

**An exploratory study of the knowledge,
attitudes and sexual practices of Bulk Vehicle
Operators at a company in Gaborone,
Botswana**

by
Nandi Lindelwa Ngcongco

*Assignment presented in fulfilment of the requirements for the degree of
Master of Philosophy (HIV/AIDS Management) in the Faculty of
Economic and Management Sciences at Stellenbosch University*



Supervisor: Prof. JCD Augustyn

December 2014

DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

December 2014

Copyright © 2014 Stellenbosch University

All rights reserved

ABSTRACT

This study explores the state of transmission and prevention knowledge as well as attitudes on HIV and AIDS, among a group of specialist trained long distance truck drivers, known as bulk vehicle operators, at a company transporting dangerous goods in Gaborone, Botswana. It examines the prevalence of both condom use, condom use consistency, as well as the extent of sexual partner concurrency within this group, taking their demographic and socio-economic characteristics into consideration. This study found low barriers to condom use, high levels of reported current condom use, but lower consistency of condoms particularly with wives and regular partners and widespread practice of multiple sexual partners among this group. Over half of bulk vehicle operators perceived themselves as being exposed to sexual temptation outside their usual unions and at risk of HIV infection because of the nature of their occupation. Conducted in the context of well-documented occupational vulnerabilities of distance truck drivers and organizational vulnerabilities of road freight companies to HIV and AIDS, the research considered the extent to which participants found the workplace non-discriminatory and accommodative to those living with HIV and AIDS. The study concludes by making recommendations on the ways company X's HIV/AIDS workplace programmes may be strengthened – which recommendations are based on the opinions and practices of the bulk vehicle employees, company X's most critical occupation.

OPSOMMING

Die doel van hierdie studie was 'n verkennende studie na die kennis, houdings en seksuele praktyke van 'n steekproef swaarvragmotorbestuurders by 'n vervoeronderneming in Gaborone, Botswana.

Die studie ondersoek die mate waartoe kondome gereeld deur die bestuurders gebruik word en wat hulle persepsie van die gebruik van kondome is. Aspekte soos meervuldige verhoudings en die invloed daarvan op die verspreiding van MIV/Vigs word onder die soeklig geplaas. Meer as die helfte van die vragmotorbestuurders het hulle as besonder blootgestel aan seksuele versoeking beskou en hulle het ook aangetoon dat hulle seksuele gedrag anders is as in 'n gewone verhouding.

Die gedrag van vragmotobestuurders as drywers van die pandemie word verder toegelig in die studie en aanbevelings word gemaak oor wyses waarop ondernemings in die swaarvragmotorbedryf kan meehelp om die pandemie in Botswana te beveg.

Hierdie is waarskynlik die eerste deeglike studie onder swaarvragmotorbestuurders en die resultate van hierdie studie behoort van groot waarde te wees vir die groter Suider-Afrikaanse swaarvragmotorindustrie.

ACKNOWLEDGEMENTS

I am truly thankful to the Bulk Vehicle Operators (BVOs) and all other staff at the Gaborone Depot of Company X who participated in this research study. *Kea leboga bo Rra, le kamoso.*

I am very thankful to the all the Management of company X who granted me permission to conduct this study at their company and were entirely supportive along the way.

I earnestly thank the academic and administrative staff at the Africa Centre for the Management of HIV/AIDS for conceptualizing and offering this vibrant and applied programme of study, and for all their support.

I owe a huge debt of gratitude to the Tetteh Family of 5424 Partial, Gaborone for sharing their home with me, their true enduring friendship and their unwavering support of my studies.

I am deeply grateful to Prof Johan C. D. Augustyn, for the riveting lectures that inspired this work in the first place, his ceaseless encouragement and guidance in shaping this thesis. Your palpable enthusiasm for your discipline ignited the interest that brought this work to life.

I am monumentally indebted to my Mother, Vuyelwa Ndiki Ngcongco (nee Tabata) for her relentless dedication to my educational growth, and in particular, for her stellar example of upright, dignified and fearless womanhood and parenthood. I dedicate this work to my Mother.

Ndiyabulela MaMpinga Senzwa Mawawa

Table of Contents

Chapter 1: Background and Introduction to the Study	1
Chapter 2: A Review of the Literature	4
2.1 The role of mobility in the spread of HIV	4
2.2 Transport corridors and long distance truck drivers: spatial and occupational vulnerability to HIV/AIDS	5
2.3 Alcohol and risk-taking behaviour	6
Relationship status and condom use	7
2.5 Education status	8
2.6 Duration away from home	8
Chapter 3: The Research Problem in the Context of Company X	10
3.1 Introduction to Company X -The Research Context	10
3.1.1 The Impact of HIV/AIDS on company X	15
3.1.2 The Impact of counter-productive workplace behavior – theft	18
3.1.3 Additional challenges faced by company X	21
3.2 The Research Problem	21
3.3 The Gap in our Knowledge	23
3.4 The Significance of Condoms and Condom usage	23
3.5 The Significance of Multiple concurrent partnerships	24
3.6 Statement of the Research Questions	26
3.7 Significance of the Study	27
3.8 The Study Aim	28
3.9 Specific Study Objectives	28
Chapter 4: Research Design: Data Collection and Methodology	30
4.1 Research Study Design	30
4.2 The Study Setting and Study Sample Selection/Exclusion criteria	33
4.3 Data Collection	34
4.4 Study Limitations	38
4.5 Ethical Issues	39
Chapter 5: Presentation, Analysis and Discussion of Study Findings	40
5.1 Demographic and Socio-economic characteristics of BVOs	40
5.1.1 Age distribution	40
5.1.2 Educational Attainment	40
5.1.3 Marital Status	42
5.2 General Knowledge of HIV and AIDS	42
5.3 Common Health-seeking Behaviours in addressing STIs	48
5.4 Attitudes of BVOs to Testing for HIV	50
5.5 Actual Condom Use and Consistency of Condom Use among BVOs	53
5.5.1. Current Condom Use	53
5.5.2. Condom Use Consistency across Different Contexts	55
5.5.3. BVOs Attitudes on the Use of Female condoms by Primary Partners	56
5.5.4. Attitudes and Perceptions indicating Barriers to Condom Use	59
5.6 Sexual Partner Concurrency among BVOs	62

5.6.1 Number of Sexual Partners at Any Given Time	63
5.6.2 Sexual Partners in the Last Year and in the Last Two Months	63
5.6.3 Marital Status and the Number of Sexual Partners	67
5.6.4 BVOs Perceptions on the Impact of Duration Away from Home on the Likelihood of Sexual Partner Concurrency	67
5.6.5 BVOs Self-Perception of the Likelihood of Sexual Temptation and the Risk of HIV Infection as a Risk or Hazard of their Occupation	69
5.7 BVOs Perceptions of the Ethos on Company X on HIV/AIDS, and Company X's Accommodation of Employees Living with HIV and AIDS	71
5.8 HIV and AIDS and Activities Desired by BVOs at the Gaborone Depot	77
Chapter 6: Study Conclusions and Recommendations for Company X	81
A. Summary and Conclusions	81
B. Recommendations for Company X HAW Programme activities	84
REFERENCES	89

List of Tables

Table 4.1: Summary of study objectives, questions asked, and analysis/presentation	33
Table 5.1: Age distribution of BVOs	37
Table 5.2: Education level completed of BVOs	38
Table 5.3: Marital status of BVOs	39
Table 5.4: General knowledge of HIV/AIDS	40
Table 5.5: Knowledge of HIV/AIDS transmission and prevention table	43
Table 5.6: Most common health-seeking responses in the event of STI-like symptoms	45
Table 5.7: BVOs Attitudes to HIV testing	47
Table 5.8: Reported reasons for non-use of condoms	51
Table 5.9: Cross-tabulation of BVOs sexual partners in the last year by age group	59
Table 5.10: Cross-tabulation of BVOs sexual partners in the last 2 months	61
Table 5.11: Number of sexual partners by BVOs marital status	62
Table 5.12: Trips that take me away from home for the longest time are where the likelihood of me having sex with someone other than my wife/regular partner is greater/higher	63
Table 5.13: BVOs self-perception of sexual temptation with others and exposure to HIV as an occupation-specific hazard	65
Table 5.14: Summary table showing BVOs perception of company X with regard to employees living with HIV and AIDS	70
Table 5.15: BVOs perception on whether there is a known person at company X's Gaborone depot any BVO can go to for general, family/relationship, bereavement and HIV/AIDS and other sexual health concerns	72
Table 5.16: BVOs opinions on whether there should be a person available and based at company X's Gaborone depot to assist in counselling BVOs general health, family/relationship issues, grief and depression and sexual health & HIV/AIDS concerns	73
Table 5.17: BVO's assessment of the adequacy of HIV/AIDS-related information, activities & personnel at company X's Gaborone depot	74

List of Figures

Fig 3.1: Complete work process of company X	11
Fig 4.1: An Organogram for company X showing key departments	29
Fig 5.1: If company could arrange for the complete confidential and anonymous HIV testing of all employees every 2 years by independent services it would be fine with me	49
Fig 5.2: BVOs reported condom use at most recent sexual experience	50
Fig 5.3: BVOs consistency of condom use	51
Fig 5.4: BVOs consistency of condom use with wife or regular	54
Fig 5.5: Perceived lack of condom use when having sex with regular partner	54
Fig 5.6: BVOs receptiveness to their wives and partners use of the female condom	55
Fig 5.7: Attitudes about condom and the loss of sensation during sex	56
Fig 5.8: BVOs attitudes with regard to the lack of sexual arousal and satisfaction when using a condom	56
Fig 5.9: Lack of sexual fulfillment from condomised sex	57
Fig 5.10: Wife or partner's dislike of condoms	57
Fig 5.11: Number of sexual partners at any given time	58
Fig 5.12: Distribution of the number of sexual partners BVOs have had in the last 2 months	61
Fig 5.13: Likelihood of having sex with someone other than wife or regular partner during trips with long waiting times	63
Fig 5.14: Self-perception of the risk of sexual temptation with people other than a wife or regular partner as an occupation-linked hazard risk	66
Fig 5.15: Self-perception of risk of HIV as an occupation-linked risk	66
Fig 5.16: BVOs perceptions of company X as company respecting confidentiality and privacy of employees living with HIV/AIDS	67
Fig 5.17: BVOs perception of company X as non-discriminatory towards employees living with HIV or AIDS	68
Fig 5.18: BVOs perception that company X accommodates employees suffering from HIV/AIDS-related illness or adjusting the effects of medication	69
Fig 5.19: BVOs perception of availability of workplace emotional and psychological support from some known person at the depot	70

Appendices

Appendix A: Individual Questionnaire for BVOs	89
Appendix B: Some Questions and Background information for Senior Management ('Institutional Interviews)	104

CHAPTER 1. BACKGROUND AND INTRODUCTION TO STUDY

The Southern African sub-continent has experienced some of the highest HIV prevalence rates globally, with Botswana for a time exhibiting the highest HIV prevalence rates in the World (Stoneburner, Korenromp, Lazenby, Tassie, Letebele, Motlapele, Granich, Boerma and Loe-Bereer, 2014), which stood at 35.8% in 2002, even though the highest number of persons infected with HIV were to be found in the Republic of South Africa (UNAIDS, 2002:4). From the time the first case of HIV was reported in Botswana around 1985, the rapid rise in infection within the population was attributed to the high mobility of the population internally between villages, towns and lands/cattle-post areas, facilitated by well-developed road and transport network, multiple sexual partnership concurrency as well as inter-generation sexual patterns are factors that have circulated the HI virus, from urban to rural areas, from older to younger groups and across socio-economic strata (Zaffiro, 1994:84 cited in Stegling, 2004:229). Thus the accelerated economic growth and particularly the infrastructure development Botswana achieved between independence in 1966 and the mid - 1980s, which enabled considerable demographic mobility thus became the ‘facilitator’ of the rapid transmission of the spread of the HI virus, with the North-east and east-central districts, particularly Francistown, Sowa and Selebi-Phikwe exhibiting the highest HIV prevalence rates geographically, while the most remote districts such as Ghanzi and Kgalagadi recording the lowest rates of HIV prevalence (Kandala, Campbell, Rakgoasi, Madi-Segwagwe and Fako, 2012) NACA (2003:17) in the first Botswana National Strategic Framework for HIV/AIDS 2003-2009, identified demographic mobility as one of the key determinants of the rapid spread of HIV. Consistent rises in HIV prevalence between 1985 and 2000 and the attendant rise in adult morbidity and mortality nationally saw Botswana’s life expectancy decline from 65 years in 1990 to less than 40 years in 2000-2005 (Ray and Sinha, 2011:3), the far-reaching consequences of which compelled government to respond by formulating a National HIV/AIDS Policy, and declaring HIV/AIDS a ‘national disaster’ as well as outlining the national response to the epidemic, through the National Strategic Frameworks of 2003-2009 and 2010-2016 which aimed to guide HIV infection rates and promote a multi-sectoral approach to responding to the monumental threat posed by this generalized epidemic (NACA, 2003 and NACA 2009 and FHI 360,2013:5:). Businesses too were not spared the devastating impacts of the epidemic. Farahani, Roumis, Mahal, Holmes, Moalosi, Molomo and Marlink (2013:414) observed the higher levels of absenteeism among working age adults with HIV-related illness than those without and the negative effect on their earnings. Rivello, Ster-ling, Shepard, Fantan and Makhema (2007) similarly noted that working males and

females were absent from work by 5.2 and 3.3 additional days respectively in the month before their workplace survey, compared to those without HIV-related illness. The major blow to businesses were in those occupations which were identified as ‘critical’ to the execution of the core business function of that particular enterprise – and this negative impact was amplified where such cadres had been trained at direct cost to the company. It therefore became clear that protection of most critical and essential posts must form the major thrust or target of workplace HIV/AIDS management or mitigation strategies (UNAIDS, 2002:37-39).

The early response with regard to monitoring progression of HIV through the population was through sentinel surveillance on pregnant women and new mothers through ante-natal clinics, and it is from such sentinel surveillance that the gravitas of the epidemic in Botswana became evident, and it is on the strength of such data that the pre-cursor to the national rollout, the PMTCT programme under which AZT was given to HIV positive mothers and their infants, was introduced (Stegling, 2004:235). The realization that wider population-based surveillance was required saw the introduction of the Botswana AIDS Impact Assessment Survey (BAIS I) carried out in 2002, this was followed by BAIS II in 2004 and BAIS III in 2008. At the present time BAIS IV, carried out in 2013 has released preliminary summarized findings. The BAIS series of population based surveys were beneficial in three crucial respects; firstly, in that they included aspects of HIV knowledge, HIV status, sexual and health-seeking behaviour and condom use information in relation women who were not in attendance at antenatal clinics and men and secondly, from BAIS II, a company or workplace schedule was included which made available empirically based data on private and public sector enterprises responses to the threat of HIV/AIDS. The BAIS surveys were especially insightful in revealing that some industrial categories were more intensely affected by HIV than others whilst the National Strategic Framework NSF I (2003 – 2009) identified among priority groups to be targeted with a “Minimum Implementation Package” (MIP) of interventions – “mobile populations” which it specified as ‘commercial sex workers’ and ‘truck drivers’, alongside the poor, mineworkers, orphans and people living with HIV/AIDS i.e. PLWHAs (NACA, 2003:33). The NSFs further specifically spelt out the role of the private sector in the national response to HIV as well as AIDS urging the ‘mainstreaming of HIV/AIDS’ into their activities and business models (NACA, 2009:33).

In January 2002, the Botswana government was among the first in Sub-Saharan Africa, to introduce a national roll-out of antiretroviral therapy (ART) to the wider citizen population,

under the “National ARV Programme” which saw all HIV positive persons with a CD4 count of less than 200 or exhibiting “AIDS-defining illness” being eligible for antiretroviral therapy at no cost (Stegling, 2004:236,238). A 2010 Modes of Transmission Study noted that PMTCT and ART coverage in the country were “among the highest in Sub-Saharan Africa” and further speculated on the strength of projections, that by 2015, total coverage of ART (100%) and 95% coverage of PMTCT will have been achieved (NACA, 2010: 30). Significant for business is that the national roll-out of HAART in a country foremost in terms of HIV prevalence, has relieved companies of the financial burden of provision of HIV treatment for employees and in this respect enabled them to achieve considerable savings with regard to treatment costs. The greatest benefit of the national roll-out has been to significantly reduce overall levels of HIV-related morbidity as well as avert HIV-related deaths in the general and working populations – which has benefitted businesses and their productivity (Stoneburner et al, 2014; Stover et al 2009 cited in NACA, 2010:32). However, these improvements have not removed the vulnerability of certain groups for whom the risk of infection remains higher than that of the general populace – ‘key populations’ or ‘most-at-risk populations’ (MARPS). This study has chosen to focus on one among this group, namely long-distance truck drivers with their workplace context.

CHAPTER 2. A REVIEW OF THE LITERATURE

This chapter demonstrates through a review of the literature that workplaces have been affected by the HIV/AIDS epidemic, and that some businesses are inherently more vulnerable than others. It is demonstrated that regardless of the reductions in AIDS-related deaths experienced through national roll-outs of antiretroviral therapy, truck drivers as an occupational group remain particularly susceptible to being infected with HIV, whilst the road freight sector remains vulnerable to threats to productivity, critical manpower through HIV and its impact. This review of key studies identifies the factors impacting on the risk of exposure to HIV, particularly with regard to the population of direct interest to this study, namely long distance truck-drivers.

2.1 The role of mobility

Epidemiological studies have highlighted the role of mobility, particularly truckers, migrant workers, traders and uniformed service persons in the distribution of HIV. Similarly a number of studies have demonstrated that long distance truck drivers have an elevated risk of sexually transmitted infections (STIs), and HIV infection, relative to the general population (The Synergy Project, n.d:27; The World Food Programme, 2009; International Organization for Migration, 2003, 2005 and 2008; Marck, 1999; Moon 2002; Onwuliri and Jolayemi, 2007; Chaturvedi, Singh, Khera, Joshi and Dhruvajyoti, 2006:153; Morris and Ferguson 2006:368 and UNDP, 2003). The Southern African Migration Project (SAMP, 2006:1) observed the link between the epidemiology of the Highest HIV prevalence and incidence in Sub-Saharan Africa (SSA) and the good transport infrastructure of the sub-region, relative to other regions in the African continent. Furthermore, an International Organization for Migration Assessment (IOM, 2012: 7) observes that most of the transport of goods between northern and southern countries, and across the sub-continent, is predominantly via road, entailing long waiting times - and it is along the stop-overs and border-posts and “hot spots”, at where alcohol and transactional sex are peddled, and this in large measure accounts for higher HIV prevalence often found along major transport corridors (IOM, 2012:7 - 8).

2.2 Transport corridors and long distance truck drivers: Spatial and occupational vulnerability to HIV/AIDS

Lengthy hours on road trips occasionally spanning several days during which they are separated from spouses and partners (Marcus 2000 ,cited in The Synergy Project, n.d: 24), expose them to loneliness and temptation, whilst dislocation from familiar environments where dominant societal norms are less binding on behaviour, and where bars, gambling and women are plentiful, provide a milieu in which the shedding of inhibitions is all too easy (The Synergy Project, (n.d:22); International Organization for Migration, (2003:13); Sekadde-Kigonde, Nyonyintono, Sanghvi, Ojwang, Muthami, Bwayo, Omari, Sempebwa, and Thagana, (n.d:3) and International Organization for Migration (IOM, n.d.:6). Indeed higher rates of STIs and HIV prevalence have been found among populations resident along major transport corridors, with commercial sex workers along such corridors exhibiting especially high HIV prevalence (The Synergy Project, n.d:2 and Nyamuryekung et al 1997 cited in The Synergy Project, n.d:34).

Singh, Piramanayagam, Bayapa, Pallavi, Naggarjuna and Choudhary (2012:71) perceive truck drivers as a “bridge population” through which the HIV epidemic shifts from high risk groups of HIV concentration such as commercial sex workers (CSWs), intravenous drug users (IDUs) and men who have sex with men (MSM), into the general population, as truck drivers having sexual contact with these groups, transmit the infection to wives and usual partners on their return journeys. Studies have additionally shown that truck drivers often do not have time to get treatment for sexually transmitted infections (STIs) whilst on trips (The Synergy Project, n.d: 28 and IOM, 2005). The International Organization for Migration (IOM) Assessment identifies this as a particular challenge noting “the high mobility of migrant and mobile workers, especially in road transport, means that programs established to service more settled population are not easily accessible to migrant and mobile workers in terms of location and opening hours” (IOM, 2012:20 and ION, n.d:6). The Southern African Migration Project (SAMP) recommends that “itinerant or mobile populations such as truckers and traders, who either have no fixed home or spend most of their time away from home...require interventions that mirror their movements....” (SAMP, 2006:2). Lurie (cited in SAMP 2006:6) found from a longitudinal study sample of couples in Hlabisa district, in KwaZulu-Natal (KZN) that migrant men were two and a half times more likely to be infected with HIV than non- migrant men. Lurie similarly found that in 30% of discordant couples, it was the non-migratory woman who was infected with HIV rather than the migrant

man. Therefore migration and the separation of spouses did not only pose a risk of HIV infections for women, but also for migrant males who left spouses behind.

The International Organization for Migration (IOM) noted that “Demographic mobility and rapid urbanisation have been identified as one of the key underlying determinants of the rapid spread of the HIV epidemic in Botswana. The country has one of the highest HIV prevalence rates in the world...” (IOM, n.d:3). In addition, the Botswana National HIV/AIDS Strategic Framework (NSF) identified truck drivers, alongside mine workers and commercial sex workers (CSWs) as being among the ‘vulnerable’ population groups (IOM, n.d:4). Without a doubt, the road-freight sector, as well as the occupation of truck driver, face heightened vulnerability in terms of sexually transmitted infections (STIs), HIV and AIDS. The International Organization for Migration (IOM, 2008) refer to this as “**organizational vulnerability**” of road freight companies and for this reason, Hsu (2001) makes the case for a ‘**sectoral approach**’ to HIV/AIDS policy and programming premised on an appreciation of the sector’s defining features and characteristics (Hsu, 2001).

2.3. Alcohol and Risk-taking Behaviour:

The International Organization for Migration (IOM, 2012) has identified “Sector-specific vulnerabilities” as being poor living conditions; long delays at border posts, weigh-bridges and ports; duration at ‘hot spots’; hazardous conditions at work: lengthy spells of absence from one’s home; tedium and solitude; restricted access to health services and care; supply of commercial sex workers (CSWs); heavy drinking; sex across generations; a lack of company wellness policy and programmes especially among smaller companies (IOM 2012:10 – 12 and ILOAIDS, 2012:10). Chaturvedi et al (2006:155) in a study of 283 long distance truck drivers on a highway in Pune District, Maharashtra, India found that; (i) a higher proportion of TDs who consumed alcohol gave a history of exposure to CSWs (68.2%), as opposed to 44.2% of TDs who did not imbibe alcohol (ibid, 155) and this difference was highly significant. Consequently the study noted; “those who consumed alcohol were 2.71 times more likely to visit a commercial sex worker than those who did not” (Chaturvedi et al., 2006:156). These studies therefore cite alcohol consumption, and sometimes drug use, among truck drivers as important predictors of risk-taking behaviour.

2.4. Relationship Status and Condom Use

Knauth, Keal and Pilecco (2010) studying sexual partnerships and condom usage among a sample of truck drivers in Southern Brazil concluded, “condom use falls significantly with a primary partner (wife or girlfriend) to 14%” – whereas the same study noted that the same respondents reported a 98.2% condom usage with ‘sex workers’ – however overall, only 68.8% of respondents used condoms, and of these only 36.5% used them ‘always’ (Kanuth et al.,2010). The International Labour Organization AIDS (ILOAIDS) Assessment of 2012 suggests that Condom usage within marriage and other stable relationships such as cohabitation, is not seen as a ‘sensitive’ indicator of ‘condom use’ – rather deemed a “non-risk” behaviour in ideal conditions (ILOAIDS, 2012:40). These findings reveal that simply asking about ‘condom use’ in binary form (yes/no) is not sufficiently sensitive to capture the complexity of this variable. Rather an approach which captures not just whether condoms are used but also the consistency of condom use (whether, ‘always’, ‘sometimes’ or ‘never’), as well as the relationship context of condom usage, is better captured through the use of likert scales.

A study of Paraguayan truck drivers found that “...those drivers ‘without stable partner’ had the highest proportion of occasional sex and with a greater number...than those who were married or living with a partner...” (ILOAIDS, 2012:42). The ILOAIDS Report (2012) observes that “a higher proportion (64%) of respondents that were not in stable relationships had engaged in transactional sex than those that were (34%), and the average number of sex workers with whom they had engaged in transactional sex was also higher” (ILOAIDS, 2012:46). Informal discussions with a few truck drivers and non-mobile depot workers revealed that some of these men preferred to pay a commercial sex worker (CSW) for sex than keep a steady girlfriend who expected to be supported materially, by a boyfriend. For some men who were not high earners and had family support obligations of their own, once-off payment for sexual encounters with CSWs were less financially burdensome and therefore preferable. Indications from a review of the relevant literature were that unattached truck drivers merited particular attention and STI/HIV prevention awareness. The ILOAIDS assessment similarly noted that the use of condoms was more prevalent in occasional sex involving money (almost 95%) than in occasional sex not involving money (83%)” ILOAIDS (2012:47). Ramjee (2000) made the observation that truckers additionally engaged in practices known to be particularly risky such as anal sex, for which 42% in her sample did not use condoms. Therefore wives and partners of TDs faced particular risks,

given the sexual behaviour of an appreciable proportion of their truck driver husbands and partners, in conjunction with the low condom usage within marital unions.

2.5. Educational Status

Level of educational attainment has been found to account for significant differentials in condom use among some communities of truck drivers. For instance, Sekadde-Kigonde et al., (n.d:7) found that higher educational status was associated with higher condom use. This same study found that 'ever use' of condoms was high whilst 'current use' was low (ibid:7) and that High knowledge on how HIV was contracted was not matched with appropriate behaviour. The gap between knowledge and practice persisted. According to Anieubue and Anieubue (2009:56), "use of condoms in the last episode of extramarital sex was significantly higher among drivers with secondary education or above, those who were single and the younger age group". Chaturverdi et al, in the aforementioned study among a sample of long distance truck drivers in District Pune, Maharashtra, India found that the truck driver's level of education "...was found to be significantly associated with condom use" when visiting a commercial sex worker (2006:155). These findings suggest that educational status is an important differentiator or even predictor of risk-taking behaviour among truck drivers.

2.6. Duration away from home

The length of time spent away from home emerges as another factor accounting for differences in sexual behaviour in the literature. Chaturvedi et al., (2006:155) found that TDs who stayed away from home for the longest days per month were more likely to have been exposed to commercial sex workers, which association was statistically significant. For instance in Chaturvedi's study sample, 21.6% of truck drivers who were absent from home for less than 10 days saw a CSW. The proportions seeing a CSW who were absent from home for 10-20 days and those staying away for more than 20 days, were 50.7% and 80.6% respectively. This association was also statistically significant (Chaturvedi, 2009:155). In contrast, Singh et al. 2012:74, found that "drivers who had been on the road for over 15 days in a month are less likely to be exposed to CSW as compared to drivers who were on the road for less than 15 days in a month" (Singh et al., 2012:74). Despite the somewhat contradictory findings, one nevertheless recognizes the importance of duration away from home' as a risk-factor for truck drivers. Jackson cited in The Synergy Project (n.d: 25) revealed from his analysis, that Kenyan males who were away from home for over two weeks in a month, "...had significantly more STIs than those who travelled less for work."

The foregoing account has highlighted key findings of relevant studies, and has indicated some of the variables which stand out as impacting on the vulnerability of long distance truck drivers to sexually transmitted infections (STIs) and HIV infection. In the chapter which follows, the unique nature of company X, in which the research study was undertaken is introduced, and the knowledge deficit to be addressed by this study is explained. The study aims, significance and specific objectives of the research are then outlined.

CHAPTER 3. THE RESEARCH PROBLEM IN THE CONTEXT OF COMPANY X

3.1. Introduction to Company X - The Research location

Company X in Gaborone, in which this study is located, has as its core business, the transportation of fuel, and more recently cement and lime. More recently company X had expanded its business operations to cover not just fuel and construction, but also agriculture and mining and articulated its mission loosely as *delivering the safest supply chain solutions innovatively, in partnership with its clients or customers*. For this company, the opportunities for growth came from the discovery of minerals and the establishment of mines, the growth of new settlements as well as commercial agriculture whilst the threats or constraints to business were identified as hijackings, accidents and spillages, both contracts and truck drivers lost through fuel theft as well as trips missed through illnesses of truck drivers (TB/Flu/ HIV and AIDS-related illnesses). Being a fuel, chemicals and agric-products logistics company, the transportation of these products from source to client/customer is fundamental and as such company X relied upon an ‘army’ of specialist-trained extra heavy duty drivers known as bulk vehicle operators (BVOs) to execute this core business.

As illustrated by the Figure 3.1 below, business is typically initiated through winning or securing an advertised tender for the supply of fuel or cement or lime or alternatively through a negotiated agreement or contract with a company, for a limited number of years or on an ‘ever green’ basis, although the latter arrangement was much less common now. After securing a contract, securing and servicing the requisite number of trucks or ‘fleeting up’ alongside training of BVOs and associated contract staff and route-risk assessments are carried out. This is followed by a second *planning* stage in which, having being notified of the specific product to be loaded/type of trucks required, the quantities and delivery schedule, Dispatch managers then briefed the BVOs, prior to their setting off to load empty trucks/tankers and return with the loaded product. Stage three (3) of company X’s work process as shown below, indeed illustrates that from the start of the *execution* of Company X’s operations to the delivery of product to customers, BVO’s are indispensable to this ‘critical path’ (UNAIDS, 2002:24 and 39). Interviews with management reveal that the operations department is the ‘nerve centre’ of the company, under which fall the ‘most critical post’ of bulk vehicle operators (BVOs) without whom the company is unable to conduct its fundamental business – namely the collection and delivery of fuel and other

materials sourced from depots, refineries, gantries and quarries in South Africa, and occasionally other countries, delivered to clients' stations and mines in around Botswana.

