

**ACCESS TO VOLUNTARY COUNSELLING AND HIV TESTING SERVICES
BY TONGA HOSPITAL EMPLOYEES**

by

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DECLARATION

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ABSTRACT

The advent of HIV/AIDS poses a gigantic challenge to mankind. This global pandemic calls on all of us-regardless of whether we operate within government circles or in the private sector-to cooperate in eradicating the scourge of HIV/AIDS. The global impact of HIV/AIDS has wreaked grave havoc on family structures, the Health and Education sectors as well as various crucial productive industries, namely, the agricultural, mining, retail and financial services sectors.

The South African national Department of Health is charged with leading the provision of access to HIV VCT services for all deserving members of the South African community. It behoves of all of healthcare service providers to ensure ease of access to such services to all deserving individuals.

The South African Department of Health contends that the number of people enrolled into ARV roll-out program in South Africa is low. The South African community may access this service at accredited HIV VCT sites in CCMTs as well as in district and regional hospitals. People who are covered by medical insurance may access these services at private institutions of their choice.

HCWs at government institutions suffer a triple whammy from HIV/AIDS, namely, caring for HIV positive patients in the hospital wards daily, supporting relatives stricken by HIV/AIDS (and AIDS-orphaned relatives) as well as carrying out duties of colleagues who are debilitated by HIV/AIDS.

Access to HIV VCT services at Tonga Hospital-a 250-bed district hospital in the east of the Mpumalanga province is extremely low.

A quantitative and descriptive study was performed to unravel the causes of the low access to HIV VCT services by HCWs at Tonga Hospital. Using an anonymous questionnaire (for which names and surnames were not required), this study found that fear and stigma of a HIV diagnosis played a huge role in preventing HCWs at Tonga Hospital from accessing free HIV VCT services at their place of work.

OPSOMMING

Die MIV-pandemie raak elke besigheid, klein of groot, en die gekombineerde poging van almal is nodig om die pandemie suksesvol te bestuur.

Die Suid-Afrikaanse Departement van Gesondheid het die opdrag om Vigs-medikasie aan almal te voorsien en seker te maak dat die verspreidingsnetwerke effektief funksioneer. Die Departement van Gesondheid hou dikwels vol dat die opname van medikasie baie laag is en gee dikwels nie bevredigende redes vir hierdie lae opnamekoers nie.

Die doel van hierdie studie is om op 'n wetenskaplike wyse te probeer vasstel waarom hierdie opnamekoers so laag is. Gestruktureerde vraelyste is gebruik en 'n studie is by die Tonga hospitaal gedoen.

Belangrike bevindings word rapporteer en aanbevelings word gemaak vir die verbetering van hierdie lae opnamekoers.

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GLOSSARY

HIV – Human Immunodeficiency virus

VCT – Voluntary Counseling and Testing

DoH – Department of Health

CCMT – Comprehensive Care, Management and Treatment

SAHRC – South African human Rights Commission

OPD - Out-patient department

ARV/HAART – Antiretroviral drugs/ Highly Active Antiretroviral Therapy

Nevirapine – An example of an ARV drug

Efavirenz – An example of an ARV drug

MDR-TB – Multi-drug resistant form of Tuberculosis infection

XDR-TB – Extremely resistant form of Tuberculosis infection

CSI/CSR – Corporate Social Investment/Responsibility

Hospersa – Health and other Service Personnel Trade Union of South Africa

Denosa – Democratic Nursing Organization of South Africa

PLWHAs – People Living with HIV and AIDS

NGO – Non-governmental organization

PEP – Post-exposure prophylaxis

HCW – Healthcare worker

HBV – Hepatitis B virus

HCV – Hepatitis C virus

STI – Sexually Transmitted infection

SAQA – South African Qualifications Authority

SETA – Sector Education and Training Authority

PEPFAR – US President’s Emergency Plan for AIDS Relief

HAST – HIV/AIDS/STI/TB (Directorate)

RTC – Right to Care (a Johannesburg based PEPFAR funded NGO)

HRW – Human Rights Watch

CDC – Centers for Disease Control and Prevention

SOP – Standard Operating Procedure

CMO – Chief Medical Officer

IRIS – Immune reconstitution syndrome

MEC – Member of the Executive Committee

SCOPA – Standing Committee on Public Accounts

WHO – World Health Organization

DOTS – Directly Observed Treatment

CCMA – Commission for Conciliation, Mediation and Arbitration

CHAPTER 1

INTRODUCTION

Voluntary counseling and testing for HIV, namely HIV VCT, is a government-led program through which an individual, whether sexually active or not, may know his/her HIV status. It is a free service at any regional or district hospital, as well as in satellite clinics and CCMTS countrywide.

Some large private companies like Anglo-American and Debswana, offer this service to their employees (and their families) in company-owned healthcare centres.

