FACTORS AFFECTING THE UTILISATION OF A WORKPLACE VOLUNTARY COUNSELLING AND TESTING PROGRAMME IN THE EASTERN CAPE

BY

NOMONDE JUSAYO

Submitted in partial fulfilment of the requirements for the degree of Master of Arts (Labour Relations and Human Resources) in the Faculty of Business and Economic Sciences at the Nelson Mandela Metropolitan University

December 2013

SUPERVISOR: J Bowler
DECLARATION

I, Nomonde Jusayo, S196130670, hereby declare that the treatise for Master of Arts (Labour Relations and Human Resources) is my own work and that it has not previously been submitted for assessment or completion of any postgraduate qualification to another University or for another qualification.

NOMONDE JUSAYO
ABSTRACT

The world has entered the third decade of the HIV and AIDS epidemic under different times in which the epidemic is treatable. The International Labour Organisation (ILO) (2005) declares HIV and AIDS a developmental crisis destroying developmental gains over generations.

Since HIV and AIDS affect the most productive segment of the labour force, it is therefore not only a threat to development but also to the world of work without which development will be sacrificed (ILO, 2001). Collaborative response efforts that seek to mitigate the HIV pandemic by government, business and higher education institutions have been fraught with challenges.

The main challenge that beset these efforts is that, in the absence of an HIV vaccine, voluntary counselling and testing remains the gateway to access treatment and care. Regrettably, participation in VCT has been confronted by challenges of low utilisation. This precedes the objectives of this study, which were to explore and describe factors that serve as barriers and facilitators of workplace VCT programmes with the objective to improve participation in these programmes.

The current study was a product of a qualitative and exploratory-descriptive research design. A nonprobability convenience sampling method was used to sample participants for this study. The targeted population in this study were the non-academic employees of an academic institution in the Eastern Cape. Data was collected by means of focus group discussions and by using semi-structured interviews. The focus group samples comprised of an equal number of men and women with an overall participation of fifty-six participants. Data obtained was transcribed, thematically analysed and coded using Henning, Van Rensburg, and Smit's (2004) qualitative analysis and interpretation method.

Findings of this research revealed that factors that facilitate and inhibit voluntary counselling and testing are psychosocial and cultural by nature. At psychosocial level, participants reported factors that facilitate voluntary counselling and testing to include psychological readiness to go for HIV testing, reassurances of confidentiality of HIV test results and normalising HIV testing (making the process more like that for
screening and diagnostic testing). Cultural factors included cultural practices and beliefs such as "intonjane" and traditional circumcision - positive cultural nurturers that could facilitate VCT participation.

Results of this study showed a lack of basic knowledge about VCT and fear of knowing one's status, fear of breach of confidentiality, fear of being stigmatised and a lack of trust towards health professional as the major psychosocial factors that serve as barriers to VCT participation. The cultural barriers to VCT pointed to hegemonic masculinity as a socially constructed gender identity that encourages gender inequalities and undermines efforts to improve HIV testing. The study suggested that strategies to increase VCT participation should consider leadership support of VCT programmes, incentivisation of VCT programmes, institutionalisation of HIV and AIDS education and the establishment of integrated wellness services for employees.

**Key words:** HIV and AIDS, VCT, psychosocial and cultural factors
ACKNOWLEDGEMENTS

I am gratefully indebted to individuals and the institution that provided with the research platform which enabled me to complete this research project.

- This research would not have been possible without the invaluable supervision and mentorship of my supervisor, Ms Jennifer Bowler. I greatly appreciate her unwavering support and encouragement and thank her for patiently working with me through the research process.

- I am also indebted to Prof Mark Anstey for his encouragement, support and belief in my capabilities.

- I extend my gratitude to my research teacher, Mrs Dalray Gradidge, for her tutorship, especially when I battled with the chapter on research design.

- I wish to express my heartfelt gratitude to my mother, for valuable education and instilling in me the values of diligence and perseverance. I thank her for support and for holding the forte (looking after my two children) while I was working long hours trying to complete this research. May God bless you always!

- My cousin, Mzukisi Hlangwana, for providing support to both my mother and my boys when I was working late hours and away from my family. I thank God for having a cousin like you! Thanks, "Bhungane".

- My two sons, Camagwini and Lihlumelo, for their love and support. I hope this project will motivate you to internalise the value of education.

- I am thankful to Dr NN Sipholi, for his encouragement, generosity of spirit in providing emotional and financial support throughout the entire research project. You an epitome of UBUNTU, Ndish!

- A special thank you to Dr Marshall Mokoena (my clinical psychologist) for his belief in my capabilities, reading the manuscripts and for empowering me with clinical skills to keep me focused throughout the research project.

- A special thank you to my HOD, Mr Horne, for his timely words when anxiety sat in.
• I wish to thank my research participants sincerely for their valuable contribution during the data collection process.

• Lastly, to all my friends who waited patiently to see this project finished: this is it! I thank you for your words of support and validation of my capabilities.
<table>
<thead>
<tr>
<th>ACRONYMS AND ABBREVIATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACU</td>
</tr>
<tr>
<td>ADM</td>
</tr>
<tr>
<td>AIDS</td>
</tr>
<tr>
<td>ART</td>
</tr>
<tr>
<td>ASSA</td>
</tr>
<tr>
<td>BCEA</td>
</tr>
<tr>
<td>CHS</td>
</tr>
<tr>
<td>DMP</td>
</tr>
<tr>
<td>DoE</td>
</tr>
<tr>
<td>DoH</td>
</tr>
<tr>
<td>ECPGD&amp;P</td>
</tr>
<tr>
<td>ECSECC</td>
</tr>
<tr>
<td>EDC</td>
</tr>
<tr>
<td>EEA</td>
</tr>
<tr>
<td>ELRC</td>
</tr>
<tr>
<td>FDI</td>
</tr>
<tr>
<td>GDP</td>
</tr>
<tr>
<td>GRI</td>
</tr>
<tr>
<td>HCT</td>
</tr>
<tr>
<td>HDI</td>
</tr>
<tr>
<td>HE ACT</td>
</tr>
<tr>
<td>HEAIDS</td>
</tr>
<tr>
<td>HEIs</td>
</tr>
<tr>
<td>HIV</td>
</tr>
<tr>
<td>HSRC</td>
</tr>
<tr>
<td>ILO</td>
</tr>
<tr>
<td>LRA</td>
</tr>
<tr>
<td>MCP</td>
</tr>
<tr>
<td>MMC</td>
</tr>
<tr>
<td>NEDLAC</td>
</tr>
<tr>
<td>NEHAWU</td>
</tr>
<tr>
<td>Acronym</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>NMMM</td>
</tr>
<tr>
<td>NMMU</td>
</tr>
<tr>
<td>OHSA</td>
</tr>
<tr>
<td>PICT</td>
</tr>
<tr>
<td>PLWHA</td>
</tr>
<tr>
<td>PMTCT</td>
</tr>
<tr>
<td>SADC</td>
</tr>
<tr>
<td>SAUVCA</td>
</tr>
<tr>
<td>SSA</td>
</tr>
<tr>
<td>UNAIDS</td>
</tr>
<tr>
<td>UNESCO</td>
</tr>
<tr>
<td>VCT</td>
</tr>
<tr>
<td>WHO</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

Declaration .......................................................................................................................... i
Abstract ................................................................................................................................... ii
Acknowledgements ................................................................................................................ iv
Acronyms and abbreviations ............................................................................................... vi
Table of contents ................................................................................................................... viii

## CHAPTER 1

INTRODUCTION .................................................................................................................. 1

1.1 BACKGROUND TO THE STUDY .............................................................................. 2
1.1.1 Psychological and socio-cultural factors .............................................................. 2
1.1.2 Location of the study: Eastern Cape ................................................................. 3
1.1.3 Population profile of the Eastern Cape Province .............................................. 4
1.2 LITERATURE REVIEW ............................................................................................ 5
1.3 STATEMENT OF THE PROBLEM ........................................................................... 6
1.3.1 Aims and objectives .............................................................................................. 8
1.3.2 The research questions ......................................................................................... 8
1.4 RESEARCH METHOD ............................................................................................ 10
1.4.1 Population ........................................................................................................... 10
1.4.2 Sample and sample selection .............................................................................. 10
1.4.3 Research Instrument ............................................................................................ 11
1.4.3.1 Procedure ....................................................................................................... 11
1.4.4 Data capture and analysis .................................................................................... 12
1.4.5 Dissemination of results ....................................................................................... 12
1.5 THE THESIS OUTLINE ......................................................................................... 12

## CHAPTER 2

LITERATURE REVIEW ....................................................................................................... 15

2.1 INTRODUCTION ....................................................................................................... 15
2.2 HIV AND AIDS ......................................................................................................... 15
2.3 HIV PREVALENCE AND GENDER ......................................................................... 16
2.4 HIV AND AIDS IN THE WORKPLACE ..................................................................... 18
2.5 HIV AND AIDS IN SOUTH AFRICAN HIGHER EDUCATION .......................... 20
2.6 RESPONSES TO THE FIGHT AGAINST HIV AND AIDS .................................... 20
2.6.1 International Labour organization (ILO) ................................................. 21
2.6.2 South Africa’s legal framework on HIV and AIDS and government’s responses .................................................... 22
2.6.3 Employer’s and organised labour responses ........................................... 24
2.6.4 Quest for good governance ..................................................................... 25
2.6.5 The trade union federation ..................................................................... 25
2.7 HIGHER EDUCATION’S RESPONSE TO HIV AND AIDS .................. 26
2.8 SOUTH AFRICA’S HE HIV AND AIDS WORKPLACE PROGRAMME FRAMEWORK ................................... 27
2.9 CONCLUSION ............................................................................................. 28

CHAPTER 3
VOLUNTARY COUNSELLING AND TESTING ........................................... 29
3.1 INTRODUCTION ....................................................................................... 29
3.2 HIV TESTING: APPROACHES AND CHALLENGES ............................. 29
3.2.1 Approaches to HIV testing .................................................................... 30
3.2.2 Importance of VCT services .................................................................. 30
3.3 FACTORS THAT SERVE AS BARRIERS TO HIV TESTING ............. 31
3.3.1 Individual Level barriers ...................................................................... 32
3.3.2 Barriers: Systems/structural ................................................................. 35
3.4 BARRIERS: COUNSELLING AND TESTING ........................................... 35
3.5 FACTORS THAT FACILITATE HIV TESTING ....................................... 38
3.6 CONCLUSION ............................................................................................. 39

CHAPTER 4
RESEARCH METHOD .................................................................................. 41
4.1 INTRODUCTION ....................................................................................... 41
4.2 RESEARCH DESIGN .................................................................................. 41
4.2.1 The value of qualitative research .......................................................... 41
4.2.2 Exploratory research ............................................................................ 42
4.2.3 Descriptive research ............................................................................ 43
4.1.4 Population .............................................................................................. 44
4.3 SAMPLING AND SAMPLE SELECTION ............................................... 45
4.4 ACCESS AND ETHICAL CONSIDERATION .......................................... 46
4.4.1 Permission ............................................................................................. 46
4.4.2 Informed consent .................................................................................. 47
4.4.3 Autonomy and confidentiality .......................................... 49
4.5 DATA COLLECTION ................................................................... 49
4.6 PILOT STUDY .............................................................................. 51
4.7 DATA COLLECTION AND INTERVIEW TRANSCRIPTION .......... 52
4.7.1 Coordinating study participants ......................................... 52
4.8 DATA ANALYSIS ........................................................................ 55
4.9 DATA VERIFICATION ................................................................. 56
4.10 CONCLUSION ............................................................................. 57

CHAPTER 5
RESULTS AND DISCUSSION ............................................................ 58
5.1 INTRODUCTION ........................................................................... 58
5.2 DEMOGRAPHIC ATTRIBUTES OF PARTICIPANTS ................. 58
5.3 PRESENTATION OF FINDINGS ...................................................... 59
5.3.1 Theme 1: Knowledge about VCT ........................................ 60
5.3.2 Theme 2: Accessibility of and attitudes towards VCT .......... 63
5.3.2.1 Theme 2: sub-question 1: What makes it difficult for people to go for an HIV test? .............................................................. 63
5.3.2.2 Theme 2: Accessibility of and attitudes towards VCT (positive) .................................................................................. 66
5.3.3 Theme 3: Culture ....................................................................... 67
5.4 THEME 4: DISCLOSURE AND STIGMA ................................. 70
5.5 WORKPLACE ISSUES PERTAINING TO HIV AND AIDS ........ 72
5.6 DISCUSSION OF FINDINGS: INTRODUCTION ......................... 74
5.6.1 Theme 1: Knowledge about VCT ........................................ 74
5.6.2 Theme 2: Accessibility of and attitudes towards VCT ......... 79
5.6.3 Theme 3: Cultural beliefs and other practices .................... 87
5.6.4 Theme 4: Disclosure and stigma .......................................... 93
5.6.5 Theme 5: Workplace issues pertaining to HIV and AIDS .......... 94
5.7 CONCLUSION ............................................................................. 97

CHAPTER 6
CONCLUSIONS AND RECOMMENDATIONS ..................................... 99
6.1 INTRODUCTION ........................................................................... 99
6.2 SUMMARY AND CONCLUSIONS OF THE STUDY ................... 99
6.2.1 Positive factors to affect employee participation in HIV testing ................................................................. 99
6.2.2 Negative factors to affect employee participation in HIV testing ............................................................. 103
6.3 RECOMMENDATIONS ............................................................................................................................... 108
6.4 VALUE OF THE STUDY ............................................................................................................................ 110
6.5 LIMITATIONS OF THE STUDY ................................................................................................................ 111
6.6 RECOMMENDATIONS FOR FURTHER RESEARCH .......................................................... 111
6.7 CONCLUSION ............................................................................................................................................ 112

REFERENCES ................................................................................................................................................ 114

Appendix 1: Application for approval from NMMU Research Ethics Committee (Human) .................................... 140
Appendix 2: Research method ....................................................................................................................... 146
Appendix 3: Unstructured interview schedule ............................................................................................... 149
Appendix 4: Invitation to participate in study ............................................................................................... 151
Appendix 5: Request for permission to conduct research at WSU premises .................................................. 152
LIST OF TABLES

Table 4.1: Sample of the of focus group participants ......................... 54
Table 5.1: Socio-demographic details of focus group participants
(n=56) ................................................................................................. 59
Table 5.2: Semi-structured interview schedule ............................... 60
CHAPTER 1
INTRODUCTION

Heymann (2003 cited in Shisana, 2007:2) noted,

"of all diseases, AIDS provides the most dramatic and disturbing example of the capacity of a previously unknown pathogen to rapidly spread throughout the world causing social and economic upheaval of a scale that threatens to destabilise a large geographic area".

The International Labour Organization (ILO) (2005) concurs with this assertion and declares HIV and AIDS as a developmental crisis destroying developmental gains over generations. Since HIV and AIDS affect the most productive segment of the labour force, it is therefore not only a threat to development but also to the world of work without which development will be sacrificed (ILO, 2001). Various scholars agree that HIV and AIDS have far-reaching consequences on the social, economic and psychological wellbeing of people and organisations as opposed to being only a public health problem (Cairns, Dickson, & Orr, 2006 Chetty, 2000; Ijaiya, Raheem, Olatinwo, Ijaiya, & Bello, 2012; Nattrass, 2004; Nattrass, 2012).

HIV and AIDS, if not properly managed, can reverse development gains by ten years (Barnett & Whiteside, 2000, 2006). Risk assessment and identification is a key component of HIV and AIDS workplace programmes (Brink, 2003; King, 2002; National Economic Development and Labour Council [NEDLAC], 2002; Vass, 2004). Risk profiling provides critical information regarding behavioural factors related to the prevalence of HIV transmission. In the absence of an HIV vaccine, voluntary counselling and testing (VCT) remains the only prevention strategy that could mitigate the reversal of developmental gains because of the correlation between early diagnosis, treatment and prolonged life expectancy (European Centre for Disease Prevention and Control [EDCD], 2010). The success of any VCT programme would arguably be affected by an understanding or lack thereof of factors that facilitate or inhibit VCT.
1.1 BACKGROUND TO THE STUDY

This study was broadly located in the field of integrated risk and employee wellness programmes. The specific focus was on HIV risk behaviour change and voluntary counselling and testing (VCT) within the workplace. The study was set within the context of the Eastern Cape in South Africa. More specifically, the study explored the impact of psychological as well as socio-cultural indicators on the uptake of VCT programmes by non-academic employees of an Eastern Cape university.

1.1.1 Psychological and socio-cultural factors

The World Health Organization (WHO) (Bradshaw et al., 2007) reports the three leading risk factors that contribute to the burden of disease in South Africa as unsafe sex, interpersonal violence and alcohol abuse. Studies in HIV and AIDS profess that prevention measures such as VCT cannot be effectively implemented unless organisations understand the social behavioural context that influences risky (unsafe) behaviour associated with HIV transmission (Bolton & Singer, 1992; DiClemente & Wingwood, 1997; Gilbert & Selikow, 2011). An increase in VCT uptake will reduce reliance on broad assumptions of actuarial modelling and provide an organisation with "reliable" data for cost-benefit analysis (Dickson & Stevens, 2005; Dorrington & Bradshaw, 2002). In turn, the cost-benefit analysis will inform broader human capital decisions, thereby prolonging employees' lives and making the optimal health of employees a strategic priority.

Within the realm of wellness, Adkins, Quick and Moe (2000) assert that the concept of health reflects a continuum from mortality to wellbeing and therefore the purpose of organisational wellness is not merely to avoid ultimate destruction, but rather a quest to move toward abundant life. Integrating the assessment of health risks into organising wellness programmes has led to the inclusion of HIV screening for HIV as part of a continuum of care (George & Quinlan, 2008). Such a continuum of care is said to be a common feature of most South African organisations, including institutions of higher education (Anderson & Louw-Potgieter, 2012; Dube & Ocholla, 2005; Von Der Marwitz & Were-Okella, 2010).
The doctrine of workplace VCT programming with access to treatment aspires to provide abundant life (a prolonged productive life) for those diagnosed with HIV. Coovadia (2000) agrees and acknowledges that VCT prevents HIV transmission through information, education and psychological benefits that help the individual cope better and lead a positive life. The paradigm of positive psychology purports that optimum health and wellness can lead to productivity and a flourishing organisation (Cameron, Dutton, & Quinn, 2003). The WHO (1948 cited in Els & De la Rey, 2006:48) defines optimal health as a state of complete physical, mental and social being and not merely the absence of disease or infirmity. Investing in the prevention of HIV and AIDS through a workplace VCT programme provides the net benefits of avoided cost of that infection minus the costs of the prevention programme (Rosen, 2004). An actual finding on the roll-out of anti-retroviral therapy (ART) to DEBSWANA employees and their spouses in 2001 found that only twelve per cent of the company’s payroll would account for the project (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2002). This is the case because VCT programmes can reduce illness-related costs (absenteeism, medical costs) and reduce termination-related costs for further future (Rosen, 2004).

The current study sought to describe factors that serve as barriers and facilitators of a workplace VCT programme with the objective to improve the uptake of the programme.

1.1.2 Location of the study: Eastern Cape

Following a re-demarcation process of South African municipalities under the banner of "one city one municipality", the Eastern Cape Province was split into two big municipalities, namely the Nelson Mandela Metropolitan Municipality (NMMM) in Port Elizabeth and the Amathole District Municipality (ADM) in the former Transkei and Ciskei homeland administration as well as other former areas of the Cape Administration (Amathole District Municipality, 2008–2009; Pillay, Tomlinson, & Du Toit, 2006). The ADM’s areas of jurisdiction are comprised of eight municipalities, which these include the Buffalo City Municipality where the target site is located. Buffalo City lies on the eastern seaboard of the province with East London and King William’s Town being the two main city centres. Industrial zones are found in
locations such as Fort Jackson in Mdantsane, which is also adjacent to Berlin and Postdam as well as King William's Town's adjacent Zwelitsha and Dimbaza.

1.1.3 Population profile of the Eastern Cape Province

Out of the nine provinces of South Africa, the Eastern Cape is the province with the third largest population after Gauteng and KwaZulu-Natal. Currently, the population figure is 6.9 million and this has increased by 4.5% since 2001 (Eastern Cape Socio-Economic Consultative Council [ECSECC], 2013). While the Eastern Cape Province remains the third biggest province, its poor economy has ironically caused it to be registered as the second poorest province after Limpopo (Erasmus, Leodolff, Mda, & Nel, 2009).

Economic growth is driven by, amongst others, the human development index (HDI). The HDI was developed in 1990 by the United Nations (UN) to measure the average achievements in basic human development (Boutayeb, 2009). The main composite indices of HDI are education, gender inequalities and empowerment, health, income or gross domestic product (GDP) and human poverty. Regrettably, all these indices of human development are at odds with economic development in the Eastern Cape Province (ECSECC, 2013). First, other than the Limpopo Province, the Eastern Cape has the highest percentage of illiteracy, which is currently at 10.5% of the population. Second, with illiteracy, poverty becomes inevitable. Of the 22 million people living in poverty in South Africa, 3.9 million live in the Eastern Cape (ECSECC, 2013). Third, whilst South Africa’s narrow definition of unemployment was at 29.8% and expanded definition at 42% in 2011. The Eastern Cape figures on both definitions were high. For instance, during the same year (2011) the unemployment rate informed by the narrow definition stood at 37%, while the expanded definition accounted for 51%. Finally, gender-based violence and alcohol abuse are cited as two of the problems in the province by the Ministry of Safety and Liaison (ECSECC, 2013).

Against this backdrop, the HDI in the Eastern Cape has been coming down since 1995 (i.e. dropped from 0.582 in 1995 to 0.513 in 2010). This trend has continued to spiral downwards over the past five years due to changes in life expectancy resulting from HIV and AIDS-related illness and deaths (ECSECC, 2013). Research indicates that where HDI indices have been reversed, they become causal drivers or structural
drivers of HIV and AIDS (Boutayeb, 2009). A study conducted in the Eastern Cape on the social determinants of HIV and AIDS revealed that cultural norms, unemployment, poverty, gender inequality, stigma and migration were the key drivers of HIV risk behaviour (Phaswana-Mafuya, Seager, Peltzer, Jooste, & Mkhonto, 2009). The same study showed that multiple partners in the age group 15–49 increased from 12.1 per cent in 2002 to 13.1 per cent in 2008.

1.2 LITERATURE REVIEW

The European Centre for Disease Prevention and Control (ECDC) (2010) maintains that HIV voluntary counselling and testing are inextricably linked in that early diagnosis facilitates early referral for treatment and care (Asante, 2007; Dallimore et al., 2002 cited in Mundy & Dickinson, 2004; ECDC, 2010). The importance of HIV testing is expressed by De Cock, Mboriga Nanga and Marum (2002) who profess that the process of discovering one’s status - irrespective of the test results - is an opportunity for education and motivation to modify behaviour aimed at reducing the risk of HIV transmission. The survival of many HIV-positive people is testimony to the advances in the treatment of HIV infection, which has dramatically improved the health and life expectancy of those infected, and thus transformed AIDS from an acute life-threatening disease to an established chronic condition (ECDC, 2010; Gilbert & Selikow, 2011).

Reporting on findings of studies regarding management responses to HIV and AIDS, Bolton (2008) writes that most companies agree that assertive action against HIV and AIDS is critical and cost-effective for both short- and long-term profitability. A case in point is a 2005 evaluation by Anglo-American, which reported a 70 per cent return over the first twelve-month period on every dollar spent for employee treatment with antiretroviral drugs (Bolton, 2008).

Whilst various reports lament the low uptake of workplace VCT programmes (Bhagwanjee, Petersen, & George, 2008; George & Quinlan, 2009), others (Dallimore et al., 2002 cited in Mundy & Dickinson, 2004) argue for the establishment of an environment in which employees learn about the benefits of knowing their sero-status early as a key in the rolling-out of workplace VCT programmes. The litmus test for such an environment is the identification of factors that support and undermine
VCT through worker participation (Dickinson & Mundy, 2004). As an inclusive and consultative process, worker participation recognises the needs and rights of employees to be individually and collectively involved with management on matters of decision-making beyond those associated with collective bargaining (Anstey, 1997).

Worker participation is a preferred choice in order to eliminate the traditional top-down approach reminiscent of an adversarial approach to labour relations (Barnett & Whiteside, 2000). The adversarial approach has shouldered the blamed for the poor enrolment in VCT programmes in the workplace (Dickinson & Mundy, 2004). In conformance with the participative approach to workplace VCT programmes, this study explored and described the factors that facilitate or inhibit HIV testing in the workplace by voluntarily inviting employees to be study participants.

Chapter three will draw from literature studies and present a discussion on the factors that facilitate or inhibit the utilisation of VCT.

1.3 STATEMENT OF THE PROBLEM

The Joint United Nation’s Programme on HIV and AIDS (UNAIDS, 2008) defined South Africa’s HIV and AIDS epidemic as a hyper-endemic epidemic since more than 15% of the population aged 15–49 years were living with HIV and AIDS. Dorrington, Johnson, Bradshaw and Daniel (2006) adopted the ASSA3 model estimates and report that at that stage, 90.8% of those living with HIV were in the age group 20–64 years - which is the age group most likely to form part of the labour force (ILO, 2001). The effect of HIV and AIDS on the economically active populations poses a serious threat to the demand and supply of labour, capital investment and utilisation (Natraz, 2012).

The high prevalence rate of HIV amongst the high-risk group (15–49 years) poses an imminent threat to the financial viability of higher education Institutions (HEIs) through low student enrolments and lead time in completion of studies (Cohen, 2002; Mahal, 2007; Von Der Marwitz & Were-Okello, 2010). This is the case because parents who are affected by the macroeconomic impact of AIDS will find it difficult to cope with university fees (Ijaiya et al., 2012). In addition, HEIs face a real risk of
losing skilled and experienced HEI employees to the epidemic, and with them also institutional memories (Von Der Marwitz & Were-Okello, 2010). The consequent loss of skills will lower the standard of HEIs’ workforce inputs to enterprise development and thus undermine the consolidation of the transformation agenda through quality education. In the light of the pervasiveness of the pandemic, the South African Universities Vice-Chancellors Association (SAUVCA) acknowledged AIDS as not just a health issue but also as a developmental crisis (SAUVCA, 2000).

In the absence of an HIV vaccine, Dickinson (2010) provides a summary of key aspects of recommended workplace HIV and AIDS responses in corporations. One of these key aspects was to encourage voluntary HIV testing as well as to provide related counselling. One study confirmed a mutually reinforcing relationship between HIV counselling and testing and retroviral treatment (Phakathi, Van Rooyen, Fritz, & Richter, 2011). The South African government bolstered prevention strategies by aiming to reduce infection by 50% in 2011 by using testing and available antiretroviral therapy in 80% of those in need of treatment (Motsoaledi, 2010).

Phakathi et al. (2011) emphasise the importance of taking an HIV test as a significant part of HIV prevention. Whilst there has been an increase (from 11.9% to 24.7% in 2008) in the number of people who are aware of their HIV status in South Africa (Shisana et al., 2008), Phakathi et al. (2011) still maintain that far too many people still do not know their status. Coleman (2009:26) explains, 'going for HIV testing is not easy' Rehle et al. (2007 cited in Dickinson, 2008) also observed a continued reluctance to test. This happens against the backdrop of evidence which points to a correlation between early diagnosis and treatment of HIV infection in reducing morbidity and mortality, yet still, little evidence exists that these workplace programmes are achieving the desired results (Bhagwanjee et al., 2008; George, 2006).

Part of the continued reluctance to test for HIV can be attributed to the bio-medical approach to testing which ignores contextual factors such as socio-economic, political, gender and cultural and organisational realities, which confront workers in their society and workplace (Gilbert & Selikow, 2011; Sibanda, 2011). DiClemente and Wingwood (1997) support this view and assert that, because HIV links sexuality with the disease, it is important to establish the psychosocial and economic factors
that underlie the decision-making process in peoples' engagement in risky behaviour. Gilbert and Selokow (2011) identified the following contextual factors that underpin the differential vulnerabilities between men and women: patriarchy, sexual norms (such as intergenerational sex and having multiple sex partners), high levels of violence against women, women's subordinate roles to men, as well as inadequate material resources. George and Sprague (2011:293) refer to a "feminized HIV pandemic". Baxen, Wood, and Austin (2011) assert that HIV and AIDS literacy implies that teachers must be knowledgeable about wider and complex cultural, economic and social factors than only the bio-medical facts.

