

**Attitudes and personal behaviours of professional health care personnel towards
fellow employees living with HIV/AIDS**

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Declaration

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Abstract

The study was undertaken to establish professional health care personnel's attitudes and personal behaviours towards their colleagues living with HIV and AIDS in a rural government hospital, Mokhotlong - Lesotho. Three fundamental principles from the Belmont report (1976) generally guided the ethical measures engaged in this study; beneficence, respect for persons and justice. Quantitative methodology was used to elicit information; due to the personal nature of some of the questions inherent in an instrument that questioned personal values and attitudes, the research chose the instrument to be a self-administered questionnaire.

The population of this study included 39 professional healthcare personnel from six different disciplines, however, the researcher categorised them into three main strata, namely: medical services (12.8 %, n = 5), nursing services (59.0 %, n = 23), and support services (28.2 %, n = 11). The results of this study has indicated that, a vast majority of the respondents had very positive attitudes and supportive behaviours towards PLWHIA and/or their CLWHIA.

It is important for the institution to design and implement HIV/AIDS related programs, activities and policies that can provide support to both professional and non-professional health care personnel about HIV/AIDS-related issues; such as shaping their personal behaviours and attitudes towards HIV infection, as well as promoting care for PLWHIA and/or their CLWHIA and opposing stigmatization.

Opsomming

Die doel van hierdie studie was om die houding en persoonlike gedrag van professionele gesondheidswerkers teenoor kollegas, wat MIV-positief is, te bepaal. Die studie is onderneem in 'n landelike hospitaal in Mokhotlong, Lesotho.

'n Steekproef van 39 professionele gesondheidswerkers is vir die studie gebruik.

Hierdie gesondheidswerkers het ses verskillende dissiplines verteenwoordig en is deur die navorsing in drie strata, naamlik mediese dienste, verpleegdienste en ondersteuningsdienste verdeel.

Resultate van die studie toon aan dat die meerderheid van die proefpersone wel 'n goeie kennis van MIV/Vigs het en dat hulle 'n positiewe houding het teenoor teenoor mede-werkers wat met MIV leef.

Die studie beveel aan dat instellings MIV/Vigs-verwante programme moet ontwikkel en implementeer ten einde steun te verleen aan professionele en nie-professionele gesondheidswerkers wat met persone werk wat MIV-positief is. Die programme moet veral bevorderlik wees vir die bou van gesonde houdings teenoor MIV-pasiënte en moet ook daarop gemik wees om stigma te verminder.

List of abbreviations

AIDS	Acquired immune deficiency syndrome
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CLWHIA	Colleagues Living with HIV and AIDS
CHAL	Christian health association Lesotho
GOL	Government of Lesotho
HIV	Human immunodeficiency syndrome
MCHIP	Maternal and Child Health Integrated Program
MOH	Ministry of Health
ILO	International Labor Organization / Office
PEP	Post - Exposure Prophylaxis
PLWHA	Person/people living with HIV and AIDS
UNAIDS	United Nations Program on HIV and AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

BACKGROUND

In Sub-Saharan Africa, United Nations programme on HIV and AIDS (UNAIDS) report shows that more than 22 million people are living with HIV/AIDS, while a proportion of over 5 million people each year contract the Human Immuno-Deficiency Virus (HIV) (UNAIDS/ World Health Organisation, 2009:27). The report goes on to say that the Southern African countries continue to bear the brunt of the global epidemic, having an adult HIV prevalence rate above 10%. In addition, almost 90% of the people living with HIV and Acquired Immuno-Deficiency Syndrome (AIDS) in this region are adults between 15 – 49 years of age (ILO, 2006: 11). Among the nine southern-most countries in Africa, Lesotho has the highest adult HIV/AIDS prevalence rate, estimated at 23. 2% with about 70 HIV/AIDS-related deaths daily (Khobotlo, 2009) in (UNAIDS/WHO, 2009: 26)

In response to the HIV epidemic, Lesotho drew up the National AIDS Strategic Plan (NASP) in the year 2000. This strategic plan was last replaced in 2006. The aim of the strategic plan was to frame the response of the government to the impact of HIV and AIDS. Contained in the plan was a strategy to assist the country in developing various policies that were meant to direct various sectors of government including the health sector, in mitigating the impact of HIV and AIDS. Some of the policies developed related to the behavioural response policies, bio-medical frameworks for HIV and AIDS and even structural response to the epidemic.

Inherent within the NASP, is that organisation should have policies that address HIV/AIDS within the workplace. Mokhotlong hospital, which is a government owned hospital in Lesotho, does not have institutional HIV/AIDS policies that address its own professional health care personnel. This lack of policy related to HIV and AIDS may affect regulation regarding treatment and management of professional health care personal who are affected and infected by HIV and AIDS.

According to Pharoee, (2008: 7) the impact of the HIV/AIDS has been identified as a major factor that is accentuating high attrition rate of the working population,

this includes professional health care personnel in Lesotho. The ill-effects of poor support to professional health personnel living with HIV and AIDS may result in low morale and high levels of professional health personnel attrition (Pharoe, 2008: 7 - 11).

1.2. PROBLEM STATEMENT

In Lesotho's Health sector facilities; there are still no HIV and AIDS programs, policies, or activities that are specifically targeting the working population and their direct dependants in the workplace (Government of Lesotho, 2007: 7). Professional healthcare personnel seem to initiating themselves on ART without following standard operating procedures, and other professional healthcare personnel seek their HIV/AIDS services from other hospitals. Anecdotal evidence from Mokhotlong Government hospital suggests that the attitudes of professional health care personnel in the same facility hinders them from accessing treatment and care related to HIV/AIDS with confidentiality. According to Dray-spira and France (2003: 283), the need to address the attitudes of professional healthcare personnel towards HIV positive colleagues should be accommodated to allow the continued employment of such individuals. Therefore, the purpose of this study is to describe the attitudes and personal behaviours of professional healthcare personnel at Mokhotlong Government Hospital regarding the treatment and care of professional healthcare personnel living with HIV/AIDS at the workplace.

1.3. RESEARCH QUESTION

What are the attitudes and personal behaviours of professional healthcare personnel towards health care workers living with HIV/AIDS in Mokhotlong Government Hospital?

1.4. AIMS AND OBJECTIVES OF THE STUDY

1.4.1. Aim of the study:

To describe the attitudes and personal behaviours of professional healthcare personnel towards health care workers living with HIV/AIDS in Mokhotlong Government Hospital.

1.4.2. Research objectives:

The study sought to;

- a) To identify attitudes of professional healthcare personnel towards health care workers living with HIV/AIDS in Mokhotlong Government Hospital.

- b) To identify the personal behaviours of professional healthcare personnel towards health care workers living with HIV/AIDS in Mokhotlong Government Hospital.
- c) To describe possible solutions that can promote a non-prejudicial working environment for professional health care personnel living with HIV/AIDS at Mokhotlong Hospital.

1.5 SIGNIFICANCE OF THE STUDY

The study is of value to the management of Mokhotlong hospital, as it illuminates the challenges that are faced by health care workers living with HIV/AIDS in their facility thus underpinning the development of a hospital specific HIV/AIDS policy. Results from this study may be used to influence staffing patterns and allocation of professional healthcare personal within the hospital departments thus accommodating health care workers living with HIV/AIDS. Anti-stigma interventions which are tailored for professional healthcare personnel may be developed by the Ministry of Health based on their attitudes and personal behaviours.

1.6 CONCLUSION

The research assignment will be presented in five chapters numbered in words (one, two, three and four). The current chapter (one) has highlighted the background of the study, the problem statement, the aims and objectives of the study. The chapter further discussed the significance of this study. The next chapter (two) will entail the reviewed literature on the existing knowledge of the study. When chapter three will clearly articulate the entire research process with the research design and methods used in this study. The fourth chapter (chapter four) will clearly outline the summary of results as well as the discussion of findings, while the last chapter (chapter five) will cover both the concluding remarks and the recommendations made.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter reflected an overview of the study. This chapter will discuss literature reviewed in enhancing the description of the attitudes and personal behaviours of professional healthcare personnel regarding HIV/AIDS. The discussion will be framed under three main concepts underpinning the study namely, attitudes, personal behaviours and professional healthcare personnel all in the context of HIV/AIDS in the work place.

