THE IMPORTANCE OF VOLUNTARY COUNSELLING AND CONFIDENTIAL TESTING FOR HIV IN THE WORKPLACE

PONTSHO ELIZABETH MORE

Assignment presented in partial fulfilment of the requirements for the degree of Master of Philosophy (HIV/AIDS Management) at Stellenbosch University

Supervisor: Prof J.C.D. Augustyn

December 2007
DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously, in its entirety or in part, submitted it at any university for a degree.

Signature:

Date:
ABSTRACT

“Managing the epidemic appropriately and effectively in the workplace is in itself a critical factor for the future viability of the organisation and for the health and welfare of its employees. In this respect, the organisation and all its employees need to understand the various complexities of the epidemic and find joint solutions for the challenges faced through a participatory process”. This is a preamble to the organisation’s AIDS Policy (which from now henceforth will be referred to as the Bank).

The organisation in question is a financial institution which has come to realise that not only is it exposed to escalating business risks because of HIV/AIDS, which remains foreign, unquantifiable, poorly understood and inadequately addressed.

The aim of the research study was to focus on the importance of voluntary counseling and confidential testing (VCT) for HIV/AIDS affected and infected employees in the workplace. It is imperative that the epidemic will affect every workplace, with prolonged employee illness, absenteeism, and death impacting on productivity, employee benefits, occupational health and safety, production loss and workplace morale.

The research study and article aims at providing and critiquing the VCT approach initiated during 2005 and implemented over a period of 18 months at the bank as a sequel to its HIV/AIDS campaign in a manner that establishes whether the campaign influenced employee motivation for VCT.

The research also examined the specific approach for voluntary testing, and the degree to which this approach has enhanced both the client – personal mastery and Wellness models in the bank. The suggestion is the scepticism around VCT and its effect will be reduced.

VCT wellness and personal mastery will be discussed, and suggestions and guidelines on how this could be successful will be summed at the end of the
article. VCT, in these discussions, will be defined to address pre-test
counselling and post-counselling, associated with HIV/AIDS testing. The
approach used by the organisation will be discussed further and elaborated
on. In order to ensure success the following variables were adhered to:

- Passion for people;
- Passion for communication;
- Passion for acknowledgement and understanding people.
OPSOMMING

Alle ondernemings is op risiko as gevolg van die negatiewe impak van MIV/Vigs op die resultate van die onderneming en alle pogings word huidiglik aangewend om hierdie negatiewe impak te beperk.

Die doel van hierdie studie is die bepaling van die belangrikheid van vrywillige- toetsing en voorligting aan ge-affekteerde en MIV-positiewe werknemers binne 'n onderneming in die finansiële sektor asook die bydrae wat behoorlike voorligting kan maak tot die beperking van finansiële risiko.

Die studie is oor 'n tydperk van 18 maande gedoen en die belangrikheid van behoorlike voorligting aan werkers binne ondernemings word herbevestig deur die studie. Die studie toon verder aan dat dit die impakkoste van die pandemie beduidend kan beperk."
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
<th>PAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>2. RESEARCH OBJECTIVES</td>
<td>2</td>
</tr>
<tr>
<td>3. SOCIAL DESIRABILITY AS A BARRIER TO BOTH TESTING AND HONESTY</td>
<td>6</td>
</tr>
<tr>
<td>4. GENERAL INSIGHTS ON VCT BY THE BANK</td>
<td>7</td>
</tr>
<tr>
<td>5. RESEARCH PROBLEM</td>
<td>9</td>
</tr>
<tr>
<td>6. RESEARCH DESIGN</td>
<td>10</td>
</tr>
<tr>
<td>7. SAMPLING</td>
<td>13</td>
</tr>
<tr>
<td>8. DATA COLLECTION</td>
<td>14</td>
</tr>
<tr>
<td>9. RESULTS</td>
<td>18</td>
</tr>
<tr>
<td>10. RECOMMENDATION</td>
<td>28</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>32</td>
</tr>
<tr>
<td>ANNEXURE A</td>
<td>35</td>
</tr>
<tr>
<td>ANNEXURE B</td>
<td>36</td>
</tr>
<tr>
<td>ANNEXURE C</td>
<td>38</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

It has been evidenced that VCT programmes can be effective in modifying sexual behaviour in developing countries (Merson et al. 2000). VCT is encouraged by UNAIDS with pre- and post-test counselling as a vital component of HIV/AIDS prevention. This is a process by which an individual voluntarily presents himself/herself for counselling, enabling him/her to make informed choices about testing for HIV. Individuals with positive result can be counselled and offered information on ways to reduce the risk of transmitting the virus to others.

Individuals with negative results can also be educated to maintain their negative status. Knowledge of sero-status through the created conducive and accommodating environment of VCT can motivate both HIV+ and HIV-individual employees to adopt safer sexual behaviour that might result in transforming their attitudes.

There are general principles for the delivery of VCT services that are applicable to any context anywhere in the world (Baggaley et al, 2002). Different organisations embrace these same principles with different approaches to VCT service delivery. These include among others the following:

- The decision to have an HIV test is voluntary and entirely the person’s choice;
- The test is confidential;
- The testing is reliable and automatically includes confirmatory tests;
- Pre-test and post-test counseling are offered;
- Continued counseling if one tests positive;
- Counseling if needed by one who tests negative to remain negative

Although there are some studies supporting this, there are people who are failing to acknowledge the importance of VCT. There are serious measures
that need to be taken to realistically accomplish education about HIV/AIDS in the workplace, which among others, will be to gather information through literature studies and consultations with experts, including infected and affected individuals.

It should be noted that the aim of this study is not to reinvent, or undermine studies already done around VCT but this study will argue that a certain approach has managed to influence and motivate individuals to go for VCT; and laying the foundation for this, understanding the Bank’s wellness program and personal responsibility was imperative.

2. RESEARCH OBJECTIVES

The objectives of this research were to:

- determine if the approach taken by the organisation did motivate employees to go for HIV VCT;
- determine if it did lay the foundation for the wider understanding and foundation for continuously educating the workforce about HIV/AIDS;
- attempt to answer certain clinical and sociological questions raised by employees

In one study by Shisana and Simbayi adults who had had an HIV test were compared with those who had not tested. It was found that 25.1% of those who had tested \( n = 1,659 \) used condoms as compared to 20,2% of those who had not tested\( n = 5,364 \). This suggests that HIV testing has a positive influence on condom use (2002:76)

While a strong case can be made that HIV testing and counselling is likely to promote change, one cannot read the direction of causality from simple correlation as done above. Quantitative household survey data of this kind need to be supplemented with information from randomised trials, and more qualitative information about the relationship between VCT.
The ASSA2000 Interventions Model assumes that people who have experienced VCT subsequently modify their behaviour, although this improvement is assumed to be short lived for those who test HIV-negative. A 20% reduction in the improvement in safe sex behaviour among those who test HIV-negative is built into the model for each year following VCT (Johnson and Dorrington 2002: 13). Combining the results from randomised control trials in Tanzania, Kenya and Trinidad (VCTESG 2000) and European data (de Vincenzi 1994) the model came up with the following assumptions about the effectiveness of VCT.

