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**FACTORS INFLUENCING HEALTHCARE WORKER'S RELUCTANCE
TO UTILIZATION OF HIV AND AIDS SERVICES WITHIN THEIR
WORKPLACE: A CASE OF DONALD FRASER HOSPITAL**

BY

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**A Mini - Dissertation submitted in partial fulfilment of the requirements for
the Degree of**

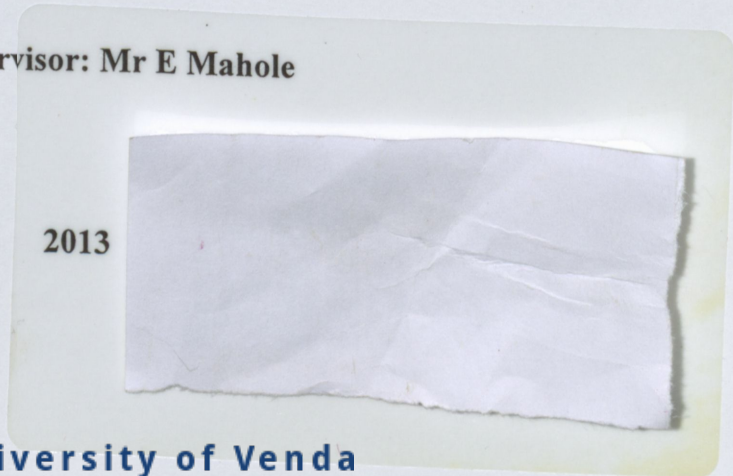
**MASTER OF PUBLIC MANAGEMENT
SCHOOL OF MANAGEMENT SCIENCES**

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2013



DECLARATION

I, **MUSHAISANO EUNICE RAMATHIKHITHI**, hereby declare that the mini dissertation for the degree of Masters of Public Management at University of Venda, hereby submitted by me, has not been submitted previously for a degree at this University, or any other University, that it is my own work in design and execution, and that all reference materials contained therein has been duly acknowledged.

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28-07-2014

Date

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- The Limpopo department of Health for granting me the permission to conduct research
- Donald Fraser Hospital management for granting me the permission to conduct research
- Mr Matodzi Mabuge who taught me how to master the computer skills

DEDICATION

I would like to dedicate this project to my God who gave me the courage to go on even through difficult times, my parents Mr George Mudau and Mrs Jane Mudau especially my mother Mrs Jane Mudau who used to encourage me to study, and my late beloved husband Mr Mboneni Richard Ramathikhithi.

The researcher used a mixed research methodology both qualitative and quantitative research methodology. A qualitative design ensures a close interaction between the researcher and the respondent and a quantitative design to be able to quantify the number of occurrences in each theme or category so that the theme with highest frequency can be regarded as significant to the problem under investigation. The researcher used a descriptive study design to obtain complete accurate information about the phenomenon under study. The sampling method used in the study is the non-probability purposive sampling method. Data collection was done using both interviews and questionnaires. Interviews due to the fact that open ended questions allow participants to answer questions freely, provide new ideas and enriches data and questionnaires are economical, have standardized questions and ensures anonymity. Data analysis for questionnaires used Statistical Package of Social Science Programme (SPSS). Data analysis for interviews was done through thematic analysis. Ethical consideration was considered and an ethical clearance certificate was obtained from the University.

The Major findings of the study are:

Major findings on the factors influencing healthcare worker's reluctance to utilization of HIV and AIDS services by healthcare workers in their workplace.

- The findings of this study clearly indicate that HIV and AIDS counseling is provided for healthcare workers as indicated in the responses but even though the healthcare workers are provided with HIV counseling they do not utilize the service provided for them.
- Finally fear, stigma, and concern about the risk of getting infected were identified as major findings.

ABSTRACT

The study is about describing the factors influencing healthcare worker's reluctance to utilization of HIV and AIDS services within their workplace: A case of Donald Fraser Hospital. The study population is the health care workers at Donald Fraser Hospital consisting of doctors, assistant managers, operational managers, professional nurses, enrolled nurses, and enrolled nursing assistants.

The researcher used a mixed research methodology both qualitative and quantitative research methodology. A qualitative design ensures a close interaction between the researcher and the respondent and a quantitative design to be able to quantify the number of occurrences in each theme or category so that the theme with highest frequency can be regarded as significant to the problem under investigation. The researcher used a descriptive study design to obtain complete accurate information about the phenomenon under study. The sampling method used in the study is the non-probability purposive sampling method. Data collection was done using both interviews and questionnaires, Interviews due to the fact that open ended questions allow participants to answer questions freely provide new ideas and enriches data and questionnaires are economical, have standardized questions and ensures anonymity. Data analysis for questionnaires used Statistical Package of Social Science Programme (SPSSP), Data analysis for interviews was done through thematic analysis. Ethical consideration was considered and an ethical clearance certificate was obtained from the University.

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- The study found out that the respondent revealed that the use of Antiretroviral treatment reduce the untimely deaths by HIV infected patients, Most striking is the fact that some healthcare workers do report needle pricks when also a small number of respondent do not report needle pricks this is also a course for concern that we still find healthcare workers who do not report needle prick injuries so that proper steps can be taken to prevent exposure to infections.

The recommendations of the study were;

Recommendations on factors influencing healthcare worker's reluctance to utilization of HIV and AIDS services by healthcare workers in their workplace:

- The institution should enforce confidentiality in hospitals though a certain percentage indicated that there is confidentiality we still have those who deny that there is confidentiality, The HIV education should integrate a change from fear to caring for people living with HIV.
- Healthcare workers should be given regular workshops indicating also incidences where needle prick injuries had led to healthcare workers having infected and emphasize the importance of reporting needle prick injuries.
- The needle stick policy should be communicated to employees and employees are to be shown the benefit of reporting needle prick injuries. Encourage and monitor infection control practices such as the use of protective equipment and clothing.
- Introduction of mobile phone messaging applications such as short message services (SMS) and the use of multimedia messages (MMS) may be an effective way of reminding healthcare workers on medications or providing them with support messages and the use of voice messages to improve adherence to treatment and reduce risky behaviors.
- Healthcare worker support group should be formed where infected healthcare worker can have an avenue for discussion, reflections and empower each other, this will assist healthcare workers realize that they belong.

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INTRODUCTION AND BACKGROUND OF THE STUDY

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BACKGROUND OF THE STUDY

The country's healthcare workers are charged with meeting the needs of clients and patients, including HIV positive patients, yet very few programmes address the needs of HIV positive healthcare workers including how they cope with the epidemic in their private and personal lives (Kiragu, et al, 2008:3). There has been little research on whether HIV infected healthcare workers are utilising the HIV/AIDS services within their workplaces. The researcher has observed that those who disclosed their status will only co-operate with us successfully when the researcher was still working as an occupational health nurse and were reluctant to fetch the treatment at the antiretroviral treatment site where the rest of the people are taking treatment. Three colleagues who were HIV infected refused to access treatment and two ended up dying despite efforts done to research and encourage them to take anti retroviral viral treatment (ARV's).

One of the nurses who disclosed to the researcher refused to start treatment and also indicated that she would never go there to take antiretroviral treatment (ARV's). Those who disclosed their statuses would hide when coming to consult and they would come with a cardboard box to put in treatment and some would even beg

CHAPTER 1: INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 INTRODUCTION

The study focuses on the factors influencing healthcare worker's reluctance to utilization of HIV and AIDS services within their workplace. A functioning and effective health care system is critical if the health of healthcare workers are to be maintained and their productivity maximized (Kiragu, Nyumbu, Ngulube, Mjovu, Mwaba, Kalimbe, and Bradford 2008:3). In addition, nurses and care-givers are also living with Human Immuno Virus (HIV). As one nurse commented that they continue to hear stories of people with Acquired Immune Deficiency Syndrome (AIDS) being shunned and isolated, forced out of their jobs or homes, refused medical treatment, stripped of their human rights, and all that for a disease that does not even spread through casual contact; that people already suffering should be subjected to such indignity is intolerable and even more so when it occurs in health care institutions by healthcare professionals who should know better (UNAIDS, 2006:1).

This chapter highlights the background of the study, problem statement, aim of the study, objectives of the study, research questions, significance of the study, delimitations of the study, limitations of the study, definitions of operational concepts, and the organisation of the study.

1.2 BACKGROUND OF THE STUDY

The country's healthcare workers are charged with meeting the needs of clients and patients, including HIV positive patients, yet very few programmes address the needs of HIV positive healthcare workers including how they cope with the epidemic in their private and personal lives (Kiragu, et al, 2008:3). There has been little research on whether HIV infected healthcare workers are utilising the HIV/AIDS services within their workplace. The researcher has observed that those who disclosed their status will only co-operate with the researcher when the researcher was still working as an occupational health nurse and were reluctant to fetch the treatment at the antiretroviral treatment site where the rest of the people are taking treatment. Three colleagues who were HIV infected refused to access treatment and two ended up dying despite efforts done to counsel and encourage them to take anti retroviral viral treatment (ARV's).

One of the nurses who disclosed to the researcher refused to start treatment and also indicated that she would rather die than to take antiretroviral treatment (ARV's). Those who disclosed their statuses would hide when coming to consult and they would come with a card board box to put in treatment and some would even beg

one to go fetch treatment for them. When asked why they indicated that they would not want to be seen by patients whom they nurse. The two nurses always wanted informal ways to collect treatment. Some health care workers are known in the health care setting and it may be hard for them to seek treatment due to issues of stigma and lack of confidentiality. Doctors and nurses may have an even greater handicap in seeking help because they are often the ones who treat and care for patients. It may be even more difficult for them to admit when they need support themselves (Kiragu, et al, 2008:5). However data from different countries within the region show that health care workers face a number of challenges in accessing HIV and AIDS related services (Bongololo, Chilipaine – Banda and Makwiza-Namakhoma, 2008:16).

The challenges that health care workers face when nursing Human Immune Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) patients, and those that they face if they are HIV and AIDS positive or observe others suffer, lead to health care workers refraining to seeking out information, they discourage HIV testing and lead to delay in getting treatment especially within the workplace with the resultant complications and death in some. Very few or none do come for HIV Counseling and Testing or Anti-Retroviral drug clinics within their workplace. Therefore, the researcher would like to describe the factors influencing healthcare worker's reluctance to utilization of HIV and AIDS services within their workplace.

1.2.1 Global overview of H.IV and AIDS in 2011

Below is the table indicating the global overview of HIV and AIDS in 2011

Table 1.1 Global overview of HIV and AIDS in 2011

| | |
|-----------------------------------|--------------|
| People who know their HIV status | 34 million |
| People eligible for HIV treatment | 14.8 million |
| New HIV infections | 2,5 million |
| People on HIV treatment | 8 million |
| Number of AIDS related deaths | 1, 7 million |

Source (UNAIDS 2012:8)

1.2.2 Regional overview of HIV and AIDS (UNAIDS, 2012, Global Report).

Table 1.2: Regional overview of HIV and AIDS in 2011

| | |
|------------------------------|--------------|
| Sub-Saharan Africa | 23,5 million |
| Asia | 4,8 million |
| Latin America | 1,4 million |
| Middle East and North Africa | 300, 000 |
| South Africa | 5,6 million |
| Nigeria | 3 million |
| Mozambique | 1,4 million |
| Tanzania | 1,6 million |
| Zimbabwe | 1,2 million |
| Zambia | 970,000 |
| Uganda | 1,4 million |

Source: (UNAIDS,2012:14)

South Africa with the highest HIV infections in the African Countries reduced new infections by 41%. The latest data gathered around the world indicates that number of lives have been saved in the past six years. In 2011, more than half a million people died from AIDS related illnesses than six years earlier (UNAIDS, 2012, Global Report:12).

1.2.3 Deaths due to HIV and AIDS

In South Africa, 100,000 deaths occurred followed by nearly 90,000 in Zimbabwe and 71,000 in Kenya. South Africa scaled up its treatment services to reach 1,7 million people, an increase of 75% in the last two years (UNAIDS, 2012, Global Report). Healthcare workers are part of the South African community which is a scarce resource and they are also infected and affected by the disease and some are also dying due to Human Immune Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) related conditions which is worrisome because they are saving peoples lives when they themselves are not accessing the care treatment and support services.

1.3 PROBLEM STATEMENT

The government of South Africa has put in place policies, guidelines and strategies to deal with the scourge of HIV and AIDS in workplaces, The National Strategic Plan for HIV,STI and TB 2012-2016 aims to: Reduce new HIV infections by atleast 50% using combination prevention approaches, initiating atleast 80% of all

eligible patients on Anti Retroviral Treatment (ART) with 70% alive and on treatment five years after initiation and reducing self reported stigma related to HIV and TB by atleast 50%. The HIV and AIDS, Sexually transmitted diseases in the workplace policy guideline 2000 stipulates that employees and prospective employees with HIV and AIDS shall have the same rights and obligations as all other employees or prospective employees and they shall be treated in a just, humane and life affirming manner and also states that employees has a right to confidentiality with regards to their Human Immune Virus (HIV) status. On the 25th April 2010 the South African government launched an Human Immune Virus counselling and testing (HCT) campaign which emphasizes that HIV counselling should also be provider initiated so as to increase access to treatment care, and support and to increase health seeking behaviour (Nursing magazine 2010:8).

Despite all the efforts that the government is putting to assist people with HIV and AIDS proportion of people testing for HIV remains very low amongst health care workers (DENOSA 2006: 42). Recent data show that some HIV positive health care workers tend to leave HIV services at their workplace to access treatment from far away sites while some just prefer not to access treatment at all for fear of stigma they succumb to stigma and thus do not benefit from treatment, care and support programmes (Bongololo et al 2008:16). In South Africa the prevalence of HIV among professional health care workers was found to range from 12% to 19.9% in 2011 and over the coming years the sub-Saharan African health systems may lose up to one fifth of their employees to HIV and AIDS the attrition may have a severe impact on human resource, however, while health workers tend to know where to go to obtain an HIV test reluctance to test has been found in the literature (De Vries, Galvin, Mhlanga, Cindzi, Band Dlamini, 2011:1). In 2011 deaths due to HIV and AIDS in South Africa amounted to 11000 and health care workers are part of the community which is infected and dying, we cannot afford to lose such an important scarce human resource. It is therefore crucial to establish if health care workers are utilising the services or programmes for HIV and AIDS and to identify problems they encounter in order to assist them through putting strategies in place at workplace that will encourage utilization of services and preserve lives.

1.4 AIM OF THE STUDY

The study aims at describing factors influencing healthcare workers reluctance to utilization of HIV and AIDS services within their workplace.

1.5 OBJECTIVES OF THE STUDY

- To identify factors influencing healthcare workers' reluctance to utilization of HIV and AIDS services within their workplace.
- To reduce HIV and AIDS related morbidity and mortality amongst healthcare workers, thus improving the quality of life of healthcare workers.
- To suggest mechanisms to address healthcare workers' challenges related to seeking HIV testing and treatment services within their workplace.

1.6 RESEARCH QUESTIONS

- What are the factors influencing healthcare worker's reluctance to utilization of HIV and AIDS services within their workplace?
- How would HIV and AIDS morbidity and mortality be reduced amongst healthcare workers to improve the quality of life?
- What are the mechanisms to address healthcare worker's challenges related to seeking HIV testing and treatment?

1.7 SIGNIFICANCE OF THE STUDY

The research will contribute to the body of knowledge in that it will identify barriers to utilization of HIV and AIDS services by health care workers and find ways of resolving or addressing those barriers, thus reducing HIV and AIDS-related morbidity and mortality amongst healthcare workers who are a scarce human resource.

