

**REPORT ON RESEARCH STUDY ON HIV AND AIDS
RELATED KNOWLEDGE, ATTITUDES, PERCEPTIONS
AND BEHAVIOURS AND HIV PREVALENCE FOR THE
DEPARTMENT OF LOCAL GOVERNMENT AND
HOUSING, LIMPOPO.**

Compiled for:

**The Department of Local Government
and Housing, Limpopo**

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LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
LOCAL GOVERNMENT AND HOUSING

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral
DHS	Demographic and Health Survey
DHIS	District Health Information System
DLGH	Department of Local Government and Housing
HIV	Human Immunodeficiency Virus
KABP	Knowledge, Attitudes, Behaviors/ Practices and Perceptions
NAP(s)	National AIDS Program(s)
NDoH	National Department of Health
NGO(s)	Non-Governmental Organization(s)
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
SANAC	South African National AIDS Council
STI(s)	Sexually Transmitted Infection(s)
TB	Tuberculosis
UNAID	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
HSRC	Human Science Research Council
SBU	Specialized Business Unit
LMF	Labour Management Forum

Definition of Terms

KAPB Study: The preferred and universally-recognized instrument best suited for measuring the Knowledge, Attitudes, Practices/ Behaviors and Perceptions regarding HIV and AIDS and, to a lesser extent, the linkages with TB and Sexually Transmitted Infections (STIs) in the workplace.

Prevalence Rate: the percentage of the population exhibiting HIV/AIDS at a particular time (or averaged over time).

Prevalence: the absolute number of people infected, or the level of a disease in a population at a designated time.

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EXECUTIVE SUMMARY

This study, commissioned by the Department of Local Government and Housing (DLGH) in Limpopo, was aimed at filling a gap in information around HIV and AIDS among the employees of this department. It specifically intended to investigate behavioral patterns of workers at DLGH, assess current HIV prevalence and assist with future projections and impact on the workforce.

The findings will inform the DLGH management about the actual prevalence of HIV and AIDS among the workers, and their behavioural patterns, in order for them to implement appropriate and effective intervention strategies in combating the epidemic.

OBJECTIVES:

- (1) Among the DLGH employees to:
 - Assess knowledge, attitudes, perceptions and behaviors/practises with respect to HIV/ AIDS,
 - Determine prevalence of HIV.
- (2) Project impact of HIV / AIDS on the Department with specific reference to human resources and financial planning.
- (3) Make recommendations to the DLGH on appropriate cost-effective intervention strategies.

FINDINGS:

The prevalence rate of HIV infection at DLGH is **6.04%**, comparable to the Provincial estimate, translating to **65** HIV infected people within DLGH. Amongst those who participated in the study, the majority were Sepedi speaking males, at middle level employment and relatively well educated. These were in steady relationships but mainly with relatively young partners and/or wives. From previous ante-natal care surveys and other studies, the teenage groups were found to be particularly vulnerable and at a relatively higher risk of contracting HIV and AIDS.

Knowledge:

The message about HIV and AIDS though heard by the majority, there was little understanding of the syndrome and in particular how a diagnosis of HIV and AIDS is and should be made.

Of much serious concern is the huge majority that does not know about the recommended methods of prevention and thus not using these, and some who believe that a cure for HIV and AIDS does exist.

Attitudes:

HIV and AIDS have directly affected many of DLGH employees through relatives, friends, colleagues, partners, and others.

There are worrying attitudes displayed towards the HIV positive individuals, including open confrontation and wanting to ostracise them.

Perceptions:

It is very disconcerting to discover that the risk of contracting HIV infection was not perceived for what it is, with a large majority not seeing themselves to be at risk, forwarding a number of reasons to justify this false sense of security (including prayers, being physically fit, etc).

Encouragingly though, the majority do believe in the protective capacity of condoms and they dismissed the myths about sexual intercourse with virgins as a cure.

Behaviors / Practices:

Consistent with other studies in SA, the majority were found to be sexually active, beginning their sexual experience during their teenage lives. Worryingly though, the majority have or had multiple partners up to ten. Even more serious is that condoms were not used by this majority during these sexual encounters.

Male dominance in relationships including decisions about condom use was confirmed and these male partners would go to the extent of using force to have sexual intercourse without a condom.

Testing for the virus seemed to be acceptable by the majority, but there still are some who would not go for testing and do not want to know their status. Fear of consequences of being HIV positive, including stigma there-of, was the main reason for them not wanting to know their status.

The workplace is not perceived to be particularly risky for contracting HIV by the majority, but again, possible protective methods are not known. Minimal, discrimination against HIV positive workers is said to exist at DLGH.

Recommendations

- ❖ An HIV and AIDS policy be made available and known through training, to all at DLGH.
- ❖ Senior management involvement and buy-in must be visible and management must take a lead in HIV /AIDS forum so as to be exemplary to the whole workforce.
- ❖ Constitutional and statutory obligations must be adhered to by all and at all times. Any form of discrimination against the HIV positive individuals is a serious violation of the constitution and must be urgently addressed.
- ❖ Inadequate knowledge, perceptions, attitudes and behaviour by DLGH employees must be dealt with through awareness programmes, health promotion, Training/Access to information.

Chapter 1: Literature Review

INTRODUCTION and BACKGROUND

Limpopo Province is one of the nine provinces in South Africa (SA). A recent report by the Statistics South Africa (Stats SA) confirmed that this province is one of the poorest in the country. (Stats SA. 2000)

Precise information about morbidity and mortality (HIV/AIDS in particular), its consequences, causation, and trends, is critically necessary for appropriate policy development and planning. For planning purposes, a number of indicators should be investigated before decisions are made about appropriate and feasible intervention programs. Among these, demographic, epidemiologic (with specific reference to HIV & AIDS), and socio-economic indicators, are very crucial. Indeed, the National Policy on Research in SA proposes among other categories in priority setting, that the burden of ill-health as a measure of health needs, be considered as a very important criterion. (Health Research Policy in SA, 2001)

Problems with the existing health information systems in SA are quite serious. Lack of reliable health information is one of the major obstacles to effective planning of health services country and sector-wise. An analysis of the 1994 status of health information systems in South Africa conducted by the National Health Information System for SA (NHISSA) committee, found the existing information systems to be fragmented, incompatible, uncoordinated and not comprehensive; software and hardware were incompatible and not user friendly, systems manually driven, and most importantly there was inadequate analysis, interpretation and use of data at local level. (Dept of Health, 1997)

The national mortality data that should form the corner stone of the burden of disease information has also been shown to be deficient, with significant under-registration and mis-classification. (Botha and Bradshaw, 1985; Bradshaw et al., 1987; Bradshaw et al., 1992). However, the recent data analysis has shown an improvement in death registration, and described a shift from the traditional triple to a quadruple burden arising

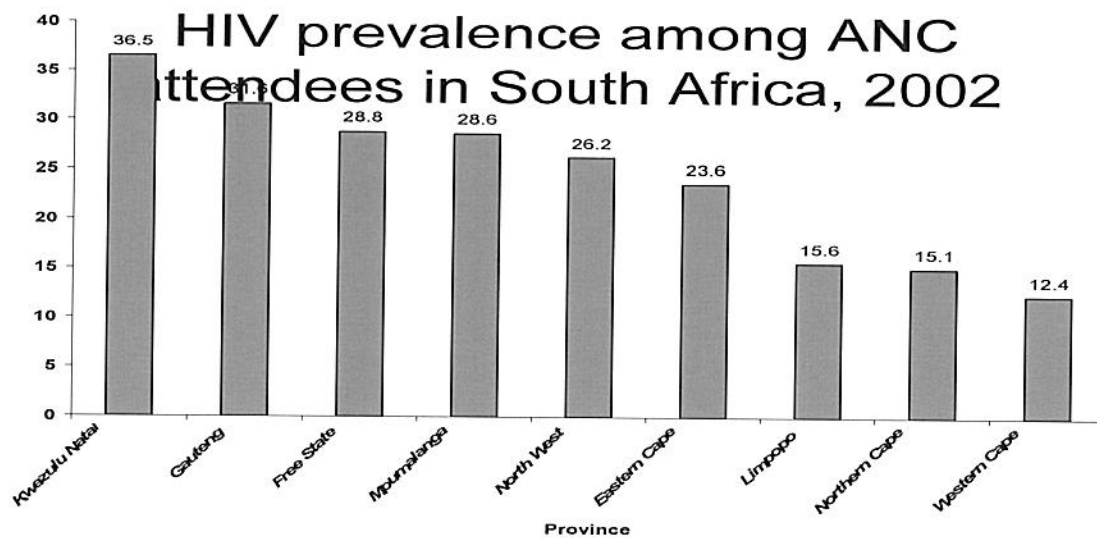
from poverty related conditions, emerging chronic diseases, injuries and AIDS. (Dorrington et al., 2001; Bradshaw et al., 2002).

HIV / AIDS in LIMPOPO

Despite all the advances made in improving knowledge about HIV/AIDS prevention, the disease continues unabatedly to spread worldwide, especially in sub-Saharan Africa. The Southern African Development Community (SADC) is said to be home to more than half of all people living with HIV/AIDS in the region. (UNAIDS 2000)

The cornerstone of HIV prevention is now, and for the foreseeable future will remain, behavior change. It is essential that we develop a scientific knowledge base on effective behavior change interventions and that we make scientifically informed decisions about which of these to promote widely.

Over the past decade HIV infection estimates were based mainly on the annual surveys of women attending antenatal clinics (ANC). These surveys however have strong limitations for estimating national prevalence levels in the general population. The limitations relate to inter alia, select groups (sexually active pregnant women, aged between 15-49 years; individuals who have adopted HIV prevention practices, for example condom use, are unlikely to be represented in the ANC sample). These factors may have led to the antenatal surveys overestimating HIV prevalence. On the contrary, because HIV infection is known to lower fertility, underestimation might have occurred.



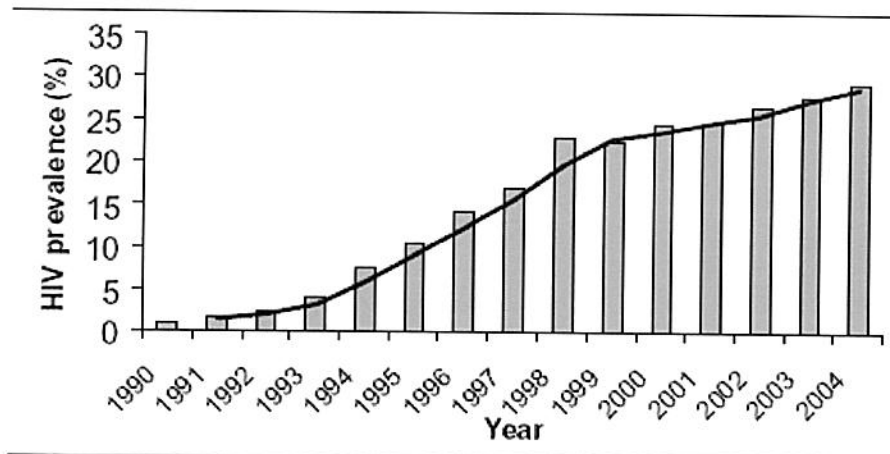
South Africa has the world's fastest growing AIDS epidemic with new infections estimated at 1500 a day, and there is an urgent need for effective HIV risk reduction interventions. Interventions that are grounded in behavioral theories of risk reduction and are targeted to the highest population group may prove to have greatest impact.

The HIV prevalence in Limpopo estimated at 7% in the general population and up to 15.6% among pregnant women is of a scale similar to that of many sub-Saharan African nations. (table below)

	Total HIV (thousands)	Total HIV prevalence	15-49 HIV prevalence	Life expectancy
KwaZulu-Natal	1 520 000	16%	26%	43.3
Gauteng	1 370 000	14%	22%	52.4
Free State	380 000	14%	22%	47.2
Mpumalanga	440 000	13%	22%	46.5
North West	470 000	12%	20%	50.7
Eastern Cape	630 000	9%	17%	49.4
Limpopo	380 000	7%	12%	56.4
Northern Cape	60 000	7%	11%	57.8
Western Cape	250 000	5%	8%	61.8
South Africa	5 200 000	11%	18%	51.0

Source: ASSA Press Release

The rising mortality rate from AIDS related illnesses, changes in the demographic profile and consequent further decline in the economy, will continue to enslave the province in poverty.



Prevalence of HIV Among Antenatal Care Attendees in South Africa, 1990-2004. Credit: SA National Department of Health. [National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa, 2004.](#)

In Limpopo, as in the rest of the country, based on the annual ANC prevalence data, there has been a consistent and steady increase in HIV prevalence over the past 5 years.(see figure and table below)

HIV Prevalence By Province Among Antenatal Clinic Attendees, South Africa: 2001 — 2004

Province	2002	2003	2004
KwaZulu-Natal	36.5%	37.5%	40.7%
Mpumalanga	28.6%	32.6%	30.8%
Free State	28.8%	30.1%	29.5%
North West	26.2%	29.9%	26.7%
Gauteng	31.6%	29.6%	33.1%
Eastern Cape	23.6%	27.1%	28.0%
Limpopo	15.6%	17.5%	19.3%
Northern Cape	15.1%	16.7%	17.6%
Western Cape	12.4%	13.1%	15.4%
South Africa	26.5%	27.9%	29.5%

The actual prevalence among workers, one of the most vulnerable population groups, however, remains unknown and speculative. Despite all the multiple interventions by Government to promote safe sex practices and create awareness about HIV/AIDS and its effects, there seems to be no change in people's behaviour. This assertion is based on the consistent rise in annual prevalence of HIV among ANC attendees.

Whilst this province has committed itself to take the HIV & AIDS challenge and fight the epidemic through comprehensive strategies of unprecedented scale, without appropriate, accurate and timely data, all these plans will be meaningless. The actual HIV prevalence among the SA population remains unknown. Worse still is unavailability of data among working people in the country.

An essential, though perhaps obvious point to make is that information is the lifeblood of the planning process. Without information, it is almost impossible to make realistic, rational decisions. Information is power, and any planner with a confident grasp of information is in a strong position in any discussion that concerns his/her organization. Lack of reliable health information is one of the major obstacles to effective planning of health services in SA.

Very few large scale population based national studies have been conducted in SA to explain social and behavioural risk factors in HIV/AIDS. A household national survey conducted in 1994 by the South African Health Inequalities Survey (SAHIS), showed a high level of awareness among respondents of the rapid spread and modes of transmission of the HIV. (SAHIS 1994)

A KAP study by the South African Demographic and Health Survey (SADHS) also showed a high level of knowledge of HIV/AIDS, a number of myths and misperceptions (e.g. >50% did not know that a healthy looking person could be HIV positive, low levels of condom use. (Department of Health 1998b)

A KAP and prevalence study conducted by a private company *Siemens* in 2001, estimated a workplace prevalence of 3.1% and a mixed picture in knowledge and behaviour. These findings assisted Siemen's Human Resource department to develop an HIV/AIDS policy. (Private Sector Intervention Case Example; Siemens. 2004)

Extensive reviews of behavioural research literature have been conducted elsewhere. (Attawell 1998; Kelly et.al. 2001). Some of the major findings in these included unprotected sex with multiple partners (Caldwell et.al. 1994); anal sex (A Karim & Ramjee 1998); poor and inconsistent male condom use (Peltzer 2000; Reddy et.al. 2000); stigma and discrimination at community and family level (Achmat 2001; Johnston 2001; Qwana et al. 2001; WHO/UNAIDS 2000)

International Perspective (HIV/AIDS)

Studies in China found that only a minority (18%) of the respondents had heard of HIV/AIDS, and only 28% had heard of condoms. (S Liao 1997). A survey of health professionals from eleven areas of China found that 68% of these workers knew about HIV transmission routes. This raises serious concerns about the general population if health professionals are also not that knowledgeable about the disease (Z Wu. 1999).

