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A Situational Assessment of a Workplace Voluntary Counselling and Testing (VCT) and HIV/AIDS Treatment Programme in the Mining Sector:

A Case Study

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Declaration

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Masters in Health Promotion in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

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Abstract

Introduction: Globally, over forty million adults are infected with the Human Immunodeficiency Virus (HIV), with twenty-five million people having already died of Acquired Immunodeficiency Syndrome (AIDS) worldwide by 2007. To date, approximately twenty-eight million members of the labour force have been lost to AIDS. In terms of the settings approach to Health Promotion, the workplace presents as one of the most effective and significant settings in which to respond to the epidemic. This study formed part of The Workplace VCT/Treatment Uptake Project (WVUP), which is a longitudinal study located in a company in the South African mining sector. The broad aim of the WVUP was to provide new knowledge on the reasons for low and slow uptake of VCT and treatment services in workplace settings and to implement and evaluate interventions to improve uptake of these services. The specific aim of this phase of the study (a Situational Assessment) was to unravel the contextual influences on VCT and treatment participation rates at the selected site, as a precursor to succeeding phases of the WVUP.

Method: This Situational Assessment comprised of an archival documentary analysis (aimed at developing a historical perspective of the company's HIV/AIDS program) and interviews and focus groups with key organisational stakeholders (aimed at a contextual assessment of the program). A qualitative approach was used for this study, as it provided an in-depth and detailed understanding of the organizational and personal experiences, incidences and occurrences that make up the contextual milieu for the VCT and HIV/AIDS treatment services at the study site. Fourteen individual interviews were conducted with key stakeholders, followed by eight focus group interviews with these constituencies. Data was collected using audiotapes and were

transcribed verbatim. A quality assurance check was conducted with random sections of the tape compared against the transcripts. A list of themes across all interviews and data was developed and then reduced and coded using Nvivo7, a qualitative data-management software programme. This tool enabled the researcher to store and code the data and search the data thematically. The results of the study were interpreted through the lens of two theoretical frameworks, viz., the Precede-Proceed model and the Elaboration Likelihood Model.

Results and Conclusions: The discussion of results incorporated the findings from the archival audit and documentary analysis as well as the various factors that emerged from the key stakeholder and focus group interviews. Even though the mine had high VCT uptake rates, significant concerns were apparent with regard to the VCT and treatment programmes. Some of these concerns centered around the levels of support from mine management and Head Office, support of employees for the HIV/AIDS programme, relational challenges with the union, confidentiality issues, treatment and treatment adherence issues, environmental influences, spousal VCT uptake, race, culture and sexism, and fear. Salient findings have been discussed using the selected theoretical frameworks and several theoretically and empirically derived recommendations were offered to inform the next phase of the WVUP study.

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Chapter One: Introduction

1.1. HIV/AIDS and the Workplace

Globally, over forty million adults are infected with the Human Immunodeficiency Virus (HIV), with twenty-five million people having already died of Acquired Immunodeficiency Syndrome (AIDS) worldwide by 2007 (www.hivaids.co.za). A devastating seventy percent of those infected throughout the world live in Sub-Saharan Africa (www.avert.org), making this region the most affected part of the world (UNAIDS, 2006). Infections due to HIV, and deaths resulting from AIDS, have risen incredibly in the past decade in South Africa (Kalichman et al., 2006), such that at present approximately 18.8% of adults aged 15 to 49 years are estimated to be HIV positive (UNAIDS, 2006), such that nine out of ten South Africans who are living with AIDS are adults in their most productive years (UNAIDS, 2007).

Globally, approximately twenty-eight million members of the labour force have been lost to AIDS (UNAIDS, 2007). Most infected people in Africa are between the ages of 15 and 49, and this age group is generally at the peak of their working lives, resulting in a tremendous negative impact on the family as well as the workforce (www.hivaids.co.za). Infected individuals can only perform well at work if they are well themselves; however, if this illness progresses to deeper stages, they will not be able to work, resulting in a great financial burden to the company.

Research conducted by UNAIDS showed that while most businesses believed that HIV/AIDS will threaten their business and that this threat will increase with time (UNAIDS, 2005), most business executives were unaware of the number of infections

and the areas of the business that were affected the most (UNAIDS, 2004). Risk assessments were hardly conducted, and not much was done by way of assessing the business situation. In developing countries with soaring infection rates, businesses started with the development of informal HIV/AIDS policies, in the context of a lack of knowledge on how to deal with HIV/AIDS. Prevention was the focus of these policies, since home-based care was relatively under-developed and treatment was too expensive (UNAIDS, 2005).

Despite these policies being in place, seventy-two percent of firms did not provide on-site condoms, which are a cheap and effective prevention intervention, there was a lack of prevention information and informal policies outweighed more comprehensive and systematic ones (UNAIDS, 2005). Firms were open to partnerships with both government and non-governmental organizations, and these alliances were seen to provide a vehicle for sharing knowledge and information, and for disseminating strategies and actions throughout the business sector within a country. For their part, governments found it difficult to reach out to all citizens, making alliances with companies an ideal way to deliver HIV/AIDS programmes (UNAIDS, 2005).

More recently, UNAIDS (2007) demonstrated that businesses now understand that HIV/AIDS is a threat and is a reality for their employees and clients. There is now a shared understanding between governmental and non-governmental organizations that the private sector has a vital role to play in the fight against HIV/AIDS. Over a short space of just five years, there has been a reduction in HIV prevalence among young people, treatment has indeed provided hope to millions of people worldwide and

funding for HIV/AIDS has increased dramatically. There are still many challenges that lie ahead, as shown in the following strategic imperatives:

- Broaden access to HIV prevention, treatment and support, mainly through workplace programmes,
- Strengthen the health system as well as HIV programme management and ensure that the AIDS funding does assist people in need,
- Take HIV information and tools to populations that are most vulnerable to HIV (UNAIDS, 2007).

In the context of the above imperatives, the workplace is acknowledged to be one of the most effective and important settings for responding to the epidemic. Two out of three people living with HIV go to work each day, thereby making the workplace an ideal setting to promote and enable prevention, care and treatment. The workplace provides an ideal environment to target the highest risk groups susceptible to HIV infection and provides opportunities for building awareness, education, access to VCT and treatment, and helps in promoting non-discriminatory attitudes towards HIV/AIDS (UNAIDS, 2007).

Although there may be innumerable responses to HIV/AIDS by the business sector, these initiatives often fall into four main categories, namely, *Workplace programmes:* including VCT and treatment which provides direct access to HIV prevention, care and treatment; *Advocacy:* through which businesses can disseminate information on HIV/AIDS through print; *Cash Donations:* in which businesses have started to donate much needed financial resources for HIV/AIDS programmes; and *In-kind contributions:* which can include the donation of advisory services, personnel,

printing, office facilities, equipment and supplies. In sub-Saharan Africa, VCT has become a cost effective method for businesses for the reduction of high-risk sexual behaviour and for the prevention of HIV transmission (Theilman et al., 2006).

The World Health Organisation and Joint United Nations Programme on HIV/AIDS have recently implored companies to move from client-initiated requests for VCT to provider-initiated approaches (Theilman et. al., 2006). This means that companies or service providers should no longer wait for employees or clients to request VCT; rather VCT should become more readily available to all employees and individuals through regular service provision. In this context, it has been argued that VCT does not change behaviour only, but can be used as a referral point for preventative services. These can include services for the prevention of mother-to-child transmission as well as an entry point for treatment programs for sexually transmitted infections (Theilman et al., 2006).

1.2. Background to this Study

This research study is part of The Workplace VCT/Treatment Uptake project (WVUP), which is a longitudinal, comparative study of a workplace VCT/Treatment service located in the mining sector in South Africa, which sets out to provide new knowledge on reasons for the generally low and slow uptake of VCT and treatment amongst employees. The broad purpose of this study is to illustrate how to increase the uptake of VCT and treatment, thereby informing future HIV/AIDS strategies. The WVUP study is being conducted by a team of researchers from the School of Psychology and the Health Economics and HIV/AIDS Research Division (HEARD)

at the University of KwaZulu-Natal. The selected company, which has formally agreed to participate in this study, shall remain anonymous for the purposes of reporting on this dissertation. The WVUP project comprises three phases, i.e., the contextual phase, the development of an intervention to improve VCT/Treatment participation rates, and the implementation and evaluation of the intervention.

For the purpose of this dissertation, a part of Phase One of the WVUP was conducted, independently but under the supervision of the one of the co-principal investigators of the WVUP. This study is concerned with the situational assessment component, which will inform the next phase, the ethnographic phase. It is envisaged that at the end of this longitudinal study, the findings and recommendations will inform other companies as to best practice for HIV/AIDS. Therefore this study focuses on HIV/AIDS in the workplace, and more specifically the VCT/Treatment programs that the company offers to its employees.

1.3. WVUP Study Aims and Objectives

This WVUP study aims to achieve the following:

- Provide new knowledge on the reasons for low and slow uptake of VCT and treatment services in workplace settings.
- Show how to increase VCT and treatment uptake in workplace settings on the basis of improved practical interventions;
- Estimate the associated human and economic costs and benefits

The specific objectives of this study were to:

- Understand the nature and dynamics involved in the development and implementation of the VCT/treatment programmes at selected site;
- Identify the specific strengths and weaknesses of the VCT/treatment service;
- Unravel the contextual influences on VCT and treatment participation rates at the selected site.

Chapter Two: Review of Literature

2.1. HIV/AIDS-Epidemiological Profile:

Estimates based on actuarial models from the University of Cape Town suggest that between 5.3 and 5.4 million South Africans are currently infected with HIV and that this figure will rise to 7 million over the next ten years (www.hivaids.co.za). One thousand eight hundred people become infected on a daily basis, and it is assumed that 24.5% of South Africa's economically and sexually active population is already HIV positive (www.avert.org). In the Unites States, economists at a leading mining and extraction company have estimated that the cost of not providing treatment for an HIV infected employee, which results in absenteeism, early retirement, treating AIDS-related conditions and death benefits as well as recruiting replacements, is approximately 32 000 U.S. dollars (UNAIDS, 2007). HIV/AIDS negatively affects the workplace in many ways. It reduces the supply of labor, increases operational costs, reduces productivity, slows down economic growth and threatens the lives of all staff (UNAIDS, 2007).

2.2. The Impact of HIV/AIDS:

2.2.1. Household

HIV/AIDS has a severe impact on the household. Although everybody is affected by this epidemic, it is usually the poorest of people who are most vulnerable. This is because the household dissolves as parents with AIDS die, and their children, some of whom are infected themselves, will be sent to live with relatives (www.avert.org).

Bachmann & Boysen (2003) investigated the health and economic impact of HIV/AIDS on South African households, and revealed that people in affected households were more likely to be poorer and suffer continuous illness, leading to eventual death, in comparison to households that were not affected. Children's lives become disrupted, as they have to take responsibility for the household and most times even provide an income.

Kidder, Wolitski, Campsmith & Nakamura (2007) investigated differences in health status, health care, treatment usage, and HIV medication adherence between people with housing as compared to homeless people who were living with HIV/AIDS. Survey ratings of mental, physical and overall health showed that the health status of homeless individuals were worse than housed individuals. Also, homeless individuals were more likely to be uninsured and have a history of hospital admission to a hospital. Homeless individuals hardly took treatment medication, were less adherent to medication and demonstrated lower CD4 counts. Homeless individuals required more HIV social and medical services, but both homeless and housed individuals in the study had received the necessary services (Kidder, et. al, 2007). The findings showed that homeless people were more likely to have increased negative health outcomes and that housing proved to be a necessary mechanism to improve the health of homeless HIV positive people (Kidder, et. al, 2007).

2.2.2. Economy

HIV/AIDS has a devastating effect on Africa's economic growth and development, thereby depriving the continent even further of the considerable resources required to assert some degree of control over this rampant epidemic (www.avert.org). The

consequences of the epidemic on South Africa's economy include an erosion of the labor force and productivity, an increase in direct and indirect costs to companies and a demand for health services from the private and public sectors (Quattek, 2000). Quattek (2000) states that the economically active population of the country is the worst affected and infection rates in this sector are predicted to reach 26% during the next ten years. While most of the deaths and infections will arise from the unskilled and semi-skilled sectors, the skilled and highly skilled sectors will increasingly be affected. Government income also decreases as tax revenues decline and this pressurizes government to increase spending to deal with the increased prevalence of HIV/AIDS (www.avert.org). Recent findings show that economic growth has declined by 2% to 4% in Sub-Saharan Africa (www.avert.org). Economic theory predicts that HIV/AIDS reduces labor supply and productivity, reduces exports and increases imports (Dixon, McDonald, & Roberts, 2002). Using economic modeling, Dixon et. al. (2002) showed that the epidemic will have far-reaching economic consequences that can only be overcome by international economic assistance.

2.2.3. Health Sector

The epidemic has brought an incredible amount of pressure to bear on the health sector. As infection rates increase, the demand for care for infected people rises and this creates an enormous burden of care for health professionals to fulfill (www.avert.org). There has been a tremendous increase in the number of hospitalizations for those persons who are HIV positive and moving into the AIDS stage (www.avert.org). The epidemic has a negative knock-on effect on the quality of care provided and received in hospitals. There is a resulting shortage of bed space and added stress and pressure on health workers, thus exacerbating the brain drain as

increasing numbers of professionals emigrate. This further denudes local capacities for treatment and prevention activities (www.avert.org).

2.2.4. Workforce

The HIV/AIDS epidemic has a tremendous negative impact on the workforce, setting back economic and social progress substantially. Most infected people living in Africa are between the ages of 15 and 49, i.e., they are at their peak working lives. These infected individuals can work only until they are remain well, but as the illness progresses to maturation, they will not be able to continue working, thereby increasing the financial burden to their companies. Productivity decreases through an increase in absenteeism, an increase in accidents, a loss of skills and labor because of illness, death or emigration, a decline in employee morale, human resource and industrial relations issues and increased costs to the company (www.hivaids.co.za).

2.3. Reviewing HIV/AIDS Interventions:

2.3.1. Prevention

Although there have been significant advancements in the science and technology of dealing with illness and disease, health experts still emphasize disease prevention, rather than cure and therapy (Sarafino, 1998). Unfortunately, however, interventions aimed at preventing HIV infection have enjoyed only limited success in decreasing the rates of the epidemic (Sarafino, 1998). Risky sexual behavior has hardly decreased, with some of the reasons for this including personal beliefs, negative attitudes and inaccurate evaluations of the risk of infection, of engaging in protective

behaviors, perceptions of others' sexual behavior and the impact of condom usage on the sexual encounter (Sarafino, 1998).

HIV counseling and testing is essential for HIV prevention and care. , In their study of HIV voluntary counseling and testing services (VCT) and HIV care in workplace occupational health clinics, Corbett, et.al, (2006) reported that VCT was seen as the key to HIV care and also contributed to HIV prevention through the reduction of risky sexual behavior by those who knew they were HIV positive. High impact VCT strategies were reportedly required for increasing HIV prevention and care (Corbett, et.al, 2006).

Piot & Seck (2001), state that for interventions to succeed and for prevention to be made possible, it has to be carried out in the appropriate environment. Success requires a combination of prevention methods to change behavior patterns in their social environments. Prevention efforts are vital for young people, since it is primarily young people that are capable of changing the course of the epidemic (Piot & Seck, 2001). Prevention, care and treatment are seen as the reinforcing factors underpinning an effective response. Brazil is a good example of integrating commitment to prevention with comprehensive care (Piot & Seck, 2001). In 1996, a law on the right to free medication was passed. Usage of antiretrovirals increased from 25 000 in 1997 to around 90 000 in 2000. The yearly cost of antiretroviral treatment was over US$ 350 million, but the estimated savings from avoiding hospitalisation was estimated at US$ 420 million, and healthy and productive life-years were gained (Piot & Seck, 2001).

Piot & Seck (2001) stated that the commitment to prevention and care efforts are soaring and prevention goals and actions must be privileged. They argue that a failure to act now will result in a failure to prevent a global catastrophe. Since prevention rather than cure is emphasised, it should be made a priority, as success with prevention efforts have been empirically demonstrated.

2.3.2. Treatment

Treatment for HIV infected people has had a more significant impact on industrialized countries than on poorer countries, largely because of the relative lack of health infrastructure and the high costs of implementing treatment (Farmer, et.al. 2001). However, Farmer et.al. (2001) demonstrated that treatment does work in an under-resourced African environment, through the implementation of a treatment program that uses an already existing tuberculosis-control infrastructure. Therefore, if the proper infrastructure is in place, and expenses can be met, treatment could become successful in delaying HIV-related deaths, and can lead to an improved quality of life. However, a significant factor influencing effectiveness is treatment adherence. Patient non-adherence is found to be a major problem in health care and can be related to many factors, for example, environmental factors, educational level, social status, health status, etc. (Schlebusch, 1990).

2.3.3. Care

Community-based care programs, often driven by non-governmental organizations and religious groups, help to ease the impact of HIV/AIDS and are characteristically more affordable than other options. The effectiveness of these community-based care programs, however, often depends on support from the health, welfare and other

social sectors (www.avert.org). Chester, Morris, & Cheevers (2001), showed how a package of care, comprising prevention, education and therapeutics, can be effective in caring for HIV infected persons and in preventing new infections in an occupational setting in Sub-Saharan Africa. Subsequent to the identification of infected individuals through a Voluntary Counseling and Testing program, this program resulted in a significant increase in condom distribution and a decrease in sexually transmitted infections, thus demonstrating the effectiveness of a comprehensive approach to prevention and care.

Prevention, treatment and care interventions are collectively necessary in dealing with the HIV/AIDS epidemic (Creese, Floyd, Alban, & Guinness, 2002). But, due to the costs associated with each level of intervention, governments are often forced into making difficult choices in their prioritization of these crucial activities (Creese et. al., 2002). In their review, Creese et. al. (2002) reported that while there were few studies on the cost-effectiveness of HIV/AIDS prevention, treatment and care programs in Africa, the most cost-effective intervention is for the prevention of HIV/AIDS and the treatment of tuberculosis, whereas the care aspect is the least cost-effective. Undoubtedly, however, in addition to prevention programs, there has to be a global effort in providing treatment and care, through voluntary counseling and testing (VCT) services, nutritional support, treatment provision, etc. (www.avert.org).

2.4. Towards a Framework for Action:

2.4.1. The Settings Approach in Health Promotion

An over-emphasis on individualistic perspectives and frameworks led to the development of the Settings Approach in Health Promotion in the 1980's (Naidoo & Wills, 2000), which privileges the importance of context (Whitelaw, Baxendale, Bryce, Machardy, Young, & Witney, 2001). Given that health is created and experienced by people in their daily lives in their own settings, where they live, work, play and love (Naidoo & Wills, 2000), these contexts offer ideal settings for health promotion interventions. Thus, the social and cultural environment has been identified as the central feature of this approach (Whitelaw, 2001). In terms of the HIV/AIDS epidemic, it is of utmost importance that the settings approach is used when trying to prevent, treat and care for society. Health should become a part of each system and find a place in organizations and institutions that were created for other purposes. The settings approach is long term and is realized through projects that aim to intervene to create healthy living and working environments, to develop healthy policies and to integrate health into evaluation procedures, in order to show how health can make the system function better (Naidoo & Wills, 2000).

Some of the main settings used for health promotion include the workplace, schools, neighborhoods, primary health care clinics and hospitals. This study will be conducted in the workplace environment. The workplace provides a critical setting for health promotion in that it provides good access to working people, especially males, who are otherwise difficult to reach (Naidoo & Wills, 2000). Interventions are usually easy to evaluate and follow-up as an already established infrastructure and

modes of communication exists. Also, it is common that most men do not access health services as often as most women do; therefore, intervening in the workplace helps to reach the economically active male population (Naidoo & Wills, 2000).

2.4.2. The Role of the Private Sector

The UNAIDS 2007 report states that for a successful response to the HIV/AIDS epidemic, it is vital that there is engagement from the private sector. HIV/AIDS is viewed as a multisectoral issue that cannot be successfully addressed without the long-term commitment and engagement of the global business community (UNAIDS, 2007). Price-Waterhouse and Coopers (2003) surveyed two hundred and sixteen businesses across Kenya, Tanzania, Uganda and Zambia on their response to the epidemic (www.pwc.com). The findings showed that the costs of HIV/AIDS to the company included the training of new recruits, recruitment processes, insurance premiums, absenteeism, sick leave, benefit claims and the costs of funerals (www.pwc.com). Further, the size of the company, its workforce, its financial abilities and its capabilities were key factors in determining the way a company responded to the epidemic. This report provided recommendations with regard to the ideal composition of a workplace HIV/AIDS program. Key components included risk assessment i.e., the impact of HIV/AIDS on that specific company, the development of a non-discriminatory HIV/AIDS policy, a prevention and awareness component, voluntary counselling and testing, care, support and treatment through available clinics, and the possibility of treatment provision (www.pwc.com).

An important workplace initiative is the PEP Africa-IFC against AIDS program called “Managing HIV/AIDS in Your Workplace” (www.ifc.com). This three-year

program addresses the HIV risk management needs of small and medium size business enterprises (SME's), based on the finding that SME's demonstrated limited understanding about the impact HIV was having on their business. The program comprises three main focal areas. These are firstly, to build the business case to take action in response to the epidemic. Secondly, to provide training to SME's to develop skills so that they can take action against the epidemic, and thirdly to sustain a follow-up program to guarantee the participation of SME's in the fight against HIV/AIDS (www.ifc.com). Program success is contingent on staff commitment, the building of alliances and continuous program evaluation.

The Bureau for Economics Research (BER), funded by the South African Business Coalition on HIV and AIDS (SABCOHA), studied the impact of HIV/AIDS on various workplace sectors (including transport, mining, trade, finance, etc.), assessed their awareness of HIV/AIDS and examined the programs they had developed and implemented (Ellis & Terwin, 2005). They found that despite the significant social and economic consequences of HIV/AIDS, many companies do not have a prevention program in place, probably because of a lack of understanding of the direct economic impact of HIV/AIDS on the business.

Responses to the epidemic among companies varied by sector of operation, size of company, skills levels and provincial location (Ellis & Terwin, 2005). Firstly, major companies were more responsive to the epidemic, while smaller companies had made little significant effort. Businesses with predominantly unskilled or partly skilled workers suffered higher HIV prevalence rates and were consequently exposed to more negative impact, specifically with regard to a decrease in labour productivity and an

increase in absenteeism. Finance, manufacturing, mining and transport companies were most likely to have HIV/AIDS programs and policies in place, whereas retailers, wholesalers, vehicle dealers, building and construction companies were not even considering any policy or program. Stigma and discrimination was reportedly a significant obstacle to successful program implementation (Ellis & Terwin, 2005).

