards to conduct counselling to patients after the lapse of 10 days. But while the social distancing problem in the confined office spaces seemed to have been resolved by switching to the wards, it compromised confidentiality and meant that services were delayed. Because a ward is a public space, observing social distance in the conduct of counselling created a confidentiality problem as the distance between the social worker and the patient was achieved at the expense of confidentiality. The distance of at least 2 metres maintained entailed that, counselling sessions could not be conducted in a low voice to maintain confidentiality as the patient and the social worker were not going to hear each other. This is how this scenario was characterised by a study participant:

We ended up conducting some counselling sessions in the wards when there was a need, which again was like jumping from a frying pan into the fire. We avoided infection in our small offices to wards where again due to social distancing of maintaining more than a 1-metre distance, we compromised confidentiality as we could not talk softly to be audible enough (SWK3).

Social distancing regulations that were implemented to prevent the transmission of COVID-19 infections harmed the provision of counselling services to patients. The social workers could not provide the counselling services from their offices as they are too small to comply with social

distancing, but conducting counselling sessions from the ward came at the expense of the ethical requirement of privacy and confidentiality which could not be respected due to social distancing regulation. The choice between safety and ethics in the provision of social work services was one of the dilemmas and challenges social workers had to consider during the COVID-19 pandemic emergence as the study by the International Federation of Social Workers (IFSW) revealed (Banks *et al.*, 2021).

COVID-19 made the provision of social work services to patients not possible from the moment they were admitted to the hospital contrary to the pre-COVID-19 outbreak where they had immediate access to the patients. This was due to the ten (10) days quarantine requirement to ensure that those who might have been infected or were presenting with COVID-19 symptoms could not spread the virus to others. One study participant explained how the waiting period of 10 days was a hindrance to service delivery saying:

We had to wait for ten days before going to see the patient in the ward. They had to be monitored first. Our services were hindered and delayed because we had to wait instead of seeing the patients right away (SWK5).

The lost time meant a delay and hindrance to access to critical information the social workers would have needed for the care of the patient. Whereas the ideal would be that the first-day patients come to the hospital, they should have access to all the necessary services; and social workers can commence necessary care interventions without delay instead of waiting for ten long days.

4.3.1.2 Medication non-adherence

One of the reasons for the high non-adherence to treatment was due to the hard lockdown imposed restrictions on the movement of people from one place to another thereby confining them to their homes as one of the Non-Pharmaceutical Interventions (NPI) to limit the rate of the spread of COVID-19 and flatten the curve of its spread (Cao & Heydari, 2022). As argued by two study participants, patients could not go out and get their medication from clinics and hospitals saying:

People were even scared to go to the clinics and to come to the hospitals. People were defaulting on their treatment because they were confining themselves to their homes because they were scared (SWK7).

Our patients defaulted on the treatment too much during the beginning of COVID-19 (SWK3).

Patients made a direct association between the hospital and COVID-19. They decided it would be gambling with their lives to come to the hospital to collect medicine and any required follow-up appointments. They were forced by the fear of infection into non-adherence to their treatment instead of risking their lives. As a consequence of the loss of follow-up driven by the fear of COVID-19, the hospital experienced high admissions of patients coming back critically ill. One participant explains this situation as follows:

What is happening now is that our patients come back critically ill because the focus was on COVID-19 more than on other diseases. Now the admissions are very high and the conditions of the patients are very critical as they defaulted at the beginning of COVID-19. Most of our patients who defaulted to the treatment are now in risk management, the last line for them to be treated (SWK3).

The hard lockdown impacted the TB patients' ability to adhere to their treatment. The social and economic lockdown imposed to contain the COVID-19 pandemic had a massive effect on millions of South Africans depriving them of their livelihoods and exacerbating unemployment, poverty and hunger already a crisis before the COVID-19 pandemic (Seekings, 2020).

The hard lockdown resulted in many jobs being lost leaving the majority of poor people even more vulnerable to poverty. Consequently, the loss of jobs and other sources of income and livelihoods resulted in decreased food security households rely on to support their families and others. For most TB patients, as they fall into the category of poor people (Benatar, & Upshur, 2010; Oxlade, & Murray, 2012; Upshur, Singh, & Ford, 2009), their ability to continue treatment was affected. Under such socioeconomic conditions in the wake of the COVID-19 pandemic, social workers referred patients to SASSA for disability grants and DSD for food parcels. Hereunder are the two detailed explanations of the difficulties patients referred to SASSA and

DSD went through in pursuit of support of lifesaving resources they needed as patients under medication:

As a social worker, you get to see the patient for counselling when is starting the treatment and refer the patient to the South African Social Security Agency (SASSA) for the grant. The patient would wait while is on treatment and tell you that the grant is approved only for two or three months rather than the whole six months because now they feel that the person is about to complete the treatment, especially TB patients. That causes the problem because of the delays at SASSA as they have several people that they could take. The service delivery for patients was affected all emphasis was just on Covid-19 (SWK7).

The patients could come and say is unemployed and is having no food which is why they are not taking the treatment, you will write a referral letter to the Department of Social Development (DSD) for food parcels but the social worker in DSD would take only ten people a day after 12 hours they are gone. The service delivery was interrupted for our patients. We refer people outside but when they are there they won't get any help. You'll find that the patient would come back to you to say, I went to the place where you referred me but they did not help me, so there is nothing much you can do as well (SWK2).

Social workers who offer services of helping and supporting TB patients to adhere to their treatment had their work cut out as organisations and government agencies such as SASSA and the DSD failed to deliver some promised social benefits in part due to lack of capacity and leadership failure (Seekings, 2020). The service delivery of helping patients adhere to treatment in the absence of financial and material support from families due to lockdown-related poverty, the inefficiencies and lack of capacity by SASSA and DSD (Seekings, 2020) made it difficult for social workers to help patients adhere to treatment. Therefore difficulties in accessing disability grants from SASSA and food parcels from DSD resulted in non-adherence to the treatment for TB patients who could not provide food and transport for themselves.

4.3.1.4 Cancellation of home visits

The other one of the social work services that was affected by the COVID-19 pandemic was family visitations. Social workers have a responsibility to familiarise themselves with the

families where their patients come from. As argued by two study participants, home visits meant for the understanding of their patient's conditions were cancelled due to COVID-19:

Sometimes we do home visits for our patients if there is a need, but this time we couldn't do that because of the fear of infections (SWK1).

Sometimes if there is a need we drive our patients home as social workers to see their circumstances or conditions, but that has changed due to the fear of contracting the COVID-19 virus from the patients (SWK6).

These family visitations that were conducted on a need basis could however not take place due to the fear and possibility of getting infected with the COVID-19 disease. This prevented social workers from having access to the real on-the-ground information needed to educate and formulate treatment plans that involve family members who are a critical support structure to the TB/HIV patients. Understanding “circumstances and conditions” (SWK6) in the families from which patients come is important as it is used to inform the formulation of the support for treatment plans.

4.3.2 Social work services

4.3.2.1 Psychosocial assessment

Social workers at King Dinuzulu Hospital complex play a critical role in delivering social work services to TB/HIV patients, including providing comprehensive psychosocial assessments to understand and support families and communities better. Hereunder, are the perspectives shared by the two study participants on the psychosocial assessment conducted by the social workers:

We provide psychosocial assessments to patients. If the patient is not adhering to the treatment we seek to understand the reasons and causes leading to the failure to adhere to the treatment. We also provide counselling (SWK4).

We provide counselling and psychosocial assessment holistically. We find out where the person is coming from. Is he or she having the support? How is the condition at home? What is the understanding of the patient about the treatment? We also educate

the families about the illness and their role in assisting the patient to take the treatment. We also trace and locate families of those patients who have found themselves at the hospital but are no longer connected with their families. We also trace the lost patients, those who are discharged but no longer coming for follow-ups or check-up appointments in our clinic (SWK3).

The psychosocial assessment the social worker conducts is supposed to provide an all-around understanding of the patient's condition and circumstances. A comprehensive understanding of patients is needed for their support at home, in the community, and at work for those who are employed. The social workers act as a link between their patients and their community in seeking support for them from nearby resources such as clinics and, caregivers. They also help those employed with the kind of support and conditions they would require from their workplace due to the treatment and/or ill health.

The COVID-19 pandemic had a negative impact on conducting psychosocial assessments with patients, which is considered to be a “unique core of the social work scope of practice” (AASW, 2015, p. 3). A study conducted in the United States of America focused on the experiences of social workers during the COVID-19 pandemic and found that 80% of participants were not able to provide full psychosocial assessments to patients (Wiener *et al.*, 2021).

Under the COVID-19 pandemic conditions, social workers at King Dinuzulu Hospital could not conduct thorough psychosocial assessments with patients. Mindful that conducting a professional psychosocial assessment requires among others, “establishing an empathic and respectful working relationship with the client; exploring with clients their understanding of their difficulties and strengths” (AASW, 2015, p. 4), such relationships with patients were not possible due to COVID-19 health protocols. Social workers had to find ways of working in less-than-ideal ways of conducting psychosocial assessments which were incomplete in some cases without input from the patients. Some of the barriers to the provision of professional psychosocial assessments as the two study participants stated were based on fear of infection, lack of physical interactions with patients and lack of a conducive environment that predates the COVID-19 pandemic outbreak:

We discussed this in the departmental meeting and agreed that we will take the information from the file and call the family and get the information from the family about

the patient rather than going to the patient. We chose to work with the families to get the information. At some point, we suggested that the patients should have the phone among themselves in the ward so that we will communicate telephonically with them but it didn't work. We relied more on working with the families in order to access the information about the patient because we were scared of being infected with Covid-19 (SWK1).

We couldn't have interviews in our offices so we couldn't maintain confidentiality. Most of the time we had to rely on the file to find the information about the patient because we couldn't have proper interviews with our patients and this was limiting our interactions with the patients (SWK5).

In the absence of physical interactions with patients, social workers relied on the limited available information from the files. They also relied on the information they got from the families of the patients through phone conversations. As the development of social interventions to improve the well-being and functioning of a client requires that a social worker considers “a person's psychological well-being and social context” (AASW, 2015, p.3), it was very difficult for them to formulate interventions with a complete picture without the participation of the patients. So, the COVID-19 pandemic had a negative impact on the psychosocial assessment service provision by social workers.

4.3.2.2 Adherence counselling support to patients

Drug-sensitive TB is a curable disease provided treatment is commenced early and, the 6-9 months treatment course is uninterrupted (Adisa, Ayandokun, & Ige, 2021). However, poor treatment outcomes and failure persist due to treatment interruption and high non-adherence rates by patients (Adisa *et al.*, 2021). Among the factors that lead to non-adherence to TB treatment therapy are patients feeling well after the commencement of treatment, lack of money for transport and food, medication side effects, fatigue from taking medication for a long time, fear of stigma, and substance abuse (Adisa *et al.*, 2021; Baloyi, 2020).

