

Health workers' participation in voluntary counselling and testing in three districts of Mashonaland East Province, Zimbabwe

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Abstract

Objectives: To determine the proportion of health workers who had undergone VCT for HIV in three districts of Mashonaland East Province and to further explore reasons for non-participation in those who had not been tested.

Settings: The study was conducted in the rural Districts of Murewa, Mutoko and Mudzi in Mashonaland East province.

Design: The study was a descriptive cross sectional survey.

Subjects: All categories of health workers in Murewa, Mutoko and Mudzi.

Main Outcome Measures: Participation in VCT, and reason for non-participation.

Results: Out of 200 questionnaires sent out 183 (91.5%) were completed and returned. The majority of the respondents were nurses 142 (77.6%), female 113 (61.7%), married 135 (73.8%). The median age was 33 (Q1: 28; Q3: 38) and they had attained a high school education 137 (74.9%). Of the respondents 160 (87.4%) had not gone for VCT; 141 (77%) did not want to have an HIV test. The reasons for not being willing to have an HIV test included not being ready to go for VCT 154 (84.2%); could not cope with the results, 143 (78.1%), do not have the courage to go 133 (72.7%); no need for testing as there is no cure for HIV/AIDS 106 (57.9%). One hundred and twenty six (69%) indicated that they needed counselling for them to be able to go for VCT.

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Conclusion: HIV/AIDS programmes have been directed at the community at large neglecting the health worker. This study, therefore, recommends programmes specifically tailor-made for health workers. These programmes should have a strong counselling component and should focus on self-efficacy so that health workers can finally be ready, be able to cope with HIV results and have the courage to participate in VCT.

Introduction

Zimbabwe is one of the countries with the highest prevalence of HIV infection south of the Sahara. It has been estimated that among pregnant women attending antenatal clinics the prevalence rate ranges from 30 to 40%. The Minister of Health has announced that about 2 000 people are dying with AIDS-related conditions every week.¹

One of the strategies of addressing the HIV pandemic is behavioural change. VCT is an important intervention in motivating those who test sero-negative to maintain their status and those who are positive to adjust their life styles.

Health workers are key informants of the community. Significant gains in improving the quality of life of the community have been achieved through the various contributions of health workers. In Zimbabwe HIV/AIDS is now threatening those gains.

The national response to the pandemic includes intensifying HIV/AIDS awareness, offering counselling for the infected and affected and establishing VCT centres across Zimbabwe. The Population Services International (PSI) has reported that there are nine New Start Centres established country wide.² More centres will be established as the programme expands.

VCTs are being advocated as a way of increasing behaviour change and promoting responsible behaviour. Moses indicated that the Ministry of Health and Child Welfare in collaboration with the Population Services International and USAID has implemented some VCT centres (in major towns) distinguished by a common logo 'NEW START CENTRES'.³ As yet there are no VCT centres in the rural communities.

In VCT programmes, health workers are playing both an informative and counselling role. However, for the community to participate in the VCT, health workers as social models have to take a leading role by participating in voluntary HIV testing, as this has a motivating effect on behaviour change of not only health workers but also the community.

If communities have to be motivated to participate in VCT, health workers have to be motivated themselves so that they can motivate the community. If communities are expected to change their behaviour health workers as role models should be seen to be changing their behaviour. For health workers to be effective in giving information in HIV prevention programmes and counselling they need to have first hand experience of how it feels to go through a voluntary HIV counselling and testing process.

To date there is insufficient data in Zimbabwe that shows the participation of health workers in VCTs. We therefore conducted a survey in three rural districts among health workers to explore their views on participation in VCT.

We sought to determine the proportion of health workers who had participated in VCT undergoing testing for HIV, to establish reasons for non-participation in VCT and their views of what would improve their participation in VCT.

Materials and Methods

Settings.

The study was conducted in Murewa, Mutoko and Mudzi Districts. These are rural districts in Mashonaland East province of Zimbabwe. There were 55 health facilities, comprising 46 Rural Health Centres (RHC), two rural hospitals, four Mission Hospitals and three district hospitals. The health staff in these facilities included eight medical doctors, 214 nurses, 32 environmental health technicians and 21 allied health workers.