Table 1.1: Assumptions about sexual change following VCT, by HIV status when VCT is received (ASSA2000 Interventions Model) – Source: Johnson and Dorrington.

<table>
<thead>
<tr>
<th></th>
<th>HIV- negative (pre- AIDS)</th>
<th>HIV+ positive (pre- AIDS)</th>
<th>HIV+ positive (AIDS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in the proportion of sex acts that are unprotected</td>
<td>24%</td>
<td>36%</td>
<td>53%</td>
</tr>
<tr>
<td>Reduction in the amount of sex</td>
<td>9%</td>
<td>19%</td>
<td>31%</td>
</tr>
</tbody>
</table>

It assumes that the number of individuals receiving VCT in a given year, when VCT programme is fully implemented, will be 4% of untested HIV+ positive people, 3% of untested people who are not at risk of HIV infection. These assumptions which are inevitably arbitrary generate the same projected rate of HIV prevalence among individuals who have received VCT as that observed by a Natal-based study (Johnson and Dorrington 2002).

One of the sources of information used by the demographers who designed the ASSA2000 Interventions Model was a randomised trial in the countries mentioned above. The study was set up explicitly to determine the efficacy of VCT in reducing unprotected sexual intercourse among individuals and sex-partner couples in Nairobi, Dar es Salaam, and Port of Spain. Individuals and couples were randomly assigned VCT or basic health information. At the first follow up between three and seven months after the base-line, those who had
been provided with basic health information were offered VCT, and those who had been offered VCT were offered retesting. A second follow up asked questions about sexual behaviour, this study has two reasons that make it important: the fact that it was made in developing countries two of which African; and it was a randomised trial.

The study found that “the proportion of individuals reporting unprotected intercourse with non-primary partners declined significantly more for those receiving VCT than those receiving health information (men 35% reduction with VCT versus 13% reduction with health information; women 39% reduction with VCT versus 17% reduction with health information)” (VCTESG 2000:103).

This represents strong support for the proposition that VCT affects behaviour change. Sweat et al (2000) in their study of the cost-effectiveness of VCT in Kenya and Tanzania, found that the intervention did lead to behaviour change, and that it was most cost-effective with regard to HIV+ positive people and for those who received VCT as a couple. Other studies have found that counselling couples had major benefits in terms of facilitating disclosure and negotiating risk reduction strategies (VCTESG 2000:109-10). According to De Cock et al, “increased efforts are required to arrange for couples to be tested together for HIV infection, so that HIV/AIDS can be approached as a disease of the family and of society”(2002: 70).

Various individuals and organisations, have been engaged in all types of surveys and research around VCT, and have emphasised the aspects of confidentiality however there are still people who are sceptical. “Is this not a ploy? Are you certainly sure that people will not know or see my test results?” This echoed by many who were being sourced for interviewing in this study.

The stigma is still so strong that many employees are known to have died without ever disclosing their status, simply to protect themselves and their families. Some still believe that the disclosure can even be life threatening, as was the case in the well-publicised case of the Kwa Mashu AIDS worker who
was killed after revealing her HIV+ status. The AIDS epidemic produces varied reactions from different people. One author has described the disease as an epidemic of fear, of stigmatisation and of usually religiously motivated moralising. This is paradoxical as De Cock et al. (2002) argues that one of the reasons why the AIDS pandemic has gained such a grip in Africa is that the public health response has not sought to challenge this ‘quest for secrecy’ more effectively. Ramotlhwa (2003) makes a similar point with regard to Botswana, arguing that the ‘confidentiality paradigm’ has prioritised human rights concerns over public health issues and that routine HIV testing should be introduced.

According to Nattras (2004), negative social attitudes towards people living with AIDS should not be reason for inaction, instead appropriate policies and procedures should be designed to address them. The alleged Mbeki’s questioning of AIDS knowledge and best-practice medical interventions reinforced the doubts and denial that have caused society’s lack of behavioural change. The dissidents’ claim that HIV neither causes AIDS nor infectious, nullified the safe sex message of responsible sexual decision-making. This has thus nudged the organisation into considering VCT approach as a campaign for the past eighteen months.

What is personal mastery?
The term mastery descends from the Sanskrit root main, meaning "greater." Through centuries in Lahn, and Old English the meaning of "mastery" as domination over something else ("I am your master") has endured. But a variation of the word evolved in medieval French: “matre”, meaning someone who was exceptionally proficient and skilled, a master of a craft (Senge et al., 1994; 1999).

"Mastery", as it is used in this article and by various people these days, and according to Senge et al. (1999), reflects “matre”. It means the capacity not only to produce results, but also to "master" the principles underlying the way you produce results. If someone can create great work only with constant struggle, we wouldn't call him or her masterful. In mastery, there is a sense
of effortlessness and joyousness. It stems from your ability and willingness to understand and work with the forces around you.

True vision is inner vision, an ability to convert past experience into positive input and to visualise a desired future. People who can do this become leaders, many also attaining great wealth. Storing every transaction as a learning opportunity, keeping their vision unclouded by negativism from past setbacks, they can see their missions clearly and describe them vividly. This combination of insight, hindsight, and foresight—the ability to filter out failure, reinforce what has worked before, and see accomplishments ahead—attracts followers who share a similar mission but not the vision. This has been the philosophy that was used as a basis to introduce and encourage employees’ to be part of the VCT campaign.

3. SOCIAL DESIRABILITY AS A BARRIER TO BOTH TESTING AND HONESTY:

Social desirability in its extreme can cause difficulties in research particularly in psychology and medical research. When respondents provide socially desirable responses, results can often be confounded. Cynics often say that humans attempt at every turn to present themselves as they are not, in reality a long-standing and complex system underlies both humans need to be seen as “good” and the mechanisms by which humans preserve feelings of self-worth.

