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Workplace peer educators and HIV testing: understanding the challenges faced in a South African mining company

Sibanda, Ochard

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University of the Witwatersrand

Global Labour University

Research Report

On

Workplace Peer Educators and HIV Testing: Understanding the challenges faced in a South African Mining Company.

Submitted to the Faculty of Humanities in Partial Fulfillment of an MA in Labour, Policy and Globalisation

By

Ochard Sibanda

Student No: 510772

Email: ochrdsibanda@gmail.com

Supervised by: Prof. David Dickinson

Abstract

South Africa has a high number of people living with HIV as UNAIDS (2009) projected the population of people living with HIV to be 5.7 million of which 20% of this population is said to be in employment. As a corrective measure, various strategies at national and company levels are being employed to get people to test for HIV. HIV testing helps people to know their status which is a gateway to informed prevention behavior and treatment. In workplaces, peer educators play an important role in getting workers to take up HIV test. As workplace peer educators mobilize workers to take up HIV test, they continue to face challenges. This precedes the broad objective of this study, which is to understand challenges faced by workplace peer educators in getting workers to take up HIV test.

This report is a product of in-depth interviews, with fourteen peer educators, two wellness officers and the wellness coordinator. Participant observations and document analysis were also employed in gathering data. The data collection process extended from July to December 2010 in a mining company in the North West province in South Africa. Findings of the research revealled that despite the company's HIV testing programme being a success as evidenced by a recorded cumulative annual uptake rate of 82% (2009), peer educators still face challenges emanating from environmental, programmatic and socio-interactional and perceptional factors. Environmental factors include skepticism based on precarious employment contracts while programmatic factors include certification of test results, speculation of test results based on time spent in the testing cubicle, consent procedures and incentivisation of testing. Lastly socio-interactional and perceptional factors that include stigma and discrimination, cultural beliefs, poor disclosure strategies, perceived racialisation of workplace testing centers and male workers

relying on results from partner's antenatal test were identified as another set of challenges faced by peer educators.

The study suggests that in order to improve the HIV test uptake rate, in this context referring to the attainment of an absolute uptake rate, mitigation measure which include the use of trade unions in mobilizing workers for HIV testing, training on disclosure, re-negotiation and design of testing programmes and education must be considered. The adoption and administration of these measures into the case study company's HIV test programme and other institutions facing the same challenges will help improve the HIV test uptake.

Dedication

This is dedicated to all Peer Educators who have offered themselves to serving others in the fight against HIV/AIDS and to my young brother's newly born daughter Milumbe, I say be selfless and serve others!

Acknowledgement

- I am greatly indebted to individuals and institutions that assisted in various ways that enabled me to complete this research project.

- This research would not have been possible without the invaluable lectureship, supervision and mentorship by Professor David Dickinson. I greatly appreciate his unwavering support, encouragement and for patiently working with me throughout the research process. David, *ke a leboga ntate!*

- I extend my gratitude to Jacky, Elvis and all peer educators at "Belvedere Consortium" for their valuable support during the data collection process.

- Lastly, I am grateful to the International Labour Organisation (ILO) who funded my study programme.

Declaration

I declare that this research report is my own unaided work. It is submitted for the degree of Master of Arts in Labour, Policy and Globalisation at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination at any other University.

Signed_____ _____day of_____2011

Ochard Sibanda

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Acronym and Abbreviation

AFA Aid-For-AIDS

AIDS Acquired Immune Deficiency Syndrome

COSATU Congress of South African Trade Unions

HCT HIV Counselling and Testing

HIV Human Immunodeficiency Virus

IEC Information Education and Communication

NALEDI National Labour and Economic Development Institute

PMTCT Prevention of Mother To child Transmission

VCT Voluntary Counselling and Testing

UNAIDS Joint United Nations Programme on HIV/AIDS

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CHAPTER ONE

INTRODUCTION

HIV testing is the only way people get to know their HIV status. The significance of HIV testing can be broadly and dually conceptualised as, on the one hand, allowing reactive, 'timely' intervention programmes through treatment administration and, on the other hand, proactive prevention programmes (see, Alcorn and Smart 2006 and De Cock 2002). The importance of HIV testing is expressed in Mear's (cited in Heynike 2010:1) lamentation that new infections are persisting, patients are presenting too late HIV/AIDS related illness cases and the low number of people accessing HIV treatment through medical schemes. Mear (2010) further alludes that these missed opportunities are costing lives and costing business money. In as much as HIV testing is important, it is important to note that, as envisaged by Jackson (2002:179), people need support to plan for a test and to cope with results so that they can respond appropriately. In workplaces, companies have used workplace peer educators to help workers decide to test, plan for a test, take a test and cope with results, thus the entire HIV test mobilization process. However the task of mobilizing workers to take up HIV test is a process that is fraught with challenges (Rujumba *et al*; 2010), peer educators negotiate with colleagues, spelling out the importance of HIV testing, in the process interacting with the environmental sphere which determines conditions and the context under which testing takes place. Peer educators have to deal with workplaces institutions. Programmatic factors deal with the way the HIV testing programme is designed and socio-interactional and perceptional factors explore the interaction between peer educators and workers and perceptions individual workers are socialized into. Socio-interactive and

perceptional factors discuss the cascading down effect of sexual norms, folk theories and social shame associated with HIV/AIDS (see Dickinson 2009) which impede HIV test uptake.

This research report of a study conducted in a mining company in the North West province of South Africa is divided into five chapters. This chapter, Chapter One, justifies the importance of the study by highlighting the knowledge gap that the study seeks to bridge. Chapter Two envisages an array of both conflicting and concurring literature on key thematic areas on peer education and HIV testing. Chapter Three discusses the processes and methods of data collection used in the study with Chapter Four outlining and discussing findings of the research. Lastly, Chapter Five draws conclusions of the study and makes recommendations as mitigation measures to challenges obtaining in the case study company. The next section states the research objective and outlines research questions as part of Chapter One's justification of the study.

1.1. Research Objective

The broad objective of the research was to explore and understand challenges faced by workplace peer educators in getting workers to take up HIV Test.

1.2. Research Questions

This case study research conducted at "Belvedere Consortium", a pseudonym for the giant mining company in the North West province of South Africa where the research was conducted, was guided by three research questions which act as a running motif in the entire research report.

These research questions are:

- How do workplace peer educators get workers to take HIV test?
- What are the barriers to HIV testing as identified by Peer Educators?
- How can the barriers to HIV testing be mitigated?

1.3. Rationale of the Study

Peer educators play a significant role in the fight against HIV, both at workplaces and in the broader society through educating people on the importance of knowing their HIV status through HIV testing talks and campaigns. Peer Educators are change agents who operate within a diverse socio-cultural, economic and political environment. While they remain an alternative source of hope in the fight against the AIDS pandemic (Dickinson 2009) their enthusiasm is often fraught with challenges. This is in light of portrayed continued incidence of HIV infection against people's continued reluctance to test (Rehle et al 2007 cited in Dickinson 2008:281) that Coleman (2009:26) observes and acknowledges that "going for an HIV test is not easy" and hence Rehle's (2007) observed continued reluctance to test. This sets the tone that peer educators need to battle with people's reluctance to test and their feeling that going for an HIV test is not easy. Exploring the relationship between workplace peer educators and employees over HIV testing help in understanding the social interactions and education approaches that can be adopted in the process of talking to colleagues about the importance of HIV testing and getting them to opt-in for the test.

Challenges faced in HIV test uptake are viewed by a wide spectrum of society ranging from ordinary persons, researchers, health care providers and practitioners, civil society, the corporate persona, government, labour and, as applicable to this research, workplace peer educators. While peer educators play a significant role in various workplace HIV/AIDS programmes (see, Dickinson 2009), *inter alia,* HIV testing, little is known about specific challenges they face in getting people to take up HIV test(s). These challenges sometimes have debilitating effects that eclipse peer educators' contribution in HIV testing. HIV testing has been riddled with many challenges ranging from lack of counselling skills, failure to cope with knowledge demand, heavy workload, lack of support services, limited space and lack of antiretroviral (Rujumba et al; 2010), fear of being known to have taken an HIV test which is a manifestation of stigma and discrimination (Liz-Thebus; 2010). As such questions that come into mind are whether these challenges are universal i.e. uniformly applying across the corporate spectrum or they differ, depending on socio-economic, cultural, behavioural, religious, gender, communication or infrastructural trajectories which trigger specific HIV testing challenges. In South Africa, it is important to explore these challenges, more so during the trail HIV Counselling and Testing (HCT) campaign running from April 2010 to the end of 2011 (see Section 4.5 of Chapter Two).

While there is literature on HIV/AIDS in the workplace (Sprague and Dickinson 2008, Bhagwanjee et al 2008, Evian 2008, Muskat-Gorska 2008), peer educators in South Africa (Dickinson and Kgatea 2008, Dickinson 2009), general challenges faced in Voluntary Testing and Councelling (VCT) in certain geo-political, cultural and socioeconomic phenomenon (see, Rujumba *et al* 2010, Dickinson 2009) little is known about specific challenges faced by workplace-based peer educators, in the mining sector of South Africa, in getting people to take up HIV tests. What is acknowledged is that there is reluctance to test and that going for HIV test

is not easy (Rehle 2007 and Coleman 2009, respectively). It is the knowledge gap of knowing the challenges faced by workplace peer educators in mobilizing workers to test for HIV that this research seeks to bridge. The research will be a contribution to the knowledge on peer educators and HIV testing in workplaces. Having discussed the significance of the study, the next chapter reviews the literature on workplace peer educators and HIV testing by focusing on key thematic areas of the study.

CHAPTER TWO

LITERATURE REVIEW

2. Introduction

The World Health Organisation representative (2009) notes that, "of all diseases, AIDS provides the most dramatic and disturbing example of the capacity of previously unknown pathogen to rapidly spread throughout the world causing social and economic upheaval of a scale that threatens to destabilize a large geographic area." Barnett and Whiteside (2002:14) concur with the assertion through exploring the economic impact that HIV /AIDS has had on education, agriculture, health and the mining sector. Barnett and Whiteside (ibid) assert that HIV/AIDS, if not properly managed, can reverse development gains by ten years. HIV testing becomes a gateway for effective intervention and prevention measures so that development gains are not reversed.

This chapter reviews literature on workplace peer educators and HIV testing with a bias towards unearthing challenges faced by workplace peer educators in getting workers to take up HIV test. While HIV testing is an important step towards informed prevention and treatment, ironically people are reluctant to test (Rehle et al 2007 cited in Dickinson 2008:281). Arguably, challenges faced in getting workers to take up HIV testing have partly emanated from the fact that HIV testing has been conducted through a bio-medical approach which ignores socio-cultural and organizational realities workers confront in the society and at workplaces. The bio-medical approach has, since the spread of western centred knowledge and ways of conceiving social

reality, been the dominant strand in determining peoples' health status. Leah *et al* (2010) explore the central tenets underlying the bio-medical approach, and note that it is informed by the assumption that all diseases have a specific aetiology (origin) such as a virus, parasite or bacterium. This assumption implies that diseases and ill-health occur exclusively within the body and as such treatment should focus on a patient's body which becomes the sole domain for treatment and attention. While the bio-medical approach has seen great gains being realized in the area of health and people's wellbeing it has drawn a number of criticism from a number of social commentators such as Gilbert *et al* (2010), Jackson (2002), Zimbabwe Human Development Report (1999), Navarro (1976), Dubos (1992), Garhardt (1995), Armstrong (2000), Turner (2000) and Tarlov (1992), among others. The afore outlined social commentators argue that the bio-medical approach is seen as isolating the human being/patient/worker, who is a social actor, from his socio-political, economic and cultural context which is central in shaping his/her health and well-being to health institutions i.e. a clinic, hospital, pharmacy, laboratory or testing cubicle. It is the bio-medical approach of sidelining socio-political, economic and cultural factors which contribute to HIV testing challenges.

This chapter comprises of thirteen sections which will be first outlined and discussed later. Section one provides an overview of HIV/AIDS in South Africa which is the national context of the study. Section Two looks at HIV/AIDS in the workplace in order to understand workplace-based peer educators' primary domain. Section Three locates the role of organized labour in company HIV/AIDS programmes. Section Four delves into how HIV testing is regarded as a stepping stone towards prevention and treatment and this will be done through discussing different HIV testing approaches. Section Five defines the roles of workplace peer educators in HIV testing. While Section Six looks at the general influence of culture on health and the

influence of culture to HIV testing. Section Seven discusses medical and health care pluralism in the context of the influence of culture on health. Section Eight explores the effects of stigma and discrimination on HIV/AIDS in order to understand how that affects HIV testing. Section Nine looks at theories of behaviour change in order to understand the applicability of behaviour change theories in HIV testing. Section Ten adopts the social interaction model as the conceptual and theoretical framework of the study and this is based on the interactions that ensue as peer educators mobilize workers to take up HIV test. Section Eleven borrows principles of participation education into the process of HIV testing with the desire to understand implications of worker participation in HIV/AIDS education on HIV test uptake. Section Twelve locates peer educators on different HIV testing stages as depicted on a tailored HIV testing flow chart and Section Thirteen draws a conclusion of the literature reviewed.

2.1. HIV/AIDS in South Africa: National Context of the Study

De Cock et al (2002:68) spell out how Africa is hard hit by HIV/AIDS through asserting that while Africa only comprises 10 per cent of the world's population, it accounts for two-thirds of the people living with HIV in the world. This supports the UNAIDS report (2009:4) which is based on a survey carried out in 2007, which envisages that South Africa's population living with HIV is estimated to be 5.7 million people and this is reported, UNAIDS (2009), as the world's largest national number of a population living with AIDS. This has prompted the government to seek ways of responding to the pandemic as epitomized by South Africa's President Zuma's sentiments on World AIDS day 2009 and the subsequent speech by the minister of Health Dr Motsoaledi (2010:1). They both concur that HIV/AIDS is wrecking havoc

in the country and there is need for concerted effort to combat the pandemic through, particularly, prevention strategies.

As part of prevention endevours, the government has rolled out the HIV Counselling and Testing (HCT), see Section 4.5, program which aims to reduce infection by 50 per cent by 2011 through testing and availing Antiretroviral Therapy (ART) to 80 per cent of those in need of treatment (Health E-news: 18 March 2010). A goal of universal "voluntary" HIV testing has been set by the government through intensive mobilization of the people to take up HIV testing. This is epitomised by a call made on World AIDS Day (2009) by the first citizen of South Africa for everyone to know his/her status. While the minister of health has echoed the same sentiments, in line with the president's, he has gone further to spell out the government's work plan. He has given insights on the government's proposed shift of approach from traditionally voluntary approach to a contemporary opt-out approach envisaged in the HCT. The latter approach offers testing to all patients on admission to all health institutions unless if they opt-out. This approach is more emphatic on testing; it presents testing first and opting-out as a second option. While this approach might arguably infringe on individual's rights to consent, people still have the right to opt-out. If effectively implemented, it is alleged that HCT could increase the number of people taking up HIV tests. Although the target of testing fifteen million people by June 2011, has been spelt out to be ambitious (Heywood in Motsoaledi 2010:1), it challenges parties involved in HIV testing to work hard. Through the HCT approach, many people are expected to test.

2.2. HIV/AIDS in the Workplace: Workplace Peer Educators' Primary Domain

Eighteen to twenty per cent of South Africa's more than five million HIV-positive individuals are formally employed (Rothberg and Huyssteen 2008:335). As such Gorska (2008:317) notes that HIV/AIDS epidemic continues to affect South African companies. It has adverse effects in the workplace and beyond as Sprague and Dickinson (2008: iii) assert that while employees discharge their duties at work, "they live, have sex, raise children, are ill and die elsewhere". Premature illness and death mean, on one hand, low productivity due to absenteeism from work, low morale emanating from being stigmatized and discriminated and financial cost on medical expenses. UNAIDS (2003:1) asserts that in East Africa business has shown that HIV/AIDS related absenteeism account for as much as 25 to 54 per cent of company costs. Deaths of workers mean loss of skilled labour force and craftsmanship, loss of organizational memory, financial cost for funeral expenses and replacement cost. Furthermore, UNAIDS (ibid) observed from a study in countries in the global South and estimates the combined impact of AIDS related absenteeism, productivity decline, health care expenditures, and recruitment and training expenses to cut profits by 6 to 8 per cent at any given time. It is further alluded that nine per cent of companies in South African countries have suffered negative impact due to HIV and AIDS (UNAIDS 2003:1).

Companies have realized that HIV/AIDS invariably affects workers and ultimately company performance and have become interested in managing HIV/AIDS in the workplace by providing testing and treatment possibilities for employees (Gorska : ibid). While Trade Unions support workplace HIV/AIDS programmes, just like managers, they are biased towards outsourced HIV management services than to in-house service providers as they argue that despite being

expensive, outsourced organisations preserve confidentiality and render quality services as they are specialist.