Ramachandran, Kedia, Shah & Turner (2005), studied worker and manager perceptions about the epidemic, and its impact on the private sector, in firms throughout Uganda, Kenya and Tanzania. Like Ellis & Terwin, they also found that larger companies were more responsive to the epidemic than smaller companies. Interestingly, however, they found that companies who were unionised were more likely to intervene programmatically than those without unions. Companies were motivated by the desire to engage in activities that would decrease the number and frequency of sick employees as a means to avoid recruitment of new employees, which bears high direct and indirect costs Although employees were found to be concerned about HIV/AIDS and were generally willing to take an HIV test, VCT uptake rates were relatively low, due primarily to the stigma attached to the disease (Ramachandran, et. al. 2005).

Rosen, Feeley, Connelly, & Simon (2006) conducted a six-year longitudinal study of the impact of HIV/AIDS on the private sector. The consequences of the epidemic can be illustrated at three different levels:

- The cost-to-company for a single employee with HIV/AIDS occurs at direct and indirect levels. Direct costs include benefit payments, medical aid costs, and training and recruitment of a new employee. Indirect costs include an

increase in absenteeism, a decline in job productivity, poor performance of new recruits, etc.

- The direct cost to the company for many employees with HIV/AIDS also include accidents that could occur as a result of sick or inexperienced employees, and indirect costs could include disruptions of production, breakdown of work morale and cohesion and deteriorating labour relations.
- With high HIV prevalence rates in the society, the direct costs to the company would include a higher cost of material input, the requirement of stability due to a breakdown in civil society and higher wages due to a lack of skilled workers, while indirect costs would include a decline in demand for products, a higher risk on investments, higher cost of dealing with government, etc. (Rosen, et. al., 2006).

Through the medical, human resource and financial data collected from different companies across many countries, Rosen, et. al. (2006), found that larger companies were more likely to have therapy available to employees than smaller companies. Although sixty-three percent of about a million employees in the study had access to treatment services, uptake was relatively low. The effectiveness of preventative measures that were implemented in the companies sampled was largely unknown (Rosen, et al., 2006).

George (2005) investigated the impact of and response to HIV/AIDS by seven formal sector companies in South Africa, Namibia, Zambia and Botswana. This study revealed that many of these companies have failed to realise and act on the long-term damage caused by the epidemic, with only 26% having implemented HIV/AIDS

policies and intervention programmes. In this regard, the larger companies were found to be more likely to make education and treatment services available, in comparison to smaller companies (<100 employees), who have displayed a limited response.

According to Fraser (as cited in George, 2005) small and medium-sized companies lack adequate knowledge of the necessity to do something in their companies in order to decrease the impact of HIV/AIDS on their business. Some of the other reasons for their inaction include a lack of funds, too much focus on operational activities, a lack of information on how to handle the situation, etc. This study suggested that non-governmental organizations (NGO's), unions and larger companies needed to develop strategies to assist smaller companies to provide cost-effective and appropriate interventions to mitigate the epidemic.

2.5. Voluntary Counseling and Testing (VCT):

2.5.1. What is VCT?

Voluntary HIV counseling and testing is a three-stage process, starting with pre-test counseling, testing and post-test counseling, all aimed at enabling the individual to make informed decisions to take the test, to cope with the result and to avoid high risk sexual behavior (www.popcouncil.org).

The pre-test counselling session is aimed at helping the individual decide whether to take the test and to provide information about the personal risks for HIV infection (McCauley, 2004). During the pre-test stage, the counsellor will ascertain the individual's personal history, what the individual knows about HIV/AIDS, determine

why the individual decided to come for the test, explain to the individual what counselling is, the role of the counsellor, the advantages and disadvantages of being tested and the support systems available (PAAU, 2005). After the individual takes the test, s/he will receive the results of the test during a post-test counselling session. During this session the counsellor helps clients to develop life plans to enable them to protect themselves and others from HIV transmission and provides information about available services as required (McCauley, 2004). Post-test counselling helps individuals to express their feelings about the test or their results, helps them decide on a personal action plan, such as ways for positive living, and also determines answers to any questions needed (PAAU, 2005). VCT services were designed to motivate people who are HIV-positive or HIV-negative to change their behaviours so that they could avoid passing the virus on to someone or become re/infected themselves (McCauley, 2004).

2.5.2. VCT at a Community Level

Various studies have been conducted on the implementation of VCT and its impact on the community, some of which show that adults have responded well to the implementation of VCT in developing countries, as they have shown signs of positive behavioural change, such as condom use and fewer sexual partners, and a reduction in sexually transmitted infections (WHO, as cited in McCauley, 2002).

Despite tremendous community education and awareness raising campaigns, only a mere 10% of the estimated 26 million Africans living with HIV know their status. But this will and is slowly changing with widespread access to rapid testing and the availability of treatment (Morah, 2007). A 2003 survey on perceptions of the response

to the epidemic in Malawi found that 94% of the population believe that HIV is spread by the same people who know their positive status and who refuse to change their behaviour (Zogby & Schneidmann, as cited in Morah, 2007). Morah's (2007) study refuted this perception, and showed that Malawians who were aware of their HIV positive status demonstrated a preventative approach in comparison to those who did not know their sero-status. HIV positive Malawians showed more in-depth knowledge about HIV/AIDS, displayed positive health-seeking behaviours, have changed their behaviour patterns and were following a more healthy way of life in comparison to others who did not know their status (Morah, 2007).

Pronyk, Kim, Makhubele, Hargreaves, Mohlala & Hausler (2006), investigated the impact of the introduction of VCT through five rural Primary Health Care (PHC) facilities in South Africa. Health workers were trained in the administration of VCT prior to implementation of the service. Results showed that the community made good use of the services, with increasing uptake rates over time (Pronyk et. al., 2006). Positive attitudes and satisfaction by health workers were noticed and attitudes towards HIV positive individuals changed in the community (Pronyk, 2006). Most of the health workers were confident and enjoyed the program, but some of them felt that VCT was stressful, especially when reporting positive results in post-test counselling. A reason for a higher uptake rate was that VCT was easily available and results were given on the same day. However, mostly women and individuals aged between twenty and forty attended these VCT programs, suggesting the urgent need for programme diffusion across gender and age groups, especially the youth (Pronyk et al, 2006). Although this study showed that VCT is an achievable public health intervention to

implement in PHC facilities in rural areas, it does not make recommendations with regard to possible future studies in this area (Pronyk et al, 2006).

Horizons Program, Kenya Project Partners & Uganda Project Partners (2001), found that VCT programs have increased the adoption of safer sexual practices (www.popcouncil.org). Youth, parents, community members and service providers were interviewed to determine the opportunities VCT offered and the barriers it posed for the youth. The youth preferred the service if it was cheap and confidential. Findings showed that most of the youth that underwent VCT intended safer sexual practices, including condom use and fewer partners, they wanted to know their serostatus, they were aware of at least one testing venue, and saw the counselling process as valuable (www.popcouncil.org). However, it was also found that, at the different sites, the youth who did not want to be tested felt that they were not at risk of HIV and they feared a positive test result. The outcomes of this study were used to develop strategies for more effective VCT programs for the youth (www.popcouncil.org).

In the absence of effective preventative strategies in China, it is assumed that by 2010, approximately ten million Chinese people will be HIV positive (Li et. al, 2006). The major problem area with regards to transmission lies within the high-risk populations, such as commercial sex workers. Li et. al (2006) designed a focused study based on a brief VCT intervention program on female sex workers. The findings showed that the VCT intervention, with appropriate cultural adaptation is likely to increase condom use and keep it constant as well as to decrease sexually

transmitted infections within a six-month follow-up period with this female sex worker cohort.

2.5.3. Attitudes towards VCT at a Community Level

A study in the Eastern Cape by Hutchinson & Mahlalela (2006) found that while the overall usage of VCT services are relatively low, uptake of VCT is positively associated with age, gender, education, socio-economic status, proximity to clinics, availability of rapid testing and outreach services as well as a decrease in HIV stigma levels. Data from a population-based household survey and a government –linked survey was used to examine the attitudes towards VCT services, patterns of utilization of VCT, and the relationships between HIV/AIDS related stigma, VCT availability and quality and use of VCT. Regression analysis showed that the rapid expansion of VCT could have substantial positive impact on testing rates for men, but that increasing testing uptake rates for women will require interventions that successfully reduce stigma and address other psychological factors that restrain testing (Hutchinson & Mahlalela, 2006).

Searle, Ndlovu, Fisher, & Miller (2003), investigated the availability and quality of VCT services, family planning, antenatal care, STI services, condom promotion and other HIV prevention strategies in Kwa-Zulu-Natal to identify service delivery gaps at health care facilities. Observations and exit interviews were used for data collection, in two West African countries. HIV counselling and testing was offered to all women who attended the antenatal clinics. On a large scale, HIV counselling and testing was well received among pregnant women, probably because they considered themselves low-risk candidates for HIV infection (Cartoux et al, 1998). Attitudes towards VCT

were positive in cases where individuals were aware of its benefits and they were not afraid of being tested. The educational level of the women was also a predictor of whether or not they will be tested. Delivering before the completion of the process, fear of an HIV-positive test result and ignorance of HIV/AIDS were the common reasons why (Naidoo & Wills, 2000). Women did not return for their test results (Cartoux, et. al., 1998).

In another study on pregnant women's attitudes towards VCT, Okonkwo, Reich, Alabi, Umeike & Nachman (2007), investigated the attitudes, awareness and beliefs of pregnant women towards VCT in Nigeria. Knowledge of HIV infection, routes of transmission, and treatment options were the focus of questions. Most women approved of VCT, and most of them were aware that VCT could reduce the risk of transmission to their unborn babies (Okonkwo, et. al, 2007). The women who refused VCT attributed their refusal to the stigmatisation of HIV in general. If was found that the acceptance of VCT depended on knowledge that VCT has proven benefits to the unborn child. The major barrier towards testing in Nigeria proved to be socio-cultural factors such as stigma of HIV positive individuals. Therefore the development of innovative health programs is essential in providing knowledge about the benefits of VCT for the unborn child (Okonkwo, et. al, 2007).

People who don't know about VCT services often have negative attitudes about it, as shown in a study conducted by Samet, Winter & Hingson (1997). Samet et. al., (1997), investigated the attitudes of sexually active adolescents towards HIV testing and the factors that motivated them to use VCT services. A number of misconceptions of HIV testing were found to exist. Some participants didn't believe that their results

were kept confidential; some believed that their partners would be informed if they were positive, while some thought that the test was not accurate (Samet, et. al., 1997). Participants displayed negative attitudes to HIV testing due to issues such as unclear communication of the testing process, its availability, accuracy and confidentiality. However, a clear understanding of the process instilled confidence in individuals to take the test and the counselling sessions (Samet, et. al., 1997).

Therefore, the effectiveness of VCT is quite evident from the above studies, but only if there is an adequate knowledge and attitudinal base. It is vital that people are educated about the availability of VCT services, and it is necessary to implement VCT programs in places where a broad cross-section of people can be reached. This is possible through the workplace, where people vary in age, race, gender, culture and economic status. Also, it is likely that not everybody knows of the importance of HIV testing. The workplace provides an ideal environment for intervention in this regard.

2.5.4. VCT in the Workplace

Businesses require the skills and experiences of employees at all levels, ranging from managers to labourers. The business world is experiencing rapid change and this change requires flexibility and spontaneous co-ordination (www.fhi.org). One of the many challenges facing business is the HIV/AIDS epidemic and it is in the best interests of businesses to develop meaningful ways of dealing with the epidemic (www.fhi.org). HIV infections cause disruptions to the business at all levels. For example, if a sales assistant is HIV positive, s/he will be away on sick leave for most of the time, will face workplace discrimination, and the company will have to replace the assistant due to pressure being put onto other staff members. This becomes a

financial burden for the company, especially where medical expenses are involved. Therefore, most large businesses now have policies and programs in place for protecting employees and helping them to deal with their situation (www.fhi.org).

HIV/AIDS presents a major challenge to the economic growth and stability of the workforce (Nabila, Antwi, Yeboah, & Kwankye, 2001). HIV threatens profit making, productivity and human welfare; hence business has started to vigorously promote HIV prevention and care facilities, one such program being VCT services at the workplace (Nabila, et. al., 2001). In a study of the impact of HIV on construction workers in Ghana, Nabila, et. al., (2001), found that employees and management didn't regard HIV as a serious problem and displayed limited knowledge on HIV transmission and high-risk behaviour. The study made a case for workplace interventions aimed at promoting safer sexual behaviour, improving the management and control of sexually transmitted diseases, and the provision of appropriate VCT and treatment services to employees (Nabila et. al., 2001).

Mundy and Dickinson (2004) investigated the factors that influence the likelihood of VCT uptake rates in the workplace. The results show that these factors are the availability of company support, proximity of people that are HIV positive or have died of AIDS, and confidentiality of VCT services. Recommendations include that the benefits of VCT be well-understood, accessible to staff and their families, involve staff representatives and that the social and political barriers to the uptake of VCT are reduced (Mundy & Dickinson, 2004). This research also confirmed that knowledge alone is insufficient in changing VCT-uptake behaviour, with the workplace being found to be an effective environment for interventions to increase the uptake of testing

and counselling (Mundy & Dickinson, 2004).

2.5.5. Attitudes towards VCT in the Workplace

Despite the high prevalence of HIV/AIDS in South Africa, VCT has only recently become a priority in addressing the disease (Swanepoel, 2006). Since people at risk of infection most often fail to participate in VCT programs, there is a need to implement VCT communication programs to promote uptake (Swanepoel, 2006). While VCT messages are a common part of many HIV media campaigns, the lack of individual utilization suggests that something different needs to be done to encourage those at risk to present themselves for VCT (Swanepoel, 2006). Swanepoel (2006) used the Integrative Behavioural Model (IM) to discuss attitudes towards VCT. The IM predicts that individuals' intention to go for VCT is the strongest predictor of whether they will actually go for it, and their willingness to attempt VCT is governed by three beliefs, i.e., whether they will test positive or negative, whether they will be in harmony with social norms and whether they are brave enough to go for it (Swanepoel, 2006). An understanding of personal and contextual variables needs to inform programme design, so that people and employees can be motivated to participate in VCT services.

VCT programs are indeed beneficial to individuals; however, there is a need for strategies to be developed to encourage individuals to become involved in regular testing. Although it has been found that the counselling sessions in the VCT process are beneficial and helpful to the individual (Searle, et. al., 2003), VCT still needs to be promoted and made accessible to everybody, as people still display limited

knowledge, erroneous beliefs, negative attitudes and significant fear of testing.

2.6. Stigma and HIV/AIDS

"I make love, I eat, I get dressed, I do the same things as everyone else. Is there a difference between me and them? Is there something on me which shows that I'm sick? I'm not a danger to anyone." (Arsene Tao as cited in Dussault, 1999). Stigma is a common human reaction to any disease, including HIV. For many years HIV-related stigmatization, discrimination and denial have been a tremendous negative characteristic of the pandemic and has presented a major challenge to the effectiveness of treatment, care and prevention (Malcolm et al, 1998). While prevention is recognized as the key strategy to reduce the disease burden, prevention efforts have been failing as a result of discriminatory public policies, attitudes and behavior (Malcolm, et. al, 1998). Factors such as fear, denial and a lack of knowledge have negatively impacted on families, individuals and communities. Stigmatization and discrimination against HIV positive people poses a major barrier for people who want access to treatment and care. Stigma is a major hindrance to the treatment and care of HIV positive persons in Thailand, where the main modes of HIV transmission include injection drug use and commercial sex (Chan & Reidpath, 2007). In their study on college trainees and nurses in Thailand, Chan & Reidpath's (2007) interviews resulted in regression analysis showing that while injection drug use, HIV/AIDS and commercial sex were all individually stigmatizing, inter-relationships between all three, with damaging consequences to the treatment and care work that is being undertaken (Chan & Reidpath, 2007).

Visser, Makin, & Lehobye (2006) explored the personal stigma and perceived community stigma of HIV/AIDS in a South African community. Participants included people of varying race, gender and age groups. This study found that while respondents were likely to personally stigmatize people with HIV/AIDS the degree of stigma was less severe than the stigma respondents projected onto towards the community at large. Further, the respondents' age, race, gender, area of residence, and personal knowledge of someone with HIV/AIDS impacted on the respondents' tendency towards stigmatizing HIV positive individuals (Visser, et. al, 2006).

2.7. Treatment

HIV/AIDS treatment consists of medication that has to be taken by the person for the rest of her/his life. It can stop people infected with HIV/AIDS from becoming ill for many years. This medication works against the HIV infection by slowing down the replication of HIV in the body. These drugs are often referred to as antiretroviral, anti-HIV drugs or HIV antiviral drugs. For effectiveness of treatment, it is known that HIV patients have to take more than one drug at a time, and this is known as Combination therapy. Sometimes more than three drugs are required and treatment now becomes Higher Treatment (www.avert.org). Treatment generally begins when one's CD4 count, (which is a protein that HIV uses to attach itself to before gaining entry into one's immune system) is between 200 to 350Although there has been a move forward in terms of global initiatives and partnerships to increase access to treatment, many poor people with sexually transmitted infections are forced to seek care outside of government services for fear of experiencing stigma. This is problematic, since the main care providers for HIV are likely to be private medical

practitioners, pharmacists and traditional providers who often dispense drugs illegally. This improper use of treatment is dangerous, making it essential that private providers are accounted for and their behavior is regulated (www.avert.org). This study showed that while increased access to treatment is essential in developing countries with high infection rates, drug availability and access needs to be carefully controlled in order to avoid unintended negative consequences.

Rintamaki, Davis, Skripkauskas, Bennett, & Wolf (2006) studied the relationship between social stigma concerns and HIV medication adherence. This study found that people with high HIV stigma concerns were 2.5 times less likely to interpret and define the meaning of a CD4 count correctly and 3.3 times more likely to be non-adherent to their medication than those with lower stigma concerns (Rintamaki et al, 2006). Thus, clinical care for individuals living with HIV should take account of patient sensitivity to social stigma. This could be in forms of modifications to medication schedules and counseling before enrolling for treatment (Rintamaki et al, 2006).

2.8. Conclusion:

According to the Health Systems Trust, studies show that only a quarter of companies under study had any formal policy in place and not even a fifth of these companies provided VCT for their staff (www.hst.org). Businesses throughout the world have begun to realize that HIV/AIDS affects their business, decreases productivity and profitability and increases the costs of doing business (UNAIDS, 1998). Given that the workplace provides a great opportunity for reaching out to, and educating the majority of the adult population, companies need to form coalitions with

other companies and sectors to develop HIV prevention and educational programmes for their staff. Businesses will benefit from an unambiguous acceptance of the impact of the virus and should urgently develop and implement concrete action plans to reduce the burden of disease. According to UNAIDS (1998), key elements of a workplace HIV/AIDS program should include: an equitable set of policies that are well communicated and implemented properly; the provision of ongoing formal and informal information, made easily accessible to staff; the ready availability of condoms; the provision of VCT and treatment services, aimed at diagnosing, treating, and managing sexually transmitted diseases for employees and their partners; all of these components should be periodically monitored and evaluated for the program to be effective.

2.9. Theoretical Framework

According to Umerah-Udezulu, & Williams (2001), the application of different health intervention models and behavioral theories is fundamental for HIV education and interventions to be successful. Many theories prove to be applicable to this project. Green & Kreuter's Precede-Proceed model is a widely used planning model that has been utilized for designing programs and interventions for different health problems, including HIV/AIDS (Green & Kreuter, 1991). The Elaboration Likelihood Model will be adopted as a primary framework model that will be used in this project. This model tries to "explain how a persuasive message works to change the attitude of the receiver" (Moore, 2001) and is therefore useful in showing how employees are persuaded into changing their attitudes and behavior with regards to VCT and treatment. These two models are discussed in more detail below.

2.9.1. The Precede-Proceed Model

The underlying premise of the Precede-Proceed model is that the success of an intervention or health education program lies in the voluntary participation and co-operation of the participant in a process which allows personal determination and acceptance of behaviors, and the change resulting from this rests on the willingness of the participant to become actively involved (Brown, 1999). In this sense, the Precede-Proceed Model is synchronous with the approach adopted in this study, specifically with regard to qualitative, ethnographically derived meaning.

This model recognizes that health and health behaviors have many causes, and this needs to be evaluated for a successful intervention to occur. Therefore, this model is appropriate in its application to this study, since it calls for identification and systematic understanding of the existing health behaviors in order to inform a successful intervention. The purpose of this model is to direct attention towards outcomes rather than inputs, thereby making researchers work from the desired outcome backwards, in the planning process, to achieve programme objectives (Brown, 1999).

The Precede-Proceed model entails the researcher planning the intervention by assessing the target population's needs at different levels of the health problem, whether at individual, organizational or community level (Croyle, 2005). This model offers a framework for determining an appropriate intervention for a particular problem (Croyle, 2005). Health behavior is viewed as having both individual and environmental forces impacting on it.

The Precede-Proceed model is characterized by nine steps (Green & Kreuter, 1991). The first five are purely diagnostic, focusing on social assessment, epidemiological assessment, behavioral and environmental assessment, educational and ecological assessment and administrative and policy assessment. The latter four steps deals with the implementation and evaluation of the intervention, and are implementation, process evaluation, impact evaluation and outcome evaluation (Green & Kreuter, 1991).

In *social assessment, different data collection techniques are used, such as focus groups, interviews, observations, surveys, etc. to collect information on the population and their needs. In epidemiological assessment, the population's health needs are determined and prioritized and goals and objectives are established. The behavioral and environmental assessment* includes identifying factors that affect the health situation in that community. In educational and ecological assessment, predisposing, enabling and reinforcing factors are identified and have to be in place for sustainable change. The predisposing factors are the motivation or the reason for a specific behavior, for example, attitudes, knowledge, cultural beliefs, etc. The enabling factors makes people act on their predispositions, for example, the resources that are available, policies and services that exist and are available, etc. The reinforcing factors include the repetition of a behavior by providing rewards or incentives, such as praises from others, social support, etc. The fifth diagnostic step considers administrative and policy assessments, which focus on a reflection of the gathered information, the resources, policies and regulations that affect the intervention (Croyle, 2005).

While this situational assessment is to be conducted after the fact, that is after the program has been in place for some years now, these five phases of the Precede-Proceed Model will be useful in guiding the researchers assessment of what was done or not done, and indeed of how well it might have been done, at each stage of planning and implementation of the VCT/ treatment programme. Given that this study is concerned with what is already in place, the focus will not be on an empirical outcome and process evaluation, but rather on what exists and how it came to be, informed by the five diagnostic stages of the model, and in particular the *educational and ecological assessment*.

