CHAPTER 1

1. BACKGROUND OF THE STUDY

1.1 Introduction

Human immune deficiency virus (HIV) is a serious problem for many countries and its impact is felt globally as statistics indicated that in 2008 a total of 33.4 million people lived with HIV and AIDS (UNAIDS, 2011). Reports on HIV reveal that in 2011 the prevalence of HIV globally was 0.8%, with Sub-Saharan Africa being at 4.9% and South Africa at 17.3%. In South Africa in 2010, 34 million people were reported to be living with the HI virus (DOH, 2010). KwaZulu-Natal is the second largest province in South Africa with a population size of about 10.8 million. It is reported that 37.4% of people in this province would have been infected with HIV by 2011 (UNAIDS, 2011). South Africa is amongst countries with a high prevalence of HIV and AIDS and it continues to experience a severe HIV and AIDS epidemic. In this country, the spread of HIV is mainly through sexual contact, breast feeding and mother to child transmission.

Initially, in South Africa the disease was perceived as particularly affecting gay men and people receiving blood transfusions, however, in the course of time it became apparent that HIV and AIDS was not confined to a particular group of people but was becoming a general epidemic in broader South Africa (UNAIDS, 2009). It is estimated that about three quarters of HIV/AIDS cases are among adults aged between 20 and 40yrs (UNAIDS, 2011).
This is believed to be the most sexually active group and unfortunately the most economically productive segment of the population therefore deaths in this age group places an economic burden on individuals, families, workplaces and have a negative impact on the economy of the country. The impact of the HIV and AIDS epidemic on the South African socio-economic development has been a concern since its beginning. Individuals and their families experience the immediate impact of HIV and AIDS as they suffer financial hardships especially if the sick or dead relatives are the sole bread winners. The workplaces suffer a high turnover rate through incapacity and deaths, high absenteeism rate due to sickness and care for the loved ones and also low productivity thus causing an economic burden to the employer. The government expenditure increased as it is spent mainly on HIV, Tuberculosis, neonatal, maternal and women’s health (UNAIDS, 2011; Tapscott, 2008)

The studies have shown under-utilization of HIV counseling and testing (HCT) services by South African communities. Despite the high prevalence of Human immune deficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) as well as high level of awareness on HIV and AIDS only a small portion of the South African population have been tested for HIV. In 2009 it is reported that only 24.7% of adults aged 15 to 48 had tested for HIV and in 2010, during the HCT campaign which was targeted at testing 15 million people, only 4.6 million people tested (Pillay, 2011). This low HCT uptake significantly hampers the enrolment of HIV infected individuals to treatment programs, therefore further decreasing the life expectancy of infected
individuals who could have had a better chance of survival if they were treated early in the disease (Helleringer et al, 2009).

The following factors were identified as barriers to HIV counseling and testing: Poor or inaccessibility of health facilities, fatalism, HIV related stigma, confidentiality, socio-economic status, proximity of clinics, availability of rapid testing and outreach services, age, level of education, lack of trust of health care providers, fear of discrimination and stigmatization, and concern about privacy. (Hutchinson & Mahlalela, 2006; Motshabi et al, 2011; Helleringer et al, 2009).

Fifty eight per cent of top African countries were surveyed between 2002 and 2003 and the findings were that large corporations lag behind in provision of prevention and care programs to employees and South Africa has the highest number of HIV positive citizens than any country but has been slow to respond to HIV. Low uptake however is not unique to South Africa, it is reported that in Sub-Saharan Africa, the number of people who know their HIV status remain low at below 40% and the number of employees making use of available HCT services also remains low (Goldberg, 2011).

2. Problem statement

The number of people living with HIV as well as deaths due to the pandemic in workplaces continues to grow. There is also lack of trust between employees and
supervisors making it difficult for employees to seek assistance on HIV related matters or disclose their HIV status at work.

Fear of rejection, stigma and discrimination also contributes to this. The low uptake of HIV counseling and testing by employees especially among managers has been identified as a challenge even though knowing one’s status is important. There is no care, treatment and support services available for employees and the challenge is to find ways to build a trusting relationship between management and their employees and emphasize the importance of professional secrecy and confidentiality.

The South African Correctional Services is faced with a high absenteeism rate due to employees getting sick, attending funerals and taking care of sick loved ones and high turnover rate due to incapacity and deaths. This poses a huge challenge to the department as it contributes to staff shortages and low productivity. The monthly statistics in the department shows that only few employees avail themselves for Human Immune Deficiency Virus counseling and testing (HCT) (Human Resource, 2012).

The factors influencing the uptake of HIV counseling and testing services in this department is not known and need to be investigated and also the level of knowledge on HIV and AIDS needs to be assessed as this can influence the employee’s decision to take an HIV test.. Moreover, seeing that KwaZulu-Natal has the highest number of HIV positive people with a low HIV counseling and testing uptake, reasons
for this low uptake need to be explored so as to improve the rate of uptake in this province.

The question is thus: What are the factors influencing the uptake of HIV counseling and testing at Pietermaritzburg Correctional Services? There has been no study of this nature in the KwaZulu Natal Province.

3. Study aim
To investigate factors influencing the uptake of HIV counseling and testing services by employees at Pietermaritzburg Correctional Services, South Africa.

4. Research questions

- What are factors influencing the uptake of HIV counseling and testing services by employees at Pietermaritzburg Correctional Services?

5. Study objectives

1. To determine the socio-demographic profile of employees at Pietermaritzburg Correctional Services
2. To determine the level of uptake of HCT among employees at Pietermaritzburg Correctional Services.
3. To determine other factors (such as knowledge, awareness, etc) influencing the uptake of HIV counseling and testing services by employees at Pietermaritzburg Correctional Services.
6. Significance of the study

In October 2006 a national HIV and AIDS counseling and testing survey was conducted by the National Department of Correctional Services on employees and offenders. The results of the survey which were released in 2007 revealed patterns which were similar to the National Department of Health norms as KwaZulu Natal recorded the highest HIV prevalence rate of 22.7% among personnel who were tested (Tapscott, 2008)

The findings of this study will assist the department to discover effective ways of executing the HIV and AIDS program for its personnel and will guide allocation of resources to ensure its full implementation. This will benefit the department in reducing the high staff turnover and absenteeism rate and improve staff morale and productivity. Implementation of this program will also assist in reduction of medical costs borne by the department of Correctional Services, Department of Health and the Medical Aid Scheme as it will see more employees getting information and testing for HIV and get medical assistance and support before they get sick.

The study will benefit management and employees hence the challenges identified will receive attention of top management to design a workplace program for employees to receive information on HIV and AIDS, have HIV counseling and testing program at the workplace, have treatment programs available and create an environment which is conducive to disclosure and addresses the issue of
discrimination and stigmatization in the workplace and promote establishment of support groups.

HIV Counseling and Testing (HCT) will help to prevent and mitigate the spread of the HIV virus through information on HIV and Acquired Immune Deficiency syndrome (AIDS) that is given during pretest and posttest counseling. Knowing their HIV status, employees will be able to have access to Anti- Retroviral treatment (ART) early, therefore improving their quality of life. The findings from this study will be used to make recommendations to improve HCT service delivery among the population within Pietermaritzburg Correctional Services regarding the uptake of HCT.

The outcome of the study will influence policy formulation regarding the HIV and AIDS program for personnel e.g. adequate allocation of financial, material, and human resources in particular. The department need to have a permanent structure on the HIV and AIDS workplace program, adequate resources and needed infrastructure for full implementation of the program.
CHAPTER 2

2. LITERATURE REVIEW

2.1) Introduction

It has been found that South Africa has a high prevalence of the HI Virus with 34 million people reported to be living with the virus DOH (2010). Motshabi et al, (2011) refers to “HIV voluntary counseling and testing (HCT) as the process whereby an individual undergoes counseling to enable him or her to make an informed choice about being tested for HIV. In consideration of the human rights clause that is enshrined in the South African Constitution the department is obliged to provide the HCT services to employees as they don’t have enough time to access such services in their communities owing to their busy work schedule (Corbett, 2006).

The department of labor came up with a code of good practice in 2000 which provides a significant framework which guides the implementation of the HIV and AIDS program in the world of work by all employers (private or public) This code emphasizes the need for an integrated approach in the management of this epidemic since it impacts negatively on the workplace, individuals, families and the economy of the country. Communities and industries alike are severely and pervasively affected by HIV and AIDS and its impact has far reaching consequences including a severe economic impact in the world of work. The code also stresses the importance of care and support to those employees who happened to be infected or affected by HIV and AIDS for them to be able to continue work and be productive as much as it is possible (DOL, 2000; Goldberg, 2011).
Another code of good practice was set by the international labor organization (ILO) on HIV and AIDS management in the workplace. This code regarded HIV and AIDS as a workplace issue which needs to be taken seriously just like any illness and the workplace has a role to play in the struggle against the epidemic. The South African Business coalition on HIV and AIDS established a coalition fund which aimed at making HIV counseling and testing available to vulnerable employees and their families and a number of businesses followed suit by incorporating HIV and AIDS policies and policy procedures into their organizational policies (Goldberg, 2011).

