AN EXPLORATION OF VOLUNTARY COUNSELLING
AND TESTING: A PORT ELIZABETH — BASED STUDY

Caron Foster

Submitted in fulfilment of the requirements for the degree of

MAGISTER ARTIUM (SOCIOLOGY)

In the Faculty of Arts

at the

NELSON MANDELA METROPOLITAN UNIVERSITY

April 2010

Supervisor: Professor F J Bezuidenhout
DECLARATION

I, Caron Foster, in accordance with Rule G4.6.3, hereby declare that the dissertation, *An exploration of Voluntary Counselling and Testing: A Port Elizabeth — based study*, is my own work and that to the best of my knowledge and belief, it does not contain material previously submitted for assessment to any other institute of higher learning for any other degree or diploma. I declare that all the sources that I have quoted have been indicated and acknowledged by means of complete references.

Signature: __________

          Caron Foster

Date: April 2010
ACKNOWLEDGEMENTS

I would like to thank certain individuals without whom the completion of this treatise would not have been possible.

I am deeply grateful to my supervisor, Prof Frans Bezuidenhout, for his supportive and patient guidance and insights into this research study.

My appreciation goes to Jennifer Bowler, Lesley Foster and Dr. Veronica Bowker for sharing your varied research experience, your insights, generous assistance, valuable time, encouragement and constructive criticisms with me.

Words cannot express my gratitude to my family for their endurance and love. Many thanks to my friends, Candace, Shannon and Will, your support and laughter sustained my efforts through the entire process.

I wish to thank my research participants for voluntarily, generously and courageously contributing of their time, voices, stories and experiences. My thanks is also extended to the company they work for who opened their doors and allowed me access to their employees.

This treatise is dedicated to all the South Africans living with HIV.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Declaration</th>
<th>ii</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>iii</td>
</tr>
<tr>
<td>Table of contents</td>
<td>iv</td>
</tr>
<tr>
<td>List of tables</td>
<td>xiii</td>
</tr>
<tr>
<td>List of figures</td>
<td>xiii</td>
</tr>
<tr>
<td>Summary and Key words</td>
<td>xiv</td>
</tr>
<tr>
<td>List of Acronyms and Abbreviations</td>
<td>xvi</td>
</tr>
</tbody>
</table>

## CHAPTER ONE: EXPLORING HEALTH-SEEKING AND DECISION-MAKING BEHAVIOUR PERTAINING TO HIV VOLUNTARY COUNSELLING AND TESTING

| 1.1 Introduction                   | 1   |
| 1.2 The HIV/AIDS pandemic         | 1   |
| 1.3 Impact of HIV/AIDS on the world of work | 3   |
| 1.4 Voluntary counselling and testing or client-initiated HIV-testing | 5   |
| 1.5 Health-related behaviour      | 9   |
| 1.6 Integrated approach.          | 10  |
| 1.7 Problem identification        | 12  |
| 1.8 Outline of the study          | 13  |
| 1.9 Summary                       | 16  |
## CHAPTER TWO: METHODOLOGICAL FOUNDATION AND ACCOUNTABILITY

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Introduction</td>
<td>17</td>
</tr>
<tr>
<td>2.2</td>
<td>Rationale and motivation</td>
<td>17</td>
</tr>
<tr>
<td>2.3</td>
<td>Research questions</td>
<td>18</td>
</tr>
<tr>
<td>2.4</td>
<td>Research objectives</td>
<td>19</td>
</tr>
<tr>
<td>2.4.1</td>
<td>General research objectives</td>
<td>19</td>
</tr>
<tr>
<td>2.4.2</td>
<td>Specific research objectives</td>
<td>19</td>
</tr>
<tr>
<td>2.5</td>
<td>Method</td>
<td>19</td>
</tr>
<tr>
<td>2.6</td>
<td>Target group and sampling</td>
<td>21</td>
</tr>
<tr>
<td>2.7</td>
<td>Data collection and analysis</td>
<td>23</td>
</tr>
<tr>
<td>2.7.1</td>
<td>Pilot study</td>
<td>23</td>
</tr>
<tr>
<td>2.7.2</td>
<td>Data collection instrument: Pilot study</td>
<td>24</td>
</tr>
<tr>
<td>2.7.3</td>
<td>Data collection and interview transcription</td>
<td>26</td>
</tr>
<tr>
<td>2.7.4</td>
<td>Data analysis</td>
<td>28</td>
</tr>
<tr>
<td>2.8</td>
<td>Wilber’s framework</td>
<td>30</td>
</tr>
<tr>
<td>2.9</td>
<td>Rigour in research</td>
<td>33</td>
</tr>
<tr>
<td>2.9.1</td>
<td>Validity</td>
<td>33</td>
</tr>
<tr>
<td>2.9.2</td>
<td>Reliability</td>
<td>34</td>
</tr>
<tr>
<td>2.9.3</td>
<td>Researcher reflexivity</td>
<td>34</td>
</tr>
<tr>
<td>2.9.4</td>
<td>Saturation</td>
<td>35</td>
</tr>
<tr>
<td>2.9.5</td>
<td>Generalisation</td>
<td>36</td>
</tr>
<tr>
<td>2.10</td>
<td>Ethical considerations</td>
<td>36</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>2.11 Summary</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>CHAPTER THREE: VOLUNTARY COUNSELLING AND TESTING</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>3.1 Introduction</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>3.2 What is voluntary counselling and testing?</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>3.3 Current global guidelines for voluntary counselling and testing</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>3.3.1 Ensuring a ‘Rights’ based approach</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>3.4 Voluntary counselling and testing as an HIV/AIDS intervention strategy</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>3.4.1 Prevention of HIV/AIDS transmission — primary prevention</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>3.4.2 Prevention of HIV/AIDS disease progression — secondary prevention</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>3.5 HIV/AIDS treatment, care and support</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>3.6 Voluntary counselling and testing in South Africa</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>3.6.1 Availability of voluntary counselling and testing services in South Africa</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>3.6.2 The use of voluntary counselling and testing services in South Africa</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>3.7 Barriers to the use of voluntary counselling and testing in South Africa</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>3.7.1 Confidentiality</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>3.7.2 Fear</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>3.7.3 Stigma</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>3.7.4 Discrimination</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>3.7.5 Level of education</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>3.7.6 Belief System</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>3.7.7 Gender and the fear of violence</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>3.7.8 Accessibility of voluntary counselling and testing services</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>3.7.9 Availability of HIV/AIDS treatment care and support</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>3.8 Summary</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER FOUR: CONTEXTUALISING A RESPONSE TO HIV/AIDS AND VOLUNTARY</strong></td>
<td>66</td>
<td></td>
</tr>
<tr>
<td><strong>COUNSELLING AND TESTING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 Introduction</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>4.2 Initial response to the HIV/AIDS pandemic</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>4.2.1 The Health Belief Model</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>4.2.2 The Theory of Planned Behaviour</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>4.2.3 The Stages of Change Theory</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>4.3 Change in approach to the HIV/AIDS pandemic</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>4.4 South Africa’s response to HIV/AIDS</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>4.5 The voluntary counselling and testing dilemma</td>
<td>82</td>
<td></td>
</tr>
<tr>
<td>4.6 The Integral Framework.</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>4.6.1 Upper Left Quadrant “I” – Self (Psychology and Worldviews)</td>
<td>87</td>
<td></td>
</tr>
<tr>
<td>4.6.2 Upper Right Quadrant “It” – Behaviours (Individual Practises and</td>
<td>87</td>
<td></td>
</tr>
<tr>
<td>Actions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.6.3 Lower Left Quadrant “We” – Culture (Traditions and Social Norms)</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>4.6.4 Lower Right Quadrant “Its” – Systems (Social, Political,</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>Economic, Ecological)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.7 Using Wilber’s quadrants as a framework for analysis and</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>recommendations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Table of Contents (Continued)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.8  Summary</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>End notes for Chapter Four</td>
<td>93</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 5: DATA ANALYSIS</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>5.1  Introduction</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>5.2  Lower Right Quadrant</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>5.2.1 Collective Exterior: Social Systems and Environment</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>5.2.2 Political system and related structures</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>5.2.3 Geographical area: Port Elizabeth townships</td>
<td>196</td>
<td></td>
</tr>
<tr>
<td>5.2.4 Clinics</td>
<td>97</td>
<td></td>
</tr>
<tr>
<td>5.2.5 Access to HIV-testing and treatment</td>
<td>98</td>
<td></td>
</tr>
<tr>
<td>5.2.6 Community activity (government led)</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>5.2.7 Community-focused organisations</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>5.2.8 Media</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>5.2.9 Workplace interventions in a construction company</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>5.3  Lower Left Quadrant</td>
<td>103</td>
<td></td>
</tr>
<tr>
<td>5.3.1 Collective Interior: Culture and Worldview</td>
<td>103</td>
<td></td>
</tr>
<tr>
<td>5.3.2 Gender</td>
<td>104</td>
<td></td>
</tr>
<tr>
<td>5.3.3 Differences in treatment between HIV-positive men and HIV-positive women</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>5.3.4 The family</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>5.3.4.1 A rural household vs an urban household</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>5.3.5 Family response to HIV-positive member</td>
<td>107</td>
<td></td>
</tr>
<tr>
<td>5.3.6 Church (belief system)</td>
<td>107</td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>5.3.7 Church’s HIV/AIDS message</td>
<td>108</td>
<td></td>
</tr>
<tr>
<td>5.3.8 Church’s support for HIV/AIDS affected or infected individuals</td>
<td>108</td>
<td></td>
</tr>
<tr>
<td>5.3.9 Friends</td>
<td>109</td>
<td></td>
</tr>
<tr>
<td>5.3.9.1 What women discuss with their friends about HIV/AIDS</td>
<td>110</td>
<td></td>
</tr>
<tr>
<td>5.3.9.2 What men discuss with their friends about HIV/AIDS</td>
<td>110</td>
<td></td>
</tr>
<tr>
<td>5.3.10 Colleague discussion about HIV/AIDS</td>
<td>110</td>
<td></td>
</tr>
<tr>
<td>5.3.11 Language</td>
<td>112</td>
<td></td>
</tr>
<tr>
<td>5.3.12 Community attitude towards HIV/AIDS infected individuals</td>
<td>112</td>
<td></td>
</tr>
<tr>
<td>5.4 Upper Left Quadrant</td>
<td>113</td>
<td></td>
</tr>
<tr>
<td>5.4.1 Individual Interior: Self and Consciousness</td>
<td>113</td>
<td></td>
</tr>
<tr>
<td>5.4.2 Amount of formal education attained by respondents</td>
<td>114</td>
<td></td>
</tr>
<tr>
<td>5.4.3 Knowledge about HIV/AIDS</td>
<td>114</td>
<td></td>
</tr>
<tr>
<td>5.4.4 Knowledge of voluntary counselling and testing and its importance</td>
<td>116</td>
<td></td>
</tr>
<tr>
<td>5.4.5 Personal observation and experience</td>
<td>117</td>
<td></td>
</tr>
<tr>
<td>5.4.6 Fear</td>
<td>119</td>
<td></td>
</tr>
<tr>
<td>5.4.6.1 Fear of illness and disability</td>
<td>119</td>
<td></td>
</tr>
<tr>
<td>5.4.6.2 Fear of dying</td>
<td>119</td>
<td></td>
</tr>
<tr>
<td>5.4.6.3 Additional aspects of fear</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>5.5 Upper Right Quadrant</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>5.5.1 Individual’s Exterior: Behaviour and Organism</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>5.5.2 HIV-testing behaviour</td>
<td>121</td>
<td></td>
</tr>
<tr>
<td>5.5.3 Sharing HIV/AIDS knowledge with others</td>
<td>121</td>
<td></td>
</tr>
</tbody>
</table>
5.5.4 Personal actions to assist others 122
5.5.5 Disclosure of HIV-status to others 122
5.7 Summary 123

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS 127

6.1 Introduction 127
6.2 Research findings placed within Wilber’s Integral Framework 127
6.2.1 The Lower Right Quadrant: Collective Exterior (Social Systems and Environment) 128
6.2.1.1 The construction company that employs these respondents provides an HIV/AIDS workplace policy and programme that creates a positive environment, through which employees are encouraged to volunteer for HIV-testing. 128
6.2.1.2 There exists a relationship of trust between employee and employer, Labour Union representatives and employee, as well as between colleagues. 129
6.2.1.3 The importance of knowing one’s HIV-status is well understood and the benefits of HIV-testing are clear to respondents. 130
6.2.1.4 The quality of Public Health Care services is of critical importance of employees if they require HIV-testing or test HIV-positive. 130
6.2.1.5 Different media provide opportunity for informal discussion about HIV/AIDS among employees and with members of their family/household and friends. 131
6.2.1.6 High-density living of individuals in small houses or informal dwellings is characteristic of urban or township community living and cited as cause for the high HIV/AIDS prevalence rate in these urban communities. 132
6.2.2 The Lower Left Quadrant: Collective Interior (Culture and Worldviews) 134
6.2.2.1 Respondents’ communities do not stigmatise or discriminate against HIV-positive individuals or against those that develop AIDS-related complications yet the respondents conceded that this had not always the case.

6.2.2.2 Significant events have gradually brought a change in the perceptions and attitudes in members of the respondents’ communities resulting in a greater understanding of HIV/AIDS with a subsequent decrease in discriminatory behaviour and stigmatising attitudes toward known or assumed HIV-positive individuals.

6.2.2.3 The churches to which employees are affiliated assist in decreasing HIV/AIDS stigmatising attitudes and discriminatory behaviour in community members.

6.2.2.4 Families are proactive in attempting to prevent HIV-infection amongst their members.

6.2.2.5 Interaction between respondents and friends contribute to information exchange leading to better informed individuals who know how to prevent HIV-infection, which increases the motivation of individuals to use voluntary counselling and testing services.

6.2.2.6 HIV/AIDS is a gender defining disease due to modes of transmission, as well as the inequalities facing women in South Africa.

6.2.2.7 Language and terminology used to define a disease such as HIV/AIDS and words used to describe individuals known to be HIV-positive indicate how a cultural group that share a language perceive the disease.

6.2.3 The Upper Left Quadrant: Individual Interior (Self and Consciousness)

6.2.3.1 These respondents have extensive knowledge about HIV/AIDS and related opportunistic infections as well as of HIV-testing.

6.2.3.2 The respondents believed that fear of illness and death is the major obstacle for community members not volunteering for HIV-testing.
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.2.3.3 Respondents’ fear of HIV-infection has been lessened by their knowledge of HIV/AIDS thus their fear no longer inhibits them from volunteering for HIV-testing.</td>
<td>139</td>
</tr>
<tr>
<td>6.2.4 The Upper Right Quadrant: Individual Exterior (Behaviour and Organism)</td>
<td>140</td>
</tr>
<tr>
<td>6.2.4.1 Respondents undertook regular HIV-testing and encouraged colleagues and friends to do the same.</td>
<td>140</td>
</tr>
<tr>
<td>6.2.4.2 Respondents shared their HIV/AIDS knowledge and information pamphlets with their family members and friends.</td>
<td>141</td>
</tr>
<tr>
<td>6.2.4.3 Respondents had a high degree of care for their fellow community members who had been affected or infected with HIV/AIDS and would not sanction any discrimination or stigma towards HIV-positive individuals.</td>
<td>141</td>
</tr>
<tr>
<td>6.3 Recommendations</td>
<td>142</td>
</tr>
<tr>
<td>6.3.1 Workplace recommendations</td>
<td>142</td>
</tr>
<tr>
<td>6.3.2 South African Government. Department of Health recommendations</td>
<td>145</td>
</tr>
<tr>
<td>6.3.3 Recommendations to the research community</td>
<td>146</td>
</tr>
<tr>
<td>6.4 Limitations of the study</td>
<td>147</td>
</tr>
<tr>
<td>6.5 Assessment of attainment of research objectives</td>
<td>147</td>
</tr>
<tr>
<td>6.6 Concluding remarks</td>
<td>149</td>
</tr>
<tr>
<td>References</td>
<td>150</td>
</tr>
<tr>
<td>Appendix 1: Participation letter given to respondents</td>
<td>164</td>
</tr>
<tr>
<td>Appendix 2: Unstructured interview guide</td>
<td>165</td>
</tr>
<tr>
<td>Appendix 3: Consent form</td>
<td>169</td>
</tr>
<tr>
<td>Appendix 4: Ethics (human) Committee Approval Letter</td>
<td>173</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 2.1 Characteristics of respondents 23
Table 2.2 Data analysis frame identifying categories and codes 31

LIST OF FIGURES

Figure 1.1 Wilber’s Four-Quadrant Framework. 11
Figure 4.1 Wilber’s Four-Quadrant Framework. 87
Figure 4.2 Current responses to VCT from research studies 90
Figure 5.1 Collective Exterior: Social System and Environment 95
Figure 5.2 Collective Interior: Culture and Worldview 104
Figure 5.3 Individual Interior: Self and Consciousness 114
Figure 5.4 Individual Exterior: Behaviour and Organism 121
Figure 5.5 Summary of factors that hinder individuals volunteering for VCT 124
Figure 5.6 Summary of factors that facilitate individuals volunteering for VCT 125
Figure 5.7 Summary of important findings 126
Figure 6.1 Wilber’s Four-Quadrant Framework. 128
SUMMARY

The purpose of this study was to explore and identify factors that either facilitate or inhibit individuals volunteering for HIV-testing. The target group was comprised of Xhosa first-language construction workers in a company with an HIV/AIDS workplace policy and programme. This programme provides basic education and awareness about HIV/AIDS. This education includes information about where to access voluntary counselling and testing (VCT) services.

Interpretive qualitative research was undertaken in order to explore the beliefs, perceptions and intentions of the target group in regard to the utilisation VCT services. Data was collected using an unstructured interview guide. The data was analysed using Tesch’s approach to content analysis. Concerns about validity and reliability were engaged throughout the research process and supported further by using researcher reflexivity and an independent researcher. The independent researcher analysed data separately and only after discussion and consensus being found between the two researchers were final categories and codes agreed upon and data analysis considered complete. Findings revealed that an HIV/AIDS workplace programme has a positive impact on the health-seeking behaviour of workers in the construction company used in this research. Respondents knew how HIV/AIDS is transmitted, how to prevent transmission and where to find HIV-testing treatment and support. In this case HIV-testing services can easily be accessed further facilitating respondents volunteering for HIV-testing. It was also found that family, friends and churches support HIV-testing behaviour by providing education, guidance and support to respondents encouraging behaviour change. On the other hand, respondents held that community members who had not benefited from an HIV/AIDS workplace programme such as theirs are exposed daily to the devastating effects of HIV leading to AIDS deaths and live in fear of the disease. Debilitating illness and eventual death is equated with an HIV-positive diagnosis which causes community members to believe it is better not to volunteer for HIV-testing than to ascertain one’s HIV-status. The HIV/AIDS workplace policy and
programme on the other hand is seen to have provided respondents with HIV/AIDS knowledge enabling them to overcome their fear of an HIV-positive diagnosis and to volunteer for regular HIV-testing.

**Key words:** Debilitating illness, HIV/AIDS, Interpretative, Voluntary counselling and testing, Xhosa first-language employees.
### LIST OF ACRONYMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC</td>
<td>Abstain; Be faithful; Condomise</td>
</tr>
<tr>
<td>AIDC</td>
<td>Automotive Industry Development Centre</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>African National Congress</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retroviral</td>
</tr>
<tr>
<td>ASSA</td>
<td>Actuarial Society South Africa</td>
</tr>
<tr>
<td>AZT</td>
<td>Azidothymidine (one of the first antiretroviral drugs developed to alter the course of HIV)</td>
</tr>
<tr>
<td>BER</td>
<td>Bureau of Economic Research, Stellenbosch University</td>
</tr>
<tr>
<td>CD4</td>
<td>“Helper” T-lymphocytes in human blood. A count of less than 200 CD4-cells per cubic millimetre of blood (or where the CD4-cells are less than 14 per cent of all lymphocytes) and the presence of HIV are diagnostic indicators for AIDS.</td>
</tr>
<tr>
<td>CDC</td>
<td>Coega Development Corporation</td>
</tr>
<tr>
<td>CITC</td>
<td>Client-Initiated Testing and Counselling</td>
</tr>
<tr>
<td>COSATU</td>
<td>Congress of South African Trade Unions</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>G8</td>
<td>Forum of leaders from the 8 richest countries in the world</td>
</tr>
<tr>
<td>HAART</td>
<td>Highly active antiretroviral therapy</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HSRC</td>
<td>Human Sciences Research Council</td>
</tr>
<tr>
<td>IDU(s)</td>
<td>Injecting drug users</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
</tr>
</tbody>
</table>
KAPB: Knowledge attitudes behaviour and practices
MDG(s): Millennium Development Goals
MTCT: Mother-to-child-transmission
NACOSA: National AIDS Convention of South Africa
NGO(s): Non-governmental organisation(s)
NSP: National Strategic Plan
NUMSA: National Union of Metal Workers of South Africa
PEPFAR: President’s Emergency Plan for AIDS Relief
PLWA: People living with HIV/AIDS
PMTCT: Preventing-mother-to-child-transmission
SABCOHA: South African Business Coalition on HIV/AIDS
SACTWU: South African Clothing and Textile Workers Union
SADC: Southern African Development Community
STI(s): Sexually transmitted infection(s)
TAC: Treatment Action Campaign
TB: Tuberculosis
Three “C’s”: Consent Counselling and Confidentiality in reference to the UNAIDS and WHO voluntary counselling and testing guidelines
Ubuntu: Most Nguni languages in Southern Africa will say: “umuntu ngumuntu ngabantu [a person is a person through other persons, or I am because we are]”.
UN: United Nations
UNAIDS: Joint United Nations Programme on HIV/AIDS
UNGASS: United Nations General Assembly Special Session
UNISA: University of South Africa
**USAID:** United States Agency for International Development  
**VCT:** Voluntary counselling and testing  
**WHO:** World Health Organisation  
**Z3:** A community term used to describe individuals who are taking antiretrovirals derived from the well-known antiretroviral—AZT
Chapter One

EXPLORING HEALTH-SEEKING AND DECISION-MAKING
BEHAVIOUR PERTAINING TO HIV VOLUNTARY COUNSELLING AND TESTING

1.1 Introduction
Voluntary counselling and testing (VCT) services are widely available throughout South Africa. Despite the availability of these services they are not fully utilised and as a result do not make an adequate contribution towards HIV/AIDS prevention. In this introductory chapter the global pandemic, regional and national HIV/AIDS epidemic is described. In addition, it introduces readers to the focus of this interpretative qualitative research (See Chapter 2), as well as to voluntary counselling and testing as a strategy in the prevention of HIV/AIDS and health service delivery (See Chapter 3). Further to this, the need is stressed for an integrated approach to HIV/AIDS prevention and health service delivery (See Chapter 4).

1.2 The HIV/AIDS pandemic
It has been close to 30 years since the HIV/AIDS pandemic began and HIV/AIDS continues to challenge efforts in all areas of prevention, treatment and care. In 2009, UNAIDS estimated that globally 33.4 million people were living with HIV (UNAIDS 2008: 16). Of these 2.7 million people became infected with the virus, and 2 million people died of HIV-related causes (UNAIDS 2008: 16-17).

Sub-Saharan Africa continues to bear the brunt of the epidemic with 35% of the new HIV-infections and 38% of AIDS deaths occurring in the sub-region in 2007. It is also home to 67% of all people living with HIV (UNAIDS 2009: 1).

HIV data from antenatal clinics in South Africa estimated that 5.7 million were living with HIV in 2007. In the same year, the South African Health Department estimated 17.64% of working
age adults (15 – 49 years) was living with HIV (South African, DoH 2007b: 48). In a recent research report released by the HSRC: *S.A. National HIV prevalence, incidence, behaviour and communication survey 2008*, the prevalence rate for the Eastern Cape was estimated to be 9% (Shisana, Rehle, Simbayi, Zuma, Jooste, Pillay-van-Wyk, Mbelle, Van Zyl, Parker, Zungu, Pezi & the SABSSM III Implementation Team. 2009: 25). In the Nelson Mandela Metropolitan area the HIV/AIDS prevalence rate in 2007 was 27.9% (South African Government, DoH 2007b: 48).

The 192 United Nations member states and 23 international organisations agreed to achieve eight international development goals by the year 2015. These eight international development goals became known as the Millennium Development Goals (MDGs) (UN 2009). According to the World Health Organisation (WHO), the HIV/AIDS pandemic has had a negative impact on six out of the eight key areas covered by the Millennium Development Goals. These development goals derive from earlier international development targets, and were officially established at the Millennium Summit in 2000 at which all world leaders who were present adopted the United Nations Millennium Declaration which included the eight goals. These goals are: (1) to eradicate extreme poverty (2) achieve universal primary education, (3) promote gender equality and empower women, (4) reduce child mortality, (5) improved maternal health and (6) to combat major infectious diseases, including HIV/AIDS and malaria, (7) to ensure environmental sustainability and (8) to develop a global partnership for development (UN 2009). Despite an increased global response to the HIV/AIDS pandemic these goals are undermined by continued transmission of HIV and its progression to AIDS (WHO 2008a).

Apart from and beyond the suffering inflicted, the pandemic is destroying development gains achieved over generations because it reinforces every problem that connects ill health to poverty (ILO 2005a). Consequently HIV/AIDS is a developmental crisis, as it is a major threat to social and economic development, and, according to the International Labour Organisation (ILO), the single greatest obstacle to the attainment of the Millennium Development Goals — especially in Africa (ILO 2005a).

---

1 There have been no 2008 statistics released for the Nelson Mandela Metropole by the South African or Eastern Cape Department of Health
1.3 Impact of HIV/AIDS on the world of work


The ASSA2002 model developed by Professor Rob Dorrington and the Actuarial Society of South Africa (ASSA) (BER – Bureau of Economic Research - 2005) allows for the implementation of five interventions that should help to curb the spread of the disease. These five interventions are: information and education; improved treatment of sexually transmitted infections; voluntary counselling and testing (VCT); mother-to-child-transmission prevention (PMTCT) and antiretroviral treatment (ART). The implementation of these interventions is vitally important to counter the effect that HIV/AIDS will have on the South African working age population.

Estimates indicate that more than nineteen percent of adults between the ages of 20 years and 64 years are currently infected with HIV (BER 2005). The workplace has therefore been identified by international and national agencies involved in the struggle against HIV/AIDS as an ideal site for combating the effects and spread of HIV/AIDS (Rosen, Simon, Vincent, MacLeod, Fox & Thea 2003; UNAIDS 2002a; UNAIDS 2002b).

In September 1997 the Southern African Development Community (SADC) Council of Ministers approved a SADC code on AIDS and employment (Pembrey 2006; Stevens 2001). While this code is not legally binding it is based on fundamental principles of human and patient rights drawn from the United Nation’s declarations. The code aims to ensure that its guiding principles are reflected in the relevant laws of all member countries. In December 2000, the South African Government published a Code of Practice on key aspects of HIV/AIDS and Employment to provide guidelines for employers and employees regarding non-discriminatory behaviour (Stevens 2001). The International Labour Organisation produced a code of practice on HIV/AIDS and the World of Work in 2001 which builds on the work of the UNAIDS declarations and the SADC Code (Stevens 2001). These codes and guidelines, designed for
workplaces and the working population, are intended to assist in reducing the economic and personal impact of HIV/AIDS and to ensure that no persons affected by or infected with HIV suffer discrimination in the workplace.

UNAIDS (2002a), in recognising that business organisations operate within a broader social and economic contexts suggests that these organisations also develop and extend HIV/AIDS programmes to address four key areas of business practice, namely, their employees and families; suppliers; community, and to the performance of leadership and advocacy roles within the broader society. By doing so business will be better able to cope with the negative impact of HIV/AIDS while also helping to prevent its spread and fulfilling their social responsibility role. To ensure this, business should develop an effective HIV/AIDS workplace programme:

- That focuses on maintaining a healthy and vigilant workforce and family environment while sustaining their core business operations.
- That aims to minimise the risk of their suppliers not being able to deliver core services and to support smaller business entities that may not have the capacity to develop their own HIV/AIDS programmes.
- That protects their internal labour force in the light of changes that might occur due to the negative manifestation of HIV/AIDS in the broader community.
- That extends its advocacy and leadership potential with both communities and government, as a partner in the struggle against the HIV/AIDS pandemic (UNAIDS 2002a).

The impact of HIV/AIDS on the workplace will vary, depending on the skills mix, geographic location and social context. The impact of HIV/AIDS on the workplace will also be affected by the prevalence of other illnesses, such as, tuberculosis and cholera which may give rise to higher morbidity or mortality in HIV-infected people (Rosen, Freely, Connelly & Simon 2006). Further factors influencing the impact of HIV/AIDS are people’s access to quality health services and different forms of treatment and the degree of stigmatisation and discrimination people experience (Heywood 2000a: 7 in Stevens 2001). According to Rosen et al. (2003) HIV/AIDS workplace prevention programmes based on good practice should therefore, include: educating employees, families, and the surrounding community about HIV/AIDS and its prevention;
distributing condoms to employees; treating other sexually transmitted infections; and providing free counselling and testing (VCT) services for employees and families.

Policies are often the first and easiest response to HIV/AIDS within a workplace. However, to be effective such policies should reflect the legal framework for addressing HIV/AIDS in the workplace provided by the South African constitution and labour legislation (ILO 2005b; Mapolisa & Stevens 2003). An HIV/AIDS workplace policy should contain the correct information regarding the transmission, prevention and treatment of HIV/AIDS including where to access HIV-testing and obtain care and support. Proper implementation of a workplace policy entails the provision of basic education concerning HIV/AIDS transmission, prevention, treatment, care, support and where to access HIV-testing. A policy which meets these criteria should minimise the impact of the HIV/AIDS epidemic on the company and its employees (ILO 2005c). This will also lead to the development of an educated workforce, aware of and knowledgeable about HIV/AIDS prevention, treatment and care.

1.4 Voluntary counselling and testing or client-initiated HIV-testing

The WHO (2003a) has been aware of the increasing importance of the health sector in the drive for universal access to HIV-prevention, treatment, care and support, as well as in monitoring and tracking the pandemic. Priority interventions are recommended by the WHO as necessary to mount an effective and comprehensive health sector response to HIV/AIDS. Priority health sector interventions for HIV-prevention, treatment and care include:

- **Information and education together with supplies and services for preventing HIV-transmission in health care settings:** prevention of sexual HIV-transmission; management of sexually transmitted infections (STIs); prevention of mother-to-child HIV-transmission (PMTCT); provision of harm reduction for injecting drug users (IDUs); provision of HIV counselling and testing (VCT); prevention of HIV-transmission by people living with HIV; prevention of progression of HIV-infection to AIDS; and clinical management, treatment and care for people living with HIV.

- **Community based prevention, treatment preparedness and support for HIV and tuberculosis (TB):** condom promotion; provision of clean injecting equipment; HIV
counselling and testing (VCT); home-based care and psychosocial support including peer support.

- **Interventions delivered through outreach to most-at-risk populations:** integrated HIV counselling and testing (VCT), treatment and care services in drop-in centres and similar locations, including mobile ones.

- **National measures required for supporting service delivery:** leadership; advocacy; strategic planning; programme management; procurement and supply management; laboratory services; human resources; financing and HIV/AIDS and STI strategic information management systems (WHO 2003a).

Universal access in the health sector requires priority interventions to be delivered in ways that are physically accessible, publicly acceptable and affordable, and also of satisfactory quality (WHO 2008a). Priority interventions aim to increase the numbers of people, especially those in most-at-risk populations, who know their HIV-status through their use of counselling and HIV-testing services (VCT). This is seen as the key to expanding access to HIV-prevention, treatment, and care. The WHO’s guidance on HIV counselling and testing aims for synergies between medical ethics, human rights and clinical and public health objectives (WHO 2008a).

The HIV/AIDS and STI National Strategic Plan 2007-2011 (South African Government, DoH 2007a) represents the country’s multi-sectoral response to the challenge of HIV-infection and the wide-ranging impact of AIDS. The interventions that were identified as essential to ensure that the National Strategic Plan reaches its goals are grouped in four key priority areas:

1. **Prevention:**
   - Reduce vulnerability to HIV-infection and the impact of AIDS.
   - Create an enabling environment for HIV-testing.
   - Treatment, care and support.

2. **Increase coverage of voluntary counselling and testing and promote regular testing.**
   - Increase access to VCT services that recognise the diversity of needs.
   - Increase uptake of VCT.

3. **Research, monitoring and surveillance.**

4. **Human rights and access to justice** (South African Government, DoH 2007a)
Voluntary counselling and testing is directly identified in the first two priority areas of the National Strategic Plan. It is also intrinsically part of the second two priority areas, as research, monitoring and surveillance will enable the assessment of whether the first two priority areas have been met. In terms of the South African Constitution this implies that access to medical treatment and care is a basic human right (Stevens 2001).

Voluntary counselling and testing is a combination of two activities, counselling and testing. The fundamental principle of HIV-testing is that it must be accompanied by basic pre-test counselling and information to enable the client to make an informed and voluntary decision to be tested. The objectives of VCT are prevention of HIV-transmission and provision of emotional support to those who wish to consider HIV-testing; to help individuals make a decision about whether or not to be tested, and to provide support (medical and emotional) via post-test counselling to facilitate decision-making following testing. The “Three C’s” — informed Consent, Counselling and Confidentiality - should always be maintained (ILO 2005a; WHO 2008a).

The rationale for HIV counselling and testing (VCT) to be part of the response to the HIV/AIDS pandemic is well established (WHO 2008a). HIV/AIDS is primarily a social phenomenon stemming from a disease that gives rise to a range of behavioural, psychological and social consequences for both those infected with and those affected by HIV/AIDS. Voluntary counselling and testing is a significant primary prevention strategy as it provides an opportunity for the dissemination of accurate information about HIV/AIDS and for risk assessment and risk reduction counselling for the general population. In addition it makes the following available: counselling about options to reduce HIV mother-to-child-transmission (MTCT) for pregnant women; and information about and referral to medical services specific to the treatment of associated infections, such as sexually transmitted infections or opportunistic diseases such as tuberculosis. Voluntary counselling and testing has proved to be an effective secondary prevention strategy (Mathews 2005; McCauley 2004) that assists HIV-positive individuals and serodiscordant couples (where one partner is HIV-positive and the other not) reduce the risk of infecting others or of re-infecting themselves (Leach-Lemons & Owuor 2009; Strode, van
Rooyen, Heywood, & Abdoel Karim 2005a). It also allows for effective treatment, care and support to assist in preventing HIV disease progression to AIDS.

A crucial component of strategies to prevent new HIV-infections is that persons at risk of contracting HIV have access to, and regularly use voluntary HIV counselling and testing services. The availability of HIV voluntary counselling and testing services in South Africa is widely spread, yet it is estimated that less than a quarter of HIV-infected people in the country know their status (Williams 2005). Care for HIV/AIDS cannot begin without diagnosis of HIV-infection. It is possible that people who are HIV-positive and do not know their status may continue to engage in risky sexual practices that might further spread the disease. Raising the numbers of infected persons who know their status regarding HIV-infection is, therefore, an important prevention goal (Family Health International 2002; Frohlich 2005).

According to Maibach et al. (2002:441 in Swanapoel 2006) providing information to effect behaviour change is in fact only adequate "...when the benefits of the recommended behaviour are sufficiently attractive, when the barriers to performance are sufficiently minor, or when the alternative behaviours offer relatively less attractive benefits". In terms of HIV-testing, the benefits currently do not outweigh the drawbacks of knowing one’s status (Swanapoel 2006). Besides physical consequences such as coping with opportunistic infections, a weakened immune system, pain and suffering and eventually death, there are also psychosocial consequences which include coping with a positive test result, shame and self-blame, uncertainty and fear of disclosing one's positive status, depression, and eventually dementia (WHO 2003b). There are a multitude of social consequences: fear of lack of confidentiality, rejection by sex partners, family, friends, and the community, being stigmatised and discriminated against, living with a chronic illness and not being able to fulfil one’s social roles (van Dyk & van Dyk 2003). Finally, ill health may result in an individual not being able to financially support themselves and their family, inability to pay health care and the denial of insurance or loans (ILO 2004; ILO 2005a; Swanapoel 2006).

Research indicates (de Saxe Zerden, Zerden & Billinghamurst 2006; ILO 2004; ILO 2005b; Reed 2005; Swanapoel 2006; van Dyk, & van Dyk 2003) that people have more concerns about the
consequences of testing HIV-positive than merely the clinical management of the illness. These physical and psychosocial concerns, listed in the previous paragraph, about HIV-testing and knowing one’s status demand a broad range of social and contextual measures to avert, avoid or minimise them (van Dyk & van Dyk 2003). If voluntary counselling and testing is to be a useful primary and secondary prevention strategy, considerably more information about how to make the service as effective as possible is required (Solomon, Van Rooyen, Griesel, Gray, Stein & Nott 2004).