1.3.1 Aims and objectives

The general aim of this study was to add to the evaluative body of knowledge regarding HIV testing programmes by exploring the self-reported factors affecting participation of employees at a university in the Eastern Cape. The specific research objectives were:

- to explore and describe factors perceived to affect employee participation in a workplace HIV testing programme positively;
- to explore and describe factors perceived to affect employee participation in a workplace HIV testing programme negatively; and
- to make recommendations regarding the improvement of the programme to management in order to improve HIV testing rates.

1.3.2 The research questions

Research questions are those questions researchers propose to answer through data collection (Hennink, Hunter, & Bailey, 2011). There are two purposes of research questions: namely (1) to identify the objects or entities that the researcher wants to investigate, and (2) to serve as chief criterion in determining the research design of the study (Willig, 2001). Research questions can take two forms, the central question and associated sub-questions (Creswell 2013). The central question is a broad question that asks for an exploration of the central phenomenon in the
study and it is posed so as not to limit the inquiry (Creswell, 2009). This study presented the following questions to the participants:

**KNOWLEDGE ABOUT HIV TESTING**

- Tell me about what you know about HIV voluntary counselling and testing (VCT).
- How did you get to know about VCT?
- When do you think people should go for HIV testing?

**ACCESSIBILITY AND ATTITUDES TOWARDS VCT**

- What do you think makes it difficult for people to go forward for HIV testing?
- What are the things that encourage people to go for HIV testing?
- If you were to go for an HIV test, where would you prefer to go to, and why?
- What are your views regarding VCT campaigns that have been launched on campus?
- Do you think that the results will kept confidential if you go for testing on campus?

**CULTURAL BELIEFS AND OTHER PRACTICES**

- Can you describe ways in which cultural (traditional) beliefs encourage or discourage people's decisions to go for an HIV test?
- In what ways do you think being male or female affects people's decisions to go for HIV testing?
- Are women and men who are HIV+ treated differently?
- What role (if any) does alcohol abuse play in participation in HIV testing?

**DISCLOSURE AND STIGMA**

- In conversations you had with your friends or colleagues, which views did they present about HIV testing?
- Which comments did they make about people who are HIV+?
• Are you aware of any discrimination against HIV+ individuals at this institution?

WORKPLACE ISSUES PERTAINING TO HIV

• Could you tell me about this institution’s HIV and AIDS workplace policy?
• What is for you the most important issue in the workplace policy?
• What do you feel about the support available for HIV+ people at the current institution?
• What would you like to see at this campus that would support HIV testing?
• What would you like to see at this institution that would support HIV+ employees?

1.4 RESEARCH METHOD

The research method of this study was qualitative and exploratory-descriptive by nature. Exploratory research refers to a "broad ranging, purposive, systematic, pre-arranged undertaking designed to maximise the discovery of generalisations leading to a description and understanding of an area of social or psychological life" (Stebbins, 2001, p. 3). This study was not only exploratory but also descriptive by nature. Exploratory-descriptive studies attempt to source the quality and texture of the participants’ perceptions, while simultaneously endeavouring to foster an understanding of the participants’ experiences about the subject under investigation (Willig, 2001).

1.4.1 Population

The targeted population in this study were the non-academic employees working at a particular site of a tertiary academic institution in the Eastern Cape.

1.4.2 Sample and sample selection

A nonprobability convenience sampling method was used to sample participants for this study. Sample inclusion criteria were as follows:
• only non-academic employees; and
• a minimum qualification of matriculation (to ensure an appropriate English language literacy level since the focus groups were conducted in English) using equal numbers of men and women to explore the gendered nature of factors affecting testing.

The sample for the study comprised of an equal number of male and female participants. Six focus group discussions were conducted and the total number of participants was fifty-six.

1.4.3 Research Instrument

Focus group data was gathered using a semi-structured interview schedule based on the research questions outlined above (see Appendix 1).

1.4.3.1 Procedure

Ethics approval was sought and obtained from the Nelson Mandela Metropolitan University (NMMU). A letter of consent was obtained from the Directorate of the Centre for HIV and AIDS at the target site (see Appendix 5). Letters of invitation to participate in the study were issued by the Directorate for the Centre for HIV and AIDS to all non-academic staff of the target site via email (see Appendix 4) to indicate institutional support of the study. However, correspondence regarding interest in participation was sent back directly to the researcher for the sake of maximum confidentiality. Interested staff was asked to correspond with the researcher and book their place in the study. Interview times and venue details were communicated via email by the researcher to those agreeing to participate. Participants were kept completely informed at all times as to which kind of data was being collected, and what would be done with it (see Appendix 3).

Focus groups each included eight to twelve participants. The final number of focus group participants was fifty-six and the average number of each focus group was nine. The researcher over-recruited by 20% to allow for participant withdrawals. Owing to the sensitivity of the topic under investigation and for purposes of eliminating possible feelings of discomfort on the part of the participants, male and
female focus group interviews were conducted separately. A minimum of three focus groups per gender group (six focus groups in total) were arranged initially in order to ensure adequate sampling for saturation purposes.

1.4.4 Data capture and analysis

The interviews were recorded and were conducted until data saturation was reached. The researcher conducted interviews in English. The interviews were tape-recorded and informed consent pertaining to the use of recording instruments was sought from participants. Participants were also informed of their rights to participate voluntarily in the interviews and that they could withdraw at any stage of the process. Data obtained was transcribed, thematically analysed and coded using Henning, van Rensburg, and Smit's (2004) qualitative analysis and interpretation method. The results were written up by the researcher.

1.4.5 Dissemination of results

The study was done in partial fulfilment of the requirements for the master's degree in Labour Relations and Human Resources at the Nelson Mandela Metropolitan University, South Africa. A copy of the thesis will be presented to the Research Unit and Directorate of HIV and Centre of the target site.

1.5 THE THESIS OUTLINE

The first chapter provided an overview of the focus of the study and a brief discussion on the methodology adopted to achieve the objectives of the study. The literature review of this study is reflected in two chapters: Chapters two and three. Chapter two summarises the literature on HIV and AIDS in the workplace specifically with regard to:

- the difference between HIV and AIDS;
- the prevalence of HIV and AIDS;
- the gendered aspects of the pandemic;
- the impact of HIV and AIDS in the workplace;
• the impact of HIV and AIDS on Higher Education; and
• the response to HIV and AIDS in the employment environment.

Chapter three provides a discussion on voluntary counselling and testing. In providing a discussion on VCT, this chapter -

• describes HIV testing approaches and challenges;
• explores the various approaches to VCT;
• elucidates the importance of VCT; and
• describes the factors that facilitates and those that serve as barriers to VCT.

Chapter four reports on the methodological structure of the study, more specifically -

• the population and sampling;
• the ethical considerations;
• the procedure for the data collection and analysis; and
• explanation of data verification.

Chapter five reports on and discusses the research findings. The chapter is divided into three broad sections:

• section one looks at the profile of the study participants;
• section two presents results of the factors that influence workplace VCT by non-academic staff of an academic institution in the Eastern Cape. These factors are presented according to five themes, namely
  – knowledge about HIV and AIDS;
  – accessibility and attitudes towards VCT;
  – cultural beliefs and other practices;
  – disclosure and stigma; and
  – workplace issues pertaining to HIV;
section three provides a thematic discussion of the findings and makes use of relevant literature;

Chapter six provides a summary of the conclusions derived from the study findings. The chapter also discusses the value of the study, limitations encountered during the study, and offers some suggestions for both more effective use of workplace VCT and further research.
CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents a summary of the literature on HIV and AIDS in the workplace specifically as regards:

- the difference between HIV and AIDS;
- the prevalence of HIV and AIDS;
- the gendered aspects of the pandemic;
- the effect of HIV and AIDS in the workplace;
- the effect of HIV and AIDS on higher education; and
- the response to HIV and AIDS in the employment environment

2.2 HIV AND AIDS

AIDS is an acronym for acquired immune deficiency syndrome and is the final stage of the human immuno-deficiency virus (HIV). The HIV is a virus that infects the human immune system upon entering the body. When the human immune system is infected by HIV, it becomes vulnerable to the development of opportunistic diseases. When opportunities of early diagnosis of HIV infection with appropriate initiation of treatment have been missed, a breakdown of all body immunity leads to the development of AIDS (Ijaiya et al., 2010).

The epidemiological transmission trend of HIV transmission has changed. Previously, the virus was dominant amongst homosexual groups (Abdool Karim & Gouws 2005; DiClemente & Wingood, 1997). Heterosexual intercourse accounts for the greater proportion of cases within developing countries (UNAIDS, 2010; World Bank, 1997). As a mode of HIV transmission, heterosexual intercourse links sexuality to the HIV disease and therefore it is important to confront factors associated with risk-taking behaviour when dealing with the HIV epidemic. Whilst HIV is as an etiological agent of AIDS, a lack of appropriate preventative behaviour drives the epidemic
The HIV epidemic must be understood from all the domains of the psychosocial and cultural context (DiClemente & Wingood, 1997). Guided by that assertion, the next section explores the global statistical impact of HIV with reference to gender.

2.3 HIV PREVALENCE AND GENDER

The UNAIDS 2012 Report on the global AIDS epidemic estimates that in 2011, 334 million people worldwide were living with HIV. The geographical distribution of modes of transmission indicates that heterosexual transmission of HIV is an important mechanism of transmission (Abdool Karim, 2005). A striking characteristic of heterosexual transmission is the disproportionate burden of HIV infection in young women compared to men (Abdool Karim, & Gouws, 2005; Gilbert & Selikow, 2011; Setswe, 2011; Sowell, Holtz, Van Brackle, Velasquez, & Alonso, 2013). Of the 334 million HIV-positive people, 69% were found to be living in sub-Saharan Africa (UNAIDS, 2012).

The sub-Saharan African region accounts for 10% of the world population (HEAIDS, 2010), yet in the region as a whole, women are affected by approximately 60% of estimated HIV infections. Reports attribute the disproportionate share of HIV and AIDS burden to women, to the fact that they are most likely infected by men and simultaneously are more likely to be the ones caring for HIV-infected people (Gilbert & Selikow, 2011; Sowell et al., 2013).

Southern Africa remains the area most heavily affected by the epidemic (UNAIDS, 2009, p. 29). The nine countries with the highest prevalence worldwide are all located in the sub-region, with each of these countries experiencing adult HIV prevalence greater than 10%, and consistently disproportionate feminisation of the pandemic (UNAIDS, 2009, p 27).

In South Africa, among all adult age groups, there are more women than men living with HIV and AIDS (UNAIDS, 2012). The UNAIDS estimates that in 2011 there were 5.6 million South Africans infected with the virus, of which 2.9 million were women above the age of 15 years (UNAIDS, 2012). According to Luseno and Wechsberg (2009), HIV prevalence among pregnant women in South Africa is 30%, and
prevalence rates among young females of childbearing age are up to four times higher than among their male counterparts. The national prevalence survey (Human Science Research Council [HSRC], 2008) also notes gender variations in HIV prevalence and recorded a sustained increased infection rate amongst young females. More specifically, the national prevalence survey (HSRC, 2008) reports a 32.7% increase in prevalence rates in females aged 25–29 years, and only a 25.8% increase for males in the 30–34-year-old age group. Although the gender difference varies between provinces amongst adults, prevalence is a little higher for women than for men for the country as a whole (Dorrington, Johnson, Bradshow, & Daniel 2006).

The Eastern Cape is one of four provinces identified by (Dorrington, Johnson, Bradshow, & Daniel 2006) as having HIV epidemics, which are still emerging (as opposed to provinces with more advanced epidemics). A study conducted in the Eastern Cape (Hutchinson & Mahlalela, 2006) on utilisation of VCT services revealed that for the province as a whole, over 14% of women and 17% of men reported that they had been tested for HIV, but in rural areas, this rate was considerably lower (approximately 9% of women and 11% of men).

Hutchinson and Mahlalela (2006) showed that the probability of being tested for HIV was tied to the adult biographical constructs of age and education as well as to psycho-social indicators. This finding was true in both urban and rural samples. Women with a secondary education were more than five times more likely to use VCT than women with no education. Regarding their male counterparts, the effects of education as well as many other personal characteristics were considerably smaller as 12.4% of men without any formal education were predicted to use VCT compared to 20.3% of men with secondary education (Hutchinson & Mahlalela, 2006).

Female socioeconomic status in the workplace and at home has also been cited as one of the biographical factors affecting differential HIV prevalence between men and women. It has been argued that the feminisation of the epidemic is in part a consequence of the inferior socioeconomic status of women (George & Sprague, 2011; Gilbert & Selikow, 2011; Olowu, 2011; Nattrass, 2004). Even where women are earning an income, the ILO’s (2001) Code of Practice on HIV and AIDS and the world of work reports that the risk of infection for women is increased in workplaces
dominated by men. The ILO (2001) strongly laments the power of such gender imbalances in the workplace as it exposes women to the threat of sexual harassment and an increased risk of HIV infection. Many women also experience sexual and economic subordination in their marriages or relationships, and are therefore unable to negotiate safe sex or refuse unsafe sex (Gilbert & Selikow, 2011; ILO, 2001).

Another explanation for the gender differences in HIV and AIDS prevalence is the biological vulnerability of women to HIV infection (Gilbert & Silkow, 2011; Nzisabira & Foster-Towne, 2011; Solomon & Venkatesh, 2009). Abdool Karim (2005) reports that in South Africa, the differential gender transmission rates of HIV are attributed to anatomical and physiological differences between men and women.

The final factor found by this researcher in the quest for an explanation for these gender differences referred to the fact that researchers and policy makers are increasingly citing gender-based violence and gender inequalities as essential determinants of women's HIV risk both world-wide and within sub-Saharan Africa (Dunkle et al., 2004; Gilber & Silkow, 2011; Nzisabira & Foster-Towne, 2011; Olowu, 2011). Pronyk et al. (2006) identify violence as an independent risk factor for HIV infection, and report that one in four South Africa women as having been in an abusive relationship. A report by Peltzer and Pengpid (2008, p. 1466) on a national study comprising 14% sample of Xhosa speaking people found that 23% of females experienced physical and or sexual violence in a relationship.

### 2.4 HIV AND AIDS IN THE WORKPLACE

At an International Labour Organization (ILO) conference (ILO, 2008), it was declared that "ninety percent of the people living with HIV in the world will get up today and go to work". Between 18 and 20% of South Africa's more than 5 million HIV-positive individuals are formally employed (Rothberg & van Huyssteen, 2008). The ILO reports that the size of the labour force in high-prevalence countries would be between 10 and 30 per cent smaller in 2020 than it would have been without the effects of HIV and AIDS (Bolton, 2008). The Bureau for Economic Research (BER) projected that South Africa's labour force will have decreased by 21% by 2015 (BER, 2006). The same report provides a projected statistical profiling of the impact of the pandemic in three different skills categories as follows:
• 16.8% on highly skilled workers;
• 19.3% on skilled workers; and
• 22% on both the semi-skilled and unskilled workers (BER, 2006).

It would follow that the HIV and AIDS epidemic continues to affect South African companies (Gorska, 2008).

At macro level, the South African economy depends on, amongst others, the Foreign Direct Investment (FDI), which is a function of a high level of investor confidence influenced by perceptions of labour market health, skills, cost and union activity (Bruton, 2002 in Bowler, 2003). Erasmus et al. (2009) point out that whilst production costs will be affected (in terms of human capitalisation skills and availability) major cost-push factors for industry will be on insurance, medical aid contributions and recruiting costs to replace labour. This scenario will invariably affect the country’s investor confidence. Whiteside and Sunter (2002) argue that there will be two factors at work. Firstly, South Africa is more dependent on skilled labour than other countries in the region, and the skills base is extremely small. Losses of skilled and professional staff could hamper business and government operations, and possibly slow economic growth. The second factor is that South Africans have more interaction with and expectations of service from their government than is the case in the rest of Africa. AIDS reduces the economic security of households by reducing the productivity of and eventually killing income earners, which in turn renders their disposable income insufficient as it is spent on medical care (Ijaiya et al., 2012; Nattrass, 2004). Invariably, income earners suffer double pressure, which leaves them with a meagre cash flow to spend on services and products. Consequently, business will suffer a dual blow as the negative effect on consumer markets will put pressure on the sustainability of business profits.

A UNAIDS (2003, p. 1) report on the effect of HIV and AIDS on East African businesses states that absenteeism accounts for as much as 25 to 54 per cent of company cost. In South Africa, a report by the Department of Labour (DoL, 2003) estimated that a typical employee of a South African company loses about 250 productive days over the course of one year as a result of illness. About 4.5% of the South African workforce are absent on any given day and the levels of absenteeism
in some companies can be as high as 18% (Vaida, 2005). Furthermore, the Global Business Council on HIV and AIDS (2002) maintained that companies would experience not only a decrease in skilled labour force and craftsmanship but also in employee morale as a result of the disease.

The next section discusses the adverse influence of the epidemic on education.

2.5 HIV AND AIDS IN SOUTH AFRICAN HIGHER EDUCATION

Higher education Institutions (HEIs), like all knowledge-intensive organisations, have a role to play in generating wealth (Scott, 2007; Wood, 2011). However, the provision of education depends on the health of educators and therefore health and education are inextricably linked (Bowler, 2003). Mahal (2007, p. 50) writes, "health and education play a critical role in enhancing economic performance and improvements in one or both ends tends is associated with expanded human capabilities".

A study commissioned for the Education Labour Relations Council (ELRC) (Peltzer, et al., 2005) reported a prevalence rate of 12.7% amongst educators at national level and 10–19% amongst Eastern Cape educators. The same study (Peltzer, et al., 2005) adopted an educator demand and supply projection model and shed light on the implications of HIV and AIDS in the education sector. The results of that study (Peltzer, et al., 2005) projected that HIV and AIDS would add to the exiting levels of education attrition and, as a consequence, the sector would need 60 0000 educators by 2010.

2.6 RESPONSES TO THE FIGHT AGAINST HIV AND AIDS

The manner in which management addresses HIV and AIDS in the workplace will determine the company's survival in the 21st century (Moore, 1999). Anstey (2010, p. 1) defines labour relations as a product of strategic choices made by the key social actors (owners of capital and their representatives, employees individually through their collectives and state and their agencies). This section discusses the role played by the global actors (community), followed by the role of the three social actors in the South African context.
2.6.1 International Labour organization (ILO)

Founded on the principles of fostering humanitarian, political and economic motives for international labour standards, the ILO is the embodiment of governance when it comes to global matters pertaining to the world of work, including HIV and AIDS. Governance can be defined as the "formation and stewardship of the formal and informal rules that regulate the public realm, the arena in which states and social actors interact to make decisions" (Strand, 2007, p. 219). Within the realm of governance, the ILO launched a unified global response to address HIV and AIDS in the workplace, which culminated in the establishment in January 1996 of the Joint United Nations Programme on HIV and AIDS (UNAIDS) (Knight, 2008). The global response to HIV saw a shift from formal, didactic, health medication methods towards participatory approaches within HIV prevention (Barnett & Whiteside, 2006).

In 2000, the United Nations Millennium Declaration was signed by 189 member states, and ushered in the codification of eight Millennium Development Goals (MDGs). Goal 6 of the MDGs directly addresses HIV and AIDS and stipulates a time-bound effort to combat HIV and AIDS by 2015 (Boutayeb, 2009). International mobilisation to combat HIV and AIDS had increased substantially since the introduction of MDGs.

In 2003, UNAIDS and World Health Organisation launched a three by five initiative (Boutayeb, 2009). The 3 by 5 initiative was a global target to provide three million people living with HIV and AIDS in low- and middle-income countries with life-prolonging anti-retroviral treatment by 2005.

In 2005, 191 United Nations member states endorsed the universal accesses at the High-Level Plenary Meeting of the 60th Session of the United Nations General Assembly (Knight, 2008). "Universal access is concerned with establishing an environment in which HIV and AIDS prevention, treatment, care and support are available and accessible to all who need them (WHO, 2008a). In 2009, and during a G8 Summit, global leaders reaffirmed their commitment to the universal access's goal and called for enhanced efforts to address gender inequalities, stigma and discrimination well as to expand access to sexual and reproductive health services (UNAIDS, 2009).
These efforts resulted in a variety of tools, models and guidelines for HIV and AIDS programmes (WHO, 2008b). The ILO Code of Practice and the World of Work (2001) established a set of operating principles as the basis for addressing HIV and AIDS epidemic in the workplace:

- Firstly, the Code recognises that HIV and AIDS is a workplace issue and that it affects fundamental rights at work. In particular, the Code notes the discrimination and stigmatisation of workers living with and affected by HIV/AIDS.

- Secondly, in an effort to address challenges associated with the epidemic in the workplace, the Code recommends the following as fundamental in eliminating practices associated with the epidemic in the workplace:
  - non-discrimination in employment;
  - gender equality;
  - screening and confidentiality;
  - social dialogue;
  - prevention and care and support.

- Thirdly, and as regards voluntary testing in the workplace, section 8 of the Code prescribes that, where adequate medical services exist, voluntary testing may be undertaken at the request and with the written informed consent of a worker, with advice from the workers' representative if so requested. Furthermore, the Code provides that voluntary testing should be performed by suitably qualified personnel with adherence to strict confidentiality and disclosure requirements.

2.6.2 South Africa’s legal framework on HIV and AIDS and government’s responses

The South African Constitution (Act 108 of 1996) (Republic of South Africa [RSA], 1996) is the supreme law of the country whose provisions set the tone for compliance with all laws of the Republic. The Constitution entrenches the Bill of Rights, which reinforces basic human rights applicable to all citizens, including people living with
Reaffirming the Bill of Rights, the South African Law Commission (1999, p. 71) proclaims that the current legal position on consent for medical treatment is that every person has the right to privacy and bodily integrity in terms of both the 1996 Constitution as well as the country's common law. Furthermore, the Commission states that, as a general rule, there can be no question of legal consent unless the person who gives consent is fully informed and understands what he or she is consenting to. In line with that provision, the National Health Act (Act 61 of 2003) (RSA, 2003) codified and prescribed ethical duty guidelines for health practitioners on HIV testing, which endorse the concept of informed consent for HIV testing.

As the supreme law of the country, the Constitutional imperatives provide guidance to the employment-related statutes that influence employees' health and wellness as well as HIV management. In that regard, Grogan (2010) asserts that South Africa's Employment Equity Act (EEA) (Act 55 of 1998) and the Labour Relations Act (LRA) complement each other on the aspect of unfair discrimination. In the case of EEA, section 5 places a positive obligation on employers "to promote equal opportunities in the workplace by eliminating unfair discrimination in any employment policy or practice". Similarly, section 7 (1) of the EEA, prohibits medical testing of employees or applicants for employment unless permitted by legislation, and in relation to testing for HIV, the EEA upholds that permissibility to conduct such tests is subject to authorisation by the Labour Court.

The Basic Conditions of Employment Act (BCEA) (Act 75 of 1997) set out provisions for minimum working hours and days of entitled sick leave. The leave provision allows for employees to negotiate their sick leave within the prescribed guidelines. The Occupational Health and Safety Act 85 of 1993 (OHSA) imposes a general duty on employers to provide a reasonable safe and healthy working environment. More specifically, the OHSA places a duty on employers to make sure that the risk of occupational infection is minimised. In that regard, the OHSA monitors occupational and safety on incidents of training in infection control procedures to be used in any situation of blood exposure (Bowler, 2003). Lastly, the Act obliges workers and employers to report and place on the agenda of health and safety committees' occupational transmission of HIV and AIDS, and prescribes the appropriate measures to be taken under such circumstances.
2.6.3 Employer's and organised labour responses

The South African workplace has been an important site for transformation for many years and a platform where employers, employees and their trade union representatives found and engaged each other to lend a collective shoulder to work-related matters (Anstey, 2005). Rogers, Adetoro, Burke, Llado and Lukyanova (2010) also describe the workplace as a strategic venue for implementing HIV and AIDS programmes and policies meant to combat the global epidemic.

A constitutional victory in upholding these rights was cemented in September 2000, when the country's Labour Court ruled against the adoption of pre-employment testing. This was in the case against South African Airways (AIDS Law Project, 2000). As a result, a Code of Good Practice on Key Aspects of HIV/AIDS and Employment was negotiated in 2000 by the tripartite National Economic, Development and Labour Council (DoL, 2000). This Code of Good Practice affirms the rights of HIV-positive employees and prescribes what companies' HIV/AIDS policies should entail. Flowing from that, the Department of Labour (DoL) subsequently developed HIV/AIDS Technical Assistance Guidelines in 2003, which provided detailed suggestions on workplace HIV/AIDS programmes (DoL, 2003). Adapted from the Department of Health (DoH) (1998), Department of Labour (DoL) (2000, 2003), Family Health International (2002), ILO (2001) and NOSA (2003), Dickinson (2010, p. 54) provides a summary of the key aspects of recommended corporate responses to HIV/AIDS in the workplace:

- identify and understand the risk HIV/AIDS poses;
- establish commitment from management and employee representatives for the workplace response;
- draw up an HIV/AIDS policy;
- establish implementation structures that include management and employee representatives;
- ensure good internal and external communications;
- establish partnerships with groups able to assist in the workplace programme;
- run awareness and education interventions;
• encourage and assist behaviour change that will prevent HIV infection;
• encourage voluntary HIV testing and provide counselling;
• offer wellness programmes, HIV/AIDS treatment and care (subject to resource availability);
• extend programmes to families of employees and the community (subject to resource availability);
• create an environment in which fears, stigma and discrimination around HIV/AIDS are minimised; and
• monitor, evaluate and review the programme.

As a practical measure in fulfilling the above responses, South African companies have implemented four models that provide treatment and support for infected employees: a third-party health insurance plan or medical aid, outsourced stand-alone HIV/AIDS disease management programmes (DMP), a full service in-house programme, and a clinic contracted to provide care for employees (Connelly & Rosen, 2004).

2.6.4 **Quest for good governance**

According to Dickinson and Stevens (2005), the drive towards good governance noted in the King II Report provided expectations for listed companies’ responses to HIV and AIDS. Companies with international footprints also conform to good governance emanating from regulatory expectations, such as those issued by a self-regulatory body called the Global Reporting Initiative (GRI), which developed its own reporting guidelines in 2003 (Dickinson and Stevens, 2005).

2.6.5 **The trade union federation**

The role of trade unions in an employment relationship is to safeguard the right of employees in relation to conditions of employment (which can either be of interests or of rights-based matters). Equally, the role of trade unions in HIV testing and AIDS-related issues in the workplace is to safeguard the rights of workers according to the
dictates of the Code of Good Practice on Key Aspects on HIV and AIDS and Employment of 2000.

The Code of Good Practice on Key Aspects on HIV and Employment of 2000 established a set of guidelines, which should be implemented by both employers and trade unions so as to protect the rights of HIV-positive individuals against unfair discrimination in the workplace (DoL, 2003). Relating to HIV testing, the Code reaffirms the position of the Constitution by upholding the principle of confidentiality and defining the legal parameters of disclosure. Equally, the Code endorses a voluntary approach to HIV testing with workers having to give their informed consent, and being entitled to privacy. In this sense, informed consent means that "an employee is provided with full information, understands it and based on this, the employee agrees to undertake the HIV test" (The Code of Good Practice on Key Aspects on HIV and Employment of 2000:8). Furthermore, "where an employee chooses to voluntarily to go for an HIV test, the Code condones the legal right to non-disclosure of HIV status to employers or co-workers. However, the waiver of non-disclosure is reconsidered in cases where an employee has submitted written confirmation of consenting to disclosure" (2000, p. 9).

2.7 HIGHER EDUCATION'S RESPONSE TO HIV AND AIDS

The first case of HIV was reported in 1982 (Whiteside & Sunter, 2000). South African businesses, intellectuals and political elite only became aware of the major implications HIV and AIDS would have for the country in 1987 (Grundling & Marais 2000 cited in Dickinson, 2010). Worse still, the higher education institutions (HEIs) only responded to the HIV and AIDS epidemic twelve years later in 1999. In 1999, South African HEIs organised a conference as their initial response to HIV and AIDS under the banner of "Tertiary Institutions Against AIDS" (Chetty, 2000).