2.2 Attitudes

Muoghalu and Jegede (2011: 355) defined attitude as a complex tendency of persons to respond in positive or negative ways. Attitudes are formed through experience and contact with the world around us. Attitudes toward PLWHIA have been shown to be prevalent in most countries, and professional health care personnel may be affected by either positive or negative attitudes that exist in the local community (Abdebajo, Bamgbala, & Oyediran, 2003 in (Tartakovsky and Hamama, 2013: 569). For example, in a study which was carried out in Oyi local government of Anambra state, Nigeria; the community locales (the Anambra people) defined HIV and AIDS as a very serious disease and their attitudes to PLWHIA are their normal attitudes toward sick relations. Unlike the Anambra state, Lesotho's unique topography has resulted in Basotho (professional health care personnel included) living and working in different geographical areas of the country, having different cultural practices, values, attitudes and beliefs about health (Stender, Phafoli, Christensen, Skolnik, Nyangu, Lemphane, Ramokhitli and Whalen, 2014: 3).

Furthermore, personal attitudes are often influenced by the perception of how other individuals in a social group behave and may also result from a blend of social reality and personal interpretation (Li, Comulada, Wu, Ding and Zhu, 2011: 105).

According to the historical evolution of HIV in the USA, the disease was associated with behaviors that fell out of the societal norms such as prostitution, homosexuals,

and intravenous drug users (Herek and Glunt, 1988 in Li et al, 2011: 110). These 'deviants' from the societal norms were therefore reduced from accepted people to discounted ones, thus isolating the individual from the societal acceptance (Goffman, 1963 in Muoghalu and Jegede, 2011: 354).

In the absence of any plausible explanation, professional health care personnel's HIV-related avoidance becomes a reflection of the existing general attitudinal problems towards all sick relations (HIV/AIDS and PLWHIA included) in their communities. Petro-Nurstas (2002) in Ozakgul, Sendir, Atav and Kiziltan (2013: 929) substantiated the point that the attitudes of professional health care personnel towards their colleagues living with HIV/AIDS are affected by both cultural differences and fear of contracting the infection, resulting in unsupportive attitudes towards PLWHIA, including their CLWHIA.

Today, negative attitudes are more prevalent among professional health care personnel through labelling, ignorance, communicating in a minimal way, verbal harassment, avoidance and using unsuitable isolation techniques, and refusing to care for PLWHIA (Walusimimbi and Okansky, 2004) in (Ozakgul et al, 2013: 929).

Against this background, as people develop, they usually acquire a set of beliefs and attitudes that in part influence how they interact and this may be altered by new experiences and information (Davis and Houghton, 1995 in Muoghalu et al, 2011: 355). According to Li, Comulada, Wu, Ding and Zhu (2011: 110), the educational preparation of professional health care personnel providing care to PLWHIA (including caring for their CLWHIA) and use of universal precaution supplies and procedures in the hospital have been known to affect professional health care personnel's attitudes and the effectiveness of the care provided to this group. In Lesotho, nurses are considered to be the frontline professional health care personnel who provide the majority of HIV and AIDS care services to the Basotho population. Seeing that they are well prepared educationally, Lesotho Ministry of Health (MOH) is working closely with Maternal and Child Health Integrated Program (MCHIP) and the Christian Health Association of Lesotho (CHAL) to build sustainable capacity in nursing pre-service education (Stender, Phafoli, Christensen, Skolnik, Nyangu, Lemphane, Ramokhitli and Whalen, 2014: 3).

In a very sharp contrary, demographic impacts of HIV and AIDS are seemingly unstoppable because the health sector all-round the globe has been found to be one of the major areas in social life where PLWHIA, professional health care personnel included often suffer discriminatory attitudes of all sorts (Sadoh, Fawole, Sadoh, Oladimeji and Sotiloye, 2006: 40). Li et al (2011: 109) suggested that organizational culture could affect professional health care personnel attitudes and thereby affect management of HIV/AIDS in the workplace. Institutional norms within each hospital can play an integral role and result in various levels of avoidance attitudes towards CLWHIA among the hospitals involved. Institutional norms could also be influenced by other factors such as education, training and policy implementation (Li et al, 2011: 110).

2.3. Personal behaviour

The health care setting is a context where prejudicing behaviors against PLHIA and/or CLWHIA are found (Myblade, 2006 in Yiu, Mak, & Chiu, 2010: 1). Prejudicing behaviours against CLWHIA in the medical setting are mostly based on social judgements of the behaviour of CLWHIA that are inconsistent with the social values and beliefs of the person making that judgment (Yiu, Mak, & Chiu, 2010: 1).

Studies have shown that gender, sex, ethnicity, and family status are not strongly related to professional health care personnel's behaviors toward their colleagues living with HIV/AIDS (Brown, MacIntyre, & Trujillo, 2003 in Tartakovsky and Hamama, 2012: 3). According to Tartakovsky and Hamama, (2012: 3) it is stated that behaviours most often related to socially disapproved acts in western countries like Turkey are drug use and/or sexual activity. For example, even though close to 80% of the HIV/AIDS cases in Turkey are a result of heterosexual contact; a Turkish man living with HIV and AIDS might be assumed to be homosexual, bisexual or having slept with a sex worker. On the contrary, a Turkish woman living with the infection might be assumed to be a sex worker. (Republic of Turkey Ministry of Health, 2011 in Tartakovsky and Hamama, 2012: 3).

Studies also reported that professional health care personnel exhibited discriminatory behaviours toward their colleagues living with HIV/AIDS through the form of inappropriate comments, breaches of confidentiality, delayed treatment, or refusal of treatment (Reidpath and Chan, 2005 in Yiu, Mak, & Chiu, 2010: 1)

Length of practice in the field of HIV and AIDS care services has also been related to more supportive personal behaviors toward CLWHIA (Brown, 2003 in Tartakovsky and Hamama, 2012: 3). Researchers assume that prolonged or increased contact with PLHIA help increase professional health care personnel's empathy toward their colleagues living with HIV/AIDS (Pettigrew and Tropp, 2008 in Tartakovsky and Hamama, 2012: 3). More years of university studies, as well as special training and additional education related to HIV, have being associated with more supportive behaviours toward PLWHIA / CLWHIA (Adebajo, Bamgbala, and Oyadiran, 2003 in (Tartakovsky and Hamama, 2012: 3).

2.4 Professional Health care personnel

According to Kaponda, Jere, Chimango, Chimwaza, Crittenden, Kachingwe, McCreary, & Norr (2009), it is stated that nowhere in the globe is the tragic negative effects of HIV and AIDS more apparent than in the nine southern-most countries in Africa, Lesotho included. Much has been written about negative attitudes and unsupportive behaviours towards PLWHIV in this region, and has extended their impact into the world of work. Conclusively, stigmatizing against HIV positive employees can prominently hamper HIV prevention efforts in the working environment (Tee and Huang, 2009: 180).

It is therefore an undeniable fact that HIV and AIDS among many other pandemics of infectious diseases can adversely affect the world of work in the African continent, the health sector included (Tee and Huang, 2009: 179). The HIV/AIDS pandemic is surrounded by ignorance, fear, prejudice, and discrimination in the field of health. Unless the social and economic impact of the disease in the health sector is addressed, many more young, highly-skilled, and economically productive professional health care personnel will be lost to ignorance and HIV/AIDS. And in a future that is nearer than we think, the health workforce in Sub-Saharan Africa will later lose millions of their young doctors, nurses, laboratory and pharmacy technicians to avoidable AIDS-related illnesses and deaths (Tee and Huang, 2009: 180).

In an organizational setting, people are usually collected together to achieve a wide variety of goals – goals such as achieving certain levels of power and prestige, as well as enjoying a satisfying work experience (Schultz, Bagraim, Potgieter, Viedge & Werner, 2006: 5). But the general staff in a hospital setting are often confronted with a

daunting challenge of being in the same working environment where there is a close contact with their CLWHIA. According to Li et al. (2011: 105), it is stated that stigma and discrimination towards CLWHIA remain prevalent in medical setting and prevents professional health care workers from being tested.