1.8 DELIMITATIONS OF THE STUDY

The Study is based on the factors influencing healthcare worker's reluctance to utilization of HIV and AIDS services within their workplace at Donald Fraser Hospital. The study will be conducted on doctors, assistant managers, operational managers, professional nurses, enrolled nurse and enrolled nursing assistance only. Donald Fraser is one of the 8th hospitals in Vhembe district.

1.9 LIMITATIONS OF THE STUDY

The researcher is known by health care workers. There is a possibility that a respondent may be reluctant to talk about issues concerning their sexual life. The study is based on respondents' self declarations. Declarations may be affected by biases when it comes to behaviours in the sphere of individual private life such as sexual behaviour. Respondents' answers may also be affected by a social desirability bias that respondents tend to provide the answers that they think are socially acceptable (Phaswana and Peltzer 2006: 403). The researcher will incur financial costs like transport, typing, stationery and binding as the researcher will be paying from her pocket. HIV is associated with promiscuity and it has stigma attached the sensitivity of the topic itself may be a limitation in that respondents may withhold some of the important information.

1.11 DEFINITIONS OF OPERATIONAL CONCEPTS

The following section will define the operational concepts of the study:

- **Healthcare Worker**

A group of people that includes doctors and others who work in healthcare facilities. A health care worker is someone who works in a hospital or health centre (<http://dictionary.reverso.net/english-cobuild/health%20care%20worker>).

- **Utilization**

To make practical and effective use of the extent to which a given group uses a particular service. For the purpose of the research it would mean the extent to which healthcare workers use HIV and AIDS services in their workplace.

- **Reluctance**

Reluctant feeling or action, unwillingness (Barnhart 1996:1766).

- **HIV/AIDS Services**

HIV and AIDS services would mean the following for the purpose of the research

HIV Counselling and Testing (HCT).

Anti-Retroviral Treatment (ART).

1.12 ORGANISATION OF THE STUDY

The study consists of five chapters which are background of the study, literature review, research methodology and research design, presentation of data analysis and interpretation, findings conclusions and recommendations.

Chapter 1: Introduction and Background

This chapter introduces the topic and gives the background of the study, problem statement, aims of the study, objectives of the study, research questions, significance of the study, delimitations of the study limitations of the study, and definition of operational concepts and organization of the study.

Chapter 2: Literature review

This chapter presents literature study what other researchers have written about the topic, the statistical overview, argument about the topic by the researcher and other researchers and findings of other researchers and the elaboration of the relevant theoretical framework used in the study.

Chapter 3: Research Methodology and Design

This chapter describes the methodology and the research design used and the reason for using the methodology and design, study area, population under study, sampling method used and the reason and sample size, data collection instruments used and the reason, data collection method, ethical considerations

Chapter 4: Data Presentation, Analysis and Interpretation

This chapter presents all the information gathered through interviews and questionnaires and how the collected data is analysed and interpreted by the researcher, the techniques used for analysing data, the steps used for analysing data and how the information is interpreted.

Chapter 5: Synthesis, Findings, Recommendations and Conclusion

This chapter describes findings of the research, facts and figures collected for the research and causes of action suggested by the researcher depending on the findings recommendations made by the researcher and conclusions the researcher has arrived at.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, some of the literature regarding factors influencing healthcare workers reluctance to utilization of HIV and AIDS are discussed. The discussion includes, introduction, legislative framework on matters concerning HIV, factors related to reluctance to utilization of HIV services such as fear, stigma and lack of confidentiality, healthcare worker's utilization of HIV and AIDS services, HIV and AIDS related morbidity and mortality in the Sub Saharan countries, South Africa, and in Limpopo, the impact of HIV and AIDS in the workplace, strategies to overcome challenges in utilizing HIV and AIDS services and the conclusion.

2.2 LEGISLATIVE FRAMEWORK ON MATTERS CONCERNING HIV

The section will discuss legislative framework on matters concerning HIV.

2.2.1 The Constitution of the Republic of South Africa 1996, (Act No 108 of 1996)

The constitution of South Africa gives all employees the right to fair labour practices, the equality clause also states that everyone is entitled to equality and freedom from unfair discrimination, and freedom from unfair discrimination, including HIV status and the stigma surrounding the disease

<http://south.africa.smetoolkit.org/sa/en/content/en/4>

In accordance with Section 14 of the Constitution of South Africa 1996, No. 108 of 1996, all persons with HIV or AIDS have a right to privacy, including privacy concerning their HIV or AIDS status. Accordingly there is no general legal duty on an employee to disclose his or her HIV status to their employer or to other employees.

2.2.2 Employment Equity Act, 1998 (Act No. 55 of 1998)

Section 6(1) of the Employment Equity Act, 1998(Act no55 of 1998) provides that no person may unfairly discriminate against an employee, or an applicant for employment, in any employment policy or practice, on the basis of his or her HIV status. In any legal proceedings in which it is alleged that any employer has discriminated unfairly, the employer must prove that any discrimination or differentiation was fair.

2.2.3 Labor Relations Act, 1995 (Act No. 66 of 1995)

The labor relations Act (LRA) regulates the relationship between employers and employees. It prohibits unfair discrimination and protects employees against arbitrary unclear or unfair dismissals. Clear boundaries have been established that protects employees from being dismissed simply because they are HIV positive and from being discriminated against when it comes to employee benefit promotions, staff training and other related opportunities (<http://south.africa.smetoolkit.org/sa/en/content/en/4>).

In accordance with Section 187(1) (f) of the Labour Relations Act, No. 66 of 1995, an employee with HIV/AIDS may not be dismissed simply because he or she is HIV positive or has AIDS. However where there are valid reasons related to their capacity to continue working and if fair procedures have been followed, their services may be terminated in accordance with Section 188(1)(a)(i).

2.2.4 Occupational Health and Safety Act, 1993 (Act No. 85 of 1993)

employees must ensure that universal precautions are used when responding to an occupational accident. The Occupational Health and Safety Act requires employees to take whatever necessary steps to create safe working environment. In an HIV context this means that equipment needed to protect staff against possible infection and appropriate information in the use of universal precautions is provided <http://south.africa.smetoolkit.org/sa/en/content/en/4>

In terms of Section 8(1) of the Occupational Health and Safety Act, No. 85 of 1993; an employer is obliged to provide, as far as is reasonably practicable, a safe workplace. This may include ensuring that the risk of occupational exposure to HIV is minimized.

2.2.5 Mine Health and Safety Act, 1996 (Act No. 29 of 1996)

Section 2(1) and Section 5(1) of the Mine Health and Safety Act, No. 29 of 1996 provides that an employer is required to create, as far as is reasonably practicable, a safe workplace. This may include ensuring that the risk of occupational exposure to HIV is minimized.

2.2.6 Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993)

The Act provides compensation for employees who are injured in the course and scope of their job it also provides guidelines on appropriate steps to be followed in case of injury on duty or illnesses caused by work. The Act stipulates that an employee who is infected with HIV as a result of an occupational exposure to infected blood or bodily fluids may apply for benefits in terms of Section 22(1) of the Compensation for Occupational Injuries and Diseases Act, No. 130 of 1993.

2.2.7 Basic Conditions of Employment Act, 1997 (Act No. 75 of 1997)

The Act sets out the minimum employment standards to which every employee is entitled this includes amongst others payments, maximum working hours and the minimum number of days of sick leave every employee is entitled to (<http://south.africa.smetoolkit.org/sa/en/content/en/4>)

In accordance with the Basic Conditions of Employment Act, No. 75 of 1997, every employer is obliged to ensure that all employees receive certain basic standards of employment, including a minimum number of day's sick leave [Section 22(2)].

2.2.8 Medical Schemes Act, 1998 (Act No. 131 of 1998)

In accordance with Section 24(2) (e) of the Medical Schemes Act, No 131 of 1998, a registered medical aid scheme may not unfairly discriminate directly or indirectly against its members on the basis of their "state of health". Further in terms of section 67(1) (9) regulations may be drafted stipulating that all schemes must offer a minimum level of benefits to their members.

2.3 FACTORS RELATED TO RELUCTANCE TO UTILISATION OF HIV SERVICES

According to Sadoh, Fawole, Sadoh, Oladimeji and Satiloye (2006: 39), from the moment scientist identified HIV and AIDS, social responses of fear, stigma and discrimination have accompanied the epidemic. Despite the passing of resolution 49/1000 of the UN commission on human rights prohibiting discrimination on the basis of HIV serostatus, these negative responses persist. The field of health has been identified as one of the major areas in social life where persons with HIV and AIDS may suffer discrimination, ignorance and lack of knowledge about HIV transmission, fear, moralistic assumption of guilt and perceived incurability of HIV and AIDS have been reported of being contributory to such responses (Sadoh et al 2006:44,) further says

discriminatory attitude based on serostatus was found to be significantly associated with the profession of respondents. Doctors were less likely to refuse to offer service to HIV and AIDS patients compared to other healthcare workers, moralistic and judgmental attitudes have also been identified as reasons for stigmatization and discrimination against HIV and AIDS. One manager from the same results said the program has softened the blow. HIV is no longer a disease of outside, of only the patients, it is also our disease. So now we understand each other, we care for each other'

2.3.1 Fear

The AIDS epidemic is one of the most destructive health crises of modern times ravaging families and communities throughout the world. By 2005, more than 25 million people had died and an estimated 39 million were living with HIV. An estimated 4 million people were newly infected with HIV in 2005, 95% of them in Sub Saharan Africa have been hardest hit. Business has also been seriously affected by HIV and AIDS; employers are hard-hit by loss of workers and absenteeism (Lori, 2006: 1). Fear of discrimination often prevents people from seeking treatment for AIDS or from admitting their HIV status publicly (Fredrickson and Kananabus, 2006: 5). Lack of confidentiality has been repeatedly mentioned as a particular problem in health care settings. Many people living with HIV and AIDS do not get to choose how, when and to whom to disclose their HIV status. When surveyed recently, 29% of persons living with HIV and AIDS in India, 38% in Indonesia, and over 40% in Thailand said their HIV positive status had been revealed to someone else without their consent (Fredrickson and Kanabus, 2006: 4).

Fear of contracting HIV and AIDS is fuelled by inaccurate information and overwhelming fears of death, fear is often an involuntary reaction towards supportive individuals but one that further drives stigma and discrimination (Gender, 2006:6) It is further stated that even when people know how HIV is transmitted or prevented, fear of casual transmission persists. Often people feel compelled to adopt extraordinary risk - adverse behaviour which can leave sero-positive individuals feeling isolated and blamed. Even highly knowledgeable people have genuine fears and concerns about casual transmission and believe that death is imminent once infected with HIV (Gender, 2006:6).

Being infected with HIV can be a source of personal and professional shame for a healthworker, and may also invoke fear of losing one's job and damaging future career prospects. To access HIV services, healthworkers may have to attend with the people that they serve, which may undermine the relationship of trust and authority that they have with clients, furthermore, being tested and or treated for HIV by a colleague might compromise

confidentiality, and the service provider might be burdened by the knowledge of their colleague's HIV status (Mavedzenge, Baggaley, Ying Ru Lo, Corbett 2011: 8). According to Lawson, Gardez, Calzavara, Husband, Myers and Tharao (2006:31-39) people living with HIV discussed the enormous fear felt on a daily basis related to physical health, income security and social wellbeing. Participants living with HIV spoke in particular about fear regarding the social consequences if or when others find out their diagnosis, specifically fear of being judged and gossiped about and many feared losing the most important relationships in their lives and concealed their HIV status from people in their immediate support system. Some women mentioned being very afraid to disclose to partners, as a consequence of fear, many participants curtail relationships or social interaction in general, fear of being seen and having their status disclosed caused many people to avoid seeking health and support services.

The fear of the impact of a positive HIV result on an individual's mental health presented a major barrier to accessing Voluntary Counseling and Testing (VCT) services, with respondents underlying how serious this issue was with several examples of individuals contemplating or committing suicide after learning about their positive status. As a result of this fear, some reported going for testing, but not returning for their results, while others were in denial that they could be HIV positive, as they did not have any symptoms to suggest that they were unwell (Beattle, Battacharjee, Suresh, Isaac, Ramash, Moses 2012:2). According Obemeyer and Osborn (2007:80) A recurrent finding is that the main reason people do not take HIV tests or return for results are fear. This is, not surprising, since HIV is life threatening. But fear is also about the social consequences of illness – rejection by loved ones, loss of job or housing, discrimination and violence. In addition, where it is a terminal illness HIV represents a breakdown in the ties of reciprocity that link individuals, because its not worth “investing” in a relationship with someone who will not be around for long, this may lead, to ostracism and Isolation. According to de Vries, Galvin, Mhlanga, Cindzi and Dlamini (2011:2) healthcare workers fear that if they disclose their HIV positive status or if they have to queue alongside their patients for treatment, patients will lose confidence in them as they will be perceived as sinful and unable to follow their own prevention messages. De Vries et al (2011:2) further indicate that some health workers fear that this loss of authority could lead to loss of patients, impact their social status and affect their employment security, this negative attitude towards people living with HIV (PLHIV) appears to be not restricted to patients and the larger community but is also prevalent among professional health workers through charting, labeling, gossip, verbal harassment, avoidance, isolation and referrals for testing.

De vries et al (2011:7) further indicates that health workers fear of being classified as one of “the others” is arguably related to a perceived and professionally imposed sense of morality in which there is no place for an HIV positive status. Members of the health worker profession are expected to be HIV and AIDS free, and this boundary is explicitly patrolled by health workers themselves and embodied rituals of the profession such as prevention behaviours, help reinforce this immediate boundary between the health worker population and the “others” from both internal and external perspectives. While health care worker living with HIV may face the same kinds of stigma as their patients because of perceived improper or immoral behaviors, their self-blame shame may be compounded by educational status in the community (Nyblade, Stang, Weiss, and Ashburn 2009:37).

2.3.2 Stigma

UNAIDS 2003 defines HIV related stigma as a process of devaluation of people either living with or associated with HIV and AIDS. Goffman (1963:3) defines stigma as a mark that links a person to undesirable characteristics. Stigma is a powerful tool of social control, stigma can be used to marginalize, exclude and exercise power over individuals who show certain characteristics. In many societies, people living with HIV and AIDS are often seen as shameful. In some societies the infection is associated with minority groups or behaviors’, for an example, homosexuality, also in some societies; HIV and AIDS are believed to bring shame upon the family or community. In South Africa where adult HIV prevalence is according to UNAIDS (2007) more than 15%, it is essential to address the many aspects which contribute to the continuing epidemic. HIV and AIDS-related stigma is one such important efforts (Simbayi, Kalichman, Strebel, Cloete, Henda, and Mqeketho, 2007 and UNAIDS, 2008). Stigma prevents, both directly and indirectly people living with HIV (PLHIV) from accessing treatment, resources and much needed support. In the study conducted by Phaswana and Peltzer (2006:) on HIV and AIDS knowledge, risk perception, stigma and support amongst staff in tertiary institution in the Eastern Cape, South Africa, a sizeable percentage of the respondents indicated that there is stigma attached to HIV and AIDS at their workplaces. According to Fredrickson and Kanabus (2006:2) contend that together with the widespread belief that HIV and AIDS is shameful, these images represent ready- made but inaccurate explanations that provide a powerful basis for both stigma and discrimination The stereotypes also enable some people to deny that they personally are likely to be infected or affected. There is also evidence that if people living with HIV and AIDS are open about their infection status at work, they may experience stigmatization and discrimination by others.

