



UNIVERSITY OF
KWAZULU-NATAL

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**A PROCESS EVALUATION OF THE IMPLEMENTATION OF THE HIV/AIDS
COUNSELLING AND TESTING (HCT) PROGRAM FOR EMPLOYEES AT A SELECTED
PUBLIC HOSPITAL IN KWAZULU - NATAL (KZN).**

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MASTERS DEGREE IN HEALTH SCIENCES

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COUNSELLING AND TESTING (HCT) PROGRAM FOR EMPLOYEES AT A SELECTED
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By

SELVARANI MOODLEY

**THESIS PRESENTED IN PARTIAL FULFILMENT FOR THE REQUIREMENTS FOR THE MASTERS
DEGREE IN HEALTH SCIENCES (MANAGEMENT) AT THE UNIVERSITY OF KWAZULU - NATAL**

FACULTY OF HEALTH SCIENCES

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DECEMBER 2011

DECLARATION

Selvarani Moodley, hereby declare that the entirety of the work contained in this dissertation therein is my own original work and has not been submitted for any other Degree or examination in any other University other than the University of KwaZulu - Natal. The work performed in this research report has been referenced from books, journals, articles, publications, Internet, magazines, SABC News etc.

I have given complete acknowledgement to the resources referred to in this study. I am the sole author and the UKZN cannot claim any third party publishing rights.

Signature_____

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Supervisor

Date:

DEDICATION

I dedicate this dissertation to my late dad for instilling in me the value of education, faith and prayer from an early age.

I also dedicate this dissertation to my loving husband, Desigan, for his constant support, patience and motivation without which I would not have been able to complete this time consuming program.

To my sons, Tristan and Luke and my only daughter, Leah; whose precious moments were sacrificed so I could complete my studies. May you also know the value of a good education!

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ABSTRACT

AIM

The aim of the study was to conduct a process evaluation of the implementation of the HIV/AIDS counselling and treatment program (HCT) for employees to ensure the delivery of standardised, high quality and ethical HIV counselling and testing services at a selected Regional Hospital in KwaZulu-Natal.

METHOD

A quantitative, non-experimental descriptive evaluative design was used to conduct the study. The study consisted of a two (2) questionnaire survey of a sample of 140 participants; One for the staff working in the HCT clinic (n=8) to evaluate the implementation of the HCT activities and the other for the staff that are employed at the selected public hospital (n=132) to evaluate their knowledge, attitudes and practise towards the HCT program. A checklist of the venue was also completed to evaluate the resources available at the HCT clinic. Informed consent was obtained from each participant. SPSS version 19 was used for data analysis.

RESULTS

The study revealed that the implementation practises of the HCT program were not according to the National Policy for HIV Counselling and Testing Guidelines (Department of Health, 2009) with regards to the availability of resources at the HCT clinic such as HIV test kits, chairs, gloves and sharps containers were available. Privacy was maintained while resources including condoms; directions such as posters to the clinic; pamphlets and reading material were unavailable. Nurse's knowledge and attitude was neutral. There were no correlations between nurses that attended a HIV course and those that did not. The distribution of knowledge was the same across all categories of experience and level of education. The majority of nurses had an HIV test voluntarily and found out the results. The finding of the study does not indicate whether or not the HIV test was done at the staff HCT clinic or elsewhere. A small minority reported that they tested for employer and insurance purposes.

A significant proportion of participants did not test because they were afraid that a person they know may test them and tell others and also because they did not think that the medical and nursing staff kept their testing information confidential.

CONCLUSIONS AND RECOMMENDATIONS

For the HCT program to be successfully implemented, resources and supplies must be available at the HCT clinic should an employee wish to use its services. It is recommended that funds be made available and budgeted for to increase the supplies of HIV test kits; provide condoms, books, pamphlets and reading material at the clinic.

The researcher also recommends courses be offered to nurses that are interested; include HIV/AIDS courses in the curriculum of nurses attending the college; provide in-service education/training for employees regarding the HCT program, its resources and activities; provide anti-retro viral treatment (ART) to employees at the HCT clinic in order to decrease untimely AIDS deaths.

KEY TERMS: HIV/AIDS; stigma; nurses; workplace, attitudes, HCT program.

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DEFINITIONS OF TERMS

Table 1: Definition of Terms

Term	Definition
Activities	“These are what a program actually does to bring about the intended change, such as surveillance, formation of partnerships for capacity development, referral for services, and the dissemination of prevention messages for healthy birth outcomes”(Centre for Disease Control, 1999).
AIDS	AIDS is the acronym for “acquired immune deficiency syndrome” and is the clinical definition given to the onset of certain life-threatening infections in persons whose immune systems have ceased to function properly as a result of infection with HIV (Department of Labour, 2000:15)
Health care worker	“Any person involved in the provision of health services to a client, not including health care providers. This includes lay counsellors and community caregivers and may also include a person who is trained to offer the same service to the deaf community” (Department of Health, 2009).
HIV	HIV is the acronym for “human immuno deficiency virus”. “HIV is a virus which attacks and may ultimately destroy the body’s natural immune system”. (Department of Labour, 2000: 25)
HIV Counselling	“An intervention which gives the client an opportunity to be educated and supported in order to explore his or her HIV risk; to learn about his or her HIV status and manage the consequences; to learn about HIV prevention and HIV and AIDS treatment, care and support services; and to learn how to modify their behaviour to reduce the risk of HIV infection” (Department of Health, 2009).
HIV Counselling and testing (HCT)	“An umbrella term used to describe services that combine both HIV counselling and testing. The policy distinguishes between two types of

	counselling and testing services – those that are client initiated and those that are provider-initiated” (Department of Health, 2009).
Human Immuno-Deficiency Virus (HIV)	“The virus that causes suppression which leads to destruction of the human immune system” (Department of Health, 2009).
Inputs	“These are the resources available for a program, such as: Funding, staff and leadership, expertise, program infrastructure, scientific knowledge and evidence-based strategies, and partnerships” (Centre for Disease Control, 1999)
Short-term outcomes	“Short-term outcomes represent the most immediate effects attributable to a program, such as changes in learning, knowledge, and attitudes. Examples include: Knowledge and awareness of the surveillance of local birth defects surveillance, and referral and prevention messages through the improved dissemination of accurate and timely information to organisations, agencies, and individuals” (Centre for Disease Control, 1999).
Outputs	“These are the products or direct services resulting from the program activities. Outputs are the direct evidence of implemented activities” (Centre for Disease Control, 1999).
Post-test Counselling	“A dialogue between a health care provider/worker and a client, with the aim of informing the client of his or her HIV test results and assisting him or her to understand the implication of the results, to reduce the risk of infection and to facilitate access to appropriate services” (Department of Health, 2009).
Pre-test Counselling	“A dialogue between a health care provider/worker and a client with the aim of assisting the client to assess his or her own risk from HIV and to make an informed decision about whether or not to take an HIV test” (Department of Health, 2009).
Referral	“A process of referring a client/patient to another health care worker or service for further investigation, management and treatment. This may

	<p>be horizontal referral or vertical (upwards and downwards) referral. Downward referral may be from a health facility to a local clinic or service, whereas upward referral maybe from a district or local service to a health facility“(Department of Health, 2009).</p>
Workplace health facilities	<p>“These facilities are situated at the workplace to provide staff with health and wellness programs, including those relating to TB, HIV counselling and testing and occupational health and safety” (Department of Health, 2009).</p>
Reliability	<p>“is concerned with the consistency, stability and repeatability of the informant’s account, as well as the investigator’s ability to collect and record information accurately” (Department of Health, 2009).</p>
Validity	<p>“Deals with credibility and authenticity” (Department of Health, 2009).</p>
Equipment	<p>“A set of tools, devices, kit, etc., assembled for a specific purpose and used in the HCT clinic” (Department of Health, 2009).</p>

Table 2: Abbreviations

Abbreviations	Terms
AIDS	Acquired Immune Deficiency Syndrome
DOH	Department of Health
DOL	Department of Labour
DPSA	Department of Public Service and Administration
EH&W	Employee Health and Wellness
EH&WSF	Employee Health & Wellness Strategic Framework
ILO	International Labour Organisation
HCT	HIV counselling and testing program
KAP	Knowledge, Attitude and Practice
MDG's	Millennium Development Goals
M&E	Monitoring and Evaluation
WHO	World Health Organisation
UKZN	University of KwaZulu-Natal
SANC	South African Nursing Council

CHAPTER ONE

INTRODUCTION

1.1. Introduction

South Africa is facing a quadruplet Human Immunodeficiency Virus (HIV) pandemic: Firstly HIV and Acquired Immune Deficiency Syndrome (AIDS) and tuberculosis (TB), and the second pandemic are that of maternal, infant and child mortalities (children under the age of 5 years). The third pandemic is violence and injury of the people infected with HIV and AIDS, and the fourth pandemic is that of non-communicable diseases including high blood pressure, heart disease, diabetes mellitus and cancer. According to the Minister of Health's speech, Dr Motsoaledi (2010:2), the HIV Counselling and Testing (HCT) program was developed to try and meet the targets of the National Strategic Plan on HIV, AIDS and Sexual Transmitted Infections (STIs). HIV testing is confidential. People need not disclose their status publicly, but are encouraged to disclose their status to friends and family. Part of this campaign is to fight stigma. Monitoring and Evaluation is an essential constituent of the implementation and management of the HCT program to ensure that the resources going into a program are being utilised, services are being accessed, activities are occurring in an efficient and guided manner, and the expected results are being achieved. This is for improving service quality and thus obtaining the maximum health benefit for the population served (Department of Health, 2009:78). Effective program evaluation is a systematic way to improve and account for public health actions by involving procedures that are feasible, propriety, useful and accurate.

1.2. Background

The impact of HIV/AIDS and other chronic diseases is being felt in the country as a whole, and the workplace is no exception. With infection rates still on the increase, departments must be prepared to deal effectively with HIV/AIDS so as to maintain high productivity and service

delivery levels whilst avoiding discrimination of those infected or affected (Department of Public Service and Administration, 2002:1). The HIV/AIDS pandemic has a major impact on the work places in South African as well as the economy as a whole. As the epidemic primarily affects working age adults, it's impact will be seen mainly by an increase in absenteeism and sick leave; faster staff turnover due to early deaths, more employees placed on disability pensions, lower staff morale, greater pressure on employee benefit funds and possibly a change in markets and demands for services (Department of Labour, 2001:3). HIV Counselling and Testing has a central role to play in the response to these problems, both for the health sector in general but most especially for the individual health professional. Thus, a process evaluation of the implementation of the HIV Counselling and Testing program for this group of professionals is crucial in South Africa's quest to reverse these negative trends.

As the single biggest employer in South Africa, with nearly 1.2 million public servants employed by approximately 140 government departments at national and provincial level, there is no doubt that the Public Service has a crucial role to play in mitigating the impact of HIV/AIDS as part of its overall focus on the health and well-being of its members (Department of Public Service and Administration, 2011:1). Thirty per cent of employees are employed in national departments, and 70% in provincial departments. Women now constitute 51% of the total Public Service staff complement, only one per cent short of their proportion within the total population. Large numbers of people are also direct dependants of public servants, and as a result, the fate of society as a whole is closely intertwined with the health and wellbeing of public servants (Department of Public Service and Administration, 2011:16).

Service delivery will be negatively affected – not only due to the number of infected employees, but also due to the increased demand for certain services, especially health and welfare, and the ability of the Public Service to attract and retain adequate levels of skilled staff (within the broader labour market). Services in remote areas and disadvantaged communities will be particularly vulnerable to absenteeism or deaths among staff, because of shortages of skilled staff and resource constraints. Sick leave could increase dramatically (Department of Public Service and Administration, 2011:16).

A literature search was conducted regarding the prevalence of HIV amongst health care workers and 2 empirical studies were found. The studies by Connelly, Veriava, Roberts, Tsotetsi, Jordán, & De Silva, (2007:1) and Shishana (2005:846), both yielded similar results that 13.7% of health care workers are HIV positive. The current production of nurses is 1896 per annum and given the fact that in one year 2745 nurses are succumbing to HIV/AIDS not considering the number of nurses who have already succumbed to the illness and may be sick or have died, it is evidently clear that the supply of nurses is not meeting the demand. Nurses are the backbone of the health care system, but if the nurses themselves are getting sick with HIV, who will care for the rest of the population? According to Connelly et al. (2007:1), one (1) out of 7 nurses and nursing students in this public sector workforce was HIV-positive. It can therefore be concluded that the HIV prevalence among health workers in South Africa is high, and this calls for the introduction of antiretroviral programs targeting them. This was of concern to the researcher, who therefore decided to do a process evaluation of the implementation of the HIV Counselling and Testing program for the nursing component of health care employees.

1.3. Description of the HIV Counselling and Testing Program for Employees

According to the Department of Health Policy (2009:22), HIV and AIDS is one of the most important challenges facing South Africa today. The government has made the fight against this disease one of its top priorities. In order to guide the National response, the South African government recently updated previous commitments and developed the National Strategic Plan (NSP) for HIV & AIDS and Sexually Transmitted Infections, 2007-2011. The National Strategic Plan outlines four key priority areas for the country; namely Prevention; Treatment, Care and Support; Research, Monitoring and Surveillance; and Human Rights and Access to Justice. Two primary goals inform all four priority areas: To reduce the incidence of new HIV infections in South Africa by half by 2011, and to ensure that at least 80% of those who are already HIV-positive have access to treatment. Knowledge of one's HIV status is critical to both these prevention and treatment goals. The implementation of the HIV Counselling and Testing program for staff within a legal and human rights framework is a key intervention towards the realisation of the goals of the National Strategic Plan (Department of Health, 2010:13).

According to the Department of Health (2010:46), HIV Counselling and Testing for staff is the entry point for the continuum of prevention, treatment, care, support and wellness of HIV/AIDS affected patients. The most important goal of an HIV Counselling and Testing program is for staff to improve their knowledge of their HIV status through these services. This program for staff is a critical element to increasing the awareness of HIV/AIDS, in order to reduce transmission and to improve early access to care and treatment. HIV/AIDS counselling and testing of staff forms part of the prevention program. It is only this component of the program for staff that was evaluated.

1.4. Purpose of the HIV Counselling and Testing Program for Employees

The purpose of the employee HIV/AIDS Counselling and Treatment Program in the workplace is to reduce the HIV infection rate among staff by providing education and support in the workplace. The purpose of this study will assist the institution and employees at a selected public sector hospital, by enhancing the HIV prevention and treatment services available to them. To be able to do this effectively, the researcher sought to do a process evaluation of the implementation of the program. (Department of Health Policy, 2009: 27)

1.5. The Overall Aim of the HIV Counselling and Testing Program for Employees

To provide universal access to good quality, effective HIV counselling, testing and referral services to all people in South Africa (Department of Health, 2009:27).

1.6. Objectives of the HIV Counselling and Testing Program for Employees

The objectives of this policy are to:

- ❖ Provide the core requirements and guidance to ensure the delivery of standardised, high quality, ethical HIV counselling and testing services.

- ❖ Outline different types of HIV counselling and testing approaches for different circumstances and target groups.
- ❖ Ensure compliance with a legal and human rights approach to HIV Counselling and testing.
- ❖ Expand access to HCT beyond formal health care settings into community, private sector and non-health care environments.
- ❖ Ensure appropriate referral to treatment (Department of Health, 2009:27).

1.7. Activities of the HIV Counselling and Testing Program for Employees

According to the Minister of Health, Dr Motsoaledi (2010:1), the HIV Counselling and Testing program will not only consist of HIV testing and counselling, but will also include:

- ❖ Information, education and mass mobilisation
- ❖ Detection and management of sexually transmitted infections
- ❖ Massive voluntary HIV counselling and testing
- ❖ Widespread provision of condoms, both male and female
- ❖ Embarking on a plan to introduce medical male circumcision on a large scale
- ❖ Prevention of mother to child transmission, aimed at totally eradicating the prospects of children being born with HIV
- ❖ Safe blood transfusions
- ❖ Post exposure prophylaxis for rape survivors at all health facilities
- ❖ Life skills education for learners.
- ❖ Blood pressure testing for the detection of hypertension
- ❖ Blood sugar testing for the detection of diabetes mellitus
- ❖ Haemoglobin testing for the detection of anaemia
- ❖ Symptomatic TB screening will be performed: Staff will be asked 5 questions, and should a positive answer be obtained for 1 of the questions, then the staff member will be screened for TB using sputum tests and an x-ray.

1.8. The Monitoring and Evaluation Framework of the HIV Counselling and Testing Program

According to the Department of Health (2009:80), the “input-output-outcome-impact” (logic model) framework is used in most Monitoring and Evaluation environments. To ensure that the HIV Counselling and Testing program achieves its goals in terms of the National Strategic Plan, inputs (policies, budget, staff, HIV-test kits), must result in outputs (HIV-test kit stocks and supply systems, new or improved HIV Counselling and Testing services and appropriate ratios of trained staff) within an enabling environment. These outputs are often the result of specific processes, such as training sessions for staff and campaigns aimed at promoting HIV testing. If these outputs are well designed and reach the target populations, the program is likely to have positive short-term effects or outcomes, such as an increased number of people testing for HIV in a target population. These positive short-term outcomes should lead to changes in the longer-term impact of HIV Counselling and Testing programs, possibly reflected in fewer new cases of HIV infection in a target population (Department of Health, 2009:80)

1.9. Research Framework

The Logic Model Evaluation framework was used for this research project (Centre for Disease Control, 2009: 14). The Model has 2 components:

- 1) The ‘Logic Model Framework’ to guide the evaluation process
- 2) The Logic Model Component Evaluation Model to focus the evaluation on the components of process evaluation.

A logic model is a visual “snapshot” of a program (or project) that communicates the intended relationship between program goals, activities, outputs, and intended outcomes. Logic models are an iterative tool useful for planning and evaluation purposes. Simply put, logic models graphically describe the theory—or logic—of how a program is supposed to work.

A basic logic model has two “components”—a process and outcome. When seen as a whole, these two components visually illustrate a program’s structure of processes and activities, the

outputs of these activities, and the intended changes resulting from these activities. Change is denoted at three levels of outcomes—short term, midterm, and long term.

The generic logic model reads from the left side of the page to right side. The process side identifies:

1. Inputs—these are the resources available for a program, such as funding, staff, and leadership, expertise, program infrastructure, scientific knowledge and evidence-based strategies, and partnerships.
2. Activities—these are what a program actually does to bring about the intended change, such referral to services, and the dissemination of prevention messages for HIV outcomes.
3. Outputs—these are the products or direct services resulting from the program activities. Outputs are the direct evidence of implemented activities.

The outcomes component of a logic model identifies the sequence of changes, that is, the results expected to be achieved by the program.

There are different types of evaluations that can be done such as process evaluations and outcome evaluation.

A Process evaluation can be described as a methodical gathering of evidence which is used to determine how well a program is intended to function and how it is actually functioning.

An Outcome evaluation can be described as the (sequence of) proposed changes that occur as a result from the program activities.

Adhering to the steps and standards of this framework will allow an understanding of each program's context and will improve how program evaluations are conceived and conducted. Furthermore, the framework encourages an approach to evaluation that is integrated with routine program operations. The emphasis is on practical, on-going evaluation strategies that involve all program stakeholders, not just evaluation experts. Understanding and applying the elements of this framework can be a driving force for planning effective public health

strategies, improving existing programs, and demonstrating the results of resource investments.

Figure 1: Logic Model Evaluation Framework (Centre for Disease Control, 1999: 14)

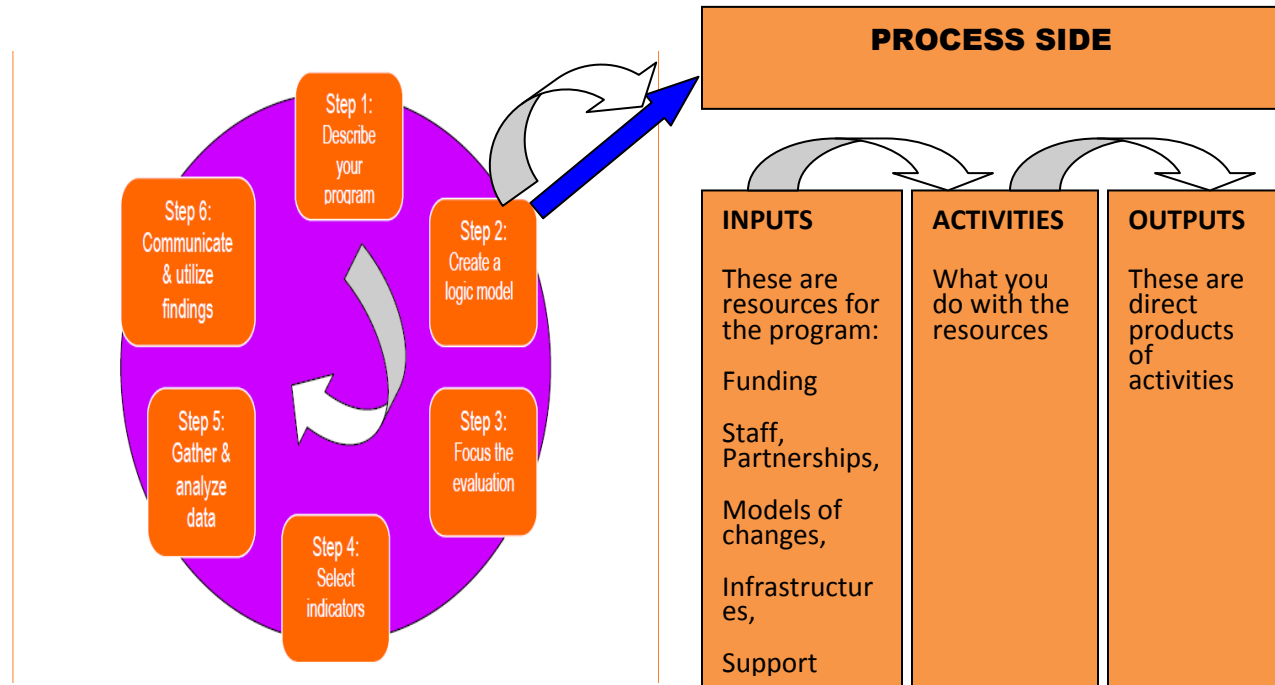


Figure2. Generic Logic Model Layout

(Centre for Disease Control, 2009:11)

The Logic model evaluation framework has six steps to it and is illustrated in Figure 1 above.

According to the CDC (1999:8), effective program evaluation is a systematic way to improve and account for public health actions by involving procedures that are useful, feasible, ethical, and accurate. The logic model evaluation framework comprises of six steps that are interdependent and must be taken in any evaluation. An order exists for fulfilling each step; earlier steps provide the foundation for subsequent progress. Thus, decisions regarding how to execute a step are iterative and should not be finalized until previous steps have been thoroughly addressed.

The steps are as follows:

Step 1: Engage stakeholders.

Step 2: Describe the program.

Step 3: Focus the evaluation design.

Step 4: Gather credible evidence.

Step 5: Justify conclusions.

Step 6: Ensure use and share lessons learned.

Adhering to these six steps will facilitate an understanding of a program's context (e.g., the programmes history, setting, and organization) and will improve how most evaluations are conceived and conducted (CDC: 8).

1.9.1. Step 1: Describe the Program

The description of the program is an essential component in any evaluation. If the program is not described, then it cannot be evaluated. In an evaluation, the effectiveness (outcomes) of the program evaluated against its aims, the impact of the program against its objectives and the process evaluation against the activities, processes and resources of the program. For the purpose of this study, a process evaluation was conducted on selected aspects of the implementation of the employee HIV Counselling and Testing Program, namely the counselling, testing and referral components.

I met with the CEO and Nursing service manager of the selected Public Hospital to inform them of my study and my intention to evaluate the HCT program for employees. They were happy to approve permission for my study provided that it was approved by the ethics committee of UKZN. After receiving an ethical clearance letter from UKZN they issued an official letter giving me permission to conduct the study at the institution.

1.9.2. Step 2: Create a Logic Model

The Logic Model process is a tool that has been used for more than 20 years by program managers and evaluators to describe the effectiveness of their programs. The model describes linkages among program resources, activities, outputs, audiences and short, intermediate and long term outcomes related to a specific problem or situation (Millar, Simeone & Carnevale,

2001:1). For the purpose of this evaluation, a process evaluation was done based on the first three components of the Logic Model as indicated in Figure 2.