Another study of HIV positive individuals in New Orleans, Louisiana, found that the majority of patients disclosed to their partners and family members but less than 25% disclosed their status to casual sex partners. It was also found that many HIV infected individuals delayed disclosure until the disease had progressed. (Kissinger et al. 2003)

HIV/AIDS in the workplace

Despite all the available body of knowledge on HIV/AIDS very few studies have been specifically conducted among workers in SA. These have mainly been in the private sector, like the Siemens study. At DaimlerChrysler SA, estimates of HIV prevalence in 2001 were found to range from 6% in Zwartkop; 10% in East London and 13% in Pinetown. This company has since developed a strong HIV/AIDS programme. (www.hivaid.s.daimlerchrysler.co.za)

The impact of HIV/AIDS in developing countries is an undeniable fact. Currently HIV/AIDS has the greatest potential and actual impact on individuals, families, sectors and nations. It is not possible for health care workers alone to restrain the HIV/AIDS epidemic. With the help of employers providing adequate, accessible and worker friendly support bases employers can assist health care workers with this colossal task. *"The power to defeat the spread of HIV/AIDS lies in partnership: as youth, as women and men, as business, as workers, as religious people, as parents and teachers, as students, as healers, as farmers and farm workers, as the unemployed and the professionals, as the rich and the poor – in fact, all of us"*. (President Thabo Mbeki, Partnership Against AIDS, October 1998).

As the impact of HIV/AIDS pandemic becomes clearer, some large corporations have realized that they 'have to act', by addressing the disease in the workplace, the Financial Times reports. One of the ironies about HIV/AIDS is that it kills people in their most productive years. It makes good business sense for companies to respond to the pandemic because of the direct impact of Aids on business resulting from increased costs, loss of productivity and overall threats to the foundation of the economy in which they operate. The current and future workforce is placed at increasingly high risk as the epidemic disproportionately affects people during their most productive years. HIV and AIDS is a workplace issue not only because it affects labour and productivity, but because the workplace has a role to play in the wider struggles to limit the spread and effects of the epidemic. Even when companies try to protect themselves against the impact of HIV/AIDS they cannot escape the impact it is having on the broader society of which they are a part of. HIV/AIDS pushes people further into poverty as the households lose their breadwinners and savings are consumed by the costs of health care and funeral costs.

Organizational Rationale:

A number of features typifying the South African epidemic have direct implications for businesses:

- HIV/AIDS reduces macroeconomic management of Governments through reduced domestic savings and increased fiscal deficits (Bonnell 2000:824-849). For instance, a reduction in the rate of growth of labour force combined with falling productivity means less Government revenues from individuals and enterprises. HIV/AIDS affects profitability- the epidemic has a clear impact on a company's profits through direct costs and declining economies.
- Increased costs - with the increasing number of employees falling sick, companies have to bear the costs of health insurance, sick leave, as well as recruitment and training of new staff.
- Declining markets - HIV/AIDS threatens economic prosperity by putting national economies at risk.
- Threats to consumer base - overall demand for goods and services decreases and companies are forced to be less dependent on their consumer base.

- HIV/AIDS affects productivity - companies heavily affected by the epidemic have reported decline in productivity caused by :-
 - Increased absenteeism- from sickness and caring for sick family members, and preparing for and attending funerals of family members and friends.
 - Staff turnover is high due to death and illness.
 - Operations increasingly focused on training new employees rather than on company output. Some of the specific skills are now in limited supply.
- Lowered staff morale – as a result of illness, suffering and loss of colleagues, friends and family.

AIDS tends to strike young adults. Most people who die from AIDS are between 25 - 45 years old. HIV/AIDS reduces the life expectancy and the rate of population growth. As a consequence, this increases the burden on the working population, who will have to care for the young and the sick.

The medium span between infection with HIV and death of AIDS is estimated at 8 to 10 years. When a person with HIV progresses to an AIDS defining stage, he/she is likely to have declining labour productivity and the medical costs increase. Infection rates differ by skill and/or class. A study conducted by ING Baring reports that among semi-skilled and unskilled workers, infection rates are almost three times higher compared to highly skilled workers. These results relate to the different racial and age composition of unskilled, semi-skilled and highly skilled workers.

Another study confirmed that HIV/AIDS prevalence is indeed higher among the lower skilled employees, it shows that HIV/AIDS is also prevalent among the skilled workforce and management (Evian et al 2004). These are the sections of the workforce usually more difficult and more costly to replace taking into account the loss of knowledge and experience and the scarcity of higher skilled people.

In the face of this unprecedented challenge, Business like the Public Sector and the Civil Society must respond decisively. Yet despite the scale of the threat posed by HIV/AIDS, the business and Public sector have been very slow. Numerous sources report and show that the majority of South African companies response to the HIV/AIDS pandemic has been very slow, weak or deficient(Dickinson 2004, Global Business Coalition 2002,

SABCOHA 2002). The results of the most recent SABCOHA study showed that most companies have still not conducted any research on the actual or potential impact of HIV/AIDS on their labour force, production costs or consumer base (SABCOHA 2004). There is a need to invigorate attitudes and activities in the Public Sector, making it a recognised and valued partner in the war against AIDS. The challenge is to seek ways to minimise its effects, to prepare for its impact and co-operate for long term solutions.

The need for contextual Research in HIV/AIDS

There are different motives that come to play when addressing HIV/AIDS in the workplace: Economic, Political and Moral motives. The perceived relevance of these motives to the decision makers of the business is influenced by the organisational context. Apart from a proactive and forward looking approach, which would be aimed at the prevention of new infections and the management of those employees living with the virus through a comprehensive HIV/AIDS strategy based on research and monitoring and evaluation (Barnett and Whiteside 2002: 266, George 2001:2). How the company will perceive and address the problem depends on many factors. One of these factors is the nature of the organisational context in which the organisation operates. No organisation is self sufficient nor is it isolated from its environment. Exploring the role of the different contextual factors places the organisation's perception of and responses to the impact of HIV/AIDS in a broader context. It hereby responds to a demand for more qualitative social research on HIV/AIDS in South Africa. While there have been a number of quantitative studies on organisations' responses to HIV/AIDS in South Africa that provide important data, they do not give insight into the stories behind the statistics. In a special issue of African studies on 'HIV/AIDS in Context', it is argued that there is a limited understanding of the role of social factors in the HIV/AIDS epidemic.

In a study (Mrije Versteeg) to deepen the understanding of corporate responses to HIV/AIDS the majority of the responses were reactive in nature, politically motivated and limited to low cost prevention and awareness programmes. HIV/AIDS was not perceived as a threat. Companies perceived little pressure from the government, Trade Unions and other sectors to respond to HIV/AIDS in a proactive manner. An HIV/AIDS policy and awareness campaign was believed to be sufficient for a good image. Monitoring of corporate compliance with HIV/AIDS related laws was perceived to be poor.

The stigma of HIV/AIDS, low disclosure and high resistance against HIV testing, difficulties with the interpretation of the legal framework, the Government Debate on HIV/AIDS, competing priorities in the workplace and a weak economic climate were said to be complicating factors for proactive workplace responses.

In another study both economic and political motives were identified in the HIV/AIDS workplace responses of the participating companies. In different ways, but with the same underlying meaning, it was argued unambiguously that the HIV/AIDS workplace response was a matter of corporate responsibility. One respondent described the company's HIV/AIDS programmes as a nice-to-have and more of a social responsibility pressure than anything else. In another company it was argued that it was politically unacceptable for companies not to have an HIV/AIDS policy. In the perception of some respondents, the Government expected companies to have an HIV/AIDS policy. This perceived demand was a reason to address HIV/AIDS in the workplace. One respondent argued that companies would not do more than what they perceived as 'The Necessary'. In this regard the environment sets the standards.

While the economic and political motives were clearly defined in corporate decision making on HIV/AIDS, it has been more difficult to appreciate the role of moral motives. Obviously companies are no welfare organisations, they are however run by people, and the moral perspective of the decision makers can be of influence on the choices made by addressing HIV/AIDS in the workplace. In one study the type of response did not reflect an attempt to reduce the human impact of HIV/AIDS. In these cases the companies had not moved beyond low budget prevention and awareness programmes. Respondents indicated that their campaign was aimed at reducing the incidence rate of HIV/AIDS among the workforce. For employees already living with HIV/AIDS, little to nothing had been put in place. Respondents at lower positions in the organisations gave more insight around the moral motive. They felt that their voices seemed poorly listened to. A lack of support from the management in the execution of their work was an often heard complaint. In the perceptions of different respondents, management 'thinks they have better things to do' or 'simply do not care'.

HIV/AIDS already affects all our workplaces, and is likely to grow worse. Some of the concerns around managing HIV/AIDS in the workplace are:

- Dealing with the denial and discrimination against people with HIV and AIDS, from employers, other workers and communities
- Ensuring that we are all empowered to prevent HIV including in the workplace, and have access to free condoms
- Getting medical treatment, adequate nutrition and wellness support, additional time off for opportunistic illnesses, and appropriate working conditions for workers with HIV/AIDS
- Making sure workers who can no longer work because of HIV/AIDS get disability pay when they need it and that if they die, their dependents – including their children – get adequate support from their retirement funds
- Empowering women, who often have to care for family members with HIV as well as facing sexual harassment and other kinds of discrimination, which make it harder for them to prevent and live with HIV. (COSATU Draft on HIV/AIDS in the Workplace – October 2002).

From the above, it becomes clear that employers and trade unions should develop appropriate strategies to understand, assess and respond to the impact of HIV/AIDS in their particular sector and workplace. This should be done in cooperation with sectoral, local, provincial and national initiatives by the government, civil society and non-governmental organisations.

Chapter 2: Purpose and Objectives of the Study

This study was aimed at filling a gap for the Department of Local Government and Housing (DLGH) in Limpopo around HIV and AIDS issues. It specifically intended to investigate behavioral patterns of workers at DLGH, assess current HIV prevalence and assist with future projections and impact on the workforce.

Purpose:

The purpose of this study was to establish the HIV and AIDS prevalence, knowledge, attitudes, practices and behaviour among the workers of DLGH – Limpopo.

Goal:

The findings from this study are to inform the DLGH management about the actual prevalence of HIV and AIDS among the workers, and their behavioural patterns, in order for them to implement appropriate and effective intervention strategies in combating the epidemic.

Objectives:

1. Among the DLGH employees to:
 - 1.1. Assess knowledge, attitudes, perceptions and behaviors/practises with respect to HIV/ AIDS,
 - 1.2. Determine prevalence of the HIV.
2. Project impact of HIV/AIDS on the Department with specific reference to human resources and financial planning.
3. Make recommendations to the DLGH on appropriate cost-effective intervention strategies.

Chapter 3: Methodology

Study design:

This was a cross-sectional descriptive study conducted over a period of three months from January to March 2007 among the DLGH employees.

The study was unlinked and anonymous with informed consent (no name, employee number, identification number or address) and HIV test results were linked by a unique identifier (bar-code) to the KABP questionnaire. This study design allows for the person to refuse to participate in the study, thereby introducing a possible participation bias.

Study area and population:

All employees of the Department of Local Government and Housing in Limpopo Province comprised the study population to which the study results will be generalized. The study was conducted at Polokwane in Limpopo where all DLGH employees are based. The Department has a staff complement of about 1000 employees.

Consultative process and community preparation:

The study researchers ensured that the study process was as transparent as possible and that the key stakeholders i.e. DLGH management and the workers' union were kept abreast of the activities. A participatory process was used by the research team to engage key stakeholders who comprised of managers, EWP unit, peer educators, labour representatives, and staff as a whole.

The research team was afforded an opportunity to make presentations to the management forum and deliberations were made on issues pertaining to sampling of individuals as against testing the whole workforce; confidentiality; provisions for refusal; and how consent was going to be obtained from the research participants.

Also all the labour unions within the department were addressed and given an opportunity to ask questions from the research team. There was consensus on the value of the survey with emphasis on destigmatisation and demystification of the disease in the workplace.

A KABP committee was established that comprised of EWP unit members, the research team and peer educators within the department. Emphasis was put on popularizing the

process in the form of intranet communication of the survey to the employees who have access to the internet. Posters and pamphlets were also designed with the help of the communications department and were visibly placed in all four office entrance halls.

Prior to commencement of the study a briefing session was organized with all the departmental employees. The EWP unit arranged a venue away from the workplace and transport was arranged to ferry people to the venue.

This was done to address workers' right to information. In addition, researchers also believed that transparency and providing all the relevant information to the workers concerning the purpose and the goals of the study would improve participants' response rate. Some members of the management explained the goals of the study and the ultimate benefits envisaged by the department; the union representatives explained their position with regard to the process and the principal investigators explained the study procedures, sampling, confidentiality issues, the importance of participating for those selected, signing of informed consent, the right to refuse as well as answering any questions that may relate to the study procedures.

Researchers ensured that they worked as closely as possible with the workers' representatives, the EWP unit and peer educators from whom they sought guidance on the best approaches to access and inform the workers about the study through a number of meetings.

Sampling:

- *Sample size determination:*

The sample size used in this study was based on the workforce of 1000 employees. For the study results to be generalized to national DLGH employee population, an adequate randomly selected sample was required. The study assumes that the true prevalence in this population is 25%. This prevalence is based on the upper confidence limit of HIV of 21.5% (95% CI= 18.5-24.6) reported among pregnant women in the Limpopo Province in 2005 national ANC survey (DOH, 2005).

A probability proportional to size (pps) random sample was drawn from the total population of the DLGH employees.

The estimate was based on 95% significance level and was estimated within 5% of the true prevalence. Following these assumptions and the formula $n = ((1.96)^2 pq)/d^2$, where p is the assumed proportion, $q=1-p$ and d is the margin of error, a sample size of 288 employees was required to participate in the study. Assuming a 10% refusal rate, a total of 320 DLGH employees were recruited to participate in the study.

- *Sampling strategy*

The departmental personnel and salary administration (PERSAL) database constituted the sampling frame for this study; individual employees as primary sampling unit (PSU). In order to increase precision and accuracy of the study and to minimize selection bias, stratified random sampling was chosen by sex and employee categories. Simple random sampling was then conducted within each stratum to give each employee in the stratum an equal chance of being selected. To ensure employee confidentiality weighting was done and more weight placed on employee categories with fewer employees.

The principal investigators requested a list of employee numbers, names and their email addresses from the PERSAL database, stratified by gender and job categories. Sampling of participants was by an independent consultant epidemiologist. Selected employees were then sent invitation letters (Appendix 1) which were hand-delivered by research team. They in turn would be required to produce these invitation letters as proof of selection at the testing station. The letters specified the venue and the study date.

Data collection

In order to address the study objectives, quantitative data collection methods were used. Data collection was done by testing for HIV antibodies in oral fluid and administration of semi-structured questionnaires (Appendix 2). Both the test results and the questionnaire were anonymous but linked to each other by a unique identifier (bar-code).

Management of the process

After the sample was drawn, participants were individually phoned and invitations extended to them for the pilot phase of the project. This gave every person an opportunity to get clarity on issues they were not clear with. Thereafter invitation letters were delivered to invited individuals and appointments were secured for times for the

testing on the scheduled dates. The pilot was intended to test the research tool and identify any logistical challenges that could be encountered during the project roll-out.

The study was piloted at Polokwane over two days. A review of the pilot was done thereafter and any challenges experienced during the pilot were discussed and addressed.

The same process was followed for the roll-out phase which was undertaken in one region, Polokwane where all four Departmental offices are situated. A few people who are stationed in different districts outside Polokwane who were traced and invited telephonically managed to travel to Polokwane and were tested.

HIV testing

In the case of DLGH, *an unlinked anonymous testing with informed consent* was done. No personal identifiers or names, identification or employee numbers were used.

HIV testing was anonymous and not linked to the employee name, identification number, employee number or address.

HIV testing in this study was done using OraQuick® ADVANCE HIV-1/2 antibodies test. Research nurses collected oral fluid specimens from the study participants. The oral fluid specimens were bar-coded and these would be taken to a private central “make shift” laboratory where a trained research nurse or principal investigator would evaluate and read them.