In respect to the infrastructure and the workplace setting, much has been written about HIV-related stigma and discrimination as major barriers to HIV care services for professional health care personnel; while in some health facilities, professional health care personnel are made to publicly queue alongside their clients for HIV/AIDS care services (Fesko, 2001 in Twinomugisha, Daniel and Lie, 2011: 38 - 39).

According to Vries, Galvin, Mhlangu, Cindzi, and Dlamini (2011: 1758) it is stated that many health workers fear that clients or patients will definitely lose trust in them as they will be noticed as Hippocrates and unable to comply with their own health messages. Consequently, there is a significant under-utilization of HIV and AIDS care services by professional health care personnel in their respective workplaces all over the globe; they resort to seeking HIV/AIDS care services in the far-away places from where they work and live, which incurs more burden on the financial aspect of the HIV positive health care personnel (Vries et al., 2011: 1758 - 1759).

The crisis of poor management of HIV and AIDS epidemic in the health sector has been aggravated by the corrupt and unethical practices such as denial of equal employee benefits, unfair dismissal for being HIV positive, and unnecessary pre-employment HIV testing (Li et al., 2011: 105). Among professional health care personnel, the clinical application of patient's right to confidentiality, self-determination, and informed consent are critical with a diagnosis of HIV/AIDS (Relf, Laverriere, Devlin & Salerno, 2009: 1449).

2.5 Conclusion

Based on the reviewed literature presented in this section, prejudicing attitudes and behaviours of professional health care personnel towards CLWHIA often result from a blend of social reality and personal interpretation. In the absence of any plausible explanation, it can be concluded that professional health care personnel's HIV and AIDS – related avoidance becomes a reflection of the pre-existing general attitudinal and behavioural problems towards all PLWHIA in their respective communities. The next chapter will outline the methodology used in the study; looking at the research design, the population and sampling, data collection procedures, and lastly the Belmont report's principles (1976) as the primary ethical basis for the protection of the rights and welfare of the people who participated in this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter presented a summary of literature that was used to frame the study. The current chapter will discuss the methodology used in achieving the aim of this study. The research design will be discussed first, then the population and sampling. The chapter will present lastly measures engaged to enhance ethics and reliability and validity of the results of the study.

3.2 RESEARCH DESIGN.

This study utilised a simple descriptive quantitative research design. Descriptive research is research that has as its main objective the accurate portrayal of the characteristics of persons, situations, or groups, and/or the frequency with which certain phenomena occur (Polit and Beck, 2008: 753). The researcher chose to utilise this design as its main aim resonated with the overall purpose of this study which was to describe the attitudes and personal behaviours of professional healthcare personal towards health care workers living with HIV and AIDS.

3.3 POPULATION

The population of a study refers to the entire set of individuals or objects, having some common characteristics (Polit and Beck, 2008: 761). In this study the population will include all professional health care workers at Mokhotlong government hospital. As of 2015 there were 55 professional healthcare workers that were employed by the Hospital.

3.4 SAMPLING

A sample is defined as a representative of the total population and the researcher needs to define a criteria of inclusion into the sample and the process of sampling. Sampling will be described through specifications of the inclusion criteria and the sampling technique.

3.4.1 Inclusion criteria

The inclusion criteria of this study was;

- Professional healthcare personnel with training in health care for more than a year
- Above the age of 18 years
- Mentally stable

However, due to the sampling technique employed each stratum had specific inclusion criteria.

3.4.2 Sampling technique

Sampling is the process of selecting a portion of the population to represent the entire population. The research engaged stratified sampling techniques which involves the selection of a study participants of two or more strata from a population independently (Polit et al, 2008: 767). The population of this study included professional healthcare personnel from six different disciplines, however, the researcher categorised them into three main strata, namely: medical services which included medical officers, anaesthetists and dentists; nursing services which included registered nurses and trained nurse assistants and support services including X-ray technicians, Laboratory technicians, physiotherapists, Pharmacy technicians and nutritionist. The following description will reflect how the participants were included in the study per strata.

- **Strata One: Medical Services.**

All professional healthcare personnel within these strata were included in the study (n=5).

- **Strata Two: Nursing Services.**

The research refined the inclusion criteria to include at least two years of employment experience at Mokhotlong Hospital. This decision was used to reduce the possibility of a sampling bias thus enhancing representativeness of the overall population. Polit and Beck (2008; 765) define sampling bias as the distortions that arise when a sample is not representative of the population from which it was drawn. In this study, most (23) of the professional healthcare personnel are in nursing services.

- **Strata three: Support Services**

All members (n= 11) of the support services were included in the study.

Therefore, the total number of the sample was 39.

3.5 RESEARCH TECHNIQUE

The research technique involves an in-depth description of strategies the researcher used in collecting the data and how the instrument for collecting data was generated. Due to the personal nature of some of the questions inherent in an instrument that questions personal values and attitudes the research chose the instrument to be self-administered. Self-administered refers to a situation when a respondent completes the instrument themselves, usually on a paper and pencil instrument (Polit and Beck, 2008: 414). Such a technique enhanced the quality of the data generated and reduced any form of influence from other respondents.

The question was crafted based on literature that examined attitudes and personal behaviours of professional healthcare personnel. The questionnaire was divided into three sections namely; demographics of the participants, the attitudes of the participants and personal behaviours. The first section of the questionnaire (the demographic data sheet) included basic demographic variables such as age, gender and marital status, professional background, employment history and work experience in the patient care area. The responses of the last two sections were based on a five point Likert-type scale of which the responses were classified in an ordinal scale. Ordinal scale is a measurement level that will rank phenomena along some dimensions of which in this study attitudes and personal behaviours were classified in a scale of negative to positive (Polit and Beck, 2008: 760). The researcher calculated the scores by summing the overall number of correct responses ($n = x$) and converting to percentage ($x / 100$ multiply by 39 = %). Respondents with lower scores on attitudes had negative attitudes while those with higher scores meant they had positive attitudes. In a similar manner, higher scores represent a more supportive behaviour toward Colleagues living with HIV/AIDS while those with lower scores meant they had unsupportive behaviours.

3.6 DATA COLLECTION

The researcher sought the approval of authorities in the Ministry of Health - Lesotho (Director General Health Services - DGHS) before the actual field work. The research protocol, letter of intent, and the questionnaire were submitted to Lesotho's National Health Research and Ethics Committee (NHREC) for clearance, approval and registration. January 2015, the study was authorized and given a reference number (ID01-2015). The management team of the selected place of study (Mokhotlong Government Hospital in Mokhotlong) received a formal communication from the office of DGHS informing them about the study.

Customarily professional health care personnel working at Mokhotlong Hospital were holding a monthly educational event (every first Wednesday of the month in a hospital's library, at 10h00 to 11h00), known as Mokhotlong Government Hospital Clinical Meeting (MGHCM). The event was aimed at facilitating inter-disciplinary learning among medical services, nursing services and support services staff on the latest research findings, updates on medical breakthroughs, policies or technological enhancements to clinical practices. In one of this meetings, the researcher took an opportunity to verbally provide the potential respondents with the purpose of the study, assurance of confidentiality and anonymity.

To be eligible for participation in this study, the respondents had to be professional healthcare personnel aged 18 years or older with training in health care for more than a year. The researcher therefore distributed questionnaires to readily available potential respondents who voluntarily agreed to participate in the study by signing the informed consent forms. The respondents were given five working days to complete the questionnaire. They were allowed to complete the questionnaire in their own respective departments where they would feel more free and secure. There was one designated location (drop box) in each chosen site or spot for the respondents to deposit completed questionnaires (1 = administration block, 1 = Outpatient department, and 1 = maternity ward respectively).

3.7 VALIDITY AND RELIABILITY

Validity is defined as a quality criterion referring to the degree to which inferences made in a study are accurate and well-founded; in measurement, the degree to which an instrument measures what it is intended to measure (Polit and Beck, 2008: 768). While reliability is the degree of consistency or dependability with which an instrument measures an attribute; putting it succinctly statistical reliability refers to the probability that the same results are an accurate reflection of a wider group than just the particular people who participated in the study (Polit and Beck, 2008: 196). The questionnaire was firstly reviewed by the research supervisor, and all the study documents and procedures were approved by Departmental Ethics Screening Committee (DESC) at Stellenbosch University for opinion on reliability, ambiguity, layout, and appropriateness of the questions.