1.9.3. Step 3: Focus the evaluation design

Step 3 focuses on the design that was used in the evaluation process. This step normally involves the development of the methodology of the evaluation.

1.9.4. Step 4: Select Indicators

This step involves selecting the indicators for each component identified in the logic model that measures the progress towards implementation and outcomes. Objectives, indicators, and data sources should be linked to each other across time. The indicators provide the standards against which the program was evaluated.

1.9.5. Step 5: Gather and Analyse Data

Step 5 involves the collection of the data. At this stage the stakeholders were also included, the reason being that the data collected is more credible if the stakeholders were included. It is also more likely that they will accept the evaluation conclusions and act on its' recommendations (Centre for Disease Control, 1999).

1.9.6. Step 6: Communicate and Utilise Findings

The stakeholders were included in this step so that the conclusions can be used with confidence (Centre for Disease Control, 1999:9). The data collected was analysed and interpreted, judgements were made regarding the findings, and recommendations are made regarding the program.

Rationale for choosing only one component

For the purpose of this evaluation, only a process evaluation was done because both the process and outcomes evaluations have a different purpose. Outcome evaluations should not be done until a process evaluation is done to determine whether the program was in fact implemented and running according to its stated objectives. A process evaluation is also on-going whereas an outcomes evaluation is done only after we know that the program is implemented and running; to assess whether the program is effective.

The evaluation framework is briefly described below and how it was proposed to be applied to this research study.

1.10. Problem Statement

In a study done by Evian, Fox, Macleod, Slotow & Rosen (2001:125) to determine the prevalence of HIV within workforces of Southern Africa, it was found that an average 17% of workers across all countries, sectors, job levels and age groups was HIV positive at the time of the survey. Health workers, including health professionals, have also been affected by this raging epidemic. Not only has the epidemic presented the health work force with a remarkably increased workload, with estimates of 50% of hospital beds being occupied by AIDS patients (Uebel, Friedland, Pawinski & Holst (2004:3), but 11.5% of the health workers in two of Gauteng province's public hospitals (Connelly et al., 2007:1) and 15.7% of the health workers in four of the other provinces in the country are themselves HIV positive (Shisana, Hall, Maluleke, Chauveau, Schwabe, 2005:846).

The HCT program for staff is a key element in the fight against the HIV epidemic and health care workers are encouraged to use the HCT facilities as a source of support. The objective of an HIV/AIDS program for staff is to build on employee's awareness by developing their knowledge and skills to personally respond to the epidemic. According to the National Strategy (2008:21),

none of the departments have formally evaluated their prevention programs. Stigma and discrimination are regarded as major obstacles to the successful implementation of the HIV Counselling and testing workplace programs (Mahajan, Colvin, Rudatsikira & Ettl, 2007:31; and the Population Council, 2002:1). One of the key challenges faced by the Public Service pertains to HIV/AIDS education and prevention programs which must receive solid, sustained support and become more rigorous and strategic (Department of Health, 2008:21). Evaluating the HIV Counselling and Testing program for staff will inform program coordinators of its effectiveness.

1.11. Significance of the Study

The provision of health, counselling, testing, treatment, care and support to health care workers infected or affected by the HIV/AIDS pandemic, minimizes disruption to the provision of care for patients. It also reduces the loss of essential skills and experience of nurses. The provision of HIV/AIDS counselling and testing respects the rights of the employees to remain productive in employment as long as they are healthy enough to work helps maintain their income and also contributes to their general wellbeing as a person. In this context, employers should facilitate admission to HIV Counselling and Testing as a comprehensive package for employees and their families. Key elements should include voluntary counselling and testing, disclosure, care and on-going support for the infected and the affected, as well as for those that test HIV negative. They should be counselled to live a healthy lifestyle in order to remain HIV negative (World Health Organisation & UNAIDS, 2005:21). Although government departments have implemented sound HIV/AIDS workplace programs, they are challenged by the problem of stigma and discrimination. Dickinson (2003:25) declares that stigma and discrimination are particular barriers to any response to HIV/AIDS in the workplace. Monitoring and evaluation is an important component of any program, as it provides feedback on the implementation of the program and the extent to which it is meeting its objectives. The findings of the HIV Counselling and Testing program can be used as baseline data for the implementation, monitoring and evaluation of consequent workplace programs for staff. The findings can also be used to obtain funding for the sustainability of the program.

Research area: This study will provide a basis for further researcher in the area.

Practise area: The study will assist managers in the Department of Health to recognise and take into account the strengths and weaknesses of the program.

Education area: It can serve as a source of reference for program coordinators, policy makers and in-service education and training departments.

1.12. Relevance of the Study to South Africa

Hall (2004:2) reports that nurses can also be infected with HIV/ AIDS, which will eventually lead to increased absenteeism, stress and lower performance on their part. It will also result in an increase in workloads and unhappiness for the remaining workforce. Many nurses emigrate, and many succumb to AIDS related illnesses, which results in a shortage of nurses in an already overburdened health care system in South Africa. The South African public service is the largest employer in the country, with approximately 1.2 million employees. The impact of HIV/AIDS on the public service sector includes a loss of skills development, challenges in addressing employment equity, a decline in service delivery improvement and a slowdown in poverty alleviation (DOL, 2000:2). In addition to this, some employees are reluctant to disclose their statuses, with a resultant low uptake of the HIV/AIDS related services available in the workplace (Mahajan et al. 2007:38).

The research study and findings would benefit the institution at large as well the people living with HIV and AIDS, the affected employees and the community. The findings of the study are used to inform nursing practice and make recommendations, as well as influence decision-making and policy formulation. This knowledge is necessary to provide the relevant information required to improve the implementation of the HIV Counselling and Testing program to enable the health care worker (and the hospital as a whole) to care for themselves and HIV/AIDS patients more effectively. The study will serve two purposes, namely to provider recommendations for the nurses, as well as for the program coordinators for HIV/AIDS, in order to address the gaps identified regarding the HCT program. Secondly, the study will provide baseline information that may be used for further monitoring and evaluation.

1.13. Rationale

The nursing workforce comprises mostly of women who are at increased risk for infection with HIV as a result of their cultural and social status in relation to men. Indeed, women account for 52% of all people living with HIV in Sub-Saharan Africa (UNAIDS, 2010:10), a figure that reflects their relative lack of capacity to protect themselves. Furthermore, nursing in Africa is not a highly valued or respected profession; nurses are often the victims of violence in the workplace, with little opportunity for compensation or alternative employment. In the absence of adequate supplies of personal protective equipment, nurses are constantly exposed to the transmission hazards inherent in the work environment. Fear of stigmatisation inhibits many nurses from being tested for HIV (Dieleman, Bwete, Maniple, Bakker, Namaganda, & Odaga, 2007:205; and Kyakuwa, 2009:367). Consequently, those who are infected may avoid disclosure and delay treatment until the disease is advanced.

According to the Department of Health (2010:53), monitoring and evaluation has the following objectives: to monitor the progress of HCT services and measure its effectiveness, it also identifies weaknesses and gaps in the provision of services and takes measures to address it. It also informs planning, allocation, prioritization and management of resources and maintains a referral system.

According to the World Health Organization (2004:10), evaluation assesses the worth or value of a program. Monitoring and evaluation research/activities allow country health authorities and their partners to assess the extent to which programs are being implemented and are achieving the intended objectives.

1.14. Aims and Objectives of the Study

1.14.1. Aim

The aim of the study was to conduct a process evaluation of the implementation of the HIV/AIDS counselling and treatment program (HCT) for employees to ensure the delivery of standardised, high quality and ethical HIV counselling and testing services at a selected Regional Hospital in KwaZulu-Natal.

1.14.2. Objectives

- ❖ To evaluate the availability of the resources in the employee HCT clinic.
- ❖ To evaluate the implementation of the HCT activities for employees at a selected hospital in KZN.
- ❖ To evaluate the Knowledge, Attitude and Practice of nursing staff towards the employee HIV Counselling and Testing program.

1.14.3. Research questions

- ❖ What resources are available at the employee HCT clinic?
- ❖ What activities are available at the employee HCT clinic?
- ❖ What is the level of knowledge, attitude and practise of nursing staff towards the HIV counselling and testing Program?

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

The Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) are serious public health problems, which have socio-economic, employment and human rights implications. It is recognized that the HIV/AIDS epidemic will affect every workplace, with prolonged staff illness, absenteeism, and death impacting on productivity, employee benefits, occupational health and safety, production costs and workplace morale. HIV knows no social, gender, age or racial boundaries, but it is accepted that socio-economic circumstances do influence disease patterns. HIV thrives in an environment of poverty, rapid urbanization, violence and destabilization. Transmission is exacerbated by disparities in resources and patterns of migration from rural to urban areas. Women particularly are more vulnerable to infection in cultures and economic circumstances where they have little control over their lives.

Furthermore HIV/AIDS is still a disease surrounded by ignorance, prejudice, discrimination and stigma (The South African Labour Guide, 2011:1). In the workplace, unfair discrimination against people living with HIV and AIDS has been perpetuated through practices such as pre-employment HIV testing, dismissals for being HIV positive and the denial of employee benefits.

The majority of the employees in the health sector are woman who are very young when they commence training as a nurse. According to the WHO and UNAIDS, in some cases the workforce comprises of 80% women. Women are more likely to become infected with HIV than men, and are also more adversely affected by the consequences of the epidemic for a wide variety of reasons including biological, socio-cultural and economical reasons. In this context, it is essential that the gender dimensions of HIV/AIDS and occupational health and safety are fully recognised and those both male and female health care workers are sensitised through education, training and information (WHO & UNAIDS, 2005:9).

One of the most effective ways of reducing and managing the effect of HIV/AIDS in the workplace is through the implementation of an HIV/AIDS policy and program. Addressing the aspects of HIV/AIDS in the work environment will enable employers, trade unions and government to actively contribute towards local, national and international efforts to prevent and control HIV/AIDS (The South African Labour Guide, 2011:1). This led to the development of the Code of Good Practice on key aspects of HIV/AIDS (DOH, 2000), as a guide to employers, trade unions and employees.

A collective agreement between the Department of Public Service and Administration and the Public Service Coordinating Bargaining Council (PSBC) reached a conclusion that it is crucial to prevent “*unfair discrimination and stigmatisation of people living with HIV or AIDS through the development of HIV/AIDS policies and programs for the workplace*”(Department of Public Service and Administration, 2002:135). Despite this agreement, however, the use of HCT facilities remains low, regardless of their establishment within the workplace (Department of Labour, 2001:2).

The Public Service embraces four broad objectives based upon the Department of Health’s National Strategic Plan for HIV and AIDS and Sexually transmitted infections (2007-2011):

- ❖ The rate of HIV prevalence must be reduced through prevention
- ❖ Employees that are infected must be provided with treatment, care and support
- ❖ human rights of individuals and access to justice must be protected
- ❖ The Public Service in South Africa must have a research program (Department of Public Service and Administration, 2008:25).

As stated in the Technical Assistance Guidelines (Department of Labour, 2001:55), “workplace prevention programs are essential to combat the spread of HIV and to foster greater tolerance towards persons living with HIV/AIDS”. The Workplace Wellness Management program grew out of the Employee Assistance Programs (EAP) and Work-Life Balance Programs. Historically the EAP mainly supported individual wellness, through counselling and such educational efforts as stress management, managing change, and other wellness promotion strategies. Some institutions include HIV Counselling and Testing into the EAP to prevent discrimination against people living with HIV and AIDS because of the stigma attached to the disease. The objective of

a wellness program is to ensure that HIV positive staff remains healthy and fit to work for as long as possible (Department of Labour, 2001:93).

According to Uebel, Friedland, Pawinski, & Holst (2004:425); Naidoo, Uys, Greef, Holzemer, Makoae, Dlamini, Phetlhu, Chirwa & Kohi (2007:21), health care workers carry a tremendous burden, as well as the silence fear and hopelessness surrounding a diagnosis of HIV infection, both in patients and themselves (internal stigma). Specific treatment and care programs for health care workers should be convenient and offer integrated, comprehensive services. The programs may lead to decreased stigmatisation and a greater willingness to discuss their HIV infection status and treatment. Incorporating HIV services for health care workers into comprehensive health care services instead of within specialised Anti-retroviral clinics normalises this disease and reduces the stigma.

Interventions within the health services are more successful when they are part of a broader campaign to reduce stigma and discrimination, and these can be significantly reduced by combining a complementary interventions such as the appropriate training of personnel at all levels of responsibility, in order to increase their understanding of HIV/AIDS and to help reduce negative and discriminatory attitudes towards colleagues and patients living with the disease. This training should provide health-care workers with: information on the modes of transmission of HIV/AIDS and other infectious diseases; the level of occupational risk involved in order to address the fear of physical contact with patients; and provide a platform for continuous learning.

Once an institution has implemented an HIV/AIDS workplace program, it is necessary to embark on an evaluation process of that intervention (Department of Labour, 2000:13). The reason for this is to determine if the program is addressing the issues that it was intended to deal with (Esu-Williams, Pulerwitz & Mgilane, 2005:1). Monitoring and evaluation is an important component of the HIV Counselling and Testing program to determine if it is suitable, resourceful, cost effective and meeting the set objectives (Department of Public Service and Administration, 2002: 64). Reporting, monitoring and evaluation is an important and often neglected, component of a workplace HIV/AIDS response. It also has an important function in every HIV/AIDS intervention in the place of work. Delobelle, Onya, Langa, Mashamba & Depoorter

(2010: 34) assert that more research is required to evaluate the effectiveness and applicability of different health promotion strategies, and to test and refine innovative approaches. The relative lack of indicators, research and evidence of health promotion interventions constitutes an on-going challenge. The researcher therefore found it interesting to evaluate the implementation of the HIV Counselling and Testing program at her place of work.

In a study done by Evian, Fox, Macleod, Slotow & Rosen (2001:125) to determine the prevalence of HIV in workforces in Southern Africa, it was found that on the average 17% of workers across all countries, sectors, job levels and age groups was HIV positive at the time of the survey. The health workers, including the health professionals have also been affected in a confused way by this raging epidemic. This is not only because of the fact that the epidemic has presented the health work force with a remarkably increased workload with estimates of 50% of hospital beds being occupied by AIDS patient (Uebel, Friedland, Pawinski & Holst (2004:3) but also because of the fact that 11.5% of the health workers in two of Gauteng provinces public hospitals (Connelly, Veriava, Roberts, Tsetetsi, Jordan, De Silva, et al, 2007:205) and 15.7% of the health workers in four provinces of the country are themselves HIV positive (Shisana, Hall, Maluleke, Chauveau, Schwabe, 2004:846).

This has an enormous implication due to the fact that HIV/AIDS in the health care work force challenges the success of both general and AIDS-related health care investments, by reducing the average level of work experience and driving up costs for public sector health budgets (Connelly et al., 2007:205).As such, the importance of sustaining and expanding the fight against HIV/AIDS within the whole population in general and the health work force in particular cannot be over-emphasised.

The following effects might be characteristic of employees suffering from chronic conditions (especially if the condition is not well controlled):

- ❖ Increased medical costs (hospitalisation, medicine usage, and other healthcare costs)
- ❖ Increased absenteeism and sick leave utilisation
- ❖ Loss of experience due to early retirement and/or premature death due to ill health
- ❖ Diminished performance and/or productivity due to physical incapability

- ❖ Diminished overall effectiveness of the employee (International Labour Organisation, 2001:27).

HIV and AIDS are most prevalent in adults in their productive prime. With prevalence rates of over 20% in many Sub-Saharan countries, and with infections rising rapidly in many other regions, organisations are increasingly finding that HIV/AIDS is affecting their operations. As a result of this, addressing HIV/AIDS in the workplace is becoming a priority for governments, commercial organisations and non-governmental organizations (NGOs). At the heart of HIV/AIDS workplace strategies are three components: A comprehensive policy supported by management guidelines; an education and prevention program, and a treatment and care program. The initial focus was on education and prevention, but it quickly became clear that in order to be effective (and to overcome the stigma associated with HIV/AIDS) these programs needed to be addressed within the context of clear HIV/AIDS workplace policies. Early programs focused on education and free condom distribution. Over time these were expanded to include treatment of opportunistic infections, prevention of mother-to-child transmission and counselling.

According to the Code of Good Practise on key aspects of HIV/AIDS (DOH, 2000), “the effective management of HIV/AIDS in the workplace requires an integrated strategy that includes, amongst others, the following elements:

- ❖ An understanding and assessment of the impact of HIV/AIDS on the workplace
- ❖ Long and short term measures to deal with and reduce this impact, including:
- ❖ An HIV/AIDS policy for the workplace, a prevention program,
- ❖ A wellness program
- ❖ Management strategies to deal with the direct and indirect costs of HIV/AIDS

Workplace prevention programs are essential to combat the spread of HIV and to foster greater tolerance towards persons living with HIV/AIDS. A prerequisite for behaviour change is the correct basic knowledge of the disease,” and its treatment, through the HIV education program; and the support of top management. The impact of the HIV/AIDS pandemic is severely felt throughout the world. The estimated number of people living with HIV worldwide is about 33

million and 2, 6 million were newly infected with HIV in 2009 (UNAID, 2010:20). Research has shown that HIV-infection tends to follow the contours of poverty and vulnerability (Prentice, 2004:4).

Sub-Saharan Africa is the region worst affected by HIV/AIDS (UNAIDS, 2010:9) and accounts for 68% of the global prevalence of HIV, with diverse, generalised HIV epidemics that disproportionately affect women and young people (particularly young women). Women are a more vulnerable group, and Dlamini, Kobi, Uys, Phetlhu, Chirwa & Naidoo (2007: 390), reported that they had a fear of disclosing their status because they experienced discrimination and violence. Women now account for almost 52% of the global adult prevalence of HIV and AIDS, and account for 60% of cases in Sub-Saharan Africa. A joint report by the International Federation of Red Cross and Red Crescent Societies, the Global Network of People Living with HIV/AIDS and UNAIDS (2004:1) indicates that, although Sub-Saharan Africa has approximately 10% of the world population, it is home to 70% of all of the people living with HIV. It has been observed that of all people living with HIV in the world, six out of every ten men, five out of every ten women and nine out of ten children live in Sub-Saharan Africa (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste & Pillay, 2005:19).

In Sub-Saharan Africa, heterosexual intercourse remains the epidemics' driving force, but the UNAIDS report (2010:17) asserts that unprotected sex between men who have sex with men is also an important factor in the Sub-Saharan African HIV epidemic. Although homosexual behaviour is very common in this region, it is highly stigmatised. There is also an extensive transmission from mothers to new-borns and breastfed babies, with 91% of all new infections seen in children (UNAIDS, 2010:17). Injecting drug users also appear to be at high risk for the disease.

South Africa is currently experiencing one of the most severe AIDS epidemics in the world. Of the 48 million South Africans estimated in the last census, 5 700 000 were estimated to be HIV infected (Department of Defence HIV/AIDS Prevention Program, 2009, p. 78) with a prevalence rate of 18, 1% for people between the ages of 15-49 years. Of these, 3 200 000 are women in urban and rural informal environments (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste & Pillay, 2005:19)

Currently, South Africa has more people living with HIV than any other country in the world (UNAIDS, 2010:8). In spite of having the largest Antiretroviral (ARV) program in the world, less than half of those requiring treatment are currently able to access ARV's. HIV-related mortality remains high. It is thought that almost half of all deaths in South Africa, and a staggering 71% of deaths among those aged between 15 and 49, are caused by AIDS. So many people are dying from AIDS that in some parts of the country, cemeteries are running out of space for the dead (World Health Organisation, 2011:9).

Apart from the death and suffering that HIV has caused on an individual and community level, South Africa's AIDS epidemic has significantly undermined the country's overall social and economic progress: Average life expectancy in South Africa is now 54 years – without AIDS, it is estimated that it would be 64. Hospitals are struggling to cope with the number of HIV-related patients that they have to care for, and a 2006 estimate was that HIV-positive patients could be accounting for 60-70% of medical expenditure in South African hospitals (World Health Organisation, 2011:10). Walker, Reid, and Cornell (2004:16) attribute the widespread prevalence of HIV-infection in South Africa to a number of phenomena such as poverty, illiteracy, the apartheid system, occupational health risks, migrant labour, overcrowded and unhygienic accommodation, as well as the controversial stance of key political leaders in the fight against HIV/AIDS.

HIV Wellness Management addresses the individual and organisational wellness in a proactive manner. This development of the Wellness Program is a drastic departure from the Employee Assistance Program which was limited in scope and practice, and was reactive but failed to focus strongly on disease prevention. The vision for the Employee Health and Wellness Strategic Framework (Department of Public Service and Administration, 2008:24) is to provide programs that can develop and maintain healthy, dedicated, responsive and productive employees within the public service who can add value to their organisations. Some two decades since the introduction of this disease in the general population, the epidemiological situation is still characterised by very large numbers of people living with HIV and a disproportionate effect on particular sectors of society, viz.; young women, the poor, as well as those living in underdeveloped areas in the country. HIV infection and AIDS disease however,

affects the lives of all South Africans in many different ways (Department of Public Service and Administration, 2008:24).

Employee Health and Wellness Programs (Department of Public Service and Administration, 2008:25) within the Public Service are rapidly transforming the nature of the holistic support provided to employees to ensure risk management, the occupational health, safety, productivity and the wellness of government employees and their families, and the safety of citizens in the Public Service world of work. One of the key challenges faced by the Public Service pertains to HIV/ AIDS education and prevention programs, which must receive solid, sustained support and become more rigorous and strategic (Department of Public Service and Administration, 2008:21). A department's policy and program should comply with the minimum standards on HIV/AIDS which include amongst others: non-discrimination; safety in the workplace; the prohibition of HIV testing; the encouragement of voluntary counselling and testing; confidentiality of test results; openness and acceptance and comfort for employees living with HIV/AIDS.

A positive behaviour change can alter the course of the epidemic—while stigmatisation and discrimination, the lack of access to services and poor legislation can make epidemics worse (UNAIDS, 2010:8). In both cases, the effects are often profound. According to the Department of Labour (2011:55), HIV prevention programs in the place of employment are crucial to fight the spread of HIV/AIDS. It is also necessary to increase acceptance for colleagues infected with HIV/AIDS. The implementation of HIV prevention and wellness programs and HIV/AIDS counselling and treatment programs in Sub-Saharan Africa is a complex undertaking that requires the training of health care providers. Many Sub-Saharan African countries have introduced training programs to build human resources for health. Evaluation of the on-going trainings is warranted so that programs can be improved and updated to meet the needs of health care (International Labour Organisation, 2001). According to the National Strategy (2008:21), none of the departments have formally evaluated their prevention programs. This has aroused the researcher's interest to evaluate the implementation of the HIV/AIDS counselling and testing program for employees at a selected Regional Hospital in KwaZulu-Natal.

2.2. The Impact of HIV / AIDS in the Workplace

According to the Department of Public Service and Administration (2002:15), within the workplace are many employees who are HIV infected, the impact will be evidenced in a number of ways:

2.2.1. Morbidity and Absenteeism

Employees who are infected with HIV will become sick requiring sick leave. This will disrupt the operation of the institution for which they work especially if the employees that are absent are either more experienced or more qualified. HIV leads to increased deaths; this will affect the absenteeism of all staff as employees will need to attend funerals of both colleagues and loved ones. Female employees, due to their socially defined role as care givers, will have to care for sick children and partners, and this will involve time off from work (Department of Public Service and Administration, 2002:15).

2.2.2. Mortality or Retirement

The impact of the death or retirement of an infected employee is similar to that of morbidity, although the problems are permanent. When an employee dies, the institution has to replace the employee. The new employee will need training. It can be very difficult to replace highly qualified staff especially in countries where there is already a shortage of skilled personnel. Training and recruitment are costly and disrupt operations (Department of Public Service and Administration, 2002:15).

2.2.3. Staff Morale

The epidemic has a negative impact on morale in the workplace. Employees have a fear of occupational infection and even death. Employees become suspicious about other staff that

are off sick and may not want to take on the additional responsibilities of those off sick. (Department of Public Service and Administration, 2002:15).

2.2.4. Benefits

Employers and employees are affected as the cost of employee benefits increases (Department of Public Service and Administration, 2002:15).

2.2.5. Demand for Services

The demand for services, particularly health and welfare services is likely to increase dramatically. This will have major implications for departments that provide these services, and even more so if they already face capacity constraints or are short staffed (Department of Public Service and Administration, 2002:15).