According to Baptiste (2008: 8) Increasing HIV and AIDS related stigma and discrimination are acknowledged as one of the greatest challenges to slowing the progress of the disease and has been a major roadblock to the goal of universal access to treatment, care and support, Baptiste (2008:8) further assert that the very diagnosis of HIV and AIDS makes one vulnerable to, and a likely victim of discrimination and denial of basic human rights. Evidence suggests that negative attitude beliefs and practices of healthcare workers toward individuals who are HIV positive compounded by fear of infection in the workplace perpetuate HIV and AIDS related stigma and discrimination towards people living with HIV and AIDS. In more recent studies, perceived stigma among healthcare providers was found to be associated with lower access to services resulting in lower uptake in HIV and AIDS prevention, treatment and care.

Furthermore Baptiste (2008: 23) in the study conducted in Rwanda more than 3 quarters of participants were personally aware of discrimination that occurs against people living with HIV and AIDS in hospitals and health centers and majority of respondents, 89% reported knowing that health care providers discriminate against patients with HIV and or AIDS. So if health care providers themselves can discriminate or stigmatize people living with HIV and AIDS can a health worker himself want to get services from such people? Except to retreat and not seek help for fear of being stigmatized or discriminated once the health worker is diagnosed of HIV/AIDS. It is now recognized widely that HIV and AIDS is not only a concern of biological and medical importance but also as a social phenomenon. This disease has cut across class, race, and socio-economics, affecting though in an unequal distribution residents of rich western countries as well as poor ones. Around the world, People living with HIV and AIDS have experienced compassion, solidarity and support but also stigma repression, discrimination and rejection. Research shows that stigma against this population continues to be a powerful tool of social control and could provide members of society with an excuse from the joint responsibility to respond to the root causes of the disease. This expressed not only in placing responsibility for the spread of HIV among certain groups of people, but also at times in denying such groups access to services and treatment they need (Baptiste, 2008: 28).

In a study conducted by (Dieleman, Biemba , Mphuka , Sidhinga – Sichali : Sissolak , Vander Kwaak ,and Van der Will, 2007:139-148) in Zambia The results show that in both districts, HIV and AIDS has had a negative impact on workload and has considerably changed or added tasks to already overburdened health workers. In Mpika, 76% of respondents (29/38), and in Mazabuka, 79% (34/44) of respondents, expressed fear of infection at the workplace. HIV-positive health workers remained 'in hiding', did not talk about their illness and suffered in silence. Despite the fact that health workers were still relatively motivated, emotional exhaustion

occurred among 62% of the respondents (26/42). The interviews revealed that counselors and nurses were especially at risk for emotional exhaustion. In each of the selected facilities, organizational support for health workers to deal with HIV and AIDS was either haphazardly in place or not in place at all. AIDS complicates the already difficult work environment. In addition to health workers, management also needs support in dealing with AIDS at the workplace.

Data on absence of health workers due to HIV and AIDS-related problems was not obtained as absence was not systematically registered. The issue of HIV-infected health workers was very difficult to discuss, especially when it concerned their own status or that of immediate colleagues. Health workers, managers and volunteers did suspect some staff to be HIV-positive, due to absence and frequent illness, although sick workers tried to hide their illness as much as possible (Dieleman et al 2007:148). The difficulties in discussing HIV/AIDS among health workers confirmed the fear of being stigmatized if you are HIV-positive. A consequence of this was that many health workers did not get tested. Respondents indicated that HIV-positive health workers remain 'in hiding', do not talk about their illness and suffer in silence, despite the willingness of co-workers to assist. 'The social control is changing. But health workers still rather die. They deny their status and do not come to the healthcare. They don't disclose it to the hospital, but sometimes get treated somewhere else and come back in a better shape. The number of HIV-positive workers is increasing (Dieleman et al 2007:148).

According to Chokoe (2005:20), it is difficult for most people to admit that they are HIV positive or are suffering from AIDS. This is due to the risk that they may lose their friends, children, wives, families or rejection by the community at large. Discrimination and prejudice against people who are HIV positive or who have already developed AIDS enforces the need for them to remain hidden and thereby spreading the disease. As a result, the very people providing HIV care and treatment might not secure access to these same services (Uebel, Nash, and Avalos, 2007:501).

2.3.3 Lack of confidentiality

Confidentiality is an ethical principle particularly relevant in the provision of health care. The principle of confidentiality encompasses the view that person should be entitled to privacy with regard to his or her most personal physical and psychological secrets, but is also the basis of an effective relationship between patient/client and healthcare provider and hence the basis for the effectiveness of many public health interventions which rest on these relationships. Only if a person feels sure that the care provider will keep

confidential any information that may be critical to making decisions about clinical care and treatment (UNAIDS/WHO 2000:10).

Confidentiality is one of the core duties of medical practice which requires healthcare providers to keep a patient's personal health information private unless consent to release information is provided by the patient. Creating a trusting environment by respecting patient's privacy encourages the patient to seek care and to be as honest as possible during the course of a healthcare visit, it may also increase patient's willingness to seek care. The obligation of confidentiality prohibits the healthcare provider from disclosing information about the patient's case to others without permission and encourages the providers and healthcare systems to take precautions to ensure that only authorised access occurs (De Bord, Burke, and Dudzinski 2013:1).

Lack of confidentiality has been reportedly mentioned as a particular problem in health care settings. Studies by the WHO in India and Indonesia the Philippines and Thailand found that 34 percent of respondents reported breaches of confidentiality by health workers (www.avert.org/hiv-aids-stigma.htm). Fear of lack of confidentiality has been highlighted as one of the major reasons for young people's reluctance to seek help from health professionals ([Http://www.walk-the-talk.org.uk](http://www.walk-the-talk.org.uk)).

Disclosure can be beneficial or harmful, harmful disclosure involves cases where disclosure is made without the consent of the person who is HIV positive and has adverse consequences for that person such as stigma, it impairs prevention and care activities, where people fear disclosure involving lack of confidentiality they will avoid HIV counseling, testing treatment and support because these are likely to mean their HIV status will become known against their will and they will face stigma, discrimination, lack of privacy and other negative effects, Thus, fear of lack of confidentiality and forced disclosure drives people away from HIV services, reducing opportunities to encourage and empower people to change their behaviour in order to avoid getting infected or to avoid passing on their infection (UNAIDS/WHO 2000:13).

As of the year 2000, there were no reported studies investigating the prevalence of HIV among health workers (Shisana, Hall, Maluleke, Chauveau, Schwabe 2004: 846). There is a genuine worry that if those who are at risk of the disease and those who actually have contracted the disease are not protected by a legal obligation demanding confidentiality then they will be slow to come forward and more people will be put at risk. The Hippocratic oath imposes confidentiality on the doctor in all his dealings with patients, but there are situations in which the interest of the individual may be overtaken by the public interest. What protection then, should

there be for the individual at risk so that he will not be deterred from seeking medical help (Almond, 1990: 117).

According to Buregyeya, Wanyenze, Mitchell, Criel, Verver, Kasasa and Bunders (2012:4) other healthcare workers reported that refusing to disclose is because of feeling guilty and embarrassed since as healthcare workers, they should have prevented it. On the other hand, some healthcare workers felt that disclosure was not necessary since as healthcare workers they know the necessary steps to take in terms of treatment and adherence to treatment, though disclosing to their colleagues was described as optional and most times not necessary, they felt that disclosing to their supervisors was important, however there was fear that supervisors might fire them or breach their confidentiality.

Buregyeya et al (2012:7) further asserts that in both his quantitative and qualitative findings healthcare worker's have concerns about confidentiality of their results within their own health facilities. Those in doubt of their status tend to test outside their workplaces. These fears and preferences have implications for various interventions related to reduction of nosocomial Tuberculosis among healthcare workers, relocation of HIV infected staff to safer working areas as recommended by World Health Organisation and International Labour Organisation. According to NCHSR report (2012:22) while breaches of confidentiality may, in many circumstances, be unintentional, they nonetheless appear to be common place within the healthcare sector. These unintended breaches of confidentiality have potentially devastating implications for the wellbeing of people living with HIV by removing the possibility to choose whom they share information about their status with. According to Lawson et al (2006:32) many have experienced disclosure of their HIV status by third parties, one participant had her status disclosed within her community by a hospital staff person, and one by a relative who worked with an AIDS service organization the other found out that his doctor told another of his patients who knew the participant and three people had their status disclosed by friends, within their social networks including one by a friend who work in a medical field.

(a) **Importance of the duty of confidentiality with regards to HIV and AIDS**

McClelland (2001:2) argues that the duty of confidentiality is important because it encourages people to voluntarily come forward to seek treatment or advice. Preservation of confidentiality is the only way of securing public health; otherwise individual patients will not come forward if doctors are not going to sequel on them. The success of the different policies depend entirely on the mutual respect for the confidentiality of the patient care information that flows from the patient to the medical practitioner, a medical practitioner

cannot diagnose a patient unless the patient provides all the relevant information, however, relevant information can only be provided if a patient has confidence that such information will not be disclosed (HIV Testing and Confidentiality final report for Canada,1998:211). Confidentiality is important because of its assistance in preventing discrimination against people living with HIV/AIDS, the knowledge of a people's HIV status may lead to inferences about their sexual habits, drug taking habits, or social contacts, people living with HIV/AIDS may lose certain benefits when their identity is made known (Godwin, 1993:67).

2.4 HEALTHCARE WORKER'S UTILIZATION OF HIV AND AIDS SERVICES

Like the general population, health care workers may become infected with HIV as a result of their personal sexual behaviour. Health service personnel also face additional occupational risks and accidental exposure to blood or blood products. In the study conducted in Zambia, based on an examination of death certificates the observed increase in mortality of healthcare workers was attributed largely to HIV infection (Tawfik and Kinoti 2003: 5). There is evidence that healthcare workers do not have priority access to effective HIV prevention and treatment services (Mavedzenge et al 2011: 1). Under the WHO guidelines, the HIV treatment coverage in low and middle income countries represent only 34% of the 28.6 million people eligible in 2013 to start treatment people need to know their status, Globally it estimated that only half of all people living with HIV know their HIV status and 9.7 million people in low and middle income countries had access to anti retroviral therapy at the end of 2012 (UNAIDS, 2013:3).

Access to Human immune virus Counseling and Testing (HCT) at South African hospitals and clinics are a free service that should be available to all deserving community members (SAHRC, 2009). South African healthcare workers reside within the same communities where there's a high prevalence of HIV infection (World Bank, 1999). Human rights are increasingly a part of national strategies. Human rights are no longer considered peripheral to the AIDS response. Today, the vast majority of countries (89%) explicitly acknowledges or addresses human rights in their national AIDS strategies with 92% of countries reporting they have programs in place to reduce HIV related stigma (Global Report, 2010). 'Access to HIV and AIDS services in most health facilities takes place within an environment of fear, stigma and lack of confidentiality (Bongololo et al, 2008: 12).

According to Buregyeya et al (2012:5), almost half of the respondents preferred to get treatment outside the facility where they worked if they were HIV infected, participants also reported preference to be tested for HIV outside their workplace because they feared that colleagues and patients would know their HIV status, the

majority suggested that there should be a special clinic for healthcare workers run by trustworthy people who are also HIV positive. Some suggested an outreach arrangement where healthcare workers from outside their facility provide HIV counseling and testing (HCT), and those who test HIV positive access treatment in another facility, in order to avoid stigma.

Healthcare workers play a major role in reducing the negative impact of the HIV and AIDS epidemic especially in the Southern Africa where HIV prevalence is one of the highest in the world (UNAIDS and WHO, 2006). However, data from different countries within the region show that healthcare workers face a number of challenges to access HIV and AIDS related services. Recent data show that some HIV positive healthcare workers tend to leave HIV services at their work place to access treatment from far away sites while some just prefer not to access treatment at all for fear of stigma. By succumbing to stigma healthcare workers cannot benefit from HIV treatment, care and support programs. Although data of Anti-Retroviral treatment (ART) patients in Malawi show that health workers access Anti-Retroviral treatment (ART) more than other population groups, it is important to consider health workers as a special group due to the country's high demand for healthcare workers (Bongololo et al, 2008: 16).

Bongololo (2008: 11), further states that although 52% indicated to have ever experienced an occupational exposure in the past 12 months, only 30% reported the injury. Of these, 26% went for testing; only 7% started post exposure prophylaxis and only 4% finished post exposure prophylaxis treatment. Qualitative data shows that some healthcare workers failed to report occupational exposures to Human Immune Virus (HIV) because they feared that their bosses would look down on them as negligent in conducting their duties. At Donald Fraser, healthcare workers that have disclosed their statuses would only collaborate with an occupational health nurse and or doctor or staff at the ART site so that informal ways can be devised to collect treatment for them or they may collect treatment when the ART clinic is almost empty to avoid meeting the general community members and some workers would go to ART clinic with files as if they want to collect some information. This observation also concurs with the study conducted by Bongololo.

According to Mkhulisi,(2010: 17 - 18) Access to health care barriers include stigma, specific beliefs and attitudes by groups of people (including healthcare workers themselves), that becoming HIV positive is intimately linked with shameful sexual behaviour which brings disgrace to the sufferer and his/her next of kin to the point that HIV positive person feels shunned despised by relatives and friends. Stigma often leads to victims being discriminated against at work and or in the community. Stigma leads to paralytic fear at different

levels that is fear by the HIV positive person, leading to delay in disclosing his serostatus to relatives. Fear by the sufferer that colleagues or spouses might say that all is not well even when he/she has not disclosed his/her HIV status. Fear by workmates who though not officially aware of their mates' HIV status start gossiping about his recurrent absenteeism and "loss of weight" Mkhulisi (2010: 18), categorizes stigma, discrimination, inequity and human rights abuses as primary obstacles to scaling up services in HIV and AIDS and achieving universal access to comprehensive HIV prevention, treatment, care and support by 2010.

In a study conducted by Bongololo et al (2008: 8) in Malawi to explore challenges health care workers face to access HIV treatment care and support services the study revealed that almost all respondents (99%) demonstrated good knowledge of anti-retro viral treatment (ART). About 51% of the healthcare workers at least knew a healthcare worker at their workplace who was on antiretroviral treatment (ART). Qualitative data show that most respondents knew their fellow workers' HIV status through gossip. Respondents were asked where they would prefer to access antiretroviral viral treatment (ART) in the case that they were living with HIV and where they were eligible for ART, A higher proportion of the respondents (62%) reported that they would prefer to access ART within their place of work; 31 % at another public facility and 3% would prefer a private health facility. Qualitative data show that both perceived and actual stigma about the ART site partly influenced the choice of where to access ART for most respondents (Bongololo et al 2008:11).

Further Bongololo et al (2008:11) states that Twenty one (21) respondents voluntarily disclosed their HIV positive status. The majority 81% of those who disclosed their HIV status were on ART. Most of the respondents (53%) were accessing ART at a different public facility; 40% indicated that they access ART at their place of work; and only 7% were accessing ART at a private facility. Short distance to ART facility and quality of services were the major determinants in choosing where to access ART. Some respondents indicated that nutrition is one of the major challenges healthcare workers on ART face while on treatment.

2.5 THE IMPORTANCE OF HIV TESTING

HIV testing is the entry point for an individual to be able to access treatment, support and care. HIV Counseling and Testing is central to HIV/AIDS control efforts in many developing countries is important that people are encouraged to undergo HIV counseling and testing.

2.5.1 HIV testing informs an individual about his or her status

HIV counseling and testing can tell the tested person whether a person is carrying the virus or not to expect the onset of a serious illness and secondly, it tells the person whether or not he/she is likely to transmit the virus to other persons (Alcamo 1993: 9). HIV Counselling and Testing, individuals, couples and families can learn their HIV status and receive personalized risk reduction counselling to help prevent acquisition or further transmission of HIV. HIV positive individuals can be enrolled in rapidly expanding services for support, care, and treatment, as well as efforts to reduce onward transmission through prevention with positives programmes (Grabbe, Menzies, Taegtmeier, Emukule, Angala, Mwega, Masango, and Marum 2010: 1).