3.8 ETHICAL CONSIDERATIONS

Ethical principles for the protection of the rights and welfare of human subjects of research were respected in this study. The researcher cited the Belmont report (1976) as the primary ethical basis for the protection of the rights and welfare of the human subjects. The report is defined as a statement of basic ethical principles and guidelines that provide an analytical framework to guide the resolution of the ethical problems arising from biological and behavioral researches with human subjects. The Belmont report (1976) consists of three basic principles namely; respect for persons, beneficence and justice (De Landa, 2009: 2).

3.8.1. Respect for persons

The Belmont report (1976) defined respect for persons as the principle used to protect the rights of vulnerable populations or Individuals with diminished autonomy such as children, mentally handicapped and elderly people (De Landa, 2009: 2). In this study, subjects were treated as autonomous agents; they were given an opportunity to stop participating to the study at any time without repercussions.

The researcher obtained the ethical approval to undertake the study from Stellenbosch Departmental Ethics Screening Committee (SU – DESC) and National Health Research and Ethics Committee (NHREC) in Lesotho (Addendum 2 and 3 respectively) The study sample included a total number of thirty-nine ($n = 39$) professional health care personnel

who were working at a participating government hospital (Mokhotlong), aged eighteen (18) and older, mentally stable and voluntarily agreed to participate (informed consent was obtained).

3.8.2. Beneficence

The principle of beneficence is defined as a fundamental ethical principle that seeks to minimize benefits for the study participants, and prevent harm (Polit et al, 2008: 748). The study used an anonymous questionnaire and there was no way to identify the respondents based on their responses. Psychosocial support and counseling services were also made available during the study in order to mitigate the risk of discomfort some respondents might experience when completing the questionnaire.

3.8.3. Justice

According to De Landa (2009: 3), the desirability of the most equal distribution of burdens, risks and benefits of research is a much more pressing requirement of justice in the Belmont report (1976). The report and similar ethical frameworks for protecting human subjects in the field of research urge a stance of equality and fair distribution of the risks and the benefits of the study based upon the problem under investigation. Application of the principle of justice in this study led to consideration of equitable selection of research subjects and risks/benefits assessment (risks reasonable in relation to benefits).

3.9. CONCLUSION

This chapter discussed the methodology that was used to select the participants and to collect data. The Belmont report (1976) was engaged as the ethical framework for the protection of the rights and welfare of the human subjects in order to enhance ethics, reliability and validity of the results of the study. The next chapter will outline the results of the study.

CHAPTER FOUR

DATA ANALYSIS AND RESULTS

SECTION A

4.1. INTRODUCTION

The previous chapter discussed the methodology used to select and recruit participants in this study, and also the ethical measures that were engaged to protect the human subject of research (participants in this study). The current chapter will present the results in writing, through frequency tables and charts.

4.1.1. Data analysis

The IBM SPSS statistics version 20 and Microsoft office excel 2010 were used to analyse data. Descriptive analysis to summarize the respondents' socio-demographic characteristics, their attitudes and personal behaviours was performed through the dataset. None analytical analysis was presented in this report. Frequency tables and charts were used to present the computed data.

4.1.2. Overview of the computed data / results

The population of this study included professional healthcare personnel from six different disciplines, however, the researcher categorised them into three main strata, namely: medical services (12.8 %, n = 5), nursing services (59.0 %, n = 23), and support services (28.2 %, n = 11). Out of 55 eligible respondents (the sum number of all professional health care personnel at Mokhotlong Hospital), only 45 respondents were approached, however, 4 did not give informed consent, and two questionnaires were deemed unusable; leaving a total of 39 respondents as a remainder. The response rate was therefore calculated as 86.7 % (39 out of 45 respondents).

4.2. GENDER COMPOSITION OF SELECTED PROFESSIONAL HEALTH CARE PERSONNEL FOR THE STUDY

Figure 4.1 represents the composition of the respondents who were included in the study; almost three-quarter (74.0 %, n = 29) of the respondents were women. While the remaining one-quarter (26.0 %, n = 10) were their male counterparts.

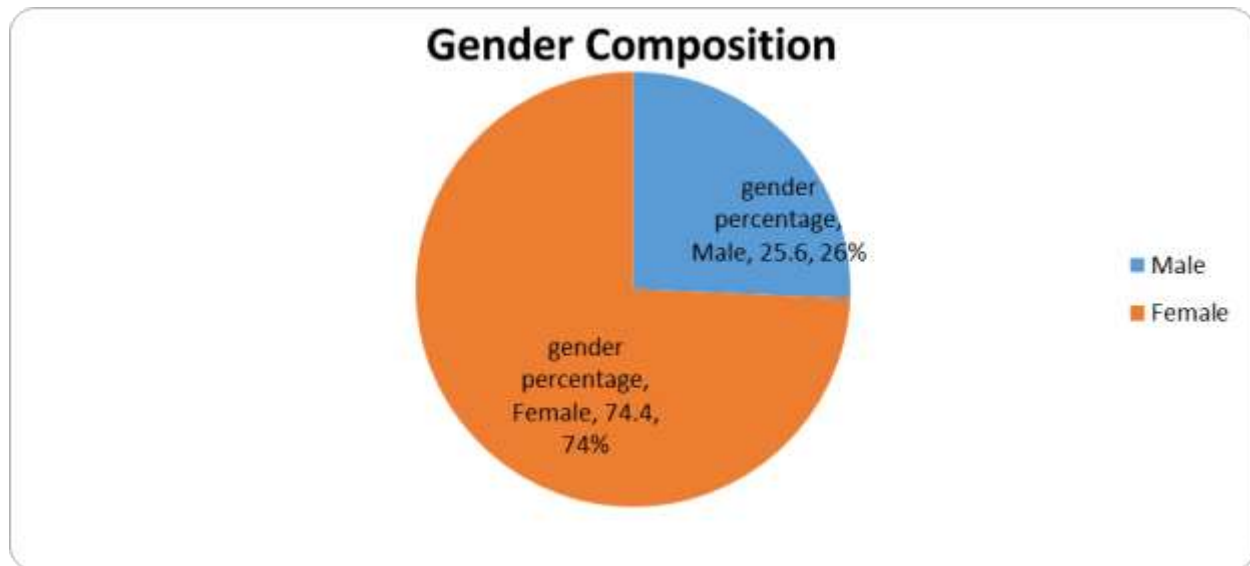


Figure 4.1: Percentage composition of respondents by gender

Table 4.1: characteristics of selected Mokhotlong hospital staff by sex

Characteristics	Category	Male		Female		Total	Percent
		Number	Percent	Number	Percent		
Employment status	Permanent and pensionable	5	17	25	83	30	77
	Contract	5	56	4	44	9	23
Marital status	Married	9	43	12	57	21	54
	Never married	1	6	15	94	16	41
	Widowed	0	0	1	100	1	3
	Divorced	0	0	1	100	1	3
Services	Medical services	2	40	3	60	5	13
	Nursing services	2	9	21	91	23	59
	Support services	6	55	5	46	11	28
Work experience	Less than 10	8	31	18	69	26	67

	years						
	10 - 20 years	2	33	4	67	6	15
	Greater than 20 years	0	0	7	100	7	18
Age	24 - 35 years	5	28	13	72	18	46
	36 - 53 years	5	29	12	71	17	44
	54+ years	0	0	4	100	4	10
Total		10		29		39	100

4.3. RESPONDENTS' SOCIO-DEMOGRAPHIC CHARACTERISTICS

Characteristics for participating professional health care personnel are summarized in Table 4.1. The analysed data indicates that 77.0 % (n = 30) of these respondents were permanent and pensionable. However, 83.0 % (n = 25) of permanent and pensionable were females, and only 17.0 % (n = 5) were males. In a sharp contrast, there were more males (56.0 %, n = 5) on contract than females (44.0 %, n = 4). Slightly more than half (53.8 %, n = 21) of the sample were married and nearly 41.0 % (n = 16) reported to have never married.

The socio-demographic characteristics for participating respondents which accounted for least percentages were widowed (3 %, n = 1), and divorced (3 %, n = 1) respectively; and they were both females.