Ethical Issues.

Authority to conduct the survey was obtained from the Provincial Medical Director, Mashonaland East province. The respondents were assured that their responses would be kept confidential and that it would be impossible to identify individuals once the data had been combined.

Study Population.

Doctors, nurses, environmental health technicians, rehabilitation technicians, pharmacy technicians, laboratory technicians and radiographers formed the study population for the study.

Sampling Procedure.

A convenience sample of 200 was selected for the administration of the questionnaire. Health workers were identified using the District Staff Return forms. Names were assigned numbers and then a sample of 200 was randomly selected using a table of random numbers.

Data Collection.

A self-administering questionnaire was used for data collection.

The self-administering questionnaire was distributed to health workers and then collected after one week.

Collected data were entered into the computer using the Epi info 6 statistics package. Data are presented in tables and figures. Statistical computation was done (subjecting data to measures of central tendencies and dispersion) to aid summarizing, describing and interpreting of findings.

Results

Out of 200 randomly selected respondents, 183 (91.5%) successfully complied and fully completed the self-administering questionnaire.

The demographic profile of the respondents is presented in Table I.

Table I: Demographic data (N =183).

Variable	Frequency	Percentage
Doctors	2	1.1
Nurses	142	77.6
Environmental Health Technicians	28	15.3
Pharmacy Technicians	4	2.2
Rehabilitation Technicians	4	2.2
Radiographers	1	0.5
Laboratory Technicians	2	1.1
Age (years)		
19-29	59	32.3
30-39	95	51.9
40+	29	15.8
Median age 33 (Q1: 28: Q3: 38)		
Sex		
Males	70	38.3
Females	113	61.7
Marital Status		
Married	135	73.8
Single	38	20.8
Widow	6	3.3
Divorced	4	2.2
*Level of Education		
Form two	26	14.2
Form four	137	74.9
Form six	20	10.9
Religion		
Denominational Christian	112	61.2
Pentecostal Christian	43	23.5
Traditional	28	15.3

*In years of secondary school education.

The majority of the respondents were nurses 142 (77.6%). Only 23 (12.6%) of respondents had undergone testing for HIV. Of those who had not been tested, 141 (77%) did not want to go for VCT.

In Table II we show the reasons given by respondents for refraining from VCT.

Table II: Reasons for refraining from VCT (N=183).

Reason	Frequency	Percentage
Not prepared for positive result	154	84.2
Have no courage to go	133	72.7
Would not cope with positive result	143	78.1
There is no cure	106	57.9
Would be miserable	89	48.6
Would harm themselves or partner	140	70

The majority 154 (84.2%) stated that they were not yet ready to go for VCT. However, a significant number indicated that they would not cope with the results 143 (78.1%) and 133 (72.7%) do not have the courage to go. More than half, 106 (57.9%) stated that they would not go because there is no cure for HIV/AIDS. On their response to a positive result, the majority 140 (70%) indicated that they would harm themselves or their partner.

In order to be motivated to go for VCT, Health workers reported the following needs shown in Table III.

Table III: Needs of health workers (N=183).

Needs	Frequency	Percentage
Information	75	41
Counselling	138	75
Facilities	66	36
Nothing	68	37

As shown in Table III, the majority of health workers 138 (75%) indicated that they needed counselling before they could go for VCT.

Discussion

From the research findings, policy makers, programme planners and programme implementers have created a neglected species (the health worker). Efforts in all HIV/AIDS programmes have been directed to the community at large, neglecting the health worker.

From the study it was noted that 160 (87.4%) had not participated in VCT and 141 (77%) did not want to participate. This is an indication that the health workers may be holding negative attitudes towards the VCT programme. The non-participation by the majority may have negative effects on them motivating the rural community at large to also participate in VCT.

Coovadia observed that in developing countries VCT is difficult in many respects.⁴ The medical services are often unavailable, support is absent, availability of VCT is restricted and there are few trained counsellors whose workloads are heavy.