1.5 Health-related behaviour
The strategy of the WHO (2003a) to increase uptake of HIV-testing is in line with an empowerment philosophy, which in terms of HIV-prevention and care, proposes that a supporting and empowering environment be created to motivate at-risk individuals to make the healthy choice of going for voluntary counselling and testing the easy choice. The strategy is thus based on a broad definition of the concept of health and of the determinants of human agency that underlie the health-related decision-making processes. While health is defined in biomedical terms as the absence of disease, it is also referred to as a state of complete physical, mental and social well-being. On the other hand health-related decision-making is not only restricted to a set of individual, psychosocial determinants but includes contextual determinants such as access to treatment, care and support. This implies that while well-being and decision-making occur on different levels [the individual, the interpersonal, the communal, the social and the institutional (Tones & Green 2004 in Swanapoel 2006)] they become integrated into patterned behaviour.

Tones and Green (2004) in reviewing early criticism on health education and promotion which emphasised individual responsibility and ignored broader social and contextual constraints stress the role of the community as opposed to the individual in addressing health-related issues. For them a focus on the individual leads to ‘victim-blaming’, which is based on the assumption that individuals possess complete control over their personal health decisions. This view neglects to account for social and contextual factors which are outside the control of the individual.
This notion of Tones and Green (2004) is reiterated by research (compare de Saxe Zerden et al. 2006; Maman, Mbwambo, Hogan, Kilonzo, Sweat & Weiss 2001; Strode et al. 2005a) on voluntary counselling and testing which confirms that the use of VCT is hampered by many of the same factors that limit the use of other HIV-related services. Poor decisions by individuals are unlikely to be the sole cause of their health status. Social and environmental issues such as limited access to treatment, care and health services in general, stigma and discrimination, as well as gendered-related issues, to mention only a few, are among the issues which influence decision-making and often lead to individuals relinquishing their control over health decision-making. A four-country survey undertaken in Asia (Vietnam, Indonesia, Cambodia and Thailand) showed that women were more likely to seek HIV-testing and counselling only after their partner became ill with an AIDS-related opportunistic infection because of failure in diagnosing the HIV-positive partner and also due to failure of prevention, treatment and care (UNAIDS/WHO 2007). In a similar vein, Solomon et al. (2004) mention underestimation of personal risk for HIV as a common obstacle to the uptake of client-initiated HIV-testing and counselling, especially on the part of men.

The above factors indicate a need for the consideration of an integrated approach to understanding the behaviour of individuals that will offer insights into how they perceive, use reason and act upon a health threat.

1.6. Integrated approach

According to Tones and Green (2004), social groups or cultural groupings develop perceptions and attitudes towards illness and disease, which can affect how individuals react to such conditions. These perceptions and attitudes may be manifested in the communication between doctor and patient; attitudes of family and friends; values and acceptance of illness and disease; all of which will impact on the behaviour of an individual. Linked to this, contextual factors such as poverty, gender and gender-based violence; cultural attitudes and practices; stigma, denial, exclusion and discrimination; mobility and labour migration and informal settlement (South African Government, DoH 2007a; Tones & Green 2004) may impact in various ways on health-seeking and illness behaviour of individuals. This accentuates the multifaceted nature of illness
and disease, while in a sense also reiterating the need for an integrated approach to an insightful understanding of individual and/or group behaviour.

Researchers, in their quest for insight, need to understand why individuals develop specific perceptions and attitudes and/or maintain or relinquish control over health-related matters. The Integral Framework developed by Wilber\(^2\) (Wilber 2001; also see Chapter 4) can act as a vehicle or simple tool for discovering answers to the question of ‘why’. It enables, amongst other things, insightful understanding of the experiences of individuals and the origins of their perceptions, attitudes and decisions (Esbjörn-Hargens 2009) (See Chapter 5). The Integral Framework provides researchers with an opportunity to study the different contexts [i.e. the interior (‘I’), the exterior (‘IT’); the cultural or world space (‘WE’); and the social systems (‘ITS’)], that impact on the health-seeking decisions and actions of individuals. Furthermore, it serves as a tool for the analysis of felt-experiences, observations, mutual resonance and the scrutinising of experiences, behaviours, cultures and systems. This is depicted in Figure 1.1 below.

---

\(^2\) Wilber wrote *Sex, Ecology, Spirituality* (1995), the massive first volume of his *Kosmos Trilogy*. *A Brief History of Everything* (1996) was the popularised summary of *Sex, Ecology, Spirituality* in interview format. *The Eye of Spirit* (1997) was a compilation of articles he had written for the journal *ReVision* on the relationship between science and religion.
An additional motivation for an integral framework is provided by the outcome of different research endeavours [alcoholism (Nixon 20013), social work (Jarrin 20064; Larkin 20055), leadership (Hessler-Key & Wood 20096; Hochachka 20067); and education (Esbjörn-Hargens 20068)] in which Wilber’s Integral Framework was used. These research endeavours enabled an understanding of how the Integral Framework can be used to examine data (See Chapter 5).

In terms of this research, the quadrants outlined within Wilber’s framework was used to identify and understand perceptions, attitudes, opinions, experiences and choices of a target group within the context of HIV/AIDS and voluntary counselling and testing to uncover the personal, workplace, family, social and community factors that either inhibit or facilitate employees volunteering for HIV-testing in a workplace that has an HIV/AIDS workplace programme (See Chapter 5) – this is also the purpose of this study.

1.7 Problem identification
It is a matter of concern that employees who have volunteered for HIV-testing at work after a concerted voluntary counselling and testing campaign on company premises do not continue to volunteer for regular HIV-testing after the campaign has ended. It would appear that such employees do not view themselves as at risk for HIV-infection, even after participating in what is considered high-risk behaviour (Solomon et al. 2004; Stevens 2001). Research has shown (de Saxe Zeerden et al. 2006; Mhlanga, Tlebere & Xundu. 2006; Strode et al. 2005; Swanapoel 2006; van Dyk & van Dyk 2003) that certain barriers compromise the objectives of VCT. Individuals continue to be afraid of the consequences of taking an HIV-test and of speaking openly regarding their HIV-status.

The impact of HIV/AIDS on South African businesses is felt in both direct and indirect costs through lower productivity and loss of skilled workers (BER 2005; ILO 2002/2003; ILO, 2005a; Mapolisa & Stevens 2003; Reed 2005). Raising the numbers of persons who know their HIV-status in order to minimise the impact of the disease is an important prevention and treatment goal of HIV/AIDS workplace programmes (BER 2005). The need to identify the individual, proximal and distal drivers of disease within the workplace and community context are critical if the underlying causes of sexually transmitted infections within the workplace and society at large are to be controlled (Bowler 2007).

To inform the reader of the content of this treatise, the following outline is provided.

1.8 Outline of the study

- **Chapter 1: Exploring health-seeking and decision-making behaviour pertaining to HIV voluntary counselling and testing**
  
  It provides the reader with an overview of the HIV/AIDS pandemic to date, a brief reference to global, regional and national community response and the need for an integrated understanding of health-seeking behaviour within the context of voluntary counselling and testing.

- **Chapter 2: Methodological foundation and accountability**
  
  This chapter explains why a particular research methodology was selected and how it was implemented. It describes how provisions were made to ensure validity and reliability, and also reports on the ethical issues to be considered when undertaking research of this nature.

- **Chapter 3: Voluntary counselling and testing (VCT)**
  
  Literature relevant to the topic is reviewed detailing what voluntary counselling and testing is and why it is important for HIV/AIDS prevention, treatment, care and support. It, further, sets out the guidelines that need to be adhered to in order to ensure that the human rights of individuals are not violated. Finally, it identifies the barriers to the use of voluntary counselling and testing by individuals as reported in the literature review.
• **Chapter 4: Contextualising a response to HIV/AIDS and voluntary counselling and testing**

The initial global response to HIV/AIDS is outlined and the reasons for calls for a more integrated approach by both the global community and the developers of the National Strategic Plan 2007-2011 (South African Government, DoH 2007a) are discussed. The rationale for using Wilber’s (2001) four-quadrant Integral Framework for analysing factors inhibiting and facilitating HIV-testing in the target group is motivated.

• **Chapter 5: Data Analysis**

This chapter sets out the findings revealed through the content analysis (Tesch in de Vos 1998) of the in depth unstructured interviews conducted by the researcher. The respondents were Xhosa first-language construction employees of a company in the Nelson Mandela Metropolitan area.

• **Chapter 6: Conclusions and Recommendations**

This chapter contains recommendations for further research. It also provides recommendations for workplaces that are implementing HIV/AIDS workplace programmes to ensure that their interventions, in particular those regarding voluntary counselling and testing in the workplace, remain needs based and are as effective as possible. In addition it mentions other possible interventions that might assist in breaking down the barriers to the use of the voluntary counselling and testing services in the Nelson Mandela Metropolitan area.

Below follows a list of concepts used throughout the treatise.

<table>
<thead>
<tr>
<th>Concept</th>
<th>Operationalisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Illness</td>
<td>A disease that cannot be cured but can be managed. An individual can live with the particular disease under the correct medical supervision e.g. diabetes, high blood pressure and, with the advent of antiretroviral medication, HIV. If an individual is not under medical supervision or is unaware that have the disease this may lead to their premature death.</td>
</tr>
<tr>
<td>Distal Driver</td>
<td>A phenomenon distant from the immediate environment yet one that will have an impact on the immediate environment.</td>
</tr>
<tr>
<td>Epidemic</td>
<td>A widespread outbreak of a disease that attacks great numbers in one place at one time.</td>
</tr>
<tr>
<td><strong>Four-quadrant Framework</strong></td>
<td>Ken Wilber’s map of reality. It incorporates four irreducible (can be reduced no further) perspectives, namely subjective, inter-subjective, objective and inter-objective perspectives that must be consulted when attempting fully to understand any issue or aspect of reality.</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Health-Seeking Behaviour</strong></td>
<td>Behaviours demonstrated by individuals aimed at maintaining or improving their health.</td>
</tr>
<tr>
<td><strong>HIV Incidence</strong></td>
<td>The number of individuals that have become infected with HIV in a certain time period – in the case of HIV it is usually calculated annually. The HIV incidence rate is then added to the HIV prevalence rate to provide an estimation of the total number of individuals infected with HIV.</td>
</tr>
<tr>
<td><strong>Individual Driver</strong></td>
<td>An individual’s behaviour that impacts on their health.</td>
</tr>
<tr>
<td><strong>Inter-objective perspective</strong></td>
<td>Refers to the mutual networks of objects. Those factors detached from the individual.</td>
</tr>
<tr>
<td><strong>Inter-subjective perspective</strong></td>
<td>Refers to the mutual constitution of social relationships (communal interiors).</td>
</tr>
<tr>
<td><strong>Integral Theory</strong></td>
<td>Is an over-arching model of human and social development that attempts to incorporate all approaches to human development into its explanatory framework</td>
</tr>
<tr>
<td><strong>Integrated Approach</strong></td>
<td>An approach seeking to unite micro and macro levels of analysis.</td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td>The action of intervening or ‘stepping in’ or interfering in a situation so as to affect its outcome.</td>
</tr>
<tr>
<td><strong>Pandemic</strong></td>
<td>A disease prevalent over the whole region, continent or world in contrast to an epidemic which is limited to a smaller area.</td>
</tr>
<tr>
<td><strong>HIV Prevalence</strong></td>
<td>The accumulated numbers of individuals living with HIV from the onset of the data capture of how many individuals have become infected with HIV.</td>
</tr>
<tr>
<td><strong>Proximal Driver</strong></td>
<td>Close to or near to the immediate environment of an individual that impact on an individual and their health.</td>
</tr>
<tr>
<td><strong>Subjective perspective</strong></td>
<td>The self-conscious perspective of an individual.</td>
</tr>
<tr>
<td><strong>Verstehen</strong></td>
<td>Max Weber (The methodology of Social Sciences, 1904-17). Meaning the understanding of people’s actions.</td>
</tr>
<tr>
<td><strong>Voluntary Counselling and Testing (VCT)</strong></td>
<td>When an individual chooses to have an HIV-test to ascertain whether they are infected with HIV. The guidelines for HIV-testing state that the individual must volunteer and must receive both pre-test and post-test counselling. This term has been replaced by Client-Initiated HIV-testing which is governed by the same guidelines as VCT. It is still commonly known as VCT.</td>
</tr>
</tbody>
</table>
1.9 Summary

This introductory chapter provides a brief description of the HIV/AIDS pandemic and the role of voluntary counselling and testing as a strategy for the prevention of HIV/AIDS and health service delivery (See Chapter 3). Further to this, readers are introduced to the need for an integrated approach to understanding HIV/AIDS prevention and service delivery (See Chapter 4), with specific reference to a construction company with an HIV/AIDS workplace programme that includes an HIV/AIDS workplace policy and provision of basic HIV/AIDS education and awareness of transmission, prevention, testing and treatment.
Chapter Two

METHODOLOGICAL FOUNDATION AND ACCOUNTABILITY

2.1 Introduction
The researcher undertook an interpretative, qualitative study with the aim of identifying factors that respectively inhibit or facilitate individuals volunteering for HIV-testing or voluntary counselling and testing (VCT) within the Nelson Mandela Metropolitan area, South Africa (See Chapter 3). For the purposes of this study Xhosa first-language construction workers within a construction company that has an HIV/AIDS workplace programme that includes an HIV/AIDS workplace policy were interviewed. The HIV/AIDS workplace programme included basic education and awareness regarding HIV/AIDS transmission, prevention, treatment, care and support and where to access HIV-testing. This chapter provides information on the methodology used during this research and the provisions that were made to ensure a valid and reliable research outcome. The researcher will also report on ethical considerations required for research of this nature.

2.2 Rationale and motivation
The researcher wished to determine whether the obstacles to HIV-testing identified by other researchers, such as the fear of lack of confidentiality, rejection by their sex partners, family, friends, and the community, or fear of being stigmatised and discriminated against (Hutchinson & Mahlalela 2006; Solomon et al. 2004; UNGASS 2001), would also function as barriers preventing Xhosa first-language speaking workers, in the Nelson Mandela Metropolitan area, from volunteering for HIV-testing. The researcher further wished to discover what factors acted as facilitators that encouraged Xhosa first-language speaking workers to volunteer for HIV-testing or whether barriers other than those mentioned above would emerge from the data.
The UNAIDS and ILO guidelines for HIV/AIDS workplace programmes are generalised to suit all workplaces globally (ILO 2004). Therefore, it becomes important that consideration is taken of the particular contexts in which they are implemented, in the case of this research, Xhosa-speaking employees in a construction company. This ensures that the specific needs of the context are matched by the intervention especially when such interventions are designed to promote behaviour change. Research into the factors that either facilitate or inhibit this change in behaviour is important to ensure HIV/AIDS workplace programmes, which recognise the uniqueness of different contexts (be they cultural, geographic or sector specific), can be designed and implemented in different workplaces. It is important, therefore, to ascertain whether there are specific challenges that face individuals in the Nelson Mandela Metropolitan area that prevent them from volunteering for HIV-testing.

In order to isolate and identify these challenges the researcher focused on Xhosa first-language speaking construction workers who are employed in a construction company that has implemented an HIV/AIDS workplace policy and conducted basic HIV/AIDS awareness and education including where to access VCT, treatment, support and care in the Nelson Mandela Metropolitan area. Xhosa first-language speakers comprise the largest language group in the Eastern Cape Province. Those that participated in this research were located in a construction company as it was the first company that met the criteria of having an HIV/AIDS policy and programme and were willing to participate in the research.

2.3 Research questions
Guiding the research, were a number of questions. These were:
1. What influence does an HIV/AIDS workplace policy and programme have on perceptions about HIV/AIDS and attitudes towards HIV-positive individuals in the workplace as well as motivation to volunteer or not to volunteer for HIV-testing?
2. How has experience of the impact of HIV/AIDS on communities influenced individuals’ perceptions, attitudes, interpersonal interactions, and motivation to volunteer or not to volunteer for HIV-testing?
3. How do the different social groups an individual belongs to impact on their perceptions, attitudes, interpersonal interactions, and motivation to volunteer or not to volunteer for HIV-testing?

4. What influence do the public health services have on individuals to encourage or discourage them to volunteer for HIV-testing?

2.4 Research objectives

2.4.1 General research objective
The researcher aims to identify the factors that respectively inhibit and facilitate Xhosa first-language construction workers to volunteer for HIV-testing in a company that has an HIV/AIDS workplace policy and programme that provides basic education and awareness about HIV/AIDS transmission, prevention, testing and treatment and care and support.

2.4.2 Specific research objectives
1. To identify the personal, workplace, family/household, social, and community factors that facilitates construction workers volunteering for HIV-testing.
2. To identify the personal, workplace, family/household, social, and community factors that inhibits construction workers volunteering for HIV-testing.

2.5 Method
An interpretative inductive methodological approach was selected for this study. The primary goal of interpretative qualitative research is to obtain, “a rich, detailed description of specifics” (Geertz, 1975, as cited in Babbie & Mouton, 2008: 272) of the lived experiences of the respondents. This approach assumes that social reality can be understood through social constructions such as language, consciousness and shared meanings. It is particularly appropriate for use in attaining the research objectives in which human sense making in naturalistic settings (Chesebro & Borisoff 2007) is aimed at, thus allowing the researcher to gain verstehen⁹[compare Weber’s verstehen (Martin 2000)] of the phenomenon being studied. This research study aims to uncover the perspectives and opinions of construction workers through data obtained by means

---

of an unstructured interview schedule. The idea was not to generalise findings to theoretical populations, but to understand the social actions of this group in a specific workplace in the Eastern Cape in South Africa in order to gain a deeper understanding of the factors that inhibit or facilitate HIV-testing behaviour.

Effecting behaviour change in individuals is difficult. Therefore, to enable understanding, insights can be used to encourage individuals through appropriate interventions to change their behaviour. One means to attain this is through qualitative methodology as initiated during this research to identify and analyse the motives underlying sexual behaviour of a target group, to document the practise of voluntary counselling and testing, and to establish the preconditions for the efficacy of VCT as a preventative and supportive health tool.

Experiencing episodes of death and dying due to AIDS, observing the impact of HIV/AIDS illness-related behaviour on households, health-care sites, workplaces and church gatherings, to mention a few, are a constant reminder of the presence of HIV/AIDS and its impact. There is a need in individuals to understand this impact at an individual and community/societal level and know how to deal with this. On the other hand researchers are motivated to find ways to verstehen human thought and behaviour in an effort to make (with insightful understanding) recommendations to prevent further spread of the epidemic and to contribute towards enhancing the quality of life of those affected by HIV/AIDS.

In order to obtain insightful understanding of human thought and behaviour the researcher selected Wilber’s four-quadrant framework to be used as an analytical tool in this study as it encourages exploration of a holistic understanding of human thought and behaviour. Although there has been criticism of Wilber’s Integral Theory there have also been positive critiques as it allows for understanding of the behaviour of individuals (See Chapter 4). Using merely the framework and not the entire theory, allowed the researcher the opportunity to analyse how the system, culture, individual experiences, and behaviour influence respondent’s use of HIV voluntary counselling and testing.
2.6 Target group and sampling
This interpretative qualitative research forms part of a larger project. The goal of the larger research project is to assist workplaces with the design, monitoring, and evaluation of health interventions with particular reference to HIV/AIDS. In order to achieve this, the following objectives were set:

- Develop and apply an integral perspective to health behaviour in workplaces with diverse employee populations. This will involve the use of Wilber’s four-quadrant framework to test and assist in the development and elucidation of a “comprehensive framework” using HIV/AIDS as an example of a health problem.
- Identify relevant interventions to address the factors influencing HIV/AIDS related behaviours.
- Develop a reliable assessment tool to measure the factors affecting health related behaviours in order to manage HIV/AIDS interventions (Bowler 2008).

The nature and scope of the greater research endeavour largely predetermined decisions pertaining to the choice of target group and company selected in which the research would be undertaken, as this research would be viewed as a pilot case study for the greater study.

The researcher was able to secure the participation of a construction company within the Nelson Mandela Metropolitan area which has an HIV/AIDS workplace policy and programme that provides basic education and awareness about HIV/AIDS prevention, transmission, treatment, care and support.

Prior to entering into further negotiation with this construction company the researcher identified companies that met the criteria for this study by approaching organisations such as the South African Business Coalition against HIV/AIDS (SABCOHA), Automotive Industry Development Centre (AIDC) and Coega Development Corporation (CDC) who offer technical and expert advice to companies who wish to implement HIV/AIDS workplace programmes. The researcher then approached the Human Resource Managers of the identified organisations that matched the research criteria in order to gain permission to approach their employees to become research respondents. Once a Human Resource manager agreed in principle to allow access, the
researcher then approached the Labour Unions, which have shop stewards working within the organisation in order to gain permission to approach the employees that they represent.

After contacting four different companies the researcher was able to obtain the participation of the construction company in which the research was undertaken. To ensure both the Human Resources Manager and Labour Union representatives gave permission for the researcher to approach construction workers of their organisation the researcher reiterated the importance of safeguarding each respondent’s human rights in terms of consent, maintenance of confidentiality and dignity (Declaration of Helsinki 2008).

The researcher requested permission to address all Xhosa first-language construction workers together with the Labour Union shop stewards present in order to explain the nature of the research, i.e. that participation was voluntary and that all information received through the research was anonymous and that the identities of the respondents would be kept confidential. The researcher was told that this was too difficult for the company to arrange and an alternative plan was agreed upon, which was that the Human Resource Manager and shop stewards would speak to construction workers on behalf of the researcher.

The Human Resource Manager and Labour Union shop stewards addressed all the Xhosa first-language construction workers and explained the nature and objectives of this research study and asked if they would consider participating. The construction workers discussed whether they wished to participate amongst themselves. Not all Xhosa first-language construction workers were willing to participate but those who were willing were known to one another. Under these circumstances snowball sampling was deemed appropriate (Babbie 2007). Respondents who came forward to participate in the research would, once their interview was complete, call the next respondent to the room used for interviewing, as they knew who was willing to participate in this study and the researcher did not. Prior to the interview each respondent was given a letter (See Appendix 1), which explained the conditions of participation in the study.

The table below provides the general salient characteristics of all 12 respondents of this research study. There were an equal number of males and female respondents in this study due to the willingness of these individuals to participate and not through the design of the researcher.
herself. The different ages and varying length of time spent in formal schooling was also unplanned due to the sampling technique used. The different characteristics of the respondents ensured that data was gained from different age groups, educational level and gender.

### Table 2.1: Characteristics of respondents

<table>
<thead>
<tr>
<th>Female Respondents</th>
<th>Male Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td><strong>Education</strong></td>
</tr>
<tr>
<td>21 yrs old</td>
<td>Matric (12 yrs of formal education)</td>
</tr>
<tr>
<td>26 yrs old</td>
<td>Matric (12 yrs of formal education)</td>
</tr>
<tr>
<td>27 yrs old</td>
<td>Matric plus 1 yr mechanical engineering (12 + 1 yrs of formal education)</td>
</tr>
<tr>
<td>30 yrs old</td>
<td>Matric (12 yrs of formal education)</td>
</tr>
<tr>
<td>36 yrs old</td>
<td>Matric (12 yrs of formal education)</td>
</tr>
<tr>
<td>43 yrs old</td>
<td>Standard five (7 yrs of formal education)</td>
</tr>
</tbody>
</table>

### 2.7 Data collection and analysis

#### 2.7.1 Pilot study

The term pilot study is generally used in two different ways in social science research. It can refer to so-called feasibility studies, which are done in preparation for the major study (Babbie 2007). However, a pilot study can also be the pre-testing or 'trying out' of a particular research instrument. In the words of De Vaus (1993: 54 in Morse, Barrett, Mayan, Olson & Spiers 2002) "Do not take the risk. Pilot test first." These are important reasons for undertaking a pilot study. This interpretative, qualitative study was conducted to obtain insight into factors that respectively facilitate and inhibit Xhosa first-language speaking individuals, employed by a
construction company in the Nelson Mandela Metropole volunteering for HIV-testing. As HIV-testing behaviour is one aspect of health-seeking behaviour in the context of the HIV/AIDS epidemic this study forms part of a greater research undertaking and should be viewed as a preliminary investigation (feasibility study) for that research project. The greater research project seeks to identify all contextual factors as these manifest themselves on different levels: the individual, the interpersonal, the communal, the social and the institutional and investigate how they impact on health-seeking behaviour in order to explore the high prevalence of HIV/AIDS and sexually transmitted infections (Bowler 2007).

2.7.2 Data collection instrument: Pilot study
An unstructured interview guide or schedule was developed and then tested with three Xhosa first-language construction workers of the construction company who had agreed to participate in the research study. These pilot interviews took place at the construction site where the rest of the interviews would be held to test the feasibility of the unstructured interview guide.

The need for piloting the data collection instrument was twofold. Firstly, the researcher needed to ascertain whether the questions asked elicited the type and quality of information required to meet the research objectives and answer the research questions. Secondly, the researcher is a white English-speaking female who would be interviewing respondents from a different language and culture from her own. Particular issues that may impact on the research findings were the cultural and language differences. However, the researcher had ascertained that all workplace training programmes, including the regular obligatory safety talks delivered weekly by the Health and Safety Officer, were delivered in English. All the posters and organisational communiqués were also in English. Thus, it was established that English was the language used in the workplace for formal discussion and education about HIV/AIDS therefore it was deduced by the researcher that the respondents would be able to respond in English to the interview questions. Yet, the researcher was still aware that this created the need for the researcher to be sensitive and acknowledge the possibility that research questions could contain language and concepts that were unknown or were culturally unacceptable to the respondents. Both these factors may create bias in the research findings and by undertaking these pilot interviews the
researcher could ascertain whether her ability to interact and converse with this population group was as natural as possible and to identify any hindrances.

The researcher was assisted in the pilot study by a number of individuals. Namely the H.R. manager who arranged the venue; a shop steward who had asked construction workers to participate and brought the three respondents to the venue where the interviews took place and finally the respondents themselves who were willing to participate even though the researcher was white and female.

The unstructured interview schedule consisted of a number of open-ended questions dealing with pre-established topics gained from an analysis of relevant literature to elicit detailed accounts of the respondents’ thoughts, perceptions and beliefs.

Respondents in this pilot study were asked to assist the researcher by providing feedback on a number of issues. They were asked to point out any questions creating discomfort for any reason so that the questions could be adapted or removed from the unstructured interview schedule. The importance of respondents feeling at ease with the language used and their ability and willingness to share their thoughts and feelings throughout the data collection process was of paramount importance. The manner in which respondents were approached and any language or English words used by the researcher, which created misunderstanding or reluctance in providing in depth information, should be shared with the researcher. They were asked, further, not to discuss any questions posed to them with colleagues so as not to bias research findings. These pilot unstructured interviews also allowed a time frame for length of average interview to be established allowing for easier management of the data collection process.

Positive responses to the unstructured interview questions and process were received from all respondents in the pilot study. Respondents displayed no reluctance in answering any questions. The language used in the questions and further discussion was perceived as easy to understand by the pilot sample group. In an effort to recognise that different cultures vary in their attitude toward discussions about sex the researcher needed to ensure that she handled discussion concerning sexual partners and practises as sensitively as possible. No cultural taboos were
reported to have been transgressed in the wording of questions or by the researcher personally. Therefore it was decided not to change any questions contained in the unstructured interview schedule and actual data collection could begin.

2.7.3 Data collection and interview transcription

To obtain in depth and thick descriptions, to gain an authentic understanding of individuals’ experiences, the use of open-ended questioning is an effective technique (Stenbacka 2001). The objective of data collection in qualitative research is to create a comprehensive record of the respondents’ ‘words and actions’; making sure that as little as possible is ‘lost in translation’ (Creswell 1998; Potter 1996). Therefore, the type of data collected in a qualitative study is naturalistic, meaning that it is not coded, summarised, categorised or otherwise ‘reduced’ at the point of collection.

An unstructured interview was used as it provided the researcher with the opportunity to hear the participants ‘talk’ about a particular aspect of their life or experience, in this case HIV-testing. The questions asked by the interviewer were triggers that encouraged respondents to talk (See Unstructured interview guide: Appendix 2). The interviewer needed to find a balance between maintaining control of the interview and where it was going and allowing the interviewees the space to re-define the topic under investigation and thus generate new insights for the researcher. A carefully constructed unstructured interview guide ensured the researcher did not lose sight of the original research questions (Creswell 1998; Willig 2001). Babbie (2007) describes a qualitative interview as an interaction between interviewer and respondent in which the interviewer has a general plan of inquiry, including topics to be covered, but not a set of questions that must be asked with particular words in a particular order.

To implement the interviews the researcher set up dates and times with the Human Resource Manager which suited their construction site work schedules, shift times and started with the data collection process. All the interviews occurred at the company’s construction site. Requirements for effective unstructured interviews are privacy and minimum noise. A spare office with the desk and chairs was found at the site and utilised for data collection. It was decided that afternoons were the best time to conduct interviews with construction workers. Afternoons that
suited the construction timetable were selected. Each afternoon three to four interviews were conducted. The number of interviews was dictated by the length of each interview and whether respondents needed to be brought to the site for the interview. Each interview was recorded using a dictaphone that was fit for the purpose and could record hours of data. The length of the interviews ranged between forty-five minutes to an hour.

The researcher interacted with each respondent in a similar manner to ensure she did not influence information offered by respondents or unintentionally bias the interview proceedings. Each respondent was warmly welcomed into the room where interviews took place. Each interview was begun with introductions; the researcher introduced herself and exchanged greetings with respondents and went on to explain her research study. Further, each respondent was told they could halt proceedings at anytime, refuse to answer a question they did not want to and it was emphasised that all information would remain anonymous. Then the researcher showed respondents the dictaphone and explained how it worked and how it was going to be used. In addition, she carefully discussed the consent form (See Appendix 3) making sure that the respondents had no objections to the use of a dictaphone. This ensured that if any of the respondents felt any unease about being part of this research, they would be free to decline to participate before the interview had begun. Once a respondent had agreed and signed the consent form the interviews could then proceed.

The researcher was equipped with a pre-designed unstructured interview schedule. This helped her to keep focussed on the information she wanted to gather during the interview session (Greef 2002). Even though unstructured interviews afford researchers the opportunity to hear respondents talk about a particular aspect of their life and experience the researcher needs to find a balance between maintaining control over the unstructured interview and still allowing respondents the space to re-define the topic under investigation and thus generate new insights for the researcher (Willig 2001).

After each interview a 10 – 15 minute break was taken by the researcher in order to have time to prepare properly for the next respondent and to review important points gained from the interview, which might require attention in the next interview. Each interview was transcribed
after all the interviews for the day were complete. The interviews took place over a two-week period, which allowed the transcription process to happen concurrently with the data collection.

Each interview was transcribed in a Microsoft Word document correctly formatted for the purpose of qualitative data analysis. This entailed replacing names of respondents with a letter of the alphabet so they could not be identified by anyone other than the researcher. Further, single line spacing format was used and line numbers inserted in all transcripts to ensure easier and more accurate data analysis by the researcher herself, and the second independent researcher contracted to independently analyse data using the same qualitative data analysis method. The researcher noted the following during the interview process:

1. A positive rapport was easy to establish with respondents. This allowed for practical yet insightful interviews involving an exploration of the respondent’s feelings, perceptions and emotions regarding HIV/AIDS and HIV-testing.
2. Respondents were able to talk about the topic in detail and in-depth and thus were able to reveal the meaning behind what inhibited or facilitated them and other individuals from volunteering for HIV-testing.
3. The researcher was able to ask for clarification and pick up on and probe areas that had not occurred to her beforehand or of which she had had no prior knowledge.
4. The unstructured interviews were easy to record and transcribe.

This experience confirmed the strengths of an unstructured interview as a method for data collection recorded by Greef (2002) and Morse et al. (2002). Further, the use of an unstructured interview enabled the researcher to present the explanatory and descriptive data on which qualitative research depends (de Vos 2002).

2.7.4 Data analysis

Content analysis is an appropriate strategy and procedure available for ensuring accurate coding, sampling and handling of unstructured data from texts (interview transcripts etc.) as a basis for making reliable and valid inferences about the phenomena of interest (Henwood 1996). The researcher made use of Tesch’s (1990 in de Vos 1998) approach to content data analysis. Tesch’s approach allowed for a comprehensive analysis of the respondents’ responses and provided the
researcher with the opportunity to eliminate subjective bias by using an independent researcher in the data analysis.

Tesch proposes eight steps to consider in content data analysis and they are summarised as follows:

1. The researcher gets the sense of the whole by reading all the transcriptions and writing down ideas as they come to mind.
2. The researcher picks one interview, and thinking about the underlying meaning in the information, writes thoughts that come to the researcher in the margin.
3. When the researcher has done that for several respondents, lists of topics are made, clustering similar topics together.
4. The researcher then abbreviates the topics into codes and these codes are written next to appropriate segments of the text and the researcher tries to see whether there will be new categories and codes.
5. The topics are then turned into categories, thus allowing the reduction of the total list by grouping topics that relate to each other.
6. The researcher abbreviates the categories and turns codes into alphabets.
7. Data for each category is put in one place and a preliminary analysis performed and, if necessary, the existing data is re-coded.
8. An independent researcher should repeat the analysis in order to eliminate subjective bias in the analysis.

The researcher followed these steps outlined by Tesch when she analysed the data. The process was repeated by an independent researcher. The independent researcher’s role was to ensure the researcher remained open, sensitive, creative and insightful during the data analysis process. In addition, the independent researcher ensured that any ideas that were poorly supported were not included in the data analysis. Furthermore, discussions held with the independent researcher enabled the researcher to be more reflexive, assisting in the prevention of the researcher’s preconceptions and motivations impacting on the data analysis.

Once congruence between researcher’s analysis and that of the independent researcher was ascertained, Wilber’s framework was used to analyse the data (See Chapter 5).
2.8 Wilber’s Framework

In order to further provide structure and make meaning of data, the researcher made use of Wilber’s Integral four-quadrant framework (2001). This is an analytical tool used in other studies (See end notes in Chapter 4) to explore the relationship between intentions and values, on the one hand, and actions on the other. It does so at both the individual and collective levels.

According to Wilber’s Integral Theory, there are four immutable perspectives (subjective, intersubjective, objective, and inter-objective) that form the basis for the four-quadrant framework that should be consulted when attempting to fully understand any issue or aspect of reality (Esbjörn-Hargens 2009). Indicated as four-quadrants, these offer four different perspectives and also represent different dimensions of reality (Wilber 2001). It is possible to gain a deeper, more profound understanding of the HIV/AIDS epidemic and HIV-testing by identifying, analysing and reviewing the causes and origins of actions using this four-quadrant framework.

Placing the responses of respondents to HIV-testing in their respective quadrants makes possible a deeper understanding of the interrelationship among intentions, values and actions. For example, after situating the different responses from respondents in the different quadrants, it may become clear that a specific quadrant did not receive any responses; this may indicate that there is a general lack of understanding or a need for understanding of this particular area, and thus, opportunity for recommendations to enable this.

The researcher aimed to provide a rich, substantive account with strong evidence for inferences and conclusions in the analysis of the data. Wilber’s four-quadrant framework was a useful tool to identify elements of the respondents’ world (personal, family, social, community and workplace) that respectively inhibits or facilitates HIV-testing. In addition it enabled clear analysis of reported lived experiences of respondents and their perspectives on HIV/AIDS and HIV-testing (See Chapter 5). The researcher’s goal throughout the research process was to understand and provide a meaningful account of the complex perspectives and realities of the respondent’s lives.
The table below describes the themes, categories and codes that emerged from data analysis.