The challenge of non-adherence caused by factors referenced above is one of the reasons why one of the key social work services social workers render to patients living with TB/HIV at King Dinuzulu Hospital complex is adherence counselling support. Patients not adhering to taking their medication for TB/HIV treatment is common. As HIV and TB treatment is taken for life

and a long time respectively, medication adherence counselling to patients by social workers as part of healthcare support is critical. As highlighted by one participant, social workers conduct assessment, counselling and treatment plans with patients:

We provide adherence counselling. We conduct assessments for our first-time patients to check whether the patient is having a history of defaulting to the treatment or not. We tell the person about the treatment plan, and the services we provide (SWK1).

The adherence counselling support services offered to TB/HIV patients by social workers are very important given non-adherence to treatment by patients that lead to treatment failure and drug resistance. The COVID-19 pandemic presents challenges to this important service that makes patients heal from the disease and improve their well-being.

Among the ways in which the COVID-19 pandemic made it hard for social workers to efficiently and effectively provide adherence counselling support services to patients had to do with the restrictions on face-to-face interactions. Effective adherence counselling is supposed to be built on a trusting, honest and empathetic relationship that includes respect for privacy and confidentiality (Blanks *et al.*, 2020), which was mostly not possible under COVID-19 regulations. Even in instances where face-to-face interactions would have been possible, the available workspaces at King Dinuzulu Hospital were not conducive and do not meet recommended in-door occupational health and safety regulations of a spacious space with good ventilation (Shimasaki & Morikawa, 2021; Titanji *et al.*, 2021; WHO, 2021b).

The findings from studies among social workers around the world indicated that the use of PPEs in instances where face-to-face counselling sessions were possible, was a hindrance to “communication, the ability to pick up non-verbal cues, the experience of empathy and the possibility of using touch as a gesture of caring or reassurance” (Banks *et al.*, 2020).

The concern for occupational health hazards that COVID-19 presented to HCWs (Banks *et al.*, 2020) was one that social workers had to grapple with. Working in a COVID-19-designated health facility was not taken lightly, as they had firsthand experience of many people including workmates and patients dying from COVID-19. The fear of infection from COVID-19 which is a natural basic human instinct of self-preservation (Khantzian, & Mack, 1983), in an environment that is a threat to one’s life made social workers fearful and reluctant to engage patients using

the face-to-face method which is ideal for counselling. In the quote below, a study participant expresses the feeling of fear at the thought of attending to a patient in a face-to-face interaction:

I've been anxious especially when the patient I need to assist is in the Covid-19 ward. Sometimes we have been dragging our feet in assisting the patients because we feared for our lives (SWK5).

The COVID-19 pandemic disrupted or made the provision of adherence counselling support services by social workers at King Dinuzulu Hospital difficult. The physical distancing and use of PPEs and fear of infection, and lack of conducive workspace made face-to-face adherence counselling not ideal under the prevailing COVID-19 pandemic circumstances.

4.3.2.3 Educating families to understand the illness and their supportive role

Family members form part of a very important source of support for TB/HIV patients. As such, therefore, one of the services offered by social workers at the King Dinuzulu Hospital complex is the provision of education to families. This education is designed to offer families the information needed in their support to sick family members on chronic or long-term medication. The education to families, as articulated by one of the participants in their support to patients is aimed at making them understand the illness and their role as a support structure in treatment literacy:

We also educate the families about the illness and their role in assisting the patient to take the treatment (SWK3).

Families are primary caretakers of patients, they should receive education about TB, the treatment that a patient is receiving and the adherence needed for the treatment to be successful. The information and education given to families should be about the medication, “the use of drugs, length of treatment, possible side effects, and mechanisms to access support that will be available to the patient” (WHO, 2014b, p. 176). Social workers also have the responsibility of sharing information with the patient and family caregivers concerning the available social support and social protection according to the eligibility criterion

The support patients require for them to be helped with treatment adherence goes beyond the confines of their family members. The communities they come from also provide another layer of support to them.

4.3.2.4 Provision of linkage to community social support structures

Social work support services for patients go beyond the confines of the patients and their families. The social work services offered by social workers to patients also extend to their communities. While their families form the innermost closer layer of support to the patients, the community support structure provides another layer of support. Social workers help link patients and their families to support structures in the community to help them “focus on problems related to different stages of treatment, the social stigma of the illness, treatment adherence, side effects, socioeconomic difficulties” (WHO, 2014a, p. 177). This service provided by social workers elicits multi-dimensional support from the community that is not limited to financial and material support. It also helps the community around the patient to have a better understanding of the illness of the patient that is needed for the acceptance and respect of the patient, their rights and human dignity that prevents stigma and discrimination based on ignorance. The community as noted by one of the participants below provide another layer of care structure to patients that are important to their treatment adherence support, saying:

We also link the patient with the community care structures, like the nearest clinic and the social development offices and the community caregivers to help the person adhere to the treatment (SWK6).

The community care structures according to SWK6 as cited above include clinics, department of social development offices and community caregivers closest to the patients. Supportive care from community care structures for TB patients and people living with HIV became difficult as resources and attention were focused on combating the deadly COVID-19 pandemic. One participant said:

Patient service delivery was affected as all emphasis was just on COVID-19. A patient could come and say is unemployed and is having no food which is why they are not taking the treatment, you will write a referral letter to the Department of Social Development (DSD) for food parcels but the social worker in DSD would take only ten

people a day after 12 hours they are gone. The service delivery was interrupted for our patients. Here we refer people outside but when they are there they won't get any help. You'll find that the patient would come back to you to say, I went to the place where you referred me but they did not help me, so there is nothing much you can do as well. The transport also was a challenge for our patients for them to come to collect their treatment (SWK7).

The lack of supportive care services from the community care structures that were now almost singularly focused on fighting COVID-19 also contributed to the non-adherence to treatment for some patients. This study's findings are confirmed by other studies that show that the COVID-19 pandemic made access to food required for the treatment they were taking making non-adherence to treatment more acute (Adisa *et al.*, 2021; Baloyi, 2020). Some could not afford to travel due to lack of transport a consequence of which they could not collect their drugs for treatment from collection points. According to a study conducted in 64 countries including South Africa, 40% of TB and HIV patients found it impossible or very hard to access health facilities during the COVID-19 pandemic due to transportation challenges (Khan *et al.*, 2021). While food and transport have been an issue before the outbreak of the COVID-19 pandemic, it has worsened in part due to severe travel restrictions and severe loss of jobs and economic activities that impact the ability of family members to support TB/HIV patients.

4.4 Theme 3: Effect of COVID-19 on the provision of nursing services for TB/HIV patients

4.4.1 Some changes introduced to nursing services

4.4.1.1 Dispensing medicine and giving health talks

Nurses play a vital role in the provision of treatment, care and support to patients in health facilities. They are also involved in administering medication, screening, testing, taking samples, pulses, temperatures and blood pressures, assessing patients and writing records. At King Dinuzulu Hospital, they provide medication to TB/HIV patients who depend on drugs prescribed and provided by health professionals to control or cure their sicknesses. They also develop treatment plans and guidelines for patients and families on how to manage illnesses and treatment literacy to aid adherence. Hereunder, one of the study participants describes the nursing services provided by nurses in the following way:

As I was being called I was doing a health talk with my patients and we do that on clinic days mostly, because that's where patients or even relatives are. We screen, test, and give them treatment. We offer expert advice on adherence, and protocols according to the guidelines (NRS1).

The administration of medication was always complemented with education to patients especially around issues of adherence due to its importance to successful treatment of TB. It is for this reason that the nurses continued to give health talks to patients despite the outbreak of the COVID-19 pandemic during the clinic days. The only difference was that the health talks were conducted in strict compliance with COVID-19 health guidelines. Hereunder, one of the participants describes the continuation and importance of health talks despite COVID-19 but with changes respectful of COVID-19 health guidelines:

We have also continued giving health talks in our TB department during the Covid-19 pandemic as we used to before the outbreak of the pandemic to our patients during the clinic days for those that continued collecting medication from our hospital. We could not stop conducting health talks because they are very important in helping our patients to adhere to their treatment, for failure at adherence can result in drug resistance and treatment failure. The only thing we did was to ensure Covid-19 compliance through social distancing in the seating arrangement, wearing masks, and sanitizing and the time was shortened. These patients were already screened upon entry to our hospital (NRS8).

Health talks were conducted with changes designed to ensure compliance with health regulations to minimize and prevent the spread of the virus. Some of the changes that happened were in the sitting arrangement meant to consider physical distancing between patients attending health talks, the wearing of masks was mandatory and so was sanitizing upon entry into the venue. The duration of the health talks was also kept short as per COVID-19 regulations for indoor gatherings. And due to the decentralization introduced in the collection of medication from KDH to health facilities close to the homes of patients, fewer patients attended these health talks which was convenient for meeting the physical distancing regulation.

COVID-19 became a new topic that now became one of the most important health issues they considered in the health talks with patients. They relied on the guidelines provided by the Department of Health to educate patients about this novel killer disease.

The COVID-19 pandemic affected the vital nursing service of administering medication to patients which is augmented with education for patients. In keeping with COVID-19 health guidelines meant to reduce physical contact with patients as much as possible to minimize the spread of COVID-19, decentralization was introduced for the collection of medication from KDH to health facilities closer to patients' homes. The implication for this change though not stated by the study participants would imply fewer hospital visits, meaning that nurses can assist those who need the most support, shorter waiting times, and enhanced and specialised standard of care. This would have also meant that the needs of patients were met better and the workloads of HCWs would be lower. The second change that was made was the bi-monthly collection of medication from the monthly collection was aimed at reducing the number of times patients had to travel exposing them to possible infection.

4.4.1.2 Decentralisation of medicine collection away from KDH

The outbreak of the COVID-19 pandemic required measures to minimise the spread of COVID-19. Apart from the health protocols of social distancing, sanitising and masking, people were also encouraged to avoid being in crowded places, to stay at home and avoid movements that would make the spread of the virus possible.