2.3. HIV / AIDS Legislation

In South Africa, there are various policies and legislation pertaining to caring for and protecting the rights of an HIV patient. It includes the Constitution of South Africa, Act 108 of 1996; the Labour Relations Act 66 of 1995; the Basic Conditions of Employment Act 75 of 1997; the Employment Equity Act 55 of 1998; the Compensation for Occupational Injuries and Diseases Act 133 1993); the Medical Schemes Act no 131 of 1998;, and the Promotion of Equality and Prevention of Unfair Discrimination Act no 4 of 2000.

2.3.1. Constitution of the Republic of South Africa Act, No.108 of 1996

“The Constitution provides that every person has the right to privacy and bodily integrity. This means that no person may be treated (including HIV testing) without informed consent and they have the right to privacy regarding their HIV status.”

2.3.2. Employment Equity Act, No. 55 of 1998

“The Employment Equity Act prohibits testing of an employee for HIV without authorisation by the Labour Court. This means employers are required to apply to the Labour Court for a Court Order granting permission to test for HIV before requiring employees to submit to such a test.

Section 7(2) of the Act states: “Testing of an employee to determine that employee’s HIV status is prohibited unless such testing is determined justifiable by the Labour Court in terms of section 50(4).”

Section 50(4) provides the Court with the power to impose conditions on authorised HIV testing”.

2.4. Measures to Deal with HIV / AIDS within the Workplace

“Every workplace should develop an HIV/AIDS policy, in order to ensure that employees affected by HIV/AIDS are not unfairly discriminated against in employment policies and practices” (South African Labour Guide, 2011:10). This policy should show the nature and requirements of the organizations workplace HIV/AIDS intervention; an outline of the HIV/AIDS program; details on employment policies (e.g. It’s position regarding HIV testing, employee benefits, performance management and procedures to be followed to determine medical incapacity and dismissal); and details of employee assistance available to persons affected by HIV/AIDS (The South African Labour Guide, 2011:9). According to the South African Labour Guide (2011:5), an employee cannot have their employment terminated due to their HIV status. An employer cannot enforce an HIV test in the pre-employment check-up, and can only provide testing as part of the health care services rendered to existing employees or in the event that the employee had an occupational accident carrying a risk of contact with infected body fluids (The South African Labour Guide, 2011:6). The policy should reflect the nature and needs of the particular workplace. Policy development and implementation is a dynamic process, so the workplace policy should be communicated to all concerned, monitored for its successful implementation and evaluated for its effectiveness.

2.5. Employee Wellness Program

According to Department of Public Service and Administration (2005:11), even though many of their departments had implemented Employee Assistance Programs (EAP) and Employee Wellness Programs (EWP), these programs were very limited in their integration of HIV/AIDS as a major concern to health care professionals. In some departments, the HIV/AIDS program was incorporated into the EAP or EWP, as they found it was better for it to be integrated than having a standalone HIV clinic where employees felt exposed and stigmatised. In other cases, HIV/AIDS programs fell under a completely separate organisational structure such as Human Resources, who had special clinics for this purpose (Department of Public Service and Administration, 2005:11).

According to Magwaza (2009:4), who investigated the exposure of employees in the South African Police Service (SAPS) to the HIV/AIDS workplace program, stigma and discrimination were reported as major obstacles to the successful implementation of the HIV/AIDS workplace program. Even though majority of the staff at the Police Service had high levels of knowledge, a small minority disclosed that they would not feel comfortable disclosing their status because of the consequences thereafter.

At the public hospital selected for this study, the HIV Counselling and Testing program is a component of the Human Resource Department and includes other wellness aspects such as the checking of blood pressure, glucose monitoring, haemoglobin measurement and the symptomatic screening of TB (Dr.Motsoaledi, 2010:3)

2.6. Management of HIV in the Workplace

The first meaningful HIV/AIDS workplace program was implemented in 1994. The Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment was formulated in 2004 and finally the National Strategic Plan for HIV and AIDS 2007-2011 was developed (Department of Health, 2008b:7). Voluntary HIV counselling and testing was an important

component of the National Strategic Plan (Department of Health, 2008b:24). But with the voluntary HIV counselling and testing, other efforts were made to prevent the spread of HIV, such as patient counselling and testing. This then led to the formulation of the HIV Counselling and Testing policy and program.

The efficient administration of HIV/AIDS in a place of employment demands an incorporated strategy of assessing the impact of HIV/AIDS on the workplace, and ways of reducing and dealing with this impact. These measures include an HIV/AIDS Policy for the workplace, and HIV/AIDS Programs which incorporate the on-going sustained prevention of the spread of HIV among employees and their communities; the management of employees with HIV so that they are able to work productively for as long as possible; and strategies to deal with the direct and indirect costs of HIV/AIDS in the workplace. According to the Department of Labour (2001:55), “workplace prevention programs are essential to combat the spread of HIV and to foster greater tolerance towards persons living with HIV/AIDS”. The annual reports do not report on workplace based HIV and AIDS specifically. Reference is made to HIV and AIDS as part of the wellness program or a broader staff development program (Department of Health, 2008b:44).

2.7. Organisational Wellness

Individual wellness is the promotion of the physical, social, emotional, occupational, spiritual, and intellectual wellness of individuals (Department of Health, 2008:32). This is attained by creating an organisational climate and culture that is conducive to wellness and the comprehensive identification of psycho-social health risks. Organisational wellness promotes an organisational culture that is conducive to individual and organisational wellness and work-life balance, in order to enhance the effectiveness and efficiency of the Public Service. The intended outcome of wellness management is to maximise and sustain the potential of human capital and an effective and efficient Public Service that is positively responsive to the needs of the public. Wellness Management emerged as a priority due to an increasing recognition of the fact that the health, safety and wellness of employees directly impacts on the productivity of the entire organisation. As employees are the life-blood of a workplace, and workplace factors

influence the overall wellness and employee performance, it is vital to help them to produce at their optimum levels.

The Workplace Wellness Management program (Department of Health, 2008:32) grew out of the Employee Assistance Programs (EAP) and Work- Life Balance Programs. Historically the EAP mainly supported individual wellness, through counselling and such educational efforts as stress management, managing change, and other wellness promotion strategies. The Work-Life-Balance Program promotes flexibility in the workplace to accommodate work, personal and family needs. This benefits the organisations because employees are more satisfied and motivated. Wellness Management strives to meet the health and wellness needs of the Public Servants through preventative and curative measures, by customising those aspects from the traditional programs such as EAP, Work-life Balance and Wellness Management programs that are the most relevant and fit the uniqueness of the Public Service and its mandate (Department of Health, 2008:32). The objective of a wellness program is to ensure that HIV positive staffs remain healthy and fit to work for as long as possible (Department of Public Service and Administration, 2002:93).

HIV and AIDS affect all spheres of life including the workplace. There is a dire demand for each work environment to develop its respective HIV/AIDS policy and eventually implement HIV/AIDS program to mitigate the impact of the epidemic. However, stigma and discrimination are major challenges to be tackled as part of a successful implementation of the workplace program.

2.8. HIV / AIDS Workplace Programs

According to the Code of Good Practice on key aspects on HIV/AIDS in the Workplace (DOH, 2000); the Employment Equity Act, Act No. 55 of 1998; and the Department of Public Service and Administration (2002:77), the minimum requirement for effective management of HIV/AIDS in the workplace requires an integrated strategy, which includes a workplace HIV/AIDS policy and an outline of the company's HIV/AIDS program. The Code of Good Practice

on key Aspects of HIV/AIDS and Employment also recommends that every workplace HIV/AIDS program incorporate and address the following key issues:

“Hold regular HIV/AIDS-awareness programs; Encourage HIV testing; Conduct education and training on HIV/AIDS; Promote condom distribution and use;

Encourage health-seeking behaviour for those with sexually transmitted diseases (STDs); Enforce the use of universal infection-control measures; Create an environment that is conducive to openness, disclosure and acceptance among all staff; Endeavour to establish a wellness program for employees affected by HIV or AIDS; Provide access to counselling and other forms of social support for people affected by HIV or AIDS;

Maximize the performance of HIV-affected employees through reasonable accommodation, such as investigations into alternative sick-leave allocation;

Develop strategies to address the direct and indirect costs associated with HIV/AIDS in the workplace; and regularly monitor, evaluate and review the workplace HIV/AIDS program”.

2.9. Prevention Programs

“Item 15 of the Code of Good Practice on key aspects on HIV/AIDS in the Workplace (DOH, 2000) recommends the establishment of workplace HIV/AIDS programs suited to the needs and capacity of each workplace”.

2.9.1. Rationale

- ❖ There are many people who are already HIV positive.
- ❖ The health care departments cannot meet the health needs of the population.
- ❖ It assists in keeping employees working for a longer period of time.

2.9.2. Summary of Prevention Elements

The workplace program should aim to:

- ❖ Prevent new HIV infections
- ❖ Change high risk behaviour
- ❖ Provide services to support the above. (Department of Public Service and Administration, 2002:75).

Typically, a workplace HIV/AIDS and STI prevention program will consist of the following core components: Awareness, education and training, the creation of a non-discriminatory environment, STI prevention and treatment, Infection control, voluntary counselling and testing, and condom promotion and distribution. “These programs should include a wellness component on the following:

- ❖ Programs to create a workplace that is conducive to openness and acceptance among all employers, employees and trade unions
- ❖ Wellness programs for employees affected by HIV/AIDS in the workplace
- ❖ Access to counselling and other forms of social support
- ❖ Reasonable accommodation of affected employees to maximize performance” (Department of Labour, 2001:22).

2.10. Wellness Programs

A wellness program in a work environment should ensure that the work life for those infected with HIV is improved. It should also aim to improve the productivity of employees; and reduce morbidity and mortality. It should be a part of prevention and care in the workplace (Department of Health, 2008:32). A wellness program should consist of an acceptance program aimed at promoting a supportive and accepting environment for persons infected with and affected by HIV/AIDS; the medical management of infected employees within a continuum of care; access to on-going counselling and support groups; referral systems and collaboration with other health care providers and specialised agencies; family assistance programs; and reasonable accommodation for infected persons to maximise their health and productivity. A

wellness program should meet the needs of all employees including those that are HIV negative but at risk, those that are HIV positive but with no symptoms, those that are in the early and late stages of HIV and those that are terminally ill.

2.11. HIV / AIDS Education and Training

The objective of an HIV/AIDS education program is to build on employees' awareness by developing their knowledge and skills to personally respond to the epidemic. Successful education programs are structured around two key strategies:

Firstly, informal education through peer educators; and secondly, formal education through peer educators and trainers. Whilst there are some generic components of any HIV/AIDS education and training program, experience has shown that programs that are flexible and can be targeted to meet the specific needs and issues of different groups are more successful than those that are rigid and non-responsive to specific needs and issues. One way of informing an HIV/AIDS education and training program is to base it on knowledge, attitudes and practices (KAP) study. A KAP study, which is generally administered as a questionnaire, explores the knowledge, attitudes and practices of individuals in a group. This information can be used to highlight areas for special attention in subsequent education and training programs. KAP studies repeated at intervals can also be used to track changes in knowledge, attitudes and practices over time page (International Labour Organisation, 2001:84).

2.12. Communication Strategies

A communication strategy ensures that all members of the workplace are aware of the policy and program. Mechanisms need to be created to facilitate dialogue between role-players and to ensure that the program is 'owned' by those involved in it and affected by it. The Minimum Standards require departments to ensure that their health promotion program includes an effective communication strategy (Department of Public Service and Administration, 2002:105). One of the key challenges experienced is the fact that the communication of the policy and program is often a forgotten component. This resulted in a number of common

problems such as the low utilisation of the services provided by the program; and the fact that management and staff alike are not committed to the policy and program as they are unaware of developments and feel left out of the process.

In the context of a workplace HIV/AIDS policy and program this means:

- ❖ Ensuring that employees and employers are aware of the HIV/AIDS policy and program and understand what it can offer them
- ❖ Allowing all staff an opportunity to provide input into and contribute to the development, maintenance and review of the HIV/AIDS policy and program (Department of Public Service and Administration, 2002:105)

2.13. Reporting, Monitoring and Evaluation

2.13.1. Evaluation Research

Brink (2001:117) asserts that the purpose of Evaluation Research is to determine how well a program, treatment or policy regarding an intervention is working. For the purpose of this study, an Evaluation Research approach was chosen in order to evaluate the implementation of the HIV Counselling and Testing program for employees at the selected public hospital.

2.13.2. Process Evaluation

A Process Evaluation is conducted when a program is implemented and there is a need to examine whether or not the program is being carried out according to its objectives. Both input (the basic resources required in terms of manpower, money, material, and time) and output (the immediate service improvement expressed as trained staff and service units delivered) are key elements of a Process Evaluation. A Process Evaluation requires one to examine the data closely, becoming intimately acquainted with the details of the program, and observing not only the anticipated effects, but also the unanticipated consequences. A Process Evaluation can also play an important role in improving or modifying interventions, by providing the

information necessary to adjust the delivery strategies or program objectives in a changing epidemic (Rehke, Saidel, Mills & Magnani, 1997:10).

The purpose of a monitoring and evaluation component of a workplace HIV/AIDS prevention program is to plot the progress of the program and to ensure that it is meeting its set objectives. The rationale for undertaking monitoring and evaluation is to assess whether or not a program is suitable, resourceful and useful in terms of monetary value. The reporting of the monitoring and evaluation finding is an important function of any workplace intervention, however it is often neglected. (Department of Public Service and Administration, 2002:105).

Monitoring and evaluation often fulfil a more basic function of determining whether HIV/AIDS policies and programs are being implemented at all, in an environment where departments struggle to maintain commitment to HIV/AIDS. Ineffective HIV/AIDS programs undermine efforts to secure the commitment of all stakeholders to such programs. This has detrimental effects since resources are scarce. For example, if when following an openness and acceptance campaign, the levels of discrimination between staff are still high, it is unlikely that management will allocate further funds to the program, unless some explanation can be given for the program's failure. Such an explanation can only be reliably obtained from an effective monitoring and evaluation strategy (DPSA, 2002:105).

Some of the challenges experienced with monitoring and evaluation is the lack of data on the most at risk population. There is also a lack of consistency across the provinces in computing some of the indicators (Department of Public Service and Administration, 2008:44)

2.14. Evaluating the HIV Counselling and Testing Program

As per the World Health Organization, voluntary HIV counselling and testing (VCT) can be described as a confidential discussion between a client and a care provider, with the aim of assisting the patient to deal with the pressure as well as to make personal decisions about HIV/AIDS (Kamenga, Coates & Rehle, 2011:81). The HIV Counselling and Testing Program (HCT) is a major component of the prevention and care programs in most developed and developing

countries. According to Kamenga, Coates & Rehle (2011:81), the existing literature on HCT is almost exclusively composed of reports on studies that have tried to assess the effects of counselling and testing on behaviour, with before and after intervention evaluations as the most commonly used design. Very little in the literature addresses how well the service is provided, how the service is perceived by both the client and the provider, or how cost effective the service is. This information is needed for future planning, and the sustainability of the program, as well as for the motivation for financial aid. One of the key aspects of a counselling and testing intervention is the evaluation of the program to determine whether it is provided for in the pre-determined protocol and whether it satisfies the clients. For the purposes of this study, the clients are nurses at the provincial hospital.

One of the main priorities of the South African Government is to fight the HIV pandemic (Department of Health, 2010:2). The primary goals are to reduce the number of HIV infections and to reduce the impact of HIV/AIDS on individuals, families, communities and society by extending access to a comprehensive package of treatment, care and support to all people affected with HIV. According to the Department of Health (2010:2), HIV Counselling and Testing is an entry point for the continuum of care. Once an individual has been tested for HIV, referral can be made for the appropriate care, and prevention can be reinforced.

The objectives for HIV Counselling and Testing are to enable the client to cope with issues relating to HIV/AIDS and to provide universal access to good quality, effective HIV counselling, testing and referral services. All patients that are tested and counselled have a legal right to privacy and are not required to disclose their status to their employer (the South African Labour Guide (2011:6). According to the Department of Health (2010:14), the objectives of the HCT programs at the selected regional hospital are to:

- ❖ Provide guidance to ensure the delivery of standardised, high quality and ethical counselling and testing services.
- ❖ Ensure compliance with a legal human rights approach to HIV counselling and testing.
- ❖ Ensure appropriate referral and treatment.

2.15. Evaluation Framework

There are 2 components of the framework: Firstly, the Logic Model Evaluation Framework to guide the evaluation process and secondly, the Logic Model Component Evaluation process.

2.15.1. Logic Model

Definition: A logic model communicates the proposed relationship between program inputs, activities, outputs, and the intended outcomes. Logic models are an important tool that is used for planning and evaluation purposes. Logic models are a graphic representation used to describe the theory—or logic—of how a program is supposed to work. The term logic model was proposed by the Centre for Disease Control (1999:9)

Inputs— are the resources that are available for a program, such as funding, staff, and leadership, expertise, program infrastructure, scientific knowledge and evidence-based strategies, and partnerships.

Activities—these are the activities of the program which are carried out to bring about the intended change, such as surveillance, the formation of partnerships for capacity development, referral to services, and the dissemination of prevention messages for healthy birth outcomes.

Outputs— are the products or direct services resulting from the program activities. Outputs are the direct evidence that resources are used and activities are implemented (Centre for Disease Control, 1999:11).

Outcomes- are the results that are expected to be achieved by the program. Short-term outcomes are those outcomes that can be achieved in a relatively short period of time.

2.16. Core Ethical Principals

Some of the core ethical principles to be considered include counselling, consent, confidentiality and privacy. According to the Department of Health (2010:26), counselling should always precede and follow testing. Counselling should also be done by a trained, mentored and supervised counsellor or health professional. Consent should be obtained prior to testing. Consent must be voluntary and the client should not be coerced to test. The client's tests result should be kept confidential and should only be disclosed by the client or with the client's consent (Department of Health, 2010:28). The test results may be communicated to members of the multidisciplinary health team for the benefit of the client, but may not be disclosed to the client's sexual partners although clients are encouraged to disclose their status. Counsellors should be aware that the client's status should not be disclosed to the employer without the consent of the client.

2.17. Risk of Health Care Personnel Contracting HIV

The primary mode of acquiring HIV infection is associated with individual behaviours. In addition, the health workforce, in providing care for patients with HIV/AIDS, can also be at risk from transmission, especially where the basic rules of occupational safety and health are not implemented or where personal protective equipment is not provided. The greater workload resulting from the epidemic, the fear of infection, and the lack of adequate safety and health provisions or HIV/AIDS-specific training mean that healthcare workers suffer enormous psychological and physical stress. This is often in addition to inadequate staffing levels, long working hours and violence against the nursing staff. Under these pressures, many feel compelled to leave the health profession, leave the public sector, or migrate to work in other countries. Because of the fear of the stigma attached to the health profession, lower intakes of new staff are being observed in developing countries, in particular that of front-line workers such as nurses. This compounds the lack of capacity to address HIV/AIDS in the health system.

2.18. Promoting a safe working environment

The Code of Good Practice on Key Aspects of HIV/AIDS and Employment (Department of Health, 2000) provides that: “Every employer is obliged to provide and maintain, as far as reasonably practicable, a workplace that is safe and without risk to the health of its employees. Although the risk of HIV transmission in the workplace is minimal, occupational accidents involving bodily fluids may occur, and therefore, every workplace should ensure that it complies with provisions of the Occupational Health and Safety Act, including the Regulations on Hazardous Biological Agents (Department of Labour, 2001:13). Health and safety in the context of HIV and AIDS requires more than simply providing materials and equipment for dealing with occupational incidents. It requires clear policy guidelines on the procedures to be followed in the event of an occupational accident, as well as education and training for all employers and employees”.

A cross-sectional study by Li, Lin, Wu, Wu, Rotheram-Borus, Detels, & Jia. (2007:260), was conducted to assess the impact of the AIDS epidemic on medical care systems and service providers in China. The study provides clear evidence that institutional support such as increased access to more preventive measures such as sterile rubber gloves, HIV-related training, and sufficient health insurance coverage, are all important steps in maintaining a stable workforce and improving the quality of care for PLWHA. This study suggests the need for more attention by the government to ensure HIV/AIDS resources are effectively allocated.

2.19. The Manifestation of HIV / AIDS Related Stigma and Discrimination in the Workplace

Irin (2002:11) emphasizes that although South African laws expressly outlaw stigmatisation and discrimination in the workplace, and strive to protect people living with HIV, stigmatisation and discrimination against people living with HIV and those perceived to be affected by HIV/AIDS still occurs. Policies have been introduced by different member states of the United Nations to

address this world-wide practice. The degree of stigmatisation and discrimination varies from country to country, depending on the laws and the extent of the enforcement of such laws, as well as other HIV/AIDS intervention programs.

Disease related stigma and discrimination manifest themselves in various ways in the workplace. NY blade (2003:4) concurred with Irin (2002), and raised concerns that it was still happening, despite HIV and AIDS having been around for more than a decade. An international study conducted by the Centre for Research on Women (2006:1) in various countries found that *“HIV-related stigma exists in workplaces across the globe and there were several accounts of serious workplace discrimination and violations of employees’ rights”*.

According to Stewart (2003:1) stigma and discrimination are major challenges to the successful implementation of an HIV/AIDS workplace program. He further states that employees can be stigmatised by their fellow employees. As a consequence of this, workers are discouraged from utilising services such as voluntary counselling and testing (VCT). Kauffman and Lindauer (2004:84) suggest that sexually transmitted infections (STIs), such as HIV are perceived as indicators of social transgression and a violation of the social norms of conduct. Thus, people infected and affected by HIV and AIDS become stigmatised. Moreover, this stigma and discrimination (or the fear of suffering stigmatisation and discrimination at the hands of others) may prevent people from accessing workplace services to get tested or to obtain information.

AIDS-related stigma and discrimination remains a persistent problem in health care institutions worldwide, according to Mahendra, Gilborn, Bharat, Mudoi, Gupta & George (2007:616). People living with HIV/AIDS are more likely to be discriminated against than patients diagnosed with any other condition, because the HIV/AIDS stigma is influenced by many factors, including its association with injection drug users, sex workers and the fact that it is a sexually transmitted disease. The stigma associated with the disease is in turn one of the catalysts for the further spread of the disease, because it discourages people from utilising health services, and delays testing and disclosure of their status. In addition to this, it leads to the verbal and physical abuse of these people. (Nyblade and Carr, n.d:3; Dlamini, Kobi, Uys, Phetlhu, Chirwa, Naidoo, &

Makoe, 2007:389). Stigmatisation occurs among people in general society, but nurses, as members of society, can also be guilty of stigmatisation (Li, Wu, Zhaoc, Jia, & Yan, 2007:753).

Because HIV is a pandemic, nurse's encounter people living with HIV and AIDS on a daily basis, in a variety of health care settings, and are at an increased risk of occupational exposure. Nurses are responsible for the provision of holistic patient care to HIV/AIDS patients, but they may experience difficulty doing this because they are apprehensive and often have a fear of contagion in the workplace.

It has been more than 25 years since the first case of HIV/AIDS in the 1980's, but the world still experiences the complications resulting from the stigma attached to the disease. Over the past 27 years, an estimated 36 million people around the world have been living with HIV and nearly 25 million have died from HIV/AIDS (UNAIDS, 2010:25), with a resulting infection by HIV of 61 million people. More than 90% of people living with HIV and AIDS live in developing countries, with Sub-Saharan Africa remaining the epicentre of the disease (UNAIDS, 2010: 17). Even though it contains just over 10% of the world's population, 2/3 of the adults and children living here are infected with HIV/AIDS (UNAIDS, 2010: 10). Presently, South Africa has the most number of infections with an HIV prevalence of 18.1% (UNAIDS, 2010: 7) and a decrease in life expectancy from 63 years in 1990 to 54 years in 2007 (World Health Organisation, 2011: 53). South Africa has 17% of the global total number of children and adults infected with HIV/AIDS. The estimated number of children aged between 0-17 years who have been orphaned due to HIV/AIDS ranges between 1.4 million and 1.9 million (UNAIDS, 2010: 8).

The Siyam'kela Project (Futures Group International, 2003: 5) conducted by the University of Pretoria identified two types of stigma. The first type 'can be felt' (internal stigma), and is not exerted by the external world onto an individual, but rather is generated within the HIV positive person themselves. Attitudes and stereotypes of the broader community cause the infected or affected person to feel guilty and ashamed.

