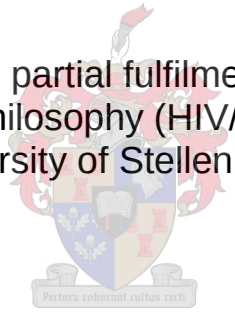
# A Study on Knowledge, Attitude and Practice (KAP) on HIV/AIDS amongst the employees of Telkom SA Ltd.

Yusuf Kamaldien



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

Supervisor: Mr. Burt Davis December 2009

## Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

25 November 2009

## Summary

This study examines the level of HIV/AIDS Knowledge, attitudes towards HIV/AIDS as well as practices amongst the employees of Telkom SA Ltd. Furthermore it also aims to determine the effectiveness of the Peer Education programme within the company as well as the role that promoters are playing in encouraging Peer Educators to do awareness in the workplace on the one hand and encouraging their subordinates to attend such programmes on the other hand.

A total of 80 employees were invited to participate in the survey. At the end of the survey period, which ran from 2 to 21 February 2009, it was found that a total of 66 employees responded by completing the on-line survey. This represents a return of 82,5%.

While the survey results shows a remarkably high level of HIV/AIDS knowledge amongst the responds, it could not be conclusively proven that it was as a result of attending HIV/AIDS workplace awareness programmes. However, it can be said that this knowledge was sufficient to:

- Enable employees to make informed decisions about their own sexual behaviour
- Peer Educators were confident that their knowledge levels were sufficient to educate their peers.

The results also show quite a high level of disinvolvement on the part of promoters with regard to HIV/AIDS workplace issues.

Finally this study also contains a range of recommendations and suggestions which were derived from the findings.

# Opsomming

Hierdie studie ondersoek the vlak van MIV/VIGS Kennis, houdings teenoor MIIV/VIGS sowel as die gebruike van die werknemers van Telkom SA Bpk.
Dit poog ook om die effektiwiteit van die Portuur Voorligtingsprogram binne die maatskappy te ondersoek sowel as om te bepaal watter rol toesighouers speel om enersyds Portuur Voorligters aan te moedig in bewusmakings sessies in die werkplek te reel en om andersyds die rol wat toesighouers speel om hulle ondersgeskiktes aan te moedig om sodanige sessies by te woon.

'n Totaal van 80 werknemers was genooi om die navorsing mee te maak. Aan die einde van die navorsingstydperk, wat vanaf 2 tot 21 Februarie 2009 geloop het, was daar bevind dat 'n totaal van 66 werknemers die aan-lyn vraelys voltooi het. Hierdie syfer verteenwoordig 'n opbrengs van 82,5%.

Onderwyl die resultate 'n merkwaardige hoë vlak van MIV/VIGS kennis onder die respondente getoon het, kon dit nie onteenseglik bewys word dat dit as gevolg van die bywoning van MIV/VIGS werkplek bewusmakings sessies was nie. Ten spyte van die voorgenoemde, kan daar egter met sekerheid gesê word dat hierdie kennis genoegsaam is om:

- Werknemers in staat te stel om ingeligte besluite te neem oor hulle eie seksuele gedrag
- Portuur Voorligters in staat te stel om hulle gelykes voldoende op te voed by wyse van bewusmakings sessies.

Die resultate het ook 'n hoë mate van onbetrokkenheid van toesighouers getoon ten opsigte van MIV/VIGS werkplek angeleenthede.

Hierdie studie bevat ook 'n reeks van aanbevelings en voorstelle wat voortspruit uit die bevindinge.

## Acknowledgements

First and foremost my eternal gratitude and thanks to my LORD (Allah SWT) for granting me the wisdom, inspiration and perseverance to undertake and successfully complete this very important task.

My thanks also go to the faculty members of the School of Industrial Psychology of the University of Stellenbosch and in particular Professors Augustyn and Du Toit as well as Ms Anja Laas. To Professor Daan Nel, Centre for Statistical Consultation, for his help and guidance with the statistical calculations and analysis.

To my employer, Telkom SA Ltd, for providing the funding to register for the programme and for granting me study leave to enable to conduct my research and write my thesis. To my colleagues who responded to the invitation to be part of this study. A big thank you to Ms Galima Barnes, who responded so willingly by donating her time to assist with collating the survey data.

Last but not least, thanks to my study leader and mentor, Mr. Burt Davis, for his guidance and ongoing support, thank you.

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- Chapter 1 introduces the study, defines the research problem, and highlights the objectives of the research, the scope of the study as well as the significance of the research.
- Chapter 2 reviews literature pertaining to HIV/AIDS Peer Education, definitions of Peer Education, examines various behaviour change strategies, and the assessment of the effectiveness of peer educator interventions.
- Chapter 3 deals with research methodology. It includes research design and the advantages/disadvantages of computer direct interviews.
- Chapter 4 represents the analysis and findings of the research project. It also sketches a brief background of the Telkom THUSO WELLNESS Programme, how the research was conducted and respondent data.
- Chapter 5 concludes the research with recommendations of enhancing the Peer Education process in Telkom SA Ltd and it also contains recommendations of how to increase promoter involvement in this process.

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# Chapter 1: Introduction

## *1.1 Background*

South Africa is facing a major social and developmental challenge presented by the HIV/AIDS pandemic. In 2005 the Human Sciences Research Council (HSRC) estimated that 16.2% of the adult population (15 to 49 years of age) is HIV positive. With a cure for HIV a very remote possibility, it is guaranteed that South Africa will still have to deal with the epidemic for years to come. The average life expectancy is expected to drop to 46 years in 2010, 22 years less than it would have been in the absence of HIV/AIDS.

South Africa has the largest number of people (±5 million) living with HIV/AIDS in the world. The social and economic consequences of these figures are far reaching and will affect almost every facet of life in South Africa. As in the case of any business-related risk, HIV/AIDS must be proactively managed. In order to effectively assess and manage risk, it is essential to have adequate information regarding both the nature and the extent of the risk. The hesitancy of many companies to invest in comprehensive HIV/AIDS workplace programmes may be due to a lack of reliable data to show the economic impact of the epidemic. Sustainable private sector responses to the epidemic will only be achieved if senior management is convinced of the business rationale for action. **(SABCOHA, 2004)**

Worldwide, peer education is one of the most widely used strategies to address the HIV pandemic. Despite its popularity, there has been little documentation and analysis of operational issues facing peer education programme managers. Peer Education is a popular concept that variously refers to an approach, a communication channel, a methodology, a philosophy, and or an intervention strategy. The English term peer refers to “one that is of equal standing with another; one belonging to the same societal group” **(Horizons, undated)**

UNAIDS (1999) reports that Peer Education is a widely used tool by business and NGO's against HIV/AIDS and involves training and supporting of a specific group to bring about change among members of the same group. Peer Education is used to effect change at the individual level by attempting to modify an individual's knowledge, attitudes, beliefs or behaviour. It may also bring about change at the group or societal level by modifying norms and stimulating collective action that leads to changes in programmes and policies.

Telkom SA Ltd. developed its own HIV/AIDS Policy which makes provision for a multi-disciplinary approach to HIV/AIDS under the banner of the THUSO Wellness Program. One of which is education and awareness. Since June 2005 a total of 680 Peer Educators were trained by a dedicated team of 12 Master Trainers. Peer Educators in turn arranged and conducted informal HIV/AIDS awareness and education sessions in their respective workplaces on a monthly basis. They are provided with educational material i.e. posters, fliers, and DVD's dealing with specific HIV/AIDS topics. Peer Education sessions usually preceded or followed "Thuso Wellness Days" which also included Voluntary Counselling & Testing sessions.

## *1.2 Research Problem*

Every year there are more and more new HIV infections, which shows that people are not learning about the danger of HIV, or unwilling to act on it. Many people are dangerously ignorant about the virus, with surveys around the world showing alarmingly low levels of awareness and understanding about HIV amongst many groups. **(AIDS Education, undated)**

HIV/AIDS education needs to be an ongoing process, because each generation of young people needs to be informed about how they can protect themselves from HIV as they grow up. Older generations, who have already hopefully received some AIDS education, may need the message reinforced, so that they may continue to take precautions against HIV infection, and are able to inform younger people of the dangers of engaging in unprotected sexual relations. **(AIDS Education, undated)**

It therefore begs the question:

***"Did the attendance of an HIV/AIDS Education/Awareness sessions conducted by trained Peer Educators have an impact on the knowledge, attitudes and practices (KAP) of Telkom employees who have attended such sessions?"***

## *1.3 Three main reasons for HIV/AIDS education*

### 1.3.1 To prevent new infections from taking place

Prevention of infection can be described as a two-pronged approach: Firstly giving people information about HIV/AIDS, such as transmission modes and how people can protect themselves from infection. Secondly, people must be taught how to use this information to use and act on it practically – how to get and use condoms, how to suggest and practice safer sex, how to prevent infection via accidental exposure or when injecting drugs. **(AIDS Education, undated)**

### 1.3.2 To improve quality of life for HIV positive people

AIDS education is often seen as being something that should be targeted only at people who are HIV negative in order to prevent them from becoming infected. When AIDS education with HIV positive people is considered at all it is frequently seen only in terms of preventing new infections by teaching HIV positive people about the importance of not passing on the virus.

An important and commonly neglected aspect of AIDS education with HIV positive people is enabling and empowering them to improve their quality of life by advocating healthy lifestyle adjustments. HIV positive people have varying educational needs, but among them are the need to be able to access medical services access to anti-retroviral drugs and the need to be able to find appropriate emotional and practical counselling, support and help. **(AIDS Education, undated)**

### 1.3.3 To reduce stigma and discrimination

There exist a great deal of fear and stigmatisation of people who are HIV positive. Ignorance, resentment and ultimately, anger often accompany this fear. Sometimes the results of prejudice and fear can be extreme, with HIV positive people being burnt to death in India, and many families being forced to flee their homes across the United States when neighbours discover a family member's positive status.

Discrimination against HIV positive people can help the epidemic to spread, because people are fearful of being tested for HIV, and then they are more likely to pass the infection to someone else without knowing.

"Peer education gives people the opportunity to ask questions outside an academic environment and with someone who isn't an authority figure".
**(AIDS Education, undated)**

## *1.4 Research Objectives*

This research project attempts to:

- Explore the extent to which the HIV/AIDS education/awareness sessions conducted by Peer Educators have impacted on the knowledge, attitudes and practices (KAP) of Telkom employees who have attended such sessions.
- Develop a set of guidelines to be implemented in the workplace to ensure the ongoing and sustainability of the Peer Education process in Telkom SA Ltd.

## *1.5 Scope of the Study*

The study will be limited to a selected and representative group of employees of Telkom SA Ltd. This group of employees represents supervisors, operational as well as support staff.

## *1.6 Significance of the Study*

- Only a limited number of studies were found that document programme effectiveness, as defined above, by evaluating HIV-related risk behaviours and/or STI or HIV incidence among the intended audience. **(UNAIDS 1999)**
- The results of this study will enable the division charged with the responsibility of the THUSO Wellness Programme to develop a set of guidelines to be implemented in the workplace to ensure the continued success and sustainability of the Peer Education process in Telkom SA Ltd. Telkom SA Ltd is also a business entity and, like all other corporate entities, profit driven and answerable to its shareholders and management board in terms of how its financial resources are used and what the return on investment is expected to be. The success of the Peer Education programme itself does not have a direct rand value, but its efficacy has an indirect monetary value i.e. increased productivity, reduced sick leave utilisation, improved employee morale etc.

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# *Chapter 2: Literature Review*

## *2.1 Defining Peer Education*

Flanagan and Mahler (undated) aver that peer education occurs in a variety of settings and includes many different activities. According to them peer education may be:

- Factory workers giving HIV prevention talks in the rest room during lunch breaks.
- Women making house-to-house calls to distribute flyers and talk to housewives.
- Youth organizing video and information shows for other young people in their respective communities.
- Military personnel counselling new recruits.
- Students meeting in colleges residences to demonstrate correct condom use
- Commercial sex workers discussing STI treatment.

## *2.2 Why Peer Education?*

Peer education is a popular intervention approach and the reasons why programme managers use this method are manifold:

- Peers are traditional providers of information to their peers/equals. People will readily talk to their peers about most things, including sensitive issues such as sexual health and HIV/AIDS.
- Peer education programmes tend to be flexible and are community based, easily adaptable to individual needs and can be used in a variety of settings and can also be combined with other activities and programmes such as “Wellness Days”.
- Peer education can be beneficial to Peer Educators themselves. It promotes positive life skills such as leadership and communication and creating opportunities for mentoring and future job contracts.
- Peer education interventions can be launched economically especially if it forms part of a larger programmes with management, supervisory and measuring systems already in place. **(Mason, 2003)**

### 2.2.1 Benefits for Peer Educators

People undergoing peer education training, benefit as follows:

- They receive special training in decision-making, clarifying roles and values and acting in accordance with those roles and values
- Obtaining extensive sexuality information relevant in their own lives
- Being recognised as leaders by their community and their peers
- Having a voice, being involved and some input in programmed design and operation
- Learning skills such as facilitation and communication
- Committing to responsible sexual behaviour

**(Mason, 2003)**

### 2.2.2 Disadvantages of Peer Education

While there are many advantages to the peer education approach, there are some disadvantages that should be taken into account:

- Training of peer educators are time consuming when comparing the duration of training programmes which could be as long as four days as opposed to the time that peer educators spend educating their peers.
- Becoming a peer educator is based on volunteerism and as soon as other career demands increases, peer education programmes are abandoned.
- Research has shown that peer educator programmes have a greater impact on the educators than on their peer contacts. **(FHI, 2005)**

## *2.3 Different Approaches to Peer Education*

Everts (2003) posit that peer education can be divided into different approaches which can be used by peer educators. The most important approaches, based on the level of training, supervision and the roles and responsibilities of peer educators, are as follows:

- **Buddy System.** This system can be described where students involved in HIV/AIDS awareness provide other students with support and friendship using very basic counselling skills. This method assists in breaking down the feeling of isolation experienced by many people, especially newly infected people and/or minority groups.

- **Peer Tutoring.** This is applicable in a more academic environment. Academically advanced students are trained as tutors to help their peers with specific subjects, thereby extending the function of the educator.
- **Peer Support.** This is a more formal and comprehensive approach to peer education. People, who are trained as group leaders, administer personal development interventions and information sessions for other persons.
- **Peer Advocacy**. Peer advocacy occurs when employees themselves take the initiative to advocate for the rights of their specific group. The programmes and activities in peer advocacy can be similar to that of other types; it is fundamentally different in that the effort comes from the employees themselves.
- **Peer Counselling:** This type of intervention involves employees who are trained and well supervised in the actual provision of counselling as well as offering inter-personal skills such as active listening, providing support, examining and suggesting alternatives and engaging in verbal/non-verbal dialogue with their peers.
- **Peer Empowerment:** This involves developing collaborative networks between employees and staff based on the principles of empowerment and mediation to resolve inter-group tension in multi-cultural societies.

## *2.4 Changing Set Behaviours*

Parnell and Benton (1999) aver that changing set behaviours is fundamental to most effective responses to the HIV/AIDS epidemic. It can be important to:

- reduce further transmission of HIV
- reduce discrimination against the people most directly affected by HIV
- Mobilise community wide responses
- Build consensus regarding legal, ethical and human rights concerns
- Reduce damage associated with drug use and expansion of the sex industry
- Organise community based palliative care, their dependants and the surviving family

- There is no single method that works to facilitate behaviour change to address all issues in all settings because of the nature of the HIV epidemic and the way it interacts with the world. In different settings, the epidemic has different effects on the individuals, families, communities and nations. It is interwoven with various aspects of people's lives including the social, cultural, economic, political and developmental circumstances in which they live.

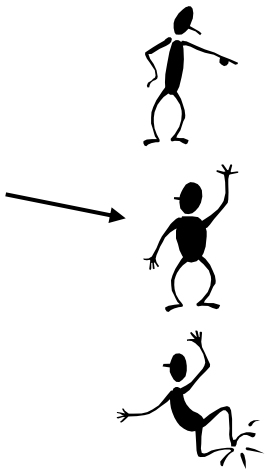
However, much is now known about what approaches work best. The most effective programmes are those that encourage and nurture change and the least effective are those that rely on coercion and force.

## *2.5 Effecting Behavioural Change*

Peer education involves peers communicating HIV prevention information and strategies in ways that can lead to behavioural change.

How is behaviour change effected? This question probably has as many answers as there are diverse cultures and populations. Every HIV prevention programme is based on those answers-theories about why people change their behaviours. **(FHI, 2002)**

Programmes to promote behaviour change are often based on the assumption that people react in standard and rational ways to new information they receive. Many programmes, although differing in detail, follow the framework shown below:



Individual practices, unhealthy or unsafe behaviour

Programme "intervenes" by interacting directly with that individual

The individual moves to practice only healthy, or safe behaviour

**(Parnell and Benton, 1999)**

### 2.5.1 Theories on Behavioural Change

Peer Education draws from elements of each of the below mentioned behavioural theories as it implies that certain members of a given peer group i.e. peer educators can be influential in bringing about behavioural change amongst peers.

#### 2.5.1.2 Social Learning Theory

Behavioural change strategies draw on several well known behavioural theories. Bandura (1986) states that the **Social Learning Theory** is about people serving as models of human behaviour and that some people are capable of bringing about changes in behaviour in certain individuals based on that individuals' value and interpretation system. Bandura avers that most human behaviour is learnt by what humans observe through modelling: by observing how others behave, one forms an idea how new mannerisms are performed and at a later stage these ideas serves as a guide for action.

The **Social Learning Theory** explains human behaviour in terms of ongoing and mutual interaction between cognitive, behavioural and environmental influences.

### Conditions for effective behaviour modelling

- **Attention:** The amount of attention paid is influenced by various factors. These factors include distinctiveness, affective valence, complexity, functional value and arousal level. The following characteristics e.g. sensory capacities, arousal level, past reinforcement and perceptual set, affect attention.
- **Retention:** Is what a person paid attention to and it includes symbolic coding, symbolic rehearsal, mental images, motor rehearsal and cognitive organization.
- **Reproduction:** means reproducing images which includes physical capabilities and self-observation of reproduction.
- **Motivation:** refers to having a good reason to imitate and it includes motives such traditional behaviours, what has been promised (imagined incentives) and vicarious (seeing and recalling the reinforced model).

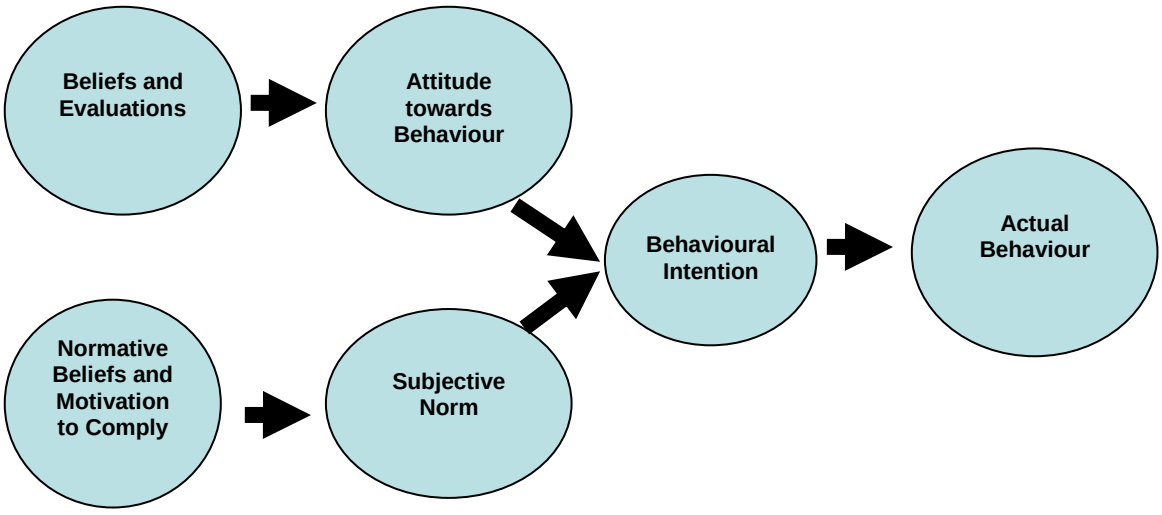
### 2.5.1.3 Theory of Reasoned Action (TRA)

Fishbein and Ajzen (1975) says that the **Theory of Reasoned Action (TRA)** avers that one of the influential elements for behavioural change is that an individuals' understanding of social norms or beliefs, attitudes, intention and behaviours of what people who are important to the individual, do or think about a specific behaviour. According to the TRA a persons' behaviour is determined by its' behavioural intention to perform a certain action. This intention is in turn determined by the persons' attitudes and subjective behaviour towards the specific behaviour. Fishbein and Ajzen (1975, p. 302) define the subjective norms as "the person's perception that most people who are important to him to think he should or should not perform the behaviour in question".

This theory can be summarized as follows:

***Behavioural Intention = Attitude + Subjective Norms***

According to this theory the attitude of a person towards a particular behaviour is determined by his beliefs and the results of this behaviour, multiplied by his own evaluation of these results. Beliefs are defined by a person's subjective probability that performing a particular action will produce specific consequences. This model therefore suggests that external triggers influence attitudes by modifying the structure of the person's belief system. Intention driven by behaviour is also influenced by the subjective norms that are themselves determined by individual standards (normative beliefs) and by motivation to comply with these standards.




**(Davis, Bagozzi and Warshaw – 1989)**

### 2.5.1.4 Diffusion Innovation Theory

Rogers (1983) on the other hand says that the **Diffusion Innovation Theory** posits that certain influential people from a given population group acts as behavioural change agents by disseminating information and influencing group norms in their respective communities.

### 2.5.1.5 Theory of Participatory Education

Freire (1970) states that the **Theory of Participatory Education** has also been important in the development of peer education. Participatory models of education suggest that powerlessness at community or group level and the economic and social conditions inherent to the lack of power are major risk factors for poor health.

Many advocates of Peer Education claim that the horizontal process of equals (peers) talking amongst themselves and determining a course of action is fundamental to peer education influence working towards a behavioural influence. **(UNAIDS, 1999)**

## *2.6 Peer Education Reduces Risky Sexual Behaviours*

Mason (2003) posits that if people believe that the person delivering the message is similar to them and faces similar concerns and pressures, they are more inclined to hear and internalise messages and in so doing change their attitudes and behaviours. He cites the following case studies in support of his theory:

- Studies conducted by the Advocates for Youth organization show that young people who believe their equals are practising safer sex (i.e. using condoms) are also more than twice as likely to practise safer sex compared to teenagers who do not believe their equals are practising safer sex.
- Black, urban females ages 12 through 19 living in the United States, who attended a peer education programme, significantly improved their HIV / AIDS knowledge and preventive behaviours. Before the program, 44% of sexually active participants stated that they did not use condoms compared to 33% after the programme.