The employment relationship between a worker and an employer is guided by an employment contract. The nature of the employment contract can have implications on how either part behaves in relation to HIV/AIDS programmes. This is particularly so to contract workers who are vulnerable to precarious employment. Coates et al (2007:6) warns that "there is need to develop legal and policy remedies for individuals employed under contract or casual labour so that they can benefit from company testing, treatment and prevention programmes". This comes in light of precarious work, defined by Kalleberg (2008:1) as "employment that is uncertain, unpredictable and risky from the point of view of the worker", that contract workers are subjected to. It is the precarious nature of contract workers' employment that makes some companies to provide substandard health services. Exploring effects of HIV/AIDS in the workplace, understanding the preference of outsourced HIV/AIDS management services by management and trade unions and the nature of employment contracts in relation to accessing HIV testing services, treatment and prevention help to understand the workplace as the primary domain of workplace based peer educators. Having explored HIV/AIDS in the workplace, the domain of peer educators, the next section looks at organised labour and HIV/AIDS.

2.3. Organised Labour and HIV Testing and AIDS

In as much as organized labour has an obligation towards employment conditions of workers, it has an equal obligation on health concerns of workers and this relate even to HIV testing and AIDS related situations. At a national level in South Africa, Craven (2010) asserts that COSATU

(Congress of South African Trade Unions) enthusiastically supported the HIV Counselling and Testing (HCT) (see Section 4.5 of this chapter) programme. This national programme relates to the mobilization of people (workers included) to take up HIV test after it was realized that people were reluctant in taking up HIV test. While COSATU's stance, as the labour mother body in South Africa, of fully supporting the HCT reflects the desire to get labour into national HIV testing programmes and policies with the hope that this will cascade down into the workplace, little has been achieved in workplaces. The assessment done by NALEDI (the National Labour and Economic development Institute) in 2007, as reported in the AIDS Foundation news letter, depicts that "labour was still a long way to go in tackling HIV/AIDS" and "ensuring that all workers are protected by workplace HIV policies." Furthermore the news letter asserts that "majority bargaining councils", councils comprising of employer and worker representatives assigned in deliberating and agreeing on employment issues which become binding, "do not have HIV/AIDS policies or where policies are in place there is poor compliance" and "sectors subject to high casualisation of labour were less likely to have policies in place."

The role of labour in HIV testing and AIDS related issues, in the workplace, is to safe guard the rights of workers according to the dictates of the Code of Good Practice on Key Aspects on HIV/AIDS and Employment of 2000. The Code of Good Practice on Key Aspects on HIV/AIDS and Employment (2000:3) seeks to "set out guidelines for employers and trade unions to implement so as to ensure individuals with HIV infection are not unfairly discriminated against in the workplace." The Code also defines ways of dealing with HIV testing, promoting confidentiality and the legal parameters of disclosure. The Code envisages that HIV testing must be voluntary, with workers having informed consent and entitled to privacy. Informed consent mean that "an employee is provided with full information, understands it and based on this, the

employee agrees to undertake the HIV test", thus according to the Code of Good Practice on Key Aspects on HIV/AIDS and Employment (2000:8). Workers' legal right to privacy means that an employee is not obliged to disclose his/her HIV status and "where an employee chooses to voluntarily disclose his or her HIV status to the employer or other workers, this information may not be disclosed to others without written consent or any confirmation of consent", according to the Code of Good Practice on Key Aspects on HIV/AIDS and Employment (2000:9). While the Code of Good Practice on Key Aspects on HIV/AIDS and Employment broadly spells out the conditions of HIV/AIDS management in the workplace, concern is whether companies abide by the Code or not. Relating to confidentiality, Gorska (2008:317) notes that there is "lack of data confidentiality which prevents workers from using the HIV testing and treatment provided by the employer", such are concerns labour have on company HIV testing and treatment programmes and these breed challenges that peer educators face in getting workers to take up HIV test in workplaces. Having discussed the role of labour in HIV testing and AIDS programmes and the significance of the Code of Good Practice on Key Aspects on HIV/AIDS and Employment (2000), the report will now discuss HIV testing approaches.

2.4. HIV Testing as an Intervention: Approaches and Challenges

Alcorn and Smart (2006:71) assert that HIV testing is the gateway to treatment and De Cock et al (2002:68) concurs by asserting that testing affords the mapping out of treatment and prevention strategies. However it should be realised that while HIV testing is primarily meant for prevention and treatment measures not all testing approaches are meant for that. Mandatory testing is one such approach and will be later discussed in Section 4.1 of this chapter. The entire section on HIV testing as an intervention will discuss five testing approaches namely mandatory,

anonymous, opt-out, opt-in or Voluntary Counselling and Testing (VCT) and HCT. Furthermore, this section will explore possible constraints that are experienced with each testing approach.

2.4.1. Mandatory Testing

According to De Cock et al (2002:69) this is coerced testing approach for reasons of blood, organ or semen donation other than for treatment purposes. Mandatory testing approach is top-down and autocratic much that a person has no choice but is compelled to take an HIV test. The ethical dimension of the testing approach is questionable as it infringes on the human right of choice to test. However they are compelling situations that can influence a compulsory test, for instance insurance policies may require an individual to take a test before enrolling for policies, also on admittance in prison, a prisoner or convict may be required to take an HIV test or in situation where they have to be organ donation.

2.4.2. Anonymous Testing

This is an unlinked surveillance testing approach that can be used to ascertain the workplace epidemiological HIV prevalence rate. It enhances and informs planning for workplace HIV/AIDS programmes. Unlinked blood samples are obtained from all workers for HIV tests after which individuals do not get their results and the results cannot be linked to blood sample donors. Dickinson (2009:53) argues that participation rates are high because results cannot be traced to specific individuals. While this is arguably true, some workers might not have confidence in the approach and its purpose and be tempted to think that there are hidden mechanisms of linking results to persons, Dickinson (ibid). However in as far as planning purposes are concerned, it remains an important approach. Given the short comings of

anonymous testing, the actuarial modeling approach is another substitute. This entails (Dickinson 2009:54) modeling the demographic profile of a company against HIV prevalence surveys and, through inference; the HIV prevalence rate is deduced. It also has its own short comings which include difficulties in deducing the authenticity of the prevalence surveys and obsolesces of survey data on which inferences are premised. This may give a false prevalence. In as much as this can give a contested picture about the real prevalence of the company, if properly managed and administered, it remains an important planning tool in HIV/AIDS programming.

2.4.3. Opt–Out testing approach

This approach is situational based; the situation can be antenatal care programme, employee medical check-ups, workplace wellness programmes or health and safety workplace activities, among other situations. A person is offered a chance to test and has the choice to decline (opt-out). It maybe, arguably, difficult for an employee or antenatal attendee to decline under circumstances that the test has serious implications to either employment or pregnancy, respectively. This means that all pregnant women or employees unless they specifically decline, will be tested. Before undergoing a test, they should be first counselled, given information about HIV/AIDS and the purpose of the test and then tested. Simpson (1999:17) argues that this approach is only effective if treatment will be availed to those who test positive. People are bound to question the rationale for encouraging testing if no treatment will be availed. Furthermore, Simpson (ibid) argues that eighty-five to ninety-five per cent of women who are offered such a test agree to take up the test. As for workers, there can be fear resulting from suspected loss of job should the person opt-out from testing. However the opt-out approach has been fraught with criticism. Alcorn and Smart (2006:11) argue that the approach restricts the

voluntariness of the exercise as it subtly, "coerces" people to undergo a test. Furthermore Alcorn fears that people may be subjected to less counseling which will have an effect on how they respond to test results.

2.4.4. Opt-in or Voluntary Counselling and Testing (VCT)

Opt-in is the direct opposite of the opt-out approach and is premised on VCT tenets although it is housed under a specialised functional area e.g. antenatal clinic services or family planning or hospital, workplace health programmes. In this scenario, unlike in the opt-out approach, a person is advised, over and above a specialised service one requires, of the availability of testing services and can consent to it (opt-in for the test). This approach has been argued, as recorded in the Morbidity and Mortality Weekly Report (MMWR) (2002:13), to be less effective than the opt-out as there is a "loose" degree of voluntarism. Although voluntarism is central in HIV testing (Jackson 2002:179) unrestricted voluntarism may arguably result in low test uptake. For reasons of fear to knowing results or perceiving the test not important, this may breed reluctance in testing, MMWR (ibid). Having referred to voluntary testing, the following paragraph will discuss on Voluntary Counselling and Testing in Uganda.

Moodie et al (1993:543) and Jackson (2002:190) note that after realizing the importance of HIV testing in preventing the spread of HIV, Uganda was the first country in Sub-Saharan Africa to roll out VCT programmes to its citizens. VCT requires people to willingly take up HIV testing. This testing method is in line with the WHO's health ethics (ILO 2001:7) and is cognisant of human rights of informed consent to HIV testing (Jackson 2002:179). Under VCT people are encouraged to consider testing, as this enables them to know their status early enough. This is important, as Moodie et al (1993:652) observe that, should one be found to be HIV positive, this

allows early diagnosis which enables effective treatment, care and reduces the risk of onward transmission and re-infection. This is premised on the assumption that once individuals know that they are HIV positive status, they are likely to be precautious and responsible enough not to infect others. However this approach (VCT), in a South African perspective, has not been effective enough and as such it is being overtaken by HCT approach as South Africa continue its fight against HIV/AIDS (Heywood in Motsoaledi 2010:1).

2.4.5. HIV Counselling and Testing (HCT)

This is a new approach to HIV testing adopted by the government of South Africa. It marks a shift from VCT to HCT and the difference between the two approaches is premised on the focus of emphasis. HCT emphasizes on getting people tested, typical of a bio-medical approach. It seeks to enroll huge numbers of people to take up HIV tests at the possible neglect of procedural and ethical considerations emphasised in the voluntarism of the VCT, typical of the sociological approach. In South Africa, HCT is targeting to get fifteen million people to take up HIV test by June 2011 (Heywood in Motsoaledi 2010:1). From the fifteen million, business has pledged to mobilise two million by December 2011 (Heynike 2010:1). Heywood hails the project the world over for its endeavour to have high HIV test uptake (Mears in Heynike 2010: ii). HCT has four objectives, reproduced as, namely, to increase health seeking behavior; to encourage South Africans to know their HIV status; to equip those who test HIV negative with ways of ensuring that they do not contract HIV and to create a quick and easy entry point to accessing wellness and treatment for those who test positive (Motsoaledi 2010). In this campaign everyone who attends a clinic or hospital will be offered an HIV test, regardless of whether they have symptoms of the disease or not (Motsoaledi ibid). However patients have an option to decline

(opt-out) taking up the test. To this end, HCT shares parameters with the opt-out approach; it is an opt-out approach which emphasises testing through its proactive initiation of testing to everyone attending health institutions. Companies have also been encouraged to advance HCT programmes through developing comprehensive HCT plans and testing strategies, thus according to Heynike (2010:1)

The advent of HCT has raised questions among social comentators, human resources and medical practitioners. In the face of workplace peer educators and their contribution in getting people to take up HIV test, HCT has been riddled with questions, *inter alia*, is there any practical difference between VCT and HCT beyond the guiding principles of these two approaches? What are experienced realities of HCT and how does that impact on peer educators' workload of getting people tested? Are industrial health institutions complying with HCT requirements? These are questions that can be addressed in other researches, since this study is interested in understanding challenges encountered by peer educators in mobilizing workers to test, the next section will discuss the role of peer educators in HIV testing.

2.5. Peer Education and HIV Testing: Defining Peer Educators' Roles

UNAIDS (1999:1) define peer education as involving the use of individuals or group of persons who volunteer or are elected to effect change among other members of the same group. Peer educators are named after the location they operate from and hence they are workplace educators, community peer educators and church peer educators. However peer educators overlap their location of operation as they discharge their duties from workplaces, churches, communities, across different spaces as long as it is within the same field. At workplaces, peer educators interact vertically with either other employees of authority or them (peer educators)

being of authority and horizontally with members of staff that they are in the same level in HIV prevention and treatment company programmes.

Peer education enlightens workers on HIV/AIDS realities and intervention strategies. Peer educators' duties are as envisaged by Dickinson (2009:76-85) who highlight that it involves both formal and informal talks with co-workers either in group settings or as individuals; their duties are not restricted to the workplace, instead they trickle out to the community (Dickinson 2009). They spearhead workplace HIV/AIDS activities that include among others, visiting child care centers and other organizational social activities on HIV/AIDS including AIDS wellness campaigns. They are also responsible for distributing HIV/AIDS literature as part of Information Education & Communication (I.E.C) programming, they act as distribution outlet of HIV/AIDS related supplies e.g. condoms, literature, regalia, among other products and they spear head community HIV/AIDS programmes. They also encourage people to take-up HIV tests as the basis for intervention measures. Peer educators dialogue with peers, spelling out the significance of testing. However keen research interest is embedded on how they dialogue, what negotiation skills are a prerequisite and what challenges they face? Having defined the role of peer educators in HIV testing, it is equally important to discuss the effects of culture to health in general and HIV testing in particular as peer educators and workers hail from different cultures, the next section will discuss culture, health and HIV testing.

2.6. Culture, Health and HIV Testing

Culture has been defined by Jezewski (1990) as "as a system of learned and shared codes or standards for perceiving, interpreting and interacting with others and with the environment". In every day talk culture is 'generally' regarded as a way of life. Because of lack of a universal

definition, culture is a contested concept with no singular and absolute definition, note Gilbert et al (2010:76). As such culture is complex and has been defined in various ways and assumes a fluidal state. Such terms as norms, values, religion, beliefs, tradition, customs crop up when attempting to exhaustively define culture. However despite many attempts to define culture and yet no single agreed-upon definition (Gilbert et al, ibid), key underpinning tenets of culture, universally agreed by sociologist are noted hereunder. Gilbert et al (ibid: 77) outlines these tenets as, culture is socially learnt and constructed, it is linked to identity, culture shapes human behaviour and is linked to tradition; customs and beliefs, culture is dynamic; it varies from community to community and with time, culture is a relative concept, culture is group based and defines what is acceptable in a particular community. Furthermore, broader exogenous economic, social, political, technological, historical and environmental factors shape up prevailing cultural practices in a given setting. Because culture affects and determines how society perceives issues, it even has an effect on how society conceptualise health, disease and their treatment. Mc Elroy and Jezewski (2000:191) assert that culture is an integral component in defining and achieving a state of health, maintaining health and treating illness.

Rubel and Garro in McElroy and Jezewski (2000:200) coined the 'health culture' concept from which they assert that, "sick people use it to interpret symptoms, give them meaning, assign them severity, organize them into a named syndrome, decide with whom to consult and for how long to remain on treatment". Symptoms of diseases are discussed and interpreted with people around the sick person i.e. relatives, family members and compatriots, peers (workmates) based on lay knowledge. The course of action to be taken, in the same vein, will be decided by and with significant influence of people or peers around a person who is sick, seeking medical attention, seeking to test for HIV or being mobilized to take an HIV test. These people are part of social

systems which, McElroy and Jezewski (ibid), assert as transmitters of information about the meaning and significance of health, sickness, care, prevention and treatment. To this end, it is evident that culture influences how people conceptualise their lives, well-being, health, diseases and illness and different routes towards prevention, treatment and HIV testing is not an exception. Culture influences how people conceptualise HIV/AIDS and this has implications on HIV test uptake.

In cultures where there are strong beliefs on witchcraft or where the practice is prevalent, people may believe and associate illness with witchcraft. Anyone who falls sick is perceived to have been bewitched. In such a situation, 'relevant' bio-medical health care may not be timeously sought but instead witch doctors, traditional and spiritual healers will be consulted. This does not mean to discredit traditional and spiritual healers as such an act will be short sighted particularly in the face of health pluralism. However some illnesses may genuinely require bio-medical attention e.g. a disease may require specialised diagnosis, surgery or immunization, for example HIV testing and this is best dealt with when employing scientific approach which must be complemented with the social approach to health.

Some cultural practices have endangered the lives of people, making them susceptible to contracting diseases or delay health seeking or cause absolute refrain from seeking treatment and care. In the era of HIV/AIDS, cultural practices, such as polygamy, widow inheritance, genital mutilation, girl pledging (see Barnett and Whiteside 2002, and Hellen 2004), *boswagadi* (see Section 5.3.4 of Chapter Four) common in Sub Saharan Africa are among cultural beliefs that influence people's perception about HIV testing and AIDS. To this end, Dilger in Taylor (2006:970) rightly asserts that "health interventions fail to meet their goal when they fail to consider culture's impact on health related behaviour." Because culture is diverse, this influences

people's diverse health behaviour which gives birth to health care pluralism discussed in the next section.