Three types of HIV VCT are offered in South Africa, namely:

- 1) One-on-one HIV pre-test counseling
- 2) Couple HIV pre-test counseling
- 3) Group HIV pre-test counseling

In the first type of counseling a trained counselor dispenses detailed information on HIV/AIDS as well the implications of a positive and a negative HIV test result. Couple counseling involves HIV pre-test counseling of a consenting pair of individuals, for instance, a young couple preparing for marriage. Members of a self-contained employee group, for instance, laundry staff at a hospital, or even members of a soccer team, may be pre-test counseled together where permissible.

Pre-test counseling is followed by a period of introspection, where a client is allowed to take enough time in order to make an informed decision-without any undue pressure-to undergo a HIV test.

The commonly used test is called Rapid test-where a droplet of a client's blood-using an aseptic technique-is tested in a small reagent-filled disposable container. In about two minutes the client may receive the initial test result. If the client has tested positive, more blood is taken (3milli-litres) for a confirmatory test at a laboratory. The laboratory runs such a test using an advanced Enzyme-linked Immunosorbent Assay (ELISA) method. For this test results are often available in about seven days-depending on the proximity of the laboratory to the test site.

For HIV negative people a post-test counseling session-always on a one-on-one format-involves emphasis on ideas to ensure a lifestyle that attempts to keep the client HIV negative. A re-test is recommended in eight weeks-to ensure that the negative test result is a true negative result-not taken during the "window period" (during the first fourteen or so days of infection when the client is already HIV positive but the client has not yet had enough HIV antibodies formed, sufficient enough to register on the Rapid test template). For confirmed HIV positive individuals, implications are re-emphasized, as is the care of loved ones (spouses, colleagues and children). Also a CD4 count is done-which reveals the amount of protective cells (lymphocytes) a person has. Currently, the South African national guidelines provide for the initiation of ARV's once the CD4 count hits 200 for adults and a CD4 percentage of 15 for children. Stakeholders are currently engaging government on the countrywide proposal that the cut-off point be raised to 350, supposedly to harness more gainfully employed and supposedly healthier individuals into the HAART program.

Prior to receiving ARVs clients have to undergo mandatory ARV

adherence classes-commonly four two-hour weekly sessions at the local accredited VCT site. From there clients are seen by a relevantly trained medical officer who'll essentially look for treatable opportunistic infections like Candidiasis and Tuberculosis. For clients/patients with very low CD4 counts and those with overt infections, a dietetic consultation is arranged as is a social worker assessment. Once the all clear sign is given, the patient is given a thirty minute ARV refresher pep talk, is allowed to sign a contract binding him/her to good compliance to treatment, safe lifestyle and cooperation with the ARV site on any difficulties the client may face (including drug side effects) and thereafter ARV's are issued for the first time. Patients are also issued with a reminder calendar where they tick each time they take tablets. This is a three month calendar which is a tool designed to ensure good treatment compliance.

Persons with medical aid cover receive these services at the private medical practitioner of their choice.

Study necessity

Tonga hospital employees do not use this free service at the designated site within Tonga Hospital. The ARV roll-out personnel at Tonga Hospital have noticed that-since the accreditation of their site in 2004-less than five members of staff have come forward to be enrolled for the ARV roll-our program. This study will reveal the real reasons why Tonga hospital employees shun this free service.

The aims of this study are the following:

- 1) To ask the employees themselves the reasons for them not using these free services.
- 2) To seek constructive suggestions-from the employees themselves-which will help
Tonga hospital management restructure this free service to suite employees too.
- 3) To advise the Mpumalanga Department of Health on ways to improve this crucial service offering province-wide.

The study of the literature will be presented in chapter 2. Chapter 3 will detail the research problem and hypothesis. The research design-incorporating the survey methodology, sample design, measuring instruments and the statistical analysis-are outlined in chapter 4. The results of the study are analyzed in detail in chapter 5. Chapter 6 closes off with the conclusions emanating from the study as well as the investigators' recommendations to the Mpumalanga Department of Health.

CHAPTER 2

STUDY OF THE LITERATURE

Access to HIV VCT at South African hospitals and clinics is a free service that should be available to all deserving community members. (SAHRC, 2009). South African healthcare workers reside within the same communities where there's a high prevalence of HIV infection. (World Bank, 1999). With South Africa having nearly 5,7 million people living with HIV, it is fair to say that access to HIV VCT by healthcare workers should be free and easily available at their workplace-much like preventative antenatal care. In the Mpumalanga province-where 67% of nursing posts are vacant, it is of great importance to take very good care of the remaining nurses as well as the newly qualified ones. Tonga Hospital does not have a dietician, occupational therapist, speech therapist nor a psychologist. Every South African has a right to have access to healthcare services including reproductive healthcare. The Department of Healthcare is tasked with managing healthcare delivery all over South Africa.