In San Francisco an employee in Pacific having observed how people who dared to disclose their status were ostracised, he took a decision not to disclose to a point of being dishonest. “It would be like putting a limit on the amount of time I have not only with company maybe also on earth”. It is therefore senseless to attempt to change the way humans determine to portray themselves, instead the responsible researcher anticipates prior to test or survey development those items which are likely to cause distress or socially desirable responding, and to take into consideration the needs of both the participants as well as the study (Roosevelt, 1994). It then becomes
imperative for the researcher to impress upon all respondents that anonymity and confidentiality are clearly guaranteed, and during live interview, the researcher must demonstrate empathy.

4. GENERAL INSIGHTS ON VCT BY THE BANK

- The Bank has as its aim to continually prepare and support the employees to choose health by knowing their current health status and the way to live a healthy and productive life;

- Produce a trend response through the whole Bank that will succeed in getting more people to undergo a personal health risk assessment and HIV VCT within a period of 18 months.

- The Health Risk Assessment asked questions about employees’ lifestyles, relevant personal and family health history, other specific risk factors and demographics such as age and gender. The assessment also required some clinical information, such as blood pressure measurement, cholesterol test, height, weight measurements, stress screen and dietary intake.

- The aim was to provide a holistic understanding of health; enable the delivery of cost effective wellness interventions; promote health and disease prevention and personal coping skills, and encourage shared responsibility for health and wellness by individuals, their families, communities and the Bank.

- VCT opens the way to live, especially these days where testing is often done with a “rapid test”, sometimes using a finger-prick droplet of blood or even using fluid from mouth. These tests are extremely accurate at finding antibodies, so an HIV negative test is very trustworthy as long as it is not done in the ‘window period’ before a person who is infected with HIV has
begun to produce antibodies’ – Peter Piot – Director of Joint United Nations Program on HIV/AIDS.

- Gary Banas says: “Don’t let anyone kid you, when you confront HIV/AIDS in the workplace, you will face untenable choices that seem to pit your obligation to humanity against your obligation to your organisation. Contrary to popular opinion you will almost certainly fall short in both areas if you are not prepared.”

- The reality is most people are not prepared. Estimates of people living with HIV/AIDS in South Africa have often been disputed – probably because the numbers are so large that they seem unbelievable. The conference in Toronto – Canada has shown that South Africa had the highest number of AIDS related deaths in the previous year approximately 360000; and more than one and half million South Africans have already died of AIDS.

- “I know! The way to live” campaign was introduced as every employee’s personal guide for moving from HIV/AIDS to where everyone realises their own contribution in making the world a better place to inhabit.

- Readiness in the context of the campaign is about individual willingness to do, and quickening the pace what needs to be done; it is also about being adequately prepared for getting knowledge on your HIV status and being prepared for any action.

- Taking action against this greatest killer – HIV/AIDS will be making a serious assertion and reclaiming our freedom to live. According to Nelson Mandela (2004) HIV/AIDS will continue to rob us of our freedom to survive, of our economic and social freedoms and of the gains that have been made to create a free country and a home for all South Africans.
Confidentiality has been the fundamental basis of the approach, the fact that every person has the right to privacy was advocated right through the campaign.

Confidentiality regarding the HIV status of any employee whether they participated in the research or not would be maintained at all times; the HIV status of any employee will not be divulged to any other person without prior written permission or consent of the employee, concerned.

Addressing gender-related determinants vulnerability to HIV infection. Although only a limited number of programs have so far addressed gender and societal vulnerability, their numbers are growing along with a wider recognition of the link between the socio-cultural and economic contexts of men’s and women’s differential vulnerability to HIV and the impact of AIDS.

UNAIDS encourages VCT with pre- and post-test counselling as a vital component of HIV/AIDS prevention. Individuals with a positive result can be counselled and offered information on ways to reduce the risk of transmitting the virus to others and/or re-infecting themselves further. Pregnant HIV-positive women and discordant couples who wish to have children can additionally be advised on preventing mother-to-child transmission. Individuals with a negative result can be educated to maintain their negative status.

5. RESEARCH PROBLEM

The research study was to determine whether individual employee could be motivated to go voluntarily for testing for HIV after the approach – “I Know! – the way to live” was launched.

The perspective is that HIV/AIDS has had a devastating effect on the South African society, negatively impacting on all aspects of life. To this extent and
with all efforts employed to combat this pandemic, none can claim to have overcome it. However work needs to continue, therefore the research problem to be analysed and discussed is as follows:

Did the “I know!– the way to live” VCT approach influence employee motivation to go for VCT?

Determining whether the “I Know! – the way to live” approach of VCT did influence employees’ motivation for voluntary testing demanded that focus be on primarily selling the concept of “personal mastery” and secondly customising and articulating the VCT approach in terms of how it is understood and undertaken in the organisation and by employees.

Initially a suggestion – cum – questions and comments box was placed at the canteen and reception area, for head office employees to suggest, question, or comment on HIV/AIDS. This was over a period of 8 weeks. The “Dipstick” prompted questions rather than comments and/or suggestions. The list of questions and the responses given (from different consultations) is attached. The questions were categorised into medical and general social context questions (see Annexure C).

6. RESEARCH DESIGN

The survey methodology
The study is of a descriptive nature not only to verify the information gathered in the research study, but also to make sense of the importance of VCT. The other, perhaps important rationale is that neither the VCT approach (the independent variable), nor employee motivation (the dependent variable) for VCT can for now be controlled by the researcher, nor can it be a subject of manipulation. The researcher can not control who comes for testing and counselling, but can only encourage that the decision to come for testing or not to come is theirs (Christensen, 2001).
A letter of appeal to participate in the research study was sent to 350 employees; only 250 responded positively. A survey was then done with 250 employees at the ABSA Head Office in Johannesburg, South Africa, during June – July 2006 to determine if the VCT Approach – “I Know! – the way to live” did motivate them to go for VCT.

Head Office employees were chosen for this survey because they were the first group to be exposed to the “I Know! – the way to live” VCT approach, had been in road shows that communicated the issues surrounding HIV/AIDS, and some had been in the focus groups dialoguing about HIV/AIDS.

The framework of the research was based on four guiding principles:

- Contributory in advancing wider knowledge or understanding;
- Defensible in design by providing a research which can address the evaluation questions posed;
- Rigorous in conduct through the systematic and transparent collection, analysis and interpretation of qualitative data;
- Credible in claim through offering well-founded and plausible arguments about the significance of the data generated.

The survey represents a probe into a given state of affairs that exists at a given time. Therefore, direct contact with individuals whose characteristics, behaviour or attitudes are relevant to the investigation (Christensen, 2001). In essence there will be the observation with close scrutiny of the population bounded by this research parameters; careful recording of the observation so that when the aggregate record is made, one can then return to the record to study the observation that have been described earlier (Leedy, 1980). It should be clarified that the seeing, the looking or the observation is not restricted to perception through the physical eye.