- Incidence of sex in the two weeks prior to the programme fell from 21% at baseline to 14 % at follow-up. When a sexual health peer education program, conducted in Peru in 2000, was evaluated it was found that, when compared to a control group, males taking part in the programme had increased knowledge about pregnancy prevention. They also reported reduced sexual activity and increased use of condoms at most recent sex.
- An assessment of a peer health education program in Cameroon showed increased use of modern preventative methods and increased condom use at most recent sex among participants versus youth in a comparison group. The program was more effective amongst school going youth than those who were out of school. The West African Youth Initiative conducted peer education programmes in schools and out-of-school settings in Ghana and Nigeria.
- Evaluation showed that peer education significantly increased contraceptive (condom) use among school-going youth. The proportion of youth reporting use of modern contraception methods increased significantly from 47 to 56% while use in comparison areas decreased slightly. A peer education program resulted in Florida (alternative school) increased reports of condom use at most recent intercourse (up from 45 to 55 %) and fewer reports of unprotected sex (down from 15 to 4%) among sexually active students.
- Peer leaders in the gay communities in two small cities were identified in a program in the South. The leaders were then trained to talk with their peers about HIV risk behaviours. As a result, the recorded incidences of men who engaged in any unprotected anal intercourse in a two-month period decreased from 36, 9% before the intervention to 27, 5% after the intervention.

At BMW, South Africa, Peer Educators are selected on the basis of personal qualities (e.g. emotional maturity, popularity with their peers) and their specific skills and aptitudes, including interpersonal and communication skills. They are supported through monthly peer educator support group sessions. They receive specialized training to equip them for their task. This training includes carrying out HIV/AIDS training on a monthly basis during staff meetings and providing advice, support, assistance and referrals**. (Paul, 2003)**

## *2.7 Assessing Programme Effectiveness/Impact*

Rossi & Freeman (1993) avers that the terms effectiveness and impact are often used interchangeably with regard to evaluation research. Programme effectiveness or impact refers to "whether and to what extent a programme causes changes in the desired direction among a target population".

Review of the HIV/AIDS peer education literature shows that many evaluation studies document programme outputs or process indicators such as the number of peer educators trained, the number of persons in the target population contacted, and/or the number of condoms distributed by peer educators.

While measurement of programme outputs is an important part of the evaluation process, it is not sufficient for understanding whether a programme has reduced vulnerability to HIV in a particular intended audience. Although they recognized the importance of conducting an impact evaluation, programme managers participating in the need assessment cited lack of time, funding, and technical expertise as barriers to measuring behavioural and biological outcomes.

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# Chapter 3: Research Methodology

## *3.1 Introduction*

Research methodology can be defined as the manner in which data is collected for a research project.

## *3.2 Research Design*

### 3.2.1 KAP Survey (post questionnaire survey) Methodology

Surveys represent one of the most common types of quantitative, social science research. In survey research, the researcher selects a sample of respondents from a population and administers a standardized questionnaire to them. The questionnaire, or survey, can be a written document that is completed by the person being surveyed, an online questionnaire, a face-to-face interview, or a telephone interview. Using surveys, it is possible to collect data from large or small populations - sometimes referred to as the universe of a study. **(Barribeau et al, 2005).**

As this research focuses on past events and interventions and how these interventions influenced the Knowledge, Attitudes and Practices pertaining to HIV/AIDS, a retrospective study will be performed. A retrospective study is a study in which data is collected and analysed after all measurements, interventions or events in the participants have taken place.

To determine the extent of the knowledge transfer took place amongst the participants, It is the intention to formulate a number of questions specifically focused at HIV/AIDS knowledge and sexual practices. It is also the intention to incorporate a series of questions to evaluate the respondents' reaction to the HIV/AIDS workplace awareness interventions.

### 3.2.2 Computer Direct Interviews

For the purpose of gathering data for the survey, It has been decided to use the abovementioned method. Interviewees will be able enter their own responses direct onto the computer. It is the intention to use the Question Mark Perception Software® to design an on-line questionnaire that can be accessed from any desktop computer in the company.

#### 3.2.2.1 Advantages

- The virtual elimination of data entry and editing costs.
- One will get more accurate answers to sensitive questions. Recent studies of potential blood donors have shown respondents were more likely to reveal HIV-related risk factors to a computer screen than to either human interviewers or paper questionnaires. The National Institute of Justice has also found that computer-aided surveys among drug users get better results than personal interviews. Employees are also more often willing to give more honest answers to computer than to a person or paper questionnaire.
- The elimination of interviewer bias. Different interviewers can ask questions in different ways, leading to different results. The computer asks the questions the same way every time.
- Ensuring skip patterns are accurately followed. The Survey System can ensure people are not asked questions they should skip based on their earlier answers. These automatic skips are more accurate than relying on an Interviewer reading a paper questionnaire.
- Response rates are usually higher. Computer-aided interviewing is still novel enough that some people will answer a computer interview when they would not have completed another kind of interview.

#### 3.2.2.2 Disadvantages

- The Interviewees must have access to a computer or one must be provided for them.
- As with mail surveys, computer direct interviews may have serious response rate problems in populations of lower educational and literacy levels. This method may grow in importance as computer use increases.

  **(The Survey Systems Tutorial, 2009)**

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# Chapter 4: Analysis and Findings

## *4.1 Introduction*

This chapter makes a qualitative analysis and interpretation of the data collected. It begins with a brief overview of Telkom SA Ltd with special reference to the THUSO Wellness Programme under whose banner the in-house HIV/AIDS programme resides.

### 4.1.2 Telkom THUSO Wellness Programme

Telkom SA Ltd realised as early as 1995 that the HIV/AIDS pandemic could have a devastating impact on the wellbeing of its employees and its business operations.

Telkom SA Ltd therefore launched the Thuso Wellness Programme to address this very serious concern. The following structures were built into this programme to provide a holistic approach to employee wellness:

- **HIV/AIDS Management Structure and System**
  The HIV/AIDS Steering Committee was established to oversee the overall implementation of the HIV/AIDS workplace programmes in the company. This committee consists of Line Management Representatives, Organised Labour and an external vendor.
- **Prevention Programme**
  This dealt mainly with the distribution of free condoms to its employees. Telkom SA Ltd performed a Lifestyle Modification Survey amongst its' employees and found that more than 97% of its employees had proficient levels of knowledge in terms of HIV/AIDS.
- **Peer Educator Programme**
  The Peer Educator Programme focused on various awareness and sensitization campaigns in the workplace.

- **Voluntary Counselling and Testing**

  On-site VCT is performed on an on-going basis at various workplaces to afford employees the opportunity to “know their status”. Incorporated into the VCT is “Wellness/Health Days” where employees are tested for high cholesterol, high blood pressure and diabetes.

- **Chronic Disease Management**

  HIV positive employees are taken up into the CDM programme managed by a private health care provider (vendor). The vendor in turn manages the health of that employee with regard to medication, counselling and general medical services needed to maintain and enhance that employee’s health. All employees have access to a toll free helpline on a 24/7 basis which provides confidential telephonic advice, support and assistance in terms their personal health. **(Aids Guide, 2007)**

## *4.2 Method of Research*

### 4.2.1 Permission

Permission was obtained from the Telkom Safety, Health and Environmental Corporate division under whose auspices the “Thuso Employee Wellness Programme” which includes HIV/AIDS resides. Permission was granted on condition that participation in the survey is totally voluntary and that the respondents’ identities are protected.

### 4.2.2 Measuring Instrument

It is the intention of the researcher to separate the gathered data into two distinct groups i.e. those who attended an HIV/AIDS awareness session and those who did not. A comparative analysis will be performed on the data of the two groups in an attempt to show a correlation between the knowledge attitudes and practices of these groups.

A questionnaire, consisting of 58 questions, were developed which was divided into five main categories i.e.

#### 4.2.2.1 Section A: Socio-demographic Characteristics

In this section, respondents were required to provide information on the following aspects:

1. Age Group (years)
2. Gender
3. Job Grade/Level
4. Marital Status
5. Educational Level
6. Ethnic Group

#### 4.2.2.2 Section B: HIV/AIDS Peer Education Training

This section was reserved for those employees who underwent the formal in-house HIV/AIDS Peer Educator training. They were required to respond to the following questions:

8. When did you undergo training?
9. My knowledge on HIV/AIDS increased as a result of the training:
10. My knowledge is adequate to conduct successful awareness sessions.
11. How many awareness sessions have you conducted since you completed your training?
12. The manner in which I presented awareness sessions contributed to its success
13. The support material I used during the awareness sessions contributed to its success
14. The awareness sessions were successful because my knowledge on HIV/AIDS is adequate
15. The awareness sessions were successful due to attendee interest in HIV/AIDS
16. The awareness sessions were successful because promoters allocated enough time to their subordinates to attend.

17. I am aware of the on-line Peer Educator Toolkit on the Telkom Intranet

18. I was taught how to use the on-line toolkit

19. I have used the on-line Peer Educator Toolkit to record details of the awareness sessions I conducted

20. I do not know how to use the on-line Peer Educator Toolkit to record awareness sessions

21. I have made use of the support material available on the Toolkit

22. There is support material on the Peer Educator Toolkit

23. I do not know how to access the support material on the Peer Educator Toolkit

24. My promoter actively encourages me to conduct HIV/AIDS awareness sessions during working hours

25. My promoter actively encourages his/her subordinates to attend HIV/AIDS awareness sessions during working hours

26. How much time did your promoter allow you per session?

27. How often did your promoter allow you to conduct HIV/AIDS awareness sessions?

28. If you selected “never” in question 27, which of the following factors describe best the reasons for your promoter refusing permission?

29. I think it is necessary to conduct a HIV/AIDS refresher workshop on an annual basis

30. How would you go about encouraging as many of your fellow workers as possible to attend a HIV/AIDS awareness session in your workplace?

31. What would you do to make the content of future HIV/AIDS awareness sessions more interesting?

#### 4.2.2.3 Section C: HIV/AIDS Knowledge & Attitudes

This section examines the HIV/AIDS Knowledge and attitudes of the respondents. (Question 32 to 41 focuses on HIV/AIDS knowledge whereas questions 42 to 47 focus on the respondents attitudes towards HIV/AIDS)

32. I have attended an HIV/AIDS awareness session in the workplace.

33. There is a cure for HIV/AIDS

34. Healthy looking persons who are HIV positive can transmit the disease to others

35. Most of the HIV infections are as a result of unprotected sexual intercourse

36. Drug addicts sharing needles are exposing themselves to the risk of being infected with the HI Virus

37. Babies born of mothers who are HIV positive have a smaller chance of becoming HIV positive if mothers take ARV's

38. A person who totally abstains from sexual intercourse will not become infected with the HI virus

39. Persons who use condoms correctly each time they have sexual intercourse have little or no chance of becoming infected with the HI Virus

40. Partners who are faithful to each other are very unlikely to become infected with the HI virus.

41. Males who are circumcised, while taking the proper universal precautions, are less likely to become infected with the HI virus than those who are not taking the proper universal precautions

42. I believe that couples should engage in sex before marriage

43. People who are HIV positive are more likely to become sick with Tuberculosis (TB)

44. I believe that couples should have themselves tested for HIV before marriage

45. I believe that people who are HIV positive should be isolated from the rest of the population

46. I believe that the status of an HIV positive person should not be disclosed to others

47. I believe that the practice of Voluntary Counselling and Testing (VCT) for HIV is necessary in the workplace.

**4.2.2.4 Section D: Promoter Involvement**.

48. My promoter has attended an HIV/AIDS awareness session

49. My promoter actively encourage his/her subordinates to attend HIV/AIDS awareness sessions

#### 4.2.2.5 Section E: Sexual Practices

This section examines the sexual behaviours/practices of the respondents as well as issues around sexually transmitted infections

50. I am sexually active
51. I had a non-regular sexual partner in the last year
52. I think single persons in non-committed relationships should use a condom each time they have sexual intercourse.
53. I have contracted a Sexually Transmitted Infection (STI)
54. I have received treatment for a Sexually Transmitted Infection (STI)
55. Male condoms are readily available and easily accessible in my workplace
56. I am more aware of the dangers of unprotected sex as a result of attending the HIV/AIDS awareness sessions
57. I think attendance of HIV/AIDS awareness sessions should be made compulsory for all employees as everyone can benefit from it.
58. If employees who underwent Voluntary Counselling and Testing (VCT) were rewarded in some way, more employees would go for VCT.

A total of 37 questions were posed in a closed ended 5 point Lickert - scale (Fully Agree, Agree, Neither Agree nor Disagree, Disagree and Fully Disagree). A further 7 questions were “Agree/Disagree” type questions and the remainder of questions contained specific responses except for two questions where the respondents were required to provide their own opinions.

### 4.2.3 Collection of Data

With the assistance of the Corporate HR services the questionnaire was loaded onto a secure server and 80 previously identified employees were invited to participate in the KAP survey. The survey was made accessible only to invited participants who were required to access the survey via their unique personnel numbers. The questionnaire was available from the 2nd to the 21st February 2009.

### 4.2.4 Research Design

The research design can be described as a cross-sectional research design. This design was selected as it was considered to be the design best suited to achieve the objectives of this survey.

### 4.2.5 Statistical Analysis

The statistical calculations were done with the very able assistance of Professor Daan Nel of the Centre for Statistical Consultation (CSC) of the University of Stellenbosch:

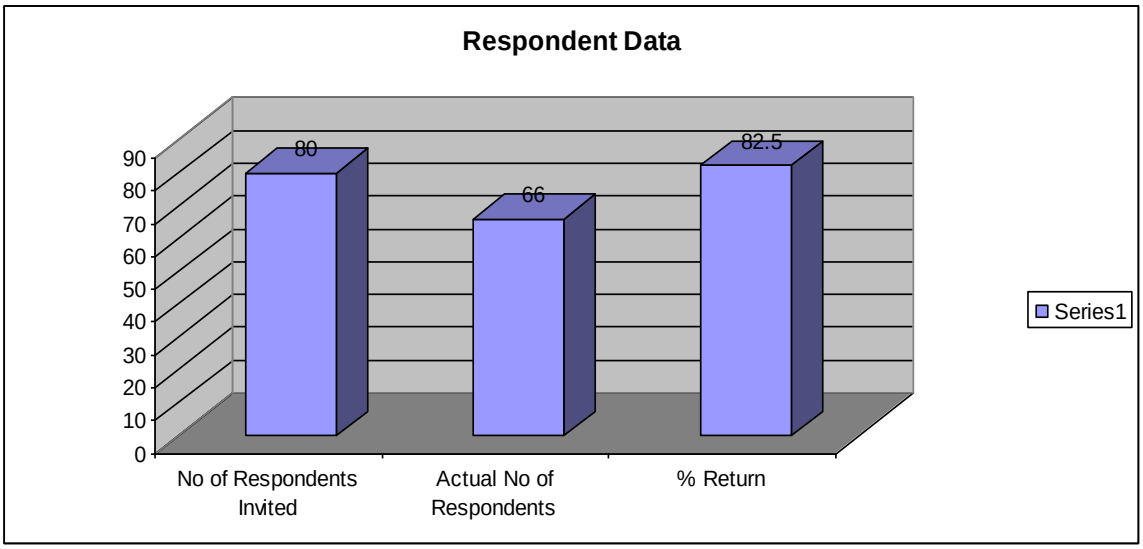
- Frequency Tables
- Mann-Whitney U Test
- Chi-square Test
- Spearman's Rank Correlation Test

The above-mentioned analyses were done by using STATISTICA 8, statistical analysis software programme.

## *4.3 Respondent Data*

### 4.3.1 Number of Respondents

Of the 80 participants invited to participate in the survey, 66 (n=66) responded by completing the questionnaire. The number of respondents represented a return of 82.5% as shown below:



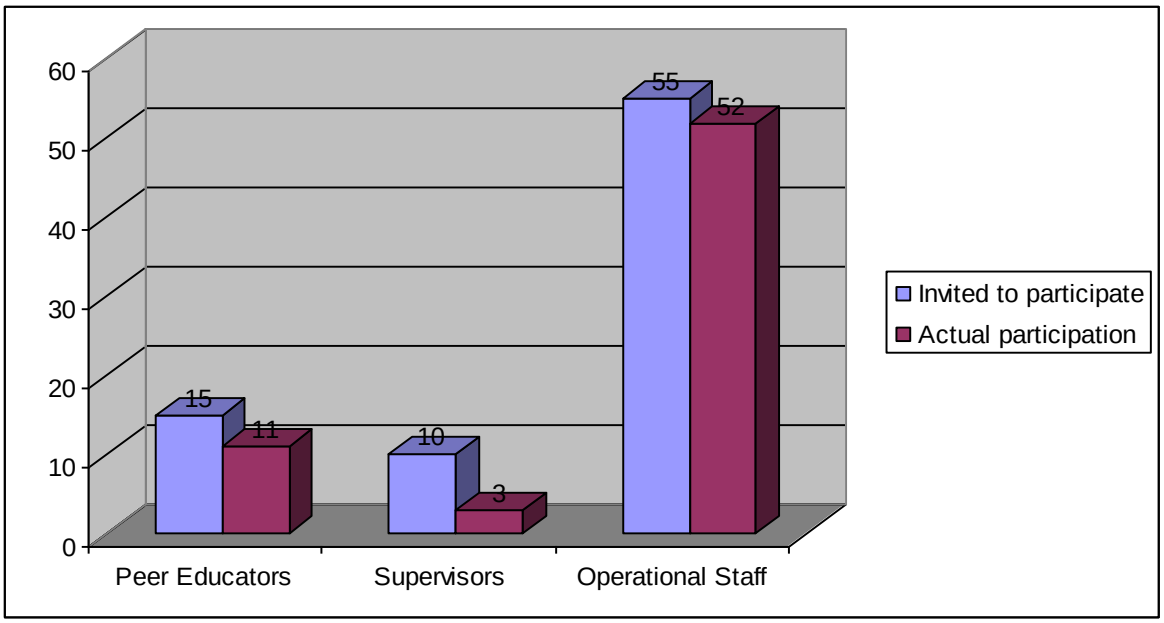

- Number of respondents invited to participate in study: 80
- Actual number of respondents who participated in the study: 66
- Actual number of respondents as a percentage: 82.5%

This response was better than expected. The high return/response rate actually guarantees a more accurate reflection of what is really happening in the workplace.

### 4.3.2 Breakdown of Respondent Data

The respondent data (80 invited participants) can be further broken down per job grade:

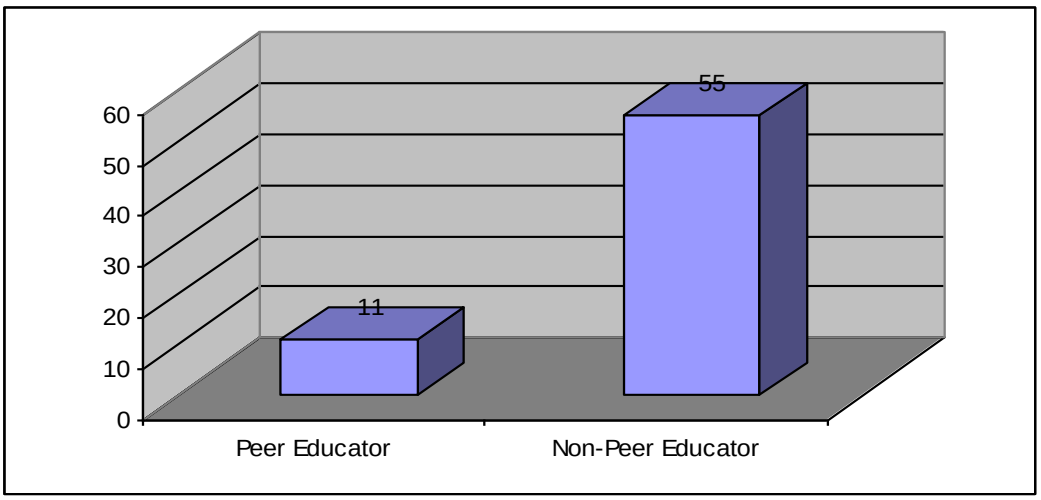
| Job Grade of respondents | Invited to participate | Actual participation | Participants as percentage of invitees |
|---|---|---|---|
| Peer Educators | 15 | 11 | 13.75% |
| Supervisors | 10 | 3 | 3.75% |
| Operational Staff | 55 | 52 | 65% |
| **TOTALS** | **80** | **66** | **82.5%** |




- The number of Peer Educators as well as the number of operational staff who actually participated in the survey was very encouraging as can be seen in the breakdown shown above. However, the same cannot be said of the supervisor response where only 3 out of the 10 supervisors invited to participate, actually did. This is indicative of the high level of disinvolvement on the part of supervisors regarding HIV/AIDS in their own workplace.

### 4.3.3 Peer Educators vs. Non-Peer Educators

A total of 11 of the 66 (n = 66) respondents were trained Peer Educators. An analysis of the Peer Educator response will be done separately:

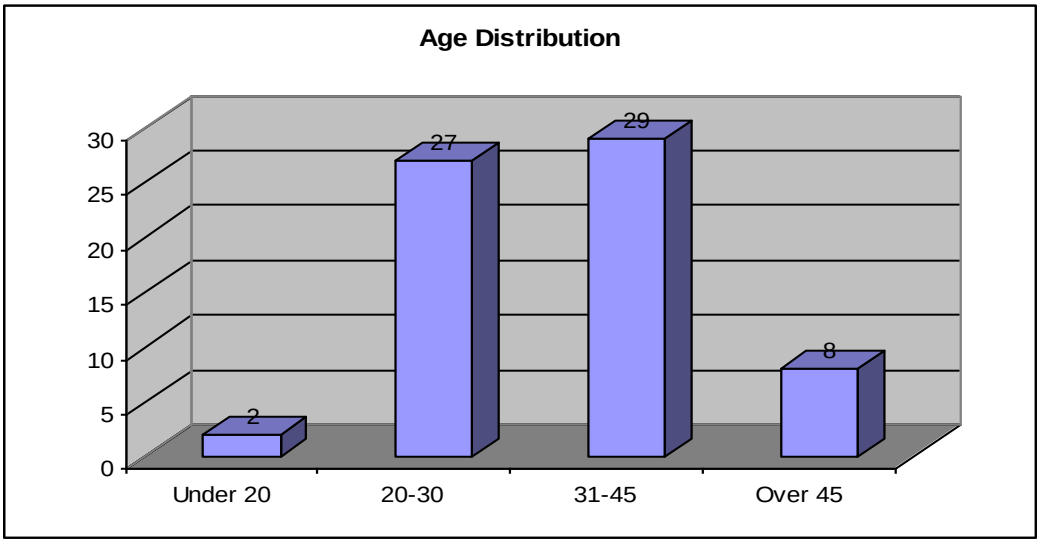



- Number of HIV/AIDS Peer Educators who participated in the study: 11
- Number of non-HIV/AIDS Peer Educators who participated in the study: 55

## *4.4 SECTION A: Socio-demographic Data*

The socio-demographic data is represented below under their respective headings.