The right to healthcare access extends to healthcare workers as well. The Sixtieth World Health Assembly (2007) articulates this very well as it considers that the workers' health (and, by extension, the healthcare worker's) is determined NOT only by occupational hazards, but also by social and individual factors as well as access to health services.

It identified "major gaps" between and within countries in the exposure of workers-as is The case at Tonga Hospital (absence of N95 masks which protect people in contact with MDR-TB and XDR-TB patients)-and local communities to occupational hazards and in their access to occupational health services. It stresses that the healthcare workers form

an essential prerequisite for productivity and economic development. A sick nation can never be economically sound. It therefore endorsed the Global Plan on Workers' Health 2008 - 2017.

Of the eight elements with which the assembly urges member states to conform to, four are directly relevant to Tonga Hospital, namely:

- 1) Full coverage of all workers with essential interventions (treatment of chronic diseases like Diabetes Mellitus as well as monitoring the workers' functional capacity) and basic occupational health services for the primary prevention of occupational and work-related diseases and injuries.

- 2) Establishment of core institutional and human resource capacities for dealing with special health needs of workers (confidential and non-stigmatizing HIV VCT services) and to generate evidence on workers' health and translate that evidence into policy and actions. The care of HIV positive workers with Tuberculosis comes to mind. Tonga Hospital needs to collaborate with spouses of healthcare workers to stop the practice of moving sick healthcare workers from a government hospital to a private hospital and then return them once medical aid benefits are exhausted-only for the patients to die on our laps!

- 3) Incorporation of workers' health in national and sectoral policies for sustainable development, poverty reduction, employment, trade, environmental protection and education.

- 4) Once a debilitated healthcare worker is terminated from active duty, he/she should

be helped with funded self-help income producing skills. A disability grant or even an early pension payout cannot sustain that person till death.

The number of operational VCT sites (all over South Africa) exceeds 85% of active South African health centres. Through HIV counseling and testing, access to HIV interventions will be accelerated. At Tonga Hospital staff members have to queue with ordinary patients for consultations with Out-patient clinic doctors. Staff members wear name badges-and most of them are in uniform. OPD opens three times a week and-as queues are long before 12h00-staff members are loathe joining in and following those lines/queues.

It is well documented that client-initiated testing has not resulted in significant testing levels-though the roll-out of ARV's has accelerated over the past two years.

Provider-initiated testing for HIV has also contributed to an increased uptake of this service especially in enhanced antenatal clinics, in hospitalized patients, in primary healthcare centres and in prisons where the HIV prevalence is high.

The impact of HIV/AIDS locally and globally dictates that in-depth discussion of pertinent issues be brought to the fore, namely;

2.1 Access to healthcare

Access to healthcare faces numerous barriers, namely;

a) **Stigma**, specific beliefs and attitudes by groups of people (including healthcare workers themselves), that becoming HIV positive is intimately linked with shameful sexual behaviour which brings disgrace to the sufferer and his/her next of kin to the point that the HIV positive person feels shunned, despised by relatives and friends. Stigma often leads to victims being discriminated against at work and/or in the

community. Stigma has also been perpetrated by healthcare workers at Tonga Hospital and takes the following forms:

- i) Junior nurses who refuse to do preliminary tests (temperature management, basic urine tests, blood pressure measurement, finger prick blood sugar testing) on HIV/AIDS patients.
- ii) Refusal by ambulance drivers and junior nurses to accompany Kaposi Sarcoma patients to Steve Biko Hospital (Pretoria) for Chemo-therapy and/or Radio-therapy because they “smell”.
- iii) One medical doctor initially refused to do a skin biopsy on a HIV positive patient with suspected Kaposi’s sarcoma lesions.

Stigma leads to paralytic fear at different levels, namely:

- i) Fear by the HIV positive person, leading to delay in disclosing his sero-status to relatives.
- ii) Fear by family members to confront the sufferer who has suddenly distanced and neglects himself.
- iii) Fear by family members of community backlash and isolation once neighbours suspect that someone in the family is HIV positive.
- iv) Fear by the sufferer that colleagues or spouses might suspect that all is not well even when he/she has not disclosed his/her HIV status.
- v) Fear by workmates who-though not officially aware of their mate’s HIV status-start gossiping about his recurrent absenteeism and “loss of weight...”

Other sequelae of stigma include discrimination which-as described by UNAIDS (2000)

in the Protocol for Identification of Discrimination Against People Living with HIV, refers to any form of arbitrary distinction, exclusion or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group-in the case of HIV and AIDS, a person's confirmed or suspected HIV-positive status-irrespective of whether or not there is any justification for these measures. Discrimination may manifest itself by blatant or subtle actions and omissions that prevent stigmatized persons from receiving deserved services or fair entitlements which can take various forms, namely, marital expulsion-as experienced by a female nursing colleague in our unit-whereby the spouse coerces his HIV positive wife to seek medical help away from him, instead seek "constant help of your parents..."