Dodge et al (2001) investigated whether a comprehensive intervention for HIV and or sexually transmitted diseases (STD's) would improve and sustain rates of HIV/STD risk assessment and counseling by service providers within a clinical setting. The Precede-Proceed planning model was used as the intervention, focusing mainly on the three factors that influence behavior, namely, predisposing, enabling and reinforcing factors. Using a pre and post-test design, with multiple measures, this study showed that a comprehensive systems intervention based on the Precede-Proceed planning model can significantly improve the quality of HIV/STD risk assessments and counseling of patients by primary care service providers (Dodge, 2001).

Darrow et. al. (2004) suggest that the Precede-Proceed model is appropriate for primary HIV prevention at the community level, and adopted it as the guiding framework for eliminating local disparities in HIV/AIDS through community planning and health promotion. These authors argue that the model allows for

community members to participate in the planning process through an examination of the predisposing, enabling and reinforcing factors that are associated with their behaviors, and it has the advantage of encompassing the policies and organizational issues that will either facilitate or hinder program implementation and the capabilities of individuals to actually change their behaviors.

Once the ethnographic research has been conducted in phase two of this research project, a tailored intervention will be developed and implemented, and phase three of the research will focus on a rigorous prospective evaluation of the modified VCT/ treatment programme. These successive phases of the project will also be informed by the Precede-Proceed Model, rendering a comprehensive approach to programme planning and evaluation.

2.9.2. The Elaboration Likelihood Model

Persuasion is a major part of all types of communication, and therefore a part of everyday life. Messages are not really good messages if they are not persuasive to the target audience. The elaboration likelihood model is based on the presumption that in order for someone's attitude towards a certain idea or concept to change, there are two paths to persuasion, the central route and the peripheral route. The central route entails message elaboration, where the message is very specific and provides all the relevant information (Griffin, 1997). The central route is used to scrutinize ideas, think of its implications and determine whether or not it has value. The peripheral route entails ways to either accept or reject a message without actually thinking about the issue (Griffin, 1997). Therefore the peripheral route allows a person to make a decision

through the use of various cues and these cues include communication techniques that individuals already feel positive towards.

Where an individual is not motivated to think about or unable to process the message, it is channeled to the individual through the peripheral route, using specific cues. Peripheral cues include reciprocation, consistency, social proof, liking, authority and scarcity (Moore, 2001). *Reciprocation* occurs when the receiver of the message feels obligated to agree with the message due to past experience or information. *Consistency* is when the receiver relies on thoughts that they held true previously. *Social proof* is similar to peer pressure, where the actions and words of others will influence the receiver. *Liking* entails the speaker being likeable to the receiver, where the speaker may be attractive or charming and this helps to convince the receiver. *Authority* is when the speaker takes an authoritative stance over the receiver, almost instilling fear in the receiver to accept the message, and *scarcity* involves the idea that the receiver should take in the message while it is still around, before it becomes scarce (Moore, 2001). Although attitude change is temporary through the peripheral route, it could be enough to encourage action, and when repeated at a later stage, it could then be taken in through the central route, making attitude change permanent.

Attitude change for both routes differ significantly, in that attitude change from the central route would be much more intense and deeper than the peripheral route, since it is predictive of behavior, whereas the peripheral route is more superficial (Holwerda, 2006). When individuals take a central route to make decisions, they are motivated and able to pay attention, which can lead to permanent change in attitudes. But when the peripheral route is used to make decisions, the individual is persuaded

by some characteristics that they are attracted to, for example if the individual takes liking to the person who is conveying the message. However, this is only a temporary change (Moore, 2001). Hence, it is essential to motivate individuals to take the central route for sustained change in attitude, and this can happen by making the message personally relevant to them (Moore, 2001). These two routes, as well as the peripheral cues, will be extremely useful in this study, in that they will help determine how employees react to and take in VCT and treatment messages, and whether these messages will result or have resulted in attitude and behavior change or not.

Chapter Three: Research Methodology

3.1. Introduction

Drawing on the larger organizational landscape and study design, this chapter focuses on the aim and objectives of this phase of the study, the research design, sampling strategy, data collection techniques, methods of analysis and ethical considerations.

3.2. Background to the WVUP Study

The Workplace VCT/ treatment uptake study is a longitudinal, comparative study of a private sector workplace VCT/ treatment programme that sets out to provide new knowledge on factors that inform the uptake of VCT and treatment services amongst employees and contractors of a company in the mining sector. The purpose is to illustrate how to increase the uptake of VCT and treatment, thereby providing lessons for future company testing and treatment strategies.

3.3. Aims and Objectives of the WVUP Study

The WVUP project has a scientific aim:

- To provide new knowledge on factors informing VCT and treatment uptake rates in workplace settings and to estimate the associated economic costs.

The project also has a practical aim:

- To show how to increase VCT and treatment uptake in workplace settings on the basis of improved practical interventions and to estimate the associated economic costs and benefits.

The scientific aim of the project entails three objectives:

1. To develop an understanding of the individual and contextual influences informing VCT and treatment participation rates, and estimate the associated economic costs within one multinational corporation in the mining sector;
2. To develop a VCT/treatment intervention that is informed by the strengths and weaknesses of the existing services and is aimed at improving uptake rates;
3. To implement the intervention as a pilot programme to test its efficacy in relation to proximal outcomes at the level of attitudes towards VCT and treatment, stigmatizing attitudes towards people infected with HIV, HIV prevention knowledge, motivation to engage in behaviours to prevent HIV infection and transmission and to estimate the net economic benefit of the intervention programme.

3.3.1 Key Questions

- What are the constraints to increasing the uptake of VCT and treatment services in workplace settings?
- What are the costs of a less than optimal uptake of VCT and treatment services?
- What factors will increase VCT and treatment uptake in workplace settings?

3.3.2 Specific purpose

To obtain data that will inform:

- Analysis of factors that drive VCT and treatment uptake;

- Design of a revised workplace programme to improve uptake of these services;
- Analysis of the costs of current VCT and treatment services to the company and develop baseline on which to derive the costs of the revised programme design.

3.4. Study Design

The combination of scientific and practical aims dictates a two-phase project; Phase One of the project will involve an empirical study aimed at understanding and costing out an existing workplace VCT and HIV/AIDS treatment programme. This phase will establish baseline knowledge of the existing VCT and treatment services, situated in its prevailing organisational milieu, through:

- An economic cost-benefit study to measure the value of the VCT and treatment services
- A situational analysis, comprising a situational assessment (focusing on key organisational stakeholders) and focused ethnographic study (focusing on a sample of employees), to understand the individual & contextual risk influences associated with employees' use of existing workplace VCT/Treatment services.

Phase Two of the project is concerned with the development of an intervention to improve the uptake of VCT and treatment services, followed by the implementation, evaluation and costing of this intervention.

The methodology for the study, as dictated by the scientific and practical aims of the project, consists of three principal features:

- Longitudinal format to enable the project to achieve its linked objectives incrementally and iteratively;
- Participatory research to help identify the determinants of service uptake, to identify critical issues that need to be addressed in the intervention and to inform the design of the intervention;
- Empirical observation and measurement of the performance of the intervention in comparison with the performance of the original VCT and treatment services.

3.4.1 Study Site

The study was conducted at a selected site within a specific mining company. Key inclusion criteria for site and company selection included:

1. The corporation has the same workplace health management, including VCT and treatment services, operating at more than one of its plants. This is to ensure that the findings from the selected site are generalisable across sites;
2. The corporation's VCT and treatment model must be broadly in keeping with that used across most other companies in the mining sector at the very least, so as to ensure generalisabilty of the findings to other workplace settings;
3. The corporations VCT and treatment services must have been in operation for more than two years prior to the proposed project, so as to ensure existence of an adequate database of records on investment and operating costs and on uptake rates;
4. Sites/plants must be in distinct, different locations (e.g. different South African provinces or different southern African countries). This will enable the project to take into account and, later, assess common and particular characteristics of

the workforce in the operation of the VCT and treatment services and in designing the intervention;

5. Plants/sites that are eligible for sampling selection must have at least 500 employees, so as to ensure sufficient statistical power in the analysis of quantitative data in the evaluation stage of the intervention*;*
6. The corporation should be enthusiastically willing to participate and contribute to the costs of the study.

The corporation that satisfied these criteria had ten mines located in South Africa, and four of the sites in this multinational company were considered for the study purposes. While two of these shortlisted sites satisfied the broad inclusion criteria, one site in particular was selected for the study because it emerged as being particularly favorable in terms of travel costs, time, population sizes, contractor access, access to labour-supply communities, and importantly, strong support from both mine management and union representatives. The employee population at the study site comprised 951 permanent employees and approximately 250 external contract staff.

3.4.2 Locating the Situational Analysis

This report focuses on the first phase of the project – the situational analysis- that has been conducted from May 2007 to August 2008. The aims of the situational analysis were to understand the individual & contextual risk influences associated with workers' use of existing workplace VCT/ treatment services.

The Situational Analysis included:

- A Situational Assessment comprising:

  - An analysis of key company documents concerned with the company's HIV/AIDS programme and information provided on the company's website;
  - Interviews and focus group discussions with key organisational stakeholders at company and site level;
- A focused ethnographic study comprising interviews with selected users of the VCT and HIV/AIDS treatment services.

In essence, the purpose of the situational assessment was to establish contact with all stakeholders, in the first instance to gain a broad understanding of the contextual landscape, and also to secure buy-in and negotiate the logistics for the ethnographic study to follow, which was concerned with interviews with employees themselves. Thus, while the situational assessment interviews were designed to elicit a broad organisational picture, the ethnographic interviews were designed to add vertical depth to this tapestry, thereby rendering an understanding of the individual and contextual influences on VCT and treatment participation rates at this workplace. This would in turn enable the design, implementation and evaluation of a revised intervention, to follow in phase two of the project.

Given the scale of this dissertation, this report is concerned only with the situational assessment, with the ethnographic study comprising a separate and forthcoming report. In this sense it must be recognised that the data reported on in this situational assessment will render a preliminary organisational picture only, and will need to be reviewed and tested against data emerging from the ethnographic study to follow.

3.4.3 Locating the Situational Assessment:

The situational assessment consisted of 1) An analysis of key company documents concerned with the HIV/AIDS programme; followed by 2) Interviews and focus group discussions with key organisational stakeholders. Both the documentary and interview data was analysed and written up to provide recommendations and guidelines for conducting the ethnographic and cost impact study. The central foci of the situational assessment, and hence of this dissertation report, included:

- A review of policies, procedures and practices to identify key social and organisational factors governing the operation of the company's HIV/AIDS workplace programme and, specifically, the uptake of these services
- A review of the company's HIV/AIDS programme and specifically its VCT and treatment services, including stakeholder roles and organisational dynamics

The broad aim of this dissertation was therefore to unravel the contextual influences on VCT and treatment participation rates at the selected site, from a historical perspective (archival documentary analysis) and from the perspective of organizational stakeholders (interviews and focus groups).

It was recognised from the outset of this study that company management and unions, the HIV/AIDS coordinator and/or coordinating structures, and other key stakeholders, will desire particular outcomes with regard to this situational assessment. It was therefore considered critical that the issues, claims and concerns of all relevant stakeholders be included and addressed in this formative phase of the study in order to consolidate their fullest participation through the various phases of this project. Therefore, the key informant interviews to be conducted in this

situational assessment phase also served to inform and refine the content and methods to be employed in the succeeding stages of the project.

3.5. Data Collection

3.5.1 Documentary Analysis

An analysis and synthesis of archival and documentary data was conducted so as to inform the interviews and focus groups to follow. The following company policy and reporting sources were analysed:

Updated HIV/AIDS Impact Analysis Report (2006)

Company Cost of AIDS Project

Company and Union: Joint HIV/AIDS Policy

The VCT Campaign for the mining site: 2006 Report

Know Where You Stand Report (VCT) 2006

Review of the Company HIV/AIDS Disease Management Programme

Mine Treatment Statistics

Company website

3.5.2 Stakeholder Interviews and Focus Group Discussions

Saturation sampling was used so as to ensure that all the key stakeholders in the HIV/AIDS programme at the selected mine were interviewed. Interviews were conducted with the following key stakeholders:

1) National HIV/AIDS Coordinator (Company Head Office)

2) The Union's mining Sector and HIV/AIDS coordinators

3) Operations Manager of the selected mine

3) Mine Human Resources Services Manager

4) Mine HIV/AIDS Coordinator

5) Mine Wellness Coordinators (X2)

6) Mine Peer Educators: who were sometimes also Shop Stewards

7) Shop Stewards: who were sometimes also Peer Educators

8) Clinic Personnel: Including Doctor and Nurses (X2)

9) Mine Pharmacist: located centrally

In addition, focus group discussions were conducted with the following stakeholders:

1) Mine HIV/AIDS Coordinating Committee

2) External VCT Service Provider: comprising nurses and counselors

3) Shop Stewards Forum at the selected mine

Key issues to be explored in the interviews and focus groups were foreshadowed using three sources, viz. a preliminary documentary analysis, a review of the empirical literature on factors impacting on uptake rates of VCT and treatment in the workplace and the theoretical frameworks considered appropriate to the study. A semi-structured interview/focus group schedule was accordingly devised so as to guide the interview process, without being overly prescriptive (Appendix 1).

Eight focus group discussions were conducted first, which helped the researcher to understand the organisational terrain and the issues, claims and concerns of all stakeholders. Through this iterative process, key areas of agreement and divergence amongst stakeholders were identified and these issues in particular were explored in greater depth in the fourteen individual interviews that followed.

3.6. Epistemological Approach to Qualitative Research

In all research, the researcher seeks to examine data to discover patterns, and even to identify cause-and-effect relationships (Ulin, 2002). However, qualitative and quantitative analysis differs in the methods of analysis. The researcher from a quantitative paradigm focuses the research question, identifies variables and controls confounding variables, whereas the qualitative researcher seeks to understand a detailed, in-depth broader context, where meanings of ideas or concepts are formed while data is being collected (Ulin, 2002). Therefore, a qualitative approach will be used for this study, as it will provide an in-depth and detailed understanding of the organizational and personal experiences, incidences and occurrences that make up the contextual milieu for the VCT and HIV/AIDS treatment services at the study site. This method is a better option than quantitative methodology in this formative stage of this longitudinal study as it considers the importance of understanding the meaning of experience and action through the eyes of the participants and researcher (Richardson, 1996). It is also sensitive to complex behavior and meaning as it occurs in its natural context (Richardson, 1996).

Padget (1998) states that qualitative methods are inductive and naturalistic, seeking to discover meaning, instead of testing explanatory theories and relying on traditional scientific enquiry. Qualitative methods convey meaning or behavior through 'thick description', instead of determining variables and categories, as in quantitative methods. Qualitative research involves the context under study as well as the observer, who is seen as an integral part of the observation made. This is different

from quantitative research, where the effects of the context as well as the observer are neutralized.

Bannister, Burman, Parker, Taylor & Tindall (1994), define qualitative research as firstly, an attempt to capture the sense that lies within, which in turn informs what we say about the things we do, secondly, as an exploration, elaboration and systematization of the significance of an identified phenomenon and thirdly, as the representation of the meaning of a specific problem. However, Bannister et.al. (1994) argue that qualitative research is part of a debate and is not something that is fixed in meaning. Qualitative research is an awareness of the gap between an object of study, the way it is represented by the researcher and the way interpretation fills the gap. Many qualitative approaches exist, including discourse analysis, ethnography, phenomenology, etc. Ethnography is seen as a method which touches upon or changes a person and/or a community (Bannister, et.al. 1994). Therefore, this study will take on an ethnographic approach, as it is hoped that at the end of the entire study, the improvement of the interventions at these sites will be derived from the experiences of the participants themselves and importantly also, inform a process of change in the way all stakeholders view, respond and participate in their VCT and HIV/AIDS treatment programme.

3.7. Data Analysis

A total of fourteen interviews and eight focus groups were conducted. All interviews and focus groups were conducted in English, were recorded with the permission of respondents and were subsequently transcribed verbatim (Appendix 2). A quality assurance check was conducted with random sections of the tape compared against the transcripts. Data from the interviews and focus groups were coded and analyzed by using a modification of the system developed by Morgan & Krueger (1993). A coding framework, which included a priori codes as well as emergent codes, was developed from themes & concepts from across groups & individual interviews. Essentially, this involved the identification of themes through a reading and re-reading of transcripts and by listening to the tapes. Then a list of themes across all interviews and data was developed and then reduced and coded using Nvivo7, a qualitative data-management software programme. This tool enabled the researcher to store and code the data and then search for the data thematically.

3.8. Ethical Considerations

Consent to conduct the study was obtained through a consultative process with the company and with relevant trade unions operating at the study site. This consultative process served not merely to secure the consent of these stakeholders, but to ensure that they participated fully in defining the research questions and methods, in line with the epistemological paradigm adopted in this study. Ethical approval for the study was obtained from the Ethics Committee of the Faculty of Medicine of the

University of KwaZulu-Natal (Appendix 3). The company consent letter is not provided in the appendices to preserve the confidentiality of the company identity.

Most importantly, informed consent was obtained from all participants in the study, including managers, shop stewards, health educators, peer educators, clinical staff and the HIV/AIDS coordinator. These participants were informed of their right to withdraw from the study at any stage. They were assured that results will not be reported by individual name, but by group, meaning that while individuals will remain anonymous, it is possible that the opinions or views of constituencies might indeed be identified from the study report. The researcher presented and explained an informed consent form, detailing the above issues, to each participant prior to them being asked to sign the said form (see Appendix 4).

Chapter Four: Research Results

4.1. Documentary and Archival Analysis

4.1.1 Cost and Impact of HIV/AIDS (based on the *Updated HIV/AIDS Impact Analysis Report, 2006*)

This report provides relevant information for informed management decisions in response to the progression of HIV/AIDS. It supports reporting on the impact of the epidemic on operational sustainability and estimates current and future costs and funding liabilities that arise with the provision of treatment for employees and their spouse/life partner. It provides an updated impact analysis to test and validate the assumptions underlying projections in comparison to actual experiences.

Treatment Programme Registrations

Table 1 below compares the actual patient registration numbers in September 2005 to the expected numbers derived from projections made in 2003. While it was assumed that a limited enrolment period would encourage a larger number of employees seeking treatment, the evidence indicates that enrolment by both employees and spouses and life partners proved to be poorer than anticipated.

Table 1: Treatment Programme Registrations as at September 2005 (Source: *Updated HIV/AIDS Impact Analysis Report,* 2006)

	Employees On Wellness	Employees On Treatment	Active Employees In Programme	Partners Of Active Employees	Former Employees And Partners	Total Number of Patients on Programme
Actual (2005)	51	194	245	68	93	406
Expected (2003)	648	210	585	427	126	1139

Projections of Future Treatment Programme Use

Table 2: Projection of number of patients on the treatment programme over 15 years (2006-2020) *(Source: Company Cost of AIDS Project)*

Year	Employees On Wellness	Employees On Treatment	Active Employees In Programme	Partners of Active Employees	Former Employees And Partners	Total Number of Patients on Programme
2006	48	184	231	59	93	**384**
2007	59	223	282	72	87	**441**
2008	65	252	317	81	79	**477**
2009	70	272	342	88	70	**499**
2010	71	287	358	92	60	**510**
2011	72	297	369	95	50	**513**
2012	73	302	374	96	41	**511**
2013	72	306	378	97	33	**508**
2014	71	304	375	96	27	**498**
2015	70	304	374	96	22	**492**
2016	69	302	371	95	18	**484**
2017	68	301	369	95	16	**480**
2018	67	300	367	94	14	**475**
2019	67	299	366	94	12	**472**
2020	67	301	368	94	11	**474**

The projections in Table 2 above are based on the assumptions that uptake of the treatment programme will continue in future and that the treatment programme will continue in its current form. In an ideal situation HIV positive employees will attend VCT and then join the treatment programme and if it is too early to treat these patients with the particular mine treatment programme, they can still be monitored though the wellness programme. However, the relatively small number of Wellness patients shows that this is not happening. The data in fact demonstrates that employees are only joining the mine treatment programme when they are in the advanced stages of the disease and they require the treatment. The high VCT attendance level means that employees are aware of their HIV status but are choosing not to join the treatment programme, with possible reasons for this including confidentiality and attitudinal factors.

Impact of HIV/AIDS on Sustainability

Table 3 below illustrates the projected HIV/AIDS related costs to the company. But these figures only represent costs related to HIV/AIDS and not costs such as paid sick leave taken for reasons other than HIV/AIDS. Further, the impact of HIV/AIDS on the retirement fund and medical scheme arrangements were not included in this analysis. The cost projections show that while HIV/AIDS impacts on the workforce and on the company's operations, the magnitude of the impact will not be uniform for all operations. The HIV/AIDS epidemic is a risk that will require continuous management, but it doesn't pose a significant threat to the long-term sustainability of the company. This can be seen in the relatively low proportion of HIV/AIDS related costs as a percentage of total labour costs.

While treatment costs for active employees and their partners can be expressed on an annual basis, providing post-employment benefits will be a less easily quantifiable liability for the company. According to company policy, employees and their partners who register for the treatment programme are entitled to life-long benefits from the programme. Employees who are disabled, retired or retrenched will continue to receive benefits, while employees who resign or are dismissed will not.

Table 3: Projected Cost of HIV/AIDS for All Employees: 2006 – 2020 (Source: *Company Cost of AIDS Project)*

Year	Paid Sick Leave Costs (R'000)	Productivity Lost while as Work (R'000)	Training and Replacement Costs (R'000)	Cost of Processing Medical Disability Cases (R'000)	Cost of HIV/AIDS treatment Programme (R'000)	Other Medical Costs (R'000)	Total HIV/AIDS related costs (R'000)	Average cost of HIV/AIDS per employee (R)	Average cost of HIV/AIDS per HIV + employee (R)	Average cost of HIV/AIDS as % of Gross Payroll
2006	1,263	4,881	251	243	6,083	1,544	**14,265**	1,081	16,982	1.1%
2007	1,256	4,922	248	241	5,972	1,531	**14,356**	1,095	17,422	1.2%
2008	1,231	4,886	252	243	5,833	1,492	**14,301**	1,092	17,765	1.2%
2009	1,191	4,777	234	226	5,671	1,431	**14,065**	1,067	17,986	1.3%
2010	1,145	4,631	224	217	5,489	1,369	**13,777**	1,036	18,032	1.3%
2011	1,097	4,480	212	206	5,303	1,302	**13,461**	1,002	18,092	1.3%
2012	1,047	4,308	193	189	5,114	1,242	**13,108**	962	18,030	1.4%
2013	997	4,126	177	180	4,930	1,182	**12,755**	922	17,864	1.4%
2014	957	3,980	163	157	4,743	1,125	**12,430**	884	17,732	1.4%
2015	916	3,818	148	146	4,568	1,082	**12,121**	848	17,440	1.5%
2016	880	3,673	144	140	4,398	1,042	**11,852**	817	17,227	1.5%
2017	850	3,565	132	132	4,241	1,016	**11,639**	792	16,991	1.6%
2018	818	3,444	128	127	4,089	985	**11,416**	766	16,666	1.6%
2019	788	3,321	114	113	3,948	968	11,195	740	16,296	1.7%
2020	760	3,213	115	115	3,813	947	**11,021**	719	15972	1.7%

Central recommendations arising from the above analysis included:

- Need for information gathering system to obtain ongoing data on the impact of HIV/AIDS on employees, assessment of the effectiveness of the interventions and an indication where more drastic measures are required;
- The impact of HIV/AIDS on the workforce needs to be managed continuously, but must be managed in relation to other employee health issues;
- Early uptake of the treatment programme is low; therefore efforts promoting the programme in future must address concerns regarding confidentiality issues and emphasis should be on joining the programme early.

