An exploration of factors affecting Voluntary Counselling and Testing (VCT) amongst employees in the private sector. A company case study.

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Declaration

I Sibusiso Steven Mthembu hereby declare this dissertation represents my original work as the author and has never been submitted for any degree or examination in any university. Full acknowledgement is given for all the sources referred to in this thesis.

Signed..... Date.....

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ABSTRACT

Voluntary Counselling and Testing (VCT) is known as the key component of HIV-prevention and treatment programmes in workplace settings. The main objective of this study was to explore factors affecting the uptake of VCT amongst employees in the private sector. This study was also indirectly aimed in examining the effectiveness of HIV-prevention and treatment programmes in workplace settings.

The Social cognitive theory (SCT) was adopted as the core theoretical framework in this study. The SCT explains behaviour change as a complex phenomenon and a product of multiple, complex factors embedded on the individual's characteristic and his/her surrounding environment. This theory recognises the strength of other health promotion theories such as the health belief model (HBM), theory of reasoned action (TRA) in explaining behaviour change, but it mostly helps to provide a more holistic and coherent understanding of the complex factors affecting VCT uptake.

This was a qualitative case study. Individual, semi-structured interviews were utilised to collect data from 6 male and 4 female participants, who are employees of a courier company operating around Durban. This company implemented an HIV/AIDS policy about 10 years ago, with an aim to introduce HIV-prevention and treatment initiatives, and to facilitate easy access to these initiatives within the workplace setting.

Data was analysed using thematic analysis. Themes were analysed and discussed in relation to the topic of the study. Factors that affect VCT in the workplace were categorised thematically and critically discussed as findings of the study.

Despite the convenient and easily accessible VCT and ART initiatives, rapid testing and on-site nature of VCT campaigns, the uptake of VCT appeared to be relatively poor within the compnay. The perceived lack of confidentiality regarding results, fears of stigma and discrimination, as well as organisational factors, were identified as barriers to the success of HIV-prevention and treatment initiatives in this company. In light of these findings, the study recommends measures that might help improve service delivery. The study also contributes to the body of knowledge with respect to challenges facing HIV-prevention and treatment initiatives in workplace settings.

GLOSSARY OF TERMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
FHI	Family Health International
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
SCT	Social Cognitive Theory
TRA	Theory of Reasoned Action
UNAIDS	United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

CHAPTER ONE: INTRODUCTION

1.1 Background to the Study

Voluntary Counselling and Testing (VCT) serves as a major component of HIV-prevention and treatment programmes in South Africa as well as in many other low-to-middle income countries (Coovadia, 2000). HIV-prevention and treatment programmes are currently the only interventions available to address the high rate of HIV infections and AIDS-related deaths in South Africa and other Sub-Saharan Africa countries (Bhagwanjee, Petersen, Akintola & George, 2008). HIV infections in this country are ever-increasing; the workforce is also equally affected, as they form such an important part of the general population. HIV/AIDS predominantly affects individuals who are in the prime of their working lives, and this tends to have serious implications on the income and financial stability of both families and organisations (Deloitte & Touche, 2003).

Recent evidence indicates that HIV/AIDS poses numerous and complex challenges within the workplace setting, including illness, death, disability and absenteeism amongst employees, and these compromise the productivity and competency of employees as financial stabilities of companies (Charalambous, Grant, Day, Rothwell, Chaisson, Hayes & Churchyard, 2004). While VCT was initially located in healthcare settings, such as clinics and hospitals, recently this HIV-prevention and treatment initiative has been expanded to workplace settings, probably due to the recognition of the negative impact of the epidemic in the workplace environment (George, 2006). In addition, the implementation of HIV-prevention and treatment initiatives in the workplace is further enhanced by its cost-effectiveness and economical viability (Connelly & Rosen, 2006).

The workplace is regarded as a favourable setting for men and women of reproductive age to access VCT and participate in various HIV-prevention and treatment initiatives. The severity of the epidemic has forced the South African government to design HIV/AIDS guidelines (code of good practice on key aspects of HIV/AIDS) to assist companies in developing effective workplace interventions (Department of Labour, 2003).

Workplace HIV-prevention and treatment programmes are meant to comply with the HIV/AIDS Technical Assistance Guidelines for ethical reasons and for the benefit of employees. However, the primary goal of these technical assistance guidelines is to help companies address the challenges posed by HIV/AIDS in workplace settings. As a result, South Africa has seen many companies implementing HIV/AIDS interventions in their workplace in recent years (Deloitte & Touche, 2003). Recent studies have shown that establishing HIV/AIDS interventions and policies appears to be a cost-effective solution and prevents the consequences of the epidemic, like deaths, absenteeism and the need to recruit and train new employees (Bhagwanjee et al., 2008). Workplace HIV/AIDS interventions involve educating employees about the epidemic, encouraging HIV testing and providing access to antiretroviral therapy (ART). VCT and ART have thus far been the only strategies for HIV-prevention and treatment in workplace settings. However, despite the availability of these services within the working environment, the rate of VCT and ART uptake have been relatively poor across companies surveyed (Coates, Richter & Caceras, 2008).

The biggest challenge faced by the VCT and ART initiatives within the private sector is that employees often present for treatment services only in the advanced stages of the disease. Consequently, this suggests that companies have not yet experience the anticipated gains of investing in their HIV-prevention and treatment programmes (George, 2006). Recent literature on workplace VCT initiatives have revealed that stigma, discrimination, lack of confidentiality and other related factors are potential barriers to the success of HIV-prevention and treatment programmes in the private sector (Connelly & Rosen, 2006). The under-utilisation of VCT and ART services, weighed alongside the devastating impact of HIV/AIDS on employees, significantly undermines HIV/AIDS prevention strategies in the private sector, pointing to the need to revisit prevention strategies with a view to improve them and devise alternative strategies.

This study was set at one of the smaller sites of a courier company in South Africa that has 10 years' experience in workplace HIV-prevention and treatment programmes, but has been characterized by relatively poor uptake of VCT. The purpose of the study was to develop an understanding of the issues and concerns facing employees with respect to the VCT and ART services offered by the company. Upon analyzing the employees' issues and concerns, recommendation were to be made on how to improve service delivery in order to increase the uptake of VCT and ART treatment within the company. It was also assumed that findings from this study may add to the body of evidence pertaining to factors that impact on workplace HIV-prevention and treatment initiatives.

1.2 Definition of Key Concepts

HIV/AIDS

According to WHO (2003) **HIV** is the virus that attacks and weakens the body's immune system. Evidence has shown that once the body's immune system becomes weak, the individual becomes vulnerable to a wide range of diseases, popularly known as **AIDS**. The virus is said to be mainly transmitted through body fluids, mainly blood and semen, and can stay in the body of a person for life. Medical experts agree that there is no evidence that HIV can be transmitted through sharing kitchen utensils, toilets, baths, kissing, telephone usage, hugging, shaking hands, swimming, coughing, touching and laughing. The most common modes of HIV transmission are unprotected sex, blood and blood products and mother-to-child transmission (WHO, 2003).

Voluntary Counselling and Testing (VCT)

Voluntary counselling and testing (VCT) is a strategy for the prevention and care for HIV/AIDS. It is the process whereby an individual undergoes counselling in order to make an informed decision regarding testing. VCT sessions are divided into three parts, namely: pre-test counselling, testing and then post-test counselling. The testing part often takes the form of rapid testing, comprising of a saliva and blood based HIV screening. It should be noted that testing for HIV is voluntary, as stipulated in the Department of Labour's technical assistance guidelines. Due to the personal nature of VCT, it takes place in a private and confidential environment (Labour Department, 2003). VCT addresses issues related to HIV/AIDS, condom use, ART and social support systems (WHO, 2003).

Antiretroviral Treatment (ART)

According to WHO (2003), ART is an effective pharmacological treatment that slows down the spread of HIV in the body. It is important to note that ART is not a cure, but helps to fight HIV to delay the progress to AIDS and death. Good adherence to ART can lead to healthy living despite the presence of the virus. However, ART is said to have side effects that to different degrees can challenge the person taking the medication. Thus, some people become reluctant to take ART (Connelly & Rosen, 2006). Because there is currently no known cure for HIV/AIDS, emphasis is placed predominantly on prevention rather than on treatment (Padian, Buve, Balkus, Serwadda, & Cates, 2008).

1.3 Benefits of Voluntary Counselling and Testing

Communities, couples, families and individuals benefit in various ways from the provision of VCT (Kalichman & Simbayi, 2003). For couples and families, VCT enables planning for the future in regard to issues such as marriage, pregnancy and contraception (Family Health International, 2003b; Centre for International Health, 2006). VCT has been found to enhance faithfulness among couples, helps alleviate anxiety, increases an individual's perceptions of their vulnerability to HIV and promotes behaviour change (WHO, 2004).

At a community level, VCT has been found to reduce stigma by shifting the image of HIV/AIDS from one of illness, suffering and death, to one of living positively with HIV (WHO, 2004). It also facilitates early referral and access to care and support services such as medical and psychological interventions for those affected (WHO, 2003).

In the light of the outlined benefits of VCT and the fact that there is no known cure or vaccination for HIV/AIDS, there is a need for the expansion of VCT services and promotion of its utilisation as a priority intervention, among society in general and the most vulnerable groups in particular. Employees are an important source of financial support to their respective families, and therefore their psychological and physical well-being is critical to their continuous support to their families.

1.4 Justification for the Study

This study aims to explore and identify factors that may be inhibiting and facilitating VCT among employees in the workplace. The notion that the uptake VCT among employees in the private sector continues to be relatively poor despite the substantial financial investments and sophisticated HIV-prevention and treatment programmes put in place, is a cause for grave concern (Bhagwanjee et al, 2008). In addition, recent evidence suggest that despite the convenient and easily accessible HIV-prevention and treatment initiatives within the workplace, VCT and ART uptake are still relatively poor (Dickenson, 2004).

Brink & Pienaar (2007) note that a majority of employees are often keen to know their status, but are sometimes prevented by certain contextual factors from utilising workplace HIV/AIDS interventions. Notwithstanding this common challenge faced by private-sector workplace health-management, the researcher wanted to develop an understanding of the employees' issues and concerns with respect to HIV-prevention and

treatment programmes in workplace settings. Furthermore, the high infection rate among adults in their prime period of employment makes it imperative that employees should be a prioritised group for targeted HIV/AIDS research and interventions (Deloitte & Touche, 2003). Lastly, it should be noted that workplace HIV-prevention and treatment programmes are new implementations within the South African context, therefore, there need to be more research focusing on developing knowledge regarding challenges faced by HIV-prevention and treatment programmes in workplace settings. Thus, the researcher is motivated to conduct the study with a view to add to the body of evidence pertaining to the HIV-prevention and treatment programmes.

1.5 Key Aspects of the HIV/AIDS Policy in Workplace Settings

The Department of Labour (2003) has designed technical assistance guidelines for employers, employees and other relevant stakeholders to adopt when implementing workplace HIV/AIDS interventions. These guidelines serve to provide a frame of reference for companies to implement their workplace interventions ethically and responsibly. Workplace HIV/AIDS interventions are part and parcel of prevention and wellness programmes in workplace settings. The purpose of prevention and wellness programmes is to improve both the psychological and physical well-being of employees, considering that successful business relies on a productive labour force. According to the Department of Labour (2003), workplace prevention programmes are the pillars of a comprehensive workplace response to HIV/AIDS.

As indicated in the technical assistance guidelines, the essential elements of a comprehensive workplace HIV/AIDS prevention programme include the following:

- Awareness campaigns
- Voluntary counselling and testing, and social support systems
- Peer education
- Condom distribution
- Optimal management of diseases
- An infection control programme.

According to the Department of Labour (2003), a well implemented HIV/AIDS programme can yield the following benefits:

- It can minimise the negative impact of HIV/AIDS in the workplace
- It can facilitate and increase VCT uptake among employees
- It can create open dialogue, peer-learning and social support
- It can help prevent HIV infection, promote condom use and can facilitate access to early medical interventions
- It is cost-effective.

Other companies choose to design their own in-house HIV-prevention and treatment initiatives, which are largely the customary opt-in model of VCT; on the other hand some companies outsource their initiatives to external agencies or providers who often follow the provider-initiated opt-out model of VCT. The customary opt-in model of VCT holds

the principle that healthcare providers should wait for individuals to present themselves for testing. While the provider-initiated opt-out model of VCT holds the principle that healthcare providers should routinely take VCT to individuals. The model recommends that after being fully informed and given pre-test counselling, individuals choose whether or not they want the HIV test, or opt-out of knowing their results. The opt-out model of VCT has largely been followed by external VCT and ART service providers, and has received massive support in workplace settings in recent years (Bhagwanjee et al., 2008).

Recent evidence has indicated that the opt-out model of VCT has an element of social support, addresses stigma and discrimination, and enhances the confidentiality of test results. Recent literature has also shown that most employees prefer external service providers for VCT and ART services to avoid the consequences of stigma, discrimination and confidentiality problems within the workplace setting, which have been reported as common challenges faced by in-house VCT and ART services (Connelly & Rosen, 2006).

1.6 Summary of the Introduction

The introduction and background in this study have demonstrated that HIV has devastating effects on employees, as its affects employee productivity, competency and health. As a result, most companies have opted to implement their own HIV-prevention and treatment programmes, with a view to minimise the negative impact of the epidemic on employees and the organisation. Workplace VCT and ART services in particular have become the main strategies adopted by a majority of companies to respond to the

challenge of high HIV/AIDS infections and deaths. VCT and ART services provide a range of benefits to communities, families and individuals as they prevent further infections, and the advancing of HIV to AIDS. As the disease has no cure, VCT and HIV testing are vital to prevent infections and death, and also provide access to medical and psychological interventions.

Further, the above-mentioned services are presumed to be essential for employees to ensure that they continue to provide for their families and themselves in the face of the epidemic. With the help of the guidelines designed by the Department of Labour, most companies are able to adapt and utilise the guidelines to implement their own programmes that they found suitable within their settings. However, it is disappointing to learn that the uptake of VCT in workplace settings is still relatively very poor, despite all the efforts put in place by respective companies and the government to enhance of HIV-prevention and treatment initiatives. Hence, there is a need for studies that will investigate and identify barriers to the success of VCT and ART services in the private sector in particular. The next section focuses on the literature review.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

According to the WHO (2003), the global perception and opinion of HIV/AIDS as primarily a health problem resulted in a slow initial response to the epidemic by countries all over the world. Furthermore, AIDS was primarily seen as a phenomenon that only affected homosexuals and drug users (Buve, Bishikwabo-Nsashaza & Mutangadura, 2002). As a result, organisations outside the health sector had shown little interest in the disease, and this disease was viewed as irrelevant and unimportant. As the impact of the disease on the heterosexual population became more visible, the medical, social and economic implications of the disease came to be more explicitly acknowledged, the whole world got shaken (Buve et al., 2002). Currently, the significance of the problem is undisputed and business organisations have recognized the negative impact it has on productivity and business profitability. As a result, HIV-prevention and treatment initiatives are put in place, with a view address the challenges posed by the epidemic in workplace settings. VCT has become a key component of HIV/AIDS prevention in many countries, particularly in workplace settings (Bhagwanjee et al., 2008). As such, the review of literature in this study has focused on VCT and the factors affecting VCT uptake in workplace settings.