As part of the efforts aimed at decongesting health facilities, more so for the study site hospital, a decentralisation decision for the collection of drugs was made. Instead of patients around KwaZulu-Natal to be coming to King Dinuzulu Hospital for the collection of their TB/HIV drugs, a mechanism was put in place for them to be able to access their medication from clinics close to their homes. The introduction of decentralization in the collection of medication from clinics nearest to places where patients come from did not mean that patients in need of follow-ups and check-ups could not go to King Dinuzulu Hospital as that was dependent on the condition of patients and the determination of health professionals. This was done to minimise and prevent the spread of COVID-19 by reducing long travels that expose physical interactions between patients and other passengers and between patients and HCWs working in a COVID-19 health

facility. One study participant describes the decentralisation of the collection of medication for TB/HIV patients as follows:

The changes that were made were to make it easy for TB patients to get their medication. Before, all KZN hospitals were referring their patients to King Dinuzulu Hospital to collect their treatment, but now all the hospitals were offered information and were educated about TB treatment and started to supply as well. Although there are patients who still need to come to King Dinuzulu Hospital because it depends on the condition of the patient, and the hospital that specialises in TB is King Dinuzulu (NRS7).

Another study participant wondered whether the decline in the number of patients being admitted to King Dinuzulu Hospital was among others, a result of the decentralisation in medication collection. Having noticed a drop in the number of TB patients being admitted during the COVID-19 pandemic, she speculated on the causes, saying:

Since the pandemic, what I have noticed is that the number of our TB patients being admitted declined a lot, compared to COVID patients. We are not sure whether the patients are afraid of using, or accessing the healthcare facilities because they are afraid of COVID-19 or whether the numbers in the community among TB patients have dropped, because of using masks and social distancing. But we also had the decentralised institutions where our patients went. Maybe they have been using decentralised institutions. (NRS4).

She concludes her speculation by suggesting that the use of other health facilities due to the decentralisation had to do with the reduction in the numbers admitted to King Dinuzulu Hospital. This is consistent with findings from other studies showing that patients take advantage of shorter travel distances and thereby decrease treatment-related challenges such as long travel distance costs (Kapwata *et al.*, 2017; Leavitt *et al.*, 2021). The provision of treatment care at local clinics closer to patients' homes due to decentralisation removes the need for patients to access their treatment at TB-specialised health facilities such as King Dinuzulu Hospital, resulting in the decongestion or less than the usual number of patients at these facilities. The disadvantage is that without strict directly observed therapy (DOT) which is possible in hospitals under the supervision of trained HCWs, chances of fidelity to treatment as studies show are 60% compared to 86-90% under DOT (Minnesota Department of Health, 2022). This would expose family and

community members to infection and make the patient develop drug-resistant TB (Moonan *et al.*, 2011)

4.4.2 Some challenges to nursing service delivery

4.4.2.1 Personal toll on nurses due to COVID-19

Nurses are a category of HCWs who are at the front of the COVID-19 pandemic incurred the highest number of infections compared to other population groups. The highest number of infections and death among nurses means that the number of nurses was further reduced as the shortage of staff in South Africa is one that predated the COVID-19 pandemic (Engelbrecht *et al.*, 2021; Kelly *et al.*, 2021).

The Covid-19 pandemic had a negative impact on nursing services across the globe and in South Africa. Nurses are considered to be the backbone of the healthcare system and are the first point of call when patients come to the hospital (Engelbrecht *et al.*, 2021). The high rate of infections, resulting in isolation and loss of life among nurses who succumbed to COVID-19 disease had a severe negative impact on the provision of nursing services in healthcare facilities across South Africa.

The nurses who were spared by the virus were overwhelmed with heavy workloads and had to work for long hours. Here are a few quotes from the study participants underscoring the infections, isolation and death of nurses in their line of duty fighting the COVID-19 pandemic and the severe strain it put on nurses who had to fill the gap:

...it was difficult because if a member of staff is infected with Covid-19 at that time nobody was replacing that worker, so we were overloaded with work (NRS7).

The way we experience Covid-19, we lost doctors and staff... We lost the head of our department here in this building. It was quite a shock, everybody that I know has lost someone (NRS3)

We lost most of our staff members. So it was too traumatic (NRS1).

If you can remember very well other nurses have died and others were sick through this Covid-19 disease. They did not get anything, we are human beings as well we live in a challenging and expensive world, and we need to be appreciated (NRS7).

The understaffing, overloading and overworking of nurses resulting from the depletion of the nursing human resource by COVID-19 was a big drain on the provision of quality nursing services to TB/HIV patients. The pandemic had taken such a toll on HCWs who were weighed down by fatigue, depression and burnout (Nicolson, 2021) and could not, therefore, perform their functions effectively as they were equally in need of help as well.

4.4.2.2 Increased non-adherence rates

One of the noted experiences nurses encountered associated with the COVID-19 pandemic outbreak is that of high treatment non-adherence rates among TB/HIV patients. The nurses ascribe this high treatment non-adherence rate to the fear of COVID-19 and their association of the hospital with COVID-19. One study participant quoted below points to the fear of COVID-19 and the association made between COVID-19 and the hospital as the main driver of high treatment non-adherence rates:

The patients were scared to come to the hospital therefore we had many non-adherence due to the COVID-19 pandemic. When they think about the hospital, they think about COVID-19 and nothing else. In trying to run away from the COVID-19 disease they neglected the existing diseases they were already having. The patients missed their appointments to collect the treatment due to the fear of being infected with the COVID-19 disease; they defaulted a lot (NRS7)

The designation of King Dinuzulu Hospital as a COVID-19 health facility might have heightened the fear TB/HIV patients developed. This is consistent with findings that show a consensus that patients avoided going to hospitals for fear of getting infected with COVID-19 (Mantica *et al*, 2020). As such, to avoid COVID-19 infection, they avoided coming to the hospital which made them non-adherence to their TB treatment.

4.5 Theme 4. Unique challenges faced by social workers and nurses when attending to people living with TB/HIV

4.5.1 Challenges experienced by social workers and nurses

4.5.1.1 Lack of sufficient and conducive workspace

One of the issues that presented a challenge especially so under the cloud of the COVID-19 pandemic, was the lack of a conducive workspace that was of acute nature to social workers. Hereunder, two study participants describe the challenges they experienced due to the lack of a conducive workspace, saying:

The office space is also a challenge as we are sharing the offices which are compromising confidentiality. Our offices are also small, there is no space while we are working with the people who are having TB and not just TB but the people who are having a very dangerous TB who are no longer responding to the treatment, and who are now on the last line of TB. You as the social worker have to confine yourself in the park home that is having only one window with such a patient which is very dangerous. We feel unsafe as workers, we are at risk (SWK3).

We are sharing the offices and this is compromising our values as social workers for example confidentiality. The patients become uncomfortable talking about their issues in front of another worker. We are also inconveniencing each other as social workers. The offices are without windows as well, there is air conditioning and it is very cold (SWK7).

The lack of a conducive workspace prevented them from providing services to the patients in a professional manner (in keeping with ethical requirements). It made it hard to conduct professional and ethical counselling sessions that require confidentiality as the workspace is shared with other workmates. Confidentiality is an ethical requirement that underpins professional counselling that social workers have to abide by except only in very exceptional circumstances (Bowles *et al.*, 2020; Millstein, 2000). The lack of confidentiality in the workspace also made it difficult for patients to express themselves freely.

The second challenge linked to the lack of a conducive workspace is the discomfort and fear it gives social workers. Under the shadow of the COVID-19 pandemic, the confinement of TB

patients in a small workspace with poor ventilation was considered a frightening proposition to social workers. The workspace presents the very conditions that are not compliant with COVID-19 health protocols meant to minimise or prevent its spread.

4.5.1.2 Lack of sufficient communication facilities

The lack of telephone facilities was another challenge experienced by social workers made acute due to COVID-19. This presented a dual problem to the social workers. During these first ten days, social workers could not interact and communicate with patients. Had there been communication facilities provided, communication between the social workers and patients still would have been possible for them to gather the necessary information for their care when the isolation period ended. The study participant (SWK5) underscored this experience by saying:

I think it would be nice if the wards are having phones for the patients to use because waiting for ten days is delaying our services (SWK5).

The second problem emanating from the lack of telephone challenges experienced by social workers at King Dinuzulu Hospital is centred on external communication. Communication between social workers and the TB/HIV patients' family members is not an option but a must for treatment, care and support. Social workers cannot come up with treatment plans for the patients that would require the support of their family members without knowing their families and having a clear understanding of the conditions of the families they come from.

One of the ways they used and depended on was telephonic communication between social workers and families of TB/HIV patients is made more important, especially under the COVID-19 pandemic. The social distancing COVID-19 health protocol is meant to stop physical contact to minimise the transmission of COVID-19. In keeping with this COVID-19 health protocol, physical interactions with families thereby make telephonic communication the most convenient and necessary means for social workers to know and understand their patients' families for their support. Hereunder is one participant's articulation of how critical telephonic communication with families of their patients is and how the lack of this facility is a real challenge to them:

Currently, we have no phones and it is not easy to practice as a social worker without a phone. As I have mentioned that we also work with families, you can't finish working

with the patient without contacting the family to explain their role and educate them about the illness of the patient. The person ends up leaving or being discharged without you knowing whether the person would really follow all the instructions because the patient would say I do have the support but it is very much important for me as the social worker to communicate with the family for the assurance that the person will have the support even at home (SWK3).

The lack of telephones in practical terms as per the description of SWK3 in the TB Department means that they have to walk far to the district hospital and have very limited time to have meaningful conversations with their patients' families:

If you want to make a call there is only one phone at the hospital, and it is very far, from the district hospital. You need to walk all the way from the TB department to the district hospital, and you are limited in making a call for a short time; if you have called for 3 minutes you have taken a long time. As a social worker, I think that you understand that it is not practical to do that (to cut off people) while they are still asking questions that will help your patient and yourself (SWK3).

The communication problem predated the COVID-19 pandemic. However, with the outbreak of the COVID-19 pandemic, its usage became prominent. This resulted from the restrictions introduced on physical interactions through social distancing, restricted movements and confinement of non-essential workers to their homes. But it was also driven by the fear of infection because social workers as essential workers were not bound to work from home. The phone, therefore, became a primary instrument of choice for interaction between HCWs themselves, between HCWs and patients/family members of patients, and between HCWs and various community support service providers.

4.5.1.3 Psychological distress

The COVID-19 pandemic wreaked death and destruction of a magnitude that is frightening and difficult to comprehend. It was therefore natural and to be expected that it instilled fear and panic as people across the world worked so hard to understand it and fight it. The COVID-19 health protocols put in place to minimise its spread made non-essential workers stay or work from home. Nurses and social workers at King Dinuzulu Hospital as part of the healthcare

professionals were considered essential workers at the very forefront of the fight against the COVID-19 pandemic.