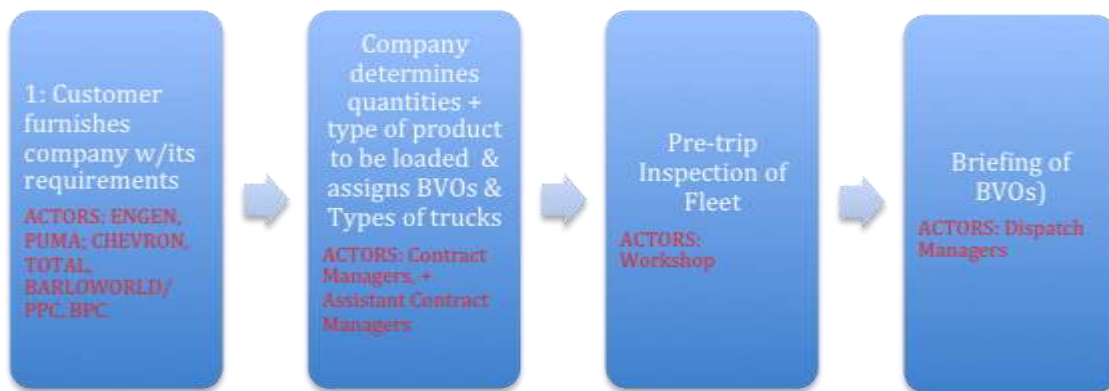
'Institutional interviews' with the company management cadre further revealed that there is a perpetual shortage of eligible bulk vehicle operators (BVOs), and that company X had had to be proactive in ensuring its critical manpower needs through establishing an in-house training academy and programme, without which, the company would not have been able to meet its own demand for BVOs. An interview with the Managing Director confirmed that recruitment and training was the second largest expenditure category, after the payment of salaries and in the year 2013, company X had spent approximately P4 million on the training of BVOs.

THE WORK PROCESS OF COMPANY X

I. THE INITIATION OF BUSINESS – STAGE 1



II. PLANNING STAGE – STAGE 2



III. EXECUTION OF OPERATIONS – STAGE 3



Figure 3.1: The Complete Work Process of Company X

Fundamentally, BVOs were Extra heavy duty truck drivers or code 14 drivers, additionally trained and experienced in the movement and handling of dangerous goods, remained a scarce skill in Botswana, which had required that company X be innovative in securing sufficient numbers of this adequately trained cadre. Thus this supply constraint of this ‘highly critical’ post was recognized as a vulnerability for the company.

Of particular concern to company X, was the recruitment of new, and as well as the retention of experienced bulk vehicle operators to ensure the desired ratio of BVOs per truck, and so ‘buffer’ the company against manpower shortages and shocks (Augustyn, 2012 b) and enable optimum ‘utilization’. In order to qualify for the post of bulk vehicle operator, the industry

required three years' experience as an inter-linked extra heavy duty truck driver and that drivers be aged 25 years and older, and that background checks with the police (trainee BVOs were not to have criminal records), as well as medical checks had been satisfied. Crucially, in addition, to the preceding requirements, trainee BVOs were to have successfully cleared the in-house theoretical and practical training, with specialist training in the handling of dangerous goods, over and above vehicle handling, mechanical and maintenance training. Consultations with one middle-level manager revealed that it was not uncommon for among 150 - 200 odd applicants for the position of trainee BVOs, to find that less than 30 actually met the criteria for employment, the remainder being ruled out by criminal records and having been taxi drivers, who were widely acknowledged to be among the most undisciplined drivers locally. Therefore, even without factoring-in the impact of HIV/AIDS, the supply-constraint with regard to BVOs was well-recognized by all management at company X.

The fleet-size of company X stood at 190 trucks, and the company calculated that it required 1.67 BVOs per vehicle, and therefore ideally 320 BVOs in total were sought for the current fleet, although at the time of interviewing, about 20 bulk vehicle operator vacancies had not yet been filled. Therefore, in all of company X's depots (Gaborone, Lobatse in the South, Palapye in Central District and Francistown in the North), there were a total of around 300 BVOs currently employed by this company. In fact, in all the years of company X's operating in Botswana since 1969, BVOs had only ever been laid off on two occasions – first in 1996, when eight (8) BVOs were laid off, and in 2008 when the company lost a contract in Selebi-Phikwe and laid off about 30 BVOs. However, this was not for long, in a few months, they were re-hired. Bulk vehicle operators were very much a 'scarce skill' in Botswana. In the words of the Managing Director "...we have not had much of a problem with recession, on the contrary, we have had growth, growth, growth..." The growth of the economy in general, the development of infrastructure, the growth in mining all led to the demand for fuel and cement, and hence the growth of opportunities for company X's niche – the transportation of fuel and chemicals, and consequently demand for BVOs. The Managing Director of company X further noted;

"We work around the notion of generating as much 'utilization' as possible...and the minimization of 'down time' due to breakdowns, loading and off-loading delays, minimizing the stalling of BVOs to create overtime...but workshop time we see as preventive maintenance....The average cost of a truck, that is parked, that should in fact be on the road is approximately P4,500-00t per day, per truck across all contracts in our industry...as a company, we expect P200,000-00 per vehicle per month, or we

won't make good on our returns...at the present time we have a fleet of about 190 trucks and around 300 BVOs across the country ”

This was the guiding principle that ensured that all trucks scheduled to be on the road, were indeed on the road. A parked truck due to illness or death of a BVO potentially costs the company heavily in profit and productivity terms. Shortages of BVOs had the effect of putting company X at risk of flouting labour laws, through exceeding the mandated hours to be worked per BVO per day where more intense working spans were then required to cover BVOs who were unavailable due to illness-related absence or dismissal. On average, BVOs worked between 60 hours per week and 90 hours per week. Company X's clients differed in terms of the number of hours they allowed BVOs to work, for instance *Total* permitted a 60 hour work week; *Chevron* a 72 hour work week while *Engen* allowed BVOs to work more hours per week than both these clients. It was acknowledged that some clients were stricter on safety needs than others. The majority of Company X's BVOs appeared to work a 72 hour week, although in times of pressure they could be called upon to do more than this.

The Human Resource Manager of company X conveys the criticality of the bulk vehicle operators to company X as follows;

“Our BVOs are the foot soldiers in the frontline, followed by the Dispatch Managers who schedule the vehicles and the BVOs...as with the BVOs we have to send our Dispatch workers for training... there are three (3) Dispatchers for every 20 vehicles....both the BVOs and then the Dispatchers are a scarce skill...”

Without the bulk vehicle operators (BVOs) to load, transport and deliver as well as off-load product to clients, conducting company X's core business was simply not possible. Similarly, Dispatch managers who scheduled trips, and assigned drivers were essential for the smooth execution of operations. This cadre often had to be trained outside the country at company X's own expense. Noteworthy, is that the establishment of an in-house training Botswana Training Academy (BOTA)-accredited academy to attempt to ensure the minimum supply of well-trained BVOs which supply almost 90% of company X BVOs, and the determination of the numbers of BVOs to be recruited in line with the desired driver-truck ratios across contracts so as to optimize utilization, all demonstrate company X's strategic approach, to the management of its critical human resources – which is entirely geared to enabling company X to achieve its mission and business goals (Noe, Hollenbeck, Gerhart and Wright, 2012:75).

3.1.2 The Impact of HIV/AIDS on company X:

In the absence of reports documenting the prevalence of HIV within company X, and mindful of the fact that pre and post-employment HIV testing were no longer permitted by law, and that company X's HIV/AIDS Policy disallowed this, interviews with various managers were relied upon to gain a view of the prevalence and impact of HIV on company X over the years. These institutional interviews revealed that indeed, company X had been adversely affected by the HIV/AIDS epidemic in the previous years.

The Managing Director (MD) divulged;

“...in 1990, of 50 BVOs employed by our company, five were HIV positive...in 1992, of 50 BVOs employed, 17 were HIV positive...In 1994/5, 50% of our truck drivers (BVOs) were HIV positive, and thereafter we stopped testing them for HIV...In 2004 in our Francistown depot alone, 80% of BVOs were HIV positive...of the first five who tested positive in the early days, the last of the HIV positive drivers died a few years ago...he had been managing his condition...my observation is that we lose more of the lower paid guys around the depot and workshop than we do BVOs...the BVOs are with themselves most of the time so chances of catching flus and coughs from more crowded environments is much less....”

Commenting in a similar vein about the impact of HIV on company X, another Manager remarked “...in the past, we have had men who have been so weak, they have literally fallen out of their trucks and had to be carried off....”

Another company X Manager put it thus;

“Before we were educated about HIV/AIDS as Managers...we had problems, people were dying because they did not want to disclose their status...drivers would take several months off on leave because they were just not recovering...nowadays, with regular testing, drivers know their status early and get on medication early....So the question as to whether HIV is really affecting our company...nowadays, the answer is No...not directly, anyway...but HIV is a problem generally, in the families of our BVOs....so we are prone to the indirect effect of worried, preoccupied drivers on the wheel...safety....Actually, high blood pressure, level 2 Diabetes and their effect on the health and concentration of a driver pulling 40,000 litres of diesel on public roads is a safety concern for us...I have had 4 or so men come into my office to disclose their status, but I have to treat it as a secret which I cannot disclose...I send them for counselling...it's not long before you see the changes in those diagnosed with HIV, their appearance changes...they start looking better, they eat well, bring in their own packed lunches and monitor their health, because they have been counselled professionally...”

This first-hand experience and observation of managers with long experience in the company amply demonstrates the impact that HIV and AIDS have had on company X over the years, particularly at the height of the HIV/AIDS epidemic, but that this impact has abated considerably. The impact of HIV and AIDS had led company X, led by its parent-company in South Africa, to introduce both an HIV/AIDS Workplace Policy as well as an HIV/AIDS Health and Safety workplace programme (CPSHEQ022 and CPSHEQ90-SHEQ). Also of

concern from a safety perspective was the impact of non-communicable diseases such as epilepsy, diabetes and hypertension on the fitness, sight and alertness of BVOs, and the effect of these for safety behind the wheel. However, at the present time, interviews with both the Managing Director and the SHEQ manager revealed that company X had not lost a BVO to HIV/AIDS in as many as five (5) years, the most recent death of a BVO being due to robbery and murder by criminals, which occurred in a company X truck at the Swartruggens truck stop in South Africa, in July 2012. Whilst there were known to be HIV-positive BVOs in company X's employ, despite occasional illness, none were known to have died from AIDS-related illness in the last five or six years at the Gaborone depot, despite the afore-mentioned susceptibility of truck drivers to HIV in the preceding review of the literature. Undoubtedly, the positive effects of the national roll-out of highly effective antiretroviral therapy (HAART) which commenced in 2002 in Botswana, in which all nationals with a CD4 count of 350 or less were eligible for free ARV treatment, have been reaped and observable even in company X (Stoneburger, Korenromp, Lazenby, Tassie, Letebele, Motlapele, Granich, Boerma and Loe-Beer, 2014). A *2010 Modes of Transmission Study* report notes that upscaling the population eligible for ARVs from 7.3% in December of 2003 to 82.3% in December of 2007 resulted in a significant decline in AIDS-related deaths among both children as well as adults (NACA, 2010:30). On the strength of a mathematical model, Stover et al., (2009 cited in NACA, 2010:32) estimated that between 2000 and 2007, Botswana's national roll-out of HAART averted some 53,000 deaths. Masha makes the point that projected deaths from HIV/AIDS related causes are significantly lower in scenarios "with intervention" than those scenarios "without intervention" (Masha, 2004:295). An additional explanation for the almost lack of deaths due to HIV/AIDS among BVOs at company X, may be due to the fact that seriously ill and incapacitated BVOs, having exhausted both their sick leave and other leave entitlement, were encouraged to collect what benefits were due to them and leave service. Therefore such persons were more likely to die 'at home' or no longer in the employ of company X. In high HIV prevalence areas, 'cost avoidance', alongside introduction of HIV/AIDS workplace programmes, has been part of many companies' response to the HIV/AIDS epidemic in Sub-Saharan Africa.

3.1.3. Impact of counter-productive workplace behaviour – product theft:

However it is important to note that at the present time, HIV/AIDS was not the leading cause of attrition of BVOs from company X's workforce – rather, counter-productive workplace behaviour (CWB) in the form of the theft of fuel, and consequent dismissal was now the leading cause. Typically, after off-loading their fuel consignment, or sometimes whilst still

on trips, some BVOs parked the trucks at an angle, collected remaining fuel in the tank or pipes, and clandestinely sold this, keeping the cash for themselves. Despite the company having myriad ways of detecting shortfalls including measuring devices installed in trucks, the practice has nevertheless persisted unabated spurring company X's management to be proactive and innovative in addressing this by introducing a uniquely culturally based *family-centred approach* aimed at curbing this practice. This involved summoning the BVOs registering such unexplained shortfalls, together with his family to a meeting at which his conduct was reprimanded and the BVO in question warned him of the consequences of continuing in his family's presence. Family members, spouses, siblings, parents – 'next of kin' would also have a chance to confront the BVO in question, and demand explanations. The Human Resources Manager noted that the problem had become so pervasive and recurrent, that on average company X lost almost one BVO each month because of fuel-theft related dismissal. He noted;

"...it's like flies and milk, it just keeps going on, we can't keep them away from it...they just keep on doing it, knowing the risks and the question is Why?"

He further noted;

"...we've gone from zero tolerance...to considering a 'tolerance strategy'...only taking action on losses beyond 200 litres...Inadvertently it's akin to saying '*do take fuel but Don't kill us*'...Remember, for every shortage we - company X - must make good the shortage (difference)...we have reached the point where we have to budget for this (theft) as a contingency loss...even with this, we still get shortages of 600 litres...800 litres and 1000 litres...so we would only say "Go!" to the guy at the top in terms of theft..."

Another manager noted;

"...they also have a tendency of stealing from the trucks own fuel supply, so we have put in anti-siphoning devices, but they have a way of breaking even these...they steal mainly because they want money for food...those who steal in bulk do it to have money to buy cars and phones..."

It was duly acknowledged that there were acceptable levels of 'shrinkage', provided seals had not been tampered with. However, where fuel-shortages were in excess of the 'tolerance zone' or limit, an investigation was instituted including tests to rule-out leaks; statements from the BVO in question were taken, and they also underwent a polygraph test. After tests, and in the absence of satisfactory explanation, a disciplinary hearing often followed. The disconcerting problem for management of company X were the widespread and persistent shortfalls between the quantities of product loaded at the gantry and the quantities delivered to the client, for which if a principle of absolute 'zero tolerance' were to be applied, the ensuing rate of dismissals would impact negatively on the company. The enduring question

was why some in this relatively well-paid cadre were prepared to risk well-paid jobs for a few illicit litres of fuel. The situation was a major source of angst for company X's management and posed an internal threat to the attainment of company X's mission and business objectives. Although the *family centred approach* to curbing fuel-theft had had partial success, it nevertheless reflects company X's innovative strategic attempts or strategic actions to devise a plan of action aimed at curbing the practice, protecting its contracts with clients and its profits. Such approach was certainly rooted in Setswana culture where deviant behaviour is addressed within the family and not just within strict formal law legal disciplinary terms. The latter were certainly invoked where the cultural approach failed. It is worth noting here, that this dual approach mirrored the legal dualism that has obtained in Botswana since Independence, where a customary system has survived alongside a formal legal system based on Roman-Dutch law. It must be further noted that this family centred approach, which was thought to be yielding some results a few years ago in the last year or two had waned considerably, due to more tense and confrontational relations between management and the BVOs after the truck drivers' affiliation to a new transport workers' union.

The institutional interviews with key management figures indicated in the company hierarchy shown below, further revealed that it cost between P14,000-00t to P15,000-00t to recruit and fully train a bulk vehicle operator from entry or 'trainee BVO' to fully fledged BVO status and that after salaries, recruitment and training were company X's single largest expenditure. Unlike mechanics and artisans who usually came trained and benefitted from some in-house training and induction, the recruitment and training of every BVO required considerable outlay for three to four months before real 'value' could be extracted from them.

The Human Resources Development Manager noted;

"Our BVOs require much more extensive and expensive training...our truck drivers (BVOs) are the ones who pay our salaries...without them we are nothing...I make sure that I always have people ready to take on the job..."

Therefore the loss of BVOs due to fuel theft dismissal represented a loss on investment, it destabilized driver-truck ratios and called for new recruitment and training, or augmenting manpower from another of company X's depots in the region. This problem was a constant human resource challenge to management and threat to BVO-truck ratios, much more so than HIV/AIDS, which was deemed as less of a threat to the company workforce. Product-theft

was also recognized as a threat to the retention/renewal of business contracts with clients/customers. The lesser threat of HIV/AIDS was attributed to the widespread availability of free treatment through the national roll-out of antiretroviral therapy in Botswana, from 2002 and the attendant reduction in HIV-related deaths over the years (NACA, 2010:30). The problem of fuel-theft and attendant dismissals, on the other hand, continued unabated and resulted in a higher loss of BVOs to company X than did HIV/AIDS. Such was the reality with regard to the relative severity of threats to critical manpower found on the ground at company X.

There was, however, widespread acknowledgement within the senior management of company X that organizational and occupational vulnerability to HIV/AIDS remained a reality for the road freight sector and long distance truck driver occupation, which included BVOs, one that the company could ill-afford to ignore. This recognition was clearly articulated in company X's HIV/AIDS Health and Safety workplace program (HAW) which primarily aimed to ensure all workers retained good health longer and particularly to mitigate the impact of HIV/AIDS on BVOs, given their centrality or 'criticality' to core business and the fact of their scarcity of supply (CPSHEQ90-SHEQ and UNAIDS, 2002). This HAW programme was combined with Safety training and run through the Safety Health Environmental Quality (SHEQ) department in conjunction with the training section, under Human Resources.

Of the two main 'people-centred' threats to company X's core business and productivity, dismissals due to inexplicable fuel-shortages (fuel theft) and HIV-related morbidity and mortality, this research study focussed entirely on the latter, and especially the ways in which such threats from STIs and HIV and AIDS could continue to be addressed and minimized through the company HIV/AIDS workplace programme.

3.1.4. Additional challenges

A looming threat for company X's workplace HIV/AIDS response was also the fact that in recent months, in some depots, it had become less easy to access condoms in the desired quantities, and at the desired intervals, as in the past. The Botswana Government and private sector companies which would make condoms available to highly vulnerable companies had slowed down greatly in distributing condoms. For company X, distribution of condoms has been the main workplace activity in terms of responding to HIV/AIDS, alongside promoting

awareness of HIV/AIDS. Whereas scores of millions were being spent nationally on making ARV **treatment** widely accessible to Botswana nationals, the supply of condoms, a cost-effective means of **prevention** had become less easily and widely available than before, in certain depots more than others. The *Modes of Transmission Study Report 2010* for Botswana, observed at the time, that national resources dedicated to fighting the HIV/AIDS epidemic were heavily skewed towards treatment and care, rather than stemming the tide of new infections – through prevention (NACA, 2010: 20), despite the Second Botswana National Strategic Framework for HIV and AIDS 2010-2016 (NACA, 2009) which lists “*Prevention of New Infections*” as the leading priority area (NACA, 2009:8). This was a source of great concern to management, particularly in the light of emerging highly virulent forms of sexually transmitted infections, such as antimicrobial resistant gonorrhoea, alongside the ongoing threat of HIV infection for this critical post of highly mobile men, separated from their wives and partners for up to half to three quarters of each month. This study proceeded cognisant of these challenges.

3.2. The Research Problem

Long distance truck drivers are often portrayed as an undifferentiated or homogenous category, and their sexual and social behaviour discussed in this same vein. For instance, The Synergy project, itself an amalgamation of numerous studies on the road freight sector and HIV, observes; “Numerous studies around the world have shown that truckers are reluctant to use condoms with their wives or girlfriends because then they would be admitting that they have sex with other people” (The Synergy Project, n.d: 29), whilst an IOM Report (2005:14) found inconsistent condom usage among truck drivers. At Company X, there are BVOs aged in their 20s, 30s, 40+, with varying levels of completed education and from different regions of Botswana. Onwuliri and Jolayemi (2007) observe that “Long-distance truck drivers in Africa, India and Thailand have been found to participate in highly active sexual cultures at roadside settlements and border crossings whose transient residents include poor, often young women from rural areas. Many of these truckers have multiple sexual partners, and they spread HIV widely through the rural by ways ” (Onwuliri and Jolayemi, 2007:315), which observation is similarly supported by USAID and T.MARC (2009). Reference is frequently made to the “*sexual culture* of truck drivers”, which phrase is underpinned by assumptions of homogeneity in sexual behaviour. However Marck (1999:92) noted that “sexual cultures were diverse” – with Nigerian truck drivers, frequently Muslims from the North, maintaining a ‘semi polygamous’ arrangement entailing support of about an average of 6.3 regular partners a year, in contrast to the Indian truck driver sexual culture which was characterised

by 12 – 24 commercial sexual partners, none of whom were visited regularly (Marck 1999:92). On the otherhand the same study observed that Zimbabwean truckers were predominantly married (95%) with no less than 55% of these keeping regular girlfriends, extra-maritally. Marck (1999) further highlighted the institutionalised practice of having extramarital girlfriends and liaisons for truck drivers in the Sub-Saharan African (SSA) setting. According to Marck (1999) in this context, there is hardly any motivation for partner reduction ; firstly, culturally, there is not a high premium set on marital fidelity in the Sub-Saharan African context and second, the services and comforts of home-cooked meals, a hot bath, companionship that the American truck driver would typically find at a Truck Stop, for the African trucker, these were often obtainable through a mutual understanding with a woman in a settlement along a transport route (Marck, 1999:96 and The Synergy Project, n.d:25).

Often an integral part of the working conditions of truck drivers included, inadequate bathing, toilet and sleeping facilities, over and above long hours of solitude behind the wheel. An International Organization for Migration study suggests that truck drivers often find themselves in the rooms and homes of commercial sex workers and bar girls along transport corridor settlements and stop-overs mainly to be able to have a decent meal, a bath and a rest, even in the times where sexual activity was not their original intention (IOM, 2005:9). These were just some of the forces fuelling the persistence of organizational and occupational HIV hazards of trucking in the African context, which have been identified by the studies reviewed in the afore-going section.

3.3. The gap in our knowledge

However not enough is known about perception of risk, as well as sexual behaviour or practices, among truck drivers, particularly among BVOs at Company X, Gaborone Botswana. No study was found on the condom use or sexual practices of long distance truck drivers in the Botswana context, despite their recognition as a vulnerable group in the Botswana National Strategic Framework NSF 2010-2016 (NACA 2009:32). Preliminary discussions with ‘informed insiders’ at company X suggest that truck drivers’ sexual behaviour is not uniform and differs according to personal characteristics. Understanding the spread of attitudes and behaviour around condom use and multiple sexual partners is especially important given the aforementioned occupational vulnerabilities of bulk vehicle

operators (BVOs), the specialist trained extra-heavy duty long distance drivers, the single largest occupation category ‘critical’ to the company X’s core business.

3.4. Condom Usage

Condoms are still, bar abstinence, the most effective means of preventing transmission of HIV as well as STIs (Chin, 2007), therefore (consistent and correct) use of condoms are important in preventing transmission. For this reason Botswana’s National AIDS Coordinating Agency (NACA, 2008) has identified up-scaling of condom usage as one of five core prevention interventions in the ‘**Minimum Prevention Package**’, the major strategy employed for achieving ‘Zero New Infections’ alongside the prompt diagnosis and treatment of both symptomatic and asymptomatic STIs (NACA, 2008:18-19). Morris and Ferguson (2006:370) in a study which used the AVERT Model of HIV prevention in Kenya and Uganda, found that a basic HIV prevention programme effort which “...assuming an HIV prevalence of 30 - 50% for sex workers and 15 – 25% for clients...increased condom use to 90 % would avert two thirds of new infections” in the space of a year along the Mombasa-Kampala trans-Africa highway. This study and its findings point to the mileage than can be derived from the implementation of targeted HIV prevention interventions in the context generalized HIV epidemics (Morris and Ferguson, 2006:370 and Anieubue and Anieube, 2009: 56). In a cross-sectional study of a sample of truckers in Surat City, India, Upadhyay, Pawar and Bansal (2010:21) confirmed the proclivity of long distance truck drivers to have multiple partners, and further revealed that 73.5% of their sample population reported not knowing that STIs were preventable (2010:21). This finding hints at the fatalism that is mentioned in studies by some authors (notably Marck 1999 and Onwuliri and Jolayemi 2007), where eventualities such as illness and death were seen as inevitable and beyond the individual’s control. Mindful of findings from these studies, this particular study also assessed bulk vehicle operators’ knowledge of STI and HIV transmission and prevention. This research study also looked at common health-seeking behaviour choices of BVOs at company X, in the event of STI-like symptoms.

Chaturvedi et al., (2006:155) observed that around 60% of truck drivers in his study sample who had visited commercial sex workers (CSWs) had never made use of a condom. In stark relief to Chaturvedi’s findings, Singh, Piramanayagam, Pallavi, Nagarjuna and Choudhary (2012:74) in a cross-sectional study of truckers on Lucknow highway, Uttar Pradesh, India, found much higher condom usage (of 83.9%) among truckers who visited commercial sex

workers (CSWs) some years later, indicating the rise in awareness of the importance of safe sex. Sekadde-Kigonde et al., (n.d:4) conclude that the dominance of heterosexual, rather than homosexual transmission in the African HIV epidemic necessitates that we focus on significantly up-scaling condom use, given their high effectiveness in preventing HIV transmission, which is second only to sexual abstinence. Condoms therefore remain a very important prevention technology because in addition to being a contraceptive, they are effective protection from STIs and HIV. Informed by these studies reviewed, a core part of this study sought to ascertain current condom use; consistency of condom use, and constraints to condom use among a sample of BVOs at the Gaborone depot of company X.

3.5. Multiple concurrent partnerships

Multiple concurrent partnerships (MCPs), are strongly associated with increased risk of HIV infection, and those in such relationships are deemed to be among the most-at-risk populations (MARPs). A USAID and T.MARC Study found 64% of the truckers stated that their most recent sexual encounter was with a casual sex encounter (2009:4). The behavioural dimension of sexual partner concurrency remains important in any behavioural study among truck drivers and was probed in this study. Epstein (2007) identifies partner reduction as an important HIV prevention strategy. The International Organization of Migration (IOM) has called for further research identifying the drivers of HIV in the transport sector, sexual partnerships concurrency and networks at border posts and transport corridors in the southern African SADC zone (IOM, 2012:6). The aforementioned USAID and T.MARC Study further observed (2009:7) that "...most truck drivers had established sexual relationships with partners at truck stops whom they consider as permanent/second wife.." In the truck drivers estimation, these 'second wives' were not perceived as sex workers, even as these 'second wives' clandestinely engaged in sex for cash and gifts/favours with other truckers passing through the same corridors.

Helen Epstein (2007) central thesis, in this regard, is noteworthy;

"If the network of concurrent relationships serves as a superhighway for HIV, partner reduction would be like a sledge-hammer, breaking up the highway into smaller networks and destroying the 'on-ramps'-the casual relationships that let HIV onto the superhighway in the first place" (Epstein, 2007:176).

Epstein laments that 'sexual partner reduction' has been a neglected strategy or intervention, dwarfed by the up-scaling of condom distribution and condom use in the fight against HIV

and AIDS, whereas in the African countries that first began to see reductions in HIV incidence, condom usage was already high, but it was not until significant ‘partner reduction’ spurred by “Zero Grazing” campaigns in Uganda, and even in gay communities in San Francisco occurred, that HIV infection rates fell (Epstein, 2007:177). She further observes that decline in HIV rates in the Southern African countries of Botswana, Lesotho and South Africa took longer than declines in Uganda and Zimbabwe despite the former southern states having considerably higher rates of condom use – the difference being the lack of any noticeable multiple partner reduction in these, compared to Uganda and Zimbabwe. According to Epstein, long-term sexual concurrency enmeshes a wide network of individuals in an interlinked web, in which their exposure to HIV infection is broadened and accelerated; in contrast to serial monogamy, which would ‘lock’ HIV infection within a pair or couple for all the years that relationship ensued, reducing widespread exposure (2007:57 – 85). Most studies suggest that there is greater consistency of condom use in commercial sex than in private encounters (WHO, 2005:8).

The consequences of sexual networks of partner concurrency are far-reaching. An additional danger of sexual concurrency was also the strong likelihood of a decline in consistency of condom usage with increasing intimacy and familiarity with each partner. Bryan, Fisher and Benziger (2000) in a study of HIV prevention among a sample of truck drivers in Chennai, India found that whilst 96% of married truck drivers in their sample reported having had sex with women other than their wives, and 74% with a commercial sex worker “only 2% reported *always* using condoms with non-marital partners...” (Bryan et al, 2000:758). USAID and T.MARC (2009:6) citing findings from a dipstick study of truck drivers and Risk behaviours at three truck stops in Tanzania observed the following; “90% of truck drivers said they used a condom when they had sex with a sex worker”, while just a quarter of truck drivers mentioned using a condom at last sexual intercourse with their spouse, and 92% admitted not using a condom “very often” with wives or cohabiting partners (USAID and T.MARC, 2009:6). However the aforementioned study of Bryan, Fisher and Benziger (2000) suggests that even with commercial sex workers, *consistency* of condom use was less than total. Sexual partnership concurrency, alongside low or sporadic condom use is therefore risky and potentially epidemiologically explosive in a hyper-endemic and generalized epidemic, such as that of Botswana and other countries in Southern Africa. In such a milieu, HIV infection risk maybe determined more by partner’s sexual behaviour than one’s own behaviour. Mindful of these findings and insights from the review of the literature, reported

sexual partner concurrency as well as attitudes about multiple partners among bulk vehicle operators were also investigated by this study.