In practice most companies and industries have taken the HIV and AIDS in the workplace seriously as they developed and implemented the HIV and AIDS policies and programs e.g. Daimler Chrysler, Toyota, South African Shell and BP Petroleum Refineries (SAPREF) etc. AT SAPREF the HIV counseling and testing services were outsourced to a private company which visits this industry once a month to offer these services to employees and there is also an occupational health nursing facility available on site to provide care, support and treatment to employees (SAPREF, 2000).

In the Department of correctional services there is no structured HIV and AIDS program in place and HIV counseling and testing and awareness programs are provided occasionally during wellness days by visiting companies like government
employees medical scheme, Old mutual etc. and despite this, utilization of these services by employees is very low (DCS, 2012).

Accessibility and availability of HCT services motivates people to partake in the service thus increasing the uptake. This was confirmed in a survey that was conducted to patients in two Ugandan hospitals whereby 98% accepted HCT because the service was accessible to them (Wayenze et al, 2008).

2.2) Benefits and utilization of HCT

Testing and immediate treatment can mitigate or eliminate the spread of HIV but despite the global efforts in expansion of HIV counseling and testing services utilization of this service in Sub-Saharan Africa remains low with subsequent late presentation to medical care and treatment. With the increasing number of HIV/AIDS infections, people should be encouraged to know their HIV status for them to decide and plan on their lifestyle and their future. (Ziraba et al, 2011; Osterman et al, 2011)). In 2007 WHO recommended routine HIV counseling of all persons who are willing to take the test in all countries with generalized epidemics like South Africa and this recommendation is still far from being implemented as over 3 million South Africans are still unaware of their HIV status and are therefore unable to benefit from the service (WHO, 2007).

HCT has multiple benefits such as reducing HIV/AIDS and other sexually transmitted diseases; improving HIV care and support including access to antiretroviral therapy.
(Bwambale et al. 2008; Motshabi et al., 2011). When treatment is available HCT can be an effective intervention in the fight against HIV and even in the absence of treatment HCT can assist with lifestyle changes and behavior modification.

HCT can also assist in health promotion as the information given during pre and posttest counseling can promote changes in risky behaviors and lifestyle. Perceived benefits may also be low when treatment is not readily available or is not available as is the case in some areas of Africa (Corbett, 2006) More benefits to HCT were identified by (Wayenze et al., 2008) He stated that people who tested positive for HIV can prevent transmission of the virus to their partners and children and can avoid re-infecting themselves by practicing safe sex. He further stated that HCT can assist in identification of discordant couples, increase access to medication, care and support, prevention of mother to child transmission and can also facilitate disclosure.

In South Africa there is over 4000 HCT centers and in spite of the benefits of HCT mentioned above there is low level of uptake on HCT services by the general public with correctional services employees inclusive and as suggested by UNAIDS (2011) “only 47% of South Africans reported to have ever tested for HIV infection and only an estimated 34% of all HIV-infected individuals (1.9 million) are receiving care”.

In a study which was conducted in the Kilimanjaro area of Tanzania the findings were that nearly half of females and more than half of males have never been tested before (Osterman et al., 2011) and more males were less likely to avail themselves for HIV counseling and testing as compared to their counterparts. Few persons aged 20-
24 tested for HIV. Divorced, separated and widowed were more likely to test for HIV than married people with the never married less likely to have tested (Ziraba et al, 2011)

2.3) Factors hindering utilization of HCT services

There are various reasons as drawn from the review of the literature that have been found to be the cause of prohibition of voluntary, counseling and HIV testing. Both women and men when asked if they would like to participate in HIV testing they all showed interest but highlighted some substantial barriers which inhibit the uptake of these services. Motivation to utilize HCT services is low even in areas with high prevalence of HIV or subsequent to high risk behavior. Fear of stigma and discrimination, negative attitudes and lack of trust of health care workers, unavailability or lack of knowledge of HCT services, perceptions of being low risk to HIV, long distances to health care services, lack of knowledge on HIV and AIDS and HCT, lack of privacy, lack of follow up support, shortage of trained counselors, influence by partners and busy work schedule were all sighted as the reasons for not partaking in HCT (Helleringer et al, 2009; Hutchinson and Mahlalela 2006; Osterman et al, 2011; Walensky et al, 2011; Peltzer 2009))

The ILO code of conduct states that in the spirit of decent work and respect for human rights and dignity of persons infected and affected by HIV and AIDS there should be no discrimination and stigmatization of employees on the basis of real or perceived HIV status but despite this ethical clarity stigma and discrimination are still
intimidating the HIV and AIDS prevention, care and support programs initiatives as this inhibits these efforts, even when structured HIV counseling and testing programs are in place utilization of these programs is very low and this is attributed to stigma and discrimination among other factors (Goldberg, 2011)

Studies have revealed that more women partake in HCT services than men because men viewed HIV testing as being inaccurate, had fear of family disorganization like divorce or separation from the partner and the family if tested positive and they also fear that they will be denied social rights and privileges e.g. nominations to social or political positions in their communities, sexual rights etc. fear that if women tested positive this would automatically mean that their male partners are HIV positive. Superiority of men to women e.g. dominated unchallenged decisions, fear of being labeled an HIV victim, confidentiality- preferred to be tested somewhere else, consequences of a test result, long waiting time before HCT (Bwambale et al. 2008; Ma et al, 2010; Nuwaha et al, 2002). Supervisor, employee relationship, co-worker hostility, negative perception of organizational support, non-support by unions also affected the decisions for HIV testing by employees. (Mundy and Dickinson, 2004).

Unavailability of HIV counseling and testing service in the workplace can be a contributory factor to low uptake of this service and this was confirmed in a cluster randomized study that was conducted in Zimbabwe where HCT services were offered to participants in site and offsite, the onsite uptake was more by 51% as
compared to offsite with only 4.3% of participants accepting the test, these findings confirm that availability of these services with competent staff and continuous provision in the workplace can improve the current low uptake in Africa (Corbett et al, 2006. This was also revealed in a study which was aimed at investigating acceptability of routing HIV counseling and testing in Ugandan hospitals (Wayenze et al, 2008). Participants in this study confirmed that they never tested for HIV before because of the distance to testing health facilities and not having time and/or money to access those services. HCT offered at the hospital was more convenient to them because there were no costs involved resulting in improvement in utilization of the service (Ma et al, 2010).

Goldberg also mentioned that in a study that was conducted in a large South African company the nature of social interaction e.g. gossip, social isolation, and in some cases verbal abuse resulted in reluctance to test and/or disclose the HIV status by employees (Goldberg, 2011) In another study it was revealed that HIV counseling in the workplace may increase the uptake of this service if offered on site (Corbett, 2006) but one researcher had a different view to this, the findings of his study have shown that the HCT on site may subject employees to stigma and discrimination as there is a high possibility of the results being made public due to the length of post-test counseling when the HIV results are positive. In this study both onsite and off-site HCT was offered and the acceptance of this service off site was 12 times more than the on-site HCT (Goldberg, 2011).
In another study that was conducted on knowledge, attitude and practices towards voluntary counseling and testing it was revealed that fear of positive results, stigma and discrimination, level of education with the educated being more likely to accept the test as compared to the less educated or the illiterate, sex where females availed themselves for HIV testing than men, religion and knowledge about HCT were discovered to be influencing the uptake of HCT. Literature found that distance from available testing sites, not knowing where to test, lack of knowledge about available testing options, fear of test results, travelling, don't want to be seen at the site, lack of confidentiality, never thought about getting tested and partner disagreement were confirmed to have an influence on the low utilization of HCT services (Osterman, 2011; Bauserman et al, 2001).

Some studies revealed that attitude that the individual who is testing for HIV must have engaged in a dirty behavior or must have AIDS and low education levels and negative attitudes affected HCT uptake negatively, some thought there were no benefits or didn't know the benefits of testing for HIV, HCT related knowledge which was closely related to level of education, being afraid of needles, difficulty in travelling to HCT sites because of long distances and unavailability of transport, poor health, and being judged, all these affected the decisions to take up an HIV test. (Ma et al, 2007).

Other reasons that were cited for non-acceptance of HCT services were that other people do not have enough coping mechanisms to deal with results, fear of
disharmony in the house and the fear that testing will indicate that a person is sexually active (Chirawu et al, 2010). Health personnel attitudes with lack of professional secrecy, perceived risk of HIV infection, fear of disclosure of the HIV status, being married, cultural, social and biological factors like male dominance where men are in control of relationships, vulnerability to risk were revealed to be influencing the uptake of HIV counseling and testing negatively (Abamecha et al, 2013).