2.7. Medical and Health-Care Pluralism: A Remedy to the Impacts of Culture on Health

Gilbert et al (2010) define medical and health care pluralism as "the co-existence and availability of different ways of perceiving, explaining and treating illness". Cant and Sharma (1999) concur with the above definition as they note that the concept of pluralism signals multiplicity. The key players of the universal and plural health care discourse are bio-medical practitioners and traditional health practitioners. In a South African context, Peltzer and Mngqundaniso in Gilbert et al (2010) classify either as traditional doctors (Inyanga or herbalist), isangoma in Zulu (diviners, usually women who are spirit mediums) or faith healers: these integrate Christian and Traditional practices and command their practice through the spirit and hence they are sometimes referred to as spiritual healers. It is of significance to point out that health care pluralism is functional in South Africa with, on one hand, bio-medicine reflected by hospitals, clinics and medical schools, HIV testing centers, which Helman (2001) identifies as institutional structures of scientific medicine. On the other hand, the functionality of traditional health practice is substantiated by the fact that almost 80% of South Africans rely on traditional medicine (see Gilbert et al 2010, Sodi 1996, Pretorius, Peltzer and Mngqundaniso in Gilbert et al (ibid) and Bannerman et al in Airhihenbuwa 1995) in which health related cultural beliefs are embedded. The fact that 80% of South Africans rely on traditional medicine informs the high level to which culture impacts on health and the extent to which traditional medicine is deemed effective and accessible. To this end, HIV testing must be cognisant of various cultural beliefs which call for a plural health care system. This helps confront diverse cultural challenges faced

in HIV testing. In as much as health care pluralism must be adopted in managing HIV/AIDS related illnesses, particularly in the face of there being no cure for the disease and the fact that the diseases is mostly spread through sexual intercourse, it is important to tackle the effects of stigma and discrimination associated with HIV/AIDS. It is therefore important to discuss HIV/AIDS related stigma and discrimination. As such, the next section looks at the literature on stigma and discrimination in the face of HIV/AIDS and its possible effect to the uptake of HIV test.

2.8. Stigma and Discrimination in the face of HIV/AIDS

HIV/AIDS is the most stigmatized medical condition in the world, argues Simbayi *et al* (2007). This is partly attributed to a notion that "people infected with HIV are often blamed for their condition and many people believe HIV could be avoided if individuals made better moral decisions" (Gilbert and Walkers 2010: 140). Stigma is defined by Scambler (2009:141) as "a social process experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgement about a person or group". Scambler's definition is substantiated by Goffman (1963) who describes stigma as "an attribute that is deeply discrediting within a particular social interaction". In analysing Goffman's description of stigma, Gilbert and Walker (ibid) note that "stigma focuses on the public's attitude towards a person who possesses an attribute that falls short of societal expectations". The concept of stigma has long existed and remains significant in the context of HIV/AIDS in South Africa (Gilbert and Walker 2010). Stigma leads to discrimination which is also a social construction of treating unfairly. Walker *et al* (2004) observe the effects of discrimination as possibly leading to "loss of employment and housing,

estrangement from family and society, increased risk of physical violence and even murder". Furthermore, it is pointed out that HIV/AIDS related stigma can deter people from testing as observed by Gilbert and Walker (2010:139). While a body of literature on HIV/AIDS related stigma and discrimination has been built by, among other scholars, Gilbert and Walker (2010), Scambler (2009), Goffman (1963), Walker *et al* (2004), Simbayi et al (2007), Parker and Aggleton (2003) Green 91995) Delius and Glaser (2005), Reid and Walker (2003), Goldin (1994), there is need to explore the extent to which of stigma and discrimination deter workers from taking up HIV test in workplace test centers. I was in the interest of the research to investigate how stigma and discrimination frustrate peer educators' effort in mobilizing workers to test for HIV in workplaces. However before getting to findings on the effects of stigma and discrimination in HIV test uptake, as unfolded in the research, it is important to understand theories of behavioural change in the context of HIV testing as this explores socio-behavioural interactions between peer educators and workers, behaviour change theories are discussed in the next section.

2.9. Theories of behaviour Change and HIV Testing: Locating Challenges

Because peer education is a behavioural change preventive and treatment intervention strategy as it seeks to foster preventive and treatment uptake behaviour, for it to be fully conceptualized, one has to understand behavioural theories which explain and predict human behaviour. Theories to be discussed in this submission include the Social Learning Theory; Reasoned Action Theory; Stages of Change and AIDS Risk Reduction Model. These will be explored and verification on how they determine behavior change in line with HIV testing and limitations of these theories will be discussed too.

2.9.1. Social Learning theory and HIV Testing

This theory was developed by Bandura A (1963), it asserts that people learn by observing the behaviour of others who serve as role models who influence behaviour change in individuals. With this in mind, peer educators and other employees of authority are role models and have the potential to determine work mates' attitudes towards HIV testing. For example, a peer educator or manager who takes the lead and goes for HIV/AIDS test first before encouraging others to do the same are more influential than peer educators who do not lead by example. To this end, co-workers can observe peer educators and managers' behaviour and learn from them. However not all peer educators or employees of authority are good role models, from such personnel workers are bound to learn negative attributes that would have been observed. Workers can also learn some attributes through observing members of the society; as such social learning is a complex phenomenon.

2.9.2. Reasoned Action Theory and HIV Testing

This theory is modeled on the belief that a person's perception, norms, beliefs and intentions influence an individual's behaviour. It is premised on the notion that human beings are reasoning i.e. they rationalize all their actions based on their beliefs, attitudes and intentions which ultimately define their actions (Fishbein and Ajzen's 1980, Fishbein et al 1989 and Fishbein et al 1994 cited in The Family Health International Report (FHI Report) 2004:10&11). It is therefore incumbent upon workplace peer educators to help people to rationalize on the importance of HIV testing to an extent of changing the general negative attitude and belief of employees who are reluctant to test. This will motivate their behaviour towards HIV testing. However the theory is critiqued for focusing much on individuals (FHI, 2004:11) ignoring external socio-cultural,

religious and economic factors that also have an impact on individuals' notions, attitude, beliefs on HIV testing, and this ultimately model a person's behaviour.

2.9.3. Stages of Change Theory and HIV Testing

To view the social interactions that ensue between peer educators and workers intending to take up HIV test as an event will be short-sighted as this is a process and hence the relevance of the stages of change theory in understanding the likely behaviour change movements in the interaction process . The stages of change theory outline, basically, four stages i.e. pre-contemplation, contemplation, action and maintenance. These stages will be explained in line with social interaction and HIV testing. During the pre-contemplation stage there is a problem of abstinence from testing a workers is not aware of that. At the contemplation stage, a worker receives information, there is informed consciousness about HIV/AIDS and serious ponder about HIV testing. It is this ponder that will determine the course of action to be taken. On one hand, if one chooses to be tested the results will effect behaviour change in terms of positive living, whether one test negative or positive. This behaviour will have to be maintained. On the other hand, should one decide not to test; one may decide to maintain that behaviour which might be changed latter. The stages of change, in the context of HIV testing, are embedded within the social interaction of the peer educator and a person intended to take up HIV test. However this theory has a lot of generalization and assumes that human behaviour is predictable and can be easily interpreted and understood in a linear, straight forward way.

2.9.4. AIDS Risk Reduction Model (ARRM) and HIV Testing

This theory seeks to understand individual behaviour in light of HIV/AIDS transmission. Individuals recognize that they are susceptible to contracting the deadly HIV and will rationalize on the costs and benefits of certain behaviour which define the level of risk towards HIV infection. This will motivate actions that reduce chances of contracting HIV (Catania, Kegeles and Coates 1990 cited in The FHI Report 2004:5). Central to this theory is the need to reduce the risk of an individual contracting HIV. Workplace peer educators may adopt this theory in explaining the need to test such that if one is HIV negative then that will motivate risk reducing behaviour. This theory has also been criticized, particularly by the married, for being individualistic. "Women in an ARRM-based study in Kampala, Uganda, felt at risk for HIV, not due to their own behaviour but because of the bahaviour of their sexual partners" (McGrath et al 1993:438). In the social interaction of peer educators and people, this theory will be more relevant in explaining the after test benefits of risk reducing behaviour of knowing results particularly if one is negative.

2.10. Social Interactionism: A Theoretical and Conceptual Framework

The relationship between workplace peer educators and people intended to take up HIV tests is conceptualized as a social interaction. This is premised on the hypothesis that effective social interaction between peer educators and workers results in increased HIV test uptake and thus promoting informed and timely intervention. As such the social interactionist model was adopted as the theoretical framework on which the research is premised. Haralambos and Holborn (2008:881) regard social interactionism as a small-scale approach in explaining the meaning of social actions individuals take. Social interaction is a face-to-face process consisting of actions,

reactions and mutual adaptation between two or more individuals. Goffman, cited in Woods (1983:5) explores the importance of social interaction as being to communicate with others. Furthermore Woods notes the importance of control during the interaction, where one tries to control other's behaviour in order to attain the information, influence attitudes, values, culture, beliefs, control perception and action of an individual. This is substantiated by Woods' (1983:1) notion that people are constructors of their actions and meanings through symbols. A symbol is defined by Ross in Woods (ibid) as "a stimulus that has a learned meaning and value for people". Furthermore Ross (ibid) affirms that an individual's response to a symbol is dependent on the meaning and value derived from the symbol (constructed meaning) which ultimately determines the course of action of an individual. The impact of challenges peer educators face in getting workers to test for HIV is experience during the interaction stage of the process. It is for the reason that interaction is vital in negotiating with co-workers that a social interaction has been adopted as the theoretical framework. Communication, negotiation and education in social interaction have implications to the uptake of HIV testing.

2.10.1. Communication and Negotiation in the social interaction theory

The social interaction theory assets that roles of social actors, generally, lack clarity because they are complex to conceptualise to an extent that there is need for continued negotiation and creative action. As such action emanates from negotiated meaning construed from ongoing interaction (Haralambos and Holborn 2008; 13) and this depends on the subject matter and the situation. In this research therefore, workplace peer educators and individuals expected to take HIV tests are social actors involved in a face-to-face social interaction embedded in systematic negotiations and role play that seeks to convince people to take HIV tests. The importance of

communication and negotiation skills is realised when it comes to relaying HIV/AIDS information, mobilization of peers and disclosure of one's HIV status to spouse, relatives and compatriots. Shisana et al (2005) as cited in Gilbert and Walker (2010:141) assert that "public health policy outlines disclosure for HIV persons and advocates campaigns for 'coming out in the public". To this end, IEC, peer mobilization and disclosure ("coming out in public") are important components of communication and negotiation in getting workers to test for HIV.

It should be noted that the entire social interaction between peer educators and workers intended to take HIV test also regards education as a means of communication. Education is central in the interaction of peer educators and workers and hence it will be explored, in tandem with the theoretical concept adopted, in the next section.

2.10.2. Communication and Education in Social Interaction: Implications to HIV Testing

Education is the general acquisition of knowledge. Freire (1978:187 & 196) critiques the orthodoxy education practice that seeks to dominate the student through portraying students as docile, ignorant and unknowledgeable parties much to an extent of passively anticipating in a narrative top-down deposition of knowledge from teachers and students having to simply memorise and regurgitate the knowledge without being improved by it. In this instance orthodox education is critiqued for being non-participatory. Instead Freire (ibid) advocates that education must be a practice of freedom in which students and teachers are regarded as equal partners, critical co-investigators into life issues and learn from each other through engaging in a learning dialogue. According to Freire (1978:192), participatory education instigates authentic thinking, "thinking that is concerned about reality" and "problem-posing education makes them (students) critical thinkers" and "stimulates true reflection and action upon reality" (Freire 1978:192 &

198). It is in the context of non-domination, participatory, problem-solving, co-investigative education practices that workplace peer educators can effectively engage workers in HIV testing education much to an extent that this will have an influence on them to consider HIV testing. Simulations and role plays can be employed to empower workers with investigative and problem solving thinking capacity in HIV testing in workplaces. Participatory education is important in mobilising workers to take up HIV test and hence the next section will look at the principle of participatory education in HIV testing.

2.11. Principles of Participatory Education in HIV Testing

Participatory education resonates on the idea that learning is more effective when learners participate in the process of learning. This can be through dialogue, discussions or working on group or individual assignments. While Wallerstein (1988) notes collectivity in problem solving, that through dialogue the affected community plans and implements a response to the problem or health condition in question, this is slightly different with a worker making a decision to test for HIV. Peer educators and workmates influence the worker in the decision making process but the final decision to test or not lies with the individual worker. Through participatory dialogue, an individual can be part of the response or solution to the problem. Through Freire's (1978) submission on the importance of the theory of participatory education, it can be realised that this has implications in the development of effective peer education. The orthodoxy education perspective asserts that the peer educator assumes a teaching role, facilitating education programmes for people who intend to test and this top-down approach is the one that Freire critics. It is important to draw important aspects of Wenger's (1998) Communities of practice theory which can be blended with peer education and HIV testing. This theory puts participatory

education in “groups of people who share a concern or passion for something. They do and learn how to do it better as they interact regularly”. As such participatory learning is more effective in a community of individuals with common interests, for instance employees being mobilized to test for HIV in the workplace community.

Since individual theories have setbacks, it is crucial to blend, among others, the social learning theory, reasoned action theory, stages of change theory and the AIDS Risk Reduction theory for a better approach in understanding workers’ complex behaviour. These theories must be blended with models of education and communication and this helps explore how peer educators mobilize workers to test for HIV in workplaces. The next section depicts HIV testing stages through a flowchart.

2.12. Conceptualising HIV Testing Stages: Flow Chart Depiction

Figure One is a flow chart depiction of peer educators’ social interactional and educational roles in HIV testing stages. While the flowchart depicts stages that peer educators take colleagues through in the testing process, of importance is to locate and understand roles peer educators play and mechanisms that enhance social interaction much to an extent that co-workers decide to take up HIV test. Boxes labeled A, B and C (in the flowchart) represents social interaction processes between two parties, peer educators and peers, in the testing process. Boxes labeled D, E and F depict social interaction processes among peer educators, counsellors and peers and boxes labeled E and F dealing with post test social interactions. All the labeled boxes (A, B, C, D and F) keep people asking the underlining question, “what social interactions ensue in the box and how does the interaction link to HIV testing?” These social interactions are premised on different education approaches which can be participatory, orthodoxy’s top-down, teacher-student model.

Furthermore, understanding relationships and interactions between and or among peer educators, workers and counsellors in the boxes labeled (A, B, C, D, E and F) help explore mechanisms that can frustrate efforts to get people take up HIV test.

There is limited knowledge on what happens in the black box, it represents areas where peer educators have no power over. For instance peer educators have limited power over what happens in the testing room unless if a peer educator is required to accompany a peer into the testing cubicle, then the peer educator will have a role to play. For an individual to be tested, one should get counselling first. Coleman (2009:26) outlines what individuals should be told during counselling. In the pre-test counselling, counselling before the test, individuals should be told about the reason for the test, how the test works and what results mean. In the post-test counselling, counselling after the test, individuals should be told about results (HIV negative or HIV positive), the meaning of the results, the window period (period when a virus is not detectable in the body, approximated to be around three months) and who one can speak to depending on the results, all this takes place in the black box.

Once a person is tested and walks out of the testing cubicle, peer educator's roles resume. The roles are two-fold depending on the test results. On the one hand, should a person test negative the peer educator will help impart prevention measures on means of maintaining a negative status. On the other hand, should an individual test positive, peer educators have to enforce positive living strategies which will include use of condoms to avoid reinfection, healthy diet and timeously enrolment for antiretroviral therapy. In as much as it is important to understand the roles of peer educators after a worker has taken an HIV test, this research is interested in knowing how peer educators get workers to test for HIV and the challenges they face. Basically, social interaction between and among peer educators and workers is at the centre of HIV testing.