### 4.4.1 Age Distribution

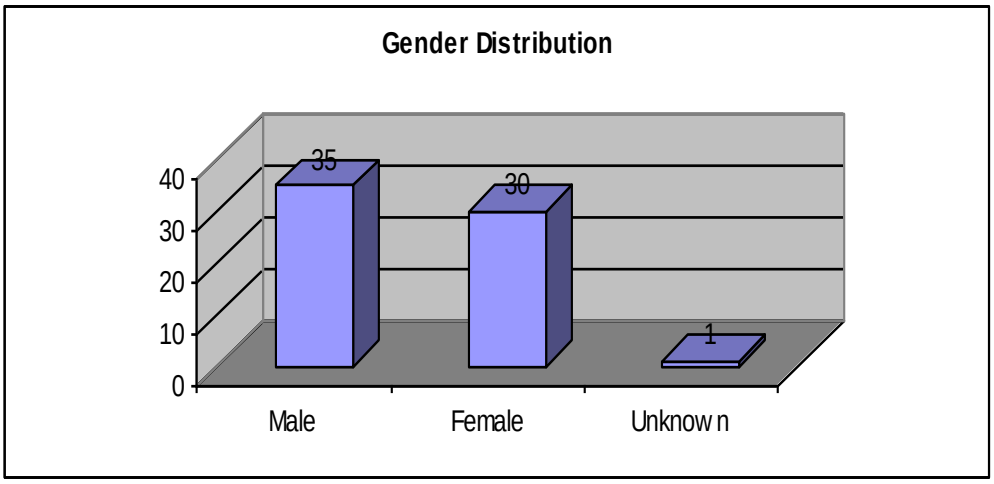


The age distribution of all the participants (N=66) is as follows:

- Under 20 years of age : 2
- Between 20 and 30 years of age : 27
- Between 31 and 45 years of age : 29
- Over 45 years of age : 8

The age distribution of the participants is representative of the different age groups in Telkom SA Ltd. The age of the Telkom workforce is fairly young, ranging from between 20 and 45 years of age. Once again it must be reiterated it is not the purpose of the study to measure the responses of the participants in relation to their respective age groups.

### 4.4.2 Gender Distribution

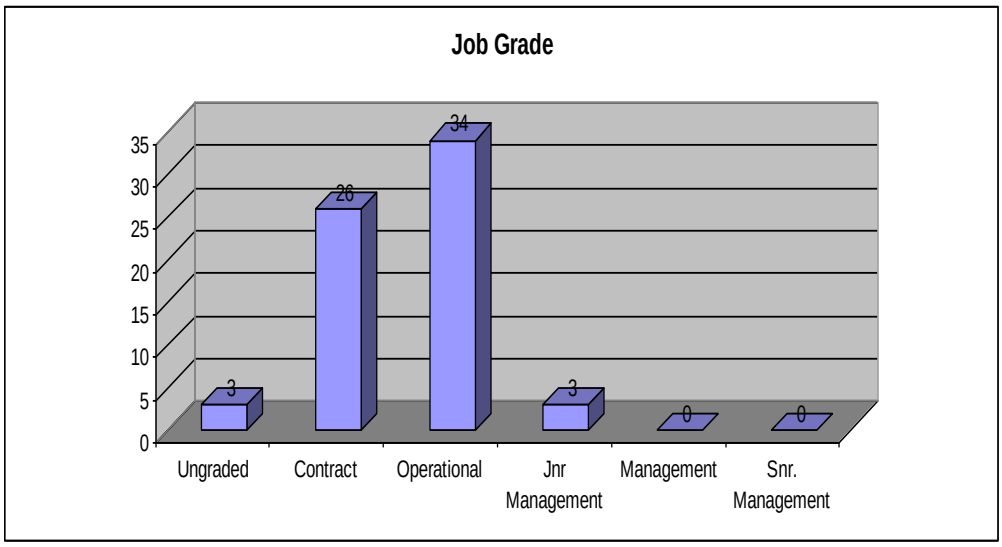



The gender of all the participants (n=66) are represented as follows:

- Male : 35
- Female : 30
- Unknown : 1

The male and female gender is evenly represented in this study. No attempt was made to manipulate gender numbers of the respondents. The opinions of both male and female were combined and represented without making reference to a specific gender.

### 4.4.3 Job Grade



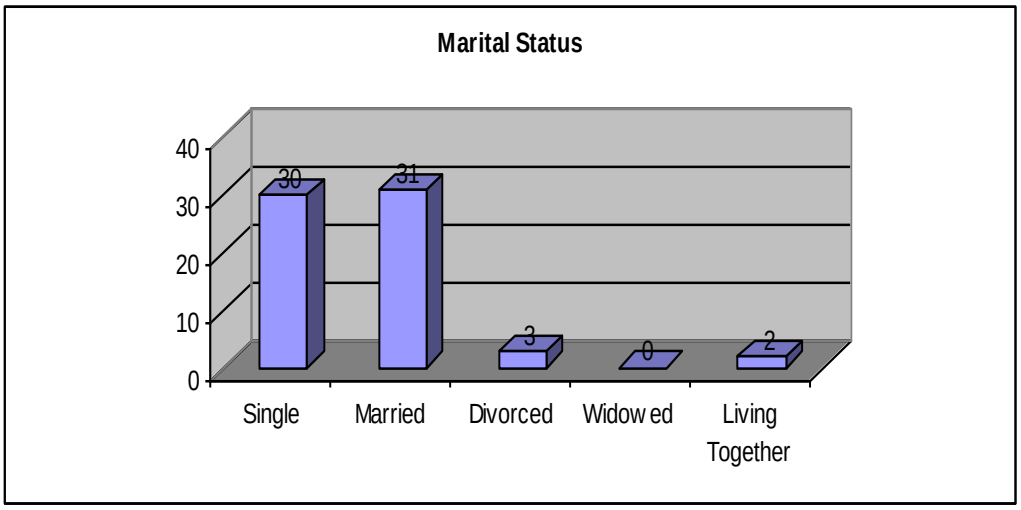

The job grades of the participants (n=66) are as follows:

- Ungraded : 3
- Contract Employees : 26
- Operational Staff : 34
- Junior Management : 3 (Supervisory staff)
- Middle Management : 0*
- Senior Management : 0*

The fact that a large number of contract employees participated in this study will not have a negative effect on the results obtained in the study. In fact, in terms of the Telkom HIV/AIDS Workplace Policy, all contract workers enjoy the same privileges under the THUSO Wellness Programme, as their permanently employed counterparts.

*It was decided not to invite members of middle and senior management to participate in the study due to their slow/poor response in past surveys as well as them not being available to participate due to work requirements.

### 4.4.4 Marital Status

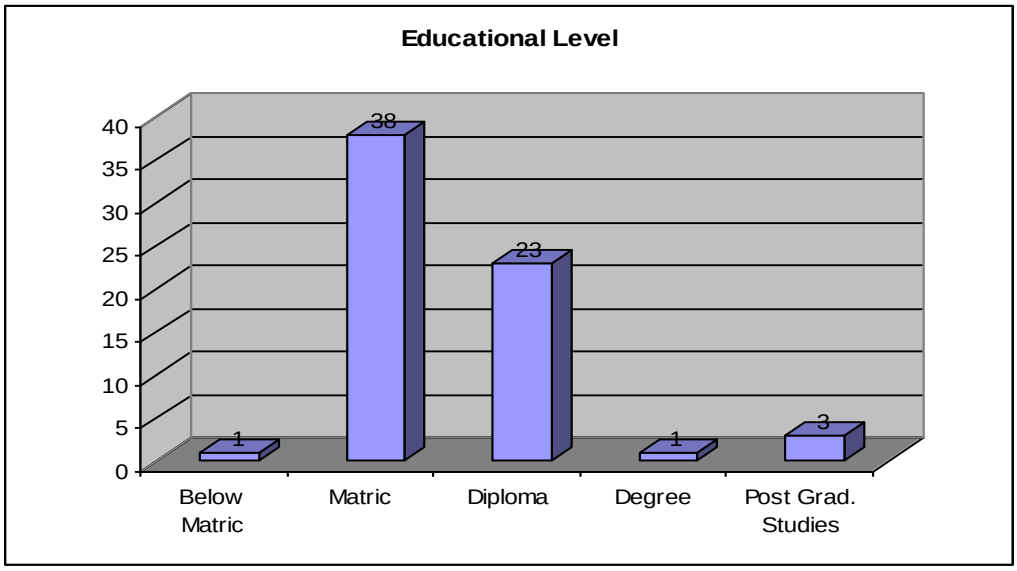



The marital status of all the participants (n=66) are as follows:

- Single : 30
- Married : 31
- Divorced : 3
- Widowed : 0
- Living together : 2

The marital status of the respondents was equally split between married and single with three respondents divorced and a further two indicating that they were co-habitating with their respective partners. It is not known if their partners were Telkom employees or whether they participated in the study.

### 4.4.5 Educational Level

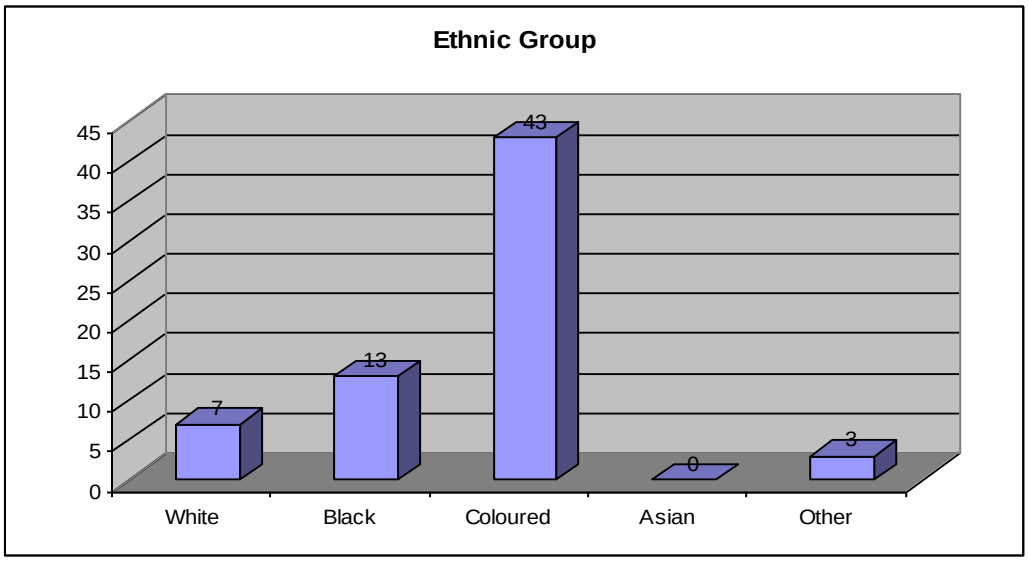



The educational levels of all the respondents (n=66) are represented as follows:

- Below Matric : 1
- Matric : 38
- Diploma : 23
- Degree : 1
- Post Graduate Studies : 3

Forty one percent (41%) had post matriculation qualifications and 57% of the respondents had a matriculation certificate with only one respondent who did not have a matriculation certificate. The education levels of the respondent group were relatively high. While there is no correlation between academic qualifications and level of HIV/AIDS knowledge as far as this study is concerned, it is almost expected that their general HIV/AIDS knowledge would be relatively high too.

### 4.4.6 Ethnic Grouping




The respondents (n=66) were split along the following ethnic lines:

- White : 7
- Black : 13
- Coloured : 43
- Asian : 0
- Other : 3

The different ethnic groups are not well represented in this study. However it is not the intention to split the analysis along ethnic lines. The ethnic distribution will therefore have no effect on the outcome of the study.

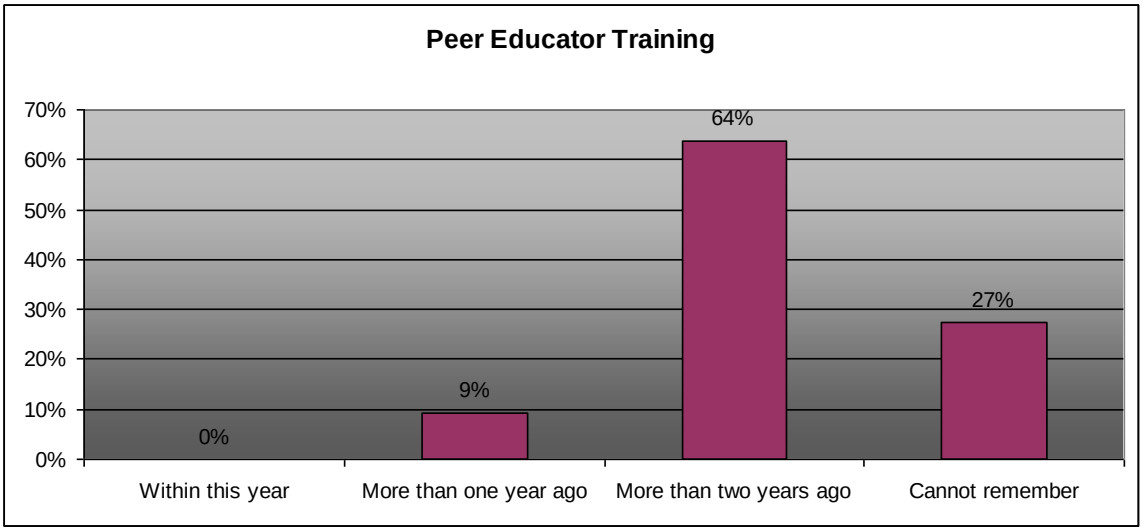
## *4.5 SECTION B: Peer Educator Responses (N=11)*

4.5.1 This section examines the HIV/AIDS Peer Educator responses to a range of questions listed below.

4.5.2 Legend:

- FA = Fully Agree
- A = Agree
- NA/ND = Neither Agree/Nor Disagree (Neutral)
- D = Disagree
- FD = Fully Disagree

**Q8.When did you undergo training?**

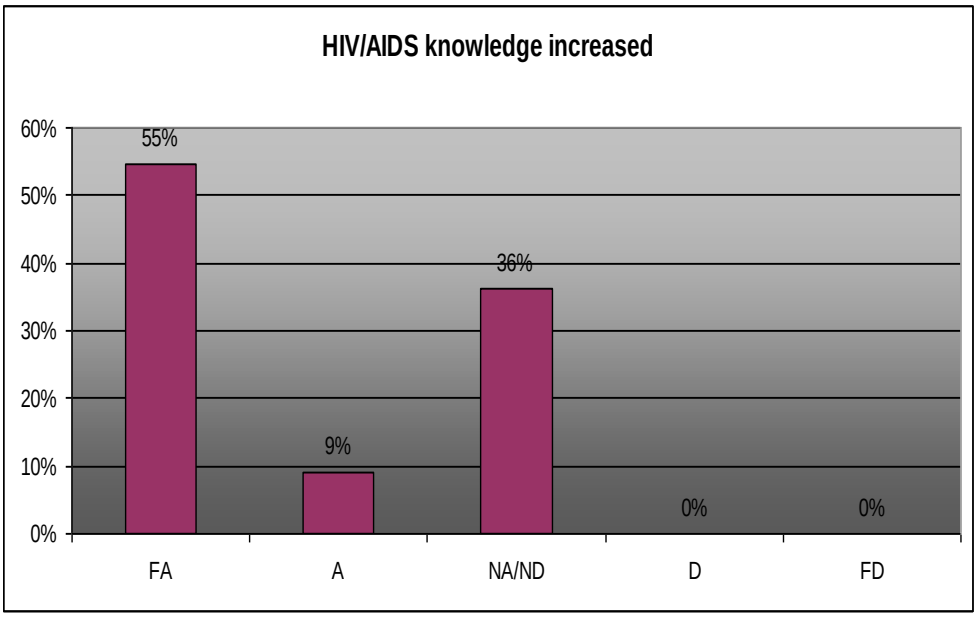



- Twenty seven percent (27% =3) of the Peer Educators indicated that they could not recall when they had undergone training.
- Sixty four percent (64%=7) underwent training more than two years ago.
- Nine percent (9%=1) had undergone training more than a year ago
- None of the Peer Educators had undergone training in the current year.

The Peer Educators who could not recall (27%) when they had undergone training was in all probability of the very first group who were trained. The bulk of the Peer Educators (64%) were trained two years and more ago. Thereafter training levelled off (9% trained more than a year ago) as the training demand for Peer Education diminished.

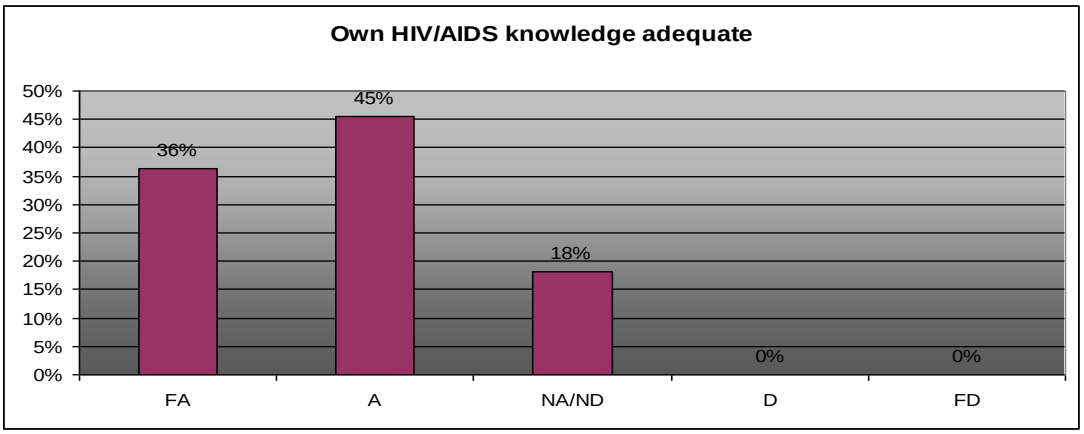
Peer Educator training commenced in Telkom in June 2005. The 3 Peer Educators who indicated that they could not recall when they had undergone training was in all probability one of the first volunteer employees who had undergone training. Sixty four percent (64%) had undergone training at a time when the bulk of the peer educators were trained. After that Peer Educator levelled off when saturation levels were reached. The responses by the Peer Educators regarding when they had undergone training is in line with what actually transpired in the organisation.

**Q9.My knowledge on HIV/AIDS increased as a result of the training**



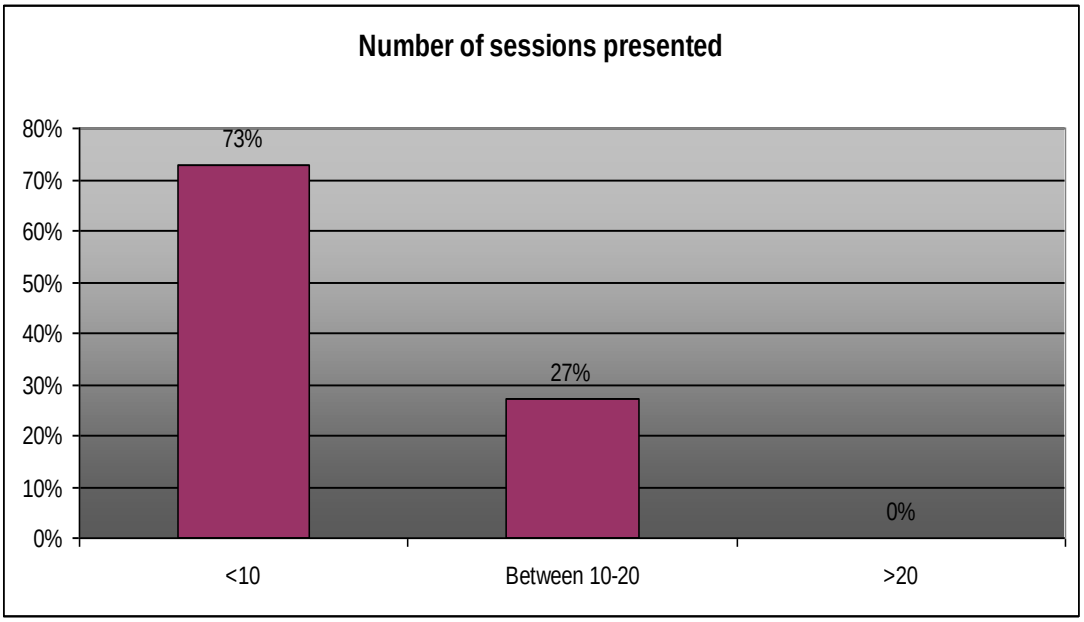

- Sixty four percent (64%) of the respondents stated that their knowledge increased as a result of the training they underwent. Thirty six percent (36%) of the respondents remained neutral on this statement. None of the Peer Educators disagreed with this statement.

**Q.10 My knowledge is adequate to conduct successful awareness sessions.**



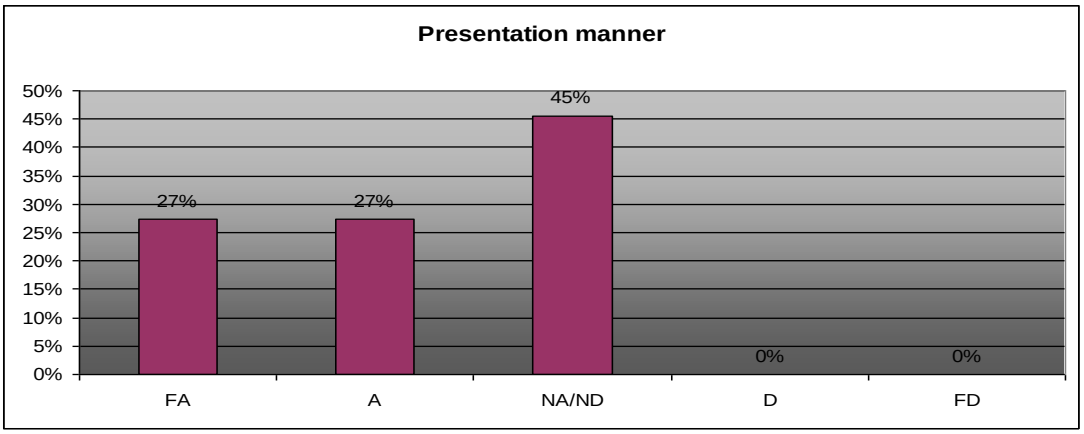

- Eighty one percent (81%) of the respondents stated that their HIV/AIDS knowledge was adequate to successfully conduct awareness sessions in the workplace. Eighteen percent (18%) of the respondents had a neutral response to this statement. Once again, none of the respondents disagreed with this statement.

**Q.11 How many awareness sessions have you conducted since you completed your training?**



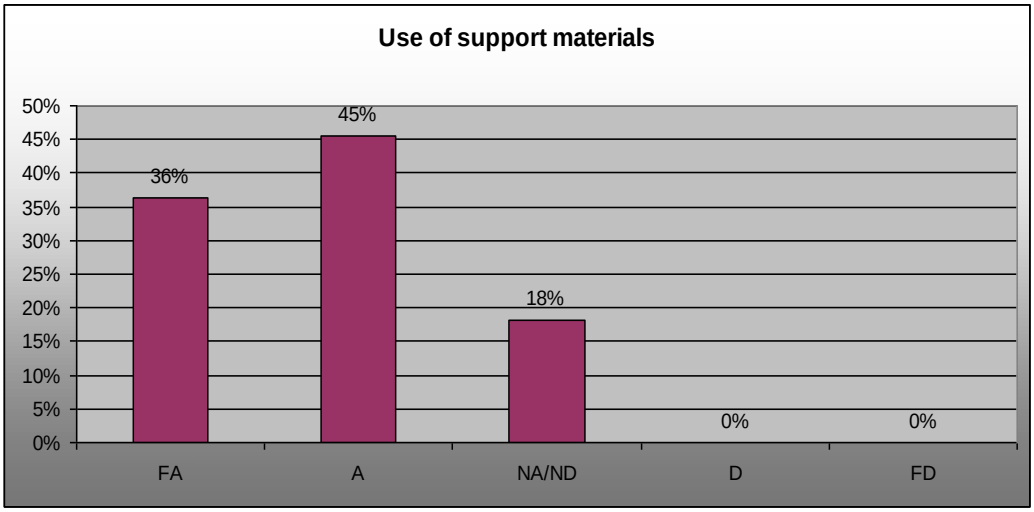

- Seventy three percent (73%) of the respondents indicated that they conducted less than 10 awareness sessions in the workplace up to the time when this survey was conducted. Twenty seven percent (27%) of the respondents stated that they conducted between 10 and 20 awareness sessions since completing their training up until the time when this survey was conducted. None of the respondents conducted more than 20 awareness sessions. In terms of the Telkom HIV/AIDS policy, Peer Educators were required to conduct at least one HIV/AIDS Awareness session per quarter. The HIV/AIDS Peer Educator programme commenced in June 2005 and the number of sessions conducted up until the research was conducted by the Peer Educators is in line with the targets stipulated in the Telkom HIV/AIDS Peer Educator Policy.
- It is suggested that the HIV/AIDS policy be amended to make the attendance of the workplace HIV/AIDS awareness sessions compulsory to all permanent as well as contract employees.