Financial Costs

The cost of the wellness programme for each registered patient on pre-HAART per annum is R1 700 and the cost of treatment per patient on HAART is R18 000 per annum. Previously, HIV/AIDS related hospitalizations for employees and their spouse or life partner was assumed to have been funded through the mine medical facilities, on those sites where these facilities exist. However, it is now assumed that hospitalization will only be provided in cases where the employee is currently entitled to such services at a mine hospital and other hospitalizations will occur at state facilities. In terms of its policy, the company will not subsidize terminal and home-based care.

The Company Fund (Source: the company website)

The Company's Fund, managed by a non-profit organization, was developed independently of the company in 1998. While this entity manages the social investment

funds of client companies, these funds are held independently, with their own funding and strategic criteria. Hence, the role of the management company is to manage and provide a governance structure to the funds, administer client funds and projects, manage beneficiary relationships, make recommendations to a fund board of trustees as well as to initiate projects and monitor and evaluate projects. It is stipulated that a minimum of 75% of funds received by the company's fund, must be dispersed on an annual basis.

The Company's Fund's board of trustees has mandated the management entity to decide and execute project funding up to R100 000. Consent was given for funding of up to R10 000 per project for small social investment initiatives in company's mining areas of operation. Beneficiary or partner organizations receive guidelines that outline performance and reporting requirements, which is monitored and managed by the management entity. However, when larger projects take place, the management entity and the Company Fund becomes involved on an ongoing process.

The Company Fund has also received significant requests to support people and projects at a community level. The Company Board has accordingly committed a substantial sum of money for the next three years to a separate community-based HIV/AIDS programme in South Africa.

4.1.2 The Company and Union: HIV/AIDS Policy

The joint HIV/AIDS workplace policy, agreed in partnership by the Company and the Union, had been developed in line with national and international guidelines and codes of practice. The purpose of the policy is as follows:

- Provide a framework for HIV/AIDS awareness, prevention and wellness programmes
- Provide a framework for managing HIV/AIDS in the workplace in an appropriate, effective and consistent manner
- Aim to eliminate unfair discrimination in the workplace based on HIV infection, whether infected or affected
- Promote a supportive workplace environment regardless of workplace status
- Provide clarity with regard to the extent and source of assistance made available to those infected and/or affected by HIV/AIDS
- Provide a framework for the effective use of quality controlled anti-retroviral therapy in a careful and appropriate manner.

In terms of VCT, the company will provide and facilitate access to VCT for employees and their spouse/life partner, in terms of the following conditions:

- Testing will only take place on the initiative of an employee or where he/she has been advised by his/her doctor to test for medical reasons
- Testing will only take place within a health care or professional-patient relationship
- Testing has to include pre-test and post-test counselling
- VCT will take place in adherence to strict confidentiality and disclosure requirements

- Tests will be conducted in terms of the Department of Health's National Policy on testing for HIV/AIDS.

It has also been acknowledged that individuals will only participate in VCT if they will not be discriminated against by the company, their fellow employees and the community in the event that they are HIV positive, and only if they stand to gain from doing so by having access to appropriate medical care for HIV/AIDS. The HIV/AIDS policy was to have been taken to employees through shop stewards and peer educators. Their stated role is to make employees aware of the key policy imperatives regarding their rights in respect of HIV/AIDS, as a means of precluding or ameliorating fear of a positive diagnosis and its consequences, and reinforce their right, in terms of the policy, to receive proper care and treatment for HIV/AIDS.

4.1.3 Voluntary Counseling and Testing (based on *The VCT Campaign for the Mine 2006 Report* and *Know Where You Stand Report (VCT) 2006.)*

In the past, the purpose of testing for HIV was to diagnose people who showed clinical signs of infection. However, today it is possible to identify infected people years before they show signs of HIV infection, and give them all the information and support possible for them to live a longer, better quality life than would have been the case if they were only identified when clinical indicators of infection became visible. The Company's approach is to encourage regular testing for HIV for various reasons, including: identifying and treating persons who are HIV+, recognition that a negative result should create peace of mind for employees, VCT would improve risk management regardless of

the outcome of the test, and it would also encourage employees to reduce high risk sexual behaviours.

The Benefits of VCT

These documents outline several benefits of VCT, including the following:

- There is sustainable economic value for organizations in implementing HIV/AIDS initiatives (including VCT), monitoring it, measuring outcomes, and achieving optimal performance standards through an AIDS Management System
- Early detection of HIV positive employees can be effectively addressed with a lifestyle plan, knowledge inputs and new skills to allow these employees to make decisions to manage their own health and well being.
- Pharmacological treatment can be introduced at the appropriate time in terms of disease progression.
- VCT is an effective and critical strategy in preventing HIV/AIDS infection and in identifying and caring for those who are infected.
- People who go for VCT would be more likely to engage in safer sexual practices, irrespective of the test result.
- Provides an opportunity to learn more about the virus and how to take care of ones' health.
- People who are diagnosed as HIV positive will be given information, counselling and treatment on how to live positively with the virus.

The VCT Process

A typical Company Clinic has two nurses, a wellness coordinator and a supervisor who facilitates VCT and coordinates the treatment service. The Company provides or facilitates VCT access to all employees and his or her spouses or life partner and encourages testing for everyone. The VCT process is typically as follows:

- The employee arrives at the medical centre, either on or off-site
- Employee is pre-counselled and undergoes a saliva or blood-based rapid test
- For a positive result, a secondary, confirmatory blood test is done during the same visit. For an inconclusive result the test is sent to the laboratory for analysis
- The employee is given his or her result during post-test counselling which will occur, irrespective if the test is positive, negative or inconclusive
- If the employee has a positive result, he is encouraged, together with his life partner or spouse, to join the company treatment programme, and all necessary information and contact details are provided in this regard. Treatment for employees is managed through the treatment programme, while treatment for contractors is managed through the contractor treatment programme.
- If possible, the person should also be referred to a community health programme for additional support, counselling and information.

At the Mine, management and union took the test together to officially launch the VCT programme for 2006. Testing was divided into three main sections, with the test being conducted at the first mining section over the first three weeks, followed by the second mining section for another three weeks and finally at above-ground Business

Units for four days. Community testing was also conducted. For the employees on leave during the time of the VCT campaign, a follow-up campaign was held three months later.

Some of the major observations were that most infected employees were contractors between the ages 24-35, the most productive age group, thus producing serious concern for the company and the economy. Contractors are highly mobile, making it really difficult for them to stay on their treatment programme. Of further concern, infection patterns of women in isolated community's are often closely linked to the sexual behaviors of contractor populations. Literate employees and those with their own medical aid did not regard the VCT programme as useful, though this is known to not necessarily result in preventative actions.

Participation Rates for the mine VCT Campaign (2006)

Table 4: Employee Participation in the Mines' VCT Campaign 2006

VCT GROUPS	***PERM & TEMP EMPLOYEES***	***CONTRACTORS***	***AVERAGE***
Ore Extraction	75%	86%	80%
Ore Processing	82%	92%	87%
Technical Services	67%	95%	81%
Admin & IT	88%		
HR	76%		
RPS	85%		
Mine & Contractor Average	**78%**	**91%**	**84%**

Success Factors: VCT 2006

Some of the factors that contributed to the success of the VCT campaign for 2006 were as follows:

- Strong leadership, whereby managers and supervisors took the lead in testing in their numbers. Leadership among contractor employees also proved to be essential to assist employees who tested for the first time.
- The theme,*" Responsible teams test together",* was incorporated into the mine values resulting in a positive message being built into the campaign.
- Well-planned programmes prepared by the Wellness team.
- Good logistical arrangements, including in particular the VCT launch
- The provision of incentives for testing
- Option of an oral test or a rapid blood test

Issues Raised by Employees

Some of the major concerns of the employees included:

- How accurate and sensitive is the test?
- How regularly should the test be taken if one's status was negative?
- How effective are condoms and why is the female condom not commonly available?
- If the virus is present in saliva is kissing dangerous?

4.1.4 Treatment (based on *Review of the mines' HIV/AIDS Treatment Programme*)

In August 2002, the provision of treatment to employees and their spouse/life partner was approved (although the company retained the right to review its position after two years) and the treatment programme was formally introduced on 1 July 2003. According to the *Joint HIV/AIDS Policy* and the *Review of the Company's Disease Management Programme*, an integrated strategy is required for the effective management of HIV/AIDS in the workplace. The Company and Union have agreed that the following key components should constitute the HIV/AIDS disease management programme:

Components of the HIV/AIDS Disease Management and Prevention Programme

Workplace information and education programmes are essential to tackle the pandemic, foster greater tolerance of employees with HIV/AIDS and capacitate employees to protect themselves against HIV infection. An effective workplace programme will consist of the following components:

- Sero-prevalence testing and knowledge, attitude and practice (KAP) surveys
- A culturally appropriate awareness, education and counselling programme
- Health promotion campaigns, including promoting VCT and distributing condoms
- Establishing peer education programmes with continued support by HIV/AIDS coordinators and shop stewards
- Systematic and ongoing provision of credible information about HIV/AIDS
- Strong awareness-raising messages
- Treatment of other sexually transmitted infections, which is an important risk factor in the spread of HIV/AIDS.

Voluntary Counseling and Testing

Individuals will only participate in VCT if they are convinced that they will not be discriminated against by the company, fellow employees and community members and if they stand to gain by acquiring access to medical care related to HIV/AIDS. The Company will provide treatment to employees and their spouse or life partner, under specific conditions, including that testing will only take place where a doctor has recommended testing for medical reasons, testing will take place within a health care setting, testing must include pre and post test counselling, VCT will take place in strict confidentiality and will be conducted in line with the Department of Health's National Policy on VCT.

Epidemiological Surveillance and Research

The Company and union are committed to conducting regular and systematic epidemiological and surveillance research so that policy, HIV prevention and care initiatives are planned and evaluated effectively. Anonymous, unlinked surveillance and epidemiological testing will take place in accordance with the ethical principles of scientific research and the protection of individual rights and confidentiality.

Employee Counselling and Support Programmes

The need to provide employees living with HIV/AIDS access to confidential counselling and assistance was recognized. This resulted in the company striving to establish and expand employee assistance programmes, identify appropriate service providers and facilitate the referral of employees affected by HIV/AIDS to self-help

groups and support organizations, and empower HIV/AIDS coordinators and peer educators to facilitate such services.

Medical Treatment of HIV/AIDS

Medical treatment is provided to any employee that is rendering a service at the mine's South African operations. This includes employees who provide temporary services, independent contractors, and individuals providing services to the company through a contractor, labor broker or temporary employment service. Treatment was also recognized to be a part of the workplace HIV/AIDS treatment programme. The individual must be permanently employed by the company, be a legally married spouse or life partner of a qualifying employee, be a retiree, retrenchee, employee on ill-health retirement or an employee whose services have been terminated due to medical incapacity and had registered on the programme before leaving the company. The medical treatment of employees, spouses or life partners with HIV/AIDS will include information and education on a healthy lifestyle, regular medical examinations, outpatient treatment of HIV/AIDS at operational sites and community facilities, access to adult treatment, access to pre-natal mother-to-child transmission prophylaxis to employee, spouse or life partner, access to VCT, access to prophylactic treatment for employee, spouse or life partner, training and information on home based care.

Since the launch of the treatment programme in 2003, a total of 362 patients were enrolled on the treatment programme as at December 2005. 7 registered patients left the programme, while there were 24 deaths on the programme. 258 of the then currently

registered patients were employees. 15 mother-to-child-transmission prophylaxis interventions occurred. Of the 362 patients, 194 enrolled at an advanced stage of the disease (i.e. pre-AIDS and AIDS), and 168 of the then currently registered patients were on treatment. Although the above figures are from 2005, a much more recent look at the treatment statistics follows.

The Mine Treatment Statistics

According to the Mine treatment statistics for treatment patients as at August 2007, 28 employees had been registered on treatment for the year to date, 24 of whom were currently registered. The spousal uptake of treatment proved relatively low, with just 5 spouses being registered on treatment. Of the 24 patients currently registered on treatment, 10 were adherent to the treatment and 2 defaulted. Regarding wellness, 8 were compliant, while 4 defaulted. 2 of the patients were retired, 5 were off the programme through death and 1 patient was off the programme through a dismissal or resignation.

Table 5: Mine- Treatment Programme Statistics

MINE TREATMENT STATISTICS 07-Aug 2007	
Total employees Registered	28
Spouses Registered	5
Patients currently Registered	24
Treatment-Compliant	10
Treatment-Default	2
Wellness-Compliant	8
Wellness-Default	4
Retired-F/U LAC	1
Retired-Left LA	2
Off programme-Died	5
Off programme-Dismissed/resigned	1

The contractor treatment programme is an external service provider that renders treatment to the contractor population at the mine. The contractor population is mobile, i.e. they do not stay at one site all the time. This treatment programme provides treatment to HIV positive contractors and this treatment is available at all company sites, therefore when contractors move around from site to site, they are still entitled to having the same treatment. However, because treatment has to be taken up on their own initiative at various sites, treatment uptake in the contractor population is much more difficult to promote and manage.

Table 6: Mine-Contractor Treatment Statistics for 2006 and 2007

Date	Registered	Treatment Started	Contractors	Community	Deregistered
Totals 2006	59	8	56	3	2
Totals 2007	33	8	23	10	9

The contractor treatment programme statistics for 2006 and 2007 reflected above shows that 59 patients were registered for 2006, while 33 were registered for 2007. Of these figures, 8 started treatment in 2006 and 2007 respectively. Of the totals registered, 56 were contractors in 2006 and 15 in 2007, while 3 were community members in 2006 and 10 in 2007. At the end of 2006, 2 patients deregistered, while in 2007, 9 had deregistered.

Table 7: Mine-Contractor Treatment Adherence and Default Statistics as at August 2007

2007	AUG
Total Registered	92
Currently registered	81
On Treatment-Adherent	15
On Treatment-Defaults	0
Wellness-Adherent	68
Wellness-Default	19

The above statistics shows that at the end of August 2007, 92 patients were registered on the contractor treatment programme, with 81 being the total of those currently registered. 15 patients were on treatment, of whom none had defaulted. 68 patients were adherent with the wellness programme, while 19 had defaulted.

The company has responded comprehensively to model, monitor, minimize and manage the impact of HIV/AIDS on the organization and this response includes sustainable access to treatment for employees and their life partner or spouse. The *Review of the Mines' HIV/AIDS Treatment Management Programme* shows the major gaps in the programme to be the relatively low enrolment of employees who know their HIV positive status on the treatment programme, as well as relatively poor uptake by spouses.

4.1.5 Prevention and Community Outreach

After a thorough review of archival documents, it is clear that formal documentation on the company's HIV/AIDS prevention strategy and monitoring and evaluation of preventions interventions and actions does not exist. Peer education programmes and management training programmes do take place, and there is evidence of great effort to ensure quality and best practice, but the history, form and substance appear to have varied considerably by site. The extent and frequency with which preventions interventions are monitored, even informally, is not clear.

From a community perspective, there is evidence of impressive efforts to extend the company's HIV/AIDS intervention programme into labour supply communities at the

various mine sites. A few examples taken from the company website will be highlighted. These community HIV/AIDS programmes span a range of different projects, including prevention, provision of treatment, care and support, as well as the provision of healthcare services and action research projects. The purpose of community based HIV/AIDS programmes is to extend what has been implemented in the workplace setting into communities around each mining operation. In keeping with the confidential nature of this project, the true names of the programmes will not be mentioned.

Programme One: Programme for Children

This scheme was established to alleviate malnutrition amongst destitute children in Gauteng and distributes food to approximately 18 000 children daily. Approximately one-third are HIV positive or have AIDS-related illnesses. There are also 3 rehabilitation centers for extreme cases, and about 75% of the children in these centers are living with HIV or have become orphans due to AIDS. The Company Fund has distributed R750 000 to the scheme since 2003.

Programme Two: Scheme for Single Mothers and their Infants

This scheme is a care centre for single mothers and their infants, which also provides shelters and services such as home-based care, community development and capacity building to abused and abandoned children who are living with HIV. The Company Fund has supported this scheme since 1999, and provided at least R480 000 in 2006 for the purchasing of a building so they could care for older HIV positive children on treatment.

Support has included outreach programmes and home-based care at Chris-Hani Baragwanath Hospital, providing more than 1200 children with treatment.

Programme Three: Non-Governmental Organization Initiative

Institute for Health and Development Communication is a non-governmental organization promoting health and development through the use of mass media. It aims to have an impact on society at the individual, community and socio-political levels. Good health is envisaged as a product of an enabling environment to achieving health and development, rather than as the product of individual choices. These non-governmental initiatives capacitate communities through the training of NGO's and community leaders who use materials covering a wide range of issues, such as HIV/AIDS, water and sanitation and violence against women. The Company Fund has supported this initiative with R2.5 million per annum for a three-year period, based on an annual review of progress. In collaboration with the company, this initiative is extremely active in the labour-sending communities neighboring the mine.

Programme Four: Scheme for Child and Youth Care Workers

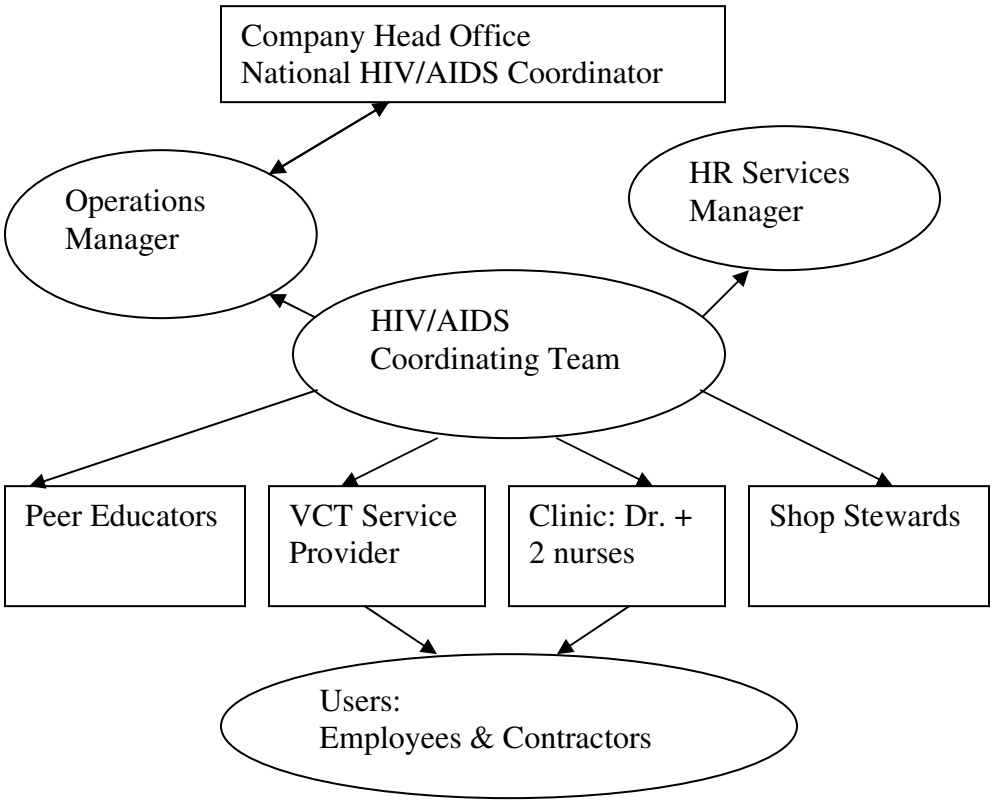
This disadvantaged area is home to important labour-sending communities for the company's mining operations at another site. The effects of HIV/AIDS on this community have led to an increase in child-headed homes. This initiative is a model of child-care that aims to address this challenge through training community members as qualified, registered child and youth care workers. Child and youth care workers work intensively with individual families and provide assistance in securing social support

grants, counselling, help with homework and household chores, and emotional support normally provided by a parent.

4.2. Stakeholder Interviews and Focus Group Discussions

The results from the stakeholder interviews and focus groups are discussed in terms of the current structure of the HIV/AIDS Steering Committee and the provision of HIV/AIDS services at the mine. The structure is organized as demonstrated in Figure 1 and explained below:

Figure 1: Structure of HIV/AIDS Steering Committee and Role of Stakeholders



1) HIV/AIDS Coordinator: Responsible for all aspects of the HIV/AIDS programme. She reports directly to the Human Resources Service Manager, but has a dotted line to the Company's National HIV/AIDS Coordinator at Head Office

2) Wellness Counsellors: Two nurses who support the HIV/AIDS Coordinator in the execution of her functions. They do not perform a clinical role at the clinic

3) Operations Manager: is the mine manager

4) Human Resources Services Manager: Reports to the Operations Manager on all aspects of the HIV/AIDS programme

5) Clinic Personnel: Includes one Doctor and two Nurses

6) Peer Educators: Sometimes both Peer Educator and Shop Steward (approx. 30)

7) Shop Stewards: Sometimes both Shop Steward and Peer Educator (approx. 25)

8) VCT Service Provider: External Service Provider, with a team of 10 Counselors

9) HIV/AIDS Coordinating Team: HIV/AIDS Coordinator and two health educators

10) Union Shop Stewards Forum: Comprises all shop stewards (25) at the mine

11) Chief Pharmacist: located at the other site, the chief pharmacist is responsible for the provision of treatment to all of the company's operations

12) Users of Mines' VCT/Treatment Services: Employees/contractors/spouses/partners

4.2.1 Mine Management

Support from Company Head Office

For any programme or campaign to be successful, support and buy-in from the highest level of an organization is crucial. Through the interviews with the mine manager and HR

Services Manager, it was clear that there has been a fair amount of support from Head Office.

> *"I think we are very much in line with Head Office. So the alignment I think is very good and they also give us guidance, you know, showing which areas we could spend more focus on"* (Operations Manager).