Owing to the fragmented HEIs at that time in which universities were separated from technikons, two streams of leadership were formed in order to consolidate the higher education’s response to HIV and AIDS (Chetty, 2000). Firstly, the South African Universities Vice-Chancellor's Association (SAUVCA) forged a partnership with the Association of Commonwealth Universities (ACU). Secondly, the Committee of Technikon Principals (CTP) was formed. Following a merger of South African HEIs, a
partnership between the Department of Education (DoE), SAUVCA and CTP gave birth to the Higher Education HIV/AIDS Programme (HEAIDS) (HESA, 2010).

The HEAIDS programme aligned its activities with the Department of Health’s national strategic plan on HIV and AIDS to formulate its own South African higher education strategic plan (SA HE strategic plan) in 2004 (Von der Marwitz & Were-Okello, 2010). Three areas that complemented the Department of Health’s national strategic plan were identified in order to give support to the SA HE strategic plan, namely peer educators, curriculum integration and voluntary counselling and testing (Von der Marwitz & Were-Okello, 2010). The main goal of the SA HE strategic plan was to mobilise the sector and respond sensitively, appropriately and effectively to the HIV and AIDS epidemic through its core functions of teaching, research management and community service (HEAIDS, 2004). Accordingly, the SA HE strategic plan recognised a continuum of HIV and AIDS interventions such as, prevention, care and support as key in minimising the spread of the epidemic within the higher education sector (Von der Marwitz & Were-Okello, 2010). One of the major contributions of the SA HE strategic plan in the fight against HIV and AIDS was the establishment of the workplace programme framework (Von der Marwitz & Were-Okello, 2010).

2.8 SOUTH AFRICA’S HE HIV AND AIDS WORKPLACE PROGRAMME FRAMEWORK

The focus of the higher education workplace programme framework (herein referred to as “HE HIV workplace programme”) is to provide guidance for institutional development of comprehensive HIV prevention, treatment and mitigation programmes for employees in the higher education sector (HEAIDS, 2010). The HE HIV workplace programme is aligned with all South African legislation affecting and informing employment practices as enshrined in the country’s Constitution (HEAIDS, 2004). The scope of the HE HIV workplace programme covers all constituencies of the academic enterprise including contract staff.

Broadly speaking, the purpose of HE HIV and AIDS workplace programme is to ensure that the HE workplace sub-sector is able to continue to fulfil its mandate unimpeded by the impact of HIV and AIDS epidemic. Whilst most HEIs have
wellness programmes that include HIV and AIDS management (Anderson & Louw-Potgieter, 2012; Dube & Ocholla, 2005; HEAIDS, 2010; Von der Morwitz & Were-Okella, 2010). A lack of leadership has been identified as a challenge facing these programmes (Von der Morwitz & Were-Okello, 2010).

2.9 CONCLUSION

This chapter provided an overview of HIV and AIDS in the workplace. In order to provide context to the chapter, a discussion of the global effect of HIV and AIDS was presented. The gendered aspects of the pandemic were explored and literature revealed that young women carry a disproportionate burden of HIV infection compared to men. The discussion on the effect of HIV in the workplace pointed to business risks associated with HIV infection. Literature review points to an inextricable link between health and education, and therefore, if HIV and AIDS are not properly managed, it may reverse developmental gains. Collaborative response efforts that seek to mitigate the HIV pandemic by government, business and higher education institutions have been fraught with challenges. The main challenge that beset these efforts is that, in the absence of an HIV vaccine, voluntary counselling and testing remain the gateway to accessing treatment and care. Regrettably, VCT too has been confronted by challenges of low utilisation. The second part of literature review is linked to the study objectives and explores the factors that serve as barriers and facilitators of VCT.
CHAPTER 3

VOLUNTARY COUNSELLING AND TESTING

3.1 INTRODUCTION

This chapter provides a discussion on voluntary counselling and testing (VCT). This chapter describes HIV testing approaches and challenges, explores the various approaches to VCT, elucidates the importance of VCT, and describes the factors that facilitate VCT and those that serve as barriers to VCT. The chapter ends with a summary of the discussion.

3.2 HIV TESTING: APPROACHES AND CHALLENGES

HIV testing serves as a gateway for both HIV prevention as well as early access to treatment, care and support (United Nations Population Fund [UNFPA], 2002). Access to VCT remains an important human rights issue (Van Dyk, 2012). De Cock et al. (2002) explain that, unlike other infectious diseases for which consent is implicitly assumed by virtue of medical consultation and where diagnosis is encouraged, the diagnosis for HIV is often avoided. Van Dyk (2012) agrees and argues that voluntary informed consent is especially important given the emotional, psychological and social implications that diagnosis might have for the client. VCT can be described as a process which includes confidential individual counselling to assist the client to cope with stress and to make informed choices about learning his or her status (UNAIDS, 2000; UNFPA, 2004). VCT places an emphasis on the need for voluntary informed consent prior to testing and pre- and post-test counselling (Obermeyer & Osborn, 2007). In the event that informed consent has been granted, pre-test and post-test counselling services are a mandatory prerequisite for HIV testing (Van Dyk, 2012; Obermeyer & Osborn, 2007; UNAIDS, 2002; UNAIDS, 2008). The principle of informed voluntary consent in the VCT process inextricably links the concepts of health and human rights, and as such can be said to include three main components referred to as the three Cs, namely: confidentiality, counselling and consent (Van Dyk, 2012). From an ethical point of view, without the three Cs, HIV testing would be deemed a violation of an individual’s rights to privacy (UNAIDS 2007; WHO, 2007).
3.2.1 Approaches to HIV testing

There are two main approaches to VCT, namely client-initiated counselling and testing (CICT) and provider-initiated counselling and testing (PICT – also referred to as routine offering of HCT or HIV counselling and testing) (Van Dyk, 2012). CICT is based on the tenets of VCT and refers to individuals, couples or sex partners who actively seek HIV counselling and testing at facilities that offer these (Jackson, 2002; Van Dyk, 2012; UNAIDS, 2000). The WHO implemented PICT following the disappointing results of CICT reported worldwide (Van Dyk, 2012). The PICT health care provider routinely offers and recommends an HIV test to all clients irrespective of medical diagnosis. Whilst PICT has been viewed as a shift from VCT (Motsoaledi, 2010), the difference between the two lies in form (emphasis) rather than in substance. In that regard, PICT complements VCT by offering HIV testing integrated into routine medical care and thereby facilitates early diagnosis. However, patients can still exercise their ethical duty to opt out as is applicable with CICT methods. Arguably, the fact that PICT (or HIV counselling and testing [HCT]) is integrated into routine medical doctor’s consultations may improve VCT uptake as some authors believe that HCT minimises stigma.

The objectives of PICT are to increase health-seeking behaviour, encourage South Africans to know their status, equip those who test negative with a way of ensuring that they did not contract HIV, and create a quick and easy entry point to treatment for those who test positive (Motsoaledi, 2010). Whether the HCT project will achieve its set objectives is something only time will tell; however, the project marks a milestone in the history of HIV testing in South Africa.

3.2.2 Importance of VCT services

VCT has become an integral component of HIV prevention programmes in developing countries due to the demonstration of its efficacy in promoting behaviour change, in decreasing rates of sexually transmitted infections, and as a precursor for treatment of HIV-infected individuals (Fylkesnes & Siziya, 2004). Mathematical modelling (Menon, 2010) showed that in countries with high HIV prevalence, voluntary HIV testing and immediate ART for everyone diagnosed with HIV could reduce new infections by 20% within 10 years. A survey conducted by Connelly and
Rosen (2006) reports that about 50% of South African companies in the mining and private sector offer VCT facilities.

Anglo American implemented a workplace VCT programme in 2001 based on four main strands (Brink & Pienaar, 2007, p. 80):

- to pursue vigorous HIV prevention programmes, with voluntary counselling and testing as the key entry point to the programme;
- to implement wellness programmes for HIV-positive employees, including the provision of free ART when clinically indicated;
- to extend workplace programmes into surrounding communities in partnership with government, unions, non-governmental organisations and international donor agencies; and
- to monitor and evaluate programme outcomes against a series of clearly defined targets.

The results of Anglo America’s workplace VCT programme revealed that over an 18- and 24-month period, ART provision was associated with a net monthly savings of US$29 to US$63 (Bolton, 2008). In addition, savings from reduction in absenteeism covered between 20 and 60% of treatment cost, whilst savings from reduced hospitalisation offset, a further 45–70% (Bolton, 2008, p. 284).

Despite sophisticated programme designs and substantial financial investments, Bhagwanjee et al. (2008) report relatively low participation of available VCT as a common challenge faced by private sector workplace health management programmes in Southern Africa. Conversely, programmes that have been operating for several years do show increases in VCT participation (George, 2006). The next section will explore factors that serve as barriers to facilitators of HIV testing.

### 3.3 FACTORS THAT SERVE AS BARRIERS TO HIV TESTING

While there is an increase in the number of South Africans who are aware of their status, many people still do not know their status (Phakathi et al., 2011). Organisations should seek to understand current barriers to HIV testing in order to maximise the benefits of HIV counselling and testing (Spielberg, Pamina, Gorbach, &
Goldbaum, 2001). Factors that serve as barriers to HIV testing can be categorised as: individual barriers, systems barriers, and counselling and testing barriers (Spielberg et al., 2001). A brief discussion of these is provided below:

### 3.3.1 Individual Level barriers

Several psychosocial factors have an influence on risk taking and HIV testing (Spielberg et al., 2001). Psychosocial factors include fear of having a positive result, fear of physical death and social discrimination, or fear of a radical change in one’s life should sero-positivity be confirmed (Spielberg et al., 2001) At individual level, such barriers have two implications for HIV testing. Firstly, fear of infection means that individuals may prefer not to know what their status is rather than taking the risk of having to deal with being infected (Obermeyer & Osborn, 2007; Spielberg et al., 2001).

A study that investigated knowledge of prevention of mother-to-child transmission (PMTCT) amongst pregnant South African women reported reluctance to undergo an HIV test as they feared being declared HIV-positive (Peltzer, Matseke & Metcalf, 2006) Obermeyer and Osborn (2007) also noted a discrepancy between intent to be tested and returning for results. Obermeyer and Osborn (2007) report that 44% of South African women did not accept antenatal screening and refused to know their status. One explanation is offered by Olowu (2011) who reports on a fear that disclosure of an HIV-positive status increases a woman’s vulnerability to abuse.

Secondly, the social costs of testing could result in a fear of being ostracised and also reduces participation in HIV testing (de Wit & Adam, 2008). Kalichaman and Simbayi (2003) found that people who had never tested for HIV were more negative about testing, demonstrated greater AIDS-related stigma, and ascribed greater shame, guilt and social disapproval to the disease than people living with HIV.

The misconception that HIV and AIDS is a “death sentence” also increases fear and obstructs testing (Asante, 2007). Studies indicate that late diagnosis of HIV infection (where people show symptoms of AIDS or are very ill) undermines efforts to neutralise HIV as a normal medical condition (ECDC, 2010). Traditional healers are preferred as a first line of call in poor African countries (Asante, 2007). A report by
the WHO (2007) confirms this preference by stating that around 80% of people living with HIV/AIDS (PLWHA) in African countries initially consult traditional healers for primary health care. Similar findings were reported on by a South African study, which revealed that 75% of HIV people used remedies dispensed by traditional healers (Ojikutu & Ramjee, 2007).

Within the workplace setting (Van Dyk, 2008) explains that in a South African study on psychosocial barriers to voluntary HIV counselling and testing, 1 422 participants expressed their needs attitudes and beliefs as follows:

- they felt they had no treatment options;
- they feared prejudice and rejection by loved ones, health care workers and the community; and
- knowledge of their status would lead to depression, despair and early death.

Van Dyk (2008) reports that of those participants who were prepared to present themselves for VCT, 19% who were white and 40% who were black preferred undergoing testing at a doctor or clinic or hospital where nobody knew them. The main reasons being:

- lack of trust in the health care system;
- fear that confidentiality will be broken; and
- fear of prejudice and rejection by health care professionals.

The latter findings were supported in a study by Rothberg and van Huyssteen (2008). The study involved two organisations whose aim was to solicit HIV-positive employees’ late registration with an “AID for AIDS” (AFA) disease management programme. Respondents suggested, amongst others, on-site education and awareness programmes for managers in order to reduce HIV/AIDS discrimination and stigmatisation in the workplace (Rothberg & van Huyssteen, 2008).

Further support for these suppositions were garnered from the main findings of a qualitative study of eight focus group discussions held with a total of 83 participants from people living with AIDS (PLWA) (Price, Louw, Roe & Adams, 2007). Participants were interviewed by various stakeholders, including management and
representatives of AIDS non-governmental organisations. In this study, Price et al. (2007, p. 14) report that AIDS-related stigma is still pervasive in many communities. PLWA link this perceived stigma to the difficulty of or the resistance to disclosure of their status for fear of being rejected by family members, friends or partners. Another study of 1,054 PLWA participants (Prince et al., 2007, p. 15) found the majority reporting high levels of internalised stigma, which was closely associated with signs of depression, accounting for a unique and significant proportion of the variance in depression scores.

Perceived socio-cultural norms constitute another barrier to HIV testing. Such socio-cultural norms are: accepting or encouraging a large number of sexual partners especially amongst men, and impeding the use of condoms and safer sexual practices that would control the spread of HIV (Love Life, 2006). Gender inequalities constitute another barrier where the percentage of working men in the Eastern Cape is higher than their female counterparts, leading to a lower socio-economic status for women (Phaswana-Mafuya & Peltzer, 2007). In addition, high poverty levels increase the likelihood of transactional sex for survival amongst women and reduce women’s efficacy to negotiate the use of condom (Johnson, Kincaid, & Chikwava, 2010). Transactional sex work has been flagged as a key driver of the HIV epidemic with the reported prevalence rate as high as 21.1% in some communities (Gilbert & Selikow, 2011).

The role of multiple and concurrent sexual partners is increasingly recognised as a significant factor for heterosexual transmission of HIV in Southern Africa (Gilbert & Selikow, 2011; Setsewu, 2011). The South African Development Community (SADC) called on the region to focus on multiple, concurrent partnerships (MCP). As a key driver for HIV and AIDS (Gilbert & Selikow, 2011), MCP can be defined as a relationship whereby an individual has two or more sexual partners that overlap in time (Gilbert & Selikow, 2011; Setsewu, 2011). MPC can further be explained as a social construction of masculinity where “real” men are constructed as having sexual prowess by visibly having many girlfriends (Gilbert & Selikow, 2011).
3.3.2 Barriers: Systems/structural

The health system in sub-Saharan Africa is weak, with staff shortages and poor working conditions undermining efforts for HIV prevention and care (Asante, 2007). Survey findings on the impact of HIV on the health sector in South Africa show a similar situation, with absenteeism, illness and low staff morale of health care workers being attributed to HIV (Shisana, et al., 2003, p. 129).

Sprague, Cherish, and Black (2011) note the following barriers to HIV testing in the South Africa’s health system:

- Staff and resource shortages: a 36% staffing gap for public sector hospitals, and a staffing shortage of between 40% and 50% in the Eastern Cape with accompanying shortages of clinics, HIV test kits and stock. This deficit in human resources threatens to undermine efforts to scale up treatment.

- Burnout of health care professionals: the tremendous burden of caring for the ill under stressful circumstances can lead to posttraumatic stress and depression. Some health practitioners either migrate to other countries or leave the profession entirely because of this emotional strain (Uebel, Nash, & Avalos, 2007).

A limited number of counsellors, poor quality of the counselling process and lack of trust may lower VCT participation. In addition, health professionals who disapprove of early sexual activity amongst young people may also discourage them from seeking VCT services (Family Health International (FHI, 2001).

3.4 BARRIERS: COUNSELLING AND TESTING

Confidentiality remains a key element of VCT. There are gender differences in perceptions regarding HIV testing and disclosure (Basset, 2002; Daftary, Padayachy, & Padilla, 2007). It is reported that the cost of an HIV-positive diagnosis is higher for women on two fronts (Basset, 2002). Firstly, an infant born HIV-positive needs a shelter, which the mother may depend on the spouse to provide. Secondly, a woman diagnosed with HIV risks being accused of infidelity by her partner upon disclosure. These two eventualities might lead to women choosing not to be tested.
Other barriers include a lack of trust in health care workers and a fear that health care workers will inform others of their sero-status (Meiberg, Bos, Onya, & Schaalme, 2008). Furthermore, while some patients appreciate the privacy and time spent on HIV counselling, the pressure to test and the perceived lack of empathy from counsellors remain a challenge (Daftary, Padayatchi, & Padilla, 2007).

According to Deacon, Stephney and Prosalendis (2005, p. ix), the HIV and AIDS stigma in Africa has been mentioned in related research on barriers to testing, treatment care, quality of life and social responses to HIV and AIDS. An emphasis is therefore placed on understanding the HIV and AIDS stigma within social, economic, political as well as cultural contexts. In Deacon, Stephney and Prosalendis (2005) it is submitted that the idea of social constructs – people construct their reality through socio-cultural processes – underlie most modern understanding of prejudice. Furthermore, it is argued that people who possess a characteristic defined as socially undesirable (HIV and AIDS) acquire a spoiled identity which then leads to social devaluation and discrimination (Goffman, 1963 in Deacon et al., 2005).

Van Dyk and Van Dyk (2003) posit that, since women are often blamed for bringing AIDS into the family, they tend to cope silently with this burden, without protecting themselves or their sex partners from further infection, and without accessing health care and support services. The reluctance to disclose their HIV-positive status is therefore a major barrier to the successful implementation of VCT programmes. This self-imposed silence prevents women from reaping the important benefits of knowing their HIV secondary prevention for HIV-positive individuals, but that VCT is not an effective primary prevention strategy for uninfected participants.

As regards the cultural aspects of HIV, Abdool Karim, Meyer-Weitz and Harrison (2009), note that social and community norms are particularly important in African collectivist communities, where individual decisions are largely mediated by socio-cultural values and norms. Nattrass (2004) asserts that not only female biology makes females more susceptible than males to HIV infection, but also that the disproportionate socio-economic strata of women explains the influence of gender on the socio-cultural determinants of HIV and AIDS in areas that are geographically isolated and where poverty is more pronounced. While there is an inextricable link between HIV and AIDS and poverty, which in turn affects both men and women,
gender-related factors increase women’s economic vulnerability and their dependence on men. As women are preoccupied with immediate survival, poverty is a root cause of women using sex as a commodity (Abdool Karim, p. 247). It is further stated that HIV infection in mobile couples is two to three times higher than in a stable couple (Abdool Karim, 2005). An important factor contributing to the high prevalence of HIV among women in South Africa is migrant labour system. In the migrant labour system a number of men leave their rural home and work in the cities. Whilst in cities they arrange for city wives, while maintaining their spouses and children in rural areas (Abdool Karim, 2005).

A study conducted in the Eastern Cape on the social determinants of HIV/AIDS revealed that cultural norms, unemployment, poverty, gender inequality, stigma and migration were the key drivers of HIV risk behaviour (Phaswana-Mafuya et al., 2009). The same study showed that multiple partners in the age group 15–49 increased from 12.1 per cent in 2002 to 13.1 per cent in 2008. Documenting her observations as a field work researcher in a study she conducted on young Zulu women, Leclerc-Madlala (2001, pp. 43–4) noted, “for most the present economic situation seems to be a major driving force in their new sexual assertiveness – women played the field for all its worth and the worth was definitely in financial terms”.

Solomon and Venkatesh (2009) argue that the social construct of gender is a product of a larger religious, colonial and nationalist discourse that can make women highly vulnerable to HIV infection within traditionally patriarchal societies. These authors assert that in patriarchal social systems, marriage often serves as an institution that gives a woman permission to participate in sexual activity and gain a culturally sanctioned identity as a married woman within her husband’s household. For women who define themselves by the men with whom they are, disclosure strikes at the core of their emotional and social stability for it means facing the loss of their partners but also the status that being with him confers on them socially, emotionally and economically (Worth, 1990). As a result, many women may not perceive themselves as being at risk of HIV infection due to a strong belief in marriage and their husband as a maintainer of familial well-being. Abdool Karim (2005, p. 254) reports that in a study of rural and peri-urban women in KwaZulu-Natal, it was found that, whilst knowledge of HIV and AIDS was high, women underestimated their personal risk of
acquiring HIV/AIDS and that despite the high likelihood of their partners being HIV-positive, unprotected sexual intercourse was still the norm. It is further reported that in India, the married monogamous wife who symbolises Indian womanhood has become the new face of the AIDS pandemic, as they are primarily put at risk of infection from their husbands (Solomon & Venkatesh, 2009). A survey conducted to describe associations between socio-demographic, behavioural characteristics and VCT in Tanzania reported women in monogamous marriages as at risk of HIV infections (57% were HIV-positive) (Wringe et al., 2008).

Faced with these societal constructed norms, women who tested HIV-positive through antenatal testing face a double-edged sword as revealing one’s status may lead to blame or labelling (for bringing an infected child into the world) and this will inflict, self-stigmatisation as a response to stigma and prejudice from the society that once idolised marriage as personifying womanhood (Solomon & Venkatesh, 2009).

### 3.5 FACTORS THAT FACILITATE HIV TESTING

A study on factors affecting VCT participation in South African workplaces categorised the characteristics of successful HIV counselling and testing interventions amongst high-risk populations into three categories: demographics, beliefs, and external influences (Dickson & Mundy, 2004).

The demographic factors associated with testing include increasing age, educational attainment and socio-economic status (Hutchinson & Mahlalela, 2006). A survey seeking to describe the association between socio-demographic behaviour and the use of VCT in Tanzania (Wringe et al., 2008) found a correlation between higher educational levels and an increase in VCT participation.

Factors that relate to belief include factors at an individual level. A study on the acceptability of VCT in Zimbabwe (Chirawu et al., 2010) indicated two reasons for volunteering for HIV testing amongst women:

1. a concern for their own health after the death of their spouses; and
2. those who were pregnant were concerned about the life of their unborn children – especially when nurses informed them about the availability of a medical intervention to prevent HIV transmission from mother to child.
The same study also revealed that whilst women sought VCT services at an asymptomatic stage, men were likely to only test when they were weak (Chirawu et al., 2010).

One study reported that living testimonies of knowing and seeing someone with HIV recovering from treatment were the biggest incentive for testing (Phakathi et al., 2011). The same study pointed out that the availability and accessibility of ART increases VCT uptake. Furthermore, a study conducted on the gender vulnerabilities to HIV amongst women in Lesotho found that trust in the health services was cited as a facilitator of VCT participation (Olowu, 2009).

3.6 CONCLUSION

This chapter provided a literature review of VCT and insights into the factors that influence its low utilisation. The literature review highlighted psychosocial and cultural factors as key barriers to and facilitators of VCT participation. The psychosocial determinants of HIV testing highlight the individual (cognitive) factors that interfere with one’s decision-making processes when faced with a decision to participate in a VCT programme. As barriers for VCT participation, these individual factors are explained as fear of results with the associated consequences of rejection, stigma and perception of a lack of confidentiality. Human beings are social beings who through social interaction learn societally acceptable ways of doing things. Culture as a societally established construct that defines how things are done in a given society has led to the identification of a health culture concept. This concept is premised on the view that, since culture influence people’s spheres of life, it invariably influences people’s decision to present themselves for HIV. Gender is one cultural construct identified as an important factor in facilitating or encouraging people to go for an HIV test.

In order to mitigate the psychosocial and cultural barriers to testing, HIV and AIDS awareness and education campaigns that are culturally sensitive may facilitate an empowerment agenda necessary to enhance people’s ability to internalise the importance of HIV testing.
The next section links to the objectives of this study (in Chapter one) and reports on the design element which addressed the study objectives.
CHAPTER 4

RESEARCH METHOD

4.1 INTRODUCTION

This chapter will report on the method and structure behind this study. More specifically, the design, participants and sampling, research instruments, ethical considerations, data collection, analysis and verification and sources of error and research limitations will be explained.

4.2 RESEARCH DESIGN

A research design is a framework or general guide regarding how to structure studies conducted to answer certain types of research questions (Brown, 2009). A research design serves two purposes: firstly, to serve as a bridge between the research question and the execution or implementation of the research (Terre-Blanche & Durrheim, 2004); and secondly, to present an overall relationship between the research question and the data collected (England, 2012). The researcher has to ask, given the research questions, what type of research design will provide answers to the research questions in a convincing manner.

4.2.1 The value of qualitative research

Qualitative research attempts "to answer questions about the complex nature of phenomena, often with the purpose of describing and understanding the phenomena from the participants' point of view" (Leedy & Ormrod, 2001, p. 101). Qualitative research allows researchers to examine people's experiences in detail by using a specific set of research methods such as in-depth interviews, focus group discussions, etc. (Hennink et al., 2012). All qualitative studies serve three purposes, namely to explore, describe and explain. The research design should serve one or more of these purposes (Babbie, 2010). The research design of the current study aimed to be qualitative and exploratory-descriptive by nature. Each design element is discussed in more detail below.
The word "quality" places emphasis on the processes and that are not experimented upon or measured in terms of quantity, amount and frequency (Creswell, 2013; Hennink et al., 2011). In this sense, qualitative research distinguishes itself as concerned with the quality and texture of an experience rather than with the identification of cause and effect (Willig, 2001). Factors that facilitate or inhibit HIV testing are complex and detailed by nature. These details can be established by talking directly to people and allowing them to tell their stories (Creswell, 2003).

There are several disadvantages to the use of qualitative research (Creswell, 2003). Firstly, subjectivity may lead to difficulties in establishing valid data collection. Secondly, the scope might be limited due to insufficient depth in data collection approaches. Thirdly, qualitative research is time-consuming in terms both of the collection and of the analysis of data (Creswell, 2003). Finally, owing to the judgement that led to the selection of the sample, the results of the study cannot be generalised to the entire population.

However, Willig (2001) notes that advantages of the use of qualitative research also exist. One such advantage is that in qualitative research, study participants are allowed to construct the social world (using words or pictures). Researchers are simultaneously empowered in constructing the social world through participant's interpretations (Willig, 2001). Another advantage of the use of qualitative research is that both the researcher and participants contribute to the process of interpreting events. Focusing on participants’ natural settings means that the underlying assumptions and attitudes are examined from the context within which they occur (Babbie, 2010; Brown, 2009; Creswell, 2013). Another advantage of the use of a qualitative research design is that the benefits of navigating participants' lived experiences place qualitative research on a road of discovery that the quantitative researcher is unlikely to navigate in the same way (Creswell, 2013).

### 4.2.2 Exploratory research

Exploratory research refers to a "broad-ranging purposive, systematic, pre-arranged undertaking designed to maximise the discovery of generalisations leading to a description and understanding of an area of social or psychological life" (Stebbins, 2001, p. 3). The operative word in the exploratory element of this study is "explore"
which means to travel over or through a particular space for discovery or adventure (Stebbins, 2001). Exploratory research is appropriate when the researcher seeks to satisfy his/her curiosity for a better understanding of a persistent or a new phenomenon (Babbie, 1998, 2010).

In the academic institution within which the current study was undertaken, employees are aware of VCT campaigns aimed at communicating the importance and benefits of HIV testing. However, little was known about the factors that facilitate or inhibit voluntary employee participation on HIV testing. The exploratory element of this study sought to explore the dimensions of the phenomenon, the manner in which they are manifested and the factors to which they are related (Polit & Hungler, 1995). The current study sought to make recommendations regarding the improvement of the VCT programme to management in order to improve HIV testing rates. To achieve that goal the researcher had to explore and describe the factors that serve as facilitators and inhibitors of VCT participation from the study participants.

Exploratory studies may not be free from biases or subjectivity in cases where selective participation and biased interpretation on the part of the researcher occur (Stebbins, 2001). However, the advantage of using exploratory research is that it utilises flexible open-ended data collection methods (Brink & Woods, 1998). Exploratory methods facilitate an understanding of the participant's experiences and perceptions that might otherwise remain undiscovered without deep and open-minded exploration (Brown, 2009).

4.2.3 Descriptive research

Descriptive research refers to all the enquiries that give a neutral and close, detailed account of the topic under investigation in words (Moustakas, 1994). Most descriptive studies are conducted from a qualitative perspective (Moustakas, 1994). The current study was not only exploratory but also descriptive by nature. The aim of descriptive studies is to expose the salient aspects of a phenomenon with a focus on the patterns that emerge (Willig, 2001). This approach assumes that social reality can be understood through social constructions such as language, consciousness and shared meaning (Foster, 2010). Experience is a product of the intrinsic relationship
between man and the world (Moustakas, 1994) and in order to study experience one needs the description of an experience (Polkinghorne, 1989).