3.6. Statement of the Research Questions:

Firstly, “What are the demographic and socio-economic characteristics of BVOs at company X’s Gaborone depot?”

Second, “What is the state of HIV/AIDs transmission and prevention knowledge and attitudes of BVOs at company X’s Gaborone Depot?”

Third, “What are the levels of condom use, condom use consistency and sexual partnership concurrency among BVOs at company X’s Gaborone depot?”

Fourth, “Do BVOs perceive company X to be a non-discriminatory workplace, empathetic to employees living with HIV/AIDS?”

Fifth, “Do BVOs at Company X perceive the current HIV/AIDS workplace interventions as being sufficient for their needs?” What kinds of HIV/AIDS activities would be desired by BVOs at company X ?

3.7. Significance of the Study

The National Strategic Framework (NSF) 2010 - 2016 for Botswana emphasizes multi-sectoral responses to the reality of HIV/AIDS, of which workplaces, particularly in the private sector, are an integral part of The Response (NACA 2009:). The First Botswana National Strategic Framework (2003 – 2009) singles out among others, mobile populations as a group meriting “priority response”, and recommends “...the segmentation of mobile populations for more appropriate targeting of interventions” (IOM, n.d:10). Among the broad categories for intervention cited as priority by the National Strategic Framework (cited in IOM, n,d:10) are truck driver recreational activities at truck stops, internal HIV programmes for trucking companies...etc” (IOM, n..d:10). The high road freight sector and truck driver occupation vulnerability *demand* that the road freight industry formulates viable and vibrant workplace HIV/AIDS programmes, which can be beneficial to both mobile, as well as non-mobile company staff in a supportive role to the critical role of BVOs, within

companies similar to company X. This study was therefore relevant and significant at the national, sector and company level.

The findings of the proposed research study are intended to be useful in guiding company X's efforts in addressing HIV/AIDS in the workplace and closely inform HIV/AIDS programme design specifically, to provide management with strategic information to facilitate the 'scaling-up' of existing activities and to plan for the introduction of new activities, particularly targeted interventions (Fisher and Foreit et al., 2002:2). It is hoped that as a consequence of this research, Company X will be better equipped to fine-tune its response to the threat of STIs, HIV and AIDS on its critical post, since such response will be directly informed by the data and opinions derived from a sample of its own BVOs. In this way, the company may be better equipped to respond to its employees' sexual health concerns and wellbeing and ultimately better placed to safeguard its productivity from the impact of HIV and AIDS related morbidity and mortality. The baseline data provided by this study may be a start towards furnishing those tasked with employee wellness, health and safety with much-needed baseline data which will reveal the 'state of play' or a snap-shot of BVOs attitudes, knowledge and practices pertaining to STIs and HIV/AIDS; in addition to revealing in a pooled and anonymous way, employees perceptions on the adequacy of HIV/AIDS activities available through the workplace, the interventions they would most wish to see introduced, and whether they feel the workplace has a 'climate' or 'ethos' which is accommodative of employees living with HIV/AIDS. The study findings may also have the impact of stimulating "social dialogue" between BVOs and management, possibly between company X and government, which the ILO under key principle Number Five, deems a prerequisite to effectively fighting HIV/AIDS (ILO Code of Practice, n.d.: www.ilo.org).

3.8. The Study Aim

Firstly, to identify the knowledge, attitudes and practices with regard to condom use and sexual partner concurrency of BVOs at company X in order to inform the formulation of targeted interventions in the company's HIV/AIDS programme.

Second, to provide those tasked with wellness, health and safety at company X, anonymous and unlinked baseline data capturing the 'status quo' with regard to BVOs self-assessment of risk, attitudes, knowledge and practices concerning STIs and HIV/AIDS, and to provide them with employee-informed suggestions and opinions on the nature and range of workplace interventions desired in this regard.

3.9. Specific Study Objectives:

1. To identify the demographic characteristics (ie. Age and marital status) of BVOs and non-mobile workers at company X
2. To identify the socio-economic characteristics (ie, education attainment) of BVOs at company X
3. To demonstrate the knowledge of STIs and HIV prevention that BVOs possess
4. To illustrate the common health seeking behaviours of BVO when faced with STI-like symptoms
5. To show BVOs attitudes to HIV Testing
6. To illustrate condom use among BVOs at company X
7. To illustrate sexual concurrency of BVOs at company X
8. To explore BVOs perceptions on the impact of the duration away from home on the likelihood of sexual partnership concurrency
9. To explore BVOs self-perception of risk of sexual temptation and risk of HIV infection as a 'hazard' of their occupation
10. To explore BVOs perception of the ethos of company X on HIV/AIDS and accommodation of employees living with HIV and AIDS
11. To highlight some of the kinds of HIV-related workplace interventions BVOs at company X would like to see facilitated through the workplace
12. To provide guidelines for targeted interventions in company X's HIV/AIDS workplace programme

CHAPTER 4. RESEARCH DESIGN: DATA COLLECTION AND METHODOLOGY:

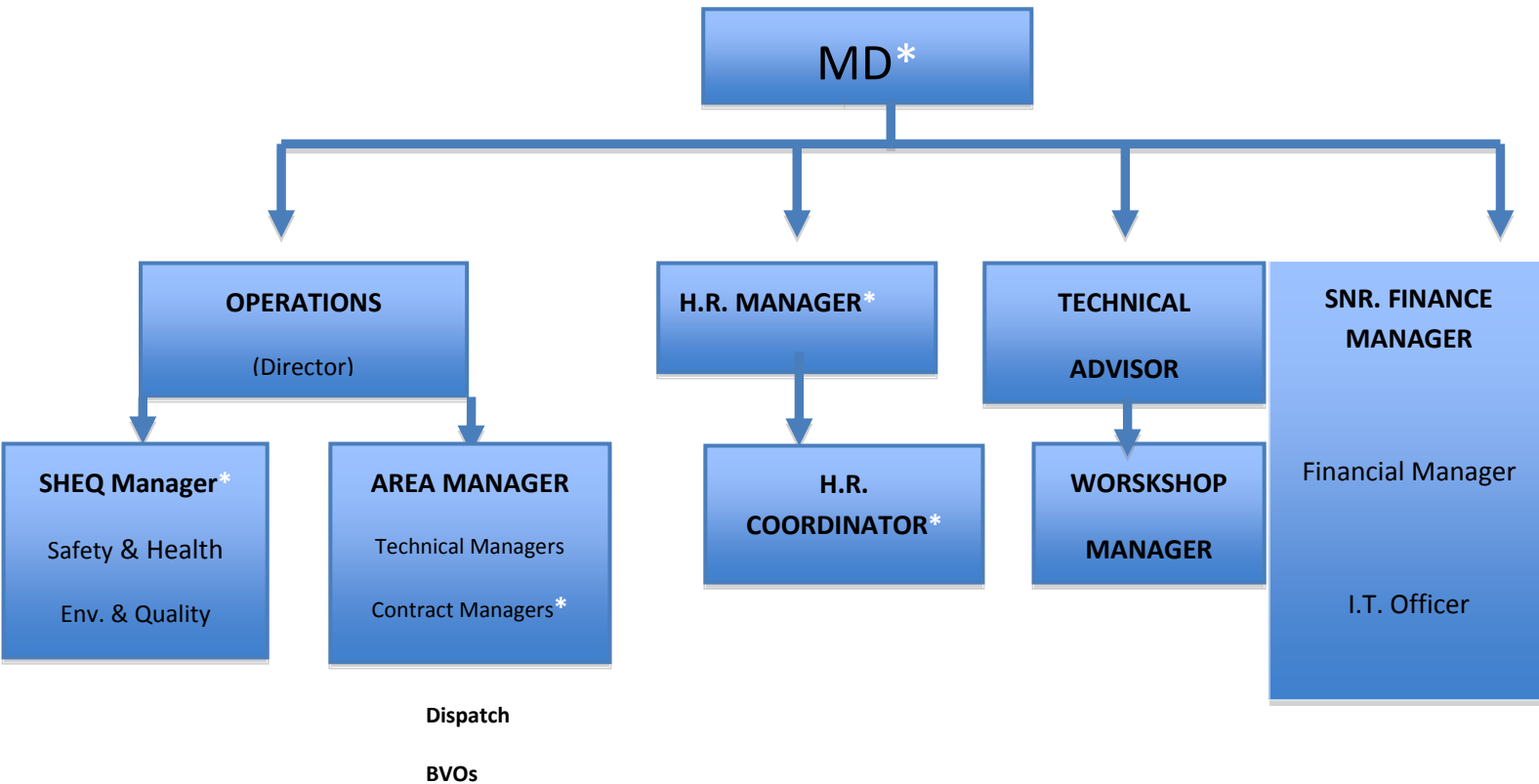
4.1 Research Study Design:

The design of the study was exploratory in nature seeking primarily to establish the existing patterns with regard to the demographic and socio-economic characteristics of bulk vehicle operators (BVOs) operating out of the Gaborone Depot of company X; as well as establishing the knowledge, attitudes with regard to HIV and AIDS, HIV-testing, STI treatment seeking among bulk vehicle operators (BVOs). Of particular interest to this research study, were the broad behavioural patterns, similarities and differences observable, as well as the general attitudes prevailing among BVOs with regard to concurrent sexual partnerships, condom use, HIV testing and the activities they most wished to see introduced at the Gaborone Depot of Company X. The positivist paradigm informed the non-experimental, largely descriptive and cross-sectional design strategy of this study (Christensen et al., 2011 and Rudestam, 1992: 23-29).

Individual primarily self-administered questionnaires were therefore the main means of collecting data. Returned questionnaires were coded and analysed using SPSS Version 19.

Given that this study is ‘embedded’ within company X, the organizational structure or organogram is depicted in the diagram below and shows the four key ‘arms’ of company X – operations, human resources, technical/workshop and finance/IT. As earlier mentioned, brief ‘institutional interviews’ were held with key company officials, namely the Managing Director, Human Resources Manager, Human Resources Development Manager, a Contract Manager, and SHEQ Manager – with a view to obtaining a more complete understanding of Company X, its core business and vision, historical development, its strengths and weaknesses, and especially the training process and skill requirements of bulk vehicle operators. These management-based or ‘institutional interviews’, largely with senior-management, operations and human resources, were especially useful for gaining this background information about the organization, its goal, priorities, challenges, company X’s work-place HIV/AIDS policy and programmes on HIV/AIDS alongside the main information, gathered from the main study participants, the BVOs themselves.

THE ORGANIZATIONAL STRUCTURE OF COMPANY X



*** Indicates Company Management
Interviewed**

Figure 4.1: An Organogram for Company X showing key departments

4.2 The Study Setting and Study Sample Selection

The research study employed a non-random approach to selecting study participants at the workplace, in the form of convenience sampling, in which the first 60 BVOs encountered and available for interview, were given a detailed questionnaire explained to them briefly before hand, which they responded to privately, with full assurances of anonymity and confidentiality outlined in a covering consent form, of the approximately 120 BVOs based at the Gaborone depot. The researcher usually remained in the vicinity of the depot to give guidance and explanation where this was sought either from her or a trained male research assistant – as the participant preferred, or indeed administer the questionnaire to them when

requested. Mostly the BVOs sat in the common room, or outside the depot and filled out their questionnaires, whilst in some instances, BVOs took questionnaires away with them and filled them out at home, or whilst out on trips, returning them upon arrival, or seeking clarification before completing and returning them. This convenience approach to the selection of study participants was appropriate for practical reasons (Christensen, Johnson and Turner, 2011:158). The BVOs were on tight time-schedules and upon returning from trips, needed to complete extensive paper work, time sheets and trip reports and submit these to Dispatch Managers, before attending to anything else. However, some bulk vehicle operators, whilst awaiting their trucks to be released from the workshop or wash-bay, completed questionnaires during these times, or on their off-days. The BVOs were a highly mobile group, as such some questionnaires were not used because only partially completed, invariably because the BVO in question was called up to take his truck and begin his journey and could not be located again within the time-frame of the fieldwork period. Ironically, mobile as the BVOs were, in the end, it was considerably easier to access them at the depot, than it was to access the largely non-mobile workshop employees who worked in a restricted area, accessible only with protective foot wear, with very little waiting time in between jobs. As the BVOs were company X's single largest category of employees and had been identified as their 'most critical post', the focus of the study remained firmly on bulk vehicle operators.

Exclusion criteria: The largely non-mobile staff, namely; mechanics, artisans, charge-hands collectively numbered between 30-40 at the Gaborone Depot of Company X, but were excluded from the study for the prime reason of constrained access to them within the allotted fieldwork period. While company X had enjoyed expanded business opportunities in the form of award of a new contract to supply fuel to Engen in the North of Botswana, alongside the standing contract to supply *Engen* in the South, this had meant additional recruitment of BVOs as well as 'fleeting up' – increasing the number of trucks. The mechanical staff at the workshop were yet to fill their quotas for additional skilled labour and as such their workload had increased. Because of constrained access, and in the interests of time, the non-mobile employees were not included in this study. The workshop, often referred to as 'the backbone' of the company', and while its services were essential for fleet maintenance, workshop staff were not seen as critical posts at the same level as bulk vehicle operators, or even Dispatch Managers, for company X because the workshop could out-source some of these skills. Mechanics from *SCANIA* worked alongside company X's own employees, and employees from *Maxi-Priest Tyres* managed the tyre-bay at the Gaborone Depot. These

specializations were readily out-sourced, to augment skills required at the Gaborone Depot, for which company X did not wish to invest additional resources in training its own expertise and acquiring its own equipment for this function (Noe, Hollenbeck, Gerhart and Wright, 2012: 206). In contrast, BVOs, as indicated in the preceding chapter, under-went mandatory intensive in-house training, so as to ensure the highest quality of training and safety standards, a 3 - 4 month additional theoretical and practical in-house training, over and above their extra heavy duty truck driver (code 14) qualifications, before they could be confirmed as fully-fledged BVOs, with additional specialized training in the handling and transporting of dangerous goods.

4.3. Data collection

Cognisant of the study's main objectives, a KAP-type approach was used to enable the company to collect data focussed ostensibly on the following areas;

A: Background characteristics of BVOs

- Demographic information (age, marital status)
- Socio-economic status (level of education completed)

B: HIV/AIDS Knowledge information

- BVOs knowledge of HIV and AIDS in general
- BVOs Knowledge of transmission and prevention of HIV/AIDS

C: Attitudes towards addressing sexually transmitted infections

- BVOs common health-seeking behaviour in the event of STI-like symptoms

D: Actual condom use

- Condom used as last or most recent act of sexual intercourse
- Establishing current condom use and multiple partner concurrency differs according to the characteristics of BVOs

E: Consistency of condom usage

- Attitudes of condom use across various contexts
- BVOs attitudes to the use of female condoms

F: Attitudes indicating barriers towards condom use

G: Multiple sexual partnership concurrency

- Actual number of sexual partners in the last year and in the last two months
- Extent of sexual partnership concurrency among BVOs

H: Attitudes on the effect of duration away from home on multiple concurrent partnerships

-Length of time away from home and length of waiting times on sexual temptation with one other than a wife or regular partner

I: BVOs self-perception of multiple concurrent partnerships and HIV infection as an ‘occupational hazard’ or risk

J: BVOs Attitudes to HIV Testing

K: BVOs Attitudes towards Company X’s ethos and practice with regard to employees living with HIV/AIDS

- Perception of ‘reasonable accommodation’ and Company X’s Gaborone Depot
- Perception of company empathy and accommodation of employees living with HIV/AIDS
- Perception of HIV/AIDS-based discrimination at company X’s Gaborone Depot

L: Desired HIV/AIDS activities at Company X’s Gaborone Depot

Attitude and condom usage, as well as their sexual partnerships formed the core of the questionnaire. Additionally, the questionnaire sought an indication of employees’ perception of the adequacy of HIV/AIDS and STI – related services at the Depot, as well as BVOs perceptions on the Company X’s respect for the privacy and confidentiality of employees HIV status; generally empathy and accommodation of employees living with HIV and AIDS. Mindful of company X’s HIV/AIDS and Safety workplace programme (HAW), the KAP-informed approach was best-suited to yield results which would enable company X to assess the level of awareness of knowledge on HIV risk factors and transmission, illustrate widespread misconceptions, reveal stigma and document attitudes to HIV/AIDS and actual behaviours in relation to condom use and sexual practices. The findings of the study are intended to inform company officials charged with the task of implementing the HAW programme.

Table 4.1 below gives an overview of this study’s objectives and shows the specific questions in the questionnaire that were used to elicit the required information and how the resulting analysis was presented. Because the entire study was ‘operations research’ – orientated and was ‘embedded’ in company X, it took cognisance of company X’s management research concerns, which were beyond the scope of this study, or even HIV/AIDS. The company had

very real concerns about non-compliance, fuel-theft, job satisfaction, training etc., for which it wanted answers from its BVOs, which questions were asked within the same questionnaire. The questionnaire enabled the gathering of this information, which will be analysed and presented to the company separately.

Table 4.1: Summary table of study objectives, questions asked and analysis and presentation

Objective	Information required	Question(s) selected	Presentation
Identify demographic characteristics of BVOs	Date of Birth; Age in complete years;	Q1; Q2	Frequency table + Histogram
	Marital status	Q3	Frequency table
Identify socio-economic characteristics of BVOs	Level of formal schooling completed	Q5	Frequency table
Demonstrate BVOs Knowledge of STIs and HIV transmission & prevention	General Knowledge of HIV and AIDS in general	Q25	Table (YES/NO) binaries
	General Knowledge of HIV Prevention and transmission	Q26	Table (YES/NO) binaries Knowledge scores
Illustrate BVOs common health-seeking behaviours when presented with STI-like symptoms	Action most likely to be taken first when presented with STI-like symptoms (burning while urinating/penal discharge/genital sores etc.)	Q27	Table illustrating most common action(s) taken
Illustrate BVOs experience of HIV testing	Whether HIV test done in last year;	Q28	Summary Table (AGREE/DISAGREE) binaries
Illustrate BVOs attitudes to HIV testing	desirability of HIV testing; perceived barriers to HIV testing	Q28	“ “

OBJECTIVE	Information Required	Questions Selected	Analysis/Presentation
<p>Illustrate condom use among BVOs</p>	<p>Actual/Current condom use;</p> <p>Condom-use consistency</p> <p>Condom use consistency across various contexts</p> <p>Attitudes on wives/partners use of female condom</p> <p>Barriers to condom use</p>	<p>Q29</p> <p>Q31</p> <p>Q32; Q34; Q33</p> <p>Q35</p> <p>Q39; Q40; Q42; Q41</p>	<p>Pie Chart</p> <p>Pie Chart</p> <p>Pie Charts</p> <p>Pie Chart</p> <p>Bar charts</p>
<p>Illustrate sexual partner concurrency among BVOs</p>	<p>Reported No. of sexual partners in the last year/ in the last two months</p>	<p>Q66</p> <p>Q67</p>	<p>Cross-tabulations</p> <p>Cross-tabulations</p> <p>Histogram</p>
<p>Explore BVOs perception of impact of long waiting times and duration from home on the likelihood of having concurrent sexual partners</p>	<p>Whether BVOs perceive themselves most likely to have sex with non-regular partner(s) on trips with long waiting times; or on trips away from home for the longest time</p>	<p>Q54</p> <p>Q55</p>	<p>Pie Chart</p> <p>Pie Chart</p>
<p>Explore BVOs self-perception of risk of sexual temptation with non-regular partner as result of/ 'hazard' of job/occupation</p>	<p>BVOs own perception of whether the nature of their job exposes them to sexual temptation with persons other than wives/regular partners</p>	<p>Q109</p>	<p>Pie Chart</p>

Objective	Information required	Questions Selected	Analysis and Presentation
Explore BVOs self-perception of risk of HIV infection as result or 'hazard' of occupation	BVOs own perception of whether the nature of their job exposes them to higher risk of getting infected with HIV	Q110	Pie Chart
To Explore BVOs perception of company X's ethos and accommodation of employees living with HIV and AIDS	Whether BVOs perceived company X as non-discriminatory; and empathetic+ accommodative of employees living with HIV and AIDS	Q73; Q74 Q75; Q76	Pie Charts; Summary table Pie Charts
To highlight kinds of HIV/AIDS-related workplace activities BVOs would like to see facilitated within the workplace at company X	BVOs perception of the adequacy of HIV/AIDS and STI related activities at the Depot Kinds of activities desired by BVOs at the depot	Q68; Q69; Q70 Q71	Tables Tables

4.4. Study Limitations

Perhaps the main limitation of the study, is the fact that a sample size of sixty (60) bulk vehicle operators was ultimately achieved, which limited the kinds of analyses possible. This was largely beyond the control of the researcher, given the necessarily high levels of mobility of BVOs, which was intensified over the festive season and with the commencement of the new *Engen* North contract. With all these considerations in mind the researcher nevertheless deemed that coverage of approximately half of the number of BVOs operating out of the Gaborone depot (120) was not insufficient to observe commonalities in condom use, health-seeking behaviours, and sexual practices among age groups and marital status categories.

Furthermore, informed insiders suggested that unless in exceptional circumstances, it was very rare that all BVOs were all present at the Depot at the same time.

4.5. Ethical Issues

Participation in the study was entirely voluntary, with the BVOs being briefed of the rights and provided with complete assurances of confidentiality and anonymity, and that none of their responses or views whether supportive of, or contrary to management, could be traced to them, nor would their participation in any way put their continued employment at company X in jeopardy. The BVOs had the option to decline participating in the study without consequence, therefore for all these reasons, the risk-ratio was deemed favourable.

In the chapter that follows, main study findings emanating from the questionnaire-based survey are presented, and interpreted. Recommendations are made for refining company X's HIV/AIDS workplace programme efforts.

CHAPTER 5. PRESENTATION, ANALYSIS AND DISCUSSION OF STUDY FINDINGS

In this chapter the findings of the study, are presented, analysed and interpreted making suggestions where possible for ways in which company X's HIV/AIDS and Safety (HAW) workplace activities may be enhanced through the research findings and recommendations.

5.1: Demographic and Socio-economic characteristics of BVOs

5.1.1. Age distribution

In line with the first objective of this study, the starting point was to identify and present the demographic (age and marital status) and socio-economic characteristics, namely educational attainment of BVOs at company X such that salient background information about BVOs, company X's most critical resource is evident. Of the 60 BVOs who responded to the questionnaire, three quarters of BVOs were below the age of 44, whilst only a quarter were 45 years and beyond, with the modal class being 35 – 44.

Table 5.1: Frequency Distribution of BVOs by 10 year Age Group

Age Group	Frequency	Percent	Cumulative Percent
25-34	19	31.7	31.7
35-44	26	43.3	75.0
45-54	15	25.0	100.0
Total	60	100.0	

While no data whatsoever was collected on the HIV status of BVOs at company X, it is worth noting that the most recent Botswana AIDS Impact Survey (BAIS) IV conducted in 2013, noted the differential peaks in HIV-prevalence by age group and gender, and that among males nationally, HIV prevalence peaked in the age group 40-44 at 43.8%, whilst that for women peaked earlier in the age group 35-39 at 50.6% (Republic of Botswana, 2014:8).

5.1.2. Educational Attainment

With regard to educational level completed, the majority of BVOs in the study sample (53%) were Junior Certificate Secondary School completers, with an average 10 years of formal education, followed by Senior Secondary School/BGCSE or Matric-equivalent completers, who comprised 25%, and then 13% were Primary School leavers. Just five BVOs in the study sample had embarked on a Tertiary qualification, with only two completing tertiary

level education (see Table 5.2 below). Most BVOs included in this study had been educated up to complete secondary level and below.

Table 5.2: Frequency Distribution of BVOs at company X's Gaborone Depot by Education Level Completed

Age Group	Frequency	Percent	Cumulative Percent
Complete Primary	8	13.3	13.3
Junior Secondary	32	53.3	66.7
Senior Secondary/BGCSE/IGCSE or Matric	15	25.0	91.7
Incomplete Tertiary	3	5.0	96.7
Complete Tertiary	2	3.3	100
TOTAL	60	100	

An over-view of educational attainment, or completed education is of interest to see the educational composition of BVOs. Even as no HIV status information was collected in this study, the national Botswana AIDS Impact Survey (BAIS III) of 2008, clearly documented a strong inverse relationship between HIV prevalence and level of education for males. The BAIS Preliminary Stats Brief noted;

“HIV prevalence decreases steadily as education level increases. Those with no formal education or non-formal education have the highest HIV prevalence of 28.4% and 28.6% respectively, whilst those with higher than secondary education have an HIV prevalence of 16.3%. A similar pattern is seen with incidence rates....” (NACA 2009b:5)

Dinkelman, Levisohn and Majalantle (2007:4) studying knowledge of HIV/AIDS levels in Botswana, in a similar vein noted that knowledge about HIV/AIDS was strongly correlated with education. While information on basic monthly income was collected, it was not analysed because the reality of the BVOs situation was that overtime and night-out allowances greatly enhanced their salaries each month. Institutional interviews with Human Resources revealed that on average, BVOs earned an average salary of P12,000-00 - P14,000-00 per month, but some high-earning BVOs, salaries of P18,000-00 – P20,000-00 per month were earned by some BVOs. This was inclusive of the aforementioned allowances. Despite not having particularly high levels of education, BVOs were still capable of earning relatively high incomes.

5.1.3. Marital Status

A further demographic characteristic of the BVOs this study sought to illustrate was their marital status. A majority of BVOs in the study sample were never married (42%), followed by formally married (31.6%) and cohabiters (21.7%), with only three (3) BVOs in the sample being divorced and widowed. Therefore over half of the BVOs who participated in this study, were in some sort of stable relationship context (53.3). Among this group, the divorced and the widowed accounted for only a small proportion (5%) of participants.

Table 5.3: Marital Status of BVOs at company X's Gaborone Depot

Marital Status	Frequency	Percent
Single/Never Married	25	41.7
Living together	13	21.7
Formally married	19	31.6
Divorced	2	3.3
Widowed	1	1.7
TOTAL	60	100

From the point of view of HIV prevalence, marital status has been found to be a variable according for differences in prevalence. The BAIS III 2008 survey found the highest HIV prevalence rates among the widowed (39.6%) and whilst the never-married survey participants had prevalence rates of 16.1%, with incidence mirroring this trend (BAIS 2009b:5). Similarly, the BAIS IV of 2014 reveals higher HIV prevalence for (formally) married males of 23%, compared to married females 18.7%, whilst males in cohabiting unions have an HIV prevalence of 34% (identical to that of cohabiting females), whilst separated males have an HIV prevalence of 14.9% and a prevalence of 12.6% for never-married males (compared to 22.0% for never-married females) (Republic of Botswana, 2014:12-13).

5.2. General Knowledge of HIV and AIDS:

Ray and Sinha (2011b:682) observe that a knowledge deficit of HIV/AIDS is linked to a lack of adoption of protective behaviours and practices and therefore an elevated risk of exposure to HIV and AIDS. Knowledge and awareness of HIV/AIDS, therefore facilitate correct decisions and actions in terms of protecting oneself from STIs and HIV infection and even re-infection and as such was a necessary step in the response to the HIV epidemic, and mitigating its impact on the critical posts in companies. Given company X's stated commitment to *educating all employees on the transmission, prevention and treatment of HIV/AIDS in the workplace*, as explicitly stated in its HIV/AIDS Policy as well as its HIV/AIDS and Safety Workplace (HAW) programme goal of providing employees with *accurate factual information pertaining to HIV/AIDS and STDs*, this study, as its **third objective**, set out to demonstrate the BVOs current knowledge of HIV/AIDS transmission and prevention.

The BVOs general knowledge was assessed through a series of statements about HIV and AIDS to which respondents had to answer either “YES” or “NO”, with a view to identifying levels of knowledge in the group of BVOs as a whole. This binary approach compelled the BVOs to commit to one answer or another, through removing a “don’t know” or “neutral” option. This also enabled immediate identification of areas in which BVOs were poorly informed and as well as giving an indication of some of specific misconceptions about HIV and AIDS. Areas which could be re-visited for clearing up factual knowledge were highlighted in red. However, in the main, general knowledge about HIV/AIDS was found to be high.

Table 5.4. BVOs General Knowledge of HIV and AIDS

KNOWLEDGE QUESTION	Yes (%)	NO (%)
An HIV positive person can still be healthy and work	56 (93.3)	4 (6.7)
All HIV positive persons have AIDS	22 (36.7)	38 (63.3)
AIDS leaves your body unable to fight off infections and diseases	54 (90)	6 (10)
An HIV positive person can still be healthy and work	59 (98.3)	1 (1.7)
A person can be HIV positive without being ill	57 (95)	3 (5)
An HIV positive person may not know that they are HIV positive	58 (96.7)	2 (3.3)
You can prevent yourself from becoming infected with HIV	56 (93.3)	4 (6.7)
Being HIV positive leads to certain death in a few years	7 (11.7)	53 (88.3)
Testing for HIV a few days after un-condomised sex will reveal whether you are HIV positive	9 (15.3)	50 (84.7)
Drinking certain medicines just before sex will prevent you from getting infected with HIV	3 (5)	57 (97)

KEY: Highlighted in red ink would be some of the areas which could be clarified in awareness training with a view to completely eliminating misconceptions and incorrect knowledge even among the minority

For a company seeking to enrich its workplace programme, through awareness raising, and subsequent evaluation of the impact of such activities, establishing the state of knowledge remains an invaluable starting point. It is evident from Table 5.4, that general knowledge about HIV and AIDS is widespread among BVOs. The majority of BVOs in the sample possessed the right knowledge. However a minority gave incorrect responses and for these, the area for strengthening knowledge are indicated in red ink. Similarly the small minority who deemed imbibing certain medicines just before sex would prevent them from being infected with HIV needed to be disabused of this incorrect knowledge or potentially dangerous misinformation. From Table 5.4, we see that another important area for

clarification is distinguishing for BVOs, the difference between having an HIV positive status and a diagnosis of AIDS disease or syndrome. Likewise those who disagreed that “AIDS leaves your body unable to fight off diseases” needed to be assisted to understand the nature and manifestation of AIDS disease, as opposed to HIV. Clarifying this would also be a suitable opportunity to demonstrate the various ways in which progression from being HIV positive to having full blown AIDS illness should be stalled, through close monitoring of CD4 counts, nutrition, exercise and the adoption of generally ‘positive lifestyles’. This could also be the point at which to make all BVOs aware about “Prevention with Positives” initiatives and the individual’s role in prolonging progression from HIV positive to full-blown AIDS status and prolonging productive lifespans. This is all the more important given company X’s expressed objective of their HAW programme as *retaining existing employees in a state of good health for longer*, especially in the light of the scarcity of BVOs and the great costs incurred in their training. As HIV/AIDS is increasingly seen as a chronic manageable, rather than life-threatening condition, alongside hypertension and diabetes, Company X had a vested interest in ensuring it retained the services of HIV positive employees through offering an appropriate supportive stigma-free environment and support to adhere to treatment and obtain good health. This much is spelt out as an objective in company X’s HAW programme.

