INTRODUCTION

Ghana has made significant strides in the management of HIV and AIDS, and nurses have played a critical role in working with people living with HIV (PLWH). While HIV and AIDS have an impact on all healthcare providers, nurses, as frontline workers and the largest health work force, are most vulnerable (Chan, Rungpueng, & Reidpath, 2009). Nurses are exposed to HIV-related stigma (Ha,
Chuc, Hien, Larsson, & Pharris, (2013) and burnout (Rowan, Lynch, Randall, & Johnson, 2015). While research has been undertaken with nurses working with PLWH, the focus has often been on educational and mentorship opportunities to enhance nurses’ knowledge and skills about HIV and/or to create positive attitudes towards PLWH. In this study, we were particularly interested in the experiences of hope in nurses working in Ghana in the acute care HIV ward.

1.1 | Narrative conceptions of hope as interwoven within experience

According to Havel (2004) hope, in the profound and influential sense, is not the same as happiness that things are going well. Instead, hope is the capacity to work for something for the reason that it is good, not just because it has a chance to succeed. Hope is nurtured and sustained within specific contexts and practices, and embedded in people’s experiences across time. It is important to recognizing experience as key to narrative conceptions of hope. In this study, we explore the experiences of hope through narrative inquiry. Epistemologically, narrative inquiry is rooted in a Deweyan-informed theory of experience (Clandinin & Connelly, 2000) within which experiences are understood as continuous, interactive, and able to shape our identities, our stories to live by.

1.2 | Stories to live by: a narrative concept of identity

One of the key concepts within narrative understandings of experience is the narrative conceptualization of identity. Stories to live by, a narrative term for identity, are situated at the nexus of narrative understandings of context and knowledge (Connelly & Clandinin, 1999). Stories to live by give people meaning and purpose in life and shape the way people feel, think and behave. While stories to live by are sometimes expressed in told stories, they are also lived out as embodied expressions (Clandinin & Connelly, 2000). In developing a concept of stories to live by, Clandinin and Connelly drew on Kerby (1991) who wrote:

For the story of my life is always embedded in the story of those communities from which I derive my identity. I am born with a past; and to try to cut myself off from that past, in the individualist mode, is to deform my present relationships.

(p. 116)

According to Connelly and Clandinin (1999), stories to live by constitute not only what motivates us but also what shape our experiences in places where we live and work. Our stories to live by are who we are and are becoming, an unfolding view of identity making that shows that each of us are always in the making (Greene, 1995). People are embodiments of their stories to live by (Clandinin & Connelly, 2000).

1.3 | Research puzzle

Our research puzzle was shaped by awakening to feelings of disengagement from the first author’s practice as a nurse caring for PLWH. It was wonders about sustaining experiences of hope that brought us to our research puzzle. Using narrative inquiry, we wondered about how other nurses in Ghana working with PLWH in acute care settings experience hope. Or what sustains nurses’ hope when working with people living with HIV in an acute care setting?

2 | METHODOLOGY AND METHODS

Clandinin (2006) defined narrative inquiry as:

a way of understanding experience. It is collaboration between researcher and participants over time, in a place or series of places and in social interaction with milieus. An inquirer enters this matrix in the midst of living progress in the same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of experience that made up people’s lives, both individual and social.

(p. 20)

Clandinin (2013) asserts that narrative inquiry is an “approach to the study of human lives conceived as a way of honouring lived experience as a source of important knowledge and understanding” (p. 11). Clandinin and Rosiek (2007) argue that it is also important to understand experience in the context of social, cultural and institutional narratives. Narrative inquiry is qualitative method whereby resonant threads are identified across the experiences of participants. These threads reflect the temporality, continuity and the sociality of individual’s experience.