Each site has been given the space to do what is suitable for their mine, in terms of HIV/AIDS and the VCT campaigns and they have to develop suitable strategies and plans in order to reach the demanding targets set annually by mine management.

> *"So we got a lot of freedom from them, but there is also a lot of demands in terms of results. Our target this year is 90% uptake, you come up with the initiatives and strategies and so on, this is the result we want"* (HR Manager)

Role of Management in VCT

Management support for reaching goals and targets in the VCT campaign is essential, especially because employees are more willing to participate in any campaign if they witness active participation by management. At the mine, management has been included by the HIV/AIDS coordinating team in all campaigns and meetings, viz.:

> *"See with the management they have to set an example. That is why when we do our campaign; we will always invite them, together with the branch leadership, the union"* (Health Educator)

There was one incident, in 2003, where a management member disrupted the VCT session by saying that VCT was 'time-wasting', however this was dealt with quickly and effectively.

> *"… 2003 or 2004 we had some situation where one of the EXCO members actually disrupted the session. That was an ugly scene."* (Health Educator)

Management from the mine underwent HIV/AIDS management training, where managers were trained on four modules on HIV/AIDS including day-to-day situations and the HIV/AIDS policy. In addition, quarterly sessions are held, where managers discuss the company's current and future HIV/AIDS situation with employees.

> *"And I think what has assisted us, was that last year this was the first site that underwent. …what they call HIV/AIDS management training. Different models, we had four modules telling you, giving you more information as far as HIV/AIDS is concerned."* (Operations Manager)

4.2.2 HIV/AIDS Coordinating Committee

Role of the HIV/AIDS Coordinating Team

From the perspective of management, the HIV/AIDS coordinating team runs very successful campaigns. The coordinator reports to the HR Services Manager, who allows a fair degree of latitude for her to produce innovative, successful campaigns. Tremendous

work has also been done with contractors through education and communication interventions. The team puts in a great deal of time, effort and creativity into their initiatives and this has been crucial in developing trusting relationships with employees.

> *"…they are very innovative and in the past they've come up with great ideas and implemented great suggestions which I believe contributed to our success…great work among the contractors, the uptake we can attribute purely from an educational and communications point of view and a commitment point of view"* (HR Services Manager).

In 2002, when the VCT programme was being developed, there was minimal support from management and Head Office due to a perception that the HIV/AIDS problem was minor and their involvement was not required. However their perception changed when the current HIV/AIDS coordinating team attained a high percentage of participation in VCT and much improved results a few years thereafter. The HIV/AIDS coordinating team at the mine has been consistently proactive in their campaigning and strategies as can be seen in the tremendous participation rates achieved.

> *"… the VCT was non existent, they thought the doctors and the nurses will do VCT and the problem is not so big and we will do what all the others are doing.. but we showed what we can achieve with everybody's combined effort"* (HIV/AIDS Coordinator)

Relationship Issues with Management

The HIV/AIDS coordinator was concerned about her reporting structure, which creates a degree of distance from mine management.

> *"I report to the HR Services Manager, who in turn reports to the HR Manager, which means that I do not have direct access to the mine Operations Committee (OPCOR). This is a pity, as direct access would really facilitate the work of my office"* (HIV/AIDS Coordinator)

The coordinator was of the view that while conducting presentations at OPCOR level is essential in order to gain access to people, there is not much opportunity for her to do so. The incident reported on below clearly shows her level of concern with regard to her experience of communication with management.

> *"…the moment I started in my first sentence of my presentation, I was interrupted by the then commercial manager, who said, you are just going to ask for more money and we've dealt with this. In the end it was such an unfortunate meeting…"* (HIV/AIDS Coordinator)

She reports ongoing difficulties in negotiating between the local demands at mine level with the expectations at Head Office level, the two often not being aligned. This difficulty arises partly from the fact that although her direct line manager is the HR

Services Manager at the mine; she is expected to be in line with what is required from various parties at Head Office.

> *"Communication is made more difficult because it is compounded by the fact that HIV and CSI line functions at Head Office, often pull in different directions, which might not be in tune with local realities at our mine level"* (HIV/AIDS Coordinator)

The composition and frequency of steering committee meetings is also problematic. The structure of the steering committee consists of the HR Services Manager, union members, health and safety representative, ore processing and ore extraction representatives, an admin representative and a contractor representative. However, attendance at these meetings is problematic.

> *"And we have a meeting like that at eleven o` clock and I tell you if there is four people that's going to be there…you'll be lucky"* (HIV/AIDS Coordinator)

4.2.3 Peer Educators

Peer educators are employees who volunteer to do educational work with fellow colleagues and represent them by expressing their concerns and identifying their needs in meetings. Since shop stewards are trusted and capable, they are often trained to become peer educators therefore many shop stewards at the mine are also peer educators.

> *"Peer educator, it's like to advise people, go out, let me say my section, if there is a safety topic around HIV/AIDS that's been given to the peer educators. A peer educator, it's the topic around HIV, then we'll bring it up."* (Shop Steward)

According to the VCT Service Provider and the HIV/AIDS Coordinator, the peer educators are being under utilized.

> *"…we need to make use of the peer educators. We hardly use the peer educators."* (Service Provider)

> *"No, no, their only opportunities is in green areas, safety meetings and then one on one. I feel they are under utilized."* (HIV/AIDS Coordinator)

The coordinator believes they should become part of the coordinating team, which currently consists of only the coordinator and her two Wellness Counsellors, and can therefore only do a limited amount.

At the mine, four training sessions for peer educators occur annually and this year the aim was to train a group of peer educators from the company in advanced skills. The coordinator prefers to improve the competencies of existing peer educators rather than train new ones

"What we normally do, we have four trainings a year, but this year, we only trained community and youth peer educators so far, we haven't trained employees, because we are thinking of getting the twenty-five most motivated peer educators and skill them up."(HIV/AIDS Coordinator)

4.2.4 The Union

Support for HIV/AIDS programme

According to the HIV/AIDS Coordinator, she has a very good working relationship with the shop stewards and she firmly believes that the shop stewards are supportive of the HIV/AIDS programme and the various initiatives undertaken

"The union, what influenced my relationship with the union is I knew a lot of the union members since I've been a social worker, trying to do other things, and some of them may not necessarily like me but they respect me." (HIV/AIDS Coordinator)

Before campaign start-up, shop stewards are called in and the campaigns are discussed with them. From the union's perspective, shop stewards are involved in almost all the company campaigns or initiatives and they feel strongly that they should be involved from the planning stage.

> *"…at this stage in time there is quite a good relationship with unions itself. But generally I think they bought into the scenarios that we offer. Before we start with campaigns, we normally call them in"* (Operations Manager)

However, the shop stewards did not necessarily share this view, viz.:

> *"Because the problem we have raised is that we don't want to catch something that is already upfront, then you call us just to come and assist."* (Shop Steward)

Relational Challenges with the Union

Confidentiality Problems

There was a major confidentiality breach a few years ago, when a senior manager unilaterally released HIV prevalence statistics to the local media. This caused unprecedented problems with the union and employees in general, as they felt that testing had been conducted under false pretences, because they were not informed that the results would be released. This undermined the promise of confidentiality, which is sacrosanct to the VCT campaign, and fuelled rumours at community level about the HIV status of the employees.

> *"Newspapers or radios. Some of it was on television…then when we come back over the weekend, we go to the mass meeting where the issue was raised, how can we trust the company if they do something, if they go out and say each man who works here has HIV. Everyone who works at this site, they already look at you, and they say this is the people; they got AIDS."* (Shop Steward)

Issues raised by the Union HIV Chairperson

The Union has appointed the chief shop steward at the other mine as a dedicated HIV chairperson for all mine sites. His interview is discussed here as it is relevant to understanding the organisational dynamics pertaining not only at this particular site, but also at the entire mine more broadly. The chairperson felt that when the company HIV/AIDS policy was being established there was a mutual engagement of all parties, including the union, at a national level through a joint national committee. But once the policy had been accomplished, actual responsibility was disaggregated to each mine, with no effort at coordination amongst stakeholders at a national level.

> *"We were one team when we started negotiating the HIV/AIDS policy, with a clear objectives…ensuring that you deal with the pandemic jointly."* (Chairperson)

Since the demise of the national steering committee, the union feels cut off from the decision-making process for the HIV/AIDS programmes, leading to much confusion, mistrust and dissatisfaction. He believes that a more inclusive process is vital to success, such that the union should be involved in planning and evaluation in an ongoing fashion.

> *"… if there should be a VCT programme, the first people that should be, you know talked to, is the union, then the union will go back to the members, then the*

members, based on the relationship that they have, will make sure that we are successful…" (Chairperson)

Thus, the relationship between the workers and the company has been reportedly deteriorating over the past few years. This relationship has soured more recently because of the mass retrenchments currently occurring at another mine site. While employees from all the mines have responded angrily to these retrenchments, impacting negatively on their willingness to participate in HIV/AIDS interventions or initiatives, the two sites have been most directly affected. Despite this, the study site was able to sustain relatively high participation levels in the VCT campaign primarily because of the continued support of the union, who realized the severity of HIV/AIDS.

"So coming to the VCT campaign, the reason why it is a success is because we are realizing that we need to support it even though we have these difficulties" (Chairperson)

The chairperson indicated that issues at a national level were causing problems at mine level, both with management and especially with the HIV/AIDS coordinator at another site. He acknowledges that because she is in close proximity to him, she bears the brunt of his frustration and that of the workers. He stated that because the union membership trust and look up to their shop stewards to be their champions, this puts him as coordinator in an invidious position of having to support HIV/AIDS initiatives, while trying to settle significant organizational and labor conflicts with them.

> *"Ja there is a problem. But how it affects us here, is that, you must understand that there is a different relationship between her (HIV Coordinator) and management. …… people have got a lot of mistrust on the employer, and they tend to trust me more…they are looking upon people like us as champions, you know, champion their rights look at the fight…"* (Chairperson)

On enquiry, it was acknowledged that the union had not yet submitted a memorandum to Head Office regarding their concerns and grievances, but the chairperson was adamant that the union would take formal action in an attempt to secure representation at national level regarding HIV/AIDS programme activities, and would attempt to resolve their grievances by direct communication.

4.2.5 Treatment

The Company's anti-retroviral treatment programme caters for infected employees and one spouse/partner per employee. The treatment programme includes access to doctors' consultations, pathology testing, nutritional supplements, counselling, support and medication. Medical practitioners, including the mine medical staff and private doctors, provide treatment in the areas that the employees and their partners live, thereby allowing easy access to spouses/partners who live elsewhere or for employees who are uncomfortable or do not wish to risk breach of confidentiality when receiving treatment from the mine doctor.

"…if you are not comfortable here with the doctor regarding information… then I'll rather go home to my doctor because they give us the list of doctors." (Shop Steward)

Health educators play an important role in encouraging employees to go for treatment and tracing and doing follow-ups on defaulters who do not adhere to the medication

"…where I feature in the programme is when I have to do a follow up or if the doctor cannot trace one of his clients. That's where I come in, because I have to follow up, because I know where they are." (Health Educator)

Treatment Statistics

There are two distinct but parallel treatment programmes in place, viz.: the treatment programme for permanent staff and the contractor treatment programme for contractors. The treatment programme is funded by the Company whereas the contractor treatment programme is a private organisation that follows government treatment guidelines. Treatment for patients begins at a CD4 count of 350, whereas for contractors treatment will begin at about a CD4 count of 250. Approximately 35 employees are registered on the mine treatment programme: 15 are on treatment, 15 are wellness patients, and 5 are registered with other doctors. There are 60 contractors registered on the treatment programme, out of which 6 have left Lime Acres due to being transferred. Although treatment and wellness patients should go for follow-up counselling and testing every three months, this is an ideal that is difficult to achieve.

Treatment Adherence

While HIV positive patients are meant to move directly onto registration for treatment, there is significant patient attrition between the VCT campaign and the clinic with regard to uptake and adherence. According to the mine doctor, people who are difficult to get registered onto the programme in the first place, tend to be the ones who end up being non-adherent in the middle to long term. These are probably the patients that are cajoled or bullied into coming for testing and registering for treatment.

> *"I think there is a connection in that the people we battle to get registered tend to be non-adherent, I would say."* (Doctor)

The HR Services Manager believed that employees pull out of testing and treatment because they don't trust the system enough to participate. This is where the challenge lies, to get people to believe in the system and show them that it really works and to get them registered on the programme. Developing partnerships with the union is a great success factor for the mine, and once employees are assured of union representation, they are much more comfortable with the system

> *"I'm not sure about the pulling out side, I haven't got statistics, obviously it is quite confidential in terms of who's on it and I'm not sure, I'm not going to speculate why people pulled out. But what I can say is, I don't think people trust the system enough to take it up initially."*(HR Services Manager)

4.2.6 Users: Employees and Contractors

Employee Issues

Environmental Influences

In agreeing to participate in VCT, employees use the opportunity to bargain for other things, such as bonuses. This is particularly problematic in the so-called 'hotspots' in the mine, where employees have their own ideas and own beliefs, resulting in a refusal to participate in VCT and other programmes that the company offers. In this regard, according to the wellness counsellor, significant emphasis has been placed on ensuring buy-in and support from the shift supervisors who play an important role in ameliorating resistances from employees at departmental level. But handling issues such as bonuses proves difficult for the team, given the fact that they work only with wellness and HIV/AIDS.

> *"That's why when we go to that section, we always make sure that the supervisors are there, so that if they read the question or maybe they didn't get their bonuses, that's not part of our job, here's the supervisor, you can speak to him."* (Health Educator)

Another hindrance to VCT uptake related to the timing of wage negotiations. Usually wage increases are negotiated annually in July, but in instances where negotiations drag out through the latter part of the year, VCT is sometimes used as a bargaining chip. For 2007, employees have indicated that they want to receive their increases timeously and that they don't want to be kept waiting. The health educator feared that if they don't

receive their increments at the specified time, they would use VCT to as leverage to bargain with.

> *"I am hopeful they will resolve it. Because even in any normal environment, you can't do VCT when people got issues, otherwise they are not going to take part."* (Health Educator)

According to the HR Services Manager employees are sceptical about going for any interview, unless they have good union representation. If employees hear of restructuring, it also impacts negatively on VCT uptake rates. Therefore it is very easy for employees to get destabilised by factors that are not related to HIV/AIDS.

> *"…because our mines are unionised, you will also find if you interview the employees they are sceptical to come to the interviews unless they are represented by a union member. Then there's other things, you know, when people are negative and so on, the company is going to let me go in any case, so why test. If they get a sniff of restructuring and things like outsourcing and so on its damages their chances of participation."* (HR Services Manager)

Trust and Confidentiality Issues

Another issue that restrains employees from participating in VCT and treatment are trust issues. Employees fear going for treatment, as they don't trust doctors and nurses to keep their status confidential

> *"From a treatment point of view, yes we would like to increase our numbers; we have not been successful in getting people to the programme. Once again I can only speculate as to why, I can only say it is the trust thing, you know are people going to talk about me, confidentially a priority"* (HR Services)

The HIV/AIDS coordinator believes that employees harbour residual but significant mistrust of the system because there were times when people misused their positions and abused the information they had. Hence, it is not necessarily through having experienced something of this nature, that employees have doubts and do not trust the company, it may what they have heard from others.

> *"There is a lot of mistrust regarding the information in the systems and who's got access to the systems and if individuals will be labelled. Thee are examples of people who have misused their position of using information, you understand?"* (HIV/AIDS Coordinator)

As mentioned an incident occurred in 2001, when prevalence data and statistics were released to the media resulting in a furore in the workplace and at community level. This undermined the painstaking efforts of the HIV/AIDS team and was harmful to VCT uptake as well as other HIV/AIDS initiatives.

"It still an issue that unions are raising, you know, we don't want to be the mine that has x amount of prevalence. Obviously that information needs to be contained somehow." (Ops.Manager)

Spousal VCT Uptake

Getting spouses to go for VCT or any other initiatives held for them is no easy task for the coordinating team. Firstly, the term is complex and has to be defined more broadly to encompass a spouse, a life partner or a girlfriend. Therefore:

"I think if you want to go into spouses, you will have to define it a bit wider. Because remember you can be a spouse now, but you could have been a life partner, a girlfriend and you can still be something else in the future." (HIV/AIDS Coordinator)

A significant barrier to spousal testing is the apparent reluctance of employees to confide in their partners about their status. This is a difficult undertaking, as it means that the HIV positive employee would have to admit to having other partners. Even HIV positive employees on the treatment programme find it difficult to communicate their status to their life partner. This causes major adherence problems as patients often hide their medication from their partners.

The HIV/AIDS coordinator also spoke of a time when spouses had to complete forms but most left the place marked 'spouse' blank and rather marked community members,

even though they were someone's spouse or girlfriend. Therefore, identifying spouses is complicated, and it is essential that the term be defined appropriately

> *"They all marked 'community members'. Even though they are spouses, girlfriends, life partners or whatever, employees, contractors…"* (HIV/AIDS Coordinator)

It is also difficult to get spouses to attend any function that the company holds for them. The coordinator found this to be a problem especially with the white women as these women feel that their husbands work for the company and they don't, so why should they participate or be involved

> *"And the thing is what you will also find with the spouses, especially the white women, is that, "my husband works for this company, I don't." Straight forward. Because we used to have spousal breakfast and tell them what's happening on the mine and they say please don't waste our time."* (HIV/AIDS Coordinator)

<u>Race, Cultural Issues, Sexism</u>

In terms of race, some comments were made about the white community's perception that they are not at risk for HIV/AIDS because they don't sleep around. However, the health educator believes that participation should not be based on levels of risk behaviour but rather as a sign of support for the company's campaign.

"With the white community, they will tell you, I am committed to my relationship, I am committed to my marriage, I don't move around. But, what we usually say to them is this is a campaign, it's not a question that we want to see who's moving around, who's not moving around." (Health Educator)

The coordinator and the health educators from her team have been directly exposed to racism by some white employees on the mine.

"The other thing is racism, look [Deleted], myself, more [Deleted] has been exposed to terrible racism by white people here." (HIV/AIDS Coordinator)

The Coloured community were reportedly generally supportive of the VCT campaign and does participate. However, problems have been experienced with the black community; especially with older men will not test because they believe they are too old to get infected.

"Look with the coloureds, we don't have the problem, because they always, they, they always go hand in hand with us, because they classify themselves with us. With them, we don't have the problem. And with the Africans, yes, we do have the problems, here and there" (Health Educator)

The shop steward felt that culture was an issue mainly with Xhosa-speaking people, who believe more in traditional doctors and traditional healing. Therefore when the

employees go to their own homes over holiday periods, they bring back traditional medicines

> *"No, for them (Xhosas), they rather believe in traditional doctors, they can go to a traditional doctor that can cure them, then if he say, but he wont cure as there's a problem in the company that he can assist you with medication and what. Then he said, "No I'll rather prefer traditional doctor"* (Shop Steward)

Fear

Employees are fearful of going for the test as they are scared they will test positive and then their life will have to change drastically. The health educators constantly dealt with the issue, but fear still persists.

> *"…they will say, we did one or two bad things in the past or in our lifetime, so I'm just scared. Because they will always tell you, "look, I have been enjoying my life", now if you bring a question of testing and if I test positive, that means my life that I've been enjoying, is now over.*" (Health Educator)

Contractors

The HIV/AIDS coordinating team ensures that all new contractors at the mine are briefed on the health standards required and the facilities available. The education and information sharing with the contractor population is taken very seriously due to the risk these contractors pose to local communities. Monthly forums are held for contractors

where HIV/AIDS is covered, and there is a quarterly forum for managers where all HIV/AIDS issues are dealt with. This has led to a participation rate of close to 100% for contractors in 2006. This is a tremendous success for the mine; given the problems the contractor population poses to a company. According to the HR Services Manager, there are no 'contractors' at the mine, rather they are considered as employees working from different companies who work for this company.

> *"I think the important thing is what we do and I'm not sure if other companies' do the same. We can't assume that their companies do what we do, so we take them as our employees; they just work for different companies."* (HR Services Manager)

Although the contractor population has had high participation rates, their presence brings specific problems that must be attended to. Due to contractors moving around so often, and their financial means, the local sex worker population has increased rapidly, and women tend to leave their partners for these contractors. This obviously poses significant risks in terms of HIV transmission patterns.

> *"These guys here, you know even if you got a lady, she will leave you, just for those guys. You can give somebody R500 or R600 or R300 and the one that works hard gives him a R100."* (Shop Steward)

The contractor population at the mine falls into a younger age group than the permanent employees, meaning that they are a higher risk group anyway.

> "*… there so little for them, and because they so young, because remember their age profile is much younger than ours, its young people who are infected. Its something about the age could have an influence and also some of these individuals, they suffer so much before"* (HIV/AIDS Coordinator)

Another problem that the HIV/AIDS coordinator raised was the difficulty in accessing primary health care services at a community level, which compromises treatment uptake and adherence

> *"…we've looked at our labour sending areas, the access that people have, in general out there, to VCT and treatment. The North West and the Northern Cape has been the last two provinces that got treatment centers, and because of distance and poor infrastructure it is still very difficult for people to access any kind of primary health care service, let alone treatment or VCT…..often there's a clinic that's under-staffed and there's no-one present."* (HIV/AIDS Coordinator)

Chapter Five: Integration of Findings

Using various psychological theories, this chapter provides an integration of the findings of this study, as detailed in Chapter Four. In line with the broad aims of this study, the discussion will focus on unraveling the VCT and treatment participation rates, from a historical and organizational perspective. In line with the theoretical framework for this study, the Precede-Proceed Model and the Elaboration Likelihood Model will be used to interpret the findings.

A Theoretical Understanding of the Findings

5.1. The Precede-Proceed Model

In the context of the multiple determinants of health and health-related behaviours, this study was concerned with understanding the contextual factors that informed the uptake rates of the VCT and treatment components of the company's HIV/AIDS programme from the perspective of all relevant stakeholders. The Precede-Proceed Model is ideally suited to this task, in that it is based on the principle that the success of an intervention or health programme lies in the voluntary participation and cooperation of the participant in a process which allows for personal determination and acceptance of behaviours and the change that should take place thus rests largely on the participants' willingness to become actively involved in the change process (Green & Kreuter, 1991).

The Precede-Proceed Model is characterized by nine phases, the first five being diagnostic, and the latter four being the implementation and evaluation steps. Of the five diagnostic phases (see Chapter Two, pp. 38-40, for a description of these five phases), phase four (viz. the educational and ecological assessment) is pertinent to the aims of this study, and is the primary focus of the discussion of findings below.