Exploratory-descriptive studies attempt to source the quality and texture of the participants' perceptions, while simultaneously endeavouring to foster an understanding of the participants' lived experiences about the subject under investigation (Willig, 2001). The researcher in this study aimed to be conversant with verbal descriptions of factors that facilitate and inhibit HIV testing by exploring and capturing an accurate account of these factors from the participants. Benefits of using an exploratory-descriptive qualitative type of research design in this study were that:

- the researcher was be able to provide a comprehensive list of factors affecting participation in VCT programmes sourced directly from study participants;
- the findings could be compared with the existing literature and previous research on the topic and thereby allowed the researcher to add a timely African perspective to existing knowledge in the field; and
- the factors uncovered in the study may be used as the basis for constructing a quantitative questionnaire for future research in other settings to explore the generalisability of the findings.

4.1.4 Population

South African higher education institutions (HEIs) have undergone a process of restructuring (Von der Marwitz & Were-Okello, 2010). The two bodies responsible for higher education prior to the transformation process were the Committee for Technikon Principals (CTP) and the South African Universities Vice-Chancellor's Association (SAUVCA). The restructuring process culminated into the unification of 36 disparate institutions into 23 (HEAIDS, 2004). Consequently, the 23 unified tertiary institutions ushered in the replacement of the former two bodies responsible for higher education (CPT and SAUVCA) to form a South African statutory body for HEIs called Higher Education South Africa (HESA, 2011).

The target institution came into existence in 2005, and was the result of a merger between two technikon structures and a former university to form a comprehensive
university of technology (Higher Education Act 101 of 1997). The target institution has four campuses and employs 2 000 members of staff (Institution’s Bureau of Statistics). The target site for the study had an overall staff complement of 200 employees who were both academic and non-academic staff. Of the 200 employees, 120 were non-academic staff while 80 represented academic employees.¹

4.3 SAMPLING AND SAMPLE SELECTION

A sample is a subset of a study population to be selected for data collection (Henry, 2010). For the purposes of data collection, the sample for the current study included only non-academic employees with a minimum qualification of matriculation. This minimum qualification was set because the language of the focus group was English. Since research on HIV VCT has established the influence of gender on VCT testing behaviour, equal numbers of men and women were recruited for the sample. The intention was to recruit a minimum of 48 participants (6 focus groups with a minimum of eight per group). However, the actual number of the focus group participants was 56 (see Table 4.1 below).

Initially, the researcher intended to sample two sites of the target institution. However, only one site was sampled due to practical limitations (problems associated with organisational structure made it difficult to obtain a reliable staff complement). According to the director of HIV and AIDS at the target institution, HIV and AIDS awareness and testing programmes were introduced at the sample site in 2001 and is being provided on an ongoing basis ever since. Given the history of HIV and AIDS testing campaigns at the target institution, the researcher deduced that a general level of awareness of HIV VCT existed amongst employees. As a result, therefore and for the purpose of the study, a nonprobability convenience sampling method was selected as the most appropriate sampling technique. This method is based on “taking them where you find them” (Cozby, 2001 p. 57). Nonprobability convenience sampling was also utilised because of its focus on how relevant the sample is rather than on how representative it is (Babbie, 2010).

¹ Estimated figures from the Institution’s Bureau of Statistics. These numbers fluctuated as most academic staff are employed on a contract basis. Academic staff were educators while non-academic staff, included managers and other support staff employees please delete when done.
4.4 ACCESS AND ETHICAL CONSIDERATION

In De Vos, Strydom, Fouché, and Delport (2005) it is suggested that once the research population and appropriate strategies have been considered, the researcher then decides on how to gain entry to the research site. Researchers examine and experiment with issues that directly affect peoples’ lives, such as education, health, family life, work, and thus has an obligation to respect the interests of subjects and their communities (Sieber, 2009). The fact that human beings were objects of the study brought unique ethical problems to the fore (De Vos et al., 2005). The most concerns revolved around issues of harm, consent, deception, privacy and confidentiality of data (Denzin & Lincoln, 1998). In the current study, the main point of concern was the nature of the concept to be discussed, as it was a highly sensitive topic. There was concern that participants might be reluctant to participate if they were uncertain as to who would collect, see, manage and store their data, how and when the data would be used, and what the possible risks and benefits would be for them. However, the researcher assured participants verbally as well as in writing that compliance with professional ethics in respect of permission, informed consent and confidentiality was respected. The process of ensuring adherence to the aforementioned aspects of professional ethics is outlined below:

4.4.1 Permission

The researcher adopted a two-pronged approach in gaining entry to the research site (Sieber, 2009). This approach was in the form of personal presentations to the relevant stakeholders (including prospective participants), which was later followed by a formalised written request to gain entry and access to study participants. First, the researcher made a telephonic appointment with the director of HIV and AIDS and then personally presented herself to explain the aims and objectives of the study. Secondly, the researcher secured an appointment with the Head of Labour Relations for the relevant site for the purposes of obtaining institutional support and provisioning of demographic data which was essential to identify the sample. In the meeting with the Labour Relations manager, the researcher explained the objectives of the study. Thirdly, similar arrangements were effected with the union leadership of the National Education, Health and Allied Workers' Union (NEHAWU), which has a majority representation of non-academic employees at target site. The rationale for
meeting with the site trade union leadership was to explain the objectives of the study for the purpose of soliciting institutional support. These informal sessions yielded positive support. After meeting with the trade union leadership, the researcher requested a list of non-academic employees and organised departmental meetings through the heads of departments.

The researcher communicated directly with the identified groups of employees. This method of communicating directly (personally) with the prospective participants was chosen on the premise that when employees feel involved in the communication process, it would persuade them to agree to partake in the study (Sieber, 2009). During the presentation sessions, the researcher introduced herself as an independent student researcher with specific interest in the field of workplace HIV VCT programmes. Guided by the research proposal, the researcher outlined the aims and objectives of the study together with the detailed mode of data collection. The credibility of the research was substantiated by mentioning the fact that the study would be conducted under the supervision of Ms Jennifer Bowler of Nelson Mandela Metropolitan University. The mention of an external institution allayed their suspicions of breach of confidentiality as it might have been the case if a study of this nature were supervised by an internal academic from the institution. The reaction to the presentation was participative with most of the prospective candidates consenting to sign up for participation.

4.4.2 *Informed consent*

The next step was to file an application for ethics clearance with the Research Ethics Committee (Human) of Nelson Mandela Metropolitan University (NMMU). The Research Ethics Committee (Human) of NMMU granted clearance to conduct the research (Protocol number: H 13 BUSIOP 010).

Upon receipt of the study clearance number from NMMU's Research Ethics Committee, the researcher wrote a formal letter to the director for HIV and AIDS introducing the study and requesting consent to conduct the study (refer to Appendix 5).
The researcher submitted both the consent letter and the clearance letter from NMMU's Research Ethics Committee (Human) to the union leadership and the Labour Relations manager of the sample campus. Upon offering reassurance to the trade union leadership that participation was voluntary, the study was independent of the management of the institution and ethical considerations were considered, the leadership undertook to provide support to all the study communiqués sent to prospective participants. Later the Directorate for HIV and AIDS served as a gatekeeper and introduced the researcher to the Head of Nursing Services at the sample site.

Gatekeepers are people who have a prominent and recognised role in the local community (Hennink et al., 2011). The Director for the Centre for HIV and AIDS at the target institution is a respected and trusted person and played a pivotal role in encouraging participation of the targeted sample in this study. The centre had peer-educators, health promoters (HPs) and counsellors seconded by the Department of Health (DoH) who also contributed significantly in creating awareness for participation. The role of the site peer-educators and HPs was to assist in clarifying the purpose of study as stated in the email inviting voluntary participation.

To communicate with the potential participants the following was done:

- An email and letters inviting prospective participants were sent through the office of the Director for the Centre for HIV and AIDS. The letters emphasised to potential respondents that participation was entirely voluntary and that they could withdraw from the study at any stage of the data collection (refer to Appendix 4).
- The letter stressed to all participants that their sero-status would not be revealed.
- Part of the informed consent pertained to participants agreeing that the interviews could be recorded.
- Interested participants were requested to confirm their participation to the study directly with the researcher so as to ensure confidentiality. Their confirmation via email was deemed to constitute oral consent reflecting their voluntary decision to participate in the study. As such, prospective participants
were not required to complete a written consent form other than confirming participation directly to the researcher’s email address.

- As stated (above) the researcher supplemented the emailed letters of invitation with presentation of the purpose of the study to prospective participants. The face-to-face interactions with prospective participants offered them an opportunity to engage with the researcher in seeking clarity on matters relating to the study and participation. That in turn, encouraged voluntary participation.

4.4.3 Autonomy and confidentiality

Anonymity occurs when the identity of participants is not recorded or stated at all (Mouton, 2001). Rubin (1995) notes the researcher’s obligation to ensure that research participants are not subjected to emotional, physical or psychological harm because of their participation in the research project. In this regard, the researcher ensured anonymity of participants by using codes instead of their real names. As a result, their names did not appear in any document pertaining to the study. Furthermore, in the final report of the study, some participants’ responses were cited as quotes and there they also remain anonymous. Lastly, except for the researcher and research supervisor, no one had access to the research data and no one was able to identify individuals from information cited in the research report. The Director for the Centre for HIV and AIDS’s staff involvement in the study was restricted to assisting the researcher with logistical arrangements pertaining to data collection.

4.5 DATA COLLECTION

Data collection is the process of acquiring subjects and collecting the data needed for the study (Burns & Groove, 1995). In the current study, focus groups were utilised as a qualitative means of data collection. Focus groups collect data through group interaction on a topic determined by the researcher (Morgan, 1997). Focus groups serve as a powerful means to uncover factors that influence opinions, behaviour or motivation in studies where researchers investigate a complex behaviour (De Vos et al., 2005).
The major challenge in the use of focus groups relates to the researcher's competency in guiding the interview process (Babbie, 2010). However, the presence of a skilled facilitator ensures that the voices of all participants are considered. In the absence of a skilled facilitator, passive participants may be unduly influenced or inhibited by active participants (De Vos et al., 2005). The advantage of relying on focus groups is their ability to produce a concentrated amount of data through an interactive exchange of ideas which could otherwise be impossible in individual interviews (Willig, 2001). In this way, statements are challenged, extended and developed in ways that generate rich data for the study. The current study sought to uncover factors that positively and negatively influence HIV testing; therefore, focus groups are suitable to create a process of sharing and comparing amongst participants.

Focus group data was gathered through the use of a semi-structured interview schedule (Willig, 2001). Semi-structured interviews are defined as those organised around areas of particular interest, while still allowing considerable flexibility in scope and depth (De Vos et al., 2005). The interview agenda for semi-structured interviews consists of a relatively small number of open-ended questions (Willig, 2001). The major weakness of using a semi-structured interview schedule is that its success depends on the rapport that the researcher establishes with the study participants (Willig, 2001). To mitigate this challenge it is suggested that researchers respect ethical negotiations of rapport especially when dealing with sensitive topics such as the one under investigation. However, the advantages in the use of a semi-structured interview schedule far outweigh the disadvantages, because:

- Semi-structured interviews are considered to be of particular value when attempting to expose the dynamics of a research topic (Dickinson, 2004).
- The researcher can employ additional interviewing techniques such as probing, clarifying statements as well as paraphrasing so that the essence given to the meaning of the experience is captured (Willig, 2001).
- Semi-structured interviews allow the researcher to explore issues that are complex or personal (De Vos et al., 2005).
Interview questions help the researcher to stay focused throughout the interview, while still allowing participants to lead the discussion around issues salient to them.

4.6 PILOT STUDY

The New Dictionary of Social Work (1995) describes a pilot study as a process whereby the research method chosen is tested in order to establish whether it is appropriate and to verify whether participants will be able to understand the questions that will be asked. In this regard, the researcher intended to establish whether the questions asked converged with the type and quality of data required to answer the research question. Whilst the researcher observed that English was the medium of communication within the institution, she felt bound to acknowledge the probability that research questions may contain unfamiliar or culturally insensitive concepts.

An unstructured interview schedule was developed and tested with the target site's administrative staff who volunteered to participate. To coordinate participants and to organise the venue, the researcher was assisted by the human resources officers, the clinic staff and the institution's shop steward for administrative staff. The pilot interviews took place in the site's clinic counselling boardroom. Through the guidance and tutorship provided by the researcher's supervisor, an unstructured interview schedule with constituted open-ended questions was drawn from an analysis of relevant literature. Respondents in this pilot study were requested to assist the researcher by providing feedback on a number of issues. The pilot session yielded a positive response and served as the test ground for the interviews. The pilot study assisted the researcher to establish a flow in the manner in which questions were to be asked. Furthermore, conducting a pilot study was useful in estimating the time and the costs involved in administering the data-collecting tool to the prospective participants. The respondents were asked not to discuss any questions posed to them so as not to bias the research findings. Since there were no changes to the questions contained in the unstructured interview, the actual data collection process began.
4.7 DATA COLLECTION AND INTERVIEW TRANSCRIPTION

The purpose 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). The researcher's approach to conducting interviews was guided by the attached interview agenda (refer to Appendix 1). Babbie (2007) substantiates on the use of an unstructured interview schedule in qualitative research. In Babbie (2007) qualitative interview is described as an interaction between the interviewer and the respondent in which the interviewer has a general plan of inquiry, including topics to be covered, but not a set of questions which must be asked with particular words or in a particular order. In order to elicit responses that would specifically address the research questions, the interview agenda was structured according to the following five broad themes:

- knowledge about HIV testing;
- accessibility of and attitudes towards VCT;
- cultural beliefs and other practices;
- disclosure and stigma; and
- workplace issues pertaining to HIV.

The interview discussion was punctuated by words such as "what", "how" and "describe", which illustrate the open-ended approach to the session. In turn, such open-ended approach allowed respondents to express their views freely whilst allowing the researcher leeway for probing on the questions relating to the study. The interview started with some defined questioning plan but pursued a more conversational style that saw questions answered in an order more natural to the flow of conversation and the level of probing to some issues of interest cropping up (O'Leary, 2004, p. 164).

4.7.1 Coordinating study participants

The researcher collated the names of the respondents who confirmed partaking in the focus group discussion and sorted them according to gender. Each focus group was assigned a group code other than the code name that was assigned to each
participant. The focus groups were homogenous in terms of gender with a minimum number of eight participants and a maximum of twelve (see Table 4.1 below). Since HIV VCT has established the gendered nature of testing, male and female focus group sessions were conducted separately.

To set up the focus groups, the researcher drew up a timetable for each group and made a personal follow-up to confirm the agreed-upon dates. It was anticipated that the duration of the focus groups would range from between forty-five minutes and an hour. All participants who volunteered to partake in the study suggested that the interview sessions should be held during their lunchtime. However, the researcher negotiated a thirty minutes' release time with the affected heads of departments for each participant and that was duly granted. The request for thirty minutes release time before the normal lunch break was made to accommodate a ten minutes' walk to the clinic and another fifteen to twenty minutes for the researcher's address to the participants prior the commencement of the session.

To implement the focus groups, the researcher set up dates and confirmed venues and then started the data collection process. All the interviews were conducted in the counselling boardroom of the target site's clinics. The counselling boardroom was chosen because of its quiet surroundings, which was in line with the condition that effective unstructured interviews require privacy with a minimum noise level. The seven focus group interviews were conducted during the period between 28 May and 15 June 2013. There were eventually seven interviews instead of six because a special group of male contract employees voluntarily registered for participation. Owing to the number of years that these contact employees had been with the institution, which ranged between five and fifteen years of service, they were deemed to be employees in terms of the Labour Relations Act no 66 of 1995 (RSA). De Vos et al. (2005) recommend that the focus groups should be over-recruited by over twenty percent to allow for participants' withdrawals.

A form collating data on the socio-biographical details of each respondent was developed and completed by each focus group member on the day of the scheduled interviews. The socio-biographical form required confirmation of gender, age, education qualifications, years of experience and nationality, and the coded name of each participant.
Prior to the commencement of the focus groups sessions, the researcher welcomed each participant, introduced herself and outlined the purpose and importance of the study. In addition, the researcher explained the relevance of using focus group discussions as a mode of data collection as opposed to administering a survey. An emphasis was placed on the fact that participation was voluntary, that they could withdraw from the session at any time and that their information would be kept confidential.

The researcher assigned each participant a code and explained to them that, during the process of the interview discussion, participants would address each other according to their designated codes. The assigned codes were served as nametags and were placed in front of each participant for ease of reference. Prior to the commencement of each focus group discussion participants were provided few minutes, to internalise each other's assigned codes. This was done to secure their identity and in particular to uphold the ethical requirement of preserving participants' anonymity and confidentiality. Then the researcher showed participants the audio recorder – they had no objections to its use. The interview discussions commenced as scheduled and was guided by the pre-designed unstructured interview schedule. Together with the notes made by the researcher, the responses were later transcribed for purposes of the analysis. The coordination and grouping of focus group participants were arranged in accordance with according to Table 4.1, below:

Table 4.1: Sample of the focus group participants

<table>
<thead>
<tr>
<th>Focus group code</th>
<th>Participants' code ranges</th>
<th>Date of discussion</th>
<th>Gender</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group A</td>
<td>A1–A8</td>
<td>4 June 2013</td>
<td>Males</td>
<td>8</td>
</tr>
<tr>
<td>Group D</td>
<td>D1–D10</td>
<td>10 June 2013</td>
<td>Males</td>
<td>8</td>
</tr>
<tr>
<td>Group X</td>
<td>X10–X80</td>
<td>14 June 2013</td>
<td>Males</td>
<td>10</td>
</tr>
<tr>
<td>Group A</td>
<td>A2021–2032</td>
<td>29 May 2013</td>
<td>Females</td>
<td>12</td>
</tr>
<tr>
<td>Group B</td>
<td>B101–112</td>
<td>30 May 2013</td>
<td>Females</td>
<td>9</td>
</tr>
<tr>
<td>Group C</td>
<td>C10–C90</td>
<td>5 May 2013</td>
<td>Females</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Total 56</strong></td>
</tr>
</tbody>
</table>
4.8 DATA ANALYSIS

Viljoen (2004, p. 60) asserts that it is profoundly impossible to follow any one epistemological approach in the analysis of qualitative data and argues that:

... the approach any researcher uses develops as a process in language and is as a result of the voices that inform the creation of the socially constructed self. In this way one uses parts of different approaches (some which may be in conflict) in the process. There is no meta-theoretical perspective, meta-narrative or single overarching epistemology.

Notwithstanding that, Terre-Blanche and Durrheim (2004) assert that the main purpose of analysing data in qualitative research is to provide a rich and thorough description of the characteristics, processes, transactions and contexts that constitute the phenomenon being studied and to provide an account of a researcher’s role in constructing such a description. Thematic analysis makes use of categories that are defined according to some conceptual framework (Willig, 2001).

Data analysis is a summary of completed observations, which yield answers to the research question (Trutty, Rothery & Grinell, 1996). When conducting data analysis, researchers find ways to tease out what is considered the meaning in the raw data, then they reduce and combine it so that the readers share the researcher’s findings in the most economical and interesting fashion (Elym, Anzul, & Friedman, 1999). There are two purposes of data analysis. First, the data has to be coded so that themes and categories can be categorised, analysed and behaviours noted. Secondly, a data filing system that will provide a flexible storage system with a procedure for retrieving the data must be developed (Field & Morse, 1985). Thematic analysis makes use of categories that are defined according to some conceptual framework (Willig, 2001).

The qualitative data obtained was transcribed in English, coded and thematically analysed in the same language, using the qualitative analysis and interpretation method outlined in Henning, Van Rensburg, and Smit (2004). The process described in Henning Van Rensburg, and Smit (2004) is outlined below:

The researcher reads through all transcribed data.
In the current study, the semi-structured questionnaire deployed to collect data was organised according to five thematic units. Willig (2001) notes that thematic analysis makes use of categories that are defined according to some framework. The same thematic units were adopted to create descriptive, multi-dimensional categories that provided a preliminary framework for data analysis. The pre-establishment of thematic units (during the data collection stage) facilitated a manageable process of coding.

Coding is an inherent part of qualitative analysis. In the current study, the coding process involved two steps: first-level coding and second-level coding.

First-level coding involves extracting the relevant quotes from the transcripts. In the current study, first-level analysis was conducted by extracting direct quotes from the data representing each thematic unit.

Second-level coding relates to the process of attaching meaning to a quotation so as to make sense of the data. The process involves searching for patterns, relations and trends necessary to capture an integrated picture of the phenomenon that is being studied. In the current study, searching for such trends was facilitated by the pre-establishment of thematic units.

Finally, after codes and categories had been established, the final step was to merge the data with other text(s) from literature and for the researcher to forge her own position in relation to how such literature relates to the objectives of the study and the research question.

4.9 DATA VERIFICATION

It is said that all research must respond to the canons that stand as criteria against which trustworthiness of the project can be evaluated (De Vos et al., 2005). The canons of data collection are found in Lincoln and Guba's (1998) model of trustworthiness. The model makes reference to four aspects of trustworthiness for verifying qualitative data, namely applicability, neutrality, truth value and consistency (Lincoln & Guba, 1998).

The findings from this study are data-specific (given the qualitative nature of the data collection and analysis) and can therefore not be generalised to another setting. The
factors uncovered in the study can be used as the basis for constructing a quantitative questionnaire to explore the generalisability of the findings.

"Neutrality" refers to the "degree to which the findings are a function solely of the informants and conditions of the research and not of other biases, motivation and perspectives" (De Vos, 2005, p. 348).

"Truth" value is concerned with the truth of the findings based on the design and the context of the informants. The design elements of this study point to the discovery of lived human experiences as the key to establish the truth value of a study (De Vos, 2005). As the researcher's role was to allow participants to tell their story, this was regarded as testimony to the criterion of consistency. Consistency of data is concerned with whether the findings would be consistent if the research study was to be conducted with the same subjects or in a similar context (De Vos, 2005). This is established though the strategy of dependability. It is recommended that other research investigate the same issues in order to evaluate the consistency of data obtained.

4.10 CONCLUSION

The chapter on research methodology described the process employed in collecting data. The chapter presented a discussion of the choice of research design adopted in the study and gave a justification thereof. In addition, the chapter explained the relevance of using focus group discussions and adopting semi-structured interviews as data collection instrument. Since data had been collected, the next step was to make sense of it, and the next chapter will present a discussion of the study findings.
CHAPTER 5
RESULTS AND DISCUSSION

5.1 INTRODUCTION

The overall aim of the study was to explore and describe factors that positively and negatively affect a workplace VCT programme, and to make recommendations on strategies to increase programme participation. This chapter describes the analysis of data collected and overall findings. The chapter is divided into four broad sections. The first section examines the demographics of study participants. Section two presents results of the factors that influence workplace VCT participation by non-academic staff of academic institutions in the Eastern Cape. These factors are presented according to five themes, namely knowledge about HIV and AIDS; accessibility of and attitudes towards VCT; cultural beliefs and other practices; disclosure and stigma; and workplace issues pertaining to HIV. Section three provides a thematic discussion of the findings and makes use of relevant literature. Lastly, section four presents a summary of the chapter.

5.2 DEMOGRAPHIC ATTRIBUTES OF PARTICIPANTS

The socio-demographic details of participants are presented in accordance with the format of the biographical questionnaire, administered on each day of the scheduled focus group discussions. Below is a tabulation of the demographic characteristics of the study participants.
Table 5.1: Socio-demographic details of focus group participants (n=56)

<table>
<thead>
<tr>
<th></th>
<th>Males n=26</th>
<th></th>
<th>Females n=30</th>
<th></th>
<th>Total n=56</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>f</td>
<td>%</td>
<td>f</td>
<td>%</td>
<td>f</td>
</tr>
<tr>
<td>Educational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matriculation</td>
<td>17</td>
<td>65</td>
<td>30</td>
<td>100</td>
<td>47</td>
</tr>
<tr>
<td>No matriculation</td>
<td>9</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Race and nationality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African</td>
<td>26</td>
<td>100</td>
<td>30</td>
<td>100</td>
<td>56</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 24 years</td>
<td>1</td>
<td>4</td>
<td>6</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>&lt; 34 years</td>
<td>7</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>35–44 years</td>
<td>11</td>
<td>42</td>
<td>12</td>
<td>40</td>
<td>23</td>
</tr>
<tr>
<td>45 years +</td>
<td>7</td>
<td>27</td>
<td>12</td>
<td>40</td>
<td>19</td>
</tr>
<tr>
<td>Occupational positions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White collar</td>
<td>17</td>
<td>65</td>
<td>30</td>
<td>100</td>
<td>47</td>
</tr>
<tr>
<td>Blue collar</td>
<td>9</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Years of occupational experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 10 years</td>
<td>20</td>
<td>77</td>
<td>20</td>
<td>67</td>
<td>40</td>
</tr>
<tr>
<td>10 years +</td>
<td>6</td>
<td>23</td>
<td>10</td>
<td>33</td>
<td>16</td>
</tr>
</tbody>
</table>

Of the 56 participants, 46% were males and 54% were females. The participants' ages ranged from younger than 24 to 45 years and above (median was 36). A total of 84% had obtained secondary schooling or even a matriculation qualification. An analysis of occupation and gender indicated that 84% of the participants were employed in white-collar positions (administrative functions) while 16% worked in support services. All female participants occupied white-collar positions, compared to 65% of males. However, the percentage female participants with more than ten years of experience (67%) was slightly lower than that of male counterparts (77%).

5.3 PRESENTATION OF FINDINGS

The study adopted Henning et al.'s (2004) method of qualitative analysis and interpretation. Five broad themes were used to guide the semi-structured interview schedule. Each theme had a set of questions, which were posed to the participants. Table 5.2, below presents the semi-structured interview schedule.
## Table 5.2: Semi-structured interview schedule

<table>
<thead>
<tr>
<th>THEME (CATEGORY)</th>
<th>SUB-THEME (SUBCATEGORY)</th>
</tr>
</thead>
</table>
| 1. Knowledge about HIV testing | 1.1 What do you know about HIV voluntary counselling and testing (VCT)?  
1.2 When do you think people should go for HIV testing? |
| 2. Accessibility of and attitudes towards VCT | 2.1 What do you think makes it difficult for people to go forward for HIV testing?  
2.2 If you were to go for an HIV test, where would you prefer to go to and why?  
2.3 What are your views regarding VCT campaigns that have been launched on campus?  
2.4 Do you think that the results will be kept confidential if you go for testing on campus? |
| 3. Cultural beliefs and other practices | 3.1 Can you describe ways in which cultural (traditional) beliefs encourage or discourage people’s decisions to go for an HIV test?  
3.2 In what ways do you think being male or female affects people’s decisions to go for HIV testing?  
3.3 Are women and men who are HIV+ treated differently?  
3.4 What role (if any) does alcohol abuse play in participation in HIV testing? |
| 4. Disclosure and stigma | 4.1 In conversations you had with your friends or colleagues, what views did they present about HIV testing?  
4.2 What comments do they make about people who are HIV+?  
4.3 Are you aware of any discrimination against HIV+ individuals within the institution? |
| 5. Workplace issues pertaining to HIV | 5.1 Could you tell me about the institution’s HIV and AIDS workplace policy?  
5.2 What for you is the most important issue in the workplace policy?  
5.3 What do you feel about the support available for HIV+ people within the institution?  
5.4 What would you like to see at this institution that would support HIV testing?  
5.5 What would you like to see at this institution that would support HIV+ employees? |

### 5.3.1 Theme 1: Knowledge about VCT

The view that knowledge is power professes that behavioural change is possible only when people are empowered to know exactly what to change through an inclusive and culturally sensitive approach aimed at identifying a behavioural change process with them as opposed to instructing them (Van Dyk, 2012). In order to assess the
knowledge of participants, Theme 1 comprised one broad question with a follow-up question constructed as follows:

- What do you know about HIV and AIDS voluntary counselling and testing?
- When do you think people should go for HIV testing?

All study participants claimed to have heard about VCT and displayed a basic knowledge of VCT. Their interpretation of the VCT programme was framed along the lines of "knowing your status" and advocating early diagnosis of the HIV-virus as an important factor in accessing treatment. Below is an extract of the responses from participants:

- **You must get tested to know your status early, so that you can access treatment.** [X90]
- **Testing is important for someone to know her status, so that if she is infected, she can get treatment before she becomes sick.** [A20 and A21].