2.5.2 Public safety

Testing is an instrument for guarding the public health. Only if it is known that a person is a carrier of a virus can it be decided as to whether that person's sexual contacts are at risk (Almond, 1990: 12). In the study conducted by Khosa (2004: 270) on the attitudes of teenagers towards HIV testing, the findings revealed that 75% of teenagers have never visited the nearby clinic to ask about HIV testing and 90% of teenagers indicated that HIV testing is not essential. Furthermore, HIV Counselling and Testing can help communities address issues of prevention, denial, stigma, and discrimination associated with HIV and AIDS, and can mobilise support for HIV and AIDS control efforts (Grabbe et al, 2010: 1).

2.6 HIV AND AIDS RELATED MORBIDITY AND MORTALITY

The following is the HIV and AIDS morbidity and mortality in Sub Saharan countries, South Africa, and Limpopo.

2.6.1 HIV and AIDS morbidity and mortality in Sub Saharan countries

Sub Saharan Africa, the region of the world that has been worst affected by the AIDS epidemic has caused vast amounts of human suffering. Nearly two thirds of all HIV positive people live in the area, although it contains little more than 10% of the world's population. The most obvious effect of this crisis has been illness and death, during 2005, an estimated 2 million adults and children died as a result of AIDS in Sub Saharan Africa. Since the beginning of the epidemic more than 1, 5 million Africans have died from AIDS (Fredrickson and

Kannabus and Graham 2007:1). UNAIDS estimates that there were 33.3 million living with HIV at the end of 2009 which is a 27% increase (Global report 2010: 25).

Sub Saharan Africa still bears an inordinate share of the global HIV burden, although the rate of new HIV infections has decreased the total number of people living with HIV continues to rise. In 2009 that number reached 22.5 million, 68% of the global total. The largest epidemic in Sub Saharan Africa. The 1.3 million people who died of HIV-related illness in Sub Saharan Africa in 2009 comprised 72% of the global total of 1.8 million deaths attributed to the epidemic with an estimated 5.6 million people living with HIV in 2009, South Africa's epidemic remains the target in the world at the end of 2010, 34 million people were living with HIV and 1.8 million had died from an AIDS related illness that year (Global report 2010:25).

Most of the studies that have reported HIV and AIDS mortality among health workers are based on indirect estimates of HIV and AIDS. In Malawi, researchers reported that in 1999, 2% of healthcare workers died of AIDS (60 deaths out of 2979). Among female healthcare workers, the highest death rates were among those aged 25-34 years (Shisana et al, 2004: 846). Shisana et al, (2004: 850) 'further observed that HIV prevalence of 15,7% among health workers aged 18 years and older is very high.

Data from Zimbabwe, Mozambique, Malawi, Kenya, and Ethiopia indicate that 43% of deaths or medical retirement were suspected or known to be caused by HIV. In Swaziland 3-4% of nurses are lost to HIV infection annually and in Kenya, HIV incidence among the healthcare workers is twice the national average. In Kenya, Lesotho, and Malawi death is the leading cause of attrition among health workers in addition to high attrition rate due to death or medical retirement these statistics do not take into account absence from work due to HIV- related illness, which can be up to 50% of the expected time in the last year of life. The high rate of health workforce attrition in Sub Saharan Africa attributable to HIV of the health workforce implies low uptake of HIV services among this group. Health workers usually know where to access services, usually at their own workplaces, However, this knowledge is often not enough to promote widespread uptake of services among healthworkers (Mavedzenge et al 2011: 7). In 2012 there were about 25 million people living with HIV and about 1.6 million people who were newly infected and about 1.2 million deaths due to HIV related illnesses (UNAIDS 2013:3).

2.6.2 HIV and AIDS morbidity and mortality in South Africa

There were 5.4 Million people in South Africa living with HIV and AIDS on 1 July 2006, of these, over 4.9 Million (90.8%) were in the age group 20-64 years. This is also the age group which is most likely to form part of the labour force (Dorrington, Johnson, Bradshaw and Daniel, 2006: 27). Many people being hospitalised are HIV positive and hence nurses are in more regular and prolonged contact with people suffering from HIV and AIDS than is the case in other working environments (Smit, 2005:22).

Much has been written about the burden placed on the health sector in South Africa by HIV and AIDS. Most of this work focuses on the increased demand for health services created by AIDS and costs for providing health care to HIV infected patients; little has been published about the impact of HIV and AIDS on nurses, doctors and other trained professionals who are responsible for keeping increasingly overburdened public health care facilities functioning. Little is known about the contribution of AIDS to the high attrition of healthcare personnel and more so little is done to find out about the utilization of HIV and AIDS services by healthcare workers (Veriava, Conelly Servilla, Roberts Jordan, Tsotetsi, Badiman and Rosen, 2005: 3).

2.6.3 HIV and AIDS morbidity and mortality in Limpopo

In Limpopo, by mid-2006, the total HIV infected was 397 000, adults 20-64 were 348 000, deaths during 2005 were 61 000 (Dorrington et al., 2006: 68). It was also estimated that by 2010 the total of HIV positive people will be 468 659 with a cumulative death 226 131 (Dorrington et al., 2006: 70). The researcher has observed that more researchers focus on the attitude or experience of taking care of patients but little is known or monitored on whether the health care workers are utilizing the services themselves. It is also important to identify factors related to utilisation of HIV and AIDS services amongst health care workers, so that assistance should be provided, and HIV and AIDS morbidity and mortality amongst health care workers is reduced and or addressed.

2.6.4 The impact of HIV and AIDS on workplace

Healthcare workers have the same social and economic pressures as the general population and they are vulnerable to HIV in the workplace and their personal lives outside the workplace (Mavedzenge et al 2011:1). There can be no question about the impact that HIV and AIDS has on the workplace. It severely impacts on the workplace and also on the employer-employee relationship as a whole. Not only does it have legal implications in the workplace, it also has extreme economic consequences for the employer. This may be as a result of, but

not limited to, the failure on the part of the employee to attend work regularly and to contribute productively to the wellbeing of the company as a result of his/her HIV related illnesses (Poggenpoel 2006:2). Health care workers more than in any other profession in society are to an increasing extent becoming engaged in caring for people living with HIV and AIDS. Nurses in particular are the group of care givers who have regular and prolonged contact with such patients. Many nurses are experiencing occupational, stress, fatigue and symptoms of occupational burnout which may be escalated further as a result of fear of HIV transmission and exposure to HIV infected body fluids (Smit, 2005).

In a study conducted by Dieleman et al (2007: 139 - 148) in Zambia to explore the impact of HIV and AIDS on health workers, describe their coping mechanism and recommend supportive measures the results show that in both districts HIV and AIDS has had a negative impact on workload and has considerably changed or added tasks to already overburdened healthcare workers. In Mpika 76% of respondents expressed fear of infection at the workplace. HIV positive health workers remained in hiding did not talk about their illness and suffered in silence.

In the study conducted in 2004 on HIV/AIDS and the workplace: Perceptions of nurses in a public hospital in South Africa. The findings were that the majority of participants experienced feelings of helplessness when caring for people living with HIV and AIDS, because of the fact that no cure is available for HIV and AIDS (Smit R. 2005). The health care system, already markedly under resourced, has been severely stressed as increasing numbers of people require care and treatment for HIV. The prevalence of HIV among doctors and nurses approximates that of the general population leading to higher rates of illness and absenteeism among the very people needed to provide health services combined with attrition and brain drain. The result is a vicious circle in which the epidemic fuels the crisis in the health workforce at the same time that the shortage of health workers presents a major barrier to preventing and treating the disease. (Dohrn, Nzama, and Muurman: 2009).

According to Fredrickson and Kannabus and Graham (2007: 1), in all affected countries the AIDS epidemic is bringing additional pressure to bear on the health sector. As the epidemic matures the demand for care for those living with HIV raises, as so does the toll among healthcare workers. The HIV and AIDS epidemic is now a global crisis and constitutes one of the most formidable challenges to development and social progress. The epidemic is gradually but yet steadily eroding decades of development gains and has the potential, of seriously undermining our economy with its attendant adverse social and political implications.

Fredrickson, Kannabus and Graham (2007:2), further indicate that HIV and AIDS is a major threat to the world of work. It is affecting the most productive segment of the labor force and reducing earning. The impact of HIV and AIDS is seen through declining productivity, increasing healthcare bills, increasing labor costs due to increasing staff absenteeism, among others, additionally, the issue of HIV and AIDS is creating unwarranted stigmatization and discrimination aimed at workers and people living with and affected by HIV and AIDS.

According to Shisana et al (2004: 847) the sick healthcare worker will not be able carry out their responsibilities effectively because of frequent absenteeism and non infected workers will be expected to fill the gap left by the sick colleagues, which may lead to low morale, several studies have recognized that the healthcare workforce in South Africa is adversely affected by HIV and AIDS in countries with high HIV burden. HIV accounts for extremely high proportion of the morbidity and mortality experienced by healthcare workers.

2.7 REDUCING HIV AND AIDS RELATED MORBIDITY AND MORTALITY

According to President's Emergency Plan for AIDS Relief PEPFAR (2009: 5) the medical needs of an HIV-positive begin long before initiation of Anti-Retroviral treatment. It is critical to identify HIV infected persons early, refer them to services and retain them in care. Many of the care and support services offered to HIV-infected persons can improve health and quality of life, and reduce HIV related complications and mortality.

2.7.1 Ensuring access to treatment, care, support and prevention services

The timely provision of Antiretroviral treatment to people in need supports their ability to work and several studies has shown that providing anti retro viral treatment to healthworkers is a particularly wise investment as it greatly contributes to reduced attrition (Bemelmans, van den Akker, Pasulani, Tayub, Herman, Mwangomba, Jalasi, Chiomba, Ford, and Philips (2011:5). Universal Access to ART is guided by core ideals of equity accessibility, adequate, large scale financial backing and international interventions with continuing rollout of ART due to the realization that fundamental issues in vulnerability to infections must be addressed to control the epidemic. The integrated interventions include the combination of behavioral and bio medical approach as delay in sexual debut, reduction in multiple sexual partners, condom use, Voluntary HIV Counseling and Testing (VCT) AIDS treatment of the general and high risk populations, antiretroviral treatment to prevent Mother to child transmission and male circumcision and Post Exposure Prophylaxis (PEP) (Tadele, Amde, and Kloos 2013:147). A number of Sub-Saharan Countries that implemented combination HIV prevention

programs have reported sharp decreases in HIV infection since the end of 1990. In Namibia, which was able to achieve both significant reduction in risk behaviors and increases in ART, new infections declined by 60% by 2010. In Botswana, Zimbabwe and Lesotho, declines in infections were associated with improvements in their combined prevention programs. A number of recent randomized trials in Sub-Saharan Africa have demonstrated the effectiveness of male circumcision in reducing the transmission of HIV infections (Tedebe et al 2013:149). PEPFAR has developed a package of interventions with proven efficacy in both reducing HIV related morbidity and mortality and reducing HIV transmission. The basic preventive care package may differ depending on the setting and prevalence of other HIV related infections but often includes many of the following interventions, Giving of prophylaxis for the opportunistic infections most importantly, cotrimoxazole, which has been shown to significantly reduce mortality in HIV infected individuals, screening, prophylaxis and treatment for Tuberculosis (TB) Improved screening and treatment of opportunistic diseases and improved nutrition, including micronutrient supplementation, which may reduce mortality independent of ART and improve outcomes for patients on ART. It also include optimizing early identification, referral, and retention of HIV-infected individuals, reducing HIV related morbidity and mortality through utilizing the interventions.

In Sub-Saharan Africa 56% of people needing treatment were receiving it, 19% more than in 2010 (UNAIDS; 2012:19). The total number of new infections decreased from 2.6 million in 2010 – and in 22 countries, HIV incidence fell more than 25% between 2001 and 2009 (UNAIDS; 2012:19). A study in Uganda estimated that life expectancy of people living with HIV and AIDS (PLWHA) taking ART increased to nearly normal levels (Mills, Bakanda and Birungi 2009:143-216). The rapid increase in the equilibrium and use of ART in Sub-Saharan Africa has contributed significantly to increasing the life expectancy of PLWHA, reducing suffering, easing long-term care, promoting the use of HIV testing services, providing hope to infected people living with HIV/AIDS, reducing number of AIDS orphans, and generating socio-economic benefits at all levels of society (UNAIDS, 2010).

2.7.2 Preventing Occupational exposure to HIV

Healthcare workers should be made aware of the possible risks from occupational exposure to HIV and other blood Borne viruses and the importance of seeking medical advice following any exposure. All healthcare employees are supposed to have clear and specific local arrangements for the assessment and management of

such incidents, including written policies and named departments and personnel responsible for providing such a service (Omrani and Friedman 2005:5).

2.7.3 Nutritional Interventions for reducing HIV and AIDS related morbidity and mortality

According to Grobler, Siegfried, Visser, Mahlangu and Volmink (2013: 1) People living with HIV are at great risk of nutritional disorders this is the case in both untreated and treated HIV infected individuals furthermore HIV infection is most prevalent in parts of the world where food security is compromised. Population at high risk of HIV infection may lack appropriate nourishment prior to infection by HIV. Untreated HIV infections characterized by increased resting energy expenditure, decreased appetite, decreased intake and digestion of food and decreased absorption of nutrients adequate nutrition is important for optimal immune and metabolic function. Dietary support may, therefore improve clinical outcomes in HIV-infected individuals by reducing the incidence of HIV associated complications and attenuating progression of HIV disease, Improving the quality of life and ultimately reducing disease related mortality. In keeping with previous World Health Organization everything possible should be done to promote and support adequate dietary intake and food security while recognizing that this may not be sufficient to correct specific deficiencies in all HIV related infected individuals.

2.7.3 The use of telephone, mobile phones in reducing HIV and AIDS related morbidity and mortality

According to de Jongh, Gurol-Urganci, Vodopivec-Jamsek, Car and Artun (2013:1) Long term illness affect a significant proportion of the populations in developed and developing countries. Mobile phone messaging applications, such as short message service (SMS) and multimedia messages (MMS) may present convenient, cost effective ways of supporting self-management and improving patient's self-efficacy skills through, medication reminders, or supportive messages. According to Gentry, van Velt Hoven, Tudor and Car (2013:1) telephone voice interventions may play a role in improving medication adherence, reducing risky sexual behavior, and reducing depressive and psychiatric symptoms.

2.8 STRATEGIES TO OVERCOME CHALLENGES IN UTILIZING HIV SERVICES

According to Monjok, Smesny and Essien (2009:11) they recommended the following strategies; The news media, home video, radio, jingles should be used to produce destigmatisation programs in schools, hospitals, and religious centers. The introduction of AIDS education can be integrated into the curriculum of teaching in the country from primary to University. Empowerment of the stigmatized group like people living with HIV and AIDS and involving them in the design and implementation of prevention programs in the country. Health education Campaigns should integrate a change from fear to caring for people living with Human immune virus and acquired immune deficiency syndrome (PLWHA) as this is particularly important for the health care personnel. According to Nyblade, Stang, Weiss, Ashburn (2009:4) pointed out that to reduce stigma focus should be on a key lesson that has emerged from recent research and field experiences that to combat stigma, in the health setting, Interventions must focus on individuals level, environmental level and policy levels. The following are the strategies as suggested.