Opportunities to attend work-related workshops dry up for HIV positive people. In the staff allocation roster hospital departmental heads are sometimes loathe to accept HIV positive workers with Tuberculosis in their units/departments ostensibly because they can't "tolerate recurrent absenteeism". Acts of omission also include the absence of or failure to implement laws, policies and procedures that offer redress to and safeguard the rights of people living with HIV/AIDS.

UNAIDS (2006) categorizes stigma, discrimination, inequity and human rights abuses as primary obstacles to scaling up services in HIV/AIDS and achieving Universal Access to comprehensive HIV prevention, treatment, care and support by 2010.

Nyblade et al (2009) argue that stigma is globally prevalent, severe for women, lowers uptake of preventive services, delays disclosure (of sero-status), delays care seeking and undermines treatment. Therefore stigma is cited as a major barrier to achieving the goal

of universal access to comprehensive HIV prevention programmes, treatment, care and support of PLWHAs. The 2006 Political Declaration adopted at the UN High Level Meeting on AIDS notes that addressing stigma and discrimination is “a critical element in combating the global HIV/AIDS pandemic”. Ogden and Nyblade (2005) argue that stigma operates at multiple levels, namely, within families, communities, institutions such as healthcare facilities and places of employment, in the media and in government policies. Morrison and Negroni (2006) and Visser et al (2006) include South Africa and Botswana as countries with a high prevalence of HIV stigma in their research.

They found that stigma was consistent across contexts, in forms, consequences and key drivers, namely;

- i) Lack of awareness of stigma, fear of acquiring HIV through everyday contact with infected people and values linking PLWHAs with improper and/or immoral behaviour. HIV stigma on women and prisoners tends to be magnified and debilitating. (Carr and Gramling, 2004), (HRW, 2004), (Foreman et al, 2003). Tonga Hospital employees’ behaviour confirms what Campbell (2005) and Kalichman et al (2006) found, namely, that stigma deters them from getting HIV tested in order to know their status and then change their lifestyles accordingly and seek relevant intervention. Even those that test HIV positive, delay sero-status disclosure to next of kin for up to four years. (Liu, 2006), (Tanzania stigma indicators field testing group, 2005).
- ii) Stigma leads to gender-based violence in several African countries-including

Uganda and Ghana. (Amoakohene, 2004), (HRW, 2003). This form of violence occurs whilst the victims are exercising their rights, namely, requesting condom usage with partners prior to sexual activity and whilst accessing VCT services.

iii) Mills (2006) reports that some patients grind ARVs into powder and take them away from the presence of relatives-in order to try and hide the fact that they are HIV positive.

b) Dysfunctionality of the district health system (SAHRC, 2009). Since 1994 the healthcare system has undergone radical transformation, with new structural arrangements, policies and protocols being implemented.

With the establishment of three tiers of government, namely, national, provincial and district level, roles and functions at each level have had to be defined and internalized. (See appendix). Healthcare managers at district level feel disempowered as most critical decisions are made at provincial level. They cannot solve problems quickly, for instance, the hiring of critical staff members (doctors, occupational therapists, et cetera) occurs over nine months and-by then-prospective candidates will have accepted employment elsewhere.

c) Cost of medicines is borne by and provision of healthcare is spearheaded by national government. (Tawfik, Kinoti, 2001). The medicine exit price from the factories caused a delay in the government's ARV roll-out in 2001. Generic sub-licensing by Roche, Glaxo SmithKline and others to Aspen, Enaleni and Adcock-Ingram Pharmaceuticals helped in getting the process going. Further exacerbating the problem is the recurring shortage of medicines and nutritional supplements. (Hardon et al, 2006).

d) Lack of recognition (by provincial government) of consistent effort on the part of the Tonga Hospital staff compliment-especially nurses-in healthcare delivery leads to nurses and allied staff feeling undervalued. They feel that “their issues” (for instance, job-related personal development), concerns (safety in the work environment, for instance, provision of N95 masks when caring for MDR-TB and XDR-TB patients) and complaints (against malfunctioning and/or inadequate equipment), do not receive the desired attention.

e) Capacity constraints result from increased absenteeism from healthcare workers seeking help from their private medical practitioners. When senior colleagues fall ill, junior personnel end up having to perform more specialized duties for which they are not well-trained. This role expansion is detrimental to the general patient care.