Participants also articulated their perception of the VCT programme through two additional strands, namely, confidentiality and voluntariness of the programme. In that regard, participants stated:

- **What I know about testing, you go to the clinic or where they test; they do counselling first and then you test and get your results in fifteen minutes, if I am not mistaken. I know that when you go for testing … the nurses will not disclose any information.** [A2030 and A2031]
- **It is voluntary; you don’t have to be forced.** [C90]
- **I agree with C30 and C90, voluntary as the word might say … nobody should force you.** [C60]
- **… without any one forcing you.** [All participants in this group agreed]

Preoccupation with confidentiality and privacy in describing knowledge about VCT was the most important factor for one female participant referring to an off-the-shelf HIV testing kit.

- **I know you can get an HIV testing kit from any pharmacy and you don’t have to go to the doctor or clinic – you can do it in your own privacy.** [A2029]
A follow-up question to Theme 1 was "When should people voluntarily present themselves for testing?" This question was meant to ascertain respondents' level of knowledge in terms of when one should seek VCT services. The wide range of responses revealed an insufficient level of knowledge about VCT. Most respondents cited psychological readiness as the main deciding factor whether people would voluntarily participate in a VCT programme. All female participants (8) in Group B attested that, whilst individuals may present themselves anytime or regularly for HIV testing, the deciding factor remained readiness (… whenever you feel like, whenever you think you are ready). The same attitude was displayed by males in Group A.

The question “When do you think people should go for an HIV test?” further emphasised the importance of psychological readiness to go for an HIV test as part of the expected consequences of testing. Confirming this attitude, one male participant stated:

- I think people should go [for testing] when they are fit to face whatever the consequences [may be] that may come out. [A4]

The descriptive narrative of this study highlighted the perceived susceptibility (i.e. subjective way in which an individual evaluates the probability of developing a specific health problem) as another cognitive factor interfering with individual decision-making whether or not to participate in a VCT programme. One female participant echoed this sentiment, stating:

- You have to go for an HIV test when you know you have engaged in unprotected sex. [C30']

Other female participants expressed a gender-punctuated view as a reason for them to utilise HIV testing services and stated:

- … when you are pregnant, for the safety of the baby. [C10 ]
- I agree, because when you are pregnant, it is important that you get tested so that the baby will be protected [A2026 and A2021]

A different slant was given to reasons for getting tested, with actual sickness being a reason that individuals should seek VCT services. A female participant attested to this view and stated:
• People should go for testing when they are sick; maybe the doctor will suggest an HIV test. [C20]

The importance of seeking VCT when making decisions about getting involved in an intimate relationship was described by another female respondent:

• When you are married, you have to go for testing, your partner and you must get tested; and when you are starting a new relationship with someone to make sure that both of you are negative and both of you are safe. [A 2032]

5.3.2 Theme 2: Accessibility of and attitudes towards VCT

Theme 2 explored the role of attitudes and accessibility in serving as a facilitator or as barriers to VCT participation. In psychology, attitudes are described in terms of three components, namely cognition, affection and behaviour (Milner, 2009; Werner, 2012). The components affection and behaviour can be used to form evaluative statements, which are either favourable or unfavourable about objects, events or people (Milner, 2009). Attitudes can influence an individual's decision to participate in a VCT programme (Obermeyer & Osborn, 2007; Van Dyk, 2012). The following questions were asked to explore how attitude influences VCT participation factors.

5.3.2.1 Theme 2: sub-question 1: What makes it difficult for people to go for an HIV test?

Fear was reported as the major barrier to accessing VCT services. Respondents described the negative effect fear has on VCT participation as follows:

• ... some are scared of the results [C80]

The pervasiveness of fear as a negative barrier to VCT – especially in cases where perception of risk is acknowledged – is demonstrated by the following explanations by males:

• When I know I did not condomise; if I have multiple sex partners, I could be positive ... so I am scared of knowing my status. [C90]

• Fear of the known because, every time you are about to do the test, the past risk behaviours you have done will come back and you always think: I slept with someone, not using protection. [A8]
On the other hand, female participants associated fear with different consequences of HIV disclosure and stated:

- Fear of being rejected by your partner is the deterrent in seeking VCT services [C90 and C30].
- … the reason why people are scared to get tested is because when they are positive, they have to disclose their status to their family and so people will rather not know, so as to protect their families. [A2022]

Incorrect information about HIV promotes negative attitudes towards a VCT programme. Participants expressed fear based on myths about HIV and AIDS and noted the negative effect such myths have on HIV testing efforts. Respondents stated:

- The message that was sent before was that if you are positive you are going to die. This makes people afraid to go and get tested, because we are scared of dying. [D9]

Furthermore, the study observed misperceptions about HIV which discouraged people from accessing VCT services. This belief was expressed by participants in the study:

- … once your family is tested positive, in most cases all of the guys in that household will be tested positive – we do not know how it is transmitted from me to my sister. [A2030]
- If you are HIV positive, a lot of things come to your mind; you might end up thinking of committing suicide. [X90]

In this study, participants conceded that perceived breaches of confidentiality and lack of trust were important factors that inhibited the utilisation of VCT. Respondents stated:

- The other reason for people to be afraid of testing is that they are afraid that people will gossip about their status. [C70]
- The other reason that makes it difficult for people to go for HIV testing is that they think there is no confidentiality and they do not trust the people who are
doing the test because maybe that person will go outside and then tell people about your status. [D8]

The concern over fear of a lack of confidentiality and trust as a barrier in accessing VCT services is further illustrated by one of the male participants who advocated that a pregnancy version of an HIV testing kit should become available:

- I think that if it was possible [to test] like a pregnancy testing, I could test myself. [D9]
- They must make those things like pregnancy tests, I agree with D9. [D6]

Easy access to VCT services within the target institution is facilitated by the presence of VCT mobile clinics. A gender-biased response was noted from participants when they were asked: "What views do you hold about on-site VCT mobile clinics?" One participant stated:

- Clinics are mainly for females, they are not men-friendly and this makes us men afraid to go to clinics. [D11]

Stigma was one of the major concerns mentioned by respondents of this study. They described the impact stigma has on VCT participation:

- Stigma around HIV and AIDS makes people not to go to test. [X90]
- Some are scared of the results and the stigma. [C80, C70, C60; A2030, 2021 and A2024]

The impact of stigma caused – unintentionally – by HIV communication, drew the following comments from female respondents:

- HIV messages say "be faithful", as if you get HIV when you are unfaithful. [A2030]
- It represents part of HIV and AIDS communication that stigmatised the epidemic, the way it was introduced in the society. We were made to believe you will get HIV if you are a prostitute. [A2030]

The negative HIV communication was blamed for having contributed to the "labelling" or "judging" of people. Study participants stated:
• People who are found [to be] HIV-positive are regarded as promiscuous. [D9]

• I think most people are afraid to test because they are afraid of their status. If you are HIV positive, it is like the way you behave and the way you are doing things, it reflects on your status. [D10]

• The first thing that comes to mind whenever someone is diagnosed with HIV is: Who was she dating? Probably she was sleeping around. [A2029]

5.3.2.2 Theme 2: Accessibility of and attitudes towards VCT (positive)

In order to discern positive factors that affect VCT, participants were asked to describe things that encourage people to go for HIV testing. Normalisation of the HIV pandemic was described by both female and male participants. They stated:

• Another thing that would motivate people, it must be more advertised as just a sickness, a usual sickness like flu. Even adverts must be there showing even these ARVs as just something to take, like flu pills. [A7]

• If all of us can treat HIV like diabetes, then I do not see why people are not testing. [A2029]

Also, education was suggested as having a pivotal role to play in promoting the participation of VCT. Respondents believed:

• … give people more knowledge about this HIV testing, because people are afraid of that. [D5]

• … when people are taught the dos and don'ts and everything entailing HIV and AIDS, people will feel free to go and test. [C30]

• We need more education, health education on this particular subject. [B102]

• I think people must be educated about HIV and AIDS. [A20 and A21]

One respondent particularly stressed the importance of educating people about the benefits of HIV testing in facilitating participation in VCT services. He stated:

• We need to tell people what is good about doing the HIV test. People must know that it is not a manhunt for people who are HIV-positive. [A8]
Some respondents suggested the provision of incentives for attendance as another positive factor that could facilitate VCT participation. Participants stated:

- *Gift packs would also help people to go and test, because black people enjoy gift packs.* [X80]
- *The fact that I know after testing I will get AIDS.* [A2]
- *If you want young people to go and test, you need bursaries because those young people want to go to school more than going to test. For older people at least, we need food parcels as a stress reliever.* [D9]

### 5.3.3 Theme 3: Culture

As observed by Chipkachta (1997 cited in Mundy & Dickinson, 2004), the health care of any culture includes patterns of belief about causes of illness. Governing choices of evaluation, therefore, the belief held by people with external locus of control that their health depends on exogenous factors (luck, fate, chance, etc.) validates that culture has an influence on the individual decision-making process to partake in a VCT programme. Mbiti (1969 cited in Van Dyk, 2012) agrees, and asserts that the identity of the traditional African is totally embedded in his or her collective existence with all decisions (including health) taken with the group’s knowledge and approval. The current study explored the concept of culture as a factor that facilitates or inhibits VCT participation through the following questions:

1. Can you describe ways in which cultural (traditional) beliefs encourage or discourage people’s decisions to go for an HIV test?
2. In what ways do you think being male or female affects people’s decisions to go for HIV testing?
3. In what ways do you think being male or female affects people’s decisions to go for HIV testing?
4. Are women and men who are HIV+ treated differently?
5. What role (if any) does alcohol abuse play in participating in HIV testing?

In describing the cultural factors that facilitate the utilisation of VCT, most participants mentioned circumcision as one of the cultural practices facilitating VCT participation. Participants stated that:
- I am a Xhosa man, so I have to become a man and so I have to go through initiation, so culture in that instance does encourage it. [A7]

- Young boys, before going to the mountain for their initiation period, should go for HIV testing so that they can't infect people and even the traditional surgeon or else other initiates. [D11]

- Intonjane are cultural practices that encourage young women to abstain from sex until they are at a certain stage. [D9]

- I don't know the English name of intonjane, but I think it is like a traditional circumcision done for females. [C80]

The descriptive analysis of this study made a distinction between medical male circumcision and traditional male circumcision, whereby the former was met with acceptability challenges. Respondents believed that:

- We are traditional men, we would prefer to stay at home [rather] than to go to hospital visiting nurses letting them examine us. [X10]

- Our fathers, the old fathers, say: You cannot go and test because this thing must be done in the forest, so they say no one must go to the hospital. If you go to the hospital and test, it means you are not a man enough. [C70]

Regarding cultural practices that serve as barriers to HIV testing, most participants in this study mentioned witchcraft and explained that:

- I want to align myself with A4 in that part of witchcraft. At a certain stage, HIV was said to be a curse in a way. Like something you have been given by witchcraft. [A7]

- Witchcraft plays a role in deluding people to think that they do not need to test. [D9]

- As Africans, we have a belief in witchcraft, so there is no need to test if you are bewitched. [X40]

On the other hand, some participants blamed the role of sangomas (traditional healers) as another factor that emerges as a barrier for HIV testing. For example, one participant stated:
• Sangomas, they tend to tell people lies that they can cure HIV and AIDS and then make it difficult to go for HIV testing. [D11]

On the question of whether gender affects people’s decisions to test, respondents agreed and said:

• There is this practice of us saying, “I am a man. Then I am the head of the family and then I am not a softie.” So going to the clinics it is for women and culturally we use women as barometers of our status. [A8 male]

• I am A2 and I totally agree with A8 – there is this thing called “indirect testing”. Us as man we are good at that. If she goes for testing, she can’t even wait to come home. She is giving you a call: “Baby, are you around?” “What for?” “No, I have got news man. I just want to discuss something with you.” Then, she comes home and gives you the results. She is negative. Then you know for a great fact, no, everything is still good. [A2]

• Another thing that makes males not to go for testing is that males, they don’t want to stand long. They don’t want to queue. [C30]

• There is a tendency that it is seen as a female illness and that females should go and test because it is their illness and their responsibility to go and test. [X10]

• And when you have a new boyfriend. Obviously after some three months, the man now wants to stop using condoms, so they would suggest that you go for an HIV test. He does not want to go. [A20 and A29]

Hegemonic masculinity as a culturally defined construct yielded insights into what undermines the efforts to positively promote VCT participation. Males in this study stated:

• Real men must have many girlfriends. It is OK to have many partners but not in the same way for women. [D10]

• Culturally, men are perceived as providers – so my woman won’t ask me anything about my relationships because I am providing. A woman can’t ask me about using a condom when I am a paying partner. A woman cannot negotiate safer sex. [A8]
To zoom into what D10 is saying, is that as a man, if you have many women, like me, you are regarded as "ingakara" – a man of great stature, a man of integrity. But if you are a woman, then it says otherwise about you and the whole community looks down on you. [D9].

Female participants in this study also confirmed elements of hegemonic masculinity and stated:

- It becomes a challenge when you are the wife and you are suggesting to the husband that: let's go and get tested. The husband will have this perception that you are cheating. Even if you are a girlfriend and you are in this new relationship. So, it is not easy for females. [A2022]

- In terms of getting married to a man who is a provider, you know, imagine if you are going to go and test and bring back the news that you are HIV+ positive to this person who is the provider of the family – there is just no way you are going to deliver those news. [B101]

Regarding the role played by alcohol in HIV testing, respondents described its effect on HIV and AIDS testing as follows:

- Alcohol abuse is one of the drivers of the epidemic because if I am drunk when I enter that shebeen, when I see those girls, I say: "No, no, they are not my type." Should I take one or two, I do not know what is going on with my vision. I will always look at them and say, "you know that is the most beautiful one", you know and even I cannot make good decisions. Even if I do not have a condom, I won't have time to use a condom. I will just go down straight, whatever, because of the abuse. And after that I will not go for HIV testing. [A7]

- Alcohol is very dangerous and it makes people – because sometimes when you have drunk alcohol, you tend not to use condoms, you forget everything, so alcohol makes a big rate of HIV. [C70]

### 5.4 THEME 4: DISCLOSURE AND STIGMA

In order to obtain data on the role of disclosure and stigma in facilitating or discouraging VCT participation, the following questions were asked:
1. In conversations you had with your friends or colleagues, what views did they present about HIV testing?

2. What comments do they make about people who are HIV+?

3. Are you aware of any discrimination against HIV+ individuals within the institution?

Both male and female participants held diverse attitudes on how friends or colleagues and the community influenced their decision to participate in HIV testing. This is reflected in the following statements:

- *I am A3 [male group]. I recently had an argument with my friends. We were discussing about HIV testing, the majority of them were saying it is better not to know your status, because once you know your status that is what kills you more than the virus.*

- *Some of the friends, they will tell you straight that they won't do that because it is destructing. Still they want to enjoy life, so you go alone. They don't want to go there.* [A4]

- *We always have a lot of conversations with my colleagues. It is like what you are getting from them, it is like: I will wait up until I am in a death bed, then I will go and test.* [B101]

- *Some of my friends say that "I would rather not know my status."* [C50]

- *If you tell them about HIV testing, they will tell you to go and test yourself, keep it to yourself. They do not want to engage in such conversation.* [X60]

- *We encourage them to hold on, to eat robot effect, healthy food and to use robot effect.* [D6]

- *We encourage them to accept their HIV status.* [D7]

Regarding comments people make about people living with HIV, participants had this to say:

- *They call you names. They tag you. They won't even come near me.* [B109]

- *They will start to treat you differently: they will never share things with you because of the shock knowledge that they have. They will never share things with you even in a shebeen. They will never share a smoke with you.*
will even stay away from your girls, so that is different. They used to do these things with together with you, but the day they hear that you are positive, that's when they will end of all those things. [A4]

All participants agreed that they have never experienced or heard of anyone being discriminated against on the basis of his/her HIV status within the target institution.

## 5.5 Workplace Issues Pertaining to HIV and AIDS

Participants in this study were asked the following questions in order to ascertain whether workplace issues (such as policies and programmes) serve as facilitators or barriers for VCT:

1. Could you tell me about the institution's HIV and AIDS workplace policy?
2. What is the most important issue in the workplace policy for you?
3. What do you feel about the support available for HIV+ people at this institution?
4. What would you like to see at this institution that would support HIV testing?
5. What would you like to see within this institution that would support HIV+ employees?

Most participants (except for one group that had the clinic staff as participants) expressed lack of knowledge of the HIV and AIDS policy within the institution. Consequently, they had no knowledge of the support for HIV-positive people within the institution. In this regard, participants stated:

- *I am not aware of any; I don't think there is a policy for HIV and AIDS. I am not aware.* [B1–04 and A2021]
- *Yes, there is a policy, but the policy is on HIV and AIDS in this institution, it is not well publicised, I don't know the contents.* [D9]
- *Honestly, honestly, I do not know whether there is any support, any form of support for people with HIV and AIDS within the institution. I have been with this institution for the past how many years – since 1992.* [B102]
I agree with B1–01 and 04, that there is no support, but I have heard that there is a wellness centre at the university. I do not know what it does. [B103]

On the question "What can be done to support HIV testing at the target institution", participants made a call for peer educators and stated:

- I think there should be support groups for people living with HIV and AIDS, whereby they will get taught by people who know more about HIV and the way that you should behave if you are HIV-positive. [D5]
- I think that people would never succeed in isolation. We need support groups to help us get through difficult times. [X30]

Regarding the same question, some participants suggested more education as the catalyst in facilitating HIV testing within the target institution.

A descriptive analysis of the participant's responses to the question "What would you like to see at the current institution that would support HIV positive people", suggested that some participants advocated for the end of HIV exceptionalism and a move towards normalisation and de-stigmatisation of HIV and AIDS. In this regard, participants had this to say:

- But I would ask what makes them different from me? I am a chronic person myself and I am not treated differently. Why does an HIV-positive have to be treated differently if she is not disabled? If she is on ARVs, just take your ARVs, just like me. [A2030]
- I agree with A2030. They should not be given special privileges because they are HIV-positive. They should be given the same treatment as other people that have other chronic diseases. [A2022]

Respondents to this study made a call for an establishment of an employee wellness centre and stated:

- If you talk about HIV and AIDS here at school, it is for the students. There is no wellness for workers. [A8]
- There must be a dedicated section under the Human Resources Department that would deal with wellness of our employees, too. [A5]
5.6 DISCUSSION OF FINDINGS: INTRODUCTION

This section presents the findings of the study. The findings are categorised according to the five themes used in the data collection process. The section provides a brief description of the relevance of each theme to the study objectives. The aim is to provide a systematic and integrated picture of the phenomena being studied. The thematic findings are then linked to literature studies that confirm or dispute the established findings.

5.6.1 Theme 1: Knowledge about VCT

The first theme in the unstructured interview guide was knowledge about VCT. This theme is embedded in the presumption that when people are empowered with knowledge of the benefits of VCT, that will influence their decision-making processes towards participation in VCT programmes (Solomon et al., 2004). The construction of VCT services as the primary access point to HIV and AIDS care positions the VCT process as responsible for the provision of knowledge, which will be a source of the spread of HIV and AIDS transmission (Shisana et al., 2009). Whilst Mundy and Dickinson (2004) posit that information and education initiatives alone can have a transitory effect, eroded over time by contradictory pressures, DiClemente (1994) objects and asserts that the transformative impact of knowledge professes to enhance the role of VCT in promoting risk reduction through increasing the perception of risk as well as through reinforcing social norms and responsibility. Central to the dichotomous relationship between knowledge transfer and the decision-making process lies an elusive quest regarding whether knowledge transfer promotes VCT participation.

To establish whether knowledge plays a positive or negative role encouraging people to seek VCT services, study participants were asked these questions: "What do you know about VCT?" and "When do you think people should go for HIV testing?" These two questions generated responses that revealed individual psychosocial factors as variables that influence people's perceptions or beliefs about VCT.

In this study, it was encouraging to observe that participants had some knowledge of VCT, albeit, from a perspective of knowing their HIV status. Furthermore, the
researcher observed that none of the participants provided in-depth knowledge regarding the procedural steps that form standard or basic operating procedures regarding VCT. In that regard, none of the participants explained what information is shared during pre- and post-testing counselling sessions of the VCT programme. Instead, they chose to present a particular standpoint or single aspect of VCT. Worrisome was that the majority of study participants could be construed as relatively educated, as 87% had obtained a secondary qualification. Findings also revealed that participants articulated their understanding of VCT programme from two additional strands, namely, confidentiality and voluntariness of the programme.

On the question "When do you think people should go for testing?" participants made reference to psychological readiness as an intervening factor in deciding to participate in a VCT programme. HIV and AIDS were seen to be a gender-biased disease where female participants explained their rationale for seeking VCT services on the grounds of maternity (pregnancy). On the other hand, some participants believed that people should seek VCT services only once they are sick. In addition, the notion of perceived susceptibility was established as a determining factor for people to seek VCT services. The study revealed that some people only seek VCT services when they know that they have indulged in risky behaviour. In other words, susceptibility of risk sometimes facilitates people's decision to go for an HIV test. Finally, it was encouraging to note participants' awareness that VCT services should be made use of when planning long-term intimate relationships such as marriage. The next section will discuss these findings in relation to established literature reviews.

**Finding 1: VCT from a singular perspective (Know-your-status perspective)**

The implications of defining VCT from the "know-your-status" paradigm are well articulated by Van Dyk and Van Dyk (2003) who assert that such confinement reflects an erroneous or ignorant perception, namely that it is for diagnostic purposes and that it is a stumbling block in the way of people getting tested and that it can thus suggest a lack of knowledge. Van Dyk (2003) explores the importance of knowing the entire process of VCT and asserts that post-test support services play a critical role in reinforcing long-term behavioural change, and thus believes that an expectation of a behavioural change through a single exposure to VCT is unrealistic and
inconsistent with theories of behavioural change. This observation disputes established research findings on the association between a lack of education and a lack of knowledge regarding VCT (Hutchinson & Mahlalela, 2006). Suffice it to add that the lack of in-depth knowledge regarding VCT among staff can be attributed to the non-existence of a dedicated department or section within HR that caters for staff wellness programmes and not only for students.

**Finding 2: VCT defined from a confidentiality perspective**

Claimed knowledge of VCT from a confidentiality perspective supports reported assertions by Obermeyer and Osborn (2007) that perceptions of how confidentiality is handled can have an influence on the client's willingness to test. In the HIV and AIDS literature, the "off-the-shelf testing kit" is synonymous with self-tests for HIV, which are still unregulated in South Africa and thus pose a challenge to quality and reliability (Richter, Venter, & Gray, 2010). In the context of VCT, the self-test strategy has fuelled a debate of HIV exceptionalism and the normalisation of HIV and AIDS. Notwithstanding the challenges associated with this strategy, Richter, Venter, and Gray (2010) argue for greater access to and quality of HIV self-testing methods. Richter, Venter, and Gray's (2010) support for the HIV self-test is based on the hope that it will encourage regular HIV testing and allay fears of confidentiality. From the theories of behavioural change, reference to the "off-the-shelf HIV testing kit" signified the respondents' health locus of control theory (Van Dyk, 2012). The health locus of control theory is premised on the belief that the success of prevention strategies (such as VCT programmes) depends on whether people believe that they have control over their health (Van Dyk, 2012). As a result, people who do not believe that they can control their own health (external locus of control) are reported to be less inclined to get involved in preventative behaviour (Van Dyk, 2012). In contrast, people who believe that they can influence and control their own health through personal behaviour (internal locus of control) (Van Dyk, 2012) will also take steps to test themselves.

**Finding 3: VCT defined from a voluntary perspective**

The significance of placing emphasis on voluntariness of the programme resonates with a common construction of VCT as being a process of informed consent, in that
VCT equips the respective clients to make a decision about whether or not they wish to go ahead and be tested, or not (Solomon et al., 2004). The process of informed consent is linked to the human rights approach, and invokes an ethical dilemma between safeguarding individual rights and protecting public health (Obermeyer & Osborn, 2007; Orisakwe, Ross, & Ocholla, 2012). This dilemma was highlighted as the goals of achieving HIV testing targets through "know-your-status" campaigns remained an elusive quest where voluntarism in HIV testing guarantees people their right to self-determination and autonomy (Orisakwe et al., 2012). Paradoxically, in the Prevention of Mother To Child (PMTC) sites, Solomon et al. (2004) report that women attending antenatal clinics are routinely tested as part of a package of pre-natal tests and medical services. In an effort to balance these health imperatives, the WHO (2007) proposed a formulation that distinguishes between two types of HIV testing (both voluntary), namely client-initiated testing (VCT) and provider-initiated testing (P/HCT). A detailed discussion of the two approaches was provided in Chapter 4 of this study.

**Finding 4: Readiness as a pre-condition for seeking VCT services**

"Readiness" can be defined as a state of being suitable for an activity or action (Pearsall, 2002). Respondents' reference to a psychological state of readiness as a precondition for participating in HIV testing concurs with the contextualisation of the meaning of HIV testing found in Shisana et al. (2009) and Obermeyer and Osborn (2007). These writers describe the diagnosis of HIV as devastating as it brings unexpected changes (Shisana et al., 2009). Obermeyer and Osborn (2007) explore the impact that HIV results have on a patient's life. Obermeyer and Osborn (2007) also argue that HIV often leads to a complete redefinition of a person's social relationships. As participants defined VCT from a rights perspective (the right to know one's status) and simultaneously expressed a probability of fear of results (punctuated by "readiness" as a precondition to go for an HIV test), it can be deduced that participants expressed ambivalence about HIV testing. The finding on HIV testing ambivalence is consistent with studies that report the disconnect between intentions and behaviour translating into participation in VCT programmes (Obermeyer & Osborn, 2007). It can be concluded that educational programmes are
needed to raise awareness of culturally sensitive interventions aiming at changing people's health locus of control in a manner that complements the rights discourse.

**Finding 5: Role of perception in seeking VCT services**

Against the backdrop of VCT, research provided a correlation between educational qualification and VCT knowledge of awareness programmes (Hutchinson & Mahlalela, 2006). Lack of accurate and in-depth knowledge of VCT by the participants should thus be ascribed to individual perceptions regarding VCT. Perceptions facilitate a process by which individuals organise and interpret their sensory impressions and provide meaning to the environment (Odendaal, 2009). Whilst beliefs are enduring individual ideas which shape behaviour, they are acquired through primary observations in which culture is a powerful influence (Airhihenbuwa & Webster, 2004). Consequently, health behaviours are an outcome of decision-making based on beliefs (Airhihenbuwa & Webster, 2004). In the context of HIV and AIDS, perceptual processes signify the cognitive processes interfering with the individual decision-making process when contemplating to participate in a VCT programme on a voluntary basis. This finding is consistent with various studies conducted on individual barriers that inhibit individual participation in VCT programmes.

**Finding 6: Perceived susceptibility in seeking VCT services**

Results of this study point to the notion of perceived susceptibility as an individual factor that influences individuals to seek VCT services (or not). "Perceived susceptibility" refers to the subjective way in which an individual evaluates the probability of developing a specific health problem. Perceived susceptibility is relevant to the context of HIV and AIDS in that individuals who perceive themselves as being vulnerable to the health problem, would be more encouraged to take action. In this study, both male and female participants raised the notion of perceived susceptibility. Participants acknowledged that getting involved in risky behaviour facilitates one's decision to seek VCT services.

On the other hand, the opinion of some participants that people should only seek VCT services when they are (already) sick presents an anathema to an early
diagnosis of HIV and timely access to treatment and care. A positive approach to this dilemma is reported in a qualitative study that investigated factors influencing the decision to participate in HCT (Phakati et al., 2011). The study recommendations suggested linking of HCT with treatment and care services in cases where most participants chose to test because of perceived AIDS-related symptoms. In the HIV and AID literature this approach promotes couple testing as one of the factors that would increase VCT participation (Phakati et al., 2011). Similar findings were reported in the current study as participants mentioned being in a relationship or planning a marriage as a motivator for seeking VCT services.

Various researchers attribute high the HIV infection rates in sub-Saharan Africa to heterosexual transmission. Tabana et al. (2013) report that efforts have been increased to evaluate the extent of HIV transmission within marriages or cohabitating partnerships. One of these efforts was the recognition of couple HCT as a strategy to improve testing rates and a gateway to prevention and treatment Tabana et al. (2013). Horizon (2001) found that people who were planning a marriage or who were entering into a new relationship were more motivated to seek VCT services. Solomon et al. (2004) agree and add that VCT is more effective when it targets both partners. Solomon et al. (2004) further add that VCT would be more effective in an African context if it targeted males rather than females attending antenatal clinics.