The participants in this study experienced fear and the associated stress and trauma. This was a natural and expected experience especially so, given that they are working in the very facility where COVID-19 patients were brought for treatment. The fear experienced by these participants is consistent with the findings from many studies done on HCWs during the COVID-19 pandemic and other similar pandemics who were stressed by the fear of infection as a threat to their mortality (Cabarkapa *et al.*, 2020; Hu *et al.*, 2020; Ji *et al.*, 2017; Maunder *et al.*, 2004; Tam *et al.*, 2004). The quotations below from two participants speak to the fear experienced by the nurses and social workers at King Dinuzulu Hospital, as they went about the work of taking care of their patients, saying:

I've been anxious especially when the patient I need to assist is in the COVID-19 ward. Sometimes we have been dragging our feet in assisting the patients because we feared for our lives (SWK1).

It was the fear and it is still there even now as we are working (NRS7).

COVID-19 has caused so much stress and trauma to me, but I had to continue doing my job as I'm supposed to (NRS8).

I was scared and anxious but I had to act strong in front of the patients because you could see that they are also scared and anxious. People were even scared to go to the clinics and to come to the hospitals (SWK7).

The lethality of COVID-19 was not something they read about from various media platforms electronic and print media. This was something they experienced each time they came to work daily. They experienced the deaths of so many patients at King Dinuzulu Hospital. And, as other studies have shown that HCWs' fear is also based on the vulnerability from the hospitalisation or quarantining of their family members and workmates (Cabarkapa *et al.*, 2020; Rossi *et al.*, 2020), the participants in the study also experienced the trauma of having some of their work colleagues and family members get infected and die from COVID-19.

Many of the nurses and social workers that participated in this study also got infected presumably from King Dinuzulu Hospital, their place of work. The following two study participants emotionally describe in vivid terms the fear, helplessness and trauma of losing close colleagues in the same department and loved ones, saying:

The way we experienced COVID-19 was scary and frightening! We lost doctors and staff. What I can say is that I'll never take anything for granted again, because, the truth is, it was all left in God's hands. Because people that you looked at, were physically fit; nothing was wrong with them today, and then in a week's time, they had COVID. In another week's time, they were gone. Everything was happening so fast, and it was out of our hands, and there wasn't anything that medicine could do. We felt helpless; I suppose that's why I feel emotional. We lost the head of our department here in this building. It was quite a shock, everybody that I know has lost someone (NRS3).

We lost most of our staff members. It was too traumatic. Even though I am still new in the hospital, seeing others die and attending their funerals, was really sad (NRS1).

The pain, fear, trauma and hopelessness experienced by the nurses and social workers were very personal. The dangers they must have braved daily in caring for their patients were very real, natural and expected. COVID-19 took many of their patients, workmates, relatives, and friends for comfort. One such loss of a member of staff at KDH to COVID-19 that was so personal to the TB department was that of Doctor Iqbal Master, a global and national expert on the treatment of drug-resistant TB (Christie, 2021). As a result of such personally felt experiences of pain and loss, some of the HCWs went through different grieving stages of denial, anger, bargaining, depression and acceptance (Kübler-Ross, 1969), owing to the pain and trauma of losing their beloved ones, friends, colleagues at work and patients to COVID-19. Some were traumatised with guilty knowing that they brought the deadly virus home to their families (Unützer, Kimmel, & Snowden, 2020).

4.5.1.4 Lack of sufficient PPEs

The findings from this study have established that HCWs at KDH were supplied with PPEs during the COVID-19 pandemic emergence for their protection due to the high exposure they had to the virus. This commendable commitment however did not result in the sufficient

provision of the PPEs to all HCWs at all times during the COVID-19 pandemic emergence. This caused real anxiety and fear among the HCWs. Here is how one participant describes how scary it was to have insufficient PPEs:

To be honest, we were feeling low because we didn't have enough PPEs and stuff, and we had an overload of COVID-19 patients, so, everybody was scared. The PPEs were very scarce in the hospital. The wards were full, and it was difficult, but through the grace of God, I suppose He saw us through it. It was scary! (NRS3).

The shortage in the supply of PPEs to health facilities battling the pandemic was not a KDH problem alone, it was a national and global problem that took a toll on HCWs (Msomi, 2020; Chersich *et al.*, 2020). And, while there was a generally insufficient provision of PPEs at KDH there were other variables that made some HCWs feel insecure. Healthcare workers such as social workers for instance were not given complete sets of PPEs that would include gowns, gloves, etc. A study participant had this to say on this problem:

There was unusual tension because we felt that the PPEs that were provided were not enough for our safety or our protection. Our PPEs as social workers were not the same as the ones for the nurses. We were just provided with a plastic apron and masks and sanitisers. We felt that the PPEs were not enough for us to enter the Covid-19 space or ward, even though they were saying, if you are going to Covid-19 ward they will provide us with the PPE that covers the whole body, still we did not receive it (SWK4).

The insufficiency in the provision of PPEs was experienced differently, some in quality, others in incomplete sets and generally availability irrespective of quality or completeness of sets. The lack of a sufficient supply of PPEs undermined the effort at trying to calm the HCWs given the backdrop of fear of operating from a place with an existing COVID-19 occupational health hazard.

4.5.2 Measures that helped mitigate COVID-19 challenges

4.5.2.1 Provision of Personal Protective Equipment (PPEs)

The Department of Health provided Personal Protective Equipment (PPEs) to minimise the likelihood of infection and to protect the lives of their frontline workers. PPE includes surgical masks, gloves, gowns, face shields/goggles, respirators and aprons; considered the last line of defence meant to reduce the risk for healthcare workers from getting infected or transmitting COVID-19 (WHO, 2020e). While this measure did not completely take away all the fear among the nurses and social workers at King Dinuzulu Hospital, together with the guidance and training provided, it was intended to instil confidence and protect them as they went about working in the COVID-19 health facility (Hoernke *et al.*, 2021; Houghton *et al.*, 2020). As the three study participants show, the nurses and social workers were provided with PPEs:

Safety measures were introduced, the wearing of masks and PPEs, sanitizing all the time and social distancing was encouraged. (SWK7).

We are more strict in the wearing of our PPEs unlike before. Every individual passing through the facility is having a mask. And sanitisation is now happening continuously. We sanitise all the time (NRS1).

There were some educational workshops at the beginning of COVID-19, teaching us about how to wear PPEs (NRS6).

Social Workers and nurses were, before the outbreak of COVID-19, already using PPEs such as masks when interacting with patients at King Dinuzulu Hospital, a specialised TB health facility to prevent transmission of TB from patients. This point was highlighted by a study one participant saying:

There is nothing much that has changed because, from the TB department, we were already using masks and implementing social distancing because of TB. Our windows are always open especially when we were offering counselling to a TB patient. It was just a matter of sanitising and being more cautious because you do not know where the patient is coming from. The infection control measures were already there (SWK1).

But that was not all, with the outbreak of COVID-19, many other PPE elements were included such as aprons, gloves, face shields, goggles, respirators, headwear caps and shoe protective covers. These were needed to give full body protection against exposure, especially for HCWs going into COVID-19 wards or having face-to-face interaction with COVID-19 patients. The hospital took measures to protect their personnel working in a COVID-19 “risky” environment.

4.5.2.2 Provision of up-to-date COVID-19 information

The King Dinuzulu Hospital and the Department of Health came up with measures designed to help the nurses, social workers, and all healthcare professionals at King Dinuzulu Hospital deal with the COVID-19 pandemic. One of the measures put in place was providing up-to-date information about COVID-19 to not only deal with misinformation on the COVID-19 pandemic but also equip, reassure and empower healthcare professionals. As put across by one study participant:

They were providing us with information about the COVID-19 virus. They were sending the information to us via emails updating us about the new information based on COVID-19, and also encouraging us to go to the staff clinic if you are not feeling well (SWK3).

Information or knowledge being power, the regular and up-to-date information provided to nurses and social workers was a good and positive development. As COVID-19 was a novel, highly infectious and dangerous disease that instilled fear and created panic, and with so much misinformation enhanced by social media, regular, up-to-date information by the DoH was very important. The information gave HCWs knowledge about how to care for their patients and also minimise the chances of being infected and what to do when and if they got infected.

4.5.2.3 Availability of the Staff Clinic

The availability of the staff clinic for the care and treatment at King Dinuzulu Hospital for the members of staff at the front fighting COVID-19 was very helpful. Having such a staff-dedicated facility was reassuring as it was inevitable that many members of staff would get infected by COVID-19 despite all the precautionary measures due to its high transmissibility and the exposure posed by their proximity to the front. The two study participants described how the staff clinic became more visible and appreciated by HCWs as it provided care, treatment and counselling to COVID-19 cases among members of staff as follows:

The management opened the staff clinic for us to go there in case we are not feeling well or suspect that we have COVID-19 symptoms and also to go for counselling here at the hospital (NRS7).

It was the availability of the staff clinic if maybe you suspect that you have contracted the COVID-19 virus you go there for checkups and counselling. There was also in-service training on how to deal with risk situations and infection control (SWK6).

They made the staff clinic available for all of us the workers at any time (NRS8)

The staff clinic provided prioritised and dedicated care and treatment to these frontline workers. This was a remedy to the common problem of long waiting periods that was characteristic of the care for COVID-19 patients due to the congestion experienced resulting in long queues in a public health institution (Levine, & Manderson, 2021; Rathnayake, Clarke, & Jayasinghe, 2021). Having a dedicated clinic for the staff took away the added stress, knowing that they would be attended to promptly. Though the staff clinic was always available, it became more visible, central and appreciated during the COVID-19 pandemic. Apart from the treatment and care of staff members suffering from COVID-19, it also provided COVID-19 testing and vaccination services.

4.5.2.4 Debriefing sessions

Some of the ways in which the social workers tried to instil calm and dispel fear among themselves in their department were through the debriefing sessions being conducted on their own. Debriefing sessions are a post-experience analytic process that allows participants to discuss, analyse and evaluate experiences, and integrate lessons learned to bring about improvement (Gardner, 2013).

These sessions allowed them (social workers) to share their experiences, strengthen each other and face their fears together knowing that they were not alone in this fight. The debriefing sessions provided emotional and psychological support to social workers to deal with their fears and stress. Two study participant hereunder makes the following explanation about the efficacy of the debriefing sessions:

What was helping me was talking about my feelings, we used to have debriefing sessions with the staff and talk about our fears. To share with other colleagues was consoling because sometimes you'll feel like maybe now you are exaggerating, you fear too much, but when sharing with other colleagues you will see that you share the same fears. That was quite consoling to know that I am not alone (SWK3).

We were having debriefing sessions with other social workers, talking every day about the situation we are facing (SWK4).

These debriefing sessions gave the social workers a sense of unity and comfort. It helped them to console each other amid fear and hopelessness. They got the strength to face their fears together, rely on each other and work together as social workers.