Hardon et al (2006) argue for community level HAART provision in order to increase access and reduce costs. However, CCMTs also suffer from capacity constraints too. Dlamini et al (2005) reveal that the rapidly increasing mortality rates for patients and HIV prevalence statistics in healthcare providers themselves were identified as major causes of provider/staff burnout. Veriava et al (2005) conducted a prevalence study at both Helen Joseph and Coronation Hospitals which revealed that 13,7% of 644 nurses anonymously tested (with a 91% response rate) were HIV positive. Nurses who resigned from these hospitals cited increasing workloads and perceived poor managerial support as causes for their decision to leave. Such workloads correlate with poor quality of healthcare delivery as Doherty (2002) contends that only a third of all doctors working in

South Africa are in the public service domain.

f) Fear of HIV diagnosis worsens the productivity of hospital personnel who are also inadequately trained to cope with ever increasing numbers of hospital admissions often from their own neighborhoods. Tonga Hospital's only psychologist resigned in August 2009-after only three months on the job, leaving patients without any psychosocial support. (HSRC, 2000).

2.2 Legislation that governs the management of healthcare delivery in South Africa.

The following legislation governs the management of healthcare in South Africa

i) The National Health Act Number 61 of 2003 outlines the duties and responsibilities of all stakeholders in the healthcare sector in South Africa. It also provides for the overall management and roll-out of occupational health services. The South African Health Review (2007) cites the uneven-and in some cases absent-delivery of this service by some provinces, attributed to a lack of capacity and financial support. This scenario is worsened by the lack of a health information system that can provide data generated by occupational health service programmes at provincial level.

ii) The Labour Relations Act Number 66 of 1995 provides for the establishment of bargaining councils at the workplace and at sectoral level, regulates trade union's organizational rights, deals with strikes and lock-outs, workplace forums, establishes the CCMA, Labour Court, Labour Appeal Court with exclusive jurisdiction on matters arising from the act.

iii) The Medicines and Related Substances Control Amendment Act Number 35 of 1997 which provides for the registration of medicines intended for human and

animal use, for the registration of medical devices, for the establishment of a Medicines Control Council (for the control of medicines, scheduled substances and medical devices, for the control of persons who may compound and dispense medicines) and for matters incidental thereto.

iv) The Medical Schemes Act Number 131 of 1998 allows for the establishment of a regulatory body to oversee the activities of medical schemes and to protect the interests of those insured with them. Medical schemes and administrators, medical scheme members and consumers, regulatory authorities and relevant government departments as well as business and labour organizations all receive regular information from the Board of Healthcare Funders relevant to payment for private healthcare.

v) The Compensation for Occupational Injuries and Diseases Act Number 138 of 1993 regulates compensation of workers for occupational diseases and injuries.

vi) Medicines and Related Substances Act Number 101 of 1965 provides for the authorization permit to be issued to a nurse to dispense schedule 1 to 4 substances at workplace healthcare delivery site. This act should shortly be able to cover nurses to dispense ARV's in Down Referral sites in accredited CCMTs like Mangweni and Ndindindi clinics-in credence to the argument of Hardon et al (2006) (for the provision of HAART at community level sites).

vii) The Promotion of Equality and Prevention of Unfair Discrimination Act Number 4 of 2000 which provides for measures to deal with discrimination of and inequality against employees stricken with chronic illnesses including HIV/AIDS.

viii) Nursing Bill Number 26 of 2005 outlines the scope of practice, duties,

responsibilities and level of accountability of nurses within government and other health service organizations.

ix) The Occupational Health and Safety Act Number 85 of 1993 which obliges Tonga Hospital-as regards HIV/AIDS-to minimize occupational HIV transmission through supply of relevant protective devices and application of universally accepted infection control procedures. Representative employee bodies like the HPCSA and SAMA have issued guidelines which are aimed at aligning employee behaviour with the relevant Acts of Parliament.

The ARV roll-out-led by the National Department of Health's Operational Plan (2003), spawned the National Strategic Plan (2001 – 2005)-which has recently been replaced by the 2007 – 2011 version.

g) Ongoing healthcare education for staff members of healthcare institutions has been neglected ever since the advent of HIV/AIDS in the early 1980's. Such employees only hear loud and discordant messages about HIV/AIDS once a year-on World AIDS day. Prevention of HIV/AIDS-a crucial tenet of HIV/AIDS management-receives insignificant attention and insufficient prominence all round. Prevention of HIV/AIDS is beset by cultural, social and economic barriers in the Black community. According to Shisana et al (2009) there are still major challenges that need coordinated, concerted and intensive effort over the short term, namely;

i) HIV prevalence stabilizing-since 2002-at high levels resulting in South Africa having the largest number of PLWHAs globally.

ii) Persistently high HIV prevalence continuing in females aged 25 – 29 years, pegged at 33%.

iii) Increase in intergenerational sex among female teenagers aged 15 -19 years, with a higher HIV prevalence group, that is, older males.

iv) Declining HIV prevention knowledge.