Furthermore, Botswana Second National Strategic Framework for HIV and AIDS (NSF II) 2010 – 2016, notes that inadequate attention to prevention efforts among individuals living with HIV had been a limitation of Botswana’s overall national response to the HIV Epidemic (NACA, 2009). Designing such a workplace “Prevention with Positives” programme would be all the more effective if it adopted the GIPA-approach (‘Greater Involvement of People Living With HIV/AIDS’) and included HIV positive BVOs in its design and launch, for credibility and impact among HIV positive BVOs. In the course of the study, two BVOs mentioned that they did not do the conventional testing but rather monitored CD4 count as they were on ‘treatment’. ‘Routinizing’ CD4 count-checking was an important thrust here, one that company X could actively champion, alongside treatment adherence, under any initiative it introduced to support BVOs already infected with HIV; BVOs afflicted with hypertension and diabetes. The Men’s Sector were ideal partners in this regard and anyone trained and identified as workplace mentors could also be motivated to give support (NACA, 2008a:30).

5.2. HIV transmission and prevention knowledge

A further series of questions, this time focused on HIV transmission and prevention knowledge, were asked of BVOs, to which answers were in YES / NO binary form, with no option of ‘Don’t know’, adapted from the knowledge elements list of a study of HIV/AIDS Knowledge among Africa-American students by Sutton, Hardnett, Wright, Walin, Pathak, Warren-Jeanpiere and Jones, (2011: 656). As before, this was done to encourage BVOs to think and weigh-up which answer felt ‘most logical’ to them, even where they did not clearly know. There were practices which some question/statements asked which were totally alien to some BVOs, such as those asking about ‘oral sex’ and ‘anal sex’ and in these instances, some BVOs refrained from giving any answer at all.

On balance, the responses were in the desired direction on most question/items, however some aspects merit further commentary and attention, most notably those highlighted in red . The statement “You cannot get infected through having sex with your regular partner” shows an almost even split between YES (45%) and NO (55%) responses. This may have been a reflection of the fact that many BVOs in the study sample had internalized the “ABCs” of preventing HIV message (“Abstain, Be Faithful and Condomise”), especially the ‘Stick to One Partner’ to avoid HIV infection messages which were the prevalent messages on billboards in Botswana in the 1990s and early 2000s (Lammers, van Wijnbergen and Willebrands. 2011:2). This message, at least in principle, continued to resonate with many BVOs in the sample as a prime means of avoiding HIV infection, however, this almost even split was disconcerting when viewed from the clinical or epidemiological stand-point. The reality is that spouses and regular partners *can* and *do* infect their significant others with HIV and there were studies which identified the status of being married, as a risk factor in HIV transmission for wives in particular. Marriages and relationships, unless ‘ring-fenced’ by cast-iron sexual fidelity, where both partners have repeatedly ascertained their HIV negative status, were ‘porous’ and partners could bring in infection from outside sexual liasons.

Areas of blatant misconception included the question/statement “Only thin sickly-looking persons can infect others through sex”, to which 15% of the study sample answered “YES”. Another misconception “Drinking and washing with ‘Holy water’ from church will cure an HIV infected person” to which 18.3% answered ‘Yes’ merited concerted clarification and ‘de-bunking’. This was especially important in the light of the proliferation of independent Churches and God channels on television, some of whose priests, pastors and ‘prophets’ claimed to be able to heal and cure people of absolutely any ailment, including AIDS, with some congregants stepping forward to give ‘testimony’ of this, and discontinuing treatment. For a few of the BVOs who answered ‘Yes’ to this statement, added ‘IF you believe...it can happen’ or ‘If you have Faith’ that an afflicted person could be ‘cured’ in this way. Awareness and education materials **had** to address this misconception in a clear, direct and understandable manner.

Once again, the specific areas for clearing up misconceptions are highlighted in red in Table 5.5, such as ‘only thin sickly looking persons infect each other through sex’, beg concerted de-bunking as with nation-wide access to treatment, most people no longer *look* visibly infected as was the case prior to the national roll-out. Likewise the lack of knowledge about the protective potential of female condoms, was yet another area to be addressed. Especially worrying was that one quarter (25%) of the BVOs in the study sample did not feel that they could prevent themselves catching sexually transmitted infections (STIs)! These ‘gaps’ and misconceptions existed even as knowledge levels with regard to transmission and prevention of HIV was generally good among BVOs. Dinkelman, Levinsohn and Majalantle (2007) in a study based on BAIS data and Demographic Health Surveys for Botswana, concluded that Botswana’s population generally possessed overall higher levels of knowledge with regard to HIV, than several other African countries but that knowledge deficits still remained and misconceptions persisted with regard to transmission of HIV, and that these were more pronounced among men (2007:10 , 17). However the same authors caution that

awareness/knowledge whilst being necessary did not in itself always guarantee adoption of protective behaviours which prevented infection. Lammers, van Wijnbergen and Willebrands note that studies have been mixed in terms of illustrating the impact of knowledge on behavior, and conclude that psychometric 7- point Likert risk scales measuring perceived risks in having uncondomised sex, have been more informative than merely ascertaining knowledge of HIV, in explaining risky behaviour (2011:2).

Value for company X: The dispelling of myths around HIV and AIDS, informed by this knowledge assessment exercise, was a suitable starting point in the ‘refreshing’ of HIV/AIDS awareness conducted through the workplace at company X, perhaps in partnership with Tebelelopele, a local clinic or epidemiologist from any of the medical research centres (UPenn or Botswana-Harvard Partnership). In the past, an epidemiologist from the UPenn Partnership facilitated the module on HIV/AIDS awareness to trainee BVOs to ensure that they were receiving correct information. Perhaps to sustain these efforts, during the annual refresher courses, ‘HIV knowledge scores’ could then be derived for all BVOs which would permit the comparison of these scores each year as a means of evaluating the effectiveness of workplace HIV/AIDS awareness initiatives. To augment these efforts, pamphlets in glove compartments of trucks and posters in their common room as constant reminders of *correct* information on the transmission and prevention of HIV. That 95% of BVOs who participated in this study were clear that the presence of untreated STIs, increased a person’s chance of HIV infection is a positive finding indicating high levels of awareness on how untreated STIs elevate risk of infection and transmission of HIV. It gives rise to the question as to how BVOs themselves would respond, when observing and feeling clear signs of sexually transmitted infection.

Table 5.5: Illustrating BVOs Knowledge of HIV and AIDS Transmission and Prevention

Knowledge of HIV/AIDS transmission and prevention	Yes (%)	No (%)
Having an untreated sexually transmitted infection can increase a person’s chance of getting HIV	57 (95)	3 (5.0)
You can get infected with HIV through using the same needles to inject drugs that an HIV positive person has used	58 (96.7)	2 (3.3)
You cannot be infected with HIV through having sex with your regular partner	27 (45)	33 (55)
Having alcohol or taking drugs before sex can increase your chance of getting infected with HIV	52 (86.7)	8 (13.3)
You can get infected with HIV from sharing plates, cups, spoons and forks with an HIV positive person	9 (15)	50 (83.3)
An HIV positive mother can infect her baby through her breast milk	52 (86.7)	7 (11.7)
An HIV positive pregnant woman can infect her unborn baby in the womb	52 (86.7)	8 (13.3)

Taking a shower after having sex without a condom can prevent you getting infected with HIV	7 (11.7)	53 (88.3)
Having sex while a woman is taking birth control pills (oral contraceptives) reduces the chance of HIV infection	1 (1.7)	57 (95)
Using a latex (rubber) condom is more effective in protecting against HIV infection than using a natural skin condom	30 (50)	27 (45)
Drinking strong traditional medicine after having sex without a condom will prevent me from getting infected with HIV	8 (13.3)	52 (86.7)
Having oral sex without a condom or barrier carries no risk of HIV infection	9 (15)	49 (81.7)
Drinking and Washing with “Holy Water” from church will cure an HIV-infected person	11 (18.3)	49 (81.7)
You can prevent yourself from becoming infected with sexually transmitted infections	45 (75)	15 (25)
Female condoms (‘Femidoms’ etc) do not protect against sexually transmitted infections or HIV at all	16 (26.7)	42 (70)
Masturbation (‘pleasuring yourself’) does not carry any risk of catching a sexually transmitted infection or HIV	52 (86.7)	8 (13.3)
Only thin sickly-looking persons can infect others through sex	15 (25)	45 (75)

Source: Some Knowledge questions in Table 5.5 are adapted from Sutton et al. (2011:656)

KEY: Problematic areas requiring addressing of misconceptions and imparting inaccurate knowledge through appropriate avenues/fora of company X’s HAW programme

5.3. Health-seeking behaviours of BVOs in addressing sexually transmitted infections (STIs):

Controlling the spread of sexually transmitted infections (STIs), alongside that of HIV infection is another explicitly stated goal of company X’s HAW programme. Considering that STI infection is not only an indicator of unprotected sexual intercourse, and when in the context of sex with a casual sexual partner, is indicative of ‘risk-taking’, and the association between untreated STIs and susceptibility to HIV infection (Matjila, Hoosen, Stolz and Cameron, n.d: 90 and NACA 2010:55) – it is imperative business such as company X, pay attention to STI prevention and treatment in their workplace programme activities. This is even moreso because the National AIDS Coordinating Agency (NACA) Report on Up-scaling Prevention in Botswana’s strategy to respond to the HIV/AIDS epidemic and progression towards “Zero New Infections” emphasizes **up-scaling condom** use alongside the **prompt diagnosis and treatment of STIs** as two core elements of the “Minimum Prevention Package” also referred to as the “Shield and Spear” strategy (“*Thebe le Segae*”) (NACA, 2008). The prompt diagnosis and treatment of STIs comprises a core element of the “Minimum Prevention Package” – essentially a ‘battle plan’ to achieve Zero New Infections by up-scaling key elements of HIV/AIDS prevention, under the Second National Strategic Framework (NACA, 2008:74).

In this study, BVOs were asked the question; “*If I have a discharge from my penis, ‘burning pain’ while urinating, or even trouble urinating (ie. passing water), a rash, a sore or swelling on my private parts (genitals) after having sexual intercourse, I will usually take the following action...*” BVOs were then required to tick all actions they would take 1st, 2nd and third, and to indicate those that they would never consider. Table 5.6 below, reflects the most common actions BVOs indicated they would take in the aforementioned circumstances. Noteworthy for company X’s HAW programme is that the most desired *and* most appropriate actions from a clinical and public health stand point, namely “Go to a clinic or hospital” and “Consult a private doctor at surgery” are the actions or responses the BVOs in the study sample most frequently reported as the *foremost* action that they would take in the event of STI-like symptoms after having unprotected sexual intercourse.

Table 5.6 showing BVOs most common health-seeking behavior in the event of STI-like symptoms

Action most likely to be taken by BVOs in the event of STI-like symptoms	YES
Drink ‘monepenepe’ or other traditional remedy	2
Consult traditional healer/ or traditional herbalist	4
Go to chemist/pharmacy to buy medicine	18
Consult private doctor at surgery	57
Go to clinic or hospital	57
Take pain killers and sleep	4
Ask friend or colleague for advice	30
Treat myself with home-made remedies	5
Ignore symptom(s) and hope it goes away	2

KEY: Worrying response requiring addressing in awareness-raising segment of company X’s HAW programme

Of particular interest in the BVOs responses however is that the third most-common response is to “Ask a friend or colleague for advice” or guidance, an action more common than “Go to the chemist/pharmacy to buy medicine”, was only in fourth place which one would imagine involved describing symptoms before asking the Pharmacist/Dispenser for advice prior to buying any medicine. Among the BVOs included in the study, a colleague’s or friend’s advice was highly valued and took precedence over going to a pharmacy or chemist to purchase medicine. Contextualizing the BVOs responses on this question in terms of national AIDS survey, BAIS III of 2008 Statistical Report which sought the same information revealed that 96% of the survey participants identified clinics and hospitals as their first port of call for STI treatment (NACA 2008b:50). Given the reality of high mobility, times

constraints working against truck drivers returning to same location to collect laboratory results, and then proceed to get medication (ILOAIDS, 2005:27), the efficacy of syndromic approaches, relying on an on-the-spot diagnosis and prescription/treatment, widely used by Pharmacists is particularly beneficial to BVOs. STI awareness training among BVOs needs to emphasize this point.

Value for company X From the view-point of workplace programme design and enrichment, this suggests that significant others in the form of colleagues at company X are more easily accessible and well trusted to give sound advice – and therefore ought to be well-informed, well-armed with correct knowledge, and be capacitated to give good advice. Emphasizing *timely* responses, BVOs needed to be made aware that Pharmacists and Dispensers at reputable chemists and pharmacies, were well-trained and competent to recommend medication on the strength of description of symptoms or **syndromic approaches** to STI detection/identification and treatment (Matjila et al., n.d:90). Such syndromic approaches, in the absence of laboratory equipment, relied on flow-charts and algorithms which enabled the diagnosis and treatment of STIs on the strength of the presence of some recognized symptoms and had been used with great success by health practitioners including pharmacists and dispensers trained in this approach (WHO Essential Medicines and Health Products Portal <http://apps.who.int/medicinedocs/en/d.../2.4.html>). Suffice it to say that syndromic approaches to diagnosis were especially helpful for highly mobile long distance truck drivers who could not entirely predict their movements, return to a location to pick up laboratory results – as such the importance of qualified chemists and pharmacists in diagnosing and treating STIs needed to be spelt-out to BVOs and emphasized in the HAW programme. STI awareness as a workplace HIV/AIDS programme component, needed to be re-visited and strengthened with additional emphasis on *correct actions* and *timely responses*, particularly in the light of the emergence of antimicrobial resistant gonorrhoea and the role of untreated STIs as a catalyst for HIV infection (Lewis, 2011).

BVOs themselves needed to be made alert or alive to unusual symptoms and the need for rapid and correct intervention. Information communication education (IEC) materials produced as part of the workplace programme, can emphasize the range of symptoms which act as ‘warning bells’ sounding infection; emphasize the *right* action to take and especially *completion of treatment*; *discourage delays* in seeking treatment, and *discourage* attempts at *self-treatment*. The National AIDS Coordinating Agency (NACA) recommends that people be encouraged to screen themselves for asymptomatic STIs, for optimum sexual and reproductive health (NACA, 2008: 74). Until such time as company X had its own depot-based clinics, some consideration should be given to periodically bringing in mobile STI awareness, screening and treatment services, alongside voluntary counselling and testing services VCT. In time, encouragement of couples’ screening for STIs messages could be encouraged in the context of company Wellness Days, as it would likely provide motivation for couples to remain free of STIs together and emphasize the importance of sexual fidelity or exclusivity within couples.

5.4 Attitudes of BVOs to Testing for HIV

The importance of testing for HIV including pre and post counselling, is central to the response to the epidemic and serves as “an entry point” to accessing ARVs, PMTCT in addition to providing the impetus or motivation to change individual behavior – i.e. prevent new HIV infection or prevent re-infection, or indeed prevent progression to full-blown AIDS (NACA, 2010:66-67). Therefore the **attitudes of BVOs at company X’s Gaborone depot, to testing for HIV formed another objective of this research study**, and were found to be strongly positive, with 85% of BVOs reporting that they had undergone an HIV test in the last year, whilst an even higher number 88% reported that their wives and partners had tested for HIV in the last year. Evidently, the BVOs in the study were proactive about knowing theirs and their wives’/ regular partners’ HIV status.

Table 5.7. BVOs attitudes to HIV Testing

BVOs Attitudes to Testing for HIV	Agree	Disagree
I have had an HIV test in the last year	49 (85)	9 (15)
My partner/wife has had an HIV test in the last year	50 (88)	7 (12)
HIV testing services are difficult to reach/access	6 (10)	53 (89)
HIV testing is costly	3 (5)	57 (95)
It is better to know your HIV status	59 (98)	1 (2)
Not testing for HIV may result in infecting someone without knowing it	59 (98)	1 (2)
Not knowing my partner’s/wife’s HIV status puts me at risk of being infected without Knowing	54 (90)	6 (10)
I would rather not know my HIV status	3 (5)	57 (95)
I would rather not know my partner’s/wife’s HIV status	6 (10)	54 (90)
It is important to take a HIV test	57 (95)	3 (5)

KEY: The statements highlighted in red ink were noteworthy especially if company X was planning the introduction of VCT at the depot

National HIV testing promotion campaign which motivated the entire population to “*Know Your Status*”, had already created a climate in which this was seen as both natural and simultaneously highly responsible. Women in Botswana visited clinics and hospitals in greater numbers than men, while antenatal clinics routinely test expectant mothers for HIV (Stegling, 2004 and NACA 2010). Only 5% of BVOs in the study viewed HIV services as costly, while 10% were of the opinion that HIV testing services were difficult to access or reach – together this added up to 15% of BVOs at the Gaborone Depot for who cost and access were impediments to voluntary counselling and testing (VCT). This perception had to be corrected and clarified during HIV/AIDS awareness raising. Perhaps the 10% who agreed

with the statement that ‘HIV testing services are difficult to reach access’, may have been referring to their own time constraints rather than distance considerations, because Voluntary Counselling and Testing services were widely and available at no charge, through Red Cross, *Tebelelopele* voluntary counselling and testing (VCT) centres, clinics and hospitals as well as at Truck Stops in South Africa. A telephonic interview with a SHEQ manager in a depot in the north of the country revealed that they had already initiated VCT at the northern depot through engaging the services of the NGO *Tebelelopele* (refer to 3.1.2) whilst interview with his senior in the Gaborone depot stated that twice a year, company X invited *Tebelelopele* to conduct VCT among employees at the Gaborone depot. Perhaps mistakenly this study did not enquire as to where BVOs had last tested for HIV.

Many BVOs, however, mentioned the Zeerust Truck Stop as a location where voluntary testing services, condoms, a shower, meal and safe sleeping place could all be obtained. The Zeerust Truck Stop was a sleep-over point for many BVOs particularly when loading at Tarlton and Langlaagte gantries in the Transvaal, South Africa. Only a small proportion (5%) opted to not know their own HIV status and 10% opted to not know their wives/partner’s HIV status. An overwhelming majority of the BVOs in the study sample (95%) agreed that it was important to take an HIV test. Encouragement of all staff including BVOs to avail themselves of *Tebelelopele*’s voluntary confidential counselling and testing services at the depot such that employees would know their status was entirely in-keeping with company X’s commitment to employees in the HIV/AIDS Policy.

However, elsewhere in the questionnaire, a question framed as the statement, “*If the company could arrange for the Complete Confidential and Anonymous HIV testing of all employees every two years by independent services it would be fine with me*”. Participants had to choose from one of five point Likert scale response anchors, which indicated the extent to which they either agreed or disagreed with the statement.

5.4 Complete confidential HIV testing of all employees every two years arranged by the company

The figure directly below, shows that the same BVOs of whom 95% felt it important to know their HIV status were now divided with just a little over half agreeing to company-arranged HIV testing even though by independent services, and just under half disagreeing with this statement. The strength or vehemence of disagreement is noteworthy in this case, with just over 40% ‘strongly disagreeing’ with the statement, indicative of unease with company arrangement of HIV testing of *all* employees, even by independent services.

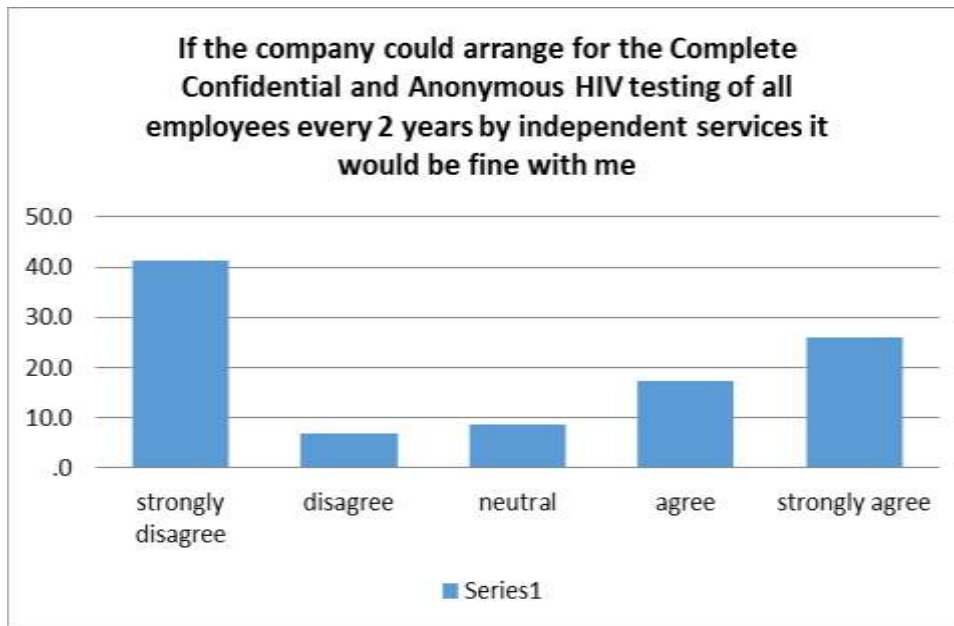


Figure 5.1. BVOs willingness to participate in Anonymous and Confidential HIV Testing by Independent Services, if arranged by Company X (Q72)

Value for company X: This finding suggests that facilitation of HIV testing organized by the company, on the Depot premises of all employees (in the form of a HIV prevalence survey), which is not in the context of a Family Fun or Company X Wellness day or the usual casual VCT offering, may receive a luke-warm or even cold reception...It remained to be seen whether this was the desired approach to encourage HIV testing, which approach would give an overall idea of company-wide prevalence, or whether the current entirely voluntary *laissez faire* ‘*test when I want to*’ approach ought to obtain. Indications were that the appropriate and least threatening approach to this remained voluntarily testing for HIV - in the context of company X Wellness days, or through entirely voluntary HIV testing provided at the workplace. BVOs were urged to be counselled thoroughly before and after testing for HIV - given the highly dangerous nature of a BVOs job which entailed driving 40,000+ tonnes of fuel. Lapses in concentration through shock and depression over an unexpected HIV positive test were potentially disastrous, even fatal, for the BVO and other road users.

The decision to test and know one’s status was potentially the start of an important ‘psychological awakening’ for the individual– in which knowledge of their status could inflame the motivation to adopt the behaviours to necessary to remain HIV negative; or to commence treatment in the form of timely commencement of ART, or TB treatment among those who are HIV positive. A modelling of HIV/AIDS impacts estimated that there were at least 60 BVOs at company X living with HIV/AIDS, and whose skills, and retention of good health; capacity to perform their job remained invaluable to the company. It was therefore imperative the company X’s HAW programme emphasized that knowledge of one’s status could only be beneficial to the individual, regardless of result and in this respect – HIV testing was a “gateway” to primary and secondary prevention – the extension of productive

working lives. This is in line with 4.7 and 4.3 of company X's HAW programme as articulated in the document CPSHEQ90 –SHEQ HIV/AIDS Health and Wellness Program version 5. However, the Labour Research Reserve Report (2008) *From Policy to Programme* cautions that peer education on HIV/AIDS, HIV testing and other workplace programme initiatives should encourage optimum input from the union as early as conceptualization stage to foster ownership and a sense of 'community' (2008:23 – 28).

5.5. Actual Condom Use and Consistency of Condom Use among BVOs:

5.5.1. Current condom use

This study had as another of its objectives, **to the illustrate the levels of reported condom use among BVOs at company X's Gaborone Depot**. Investigating and reporting on *current* condom use as well as a self-assessment by BVOs of the *consistency* of their condom use was a major aim of this study, given the efficacy of condoms in preventing STIs, HIV transmission as well as pregnancy. The importance of condoms, and their widespread and consistent use to achieving "Zero New Infections by 2016", cannot be overemphasized (USAID, 2013:2). The figure below, portrays the fairly high levels of BVOs who reported that they had used a condom during their most recent act of sexual intercourse (79%), in contrast to the smaller proportion (21%) who had not. While current condom usage seemed fairly high among BVOs, of even greater significance are the levels of *consistent condom* use particularly in the light of the threat of HIV infection in a high level, generalized epidemic. Figure 5.2 showed that 58% of BVOs reported "always" using condoms, followed by 27% who reported using condoms "sometimes", while 7% and 8% of BVOs reported using condoms "most of the time" and "hardly ever" when having sexual intercourse.

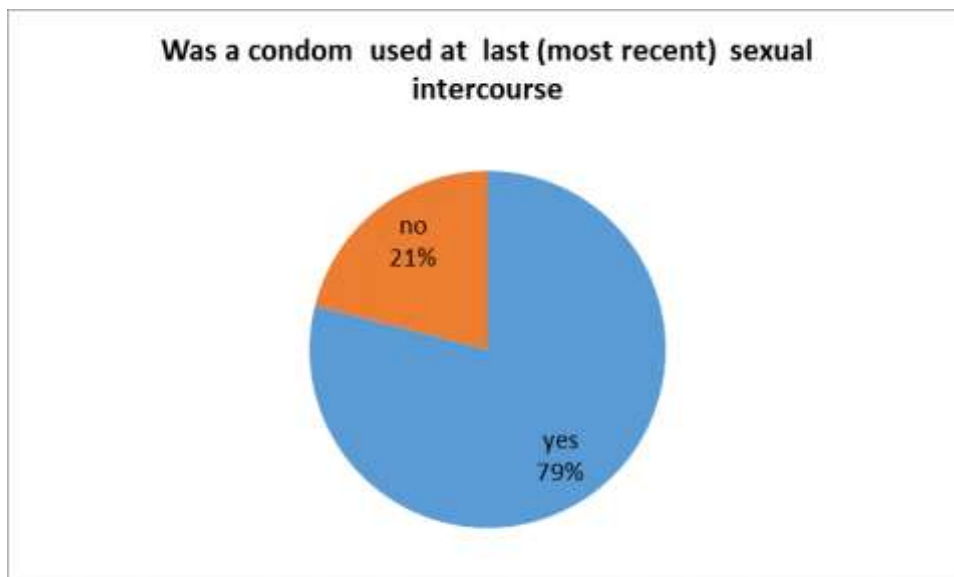


Figure 5.2 BVOs reported condom use at most recent sexual experience (Q29)

5.5.2. Condom Use Consistency across different contexts

Understanding BVOs attitudes and practices with regard to the various contexts of condom use was probed through the means of 5-point Likert scale response anchors. Just under half (47%) of BVOs reported using condoms when having sexual intercourse with their wife or regular partner, a 10% drop in the “always” response from the previous more generalized statement “condoms are used whenever I have sexual intercourse”, in which 58% of BVOs answered that they “always” used condoms. Citing BAIS III survey findings, the *2010 Modes of Transmission Study Report* observed that 45.8% of male respondents reported “always” using condoms with regular sexual partners, but that this figure declined with regular partners (NACA, 2010:55).

5.5.2. Condoms are used when I have sex with my wife / regular partner

When the same statement was amended to include wives and regular partners, the comparable figure for “always” using condoms when having sex drops to 47%, while the proportion who “never” use condoms more than doubles from 7% in the previous question to 18%, when the same question concerns wives and regular partners. The BVOs reported lower levels of condom use and lower levels of consistent condom use within the marriage and regular partner context, a trend observable in the literature (NACA, 2010:55). The most recently published *Botswana AIDS Impact Survey* (BAIS III) observes that approximately 50% reported having used a condom with their ‘most recent partner’, while a lesser proportion (43%) reportedly used a condom in their last sexual intercourse with their most recent partner (NACA, 2010:55). This pattern is additionally supported by other studies (Pandey, Mishra, Sahu, Benara, Biswas, Sengupta, Mainkar and Adhikary, 2012:44) which confirm lower levels of consistent condom use in the marriage and cohabitation context.

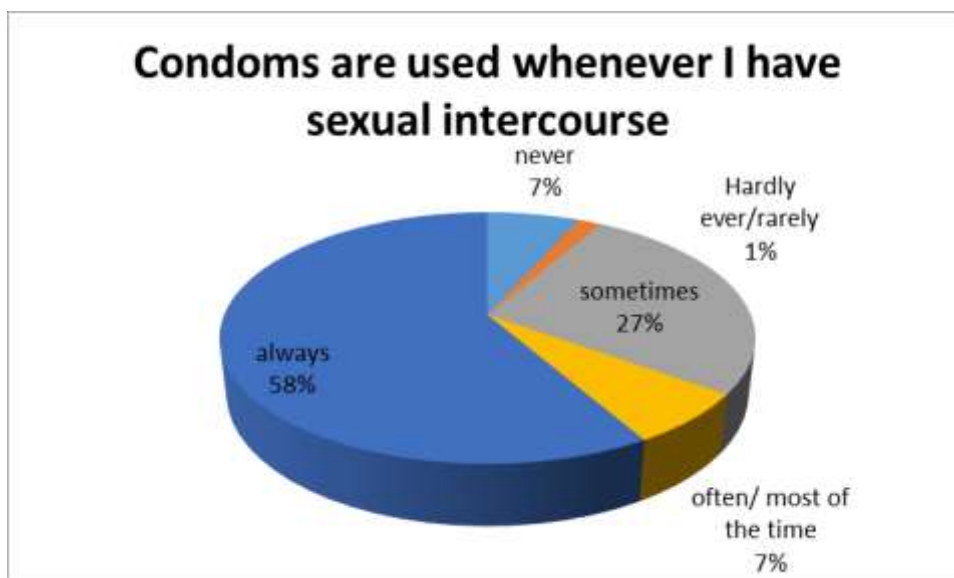


Figure 5.3. BVOs consistency of condom use (Q.30)

5.5.3. There is no need to use condoms when having sex with your wife or regular partner

However BVOs in the study sample generally disagreed in large numbers (80%) with the statement “*There is no need to use condoms when having sex with your wife or regular partner*”, showing that they were not (in terms of attitude/opinion) against the use of condoms at all in the marriage or regular partner relationship context, although the actual levels of condom use and consistency are lower in these same relationship contexts.