Since HIV results were not issued to the study participants, no pre- or post- test counseling was deemed necessary. However, an independent and separate VCT service was arranged and made available through the help of the EWP unit, to all invited employees who wished to know their HIV status irrespective of whether they agreed or refused to participate in the study. Participants who wished to know their HIV status were referred to the VCT where they received pre-test counseling before they are tested and post-test counseling on receipt of their results. Those employees who test positive for HIV, arrangements were made that they be referred to the EWP if they so wished.

Knowledge, Attitudes, Behaviours and Perceptions

Knowledge, attitudes, beliefs and practices of employees were assessed using semi-structured questionnaires (see Appendix 2). Those employees who agreed to participate were furnished with study questionnaire after signing their study consent form.

The questions were specifically designed to establish knowledge about mode of HIV transmission, awareness about prevention and early detection methods for example voluntary counseling and testing, whether they perceive themselves to be at risk, condom use practices and awareness about HIV issues at the workplace.

In addition to the English version, the questionnaires were translated and back translated into four main languages that are primarily used in Limpopo Province i.e. TshiVenda, XiTsonga, Sepedi and Afrikaans. For many people, discussing sexual issues can at times be uncomfortable and unsettling; as a result, participants were given a choice of either self-administering the questionnaire in the languages they were comfortable with or to have a research nurse administering the questionnaire on the scheduled study date.

The questionnaire was piloted immediately after the training of the study team and thereafter, any challenges emerging from there, were addressed by the team to ensure its accuracy and consistency. The pilot also sought to help the research and KABP committee on logistical arrangements for the project roll-out, which it did.

In addition to assessing the participants' knowledge about HIV, which many studies have shown high knowledge levels, the questionnaire sought to establish how the knowledge influences participants' behaviour. In this regard, the same barcode on the oral specimen was attached to the questionnaire.

Voluntary Counselling and Testing

During the pilot phase of the survey it became apparent that the majority of people who participated were interested in knowing their status. It was then decided between the research team and the EWP unit to engage the services of a service provider to be available on the same sitting and conduct VCT for those that needed to know their status and to help encourage people to participate and to help promote an individual's knowledge of their status.

There was a total of 42 VCT tests conducted. The low VCT participation was due to the fact that emphasis was not VCT take-up. Emphasis was put on a high participation

for the prevalence study and the VCT campaign will need its own marketing drive in future.

Study personnel and training

The study team was composed of five people i.e. the project managers, two research nurses and an administrator. Training workshops were conducted for the study team, where the study personnel were trained on data collection techniques, research ethics, good communication skills as well as on understanding and appreciating the importance of proper completion of the questionnaire. During the training, the study personnel tested the questionnaire on each other and also practiced collection of oral fluid using OraQuick® ADVANCE on each other.

Study venue

The Departmental EWP division identified and rented a neutral venue outside the workplace to which the study participants were invited.

Quality assurance

Quality assurance was done at two levels. Research assistants had to collect the questionnaires on completion, thank the participant for completing the questionnaire and prepare him/her for the following procedure that is, collection of saliva. Participant preparation included reinforcement of the information given on the participant information sheet, explaining the procedure that was to be followed, as well as reminding them about the available VCT service should they be interested. Once this was done, the oral specimen would be collected and a bar-code stuck on both the questionnaire and the oral specimen.

The principal investigator supervised and ensured smooth running of the study, ensured that the number of oral specimens was the same as that of the questionnaire, and that questionnaire administration and completion was in accordance with the protocol and was satisfactory. The principal investigator had to randomly select and test at intervals 15% of the oral fluid specimens already read by the research nurse. In case of any discordant readings, provision for services of a private laboratory were put in place in the event they were needed, but fortunately there was no need for such.

Data processing and analysis:

The questionnaires were coded by the principal investigator who also developed data capturing sheets in preparation of data capturing. Two data capturers were contracted to capture both HIV test results and questionnaire data into EPI-INFO 2000.

Data analysis was done using STATA statistical software and thematic analysis. The study results are presented in tabular and graphical format.

Important themes, participant opinions and comments were analyzed using thematic analysis and were picked up as they emerge. Completed questionnaires will be kept for a period of five years and to ensure confidentiality during this time period, tight security measures will be applied and these will be locked in a filing cabinet to which only the principal investigator (or a suitable staff) has a key; thereafter these will be destroyed by shredding. The sampling frame and the selected sample will be destroyed as soon as the study is completed.

Dissemination of results:

Study results will be written into a report with full recommendations and the study implications for the development and the design of an HIV intervention programme at DLGH. The report will then be submitted to the DLGH management who commissioned the study. Oral presentations of the study results will be made to the management, the workers' representatives and the entire workforce.

Exclusion and inclusion criteria:

All casual employees with a contract less than six months with the Department will be excluded from the study.

Ethical Considerations:

The study was ethically approved by the Human Sciences Research Council (HSRC) soon after which the pilot was conducted (Appendix 4). Participants were assured of total confidentiality and that all attempts were made to avoid identification of participants. The names of respondents to questionnaires were not written and the specimens bar coded with no names of individuals. The aim, goal and objectives of the study were explained to everyone recruited into the study.

A signed informed consent was sought from all participants after explaining the process, before filling the questionnaire and taking saliva sample (Appendix 3).

All participants were given options to refuse to participate, and to withdraw from the study at any time if they felt uncomfortable.

At the point of collecting specimens, participants were offered the opportunity of finding out about their individual HIV status. Those individuals wishing to know their HIV status were referred for voluntary counseling and testing (VCT) which was available at the testing centre.

Challenges and limitations encountered during the survey

- During the survey week there were lots of other activities scheduled for members within and outside town which made it difficult for invitees to attend and keep their appointments for the survey.
- Some sampled individuals refused point blank to participate in the survey citing many reasons, like they felt they were not personally consulted despite fact that some were occupying management positions and did not know about the survey taking place in the department ; some were simply not interested; others queried the sampling and did not trust in the absolute confidentiality of the process; others were scared and did not even want to know about their status and felt they were safe not knowing despite repeated assurances that VCT was voluntary.
- There was generally lack of management availability, visibility and commitment and the whole process was left to the EWP team.
- Some of the members had to be followed-up in their offices by the research team because they were just too busy to accommodate time for the survey.
- Some of the respondents were not comfortable to have their HIV test done, so they opted for the KABP questionnaire only, of which the research team allowed.
- Despite the fact that transport was arranged to ferry people, there were times when the research and EWP team had to fetch people from the offices to the venue for purposes of securing their attendance.

Chapter 4: Results of the Survey

The findings of the survey are presented in the following format:

- Overall Response rate on prevalence and KABP survey
- HIV Prevalence rate
- KABP Findings

Overall Response rate on HIV prevalence survey and KABP survey

From a sample of 320 employees, a total number of 149 were successfully recruited to participate in the study yielding a response rate of 46.6%.

Prevalence Rate

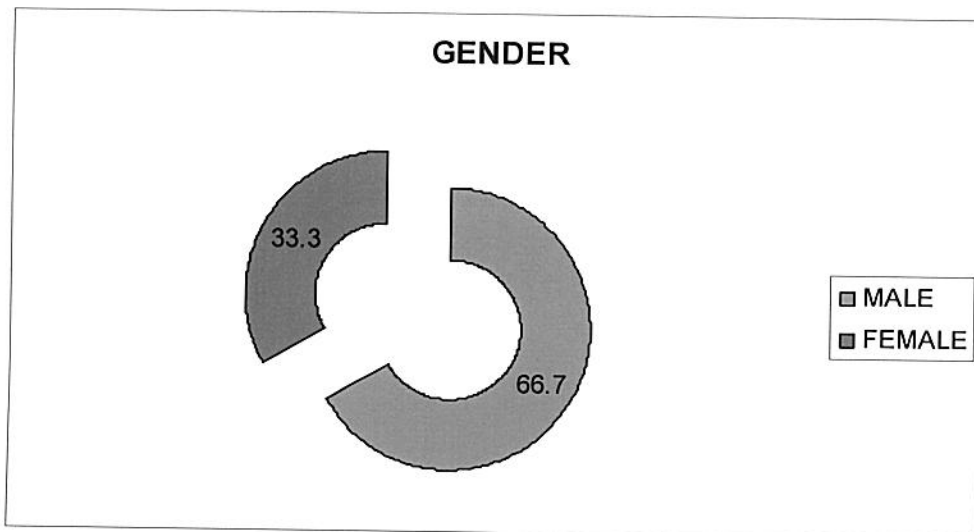
Participation	Sero-positive	Prevalence rate
149	9	6,04 %

The prevalence of **6.04%** among the employees of DLGH is not far out of the provincial 7% estimate as estimated by ASSA. When the data is extrapolated onto the whole workforce, an estimated 65 employees are HIV infected.

Demographics of the sero-positive:

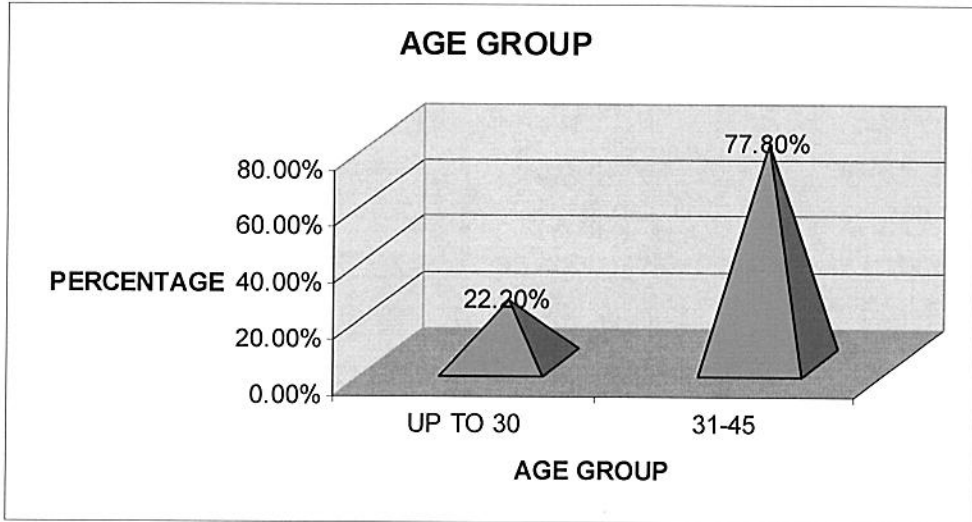
- Gender distribution

The majority of the seropositive participants are male which is in keeping with the gender profile of DLGH employees.



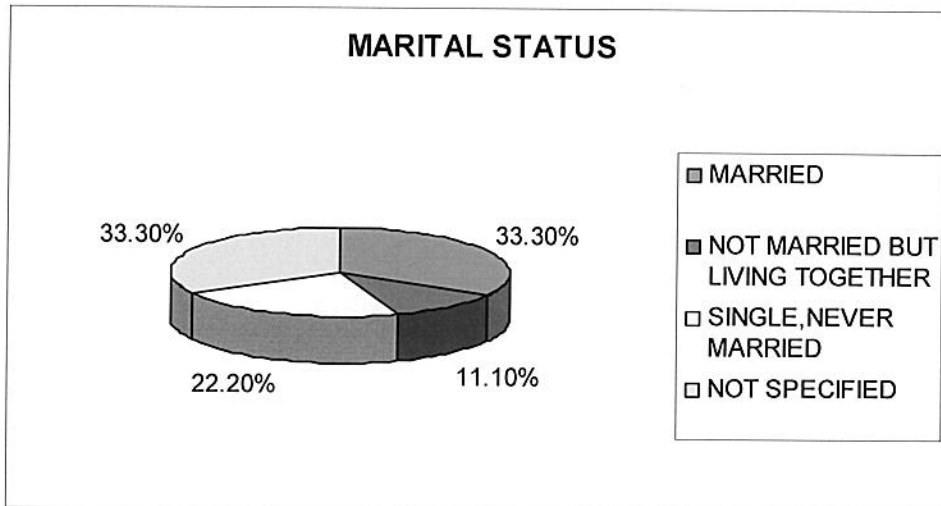
- Age distribution

Most are in the 31-45 year age group



- Marital Status

The majority of these employees are either married or not married but living together.



KABP Findings

A. Socio-Demographic Profile of all Respondents:

Gender Distribution:

The majority of respondents were males (57%).

Home Language:

SePedi was the predominant language among these respondents (53.7%), followed by Xitsonga and Tshivenda (13.4 and 10.7 respectively). English, Afrikaans, Ndebele, Setswana and Nguni were other languages used though by only small minority groups.

Educational Status:

The level of education was found to relatively adequate (matric & tertiary) among the majority of participants (85.2%).

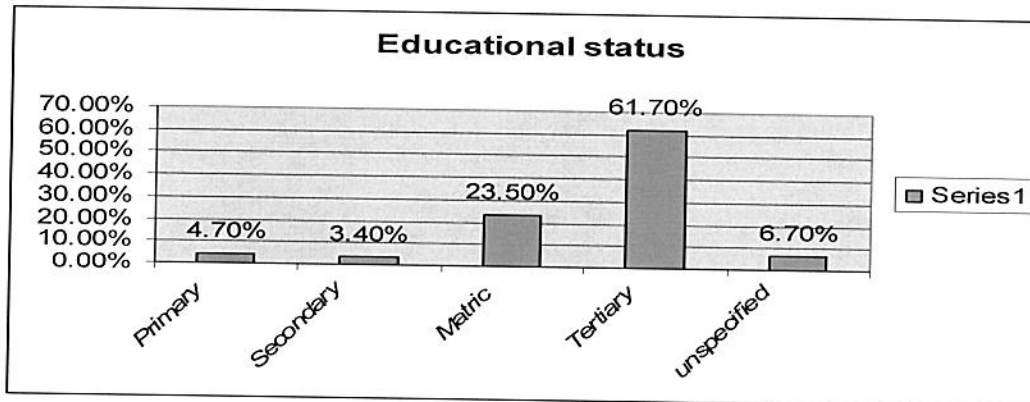


Fig 2: Educational Level

Employment Status:

The majority of respondents were in the middle level category of employment.

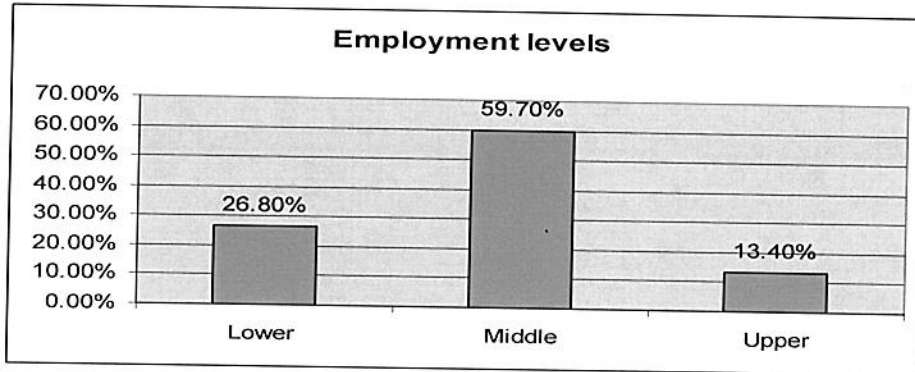


Fig.3: Employment Status

Marriage/Partner:

The majority (44%) had been married or staying with the same partner for a period less than or equal to 10 years, followed by those (29.7%) between 11 and 20 years. (Table 1)

Period with current partner	Percentage
0 – 7 years	22,2%
8yrs	33,3%
9yrs	11,1%
10yrs	22,2%
13yrs and more	11,1%

Table1: Period married or staying with same partner.

Age of partner

The majority (28.8%) of their partners were in the teenage or young adult group.