Social workers were also asked to help calm nurses who were distraught (panic-stricken) when called upon to work in COVID-19 wards during the COVID-19 pandemic. At a time when there was no medicine, cure and vaccinations available, and so many deaths even among HCWs treating COVID-19 patients, nurses were gripped with fear and still had to work having no choice. One social work participant described the experience of help and support offered to nurses in the following terms:

They asked us, social workers, to console the nurses, because some of the nurses were having anxiety as they had to rotate, meaning all of them at some point had to work in the Covid-19 wards, none of the nurses consented to that but it was a roster they had no choice. Therefore we were the ones to go to console the nurses who were scared and panicking, some were even having panic attacks. People were very scared even us but we had to go and console them (SWK7).

The COVID-19 pandemic created so much fear, anxiety, panic and stress among healthcare workers at KDH that doing nothing about it could be detrimental to their well-being at a time when they were needed the most. Debriefing sessions, a process through which social workers came together to share their fears and anxiety were one way that they were able to strengthen, encourage and support each other. And when called upon, social workers were able to encourage and strengthen some nurses at KDH to overcome fears and anxiety associated with working in the wards where COVID-19 patients were being treated and cared for.

4.6 Conclusion

This chapter was a presentation, analysis and discussion of the data that was collected from the fieldwork. The collection and presentation of the data in this chapter was guided by the social constructionism theory that allowed the researcher to present data in such a way that allowed the voice of participants to be heard. Their (participants) expressed views based on their experiences is what this presentation of data and discussion was based on, knowledge gained from human interactions with each other and the environment (McMahon, 1997; Derry, 1999; Ernest, 1999; Kim, 2001; Lombardo & Kantola, 2021).

Data were presented and analysed using the thematic analysis method from themes that were generated from the raw data in line with the study objectives: Workplace experiences of social workers and nurses during the COVID-19 pandemic; effect of COVID-19 on the delivery of social work services to TB/HIV patients; effect of COVID-19 on the provision of nursing services for TB/HIV patients; and unique challenges faced by social workers and nurses when attending to people living with TB/HIV. A summary, conclusion and recommendations will be presented and discussed in the next chapter.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter concludes the study by summarising the key research findings from the study on the experiences of social workers and nurses providing care to TB/HIV patients at King Dinuzulu Hospital during the COVID-19 pandemic. It also provides a conclusion to the findings; presents recommendations and a conclusion to this chapter.

5.2 Summary of Findings

5.2.1 Objective I: Workplace experiences of social workers and nurses during the COVID-19 pandemic

The study findings show workplace changes introduced and the challenges in the workplace as experienced by nurses and social workers under the first objective. Workplace changes introduced included: controlled entry and mandatory screening; the creation of new wards for the purpose of infection prevention and treatment of TB/HIV patients; and the cancellation of hospital visitation by family members, relatives and friends of the patients. The second part relates to the health and safety challenges in the place of work, under which are: fear and occupational-related infections, and the socialisations restrictions on HCWs in line with literature done from other studies (Ransing *et al.*, 2020; Bhanot *et al.*, 2021).

This study aimed to explore the workplace experiences of social workers and nurses caring for people living with HIV/TB during the COVID-19 pandemic at King Dinuzulu hospital. All the participants had worked at the hospital for at least one year and had experience treating TB patients before the COVID-19 pandemic outbreak. Some structural changes were made which also led to a change in procedures and processes in their workplace. Some of the changes that affected their work included access procedures to the health care facility, for instance, stringent screening at the entrance, limitation of visitors to the hospital, and quarantine of new admissions. This affected the morale and psychosocial well-being in the workplace with increased levels of vigilance, fear of infection and limited social interaction and support among the health workers.

One of the assumptions of the study was that designation of King Dinuzulu Hospital as a facility admitting symptomatic COVID-19 patients would increase psychological stress levels among public health social workers and nurses. The fears of HCWs were valid because some social workers and nurses also tested positive for COVID-19 which in all likelihood were contracted from their workplace, King Dinuzulu Hospital, while some of their colleagues died in their line of duty also due to COVID-19 consistent with national and international literature (WHO (2021c; Jordan, 2020). It made them fearful, and hypervigilant for signs of infection and this was exacerbated by the fear of infecting others (colleagues, family and patients). Despite the creation of new wards to contain the infection, this had staffing implications and limited some of the resources that they had.

5.2.2 Objective II: Effect of COVID-19 on the delivery of social work services to HIV/TB patients

Public social workers play a vital role in working side by side with other healthcare professionals in the treatment and care of TB/HIV patients at King Dinuzulu Hospital. during the COVID-19 pandemic. Informed by the information from the patients, family and other healthcare professionals and guided by the social constructionism theory and the people-centred care model, they delivered social services to TB/HIV patients during the COVID-19 pandemic. Some of the services included psychosocial assessments, adherence counselling support to patients, and linking patients to clinics, organisations, and government departments and agencies for their continued treatment and care support at home. COVID-19 presented some difficulties in the delivery of these services. Counselling support services were difficult to provide and family visitations were cancelled as a consequence of physical/ social distancing which was one of the COVID-19 guidelines for the minimisation and prevention of the spread of COVID-19.

The high rate of non-adherence to treatment during COVID-19 might also be attributable to the challenges public health social workers encountered in the provision of quality counselling services, medication treatment adherence counselling and psychosocial counselling. All of them were too conscious and afraid of being close to patients for fear of being infected by COVID-19. Some confessed to dragging their feet when it came to meeting with patients. Providing quality counselling social work services when someone is afraid of being with a patient can not result in the service provider being completely present with the patient.

5.2.3 Objective III: Effect of COVID-19 on the provision of nursing services

Nurses are considered to be the heartbeat of the healthcare profession. During the COVID-19 pandemic, the centrality of the role they play was there for all to see. Some of the services they provided were keeping information about the patients, giving health talks, dispensing medicine to patients, and counselling patients on how to take the treatment and on the importance of the need of being faithful to the treatment for it to be effective in treating the disease they are suffering from.

COVID-19 both challenged the provision of some nursing services and resulted in changes to some procedures and processes of some services. Some changes made were in the dispensation of medicine from monthly to bi-monthly, and in the decentralisation of the collection of medicine by TB/HIV outpatients to clinics nearer to them. These were done to reduce the number of times patients had to travel and decongest KDH during the COVID-19 pandemic respectively. Both these changes were aimed at minimising the transmission of COVID-19 to patients whose health was already compromised by TB/HIV.

Despite some changes made relating to the collection of medicine to make nursing services easier and accessible for patients still COVID-19 had a negative effect on the delivery of nursing services. Secondly, the study shows that there were some challenges to the delivery of nursing services, resulting in high non-adherence rates to treatment by TB/HIV patients; and the personal toll on nurses due to the COVID-19 pandemic was high.

5.2.4 Objective IV: Unique challenges faced by social workers and nurses when attending to people living with HIV/TB

The study findings under this objective indicate that measures were put in place by the DoH and KDH management that helped to mitigate the COVID-19 pandemic challenges for the safeguard and protection of their most important resource in the fight against the pandemic, the HCWs. The measures put in place include the provision of regular up-to-date information about COVID-19, the provision of PPEs, the availability of the staff clinic, and debriefing sessions. These went some way in easing some concerns about working in COVID-19 challenging and scary environment. The study also found that despite these measures, nurses and social workers still

experience challenges in their line of duty. Some of those challenges were, as experienced by social workers and nurses: the lack of a conducive and sufficient workplace especially for social workers who had small shared offices with poor ventilation that don't meet the COVID-19 indoor meeting requirements and ethical requirement of confidentiality that was not possible in shared offices; lack of sufficient communication facilities (telephones) making public health social workers walk a long distance to the district hospital to make calls; psychological distress suffered from deaths and sickness of colleagues, family members and patients; and the lack of sufficient PPEs that made them feel vulnerable to the COVID-19 and TB infection.

5.3 Conclusion drawn from the study

The COVID-19 pandemic highlighted the rather disadvantaged position of TB care in relation to other diseases such as HIV and COVID-19. Following the HIV/AIDS pandemic in the 1980s, there continues to be dedicated and ongoing funding for HIV research, prevention and support. Similarly, countless resources were made available to mitigate the spread and management of COVID-19, and research led to the development and distribution of vaccines within the shortest space of time. However, TB has not received similar attention, relegating it to the lowest rung of the healthcare ladder despite ongoing TB admittance cases and MDR-TB cases before, during and after post-COVID-19.

This study concludes that the COVID-19 pandemic had a negative impact on the experiences of nurses and public health social workers at King Dinuzulu Hospital. It also concludes that there were some positive measures put in place that helped HCWs and patients that prevented a catastrophe.

5.3.1 Negative impact

COVID-19 caused psychological stress and trauma to HCWs who experienced first-hand the death and ill-health of their colleagues, family members and patients. Many of them also got sick from COVID-19 making them worried about their own lives and of others in close proximity to them despite putting infection control measures in place. COVID-19 further created a moral dilemma for the participants as it sometimes meant choosing between caring for patients and prioritising their own health and that of their family members. The death and sickness of many HCWs due to COVID-19 exacerbated the impact of staff shortages prior to the COVID-19

pandemic. This resulted in an even heavier workload for the staff who had to work overtime, filling the places of those who either passed away or became sick. Other colleagues were in isolation and/or receiving treatment and therefore could not come to work. These overloaded and overworked HCWs could not provide quality care to patients due to mental and physical fatigue.

Part of infection control was the 10 days quarantine period before patients could be attended. The quality of care was compromised, and hospital procedures and support were also disrupted, such as the dispensing of medication, monitoring of patients for adverse events, and offering much-needed psychosocial interventions. For instance, social workers could not attend to patients before the quarantine period ended and therefore denying patients and their families access to social work interventions. Women, for instance, were most worried about their caregiving responsibilities as most patients had to be admitted upon initiation of treatment. This heightened both healthcare worker and patient stress. Further, the cancellation of home visits and hospital visitations, worsened by telephone access, compromised social work services.

5.3.2 Positive outcomes

At the pinnacle of the COVID-19 lockdown, timely up-to-date official information on COVID-19 provided to the country and healthcare workers on a regular basis proved helpful in understanding COVID-19, its prevention, management and treatment. It also helped to counter the spread of disinformation, “fake news” through social media that threatened the fight against COVID-19. It also assisted HCWs to make informed decisions in the care and support of patients, and towards self-care.