The majority of the respondents were mainly in nursing services (59 %, n = 23), of which the larger portion is occupied by females (91 %, n = 21). As opposed to the nursing services, the majority of participants in the support services were males (55.0 %, n = 6), with nearly half (45.0 %, n = 5) females comprising the remainder of the group. About 31.0 % (n = 8) of the male respondents reported serving in the field of health (work experience) for less than 10 years, and 33.0 % (n = 2) for 10 years or longer. During the time of study half (50.0 %, n = 5) of the male respondents were aged between 24 and 35 years, while the remaining half (50.0 %, n = 5) fell under the age-bracket 36 to 53 years.

Against this background female respondents seemed to have more work experience than their male counterparts; almost three-thirds (67.0 %, n = 4) in the age-bracket

(10 – 20 years) reported more than 10 years of service in the field of health, while 100% (n = 7) was found in the age-bracket (greater than 20 years of work experience). The larger proportion of the female respondents also seemed to occupy the older age groups and most of them were quite older than their male counterparts (36 – 53 years, 71.0 %, n = 12), (54 years and older, 100 %, n = 4) respectively.

SECTION B

4.4. ATTITUDES OF PROFESSIONAL HEALTH CARE PERSONNEL TOWARDS COLLEAGUES LIVING WITH HIV AND AIDS (CLWHIA)

Table 4. 2:

	Agree	Disagree	Not sure
Attitudes	%	%	%
Working with CLWHIA would put family or friends at risk of contracting the disease	5	92	3
Assigned to work in HIV clinics	3	97	0
Waste of limited resources	0	100	0
CLWHIA are not as good as others	0	100	0
I cannot befriend a CLWHIA	3	95	2
I cannot touch CLWHIA	0	100	0
I am afraid of CLWHIA	0	100	0
A CLWHIA does not deserve expensive health care	3	95	2
CLWHIA should not be allowed to continue with their caring services	0	100	0
HIV/AIDS is punishment from GOD for immorality	0	97	3
Lives of CLWHIA can be improved through counselling	85	13	2
Antiretroviral treatment improves lives of CLWHIA	95	5	0
CLWHIA can lead fulfilling lives	95	5	0
CLWHIA should be accepted and not labelled promiscuous when seeking family planning or STD	92	8	0

treatment			
The institution needs not concentrate on HIV issues only	59	28	13
The institution should not discriminate CLWHIA when employing	59	28	13
The institution should not use HIV status as a criterion for promotion of other development	85	13	2
The institution should not use having or not having HIV as a criterion for retirement	87	10	3

Suitable alternatives should be explored for CLWHIA, particularly those who cannot cope with their work	77	15	8
Flexible working conditions should be made available for CLWHIA to address issues of productivity	67	26	7
Confidentiality should be maintained related to the HIV issues	85	13	2
CLWHIA should be given the same rights as other HIV negative in the workplace	92	5	3

Table 4.2 displays attitudes of respondents towards CLWHIA. Results show that 92.0 % (n = 36) of the professional health care personnel who were included in the study disagreed that working with CLWHIA would put one's family or friends at risk of contracting the disease; while 5.0 % (n = 2) of the respondents agreed and 3.0 % (n = 1) were not sure.

However, when asked whether CLWHIA should be assigned to work only in HIV/AIDS care clinics, 97.0 % (n = 38) disagreed when 3.0 % (n = 1) were not sure. There was a mutual feeling from the respondents of 100 % (n = 39); they all agreed when asked whether CLWHIA were as good other people, and also whether the limited resources were not being wasted when assisting such colleagues. When asked whether they would befriend a CLWHIA, only 3.0 % (n = 1) revealed that they cannot be friends with CLWHIA while 2.0 % (n = 1) was not sure.

Respondents were least worried about touching a CLWHIA, 100 % (n = 39) indicated that they are not afraid of CLWHIA or even worried to touch them. The study further showed that 95.0 % (n = 37) of the respondents agreed that a CLWHIA deserves state-of-the-art health care services, while 3.0 % (n = 1) felt that they do not deserve it, and the remaining 2.0 % (n = 1) were not sure. The results designated that all the respondents (100 %, n = 39) agreed that CLWHIA should be allowed to continue with their services in the patient care area. When asked whether HIV/AIDS is a punishment from God for immorality, only 3.0 % (n = 1) thought HIV/AIDS is a punishment for immorality while 97.0 % (n = 38) disagreed with the statement.

Thirteen percent (13.0 %, n = 5) of the respondents reported that the lives of their CLWHIA cannot be improved through Counselling, while a larger fraction which accounted for almost 85.0 % (n = 33) of the chosen sample disagreed with the statement; 2.0 % (n = 1) of the respondents were not sure. The majority of the respondents (95.0 %, n = 37) reported that CLWHIA can lead fulfilling lives like any other person and the introduction of antiretroviral treatment (ART) can help to improve the quality of their lives, only 5.0 % (n = 2) of the respondents in both two statements disagreed.

Among the 39 respondents, 92.0 % (n = 36) reported that CLWHIA should be accepted and not labelled promiscuous when seeking family planning or STIs treatment, while the remaining proportion (8.0 %, n = 3) of the respondents disagreed to the issue. The vast majority (59.0 %, n = 23) of the respondents agreed that the health care institution should not concentrate on HIV/AIDS-related issues only. However, well over one-third (28.0 %, n = 11) of the respondents rejected the statement, while 13.0 % (n = 5) neither disagreed nor agreed.

When asked whether the institution should discriminate CLWHIA when employing, the distribution of responses obtained was the same with the one in the previous statement. In terms of professional development, training and promotion almost three-thirds (85 %, n = 33) of the respondents agreed that the institution should not use HIV status as a criterion for denying CLWHIA such professional opportunities. Thirteen percent (13.0 %, n = 5) of the respondents agreed while 2 % (n = 1) was not

sure. Results from table 2 also indicated that most of the respondents (87.0 %, n = 34) agreed that the institution should not use having or not having HIV as a criterion for retirement. However, the distribution of disagreement scored 10.0 % (n = 4), no opinion on this statement scored 3.0 % (n = 1).

A considerable proportion (77.0 %, n = 30) of the respondents agreed that suitable alternatives should be explored for CLWHIA, particularly to those who cannot cope with their work; the distribution of disagreement and no opinion on this item were 15.0 % (n = 6) and 8.0 % (n = 3) respectively.

When asked whether flexible work conditions should be made available for CLWHIA to address issues of productivity, the vast majority (67.0 %, n = 26) of the respondents agreed with the statement, nearly one-third (26.0 %, n = 10) of the total sample disagreed; while 7.0 % (n = 3) of the respondents had no opinion on this issue.

Most respondents (85.0 %, n = 33) agreed that confidentiality related to HIV issues and CLWHIA should be maintained. On the contrary 13.0 % (n = 5) of the respondents disagreed, while the remaining 2.0 % (n = 1) response was 'no opinion'. The last statement on attitudes asked whether CLWHIA should be given the same rights as other HIV negative or normal employees in the workplace; the distribution of agreement, disagreement and not sure on this statement were as follows; 92.0 % (n = 36), 5.0 % (n = 2) and 3.0 % (n = 1) respectively.

4.5. PERSONAL BEHAVIOURS OF PROFESSIONAL HEALTH CARE PERSONNEL TOWARDS CLWHIA

Table 4.3

Personal behaviours	Agree	Disagree	Not sure
	%	%	%
Telling some fellow professional health care	18	72	10

personnel about your HIV status is risky in this institution			
I cannot show empathy to a CLWHIA because they do not deserve it.	5	95	0
There should be policies and programs for CLWHIA in the workplace	85	10	5
It is important to work in a caring manner with a CLWHIA	74	13	13
A CLWHIA should be treated with respect and courtesy	85	10	5
Refusal to work with a CLWHIA should be treated as a disciplinary offence	69	13	18
Pre-employment test should not be used for employment	82	10	8
I feel comfortable to share food or drinks with CLWHIA	87	10	3

Table 4.3 presents personal behaviours of professional health care personnel towards their colleagues living with HIV and AIDS (CLWHIA) in the workplace. According to the results presented in table 3, a significant proportion (72.0 %, n = 28) disagreed that telling someone about your HIV status is risky in the selected health facility (Mokhotlong Government Hospital) for the study, whereas 18.0 % (n = 7) reported that it is indeed highly risky while 10.0 % (n = 4) of the respondents were not sure.