5.1.1 Phase Four: Educational and Ecological Assessment

The Educational and Ecological Assessment phase of the Precede- Proceed Model examines behavioural and environmental conditions which are linked to health or quality of life concerns in order to determine what causes them (Green & Kreuter, 1991). This phase of the model identifies factors that have to change in order to start and sustain behavioural and environmental change. These factors become the targets and objectives of the program. The process of change within this phase fuels the changes that are to happen in the behavioural and environmental phase. This phase is concerned with:

- The factors that influence the target behaviour/s;
- The conditions of living of the people that are at risk;
- The individuals that can influence the target health behaviour/s.

In terms of the model, the three categories of factors that influence behaviour and that are pertinent to this study are Predisposing, Enabling and Reinforcing factors. Outcome behaviours can be explained as a collective effect of these three factors and not just one particular factor (Green & Kreuter, 1991). Each of these factors will be discussed in light of the findings of this study.

5.1.1.1 Predisposing Factors

Predisposing factors are the motivation or rationale for a specific behaviour and these include attitudes, knowledge and beliefs, which falls into the intra-personal or psychological domain. These personal attributes positively or negatively affects the way in which an individual acts in a particular organisation or environment. The predisposing factors that emerged from the stakeholder and focus group interviews are as follows:

Trust and Confidentiality Issues

From the point of view of union shop stewards, the historical distrust of management by labour, compounded by the current retrenchment programme, created a pervasive questioning of the real reasons for the VCT campaign, and consequently undermined employees' trust in the level of confidentiality of their test results and HIV status. Both health educators and shop stewards who were interviewed therefore believed that the active and transparent participation of senior managers in the VCT campaigns would ameliorate employee fears of testing and thereby encourage employees to test. Thus, an enduring belief held by employee stakeholders (health educators and shop stewards) is that employees will participate in VCT if management participates openly as well. Conversely, if management does not participate then employees tend not to trust the system. Both stakeholders also recognised that their attitudes and behaviours had a direct bearing in promoting employee participation in testing. Both stakeholders also revealed that employees confidence in the confidentiality of their test results was severely undermined a few years ago when a senior manager made the mine's HIV prevalence data public. This led to significant mistrust of the system and compromised VCT

participation rates. According to the HR Services Manager and the HIV/AIDS Coordinator, employees were afraid that their HIV status and personal medical reports were not kept confidential and this is a huge problem that resulted in negative attitudes towards both testing and treatment uptake. This is in keeping with Samet et.al's (1997) finding that perceived violations of confidentiality resulted in negative attitudes towards participating in VCT and treatment in their sample of 567 adolescents. On the positive side, both stakeholders evidenced significant buy-in with regard to the HIV/AIDS programme and have worked hard to counter negative employee attitudes towards all programme components.

Race and Culture Issues

Several 'othering' responses emerged across race and age lines (Joffe, 1999). Firstly, several interviewees held the view that some white employees viewed HIV and AIDS as a black disease and believed that they were insulated from infection because of their (perceived) monogamous relationships. This fuelled a belief by white employees that there was no need for them to participate in VCT campaigns. Similarly, the shop stewards believed that some older black employees 'othered' the disease to younger men, who were perceived to be far more vulnerable to infection because of their (perceived) engagement in high-risk behaviours in terms of number and type of sexual partners and unsafe sexual practices. These older black male employees thus believed that they are too old to get infected and demonstrated negative attitudes towards testing and specifically towards participation in any VCT or treatment programme. Traditional belief systems also emerged as a factor that predisposed some employees not to test nor participate in

the treatment programme. Both western diagnostic systems and chemotherapy were seen to be culturally alien, thus serving as a barrier to VCT and treatment uptake.

Conditional Participation in VCT:

According to the Health Educators, shop stewards influenced employees to use wage negotiations and bonus awards as bargaining chips for their participation in VCT. The use of conditional bargaining for participation in VCT shows that employees still have negative attitudes towards testing and demonstrate an external locus of control (Rotter, 1954). It also shows that they are not knowledgeable on the benefits of VCT and treatment and have not fully internalized the severity of HIV/AIDS and their personal susceptibility to the disease, which, following the Health Belief Model (Rosenstock, 1974), would explain the relatively low levels of treatment uptake experienced at the study site.

Spousal Disclosure:

From the HIV/AIDS Coordinator's point of view, a significant barrier to treatment uptake was that HIV positive employees often do not confide in their spouses or partners about their status. These negative attitudes and behaviours with regard to partner disclosure by employees resulted in them not taking their medication as their partners would then know about their status. It is embarrassing for employees to tell their wives or partners that they are HIV positive and are being treated, since their partner would discover that they have been unfaithful. This is especially problematic, as it heightens the risk of HIV transmission to unsuspecting spouses/partners. The attitudes of the

employees were damaging as they do not make use of the treatment that is available to them and their spouse.

According to the HIV/AIDS Coordinator, the wives of employees, and mainly the white women, did not want to be included in company activities and functions, making it more difficult to get them to test or educate them on HIV/AIDS, thereby creating negative attitudes about the HIV/AIDS programme throughout the community.

Treatment:

The mine doctor reported that HIV positive employees who were reluctant to test in the first instance are the ones who were most likely to delay registration onto the treatment programme, and usually do not adhere to treatment in the long term. This is problematic, as it suggests that the high-risk groups who are the primary target of testing and treatment are in fact the hardest population to reach, thereby undermining programme efficacy and effectiveness.

5.1.1.2 Enabling Factors

Enabling factors are factors that make people act on their predispositions, for example, the availability, accessibility, and affordability of resources and health care as well as the new skills that an individual needs in order to make a change in behaviour. These resources might include health-care facilities, schools, clinics, personnel to assist or counsel, etc. Other enabling factors are the conditions of living that act as barriers to healthcare, for example, availability of transportation or child care that give mothers

enough time to participate in a health programme. It is essential to assess the extent and quality of enabling factors in the organization and their impact on VCT and treatment uptake. The enabling factors that emerged from the interviews conducted are discussed below.

VCT:

As agreed by various stakeholders, in order for any health programme to be a success, it is essential that the target audience is provided with the necessary facilities and easy access to these facilities. This is supported by Piot & Seck (2001), who demonstrated that in order for health promoting interventions to be successful, they must be carried out in the appropriate environment. According to the HIV/AIDS Coordinator, VCT campaigns were held annually at the mine, and theses campaigns are taken to each and every department, to make sure that everybody has a chance of testing. The coordinating team also spoke of the role of peer educators and health workers who ensured that employees who were unavailable during the campaign, due to leave or sick leave, had an opportunity of testing when they returned to work. The health educators ensured that testing was conducted during working hours, so that employees do not have to sacrifice their weekends or time after work to participate in the VCT programme. This level of considerable effort and commitment to prevention and care vindicates Piot & Seck's (2001) assertion that there is a huge increase in prevention and care efforts for HIV/AIDS in the workplace. It was apparent; therefore, from the perspective of the stakeholders interviewed, that all reasonable measures were taken at a programme design level to ensure that VCT is accessible to all employees. This is considered crucial in view of

Corbett et.al's (2006) view that VCT is actually the key to HIV care and also contributes significantly to HIV prevention efforts.

Treatment:

Treatment for HIV positive employees and those living with AIDS was made available free of charge through the on-site clinic at the mine. Peer educators did follow-ups with HIV positive patients to ensure that they received their treatment, took their medication and dealt with concerns that they might have had. The clinic staff consisted of well trained nurses and doctors and stakeholders expressed confidence in these clinical staff. If employees do not want to receive treatment on-site, they were provided with a list of public health clinics and private doctors in their local communities, so as to ensure they have the option of making informed treatment choices. Despite the fact that this epidemic has put an incredible amount of pressure on health care workers (www.avert.org), it seems that at this mine, health care workers have coped well with the employee health needs. The HIV/AIDS Coordinating Committee expressed its concern, however, that the combination of on-site and off-site treatment avenues made it difficult to monitor treatment uptake, progress and efficacy.

Peer educators:

All interviewees were unanimous in expressing strong support for the peer education programme. Peer educators played a major role in marketing all programme components, dealing with employee queries and fears, providing lay-counselling as required, etc. Peer educators served essentially as a support system to the wellness team and clinical staff.

The HIV/AIDS coordinator acknowledged that peer educators are an important resource for identifying employee issues and needs. They played a major role in communicating and educating employees on HIV/AIDS. Peer educators advised employees on health issues and represented their concerns and needs in meetings with management. In this way the employees' needs were brought to the forefront, hence the peer educators enabled employees to make informed decisions about VCT and treatment.

Service Providers:

The service provider used in any health programme should be well suited to the needs and attributes of the population in question. Naidoo & Wills (2000) emphasize the importance of context in order to carry out a health intervention successfully, and argue that conducting VCT and treatment in the workplace provides for an ideal setting for health interventions. In this regard there was consensus from stakeholders that the outsourcing of the VCT campaign to a local service provider, who was from the same province but not from the immediate labour-supply community, worked well for a number of reasons. Specifically, this ensured that while the service provider was familiar with the language and culture of the employees, the staff who conducted the testing were not known to the employees and were thus completely independent of the mine. These attributes were seen to enable employee participation in the VCT campaigns, though it did not completely eliminate notions of bias or perceived violations of confidentiality.

The Inclusion of Contractors:

The HR Services manager confirmed that the contractor population was fully included in the VCT process, with treatment being provided through the same mine clinic but on externally sourced funding. All new contractors were reportedly briefed about the health standards and facilities available for them, with regular forums being held to ensure continuous education with regard to HIV/AIDS and specifically with regard to resources available for testing and treatment. An unprecedented VCT uptake rate of 91% was recorded for contractors in the 2006 VCT campaign at the mine. Overall, stakeholders were satisfied that contractors were provided with the same HIV testing and treatment services as those enjoyed by full-time employees.

Training:

According to the Operations Manager, HIV/AIDS Management training was provided for all managers at the mine. This training equipped managers to support all HIV/AIDS programme components, including VCT and treatment, to manage HIV/AIDS in the workplace, and to adhere to confidentiality protocols with regard to HIV positive employees. It also kept management informed of the new trends and information on HIV/AIDS, particularly legislative changes. Interviewees were of the view that this training enabled a hands-on approach in managing HIV/AIDS.

With regard to peer educators, they underwent a comprehensive week-long training session on all aspects of HIV/AIDS, with follow-up training sessions being held annually. Both the VCT service provider and the HIV/AIDS coordinator were of the view that peer

educators were an under utilized resource with regard to supporting the testing and treatment components of the HIV/AIDS programme.

Health educators also assisted and motivated HIV positive employees to register and remain on treatment; hence they serve as a medium between the employees and the health resources available to them. The health educators at the mine comprised two professionally trained nurses who are entrusted with the roll-out of all aspects of the HIV/AIDS programme. The HIV/AIDS Coordinator believed that the enthusiasm and commitment demonstrated by the health educators was instrumental to the success of the VCT campaigns, but less so in supporting treatment uptake because of confidentiality considerations, a view that was shared by other stakeholders.

Organisational Concerns:

With regard to the organisation of the HIV/AIDS programme, the HIV/AIDS coordinator was content with the support she received from management. She expressed her concern however, that she had no direct access to the mine management structure. She felt that direct access to senior management would really facilitate and help her and her team in conducting their activities by enhancing her levels of direct support and authority. It was found by Ellis & Terwin (2005), that many companies do not have a prevention programme in place, therefore it can be seen that at this mine site, despite the problems or concerns that the HIV/AIDS Coordinator has with management, management has still recognized the economic impact of HIV/AIDS, and has demonstrated its commitment to supporting a systematic programme of action with

regard to prevention and treatment. Another concern from the HIV/AIDS coordinator was that the steering committee disabled her from making decisions as attendance was often irregular. The interview with the HIV/AIDS Coordinating Committee showed that when the VCT programme was being developed in 2002, there was hardly any support from management and Head Office. Since the support of senior management is crucial for the program success within its organisational context, the attitudes and perceptions of management and Head Office had to change. The only way this could be done was through attaining the goals and objectives of the VCT campaign, thus showing management and Head Office that employees do participate in VCT and that VCT does assist in the prevention and treatment of HIV/AIDS. This has obvious benefits to the business, given that HIV/AIDS reduces the supply of labor, increases operational costs, reduces productivity, slows down economic growth and threatens the lives of all staff, unless VCT and treatment interventions are place UNAIDS (2007). Overall, the structural concerns discussed here demand further enquiry and attention in the next phase of the study.

5.1.1.3 Reinforcing Factors

Reinforcing factors refer to the repetition of a behaviour through the provision of rewards, incentives, social support, praise, peer influences and advice and feedback by health care workers. Reinforcing factors are also the physical consequences of behaviour, which include, for example, the feeling of well being or pain that is caused through treatment uptake. Social benefits, physical benefits, tangible rewards or imagined rewards reinforce behaviour. However, it is essential to note that reinforcing factors can also

include punishments which in turn can have negative effects on a positive behaviour, leading to removal of the positive behaviour.

Social Support:

Stakeholders concurred that an essential reinforcing factor for the employees of the mine is the inclusion of management in the VCT campaign. Having management present and participating in VCT provided employees with the social support they need in order for them to test. This social support reinforced their behaviour which resulted in them taking the test. The health educator emphasized that since it is difficult to get employees to participate in certain sections, especially for instance during wage negotiations, it is essential to get buy-in and support from shift supervisors of each department. Stakeholders took the view that this active stance would enable supervisors to deal with resistances from employees by using support and praise. This was seen to be crucial in getting employees motivated to participate in VCT and to continue participating throughout the campaign.

Rewards for Participating in VCT:

The HIV/AIDS Committee made mention of other rewarding factors for employee participation in VCT campaigns and these include prizes for participants in each section (such as television sets or paid getaways for the family), and social functions for employees and management. All employees who participated were given free t-shirts on which an HIV-significant logo is printed, together with the text ‘I know my HIV status’. This was seen to give a positive spin to the testing process and reinforces employees’

behaviour and attitudes towards knowing their own status. But it was also noted by the coordinating team that although these material rewards might reinforce testing behaviour, it could produce a culture where employees only participated because of a t-shirt or because of their chance of winning a prize, rather than because they were committed to knowing their status. Such a situation was seen by stakeholders not to enable informed and sustained behaviour change.

5.2. The Elaboration Likelihood Model

The elaboration likelihood model emphasizes that persuasion is a major part of any communication and influences behavioural change. This model is based on the presumption that in order for someone's attitude and behaviour to change, two major components of persuasion must be considered, viz. the central and peripheral routes (Griffin, 1997). The central route uses message elaboration and can produce significant positive attitude change through scrutinizing ideas. The peripheral route allows a person to make quick decisions based on several specific cues, resulting in less robust changes in attitude and behaviour. These peripheral cues include reciprocation (the receiver of the message feels obligated to agree with the message through past experience), consistency (the receiver relies on thoughts that they held true previously), social proof (the actions and words of others will influence the receiver), liking (the speaker is liked by the receiver), authority (the speaker takes an authoritative stance over the receiver) and scarcity (the receiver should take in the message before it becomes unavailable) (Moore, 2001). The findings of this study will be discussed below in terms of both central and peripheral routes of message elaboration.

5.2.1 The Central Route

The key is to motivate employees to take in messages through the central route and the only way that this can be done is by making the message personally relevant to them. In this regard, the HIV/AIDS Coordinating Committee appears to have invested considerable effort in supporting each VCT and treatment campaign with several salient personal messages e.g. 'know your status', and this has been backed up by peer education which has focused on the severity and susceptibility aspects of the disease.

However, the evidence suggested that VCT and treatment messages have not been fully internalized as something that is personally relevant to most employees. This was seen in the need to provide incentives and rewards for employees in order to facilitate their participation. Further, employees felt more comfortable to participate if they have witnessed management participation first. This should not be the case if the VCT messages were taken in through the central route. It was also found that employees use other concerns as bargaining tools, such as bonus or wage negotiation issues, in order for them to participate. Hence if these issues are not resolved, they will not participate in VCT. Although the mine has achieved reasonably high VCT uptake rates, it is imperative to question whether employees are testing because of concern for their health or because of other reasons, such as winning a prize. Therefore, if these messages were not taken in through the central route, then employees will not internalize the need for VCT and the severity of HIV/AIDS in their community. It was therefore unclear whether the relatively high uptake rates that have been achieved can be maintained in the absence of peripheral rewards as currently pertain.

5.2.2 The Peripheral Route

The peripheral route contrasts the central route, through providing indirect methods of persuasion through the use of cues. These cues assist employees in making quick decisions without too much thought on what they are actually doing. The six cues with regards to message elaboration will be considered in light of the findings.

Reciprocation:

An example of reciprocation in this instance is through the HIV/AIDS Coordinator, who had gained the respect of the union and knows that the union members will agree or understand the things she does and plans for the campaigns as they know and respect her since she was a social worker previously. The fact that she was a social worker previously made the union members more likely to trust and support her, regardless of whether or not they like her personally. They were aware of her intentions through past experience which therefore made her messages appealing to them. It had also been noted that despite the trade union having specific difficulties with Head Office, they had realized the severity of HIV/AIDS and reciprocated by showing support for the VCT and treatment components of the HIV/AIDS programme. This union support is critical to programme success, given Ramachandran et.al's (2005) finding that companies that were more unionized were more likely to conduct their interventions in a systematic and successful way.

VCT campaigns have been run at the mine for a number of years and the rates of participation have improved steadily over time. Contrary to Sarafino's (1998) finding that

prevention interventions have shown limited success in increasing VCT uptake rates, employee participation in VCT has improved steadily each year at this study site. The HIV/AIDS Coordinating team expected employees to participate in VCT and in the treatment programme, and, notwithstanding the issues and concerns regarding VCT that have been uncovered in this study, the increased rates of employee participation provided evidence of employee reciprocation with this expectation. Similarly, the contractor population, who were not part of the permanent workforce, had also demonstrated remarkable reciprocation with the expectations of the HIV/AIDS Coordinating Committee, as depicted by their high VCT participation rates.

Consistency:

High VCT uptake by employees illustrated the consistency between the employees and the HIV/AIDS coordinating team. However, the same does not pertain with regard to adherence to treatment for HIV positive employees. Thus, while high levels of consistency have been achieved regarding VCT, much is still to be done in terms of achieving consistency with treatment registration and adherence. This is a vexing problem, given that patient non-adherence is a major problem in health care generally Schlebusch (1990). Consistency is essential as it emphasized that employees should start going for VCT and internalize the process so that they will test every year, and so that they will register for and remain on treatment as required. It is therefore important for messages about VCT and HIV/AIDS prevention and treatment to be a continuous rather than an annual message so as to consolidate consistency in message elaboration.

From the treatment perspective, it was difficult to get employees to register onto the treatment programme, and a key barrier that emerged in this regard was related to concerns about confidentiality violations. If there were a way to convince or guarantee employees that their test results and HIV status would be kept confidential (even though it is), this should be a huge influence on them to register for treatment. However, even though employees do not trust the system, this may not solely be due to the misuse of prevalence statistics, but also through what employees hear from other people. The findings of this study reveal that the actions of significant others tended to influence employees behaviour significantly. The releasing of prevalence data in 2001 had a negative effect on the employees and on participation rates. Hence, the action of that particular staff member in a single incident created a negative perception and influence on the employees and it still is, after 7 years, a concern for many. This illustrates a breakdown in message consistency, which is notoriously susceptible to erosion even with minor violations. The lesson that emerges is to ensure that all stakeholders take responsibility for ensuring consistency in message elaboration through all aspects of the mine HIV/AIDS prevention, testing and treatment programme.

Social Proof:

Based on the findings of this study, the issue of social proof is considered from the point of view of management, peer educators and union shop stewards. A primary manifestation of social proof was seen in employee expectations of management participation in the VCT campaign i.e. show us by your actions why we should

participate. Concerns expressed by stakeholders in this regard need to be taken very seriously as social proof is an important peripheral cue to message elaboration. Similarly, stakeholders acknowledged the vital role that peer educators play in influencing employees to participate in VCT and adhere to treatment, with their actions and words being very salient to employees. The call by several stakeholders to review the roles of both management and peer educators so as to deepen their participation should therefore be taken very seriously.

Union shop stewards complained at length about being made to feel like equal partners at the outset and subsequently being marginalised by management in the roll-out of the HIV/AIDS programme. This has exacerbated existing levels of mist-trust between these stakeholders, to the detriment of testing and treatment uptake. The point here is simply that union shop stewards believe that social proof of management's ostensible commitment to an equal partnership has been violated. The findings of the interviews and focus groups provide sufficient evidence that this strained relationship between the two major stakeholders has had a negative influence on employees' willingness to participate in testing and more particularly treatment. However, despite this strained relationship between the two stakeholders, VCT has been received positively due to various other factors alluded to in this chapter, which is supported by the findings of Hutchinson & Mahlalela's (2006) study, where VCT was positively associated with age, gender, education, socio-economic status and proximity to clinics. From the point of view of the elaboration likelihood model, the lesson here is that social proof is a critical peripheral cue to message elaboration, and suggests that great care needs to be taken by all parties to

ensure a consistent demonstration of proof of intent and action to one another and by implication to the employee and contractor populations at large.

Liking:

The Operations Manager of the mine expressed appreciation for the support received from Head Office, demonstrating liking towards Head Office by mine management. In allowing each mine site the freedom to tailor their HIV/AIDS programme in accordance with their employees needs, Head Office has ensured that mine management has taken ownership of their HIV/AIDS initiatives, rather than this being viewed as a prerogative of Head Office. When VCT was first being implemented, mine management did not see HIV/AIDS as a major life-threatening issue; however, they progressively supported the initiatives as evidence of success in VCT uptake rates emerged. For this, the HIV/AIDS coordinating team was liked for producing a continuously successful VCT campaign.

It has also been seen that employees showed an interest in a programme based on proper representation and support by the trade union. Hence, it can be noted that the trade union is liked by employees and the actions of the union has had a major influence on employees decisions to participate or otherwise. This is also seen whereby employees will not go for interviews or meetings without representation from their trade union. Likewise, the contractor population also displays liking with regard to the information and programmes that are available to them. This is illustrated by their very high participation rates in the VCT campaign.

The point of the above analysis is to illustrate that liking is a critical peripheral cue to message elaboration and to the successful uptake of testing and treatment interventions. No effort should be spared, therefore, in ensuring good synergy and relational coherence amongst stakeholders. In this regard, the dissatisfaction expressed by the HIV/AIDS Coordinator vis-à-vis her dual reporting lines and power distance from the local mine management should be attended to as a matter of urgency.

Authority:

Multiple levels of authority evidently operate to assure the success of the VCT and treatment interventions at the study site. The HIV/AIDS Coordinator explained that although the Head Office allows for each site to conduct their own VCT programmes as appropriate, each mine is given a set of outcomes from the company Head Office for the year. She emphasized that although Head Office does not dictate *how* VCT and treatment should be conducted, it does set targets that each mine has to fulfil each year, against established benchmarks. In this way Head Office guides programme outcomes. Authority can be seen here in a positive light, since the expectations from Head Office guides each mine's HIV/AIDS Coordinating Committee as to how they should perform, supported by centrally-driven performance appraisal activities at each site.