**Q.12. The manner in which I presented awareness sessions contributed to its success.**




- Fifty four percent (54%) of the respondents ascribed the success of the awareness sessions directly to their presentation skills and 45% of the respondents remained neutral. Part of the Peer Educator curriculum includes a module on presentation skills as well as the effective use of the learning material provided which includes a PowerPoint slide show, reading materials, posters and various DVD's.

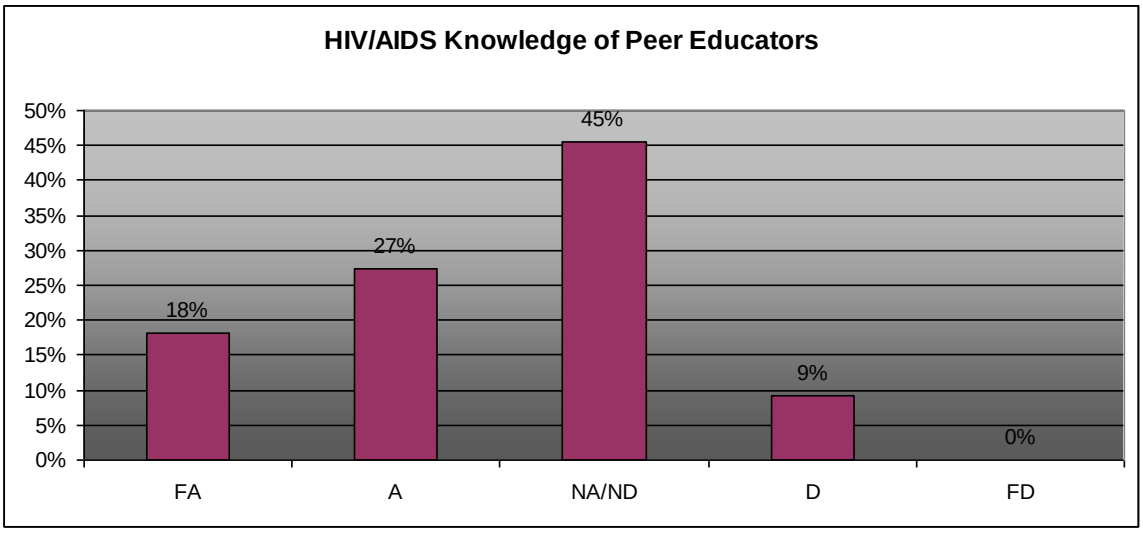
**Q.13.The support material I used during the awareness sessions contributed to its success**




- Seventy one percent (71%) of the respondents agreed that their use of the support material on the Peer Educator Toolkit assisted in making their awareness successful. Eighteen percent (18%) of the respondents were neutral on this statement. There were no disagreements.

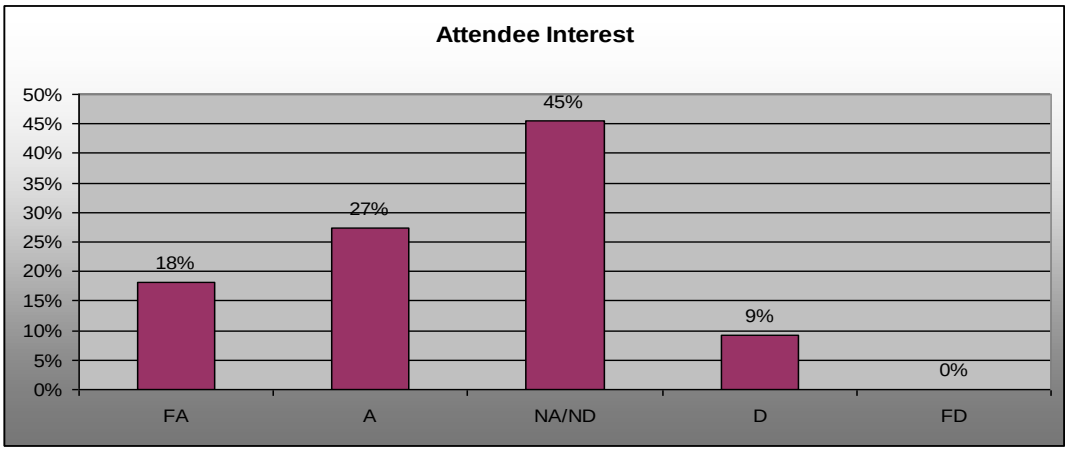
- The support material consists of:
    - Posters depicting the various stages of HIV infection
    - Fact sheets about HIV/AIDS and lifestyle issues
    - PowerPoint Slideshows to be used when doing awareness
    - Flyers about condom use and STI's

**Q.14.The awareness sessions were successful because my knowledge on HIV/AIDS is adequate**.



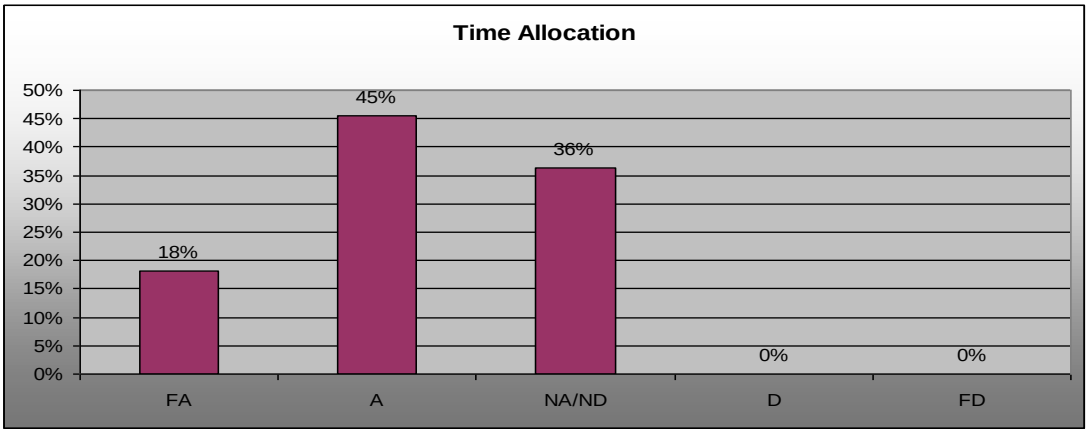

- Forty Five percent (45%) of the respondents agreed with the statement that the awareness sessions were successful due to their HIV/AIDS knowledge being adequate. A further 45% of the respondents were neutral on the topic and 9% disagreed.

**Q.15.The awareness sessions were successful due to attendee interest in HIV/AIDS**



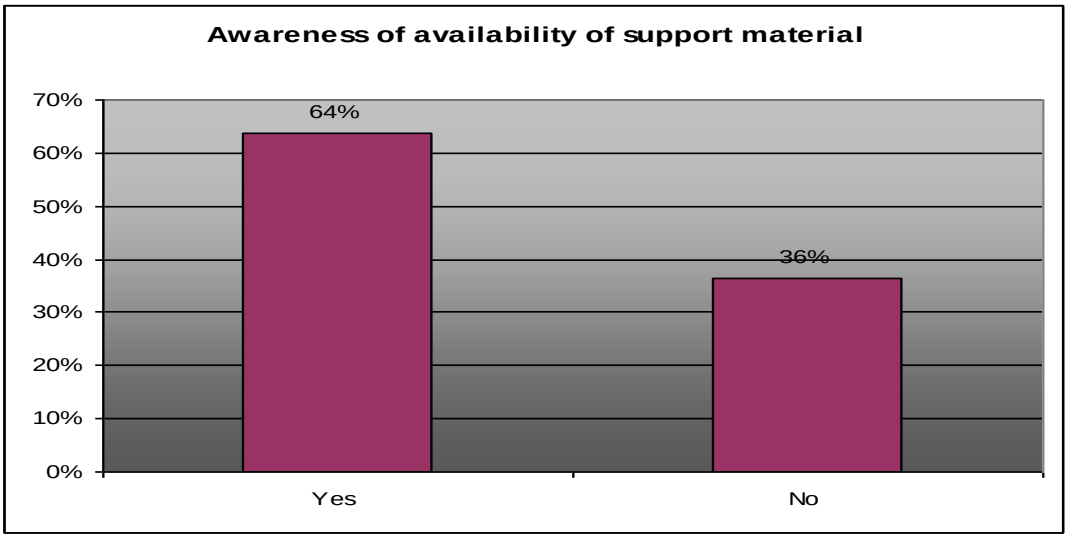
- Forty five percent (45%) of the respondents indicated that the awareness sessions they ran were successful due to attendee interest in HIV/AIDS. Forty five percent (45%) were neutral on this topic and 9% was in disagreement.

**Q.16 The awareness sessions were successful because promoters allocated enough time to their subordinates to attend.**




- Sixty three percent (63%) of the respondents agreed that the success of the awareness sessions were successful because the promoters allowed the subordinates sufficient time to attend these sessions. Thirty six percent (36%) of the respondents remained neutral on the topic.

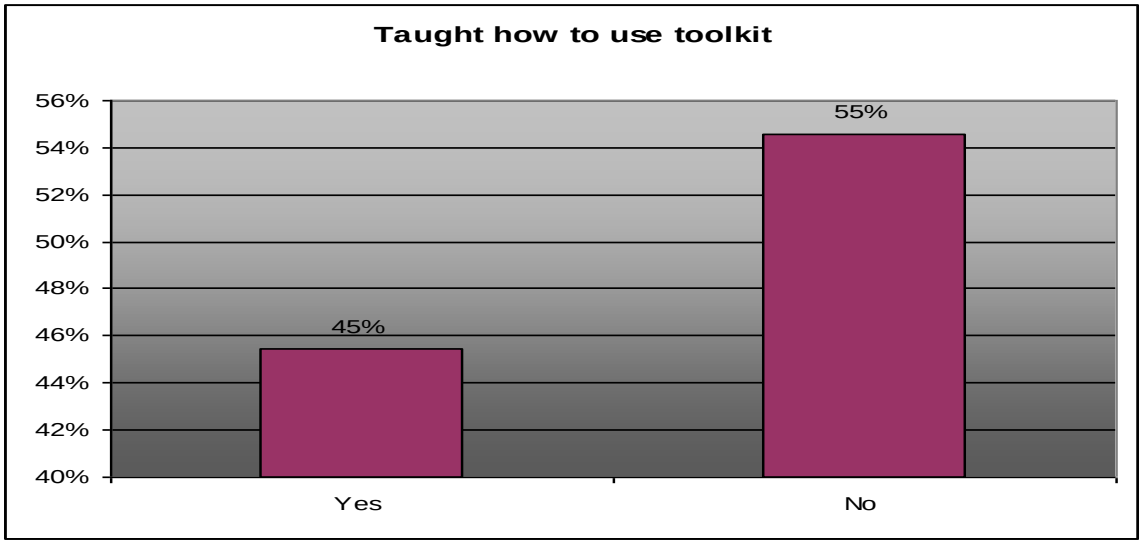
**Q.17. I am aware of the on-line Peer Educator Toolkit on the Telkom Intranet**




- Sixty Four percent (64%) of the respondents indicated that they knew of the on-line peer Educator Toolkit on the Telkom intranet.

Thirty six percent (36%) stated that they were not aware of the on-line peer Educator toolkit. The on-line toolkit was introduced 16 months after the roll-out of the peer Educator training programme began. All the Peer Educators were therefore not aware/trained on the use of the toolkit.

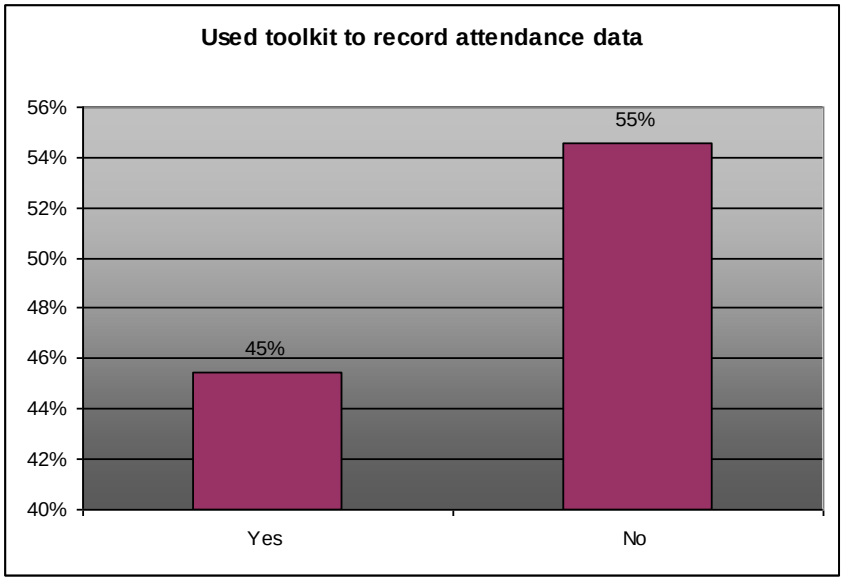
**Q.18. I was taught how to use the on-line toolkit**




- Forty five percent (45%) of the respondents indicated that they were trained on the use of the toolkit while 55% stated that they did not undergo any formal training.

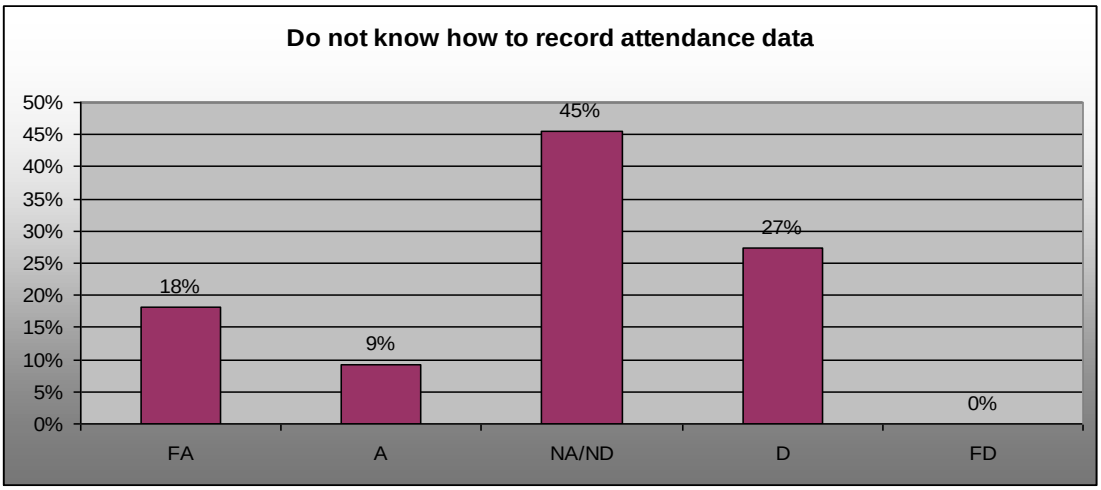
  Once again this could be ascribed to the fact that the on-line toolkit was only launched 16 months after the training of the Peer Educators rolled out.

**Q.19. I have used the on-line Peer Educator Toolkit to record details of the awareness sessions I conducted**



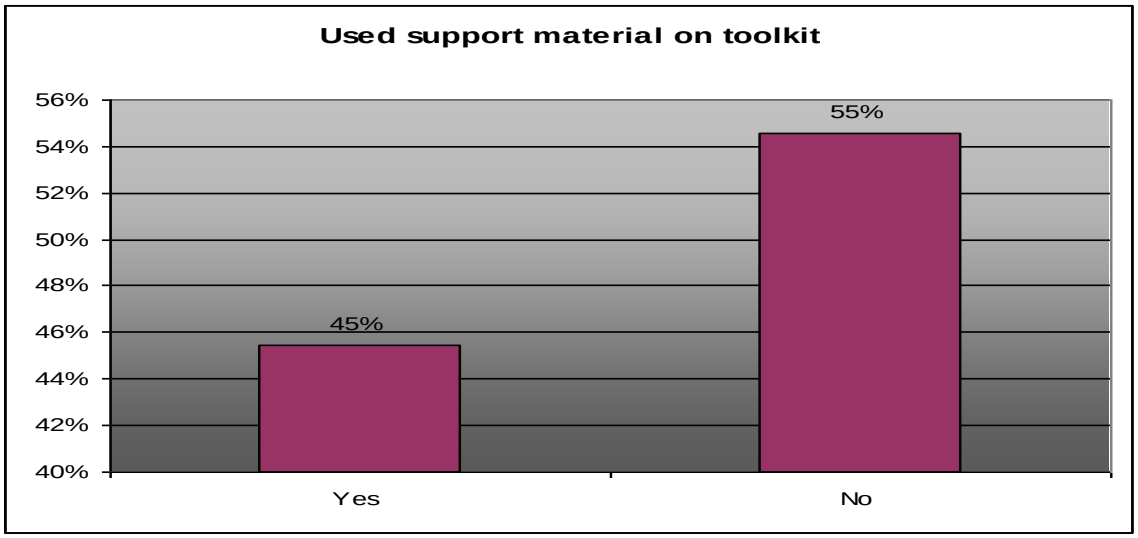
- Forty five percent (45%) indicated that they used the toolkit to record details of the awareness sessions they conducted and 55% of the respondents indicated that they did not use the toolkit. These responses are in line with the responses reported in question 18.

**Q.20. I do not know how to use the on-line Peer Educator Toolkit to record awareness sessions**



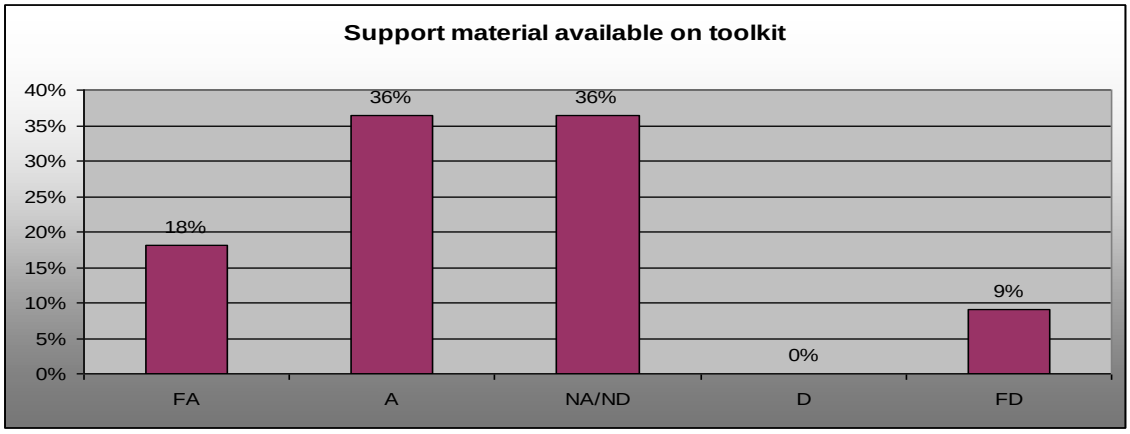

- Twenty seven percent (27%) of the respondents agreed with this statement, 45% of the respondents remained neutral while 27% disagreed with the statement.

**Q.21. I have made use of the support material available on the Toolkit**



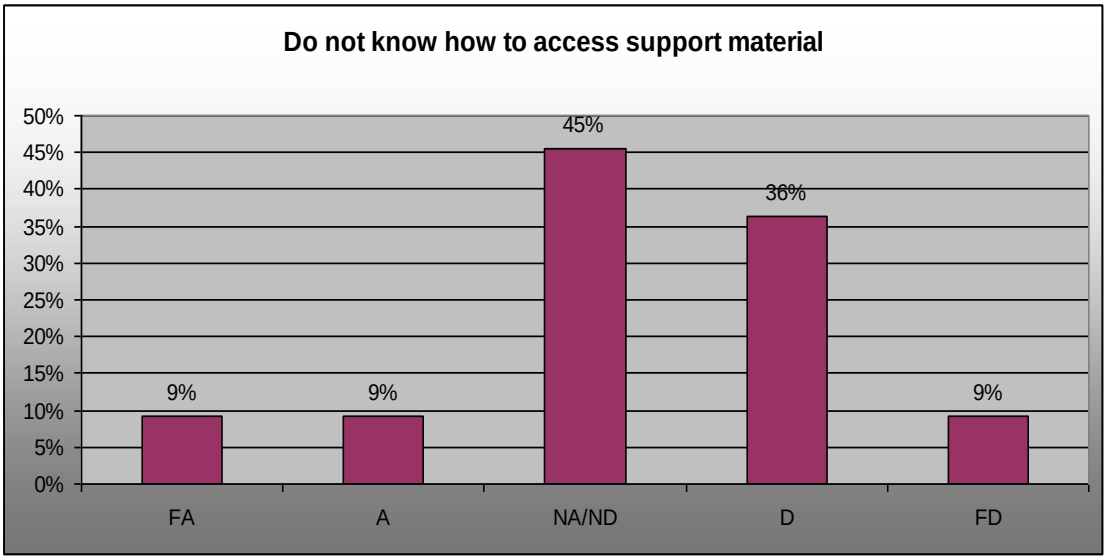
- Forty five percent (45%) of the respondents indicated that they have made use of the support materials, posters, flyers etc, when doing their awareness sessions and 55% of the respondents indicated that they did not make use of the support materials.

**Q.22. There is support material on the Peer Educator Toolkit**




- Fifty four percent (54%) of the respondents stated they agreed with the statement while only 45% of the respondents (Question 21) stated that they used the material. Thirty six percent (36%) were neutral on the topic and 9% disagreed.

**23. I do not know how to access the support material on the Peer Educator Toolkit.**



- Eighteen percent (18%) of the respondents stated that they did not know how to access the support material on the toolkit, 45% were neutral and 45% disagreed with this statement. This compares favourably with the responses in question 18 where 45% of the respondents indicated that they underwent formal training on the toolkit.