(Table 2 below)

Age	Percentage
18-25	17,1 %
26-30	11,7%
31-35	12,6 %
36-40	17,1%
41-45	13,5%
46-50	13,5%
51-55	9,9 %
>55	4,5%

Table 2: Partners' age group

B. HIV/AIDS Knowledge:

It was encouraging to find that *all respondents* had at least heard about HIV somewhere and somehow.

When further probed about their understanding of what the virus was, the majority (49% of those who responded to the question) were correct. (fig.4)

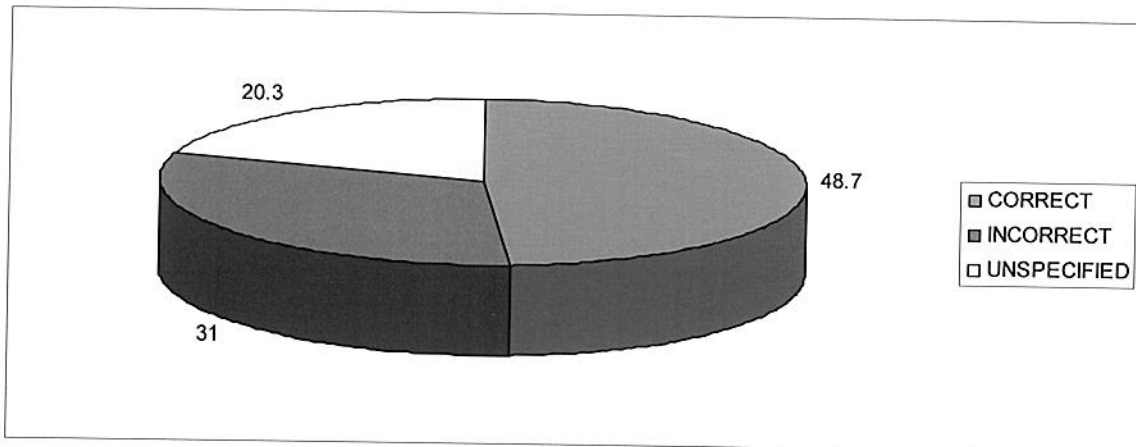


Fig 4: HIV Knowledge

It was however disappointing to note that only 32% understood how the diagnosis of an HIV positive person could be made. Most of them tend to incorrectly equate symptoms often found in sickly HIV positive patients with the diagnosis. (Fig 5)

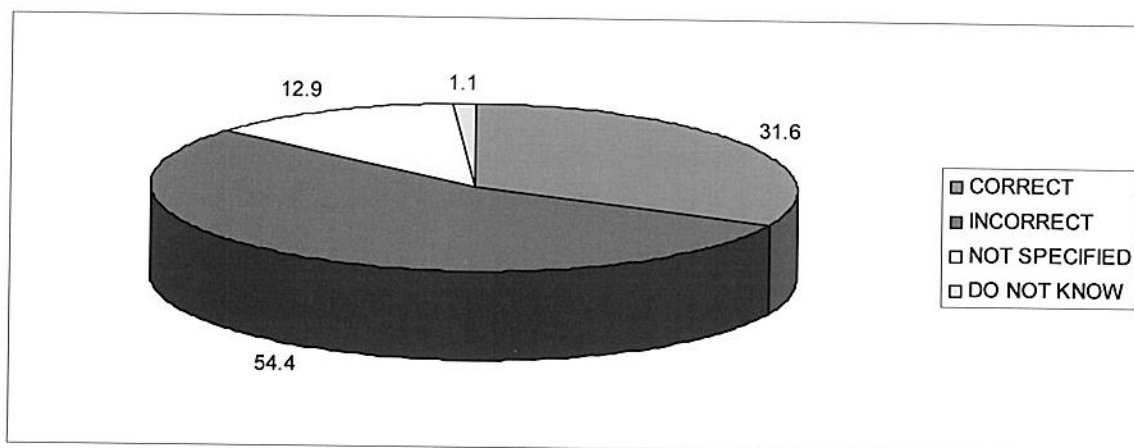


Fig 5: HIV Diagnosis

Their general knowledge on how one gets infected with the virus was adequate in the majority of respondents. (Fig. 6)

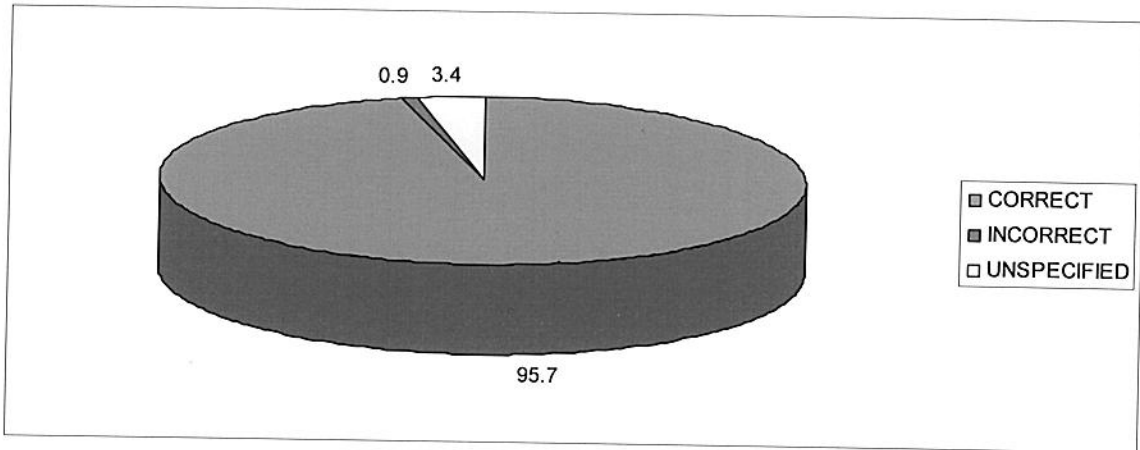


Fig. 6: Infection process

Again a huge majority had at least been told about AIDS somewhere. (Fig. 7)

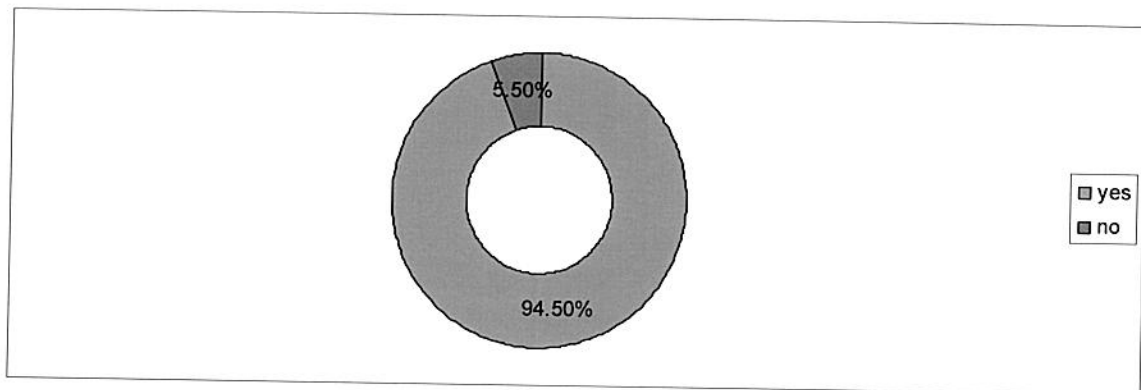


Fig. 7: AIDS Knowledge

At least about half of respondents could correctly define the syndrome (fig.8 below)

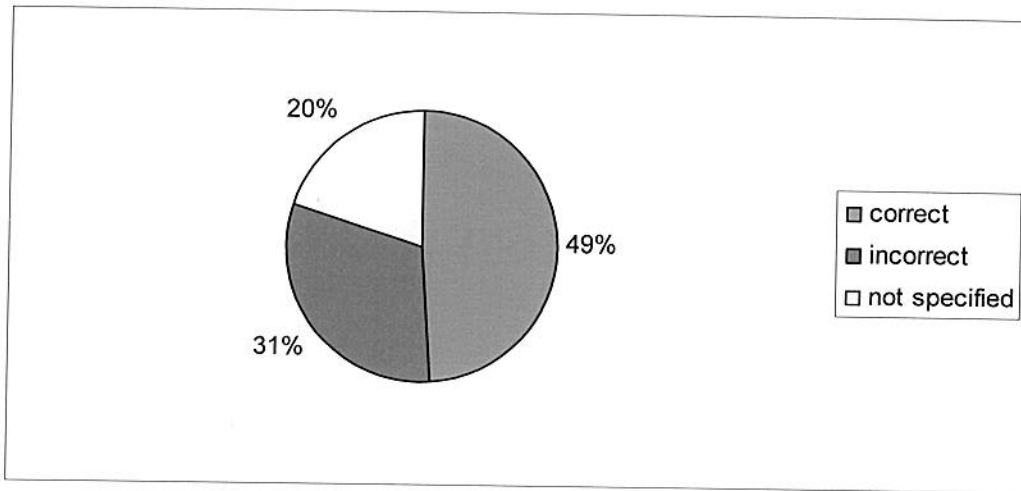


Fig 8: AIDS Definition

Like with HIV, the majority do not understand how the diagnosis of AIDS is made. (Fig 9 below)

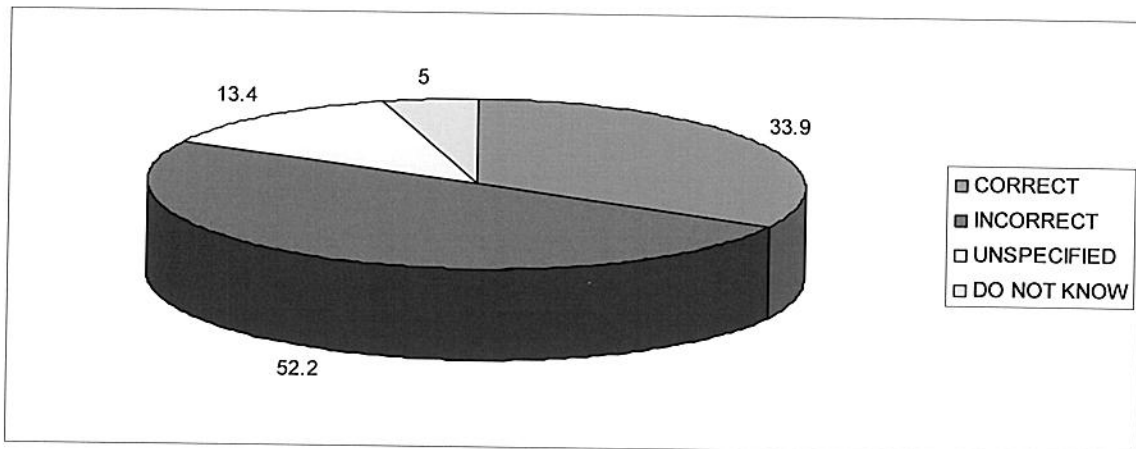


Fig 9: AIDS Diagnosis

A huge majority know the prevention modalities against HIV infection. (Fig 10 below)

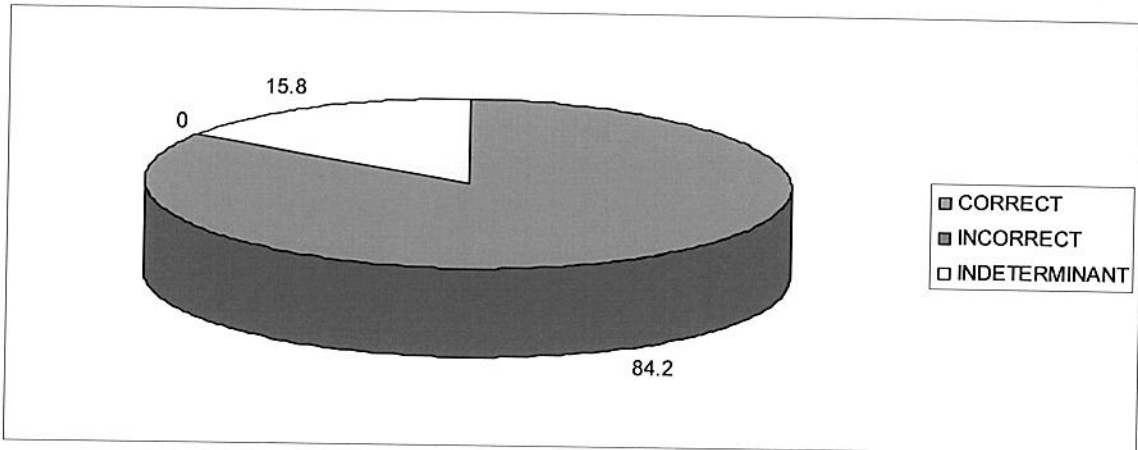


Fig 10: HIV Prevention knowledge

Although it was very encouraging to note that the large majority (90%) knew that there currently is no cure for HIV and AIDS (fig 11), it is of serious concern that there still are people who believe on a number of different methods as possible cures for HIV and AIDS (fig 12).

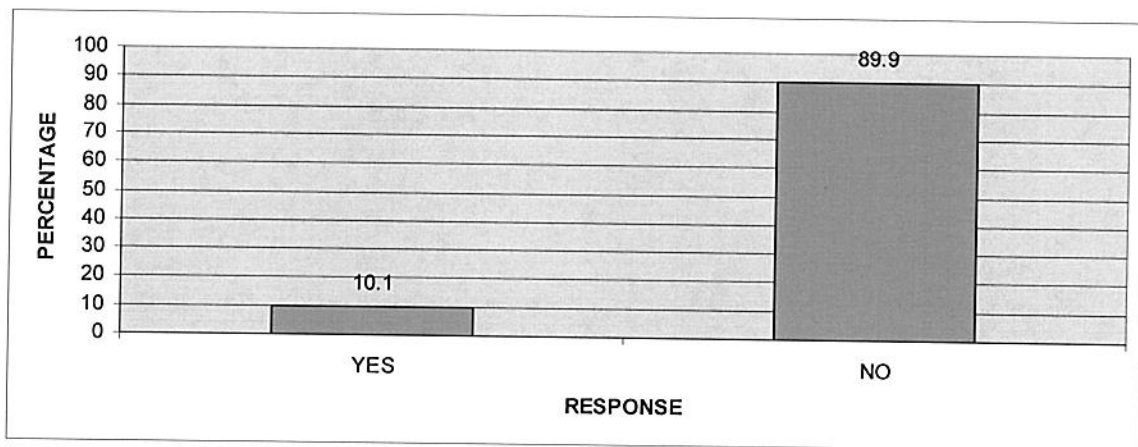


Fig 11: HIV&AIDS Cure

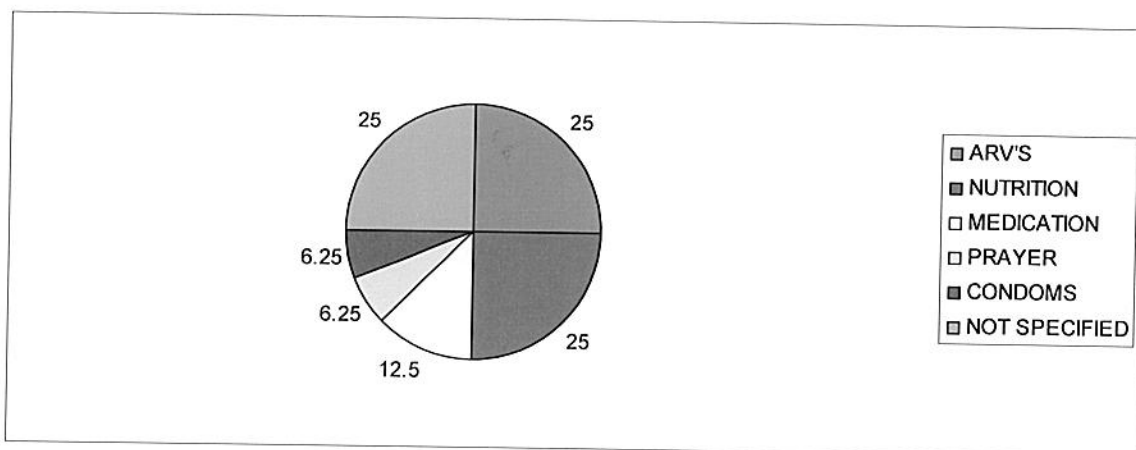


Fig 12: HIV & AIDS Cure mechanisms

A number of possibilities for improving the quality of life of HIV infected, were enlisted as in fig 13 below.