Conceptualisation of P E's Social Interaction Role in the HIV Testing Process

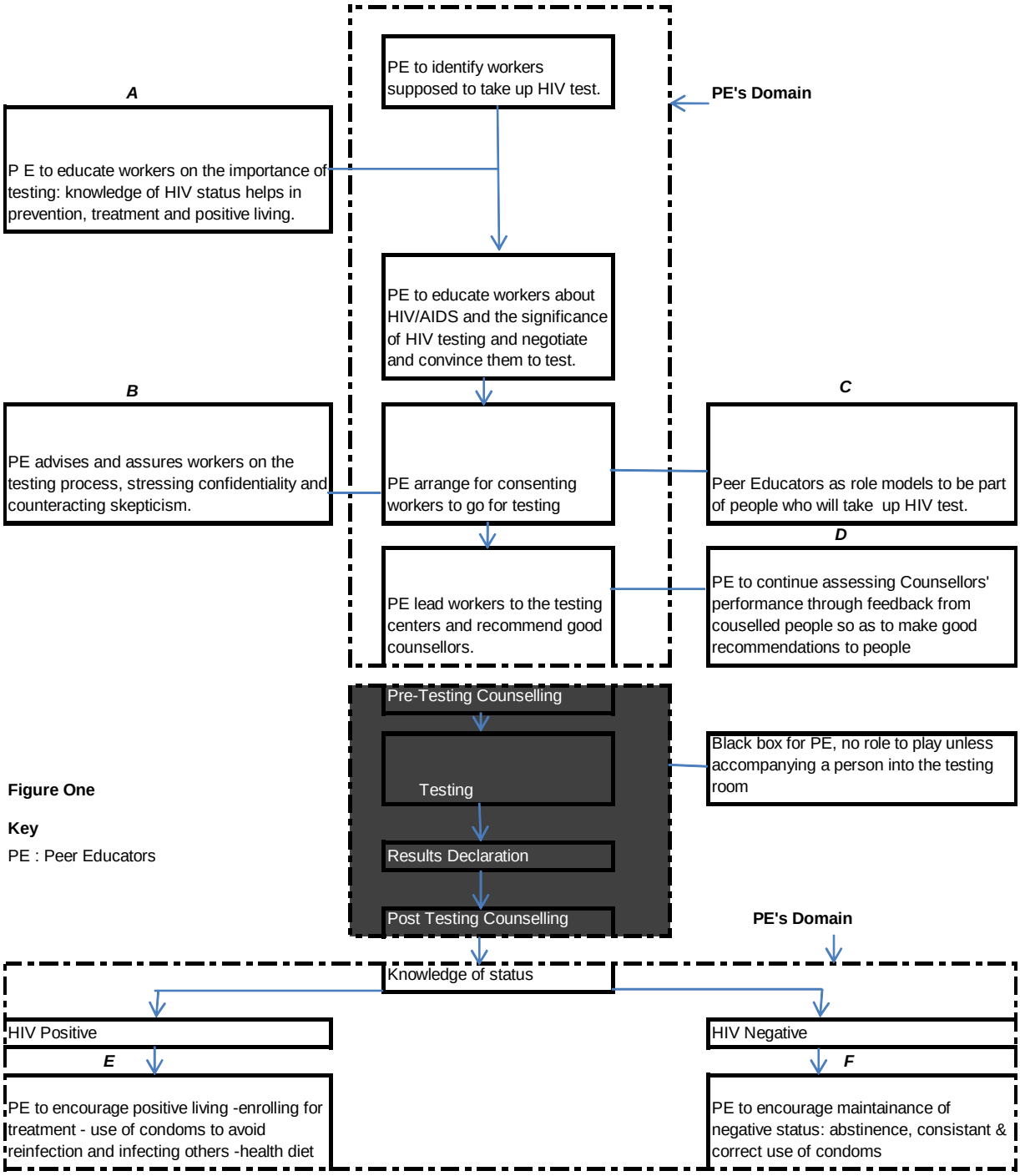


Figure One

Key

PE : Peer Educators

***NB**: This flowchart has been developed inorder to conceptualise stages in PE's social interaction role with individuals intending to take up HIV test.*

2.13. Conclusion

Having gathered literature on HIV/AIDS in South Africa, the impacts of the pandemic in the world of work, the HIV testing discourse, it was equally important to discuss issues on peer education and theories of behaviour change. There is an appreciation of the significance of the social interaction processes in getting people to take up HIV test. Social interactionism has been adopted as the theoretical framework of the study. Peer educators are therefore key players in getting people take up HIV testing which is the basis for treatment and prevention measures. In as much as the government of South Africa envisages a new approach, HCT, to testing, peer educators still have an obligation of mobilising people not to opt-out of the new approach to test. However as peer educators execute their duties, it is anticipated that their duties are fraught with obstacles and hence the need to explore and understand challenges they face. The literature, envisaged in this chapter acknowledges that there are challenges faced in mobilizing people to take up HIV test. However there is a deficit on practical research and submissions on challenges faced by workplace peer educators in mobilizing workers to take up HIV test. It is the interest of this study to use peer educators to identify challenges they face in getting workers to test for HIV. In the interest of finding out the challenges peer educators face in mobilizing workers to test, it is important to discuss how the research was conducted and as such the next chapter explains the entire data collection and analysis process.

CHAPTER THREE

Research Methodology

3. Introduction

This chapter discusses the research methods used in gathering data from the study population in order to address the following three research questions: How do workplace peer educators get people to take up HIV test? What challenges peer educators face in getting people to take up HIV test? What mitigation mechanisms can be put in place to counter the challenges faced? This chapter will justify the reason for adopting a qualitative approach, for choosing a case study research design, for selecting particular sites ahead of others and for employing interviews, participant observation and document analysis as the data collection instruments. Finally, an explanation will be given on how the gathered data was analysed.

3.1. Value of Qualitative Research

The study required a qualitative inquiry as peer educators make narrations about their experiences and social interactions they engage in when getting workers to take up HIV test. The reason for employing qualitative research is because it allows in-depth description and understanding of "social action in terms of its specific context rather than attempting to generalize to some theoretical population" given the fact that "the research is conducted in the natural setting of social actors", (Mounton 2001:270) peer educators and workers. Belvedere Consortium's working environment and its HIV testing programme provided the specific context to understand the challenges faced by workplace peer educators in promoting HIV testing.

Furthermore, the qualitative approach allowed the researcher to gain a rich and detailed description of individuals' understandings, perceptions and beliefs of HIV testing. As pointed out by Neuman (2000:126) qualitative research emphasises the human factor and the intimate knowledge of the research setting. The qualitative approach assisted the researcher to understand the life experiences of individuals, peer educators and workers, studied in their own frame of reference. In this study, it was important to understand peer educators' accounts of challenges they face as this will help recommending relevant mitigation measures that counter challenges faced.

3.2. The Case Study

This qualitative study conducted at Belvedere Consortium, a mining company in South Africa's North West province, seeks to explore challenges faced by workplace peer educators in their role of getting workmates to take up HIV test. This is premised on the fact that since peer educators are behaviour change agents involved in getting people to test for HIV as a step towards sexual behavioural change, prevention of infection and accessing treatment, face challenges as they execute their duties. The study employed a case study research approach which is defined by Kitay and Callus (1998:103) as a research design that is used to study one or more selected social phenomena so as to understand or explain the phenomena by placing them in their wider perspective. A case study is used when the researcher is interested in a clearly delineated entity (Mouton (2001:279) which in this case was a mining company. Furthermore, David de Vaus (2001:78) considers "case studies as prime examples of qualitative research which adopt an interpretive approach to data, studies 'things' within their context and considers the subjective meanings that people bring to their situation". The study sought to understand peer educators'

subjective perceptions and notions on the challenges they face in getting workmates tested for HIV using a case study approach.

3.3. Selection of the Research Case Study

The selection of a case study was challenging as many companies declined consent to conduct research in their peer education programmes. They cited an array of reasons, including, that they were busy and that the subject matter under research was sensitive. Possibly they might have misconstrued that the research was going to expose their peer education programme in a negative light despite assurance that the name of the company was going to be disguised in the research report. In fact, central to the objective of the study was to understand challenges experienced by peer educators so that practical and relevant interventions could be recommended. However because of the difficulty experience in getting access, the researcher was limited to Belvedere Consortium, the only company which consented that the study be conducted.

Belvedere Consortium is a large mining company found in the North West province of South Africa which extracts and process chrome. Its primary business activity is the production of ferrochrome. Belvedere Consortium has a population of 13 799, of which 8 371 are permanent employees while 5 428 are contract workers in its 15 plants, as of the 2009 statistics (see Section 2 of Chapter 4). This company rolled out an HIV testing programme for its employees housed under its wellness programme (see Section1, 1.2 and 1.3 of Chapter Four). However, despite Belvedere Consortium having an uptake rate of 82% which is a relatively successful record, the company was deemed suitable as a case study on the basis that, after a preliminary discussion with the wellness coordinator, the company provided detailed information to research questions which were central in determining the case study company especially considering that there was

a three phased historical account of the HIV testing programme, all depicting various challenges confronted by, among others, peer educators. Also, the wellness coordinator was making frantic efforts to attain a 100% cumulative uptake rate per year for both permanent and contract workers who would have worked for the company for at least three months to meet the company target as envisaged in the HIV/AIDS policy of 2007. Permanent employees have open employment contracts which allow them to work for the company up to retirement age, with all employment factors being constant. However contract employees have limited "short-term" employment contract which specifies when the contract will come to an end. The company HIV testing programme subjects all employees under the same HIV testing conditions, regardless of their employment status, as indicated by interviewed peer educators.

As such challenges noted from this research account for the discrepancy between 82% and an "absolute uptake" rate of 100%. Furthermore experiences and events at Belvedere Consortium provided a rich research study since the company's workplace peer educators had faced challenges in getting co-workers take up HIV test in the initial HIV testing programmes and this led the company to come up with mitigation measures so as to address setbacks faced. The history of the HIV programme at Belvedere Consortium, helped to understand the challenges faced by peer educators. The researcher was able to make an evaluation of the effectiveness of mitigation measures and consider current challenges being faced by peer educators. By considering the past and present events at Belvedere Consortium, the researcher was able to talk about testing challenges and effectiveness of current mitigation measures as experienced in one company and further recommend other mitigation measures.

3.4. Selection of Research Sites

The researcher sampled two plants, “High Glen” and “Montrose”, pseudonyms for two plants which were research sites, out of fifteen plants that make up Belvedere Consortium primarily on the basis of proximity and accessibility. However after having a preliminary discussion with the wellness coordinator, it was discovered that the two sites were heterogeneous on the basis of employees’ response to different company HIV programmes (discussed in Section 1 of Chapter Four) and this helped bring varied findings. While some findings were confirmed at both sites, in some instances they were varied findings and this helped in understanding dynamics of HIV testing challenges faced by peer educators. Furthermore, as envisaged by Molefe (2010), the highest HIV prevalence rates at Belvedere Consortium locations, ranging from 12-15 percent as of 2007, were found at plants around the major city in the North West province where the two selected research sites (High Glen and Montrose plants) are located. Ideally the research would have gathered data from all plants to reflect varying testing challenges faced by peer educators at Belvedere Consortium, but due to financial and time constraints the researcher was restricted to two out of fifteen plants. This means that caution must be exercised in relating findings to other plants, peer education programmes, companies and industrial sectors.

3.4.1. High Glen and Montrose Plants

The major functions of the two plants are smelting chrome. These plants were selected primarily on the basis of their proximity to a major city in the North West province which assured easy accessibility. However, in the preliminary discussions with the wellness coordinator, High Glen plant was reported, as having been more resistant to the management unilateral wellness programme of 2007 (discussed in Section 1.2 of Chapter Four) to the extent of embarking on an

industrial action (strike) which resulted in some workers being dismissed as the strike was not protected. This attracted the researcher's interest. The statistical information of the two plants is discussed in Section 2 of Chapter Four.

3.5. Data Collection Instruments

The researcher employed three data collection instruments, namely, in-depth interviews, observation and document analysis. In-depth interviews were conducted with peer educators, wellness officers, testing nurses and the wellness coordinator while participant observation was done among peers as they were queuing to be tested and document analysis of programme, policies provided literature on the company's HIV testing programme (as envisaged in Figure 1). The use of multiple data collection instruments allowed the researcher to better understand problems and issues from several angles (Mouton 2001:125). As Webb et al in Bryman (1988:131) states, social scientist are more likely to be confident in their findings when these are derived from more than one method of investigation, as such, it was deemed beneficiary to use multiple data collection instruments. In the study, the researcher got to understand challenges faced by peer educators from the workplace peer educators side, wellness officers, the coordinator's and the service providers' perspective through the use of interviews, observation and document analysis.

3.5.1. Semi-structured In-depth Interviews

Semi-structured in-depth interviews were employed as one of the data collection instruments. The entire in-depth interview process involved "….asking questions, listening, expressing and recording what was said" just as it applies to every interview, Neuman (1997:371). Mouton

(2001:289) notes that in-depth interviews are frequently used methods of data gathering within the qualitative study, it allows open discussions which afford respondents to speak for themselves on the subject of research. The researcher's approach to conducting interviews was guided by the fact that semi-structured interviews start with some defined questioning plan but pursue a more conversational style that may see questions answered in an order more natural to the flow of the conversation and the level of probing to some issues of interest cropping up (O'Leary 2004:164). The openness and conversational nature of interviews was deemed important by the researcher as it allowed interviewees "free talk" and the interviewer leeway for probing on roles of peer educators and challenges faced by peer educators in HIV testing.

Furthermore, Neuman (2000) points that interviews are a "a joint production of a researcher and the respondent…where respondents are active participants whose insights, feelings and cooperation are essential parts of a discussion that reveals subjective meaning". It is the interviewees' subjective understanding of challenges they face in getting peers to test for HIV that was being sought after. Rubin and Rubin in Mouton (2001) bring out an important aspect of qualitative interviews. They assert that qualitative interviewing means that the questioning is redesigned throughout the project. This helped the researcher to add new questions with unfolding findings and thus enhancing the follow-up to key findings of research themes. Since interviews were in-depth and open-ended, interviewees had the liberty to express themselves without confinement and restrictions about how they get people to test for HIV and the subsequent challenges they face.

In this research, semi-structured in-depth interviews were conducted with peer educators, wellness officers, testing nurses and the wellness coordinator. To start with, peer educators, as described in Section 5 of Chapter Two, are members who belong to the group of individuals

(workers) they intend to effect change on through influencing them to take up HIV test. Wellness officers oversee how wellness champions (referred in this report as peer educators) function at a plant level, they are in charge of peer educators and there is one wellness officer per plant. Testing nurses are auxiliary nurses with counselling qualification who report to the registered nurse who will be in charge of the testing at a plant. Nurses are outsourced health practitioner from Aid For AIDS (AFA), an organisation which provides comprehensive HIV/AIDS management solutions for medium to large businesses as well as medical aid schemes. While Gorska (2008:317) notes that trade unionists are suspicious that the commercial relationship between the company and outsourced service provider might compromise confidentiality, trade unionist strongly believe that outsourcing HIV/AIDS management services in the workplace improves workers' perception of confidentiality which might improve uptake of testing to those who were reluctant based on the fear of lack of confidentiality. As such AFA's HIV testing services are outsourced by company of study. AFA is contracted by Belvedere Consortium to conduct HIV test among its employees. Lastly, the wellness coordinator is in charge of the peer education programme in the North West region. Peer educators, wellness officers, nurses and the wellness coordinator are respondents interviewed in the research as reflected in Figure 2.

Figure 2: Categories of Respondents

Respondents	Peer Educators	Wellness Officer	Wellness Coordinator	Nurses
Interviewed	14	2	1	2
Employment Status	Company employees	Company employees	Company employees	Outsourced from AFA (refer to Section 5.1 of Chapter Three)
Duties	-mobilising peers to take up HIV test -IEC programming	-to oversee peer education programme at the plant	-overally in charge of peer education programme of the region	-conducting HIV testing services -conducting wellness programmes

Figure 2 is a tabulation of categories of respondents in the research, it also highlights the actual number of respondents interviewed, their relationship with the company and their respective duties in the HIV testing programme. A total number of nineteen interviews were conducted; fourteen interviews with peer educators, two interviews with wellness officers, two interviews with testing nurses and one interview with the wellness coordinator. It also happened that the researcher made follow-ups and verification of some information with the wellness coordinator through the telephone, telephone interview. At High Glen plant ten interviews were conducted, seven with peer educators out of a total of twenty-nine peer educators giving a sample of 24% of the total population, one with the wellness officer, two with the testing nurses while at Montrose plant eight interviews were conducted, seven with peer educators out of a total of twenty-four peer educators giving a sample of 29% of the total population (see Section 2 of chapter Four), and one with the wellness officer. The interview with the wellness coordinator was conducted at the company regional offices. In all instances a room was provided where the researcher

conducted interviews from except for the interview with the coordinator which was conducted in the coordinator's office.

All interviews were audio recorded which allowed me to preserve raw data for review at a later date as pointed out as an advantage of audio recording interviews (O'Leary 2004:169). While the audio recording captured the entire interview conversation, the researcher was taking notes at the same time to highlight major issues cropping-up and issues that required further probing, this was done with the consent of the interviewee.

3.5.2. Participant Observation

The general goal of participant observation, as envisaged by O'Leary (2004:172), is that of attempting to "preserve a natural setting and to gain cultural empathy by experiencing phenomena and events from the perspective of those observed". The reseracher employed participant observation as one of the data collection instrument by participating in the company testing programmes two times in the same way workers did. While the coordinator, the wellness officer and testing nurses knew of the researcher's participation, the general employee populace was not aware and this made their behaviour to remain natural in their social dialogue as they queued for testing. The researcher was motivated by Bryman's (1988:96) affirmation that "for qualitative researchers, it is only by getting close to their subjects and becoming an insider that they can view the world as a participant in that setting", this helped the researcher to view the world of HIV testing as a participant. This research component was also meant to verify issues such as the racialisation of workplace testing centers, long queues and perception of peers that prolonged time spent by an individual in the testing cubicle means that the person is HIV positive. In the first test the researcher spent forty-five minutes in the queue and fifteen minutes

to go through the testing process while in the second test the researcher spent thirty minutes in the queue and seventeen minutes going through the testing process. By taking up tests, this helped the researcher to understand the testing process.