In South Africa, a prominent court case relating to stigma and discrimination in the workplace involved Hoffmann and the South African Airways (Ngcobo, 2000:1). It transpired that Hoffmann applied for a post as a cabin attendant. He went through a four-stage selection process consisting of a pre-screening interview, psychometric tests, a formal interview and a final process involving role-play with the other eleven applicants. The appointment to the available posts was subject to a pre-employment medical examination involving a blood test for HIV. The medical examination detected that Hoffmann was HIV positive, however, at the time Hoffmann was still clinically fit and suitable for employment as a cabin attendant. Due to his HIV positive status, Hoffmann was not appointed. The matter was taken to the Constitutional Court for unfair labour discrimination and the Court ruled in favour of Hoffmann. The Court's ruling served as a benchmark case for discouraging HIV/AIDS discrimination in the workplace.

A collective agreement between the Department of Public Service and Administration and the Public Service Coordinating Bargaining Council (PSBC), reached a conclusion that it is crucial to prevent *“unfair discrimination and stigmatisation of people living with HIV or AIDS, through the development of HIV/AIDS policies and programs for the workplace”*. The role of the Department of Public Service and Administration is to co-ordinate the activities of all South African government departments. In line with its mandate, it has developed a policy framework called *“The South African Department of Public Service and Administration, Managing HIV/AIDS in the Workplace, a Guide for Government Departments”* (Department of Public Service and Administration, 2002).

Stigmatisation and discrimination also have public health consequences that act as a barrier to the provision of adequate health care, such as the failure to obtain appropriate medical treatment, reluctance to be tested for HIV and to disclose a positive test result, poor treatment adherence, and an increased risk of disability and drug resistance. People living with HIV/AIDS often encounter discrimination while seeking healthcare services. According to Dlamini, Kobi, Uys, Phletlhu, Chirwa, Naidoo, & Makhoae (2007:397), people living with HIV and AIDS experienced both physical and verbal abuse and neglect. This was also observed by the nurses caring for them. As the prevalence of the disease increases steadily, nurses are faced with the

challenge to provide quality care for these patients when they themselves are affected by the pandemic (Uebel, Nash & Avalos, 2006:502)

Health care workers are not immune to the stigma surrounding HIV/AIDS. Raviola, Machoki & Mwaikambo (2002:55), described a remarkable burden which resident doctors carried in a Kenyan hospital as quietness, distress, and bleakness which surrounded a diagnosis of HIV infection either in their patients or themselves. The mortality statistics of a group of Ugandan doctors indicated that, of the 22 doctors who died, 11 died of AIDS, and 5 committed suicide because of a known or suspected HIV diagnosis. It was obvious that health care workers would be discriminated against if others found out that they were HIV positive. In a separate study by Young, Hlavka, Modiba, Gray, van Rooyen, Richter, Szekeres & Coates, (2010:620) to explore the association between HIV stigma and perceptions of low HIV testing in South Africa may lead to decreased HIV testing rates, where HIV rates are extraordinarily high. The findings of the study suggested that interventions designed to increase HIV testing in South Africa should address stigma and perceptions of societal testing.

Numerous health care workers are struggling with external and internal stigma and thus fail to access timely HIV counselling, testing and treatment early which results in them succumbing to the disease and dying early. One of the utmost threats to the capability of health care systems to provide treatment for HIV infection may be the illness and death of the HIV-infected health care workers themselves (Ncayiyana, 2004:584) who commented on this threat by saying, “We are going to run out of people before we run out of money”. There is limited literature and research about the employee HCT programs that have been established to provide treatment for HIV infected health care workers.

2.20. Attitude towards VCT

According to the WHO (2007), HIV counselling and testing is fundamental to HIV deterrence, care and treatment programmes as being aware of one's HIV status is an originator to accessing

the appropriate care and treatment services. However, data from surveys conducted in 12 high-prevalence countries in sub-Saharan Africa show that only 12% of men and 10% of women know their HIV status (WHO, 2007). In a bid to increase HIV testing rates, routine antenatal HIV counselling and testing was successfully introduced in the HIV prevention programmes of several countries in sub-Saharan countries in line with Centres for Disease Control and Prevention (CDC) and Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO) recommendations. The findings of a study conducted by Byamugisha, Tumwine, Ndeezi, & Tylleskär (2010:52), to assess attitudes of antenatal attendees towards routine HIV counselling and testing at Mbale Hospital in Uganda, revealed that majority of the antenatal attendees (98.5%) had positive attitudes towards routine HIV counselling and testing.

In a previous study by Iliyasu, Abubakar, Kabir & Aliyu_ (2006:1920) to assess the knowledge of HIV/AIDS and attitude towards VCT among adults in a rural community in northern Nigeria where the uptake of VCT was low even though Nigeria had the third highest HIV infection rate. The study aimed to assess the knowledge of HIV/AIDS and attitude towards VCT among adults in a rural community in northern Nigeria. A vast majority of respondents (72.3%) said they were willing to be tested and would recommend it to friends and relatives. The remainder said they would only consent to the test if a cure were available. Three respondents said they had to do the test during a job recruitment process. Almost 99% of the respondents have not had VCT previously. Almost half of the respondents indicated that they avoided VCT testing because they were afraid of the stigma and discrimination in case they were HIV positive and a small minority (3%) indicated that they did not test because there was no cure anyway. Majority of the participants (58%) favoured government hospitals to be tested, while 26.0% chose private hospitals and clinics quoting privacy as the chief reason for their choice.

A study conducted in Tanzania amongst health care professionals aimed at assessing the perceived barriers and attitudes of health care providers towards PITC services. Predictors for positive attitude towards PITC were evaluated. The years of practice, and health facility characteristics were statistically significantly associated with attitude towards PITC. There were some barriers for effective implementation Health care professionals perceived an absence of

test kits and supply of consumables, lack of space and lack of special training at the facilities were barriers to offering PITC (Kapologwe, Kabengula & Msuya, 2011:17).

2.21. Awareness of HCT

The government of Botswana executed a new policy of routine or "opt-out" HIV testing in reaction to the increased incidence of HIV infection which was estimated at 37% of adults. 11 months after the introduction of this policy, a cross-sectional, population-based study of 1,268 adults from five districts in Botswana was conducted to evaluate the awareness of and attitudes toward routine testing, correlates of HIV testing, and barriers and facilitators to testing (Weiser, Heisler, Leiter, et al, 2006:261). Majority of the participants (81%) stated being exceedingly or greatly approves the routine testing. A large proportion of participants believed that this policy would reduce obstacles to testing (89%), HIV-related stigma (60%), and violence toward women (55%), and would intensify access to antiretroviral treatment (93%). methods should be implemented to ensure that informed consent is obtained and HIV-related discrimination avoided if routine testing is adopted elsewhere.

2.22. Knowledge of HCT

Routine HIV testing is increasingly recommended in resource-limited settings. A study by Bassett, Giddy, Wang, Lu, Losina, & Freedberg (2008:863) to evaluate factors associated with a new diagnosis of HIV infection in a routine HIV testing programme in South Africa revealed that improved interventions are necessary to expand HIV knowledge and reduce HIV risk behaviour. A comprehensive investigation of 720 test acceptors revealed that one of the categories for highest risk for a new HIV diagnosis were those with a low HIV knowledge score.

The role of knowledge about HIV as predictive of accepting HIV testing has been described previously in Africa (Perez, Zvandaziva, Engelsmann, & Dabis, 2006:514; Weiser, Heisler, Leiter, et al, 2006:261; Iliyasu, Abubakar, Kabir, & Aliyu, 2006:1917). According to Perez, Zvandaziva,

Engelsmann, & Dabis (2006:514), the findings of a study in the rural part of Zimbabwe indicated that knowledge of HIV was related with VCT uptake in an adult group. Similar results were also found in studies of HIV testing uptake in both Botswana and Nigeria (Weiser, Heisler, Leiter, *et al*, 2006:261; Iliyasu, Abubakar, Kabir, & Aliyu, 2006:1917). The study by Bassett, Giddy, Wang, Lu, Losina, & Freedberg (2008:863) also advises that HIV knowledge not only forecasts readiness to receive testing, but may also be protective against acquiring HIV infection. In the African studies noted above, those with higher educational status were more likely to accept testing; in the current study, education level did not correlate with HIV test results

2.23. Previous workplace initiatives

The employer can benefit from the worker's continued productivity if anti-retro viral treatment is provided at the place of employment. There are severe disadvantages to the strategy where health care workers have to access ARV treatment at specific health care facilities such as: Firstly, in many places, each visit to a public sector treatment clinic requires a full day of queuing. Going for the treatment escalates absenteeism at work. Second, with a planned programme, an institution has a way to encourage and evaluate the uptake of treatment or adherence to ART. When employees have to go somewhere else for treatment, there is no way to monitor and evaluate their compliance and therefore treatment of employees with AIDS is thus missed and sometimes unsuccessful. Thus the company continues to incur the costs of AIDS-related morbidity and mortality. According to Connelly & Rosen, S. (2006:128), several big corporations in South Africa and elsewhere have established that continuing to compensate for private disease management services or health insurance is a worthwhile investment, despite rapidly expanding public sector programmes.

Over the past 15 years many businesses in sub-Saharan Africa have engaged the guidance of public health professionals and implemented active HIV prevention programmes, including education and awareness campaigns, training of peer educators, distribution of condoms, treatment and prevention of other sexually transmitted infections, and the promotion of HIV counselling and testing. In a study by Corbett, Makamure, Cheung, Dauya, Matambo, Bandason, *et al*. (2007:483); it was disappointing to note that workplace voluntary counselling and testing

had no effect on HIV incidence among a large sample of employees of 22 companies in Harare, Zimbabwe.

A study was undertaken in three (3) hospitals in South Africa (McCord Hospital in Durban, South Africa; Mseleni Hospital in northern KwaZulu-Natal, South Africa; and the Tshedisa Institute in Gaborone, Botswana) which describes the staff care programs at these institutions. The findings reveal that in All 3 programs, there is increased approval of counselling, testing, and treatment among health care workers (Uebel, Nash, Avalos, 2007:500). Concerns were raised by healthcare workers indicated that there was a lack of support and guidance from management regarding the establishment of employee HCT programs. According to Minnaar (2005:31), "Nurse Managers in South Africa acknowledged that caring for HIV-infected nurses is a critical component of their work, particularly in KwaZulu-Natal, the South African province with the highest rate of HIV infection." They have also expressed that there was no formal policy indicating the management of HIV/AIDS among health care workers in the workplace.

The implementation of an in-house program at McCord Hospital and Mseleni Hospital has led to positive reinforcement and improved morale. Staff also became more aware of where to access treatment. The treatment of staff were a success which assisted in decreasing stigma as staff were more willing to discuss their status and treatment (Uebel, Nash, Avalos, 2007:500). There has been a substantial increase in the number of health care workers accessing treatment at the staff clinic at McCord's Hospital since the inception of its programme in 2001. It started with 38 staff that enrolled in the VCT programme in 2002 to 118 in 2005 and 45 staff members commenced ART which included a child of one staff member. In a separate study by Connelly & Rosen (2006:128), a survey was done amongst 64 private businesses in South Africa which disclosed that in-house disease management programs for HIV care attained greater acceptance of services for their employees than did private medical insurance and externally managed programs.

It is not enough to rely on individuals accessing HIV treatment and care outside their place of employment or in the private sector (Uebel) Programs should be located in house or close to the place of work so that the service is recognized and easily accessible. There is an urgent call to normalize this disease and to remove the barriers to testing and treatment. Care and treatment for health care workers should be convenient, holistic, and integrated into one clinic. Finally, the provision of HIV care and treatment for health care workers must become a public health priority, or universal access to ART in high-prevalence countries will remain an unmet goal.

It seems very important to negate these perceptions and to restore trust in the health care system. As long as people mistrust health care workers' skills, people will hesitate to go for an HIV test and health care workers' counselling will sort limited effects.

Health managers need to urgently address the human resource constrain as well as space and supply of consumables at the facilities

2.24. Barriers to testing

One of the barriers to testing is insisting on a formal pre-test counselling by a counsellor, any health care provider should be able to provide pre-test counselling as long as the staff member is comfortable with that person. The referral of health care workers to other institutions for treatment because of confidentiality creates barriers.

Confidentiality/trust in HCW

Findings of a qualitative study undertaken at the University of Limpopo, Polokwane, South Africa to identify psychosocial correlates of HIV voluntary counselling and testing (VCT), has revealed significant consequences for VCT. The study indicated that participants had no trust in health care workers and feared that they will inform others about their serostatus (Annemarie, Arjan, Hans, Herman, 2008:49). The researcher was concerned that if participants felt this way, how health care professionals would feel especially if staff that did the counselling and testing

were their own colleagues. It also seemed very vital in South Africa to guarantee the anonymity and privacy of participants as it prevents people from going for VCT. Additionally, the study confirmed that participants also doubted health care workers' skills to do adequate testing.

According to Annemarie, Arjan, Hans, Herman (2008:49), AIDS-related stigma is deeply rooted in South Africa and people are very afraid to become stigmatized. Fear of stigmatization is an important barrier to HIV testing and has negative consequences for AIDS prevention and treatment. It is important to educate people about AIDS-related stigma and to design theory- and evidence based interventions to reduce AIDS-related stigmatization (45-47). Such interventions should move beyond the individual level to be effective, and should also target the reduction of stigma at the organizational and community level.

2.25. Conclusion

HIV and AIDS affect all spheres of life including the workplace. There is a dire demand for each work environment to develop its respective HIV/AIDS policy and to eventually implement HIV/AIDS programs to mitigate the impact of the epidemic. However, stigma and discrimination are major challenges to be tackled as part of a successful implementation of the workplace program. According to the Department of Labour (2001: 55), "Workplace prevention programs are essential to combat the spread of HIV and to foster greater tolerance towards persons living with HIV/AIDS".

CHAPTER THREE

METHODOLOGY

3.1. Introduction

The research methodology followed in this study is presented in this chapter. The focus of the study was on the process evaluation of the implementation of the employee HCT program at a selected regional hospital in KZN. It also included the availability of resources and activities at the employee HCT clinic as well as the employee's knowledge, attitudes and practice towards the employee HCT program. The aim was to gather knowledge that would assist the management and those involved in the implementation of the HIV/AIDS Programme by identifying what the employees knew and felt about HIV and AIDS in their workplace and to ensure the delivery of standardised, high quality and ethical HIV counselling and testing services at a selected Regional Hospital in KwaZulu-Natal. A quantitative, non-experimental descriptive evaluative design consisting of a checklist and two (2) self-administered questionnaires was used to evaluate the implementation of the HCT program for employees. This chapter presents the study's procedures including setting, study design, sampling strategy, data collection, data analysis, the parameters of the research and instruments used by the researcher in gathering data and ethical issues.

3.2. Setting

The process evaluation of the HIV Counselling and Testing project for staff was conducted in a selected public sector hospital in Durban, KwaZulu-Natal.

3.3. Research Approach

A quantitative approach was used because a Positivistic paradigm systemises the knowledge generation process. The quantitative research design consisted of a survey which allowed for standardised questions to be asked.

3.4. Research Paradigm

A positivist paradigm was used.

3.5. Research Design

For this evaluation, a quantitative, non-experimental descriptive evaluative design using a checklist and two (2) questionnaires to evaluate the implementation of the HCT program for employees was conducted. A quantitative approach was used because the positivist paradigm systemises the knowledge generation process, with the help of quantification, which is necessary to improve accuracy in the description of parameters and the discernment of the relationship amongst them. Quantitative methods of data collection ensure high reliability of the information collected. The quantitative research design consisted of a survey which allowed for standardised questions to be asked. This ensured accuracy by enforcing standardised definitions on the participants. The subjectivity of the researcher is greatly eliminated in quantitative designs. A high measure of reliability can also be obtained through a survey. An additional advantage is that surveys are able to identify both factual and attitudinal data (Burns and Grove, 2009: 245). Burns and Grove (2009:245) also argue that quantitative research is most closely allied to the positivist tradition and employs deductive reasoning. It focuses on the prevalence, incidence, and size and measurable attributes of a phenomena.

3.6. Population and Sample

3.6.1. Population Sample for Nursing Staff Survey

According to Burns & Grove (2009:714), the population in research methodology refers to all of the elements (individuals, objects, events or substances) that meet the inclusion criteria for a study. The population is sometimes referred to as a target population. Investigating the views of the total population is not always practicable due to a range of factors such as the availability of researchers, time and financial constraints. For the purpose of this study, the population consisted of all categories of nurses currently employed at the selected regional hospital amounting to 157 nurses. This was also the sample.

Even though all of the nurses in the health care facility were surveyed, the minimum sample size was calculated using the Rasoft sample size calculator, 2004.

- ❖ The margin of error = 5% for this study.
- ❖ The confidence level = 95%.
- ❖ The minimum sample size = 112 nurses.

Inclusion Criteria: All nurses employed at the selected hospital and registered with the South African Nursing Council.

Exclusion Criteria: Those nurses who were on long sick leave and students.

3.7. Research Tools

Three research tools were used for the three objectives of the study. A checklist was used to evaluate the availability of resources in the HCT clinic. Two quantitative questionnaires were used to assess the additional components of the study.

3.7.1. The Construction, Testing and Administration of the Questionnaire:

Questionnaires (or research instruments) were designed by the researcher after a comprehensive literature review was conducted on HIV/AIDS programs and related fields. The drafts of the questionnaires were presented to the supervisor and various other members of the University of Kwa-Zulu Natal (UKZN) staff component for comments. The questionnaires were also submitted to the statistician at the UKZN Howard College campus for comments. The instruments were also pre-tested. The questionnaires consisted of two components.

3.7.2. Instrument 1: Checklist of the Venue for Staff HIV Counselling and Testing Clinic

A checklist was used to evaluate the availability of resources in the HCT clinic. The checklist was used by the researcher and the chairperson of the HCT committee, in order to maximize the trustworthiness of the findings. According to Burns & Grove (2009: 402), a checklist is a technique that is used to determine whether behaviour has occurred. The researcher made a mark against a data collection form when she saw that the behaviour has occurred. Any behaviour that was not on the form was ignored.

3.7.3. Instrument 2: Quantitative Questionnaire for Staff employed at the HIV Counselling and Testing Clinic

A quantitative questionnaire was administered to the members of staff that worked at the HCT clinic in order to evaluate the implementation of the HCT program for employees.

A questionnaire is a self-report form that is given to the participants to complete. There is less opportunity for bias when using a questionnaire than when collecting data through an interview (Burns & Grove, 2009:402).

The questionnaire had 2 components; the first part gathered demographic details and other background variables including name (which was coded), age, gender, designation, job title, experience working with HIV patients, whether or not they had any HIV training, etc. Part 2

consisted of a questionnaire which evaluated the implementation of the HCT activities for employees at the selected public hospital in KwaZulu-Natal.

3.7.4. Instrument 3: Quantitative Questionnaire of KAP for Nursing Staff

A quantitative, structured questionnaire was issued to all nurses employed at the selected health care facility in order to evaluate their level of knowledge, attitudes and practice towards the HCT program for employees. The questionnaire consisted of 2 scales which included demographic details and other background variables, and the nurses' knowledge, attitude and practice related to the HCT program. The demographic details included 10 questions such as: name (which was coded), age, gender, designation, job title, level of experience working with HIV patients, whether they have had any HIV training or not, etc., which was used to compare the participant's responses. Part two entailed the knowledge, attitude and practice questionnaire regarding the HCT program for staff.

3.7.5. Validity and Reliability of the Evaluation Tools

According to Burns & Grove (2009:713), a pilot study is a smaller version of the actual study, which is conducted to develop and/or improve the methodology such as the instrument or data collection process.

A pilot study was done on a small sample (5 participants) to assess the clarity of the questions and to ensure the validity and reliability of the answers obtained. Any necessary changes were made to the tool, and the tool was handed to the research group to fill it out. In addition, an Alpha's Chronbach was calculated, in order to check for internal consistency of the questions. This sample group was not included in the sample for the study. A test retest can also be done to ensure that the same results are yielded after a period of time.

The validation of the quantitative tools was done to assess the face and content validity. The face validity was evaluated by providing the tool to Evaluation and Clinical Specialists for approval. Content Validity is established by relating the tools to the evaluation framework for process evaluations.

The table below illustrates how the types of Evaluation relate to the questions being used in the questionnaires/surveys that the stakeholders will complete:

Table 3: Table of Content Validity Process for Tool Development

Objective	Tool	Model
1. To evaluate the availability of the resources in the HCT clinic.	Checklist	Logic model: input
2. To evaluate the implementation of the HCT	Questionnaire	Logic model: process/activities
3. To evaluate the Nursing staff's Knowledge, Attitude and Practice towards the HCT program	Questionnaire	Logic model: output

3.8. Data Collection Procedure [Step 5 (Gather Credible Evidence)]

After the study has been formally approved by UKZN and the Ethics Board of the UKZN, then a further request for ethical approval was submitted to both the eThekweni district office of the Department of Health and the Health Research and Knowledge Management section of the Department of Health in Pietermaritzburg. Upon receipt of ethical approval from the above mentioned two bodies, permission was obtained from the Chief Executive Officer and the Nursing Service Manager of the selected hospital for the data to be collected from the employees. The data was collected over a period of one week. As the researcher is an educator at the selected hospital, cognizance was taken of the fact that employees may feel obliged to participate in the study and may provide information which they believe the researcher may wish them to provide. For this reason a research assistant was used to collect the data, in order

to eliminate bias. The researcher ensured that the research assistant was trained and familiar with the questionnaire.

A neutral venue was secured, where participants completed the questionnaire in the presence of the research assistant, in order to ensure that the participants did not discuss their answers. The research assistant administered the questionnaire to each participant, together with a covering letter explaining the purpose and background of the study. It included clear and concise instructions regarding the completion of the questionnaire. The participants were given 10 minutes in which to read the questionnaire and a further 30 minutes in which to complete it. After the 30 minute period was up, the researcher or the research assistant collected the questionnaires. More time was allocated to anyone who required it.

3.8.1. Checklist for the HCT Clinic

The resources at the HCT clinic was examined and evaluated by the researcher and a second colleague, by means of a checklist. This was done to ensure the reliability of the evaluation of the resources.

3.8.2. Quantitative Questionnaire for Staff employed at the HIV Counselling and Testing Clinic

The quantitative questionnaire was given to the employees who are employed at the HCT clinic, and who are involved in the actual counselling, testing and referrals of the patient's for completion. The research assistant administered the questionnaire to the staff working at the HCT clinic.

3.8.3. Quantitative Questionnaire of KAP for Nursing Staff

The research assistant administered a quantitative questionnaire to all employees in the hospital to assess their knowledge, attitudes and practice towards the employee HCT program.

3.8.4. Data Analysis, Utilisation and Communication

The data analysis plan comprised of three components, namely the analysis of the questionnaires completed by the employees that work in the HCT clinic, analysis of the questionnaires that were administered to the entire nursing staff of the hospital to evaluate the KAP towards the HCT program and the checklist of the resources at the clinic venue.

The data collected was captured and subsequently analysed using the Statistical Package for Social Sciences (version 19). Descriptive statistics such as frequencies and percentages was used to summarise the data. Knowledge and attitude data was aggregated and presented numerically in tables and graphs. An Analysis of variance, or Kruskal – Wallis test, was used to check if the nurses' knowledge and attitudes differ by level of education and years of experience. Two independent samples, t–test, or Mann-Whitney t-test, was used to test if the nurses' knowledge and attitudes of those who attended an HIV/AIDS course differs from those who did not attend such a course.

An observation of the equipment available in the clinic was made, and then an evaluation of the equipment was done by means of a checklist and an ordinal rating scale. The ordinal data rating scale was treated as a numerical scale and a total score was derived. In addition, percentages obtained from the data gathered were illustrated as a bar graph.

3.9. Ethical Issues

According to Emmanuel, Wendler, Killian & Grady (2004:89), the following ethical issues were discussed:

Collaborative Partnership: Both the recruited participants and the patients who are members of the community will benefit from the research results, which will be used as a baseline for the education and training of nurses, if necessary. Patients and the community will also benefit, in that they will be nursed in an environment free of negative behaviour from health care personnel. This research project has no financial benefits. The cultures, values, traditions and

social practice of the community and health care institution were respected. The results of the research may also be used when drawing up policies and procedures.

Social Value: The research will benefit both the participants and the community. The participants were given an opportunity to know whether or not their knowledge, attitudes and practices are adequate to provide efficient, high quality patient care. This will also ensure that patients that seek health care are treated in a fair and just manner by nurses.