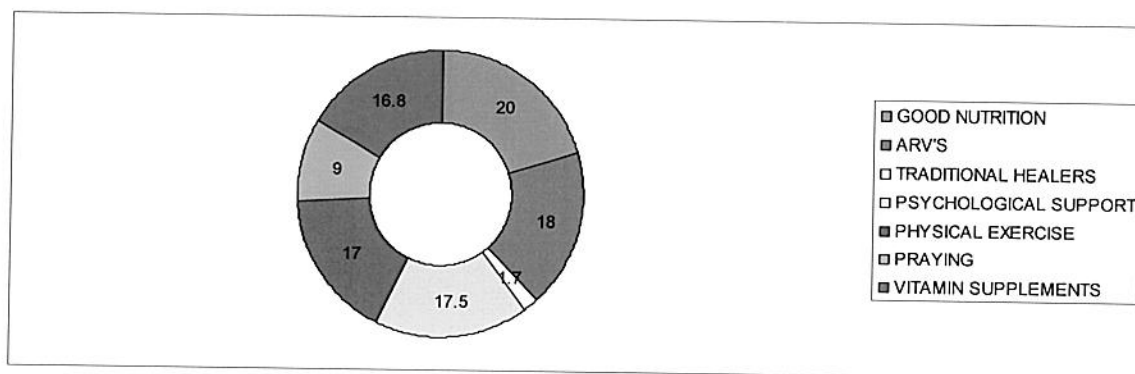


Fig 13: Improving quality of life

VCT Knowledge:

It was encouraging to find that the majority (76%) had been told about VCT at some point.

They also correctly could tell where they could access this service in their localities.

C. ATTITUDES towards HIV/AIDS

At least 53% of respondents know of a person infected with HIV and they got the information from the infected individuals themselves (fig 14).

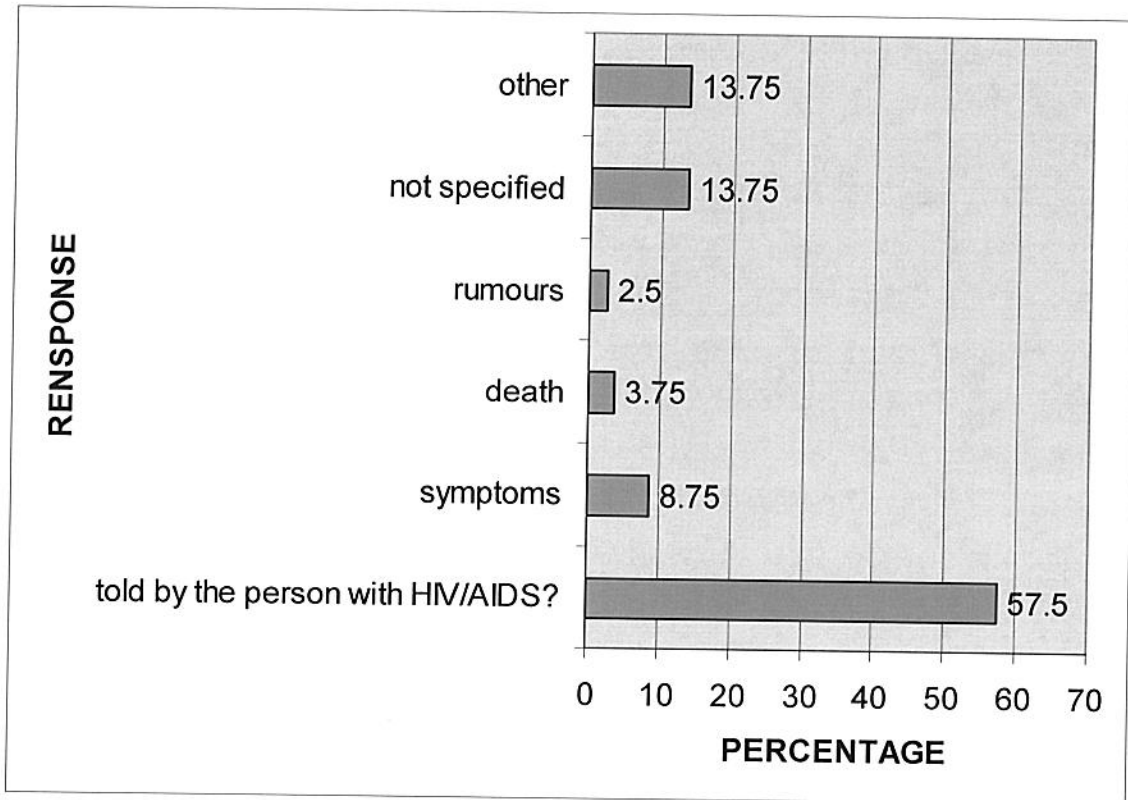


Fig 14: Information about the infected's status

Their individual relationship to the infected ranged from relatives to colleagues.

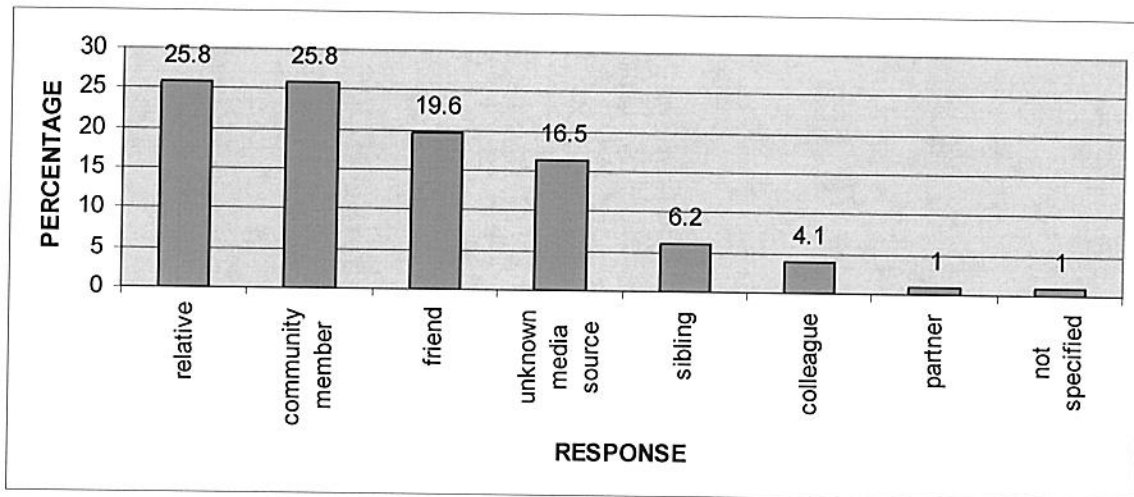


Fig 15: Relationship to the infected

Seventy seven percent (77%) know at least one person who died from AIDS related illness and their relationships to these ranged from family members to partners (fig 16)

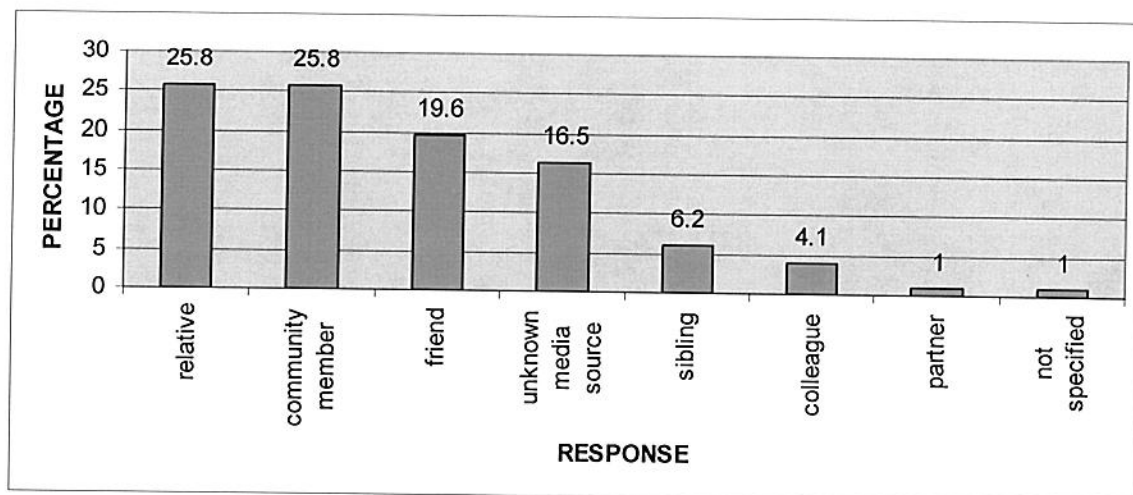


Fig 16: Relationship to the dead from AIDS

Source of information on STI's, HIV and AIDS

A wide range of sources of information on HIV/AIDS were mentioned but mainly from the health facilities and the media. At least 13% mentioned receiving this information from

the work environment. Equally, a number of reasons were cited for trusting these sources of information but mainly because these were professional sources.

Attitude towards the infected:

There were worrying responses to what people would do to HIV positive individuals, including ostracizing and confrontation.

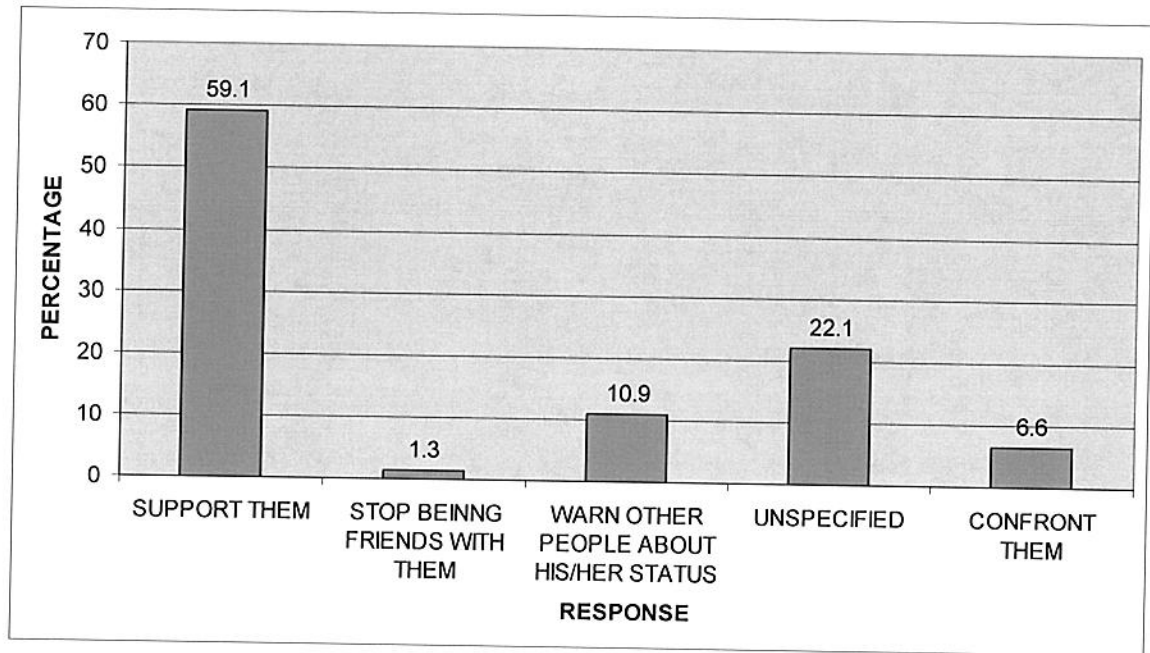


Fig17: attitude towards infected individuals

D. Perceptions

Risk of HIV infection

It was also very worrying to discover that a very large majority of participants (67%) felt they were not at risk or were at minimal risk of being infected by the virus.

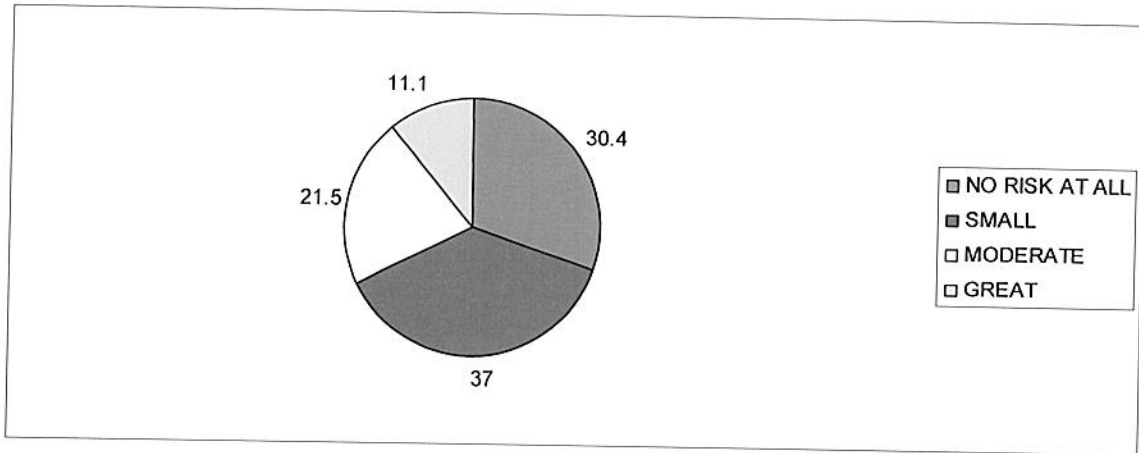


Fig 18: Risk perception

All the reasons cited for the perceived low risk exposure were equally of serious concern. (fig 19)

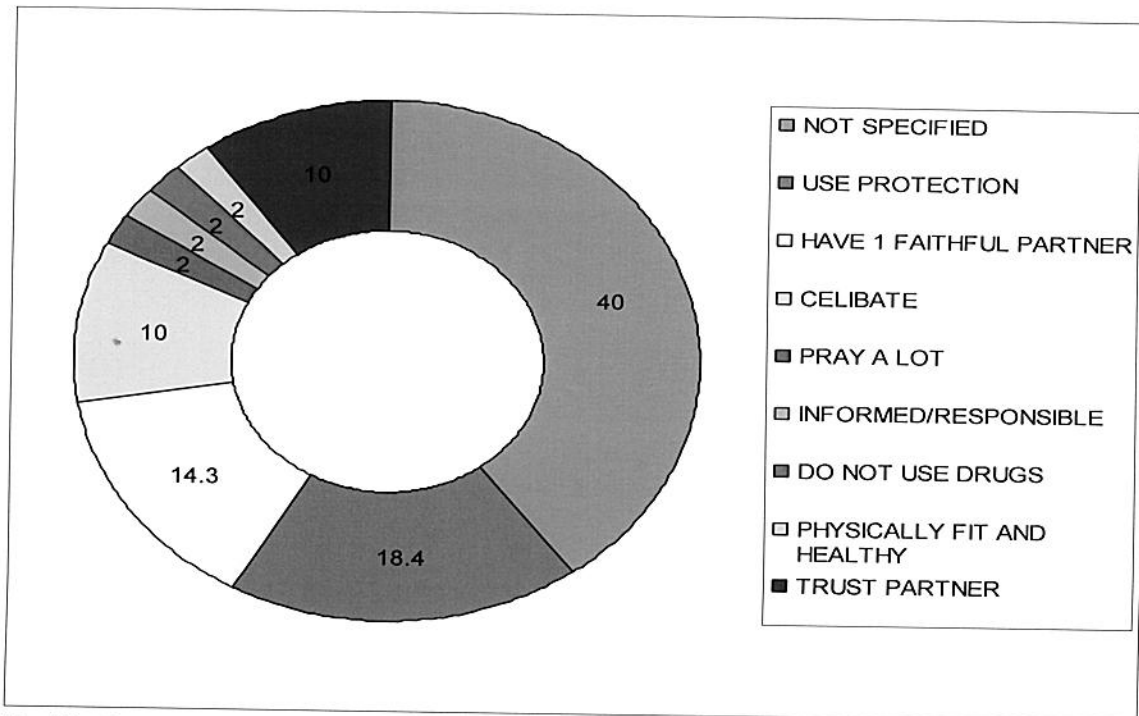


Fig 19: Reasons for no risk perception

A number of correct reasons about why they perceived themselves to be at high risk of being infected, were enlisted. (fig 20 below)