The following section begins by examining the prevalence of HIV infections globally and infections among the workforce in South Africa as well. The section also focuses on the discussion of the relationship between VCT and behaviour change. Various studies have been reviewed with an aim to identify factors that affect the uptake

of VCT among employees. The greater emphasis is on identifying and discussing factors affecting VCT uptake in workplace settings. A review of previous studies, especially in South Africa, has indicated that factors such as stigma, discrimination, a low-risk perception to HIV and many others have the potential to hinder VCT among employees. These factors will be discussed in detail later in this chapter. This chapter ends by discussing the theoretical resources informing this study.

2.2 HIV/AIDS Prevalence

According to the WHO (2007) there are about 33.2 million people living with HIV in the world. More than 2.1 million have already died as a result of AIDS. It has been mentioned above that the African continent accounts for the highest number of HIV/AIDS infections and deaths in the world. In Africa, the Sub-Saharan region has the highest number of infections, where approximately 22.5 million people are living with HIV and more than a million have died of AIDS related illnesses (WHO, 2007).

According to the WHO (2007), countries like Botswana, Swaziland, Lesotho and South Africa are reported to have high employee infections. In South Africa, around 30% of the population is living with HIV and thousands of people have already died of AIDS (Department of Health South Africa, 2007). Incidences of illnesses and deaths in workplace settings are evidence of the said higher infections in the country. Important to note is that the effectiveness and efficacy of HIV-prevention and treatment programmes implemented by corporate companies is rarely communicated by service providers. This is largely due to the confidential nature of VCT and ART services and the reluctance to

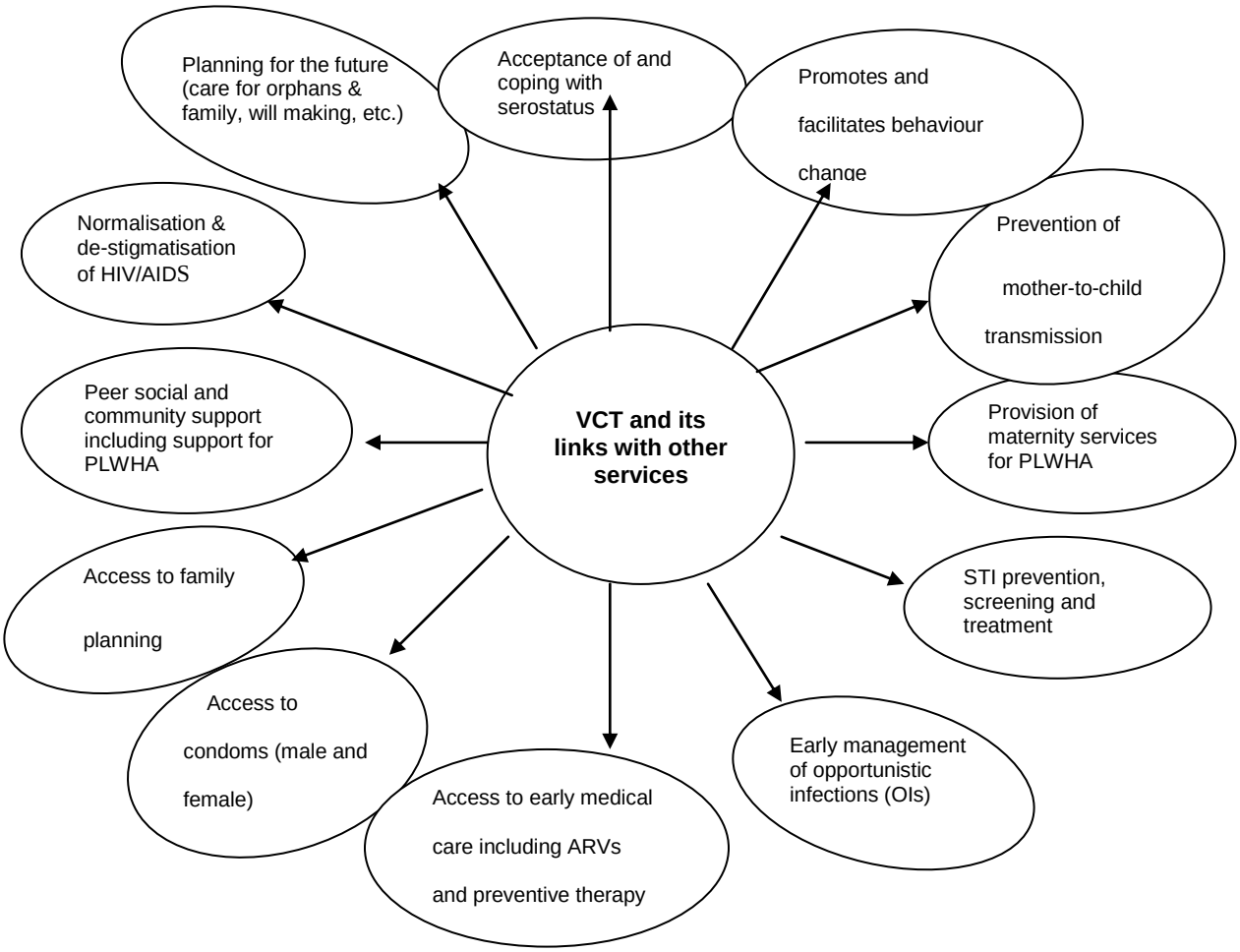
reveal the severity of the disease-related burden facing the company, as this may cause serious implications for investors, management and employees themselves (George, 2006). Thus, accurate statistics of HIV/AIDS infections are rare; nonetheless, the high number of illnesses and death rates are generally suggestive of the severity of the epidemic in workplace settings.

2.3 VCT and Behaviour Change in the Workplace

The implementation of the provider-initiated opt-out model has largely made VCT more accessible and less stigmatising than the customary opt-in model in workplace settings (Brink & Pinaar, 2007). This model holds the principle that after being fully informed and given pre-test counselling, individuals choose whether or not they want the HIV test, or opt-out of knowing their results. Such model of VCT plays an important role as a form of educating and providing access to HIV treatment. One of the key objectives of VCT is to facilitate sexual behaviour change in order to reduce the risk and spread of HIV infection (WHO, 2003). It also facilitates and encourages people to disclose their HIV status to significant others, which has an important social role in reducing the stigma around HIV and AIDS (Bhagwanjee et al, 2008). According to Deloitte & Touchee (2003) VCT plays an important role in helping people change their sexual behaviour and thus reduce HIV transmission. As noted by Deloitte and Touch (2003), the workplace provides a sense of shared identity and community, and determines rules and regulations that facilitate healthy living among employees.

As such the workplace presents the ideal setting/conditions for individuals to influence each other for VCT behaviour change. For example, peer education initiatives are one of the important means to which employees can share HIV/AIDS information with each other (Brink & Pienaar, 2007). This suggests that peer group interaction provide employees with the opportunity to exchange ideas, information and experiences to influence one another's opinion and behaviour. Peer group pressure becomes a major factor in this process. Employees are said to have a potential to positively influence each other with respect to the uptake of VCT. However, a negative influence regarding the uptake of VCT among employees can also in turn result in a poor response to VCT among employees. It is argued that VCT, especially educating individuals about the epidemic, promotes behaviour change and facilitates access to other services, such as family planning, medical care and community support (WHO, 2004). Figure 1 below illustrates how VCT can serve as an entry point for prevention and treatment of HIV/AIDS, as well as how it facilitates access to other services.

Figure 1: VCT as an entry point for prevention and treatment as well as its links with other services



Adapted From: UNAIDS technical update (May, 2001)

The figure above shows how VCT can be beneficial in facilitating access to other services, such as medical services, family planning and others. There is strong evidence that educating people about VCT and the related services promotes VCT behaviour change and HIV testing (UNAIDS, 2001). However, this notion is still highly debatable. Evidence-based practice has demonstrated that education alone may not be sufficient to promote behaviour change and HIV testing – the ultimate aim of best-practice HIV/AIDS interventions (Dickenson, 2004).

This has been evidenced by the failure of the widespread VCT awareness campaigns through the media, healthcare institutions and workplace settings to influence the population to test in numbers (Dickenson, 2004). The indication is that promoting VCT behaviour change is complex, and requires identifying and addressing gaps in the current HIV/AIDS interventions. Literature has revealed that factors such as the perceived lack of confidentiality, perceived risk of HIV infection, stigma and discrimination and other issues are the potential barriers to VCT behaviour change (Bhagwanjee et al., 2008). In addition, factors such as the desire to know one's status, preparation for long-term relationships, the model of VCT and organisational factors have been found to have an effect on facilitating VCT among individuals (Connelly & Rosen, 2006). The following section discusses factors that affect VCT in the workplace.

2.4 Factors Affecting VCT in the Workplace

Research evidence shows that due to the significant impact of HIV/AIDS in the workplace, most companies have been forced to implement HIV-prevention and

treatment programmes within the workplace – with a majority of these companies adopting the provider-initiated opt-out model of VCT discussed above (Brink & Pinaar, 2007). However, despite these sophisticated workplace programmes and substantial financial investments, most companies have not experience the anticipated gains from investing in VCT and treatment services (Bhagwanjee et al., 2008). This has been evidenced by the relatively poor uptake of VCT in many companies in the private sector (Day, Miyamura, Grant, Leeuw, Munsammy, Baggaley & Churchyard, 2003). The factors affecting VCT are reviewed in two broad categories: those that facilitate the uptake of VCT and those that are barriers to the uptake of VCT.

2.4.1 Factors Facilitating VCT uptake

In this study, the following factors have been identified as factors having a potential to facilitate VCT within workplace settings; and these factors are discussed in details below:

- the desire to know one's status
- plans for long-term relationships
- Cost-effectiveness and availability of ART
- Model of VCT service
- Organisation of the VCT service.

2.4.1.1 Desire to know one's HIV status

A study of 150 teachers in the Limpopo Province established that the participants demonstrated a willingness to seek VCT while they were still healthy, and the reason to test was the desire to know their status (Mulaudzi, 2005). Likewise, Bhagwanjee et al. (2008) noted that participants in a mining company reported a desire to know their status; however, their desire was influenced by the desire to prevent spreading HIV if they were found to be infected. This could suggest that through HIV/AIDS awareness campaigns individuals are slowly realising the need to know their status in order to prevent further infections and access medical interventions.

In contrast to the above studies, Charalambous, Grant, Day, Rothwell, Chaisson, Hayes & Churchyard (2004) noted that a majority of employees presented for VCT due to illnesses, as opposed to the desire to know their status. This suggests that in addition to the desire to know their respective HIV status, employees can also be influenced by the manifestation of physical symptoms and illness to seek VCT, with a view to get medical attention. Nonetheless, it should be noted that the desire to know one's HIV status is also on the rise following the massive VCT campaigns by government and other relevant stakeholders (WHO, 2007). In workplace settings in particular, most employees are also influenced by the need to capitalise on the easily accessible and convenient VCT and ART services (Charalambous, Innes, Muirhead, Kumaranayeke, Fielding, Pemba, Hamilton, Grant & Churchyar, 2007). These findings suggest that individuals are becoming more and more health-cognisant in the face of the HIV epidemic.

2.4.1.2 Plans for long-term relationships

A greater spousal/partner involvement in HIV-prevention and treatment initiatives helped increase the uptake of VCT in a mining company, and this demonstrated that HIV testing behaviour was greatly influenced by sexual relationships among the mine workers (Charalambous et al., 2004). Likewise, a global report by the WHO (2004) on young people and HIV testing stated that young people, in particular, access VCT before proceeding with marriage arrangements. Similarly, other studies have shown that testing is a preventive health measure prior to engaging in sex and long-term relationships for many people (Andemarian, 2004; Family Health International, 2004). These studies suggest that sexual relationships can be a great source of motivation for individuals to get tested.

In contrast to the above findings, Smart (2004), in a study of miners, noted that the fear of having discordant results with partners prevented participants from getting tested together with their partners. Smart (2004) also noted that the miners were also reluctant to be tested because of the fears of possible rejection by their partners once found to be infected. Gender was also found to be a cofounding variable in these findings, as more women than men reported reluctance to access VCT due to the perceived negative reaction from their partners if they were to be found infected with the HI virus (Exner, Hoffman, Parikh, Leu & Ehrhardt, 2002). This shows that women are more likely to avoid VCT in order to keep their relationships than men. This suggests that VCT behaviour change, like other psychosocial realities, is still embedded and dominated by gender power inequities and socio-historical ideologies.

2.4.1.3 Cost-effectiveness and Availability of ART

In South Africa, around 80 percent of the population relies on public health facilities for health services due to financial difficulties (Petersen, Mason, Bhana, Bell, & McKay, 2006). However, work demands often prevent a majority of the workforce from accessing health services from such facilities as they are forced to spend most of their time within their organisations (George, 2006). Thus, a majority of employed individuals are expected to capitalise on the cost-effectiveness and the easily accessibility VCT services and treatment within their respective workplace settings (Connelly and Rosen, 2006). A piloted quantitative questionnaire on small-to-medium sized companies established that the perception of a company's support, the cost-effectiveness of the on-site VCT as well as the availability of ART within the workplace setting played a major role in facilitating HIV testing behaviour among employees (George, 2006).

However, a survey of eight mining companies reported a relatively poor uptake of HIV testing among employees; despite the fact that these companies were providing workplace VCT and ART services (Connelly and Rosen, 2006). This suggests that the anticipated benefits of company-sponsored HIV-prevention and treatment initiatives are yet to be witnessed.

2.4.1.4 Model of VCT Service

Bhagwanjee, Petersen, Akintola & George (2008) noted that the model of the VCT can to a certain extent facilitate the uptake of VCT among employees. The provider-

initiated opt-out model of VCT, in particular, has received massive support in most workplace settings in comparison to the customary opt-in model. The strength of the opt-out model is its continuity of care by the same healthcare facility, from the moment of HIV testing to the provision of treatment as well as further management of those individuals found to be infected. The model also accommodates partners of employees to access the provider-initiated opt-out VCT service, and this might help to eliminate disclosure problems and facilitate spousal/family support for employees' treatment uptake and adherence (Feeley, Collier, Richards, Van Der Borght & De Wit, 2007). Bhagwanjee et al. (2008) conducted a study with a mining company and noted that their participants supported this model due to its ability to narrow the gap between VCT and the treatment uptake. Thus, it can be argued that the appealing and comprehensive nature of this model carries a great potential to facilitate HIV testing behaviour among employees.