Scientific Validity: The research study was feasible as it has the aim of improving HCT services among employees.

Fair Selection of Study Participants: All nurses at the health care facility were eligible to participate in the survey. A research assistant was utilised to prevent bias during data collection.

Favourable Risk Benefit Ratio: The researcher did not foresee any potential risk in this study to either the participants or the organization in which the study was conducted.

Informed Consent: Participants were given information leaflets to read and keep, which contained information about the background of the study and how the data collected was used. Thereafter, each participant was required to sign an informed consent, a copy of which they kept for themselves, before data is collected. Participants were informed that participation was voluntary and that they could withdraw at any time without penalty to their employment. Since the participants were nurses from the institution, they were reassured that their names would be kept confidential and their right to self-determination, privacy, anonymity, confidentiality, fair treatment and protection from harm and discomfort were respected. The personal details of the participants were not revealed to anyone. A research assistant was used to prevent researcher bias. Confidentiality was ensured by providing the participants with an envelope in which to place their completed questionnaire.

Respect for Recruited Participants and Study Participants: Privacy is the autonomy a person has to agree on the time, degree and general circumstances under which confidential information can be shared with or withheld from others (Burns & Grove 2009, p. 715). Each

participant's details was coded, these codes were used on the instruments instead of their names to ensure anonymity and confidentiality hence no information can be linked to specific participants. Participants were reassured that they could withdraw at any time with no penalty and no questions being asked. Furthermore confidentiality was guaranteed because the data collected was stored in locked cupboards at the University Of KwaZulu-Natal School Of Nursing where only the researcher and the supervisor had access to the data. The results of the study will be published in a thesis and a SAPSE accredited Nursing Journal without disclosing the identification of the participants or the organization in which the study was conducted. Participants were informed of the results of the study and a copy was issued to the site. An information guide with the researcher's name, telephone numbers and address as well as UKZN Ethics Committee were given to the participants if any of the participants had any questions regarding the study.

3.10. Data Dissemination

Data dissemination was consistent with positivism by contributing to the existing body knowledge. A copy of the study will be published and findings were disseminated. A copy of the published research will be issued to the UKZN and the selected Hospital for obvious reasons.

3.11. Limitations of the Study

A research assistant collected the data because of the non-probability convenience sampling used, as well as to eliminate any bias when the findings are to be generalised. The study was conducted in one site only. This limits the ability to generalise the results and apply them to all of the hospitals in Durban or KwaZulu-Natal. More hospitals in KwaZulu-Natal should be targeted using similar studies. A small sample size was used due to time constraints and financial constraints. The environment where this research was conducted may differ from other health care services, which could lead to discrepancies in findings.

CHAPTER 4

PRESENTATION OF DATA

4.1. Introduction

The findings of the study are reported in this chapter. The presentation of the findings is made in three components according to the objectives of the study, namely the analysis of the questionnaires completed by the employees that work in the clinic, the analysis of the questionnaires completed by the entire nursing staff complement of the hospital, and the checklist of the venue resources.

A sample size of 150 respondents was invited to participate in the survey; a total of 140 respondents completed the questionnaire. One hundred and thirty-two respondents completed instrument 3, which was administered to the nurses employed at the selected public hospital; and 8 respondents completed the questionnaire for instrument two, which was administered to nurses working at the HCT clinic and HIV counselors. There was only one member of staff that worked at the HCT clinic. The HCT clinic is part of the occupational health clinic. After conversing with the occupational health nurse and health care employees at the institution, it was noted that health care workers are also HIV counselors who are used to counsel employees and staff at the institution if and when the need arises. A snowballing technique was therefore used to identify 8 participants and HIV/AIDS counselors at the institution and to collect data from them. Observations of the equipment and resources were done by means of instrument one, which was a checklist of resources at the venue.

4.2. Data Analysis and Interpretation

The data collected was captured and subsequently analysed using the Statistical Package for Social Sciences (SPSS version 19). Descriptive statistics such as frequencies and percentages were used to summarise the data. Knowledge and attitude data was aggregated and presented

numerically in tables and graphs. An analysis of variance, or Kruskal–Walis, test is used to check if the nurses' knowledge and attitudes differ according to their level of education and years of experience. Two independent samples, t - test and Mann - Whitney t-test, were done to test the difference in the knowledge and attitudes of nurses' who attended an HIV/AIDS course from those who did not attend such a course. Microsoft excel was also used to analyse the data and to illustrate graphs.

The p value is the measure of all tests of statistical significance. It can be defined as the probability that the effect of a particular study could have been by chance alone. If the p value is greater than 0.05, the findings of the study is considered to be statistically insignificant at that level. The confidence interval of 95% was applied to establish any associations between variables.

This chapter consists of four (4) components: Section A represents the socio-demographic data of the sample; section B presents the findings of instrument one, i.e. the checklist of the venue; Section C reflects the findings of instrument two: The activities of the HCT program, which was completed by the staff that work at the HCT clinic and the HIV/AIDS counsellors; and Section D represents the findings of instrument three i.e. the nurses' knowledge, attitudes and practices towards the HCT program.

4.3. Section A: Socio-demographic Data

The socio-demographic data is presented according to the sample size, age, gender, highest educational level, designation of nurses, years of nursing experience, attendance of an HIV/AIDS course, frequency of when nurses care for patients who are HIV positive, interest in attending an HIV/AIDS course and awareness of the hospital HCT program.

4.3.1. Age of Respondents

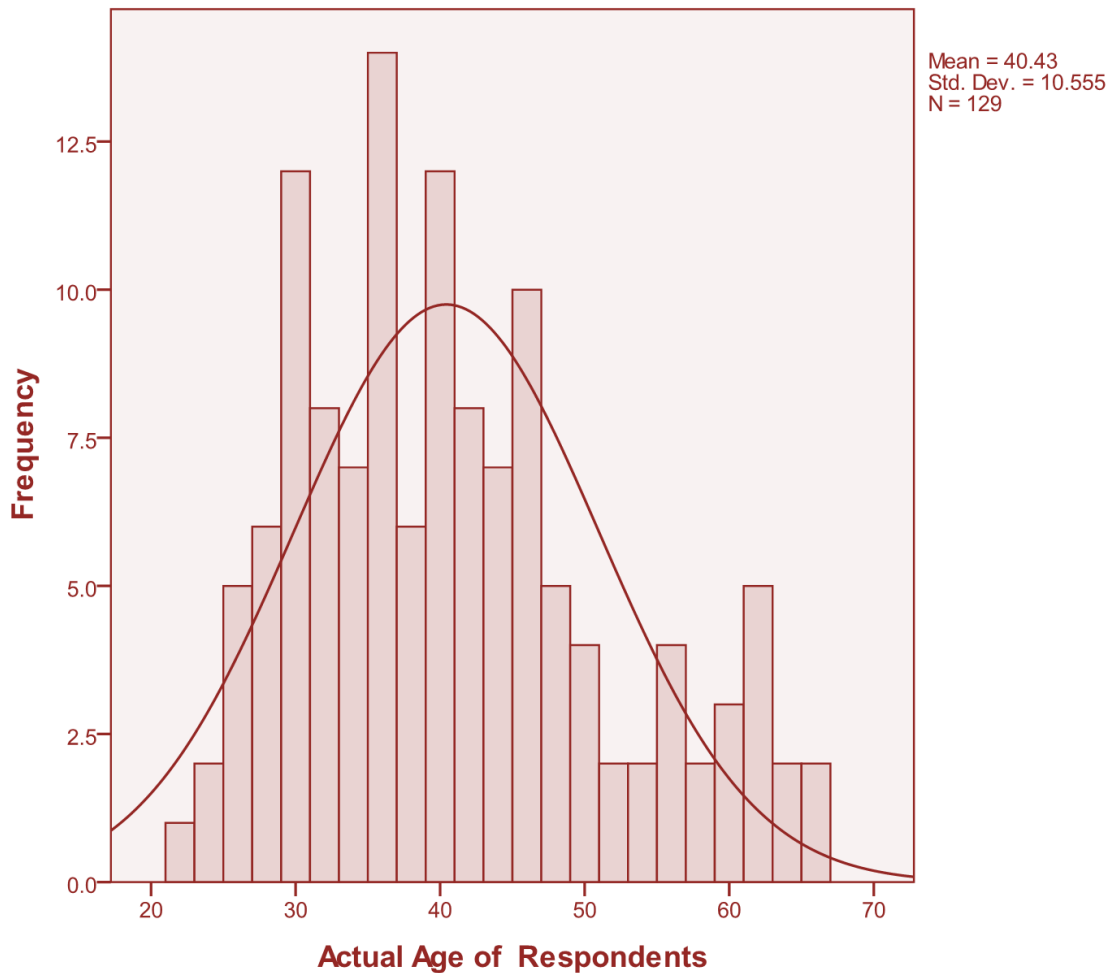


Figure 4.1: Age of Respondents

The actual ages of the respondents are presented in Figure 4.1.above in a histogram. The ages of nurses' ranged between 22 years and 65 years. Of the respondents, 20.5% (n=25) were between 22-30 years of age; 37.5% (n=45) were between 31-40 years of age; 26.2% (n=32) were between the ages of 41-50 years and 15.6% (n=19) were between 51-65 years of age. There is a peak between the age groups of 25 years and 47 years. The highest age group is 35 years with a mean of 40 (n=129) and a standard deviation of 10.5. Thereafter, there is a percentage decrease as the age increases, as indicated by only 15.5% (n=19) of nurses aged between 51-65 years.

4.3.2. Gender

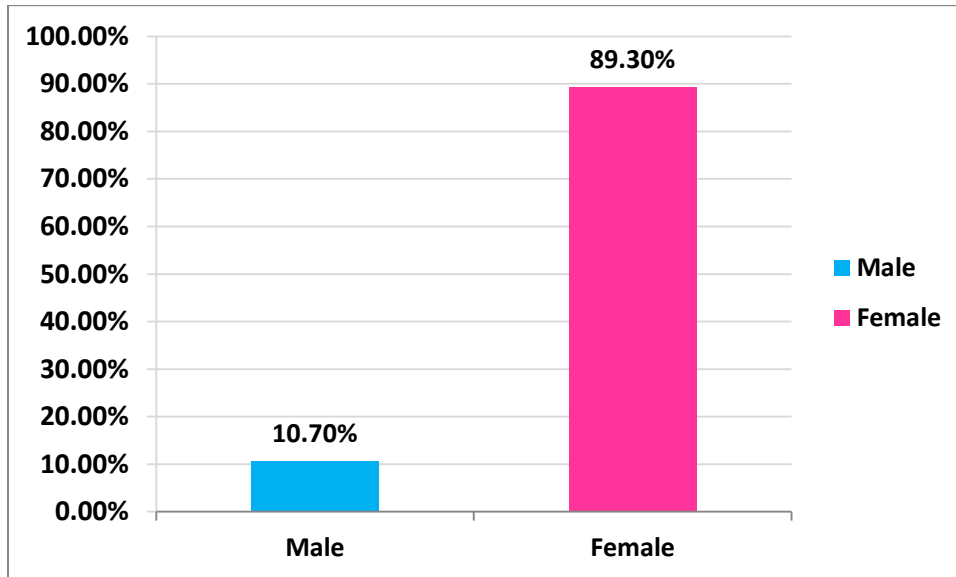


Figure 4.2: Gender of Participants

The sample consisted of a heterogenous group of only 10.7% (n= 15) males and a great majority females 89.3% (n= 125).

4.3.3 Highest Level of Education of Employees at the Selected Hospital

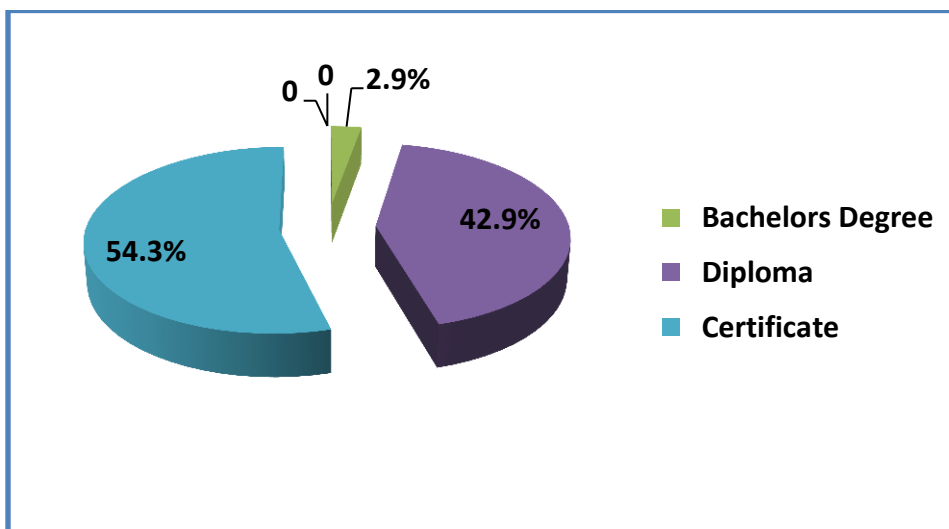


Figure: 4-3 Participants Level of Education

The highest level of education of employees was a Bachelor's Degree held by only 2.9% (n=4) of participants; followed by a Diploma held by 42.9% (n=60) and certificates 53.3% (n=76) held by Enrolled Nurses and Enrolled Nursing Auxiliaries. Diplomas and Bachelor's Degrees are held by Registered Nurses. The highest qualification is a Bachelor's Degree, which was held by only 2.9% of Registered Nurses.

4.3.4. Designation of Nurses

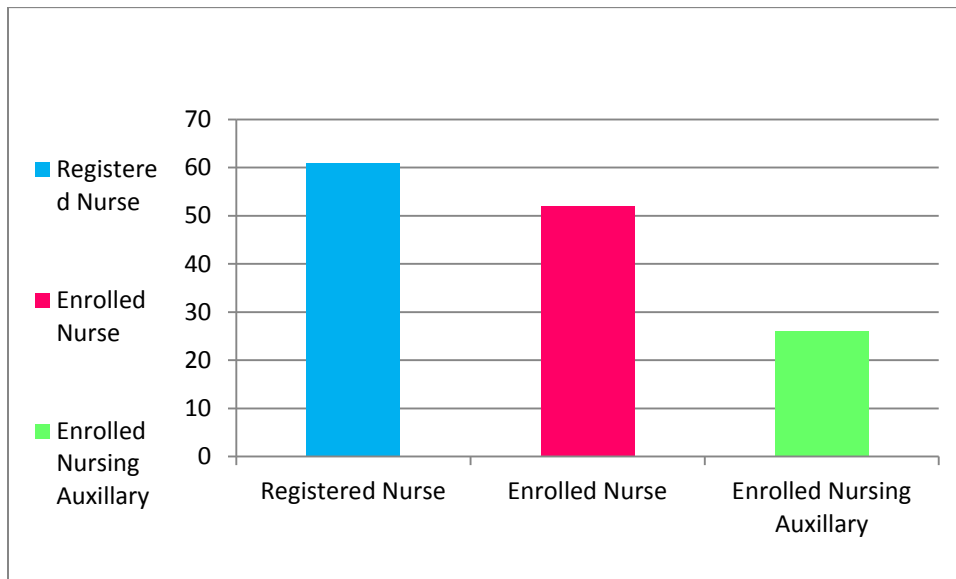


Figure 4.4: Designation of Nurses

The sample (n=139) in the selected public hospital consisted mostly of Registered Nurses, 43.9% (n= 61); Enrolled Nurses, 37.4% (n= 52) and Enrolled Nursing Axillaries, 18.7% (n=26).

4.3.5. Years of Nursing Experience

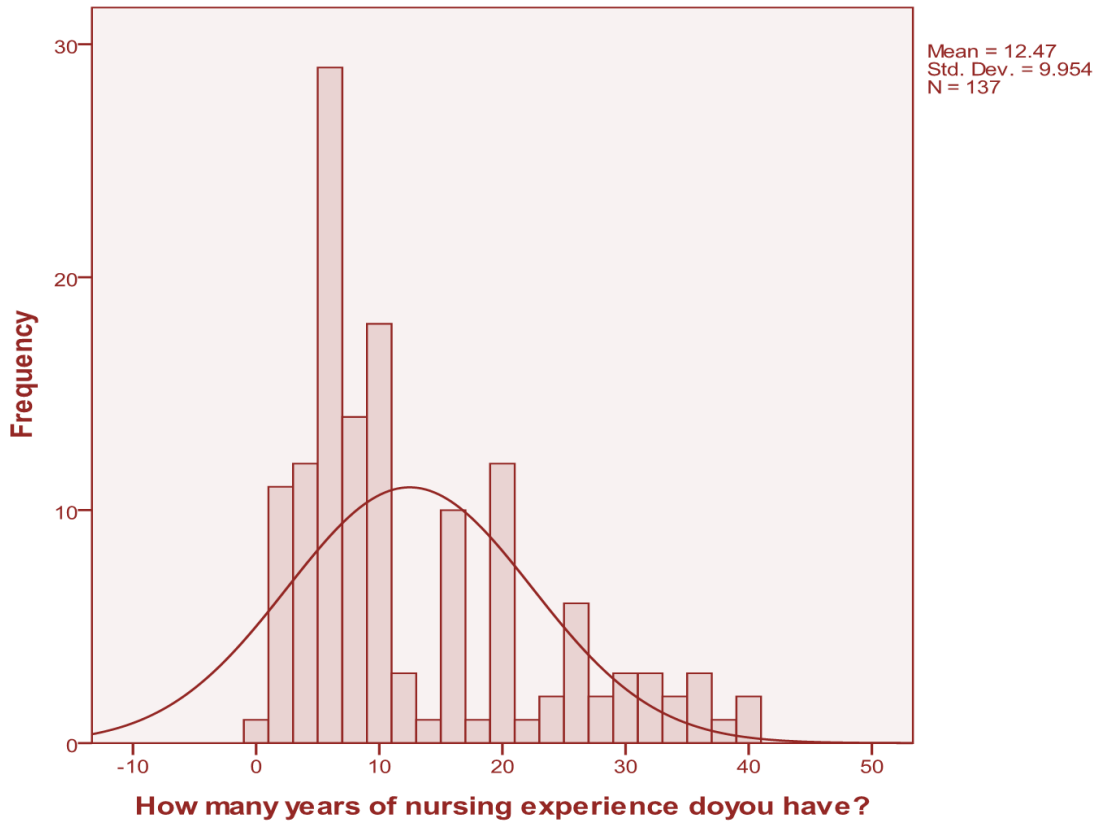


Figure 4.5: Years of Nursing Experience

The findings of the research indicate that 22.6% (n=31) of the respondents had 0-5 years nursing experience; 39.4% (n=54) had 6-10 years nursing experience; 19.8% (n= 27) had 11-20 years of nursing experience; 10.2% (n=14) had 21=30 years nursing experience and 8% (n=11) had 31-40 years of nursing experience.

The histogram above indicates that most of the respondents had between 2 and 12 years of nursing experience. It peaks between 6 and 8 years of nursing experience with a median of 12.02 (n =129) and a standard deviation of 9.57. This reflects a wide range of nursing experience of between 2 and 20 years.

4.3.6. Did You Attend an HIV/AIDS Course?

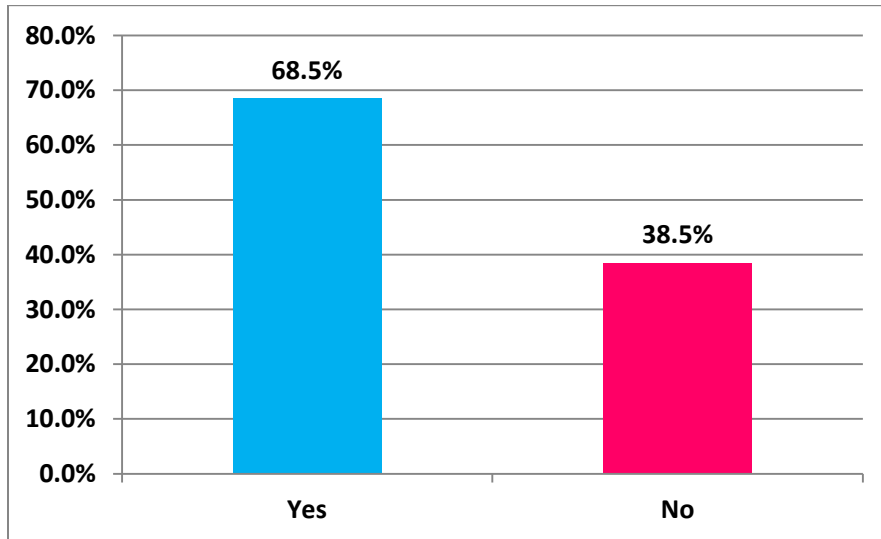


Figure 4.6: HIV / AIDS Course Attendance

All of the respondents that attended an HIV/AIDS course were grouped together irrespective of whether they attended the course in the last 2 years, 5 years or more than 5 years ago. The bar graph above indicates that in a sample of 123 participants; 68.5% (n=84) attended and HIV/AIDS course at some time and 31.5% (n=39) did not attend an HIV/AIDS course.

4.3.7. How Often Do You Care For Patients With HIV / AIDS?

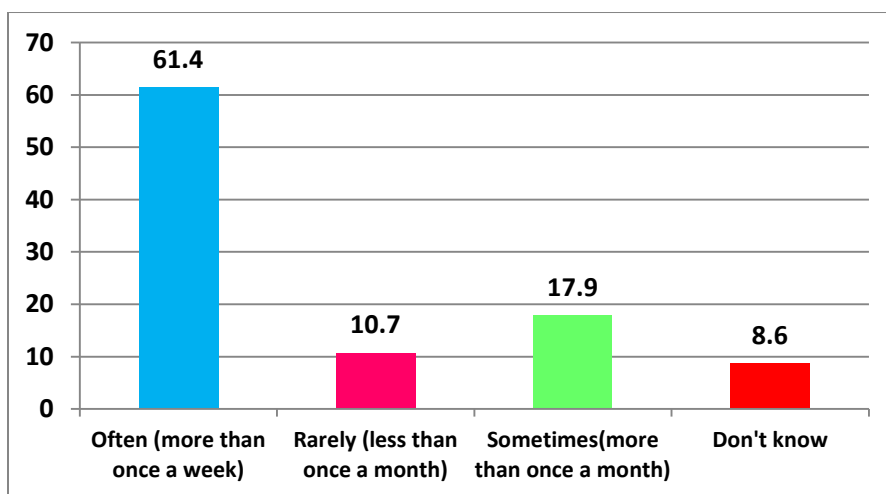


Figure 4.7: Frequency with Which HIV Positive Patients are Nursed

According to Figure 4.7 above, the majority of the participants 63.1% (n=82) reported that they cared for HIV/AIDS patients often (more than once a week); 11.5 (n=15) cared for patients rarely (less than once a month); 16.9% (n=22) cared for patients sometimes (more than once a month) and 8.5% (n=11) did not know. This confirms the magnitude of HIV/AIDS infections in the hospital, as 63.1% (n=82) of nurses reported that they cared for HIV Positive patients more than once a week. In summary, 91.5 % (n=119) cared for HIV Positive patients and only 8.2% (n=11) did not know.

4.3.8. Are You Interested in Attending an HIV/AIDS Course at the Workplace?

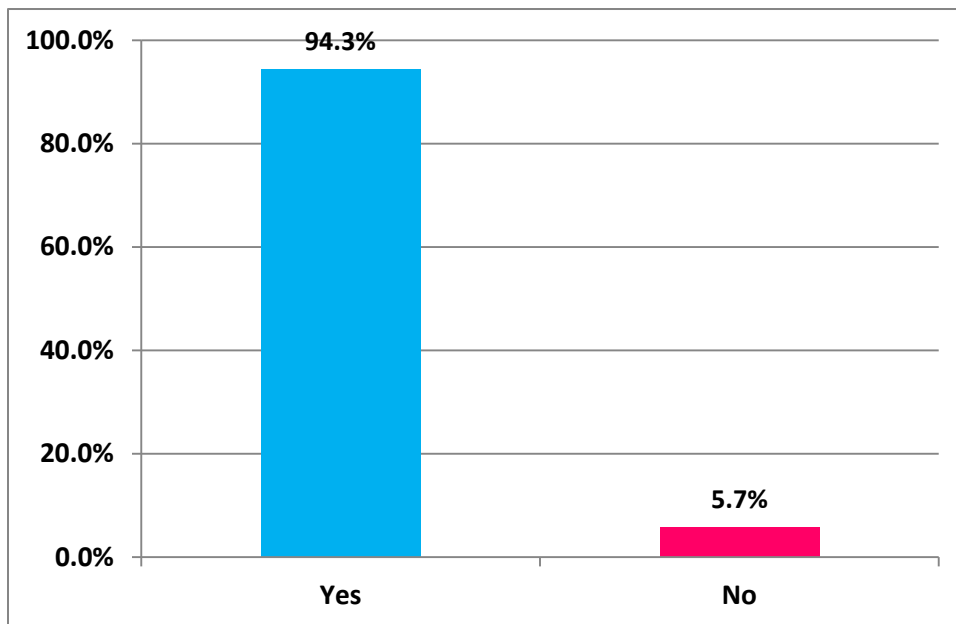


Figure 4.8: Interest Expressed at Attending an HIV /AIDS Course

The findings of the study are represented in a bar graph above, which indicates that in a total sample of 130 participants; 95.5% (n=126) are interested in attending an HIV/AIDS course at the workplace and only 4.5% (n=6) of the respondents reported that they would not like to attend such a course.