Another study showed that attitudes, perceptions of not being at risk of contracting HIV, not knowing where to go for the HIV test and STI diagnosis can also contribute to low HCT uptake (YI et al, 2009). The attitudes of managers and supervisors also contribute to non-acceptance of HCT (Athanasiades, 2008). In a study that was conducted on student nurses in Tanzania fear of testing for HIV, attitudes towards VCT, don’t see the need, religion and diagnosis of STI’s also had a negative impact on taking the HIV test (Charles et al, 2009) This was also confirmed in studies that were conducted by (Sasaki et al, 2011; Fylkesnesk and Siziya, 2004).

2.4) Factors motivating the uptake of HIV counseling and testing

For people to change their behavior and take informed and appropriate action they need to know their HIV status hence HCT is perceived as the corner stone and an effective entry point to HIV prevention and care program. Despite the low utilization of HCT literature also revealed motivating factors to the service. Observational studies showed that convenience, direct offer of HIV testing and the positive attitude of the
health care staff e.g. counselors and nurses can have a positive impact on the utilization of HCT services by employees and these motivating factors seem to outweigh the individual factors Cobbett (2006); Wayenze et al (2008) Cobbett also mentioned the availability of Anti-Retroviral Treatment as a motivating factor to utilization of HCT as it can serve as an entry point to medical treatment (Cobbett. 2006).

According to literature the quality of interaction between the client and the counselor e.g. confidentiality and trust can have a positive influence on acceptance of HCT by employees. Home visiting by the health care staff also proved to be motivating people to test for HIV as they hoped to be monitored and well cared for during these visits. The educational level was also a motivational factor as this study found that participants with secondary education were five times likely to accept the HIV test than those with no formal education. House hold resources, knowledge that HIV causes AIDS, discussions with partners about HIV prevention and condom use at last intercourse, all these factors were found to be positively associated with acceptance of HIV counseling and testing (Hutchinson and Mahlalela, 2006).

Couple testing, intention to disclose HIV status to partner, desire to know status, the decision to abstain from sex if tested positive, living positively with the virus, to seek medical help and treatment, hoping to join support groups, proximity and convenience of HIV testing centers and the age factor i.e. 35 years and below, all these were found to impact on the HCT program positively. (Bwambale et al, 2009).
More factors with a positive influence on the HCT program were identified in another study and these are age -25 to 35 years old were more likely to accept the HIV test than any other age, gender with females more willing to take the HIV test than men, other population than black e.g. whites, colored, Indians etc., being married or co-habitating, educational level i.e. grade 12 and more, being employed, awareness of a place nearby, urban residence, higher knowledge score of HIV, knowledge of serodiscordence, impact of HIV on the house hold, high risk perception- two or more sexual partners and non-condom use with the last sex, knowing someone living with HIV, caring for someone with HIV/AIDS and knowing someone who have died of AIDS. (Peltzer et al, 2009; Abamecha et al, 2013).

Some other factors with a positive influence on the decision to test for HIV were revealed by other studies and these are: Influence from a sexual partner, physical accessibility, awareness about HIV, availability of ARVs, perceived quality of care and availability of VCT services, showing symptoms of AIDS, loss of sexual partner, intentions of getting married, mandatory requirements like joining the army, about to get a scholarship, when demanded by a sexual partner, secrecy in handling results, specificity and sensitivity of results (Nuwaha et al, 2010).

On site HCT in the workplace can be one way to improve the uptake of HIV counseling and testing in Africa from its current low level and continuous provision of HCT. In one of the studies where on site and off site HCT was offered 51% tested on
site and only 4.3% tested off site and also age below 25 years and linking HCT to HIV care can motivate people to test (Corbett et al, 2006). Participation of stakeholder representatives especially union representatives is key to success of workplace HIV and AIDS interventions (Mundy and Dickson, 2004). Knowledge of HIV acquisition, had sex with a casual partner in past 12 months, being HSV 2 seronegative, lifetime number of partners, casual partners, past or current STI’s, increased knowledge of pregnancy prevention, being uncircumcised, current syphilis infection, knowledge of STI’s were cited as reasons to test for HIV (Baisley et al, 2012) Fear of being positive with its consequences e.g. job loss, death, easily identified and earmarked for redundancy at work were also revealed in a study that was conducted by (Ginwalla et al, 2002) Concern for own health after death of HIV positive partner, being pregnant, don’t perceive themselves to be at risk was also mentioned (Chirawu et al, 2010)

More studies were conducted on factors motivating people to avail themselves for HIV counseling and testing and findings were: consistent condom use, one or zero partners, previously undergone HCT, polygamous marriages (Wringe at al, 2008), improvement in conditions of employees who tested HIV positive and were put on ART., confidentiality, trust (Van der Borght et al, 2010). Management being supportive of program, employees being well informed about the service, counselors available to employees (Athanasiaides et al, 2008) Being at risk, perceived benefits (Charles et al, 2009)
Lots of studies on HCT uptake and the barriers to the service have been conducted on African communities but little has been done in studying these on employees. (Motshabi et al, 2011) conducted the study in the same study setting the researcher is interested in which is correctional services but the study was conducted on inmates investigating the utilization of HCT by them and their attitudes towards the service and different objectives in this study will be addressed and also different design, approach and sample size will be used.

There is lack of research on management of HIV and AIDS for officials and establishment of policies and strategies to reduce the spread of the disease in order to minimize the impact it can have on the department of Correctional Services (DCS, 2012). This study will therefore bridge the gap by investigating the level of HCT uptake by employees at Pietermaritzburg Correctional Services and barriers thereof.
CHAPTER 3

3. RESEARCH METHODOLOGY

3.1 Introduction

In this chapter the methods, research design and approach are presented. It further explains the study and target population, the study setting, sampling and sampling techniques, data collection tools and procedures followed in collecting data. It also describes the statistical tests used to analyze data and ethical considerations. Also in this chapter the approaches used to ensure reliability and validity and to minimize bias are discussed.

3.2 Research Design

The design that was used in this study was cross sectional descriptive study design Osterman et al,( 2011), because this study seeks to describe factors influencing the uptake on HCT programmes by employees of the three correctional centers and the Area Commissioner’s office at Pietermaritzburg Correctional Services. It therefore seeks to answer the question “why employees seek or do not seek these services” within the correctional services setting.

A quantitative approach was used to get information on the factors influencing the uptake on HCT services by employees. From this study the researcher wanted to get the actual factors that influenced health-seeking behaviors and perceptions towards HCT services by correctional services employees. Questionnaires were administered to the employees.
3.3 Study setting

The study setting was all correctional centers at Pietermaritzburg Correctional Services in KwaZulu Natal, South Africa. Summary of employees at Pietermaritzburg correctional services, including administrative block/ Area Commissioner’s office is as follows: The administrative block consist of workers who are responsible for all administration of activities such as payroll, processing of leave, staffing etc. within the Pietermaritzburg correctional Services, i.e. clerks, finance department; logistics, whilst correctional centers consist of correctional officials of different ranks. The following are the total numbers of employees in each correctional center.

<table>
<thead>
<tr>
<th>MEDIUM A</th>
<th>MEDIUM B</th>
<th>SEVONTEIN</th>
<th>NEW HANOVER</th>
<th>IXHOPO</th>
<th>ADMINISTRATION</th>
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<tr>
<td>381</td>
<td>69</td>
<td>269</td>
<td>98</td>
<td>45</td>
<td>57</td>
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3.4 Population and sample

There are 5 correctional centers and 1 central administrative block/head office with a total of 919 employees and the sample was drawn from three correctional centers and administration block: medium A; Medium B; Sevontein and Administration. The number of employees differs according to the capacity of each correctional service e.g. Medium A correctional center has the highest number of employees about 381. The number selected from the 3 correctional centers and administration as a sample
will be enough to ensure representativity of all employees at Pietermaritzburg Correctional Services.

3.5 Sample and sampling technique

The sample was selected using the stratified random sampling method. The researcher got the name list from the PERSAL database at human resource directorate representing all the employees working at all 3 correctional centers and administration block in Pietermaritzburg to recruit participants. The number of employees selected was based on the stratum size divided into: Administrators; health professionals and Correctional officers.

Power, confidence level and software was used to determine the sample size

Sample size was calculated using Epi-info software.

Estimated population: 919 Power: 0.5; Confidence: 95%

Sample size: 345 and 30 employees were added to cater for non-response/drop-out, meaning the sample size was 375.