2.4.1.5 Organisation of the VCT Service

The success of VCT campaigns in workplace settings has largely been due to the group nature of pre-test counselling information which harnesses peer influence and encourages HIV testing behaviour among employees, while also providing an element of social support (Brink & Pienaar, 2007). Amongst Eskom employees, social support was cited as an important element of VCT uptake (Rambharos, 2005). In the Rambharos (2005) study, fellow employees were cited as the primary source of motivation for individual employees to participate in VCT initiatives. Likewise, social support was also reported as a major component of the provider-initiated opt-out model of VCT in

workplace settings (Bhagwanjee et al., 2008). It is therefore, evident that the organisation of the VCT service in a way that enhances social support can influence HIV testing among employees.

In the same way, peer influence has also been found to be particularly effective in outreach and promotional activities. It is not surprising to see organisations such as Love Life advocating for peer education and utilising the outreach programmes to help increase VCT awareness nationwide (Parker & Kelly, 2003). Peer education has also been shown to assist in reducing HIV/AIDS stigma, and facilitating social support networks for people living with HIV (Parker & Kelly, 2003). Furthermore, the role of peer education initiatives has been welcomed and supported in workplace settings as part of HIV-prevention and treatment initiatives (Rambharos, 2005). Recent literature (Parker & Kelly, 2003; Rambharos, 2005) indicates that activities undertaken by the peer educators included distributing educational materials, conducting home visits for care and support, referring workers and community members for VCT, providing informal counselling, and organising educational sessions at workplaces and in the community. Peer educators also organize special events on World AIDS Day. Peer educators have been found to be a more desirable source of information because they communicate in languages that can be understood by their peers, and they serve as role models to their fellow employees (Rambharos, 2005).

The group nature of pre-test counselling appears does however, appears to carry an element of coercion as some participants in a mining company indicated that they felt

obliged to test because their fellow employees were doing so (Bhagwanjee et al., 2008). This seems to raise questions whether or not the decision to test for HIV was in fact located at the level of the individual in terms of the locus of control. Nonetheless, the WHO (2007) argues that in contexts where HIV/AIDS threatens national development and security, prevention strategies need to move away from the customary opt-in model of HIV counselling to the opt-out approach, whereby healthcare workers routinely recommend and conduct HIV testing for anyone who visits a healthcare facility. Thus, VCT becomes a standard component of care and helps to de-stigmatise the epidemic and testing.

Workplace VCT services and the use of rapid-testing make it convenient and easy for employees to participate in HIV-prevention and treatment initiatives, and this convenience can facilitate VCT uptake as well (George, 2006). With the rapid-testing approach, individuals do not wait for long periods to get their results because results are often available within a few minutes after testing. Due to the delay or waiting period for results, many individuals were reluctant to return to VCT sites for their results (Dickenson, 2004). Thus, it can be argued that the rapid-testing appears to have addressed the challenge of the delay or waiting period for results. The delayed availability of HIV-test results have consistently been reported as the main limitation of early HIV-prevention and treatment initiatives (Kalichman & Simbayi, 2003; Dickenson, 2004). The next section focuses on the discussion of the factors identified as barriers or inhibiting VCT in workplace settings.

2.4.2 Barriers to VCT

Judging by the concerns of the government and other relevant stakeholders regarding the slow uptake of VCT, it can be concluded that barriers to VCT uptake outweigh the factors that may be facilitating or motivating individuals to access this service. A wide range of factors that inhibit VCT have been identified and are discussed next.

2.4.2.1 Lack of Adequate Knowledge of VCT

According to the WHO (2007), the dispensing of HIV/AIDS information is the major element of VCT, as knowledge helps individuals to make informed decisions with respect to testing. Thus, there has been an international focus on raising HIV/AIDS and VCT awareness with a view to facilitate HIV testing behaviour among individuals (UNAIDS, 2001). The lack of adequate VCT awareness is a major obstacle to the success of HIV-prevention and treatment programmes. However, recent evidence has shown that adequate HIV/AIDS information and VCT awareness does not guarantee that one will decide to test (Bhagwanjee et al, 2008, Connelly & Rosen, 2007, George, 2006). This finding seems to be in contrast with the popular notion that individuals with advanced HIV/AIDS information and VCT awareness are more likely to participate in VCT than those who do not. As noted by Mulaudzi (2005), in a study of perceptions and attitudes of teachers regarding HIV/AIDS, participants with advance information and VCT awareness also showed reluctance to test. This notion can be quite disturbing considering the fact that VCT had been incorporated into school curricula, with a view to encourage VCT in

school settings. However, Mulaudzi (2005) did not explain why such teachers were reluctant to test for HIV, with their said advanced level of education and VCT awareness, in comparison to their fellow teachers who were interested in participating in VCT. This could possibly be a limitation of the quantitative nature of Mulaudzi's study, as it consisted of closed-ended questionnaires.

Regardless, relying on HIV/AIDS information as the only strategy to promote VCT has failed to provide the anticipated VCT uptake, and this has also been noted in the national HIV and syphilis antenatal prevalence survey on women attending antenatal clinics nationwide (Department of Health South Africa, 2007). Likewise, recent literature on the uptake of VCT has indicated that the poor uptake of VCT cannot be solely attributed to the lack of HIV/AIDS information, but rather can be linked to an interaction of various other factors such as stigma and discrimination, low risk perception, ignorance and other factors (Bhagwanjee et al., 2008). Therefore, it can be concluded that challenges to VCT uptake are complex, thus requiring more sophisticated approaches that will be adequately responsive to the challenges.

2.4.2.2 Low-risk Perception to HIV infection

Literature has revealed that most people do not access VCT because of their perceived low risk of contracting HIV/AIDS (WHO, 2007). The commonly cited reasons in this regard include never having had sex, abstinence, condom use and having only one sexual partner. A study done on HIV testing attitudes, AIDS and VCT in a black township in Cape Town revealed that the low risk perception is fuelled by the erroneous

belief that HIV testing is meant for diagnostic purposes and only for those who suspect that they might be infected (Kalichman & Simbayi, 2003).

Other studies on the same topic have shown that HIV infections are higher among the youth than elderly people, and this seems to fuel a misconception that HIV/AIDS is a youth disease, and thus, young people are commonly perceived as more at risk than elderly people. According to the WHO (2007) epidemic update, HIV infections are higher in females than males. As a result males are more likely to assume a low-risk to the HIV infection than females, which can also explain why more females than males participate in VCT (WHO, 2007). This could be suggesting that a perceived low risk of HIV infection can prevent individuals from testing, and this poses a serious challenge to HIV-prevention and treatment programmes. On the other hand, there appears to be a relationship between lower levels of education and reluctance to HIV-test, as the WHO (2004) noted that less educated individuals were more likely to perceive themselves at low risk of HIV infection than people with an advanced level of education.

However, this could just be a superficial relationship between the lower levels of education and the low-risk perception, and may not be suggestive that individuals with advanced educations perceive themselves as being more at risk of infection than people with lower levels of education (Mulaudzi, 2005). Interestingly, in some cases a perceived risk of HIV exposure often make individuals eager to test for HIV, as noted in most victims of sexual abuse and health workers who sustain injuries while on duty (South African Department of Health, 2007). This eagerness to test among the groups noted

above, however, is often motivated by the need to receive post-exposure treatment following the sexual abuse or injury. In contrast to this notion above, a survey on mining and financial sectors revealed that the majority of employees were reluctant to access VCT following a perceived exposure to the HIV infection (Conelly & Rosen, 2006). This shows that the underlying stigma attached to the nature in which one was exposed to the disease also plays a significant role in one's decision to test for the virus – as opposed to solely basing the decision to test on the generally perceived risk of infection. Therefore, it can be argued that both the perceived low and high risk of HIV infection negatively impact on testing behaviour, and these seriously challenges HIV-prevention and treatment programmes. These challenges call for awareness campaigns to focus on addressing stigma and misconceptions around the epidemic.

2.4.2.3 Confidentiality, Stigma and Discrimination

The stigma attached to HIV/AIDS is a real barrier to effective interventions. It can hamper the communication of prevention messages; undermine efforts to change behaviour including abstinence, fidelity and condom use; and can compromise access to VCT, care and treatment. A qualitative study done on mine workers established that employees in a mining company were hesitant to seek and utilise VCT services due to the fear of being stigmatised and discriminated in the workplace (Bhagwanjee et al., 2008). Underlying this fear of being stigmatised and discriminated was the perceived lack of confidentiality of results.

This suggests that there are doubts concerning the confidentiality of HIV results, which has been a common finding in most of the reviewed studies (WHO, 2004; Connelly & Rosen 2006; George, 2007; Bhagwanjee et al, 2008). This shows that the general attitude of the society towards HIV has a negative impact on VCT and behaviour change. An annual report by the WHO (2004) noted that the experience of seeing HIV positive people facing discrimination and stigma has the potential of making HIV testing, and VCT in particular, unpopular in communities. There seems to be consensus agreement among the studies reviewed that stigma and discrimination are the key barriers to the success of VCT and ART services (Connelly & Rosen 2006; George, 2007; Bhagwanjee et al, 2008). Thus, HIV/AIDS-prevention and treatment interventions that focus on addressing stigma and discrimination may succeed in facilitating the uptake of VCT among individuals.

2.4.2.4 The Fear of Testing HIV Positive

The fear of testing positive and the perceived psychological consequences of living with the virus have the potential to prevent individuals from utilising HIV-prevention interventions (Remein & Mellins, 2007). A study done by Peltzer (2003) drawing on a rural adult population also revealed that the majority of the participants reported that they could not access VCT due to the perceived possibility of testing HIV positive. Likewise, a study on small-to-medium enterprise companies revealed that employees perceived HIV/AIDS as a death sentence, and cited that it would be distressing for one to know that he/she was infected with the virus (Parsadh, 2004). Knowing that HIV/AIDS does not have a cure can be detrimental to the mental and

physical wellbeing of people living with the virus, and thus, individuals avoid testing (Padian, Buve, Balkus, Serwardda & Cates, 2008).

The WHO (2004) noted that severe depression and suicide were common among individuals living with HIV. Similarly, Connelly & Rosen (2006) noted that a majority of illnesses and deaths in the workplace were attributed to HIV/AIDS. A study done by Smart (2004) on mine workers revealed that that a majority of the miners who had witnessed another person dying or sick due to HIV/AIDS were more reluctant to test for HIV than those who did not have such experience. This could have resulted from the high rates of HIV/AIDS in the mining sector as compared to other sectors (Day et al., 2003). It is therefore apparent that the fear of testing positive interacts with other factors to prevent individuals from accessing VCT.

2.4.2.5 Fear of Losing Employment after Testing Positive

Within workplace settings it is common that employees will be reluctant to test because they fear that they might lose their job if they test positive. A survey study done on the impact of HIV/AIDS on business revealed that workplace HIV-prevention and treatment initiatives were perceived by employees as a strategy to identify infected employees for retrenchment purposes (Western, Churchyard, Mametja, McIntyre & Randera, 2007). This suggests that employees have doubts and anxiety about confidentiality of HIV results, and fears that healthcare professionals may share their confidential results with the employers, and that could result in job loss. In a country with high rate of unemployment, it is not surprising that employees prioritize their jobs over

their state of health. Thus, the need to keep one's job becomes a potential barrier to the success of VCT and ART services in workplace setting.

2.5 Concluding Remarks on the Literature Review

Literature has indicated that the purpose of HIV-prevention and treatment initiatives is to encourage HIV testing among individuals and to facilitate access to medical attention. In workplace settings in particular, these prevention and treatment initiatives help to facilitate easy and convenient access to health services, with a view to reduce the negative impact of HIV/AIDS on business. Currently, VCT and ART initiatives have been the only prevention and treatment strategies for this disease. And there seems to enough evidence to support the efficacy of VCT and ART strategies as promoting behaviour change, reducing infections and delaying death of those infected with the disease. Because of this, most companies have decided to implement their own HIV-prevention and treatment initiatives to make it convenient and easy for employees to access these services. Despite the fact that these initiatives are said to involve substantial financial investments, recent research have shown that they are cost-effective, convenient and easily accessible by employees.

The challenge, however, is that the uptake of VCT in workplace settings has remained relatively poor despite the sophisticated and substantial financial investment put into HIV-prevention and treatment programmes. There have been multiple factors that have been identified as affecting the uptake of VCT and ART services, as key components of HIV-prevention and treatment programmes in workplace settings.

The review of literature in this study provided an overview of the most commonly reported factors affecting VCT in workplace settings, and has also highlighted the complex nature of these factors. On one hand, literature has revealed that the following factors facilitate HIV testing behaviour among individuals: the desire to know one's status, plans for long-term relationships, cost-effectiveness and availability of ART, the model of VCT service used and the organization of on-site based VCT campaigns. On the other hand, barriers to VCT uptake included the following: lack of adequate knowledge, inaccurate risk perception, stigma and discrimination, perceived lack of confidentiality, a fatalistic attitude to HIV testing, fear of testing positive and few others. It has been apparent from the literature that the barriers to VCT uptake outweigh factors that motivate for VCT uptake, which then explain the relatively poor uptake of VCT in workplace settings. This has been reported as the common challenge faced by private-sector workplace HIV-prevention and treatment programmes countrywide (Connelly & Rosen, 2006, George, 2007, Bhagwanjee et al, 2008).

2.6 Theoretical Framework

The previous section highlighted key literature on the role of HIV-prevention and treatment initiatives and the factors that affect the uptake of VCT and ART services in workplace settings. The current section will present the theoretical underpinnings in this study, primarily the health belief model (HBM), the theory of reasoned action (TRA) and the Social cognitive theory (SCT). These three broad theoretical concepts are discussed in details below.

2.6.1 The health belief model (HBM)

The health belief model (HBM) attempts to explain and predict health behaviours by focusing on attitudes and beliefs of individuals (Airhihenbuwa & Obregon, 2000). The HBM was developed in the 1950's as an attempt by psychologists in the United States Public Health Service to explain why people refused to participate in health screening and prevention programmes such as free tuberculosis screening services (Airhihenbuwa & Obregon, 2000).

This model draws on the cognitive behavioural approach. According to the HBM, health behaviour can be predicted by examining a person's perceived vulnerability to a disease, the perceived seriousness of the disease, the perceived benefits of prevention, the perceived barriers or costs of prevention and the cues to action that may initiate the behaviour change. The HBM argues that and individual's perceptions of vulnerability and the seriousness of the disease determine his/her health behaviour (Airhihenbuwa & Obregon, 2000).

The HBM has certain limitations. It places too much emphasis on abstract conceptual beliefs. At the same time, combining the health predictors interactively may be more fruitful than simply adding them up. Most of the research based on the HBM to date has incorporated only selected components of the HBM, thereby not testing the usefulness of the model as a whole. The HBM also ignores the fact that environment and social factors such as stigma and discrimination also influence behaviour change.