The following suggestions are made to compel Peer Educators to use the Online Peer Educator Toolkit:

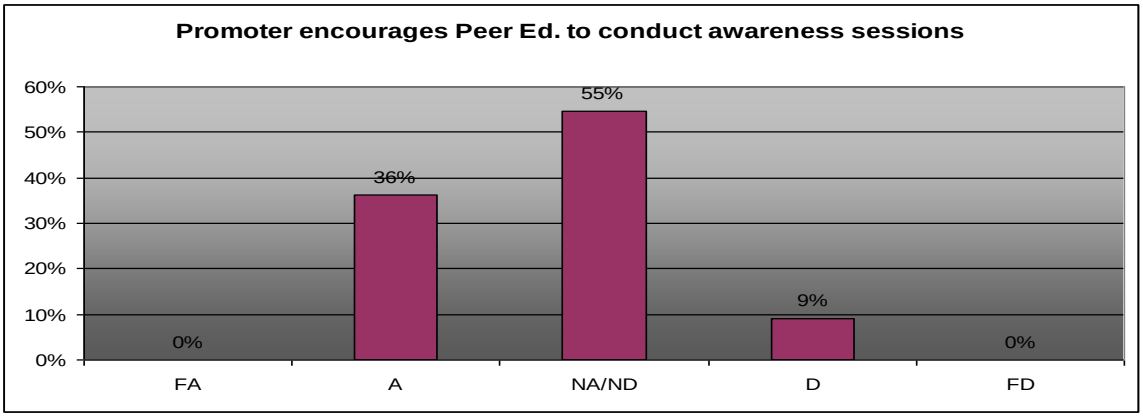
The use of the on-line toolkit must be aggressively marketed amongst peer educators and training interventions for the proper utilization of the toolkit. Data captured via the toolkit would be valuable to:

- Determine the number of employees attending VCT/Wellness sessions
- Determine the grade of employees attending VCT/Wellness sessions
- Actual duration of the individual VCT/Wellness sessions
- Record of specific HIV/AIDS topic/s presented at the VCT/Wellness sessions

It is further recommended that a selection of topics (at least one for each month) with supporting materials be made available on the toolkit. In this way the a uniform message with regard to HIV/AIDS can be disseminated throughout the company on a monthly basis.

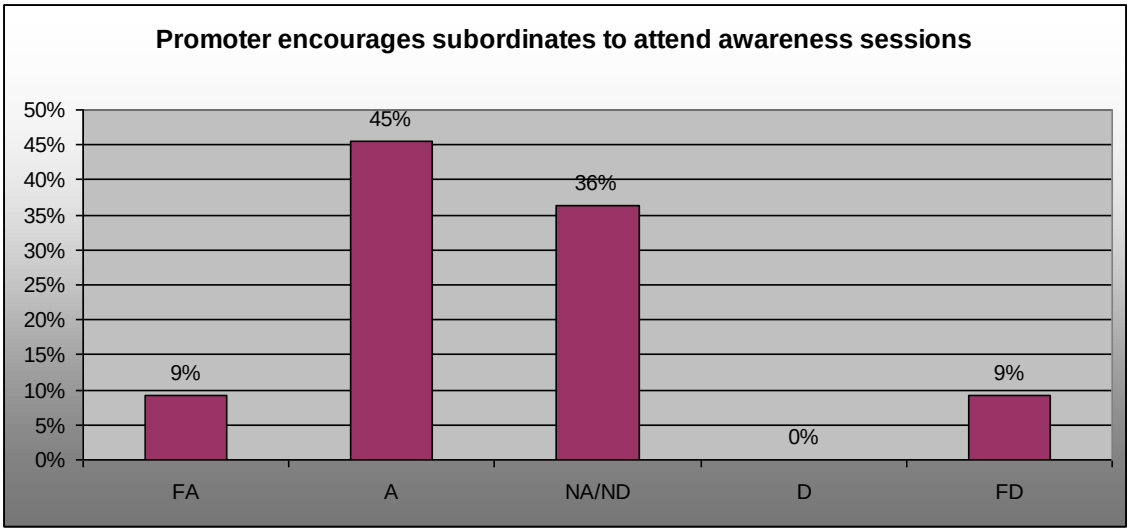
Training materials must be kept relevant in terms of the latest developments in the field of HIV/AIDS prevention and vaccine research as well as the statistical data in terms of national prevalence rates.

**24. My promoter actively encourages me to conduct HIV/AIDS awareness sessions during working hours**



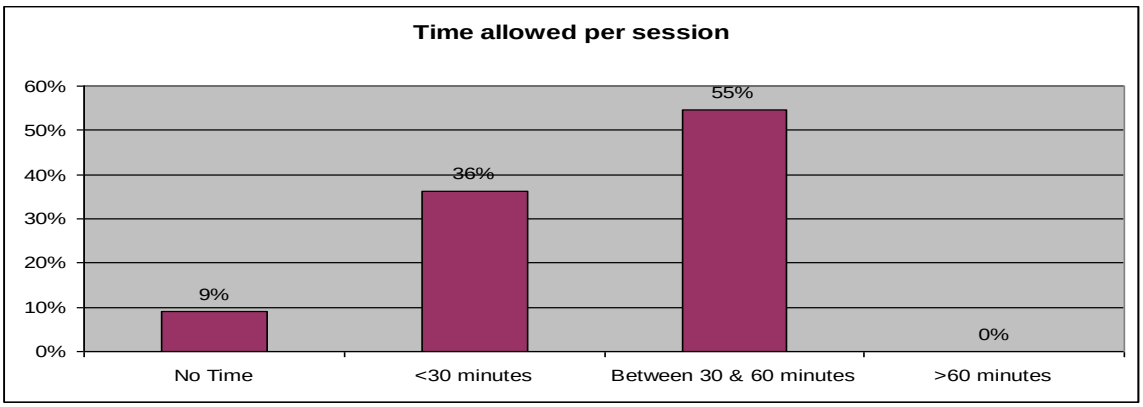

- Thirty Six percent (36%) of the respondents agreed with this statement. Fifty Five percent (55%) remained neutral and 9% disagreed with the fact that their promoters actively encouraged them to conduct HIV/AIDS awareness sessions during working hours. In terms of the Telkom HIV/AIDS policy, promoters were compelled to allow Peer Educators to conduct at least one awareness session per quarter. This could be the reason why they did not overly encourage Peer Educators conduct awareness sessions during working hours as they may have felt that it could impact negatively on productivity.
- It is recommended that promoters be informed that the suggested one awareness session per quarter is the minimum requirement and that they should be encouraged to allow peer educators more opportunities to run awareness sessions and that they should also allow peer educators more time per awareness sessions. This should be made an output in their personal performance plans.

**Q.25.My promoter actively encourages his/her subordinates to attend HIV/AIDS awareness sessions during working hours**



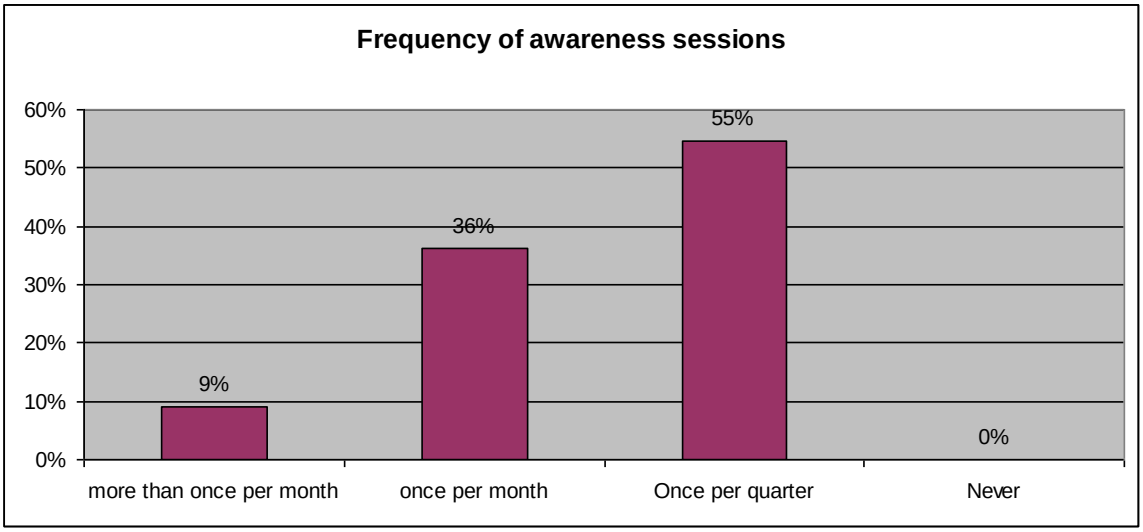

- Fifty four percent (54%) of the respondents indicated that their promoters actively encouraged their subordinates to attend the HIV/AIDS awareness sessions during working hours. Thirty six percent (36%) were neutral on the topic while 9% disagreed with this statement.

**Q.26. How much time did your promoter allow you per session?**




- Nine percent (9%) of the respondents indicated that their promoters did not allow them any time during working hours to do HIV/AIDS awareness.
- Thirty Six percent (36%) of the respondents were allowed less than 30 minutes per session to do HIV/AIDS awareness
- Fifty five percent (55%) were allowed between 30 and 60 minutes per session.

**Q.27.How often did your promoter allow you to conduct HIV/AIDS awareness sessions?**

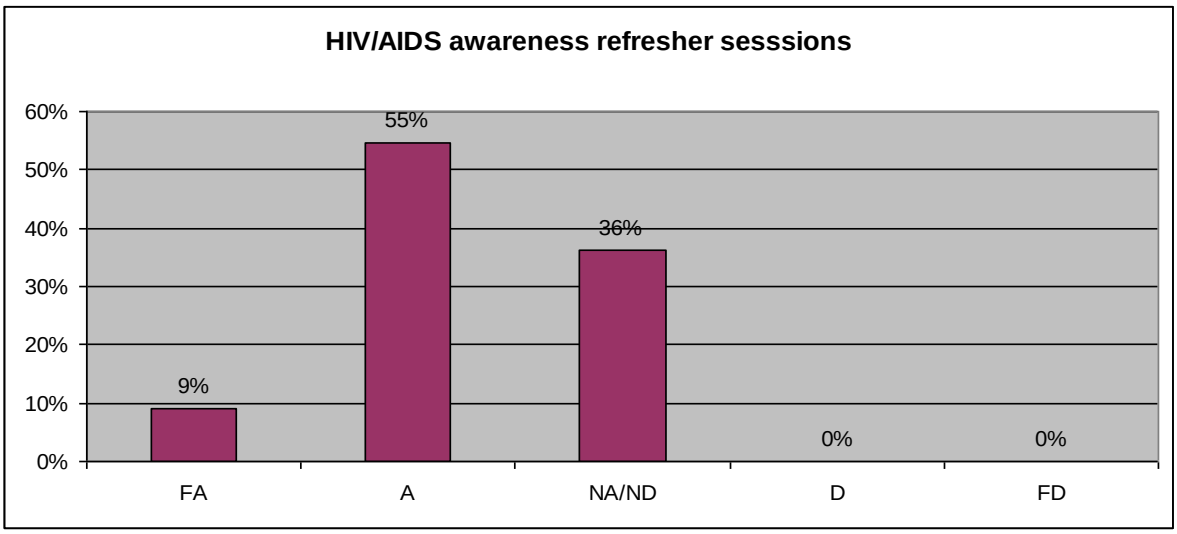



- Nine percent (9%) of Peer Educator were allowed to conduct HIV/AIDS awareness sessions more than once per month.
- Thirty Six percent (36%) of the Peer Educators were allowed to conduct one awareness session per month.
- Fifty five percent (55%) of the Peer Educators were allowed to conduct an one awareness session per quarter. (In terms of the Telkom HIV/AIDS Policy Peer Educators were required to conduct one awareness session per quarter in their respective workplaces.)

**Q.28 If you selected "never" in question 27, which of the following factors describe best the reasons for your promoter refusing permission?**

- None of the respondents selected "never" in question 27 and they were therefore not required to respond to this question.

**Q.29. I think it is necessary to conduct a HIV/AIDS refresher workshop on an annual basis**




- Sixty four percent (64%) of the respondents agreed that it was necessary to attend a refresher course on an annual basis. This was necessitated due to the ever changing developments in the HIV/AIDS arena and they felt it was incumbent upon them be up to date with the latest information. Thirty six percent (36%) of the respondents were neutral on this topic.

**Q.30 How would you go about encouraging as many of your fellow workers as possible to attend a HIV/AIDS awareness session in your workplace?**

Responding to the above question, the respondents made the following recommendations:

- To encourage supervisors to take a more active role in the HIV/AIDS awareness programmes by training them as Peer Educators (currently there are no supervisors who are trained as HIV/AIDS Peer Educators).These supervisors would then be in a better position, having acquired knowledge on HIV/AIDS to actively encourage their performers to attend such sessions or even conducting these sessions themselves.
- To make the attendance of the awareness sessions compulsory but let the attendance of the VCT sessions that normally such sessions, voluntary.
- To "reward" those who attend such sessions by handing mementos and gifts to attendees. This has worked well in the past where the following **"THUSO WELLNESS"** branded items were handed out:
    - Frisbees
    - Key rings
    - CD Holders
    - Coffee Mugs
    - T-shirts
    - Health Packs (Containing pure fruit juice, Health bar, Vita C sweets)
    - Lanyards
    - Stress Balls
    - Pen & Pencil sets

(However, these items were not available at each and every Wellness Intervention due to financial constraints, and that is probably the reason why the interest started to wane in subsequent VCT sessions. Certain expectations were initially created and when these items were distributed and when it was not available at subsequent sessions, employee interest dropped off – This is based on attendance records maintained during each VCT intervention.)

This aspect should definitely be investigated with a view to making it a permanent part of all Wellness interventions.

**Q.31. What would you do to make the content of future HIV/AIDS awareness sessions more interesting?**

In response to the above question, all the respondents indicated that HIV/AIDS awareness sessions in the workplace should be made more interesting by the following:

- Design and display posters showing the effects on human beings before and after HIV infection and the stages of AIDS development in humans.
- Capture “real life” stories of individuals showing the human suffering brought by HIV infections.
- Use HIV infected persons as role models and spokespersons to educate employees on HIV prevention.

## *4.6 SECTION C: HIV/AIDS Knowledge & Attitudes*

4.6.1 Comparative analysis of findings between respondents who attended HIV/AIDS awareness sessions *(histogram on the left)* and those who did not *(histogram on the right).* For the purposes of this analysis the group who attended an HIV/AIDS awareness session will be referred to as Group 1 and those who did not attend such a session will be referred to as Group 2.

4.6.2 Legend:

1 = Fully Disagree

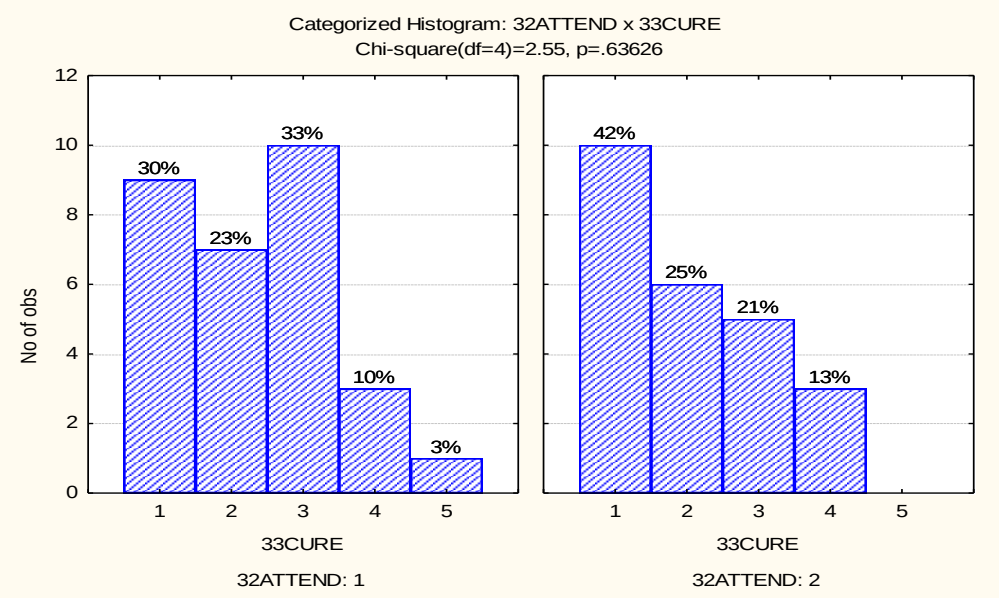
2 = Disagree

3 = Neither Agree nor Disagree (Neutral)

4 = Agree

5 = Fully Agree

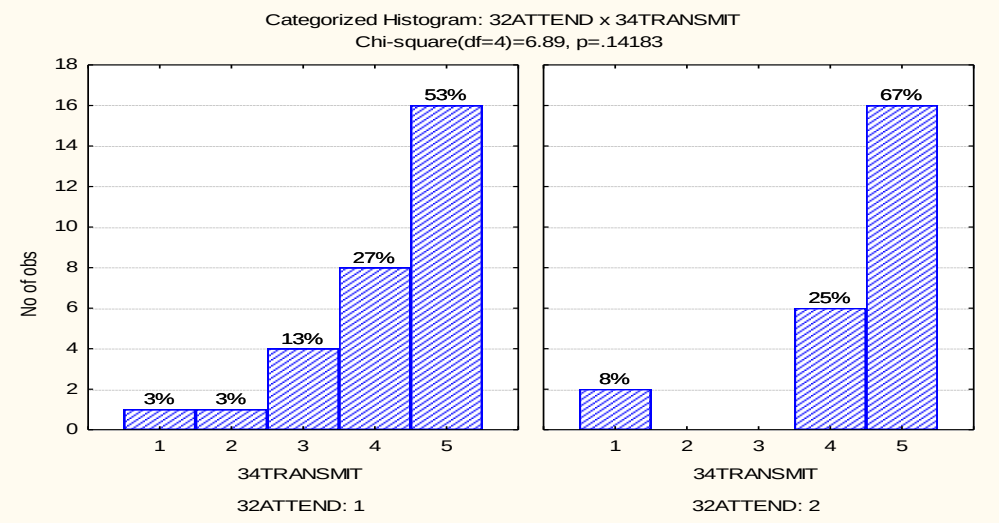
**Q.33: There is a cure for HIV/AIDS**




- Both Groups 1 and 2 stated that 13% of their respective respondents *agreed* with this statement. Ideally Group 1 should not have agreed with this statement at all as it is emphasised throughout the awareness sessions that there is currently **no cure** available for HIV/AIDS.

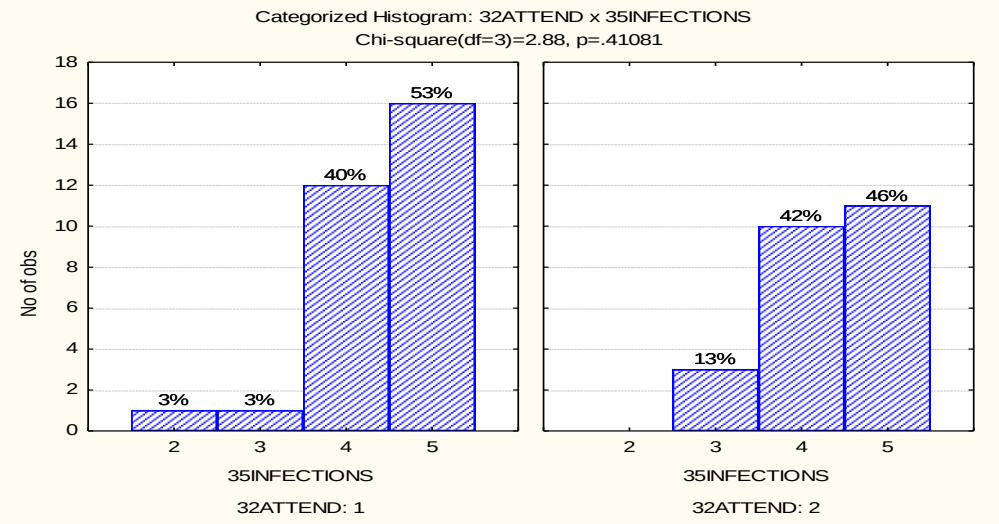
On the other hand the level of confidence of Group 2 is marginally higher than that of Group 1 in that 67% disagreed with this statement as opposed to the 53% of Group 1. Bearing in mind that the fact there is currently **no cure for HIV/AIDS** is emphasised throughout the programme, the reasons as to why this group of respondents (Group 1) agreed with this statement warrants further investigation.

**Q.34: Healthy looking persons who are HIV positive can transmit the disease to others.**



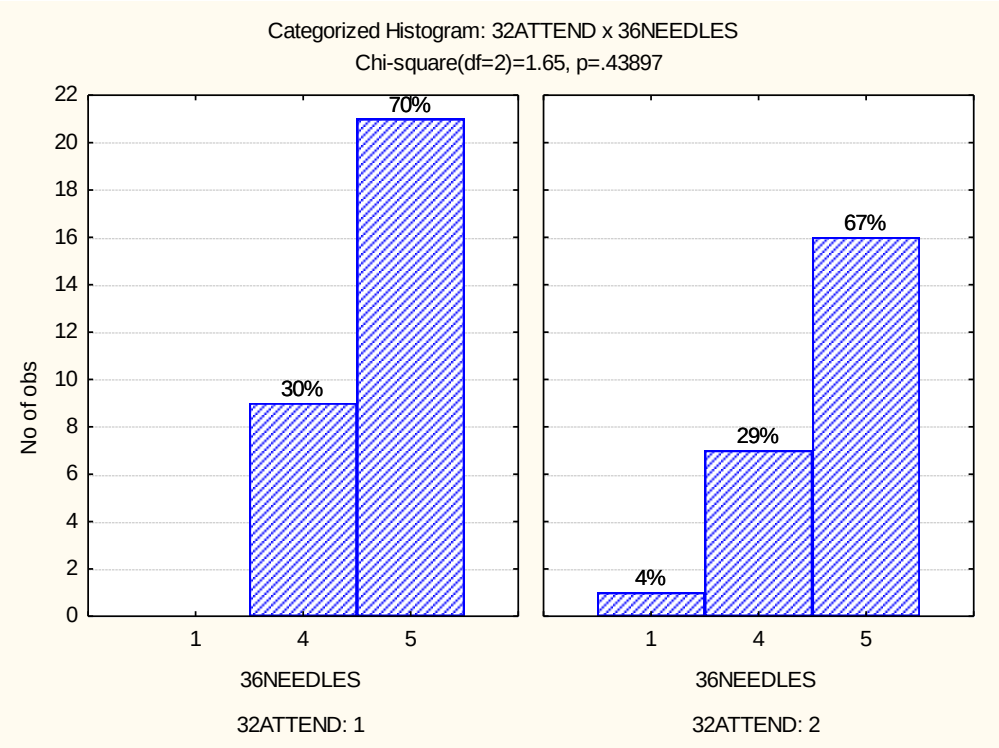

- In Group 1 80% of the respondents agreed with this statement and 13% remained neutral, while 92% of the respondents belonging to Group 2 agreed with the statement. It is emphasised troughout the programme that newly infected and healthy looking persons are very capable of infecting others The level of confidence in Group 2 is also marginally higher. The responses of Group 1 warrants further investigation.

**Q.35 Most of the HIV infections are as a result of unprotected sexual intercourse**




- The respondents in both groups (93% and 80% respectively) agreed that most HIV infections occurred as a result of unprotected sexual intercourse. Three percent of the respondent group 1 disagreed while 13% in the opposing group was unsure about this statement. The confidence level of the Group 1 are much higher.