**Table 2.2: Data analysis frame identifying categories and codes**

<table>
<thead>
<tr>
<th>Theme based in Lower Right Quadrant</th>
<th>Low level categories</th>
<th>Alphabetical code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Political system and related structures</strong></td>
<td>Community activity: Government</td>
<td>A1</td>
</tr>
<tr>
<td></td>
<td>Clinics</td>
<td>A2</td>
</tr>
<tr>
<td></td>
<td>Confidentiality</td>
<td>A3</td>
</tr>
<tr>
<td></td>
<td>Access to testing and treatment</td>
<td>A4</td>
</tr>
<tr>
<td></td>
<td>Community-based events</td>
<td>A5</td>
</tr>
<tr>
<td><strong>Geographical area: Port Elizabeth townships</strong></td>
<td>Community focused organisations</td>
<td>B1</td>
</tr>
<tr>
<td><strong>Media</strong></td>
<td>Newspapers</td>
<td>C1</td>
</tr>
<tr>
<td></td>
<td>Radio</td>
<td>C2</td>
</tr>
<tr>
<td></td>
<td>Television</td>
<td>C3</td>
</tr>
<tr>
<td><strong>The company</strong></td>
<td>Workplace HIV/AIDS policy</td>
<td>D1</td>
</tr>
<tr>
<td></td>
<td>Union HIV/AIDS activity</td>
<td>D2</td>
</tr>
<tr>
<td></td>
<td>HIV/AIDS workplace interventions</td>
<td>D3</td>
</tr>
<tr>
<td></td>
<td>Manager's reaction to HIV-positive construction workers</td>
<td>D4</td>
</tr>
<tr>
<td></td>
<td>Workplace support for HIV-positive construction workers</td>
<td>D5</td>
</tr>
<tr>
<td><strong>Theme based in Lower Left quadrant</strong></td>
<td>Low level categories</td>
<td>Alphabetical code</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Are HIV-positive men and women treated differently?</td>
<td>E1</td>
</tr>
<tr>
<td></td>
<td>Worst thing for a man if he is HIV-positive</td>
<td>E2</td>
</tr>
<tr>
<td></td>
<td>Worse thing for a woman if she is HIV-positive</td>
<td>E3</td>
</tr>
<tr>
<td><strong>The family and important groups the respondents' belong to</strong></td>
<td>Colleague reaction to HIV-positive individuals</td>
<td>F1</td>
</tr>
<tr>
<td></td>
<td>Family guidance concerning HIV/AIDS</td>
<td>F2</td>
</tr>
<tr>
<td><strong>Belief system</strong></td>
<td>Church reaction to HIV-positive individuals</td>
<td>G1</td>
</tr>
<tr>
<td></td>
<td>Education of community during service</td>
<td>G2</td>
</tr>
<tr>
<td></td>
<td>Church action taken towards HIV-positive individuals (collection of money, food and visiting)</td>
<td>G3</td>
</tr>
<tr>
<td><strong>Friends</strong></td>
<td>Friend reaction to HIV-positive individuals</td>
<td>H1</td>
</tr>
<tr>
<td></td>
<td>What women talk to their friends about concerning HIV/AIDS</td>
<td>H2</td>
</tr>
<tr>
<td>Theme based in Upper Left Quadrant</td>
<td>Low level categories</td>
<td>Alphabetical code</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Knowledge about HIV/AIDS</td>
<td>Knowledge of transmission and prevention of HIV/AIDS</td>
<td>L1</td>
</tr>
<tr>
<td></td>
<td>Knowledge of the importance of HIV-testing</td>
<td>L2</td>
</tr>
<tr>
<td></td>
<td>Knowledge of HIV/AIDS treatment, care and support</td>
<td>L3</td>
</tr>
<tr>
<td></td>
<td>Importance of HIV-testing</td>
<td>L4</td>
</tr>
<tr>
<td>Personal observation and experience</td>
<td>Observation and experience regarding HIV/AIDS</td>
<td>M1</td>
</tr>
<tr>
<td></td>
<td>False sense of security</td>
<td>M2</td>
</tr>
<tr>
<td></td>
<td>Recommendations - more people test for HIV/AIDS</td>
<td>M3</td>
</tr>
<tr>
<td></td>
<td>Deliberate distancing from the disease</td>
<td>M4</td>
</tr>
<tr>
<td></td>
<td>Emerging confidence in the face of HIV/AIDS</td>
<td>M5</td>
</tr>
<tr>
<td></td>
<td>Courage to be tested for HIV-infection</td>
<td>M6</td>
</tr>
<tr>
<td></td>
<td>Reason for HIV-testing</td>
<td>M7</td>
</tr>
<tr>
<td>Fear</td>
<td>Fear of the illness and disability</td>
<td>N1</td>
</tr>
<tr>
<td></td>
<td>Fear of dying</td>
<td>N2</td>
</tr>
<tr>
<td></td>
<td>Fear of stigma</td>
<td>N3</td>
</tr>
<tr>
<td></td>
<td>Fear of loss of status</td>
<td>N4</td>
</tr>
<tr>
<td></td>
<td>Fear of manager's not keeping HIV-status confidential</td>
<td>N5</td>
</tr>
<tr>
<td></td>
<td>Engendered fear because of past unsafe behaviour</td>
<td>N6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme based in Upper Right Quadrant</th>
<th>Low level categories</th>
<th>Alphabetical code</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-testing behaviour</td>
<td>HIV-testing behaviour</td>
<td>O1</td>
</tr>
<tr>
<td>Personal actions to assist others</td>
<td>Sharing HIV/AIDS knowledge with others</td>
<td>P1</td>
</tr>
<tr>
<td></td>
<td>Personal actions to assist others</td>
<td>P2</td>
</tr>
<tr>
<td></td>
<td>HIV-positive status disclosure</td>
<td>P3</td>
</tr>
</tbody>
</table>
2.9 Rigour in research

2.9.1 Validity

Validity in quantitative research can be defined as the extent to which research describes or measures or explains what it aims to describe or measure or explain. Whittemore, Chase and Mandle (2001) point out that, “validity is broadly defined as the ‘state or quality of being sound, just and well founded’, [Random House Webster’s Unabridged Dictionary, 1999] “.

With the purpose of understanding and gaining insight into a social phenomenon the researcher attempts to gain an understanding the respondent’s reality of a very specific research problem, in this case HIV-testing. Therefore, the understanding of the research problem is valid if respondents have direct lived experience of the social phenomenon the researcher is attempting to gain an understanding of and is given the opportunity to speak freely according to their experiences and understanding. Thus, validity in interpretative qualitative research is accomplished if respondents that participate in the research meet the objectives of the research study (Stenbacka 2001).

The research design engaged with concerns regarding validity in a number of ways:

1. Authenticity: The researcher recorded the entire interaction with each respondent and faithfully transcribed these conversations verbatim in order to provide a true and real account of the lived experiences of the respondents.
2. Credibility: The respondents answers and descriptions did not vary from one respondent to another, thus the researcher was assured that the respondents were providing a believable account of their lived experiences.10
3. Plausibility: The respondents’ answers and descriptions were closely related to the research literature on the topic under investigation (See Chapter 3).
4. Descriptive: The researcher endeavoured to provide a rich and in depth account of the data (See Chapter 3) (Whittemore et al. 2001)

10 The independent researcher concurred with the researcher that the transcripts provided an authentic account of the lived experiences of the respondents and that due to the lack of variation in the respondents’ accounts that the descriptions of their lived experiences were credible.
2.9.2 Reliability
Validity is a critical basis for establishing rigour in research; ensuring reliability is validity’s counter weight. In quantitative research a measurement is reliable if it yields the same answer on different occasions. The notion of measurement is not present in qualitative research instead a thorough description of the whole process, in order to enable an exposé of judgements and methodological decisions made by the researcher throughout the course of this research study, has been described (Seale 1999; Stenbacka 2001).

The researcher ensured the reliability of the research process by creating a clear account of the method used and the process of content analysis selected for data analysis (Mays, Ziebland & Pope 2000). This account of the method and process used stands independently so that another researcher can analyse the exact same data (interview transcripts) using Tesch’s content analysis method and come to the same conclusions that both the researcher and the independent researcher came to. A plausible, coherent explanation of phenomena that was under scrutiny for examination by other researchers in Chapter 5 was also produced.

Finally, the same data, when collected and analysed by different researchers using the same method, ought to generate in depth, rich descriptions of the new respondents lived experiences, irrespective of who carried out the research (Willig 2001). In order to ensure that personal and intellectual biases do not affect the analysis of the data and to enhance the reliability of the findings the researcher employed an independent researcher as a second data coder. The researcher on completion of the data analysis met with the independent researcher in order to compare the identified categories and consensus followed where an agreement needed to be reached on descriptive words and categories in order to ensure reliability.

2.9.3 Researcher reflexivity
From the onset of this research study the researcher has been aware that it is impossible to remain ‘outside’ of one’s subject matter when conducting this form of research and that the researcher herself contributes to construction of meanings throughout the research process (Willig 2001).
The reliability of the research was increased due to piloting the unstructured interview schedule first and the employment of an independent researcher. Further, the independent researcher assisted in ensuring researcher bias was kept to a minimum and that the researcher was constantly reflecting on how her belief system, knowledge of HIV/AIDS and research experience played no part in the outcome. Researcher reflexivity was maintained in the following manner:

- By conducting the pilot study to test the efficacy of the unstructured interview schedule and, in addition, checking with pilot study respondents that the manner in which the researcher interacted with the respondents, from a very different culture from her own, the researcher attempted to be culturally sensitive, thus adding to the reliability of the data gathered.
- By being responsive to the independent researcher’s feedback in terms of selected topics, sub-topics and categorisation during data analysis. This forced her to be open, be sensitive, remain creative, and use insight and to be willing to let go of ideas that were poorly supported regardless of the excitement and potential they first appeared to provide (Morse et al. 2002).
- Discussions held with the independent researcher enabled reflexivity on the part of the researcher ensuring that relevant preconceptions and motivations did not impact on the data analysis (Cohen & Crabtree 2008). Thus, the researcher’s way of seeing has shaped the qualitative research design but not process.

In addition, the researcher provided a clear account of the process of data collection and analysis (Mays, Ziebland & Pope 2000). The researcher also ensured she was sensitive to the ways in which the researcher and the research process shaped the collected data, including the role of prior assumptions and experience, which can influence inductive inquiries.

2.9.4 Saturation

In addition to the need for reflexivity, a researcher needs to be certain sufficient information is gathered from a number of different respondents. An appropriate sample size in qualitative research is one that adequately answers the research questions and in this case adequately tests the unstructured interview guide and Wilber’s four-quadrant framework for the purposes of the greater research project. Due to the fact that after the twelfth participant no other employees
volunteered to come forward for an interview, the researcher is not certain that true saturation point was reached. However, sufficient data was gathered to portray the lived experience of VCT as well as the HIV/AIDS epidemic of these respondents for the researcher to claim that the unstructured interview guide was fit for purpose and Wilber’s four-quadrant framework a useful tool to identify what factors played an influential role in the respondents decisions to volunteer for an HIV-test.

In summary, while the lived experiences were personally lived, their stories or answers did not differ significantly. There is reason to believe that a larger sample would most probably yield the same results.

2.9.5 Generalisation
Yin (1989, in Babbie & Mouton 2008) points out that in a qualitative study, results are intended to be general in respect to theory, not to population. Further, Yin (1989, in Babbie & Mouton 2008) states that analytical generalisation, meaning that analytical understanding is made possible as a result of the study by lifting the data to a general level. Therefore, the analysis of the respondents’ behaviour is made possible with the purpose of understanding their motivations (Yin 1989, in Babbie & Mouton 2008).

The researcher has endeavoured to analyse the data (See Chapter 5) in order to identify and understand the inhibitors and facilitators that motivated the respondents’ behaviour in relation to HIV-testing. This, the researcher believes, will create a deeper understanding of HIV-testing behaviour of individuals who are similar in education level, language, age and gender to the respondents of this study.

2.10 Ethical considerations
The fact that this study required the researcher to record in depth unstructured interviews with construction workers meant that there were serious ethical implications that needed to be considered.
In order to ensure that the research study did not pose a risk to the participants the researcher did the following:

1. Completed an application form that was submitted to the NMMU research ethics (human) committee. This form provided details of the research study in order to ensure that the committee was fully aware of what the researcher wished to do and could decide whether the research posed any risks to the prospective respondents. No risk was found and the committee granted permission to the researcher to go forward with the research.

2. Adapted a proforma research consent form, which all the prospective respondents signed before they participated in the research. This form with its emphasis on the voluntary nature of participation to ensure that all prospective respondents were free to decide whether or not to participate in the research was explained to every participant individually by the researcher.

3. Each respondent received a letter that contained all pertinent information regarding the research and what the requirements were for participation. This letter also informed the participants that the research had been submitted to the ethics committee (human) of NMMU and approval obtained before the respondents were approached in order to complete the research.

Once the ethics (human) committee granted it’s approval\(^1\) the researcher gained entry to a workplace by initially approaching the Human Resource Manager and representatives of the different Unions (shop stewards) to obtain permission to speak to the construction workers of their organisation. Secondly, to ensure that the individuals who participated in the study agreed to do so of their own free will, each respondent received a letter detailing the research and what was required for participation in the study. Before any interviews took place each respondent signed a consent form. This consent form was explained verbally to each participant to ensure a thorough understanding of what was required and that participation was completely voluntarily. These consent forms were stored together with the transcriptions in a locked draw in the researcher’s office. As soon as the treatise has been accepted, bound and handed to the university; the researcher will shred these documents to ensure that the respondents’ anonymity will be maintained. Thirdly, the letter explained that all the information they shared within the

\(^1\) See Appendix 4: The Ethics clearance reference number for this research study is H/09/ART/SA-002
interview process would be kept strictly confidential and no one would be able to identify them if they were to read this research study.

The recorded transcripts were kept on the dictaphone until all interviews were transcribed and the transcripts were checked for accuracy. The dictaphone recordings will be kept in a securely locked drawer of the researcher’s office until results of the treatise are obtained after which all recordings will be deleted.

2.11 Summary

The rationale underpinning the researcher’s choice of using qualitative methods was the need for the exploration of how people make sense of their social world, in order to provide insights into people’s health-related behaviour in regards to HIV-testing. The interpretive qualitative research method was outlined and research steps discussed as they were applied to the study. Techniques for enhancing rigour of the research such as validity, reliability and generalisability were discussed in this chapter.

Chapter 3 discusses what voluntary counselling and testing is, the protocol suggested by both UNAIDS and the WHO, its’ functions and the identified barriers to its use. In Chapter 4, the HIV/AIDS pandemic is contextualised and an integrated approach motivated. Chapter 5 examines the results from the data analysis process and in Chapter 6 findings and recommendations are described concluding with an assessment of the attainment of the research objectives.
Chapter Three

VOLUNTARY COUNSELLING AND TESTING

3.1 Introduction
A review of literature on Voluntary Counselling and Testing as it is practised throughout the world, in Africa and more specifically in South Africa has provided the background to this chapter. Furthermore, a review has enabled understanding of VCT, also known as client-initiated HIV-testing and counselling (CITC), which is defined in this chapter while guidelines for VCT as provided by UNAIDS and the World Health Organisation (WHO) are outlined.

Further to this a discussion of the function of voluntary counselling and testing as an intervention to prevent new infections and its role in facilitating access to treatment and care services for those already infected with HIV/AIDS is described.

The chapter also provides information on prevention and service delivery through VCT within the South African context. In addition reasons for individuals not volunteering for VCT namely; lack of confidentiality, fear, stigma, discrimination, level of education, belief system, gender and the fear of violence, accessibility to VCT services, availability of treatment, care and support found in research literature are discussed.

3.2 What is voluntary counselling and testing?
Voluntary counselling and testing takes place when individuals access a testing service (e.g. mobile clinic, clinic or public hospital) to have an HIV-test in order to ascertain their HIV-status and to receive counselling. VCT emphasises individual risk assessment, addresses the implications of taking an HIV-test and promotes strategies to reduce the risk of HIV-infection. Counselling covers prevention both prior to and after receiving test results. If results are positive, the individual is referred to care, treatment and support services (Leach-Lemons & Owuor 2009; Maman et al. 2001; Sahu, Kassa, Agonafer, Tsegaye, Rinke de Wit, Gebremariam, Doorly, Spijkerman, Yeneneh, Coutinho & Fontanet, 1999; Strode et al. 2005a).
Voluntary counselling and testing is important for early detection of HIV-infection and prevention as people who are unaware they are infected with HIV and practise unsafe sex are major drivers of new infections (Maman et al. 2001; UNAIDS 2004b). Furthermore, individuals who are unaware of being infected with HIV frequently test late in the progression of HIV thereby minimising their opportunities for effective treatment. Early detection of HIV-infection by means of an HIV-test within a voluntary counselling and referral protocol (VCT) is therefore viewed as a critical intervention in the prevention of HIV/AIDS, and the management of morbidity and mortality associated with the disease (Abdool Karim, Churchyard, Abdool Karim & Lawn 2009; Mhlanga & Xundu 2006; Sahlu et al 1999; Solomon, Van Rooyen, Griesel, Gray, Stein & Nott 2004).

### 3.3 Current global guidelines for voluntary counselling and testing

The availability of voluntary counselling and testing is vital in order to stem the growth and impact of the HIV/AIDS pandemic (Leach-Lemons & Owuor 2009; Maman et al. 2001; McCauley 2004; Strode et al. 2005a). This is the reason why the WHO (2003a) and UNAIDS (2004b) recommend that known and innovative approaches be used to scale up and expand access to VCT. These approaches should optimise convenience for clients, decentralise services and provide HIV-testing and counselling in a wide variety of settings, including health facilities, community-based locations, workplaces and outreach service bases. Services should be offered both during and outside normal working hours and any financial barriers to testing and related services should be removed (Kigozi, Dobkin, Martin, Geng, Muyindike, Emenyonu, Bangsberg & Hanhn 2009; Mathews 2005; Strode et al. 2005a).

The significance of voluntary counselling and testing is recognised globally as one of the most significant strategies whereby global targets and programmes can be reached. VCT needs to be increased if the globally established programmes listed below are to meet their targets:

- ‘Universal access’ to antiretroviral treatment for all HIV-positive individuals (UNAIDS/WHO 2007).
Confidentiality, counselling and consent, the ‘3 Cs’ are a key component of voluntary counselling and testing and have been advocated since the HIV-test became available in 1985 (UNAIDS 2004a). The ‘3 Cs’ embed HIV-testing in a human rights approach as mandatory. Without the ‘3 Cs’ HIV-testing is neither effective for public health purposes nor ethical, because it denies individual choice, and violates principles such as the right to privacy and the ethical obligation to obtain informed consent and maintain confidentiality (ILO\textsuperscript{12} 2002/3; UNAIDS 1999; UNAIDS 2004a; UNAIDS/WHO 2007).

The UNAIDS/WHO guidelines require that HIV-testing of individuals must be:

- **Confidential**
  All medical records, whether or not they involve HIV-related information, should be managed in accordance with appropriate standards of confidentiality. Only health-care professionals with a direct role in the management of patients or clients should have access to such records and only if an HIV-positive patient is in need of further care such as having to undergo an operation, should their status be shared with any other health professionals. Thus an individual’s HIV-positive status can be made available only on a “need-to-know” basis (UNAIDS 2004a; WHO 2003a).

- **Accompanied by counselling**
  The result of the HIV-test should always be offered to the person being tested. Appropriate post-test information, counselling or referrals should also be given along with the result. People who receive HIV-positive test results should receive counselling and referral to care, support and treatment. These HIV post-test support services are crucial for HIV-infected individuals (UNAIDS 2004a; WHO 2003a).

- **Voluntary**
  An HIV-test can only be conducted if the individual gives his or her informed consent. This means the decision to undergo an HIV-test is both informed and voluntary. Although the process of obtaining informed consent for HIV-testing will vary according to different settings, all those offered the test should receive sufficient information and be helped to reach an adequate

\textsuperscript{12} ILO – International Labour Organisation
understanding of what is involved. The three crucial criteria in obtaining truly informed consent in HIV-testing are:

- To provide pre-test information on the purpose of testing and on treatment as well as the support available once the result is known.
- To ensure understanding of an HIV-test procedure.
- To respect the individual’s autonomy.

Only when all these criteria are in place will individuals be able to make a fully informed decision on whether or not to be tested in the light of their own circumstances and values (McCauley 2004; UNAIDS 2004a; WHO 2003a).

3.3.1 Ensuring a ‘Rights’ based approach

Voluntary counselling and testing needs be grounded in sound public health practice as well as in respect for and protection of human rights norms and standards (Family Health International 2002; ILO 2002/3; Strode et al. 2005a; UNAIDS 2004a; WHO 2003a) The voluntary nature of testing must remain at the heart of all HIV/AIDS policies and programmes both to comply with human rights principles and to ensure sustained public health benefits (UNAIDS 2004a). To ensure this, the following key issues should be addressed simultaneously:

1. **An ethical process for conducting HIV-testing must be ensured.** This includes defining the purpose of the test and its benefits to individuals being tested, providing linkages between the site where the HIV-test is conducted and relevant treatment and access to care and other services in an environment guaranteeing confidentiality of all medical information.

2. **The implications of an HIV-positive test result must be addressed.** This involves dealing with concerns regarding discrimination and access to sustainable treatment and care for people who test HIV-positive.

3. **HIV/AIDS-related stigma and discrimination must be reduced at all levels.** It is particularly important within health-care settings.

4. **A supportive legal and policy framework must be ensured.** Any response to HIV/AIDS includes safeguards to the human rights of individuals seeking services.

A functioning healthcare infrastructure needs to be in place to ensure that the above-mentioned issues are adequately dealt with in order to guarantee that voluntary counselling
and testing provides a service through which HIV-positive individuals can be referred for care, treatment and support (Strode et al. 2005a; UNAIDS 2004b; WHO 2003a; WHO 2008a).

3.4 Voluntary counselling and testing as an HIV/AIDS intervention strategy

3.4.1 Prevention of HIV/AIDS transmission — primary prevention

Voluntary counselling and testing is the most targeted and focused set of social interventions intended to achieve individual behaviour change (Hutchinson & Mahlalela 2006; Sahlu et al. 1999; UNAIDS 2008). While specific strategies do exist to prevent every mode of HIV-transmission, be it sexual transmission or blood borne transmission (including drug injection or in health-care settings), or mother-to-child transmission (MTCT), extensive experience in diverse regions around the globe has demonstrated the effectiveness of combining a broad range of HIV-prevention strategies — for example condom use; providing clean needles for drug users and prevention of mother-to-child transmission of HIV/AIDS (PMTCT) — into the voluntary counselling and testing process (Family Health International 2002; Loeto 2008; McCauley 2004; Strode et al. 2005a).

Voluntary counselling and testing affects the spread of the HIV/AIDS by reducing risk behaviour in individuals in a number of ways:

- By increasing public awareness of the seriousness of the epidemic.
- By promoting the social and cultural norms supportive of HIV-prevention.
- By minimising the stigmatisation of HIV-positive individuals through providing knowledge of transmission and prevention.
- By mobilising social forces to increase HIV-prevention care and support. (Hutchinson & Mahlalela 2006; Leach-Lemons & Owuor 2009; UNAIDS 1997 in UNAIDS 2008).

Voluntary counselling and testing therefore, not only enables more individuals to know their status in a supportive environment but also assists individuals to understand the need to behave in a manner that reduces their risk of HIV-infection and helps in mitigating disease stigma in
society (Hutchinson & Mahlalela 2006; Leach-Lemons & Owuor 2009; Solomon et al. 2004; Strode et al. 2005a).

3.4.2 Prevention of HIV/AIDS disease progression — secondary prevention

From the onset, voluntary counselling and testing has been advocated as an intervention to assist in the prevention of HIV-infection: to assist those already infected with HIV, to reduce the risk of transmitting the virus and to act as an intervention to limit disease progression (Strode et al. 2005a; WHO 2003a; WHO 2008a). Furthermore, it facilitates the entry of HIV-infected individuals into care, support and treatment programmes referred to as secondary prevention.

Voluntary counselling and testing provides the opportunity for the dissemination of accurate information about HIV/AIDS and for risk assessment and risk reduction counselling (regardless of HIV-status) during the pre-test counselling session for the general population. In addition VCT provides counselling about the options available to reduce HIV mother-to-child-transmission (MTCT) for pregnant women, as well as information and referral to medical services specific to the treatment of associated infections such as sexually transmitted infections (STIs) or opportunistic infections such as tuberculosis (Hutchinson & Mahlalela 2006; Pronyk, Kim, Makhubele, Hargreaves, Mohlala & Hausler 2002; Strode et al. 2005a). Voluntary counselling and testing has also been shown to be an effective prevention strategy that assists HIV-positive individuals and serodiscordant couples (one partner is HIV-positive and the other is not) reduce the risk of infecting others or of re-infecting themselves during the post-test counselling session period (Hutchinson & Mahlalela 2006; PEPFAR 2009\textsuperscript{13}; Strode et al. 2005a).

Research provides evidence that counselling as part of HIV-testing leads to behaviour change in individuals (Hutchinson & Mahlalela 2006; Maman et al. 2001). A study in Kampala, Uganda showed that people who had been counselled and tested for HIV reported safer sexual behaviour as compared to those who had not been tested regardless of their HIV-status (Muller et al. 1992 in Solomon et al. 2004). A voluntary counselling and testing efficacy trial conducted in Kenya, Tanzania and Trinidad showed that HIV-infected couples who knew their status were more

\textsuperscript{13} PEPFAR HIV counselling and testing technical working group with Zambia Emroy HIV research group. 2009.
likely than those who knew they were not infected with HIV to reduce the practice of unprotected sex (Coats et al. in Solomon et al. 2004). A consistent finding (Strode et al. 2005a) is that voluntary counselling and testing is more effective as a means of secondary rather than primary prevention. This means that VCT is more effective at facilitating behaviour change in people who test HIV-positive than in those that test HIV-negative.

Studies show that voluntary counselling and testing is most effective in facilitating behaviour change in both HIV-negative and HIV-positive clients when the client is one of an HIV serodiscordant couple\textsuperscript{14} who were counselled together, rather than individually (Hutchinson & Mahlalela 2006; Maman et al. 2001; Rachier, Gikundi, Balmer, Robson, Hunt & Cohen 2004; Strode et al. 2005a). In these cases VCT has been shown to reduce unprotected sexual intercourse and increase condom use between such couples (Allen et al. 1992, Kamenga et al. 1991, Mckenna et al. 1997, Roth et al. 2001 in Solomon et al. 2004).

The voluntary counselling and testing efficacy trial conducted in Kenya, Tanzania and Trinidad found a number of reported behaviour changes in individuals due to VCT (\textsuperscript{15}McCauley 2004). Behaviour change among adults after voluntary counselling and testing was measured on a range of indicators including: condom use, reduction in number of partners and reduction in STI incidence. Results indicate that there was a significantly greater decline in the percentage of individuals who had unprotected sex with non-primary partners among the group that received voluntary counselling and testing compared to the group who simply received health education consisting of information regarding HIV/AIDS and STIs transmission and prevention. Results indicate that HIV-infected men and women were likely to reduce sexual risk behaviours with primary partners and HIV-positive men were likely to reduce risk behaviours with non-primary partners. Couples that participated in voluntary counselling and testing showed a significant reduction in unprotected intercourse with their research study enrolment partners after VCT compared with those who received health education which consisted of information about HIV/AIDS and STIs transmission and prevention only and no HIV-test or counselling. The

\textsuperscript{14} Serodiscordant couple: One member of the couple is HIV-positive and the other is not

\textsuperscript{15} Voluntary Counselling and Testing Efficacy Group 2000, in McCauley, 2004
researchers concluded that voluntary counselling and testing is effective in promoting behaviour change (Coats et al. 2000 in McCauley 2004).

Health professionals regard disclosure of one’s HIV-status as a means not only of achieving psychosocial support but also as a means of HIV-prevention. Many studies (Leach-Lemons & Owuor 2009; McCauley 2004; Sahlu et al. 1999; Solomon et al. 2004) that have focused on the impact of voluntary counselling and testing have concentrated on whether or not individuals disclose their HIV-status to others. An important hindrance to disclosure of HIV-status to significant others is the negative experiences that have been reported by HIV-positive individuals resulting from such disclosure (Kigozi et al. 2009; Leach-Lemons & Owuor 2009; Peltzer, Maseke, Mzolo & Majaja 2009; Solomon et al. 2004). Negative experiences include discrimination, violence and stigmatisation (Leach-Lemons & Owuor 2009; Strode et al. 2005a; Swanapoel 2006). Negative experiences emphasise that for voluntary counselling and testing programmes to be effective, the programmes need to be linked to a circle of care which connects HIV-positive individuals to a comprehensive set of treatment, support and care services after HIV-testing in the event of the test results being positive (Leach-Lemons & Owuor 2009; O’Conner et al. 1999 in Richter et al. 2001).

Condom use is often used to measure behaviour change regarding HIV/AIDS, but according to Solomon et al. (2004) it may not be an appropriate outcome measure for HIV-negative individuals. This is because many individuals undergo voluntary counselling and testing or repeat HIV-testing to establish their HIV-status at the outset of a new monogamous relationship with the intention of ceasing condom use. In a study conducted in Uganda, 27% of the samples of participants were taking an HIV-test because of a planned marriage or a new relationship. Undergoing HIV-testing before marriage or a new relationship was even more common in the case of couples coming for voluntary counselling and testing where 84% of the sample of participants was planning a new marriage/relationship (Muller et al. 1992, in Solomon et al. 2004). When individuals who tested HIV-negative were asked what behaviour changes they planned, the most frequently reported intentions were marriage (81%) followed by monogamy (17%). The use of condoms was only mentioned by 2% of the participants. In these cases voluntary counselling and testing clearly functions as a way to identify whether it is safe to have
unprotected sex with an individual who is to become a long-term or life partner (Watney 1990 in Beardsell 1994 in Solomon et al. 2004).

Researchers (Coats et al. 2000 in McCauley 2004) who did not use condom use as the only measure of behaviour change but instead asked participants their reasons for testing found voluntary counselling and testing as the primary intervention to be effective. Since the efficacy of voluntary counselling and testing as a secondary intervention has been clearly demonstrated; VCT can be said to affect behaviour change in a positive manner in the face of HIV/AIDS (Leach-Lemons & Owuor 2009; Maman et al. 2001; Obare 2009; Solomon et al. 2004).

3.5 HIV/AIDS treatment, care and support
There is growing evidence (Maman et al. 2001; Richter, van Rooyen, Solomon, Griesel & Durrheim 2001; Solomon et al. 2004; Strode et al. 2005a) to suggest that voluntary counselling and testing plays an important role in assisting people to cope with a range of psychosocial consequences (e.g. stigma, discrimination, socio-economic duress) associated with a HIV-positive diagnosis. A study by Strode et al. (2005a) highlights that effective counselling is integral to the prevention of mother-to-child transmission (PMTCT) in terms of implementation and effectiveness. The study ascertained that effective counselling was vital in helping pregnant women manage potentially negative reactions of spouses or family members, but also in encouraging partner support, co-counselling and HIV-testing. There is evidence that voluntary counselling and testing works as an important support to individuals who test either positive or negative (Leach-Lemons & Owuor 2009; Loeto 2009; Strode et al. 2005a).

Comprehensive post-test support services are aimed at improving the psychosocial health of people living with HIV/AIDS and helping those who test negative to maintain their negative status by providing a culturally relevant support system. Post-test support services improve an individual’s technical skills, for example, consistent condom use; social skills including safer sex negotiations; and interpersonal skills, which might include problem-solving skills, all of which could help reduce HIV-transmission. Support groups in conjunction with coping-effectiveness training and stigma-reduction workshops help people living with HIV/AIDS to manage depression and stress (Leach-Lemons & Owuor 2009). This provision of services post-HIV-
testing is to ensure the continued health and well-being of HIV-positive individuals. Treatment, care and support for HIV-positive individuals empower them by providing the necessary skills to manage their illness and connect them to similarly infected individuals from whom they receive empathy and support for treatment adherence and keeping their immune systems as strong as possible (Swanapoel 2006).

3.6 Voluntary counselling and testing in South Africa

Voluntary counselling and testing is recognised as playing an important role in preventing HIV/AIDS transmission, inhibiting HIV-infection progression to AIDS and providing care through treatment and emotional support for those infected and affected by the disease (Busse 1994, Centre for Disease Control 1992 in Richter et al. 2001). The South African Government, Department of Health National AIDS Plan (2000) highlighted four goals in the HIV-counselling strategy:

1. To ensure that all people receive pre- and post-test counselling.
2. To develop an extensive network of trained counsellors both within the health care settings and in the community.
3. To develop and sustain an ethos of confidentiality and support.
4. To integrate counselling into other services (Richter et al. 2001).

The above is in line with the South African Constitution, which provides that every person has the right to bodily integrity (physical aspect of self) and privacy (section 12 and section 14, Constitution of the Republic of South Africa Act, No. 108 of 1996 in Strode, Slack, Grant & Mushariwa 2005b). These rights, which are also well-established principles in our common law, give individuals control over their bodies and enable them to make autonomous decisions. The National Health Act (No. 61 of 2003) has codified these rights, stating that no health service may be provided to a user without their consent (Section 7, National Health Act). In other words, patients must give their consent to medical treatment including HIV-testing (Strode et al. 2005b). They may also refuse to be treated or undergo a diagnostic test. Requirements for valid consent stipulate that the patient:

- Must have knowledge of the nature and extent of the harm or risk involved.
- Be enabled to appreciate and understand the nature of the harm or risk.
- Must give consent to the harm or assume the risk (Strode et al. 2005b).

As with other health services, such as undergoing an operation, many countries require young people to be a specific age before they can agree to a medical procedure such as voluntary counselling and testing without parental consent. This legal age of consent is often set at an age by which the majority of youth are already sexually active (Strode et al. 2005b). In South Africa an individual may request an HIV-test without a parents or a guardian’s consent at 14 years of age (Boswell & Baggaley 2002, Crowley 2002 in McCauley 2004). This stipulation acknowledges that some South African youth are sexually active by the age of 14 and that all sexually active members of the population should have access to HIV-testing services.

3.6.1 Availability of voluntary counselling and testing in South Africa

Voluntary counselling and testing in South Africa, especially in rural areas had only limited availability until 2003. However, expansion of VCT was highlighted as a focal point of the South African Government's Department of Health National Strategic Plan for HIV and AIDS 2000-2005 and voluntary counselling and testing is now viewed as a crucial entry point for the HIV/AIDS care and treatment programme (South African Government, DoH 2000).

Testing facilities and programmes of care and support (community mobilisation, home-based care, support groups, psychosocial programmes, and counselling and hospice services) have been expanded, as have rapid HIV-testing capacities in testing facilities. These programmes have shown demonstrable effects on testing rates even in remote rural areas (Leach-Lemons & Owuor 2009; Pronyk et al. 2002). In the Eastern Cape Province, there are now over 403 voluntary counselling and testing sites, a large expansion from a mere 52 VCT sites in 2001. Linked to the growth in the availability of voluntary counselling and testing there has been an increase in the accessibility of a range treatment options. The government has initiated programmes for the prevention of mother-to-child transmission (PMTCT) and expanded access to Highly Active Antiretrovirals Therapy (HAART) (Martinson et al. 2002 in Hutchinson & Mahlalela 2006). These treatment programmes and the increase in voluntary counselling and testing services allow for VCT to fulfil its function in the prevention of HIV-transmission and the prevention of HIV/AIDS disease progression in HIV-positive individuals.
3.6.2 The use of voluntary counselling and testing services in South Africa

South African citizens need to receive information on HIV/AIDS modes of transmission, how to prevent transmission, where one can go for an HIV-test and why it is important to know one’s status and discuss it with one’s household members in order to facilitate openness to HIV-testing (de Saxe Zerden et al. 2006). However, according to the same authors, voluntary counselling and testing and HIV-testing is not discussed openly in South African households. In a study of HIV-testing and HIV/AIDS volunteer home-based carers 72% did not know of anyone from their household who had gone for an HIV-test despite their connection to an HIV/AIDS community-based organisation with available educational resources (de Saxe Zerden et al. 2006).

The fact that HIV-testing is not commonly discussed is of concern as it is an essential entry point to medical care programmes and highly active antiretroviral therapy (HAART) (Shisana et al. 2009). In South Africa an estimated 7% of the population are tested for HIV every year. This proportion needs to increase to 25% per year if both the prevention and treatment goals articulated in the South African National Strategic Plan (NSP) 2007-2011 are to be reached. To ensure this the NSP aims to:

- Reduce the number of new infections by 50%.
- Reduce the impact of HIV/AIDS on individuals, families, communities and society by expanding access to an appropriate package of treatment, care and support to 80% of all people diagnosed with HIV (South African Government, DoH 2007a: 63).

Furthermore, HIV-testing has to be accompanied by CD4-cell count measurement which is the measure of the strength of an individual’s immune system required in order to identify HIV-infected individuals who are eligible for highly active antiretroviral therapy (HAART) (South African Government, DoH 2007a). An HIV-infected individual on HAART experiences a decrease in their HIV viral load which lessens the likelihood that they will transmit the virus to another individual. Therefore HAART not only extends the lives of HIV-infected individuals but also impacts on HIV-transmission (Abdool Karim, Churchyard, Abdool Karim & Lawn 2009; Martinson, Radebe, Mntambo & Violari 2002).
The creation of an open environment where HIV/AIDS and its implications are known and can be discussed will make it likely that more individuals will undergo an HIV-test (de saxe Zerden et al. 2006; Shisana et al. 2009). If the intervention, which ensures that HIV-positive individuals can access treatment and care through voluntary counselling and testing, remains unspoken in South African households ignorance and denial will remain an obstacle to South Africa’s ability to reach both the prevention and treatment goals of HIV/AIDS (de saxe Zerden et al. 2006).

3.7 Barriers to the use of voluntary counselling and testing services in South Africa

Silence about HIV/AIDS creates an invisible barrier between individuals and health care services designed to treat and deal with HIV/AIDS. Research indicates (Campbell 2003; Deacon, Stephney & Prosalendis 2005; de Saxe Zerden et al. 2006; du Plessis 2008; Swanapoel 2006) that people have concerns about the consequences of testing HIV-positive that are much larger than the merely the clinical management of the illness. These larger concerns are of a physical, psychosocial and economic nature and include coping with:

- Physical consequences: Opportunistic infections, a weakened immune system, pain and suffering and eventual death.
- Psychological consequences: Fear of disclosing one's positive status and the accompanying shame, self-blame and depression.
- Social consequences: Rejection by sex partners, family, friends and the community; experiences of stigmatisation and discrimination at work or in the community; acceptance of the sick role and needing assistance; and not being able to fulfil one’s social roles (Swanapoel 2006; van Dyk & van Dyk 2003).
- Economic consequences: Not being able to pay for health care or losing the ability to support oneself and family, and being denied insurance or loans.