2.6.2 Theory of reasoned action (TRA)

Like the health belief model, the theory of reasoned action (TRA) also draws from the cognitive behavioural approaches. The TRA assumes that human beings think logically, they consider the consequences of their actions and make systematic use of available information (Airhihenbuwa & Obregon, 2000). The theory postulates that behaviour is determined by an individual's attitudes towards certain behaviour and social influence. Social influence or subjective norms refer to individual perception of what others may think of their action. For instance, a study on teachers established that teachers were labelled potential victims of HIV/AIDS if they took the initiative to undergo VCT (Mulaudzi, 2005). This is likely to influence most people to avoid HIV testing. The TRA places particular emphasis on personal intentions to determine whether behaviour change will occur. The shorter the time spans between the formation of the intention and the behaviour, the stronger the predictive value. The theory suggests that individuals consider the implications of their actions and that most actions are consciously controlled. By determining and influencing intention, behaviour becomes relatively easy to predict and manipulate (Airhihenbuwa & Obregon, 2000).

The main strength of the TRA is that it accounts for the variables that can intervene between an attitude and its corresponding behaviour to change the direction of the person's actual behaviour (Airhihenbuwa & Obregon, 2000). However, the theory is criticised for its individualistic approach and failure to consider the role of environmental and structural factors. The assumption of the TRA that individuals are rational in decision making is also criticised as not entirely accurate in relation to HIV testing, considering

the fact that HIV/AIDS-related behaviours are heavily influenced by emotions, individual characteristics and environmental factors (Airhihenbuwa & Obregon, 2000).

2.6.3 Social Cognitive Theory (SCT)

Most individual orientated behavioral theories tend to oversimplify the process of behaviour change by focussing on cognitive abilities only, despite that recent evidence have suggested that behaviour change is no longer determined by one's cognitive reasoning, but also involve broader social factors existing within communities (Airhihenbuwa, & Obregon, 2000). The main limitation of individual orientated behavioural theories has been their tendency to neglect the larger familial and social-cultural context, which are crucial determinants of behaviour change (Airhihenbuwa, & Obregon, 2000). Unlike the theories described above, the Social Cognitive Theory (SCT) recognizes that behavior change results from the interrelationship between behavior, environmental factors, and personal factors. As it has been noted from the above literature, that factors affecting VCT uptake exist along the continuum of personal characteristics to broader socio-cultural factors (Airhihenbuwa, & Obregon, 2000). The SCT seems to be useful in guiding HIV/AIDS related health promotion interventions. For example, SCT could be used to help encourage VCT among individuals in so far as the surrounding environment promotes testing behavior by facilitating self-regulation and observational learning.

The SCT recognises that people do not exist in a vacuum, but are found within particular social contexts that inform their functioning. Community settings such as

family, school, work, church and many others are viewed as settings where people share resources, beliefs, ideas and provide social support to one another to participate in health enhancing social practices. VCT as a social practice is no difference – people share beliefs, ideas and provide support to each other to get tested. However, when the shared beliefs and ideas with respect to VCT are not health enhancing, they become challenges to VCT uptake. Thus, stigma and discrimination attached to HIV/AIDS in many communities has become the main challenges to HIV-prevention and treatment programmes (Airhihenbuwa & Obregon, 2000). This provides an example of how the environment and social contexts can influence behaviour change.

In African contexts, HIV-prevention and treatment initiatives need to pay more attention to the role of group processes in facilitating health-enhancing social practices, given the dominance of communal value systems that are at odds with an exclusive focus on individual behaviour (Petersen, Maso, Bhana, Bell & McKay, 2006). HIV/AIDS and its prevention and treatment initiatives are viewed as taboos in many communities, and individuals infected with HIV have been highly discriminated against, and this has been the main challenge to VCT uptake. Underpinning this negative view of HIV/AIDS and related issues, are myths and misconceptions that are not health enhancing. Thus, the SCT suggests that these myths and misconceptions need to be addressed at a social level, with a view to destigmatize HIV/AIDS as well as prevention and treatment initiatives. Hopefully, this might help improve the uptake of VCT both in the general communities and in workplace settings.

Research evidence from studies conducted in Eastern and Southern Africa shows that social settings are an important source of information on HIV-prevention and treatment (Petersen, Maso, Bhana, Bell & McKay, 2006). The key strength of the SCT is that it advocates for social support and peer influence which is essential in prevention and treatment initiatives in communities where the communal value system dominates. In addition, the SCT recognizes that factors that affect VCT exist beyond the individual level to the broader social context.

A summative comment on the theoretical framework is that the health belief model, the theory of reasoned action and social cognitive theory provide us with an understanding of the complex nature factors affecting the uptake of CVT and ART services. The SCT has been adopted as the major theoretical framework for the study because it provides with a more holistic and coherent understanding of the complex factors affecting VCT uptake.

2.7 Research Problem and Rationale

Workplace HIV-prevention and treatment initiatives are meant to make VCT and ART services convenient and easily accessible to employees, with a view to encourage all employees to get tested. However, research evidence has shown that the uptake of VCT and ART services in workplace settings has been relatively very poor. Therefore, this relatively poor VCT uptake has motivated the researcher to investigate the factors affecting VCT uptake in workplace settings. As stated by Ulin, Robinson & Tolley (2005), research can be conducted to identify gaps in knowledge relating to social and health interventions.

The objective or goal of the study is to explore and describe factors affecting HIV testing among employees. Studies of this nature are very important because they can provide an understanding of the issues and concerns facing employees with respect to HIV-prevention and treatment interventions offered in workplace settings. Depending on the nature of findings, the researcher intends to provide recommendations with a view to improve service delivery in workplace settings, and also add to the body of evidence pertaining to the prevention and treatment of the disease.

CHAPTER THREE: RESEARCH METHODOLOGY

This chapter discusses the methodology of this study, including the context of the study, research design, data collection, data analysis and ethical considerations.

3.1 Context of the Study

The study was conducted at one of the smaller sites of a larger courier company located in Kwa-Zulu Natal. At the time of the study the company's human resources department estimated the number of employees to 390. The company consisted of the following departments: Management, Human Resources, Information Technology, Call Centre, Accounts and the Warehouse department. This company established its HIV-prevention and treatment program about 10 years ago, utilizing the provider-initiative opt-out model of VCT. An HIV/AIDS committee was established to steer the VCT and ART services at the workplace. This committee liaise with the management, peer-educators, shop-stewards, unions and clinic staff in dealing with HIV/AIDS issues.

In terms of the courier company's policy, VCT was available to all employees from the various departments of the company. However, negotiations regarding availing VCT and ART services to spouses or partners of employees were still in process. The VCT and ART initiative at the study site took the form of annual VCT campaigns, which had been out-sourced to a local service provider since 1998. Contrary to many other workplace VCT programmes, where employees are encouraged to present themselves in a particular venue for testing, in this company pre-testing counselling takes the form of a

group presentation, with HIV testing and post-test counselling provided to those who decide to test.

The VCT campaigns follow the rapid HIV testing process. This process comprises of a saliva- based HIV screening, and is often followed by confirmatory blood test for individuals who test positive. Test results are often available within a few minutes, and followed by post-test counselling. Employees found to be infected with HIV are further managed by the service provider, with their treatment being financed by both the company and the individual employee's medical aid schemes.

The 2008 VCT campaign at the company achieved a 52 percent average uptake of VCT, which is likely higher than the 48 percent reported in 2007. A challenge was that the majority of employees who tested HIV-positive during previous VCT campaigns were reluctant to register with the company-sponsored treatment programme. It was reported that employees tended to enrol in the treatment programme only when they were in an advanced stage of the illness. This appears to be a common challenge across the private sector in South Africa (Bhagwanjee et al, 2008).

3.2 Research Design

The study followed a qualitative case study approach. Case study research is more than simply conducting research on a single individual or situation, but enables the researcher to ensure that the topic of interest is well explored, and that the essence of the phenomenon is revealed, while taking into consideration how a phenomenon is

influenced by the context within which it is situated (Yin, 2003). For the novice researcher, a case study is a good opportunity to gain insight into a case. It enables the researcher to gather data from a variety of sources and combine the data to enlighten the case. This approach is valuable for health science research in order to develop theories, evaluate programmes and develop interventions regarding health problems (Baxter & Jack, 2008). Indeed, the purpose of this study was to investigate and identify factors that affect the VCT uptake in workplace settings, with a view to understanding barriers to the success of HIV-prevention and treatment initiatives.

The questions in this qualitative case study were meant to explore themes about perceptions and concerns of employees with respect to the VCT and ART service within the workplace settings. Through exploration of these themes, the researcher hoped to identify the factors that affect the uptake of these services in the private sector with a view to make recommendations to improve service delivery and increase the uptake of VCT. The following issues were explored during the interviews:

- Knowledge and awareness of VCT
- Sources of VCT knowledge
- Participants understanding of VCT
- Awareness of VCT in the workplace
- Feelings towards HIV testing in the workplace
- General perception of VCT and HIV testing
- Factors that may inhibit HIV testing in their workplace

- Issues of stigma, confidentiality and discrimination
- Individual opinions and recommendations regarding their workplace VCT campaigns.

3.3 Sampling Technique

The human resources department of the company played a vital role in spreading the information about the proposed study. Of the estimated 390 employees, around 120 volunteered to participate in the study. The ages of the employees that volunteered to participate in this study ranged between 24-55 years. The employees interested in participating in this study were requested to forward their names to the human resources department. The department received 120 names of interested individuals. To get a close representative approximation of the country's demographics, volunteers were categorised according to historical racial groups (White, Black, Indian and Coloured), as well as gender (male and female).

A non-probability convenience sampling method was adopted due to the availability of participants and the need to have a fairly representative sample in terms of both race and gender. Ten employees were selected due limited to do the dissertation for academic purposes. The selected sample was fairly representative of the company statistics with regard to race, gender, and age demographics. Indeed, much of research in the behavioural sciences uses non-probability sampling methods (Ulin, Robinson & Tolley, 2005). Furthermore, Ulin, Robinson and Tolley (2005) propose that convenience sampling is suitable for studies that target a specific pre-defined group, where sampling

for proportionality and statistical inference is not the main concern. The researcher interviewed employees during lunch times and after working hours to avoid disrupting the daily functioning of the company.

The advantage of convenience sampling is that it is cost-effective and facilitates reaching the target sample quickly. With the convenience sampling method, one is likely to get the opinions of the target population. However, the main limitation of convenient sampling is that it compromises the possibility of generalising research findings to the entire population (Babbie & Mouton, 2001). The primary purpose of this study then was not to generalise findings, but to develop an understanding of the factors affecting VCT within the company with a view to make recommendation and to add to the body of evidence pertaining to challenges facing HIV-prevention and treatment programmes. Thus, in this study, the representativeness of the sample was of less concern.

3.4 Participants

The participants in this study were employees working for the courier company operating around Durban. The majority of the employees are African, followed by Indians, Whites and, lastly, Coloureds. It is estimated that males comprise of approximately 66% of the company population while remaining 34% of the population are females. The participants of this study came from all the above mentioned departments of the company. The sample of 10 participants consisted of 6 males and 4 females. The ages of the participants ranged between 24-55 years, with a mean age of 36 years. The sample reflected a fairly proportional representation of the company's population by sex and race.

The distribution by race was as follows: there were 5 Africans, 3 Indians, 1 White and 1 Coloured participant. A majority (5) of the participants were married, 3 of the participants were single, but living with their sexual partners. The remaining 2 were also single and living with their original families. The socio-demographic characteristics of the sample are summarised in Table 1 and 2 below; note that participants were given pseudonyms:

Table 1: Individual socio-demographic characteristics of the sample

Pseudonym	**Gender**	**Age**	**'Race'**	**Department**	**Marital Status**
Mandla	Male	24	African	IT	Single
Thembi	Female	27	African	Call Centre	Single, Live-in
Amanda	Female	30	Coloured	Call Centre	Single, Live-in
Nitesh	Male	40	Indian	Hum. Res.	Married
Jane	Female	32	Indian	Call Centre	Married
Reshma	Female	36	Indian	Call Centre	Married
John	Male	41	White	Accounts	Single
Sabelo	Male	27	African	Driver. Ass.	Single, Live-in
Mr Mahlaba	Male	56	African	Driver	Married
Mrs Msomi	Female	45	African	Cleaner	Married

Table 2: Grouped socio-demographic characteristics of the sample

Socio-demographics	**Employees (N=10)**
Age	**Years**
Age Range	24 -55 years
Mean	32 years
Gender	**Number of Participants**
Male	6
Female	4
Race	**Number of Participants**
African/Black	4
Indian	3
White	2
Coloured	1

Marital status	Number of Participants
Single, Living together with partners	2
Married	3
Single, Not living with partners	5

3.5 Data Collection and Procedure

Data collection took place within the company premises in a venue that ensured privacy and confidentiality. Individual interviews with semi-structured questions were utilised to interview participants regarding the topic of the study. Interviews took place between the researcher and the individual participants. Probing was applied to elicit more information and clarification from employees. According to Ulin, Robinson and Tolley (2005) the strength of semi-structured questions and probing is that they make the interview flow and provide the space for freedom of expression. In addition, such questions make the interview a natural conversation, and empower the participant to talk freely and determine the flow of the conversation (Babbie & Mouton, 2001). The dominant languages within the company were IsiZulu and English. Thus, interviews were conducted both these languages. All interviews were audio-recorded, translated and transcribed. The isiZulu interviews were back-translated into English before the commencing of data analysis. For an outline of the interview schedule, see **Appendix A**.

The researcher acknowledged the interview schedule at the start of the research to guide questions and the purpose of the study was clearly explained to participants. Exploratory questions thereafter stemmed from the direction of the participants' conversation. The researcher was cautious in his use of leading questions and has acknowledged this in his interpretation and analysis of data. The structuring of themes during the thematic analysis was influenced by the pattern of participant responses, with these themes then being shaped by the researcher's personal interests.

3.6 Reflexivity of the Researcher

The researcher is a Black South African male, first-language Zulu speaking with fluency in English language. Thus, language was never an issue. Firstly, participants consisted of both genders (females and males) so the extent to which female participants would easily express their thoughts and feelings to someone of the opposite sex remained questionable. However, it appears that gander was never an issue during interviews. Secondly, HIV/AIDS and related issues are very sensitive issues, thus other participants may have struggled to communicate their views and thoughts freely. Thirdly, the researcher acknowledges that racial differences can have a negative impact on interviews sessions. However, these racial did not seem to detract the quality of relationships established with the participants. The researcher does acknowledge the three factors mentioned above; however, an open, flexible and non-judgmental atmosphere was created by the researcher during interview sessions with a view to facilitate openness and freedom of expression to the participants of this study.

3.7 Trustworthiness of Information

The audio recordings of the interviews were transferred electronically and then transcribed. At the completion of each transcript, the researcher screened the transcript to correct any errors and ensure that the transcripts adequately reflected what was said by the participants. Inaudible dialogue was noted as such, and additional descriptive information was included in parentheses to clarify participant statements. The researcher holds no financial and legal obligation towards the company or the participants, eliminating bias in the research in the form of secondary gains.

3.8 Data Analysis

Thematic analysis was used as a means to analyse the data. Within this framework, a rich broad thematic description of the entire data set was obtained. NVivo 8 software was used as a means to analyse the data. This is qualitative empirical research software that is used to organise the information into coding fields. According to Braun and Clarke (2006) phase one of analysing the data involves the researchers familiarising themselves with the data. This stage of the study involved reading repeatedly and searching for meanings and patterns.