2.1 | Meeting participants

Following ethical approval from the University of Alberta Research Ethics Review Board, the Nuguchi Research Review Board and operational approval from the Korle-Bu Teaching hospital, the Director of a large regional unit for People with HIV was approached and asked for permission to talk with the nurses to inform them of this study. The Director was kind enough to introduce the corresponding author to several nurses at the unit. Following Wengraf (2001), the author followed a purposive sampling method to find participants. Five nurses were engaged, and the purpose of the study, the composition of field texts and the nature of the participation were explained. Following the interaction with the nurses, those who met the research criteria (at least 5 years of experience in HIV care) were invited to participate in the research. They were all interested and willing to participate in conversations over a year. Permission was sought from participants by means of written consent through
which their rights were outlined. They were subsequently met individually at the workplace or at home as agreed to have a conversation. Permission to use an audio recorder during conversations was granted. The consent language was English as all participants were fluent and comfortable with it. The participants were engaged in six to eight conversations or face-to-face interviews. Participants were constantly reminded that in qualitative studies researchers use quotes from the conversations to justify their analysis and that these quotes are sometimes used in presentations and publications. The participants were assured that their identities would be kept private and their real names would not be used.

2.2 | Data collection and analysis

During the first conversation, the participants were asked to describe memories of significant experiences in their past and present lives, and stories that they experienced as hopeful in their HIV nursing practice. In subsequent conversations, field notes and transcripts from previous conversations were reviewed to frame further topics. In this recursive process of data collection, we engaged in preliminary coding and analysis within the three-dimensional narrative inquiry space of temporality, place and sociality (Clandinin, 2013). Participants were asked for additional stories in light of previous conversations. Often participants described current daily experiences of hope and hope-related practices.

2.3 | Methodological rigour (trustworthiness of the study)

A research journal was maintained throughout the prolonged engagement of the course of the study to record personal observations, emerging ideas and the researchers’ role in the research process. At the completion of the conversations with each participant, a narrative account was written (Clandinin, 2013). Narrative accounts are composed to “give an account, an accounting, a representation of the unfolding of lives” (Clandinin, 2013, p. 132). The narrative account of each person’s experience was shared (member checking) with the participant, and further additions or revisions were negotiated with each participant. Narrative threads are then composed reflective of each participant’s experiences and are a means of viewing experiences. Threads are composed around plots or subplots in each person’s stories to live by that make up their experience. The several sources of data such as field notes, narrative account, conversations promote triangulation and credibility of the results.

3 | RESULTS

There were four narrative threads that resonated across participants’ stories to live by: becoming a nurse working with PLWHs over time; practising with hope despite hope threats; faith in God from which they gained strength; and learning to live with hope. Narrative threads are often complex and difficult to untangle (Clandinin & Connelly, 2000), yet they “offer a deeper and broader awareness of the experiences” (p. 132).

3.1 | Thread 1: becoming a nurse working with PLWH over time

While all participants initially accepted postings to the Service Unit (this is the name of the Unit where nurses predominately care for PLWH in the acute care setting) with feelings of anxiety, worry, uncertainty, confusion and perplexity, they all chose to stay on the Service Unit to work with PLWHs. They initially feared to work with PLWH because of fears of contagion (Chan et al., 2009). It was over time that they learned to become nurses working with PLWH.

All of the participants started their nursing journey in relation to HIV at different times. Eva was posted to the Service Unit over two decades ago after eight years of nursing. HIV at this time was well known and fear of it had already spread amongst the general population. Eva continued to work at the Unit despite the discrimination and name calling she experienced. Eva worked with PLWHs for almost two decades. Her stories to live by were shaped by the changing social and institutional contexts where she worked overtime. Eva began nursing when HIV was still a dread to many nurses. When she began nursing PLWHs, patients arrived in debilitated conditions. Eva was uncomfortable working on the Service Unit until she had worked there for a while. Her family was supportive. Her everyday life consisted of routines around patient care, patient education, providing medication for patients and patient and family counselling. There were times when Eva desired a reposting to relieve her of the trapped-in feeling. Over time, Eva saw that continuing to work at the Unit was an important learning experience for her.

Lana described being frightened when she arrived at the entrance of the Service Unit when she was first posted there:

Actually, for the first time I was transferred from another hospital to here. When I came, I was given a letter to come to the Service Unit. I was afraid. I became afraid. So I cried “aah” until one nurse came to meet me at the gate and asked why I was crying and I explained that I was transferred to this place but I am afraid and she said “oh don’t be afraid” so she took me here. She brought me here.