This sample size was enough to get the information needed to meet the study objectives and it was manageable when doing analysis on research findings. Officials were selected in such a way that all sections in the correctional center were represented.
3.6 Inclusion and Exclusion Criteria

This study only included employees that were employed on fulltime basis at the Pietermaritzburg correctional services. All part-time workers and interns were excluded from this study.

3.7 Data collection

Data was collected using questionnaires that were distributed and filled by the respondents and deposited in a box, to maintain confidentiality. Questions were adapted from the existing questionnaires to suit the purpose of the study (Corbett et al, 2006). The questionnaire was written in English only as all the study participants were conversant with the language. Study participants were recruited through telephone calls and emails and in face to face and those who agreed to participate arrangements were made with them and they were issued with the questionnaires to complete. The questionnaires were delivered to the respondents at the correctional centers with clear instructions on how to fill them in and were collected after completion by the researcher. To maintain privacy and confidentiality an office inside each correctional center was used for the filling of the questionnaires by participants in the presence of the researcher and to ensure anonymity there were no names on the forms. Completed questionnaires were kept in a sealed box under lock and key.
3.8 Data analysis

Data was analysed using SPSS version 21.0. Descriptive statistical method was used to analyse frequencies, correlations and means. Chi square was be used to analyse cross-tabulations between variables. Logistic regression was used to determine odd ratios. Data was presented using tables and graphs. To analyse qualitative data from open ended questions themes were developed and the data was analysed quantitatively. Only data from 345 participants was analysed as the extra 30 was just to cater for non-responses.

3.9 Validity and reliability

3.9.1 Testing Validity

Validity is the ability of the test to measure what it is supposed to measure (Accuracy) In other words it is the ability to scientifically answer what it is supposed to answer.

External validity – This study can be believed to be true to be used in other cases.

Internal validity – This is the degree to which conclusions about causal relationships can be made. Both internal and external validity were addressed by applying the following measures:

The questionnaire was taken to experts in the field of HIV, e.g. University Lecturers to check for content validity. Pretesting of the tool on a separate sample in the same setting was done. 20 participants that were not part of the study were requested to voluntary participate to fill in the questionnaire as a pre-test of the tool on the 13\textsuperscript{th} of December 2013. From this exercise few spelling mistakes and questions that needed
clarity were identified and corrected before the study commenced on 17th December and had to stop on the 22nd because most participants were on holiday by this time. The study resumed on the 9th January and ended on the 20 January 2014 lasting for three weeks.

3.9.2 Testing Reliability

Reliability is the ability of the test to yield the same results if repeated using the same tool (Consistency or repeatability) Dependability which is a measure of reliability will be done by applying the following measures:

To test for reliability of the questionnaire the researcher conducted a pilot study on a group of employees from the same setting with similar characteristics to study participants, who were not part of the study group.

3.10 Bias

In conducting the study the researcher could encounter selection bias and this was minimized by performing random selection of study participants, according to strata mentioned above from the target group. All the names of employees were randomly selected in order to recruit participants.

3.11 Ethical considerations

An application form and an agreement form were filled for approval by the departmental research committee and thereafter permission was sought from the National Department of Correctional Services and heads of the institutions that were
investigated to gain entry and access the target population. Ethical clearance was obtained from the MEDUNSA Research Ethics Committee (MREC). The National Department of Correctional services granted the researcher permission to conduct the study in the selected correctional centers.

A research guide was appointed to make sure that the researcher conducts the study according to the agreement entered into with the department and to ensure that ethical considerations are observed and the DCS policies on research are followed. The letters of approval were sent to the Regional commissioner and the Area Commissioner to notify them of the study. The Area Commissioner in turn notified the Heads of Correctional Centers in writing of the visit by the researcher. On the 11th of December 2013 the researcher contacted the Heads of correctional centers to confirm the visits and book the dates to gain entry into the correctional centers to meet with the study participants and commence the study. Different dates and times in different correctional centers were allocated and were honored by the researcher.

The participants were informed about the purpose, the nature, the risks, the objectives and the benefits of the study. The participants were informed that the study was voluntary and they could withdraw from the study at any given time even during and after the study. They were informed that they have the right to make decisions about the study and the right to get the information on the study findings (autonomy) and the participants were informed that information would be kept confidential in a locked cupboard and privacy was maintained by ensuring that
questionnaires were filled in an office in each correctional center and anonymity was ensured by making sure that there were no names of the participants on the questionnaires.

All this information was given to participants so that they can make informed decisions whether to participate or not to participate in the study and to clarify the concerns the participants might have about the study. Because the participants were well informed about the study they were more dedicated and cooperative and gave consent freely.

The participants were informed of procedures to contact the researcher following participation in the study should stress, harm, questions and concerns arise. Information sheets with all the information mentioned above were given to participants and consent forms were given for them to sign.
CHAPTER 4

4. RESULTS

4.1 Introduction

This chapter presents results from a sample of 345 correctional officials working in the three correctional centers namely: Medium A, Medium B, Sevontein and the area commissioner's office at Pietermaritzburg correctional services in the KwaZulu Natal Province. The results were analyzed using SPSS version 21.0 and were presented in the form of tables and graphs.

The format of data presentation was divided into four sections, that is Part one – socio-demographic profile, part two- basic knowledge on HIV and AIDS, part three- Awareness of availability of HIV counseling and testing (HCT) Service at workplace and part four - Factors influencing uptake of HIV counseling and testing (HCT)

4.2 Socio – demographic profile of respondents

Table 4.1: The frequency distribution, means, median and standard deviation of the participants according to gender, age category, marital status and race

<table>
<thead>
<tr>
<th>Variable (n=345)</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Means ,median ,std deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>197</td>
<td>57.1</td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td>148</td>
<td>42.9</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30 years</td>
<td>86</td>
<td>24.9</td>
<td>Mean = 37.0, Median = 36, Sd = 8.4</td>
</tr>
<tr>
<td>31-40 years</td>
<td>148</td>
<td>42.9</td>
<td></td>
</tr>
<tr>
<td>41-50 years</td>
<td>83</td>
<td>24.1</td>
<td></td>
</tr>
<tr>
<td>51-63 years</td>
<td>28</td>
<td>8.1</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not married</td>
<td>180</td>
<td>52.1</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>165</td>
<td>47.8</td>
<td></td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suburb</td>
<td>114</td>
<td>33.0</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.1 above shows that the age of the respondents varied from 22 years to 63 years with the mean age of 37.0, median 36 years and standard deviation of 8.4. There were more male respondents (57.1%) than female respondents at (42.9%). Just over half of the respondents were not married (52.1%) and the married were (47.8%). Most of the respondents resided in townships (42.6%) followed by (33.0%) who resided in suburbs and 24.3% resided in rural areas.

Table 4.2: The frequency distribution, means, median and standard deviation of the participants according to job title, education level, and employment duration and Job category

<table>
<thead>
<tr>
<th>Variable</th>
<th>n=345</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Matric or less</td>
<td>153</td>
<td>44.3</td>
</tr>
<tr>
<td></td>
<td>Cert or Diploma</td>
<td>110</td>
<td>31.9</td>
</tr>
<tr>
<td></td>
<td>Degree</td>
<td>82</td>
<td>23.8</td>
</tr>
<tr>
<td>Employment duration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;=5yrs</td>
<td>81</td>
<td>23.5</td>
<td></td>
</tr>
<tr>
<td>6-10yrs</td>
<td>132</td>
<td>38.3</td>
<td></td>
</tr>
<tr>
<td>&gt;10yrs</td>
<td>132</td>
<td>38.3</td>
<td></td>
</tr>
<tr>
<td>Job title</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerk</td>
<td>47</td>
<td>13.6</td>
<td></td>
</tr>
<tr>
<td>Manager</td>
<td>34</td>
<td>9.9</td>
<td></td>
</tr>
<tr>
<td>Correctional Officer</td>
<td>236</td>
<td>68.4</td>
<td></td>
</tr>
<tr>
<td>Health Worker</td>
<td>28</td>
<td>8.1</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.2 shows that most respondents had matric or less (44.3%) and 55.7% had certificates and degrees. Also, most of respondents were employed for 6 to 10 years. The job title of the respondents ranged from correctional officials in majority at (68.4%), clerks (13.6%), managers (9.9%) and health care workers at (8.1%).
4. 3. Section 2: Basic knowledge on HIV and AIDS

Fig 4.1: Respondents’ response to having Received HIV Information
Of the 345 respondents (92.8%) report that they had received information on HIV and only (7.2%) have not received information on HIV.