5.6.2 Theme 2: Accessibility of and attitudes towards VCT

The second theme explored the role of attitudes and accessibility in serving as a facilitator or barrier to VCT participation. The scaling up of VCT access is the cornerstone in facilitating HIV response and subsequent stabilisation of the epidemic. Providing access and prevention and support services with clear pathway referrals comprise the hallmark of an effective HIV testing strategy (ECDC, 2010). Psychology describes such strategy as having three components, namely cognition, affection and behaviour (Milner, 2009; Werner, 2012). The affection and behaviour components can be used to form evaluative statements in seeking VCT services irrespective of whether facilitation of access to VCT is present or not (Milner, 2009).

Attitudes can influence an individual's decision to participate in a VCT programme (Obermeyer & Osborn, 2007; Van Dyk, 2012). Theme 2 was made up of two broad
questions, and each had follow-up questions or sub-themes. The first question asked participants to describe things that make it difficult for people to go for an HIV test. This was followed up by a set of questions that requested participants to explain with reasons:

- where they would prefer to go for testing; and
- their attitudes towards campus-launched VCT programmes; and
- to comment on whether they believed that results would be kept confidential should they go for testing on campus.

The second part of this theme requested participants to describe things that would encourage people to go for HIV testing.

**Theme 2: Things that made it difficult for people to go for HIV testing**

A recurring finding regarding this theme reported fear of finding out one’s status as well as the fear of the consequences thereof, such as stigma, as the main reason that makes it difficult for people to go and test. Participants of this study described the role played by fear in facilitating or inhibiting access to VCT from five perspectives:

- fear of the unknown - explained the unknown consequences associated with disclosure of the HIV test results to their partners;
- fear of being stigmatised by family members;
- fear of the known, which related to participants’ acknowledgement of their past risky sexual behaviours, e.g. having multiple or concurrent partners; and
- fear of results, which was explained from a fatalistic perspective associated with inability to accept one’s HIV status.

The findings of this study also point out the important role played by negative HIV discourse in shaping negative attitudes towards VCT. Particularly, participants made reference to prejudicial and judgmental HIV and AIDS messages, which present moralistic overtones. Campaigns with fear-based messages, which portray HIV and AIDS as a killer disease, was described as facilitating negative perceptions about
VCT. These campaigns heightened the fear in respondents, keeping them from wanting to know the truth.

Another finding regarding this theme comprised the perceptions of potential breaches of confidentiality as a negative factor in shaping people's attitudes towards VCT. Participants' concerns pointed to a lack of trust that their information would be kept confidential if they were to test on campus. This lack of trust explained the negative attitudes, resulting in a preference to test off campus rather than accessing or utilising the campus-provided VCT mobile services. According to respondents, societal norms which made men believe that clinics are only for women and not for men, also fuelled a reluctance to go for testing at these clinics. In addition, preoccupation with potential breaches of confidentiality led many respondents to prefer self-test kits, much like pregnancy tests, in order to counteract potential breaches of confidentiality.

A review of literature revealed that these findings concur with the impact of attitudes in shaping people's decision-making process in seeking VCT services. In Van Dyk (2012) and Sarafino (2002), it is posited that attitudinal beliefs influence a person's attitude towards an action and that this is related to moral beliefs and perceptions of relevant social norms. Sarafino (2002) refers to the health belief model (HBM) and explains that motivational factors that drive individuals' decisions to go for an HIV test rest on a person's attitude toward the threat of HIV and the cost benefits of being tested.

**Theme 2: Fear of HIV testing**

Obermeyer and Osborn (2007) insist that researchers must provide evidence of the demand and supply factors that explain stigma and discrimination related to HIV testing. Fear of the unknown may offer an explanation for the well-documented discrepancy between testing behaviour and not returning for results (Obermeyer & Osborn, 2007). The point about this discrepancy is that it underscores problems of HIV prevention, including VCT, and may be an explanation for universal testing. The current study revealed that fear of knowing the results could also contribute to non-participation in VCT services. In the normal course of events, "fear of the known" would suggest that individuals who acknowledge their perception of risk should take
appropriate action such as volunteering for VCT services so as to minimise their risk. However, the individual perception of HIV risk does not necessarily translate into risk-avoidance behaviour (Obermeyer & Osborn, 2007). This finding disputes a proposition by the health belief model, which argues that the likelihood that someone will engage in health-protective behaviour depends on, amongst other factors, that the person must feel threatened by the disease (Van Dyk, 2012).

**Theme 2: Fear of stigmatisation**

Studies reveal that stigma still exists at every level of society (Mundy & Dickinson, 2004; Obermeyer & Osborn, 2007; Parker & Aggleton, 2003; Shisana et al., 2009; Sarafino, 2002; Van Dyk, 2012), including within workplaces. Literature evidence (Mundy & Dickinson, 2004) supports the hypothesis that VCT services are likely to be underutilised if perceived threats outweigh benefits. Recent confirmation of these findings was found in the results of a survey that examined HIV stigma and employment discrimination (George & Sprague, 2011). The results of that survey demonstrated the existence of high levels of employment discrimination based on HIV status worldwide (George & Sprague, 2011). For instance, in Kenya and Zambia, the respondents' experiences included forced disclosure of HIV for employment status and the employer's related refusal to hire or promote following such disclosure (George & Sprague, 2011).

**Theme 2: Fear of results**

Fear of results had been cited as another barrier in the utilisation of VCT services (Obermeyer & Osborn, 2007). A report which reviewed 17 African countries, described the adverse consequences associated with disclosure (Bhagwanjee et al., 2008). On the other hand, negative effects of non-disclosure were reported on in an explorative study on psychosocial barriers to HIV disclosure through the lived experiences of 19 HIV mineworkers in South Africa (Bhagwanjee et al., 2008). Findings of the study revealed a negative correlation between participants' adherence to ART and non-disclosure. However, one study point to the benefits associated with disclosure. For instance, a study conducted in Nairobi (Moyer, Igonya, Both, Cherutich, & Hardon, 2013) found that disclosure was critical in
garnering social support for preventative actions; facilitating treatment; and prevention of HIV transmission amongst sexual partners.

**Theme 2: Fear induced by (communicated) myths**

In literature, HIV-related myths can be traced from the early days of HIV fear-based communication, which portrayed an image of a skull containing cross bones and a slogan "AIDS is a killer" (Parker & Aggleton, 2003). There is no point in trying to scare people who are already scared (Werner, 2012). For this reason, HIV messages have since shifted from knowing your status to focusing on behavioural change. Whilst Van Dyk (2012) and Shisana et al. (2009) acknowledge the necessary shift in designing HIV messages, they also note the remaining fatalistic thinking that HIV is a death sentence.

Van Dyk (2012) observes that traditional or rural countries such as Uganda, where HIV was viewed as a curse, require the use of culturally sensitive HIV and AIDS educational programmes. Culturally sensitive programmes explore misperceptions and impart knowledge so that people can understand how the disease is really transmitted Van Dyk (2012). In the context of HIV testing, attributing HIV infection to a curse would result in a sense of external locus of control and an implication that individuals cannot be held accountable for their own behaviour Van Dyk (2012). As a result of such misconceptions, people will discourage others from seeking VCT services.

**Theme 2: Fear induced by prejudicial HIV messages**

Van Dyk (2012) explored the language used in communicating HIV and AIDS and cautions against use of prejudicial language which fuels HIV stigma and only serves to undermine efforts of HIV testing. Solomon and Venkatesh (2009) examined the 'Abstain, Be faithful and Condomise' (ABC) message of being faithful and reported that since such messages carry the perception of moralistic and judgmental overtones, they had been narrowly interpreted in many developing countries. Arguably, the same authors posited that the ABC message of being faithful fails to acknowledge the reality that married monogamous women are the highest risk group for HIV throughout many parts of Africa and Asia, even though they are remaining
faithful to their spouses. They were being infected by their polygamous partners. In the HIV and AIDS context, such narratives evoke emotions of guilt and fear and undermine efforts to get individuals to present themselves for VCT services (Mkwakwa, 2003; Van Dyk, 2003; Van Dyk, 2012).

**Theme 2: Perceived potential breaches of confidentiality and lack of trust**

According to Kling (2010), confidentiality is the practice of keeping harmful and shameful or embarrassing client information within proper bounds. In this case, confidentiality professes respect for the patient's privacy and acknowledges the patient's feelings of vulnerability (Siegler 1982 cited in Kling, 2010). It would thus follow that confidentiality reinforces trust. Trust is described by Schlechter (2009, p. 329) as "a positive expectation that another will not, through words, actions or decisions, act opportunistically".

Within the realm of HIV counselling and testing, the term "opportunistic" describes an inherent risk and vulnerability in disclosing one's status, particularly for women as fear of accusations of infidelity tend to follow (Hardon, Desclaux, & Lugalla, 2013). Employees are expected to entrust knowledge of their health status to the employer's appointed health practitioners. Trust is consequently the defining hallmark of a workplace voluntary programme. Luhmann (1979) views trust as a dichotomous concept consisting of distinct interpersonal and systems components. In that regard, interpersonal trust reflects the relationship among employees, whereas systems trust is thought to capture trust between employees and the organisation as a whole Luhmann (1979). Douglas and Southerland (2009) agree and maintain that one of the successful strategies in the prevention of new HIV incidents is the presence of leadership commitment to compassion by ensuring systematic confidentiality and trust during the course of voluntary workplace HIV counselling and testing.

**Theme 2: Attitudes towards on-campus VCT programmes**

The question about attitudes of participants towards campus VCT mobile clinics attracted a gender-biased response. The finding on negative attitudes towards campus VCT clinics reflects a similar finding of an analysis on social practices that relates to disclosures in ART. In that study, it was found that:
86% of participants agreed that people are afraid to go for VCT services provided by such clinic; and

72% of women participate in VCT (Hardon et al., 2013). In the same study, the researchers concluded that women take health issues more seriously than men.

The current study findings on attitudes of men towards campus VCT services dispute the view that systems barriers such as proximity (distance that participants will have to travel to access VCT services) will affect the likelihood that both men and women will go for HIV testing (Asante, 2007; Hutchinson & Mahlalela, 2006). In that study, the researchers reported 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 VCT reduced the likelihood that he would be tested by 0.7% (Asante, 2007 p. 646) For women, each extra kilometre away from a clinic was associated with only a 0.4% reduction in the likelihood of being tested.

**Theme 2: Things that would encourage people to go for HIV testing**

The overall objective of the current study was to make policy recommendations that would increase VCT participation. Participants of the study called for normalisation of HIV and AIDS as the major factor that would change people's negative conceptions about the pandemic and ultimately encourage people to enrol for VCT. The call to normalise HIV and AIDS and "be advertised just like flu" is based on the belief that normalisation will mitigate the negative and incorrect assumptions that other people have about HIV and AIDS, which undermine the efforts to increase VCT participation. Furthermore, participants highlighted the role of in-depth education, particularly education that will provide them with more knowledge about the benefits of VCT as another factor that would encourage them to seek out such services. Lastly, the majority of respondents suggested that since most of them live in strained conditions, a strategy that would incentivise VCT through give-aways would increase participation in the VCT programme.

The call for normalisation of HIV and AIDS, creating the perception that it is a normal chronic disease, as a positive contributing factor to increasing VCT participation has support in literature (Dickinson, 2010). The Global Aids Programme (GAP) (2005) asserts that VCT programmes could play an important role in facilitating community
support and could thereby create a more positive perception of HIV/AIDS where a sufferer could be seen to be living positively instead of just struggling with illness, suffering and death. Solomon et al. (2004) posit that the construction of VCT as contributing to stigma reduction is premised on the view that the consequences of more people testing for HIV will reduce the fear and stigma associated with HIV, making it like other chronic and terminal illness (Dickinson, 2010). One qualitative study (Phakathi et al., 2011) which investigated the influence of ART on willingness to test validates this position. The results of the study by (Phakathi et al., 2011) revealed that personal testimonies of people who had recovered from HIV and AIDS altered negative perceptions about HIV and AIDS and thus contributed to normalising the views on the epidemic. Furthermore, the same study (Phakathi et al., 2011) reported that living testimonies of knowing and seeing someone with HIV recovering after treatment were the biggest incentive for being tested. Lastly, (Phakathi et al., 2011) pointed out that continuous and reliable availability and accessibility of ART increase HIV testing participation.

The importance of education resonates with UNAIDS (2003) where it is stated that increasing knowledge of HIV and AIDS provides reinforcement and support for sustaining behaviour change. Worrisome, though, are reports Hoque and Ghurman (2011 cited in Mealamed & Nduna, 2012) that point to a lack of in-depth knowledge which is needed to facilitate "prevention" behaviour, despite continued efforts aimed at educating young adults about the risk of contradicting HIV. To mitigate this challenge, UNAIDS (1999, p. 17) cautions that the success of individual level (HIV and AIDS) interventions depends on context-specific information and skills.

In the current study, participants agreed that employers should implement an incentive strategy in order to encourage participation in HIV testing. Western Cape Premier Helen Zille's Wellness Summit Strategy sought to incentivise HIV testing and regular drug testing under the slogan "Get tested and win" (Bateman, 2012). Regrettably, the campaign drew criticism from health activists such Mark Haywood (Director of SECTION27) and the South African Medical Association's Dr Poppie Ramatuba (Bateman, 2012). Haywood's criticism was based on the consequentiality perspective, questioning whether creating artificial incentives would overcome the real reason for testing. Ramatuba provided a moralistic approach that viewed the
campaign as inappropriate and medically unethical (Bateman, 2012). Cameron and van der Merwe (2012) questioned the morality of incentivising HIV testing through the “first-things-first” HIV testing campaign, which included prizes such as a car and computers. Cameron and van der Merwe (2012, however, found that the campaign was so successful that it even won a marketing award. Yach (2013 cited in Bates, 2013) decried that most governments assume that people will make rational choices based on provided data and evidence. Yet, the reality is that people make decisions based on their individual best interests in the short term Yach (2013 cited in Bates, 2013). Therefore, Zille’s strategy seemed to reflect an understanding of what truly motivates change.

5.6.3 Theme 3: Cultural beliefs and other practices

The centrality of culture impacting on health decisions has been reported with both negative and positive influence shown on health behaviour (Airhihenbuwa & Webster, 2004). A cultural approach to health utilises culture as a lens through which one can gain a greater understanding of individual and collective health behaviours and a means to formulate prevention behaviours within a specific context (Uwah & Ebewo, 2011). Joubert-Wallis and Fourie (2008) explain that cultural factors have been shown to play a major role in the human decision-making process, including the construction of HIV and AIDS. Price (2009) maintains that gender can be seen as a key aspect of cultural approaches to HIV and AIDS. Savron (2013) identifies culturally sanctioned gender relations as the primary factor in determining the pattern of HIV and AIDS in Africa.

This theme explored four ways in which culture influences one’s decision to participate in an HIV test. Initially, focus group respondents were asked to describe culturally based practices that discourage or encourage people to go for HIV testing. Secondly, participants had to describe ways in which being a male or female affects people’s decision to go for HIV testing. Thirdly, participants had to explain if men and women who are HIV-positive are treated differently. Lastly, participants had to describe the role of alcohol in HIV testing.
Theme 3: Cultural practices that encourage HIV testing

In this study, participants mentioned male circumcision as a Xhosa tradition that facilitates HIV participation. Worth noting is that male participants invoked their cultural identity of being a Xhosa man to signify that they were referring to traditional male circumcision. Western medical circumcision (MMC) faces acceptability challenges. Participants believed that male circumcision (as part of initiation) must be done "in the bush". Also, a so-called intojane ("female version of male circumcision"), with young women remaining virgins, was highlighted as another positive cultural practice that contributes to reducing the spread of HIV.

The descriptive analysis of this finding is illustrated by two different viewpoints. First, reference to "Xhosa man" signifies a cultural identity as espoused in Meissner and Buso (2007) who state that in a Xhosa cultural setting, circumcision is done to promote a cultural sense of manhood and sexual enhancement. This line of thought supports Gwandure’s (2011) argument that traditional male circumcision is a social institution that lies at the centre of African traditional beliefs and a way of life. Reference to tradition culminates in the second contentious strand of this debate in which the Western approach to male circumcision, referred to as the medical male circumcision (MMC), is perceived to be the replacement for traditional male circumcision under the pretext of HIV testing (Meissner & Buso, 2007). However, Gwendure (2011) observed that when medical circumcision is performed as part of the process of traditional initiation into manhood, it faces a number of acceptability challenges. In conformance with Gwendure's views, the current study reported on acceptability challenges (see sub-section 5.3.3, p. 67).

The Eastern Cape is one of the provinces where traditional male circumcision is still practised extensively, but to date the province has also experienced a significant number of young initiates dying in the process (Meissner & Buso, 2007). The irony of traditional male circumcision as noted in Gwandure (2011) is that whilst it is an old tradition, there is, however, no research that proves that traditional male circumcision leads to a reduction in HIV infection as is the case with medical male circumcision.

"Intonjane" is defined as a rite of passage of menses, marking the passage from girlhood to adulthood and eligibility for marriage (Mills, 1980). During the process of
"intonjane", girls are kept in a secluded area for 15–20 weeks and are trained for womanhood. Girls are painted in white, signifying purity, and are under the supervision of elderly females (Mills, 1980). In the context of HIV and AIDS literature, "intonjane" is described in a positive and negative manner. For instance, some ethnic groups include vaginal inspections or female genital cutting (FGC) as part of the procedure. Intonjane delays the girl's sexual debut and thus retains the cultural values of chastity before marriage as young girls are subjected to vaginal inspection.

Intonjane is explained as a type of female circumcision, with most participants in this study purporting that it is similar to MMC and that it may reduce HIV infection. Some practices of intonjane' procedures may include female genital cutting (FGC); however, it is posited that any association between FGC and HIV and AIDS should not be treated as causative (Savron, 2013). However, the relationship between female circumcision and a reduction in HIV infection has yet to be established empirically.

Finally, the above findings on cultural practices that positively facilitative HIV and AIDS affirm the domain of positive nurturers espoused in the PEN 3 cultural model of Airhihenbuwa advocated by Airhihenbuwa and Webster (2004). Positive nurturers are those values and relationships that promote health behaviour by influencing the significant others and community contexts in making positive health decisions and choices. In the context of HIV and AIDS, cultural practices such as "ukhusoma" (a Zulu term for the cultural practice of non-penetrative sex) have received little or no attention in the literature as a way of promoting cultural practices that encourage positive sexual relationships (Airhihenbuwa & Webster, 2004). In (Robins, 2009 p.31) it is posited that “ukhusoma" (thigh sex) has historical origins in the promotion of abstinence through non-penetrative sex. .

Theme 3: Cultural practices that discourage HIV testing

All participants mentioned the association of HIV and AIDS symptoms with practices of witchcraft as the barrier to seeking VCT services. Furthermore, some participants blamed the role of sangomas (traditional healers) who claim that they can cure HIV and AIDS, as another factor that serves as a barrier for HIV testing.
As noted in Obermeyer and Osborn (2007), there is something about HIV and AIDS that has made it a more fertile terrain for what Van Dyk (2012, p. 217) calls “witches and sorcerers” as causal agents of HIV illness. Similar observations were noted in the current study, as most respondents cited witchcraft as a major barrier to HIV testing. Ashford (2002 cited in Van Dyk, 2012) and Dickinson (2008) write that the belief that witches are responsible for AIDS is not only restricted to rural areas. As an illustration, it is reported that residents of Soweto often interpreted the symptoms of HIV infection as a type of poisoning (called “isidliso”) caused by witches. The problem of blaming HIV on witches underscores how important it is to achieve early detection of the HIV-virus and access to treatment and care.

There is no research or any medical proof that links sangomas to an HIV and AIDS cure. Despite this, traditional healers are preferred as a first line of call in poor African countries (Asante, 2007). A report by the WHO (2007) confirms this preference by stating that around 80% of people living with HIV and AIDS (PLWHA) in African countries initially consult traditional healers for primary healthcare. Similar findings were reported in a South African study (Ojikutu & Ramjee, 2007) which revealed that 75% of HIV-infected people used remedies dispensed by traditional healers. In the absence of a proven AIDS cure, the challenge faced because of reckless sangomas is that HIV-positive clients, who consult them under the falsely claimed promise of a cure, suffer the real consequences of lost opportunities for early diagnosis and access to treatment (Ojikutu & Ramjee, 2007). Against the backdrop of these findings, UNAIDS (2000) called for a respectful attitude of open exchange of ideas and information between traditional and Western medicine providers.

**Theme 3: Ways in which being a male or female affects people’s decision to go for a test**

All participants in this study explained HIV and AIDS as the gender-biased disease. For most men, the societally constructed role of the man as head of the family suggests that men are the ones who decide, even on family health matters. Male participants further illustrated that the societal construction of the role of a man meant that, as head of the family, men are not “softies” and thus clinics are culturally suited only for women. Male participants explained that as they believed that clinics are meant only for women, men can rely on the antenatal HIV test results of their partner
or wife as "barometers of their HIV status". Participants termed this reliance an "indirect testing". Furthermore, male participants stated that in a cultural sense, "real men ('ingakara') must have many girlfriends". Some female participants explained that women would feel pressurised to go for an HIV test because the male partner decided to stop using a condom (usually after three months), but refused to go for HIV testing. This highlights that alternative ways will have to be found to make it easy for males to be tested (not at normal antenatal clinics) and that male behaviour has to be changed before any HIV AIDS testing campaign will be successful.

Gibbs and Jobson (2011) illustrate the role of gender in HIV and AIDS by making reference to hegemonic masculinities. Connell (2005, p. 77) defines hegemonic masculinity as "the configuration of gender practice which embodies the currently accepted answer to the problem of legitimacy of patriarchy when guaranteed (or which is taken to guarantee) the dominant position of men and the subordination of women". Blackbeard and Lindegger, (2007) agree and make the point that hegemonic masculinity are dominant, socially constructed understandings of what it means to be a man in a given context. The study findings on the misconception of men about clinics being meant for women are consistent with a South African qualitative study that explored sexual health care centres and access-seeking behaviours in men (Leichliter et al., 2011). Findings in that study reported several barriers to the use of public and private clinics for sexual health care services, which included a perception that men often viewed public clinics as a place for women and that men experienced female nurses as being rude or judgmental. Reference to the notion of "indirect testing" by participants of this study concurs with findings of Sibanda's (2011) study on the role of peer educators in HIV testing (Sibanda, 2011). In that study, Sibanda (2011) laments the tendency of some males to rely on their partners' antenatal tests as a demonstration of lack of knowledge that HIV status cannot be inferred via a third party. Finally, the tendency by men to stop using condoms (after three months into a relationship) attests to research into condom use among South African women, which revealed that 44.5% of women reported inconsistent condom use (Shai, Jewkes, Levin, Dunkeld, & Nduna, 2010). This practice is an affirmation of research findings by Shisana et al. (2009) that in South Africa, consistent condom use amongst primary partners is only 15.4% while condom use amongst non-primary partners is 46.5%.
The definition of a "real man" as one with many girlfriends, is also reported in Lecler-Madlala (2000, p. 4) who noted a "widespread belief that males are biologically programmed to need sexual relations regularly with more than one woman and often concurrently". Greig, Pecock, Jewkes and Msimang (2008 cited in Gibbs & Jobson, 2011) agree with this claim and argue that hegemonic masculinities increase risky sexual behaviour by promoting multiple concurrent partners (MPC), reducing male access to health services and reducing the likelihood that men will use condoms during sex. Gilbert and Selikow (2011) attest that MPC can be explained as a social construction of masculinity – where "real" men are constructed as having sexual prowess by proving that they have many girlfriends.

**Theme 3: Difference in treatment between HIV-positive men and women**

Participants' responses to this question further affirmed the strong role of culture in constructing the meaning of "man" and the impact thereof on decisions for HIV testing. Most female participants agreed that in a society where men are viewed as providers, women are not expected to dare and suggest going for an HIV test, as that would be construed as the woman having cheated (and needing to get tested). Furthermore, women explained that where men are providers, it will be difficult if not impossible for women to disclose their HIV status as they would be outcast by the "provider".

The above practices reflect a view postulated by Hendriks et al. (2007 cited in Melamed & Nduna, 2012) that women often take submissive roles in heterosexual relationships and that some are even financially dependent on their boyfriends or spouses. In turn, that automatically places women in a subordinate position with no confidence or power to negotiate condom use with their partners. The accusation of infidelity on the part of women who suggest condom use explains the view that social pressures and cultural norms that stress women's innocence deprives them of information about HIV and AIDS, sexuality and reproductive health (Common Wealth Secretariat, 2002).
Theme 3: Role of alcohol in HIV testing

Participants in this study agreed that alcohol use/abuse is one of the drivers of the spread of HIV and AIDS. When people are drunk, they are unable to control themselves, and exhibit risky sexual behaviours, which condone the spread of HIV and AIDS. Worse still is that participants conceded that it is often difficult or impossible for such people to seek VCT services.

Paucity of literature exists to attest to the finding on the role of alcohol in driving HIV and AIDS. The World Health Organisation (WHO) (2007) and Bradshaw et al. (2007) report the three leading risk factors that contribute to the burden of disease in South Africa as unsafe sex, interpersonal violence, and alcohol abuse. Setsedi and De la Monte (2011) observed that risky sexual practices are reportedly common across all sectors of the population, including people living with HIV and AIDS – with alcohol abuse the driver of such behaviours. Alcohol abuse leads to impaired judgment and decision-making, which interfere with one's ability to discern when behaviour is risky at the time of intoxication (Sadock & Sadock, 2007).

5.6.4 Theme 4: Disclosure and stigma

Theme 4 sought to establish the role of disclosure and stigma in facilitating or inhibiting VCT participation. UNAIDS (2000, p. 12) defines HIV and AIDS disclosure "as an act of informing any individual (e.g. health authority, employer, school) of the HIV status of the infected person with or without consent". Whilst HIV disclosure has been touted as the best means of preventing new infections (Centre for Disease Control [CDC], 2001; UNAIDS, 2000). It is, however, posited in Pride (2013) that in practice, disclosure is a double-edged sword which may also inhibit access to treatment or facilitate access to VCT.

Human nature is a product of interaction with the environment. Under theme 4, participants had to describe the attitudes of their colleagues and friends towards HIV testing. The rationale for that question was to explore whether the environment (through the interaction of participants with colleagues or friends) supports HIV testing or not. Socio-cultural factors influence one’s behaviour around health issues – in particular, normative beliefs, which are thoughts and beliefs about the expectations
of people's immediate environment and which can place pressure on people to meet these expectations (Diteweg et al., 2013; Van Dyk, 2012).

Findings of the current study revealed that most respondents interact with display of an ambivalence or negative attitudes towards HIV testing, as most of them feel that they would rather not know their status. Such ambivalence towards being tested was further highlighted by the narratives of participants on comments their friends make about HIV-positive people. These comments included "name calling" and "tagging". Furthermore, participants reported discrimination from friends, as "they will never share things with you even in a shebeen". It was, however, encouraging to note that none of the participants reported witnessing discrimination of HIV-positive people at the target institution.

In literature, the findings of ambivalence towards HIV testing attest to the role of normative attitudes in HIV testing espoused in Diteweg et al. (2013). These authors postulate that if a person is positive about undergoing HIV counselling and testing and he/she believes that people around him/her think that participating in VCT is good and other are not against it, then the person will feel less negative social pressure. In addition, Pride (2013) point to various reports that show that people who never tested for HIV and did not know about ARVs blamed people living with HIV for infection and isolated them. The current study's finding on the discrimination of people by friends – expressed in their unwillingness to "even share a smoke" resonates with findings of a national survey conducted in 2002 (Kalichman and Simbayi, 2003). Findings of that survey revealed that 26% of the respondents would not be willing to share a meal with a person living with AIDS, 18% were not willing to sleep in the same room with a person living with AIDS, and 6% would not talk to a person who they knew had AIDS (Kalichman & Simbayi, 2003). To dispel myths about how the virus is transmitted, Painter (2001) indicated a need for improved basic knowledge for the development of interventions (for instance around knowing the basic facts regarding how HIV is contracted).