The Khomanani campaign-the South African government's main HIV prevention campaign-recording the lowest reach of all the national programmes.

Further exacerbating the problem are the following barriers to ongoing healthcare education:

i) Inadequate supply of personnel qualified and accredited by SAQA and the

ii) Health and Welfare SETA to deliver such a service.

iii) Budgetary constraints at provincial level which-in Mpumalanga-are so dire that the finance department's functions have recently (2009) been taken over by the national government due to "poor management of finances...

,

iv) Government's bad payer stigma which hampers the work of NGOs which are

v) able to render such services. (PEPFAR, 2009).

vi) Poor coordination of HIV/TB educational workshops for healthcare personnel,

vii) for instance, junior nurses being sent for workshops for programmes that cannot be rolled out in the short term like Isoniazid prophylaxis.

viii) Inadequate surveillance health systems-poor monitoring of patient compliance

to treatment and appropriate lifestyle changes. Patients on ARVs still continue to fall pregnant with HIV-untested and unemployed spouses. Bi-annual follow-ups of PMTCT patients are non-existent-which raises a major question about the usefulness of that program going forward.

2.3 Summary of literature findings

From the literature survey one will glean the following salient facts:

- 1) Access to HIV VCT at South African hospitals and clinics is a free service to all deserving community members.
- 2) The national Department of Health is tasked with managing healthcare delivery all over South Africa.
- 3) The right to healthcare access extends to HCWs as well.
- 4) The stigma of HIV/AIDS-which is consistent across all contexts-and discrimination against PLWHAs are major impediments to access to HIV VCT services.
- 5) Capacity constraints, dysfunctionality of the district health system and the cost of ARVs delayed the South African government's ARV roll-out program.
- 6) Sufficient and specific legislation for the management of healthcare delivery in South Africa exists.
- 7) Funding and strategic constraints are alleviated by overseas funding which incorporates capacity build-up, research and international collaboration in best practice and information sharing.

CHAPTER 3

RESEARCH PROBLEM AND HYPOTHESES

The research problem in this thesis is as follows:

What are the causes for the poor usage of free HIV VCT services at Tonga Hospital by its own staff compliment? What are the effect of HIV stigma and the location of the VCT site on the access to free VCT services at Tonga Hospital?

3.1 Research hypotheses

The research hypotheses to be investigated in this thesis are:

Hypothesis 1: Fear of HIV stigma prevents Tonga Hospital employees from accessing free VCT services at the same hospital in significant numbers.

Null hypothesis: HIV stigma does NOT prevent Tonga Hospital employees from accessing free VCT services at the same hospital in significant numbers.

Hypothesis 2: Location of the VCT site in Tonga Hospital deters Tonga Hospital employees from accessing free VCT services at the same hospital.

Null hypothesis: Location of the VCT site does NOT deter Tonga Hospital employees from accessing free VCT services at the same hospital.

3.2 Research variables

Independent variables under investigation are fear of HIV diagnosis and the stigma of HIV. The dependent variables under investigation are access to free VCT services and the level of usage of free VCT services.

CHAPTER 4

RESEARCH DESIGN

4.1 Survey methodology

A quantitative and descriptive survey was performed. It sought to analyze the relationship between the variables. Neither of the independent and dependent variables were under the control of the investigator.

4.2 Sampling design

To test the hypotheses a questionnaire was offered to the employees to fill in, in their preferred language. There was a choice of either English or siSwati questionnaires. All employees were asked to partake-with the exception of the few employees that were on maternity, paternity and bereavement leave.

4.3 Measuring instruments

The questionnaires, which were anonymous, and only require simple demographic information were collected on completion and thrown into a sealed box-once folded twice by the participant. The questions were open- ended and require the participant to apply his/her mind carefully and honestly. They were also specific and non-ambiguous.

4.4 Statistical Analysis

The data was analyzed by using descriptive statistics. In most cases percentages gave enough clarification to answer the hypotheses.

CHAPTER 5

RESULTS OF STUDY

The results of the investigation can be summarized by way of the following Tables.

Table 5.1 Reasons for usage/non-usage of Tonga Hospital's free VCT services.

	Fear of HIV Diagnosis	Location of VCT site
Yes	85%	25%
No	5%	18%
Undetermined	10%	57%

Table 5.2 The effects of Stigma, Congestion and Location of the VCT site on usage/non-usage of free Tonga Hospital's VCT services.

	Stigma	Congestion	Location of VCT site
Males (%)	88,99	71,55	37,61
Females (%)	61,65	77,82	18,80

Table 5.3 The effect of the Level of Education on usage/non-usage of Tonga Hospital’s free VCT services.