As a speaker of the Nguni languages, the researcher was able hear peers talking while in the queue and to observe the general mood as peers were going for test. The fact that an observation allows the researcher (observer) to be on the scene, according to Mouton (2001:294), this allows the recording of first hand information from chats, non verbal communication and the behaviour of peers while in the queue. This is also backed by Neuman's (2000:361) assertion that, "the core of social life is communicated through mundane, trivial, everyday minutia", which some researchers might be tempted to ignore. It was therefore valuable to join workers in the queue and be part of the "mundane, trivial and everyday minutia" at the time of waiting to be tested. That offered a more natural environment of "passively" interacting with workers unlike during interviews in which interviewees may be selective of what to say. During these talks there was an atmosphere of joking with some jokes being informative of workers' perception on HIV testing.

During participant observation, the researcher did not write down notes as he anticipated that this was going to increase awareness of surveillance among peers and ultimately disrupt the naturalness of workers 'behaviour. Furthermore, this was meant to confirm already highlighted concerns of racialised testing, long queues and perceptions on duration individuals spend in testing cubicles and it was easy to link what the researcher observed and what had been highlighted during interviews. However, at the earliest opportune time after the test, the researcher wrote notes of what was observed while in the queue and testing cubicle.

3.5.3. Document Analysis

Document analysis is one of the data collection instruments the researcher used in this study on the basis that it provides key background information relating to the company HIV/AIDS. Document analysis provided information that helped the researcher to understand the current health situation at Belvedere Consortium, reasons for the perception of company staff on HIV testing; this was revealed through a historic account of health and HIV/AIDS company realities. According to O'Leary (2004:177), document analysis involves collection, review, interrogation and analysis of various forms of text as a primary source of research data and these documents are pre-produced texts that have not been generated by the researcher. The documents used in the study are the Company HIV/AIDS Policy of 2007 and the company document on the Ned bank Capital Green Mining Awards of 2010.

3.6. Duration of Data Collection

The research was conducted between July and December 2010. During this period the researcher worked closely with the company Wellness Coordinator, in High Glen, with whom a good working relationship has been established as Kitay and Callus (1998:107) observed that in a case study the researcher establishes ongoing relationships with some respondents as they spend prolonged research time together. A maximum of two interviews were conducted on each day, as the researcher was commuting from Johannesburg with at least thirty minutes in between interviews to allow the interviewer to reflect on the interview, to highlight key issues and to plan for the next interview.

3.7. Data Analysis

Analysing the data gathered from the fieldwork was informed and guided by research questions and the nature of data the researcher gathered from interviews, participant observation and document analysis. The researcher used the content thematic analysis approach based on research themes recurring in the study of peers educators and peers' social interaction and barriers to HIV testing. This is substantiated by Neuman (2000:420) who envisages that "qualitative researchers analyse data by organizing it into categories on the basis of themes, concepts or similar issues". Kitay and Callus (1998:108) point out that "the art of a good case study is in being able to follow leads and pick up on interesting issues as they arise", in the same vein, in this study, implications of incentivisation of testing and cultural beliefs (see Section 4.3, 5.2.4 and 5.3.4 of Chapter Four) are issues that forced the researcher to make further inquiry about them despite them not being part of the original research plan.

Interviews were audio recorded, transcribed and complemented with notes taken during interviews and used to identify thematic subjects and issues of the research. The researcher used direct quotations from interviewees to substantiate findings, this is essential, according to Patton (2002:24), for revealing the respondent's depth of emotion, thoughts, perception and experiences of what is happening.

3.8. Access and Ethical Consideration

The researcher sought permission from the company to conduct the research and to have access to the company's plants and permission was granted. The company consent letter was presented to the Witwatersrand University Human Research Ethics Committee (Non Medical) which granted clearance to conduct the research (Protocol number H100 803). According to Ulin

(2002:61) all research activities focusing on human subjects should begin with informed consent of participants. As such written consent from participants was sought before the commencement of every interview. Participation in the research, by respondents, was voluntary. Participants had the right to decline participating; answering certain questions they were not comfortable with or completely withdraw from the interview if they were no longer comfortable continuing.

Rubin (1995), postulates that the researcher's ethical obligation to ensure that research participants come to no emotional, physical, financial or psychological harm because of their participation in the research project, was observed. In this regard the researcher ensured protection of the identities of interviews by using pseudonyms instead of their real names. The researcher also ensured that no form of harm, physical, psychological, financial befall them during the study by conducting interviews in a designated room, using the correct and professional language and meeting all research costs.

3.9. Limitations of the Study

Financial resources and time were major limitations of the study as this restricted the data collection to two most accessible sites out of a possible fifteen sites. More sites would have meant a bigger scope of the research and a more informative discourse that captures different challenges in different plants. However the researcher was able to make the best out of the financial resources allocated by conducting two in-depth interviews per day.

3.10. Conclusion

The chapter on research methodology basically describes the practical process employed in data gathering. This chapter gave a justification of adopting a qualitative approach to research, a case study design and the selection of research sites. It also justified the relevance of semi-structured in-depth interviews, participant observations and document analysis as relevant data collection instruments in the study. Having gathered data, it is important to make sense out of it, to derive meaning and hence this chapter also explains the content thematic analysis approach as used in this study. The methodology chapter is certainly action oriented and this arouses research interests of outcomes of the study and as such the next chapter discusses the findings of the study.

CHAPTER FOUR

Findings and Discussion

4. Introduction

This chapter presents findings from the field research on the research of understanding challenges faced by workplace peer educators in getting workmates to take-up HIV test. The chapter is divided into five broad sections. Section One looks at the background to the HIV testing environment at Belvedere Consortium through exploring the periodic account of HIV testing challenges faced by peer educators during, namely, the time when there was no company HIV testing programme followed by a period of an autocratic management driven HIV testing programme and the period of comprehensive wellness programme. Section Two looks at employment, peer educators and HIV testing statistical information. The third section looks at demographic attributes of fourteen peer educators, from two research sites, who participated in the study. Section Four examines ways peer educators employ in getting workmates to test for HIV and these are formal talks, informal discussions and incentivisation strategies. Section Five looks at challenges peer educators face as they discharge their duty of getting workers to test for HIV. These challenges are classified under environmental factors (macro), programmatic and socio-interactive and perceptive (micro), depending on the nature of the challenge.

4.1. Background to the HIV Testing Environment at Belvedere Consortium

This section presents and discusses a three phased periodic historical account of HIV Testing challenges faced by workplace peer educators in the case study mining company. The first phase

is the time when there was no Wellness programme i.e. prior to year 2007. This was followed by a period of a management unilaterally formulated wellness programme which lasted for the first six months of 2007. The third phase commenced in July 2007 to date and this is a phase of comprehensive wellness programming. In as much as the current wellness programme also faces challenges, it has been designed to counter challenges encountered in the initial two phases and hence its marked effectiveness and success as marked by the current annual cumulative HIV uptake rate of 82% as of 2009.

4.1.1. Absence of HIV Testing programme breeds testing challenges

This accounts for the period prior to 2007 when, as two wellness officers confirmed, there was no company HIV testing programme. The absence of company HIV/AIDS testing programmes is a macro-scale factor with trickle down effects because it determines the testing environment. An HIV programme envisages how testing is implemented within the company thereby guiding operations of peer educators. From the interviews conducted, six interviewees out of a total of fourteen cited the absence of an HIV testing programme as the initial challenge faced in getting workers to test for HIV at Belvedere Consortium.

Since there was no company HIV testing programme, interviewees indicated that there was lack of company support and commitment on HIV/AIDS activities as the company had not committed itself to such a programmes. Facilities such as testing centers, time off from work for workers to go for testing, a properly instituted HIV testing arm of the wellness programme within the company structure and lack of financial support were cited by interviewees as having had negative impact on their quest to get workmates test for HIV. Peers who wanted to test for HIV were referred to public health institutions. There was lack of adequately trained peer educators as

the company did not offer training services. All the six interviewees who have been peer educators before 2007 indicated that they first got the formal training at the end of 2007, not specifying the month, despite the fact that they have been peer educators before then. This means that peer educators were not equipped enough on how to execute their peer education duties, particularly convincing peers to take up HIV test and dealing with peers' reluctance to take up HIV test. After peer educators indicated that they did not receive training from the company, a follow-up question posed was, "so where did you get to know how to execute your duties? In responding to this question, interviewees indicated that they used knowledge acquired from different "trade union talk-shows" as three of them were once involved in trade union activities and this gave them experience in talking to workers. Some gained skills from social clubs and listening to campaigns in radios and televisions. One interviewee indicating that he was a community peer educator by then and so the knowledge he used was acquired from his community peer education engagement. Another interviewee indicated that he did not receive any kind of training before 2007 but used his general talking skills as an experienced trade unionist in peer education activities. To this end, there was a clear indication that due to the absence of company HIV testing programme, there was lack of defined patterns of carrying out HIV testing or general HIV/AIDS programme at the workplace

Company HIV/AIDS policies and programmes provide a broader operational framework on which company HIV/AIDS activities can be implemented. They define and guide HIV/AIDS activities within the company's objective parameters. As such, it is of importance that any company running HIV/AIDS projects or programmes has a policy that guides its activities and so that programme objectives are preserved and remain key evaluation yardsticks of progress and success. The absence of company HIV/AIDS policy or programme breeds challenges that

frustrate peer educators' effort in mobilizing peers to test for HIV. Having realized the importance of HIV testing programme the company introduce a programme, deemed by peer educators to be autocratic and that will be discussed in the next section.

4.1.2. Autocratic Management formulated HIV testing programme.

Lack of properly instituted company HIV testing programme breeds testing challenges as proved by the 2007 HIV testing programme at Belvedere Consortium. In 2007, the company rolled-out a wellness programme in an effort to respond to employee health needs to which HIV testing was part. This programme was the "brain-child" of management, it was hatched without employee consultation and input. In as far as the autocratic HIV/AIDS programme, formulated by management, is concerned, peer educators interviewed used terms like, "it was a management programme", "it served management interests", "management wanted to push it down our throats", "we don't know where management got this programme from" and "we didn't know anything about it but management wanted us to sell it to workers and to participate in its implementation". These are different phrases and terms which point to the fact that workers were discontented with the programme and that labour was not consulted during the formulation of the policy and programme. Because of that, there was general lack of labour buy-in resulting in active resistance of the programme. To substantiate that, one peer educator said,

> workers inquired from shop stewards about the wellness programme to which shop stewards professed ignorance, on the day of launching the programme, some workers staged a strike protesting against the programme, unfortunately those who participate were fired on the basis that they took part in an illegal industrial action.

The resistance of the programme was epitomised by an industrial action by a section of workers against the testing programme. The strike resulted in nine employees being dismissed for participating in an unsanctioned strike, according to one interviewee at High Glen plant who appeared privileged to understand procedural requirements for holding a legal strike. However some workers did not understand that their colleagues were dismissed for participating in an illegal strike on the basis that it was not sanctioned. This was confirmed by two peer educators who were at liberty to share employees' perception on the dismissal. Impliedly, workers thought that their colleagues were dismissed for resisting the wellness programme.

Efforts to get peers to take up HIV test were thwarted by the fact that there was lack of organised labour buy-in and sense of ownership of the programme by workers resulting in protracted skepticism about the programme on the basis that management was the only arm of the company that knew about the objectives of the programme. It was difficult to demystify skepticism, one peer educator said, as peer educators and shop stewards were equally ignorant and skeptic of the programme too. Peer educators and shop stewards are employees' confidante, workers trust and have confidence in them. The fact that peer educators and shop stewards did not endorse the programme meant that workers, in general, were not going to participate in activities of the HIv testing programme.

Speculation was rife among workers as they questioned management's intention about the wellness programme. One peer educator recalls a co-workers' argument that, "the company wants to retrench those who are found to be HIV positive that is why they are interested in knowing our status, if it is about health, why are they ignoring other diseases?" This was said in the background that the programme was perceived to be having much interest in getting workers

to test for HIV while ignoring other diseases which were claiming lives of workers, to this end one interviewee said,

> employees went on strike to protest the incompleteness of the wellness programme as it only wanted workers to test for HIV, ignoring other occupational hazards like chromatosis [an occupational disease caused by prolong exposure to chrome] which was seriously affecting employees.

The lack of properly instituted company HIV/AIDS policy and programme also presents a macro-scale front to challenges in HIV testing. However the presence of an HIV/AIDS policy or programme is not a guaranteed panacea to people's reluctance in the uptake of HIV testing and HIV testing challenges faced by workplace peer educators as reflected in the study. The policy has to be properly instituted to achieve intended objectives of high HIV uptake among other objectives. One fundamental way of properly instituting HIV/AIDS policy is by having adequate stakeholder participation in the formulation and implementation of the policy much to an extent that there is an all stakeholder buy-in. Interviewees implied that this was the component that was missing in the unilateral programme. Any HIV testing programme that seeks to make a meaningful contribution towards prevention and treatment must be grassroots grown; there must be extensive consultation with stakeholders so that they can input their needs. This will make the programme relevant to the plight of workplace peers and will guarantee policy support by stakeholders, including labour. The study revealed that inadequate stakeholder consultation resulting in unilateral HIV/AIDS programmes resulted in active resistance of the programme from other stakeholders particularly labour.

The autocratic wellness programme at Belvedere Consortium made the operational environment of peer workers not conducive in mobilising workers to take up HIV test. On realizing these

challenges, management had to go back to the drawing board, this time around with full participation of all stakeholders, particularly labour. The next section outlines the comprehensive wellness programme.

4.1.3. Comprehensive Wellness Programme: Skepticism crop up

In June 2007, having realized the failure of the initial wellness programme in getting workers to test for HIV, there was an overhaul of approach which ushered in the participatory, inclusive and comprehensive wellness programme. This was in direct response to the challenges that plagued the initial wellness programme. Belvedere consortium's comprehensive wellness programme involves HIV/AIDS training, support and treatment as well as testing and support of lifestyle diseases which include diabetes, high blood pressure, cholesterol related illnesses and tuberculosis, as described by the wellness coordinator. In the formulation of the comprehensive wellness programme there was consultation of labour as four peer educators indicated during interviewees that there was equal representation from labour and management. This assured labour buy-in the wellness programme. Since there was labour buy-in, there was significant improvement in the test uptake as indicated by statistical evidence presented in the next section. However this phase has its own share of challenges as it is yet to achieve a company target of an absolute cumulative HIV test uptake rate of 100% per year for employees who would have served the company for more than six months, Company HIV/AIDS Policy Document of 2007.

4.2. Peer Educators and HIV testing statistical information

Fig 3: tabulates HIV test uptake rates at the mother company, the overall uptake at Belvedere Consortium and its two branches, High Glen and Montrose.

Figure 3: Annual Cumulative HIV Test Uptake Rates (2009)

HIV test uptake categories	Belvedere consortium (entire company)	High Glen	Montrose
Overall cumulative uptake rate (%)	82	89	86
Uptake for permanent employees (%)	92	89	89
Uptake for contract workers (%)	72	88	84

Belvedere Consortium, whose employment population has been highlighted in Section 3 of Chapter Three, has an overall cumulative annual HIV test uptake rate at Belvedere Consortium is 82%, as of 2009, with the uptake rate for permanent employees standing at 92% while the rate for contract workers was 72%. While it is important to state the uptake rate for the entire company, the research will focus on High Glen and Montrose, the two research sites. At High Glen plant there is a total of 856 employees of which 683 are permanent while 173 are contract employees and a total of 29 peer educators. The cumulative HIV test uptake rate was 89%, of 2009, with permanent employees having 89% while contract workers have 88% uptake rate. At Montrose plant there are 1211 employees with the annual cumulative uptake rate of 86%, as of 2009, 894 are permanent employees with an uptake rate of 89% while 317 are contract employees with an uptake rate of 84% (2009).

4.3. Demographic Attributes of Peer educators

Figure 4. tabulates demographic characteristics of a sample of peer educators who participated in the study. The table is important in depicting demographic characteristic of the sample of peer educators who participated in the study.

Figure 4. Demographic Attributes of Peer Educators

Peer Educators	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Average/ Summary
Age (Years)	30	36	28	53	27	26	32	43	27	32	25	27	26	29	31.5 (average)
Sex	M	M	M	M	M	F	M	M	M	F	M	F	M	M	Males 78.5% & Females 21.5%
Employment status	P	P	P	P	P	C	P	P	P	C	P	P	P	P	P=85.7% C=14.3%

NB: M: Male F: Female P: Permanent C: Contract

The researcher interviewed sixteen active workplace peer educators from two plants, which were my research sites, and their age ranged from 25 years to 53 years with an average age of 31.5 years. This reflects a group of young adults peer educators. This means that at any given time, at High Glen or Montrose plant, it is likely to interact with a peer educator of almost 31 years of age. Out of fourteen participants, two of them were female while twelve were male.