Fig 4.2 Respondents Response on How HIV is transmitted.
Fig 4.2 shows that 47.5% of the respondents stated that HIV is transmitted through unsafe sex only, whilst 46.5% reported that HIV is transmitted through unsafe sex, injections, Mother to child transmission (MTCT) and injections (Inj), (13%) 6% of the respondents were not sure.
Fig 4.3: Prevention methods as reported by Respondents

Figure 4.3 above shows that 66.5% of the participants responded that HIV can be prevented through Abstinence, Being faithful to the partner and condomize (ABC), Condomize( and avoid sharing razors, safe blood transfusion (3.5%), and 14.5% were not sure.

Fig 4.4: Respondents report on whether they have received information on HIV

Fig 4.4 above shows that 92.8% of the respondents have received information on HIV and 7.2% never received information on HIV.
Fig 4.5 Respondents who have relatives diagnosed with HIV

Fig 4.5(66.7%) had a close relative or friend who is infected with HIV or died of AIDS, (8.6%) didn't have and (14.3%) were not sure.

Fig 4.6: Knowledge on signs of HIV infected person

Fig 4.6 above shows that, of the 345 respondents only 10.1% agreed that a healthy person cannot be infected with HIV, whilst the majority(82%) disagreed and (7.9%) were not sure.
4.4 Ever Used HCT Services

Fig 4.7: Participants' Response on whether participants have ever used HCT Centers

Fig 4.7 above shows that 40.9% of the respondents reported that they have never used the HCT centers and (59.1%) have.

Fig 4.8 HCT Centers visited by Respondents (n= 204)

Fig 4.8 above shows that the majority of respondents (79.9%) have visited HCT centers at the clinics and hospitals, whilst only 13.% and 7.1% had visited private practice and workplace for HCT respectively.
Table 4.3 Awareness of Availability and Use of HCT at Workplace, % in rows

<table>
<thead>
<tr>
<th></th>
<th>Yes n(%)</th>
<th>No n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aware of HCT at Work</td>
<td>129 (37.4)</td>
<td>216 (62.6)</td>
</tr>
<tr>
<td>Use of HCT</td>
<td>25 (7.1)</td>
<td>320 (92.9)</td>
</tr>
</tbody>
</table>

Table 4.3 above shows that, of the 345 respondents 129 (37.4%) were aware of the availability of HCT services at their workplace and the majority (62.6%) were not aware. Also, only 7.1% of the respondents have ever used the workplace HCT services.

Table 4.4 Respondents Reasons for not Using HCT at work (n = 345)

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not aware</td>
<td>216</td>
<td>62.6</td>
</tr>
<tr>
<td>Not comfortable</td>
<td>14</td>
<td>4.1</td>
</tr>
<tr>
<td>Never thought of it</td>
<td>74</td>
<td>21.4</td>
</tr>
<tr>
<td>No Confidentiality</td>
<td>41</td>
<td>11.9</td>
</tr>
<tr>
<td>Total</td>
<td>345</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 4.4 above shows that the majority of respondents (62.6%) were not aware of the availability of HCT services at their workplace, whilst (4.1%) were not comfortable using the workplace HCT services. (21.4%) never thought of using HCT services at workplace and (11.9%) were concerned about confidentiality at the workplace HCT centers as reasons for not utilizing the workplace HCT services.
Table 4.5: Reasons stated by Respondents who were aware of Workplace HCT Services but never used them n= 129

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not comfortable</td>
<td>14</td>
<td>10.8</td>
</tr>
<tr>
<td>Never thought of it</td>
<td>74</td>
<td>57.4</td>
</tr>
<tr>
<td>No Confidentiality</td>
<td>41</td>
<td>31.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>129</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Table 4.5 shows that of the 129 of the respondents that were aware of the HCT services at the workplace but never utilized the centers reasons were as follows: 10.8% were not comfortable testing at the workplace, (57.4%) never thought of testing at the workplace, (31.8%) lack of confidentiality by the health care staff at the center.
Section D

4.5 Factors influencing the uptake of HCT at the workplace as reported by the Respondents.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Always</th>
<th>Sometimes</th>
<th>Never</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>confidentiality is maintained at the HCT center at your workplace,</td>
<td>62(18.0)</td>
<td>31(9.0)</td>
<td>32(9.3)</td>
<td>220(63.8)</td>
</tr>
<tr>
<td>Does the issue of confidentiality worry you regarding HCT at work?</td>
<td>143(41.5)</td>
<td>83(24.1)</td>
<td>91(26.4)</td>
<td>28(8.1)</td>
</tr>
<tr>
<td>staff always available to do HCT at your worksite</td>
<td>69(20.0)</td>
<td>0 (0.0)</td>
<td>85(24.6)</td>
<td>191(55.4)</td>
</tr>
<tr>
<td>Does the HCT center have adequate access to ART treatment</td>
<td>83(24.1)</td>
<td>0 (0.0)</td>
<td>40(11.6)</td>
<td>222(64.3)</td>
</tr>
<tr>
<td>Does staff provide post-testing support</td>
<td>69(20.0)</td>
<td>0 (0.0)</td>
<td>57(16.5)</td>
<td>219(63.5)</td>
</tr>
<tr>
<td>What are the chances of you disclosing your HIV status to other people</td>
<td>94(27.2)</td>
<td>0 (0.0)</td>
<td>131(38.0)</td>
<td>120(34.8)</td>
</tr>
<tr>
<td>What are the chances of you disclosing your HIV status to your superior</td>
<td>72(20.9)</td>
<td>0 (0.0)</td>
<td>143(41.5)</td>
<td>130(37.7)</td>
</tr>
<tr>
<td>Do you fear intimidation by colleagues if tested positive</td>
<td>144(41.7)</td>
<td>0 (0.0)</td>
<td>155(44.9)</td>
<td>46(13.3)</td>
</tr>
</tbody>
</table>

Table 4.6 above shows that the majority of respondents were not sure (63.8%) whether confidentiality could is maintained in the worksite and whether staff provided post-test support (63.5%), Also, 41.7% feared intimidation by colleagues.
Table 4.7 Ever used any HCT vs Socio-demographic characteristics of respondents. (n= 345)

<table>
<thead>
<tr>
<th>Variable (n=345)</th>
<th>Has used HCT Centre</th>
<th>Has never used HCT Centre</th>
<th>Pvalue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males (n=197)</td>
<td>96 (48.7)</td>
<td>101 (51.7)</td>
<td>X = 3.527</td>
</tr>
<tr>
<td>Females (n=148)</td>
<td>108 (73.0)</td>
<td>40 (27.0)</td>
<td>P = .038</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30 yrs (n=86)</td>
<td>53 (61.6)</td>
<td>33 (38.4)</td>
<td>X = 11.113</td>
</tr>
<tr>
<td>31-40 yrs (n=148)</td>
<td>83 (56.1)</td>
<td>65 (43.9)</td>
<td>P = .011</td>
</tr>
<tr>
<td>41-50 years (n=83)</td>
<td>58 (69.9)</td>
<td>25 (30.1)</td>
<td></td>
</tr>
<tr>
<td>51-63 years (n=28)</td>
<td>10 (35.7)</td>
<td>18 (64.3)</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not married (n=180)</td>
<td>113 (62.8)</td>
<td>74 (37.2)</td>
<td>X = 2.072</td>
</tr>
<tr>
<td>Married (n=165)</td>
<td>91 (55.2)</td>
<td>67 (44.8)</td>
<td>P = .092</td>
</tr>
<tr>
<td>Title</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerk (n=47)</td>
<td>24 (51.0)</td>
<td>23 (49.0)</td>
<td>X = 2.146</td>
</tr>
<tr>
<td>Manager (n=34)</td>
<td>20 (58.8)</td>
<td>14 (41.2)</td>
<td>P = .543</td>
</tr>
<tr>
<td>Correctional Officer (n= 236)</td>
<td>145 (61.4)</td>
<td>91 (38.6)</td>
<td></td>
</tr>
<tr>
<td>Health worker (n=28)</td>
<td>15 (53.6)</td>
<td>13 (46.4)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matric or less (n=153)</td>
<td>84 (54.9)</td>
<td>69 (45.1)</td>
<td>X = 2.084</td>
</tr>
<tr>
<td>Certificate/Diploma (n=110)</td>
<td>68 (61.8)</td>
<td>42 (38.2)</td>
<td>P = .353</td>
</tr>
<tr>
<td>Degree (n=82)</td>
<td>52 (63.4)</td>
<td>30 (36.6)</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.7 shows that gender and age significantly influenced whether participants used HCT center or not (p=.038 and .011) whilst marital status, title and education did not significantly influence whether participants used HCT or not (p>.05)
Table 4.8 Participants who have used HCT at work vs Socio-demographic Profile