The HIV/AIDS coordinating team has clearly established its authority with regard to the HIV/AIDS programme from the perspective of employees who support and participate in its prescribed activities. The HIV/AIDS Coordinator, in particular, appears to have also established her authority, and is generally trusted by the shop stewards and

other stakeholders, especially because of their interactions with her in her capacity of mine social worker before she became the HIV/AIDS Coordinator. Likewise, the other key stakeholders who were interviewed, including the shop stewards, peer educators and health educators, all appear from the evidence available in this first stage of the study, to enjoy significant and sufficient authority in being the drivers and implementers of the mine's HIV/AIDS programme.

Overall, there is little doubt that the peripheral cue of authority functions effectively in promoting VCT and treatment uptake behaviours amongst employees at the study site. More efficient use of the authority cue can accrue by improving the structural relationship and communication between the HIV/AIDS Coordinator and the mine management and by improving the relationship between the union shop stewards and mine management and Head Office.

Scarcity:

In terms of the Elaboration Likelihood Model, a perceived scarcity of a resource can be used as a peripheral cue to promote uptake of that resource. At this study site, it was evident that there was a significant scarcity of testing and treatment facilities and resources within the public health sector in the labour-sending community. This must have undoubtedly served as an external peripheral driver of testing and treatment uptake, for both employees but significantly more so for the mobile population of contractors, which accounts for the extraordinarily high VCT uptake rates for the latter group.

Clearly however, scarcity appears to have been more effective in promoting testing rather than treatment behaviour, and despite the prohibitive cost and limited availability of treatment outside that provided by the mine, it is unlikely that scarcity alone can serve as a driver of treatment uptake and adherence, in the absence of other interventions to ameliorate the negative cues to treatment that prevail, which warrants particular attention in the next phase of this study.

5.3 Overview:

To summarize, two theories viz. the Precede-Proceed Model and the Elaboration Likelihood Model were used to understand the findings of this study. Phase Four of the Precede-Proceed model, i.e., the educational and ecological assessment, was pertinent to the aims of this study. The educational and ecological assessment included an analysis of predisposing, enabling and reinforcing factors that impacted on VCT and treatment uptake behaviours. The key predisposing factors that arose were as follows: *trust and confidentiality issues,* which illustrated the negative attitudes of employees towards trusting the system, including suspicions pertaining to management's intentions and perceived violations of confidentiality by the VCT service provider and clinic staff; *race and culture issues*, which explored the 'othering' defenses held by both white employees and older black males that made them invulnerable to HIV infection and consequently impacted negatively on their motivation to test; *traditional belief systems*, where western diagnostic systems were perceived as being culturally alien and thus served as a barrier to testing; *conditional participation in VCT,* where employees used wage negotiations as a bargaining chip for their participation in VCT; *spousal non-disclosure,* where employees

do not confide in their spouses and partners about their status; and *the testing-treatment continuum,* where negative attitudes and reluctance towards testing were seen to be related to a refusal to register for treatment and to non-adherence to long-term treatment.

The enabling factors that emerged included the following: *free provision of VCT and treatment services on the mine*, which was made available to both full-time employees and contractors; *accessible provision of VCT and treatment services on the mine,* where VCT is taken to each department and to each and every employee, even when they were on leave during the VCT campaign, and treatment; which was made available through an on-site clinic to both employee and contractor populations; *Peer Education,* which included comprehensive training and support provided for peer educators in order to enable them to promote all aspects of the mines HIV/AIDS programme and to counsel and support employees with regard to their HIV/AIDS related concerns; *provision of an external VCT Service Provider*, who was familiar with the language and culture of employees but was deliberatively external to the mining community; *Inclusion of Services for Contractors*, where they were included in the VCT process and treatment was made available to them, but through externally funded sources; and *Training*, which was provided and continuously monitored and updated for both management and peer educators. These factors enabled testing and treatment uptake for employees and contractors. Certain factors that were disenabling also arose from the findings and these included the historical tensions between the union and Head Office; difficulty experienced by the HIV/AIDS coordinating team in monitoring on-site and off-site treatment uptake; structural and communication problems between the HIV/AIDS

coordinator and the mine management, which disenables her from adequately facilitating the HIV/AIDS activities; and the irregular attendance at meetings by members of the steering committee, which hampered the work of the HIV/AIDS coordinator.

Reinforcing factors for VCT and treatment uptake that emerged included *Social Support,* which demonstrated the importance of ensuring that mine management and shift supervisors act as role-models in the VCT process; and *Rewards for Participating in VCT,* some of which included television sets, free t-shirts and paid get-aways for the family. However, although these factors reinforced employees' actions in terms of VCT participation, concerns were also expressed by stakeholders regarding the implications of these rewards for employees motivation for testing and the sustainability of testing behaviour under these conditions.

The Elaboration Likelihood Model, which emphasizes that persuasion is a major part of any communication, compliments the Precede-Proceed Model. The central route emphasized that messages need to be made personally relevant to the target audience. However, the findings showed otherwise, for example; employees apparently reacted well to incentives and rewards for HIV/AIDS activities, which showed that VCT and treatment messages were not internalized and made personally relevant by employees; they also required management participation before their participation in VCT; the use of other concerns as bargaining tools also demonstrated that they did not make messages personally relevant to them. The potential problem arising from this was that the high

VCT uptake rates may not be maintained in the long-term in the absence of personal gains to the employees.

It is likely therefore that persuasion to take a test or to register for treatment is more then likely effected through the use of peripheral cues to action, as derived from the Elaboration Likelihood Model. These peripheral cues provide an indirect method to persuasion. The key factors arising in *reciprocation* were that the HIV/AIDS coordinator gained support from the union, since she was a social worked previously and gained the support of employees and the contractor population also demonstrated reciprocation with the expectations of the HIV/AIDS coordinating committee through their high VCT uptake rates. *Consistency* factors that emerged included consistency between the employees and the HIV/AIDS coordinating team as shown in high VCT uptake rates, though much more has to be done to achieve consistency in treatment. The *Social Proof* cues were evident in employees' need for management to participate in the VCT programme and union members' belief that management's commitment to an equal partnership was violated. *Liking* was demonstrated by the mine management's finally support of the work of the HIV/AIDS coordinating team, which produced repeatedly successful VCT campaigns, trade unions having an impact on employees, showing that they like and support their activities and the contractor population showing their support for the activities available to them through their high VCT uptake rates. *Authority* was seen through the actions of the company Head Office, which while setting broad parameters for action, still allowed for each mine to conduct their own initiatives, the HIV/AIDS coordinator also enjoyed a position of authority from the perspective of all

stakeholders, and likewise the other constituencies, including peer educators, health educators, clinic staff, the VCT service provider and the shop stewards all apparently enjoyed a position of authority from the perspective of employees, who therefore complied with their collective call to action. *Scarcity* appeared to be a primary driver of testing uptake, but less so for treatment uptake, where significant other barriers acted as impediments to registration and adherence.

It must be noted that the above findings have been gleaned from the perspective of the primary organisational actors, and will need to be tested against the perspectives of rank-and-file employees in the next (ethnographic) stage of the WVUP project.

Chapter Six: Conclusions and Recommendations

The aim of this study was to determine the strengths and weaknesses of the VCT/Treatment programme within its specific organizational context. The findings of this study will be used to inform the next phase of the study, viz. the ethnographic interviews with key stakeholders involved in the VCT/Treatment programme. The key objectives of the Situational Assessment were to:

- understand the nature and dynamics involved in the development and implementation of the VCT/Treatment programme at the Finch site;
- identify the specific strengths and weaknesses of the VCT/Treatment service;
- unravel the contextual influences on VCT and Treatment participation rates at the selected site.

An archival review and file audit of all relevant documentation for the mine HIV/AIDS programme as well as key informant interviews and focus group discussions were conducted. The findings of the study were interpreted using the Preceed-Procede Model, more specifically the predisposing, reinforcing and enabling factors influencing VCT and Treatment participation rates, and the Elaboration Likelihood Model. Conclusions, recommendations and limitations of the study are detailed hereunder.

6.1. Conclusions:

6.1.1 Key Issues Identified in the Documentary and Archival Analysis:

- The joint HIV/AIDS workplace policy has been developed in line with national and international guidelines and codes of practice, and in collaboration with organized labour
- It appeared that each company mining site had a high level of autonomy in choosing service providers and determining the content and timing of VCT prevention interventions. An advantage of this approach is the space created for local autonomy and ownership, and opportunities to empower local service providers, though the equally obvious drawback lies in the lack of normative and measurable interventions and the assurance of best practice and cost savings across sites
- A remarkable strength of the companies HIV/AIDS programme is the level of commitment and action demonstrated in extending HIV/AIDS programme activities to labour sending communities in many sites. There is evidence of high levels of such activity in many mining sites, especially the site under study
- In August 2002, the provision of treatment to employees and their spouses/life partners was approved by the Board of the company and the treatment programme was introduced.
- In addition, a parallel and externally funded testing and treatment programme was introduced for contractors and their spouses/life partners

- Despite a history of peer education, complimented by communication campaigns, there is little evidence of a comprehensive strategy that integrates and aligns prevention and treatment interventions into a cohesive action plan
- As a consequence, this omission precludes the systematic monitoring and evaluation of interventions
- This is exacerbated by significant problems with data management. In terms of monitoring VCT statistics, it is noted that year-on-year, each mine produces data that sometimes includes and sometimes excludes repeat test rates, and that sometimes reflects prevalence rates over a period of time but that sometimes reflects incidence rates at a given point in time. This compromises the uniform measurement and monitoring of VCT uptake rates across the all mining sites in the company.
- With regard to the HIV/AIDS patient population, the coalescing of confidentiality considerations with multiple owners of patient data (e.g. the company, the medical aid society, the company's pharmaceutical services arm, mine clinics) has produced a veritable spiders-web that is difficult to disaggregate and that therefore makes direct comparison and hence planning and evaluation of treatment efficacy difficult at best.
- VCT uptake rates have progressively improved across sites. In 2006, the highest risk group for HIV infection was contractors between the ages of 24-35, the most productive age cohort. Contractors are highly mobile, thus compromising treatment retention.

- Differing treatment models pertain at the various mining sites, by way of historical precedent and local contextual realities. This makes it very difficult to implement a uniform model for managing VCT and treatment services across mining sites.
- Notwithstanding the above, a striking feature of the treatment ethos across sites is the high level of commitment shown by the company management and especially their clinical staff, in forging collaboration with local community-based medical practitioners
- A unique strength of the treatment programme is the centralisation of pharmaceutical services for the mining sites, which affords the opportunity for cost-containment, protocols for assuring confidentiality in the mode of drug delivery, and monitoring and evaluation of both pharmacological treatment efficacy and efficiency of service delivery
- With regard to treatment uptake and adherence, low enrolment rates of employees, and especially their spouses, on the treatment programme present as a key area requiring attention. Addressing confidentiality concerns and improving both uptake and adherence rates present as key programme priorities.

6.1.2. Key Issues Arising from the Stakeholder Interviews and Focus Groups:

Organisational Milieu and Stakeholder Dynamics

- ***Company Head Office:*** the apparent absence of a systematic HIV/AIDS strategy, alternatively the absence of a comprehensive action plan at company level, which aligns prevention and treatment initiatives, has placed the relatively new National HIV/AIDS Coordinator in an invidious position. The effect is a range of

difficulties in coordinating activities across mines, in institutionalizing best practice, and in offering effective support to HIV/AIDS Coordinators at mine level, in particular at the study site.

- ***HIV/AIDS Programme Management at mine level:*** there appears to be some blurring of responsibility between the mine management and the National HIV/AIDS Coordinator. In this regard the HIV/AIDS Coordinator st the mining site appears to be experiencing significant difficulty in assuming local agency while addressing national programme demands and working within these national parameters. In addition, the local HIV/AIDS coordinator feels somewhat distant from the mine management, as her chain of command is not to the Operations Manager directly, but via the Human Resources Service Manager, which results in a degree of distance from mine management at site level.

- ***Mine HIV/AIDS Coordinating Committee:*** all stakeholders appear to be represented, and high levels of personal investment are evident from management, union and peer educator constituencies. Notwithstanding these strengths, the committee is bedevilled by a number of process inefficiencies, viz.:
  - the composition of this committee requires urgent review
  - union-management tensions play themselves out at committee level from time-to-time, and in these instances undermine the work of this vital committee
  - the frequency of steering committee meetings is problematic;

- participation levels are uneven;
- peer educators appear to be somewhat under-utilised at committee level.

- ***The Union):*** notwithstanding the union's bona-fides and undoubted commitment to ameliorating the ravages of HIV/AIDS on and amongst its membership, a combination of political and contextual concerns has created tensions with management that hampers programme support and delivery at a local mine level, viz.:
  - The senior leadership of the union feel marginalised from the strategic and coordinating aspects of the company's HIV/AIDS programme at a national level. In this regard, their perception is that after being initially wooed and recruited as a partner to the company's National HIV/AIDS Policy and Strategy, there has been minimal to no consultation with the union on strategy and rollout of the programme over the past few years, manifested specifically in their absence from the company's HIV/AIDS Forum. This is a critical political impediment that affects programme delivery and levels of employee participation in complex ways. This situation warrants urgent discussion and resolution.
  - The ongoing retrenchment process unravelling at a neighbouring mining site has understandably produced bitterness and discord amongst both the union members and its leadership; effectively, employees appear to experience difficulty accepting that a management that can retrench hundreds of long-serving employees at once cares so deeply about the

HIV status of these same employees. This tension appears to ripple over from this neighbouring mine to all sites and undermines local HIV/AIDS programme delivery

- At the study site in particular, the 2001 "leakage" of HIV prevalence statistics by a management figure, broadcast by local newspapers and a community radio station, has produced a high level of suspicion amongst employees, a legacy that the union leadership struggles to contain and which impedes HIV/AIDS programme delivery
- Notwithstanding the above factors, the relationship of union shop stewards and HIV personnel at site level is good, as evidenced by the committed participation of the union in HIV programme activities

- ***Peer Educators:*** appear to be well trained, with relatively high levels of commitment to the HIV/AIDS programme at the study site. They appear to be the foot soldiers for both prevention and treatment initiatives. Their role could be reviewed to ensure that this vital human resource is effectively deployed, especially with regard to the VCT and treatment programme. Many of the peer educators are also shop stewards, which is an added organisational advantage to leverage.

- ***Wellness Coordinators:*** the two wellness coordinators are undoubtedly the drivers of the HIV/AIDS programme at the study site. The senior Wellness Coordinator, in particular, is a professional nurse as well as a shop steward. He demonstrates

excellent organisational skills and has established mutual respect and excellent rapport with clinical staff, managers, employees and the union. The Wellness Coordinators are the drivers of the VCT programme and play an active role in assuring treatment uptake and adherence

- ***Clinic Staff:*** good clinical programme and good communication with the HIV/AIDS Coordinator and Wellness Coordinators was readily apparent

- ***VCT Service Provider:*** the mine must be applauded for capacitating a local VCT service provider, who together with his team, are drawn from the local community and hence have a close knowledge of the cultural and contextual factors informing employee's behaviour. The same service provider has been use for the past couple of years at the study site. The VCT service provider demonstrates a sound work ethic, and high levels of skills, efficiency and organisational ability

6.2. Recommendations

The following recommendations pertain to the HIV/AIDS interventions at the mine and serves as a platform that informs the next phase of this study, i.e., the ethnographic interviews. Suggestions are made below to enhance the current programme and guide future undertakings.

- Consideration should be given to resuscitating the National HIV/AIDS Forum as a means of establishing a meaningful partnership with the union and improving bi-

lateral relations. This should have positive spin-offs at mine level, e.g. revising the timing of wage negotiations so as not to undermine the VCT campaign

- A strategic review is indicated in order to urgently align prevention and treatment elements of the programme, with strategic coherence. In this regard, the role of peer educators should be reviewed to align their activities with key programme elements
- The centralisation of pharmaceutical services by the company is a unique strength that should be harnessed not only in improving drug delivery modalities, but also in providing invaluable monitoring and evaluation data regarding ARV provision. A closer alignment of this service with local site based treatment programmes is indicated
- Every effort should be made to implement a uniform treatment model for the company, which takes account of local contextual realities. It is vital that the experience and expertise of all relevant stakeholders be harnessed to inform this process (e.g. medical staff, HIV coordinators, pharmaceutical services, medical aid society, etc.). This will facilitate effective treatment and efficient management of treatment services across all mining sites. A balance needs to be achieved between site-specific autonomy in programme planning and delivery and a more structured and uniform national approach that institutionalises best practice, provides strategic guidance and support, and achieves cost-savings through economies of scale.
- At site level, attention must be paid to deepening stakeholder participation rates in HIV/AIDS programme activities, and reporting structures should be reviewed.

- VCT campaigns that encourage spouses/partners/family to attend, such as a company "Family Day", with tailored health communication campaigns focusing on VCT and HIV treatment, should be considered.
- Ensure that the VCT campaign is wholly outsourced so as to reinforce a sense of confidentiality of test results and HIV status.
- Review the role and functions of peer educators to harness this critical resource to directly promote VCT and treatment uptake and adherence
- Since, each mine has their own HIV/AIDS coordinating team and programmes that are specific to that particular mine; the ideas and concepts behind the HIV/AIDS programmes at the various sites could be utilized positively by other mines, so that the uptake of VCT and treatment can improve across the board.
- The company HIV/AIDS Policy makes provision for the marketing of this policy to employees through shop stewards and peer educators. Their stated role is to make employees aware of the key policy imperatives regarding their rights in respect of HIV/AIDS, as a means of precluding or ameliorating fear of a positive diagnosis and its consequences, and to reinforce their right, in terms of the policy, to receive proper care and treatment for HIV/AIDS. It is recommended that this educational intervention be implemented as a matter of urgency, further to completion of a HIV/AIDS policy review.
- Tailored social marketing campaigns should be considered to counter the range of misconceptions identified in this study (e.g., confidentiality and privacy violations), and to promote specific positive messages (e.g. partner disclosure)

6.3. Limitations of the Study

- Given that this study has been conducted at just one of the company's mining sites only, caution is advised in making generalizations to all sites.
- Given that HIV/AIDS is a sensitive issue, and notwithstanding the autonomy and independence of the researcher; the participants of the study could have provided information that was socially desirable.
- Due to this study being conducted at one mining site within its specific demographic context, the findings are context specific and does not lend itself to generalizations to other mining sites, companies, and communities.
- Focus group interviews have specific shortcomings that must be borne in mind in interpreting the findings of this study. Members of focus groups often succumb to socially desirable answers and discussions. Other factors that limit focus groups from being more user-friendly include the dominance of more verbal and assertive members of the group. Even though these focus group interviews were conducted in a way that was sensitive to these shortcomings, they must be taken into account.
- Some voice recordings proved to be quite difficult to hear during the transcription process. Due to the fact that interviews were mostly conducted in rooms that were empty, leaving considerable echo that came through while transcribing.
- Since the fieldwork was carried out at the mine, which meant a lot of traveling to and from the site, the time allocated for each interview was quite restricted.

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Appendices

Appendix 1: Interview Schedule

The WVUP Study: Situational Assessment

Interview Schedule for Key Informant Interviews and Focus Group Discussions

Delivery of Program

- How was the VCT/treatment program delivered? (Probe: Was there sufficient/efficient stakeholder participation in programme planning and delivery? What criteria informed selection of the service provider?)
- Was the deliverer authoritative or displayed expertise in the field? How was the VCT/ treatment program monitored and evaluated? Who received M&E reports? How and to whom was this information conveyed? *(Authority)*
- Was the deliverer of the VCT/ treatment program 'likeable' to the employees? How did this affect employee reactions? *(Liking).*
- How are the messages about the VCT/ treatment program conveyed? (Probe: Who conveys the messages? Is it through group discussion/s among employees, done on a one on one basis, communicated by authority figures, etc.?). What are the various ways in which the messages are conveyed?). Do the employees display any aspects of peer pressure? (*Social Proof).*
- Has the advertising of the VCT/ treatment programs continued? And, if so, has there been an improvement or a change in the way it has been communicated? (*Scarcity)* (Probe: Do employees respond to adverts, posters or any other means of communication? How did this change once the methods of communication or the messages itself were changed?)

Participation Levels

- Are there any outstanding factors hindering participation of employees in the VCT/ treatment program? (Probe: Myths, traditional and cultural beliefs among that particular community group, stigma in the workplace, environmental influences, confidentiality, issues of disclosure to partner, etc.)
- Are participation rates in the VCT/ treatment program increasing? What can this be attributed to? (Probe: Do you think this VCT/ treatment program is working for employees, in terms of them being comfortable with the program and also passing on the message to others to become involved *(Social Proof)*, thereby increasing the levels of participation?)
- What is being done currently to increase participation rates in the VCT/ treatment program? (Probe: Have the program managers identified areas that require improvement in order to increase participation rates by employees? If so, what interventions have been implemented and have they been successful?)

Adherence to Program

- Have employees participated in/adhered to the VCT/ treatment program? (Probe: Do they present for testing/receive treatment regularly, are they keen on receiving new information about HIV/AIDS?)
- What are some possible factors that restrain them from participating in/ adhering to the VCT/ treatment program? (Probe: stigma attached, peer pressure, embarrassment, issues of self-esteem and confidence)

- Is there any aspect of the VCT/ treatment program that probably has a negative effect on employees? (Probe: Is there something in the program that would lead to employees not participating in/ adhering to the program and not presenting for repeat testing/ follow-up treatment regularly? What are the issues that might be a possible cause for poor participation/ non-adherence?)

Employee Attitudes towards Program

- What is your perception of employees' attitudes/responses to the VCT/ treatment program? (Probe: How appropriate is the program for the employees? Are they comfortable with it?)
- What is the general attitude of employees towards how the VCT/ treatment program is being managed? (Probe: What attitudes do employees have towards management figures, service providers, doctors, nurses, and other personnel?)
- Do their attitudes affect participation and adherence levels?
- Do they conform to an attitude, in which they behave and act just as their peers would?