The possible factors that may have contributed towards the non-participation of health workers in VCT could have been the unavailability of VCT centres in the rural areas combined with the other factors highlighted by Coovadia.⁴

This study sought to establish what health workers say about their non-participation in VCT. When these reasons are known, then appropriate interventions will be advocated to address their anxieties and concerns.

Since health workers are social models, their non-participation also negatively affects efforts being made to promote behaviour change through VCT. Many people consult health workers in many of their decisions. Given this scenario where the majority of health workers are not participating in VCT, the community members who seek guidance in VCT, are likely to be negatively influenced.

Making the decision to go for VCT may be influenced by:

1. Suspecting that one is infected by HIV.
2. The feeling that to know one's status would give one control over one's life and help plan for the future.
3. The thinking that a positive result would be harder to deal with emotionally and practically.
4. The consideration of the impact of the result on one's relationship.

Moses indicated that VCT was being advocated as it has as one of its advantages 'promotion of behaviour change through counselling'.³ Now that the majority of health workers are not participating, they are not likely to benefit from this stated advantage. (Hence they may not change their behaviour and may not influence the behaviour change of the community).

To support this assertion, Wilkinson observed that 93% of women who attended *antenatal* clinics in Northern Kwazulu Natal reported a high level of acceptance with regards to VCT in prenatal clinics.⁵ However, in the same study only seven (10%) women had had an HIV test. For these willing women to participate and benefit from the VCT, it takes the motivation of health workers.

To demonstrate the important role that health workers play in motivation of the community, Fernandez *et al.* noted that acceptance of testing during prenatal care was related to strong beliefs about benefits of testing, knowledge about vertical transmission, perceived provider endorsement of testing and social support.⁶ Other reasons for not accepting testing were noted as administrative difficulties with some aspects of the testing process (scheduling, limited number of counsellors).

All the above factors are the health worker's responsibility. If the health worker is not motivated, then giving of information will be biased towards his or her beliefs and his or her endorsement. Mothers depending on this information will therefore have their decisions affected.

An anonymous author in the *Lancet* 2000⁷ indicated that VCT was efficacious in promoting behaviour change. It is reported that the proportion of individuals reporting unprotected intercourse with non-primary partners declined significantly more for those receiving VCT than for those receiving health information (men, 35% reduction with VCT vs 13% reduction with health information; women, 39% reduction with VCT vs 17% reduction with health information).

From this study one can conclude that when health workers do not participate in VCT, behaviour change among them and the community cannot be significantly achieved.

The main reasons given for non-participation included; not yet ready, 84%; not able to cope with results 78.1% and not having the courage to go, 72.7%.

From these findings, one reflects on the Transtheoretical Stages of Change Model.⁸ It is indicative that the majority of health workers are still in the pre-contemplation stage. Their reasons show that (by them not being ready, and not being able to cope with results and not having the courage) at this juncture of the epidemic, there is no intention to change behaviour in the foreseeable future. These reasons further indicate that there is generally low self-efficacy among health workers.

Killewo *et al.* observed that in their study on acceptability of voluntary HIV testing with counselling in a rural village in Tanzania, 55.9% of those who volunteered to be tested wanted to know their HIV status.⁹ Those who did not

volunteer, stated that they felt unlikely to catch AIDS. In the same study a significant proportion were willing to volunteer and also come back for the results.

From the study the main reason for not volunteering was a perception of being at low risk. However, this was not so with the health workers. They all did not give as a reason that they could not participate because they were not at risk of getting HIV. This shows some of the variations in risk perception between community and professionals. Most of the reasons that health workers gave all had to do with fear of handling a positive result.

Since the majority of health workers indicated that they needed counselling for them to be able to participate in VCT, a few challenges need to be highlighted.

The health workers themselves offer counselling for HIV. Is it that they have so far been doubting the effectiveness of their own counselling (hence their non-participation) or they have been doubting the credibility of those who offer counselling in their institutions?

It is unfortunate that these challenges were not the focus of this study. But as the health workers indicate that they need counselling, it is important to find out from them who they think should counsel them.

In a review of 50 documents on the impact of counselling on behaviour change, Higgins *et al.* observed that through counselling there was a greater reduction of risk behaviour among counselled sero-positives than sero-negatives and among discordant couples.