It should be remembered that condoms are also a longstanding means of contraception, as well as a technology others fall on for sexual intercourse during a wife or partner’s menstruation. Lowered *actual* use and *consistency* of use in the marital relationship or living together context, existed alongside a high *acceptability* of condom use within the marriage, stable partner relationship context among BVOs interviewed in the study.

Reasons advanced for appropriateness of non-usage of condoms:

BVOs were asked whether there were “...*any other reasons that would cause you to not use a condom ?*” in order to assess the situations and contexts where BVOs felt it was appropriate to dispense with condom use.

Table 5.8. Reported reasons for non-use of condoms by BVOS

Reasons to not use condoms (from qualitative responses of BVOs)	Context in which condoms may be dispensed with
When cleared for HIV	<p>“when you’ve both been tested for HIV”...</p> <p>“only stop using condoms after checking/proving your (joint) health status with the doctor”....</p> <p>“because I have sex with my wife and we test for HIV together, we do not use condoms”.....</p>
When starting a family/having children	<p>“when you want to make a child”....</p> <p>“when planning a family”....</p> <p>“only for making a baby”.....</p> <p>“only when planning for a baby with my wife”.....</p> <p>“when trying to have a baby with my wife”....</p>

Mood	“Mood – sometimes you are not in the mood to use a condom”....
Trust; Faithful/ Know partner well	“Yes – when you trust your partner and they are faithful and they are yours”... “(when) mutual trust between you and the partner developed over a longtime”.....
When partner is on contraceptives	“when she’s using contraceptives and I know her well”.... “Yes, we have agreed with my wife”that we will not use condoms”....
When partner in confinement (after giving birth)	“when she is in <i>botsetsi</i> ”.....

5.5.3. BVOs Attitudes on the use of female condoms by wives and regular partners

The statement “*I would like it if my wife or regular partner used the female condom*” to which 58% of BVOs responded that this was “True” (including “Very True”) of my feelings”. The receptiveness of BVOs to their wives and regular partners’ use of the *femidom* was evident despite the mirthful comments among some in the common room... “I hear that it (*femidom*) has to be put in several hours before sex...so I need to call her from Magaliesburg or Zeerust to warn her of my arrival in some hours so that she can put it in?” Others wondered “What happens...is she not to urinate in all those hours before we sleep together?” Whilst others wondered if insertion of the female condom precluded the taking of a shower or having a bath once it had been inserted. Answers to all these, and other questions needed to be clarified in the best possible forum, where both BVOs and especially their wives and partners could be properly trained on the correct and effective use of female condoms in a relaxed setting.

Value for company X: Given that there are studies which document not just higher levels of HIV and STIs among truckers, but also documenting higher levels of STIs among the wives and partners of truck drivers (The Synergy Report, n.d.), there is a case for the equipping and empowering BVOs wives and partners with the skills and education to protect themselves through demonstrations of expert insertion and removal – essentially *effective* use of female condoms. Making the *femidom* more user friendly, especially as 58% of the BVOs themselves were receptive to their wives’ and partners’ use of this technology was an area of investigation when planning activities where wives and partners would be in attendance. Consultations had revealed that the *femidom* had been made available in toilets around the depot, but had not been welcomed with any enthusiasm – while condoms were very quickly

emptied out of dispensers, femidoms, on the otherhand, were considerably less popular, and moved very slowly indeed. The *Botswana Condom Programming National Quantification and Supply Chain Strengthening Report* noted a low demand for females condoms nationally, and the tendency for these to accumulate in ware houses until they expired (USAID, 2013). Consideration therefore ought to be given to not just making these available to the wives and regular partners of BVOs, but also to special sessions aimed at training wives and partners on their use, effectiveness as a viable birth control method and protective technology against STIs and HIV, whose use lies within the woman’s control. Wellness Days, or any sessions where company X reached out to the partners of BVOs were the ideal settings for implementing this.



Figure 5.4. Condom use consistency in sex with regular partner (Q32)

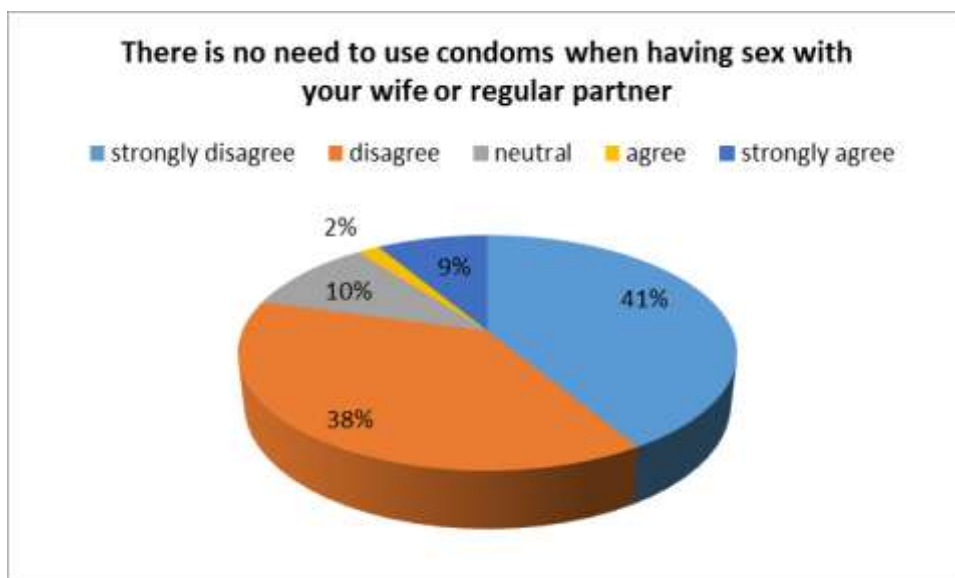


Figure 5.5. Perceived lack of need for condom use when having sex with regular partner (Q34)

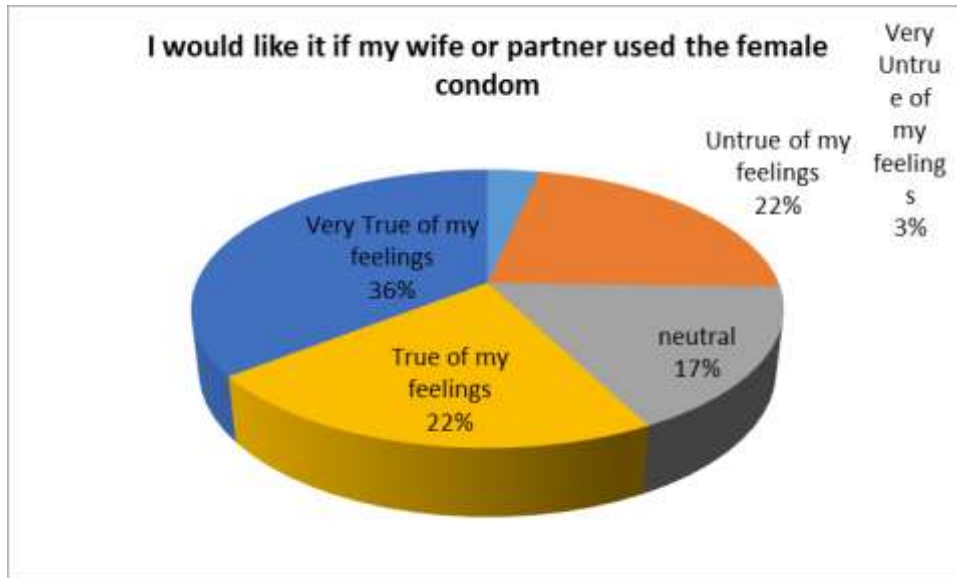


Figure 5.6. BVOs receptiveness to their wives and partners use of the female condom (Q35)

5.5.4. Attitudes and Perceptions indicating Barriers to Condom Use:

Any efforts to up-scale condom distribution and usage ought to be mindful of impediments to condom use, such that approaches rendering condoms more user-friendly and their use more psychologically and physically more appealing can be found. To this end, the study sought to establish whether BVOs thought the ‘*loss of sensation*’, ‘*failure to become sufficiently aroused when condoms were used*’, perceptions of whether sex was still ‘*real sex*’ when condoms were used and whether wives or regular partners disliked the use of condoms, were significant barriers to condom use among BVOs.

This study finds that over 60% of BVOs disagreed with the statement “*It is difficult to get aroused or excited enough (to get an erection) when using condoms*”, while less than 20% agreed with this statement. Likewise there were high levels of disagreement (in excess of 80%) with the statement to the effect that “*My wife / partner does not like it when I use a condom during sex*” suggestive of widespread acceptance of condom use among the wives and partners of BVOs. With regard to the statement that “*Sex is not ‘real sex’ when you do it using a condom*”, disagreement among the BVOs in the study was 78%.

Value for company X: Whilst the bulk vehicle operators (BVO) attitudes concerning the *lack* of perceived barriers to condom use were very encouraging, the smaller proportions of those who “agreed” and “strongly agreed” that sensation was lost when having sex with a condom, and that ‘sex was not ‘real sex’ without a condom still required some attention with possible assistance from potential partners such as **The Men’s Clinic**, for those requiring assistance with general sexual health therapy and counselling support, while **UNFPA** through its “*Condomise*” initiative could also lend assistance in this regard.

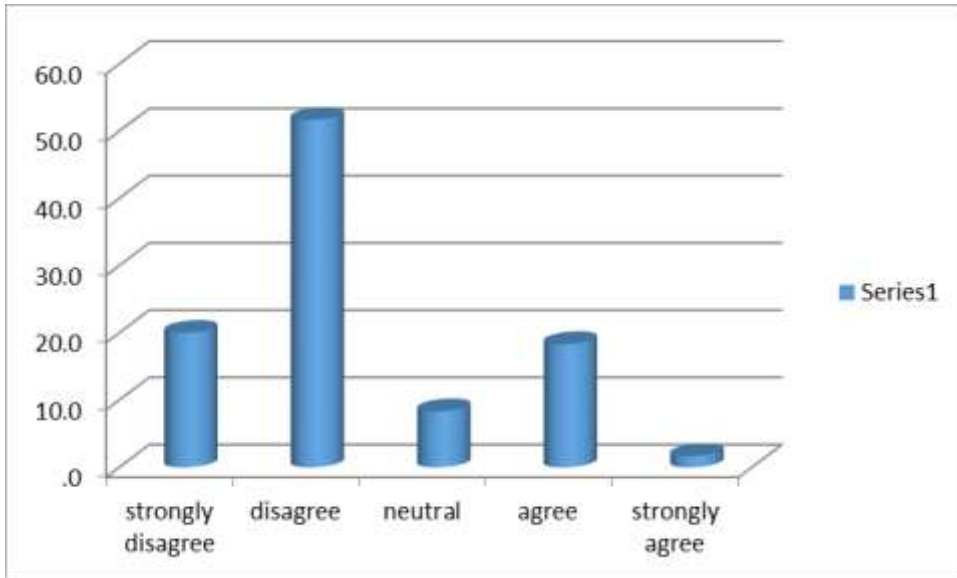


Figure 5.7. Attitudes about condoms and the loss of sensation during sex (Q39)

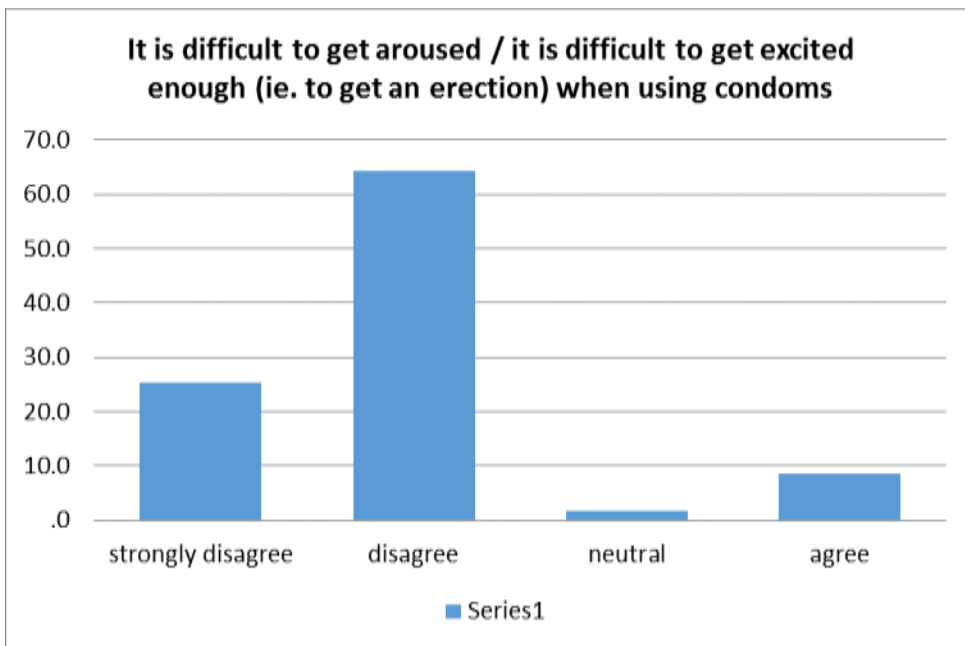


Figure 5.8 BVOs attitudes with regard to lack of sexual arousal and satisfaction when using a condom (Q40)

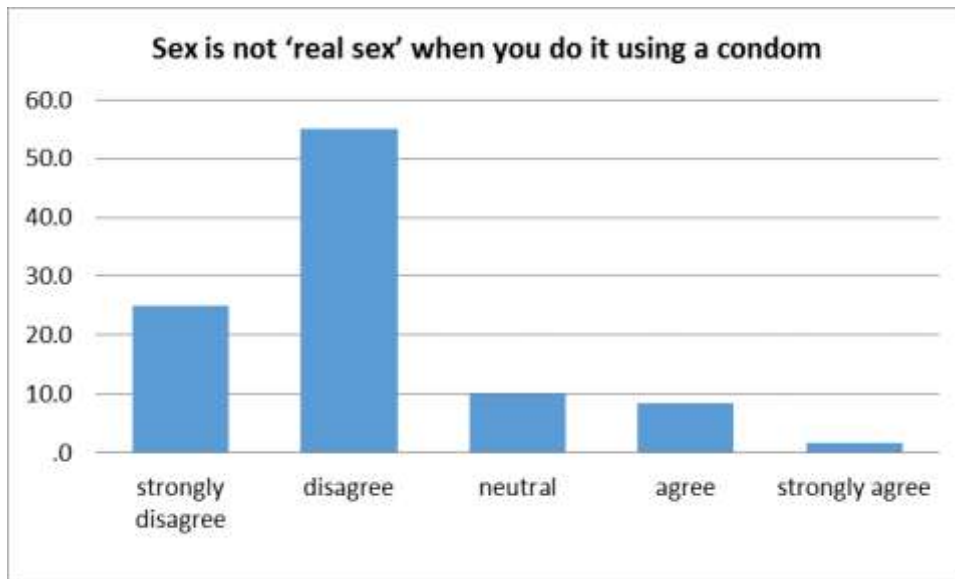


Figure 5.9 Attitudes about lack of sexual fulfillment from condomised sex (Q42)

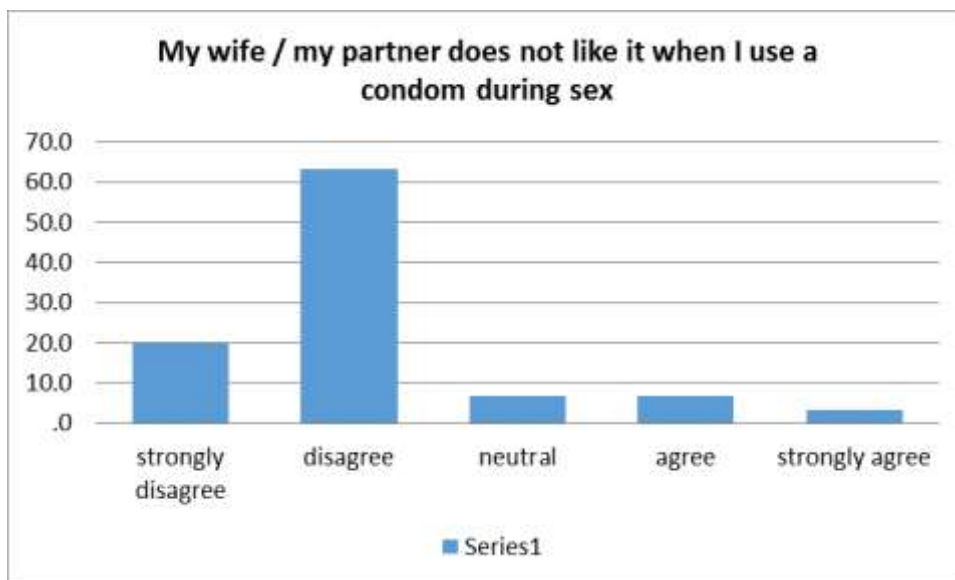


Figure 5.10 Wife or partners' dislike of condoms (Q41)

Considering that the major thrust of company X's workplace programme has been condom distribution, it was encouraging to note that condoms had to a large extent been embraced by the BVOs at the Gaborone Depot, and that attitudes which might be considered barriers to condom use were generally confined to less than 20 % and sometimes less than 10% of the BVO study sample group. BVOs wives and regular partners were especially receptive to the use of condoms with their men, suggesting high levels of awareness of the protective benefits of condoms, reported by their BVO husbands and lovers. However this receptiveness and acceptance of condoms among wives and partners way well mirror their perception that their husbands, through their lifestyle, posed a risk of infection to them as wives and partners (Prahnta and Cleland, 2005 cited in Lammers, van Wijnbergen and Willebrands, 2011:13).

5.6. Multiple and Sexual Partner Concurrency among BVOs

Sexual partnership concurrency, defined loosely ‘overlapping sexual partnerships’ or having more than one sexual partner at time, has been cited earlier in the literature review as the major driver of generally higher levels of HIV prevalence among long distance truck drivers, and as well as a major ‘transmitter’ of the HI virus in generalized epidemics such as that faced by Botswana (www.PSI.org , NACA, 2009:11 and NACA, 2010:41). It was logical therefore, that **another of this study’s objectives, was to explore the extent of multiple sexual partnerships or sexual concurrency among BVOs at company X.** Two approaches were used to explore this; first of which was through the use of a Likert-type item statement, and the second of which was numerical, at the interval level, and asked BVOs to give the actual numbers of partners in the last year and in the last two months.

5.6.1. Numbers of sexual partners at any given time

First, the study sought to gain an impression through the use of a Likert scale item “*I usually have more than one sexual partner at any given time*” to which the majority (55%) disagreed, whilst (31.6%) generally agreed with this statement, whilst 13% remained “neutral”. Therefore just under one third of BVOs reported themselves as having more than one sexual partner at any given time according to the likert approach.

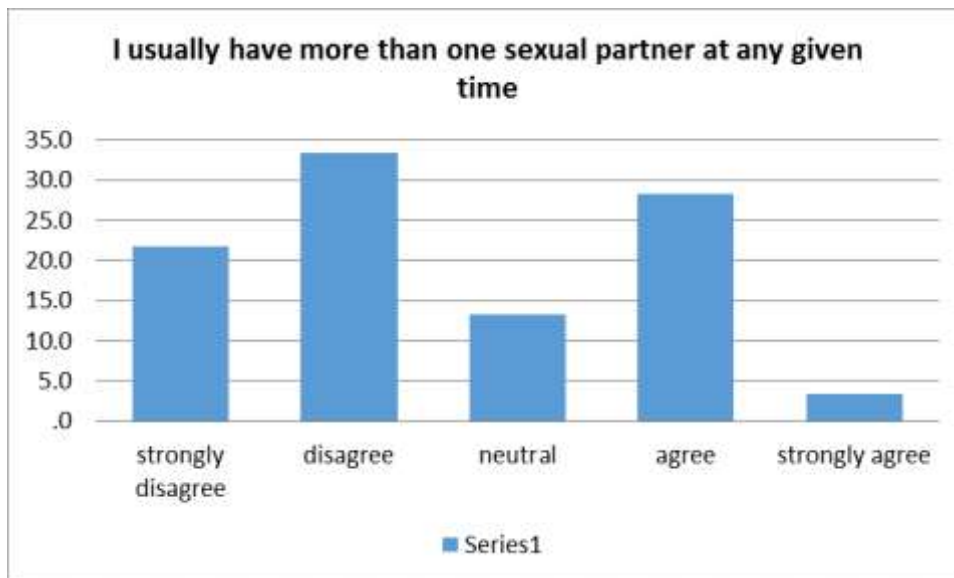


Figure 5.11. Having more than one sexual partner at any given time (Q53)

Second, BVOs were asked directly to state the number of sexual partners they had had; (a) in the last year, and (b) in the last two months. Table 5.9 below illustrates that 56% of BVOs reported having only had a single sexual partner in the last year, while 44% reported having had more than a single sexual partner in the last year, with the trend being most evident in the first two age groups, 25-34 and 35 – 44. Within the youngest age group 25-34, more BVOs

reported having had more than had one sexual partner in the time-frames in question. The actual numbers of partners were spread across several numbers, including BVOs who had answered “Many” rather than citing a specific number, for this reason all sexual partners in excess of 1, were grouped as “More than 1”. While it may be argued that these could have been serial partnerships rather than concurrent, the importance of this finding is the commonality (44%) of having more than a single sexual partner in a year.

Table 5.9. Cross-tabulation of BVOs Sexual Partners in the last year by age group (Q66)

Age Group	One Sexual Partner (%)	More than One Sexual Partner
25 – 34	8 (24.2)	10 (38.5)
35 – 44	16 (48.5)	10 (38.5)
45 – 54	9 (27.3)	6 (23.0)
TOTAL	33 (100)	26 (100)

To further interrogate the subject of sexual partnerships, BVOs were asked to indicate in the questionnaire just how many sexual partners they had had in the last two months. A third, (33%) of the study sample reported more than 1 sexual partner in the last two months (refer to the table below). The BVOs themselves used a host of names to refer to their additional partners “*mothusa mmabo*” (meaning “My wife’s helper”/ “My Wife’s Deputy”/ “The mother of my children’s helper”) or “*nyatsi*” (“mistress” or ‘concubine’), “*yo keiphitlang le ene*” (‘the one I hide with’ – essentially a clandestine sexual partner). The BVOs sentiments are deeply embedded in the culture as encapsulated in the proverb “a man is a bull, you cannot confine him to the one ‘kraal’” and “*monna ke selepe, oa adimanwa*” which literally means, ‘a man is like an axe, which is borrowed and used by different homes in the neighborhood’. Other BVOs would make the statement, as though it were a foregone conclusion “there’s no man who doesn’t hide himself with someone” as well as “a man can’t fail to have another woman on the side” and saw this as part and parcel of manhood. Therefore social and cultural norms and beliefs play a significant role in the existence of multiple and concurrent sexual partnerships in the Botswana setting (NACA, 2010:56). An AED and TMARC Report on the a Baseline Survey for HIV/AIDS and Family Planning Intervention for Risk Groups in Tanzania found that truck drivers (15%), alongside commercial sex workers (80%) and bar maids (22%), “showed high rates for having multiple partners” (AED and TMARC, 2006:4). It should be noted however that the majority of BVOs in the study reported having a single partner. In the light of the extensive nature of sexual partner concurrency, it is probably time to consider using visual awareness-raising approaches based on computer models that simulate the effect of multiple concurrent partnerships/sexual concurrency and which show how these ‘fuel’ HIV transmission, which can be shown and discussed with BVOs in tool box meetings, or during refresher training. The ideal partner in providing this training is **Population Services International (PSI)**.

The role of multiple concurrent sexual partnerships as a key ‘driver’ of the generalized HIV epidemic in Botswana has been noted. Halperin et al (2004) observed that the pattern often found in Africa of men and women having more than one sexual relationship enduring for several months or years placed individuals in the network at the risk of HIV infection for sustained periods, increasing the risk of infection among the network in time (cited in NACA, 2010:52). The longer some of these ‘on the side’ arrangements endured, the higher the likelihood that condom-use consistency would decline – therein lay the elevated risks of HIV infection (Epstein, 2007). In a study examining a sample of Ibadan long distance truckers’ self- perception of vulnerability to HIV infection, Arulogon, Oladepo and Titiloye observed that truckers tended to strike up personal relationships among some casual sex contacts whom they visited frequently when passing through those towns and after sometime ceased to view these women as ‘sex workers’ but more as ‘girlfriends’ with whom they were less likely to use condoms with as their perception of ‘risk’ decreased with frequent contact (2011:1385). Chin (2007:7) similarly maintains that sexual transmission of HIV is most intense in the groups and contexts where high-risk behaviours are present, particularly where there are “...frequent and overlapping sexual networks” but laments that transmission among HIV-infected spouses to their regular partners (discordancy) is an area of growing transmission which national responses must pay greater attention to through upscaling “secondary” and “tertiary” prevention strategies (2007:7).

Indications are that there were the conventional commercial sex workers touting for business and readily identifiable at ‘Hot Spots’ as well as those women with whom more private enduring arrangements could be made by cell phone. One BVO comments;

“There’s a well-known bridge in South Africa, when we are parked there, there are women who walk up alongside the truck and raise their skirt or dress as you pass by....they are sending out a clear message...they are ‘calling’ you...”

“When you are parked at Palapye where we wait overnight on the way to Francistown, you’ll sometimes hear knocking on the truck door late at night...if you peep through the curtain, you’ll see a woman there...you know she wants to sleep with you for money...I ignore the knocking but, if you watch through the curtain you’ll see her leaving after a short while to knock on another truck’s door...a woman like that has probably gone round the trucks quite a bit....If I’m going to cheat on my wife, I’d rather cheat with someone ‘clean’...”

“You’ll arrive at your stop-over, park...and maybe after a while you will see someone you who interests you in the area...you’ll take her cell phone number and then next time you pass through there, you’ll tell her where to meet you and take it from there....”

Another BVO confirms the use of cell phones in facilitating the setting up of liaisons with women who do not obviously look like commercial sex workers...

“Men really don’t need prostitutes anymore...there are enough willing women out there and even they want gifts, money...as long as you have cell phone contacts you can make plans to meet up even well before you get there...all you really need are cell numbers...”

These narratives suggest that approaches such as ‘risk mapping’ needed to be augmented with qualitative accounts such as these which demonstrated that ‘risk’ for BVOs and other truck drivers was not only spatially-fixed but was more fluid and was facilitated by cellular phone communication and the ability to travel. For the bulk vehicle operator (BVO), in the course of his daily driving job, access to all kinds of women is plentiful and this combined with the long absences from wives and partners and the comforts of home tended to test their resolve, or alternatively facilitate the casting off of their inhibitions. It is therefore no surprise that numerous studies single out truck drivers, along with commercial sex workers as most-at-risk populations (ILOAIDS 2005; AED and TMARC, 2006, Chaturvedi, 2006, and Upadhyay et al, 2010). Women not outwardly fitting the description of commercial sex worker (CSW) also gave BVOs sexual companionship in return for gifts and cash.

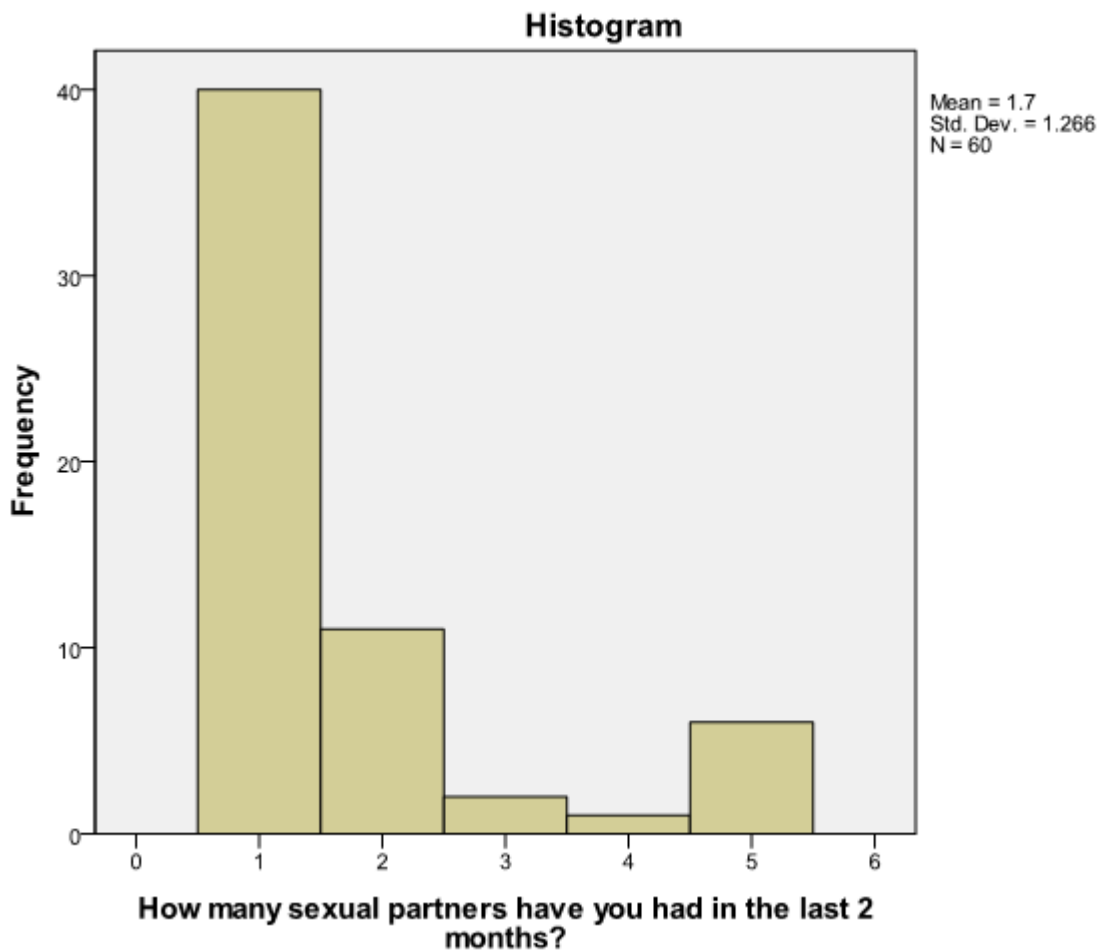


Figure 5.12. The number of sexual partners BVOs reported having in the last 2 months

The same information displayed in this histogram is laid out in the table below and indicates that even when the time period is shortened, the practice of keeping multiple sexual partners is still evident, even though reported to a lesser degree.