2.8.1 Individual level

Increasing awareness among health workers of what stigma is and the benefit of reducing it is critical. Allowing critical reflection on the negative consequences of stigma for patients, such as reduced quality of care and patients unwillingness to disclose their HIV status, adhering to treatment regimens, understanding of what stigma is, how it manifest and what the negative consequences are can help reduce stigma and discrimination. Health workers fears and misconception about HIV transmission must also be addressed. Fear of acquiring HIV through every day contact leads to people take unnecessary, often stigmatizing actions. Thus healthcare workers need to be provided with full information about how HIV is and is not transmitted and how practicing universal precautions can allay their fears. Understanding the association of HIV and AIDS with assumed immoral and improper behaviors is essential to confronting perceptions that promote stigmatizing attitudes toward individuals living with HIV. Programs need to address the shame and blame directed at people living with HIV by providing health providers with a safe space to reflect on the underlying values that lead to the shame and blame (Nyblade et al 2009:4).

2.8.2 Environmental level

According to Nyblade et al (2009:5) programs need to ensure that health workers have the information suppliers and equipment necessary to practice universal precautions and prevent occupation transmission of

HIV. This includes gloves for invasive procedures, sharps containers, adequate, water and soap disinfectant for hand washing and post exposure prophylaxis, posting relevant policies and washing procedure or other critical information.

2.8.3 Policy level

Lack of specific policies or clear guidance related to the care of patients with HIV reinforces discriminatory behavior among health workers. Health facilities need to enact policies that protect the health of patients as well as healthcare workers, to prevent discrimination against people living with HIV such policies are most successful when developed in a participatory manner clearly communicated to staff, and routinely monitored after implementation. Involve all staff members not just health professionals, in training and in drafting policy. It helps reaching everyone with whom a patient comes in contact with, this helps to ensure ownership of the stigma reduction process and a unified response by the health care facility Nyblade et al (2009:5) Make use of participatory methods such as games, role-plays, exercises and group discussions and create a non-judgmental environment that allows participation to explore personal values and behaviours, while improving their knowledge and awareness. Periodically Monitor Stigma among health workers, enact health care setting regulations, Establish anti stigma policies and benchmarks that health facilities can use for assessing their efforts (Nyblade et al 2009:5).

Provide training on both stigma and Universal precautions. Equipping health workers with the knowledge and skills necessary to protect themselves from occupational transmission of HIV is the key step in addressing fear based stigma. When designing a training programme it is important to tap into existing networks of people living with HIV to identify individuals to take part in training activities, as well as to provide adequate preparation and training to these individuals to equip them for the role they will play in training like testimonials and co-facilitation. Address the needs of HIV – infected Health workers, Health facilities should respond in a multi-faceted way to address HIV-positive health workers fear of stigma and loss of confidentiality. The response should include private and confidential counselling and testing services, access to antiretroviral therapy, and professional and emotional support, either on the premises or at convenient locations. Also important are the enactment and enforcement of anti-discriminatory policies to protect workers living with HIV (Nyblade, et al 2009:5).

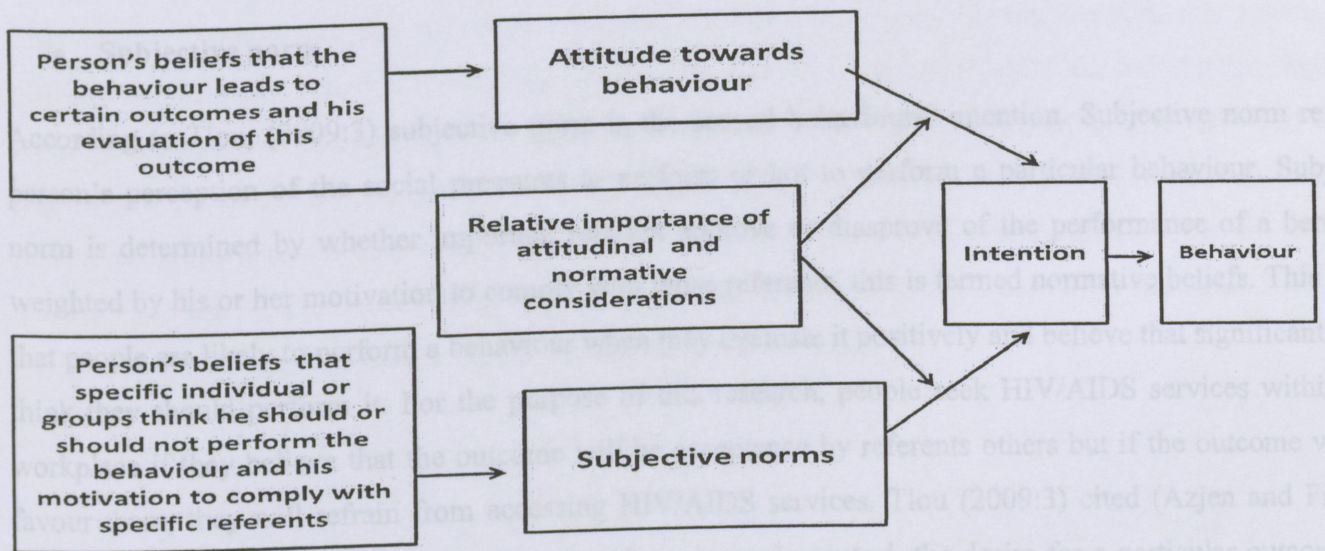
2.9 THEORETICAL FRAMEWORK OF THE STUDY

The following theory will be used for this research

2.9.1 The theory of reasoned action theory

The theory of reasoned action is chosen for this study as it is the theory most cited in HIV/AIDS research and have been found to be better predictors of HIV/AIDS health behaviour than other models (Tlou, 2009: 17). People behave differently in their lives. Their behaviours may affect their health or that of others. To be able to understand human behaviour we need to understand the factors that influence their behaviour to be able to put in strategies to address behaviour that affects people negatively. It is for that reason that the researcher will use reasoned action theory to understand the behaviours of healthcare workers and to be able to put in place strategies to address unhealthy behaviours. The theory of reasoned action attempts to explain the relationship between beliefs, attitude intentions and behaviour, based on the assumption that human beings are rational and make systemic use of available information. (Tlou, 2009: 26). The following is the schematic presentation of the theory showing factors determining a persons behaviour.

Figure 1: Factors determining a person's behaviour



Source (Ajzen and Fishburn, 1980:8)

(Ajzen and Fishban, 1980; Montano & Kasprzyk, 2002). As cited by Tlou(2009:17), states that According to the theory of reasoned action, the most accurate determinant of behaviour is behavioural intention. The direct

determinants of people's behavioural intention are their attitudes towards performing their behaviour and the subjective norms associated with the behaviour, i.e. behavioural beliefs) weighted by evaluations of those outcomes or attributes. The subjective norm of a person is determined by whether important referents (People who are important to the person) approve or disapprove of the performance of a behaviour (Normative beliefs) weighted by the persons motivation to comply with those referents .

2.9.2 Determinants of behavioural intentions

Behavioural intention are determined by the following:

- **Attitude towards performing a behaviour**

People's likelihood of performing a given behaviour will be strong if they hold a favourable attitude towards the performance of that behaviour. Thus, a person who holds a belief that positively valued outcomes will result from performing a behaviour will have a more positive attitude towards that behaviour than the one who has strong negative belief that negatively valued outcomes will result (Tlou, 2009:3). For the purpose of this research a person who strongly believe that seeking HIV testing at own workplace will yield stigma and being gossiped about may refrain from seeking HIV counselling at own workplace.

- **Subjective norm**

According to Tlou, (2009:3) subjective norm is the second behavioural intention. Subjective norm refers to person's perception of the social pressures to perform or not to perform a particular behaviour. Subjective norm is determined by whether important referent approve or diasprove of the performance of a behaviour weighted by his or her motivation to comply with those referents, this is termed normative beliefs. This means that people are likely to perform a behaviour when they evaluate it positively and believe that significant others think they should perform it. For the purpose of this research, people seek HIV/AIDS services within their workplace if they believe that the outcome will be acceptance by referents others but if the outcome will not favour them, they will refrain from accessing HIV/AIDS services. Tlou (2009:3) cited (Azjen and Fishban, 1980) as saying, although outcomes are not under a person's control, the desire for a particular outcome will determine whether or not a person engages in a particular behaviour.

2.9.3 Determinants of attitudinal and Normative Components

Azjen and Fishban, (1980) in (Tlou, 2009:34) ascertain that beliefs are viewed as underlying a person's attitudes and subjective norms and then ultimately determine intentions and behaviour.

- **Determinants of attitudes towards behaviour**

Attitudes towards any objects are determined by beliefs about that object, ie. Attitude towards HIV/AIDS services within workplace are determined by beliefs about that service.

- **Determinants of subjective Norms**

According to Tlou (2009:34) , The individual takes a normative expectation of significant others in his or her environment into account. He or she considers whether significant others think he or she should not perform the behaviour and then uses this information to arrive at his or her subjective norm.

2.10 CONCLUSION

This chapter highlighted the literature regarding Factors influencing Healthcare worker's reluctance to utilization of HIV and AIDS services within their workplace. The discussion included, introduction, legislative framework on matters concerning HIV, factors related to reluctance to utilization of HIV services such as fear, stigma and lack of confidentiality, healthcare worker's utilization of HIV and AIDS services, HIV and AIDS related morbidity and mortality in the Sub Saharan countries, South Africa, and in Limpopo, the impact of HIV and AIDS in the workplace, reducing HIV and AIDS related morbidity and mortality, strategies to overcome challenges in utilizing HIV and AIDS services and the conclusion.

CHAPTER 3 RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The researcher in this chapter presented the research design and methodology followed when conducting the study. This chapter also outlines the study area, study population, sampling method, sampling size, data collection, data analysis methods, and ethical considerations.

3.2 RESEARCH DESIGN

According to Huff (2009:85) research design is a related set of decisions that link your activities, your scholarly purpose, and its outcome. Gray (2009: 131), research design is the over arching plan for the collection, measurement and analysis of data. For this study the researcher used descriptive design because descriptive design aims at obtaining complete accurate information about a phenomenon.

3.3 RESEARCH METHODOLOGY

According to Polit and Hungler (2004:233), research methodology refers to ways of obtaining, organising and analysing data. According to Burns and Grove (2003:488), methodology includes the design, setting, sample, methodological limitations, and the data collection and analysis techniques in a study. The researcher used both qualitative and quantitative research methodology. Both qualitative and quantitative methods were used because of increasing recognition that a mixed-methods approach yields richer findings and improves interpretation of results.

Qualitative research methodology is fundamentally interpretive and views social phenomenon holistically (Marshall and Rossman 2006:3). According to Burns and Grove (2003:356) qualitative research refers to inductive, holistic, emic, subjective and process-oriented methods used to understand, interpret, describe and develop a theory on a phenomenon or setting. The study employed a qualitative approach because there is a close interaction between the researcher and the respondent and that the researcher will be able to know the situation as it happens.

According to Leedy (1993:244), quantitative research methods includes the implementation of statistics to measure data. Denzin and Lincoln (1994:4), quantitative method emphasise the use of numerical measures to

arrive at specific findings. The researcher was able to quantify the number of the occurrences in each theme or category so that the theme with high frequency will be regarded as significant to the problem investigated.

3.4 STUDY AREA

The participants in the study were from Donald Fraser Hospital in Thulamela municipality of Vhembe District, Limpopo Province. The area is a mountainous area with thick vegetation. The population served are mostly the people from Mutale municipality. Donald Fraser Hospital is one of the 8th hospitals in the Vhembe district under Thulamela municipality in the northern part of Limpopo Province. The hospital is situated 30 kilometers north of Thohoyandou, the main town in Vhembe.

3.5 STUDY POPULATION

According to Burns and Grove (2003:43), the study population includes all elements that meet certain criteria for inclusion in the study. Study population is the entire group of persons or objects that is of interest to the researcher that meets the criteria which the researcher is interested in studying (Brink, 2006:113). For the purpose of this research, the population is the healthcare workers of Donald Fraser Hospital in the Vhembe District consisting of Doctors, Assistant managers, Operational nurses Professional nurses, Enrolled nurses, and Enrolled nursing assistants which constitutes a total of 453.

3.6 SAMPLING

A sample is a part of fraction or whole, or a subset of a larger set, selected by the researcher to participate in the real study (Brink, Vander Walt and Van Rensburg 2006: 124). According to Burns and Grove (2003:233) research sampling involves the selection of the sample that can be people, events, behaviours or elements. The sampled group in this study consisted of doctors, assistant managers, operational managers, professional nurses, enrolled nurses and enrolled assistants nurses.

3.7 SAMPLING METHOD

The researcher used non- probability sampling which is purposive sampling method which is one of the most common sampling strategies, groups participants according to pre selected criteria relevant to a particular research question. Purposive Sampling method is based on the judgment of a researcher regarding the characteristics of a representative (Bless, Higson Smith, 2000: 92). According to Burns and Grove (2003:255),

purposive sampling methods involve conscious selection of certain participants to gain insight or obtain indepth understanding of a complex experience or event. This study used purposive sampling method because researcher chose the repondents with a purpose and having the understanding that respodents are involved in caring for HIV infected patients on a daily basis.

3.8 SAMPLE SIZE

The total size of the sample is 60 participants consisting of medical doctors 2, assistant managers 3, operational managers 05, professional nurses 23, enrolled nurses 15, enrolled nursing auxillries 12.

Table 3.1 Sample size

| Respondents | Population | frequency |
|------------------------------|------------|-----------|
| Medical doctors | 12 | 02 |
| Assistant Managers | 07 | 03 |
| Operational managers | 18 | 05 |
| Professional nurses | 142 | 23 |
| Enrolled nurses | 126 | 15 |
| Enrolled nursing auxillaries | 148 | 12 |
| TOTAL | 453 | 60 |

3.9 DATA COLLECTION

Data collection is the precise and systematic collection of information that is relevant to the purpose, objectives, questions or hypothesis the study (Burns and Grove 2003:45). Mouton (2006:45), says data collection focuses on gathering of information for a research project through a variety of data sources. Data was collected through the use of an open ended interview schedule and a questionnaires, The researcher went to Donald Fraser Hospital to conduct interview and distribute questionnaires.

An interview involves direct personal contact with the participant who is asked to answer questions relating to the research problem (Bless and Higson 2000:104). Interviewing is a method of data collection in which an interviewer obtains responses from a subject, and is used in exploratory and descriptive research (Brink 2006:151). Open ended questions allow participants to answer questions freely, provide new ideas and rich data. The researcher went to Donald Fraser to interview the respondents.

According to Bless and Higson (2000:105), questionnaires are based on an established set of questions with fixed wording and sequence of presentations as well as more or less precise indications of how to answer each question. McMillan (1993:23) states that a questionnaire is a relatively economical object, has standardised questions and ensures anonymity. The questionnaires were distributed to the respondents by the researcher and were completed and collected the day the researcher went to collect them at a central place as arranged with hospital management.

3.10 DATA ANALYSIS

Data analysis is a mechanism for reducing and organising data to produce findings that require interpretation by the researcher (Burns and Groove 203:479). According to De Vos (2002:339), data analysis is a challenging and a creative process characterised by an intimate relationship of the researcher with the participants and the data generated. Two data analysis methods were used.

Data collected through questionnaires were analyzed using the Statistical Package of Social Science Program, which is a windows based computer program. The information was presented in graphical tables, frequencies, and percentages.