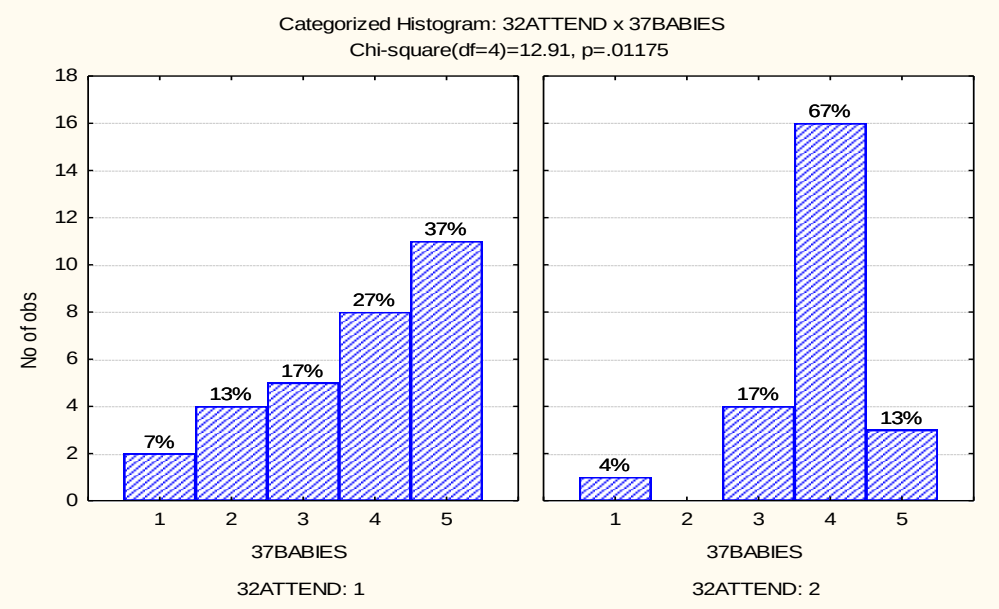
**Q.36 Drug addicts sharing needles are exposing themselves to the risk of being infected with the HI Virus.**




- All the respondents (100%) of Group 1 agreed with this statement while only 4% of the respondents of Group 2 strongly disagreed with this statement.

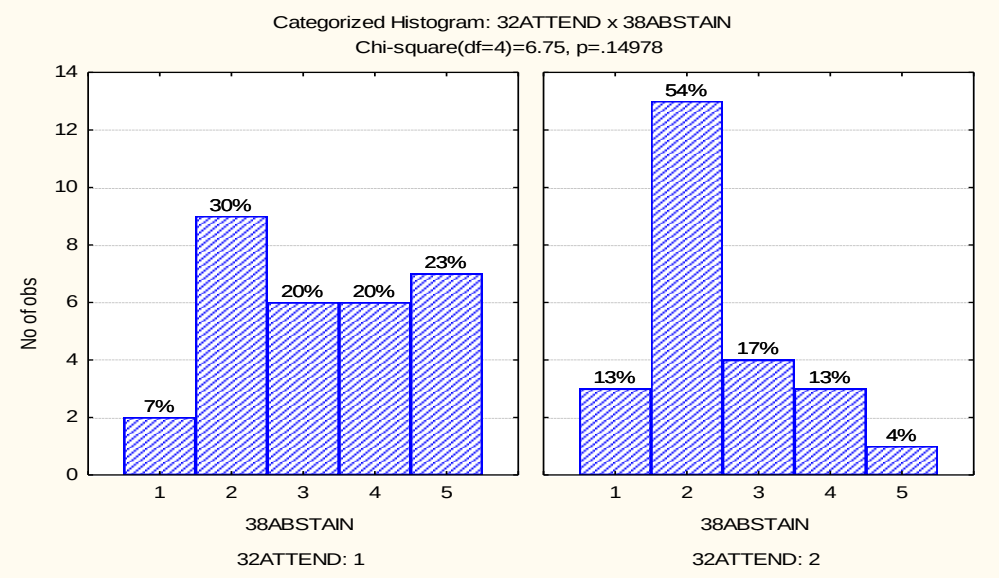
In Group 2 96% of the respondents agreed with this statement while only 4% disagreed with the statement. When the responses of both groups are compared to each other there is only a 4% difference between the two. It is a known fact that injecting drug users (IDU) have a greater chance of HIV infection when sharing needles. These facts are highlighted during the peer educator training workshops.

**Q.37 Babies born of mothers who are HIV positive have a smaller chance of becoming HIV positive if mothers take ARV's**



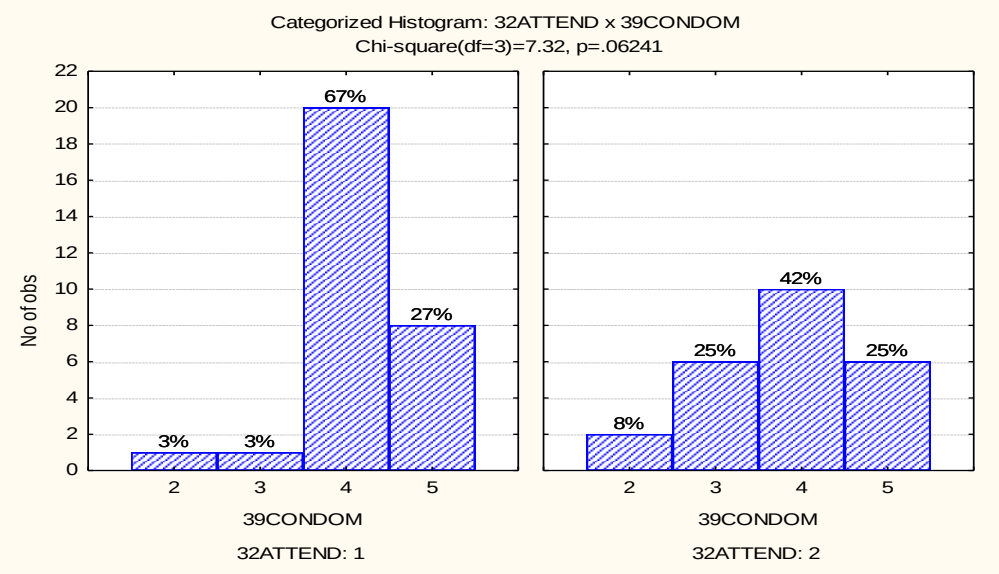

- In Group 1 64% agreed with this statement, 17% of respondents were neutral on the topic while 20% disagreed. Opposing this was that 80% Group 2 agreed with this statement, 17% were neutral on the topic and 4% fully disagreed. However, the respondents in Group 2 displayed a greater level of confidence regarding this statement. This topic is covered extensively in the Peer Educator training and the responses of Group 1 warrants further investigation.

**Q.38 A person who totally abstains from sexual intercourse will not become infected with the HI virus**



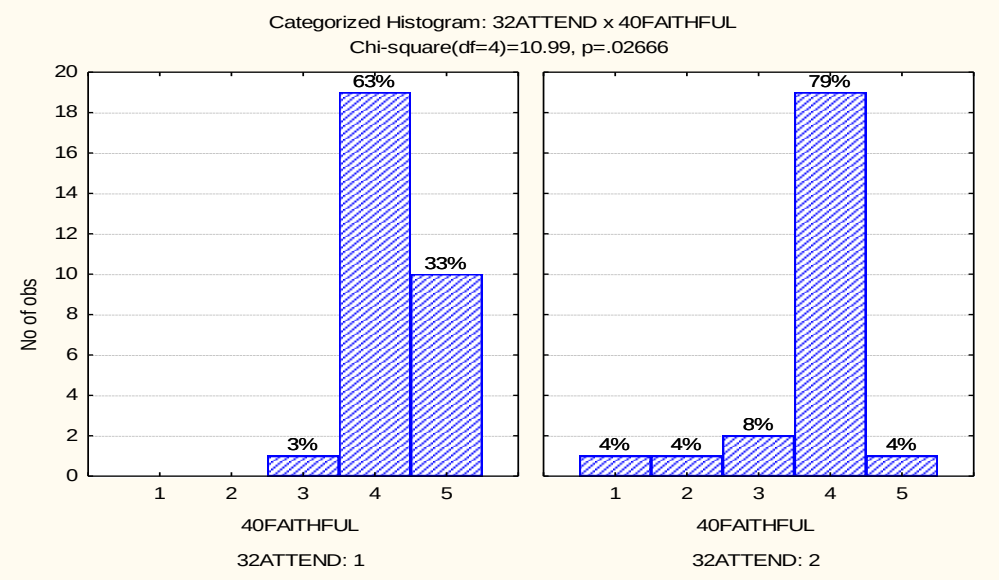

- In Group 1 43% of the respondents agreed with the statement, 20% were neutral and 37% disagreed. In Group 2 17% agreed with the statement, 17% were neutral and 67% disagreed with this statement. Although the level of confidence of Group 1 is much higher than that of group 2, It is of great concern why the respondents of Group 1 responded in the manner in which they did. Abstinence is advocated strongly during the training and awareness sessions and this phenomena definitely requires further investigation.

**Q.39 Persons who use condoms correctly each time they have sexual intercourse have little or no chance of becoming infected with the HI Virus**



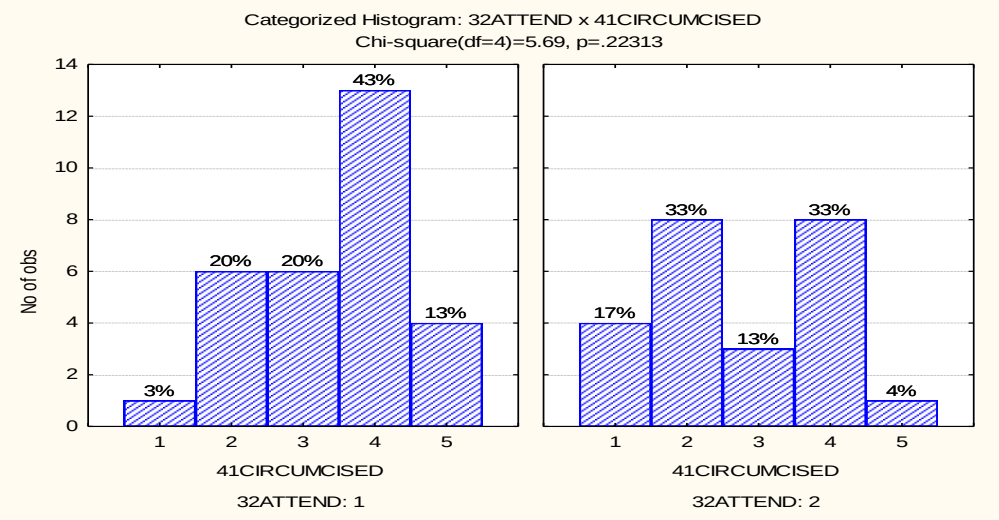
- Ninety four percent of the respondents of Group 1 agreed with this statement 3% were neutral and 3% disagreed. The level of confidence in this group regarding this statement is very high. In Group 2 67% of the respondents agreed with this statement, 25% were neutral and 8% disagreed. It is a known fact that condoms even when correctly applied do not guarantee 100% protection against HIV infection due to breakage etc. The responses of Group 1 are totally in line with this fact.

**Q.40.Partners who is faithful to each other is very unlikely to become infected with the HI virus.**



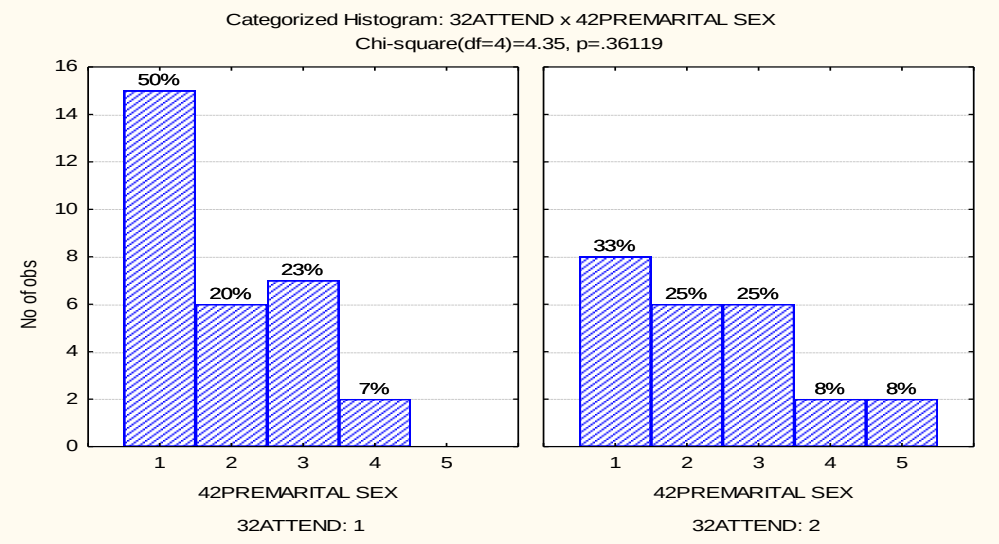

- Ninety six percent of the respondents of Group1 agreed with this statement while 3% remained neutral. Eighty three percent of the respondents of Group 2 agreed with this statement while 8% remained neutral and 8% disagreed. The level of agreement of both groups is relatively close to one another with the level of confidence marginally higher in Group 1.

**Q41. Males, who are circumcised, while taking the proper universal precautions, are less likely to become infected with the HI virus than those who are not taking the proper universal precautions.**



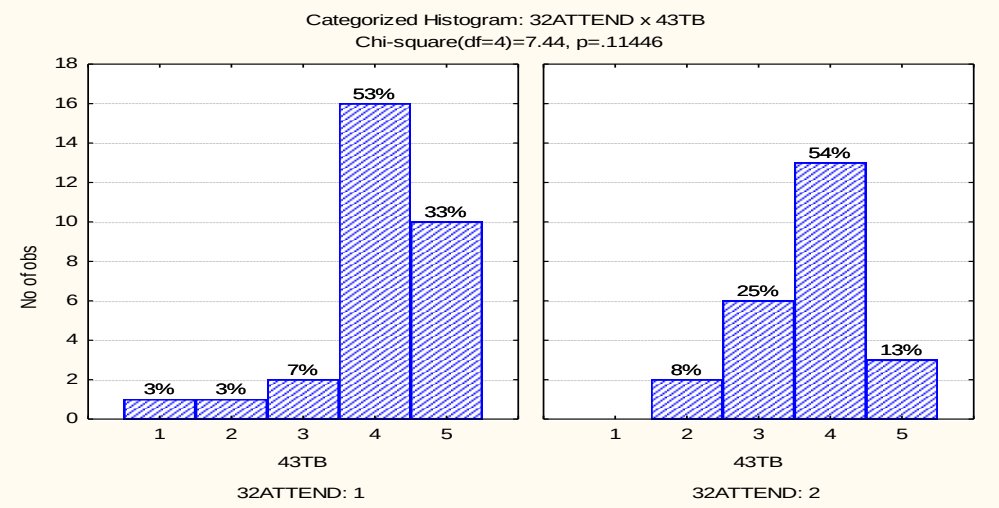

- The respondents in Group 1 indicated that 56% of them agreed with this statement, 20% were neutral and 23% disagreed with it. In Group 2 37% agreed with this statement, 13% were neutral and 50% disagreed with this statement. The confidence level of Group1 is much higher than those of Group 2. Male circumcision as it relates to HIV infection is still a very controversial topic and there as many articles confirming that circumcised males are less likely to become HIV infected than those who are not circumcised and other research that does not support this theory.

**Q 42.I believe that couples should engage in sex before marriage**



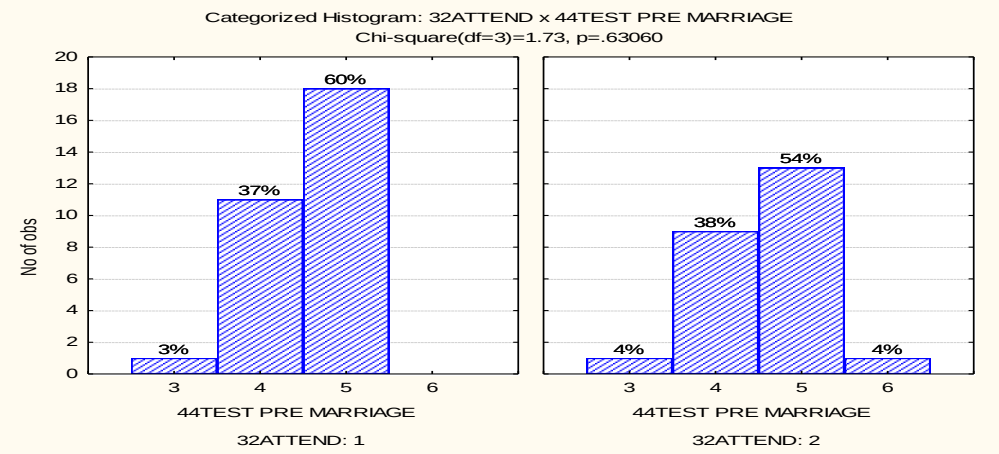
- Seventy percent (70%) of the respondents in Group 1 disagreed with this statement, 23% were neutral and 7% agreed. Of Group 2 58% disagreed with this statement, 25% were neutral and 16% agreed. If one looks at this statement in todays context , many couples do engage in sex before marriage and it seems that society accepts this. However if one takes innto cognisance the prevalence of HIV infection 18 to 25 age cohort, this should be strongly discouraged. What is not evident in this case is whether these couples are practicing safe sex.

**43. People who are HIV positive are more likely to become sick with Tuberculosis (TB)**



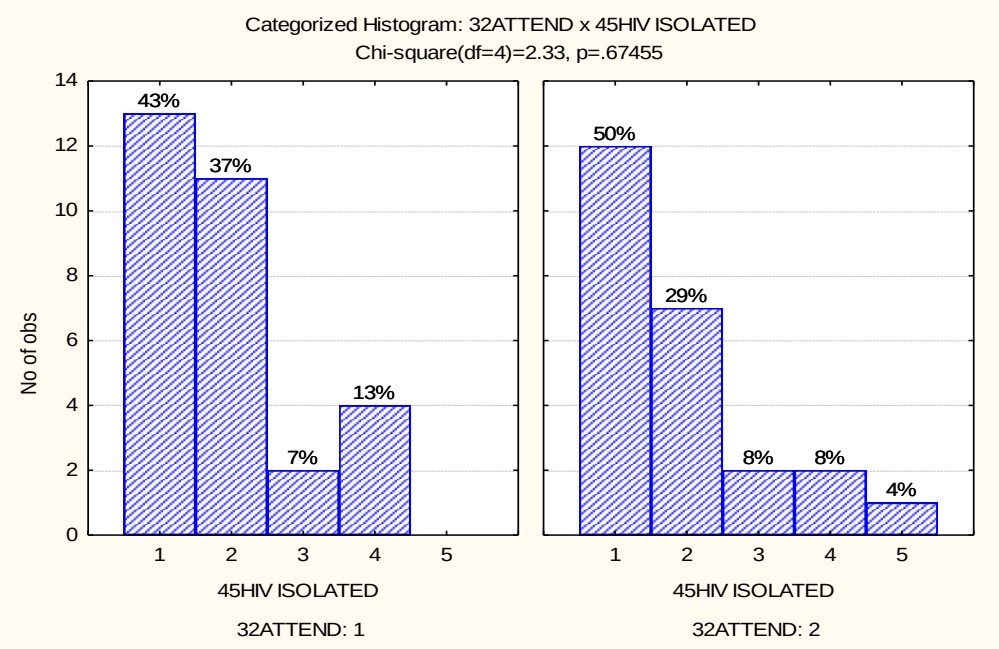

- The majority of respondents (86%) in Group 1 agree with this statement, 7% were neutral on the issues and 6% disagreed. In Group 2 67% agreed with this statement 25% were neutral on the topic while 8% disagreed. The level of confidence of Group 1 in regard to this statement is much higher than that of Group 2. It is a medically proven fact that HIV positive people are more susceptible to Tuberculosis (TB). TB is also an opportunistic illness which preys on people with weak immune systems as is the case with HIV positive people.

**44. I believe that couples should have themselves tested for HIV before marriage**



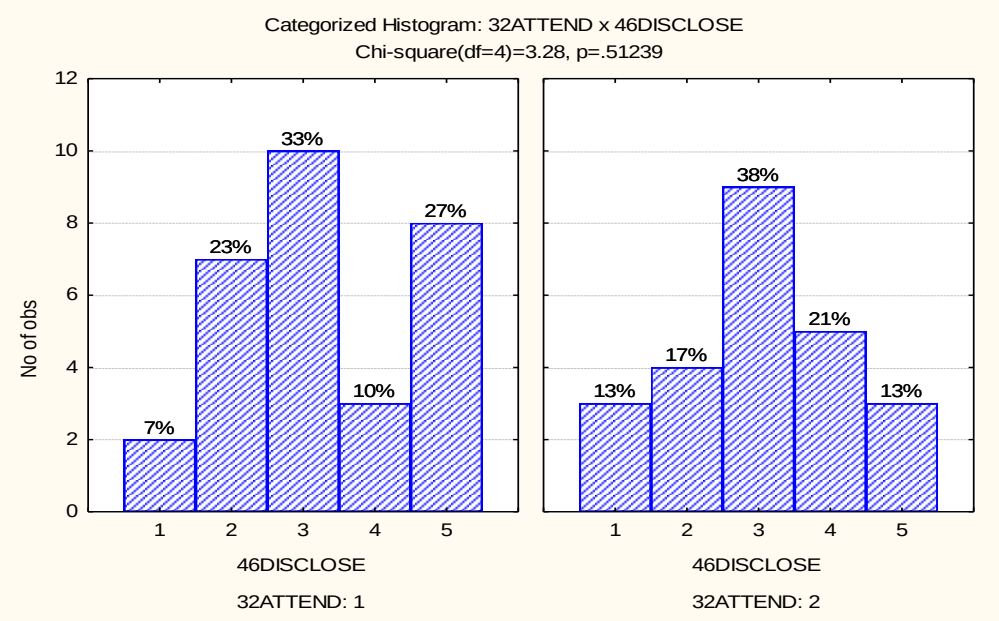

- Sixty percent of Group 1 agreed that couples should get tested for HIV before marriage, 37% were neutral on the topic and 3% disagreed. Of Group 2 58% agreed with the statement, 38% were neutral and 4% disagreed. The response of both groups shows a lot of similarities and there are no significant differences in their responses.