Phase two involved generating initial codes. In this study, coding was done by computer using NVivo. Coding involved identifying repeated patterns. Phase three was made up of searching for themes and involved sorting the different codes into potential themes. In this study codes were analysed and combined to form umbrella themes (Braun & Clarke, 2006). Phase four involved reviewing the themes and refining them. In this

study, sub-themes were joined into one theme. Phase five involved defining and naming themes and involved identifying the essence of what each theme was about. For each theme, a detailed analysis was conducted. Each theme was analysed in terms of the broader social context of the phenomenon under investigation (Braun & Clarke, 2006).

3.9 Ethical Consideration and Research Protocol

Prior to proceeding with the study, the researcher requested ethical approval from the University Faculty Ethics Committee in order to get clearance and approval to conduct the study, and this clearance was granted via electronic communication. However, the clearance certificate was not provided to either the researcher or the supervisor. This reflects a problem on the administration side, rather than an omission on the part of the researcher. In addition, the researcher applied for permission to the courier company to use their employees as participants. A formal letter was forwarded to the company outlining the personal details, purpose of the study and benefits of the study to both the researcher and company (see, **Appendix D**). The permission to conduct the study with the company was granted telephonically, and the management was sceptical of providing a written document, probably due to the sensitive nature of the research topic. This will be acknowledged in the limitations of this study.

Ulin, Robinson and Tolley (2005) stress the importance of three ethical considerations in conducting research, namely: voluntary participation, informed consent and confidentiality. Voluntary participation requires the researcher to respect the right of individuals to agree or refuse to participate in research (Babbie & Mouton, 2001). It also

includes the right of participants to refuse to answer any questions they find uncomfortable or offensive. During data collection, the researcher explicitly informed the participants that their participation was voluntary. No pressure was applied to force employees to participate in this study. The principle of informed consent requires that participants be informed about a range of matters relating to the study as well as the purpose of the study (Ulin, Robinson & Tolley, 2005). The researcher briefed the participants on these issues prior to their participation. Participants were requested to sign an informed consent form to confirm their voluntary participation and understanding of the purpose of the study (see **Appendix C**). Participants were requested to read the consent form carefully and ask for clarification before they signed their aggreement.

The researcher was extremely cognisant of the need for confidentiality and participants were given pseudonyms to ensure confidentiality anonymity of their identities. In in-depth interviews, often the researcher may know the identity of a participant, but has the duty to guarantee that no identifying information will be revealed to anyone else (Babbie, & Mouton, 2001). Participants were assured that their responses would be treated with strict confidentiality and that their names would not be recorded anywhere. The researcher avoided any possible harm to participants – physical, psychological and social – as part of ethical proceedings. During data analysis pseudonyms were utilised to identify individual participants' responses and to ensure confidentiality. Raw data will be destroyed after 5 years as per the procedure of doing academic research.

3.10 Concluding Remarks

The study adopted a qualitative case study design, with a view to objectively describe the factors inhibiting the uptake of VCT amongst employees. A convenience sampling technique was adopted to select participants for this study. Individual, semi-structured questions were utilised during data collection and thematic analysis was adopted to analyse the data. Ethical issues in conducting qualitative research, such as voluntary participation, informed consent and confidentiality were taken into consideration. In addition, a letter of ethical clearance was obtained prior to proceeding with the study and the permission to conduct the study with the concerned company was obtained. The next chapter presents and discusses the findings of the study.

CHAPTER FOUR: DISCUSSION OF FINDINGS

4.1 Introduction

This chapter presents the emerging themes from the study interviews. The main themes has been categorized into the following findings: perceptions and issues with respect to the site-based VCT campaigns and the factors identified as affecting the uptake of VCT at the courier company – comprising both factors motivating and inhibiting the workplace VCT uptake. The discussion of the findings will also be substantiated with excerpts from the transcripts. Kindly note that participants in this study were given pseudonyms in order to maintain the confidentiality of their identities.

4.2 Discussion of perceptions and issues regarding the workplace VCT

This section presents and discusses the perceptions and issues with respect to the site-based VCT campaigns.

4.2.1 Knowledge and Awareness of VCT

Data collected for this study indicated that all the participants possessed an adequate basic knowledge and awareness of the existing HIV-prevention and treatment programme in the workplace. This was evident in their explanations and understanding of the benefits of this programme. All the participants demonstrated an understanding that VCT helps one to know his/her status and also facilitates early access to treatment. In addition, the participants of this study also perceived VCT as a source of HIV/AIDS knowledge, as reflected in the following excerpt:

Mandla (24 years): "*It's like you get educated about HIV/AIDS and VCT. Sometimes you are allowed to ask questions. If you find that you have got the disease, the treatment is explained to you, as well as exercising."*

This quote seems to emphasize the fact that VCT provides with an opportunity for one to acquire information and to ask for clarifications where necessary.

4.2.2 Sources of VCT Information

The participants in this study expressed difficulty remembering where exactly they first heard about VCT. This may be due to the variety of VCT awareness campaigns spread across the country via multiple mechanisms, such as healthcare settings, schools and social settings, as evidenced in the following excerpt:

Jordan, 32 years old: "*I can't remember, cause I've come across this in many ways, but I do remember hearing about it at school …I also read newspapers and listen to programmes that talk about it …"*

As evidenced by this quote, the media was also the major source of VCT for the employees. This may be attributed to the increased public media campaigns and talk-shows regarding VCT. Social support systems, peers in particular can be an important source of VCT information and related issues.

Amanda, 29 years: "*Uhm I've got a friend that's HIV positive, so I learnt from her. She started getting sick and when she went for treatment, that's when she found out."*

In addition, the quote above also highlights the influence of experiential or observational learning to behaviour change. The quote also highlights that the need for medical attention is also one the factors that motivate for VCT uptake among individuals. An important has also emerged from the data that an awareness of VCT may not necessarily mean that one understands VCT comprehensively, but can mean that one is aware of the existence of this service, without its full comprehension. Thus, a clear distinction between awareness and understanding the importance of the VCT needs to be noted.

> ***Thembi, 26 years: "****I knew about it before though I didn't really understand, but in 2002 I got pregnant so they explained everything. I chose to do the HIV test at the clinic for me and my kid."*

This quote also suggests that pregnancy is likely to motivate women to access VCT due to perceived benefits to the well-being of their children. Healthcare workers also play an integral part in raising VCT awareness and helping individuals to make informed decisions with respect to testing. However, healthcare workers may need to be very cautious when recommending VCT to individuals, as VCT is a sensitive and highly stigmatised practice. Thus, such a recommendation may be met with defensiveness, an overreaction and can result in some participants avoiding VCT, as reflected in the following excerpt:

> ***Nitesh, 40 years****: "With me you know I started testing more than 7 years ago…and my GP advised me to get tested - not because he suspected something he just mentioned it to me…"*

As witnessed in this quote, the participant responded in a defensive mode, by emphasizing the point that his doctor did not recommend VCT because the doctor suspected anything, but his doctor was just advising him. The following table summarises the participants' first sources of VCT information:

Table 3: First source of information

First source of VCT information	**n =10**
Friends/Peers	3
Media and Other	3
Health Institution/Clinic	2
School	2
Workplace	0

Surprisingly, none of the participants cited their workplace as the first source of VCT information. This may suggest that the participants were exposed to VCT information prior to being exposed to it in their workplace. While workplace HIV/AIDS interventions may not have been the original source of service, such interventions might serve to provide easy and convenient access, facilitate treatment of symptoms and improve social support networks. Similarly, none of the participants cited parents or family as a source of information on VCT.

4.2.3 HIV Testing Behaviour

Data analysis has revealed that while other participants had regularly tested for HIV, others had never taken an HIV test before, and this automatically divided the participants in this study into regular testers and non-testers. Of the 10 participants, 7 of them indicated that they had regularly tested during campaigns, while the remaining participants reported to have never tested at all. Paradoxically, the regular testers had a history of testing for HIV outside the workplace. The following table summarises the HIV testing behaviour among the participants:

Table 4: Individual testing behaviour

Testing Site	Participant VCT Uptake
Testing at the workplace	7
Never tested	3
Testing both at workplace and else where	7

This may suggest that exposure to VCT makes testing less anxiety-provoking; and thus the regular testers were able to maintain their HIV testing behaviour. Only a minority (3) of the participants reported that they had never tested for HIV in their lives, either at or outside the workplace. However, the extent to which the participants of the study were exposed to HIV/AIDS was not assessed, as this was not seen as directly relevant to the study. The level of participation during VCT campaigns was found to be inconsistent across the departments of the company. A majority of the participants stated

that among all the departments of the company, the warehouse department, constituting drivers and driver assistants, was the least participatory during VCT campaigns.

> ***Amanda, 29 years****: "But I don't know about the drivers, and they are the majority in the company, some of them were very angry that about how they were not given the opportunity to test you know."*

However, this finding needs to be interpreted with caution, as it reflects individuals' subjective opinion regarding VCT uptake across departments. On one hand, the quote above appears to be suggesting that that VCT campaigns in this company had so far been unable to accommodate the drivers and their assistants, probably because the drivers are always outside the premises of the company, transporting goods to various destinations. As a result, even those drivers who may be interested in testing end up missing on the opportunity to be tested. However, concerns have consistently been raised by the participants that the warehouse department, which also includes the drivers, had always shown little interest in HIV-prevention and treatment initiatives.

> ***Nitesh, 40 years: "****I don't want to sound like I'm discriminating but it's mostly Indian and Black people that are reluctant to test, especially the warehouse department. You know most people don't wanna hear anything about testing there, even the authorities they don't encourage them enough to test."*

A closer examination of the quotes above suggest something very interesting and conflicting regarding the uptake of VCT by warehouse department of this company. On one hand, the perceived poor uptake of VCT in the warehouse department is attributed to the lack of interest in preventing and treating the disease from department members. On

the other hand, the slow uptake is attributed to the inability of the organisers to accommodate the department during VCT campaigns. It is therefore unclear whether the relatively poor uptake of VCT in the warehouse department is due to the reported lack of interst or due to the poor organisation of VCT campaigns within the workplace.

Consequently, the warehouse department constitutes a majority of the company's population, and thus compromised VCT uptake in the company. It is apparent that in accommodating and encouraging the warehouse department to effectively access VCT, improvements in VCT uptake could be observed in this company. Even though there may be no guarantees that the warehouse staff will easily volunteer for testing in future, the fact that some were dissatisfied with being deprived the opportunity to test during campaigns shows positive signs that their active involvement in HIV-prevention and treatment initiatives may lead to increased VCT uptake in this company.

4.2.4 Confidentiality Issues

The study participants provided conflicting opinions regarding the confidentiality of VCT and test results in their workplace. Seven of the participants perceived both the counselling and results as private and confidential, and these participants stated that there had never been any complaint regarding confidentiality issues reported in their workplace.

> ***Thembi, 26 years****: "It's confidential because since the process started, I have not heard them talking about people's positive results…"*

However, other participants reported doubts with respect to the confidentiality and the privacy of HIV results. This is despite the fact that there had never been any formal complaint regarding confidentiality issues in the company. However, a closer analysis of this theme shows that the participants concerned about confidentiality issues were the ones that had never tested for HIV before. Thus, their reluctance to test may somehow be influenced by their perceived lack of confidentiality of test results.

> ***Sabelo, 33 years****: "…here news move around quickly, you find that you after you have tested, news fell into the ears of wrong people…"*

The quote above suggests that any perceived rumours and gossip regarding lack the lack of confidentiality of results within the workplace may prevent HIV testing among employees. This becomes significant when the rumours are about an individual who has been found to be infected with the HI virus. Table 5 illustrates the employees' perception regarding their workplace VCT service.

Table 4: Perceptions of participants on confidentiality of VCT in the workplace

Confidentiality Issues	**Tested Before (Yes or No)**	Number of Participants
Doubts about Confidentiality	No	3
No Doubts about Confidentiality	Yes	7

4.2.5 Stigma and Discrimination

Almost all the participants reported concerns regarding HIV/AIDS stigma and discrimination within the workplace, and the concern were expressed by both regular testers and non-testers. There appears to be consensus agreement that if one were known to be infected, one would be subjected to stigma and discrimination in the company. However, the extent to which an infected individual will face stigma and discrimination was perceived as varying across the departments; but there was no mentioning of particular departments being more stigmatising and discriminating than others.

> ***Reshma, 27 years****: "Most likely she will be discriminated, but then it depends on the department you're working in or the people that you disclose to. Because I don't think you can disclose to people that you hear talking negative things about HIV, because they can avoid you and then you become lonely and depressed all the time."*

The quote above emphasises that the disease is still highly stigmatised, and the fact that infected individuals are likely to fall victim to discrimination, which poses a serious challenges to the uptake of VCT in workplace settings.

4.2.6 Departmental Interactions with Respect to VCT

In this study it has also been established that there seems to be poor interaction between the departments of this company when it comes to issues related to HIV-prevention and treatment initiatives. As discussed in earlier sections, the drivers and their assistants who happened to be falling under the warehouse department, had always not been accommodated in the annual campaigns. As a result, there was a relatively poor uptake of VCT in this department compared to the rest of the company's departments. This can be attributed to the problem of poor departmental interactions. However, the

reported lack of interest in participating in HIV-prevention and treatment initiatives by the warehouse department could help explain why the department is often not accommodated in the annual campaigns; as one participant who is a former AIDS Committee member stated:

> ***Resma, 27 years***: "*These kind of people who think like this* **[ignorant and disinterested to VCT and related issues],** *they are everywhere, especially the men from the warehouse. They are so stubborn. When I was in the AIDS Committee, these men used to oppose everything related to HIV/AIDS. They will come up with a lot of excuses to avoid testing; the steward is so ant-testing I'm telling you."*

Probably, those involved in organising VCT campaigns may have not seen the need to accommodate the warehouse department due to the perceived lack of interest by the people in charge of the department. The perceived lack of interest shown by this department in terms of participating in prevention and treatment initiatives is of great concern, since effective collaboration between the departments is essential to the success of HIV-prevention and treatment programmes.

> ***Nitesh, 40 years****: "…but it's mostly Indian and Black people that are reluctant to test, especially the warehouse department. You know most people don't wanna hear anything about testing there, even the authorities they don't encourage them enough to test. … You can even see them* **(authorities)** *in meetings that they don't have much interest in HIV/AIDS issues; I'm not surprised when that department participates less during VCT campaigns."*

A closer examination of the above quote suggests that in this company that the lack of cohesive departmental interactions contributes significantly to the relatively poor uptake of VCT.

4.2.7 Testing Positive, of Illness and Death

Issues of illness and death were relatively prominent in the majority of interviews done with the participants. HIV/AIDS was frequently associated with illness and death, suggesting that this disease is still viewed as a fatal disease rather than a chronic illness. Some participants reported that they were better-off not knowing their HIV status, and stated that knowing that they were infected with the disease would trigger the manifestation of physical symptoms and they would die quicker than they expected. Inherent in this notion is an element of the psychological burden known to be common among infected individuals – which is known to be immuno-suppressive, and therefore can accelerate the disease to advanced stages and eventual death.