Information collected through interviews was analysed by thematic analysis and the information was presented through narrative form. The researcher used the Zhang and Wildermuth (2009:2), steps to analyse data as follows:

- **Preparing the data**

As data was collected, notes were written, then the data was transformed into written text before it can be analysed

- **Defining the unit of analysis**

The unit of analysis refers to the basic unit of text to be classified during content analysis, for the purpose of this research themes were used as the unit of analysis, for an example a theme might be expressed in a single word, a phrase, a sentence or a paragraph or an entire document.

- **Developing categories and coding schemes**

The categories were developed inductively from raw data, using constant comparative method by: The coding manual evolved throughout the process of data analysis and was augmented with interpretive memos.

- **Test coding scheme on a sample of text**

Coding sample text, checking coding consistency and revising coding rules was done in an interactive manner and continued until sufficient coding is achieved.

- **Code all the text**

When sufficient consistency has been achieved, the coding rules applied to the entire corpus of the text. During coding process, the coding was checked repeatedly, to prevent drifting into an indio by noratic sense of what the code means.

- **Assessing their consistency**

After coding the entire data set, the consistency of the coding was rechecked.

- **Drawing of conclusions from the coded data**

It may involve exploring the properties and dimensions of categories, identifying relationships between categories, uncovering patterns and testing categories against the full range of data.

- **Reporting methods and findings**

The analytical procedures and processes will be reported as completely truthfully as possible. Presentation of research findings will be done using typical quotations to justify conclusions and other options for data display will be incorporated such as graphs or charts .

3.11 ETHICAL CONSIDERATIONS

According to Resmik (2011:1) ethics are norms for conduct that distinguish between acceptable and unacceptable behaviour. Ethics is a set of moral principles that concerns human conduct (Albertse 2007:16). According to Polit and Hungler (1996:127), great care must be exercised to ensure that the rights of those humans are protected. Burns and Grove (2003:166) concurs by indicating that researchers have an ethical responsibility to protect participants human rights during research. Ethical issues need to be considered when dealing with people and the following are the ethical considerations for the study:

3.11.1 Permission to conduct a study

The researcher obtained an ethical clearance letter from the University and letter for permission to undertake a study from the province, university and took a copy to the Vhembe District department of health. Permission was also be sought from the institution where the research was conducted.

3.11.2 Rights to self-determination (Autonomy)

According to (Brink, 2006:32), Individuals have the rights to self determination, meaning the person has the freedom to choice. The purpose of the study was explained. Privacy, confidentiality was maintained (Clark, 1992:266). No name was written on the participant's response sheet, the information will only be shared with relevant people. The respondents were allowed the right to choose to participate and to withdraw at any stage of the research. participation may require a significant portion of the respondent's time and energy. The respondents were told that participation is voluntary.

3.11.3 Anonymity and confidentiality

Polit and Hungler (1999: 143) states that confidentiality means that no information that the participant divulges made public or available to others. Anonymity exists when the subject cannot be linked to the data collected(Burns and Grove 2003:172).The researcher avoided identifying a given response with a given

respondent. No names of the participants appeared both on the questionnaire and. The respondent information was held in a confidential manner.

3.11.4 Informed consent

According to Burns and Grove 2003:177), Informing is the transmission of essential information regarding the research from the researcher to the subject. Respondents were not be deceived or lied to about the purpose of the research. A letter was included for a respondent to read before responding and consent will be given after an explanation is done to the respondent.

3.12 CONCLUSION

The researcher in this chapter presented the design and methodology followed when conducting the study. This chapter outlined the research design which is descriptive, research methodology which is both qualitative and quantitative research methodology, the study area, study population consisting of doctors, Assistant managers, Operational managers, professional nurses, enrolled nurses, and enrolled assistant nurses, sampling method, sampling size consisting of 12 medical doctors, 7Assistant managers, 18 operational managers, 142 professional nurses, 126 enrolled nurses, and 148 enrolled nursing assistants, data collection, data analysis and ethical considerations.

4.2.1 Section A: Personal Particulars of Respondents

The researcher in this sub-section presents the personal particulars of the respondents in this study. The information is presented in graphical and tabular form and followed by a synthesis of the findings.

Table 4.1 Gender of respondents

| Gender | Number | Percentage |
|--------|--------|-------------|
| 1 | Male | 17 30,9% |
| 2 | Female | 38 69,1% |
| | TOTAL | 55 100% |

Table 4.1 presents the personal particulars of the respondents in terms of gender. Thirty-eight (69,1%) were females, whereas 17 (30,9%) were males. The respondents in this study all work under Donald Fraser. Majority of the respondents who took part in the study were females.

CHAPTER 4: DATA PRESENTATION, ANALYSIS AND INTERPRETATION

Table 4.2 Age of respondents

4.1 INTRODUCTION

The following section focuses on reporting the perceptions and understanding of the factors influencing health care workers reluctance to utilization of HIV and AIDS services within their workplace: A case of Donald Fraser Hospital. The data regarding the factors influencing health care workers reluctance to utilization of HIV and AIDS services was collected by using quantitative and qualitative methods which involved the application of questionnaires and interview. The responses to the questionnaires items are presented graphically in tabular form and are followed by a brief synthesis of the findings for the item and the responses to the interview schedule are presented in a narrative form and are followed by a brief interpretation of the findings.

4.2 ANALYSIS OF DATA COLLECTED THROUGH QUESTIONNAIRE

In this section, the researcher presents data collected through questionnaire and the information was presented in tabular format, frequencies and percentages.

4.2.1 Section A: Personal Particulars of Respondents

The researcher in this sub-section presents the personal particulars of the respondents in this study. The information is presented in graphical and tabular form and followed by a synthesis of the findings.

Table 4.1 Gender of respondents

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Table 4.2 Age of respondents

| | Response | Frequencies | Percentage |
|---|--------------------|-------------|------------|
| 1 | 20 – 30 years | 13 | 23,6% |
| 2 | 31 – 40 years | 24 | 43,6% |
| 3 | 41 – 50 years | 08 | 14,5% |
| 4 | 50 years and above | 10 | 18,2% |
| | TOTAL | 55 | 100% |

Most of the respondents, 24 (43,6%) who took part in this study were aged between 31 and 40 years. 13 (23,6%) of the respondents were aged between 20 and 30, and 10 (18,2%) were between 51 years and above. Few respondent at 08 (14,5%) were between 41 and 50 years of age. It can therefore be concluded in this study that majority of the respondents who took part in the study were aged between 31 to 40 years.

Table 4.3 Marital status of the respondents

| | Response | Frequencies | Percentage |
|---|----------|-------------|------------|
| 1 | Single | 15 | 27,3% |
| 2 | Married | 36 | 65,5% |
| 3 | Divorced | 03 | 5,5% |
| 4 | Widowed | 01 | 1,8% |
| | TOTAL | 55 | 100% |

The majority of the population who took part in this, 36 (65,5%) were married, while 15 (27,3%) of the respondents were single. 03 (5,5%) of the respondents were divorced and only 01 (1,8%) respondents who was widowed. Thirty-six 36 (65,5%) respondents who responded to the questionnaires revealed that there were married.

Table 4.4 Occupation of Respondents

| | Response | Frequencies | Percentage |
|---|----------------------------|-------------|------------|
| 1 | Doctor | 02 | 3,6% |
| 2 | Professional Nurse | 22 | 40,0% |
| 3 | Assistant Manager | 03 | 5,5% |
| 4 | Operational Manager | 05 | 9,1% |
| 5 | Enrolled Nurse | 12 | 21,8% |
| 6 | Enrolled Nursing Assistant | 11 | 20,0% |
| | TOTAL | 55 | 100% |

Table 4.4 above, indicate that majority of the respondents at 22 (40,0%) who took part in the study were professional nurses and 11 (20,0%) were enrolled nursing assistant. Twelve 12 (21,8%) of the enrolled nurses took part in the study. Five 05 (9,1%) of the respondents were operational managers while 03 were (5,5%) were assistant managers. Only two 02 (3,6%) in the study were doctors. From the above information, it can be concluded that, majority of the respondents who took part in the study were professional nurses.

4.2.3 Section B: Factors influencing health care workers reluctance to utilization of HIV and AIDS services

In this sub-section, data is analysed using graphical statistics which arose from the survey questionnaire respondents. This sub-section will be divided into three themes are factors influencing the reluctance in seeking HIV and AIDS services; reducing healthcare workers HIV and AIDS morbidity and mortality; and the strategies to address the challenges related to reluctance to utilize HIV and AIDS services.

4.2.3.1 Factors influencing the reluctance in seeking HIV and AIDS services

This sub-section presents data regarding the factors influencing the reluctance in seeking HIV and AIDS services. The data is presented in the form of tables followed by brief interpretation.

Table 4.5 HIV and AIDS counselling and testing is provided for healthcare workers

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 24 | 43,6% |
| 2 | Agree | 26 | 47,3% |
| 3 | Neutral | 02 | 3,6% |
| 4 | Disagree | 02 | 3,6% |
| 5 | Strongly disagree | 01 | 1,8% |
| | TOTAL | 55 | 100% |

Table 4.5 Twenty-six (47,3%) of the respondents agreed with the idea that HIV and AIDS counselling and testing is provided for healthcare workers, 24 (43,6%) respondents strongly agreed. On the other hand, 02 (3,6%) disagreed and on 01 (1,8%) strongly disagreed with that HIV and AIDS counselling and testing is provided for healthcare workers. Two 02 (3,6%) respondents were not sure whether HIV and AIDS counselling and testing is provided for healthcare workers or not. The statistics shows that about 90,9% to a greater extent agreed that HIV and AIDS counselling and testing is provided for healthcare workers.

Table 4.6 Healthcare workers are concerned about the risk of becoming infected

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 21 | 38,2% |
| 2 | Agree | 24 | 43,6% |
| 3 | Neutral | 04 | 7,3% |
| 4 | Disagree | 06 | 10,9% |
| 5 | Strongly disagree | 0 | 0,0% |
| | TOTAL | 55 | 100% |

Table 4.6 indicate that majority of the respondents at 24 (43,6%) agreed with the statement that healthcare workers are concerned about the risk of becoming infected, while 06 (10,9%) disagreed with the idea. A total of 21 (38,2%) of the respondents strongly agreed that healthcare workers are concerned about the risk of becoming infected, and there was no respondent who strongly disagreed with the idea. Four 04 (7,3%) of the respondents were neutral on whether healthcare workers are concerned about the risk of becoming infected or not. From the above statistics, a conclusion can be drawn that majority of the respondent about 81.8% revealed that healthcare workers are concerned about the risk of becoming infected.

Table 4.7 Healthcare workers are afraid to test for HIV for fear of positive results

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 17 | 30,9% |
| 2 | Agree | 24 | 43,6% |
| 3 | Neutral | 05 | 9,1% |
| 4 | Disagree | 07 | 12,7% |
| 5 | Strongly disagree | 02 | 3,6% |
| | TOTAL | 55 | 100% |

Table 4.7 The majority of the healthcare workers 24(43,6%) agreed that healthcare workers are afraid to test for HIV for fear of positive results, and 17(30,9%) strongly agreed with the statement while 7(12,7%) disagree with the statement, 2(3,6%) strongly disagreed and only 5(9,1%) are neutral about the fact that healthcare workers are afraid to test for HIV for fear of positive results. The conclusion is that 74,5% of healthcare workers are afraid to test for HIV for fear of positive results.

Table 4.8 Healthcare workers utilize HIV testing and counselling services at other hospitals either than own hospital for fear of stigma

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 12 | 21,8% |
| 2 | Agree | 21 | 38,2% |
| 3 | Neutral | 11 | 20,0% |
| 4 | Disagree | 07 | 12,7% |
| 5 | Strongly disagree | 04 | 7,3 |
| | TOTAL | 55 | 100% |

Table 4.8 The statistics indicate that the majority 21 (38,2%) agreed that Healthcare workers utilize HIV testing and counselling services at other hospitals either than own hospital for fear of stigma, whereas 12 (21,8%) strongly agreed that healthcare workers utilize HIV testing and counselling services at other hospitals either than own hospital 11 (20.0%) were neutral about the statement, on the other hand 07(12,7%) disagreed that healthcare workers utilize HIV testing at other hospitals either than own hospital for fear of stigma and only 04(7,3%) strongly disagreed with the statement. The findings indicates that 60% of the respondents indicated that stigma is still a challenge in hospital that make healthcare workers not to utilize HIV services within their own hospital.

Table 4.9 There is confidentiality regarding HIV in hospitals

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 10 | 18,2% |
| 2 | Agree | 19 | 34,5% |
| 3 | Neutral | 06 | 10,9% |
| 4 | Disagree | 14 | 25,5% |
| 5 | Strongly disagree | 06 | 10,9% |
| | TOTAL | 55 | 100% |

Table 4.9 The respondents showed that 19 (34,5%) agree that there is confidentiality regarding HIV in hospitals 10(18,2%) strongly agreed that there is confidentiality in contrast 14 (25.5%) disagreed with the statement and 6 (10,9%) remain neutral about confidentiality regarding HIV in hospitals and 6(10,9%) strongly disagreed that there is confidentiality in hospitals. The findings reveals that 52.7% of respondents indicated that confidentiality regarding HIV is still practiced to a certain extent though it was to be practiced in totality we still find percentage of respondents who strongly disagreed that confidentiality exists in the hospitals.

4.2.3.2 Reducing healthcare workers HIV and AIDS morbidity and mortality

This portion presents the information on reducing healthcare workers HIV and AIDS morbidity and mortality. The information in this section are presented in graphical and tabular forms and followed by a discussion of the findings.

Table 4.10 Healthcare workers do die from HIV and AIDS related diseases

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 21 | 38,2% |
| 2 | Agree | 22 | 40,0% |
| 3 | Neutral | 10 | 18,2% |
| 4 | Disagree | 0 | 0,0% |
| 5 | Strongly disagree | 02 | 3,6% |
| | TOTAL | 55 | 100% |

Table 4.10 The table indicates that 22(40.0%) agreed and supports the statement that healthcare workers die from HIV and AIDS related diseases, whereas 21 (38,2%) strongly agreed that healthcare workers die from HIV and AIDS related diseases 10(18,2%) remain neutral on the statement and 0 (0,0%) disagreed that healthcare workers die from HIV and 02(3,6%) strongly disagreed that healthcare workers die from HIV and AIDS related diseases, this information concludes that 78,2% of the healthcare workers agreed that some of them die from HIV and AIDS related disease and we cannot afford to lose such an important cadre in the health fraternity.

Table 4.11 Healthcare workers who are HIV positive are encouraged to attend HIV and AIDS services in their workplace.

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 15 | 27,3% |
| 2 | Agree | 25 | 45,5% |
| 3 | Neutral | 06 | 10,9% |
| 4 | Disagree | 07 | 12,2% |
| 5 | Strongly disagree | 02 | 3,6% |
| | TOTAL | 55 | 100% |

Table 4.11 is about Healthcare workers who are HIV positive are encouraged to attend HIV and AIDS services in their workplace, the response to this indicate that 25(45,5%) agreed that healthcare workers need encouragement to attend HIV services whereas 15(27,3%) strongly agreed with the statement only 06(10,9%) decided to remain neutral and 07(12,2%) disagreed with the statement amongst those who disagreed 02(3,6%) strongly disagreed to the statement. 72,8% of the respondents agreed that healthcare workers need encouragement to attend HIV and AIDS services in their workplace.