<table>
<thead>
<tr>
<th>Variable (n=345)</th>
<th>Has used HCT Centre at work</th>
<th>Has never used HCT Centre at workplace</th>
<th>Pvalue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males (n=197)</td>
<td>35 (27.8)</td>
<td>162 (82.2)</td>
<td>X = .060</td>
</tr>
<tr>
<td>Females (n=148)</td>
<td>25 (16.9)</td>
<td>123 (83.1)</td>
<td>P = .474</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30 yrs (n=86)</td>
<td>11 (12.8)</td>
<td>75 (87.2)</td>
<td>X = 2.338</td>
</tr>
<tr>
<td>31-40 yrs (n=148)</td>
<td>30 (20.2)</td>
<td>118 (79.8)</td>
<td>P = .506</td>
</tr>
<tr>
<td>41-50 years (n=83)</td>
<td>15 (18.1)</td>
<td>68 (81.9)</td>
<td></td>
</tr>
<tr>
<td>51-63 years (n=28)</td>
<td>4 (14.3)</td>
<td>24 (85.7)</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not married (n=180)</td>
<td>62 (34.4)</td>
<td>118 (65.6)</td>
<td>X = 1.139</td>
</tr>
<tr>
<td>Married (n=165)</td>
<td>66 (40.0)</td>
<td>99 (60.0)</td>
<td>P = .170</td>
</tr>
<tr>
<td>Title</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerk (n=47)</td>
<td>7 (14.9)</td>
<td>40 (85.1)</td>
<td>X = 4.630</td>
</tr>
<tr>
<td>Manager (n=34)</td>
<td>7 (20.6)</td>
<td>27 (79.4)</td>
<td>P = .201</td>
</tr>
<tr>
<td>Correctional Officer (n= 236)</td>
<td>45 (19.1)</td>
<td>191 (80.9)</td>
<td></td>
</tr>
<tr>
<td>Health worker (n=28)</td>
<td>1 (3.6)</td>
<td>27 (96.4)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matric or less (n=153)</td>
<td>24 (15.7)</td>
<td>129 (84.3)</td>
<td>X = 2.244</td>
</tr>
<tr>
<td>Certificate/Diploma (n=110)</td>
<td>24 (21.8)</td>
<td>86 (78.1)</td>
<td>P = .326</td>
</tr>
<tr>
<td>Degree (n=82)</td>
<td>12 (14.6)</td>
<td>70 (85.4)</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.8 shows that gender; age; marital status, title and education did not significantly influence whether participants used HCT center at work or not (p>.05)
Table 4.9. Participants awareness of HCT at work vs Socio-demographic Profile

<table>
<thead>
<tr>
<th>Variable (n=345)</th>
<th>Aware of HCT at work</th>
<th>Not aware</th>
<th>Pvalue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males (n=197)</td>
<td>72 (36.5)</td>
<td>125 (63.4)</td>
<td>X = 1.060</td>
</tr>
<tr>
<td>Females (n=148)</td>
<td>56 (37.8)</td>
<td>92 (61.2)</td>
<td>P = .447</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30 yrs (n=86)</td>
<td>36 (41.9)</td>
<td>50 (58.1)</td>
<td>X = 5.601</td>
</tr>
<tr>
<td>31-40 yrs (n=148)</td>
<td>60 (40.5)</td>
<td>88 (59.5)</td>
<td>P = .123</td>
</tr>
<tr>
<td>41-50 years (n=83)</td>
<td>22 (26.5)</td>
<td>61 (73.5)</td>
<td></td>
</tr>
<tr>
<td>51-63 years (n=28)</td>
<td>10 (35.7)</td>
<td>18 (64.3)</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not married (n=180)</td>
<td>62 (34.4)</td>
<td>118 (65.6)</td>
<td>X = 1.139</td>
</tr>
<tr>
<td>Married (n=165)</td>
<td>66 (40.0)</td>
<td>99 (60.0)</td>
<td>P = .170</td>
</tr>
<tr>
<td>Title</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerk (n=47)</td>
<td>14 (29.8)</td>
<td>33 (70.2)</td>
<td>X = 8.303</td>
</tr>
<tr>
<td>Manager (n=34)</td>
<td>17 (50.0)</td>
<td>17 (50.0)</td>
<td>P = .032</td>
</tr>
<tr>
<td>Correctional Officer (n=236)</td>
<td>92 (38.9)</td>
<td>144 (61.01)</td>
<td></td>
</tr>
<tr>
<td>Health worker (n=28)</td>
<td>28 (100)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matric or less (n=153)</td>
<td>24 (15.7)</td>
<td>129 (84.3)</td>
<td>X = 2.244</td>
</tr>
<tr>
<td>Certificate/Diploma (n=110)</td>
<td>24 (21.8)</td>
<td>86 (78.2)</td>
<td>P = .326</td>
</tr>
<tr>
<td>Degree (n=82)</td>
<td>12 (14.6)</td>
<td>70 (85.3)</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.9 shows that title significantly influenced respondent’s awareness of HCT at work or not (p=.032) where 100% of HCWs were aware compared to other workers. Also, all other socio-demographic characters did not significantly influence awareness of respondents (p>.05).
Table 4.10: Regression analysis between Reasons according to age

<table>
<thead>
<tr>
<th>Reasons for not using Workplace HCT Services</th>
<th>B</th>
<th>Std. Error</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
<th>95% Confidence Interval for Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
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<td>.215</td>
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<td>.400</td>
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<tr>
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<td>.414</td>
<td>15.110</td>
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<td>.000</td>
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<td>.761</td>
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</tr>
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</table>

a. The reference category is: 7.00.

Regression analysis shows that age was not a significant predictor of respondents who cited no reason for not using HCT at workplace, never thought of it and no confidentiality; and age was a significant predictor of awareness of HCT at workplace and those that have used it, (OR = 1.421; 1.609; 1.099; CI.400-4.404; .761 – 7.782; .644-7.285) respectively.
Table 4.11: Regression analysis between Reasons and gender

<table>
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<tr>
<th>Reasons for not using Workplace HCT Services</th>
<th>B</th>
<th>Std. Error</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
<th>95% Confidence Interval for Exp(B)</th>
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<td>.016</td>
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<td>.901</td>
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<td>.317 - 3.688</td>
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<td>.000</td>
<td>.800</td>
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<td>.901</td>
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<td>.901</td>
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<td>.000</td>
<td>1.081</td>
<td>.317 - 3.688</td>
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<td>.626</td>
<td>.016</td>
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<td>1.081</td>
<td>.317 - 3.688</td>
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<tr>
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<td>1</td>
<td>.901</td>
<td>1.081</td>
<td>.317 - 3.688</td>
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</table>

Table 4.11 shows that gender was a significant predictor of reasons for not using HCT at work, except for 1 variable. \( p<.050; \text{OR}1.447; .916;1.531;1.964; \text{CI}: .227-2.820; .470 -6.007;37-3.688 and .440-4.657 \) respectively.
CHAPTER 5
DISCUSSION, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

The aim of the study was to determine factors influencing the uptake of HIV counseling and testing by employees at Pietermaritzburg Correctional Services in KZN. This section contains discussion of study results, supported by literature. This chapter also includes conclusion, limitations of the study and recommendations.

The results will be discussed according to the following objectives:

1. To determine the socio-demographic profile of employees at Pietermaritzburg Correctional Services
2. To determine the level of uptake of HCT among employees at Pietermaritzburg Correctional Services.
3. To determine other factors influencing the uptake of HIV counseling and testing services by employees at Pietermaritzburg Correctional Services.

Objective 1: To determine the socio-demographic profile of employees at Pietermaritzburg Correctional Services

5.2 Gender, age and Marital status distribution of Respondents

The results of this study showed that most of respondents were males compared to females. This finding can be attributed to the fact that the majority of employees are generally males in the correctional services in this country due to the type of work
they do, which requires a lot of physical fitness as the workers deal mainly with dangerous criminals. Studies show that males have poor health-seeking behaviors compared to females; therefore, they are likely not to seek HCT services at work or anywhere else. This, however, is not unique to SA, a study done in Jamaica also revealed poor health-seeking behavior among men in that country (Bourne, Morris & Charles, 2010).

According to USAID, (2008) men in South Africa tend to adhere to rigid notion that health seeking is a sign of weakness; as a result, HCT uptake is very low among men in this country. Also, in countries like Zimbabwe and Ethiopia, the uptake of HCT was higher among women than men among teachers in these countries (Omer et al, 2009; Leta, Sandoy & Fylkesnes, 2012), showing that gender can be one factor influencing VCT uptake in Africa. In this current study, it was found that only 48% of males had used HCT services compared to 73% of females. Of interest is that, the KwaZulu-Natal Province has the highest prevalence of HIV, and with the most number of centers that test for HIV, however, males in that province seem to pay less attention to HCT and continue to engage in risky sexual behaviors at the same time. These studies, including the current study show that there is a need to focus HCT education campaigns towards males so as to scale-up acceptability.