4.3.9. I Am Aware That the Hospital Has an HCT Clinic

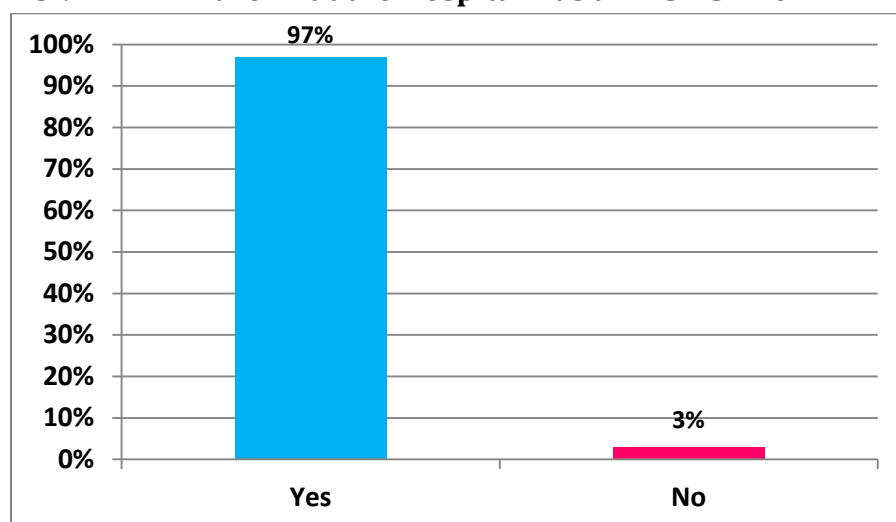


Figure 4.9: Awareness of the Existence of the HCT Clinic

Of the participants, 97% (n=128) reported that they are aware that the hospital has a staff HCT clinic and only 3% (n=4) reported that they did not know.

4.4. Resources Available at the staff HCT Clinic

The resources available at the HCT employee clinic are presented in Table 4.1 below.

Table 4.1: Resources Available at the staff HCT Clinic

Resources Available At The HCT Clinic	Yes	No	Number In Stock
1) HCT program displayed		X	
2) HIV test kits kept in stock	X		
3) Chairs available for counselling and testing	X		
4) Privacy maintained	X		
5) there are directions such as posters to clinic		X	
6) there is a stock of condoms available at the clinic		X	
7) There are pamphlets / reading material available for the clients		X	
8) there are sharps containers available	X		
9) There are gloves in stock	X		

This table presents the resources that were available at the clinic. From the table itself, it was obvious that there were some resources that are available at the employees HCT clinic and some that were not available. HIV kits were kept at the clinic, but at the time of evaluation only one (1) was in stock. There were two (2) chairs at the clinic and privacy was maintained. There were screens in the form of curtains and the door could be closed if need be. There were no directions to the HCT clinic, and condoms, pamphlets and reading material were not available to the clients at the HCT clinic at the time of evaluation. There was one sharps container at the clinic which has one consulting room, and gloves were in stock.

4.5. Activities of the HCT Program for Employees

4.5.1. Frequencies of Trained staff in HIV Counselling and Testing

Table 4.2: Frequencies of Staff Trained in HCT

	n	Frequency	%
YES	8	7	87.5
NO	8	1	12.5

Of the respondents who work at the HCT clinic and those that do the HIV/AIDS counseling and testing, 87.5% (n=7) were trained in HCT, as compared to 12.5% (n=1) who was not trained in HIV counseling and testing. There were a total of 8 respondents.

4.5.2. Frequencies of Number of Clients Counselling Per Day

Table 4.3: Number of Clients Counselling Per Day

n=7	No of clients counseled per day	Frequency	%
n=7	0	1	14.3
n=7	1 client	1	14.3
n=7	2 clients	2	28.6
n=7	3 clients	2	28.6
n=7	4 clients	1	14.3

The number of clients that were counselled per day varied from no clients, 14.3% (n=1); 1 client 14.3% (n=1); 2 clients 28.6% (n=2), 3 clients 28.6% (n=2) and 4 clients 14.3% (n=1).

4.5.3. Departments That Clients Are Referred To

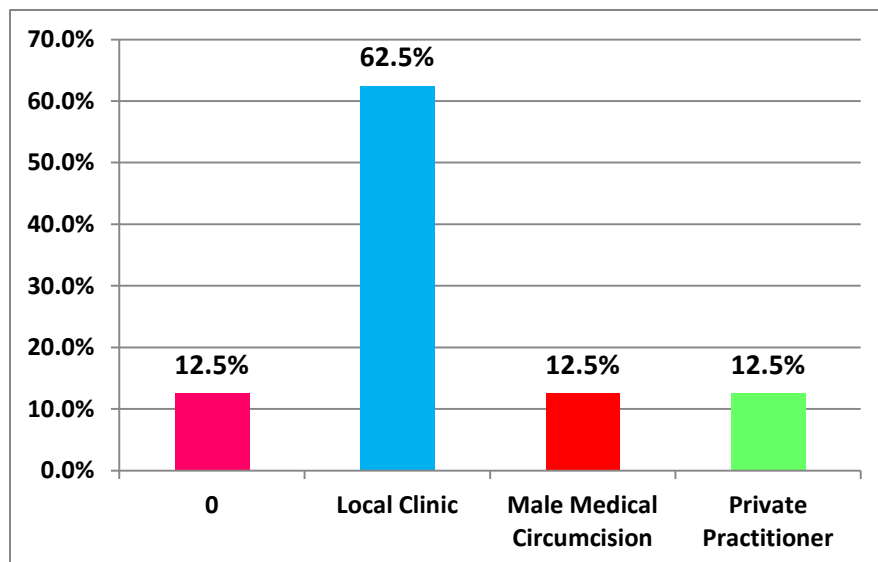


Figure: 4-10 Departments That Clients Are Referred To

The findings indicated that clients were referred to different departments including the local clinic 62.5% (n=5); male medical circumcision 12.5% (n=1); a private practitioner 12.5% (n=1) and 12.5% (n=1) of the respondents reported that they did not refer clients. In summary, 87.5% (n=7) of the respondents referred the client for support services, either to the local clinic, male medical circumcision or to a private practitioner. Only 12.5% (n=1) of respondents did not refer clients.

4.5.4. Supervision of HIV Counsellors and Testers

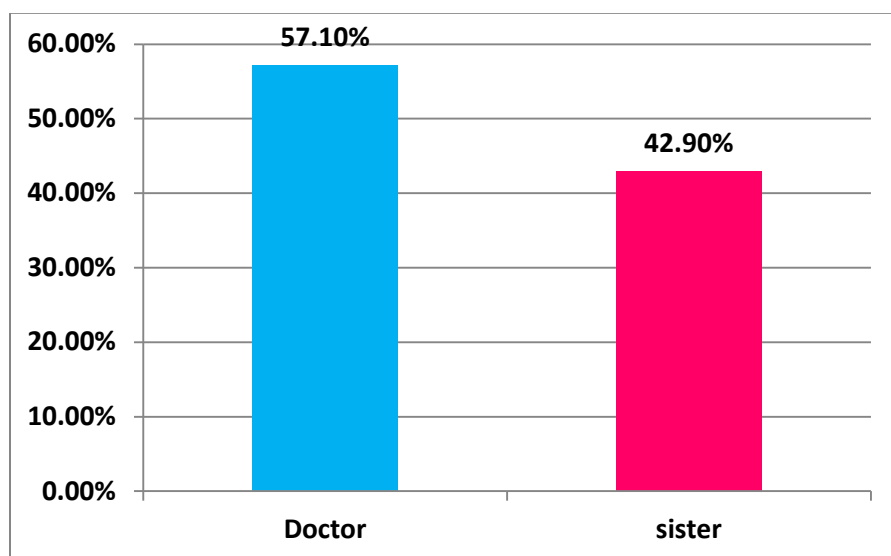


Figure 4.11: Supervision of HCT Clinic Staff

The graph above represents the supervision of the staff that works at the HCT clinic and those that were involved in HIV/AIDS counseling. They were supervised by the Doctor 57.1% (n=4) and by the sister 42.9% (n=3). There were a total of 7 respondents. This indicated that all the respondents are supervised by either the Doctor or Sister.

4.5.5. Frequency distribution of Respondents Access to the Following Items

Table 4.4: Access to Facilities, Services and Equipment

	n	Always		Sometimes		Never	
		Freq	%	Freq	%	Freq	%
Adequate space is provided for counseling	8	5	62.5	2	25	1	12.5
Referral of clients	8	6	75	1	12.5	1	12.5
Gloves are provided	7	7	100				
Sharp containers are provided	7	7	100				
Consent is obtained	7	7	100				

The findings of the study indicated that adequate space for HCT was always provided 62.5% (n=5) of the time and it was never provided 12.5% (n=1) of the time. Of the respondents, 75% (n=6) of the time and it was never provided 12.5% (n=1) of the time.

(n=8) reported that clients were always referred to other departments for treatment, 12.5% (n=8) reported that clients were sometimes referred and 12.5% (n=8) that clients are never referred. Only 7 participants answered the following questions on gloves, sharps containers and consent. The findings also confirmed that protective devices such as gloves and sharps containers are always provided 100% (n=7). All the respondents, 100% (n=7) reported that consent was always obtained prior to HCT.

4.6. Knowledge, Attitude and Practice of Employees towards the HCT Program

4.6.1 Knowledge of the HCT Program by the Participants

Table 4.5: Knowledge of the Program

	N	YES		NO		UNSURE	
		Freq	%	Freq	%	Freq	%
The hospital has a staff HCT clinic.	n=132	111	84.1%	11	8.3%	10	7.6%
Pre and post-test counselling is provided at the HCT clinic.	n=131	113	86.3%	3	2.3%	15	11.5%
Information about HIV Prevention, Infection and transmission are provided at the HCT clinic.	n=131	38	28.8%	71	53.8%	23	17.4%
If you test “negative” you are not encouraged to retest in 3 months due to the window period.	n=132	36	27.3%	77	58.3%	19	14.4%
A client cannot refuse to go for the test after the counselling	n=132	36	27.3%	77	58.3%	19	14.4%
Counselling is done in a private session where strict confidentiality is assured	n=132	124	93.9%	4	3%	4	3%
Condoms can be accessed at the toilets.	n=132	112	84.8%	15	11.4%	5	3.8%
Books, pamphlets and reading material are available at the HCT clinic.	n=131	113	86.3%	3	2.35%	15	11.5%
Directions to the HCT clinic are clear.	n=131	92	70.2%	19	14.5%	20	15.3%

The findings of the research revealed that 84.1% (n=111) of employees reported that they knew that the hospital had a HCT clinic, while 8.3% (n=11) did not know and 7.6% (n=10) were unsure. Of the respondents, 84% (n=110) indicated that pre and post-test counseling was provided at the clinic, while 4.6% (n=6) did not know and 11.5% (n=15) were unsure. 86.3% (n=113) of staff knew that information about HIV prevention, infection and transmission are provided at the HCT clinic; 2.3% (n=3) did not know and 11.5% (n=15) were unsure.

Of the respondents, 28.8% (n=38) agreed with the statement that if they were tested negative, they must retest in 3 months due to the window period; 53.8% (n=71) disagreed and 17.4% (n=23) were unsure. The findings of the study also indicated that 27.3% (n=36) of the staff knew that a client could refuse to go for testing after being counseled; 58.3% (n=77) did not know and 14.4% (n=14) were unsure. 93.9% (n =124) of staff knew that privacy and confidentiality was maintained during counseling; 3% (n=4) disagreed and 3 % (n=4) were unsure. Of the respondents, 84.8% (n=112) confirmed that condoms could be accessed at toilets while 11.4 % (n=15) could not access condoms at toilets and 3.8% (n=5) were unsure.

Books, pamphlets and reading material were said to be available at the clinic by 86.3% (n=112) of staff; 2.3% (n=3) disagreed and 11.5% (n=15) were unsure. The majority of the respondents, 70.2% (n=92) agreed that directions to the HCT clinic were not clear; 14.5% (n=19) indicated that it was clear and 15.3% (n=20) were not sure.

4.6.2. A Graph Summarising Awareness of the HCT Program by the Respondents

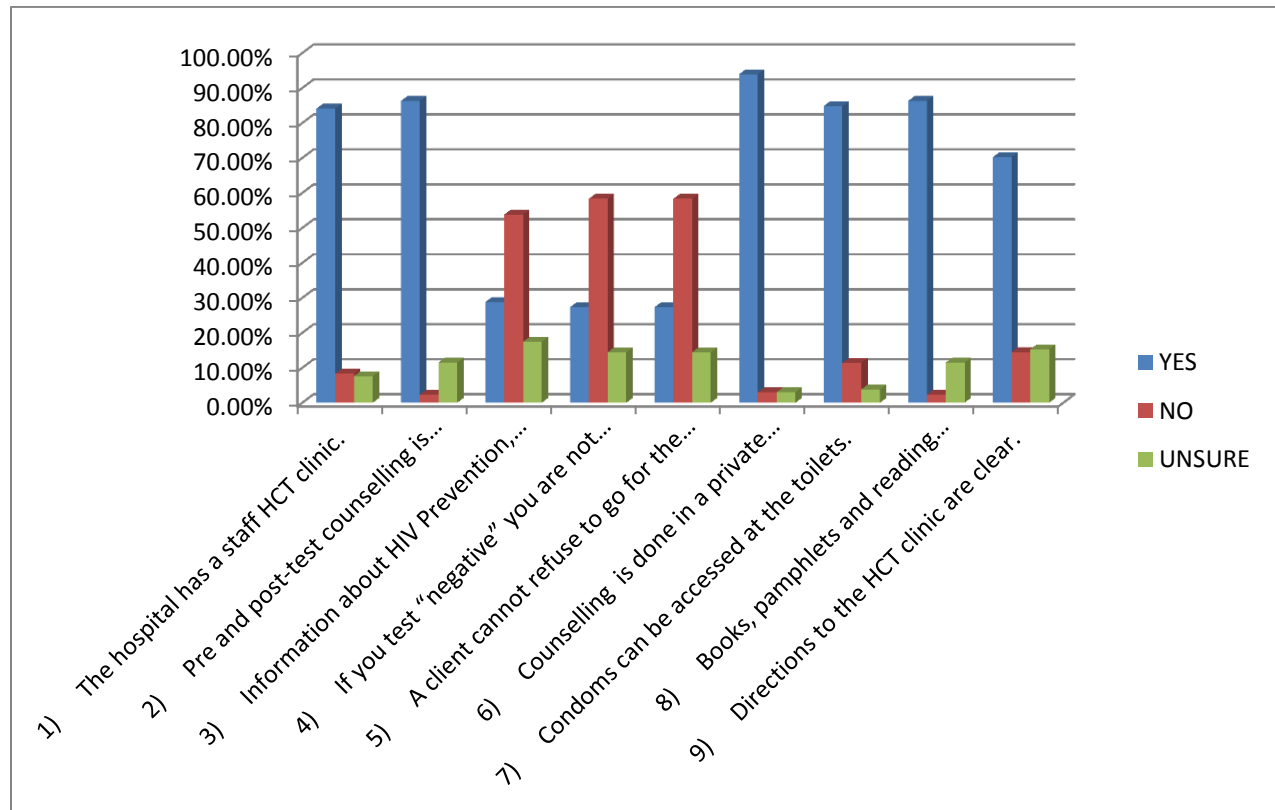


FIGURE 4.12: Summarised Knowledge of the HCT Program by Respondents

In summary, the findings of the study indicated that more than 80% (n=132) of respondents were aware that the hospital had an HCT clinic; pre and post- test counseling was done; HCT was done in private; books and condoms could be accessed at the HCT clinic and reading material and pamphlets were available at the HCT clinic. Of the respondents, 70.2 % reported that directions to the HCT clinic for employees were clear. The results indicated a gap in nurse’s knowledge and awareness of certain aspects of the HCT program, which is a major area of concern. More than 70% of nurses did not know that information about HIV prevention, infection and transmission are provided at the HCT clinic; clients that tested “negative” should be encouraged to retest in 3 months due to the window period, and that a client could refuse to go for testing after the counseling.

4.6.3. Services Offered as Part of the HCT Program

Table 4.6: Services Offered as Part of the HCT Program

Services provided	n	YES		NO	
		FREQ	%	FREQ	%
Testing	n=131	127	96.9	4	3.1
Referral	n=132	78	59.1	55	40.9
Treatment	n=132	26	19.7	106	80.3

Of the respondents, 96.9% (n=127) agreed that testing was done at the staff HCT clinic and 3.1% (n=4) said it was not done. 59.1 % (n=78) of respondents agreed that referral was done at the staff HCT clinic while 40.9 % (n=54) reported that referral was not done. The findings also indicate that 80.3% (n=106) reported that treatment was not provided at the clinic and 19.7% (n=26) reported that treatment was given at the clinic.

4.6.4. Implementation of Condom Promotion Activities

Table 4.7: Implementation of Condom promotion Activities

CONDOM PROMOTION ACTIVITIES	n	frequency	percentage
Done weekly	n=131	62	47.3%
Done monthly	n=131	9	6.9%
Done sometimes	n=131	60	45.8%

The respondents reported that condom promotion activities were provided at the clinic: 47.3% (n=63) indicated weekly; 6.9% (n=4) indicated monthly and 45.8 % (n=60) indicated that it occurred only sometimes.

4.6.5. Attitude of Nurses Regarding the HCT Program

Table 4.8: Percentage Distribution Table Attitudes of employees towards the HCT Program for staff

ATTITUDE of employees	n	SD		D		N		A		SA	
		Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Friends would treat me differently if I were tested for HIV	n=132	26	19.7%	48	36.4%	21	15.9%	30	22.7%	7	5.3%
I would be embarrassed if my friends found out I had decided to have an HIV test	n=132	52	39.4%	52	39.4%	11	8.3%	13	9.8%	4	3%
I am afraid that if I go for HIV test the staff will discriminate against me if they found out that I am HIV positive	n=132	34	25.8%	44	33.3%	9	6.8%	28	21.2%	17	12.9%
Many people do not want to know their HIV status because if they do they will always think about it and it will depress them	n=132	11	8.3%	20	15.2%	20	15.2%	53	40.2%	28	21.2%
There is no use to go for a test because if you test positive there is no cure	n=132	83	62.9%	36	27.3%	4	3%	2	1.5%	7	5.3%
My partner will think I am cheating if I decide to go for an HIV test	n=132	53	40.2%	50	37.9%	18	13.6%	8	6.1%	3	2.3%
It is not necessary to go for an HIV test if you know that you are being faithful to your partner	n=132	66	50%	47	35.6%	9	6.8%	6	4.5%	4	3%
My family would support me if I decided to be tested for HIV	n=132	12	9.1%	3	2.3%	8	6.1%	75	56.8%	34	25.8%
I am afraid that a person I know might test me for HIV and that person may tell others	n=132	19	14.4%	25	18.9%	33	25%	45	34.1%	10	7.6%
HIV antibody testing information is kept very confidential by the medical staff who do the testing	n=132	11	8.3%	17	12.9%	23	17.4%	57	43.2%	24	18.2%
I trust the HIV counsellors and nurses to keep my information confidential	n=132	12	9.1%	14	10.6%	28	21.2%	43	32.6%	35	26.5%

The participants attitude regarding the HCT program for staff at the hospital was assessed using a 5-Point Likert scale of strongly agree, agree, neutral, disagree and strongly disagree.

The frequencies for attitudes in a sample of 132 respondents yielded the following results: mean: 2.37; median: 2.36; mode: 2.36; minimum: 1.0 and maximum: 3.73. According to the findings of the study, 75% of nurses have a score of 2.36. This indicates that 75% of nurses have a score which is closer to the average of 3 with their attitudes leaning more towards a neutral attitude.

Nurses' attitude towards the HCT program was divided into various questions which yielded different responses. Of the respondents, 36.4 % (n=48) and 19.7%9 (n=26) disagreed and strongly disagreed respectively that their friends would treat them differently if they were tested for HIV. Only 5.3% (n=7) strongly agreed with this statement. The findings indicate that 39.4% (n=52) and 39.4 % (n=52) of nurses responded that they strongly disagreed and disagreed respectively that they would be embarrassed if their friends found out that they tested for HIV. Only 3% (n=4) strongly agreed with this statement. This may be associated with the fact that nurses are trained and more aware of HIV prevention, care and treatment.

A large majority of participants 59.1% (n=77) reported that they disagreed and strongly disagreed that they were afraid to go for an HIV test because staff would discriminate against them if they found out that they were HIV positive although the remaining nurses 34.1% (n=45) interestingly agreed with this statement. This is considered a negative attitude towards the HCT program, because if nurses are afraid that staff will discriminate against them if they found out that they were HIV positive, the chances are that these employees will not use the HCT clinic.

More than 62% (n=81) of nurses agreed that people do not want to know their HIV status because it will depress them while a small proportion 8.3% (n=11) strongly agreed. 62.9% (n= 83) nurses strongly disagreed that there was no use going for an HIV test because there is no cure while only a small percentage 5.3% (n=7) agreed. 40.2% (n=53) of nurses strongly disagreed that their partners would think that they were cheating if they went for an HIV test, 37.9 % (n=50) disagreed and only 6.1% (n=8) and 2.3% (n=3) nurses reported that they agreed and strongly disagreed respectively.

The majority of the nurses disagreed and strongly agreed 85.6% (n=113) that if one was faithful to their partner, there was no need to have an HIV test and only 7.5% (n=10) agreed and strongly agreed. 56.8% (n=75) of nurses agreed that their families would support them if they decided to have an HIV test; 25.8% (n=34) nurses strongly agreed. The response to the question *"I am afraid that that a person I know may test me for HIV and that person may tell others"* varied with 14.4% (n=19) of nurses strongly disagreed; 18.9 % (n=25) disagreed; 25% (n=33) of nurses remained neutral, however 34.1% (n=45) nurses agreed and 7.6% (n=10) strongly agreed.

A large majority of nurses agreed 43.2% (n=57) and strongly agreed 18.2% (n=24) HIV testing information was kept confidential by medical staff who do the testing, while 8.3% (n=11) strongly disagreed and 12.9% (n=17) disagreed. This could be closely associated with the reason why staff are afraid to test because they are afraid a person they know may test them and tell others which is reflected in the small percentage who agreed in the lack of confidentiality. 26.5% (n=35) nurses strongly agreed that HIV counselors and nurses kept their information confidential as compared to the 18.2% (n=24) who strongly agreed that medical staff keep their information confidential; 32.6% (n=43) of nurses strongly agreed and 9.1% (n=12) and 10.6% (n=14) nurses strongly disagreed and disagreed respectively.