These concerns create a complex web of barriers, which prevent the increased use of HIV-testing (ILO 2004; Pronyk et al. 2002; WHO 2003b). The South African government and health department have tried to address the possible consequences of an HIV-positive test result listed above through the increased availability of free voluntary counselling and testing, expanded support services and the creation of a legal framework to protect HIV-positive individuals.
3.7.1 Confidentiality

Due to the social consequences associated with being infected with HIV/AIDS, confidentiality has become an important issue. Maintaining confidentiality is a legal and ethical requirement that all health personnel must uphold. De Saxe Zerden et al. (2006) found 83% of respondents in their study would consider being tested for HIV if confidentiality could be ensured.

The proximity of a clinic to an individual’s home was seen to be an issue. Van Dyk and van Dyk (2003) found that 67% of participants would visit a clinic or doctor near to where they lived while 33% mentioned that they would rather not do so for fear of a breach in confidentiality. Individuals who knew at least one HIV-positive person (27.86%) were more inclined to go for HIV-testing at a clinic where nobody would know them than people who did not know an HIV-positive person (van Dyk & van Dyk, 2003). This may indicate that these individuals have had direct experience of the lack of the maintenance of confidentiality by nurses at their local clinic and their preference for undergoing HIV-testing elsewhere is a means of maintaining the confidentiality of their HIV-status.

Individuals frequently have reasons why they do not trust health care workers to keep their results confidential in spite of the fact that these counsellors are bound to uphold ethical and legal procedures (van Dyk & van Dyk, 2003). However, in some instances counsellors choose not to observe confidentiality because they consider it their moral duty to disclose a client’s HIV-positive status to the client’s partner, and often to other members of the client’s community in order to protect them (Mhlanga et al. 2006; Nyblade, Stangl, Weiss & Ashburn 2009; van Dyk 2001; UNISA Centre for Applied Psychology 2002 in van Dyk & van Dyk 2003). This may provide evidence for resistance to voluntary counselling and testing on the grounds that confidentiality procedures may not be trusted and that stigmatisation and discrimination will result from such disclosure (Nyblade et al. 2009; Solomon et al. 2004). It would also be evidence of a lack of trust in the public health care system creating a barrier to the provision of comprehensive voluntary counselling and testing services in South Africa (Mhlanga et al. 2006; Nyblade et al. 2009; van Dyk & van Dyk 2003).
3.7.2 Fear

Despite the roll out of highly active antiretroviral therapy (HAART) in South Africa in 2004, individuals still continue to observe those infected with HIV being exposed to opportunistic infections and then dying of AIDS. This observed progression of the disease exposes individuals to the mental and physical pain suffered by the victim of HIV and has led to observers having a real fear of knowing their status (Kigozi et al. 2009; Martinson et al. 2002).

Forty-six per cent of surveyed HIV/AIDS home-based care workers (de Saxe Zerden, et al. 2006) cited ‘scared to know results’ as the primary reason preventing members of the community from testing for HIV. During group interviews HIV/AIDS home-based care workers elaborated on the reasons why they, themselves do not undergo voluntary counselling and testing. Fear was an important factor and can be categorised into:

- Fear of disclosure: Fear of rejection by their loved ones and community when health care professionals do not keep HIV-test results confidential.
- Fear of illness: Fear of opportunistic infections and that illness may result in loss of work and inability to perform their roles as parents and care givers (de Saxe Zerden et al. 2006).

Fear of becoming sick with an incurable disease is understandable but when this is compounded by the fear of being rejected by one’s family and friends a formidable barrier against HIV-testing is created which diminishes the likelihood of individuals volunteering for HIV-testing.

3.7.3 Stigma

Another aspect of the fear of knowing one’s HIV-status is the fear of stigmatisation. Stigma is variously characterised as an ideology that identifies and links the presence of a biological disease agent or any physical signs of the disease to negatively defined behaviours or groups in society (Deacon et al. 2005; Jary & Jary 1991; Kalichman & Simbayi 2004; Kalichman, Simbayi, Jooste, Toefy, Cain, Cherry & Kagee 2005; Reber 1998). Stigmatising people who have contracted the disease is greater where contracting the disease is perceived to be avoidable, where transmission of the disease is linked to sex or other morally sensitive issues, and where the disease is serious or terminal (Kalichman & Simbayi 2004; Møller & Erstad 2007; WHO 2003b).
By responding emotionally rather than cognitively to danger by stigmatising others individuals may feel that they are removed from the risk of contracting the disease (Møller & Erstad 2007).

Disease stigma is not a new phenomenon both syphilis and leprosy were associated with high levels of stigma (Deacon et al. 2005; Fortenberry, McFarlane, Bleakley, Bull, Fishbein, Grimley, Malotte & Stoner 2002; Kalichman et al. 2005). In 1987, Jonathan Mann, the founding director of the World Health Organisation’s former Global Programme on AIDS, addressed the United Nations General Assembly. Mann highlighted HIV/AIDS stigma and its likely consequences if not dealt with appropriately. He distinguished three phases of the HIV/AIDS epidemic in any community. These are:

- The epidemic of HIV-infection which typically enters every community silently and unnoticed and often develops over many years without being widely perceived or understood.
- The epidemic of AIDS itself and the syndrome of opportunistic infectious diseases that occur because of HIV-infection but typically only after a delay of a number of years.
- The third epidemic, potentially the most explosive, which is the epidemic of social, cultural, economic and political responses to AIDS. This is characterised by exceptionally high levels of stigma, discrimination and at times collective denial. These, Mann states, “are as central to the global AIDS challenge as the disease itself” (Mann 1987 in Kalichman et al. 2005).

Most people living with HIV/AIDS suffer or fear stigmatisation. Studies from Africa and South Africa (Campbell 2003; de Saxe Zerden et al. 2001; Fortenberry et al. 2002; Hutchinson & Mahlalela 2006; Kalichman & Simbayi 2004; Kalichman et al. 2005; Nyblade et al. 2009; Solomon et al. 2004; UNAIDS 2008) suggest that HIV/AIDS stigma is linked to people’s sense of sexual morality and their fear of breaking taboos. A ‘conspiracy of silence’ exists in which HIV/AIDS is seldom openly discussed, even in heavily affected areas. People do not want to admit that a fatal disease spread by behaviour branded as immoral could be spreading through their community or their country. Unfortunately, in places where denial flourishes, individuals are most vulnerable to the silent spread of HIV (Campbell 2003; Maman et al. 2001; WHO, 2003b).
In a study that examined the relationship between HIV-testing and HIV/AIDS stigma, it was found that people who had been tested for HIV held fewer HIV/AIDS stigmatising beliefs than people who had not been tested (Kalichman & Simbayi 2004). However, having an HIV-test does not necessarily eliminate the possibility of stigmatising beliefs altogether. In the previously mentioned study of Kalichman and Simbayi (2004), more than one in five persons who had been tested for HIV believed that people with HIV/AIDS cannot be trusted, should feel guilty, and should not be allowed to work with children. Furthermore, according to them, this suggests that HIV/AIDS stigmatising beliefs are widely held in some population groups in South Africa and pose a substantial barrier to HIV-prevention efforts, even among people who have been counselled (Kalichman & Simbayi 2004).

In Kalichman & Simbayi’s study (2004) health workers stated that HIV/AIDS-related stigma is the most important reason why people in their community do not test for HIV. Fears of rejection and subsequent harm that may result from an HIV-positive test result are cited as reasons for this. Furthermore, stigmatising beliefs serve to distance people from HIV/AIDS and HIV/AIDS is viewed as something that only happens to other people. HIV/AIDS-related stigma can thus be viewed as an important social barrier to HIV/AIDS prevention (Kalichman & Simbayi 2004; Kalichman et al. 2005).

The perception of threat is a likely foundation for stigma (Deacon et al. 2005; Fortenberry et al. 2002; Kalichman & Simbayi 2004; Kalichman et al. 2005; Sahlu et al. 2007; Solomon et al. 2004; van Dyk & van Dyk 2003). As threats include threats to health as well as threats to moral order in society, this may be the reason for the close relationship between disease stigma, prejudice and social inequality (Link & Phelan 2001, Parker & Aggleton 2003, Stein 2003 in Deacon et al. 2005; Nyblade et al. 2009). Diseases are often employed as markers of biological and social difference and there are striking similarities in the way different diseases have been stigmatised over time. For example, leprosy, like HIV/AIDS, used to be associated with promiscuity and poverty (Deacon et al. 2005; Fortenberry et al. 2002; Kalichman et al. 2005). The dominant mode of HIV-transmission in South Africa is through heterosexual sex, which has led to associations between HIV-infection and promiscuity or immoral behaviour. Social
distancing diminishes an individuals’ perception of their risk of contracting HIV/AIDS. Therefore these individuals do not volunteer for HIV-testing (Nyblade et al. 2009).


Human beings are inherently social animals, and their physical and psychological health is damaged when they are isolated and/or ostracised from their social group (Jenkins & Sarkar 2007 in Abdool Karim et al. 2009) which is what happens when they suffer discrimination and social marginalisation as a result of their HIV-positive status.

3.7.4 Discrimination
In addition to fear and stigma, discrimination against HIV-positive individuals is another barrier to HIV-testing and knowing one’s status. Discrimination defined in behavioural terms is the unequal treatment of individuals or groups based on arbitrary characteristics such as race, sex and ethnicity (Jary & Jary 1991) and in this case signs and symptoms of HIV-infection like loss of weight, rashes on the individual’s skin and TB infection.

Discrimination against HIV-positive individuals takes different forms. In the health care sector, for example, these are breaches of confidentiality by health personnel who disclose individuals’ HIV-status to community or household members or deny proper timeous care for HIV-positive individuals (de Saxe Zerden et al. 2006; Mhlanga et al. 2006; Nyblade et al. 2009; WHO 2003a). The consequences of stigma and discrimination for HIV-infected people are profound when
leading to compromised care (Mhlanga et al. 2006; Nyblade et al. 2009; WHO 2003a). According to Mhlanga et al. (2006), fear of contagion, victim blaming and lack of confidentiality, misinformation and negative attitudes towards HIV, significantly limit a health care-worker’s role in providing effective, respectful and dignified care to HIV-positive individuals and their families. Some documented negative behaviours by health care workers include:

- HIV-positive individual is condemned as a ‘bad person’.
- Women are considered irresponsible for exposing their vulnerable foetuses to HIV.
- HIV-positive individuals are isolated or avoided because of embarrassment or inability to offer support to those infected by HIV/AIDS.
- Treatment and/or care for HIV-positive individuals are refused.
- Discussion regarding risky behaviours and HIV-prevention is avoided or refused.
- Ability or willingness to care for HIV-positive individuals and their families in a non-judgemental, caring and supportive manner is unavailable (Mhlanga et al. 2006; Nyblade et al. 2009; WHO 2003a).

Many people fear the psychosocial consequences of testing positive for HIV/AIDS, particularly when it may lead to loss of social status, to discrimination (Nyblade et al. 2009; Parker & Aggleton 2003, UNAIDS 2003 in UNAIDS 2008), to domestic violence or even to abandonment (Rothenberg & Paskey 1995 in Hutchinson & Mahlalela 2006; Maman et al. 2001). In 2006, UNAIDS facilitated consultations with civil society and government stakeholders and 122 countries consistently identified HIV-related stigma and discrimination as one of the top five barriers to achieving universal access to HIV-prevention, treatment, care, and support (UNAIDS, 2008).

Reluctance to take HIV-tests for fear of discrimination undermines HIV-prevention efforts (Nyblade et al. 2009; Ford et al. 2004, Wolfe et al. 2006, Pulerwitz & Barker 2008 in UNAIDS 2008). These efforts are further undermined by reluctance to seek information on how to protect themselves from HIV-infection and reluctance to use condoms for fear of being identified with the disease or with the marginalised populations that are most heavily affected by the disease (Nyblade et al. 2003 in UNAIDS 2008). In some instances the family members and caregivers of
HIV-infected individuals and the children of people living with HIV are also subject to discrimination and shame (Mhlanga et al. 2006). The health care system itself, through the lack of adequate planning for the provision of ARV medication for individuals in need is discriminatory. Doctors, nurses and staff responsible for care and treatment of people living with HIV, by not providing adequate care and treatment, may be prime agents of HIV-related stigmatisation and discrimination (Mhlanga et al. 2006; Nyblade et al. 2009; Reis et al. 2005, USAID 2007a in UNAIDS 2008).

The detrimental effects that negative attitudes and prejudice against people with HIV can have on voluntary counselling and testing programmes are evidenced by the responses of participants who knew somebody with HIV/AIDS (de Saxe Zerden et al. 2006). Participants in a study undertaken in Cape Town township regarding the barriers of voluntary counselling and testing who knew somebody with HIV/AIDS generally believed that it was not a good idea for everyone to know his or her HIV-status and that one should go alone for testing where nobody knows one. It is possible that these participants experienced firsthand how existing negative and prejudiced attitudes affect the lives of their HIV-positive friends, colleagues or family members and this experience has formed a barrier between themselves and testing for HIV to ascertain their status (van Dyk & van Dyk 2003).

Discrimination against people living with HIV is also apparent within the global environment. According to the European AIDS Treatment Group, 74 countries restrict entry or stay of people based on their HIV-status; this includes 12 countries that ban people living with HIV from entering for any reason or for any length of time (UNAIDS 2008).

South Africans should benefit from their country’s constitution and labour legislation, which is based on non-discriminatory principles and enshrined in the South African Bill of Rights. Yet research shows that discrimination against HIV-positive individuals by household members and health-care workers is a serious barrier to voluntary counselling and testing (de Saxe Zerden et al. 2006; Mhlanga et al. 2006; Nyblade et al. 2009; van Dyk & van Dyk 2003).
3.7.5 Level of education

Ensuring that individuals have the correct knowledge of HIV-transmission and prevention mitigates HIV/AIDS stigma and fear (Kalichman & Simbayi 2004; Nyblade et al. 2009; Strode et al. 2005a). Knowledge of HIV/AIDS and raising the level of formal education attained should, therefore, increase the use of voluntary counselling and testing by individuals. It is believed that communication and education campaigns to increase knowledge of the benefits of VCT (South African Government, DoH 2007b) may increase the numbers of South Africans who use VCT services.

An HSRC national HIV prevalence and incidence survey (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Jooste & Pillay 2005) found that among those individuals who tested for HIV, HIV-testing was positively associated with the level of education individuals had attained (Hutchinson & Mahlalela 2006). In addition, a lower level of education was associated with late HIV/AIDS diagnosis (Kigozi et al. 2009). For both males and females, the probability of being tested for HIV was generally linked to the level of education attained by an individual as well as to psychosocial indicators such as absence of stigma and knowing someone with HIV/AIDS (Hutchinson & Mahlalela 2006; Shisana et al. 2005). Women with a secondary education were five times more likely to use voluntary counselling and testing as women with no education. For men, education as well as other personal characteristics had considerably less effect, 12.4% of men without any formal education indicated the intention to use VCT as compared with 20.3% of men with secondary education (Hutchinson & Mahlalela 2006). An increase in formal education, together with knowledge concerning HIV/AIDS transmission, prevention, treatment and care of South Africans may assist in increasing the level of HIV-testing.

Kalichman and Simbayi’s (2004) study demonstrates that HIV/AIDS-related knowledge lessens much of the association between beliefs about the cause of HIV/AIDS and HIV/AIDS-related stigmas. Initially, a strong and consistent link was found in their research study between beliefs that supernatural forces cause HIV/AIDS and HIV/AIDS-related stigmas. However, nearly all of what appeared to be significant associations between beliefs and stigmas were non-significant when HIV/AIDS-related knowledge regarding transmission and prevention was analysed. The effect of HIV/AIDS-related knowledge about transmission and prevention was particularly
significant, because it occurred over and above the variance accounted for by years of formal education and other relevant covariates (Kalichman & Simbayi 2004). This finding suggests that HIV/AIDS awareness and education campaigns that are a cornerstone of South Africa’s HIV/AIDS prevention effort could do much to lesson repulsion and social sanctions against people living with HIV. HIV/AIDS awareness and education campaigns therefore provide critical support for prevention efforts as, armed with correct knowledge and information, individuals are more likely to utilise voluntary counselling and testing services.

The level of education of an individual seems to play a role in the uptake of VCT services in South Africa particularly in regard to health-seeking behaviour in women. The fact that the amount of knowledge and education regarding HIV/AIDS also mitigates HIV/AIDS stigma and discrimination emphasises the importance of education and communication campaigns as part of the South African national effort to increase the numbers of individuals who are aware of their HIV/AIDS status (Shisana et al. 2009).

3.7.6 Belief System
People who held traditional beliefs about the cause of HIV/AIDS (Kalichman & Simbayi 2004) consistently demonstrated poorer knowledge of HIV/AIDS-related facts and were significantly more likely to endorse repulsion and social sanctioning because of stigma associated with people living with HIV/AIDS. These findings are consistent with past research that shows that traditional beliefs about illnesses are related to misinformation about disease (Yamba 1997 in Kalichman & Simbayi 2004).

In South African traditional belief systems of health and disease, ancestors and God are often felt to be the ultimate cause of illness (Sow 1980 in van Dyk 2001). People become ill because they have done something to anger the spirits or ancestors or God. Ancestors may either have sent the illnesses to the afflicted persons or will have withdrawn their protection. In the case of HIV/AIDS, beliefs that the condition comes from spirits are reinforced by the fact that some people have HIV/AIDS and others do not, despite there being no recognisable differences in their lives. Attributing the cause of HIV/AIDS to ancestral spirits or an angry God leads directly to stigmatising beliefs about people with HIV/AIDS. It is thought that they must have brought
their condition upon themselves and their community (Goffman 1963 in Kalichman & Simbayi 2004). Attributing the cause of HIV/AIDS to the afflicted brings about a sense of repulsion, as well as confirming the justice of social sanctions, two major dimensions of stigmatising beliefs (Deacon et al. 2005; Kalichman & Simbayi 2004). Individuals who held traditional beliefs were more likely to present late in HIV disease progression for HIV-testing.

3.7.7 Gender and fear of violence

There appear to be important differences between the reasons why men and women seek an HIV-test. Maman et al. (2001) and Solomon et al. (2004) indicate that it would appear that men want to confirm that they are HIV-negative; whereas women who suspect that they are HIV-positive seek confirmation they are HIV-positive. This is seen as an indicator of gender inequality (Maman et al. 2001).

Maman et al. (2001) also point out that gender inequality is a significant factor affecting the uptake of voluntary counselling and testing in women. Women fear their partner’s reaction to their status should they test HIV-positive. They also fear going against their partner’s wishes and testing for HIV. These negative attitudes held by male partners towards HIV-testing are likely to limit the number of women who choose to be tested. South Africa has extreme examples of the social consequences of HIV/AIDS stigma for women that have been widely publicised in the media. Gugu Dlamini, who disclosed her HIV-positive status was stoned to death by a mob in December 1998, Mpho Motloung was killed by her husband after they both went for HIV-tests and Lorna Mlosana was gang-raped and beaten to death in a bar after revealing that she was HIV-positive (du Plessis 2008). Thus it would appear that unequal power relations that limit women’s control over their risk of HIV-infection also limit them from volunteering for HIV-testing.

Gaillard et al. (2000 in van Dyk & van Dyk 2003) found that 68% of women in stable relationships, who lived in a resource-poor setting in Africa, did not inform their sex partners that they had tested or of the result of the HIV-test, for fear of their partner’s reaction. This research study suggests that women generally have little control over whether to be tested or not as these decisions are made or influenced by their male partners (Solomon et al. 2004).
Violence, the break-up of marriages, being neglected or disowned by their families, loss of security, shelter, food and even murder, have all been reported as real consequences for women when they disclose their HIV-positive status to their sex partners (du Plessis 2008; Grinstead et al. 2001; Maman et al. 2001; Campbell et al. 1997, Kilewo et al. 2001, Tomasevski 1992 in van Dyk & van Dyk 2003; WHO 2003b). The same trend was found among pregnant women in Africa. According to Kilewo et al. (2001) and Nebie et al. (2001 in van Dyk & van Dyk 2003) only 16.7% and 18% of participants respectively informed their partners of their HIV-positive status. Married women who indicated that they would keep their HIV-positive results a secret, gave among others, the following reasons: “My husband will kill me”; “He will blame me”; “I know he has many girlfriends, but he will still blame me”; “If he gets sick with AIDS, his family will say that I have bewitched him, and they will take away my children”; “He will kick me out and take another woman” (van Dyk & van Dyk 2003). From these reasons one can deduce that a real fear of HIV/AIDS violence, stigma and discrimination prevents women from disclosure.

In a study of men who had never been tested for HIV (Woods in Fortenberry et al. 2002) 59% cited fear of negative social consequences as an important reason for not seeking HIV-testing. Similarly, 44% of the high-risk males in the same research stated that if name-based reporting of HIV-status were implemented, they would not accept HIV-testing, and they maintained this intention even after being told of the potential benefits of such reporting (Woods et al. 2000 in Fortenberry et al. 2002). In research reported by van Dyk and van Dyk (2003), males were more inclined than women to keep their HIV-status a secret and this was also evident in the case of married couples. Six and a half percent of the married male participants indicated that they would keep their HIV-status a total secret. Some of the responses from males were: “Women won’t have sex with me”; “I won’t tell, because I won’t believe that I have AIDS”; “My wife won’t look after me when I am sick, if she knows that I have AIDS”.

Fear of response from wives or sex partners and the social inequities that many women face prevent individuals from volunteering for HIV-testing (de Saxe Zerden et al. 2006; WHO 2003b). Thus social consequences for both men and women of being HIV-positive have been found to be a major stumbling block in the uptake of voluntary counselling and testing.
3.7.8 Accessibility of voluntary counselling and testing services

In addition to the fear of illness and its social repercussions there are also practical barriers to voluntary counselling and testing. Studies have highlighted a lack of access to HIV-testing services with trained counsellors and treatment for HIV-infected individuals (Grinstad & Van Der Straten 2001; Rachier et al. 2004; Peltzer et al. 2009) as a major obstacle to VCT.

The likelihood that both men and women will go for testing is affected by the distance they have to travel to reach an HIV-testing site. One research study showed that physical proximity to a clinic increased the probability that males would be tested; every one-kilometre that a man lived from a clinic offering voluntary counselling and testing reduced the likelihood that he would be tested by 0.7%. For women, each further kilometre away from a clinic was associated with a 0.4% reduction in the likelihood of being tested (Hutchinson & Mahlalela 2006). This was confirmed more recently when it was found that patients who live far from a health facility were more likely to be diagnosed late after the onset of their HIV-infection. According to Kigozi et al. (2009) 44% of patients that have a journey time of two or more hours will not volunteer for HIV-testing, compared to 35% of individuals with a journey time of less than 30 minutes to their local clinic who would volunteer for HIV-testing.

Thus if voluntary counselling and testing services are easily accessible and offer comprehensive care to individuals who test HIV-positive more individuals will make use of these VCT services (van Dyk & van Dyk 2003). Increasing accessibility and ensuring that voluntary counselling and testing services can provide the treatment, care and support needed by an HIV-positive individual, is very important in attempts to increase the uptake of VCT (WHO 2003a).

3.7.9 Availability of treatment, care and support

The quality of care and support and availability of treatment are important factors in the face of a positive diagnosis of HIV-infection (Nyblade et al. 2009; Rachier et al. 2004; Strode et al. 2005a; Swanapoel 2006; WHO 2003a;). Without care, support and treatment there is very little real benefit for an individual to find out their HIV-status by undergoing an HIV-test (Nyblade et al. 2009; Swanapoel 2006; WHO 2003a).
One study (Pronyk et al. 2002) noted a number of practical factors inhibiting the use of voluntary counselling and testing services. These factors were shortages of counsellors for the delivery of pre- and post-test counselling; waiting in long queues to have an HIV-test; lack of privacy for the individual during the HIV-testing process and lack of follow-up support by health services after an HIV-positive diagnosis. These factors compromise the use of voluntary counselling and testing services in South Africa (van Dyk & van Dyk 2003). The introduction of rapid testing has proved to be one practical factor that enhances use of VCT. The presence of rapid testing doubled the 11.4% likelihood that a man would be tested for HIV to 22.2%. For women, rapid testing barely affected the likelihood of being tested.

While HIV/AIDS is the most common infection among pregnant women in South Africa and a threat to their survival this does not mean they will receive the care they need. A research study (Mhlanga et al. 2004) found that many women receive substandard care once their HIV-status is known or suspected. Some women wait for long periods before they are assessed and treated appropriately. The guidelines for the management of HIV/AIDS seem not to be widely practised and there is limited utilisation of guidelines for the management of women infected with HIV (Mhlanga et al. 2004).

Quality of care and access to treatment are critical for the increase of HIV-testing in South Africa. Community members who know HIV-positive patients who did not receive the proper care and treatment due to their HIV-status will be less likely to seek to know their own HIV-status. According to Nyblade the benefits of HIV-testing are not currently seen to outweigh the drawbacks of knowing one’s status (Nyblade et al. 2009).

3.7 Summary
The voluntary counselling and testing protocols provided by the WHO, UNAIDS and the South African government are embedded in a human rights approach that attempts to protect the individual’s human rights and dignity in order to mitigate HIV/AIDS disease stigma and discrimination. Despite the significant strides that have been made to increase the accessibility and availability of voluntary counselling and testing, research reveals that a substantial number
of people remain reluctant to test due to the fear of a lack of confidentiality, stigma, discrimination, fear, belief systems, education level and lack of knowledge of HIV/AIDS transmission and prevention. This suggests that there is a need for further research in South Africa at a local level to identify the personal, workplace, family, social and community factors that either inhibit or facilitate South African individuals volunteering for HIV-testing.


Chapter Four

CONTEXTUALISING A RESPONSE TO HIV/AIDS AND VOLUNTARY COUNSELLING AND TESTING

4.1 Introduction
In this chapter the researcher looks at the responses to the HIV/AIDS pandemic and comments on their effectiveness. While much has been done to prevent the spread of the HIV/AIDS pandemic and to render services to those infected and affected by HIV/AIDS, there remain concerns about the desired impact of these interventions. This has resulted in calls from the global community (UNAIDS 1999; UNAIDS 2007) and South Africa (South African Government, DoH 2007a) for a more integrated and holistic approach to combat HIV/AIDS. An integrated approach recognises the multifaceted nature of the HIV/AIDS pandemic and its impact on individuals, communities, and countries. The researcher provides an overview of The Health Belief Model, The Theory of Planned Behaviour, and The Stages of Change Theory which have been used to develop HIV/AIDS interventions and thereafter briefly discusses the contributions and limitations of these models.

In order to attain greater insight into behaviour associated with VCT and the call for an integrated approach to the understanding thereof, Ken Wilber’s (2001) four-quadrant framework was selected. This is explained in this chapter and expanded upon in both Chapter 5 and 6.

4.2 Initial response to the HIV/AIDS pandemic
Once the World Health Organisation (WHO) recognised that HIV/AIDS would affect the global population it began to strategise as to the best way to combat the growth of this disease, in order to meet its mandate to protect global health (WHO 2003a). This resulted in the WHO initiating the Global Programme on AIDS to contain the pandemic in the 1980’s and 1990’s (Barnett & Whiteside 2006). The WHO adopted a series of “Short Term Programmes’ and ‘Medium Term Programmes’ in an effort to contain the pandemic (WHO 2003a). These HIV/AIDS programmes
were exported from Geneva to the countries of Africa, Asia and Latin America (Barnett & Whiteside 2006). Further, these programmes represented the best experience and thinking of health experts (Barnett & Whiteside 2006) and were based on knowledge of the modes of HIV/AIDS transmission, as well as on past experience of epidemics and motivated by urgency to react to a crisis and the need for economic sustainability.

HIV/AIDS is a disease transmitted through exposure to infected blood and unprotected sexual intercourse (WHO 2003a). HIV/AIDS programme managers, working anywhere in the world needed to be acquainted with the details of the local sexual culture in order to implement effective programmes. The tools used to gather this information were known as *Knowledge, Attitude and Practise* studies (KAP) (Barnett & Whiteside 2006). Information from such studies enabled programme managers to adapt general programmes designed by the WHO so that they could find acceptance in the local culture (WHO 2003a). However it was soon recognised that what really mattered was how people acted and reacted to HIV/AIDS. This led to expanding these KAP studies to include a focus on behaviour. ‘B’ for ‘Behaviour’ was subsequently added to the studies which became known as *Knowledge, Attitude Practise and Behaviour* studies [KAPB] (Barnett & Whiteside 2006). The programmes that were developed based on the information provided by the KAPB studies were firmly based on the tradition of individualistic psychology with the emphasis on three main theories (Denison 1996), the Health Belief Model (Hochbaum, Rosenstock & Kegels 1952 in Airhihenbuwa & Obregon 2000), the Theory of Planned Behaviour (Ajzen 1991), and the Stages of Change Theory (Fishbein & Guinan 1996).

### 4.2.1 The Health Belief Model

Hochbaum, Rosenstock and Kegels (Airhihenbuwa & Obregon 2000) developed the Health Belief Model in the 1950’s. It is a psychological model that attempts to predict individuals’ responses to the availability of testing and screening and other preventative health services.

According to the Health Belief Model, the likelihood that someone will adopt or continue to engage in health protective behaviour is primarily a function of two factors (Fishbein & Guinan 1996). First, the individual must feel personally threatened by the disease, i.e., he/she must feel personally susceptible to or at risk for a disease with serious or severe consequences. Second, the
individual must believe that the benefits of taking the preventative action outweigh the perceived barriers to and/or costs of taking that action (Amaro 1995). For example the costs and benefits of performing one behaviour, such as always using a condom for vaginal sex with one's spouse, may be very different from those associated with performing another behaviour, such as always using a condom for vaginal or anal sex with an occasional partner (Fishbein & Guinan 1996).

According to Denison (1996) using the Health Belief Model to effect behaviour change to prevent new cases of HIV-infection met with certain challenges. As a psychological model it does not take into consideration environmental or economic factors that may influence health behaviours. In addition the Health Belief Model does not incorporate the influence of social norms and peer pressure on individual’s decisions regarding their health behaviours (Denison 1996). Barriers to taking action may not, therefore, be due to individuals personal choices but rather the context and circumstances they find themselves in (UNAIDS 1999).

4.2.2 The Theory of Planned Behaviour
Fishbein and Ajen formulated the Theory of Reasoned Action, later expanded to include perceived behavioural control, now referred to as the Theory of Planned Behaviour (Fishbein & Guinan 1996). It is based on the assumption that behaviour can be predicted because it can be deliberate and planned (Ajzen 1991). In practice this would imply that human beings are usually quite rational and make systematic use of information available to them (UNAIDS 1999). The Theory of Planned Behaviour is conceptually similar to the Health Belief Model but adds the construct of behavioural intention as a determinant of health behaviour (Denison 1996). Individuals, after experiencing cues to action, may move into intention to change behaviour and then behave according to their intentions. For example: “I will use a condom the next time I have sex” (Ajzen 1991).

According to the Theory of Planned Behaviour, performance or non-performance of a given behaviour is primarily determined by the strength of an individual's intention to perform (or not to perform) that behaviour, where intention is defined as the subjective likelihood that one will perform (or try to perform) the behaviour in question (Fishbein & Guinan 1996). The intention to perform a given behaviour is, in turn, viewed as a function of two basic factors: the individual's
attitude towards performing the behaviour (i.e. one's overall positive or negative feeling with respect to personally performing the behaviour) and/or the individual's subjective norm concerning the behaviour (i.e. the individual's perception of normative pressure to perform or not to perform the behaviour in question) (Amaro, 1995; Jemmott, Heeren, Ngwane, Hewitt, Jemmott, Shell & O’Leary 2007). Intentions are assumed to capture the motivational factors that influence a given behaviour and are indications of how hard individuals are willing to try or how much of an effort they are planning to exert in order to perform the behaviour (Denison 1996). As a general rule, the stronger the intention to engage in the behaviour, the more likely it is that it will be actualised (Ajzen 1991). It should be clear, however, that a behavioural intention can find expression in behaviour only if the behaviour in question is under volitional control, i.e., if the individual can decide at will to perform or not perform the behaviour (Ajzen 1991). Although some behaviour may in fact meet this requirement quite well, the performance of most behaviour depends at least to some degree on such non-motivational factors as the availability of opportunities and resources, for example: time, money, skills and cooperation of others. Collectively, these factors represent an individual's actual control over the behaviour (Fishbein & Guinan 1996). To the extent that an individual has the required opportunities and resources, and intends to perform the behaviour, he or she should succeed in doing so (Ajzen 1991).

The Theory of Planned Behaviour also considers the social influences on attitudes towards the behaviour in question (subjective norms). Attitudes are viewed as a function of behavioural belief (i.e. belief that performing the behaviour will lead to certain outcomes) and their evaluative aspects (i.e. the evaluation of these outcomes). Subjective norms are viewed as a function of normative beliefs (i.e. beliefs that a specific individual or group thinks one should or should not perform the behaviour in question) and motivations to comply (i.e. the degree to which, in general, one wants or does not want to do what the referent thinks one should do) (Fishbein & Guinan 1996).

Generally, the more one believes that performing the behaviour will lead to positive outcomes or will prevent negative outcomes; the more favourable one's attitude will be towards performing the behaviour. Similarly, the more one believes that specific referents (i.e. individuals or groups) think that one should or should not perform the behaviour, and the more one is motivated to
comply with those referents, the stronger will be the perceived pressure (i.e. the subjective norm) to perform or not to perform that behaviour (Fishbein & Guinan 1996).

While both theories focus on the perceived susceptibility and benefits as well as constraints to changing behaviour, the Theory of Planned Behaviour specifically focuses on the role of personal intention in determining whether behaviour will occur (Denison 1996). Therefore, in terms of the Theory of Planned Behaviour an individual’s intention is a function of two basic determinants: an attitude (towards behaviour) and social influence (i.e. subjective norms) (Fishbein & Guinan 1996). Thus, interventions using this theory, would guide individuals to focus on their attitude towards risk reduction in response to social norms with the intention to change risky behaviour (UNAIDS 1999; Jemmott et al. 2007). For example, individuals may start to use condoms if they take up the attitude that “to have sex with condoms is as fulfilling as sex without condoms,” which is then augmented by the normative belief that most of their peers are using condoms (Fishbein & Guinan 1996). Normative beliefs play a central role in the theory. Interventions based on this theory include activities which focus on attitudes about risk reduction, responses to social norms, and intentions to change risky behaviours (Jemmott et al. 2007; UNAIDS 1999). Perhaps the main limitations of the Theory of Planned Behaviour are its failure to consider the role of environmental and structural issues and the linearity (step by step process) components of the theory (Denison 1996). Issues that all impact on the spread of HIV/AIDS but are not considered by this theory are; gender inequality within communities; the individuals’ cultural values and mores; the level of poverty experienced by individuals; the political stability of the area and access and availability of health care services (Denison 1996; UNAIDS 2008).

There is evidence (Fishbein & Guinan 1996) that in a supportive environment, with understanding, motivation and intention, individuals can and do change their behaviour. However, if individuals’ situations change or their motivation, understanding and intention shift, then they may revert to former behaviour patterns (Fishbein & Guinan 1996). This aspect of human behaviour is acknowledged in the Stages of Change Theory.
4.2.3 The Stages of Change Theory

The Stages of Change Theory was originally developed by James Prochaska and Carlo DiClemente (O’Reilly & Higgens 1991; de Zoysa 1995 in UNAIDS 1999) early in the 1970’s and 1980’s specifically for the cessation of smoking. It proposes five stages that individuals or groups pass through when changing behaviour with an additional sixth stage: pre-contemplation, contemplation, preparation, action, maintenance and relapse.

According to the Stages of Change Theory, adoption of a new behaviour may involve five distinct stages of change including the possibility of the sixth stage, that of relapse (O’Reilly & Higgens 1991). Many individuals who are performing risky behaviour may have no intention to change that behaviour or to adopt a given preventive health behaviour (pre-contemplative stage). Any one of several events, for example, perceiving that one is personally at risk of an illness, may lead an individual to consider change and perhaps to form an intention to adopt the behaviour immediately or at some time in the future (i.e. contemplative stage) (Fishbein & Guinan 1996). This immediate intention is often accompanied by initial exploratory attempts to adopt the behaviour (i.e. preparation or readiness for action stage). Then the new behaviour is adopted (i.e. action stage), and ultimately it becomes a routine part of one’s life (i.e. maintenance stage) (Airhihenbuwa & Obregon 2000; Fishbein & Guinan 1996).