The results of this study also show that the majority of respondents were less than 40yrs of age, with a mean age of 37yrs. This means that these workers were of child-bearing age, therefore are sexually active. It is expected that these workers should be able to seek information that will benefit their own health. Similarly, Kirakoya-Samadoulougou conducted a study in Burkina Faso, and found that people over
20yrs were likely to visit HCT services in that country, compared to younger people. Also, a study by Amu et al, (2013) showed that adults of reproductive age, had a poor uptake of HCT in Nigeria. In this current study, it was however found that most of respondents (69.9%) over 40yrs had used VCT services compared to those less than 40yrs. These findings are in contrast with many findings where HCT uptake was reportedly as low as 18% (Amu et al, 2013).

The results of this study further revealed that just over half of respondents were not married. Studies show that most unmarried people are usually in unstable relationships, where lack of commitment can expose them to promiscuity. At the same time, reports reveal that unmarried respondents utilized HCT services more than their married counterparts, meaning that, being married has been reported to have a negative influence on the HCT uptake (Abamecha et al, 2013). Wringe et al, (2008) reported that marital status among other socio-economic factors influenced HCT uptake among rural residents of Tanzania.

**Objective 2: To determine the level of uptake of HCT among employees at Pietermaritzburg Correctional Services.**

The VCT uptake remains at its lowest in Africa, however, in South Africa, HCT uptake differ according to Province. According to Helleringer et al, (2009), the low uptake of HCT is a serious concern, because it significantly hampers the enrolment of HIV infected individuals to treatment programs, thus, further decreasing their life expectancy. The current study results showed a high HCT uptake by prison staff in
six prisons of Pietermaritzburg, South Africa, where 59% of respondents reported that they had ever tested for HIV in their lifetime. Similarly, in Gauteng, Kempton park, it was also reported that there was a high level of uptake of HCT (Otasowie, 2010). This increased level of HCT uptake could be due to its incorporation to HIV prevention strategy by the National government (Birdsall et al, 2004). However, lack of human resources and physical infrastructure remain a challenge in scaling up HCT in many provinces of SA (UNAIDS, 2008).

The results of the current study further reveal that only 7% of respondents had ever used VCT services within the workplace. This low uptake of VCT at workplace was due to the fact that close to two thirds (62.6%) of respondents reported were unaware such services existed in the workplace. However, of the 37.4% (n=129) who were aware of such services, only 7.1% used the service. Of interest is that, there was no significant difference in the level of uptake according to gender, age, marital status, title and education level, p>.050. As reported under objective 1 above, the HCT uptake was higher among women than men, differed according to age and marital status, this was irrespective of where they sought for the HCT services. Corbet et al, (2006) conducted workplace study on HCT, and reported that the mean uptake by employees was 19.2% in many workplaces in Zimbabwe. The fact that the uptake of VCT by employees at workplace, was very low in the current study, does not imply that employees’ uptake of VCT was low. Close to two thirds of employees reported that they had ever used VCT services elsewhere, e.g. clinics and hospitals and
private practices. It is however a concern why they would seek such services from other institutions whereas such services exist within their workplace.

**Objective 3**: To determine factors influencing the uptake of HIV counseling and testing services by employees at Pietermaritzburg Correctional Services.

**5.3 Awareness of VCT services at workplace**

As reported earlier, most employees reported that they were not aware that HCT services were available at their workplace. However, even the majority of those who knew of the availability of these services at workplace had never used them. This is a concern because the main reason for ensuring that HCT was available at workplace was to ensure that all employees can easily access these services at their nearest convenience. Thiede et al, (2006) conducted a qualitative study in Cape Town, to establish why people would prefer one clinical setting over the other when it comes to HCT, and reported that many people didn’t want to test at nearby clinics because they feared being recognised by their own communities. This implies that people could be aware of services, but prefer to seek similar services elsewhere due to different reasons. Similarly, Bwambale et al, (2008) found that employees preferred to be tested somewhere else for HIV than at the workplace.

Although most employees were not aware of HCT services at workplace, the results further show that 21% of respondents never thought of HCT at all, meaning, they had never bothered to check whether these services are there or not, nor did they ever thought of testing for HIV. These factors were confirmed as barriers to HCT in studies
that were conducted by Hutchinson & Mahlalela, (2009); Motshabi et al, (2011); Helleringer et al, (2009)

**Confidentiality**

Confidentiality remains the main reason why employees would rather not use HCT services at workplace. The results of the current study showed that two thirds of the respondents cited confidentiality concerns as one of the factors influencing HCT uptake at workplace. Furthermore, only 27% of the respondents reported that confidentiality is always maintained at the HCT centre in their workplace. Thiede et al, (2006) also reported similar findings, where respondents reported that they do not want their community to find out that they had utilized VCT services in their vicinity and some further reported that confidentiality issues remain worrisome when one use HCT where they work or stay.

**Access to ART Treatment**

The results of this study further revealed that only a quarter of respondents reported that there was adequate access to ART treatment at the worksite, of concern is the fact that the majority of respondents were not sure whether treatment was available or not. Also, only 20% of respondents reported that HCT staff offered post-testing support. These results indicate the need for staff to increase the level of awareness of the HCT services they render, and assure employees of what is available and intensify post-test support, irrespective of the HIV status of individuals. Corbett, (2006) further emphasize that availability of ART is a motivating factor to utilization of HCT which can serve as an entry point to medical treatment. Also, availability of
counselors to employees and employees being well informed about HCT services can have a positive influence on the HCT uptake (Athanasiades et al, 2008).

**HIV Disclosure**

The results of this study further show that only a quarter of respondents reported that they would disclose their HIV status to other people and only 20% reported that they would disclose to their superiors, whilst 38% and 41.5% respectively reported that they would never disclose, probably due to fear of intimidation by colleagues (41.7%). Madiba et al, (2013) reported similar findings, where employees reported that they would never disclose their status to partners, colleagues or employers.

**5.4 Knowledge on HIV and AIDS**

The results of this study revealed that the majority of respondents stated that they had received information on HIV and AIDS. This could be attributed to extensive awareness strategies embarked on by the National Department of health (NDOH, 2011) in partnership with other government departments and NGO’s e.g. awareness campaigns, activities and commemoration of HIV and AIDS events etc. as stipulated in the National strategic Plan 2012-2016 on HIV and AIDS, STI’s and TB. (NDOH, 2011). The level of knowledge on HIV and AIDS is crucial because it is the cornerstone of HIV prevention strategies. Studies found that higher knowledge of HIV and AIDS can contribute positively to utilization of HCT services (Peltzer et al, 2009).
The study results further revealed that the majority of respondents had an insight of how HIV is transmitted (through all modes of transmission). Knowledge of the mode of transmission of the HIV is significant as it can inform the sexual behavior, attitudes and practices of the sexually active people. On the issue of HIV prevention, half of the participants had good knowledge on how HIV can be prevented. According to Peltzer et al, (2009) the high level of knowledge on HIV and AIDS and condom use can result in high level of HIV prevention which incorporates up scaling of HCT uptake.

5.5 Conclusion

This study revealed that Gender, age and marital status were significant predictors of HCT uptake and that the majority of employees were not aware of HCT services offered at workplace. Also in this study it was shown that there is a low level of uptake of HCT by employees at the workplace.

The study further revealed that the majority of employees were reluctant to avail themselves for HCT in the workplace and many of those who utilized HCT centers preferred to do so somewhere else outside the workplace.

5.6 Study limitations

The study did not have the qualitative component to explore the reasons for poor uptake of HCT at work from respondent’s mouth. The findings of the study have limited generalizability to employees in the general public service because the
sample was taken from only three correctional centers and Area Commissioner’s offices of the Department of Correctional services and their views may differ to those of other employees in the entire public sector. Further research is therefore recommended from other public sector institutions.

5.7 Recommendations

It is recommended that the department of Correctional Services provides employees with onsite HCT services with enough health care staff e.g. nurses and HIV and AIDS counselors who are able to provide treatment, care and support to employees and they should be trained on importance of confidentiality and building a trusting relationship with employees. There is also a need to have trained and permanently employed HIV and AIDS coordinators for the workplace HIV and AIDS program.

HIV prevention and Health promotion strategies should be strengthened e.g. training of all employees on HIV and AIDS, identification and training of some employees as peer educators to ensure continuation of health education and information giving on HIV and AIDS and related issues. Establishment of workplace support groups for employees that are infected and affected by HIV and AIDS. Commemoration of all HIV and AIDS calendar events for employees, conduct HIV and AIDS awareness sessions and ensure availability of condom containers filled with condoms at all times.
Formulation and implementation of HIV and AIDS workplace policy and policy procedures for the department.