Further analysis demonstrated that 95.0 % (n = 37) of the respondents agreed when asked whether they can show empathy to their CLWHIA, only 5.0 % (n = 2) indicated the opposite. When asked if there should be policies and programs for CLWHIA, the percentage of the respondents who agreed in the previous slightly dropped to 85.0 % (n = 33), 10.0 % (n = 4) of the respondents disagreed while the remaining 5.0 % (n = 2) were not sure. As shown in table 3, 74.0 % (n = 29) of the respondents agreed when asked whether it is important to work in a caring manner with a CLWHIA, while

the distribution of disagreement and no opinion on this statement was 13.0 % (n = 10) for both responses.

When asked if their CLWHIA should be treated with respect and courtesy, the percentage of the respondents who agreed in the previous remarkably increased to 85.0 % (n = 33), 10.0 % (n = 4) of the respondents disagreed while the remaining 5.0 % (n = 2) poised no opinion on this issue. Responses to those who agreed that refusal to work with a CLWHIA should be treated as a disciplinary offence was 69.0 % (n = 27), 13.0 % (n = 5) disagreed while 18.0 % (n = 7) reported no opinion on this item.

The issue of pre-employment test for employment was not supported by the vast majority of the respondents (82.0 %, n = 32), with only 10.0 % (n = 4) in favour while 8.0 % (n = 3) of the respondents gave no opinion. Lastly, when asked if they feel comfortable to share food or drinks with CLWHIA, a very significant proportion (87.0 %, n = 34) of the respondents agreed that they do feel comfortable to share their food and drink with their CLHIA. However, 10.0 % (n = 4) of the respondents disagreed while 3.0 % (n = 1) was not really sure on this statement.

4.6. CONCLUSION

In this chapter, computed data and/or results obtained from professional health care personnel aged 18 years and above working at Mokhotlong government hospital were presented; 12.8 % (n = 5) of the respondents were from the hospital's medical services, while 59.0 % (n = 23) from nursing services, and the remaining 28.2 % (n = 11) from support services. The next chapter will present, compare and contrast the findings of the current study with the findings from other carried-out relevant studies in the past.

CHAPTER FIVE

DISCUSSION ON FINDINGS

5.1. Introduction

The previous chapter presented data analysis and the results obtained from the total sample of 39 professional health care personnel who were working at Mokhotlong Government Hospital during the time of study. The current chapter will establish whether the findings obtained from this study are consistent and relevant with the findings from other studies carried out in the past locally, regionally and globally.

5.2. DISCUSSION

5.2.1. Background characteristics of the sampled professional health care personnel

In accordance with other similar studies conducted in Lesotho's health sector, the study population mainly comprised of female respondents (74.0 %, n = 29). Keenly fascinating the majority of the respondents were mainly in the nursing services (59 %, n = 23), of which the larger portion is still occupied by the females (91 %, n = 21).

According to Rigodon, Joseph, Keshavjee, Cancedda, Haidar, Lesia, Ramangoaela, & Furin (2014: 3 – 4) the findings were not surprising since there is a severe depletion for human resources for health in Lesotho with an estimated 60% of health posts left vacant. Nurses in Lesotho are therefore considered to be the primary workforce or the frontline professional health care workers who provide the majority of services in the medical setting to the Basotho population (Stander, Phafoli, Christensen, Skolnik, Nyangu, Lemphane, Ramokhitli & Whalen, 2014: 3). They are relatively homogeneous with respect to gender; almost 95 % of the nursing profession in Lesotho are women (Prithiviraj, 2011: 54) In a study conducted by Seyman (2007) on employed professional health care personnel, females had better attitudes than males (Ozakgul et al., 2013: 932). The findings of this study are more or less the same, females have remarkably higher empathetic tendency scores than their male counterparts.

The demographic characteristics of the respondents further depicted that a significant number of them were within the age-bracket 24 to 35 (46.0 %, n = 18) and were mainly females (72.0 %, n = 13). Against this background, reviewed literature makes it very clear that with an estimated 25% of the general population infected (professional health care personnel included) with HIV, the country has one of the highest rates of HIV in the world; at the same time. High attrition rates among the professional health care personnel of prime working ages like this one are often due to HIV related illnesses and death. Regrettably, about 54 to 60 % of health posts in Lesotho are left vacant (Icon Institute 2011) in (Rigodon et al., 2014: 1)

Moreover, it is of vital importance to note here that even as the vast majority were in their prime working ages (24 – 35 years), the health workforce in the African region has one of the lowest levels of job satisfaction due to severely depleted health posts, inadequate to lack of equipment, drug and medical supplies, proper infrastructure, and low wages. Retention and recruitment of professional health care personnel in Lesotho is especially challenging (Stender et al., 2014: 3).

About 31.0 % (n = 8) of the male respondents reported serving in the field of health (work experience) for less than 10 years, and 33.0 % (n = 2) for 10 years or longer. According to Brown (2003) in (Tarkovsky et al, 2013: 571), a longer work experience is in the field of HIV/AIDS care has been related to more positive attitudes towards PLWHIA and thus CLWHIA. But as noted from the results of the study conducted by USAIDS/MCHIP (2014) in Lesotho; these insignificant numbers of professional health personnel with a longer work experience may be attributable to the country's inability to retain professional health care personnel after they are trained and deployed to the areas where they are most critically needed (Stender et al., 2014: 4).

5.2.2. Attitudinal and behavioural problems towards CLWHIA based on personal vulnerability

According to Li et al. (2011: 109), it is stated attitudinal and behavioural indicators are often seen as individual attributes, but collectively, individual attitudes and behaviours are often influenced by the perception of how other individuals in a social group

behave. Deeply seated norms and values within each and every medical setting can play a vitally important role and result in wide and varied-range of levels of avoidance attitude towards PLWHIA and/or CLWHIA among the hospitals involved (Li et al, 2011: 110). This supports the findings of Prithiviraj (2011) who identified that negative attitudes are not limited to patients in the hospital setting, but can be a barrier to various cadres of professional health care personnel working as a team among the hospitals involved.

Against this background, a vast majority of the respondents in this study rejected the statement that CLWHIA would put one's family or friends at risk of contracting the disease. In terms of personal vulnerability, few more statements were included that ranged from sharing food and working space with, to touching a CLWHIA in an attempt to determine whether the respondents had different opinions or claims on this particular issue. However, the modal response for almost three quarter of the items in this section was either 'agree' or 'not sure'.

According to Tarkovsky et al. (2013: 571), it is indicated that being empathetic and caring to CLWHIA gives professional health personnel a pleasant sense of affiliation and satisfaction derived from their contribution to the welfare of their colleagues. While the development of positive attitudes and supportive personal behaviours will improve the quality of care given to PLWHIA and/or CLWHIA (Ozakgul et al., 2013: 932). Pettigrew and Tropp (2008) in Tartokovsky et al. (2013: 571) also suggested that prolonged contact with PLWHIA and/or CLWHIA can help to weaken prejudices and thus lead to more positive attitude and supportive behaviour toward this group.

5.2.2. Ethical and medicolegal atmosphere for CLWHIA in the workplace

On a number of items under this sections, a considerable proportion of sampled professional health workers responded 'agree'. More than three-quarter of the professional health care personnel who were sampled in this study reported that CLWHIA deserves state-of-the-art health care services when they are sick. As long as they are medically health, they should be allowed to continue with their caring services because they are as good as other people in the medical setting.

Moreover, over 92.0 % (n = 36) of the respondents reported that CLWHIA should be accepted and not labelled promiscuous when seeking family planning or STIs treatment because they are sexual beings like any other normal person. The majority of the respondents (95.0 %, n = 37) reported that CLWHIA can lead fulfilling lives like any other person and the introduction of antiretroviral treatment (ART) can help to improve the quality of their lives. Lowther, Selman, Harding and Higginson (2014: 1184) argued that from 42 to 83 % of PLWHIA on antiretroviral therapy (ART) experience some type of prejudicing attitudes or behaviours from family, friends, colleagues or community. On the contrary, some studies have found that holding a stigmatizing attitude or behaviour is associated with fewer PLWHIA in the village, observing stigmatizing behaviour and the utilization of no-professional sources of HIV information (Sullivan, Xu, Feng, Su, Xu, Ding, Gao and Dou, 2010: 110).