Strategies of inquiry and reflection put paradigms of interpretation into motion. It helped in connecting specific methods of collecting and analysing empirical
materials. The intention was to ensure that the required data was obtained by means of structured interviews. Kerlinger (1992) states that surveys are appropriate for gathering data regarding opinions and attitudes on the other hand, and behaviour on the other. According to Shiffman and Kanuk (1994) the survey is an accepted method of measuring both attitudes and perceptions.

Those who were approached reserved the right to engage in an interview. Employees were assured anonymity, and confidentiality; it was their decision whether to get counselling and be tested or not and therefore be assigned to one of three groups:

- The motivated enough to go for HIV testing;
- The ones who did not want to go for HIV testing;
- Those indifferent towards HIV testing.

Face-to-face method and random digit dialling were used. Face-to-face method involved going to the interviewee’s place and obtaining responses to the survey by conducting personal interviews. This was partly due to time constraints; second language issues and because the mail method has the disadvantages of most sent questionnaires are never returned. This allowed for clearing up any ambiguities in the questions asked, and it was done after the response to the letter requesting assistance was delivered. It also affected the anonymity, although it was reiterated and stressed to all those who were interviewed that their identities would not be revealed without their permission, nor their responses be discussed with anyone. Confidentiality was guaranteed.

The random digit dialling, involved dialling telephone numbers composed through random process, using the organisation’s internal directory. This was done through the computer and permission from Human Resources (HR.) was sourced. The telephone numbers were dialled through a random process (Christensen, 2001).
Once individual employees who have indicated their interest in testing have been identified, they were assigned to one of the two groups. Questions regarding the operational zed VCT approach were asked. Thereafter a correlation study, to find out as to whether the VCT approach did influence employee motivation for voluntary testing was done.

The study seeks to describe the degree of the relationship existing between the two measured variables, i.e. the operational zed VCT approach (the independent variable) and employee motivation to go for testing or not to test for HIV (the dependent variable). These variables are observed to establish the extent to which they co-vary (Christensen, 2001 & Theron 2001).

This research approach was however plagued by a number of difficulties, therefore limitations and weaknesses were taken into account when results were being interpreted. The limitations included sampling error, time required and constraints in the length of the survey, and with the correlation study, the fallacy of assuming causation from correlation (Christensen, 2001).

7. SAMPLING

The population was randomly selected. Kerlinger (1992) specifies that 20 respondents per questionnaire item can be sufficient. The assumption is that the questionnaire will highlight trends, themes and issues that have emerged from recent literature on the relationship between voluntary counseling, testing, attitude and behavior and HIV/AIDS management in the work place.

According to Leedy (1989) the sample should be so carefully chosen that through it the researcher is able to see all the characteristics of the total population in the same relationship that he would see them were the totality of the population to be inspected.

As the survey was optional, each employee in the sample of \( n = 250 \) had the same probability of participating in the survey. All responses were gathered within a period of three weeks.
8. DATA COLLECTION

The proposal and notification to respondents was telephonically done using the internal directory and the mail method was used to send the questionnaire. The survey questionnaires were mailed directly to employees who were randomly selected at various head office divisions, asking them to return the completed questionnaires in envelopes provided by researcher.

The respondents were given the assurance of the survey being voluntary, anonymous and confidential. All aspects of what would be entailed in the questionnaire were earlier well explained in a letter that was sent to 350 possible participants, with 250 responding positively. It became clear during the process that it would be difficult as at least twenty percent (+/- 20%) of respondents did not understand English and wanted their questionnaire be interpreted or translated into their home language and this called for the researcher to arrange face-to-face interviews as translation would be costly, both financially and time wise.

The first survey question will try to ascertain how the approach “I Know! – the way to live” was perceived by respondents during the recent launch. There will be three groups assigned as follows:

- Those responding with a “yes” to being motivated enough to go for HIV testing;
- The ones who respond “no” to being motivated want to go for HIV testing;
- Those who were indifferent towards the campaign and HIV testing.

The second survey question was about preference, and it was as follows: “Would you have been willing to go for HIV testing voluntarily and receive both pre and post- counseling had it not been for the campaign? There will be three groups as follows:
Those who respond with a “YES” to willing to go voluntary for HIV testing before the campaign.

Those who respond with a “NO” to willing to go voluntary for HIV testing before the campaign;

Those who are indifferent to HIV testing

The third survey was done in a form of questionnaires; according to Christensen (2001) open-ended questions requires the respondents to come up with the answer the way they please; and the close-ended questions require the respondents to choose from a limited number of predetermined responses. Generally closed-ended questions are appropriate when the dimensions of a variable are known. In such an instance the alternative responses can be specified and the respondents can select among these alternatives. However the researcher used a number of survey questions in a form of attitude statements and completed the survey by using a Likert scale as already indicated.

The questions were coined to measure attitude and subjective norm and were presented as statements utilising the Likert scale format as described by Rosnow and Rosenthal (1996). The scale is named after Rensis Likert, who published a report describing its use (Likert 1932). Respondents were asked to select a response on a 5-point scale. A typical test item in a Likert scale is a statement, the respondents are asked to indicate their degree of agreement or disagreement with the statement. Traditionally a five-point scale is used, however many psychometrics advocate using a seven or nine point scale.

The reasons for using Likert scale was that the survey could only be done after the whole “I Know! –the way to live” campaign was completed, as well as the fact that those who took part in this would also volunteer to test for HIV, which guaranteed anonymity and confidentiality. If the survey questions were asked using open-ended or closed-ended questions, it would have meant that employees who tested had to first be identified in order to complete the questionnaire. This was impossible to do, as testing was done voluntarily and
anonymously, and such actions would have jeopardised confidentiality in any case.

Initially 350 Head Office employees who had attended “HIV/AIDS Awareness road shows” were requested to be in the survey and had shown interest, but only 250 responded to the letter sent requesting participation in the survey. Not all employees that completed the survey submitted themselves to be tested for HIV. In the chosen population however, there was a 90% testing take-up. Taking into account the high testing take-up, as well as the fact that about 95% Head Office employees learned about HIV/AIDS, during the compulsory HIV/AIDS awareness training and pre-test counselling sessions before and during the “I Know! –the way to live” intervention, the following deductions are made:

- The majority of respondents who completed the survey did not only understand about the VCT approach but also tested, and
- The small percentage who did not test but completed the survey, were exposed to “I Know! –the way to live” and received a ‘personal’ guide of ‘moving from HIV/AIDS readiness into action’

Therefore, the assumption is made that all respondents were able to form a learned and informed opinion of the VCT approach – “I Know! –the way to live”, irrespective of whether they tested or not. The employee’s response and opinion were thus considered as pivotal to providing an answer to the stated research problem.