Changes in the collection of medicines helped to reduce the frequency of times TB patients had to travel to the hospital and clinics to collect medicines. This also helped reduce their transport expenditure, and the instances of physical contact with other people thereby minimising COVID-19 infection opportunities. This reduction in the number of times for medicine collection is in line with the differentiated service delivery (DSD) model applied to people living with HIV that reduces their frequent visits to the clinics and helped patients take increased control of their treatment.

With fewer clinic visits, this decongested the hospital and somewhat reduced the workload of staff, therefore availing them to attend to patients with severe side effects or reactions to

treatment. Further, there were shorter waiting times for patients who visited the hospital during this time.

Employee support services improved during the COVID-19 pandemic. The staff clinic was expanded and marketed across the hospital. Debriefing sessions helped the HCWs to share their fears, pain and anxiety, which were experienced individually or collectively in certain teams. Sharing, consoling and supporting each other during the pandemic not only helped the staff but also enhanced teamwork among the multidisciplinary teams in the same institution.

5.4 Recommendations

5.4.1 Address shortage of staff

The shortage of HCWs predated the COVID-19 pandemic outbreak but it was made more acute as the healthcare systems across the world including South Africa teetered on collapse (Moyo *et al.*, 2021). Health facilities were especially overwhelmed by overflowing admissions from hospitals during the second wave of COVID-19 causing heavy workloads (Moyo *et al.*, 2021). The increased COVID-19 infections also led to the death of many healthcare professionals making worse the already existing shortage of HCWs (Department of Statistics Republic of South Africa, 2021; Moyo *et al.*, 2021).

This study recommends that the Department of Health consider hiring more staff to address the shortage of staff challenges experienced by HCWs which predates COVID-19 but was made worse due to many more who died fighting the pandemic. Participants strongly expressed the need for more staff as the burden of being understaffed was compromising their ability to provide quality care to patients before, during and after the COVID-19 pandemic emergence. Given that HCWs were overloaded with work due to the shortage of staff and working under TB/HIV and COVID-19 stressful conditions, the hiring of new staff to fill vacancies that were created by the staff that died due to COVID-19, and those that left or retired before the COVID-19 outbreak is of vital importance and urgency. There is a need to hire new staff to fill the vacancies left would also solve the work overload for HCWs which is not good for them as it leads to burnout and is not good for patients as they cannot receive quality care.

5.4.2 Provision of sufficient and conducive working spaces

This study recommends that the social work department at King Dinuzulu Hospital should be provided with offices that are sufficient and conducive to addressing two challenges of occupational health and safety; and professional ethical requirements. This would address the double challenge of, i) Lack of spacious offices that remove physical barriers like the office desk and the computer between the counsellor and the patient that conveys a distant uninterested demeanour by the counsellor while its absence would signify and encourage an open and trusting relationship (Lattimore, 2013). And King Dinuzulu Hospital being a TB and COVID-19 specialised and designated health facility respectively, masks in confined spaces ought to be worn. This adds another barrier as they would interfere with the role played by facial expressions in communication and hinder interpersonal connection and communication between the counsellor and patient (Mheidly *et al.*, 2020). A spacious office space with good ventilation would also meet the required standard for COVID-19 and TB health protocols for indoor meetings, and ii) Lack of sufficient offices that are respectful of social work professional ethical value of confidentiality that is not possible in shared offices as currently is the case would be resolved as each social worker would have their own space. Alternatively, there should be a conducive office or offices that is/are reserved for counselling sessions. Ultimately, a counselling space is not shared during counselling sessions, it should offer a comfortable, safe, secure and confidential environment to the patient (client) and the counsellor.

5.4.3 Provision of sufficient communication facilities (telephone/ mobile phone)

The outbreak of COVID-19 and the subsequent lockdown and physical distancing meant to combat transmission of the disease set off seismic shifts in society (Moolla *et al.*, 2020). Social work practitioners had to quickly transition from face-to-face to telehealth using Information and Communication Technology (ICT) platforms to allow for the continuity of care and maintain therapeutic relationships during the pandemic (Mishna *et al.*, 2022). In South Africa, ICTs played a critical role as they were deployed to provide virtual healthcare services at a time that physical face-to-face interactions were restricted (Mbunge *et al.*, 2022).

The provision of sufficient and efficient ICT platforms such as phones in the social work profession is not an option but a must whose importance predates the COVID-19 pandemic but has gained much appreciation. This study recommends the provision of sufficient ICT platforms,

a phone (fixed phone/mobile) in each office with auxiliary utilities such as scanners and printers and a phone in each TB ward, in the light of the problems revealed by the study findings in accessing telephone services, especially in social work services at King Dinuzulu Hospital.

This recommendation if attended to would enhance timely and efficient communication between, i) social workers and patients at King Dinuzulu Hospital that requires the installation of phones in each ward and would solve the ten days waiting period or in health emergencies that do not allow for physical contact with patients, ii) social workers and patients at home for those being cared for at home, for follow-up calls, iii) social workers and family members providing supportive care to patients at home, iv) social workers and other healthcare professionals at King Dinuzulu Hospital such as nurses, doctors, pharmacists, and also with fellow social workers, and v) social workers and other supportive service providers such as SASSA, DSD, NGOs, community health clinics closest to their clients (patients), etc. Sufficient and functioning telephones are not only of critical importance during a pandemic such as COVID-19 but are essential for the social work profession.

5.4.4 Expedited processing of grants and food parcels

In South Africa, people from lower socioeconomic strata are more at risk of developing active TB and the majority of them, 56% are unemployed, making the 6 months Disability Grant (DG) government social support for TB patients so important (Vanleeuw, Zembe-Mkabile, & Atkins, 2022). But getting timely access to this grant as the findings from this study and other studies show is difficult and costly for the majority of TB patients; by the time it is approved a patient would have been in the 3rd month or at the end of their 6 months treatment. It is therefore the recommendation of this study that mechanisms, procedures and processes must be worked out between DoH and SASSA/DSD, and put in place that should trigger the timely processing of social grants for TB patients within the first month. It must be put as a matter of policy that the DG for TB patients must be processed and accessed within the first month.

Have a SASSA/DSD officer/s stationed and working from King Dinuzulu Hospital with an office next to the Social Work Department for the processing of Disability Grants for TB/HIV patients. The office at King Dinuzulu Hospital would serve as a one-stop shop where after diagnosis by doctors, psychosocial assessment by the social workers and processing of the DG all being done at the same site would offer convenient and efficient service delivery to the patients in many

respects. This would make the DG processing time shorter, and the provision of food parcels less burdensomeness and save patients the time, energy and money they do not have, given that there is a relationship between TB and poverty (Vanleeuw, 2022). This would also prevent the spread of TB as it is a highly transmissible disease as a patient diagnosed would not be moving up and down chasing after the application process while exposing others to the disease.

5.4.5 Regular up-to-date information provision

In a modern world powered by the instant transmission of information in real-time, the uncertainty around the COVID-19 emergence quickly allowed an opportunity for the rapid widespread of misinformation, and delays in providing correct and authentic information can saw panic and hinder the fight against a pandemic (Kadam and Atre, 2020). The provision of regular up-to-date information to HCWs during the COVID-19 pandemic emergence was highly commendable and useful to HCWs. This study recommends that robust, regular up-to-date provision of information to HCWs should be extended beyond the COVID-19 pandemic emergence to other ongoing epidemics such as TB and HIV/AIDS and future pandemics.

5.4.6 Provision of sufficient PPEs

The provision of PPEs by employers to their employees is mandated by the International Labour Organisation (Benjamin, 2001) and the Department of Labour in the Republic of South Africa (Department of Labour, 1993), meant to protect them from occupational health hazards. In line with the provisions of the ILO and the DoL, the study recommends the provision of sufficient PPEs to staff members working at King Dinuzulu Hospital. PPEs comprise sanitisers, face masks, gloves, aprons, face shields, goggles, respirators and boots. PPEs are critical for the safety and protection of HCWs working in an environment with occupational health hazards, such as TB and COVID-19, as King Dinuzulu Hospital is a TB and COVID-19 specialised and designated health facility respectively. While PPEs were supplied to HCWs, they were not in sufficient numbers; as such, therefore, led to fear and stress among HCWs owing to COVID-19 being highly transmissible and lethal.

5.4.7 Facilitate engagement between HCWs and management

The study recommends that during stressful pandemic emergencies of the COVID-19 kind, there is a need for periodic engagement between HCWs and management. This is an important exercise through which workers would be accorded the opportunity to share their anxieties, fears and concerns as well as suggestions under such challenging times. As much as management and other officials from the Department of Health consider the conditions of workers in decisions and support made, it is vitally important to check, through such engagements, how support systems and decisions made for their well-being are impacting them.

5.4.8 Debriefings sessions

Healthcare workers at the frontline during pandemics endured the highest risk and rate of infection, death, burnout, psychological distress and post-traumatic syndrome disorder (PTSD) during and after the pandemics have passed as evidenced during the Ebola, SARS, MERS and now COVID-19 outbreaks (Wong, 2003; Chersich *et al.*, 2020; Diamond, & Woskie, 2020; Engelbrecht, Heunis, & Kigozi, 2021). These conditions in HCWs if left unattended can have an adverse impact on their well-being even long after the COVID-19 pandemic emergence. The experiences of trauma, distress, hopelessness, fear and anxiety at the height of the COVID-19 pandemic by the study participants are a call for help.

This study recommends the introduction of debriefing sessions on a regular basis for HCWs during and after future pandemic emergencies of the COVID-19 kind. Due to COVID-19 being highly infectious and deadly, HCWs were engulfed in fear and stress brought about by attending to patients in a COVID-19-designated health facility. The fear and stress, and loss of fellow workmates who had succumbed to the disease took a toll that debriefing sessions would go some way in providing support and comfort. Debriefing sessions, as was the case with social workers would help workmates to share their experiences, and fears, support and lift each other knowing that they are not alone but share the same burdens and anxieties. Similarly, a study conducted by Engelbrecht, Heunis and Kigozi, (2021) among others recommended positive coping strategies-based debriefing intervention sessions for nurses during COVID-19 in South Africa.

5.4.9 Differentiated service delivery (DSD) model in medication collection for TB patients

This study based on the findings recommends bi-monthly medication collection for TB-stable patients on medication in line with the differentiated service delivery (DSD) model. This DSD model has been used in the collection of medication once every 6 months by HIV-stable patients. It has the benefits of spending less on transportation and less physical interaction that gives rise to the possibility of COVID-19 infection and reduces stigma and discrimination patients suffer due to frequent hospital/clinic visitations for collection of their chronic medication. This model is also beneficial to healthcare facilities and healthcare workers as it lifts the burden on them by minimising congestion and workload (Larson *et al.*, 2020).