Table 5.10. BVOs sexual partners in the last 2 months (Q67)

No of sexual partners in the last 2 months	Frequency	%
1	40	66.7
More than 1	20	33.3
TOTAL	60	100

5.6.3. Marital status and the number of sexual partners

The question may then arise as to whether sexual partner concurrency would still be in evidence among the formally married or cohabiters (living together relationship)? Table 5.11 below in which marital status is cross tabulated with the number of sexual partners reveals that about half the BVOs who were formally married and in living together relationships had had more than one sexual partner in the last year.

Table 5.11. The number of sexual partners by BVOs marital status

Marital Status Category	One Sexual Partner	More than 1 Sexual Partner
Single/ Never married	10	15
Living Together	8	4
Formally Married	13	6
Divorced	2	0
Widowed	0	1
TOTAL	33	26

This was over and above their spouse or regular partner and in this regard multiple partnership concurrency, rather than serial monogamy, is much more clearly the case. Sixty per cent (60%) of single/never married BVOs in the study sample reported having had more than one sexual partner in the last year, compared to 33% of cohabiting men, and 32% of formally married men. This finding is consistent with a study among long distance truckers in India in which Pandey, Mishra, Sahu, Benara, Biswas, Sengupta, Mainkar and Adhikang (2012:44) found that unmarried long distance truck drivers were more likely to have sexual encounters with casual or non-regular partners more so than married men.

5.6.4 BVOs perceptions on the impact of duration away from home on the likelihood of sexual partner concurrency:

The literature review in the first chapter indicated several studies had identified the role of duration away from home as a factor influencing exposure to sexual risk-taking, particularly engaging the services of commercial sex workers, and contracting STIs (Chaturvedi, 2009:155 and Singh, Piramanayagam, Bayapa, Pallavi, Nagarjuna and

Choudhary, 2012 and The Synergy Project, n.d). As such this study considered the variable of duration in two dimensions; firstly, in terms of the ‘waiting times’ involved in loading and off-loading fuel or cement and second, in terms of the time/duration away from home.

5.6.4. Likelihood of sexual transgression with non-regular partner on trips with long waiting times

When BVOs were asked to respond to the statement “*I am most likely to have sex with someone who is not my wife or regular partner during trips that have long waiting times*”, their responses showed some ‘polarization’ among the BVOs, with a majority 61% generally disagreeing with this statement, compared to 32% who generally agreed with the statement (see the figure below). When asked about this, one BVO who disagreed with the statement, not seeing himself as being at risk in either respect noted;

“When there’s a long queue at the gantry, you simply get in line and await your turn...loading up is your first priority... I have never had this problem...as a BVO, I never get tempted to buy prostitutes...at a stop-over or delay, I don’t go looking for women, I just pull out my book or my newspapers and read until it’s time to sleep or time to move on...I am willing to wait and get intimate with my partner when I get home, no matter how much time I spend on the road...” Another BVO pointed out that loading sites, gantries and refineries were generally not places where women loitered waiting for truckers. Rather these were found at weigh bridges, near border posts, in settlements at bars and motels.

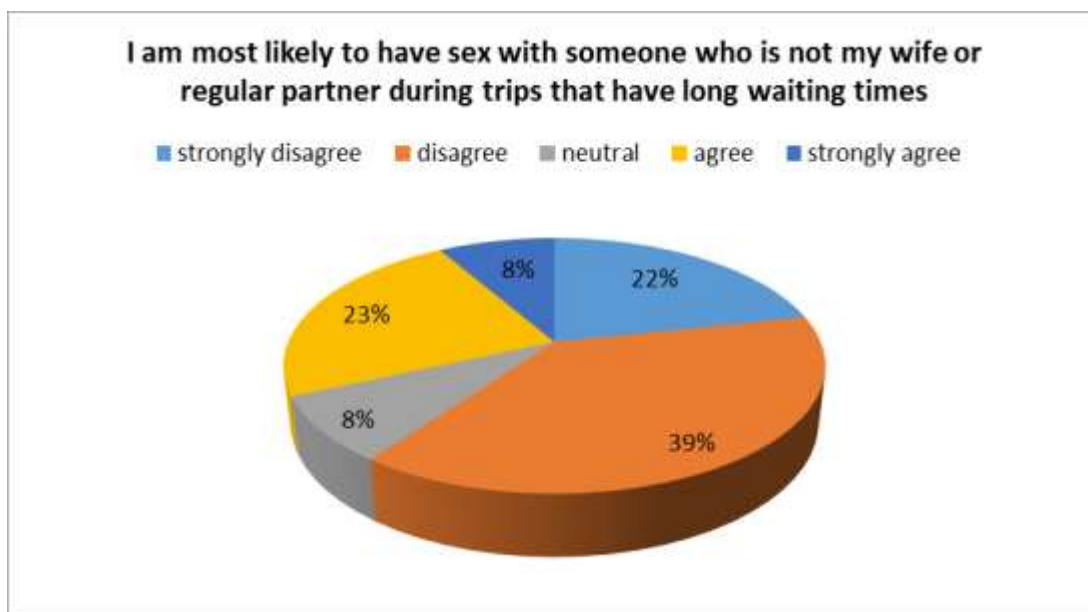


Figure 5.13 Likelihood of having sex with someone other than wife or regular partner during trips with long waiting times (Q54)

5.6.4. Likelihood of sexual transgression with a non-regular partner during trips away from home for the longest times

The second dimension of ‘duration’ involved the statement to the effect that “*Trips that take me away from home for the longest time are where the likelihood of me having sex with*

someone other than my wife or regular partner is higher”, to which 46% generally disagreed (of this 18.6% “strongly disagreed”), in contrast to 41% who generally agreed with the statement (with only 13.6 “strongly agreeing”). It is insightful that the levels of agreement with the second dimension “*away from home for the longest time*” were higher (41%) when compared with the first aspect of “*trips that have long waiting times*” (32%) . Additionally, levels of general disagreement fell from 61% to 46% with the second statement pertaining to being *away* for the “longest time”.

Table 5.12. Trips that take me away from home for the longest time are where the likelihood of me having sex with someone other than my wife or regular partner is greater/higher

Response Anchor	Frequency	Percentage
Strongly Disagree	11	18.6
Disagree	16	27
Neutral	8	13.6
Agree	16	27.1
Strongly Agree	8	13.6
TOTAL	59	100

Value for the study: BVOs who participated in this study at company X therefore considered being *away from home for the longest time* as the context more likely to pose the risk of sex/ or temptation to have sex with someone other than wives or regular partners, more so than trips which involved *long times awaiting loading* at gantries and refineries. This result suggests that the ‘wear’ on human resolve and restraint increases with longer times away from home.

5.6.5. BVOs Self-perception of the likelihood of sexual temptation with some one other than their wife or regular partner and the risk of HIV Infection as a risk or hazard of their occupation

This study additionally **set out to explore BVOs self-assessment or self-perception of the likelihood of sexual transgression with a woman other than their wives** or regular partners and their self-perception of their heightened exposure to HIV infection **as a result of the nature of their occupations as BVOs.**

Table 5.13. BVOs self-perception of sexual temptation with others and exposure to HIV as an occupation-specific risk/hazard

Response Anchor	“BVO Job/occupation exposes me to higher risk of sexual temptation with people other than my wife/regular partner” (%)	“BVO Job/occupation exposes me to higher risk of getting HIV” (%)
Strongly Disagree	5 (8.5)	6 (10.5)
Disagree	13 (22.0)	13 (22.8)
Neutral	3 (5.1)	6 (19.5)
Agree	28 (47.5)	25 (43.9)
Strongly Agree	10 (16.9)	7 (12.3)
TOTAL	59 (100)	57 (100)

To this end two statements were put to the study participants; firstly; *“The job or occupation of being a BVO exposes me to a higher risk of sexual temptation with people other than my wife / regular partner”* and secondly; *“The job or occupation of being a BVO exposes me to a higher risk of getting HIV.”*

Over half of the BVOs in the study showed overall agreement with both statements, therefore perceived themselves to be at greater risk of sexual transgressions outside of the marriage or regular partner context (64.4%) and at greater risk of getting HIV (56.2%) because of all that their jobs as BVOs entailed, particularly the numerous days and nights away from home and families. This finding shows that the differences in overall disagreement between BVOs self-assessment or perception that sexual temptation and a higher risk of getting HIV were not remarkably different (30.5% and 33.3% respectively), on both statements. The perception of vulnerability to (yielding to) sexual temptation among BVOs in the study sample, at company X’s Gaborone Depot, was high at 64%, somewhat less so the perceived risk of HIV infection which was 56.2%. Sexual temptation with a woman other than the BVOs wife or regular partner, was clearly seen as a more likely event than the risk of HIV infection, which could be countered with a condom. Bisika (2009) in a study on HIV risk perception in Malawi’s Tourism Industry revealed that 41.5% of the tourism, wildlife parks and travel workers reported that their occupations put them at a higher risk of getting infected with HIV, being impregnated and contracting an STI. Over half of the BVOs in the study sample were well aware of their own susceptibility and perceived their occupation, by its very nature, as exposing them to a higher risk of HIV. This finding is supported by AED and TMARC study on HIV/AIDS interventions among risk groups in Tanzania in which 62% of truck drivers in the sample perceived themselves as having an enhanced likelihood of becoming infected with HIV (AED and TMARC, 2006:23).

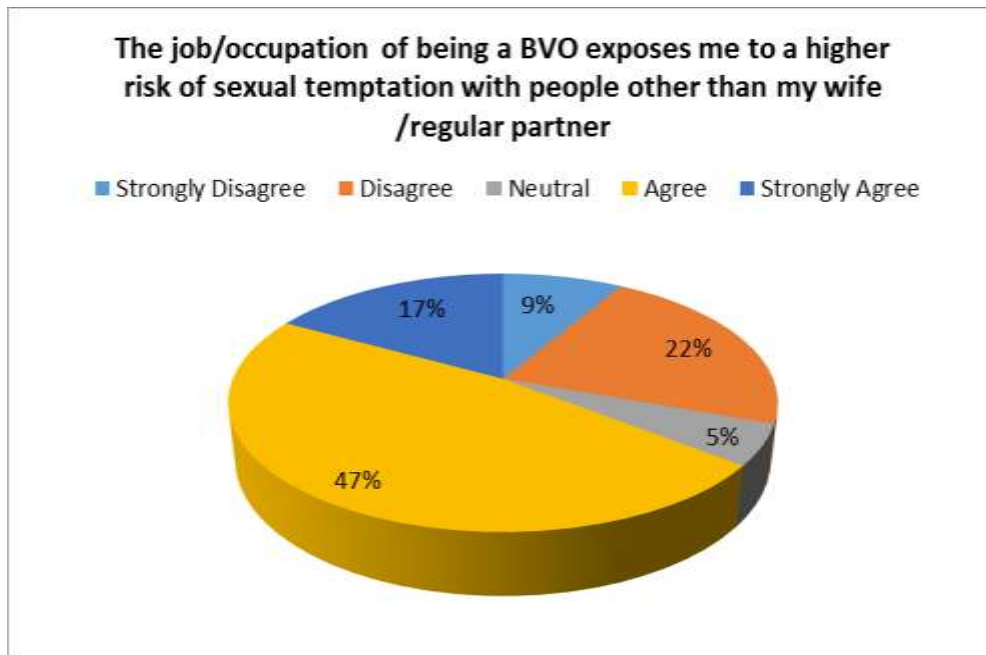


Figure 5. 14 BVOs self-perception of the risk of sexual temptation with people other than a wife or regular partner as an occupation-linked risk (Q109)

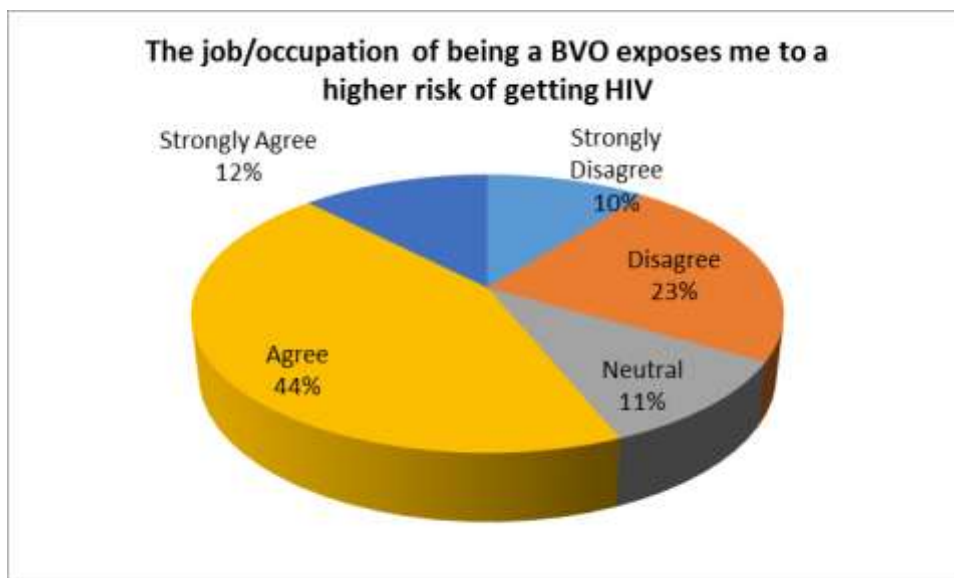


Figure 5. 15 BVOs self-perception of risk of HIV as an occupation-linked risk (Q110)

5.7. Company respect for rights and privacy of employees living with HIV/AIDS

Company X has an HIV/AIDS Policy, updated in August 2014, which encapsulates the company's response to the threat of HIV/AIDS and which unequivocally lays down the company's non-discriminatory stance with HIV and AIDS in the workplace; namely, its undertakes to reduce the impact of HIV/AIDS on the company; affirms respect for the employment rights and national laws with regard to HIV/AIDS; as well as reiterates the company's respect for the privacy and confidentiality of employees' HIV status, and No HIV-related discrimination of applicants. BVOs were familiarized with all company policies,

Health and Safety, including Company X’s HIV/AIDS Policy, during induction and other training. The overriding aim of company X’s policy, was **the facilitation of a fair, accommodative and non-discriminatory work place in which the adverse repercussions of HIV and AIDS were lessened**. In this regard, company X’s policy is compliant with principles laid out in the ILO Code of Practice on HIV/AIDS in the Workplaces (www.ilo.org, n.d). From this research study’s perspective, the study objective in this regard was **whether BVOs were believed or were convinced of the company ethos, as laid out in the HIV/AIDS Policy and whether they felt their work environment to indeed be accommodative and non-discriminatory** (CPSHEQ22-HIV/AIDS Policy version 10).

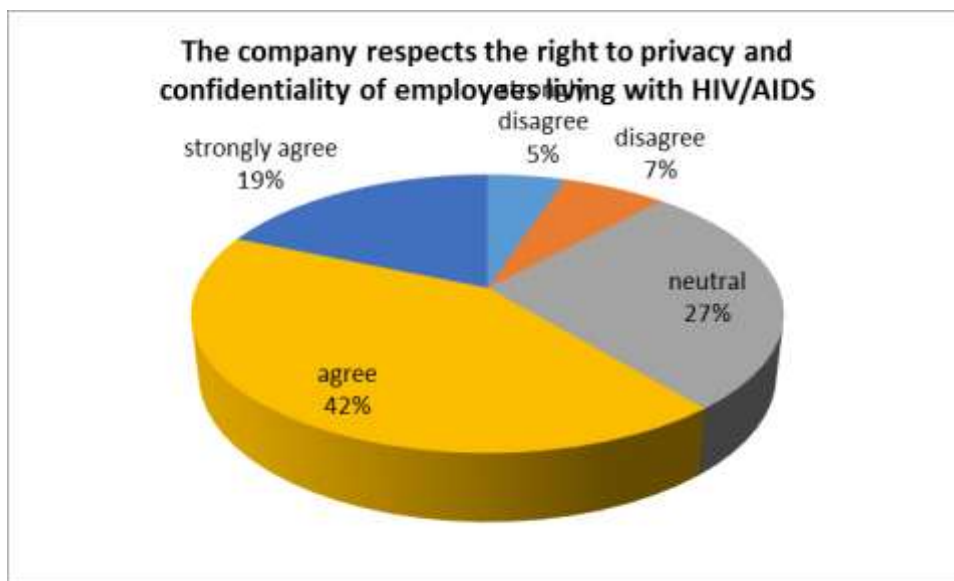


Figure 5. 16 BVOs perception of company X as company respecting confidentiality and Privacy of employees living with HIV/AIDS (Q73)

Figure 5.16 above illustrates that 61% of the BVOs in the study sample agreed with the statement to the effect that “*The company respects the right to privacy and confidentiality of employees living with HIV/AIDS*”, while overall, only 12% of BVOs disagreed with this statement and 27% remained “neutral”. This finding suggests that the majority of BVOs did not feel that the company sought to pry as to whether they were HIV positive or not. Therefore, company X’s commitment outlined in its HIV/AIDS Policy to prohibit pre- or post-employment testing for HIV in accordance with national laws and to “...ensure the privacy and confidentiality of all registered on the Wellness programme” and to protect confidentiality of employees through threatening “disciplinary action...against any member of staff who is found to have disclosed the HIV status of an employee or third party”. Therefore in this crucial respect, company X’s HIV/AIDS Policy enjoyed reasonably high levels of credibility among the BVOs who participated in this study (CPSHEQ22-HIV/AIDS Policy Version 10).

5.7. Company does not discriminate against employees living with HIV/AIDS

Additionally, the study sought to establish bulk vehicle operators' perceptions with regard to HIV-related discrimination in the work place. To this end the item statement "*The company does not discriminate against employees living with HIV or AIDS*" was put to BVOs in the study sample, to which an overall proportion of 55% agreed, while an increased proportion (19%) of BVOs disagreed. Noteworthy is that an even larger proportion of BVOs (35%) remained "neutral", many feeling, as with the previous statement, that they were not qualified to respond in either direction as they could not pin-point BVOs at the Gaborone Depot, who were openly HIV positive, and neither could they comment on whether they felt any discrimination. Overwhelmingly, though, most BVOs still generally agreed that company X did not discriminate against HIV positive employees. In this regard, the company HIV/AIDS policy was successful in achieving its aim of "continuing its non-discriminatory practices against HIV/AIDS infected employees, including job applicants" as well as ensuring "...equal access to employee benefits provided for in each category of work" (CPSHEQ22 HIV/AIDS Policy version 10)

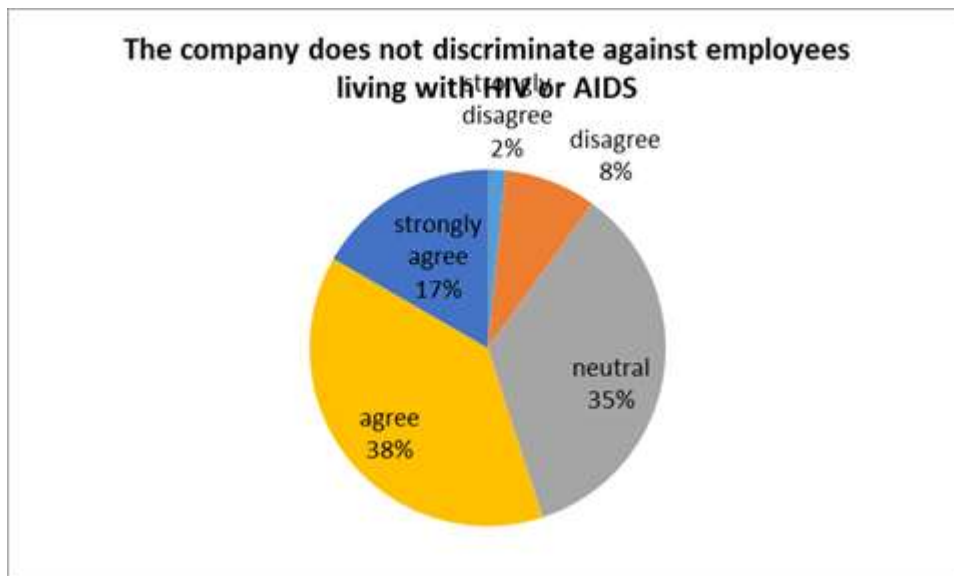


Figure 5.17 BVOs perception of company X as non-discriminatory towards employees' living with HIV or AIDS (Q74)

5.7. The company accommodates employees suffering from HIV/AIDS-related illnesses/adjusting to effects of ARVs to do less physically hard work if not well

When the statement "*The company accommodates employees suffering from HIV/AIDS related illness or adjusting to the effects of ARVs to do less physically hard work whilst they are not well*" was put to the BVOs in the study sample, to which only 20% agreed, whilst a larger proportion (27%) generally disagreed. Most striking here is that the portion of BVOs who remained "neutral" was sizeable (53%). A BVO who agreed with the statement observed "Sometimes they will take you off the truck so that you are no longer crossing

borders and instead you will be driving the company *bakkies* and vans around Gaborone...I have seen it happen”. Others mentioned that while they were aware of some BVOs who had been released from driving heavy trucks, they could not say that it was due to HIV/AIDS rather than some other illness.

Implication of finding: This demonstrated the company X had ‘re-designed’ or adapted roles for BVOs unable to do their usual distance traveling in heavy articulated trucks due to diminished health or concentration (Noe, Hollenbeck, Gerhardt and Wright, 2012:177), and that some sort of ‘reasonable accommodation’ was occurring at company X, albeit in a *de facto* way, was progressive even though general awareness of this among BVOs was low. Given the paramount concern with safety at company X, such a measure would also have been taken in relation to the reported ill-effects of chronic illness which could jeopardize safety, ie. visual disturbances due to diabetes, or dizziness due to hypertension.

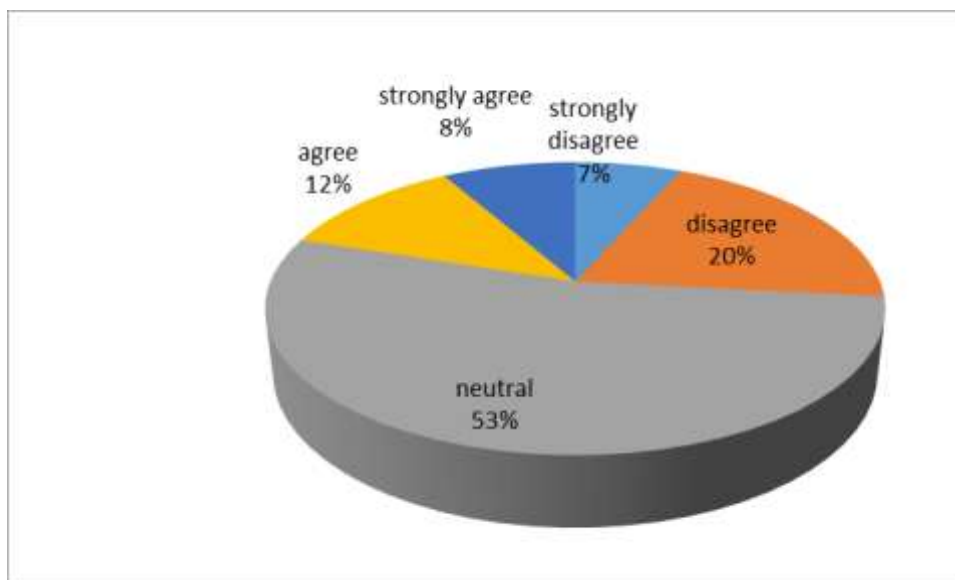


Figure 5.18 BVOs perception that company X accommodates employees suffering from HIV/AIDS-related illness or adjusting to the effects of ARVs to do less physically hard work whilst they are not well (Q76)

5.7. Employees suffering with an HIV/AIDS-related illness can access emotional and physiological support from some known person at the depot

Finally, the study inquired as to whether “*Employees suffering from HIV/AIDS-related illnesses can access emotional and psychological support from some known person at the depot*”, to which 38% generally agreed, whilst 18% generally disagreed. Forty-four percent (44%) remained neutral. Agreement with this statement was just above one third of the BVOs interviewed and it was clear that BVOs were not convinced of this as a group. This could be attributed to respondents knowing very few BVOs who have suffered with HIV-related illnesses and therefore preferring to be non-committal about the statement. If this was indeed the case, this was also a reflection of the confidentiality around the HIV statuses of other BVOs to which company X was committed, in terms of its HIV/AIDS Policy (CPSHEQ22-HIV/AIDS Policy Version 10).

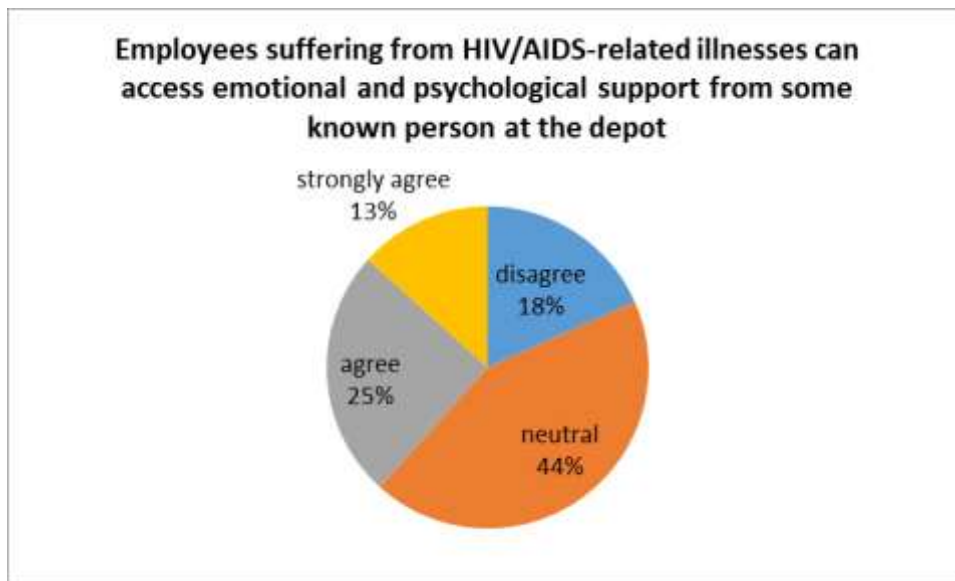


Figure 5.19 BVOs perception of workplace availability of emotional and psychological Support from some known person at the Depot (Q75)

The foregoing section sought to illustrate whether BVOs perceived their employer, company X as empathetic, fair, non-discriminatory, accommodative and respectful of the privacy and confidentiality of employees. Additionally, this section sought to establish whether company X was empathetic and supportive of employees living with HIV/AIDS or afflicted with HIV-related illnesses. Many BVOs were unwilling to ‘vouch’ for that which they had not personally witnessed. On the other hand, BVOs who had themselves experienced this ‘reasonable accommodation’ were emphatic of company X’s support of HIV positive employees working, in line with the ILO 200 Recommendation and the ILO Code of Practice on HIV/AIDS and the World of Work (ILO, n.d).

Table 5.14. Summary table showing BVOs perception of company X with regard to employees living with HIV and AIDS

Statement	Attitude
‘Company respects the right to privacy and confidentiality of employees living with HIV and AIDS’	Generally Agree 61%
	Generally Disagree 12%
	Neutral 27%
‘Company does not discriminate against employees living with HIV or AIDS’	Generally Agree 55%
	Generally Disagree 10%
	Neutral 35%
‘Employees suffering with an HIV/AIDS-related illness can access emotional and psychological support from some know person at the depot’	Generally Agree 38%
	Generally Disagree 18%
	Neutral 44%

<p>‘Company does accommodate employees suffering from HIV/AIDS-related illness or adjusting to effects of ARVs to do less physically hard work’</p>	<table> <tr> <td>Generally Agree</td> <td>20%</td> </tr> <tr> <td>Generally Disagree</td> <td>27%</td> </tr> <tr> <td>Neutral</td> <td>53%</td> </tr> </table>	Generally Agree	20%	Generally Disagree	27%	Neutral	53%
Generally Agree	20%						
Generally Disagree	27%						
Neutral	53%						

Of all the related questions on the subject of how BVOs perceived company X’s ethos and demeanour with regard to HIV/AIDS, BVOs generally agreed in greatest numbers that the company respected the right to privacy and confidentiality of employees living with HIV/AIDS was shown by the clearest and strongest agreement (61%) with the lowest levels of neutrality (27%) and 12% of overall disagreement on this item statement. The information is summarized in the preceding table.