Movement through the stages is assumed to be sequential, although people may skip certain stages or relapse (at any stage) and cycle back through the stages repeatedly before achieving long-term maintenance (Denison 1996). According to the Stages of Change Theory for people to change their behaviour they should first determine where they are with reference to the continuum of behaviour change, and then develop interventions to assist them move to a subsequent, more advanced stage (Fishbein & Guinan 1996). The model further suggests that different behaviour change processes, such as consciousness-raising and self-reinforcement, are necessary at different stages. More specifically, it has been suggested that interventions focusing on cognitive and emotional factors will be most influential in the early stages of attempted behaviour change while action-oriented approaches will be more effective in later stages of attempted behaviour change (Fishbein & Guinan 1996; Mathews 2005).
The rationale behind "staging" people, as implied in this model, was to tailor therapy to an individual's needs at a particular point in the change process (Fishbein & Guinan 1996). As a result, the four original components of the Stages of Change Theory (pre-contemplation, contemplation, action, and maintenance) were identified and presented as a linear process of change (O’Reilly & Higgens 1991). Since then a fifth stage (preparation for action) has been incorporated into the theory as well as ten processes that help predict and motivate individual movement across stages (Denison 1996; O’Reilly & Higgens 1991). In addition, the stages are no longer considered to be linear; rather, they are components of a cyclical process that varies for each individual (O’Reilly & Higgens 1991).

As a psychological theory, the Stages of Change Theory focuses on the individual without assessing the influence that structural and environmental issues may have on a person's ability to enact behaviour change. In addition, since the Stages of Change Theory presents a descriptive rather than a causative explanation of behaviour, the relationship between stages is not always clear (Denison 1996).

Based upon these theories discussed above (Health Belief Model, Theory of Reasoned Action and The Stages of Change Model), one can identify three variables that may influence a person's intentions and behaviours:

1. The person's *perception* that he or she is personally susceptible to acquiring a given disease or illness.
2. The person's *attitude* towards performing the behaviour, which is based upon his or her beliefs about the positive and negative consequences of performing that behaviour.
3. Perceived *norms*, which include the perception that others in the community, are also changing, and that those with whom the person interacts most closely support the person's attempt to change (Fishbein & Guinan 1996).

There is growing evidence that the perceived risk of exposure to HIV (or of getting AIDS) is, in many cases, unrelated to the likelihood that one will take any given preventive action (Fishbein & Guinan 1996). Indeed, it appears that perception of risk of HIV-infection may be a necessary first step in a change process but may not be sufficient to actually bring about changes in
behaviour. Whether one does or does not change depends primarily on one's attitudes or prevalent norms (Fishbein & Guinan 1996).

The relative importance of these variables (i.e. perceptions, attitudes and norms) as determinants of intention and behaviour is expected to vary, both in relation to behaviour and the population being considered (Mathews 2005). That is, while some behaviour is determined primarily by attitudinal considerations, others are determined primarily by norms or self-efficacy (Denison 1996). Equally important is that a given intention (or behaviour) may be influenced primarily by attitudes in one population while in another primarily by norms or self-efficacy in another population (Amaro 1995). Therefore, prior to developing an intervention, it is important to determine whether, in a given population, a specific intention or behaviour is determined primarily by attitudes, norms, self-efficacy, or by two or all three of these factors (Fishbein & Guinan 1996); only then can the intervention be developed.

While the behavioural theories discussed above have been established to assist individuals with smoking cessation and responses to availability of health preventative services, they are key components of various countries’ national level HIV-prevention programmes based on the WHO and UNAIDS guidelines (Denison 1996). Despite the usefulness of these theories, it has become increasingly evident that on their own these theories do not entirely explain why some populations have higher HIV-prevalence than others or explain the complex interactions between contextual factors and individual behaviour (Barnett & Whiteside 2006; Pisani 2008). It is for these reasons that Fishbein and Guinan (1996) suggest that partnerships between behavioural scientists, public health workers/practitioners and community stakeholders are necessary for developing appropriate interventions for HIV-prevention (Fishbein & Guinan 1996). Linked to this, UNAIDS (1999) advocates the need for community and structural level programmes that would be a critical complement to these individual approaches. This fact was recognised by experts at UNAIDS, who advocated that HIV/AIDS programmes should emphasise trans-theoretical approaches that combine individual level constructs with community level projects that focus on cultural norm changing (UNAIDS 1999; Mathews 2005). This emphasis demands a transcontinental response to meld the resources, political power and technical capacity of wealthy countries with the needs and capacities of developing countries (Merson 2006; UNAIDS
2007). Such a response requires policy makers to address issues such as taboos concerning sexual behaviour, drug use, and power relations between sexes, poverty, and death (Merson 2006; Pisani 2008). However, this collective response did not materialise and what happened was that HIV/AIDS continued to engender stigma, discrimination, and denial, because of its association with marginalised groups, sexual transmission and lethality (Pisani 2008). The result was two decades of a slow and often inappropriate response still predominantly directed at individual behaviour change (Merson 2006; Pisani 2008).

4.3 Change in approach to HIV/AIDS pandemic
A unified global response was required to address the HIV/AIDS pandemic and to build on this common understanding a new global body was formed, UNAIDS (Knight 2008). On 1 January 1996, UNAIDS, the Joint United Nations Programme on HIV/AIDS opened for business (Knight 2008). The ensuing decade saw a shift away from formal, didactic, health educational methods towards participatory approaches within HIV-prevention (Barnette & Whiteside 2006). This change in practice went hand in hand with a conceptual shift away from understanding ‘sexual behaviour’ as the product of individual decisions, in favour of the concept of ‘sexuality’ as a socially negotiated phenomenon, strongly influenced by group-based social identities and more particularly, peer identities (Campbell 2003; Mathews 2005).

In 2000, world leaders set far-sighted goals to free a major portion of humanity from extreme poverty, hunger, illiteracy and disease. The origin of these targets was to be found in the international conferences and summits from the 1990’s that were compiled as the International Development Goals (UN 2005). They established targets for achieving gender equality, the empowerment of women, environmental sustainability and a global partnership for development (UN 2009). In short, they adopted a blueprint for a better world; and pledged to spare no effort in fulfilling that vision. This blueprint, the Millennium Declaration (UN 2009), was approved by all 189 Member States of the United Nations and since then the Millennium Development Goals for 2015 have been considered the road map to implement the declaration (UN 2005).

The Declaration set out a collective vision for the future; a world with less poverty, hunger and disease, greater survival prospects for mothers and their infants, education for all, equal
opportunities for women, an improved physical environment and a partnership between
developed and developing countries to achieve these objectives (UN 2005). The eight
Millennium Development Goals (MDG’s) provide a framework of time-bound targets by which
progress towards the fulfilment of the commitments in the Millennium Declaration would be
measured (UN 2009). The Declaration established 2015 as the target date for the achievement of
most of its quantifiable commitments. Half the period to this target date has now passed (UN
2009).

The HIV/AIDS pandemic has been recognised as the main obstacle in preventing this vision of
the world becoming a reality (ILO 2005a; UN 2009): it impacts on the ability of countries to
eradicate extreme poverty and hunger, as the majority of infected individuals form part of the
economically active segment of society and this has an impact on MDG 116 (UNAIDS 2008; UN
2009). Further to this, HIV/AIDS transmission from mother-to-child affects both maternal health
and child mortality that impacts on both MDG 417 and MDG 518 (UNAIDS 2008; UN 2009).
HIV/AIDS disease stigma and discrimination endanger gender equality and empowerment of
women, thus affecting the attainment of MDG 319 (UNAIDS 2008; UN 2009). Inadequate
education and health systems are further eroded as educators either become ill and health
practitioners become ill or overburdened and thus exit their workplaces, all of which has a direct
bearing on reaching MDG 220 and 621 (UNAIDS 2008; UN 2009).

International mobilisation to combat HIV/AIDS has increased substantially since the Millennium
Development Goals were established. The 2001 Declaration of Commitment on HIV/AIDS
marked the beginning of change in response to HIV/AIDS (UNGASS 2001). It was followed, in
subsequent years, by ever increasing political and financial commitment. In 2003, the WHO and
UNAIDS led the ‘3 by 5’ initiative — a global programme to increase the number of HIV-
positive individuals accessing life-saving antiretroviral drugs (UNAIDS 2004b). Major donors

16 GOAL 1: Eradicate extreme poverty and hunger
17 GOAL 4: Reduce child mortality
18 GOAL 5: Improve maternal health
19 GOAL 3: Promote gender equality and empower women
20 GOAL 2: Achieve universal primary education
21 GOAL 6: Combat HIV/AIDS, malaria and other diseases
all contributed to a dramatic global increase in the availability of highly active antiretroviral treatment (HAART) for HIV-positive individuals in many developing countries (WHO 2008a).

In September 2005, 191 United Nations Member States endorsed the ‘universal access’ goal at the High-Level Plenary Meeting of the 60th Session of the United Nations General Assembly (Knight 2008). ‘Universal access’ entails establishing an environment in which HIV/AIDS prevention, treatment, care and support interventions are available, accessible and affordable to all who need them (WHO 2008a). It covers a wide range of interventions that are aimed at individuals, households/families, communities and countries (WHO 2008a). In July 2008 at their Hokkaido, Tokyo Summit, G8 leaders reaffirmed their commitment to the ‘universal access’ goal, calling for enhanced efforts to address gender inequalities, stigma and discrimination, and to expand access to sexual and reproductive health services, especially for adolescents and most-at-risk populations (UN 2009). The continued support of global partners towards ‘universal access’ to HIV/AIDS treatment, care and support goal, highlighted commitment towards accelerated scaling up of a comprehensive package of HIV/AIDS prevention, treatment and care, and accelerated strengthening of health care systems (Knight 2008).

Efforts to scale up HIV/AIDS programmes have resulted in a wide variety of service delivery models, guidelines and tools (WHO 2008a). The WHO/UNAIDS promotes a public health approach to health service delivery (UNAIDS/WHO 2007). The foundation of this approach is the identification and implementation of HIV/AIDS prevention, treatment and care interventions to be delivered by the health sector. This includes standardisation and simplification of protocols and tools to allow broad delivery, and optimisation of financial and human resources to deliver the most appropriate and effective interventions for the greatest good for the most people (WHO 2008a).

Despite progress in expanding access to HIV/AIDS treatment, more than two out of three people in low- and middle-income countries who needed antiretroviral medications in 2007 did not receive it (UNAIDS 2008). Countries from all regions identified obstacles to increased access to

---

22 The Group of 8 formerly Group of 6 and also Group of 7 is a forum created by France in 1975 for governments of the six richest countries in the world: France; Germany; Italy; Japan; United Kingdom; United States. In 1976 Canada joined followed by Russia in 1997.
HIV/AIDS treatment programmes, including continued stigmatisation of the disease, which limits access to and use of services; unique barriers faced by marginalised groups, such as sexual minorities, sex workers, injecting drug users, indigenous peoples and women and young girls and sub-optimal coverage for children living with HIV/AIDS (WHO 2008a). In addition, the cost of ARV drugs remained a barrier to universal access in many countries (UNAIDS 2008). Even though countries have adapted, changed or up-scaled their HIV/AIDS programmes and response to the pandemic, HIV/AIDS is predicted to be the major contributing force preventing many of the world’s countries from attaining the Millennium Development Goals (UN 2009).

The HIV/AIDS pandemic has long been recognised as the main presenting problem globally. Countries’, communities’ and individuals’ vulnerability to HIV-infection stems from their poverty, lack of access to education, gender inequality and undeveloped health care services (Barnette & Whiteside 2006). To address the broader structural determinants of sexual behaviour is a daunting task. Structural factors such as poverty, unemployment and gender inequality are difficult to modify, and social and political norms are slow to shift (Pisani 2008). Yet, efforts are being made to address forces such as gender inequality and poverty in innovative ways. Addressing structural determinants, particularly poverty, demands involvement of social as well as health sectors (Pisani 2008). This requires coordination and collaboration across sectors and agencies and cooperation with other social interventions (Wellings, Collumbien, Slaymaker, Singh, Hodges, Patel & Bajos 2006). Millennium Development Goal Six states that, by 2015, the world will have halted and begun to reverse the global HIV/AIDS pandemic. By making the HIV/AIDS response one of the overriding international priorities for the 21st century, world leaders acknowledged the centrality of this response to the future health and well-being of our increasingly interconnected planet (UNAIDS 2008).

4.4 South Africa’s response to HIV/AIDS

South Africa’s HIV/AIDS epidemic is defined by the Joint United Nations Programme on HIV/AIDS as a hyper-endemic epidemic — a result of the country having more than 15% of the population aged 15–49 living with HIV/AIDS (UNAIDS 2008; Shisana, et al. 2009).
A combination of historical, socio-economic and developmental factors has made and will continue to make South Africa susceptible to a severe HIV/AIDS epidemic (Whiteside & Sunter 2000). These factors due in part to apartheid, migrant labour patterns and high levels of poverty include disrupted family and communal life; the low status of women in society and the high prevalence of violence against women; resistance to the use of condoms; social norms that do not frown on high numbers of sexual partners, especially in the case of men; high levels of other sexually transmitted infections, which increase the likelihood of the transmission of HIV/AIDS (Pembry 2006). In addition South Africa, in comparison to any other African country, has the most developed transport infrastructure which facilitates the easier spread of the virus into new communities (BER 2005).

Initially, South Africa was slow to respond to the HIV/AIDS pandemic (Pembry 2006). In October 1992, 10 years after the first scientific paper on HIV/AIDS in South Africa (Griesel & Mambo 2000 in Richter et al. 2001) was read a formal consultative process began that culminated in a national plan to deal with the HIV/AIDS epidemic. The Department of Health and the African National Congress, in partnership with representatives from labour, business, local authorities, faith- and community-based and non-governmental organisations, formed a networking structure, the National AIDS co-ordinating Committee of South Africa (NACOSA) to develop a national strategy for the country (Richter et al. 2001). It was agreed that the national strategy would be consistent with the emancipatory political agenda which was the underlying policy development at the time. Furthermore, the HIV/AIDS epidemic needed to be understood in terms of complex social, political and economic factors, inherent in South Africa’s apartheid past (Richter et al. 2001). To achieve any substantial impact on the epidemic, several factors rendering people vulnerable to all forms of health and disease, including HIV-infection, would require to be addressed (Barnette & Whiteside 2006). The national HIV/AIDS strategy was therefore based on fundamental human rights, socio-economic development (to improve the quality of life for all South Africans) and the integration of HIV/AIDS activities into the primary health care system (Richter et al. 2001).

The most rapid increase in South Africa’s HIV/AIDS prevalence took place between 1993 and 2000, during which time the country was distracted by major political changes (Richter et al. 2001).
While the attention of the South African people and the world's media was focused on the political and social changes occurring in the country, HIV/AIDS was rapidly becoming more widespread. Although the results of these political changes were positive, the spread of the HIV/AIDS virus was not given the attention that it deserved; neither was its pervasiveness acknowledged (Pembry 2006).

In 1994 the Minister for Health accepted the basis of the NACOSA strategy as the foundation of the government's HIV/AIDS plan (Richter et al. 2001). There was criticism of this plan, as however well intended, it was poorly thought-out and disorganised (Pembry 2006). The AIDS programme was too ambitious and had insufficient financial, institutional and human resources to meet its goals (Whiteside & Sunter 2000). In 2000 the Department of Health outlined a new five-year strategy called the HIV/AIDS & STDs Strategic Plan for 2000-2005. A National AIDS Council was set up to oversee the NSP 2000-2005 and coordinate the country’s response to HIV/AIDS (Pembry 2006). A great deal of pressure was brought to bear on the South African government by the global community and the Treatment Action Campaign in an attempt to persuade the South African government to follow Brazil’s lead in providing antiretroviral drugs to HIV-positive individuals in South Africa (Barnette & Whiteside 2006).

In 2003 the decision was made by national government to roll out antiretroviral treatment for HIV-positive individuals through public health facilities in South Africa (South African Government, DoH 2004). The comprehensive HIV/AIDS care, management and treatment plan was implemented in April 2004 (South African Government, DoH 2004). This rollout plan was a welcome change after the resistance shown by the South African government to provide HIV-positive South Africans with access to these drugs. Now those who are HIV-positive can access life-saving treatment and individuals who volunteer for HIV-testing will have immediate access to treatment, care and support. At last volunteering for HIV-testing to ascertain one’s HIV-status has a real health-seeking benefit in the availability of treatment and expanded care and support (South African Government, DoH 2004). It was hoped that as a result of the national rollout of ARV’s there would be a significant increase in the use of voluntary counselling and testing services.
In March 2007, following extensive consultation with civil society and other stakeholders, the South African government released the National Strategic Plan (NSP) 2007-2011 (South African Government, DoH 2007a). The two major goals of the NSP are to reduce the incidence of HIV/AIDS by 50% by 2011 and to ensure that at least 80% of those eligible for antiretroviral treatment (HAART) have access to it (Shisana et al. 2009).

South Africa only constitutes 0.7% of the world's population yet it accounted for 17% (about 5.5 million people) of the global burden of HIV/AIDS infection in 2007 (UNAIDS 2009). The number of South African individuals who know their HIV/AIDS status is growing but it is still far from sufficient for voluntary counselling and testing to fulfil its function in HIV/AIDS transmission and prevention, as well as in HIV/AIDS disease progression prevention. This inability to fulfil the goal envisioned by the NSP 2007-2011 is evidenced by the continued high prevalence rate, 15.3-18-4% of South Africans aged 25-49 (Shisana et al. 2009), and the fact that most adult South Africans are dying in the economically active period of their lives. Mean life expectancy in South Africa is 48.4 years for men and 51.6 years for women (Abdool Karim et al. 2009).

Keeping to the emancipatory and human rights-based approach, the South African government responded with a body of labour legislation to ensure non-discrimination, fair treatment of persons with HIV/AIDS and a safe working environment (Reed 2005). It also published the ‘Code of Good Practice on Key Aspects of HIV/AIDS and Employment’ to guide workplace policies and programmes (Barnett & Whiteside 2006). South African trade union federations are active and vocal at national level and COSATU, the umbrella union body, developed guidelines for shop stewards as well as forming alliances with non-governmental organisations (NGOs) to assist employees and their family members (Mapolisa & Stevens 2003). Individual trade unions like the National Union of Mineworkers (NUM) and the South African Clothing and Textile Workers’ Union (SACTWU) have actively engaged employers on the issue of HIV/AIDS (Bisseker 2001; Meeson 2000; Petros 2003 in Bowler 2007).

The latest South African National HIV/AIDS Prevalence, Incidence, Behaviour and Communication Survey 2008 conducted by the HSRC (Shisana et al. 2009) found that there are
still challenges to overcome if the country is to meet targets set out in the NSP 2007-2011. In spite of non-discriminatory legislation and the national roll out of antiretroviral treatment there is still no significant decrease in prevalence across all age groups. A coordinated, concerted and intensive effort to complement and sustain HIV/AIDS programmes would be needed to bring about change. The HSRC survey identified efforts that focussed on the key drivers of the epidemic, and interventions to target particular issues relevant to each province. Furthermore, communication programmes need to expand their reach and intensify their messages (Shisana et al. 2009).

The challenges identified by the HSRC survey (Shisana et al. 2009) include:

- The high level of HIV/AIDS prevalence among females aged 25-29 is persistent, and has been at a level of 33% over the period of three National surveys conducted by the HSRC.
- Intergenerational sex has increased substantively among female teenagers aged 15-19, which exposes them to a group of older males with a higher HIV/AIDS prevalence.
- Having many sexual partners increases the risk of exposure to HIV/AIDS, and this high-risk practice has increased markedly between 2002 and 2008. Among males aged 15-49 having more than one sexual partner in the past year increased from 9.4% in 2002 to 19.3% in 2008 whilst among females the increase was from 1.6% to 3.7%.
- HIV/AIDS prevalence levels among adults aged 15-49 has increased between 2002 and 2008 among populations of KwaZulu-Natal by 10.1% and in the Eastern Cape by 5.0%. Smaller increases were noted in North West, Mpumalanga, and Limpopo.
- HIV/AIDS prevention knowledge has declined among the age cohort 15-49 years at national level, from 64.4% in 2005 to 44.8% in 2008, and has also declined in the Eastern Cape, KwaZulu-Natal, North West, Gauteng, Mpumalanga, and Limpopo.

Therefore it can be deduced that South Africa still carries a disproportionately high burden of disease in spite of coordinated national planning and comprehensive National Surveys investigating HIV/AIDS prevalence and legislation that protects individuals with HIV/AIDS from discrimination.
In order to stem the tide of the HIV/AIDS epidemic South Africa needs to overcome these challenges. Action is required particularly in the area of gender inequality (du Plessis 2008; Maman et al. 2001), poverty alleviation (Barnett & Whiteside 2006), effective health care and HIV/AIDS education (Shisana et al. 2009).

4.5 The voluntary counselling and testing dilemma
HIV/AIDS infection does not immediately manifest itself to infected individuals or others and it often goes undetected and infected individuals may unknowingly infect others (Abdool Karim et al. 2009). This emphasises the importance of voluntary counselling and testing to confirm an individual’s HIV-status. If the individual is found to be positive then a process of supportive assistance in the management of the disease can be implemented. In addition, HIV-testing needs to reach more individuals because it is an essential entry point to HAART treatment programmes (Abdool Karim et al. 2009).

The most important aspect of voluntary counselling and testing is its primary preventative role and function which is to reduce the spread of the disease. This preventative function is described in two ways. Firstly, voluntary counselling and testing is seen to be preventative in terms of inhibiting and/or preventing the spread of HIV/AIDS among people. Thus, the direct benefit of promoting HIV/AIDS counselling and testing is its primary role of preventing the spread of HIV/AIDS (Loeto 2008). The secondary preventative function of voluntary counselling and testing is to prevent HIV-positive individuals transmitting the virus to others and the preclusion of further illness in people who are diagnosed as HIV-positive (Leach-Lemons & Owuor 2009). This is directly related to early detection of HIV/AIDS and health promotion (Abdool Karim et al. 2009; Leach-Lemons & Owuor 2009; Solomon et al. 2004). Voluntary counselling and testing serves as an early HIV/AIDS detection service and an entry-point into treatment and care thus promoting health and prolonging life (Nyblade et al. 2009; Solomon et al. 2004).

While voluntary counselling and testing programmes are regarded worldwide as an important strategy in the prevention of new infections and management of the HIV/AIDS pandemic, VCT has experienced various problems and barriers, which limit its success (Peltzer et al. 2009; van Dyk & van Dyk 2003). These barriers to voluntary counselling and testing may relate to
problems with facilities and services, or to psychosocial obstacles, such as the fear of breaches of confidentiality, social ostracism, disclosure of HIV-status, and the inability to handle the psychological turmoil of an HIV-positive test result (Nyblade et al. 2009). In addition, feelings of fatalism and a lack of incentives for knowing one’s HIV-status negatively impact on people’s willingness to participate in voluntary counselling and testing programmes, in this way impacting on the efficacy of such programmes (van Dyk & van Dyk 2003; Swanapoel 2006).

Identifying barriers to voluntary counselling and testing becomes imperative if VCT is to affect HIV-positive individuals and limit the further spread of the epidemic in South Africa. It is for these reasons a HSRC survey (Shisana et al. 2009) placed emphasis on the need for efforts to focus on key drivers of the epidemic in each province of South Africa. In the light of the voluntary counselling and testing dilemma it has become critical also to understand and identify barriers to the uptake of HIV-testing, not only in each province, but also with regard to specific target groups. It is therefore time to act with greater urgency upon the call by world leaders and organisations for an integrated and holistic understanding of behaviours relating to HIV/AIDS and voluntary counselling and testing in an attempt to prevent further spread of the epidemic.

In response to this urgency, the researcher has undertaken to investigate factors that respectively facilitate or inhibit HIV-testing behaviour in individuals employed in a workplace in the Nelson Mandela Metropolitan area in order to explore perceptions, attitudes and norms prevalent within this target group. Ken Wilber’s Integral Framework (2001) was selected for the analysis of the data gathered by this investigation for two main reasons: firstly, there is a steady growing number of researchers23 who have contributed to insights into various phenomena using this framework1, and secondly, major research projects and surveys such as UNAIDS (1999), Mathews (2005) Merson (2006) and the HSRC (Shisana et al. 2009) have emphasised a need for an integral approach.

Literature on the topic indicates a growing emphasis on qualitative research using smaller or specific target groups to enable a greater depth of analysis, irrespective of the challenges presented by using this research methodology. It is also the researcher’s view that a key lesson from three decades of responding to the HIV/AIDS pandemic is the importance of understanding the main drivers and risk factors associated not only at local and country level, as maintained by Abdool Karim et al. (2009), but also specific to clearly demarcated target groups. The aim of the larger research for which this study serves as a pilot project is to add to existing insights into the factors that inhibit or facilitate HIV-testing through the use of Wilber’s Integral Framework as an analytical tool.

4.6 The Integral Framework
Integral Theory, developed by Ken Wilber, is an over-arching model of human and social development that attempts to incorporate all approaches to development into its explanatory framework (Wilber 2001). He has called this theoretical construct AQAL; all quadrants, all levels, all lines, all states, and all types (Esbjörn-Hargens 2009). This construct draws on ideas of development and change from many different cultural sources: traditional, modern and post-modern spheres; the natural and social sciences and Eastern and Western philosophies across all cultures to propose a general framework or construct that can be used to consider development within the personal and social domains. Thus Integral Theory can be applied to a very wide range of social settings which is why it was chosen for the larger study (Cacioppe & Edwards 2005; Esbjörn-Hargens 2006; Esbjörn-Hargens & Zimmerman 2009; Larkin 2005).

The foundation for the AQAL Model is the four-quadrant framework which incorporates four irreducible perspectives, namely subjective, inter-subjective, and objective and inter-objective that must be consulted when attempting fully to understand any issue or aspect of reality (Esbjörn-Hargens 2006). This is the only part of the AQAL Model that the researcher is utilising in this study. These perspectives are presented as four quadrants with each quadrant representing a different dimension of reality. These dimensions of reality are actual aspects of the world, which are always present in each moment. For instance, all individuals have some form of subjective experience and intentionality (referred to as interiors) as well as various observable
behaviours and physiological components (referred to as exteriors) (Esbjörn-Hargens & Zimmerman 2009). In addition, individuals are members of groups or collectives. The interiors of collectives are known generally as inter-subjective cultural realities (i.e. with reference to their characteristic language, histories, stories values and mores) (Brown 2005). Exteriors of collectives, referred to as ecological and social systems, are characterised by inter-objective dynamics and manifest in the form of political systems, policies, laws and infrastructure (Brown 2005; Esbjörn-Hargens & Zimmerman 2009; Larkin 2005).

Wilber observes that a fundamental distinguishing feature of our modern period is the differentiation of cultural value spheres, described as the following realms: the individual, depicted as “I”; culture represented by the notion of “We”; nature, indicated as “It” and society, referred to as “Its” (Wilber 2001). These four dimensions of reality are depicted within the framework as quadrants where “I” represents the Upper Left (UL), “We” the Lower Left (LL), “It” the Upper Right (UR), and “Its” the Lower Right (LR) (Wilber, 2001). In effect, these quadrants express recognition of two fundamental distinctions during analysis: an ‘inside’ and an ‘outside’ perspective, and a ‘singular’ and ‘plural’ perspective (Brown 2005; Esbjörn-Hargens 2009; Hochachka 2006).

On their simplest level, quadrants acknowledge that there is an ‘inside’ (interior) and an ‘outside’ (exterior) to individuals and collectives. Individuals have an interior no-one else can enter, for example individuals’ thoughts, feelings and self-awareness. Similarly, individuals have an exterior, which others can experience, for example physical body and behaviour. With reference to collectives, there is also an interior, such as shared values, relationships, customs, morals, and communication as well as an exterior, such as economic and political systems and habitats. Essentially, the Right Quadrants (i.e. behaviour and systems) examine the exteriors of individuals and collectives, while the Left Quadrants (consciousness and culture) look into their interiors (Brown 2005; Hessler-Key & Wood 2009; Larkin 2005).

As noted above, there are at least two ways to depict and use the quadrant model: as dimensions or as perspectives. The first, a perspectives approach, depicts an individual situated in the centre of the quadrants. The arrows point from individuals towards the various realities that individuals
can perceive as a result of their own embodied awareness (Brown 2005; Hessler-Key & Wood 2009; Larkin 2005). Through individuals’ use of different aspects of their own awareness, or through formal methods based on these dimensions of awareness, they are able to encounter these different realities in a direct and knowable fashion. In brief, individuals have direct access to experiential, behavioural, cultural, and social/systemic aspects of reality because these are actual dimensions of their own existence. This is useful to them because it empowers individuals to notice, acknowledge and interact more effectively with their world (Brown 2005). In short, the more of these “channels” they have open the more information individuals will be able to obtain about what is happening around them and they will be able to feel and act in ways that are timely and insightful (Brown 2005; Esbjörn-Hargens 2009; Larkin 2005).

A second way to represent the quadrant model is as four ways of seeing. In this approach the different perspectives associated with each quadrant are directed at a particular reality, which is placed in the centre of the quadrants (Brown 2005; Esbjörn-Hargens 2009; Larkin 2005). In sum, the quadrants highlight four irreducible dimensions that all individuals have and in addition refer to the four fundamental perspectives that can be taken on any phenomena. In either case, the four quadrants are implicated in each other. This understanding is useful because it honours the complexity of reality in a way that allows a developmental practitioner to address problems in a more skilful and nuanced way. Furthermore, the quadrants represent the natural ways in which reality is experienced by individuals in each moment, and at the same time can represent the most common ways we can and often do look at reality in order to understand it (Larkin 2005; Brown 2006). See Figure 4.1 below:
### Figure 4.1: Wilber’s Four-Quadrant Framework (Wilber 2001)

| INDIVIDUAL | INTERIOR | Terrain of experiences | The subjective realities of any being at all levels of its perception | Known by felt-experience |
| I | IT | WE | COLLECTIVE |
| | | | **EXTERIOR** |
| | | Terrain of behaviours | The objective realities of any being at all levels of its organisation | Known by observation |
| | | | Terrain of culture | The intersubjective realities of any being at all levels of its communion | Known by mutual resonance |
| | | | Terrain of systems | The interobjective realities of any being at all levels of its intersection | Known by systemic analysis |

#### 4.6.1 Upper Left Quadrant: ‘I’ — Self (Psychology and Worldviews)

The Upper Left Quadrant is the subjective, internal reality of an individual. It is the individual’s interior area of cognitive, psychological and spiritual development (Hessler-Key & Wood 2009). This quadrant concerns the inner development of people, recognising that no substantive change is possible without a prior change in consciousness, for example the self-perception of risk in contracting HIV/AIDS (Brown 2006). Contextually it maps an individual’s intrapersonal consciousness; intentions; personal values; attitude; commitment; cognitive; emotional; spiritual; moral; cognitive capacity; depth of responsibility; degree of care for others and the environment (Hessler-Key & Wood 2009; Hochachka 2006).

#### 4.6.2 Upper Right Quadrant: ‘It’ — Behaviours (Individual Practises and Actions)

The Upper Right Quadrant has to do with the individual and external aspects of change. This is the domain of the individual exterior (IT), which includes technical and interpersonal skills as
well as the science, physiology, neurology, and psychology of behaviour, focusing on the physical, objective reality of an individual, the brain and the organism (Brown 2006). Contextually it maps an individual’s physical health; intentional behaviour; skills; capabilities; actions (Hessler-Key & Wood 2009; Hochachka 2006).

4.6.3 Lower Left Quadrant: ‘We’ — Culture (Traditions and Social Norms)
The Lower Left Quadrant deals with the collective and internal aspects of change. This is the domain of culture. It is the collective interior of an individual’s culture and worldview or the inter-subjective, internal reality of groups, which is often the hidden territory of an individual’s shared assumptions and images that direct what happens when individuals come together to form a group (Brown 2006). Contextually it maps the shared values and worldviews; shared meaning; cultural norms and mores; language; customs; stories; symbolism and agreed upon ethics of individuals (Cacioppe & Edwards 2005; Hochachka 2006).

4.6.4 Lower Right Quadrant: ‘Its’ — Systems (Social, Political, Economic, Ecological)
The Lower Right Quadrant has to do with the collective and external aspects of change, the social, technical, organisational system. It is the quadrant of organisational design, technology, workflow, policies and procedures (Hochachka 2006). This is the domain of the individual’s collective exterior (WE), the physical, inter-objective reality of groups and nature, in other words, the social system and environment where individuals find themselves (Brown 2006). Contextually it maps an individual’s visible societal structures; systems and modes of production; economic; political; social; informational; educational, and technological strategies; policies; measures; work processes; technologies and natural environment (Esbjörn-Hargens 2009; Hochachka 2006).

Each of these quadrants is related to the others. Development of one quadrant is inextricably bound up with all the others as shown by these few examples:

- Individual consciousness affects physiology and vice versa.
- Culture stimulates or hampers individual behaviour and development and vice versa.
- Organisational structure shapes culture and vice versa, which defines the opportunities people have for self-expression and growth.
Consciousness shapes and guides the design of the system and vice versa. Each quadrant affects all the others. Each is powerful. Ignoring any one of them can lead to haphazard results in our attempt to understand any behaviour (Brown 2006).

The four-quadrant framework, adapted from the work of Ken Wilber (2001), is an analytical tool that can be used to explore the relationship between intentions and values, on the one hand, and actions on the other hand. It does so at both the individual and collective levels. It is possible to gain a deeper, more profound understanding of the South African HIV/AIDS epidemic and HIV-testing by identifying, analysing and reviewing the causes and origins of actions.

The degree of collective care, compassion and respect or disregard, stigma and avoidance with which a culture views a problem like HIV/AIDS directly affects the way a member of that culture views the problem (UL). This view, in turn, influences an individual’s behaviour (UR) (Hochachka 2006). Thus, the many forces arising from the culture complement those arising from individual consciousness and behaviour as well as those that arise from systems, and together they affect the cause and cure of social, environmental and economic problems (Hochachka 2006). With this awareness, a Public Health Practitioner or HIV/AIDS Programme Implementer either counters or encourages these Lower Left Quadrant forces to help collectives achieve their goals (Brown 2005).

Placing current responses to HIV-testing from respondents in research studies (de Saxe Zerden et al. 2005; Hutchinson & Mahlalela 2006; Loeto 2008; Maman et al. 2001; Solomon et al. 2004; van Wyk & van Wyk 2003) in their respective quadrants creates the possibility of a deeper understanding of the interrelationships among intentions, values and actions (See Figure 4.2). After situating the different aspects of the respondents’ ways of seeing their reality in terms of voluntary counselling and testing in the different quadrants, it may become clear that the Lower Left Quadrant (that of values on a collective level) might look empty relative to others. This shows that there is a general lack of understanding of the cultural mores and norms and a need to start addressing cultural values and beliefs before rushing to act. In this way, blaming others for certain actions can be prevented, for example an individual not volunteering for HIV-testing (Brown 2006).
### Possible barriers to voluntary counselling and testing behaviour

**INDIVIDUAL**
- Fear of being HIV-positive (illness & death)
- Men fear lack of ability to have sexual partners
- Women fear total rejection from partner
- Fear of family (rejection)
- Knowledge about HIV/AIDS

**COLLECTIVE**
- Fear of rejection from community
- Stigma
- Social inequality between genders
- Belief System
- Fear of being rejected by friends
- Fear of being rejected by work colleagues

**WE**
- Worldviews; Cultures & Value Systems; Stories; History

**ITS**
- Social System/Environment; Economic Systems; Policies and Procedures; Technologies

**EXTERIOR**
- Form & Organism; Behavioural; Objective; Skills, Behaviours; Performance

**Possible barriers to voluntary counselling and testing behaviour**
- Physically being unable to undergo a HIV-test
- Lack of confidentiality
- Discrimination
- Violence against women
- Accessibility to HIV-testing services
- Receiving result immediately vs. having to return a few days later to receive their results
- Availability of treatment care and support for HIV-positive individuals and their families
- Professional Health Care worker's denying HIV-positive individuals care

### Figure 4.2: Current responses to VCT from research studies

This mapping approach looks specifically at direct and indirect factors that facilitate and inhibit HIV-testing, and the factors that favour or impede achieving the best possible results for individuals, including those living with HIV/AIDS, their families, communities and countries. For example, increasing HIV-testing is about individuals changing their behaviours (Brown 2006). Yet very few responses to HIV/AIDS address the underlying individual attitudes and behaviours or the collective norms and views but focus on the availability of health care, procurements, organisations and other systemic issues (Hochachka 2006).
A key lesson from three decades of responding to the HIV/AIDS pandemic is the importance of a common understanding of the main drivers and risk factors in the HIV/AIDS epidemic at a local and country level (Abdool Karim et al. 2009). Using the integral framework as an analytical tool it is hoped to develop this common understanding.