Appendix 2: Excerpts from Transcriptions of Key Stakeholder and Focus Group Interviews

Excerpt 1: ***(Taken from first interview - Individual Interview with the HIV/AIDS Coordinator)***

Coordinator: I report to the services manager hats under the HR manager. It's also the decision that he has taken when he came here as part of the BMR, that he doesn't want people reporting directly to him. And he thought he was only going to be here for two years and they've changed his contract. Now as a person out there, I'm sure his family and all the other people love him and he's a good HR manager, whatever, but he's not a good HIV champion. Sorry to say. We had monthly meetings, he got it down to quarterly meetings and those meetings are poorly attended. He supposed to go to the Head Office team and say look, "each of you must give us a representative" but he doesn't want to do that. He's reluctant. Now that system we've seen for years is working, it's the tried and tested way that he person just under the departmental head, the one that also what we call on a level two scorecard that they report on their department on their department or section. That person sits in those meetings, so if he wants to give a message to the HOD to take up, they can do it, and the HOD can bring messages down. Because we don't attend all the meetings.

Interviewer: Yes, right.

Coordinator: Now I can try to discuss my concerns with this man, but to get into his schedule is almost impossible for me. Now this Friday we going to have a meeting and it's probably going to be conflict. Because what is now being decided on the other hand is they want me to do corporate social investment. I cannot do both, not with my resources or my time. I find it very difficult to work with him.

Interviewer: You don't have a dotted line to join? You do have a dotted line to join?

Coordinator: Ja, but that is the other problem.

Interviewer: Ja

Coordinator:: You see what you will find with me and my health educator, we are two people that work on an ethical basis because we care about people. We not into company politics, we not into getting money.

Interviewer: Image building?

Coordinator: No we not into any of those things. That's why I know if we leave, there will be nothing left here.

Interviewer: That's what, thank you, you said what I was going to ask.

Coordinator: No you don't have to ask, I'm a very honest person. If the health educator or myself leave tomorrow, this mine will not have the program that they do. And it's not because we want to have all the shine and own it. It's because we work.

Interviewer: And it's because the blockages higher above you that's not institutionalising the program.

Coordinator: Ja, because the national HIV/AIDS Coordinator wants to please high level management, there is no other way that she operates.

Interviewer: Yes

Coordinator: And it makes it very difficult. I am the most unpopular coordinator and I can understand why my colleagues do not like me. I would not like me either.

Interviewer: You speak it…

Coordinator: But that's the whole VCT thing. When I started talking about VCT in 2002, there was no support. Not here, not there.

Interviewer: Right

Coordinator: The mine was, the VCT was non existent, they thought the doctors and the nurses will do VCT and the problem is not so big and we will do what all the others are doing.

Interviewer: Yes, yes

Coordinator: But in that year, my health educator started. We started basically, I started in 2002 May in this position, and he started in 2002 and I think in a certain respect, we compliment each other, on what we can bring to the table. Sometimes relationship is also, there is conflict, because he has to get things done because he's in touch with people out there. I still have to have the big picture to get money.

Interviewer: That's right

Coordinator: So I still have to sometimes think, do I compromise 20% to get 80% done. Now my compromise is sometimes the things that I really have to do that is offensive to my health educator.

Interviewer: Understood.

Coordinator: And he gets angry at me and I get angry at him. Also the company wants him to sit in front of his pc and do all kinds of things. He hates it.

Interviewer: He's like a doer out there.

Coordinator: Yes, then I must be like a school teacher and say look, please just look at your sentences, you know start with a capital letter. That in turn influences our working relationship.

Excerpt 2: ***(Taken from the fifteenth interview - focus group interview with the HIV/AIDS Steering Committee)***

Coordinator: Well, that's the logical way it should be in my mind. But, I think one of the things that may come into here, if we look at our total contractor employees, what I call them the second economy here they are very marginalized. You know, as I said before, we had to fight to get them, two people in twelve square meters, they wanted to put four people in there. I think the uptake is in a certain regard, there so little for them, and because they so young, because remember their profile of age is much younger than ours, its young people who are infected. Its something about the age could have an influence and also some of these individuals, they suffer so much before, they do see benefits in certain things, by not sitting there and thinking, "I've had this lifestyle, what do I care?" And also on the other hand, I don't know their relationship with their employers is on a different level, and I think in the company, some of our culture and other issues are influencing people's perceptions. They should contemplate 'if they should register on the company program or not'. There's issues there and look one of the issues of the company is because it's not open for children, children, I mean here not babies, teenagers and other family members.

Interviewer: Not?

Coordinator: No, and you have to choose between your spouse and your life partner, now you may have a spouse and a life partner, so who do you choose now? So there's other things, you can look at.

Interviewer: Just…

Steercom: There is an option, there is a contractor treatment option isn't it that covers contractors.

Coordinator: Ja, there's a contractor treatment option, there's a government option, but you see the health educator, you also look at, and we've said this before, the health educator maybe done more than I've, we've looked in our labor sending areas, the access that people have, in general out there to VCT and treatment, now the North West and the Northern Cape has been the last two provinces that got treatment centers, and because of distance and no infrastructure it is still very difficult for people to access any kind of primary health care service, why alone treatment or VCT, if there's a clinic that's under-staffed and there's no-one.

Interviewer: Ja

Coordinator: So that is part of our challenge.

Steercom: I'm having a problem, if we do this, you know, without the company number or the employee number, will there be a problem from your side?

Interviewer: Ja

Steercom: I'm looking at it this way, because every time, you know, we are dealing with the workers, where a company number is required; believe me, and that without a filled questionnaire, that one's a….. (problem). So long something has to deal with the ID numbers.

Mine Doctor: Using peoples' ID numbers, putting it all on their ID numbers?

Steercom: I think with the humans, we can try our level best to convince them to use their company number, but I don't see them really buying into this. That's why I was suggesting that is there a way that maybe we cannot going to go the company number way, but maybe we can do something. The other thing is that, I know you spoke about it before, but I'm just saying, because the other time you spoke about this the union members was not there. Are you going to re-work this into different languages?

Interviewer: That will be re-written, seven

Coordinator: There are about four major languages that we told we can get away with.

Interviewer: As we speak it's being translated into Afrikaans, and we must just check for the other languages. So what other languages would you like to see it translated into?

Steercom: Tswana, Xhosa, and then from a contractor's point of view, Sotho, Shangaan, Venda, Portugual,

Interviewer: Shangaan, I'm writing it down, Shangaan, Venda, Portuguese

Steercom: We got three guys Mozambique who will speak Portuguese, so…

Interviewer: How many guys? How do you communicate with them?

Mine Doctor.: Well, if you looking at the contractors, communication is a major problem, for those who tell me. Vanagalo will manage you to communicate with 50% of the patients.

Coordinator: All process, people who work on surface, vanagalo is an underground….

Interviewer: Literacy Rates? You see, don't ask me to translate into Portuguese when they cant read Portuguese. Yes, that's the problem we have.

Coordinator: Look I would say if its four major languages then…

Interviewer: English, Afrikaans, Tswana and Xhosa.

Coordinator: Well, that will cover 80% of the people, we not looking for a 100%.

Interviewer: Because, because, you see the other thing is, we trying to make this as automated as possible, so those people who facilitate the process, the VCT process, we are hoping that they will play a role in guiding the employees to fill this in. it will only take 10minutes to fill in.

Mine Doctor: Do we anywhere on mine have a register of different groups, with regards to the contractors. Is there a register anywhere to say there are a 1000 Tswana and 500 Sothos?

Coordinator: We have that information for permanent, but or contractors…you see contractors sign a form, if they come and work here that they can speak English, so that is what they do.

Mine Doctor: I mean I can go through the contractors that I've registered and pull out the languages that one needs. I mean, the information sheets that we use for them, we have in Sotho, Zulu, Xhosa, Shangaan, Tswana, Afrikaans and English.

Excerpt 3: (Taken from the sixth interview- Individual Stakeholder Interview with the Union Chairperson)

Interviewer: All right then, just start with the HIV program, how long have you been at this mine?

Chairperson: More or less, you can say 16.

Interviewer: 16 huh, that's a long time, okay. Just share your insight, your opinion on this program, its running for, you've done, this is the fourth VCT campaign. There's peer education, there's a whole lot of stuff that's rolling out. Over the last few years, how's this program been, from a shop steward point of view?

Chairperson: Look, what I can tell you, the program is there, it's only the resistance and the workers you know maybe it's a culture issue, because people tend to, we can go, normally as a union, we go to the mass meetings with our guys, let's volunteer we are going to do HIV counselling and testing.

Interviewer: Right

Chairperson: You'll have those who are saying no, others willing others won't go. Most of them want to go on their own. And most of them will tell you, my culture, I don't believe in that, I cant be HIV, some will go, but no-one must know, you understand, and the problem that we had, last year or the year back some people died, some members died, say two, and I visited one at the hospital. It was difficult because the guys that went December to the home, it was something that was eating him inside and he said no man, why you don't go back to the hospital, he said, no I cant, I don't get any help, joy at the hospital. Then a week he got sick then we have to move him to the hospital and then unfortunately, but the guys don't want to test because of the culture issues, especially when it comes to mostly Xhosa speaking people, definitely those.

Interviewer: That's a particular problem?

Chairperson: Ja, they said no. The second one was also a Xhosa speaking person, same thing also happened. But for me to look, this was also the course of it, but for them it's not. Ja

Interviewer: Right, so from a culture point of view, take the Xhosa people, I'm not going to test, how do I explain what's happening to my body that I'm sick? What do you think, what are they saying in their head to explain something eating me? What are they saying, I don't need the hospital, they have an explanation, what is that?

Chairperson: No, for them, they rather believe in traditional doctors, they can go to a traditional doctor that can cure them, then if he says, but he wont cure as there's a problem in the company that he can assist you with medication and what. Then he said, "no I'll rather prefer traditional doctor," but then he said let's look at your body, then he said, "no, I cant do that". So we force somebody to do something.

Interviewer: So over the last five years, right, take this problem of resistance right, with workers; let's deal with that problem, because of the cultural factor. Has it improved, how's it been? You know you look from where you are, as the chair of the Union, you look over five years, has that improved, got better, is there less resistance still, or still you are battling with this problem?

Chairperson: No, for now I can say we don't get resistance like before, because it seems like people are understand now that HIV/AIDS is there and there is no cure for it. And what they are doing, people go for testing and in the problem also they do include their wives, because apparently there is a lot of change. Even when they started with the prevalence test, most of us have now, at the end we see now let's go for the test, because leadership have to start and support the program before it kicks off.

Interviewer: Correct, correct. So does leadership, let's take the VCT, does leadership go for the test publicly? You'll go front line, take the pictures?

Chairperson: Yes, we…

Interviewer: That's what we heard the coordinator wants to do.

Chairperson: Exactly, that's what we doing with management.

Interviewer: And your shop stewards are cool with that.

Chairperson: They are cool with that.

Interviewer: You'll will come frontline and take your test, be in the Sunday Times, everything?

Chairperson: Ja, no, no we got a Bulletin on mine, but only if you work here you can take it off the mine…

Interviewer: Right, right, right. Besides the cultural barriers, resistance, I want to understand this first, just how it is rolling out, your membership, what it is, what the attitudes are, besides the cultural problem, in your mind are they, is there anything we've done wrong over here in the company in five years, that we should have done better? Are there any organizational problems that have hurt the program, you know what I mean, if you don't organise properly anything, whether you going to take fifty people or what, anything, if you don't organise, they'll be five people on the bus. Any organizational comment here?

Chairperson: From the organization, most of the time encourages us, to go to and volunteer, even when the health educator brought it down for the guys that, we as a union we need to volunteer and assist the company, stakeholders of the company, you cant just say when they bring something, all the time we are fighting and saying we cant do this, although members view it the other way than us, but in the end we have to convince them that they can see the light going forward, to say this is the intention of the union, what

they want to achieve is for the workers, not only for the leadership, but at the end there must be a light somewhere, if we going forward.

Interviewer: Yes

Chairperson: That's how we look at it. But how, the other issue that was brought up, was when we do a prevalence test, we have this legal aids network workshop, and there was a lady that said when we do the prevalence test we will give t-shirts out. These lines, you are bribing someone to go and do the test. Then we said it's not a matter of bribing, it's just to say thanks for somebody, you have done this. What the use of giving the t-shirt to management and union leadership, when at the end members' cant get from the floor?

<u>Excerpt 4:</u> (Taken from the tenth interview- Individual Stakeholder Interview with the Operations manager)

Operations Manager: All right, as far as the executive committee is concerned I don't know if they explained to you what it consists of, but the executive committee is basically on the mine itself, so it's myself, it's the commission manager, it's the engineering manager, mining operations management in charge of all processes on plant as well as the HR manager. And our role, I think in relating to the subject is on e of the most important ones because we need to believe and we need to live with whatever we are requesting the people to do. And I think what has assisted us, was that last year this site was the first Company mine to undergo the first what they call HIV/AIDS management training. Different models, we had four modules telling you, giving you more information as far as HIV/AIDS is concerned. Putting you into different situations as far as day-to-day management is concerned. We went through the company policy as far as HIV/AIDS is concerned, etc. Yes, it is imperative for us, the role that we play, is we need to assist with the focus as far the testing, VCT and treatment is concerned. I have Ops. Managers' communications session on a quarterly basis whereby we try and get a hold of each and every employee at this mine, it normally takes about 2 weeks to cover the total workforce. We have different time slots to cover the shifts, and in those sessions we try and what we busy with now at the moment is one of our strategic initiatives, part of it is chapping the future, getting each and every employee to know where we are at the moment, where we heading in the future. One of those items are, not just HIV/AIDS. But, basically where we are in the business and where we going to. Part of that is the HIV/AIDS issue that we also discuss at those sessions as well, and we will be actually increasing the amount or the time slots spent on HIV/AIDS because I think our next focus VCT sessions actually start now, this part of the year, and which is very much in line with last year. So the role that we play is we need to make sure that through the training they receive, through the information that we receive on a frequent basis, to make sure that, first of all, that we assist with the awareness making, that we assist the other departments through the HIV/AIDS Coordinator and should they require added time with the labour force, for us to be aware why it is important and I think at the end of the day it is imperative that we know why it is important to work against the whole

awareness issue itself. In addition, in my capacity, I am aware of several initiatives taking place through the Coordinator and her department, some excellent work taking place there, through regular communication, not just with the system mine, but with the local community as well. I think the peer educators, we got just under 300 that we trained up, in total in the areas, is that correct?

Interviewer: Ja, if we combine them with the communities.

Operations Manager: Yes, 300, just close to 300. You know for us it is awkward to be aware of that in order for us to assist whenever necessary from a departmental point of view.

Interviewer: Right, I want to throw the first thing at you, this is not a curveball, just an outside observation. I've got significant experience at the workplace. It is not just a, just happens that you get a committed executive committee, an executive committee that commits itself to HIV. In some of the ways that you haven't told me but I have already heard. Like how you did your VCT, the leadership role the executive committee played, the role model, etc. It doesn't just happen. Explain to me how you got here.

Operations Manager: You talking about the awareness now?

Interviewer: Yes that the executive is driving like this under your leadership. How does that happen, that is also very important to share?

Operations Manager: I think that how it happened is that it didn't just start here at this site. A lot of us, more than half of us come from other operations. Look at the executive committee team; I think have been at this mine for less than two years at this time. So it didn't specifically happen at this mine. I think it happened basically when we where at different operations. And I think we were all made aware, not just the executive members, but the management, we were made aware that the effects of HIV/AIDS could have not just on the organisation, but on the entire country, should we not just start to

manage it as soon as possible. I actually had a discussion with my first manager, and I'm talking now when I was still young and beautiful, I'm just beautiful at the moment, that was about 20 years ago, we had a face-to-face session, I'm talking now in the 80's, on what could happen should we not manage it effectively. Actually you sit down and think should we have no VCT campaign, should we have no treatment, etc, what can happen to our organisation, what could happen to our country. It's devastating. So I think what we picked up along the way if what effect this pandemic could have should we not manage it properly? And I think that is where it all started, for us to realise and be aware of what could happen should we not manage it effectively.

Interviewer: And what would be the relational influence, ja what's the relationship with Head Office on HIV, I mean there's corporate HIV strategy, etc, from board level, just unpack that.

Operations Manager: I think we are very much in line with Head Office. This company is a global company. I think the company is more focused because the amount of HIV/AIDS within South Africa is significant so I think the focus on this company is significantly high if you take it globally for the whole of this company group. Our line, I can say is very good, we get sent certain targets. I can show you my key performance indicators on an annual basis. I got certain set KPI's that I need to work according to as far as VCT and treatment is concerned. And so each and every operation, so yes, I think hey basically at it from an eagle's perspective and they say okay, for instance the amount of work done here compared to the other site may be different, like you said the results in the other site are different compared to the results here. The other site is a more isolated place. If you look at the local communities, we also compare ourselves to the prevalence rate within the community itself, where we sitting here or at another site, compared to the third site, this third site much lower than what the other site is, so the effort that needs to go into a place like this site or the second site is different from other places. So the alignment I think is very good and they also giving us guidance, you know which areas we could spend more focus on.

<u>Excerpt 5:</u> (Taken from the twentieth interview- Focus Group interview with the HIV/AIDS Coordinating Team)

Coordinator: You see what we try to do, and I know we irritating, but in every program we focusing on different factors you cant focus on everything. Like this year the big thing is we want to feed everybody through the process as possible, but the thing is we want to pick up o the positives, we didn't register last year and you know were out of our system and also those who have been contemplating since last year to test or to do something about their status, either the contractors or the employees. So what we actually chasing in the end, we chasing that people know that they positive and take a decision.

Interviewer: Yes

Coordinator: The second thing that we are chasing is if you were negative last year, are you still negative this year. Now we don't know, understand the incidence, but we count, we ask that person have you tested before and when and then we look at the number of people that are positive, because the contractors sample, or the group that was bigger last year, it is good to see what the trends are going to be. Because they were large compliance and ten because we were tracking it so long for employees, we can see certain trends.

Interviewer: Yes

Coordinator: Because we are trying to close the gap in those that have never been part of making a choice.

Interviewer: Right and you also measuring your repeat test rates, huh?

Coordinator: Yes. So that's in there.

Interviewer: As an index?

Coordinator: Yes. So there are different things that we are actually trying to do.

Interviewer: How do you go about knowing if those that are positive tested again?

Coordinator: You know what the strange thing is, they volunteer to test again.

Interviewer: Just because they want a cap maybe?

Coordinator: No some of them want to explore more; some are testing again to see…

Interviewer: If it's wrong.

Coordinator: If it's wrong, you know so there's different reasons and that is that I find people don't understand about VCT is that you get groups of people in their minds about different things that are moving on or are moving backwards or whatever. You are not testing a group that is all thinking the same, so. But what we find last year is we did a big campaign for these three groups and we did three days in October, last year. And those people some of them who tested positive, who sort of disappeared; they came back into the system.

Team: And some of the people who are nowhere to be found, maybe we are finished underground, those who show interest, will call us and say, "guys, I didn't test, so when are you coming down underground again, or where can I go and do the test." So it's some kind of a process where even the workers themselves can actually go out and influence the others, especially those who believe that they are HIV positive and when they go for the test they are HIV negative. You know they will go out and say look I thought this could be the case but I'm negative, so automatically you are influencing somebody who was just scared, "this guy is not scared" then that mean yes why not, why not me.

Interviewer: Now team let me ask you a difficult question, we put our finger on a very important thing. Often if you sample enough, like 60-80 people here, we going to get more. We should pick up the key variables, but I just want to alert you to what we raised. In your interest, very important, like areas 62, 63, like other problem areas, I'm asking you, you know, give me, give me people from here, so I can give you feedback. But like that…I just wanted to say it's going to be a very interesting finding for us. Very interesting, but like that, very important to know, would you love to know from ethnographic data, why actually a person comes back for a repeat test. After a person knows he's HIV positive. After he knows his status. Now what that means is, and it's not so easy, that's why I came I came with a blank state here for this conversation, from the HIV positive cohort, we going to sample, I would love to get people in this sample who I know was positive last year. That's another variable.

Coordinator: But you see that you will be able to get through the contractor treatment program, because we have the 4 people we had lost, so we may find them again this year.

Appendix 3: Proof of Ethical Clearance

UNIVERSITY OF
KWAZULU-NATAL

RESEARCH OFFICE (GOBAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL: ximbap@ukzn.ac.za

30 JUNE 2008

MRS. S RAMNARAIN (205522063)
PSYCHOLOGY

Dear Mrs. Ramnarain

ETHICAL CLEARANCE APPROVAL NUMBER: HSS/0226/08M

I wish to confirm that ethical clearance has been approved for the following project:

"A situational assessment of a workplace Voluntary Counselling and Testing (VCT) an Antiretroviral (ART) Programme in the Mining Sector: A case study"

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Yours faithfully

Ximba
.....
MS. PHUMELELE XIMBA

cc. Supervisor (Mr. A Bhagwanjee)
cc. Post-Graduate Office

Appendix 4: Informed Consent Form

INFORMED CONSENT TO PARTICIPATE IN RESEARCH

Research project: An investigation into the factors that influence HIV testing and HIV/AIDS treatment behaviour and outcomes of employees at the Mine

1. We are asking you to participate in this research study, the broad aim of which is to assess whether the VCT and HIV/AIDS treatment programme at the mine is having the desired outcome.
2. You have been invited to participate because of the leadership and/or service role that you play in the development and/or implementation of the mine's HIV/AIDS programme.
3. This research is being conducted by Shivani Ramnarain, as part of the requirements for her Masters degree in Health Promotion, under the supervision of A. Bhagwanjee of the School of Psychology of UKZN
4. While permission to conduct this study has been obtained from the management of the mine, this study is being conducted independently by the University of Kwa-Zulu Natal, and not by the mine or its employees.
5. If you agree to participate in this study, you will be asked questions about your understanding of the history and dynamics involved in the development and implementation of the VCT/treatment programme, including the specific strengths and weaknesses of the VCT/treatment programme as well as the factors that influence employees to participate in the programmes.
6. The estimated time required from you to participate in this interview, will vary from one to two hours, at a time that is convenient for you.
7. Interviews will be recorded on Audio-tape with your permission.
8. If you agree to participate, you will assist in improving the effectiveness of the mine's HIV/AIDS programmes, as well as increasing the VCT/treatment uptake rates, to the benefit of the entire mine's employees.
9. If you agree to participate, your indemnity will kept confidential. We will not share any information you provide us by name; written research reports and publications from this study will be reported at a group level and not by the names of individuals who participated.
10. If you decide to take part in the study, you are now free to withdraw at any time.
11. If you decide not to participate, you will not be prejudiced in any way.
12. You may ask any questions, Mr. A. Bhagwanjee or Prof. I. Petersen is available to answer any queries you may not think off right now.
13. Signing your name at the bottom means you agree to participate in the study, in keeping with the conditions specified below.

I _____ agree to participate in the study investigating the VCT and treatment programme at the mine. I understand that my participation is entirely voluntary, that my identity will not be recorded in any publications and reports and that I can withdraw from the study at any time. If I have any questions after today I can call, Mr. A. Bhagwanjee (031-2607973) or Prof. I. Petersen (031-260 7423).

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Participant Signature Date