The demographic table also reflects that the majority of peer educators are permanent employees, with twelve of them being permanent while two being contract workers. This might be interpreted to mean that contract workers do not comprise the labour core and their generally short term contracts breeds reluctance in the recruitment of peer educators. This imply that during working hours, if contract workers are not working at the same place with permanent

workers then their time of interaction with peer educators is very low. In a way this affects informal discussions (see Section 4.2 of Chapter Four) strategy as this sometimes happens during working and is done between or among peer educators and workers.

One of the preliminary questions asked by the researcher was when were peer educators first trained, by who, for how long and when did they last receive their latest training? In responding to these questions, there was a general observation that peer educators first received training towards the end of 2007, the training lasted for an average of three days and peer educators were trained by AFA (refer to Section 5.1 of Chapter Three). In as much as it was important to understand the profile of peer educators interviewed, this submission will shift attention and dwell on understanding how workplace based peer educators get people to take up HIV test, this is in direct response to the first research question of the study.

4.4. How Workplace Peer Educators Get Peers to Test for HIV?

To fully comprehend how peer educators get workmates to take up HIV test, one has to explore and understand the interactions that ensue between the two parties i.e. peer educators and their peers. These interactions can either be formal or informal. The complex one-on-one and or group interactions between or among peer educators and peers in the context of HIV testing is fraught with setbacks and thus the quest to understand the challenges that mushroom in the interaction process which is the central objective of the study. The study is broadly guided by the social interactionist theory, the theoretical framework on which the study is premised. As such this section presents empirical ways and tactics peer educators use to get workmates take up HIV tests. It will start by presenting formal talks followed by informal interactions and the use of

incentivisation strategies in getting colleagues to take up HIV test. Generally, talking skills and right timing emanated as key traits needed for peer educators mobilising peers to take up HIV test. Talking skills enables peer educators to find "right" ways of saying what peers are supposed to hear, on occasions challenging peers' beliefs and assumptions.

4.4.1. Formal Talk and Education

Peer educators indicated that, among the ways they use to get workers to test for HIV are formal talks. These involve peer educators presented with a formal setting where they talk to peers about advantages of testing, encouraging them to take up HIV test and advising them on where they can get the testing services, particularly with company outsourced HIV testing service providers, AFA. The formal strategies used to get workers to test for HIV at Belvedere Consortium are question and answer sessions, "tool-box meetings", use of prominent people, workshops and leading-by-example strategy.

Question and answer sessions is one formal strategy that have been used to get workers to take up HIV test. One peer educators described how a question and answer session is facilitated, he said this is a section that is purely meant to respond to questions peers have about HIV testing. Workers ask questions on HIV testing within the company wellness programme and a panel of peer educators takes turns to respond to those questions. This is meant to respond to respective issues that workers want clarity on and to convince them on the significance of testing and the company testing programme. However in this strategy there was realization that the teacher-student relationship (setting) exists (see Section 10.2 of Chapter Two), with peer educators

playing the role of a teacher while workers are regarded as students, who are on the knowledge receiving end.

"Tool-box meetings" at Belvedere Consortium plants are one way of formal talk used by peer educators, despite them being meant for wellness talks in general. "Tool-box meetings" are meetings held by workplace wellness personnel every Friday before commencement of work to discuss a health subject matter of that week. Peer educators sometimes use "tool-box meetings" to talk about HIV testing. This is what one interviewee said after being asked about how they formally talk to peers,

> we have "tools-box meetings" every Friday in the morning, while these are meant for wellness issues in general, in some instances, we use them to talk about HIV testing and encourage peers to test.

This is typically a lectureship scenario where a peer educator lectures colleagues on a subject of testing. Peer educators indicated that there is little interaction as the peer educator is given much talk time while peers are given little time, "two to three questions are usually acceptable" for interaction after the presentation and the session is conducted in English. The purpose of the lecture is to spell out the benefits of getting an HIV test so that workers will consider testing.

Peer educators also indicated that sometimes they invited prominent people or experts in the field of HIV/AIDS to talk to workers about the pandemic and to encourage peers to test for HIV. The people are invited on the basis that they are people of influence in society, they can influence workers to test, thus the applicability of the social learning theory in Section 9.1 of Chapter Two. This was confirmed by fourteen interviewees who indicated that during the launch of the

wellness programme in mid 2007, experts were invited and they delivered speeches on the benefits of HIV testing, this included the Chief Executive Officer of the company's talk encouraging workers to test.

Workshops and training are also instruments used to get peers test for HIV. Four peer educators indicated that workers have had workshops and trainings on HIV testing. These workshops are meant to equip workers with knowledge on HIV and "this reinforces the significance of HIV testing as a starting point in the prevention and treatment strategies", one peer educator is quoted as saying. It can be seen that workshops are meant to encourage workers to test for HIV by educating them on HIV/AIDS first and then later encouraging them to test as it is deemed the gate way to informed preventive behavior change and treatment. However the fact that few peer educators (four out of fourteen) spoke of the use of workshops suggests that this method of formal talk is not commonly used at the company and this was confirmed by two wellness officers who suspected that this might be because workshops have a cost bearing in terms of hosting a workshop and having people away from the plant attending the workshop. "Naturally a workshop will require many workers to attend as the company want to maximise on allocated resources", that is according to one wellness officer.

Leading-by-example strategy was also adopted when it came to the actual testing. On the launch of the wellness programmes, it did not end with renowned personnel talking about testing; they led by example and went for HIV testing. This depicts the importance of peer educators taking up HIV test ahead of peers, this encourages co-workers to take up HIV test too. Upon being interviewed, all peer educators indicated that they frequently take up HIV tests for personal health reasons and as a mechanism of leading peers into testing. The company's outsourced mobile testing services provided by Aid for AIDS (AFA, referred to Section 5.1 of Chapter

Three) was pointed out by interviewees as being more accessible and convenient as it comes twice per month per plant. This means that testing services moves to work plants. Renowned people also took their HIV test at the company premise, as provided by AFA.

However, from peer educators' submissions, it can be seen that in as much as formal talks, as a communication strategy, play a significant role in getting workers test for HIV, there was an indication from eight interviewees that this had to be followed by intensive informal talks. Also considering the little time the company allocates to formal talks, as outlined by peer educators. This cements the realization that the company believes much in informal talks. An impression sent out was that formal talks lay a foundation to facts about HIV testing as it is mostly delivered in a group or formal setting or the "teacher-student" relationship which usually creates a gap between the two parties (as envisaged in Freire's (1978) critic of the orthodoxy education practice highlighted in Section 10.2 of Chapter Two). To this end, formal talks depict vertical communication (Dickinson 2006), with the peer educator being in a position of authority on the virtue of their knowledge while peers being subjects, (Freire's 1978). As such it became evident that formal talks merely introduce testing issues. It is the informal talks which usually appeal to individuals' realities and tailor make recommendations that best suit specific individuals' situations as they relate to HIV testing. Questions like, Have you tested? What are your reservations to testing? questions that appeal to workers' personal lives can best be asked and talked about in informal discussions. Such being the case, the next section looks at informal talk as an HIV mobilisation communication method.

4.4.2. Informal Discussions

Peer educators interviewed indicated that while they have used formal talks to get peers take up test, they have many times used informal talks which eleven interviewees argued to be the most effective means on the basis that this can be on-the-job talk without necessarily disrupting production, on-the-bus talk when going home, lunch-time talk or anywhere and anytime and there is intimacy instead of gap between peer educators and workers as realized in formal talks. Ironically, despite informal discussion communication strategy not defined in the company HIV/AIDS policy it remains the most effective means of reaching out to peers, this was indicated by the eleven peer educators who acknowledged its effectiveness. According to the eleven peer educators informal talks involves talking to peers in their own language which by and large is Setswana and isiZulu, at an opportune time. This makes peer educators to be identified together with peers as they will be involved in the social gossip, chats and jokes ensuing on or off the job. The commonalities among peers i.e. peer educators and workmates makes the transmission of information easier as they can relate at any level. Upon asking one peer educator on how they get to talk to peers about HIV testing, this is what the peer educator said,

> Its either I join the conversation or I start the conversation. I start by talking social issues of interest to peers, either one-on-one or in a group and in the process introduce the issue of testing, in the language they understand, the "khasi language" [local township language], for instance, is the commonly accepted language which help peers to easily identify with the peer educator. Sometimes when I find peers talking, I join them, we chat until I find the right opportunity to introduce the issue of testing. For instance, as you might be aware that in June (2010) soccer was the "in-thing" in South Africa, after chatting about soccer; I would tell my workmates that we score big by testing in this era of HIV. However what has worked for me is befriending them, diversifying talks and

> ‘good timing, [being able to get an audience]’ helps me not to make the subject of testing monotonous.

One peer educator is quoted on how he uses the “khasi” language in approaching and encouraging colleagues to take up HIV test, “Heitah magents! Kublind ngengculaza, kumele sithesthe, sazi isimo sethu….. , then sizakhona ukwazi ukuthi siziphathe kanjani” [Hie gents! (shortcut for gentlemen, referring to colleagues) HIV is wrecking havoc, it is important that we test and get to know about our status……., then we will know how to care for ourselves]. Another peer educators was quoted using such language as “ le i cheke majents……., tshuba dipone” [check out gentlemen…… put your lights on]. This encourages workers to open their eyes to the reality of HIV/AIDS and to get tested for HIV.

This is horizontal communication or informal activity (Dickinson 2006), the horizontal nature of the communication depict the fact that peer educators and peers are on the same level, they interact as colleagues, there is no power relationship. It can be summerised in linear formula to say horizontal interaction includes horizontal communication. One incident pointed out by a peer educator was the fact that under horizontal interaction, peers can easily relay their concerns and reasons for refraining from testing to peer educators, for example, “I am afraid of testing as I have been sleeping around without protection”, “I had condom failure during sexual intercourse after hiring a commercial sex worker”, “I was too drunk to remember what happened, I don’t think I had protected sex” are scenarios, highlighted by peer educators, as easily relayed through informal discussions.

4.4.3. Incentivisation Strategies

The strategy of using incentives to entice workers to take up HIV test has been used since the launch of the comprehensive wellness programme in June 2007. During the launch of the wellness programme, peer educators outlined that those who took HIV test were given R200 each, a T-shirt and half day off soon after testing. Interviews with peer educators revealed that ever since the launch of the wellness programme, those who test have been given incentives which range from T-shirts, various company branded merchandise, airtime vouchers, caps, among other items and peer educators and wellness officers have been instrumental in making sure that the company gets incentives for those who take up HIV test. After taking two tests at the company premises I also got incentives, a company branded T-shirt and a first aid kit. One peer educators highlighted that "giving incentives to those who take up HIV test is now a culture at Belvedere Consortium as they cannot be testing sessions without incentives and workers turn out because they want to get incentives. This has helped in getting workers to test." Incentives is one way peer educators use, as they demand that wellness officers provide incentives for workers who take up test, in the process of mobilising workers to take up HIV test.

4.5. Challenges faced by Peer Educators in getting workers to test for HIV

The challenges of getting workers to take up HIV test, as cropped up in the research, are classified into three categories i.e. environmental, programmatic and socio-interactional and perceptional factors. Environmental factors are macro in nature; they define and determine the conditions and context under which testing takes place. Programmatic factors look at the technical aspects in the design of wellness programme and how such factors affect HIV test uptake. Socio-interactional and perceptional are micro factors which deal with the way social

interactive and perceptive issues between or among peer educators and their peers, emanating either from society or workplace impeding the smooth uptake of HIV test. The effects of environmental, programmatic and socio-interactional and perceptional factors on HIV test uptake, as informed by workplace based peer educators, are discussed in section 5.1, 5.2 and 5.3, respectively, in this chapter.

4.5.1. Environmental Factors Breeding Challenges to Testing

Environmental factors, as alluded to in Section 5 of this Chapter, define and determine the conditions and context under which testing takes place. From the research, under the environmental category of factors, there is only one factor that cropped-up, that is skepticism based on precarious employment contracts.

4.5.1.1. Skepticism based on precarious employment contracts

Workers' skepticism of company HIV testing programme based on precarious employment for contract workers stands out as one macro problem faced by peer educators in workplace HIV testing. There is a discrepancy in HIV test uptake between permanent and contract workers as reflected by the year 2009 statistics. It reflects that uptake of HIV test for permanent workers was 92% while for contract workers it was 72% (refer to Section 2 of this Chapter). This is attributed to precarious employment contracts that contract workers are under. Kalleberg (2008:1) defines precarious work as "employment that is uncertain, unpredictable and risky from the point of view of the worker". The working conditions and employment contracts of contract workers do not guarantee job security; it is from this background that one peer educator noted contract workers' reluctance to HIV testing as emanating from the fact that their contract of

employment makes them vulnerable to dismissal. This makes them suspicious that being found to be HIV positive might lead to the termination of their employment contracts on the alleged likelihood that their health is going to deteriorate in future which will incapacitate their performance at work. To substantiate that, one peer educator, a permanent employee, is quoted as saying,

> Contract workers are afraid of testing as they fear losing their jobs. They suspect that employers will know whenever they test positive and there is nowhere employers will retain them as their performance will go down.

This was confirmed by two peer educators who are also on contract employment. They indicated that their colleagues are afraid to test as their employment contracts put them at the mercy of employers who hold their employment fate. A follow up question was posed about whether there has been a case of a contract worker who was *fired* because of an HIV positive status. While they indicated that there have never been such cases, this has not given contract workers enough confidence. Contract workers are still skeptical about the testing programme and want to defend their jobs given the fact that it is a source of their livelihood. This explains their defensive nature and their entrenched level of skepticism.

However, looking at statistical information of HIV uptake rate, with a discrepancy of 1% annual cumulative HIV test uptake at High Glen and 5% at Montrose between permanent and contract workers, with uptake in favour of permanent workers, there was interest in knowing the reason peer educators cited skepticism based on precarious employment contracts as a challenge. In responding to that, one peer educator is quoted as saying,

> they used to be a wider gap [referring to uptake rate between permanent and contract workers], few contract workers did not want to test as they suspected that their results were going to be used to determine their employment, you know contract workers can be fired anytime, so they feared that, even in some plants the fear among contract workers is still there.

A follow up question was posed as to what measures were put in place at High Glen and Montrose in order to realize almost the same uptake rate between permanent and contract workers and the same above quoted peer educator at High Glen said,

> You know our wellness officer is very clever, he knows that shop stewards have great influence on workers, so he started using shop stewards to relay the information on the importance of testing, encouraging them to test. These are the people who assured contract workers that testing for HIV would not have an effect on their employment.

The wellness officer from Montrose also indicated that they have used labour representatives to access both contract and permanent workers by saying "mostly I recruit my peer educators from shop stewards, some are doubling as shop stewards and peer educators, if you ask them they will tell you that". On the one hand, this affirmed the influence of labour on employment issues and the confidence workers have in labour representatives. However on the other hand this substantiated credible suspicion that other plants (the thirteen that were not covered) are not fully using labour in mobilizing and quenching skepticism.

To build contract workers' confidence in taking up HIV test and to assure them that whatever HIV test outcome, it will not have an effect on their employment, Coates et al (2007:6) captures that "there is need to develop legal and policy remedies for individuals employed under contract

or casual labour so that they can benefit from testing, treatment and prevention". This can be achieved when the fear of contract termination is averted through intensive education of contract employees and employers on the law of contract. In as much as labour, through shop stewards can be engaged to quench skepticism as it has been happening at High Glen and Montrose, labour must advocate for an employment contract that envisages a clause that no employment contract will be terminate on the basis of one's HIV status, at the moment this is silent in employment contracts. However it should be realized that there is nothing that peer educators can do as employers have the privilege of designing the employment contract in low skill contract employment. However an effort to lobby employers to fully engage labour in the design of employment contracts will boost the confidence of contract workers must be done.

4.5.2. Programmatic Challenges

As defined in Section 5 of this Chapter, programmatic factors look at the technical aspects in the design of wellness programme. This Section will discuss how **c**ertification of HIV test results, HIV testing procedures, consent procedures and lack of incentives for test uptake breed challenges.

4.5.2.1. Certification of HIV test results: To certificate or not?

From the fourteen interviews conducted with peer educators and two interviewees conducted with wellness officers, all interviewees concurred that the certification of testing results has been raised and debated on by peers. Eight peer educators are for the certification of test results while six are against. Certification of testing results is the act of issuing a written certificate or note on a worker's HIV status. The debate is whether to certificate test results or not. At Belvedere

Consortium, testing results are not certificated. None certification has caused some peers to refrain from taking up HIV test. As an indication of an individual's opinion against non-certification of testing results, one interviewee is quoted as saying,

> How do I test and have nothing in my hands as substantive evidence. When you are born you get a birth certificate, when you get married you get a marriage certificate, when you divorce you get a divorce certificate and when you die you get a death certificate and so what is the problem of getting an HIV test result certificate?"