### 4.7 Using Wilber’s Quadrants as a framework for analysis and recommendations

To reduce sexual transmission of HIV/AIDS, behaviour change programmes need to place greater emphasis on knowledge of HIV-status, avoidance of concurrent multiple partners and avoidance of large age difference partnering patterns, in addition to promotion of condoms (Abdool Karim et al. 2009). Individual interventions usually have modest effects, whereas a combination of interventions can have a synergistic outcome, especially if they achieve high coverage of the target population. The choice of which prevention methods should make up the combined intervention and the target populations for that intervention will need to be informed by a detailed understanding of the country’s HIV/AIDS epidemic (Abdool Karim et al. 2009). Due to this complex reality identified by Abdool Karim et al. (2009) faced by those working in the field of HIV/AIDS the researcher has adapted and used Ken Wilber’s quadrants as tools for creating a detailed understanding of the factors that inhibit and facilitate HIV-testing in Xhosa-speaking construction workers in the Nelson Mandela Metropolitan area of the Eastern Cape. Wilber’s quadrants can be seen as a map that facilitates the plotting of the HIV-testing territory in terms of the participants ‘I’ (interior thoughts and feelings); ‘It’ (their ability and actions); ‘We’ (cultural norms and values) and ‘Its’ (system in which they find themselves). In this way what is needed to create an environment in which HIV-testing becomes the norm can be ascertained.

### 4.8 Summary

The continued spread of HIV/AIDS and the lack of a generalised uptake of voluntary counselling and testing is not an individual’s responsibility alone. Instead it rests with the knowledge, skills and physical ability of the individual together with the culture and groups to which that individual belongs, and the overarching system in which the individual finds him/her. All these factors are inextricably linked and dictate the behaviour and the use of voluntary counselling and testing services by individuals. Both the international community and South African experts have
recognised that individuals’ contexts dictate their behaviour. The nature of the factors that respectively inhibit and facilitate HIV-testing behaviour will be mapped, utilising Ken Wilber’s Integral Framework, in order to assist in the development and design of contextually defined interventions which will positively support HIV-testing behaviour and provide a more conducive option for Xhosa-speaking construction workers in the Nelson Mandela Metropolitan area in the Eastern Cape.
**End Notes for Chapter Four**

**Larkin H. 2005.** She discusses the development of Social Work as a profession and its struggle to find a theory that adequately meets the need of social workers to assist individuals within the context of their environment. She discusses various theories that have been used in social work and its development as a profession. Larkin believes that Ken Wilber’s Integral Theory is very useful for social work as it allows for the articulation of the interior growth and development of both personal and social consciousness in interaction with one another, as well as the exterior form of these developments. She believes that Integral Theory provides a comprehensive framework in which social work can ground its own theoretical developments of practice models or techniques and research.

**Hochachka G. 2005.** Gail Hochachka discusses the use of Ken Wilber’s Integral Theory in International Development. She states that International Development is a field that bridges divergent disciplines in an attempt to deal with some of the most complex global issues facing humanity today. Many practitioners now recognise the degree to which economic, social, political, ecological, cultural, psychological and spiritual realities overlap and intertwine in International Development. Economic prosperity often depends on sustainable management of natural resources; good governance depends on the ethics and commitment for social well-being; participation of local people in development projects depends on personal empowerment. Each development issue has an interior (psychology and culture) and an exterior (behaviour and systems) that reflects the realities of individuals and groups. The quadrants provide a framework to identify and work with interior and exterior realities of individuals and groups. Quadrants also enable an integrated use of objective, intersubjective and subjective methodologies in development interventions. Hochacka’s premise is that an integral approach links interior development with finding solutions to exterior problems.

**Brown B. C. 2006.** Brown discusses the use of Ken Wilber’s Integral Theory in the United Nations Development Programme (UNDP). He concludes that the use of an integral approach facilitates understanding, managing, and responding to the complexity of the HIV/AIDS epidemic. In addition he believes that this approach is based on a comprehensive map of human psychology and culture as well as that of personal and organisational transformation. Therefore, it allows for a response to all of the challenges that the HIV/AIDS pandemic and development presents. He describes Wilber’s quadrants as a map of reality and change that enables the HIV/AIDS Group at UNDP to train leaders to better assess, strategise, communicate, and implement interventions. Further he encourages anyone involved in social, economic, political, organisational, or environmental change to use an integral approach and the Integral Framework, as these have proved effective for the HIV/AIDS Group at UNDP.

**Esbjörn-Hargens S. 2006.** Esbjörn-Hargens discusses the usefulness of the Integral Theory in the field of education. He believes that by using Wilber’s quadrants allows understanding of their own role in the classroom. For example, one has the “I” of the perceived self; the “We” of the intersubjective relationships between oneself and the students; the “It” of own actions and behaviours in class, as well as the activities one sets for students to engage in; and the “Its” of the educational system and its rules, regulations, policies, and institutional factors.
Chapter 5

DATA ANALYSIS

5.1 Introduction

This chapter provides the outcome of in-depth face-to-face interviews with twelve respondents (six male and six female). In it the researcher attempts to explore the thoughts and experiences about HIV/AIDS and voluntary counselling and testing (VCT) of South African Xhosa first-language speakers who work for a company that has implemented an HIV/AIDS workplace policy and provided basic education and awareness of HIV/AIDS transmission, prevention treatment and care within the Nelson Mandela Metropolitan area, Eastern Cape Province.

Wilber’s Four-quadrant Framework will be used for the discussion of the data (See Chapter Four). All quadrants in Wilber’s framework have equal value and facilitate the gaining of insight into the subjective, inter-subjective, objective and inter-objective realities experienced by individuals in the midst of HIV/AIDS and VCT. The value of using the quadrants lies in the opportunity it offers to examine the data through a different lens in each quadrant. Starting in the Lower Right Quadrant the discussion moves in an anti-clockwise direction through the four quadrants. The Lower Right Quadrant records information relevant to the collective exterior of the respondent’s world (i.e. social systems and environment). The Lower Left Quadrant looks at the collective interior (i.e. culture and worldview). Moving from the collective to the individual the Upper Left Quadrant is concerned with the individual interior (i.e. self and consciousness) while the Right Upper Quadrant considers the individual’s exterior (i.e. organism and behaviour).
5.2 Lower Right Quadrant

5.2.1 Collective Exterior: Social System and Environment

All four quadrants are integrally linked to each other as the experience and knowledge realised in one quadrant impacts on the world of the other three quadrants. However, this quadrant deals only with visible societal structures, the workplace, media, environment and the health care system, which form understanding of the collective exterior reality of individuals and groups.

---

<table>
<thead>
<tr>
<th>Lower Right Quadrant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Collective Exterior: Social System and Environment</strong></td>
</tr>
<tr>
<td>The physical, inter-objective reality of groups and nature</td>
</tr>
</tbody>
</table>

**Context:**
Visible societal structures; regulation; systems and modes of production (economic, political, social, informational, educational, technological); strategies; policies; measures; work processes; technologies; natural environment or geographical area

**Areas addressed by research:**
- The Government and Health Department’s activities and services regarding HIV/AIDS education, access to HIV-testing, treatment, care and support in the Nelson Mandela Metropolitan area, Eastern Cape.
- Health professionals’ maintenance of their professional code of conduct and ethics.
- The activity and impact of the media concerning HIV/AIDS.
- The respondents’ workplace and the implementation of an HIV/AIDS workplace policy and programme.
- The Labour Union’s shop stewards’ support of the HIV/AIDS workplace policy and programme, and messages to the workforce.
- Any acts of discrimination perpetuated within any of the above systems and structures.

---

**Figure 5.1 Collective Exterior: Social System and Environment**

Policies and laws govern these social structures and have an impact on individuals and groups who live and work within the society. Thus, the perceptions that individuals and groups have of the functioning of their social systems and structures, and the way these influence their lives are of vital concern to researchers in their understanding of the behaviour of individuals and groups — in this instance, HIV/AIDS and HIV-testing or voluntary counselling and testing.
5.2.2 Political system and related structures
Since 2003 there has been a major drive in the Eastern Cape Province to increase the number of voluntary counselling and testing sites and the number of professionals who are trained in VCT protocols. In addition, more lay counsellors have been trained to expand the support HIV-positive individuals and their families may receive. VCT sites are now available in nearly all of the public clinics and hospitals (South African Government, DoH 2007a). Furthermore, non-governmental and community-based organisations can offer voluntary counselling and testing, if they have received certification from the health department, ensuring that VCT is freely available and accessible to all that live in the Eastern Cape (South African Government, DoH 2007b). Respondents all knew they could access an HIV-test site "Yes anywhere really, like a clinic, a hospital, a doctor ... we can here at work also...so all over." (sic J=223-224).

5.2.3 Geographical area: Port Elizabeth townships
All respondents referred to the prevalence of HIV/AIDS within their community: "... you must not say to a person you are not welcome because they have HIV, you must not, not help a person because they have HIV. You know anyone can have HIV; they can be walking around, they can stand next to you at the funeral, they live next door ...you do not know – you must just treat people right". (sic H=393-397). The knowledge that many individuals with whom one is in contact daily are HIV-positive seems to guard against discrimination as the consequences of such behaviour are likely to leave one socially isolated: "No, they will not be like that, they will just talk, you know HIV walks among us... if they did that then they will have no one at the wedding" (sic J=300-301), and another who mentioned “…that AIDS is everywhere and it can come across your door at anytime” (sic K=126-127), implying feelings of vulnerability in the face of social isolation — a fear they would find difficult to deal with, especially if they were in the same situation.

Two older male respondents gave reasons for the continued high prevalence of HIV/AIDS in their communities. The first believed that the major drivers of HIV/AIDS were the pervasiveness of shebeens and abuse of alcohol and poverty:’’... that is how come HIV is so bad; there is too much of this. In the taverns and shebeens you see this all the time - old men and young girls who don’t have money for the alcohol or anything, and the men with the smart car and the money...
they go with these men. Now you don’t know these girls they look fine but they maybe have HIV’’ (sic L=71-76). He observed that men frequent shebeens after their evening meal where impoverished young girls and women drink alcohol with men and are willing to have sex with them: “...you know that these young girls they don’t have monies. They are there, and then these old men come and they drink there with these young girls, and then these young girls they go in their cars with them. You know it is very bad, if you see these men with these girls you will think: Ah, there is a man and his daughter” (sic L=63-68).

The other older male respondent, besides mentioning “...you get it from blood and they say sleeping with someone...” (sic E=231), also gave other reasons for the high prevalence of HIV/AIDS in his community “...I think because now not like the old days, now we all live so close together and there is no space between us” (sic E=224-226), and “... in the old days, there we lived on land, and your family was all together and then you would know everyone. Now where I live, I can pass strangers that I don’t know; and, I lived there for a long time, there are too many people where I live — we don’t have land anymore” (sic E=233-235). In his view urbanisation, the absence of family life and traditional family norms regulating sexual behaviour has contributed to the increase in HIV-infection.

5.2.4 Clinics

All but one respondent were happy with the service provided by public clinics for their health needs and care. The dissenting respondent preferred to use his own General Practitioner. Six respondents described clinics as over-burdened with long queues of people waiting. However, they all felt that the nurses would offer equal care to everyone regardless of their HIV-status: "They would treat them like everybody else that goes to the clinic, they don’t treat them any differently, I have gone with my friend and she was treated well, just like other people" (sic A=385-387). However, mention was made that those who visit clinics should not expect much empathy or sensitivity, as nurses were over-worked: “... you know, those nurses at the clinic, they see so many people and sometimes they are so rude. You are in a room and even though the door is shut, you can hear them shouting at the person. They can be so rude, but they treat everybody like that” (sic H=393-397). There seems to be an acceptance of this behaviour towards HIV-positive patients as it is applied equally to HIV-negative patients when visiting a
voluntary counselling and testing site. Thus fear of discrimination, irrespective of the behaviour of nurses who work at such sites, was not seen as an obstacle in visiting the clinic. The behaviour of the nurses was attributed to their being over-worked and not related to the HIV-status of the patient.

All respondents believed nurses would keep to their professional code of ethical conduct and therefore maintain the confidentiality of their patients, irrespective of the manner in which they interacted with them. They would, therefore, regard the HIV-status of respondents, as well as other health concerns for which they visited the clinic, as confidential. One respondent mentioned hearing nurses at local clinics who had not kept HIV/AIDS test results confidential and had informed family members of patients’ HIV-status. However, he thought this to be a rumour, as he himself had “...never actually heard (of an actual case) but it is just a rumour in my township” (sic G=181). While he personally did not believe such rumours were true, he did not deny rumours being spread in his community.

As to the truth surrounding such rumours, respondents reasoned nurses would maintain confidentiality, as “... they must and they have for me and I think people will be very angry if they do not, so I think they must” (sic D=163-164). Another respondent stated: “They must do that because then no one would go to visit clinic or hospital if everyone in Wells Estate knows this one she has HIV and this one she has what and what” (sic L =260-263).

Respondents, in general, felt that news about individuals who had HIV/AIDS was spread either because family members had told others and the word had spread, or community members had seen individuals take medication, identifying them as HIV-positive and spoke among themselves about this.

5.2.5 Access to HIV-testing and treatment
All respondents live in one of the many townships in the Nelson Mandela Metropolitan area, and when asked where the closest place for them to go for voluntary counselling and testing was, they all named their closest clinic, which was within the area in which they lived. However, a young male respondent referred to earlier, said he would prefer to consult his General
Practitioner, as he had never used the services of a clinic for health care and would therefore "...go to my personal doctor — I wouldn’t go anywhere else, because then he will care for me," (sic C=213-214). An older male respondent mentioned he had gone to test at Greenacres (Netcare private hospital), as he was familiar with it and the personnel treated all I.O.D.’s (Injuries on Duty) from his workplace there.

All respondents believe HIV-positive individuals have access to treatment, as “...we would have heard if people were not able to get the drugs" (sic C=234-236), and "...the clinic is not very far and they are giving it (i.e. drugs) to lots of people. They let you know there at the clinic if you are HIV-positive; how you are going to get your treatments and stuff. I have never heard of someone not being able to get treatment when they need it" (sic A=274-276). However, some respondents were uncertain where to find HIV/AIDS support group intervention, but they were nevertheless aware such groups exist. The reason for not knowing where to access such support is found in the following explanation “...nurses must first help the person whether they need treatment or not and then ... tell you where they (support group) are” (sic H=260-262). Some respondents believed that if one tested HIV-positive nurses would, as part of post-test counselling; inform them where to locate support groups and how to access them. Besides the availability of health and VCT services and respondents knowing how to access these, as well as where to find information they would require, health and illness is viewed as a personal issue. Most respondents did not consider it necessary to obtain knowledge about support groups, until it was required. This was evident in the behaviour of a respondent whose step-daughter disclosed her HIV-status to her “... she tell us that she is HIV and then I go to my manager because we don’t know all about this stuff but she knows so I go to her and she calls Immanuel Haven. Immanuel Haven asks her for all my details and she faxes them my details and then they come to my house and they talk with us.” (sic I=21-25).

5.2.6 Community activity (government led)
The most visible community-based HIV/AIDS awareness-raising activity named by all respondents was the World AIDS Day event. Very few were aware that this event marks World AIDS Day. It was referred to as a big event held in stadiums in December, which was organised for school children, youth, parents and students. No significance was attributed to having a
World AIDS Day other than it was HIV-related, the main reason being “...I am mostly at work, so I never go...” (sic H=90-94).

Most respondents were aware of volunteers who helped HIV-positive individuals in need. Support took the form of providing assistance with cooking, cleaning and dressing for those who were HIV-positive and lived alone. The identity of the volunteers was unknown as was the organisation for which they worked, although they all knew ”... they help you if you have HIV; they will clean your house, and they will make sure you have food to eat ... those people come and they help those that are all alone” (sic L=353-355).

5.2.7 Community-focused organisations
Three respondents have received HIV/AIDS education and training or HIV/AIDS support and care for family members from community-focused organisations. A young male respondent became a volunteer peer educator after school for a faith-based international organisation, Hope World Wide. He received training and a certificate enabling him as a volunteer to visit different high schools in his area to speak to grade 10, 11 and 12 learners about HIV/AIDS. One young female respondent received skills training during “Youth Meetings” at her church. They were taught through role-play how to manage different HIV/AIDS risk situations. She commented: “We even do acting like a play you know, practising how to be with someone who has HIV, how to be, when you are trying to make your boyfriend use a condom ... things like that” (sic J=113-115). The same respondent mentioned that on hearing she had family members who were infected with HIV she was able to use these skills to help her family members find ”...a support group for HIV people. We asked the group if we can bring our family members here to help them, ... they are trained counsellors and know much, much more than me, so we have taken our family members there and they have helped and counselled them and things are much better” (sic J=146-152). Another respondent revealed that after her step-daughter had disclosed her HIV-positive status to her and her husband, ”... we all went to Immanuel Haven and they counsel us. They told us how we can help my daughter, the food that helps her be strong, and to help with TB treatments...and then, when she is not TB, then they will check her blood and then she will maybe get other treatments for HIV” (sic l=386-389).
5.2.8 Media
All respondents mentioned hearing, seeing or reading about HIV/AIDS through different forms of media; "...when someone has seen something on TV or read in “The Sun” then we talk also" (sic D=44). This exposure to different aspects of HIV/AIDS provides important opportunities for discussion and sharing knowledge about HIV/AIDS by individuals with their colleagues, friends or family members. Thus, discussion about HIV/AIDS is taking place, prompted by different media. Articles in The Sun daily newspaper, which seems the newspaper of choice for these respondents, often led to informal discussion about HIV/AIDS and sharing of information at work.

5.2.9 Workplace intervention in a construction company
This construction company implemented their HIV/AIDS workplace policy and HIV/AIDS workplace programme in 2002. Employees received regular information regarding various aspects of HIV/AIDS during their weekly safety training, which is referred to as a ‘toolbox talk’. The company also provides access to freely available male condoms at all their different work sites. Regarding this, a respondent mentioned: "Each and every Monday we have our ‘toolbox talk’. That is when the SHE officers speak to us about our safety and, then after they talk about safety they talk about condoms" (sic J=35-37). This respondent gave details on the content of the information conveyed to them saying: "Yes, you know that we must use condoms, how to use condoms, what to do if someone is bleeding and why you must be careful of blood – things like that. Also how do you get HIV and how do you prevent it and even if you are HIV how you prevent it to be AIDS" (sic J=39-43). In addition, the construction company runs at least four campaigns annually to educate and raise awareness amongst their employees regarding HIV/AIDS and related issues. A respondent confirmed this saying: "Mmm ...yes, they come and test every year; they come and test ... the nurse comes and then if you want you can test. Then we had posters we all can draw posters about HIV and then, one of us, one of us won the prize, because it was best. They also had TB, they come and tell us all about TB, then they come and they test us for that also. But only if you want; you don’t want then you don’t have to test" (sic L15-18). Mention was also made of companies present in this particular area who organised "...soccer ... against the other companies at the stadium in Motherwell; we do that at the end of the year; it is fun really" (sic A=34-37).
Four respondents knew that the company had an HIV/AIDS workplace policy but knowledge of what it said varied. The more informed reported that: “...the policy says that if an employee is HIV-positive that employee has the right to come to work. They don’t just dismiss that person and they don’t give a different attitude towards that person or different treatment, they treat the person the same as anyone else. If you are HIV-positive or negative they treat all the persons the same. That’s the company rules” (sic G=21-26). Those who were uncertain of what exactly the policy contained were aware that it prevented discrimination and ensured that they could continue working: "I’m not quite sure about that; the only thing that I know is that they don’t let people stay away from work because of HIV/AIDS and stuff like that, because you are HIV-positive doesn’t mean that you can’t work; only if you are sick then you stay away from work. That is all I know about the policy" (sic A=19-23).

All respondents were of the opinion that their Labour Union was active in educating employees about HIV/AIDS. Emphasis was placed on employees’ rights in terms of HIV/AIDS and workplace policy indicating”... that we must not be worried, because even if you have HIV you can still work, as they can’t fire you, because you are HIV-positive. They told us there are all these laws that actually protect you if you work...” (sic C=21-25). They also knew that managers had to keep an employee’s status confidential, as “...everybody knows that they can’t do that then the union will be there for the person” (sic H=412-413). Respondents said that Labour Union representatives emphasised the importance of voluntary counselling and testing, as this would enable employees to access the treatment, care and the support they would require in maintaining their health should they test HIV-positive.

The Labour Union also encouraged employees to participate in all campaigns run by the company by ensuring they knew about these campaigns: “They always do talk to us when there is a campaign; like every year we play soccer against the other companies here at Motherwell — then they talk to everyone about HIV and then, when the poster competition.... they also speak to everyone about the HIV and everything like that” (sic H=35-41). This poster competition was an inter-company competition and some respondents knew that one of their colleagues had won this competition.
Respondents thought that the management of the company would be helpful to and supportive of those who disclosed their HIV-status. This was borne out by either personal experience of such support or through observing another employee being assisted by management.

Respondents also knew of cases where management had facilitated the referral of HIV-positive employees to organisations that could support them and their families: "They would be good to them, I know that a manager he saw someone was not good and he took him all the way to the clinic just to help and he does not just send him home but took him; he waited for him and then took him home in Motherwell. So I think they will be good, they are doing lots here for us; so they will be good, I know this." (sic J=279-283). Faith in management not discriminating against someone who was HIV-positive was expressed in the suggestion that they would be lenient towards the employee. "Ya, I think so, I think if they knew someone had HIV, they would be much more lenient, because they would feel sorry for the person and try and help him out here at work" (sic C=220-221).

5.3 Lower Left Quadrant

5.3.1 Collective Interior: Culture and Worldview

This quadrant, the lower left, deals with the inter-subjective and internal reality of groups. As respondents represent a specific socio-cultural grouping, they also share norms and values; a common understanding of gender roles and relations between genders, as well as a shared view of the world. In addition, respondents’ language, customs, stories, symbolism and agreed upon ethics also assist individuals in making meaning and sense out of learning and interaction with others and the environment.
5.3.2 Gender

As women are biologically more susceptible to HIV-infection through sexual intercourse and find themselves in unequal male-female power relationships in South Africa, HIV/AIDS has been identified as a gender defining disease. Also men have greater economic control than the majority of women in communities and households and they have assumed the role of decision-makers (de Saxe Zerden et al. 2006). Research indicates that this has led women to not volunteer for HIV-testing for fear of the reaction of their partners (Solomon et al. 2004). While respondents did not mention anything during the interview about women being more susceptible to contracting HIV, or the high prevalence of HIV/AIDS among the South African female population, some male and female respondents, reflecting on the use of condoms as a preventative measure, did mention they thought it might be difficult for a woman to persuade a man to wear a condom if he did not want to do this: "I think that for a woman you know I think it will be very difficult because she must get her man to wear a condom” (sic 1=306-307).
5.3.3 Differences in treatment between HIV-positive men and HIV-positive women
All respondents believed HIV-positive men and women were treated no differently from each other in the workplace or in their communities. Of this a respondent said: "No I have not seen that or think that, they are both sick yes — so they must both be treated well so they can keep as well as possible" (sic F=338-339). However, another respondent mentioned that she had heard ‘‘... once long time ago about this young girl, she had HIV, and her father would not let her cook for him or eat with the same plates’’ (sic H=341-343). She maintained that the father’s attitude towards his daughter and manner of dealing with her illness was related to the time when people did not know much about HIV/AIDS.

5.3.4 The family
Only one respondent said they did not discuss HIV/AIDS with members of their family. The younger respondents still living with their parents or older siblings, had received information and guidance from these family members about HIV/AIDS. Mention was made that families were concerned about prevention, and referring to his mother, a respondent said: ‘‘She is also telling my brothers and I always protect yourself you know how you can get this thing so don’t be stupid be careful. She is always telling us especially on a Friday when I go out with my friends. She has spoken a lot about it to us because she knows a lot about this thing’’ (sic C=138-142). Younger women respondents were encouraged not to ‘‘...have too many boyfriends, because this disease is killing people, and it is out there and we have seen people dying from this disease’’ (sic A=188-189). She also mentioned her mother’s warning: ‘‘You must use condoms all the time ... and have only one boyfriend’’ (sic A=194-195). Older respondents informed how they gave guidance to their married sons: "Three of my children, my sons they are married and I have said to them that they must only look straight and to their wives because HIV it is everywhere. You cannot see HIV you cannot see until someone is very sick and so you must only look to your wife and be safe" (sic L=185-188).

5.3.4.1 A Rural household vs. an urban household
All the respondents currently live in an urban environment while one respondent had moved from a rural area (Pedi) to Port Elizabeth to find employment. This respondent described her parents as conservative because they did not discuss HIV/AIDS with her or her other siblings,
"because my parents, yoh, they are so conservative, and they do not talk about these kind of things not with their children; it is not the Xhosa way. Here in town it is a little different and my brother’s not so conservative... he and his wife they say to me that we must all be careful because this thing is out there and it is killing us" (sic B=163-165).

Another young female respondent mentioned that she thought living in the Transkei or rural areas may be difficult for those who have been diagnosed with HIV/AIDS, as “...they don’t have as much information as we do or their clinics are not as good as the ones here in PE” (sic A=342-245). Those who are HIV-positive or have AIDS in the rural areas would therefore not receive the same understanding and support from their families as those living in urban areas where people are more knowledgeable about the disease and its treatment. They would also not be able to access the same treatment as those living in the city that has access to various voluntary counselling and testing (VCT) sites. Conservatism or traditionalism and/or lack of information about HIV/AIDS in the rural areas of South Africa may be reason why rural families and communities are regarded as being less understanding and supportive of persons with HIV/AIDS which increases the likelihood of discriminatory behaviour.

An older female respondent had observed direct discrimination due to lack of knowledge in a rural community:” You know our custom, when we share food and beer at our functions then they would not let a woman drink and eat from the same plate and cup because she was HIV-positive (sic K=254-256), and, “Yes, I did not know what was going on and when I spoke to her and she was crying, she told me they would not let her share, because she was HIV. Yoh, that made me worried” (sic K=261-263). This respondent was sure this behaviour would not occur in her urban community but still may occur in rural Eastern Cape “Oh I don’t think so but maybe it can happen if you go back to your family place in the Kei” (sic K=266-267).

One of the oldest male respondents said he took the opportunity of addressing his fellow male clan members when there was a ritual celebration saying “...they must look after their responsibilities it is so important today when you do not know when HIV comes across the door. I say that to them even to people of my clan that I do not know” (sic L=238-24). He also added it
was important to share his knowledge, gained through the workplace, with others who did not know what he now knew about HIV/AIDS in order to assist people.

5.3.5 Family response to an HIV-positive member
All respondents agreed that their family members would at first be shocked if one of their members disclosed that they were HIV-positive but would then support their family member to ensure the infected individual received the correct treatment and care, including moral support in the face of such a diagnosis. Commenting on the likely response from her mother a respondent stated: "Well, my mom would first be angry, because she has been telling us to be careful and here we weren’t careful, then she would support us completely — well shocked-angry — you know how a mother can get but once she is over the shock then she would support us 100%" (sic C=346-349).

5.3.6 Church (belief system)
Eight of twelve respondents belonged to a church in their community. They all said their priests/pastors spent time discussing and talking about HIV/AIDS during their sermons. "Yes they have, they speak about it a lot. They say we must be careful that it is out there and it can come onto anyone. So we must be safe as possible and condomise. They say that God loves you no matter what and the church will love you no matter what. And if you need to take treatment then you must eat them and pray to God because he will help you be strong and eat the treatments. He says that not only people that you think are bad get HIV but anyone can get it and God loves everyone so our church must love everyone and help everyone we can help because this is what God say." (sic I=127-135). Younger respondents all belonged to what they called “Youth” which they attended regularly on Tuesday evenings. These respondents spoke of how their church and youth leaders educated them, stressing "... that it is very important to differentiate between HIV and AIDS. You see HIV is a virus and AIDS is a disease so you must first understand those two different things then we can take it from there” (sic G=102-105). He said they were also advised to seek “...a support group and know how to live well, eat well and sleep well and not drink alcohol so much. If you have AIDS then you must make sure you are eating your treatments so that you do not have AIDS anymore” (sic G=107-111).
5.3.7 Church’s HIV/AIDS message
When asked what the priest/pastor focused on when talking about HIV/AIDS to the congregation it emerged that the same message was preached from different pulpits: “... *they say you must be aware of AIDS. You don’t say that you have not got it unless you have tested then you only be sure, sure so we must all go to test. Even the youth they must test as soon as you start to have sex you must be careful that AIDS is everywhere and it can come across your door at any time. So if you are not married you must condomise every time with the sex, and if you are married, then you must not look to other men and women, and you must both go for a test so that you can keep your house strong, even if you have it. You can keep strong and your house is the house of God so you must be strong because God he loves you and he will help you if you pray and do the right thing, so you must test, look after yourself and your family and, if you are HIV then you must know that God loves you and the church will help you all the way*” (sic K=123-135). Besides the message of understanding and support, church leaders also conveyed the HIV-prevention message of ABC - Abstain, Be faithful or Condomise.

5.3.8 Church’s support for HIV/AIDS affected or infected individuals
All respondents who attend church regularly spoke of the support their churches offer HIV/AIDS infected or affected individuals and families. This support is comprehensive, yet dependent on what the individual in need will accept. Money, clothes and food are collected by church members and distributed to individuals or households in need. Priests/Pastors and church leaders visit households or individuals and counsel and pray with them: “*He come to the house and he pray with us and the church they give us fruit juice and fruit for my daughter and vegetables for her also, mostly spinach to help her be strong. Then this old lady from the church she comes and she speaks with my daughter and she says to my daughter that she is HIV. My daughter and me we were so shocked that this old lady she has HIV*” (sic l=139-144). This particular respondent thought such visitations by the church have a powerful effect as it enables family members to understand that an HIV-positive person can remain healthy and strong. This respondent also mentioned how her husband had changed his perception of an HIV-positive diagnosis after listening to the elderly women who has been living with HIV for 15 years and he “...*knows now his daughter can be ok if she listen and be like the old woman*” (sic l=153-155). “Yes she said that she found out 15 years ago and she did not know how she could have got it but she had it.
Then she says to my daughter that she must be like her, she must stay strong and eat good things and do all the things that the doctor and the nurses say and she will be like her and be strong and live a long time. Yes it was too good” (sic I=146-150).

5.3.9 Friends

Only one respondent declared he had never discussed HIV/AIDS with his friends, while the other respondents regularly spoke about various aspects of HIV/AIDS with their friends.

Five female respondents all knew friends or family members who had been infected with HIV/AIDS. One of these five respondents related her experience about a friend who had died from HIV/AIDS complications: “I had a friend, she was so sick and she was in hospital and no one in her house would say she had this thing. They said she had TB. She was so thin and she had ... you know... the thing on her skin – what do you call when your skin is red and sore ... she had a rash on her skin and she was in hospital and she had TB. She finally told me she was HIV and it was very sad because she didn’t tell her mom and her family; they kept on saying that she has TB ...and then you know, she died” (sic H=302-311). Another respondent from this group also mentioned her friend’s suffering and death made her realise, “...I must know this thing and try and be safe” (sic J=195-200).

The respondents mentioned in the paragraph above had all at one time or another accompanied an HIV-positive individual to a clinic or hospital. They were acutely aware not to discuss the infected person’s status with anyone unless the HIV-positive individual gave them permission. One respondent mentioned the impact of friends becoming HIV-positive: “...we all know our status because we thought if my friend’s sister can have it any of us we can have it. Lucky we didn’t but now we talk about keeping safe always keeping safe and condoms” (sic K=162-164). Another respondent reflecting on the physical health status of her friend who is HIV-positive observed: “... she was sick now she eat her treatments and she is strong, she look like me and she is working and she looks fatter, her childrens and she is good. You see now it is better than before” (sic K=182-185).
5.3.9.1 What women discuss with their friends about HIV/AIDS
All female respondents discussed HIV/AIDS with their friends. Most discussions revolved around behaviour and how to stay safe: “We also talk about how we must always protect ourselves and use condoms especially if you do not know your partner’s status. My friends they are very responsible, I know this but you know one must always be careful because you don’t know what your partner is doing behind your back. That is why you must wear condoms” (sic H=124-129). One respondent mentioned that it was very important she share everything she learns about HIV/AIDS with her friends, including her boyfriend, as they did not have the same type of programme at their workplaces and did not receive the type of information that she did. “Yes they don’t — I am the only one who brings back the pamphlets for them and tells them what the nurses have said, they do read in the paper and then it is on TV and radio but I always tell them what the people said here at work also” (sic H=292-295).

5.3.9.2 What men discuss with their friends about HIV/AIDS
All male the respondents with one exception said that they had discussed HIV/AIDS with their friends. They discussed condom use and that one should wear a condom every time one had sex. They also discussed how important it was they did not get so drunk on a night out that they were unable to use a condom properly. "Yes we do talk to each other about these things. Man this thing it is killing us and we must try and we must have safe sex and we mustn’t have sex without a condom, you see you must have one partner because we are trying to aware ourselves and be careful about this thing because it is killing” (sic G=120-124). One respondent said that when one of their friends confessed they had not used a condom, they were encouraged to go and have an HIV-test: "Yes that worries them, the other Friday a friend got very drunk and he forgot where his condoms were; now he must have a test. And he is now so scared that he has this thing” (sic D=90-94). Older married male respondents spoke to their friends about HIV/AIDS itself: “I must talk this with my friends because I have been given this knowledge so I must be sure that my friends must know this too” (sic L=227-229).

5.3.10 Colleague discussion about HIV/AIDS
All the respondents had participated in conversations with their work colleagues about HIV/AIDS. Stimuli for these conversations were provided by workplace HIV/AIDS
interventions and stories or articles concerning HIV/AIDS in the media. Opportunities for informal discussion about HIV/AIDS were also triggered by the availability of condoms placed in boxes at strategic places in the workplace. These conversations might also include joking but seemed on the whole to be serious: "Ya, we do, especially like in our eating area there is a little box of condoms and they are always like, I am not going to say that they are making fun of it, but they are always saying things like people must come and take these condoms because they are free and then you can be safe. They do talk to show that they are aware about HIV/AIDS. We also talk when the nurses and counsellors have been because it so interesting, then talk about what they say to us. Also sometimes something happen like we see something on TV then we talk about that or there is something in 'The Sun' then we talk about that" (sic A= 53-56).

When asked what they thought their colleagues’ reaction would be if they found one of their colleagues was HIV-positive they all agreed that no one would change their behaviour towards that person. "They would be fine. We are all friends working together, we see people are sick and then they get better, we don’t treat anyone differently. We still joke and make fun like always" (sic D=216-218). Respondents mentioned that many of their colleagues had been sick and had lost weight. Everyone suspected that they had HIV/AIDS. However, the health of these individuals had improved and during the time of their illness no one had treated them differently.

Two respondents spoke of a colleague whom they thought had HIV. “There is this guy here at work and he got a rash on his skin and was sick and started to get thin. And we said to him has he gone to the doctor. And he said that the doctor said it is flu and fever. We said to him, that he must look at both sides, not just one side and that it is better to know properly what is wrong with you and you must go and have tests, tests for everything and you must test for HIV” (sic K=37-42). Both respondents felt if this man would test for HIV he would receive the help he required. Revealing their belief in the value of volunteering for HIV-testing, they also indicated they would “…be happy, because then he knows what is wrong, and we know, and then we can help him properly and I can even bring some vegetables from home and extra food to help him be strong” (K=62-64).
5.3.11 Language
All respondents spoke isiXhosa. As language is one of the most important cultural signifiers it is vital for educational campaigns designed to effect behaviour change to reflect on the way people actually talk about HIV/AIDS, in order to ensure the production of meaningful and relevant messages that are able to resonate with the target audience (Swanapoel 2006). The terminology used to describe something is often a pointer to how it is viewed in the society. The most common term for HIV/AIDS in the respondents’ communities was “that big thing” or “that thing”. Three respondents mentioned”Z3\(^{24}\)” which was used when an individual is known to be on antiretrovirals. The researcher also probed to ascertain whether the fact that HIV/AIDS has been given no name was significant or indicated avoidance. The respondents all agreed that: "It doesn’t have any meaning, they just say it and then you know what they are talking about. It doesn’t mean the bad or the good" (sic B=89-90). When HIV/AIDS was referred to in this way it is "because it is there; there are so many sick so it has become familiar to people. It is part of us; how we talk it is now part of our local language" (sic C=79-80).

5.3.12 Community attitude towards HIV-infected individuals
Respondents were asked how they believed the community would react to someone in their household who was HIV-positive. All respondents agreed that their community would gossip but would not discriminate against their family nor stigmatise them in any way. One respondent explained: "No they (community members) will just talk, they will invite you to this function, and that wedding and party and pretend that they care but when you go, they will discuss if you look sick, if you have lost weight. And they will say, that mother has a child with HIV. It is all gossip but they won’t do anything, just gossip about you." (sic A=455-459).

The high prevalence of HIV/AIDS has removed the threat of isolation through a community stigmatising or discriminating against an HIV-positive individual: "In our community, ...you cannot treat someone bad who is sick because say it comes into your house. You do not know it may come into your house tomorrow so you must treat everybody right by you. You do not know tomorrow you can get sick" (sic F=362-265).