The experience of being transferred to the Service Unit shaped Lana’s life. She originally feared becoming an HIV nurse as did many nurses she came to know. The help and escort of a colleague helped her gain enough courage to enter the Unit:

Berth’s experience of HIV nursing was shaped by an anxiety associated with working with PLWH. Now that she is positioned as a
I recalled anxiously thinking in the early days of the HIV epidemic that infected patients needed to pray for God’s miracle. Clearly things have changed and I was delighted to be reminded that there was accessible treatment to prolong lives.

As an administrator and former HIV nurse, Berth is not alien to the setting. Her experiences were also shaped by her acknowledgement of her fear within the HIV landscape. She lived by stories of managing her fear and working with nurses to help them manage their fears.

Joy moved to the Service Unit as a nurse from a different non-specialized unit over five years ago. She also grew to become an HIV nurse over time:

First, when I came here, I said, this place I can’t work for long [due to fear of being infected] but now I don’t want to go out of this place. I can work even if they retain me here until I go on pension...I will be a source of happiness to a lot of people. Normally when they come for the first time, when I came here, when you see the patients you feel very scared but as time goes on and you keep on working and nursing you see them recovering you get some hope and then you also start feeling happy.

Joy learned to see that she could live a story of being a source of happiness for patients. Her stories of being courageous in her work with PLWH were shaped over time. Joy practised how to counsel, do referrals, review medications and how to take care of herself as she worked with PLWH.

Jude started nursing as an HIV nurse immediately after graduation:

After my training and the clinical rotation, I was posted to the Service Unit and basically, we take care of people living with HIV and AIDS. In fact, I was scared and my family as well was terrified.

Eventually, Jude accepted the challenge of working with PLWA and also she began to experience support from her family over time. She tells of how her life is shaped by her family support for her work. Her experience of becoming an HIV nurse was shaped by her deprived work setting that was shaped, in part, around the stigma of HIV and AIDS:

Formerly when there were no ARVs (antiretroviral drugs), we were losing most of our patients and then I will say there was no hope, but now with the introduction of the HIV drugs that is ARV therapy our patients can live, depending on their adherence to the

of people living with HIV/AIDS, so financially they don’t want to put in [money].

Jude also grew into the job and gained more understanding of HIV care. She is now relaxed to be part of HIV nursing care.

Resonating across the narrative accounts is that experiences of living with hope occurred over time, often stretching over changing social and institutional narratives around nursing PLWH. While the experiences of the participants differed, they all learned, over time, to live with hope. It was over time that they came to experience hope that sustained them.

3.2 | Thread 2: practising with hope despite hope threats

Participants particularly talked about their experiences in relation to attitudes towards PLWH. They expressed their hope more vividly nonverbally than they did when asked to describe their hope verbally. For example, Eva responded in the following way when asked how she expressed her hope in her practices:

Whatever you are doing, you have to brighten your face and you have to be approachable. To patients and patient relatives, even clients. Because you are nursing HIV patients you don’t always have to frown, you should be approachable so people will be drawn near, closer to you, so they [patients will] come out with whatever is worrying them.

The participants lived stories of hope as they related to PLWH and their families. All five nurses grew to overcome feelings around their fear of infection and their fears around the stigma of working with PLWH.

Each of the nurses experienced practising hope in ways that were coherent with their stories to live by. For Lana, hope was: “important because if you’re doing something and you don’t have hope it won’t end up well so whatever I am doing I have hope that it will be well.” She experienced hope as part of her stories to live by around the power of believing that situations would work out well. For Jude, her experiences of hopeful practice were connected to patients taking: “their treatment ... though it is not curable ... it prolongs their lives ... and because we are educating the patients and they know how to live positively in their lives”.

Joy’s experiences of hope were linked to her patients’ compliance and positive attitudes towards their illness. Joy said:

Formerly when there were no ARVs (antiretroviral drugs), we were losing most of our patients and then I will say there was no hope, but now with the introduction of the HIV drugs that is ARV therapy our patients can live, depending on their adherence to the
medication and then also being on a good diet by taking care of their nutrition and then adhering to what we tell them.

Joy’s experiences of hopeful practices resonated with the experiences of Eva, Lana and Jude. Joy’s stories to live by were threaded around her experiences of hope in patient recovery. Joy saw the crucial role of medication in patient recovery. For Jude, her experiences of hopeful practice were shaped by seeing: “other patients you already helped and they are recovering”. For Jude she experienced hopeful practice when “what you are doing when you continue seeing the patients are complying, you get good results. So, it encourages me to work more”.