> ***Sabelo, 33 years***: "*...look at me, I'm healthy, but if you can tell me I'm positive, I can start getting sick quickly and die."*
>
> ***Mr. Mahlaba, 55 years****: "Once you start getting sick and skinny, not even able to walk, people can't miss that. Even the employers realize that you are now useless, therefore they retrench you."*

The quotes above also highlight the popular misperceptions that an infected individual can be easily identified by observing his/her physical appearance and that knowing your status results in rapid illness and death. These quotes also suggest that HIV/AIDS is still viewed as deadly and fatal disease; an illness that is likely to draw the negative attention of others to the infected individual.

4.2.8 Testing and Employment Issues

The majority of the employees did not express concerns that testing positive during campaigns could cost them their jobs, and this was noted among the regular testers in particular. In contrast, the non-testers felt that testing positive would lead to loss of employment, claiming that VCT could be a way of identifying infected candidates for retrenchment. There appears to be consistency between the reluctance to test and the perceived possibility of loss of employment due to a perceived known positive status by employers.

> ***Mr. Mahlaba:*** *"You never know who gets to know about your results. The next time you realise you are jobless or maybe you stop working because of illness…"*

This suggests that support shown by management with respect to HIV-prevention and treatment initiatives is viewed with scepticism by some employees. In addition, such a response shows that the rights of employees with respect to HIV-prevention and treatment initiatives need to be communicated clearly in this company. Currently, the scepticism seems to be posing serious implications on the uptake of VCT within the company.

4.2.9 Gender, Sexuality and Testing

The influence of partners on employees' testing behaviour was noted in this study. Other participants reported reluctance to test for HIV because they feared a perceived negative reaction from their respective partners if they were to be found infected with the disease. This suggests that relationships are an important element of VCT, considering that infected individuals are often encouraged to disclose their status to their partners for

reasons of social support, compliance to treatment, prevention of further transmission and to also encourage condom use in their relationships.

> ***Sabelo, 33 years:*** *"You see, this thing of knowing about your status will put pressure on you to disclose to your partner. Maybe once you tell her, she can decide to leave, and you will be left alone. All these things will cause you stress…"*

In contrast, some female participants reported that their male partners often recommended VCT to them, but it is interesting to note that the male partners were reported to be reluctant to test for HIV themselves. These female participants felt that their partners were using them to discover their (partner's) own HIV status, as reflected in the following excerpt:

> ***Amanda, 29 years****: "I don't think so because since a lot of men do not want to test, they just say you should go and test and then if you are negative, they conclude that they are also negative. They do not prevent you from going most of the time so you just go and tell them you are negative and they are happy. They just tell you if you want to go, you can, I don't want to go."*

This quote suggests that VCT behaviour change, like other psychosocial realities, is still embedded and dominated by gender power inequities and socio-historical ideologies.

4.2.10 The Desire to Test

The desire to know one's HIV status was found to motivate people to seek VCT services. A majority (8) of the participants reported that it was important for one to know his or her HIV status.

> ***Resma, 27 years**: "I think so just to get your mind at ease …. It's better to go and have yourself tested maybe every once a year or something."*

However, some participants reported that there was no need for an individual to test for HIV as testing might result in distress and, eventually, death. This suggests that the desire for one to know his or her HIV status is often overshadowed by the perceived psychological burden of living with a stigmatised and deadly disease. And this perception has a potential to impact negatively on the uptake of VCT in workplace settings.

> ***Sabelo, 33 years**: "No, no, no, whether you test late or early eventually you will die. Yah, you are right, but why not test when you are already sick because if you test when you are healthy, you will start getting sick quickly and you will always be stressed."*

4.2.11 VCT and Medical Care

The notion that VCT helps to facilitate early access to medical care, which has been associated with a good prognosis was quite prominent theme amongst the transcripts in this study, as evidenced by the following quote:

> ***Mandla, 24 years**: "Yes, it is important for a person to know their status so that they can start taking measures to be okay, start your treatment and exercise."*

This quote also highlighted the importance of ART in bringing hope to individuals living with HIV. Furthermore, this quote did not only highlighted the importance of VCT in facilitating early access to medical attention, but also highlighted the importance of VCT in influencing individuals to lead healthy lifestyles.

4.2.12 Influence among Employees

In this study, it has been noted that individuals can influence HIV testing amongst each other. Friendships and other forms of social relationships can be important sources of VCT information and encouragement for individuals to access HIV-prevention and treatment initiatives, as noted in the following excerpt:

> ***Amanda, 29 years****: "Uhmmm I've got a friend that's HIV positive so I learnt from her. She started getting sick and when she went for treatment, that's when she found out."*

While emphasizing the importance of peer influence with respect HIV testing behaviour, the quote also stresses the point that some individuals are motivated by the need to get medical attention to get tested.

4.2.13 Supports from Employers

While a few of the participants may viewed the commitment of their employers to HIV/AIDS issues with scepticism, a majority of the participants perceived their employers as supportive and committed to the fight against HIV/AIDS in the workplace. This positive stance taken by the employers demonstrates commitment to improving the quality of lives of employees, and also demonstrates the need to prevent the negative impact of the epidemic on business.

> ***Nitesh, 40 years****: "...here we have got a very supportive management and HR is very helpful and understanding when you have a problem."*

The commitment of the employers to HIV-prevention and treatment initiatives is evidenced by the establishment of an AIDS Committee and the incorporation of ART within the workplace VCT programmes. However, organisational challenges and other impeding factors seem to undermine the employers' commitment, and negatively impact on the uptake of VCT within the company. Therefore, if the employers can focus on harnessing effective interactions across the company departments and with other relevant stakeholders to address the challenges within the company, the expected benefits of investing in HIV-prevention and treatment programmes may be more clearly evidenced.

4.2.14 Participants' suggestions regarding VCT Campaigns

Most of the participants expressed satisfaction with the existing VCT and ART service in their workplace. However, the employees expressed a need for more VCT awareness campaigns and effective educational initiatives with respect to HIV-prevention and treatment programmes across the departments. However, there were concerns that the poor cooperation of the warehouse department was really undermining the implemented VCT and ART initiatives. Therefore, a suggestion was made that VCT campaigns should accommodate the warehouse department. Furthermore, there was also a suggestion that unions need to be actively involved in pushing forward the existing HIV/AIDS interventions. This suggestion was based on the notion that unions are trusted representatives of employees; and as such, they could play a significant role in influencing HIV testing behaviour amongst the majority of employees.

> ***Nitesh, 40 years****: "Hey man, most important I think is the information about this disease. I believe people need to be educated in their own languages so they can understand and ask questions, including the counselling. If people don't understand they won't ask questions you know and can be shy you know, because they cannot speak English properly. I really believe that people should be educated first and then prepared to make HIV testing decisions. There need to be both Zulu and English speaking people to provide information. The education must be more on the unions that they can also encourage the people down there."*

The importance of language was raised as part of the suggestions with respect to the current HIV-prevention and treatment initiatives. It was suggested that VCT educational initiatives needed to be communicated in a language that could easily understood by employees. This was perceived as a step that could stimulate discussion and questions during the group pre-test counselling, with a view to encourage HIV testing among employees.

In summarizing, the themes discussed above provided with an overview of the negative and positive aspects of the current existing HIV-prevention and treatment programme in the company, as well as the overall perceptions and issue with respect the VCT and ART services. With regard to knowledge and awareness, there is no doubt that the majority of the employees exhibited knowledge of the benefits of knowing one's HIV status. On one other hand, there was agreement that VCT facilitated access to medical care and also delayed the progression of the disease. On the other hand, those who did not know their HIV status reported that there was no need for VCT as everyone was expected to die after all. Thus, they reported a lack of interest in testing. This defensiveness shows that ignorance and the lack of adequate knowledge with regard to VCT and ART services

are still major challenges of HIV-prevention and treatment initiatives in workplace settings. This is despite the fact that the HIV-prevention and treatment programme of this company seems to be sophisticated and involved substantial financial investments.

Positive aspects of the programme included the group nature of pre-test counselling that facilitated social support, the perceived support from the employers, the perceived confidentiality of test results and the adequate awareness of VCT in the workplace. However, there was evidence that certain factors were undermining the HIV-prevention and treatment programme in this company, and thereby negatively impacting on the uptake of VCT. These included stigma and discrimination, fear of testing positive, perceived lack of confidentiality, fear of losing employment and the lack of adequate interaction across departments etc. These factors noted above seem to be consistent with reviewed literature on HIV-prevention and treatment initiatives in the private sector. Next, is a detailed discussion of the factors identified as affecting the uptake of VCT in the company.

4.3 Discussion of Factors Affecting VCT Uptake

The section begins by concentrating on a detailed discussion of the aspects of the existing HIV-prevention and treatment initiatives that motivate for VCT uptake. This is in turn followed by presentation of the various barriers to the current VCT and ART initiatives within the company.

4.3.1 Factors Facilitating for VCT

The uptake of VCT at the courier company was estimated at 52% in 2008, and this seems to be relatively low considering the sophisticated nature of the HIV-prevention and treatment programme and the substantial financial investments involved. The relatively poor uptake of VCT in workplace settings seems to be a common challenge in many South African companies (George, 2006). However, there appears to be various aspects of the site-based VCT campaigns which motivated VCT uptake within the company.

First, the on-site VCT campaigns and the rapid-testing made it easier and convenient for the employees to participate in the prevention and treatment initiatives. Thus, the majority of participants in this study appeared to be satisfied with their workplace VCT and ART services. As noted in previous other studies that on-site HIV-prevention and treatment initiatives are largely supported by many employers and employees (Connelly & Rosen, 2006). On-site VCT appear to be responsive to the challenge of the lack of accessibility and the longer waiting period for HIV results, previously noted as limitations of early HIV-prevention and treatment programmes (Brink & Pienaar, 2007).

Second, the group nature of the VCT campaigns appeared to harness peer influence and reduced the stigma attached to HIV testing, and also holds the potential to enhance social support among employees. However, the group approach raises questions as to whether or not the decision to test was located at the individual level in a meaningful way or whether an individual felt obliged to conform to a structurally induced social pressure.

This group approach is being criticised for possessing an underlying element of coercion and for compromising the individual's autonomous decision to get tested (Bhagwanjee et al., 2008). Nonetheless, the participants in this study did not express any concerns with regard to the group nature of the VCT campaigns.

The group pre-test counselling information has been effective in raising VCT and ART awareness within the company, as evidenced by the adequate awareness of the VCT and ART services existing within the company. Through group pre-test counselling information, the participants were able to consider the advantages and disadvantages of HIV testing. For example, all the participants in this study were aware that VCT facilitates access to medical treatment, and that treatment helps delay the progression of the disease to advanced stages. Bhagwanjee et al. (2008) in a study of a mining community found that the group nature of pre-test counselling information helped improved VCT uptake. This could suggest that HIV-prevention campaigns need to pay more attention to group processes during HIV-prevention campaigns within the African context, considering the dominance of the communal value systems over exclusive focus on the individual behavioural approach. The focus on the group process appears to possess the capacity to facilitate health-enhancing social norms and has an element social support (Petersen, Mason, Bhana & Mckay, 2006).

Thirdly, the perceived support shown by the employers, and their active involvement in HIV/AIDS-prevention and treatment initiatives brings an element of encouragement to employees. The observed commitment to the fight against HIV/AIDS

by employers has the potential to influence employees to get tested, as it creates an impression that employers are concerned about the health of the employees (Feeley et al., 2007). The perceived lack of confidentiality of counselling and test results is one of the key challenges of VCT and ART services in the private sector, as noted in previous other studies (Connelly & Rosen, 2006, Bhagwanjee et al., 2008, WHO, 2004). However, the site-based VCT campaigns in this company also need to be credited for maintaining the confidentiality of test results throughout the years. This has been evidenced by the employees' notion that there had never been any problems with respect to confidentiality of results in this company. Meanwhile, when looking at the relatively poor uptake of VCT in this workplace, several factors emerged to help explain the no-uptake of VCT by almost half of the employees in this company. Next is the discussion of the factors that emerged as the barriers to VCT and ART services within the company.

4.3.2 Barriers to the VCT and ART services

It is apparent from the discussion of the themes above that there exist aspects of HIV-prevention and treatment that inhibited the uptake of VCT and ART services in this company.

The perceived lack of confidentiality of results emerged as the key concern among the participants in this study. Some employees in this company feared that the healthcare workers may somehow reveal the test results to fellow employees, employers or community members. Underpinning this concern was the fear of being stigmatised and discriminated against within the workplace or within the community in the event of

testing positive. In addition, underlying the perceived lack of confidentiality of results is the fear of being retrenched by employers if discovered to be infected with the disease. This seems to be consistent with the finding that HIV-prevention and treatment initiatives are viewed with scepticism in workplace settings. These findings have also been noted in several other studies with workplace and healthcare settings (Connelly & Rosen, 2006; George, 2007; WHO, 2004). It has also been established in this study that the lack of adequate collaboration between the various different departments of the company was posing a serious challenge to the uptake of VCT and ART services within the company. The site-based campaigns appeared to have accommodated office employees, while the warehouse department, comprising of drivers and their assistants, rarely received the opportunity to access the site-based campaigns. This warehouse department of course constituted a majority of employees in the courier company.

It also appears that the warehouse department has rarely been accommodated during VCT campaigns due to their perceived lack of interest in HIV-prevention and treatment initiatives. Research on the attitudes of truck drivers to testing in South Africa has consistently noted negative attitudes of the drivers to HIV testing (Medical Research Council, 2000, Nyembe, 2000). Another factor identified as a challenge to the uptake of VCT and ART within the company were the difficulties of possibly coming to terms with a positive diagnosis that carries both psychological and physical consequences. Underpinning this was a fear of dying from a disease associated with promiscuity and a disease known to be without a cure. There were also concerns with respect to disclosing a positive result, and this was evidenced by some participants reporting that sharing a

positive result to a partner could lead to rejection. Such finding also emerged in this study and has been widely reported in other related studies (Day et al, 2003, Connelly & Rosen, 2006, Padian et al., 2008). The perceived low risk of HIV infection by other participants was also identified as one of the factors responsible for the relatively poor uptake in the company.

Likewise, Kalichman & Simbayi (2003) noted that their participants thought that VCT was only necessary mainly for people who suspected that they might be at risk or those who show signs of illness, and this shows the link between a perception of low infection risk and reluctance to test. The findings show that the factors that inhibit VCT and ART services outweigh factors that motivate for these services in this company. The findings suggest the need for a range of practical interventions aimed at increasing the uptake of VCT and ART in the company; most notably efforts to encourage participation in the company-sponsored VCT campaigns and ensuring of confidentiality of test results. The next chapter discuses the conclusion, recommendation and the limitations study.