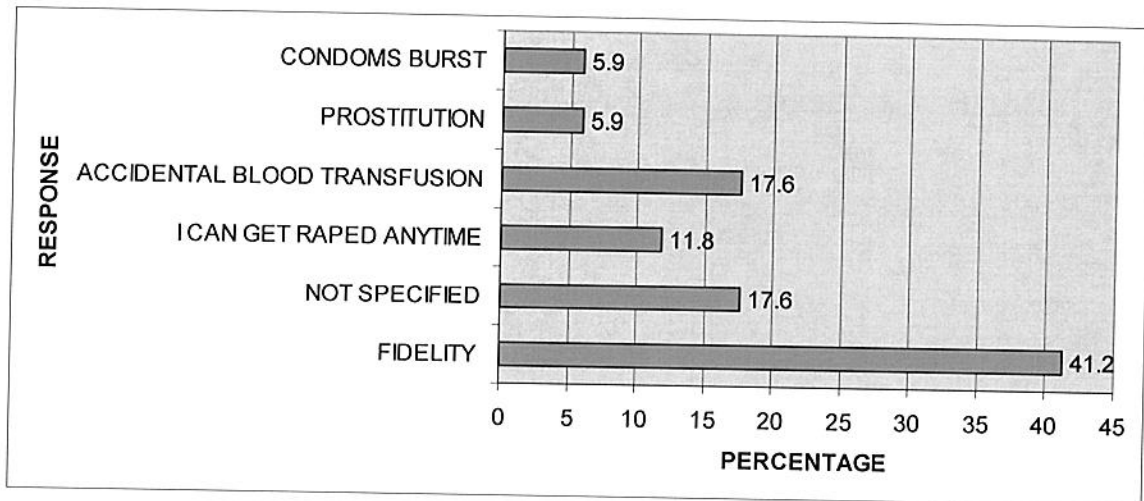


Fig 20: Reasons for high risk

Myths on HIV Cure:

Ninety six percent (96%) correctly responded in the negative about the current myth that AIDS can be cured through sexual intercourse with a virgin.

An attempt to probe the basis for this particular myth revealed a number of responses but mainly that this was due to lack of knowledge among such people. (table 3 below)

Reason	% age
Lack of knowledge	55
Outrageous reasons	21
Traditional beliefs	6
Myths	15
Insignificant	3

Table 3: Reasons for existence of myth on AIDS cure through intercourse with virgins

A very large majority (91.6%) believe that condoms are protective.

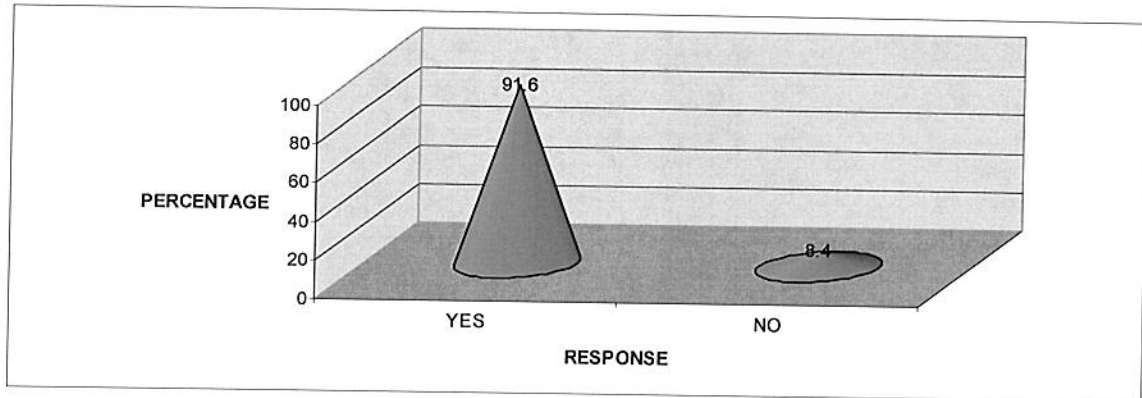


Fig 21: Perceptions about condom protectiveness

Significantly and of concern again, the majority of these participants felt that people living with AIDS should be institutionalized.

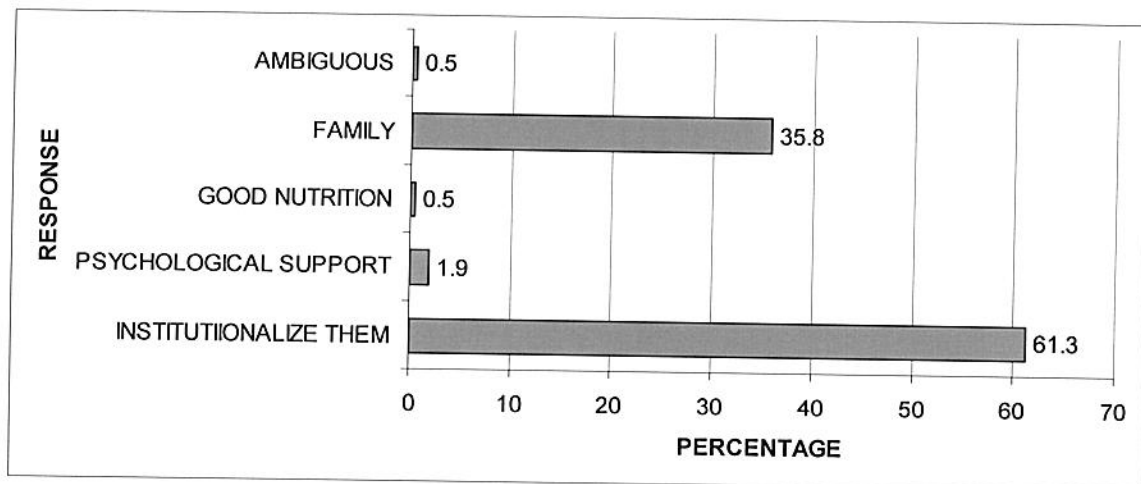


Fig 22 : Care for PLWA

E. Behaviors / Practises

Of the 98% majority that agreed to have had sexual intercourse in their lifetime, 88% were sexually active in the past 12 months. Of the minority (2%) that abstained, only 18% cited concern about contracting HIV as a reason for their abstinence.

The teenage years was the main period of first experimenting with sexual intercourse.

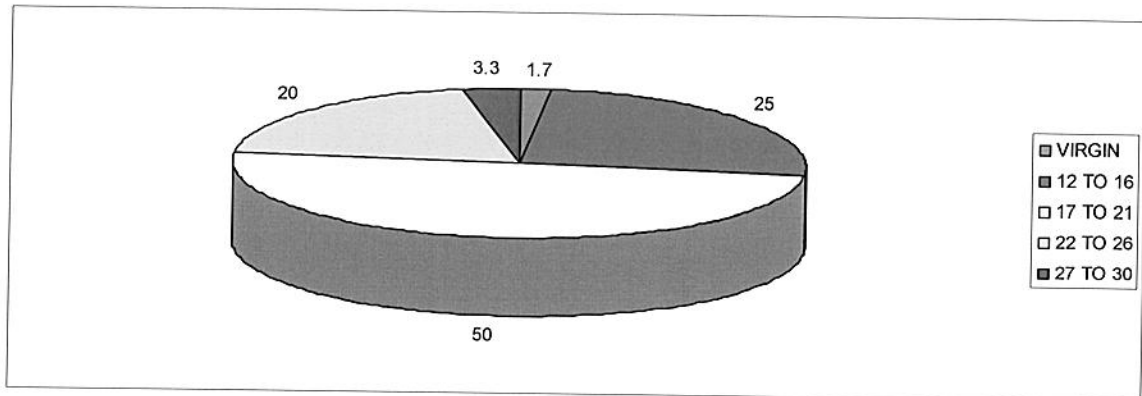


Fig 23: Age of starting sexual intercourse

Another significant finding, is on the multiple partners that the respondents have had. A very large majority (78%) have had multiple (more than 3) partners in their lifetime, and, 26% more than ten partners (fig 24 below)

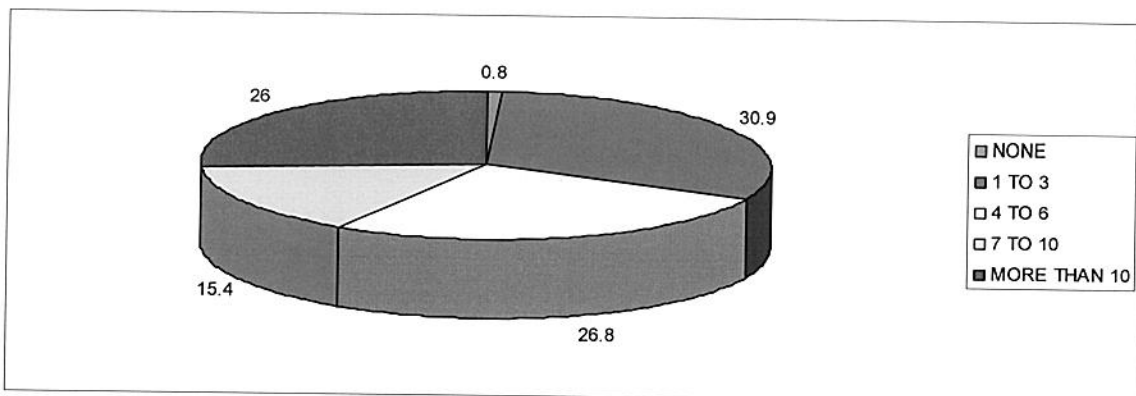


Fig 24: Number of lifetime partners

Equally, of serious concern is the fact that only 28% regularly protect themselves through condom use and the reasons for this behaviour was simply not explained. This

is further confirmed by the 52% that agreed to not having used a condom during their last sexual encounter.

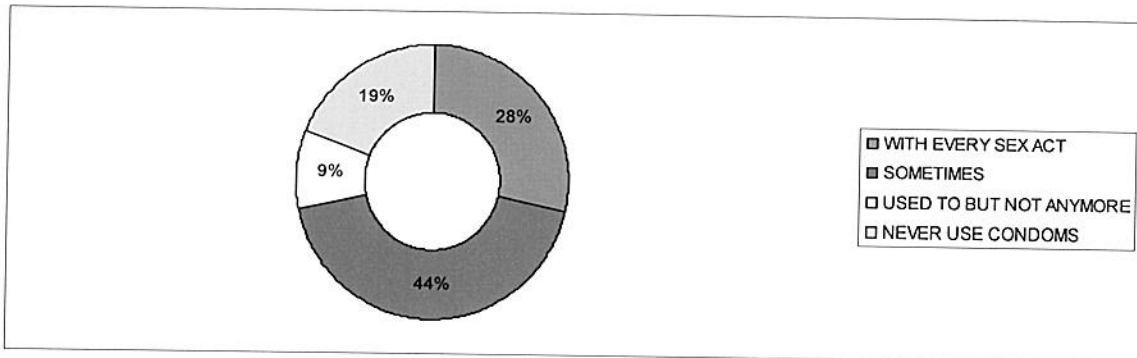


Fig 25: Frequency of condom use

Interestingly as well, is the confirmation of the often stated fact that some people (females mainly) do not make decisions about condom use by themselves but decided for by their partners, often males.

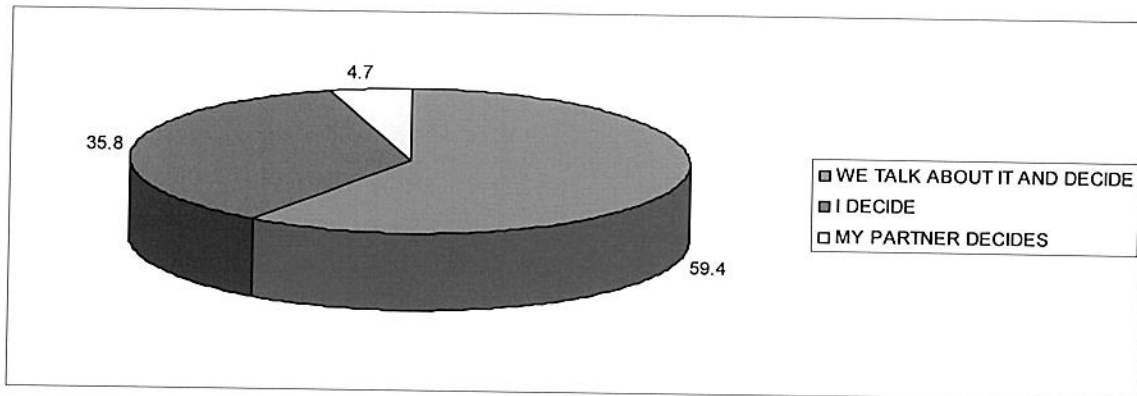


Fig 26: Decision making on condom use

Equally worrying here is that they would continue to force sexual intercourse even as the partner refuses, including actually raping the partner.

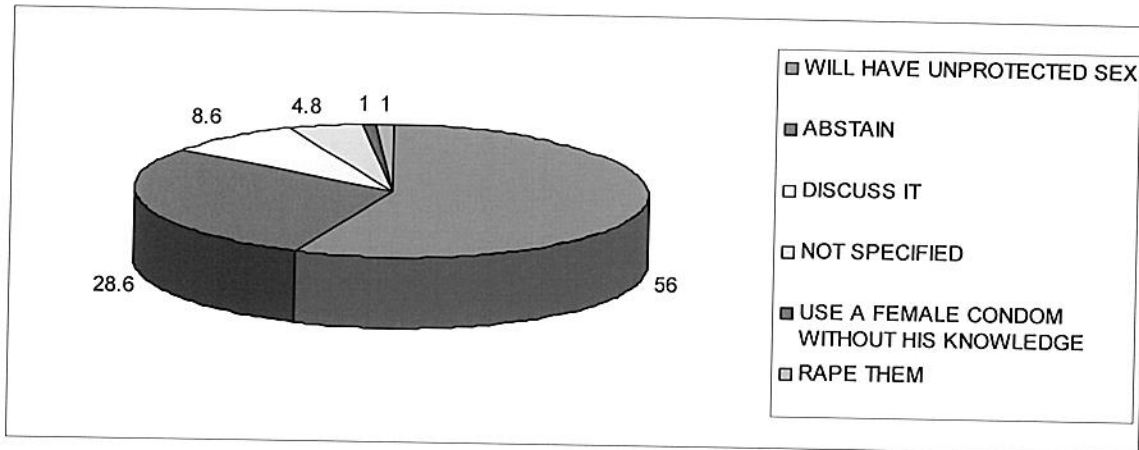


Fig 27: Response to spouse's refusal to condom use

A variety of facilities where condoms are usually accessed were in order: workplace (30%), retail outlets (26%), health facilities (25%), partners (11%) and friends (8%).