For Berth, her experiences of hopeful practice involved working with “Models of Hope” patients. These are patients: “who use their lives as a source of encouragement to our clients. They use their lives as an example though they are people living with HIV but the way they take care of their lives is a way of encouragement to our clients.” The “Models of Hope” are clients who volunteer to educate other newly infected clients by forming support groups that meet regularly.

3.3 | Thread 3: faith in god from which they gained strength

A third narrative thread that resonated across the five nurses’ experience was linked to their experiences of being connected to their faith and their belief in the power of God. They described themselves as Christians signifying faith-based hope in God. Following the Christian Faith perspective, participants renewed their sense of hope by praying with their patients. For Berth, her stories to live by were shaped by sharing her faith with her staff and patients through the use of Scriptures:

_We have a waiting room there when they [PLWHs] come [and] we meet them, we talk to them. So, we give them words of encouragement. We use the Bible. We have pastors here who preach to them every morning and we encourage them with motivational words._

Joy told resonating stories of experience when she said:

_I am a Christian and I am a Presbyterian. And they say without hope you can’t please God. Without faith it is impossible to please God so what I say is you have to be determined. So, I don’t want people who when you want to do something, they tell you it can’t be possible. I want people who would say it would be possible because that is what God likes. He wants you to believe in Him because if you don’t believe in Him how can He trust you?_

Becoming more aware of how hope is interwoven in her experience, Joy’s courage in HIV care was strengthened as her relationship with PLWHs grew stronger. Joy was resolute in working alongside PLWHs. Joy’s story to live by was shaped by her faith community who believed in possibilities. This experience allowed her to overlook the discrimination and stigma as her hope in God continued to shape who she was and was becoming. Joy’s positive relationship with God strengthened her experiences of hope.

Eva also experienced faith in God that deepened her practices with HIV care. For Eva, it is essential to do the best and leave the rest to God. She said:

_We are doing our best. We are doing what we can, usually when you are scared of nursing them rather [that you lose strength] ... so you have to feel free and nurse them ...do what you are supposed to do and God will help you ... go through everything._

Jude also practised faith and renewed her sense of hope through prayer. Describing her faith in God and how patients’ recovery strengthens her hope she said:

_As a Christian I pray and I have hope and faith, everything. Moreover, too what gives me hope is you care for patient, the patient gets better. It encourages you when you meet other patients with or without the same status.

You know that with hope this patient will get better._

For Jude, her faith in God was also strengthened by experiencing the recovery of her patients. Jude’s hope in God influences her future outlook on patients’ quality of life, and she describes them as they “will get better,”

Resonating across all five narrative accounts was the participants’ belief in God as shaping their experiences of hope. Knowing that God sustained them made a difference in their stories to live by in that they were able to practise amid stigma and discrimination.

3.4 | Thread 4: learning to live with hope

A fourth resonant thread that echoed across the narrative accounts was related to the ways their experiences of hope in childhood shaped their stories to live by. While their experiences in general education (private or public), neighbourhoods, careers, single parent homes, poverty and personal characteristics appeared quite different, what resonated across the accounts were the ways that they and those around them, taught them to live with hope. They related the ways they learned to experience their lives in hopeful ways during their early life experiences. Some of these experiences included their ability to pursue their education in private and secondary schools, their contact with nurses during their early lives and
their interest in helping people. Eva spoke of learning to handle difficult situations with hope when she told of a childhood experience:

I was interested in people, I like people. And when somebody falls sick, I really feel for the person. I remember one day ... my mother (a seamstress) had this needle prick ... That’s a needle ... went direct into her nail and into the skin. I had to remove it, people were scared, everybody was scared, but I was feeling for her and I had that courage to remove it. I have ... that talent to care for people, so maybe that’s one also contributed in coming into nursing.

Eva also storied herself as courageous and as acting in heroic ways such as when she removed the needle from her mother. For Eva, this early life experience created a space for her to imagine herself as a nurse.

Jude, another participant, had contact with nurses during her early childhood in the neighbourhood where she grew up. Nurses were the customers who shopped at her mother’s store. This early childhood experience allowed her to see nurses as people who could compose a forward-looking story for herself. She said:

I stayed close to a hospital and my mom had a very big shop [convenience store] so the nurses, almost all the staff of the hospital, they do come around. So, from even there I would say I had in mind that I will work in the hospital, but I was thinking of doing Pharmacy.