\(^{24}\) Z3 = AZT or Azidothymidine was the first approved treatment for HIV/AIDS and a major breakthrough in HIV/AIDS therapy in the 1990’s that significantly altered the course of the illness.
All the respondents acknowledged that they were aware of stigma and discrimination against HIV/AIDS individuals in their communities in the past. Half of the respondents marked the time in the change of attitude in their community members as 2001-2003. "Back then in 2002 and 2003 there were a lot of bad things happening and before that even, even worse things I can tell even worse things" (sic G=274-275). These dates indicate events that brought about changes in the struggle against the HIV/AIDS epidemic in South Africa. These events were community activism led by the Treatment Action Campaign (TAC) in order to force the government to provide access to ARV’s for all HIV-infected South Africans. The TAC then became friends of the court in the very public ARV court case the South African government brought against the pharmaceuticals in order to enable generic ARV’s to be manufactured and made available to South Africans at an affordable price (UNAIDS 2009). “Yes, my sister she died of AIDS in 2003. But at that time we did not speak about it. No one speak about it. No one know anything about it then. She got sick and then she never got better and she never tell anyone not till she was dying and in hospital ... she tells me and my mum that she has this thing and then she died” (sic K=166-170). At the end of 2003 the South African government announced it would begin a national rollout of ARV’s to all HIV/AIDS infected individuals whose CD4 count was 200 or less (UNAIDS 2009). Before this time there was very little medical treatment available for HIV-positive individuals and community attitudes towards HIV-infected individuals seemed hostile. “Before, you know that they had the treatments, then when my friend died in 2002. I think he was scared you know of what everybody would do to him because he had it but now, now it is different” (sic J=376-378).

5.4 Upper Left Quadrant

5.4.1 Individual Interior: Self and consciousness

The Upper Left Quadrant deals with the subjective and internal reality of the individual. Each respondent’s intrapersonal consciousness, intentions, personal values, attitude, and commitment are reflected in this quadrant, and are influenced by the other three quadrants. An individual’s behaviour is directly influenced by his or her cognitive capacity, knowledge of HIV/AIDS, sense of responsibility and the degree of care for others and the environment.
5.4.2 Amount of formal education attained by respondents

The amount of formal education an individual has received has been found to influence HIV-testing behaviour (Hutchinson & Mahlalela 2006). There was a big difference in the amount of formal education respondents had received: from standard two (four years of schooling) to Matric (twelve years of schooling) and one had received a year of further tertiary training at a technical college. Research also indicates (Kalichman & Simbayi 2004) that the amount of correct HIV/AIDS knowledge individuals have about HIV/AIDS will positively influence their HIV-testing behaviour, and will compensate for the relatively low level of education attained by some respondents. The impact of an HIV/AIDS workplace programme and provision of education and awareness of HIV/AIDS is evident in the answers received from these respondents who demonstrated comprehensive knowledge and awareness about HIV/AIDS confirming the benefit of working for a company with an HIV/AIDS programme for over two years.

5.4.3 Knowledge about HIV/AIDS

All respondents knew about HIV/AIDS transmission and prevention: “...you must wear a condom especially if you do not have ... one woman and not married then you must wear a condom every time not once or twice but every time. (sic L= 83-85). This respondent also referred to the risk of HIV-infection through an injury on duty stating, “...you can be in an
accident and there is much blood and you have a cut and you get it,...” while adding, “...babies they can get it from their mums, the young people that do them drugs they can get it so anyone in the end they can get it” (sic L=290-293). In addition, respondents spoke of the different stages of HIV/AIDS and eight respondents discussed Bactrim, a drug that protects HIV-positive individuals from TB infection. "Well if you find out you have HIV like if I did now, then I am still strong. I have not had TB or anything, then I will know how to look after myself and only after much time and only when I have to then I will take the treatments and that makes me strong again, so then I won’t die. Then instead I will cross the road one day and a taxi will knock me over so you see I won’t die of AIDS but something else" (sic C=62-67). It was also mentioned that "... all of us do talk about it, like the fact that now you can take treatment even before you needs ARV’s. There is Bactrim that you take to stop you to get TB and that makes you strong so you do not need ARV’s till much later" (sic H=155-158). They all described symptoms they had seen that may indicate individuals were HIV-positive, namely rashes on the skin, losing body weight and shingles. "They get sick and they become very thin and their skin goes all— it gets a rash" (sic E=119-120). They knew how important it is for an HIV-positive individual to receive emotional support, eat healthy food and not drink or smoke too much. This is apparent in the words of a respondent who mentioned:”... if someone is sick then you must support them at home first because the person needs so much support, especially from their parents, they need all the help so I tell them about how to, to help and what foods is good and what is bad like fried foods like Kentucky that is not so good for HIV. That they must not have too much to drink because otherwise this sickness it will get bigger and take your loved one away from you and no one wants that — no one” (sic I=166-172).

The importance of HIV-positive individuals receiving emotional support was emphasised again and again. In addition, sharing one’s HIV-status with loved ones was an important life-saving act. “... if someone tells his friends that he is HIV then one can support them and then they will be strong and be able to eat their treatments. You can help them not drink alcohol and you eat the right food to keep you strong. It is so much better to tell your friends that you have HIV, that you not tell them that is very bad. You see someone like me I can help them, I can support them if one of my friends has this and we can help you know, make sure he eats his treatments. Then even if he needs money I will help him, so you see it is much better to tell your friends than to
keep quiet and not tell anyone. If you keep it inside you die; if you talk then we can help" (sic F=132-145).

The construction company had implemented weekly educational sessions after compulsory safety training. A number of respondents commented on the large numbers of HIV-infected individuals and the belief that "... people always think that the only way that you can get it through sex is when you have multiple partners and have sex without a condom but there are other ways that you can get HIV-positive. Like if you are in a taxi accident and you have a cut from glass, maybe, and the person next to you is bleeding badly into your cut and that person is HIV-positive, then you will get HIV" (sic A=256-258).

5.4.4 Knowledge of voluntary counselling and testing and its importance
Only two respondents knew what the acronym VCT stood for and meant. However, when asked if they could tell the researcher everything they knew about HIV-testing, all respondents gave all the important details about voluntary counselling and testing. "Oh yes, when you go and test they must give counselling before and after. The nurse first needs to counsel you. They talk to the person all about how HIV is transmitted and how one can prevent transmission, and then they discuss the test and how it works and then they confirm that the person still wants an HIV-test. If the person says yes then they must sign a consent form like you did for me before we started the interview. Once the person has signed then the nurse will prick your finger and put your blood. Then the nurse will be able to tell you if you have HIV or not. When the nurse tells you the result then they must counsel you again. If you are negative, the nurse counsels you on how to stay negative and if you are positive, the nurse will tell you the things you need to know so that you can stay healthy and not get sick, and where to go to get help and support and where to go so that a doctor and nurses can help you. Ok so it is an HIV-test" (sic D=128-141). They all said the testing procedure was very quick, describing a HIV-rapid testing protocol. "Then you test and quickly so quickly they give you your results straight away and then they help you if you are positive, and if you are negative then they try and help you stay negative” (sic K=196-198).

All respondents, except one, described how they had encouraged others to volunteer for HIV-testing. "Yes, I have told my friends that they must go, and they have gone" (sic J=226). These
respondents believed it was important to find out one’s status as one could then avoid becoming ill. They all knew of people in their communities who had tested too late and had subsequently died. A few respondents described individuals as ‘stupid’ who had not tested and were now ill. With reference to availability of information, knowledge of where and when to undergo testing, being familiar with VCT, a respondent mentioned: "I don’t know we are so stupid about this thing... so people they still die, so stupid” (sic J=398-399). Another respondent equated volunteering for HIV-testing as courageous, "Yes, but most people know that it is the ones who are brave they are the ones that test, the others they just sit scared" (sic A=253-254). This respondent also admitted that knowing all about HIV/AIDS and voluntary counselling and testing has encouraged her to test regularly.

An elderly male respondent thought HIV-testing of all youth in this country would assist in lowering the HIV/AIDS prevalence rate in his community. He believed that if all the youth in his community were tested it would assist in changing their behaviour, “...the youths, they don’t listen ... every time they go to the doctor or the clinic then they should have no choice, they must test ...then maybe they will listen” (sic E=277-280). This respondent knew the importance of individuals finding out their status early. In particular he was concerned about the high level of HIV/AIDS prevalence and the need to protect the youth in his community “...they must test then you will find the ones that need help and the ones that don’t...then maybe we will come right” (sic E=281-282).

All respondents tested for HIV regularly. One respondent’s reason for this mirrored that of the other respondents, "...what I have done is gone to test then gone again after 3 months because of the period when they cannot say for certain, and then again every 6 months. I do it because I want to know, I don’t want this thing to ruin my life so I stay safe and I test. I think that is the only way being young now" (sic C=168-174).

5.4.5 Personal observation and experience

All respondents spoke about observing the effects of HIV/AIDS on individuals and their community. One respondent described the effects of HIV/AIDS on her community: "... there is so many people who still die because they did not tell and do not eat their treatments, then they
get thin and lose so much weight and then they get horrible shingles, then they die. We see people dying all the time at home, all the time. It is so sad, every weekend we are at funerals every week” (sic I=267-272).

The majority of respondents know individuals who are HIV-positive and have started treatment. One respondent described how receiving treatment for HIV/AIDS had brought about change in an individual: "I know a man who was so sick and he was a big man and then he could not keep anything, anything he ate just came up again. It was too terrible, but then he went to the hospital and then he came home with these treatments and now he is big again and you can’t even see he is sick. He is bigger than me, he is so strong but he really suffered before but now he is good and can work” (sic F=353-358).

This knowledge and experience, coupled with their knowledge of HIV/AIDS gained from their workplace, has allowed a confidence to emerge in the face of HIV/AIDS. These respondents had a high degree of care for others and their environment. They expressed a strong belief that discrimination and stigmatising of individuals infected with HIV/AIDS is wrong and would sanction a work colleague, a friend or a community member whom they believed was perpetuating either stigma or discrimination. “...but if they are stupid (stigmatise or discriminate) there is many people here like me who will stop the stupid ones.” (sic L=166-170).

From their observation and experience these respondents generally agreed it would be very difficult for an individual to tell their parents or partner they were HIV-positive. "... I will think what about my family, they will be so sad when I tell them so,... for me telling my family and knowing that they will be so sad” (sic J=363-365). Another significant aspect all respondents agreed upon was if you were HIV-positive it would be a challenge to ensure condoms were used every time you had sex “... I think having to wear it (a condom) no matter what will be hard...” (sic A=358). They were aware of the risk of either infecting a partner or becoming re-infected which would further compromise an individual’s immune system. Another respondent mentioned: "...to wear a condom; and, if they carry on not using condoms and the virus will just go up and up and then she will be very sick and then there may not be treatments to help her” (sic I=307-312).
Two female respondents talked of the anxiety of becoming HIV-positive and being a parent, “...I would first think of my son, what will happen to him, will I still be able to provide for him; what if I am not here to see him grow big, for me that would be the worst thing” (sic H=371-374). Two male respondents thought that if a man was HIV-positive then he would not be able to have children and that would not be easy. “...the worst thing for a man is the fact that he won’t be able to have a baby” (sic C=268).

5.4.6 Fear
All respondents spoke of the fear of becoming infected with HIV. Community members, colleagues, friends, partners and they themselves are fearful of HIV/AIDS and HIV-infection. Fear was the most frequently referred to barrier to HIV-testing and the main reason preventing individuals willingly volunteering for HIV-testing.

5.4.6.1 Fear of illness and disability
Respondents were asked to give reasons for individuals not volunteering for HIV-testing. They explained that it was due to community members’ fear of illness and disability that they did not want to know their HIV-status, "...they are scared that they will become very sick and have to get other people to help them because they are so sick." (sic A=84-86). This fear is a result of "...what we see, someone we hear has HIV then they get so sick and they can’t even walk anymore and their family they must wash and feed and clothe that person..." (sic C=44-48).

5.4.6.2 Fear of dying
Fear of death resulting from illness and disability is a further obstacle to individuals volunteering for HIV-testing. One respondent explained: "Because we see too many people who are very sick and then you come home from work and you hear they are dead" (sic B=57). These experiences and observations continue to instil a real fear that an HIV-positive diagnosis means certain suffering and death. One respondent described an instance when she wanted her partner to go with her to test for HIV: “...two years ago I said to him that we must go and test, when I mentioned the test to him I think he thought he was dead already” (sic H=208-210). Every respondent related an HIV-positive diagnosis with death or dying: “Yes, every weekend I am at
a funeral, every weekend I must stand there at the grave and hear that this person he died of TB and that and that but we all know he dies of AIDS. " (sic J=65-68). It seems these communities have yet to understand the benefits of voluntary counselling and testing.

5.4.6.3 Additional aspects to fear
Fear of testing to find out one’s status had further dimensions other than illness and death. Respondents spoke of individuals who were too scared to test, because of their past risky behaviour: "If they get many sexual partners and they like to have many partners you know... now they get very worried because now each and everyone is going to think that maybe I, I am so worried about myself... because eish... I am doing these type of things and what happens if I get HIV/AIDS..." (sic A=71-75). One female respondent believed fewer men tested for HIV "...because they see that they are men and must look after their family but maybe they think they can’t...provide for the family and be strong for the family... I think that is why..." (sic I=299-301).

Respondents believed HIV/AIDS could infect anyone at any time: "Oh anyone can get it, doesn’t matter who you are or how much money you have you can get it” (sic H=235-236). They did not blame the HIV/AIDS epidemic on one particular group and had no stigmatising attitudes, instead they had a firm belief that "HIV is just a disease and that everybody can have it. All human beings can get HIV...Anybody can gets this thing." (sic G=200-2001).

5.5. Upper Right Quadrant
5.5.1 Individual Exterior: Behaviour and Organism
This quadrant, the upper right, deals with the physical objective reality of an individual. Each individual’s behaviour is influenced by his or her physical health, skills and capabilities. This quadrant reveals an individual’s intentional behaviour and actions which are influenced by their knowledge, attitude and perceptions regarding HIV/AIDS, their culture and worldview and the systems that they need to live and work within.
5.5.2 HIV-testing behaviour

Only one respondent did not talk about personally going for an HIV-test. The others spoke openly of their HIV-testing experience: “...with my first child, and then my second child, and then I ask my husband and we go and we then test together;... now we test again...” (sic I=206-209). These respondents said that they now went regularly for HIV-testing, as "I want to know so I go first, then they say I must come back in 3 maybe 4 months, then I go back and I test again. Now I test when the nurses come here (every year)” (sic G= 203-205). Their knowledge and testing behaviour did not alleviate anxiety during the voluntary counselling and testing process, as one female respondent described this anxiety and how she managed the HIV-testing experience: “... I had to tell them that they tell me again, because I was so nervous before the test that I could not hear them; now I go to test I tell the nurse no she must not counsel me now but she must counsel me after the test result, because I cannot hear her before I am too nervous... my head it feels like it is too full and I am too nervous” (sic I=223-228).

5.5.3 Sharing HIV/AIDS knowledge with others

Respondents spoke of how they shared HIV/AIDS information received in the workplace with their friends, families and church members. They felt it was very important that share their knowledge with persons with whom they interacted in order to assist and support people who were infected or affected by HIV/AIDS. In addition, respondents wanted to help people to see how important it was to change their behaviour so they could continue to contribute to their
families and communities. One respondent explained: “I have spoken at church to the people there about HIV. When the nurses and the people like you, they come to us and they tell us all about HIV and TB and things like that, then I say to my pastor that I must tell the people ... then I speak to the people.” (sic L=100-105). Another respondent also mentioned sharing her knowledge with new employees at work: "I tell them that now there is treatment and lots of things that can help someone who has HIV and it is nothing, now it is like you have high blood. There are pills but all the people who have high blood have to take pills too otherwise they are dead too. I tell them they must test because then they will know if they need the pills and then they can stay good and strong and keep on working but if they don’t, then it will be bad and they could get very sick and then lose their jobs, because even if (the company) is good they cannot keep on paying you all the time when you cannot work, no company will do that" (sic J=49-57).

5.5.4 Personal actions to assist others
A large number of respondents had reached out to others whom they knew were HIV-positive and in need of their help. Many respondents through their church membership were active in helping others affected or infected by HIV/AIDS: “You know when we know there is someone and they do not have money for food or something and you need food if you take the treatments, then we all give R5, R5, R5 and everyone give and then all the money we go to the shop and buy as much good food as we can and give to the person who has nothing” (sic J=137-141). A respondent spoke of how she tried to help: "...I have just given food and vegetables like spinach, when I go to church I always take anything I have that I can give for the people who need, because they are sick" (sic K=138-142). All respondents spoke of how often they shared what they knew about HIV/AIDS through work with others: "...they ask me because they know I know and they do not want that to happen to them or their families, so they ask me so many questions because then they know how to help to keep the family safe and if HIV has come through the door what to do for the child who is sick." (sic I=292-295).

5.5.5 Disclosure of HIV-positive status to others
All respondents agreed that there was a need for more individuals to disclose their HIV-positive status to their communities in order to help others see the importance of knowing one’s status: "... I think that maybe more people living with HIV should stand up and tell the others what it is
like what they do to stay strong. And then people will know it is better to test. We still see the deaths every day, we see it and so it is better if we start to see the living. It is better for us to see the living, you know those that are in control of their HIV, we need to hear and see them all the time. Then I think more people will think testing is good and test." (sic B=339-342); The respondents believed “…more people need to show that they are living with HIV and not hide in secret,” (sic B=337-338); so that “… we must speak so we do not die.” (sic F=154).

5.7. Summary
Using Wilber’s framework has enabled the researcher to ensure that all aspects of her aims have been thoroughly explored. Through the use of Wilber’s four-quadrant framework the researcher could give equal weight to the following: the social systems and environment within which the respondents have to operate (Lower Right Quadrant); their culture and worldview (Lower Left Quadrant); their self and consciousness (Upper Left Quadrant) as well as their behaviour (Upper Right Quadrant). The researcher has summarised, in tabulated form, the factors that inhibited VCT and those factors that facilitated VCT. A further table depicts a summary of important findings that emerged enabling the identification of the beliefs, attitudes, perceptions, experiences and behaviours of the respondents in terms of HIV/AIDS and voluntary counselling and testing; as well as of those with whom they work and live and interact with in their communities.
<table>
<thead>
<tr>
<th>Upper Left Quadrant</th>
<th>Individual Interior: Self and Consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors:</td>
<td></td>
</tr>
<tr>
<td>▪ Lack of knowledge of HIV/AIDS transmission, prevention, treatment, support and care acts as barrier for individuals to volunteer for HIV-testing</td>
<td></td>
</tr>
<tr>
<td>▪ Fear of the illnesses and disability caused by untreated HIV acts as barrier for individuals to volunteer for HIV-testing</td>
<td></td>
</tr>
<tr>
<td>▪ Fear of death caused by AIDS-related diseases acts as barrier for individuals to volunteer for HIV-testing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Upper Right Quadrant</th>
<th>Individual Exterior: Behaviour and Organism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors:</td>
<td></td>
</tr>
<tr>
<td>▪ Fear and anxiety experienced during the HIV-testing process may be cause for individuals not continuing with regular HIV-testing after their first HIV-test</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lower Left Quadrant</th>
<th>Collective Interior: Culture and Worldview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors:</td>
<td></td>
</tr>
<tr>
<td>▪ Rural households or those who come from rural households and now live in an urban area were described as more conservative and did not discuss HIV-related issues or sex with their members. This lack of open discussion and conservatism acts as barrier for individuals to volunteer for HIV-testing</td>
<td></td>
</tr>
<tr>
<td>▪ HIV/AIDS is not referred to by its name but referred to as “that thing” or “that big thing” this may increase the fear of the disease in individuals and acts as barrier for individuals to volunteer for HIV-testing</td>
<td></td>
</tr>
<tr>
<td>▪ Individuals without familial, church, friend, workplace support may be less likely to volunteer for HIV-testing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lower Right Quadrant</th>
<th>Collective Exterior: Social System and Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors:</td>
<td></td>
</tr>
<tr>
<td>▪ The burden of high patient case loads on nurses in public clinics results in these nurses not being able to show their patients sensitivity, understanding or compassion which may act as a barrier for individuals to volunteer for HIV-testing</td>
<td></td>
</tr>
<tr>
<td>▪ Rumours in the community that nurses will not keep an individuals HIV-status confidential acts as barrier for individuals to volunteer for HIV-testing</td>
<td></td>
</tr>
<tr>
<td>▪ Workplaces without an HIV-policy or workplace programme acts as barrier for individuals to volunteer for HIV-testing as their employees do not have sufficient knowledge concerning HIV/AIDS transmission, prevention, VCT, treatment, care and support.</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 5.5: Summary of factors that may hinder individuals volunteering for VCT**
Upper Left Quadrant  
**Individual Interior: Self and Consciousness**  
**Factors:**  
- Knowledge of HIV/AIDS transmission, prevention, treatment, care and support facilitates individuals volunteering for HIV-testing.
- Knowledge of the importance of knowing ones’ HIV-status facilitates individuals volunteering for HIV-testing.
- Knowing individuals who are HIV-positive or who have died of AIDS-related causes and knowing that now there is treatment available to prevent premature death due to HIV/AIDS facilitates individuals volunteering for HIV-testing.
- Knowledge that they will be supported by family, friends, church members, colleagues and managers if they found that they were HIV-positive facilitates individuals volunteering for HIV-testing.
- Knowledge that they would not suffer from acts of discrimination or stigmatisation either at home, in the community or at work facilitates individuals volunteering for HIV-testing.

Upper Right Quadrant  
**Individual Exterior: Behaviour and Organism**  
**Factors:**  
- Knowledge of:
  - Where to access HIV-testing,
  - HIV/AIDS,
  - Their rights concerning employment and confidentiality,
  - That they will be supported if they found that they were HIV-positive all facilitated respondents to act by going regularly for HIV-testing.

Lower Left Quadrant  
**Collective Interior: Culture and Worldview**  
**Factors:**  
- Provision of support by Churches in the community facilitates individuals volunteering for HIV-testing.
- Knowledge that community members will not discriminate against a family or an individual member of a community if they were HIV-positive facilitates individuals volunteering for HIV-testing.
- Open discussion within families regarding HIV/AIDS and safe-sex practices facilitate individuals volunteering for HIV-testing.
- Provision of support for health-seeking behaviour by family members facilitates individuals volunteering for HIV-testing.
- Knowledge that family members will not reject one of their members if they were HIV-positive facilitates individuals volunteering for HIV-testing.
- Open discussion with friends regarding HIV/AIDS and safe-sex practices facilitate individuals volunteering for HIV-testing.
- Provision of support for health-seeking behaviour by friends facilitates individuals volunteering for HIV-testing.
- Lack of differentiation between the treatment of HIV-positive females and HIV-positive males facilitates individuals volunteering for HIV-testing.
- Lack of gender violence facilitates individuals volunteering for HIV-testing.

Lower Right Quadrant  
**Collective Exterior: Social System and Environment**  
**Context:** Visible societal structures; systems and modes of **Factors:**  
- Presence of an HIV/AIDS workplace policy and programme that providing employees all the pertinent information concerning HIV/AIDS and access to HIV-testing at work facilitates regular HIV-testing of employees.
- Employee awareness of legislation governing their employment status concerning HIV/AIDS facilitates regular HIV-testing of employees.
- Support provided by management through the facilitation of access to treatment, care and support for HIV positive employees facilitates regular HIV-testing of employees.
- Support for the HIV/AIDS workplace programme from shop stewards and encouraging employee participation facilitates regular HIV-testing of employees.
- Support from fellow colleagues for HIV-positive employees facilitates regular HIV-testing of employees.
- Belief that nurses in the public clinics will keep their HIV-status confidential facilitates individuals volunteering for HIV-testing.
- Belief that treatment, care and support is readily available to anyone who finds that they are HIV-positive facilitates individuals volunteering for HIV-testing.

**Figure 5.6: Summary of factors that may facilitate individuals volunteering for VCT**
<table>
<thead>
<tr>
<th>Upper Left Quadrant</th>
<th>Lower Left Quadrant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Interior: Self and Consciousness</strong></td>
<td><strong>Collective Interior: Culture and Worldview</strong></td>
</tr>
<tr>
<td>The subjective internal reality of the individual</td>
<td>The inter-subjective, internal reality of groups</td>
</tr>
<tr>
<td><strong>Context:</strong></td>
<td><strong>Context:</strong></td>
</tr>
<tr>
<td>Intrapersonal consciousness; intentions; personal values; attitude; commitment (cognitive, emotional, spiritual, moral, etc.); cognitive capacity; depth of responsibility; degree of care for others and the environment</td>
<td>Shared values and world views; shared meaning; cultural norms and mores; language; customs; stories; symbolism; agreed upon ethics</td>
</tr>
<tr>
<td><strong>Findings:</strong></td>
<td><strong>Findings:</strong></td>
</tr>
<tr>
<td>- Amount of formal education achieved by the respondents did not have an impact on their attitudes or intentions regarding HIV/AIDS and HIV-testing.</td>
<td>- There were no particular gender issues highlighted, as respondents believed all are to be treated equally.</td>
</tr>
<tr>
<td>- All respondents had observations and experiences concerning HIV/AIDS, which influenced their behaviour and actions.</td>
<td>- The majority of respondents are active Christians attending church regularly, where HIV/AIDS was discussed and guidance and support offered to the affected and infected.</td>
</tr>
<tr>
<td>- All respondents showed insight into the beliefs and attitudes of their fellow community and household members, which influenced their own behaviour and actions.</td>
<td>- Urban families discuss HIV/AIDS and offer guidance and support to their members, although this may not be the case in rural families.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Upper Right Quadrant</th>
<th>Lower Right Quadrant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Exterior: Behaviour and Organism</strong></td>
<td><strong>Collective Exterior: Social System and Environment</strong></td>
</tr>
<tr>
<td>The physical objective reality of the individual</td>
<td>The physical, inter-objective reality of groups and nature</td>
</tr>
<tr>
<td><strong>Context:</strong></td>
<td><strong>Context:</strong></td>
</tr>
<tr>
<td>Physical health; intentional behaviour; skills; capabilities; actions</td>
<td>Visible societal structures; systems and modes of production (economic, political, social, informational, educational, technological); strategies; policies; measures; work processes; technologies; natural environment</td>
</tr>
<tr>
<td><strong>Findings:</strong></td>
<td><strong>Findings:</strong></td>
</tr>
<tr>
<td>- All bar one of the respondents intend to go for HIV-testing regularly and have already done so.</td>
<td>- Access to HIV-testing, treatment, care and support is now not difficult due to the actions of the Eastern Cape government and Department of Health.</td>
</tr>
<tr>
<td>- The majority of respondents have taken personal action to share information and help others concerning HIV/AIDS.</td>
<td>- Events to raise HIV/AIDS awareness that are known and supported by community members are implemented by the Eastern Cape government and Department of Health.</td>
</tr>
<tr>
<td>- The respondents believe in the importance of disclosure of HIV/AIDS status, while realising it is more difficult for others to do so.</td>
<td>- Health professionals who interact with the respondents are believed to treat all their patients fairly and their health status is kept confidential.</td>
</tr>
<tr>
<td>- Urban families discuss HIV/AIDS and offer guidance and support to their members, although this may not be the case in rural families.</td>
<td>- The messages concerning HIV/AIDS carried by different media evoke discussion and debate concerning HIV/AIDS, thus raising awareness.</td>
</tr>
<tr>
<td>- Friends discuss HIV/AIDS and give support; also attempt to change behaviour in others to protect individuals from HIV-infection.</td>
<td>- The workplace has successfully implemented an HIV/AIDS programme supported by Labour Union shop stewards. This also leads to changed attitudes and behaviours of employees.</td>
</tr>
<tr>
<td>- Colleagues discuss HIV/AIDS informally amongst themselves, are supportive of behaviour change and of those who are affected or infected by HIV/AIDS.</td>
<td>- There are no references to any acts of discrimination concerning individuals affected by or infected with HIV/AIDS in the workplace.</td>
</tr>
<tr>
<td>- Xhosa-speakers give HIV/AIDS a ‘non-prejudice’ substitute name enabling easy discussion about HIV/AIDS.</td>
<td>- The community’s attitude seems to have changed noticeably since the provision of ARV’s and there seem to be no discriminatory or overt stigmatising attitudes.</td>
</tr>
</tbody>
</table>

**Figure 5.7: Summary of important findings**
Chapter Six

CONCLUSIONS AND RECOMMENDATIONS

6.1. Introduction
Motivated to gain insight into factors that respectively facilitate or inhibit individuals use of VCT, the researcher interviewed twelve volunteers who are employed by a construction company. This company has an HIV/AIDS workplace policy and programme providing basic education and awareness of HIV/AIDS transmission, prevention, treatment, care and support. The respondents have lived and worked for most of their lives within the Nelson Mandela Metropolitan area, while maintaining contact with family, relatives and friends who live in rural areas some distance from the Metropole.

Continuous and varied interactions between respondents and their significant others, as well as with acquaintances within their township communities, have provided them with experiences and other opportunities to gain information about HIV/AIDS and voluntary counselling and testing. This has enabled them to reflect on the impact of HIV/AIDS and to develop their own perceptions and attitudes about the disease as well as the benefits of health-seeking behaviour.

This chapter presents the important findings identified through a content analysis of unstructured interviews held with respondents that served as the target group for this research. Besides suggesting recommendations, this chapter is concluded with an assessment of the objectives that guided this research.

6.2 Research findings placed within Wilber’s four-quadrant framework
Using data from Chapter 5, the researcher chose to present the contents of this final chapter by focusing on each quadrant of Wilber’s framework commencing with the Lower Right Quadrant with its focus on social systems and environment (See arrow indication in Figure 6.1).
Figure 6.1: Wilber’s Four-Quadrant Framework (Wilber 2001)

6.2.1 The Lower Right Quadrant: Collective Exterior (Social Systems and Environment)

6.2.1.1 The construction company that employs these respondents provides an HIV/AIDS workplace policy and programme that creates a positive environment through which employees are encouraged to volunteer for HIV-testing.

- Regular weekly information sessions on HIV/AIDS, TB, and STIs are held, and voluntary counselling and testing campaigns for both HIV/AIDS and TB are run annually.
- Male condoms are available in their common dining area and restrooms to ensure free access to condoms. The latter also serving as a trigger for informal discussion among employees regarding the importance of safe sex and how to use a condom properly.
Management provides support by referring employees to treatment, care and support sites for HIV/AIDS and TB infection where employees can receive psychosocial support and medical treatment.

Labour Union shop stewards support the HIV/AIDS workplace policy and its implementation by explaining and discussing planned HIV/AIDS interventions, by providing encouragement to employees to participate in these interventions, and by educating employees about their rights and responsibilities as set out in the HIV/AIDS workplace policy.

6.2.1.2 There exists a relationship of trust between employee and employer, Labour Union representatives and employee, as well as between colleagues.

- A climate of trust has developed and this is attributed to the consistency of experience between what is stated in the HIV/AIDS workplace policy and in the behaviours and actions exhibited by management, Labour Union representatives and employees.
- Management provides time and expertise to ensure that all employees receive regular training/education and skills development regarding HIV/AIDS and other health and safety issues.
- Management is known to assist employees who are ill or who are affected by having family members who are ill.
- Employees who disclose their HIV-status are assisted by management in various ways and are not discriminated against. Management is known to offer tangible help when employees require it.
- Labour Union representative support, given to the HIV/AIDS workplace policy and programme interventions, helps to strengthen the climate of trust and gives credibility to the HIV/AIDS policy and programme.
- Employees do not discriminate against any colleague they presume or know to be HIV-positive as there is a belief that any employee, family/household member, relative, or friend is vulnerable to becoming infected with HIV/AIDS.
- Employees refrain from discriminatory behaviour as there is a belief that discriminatory behaviour would prevent colleagues infected with or affected by HIV
from receiving the support required in order to enhance their health and quality of life.

- Employees are frustrated when they are prevented from offering support to a particular colleague, because despite observing a decline in the health of the colleague it cannot be directly linked to their HIV-status, as the colleague has not tested for HIV-infection.
- The climate of trust within this construction company referred to earlier motivates respondents to volunteer regularly for HIV-testing and encourages other employees to do the same.

6.2.1.3 The importance of knowing one’s HIV-status is well understood and the benefits of HIV-testing are clear to respondents.

- Respondents believe that knowing one’s HIV-status and treatment options ensures access to treatment, care, and support. Therefore it is of their opinion that knowledge of HIV-status enables individuals to enhance their quality of life and to have control over their illness should they test positive for HIV.
- The above is also the reason why they encourage others to use voluntary counselling and testing.
- Knowing that one’s HIV-status does not jeopardise one’s employment status within the company acts as a facilitator for respondents to undergo an HIV-test.
- Workplace-related HIV/AIDS information and programmes serve as important motivators for employees to undergo HIV-testing, especially those who do not practice safe sex.

6.2.1.4 The quality of Public Health Care services is of critical importance to employees if they require HIV-testing or test HIV-positive.

- The experience of the Public Health Care services by respondents is that it is accessible and provides for treatment but that it also has limitations. The ability of nurses to provide empathy and sympathy for all their clients has been eroded by a high patient load.
• Although nurses lack sympathy and empathy for their clients, those that visit these clinics for an HIV-test or follow-up treatment do not perceive such behaviour as specifically directed towards them but to all clients visiting the clinic for health care.
• Respondents know they can access HIV-testing at any clinic or hospital and are of the opinion that all employees know this too as they receive this knowledge through information sessions that are regularly held at the workplace.
• There is a belief that no one will be denied access to ARV treatment if they require it.
• There is also a belief that nurses will refer those that test positive for HIV to support groups for psychosocial support.
• In addition, there is a belief that health professionals will not disclose respondents HIV-status to others.
• Trust in the ability of staff at local clinics to provide professional VCT services can be inferred from the continued use of these services despite knowing of alternative places to volunteer for HIV-testing. This in itself facilitates the use of voluntary counselling and testing.

6.2.1.5 Different media provide the opportunity for informal discussion about HIV/AIDS among employees and with members of their family/household and friends.
• The most influential form of media referred to by respondents is ‘The Sun,’ a daily newspaper which creates, through various articles related to HIV/AIDS, the opportunity for discussion either at work, home or when among friends, which serves as a trigger to encourage a healthy life style and motivation to use VCT.
• This and other forms of media create opportunities for opinion forming, reflection, and enhancement of knowledge about HIV/AIDS.
6.1.2.6 High-density living of individuals in small houses or informal dwellings is characteristic of urban or township community living and is cited as cause for the high HIV/AIDS prevalence rate in these urban communities.

- There is opinion that the high HIV/AIDS prevalence in township communities is due to the large number of shebeens that can be accessed, which in turn, contributes to alcohol abuse and risk-taking behaviour.
- Observations are that young impoverished women socialise and accept alcoholic beverages from older men who frequent these shebeens and thereafter have sex with these men as payment.
- In contrast to urban living, a rural environment offers physical, familial and social territories where boundaries are clearly demarcated and little or no enculturation takes place. To an extent this prevents the spread of HIV/AIDS.
- The family norms and values ingrained in traditional rural living and interaction which act as a preventative measure for social misbehaviour have to an extent lost their strength within urban living. This together with the breakdown of family kinship ties is perceived as the cause for the high prevalence of HIV/AIDS in urban township communities.

In summary it can be deduced that:

- An HIV/AIDS workplace policy and knowledge of your legal rights as an employee, (e.g. that you cannot be dismissed on the basis of HIV-status), will encourage employees to volunteer for HIV-testing.
- A well-implemented HIV/AIDS workplace programme supported by management, Labour Unions and employees as well as visible consistency between what is stated in the policy and actions by management and union representatives engender an organisational culture of trust that contributes towards motivating employees to use voluntary counselling and testing.
- Where management and employees of a company with an HIV/AIDS policy and workplace programme do not discriminate against known or suspected HIV-positive employees and actively and openly show tangible support and assistance to ill employees, an atmosphere of trust is created which in turn motivates employees to use VCT.
• An HIV/AIDS workplace programme that emphasises the importance of knowing one’s status and the benefits of HIV-testing will encourage use of VCT.

• Exposure to HIV/AIDS information through different forms of media triggers discussions about HIV/AIDS among employees, their friends and family/household members, which in itself may contribute to the enhanced use of VCT services.

• Alcohol abuse and transactional sex in communities is a contributing factor to the continued spread of HIV/AIDS in the Nelson Mandela Metropolitan area.

• Living conditions, including enculturation and loss of traditional family norms and values associated with rural life, impact negatively on the prevalence level of HIV/AIDS in the Nelson Mandela Metropolitan area as these encourage behaviours that put individuals at risk of HIV-infection.

• A workplace providing usable information about HIV/AIDS and HIV-testing services and a Provincial government that provides public health clinics for HIV-testing, treatment and referral for psychosocial support, together will promote a climate which will encourage voluntary counselling and testing behaviour, and which in turn will increase the number of individuals who volunteer for HIV-testing.