CHAPTER FIVE: CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

5.1 Conclusion

The main objective of this study was to investigate and identify factors affecting the uptake of VCT in the workplace setting, with a view to understanding issues and concerns of employees with respect to HIV-prevention and treatment services offered by the company. Indeed, the study has highlighted various aspects of the workplace prevention and treatment initiatives that were found to be both inhibiting and motivating for VCT and ART uptake within the company. As noted in the theoretical framework, factors that affect HIV-prevention and treatment in workplace settings are complex and are embedded on personal factors and the surrounding environment or social context.

The easily accessible and convenient on-site campaign, the use of rapid-testing and the group-nature of pre-test counselling emerged as the main strengths of the HIV-prevention and treatment strategies in the company. The on-site campaigns have been able to harness social support and are useful for employees to consider the benefits of testing. This can be evidenced by the adequate level of VCT awareness demonstrated by the participants and the knowledge that VCT helps one to know his or her status. In addition, the participants are aware that VCT also facilitates access to ART treatment. As noted in the health belief model, perceived benefits of VCT affects one's HIV testing behaviour. The provider-initiated opt-out model of VCT appears to have provided a context in which the employees could obtain improved pre-and-post test counselling in a safe and conducive environment. This approach also focuses on group processes – an

approach that is suitable for the African context given the dominance of the communal values systems.

As noted, group processes are useful in harnessing peer influence and encouraging HIV testing among employees. As evidenced in this study, peer education and learning have been found to be an important motivation behind employees getting tested. This seems to be in line with social cognitive theory which emphasises the role of social context in behaviour change. Likewise, the theory of reasoned action maintains that testing behaviour is determined by one's attitude towards VCT and the perception of what others may think of one's decision to test for the disease.

As cited by other participants, the provider-initiated model has also helped to de-stigmatise and normalise the disease and the practice of testing. The employees seem to be enjoying anonymity and the confidential nature of the site-based VCT campaigns, as evidenced by the lack of formal complaints regarding confidentiality of counselling and results in this company. The perceived support from employers emerged as an additional motivation for employees to participate in HIV-prevention and treatment initiatives. The commitment shown by employees in HIV-prevention and treatment programmes suggests that the employers have recognised the importance of investing in VCT and ART services, with a view to address the challenges of HIV/AIDS in the workplace. Again, the social context or the environment continues to influence the employees' HIV testing behaviour. This seems to be in line with the social cognitive theory's argument that people's behaviour, including health behaviour, is partly determined by general societal

influence, but more specifically by social interactions that involve the exchange of resources for survival purposes. From the company's perspective, the provider-initiated model has been associated with a decrease in overall healthcare costs, as previously noted in other studies that workplace HIV-prevention and treatment initiatives are cost-effective and economically viable (George, 2006).

Impediments to the success of the provider-initiated opt-out model have included the perceived lack of confidentiality, perceived stigma and discrimination, lack of departmental interaction, fear of testing positive, fear of losing employment and others. These barriers and perceptions pose serious challenges to HIV-prevention and treatment in workplace settings. Likewise, the social cognitive theory recognises the fact that shared beliefs, expectations and perceptions play an important role in influencing VCT behaviour change among individuals (Airhihenbuwa & Obregon, 2000).

The notion that HIV testing is a complex phenomenon and a product of multiple factors embedded at the social or environmental context has also been evidenced from the findings of this study, and is in line with the main assumption of the social cognitive theory. For instance, a fundamental concern was the employees' fear of lacking confidentiality in the workplace environment. However, underpinning this was the fear of being stigmatised and discriminated if found infected with the disease that society has associated with promiscuity (Kalichman & SCTbayi, 2003). The result is thus, poor VCT uptake.

In summarizing, the relative poor uptake of VCT and ART services can be attributed to the perceived lack of confidentiality and other challenges in this workplace environment. The social cognitive theory, thus proposes that HIV-prevention and treatment initiatives need to concentrate on modifying the environment in ways that will be health enhancing, with a view to promote the uptake of VCT and ART services. In addition, the provider-initiated opt-out model of VCT has been found to harness group processes which in turn help to enhance social support among individuals, and this seems to be suggesting that factors that impact on VCT are complex and beyond one's cognitive reasoning. Thus, the challenges faced by HIV-prevention and treatment initiatives in workplace settings require sophisticated interventions that are relevant to the contexts to which individuals exist. The following chapter focuses on the recommendations that are aimed at improving service delivery in the current workplace context.

5.2 Recommendations

In the light of the findings presented in this study, the researcher suggests the need for a range of practical interventions with a view to increasing participation in the HIV-prevention and treatment initiatives in the company.

The fact that some departmental managers within the company are perceived as less invested and committed to the fight against the epidemic is a matter of grave concern. In the context of poor participation rates in the courier company's on-site VCT campaigns, the lack of effective cooperation and interaction among the departments contributes significantly towards the challenges faced by VCT and ART services. This suggests that all

the relevant stakeholders need to actively participate in encouraging participation in the VCT and ART initiatives within the company, and this includes ensuring that each and every department is accommodated during VCT campaigns. Previous studies have noted that effective co-operation between relevant stake-holders with respect to HIV-prevention and treatment can promote VCT and behaviour change in workplace settings (Feeley et al., 2007). It is very important then that the management, departmental managers and unions lead by example in promoting VCT within the company. These significant individuals need to be at the forefront of HIV/AIDS initiatives and must be visible during VCT campaigns.

The HIV-prevention and treatment programme need to involve spouses/partners of employees, by including them in the provider-initiated HIV-prevention and treatment initiatives. This could be facilitated by making regular medical check-ups available to partners of employees, with a view to encourage VCT among the partners or spouses. This has the potential to prevent disclosure problems and can increase partner and family support for employees' treatment uptake and adherence, as supported by other studies (Bhagwanjee et al., 2008). This approach can arguably be the most effective one to reach spouses and partners of employees, and also has an element of community outreach.

There is also evidence from the findings that some departments are less interested in the existing HIV-prevention and treatment initiatives. This could probably due to the lack adequate information with regard to HIV/AIDS prevention and treatment measures. Therefore, innovative outreach and promotional initiatives with a particular emphasis on

increasing awareness and information with respect prevention and treatment may need to be implemented.

The lack of adequate information can be addressed by involving all the relevant stakeholders from the planning stage to implementation of HIV-prevention and treatment initiatives. This will help the employees feel embraced and acknowledged as significant stake-holders. Peer education as a means of enhancing social support can also be implemented once all relevant stake-holders have actively been involved in the planning and implementation of the prevention and treatment initiatives. Initiatives that enhance social support have previously been associated with the increase in VCT uptake within the company (Brink & Pinaar, 2007). VCT promotion activities must promote positive message about VCT, with a view to bring an element of hope and encouragement, while also addressing the fear of a positive result and the associated stigma.

HIV-prevention and treatment initiatives must be specifically designed to improve the overall HIV/AIDS information and awareness of VCT, with a view to address the existing disparities with respect to information and awareness levels. In addition to the existing promotional activities, which usually reach office workers, strategies should be designed to reach the warehouse department, particularly stewards, drivers and their assistants in order to increase the uptake of VCT in this department. However, this will need to be done with great sensitivity and caution to avoid further perpetuation of HIV/AIDS stereotypes and stigma within the company. As mentioned above, actively involving the warehouse department from situation analysis and policy planning through

to implementation could help increase the uptake of VCT within the department. As suggested by the employees themselves, VCT campaigns needs to be communicated in languages understandable to individual employees during VCT campaigns.

Issues of confidentiality, stigma and discrimination need to be prioritised during VCT workshops. Employees need to be assured that VCT will not lead to loss of employment in case one is found to be infected. As suggested by one of the participants, unions could be very helpful in assuring employees that none of them will be retrenched if found infected with HIV. Most importantly, unions themselves need to utilise their influence on employees to promote VCT campaigns and also encourage VCT during union meetings. Lastly, the company may need to incorporate couples counselling as part of their strategies to increase the uptake of VCT within the company. Finally, the company may need to conduct a study on a large scale in order to further establish factors that pose challenges to their HIV-prevention and treatment programme.

5.3 Possible Limitations of the Study

First, the study had a relatively small sample and this sample may not be regarded as a completely accurate representation of the company population. Second, the sampling and the sampling procedure compromises the potential of the findings to be generalised with maximum confidence. Nonetheless, this study was a case study conducted for academic purposes; therefore, the researcher was not concerned about the generalizability of the findings. Furthermore, due to time constraints this study was done as a baseline for future extensive research on the factors affecting VCT and ART initiatives in workplace

settings. Third, the collected data was quite thin; in particular the absence of prompts for factors motivating for VCT uptake is quite visible. This can be attributed to the lack of adequate experience on the researcher's side.

Fourth, findings of the study may appear to be a repetition of many previous studies. However, in this company, in particular, there has never been any form of research done on factors affecting VCT uptake, prior to this study. Fifth, there is no written document that indicates that the researcher was granted permission by the company to conduct the study, because the permission was granted telephonically. Lastly, there is no ethical clearance certificate granted by the University Ethics Committee – neither the researcher nor his supervisor has this certificate. This seems to be a problem on the side of the administration, rather than an omission on the part of the researcher.

Nonetheless, despite these limitations noted above, the findings from the study has helped the researcher to develop an understanding of the factors that affect the uptake of VCT in workplace settings. It is believed that the recommendations made above may help to improve service delivery in the company. Lastly, the researcher believes that the findings in this study will add to the body of evidence pertaining to the factors affecting HIV-prevention and treatment programmes in the private sector.

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Appendix A

Interview Schedule

The interview will consist of the following semi-structured questions that are aimed at eliciting information from the participants, with regard to the research topic: **HIV/AIDS in the workplace: An exploration of the factors that inhibit HIV testing among employees. A company case study.**

- What do you understand about voluntary counselling and testing (VCT)?
- How did you learn/get to know about VCT?
- In your workplace, are there any VCT campaigns/HIV testing taking place?
- Who organises these VCT campaigns?
- What can you comment about the VCT campaigns at your workplace?
- What are your own feelings regarding HIV testing in your workplace?
- Do you think it is important for people to have an HIV test? Why?
- What do you think can prevent people from HIV testing in your workplace?
- Looking at the situation in your workplace, how do you think someone will be treated if he/she confesses her HIV positive status to other employees and employers?
- What can you say about the confidentiality of HIV test results in your workplace?
- What would you recommend about VCT campaigns in your workplace?

Appendix B

INFORMED CONSENT FORM

I ……. agree to be a research participant in this research project titled: **HIV/AIDS in the workplace: An exploration of factors that inhibit HIV testing among employees. A company case study.** I understand that the researcher is a student in the School of Psychology at the University of KwaZulu-Natal and he is being supervised by Dr. Jude Clark. I do understand that the aim of the study is to explore possible factors that inhibit employees of the company from testing for HIV.

I have been assured that the researcher will keep my name and other identifying information confidential. I am aware I will be interviewed by the researcher and that the interview will last approximately 60 minutes. I am aware that the interview will be tape recorded. I understand that once the research has been finalised, the recorded information will be securely stored and destroyed after an appropriate time has elapsed.

I understand that I can withdraw from participating at any time for what ever reason I might have. I have been given an opportunity to ask questions and the responses were satisfactory. I have been informed that my participation in this study will in no way whatsoever compromise my position at work or relations with my peers or employer.

I am aware that at any point in time if I need further information regarding the study I can contact Mr Sibusiso Mthembu (researcher) at 073 630 6362 or Dr. Jude Clark (supervisor) at 031- 260 7423.

…… ……..
Signature of the Researcher Date

…… ……...
Signature of the Participant Date

Appendix C

INFORMED CONSENT FORM

Mina ……..,……. ngiyavuma ukuba yingxenye yalolucwaningo oluqonde ukuthola ukuthi ngabe yiziphi izingqinamba ezivimbela abasebenzi kulenkampani ukuba bahlolelwe igciwane lesandulela ngculaza. Ngiyaqonda ukuthi lolucwaningo lwenziwa ngumfundi wesikhungo esiphezulu kwi University of Kwazulu Natal, ngokusizwa uDr Jude Clark. Futhi ngiyakuqonda ukuthi lolucwaningo lwenzelwa ukuzama ukuthola izizathu ezenza abantu bakwenqene ukuhlolelwa leligciwane.

Ngiyaqonda ukuthi igama lami neminye imniningwane ngami angeke ivezwe kulolucwaningo, okungenani kungasetshenziswa elinye igama elingesilo elami. Ngiyaqonda ukuthi umcwaningi udinga ukuxoxisana nami ukuze athole imibono yami ngesihloko salolucwaningo. Lengxoxo angeke ithathe ngaphezu kwehora. Ngiyakuqonda futhi ukuthi imibono yethu ngalesihloko izoqoshwa ngethephu rekhoda. Kuyothi lapho umcwaningi eseqedile ngocwaningo bese eyayishisa itape rekhoda ngoba evimbela ukuthi ingxoxo yaziwe ngabanye abantu.

Ngiyaqonda ukuthi noma nini uma ngingadinga ulwazi ngalocwaningo ngingathinta uSibusiso Mthembu (ongumcwningi) kulenombolo ethi 073 630 6362 noma umsizi wakhe uDr Jude Clark kulenombolo 031 260 7423. Noma nini uma sengingathandi ukuba yinxenye yalolucwaningo ngingahoxa. Nginikeziwe ithuba lokubuza ngalolucwaningo kanti futhi nganelisekile ngendlela engiphenduleke ngayo.

…… ……..
iSignature yomcwaningi Usuku

…… ……...
iSignature yomsebenzi Usuku

Appendix D

Sibusiso Mthembu
Block 2, Room 15
Anglo Clusters Residence
Howard College, UKZN
30 January 2009

Dear Sir/Madam

RE: Assistance with my research project for academic purposes

My name Sibusiso Mthembu, and currently employed by King Edward Hospital as an Intern Clinical Psychologist. I am still a student at the University of KwaZulu-Natal, currently finishing a Masters degree in Clinical Psychology. I am expected to conduct a research project as part of my degree requirement. I am a passionate about working in the field of HIV/AIDS and have a lot of interest in establishing and exploring important issues around the epidemic. As a result, the purpose of my current research project is to explore factors that inhibit Voluntary Counselling and Testing in workplace settings. The following is the title of the project:

HIV/AIDS in the workplace: An exploration of the factors that inhibit HIV testing among employees. A company case study.

I sincerely request you to allow me to bring into play/have your employees as participants in my research project. I am interested in conducting individual interviews with approximately 10-15 of your employees. Each interview may last between 45 to 60 minutes. Arrangements to conduct these interviews can be negotiated at your own convenience. If possible, the sample population will be representative of the gender, age-groups and race distribution of your company. With your kind permission, I would like to conduct these interviews as soon as it may be possible.

Maximum confidentiality and anonymity regarding the name of your company and names of participants/employees will be ensured. In addition, any information pertaining to the company and its employees will be treated with respect and dignity.

I am looking forward to your positive response to my request.

Yours Sincerely

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Appendix E

TRANSCRIPT ONE

Biographical Information

Pseudonym: Nitesh
Age: 40
Ethnic Group: Indian

INT > INTERVIEWER & RESP > RESPONDANT

INT: Afternoon Nitesh

RESP: Afternoon Sir, howzit?