Jude lived with this hope when she was growing up. It was the hope she experienced around finding ready employment in the nursing profession that made her choose nursing rather over more uncertain job prospects.

Joy lived hope in her early life by working hard while in junior secondary school to achieve her dreams and her hard work earned her a scholarship to continue her education to senior high school. Lana also lived experiences of hope even though she experienced poverty, an absent father and tensions with education. She said:

If I may relate it to my life... my father didn’t look after me. And it was my grandmother who looked after me. I couldn’t get life so easy. But I was hoping that I would become what I am today, I have seen that my hope has worked.

Lana experienced dominant patriarchal thinking about her education as the social conditions at her time did not favour women education. Nonetheless, the cultural, gendered and social narratives, which shaped her life contexts, did not stop Lana from pursuing her education.

Each participant’s stories to live by were shaped in their early years at home with their families, in schools and with their communities. These early experiences of learning to live in hopeful ways shaped the participants’ stories of working with PLWH. These early experiences also influenced the development of their identities as becoming nurses. Their evolving stories to live by continued to be ones that allowed them to experience their work with PLWH as hopeful ones.

4 | DISCUSSION

4.1 | Gathering threads

In this study, we puzzled over how nurses experienced hope in their HIV care work in their professional practice settings. We wondered how nurses experienced and sustained who they were and became in what could be seen as a work within a hopeless and difficult context. Through discerning narrative threads, we understood each nurse’s embodied ways of living over time with hope integrated practices (LeMay, 2014). The three-dimensional constructs [temporality, sociality and place] of narrative inquiry as offered by Clandinin and Connelly (2000) shaped the discussion of the findings. In other words, the discussion is done under the following headings:

4.2 | Temporality

Participants spoke often about their hopes that patients will report early during their illness, religiously take their medication and would make changes in their sexual life. A future orientation is one of the most commonly cited attributes of hope (Larsen, Edey, & LeMay, 2007). Indeed, speaking about hope in future terms opens the door to as yet unrealized possibilities (Dufault & Martocchio, 1985; Jevne & Nekolaichuk, 2003). For example, Joy viewed the future as dependent on client behaviour. As she put it, “I feel hopeful when clients report early.” Hope is when participants see clients not deteriorating. Further, Eva spoke about hope as a present-oriented phenomenon. In these terms, hope was believed to be ever-present in situations, waiting to be uncovered in simple moments or notable insights. Rather than questioning whether hope could be found in the present, Eva simply assumed the presence of hope.

The element of time has an impact on the nurses’ experiences of hope, at different places and with different people. For example, the period when the nurses were born opened doors to opportunities that gave them capacity to become nurses. The time of starting their schooling brought them to places of learning and hope. Other events brought up attributes of thinking, feeling and behaving in hopeful ways. For example, they ask about resources to manage the HIV epidemic, participants were also thinking about their own hope. Drawing on Clandinin and Connelly’s (2000) narrative conception of experience, every hopeful experience has a past, a present and is pointed to the future. Farran, Herth, and Popovich (1995) noted that before the arrival of antiretroviral therapy (ART), persons with...
a diagnosis of AIDS had significantly lower levels of hope than persons with other terminal diagnoses. This low hope in HIV patients was mirrored in some ways by nurses’ experiences of working with PLWH. Initially, the participating nurses experienced fear when they were assigned to the Service Unit. It was at this time that Eva and Berth both worked as nurses in the HIV setting. It could be argued that it was the availability of antiretroviral (ARV) therapy that calmed their fears and allowed them to be more hopeful. Indeed, ARVs allowed them more hopeful experiences as the patients began to live longer.

4.3 | Sociality

Sociality, another dimension of narrative inquiry, draws “attention to personal conditions and, at the same time, social conditions where personal conditions include feelings, hopes, desires, aesthetic, reactions and moral dispositions of both inquirer and participants” (Clandinin, et al., 2017, p. 24). Hope is experienced in relation with meaningful connections with others, a higher power and oneself (Larsen et al., 2007). Participants in this research repeatedly echoed the connection of their faith in God to hope. The participants experienced strong faith commitments and strong personal beliefs in God. Their experiences of believing in God helped sustain them as they cared for PLWH.