In a very sharp contrast, some of the respondents depicted ethical beliefs that were fully in congruent with the ethical and medicolegal atmosphere for their CLWHIA in the working environment. Almost half the respondents (59.0 %, n = 23) rejected the statement that the institution should concentrate more on HIV and AIDS issue in the workplace, while 13.0 % neither disagreed nor agreed. When asked whether flexible work conditions should be made available for their CLWHIA in order to address issues of productivity, (26.0 % (n = 10) of the total sample disagreed; while 7.0 % (n = 3) of the respondents had no opinion on this issue.

According to Li et al. (2011: 110), it is stated that professional health personnel's avoidance of CLWHIA could be attributable to the institutional norms towards all sick relations or lack of HIV/AIDS related programs and policies. Last but not the least, 13.0 % (n = 5) rejected the statement that said confidentiality related to HIV issues and CLWHIA should be maintained. According to Relf et al. (2009: 1453), it is stated that when a professional health care personnel breaches confidentiality, clients (including CLWHIA) are likely to feel betrayed resulting in distrust of the health care system.

5.3. CONCLUSION AND RECOMMENDATIONS

5.3.1. Introduction

As noted from the findings in the previous section (discussion on findings), conclusions will be drawn and recommendations will be made in this chapter.

5.3.2. Conclusion

The study aimed to establish the attitudes and personal behaviours of professional health care personnel working at Mokhotlong Government Hospital Lesotho towards their CLWHIA. However, the results of the study have actually depicted that, the majority of respondents have very positive attitudes and supportive behaviours towards PLWHIA and/or their CLWHIA.

5.3.3. Recommendations

Professional health care personnel who are working in the hard-to-reach rural and isolated health facilities like Mokhotlong Government Hospital are found to be central to the management of HIV and AIDS care services for their Colleagues living with HIV and AIDS (CLWHIA) in the involved health facilities. In the absence of any plausible explanation, provision of care for PLWHIA and/or CLWHIA in rural areas is very challenging than in the metropolitan areas of Maseru due to inadequate to lack of medical supplies, poor-rural infrastructures, and vacant health posts in the facilities. This in turn, may harm the exhibited non-judgemental acceptance of CLWHIA in Mokhotlong Government Hospital.

In response to this;

- At the institutional level, Mokhotlong Government Hospital is understood to design and implement HIV and AIDS-related programs, activities and policies that can effectively absorb this catastrophic health workforce and public health mutual threat in the medical setting or workplace. As highlighted by International Labour Office's code of good practice in the world of work (2006), the program should provide support to both professional and non-professional health care personnel about HIV/AIDS-related issues; such as shaping their personal behaviours and attitudes towards HIV infection, as well as promoting care for PLWHIA and/or their CLWHIA and opposing stigmatization.

- At the Ministerial level, Lesotho Ministry of Health should partner with other relevant Ministries in the country to design strategies that can be used to avert some of the HIV and AIDS-related challenges health workforce working in the rural and isolated health facilities are confronted with such as human and material resources needed for effective management of HIV/AIDS care services.

5.3.4. Limitations and/or challenges related to the study

The study was conducted in the hard-to-reach rural hospital of Mokhotlong district due to its challenging mountainous terrains and the poor road network. Even with the response rate of 86.7 %; the sample was small ($n = 39$), and the information was obtained from a single and isolated government hospital in the rural areas of Lesotho. Against this background, results likely do not generalize completely to the entire population of professional health care personnel working in Lesotho's health sector

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STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

ATTITUDES AND PERSONAL BEHAVIOURS OF PROFESSIONAL HEALTH CARE PERSONNEL TOWARDS FELLOW EMPLOYEES LIVING WITH HIV/AIDS

You are asked to participate in a research study conducted by Lillo Augustinus Kuape, from the Centre for HIV/AIDS management at Stellenbosch University, because you are a health care worker in the Mokhotlong Government Hospital. The results of the study will contribute to the research paper / thesis in partial fulfilment of a Master of Philosophy in HIV/AIDS Management at the afore-mentioned university (2014 – 2015).

1. PURPOSE OF THE STUDY

The study will focus on the underlying factors that contribute towards personal behavior and attitude to HIV positive staff members in Mokhotlong hospital. The results of the study will enable the facility to re-design and put into action behavior change strategies towards HIV positive employees in the workplace.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

Your participation in the study will entail filling a questionnaire on a range of HIV and AIDS related issues in the workplace. The researcher will distribute the questionnaire in person, and the respondents will be given five working days to complete the questionnaire in their own time and at a place where they may feel comfortable doing so. The time commitment required of you is 10 – 15 minutes for filling the questionnaire. There are no follow up visits involved in this study.

3. POTENTIAL RISKS AND DISCOMFORTS

Questions that do not require participant's private information such as establishing the HIV status are used, and no unauthorized people will be allowed to access any of these documents including the very same subject. In addition, some respondents might experience discomfort when completing the questionnaire. To mitigate this risk of discomfort, psychosocial support and counseling services will be made available during the study. If any need arise, you can contact:

Miss Malithebe Khubetsoana | Adherence and Psychosocial Support Officer (APSO)

Mokhotlong Government Hospital | Box 107 | Mokhotlong 500

Tel: (+266) 22920213

Mob: (+266) 63849227

email: khubetsoanamalithebe587@gmail.com

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

The study findings are expected to improve the quality of life for health care workers in Mokhotlong Hospital, particularly employees living with HIV and AIDS in the workplace. You may be a direct beneficiary should you or your colleague or dependent decide to use the facility's HIV and AIDS care services in the future, it will also benefit the society at large.

5. PAYMENT FOR PARTICIPATION

There is no direct compensation for your participation in the study other than your contribution to the pool of research knowledge.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality of all data will be maintained by not allowing any unauthorized access to such data. No names or identifying features of participants will be required. Instead, codes will be used to maintain anonymity of the participant throughout the entire process of the study. This information may include but is not limited to the name, address, physical description or any characteristics of a person, which may lead to his / her identification. Moreover, two boxes will also be used, one for consent forms and the other for the questionnaires in order to conceal any form of connection between the two. Finally, details of the participants will not be released to the third parties without the informed consent of the subject.

Participant will not be personally identified in any reports or publications that may result from this study. Any personal information about the participant that is gathered during this study will be remain confidential to every extent of the law.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You can stop participating in this study at any time or refuse to answer any question that you do not want without any repercussion and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:

Principal Investigator

Master of Philosophy student in HIV/AIDS Management

Lillo Augustinus Kuape

P. O. Box 228 | Mamathe 210 | Lesotho

Tel: +266 28500802 Mob: +266 63081544

Supervisor

Prof. Johan Augustyn

Africa Centre for HIV/AIDS Management

Stellenbosch University | Private Bag X1 | Matieland 7602 | RSA

Tel: +27 21 808 3006

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me by.....in English and I am in command of this language. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

Name of Subject/Participant

Name of Legal Representative (if applicable)

Signature of Subject/Participant or Legal Representative Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____. He /she was encouraged and given ample time to ask me any questions. This conversation was conducted in English and no translator was used.

Signature of Investigator

Date

STUDY QUESTIONNAIRE

ATTITUDES AND PERSONAL BEHAVIOURS OF PROFESSIONAL HEALTH CARE
PERSONNEL TOWARDS FELLOW EMPLOYEES LIVING WITH HIV AND AIDS

Principal Investigator

Lillo Augustinus Kuape (Master of Philosophy student in HIV/AIDS Management)

P. O. Box 228 | Mamathe 210 | Lesotho

Tel: +266 28500802 | Mob: +266 63081544 | lllkuape@yahoo.com

Supervisor

Prof. Johan Augustyn

Africa Centre for HIV/AIDS Management

Stellenbosch University | Private Bag X1 | Matieland 7602 | RSA

Tel: +27 21 808 3006

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SECTION A**1. Participant attributes**

Participant code.....Date.....