Implementation of HIV and AIDS, STI’s and TB (HAST) programs according to the National Strategic Plan 2012-2016 (NDOH, 2011)

Efforts should be made to create a work environment which is conducive to disclosure through non-discrimination and de-stigmatization of employees living with HIV and provision of support to those employees by management, supervisors and fellow colleagues respectively.

Alternative placement and incapacity leave is also recommended should an employee become sick.

Ensure availability of ART at all times in the HCT centers, this will encourage employees to avail themselves for HCT with assurance of follow up interventions e.g. ART should they test positive.

Future studies to explore further the relationship between HIV and AIDS and the age as there are contradicting findings from previous studies.
6. References


Pillay, Y. 2011. How times have changed – HIV and AIDS in South Africa. 102(2).


APPENDICES

Appendix A: Data collection questionnaire

PART ONE

Demographic data

1) What is your current age? 

2) What is your gender?
   Male  Female

3) What is your marital status?
   Married  Single  Divorced  Widowed  Cohabiting

4) How would you describe where you live?
   Township  Village  Suburb

5) How long have you been working for correctional services?
   Years  Months

6) What is your job title? -----------------------------

7) What is your highest educational qualification?
   No matric  Diploma  Doctoral
   Matriculation  Degree
   Certificate after matric  Post graduate
PART TWO: Basic knowledge on HIV and AIDS.

1) Have you received any information on HIV?
   - Yes [ ]   No [ ]   Not sure [ ]

2) How HIV is transmitted?
   - Unsafe sex [ ]   Unsafe injection [ ]   Mother to child [ ]   Blood transfusion [ ]
   - Not sure [ ]

3) Which method can a person do to prevent himself & his/her partner from getting HIV/AIDS? (you can choose more than 1 answer)
   - Abstain From Sex [ ]
   - Use Condoms [ ]
   - Limit Sex To One Partner [ ]
   - Be Faithful To One Partner [ ]
   - Avoid Sex With Person Who Have Many Partners [ ]
   - Avoid Blood Transfusion [ ]
   - Avoid Sharing Razors/Blades [ ]
   - Not sure [ ]

4) A healthy-looking person cannot be infected with HIV/AIDS.
   - Yes [ ]   No [ ]   Don’t Know [ ]

5) Do you have a close relative or close friend who is infected with HIV or has died of AIDS?
   - Yes [ ]   No [ ]   Not sure [ ]
6) Who is/are more at risk to contract HIV?

Males [ ] Females [ ] Both [ ] not sure [ ]

**Part 3: Awareness of availability of HIV counseling and testing (HCT) Service at workplace**

1) Where are HIV counseling and testing (HCT) Centers closest to you located?

Local clinic [ ] hospital [ ] within my worksite [ ] I don't know [ ] other -------

2) Have you used any of the HIV counseling and testing (HCT) center before?

Yes [ ] No[ ]

If yes, which center did you use?

(specify) ------------------------------

3) Are you aware of the available HIV counseling and testing (HCT) services at your worksite?

Yes [ ] No [ ]

4) Have you utilized these services before, for HCT?

Yes [ ] No [ ]

If no, why have you not utilized these services?

a) I was not aware of the availability of this service at work

b) I am not comfortable using it

c) I never thought of it

d) Other (specify)
Part 4: Factors influencing uptake of HIV counseling and testing (HCT)

1) Do you think confidentiality is maintained at the HCT center at your workplace, in terms of record keeping, confidential appointments and results?
   Always [ ] Sometimes [ ] Never [ ] not sure [ ]

2) Does the issue of confidentiality worry you regarding HCT at work?
   Yes [ ] No [ ] Not so much [ ]

3) Is staff always available to do HCT at your worksite?
   Yes [ ] No [ ] Not sure [ ]

4) Does the HCT center have adequate access to ART treatment?
   Yes [ ] No [ ] Not sure [ ]

5) Does staff provide post-testing support?
   Yes [ ] No [ ] Not sure [ ]

6) What are the chances of you disclosing your HIV status to other people?
   likely [ ] not likely [ ] not sure [ ]

7) What are the chances of you disclosing your HIV status to your superior?
   likely [ ] not likely [ ] not sure [ ]

Please elaborate on your response, if yes or not,
------------------------------------------------------------------------------------------------------------------------
------------------------------------------------------------------------------------------------------------------------
------------------------------------------------------------------------------------------------------------------------
-----

8) Do you fear intimidation by colleagues if tested positive?
Yes[ ] No[ ] Not sure[ ]

9) What would encourage you to utilize HCT services at your workplace? ---------
------------------------------------------------------------------------------------------------------------------
------------------------------------------------------------------------------------------------------------------
------------------------------------------------------------------------------------------------------------------

10) What advice would you give to improve delivery of HCT at your workplace? ---
------------------------------------------------------------------------------------------------------------------
------------------------------------------------------------------------------------------------------------------
Appendix B: Request for permission To The Correctional Services Director research.

19 Azalea Crescent
Westville
Durban
3630

The Director Research
Department of Correctional Services
Pretoria
0001

Dear Dr. Bengu

This is to acknowledge receipt of conditional approval to conduct research in the department of Correctional Services and I also wish to thank the research directorate and the committee to grant me this opportunity.

The recommendations to change the study setting was discussed with my research supervisor at MEDUNSA who gave me permission to change the study setting, now the study will be conducted at Pietermaritzburg Management Area instead of Durban.

Yours Sincerely
Nombasa Delicia Yoyo

Durban Management Area

Tel: 031-2048743

Cell: 0832595435
Appendix C: COVERING LETTER

Name of researcher: Nombasa Delicia Yoyo

Study Title: Factors influencing the uptake of Human Immune Deficiency Virus counseling and testing services by employees at Pietermaritzburg Correctional Services, South Africa.

Dear participant
The objective of this study is to explore factors influencing uptake of HIV counseling and testing at Pietermaritzburg Correctional Services, South Africa and to identify the barriers to HIV counseling and testing.

Your participation is important for the success of this study. One on one interview will be conducted by the researcher and you will be asked to fill in the questionnaire. This will take about 20 minutes of your time. The participants were selected from all sections in the correctional center to ensure representativity.

Your responses to the questions will be kept confidential under lock and key at all times, filling of questionnaire will be done in an office in each correctional center and no other people will be allowed in the office. Anonymity will be maintained as there will be no participant’s names on the questionnaire. Participation in the study is voluntary and you can withdraw from the study at any time.
Thank you for taking your valuable time to participate in the study.

For any queries, questions, stress or concerns about the study feel free to phone the researcher: Nombasa Delicia Yoyo Cell number: 0832595435 Office: 0312048743 or visit the HIV and AIDS office at the ICC Building in Durban Correctional Services.
Appendix D: Consent Form

UNIVERSITY OF LIMPOPO (Medunsa Campus) ENGLISH CONSENT FORM

Statement concerning participation in a research study.

Name of study: Factors influencing the uptake of Human Immune Deficiency Virus counseling and testing services by employees at Pietermaritzburg Correctional Services, South Africa.

I have heard the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I know that I have to fill in questionnaire and I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this provided that my name is not revealed.

I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on my work or the relationship with the researcher.
I know that this study has been approved by the Medunsa Research Ethics Committee (MREC), University of Limpopo (Medunsa Campus) / Dr George Mukhari Hospital. I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this study..........................................................

Name of participant .......................................................... Signature of participant

.......................................................... .......................................................... ..........................................................

Place. Date Witness

________________________

Statement by the Researcher

I provided verbal information regarding this study.

I agree to answer any future questions concerning the study as best as I am able.

I will adhere to the approved protocol.

.......................................................... .......................................................... ..........................................................

Name of Researcher Signature Date Place
Appendix E: Letter of motivation to DCS

UNIVERSITY OF LIMPOPO

Medunsa Campus

Department of Public Health

P O Box 1018, Medunsa 0204

Tel:       (012) 5215030

Fax:       (012) 5215746

Email: lskaal@ul.ac.za

To: DCS

From: Prof. Linda Skaal (Supervisor)

Subject: MOTIVATION TO CONDUCT A RESEARCH

Dear Sir/Madam

This letter serves to inform you that Ms Nombasa Delicia Yoyo, is a student in the department of public health. She is doing her 2nd year of study and is currently preparing to conduct research among employees of the Correctional Services in Durban. Her study is mainly on understanding why staff is not accessing Voluntary Counseling and Testing (VCT) services within their settings, despite the fact that such services are available within correctional facilities. The findings of this study will
inform management of staff concerns and eventually assist her in improving services she is rendering as part of her work.

Kindly grant her permission to collect data among the staff, as a supervisor, I am willing to assist her during her fieldwork to ensure that the study maintains ethical standards and will have no direct implications to individuals and does not harm the image of the correctional services. Attached is the protocol, including the questionnaire to be used for data collection.

Thanking you,

Sincerely

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