The participants experienced stigma as a threat to hope. This opens the door to thinking and feeling stigmatized. This hope threat is not the single outcome of stigma. Mill et al. (2013) point out that nurses who provide care for PLWH also have concerns about their well-being and health, the complexity of their role and the HIV care-related stigma. They showed that making hope visible can help nurses overcome some of the uncertainties and the fear about HIV. The conversations we engaged in with each nurse about who they were as nurses who care for PLWH helped them make their own practices of hope more visible to the authors but also to themselves.

4.4 | Place

Clandinin et al. (2016) defined place as “the specific concrete and physical topological boundaries of place or sequence of places where the inquiry or the events take place” (p.24). The conversations were opened at the Service Unit. The nurses told stories of their experiences of growing up, attending school and of practising nursing. The nurses carried with them memories of the places where they experienced hope. Eva, Lana, Berth, Joy and Jude shared many stories of places such as the hospitals of their births, their neighbourhoods, schools, the Nurses Training College and places of work. Lana recalled her tears at the Service Unit entrance gate where she felt hopeless. This place of entry into HIV nursing reminds her of her experiences with hope threats. Her hope was interwoven with this place and it became part of her stories to live by. Unlike Eva, Berth and Joy who were born in the city, Lana and Jude had rural neighbourhood experiences. Place shaped their experiences as they spoke of the need to feel safe in their work unit. Berth and Lana pointed out that the structures of the Service Unit need renovation and replacement. Jude said, “For years working here I have realized that people don’t have hope in the result or the outcome or recovery of people living with HIV/AIDS, so financially they don’t want to put in [money]”. As we listened to Jude’s story of her experiences in the Service Unit, corresponding author was reminded of a nurse’s comments several years ago that sparked this research puzzle reverberating forward—especially when stated, “Let him die, he has given it to many people.”

4.5 | Limitation

This study involved five participants working in a unique HIV setting and therefore can only speak to experiences of hope in that setting. The stories are co-composed with the participants and focused on the experiences, which depended on the memories and stories they chose to share.

5 | IMPLICATION FOR NURSING PRACTICE

The study showed that the five participating nurses learned, over time, to sustain their practices. It is important that nurses’ voices are heard in policy formulations to influence decisions that affect PLWH and the nurses who work with PLWH. This can be done through active participation in lobbying and initiating policy change actions such as presentations at forum or seminars. Policies that support nurses’ experiences of engaging in hopeful practices may, over time, reduce their experiences of hope threats, that is reduce what can cause them to stop engaging in hopeful practices. In this sense, the present study is especially timely in the face of the stigmas that HIV nurses face daily in their work. The experiences of the nurses provide insight into the larger cultural, social and institutional narratives that shape all nurses’ experiences of working with PLWH. The nurses’ experiences also spoke to the social stigma, emanating from cultural beliefs of the promiscuity of persons who contract HIV, phenomenon associated with fear of contagion. These reflectors of the cultural, social and institutional narratives are related to the nurses’ experiences of hope and provide important information about HIV as a social illness in the health landscape.

6 | CONCLUSION

In this study, we explored the puzzle of how nurses working with PLWH experience hope. It shows that participating nurses’ experiences are shaped over time as they work with PLWH, as they learned to practise with hope. In this sense, the nurses’ hopes were initially
shaped during their early years. This study also pulled forward the importance of understanding how nurses experienced working with PLWH and suggests that their hopeful practices can be sustained through support and professional development. This study made visible shifting identities, among the Ghanaian nurses as they shaped and are shaped by the professional and personal landscapes and relationships where they live and work.

ACKNOWLEDGEMENT

We wish to acknowledge the participants who offered their time and energy; they generously shared their experiences with us. We also wish to thank the Faculty of Graduate Studies and the Faculty of Nursing at the University of Alberta for the travel grants to Ghana. Dr. Vera Caine is supported by a CIHR New Investigator Award.

CONFLICT OF INTEREST

The authors report no real or perceived vested interests that relate to this article that could be construed as a conflict of interest.