**45. I believe that people who are HIV positive should be isolated from the rest of the population**



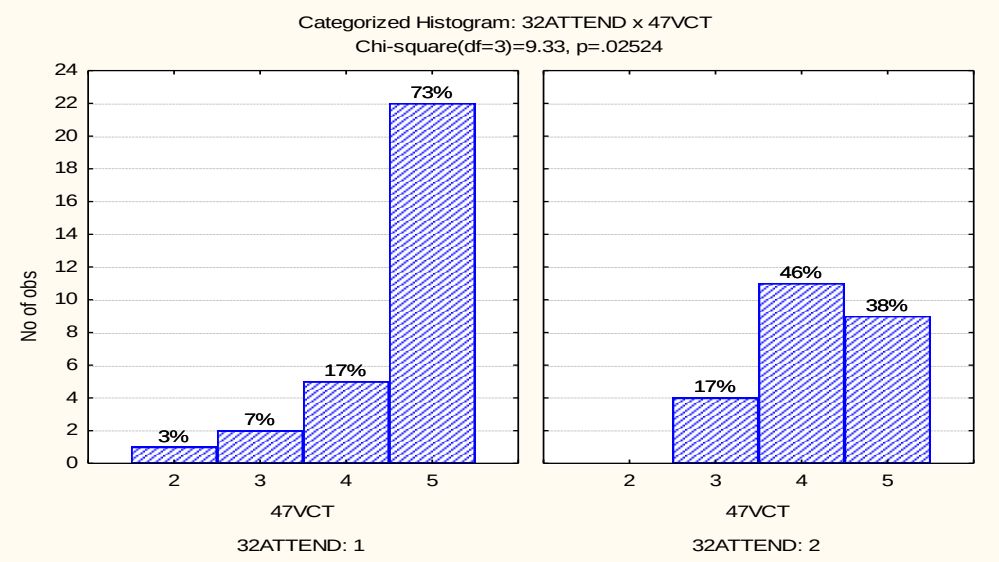
- Group 1 responded to this statement by indicating that 13% of them agreed with it, 7% were neutral while 80% disagreed. In Group 2 12% agreed with the statement, 8% were neutral and 79% were in disagreement. When comparing the responses of two groups there are no significant differences evident between the two groups. Employees should be sensitised and be made aware that it is imporatnt to acept HIV positive colleagues as productive units in their respective teams. Stigma and discrimination towards HIV positive employees are mainly as a result lack of knowledge on HIV/AIDS.

**46. I believe that the status of an HIV positive person should not be disclosed to others**




- In Group 1 37% of the respondents agreed with this statement, 33% were neutral and 30% disagreed. In Group 2 34% agreed with this statement, 38% were neutral and 30% disagreed. When comparing the results of Groups 1 & 2, no significant difference could be found. Disclosure of ones' status is protected by law and this fact is covered extensively during the awareness sessions. The responses of the respondents of Group 1 warrants further investigation.

**47. I believe that the practice of Voluntary Counselling and Testing (VCT) for HIV is necessary in the workplace.**




- A total of 90% agreed with this statement, 7% were neutral and 3% disagreed. In Group 2 84% agreed with the statement and 17% were neutral. The respondents of both groups realize the importance of VCT in the workplace and the benefits it carries. In fact, the level of confidence amongst the Group 2 respondents was marginally higher than that of Group 1.
- Employees should be encouraged to attend a VCT session and have their Sero-status checked at least once per year. Employees who have multiple sexual partners must be encouraged to have their Sero-status checked at least once every three months.

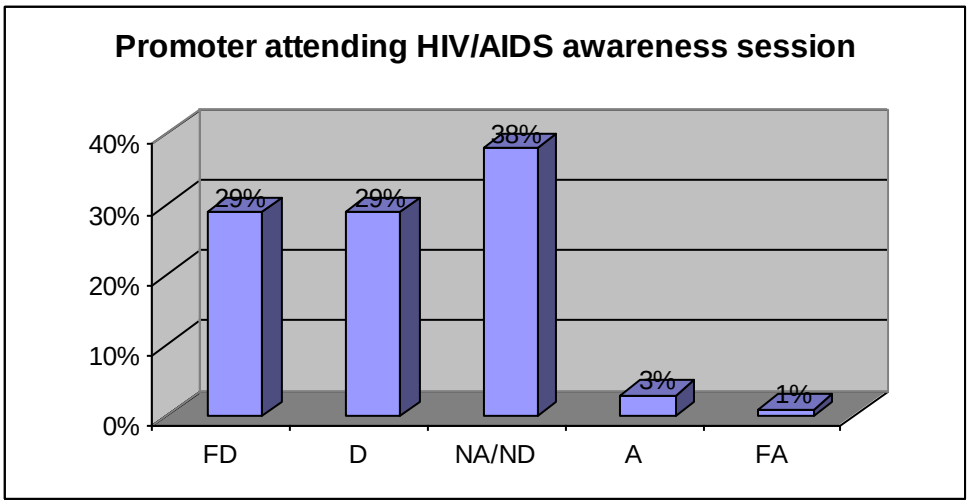
## *4.7 SECTION D: Promoter Involvement*

This section examines promoter involvement in the attendance of workplace HIV/AIDS awareness sessions as well as their role in encouraging subordinate participation in HIV/AIDS awareness sessions.

4.7.1 Legend:

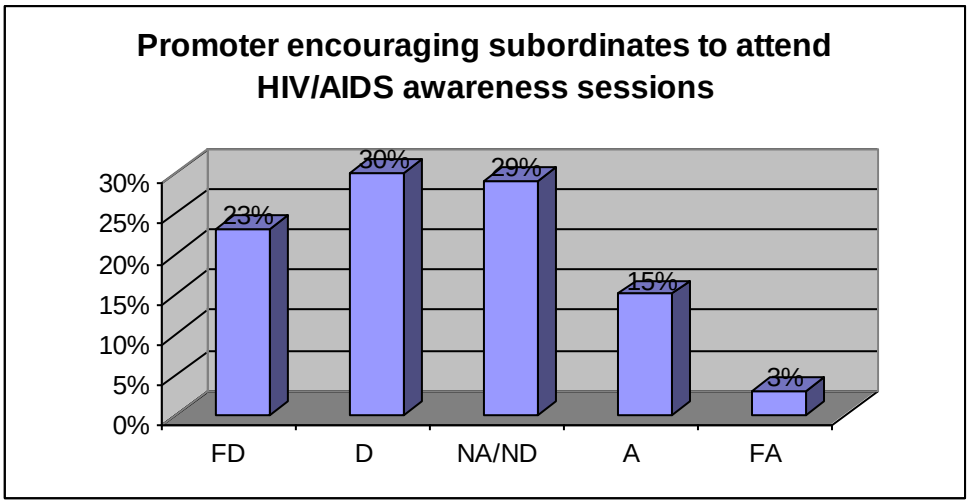
- FA = Fully Agree
- A = Agree
- NA/ND = Neither Agree/Nor Disagree (Neutral)
- D = Disagree
- FD = Fully Disagree

**48. My promoter has attended an HIV/AIDS awareness session**




- An extremely small percentage (4%) of the respondents indicated that their promoters attended an HIV/AIDS awareness session. Thirty eight percent (38%) remained neutral while 58% disagreed with this statement. This response is in line with respondents reactions and subsequent recommendations that their promoters should be encouraged to be more directly involved in the HIV/AIDS interventions in their respective workplaces.
- Promoters need to be empowered with knowledge around HIV/AIDS and be given the necessary skills and tools to deal with HIV in the workplace. Strong consideration should therefore be given to present a series of one day compulsory HIV/AIDS awareness sessions to promoters. Alternatively they should be strongly encouraged to be trained as Peer Educators.

**49. My promoter actively encourage his/her subordinates to attend HIV/AIDS awareness sessions**




A Low 18% of the respondents agreed with the statement that their promoters encouraged them to attend HIV/AIDS awareness sessions in the workplace. Fifty three percent (53%) of the respondents stated that their promoters did not encourage them to attend these sessions and 29% of the respondents remained neutral on the topic.

It is recommended that promoters be informed that the suggested one awareness session per quarter is the minimum requirement and that they should be encouraged to allow peer educators more opportunities to run awareness sessions and that they should also allow peer educators more time per awareness sessions. This should be made an output in their personal performance plans.

## *4.8 SECTION E: Sexual Practices*

4.8.1 This section examines the responses of the respondents in terms of their sexual practices.

4.8.2 Legend (Questions 50 and 51)

1 = Yes
2 = No

4.8.3 Legend (Questions 52 to 58 = Lickert Scale)

1 = Fully Disagree

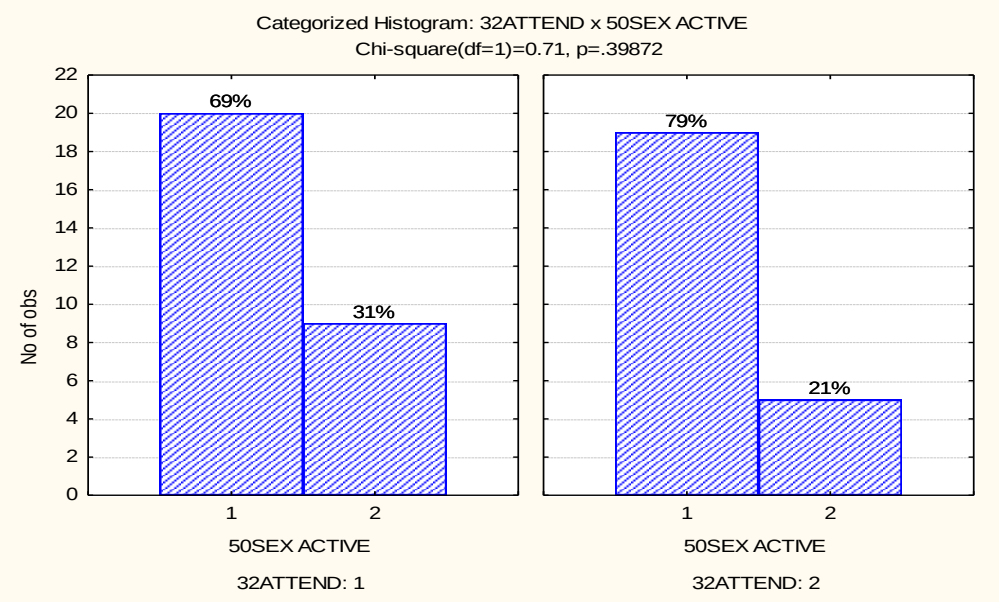
2 = Disagree

3 = Neither Agree nor Disagree (Neutral)

4 = Agree

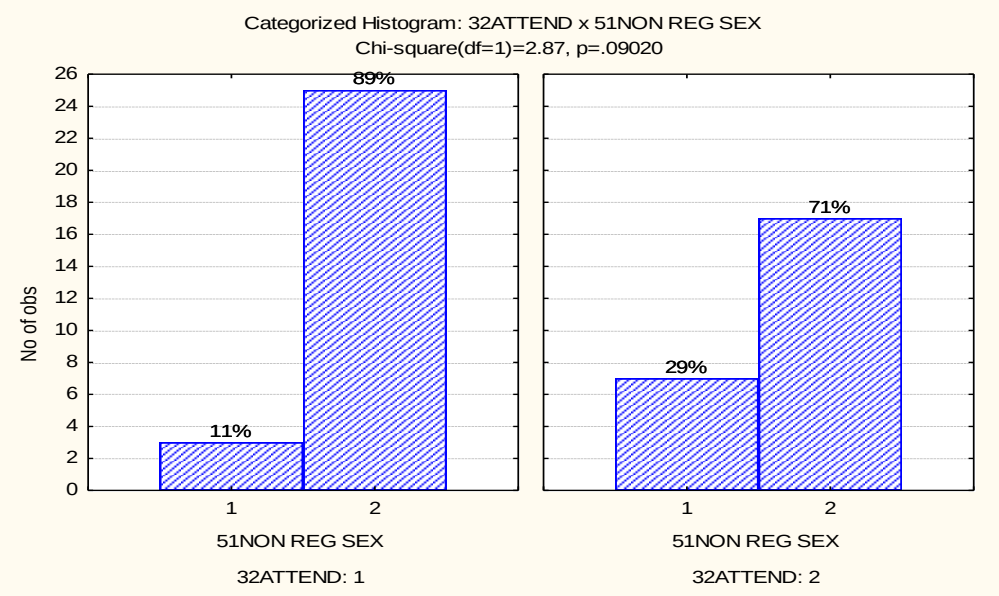
5 = Fully Agree

**Q.50 I am sexually active**



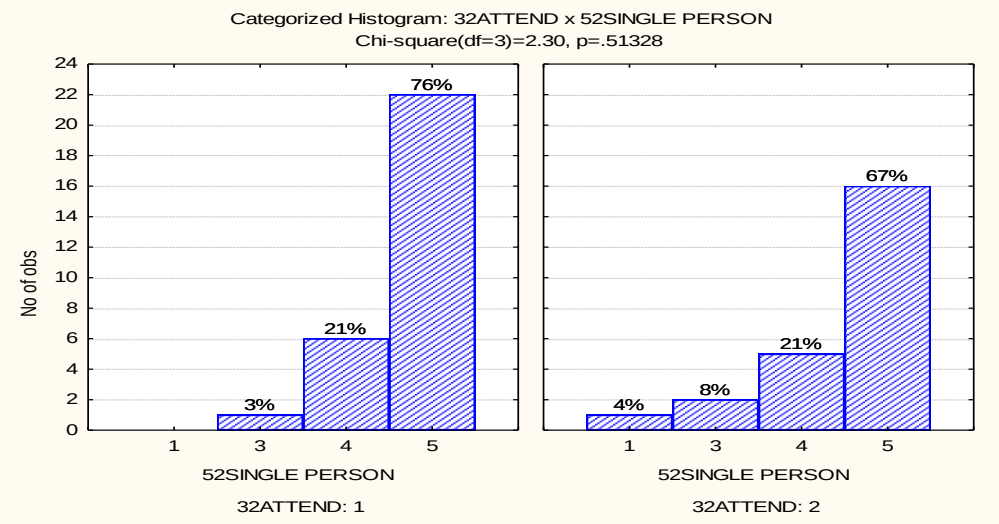

- In Group 1 69% of the respondents stated that they were sexually active and 31% said they were not. In Group 2 79% said they were sexually active and 21% said they were not. The difference in the responses of the two groups was marginal.

**Q.51 I had a non-regular sexual partner in the last year**



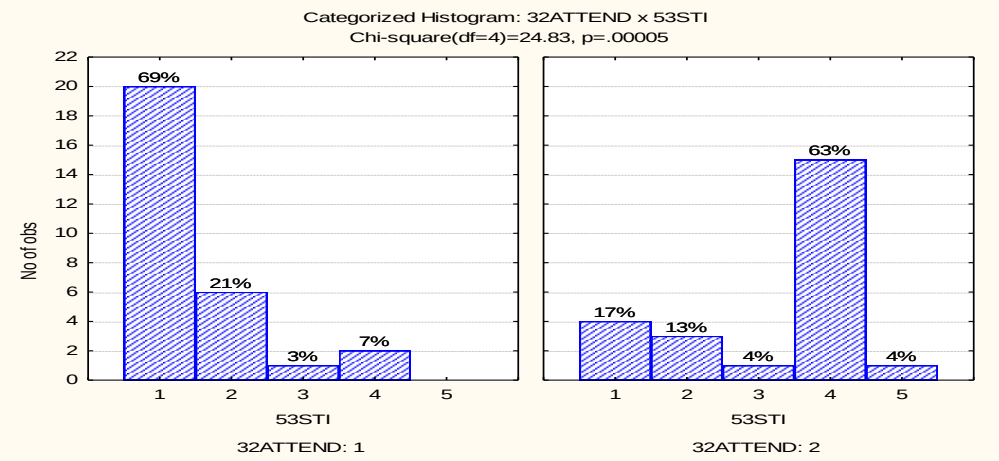

- However, only 11% of the Group 1 respondents stated that they had non-regular sexual partners and 89% had a regular sexual partner. In Group 2 29% of the respondents indicated that they had a non-regular sexual partner and 71% stated that they a regular sexual partner. In both instances a large percentage (89% and 71%) of the sexually active respondents had regular sexual partners which are indicative of high level of responsible attitude towards sexual intimacy in general.

**Q.52 I think single persons in non-committed relationships should use a condom each time they have sexual intercourse.**



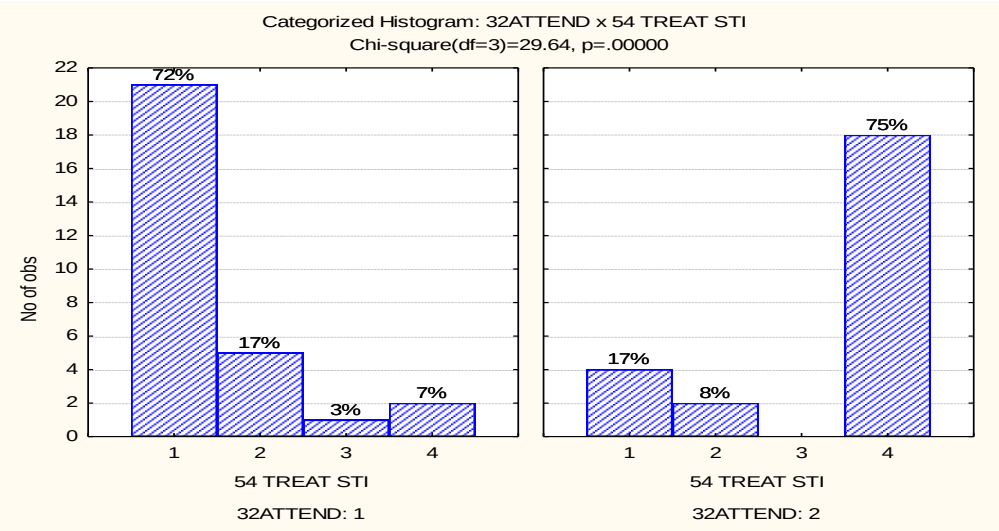
- The respondents in Group1 held strong views on this statement so much so that 97% of them agreed with it which in itself displays a high level of responsibility and 3% were neutral on the subject. In Group 2 88% agreed with the statement, 8% was neutral and 4% disagreed. While it must be guarded against promoting promiscuity, it makes logical sense to encourage the use of condoms to those who are in casual sexual relationships as prevention against HIV infection.

**Q.53 I have contracted a Sexually Transmitted Infection (STI)**



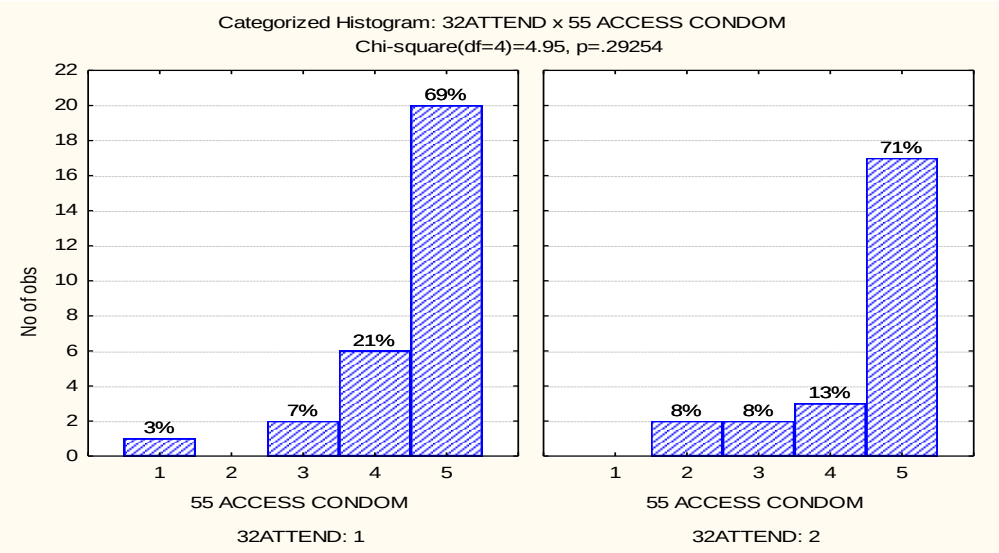

- In Group 1 7% indicated that they have contracted a sexually transmitted infection as opposed to those in Group 2 where 67% of the respondents that they had contracted such an infection. This is indicative of the fact that they indulged in unprotected sexual intimacy although the response in Group 2 was much higher than that of Group 1. The reasons for the actions of Group 2 warrants further investigation.

- **Q.54 I have received treatment for a Sexually Transmitted Infection (STI)**



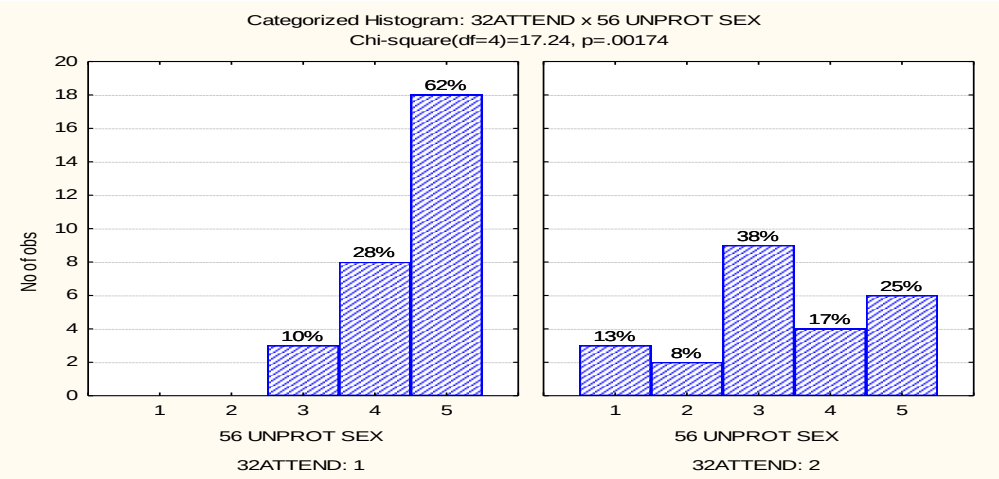

- In Group 1 7% agreed with this statement which indicates that all of the respondents who stated that they contracted an STI infection went to seek medical help. The same applies to the respondents of Group 2 who indicated that 75% of them also went to seek medical help. So while they were not very responsible in terms practicing safe sex, at least they presented themselves for treatment when they discovered that they had and STI.

**Q.55 Male condoms are readily available and easily accessible in my workplace**



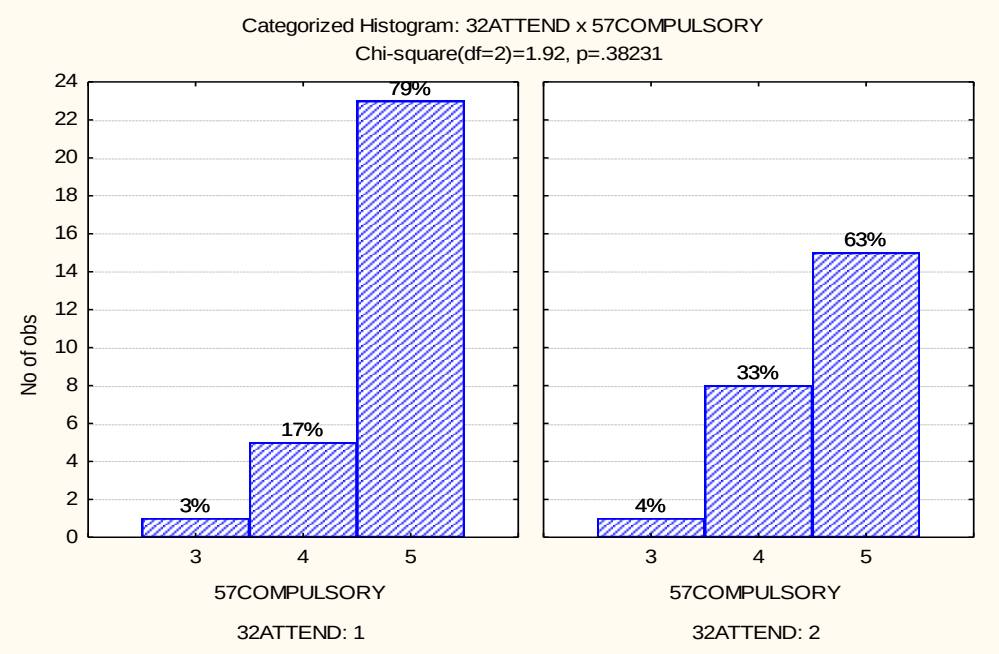
- In Group 1 90% indicated that they had access to male condoms in the workplace, 7% were neutral while 3% disagreed. In Group 2 84% stated that they had access to male condoms in the workplace, 8% were neutral and a further 8% indicated that they had no access to condoms in the workplace. Telkom SA Ltd endeavours to provide male condoms free of charge in all its workplaces and the reasons why some of the respondents (3% and 8%) indicated that they did not have access to male condoms in the workplace needs further investigation.