• Access to condoms at work triggers informal discussion about HIV/AIDS and safe sex behaviour and encourages health-seeking behaviour in employees which can lead to employees volunteering for HIV-testing.

Thus, with reference to a company that provides an HIV/AIDS workplace policy and programme that includes, but is not limited to basic education and awareness about HIV/AIDS transmission, prevention, treatment, care and support, there is evidence that employees are positively inclined towards using voluntary counselling and testing services. This is due to the opportunities afforded employees to gain appropriate and reliable knowledge, to participate in reflective interactions, and to experience trust, tangible support and assistance. These opportunities and experiences contribute towards a change in health-seeking behaviour with a favourable impact on the use of voluntary counselling and testing.
6.2.2 The Lower Left Quadrant: Collective Interior (Culture and Worldview)

6.2.2.1 Respondents’ communities do not stigmatise or discriminate against HIV-positive individuals or against those that develop AIDS-related complications yet the respondents conceded that this had not always been the case.

- Lack of knowledge and understanding by members in the community about HIV/AIDS and the government’s poor address of the emerging HIV/AIDS epidemic, gave rise to communities who socially isolated those who were known or assumed to be HIV-positive together with their families.
- Fear of social isolation created a tendency for HIV-infected individuals and their families to refuse to disclose the true nature of the illness or to attribute it to another life-threatening disease.

6.2.2.2 Significant events have gradually brought a change in the perceptions and attitudes in members of the respondents’ communities resulting in a greater understanding of HIV/AIDS with a subsequent decrease in discriminatory behaviour and stigmatising attitudes towards known or assumed HIV-positive individuals. These events were:

- The successful court case regarding patents and the manufacture of cheaper generic antiretrovirals brought by the South African government against international pharmaceutical companies.
- The South African government’s decision to implement a national roll out of antiretrovirals at the end of 2003 which commenced in 2004.
- The emergence of companies who develop an HIV/AIDS policy and programme contribute greatly to a better HIV/AIDS informed employee-corps, who in turn share this knowledge with their community members.

6.2.2.3 The churches to which employees are affiliated assist in decreasing HIV/AIDS stigmatising attitudes and discriminatory behaviour in community members.

- Congregants receive messages and education from church pulpits concerning HIV/AIDS. Priests/Pastors provide information on prevention emphasising the fact
that anyone can become HIV-positive and stating that respect, care and support should be offered to everyone regardless of their HIV-status.

- The churches concerned reinforce these messages through action, by collecting money, clothes and food and distributing these where needed. HIV-positive church members and their families are visited and offered psychosocial support through prayer and counselling.
- Young church members receive further education and in some cases skills training concerning HIV/AIDS at ‘Youth’ services held during the week.

6.2.2.4 Families are proactive in attempting to prevent HIV-infection amongst their members.

- Family or household leaders or older siblings take responsibility to educate younger members of their family on HIV/AIDS and caution them against behaviour that may put them at risk for HIV-infection.
- Regular reminders of the importance of condom use are given before young church members go out over the weekend to socialise.
- Messages concerning the importance of remembering familial responsibility are given to male family members to prevent risk-taking behaviour.
- Respondents believe their family would be shocked if they disclosed they were infected with HIV but they would be able to count on their support enabling them to maintain their health and good quality of life.
- There seems to be a high incidence of families willing to discuss HIV/AIDS and safe sex behaviour, this together with knowing that they will receive familial support if they test HIV-positive, acts to enhance the use of voluntary counselling and testing.
6.2.2.5 Interaction between respondents and friends contributes to information exchange leading to better informed individuals who know how to prevent HIV-infection which increases the motivation of individuals to use voluntary counselling and testing services.

- Discussion concerning the importance of condom use, safe sex practice with sexual partners who’s HIV-status is unknown, as well as the requirement to be faithful to one’s partner serve to prevent HIV-infection.
- Information received in the workplace is shared with friends outside of the workplace.
- Respondents believe their friends would be supportive of anyone they knew who became HIV-positive and this lessened their fear of being isolated or ostracised.
- Being better informed about HIV/AIDS and being responsible towards friends who do not receive this information motivates respondents to encourage friends to use voluntary counselling and testing services.
- Knowing friends who are HIV-positive acts as a deterrent for at-risk behaviour that may cause HIV-infection.

6.2.2.6 HIV/AIDS is a gender defining disease due to its modes of transmission and the inequalities facing women in South Africa.

- While it is believed that HIV-positive men and women would receive the same care and support from health care professionals, community and family members, there is also the perception that women would find it difficult to enforce condom use in a sexual relationship if the male partner did not want to use condoms.
- Married female respondents and those with long standing relationships who benefited from a HIV/AIDS workplace programme were more likely to undergo regular HIV-testing with their husbands and/or partners than those not participating in a programme.
6.2.2.7 Language and terminology used to define a disease such as HIV/AIDS and words used to describe individuals known to be HIV-positive indicate how a cultural group that share a language perceive the disease.

- Within the isiXhosa-speaking community members often use the phrase “that thing” or “that big thing” when referring to HIV/AIDS. Respondents explained that there was no positive or negative meaning attached to the term used to describe HIV/AIDS in their everyday conversations.

- It is known in Xhosa culture that if someone or something needs to be shown respect or is feared it remains un-named (Finlayson 1995), but whether this is the case concerning HIV/AIDS the researcher could not ascertain from the respondents.

In summary it can be deduced that:

- When members of a community lack knowledge and understanding about HIV/AIDS, and there is a lack of government action to prevent the spread of a life-threatening disease and/or to provide education on HIV/AIDS transmission, prevention, treatment, care and support this will have a negative impact on individuals volunteering for HIV-testing.

- Change in perception and attitude in the members of the community towards HIV/AIDS and those affected by it has decreased stigmatisation and discriminatory behaviour making it easier for individuals in the community to volunteer for an HIV-test than it has been in the past.

- Information about HIV/AIDS passed on through priests/pastors and other church leaders to congregants who in turn passed this on to members of their community, has a positive effect on counteracting stigmatisation or other forms of discriminatory behaviour and/or enabling change in perceptions and attitudes of members of the community about HIV/AIDS.

- Churches not only serve to decrease stigmatisation and discriminating behaviour within the township community but also create a favourable environment for members of the township community to use voluntary counselling and testing.

- There is a realisation that all persons are prone to being infected or affected by HIV/AIDS and therefore the fact that everyone is at risk for HIV-infection emphasises the importance of HIV-testing.
A change in attitude towards HIV/AIDS and those infected or affected by the disease and the high prevalence of HIV/AIDS has led to a decrease in stigmatisation and discriminatory behaviour by community members. It has also created a positive environment in which individuals are less afraid of being socially isolated or ostracised and are better motivated to use voluntary counselling and testing and to encourage their friends and family to volunteer for an HIV-test.

6.2.3. The Upper Left Quadrant: Individual Interior (Self and Consciousness)

6.2.3.1 These respondents have extensive knowledge about HIV/AIDS and related opportunistic infections as well as of HIV-testing.

- Self-efficacy, attitudes and intention of respondents concerning HIV-testing behaviour have been influenced by their knowledge of HIV/AIDS gained from their workplace and what they observed and experienced in their community.
- Respondents know about the different stages of HIV/AIDS disease progression and what treatment other than ARV’s is available to them to assist in managing the progression of the disease.
- Through the knowledge that respondents gained from the HIV/AIDS workplace programme there emerged a growing self-confidence in the face of the HIV/AIDS epidemic.
- This confidence is displayed in their belief in the importance of testing regularly for HIV/AIDS and knowing one’s HIV-status despite fear of the disease and of being infected.

6.2.3.2 The respondents believed that fear of illness and death is the major obstacle for community members not volunteering for HIV-testing.

- According to respondents their fellow community members are fearful of HIV/AIDS and they believe that this fear is a major inhibiting obstacle for community members and the reason why they do not volunteer for HIV-testing.
Observing HIV/AIDS disease progression in many members of the community has instilled a fear of HIV-infection and has firmly linked being HIV-positive with a debilitating disease that causes pain, suffering and eventual death.

6.2.3.3 Respondents’ fear of HIV-infection has been lessened by their knowledge of HIV/AIDS thus their fear no longer inhibits them from volunteering for HIV-testing.

This fear in respondents has been moderated by all the HIV/AIDS information they have received and interventions they have participated in at work, as well as through their family and churches.

Their fellow community members have not had the same benefits and their fear of illness, pain, suffering and death which they equate with an HIV-positive diagnosis, prevents them from volunteering for HIV-testing.

In summary it can be deduced that:

- **Individuals who have received effective education and training about HIV/AIDS transmission, prevention, treatment, care and support and know where to access HIV-testing develop a strong sense of self-efficacy, which supports their motivation and intentions to regularly test for HIV-infection.**

- **Knowledge about HIV/AIDS transmission, prevention, treatment, care and support and where to access HIV-testing empowers individuals to overcome their fear of HIV-infection and its possible impact on their lives, which supports HIV-testing behaviour.**

- **Respondents’ fellow community members who have not received the same HIV/AIDS education and training about HIV/AIDS transmission, prevention, treatment, care and support and don’t know where to access HIV-testing remain fearful of ascertaining their HIV-status thus inhibiting them from volunteering for HIV-testing.**

- **In addition, lack of knowledge and continued observation and experience of known or assumed HIV-positive community members’ suffering and eventual death from HIV/AIDS complications, further reinforces the fear of finding out whether they are infected with HIV thus inhibiting them from volunteering for HIV-testing.**
According to respondents, community members’ fear of illness and an AIDS death is the biggest factor inhibiting their fellow community members from volunteering for HIV-testing.

Respondents’ attitudes, perceptions, and intentions regarding HIV/AIDS have been influenced by the knowledge and guidance received from their workplace, family, friends, and churches. This knowledge has moderated their fear of HIV/AIDS. Although still fearful of HIV-infection this fear acts as motivation to implement safe sex behaviour and regular HIV-testing. However, their fellow community members, who do not have the benefit of the same amount of knowledge, live in fear of HIV-illness and an AIDS death, which inhibits them from volunteering to undergo HIV-testing.

6.2.4 The Upper Right Quadrant: Individual Exterior (Behaviour and Organism)

6.2.4.1 Respondents undertook regular HIV-testing and encouraged colleagues and friends to do the same.

- Respondents’ positive actions, resulting from their HIV/AIDS knowledge and the belief that they will receive support from family, friends and church leaders and members allows them to volunteer regularly for HIV-testing and motivates them to encourage colleagues and friends to do the same.

- If a friend confessed that they had had unprotected sex then respondents would advise them to volunteer for an HIV-test to alleviate anxiety and to ascertain their HIV-status. The respondents encourage HIV-testing in these circumstances by emphasising that knowledge of their HIV-positive status would allow them to receive the correct HIV/AIDS treatment, care, and psychosocial support.

- If a colleague at work was struggling with their health and did not seem to get well, they would suggest to the colleague that they should test for HIV in order to ensure they would receive the correct care, treatment and support, so as to improve the quality of their lives and recover their health.
6.2.4.2 Respondents shared their HIV/AIDS knowledge and information pamphlets with their family members and friends.

- All respondents share all their HIV/AIDS knowledge and the information pamphlets they receive from work with their friends and family members. In addition, one of the respondents takes this a bit further and shares what he has learnt from his workplace with his fellow church and clan members.

6.2.4.3 Respondents had a high degree of care for their fellow community members who had been affected or infected with HIV/AIDS and would not sanction any discrimination or stigma towards HIV-positive individuals.

- Respondents reach out to help others who are either infected with or affected by HIV/AIDS.
- Respondents, who understand the importance of managing HIV-infection in order to slow down its progression to AIDS, have found support groups and organisations that provide support for HIV-infected family members so that these members of their family would be better able to manage their HIV-infection and maintain a good quality of life.
- Respondents actively contributed food, clothes, and money to HIV-infected or affected friends, colleagues, and community members who are in need.

In summary it can be deduced that:

- Correct knowledge concerning HIV/AIDS transmission, prevention, treatment, care and support and understanding the importance of knowing one’s HIV-status leads to individuals changing their behaviour in the form of taking the necessary precautions to prevent HIV-infection as well as volunteering regularly for HIV-testing.
- Correct knowledge concerning HIV/AIDS transmission, prevention, treatment, care and support, and understanding the importance of knowing one’s HIV-status, has led respondents to encourage friends and colleagues to volunteer for HIV-testing.
- The absence of stigmatising beliefs and knowledge of HIV/AIDS transmission, prevention, treatment, care and support has led these respondents to engage in reaching out to assist individuals they know to be infected with or affected by HIV/AIDS.
The support respondents receive from significant people in the groups they are part of has empowered these respondents to carry out their intentions and modify their behaviour in order to stay healthy and HIV-negative and to regularly volunteer for HIV-testing. The confidence engendered by HIV/AIDS knowledge and support from family and their churches allows respondents to play an active role in the community by sharing HIV/AIDS information and assisting others whom they know to be HIV-positive, or personally affected by the illness of someone close to them, with tangible support.

6.3 Recommendations
The recommendations based on the findings of this study have been developed with two main aims in mind: Firstly, to contribute towards existing HIV/AIDS prevention initiatives in the Nelson Mandela Metropolitan area by way of recommendations. Secondly, to suggest how the use of VCT can be enhanced. The recommendations are aimed at:

A: Workplaces
B: South African Government, Department of Health
C: Research community

6.3.1 Workplace recommendations
A.1 All construction companies should be motivated to develop and implement an HIV/AIDS workplace policy in order to assist in the management of HIV/AIDS and other related health issues that impact on the workplace through direct and indirect costs of employee illness and attrition due to HIV/AIDS and related health issues.

- Consideration should be given to developing a generic HIV/AIDS workplace policy that serves as a benchmark to enable companies without a policy to develop one.
- The development and distribution of the generic HIV/AIDS workplace policy should be done in conjunction with the Master Builders Association (MBA) and other business organisations (e.g. SABCOHA) that offer expertise and assistance to all construction companies registered with the MBA.
In the Nelson Mandela Metropolitan area an HIV/AIDS workplace policy can also be distributed via the local MBA, PERCCI and CDC. There should be close co-operation between management and representatives from the Labour Union in order to ensure the quality and sustained implementation of the HIV/AIDS policy. Collaboration between the important stakeholders within the company should be a continuous activity of reflection, assessment and, where and when applicable, revision.

A2. The importance of the policy itself should be effectively communicated to all employees.

- All employees should be provided with a copy of the HIV/AIDS workplace policy.
- Management together with Labour Union representatives of the company should officially launch the HIV/AIDS policy in the presence of employees to emphasise the policy is a product of a collaborative effort and is sanctioned by employees and other relevant stakeholders.
- Representatives of the Labour Union should explain the contents of the policy to employees and how it affects them, taking care to include, details of employee rights as set out in South African Labour legislation.

A3. HIV/AIDS or Wellness education and awareness materials that highlight various aspects relating to the disease and health-seeking behaviour should be distributed to employees through their construction companies.

- These materials should contain:
  - Correct, understandable, and user-friendly information about HIV/AIDS and other health issues.
  - Information about where to access HIV- and TB-testing, as well as how to contact organisations that offers psychosocial support.

---

25 PERCCI – Port Elizabeth Regional Chamber of Commerce and Industry; CDC – Coega Development Corporation
• Construction companies should source these materials from organisations specialising in the development of such education and awareness materials, such as Soul City, LoveLife and Khomanani.

• Labour Union representatives who have access to materials that are developed for employees through their national and international organisations such as COSATU, NUMSA, SOLIDARITY and the ILO, should be encouraged to distribute these at accessible points on the various construction sites.

A4. Distribution points for male and female condoms throughout the construction company sites and premises should be established and regularly serviced.

• These condoms should be timeously sourced at no cost from the Eastern Cape Department of Health, as the distribution of condoms in the workplace allows for informal discussion about HIV/AIDS and safe sex, which in turn encourages positive health-seeking behaviours.

A5. HIV/AIDS or Wellness education and awareness workplace programmes should be considered by construction companies who are experiencing the impact of HIV/AIDS or other health issues through the morbidity and mortality of employees.

• A workplace programme should include targeted interventions linked to HIV/AIDS, TB and related health issues which are linked to the National Health calendar developed by the South African National Department of Health annually and available on their website, for example, a Safe Sex campaign in February linked to Reproductive month and condom awareness week; TB education and testing campaign linked to TB month in March every year, 24th March is world TB Day; HIV/AIDS awareness and HIV-testing linked to the 17th May HIV/AIDS Candlelight Memorial Day.

• Two persons should be assigned the role of coordinators to manage, monitor, implement, and evaluate the programme in collaboration with relevant internal stakeholders (e.g. representatives of the Labour Union) at pre-determined periods.

---

26 National Health calendar can be found on the South African Government Department of Health website: http://www.doh.gov.za
Alternatively, a group of companies may opt to appoint a coordinator to fulfil this position.

- As far as it is possible HIV/AIDS workplace and/or Wellness programmes should be developed with corporate social responsibility in mind as companies, through their employees, are conduits for information passed on to family and household members, friends and others of significant importance to them in their township communities.

6.3.2 South African Government, Department of Health recommendations

**B1. The National Health Department should consider implementing a Task Shifting** and training programme in order to alleviate the high patient load currently experienced in the Public Health Care system [compare WHO 2008b].

- Individuals should be trained in specified areas of health care such as voluntary counselling and testing protocols in order to alleviate the patient burden on highly trained doctors and nurses.

**B2. Important details of all organisations, support groups and lay counsellors who offer outreach psychosocial support and care should be known by health care professionals who conduct VCT.**

- Posters displaying this information should be displayed in client waiting areas and treatment rooms.
- The availability and effectiveness of medication such as Bactrim to prevent TB infection should also be communicated through posters and pamphlets displayed in client waiting areas and treatment rooms.
- The availability and effectiveness of ARV’s should be communicated through posters and pamphlets and should also be displayed in client waiting areas and treatment rooms.

---

27 The global recommendations and guidelines on task shifting suggest that the task shifting approach as one method of increasing and expanding the health care workforce in order to create better access to HIV and other health services. Task shifting is the rationalisation of tasks among different health workers. Specific tasks are moved, from qualified health workers to health workers with shorter training and qualifications at a lower level so there is more effective use of health practitioners and their various skills.

All individuals accessing the clinic for health care should be encouraged to volunteer for HIV-testing.

6.3.3 Recommendations to the research community

C1. Research of a similar nature should be undertaken in more workplaces in the Nelson Mandela Metropolitan area taking care to include those companies without HIV/AIDS policies or programmes.

C2. Duplication of this research study should be conducted with all the different population groups within the different categories of employment in a workplace.

C3. Research of a similar nature should be undertaken with unemployed community members to facilitate comparison between the employed and unemployed.

C4. Research investigating how the philosophy of Ubuntu\(^29\) can be enhanced in individuals within the Nelson Mandela Metropolitan communities in order to decrease stigma and discrimination of HIV-positive individuals and increase the care and support they receive from their community members.

C5. Research investigating what role ethnicity and social class plays in individuals health-seeking behaviour, in particular HIV/AIDS and VCT, to allow for a deeper understanding of how to mitigate the impact of the HIV/AIDS epidemic on the diverse populations groups in South Africa.

\(^{29}\) Ubuntu means each one of us can only effectively exist as fully functioning human being when we acknowledge the roles that others play in our lives. Most Nguni languages in Southern Africa will say: “\textit{umuntu ngumuntu ngabantu} [a person is a person through other persons, or I am because we are]”. It is about accepting our inherent interconnectedness. Initially, Ubuntu seems idealistic. Yet, when understood, it is the foundation for social coherence.
6.4 Limitations of the study

This research served as a pilot study for a greater research project that will investigate the proximal and distal drivers of HIV/AIDS and sexually transmitted infections in workplaces in the Eastern Cape. This posed certain limitations on the current study but did not deter the researcher from applying a methodology aimed at reliable and valid research.

The research study was limited geographically to one construction company situated in the Nelson Mandela Metropolitan area in the Eastern Cape Province. Furthermore, this sample only included Xhosa-first-language speakers. However, being a pilot study for a greater research endeavour determined that a specific research target group being identified. The use of interpretative qualitative design to an extent dictated the size of the target group. However, the research design chosen enabled the researcher to achieve understanding, through face-to-face interviews, of the focus of the research. It also allowed for use of Wilber’s four-quadrant framework as a tool for the analysis of data concerning the factors that respectively facilitate or inhibit health-seeking behaviour. However, comparative research should be undertaken to assess the extent to which Wilber’s model provides a truly integrated perspective of the facilitators and inhibitors concerning VCT behaviour in South African population groups.

6.5 Assessment of attainment of research objectives

In assessing the outcome of the objectives that guided this research, the researcher by undertaking a critical review of literature (presented in Chapters 1, 3, 4), was able to identify factors that respectively facilitate and hinder individuals volunteering for HIV-testing. This secondary research methodology, together with the implementation of Wilber’s Integral Framework (explained in Chapter 4) was used to guide her research to achieving her research objectives.

With reference to Research Objective 1: To identify the personal, family, social, community and workplace factors that facilitate individuals volunteering for HIV-testing the following substantiate the claim that this objective was achieved:

- Findings that relate to the place of work are: 6.2.1.1, 6.2.1.2, 6.2.1.3, and show the positive impact a HIV/AIDS workplace policy and programme has on employees.
Knowledge of HIV/AIDS, the importance of knowing one’s status and that one’s job is secure, even if one is HIV-positive, acts as a motivator for individuals to volunteer for HIV-testing.

- Findings that relate to colleagues interactions are: 6.2.1.1, 6.2.1.3, 6.2.1.5 which are linked to the above findings of the impact of a HIV/AIDS workplace policy and programme as employees discuss HIV/AIDS, safe sex and HIV-testing amongst themselves triggered by HIV/AIDS interventions. They further encourage each other to test for HIV especially if a colleague has been unwell. Open discussion and the supportive environment provided by the policy and programme have created a climate of non-discrimination and non-stigmatising attitudes towards HIV-positive individuals. It is known that HIV-positive colleagues are supported in the workplace.

- Findings that relate to the contributions made by churches are 6.2.2.3 these reveal that churches educate community members about HIV/AIDS and support those affected or infected by it. This support provides further motivation for these respondents to volunteer regularly for HIV-testing.

- Findings that relate to family/household members and friends are reflected in point 6.2.2.4 and 6.2.2.5. These show that a supportive family environment where further education about HIV/AIDS is received and safe sex and HIV-testing behaviour supported facilitates respondents to volunteer regularly for HIV-testing.

These findings indicate that although some respondents are fearful of the outcome of HIV-tests, there are no barriers that hinder them from volunteering regularly for HIV-tests.

With reference to **Research Objective 2: To identify the personal, family, social, community and workplace factors that inhibit individuals volunteering for HIV-testing**, the following substantiate the claim that this objective was achieved:

- Finding 6.4.2 shows that ignorance of the importance of knowing one’s HIV-status acts as a barrier to HIV-testing.

- Together with finding 6.4.2, finding 6.4.3 indicates that ignorance of the effectiveness of HIV/AIDS treatment prevents testing because an HIV-positive diagnosis is equated
with illness and death. Fear of death is a major inhibitor of individuals volunteering for HIV-testing, thus the process of health-seeking behaviour.

6.6 Concluding remarks

The findings recorded in this research study clearly indicate that HIV-testing is facilitated when individuals have sufficient knowledge about HIV/AIDS and have had the opportunity to develop their perceptions and opinions about this. In addition, where conditions enable positive personal and interpersonal experiences, whether in the workplace, home or community at large individuals are more likely to change their perceptions and attitudes, and in terms of this research, more likely to volunteer for regular HIV-testing or to suggest this health-seeking behaviour to others. Fear, real or unfounded, inhibits some individuals from volunteering for an HIV-test. However, the nature of the disease and its eventual outcome, if left untreated, is equally a cause of fear in individuals. More than information and positive experiences will be required to alleviate this fear. However, once an individual has undergone an HIV-test fear seems to decline once treatment begins.

The use of Wilber’s four-quadrant framework, as a reference point for data analysis enabled the researcher to penetrate the lived environment and perceptions, opinions, attitudes, experiences and behaviours of the respondents who are Xhosa first-language construction workers.

In conclusion, this research, although part of a greater research endeavour, has provided an opportunity to gain insight on how to conduct research of this nature, while also opening up the opportunity for further research that will expand insightful understanding of the use of HIV voluntary counselling and testing.
References List


PEPFAR HIV counselling and testing technical working group with the Zambia Emory HIV research group. 2009. *Couples HIV counselling and testing TA initiative work planning meeting* January 28-31. New York: PEPFAR.


Appendix 1.

Department of Sociology and Anthropology
Faculty of Arts
NMMU
Tel: +27 (0) 41 504-4083 Fax: +27 (0) 41-504-4276
E-mail [Supervisor]: frans.bezuidenhout@nmmu.ac.za

Date: 10 September 2009
Ref: H/09/ART/SA-002
Contact person: Caron Foster

Dear

You are being asked to participate in a research study. We will provide you with the necessary information to assist you to understand the study and explain what would be expected of you (participant). These guidelines would include the risks, benefits, and your rights as a study subject. Please feel free to ask the researcher to clarify anything that is not clear to you.

To participate, it will be required of you to provide a written consent that will include your signature, date and initials to verify that you understand and agree to the conditions.

You have the right to query concerns regarding the study at any time. Immediately report any new problems during the study, to the researcher. Telephone numbers of the researcher are provided. Please feel free to call these numbers.

Furthermore, it is important that you are aware of the fact that the study has to be approved by the Research Ethics Committee (Human) of the university. The REC-H consists of a group of independent experts that has the responsibility to ensure that the rights and welfare of participants in research are protected and that studies are conducted in an ethical manner. Studies cannot be conducted without REC-H’s approval. Queries with regard to your rights as a research subject can be directed to the Research Ethics Committee (Human) you can call the Director: Research Management at (041) 504-4536. If no one could assist you, you may write to: The Chairperson of the Research, Technology and Innovation Committee, PO Box 77000, Nelson Mandela Metropolitan University, Port Elizabeth, 6031.

Participation in research is completely voluntary. You are not obliged to take part in any research. If you do partake, you have the right to withdraw at any given time, during the study without penalty. However, if you do withdraw from the study, you should return for a final discussion in order to terminate the research in an orderly manner.

The study may be terminated at any time by the researcher, the sponsor or the Research Ethics Committee (Human) that initially approved the study.

Although your identity will, at all times remain confidential the results of the research study may be presented at scientific conferences or in specialist publications.

This informed consent statement has been prepared in compliance with current statutory guidelines.

Yours sincerely

Caron Foster
Researcher
Appendix 2.

Unstructured Interview Schedule

All questions will attempt to define the relationship between factors enhancing a positive attitude towards VCT and those that hinder a positive attitude towards VCT.

1. Knowledge of VCT and importance of knowing HIV-status
   1.1 What do you know about VCT?
   1.2 Do you think HIV testing is important?
   1.3 Why do some individuals not volunteer for HIV testing?
   1.4 Why do some individuals volunteer for HIV testing?
   1.5 Should individuals volunteer for regular HIV testing?
   1.6 Why do you think individuals do not volunteer regularly for HIV-testing?
   1.7 When do you think someone should go for an HIV test?
   1.8 Would you ever suggest to anyone that you knew that they should go for an HIV test?

2. Accessibility and utility of HIV-testing site
   2.1 Are you aware of where you can go for HIV-testing?
   2.2 Where would be the closest place for you to go for an HIV test?
   2.3 Would you ever go to the closest place to you for an HIV-test?
   2.4 If you were to decide to go for an HIV test, where would you choose to go?

3. Confidentiality regarding HIV-test results
   3.1 Do you think that if you have an HIV test at a clinic in your area that your results will be kept confidential?
   3.2 If you don’t think that your HIV test results will be kept confidential could you tell me why you think that?
   3.3 How do you think the nurses at your local clinic would treat an HIV+ individual?

---

30 This detailed unstructured interview guide the ethics (human) committee required in order to grant approval for the research. The researcher was asked to give examples of the types of questions that may be asked during the interviews.
4. **Knowledge of treatment options with regards to HIV-disease management**
   4.1 Do you know if there is any treatment available for people who are HIV+?
   4.2 Do you think it is easy for someone to access treatment as well as ARV’s if they need them because they are HIV+?
   4.3 Do you know if there is any support available for individuals who test HIV+?

5. **Stigmatisation of HIV**
   5.1 Who do you think gets HIV?
   5.2 How is HIV referred to you in your community?
   5.3 Why do you think it is referred to in this way?

6. **Discrimination and HIV**
   6.1 Have you ever seen anyone being treated badly because people think that they have HIV?
   6.2 Have you ever heard of someone who has been treated badly or suffered because they told or people found out that they were HIV+?
   6.3 Are you aware of any discrimination against HIV+ individuals in your community or your place of work?

7. **Community support and action with regards to HIV**
   7.1 Have you ever taken part in a community event that is aimed at HIV-AIDS awareness?
   7.2 Are you aware of any community initiatives in regards to HIV-AIDS?
   7.3 Do you belong to a community group, for example, member of a church, sport club, and stokvel?
   7.4 Has HIV ever been discussed in one of the groups that you belong to?
   7.5 What was the topic of the discussion?
   7.6 How do you think the group that you belong to would treat a member if they found out they were HIV+?

8. **Workplace issues pertaining to HIV**
   8.1 Could you tell me about your HIV-AIDS workplace policy?
   8.2 What for you is the most important aspect/thing in the workplace policy for you?
8.3 Can you tell me what your workplace has done in terms of HIV-AIDS?
8.4 Do your Union Shop Stewards ever talk about HIV at work?
8.5 Is there any support available for HIV+ individuals at your workplace?
8.6 How do you think your managers would treat someone who is HIV+?

9. **Attitudes of colleagues towards HIV and persons with HIV**
   9.1 Have you and your work colleagues ever discussed HIV?
   9.2 If you have discussed HIV can you tell me what concerns your work colleagues the most in regards to HIV?
   9.3 How would your work colleagues react if they knew that someone that they worked with was HIV+?

10. **Genders and HIV**
    10.1 Are women and men who are HIV+ treated differently from each other?
    10.2 Do you think that woman would be treated worse than a man if she were HIV+?
    10.3 What would be the worst thing for a man if he tested positive for HIV?
    10.4 What would be the worst thing for a woman if she tested positive for HIV?

11. **Social factors pertaining to HIV**
    11.1 Do you ever discuss HIV or AIDS in your circle of friends?
    11.2 If you do discuss HIV or AIDS what are your friends main concerns in terms of HIV-AIDS?
    11.3 What do you think your circle of friends would do if one of your friends told you all that they were HIV+?

12. **Home/household issues pertaining to HIV**
    12.1 Have you ever discussed HIV-AIDS at home or with your household members?
    12.2 If HIV-AIDS has been discussed what was the main concern regarding HIV-AIDS of your household members
    12.3 What would happen in your household if a member were infected with HIV?
12.4 How do you think it would affect your household if your community thought that a member of your household was HIV+?
**INFORMATION AND INFORMED CONSENT FORM**

<table>
<thead>
<tr>
<th>Title of the research project</th>
<th>Factors facilitating and inhibiting employees volunteering for Client-initiated HIV-testing: An exploration in an organisation with a HIV workplace policy in the Nelson Mandela Metropole.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference number</td>
<td></td>
</tr>
<tr>
<td>Principal investigator</td>
<td>Caron Foster</td>
</tr>
<tr>
<td>Address</td>
<td>C/O Prof FJ Bezuidenhout Group Dynamics Postgraduate Programme Department of Sociology &amp; Anthropology Faculty of Arts Nelson Mandela Metropolitan University P O Box 77000 Port Elizabeth 6031</td>
</tr>
<tr>
<td>Postal Code</td>
<td></td>
</tr>
<tr>
<td>Contact telephone number</td>
<td>041-504 4083 082 655 6956</td>
</tr>
</tbody>
</table>

**A. DECLARATION BY PARTICIPANT**

<table>
<thead>
<tr>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

I, the participant and the undersigned
I.D. number

Address (of participant)

**A.1 I HEREBY CONFIRM AS FOLLOWS:**

1. I, the participant, was invited to participate in the above-mentioned research project that is being undertaken by Caron Foster
   Sociology and Anthropology
   Arts
   of the Department of
   in the Faculty of
   of the Nelson Mandela Metropolitan University.

2. The following aspects have been explained to me, the participant:
2.1 **The aim of the study:** To explore the factors that facilitate and inhibit employees volunteering for HIV-testing in order to inform a greater research project that seeks to explore the individual, proximal, distal drivers of sexually transmitted diseases and HIV-AIDS.

The information will be used to assist in the design of HIV-AIDS workplace programmes and to inform a greater research project of which this is a pilot study.

2.2 **Procedures:** I understand that my participation will involve:
- An in-depth interview between 40 minutes to an hour in length
- Consultation with the researcher post data analysis to provide feedback on the researcher’s analysis and whether I am in agreement with the conclusions reached.

2.3 **Risks:** None

2.4 **Possible benefits:**
I am aware that my participation in this study will not result in any financial compensation or any other direct personal benefits. Any benefits, which may be derived, will be an indirect result of the awareness generated as a result of the participation in the research endeavours and the findings generated there from.

2.5 **Confidentiality:**
My identity will not be revealed in any discussion, description or scientific publications by the investigators. I am aware that any written documentation containing reference to my identity e.g. interview transcripts, research notes etc will be amended to reflect a pseudonym to protect references to my identity.

2.6 **Access to findings:**
Any new information/or benefit that develops during the course of the study will be shared as follows:
- Provision of an electronic copy of the researcher’s treatise to the HR manager and HIV-AIDS programme coordinator of the organisation in which the research took place.
- Provision of opportunities for one-on-one consultation and oral feedback from the researcher.

2.7 **Voluntary participation/refusal/discontinuation:**

<table>
<thead>
<tr>
<th>My participation is voluntary</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

| My decision whether or not to participate will in no way affect my present or future employment | TRUE | FALSE |

3. The information above was explained to me/the participant by

| Caron Foster |

in

| Afrikaans | English | X | Xhosa | Other |

and I am in command of this language/it was satisfactorily translated to me by

| |

I was given the opportunity to ask questions and all these questions were answered satisfactorily.

4. No pressure was exerted on me to consent to participation and I understand that I may
5. Participation in this study will not result in any additional cost to myself.

**A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE MENTIONED PROJECT**

<table>
<thead>
<tr>
<th>Signed/confirmed at</th>
<th>on</th>
<th>20</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of participant</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of witness</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Full name of witness</th>
</tr>
</thead>
</table>

**B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)**

I, Caron Foster declare that
- I have explained the information given in this document to

- he/she was encouraged and given ample time to ask me any questions;
- this conversation was [Afrikaans] [English] [X] [Xhosa] [Other] conducted in

and no translator was used / this conversation was translated into [language] by

- I have detached Section D and handed it to the participant

<table>
<thead>
<tr>
<th>Signed/confirmed at</th>
<th>on</th>
<th>20</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of interviewer</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of witness</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Full name of witness</th>
</tr>
</thead>
</table>

**D. IMPORTANT MESSAGE TO PARTICIPANT**
Dear participant

Thank you for your participation in this study. Should, at any time during the study:

- you require any further information with regard to the study, or
- the following occur

• Any incident, which may impede your ability to continue participation in the study.
• Any incident that you feel may threaten the confidentiality (your own and/or that of the other members of the study).
• Any incident that you feel may impact negatively on the findings of the research study.

Kindly contact Caron Foster at telephone number 041-5862851 or 083 534 7852 (during office hours only)
Appendix 4

Ethics Approval Letter

Nelson Mandela Metropolitan University
for tomorrow

NORTH CAMPUS
FACULTY OF ARTS
Tel. +27 (0) 41 5043252 Fax. +27 (0) 41 5049252
jannet.nxati@nmmu.ac.za

Ref: H/09/ART/SA-002

Student number: 191055910

7 September 2009

Ms C Foster
6 Twickenham Road
Central
Port Elizabeth
6001

Dear Ms Foster

FACTORS FACILITATING AND INHIBITING EMPLOYEES VOLUNTEERING FOR
CLIENT-INITIATED HIV-TESTING: AN EXPLORATION IN AN ORGANISATION WITH
AN HIV WORKPLACE POLICY IN THE NELSON MANDELA METROPOLE

Your above-entitled application for ethics approval served at the RTI Higher Degrees sub-
committee of the Faculty of Arts Research, Technology and Innovation Committee.

We take pleasure in informing you that the application was approved by the Committee.

The Ethics clearance reference number is H/09/ART/SA-002, and is valid for three years, from
7 September 2009 - 7 September 2011. Please inform the RTI-HDC, via your supervisor, if any
changes (particularly in the methodology) occur during this time. An annual affirmation to the
effect that the protocols in use are still those for which approval was granted, will be required from
you. You will be reminded timeously of this responsibility.

We wish you well with the project.

Yours sincerely

Jxati

Ms Jannet Nxati
FACULTY OFFICER

cc: Promoter/Supervisor
    HoD
    School Representative: Faculty RTI