Submissions on the debate of whether to certificate or not had some workers indicating that they only want to be certificated when they are found to be HIV negative, if positive then they do not want the certificate. Upon asking the views of one of the testing nurse on the position of AFA (the outsourced testing agent) on the issue of certificating results, she indicated that they will continue not issuing test certificates but should they be pursued to issue certificates, they will only issue certificates to those who test negative. In concurring with this view, peers argue that having a certificated will be a form of motivation for those who test HIV negative for them to maintain their status. Those who test positive would not receive certificates as there is nothing to show off about. However there was another perception that certificates will be used to entrench stigma and discrimination, with those who are HIV negative going around showing their certificates and asking others to show theirs too. Those who will not be able to show certificates will be deemed HIV positive.

Some argue that it is difficult to tell their spouses that they tested when they cannot prove that. A test result certificate will be ideal in proving that individuals tested. In the research there was evidence that some workers, represented by eight peer educators, support the certification of test

results while six peer educators represents a significant number of workers who are against certification and who argue that certification will breed stigma and discrimination.

As a mitigation measure to two polarized sides of certification and non-certification of HIV test result, this could be done through strategically delaying releasing test certificates, to those who would want them, so as to cool down immediate pressure and tempo from peers. This approach would mean certificates to be issued after the test day, maybe after two days and individuals will go to pick them up at their own time. This might reduce pressure on individuals to show off their certificates to colleagues however it will mean that they will be available when needed.

4.5.2.2. HIV testing procedures breed challenges: Time spent in the testing cubicle

There are procedural requirements that must be met first before an individual can be tested, these procedures are based on preserving confidentiality, the principle of adequate counselling and voluntary uptake of testing. Confidentiality preserves individual employees' HIV test results from being known by unintended people. The report will now make a "detour" and narrate on how a back channel communication strategy was used to mitigate chances of compromised confidentiality due to the co-optation of an in-house nurse in HIV testing.

4.5.2.2.1. Back Channels Communication: A Solution to Potential Compromised Confidentiality

At High Glen plant, in the first half of 2008, peers were concerned about confidentiality in the company HIV testing programme because the company nurse was part of the testing contingent. They feared that the nurse, who knew workers, was going to leak workers' HIV test results. In

the face of such suspicion, peer educators recommended that the company nurse who was co-opted to be part of the testing team be relieved from being part of the testing team, leaving the entire testing exercise in the hands of the outsourced service providers, the Aid for AIDS (AFA) personnel. This was communicated by peers to peer educators who relayed the information to the wellness coordinator. This matter was acted upon accordingly and the company nurse was opted-out of the testing exercise. Upon being asked about the effectiveness of relieving the company nurse from being part of the testing team, peer educators said while they cannot determine the statistical effectiveness of that, at least employees did have fears of compromised confidentiality as an excuse. It is under these conditions of multiple communication channels that back channel communication was used to rectify a suspected compromise of confidentiality. Having discussed the back channel communication, the report reverts to discussing how time spent in the testing cubicle breeds challenges to peer educators.

Adequate counselling help prepare an individual to undergo the testing process and to accept whatever outcome of the test and voluntary uptake allows an individual to freely consent that he/she agrees to be tested. For all this to be achieved it requires abiding by procedural standards. The time spent in the testing cubicle depends on the individual's comprehension of HIV testing knowledge and their preparedness to accept test results. However there is a perception among workers that if someone spends a comparatively long period in the cubicle then that means the worker is HIV positive. This makes workers uneasy and uncomfortable as they are in the queue of HIV testing because their status can be assumed based on the period spent in the cubicle. This has made some workers to be reluctant to go for HIV testing. This was reported by two peer educators and as the researcher participated in the testing process, the researcher started that discussion and realized that indeed that is the perception among many workers. Upon

interviewing the testing nurse on the perception that there is a relationship between the period spent in the testing cubicle and the results, the testing nurse indicated that the average testing time is about twenty minutes and this is the almost the time the researcher spent as he took twenty-two minutes in the first test and nineteen in the second test. To prove that workers know the period a normal test takes, the testing nurse said;

> workers now know, it is true, if results are positive one has to undergo vigorous counselling and this depends on how they accept the results, their behaviour when they get results. Some will "break", some will be shocked, some will be devastated and some will be strong to easily accept being HIV positive however the latter is rare.

The lay knowledge of workers on the time spent in the testing cubicle affects the uptake of HIV testing. Workers are afraid or not at easy of HIV testing because there can be inference of their HIV results upon considering the time spent by a worker in the testing cubicle. One worker joked that he was praying to have the powers to stop clocks from ticking when he goes into the testing cubicle but when in the workplace or in the queue to testing he does not mind the clock ticking faster. This joke meant to suggest that he wishes to incapacitate colleagues from determining the time he will spend while taking a testing.

In finding a solution to the above cited problem, based on physical inspection of the testing centre, it was noted that there is need to seriously reconsider the physical layout of the testing centre. While the present workplace testing centre is laid out in such a way that workers enter on one end and exit on the other end however those in the queue awaiting to be tested can see those exiting and can manage to speculate on the time an individual spent in the testing cubicle . The suggested physical layout is whereby in as much as workers intending to test will go in through

the same entrance, the exit point will lead them to the workplace much to an extent that those in the queue will not see them exit. It is through this arrangement that workers will not be able to calculate the time individuals spend in the testing cubicle. Having discussed the challenge of time spent in the testing cubicle in relation to HIV the speculation of HIV results and the physical layout of the workplace testing centre, we look at how consent procedures breed challenges to peer educators seeking to get workers to test for HIV.

4.5.2.3. Consent Procedures Breed Challenges

The testing consent form is another procedural requirement that has had negative effects on employees intending to take up HIV test. The consent form seeks to make sure that those who take up HIV test have informed consent before they test. Informed consent mean that "an employee is provided with full information, understands it and based on this, the employee agrees to undertake the HIV test", according to the Code of Good Practice on Key Aspects on HIV/AIDS and Employment (2000:8). The consent form requires those undertaking HIV test to fill in their name, surname and affix their signature. While this is meant to prove that the person undertook the HIV test without compulsion, due to prevailing skepticism proved to be emanating from the company's background to HIV testing, workers suspect that details on the consent form enhances mechanisms of tracing results to individual workers. This is alleged to compromises confidentiality that peers greatly want to see obtaining in as far as HIV testing is concerned. Assurance of confidentiality is important in getting workers to take up HIV testing and pursuant to that, three peer educators pointed out that workers do not want to be tested by the same personnel for more than three months. The workers' argument, as highlighted by peer educator is based on the philosophy that, "it is better to tell a problem to a stranger because a person that you

know will broadcast it". It is based on this concern that testing personnel are outsourced from AFA and rotated.

Furthermore, there is fear that if the results are linked to individuals, employers might use employees' HIV status for retrenchment purposes. In explaining the consent form, the peer educator said,

> The consent form requires them to fill in their name(s), surname and to sign it, this makes them suspect that results can be traced to individuals, compromising confidentiality and making them prone to alleged retrenchment if they are positive.

In the process of raising workers' skepticism on the consent form, the researcher asked, from the nurse, on the importance of the consent form and its ownership. The testing nurse pointed out that it is evidence of an individual's voluntary act to test, also that they actually conducted the test, on their part, and that consent forms are their sole property and the employer does not have access to them at all.

In as much as this is a procedural requirement, because of skepticism, this has had setback effects as it makes some employees to be reluctant to test. To this extent, peer educators argued that since the testing programme is conducted under Voluntary Counselling and Testing (VCT) (see Section 4.4 of Chapter Two) so it means that everyone who takes a test will have volunteered and so the consent form must be waived. In this scenario, what is recommended is verbal consent which does not require personal details of employees. This will counter skepticism emanating from the consent form and in the process alleviate challenges faced by peer educators in getting workers to test and hence increase testing uptake.

4.5.2.4. Successes breed challenges: Lack of incentives for test uptake

The company has employed incentives as a strategy to get workers to test for HIV (see Section 4.3 of Chapter Four). Lack of material incentives to motivate people to test for HIV emerged as one of the micro challenges in getting workers to test for HIV. Initially, at the launch of the wellness programme, people were given R200 for testing, a T-shirt and half day off (after testing, their working day would be considered completed and they could clock-out) as a reward for testing. This resulted in many people getting tested. However when incentives were withheld or suspended the turnout plummeted. At one point, at Montrose plant, the wellness officer, being in overall charge of the wellness programme, had to urgently get airtime vouchers in an attempt to entice workers to test so as to boost the turnout. This is because wellness officers are under pressure to get workers taking up tests as this reflects on their performance in the wellness programme. In support of this development, one peer educator recalls that, "one day we had the Wellness Officer getting R29-Vodacom, R30-MTN and R25-CellC as incentives for those who tested as a desperate strategy to entice workers to test". The moment airtime vouchers started being given out workers turned up and there was an increase in the uptake. The researcher, on participating in the testing process, was also given incentives.

This reflects that workers are yet to fully comprehend the importance of HIV test. It appears they are testing for the sake of material gains without which they will not test. This sends out a clear signal to peer educators, wellness officers, coordinators and managers that more education on HIV testing is needed. While one can argue that employees' behaviour is a result of the initial strategy that was used to entice them to test, there is still a realization that workers lack full understanding of the importance of testing. Such being the case, one can argue that the success of enticing workers to test through the use of material gifts will entrench transactory attitude among

workers towards testing. This breed challenges as workers become reluctant to test when honorariums are withheld. It is not only the incentivisation of HIV testing which turns out to have negative effects if not properly managed, procedural requirement as discussed in Section 5.2.2 in this Chapter, can have negative effects too. It is equally important to discuss how socio-interactional and perceptional factors impede HIV test up take; the next section looks at that.

4.5.3. Socio-Interactional and Perceptional Factors

These are socio-interactive and perception factors that breed challenges to HIV testing see Section 5 of this Chapter. They may be referred to as micro factors, they deal more with socio-interactive and perceptive issues between and among peer educators and their peers, emanating either from society or workplace, which impede the smooth uptake of HIV test. Factor to be discussed in this section are stigma and discrimination, poor disclosure strategies, perceived racialisation of workplace testing centers, cultural beliefs and actions frustrating HIV testing and male workers' reliance on partners' ante-natal test.

4.5.3.1. Stigma and discrimination

From the fourteen interviews conducted with peer educators, they all indicated that stigma and discrimination, emanating from workers finding out that they are HIV positive, were major challenges in getting people to take up HIV test. Workers who test positive would be expected to deal with stigma and discrimination in two worlds, the world of work and the broader society. There is fear among workers as they are not sure of how they will be treated by colleagues at the workplace should they be known to be HIV positive, they believe that being, so-called, "conservative" by "playing it safe" through not testing will help them avoid effects of stigma and

discrimination that will entail perceived health deterioration, failure to perform duty and ultimately being put on forced leave. An extreme case is one of a worker, as narrated by one interviewee, who actually blamed peer educators for encouraging workers to test for HIV as he argued that the act was stressing to individuals and worse more if they were found to be HIV positive. The worker further asserted that employees who get to know of their HIV status get to die fast due to effects of stress.

Interviewees indicated that stigma and discrimination also emanated from the society where people talk freely shunning people who are HIV positive without being considerate of the fact that some members of the audience might be HIV positive. One quoted interviewee said

> people in society have little knowledge on how to manage such an HIV positive status, they think it's the end of life, they associate it with promiscuity and do not know what respectable words to use when referring to issues of one being HIV positive

There is general fear of verbal abuse of the HIV positive in society which entrenches stigma and discrimination. Speculation on the kind of associational treatment employees who are HIV positive will get from co-workers is assumed to be determined by the broader society's general and sometimes uninformed negative perception. Such being the case, there was realisation that people are aware of the likely unfriendly treatment they will get from colleagues at both the workplaces and society. This is substantiated by a quote from a participant in Gilbert and Walkers (2010) research on stigma as experienced by patients in an HIV/AIDS clinic that, "my biggest fear is that people would reject me once they knew my status". This causes people, including workers to be reluctant to test. The presence of stigma in the community deter people from testing posing a challenge to peer educator both in the community and in the workplace since a workplace is a superimposed community within the broader society.

Stigma, discrimination and depression are common challenges faced by people living with HIV/AIDS within different societal spheres as discussed in the literature review. Dickinson (2009) refers to stigma, discrimination social exclusion as challenges associated with social shame. Despite massive campaigns against stigma, discrimination and social exclusion of people living with HIV/AIDS, people still believe that being HIV positive makes an individual a social miss fit or sub-human beings and hence the genesis of stigma and discrimination. During the discussion with the testing nurse on possible strategies of fighting stigma and discrimination in the workplace, she firstly acknowledged the effects of stigma and discrimination on HIV testing and that it had proved difficult to fight it. However she pointed out that

> the more people [workers included] give attention and talk about stigma and discrimination the more it is entrenched. This posits HIV/AIDS as the deadliest disease and yet they are deadlier diseases like cancer. The fact that they are not given much attention like HIV/AIDS makes them not so stigmatise and patients not discriminated on. Of course one can argue on the basis of HIV being mainly contracted through sexual intercourse. People must regard HIV/AIDS as any other ordinary disease and stigma and discrimination will decline. To do this the campaigns against stigma and discrimination must stop and HIV/AIDS will be treated "ordinarily"

This was seconded by one of the wellness officer as he pointed out that HIV/AIDS rhetoric on intensive education against stigma and discrimination actually fuels it up. While the solution suggested by the nurse is worthy thinking about, educating workers on HIV/AIDS and campaigns seems realistic and the best way.

4.5.3.2. Poor disclosure strategies

In this report disclosure is the process of spelling out one's HIV status after taking up a test. It should be noted that disclosure is not an event but it is a process particularly to those that would have tested HIV positive. This is influenced by two factors; firstly the stress thought to be associated with telling it out (disclosure) and how people are going to react and secondly lack of precedence of disclosure. According to this research, they are two factors that determine one's willingness to disclose, stress associated with telling it out (disclosure) and lack of precedence. These influence workers to be reluctant in taking up HIV test. There is need for peer educators to be trained in disclosure strategies so that they will impart the same to their workmates. At High Glen plant one interviewee is quoted as saying, "at this plant, no one has disclosed that he/she is HIV positive; it is only the testing personnel who know about workers's HIV status"

Disclosure is among the micro problems faced in HIV testing. Peers are worried on how they will disclose their HIV status to spouse(s), children, relatives and workmates, if they are found to be HIV positive after testing; as such they are reluctant to test as they do not want to carry the "burden" of disclosure. For others ignorance on one's HIV status is better than knowing the status which will breed stress on how to disclose if HIV positive. One peer educator recalls a worker's argument that, "I will rather stay in ignorance than knowing but not being able to tell it to my spouse, children, relatives and friends and keeping it to myself will stress me more".

Still at High Glen plant, one peer educator narrated on how he helped one of the workmate disclose his HIV positive status to the spouse. After going through a testing exercise, the workers was found to be HIV positive and expressed that he needed help to disclose that to the spouse. The peer educator went with the worker to his wife (peer's wife), convened a counselling session with both and disclosed the HIV positive status of the colleague. The spouse also became

interested in knowing her status and she went for test. She came out negative and the peer educator helped them to understand how they would continue living together without the transmission of the virus. This is practical application of the cascading disclosure strategy which helped in managing a potentially sensitive case of an HIV positive employee seeking to let the spouse to know about his status. This strategy "relieves" the employee from directly disclosing the test result to the spouse but invites the spouse to join the workers as they go for a test so that the HIV results will be disclosed by a professional counsellor who can handling the reaction of the two partners taking the test. This case brings out the importance of knowing disclosure strategies and counselling skills by peer educators.

4.5.3.3. Perceived Racialisation of workplace testing centers

Three peer educators at High Glen plant indicated that there was a perception among predominantly black workers that white employees do not test at workplace centers. This perception emanates from the fact that there are white workers who test with private or family doctors and as such there will not be any need to test at the workplace. Predominantly black workers allege that this (testing with private or family doctor) is just an excuse as they do not test for HIV at all. The fact that there are white employees who do not test at workplaces was confirmed by the testing nurse who put such incidents at 10%. However during the first testing session the researcher participated in, he saw four white employees who took tests while in the second session the researcher saw three. It was difficult to ascertain the actual extent given the fact that the Human Resources department withheld racial composition of employees. However the nurse's observation remains significant under the circumstances but not to mean that white employees do not test for HIV but that some test with family doctors. To rectify the perception of

racialised workplace testing centers, there is need to encourage high profile white employees to take HIV test at workplace centers.

4.5.3.4. Cultural beliefs and actions frustrating HIV testing

In the research conducted peer educators cited *boswagadi* as a major cultural challenge faced by peer educators in getting workers to test for HIV. *Boswagadi* is a Setswana and Sepedi name referring to a cultural disease believed to be caused by lack of traditional healing to the surviving spouse should one's partner die. This disease is believed to be sexually transmitted, just like HIV and the surviving partner should undergo traditional healing as cleansing or else he/she will become a transmitter of the disease and later on will also suffer from the disease and eventually die.