4.6.6. Practise of Nurses Regarding the HCT Program

Percentage Distribution

Table 4.9: Practices of nurses regarding the HCT program

Practise of nurses regarding the HCT program		n	Freq	%
I have had a HIV test?	Yes	n=131	122	93.1%
	No	n=131	9	6.9%
IF NO, Why not?	Never thought about it	n=16	6	37.5%
	Don't think I am at risk	n=16	4	25%
	Fear of stigma/consequences of a positive	n=16	3	18.8%
	Don't know where to get it	n=16	1	6.3%
	I am afraid to know	n=16	1	6.3%
	Other	n=16	1	6.3%
IF YES, Did you voluntarily undergo the HIV test, or Were you required to have the test?	Voluntary counselling and testing	n=122	93	76.2%
	Tested because a doctor/nurse suggested	n=123	6	4.9%
	Insurance related testing	n=123	16	13%
	Employer related testing	n=123	8	6.5%
	Antenatal testing	n=123	18	16.4%
	Testing after needle stick injury	n=123	5	4.1%
	Other	n=123	3	2.4%
IF YES, Did you find out the results of your test?	Yes	n=122	118	96.7%
	No	n=122	4	3.3%
IF YES, When did you have your most recent HIV test?	Within the Past Year	n=118	79	66.9%
	Between 1 & 2 Years	n=118	24	20.3%
	Between 2 & 4 Years	n=118	15	12.7%

The results indicate that a large majority of participants 93.1% (n=122) had an HIV test and only a small proportion of 6.9% (n=9) did not have an HIV test. Of those that tested for HIV, a great majority 76% (n=93) tested voluntarily.

Only 16 participants answered this question: *“IF YES, Did you voluntarily undergo the HIV test, or were you required to have the test?”* hence, the difference the findings in sample size. Some of the reasons for not having the test were: 37.5% (n=6) had never thought about it; 25% (n=4) respondents did not think that they were at risk; 18.8% (n=3) respondents were afraid of the stigma and consequences of being HIV positive; 6.3% (n=1) did not know where to get it, 6.3% (n=1) were afraid to have it and 6.3% (n=1) did not test for other reasons.

For those nurses that had an HIV test, 76% (n=93) had the test voluntarily. Those participants who were required to have an HIV test, had it for the following reasons: 4.9% (n=6) participants tested because a doctor or nurse had suggested it; 13% (n=16) participants tested for insurance related purposes; 6.5% (n=8) participants tested for antenatal reasons; 4.1% (n=5) participants testing after a needle stick injury and 2.4% (n=3) participants tested for other reasons.

Of the respondents that had an HIV test 97.6% (n=118) found out their results and only 3.3% (n=4) respondents did not find out their results. This is a good indication that majority of health care workers (nurses) are voluntarily testing and finding out their results. This would ensure prompt treatment to keep the health care worker as healthy and productive for as long as possible. The respondents that reported that they had an HIV test: 66.9% (n=79) had their test within the last year; 20.3% (n=24) had it between one (1) and two (2) years ago and a small percentage of 12.7% (n=15) had it between 2 and 4 years ago.

The researcher was interested to know whether knowledge and attitudes of nurses regarding the HCT program for employees were influenced by demographic characteristics such as the level of education of nurses and years of nursing experience therefore Correlations were done.

4.7. Correlation of Knowledge and Attitude of Those That Attended the HIV Course Compared To Those Who Did Not Attend an HIV Course

Table 4.10: Independent sample t test

Independent Samples Test									
	Levene's Test for Equality of Variances		t-test for Equality of Means						
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
attitude Equal variances assumed	.106	.746	-.802	122	.424	-.08636	.10765	-.29946	.12675
Equal variances not assumed			-.802	73.863	.425	-.08636	.10763	-.30083	.12812

An independent Sample t test and Mann Whitney U Test was done to determine whether the knowledge and attitude of nurses who attended an HIV/AIDS course differed from those who did not attend an HIV/AIDS course. Those nurses that indicated that they had attended an HIV/AIDS course were grouped together irrespective of how long ago it was and those that did not attend an HIV course were grouped together. Attitude was calculated using the means. Majority nurses, 68.5% (n=85) attended an HIV/AIDS course and 31.5% (n=39) did not attend. Attitude was calculated using the means. A one way analysis of variance was done to determine whether the nurse's knowledge and attitudes differ by level of education and years of experience. Nurse's knowledge was aggregated as follows: if they had the correct answer, they were allocated a score of 1. If they did not know or were unsure, this was grouped together and was allocated a score of 0.

The study had a confidence level of 95% and a p value of 0.42. There was no significant difference between those nurses that attended an HIV/AIDS course and those who did not. Based on the findings of the study, the nurse's attitudes were not affected or influenced by the

HIV/AIDS course that some nurses attended. Attitude was equally distributed and knowledge was not therefore a non-parametric was used for knowledge.

An independent sample Mann Whitney U Test was done to assess the knowledge of those nurses that attended an HIV/AIDS course and those that did not. The significance level was 0.05 with a p value 0.65 which indicated that the distribution of knowledge was the same for all categories of nurses.

4.8. Correlations Between Nurses Knowledge And Attitudes

Table 4.11: Tables to calculate mean score for attitude

Attitude

Highest level of education	Mean	N	Std. Deviation
Bachelor's Degree	2.6970	3	.22878
Diploma	2.3312	56	.56638
Certificate	2.3873	73	.57056
Total	2.3705	132	.56361

Attitude

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.427	2	.213	.669	.514
Within Groups	41.187	129	.319		
Total	41.614	131			

With a significance level of 0.05, the p value of nurse's attitude was 0.51. There is no significant difference in the attitude of nurses and the level of education. Based on the findings of the study, the attitude of nurses is not affected by the level of nurse's education.

The researcher was interested to know whether the level of education affected the knowledge of the nurse. It is hypothesized that the higher the level of education, the more knowledgeable the nurse is. An independent sample Kruskal-Wallis Test was done to determine whether the highest level of education affected the knowledge of staff. The confidence level was 0.05 and

the p value 0.37, because the p value of 0.37 is less than 0.05, it is not significant. The findings indicate that the distribution of knowledge is the same across all categories of highest level of education.

4.9. Knowledge and Attitude Compared To Years of Experience

Table 4.12: correlation between knowledge and attitude and years of experience

Correlations			
		How many years of nursing experience do you have? knowledge	
Spearman's How many years of nursing experience do you have?	Correlation	1.000	-.022
	Coefficient		
	Sig. (2-tailed)	.	.801
	N	129	129
Knowledge	Correlation	-.022	1.000
	Coefficient		
	Sig. (2-tailed)	.801	.
	N	129	132

A Spearman's correlation was done to determine the correlation between the years of nursing experience and knowledge of nurses. There was no linear correlation because it was close to one. The findings of the study prove that the years of nursing experience did not influence the level of knowledge of the nurses.

Attitude

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	2.727	3	.909	3.064	.031
Within Groups	37.075	125	.297		
Total	39.802	128			

Attitude

experience	N	Mean	Std. Deviation	Minimum	Maximum
1.00	83	2.4480	.52565	1.00	3.73
2.00	24	2.2273	.57308	1.00	3.36
3.00	13	2.4755	.68248	1.09	3.45
4.00	9	1.9495	.39915	1.36	2.73
Total	129	2.3749	.55763	1.00	3.73

It was initially hypothesized by the researcher, that the more experienced a nurse is, the greater the knowledge and better the attitude is because the respondent has been exposed to the HCT program for a much longer period. A one way analysis of variance was done to determine whether the nurse's attitudes differ by years of experience. The findings revealed that there was a significant p value of .031 which indicates that the attitudes of nurses were affected by their years of experience. An independent sample Kruskal-Wallis Test was done to determine whether the knowledge of nurses was affected by their years of experience. Years of experience were grouped into categories as follows: category 1:1-10 years; category 2: 11-20 years; category 3: 21-30 years and category 4:31-40 years. The results were: category 1 :(n=83) median 8.0; category 2: (n=24) median 7.0; category 3: (n=13) median 7.0 and category 4: (n=9) median 8.0. The findings indicated an insignificant p value of 0.66. This indicates that the knowledge of nurses is not affected by their years of experience.

4.10. Conclusion

The findings indicate that the nurse's knowledge and attitude is more to the neutral side. A significant minority of the participants reported that they did not trust that the medical and nursing staff and the councilors kept their testing information confidential. They were also afraid that a person they know may test them and tell others. There were no correlations between nurses that attended the HIV course and those that did not. The distribution of knowledge was the same across all categories of experience. The distribution of knowledge was the same across categories of highest education level. The attitudes of staff were not

affected by their level of education. The findings of the checklist for the venue indicated that some resources such as HIV test kits, gloves and sharps containers were available while resources such as condoms, directions to the clinic and books, pamphlets and reading material were unavailable. Summary of the findings, recommendations, limitation and conclusion will be discussed in the next chapter.

CHAPTER 5

DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

The results that were presented in chapter 4 are discussed in this chapter. The results include the availability of the resources at the HCT clinic; evaluation of the activities of the HCT program and evaluating the knowledge, attitudes and practice of nurses towards the HCT for employees at a selected hospital. Chapter 5 includes the limitations, conclusions and recommendations for the hospital and for further research. The purpose of this study was to conduct a process evaluation of the implementation of the HIV/AIDS counselling and testing program (HCT) for employees to ensure the delivery of standardized, high quality and ethical HIV counselling and testing services at a selected public hospital in KZN.

The study was conducted at a health care institution which has an HCT program for employees. The HCT program for employees is part of the occupational health clinic. There were three (3) research instruments according to the objectives of the study. Instrument one (1) was a checklist to evaluate the resources available at the HCT clinic. The checklist was completed by the chairperson of the hospital HCT committee and the Occupational health Nurse in the presence of the researcher. The researcher used a research assistant for data collection to minimize bias. The researcher ensured that the assistant was trained to use the tool. The ward sisters were given the research tools to distribute to the staff to prevent the Hawthorne effect (Brink,2001:107)as the researcher is a lecturer at the college which is attached to the selected public hospital. The Hawthorne effect occurs when the participants report what they think the researcher expects from them and not what is actually done in practice.

5.2. Discussion of Findings

5.2.1. Nurses demographic data

The ages of nurses' ranged between 22 years and 65 years. The findings of the study indicate that there is an aging nursing population which concurs with a study by Vance (2011:9) & Kick (2003:1), that there is an aging population, not only in South Africa but globally as well.

According to Kick (2003:1), this does not only refer to the population alone but includes the ageing nursing workforce.

The sample consisted of majority females and a small minority of males. This supports the traditional belief that nursing is primarily a female profession which is a usual pattern in the nursing profession. According to the demographic statistics of the South African Nursing Council (2010:1), there are 463 535 female nurses and 43 762 male nurses, which is less than 10% of female nurses.

According to UNAIDS (2010: 53), gender and HIV are imperative issues and recognizes that females (women and girls) are at higher risk than males and are more susceptible to HIV infection due to social and economic inequalities. The findings of this research prove that the majority of the nursing workforce is woman. In Sub Saharan Africa, 52% of those living with HIV are women as indicated by the UNAIDS (2010: 10). The total public service constitutes of 51% women and therefore all measures should be taken to empower woman because although they are employees, they are also at risk of HIV (DPSA, 2002:1). According to the WHO & UNAIDS (2005:9), some workforces comprise of 80% woman as in the case of this health care institution.

The highest qualification is a Bachelor's Degree which was held by only 2.9% of Registered Nurses. This is the norm in nursing education in South Africa where basic nurse training is offered at a certificate or diploma level in nursing colleges, and it is more difficult to obtain a degree or post graduate qualification due to the limited intake at the universities. This is in a process of change as nurse educators are encouraged to register for a post graduate

qualification such as a Master's Degree to prepare for the new nursing curriculum to be implemented provisionally in 2013 by the South African Nursing Council (2010:1).

The findings of the research reflect a wide range of nursing experience between Two (2) and 20 years. Most of the respondents had between 6-10 years of nursing experience, after which there was an increase in the years of nursing experience as the age increased.

Of the 96% of nurses who indicated that they would like to attend an HIV course, only 68% had actually attended a course in HIV. According to the DOH (2009: 46) the HIV/AIDS workplace policy aims to raise awareness and knowledge about HIV/AIDS, and education and training is an essential component of the program. This concurs with previous studies in Africa regarding the role of knowledge as a predictive factor in accepting HIV testing (Perez, Zvandaziva, Engelsmann, & Dabis, 2006:514; Weiser, Heisler, Leiter, *et al*, 2006:261; Iliyasu, Abubakar, Kabir, & Aliyu, 2006:1917). According to Perez, Zvandaziva, Engelsmann, & Dabis (2006:514), the findings of a study in the rural part of Zimbabwe indicated that knowledge of HIV was related with VCT uptake in an adult group. Similar results were also found in studies of HIV testing uptake in both Botswana and Nigeria (Weiser, Heisler, Leiter, *et al*, 2006:261; Iliyasu, Abubakar, Kabir, & Aliyu, 2006:1917). The study by Bassett, Giddy, Wang, Lu, Losina, & Freedberg (2008:863) also advises that HIV knowledge not only forecasts readiness to receive testing, but may also be protective against acquiring HIV infection. Hence, it would be an advantage to increase training to those staff members that are not trained in HIV as a means to improving knowledge.

A large majority of the participants 91.5 % reported that they cared for HIV patients. This concurs with a study by Uebel *et al* (2004:3) that the HIV epidemic has placed a remarkable increase in the workload of the health workforce with 50% of hospital beds occupied by AIDS patients.

It was interesting to note that even though 97% (n=128) of nurses reported that they are aware that the hospital has an HCT program, only 84.1% (n=111) knew that the hospital had an HCT program for employees. However, the findings of the research indicate that the majority of the nurses employed at the selected public hospital are aware of the HCT program for employees. This is supported by a study conducted by Ntuli, Kabengula & Msuya (2011:17) where all the

participants reported that they were aware about Provider-Initiated HIV Testing and Counselling (PITC) services.

5.2.2. Resources Available At the HCT Clinic

There were some resources that were available at the employees HCT clinic and some that were unavailable. HIV kits were kept at the clinic but at the time of evaluation only one (1) was in stock. There were two (2) chairs at the clinic and privacy was maintained. There were screens in the form of curtains and the door could be closed if need be. There was one sharps container in the one consultation room at the clinic and gloves were in stock.

There were no directions to the HCT clinic, and condoms, pamphlets and reading material were not available to the employees at the HCT clinic at the time of evaluation. The effective implementation of the HCT program depends on the availability of resources (DOH, 2009:25). This is also consistent with the findings of a study conducted in Tanzania amongst health care professionals aimed at assessing the perceived barriers for effective implementation, revealed that Health care professionals perceived an absence of test kits and supply of consumables, lack of space and lack of special training at the facilities as barriers to offering PITC (Kapologwe, Kabengula & Msuya, 2011:17).

The findings of this study indicate that the selected public hospital does not comply with the National Guidelines for quality counselling and testing (DOH, 2009:24) which stipulates that all indispensable commodities in HCT facilities, including rapid test kits; condoms; and books, pamphlets and reading material, should be made available, affordable and accessible to employees at the staff HCT clinic.

5.3. Activities of the HCT Program for Employees

According to the HIV counselling and testing Policy Guidelines (2009:29), the activities of the staff HCT program complied with the following guidelines:

- ❖ Majority of the respondents who work at the HCT clinic were trained in HCT.
- ❖ The number of clients counselled per day was less than five.
- ❖ In summary, 87.5 % of the respondents referred the client for support services either to the local clinic, male medical circumcision or to a private practitioner. This seeks to facilitate referral and access to prevention, treatment, care and support.
- ❖ Adequate space, consent and personal protective devices such as gloves and sharps containers are always provided at the employee HCT clinic.
- ❖ A large majority of the respondents reported that clients are always referred to other departments for treatment.

The findings of this study is consistent with a cross-sectional study by Li, Lin, Wu, Wu, Rotheram-Borus , Detels, & Jia (2007:260), which provided clear evidence that institutional support such as increased access to more preventive measures such as sterile rubber gloves, HIV-related training, and sufficient health insurance coverage, were all important steps in maintaining a stable workforce and improving the quality of care for PLWHA.

The findings of the research prove that 100% of the staff that work at the HCT clinic and those that are involved in HIV/AIDS counselling are supervised either by the Doctor or Sister. Supervision is done in a hierarchal approach with those HIV counsellors that hold certificates refer to the Sister who holds either a Diploma or Degree and the Sister who refers to the Doctor.

5.4. Knowledge, Attitude and Practice of Employees towards the HCT Program

5.4.1 Knowledge of HCT Program by the Respondents

It has also emerged from the study that more than 80% of nurses are knowledgeable about the employee HCT program; pre and post-test counselling and information about HIV prevention; infection and transmission provided at the HCT clinic. They also reported that more than 80% of nurses were aware that condoms could be accessed in toilets and books, pamphlets and reading material were available at the HCT clinic for employees. These are essential components of an effective HCT program in the workplace (DOH, 2009:29).

An area of concern was that only 28.8% (n=38) were knowledgeable that they must retest in three (3) months if they are HIV negative due to the window period; the remaining 70% either did not know or disagreed. Nurses also lacked knowledge (63%) that a client could refuse to go for an HIV test after already being counselled. The results indicate a gap in nurse's knowledge and awareness of certain aspects of the HCT program which is a major area of concern.

The checklist of the venue which was completed by the chairperson of the HCT committee and Occupational Health Nurse in the presence of the researcher indicated that there were no directions such as posters to the clinic. This contradicted the findings of nurses working in the selected public hospital (instrument 3) where a large majority of participants reported that directions to the HCT clinic were clear. A valid explanation for this contradiction could be based on innate knowledge that because they have been employed at the institution for a period of time and have been using the wellness clinic, they knew the directions.

A large majority of participants (86%) reported that books, pamphlets and reading material are available at the HCT clinic. The participants also indicated that they did not know that Information about HIV Prevention, Infection and transmission were provided at the HCT clinic. The researcher's explanation for the above contradiction relies on the assumption that books; pamphlets and reading material were seen as resources that are provided at the clinic for clients to take with them, where the role of the HCT providers was to ensure that "information and educational material need to be available for the clients to take home to study and discuss

with their families". Information about HIV Prevention, infection and transmission was viewed as the information that is given to the client verbally when they visit the HCT clinic.

More than 90% of nurses knew that privacy and confidentiality was maintained during counselling. This complies with the National guidelines for HIV testing and counselling (DOH, 2009:36). The findings of this study contradicts previous research which indicated that participants had no trust in health care workers and feared that they will inform others about their sero-status (Annemarie, Arjan, Hans, Herman, 2008:49). The study confirmed that participants also doubted health care workers' skills to do adequate testing.

This research proves that services offered at the employee HCT clinic include HCT and referral. However more than 80% of respondents reported that treatment was not provided at the clinic. This is a major concern to the researcher that treatment is not provided at the HCT clinic. The researcher therefore enquired about the treatment for employees should they require it. After consultation with various members of staff and pharmacy, that dispenses the medication, the researcher concluded the following: treatment is given for a maximum period of 1 month. Thereafter the client is referred to another health care institution for treatment, care and services (DOH: 30). However, according to Uebel, Nash, Avalos, (2007:500), "It is not enough to rely on individuals accessing HIV treatment and care outside their place of employment or in the private sector. Programs should be located in house or close to the place of work so that the service is recognized and easily accessible". According to Connelly & Rosen, (2006:128), several big corporations in South Africa and elsewhere have established that continuing to compensate for private disease management services or health insurance is a worthwhile investment, despite rapidly expanding public sector programmes. A study undertaken in 3 hospitals in South Africa (McCord Hospital in Durban, South Africa; Mseleni Hospital in northern KwaZulu-Natal, South Africa; and the Tshedisa Institute in Gaborone, Botswana) revealed that in all 3 staff programs, there was an increased approval of counselling, testing, and treatment among health care workers (Uebel, Nash, Avalos, 2007:500).

The respondents reported that condom promotion activities which is an essential component of the HCT program and prevention programs were provided at the clinic (DOH, 2009:29)

5.4.2. Attitude of Nurses Regarding the HCT Program

According to the findings of the study, 75% of nurses have a score of 2.36. This indicates that 75% of nurses have a score which is closer to the average of 3 with their attitudes leaning more towards a neutral attitude.

Majority of the respondents displayed a positive attitude towards the employee HCT program with regards to friends treating them differently or that they would be embarrassed if they friends found out that they tested for HIV. This may be associated with the fact that nurses are trained in HIV and are more knowledgeable and aware of HIV prevention, care and treatment. Majority of the participants had a positive attitude testing and were not concerned with the following: that their partners would think that they are cheating if they tested; that there was no need to test because there is no cure and their families would support them if they had an HIV test. This is supported by a study by Iliyasu, Abubakar, Kabir & Aliyu_ (2006:1920) to assess the knowledge of HIV/AIDS and attitude towards VCT among adults in a rural community in northern Nigeria where a vast majority of respondents (72.3%) said they were willing to be tested and would recommend it to friends and relatives.

The researcher was concerned that significant proportion of respondents was afraid to go for an HIV test because staff would discriminate against them if they found out that they were HIV positive a person they know may test them for HIV and that person may tell others. This is a major concern to the researcher that so many nurses are afraid to test. This is consistent with the findings of Stewart (2003:1) and NY blade et al (2009:12) that stigma and discrimination were major challenges to the successful implementation of HIV/AIDS workplace programs where employees themselves could be stigmatized by their colleagues. It also concurs with a study by Li et al. (2007:753) that stigma does not only occur amongst members of society but

nurses are also members of society and thus may also stigmatize. This may also be considered a negative attitude towards the HCT program, because if nurses are afraid that staff will discriminate against them if they found out that they were HIV positive, the chances are that these employees will not use the HCT clinic. According to the Constitution of South Africa, (Act. 108); every person has a right to confidentiality and privacy regarding their HIV status. More than 62% (n=81) of nurses agreed that people do not want to know their HIV status because it will depress them.

Even though a large majority of participants reported that testing information was kept confidential by medical staffs that do the testing, a significant minority did not trust that medical staff, nurses and counsellors kept their information confidential. This could be a barrier to staff using the HCT clinic. The findings of the study indicate that almost 4 in every 10 nurses disagreed that testing information was kept confidential by nurses and medical staff. However the findings of a study by Iliyasu, Abubakar, Kabir & Aliyu_ (2006:1920) refutes the findings of this study where majority of the participants (58%) favoured government hospitals to be tested, while 26.0% chose private hospitals and clinics quoting privacy as the chief reason for their choice.

5.4.3. Practise of Nurses Regarding the HCT Program Percentage Distribution

The findings of this research indicate that majority of the respondents had an HIV test voluntarily and found out their results. The goals of the National Strategic Plan indicate that knowledge of HIV status is critical for prevention and treatment (DOH; 2009:2). The findings of this study therefore prove that the respondents are knowledgeable about their HIV status and are striving to meet goals of the NSP.

However a small percentage of respondents did not test due to the stigma and consequence of being HIV positive or they thought that they were not at risk. This is consistent with a study conducted by Dieleman et al (2009:367) and NY blade et al (2009:12) which proved that fear of stigma deters several nurses from being tested for HIV. However, a study by Uebel, Nash,

Avalos (2007:500) at McCord Hospital and Mseleni Hospital revealed that the treatment of staff were a success which assisted in decreasing stigma as staff were more willing to discuss their status and treatment. There has also been a substantial increase in the number of health care workers accessing treatment at the staff clinic at McCord's Hospital since the inception of its programme. According to the South African Labour guide (2011), HIV/AIDS is still a disease related to stigma and discrimination. Some of the other reasons for HIV testing were related to post needle stick injury and employer related, this concurs with the South African labour guide (2011: 1) which also reports that stigma and discrimination in the workplace were perpetuated in the form of pre-employment testing. A previous study by Iliyasu, Abubakar, Kabir & Aliyu (2006:1920) reported that only 3% of respondents reported they had to do the test during a job recruitment process. The Employment Equity Act (55 of 1998) forbids HIV testing of an employee without approval by the Labour Court.

This is a good practise where the majority of health care worker (nurses) are voluntarily testing and finding out their results. This complies with the most important goal of HCT program i.e. to improve the knowledge of HIV status through HIV Counselling and testing service (DOH, 2009:2). This would ensure prompt and early access to care and treatment to keep the health care worker as healthy and productive for as long as possible (WHO & UNAIDS, 2005:21). A large proportion 66.9% (n=79) of respondents reported that they had their HIV test within the last year. This could have resulted from an increased awareness of the HCT program in the selected public hospital.

The researcher hypothesised that knowledge and attitudes of nurses regarding the HCT program for employees is influenced by demographic characteristics such as the level of education of nurses and years of nursing experience. Correlations were therefore done to confirm or nullify the hypothesis.