Allen *et al.* noted that there was an increase in condom use among women whose partners were counselled.¹¹ The same study showed that for women whose partners were tested and counselled, the annual incidence of new HIV infections decreased from 4.1% to 1.8%. There was also a decrease in the prevalence of gonorrhoea among the HIV positive women from 13% to 6%.

The Aids Support Organization (TASO) (1995) showed that counselling appeared to help their clients cope with their HIV infection. At least 90% had disclosed their sero status to another person and 85.3% had told their partners. Counselling helped not only individuals but also the community; 79% of families and 76% of community groups showed acceptance of HIV positive people.

In their comment, Carballo and Miller indicated that counselling seeks to encourage self-determination, enhance self-confidence, improve family and community relationships.¹³ These relationships offer support to the infected and affected and also act as pillars for the maintenance of new behaviours.

WHO¹⁴ indicated that counselling has several advantages that include:

- Helping people solve their problems arising from HIV/AIDS.
- Enabling people to share information, correct myths and misconceptions and facilitate behaviour change.
- Helping people to deal with social stigmatization, isolation and rejection.

— Offering the care and support that people need in accepting their situations and assisting them in carrying on with their responsibilities.

To help the community and health workers, WHO advocated that counselling should be an integral part of the health delivery system and should be readily available and accessible.¹⁴

Recommendations

From the research findings, policy makers, programme planners and programme implementers have created a neglected species (the health worker). Efforts in all HIV/AIDS programmes have been directed to the community at large, neglecting the health worker. This study, therefore, recommends programmes specifically tailor-made for health workers. These programmes should have a strong counselling component and should focus on self-efficacy so that health workers can finally be ready, be able to cope with HIV results and have the courage to participate in VCT.

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References

1. Ministry of Health and Child Welfare. Report on STI/HIV/AIDS, Harare, Zimbabwe. 2001.
2. Population Services International Report on New Start Centre. Harare, Zimbabwe 1999.
3. Moses P. STI/HIV/AIDS and TB report. Harare, Ministry of Health and Child Welfare. 2000.
4. Coovadia HM. Access to voluntary counselling and testing for HIV in developing countries. *Ann N Y Academy of Science* 2000 Nov; 918:57-63.
5. Wilkinson D, Wilkinson N. Acceptability of prenatal voluntary HIV counselling and testing and interventions to reduce mother to child transmission of HIV infection in rural Africa. *S Afr Med J* 2001 Jan;91(1):48-9.
6. Fernandez MI, Wilson TE, Ethier EB, Gay CL, Moore J. Acceptance of HIV testing during prenatal care; peri-natal guidelines evaluation project. *Public Health Report* 2000 Sep-Oct;115(5):460-8.
7. Anonymous. *Lancet* 2000 Jul;356(9224):103-12.
8. Green LW, Krueger MW. Health promotion planning: an environmental approach. 2nd ed. Toronto: Mayfield Publishing Company, 1991:156.
9. Killewo JZ, Kwasigabo G, Comoro C, Lugalla J, Mhalu FS, Biberfeld G, *et al.* Acceptability of voluntary HIV testing with counselling in a rural village in Kagera Tanzania. *AIDS Care* 1998 Aug;10(4):431-9.

10. Higgins DL, Galavotti C, O'Reilly KR, Schnell DJ, Moore M, Rugg DL, *et al.* Evidence for the effect of HIV antibody counselling and testing on the risk behavior. *JAMA* 1991 Nov 6;266(17):2419-29.
11. Allen S, Tice J, Van de Perre P, Serufilira A, Hudes E, Nşengumuremyi F, *et al.* Effects of serotesting with counselling on condom use and seroconversion among HIV discordant couples in Africa. *BMJ* 1992 Jun 20;304(6842):1605-9.
12. The AIDS Support Organization. Caring is sharing. *World Aids Day Newsletter* 1995;(2):12.
13. Carballo M, Miller D. HIV counselling: problems and opportunities in defining the new agenda for the 1990s. *AIDS Care* 1989;1(20):117-23.
14. World Health Organization. Brief technical report on AIDS. Geneva: WHO Information Office, 1988.