5.8. HIV and AIDS services and activities desired at the Gaborone Depot by BVOs:

5.8. Whether there was a known person at the depot listening/advising or counseling BVOs on general health/family relationship worries/grief and depression/ sexual health concerns and HIV/AIDS

Key to establishing the kinds of workplace activities and services ideally desired by BVOs at the Gaborone Depot of company X, is an assessment of what they perceive or know to already be in place. Therefore, the question was asked *“Is there any known person at the depot of company X whom a BVO can go to and talk about any health concern and get advice on; general health; family and relationship worries, bereavement, grief, depression; sexual health and HIV-related concerns?”*

BVOs had the option of answering “YES”, “NO” or “Don’t Know” for each of these concerns or worries. The table below illustrates the BVOs responses, and shows that a majority of BVOs in the study sample felt that there was no known person whom they could go to for advice and counselling in these areas, with *grief, bereavement* and *depression* being seen as particularly under-served areas of concern for BVOs, in addition to sexual health concerns and HIV/AIDS related matters. The perception with regard to a lack of available on-site or workplace advice and counselling in the area of family and relationships was also striking. As one BVO stated; “We don’t have such people to talk to us or counsel us here...if you are bereaved or down emotionally, you’ll be crying all alone in the cab of your truck”. Another BVO mentioned that they would share their concerns with their supervisor or foreman, while others mentioned confiding in a trusted colleague.

Table 5.15. BVOs perceptions on whether there is a known person at the Company X's Gaborone Depot any BVO can go to for general, family/relationship, bereavement and HIV/AIDS and other sexual health concerns

Concern/Worry	YES	NO	Don't Know
01 General health	21	34	4
02 Family/relationships	16	40	4
03 Grief/Depression	12	43	5
04 Sexual health and HIV/AIDS	14	42	4

The point was emphasized by some BVOs that fully trained professional psychologist(s) or counsellors who *really* understood the meaning of client confidentiality and were professionally bound by this, were the level and quality of counselors needed at the Gaborone Depot. Presently some BVOs did not feel that they could entrust anyone at company X with their personal challenges and issues. Other BVOs mentioned that 'news' and gossip spread fast at the depot, and that a person's private issues did not stay private for long, thus he had no desire to provide fodder for gossip at the workplace. Confidentiality issues, unrelated to HIV/AIDS, remained a source of anxiety for some BVOs even as the majority felt they needed professional help designated for these purposes to be available at the Gaborone depot. BVOs were then asked whether they would go to the same person for all categories of worries and concerns, to which 20 answered "Yes", while 34 answered "No" and four said they did not know.

5.8. The need for a depot-based professional to assist in counselling BVOs on all these concerns

The BVOs in the study sample were subsequently asked "Do you think that there should be one person available and based at company X's depot to assist with all these concerns?" Table 5.15 illustrates that of the four response options given, the majority of BVOs (43.3%) preferred that two such counselors were based at the depot to assist and counsel BVOs and other staff, while 30% preferred only one such counselor. Only one BVO preferred to seek such services away from the depot, showing a widespread and strong desire (73.3%) for services of this nature on site/at the depot.

A BVO remarked;

"Because of our lifestyles, our always being away on the road...even as you are the head of your family, your role in the family gets smaller and weaker...tensions develop with your partner and even your own children don't take your position in the home that seriously after a while...many of us have trouble in our families..."

Table 5.16. BVOs opinions of whether there should be a person available and based at Company X's Gaborone Depot to assist in counselling BVOs on general health, family & relationship issues, grief and depression and sexual health & HIV/AIDS concerns

Opinion	Frequency	(%)	Cumulative %
Should be One	18	30	30
Should be Two	26	43.3	73.3
At least Three	15	25.0	98.3
NONE (prefer non- depot based services)	1	1.7	100
TOTAL	60	100	

Another BVO commented on the impact of his occupation and its demands on his personal and family life;

“You miss funerals in your family, you miss weddings...you miss out on a lot happening in your family”.

Yet another BVO verbalized it thus; “We *live* on the road, we *visit* our families...” contrasting his lifestyle with that of the rest of society, who lived at home with family, and were on the road for travel, visits....

Some linked their constant fatigue from driving for six or seven days at a stretch and only having two intervening rest days, before resuming driving duties, as keeping them constantly fatigued, which impacted negatively on their sex lives and contributed to increasing tension with spouses and partners. It was clear from these accounts that the pressures acting on the BVOs were well beyond STIs, HIV and AIDS, but also emotional, physiological psycho-social and sexual – and for these, BVOs felt under-provided for in terms of support.

Implications for workplace programming: From these and other accounts, it is apparent that the range of skills, advice and counselling desired by BVOs is varied, well beyond the confines of STIs and HIV and were desired at the right levels of professionalism, and overlapped into the area of marriages/relationships and sexual health, which were under-provided for. While psycho-social support was required in these areas, it was emphasized that this was required and desired only with the strongest respect for confidentiality.

5.8. Activities desired at the Gaborone depot of company X

Finally, BVOs were asked to indicate their agreement or disagreement with a series of statements which asked participants to agree or disagree about the desirability of very specific activities indicated in Table 5.17. All the activities in the list provided were strongly desired by the vast majority of BVOs, with desire for a Company Wellness or Family Fun Day being articulated by most, followed by the wish for the HIV/AIDS Policy of company X to be more prominently displayed around the depot and the desire for more frequent

discussion and talks about STI and HIV prevention at the Gaborone depot being the leading three activities.

BVOs similarly agreed in appreciable numbers (all upwards of 80%) about having a trained HIV/AIDS and sexual and reproductive health counselor based at the depot and more sexual and reproductive health promotion activities were required at the Gaborone depot. In discussions in the common room some BVOs expressed a strong desire for a clinic at the Gaborone depot, where they could receive attention rapidly, and outside of conventional hours, for instance when returning at night from a trip.

Table 5.17. BVOs assessment of the adequacy of HIV-related information, activities and personnel at company X's Gaborone Depot

Activity desired at company X, Gaborone Depot	Agree (%)	Disagree (%)
there should be more frequent discussions and talks about STI and HIV prevention at company X Gaborone depot	52 (87)	8 (13)
the HIV/AIDS Policy of company X should be more prominently displayed around the depot	53 (88)	7 (12)
there is not enough promotion of sexual and reproductive health activities at the depot	49 (82)	11 (18)
the company should have a trained HIV/AIDS, sexual and reproductive health counselor at the depot	48 (80)	12 (20)
Company X should have an annual company Wellness or Family Day where talks and tests on all aspects of health (Blood Pressure; Cholesterol; HIV; Diabetes; Cancer awareness are all available)	54 (90)	6 (10)

It is hoped that these responses provide those tasked with health, safety and wellness, particularly HIV/AIDS at company X with some insights into those activities and services bulk vehicle operators at the Gaborone depot and some guidelines for enriching the activities and services currently offered under company X's HAW programme.

This study concludes with chapter six, in which the main study findings are summarized, with ideas and suggestions put forward for company X's workplace programming in terms of content; ideal forum and partners/partnerships.

Chapter 6. SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

6.1 Summary of Findings and Conclusions:

This exploratory research study undertaken with a view providing management, and especially officers tasked with formulating and implementing HIV/AIDS and STI workplace activities with strategic baseline information on the knowledge, and attitudes of bulk vehicle operators particularly with regard to HIV and AIDS. This research study focused on BVOs who were readily identified by company X's senior management as being indispensable to the execution of key business operations yet identified in the literature as being highly vulnerable to sexually transmitted diseases and HIV infection and consequently been have been cited among the 'most-at-risk' populations or as having an heightened 'occupational vulnerability'.

The detailed data collection tool used in this study was planned and designed such that is of enduring usefulness to company X, extendable to its other depots in Lobatse, Francistown and Palapye, if so desired, beyond the duration of this particular study. This would allow company X to interrogate dimensions of job satisfaction, to establish bulk vehicle operators' assessment of the adequacy of training (induction and tool box chat sessions) generally and training with regard to HIV and AIDS awareness. Therefore this study was embedded in company X – a fuel logistics company and conducted among its critical employees, the truck drivers known as BVOs, and the findings thereof were to be fed-back into this same company X, particularly to those charged with implementing its workplace HIV Health and wellness (HAW) programme. This was a study aimed at guiding various interventions in the HAW programme – either through the introduction of new activities or the enrichment of existing activities, as such it considered a fairly wide array of sub-topics pertaining to HIV/AIDS. It was a company-specific study, and a highly applied approach which generally fell in the category of operations research – exploratory in nature, with a view to identifying key areas for targeting under company X's HAW programme or else to point out capacity-strengthening required to enable the HAW programme objectives to be better met.

As reported in **section 5.1** the study achieved its first two objectives by identifying the demographic and socio-economic characteristics of BVOs, which showed that the majority of BVOs interviewed in the sample (75%) were aged 44 and below and that 92% of these same BVOs were educated up to complete secondary school level, with the single largest group being 'never married' (42%) whilst 53.4% were in a stable relationship context, being formal marriage or were 'living together'. The relevance of demographic and socio-economic differentials for HIV prevalence was also highlighted.

The study showed how the BVOs as a group scored on general HIV knowledge, as well as their knowledge with regard to transmission and prevention information on HIV and AIDS. **Section 5.2** was useful in revealing the incorrect knowledge and misconceptions held by these same BVOs. Its value lies in being able to demonstrate to those charged with HIV awareness and education at company X, the specific knowledge deficits their very own

employees, identified as a critical post, had. These were highlighted clearly, so enabling the tailoring of course content to address or target these areas of ‘lack’ and misinformation.

In a similar vein, **section 5.3** considered the health-seeking behaviours of BVOs in the event of observing STI-like symptoms on themselves, and alongside noting with satisfaction, the preponderance of the correct responses, also identified worrying responses which needed to be addressed. For instance the primacy of ‘asking a friend or colleague for advice’ over ‘go to the chemist/pharmacy to buy medicine’ was identified as an area for intervention in the context of the HAW programme of company X.

Section 5.4 was a brief overview of BVOs attitudes towards HIV testing and while the responses were in the correct direction and at fairly high levels, some areas for targeting were still identified. This was a particularly useful approach if company X wished to adopt a ‘*zero tolerance to ignorance*’ with regard to HIV/AIDS approach as part of its awareness/education activities under the HAW programme. The study similarly advocates for an intensification of the national “know your status” drive, within the company, through emphasizing VCT as a gateway to prevention – of new infection, and prevention of re-infections and progression to full-blown AIDS.

Under **Section 5.5**, condom use and condom use consistency, the context of condom use and barriers to the use of condoms among BVOs were illustrated. Marked differences were noted between the proportions of BVOs who reported using condoms at the last sexual intercourse, compared to those reporting that they “always” used condoms. Condom use declined further still with wives and regular partners, despite high proportions of BVOs expressing acceptability of their use within the marriage and regular-partner setting. Reasons for non-use of condoms were sought as were BVOs opinions on the acceptability/desirability of the female condom or *femidom* for their wives and regular partners. This section was explored in some detail given that condom distribution formed the main activity of company X, alongside HIV/AIDS awareness and education and offering occasional VCT. Crucially, this section provided some sort of baseline information on condom use among BVOs, which they could now use to monitor condom usage among BVOs at the Gaborone Depot going forward and be better-placed to evaluate their condom distribution (sub) programme.

Under **Section 5.6**, sexual partnerships, in particular sexual partner concurrency or multiple concurrent sexual partnerships (MCPs) were explored because of their identification by the NSFs and studies as key driver in generalized heterosexual epidemics. BVOs mostly reported having a single partner in the last year and in the last two months but with at least a third reporting having had more than one sexual partner in the last two months. This pattern still was most intense among the single/never married BVOs but was reported even among the married and cohabiting men. The phenomenon of multiple sexual partnerships was established among BVOs at company X and awakened one to the need for approaches which visually demonstrated the elevated risk of infection with MCPs, and the need to look in more detail at ways of communicating the need for behavioural change.

Sections 5.6.4 and 5.6.6 considered the impact of duration away from home as well as the very nature of the occupation of BVO as exposing BVOs to the risks of sexual temptation and HIV. This study concluded that BVOs deemed trips that took them away from home for the ‘longest time’ exposed presented them with more sexual temptation than those with long waiting times at refineries and gantries. While over 50% of BVOs thought the very nature of their occupation exposed them to a higher risk of HIV, they felt in higher proportions (65%), that the BVO job exposed them much more to sexual temptation with people other than their regular partners. So their self-perception of their elevated risk was revealed by this study.

Section 5.7 looked at the BVOs perception of their work environment in relation to HIV/AIDS. This section sought show how BVOs really perceived their workplace in terms of its ethos with regard to matters pertaining to HIV/AIDS and specified in its HIV/AIDS Policy. This section revealed that employees, in particular, BVOs were most convinced of company X’s respectfulness of rights to privacy and non-discrimination with regard to employees HIV status than they were about HIV-infected workers access to psycho-social support, or the company’s readiness to ‘reasonably accommodate’ HIV positive workers.

Section 5.8, sought to establish areas of deficit or lack in company X’s services or activities identified by the BVOs themselves. The salient point here is that BVOs had needs for counselling and psycho-social support beyond the STIs and HIV/AIDS, which concerned their relationships, family lives, general and sexual health and generally felt under-provided for and un-supported at the workplace in this regard, even as they did have concerns about confidentiality. The section concluded by noting the HIV/AIDS – related activities, from a pre-determined list, BVOs most wished to see introduced or intensified at the Gaborone depot.

This study seeks to furnish company X with baseline information guided by the attitudes, perceptions and practices of its most critical and most numerous cadre of employees, the bulk vehicle operators (BVOs), which it could then use to expand or refine its interventions through STI and HIV/AIDS programmes offered through the workplace.

B: Recommended Activities under company X’s HAW Programme:

On the strength of the analyses in the preceding chapter, recommended activities are outlined below;

1. HIV/AIDS Education/Awareness - strengthening and refreshing – Consider adoption of a ‘Zero tolerance to ignorance’ with regard to HIV/AIDS awareness/knowledge as focus for this effort

(a) Additional/Supplementary training session of Driver Trainers who train BVOs

(b) Reinforcing of current HIV/AIDS and STI awareness-raising among BVOs themselves, aimed at identifying and addressing Gaps in Knowledge and Dispelling/debunking Misconceptions revealed by BVOs in this study, revealed at chapter 5.0 section B – highlighted in red ink: For example;

- Understanding the difference between HIV and AIDS
- Addressing specific misconceptions i.e. De-bunking misconceptions about ‘Holy Water’ and faith-healing with regard to HIV/AIDS/ de-bunking myths .ie. ‘only sickly-looking persons infect others through sex’
- Clarifying conditions in which spouses and regular partners transmit HIV within unions
- ‘Only thin sickly people can infect others with HIV’ etc. etc..

2. Consider Introducing “Prevention with Positives” within the company’s training on HIV education and awareness in line with HAW program (CPSHEQ90 Version 5) aim of “keeping our existing employees healthier longer”

and

“..providing sufficient information and counselling to all chronically ill patients to enable them to understand the importance of their medication, and to continue the usage of such medication as prescribed by a medical doctor (CPSHEQ90 Version 5).

Consider the use of GIPA (Greater Involvement of People living with AIDS) approach to drive this “Prevention with Positives” initiative ie. HIV positive champions living healthy positive lives.

Extensive Toolkits are available, but introduction can proceed along the lines of the following suggested minimum content areas:

- **“So You’ve Tested HIV Positive? Now What?”** – What to do / What Not to do

What to Do: Seek Professional Counselling Immediately; Follow-up medical to establish viral load and eligibility for antiretroviral therapy or treatment (ART)

What Not to Do: Do Not get into Truck without professional counselling/ or still harbouring feelings of ‘shock’, ‘disbelief’ or ‘anger’ and full acceptance of your status

- **Prolonging health/ prolonging productive life-spans:** - delaying progression from HIV positive to full-blown AIDS illness
- **Routinizing CD4 count monitoring and the importance of total ARV/ART Adherence**
- **Preventing Re – infection** with multiple strands of HIV / Reducing the risk and impact of opportunistic infections
- **“Living Positively” (‘Positive Living’)** – Elements of Positive Living - ‘Staying Healthy at Home’/ ‘Staying Healthy on the Road’ initiatives

Possible Partners: HIV positive Champions from company X in partnership with external champions

3. **Emphasizing Early Diagnosis and Prompt Treatment of Sexually Transmitted Infections (STIs)**

Suggested minimum content coverage areas:

- **Awareness-raising on the range of STIs;** Emerging virulent drug-resistant gonorrhoea (Rise of Antimicrobial resistance and STIs); Recognition of Symptoms; Awareness of the Impact of untreated STIs on men, their partners sexual health; fertility and new born infants (provision of visual evidence – photographs /posters/slides); **Understanding the relationship between STIs and HIV**
- **Discussion of this study’s findings with regard to BVOs health-seeking behavior when suspecting STI infection at chapter 5.0 section C. (Emphasizing “Correct Actions” & “Timely Responses” & “Treatment adherence”).**
- **Syndromic approaches to STI diagnosis and treatment: - Clarifying the Role of Pharmacists & Dispensers in effective STI management ; the Problem with traditional herbal remedies in treating STIs**
- **Encouragement of BVOs to routinely screen for STIs** for optimum sexual and reproductive health)/ Promotion and encouragement of “Couples Screening for STIs”
- Screening for asymptomatic STIs (individuals and couples)
- Consider introducing occasional workplace screening for STIs for BVOs and other employees at the Depot
- STI prevention & Condom Promotion – need for behavioural change

4. **Understanding the Effect of Sexual Partnership Concurrency in a High HIV Prevalence setting**

- Use awareness-raising tools, i.e. models simulating the spread of HIV in multiple concurrent networks in a high prevalence generalized HIV Epidemic
- **“Know Your Vulnerability” / “Know Your Risk”** : identifying and recognizing contexts/situations STI & HIV transmission or infection is likely to occur

5. Clarifying Company HIV/AIDS Policy

Suggested approach and emphasis:

- Reiteration of Essence of Company HIV/AIDS Policy: Main message: Being HIV positive is no a reason for discrimination or unfair treatment or termination of employment at any depot of company X
- Elements of Company Position To be Emphasized:
 - (i) BVOs physical and mental health is ultimately a Safety issue, not just for company X but also for the wider public
 - (ii) BVOs in particular are encouraged to maintain the best possible mental and physical health given the nature of their job, transporting highly dangerous goods on public roads
 - (ii) BVOs are required to be aware of their general health, be on treatment and monitored for any diagnosed health condition that affects their energy, judgment or concentration levels
 - (iii) Company fully supports early testing with counselling, self-monitoring of CD4 counts and healthy lifestyles for those living with HIV; Prompt commencement of treatment where prescribed + Full adherence to antiretroviral therapy (ARVs); company supports HIV Prevention

Ideal Forum: Tool Box Chats and/or Annual Refresher Courses

Action: Internal – Driver trainers/ SHEQ dept.

6. Condom Use Promotion – in line with 4.7 of company X’s HAW programme which states “Curbing the spread of HIV/AIDS and STDs (sexually transmitted diseases)....”(CPSHEQ90 – HIV/AIDS Health and Wellness Programme)

Suggested Minimum Package of Action

- **Continued condom distribution in the workplace**
- **Encouragement of correct and consistent condom usage** to improve effectiveness (consider demonstrations; discuss use of water-based lubrication to preserve condom’s integrity)
- **Proposal-writing to relevant NGOs** (i.e. Population Services International PSI; UNFPA – United Nations Fund for Population Activities etc.) & Ministry of Health for supply/donation of Condoms to company X where necessary/ or where different variety of condoms are sought
- Encouragement of BVOs to continue to collect and use condoms from truck stops, border posts, gantries, depots, clinics & to purchase personal supplies as well

7. “Know Your Status” Workplace initiative under Company X HAW programme (as part of ‘keeping our existing employees healthier longer’ objective (CPSHEQ90 at 4.4).

- **Review study finding of ‘BVOs attitudes to HIV Testing’ chapter 5. Section D to identify and address problematic attitudes highlighted in red ink and show BVOs the danger or folly in harbouring these attitudes and perceptions**
- Promotion of HIV counselling and testing as the ‘gateway’ to Prevention – motivation to maintain HIV negative status or commencement of timely antiretroviral treatment/arresting progression from HIV +ve to full-blown AIDS
- Activity: Continued Promotion of Voluntary Counselling and Testing at the Workplace
Partners: Tebelelopele
- Encouragement of BVOs to continue to make full use of counselling, testing and treatment facilities at Truck Stops ie. Zeerust Truck Stop

8. Re-introduction of Company X Wellness of Family Fun Days

- **Wellness/ Family Fun days at which all aspects of health are addressed (diabetes/hypertension/sexual health/family planning/cancer awareness etc/ VCT)**

REFERENCES

AED and TMARC (2006)

Report on the Baseline Survey for HIV/AIDS and Family Planning Intervention for Risk Groups, December, Dar-es-Salaam

Aniebue, P.N. and Aniebue, U.U. (2009)

‘HIV/AIDS related Knowledge, Sexual Practices and Predictors of Condom Use Among Long Distance Truck Drivers in Nigeria’, *The Southern African Journal of HIV Medicine*, July 2009:54-56

Arulogon, O.S., Oladepo, O. And Titiloye, M.A (2011) ‘Perception of self Vulnerability to HIV Infection among Long Distance Truck Drivers in Ibadan, Nigeria’, *J.Basic.Appl.Sci. Res.*, 1(10): 1380-1385

Augustyn, J.C.D. (2012a) ‘Module 24.2: Problem Identification, Hypothesis Formulation and Experimental Research Design’, *PDM Lecture Notes, Africa Centre for HIV/AIDS Management*, Stellenbosch University

Augustyn, J.C.D. (2012b) ‘Recruiting Employees’ PDM Module Lecture Notes, *Africa Centre for HIV/AIDS Management*, Stellenbosch University

Bisika, T. (2009) “Sexual and Reproductive Health and HIV/AIDS Risk Perception in the Malawi Tourism Industry”, *Malawi Medical Journal*, 21(2):75-80 June

Bryan, A.D., Fisher, J.D. and Benziger, T.J. (2000) ‘HIV Prevention information, motivation, behavioural skills and behaviour among Truck drivers in Chennai, India’, *AIDS*, Vol.14(6):April:756-758

Campbell, E.K and Rakgoasi, S.D. (2002)

‘Condom Use among Youths in Botswana in the Era of HIV and AIDS’, *Soc Dev Issues* 2002; 24(1):56-67

CPSHEQ022 HIV/AIDS Policy Version 10

CPSHEQ90 – SHEQ- HIV/AIDS Health and Wellness Program – Version 5

Chaturvedi, S., Singh, Z., Banerjee, A., Khera, A., Joshi, R.K., and Dhruvajyoti, D. (2006) ‘Sexual Behaviour among long Distance Truck Drivers’, *Indian journal of Community Medicine*, July – September Vol.31(3):153-156

Chilisa, B. (2012) *Indigenous Research Methodologies*, Los Angeles, Sage

Chin, J. (2007)

The AIDS Pandemic: The Collision of Epidemiology with Political Correctness, Oxford, Radcliffe Publishing

Christensen, L.B., Johnson, R.B. and Turner, L.A. (2011) *Research Methods, Design and Analysis*, Pearson

Data Collection Quantitative Methodes (n.d) The KAP Survey Model: Knowledge Attitude and Practices

Dinkelman, T., Levisohn, J. and Majalantle, R. (2007)
'When Knowledge is not enough: HIV/AIDS Infection and Risky Behaviour in Botswana',
4th August 2007
www.levinsohn.commons.yale.edu/files/2010/10/dlm101.pdf

Ekanem, E.E., Afolabi, B.M., Nuga, A.O and Adebajo, S.B. (2005) "Sexual Behaviour, HIV-Related Knowledge and Condom Use by Inter-city Commercial Bus Drivers and Motor Park Attendants in Lagos, Nigeria", *African Journal of Reproductive Health*, 9 (1):78 – 87
April

Epstein, H. (2007) *The Invisible Cure: Africa, the West and the Fight Against AIDS*, London, Penguin Books

Family Health International (FHI) 360 (2013)
2012 Mapping, Size estimation and Behavioural and Biological Surveillance Survey (BBSS) of HIV/STIs among select High-risk sub-populations in Botswana, Technical Report, July

Farahani, M., Roumis, D., Mahal, A., Holmes, M., Moalosi, G., Molomo, C. and Marlink, R (2013)
'Effects of AIDS-related Disability on Workforce Participation and earned Income: A Quasi-experimental Evaluation', *Health*, 5:409-416

Fisher, A., Foreit, J.R., Laing, J., Stoeckel and J. Townsend (2002) *Designing HIV/AIDS Intervention Studies: An Operations Research Handbook*, New York, Population Council
www.popcouncil.org

Grappasonni, I., Paci, P., Mazzucchini, F. and Amenta, F.A. (2011) "Survey on HIV Risk Perception and Sexual Behaviours Among Seafarers", *Int Marit Health* 2011: 62, 2: 131-137

Hsu, L-N (2001) *Building An Alliance with the Transport Sector in HIV Vulnerability Reduction*, UNDP South East Asia HIV and Development Project

ILOAIDS (2005)
HIV/AIDS in the Transport Sector of Southern African Countries: A Rapid Assessment of Cross-border Regularities and Formalities, Technical Cooperation 3
www.ilo.org/aids

International Labour Organization (n.d) 'ILO Code of Practice on HIV/AIDS in the Workplace: Key Principles' www.ilo.org

International Labour Organization (2003) Mobile Populations and HIV/AIDS in the Southern African Region: recommendations for Action: Desk Review and Bibliography on HIV/AIDS and Mobile populations (May), in collaboration with Sida and UNAIDS

International Labour Organization (2005a) Using the ILO Code of Practice on HIV/AIDS and the World of Work: Guidelines for the Transport Sector, Sectoral Activities programme

ILOAIDS (2012) Report and Analysis of the Survey ‘A Truck Driver’s Life: Working Conditions and Sexual Health: HIV and Long Distance Transport in Paraguay, Geneva, ILO

International Organization for Migration (IOM) (n.d) Briefing Note: On HIV and Labour Migration in Botswana, in collaboration with Sida and PHAMSA

International Organization for Migration (IOM) (2012) Transport Sector Report: Regional Assessment on HIV Prevention Needs of Migrants and Mobile Populations in Southern Africa, Transport Sector Report

International Labour Organization (2005b) HIV and Mobile Workers: A Review of Risks and Programmes among Truckers in West Africa, IOM-UNAIDS Reports on Mobile Populations and HIV/AIDS (September), in collaboration with UNAIDS, Geneva

Kandala, N.B., Campbell, E.K., Rakgoasi, S.D., Madi-Segwagwe, B.C and Fako, T.T. (2012) “Geography of HIV Prevalence Rates in Botswana”, *HIV AIDS* 4:95-102

Knauth, D., Leal, A.F. and Pilecco, F. (2010) ‘Condom Use and sexual partnerships among Truck Drivers in Southern Brazil’, *Retrovirology*, 2010, 7(Suppl 1):P126 www.retrovirology.com/content/7/s1/P126

Labour Research Reserve (2008)

From Policy to Programme: An Empirical Assessment of Responses to HIV/AIDS in the Workplace, (ed) K.B. Butler, Salt River, Cape Town

Lewis, D. A. (2011) “Antimicrobial-resistant gonorrhoea in Africa: An important public health threat in need of a regional gonococcal antimicrobial surveillance programme”, *South Afr J Epidemiol Infect* 2011; 26(4) (Part 1):215 -220

Leigh, J.P., Lubeck, D.P., Farnham, P. and Fries, J. F. (1995) ‘Potential and actual workdays lost among patients with HIV’, *Journal of Acquired Immune Deficiency Syndromes and Human Retro-virology* 8:392-398

Marck, J. (1999) “Long-distance truck drivers’ sexual cultures and attempts to reduce HIV risk behaviour amongst them: a review of the African and Asian literature”, Chapter 8 in *Resistances to Behavioural Change to Reduce HIV/AIDS Infection*, 1999:91-100

Morris, C.N. and Ferguson, A.G. (2006) ‘Estimation of the sexual Transmission of HIV in Kenya and Uganda on the Trans-Africa Highway: the Continuing Role for Prevention of High Risk groups’, *Sex Transm Infect*, 82:368 – 371

- National AIDS Coordinating Agency (NACA) (2008) *National Operational Plan for Scaling-up HIV Prevention in Botswana: 2008 – 2010*, in collaboration with the African Comprehensive HIV and AIDS Partnership (ACHAP), Johns Hopkins University and Family Health International for the Botswana Government
- National AIDS Coordinating Agency (NACA) (2008a) *2008 Progress Report of the National Response to the UNGASS Declaration of Commitment on HIV/AIDS*, in collaboration with African Comprehensive HIV/AIDS Partnership (ACHAP) and UNAIDS, Ministry of State Presidency, Gaborone
- National AIDS Coordinating Agency (NACA) (2009) *The Second Botswana National Strategic Framework for HIV and AIDS 2010 – 2016*, Ministry of State Presidency, Gaborone
- National AIDS Coordinating Agency (NACA) (2009b) *Botswana AIDS Impact Survey BAIS III 2008 Preliminary Statistics Brief*, Central Statistics Office, Republic of Botswana
- National AIDS Coordinating Agency (NACA) (2010) *2010 Modes of Transmission Study: Analysis of HIV Prevention Response and Modes of Transmission*, The Botswana Country Synthesis Report (Final Report) September, in collaboration with UNAIDS Gaborone
- Ngcongco, N. L. (2012a) ‘Unpublished PDM Assignment 13, Strategic Human Resource Management, Modules (Lecturer: Prof JCD Augustyn), Africa Centre for HIV/AIDS Management, Stellenbosch University
- Ngcongco, N. L. (2012b) ‘Unpublished PDM Assignment 16, Research methodology’, Modules 24-24.3 (Lecturer: Prof JCD Augustyn), Africa Centre for HIV/AIDS Management, Stellenbosch University
- Noe, R.A., Hollenbeck, J. R., Gerhardt, B. and Wright, P.M. (2012) *Human Resource Management: Gaining a Competitive Advantage*, McGraw Hill, Glasgow
- Onwuliri, V.A. and Jolayemi, O.M. (2007) *Reaching Vulnerable and High Risk groups in Nigeria*, chapter 14 in *AIDS in Nigeria*
- Pandey, A., Mishra, R. M., Sahu, D., Benara, S.K., Biswas, M., Sengupta, U., Mainkar, M.K., and Adhikary, R. (2012) ‘Heterosexual risk behaviour among long distance truck drivers in India: Role of marital status’, *Indian J. Med Res (Suppl)* October: 1-10
- Ray, R and Sinha, K. (2011a) ‘Interaction between HIV awareness, knowledge, safe sex practice and HIV incidence: Evidence from Botswana’, Discussion Paper 12/11, ISSN 1441-5429 Department of Economics, Monash University