Male [] Female []

Age in years.....

2. Marital status

Married [] Widowed []

Never Married [] Divorced []

3. Professional Background

Medical Officer [] X – ray technicians []

Registered Nurse [] Nurse Assistant []

Pharmacist [] Pharmacy Technician []

Laboratory technician [] Laboratory Assistant []

Nutritionist [] Anaesthetist []

Dentist []

4. Employment history and work experience

What is your current employment status?

Probationary []

Contract []

Permanent and pensionable []

Years at Mokhotlong Government Hospital.....

Total years of clinical experience.....

-2-

SECTION B

Explanation of key-words and scores per item;**Instructions:** Please circle one answer on each line or question.

	Question	SD = strongly disagree	D = disagree	N = neither	A = agree	SA = strongly agree
1	Working with someone living with HIV and AIDS would put my family and friends at risk of contracting the disease.	1	2	3	4	5
2	Service providers living with HIV and AIDS should be assigned to work only in HIV and AIDS care clinics.	1	2	3	4	5
3	Caring for a HIV positive employee is a waste of precious and limited resources.	1	2	3	4	5
4	People living with HIV/AIDS (PLWHIA) are not as good as others.	1	2	3	4	5

-3-

5	I cannot be a friend of someone who is living with HIV and AIDS	1	2	3	4	5
6	I cannot touch someone					

	once I know he / she is living with HIV and AIDS	1	2	3	4	5
7	I am afraid of someone who is living with HIV and AIDS	1	2	3	4	5
8	An employee living with HIV and AIDS does not deserve expensive and luxurious health care services like any other person	1	2	3	4	5
9	Telling someone about your HIV status is risky in this facility	1	2	3	4	5
10	I cannot show empathy, love, or acceptance to PLWHIA because it is what they deserve for how they have lived their lives	1	2	3	4	5
11	PLWHIA should not be allowed to continue with their caring services	1	2	3	4	5
12	HIV/AIDS is a punishment from GOD for immoral people	1	2	3	4	5

-4-

13	The quality of life of employees living with HIV and AIDS can be improved through counselling	1	2	3	4	5
14	Life-prolonging drugs (antiretroviral) and the treatment of opportunistic					

	infections may improve the quality of life of an employee living with HIV and AIDS	1	2	3	4	5
15	Employees living with HIV can and do live fulfilling lives, and can still be in control of the quality of their lives in this facility	1	2	3	4	5
16	Employees living with HIV and AIDS should be accepted as being sexually active, and they are not to be labelled 'promiscuous' if they access family planning services and treatment for sexually transmitted infections	1	2	3	4	5
17	There should be support services, policies, programs, and activities that are targeting PLWHIA in the workplace	1	2	3	4	5

-5-

18	It is of vital importance to work with a colleague who is living with HIV/AIDS in a caring manner	1	2	3	4	5
19	PLWHIA should be treated with respect and courtesy as any other employee in the world of work	1	2	3	4	5
20	Refusal to work with a fellow health care worker that is living					

	with HIV/AIDS should be regarded as disciplinary offence	1	2	3	4	5
21	Pre-employment HIV test and counselling should not be a pre-condition for employment in this facility	1	2	3	4	5
22	The facility need not concentrate on issues of HIV and AIDS compared with other chronic diseases in the workplace	1	2	3	4	5
23	A health care worker living with HIV/AIDS should not be subject to discrimination in recruitment, hiring, job assignments, termination or other terms and conditions of employment on the basis of his/her real or perceived HIV status	1	2	3	4	5

-6-

24	The institution should not use HIV status as a criterion for denying promotion, training or development of an employee	1	2	3	4	5
25	HIV should not be used as a criterion for retirement during downsizing.	1	2	3	4	5
26	Suitable alternatives should be explored for health care personnel living with HIV and AIDS that cannot cope with their current job.	1	2	3	4	5
27	Reasonable accommodation (flexible work arrangements) can assist to					

	address reduced productivity for an employee who is living with HIV/AIDS in the workplace.	1	2	3	4	5
28	Confidentiality of an employee living with HIV/AIDS in the workplace should be maintained at all times, breach of which should call for disciplinary measures	1	2	3	4	5
29	Health care workers living with HIV should be given the same rights as normal employees; they should be treated with dignity and without discrimination.	1	2	3	4	5
30	I feel comfortable to share food and drinks with a colleague who is living with HIV/AIDS	1	2	3	4	5



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Approval Notice

Stipulated documents/requirements

21-Apr-2015

Kuape, Lillo Augustinus LA

Proposal #: SU-HSD-000279

Title: ATTITUDES AND PERSONAL BEHAVIORS OF PROFESSIONAL HEALTH CARE PERSONNEL TOWARDS FELLOW EMPLOYEES LIVING WITH HIV/AIDS

Dear Lillo Augustinus Kuape,

Your **Stipulated documents/requirements** received on **09-Apr-2015**, was reviewed by members of the **Research Ethics Committee: Human Research (Humanities)** via Expedited review procedures on **21-Apr-2015** and was approved.

Sincerely,

Clarissa Graham

REC Coordinator

Research Ethics Committee: Human Research (Humanities)

Investigator Responsibilities

Protection of Human Research Participants

Some of the general responsibilities investigators have when conducting research involving human participants are listed below:

1.Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2.Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use. If you need to recruit more participants than was noted in your REC approval letter, you must submit an amendment requesting an increase in the number of participants.

3.Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4.Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in REC approval does not occur**. If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5.Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6.Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouch within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the REC's requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to

the REC using the Serious Adverse Event Report Form.

7.Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8.Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

9. Final reports. When you have completed (no further participant enrollment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the REC.

10. On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.



Ministry of Health
PO Box 514
Maseru 100

09 January 2015

Lillo A. Kuape
Student Number 17353610
MPhil Student
University of Stellenbosch

Dear Mr. Lillo,

**Re: Attitudes and personal behaviors of professional health care personnel
towards fellow employees living with HIV/AIDS in Makhotlong hospital-Lesotho
(ID01-2015)**

Thank you for resubmitting the above mentioned proposal. The Ministry of Health, Research and Ethics Committee having reviewed your modified protocol hereby authorizes you to conduct this study among the specified population. The study is authorized with the understanding that the protocol will be followed as stated. Departure from the stipulated protocol will constitute a breach of the permission.

We are looking forward to have a progress report and final report at the end of your study.

Sincerely,



Dr. L. Maile
Director General Health Services



Dr. Jill Sanders
Co-Chairperson
National Health Research and
Ethics Committee



AFRICA CENTRE FOR HIV/AIDS MANAGEMENT

20 January 2015

Lesotho Ministry of Health
Maseru 100

Dear Sir/Madam

RE: Application to conduct a research at Mokhotlong Government Hospital in Mokhotlong district Lesotho.

Mr Lillo Kuape, a Master of Philosophy student (MPhil) in HIV and AIDS Management (Student Number:17353610), at the Africa Centre for HIV/AIDS Management at Stellenbosch University intends to conduct a research at Mokhotlong hospital in the mountainous north-eastern part of Lesotho on attitudes and personal behaviours of professional health care personnel towards fellow employees living with HIV and AIDS in Mokhotlong Hospital – Lesotho. The researcher will focus on professional health care personnel who are currently working in Mokhotlong Hospital. The population of 30 health care staff will be used; that is 2 pharmacy technicians and 1 pharmacist, 20 registered nurses, 5 doctors, and 2 laboratory technicians. Quantitative research using self-administered questionnaires as a survey method where the participants will be asked to provide their opinions and perceptions about the issue of HIV positive individuals in the workplace.

All participants will be requested to consent for participation before conducting the study. Confidentiality, anonymity and voluntariness of information and/or participation will be assured to all concerned. We kindly request for permission for Mr Lillo Kuape to carry out this study at the above-mentioned Hospital. The study should run from January to December 2015. The student is in the process of applying for ethical clearance from the Stellenbosch University Ethical Committee. Should you require further information, feel free to contact the university.

Kind Regards,

Burt Davis
Lecturer
Africa Centre for HIV/AIDS Management
STELLENBOSCHUNIVERSITY | Private Bag X1 | Matieland 7602 | RSA | burt@sun.ac.za