5.4.10 Prioritisation of Funding for TB Research in National Strategic Plan for HIV, TB, and STIs 2023-2028

This study highly recommends that prioritisation in the National Strategic Plan for HIV/TB/STIs for 2023 – 2028 should include meaningful TB research funding. TB research funding should be prioritised as it has not received similar attention as compared to HIV and COVID-19 epidemics despite ongoing TB admittance cases and MDR-TB cases before, during and post-COVID-19; and South Africa in possession of one of the highest populations of people living with HIV and TB, the two epidemics being of near equal gravity, and each deserving as much funding (WHO, 2020; UNAIDS, 2021).

5.5 Conclusion

The COVID-19 pandemic both revealed the nobility of the men and women in the healthcare industry considered by the World Health Organisation as “the most valuable resource for health” (Joseph and Joseph, 2016, p. 71), and the constant and complex occupational health and safety hazards they risk to care for and serve patients. This study was designed to explore the experiences of social workers and nurses treating TB/HIV patients during the COVID-19 pandemic at King Dinuzulu Hospital in Durban.

This chapter has presented in summary important salient findings from the study through the objectives it set out to explore in relation to how COVID-19 affected the experiences of nurses and public health social workers at King Dinuzulu Hospital. Mainly, COVID-19, as the conclusion to the study presents, had a negative impact on nursing and social work services, but there were positive interventions that prevented the situation at King Dinuzulu Hospital from

turning into a complete catastrophe. It ends with important recommendations that if implemented would make future interventions of pandemics of the COVID-19 kind much easier to manage.

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Annexure I: Ethical Clearance Certificate – University of KwaZulu Natal



18 March 2022

Thandiwe Bonisiwe Thabethe (217076258)
School Of Applied Human Sc
Howard College

Dear TB Thabethe,

Protocol reference number: HSSREC/00003691/2021

Project title: Exploring the experiences of social workers and nurses treating patients with tuberculosis and human immunodeficiency virus during the coronavirus disease pandemic at King Dinuzulu hospital in Durban.

Degree: Masters

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 19 November 2021 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

This approval is valid until 18 March 2023.

To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.

HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours sincerely,



Professor Dipane Hlalele (Chair)

/dd

Humanities and Social Sciences Research Ethics Committee

Postal Address: Private Bag X54001, Durban, 4000, South Africa

Telephone: +27 (0)31 260 8350/4557/3587 Email: hssrec@ukzn.ac.za Website: <http://research.ukzn.ac.za/Research-Ethics>

Founding Campuses:  Edgewood  Howard College  Medical School  Pietermaritzburg  Westville

INSPIRING GREATNESS

Annexure II Gatekeeper's Letter - DoH KZN Province



KWAZULU-NATAL PROVINCE

HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE:

Postal Address: Private Bag X9050

Physical Address: 330 Langalibalele Str, PM Burg, 3201

Tel: 0333953189/3123/2805 Fax: 033-3943782

Email address: hrkm@kznhealth.gov.za

www.kznhealth.gov.za

Health Research & Knowledge Management Unit

NHRD Ref: KZ_202203_003

Dear Ms TB Thabethe
(UKZN)

Approval of research

1. The research proposal titled 'EXPLORING THE EXPERIENCES OF SOCIAL WORKERS AND NURSES TREATING PATIENTS WITH HIV/TB DURING THE COVID-19 PANDEMIC AT KING DINUZULU HOSPITAL IN DURBAN' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at King Dinuzulu Hospital Complex.

2. You are requested to take note of the following:

- a. *All research conducted in KwaZulu-Natal must comply with government regulations relating to Covid-19. These include but are not limited to: regulations concerning social distancing, the wearing of personal protective equipment, and limitations on meetings and social gatherings.*
- b. *Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.*
- c. *Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.*
- d. *Provide an interim progress report and final report (electronic and hard copies) when your research is complete to HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200 and e-mail an electronic copy to hrkm@kznhealth.gov.za*
- e. *Please note that the Department of Health shall not be held liable for any injury that occurs as a result of this study.*

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely



Dr E Lutge

Chairperson, Health Research Committee

Date: 27/05/2022

Annexure III: Gatekeeper's Letter – King Dinuzulu Hospital



KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

P.O. Dormerton, Sydenham, 4015
75 R.D. Naidu Drive, Sydenham, 4015
Tel: 031 2426000 Fax: 031 2099586

DIRECTORATE:

King Dinuzulu Hospital Complex

Enquires: Dr Z. Dlamini

Reference: RES 212021

25/02/2022

Dear Ms Thabethe

**RE : EXPLORING THE EXPERIENCES OF SOCIAL WORKERS AND NURSES
TREATING PATIENTS WITH TB/IV DURING THE COVID-19 PANDEMIC AT KDHC**

I have pleasure in informing you that permission to conduct the above study has been supported by King Dinuzulu Hospital Complex.

Please note the following:

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. Neither the District Office nor KDHC will provide any resources for this research.
3. Your attention is drawn to the maintenance of confidentiality with respect to staff records/files and may not be removed from this Institution.
4. You will be expected to provide feedback on your findings to KDHC.

Yours faithfully



Dr Z. Dlamini
Acting C.E.O.

Annexure IV: Interview Schedule

Exploring the experiences of social workers and nurses treating patients with HIV/TB during the Covid-19 pandemic at King Dinuzulu hospital in Durban.
Demographical
<p>What is your age? What is your gender? What is your race? What is your profession? When did you start working at KDH?</p>
What are the workplace experiences of social workers and nurses treating HIV/TB patients during the Covid-19 pandemic?
<p>What changes were introduced at the workplace (hospital) due to Covid-19 What changes were made in the care for the people living with HIV/TB patients at KDH? What has been your experience of working at King Dinuzulu since it's designation as Covid-19 facility? How were you helped to deal with patients during the Covid-19 pandemic at KDH? How has the Covid-19 pandemic affected the way you relate/interact with workmates at the hospital?</p>
How has Covid-19 affected the delivery of social work services to HIV and TB patients during the COVID pandemic? (SOCIAL WORKERS)
<p>What kind of social work services do you provide to people living with HIV/TB? How do you involve the people living with HIV/TB patients to inform their care? How has your interaction with the people living with HIV/TB changed due to the Covid-19 pandemic? What changes have been made in the provision of social work services due to the Covid-19 pandemic? In what ways has the treatment/care of the people living with HIV/TB patients been affected by Covid-19? How do you interact/collaborate with nurses in the care for the people living with HIV/TB? How has your interaction/collaboration with nurses been affected/changed due to Covid-19? What should or could be done to help you offer better social work care for people living with HIV/TB under the Covid-19 pandemic?</p>
How has Covid-19 affected the provision of nursing services for the people living with HIV/TB? (NURSES)
<p>What kind of care do you provide to the people living with HIV/TB? How do you involve the people living with HIV/TB to inform their care? How has your interaction with the people living with HIV/TB changed due to the Covid-19 pandemic? What changes have been made in the provision of nursing services due to the Covid-19 pandemic? In what ways has the treatment/care of the people living with HIV/TB been affected by Covid-19? How do you interact with social workers in the care for the people living with HIV/TB/Covid-19? How has your interaction with social workers been affected/changed due to Covid-19? What should or could be done to help you offer better nursing care for the people living with HIV/TB under the Covid-19 pandemic?</p>
What are the unique challenges that are faced by social workers and nurses when attending to the people living with HIV/TB that underlie Covid-19?
<p>What unique challenges have you faced in your care for the people living with HIV/TB patients due to the Covid-19? How have you dealt with those challenges? How has the KDH management or Department of Health helped you deal with Covid-19 challenges? How can KDH management or DoH help you to overcome the challenges you experience in your workplace and in attending to the people living with HIV/TB as a result of Covid-19?</p>

Annexure V: Interview Guide (Zulu translation)

Ukuhlola ukuthi osonhlalakahle kanye nabahlengikazi bakuthola kunjani ukusebenza belapha iziguli ezinesifo sofuba negciwane lengculazi ngesikhathi sobhubhane lweCovid-19 esibhedlela iKing Dinuzulu, eThekwini.
Ulwazi ngabahlangenyeli bocwaningo
Uneminyaka emingaki? Buyini ubulili bakho? Luthini uhlanga lwakho? Uyini umsebenzi wakho? Uqale nini ukusebenza esibhedlela iKing Dinuzulu?
Kungabe osonhlalakahle nabahlengikazi abelapha iziguli ezine-HIV ne-TB bakuthola kunjani ukusebenza ngesikhathi sobhubhane lwe-Covid-19?
Yiziphi izinguquko ezenziwa emsebenzini (esibhedlela) ukuhlangabezana ne-Covid-19 Yiziphi izinguquko ezenziwa ukunakekela abantu abaphila ne-HIV noma iTB e-KDH? Ngabe ukuthola kunjani ukusebenza esibhedlela iKing Dinuzulu selokhu saqokwa njengesikhungo seCovid-19? Usizwe kunjani ukubhekana neziguli ngesikhathi sobhubhane lwe-Covid-19 e-KDH? Ingabe ubhubhane lwe-Covid-19 lube namthelela muni endleleni ohlobana ngayo noma osebenzisana ngayo nosebenza nabo esibhedlela?
I-Covid-19 ikuthinte kanjani ukulethwa kwezinsiza zezehlalakahle ezigulini ezine-HIV ne-TB phakathi kobhubhanene lwe-COVID? (OSONHLALAKAHLE)
Hlobo luni lwezinsizakalo zezehlalakahle ozihlinzekayo kubantu abaphila ne-HIV noma i-TB? Ubabandakanya kanjani abantu abaphila negciwane lesandulela ngculazi noma iziguli ze-TB ukwaziswa ngokunakekelwa kwabo? Kushintshe kanjani ukusebenzisana kwakho nabantu abaphila ne-HIV noma i-TB ngenxa yobhubhane lwe-Covid-19? Yiziphi izinguquko ezenziwe ekuhlinzekweni kwezinsizakalo zezehlalakahle ngenxa yobhubhane we-Covid-19? Ngabe ukwelashwa noma ukunakekelwa kwabantu abaphila negciwane lesandulela ngculazi noma abanesifo sofuba kuthintekile ngayiphi indlela yi-Covid-19? Uxhumana kanjani noma usebenzisana kanjani nabahlengikazi ekunakekeleni abantu abaphila ne-HIV noma i-TB? Ingabe ukusebenzisana/ukubambisana kwakho nabahlengikazi kuthintekile noma kushintshe kanjani ngenxa ye-Covid-19? Yini okufanele noma engenziwa ukuze ikusize unikeze ukunakekelwa okungcono kwezehlalakahle kubantu abaphila ne-HIV noma i-TB ngaphansi kobhubhane lwe-Covid-19?
I-Covid-19 ikuthinte kanjani ukuhlinzekwa kwezinsiza zobuhlelengikazi kubantu abaphila ne-HIV noma i-TB? (ABAHLENGIKAZI)
Hlobo luni lokunakekela olunikeza abantu abaphila ne-HIV noma i-TB? Ubabandakanya kanjani abantu abaphila ne-HIV noma i-TB ukuze bazi ngokunakekelwa kwabo? Kushintshe kanjani ukusebenzisana kwakho nabantu abaphila ne-HIV noma i-TB ngenxa yobhubhane lwe-Covid-19? Yiziphi izinguquko ezenziwe ekuhlinzekweni kwezinsiza zobuhlelengikazi ngenxa yobhubhane lwe-Covid-19? Ngabe ukwelashwa noma ukunakekelwa kwabantu abaphila negciwane lesandulela ngculazi noma abanesifo sofuba kuthintekile ngayiphi indlela yi-Covid-19? Usebenzisana kanjani nosonhlalakahle ekunakekeleni abantu abaphila ne-HIV noma i-TB noma i-Covid-19? Ingabe ukusebenzisana kwakho nosonhlalakahle kuthintekile noma kushintshe kanjani ngenxa ye-Covid-19? Yini okufanele noma engenziwa ukusiza ukuthi unikeze ukunakekela okungcono kwabahlengikazi kubantu abaphila ne-HIV noma i-TB ngaphansi kobhubhane lwe-Covid-19?
Yiziphi izinselelo eziyizingqayizivele osonhlalakahle nabahlengikazi ababhekana nazo lapho benakekela abantu abaphila negciwane lesandulela ngculazi noma i-TB ngenxa ye-Covid-19?
Yiziphi izinselelo oke wabhekana nazo ekunakekeleni kwakho abantu abaphila negciwane lesandulela ngculazi kanye neziguli ze-TB ngenxa ye-Covid-19? Uye wabhekana kanjani nalezo zinselele? Ngabe abaphathi besibhedlela iKing Dinuzulu noma uMnyango wezeMpilo bakusize kanjani ukubhekana nezinselelo zeCovid-19? Abaphathi besibhedlela iKing Dinuzulu noma uMnyango wezeMpilo bangakusiza kanjani ukuthi unqobe izinselelo ohlangabezana nazo emsebenzini kanye nokubhekelela abantu abaphila negciwane lesandulela ngculazi kanye nesifo sofuba ngesikhathi se-Covid-19?