5.6.5 Theme 5: Workplace issues pertaining to HIV and AIDS

The workplace has become the strategic venue for addressing HIV and AIDS. The Higher Education HIV/AIDS Programme (HEAIDS, 2004) highlights effective policy,
leadership and advocacy as one of the pillars of its strategy for institutional management of HIV and AIDS. Theme 5 covers positive and negative factors that facilitate VCT within the target institution. In exploring these factors, participants were expected to explain:

- what they know about the existing HIV and AIDS policies of the target site, and what for them, was the most important issue in the said policy;
- how they felt about the support available for HIV-positive people within the target site; and
- what they would like to see that would support HIV testing and HIV-positive employees.

Findings on this theme revealed a general lack of knowledge of existing HIV and AIDS policies amongst study participants. However, participants (only five) employed by the Campus Health Services (CHS) confirmed the existence of such policy. Since the majority of participants expressed a lack of knowledge of HIV and AIDS policies within the target institution, nothing was shared regarding the important aspects of the policy or the support available for people living with HIV and AIDS within the target site. As a result, participants proposed various interventions they deemed necessary for the institution, in order to increase awareness of and VCT participation. These included the following:

- A call for the institutionalisation of HIV and AIDS and implementation of peer educators who would not only empower them with education, but who would also serve as support groups to them who and who would support them during difficult times.
- Most participants made a call for the institution to invest in in-depth HIV and AIDS education so that they could have accurate information and knowledge about the pandemic.
- Participants called for the normalisation of HIV and AIDS, expecting the institution to treat people living with HIV and AIDS in the same way they treat those living without the virus and without assigning certain privileges to those living with the virus.
Furthermore, participants lamented the lack of a staff-dedicated wellness centre within the institution. They stated that the current CHS is primarily meant for students and not for staff and that the Human Resources Department should set up a section that would cater for an integrated employee wellness programme of which HIV and AIDS treatment will be part.

The general lack of awareness and knowledge of HIV and AIDS policies by participants negates an approach by HEAIDS, which is advocated by Walch, Lezama, and Giddie (2005) and the DoL (2003). In terms of that approach, workplace policies serve as the starting point in management's response to employees in the effective management of HIV and AIDS. Specifically, the policy should seek to eliminate unfair discrimination against employees affected by the pandemic (DoL, 2003). Support for this finding is found in the review of workplace policies in Eastern Cape tertiary institutions (Phaswana-Mafuya & Peltzer, 2007). Findings from the review revealed that whilst policies were generally available and positively attempted to accommodate those living with HIV and AIDS, they also found lamentable inefficiencies in the implementation thereof. Such policy gaps can be attributed in some cases to merger processes and strained resources (Phaswana-Mafuya & Peltzer, 2007). Participants in the current study supported this view.

On the call for in-depth HIV/AIDS education and support, literature on HIV/AIDS peer education is in support of the participant's proposals (Dickinson, 2010; Sibanda, 2011). Peer education can be seen to bridge the knowledge gap between formal education, social services and socialisation by immediate and extended family (Swartz et al., 2012). Peer education can enhance social learning and provide a level of psychosocial support in the target site environment by addressing socio-emotional barriers generally ignored in typical didactic education (Swartz et al., 2012).

The call for normalisation of HIV and AIDS amongst staff members resonates with some authors who question the ongoing relevance and appropriateness of AIDS exceptionalism (Richter, Venter & Gray, 2010). The term "AIDS exceptionalism" (Richter, Venter, & Gray, 2010, p. 636) describes an approach (human rights) in which health care policies favour the rights for the privacy of HIV-infected people over concerns for public safety. Accordingly, this approach led to a novel methodology in the diagnosis of HIV, namely voluntary counselling and testing.
(Richter, Venter & Gray, 2010). These authors emphasise that the advances in antiretroviral treatment and subsequent increased access to treatment mean that HIV infection is no longer a fatal illness but a chronic condition (ECDC, 2010). As such, normalising testing, makes the process more like that for other screening and diagnostic tests (ECDC, 2010) and thus, can counter stigma associated with the pandemic, remove barriers to testing and change societal perceptions of HIV and AIDS (ECDC, 2010; Richter et al., 2010).

One of the challenges that seems to hinder VCT participation amongst employees at the target site is the fact that the Campus Health Services were initially launched exclusively for students because staff members had a medical aid benefit. The exclusion of employees the Campus Health Services posed a huge challenge for the Centre for HIV and AIDS as it became difficult to change staff perceptions of the nature of the service.

5.7 CONCLUSION

The chapter provided a detailed discussion of the study results. In order to provide context for the discussion, the chapter reported on the demographic details of the participants, provided a thematic description of factors that affect the utilisation of VCT through the lens of study participants, and presented a review of literature that supported the study findings. The descriptive analyse of the findings point to psychosocial and cultural factors as mediating factors that interfere with individuals’ decision-making processes when seeking VCT. The present study used a literature review to support these findings. The psychosocial factors covered the individuals’ psychological factors, such as readiness, fear, doubt about confidentiality, institutional trust, and stigma as barriers towards seeking VCT. The positive psychological factors that would encourage VCT participation included incentivization of the VCT programme, normalisation of HIV and AIDS and offering institutional support through educational programmes. Cultural factors included cultural practices and beliefs such as “intonjane” and traditional circumcision cited as positive factors that facilitate VCT uptake. Study participants called for the establishment of a structure by the Human Resources Department, which would address workplace HIV
and AIDS issues for employees. Based on these findings and conclusions, the next section provides the recommendations.
CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter provides a summary of conclusions from the study findings. The chapter will discuss the value of the study as well as limitations encountered during the study.

6.2 SUMMARY AND CONCLUSIONS OF THE STUDY

The current study utilised six focus groups in order to explore and describe factors perceived to affect employee participation in HIV testing positively and negatively. Research into these factors was necessary to derive recommendations regarding the improvement of the programme presented to management as well as to increase HIV testing rates. The conclusions were drawn from the results of the study and are described according to their relation to the objectives of the study.

6.2.1 Positive factors to affect employee participation in HIV testing

VCT comprises different process elements, and each element carries its own definitional issues, perceptions and stand points (Solomon et al., 2004). The WHO and UNAIDS report that up to 80% of people with HIV are not aware of their status, and fewer than one out of ten adults know their partner’s status (Matovu & Makumbi, 2007). It was thus encouraging to observe that participants understood the importance of knowing one’s HIV status.

The participants’ reference to “readiness” as a precondition for voluntary participation in HIV testing resonates with the behavioural theory of a high level of perceived behaviour control (Van Dyk, 2012). Agreement with this concept is found in theories of motivation focusing on people’s belief, in particular the self-efficacy theory (Bandura, 1991). Self-efficacy influences the choices people make and those with high self-efficacy (or a high level of perceived behaviour control) are better motivated to master new situations and behaviour than people with low self esteem (Van Dyk, 2012). Research findings provide evidence that the intention to change behaviour...
together with a perception that behaviour can be controlled (high self-efficacy) significantly increases the probability that behaviour could be changed for the better (Van Dyk, 2012).

On the other hand, "readiness" presupposes that certain conditions at psychosocial level must prevail for participants to participate in HIV testing programmes. In the current study, participants suggested that reassurance that their HIV results would be kept confidential would facilitate trust in the VCT programme and encourage participation. Reports by Flykesnes and Siziya (2004 cited in Obermeyer & Osborn, 2007) point to evidence that perceptions of how confidentiality is handled influence clients' willingness to test. Van Dyk (2003) explains that clients are not against VCT, but that they have serious doubts and anxieties about the confidentiality of HIV test results. Van Dyk (2003) further elaborates that fear regarding a perceived lack of confidentiality was a key barrier preventing clients from participating in VCT services in Kenya.

Strydom (2004) investigated the degree to which the HIV and AIDS pandemic is being addressed at a company in the Eastern Cape. One of Strydom's major findings was that male and female employees differed significantly in their response to whether they were confident that staff maintained confidentiality regarding employees' HIV status. In that study Strydom (2004) report a fair proportion of respondents expressed concern over a lack of trust in the confidentiality of the Occupational Health Services. Strydom (2004, p. 85) writes, "HIV and AIDS-related stigmatisation and discrimination make prevention and treatment difficult by forcing the epidemic out of sight and underground."

In the current study, participants acknowledged that "if HIV and AIDS can be advertised as a normal chronic sickness like flu and advertisements show ARVs as something to take, like flu pills", this could encourage people to participate in HIV testing. Dickinson (2010:29) asserts that a critical point in behavioural change towards making use of HIV testing requires that "the epidemic be normalised".

Resonance with Dickinson's point was found in Solomon et al. (2004) who argue that an increase in the number of people testing for HIV would reduce the fear and stigma associated with HIV, as it would eventually become more like other chronic and
terminal illnesses. One qualitative study (Phakathi et al., 2011), which investigated the influence of ART on willingness to test, validates this position. The results of the same study revealed that personal testimonies of people who recovered from HIV and AIDS altered negative perceptions about HIV and AIDS and thus contributed to normalising the epidemic. Painter (2001) agrees and asserts that the integration of other health services that focus on PMTC could lead to higher usage of VCT services since this disguise encourages privacy and addresses social stigma.

The results of the current study dispute a view held by Sibanda (2011) who objects to the strategy of incentivising HIV testing as condoning a transitory attitude amongst workers, which - if it is withheld - will negatively affect HIV testing. In contrast, participants of the current study recommended the use of incentives to entice workers to participate in HIV testing programmes as another positive factor to influence HIV testing. A related debate regarding whether payment should be offered for research participation has also been reported (Koen, Slack, Bersdorf, & Essack, 2008). It is argued that payment for research participation facilitates such participation. Supporters of this view argued that when research is scientifically valid, has a favourable balance of risks and benefits, and meets other ethical criteria, then recruitment is an ethically sound objective (Koen et al., 2008). In the HIV testing context, this balancing act refers to avoiding discrimination by ensuring that all those who volunteered to be on the programme have the choice to opt out whilst still getting the benefit of the programme (Yach 2013 cited in Bateman, 2013).

Airhihenbuwa and Webster (2004) report that culture has both positive and negative influences on health behaviour. Culture strongly influences human behaviours (value systems, beliefs and practical knowledge) (Uwah & Ebewo, 2011). It is therefore deeply rooted in all aspects of society, including perceptions of illness and health-seeking behaviour (Somma & Bodiang, 2003 cited in Uwah & Ebewo, 2011). Results of this study affirm this position and point to traditional Xhosa male circumcision as cultural practice that could positively affect HIV testing. The Eastern Cape is one of the provinces that still practices traditional male circumcision but has, to date, experienced a significant number of young initiates dying in the process (Meissner & Buso, 2007). It is unfortunate that, whilst it is an old tradition, there has been no research to date linking traditional male circumcision to a reduction in HIV infection,
while such research findings have been indicated with reference to medical male circumcision (Gwandure, 2011). However (WHO/UNAIDS, 2007), agreed that male circumcision (MMC) does contribute to the prevention of HIV and AIDS infection. The WHO/UNAIDS (2007) declared MMC an effective HIV prevention strategy and reported that the procedure (MMC) reduced a man's risk of infection by at least 60%.

Among traditional females, "íntonjane" as a rite of passage of menses - marks the passage from girlhood to adulthood and eligibility for marriage (Mills, 1980). The concept of "íntonjane" serves to illustrate though that culture not only determines which sexual relationships are acceptable but also at what times and under which circumstances (Hrdy, 1987 cited in Sovran, 2013). However, such practice only delays sexual activity and does not lead to HIV testing at a later stage, which is then mostly controlled by the decision of traditional male husbands/partners.

The above findings are an affirmation of the concept of positive (cultural) nurturers which are values and relationships that promote the health behaviour by influencing the significant others and the community in making positive health decisions and choices (Airhihenbuwa & Webster, 2004). Such positive cultural practices include cultural practices such as "ukhusoma" (a Zulu term for the cultural practice of non-penetrative sex), which also requires an investigation into its efficacy in enhancing positive sexual relationships and whether this may lead to a reduction in risky sexual behaviours. Behaviours that undermine VCT participation are those cultural practices that encourage men to have polygamous relationships to prove that they are "real men", to insist on sex without condom, and to avoid being tested at clinics that they believe are only for women.

Peer education and support for HIV and AIDS programmes for staff were two of the factors believed to positively affect HIV testing among staff. In the context of the management of HIV and AIDS in the workplace, peers educators are the new actors shaping the labour relations system (Dickson, 2006). Dickinson (2006) noted that industrial relations scholars have recognised the need to move beyond the Dunlopian system of labour relations. Anstey (1997) explains that the key players in the Dunlopian labour relations system are employers, employees and their representatives. The perceived effectiveness of the peer educator strategy is informed by research indicating that "similarity between the message sources and
the recipient is vital to the ultimate impact of the message" (Dickinson, 2006, p. 698). The DoL (2003) acknowledges this view and recommends a ratio of one peer educator to every 50 workers.

The proposal for HIV and AIDS educational interventions as a catalyst in changing perception towards HIV testing is supported by literature on change management (Hayes, 2010). Change management scholars view education as the most powerful tool in approaches to minimising resistance to change (Hayes, 2010). Participatory education is based on the concept that learning is more effective when learners participate in the process of learning. Participatory peer education is different from traditional didactic health education, which seeks to change the views and attitudes of single individuals (Campbella & MacPhail, 2002).

6.2.2 Negative factors to affect employee participation in HIV testing

While participants of this study expressed their knowledge of VCT from the "know your status" paradigm, Van Dyk and Van Dyk (2003) assert that such confinement reflects the erroneous or ignorant perception that testing is for diagnostic purposes only and that it is a stumbling block in the way of people getting tested - and can thus suggest lack of proper knowledge. These latter views by Van Dyk and Van Dyk (2003) contain some truths as the researcher observed that none of the participants in this study provided an in-depth knowledge regarding the procedural steps that form standard or basic operating procedures regarding VCT. Instead, they chose to present a particular standpoint or single aspect of VCT. For instance, none of the participants explained which information is shared during pre- and post-testing counselling sessions of the VCT programme.

Van Dyk (2003) explored the importance of knowing the entire process of VCT and asserts that post-test support services play a critical role in reinforcing long-term behavioural change, and thus disputes an expectation of a behavioural change through a single exposure to VCT as unrealistic and inconsistent with theories of behavioural change. This observation opposes other research findings on the association between a lack of education and a lack of knowledge (Hutchinson & Mahlalela, 2006). In the current study, 80% of participants were relatively well educated. The lack of in-depth knowledge regarding VCT could possibly be attributed
to the non-existence of a dedicated section in the Human Resources Department that caters for staff wellness programmes beyond the one created for students.

Perceived lack of confidentiality was identified as a negative factor to HIV testing by most study participants. This supported the HRSC (2002) results, which found fear of a lack of confidentiality as one of the reasons for people not to test. In this study, the majority of the male participants preferred being tested off campus where no one would know them as opposed to utilising mobile clinics because they were scared that the results would not be kept confidential. Similar findings were reported by Chiwaane (2006 cited in Komanyane, 2007) who reported that in order to maintain confidentiality, respondents preferred to be tested in areas where they were not known. Horizon Project (2001) concurs with this finding as it reports on two aspects that concern youth regarding the testing process: confidentiality and the fact that they would like to go for testing and leave without being seen or recognised by anyone else.

As observed by Chipkachta (1997 cited in Mundy & Dickinson, 2004), the health care of any culture includes patterns of belief about causes of illness and governing choices of evaluation. Therefore, the belief held by people with external locus of control that their health depends on exogenous factors (luck, fate, chance, witchcraft, etc.) validates the finding that culture has an influence on the individual decision-making process to take part in a VCT programme. Mbiti (1969 cited in Van Dyk, 2012) agrees, and asserts that the identity of the traditional African is totally embedded in his or her collective existence with all decisions (including health) taken with the group’s knowledge and approval (external locus of control).

In the current study, participants displayed a selective application of knowledge by interpreting VCT through the lens of voluntarism or a rights-based approach (Obermeyer & Osborn, 2007). This perspective is an affirmation of culture as a powerful environmental construct that determines how society perceives issues, and in turn influences how people conceptualise HIV and AIDS, which will have implications for VCT participation. Participants of this study identified witchcraft and sangomas as negative cultural factors to HIV testing. In the HIV and AIDS testing context, this finding attests to Van Dyk’s (2012) observation that in cultural settings
where HIV and AIDS are associated with witchcraft, seeking an HIV test is usually the last resort, if it is considered at all.

The world is in the third decade of having identified HIV and AIDS (Tavoos, Zaferani, Enzevaei, Tajik & Ahmdnezhad, 2004). Parker and Aggleton (2003) report that as far back as 1987, three narrative phases that described the epidemic were developed by the director of the WHO and the Global Programme on AIDS. The first was the epidemic of HIV; secondly, the resultant epidemic of AIDS; and thirdly, the epidemic of stigma discrimination and denial. Results of the current study reaffirm that even nowadays, fear and the feared consequences of test results being diagnosed as having the illness, inducing stigma or being outcast by society, life partners, friends and family are still haunting HIV testing programmes even through massive campaigns have been instituted against such perceptions.

In contextualising fear within the framework of VCT services, Obermeyer and Osborn (2007) confirm that fear is about (amongst other aspects) the social consequences of illness - which could include rejection by loved ones, discrimination, violence, job loss, and so forth. According to research by Obermeyer, Baijal, and Pegurri (2011) and Obermeyer and Osborn (2007), it is suggested that disclosure regarding HIV and AIDS is not a one-time event but instead it is an iterative process fraught with hesitations and retractions. One study reported that in Tanzania, after two months only 22% of women had told their partners of their status, and 40% had disclosed their status only after four years (Obermeyer & Osborn, 2007). Similar findings were noted by Bott and Obermeyer (2013) who report on findings of a South African study which revealed that while nearly all (92%) respondents disclosed their status to at least one person, a substantial percentage (15%) waited more than a year to tell their partners.

Regarding stigma, participants pointed to the prejudicial language used in communicating HIV and AIDS as another negative factor that affects HIV testing. This confirms Bolton's (1992, p. 145) argument which explored the media-constructed narrative that "AIDS is about promiscuity". Bolton (1992) argues that such messages reflected a moralistic approach which fuelled the negative discourse in HIV and AIDS communication. The moralistic approach presupposes that HIV is
an outcome of low moral character and anyone who tests HIV-positive has engaged in some form of low moral behaviour (Hutchinson & Mahlalela, 2006; Van Dyk, 2012).

Gibbs (2011) argues for a need to go beyond what people do and to focus on the meaning embodied in people's actions. According to Strebel et al. (2006), social constructionism theory recognises that norms for masculinity and femininity, and roles allocated to women and sexual scripts vary across communities. Resonance of this view is found in the results of the current study where most male participants held the belief that clinics are only for women and that they can rely on their partner's antenatal test result. A report by Sibanda (2011) also confirms the practice of relying on the partner's antenatal results. This practice highlights lack of in-depth HIV and AIDS education combined with established cultural attitudes and behaviours. Hegemonic masculinities exist within the realm of socially constructed norms as dominant, socially constructed understanding of what it means to be a man in a given context (Blackbeard & Linger, 2007). The results of the current study point to the male construction of a "real man" as one with many girlfriends. Gibbs and Jobson (2011) confirms this construction and makes the point that through their practices, men are actively seeking to demonstrate that they can achieve hegemonic masculinities (Connell, 2005). Consequently, such practices place men and women at risk of contracting HIV through reinforcing gender inequalities (Gibbs & Jobson, 2011).

The results of the current study point to the negative role of alcohol in HIV testing. This supports a report by the UNAIDS (2010) which warns that the links between alcohol consumption, sexual risk behaviour and HIV infection warrant special attention in sub-Saharan Africa (SSA) countries where prevalence rates and levels of harmful use of alcohol are high. These results concur with report findings of a review of 50 papers on studies concerned with HIV and AIDS transmission (sexual risk behaviour and transmission) as well as HIV testing (Morejele, Nkosi, Kekwaletswe, Saba, & Parry, 2013). The overall findings of that study review found a significant link between alcohol consumption and sexual risk behaviour; and HIV infection for multiple settings, namely health care, schools and universities, drinking of alcohol; and community settings. The review findings also pointed to evidence (from two
studies) which reported that alcohol abuse may delay the intention to take part in HIV testing (Morejele et al., 2013).

Results of this study point to fragmented organisational architecture for HIV and AIDS as a negative factor affecting VCT participation. Lee, Venter and Bates (2004) explored the integration of enterprise-based HIV and AIDS strategies into the organisational architecture. In their study, Lee, Venter, and Bates (2004) make the point that, since architectures address elements of organisational structure and system relationships, these invariably include HIV and AIDS strategies. The institution under investigation has a dedicated HIV and AIDS structure - the Centre for HIV and AIDS. However, the centre faced acceptability challenges from staff as it was perceived to have been designed exclusively for students as opposed to staff.

This acceptability issue can be explored from two angles. First, currently there is no dedicated integrated risk and wellness department for employees working at the institution. In light of the fact that all employees are on a medical aid scheme, it can be surmised that both the leadership of the institution and employees are yet to comprehend the strategic imperative of managing HIV and AIDS within the institution. Secondly, the history of the Campus Health Services (CHS) is such that it was primarily designed to serve students. The coordination of VCT programmes through CHS poses acceptability challenges even though the VCT programme is outsourced to independent providers.

A policy is a statement of intent. In the HIV and AIDS context, the existence of a written policy implies a tacit admission that the institution perceives HIV and AIDS as an institutional priority that must be addressed. Although the target institution had an HIV and AIDS policy, however, the lack of policy awareness by the majority of study participants signifies the existence of a gap between policy intent and action.

It can be surmised that the lack of institutionalised action on workplace HIV policies other than for students points to a lack of awareness by the leadership that action is required for such policy for employees - beyond medical aid coverage - and to strategically position the management of HIV and AIDS amongst staff as a priority. Kelly and Bain (2005) refer to evidence that shows strong and visionary leadership as the hallmark of an effective response to HIV and AIDS. Nzioka (2006) agrees and
reports that in higher education institutions, leadership support that stems from the vice-chancellor or a designated senior manager sends a strong message within the institution and to the wider community that HIV and AIDS management is a priority. Nzioka (2006) points to a study on the response of teacher training colleges (TTCs) to HIV and AIDS and demonstrates that when institutional heads provide leadership in HIV and AIDS, college communities are likely to take such activities more seriously.

Within the realm of HIV and AIDS management, strong and committed leadership can inspire action, mobilise resources, establish policies and set up responsive organisational structures (Nzioka, 2006). A testimony to this point is the establishment of what is now the internationally renowned Health Economics and AIDS Research Division (HEARD) under the leadership of Professor Alan Whiteside, which garnered support from the vice-chancellor and made HIV and AIDS a priority (Nzioka, 2006).

6.3 RECOMMENDATIONS

This section provides recommendations for strategies that can be employed to increase the participation and implementation of a workplace VCT programme. It also outlines future research that should be undertaken following the results of this study.

Higher education institutions are crucial agents of change (Kelly, 2001) and can influence how society responds to issues such as HIV and AIDS. In this regard, Higher education institutions have an ethical and intellectual responsibility to set an example by openly debating the issues surrounding HIV and AIDS and finding creative responses to this epidemic (Kelly, 2001). The results of the current study support Kelly’s (2001) call for a process of change management focusing on both inward- and outward-looking dimensions institutional interventions. The inward-looking dimension should reflect the concern an institution should have with regard to its staff, students, academic programmes and support services (Kelly, 2001). The outward-looking dimension relates to the institution’s core functions of research and community outreach and should, therefore, focus on knowledge creation, human welfare and the needs of the society in an AIDS-affected world (Kelly, 2001). The inward-looking dimension should be guided by a strong and focused leadership
which is necessary to mitigate the disconnect between the observable culture of leadership silence on workplace HIV and AIDS within the target institution. Success in breaking such leadership silence will culminate in the acknowledgement of HIV and AIDS as a threat to institutional functions and operations (Von der Marwitz & Were-Okello, 2010). For instance, the institution needs to conduct regular surveillance of HIV and AIDS issues (Phaswana-Mafuya, 2007). The target institution has an opportunity to strategically address HIV and AIDS because it has already established an HIV and AIDS structure: the Centre for HIV and AIDS. However, the current HIV and AIDS structure must be supplemented by regular AIDS assessments among the workforce in order to project the future impact of the pandemic on variables such as medical aid schemes, pension funds, industrial relations and productivity. The Centre for HIV and AIDS needs to be strategically integrated into the organisational architecture in delivering HIV and AIDS workplace strategies that are aligned with the overall university strategy. As HIV and AIDS are developmental issues threatening the optimal functioning of university processes (HEAIDS, 2010), it is recommended that the vice-chancellor of the institution should treat HIV and AIDS programmes as one of the main strategic priorities.

Furthermore, there is a conspicuous absence of the voice of trade union leadership on workplace HIV and AIDS issues within the target institution. Through their central bargaining power, trade unions must embark on a transformational bargaining process and negotiate profound policy changes which will address HIV and AIDS issues within the institution (Jacobs, 1994 cited in Mapolisa, Schneider & Stevens, 2004). The existing policy of HIV and AIDS must be translated into action by an institutional structure and mandated with responsibility and accorded resources for this purpose. Mainstreaming of HIV and AIDS policies is a crucial outcome of successful institutional intervention (Kelly, 2001). In order to bridge the identified HIV and AIDS in-depth knowledge gap, mainstreaming of HIV and AIDS policies should seek to integrate HIV and AIDS education into the curriculum of all faculties (HEAIDS, 2010). Leadership acuity means that decisive action is taken in monitoring progress in respect of the infusion of the HIV and AIDS curriculum in all faculties and departments (HEAIDS, 2010). Furthermore, the policy must encourage and provide financial support for HIV and AIDS research. In order for staff to be HIV-aware, HIV-competent and HIV-safe (Coombe, 2003), ongoing educational campaigns are
critical, in particular the establishment of peer educators so as to bridge the lack of in-depth knowledge of HIV and AIDS, which became clear from the results of this study. In order to achieve the above, every effort must be made to ensure that trust is preserved and confidentiality and human rights are sacrosanct (Douglas & Southerland, 2009).

The outward dimension should focus on developing collaboration strategies which will share knowledge and resources as well as support research through outreach programmes of the university. The Eastern Cape is characterised by a rich culture but also by poverty, inequalities, unemployment and low literacy rates, with these elements serving as the drivers of HIV and AIDS (Eastern Cape Provincial Growth and Developmental Plan [ECPGD&P], 2004–2014). It is therefore recommended that the HIV and AIDS policy must address community outreach programmes in prioritising HIV and AIDS research, particularly with reference to cultural determinants of the pandemic.

UNAIDS (2000) called for a respectful attitude and an open exchange of ideas and information between traditional and Western medicine. Such a call is especially important in the South African context where it is said that 80% of South Africans still consult traditional healers (WHO, 2007). Dickinson (2008) reports a subjugated existence and acceptance of dual therapy amongst traditional healers of South Africa. Dickinson (2008) further explains that establishing inter-health system cooperation for HIV and AIDS interventions requires an assessment of each system’s perspective on the disease. However, a major concern about such a system is the incompatibility of perceptions regarding HIV and AIDS between the traditional healing and the bio-medical approach (Dickinson, 2008). Dickinson (2008) suggests that company initiatives should try to find a window of compatibility in trying to promote cooperation between allopathic practices and traditional healers rather than attempting to draft a comprehensive joint master plan.

### 6.4 VALUE OF THE STUDY

Research on workplace VCT amongst higher institutions of learning focuses mainly on students, and very few studies have been conducted on participation of workplace VCT amongst university employees. Furthermore, factors that inhibit or facilitate VCT
participation are contextual since humans are a product of their interaction with the environment. This study contributes to the existing body of knowledge by providing an African perspective on the variables that contribute to VCT participation or resistance towards such participation. This knowledge can be used to create focused interventions that will inform policy imperatives and improve HIV testing rates. The limitations of the study are discussed in the next section.

6.5 LIMITATIONS OF THE STUDY

Four main limitations exist to this study. First, the study was restricted to participants of the target site and the findings cannot be generalised to other samples and populations.

Secondly, sampling bias might also exist as participants who volunteered to take part in the study were black African employees, and the sample did not include managerial employees or other races.

Thirdly, while separate focus groups were held for each gender, group participants in each session recommended that the two gender groupings should have been merged in order to facilitate a richer exchange of ideas.

Lastly, while the study was conducted in English to avoid the loss of valuable data during translation, participants felt that the use of English as a medium of communication during focus group sessions disadvantaged them and held them back from providing a richer description of these factors in their home language. This also pointed to potential cultural differences that could have been assessed if the research had been conducted among all major cultural groups represented in South Africa.