5.4.5. Correlation Tests

There was no significant difference between those nurses that attended an HIV/AIDS course and those who did not. Based on the findings of the study, the nurse's attitudes were not affected or influenced by the HIV/AIDS course that some nurses attended. This is an area of concern that needs radical intervention. An independent sample Mann Whitney U Test was done to assess the knowledge of those nurses that attended an HIV/AIDS course and those that did not. This indicates that the distribution of knowledge is the same for all categories of nurses. This concurs with a study by Corbett, Makamure, Cheung, Dauya, Matambo, Bandason, et al. (2007:483); which reported that workplace voluntary counselling and testing had no effect on HIV incidence among a large sample of employees of 22 companies in Harare, Zimbabwe.

There was also no significant difference in the attitude of nurses and the level of education. Based on the findings of the study, the attitude of nurses is not affected by the level of nurse's education. The findings also indicate that the knowledge of nurses is not affected by their years of experience.

5.5. Conclusion

The findings indicate that the nurse's knowledge and attitude lean more to the neutral. There were no correlations between nurses that attended the HIV course and those that did not. The distribution of knowledge was the same across all categories of experience. The distribution of knowledge was the same across categories of highest education level. The attitudes of staff were not affected by their level of education. The majority of the nurses who participated in this study are knowledgeable about their HIV status which is the most important goal of the HCT program for employees (DOH, 2009:2).

5.6. Recommendations

5.6.1. Recommendations for practice

In light of the findings of the research as presented above, the researcher recommends various approaches to improve the implementation of the HCT services for employees at the selected public hospital.

One of the objectives of the study was to evaluate the resources at the HCT clinic for employees and the activities of the HCT program. The most important issue that needs to be addressed is the lack of resources at the HCT clinic for employees. For the HCT program to be successfully implemented, resources and supplies must be available at the HCT clinic should an employee wish to use its services. The findings of the research indicate that there is a lack of resources at the clinic such as books, pamphlets, reading material and condoms. It has been noted that there was only one HIV test kit at the time of evaluation. 80.3% (n=106) participants indicated that treatment was not provided at the clinic. The researcher recommends that treatment be provided at the clinic, this would be economical as it would save the employee time in having to take time off work to receive treatment. It would also enhance human resources as staff will not have to be absent in order to receive their treatment as reported by Hall (2004:2) that HIV/AIDS will eventually lead to increased absenteeism. Receiving their treatment at the hospital will also benefit staff in that they can develop a supportive relationship with the occupational health nurse. It will also enable to selected Public Hospital and Public Service as a whole to attract and retain adequate levels of skilled employees (DPSA, 2002:16).

5.6.2. Recommendations for education

The findings of the research indicates that 31.5% (n=39) participants did not attend an HIV/AIDS course. However, 95.5% (n=126) participants reported that they are interested in attending an HIV/AIDS should it be offered at the institution.

It is recommended that HIV/AIDS courses be offered to those nurses that are interested in it as it can benefit nurses and may increase their knowledge, attitudes and practise towards the HCT

program for employees. The HIV/AIDS courses can also be included in the curriculum of nurses attending the college. In addition, in - service education/training should be given to employees regarding the HCT program, its resources and activities.

5.6.3. Recommendations for research

This study focused on a process evaluation of the implementation of the HIV/AIDS counselling and testing program for employees at a selected public hospital. The Health Counselling and Testing program is a new program that was implemented in 2010 and a systematic search for other evaluation studies on DOH programs yielded no results. Therefore, the results of this study can be used as a foundation for further research regarding the use of the HCT clinic where they are employed. The same study can also be conducted in other institutions.

5.6.4. Recommendations for management

The findings of the study revealed that there was a lack of resources at the HCT clinic for employees. Resources that were lacking included the fact that only one HIV test kit was kept at the HCT clinic for employees. Directions to the clinic were not clear and condoms, books, pamphlet and reading material were not available at the clinic. Due to a lack of supplies and resources, health care workers may not use the clinic. The researcher therefore recommends that funds be made available and budgeted for to increase the supplies of HIV test kits and provide condoms, books, pamphlets and reading material at the clinic.

The study also indicated that more than 80% of respondents reported that treatment was not provided at the clinic. The researcher recommends that anti-retro viral treatment (ART) be made available to employees at the HCT clinic.

5.7. Limitations of the Study

Generalizability: according to Polit & Beck (2004:40), generalizability is a criterion used in quantitative studies to determine the extent to which findings can be applied to other settings or groups. This study was only conducted in one public health care setting and only 140 nurses were surveyed therefore the findings cannot be generalized to other hospitals.

Hawthorne Effect: The researcher is a lecturer at the nursing college which is attached to the hospital. The participants may have provided answers that they thought might be favourable to the researcher and not what actually happened in practice.

There were also contradictory responses from the participants regarding the directions to the clinic. The checklist of the venue that was done by the chairperson of the HCT committee and the Occupational Health Nurse indicated that directions to the HCT clinic such as posters were not available. However, in the questionnaire administered to the nurses that work at the selected Public hospital, participants reported that directions to the HCT clinic were clear. This could either be the result of the Hawthorne effect (Brink, 2001:107) or it could be innate knowledge of the participants because they have been working at the institution.

The study consisted of a sample of 140 participants. There were 132 participants that responded to the questionnaire three (3) that was administered to the nurses that are employed at the selected public hospital to evaluate their knowledge, attitude and practise towards the HCT program. There were eight (8) participants who responded to questionnaire two (2) which was administered to staff that work at the HCT clinic and HIV/AIDS counsellors to evaluate the implementation of the HCT activities. However, the participants did not answer all the questions, hence the difference in the sample sizes.

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ANNEXURE 1: Research tools

Instructions to Participants

A PROCESS EVALUATION OF THE IMPLEMENTATION OF A HEALTH COUNSELLING AND TESTING (HCT) PROGRAM FOR EMPLOYEES AT A SELECTED PUBLIC SECTOR HOSPITAL IN KWAZULU - NATAL

Number of Respondent:

Date:

INSTRUCTIONS TO PARTICIPANTS

- 1) The aim of this study is to do a process evaluation of the implementation of the HCT program for employees at a selected public hospital in KZN.
- 2) You are requested to participate in this study which is voluntary.
- 3) Please answer all the questions as honestly as possible.
- 4) Please follow the instructions at the beginning of each set of question and do not consult or discuss the answers with anyone else.
- 5) The questionnaire must be returned after completing it by the end of the session to the researcher or research assistant by posting it into the box on the table.
- 6) Do not write your name on the questionnaire as this study is anonymous.
- 7) Please be reassured that all information collected will be strictly confidential.
- 8) Please be informed that this is not a test, trick or examination and your position or job will not be jeopardised in any way for the answers provided in the study.
- 9) I would also like to thank you for your sincerity, time and patience in participating in this study.

**PROCESS EVALUATION OF THE IMPLEMENTATION OF A HEALTH COUNSELLING AND TESTING
(HCT) PROGRAM FOR EMPLOYEES AT A SELECTED PUBLIC SECTOR HOSPITAL IN KWAZULU -
NATAL**

INSTRUMENT 1: Checklist for the venue

The checklist was completed by the researcher and one other person to maximize the trustworthiness of the findings.

	Yes	No		
10) HCT program displayed				
11) Are HIV test kits kept in stock?			How many?	
12) Are chairs available for counselling and testing?			How many?	
13) Is privacy maintained?				
14) Are there directions such as posters to clinic?				
15) Is there stock of condoms at the clinic?			How many?	
16) Are there pamphlets/ reading material available for the clients?				
17) Are there sharps containers available?			How many?	
18) Are there gloves in stock?				

INSTRUMENT 2: QUESTIONNAIRE: To Be Administered To Staff That Work at the HCT Clinic to Evaluate the Activities of the HCT Program

Section 1: Biographical data

Tick one of the following options:

1.1.Designation	1.1.1.Registered nurse	1.1.2.Enrolled Nurse	1.1.3.Enrolled nursing Auxiliary	1.1.4.Lay Counsellor
-----------------	------------------------	----------------------	----------------------------------	----------------------

1.2. Gender	1.2.1. Male	1.2.2. Female
-------------	-------------	---------------

1.3. Actual Age	
-----------------	--

1.4.Highest level of education	1.4.1.Doctoral Degree	1.4.2.Master's degree	1.4.3.Bachelor's Degree	1.4.4.Diploma	1.4.5. Certificate
--------------------------------	-----------------------	-----------------------	-------------------------	---------------	--------------------

1.4.6. Please specify qualifications if you have any other training _____

1.5. Did you attend a course on HIV/AIDS?	1.5.1. In the last 2 years	1.5.2. In the last 5 years	1.5.3. More than 5 years ago.
---	----------------------------	----------------------------	-------------------------------

1.6. How many years of nursing experience do you have?
--

1.7. How often do you care for patients with HIV/AIDS?	1.7.1. Often (more than once a week)	1.7.2. Rarely (\leq once a month)	1.7.3. Sometimes (more than once a month)	1.7.4. Don't know
--	--------------------------------------	--------------------------------------	---	-------------------

1.8. Are you interested in attending an HIV/AIDS workshop at your workplace?	1.8.1. Yes	1.8.2. No
--	------------	-----------

1.9. I am aware that the hospital has an HCT program.	1.9.1. Yes	19.2. No
---	------------	----------

INSTRUMENT 2: Questionnaire to Be Administered To Staff That Work at the HCT Clinic to Evaluate the Activities of the HCT Program

Section 2:

Answer the following open ended questions:

Open ended questions	Answer
1. Have you been trained in HCT?	
2. How many clients do you counsel per day?	
3. To which departments/ facilities do you refer clients for support services?	

Choose one of the following responses:

	4.1.Doctor	4.2.Sister	4.3.Staff Nurse	4.4.Enrolled nurse
4.I am supervised by				

	Always	Sometimes	Never
5. I am provided with adequate space to maintain privacy and confidentiality			
6. I refer clients			
7.The following protective devices are supplied:			
7.1. Gloves			
7.2. Sharps containers			
8. Consent is obtained			

INSTRUMENT 3: Evaluating the Knowledge, Attitude and Practice of Nurses Regarding the HCT Program For Staff at the Selected Hospital in KZN

Section 1: Biographical data

Tick one of the following options:

1.1.Designation	1.1.1.Registered nurse	1.1.2.Enrolled Nurse	1.1.3.Enrolled nursing Auxiliary	1.1.4.Lay Counsellor
1.2. Gender		1.2.1. Male	1.2.2. Female	

1.3. Actual Age	
-----------------	--

1.4. Highest level of education	1.4.1.Doctoral Degree	1.4.2.Master's degree	1.4.3.Bachelor's Degree	1.4.4.Diploma	1.4.5. Certificate
---------------------------------	-----------------------	-----------------------	-------------------------	---------------	--------------------

1.4.6. Please specify qualifications if you have any other training _____

1.5. Did you attend a course on HIV/AIDS?	1.5.1. In the last 2 years	1.5.2. In the last 5 years	1.5.3. More than 5 years ago.
---	----------------------------	----------------------------	-------------------------------

1.6. How many years of nursing experience do you have?
--

1.7. How often do you care for patients with HIV/AIDS?	1.7.1. Often (more than once a week)	1.7.2. Rarely (≤ once a month)	1.7.3. Sometimes (more than once a month)	1.7.4. Don't know
--	--------------------------------------	--------------------------------	---	-------------------

1.8. Are you interested in attending an HIV/AIDS workshop at your workplace?	1.8.1. Yes	1.8.2. No
1.9. I am aware that the hospital has an HCT program.	1.9.1. Yes	1.9.2. No

INSTRUMENT 3: QUESTIONNAIRE TO BE ADMINISTERED TO NURSES EMPLOYED AT THE HOSPITAL: Evaluating the Knowledge, Attitude and Practice of Nurses Regarding the HCT Program.

Section 2:

Please choose one of the following options: Yes, No, Unsure.

KNOWLEDGE QUESTIONNAIRE: Please indicate whether you are aware of the following:

1.1.	YES	NO	UNSURE
1) The hospital has a staff HCT clinic.			
2) Is pre and post-test counselling provided at the HCT clinic?			
3) Information about HIV Prevention, Infection and transmission are provided at the HCT clinic.			
4) If you test “negative” you are not encouraged to retest in 3 months’ time due to the window			
5) A client cannot refuse to go for the test after the counselling			
6) It is done in a private session where strict confidentiality is assured			
7) Condoms can be accessed at the toilets.			
8) Books, pamphlets and reading material are available at the HCT clinic.			
9) Directions to the HCT clinic are clear.			

1.2. Please indicate which of the following services are offered as part of the HCT program.

1.2.1. Testing	1.2.2. Referral	1.2.3. Treatment

1.3. Are condom promotion activities implemented	1.3.1. Weekly	1.3.2. Monthly	sometimes

INSTRUMENT 3: QUESTIONNAIRE TO BE ADMINISTERED TO NURSES EMPLOYED AT THE HOSPITAL

Evaluating the Attitude of Nurses Regarding the HCT Program for Staff at the Selected Hospital

On a scale of 1 to 5 please tick whether you:

1. Strongly disagree (SD), 2. Disagree (D), 3. Neutral (N)
4. Agreed (A), 5. Strongly Agreed (SA)

Questions	SD	D	N	A	SA
1. Friends would treat me differently if I were tested for HIV					
2. I would be embarrassed if my friends found out I had decided to have an HIV test					
3. I am afraid that if I go for HIV test the staff will discriminate against me if they found out that I am HIV positive					
4. Many people do not want to know their HIV status because if they do they will always think about it and it will depress them					
5. There is no use to go for a test because if you test positive there is no cure					
6. My partner will think I am cheating if I decide to go for an HIV test					
7. It is not necessary to go for an HIV test if you know that you are being faithful to your partner					
8. My family would support me if I decided to be tested for HIV					
9. I am afraid that the person I know might test me for HIV and that person may tell others					
10. HIV antibody testing information is kept very confidential by the medical staff who do the testing					
11. I trust the HIV counsellors and nurses to keep my information confidential					

**INSTRUMENT 3: QUESTIONNAIRE TO BE ADMINISTERED TO NURSES EMPLOYED
AT THE HOSPITAL**

**Evaluating the Practise of Nurses Regarding the HCT Program for Staff at the
Selected Hospital**

Question	Question	Code
12.	I have had an HIV test?	1=Yes 2= No
13.	IF NO, Why not?	1=Never thought about it 2=Don't think I am at risk 3=Fear of stigma/consequences of a positive 4=Don't know where to get it 5=I don't think there is any advantage to getting 6=I am afraid to know 7=Do not like needles 8=Do not trust results are confidential 9=Other
14.	IF YES, Did you voluntarily undergo the HIV test, or Were you required to have the test?	1=Voluntary counselling and testing 2=Tested because a doctor/nurse suggested 3=Insurance related testing 4=Employer related testing 5=Antenatal testing 6=Testing after needle stick injury 7=Other
15.	IF YES, Did you find out the results of your test?	1=Yes 2= No
16.	IF YES, When did you have your most recent HIV test?	1=Within the Past Year 2=Between 1 & 2 Years 3= Between 2 & 4 Years

ANNEXURE 2: Ethical clearance from UKZN



UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

Research Office (Govan Mbeki Centre)
Westville Campus
Tel. No. 031 260 3587
Email: Ximbap@ukzn.ac.za

27 October 2011

Mrs S Moodley (210527921)
School of Nursing

Dear Mrs Moodley

PROTOCOL REFERENCE NUMBER: HSS/1094/011M
PROJECT TITLE: Process evaluation of the implementation of the HIV/AIDS counseling and testing (HCT) program for employees at a selected public hospital in KwaZulu-Natal (KZN)

PROVISIONAL APPROVAL – EXPEDITED

This letter serves to notify you that your application in connection with the above has been reviewed and granted provisional approval through an expedited review process. Your research protocol has been approved subject to gatekeeper permission being obtained from:

1. Department of Health.
2. Chief executive /Nursing services manager.

This approval is granted provisionally and the final approval for this project will be given once the above condition has been met. Please quote the above reference number for all queries/correspondence relating to this study.

Kindly submit your response to the Chair: Prof. S Collings c/o Ms. P Ximba, Research Office as soon as possible

Yours faithfully

.....
Professor Steven Collings (Chair)
Humanities & Social Sciences Research Ethics Committee

cc Supervisor Jane Kerr
cc Mr S Reddy

Annexure 3: Ethical approval from Department of Health



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM152/11
Enquiries : Mrs G Khumalo
Telephone : 033 – 3953189

04 November 2011

Dear Mrs S Moodley

Subject: Approval of a Research Proposal

1. The research proposal titled '**A process of evaluation of the implementation of a Health Counseling and Testing (HCT) program for employees at a selected public hospital at KwaZulu-Natal**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at St Aiden's Hospital.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely



Dr E Lutge

Chairperson, Health Research Committee

KwaZulu-Natal Department of Health

Date: 01/11/2011

uMnyango Wezempilo. Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE 4: Letter of approval by the Hospital Ethics committee



St. Aidan's Mission Regional Hospital
P.O.Box 547 DURBAN
4000
Tel: 031-3142256 Fax: 031-3093222

01 November 2011

Mrs S. Moodley
216 Avoca Road
Avoca
4051

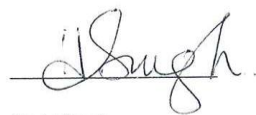
Re: Gatekeeper's Permission to conduct Research at St Aidan's Mission Hospital

Dear Mrs. S. Moodley

Please be informed that permission has been granted to conduct research at St. Aidan's Mission Hospital.

We wish you all the best with your research.

Kind regards



Dr. U Singh

Chairperson of the Ethics Committee

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE 5: LETTER TO THE HOSPITAL CEO

University of Kwa-Zulu Natal
Faculty: Health Sciences
School of Nursing
Durban: Howard College
4000

The Hospital CEO

Dr Badal R

EThekweni Health District

Durban

4000

16/09/2011

Dear Mam

Re: Application for permission to conduct a research study

I, Mrs. S. Moodley, would like to apply for permission to conduct a research study at your institution. I am registered for the Master's Degree in health Science Administration at the University of Kwa-Zulu Natal.

The topic of the research is:

Process evaluation of the implementation of the HIV/AIDS counselling and testing (HCT) program for employees at a selected public hospital in Kwa-Zulu natal (KZN).

Please find attached the following:

- A copy of the research proposal (including information and consent sheet and the questionnaire.
- A copy of the ethical letter from the UKZN ethics committee.

Your kind consideration of the application will be highly appreciated.

Kind regards

Mrs. S. Moodley

Please feel free to contact me if you should have any questions or uncertainties.

Contact details: 0847001540

ANNEXURE 6: LETTER TO THE NURSING SERVICE MANAGER

University of Kwa-Zulu Natal
Faculty: Health Sciences
School of Nursing
Durban: Howard College
4000

The Nursing Service Manager

Mrs. S. D. Pillay

EThekweni Health District

Durban

4000

16/09/2011

Dear Mam

Re: Application for permission to conduct a research study

I, Mrs. S. Moodley, would like to apply for permission to conduct a research study at your institution. I am registered for the Master's Degree in health Science Administration at the University of Kwa-Zulu Natal.

The topic of the research is:

Process evaluation of the implementation of the HIV/AIDS counselling and testing (HCT) program for employees at a selected public hospital in Kwa-Zulu natal (KZN).

Please find attached the following:

- A copy of the research proposal (including information and consent sheet and the questionnaire).
- A copy of the ethical letter from the UKZN ethics committee.

Your kind consideration of the application will be highly appreciated.

Kind regards

Mrs. S. Moodley

Please feel free to contact me if you should have any questions or uncertainties.

Contact details: 0847001540

ANNEXURE 7: LETTER TO THE PROVINCIAL DOH

University of Kwa-Zulu Natal
Faculty: Health Sciences
School of Nursing
Durban: Howard College
4000

Provincial Department of Health
EThekweni Health District
Durban
4000
16/09/2011

Dear Mam/Sir

Re: Application for permission to conduct a research study

I, Mrs. S. Moodley, would like to apply for permission to conduct a research study at your institution. I am registered for the Master's Degree in health Science Administration at the University of Kwa-Zulu Natal.

The topic of the research is:

Process evaluation of the implementation of the HIV/AIDS counselling and testing (HCT) program for employees at a selected public hospital in Kwa-Zulu natal (KZN).

Please find attached the following:

- A copy of the research proposal (including information and consent sheet and the questionnaire).

- A copy of the ethical letter from the UKZN ethics committee.

Your kind consideration of the application will be highly appreciated.

Kind regards

Mrs. S. Moodley

Please feel free to contact me if you should have any questions or uncertainties.

Contact details: 0847001540

ANNEXURE 8: LETTER OF INVITATION AND INFORMED CONSENT

A PROCESS EVALUATION OF THE IMPLEMENTATION OF A HEALTH COUNSELLING AND TESTING (HCT) PROGRAM FOR EMPLOYEES AT A SELECTED PUBLIC SECTOR HOSPITAL IN KWAZULU - NATAL

You are invited to participate in a research study conducted by Mrs. Selvarani Moodley, a Masters student in Health Sciences at the University Of Kwa-Zulu Natal School Of Nursing.

PURPOSE OF THE STUDY

The purpose of this study is to conduct a process evaluation of the implementation of the HCT program for employees at a selected public hospital to determine the extent to which the HCT programs activities for employees are meeting its objectives. The researcher will also evaluate the knowledge, attitude and practise of employees towards the HCT program for employees.

The study has 3 objectives:

1. To evaluate the availability of the resources in the employee HCT clinic.
2. To evaluate the implementation of the HCT activities for employees at a selected hospital in KZN.
3. To evaluate the Nursing staff Knowledge, Attitude and Practice towards the employee HCT program

PROCEDURES

Please follow the instructions at the beginning of each set of question and do not consult or discuss the answers with anyone else. The questionnaire must be returned and please do not write any name on the form. Please be reassured that all information collected will be strictly confidential. Please be informed that this is not a test, trick or examination and your position or job will not be jeopardized in any way for the answers provided in the study. The success of this study depends entirely on you so please try and answer the questions as honest as possible as there are no right or wrong answers. I would also like to thank you for your sincerity, time and patience in participating in this study.

POTENTIAL RISKS AND BENEFITS

The researcher has neither seen nor foreseen any risks for the duration of the study.

POTENTIAL BENEFITS TO THE SUBJECTS OR TO SOCIETY

The benefits of the study are classified into 3 main areas:

1. Research area: this study will provide a basis for further researcher in the area.
2. Practise area: the study will assist managers in the department of health to recognize and take into account strengths and weaknesses of the program.
3. Education area: it can serve as a source of reference for program coordinators, policy makers and in-service education and training departments regarding evaluation of the HCT program for employees which could be used as a point of reference for further education and training.

The research study and findings would benefit the institution at large as well the affected employees and the community to enable to stay healthy and productive for as long as possible.

PAYMENTS OF PARTICIPATION

For this study, there will be no reimbursement for participation.

CONFIDENTIALITY

All information collected for the study was strictly confidential. Names did not appear on the documents. Names were coded and only the researcher and the supervisor will have access to the codes and names to ensure confidentiality. Information will only be disclosed with your permission. Information was protected on the computer by used of a personal password that only the researcher will know. All other primary information collected was stored in a locked cupboard in the school of nursing University of Kwa-Zulu Natal where only the researcher and the supervisor will have access to. The findings of this study will be published by the university and made available to the hospital for obvious reasons but this will only be done with your written permission.

PARTICIPATION AND WITHDRAWAL

Participation in this study is voluntary and you choose whether or not to participate. If you choose to participate in this study, you can withdraw at any time without any penalty. It is important to answer all questions as honestly as possible but you may refuse to answer any questions you are uncomfortable with and still remain in the study.

IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please do not hesitate to contact any of the following people:

The researcher, Mrs. S Moodley (cell: 0847001540 or email Desiganmdl@gmail.com) or the supervisor Mrs. Jane Kerr (kerrj@ukzn.ac.za, cell: 0836269423, Home: (031) 2601432) or the

Research Faculty Officer: Humanities, Sugan Reddy,

RIGHTS OF THE RESEARCH SUBJECTS

Please note that participation is voluntary and you can withdraw at any time without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The above information and the nature of the research were described to me (the participant) by the researcher Mrs. S. Moodley in English which I understand. I (the participant) was given the opportunity to ask questions which were answered to my satisfaction.

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

Name of participant

Signature of participant

SIGNATURE OF THE RESEARCHER

I, Mrs. S. Moodley hereby declare that I have explained the above mentioned information to the participant, _____. He/she was given adequate time to ask questions and clarify any misconceptions. The conversation was conducted in the medium of English and no translation was used/ translated to Zulu by _____.

Signature of researcher: _____

Date: _____