Only a small minority (23%) reported to have ever suffered from an STI. Of these, the majority (84%) did seek treatment from appropriately trained professionals. (fig 28)

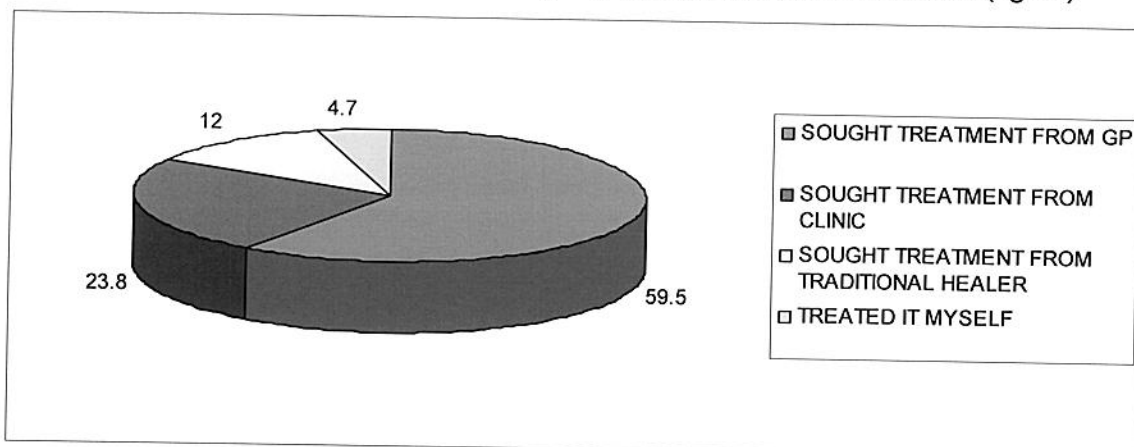


Fig 28: Treatment seeking behaviour for STIs

Those who reported self-treatment (i.e. the 5%) 50% used muti and another 50% used vaginal cream.

HIV Testing

The majority (70%) admitted to testing for HIV and of these the last test was in the last 12 months.

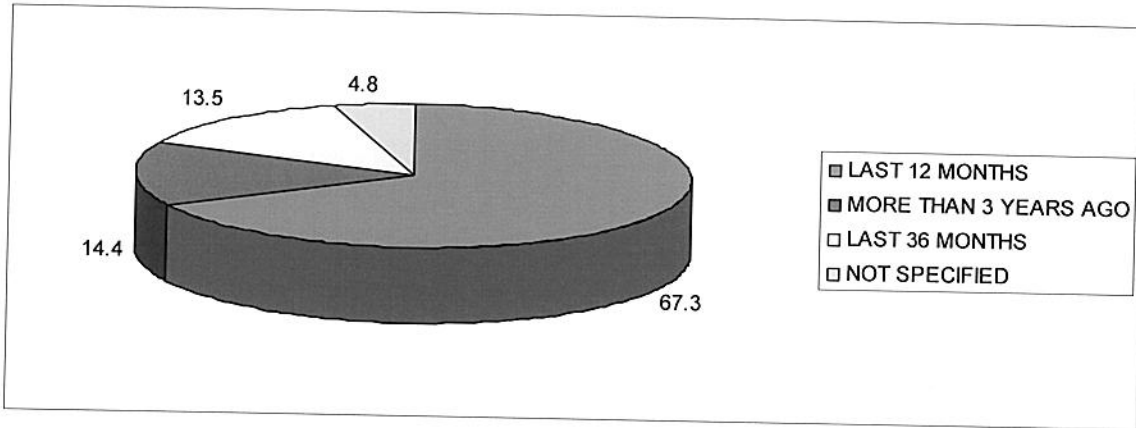


Fig 29: Latest previous test for HIV

Encouragingly, 82% were planning to test again in future but 16% reluctant to go for another test. On the other hand and of concern, only 36.4% of those who never tested for HIV were keen to know their status.

The stated reasons for wanting to know one's HIV status varied but of crucial importance. Fig 30

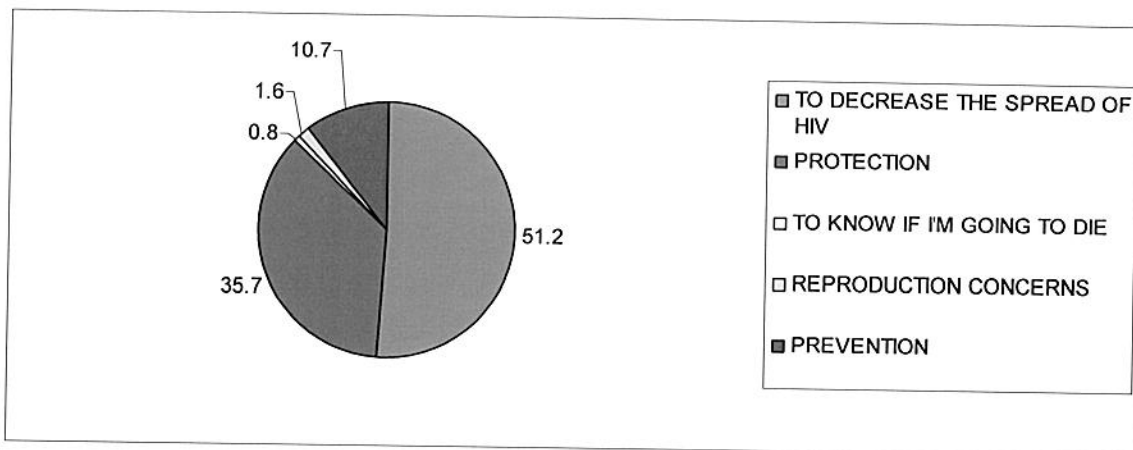


Fig 30: Reasons for wanting to know HIV status

The HIV status issues associated with knowing one's status were worrying but very crucial as well.

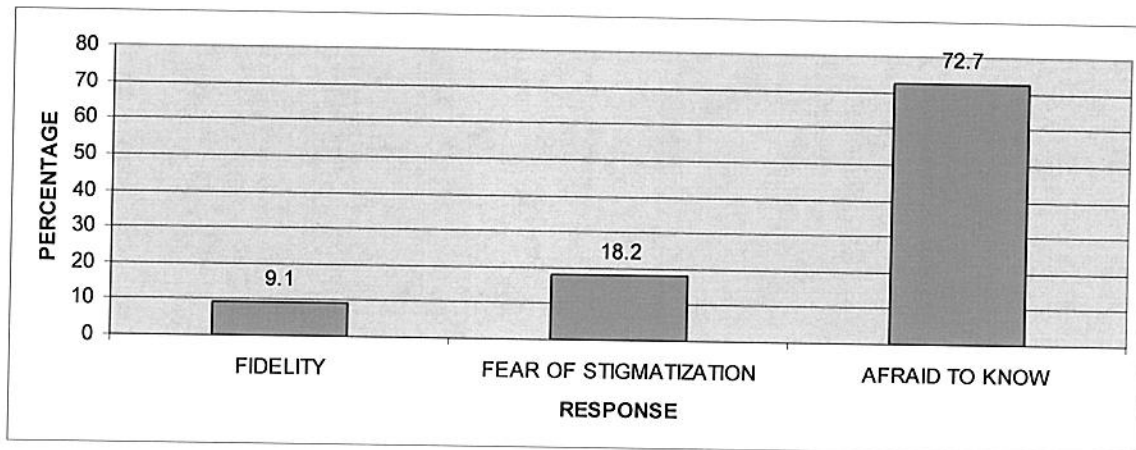


Fig 31: Problems with knowing one's status

An overwhelming majority (91%) admitted to talking about and/or discussing issues around HIV and AIDS sometimes apparently in a variety of forums and, of these only 3% felt the discussions were not beneficial. (Fig 32 below)

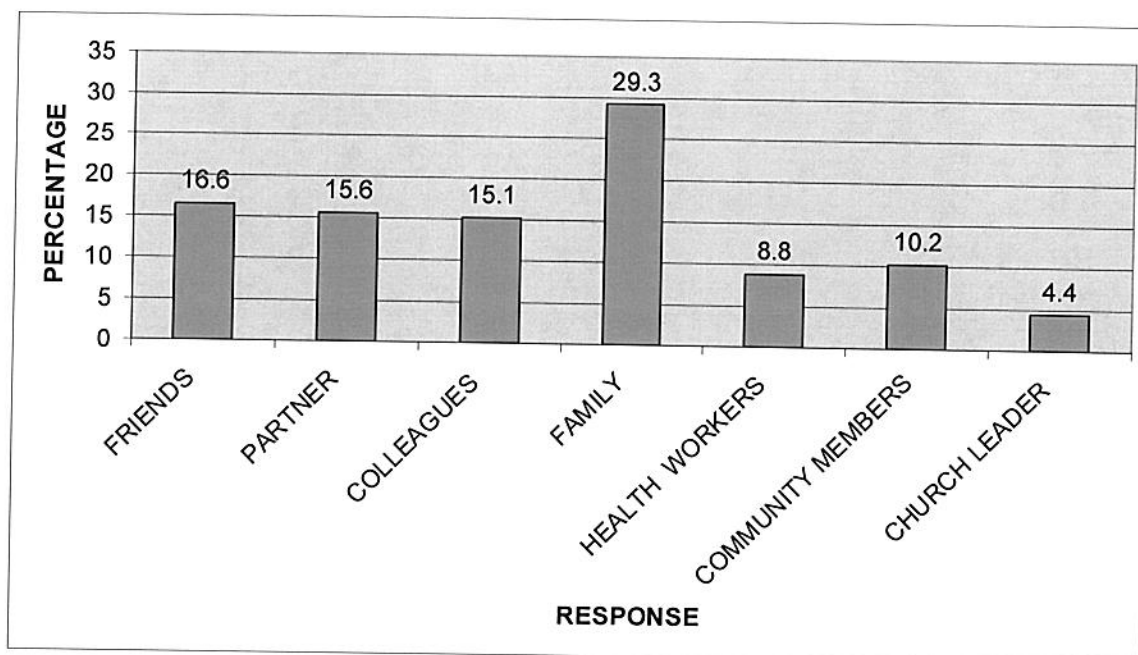


Fig 32: Discussions about HIV/AIDS

F. RISK of HIV infection at the Workplace

Only 13% of respondents thought there were work-related risks for contracting HIV within their working environment.

Of these, the risky areas were identified as in fig 33 below.

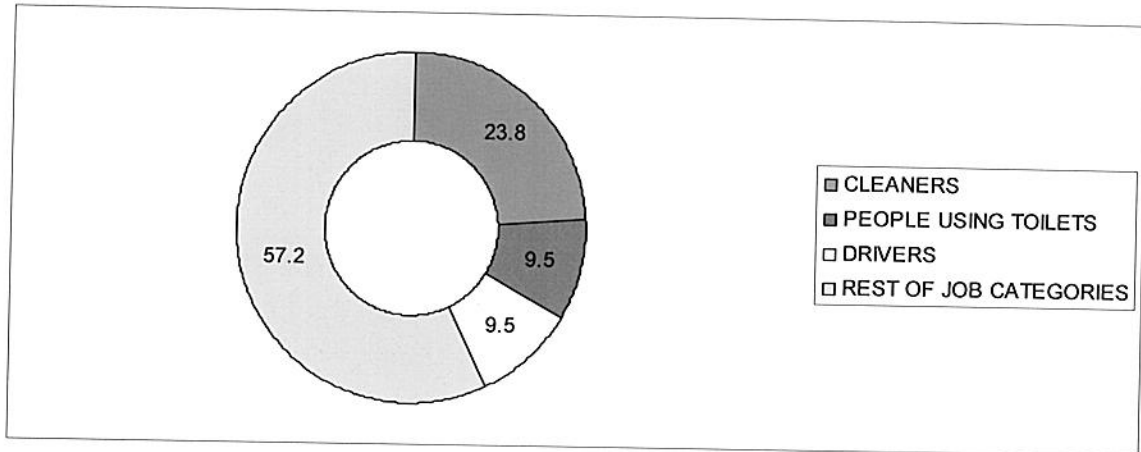


Fig 33: Risky areas

The proposed intervention to protect workers from the risk of contracting HIV are listed in table 4 below:

intervention	percentage
Protective clothes supply	37.6
Training & awareness	29.2
Keeping toilets clean	8.2
Condom supply	4.2
Testing all workers	4.2
No proposal	16.7

Table 4: proposed preventive intervention at work

A minority (19%) reported discrimination against HIV positive individuals existed at work, and 4% admitted to either being tested or asked about their HIV status.

In fact, 9% knew of employees who were asked about their HIV status by the employer and, 7% felt that the employer has no respect for the constitutional right to privacy of the HIV positive employee. (Fig. 34 below)

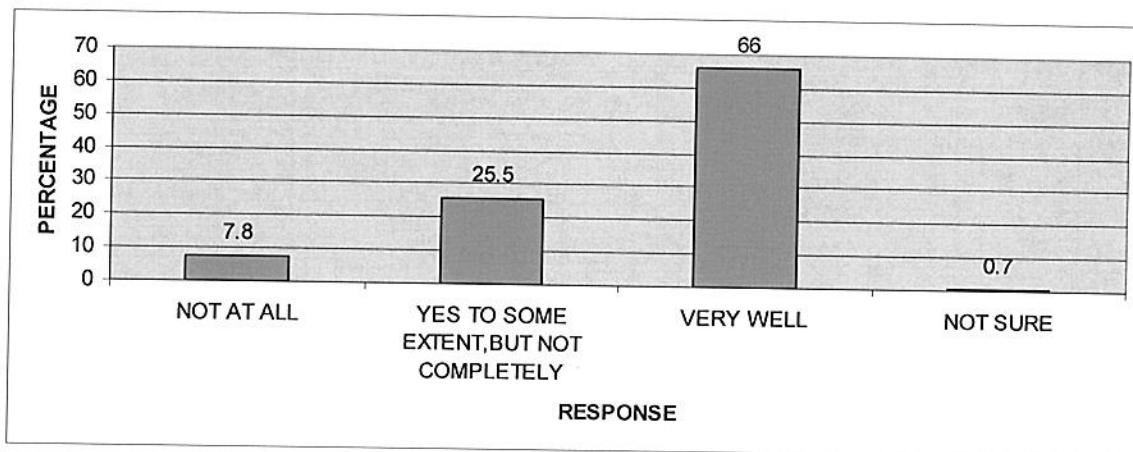


Fig 34: Employee right to privacy

HIV/AIDS Policy at Work:

There was an equal response on the awareness of HIV/AIDS policy at DLGH, but of those who were aware of this policy, the majority 61% understood the contents there-of.