	Stigma	Congestion	Location of VCT site
Matriculated (%)	88,99	78,48	37,61
Non-matriculated (%)	62	72	41,42

The results of this investigation reveal that the fear of a positive HIV diagnosis has a profound effect in the employees’ decision NOT to access free VCT services at Tonga Hospital (see Table 5.1). The location of the VCT site does not have a significant effect in the employees’ decision NOT to access free VCT services at Tonga Hospital.

The relevance of the educational level was found to be an unreliable factor in the employees’ decision whether or not to access free VCT services at Tonga Hospital.

Reasons are:

- i) Some “matriculated” employees chose the English language questionnaire BUT answered in poor English with glaring spelling errors.
- ii) Some “non-matriculated” employees chose the isiSwati questionnaire and their answers were brief, clear and very informative.

Be that as it may, 88,99% of matriculated and 62% of non-matriculated participants felt stigma was a factor in their decision to use or not to use free Tonga Hospital’s VCT

services (see Table 5.2). Again, a very high majority of both groups (78,48% of

matriculated and 72% of non-matriculated participants) cited congestion as a deterrent to them accessing/not accessing the VCT site. 37,61% matriculated and 41,42% non-matriculated participants cited location of the VCT site as a deterrent to them using the free VCT services.

A very high percentage of males (88,99%)-versus 61,65% of females-cited stigma as an important factor in their decision not to access Tonga Hospital's free VCT services (see Table 5.2).

Congestion plays a very important role in both male and female employees' decision (71,55% and,82% respectively) NOT to access free Tonga Hospital's VCT services. 37,61% males and 18,80% females cited location of the VCT site as a deterrent to them accessing free VCT services at Tonga Hospital (see Table 5.2). Though small in number, their feelings have to be factored in when these findings are mulled over by the Mpumalanga Department of Health.

From this investigation unexpected findings surfaced. These are:

- 1) Congestion of the VCT site was cited by a significant number of participants, namely, 71,55% of males and 77,82% of females (see Table 5.2).
- 2) The level of education of the participants made no appreciable difference to the level of usage of the free VCT services.
- 3) Tonga Hospital does not have an HIV/AIDS policy and program.
- 4) There's sub-standard maintenance of employee safety, for instance, inconsistent
- 5) provision of N95 masks at relevant workstations.

6) Stigma and discrimination reduction action plans are absent, despite the enactment of the Promotion of Equality and Prevention of Discrimination Act

(Number 4 of 2000).

In summary, fear of a HIV diagnosis and the stigma associated with it, are major barriers to access to free VCT services by Tonga Hospital employees. Congestion of the VCT site at Tonga Hospital is a major barrier to access to free VCT services too. This localized study confirms the globally observed devastating effects of the HIV diagnosis and HIV stigma.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The findings of this investigation lead the investigator to make the following conclusions:

- 1) Fear of HIV diagnosis, congestion of the VCT site and HIV stigma are major causes for Tonga Hospital employee apathy towards free VCT services at their place of work.
- 2) Absence of a HIV/AIDS Policy and Programme at Tonga Hospital is a serious travesty of justice as it neglects basic health needs of the core of healthcare delivery-the healthcare worker.
- 3) The HAST directorate-being a specially funded vehicle-has serious shortcomings in its operational plan.
- 4) International funding agencies like PEPFAR include local capacity scale up in their funding package.

6.2 Recommendations

In order to address all the findings of this investigation, the following recommendations have to be urgently instituted by the Mpumalanga Department of Health, namely;

- 1) Urgent institution of an employee Health and Welfare Policy and Program-incorporating holistic HIV/AIDS management-at Tonga Hospital.

- 2) A leading 'light', for instance the CEO or the medical manager should lead such a program.
- 3) The HAST directorate-being a specially funded vehicle-should realistically coordinate such a program province-wide without any further delay.
- 4) A program monitoring and evaluation committee-comprising of employee representatives-should be formed. Its first assignment should be to ensure a complete buy-in from all union members. Services that should be offered by such a program are:
 - i) Antenatal care and PMTCT services.
 - ii) Screening services for breast cancer (annual mammograms), cervical cancer PAP and HPV smears, metabolic diseases (lipograms) and Obesity related problems.
 - iii) HIV/AIDS/STI/TB services.
 - iv) Occupational health services where the site will serve as a focal point for urgent awareness and protection against endemics/pandemics, for instance, Cholera in 2008 and H1N1 in 2009.
 - v) Protection of staff members with allergies and Asthma during hospital fumigation for pest control.
 - vi) Proper care of MDR-TB and XDR-TB and TB meningitis patients and maintenance of protective measures for staff members caring for such

patients.

- vii) Clinical psychology services.
 - viii) Dietetic services for employees with special needs as in Diabetes Mellitus and stage III HIV Disease.
- 5) Replication of this research province-wide- should be encouraged, to improve external validity.