During all interviews i.e. mailed and face-to-face survey, employees were asked two questions with three options based on the organisation’s HIV/AIDS campaign. Depending on the response, specific set of suggestive statements were stated which prompted: strongly disagree; disagree; indifferent; agree, and strongly agree, as was the fact with mailed questionnaire. The questionnaire was formulated and structured in terms of operational zed VCT approach as well as the other variables.
The most important consideration in terms of analysis of relationship between variables refers to determination of correlation coefficients (Aizen & Fishbein, 1980). Correlations between the mentioned factors in the research problem were investigated, including correlation between the type reflexive loops (how beliefs affect data selection).

For all questions in the survey a Likert scale was used. This is a type of psychometric response scale often used in questionnaires, and measures the extent to which a person agrees or disagrees with a question (Kirakowski, 2004). The Likert technique presents a set of attitude statements. Subjects were asked to express agreement or disagreement on a five-point scale.

The fact that Likert scales may be subject to distortion from several causes was taken into consideration. Respondents could avoid using extreme responses categories (central tendency bias); agree with statements as presented (acquiescence response bias); or try to portray themselves in a more favourable light (social desirability bias).

Each respondent was asked to choose each statement in the survey and indicate preference in terms of strongly agreement to strongly disagreement. For the questions under discussion respondents were requested to indicate the extent of their agreement and disagreement with a particular statement. The items were rated on a 1 to 5, strongly agree to strongly disagree response scale where:

1 = Strongly agree;
2 = Agree;
3 = Indifferent;
4 = Disagree;
5 = Strongly disagree

The Likert scales are often called summative scales, as each item may be analysed separately or item responses may be summed to create a score for a group of items. After completed questionnaires were collected, item
responses were summed to create a score for a group items, they were treated as interval data measuring variable in discussion; data from the scales were reduced to nominal level by combining all agree and disagree responses into two categories of “accept” and “reject”

9. RESULTS

For the questions under discussion, respondents were asked to indicate the extent of their agreement or disagreement with a particular statement as previously stated:

Questions 3-11 dealt with aspects of both motivation and logistics of HIV testing.

For the interpretation of the Likert scale results for Questions 3-11, the answers of the three groups mentioned in Questions 1 and 2 of the survey will be used, i.e.

• Those who were motivated by the “I Know!–the way to live” campaign (Group 1);
• Those who were not motivated by the “I Know!–the way to live” campaign (Group 2); and
• Those who feel indifferent towards the issue (Group 3).

The answers for Questions 3–11 in the survey will be examined and analysed by:

• comparing the mean responses of the three groups for each of the questions respectively;
• using analysis of statistical significance to determine significant results in responses of the three groups at a 5% significance level (p<0.05); and
• noting that in statistics a result is significant if it is unlikely to have occurred by chance, if in reality the independent variable has no effect, that is if a
presumed null hypothesis is true. A total of 200 responses were gathered during the three week period. Of these, 18 did not indicate their gender, but all questions were fully completed. The discussion of the demographics and results of the survey questions are summarised as follows:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age Interval</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25 -35</td>
<td>35 - 45</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>Male</td>
<td>26</td>
<td>85</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Grand Total</td>
<td>48</td>
<td>120</td>
</tr>
</tbody>
</table>

This indicates that there were more Males than Females involved in the survey. There is about 64% male of the sample size. The remaining 36% constitutes 27% females and 9% people who did not indicate their gender.
This graph above shows respondents in terms of age and gender, what is depicted here is that there were more respondents in the age group of 35-45, followed by ages 25-35, and less 45-55 years.

The table below shows the respondents’ response to question 1 and 2

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Indifferent</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the “I know – the way to live” campaign motivate you to go for HIV test?</td>
<td>158</td>
<td>32</td>
<td>10</td>
<td>200</td>
</tr>
<tr>
<td>2. Would you have been willing to go for VCT before the campaign?</td>
<td>12</td>
<td>178</td>
<td>10</td>
<td>200</td>
</tr>
</tbody>
</table>

These pie charts describe the perceived success rate of the “I know the way to live” campaign.

The pie charts above show that the largest percentage of respondents were motivated by the “I know!–the way to live,” campaign. 79% (seventy nine) of the respondents say that the campaign did motivate them to go for VCT. Further more there is 89% (eighty nine) of respondents who say they would not go for VCT, if there had been no “I know the way to live” campaign.
From contingency table above, perhaps there is a need to know whether the employees’ responses depend upon age group or gender. This is addressed by asking question 1 as in the questionnaire:

“Did the ‘I know – the way to live’ campaign motivate you to go for HIV testing?”

The following contingency tables were then constructed on the basis of employees’ responses, and gender and age were identified.

From the table below, a test at the 5% level significance, whether there is an association between gender, age and employees responses to go for HIV testing was done:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Response of Employees Motivated to go for VCT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>43</td>
</tr>
<tr>
<td>Male</td>
<td>115</td>
</tr>
<tr>
<td>Grand Total</td>
<td>158</td>
</tr>
</tbody>
</table>

This was done in the following steps:

A

Step 1
Formulation of null and alternative hypothesis;
\( H_0 \): There is no association between gender and responses of respondents motivated to go for HIV testing voluntarily.
\( H_1 \): There is an association between gender and responses of respondents motivated to go for HIV testing voluntarily.

Step 2
Degree of freedom: \((r-1)(c-1)= 2\). From the Chi – square table, with level of significant be 0.05 and degree of freedom equal to 2, the critical (or cut-off) chi – square limit is 5.991
Step 3
Computation of the appropriate sample statistics (Chi – Square). The observed frequency table is given as:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Response of Employees Motivated to go for VCT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>43</td>
</tr>
<tr>
<td>Male</td>
<td>115</td>
</tr>
<tr>
<td>Grand Total</td>
<td>158</td>
</tr>
</tbody>
</table>

The expected frequency table is computed to be:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Response of Employees Motivated to go for VCT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>42.66</td>
</tr>
<tr>
<td>Male</td>
<td>115.34</td>
</tr>
<tr>
<td>Grand Total</td>
<td>158</td>
</tr>
</tbody>
</table>