This is more prevalent among workers of old age. One peer educator recites what the old peer said that, "HIV/AIDS is the same as *boswagadi* and people must seek traditional healing" The workplace is a society within a broader society. A broader society is comprised of cultural heterogeneity realities and the same applies to the workplace. Some of the cultural traits pose challenges on the uptake of HIV testing. *Boswagadi* has been singled out as a cultural disease, emanating from the black community beliefs, wedging challenges in HIV testing. These beliefs are more prevalent particularly among the old aged workers, those above forty-five years. These employees, based on their cultural beliefs, they believe that HIV/AIDS is the same as *boswagadi* and it can be treated through traditional medicine. Peer educators find it a challenge to help elders to accept the existence of HIV/AIDS and preventive measures.

The research confirmed that age differences can be a barrier to effective communication; there are issues that a young person cannot tell or discuss with an older one and sex is one such an

issue. In an African setting people do not talk about sex and their sexuality and it is taboo for a young person to try and talk to an elder about sex, thus the challenge of sexual norms, Dickinson 2009. One interviewee quotes an old aged employee who could not allow a peer educator (of thirty years) to discuss the subject of HIV testing because it involved sex and because the peer educator was young, young enough to be of the age of the old employee's child. The employee is quoted as saying "You are young, you can't tell me to go and test for HIV, during our time there was nothing like that……. How do you discuss issues of sex with your father?" Based on findings of this research, one can conclude that culture play a role in determining sexual norms of people which can breed challenges to HIV testing, confirming Dickinson's (2009) observation on the challenge of sexual norms to peer education.

4.5.3.5. Male workers reliance on partners' antenatal test

Four interviewees indicated that some male employees did not want to test for HIV as they argued that either their pregnant wives or their newly born babies had tested negative at the pre-natal clinics' Prevention-of-Mother-To Child-Transmission (PMTCT) programmes. PMTCT is a pre-natal programme that seeks to ascertain the pregnant women's HIV status so as to protect the baby from contracting the virus during and after birth. The peer educator observed the behaviour of men who offered their spouses or newly born babies' pre-natal HIV test results as a reason for abstaining from HIV test and hence it was observed that, "some men don't want to test for HIV; they want to rely on test results from their pregnant wives", some argue that, "I just had a baby which is negative and so I am negative". Such men are difficult to convince to take up HIV test. Such bahaviour of men emanate from limited knowledge that ante-natal tests reflect the status of the person who would have tested, not necessarily the status of the spouse or father of the baby. It

was observed that there is need to educate men so that they can appreciate that they need to test regardless of their spouse or baby's ante-natal test. Education on antenatal test will help such men to accept that there are chances of discordant results, a situation where one part in a marriage test positive while the other test negative despite the fact that the two have been having a sexual relationship.

4.6. Conclusion

This chapter managed to look at environmental, programmatic and socio-interactive and perceptive factors which challenge peer educators' effort of getting workers to test for HIV so that an absolute uptake rate can be realized. On one hand, environmental factors emanating from the study include lack of properly institutionalized HIV testing programme embedded in the background to the HIV testing environment of the company and skepticism based on precarious employment contracts. On the other hand, programmatic factors that cropped up include certification of HIV test results, HIV testing procedures, consent procedures and lack of incentives for HIV test uptake while socio-interactional and perceptional factors discussed are stigma and discrimination, poor disclosure strategies, perceived racialisation of workplace testing center, cultural beliefs and male workers' reliance on spouse's antenatal test. These discussed research findings will be used to draw up conclusion on the study.

CHAPTER FIVE

Conclusion and Recommendations

5. Introduction

This chapter outlines conclusions drawn from the research and highlights recommendations relevant to a number of challenges identified. This chapter will start by outlining how peer educators use, among other ways of getting people to test for HIV, formal talks, informal discussions and incentivisation strategies (see Section 4 of Chapter Four) to encourage workers to test for HIV. This is the socio-interactive aspect of peer educators' roles in the testing process as they negotiate with peers over testing. It strongly rests on good communication and negotiations skills on the part of peer educators. It is at this stage that peer educators start to confront challenges and a discussion on the conclusion drawn on the challenges faced will be covered in Sections 2, 3 and 4 of this chapter. The challenges faced by peer educators at Belvedere Consortium are classified into environmental, programmatic and interactional factors.

5.1. The State of the HIV Testing Programme at Belvedere Consortium

The HIV testing programme at Belvedere Consortium is generally successful with the cumulative uptake rate of 82% per year, as of 2009. Although the programme is generally a success, they are challenges that are encountered by peer educators as they mobilize workers to take up HIV test. These challenges contribute to the failure of the HIV testing programme to attain an absolute test uptake as ascertained in interviews conducted with peer educators and statistics obtained from the HIV test up take records.

5.2. Environmental factors influencing Testing uptake: Conclusion Drawn

Environmental factors, which are conditions set by management to determine the context under which testing takes place, with labour and peer educators having no power over as these are policy issues but labour only reserving the right to organize and agitate against these conditions, is one set of factors that frustrate HIV testing, as reflected by the background to HIV testing environment at Belvedere Consortium. The period before 2008 epitomised by absence of HIV testing programme and lack of properly institutionalised testing programme had HIV test uptake of 35% (2007). This proves that environmental conditions can affect HIV test uptake. Uptake rate remained low as there was no programme buy-in by labour. This affirms that while labour has limited power over company policies, they can either actively or passively agitate against policies. The passive agitation of staying away from testing and the active agitation against the programme epitomised by an industrial action, although with negative repercussion for nine employees, at Belvedere Consortium proves labour's power to agitate against management set policies. Ultimately, labour's agitation helped with the birth of a comprehensive wellness programme which has seen improved (82% as of 2009) HIV test uptake.

On environmental factors, since the HIV testing programme evolved through three phases (absence of HIV testing programme, autocratic testing programme and comprehensive wellness programme) at Belvedere Consortium, this helped eliminate some challenges in the process, the only issue that surfaced out of the research as an environmental factor was the skepticism based on precarious employment contracts. The overall uptake of HIV test at the company reflected a 20% discrepancy between permanent and contract workers (see Section 2 of Chapter Four) with uptake among permanent workers at 92% while among contract worker at 72%. While skepticism emanating from precarious employment contract, as a setback to testing, was not

concretised by test uptake rates at the two plants where the research was conducted, as High Glen had an uptake discrepancy of 1% while Montrose had 5% between permanent and contract workers in favour of permanent workers, interviewed peer educators at the two sites kept on citing precarious employment contracts as a setback for contract workers. This had two implications, on the one hand justifying the overall company test uptake discrepancy between permanent and contract workers while on the other hand proving the effectiveness of involving labour representatives in instilling workers' confidence in employment contracts. Peer education programmes at High Glen and Montrose engaged labour, through continually recruiting peer educators from shop stewards and this helped quench skepticism. This lesson suggests that the strategy should be employed in other plants where the discrepancy is high as it has been effective at High Glen and Montrose. Organised labour has an influence on employees' decision making process on workplace health issues. This is because labour has represented workers in employment relations issues and employees have confidence in the union as proved by membership. The trade union representatives can be used as a strategy to mobilise workers to take up HIV test. This has been proved twice at Belvedere Consortium; firstly organized labour resisted the autocratic management HIV testing programme, in 2007, and this ushered in the current comprehensive wellness programme which has seen test uptake rates improve from 35% to the current overall of 82% and, secondly, High Glen and Montrose have used labour (refer to Section 5.1.1 of Chapter Four) to help quench skepticism based on alleged precarious employment contracts.

5.3. Programmatic factors influencing Testing uptake: Conclusion Drawn

Programmatic factors, these are factors dealing with the technical way the HIV testing programme is designed, are another set of challenges faced by peer educators in getting workers to test for HIV. Factors encompassed under this category are certification of test results, time spent in the testing cubicle, consent procedures, and the testing incentivisation strategy, (see Section 5.2 of Chapter Four). To start with, the next section will look at the conclusion drawn on the certification of test results.

They have been noted debates around certification of testing results as proved by interviewed peer educators' conflictual submissions, some in support while some against certification of test results. Proper management of the certification process which is cognisant of divergent views of peer educators can help eliminate the possibility of certification frustrating efforts of peer educators in getting workers testing for HIV. This could be done through strategic delay in releasing test certificates, to those who would want them, so as to cool down immediate pressure and tempo from peers (see Section 5.2.1 of Chapter Four).

On the issue of time spent in the testing cubicle, it should be noted that this is an important aspect in the testing process which cannot be compromised for any reason. Workers need proper counselling before and after testing, a recommendation that can be made is to redesign the physical layout of workplace testing centers so that from testing cubicles workers walk straight into the factory without being noticed by colleagues in the queue. It is advisable to also increase the testing cubicle, from the current single cubicle so that workers do not stay long in the queue. While this might have cost implication to service providers, as more testing personnel will be required, who will ultimately transfer the cost to the company through their billing process; it reduces the time that service providers will spend at a plant and bills of service providers will be

calculated on the basis of the actual time spent at the plant. By so doing workers will not be able to project the time an individual spends in the testing cubicle.

The consent form is one procedural instrument that fuels skepticism as workers suspect that test results can be linked to individual workers, through personal details that one writes on the consent form. Workers suspect that information provided on a consent form will later be used in retrenchment. While service providers have argued that the consent form serves as evidence that an individual volunteered to take up a test, personal detail information needed on the consent form must be reconsidered as it fuels skepticism in workplace HIV testing. As long as an individual consent through providing personal details and affixing signatures, skepticism will be rife and this will be a discouraging factor to some employees who want to test. Therefore verbal consent must be seriously considered as this does not require the capture of worker's personal details and signature.

The incentivisation strategy of HIV testing has been classified under programmatic factors because it was adopted as part of the initiation of the comprehensive wellness programme (see 5.2.4 of Chapter Four). However it has elements of socio-interactional and perceptional factors as it depends on individual worker's notions (perceptions) about incentives for testing, whether to test for incentives or for health reasons. Since the launch of the comprehensive wellness programme the strategy has worked in that it has seen improved uptake of HIV test; however it has instilled a "transactory" attitude towards testing whereby workers test because they will get something. In a way this compromises the need for workers to comprehend the objective of HIV testing. Some employees do not fully understand the objective of testing; some test because they are incentives to be given to those who test. This might have an effect on how they react to results particularly if, for example, they test positive. However since the strategy has contributed

in increasing the number of workers taking up HIV test, as proved by an increase from 35% to 82%, the company must continue the incentivisation strategy and complement it with intensive education. Intensive education so that workers will fully understand that testing is meant for health care reasons not for material accumulation purposes.

Programmatic factors appeal more to the technical issues on the organisation of the HIV testing programme, it is therefore necessary to consider the interests of workers in drawing up testing programme so that test up take are not compromised. To sum it up, technicalities of HIV testing programmes must be tailor made to suit interests of workers and this will see an improved test uptake. Having drawn conclusions on environmental and programmatic factors determining HIV test rate, it is equally important to also discuss lessons learnt from socio-interactional and perceptional factors that pose challenges to peer educators' efforts of mobilizing workers to take up HIV test.

5.4. Socio-interactional and perceptional factors influencing Testing uptake: Conclusion Drawn

Socio-interactional and perceptional factors, as earlier alluded to (see Section 5.3 of Chapter Four) deal with issues of how peer educators and colleagues relate to each other at workplaces and in the community and notions emanating from those interactions, in the context of HIV testing. This section draws a conclusion on the effects of stigma and discrimination, poor disclosure strategies, racialisation of workplace testing centers, cultural beliefs and male workers relying on partner's pre-natal test on HIV test uptake.

From the study, it can be concluded that even after three decades of the pandemic, stigma and discrimination is still haunting HIV/AIDS programmes despite massive campaigns against it.

This confirms Gilbert and Walker's (2010) observation, in their study on stigma as experienced by patients in an HIV/AIDS clinic in Johannesburg, that felt and anticipated stigma affects disclosure, prevention and treatment, to which HIV testing is part. This also confirms Richter 2001 and Simbayi 2007 that HIV/AIDS related stigma in South Africa is "debilitating and intrusive" and this affect the way people (workers) respond to HIV testing. However this does not mean that people must give up on the fight against stigma and discrimination. It is recommended that the campaigns must be continued in the workplace.

Disclosure strategies are a fundamental component of communication and negotiation in HIV testing on which peer educators and workers must be well trained on. It has serious implications of discouraging workers from testing. Workers who wish to take up HIV test might be reluctant as they grapple with ways of disclosing their status to spouse, relatives and compatriots, should they test positive. As such workers must be trained in disclosure strategies, particularly the cascading disclosure strategy (discussed in Section 5.3.2 of Chapter Four) and these strategies must also be highlighted during counselling prior to testing.

The presence of cultural beliefs, (see Section 5.3.4 of Chapter Four on *Boswagadi*) at Belvedere Consortium, that frustrates peer educators' effort to get people test for HIV affirms Dickinson's (2009) assertion that they are folk theories that are setbacks to peer education programme. This will be better managed through health care pluralism where the traditional health care is used to explain the different between *boswagadi* and HIV/AIDS, traditional health care must be blended with the scientific health care system of HIV. Such a health care pluralism approach will help thrash out a notion held by old aged workers that HIV/AIDS is the same as *boswagadi*.

They are male workers who still relying on partner's antenatal test simply because they want to stay away from testing, it is important to educate such individuals that pre-natal HIV test only reflect the status of people who would have taken up the test and cannot be used as a basis for inference of HIV test to a third party. The behaviour of employees who want to rely on spouse's antenatal test reflects the general lack of knowledge on realities of antenatal test and as such intensive education, in the hope that it will change their conceptualization of antenatal test, is recommended.

The administration of mitigation measures must be both at the workplace and community as factors that include cultural beliefs and stigma and discrimination also emanate from the community. This means that company must sponsor some community programmes in the fight against stigma and discrimination, disclosure strategies, cultural beliefs and male workers relying on antenatal test of spouses. The broad administration of mitigation measure, although it might have high costs bearings, it will help undo wrong perceptions and interactional tendencies and behaviours of various origins that frustrate HIV test uptake. To sum it up, socio-interactional and perceptional challenges are real threats to HIV test uptake among workers and mitigation measures rest on intensive education through the use of labour (union) and other high profile personnel within certain groupings as education agents and intensive support of peer education work.

5.6. Conclusion

This research helped to expose some of the challenges faced by peer educators in workplaces as they get employees to take up test. It confirms Rujumba *et al*; (2010) observations that HIV testing is fraught with challenges. The research used workplace peer educators to identify HIV testing challenges at three different levels, environmental, programmatic and socio-interactive and perceptional levels. The research revealed that programmatic and socio-interactive and perceptional factors are the leading challenges to peer educators' effort of mobilizing workers to take up HIV test, in the study company. To those involved in peer education work, in their various capacities and responsibility, to HIV/AIDS work practitioners and to the general readership, this research is of great value as it provides experiences of peer educators on challenges they confront as they mobilize workers to test for HIV and envisages mitigation measures that have been suggested. While mitigation measures have been suggested in the context of Belvedere Consortium, they can still be applicable in other settings. Despite peer educators facing challenges in mobilizing workers to test for HIV, they remain a significant actor with their invaluable contribution in the fight against HIV/AIDS in the workplace.

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Appendix A: Interview Guides

Interview: Peer educators

How did you become a peer educator (volunteered/elected)?

How long have you been a peer educator?

What motivates you to be a peer educator?

Have you received any formal peer education training?

When did you last attend refresher course?

What skills do you think are necessary for a good peer educator?

How do you get people to test for HIV?

Where do peers mostly go for HIV testing?

From your own understanding what is the difference between VCT and HCT?

What are the implications of HCT to your duties as a peer educator?

How do you rate people's response to HCT?

What challenges do you face in getting people tested?

What measures do you think are necessary to counter identified challenges?

In cases of challenges, where do you seek help or advice?

Interview: Testing nurse

How long have you been conducting tests at Harmony Consortium?

What are your (you and other testing personnel) qualifications?

Who is your employer?

What does the testing process involve?

What is the duration of the normal (average) testing exercise?

What is your comment that there are long testing queues?

What is your observation on assertions that there is racialisation of testing centers?

Any particular issues you have noticed with testing at High Glen and Montrose plants?

What challenges have you faced when conducting testing at Harmony Consortium plants (High Glen and Montrose)?

What challenges have you noticed, faced by peer educator when mobilizing people to test?

Are there complaints you have received from workers? Which are those?

What do you think about the physical layout of testing centre and the cubicles?

Any comment on a notion that more time spent in the testing cubicle means that the person being tested is HIV positive?

How do you think *boswagadi* is a challenge in getting people to test?

What are the effects of incentivisation of testing?