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APPENDICES

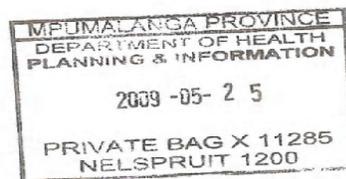
Appendix A Permission letter (from the Mpumalanga Research & Ethics Committee)

 health Department: Health MPUMALANGA PROVINCE	No. 7 Government Boulevard Riverside Park Extension 2 NELSPRUIT 1200	Private Bag X 11285 NELSPRUIT 1200 Tel.: +27 13 766 3429 Fax: +27 13 766 3458
Litiko LeteMphilo	UrnNyango WezaMaphilo	Departement van Gesondheid

Enquiries: Molefe Machaba (013) 766 3009/3102

25 May 2009

Dr Dennis Joseph Mkhulisi
P.O. Box 661
KWALUGEDLANE
1331



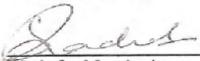
Dear Dr Dennis Joseph Mkhulisi

APPLICATION FOR RESEARCH & ETHICS APPROVAL: ACCESS TO VOLUNTARY COUNSELLING AND HIV TESTING SERVICES BY TONGA HOSPITAL EMPLOYEES

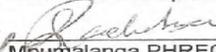
The Provincial Research and Ethics Committee has approved your research proposal in the latest format that you sent. No issues of ethical consideration were identified.

Kindly ensure that you provide us with the report once your research has been completed.

Kind regards,


Molefe Machaba
Research and Epidemiology

25 May 2009
Date


Mpumalanga PHREC
Chairperson: Dr Mosa Moshabela

25 May 2009
Date



Appendix B

Appendix B.1

English version questionnaire

Ring your preferred answer.

Q1) Knowing one's HTV status makes one feel good about one's health?

Yes / No.

Q2) Knowing one's HIV status shows that one cares a lot about one's loved ones? Yes / No.

Q3) Do you know where VCT services are at Tonga Hospital? Yes I No.

Q4) Have you used these services before? Yes / No.

Q5) Do you know that these services are free? Yes / No.

Q6) Would you recommend these free services to your relatives/loved ones? Why/ Why Not? Yes I No

Q7) If HIV stigma prevents you from using this facility, what does Tonga Hospital management need to do to make this facility easier for you/your loved ones to use?

Q8) Could it be that where the VCT site is currently situated prevents you from accessing the free VCT service? Yes / No.

(If Yes, how would you like the site changed? (Motivate, please).

II

Kindly take a moment to fill in the following basic information:

1) Gender: Male / Female

2) Age group (tick); < 30 years (Level 1- L1)

31 – 40years (Level 2 – L2)

41 – 50years (Level 3 – L3)

51 – 60years (Level 4 – L4)

61 – 70years (Level 5 – L5)

3) Have you passed Matriculation? : Yes/No.

IMIBUTO

- 1) Uyatati yini kutsi ligciwane le HIV unalo noma cha (loko kwenta uhlale utitsandza)? Yebo / Cha.
- 2) Uyati kutsi kwati ngeligciwane le HIV kuyakhomba kutsi uyatinakekela tihlobo takho na? Yebo / Cha.
- 3) Uyati yini kutsi lusito lwekuhlolwa kweligciwane lengculazi lutfolakala kuphi eTonga Hospital? Yebo / Cha.
- 4) Uke walusebentisa lolusito lwekuhlolwa kwengati ngaphambilini na? Yebo / Cha.
- 5) Uyati kutsi loluhlelo lumahhala ha na? Yebo / Cha.
- 6) Ungatitfumela yini tihlobo takho kuloluhlelo na? Yebo / Cha.
- 7) Uma ngabe kwati kutsi uneligciwane le HIV kukuletsela emahloni nokwesaba umphakatsi futhi usabe nekusebentisa loluhlelo lokutihlola, baphatsi balesibhedlela (saseTonga) bafanele bente njani kuze nikhululeke kusebentisa loluhlelo? Chaza.
- 8) Kungenteka yini kutsi lapho kutfolakala khona lolusito

awukakhululeki kuya khona? Yebo / Cha. Uma uvuma chaza kutsi ufisa kutsi singantjintja ini.

Imibuto yekuhlathiya

- 1) Bulili: Uyindvodza / Ungumfati.
- 2) Budzala bakho:
 - i) Iminyaka engaphantsi kuka 30.
 - ii) Iminyaka engaphakatsi kuka 31 na 40.
 - iii) Iminyaka engaphakatsi kuka 41 na 50.
 - iv) Iminyaka engaphakatsi kuka 51 na 60.
 - v) Iminyaka engaphakatsi kuka 61 na 70.
- 3) Uphumelele yini kuMatikuletjeni? Yebo / Cha.