Computationally the chi – square statistics is found as follows

<table>
<thead>
<tr>
<th></th>
<th>fo</th>
<th>fc</th>
<th>(fo-fc)^2</th>
<th>(fo-fc)^2/fc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>43</td>
<td>42.66</td>
<td>0.1156</td>
<td>0.002709798</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>8.64</td>
<td>0.4096</td>
<td>0.047407407</td>
</tr>
<tr>
<td>Indifferent</td>
<td>3</td>
<td>2.7</td>
<td>0.09</td>
<td>0.033333333</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>115</td>
<td>115.34</td>
<td>0.1156</td>
<td>0.001002254</td>
</tr>
<tr>
<td>No</td>
<td>24</td>
<td>23.36</td>
<td>0.4096</td>
<td>0.017534247</td>
</tr>
<tr>
<td>Indifferent</td>
<td>7</td>
<td>7.3</td>
<td>0.09</td>
<td>0.012328767</td>
</tr>
</tbody>
</table>

\[ \text{Chi - Square} = 0.11 \]

Step 4
The comparison of the sample statistics to the area of acceptance, the chi – square sample statistics is 0.11 and lies within the area of acceptance 5.991. The conclusion is to accept \text{Ho} at the level of significance, and conclude that the level of responses of gender is not dependent on campaign motivations.
Therefore since there is no association between gender and campaign
motivation, the common motivational strategy campaign for the employees to
go for VCT can be adopted.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Response of Employees Motivated to go for VCT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>25 -35</td>
<td>28</td>
</tr>
<tr>
<td>35 - 45</td>
<td>115</td>
</tr>
<tr>
<td>45 - 55</td>
<td>15</td>
</tr>
<tr>
<td>Grand Total</td>
<td>158</td>
</tr>
</tbody>
</table>

The above table is an attempt to test at the 5% level of significance,
whether there is an association between age groups and responses of
employees’ motivation to go for VCT.

Step 1
Formulation of null and alternative hypothesis;

**Ho**: There is no association between age group and responses of
employees’ motivation to go for VCT.

**H1**: There is an association between age group and responses of
employees’ motivation to go for VCT.

Step 2
Degree of Freedom: \((r-1)(c-1)=4\). From the chi – square table, with level
of significant be 0.05 and degree of freedom equal to 4, the critical (or cut-
off) chi – square limit is 9.488

Step 3
Computation of the appropriate sample statistics (chi – square). The
observed frequency table is given as:
### Response of Employees Motivated to go for VCT

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Yes</th>
<th>No</th>
<th>Indifferent</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 - 35</td>
<td>28</td>
<td>17</td>
<td>3</td>
<td>48</td>
</tr>
<tr>
<td>35 - 45</td>
<td>115</td>
<td>2</td>
<td>3</td>
<td>120</td>
</tr>
<tr>
<td>45 - 55</td>
<td>15</td>
<td>13</td>
<td>4</td>
<td>32</td>
</tr>
<tr>
<td>Grand Total</td>
<td>158</td>
<td>32</td>
<td>10</td>
<td>200</td>
</tr>
</tbody>
</table>

The expected frequency table is computed to be:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Yes</th>
<th>No</th>
<th>Indifferent</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 - 35</td>
<td>37.92</td>
<td>7.68</td>
<td>2.4</td>
<td>48</td>
</tr>
<tr>
<td>35 - 45</td>
<td>94.8</td>
<td>19.2</td>
<td>6</td>
<td>120</td>
</tr>
<tr>
<td>45 - 55</td>
<td>25.28</td>
<td>5.12</td>
<td>1.6</td>
<td>32</td>
</tr>
<tr>
<td>Grand Total</td>
<td>158</td>
<td>32</td>
<td>10</td>
<td>200</td>
</tr>
</tbody>
</table>

Computationally the chi – square statistics is found as follows:

<table>
<thead>
<tr>
<th></th>
<th>fo</th>
<th>fc</th>
<th>(fo -fc)^2</th>
<th>(fo -fc)^2/fc</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 - 35</td>
<td>Yes</td>
<td>28</td>
<td>37.92</td>
<td>98.4064</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>17</td>
<td>7.68</td>
<td>86.8624</td>
</tr>
<tr>
<td></td>
<td>Indifferent</td>
<td>3</td>
<td>2.4</td>
<td>0.36</td>
</tr>
<tr>
<td>35 - 45</td>
<td>Yes</td>
<td>115</td>
<td>94.8</td>
<td>408.04</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2</td>
<td>19.2</td>
<td>295.84</td>
</tr>
<tr>
<td></td>
<td>Indifferent</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>45 - 55</td>
<td>Yes</td>
<td>15</td>
<td>25.28</td>
<td>105.6784</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>13</td>
<td>5.12</td>
<td>62.0944</td>
</tr>
<tr>
<td></td>
<td>Indifferent</td>
<td>4</td>
<td>1.6</td>
<td>5.76</td>
</tr>
</tbody>
</table>

Chi - Square = 55.18

**Step 4**

The comparison of the sample statistics to the area of acceptance, the chi – square sample statistics is 55.18 lies outside the area of acceptance 9.488
Conclusion
Reject Ho at the level of significance, and conclude that the employees’ response is dependent on the age group.

Interpretation
Since there is association between age group and campaign motivation the “I know! – The way to live” campaign must be intensified and taken to all levels as a motivational tool for all employees to go for VCT.

Question 2: “Would you have been willing to go for VCT for HIV before the campaign?”

The following contingency tables were constructed on the basis of the employees’ responses and identified gender and age:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Yes</th>
<th>No</th>
<th>Indifferent</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>43</td>
<td>8</td>
<td>3</td>
<td>54</td>
</tr>
<tr>
<td>Male</td>
<td>135</td>
<td>4</td>
<td>7</td>
<td>146</td>
</tr>
<tr>
<td>Grand Total</td>
<td>178</td>
<td>12</td>
<td>10</td>
<td>200</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Yes</th>
<th>No</th>
<th>Indifferent</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 -35</td>
<td>38</td>
<td>7</td>
<td>3</td>
<td>48</td>
</tr>
<tr>
<td>35 - 45</td>
<td>115</td>
<td>2</td>
<td>3</td>
<td>120</td>
</tr>
<tr>
<td>45 - 55</td>
<td>25</td>
<td>3</td>
<td>4</td>
<td>32</td>
</tr>
<tr>
<td>Grand Total</td>
<td>178</td>
<td>12</td>
<td>10</td>
<td>200</td>
</tr>
</tbody>
</table>

The same procedure as in question 1, was followed and a conclusion yielded was that respondent – employees would have not gone for HIV tests had the
campaign not been introduced. Therefore respondents - employees were motivated by the campaign to go for HIV testing and start a new way to live.