6.6 RECOMMENDATIONS FOR FURTHER RESEARCH

It is recommended that the study be replicated to include employees from additional race groups, different cultural groups, different home languages as well as institutional management.
While the study uncovered the psycho-social and cultural factors that affect workplace VCT participation, some aspects emerged from the study, which require further exploration. These include an exploration of:

- "intonjane", "ukhusoma" and traditional male circumcision as cultural practices that facilitate potential positive health-seeking behaviours and the probability to increase the likelihood of seeking VCT services. Such an exploration would provide a timeous African contribution to the value of indigenous knowledge systems and also insights on how to bridge the bio-medical approach and traditional approaches to HIV and AIDS prevention.

- description of self-efficacy determinants to HIV testing. As the current study reported fear, confidentiality, trust and culture as the psychosocial factors that interfere with one's decision to go for an HIV test, an exploration of how to instil a sense of internal locus of health control through self-efficacy may provide valuable insights in this area. The advances made by the South African government in scaling up treatment (Phakathi et al., 2011) suggest that knowledge of timeous and continuous access to treatment will eliminate the consequences of fear to go for HIV testing. However, the pervasiveness of fear and the feared lack of confidentiality with concomitant expected results of stigma undermine efforts to normalise HIV and AIDS perceptions and treatments.

6.7 CONCLUSION

This study explored and described factors that affect the utilisation of the workplace VCT programme at an Eastern Cape academic institution. The research comprised six focus groups with equal numbers of female and male participants to identify these factors. Through the use of thematic categorisation for data analysis, the research revealed five factors that positively or negatively affect the utilisation of the workplace VCT programme:

- knowledge about HIV and AIDS testing;
- accessibility of and attitudes towards VCT;
- beliefs and practices determined and influenced by culture;
• disclosure and resultant stigma; and
• workplace issues pertaining to HIV and AIDS.

Thematic analysis of results confirmed the presence of psychosocial and cultural factors as mediating factors in the decision-making process that non-academic employees undergo when deciding to participate in a VCT programme. Ongoing research and HIV and AIDS education is a catalyst in empowering people and providing them with information to influence their attitudes towards HIV testing positively.
REFERENCES


UNFPA (2004). Integrating HIV Voluntary Counselling and testing services into reproductive health services. Stepwise guidelines for programme planners, managers and service providers. Joint Publication of IPPF Asia Regional Office and UNFPA. Vitesse Printing Co. Ltd. UK.


APPENDIX 1:
APPLICATION FOR APPROVAL FROM NMMU RESEARCH ETHICS COMMITTEE (HUMAN)

APPLICATION FOR APPROVAL
NMMU RESEARCH ETHICS COMMITTEE (HUMAN)

SECTION A: (To be filled in by a representative from the Faculty RTI Committee)

<table>
<thead>
<tr>
<th>Application reference code:</th>
<th>H</th>
<th>YEAR</th>
<th>FACULTY</th>
<th>DEPARTMENT</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolution of FRTI Committee:</td>
<td>☐ Ethics approval given (for noting by the REC-H)</td>
<td>☐ Referred to REC-H for consideration (if referred to REC-H, electronic copy of application documents to be emailed to <a href="mailto:imtiaz.khan@nmmu.ac.za">imtiaz.khan@nmmu.ac.za</a>)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution date:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faculty RTI representative signature:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. GENERAL PARTICULARS

TITLE OF STUDY

a) Concise descriptive title of study (must contain key words that best describe the study):

Factors affecting the utilization of a workplace HIV Voluntary Counselling and Testing Programme in the Eastern Cape.

PRIMARY RESPONSIBLE PERSON (PRP)

b) Name of PRP (must be member of permanent staff. Usually the supervisor in the case of students):

Jennifer Bowler Room 1008 10th Floor Administrative Building South Campus

c) Contact number/s of PRP: 041 504 2362

d) Affiliation of PRP: Faculty Business and Economic Sciences Specify here, if “other” Department (or equivalent): Department of Industrial and Organisational Psychology

PRINCIPLE INVESTIGATORS AND CO-WORKERS

e) Name and affiliation of principal investigator (PI) / researcher (may be same as PRP):

Nomonde Jusayo Masters student for Coursework masters in LR and HR at the NMMU. This work is a treatise.

Gender: Female

f) Name(s) and affiliation(s) of all co workers (e.g. co-investigator/assistant researchers/supervisor/co-supervisor/promoter/co-promoter). If names are not yet known, state the affiliations of the groups they will be drawn from, e.g. interns/M-students, etc. and the number of persons involved:

Directorate of the Centre for HIV and AIDS, Walter Sisulu University: Ms Nomvula Twaise

STUDY DETAILS

g) Scope of study: Local

h) If for degree purposes: Master’s

i) Funding: No specific funding

Additional information (e.g. source of funds or how combined funding is split) Not applicable
j) Are there any restrictions or conditions attached to publication and/or presentation of the study results? **No**
   If YES, elaborate (Any restrictions or conditions contained in contracts must be made available to the Committee):
   **Not applicable**

k) Date of commencement of data collection: **2013/06/03**
   Anticipated date of completion of study: **2013/11/25**

l) Objectives of the study (the major objective(s) / Grand Tour questions are to be stated briefly and clearly):
   The general aim of this study is to add to the body of knowledge regarding the uptake of HIV testing programmes
   by exploring the self-reported factors affecting the participation of non-academic employees at the Walter Sisulu
   University in the Eastern Cape. The specific research objectives are: (1) to explore and describe factors perceived
   to positively affect employee participation in a workplace HIV testing programme, (2) to explore and describe factors
   perceived to negatively affect employee participation in a workplace HIV testing programme, (3) to make
   recommendations regarding the improvement of the programme to management in order to improve HIV testing
   rates.

m) Rationale for this study: briefly (300 words or less) describe the background to this study i.e. why are you doing
   this particular piece of work. A few (no more than 5) key scientific references may be included:
   An estimated 334 million people worldwide were living with HIV in 2011. Of these, 23.5 million were found in sub-
   Saharan Africa (SSA) (UNAIDS, 2012). In SSA as a whole, women account for 78% of the estimated infections.
   The same report attributes a disproportionate share of the AIDS burden to women in that they are more likely to be
   infected than men and simultaneously are more likely to be the ones caring for HIV infected people. Of the
   countries in Southern Africa, South Africa is home to the world’s largest HIV population (6.6 million) (UNAIDS,
   2012). The Eastern Cape is one of the four provinces identified as having high epidemics which are still emerging
   (as opposed to provinces with more advanced epidemics) (ASSA, 2008). In 2006 it was estimated that 90.8 % of
   those living with HIV were in the age group 20 – 64 years which is the age group most likely to form part of the
   labour force (ASSA3, 2006). The effect of HIV and AIDS on the economically active population poses a serious
   threat to the demand and supply of labour and will retard future economic development (Natassa, 2004; 2012). In an
   absence of an HIV vaccine, Dickinson (2010) provides a summary of key aspects of recommended workplace HIV
   and AIDS responses in organisations. One of these key aspects is to encourage voluntary HIV testing and
   counselling (VCT). Despite evidence pointing to a correlation between early diagnosis and treatment of HIV
   infection in reducing morbidity and mortality there is little evidence that these VCT workplace programmes are
   achieving the desired results (George, 2008). As VCT is a gateway to access HIV treatment and care, the
   exploratory and descriptive nature of this study seeks to uncover factors that facilitate or inhibit HIV testing in the
   workplace. The study findings will provide recommendations for increasing VCT programme participation levels in
   this particular workplace.

**METHODOLOGY**

n) Briefly state the methodology (specifically the procedure in which human subjects will be participating) (the full
   protocol is to be included as Appendix 1):
   The targeted population in this study are the non-academic employees at the Postdam site of the Walter Sisulu
   University (WSU). Written consent will be sought from the WSU Directorate of the Centre for HIV and AIDS, Ms N.
   Twaise (refer to Appendix 5 for the draft letter requesting her consent). A nonprobability convenience sample (with
   gender and education qualifications used as two selection criteria) will be used to draw participants from the
   Postdam site in East London. Focus group data will be gathered through the use of a semi-structured interview
schedule. Focus groups will each include eight to twelve participants. However, the researcher will over recruit by 20% to allow for participants withdrawals as recommended by de Vos, et al (2005). A minimum of three focus groups per selected gender group will be arranged initially in order to ensure adequate sampling for saturation purposes. It is important to note that the additional focus groups will be conducted if needed in order to reach saturation. The semi-structured interviews will be guided by the attached interview schedule (Appendix1). The purpose of the interview schedule is to provide focus for the interviewer throughout the interview process whilst simultaneously allowing participants to lead the discussion around issues salient to them. Additional interviewing techniques such as probing, clarifying statements as well as paraphrasing will be employed by the researcher so that the meaning of the experience is captured (Willig, 2001).

<table>
<thead>
<tr>
<th>o) State the minimum and maximum number of participants involved (Minimum number should reflect the number of participants necessary to make the study viable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min: 48; 6 focus groups of 8 participants</td>
</tr>
<tr>
<td>Max: 96; 8 focus groups of 12 participants</td>
</tr>
</tbody>
</table>

### 2. RISKS AND BENEFITS OF THIS STUDY

<table>
<thead>
<tr>
<th>a) Is there any risk of harm, embarrassment or offence, however slight or temporary, to the participant, third parties or to the community at large?</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If YES, state each risk, and for each risk state i) whether the risk is reversible, ii) whether there are alternative procedures available and iii) whether there are remedial measures available.</td>
<td></td>
</tr>
<tr>
<td>b) Has the person administering the project previous experience with the particular risk factors involved?</td>
<td>No</td>
</tr>
<tr>
<td>If YES, please specify:</td>
<td>Not applicable</td>
</tr>
<tr>
<td>c) Are any benefits expected to accrue to the participant (e.g. improved health, mental state, financial etc.)?</td>
<td>No</td>
</tr>
<tr>
<td>If YES, please specify the benefits:</td>
<td>Not applicable</td>
</tr>
<tr>
<td>d) Will you be using equipment of any sort?</td>
<td>Yes</td>
</tr>
<tr>
<td>If YES, please specify:</td>
<td>A tape recorder and an interview schedule guide</td>
</tr>
<tr>
<td>e) Will any article of property, personal or cultural be collected in the course of the project?</td>
<td>No</td>
</tr>
<tr>
<td>If YES, please specify:</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

### 3. TARGET PARTICIPANT GROUP

<table>
<thead>
<tr>
<th>a) If particular characteristics of any kind are required in the target group (e.g. age, cultural derivation, background, physical characteristics, disease status etc.) please specify:</th>
<th>Must be a non-academic WSU employee from the Postdam sites with matriculation as a minimum qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) Are participants drawn from NMMU students?</td>
<td>No</td>
</tr>
<tr>
<td>c) If participants are drawn from specific groups of NMMU students, please specify:</td>
<td>Not applicable</td>
</tr>
<tr>
<td>d) Are participants drawn from a school population?</td>
<td>No</td>
</tr>
<tr>
<td>If YES, please specify:</td>
<td>Not applicable</td>
</tr>
<tr>
<td>e) If participants are drawn from an institutional population (e.g. hospital, prison, mental institution), please specify:</td>
<td>Walter Sisulu University non-academic staff</td>
</tr>
<tr>
<td>f) If any records will be consulted for information, please specify the source of records:</td>
<td>Not applicable</td>
</tr>
<tr>
<td>g) Will each individual participant know his/her records are being consulted?</td>
<td>Not applicable</td>
</tr>
<tr>
<td>If YES, state how these records will be obtained:</td>
<td>Not applicable</td>
</tr>
<tr>
<td>h) Are all participants over 18 years of age?</td>
<td>Yes</td>
</tr>
<tr>
<td>If NO, state justification for inclusion of minors in study:</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
### 4. CONSENT OF PARTICIPANTS

a) Is consent to be given in writing? **No**
   If YES, include the consent form with this application [Appendix 2].
   If NO, state reasons why written consent is not appropriate in this study. **No personal details will be required from the participants. Consent will be implied by their willingness to participate when they reply to the email Appendix 3**

b) Are any participant(s) subject to legal restrictions preventing them from giving effective informed consent? **No**
   If YES, please justify: **Not applicable**

c) Do any participant(s) operate in an institutional environment, which may cast doubt on the voluntary aspect of consent? **No**
   If YES, state what special precautions will be taken to obtain a legally effective informed consent: **Not applicable**

d) Will participants receive remuneration for their participation? **No**
   If YES, justify and state on what basis the remuneration is calculated, and how the veracity of the information can be guaranteed. **Not applicable**

e) Which gatekeeper will be approached for initial permission to gain access to the target group? (e.g. principal, nursing manager, chairperson of school governing body) **The Directorate for HIV and AIDS at Walter Sisulu University**

f) Do you require consent of an institutional authority for this study? (e.g. Department of Education, Department of Health) **Yes**
   If YES, specify: Faculty RTI Committee

### 5. INFORMATION TO PARTICIPANTS

a) What information will be offered to the participant before he/she consents to participate? (Attach written information given as [Appendix 3] and any oral information given as [Appendix 4])

b) Who will provide this information to the participant? (Give name and role)
   **Ms Twaise Director of the Centre for HIV and AIDS Wellness Walter Sisulu University via email Appendix 3**

c) Will the information provided be complete and accurate? **Yes**
   If NO, describe the nature and extent of the deception involved and explain the rationale for the necessity of this deception: **Not applicable**

### 6. PRIVACY, ANONYMITY AND CONFIDENTIALITY OF DATA

a) Will the participant be identified by name in your research? **No**
   If YES, justify: **Not applicable**

b) Are provisions made to protect participant’s rights to privacy and anonymity and to preserve confidentiality with respect to data? **Yes**
   If NO, justify. If YES, specify: Participants will be informed of the objectives of the study and their right to participate or not participate shall be respected. The researcher will solicit their permission to record the qualitative data collected. Participants will remain anonymous and no reference will be made of individual participants on any documents. All information will be handled in a confidential manner so as to avoid emotional harm to the employees participating in the study. Excep for the researcher, independent coder and research supervisor no one will have access to the data. Where applicable extracts from qualitative interviews data may be cited within the written report but without referring to specific study participants.

c) If mechanical methods of observation are to be used (e.g. one-way mirrors, recordings, videos etc.), will
participant’s consent to such methods be obtained?  No
If NO, justify:  Not applicable

d) Will data collected be stored in any way?  Yes
   If YES, please specify:  (i) By whom?  (ii) How many copies?  (iii) For how long?  (iv) For what reasons?  (v) How will participant's anonymity be protected?  Data will be stored with Jennifer Bowler, the PRP (i) and captured in EXCEL one copy (ii) for five years (iii) for purposes of data analysis (iv) no participant will be identified by name or by employee number as only themes will be captured.

c) Will stored data be made available for re-use?  No
   If YES, how will participant's consent be obtained for such re-usage?  Not applicable

f) Will any part of the project be conducted on private property (including shopping centres)?  Yes
   If YES, specify and state how consent of property owner is to be obtained:  Permission will be obtained from the Director of the Centre for HIV and AIDS and Wellness See Appendix 5

g) Are there any contractual secrecy or confidentiality constraints on this data?  No
   If YES, specify:  Not applicable

7. FEEDBACK

a) Will feedback be given to participants? Yes
   If YES, specify whether feedback will be written, oral or by other means and describe how this is to be given [e.g. to each individual immediately after participation, to each participant after the entire project is completed, to all participants in a group setting, etc.]:  A copy of the written treatise will be made available to the WSU community at large.

b) If you are working in a school or other institutional setting, will you be providing teachers, school authorities or equivalent a copy of your results?  Yes
   If YES, specify, if NO, motivate:  A copy of the written treatise will be made available to the WSU community at large.

8. ETHICAL AND LEGAL ASPECTS

The Declaration of Helsinki (2000) or the Belmont Report will be included in the references:  No
If NO, motivate:  This is not a biomedical research.
(A copy of the Belmont Report is available at the following link for reference purposes:  http://www.nlm.nih.gov/documents/refdocs/belmontreport.pdf)

a) I would like the REC-H to take note of the following additional information:  None

9. DECLARATION

If any changes are made to the above arrangements or procedures, I will bring these to the attention of the Research Ethics Committee (Human).  I have read, understood and will comply with the Guidelines for Ethical Conduct in Research and Education at the Nelson Mandela Metropolitan University and have taken cognisance of the availability (on-line) of the Medical Research Council Guidelines on Ethics for Research (http://www.sahealthinfo.org/ethics/). All participants are aware of any potential health hazards or risks associated with this study.
I am not aware of potential conflict(s) of interest which should be considered by the Committee.
If affirmative, specify:  Not applicable
10. SCRUTINY BY FACULTY AND INTRA-FACULTY ACADEMIC UNIT

This study has been discussed, and is supported, at Faculty and Departmental (or equivalent) level. This is attested to by the signature below of a Faculty (e.g. RTI) and Departmental (e.g. HoD) representative, neither of whom may be a previous signatory.

NAME and CAPACITY (e.g. HoD)  SIGNATURE  

11. APPENDICES

In order to expedite the processing of this application, please ensure that all the required information, as specified below, is attached to your application. Examples of some of these documents can be found on the Research Ethics webpage [http://www.nmmu.ac.za/default.asp?id=4619&bhcp=1]. You are not compelled to use the documents which have been provided as examples – they are made available as a convenience to those who do not already have them available.

APPENDIX 1: Research methodology  — see attached.

Attach the full protocol and methodology to this application, as "Appendix 1" and include the data collection instrument e.g. questionnaire if applicable.

APPENDIX 2: Informed consent form  — None

If no written consent is required, motivate at 4a). The intention is that you make sure you have covered all the aspects of informed consent as applicable to your work.

APPENDIX 3: Written Information given to participant prior to participation  — see attached.

Attach as "Appendix 3". The intention is that you make sure you have covered all the aspects of written information to be supplied to participants, as applicable to your work.

APPENDIX 4: Oral Information given to participant prior to participation

If applicable, attach the required information to your application, as "Appendix 4".

APPENDIX 5, 6, 7: Institutional permissions  — see attached.

Attach any institutional permissions required to carry out the research e.g. Department of Education permission for research carried out in schools.
APPENDIX 2: RESEARCH METHOD

RESEARCH METHOD

General approach

A qualitative research method that is exploratory as well as descriptive in nature will be adopted in this study. Exploratory research refers to a 'broad ranging-purposive, systematic, pre-arranged undertaking designed to maximise the discovery of generalisations leading to a description and understanding of an area of social or psychological life' (Stebbins, 2001:p3). This study is not only exploratory but also descriptive in nature. Exploratory-descriptive studies attempt to source the quality and texture of the participant's perceptions, while simultaneously endeavouring to foster an understanding of the participants' experiences about the subject under investigation (Willig, 2001).

Population

The targeted population in this study are the non-academic employees at the Postdam¹ campus of Walter Sisulu University (WSU).

Sample and sample selection

A nonprobability convenience sample will be utilized. For the purposes of data collection, the sample will include only non-academic employees with a minimum qualification of matriculation. The qualification minimum has been set as the language of the focus groups will be in English. Since research on HIV VCT has established the gendered nature of testing, gender is a further criteria that will be imposed and equal numbers of men and women will be recruited for the sample. The intention will be to have a minimum number of 48 participants (6 focus groups with a minimum of eight per group)

¹ This is the only campus that is sufficiently organised in terms of VCT
Research Instrument

Focus groups will be utilised as a means of qualitative data collection. Focus group data will be gathered through the use of the semi-structured interview schedule. The interview agenda for the semi-structured interviews will be guided by the attached interview questions (Appendix 1).

Data Collection

Once ethics approval has been obtained from the Nelson Mandela Metropolitan University, written consent will be sought from the Directorate of the Centre for HIV and AIDS and Wellness at WSU, Ms N. Twaise (Appendix 5). Letters of invitation to participate in the study will be issued by the Directorate for the Centre for HIV and AIDS and Wellness to all non-academic staff at the Postdam site of the WSU via email (Appendix 3). The involvement of the Centre’s Directorate is to indicate institutional support of the study. However, correspondence regarding interest in participation will be sent directly to the researcher for the sake of maximum confidentiality. Interested staff will be asked to correspond with the researcher and if they wish to participate in the study. The researcher will meet with potential participants to screen for educational qualifications and ensure that the potential participants completely understand the research project. Participants will be informed of their rights to voluntarily participate in the interviews and that they can withdraw at any stage of the process. Once all participants have been recruited, the researcher will communicate interview times and venue details via email to each participant individually.

The focus groups will each include eight to twelve participants; however the researcher will over-recruit by to allow for participant withdrawals and additional focus groups if needed.

Owing to the sensitivity of the topic under investigation and for purposes of eliminating possible feelings of discomfort on the part of the participants, male and female focus group interviews will be conducted separately. Therefore, equal numbers of men and women will be recruited in order to ensure a minimum of three focus groups per selected gender group (six focus groups in total) initially. It is important to note that the additional focus groups will be run if needed in order to reach saturation of information.

2 Note that verbal consent has already been obtained and the project thoroughly discussed with Ms N Twaise.
Data Capture and Analysis

The interviews will be conducted until data saturation is reached. The researcher will conduct interviews in English. The interviews will be tape recorded and informed consent pertaining to use of recording instruments will be sought from participants. Data obtained will be transcribed and thematically analyzed using Tesch’s content analysis and verified using a co-researcher. The final results will be written up by the researcher.
APPENDIX 3: UNSTRUCTURED INTERVIEW SCHEDULE

UNSTRUCTURED INTERVIEW SCHEDULE

PURPOSE: These questions will serve to guide an interview on factors perceived to positively or negatively affect employee participation in the WSU workplace HIV VCT testing program.

1. KNOWLEDGE ABOUT HIV TESTING
   a. Tell me about what you know about HIV Voluntary Counseling and Testing?
   b. When do you think people should go for HIV testing?

2. ACCESSIBILITY AND ATTITUDES TOWARDS VCT
   a. What do you think makes it difficult for people to go for HIV testing?
   b. What are the things that encourage people to go for HIV testing?
   c. If you were to go for an HIV test where would you prefer to go to and why?
   d. What are your views regarding VCT campaigns that have been launched on campus?
   e. Do you think that the results will be kept confidential if you go for testing on campus?

3. CULTURAL BELIEFS AND OTHER PRACTICES
   a. Can you describe ways in which cultural (traditional) beliefs encourage or discourage people’s decisions to go for an HIV test?
   b. In what ways do you think being male or female affects people’s decisions to go for HIV testing?
   c. Are women and men who are HIV+ treated differently?
   d. What role (if any) does alcohol abuse play in participation in HIV testing?

4. DISCLOSURE AND STIGMA
   a. In conversations you had with your friends or colleagues what views do they present about HIV testing?
   b. What comments do they make about people who are HIV+?
   c. Are you aware of any discrimination against HIV+ individuals at WSU?

5. WORKPLACE ISSUES PERTAINING TO HIV
   a. Could you tell me about the WSU HIV and AIDS workplace policy?
   b. What do you regard as the most important issue in the WSU workplace policy?
   c. What do you feel about the support available for HIV+ people at WSU?
   d. What would you like to see at WSU that would support HIV testing?
   e. What would you like to see at WSU that would support HIV+ employees?
EMAIL to non-academic staff Postdam Campus of the Walter Sisulu University

Sender: Director: Centre for HIV and AIDS and Wellness Ms Twaise

SUBJECT: INVITATION TO PARTICIPATE IN A STUDY ON “The factors affecting the utilization of a workplace HIV voluntary counseling and testing programme in the Eastern Cape

Dear All

This email serves to kindly inform you of the above-mentioned study and to invite you to communicate with the researcher if you would like to participate.

The aim of the project is to:
- To explore and describe factors perceived to negatively affect participation in a workplace HIV testing program.
- To explore and describe factors perceived to positively affect participation in a workplace HIV testing program.
- To make recommendations regarding the improvement of the program to management in order to improve HIV testing rates.

The study will be conducted in English, through semi-structured interviews with participants in focus groups. All the participants will be non-academic employees who volunteer to be part of the focus group sessions.

For ease of data capture it would be preferable for the interviews to be tape recorded. The researcher, therefore, humbly requests prospective participants to allow her to use the recording equipment.

The researcher wishes to place it on record that:
- Participant’s responses will be kept confidential. They will each be allocated a numerical code and only that code will appear in the analysis. The only identifiable characteristic will be gender.
- Participant’s names will not appear in any document reporting on the study.
- Copies of the transcripts will be kept in safe storage and will be only be used for research purposes.
- In the final report of the study, some responses will be cited as quotes but these will remain anonymous and thus participants will not be recognized.

Interested participants are kindly requested to contact Ms Jusayo at 082 497 1162. She will arrange to meet with you to further explain the process. If you are then still willing to participate Ms Jusayo will then communicate venues and dates for the focus groups. The researcher would like to point out that participants will have a right to withdraw from the study at any time (even during a focus group session) and that their decision will be respected.
APPENDIX 4:
INVITATION TO PARTICIPATE IN STUDY

20130429

EMAIL to non-academic staff Postdam Campus of the Walter Sisulu University
Sender: Director Centre for HIV and AIDS and Wellness Ms Twaise

SUBJECT: INVITATION TO PARTICIPATE IN A STUDY ON "The factors affecting the utilization of a workplace HIV voluntary counseling and testing programme in the Eastern Cape"

Dear All

This email serves to kindly inform you of the above-mentioned study and to invite you to communicate with the researcher if you would like to participate.

The aim of the project is to:
- To explore and describe factors perceived to negatively affect participation in a workplace HIV testing program.
- To explore and describe factors perceived to positively affect participation in a workplace HIV testing program.
- To make recommendations regarding the improvement of the program to management in order to improve HIV testing rates.

The study will be conducted in English, through semi-structured interviews with participants in focus groups. All the participants will be non-academic employees who volunteer to be part of the focus group sessions.

For ease of data capture it would be preferable for the interviews to be tape recorded. The researcher, therefore, humbly requests prospective participants to allow her to use the recording equipment.

The researcher wishes to place it on record that:

- Participant’s responses will be kept confidential. They will each be allocated a numerical code and only that code will appear in the analysis. The only identifiable characteristic will be gender.
- Participant’s names will not appear in any document reporting on the study.
- Copies of the transcripts will be kept in safe storage and will be only be used for research purposes.
- In the final report of the study, some responses will be cited as quotes but these will remain anonymous and thus participants will not be recognized.

Interested participants are kindly requested to contact Ms Jusayo at 082 497 1162. She will arrange to meet with you to further explain the process. If you are then still willing to participate Ms Jusayo will then communicate venues and dates for the focus groups. The researcher would like to point out that participants will have a right to withdraw from the study at any time (even during a focus group session) and that their decision will be respected.
APPENDIX 5:
REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT WSU PREMISES

20130429

1855, Zone 14
Mdantsane
5219
xxxxxxx, 2013

The Director: Centre for HIV and AIDS & Wellness
Ms. N. Twaise
Walter Sisulu University
CHISHEHURST

Dear Madam,

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT WSU PREMISES

As per our previous verbal and email communications the purpose of this correspondence is to formally request permission to conduct research for the purposes of completion of a Master's Degree in Human Resources & Labour Relations at Nelson Mandela Metropolitan University. In order to comply with the requirements of the said degree, I am required to undertake a research project. This project has now received Ethics Clearance, no xxxxxxxxxxx.

For your records, below are the details of the study and the role that will be played by the research participants.

The title of the research topic is: "FACTORS AFFECTING THE UTILIZATION OF A WORKPLACE HIV VOLUNTARY COUNSELING AND TESTING PROGRAMME IN THE EASTERN CAPE"

The aims of the project are to:
- Explore and describe factors perceived to negatively affect participation in a workplace HIV testing program.
- Explore and describe factors perceived to positively affect participation in a workplace HIV testing program.
- To make recommendations regarding the improvement of the program to management in order to improve HIV testing rates.

The study will be conducted through semi-structured interviews with participants in a focus group. The focus groups will comprise of males and females of non-academic staff from the Postdam campuses. Each participant will be given a consent form that will be fully explained to them and this will be to ensure that the participation is voluntary. All the information provided during the interviews will be treated confidentially and will not be used for any other research study. After the study is completed the researcher will make a copy of the study available to all the WSU community and share the research findings with the management.

Yours sincerely,
N. Jusayo