Annexure VI: Informed Consent Form

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

INFORMED CONSENT FORM

Information Sheet and Consent to Participate in Research

Date: _____

Good morning/afternoon Sir/Madam.

My name is **Thandiwe Thabethe** from the **University of KwaZulu-Natal**, School of Applied Human Sciences, contact No.: 0738121218; email address: srthabethe86@gmail.com

You are being invited to consider participating in a study that involves research on: **Exploring experiences of social workers and nurses treating HIV/TB patients during the Covid-19 pandemic at King Dinuzulu Hospital in Durban**". The aim and purpose of this research is to explore the experiences of social workers and nurses treating HIV/TB patients during the Covid-19 pandemic at King Dinuzulu Hospital. The study is expected to enroll 16 participants in total (8 social workers and 8 nurses) working at King Dinuzulu Hospital. It will involve having a one-on-one in-depth audio recorded interview with the researcher. The duration of your participation if you choose to enroll and remain in the study is expected to be 30 - 60 minutes.

The study will provide no direct benefits to participants. But the findings from this study may enable the Department of Health and the management at King Dinuzulu Hospital to provide better support to workers for effective and efficient care to patients.

This study has been ethically reviewed and given provisional approval by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number HSSREC/00003691/2021).

In the event of any problems or concerns/questions you may contact the researcher at (0738121218 via email srthabethe86@gmail.com) or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Please note that:

- The information that you provide will be used for scholarly research only.
 - Your participation is entirely voluntary. You have a choice to participate, not to participate or stop participating in the research at any time. You will not be penalized for taking such an action.
 - Your views in this interview will be presented anonymously. Neither your name nor identity will be disclosed in any form in the study.
 - The interview will take 30-60 minutes.
 - The record, as well as other items associated with the interview, will be held in a password-protected file accessible only to myself and my supervisor. After a period of 5 years, in line with the rules of the university, it will be disposed of.
 - If you agree to participate please sign the declaration attached to this statement.
-

CONSENT

I have been informed about the study entitled: **Exploring experiences of Social Workers and Nurses treating HIV/TB patients during the Covid-19 pandemic at King Dinuzulu Hospital in Durban by Thandiwe Thabethe.**

I understand the purpose and procedures of the study.

I have been given an opportunity to ask questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without being penalized in any way.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at (0738121218 or via email srthabethe86@gmail.com).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researcher then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban 4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

I hereby provide consent to:

Audio-record my interview YES / NO

Signature of Participant

Date

Annexure VII: Informed Consent (Zulu translation)

IKOMIDI LEZIMILO lase-UKZN LEZABANTU NEZESAYENSI YOMPHAKATHI (HSSREC)

IFOMU LEMVUME ENOLWAZI

Ishidi Lolwazi kanye Nemvume Yokuhlanganyela Ocwaningweni

Usuku: _____

Sawubona Mnumzane/Nkosazana/Nkosikazi.

Igama lami nginguThandiwe Thabethe ovela eNyuvesi yaKwaZulu-Natal, School of Applied Human Sciences, ngitholakala kule nombolo: 0738121218; ikheli le-imeyili: srthabethe86@gmail.com

Uyamenywa ukuthi ubambe iqhaza ocwaningweni olubandakanya ucwaningo: **Ukuhlola ukuthi osonhlalakahle nabahlengikazi bakuthola kunjani ukusebenza belapha iziguli ezine-HIV noma TB ngesikhathi sobhubhane lwe-Covid-19 esibhedlela iKing Dinuzulu eThekwini**". Inhlalo nenjongo yalolu cwaningo ukuhlola ulwazi losonhlalakahle kanye nabahlengikazi abelapha iziguli ezine-HIV/TB ngesikhathi sobhubhane lwe-Covid-19 esibhedlela iKing Dinuzulu. Lolu cwaningo lubandakanya abahlanganyeli abangu-16 sebebonke (osonhlalakahle abayisi-8 nabahlengikazi abayisi-8) abasebenza esibhedlela iKing Dinuzulu. Kuzobandakanya ukuba nengxoxo ejulile eqoshiwe yocwaningo nomcwaningi. Isikhathi sokubamba kwakho iqhaza uma ukhetha ukubhalisa nokuhlala ocwaningweni kulindeleke ukuthi sibe yimizuzu engama-30 - 60.

Ucwaningo ngeke lunikeze izinzuzo eziqondile kubahlanganyeli. Kodwa imiphumela yalolu cwaningo ingase yenze uMnyango wezeMpilo kanye nabaphathi basesibhedlela iKing Dinuzulu bakwazi ukuhlinzeka ngosizo olungcono kubasebenzi ukuze banakekele iziguli ngempumelelo.

Lolu cwaningo luye lwabuyekezwa ngokwezimiso zokuziphatha futhi lwagunyazwa isikhashana yiKomidi le-UKZN Humanities and Social Sciences Research Ethics (inombolo yemvume HSSREC/00003691/2021).

Uma kuba nezinkinga noma ukukhathazeka/imibuzo ungathintana nomcwaningi kule nombolo (0738121218 nge-imeyili srthabethe86@gmail.com) noma Ikomiti Le-UKZN Humanities & Social Sciences Research Ethics, imininingwane yokuxhumana ikanje:

ULAWULO LWEZANTU NEZESAYENSI YOMPHAKATHI

Ihhovisi Lokucwaninga, Ikhampasi yaseWestville

Govan Mbeki Building

Private Bag X 54001

EThekwini 4000

KwaZulu-Natal, ENINGIZIMU AFRIKA

Ucingo: 27 31 2604557- Ifeksi: 27 31 2604609

I-imeyili: HSSREC@ukzn.ac.za

Sicela uqaphele ukuthi:

- Ulwazi olunikezayo luzosetshenziselwa ucwaningo lwezifundo kuphela.
- Ukuhlanganyela kwakho kungokuzithandela. Unokukhetha ukubamba iqhaza, ukungahlanganyela noma ukuyeka ukubamba iqhaza ocwaningweni nganoma yisiphi isikhathi. Ngeke ujeziswe ngokwenza isenzo esinjalo.
- Imibono yakho kulolucwaningo izokwethulwa ngokungaziwa. Igama lakho noma ubuwena ngeke kudalulwe nganoma ingayiphi indlela ocwaningweni.
- Ucwaningo luzothatha imizuzu engama-30-60.
- Irekhodi, kanye nezinye izinto ezihlotshaniswa nocwaningo, lizogcinwa efayeleni elivikelwe ngephasiwedi elifinyeleleka kimina kuphela nomphathi wami. Ngemuva kweminyaka emi-5, ngokuhambisana nemithetho yenyuvesi, lizochithwa.
- Uma uvuma ukubamba iqhaza sicela usayine isimemezelo esinamathiselwe kulesi sitatimende.

IMVUME

Mina.....ngichazelwe nganeliseka ngocwaningo: Ukuhlola okuhlangene nokuthi osonhlalakahle kanye nabahlengikazi bakuthola kunjani ukusebenza belapha iziguli ezine-HIV noma i-TB ngesikhathi sobhubhane i-Covid-19 esibhedlela iKing Dinuzulu eThekwini ngu-Thandiwe Thabethe.

Ngiyayiqonda inhloso nezinqubo zocwaningo.

Nginikezwe ithuba lokubuza imibuzo mayelana nocwaningo futhi ngathola zimpendulo ngokwaneliseka.

Ngiyazisa ukuthi ukuhlanganyela kwami kulolu cwaningo kungokuzithandela futhi ngingahoxa noma nini ngaphandle kokujeziswa nganoma iyiphi indlela.

Uma ngineminye imibuzo/okungikhathazayo noma imibuzo ehlobene nocwaningo ngiyaqonda ukuthi ngingathintana nomcwaningi kule nombolo (0738121218 noma nge-imeyili srthabethe86@gmail.com).

Uma nginemibuzo noma izinkathazo mayelana namalungelo ami njengomhlanganyeli wocwaningo, noma uma ngikhathazekile ngendawo ethize yocwaningo noma umcwaningi ngingaxhumana:

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Nginikeza imvume yoku:

Qopha umsindo-wengxoxo yami YEBO / CHA

Isiginesha Lombambiqhaza

Usuku