**DISCUSSION ON LIKERT SCALE SURVEY – QUESTIONS 3-7**

Questions 3-7: These had their focus on the campaign itself, and with the general procedures and practices of the organisation regarding wellness and HIV/AIDS. The general calculations of these questions on the basis of: Strongly agree; agree; indifferent; disagree and strongly disagree, with the grand total of a thousand (1000) are as follows:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Indifferent</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>613</td>
<td>315</td>
<td>33</td>
<td>25</td>
<td>14</td>
</tr>
</tbody>
</table>

The above graph shows that about 61% of respondents strongly agree, understand and are supportive of the general procedures, policies and practices of the organisation regarding wellness and HIV/AIDS.

**DISCUSSION OF THE LIKERT SCALE SURVEY QUESTIONS 8-11**

Questions 8-11: These had their focus on personal decisions and personal responsibility and accountability. The calculations were also done generally per question and individual response, on the basis of strongly agree; agree; indifferent; disagree and strongly disagree with a grand total of eight hundred (800) as follows:
From the above graph, it can be deduced that about 58% of respondents, strongly agree to take personal authority’, responsibility and accountability of their well being. In general, percentages of responses, that agree on the issue of personal authority, responsibility and accountability is about 86%.

This can be taken to mean, therefore that many employees acknowledge that personal responsibility and accountability is a perennial challenge in health interventions.

RESULTS SUMMARY OF LIKERT SCALE SURVEY QUESTIONS

In summary, two trends have been identified:

- In all the questions, when comparing the average responses of the three groups, Group 1 had the highest average, Group 2 the lowest and Group 3 fell somewhere in between if at times not lower than group 2.

- In Question 1, Question 2, there was a statistically significant difference (p<0.05) between the averages of Group 1 on the one hand and Group 2
Group 3 on the other hand, with no significant difference detected between the mean responses for Group 2 and Group 3.

10. RECOMMENDATION

The main finding of this study is that the “I know!- the way to live” campaign did influence the employees’ motivation to go for VCT for HIV/AIDS. It also became apparent that this was a campaign, which needs to be a continual exercise. The disease will continue to pose the challenges of uncertainty and inertia to every one until the bank can demonstrate strong leadership and have sensible plans that address the risks as understood now, but remain manoeuvrable and agile in responding to changes both internally and externally. It is therefore the researcher’s recommendation that:

- The organisation should consider this approach as a beginning of a journey not a destination. It should be a starter not the main course;

- It has been accepted as logical to acquaint oneself with what is seen as influential to the spread and/or prevention of HIV/AIDS; but what makes other concerned people to have sleepless nights around HIV/AIDS, is not just that some people act as if HIV does not exist, or that it can affect some not others. It is that the “democratic government” is taking time to be seen to be serious about HIV/AIDS; it is not what seems to be ‘business as usual’ in the middle of this crisis, and the vulnerability of the nation.

- Societal vulnerability stems from the confluence of social-cultural, economic, political factors and realities that compound individual risk by limiting her/his choice and options for risk reduction. These are further compounded by lack of effective responses from the government and workplaces. Recent research by Bracks and van Wyk (2004) shows that few organisations have taken steps to protect their employees against further impacts of HIV, by implementing appropriate policies and
procedures, whereas some tend to ignore this. The other issue shown is the relaxation shown by the unions. The tenacity, loudness and vigour with which they fought against racial discrimination and its effects, is not witnessed on HIV/AIDS which some equate its deadly effects to those of Apartheid.

- There should be a continuous program established that devotes specific attention to the psychological, emotional and social wellbeing of all employees. Its aim should be to assist all employees who are experiencing HIV/AIDS related problems.

- Major studies completed in Tanzania and Uganda suggest that treating STDs reduces the rate of new HIV infections and should be especially targeted at the youth and all levels. Latex condoms provide a mechanical barrier to HIV and other STDs. When used consistently and correctly, they remain one of the cheapest and most effective ways to prevent the sexual transmission of HIV. Although not 100% reliable, one meta-analysis of 12 HIV seroconversion studies suggest condoms to be 90 to 95% effective in protecting against HIV when used consistently. In addition to spreading this message, effective prevention programs and constant counselling must also address other aspects of condom use, such as correct use, reduction of embarrassment, negotiation with sexual partner, and physical or practical dislike of condoms.

- The other message to be spread seriously is that of female condoms. Women are disproportionately affected by STDs and much research is being directed towards satisfying the unmet need for female-controlled methods of protection. The female condom is said to have various advantages over the male condom; “it is made of polyurethane which is more durable than latex; it protects the vulva as well as the vagina and cervix, and may be fitted well before intercourse” (Royce RA, et al. pg. 18).
• Establish and optimise the structure and functioning of the HIV/AIDS Steering Committee which will inter alia:

    • Support an expanded mandate to be able to oversee the organisation’s plan of response for both internal and external AIDS readiness;
    • Increase the budget of the committee for it to conduct technical work to develop the plan and to support its implementation at the SBU level;
    • Expand the constitution of the HIV/AIDS committee to enable co-option and participation by a wider range of relevant stakeholders;
    • Provide the committee with a leadership vision and endorsement from the Board placing the work of this committee as a standing agenda item that is prioritised and championed within the executive.

• Because there is little coordination in handling HIV/AIDS among business units within the bank, few initiatives that already exist to respond to HIV/AIDS seem ad-hoc, isolated and ineffective. There is need therefore for introducing serious backed procedures that will deal with individuals who test positive need to remain with the organisation and be guaranteed assistance.

• The Bank has an established employee HIV/AIDS program and interventions that are aimed at promoting the uptake on HIV testing, however there is still a significant number of those who appear very sick but still do not know their HIV status. The recommendation is that personal responsibility in HIV remains the most important factor influencing how individuals deal with and respond to their HIV status, whether negative or positive. This would promote personal action about HIV/AIDS for all people.
• Collate business intelligence that will be relevant to understanding and addressing HIV/AIDS risks and implement a coordinated Strategic Information plans.

• HIV/AIDS should be integrated into management information and reporting systems and ensure that there is knowledge transfer, skill development and principles of confidentiality are practised.

• Some managers have shown concern that by strengthening and “preaching” the HIV/AIDS gospel the bank could be perceived as “the AIDS Bank”. These should be addressed through an appropriate, coordinated marketing and communication strategies. It should also be made clear that of concern should be the risk that would be incurred should the bank not respond to HIV/AIDS appropriately.
REFERENCES


Landmark studies of STD control in rural Tanzania (Mwanza Study). The Foundation for Professional Development; in association with Southern African HIV Clinicians Society.