Table 4.12 HIV/AIDS preventive practices helps to reduce HIV infections

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 20 | 36,4% |
| 2 | Agree | 20 | 36,4% |
| 3 | Neutral | 09 | 16,4% |
| 4 | Disagree | 03 | 5,5% |
| 5 | Strongly disagree | 03 | 5,5% |
| | TOTAL | 55 | 100% |

Table 4.12 The respondents indicate that 20(36,4%) strongly agreed that HIV/AIDS preventive practices helps to reduce HIV infections, equally is the number of 20(36,4%) respondents that agreed, 9(16,4%) are those who remain neutral that HIV/AIDS preventive practices helps to reduce HIV infections,there is also an equal proportion of those who disagreed and those who strongly disagreed of 3(5,5%). The conclusion is that72,8% agreed that HIV/AIDS preventive practices helps to reduce HIV infections.

Table 4.13 Antiretroviral treatment reduce untimely deaths by HIV infected patients

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 18 | 32,7% |
| 2 | Agree | 18 | 32,7% |
| 3 | Neutral | 05 | 9,1% |
| 4 | Disagree | 11 | 20,0% |
| 5 | Strongly disagree | 03 | 5,5% |
| | TOTAL | 55 | 100% |

Table 4.13 The table reveals that 18(32,7%) strongly agreed that Antiretroviral treatment reduce untimely deaths by HIV patients and 18(32,7%) equally agreed that using Antiretroviral treatment reduces the untimely deaths by HIV infected patients and 11(20,0%) disagreed that Antiretroviral treatment reduces untimely deaths 05(9,1%) remain neutral and only 03(5,5%) strongly disagreed that Antiretroviral treatment reduces untimely deaths by HIV infected patients. The results concludes that the majority of 65.4% strongly agreed that taking Antiretroviral treatment in time will reduce the untimely deaths to an HIV infected person. It is of utmost important that healthcare workers who are HIV positive be encouraged to take treatment to prevent untimely deaths.

Table 4.14 Healthcare workers always report needle pricks injury

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 10 | 18,2% |
| 2 | Agree | 15 | 27,3% |
| 3 | Neutral | 10 | 18,2% |
| 4 | Disagree | 16 | 29,1% |
| 5 | Strongly disagree | 04 | 7,3% |
| | TOTAL | 55 | 100% |

Table 4.14 The table illustrates that 16(29,1%) disagreed that healthcare workers report needle pricks injury always and 10 (18.2) strongly agreed that healthcare workers always report needle pricks injury and 04 (7.3) highlighted that healthcare workers always report needle pricks injury, 10 (18.2%) remain neutral and only 4(7,3%) strongly disagreed that workers always report needle pricks injury. From the results it can be concluded that the majority of 45.5 % strongly agreed that that healthcare workers report needle pricks injury. Thus, given the high percentage of responded signaling that most of the healthcare workers are encouraged to always report needle prick injuries.

4.2.3.3 The strategies to address the challenges related to reluctance to utilize HIV and AIDS services

This section provide a description of the strategies to address the challenges related to reluctance to utilize HIV and AIDS services, and the information in this section are presented in graphical and tabular forms and followed by discussions.

| | | | |
|---|-------------------|----|-------|
| 4 | Disagree | 16 | 29,1% |
| 5 | Strongly disagree | 04 | 7,3% |
| | TOTAL | 55 | 100% |

Table 4.15 HIV and AIDS policies do exist in hospitals

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 26 | 47,3% |
| 2 | Agree | 18 | 32,7% |
| 3 | Neutral | 03 | 5,5% |
| 4 | Disagree | 06 | 10,9% |
| 5 | Strongly disagree | 02 | 3,6% |
| | TOTAL | 55 | 100% |

The table 4.15 illustrates that 26(47.3%) strongly agreed that HIV and AIDS policies do exist in hospitals and 18 (32,7) agreed that HIV and AIDS policies do exist in hospitals and 06 (10.9%) disagreed that HIV and AIDS policies do exist in hospitals, 03 (5.5%) remain neutral and only 06(10,9%) disagreed that healthcare workers always report needle pricks injury with 02 (3.6%) strongly disagreed that HIV and AIDS policies do exist in hospitals. Looking at the nature of response, it can be concluded that 80 % agreed that HIV and AIDS policies do exist in hospitals.

Table 4.16 HIV policies are communicated to staff members at regularly basis

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 09 | 16,3% |
| 2 | Agree | 19 | 34,5% |
| 3 | Neutral | 09 | 16,3% |
| 4 | Disagree | 16 | 29,1% |
| 5 | Strongly disagree | 02 | 3,6% |
| | TOTAL | 55 | 100% |

Table 4.16 From analyzing the response provided during data collection process it can be deduced that 09(16.3) indicated that HIV policies are communicated to staff members at regularly basis, with 19(34,5) agreeing that HIV policies are communicated to staff members at regularly basis, with 09(16.3%) of respondent being neutral on whether HIV policies are communicated to sta members at a regular basis and 02(3,6%) disagreeing that HIV policies are communicated to staff members at a regular basis. 02 (3,6%) strongly disagreed that HIV policies are communicated to staffand AIDS policies. The conclusion is that 50,8% agreed that HIV polices are communicated to staff.

Table 4.17 Healthcare worker HIV support group is available in the hospital

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 10 | 18,2% |
| 2 | Agree | 14 | 25,5% |
| 3 | Neutral | 04 | 7,3% |
| 4 | Disagree | 22 | 40,0% |
| 5 | Strongly disagree | 05 | 9,1% |
| | TOTAL | 55 | 100% |

Table 4.17 highlight that 10 (18.2%) of Healthcare worker HIV support group is available in the hospital, From analyzing the response provided during data collection process it can be deduced that 14(25,5) of healthcare worker agreed that HIV support group is available in the hospital, with 04(7.3%) of respondent being neutral on whether healthcare worker HIV support group is available in the hospital. 22(40.0%) disagreeing that healthcare worker HIV support group is available in the hospital and 05 (9,1%) strongly disagreed that healthcare worker HIV support group is available in the hospital. The conclusion is that 49,1% disagreed that Healthcare worker HIV support group is available in the hospital.

Table 4.18 Policies to address stigma and lack of confidentiality related to HIV and AIDS are implemented in the hospital

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 05 | 9,1% |
| 2 | Agree | 12 | 21,8% |
| 3 | Neutral | 03 | 5,5% |
| 4 | Disagree | 14 | 25,5% |
| 5 | Strongly disagree | 21 | 38,2% |
| | TOTAL | 55 | 100% |

Table 4.18 the table indicates that 05 (9,1) of policies to address stigma and lack of confidentiality related to HIV and AIDS are implemented in the hospital, 12(21,8) indicates that policies to address stigma and lack of confidentiality related to HIV and AIDS are implemented in the hospital, with 03 (5,5%) of respondent being neutral on whether policies to address stigma and lack of confidentiality related to HIV and AIDS are implemented in the hospital. 14(25,5%) disagreeing that Healthcare worker HIV support group is available in the hospital and 21 (38,2%) strongly disagrees that of Healthcare worker HIV support group is available in the hospital. It can concluded that 63,7% disagrees that policies to address stigma and lack of confidentiality related to HIV and AIDS are implemented in the hospital.

Table 4.19 AIDS education can be integrated into the school curriculum from primary to university level

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 13 | 23,6% |
| 2 | Agree | 19 | 34,5% |
| 3 | Neutral | 08 | 14,5% |
| 4 | Disagree | 12 | 21,8% |
| 5 | Strongly disagree | 02 | 3,2% |
| | TOTAL | 55 | 100% |

Table 4.19 From analyzing the response provided in Table 4.19 during data collection process it is can be deduced that 13 (23,6) AIDS education can be integrated into the school curriculum from primary to university level, 19(34,5) indicates AIDS education can be integrated into the school curriculum from primary to university level, with 08 (14,5%) of respondent being neutral on whether AIDS education can be integrated into the school curriculum from primary to university level. 12(21,8%) disagreed that AIDS education can be integrated into the school curriculum from primary to university level and 03 (3,2%) strongly disagreed that AIDS education can be integrated into the school curriculum from primary to university level. The conclusion is that 58,1% agreed that AIDS education can be integrated into the school curriculum from primary to university level.

This section presents data collected through interviews. The survey will be presented in narrative form.

4.3.1 Question 1: What are the factors influencing healthcare worker's reluctance to Utilization of HIV and AIDS services by healthcare workers in their workplace?

Respondent 1

The respondent indicated that people do not utilize HIV and AIDS services because they fear knowing their status, and besides healthcare workers fear disclosure of their HIV status to fellow employees, the respondent

Table 4.20 Special HIV clinics for staff is run by HIV positive staff members

| | Response | Frequencies | Percentage |
|---|-------------------|-------------|------------|
| 1 | Strongly agree | 05 | 9,1% |
| 2 | Agree | 09 | 16,3% |
| 3 | Neutral | 03 | 5,5% |
| 4 | Disagree | 29 | 52,7% |
| 5 | Strongly disagree | 09 | 16,3% |
| | TOTAL | 55 | 100% |

Table 4.20 From analyzing the data presented in the table, one can deduce that 5 (9,1) strongly agreed that Special HIV clinics for staff is run by HIV positive staff members, 09(16,3) indicates that Special HIV clinics for staff is run by HIV positive staff members, with 03 (5,5%) of respondent being neutral on whether special HIV clinics for staff is run by HIV positive staff members. 29(52,7%) disagreed that special HIV clinics for staff is run by HIV positive staff members and 09 (16,3%) strongly disagreed that special HIV clinics for staff is run by HIV positive staff membe. The conclusion is that 69% of the respondents disagreed that special HIV clinics for staff is run by HIV positive staff members.

4.3 ANALYSIS OF DATA COLLECTED THROUGH INTERVIEW

This section presents data collected through interviews. The interview will be presented in narrative form.

4.3.1 Question 1: What are the factors influencing healthcare worker's reluctance to Utilization of HIV and AIDS services by healthcare workers in their workplace?

Respondent: 1

The respondent indicated that people do not utilize HIV and AIDS services because they fear knowing their status, and besides healthcare workers fear disclosure of the HIV status to fellow employees, the respondent

further indicated that some are afraid that they would be stigmatized if at work if people know their status. Some healthcare workers are worried about confidentiality.

Respondent: 2

With regard to this the respondent indicated that knowing that you are HIV positive will make me not to be able to plan ahead it so stressful and stigma is the most worrisome factor that still exist in hospitals.

Respondent: 3

'...I do not want other people to know that I am HIV positive because as a nurse I know measures to prevent HIV it will be like I preach what I do not practice'. The respondent further mentioned the problem of lack of confidentiality.

Respondent: 4

The respondent indicated that healthcare workers lack knowledge of policies of HIV that exist and lack knowledge that if they do not report needle stick injuries they may end up becoming sick. The respondent indicated fear of stigma by fellow employees.

Respondent: 5

Some nurses' gossip about fellow employees who are HIV positive as the respondent overheard nurses talking as one employee was passing and they were pointing at the direction of one of them. This prevents nurses from opening up as they fear being stigmatized. The respondent also pointed the issue of lack of confidentiality as a problem that causes people to refrain from seeking help.

4.3.2 Question 2: How would HIV and AIDS related morbidity and mortality be reduced amongst healthcare workers?

Respondent: 1

The hospital should practice HIV infection control and make people understand how to prevent HIV infection in the hospital, nurses and doctors must practice universal precautions including handling sharps with caution, and taking care when conducting invasive procedures.

Respondent: 2

The respondent indicated that it is important for the employers to provide awareness to employees and not regard them as people who know because they are the ones who take care of the others they need to be taken care of too.

Respondent: 3 Upon exposure to blood and patient's body fluids and needle pricks doctors and nurses are supposed to report to be able to be given post exposure prophylaxis because if they don't they may have contracted HIV which one may not know that it was contracted at work and it may even cause conflicts at home.

Respondent: 4

The respondent acknowledges that some healthcare workers are dying due to HIV but if they would take Anti-retroviral treatment they would survive and live longer. Healthcare workers who are HIV positive should take care of their health and eat a well-balanced diet and they should engage in preventive practices to help reduce HIV morbidity.

Respondent: 5

Healthcare workers are supposed to seek HIV counselling and testing and they should know their status to be able to access treatment before they could complicate and die. It is time that healthcare workers realize that HIV is like any other disease and seek treatment and live a healthy long life.

4.3.3 Question 3: What strategies can be used to address reluctance to utilize HIV and AIDS services?

Respondent: 1

In response to this the respondent emphasized that there should be regular staff training and storytelling for increased knowledge, Healthcare workers who are HIV positive must be encouraged to form healthcare worker support group. The respondent further explained that HIV policies need to be communicated to all employees at regular intervals even during inductions and orientation.

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Respondent: 2

Employees lack motivation to test as such they need to be motivated by employers who will take the lead to the testing room. Not every employee knows about the policies and policies to address stigma must be developed and communicated regularly.

Respondent: 3

The respondent indicated that policies related to HIV must be communicated to staff members at regular intervals; healthcare workers must be encouraged to form healthcare worker support groups and services for healthcare workers must be integrated there should not be a separate clinic.

Respondent: 4

Commented that HIV healthcare worker support group should be formed to assist each other and share challenges and information. Healthcare workers need workshops on HIV and be made aware of the statistic of those who died due to HIV and AIDS related diseases.

Respondent: 5 states that

Healthcare worker awareness campaigns and education need to be done and not consider them to know as they are dying due to HIV related diseases. There is a need to empower healthcare workers on HIV related issues. Confidentiality policies need to be developed and communicated to all employees and appropriate steps should be taken to those who divulge other people's medical information without their consent.

4.4 CONCLUSION

In this chapter, data obtained from the respondents was presented, analysed and interpreted. The respondents highlighted the issue of stigma, fear of knowing the HIV status, concerns about the risk of getting infected and to a certain extent lack of confidentiality was mentioned as major factors that influence healthcare worker's reluctance to utilization of HIV services. The next chapter presents discussions of findings, recommendations for the study and recommendation for further research studies and recommendation.

CHAPTER 5 SYNTHESIS, FINDINGS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

This chapter concludes the study by drawing conclusions about the major findings of the study regarding the factors influencing healthcare worker's reluctance to utilizing HIV and AIDS services in their workplace, how HIV and AIDS related morbidity and mortality be reduced amongst healthcare workers, and strategies that can be used to address reluctance to utilization of HIV and AIDS services, The recommendations of the study relating to factors influencing healthcare worker's reluctance to utilizing HIV and AIDS services in their workplace, how HIV and AIDS related morbidity and mortality be reduced amongst healthcare workers, and strategies that can be used to address reluctance to utilization of HIV and AIDS services, the recommendations for future studies and the conclusions.

5.2 MAJOR FINDINGS OF THE STUDY

This section describes the Major findings on the factors influencing healthcare worker's reluctance to utilization of HIV and AIDS services by healthcare workers in their workplace, Major findings on how HIV and AIDS related morbidity and mortality be reduced amongst healthcare worker's, Major findings on the strategies that can be used to address reluctance to utilize HIV and AIDS services.

5.2.1 Major findings on the factors influencing healthcare worker's reluctance to utilization of HIV and AIDS services by healthcare workers in their workplace

The findings of this study clearly indicate that HIV and AIDS counseling is provided for healthcare workers as 90,9% indicated in the responses but even though the healthcare workers are provided with HIV counseling they do not utilize the service provided for them. Some respondent were concerned about the risk of becoming HIV infected as 81,8% indicated that the nature of work where they are exposed to blood and body fluids, including needle pricks is worrisome and make them to be concerned. 74,5% indicated that they are afraid to test for HIV for fear of positive results, However even though 60% indicated that stigma is still a challenge in hospitals 52,7% indicated that there is confidentiality regarding HIV and AIDS in hospitals. Finally fear, stigma, and concern about the risk of getting infected were identified as major findings.