INT: Very well, thanks man. Okay, eeh… look man I must start by thanking you for availing yourself for this interview.

RESP: No problem man, I think research like this need to be encouraged because of eh,…eh its importance and so I thought it will be important for me to express my views, you know as the AIDS Committee I think we need to do more to encourage testing.

INT: Oh! You are in the AIDS Committee?

RESP: Of course man, we are responsible for HIV/AIDS related issues here.

INT: Okay, please explain to me what exactly do you as a committee?

RESP: Yeah man, a lot you know we plan the World AIDS Day, prepare pamphlets for training workshops, e….h what else we also participate in arranging of for VCT days for employees. You know man, eish many things you see we also need to lead by example and go for testing as well.

INT: Wow, you seem to be doing a lot here!

RESP: Of course.

INT: Okay, if I may ask man, how long have you been with this company?

RESP: Almost 5 years.

INT: E….y man, there still information I would like to learn from you, but before e..h we go further I would like to you to read here and sign, e…y this is just a consent form, that, that will allow you to participate voluntarily.

(Shuffling of papers)

RESP: Sign where?

INT: (Int**erviewer po**int**ing to the blank space**) Here man.

RESP: Okay man, how long will this take?

INT: Mmmmh, e..eh, not much less than an hour I guess. May be are you rushing any where man?

RESP: Not really man, its just that my wife is supposed to deliver our first born today, so I'm expecting a call any time from now to go and witnessed this important day

INT: Wow, that sounds nice man, how are you feeling about this.

RESP: I don't know, I'm just over the moon you know, even here at work I'm gonna be half day.

INT: Good to hear that man. Before you gat that call lets get to business.

RESP: (**Loud laughter**) Okay man.

INT: e..e..eh, to start with, mh…mh what's your understanding of VCT?

RESP: The way I understand it, its that you need to counselled before getting tested and the person who counsel must know her stuff…or must be able to explain everything to you so you can make good decision.

INT: Okay, may be, just to ask you, how did you happen to learn about VCT?

RESP: This HIV/AIDS and VCT thing is everywhere; you hear it on TV, newspapers and clinics they talk about these things. With me you know I started testing more than 7 years ago…and my GP advised me to get tested not because he suspected something he

just mentioned it to me…but its not that it was my first time I knew a lot ago. I won't lie man, first time it's a bit scary, but you get used to it.

INT: Okay great man, let's talk about here at your workplace, how often do HIV testing takes place?

RESP: If I'm not mistaken, e…eh lets me think, I think or as far as I know it once a year and last year it was in November last year….yah it must be in November, just be before the AIDS day.

INT: Who often organises the VCT campaigns?

RESP: You know last year I wasn't in the AIDS Committee, but I know that the HR department and the committee arrange those things. You know they always get people form outside to do it because there is no HIV clinic here and may confidential can be one of the reasons

INT: What can you say about the VCT in you work place and is it organized?

RESP: As far as I know they are well run, but I'm not sure what other may say, but I guess we differ as people you know. But I don't say there are no challenges, there may be challenges there and there.

INT: May be what do you mean by challenges?

RESP: I think a lot still need to be done to encourage HIV testing here man, you know man, we are not getting good numbers in term of people testing, e….e…eh I feel like there is not much advertisement done to promote VCT well…. You know we need to have pamphlets every where and training workshops now and again……

INT: Oh1 you feel like there isn't much exposure to information that influence people to test.

RESP: …..that's exactly what I'm talking about and even people like you will keep try and get feedback for people and see what improvements are needed you know.

INT: I guess it's a good thing you are in the HIV/AIDS Committee; you will be able to make some recommendations or possible try to change things around to improve HIV testing in your workplace.

RESP: Yeah man, I hope so cause this is a serious problem, AIDS is not joke you know I have seen many lives lost man. Wish testing would be compulsory so people will know their status.

INT: What are your feelings about HIV testing in you workplace?

RESP: I think that is something that everyone need to do, whether you sexual active or not. Because even if you are not active you never know in life I don't understand people don't want test, may be its because they know the things they do like risky behaviours.

INT: You sound like you view HIV testing as important to do.

RESP: Of course man, people need to have the right information, people must get tested you know, they must know their status and get treatment if they have to. This can help them change their lives because people are very careless about life.

INT: You seem to be really concerned about poor response to HIV testing!

RESP: Yes of course man, I don't understand why. I don't want to sound like I'm discriminating, but its mostly Indian and Black people that are reluctant to test, especially the warehouse department. You know most people don't wanna hear anything about testing there, even the authorities they don't encourage then enough to test.

INT: You feel that the warehouse authorities are doing enough to promote HIV testing?

RESP: Exactly man, you can even see them in meetings that they don't have much interest in HIV/AIDS issues, I'm not surprise when that department participate less during VCT campaigns.

INT: What do you think is the cause of the lack of interest in HIV/AIDS issues and the overall reluctance of employees to test for HIV.

RESP: Eish man, I guess a lot of things can account for that. You know what, first thing is ignorance, and people think they know everything about HIV/AIDS when they don't….

INT: Okay

RESP: ……some people often use their partners to know their status, which is wrong because sometimes results are discontent. You find that some know that they engage in risky sexual behaviours and, and may be they know about the possibility to test positive, may starts looking sick and stressed and other will see that they have got it.

INT: That's possible.

RESP: They don't go and they don't know that if you have it you have it, and as you know that the earlier you know the better……

INT: That's true.

RESP: …...but then again people make their choices. Like me and my wife we make it our duty to test at least twice a year.

INT: It's a good arrangement you have with you partner.

RESP: Yes of course, if we can't make it that will make it for us, this keeps our relationship stronger. Some people are controlled by their partner, if the partner does not like a condom they won't use it. Sometimes the partner does not like the testing idea, so they won't go because they are afraid that they will be left by the partner. This is nonsense cause this is your life.

INT: I can see that being in that committee has helped you to think about HIV/AIDS in a broad way, what could be some other possible factors preventing people form testing in your workplace, especially issues like confidentiality.

RESP: As far as I know everything is confidential, but then again if you think deeper about this…..e….mh some people may not trust that confidentiality of the process especially those who are ignorant and disinterested.

INT: May be you think they may be fears that employers will know about their status and probably, or this may put them at a disadvantage or probably leading to job loss?

RESP: Ya….ah. you can say that but yet again it could only be those who are ignorant, e…..h I mean those who think they know when they know everything when they don't you know…..

INT: What you mean about this?

RESP: As you may know there are policies put in place, you can not lose your job because you are HIV positive, and if only the unions can explain this to people. And people listen better to their unions you know. The company can be sued for doing that trust me man, ethically and legally it's wrong.

INT: Do you think people here aware of this policy?

RESP: I think so, may it's just because they don't trust it.

INT: Therefore, who do you think will make them trust?

RESP: It can only be unions; people trust unions most of the time because unions always speak for them when they are in trouble. I think we can only have little influence in that as we are may considered as part of the management.

INT: Looking at the situation in your workplace, how do you think someone will be treated if he/she confesses her HIV positive status to other employees and employers?

RESP: Trust me man, very few will sympathize, I'm not gonna lie to you judging by the way things are that person is likely to be discriminated and sidelined because the

information hasn't sank in people's minds and they don't understand that everyone can get it. And that can even cause more stress to the person.

INT: Any possibility of losing a job.

RESP: I really don't think so, unless the person is very sick. The management seems to be very supportive and understands the importance of testing.

INT: Just to end our conversation, what you recommend about VCT campaigns in you workplace.

RESP: Hey man, most important I think it the information about this disease. I believe people need to be educated in their own languages so they can understand and ask questions, including the counselling. If people don't understand they won't ask questions you know and can be shy you know, because they cannot speak English properly. I really believe that people should be educated first and then prepared to make HIV testing decisions. There need to be both Zulu and English speaking people to provide information. The education must be more on the unions that they can also encourage the people down there.

INT: Okay.

RESP: And also one-on-one like what we having can help a lot to improve HIV testing here because that's you get to know about what troubles people.

INT: Thanks a lot man, you have given me a lot of insight regarding VCT at your workplace. Good luck with the coming family member, I'm sure you can't wait for the call.

RESP: (**Laughter**) Thanks a lot man, I needed that and I'm not going to wait for it I'm going there now. Keep doing the good work.

INT: Of course I will man, bye.

RESP: Bye, enjoy the rest of the day.

Appendix F

TRANSCRIPT TWO

Biographical Information

PSUDONYM: Amanda
Age: 29
Ethnic Group: Colored

INT > INTERVIEWER & RESP > RESPONDANT

INT: Erhh…can you sign for me here just to say that you volunteered to do this thing, I didn't push you….initials and surname.

RESP: Here.

INT: Yes. And the date here.

RESP: The date is the 06th?

INT: The 06th yes. Thanks very much. I am going to ask you a few questions. There is no right or wrong answer so I am not going to be saying this is right, this is wrong. I would also like for you to be natural in your responses. Don't give me answers that you think I am looking for. Okay, give me what you know and understand about HIV okay?

RESP: Mhh…

INT: That will be fine. Firstly, what do you understand about Voluntary Counselling and Testing?

RESP: HIV/AIDS?

INT: About Voluntary Counselling and Testing, VCT.

RESP: I don't know anything about that. (Not clear).

INT: Can you sit closer so that I can hear you here.

RESP: So that's my understanding….

INT: About VCT, okay, yah, you are right, VCT is called voluntary so you go there to get counselling and testing. So how did you learn about VCT or where did you learn about VCT?

RESP: Uhmmm I've got a friend that's HIV positive so I learnt from her. She started getting sick and when she went for treatment, that's when she found out.

INT: So how is she now?

RESP: She's fine, she's on treatment and she's doing well.

INT: Oh….okay. That's great

RESP: She didn't wait; you know like some people that have it, they wait till the last stages to get help. And that is when it's too late you isn't it, especially because the immune system is completely depleted.

INT: Okay that's fine so when was that by the way?

RESP: Uhm…..I think about two years ago or three years ago. She used to help out with the kids and stuff like that. Her boyfriend was very sick and they did a blood test on him. She was very traumatised and all. Later she did a blood test and first came back negative but his was positive

INT: By the way, if you don't mind, how old are you?

RESP: 29.

INT: Okay, 29, female. So which department are you working for?

RESP: The call centre.

INT: The call centre. Okay, for how long have you been with this company?

RESP: March would be… years.

INT: Two years, okay so have you experienced any VCT happening here?

RESP: Yes, the company does, I think every year they have these AIDS awareness days and also I am a member of EXCO and we sell to accumulate funds to give to charity organisations.

INT: Do you know the name of the company that came?

RESP: I don't know but I know somebody came out here and tested whoever wanted to get tested.

INT: So that was last year?

RESP: Yes and they are going to organise something like that this year as well.

INT: Okay, so you don't know the name of the company?

RESP: No.

INT: What can you say about the operations, how is VCT dones.

RESP: I think ….(unclear), its like a roaster thing, like whoever wants to go can go during the break time

INT: So what are your feelings about HIV testing? How are people experiencing it?

RESP: People put a stigma on knowing your status and they are scared. You know one lady in the call centre, contracted TB but we treated her nicely. But I find people are still very stereotyped. I think the company should arrange for people to get tested even if they don't show any signs. But ya, people are still stereotyped towards illnesses such HIV and TB. It is so stressful. You know the lady got sick and everybody had to do this family testing thing.

INT: Was it voluntary or it was compulsory that everybody does the testing?

RESP: It was voluntary but you know there was pressure in doing it. I mean we all wanted to go and have that but management was concerned and therefore wanted everybody to go directly and quickly because it was a scare.

INT: Regarding this HIV testing thing, do you think it's important for people to go for an HIV test?

RESP: I think so just to get your mind at ease because you don't just contract it through sexual intercourse but also even if you just have an open sore or cut and somebody's blood is on there, it can happen even though once in a blue moon so it's better to go and have yourself tested maybe every….once a year or something.

INT: At least once a year?

RESP: At least.

INT: Okay so how is the response of people when it comes to HIV testing? I know you told me about HIV that everyone somewhere somehow got tested and you are not sure whether it was voluntary because there was some pressure.

RESP: Some of us did not want to have that done like myself because I hate needles. The sputum was fine but the needle no but all the results came back negative anyway.

INT: So with the HIV testing, do you think people do the same thing?

RESP: The HIV test I must say last year, there was no stigma to it. People were optimistic and there was no pressure. And they were happy to do it and that the company could do something like that. And everybody went whenever they had spare time?

INT: So is the response the same across departments in terms of how people go? Like HR, driving, warehousing etc. Do you think the statistics are the same?

RESP: I think so because lots of our drivers went for the testing as well, everybody at a certain time.

INT: Okay in your own understanding and experience, what do you think are the things that may prevent people from going for a test?

RESP: Mh….what might prevent them?

INT: Mmh….

RESP: Maybe, some people are scared to go for a test, it might be that? But I can't say that the company actually stands in the way. They say somebody is here to do it but they don't force anyone like that TB thing was forced on us as contacts…..you go if you want to go.

INT: Okay, okay so you don't foresee anything looking at the way it's done in terms of confidentiality?

RESP: Yes, it was pretty much very confidential even though people made jokes afterwards but there wasn't any uh….I think they did it in a nice way even though I didn't go.

INT: What were some of the reasons that made you not to go, if you don't mind sharing?

RESP: Uh….some of the reasons was I got myself tested prior and that was last year.

INT: Okay.

RESP: And uh…since last year I haven't done anything that I might like you know…..

INT: Okay so looking at the situation in your organisation, how do you think somebody who is HIV positive would be treated or what would be the reaction in terms of other people if they know that person is HIV positive?

RESP: Uhmm……I think that person would be alienated, I think so.

INT: So you don't know of anyone who is HIV positive in the company?

RESP: No, I don't. Whoever found out about their HIV positive status, nobody has found out about their status.

INT: So in your own thinking, that person would be discriminated or alienated?

RESP: Mmh…(affirmative)

INT: Where does that thought come from?

RESP: I am relating it to TB. The lady, she feel sick and went into hospital and you know people's attitudes just started changing and these were the people that were working together with us at the call centre and they were going on about how everybody must now get tested. It wasn't nice. Their reaction to somebody that contracted TB who after a couple of months of treatment should be free from TB,…..that was their response so how would they react to somebody with HIV?

INT: So you've got the feeling that there will be the same response or even harsher?

RESP: Even harsher, that's what I think.

INT: Do the people's results are kept secret?

RESP: I think so because as I said, I didn't hear anything since the last test. It's actually very confidential.

INT: Okay, so maybe, in your experience, what would recommend regarding VCT in your organisation?

RESP: What would I recommend?

INT: Mh….

RESP: Does it need to be something to do with AIDS and….?

INT: Ya ya, something to do with HIV testing and the way it's done, the operation, confidentiality and all those things, do you have any input or anything that you can add?

RESP: I don't actually because I actually felt that they did it nicely the way that they did it the last time.

INT: Mmh…

RESP: I think they did it the right way.

INT: Thanks, thanks a lot. I'm switching it off now.

RESP: Okay.