ORCID

Gideon L. Puplampu https://orcid.org/0000-0002-1975-596X

REFERENCES

Chan, K. Y., Rungpueng, A., & Reidpath, D. D. (2009). AIDS and the stigma of sexual promiscuity: Thai nurses’ risk perception of occupational exposure to HIV. Culture, Health and Sexuality, 11(4), 353–368.

Clandinin, D. J. (2013). Engaging in narrative inquiry. Chicago, MI: Left Coast Press.

Clandinin, D. J., & Connelly, F. M. (2000). Narrative inquiry: Experience and story in qualitative research. Mahwah, NJ: Lawrence Erlbaum.

Clandinin, D. J. (2006). Narrative Inquiry: A Methodology for Studying Lived Experience. Research Studies in Music Education, 27(1), 44–54. https://doi.org/10.1177/13211033060270010301

Clandinin, D. J., Dubnewick, M., Lessard, S., & Mchugh, T-L. (2017). The Centrality of Reflexivity Through Narrative Beginnings: Towards Living Reconciliation. Qualitative Inquiry, 24(6), 413–420. https://doi.org/10.1177/1077800417727762

Clandinin, D. J., & Rosiek, J. (2007). Mapping a landscape of narrative inquiry: Borderland spaces and tensions. In D. J. Clandinin (Ed.), Handbook of narrative inquiry: Mapping a methodology (pp. 35–76). London, UK: Sage.

Connelly, F. M., & Clandinin, D. J. (1999). Shaping a professional identity: Stories of educational practice. New York, NY: Teachers College Press.

Dufault, K., & Martocchio, B. C. (1985). Hope: Its’ spheres and dimensions. Nursing Clinics of North America, 21, 379–391.

Farran, C. J., Herth, K. A., & Popovich, J. M. (1995). Hope and hopelessness: Critical clinical constructs. Thousand Oaks, CA: Sage.

Greene, M. (1995). Releasing the imagination: Essay on education, the arts and social change. San Francisco, CA: Jossey-Bass.

Ha, P. N., Chuc, N. T. K., Ho, T. H., Larsson, M., & Pharris, A. (2013). HIV-related stigma: Impact on healthcare workers in Vietnam. Global Public Health, 8(1), 61–74. https://doi.org/10.1080/17441692.2013.799217

Havel, V. (2004). An orientation of the heart. In P. R. Loeb (Ed.), The impossible will take a little while: A citizen’s guide to hope in a time of fear (pp. 82–98). New York, NY: Basic Books.

Jevne, R. F., & Nekolaichuk, C. L. (2003). Threat and hope in coping with cancer for health care professionals. In R. Jacoby, & G. Keinan (Eds.), Between stress and hope: From a disease-centered to a health-centered perspective (pp. 187–212). Westport, CT: Praeger Publishers.

Kerby, A. P. (1991). Narrative and the self. Bloomington, IN: Indiana University Press.

Larsen, D., Edey, W., & LeMay, L. (2007). Understanding the role of hope in counselling: Exploring the intentional uses of hope. Counselling Psychology Quarterly, 20, 401–416. https://doi.org/10.1080/09515070701690036

LeMay, L. M. (2014). A narrative inquiry into teachers’ experiences of working with hope. Unpublished doctoral dissertation. Edmonton, AB: University of Alberta.

Mill, J., Harrowing, J., Rae, T., Richter, S., Minnie, K., Mbalinda, S., & Hepburn-Brown, C. (2013). Stigma in AIDS nursing care in sub-Saharan Africa and the Caribbean. Qualitative Health Research, 23(8), 1066–1078. https://doi.org/10.1177/1049732313494019

Rowan, D., Lynch, S., Randall, E., & Johnson, H. (2015). Deconstructing burnout in HIV service providers. Journal of HIV/AIDS & Social Services, 14(1), 58–73. https://doi.org/10.1080/15381501.2014.912178

Wengraf, T. (2001). Qualitative research interviewing: Biographic narrative and semi-structured methods. Thousand Oaks, CA: Sage.

How to cite this article: Puplampu GL, Caine V, Clandinin JD. Sustaining hope: A narrative inquiry into the experiences of hope for nurses who work alongside people living with HIV in Ghana. Nursing Open. 2020;00:1–8. https://doi.org/10.1002/nop2.465