Dear Colleague,

Our CEO Steve Booysen is quoted a saying “Knowing our HIV status empowers us to make the right decisions to maintain a healthy lifestyle and a productive working life. “I want to believe that the “I know! – the way to live” approach was a way of empowering all of us in making informed and right decisions about our lives and how to live them.

I am therefore appealing to you for help all I need is a few minutes of your precious time in giving your candid honest opinion of the recent “I Know! The way to live” approach that focused on among other things, individual’s knowledge and understanding more about HIV/AIDS, VCT. I have a questionnaire which I am sending to you, without pressure. You have all the right to attend to this questionnaire and send the completed one back to me; or ignore it if you so feel. Let me reiterate that this is voluntary, confidential and anonymous.

As an enclosure with this letter, you will find a return stamped envelope in which you will insert and send your completed questionnaire.

Thank you for the courtesy of your assistance.

Yours truly,

Pontsho More
ANNEXURE: B

Motivation for HIV VCT Questionnaire

This questionnaire is aimed at gathering your thinking on the “I Know! - the way to live” campaign that was recently launched. It is for the Stellenbosch University study purposes. Please complete it, even if you did not participate in the campaign. Note that it is completely voluntary, confidential and anonymous.

Your co-operation is tremendously appreciated.

Please indicate below, both your gender and age group:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>25-35</td>
<td>35-45</td>
</tr>
<tr>
<td></td>
<td></td>
<td>45-55</td>
</tr>
</tbody>
</table>

Please place a tick in the column that more states how you feel:

<table>
<thead>
<tr>
<th>Please place a tick in the column that more states how you feel</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Indifferent</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Because the testing is voluntary and confidential more people will be motivated and willing to test for HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. As the “I know! – the way to live” campaign has motivated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
me to go for testing voluntarily, all others will be.

5. As the wellness clinic will be able to adhere to confidentiality we will submit to testing for HIV

6. Because of the “I Know! -the way to live” there is rife awareness of the organisation’s HIV/AIDS policies and procedures.

7. I believe that pre and post test counselling is essential and is well explained in the “I Know! – the way to live” campaign.

8. “I know! – the way to live” campaign is a personal guide for moving from HIV/AIDS readiness into action

9. I believe HIV/AIDS can be prevented if we all work together in knowing our status

10. I believe that today is the start of the rest of my life and I can choose to know the way to live

11. I believe treating HIV and preventing further spread of the virus is everybody’s responsibility.
ANNEXURE: C

**MEDICAL QUESTION** | **RESPONSE**
--- | ---
1. Medically what is HIV? | Human Immunodeficiency Virus (HIV) is the lentivirus sub-family of retrovirus comprising an RNA viral genome, a protein capsid and a lipid envelope.

2. How does one get HIV? | HIV can be transmitted horizontally:
- via sexual contact with someone who is infected;
- via infected body substances that come into contact with mucous membranes, non-intact skin or the bloodstream.
Vertically from mother to child.

3. How does one get tested for HIV? | Enzyme Linked Immunosorbent Assay (ELISA) this is the most widely used screening method for HIV detection; other serological tests are of Western blot. Tests are done with blood, saliva and urine. Diagnosis of HIV depends on well established clinical test backed by appropriate laboratory and efficient testing tools.

4. What is the window period? | **SEE TABLE BELOW**

5. Can HIV be transmitted if you already receiving HAART? | HIV can be transmitted by people already on HAART if not protected, although the risk is reduced by decreased viral concentration in the blood or other body fluids.

Table showing information on the estimated window period for different assays applied to HIV-1 diagnosis:

<table>
<thead>
<tr>
<th>ASSAY</th>
<th>Approximate time to positivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; generation ELISA’s (Lysate)</td>
<td>42 days</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; generation ELISA’s (sandwich)</td>
<td>23 days</td>
</tr>
</tbody>
</table>
recombinant and synthetic peptides)                  
P24 antigen assays                             16 days  
DNA PCR(virus integrated in PBMC nuclei)        16 days  
RNA PCR (RT-PCR for free virus; particles in plasma) 10 days

The figures in the table above are based on retrospective measurement and calculation and provide a guideline only. In some instances sero-conversion (development of antibodies to HIV -1) can be delayed and CDC still recommend 6 months follow-up antibody testing to exclude infection after exposure. Early information from the 4th generation ELISA’s (that now include the detection of p24 antigen as well as specific HIV-1 antibodies) suggests only a slight improvement (1-3 days) over the current 3rd generation tests despite the apparent advantage of p24 detection on its own. The terms lysate, recombinant and synthetic peptide are covered in the text. PBMC refers to peripheral blood mononuclear cell and RT-PCR to reverse transcription polymerase chain reaction. Data derived from Busch, MP et al. (1995) Transfusion 35:91-97

GENERAL SOCIAL CONTEXT QUESTIONS:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it proper to start educating children about HIV/AIDS in schools?</td>
<td>There is evidence that comprehensive age-appropriate sex education helps to reduce the risky behaviour among adolescents. Various studies commissioned by UNAIDS indicates that sexual health and HIV/AIDS education for children and young people can lead to among other things:</td>
</tr>
<tr>
<td></td>
<td>• later onset of sexual activity;</td>
</tr>
<tr>
<td></td>
<td>• lower unplanned teenage pregnancy rates</td>
</tr>
<tr>
<td></td>
<td>• lower teenage STD rates</td>
</tr>
<tr>
<td></td>
<td>• fewer sexual partners tried early</td>
</tr>
</tbody>
</table>
Prevention initiatives especially those packaged as part of life skills contribute in creating hope for the future and build respectful relationships among young people. It is proper to educate young, middle and old age.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can the bank force you to test for HIV without your consent?</td>
<td>No employer has the right to force anyone to test for HIV. UNAIDS encourages VCT. It is however an individual’s responsibility to want to test so as to live positively.</td>
</tr>
<tr>
<td>Which is better – being on a HAART program or receive disability grant?</td>
<td>It would be best to be on a treatment program so as to enjoy a better life, health and ability to continue being a fully functional member of your household and employment.</td>
</tr>
<tr>
<td>What is it about HIV/AIDS that makes it receive special attention over other diseases?</td>
<td>HIV/AIDS is the greatest threat to life, liberty and the pursuit to prosperity and happiness in many countries. Interventions must therefore be quantitatively and qualitatively commensurate with the magnitude of the threat posed by this disease. (De Cock et al. 2002:68)</td>
</tr>
</tbody>
</table>

Information on this table is collated from the workshop in HIV/AIDS Management organised by the Foundation for Professional Development in association with Southern African HIV Clinicians Society. (2004)