**Q.56 I am more aware of the dangers of unprotected sex as a result of attending the HIV/AIDS awareness sessions.**



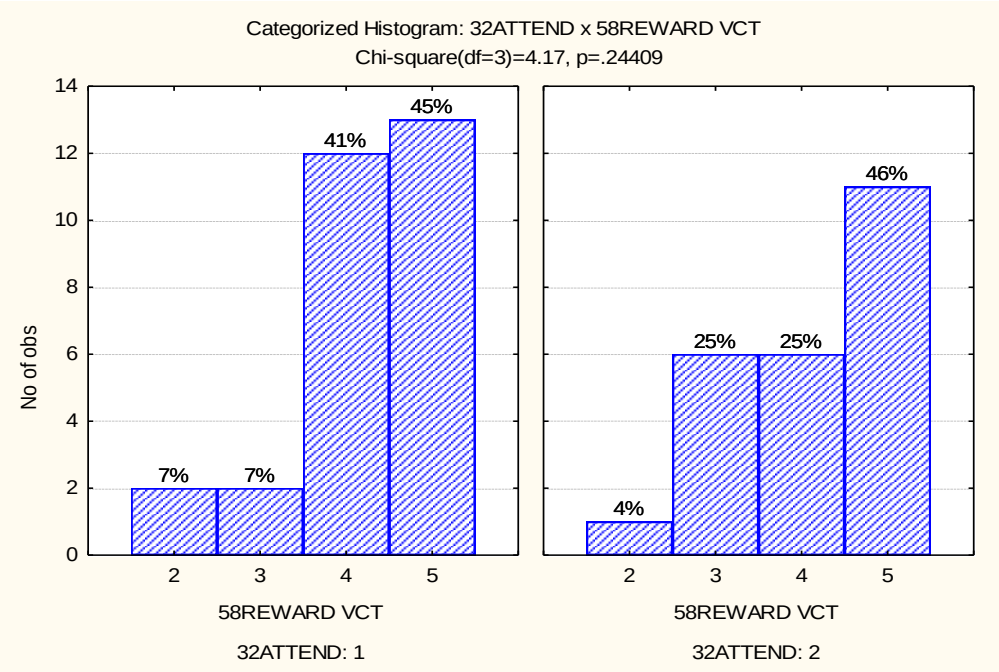

- In Group 1 90% stated that they are more aware of the dangers of unprotected sex as a result of the information shared at the HIV/AIDS awareness sessions and 10% were neutral. In comparison to Group 2 where only 42% stated that they were of the dangers of unprotected sex 38% were neutral and 21% did not agree with this statement. As Group 2 respondents did not attend an awareness session this result was expected.

**Q.57 I think attendance of HIV/AIDS awareness sessions should be made compulsory for all employees as everyone can benefit from it.**




- Both the respondents of Groups 1 & 2 96% of them felt that the attendance of HIV/AIDS awareness sessions should be made compulsory and only a very small percentage in both groups (3 and 4% respectively) were neutral on the topic. It is obvious that both groups are aware of the benefits of the attendance of HIV/AIDS awareness sessions.

**Q.58 If employees who underwent Voluntary Counselling and Testing (VCT) were rewarded in some way, more employees would go for VCT.**




- Eighty six percent of Group 1 respondents felt that those who underwent VCT should in some way be rewarded, 7% were neutral and 7%

disagreed. In Group 2 71% felt that those who underwent VCT should be rewarded, 25% were neutral and 4% disagreed. The level of confidence of Group 1 was much higher than that of Group 2. In This regard Telkom SA Ltd has endeavoured to gift those who underwent VCT with small tokens of appreciation i.e. healthy snack packs, key rings , Frisbees, CD holders etc. This was well received and actually encouraged more employees to undergo VCT during the wellness days.

# Chapter 5: Findings and Recommendations

## *5.1 Findings*

### 5.1.1 Peer Educator Responses (N=11)

- Sixty four percent (64%) of the Peer Educators indicated that their HIV/AIDS knowledge increased as a result of their training. One can conclude that the balance (36%) of the Peer Educators already had acquired some HIV/AIDS knowledge prior to attending the Peer Educator training programme.
- In addition to the aforementioned 81% of the respondents stated that their HIV/AIDS knowledge was adequate to conduct successful awareness sessions in the workplace.
- Furthermore the greater majority of the respondents ascribed the success of their peer educator awareness sessions to a combination of:
    - a high level of HIV/AIDS knowledge,
    - promoter support in terms of time allowed for employees to attend,
    - the support they enjoyed from their peers, and
    - the effective use of the learning material provided with the exception of the manner in which they presented the sessions which returned an average of 54%. However a further 54% remained neutral – question 12.
- The responses to the Peer Educator On-line toolkit was mixed and varied. This could be ascribed to the fact that the On-line toolkit was only introduced 16 months after the Peer Educator training was rolled out. This also had an impact on the use of the toolkit to record details of the awareness sessions they conducted as well as the access and subsequent use of the learning material that was available on the toolkit.
- Regarding the aspect of promoter involvement/encouragement of employees to attend the HIV/AIDS awareness sessions they did not overly go out of their way to encourage this, but rather allowed their decisions to be influenced by the Telkom HIV/AIDS Policy document which inter alia states that promoters should allow HIV/AIDS peer educators to conduct one awareness session per quarter in the workplace which they have been assigned to.

However these requirements were minimum requirements and promoters could have used their own initiative to encourage Peer Educators to conduct more awareness sessions based on their individual needs. However, having regard to their lack of involvement/interest in HIV/AIDS, they chose to adhere to the minimum policy requirements.

### 5.1.2 HIV/AIDS Knowledge and Attitudes of Respondents (N=55)

The statistical calculations show that there was no significant correlation between the attendance of an HIV/AIDS awareness session and the level of HIV/AIDS knowledge displayed by the respondents. The overall findings does however show that both respondent groups has a high level of HIV/AIDS knowledge, which can be regarded as sufficient to make informed decisions about their own sexual behaviour and practices. This level of knowledge is also regarded as adequate should they be required to inform their peers about issues around HIV/AIDS. In addition to the above, their knowledge levels are also considered to be adequate to deal with work related HIV/AIDS issues.

A large percentage of the respondents (who attended the HIV/AIDS awareness session) that they had a regular sexual partner. This is indicative of a high level of a responsible and mature attitude towards sexual intimacy in general. The respondents also felt that people who are in casual relationships should practice safer sex. It was also found that a large percentage (75%) of the respondent group (who did not attend the HIV/AIDS awareness sessions) had contracted an STI. This was indicative of the fact that they practiced unprotected sex. However, they did seek out medical treatment when they realised they had contracted an STI. A high percentage of respondents (90 and 84% respectively) indicated they had access to male condos. Condom dispensers are refilled twice per week which is indicative of high condom usage amongst the respondents.
The high frequency of condom usage is also indicative of the fact that the respondents are more aware of the dangers of unprotected sexual intercourse.

### 5.1.3 Sexual Practices

The statistical calculations show that there was no significant statistical difference between the attendance of an HIV/AIDS awareness session and the sexual practices displayed by both respondent groups.

Both groups displayed high levels of responsibility and maturity in terms of their own sexual practices. Indicative of this is the fact that, although sexually active, their incidences of having non-regular sexual partners are very low as well as their views on safe sex practices when it comes to casual sexual relations. However when it comes to actually practicing safe sex (using condoms) their responses are significantly different. The incidence of STI's amongst respondent Group 2 were high (67%) but at the same time they also indicated that they went to seek medical help for their condition.

## *5.1 Recommendations*

### 5.1.3 On-line Peer Educator Toolkit

Research findings clearly illustrates that the on-line toolkit was underutilized. It is therefore recommended that the use of the on-line toolkit must be aggressively marketed amongst peer educators and training interventions implemented for the proper utilization of the toolkit. Data captured via the toolkit would be extremely valuable to:

- Determine the number of employees attending VCT/Wellness sessions
- Determine the grade of employees attending VCT/Wellness sessions
- Actual duration of the individual VCT/Wellness sessions
- Record of specific HIV/AIDS topic/s presented at the VCT/Wellness sessions

It is further recommended that a selection of topics (at least one for each month) with supporting materials be made available on the toolkit. In this way a uniform message with regard to HIV/AIDS can be disseminated throughout the company on a monthly basis.

Training materials must be kept relevant in terms of the latest developments in the field of HIV/AIDS prevention and vaccine research as well as the statistical data in terms of national prevalence rates.

Attendees per VCT/Wellness sessions must be requested to complete a Kirkpatrick Level 1 questionnaire to determine the effectiveness and relevance of the learning materials used during such sessions. Information gathered in this manner could be used to enhance the content of the support material.

### 5.2.2 Making the awareness sessions more interesting.

The survey results indicated that the respondents wanted relevant, interesting and up to date HIV/AIDS information to be disseminated during awareness sessions.

The following suggestions are therefore put forward in order to satisfy the above-named need:

- Design posters and display showing the effects on human beings before and after HIV infection and the stages of AIDS development in humans.
- Capture “real life” stories of individuals showing the human suffering brought by HIV infections.
- Use HIV infected persons as role models and spokespersons to educate employees on HIV prevention.
- Provide up to date statistics regarding HIV/AIDS prevalence, morbidity and mortality rates.

### 5.2.3 Encouraging Greater Promoter Involvement

According to the survey results, very few of the promoters actually attended HIV/AIDS awareness sessions. None of them are trained as Peer Educators. Promoters are also required to “manage” performers who are HIV positive. In such instances they would also be required to deal with such situations of resentment/discrimination, stigma and/or rejection where it becomes known that a fellow worker is HIV positive. It is for this reason that promoters need to be empowered with knowledge around HIV/AIDS and be given the necessary skills and tools to deal with HIV in the workplace. Strong consideration should therefore be given to present a series of one day compulsory HIV/AIDS awareness sessions to promoters. Alternatively they should be strongly encouraged to be trained as Peer Educators.

In this way their knowledge pertaining to HIV/AIDS would be enhanced and hopefully they would be more accommodating to their performers who are trained Peer Educators by allowing them more time to conduct awareness sessions and also be more forthcoming to those who are eager to gain more knowledge on HIV/AIDS.

It is recommended that promoters be informed that the suggested one awareness session per quarter is the minimum requirement and that they should be encouraged to allow peer educators more opportunities to run awareness sessions and that they should also allow peer educators more time per awareness sessions. This should be made an output in their personal performance plans.

### 5.2.4 Encouraging greater employee involvement

One of the aspects that come strongly to the fore during the research was the fact that VCT participants should be rewarded. In the past anyone who underwent VCT was rewarded with one of the following “THUSO Wellness” branded gifts:

- Frisbees
- Key rings
- CD Holders
- Coffee Mugs
- T-shirts
- Health Packs (Containing pure fruit juice, Health bar, Vita C sweets)
- Lanyards
- Stress Balls
- Pen & Pencil sets

However, this practice was discontinued due to financial constraints. Serious consideration should therefore be given to reinstitute this practice as the benefit far outweighs the costs.

Employees should be encouraged to attend a VCT session and have their Sero-status checked at least once per year. Employees who have multiple sexual partners must be encouraged to have their Sero-status checked at least once every three months.

### 5.2.5 Sexually Transmitted Infections (STI's)

From the research results it is evident that there is a lack of knowledge of STI's (other than HIV/AIDS). It is therefore recommended that the following information regarding STI's must be incorporated into the learning materials used during awareness sessions:

Sexually transmitted infections (STIs) are infections one gets when having sex with someone who has an infection. These infections are usually acquired when having vaginal intercourse, but it can also be acquired through skin-to-skin contact, anal or oral sex. STI's can be viral or bacterial. Viral STI's include hepatitis B, herpes, HIV and the human papilloma virus (HPV). Bacterial STI's include Chlamydia, Gonorrhoea and Syphilis. **. (Family Doctor, Undated)**

### 5.2.6 Enhancing HIV/AIDS Peer Educator Learning Material

Flowing from the research findings it is recommended that the Peer Educator learning material be enhanced to include the following:

- Discussion topic on male circumcision and the outcomes of research done in this field
- Discussion topic on pre-marital sex, the pros and cons of pre-marital sex as well as the psychological impact thereof on the parties involved. Also include social and religious aspects regarding the practice of pre-marital sex.

### 5.2.7 The following aspects warrant further investigation:

- Incidences of HIV positive mothers giving birth to HIV positive babies
- Abstinence and the chances of becoming HIV infected
- Disclosure of the status of HIV positive patients
- Male Circumcision: There is still a lot of controversy around the question of male circumcision and HIV infection.

One must therefore exercise great caution when commenting on the question of male circumcision and HIV prevention.

- The high incidence of Sexually Transmitted Infections among the group of respondents who did not attend HIV/AIDS awareness sessions. The reasons for non-condom usage must be determined.

## *5.3 Into the Future: From HIV/AIDS and VCT to the Total Wellness Concept*

Telkom SA Ltd has enjoyed great success with its current HIV/AIDS and VCT programmes overall. However, to ensure the continued success and sustainability of its health interventions it is necessary to migrate away from HIV/AIDS Awareness and VCT to a Total Wellness Concept where the following health issues are addressed:

- Health screening for cholesterol, blood pressure, body mass, diabetes and HIV testing and awareness
- Dealing with Stress - Educational Theatre
- Eye screening
- Cancer awareness
- Alcohol, Drug and Substance Abuse
- Occupational Health – Ergonomics in the workplace
- Financial Health – Banking & lending Institutions
- Medical Health – Various Medical Aids

### 5.3.1 A Sustainable Total Wellness Peer Educator Programme

#### 5.3.1.1 Selection Criteria for Wellness Peer Educators

Currently peer educators are identified through a volunteer programme with no additional selection criteria. It is proposed that employees selected to be future wellness peer educators should meet most, if not all of the criteria mentioned below:

- The ability to interact clearly and with conviction
- Have good interpersonal skills as well as listening skills
- Come from a socio-cultural background similar to their target audience
- Be respected and accepted by their peers

- Possess a non-judgmental attitude
- Be motivated to reduce HIV risk reduction and to educate their peers regarding lifestyle medical conditions i.e. diabetes, elevated cholesterol, high blood pressure etc.
- Demonstrate compassion, respect and care towards people living with HIV/AIDS
- Be self-confident and display leadership potential
- Pass a practical knowledge-based assessment at the end of their training
- Devote time and energy to this task
- Have the potential to be a “safer sex” role model for their peers
- Be able to travel to where their target audience is
- Be able to work irregular hours

People who are HIV positive can be powerful wellness peer educators. Some may choose to make their sero-status known while others may not. Either way, they will make sensitive and insightful wellness peer educators.

Trained health workers, nurses and nurse-aides, can also be effective wellness peer educators.

It is also suggested that wellness peer educators participate in a two-week internship prior to selection.**(AIDSCAP, Undated)**

#### 5.3.1.2 Retraining of Wellness Peer Educators

The current HIV/AIDS Peer Educators are not sufficiently trained to perform effectively as wellness peer educators. It is therefore recommended that the entire Peer Educator programme be redesigned to incorporate the Total Wellness Concept as outlined in 5.3 above.

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# Annexures

## *Annexure A: KAP Questionnaire*

## A Study on Knowledge, Attitude and Practice (KAP) on HIV/AIDS amongst the employees of Telkom SA Ltd

### Dear Participant

My name is Yusuf Kamaldien. I am based at the Centre for Learning, Milnerton in the Safety, Health & Environmental Management domain. I am currently enrolled at the University of Stellenbosch, School of Industrial Psychology and I am reading for the degree Mphil: HIV/AIDS Management. This survey is in partial fulfillment of the requirements for the degree.

This survey is totally anonymous and I will make no attempt to identify the person/s who took part in this survey. I also undertake not to divulge the results of this survey to anyone other than my study leader, Mr Burt Davis of the University of Stellenbosch.

++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++

## Section A: Socio-demographic characteristics
**(Make a cross in the appropriate block)**

### 1. Age Group (years)

| Under 20 | Between 20 - 30 | Between 31 - 45 | Older than 45 |
|---|---|---|---|
| | | | |

### 2. Gender

| Male | Female |
|---|---|
| | |

### 3. Job Grade/Level

| Contract Employee | Ops Level | Jnr. Man/Ops. Spec | Management/ Specialist | Top Management |
|---|---|---|---|---|
| | | | | |

### 4. Marital Status

| Single | Married | Divorced | Widowed | Living Together |
|---|---|---|---|---|
| | | | | |

### 5. Educational Level

| Below Matric | Matric | Diploma/Higher Diploma | Degree | Post Graduate studies |
|---|---|---|---|---|
| | | | | |

### 6. Ethnic Group (For research purposes only)

| Black | White | Coloured | Asian | Other |
|---|---|---|---|---|
| | | | | |

### 7. Are you a trained HIV/AIDS Peer Educator?

| **If Yes, Complete Sections B, C & D** | **<u>If No, Complete Only Sections C & D</u>** |
|---|---|

## SECTION B: HIV/AIDS Peer Educator Training
**(Make a cross in the appropriate block)**

**8. When did you undergo training?**

| Within this year | More than one year ago | More than two years ago | Cannot remember |
|---|---|---|---|
| | | | |

**9. My knowledge on HIV/AIDS increased as a result of the training**:

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**10. My knowledge is adequate to conduct successful awareness sessions.**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**11. How many awareness sessions have you conducted since you completed your training?**

| Less than 10 | Between 10 and 20 | More than 20 |
|---|---|---|
| | | |

**12. The manner in which I presented awareness sessions contributed to its success**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**13. The support material I used during the awareness sessions contributed to its success**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**14. The awareness sessions were successful because my knowledge on HIV/AIDS is adequate**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**15. The awareness sessions were successful due to attendee interest in HIV/AIDS**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**16. The awareness sessions were successful because promoters allocated enough time to their subordinates to attend**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**17. I am aware of the on-line Peer Educator Toolkit on the Telkom Intranet**

| Agree | Disagree |
|---|---|
| | |

**18. I was taught how to use the on-line toolkit**

| Agree | Disagree |
|---|---|
| | |

**19. I have used the on-line Peer Educator Toolkit to record details of the awareness sessions I conducted**

| Agree | Disagree |
|---|---|
| | |

**20. I do not know how to use the on-line Peer Educator Toolkit to record awareness sessions**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**21. I have made use of the support material available on the Toolkit**

| Agree | Disagree |
|---|---|
| | |

**22. There is support material on the Peer Educator Toolkit**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**23. I do not know how to access the support material on the Peer Educator Toolkit**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**24. My promoter actively encourages me to conduct HIV/AIDS awareness sessions during working hours**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**25. My promoter actively encourages his/her subordinates to attend HIV/AIDS awareness sessions during working hours**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**26. How much time did your promoter allow you per session?**

| None | Less than 30 minutes | Between 30 and 60 minutes | More than 60 minutes |
|---|---|---|---|
| | | | |

**27. How often did your promoter allow you to conduct HIV/AIDS awareness sessions?**

| More than once per Month | Once per Month | Once Per quarter | Never |
|---|---|---|---|
| | | | |

**28. If you selected "never" in question 27, which of the following factors describe best the reasons for your promoter refusing permission?**

| I Do not know | My promoter did not see the need for HIV/AIDS awareness sessions | My colleagues did not show any interest | My workload did not allow me |
|---|---|---|---|
| | | | |

**29. I think it is necessary to conduct a HIV/AIDS refresher workshop on an annual basis**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**30. How would you go about encouraging as many of your fellow workers as possible to attend a HIV/AIDS awareness session in your workplace?**

……
……
……
……
……

**31. What would you do to make the content of future HIV/AIDS awareness sessions more interesting?**

……
……
……
……
……

## SECTION C: HIV/AIDS KNOWLEDGE and ATTITUDE

**(Make a cross in the appropriate block)**

**32. I have attended an HIV/AIDS awareness session in the workplace.**

| Agree | Disagree |
|---|---|
| | |

**33. There is a cure for HIV/AIDS**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**34. Healthy looking persons who are HIV positive can transmit the disease to others**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**35. Most of the HIV infections are as a result of unprotected sexual intercourse**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**36. Drug addicts sharing needles are exposing themselves to the risk of being infected with the HI Virus**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**37. Babies born of mothers who are HIV positive have a smaller chance of becoming HIV positive if mothers take ARV's**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**38. A person who totally abstains from sexual intercourse will not become infected with the HI virus**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**39. Persons who use condoms correctly each time they have sexual intercourse have little or no chance of becoming infected with the HI Virus**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**40. Partners who are faithful to each other are very unlikely to become infected with the HI virus.**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**41. Males who are circumcised, while taking the proper universal precautions, are less likely to become infected with the HI virus than those who are not taking the proper universal precautions**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**42. I believe that couples should engage in sex before marriage**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**43. People who are HIV positive are more likely to become sick with Tuberculosis (TB)**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**44. I believe that couples should have themselves tested for HIV before marriage**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**45. I believe that people who are HIV positive should be isolated from the rest of the population**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**46. I believe that the status of an HIV positive person should not be disclosed to others**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**47. I believe that the practice of Voluntary Counselling and Testing (VCT) for HIV is necessary in the workplace.**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**SECTION D: PROMOTER INVOLVEMENT**

**48. My promoter has attended an HIV/AIDS awareness session**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree |
|---|---|---|---|
| | | | |

**49. My promoter actively encourage his/her subordinates to attend HIV/AIDS awareness sessions**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree |
|---|---|---|---|
| | | | |

## SECTION E: SEXUAL BEHAVIOUR
**(Make a cross in the appropriate block)**

**50. I am sexually active**

| Agree | Disagree |
|---|---|
| | |

**51. I had a non-regular sexual partner in the last year**

| Agree | Disagree |
|---|---|
| | |

**52. I think single persons in non-committed relationships should use a condom each time they have sexual intercourse.**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**53. I have contracted a Sexually Transmitted Infection (STI)**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**54. I have received treatment for a Sexually Transmitted Infection (STI)**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**55. Male condoms are readily available and easily accessible in my workplace**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**56. I am more aware of the dangers of unprotected sex as a result of attending the HIV/AIDS awareness sessions**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**57. I think attendance of HIV/AIDS awareness sessions should be made compulsory for all employees as everyone can benefit from it.**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**58. If employees who underwent Voluntary Counseling and Testing (VCT) were rewarded in some way, more employees would go for VCT.**

| Fully Agree | Agree | Neither Agree Nor Disagree | Disagree | Fully Disagree |
|---|---|---|---|---|
| | | | | |

**END OF SURVEY**

Thank you for your participation.