Ray, R. and Sinha, K. (2011b)

‘Measuring the multi-dimensional knowledge deprivation of HIV/AIDS: A New Approach with Indian Evidence on its magnitude and determinants’, *Journal of Biosocial Science*, 43:657-684

Ramjee, G. and Gouws, E. (2000) ‘Targeting HIV Prevention Efforts on Truck Drivers and Sex Workers: Implications for a Decline in the Spread of HIV in Southern Africa’, Policy Brief No.3, December, Medical Research Council, Durban

Republic of Botswana (2014)

‘Botswana AIDS Impact Survey BAIS IV 2013’ Statistics Botswana in collaboration with NACA and Ministry of Health, Gaborone

Riviello, E.D., Ster-ling, T.R., Shepard, B., Fantan, T., and Makhema, J. (2007)

‘HIV in the Workplace in Botswana: Incidence, Prevalence and Disease Severity’, *AIDS Research and Human Retroviruses*, 23:1453-1460

Rosen, S., Ketlhapile, M., Sanne, I. and DeSilva, M.M. (2008)

‘Differences in normal activities, job performance and symptom prevalence between patients not yet on ART and patients initiating therapy in South Africa’, *AIDS*, 22:S131-S139

Rudestam, K. E and Newton, R.R. (1992) *Surviving Your Dissertation: A Comprehensive Guide to Content and Process*, California, Sage

Sorenson, W., Anderson, P.B., Speaker, R., Menacho, S., Vilches, J.E. (2007) ‘Heterosexual STI/HIV Risk Assessment Among Bolivian Truck drivers Using Mixed Methodology’, *International Electronic Journal of Health Education*, 2007:10:9-18

Southern African Migration Project (SAMP) (2006) ‘Crossings: the Deadly Link between Mobility and HIV/AIDS’, SAMP, March Vol.7(1)

Sekadde-Kigundu, Ntonyintono, R., Sanghvi, H, Ojwang, S., Muthami, L., Bwayo, J., Omari, A., Sempebwa, E., and Thagana, N. (n.d.) ‘Condom Acceptability and Use Among Long Distance Truck Drivers and their Assistants’

Singh, R.K, Piramanayagam, A, Bayapa, R.N., Pallavi, M., Nagarjuna, R.N. and Choudhary, A.K. (2012) ‘High Risk sexual behaviour among Long distance Truck drivers: A Cross sectional study’, *Nat.J.Res.Com.Med.*, 1(2):71 -75

Sohail, Agha (2000) ‘Potential for HIV transmission among Truck drivers in Pakistan’, *AIDS*: Vol 14(15):2404-2406

Stoneburger, R., Korenromp, E., Lazenby, M., Tassie, J., Letebele, D., Granich, R., Boerma, T. and Low-Beer, D. (2014) ‘Using Health Surveillance Systems data to assess the impact of AIDS and Antiretroviral treatment on Adult Mortality and Morbidity in Botswana’, *PLOS ONE*, Vol 9 (7):1-11

Sunmola, A (2001) 'Developing a Scale for Measuring the Barriers for Condom Use in Nigeria', *Bulletin of the World Health Organization*, 2001, 79 (10):926 – 932

Sunmola, A (2005) 'Sexual Practices, barriers to condom use and its consistent Use among Long distance truck drivers in Nigeria', *AIDS Care*, February 2005; 17(2):208 -221

UNAIDS (2002) *The Private Sector Responds to the Epidemic: Debswana - A Global Benchmark*, UNAIDS Case Study, September, UNAIDS Best Practice Collection

UNAIDS (2007) *Regional Workshop on HIV in the Road Transport sector in Southern Africa*, in collaboration with World Food Programme (WFP), International Organization for Migration (IOM), North Star Foundation, Piggs Peak, Swaziland

UNAIDS (2009) 'Long Distance Truck Driving and Potential for High Risk Behaviour: Findings from a Dipstick Study with Truck drivers at Chalinze, Mikumi and Mukambako Truck Stops' www.tmarc.or.tz

UNDP South East Asia HIV and Development Programme (2003) *Republic of China, Thailand and Vietnam: A collection of papers presented at a special session of the 6th Asia Pacific Social Sciences and Medicine Conference Kunming, Yunnan, Peoples' Republic of China*

Upadhyay, A, Pawar, A.B and Bansal, R.K. (2010) 'Sexual Profile of Truckers in Surat District', *National Journal of Community medicine* Vol. 1 (1)21-23

USAID (2013)

Botswana: Condom Programming: National Condom Quantification and Supply Chain Strengthening, March, USAID Deliver Project, Task Order 4, Arlington VA

World Food Programme (2006) *Getting Started: WFP Support to HIV/AIDS Training for Transport and Contract Workers* (April)

APPENDIX A

TITLE: “An Exploratory study of the relationship between the demographic and socio-economic characteristics of extra heavy duty drivers (BVOs) and non-mobile operations employees, and their knowledge, attitudes and sexual practices, at a company in Gaborone, Botswana”

INDIVIDUAL QUESTIONNAIRE

DEC 2013 /JAN 2014

QUESTIONNAIRE FOR BULK VEHICLE OPERATORS

BVOs ONLY

All Participants in this study are assured of **PRIVACY, ANONYMITY and CONFIDENTIALITY**. **NO** information supplied for this study may lead them to be personally identified, nor may the information be used to cause harm, stigmatize or jeopardize your employment. **NO** Names and **NO** ID numbers are to be included when completing this questionnaire, nor at any time in the course of this study. Nobody is required to reveal their HIV status or their sexual orientation in this study or questionnaire.

INDIVIDUAL QUESTIONNAIRE FOR BULK VEHICLE OPERATORS ONLY

A. Demographic Data:

To be answered by ALL participants in the study

1. Age: _____

2. Year of Birth: _____

3. Marital Status:

- 01: Single/Never Married _____
- 02: Living together _____
- 03: Formally Married _____
- 04: Divorced _____
- 05: Widowed _____
- 06: Separated _____
- 07: Other (Please Specify) _____

4. Living Arrangements:

- 01: Living in house owned by myself

- 02: Living in a flat owned by myself
- 03: Renting a house or renting a flat
- 04: Renting room in shared house/shared flat
- 05: Living with family or relatives or colleagues
- 06: Living (free of charge) with friends or colleagues
- 07: Other (Please Specify)_____

B: Socio-economic data

To be answered by ALL participants in the study

Education:

Q.5. Level of Formal Schooling completed:

- 01: None_____
- 02: Incomplete Primary_____
- 03: Complete Primary_____
- 04: Junior Secondary_____
- 05: Senior Secondary/ BGCSE/IGCSE/Matric

- 06: Incomplete Tertiary_____
- 07: Completed Tertiary and above_____

Q.6. What is your Total no of years of formal schooling completed? _____

Duration at Unitrans company:

Q.7. How long have you been working at company X Botswana? Please circle whichever applies

- 01: 0 - 4 years
- 02: 5 - 9 years
- 03: 10-14 years
- 04: 15 years and over

Income and expenditure:

Please indicate your take home pay (Net salary) per month in Pula?

Q.8. Income (Pula/month) _____

(State approximate monthly take home pay– Net monthly salary)

Q.9. What are the four main things that you spend most of your monthly take-home pay on ?

In the table below, Please **TICK** whichever monthly item expenditures apply to YOU. Then on the right-hand column RANK these with the LARGEST expenditure item ranked 1, followed by the next/2nd largest ranked 2....and so on.....

<u>Item expenditure</u>	<u>Rank Order</u>
01: Paying for house I have bought OR home/rooms that I am building	

02: Rent payment	
03: School or tuition fees	
04: Buying livestock/small stock/ poultry /stock Feed	
05: Car loan payments	
06: Food and ‘molora’ (soap/cosmetics)	
07: Clothing	
08: Entertainment (DStv/dvds/ music/going out/air time for cell phones and modems)	
09: Paying into Savings schemes (fixed deposits); ‘metshelo’; shares etc	
10: Other (Specify)	

Occupation:

Q.10. Please tick which broad occupation category you belong to ?

01: Bulk Vehicle Operator BVO (or Extra Heavy Duty Truck Driver) _____

02: Other Non-mobile/ Non-driving company employee _____

(IF you belong to the ‘Non-mobile’ category, PLEASE STOP filling THIS questionnaire now, and PLEASE Find the Questionnaire marked for “Non-mobile employees” only).

ALL BVOs PLSE CONTINUE ANSWERING THIS QUESTIONNAIRE.....

Time spent away from Home:

Q.11. Does your particular job in the company require you to spend nights away from home regularly?

01: Yes - Often) -----Go to Q.13

02: Yes - Sometimes) -----Go to Q.13

03: Rarely/hardly ever) ----Go to Q. 12

04: Not at all/Never) ----Go to Q. 12

But IF You answered “Rarely/Hardly ever” or “Not at all” to the previous question (Question 11), go straight to Question 12 directly below;

Q.12. IF You answered “Rarely/Hardly ever” to Question 11, Please explain why you as a BVO with this company Rarely/hardly ever or Never spend nights away from home

Please Circle correct answer that applies to you in each case;

**01: I only take short trips completed within a day True=1;
False=2**

**02: fragile health / medication stops me from doing longer trips True=1;
False=2**

03: I have been assigned other duties which do not require distance driving True=1;
False=2
04: Other (Please Specify/Explain)

ALL BVOs Please answer the remaining questions:

Q.13. How many nights did you sleep away from home because of your job in the last month (December 2013)? _____

Q.14. If your job entails regularly driving bulk vehicle trucks for Company, and you are on a trip involving 1 or more nights away from home, where do you usually sleep? Tick whichever applies

- 01: in the cab in horse of truck _____
- 02: in motel / in bed and breakfast room _____
- 03: at the home of someone I know _____
- 04: wherever I am offered a place to sleep _____
- 05: Other (Please Specify) _____

Q.15. If your job entails regularly driving bulk vehicle trucks for Company X, where will you usually get your food?

- 01: from food vendors ('bo mma seapei') selling food
- 02: from cafes along the roadside
- 03: from shops or supermarkets
- 04: from homes where cooked food is sold
- 05: from people I know who live in towns or villages along the route
- 06: Other (Please Specify) _____

Q.16. Where would you usually freshen – up/shower or have a bath?

Q.17. List 3 of the most common routes that you have covered in your pick-ups and drop-offs in the last month (December)?

Most common routes covered in Dec	Usual number of nights spent away/out on trip
1.	
2.	
3.	

Q.18. Have any new routes been added? YES / NO
(i) If "Yes" please specify _____

Assessment of "Risk": Circle or tick whichever answer applies

Q.19. Are you willing to take risks in general? YES or NO

Q.20. Does your job carry any risks to your safety or your health or wellbeing?
YES or NO

If you answered “YES” please list/explain each of these;

Q.21. If you answered “YES” can you rank these risks in order of seriousness to you, starting with the ‘Most serious’. (ie. 01 being ‘Most serious’/’Most worrying’.....03 being ‘Least serious’/’Least worrying’)

01: _____ (Most Serious Risk/Most Worrying)

02: _____ .

03: _____ .

04: _____ (Least Serious/Least Worrying)

Q.22. Does the training you receive through your job prepare you well enough to deal with any of the job-related risks that you have identified in the previous questions (Question. 20 and 21)? Circle whichever applies YES or NO

Q.23. If “Yes” please explain

Q.24. IF you answered “No” to any job-related risks (at Question 20 and 21), please say what you think the workplace can do to prepare or better support you in dealing with or managing any of the job-related risks that you mentioned in Question 20 and Question 21 earlier.

Q.25. Knowledge

Circle “YES” or “NO” in accordance with whether You agree or disagree with each statement below;

- | | |
|--|-----------------|
| 01: AIDS is caused by HIV | YES / NO |
| 02: All HIV positive persons have AIDS | YES / NO |
| 03: AIDS leaves your body unable to fight off infections and diseases | YES / NO |
| 04: An HIV positive person can still be healthy and work | YES / NO |
| 05: A person can be HIV positive without being ill | YES / NO |
| 06: An HIV positive person may not know that they are HIV positive | YES / NO |
| 07: You <u>can</u> prevent yourself from becoming infected with HIV | YES / NO |
| 08: Being HIV positive leads to certain death in a few years | YES / NO |
| 09: Testing for HIV a few days after un-condomised sex will reveal whether you are HIV positive | YES / NO |
| 10: Drinking strong medicines just before sex will prevent you from getting infected with HIV | YES / NO |

Q.26. Prevention items: Circle “YES” OR “NO” depending whether you agree or disagree with each statement below;

01: Having an untreated sexually transmitted infection can increase a person’s chance of getting HIV

YES / NO

- 02: You can get infected with HIV through using the same needles to inject drugs that an HIV positive person has used
YES/NO
- 03: You cannot be infected with HIV through having sex with your regular partner YES / NO
- 04: Having alcohol or taking drugs before sex can increase your chance of getting infected with HIV
YES/ NO
- 05: You can get infected with HIV from sharing plates, cups, spoons and forks with an HIV positive person
YES / NO
- 06: An HIV positive mother can infect her baby through her breast milk
YES/ NO
- 07: An HIV positive pregnant woman can infect her unborn baby in the womb
YES / NO
- 08: Taking a shower after having sex without a condom can prevent you getting infected with HIV
YES / NO
- 09: Having anal sex instead of vaginal sex can reduce the chance of being infected with HIV
YES / NO
- 10: Having sex while a woman is taking birth control pills (oral contraceptives) reduces the chance of HIV infection
YES / NO
- 11: Using a latex (rubber) condom is more effective in protecting against HIV infection than using a natural skin condom infected with HIV
YES / NO
- 12: Drinking strong traditional medicine after having sex without a condom will prevent me from getting infected with HIV
YES / NO
- 13: Having oral sex without a condom or barrier carries no risk of HIV infection YES / NO
- 14: You can prevent yourself from becoming infected with sexually transmitted infections
YES / NO
- 15: Female condoms ('Femidoms' etc) do not protect against sexually transmitted infections or HIV at all
YES / NO
- 16: Masturbation ('pleasuring yourself') does not carry any risk of catching a sexually transmitted infection or HIV
YES / NO
- 17: Only thin sickly-looking persons can infect others through sex
YES / NO
- 18: You can get infected with HIV from a bite from a mosquito
YES / NO
- 19: You can get infected with HIV by sitting on a dirty toilet seat
YES / NO
- 20: Drinking and Washing with "Holy Water" from Church will cure an HIV-infected person
YES / NO

Health-Seeking behaviour

Q.27. If I have a discharge from my penis (or vagina), 'burning pain' while urinating, or even trouble urinating (ie. 'passing water'), a rash or redness, or a sore or swelling on my private parts (genitals) after having sexual intercourse, I will usually take the following action;

(In the table below, TICK which ever actions BEST apply to YOU, for each of the actions 01....to 08). After this, please RANK the action that you are Most likely to take FIRST when faced with any of the symptoms listed in the question.....to the action you will take LAST (this will be ranked " 9 " on the small line provided).

**10: It is important to take a HIV test
DISAGREE**

AGREE

Condom Use Questions

Q.29. Was a condom used at last (most recent) sexual intercourse YES / NO

NOTE: The following questions are expressed as Statements, you are asked to read and understand the statement, and then CIRCLE the NUMBER of the Option that Best expresses how You feel about EACH Statement (in bold)

Q.30 Condoms are used whenever I have sexual intercourse

Always	Often/ Most of the time	Sometimes	Hardly ever/rarely	Never
5	4	3	2	1

Q31. I used condoms during sexual intercourse in the last month

Always	Often / Most of the time	Sometimes	Hardly ever/rarely	Never
5	4	3	2	1

Q.32. Condoms are used when I have sex with my wife / regular partner

Always	Often /Most of the time	Sometimes	Hardly ever/rarely	Never
5	4	3	2	1

Q.33. Condoms are only to be used when having sex when you pay for sex

Strongly agree	Agree	Neutral	Disagree	Strongly disagree
5	4	3	2	1

Q.34. There is no need to use condoms when having sex with your wife or regular partner

Strongly agree	Agree	Neutral	Disagree	Strongly disagree
5	4	3	2	1

Q.35. I would like it if my wife or regular partner used the female condom

Very True of my feelings	True of my feelings	Neutral	Untrue of my feelings	Very Untrue of my feelings
5	4	3	2	1

Q.36. Carrying some condoms when I go on a trip for work is Important

Essential	High Priority	Medium Priority	Low Priority	Not a Priority
5	4	3	2	1

Q.37. Keeping some condoms where I live is Important

Essential	High Priority	Medium Priority	Low Priority	Not a Priority
5	4	3	2	1

Q. 38. Main source(s) where condoms are obtained Please Tick whichever applies to You

01: I get my condoms from the company/work wherever they are put _____

- 02: I buy my condoms from kiosks ('dimasus') _____
- 03: I buy my condoms from shops and chemists _____
- 04: I get my condoms from clinics/hospitals _____
- 05: I am given condoms to use by my sexual partner _____
- 06: I am given condoms by my friend(s) _____
- 07: Other sources of condom _____
- 08: I Do not use condoms at all _____

Barriers to condom use:

Q. 39. Feeling (sensation) is lost when I use a condom during sex

Strongly agree	Agree	Neutral	Disagree	Strongly disagree
5	4	3	2	1

Q. 40. It is difficult to get aroused / it is difficult to get excited enough (ie. to get an erection) when using condoms

Strongly agree	Agree	Neutral	Disagree	Strongly disagree
5	4	3	2	1

Q. 41. My wife / my partner does not like it when I use a condom during sex

Strongly agree	Agree	Neutral	Disagree	Strongly disagree
5	4	3	2	1

Q.42. Sex is not 'real sex' when you do it using a condom

Strongly agree	Agree	Neutral	Disagree	Strongly disagree
5	4	3	2	1

Q. 43. Condoms break or tear during sex

Always	Often/most of the time	Sometimes	Hardly ever/rarely	Never
5	4	3	2	1

Q.44. I have condoms when I need them

Always	Often/most of the time	Sometimes	Hardly ever/rarely	Never
5	4	3	2	1

Q. 45. I know where to get condoms when I need them

Always	Often/most of the time	Sometimes	Hardly ever/Rarely	Never
5	4	3	2	1

Q. 46. I know how to use a condom properly

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Q. 47. If only the Female condom ('femidom') was available at the time, I would prefer to have sex with this rather than use nothing at all with my wife or regular partner

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Q. 48. If only the Female condom ('femidom') was available at the time, I would prefer to have sex using this rather than use nothing at all with a casual sex partner or when paying for sex

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

PRACTICES/BEHAVIOUR:

Q. 49. I am less likely to use condoms when I have had alcohol

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Q. 50. Condoms are less likely to be used when the person I am having sex with has had alcohol

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Q. 51. Condoms are most likely to be used when the person I am having sex with is not my wife or regular partner

Strongly agree	Agree	Neutral	Disagree	Strongly disagree
5	4	3	2	1

Q. 52. Are there any other reasons that would cause you to not use a condom? Please explain.....

Q. 53. I usually have more than one sexual partner at any given time

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Q. 54. I am most likely to sex with someone who is not my wife or regular partner during trips that have long waiting times

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Q. 55. Trips that take me away from home for the longest time are where the likelihood of me having sex with someone other than my wife or regular partner is greater/higher

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Current Sexual partners/sexual partnership concurrency

Q. 66. How many sexual partners have you had in the last year? _____

Q. 67. How many sexual partners have you had in the last 2 months? _____

STI/HIV/AIDS AND THE WORKPLACE ELEMENTS:

Perception of adequacy of HIV/AIDS prevention information services accessible through the workplace

Q. 68. Is there a known person at the depot whom any company X BVO can go to talk about any health concern and get advice on; answer each item below please;

- | | |
|---|------------------------------|
| 01: general health concerns | YES/ NO / Don't know |
| 02: family and relationship worries/concerns | YES / NO / Don't know |
| 03: bereavement, grief, depression | YES / NO / Don't know |
| 04: sexual health and HIV-related concerns/worries | YES / NO / Don't Know |

Q. 69. Would you go to the same person for all these worries/concerns ? YES / NO / Don't Know

Q. 70. Do you think that there should be one person available and based at the company X Depot to assist with counselling BVOs on all these concerns? Circle the option you agree with below

- 01: there should be ONE known person to assist with these concerns**
- 02: there should be at least TWO people to assist with these concerns**
- 03: there should be THREE or more people to assist with these concerns**
- 04: NONE of the above, counselling and advice are best given by counsellor(s) Not based at the Unitrans depot**

Q.71. HIV/AIDS Activities at the Depot **Circle whichever applies AGREE or DISAGREE**

- | | | |
|--|--------------|-----------------|
| 01: there should be more frequent discussions and talks about STI and HIV prevention at the company X depot | AGREE | DISAGREE |
| 02: the HIV/AIDS Policy of company X should be more prominently displayed around the depot | | |
| 03: there are no demonstrations of correct male and female condom use at the depot | AGREE | DISAGREE |
| 04: there is not enough promotion of sexual and reproductive health activities at the depot | AGREE | DISAGREE |
| 05: the company should have a trained HIV/AIDS, sexual and reproductive health counselor at the depot | AGREE | DISAGREE |
| 06: Company X should have an annual company Wellness or Company Family Fun Day where talks and tests on all aspects of health (Blood Pressure; Cholesterol; HIV; Diabetes; and Cancer awareness are available | AGREE | DISAGREE |

Q.72. If the company could arrange for the Complete Confidential and Anonymous HIV testing of all employees every 2 years by independent services it would be fine with me

Strongly Disagree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Perception of company towards employees living with HIV/AIDS:

Q.73. The company respects the right to privacy and confidentiality of employees living with HIV/AIDS

Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Q.74. The Company does not discriminate against employees living with HIV or AIDS

Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Q. 75. Employees suffering with an HIV/AIDS-related illnesses can access emotional and psychological support from some known person at the depot

Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Q. 76. The company does accommodate employees suffering from HIV/AIDS-related illness or adjusting to the effects of ARVs to do less physically hard work whilst they are not well

Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Q. 80. An employee who tests HIV positive is in danger of their job being terminated by Unitrans

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Q. 81. Company X is sympathetic to the health challenges of employees already living with HIV/AIDS

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Q. 82. The wives and partners of BVOs should be included in Company X general and sexual health promotion and education activities

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

TRAINING EVALUATION:

Q. 83. Does your training (induction and practicals) adequately prepare you as a BVO for all aspects of the reality of operating a bulk vehicle? Circle which applies
 YES or NO

Q.83.b How would you rate the “Tool Box Chats” in preparing you as a BVO for all aspects of the reality of operating a bulk vehicle?

Excellent	Very Good	Good	Fair	Poor
5	4	3	2	1

Q. 84. How would you rate your Training (both Induction and Tool Box Chats) in preparing you for the prevention of sexually transmitted infections and HIV infection?

Excellent	Very Good	Good	Fair	Poor
5	4	3	2	1

Q. 85. Does any aspect of your training address the management of health for BVOs who are already living with HIV? YES or NO

(i) If you answered “YES” to Question 85, is this enough information?

(ii) If You answered “NO” to Question 85, do you think that training and induction and ‘tool box chats’ should address the needs of HIV positive BVOs (all the time respecting their right to keep their HIV status Confidential) ?

JOB SATISFACTION QUESTIONS

General Job Satisfaction:

Q. 86. How satisfied are you with your job as a BVO at Company X?

Very Satisfied	Satisfied	Unsure/Undecided	Dissatisfied	Very Dissatisfied
5	4	3	2	1

Detailed Job Satisfaction:

Q. 87. I enjoy the job of being a Bulk Vehicle Operator (BVO)

Strongly Agree	Agree	Neutral	Disagree	Strongly Agree
5	4	3	2	1

Salary/Pay:

Q. 88. I am satisfied with my salary

Very Satisfied	Satisfied	Unsure/Undecided	Dissatisfied	Very Dissatisfied
5	4	3	2	1

Q. 89. I am paid well enough in relation to my qualifications

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Advancement Opportunities

Q. 90. I am satisfied with the opportunities to advance in this company in my line of work

Very Satisfied	Satisfied	Unsure/Undecided	Dissatisfied	Very Dissatisfied
5	4	3	2	1

Benefits:

Q. 91. I am satisfied with the benefits (Pension + Medical AID cover) I get at company X

Very Satisfied	Satisfied	Unsure/Undecided	Dissatisfied	Very Dissatisfied
5	4	3	2	1

(ii) In the long term?

Perceived threats to Job retention:

Q. 102. What do you see as the biggest, most serious threat to your keeping your job your job? (ie. what is the major thing that would make you lose your job).

Q. 103. Please look at some of company X's procedures below, and indicate the 'level of difficulty' in complying with each of these consistently (i.e. please tick in the space that best describes how easy or difficult you find it to follow or comply with each of the work procedures indicated below

Compliance item	Very Easy 5	Easy 4	Neutral/ Undecided 3	Difficult 2	Very Difficult 1
01:(Unauthorized) Transporting passenger(s)					
02: Non-use of cell phone while driving					
03: Use of PPE					
04: Adhering to Exceeding Speed Limit					
05: Observing safe following distances					
06: Not Causing Fuel Contamination					
07: Not Removal of tools/ parts					
08: Not Removing Fuel					
09: Use of seat belt					
10: Not Making unscheduled stops for social reasons					

Q.104. It matters to me to not be suspected of suspicion of stealing tools and other company property

Essential	High Priority	Medium Priority	Low Priority	Not a Priority
5	4	3	2	1

Q. 105. It matters to me to Not be suspected of stealing fuel

Essential	High Priority	Medium Priority	Low Priority	Not a Priority
5	4	3	2	1

Q. 106. It matters to me to be seen as a Trustworthy BVO

Essential	High Priority	Medium Priority	Low Priority	Not a Priority
5	4	3	2	1

Q. 107. It matters to me to keep my compliance record as clean (as good) as I possibly can

Essential	High Priority	Medium Priority	Low Priority	Not a Priority
5	4	3	2	1

Retirement:

Q. 108. What do you want to have done for yourself (your family) by the time you reach retirement age? What do you wish to have in place by the end of your working life?

Q.109. The job/occupation of being a BVO exposes me to a higher risk of sexual temptation with people other than my wife /regular partner

Strongly Agree	Agree	Undecided/Not sure/Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Q.110. The job/occupation of being a BVO exposes me to a higher risk of getting HIV

Strongly Agree	Agree	Undecided/Not sure/Neutral	Disagree	Strongly Disagree
5	4	3	2	1

THANK YOU VERY MUCH FOR AGREEING TO ANSWER THIS QUESTIONNAIRE. PLEASE BE ASSURED THAT NO COMMENTS/ ANSWERS YOU HAVE GIVEN CAN BE LINKED TO YOU PERSONALLY. THE INTENTION IS TO POOL THIS DATA AND TO PRESENT BROAD AGGREGATE FINDINGS. YOUR CONFIDENTIALITY AND ANONYMITY ARE SAFEGUARDED. THANK YOU KINDLY FOR COOPERATING.

APPENDIX B

SOME BACKGROUND QUESTIONS FOR SENIOR MANAGEMENT – Expanded Questions

1. What is the core business of Unitrans Botswana?
2. What is the Mission of Unitrans Botswana?
3. How and when did Unitrans' operations in Botswana begin?

STRENGTHS/WEAKNESSES AND FUTURE TRAJECTORY OF UNITRANS

4. What are the (business) opportunities that have emerged for Unitrans over the years?
5. What are some of the constraints the company faces?
6. What direction does the company envisage heading towards in the future?

7. What is the “nerve centre” of Unitrans Botswana? Can you say what some of the highly critical and the critical skills are at this company?

8. Please explain the principle of “minimum downtime” and its importance to the company (Operations, The Workshop etc) ?

9. What is the approximate cost (in Pula) of a ‘parked’ truck that should be on the road? Is this a contract specific cost? Or can we get a general figure of this cost?

RECRUITMENT AND TRAINING:

10. What is the total cost of recruiting a BVO? (ie. cost of the advertisement/ interview/ tests/ background tests etc.) ?
11. What is the approximate cost (in Pula) of training a BVO (Extra Heavy Duty Truck Driver) from “start” to “finish” i.e. from ‘trainee’ to Full BVO stage?
 - (i) Has there been a change in the *type* of BVO being hired by Unitrans in recent years? (i.e. are younger men, men with more education, women being hired increasingly??)
12. I have seen the range of salaries, but can we calculate the average salary of a Unitrans BVO? Can anyone assist with this?
13. Are qualified BVOs a ‘scarce’ skill? Has Unitrans been able to fill all its vacancies for BVOs? Has Unitrans ever had to ‘lay off’ or retrench any BVOs because a contract has ended or recession?

IMPACT OF HIV/AIDS OVER THE YEARS:

- 14. Can you describe the impact HIV/AIDS has had on your organization over the decades? Have you seen and felt the impact on HIV on Unitrans in the past? Is this the same now? From your observation, has the impact of HIV declined in recent years?**