5.2.2 Major findings on how HIV and AIDS related morbidity and mortality be reduced amongst healthcare worker's

The respondents acknowledge that healthcare workers die from HIV and AIDS related diseases and as such 78,2% had agreed to that furthermore 72,8% respondents had agreed that those healthcare workers who are HIV positive are encouraged to attend HIV clinic within their workplace even though they do not attend. further 72,8% agree that HIV preventive practices help reduce HIV infections and that 65,4% agree that the use of Antiretroviral treatment reduce the untimely deaths by HIV infected patients, Most striking is the fact that some healthcare workers do report needle pricks when also a small number of respondent do not report needle pricks this is also a cause for concern that we still find healthcare workers who do not report needleprick injuries so that proper steps can be taken to prevent exposure to infections.

5.2.2 Major findings on the strategies that can be used to address reluctance to utilize HIV and AIDS services

About 80% of the respondents agreed that HIV and AIDS policies do exist in the workplace the challenge is that those policies are not regularly communicated with staff as some staff disagreed that such policies exist. The respondents further revealed that there is no healthcare worker HIV support group in their hospital this is supported by about 49,1% of the respondents. Regarding policies to address stigma and lack of confidentiality related to HIV 63,7% disagrees that policies to address stigma and lack of confidentiality related to HIV and AIDS are implemented in the hospital some respondents were not aware of these policies though about 47,3% were aware of such policies and 58,1% emphasized that that AIDS education should be intergrated into the school curriculum from primary to University. There was a strong objection of 69% that HIV clinic for staff are run by HIV positive staff most respondents indicated that this will encourage stigma.

5.3 RECOMMENDATIONS OF THE STUDY

This section describes recommendations of the study Recommendations on factors influencing healthcare worker's reluctance to utilization of HIV and AIDS services by healthcare workers in their workplace, Recommendations on how HIV and AIDS related morbidity and mortality reduced amongst healthcare workers, Recommendations on the strategies that can be used to address reluctance to utilize HIV and AIDS services

5.3.1 Recommendations on factors influencing healthcare worker's reluctance to utilization of HIV and AIDS services by healthcare workers in their workplace

The institution should enforce confidentiality in hospitals though a certain percentage indicated that there is confidentiality we still have those who deny that there is confidentiality, The HIV education should intergrate a change from fear to caring for people living with HIV. To combat stigma in the health setting intervention must focus on individual level, environmental level, and policy level through conducting awareness campaigns, Showing the negative consequences of stigma, such as people refusing to disclose and unwillingness to seek HIV counseling and testing and ensure that healthcare worker's fears and misconceptions are addressed. Healthcare workers should be provided with supplies and equipment to be able to practice universal precautions and constant monitoring of whether those universal precautions are adhered to should be done. Policies to address stigma should be developed in a participatory manner and be clearly communicated to everybody in the institution, the role they are suppose to play as role models, testimony giving as lived experiences, and allow them to co-fascilitate.

5.3.2 Recommendations on how HIV and AIDS related morbidity and mortality reduced amongst healthcare workers

Healthcare workers should be given regular workshops indicating also incidences where needle prick injuries had led to healthcare workers having infected and emphasize the importannce of reporting needle prick injuries. The needle stick policy should be communicated to employees and employees are to be shown the benefit of reporting needle prick injuries. Encourage and monitor infection control practices such as the use of protective equipment and clothing. Introduction of mobile phone messaging aplications such as short message srvices(SMS) and the use of multimedia messages(MMS) may be an effective way of reminding healthcare workers on medications or providing them with support messages and the use of voice messages to improve adherence to treatment and reduce risky behaviours.

5.3.3 Recommendations on the strategies that can be used to address reluctance to utilize HIV and AIDS services

Recommendation involves empowering the stigmatized group like people living with HIV and AIDS and involving them in the design and implementation of the HIV programmes in the hospital. The institution should form an HIV and AIDS monitoring and evaluation committee to develop a monitoring and evaluation programmes and address challenges healthcare workers face and also to assess the implementation of

policies, and compliance to those policies. Healthcare worker support group should be formed where infected healthcare worker can have an avenue for discussion, reflections and empower each other, this will assist healthcare workers realize that they belong.

5.4 RECOMMENDATIONS FOR FUTURE STUDIES

The study was conducted at Donald Fraser Hospital there is a need that similar studies be conducted at other institutions. The researcher should also establish by gender which ones are more reluctant to utilize HIV services than the others.

5.5 CONCLUSION

This research highlights the background of the study, problem statement, aim of the study, objectives of the study, research questions, significance of the study, delimitations of the study, limitations of the study, definitions of operational concepts, and the organisation of the study.

highlighted the literature regarding Factors influencing Healthcare worker's reluctance to utilization of HIV and AIDS services within their workplace. The discussion included, introduction, legislative framework on matters concerning HIV, factors related to reluctance to utilization of HIV services such as fear, stigma and lack of confidentiality, healthcare worker's utilization of HIV and AIDS services, HIV and AIDS related morbidity and mortality in the Sub Saharan countries, South Africa, and in Limpopo, the impact of HIV and AIDS in the workplace, reducing HIV and AIDS related morbidity and mortality, strategies to overcome challenges in utilizing HIV and AIDS services, framework, theoretical and the conclusion.

The researcher presented the design and methodology followed when conducting the study. This chapter outlined the research design which is descriptive, research methodology which is both qualitative and quantitative research methodology, the study area, study population, sampling method, data obtained from the respondents was presented, analysed and interpreted. This chapter discussed the major findings of the study which could be summarised as major findings of the factors influencing influencing healthcare workers reluctance to utilization of HIV services, reducing HIV related morbidity and mortality, and on strategies to address the challenges of utilization of hiv services, The study further discussed the recommendations of the study and the recommendation for futre studies.

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SCHOOL OF MANAGEMENT SCIENCES
OFFICE OF THE DEAN

7 May 2014

The District Executive Manager
Department of Health
VHEMBE DISTRICT MUNICIPALITY

Dear Sir/Madam

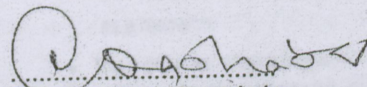
REQUEST FOR PERMISSION TO COLLECT INFORMATION FOR STUDIES (MASTER OF PUBLIC MANAGEMENT: RAMATHIKHITHI M.E (STUDENT NO.: 9813397).

The above matter refers.

We hereby wish to confirm that Ramathikhithi M.E is a registered Master of Public Management student at the University of Venda. She is researching on the following topic: "Factors influencing Healthcare Workers reluctance to utilization of HIV and AIDS services within their workplace. A case of Donald Fraser Hospital".

In order for her to complete her studies, we request your hospital to provide her with the information that she might need for her study project. As an institution of higher learning, we believe that the research she is undertaking will yield the results that might also assist your hospital. We for this reason encourage your hospital to provide her with the necessary information that will be collected through structured questionnaire and interviews from your department. We undertake that whatever information will be provided to her will be solely used for her studies.

We hope that you will find this to be in order and therefore, anticipate your assistance.



Professor M.P. Khwashaba
Deputy Dean: School of Management Sciences



University of Venda

SCHOOL OF MANAGEMENT SCIENCES
PRIVATE BAG 3505, THOHYANOHU, 0950.
LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE 015 962 8707 / 015 962 8869 / 015 962 8706
FAX 015 962 4749



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shami a

Ref:4/2/2

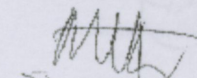
Ramathikhithi ME
University of Venda
Private Bag X5050
Tlohooyando
0950

Greetings,

Re: Factors influencing Health Care Worker's reluctance to utilization of HIV and AIDS services within their workplace : A case of Donald Fraser Hospital

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
 - Further arrangement should be made with the targeted institutions.
 - In the course of your study there should be no action that disrupts the services.
 - After completion of the study, a copy should be submitted to the Department to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.



Head of Department

13/06/2014
Date

18 Collage Street, Polokwane 0700 Private Bag x9302, POLOKWANE, 0700
Tel: (015) 203 6300, Fax: (015) 203 6211 Website: <http://www.limpopo.gov.za>

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PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH: VHEMBE DISTRICT

Enquiries: Makhwanya T E

Contact details: 084 890 0806 or Makhwanyate@gmail.com or fax no 086 266 2117

Date: 23rd June 2014.

To: CEO

Donald Frazer Hospital

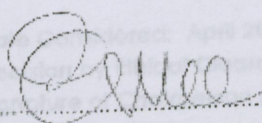
P O VHUFULI

RE: APPROVAL TO CONDUCT THE STUDY: RAMATHIKHITHI M E.

This is to confirm that the above-mentioned student has been accepted by the District to conduct the research study as approved by both the Ethics Committee of the University and the Department of Health (See attached approvals).

Your hospital is hereby requested to give her the necessary support as the study is likely to benefit profoundly the District in terms of service delivery.

Thanking you in advance for your support.


.....
ACTING-DISTRICT EXECUTIVE MANAGER

23/6/2014
.....
DATE



RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms ME Ramathikhithi

Student No: 9813397

PROJECT TITLE: Factors Influencing Health Care
Workers Reluctance to Utilization of HIV and AIDS
Services Within their Workplace: A Case of
Donald Fraser Hospital

PROJECT NO: SMS/14/PDN/08/2803

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

| NAME | INSTITUTION & DEPARTMENT | ROLE |
|---------------------|--------------------------|------------------------|
| Prof MP Khwashaba | University of Venda | Supervisor |
| Mr E Mahole | University of Venda | Co-supervisor |
| Ms ME Ramathikhithi | University of Venda | Investigator - Student |

ISSUED BY:

UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: April 2014

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee:

Name of the Chairperson of the Committee: Prof. G.E. Ekasse



University of Venda

PRIVATE BAG X3050, TLOKOVANDOU 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 967 850/8464 /8313 FAX (015) 962 8459

"A quality driven financially sustainable, rural-based Comprehensive University"

Annexure :E Letter for consent

Annexure: F Questionnaire

FACTORS INFLUENCING HEALTH CARE WORKER'S RELUCTANCE TO UTILIZATION OF HIV AND AIDS SERVICES WITHIN THEIR WORKPLACE: A CASE OF DONALD FRASER HOSPITAL

P.O. Box 2121

Thohoyandou

0950

15-05-2014

Instructions

Read the instructions carefully before you answer any questions. There will be multiple choices. Answer all questions and use a cross (X) when you select an answer in a box. Use a black pen to select your response.

SECTION A PERSONAL PARTICULARS

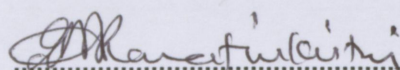
Dear Sir/ Madam

I, Mushaisano Eunice Ramathikhithi, am a registered student at the University of Venda doing Masters of Public Management and I am conducting a research on ' **FACTORS INFLUENCING HEALTHCARE WORKER'S RELUCTANCE TO UTILIZATION OF HIV AND AIDS SERVICES WITHIN THEIR WORKPLACE: A CASE OF DONALD FRASER HOSPITAL** '

This is an opportunity for you as a participant to be part of the study.

Thanking in anticipation

Yours faithfully

.....

Mrs Mushaisano Eunice Ramathikhithi

Student Number: 9813397

Cell Number: 0836622912

4 Occupation of respondents

| | |
|----------------------------|--|
| Doctor | |
| Professional Nurse | |
| Assistant manager | |
| Operational manager | |
| Enrolled Nurse | |
| Enrolled Nursing Assistant | |

SECTION B: FACTORS INFLUENCING HEALTH CARE WORKER'S RELUCTANCE TO UTILIZATION OF HIV AND AIDS SERVICES WITHIN THEIR WORKPLACE.

Annexure: F Questionnaire

FACTORS INFLUENCING HEALTH CARE WORKER'S RELUCTANCE TO UTILIZATION OF HIV AND AIDS SERVICES WITHIN THEIR WORKPLACE: A CASE OF DONALD FRASER HOSPITAL

Instructions

Read the instructions carefully before you answer any questions. The questions will be multiple choices. Answer all questions and use a cross (x) when you select an answer in a box .Use a black pen to select your response.

SECTION A: PERSONAL PARTICULARS

1 Gender of respondents

| | |
|--------|--|
| Male | |
| Female | |

2 Age of respondent

| | |
|--------------|--|
| 20-30 | |
| 31-40 | |
| 41-50 | |
| 50 and above | |

3 Marital Status of respondents

| | |
|----------|--|
| Single | |
| Married | |
| Divorced | |
| Widowed | |

4 Occupation of respondents

| | |
|----------------------------|--|
| Doctor | |
| Professional Nurse | |
| Assistant manager | |
| Operational manager | |
| Enrolled Nurse | |
| Enrolled Nursing Assistant | |

SECTION B: FACTORS INFLUENCING HEALTH CARE WORKER'S RELUCTANCE TO UTILIZATION OF HIV AND AIDS SERVICES WITHIN THEIR WORKPLACE.

Instructions

Read the instructions carefully before you answer any questions. The questions will be multiple choices. Answer all questions and use a cross (x) when you select an answer in a box. Use a black pen to select your response.

| | factors influencing reluctance in seeking HIV and AIDS services | Strongly agree | Agree | Neutral | Disagree | Strongly disagree |
|---|---|----------------|-------|---------|----------|-------------------|
| 5 | HIV counseling and testing is provided for healthcare workers at own hospital | | | | | |
| 6 | Healthcare workers are concerned about the risk of becoming infected at work | | | | | |
| 7 | Healthcare workers are afraid to test for HIV for fear of positive result | | | | | |
| 8 | Healthcare workers utilize HIV testing and counseling services at other hospitals either than own hospital for fear of stigma | | | | | |
| 9 | There is confidentiality regarding HIV in hospitals | | | | | |

| | Reducing healthcare workers HIV and AIDS morbidity and mortality | Strongly agree | Agree | Neutral | Disagree | Strongly disagree |
|----|---|----------------|-------|---------|----------|-------------------|
| 10 | Healthcare workers do die from HIV and AIDS related diseases | | | | | |
| 11 | Healthcare workers who are HIV positive must be encouraged to attend HIV and AIDS services in their workplace | | | | | |
| 12 | HIV/AIDS preventive practices helps to reduce HIV infections | | | | | |
| 13 | Antiretroviral treatment reduce untimely deaths by HIV patients | | | | | |
| 14 | healthcare workers report needle pricks injury always | | | | | |

| | Strategies to address challenges related to reluctance to utilize HIV services. | Strongly agree | Agree | Neutral | Disagree | Strongly disagree |
|----|---|----------------|-------|---------|----------|-------------------|
| 15 | HIV policies do exist in hospital | | | | | |
| 16 | HIV policies are communicated to staff members at regular basis | | | | | |
| 17 | Healthcare worker HIV support group is available in hospital | | | | | |
| 18 | Polices to address stigma and lack of confidentiality related to HIV and AIDS are implemented at hospital | | | | | |
| 19 | AIDS education can be integrated into the school curriculum from primary to university | | | | | |
| 20 | Special HIV clinics for staff is run by HIV positive staff members | | | | | |

THANK YOU FOR PARTICIPATING

3. What strategies can be used to address reluctance to utilize HIV and AIDS services?

THANK YOU FOR PARTICIPATING

Annexure G: OPEN ENDED INTERVIEW GUIDE

1. What are the factors influencing healthcare worker's reluctance to utilization of HIV and AIDS services by health care workers in their workplace?

.....

.....

.....

.....

2. How would HIV and AIDS related morbidity and mortality be reduced amongst health care workers?

.....

.....

.....

.....

3. What strategies can be used to address reluctance to utilize HIV and AIDS services?

.....

.....

.....

.....

THANK YOU FOR PARTICIPATING