The main issues addressed by this policy are in fig 35 below

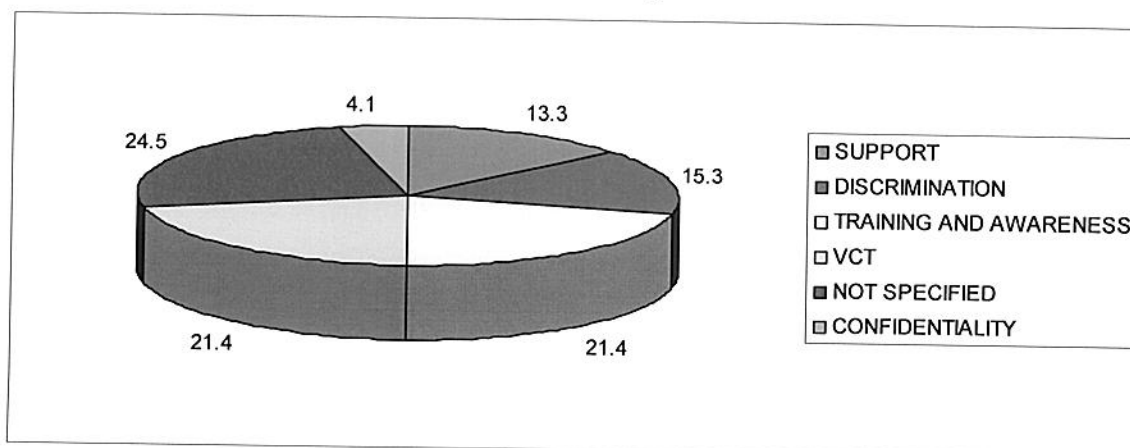


Fig 35: Issues addressed by the Policy

Awareness campaigns were proposed for DLGH to effectively conscientise employees on the HIV/AIDS policy and a number of proposals to reduce stigma of HIV/AIDS at work are presented below

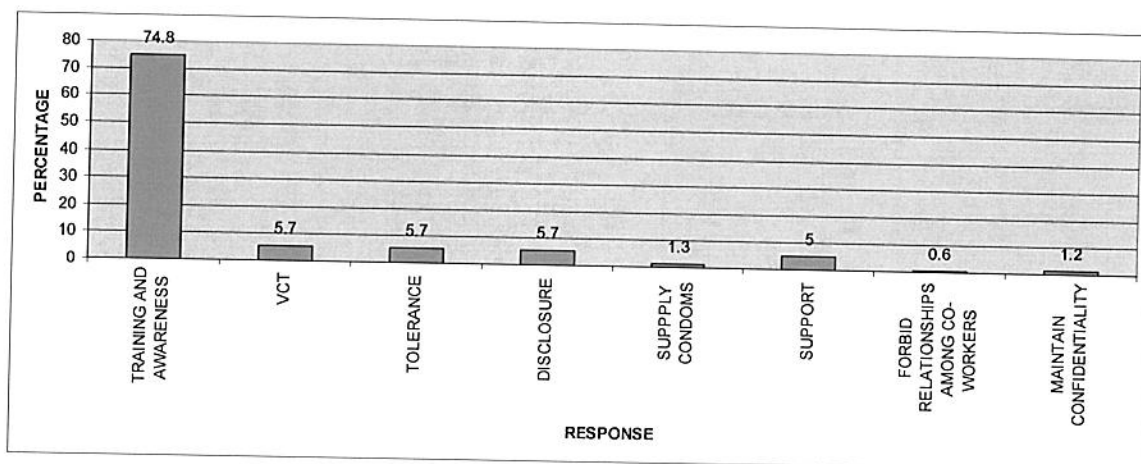


Fig 36: Proposal to reduce stigma of HIV/AIDS at work

It is important to note that some workers (40%) were not happy about the manner in which the whole HIV/AIDS issue is being managed at DLGH.

Below are the themes that emerged, proposing what DLGH management could do in fighting the epidemic at the workplace. (fig 37)

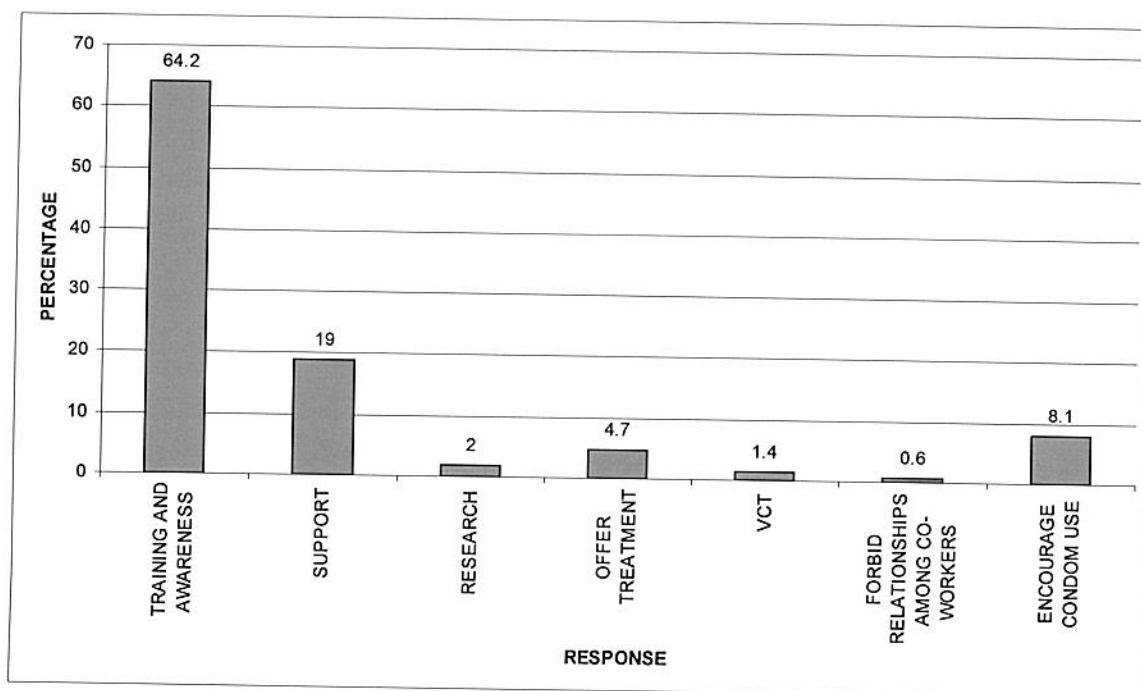


Fig 37: Proposed intervention strategies for DLGH

Chapter 5: Economic Impact of HIV/AIDS on the DLGH

The impact of the HIV and AIDS on the public sector and society in generally is beginning to be felt in a significant way. We are therefore in a period of opportunity to be advised as to what these costs may be in order to make informed decisions as to the best way to move forward to maintain productivity whilst maintaining the well-being of the workforce including those living with HIV and AIDS.

The Methodology

Assessing the financial and economic impact of HIV and AIDS requires a clear definition of scope and perspective. The costs are usually calculated from the perspective of the employer, in this case the Department of Local Government and Housing. The critical comparison is between the financial costs associated HIV and AIDS with and without workforce interventions. The status quo scenario can be established by calculating financial costs associated with the behaviour of the current labour force (see example on absenteeism due to ill health below).

There are four steps in the process of estimating future financial impact of HIV and AIDS if nothing is done for the workforce:

- Estimation of the number of new cases of HIV among employees (incidence), as well as the proportion of employees who are HIV positive (prevalence) over time.

- Understanding the progression of HIV/AIDS illness and stage of illness over time. For example, when do people get symptoms, major illnesses, or are likely to die due to HIV-related illness?

- Estimation of how illness will affect employees and the department. This will include how the illness affects current employees (e.g. absenteeism, health care utilization, productivity) and entry and exit into the current workforce (e.g. deaths, recruitment and training).

-Valuation of this impact in terms of Rands and calculation of ratios such as the percentage of HIV/AIDS related costs as proportion of the Local Government annual budget or expenditure or payroll.

Establishing the financial impact of the pandemic on the Department of Local Government and Housing workers requires the following data sets:

- a) Medical Costs - includes outpatient and inpatient care given through direct provision as well as that financed by medical schemes where appropriate;
- b) Human Resource Costs - includes medical incapacitations, deaths, early retirements and benefits associated with these, and training and recruitment costs; and
- c) Productivity Costs - estimates the consequences of lost shifts due to ill-related absenteeism.

Reductions in productivity due to illness cover three main arenas.

- Firstly the loss of production due to HIV/AIDS related absenteeism (which may be sick leave, absence without permission and family responsibility or compassionate leave taken to care for sick relatives or attend funerals).
- Secondly there will be reduced productivity of those individuals suffering from HIV/AIDS but still attending their work shift.
- Thirdly, individuals recruited due to HIV/AIDS related turnover in staff will experience reduced productivity whilst training and learning the job over time (part of what is known as the friction period).

However, the required data sets to conduct a complete financial risk assessment were not available (See Table 3). What was available was in not adequate allow for modelling the demographic impact of HIV over a number of years and hence assessment of costs with and without HIV and AIDS interventions. However, an assessment of absenteeism due to illness (regardless of HIV status was done using the sick leave database of 1083 employees for financial 2006/7).

Table 3 Summary of Data Requirements for Risk Assessment			
Variable	Data Sources	Availability	Remarks
Worker numbers by category	Human Resource Departments	Available	
Projected numbers of workers by category for the next 5 years	HR plans plus Interviews with Key informants	Available	Necessary for assessing HR gaps and replacements
Workers by sex, age, and gender	HR departments	Available	
Projected HIV prevalence estimates by age, sex and gender	To be modeled based on demographic profile data	Data inadequate to allow such modeling or projections	Incidence data unavailable
Estimates of ill-health retirements	Same as above	Not available	
Estimates of HIV/AIDS related deaths	Same as above	Not available	
Estimates of numbers requiring ART	Same as above	Not available	
Salary grades and benefits by educator category	HR departments	Salary grades available but not benefits	
Training costs by worker category	HR departments	Not available	
Recruitment costs by employee category	HR departments	Not available	
Promotions and resignations by category	HR departments	Not available	
Vacancies by worker category	HR departments	Not available	
Worker absenteeism (ill-ness related)	HR departments	Available	Not necessarily related to HIV status
Worker compassionate leave	HR departments	Not Available	

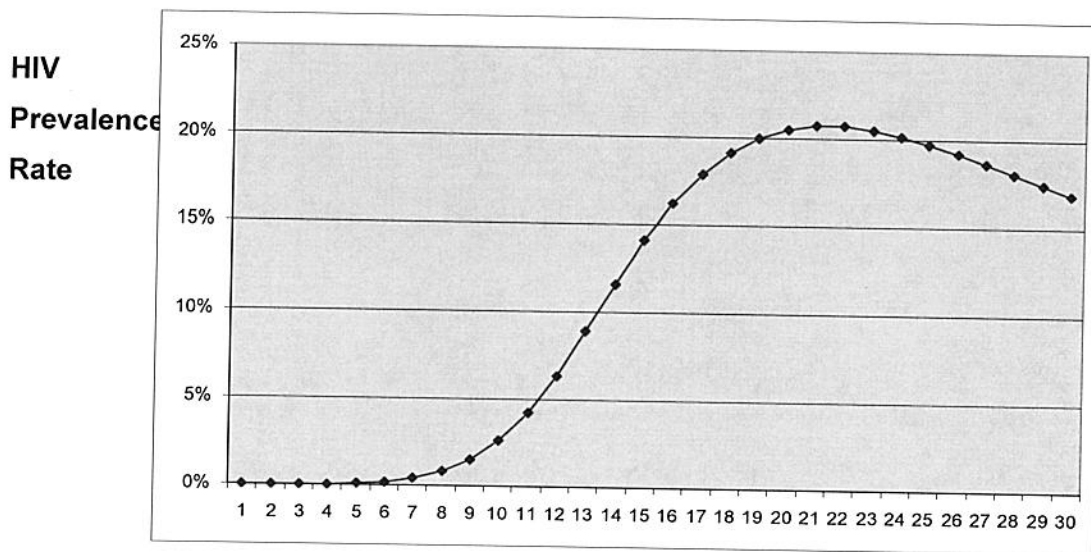
Evidence from elsewhere (as an example)

In the absence of a complete data set for a comprehensive risk assessment for the department a literature review was done on the subject matter. Evidence from the mining sector in South Africa shows clearly the link between HIV status and absenteeism and reduced productivity. In 2002 a prospective cohort study of 1792 of miners showed significant associations between HIV status and hospitalization, death and rates of leaving employment (Corbett et al 2002). Another study analyzing the provision of INH prophylaxis against TB in HIV positive miners cost less per person treated than the treatment cost of a case of TB (Kumaranayake et al, 2004).

Modelling the demographic profile of the HIV and AIDS in different companies or workforce using the Actuarial Society of South Africa (ASSA) model produces a standard

profile (see Figure 1) that differs in height and gradients across workforces. The latter that is the progression and peak of the HIV and AIDS is influenced by workforce interventions including wellness clinics and preventive programmes such as health education and provision of free condoms amongst other things. Without these the disease profile is likely to show steep progression and early pick and hence financial impact.

Figure 1. Modeling of HIV epidemic over time: ASSA Select Population Model



Note: year 1 is 1985, Year 30 is 2015.

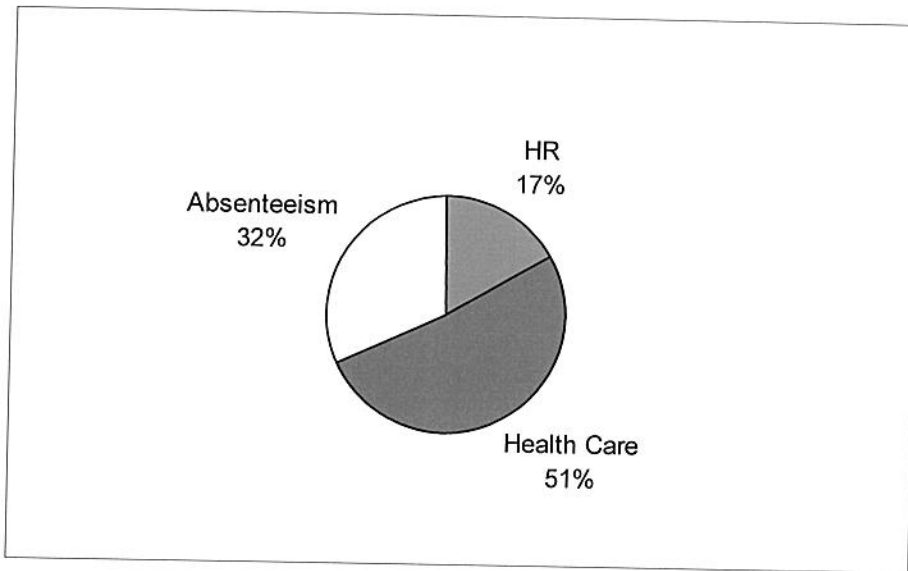
Evidence from one mining company showed a marked difference in the utilisation of medical services between those workers who are HIV positive and those of “unknown” status (including HIV negatives) in 2002 (Table 1)

Table 1: Additional outpatient visits and inpatient days associated with HIV status

HIV Positive	HIV positive	AIDS sick	AIDS sick
Inpatient days	Outpatient visits	Inpatient days	Outpatient visits
2.77	17.12	55.44	21.56

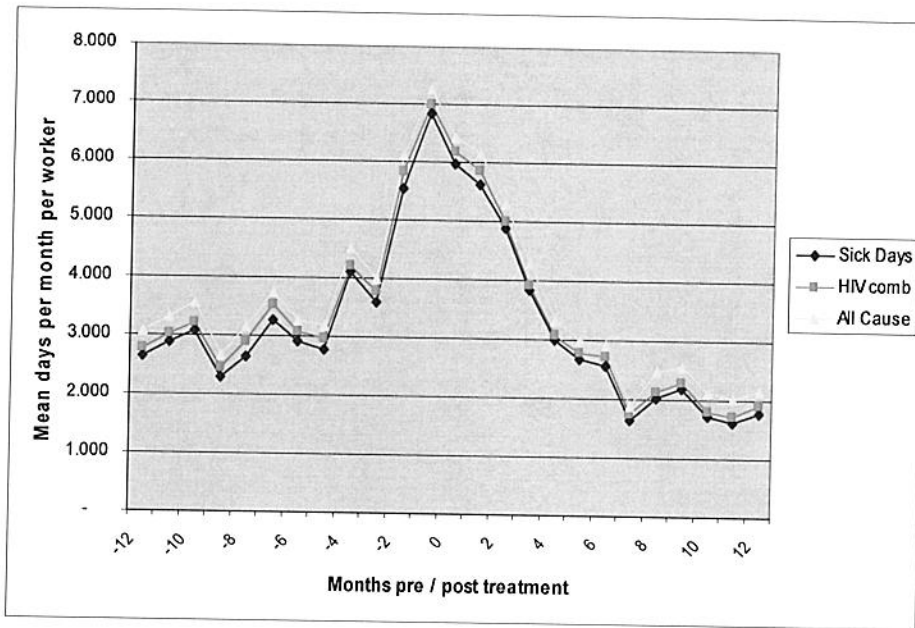
Source: Aurum 2003

Estimated impact of HIV/AIDS on selected Anglo American companies in the absence of the treatment programme to companies ranged from 0.8 to 3.0% of payroll, with impacts predicted to peak between the years 2008 and 2011. Initial breakdown of impacts excluding HIV programmes and labour productivity at work are shown in figure 1 below.



Source: Anglo-American Report 2006

Employers have an obligation to assist their employees in the interest of productivity and quality of work and reduction of costs. The figure below demonstrates the impact of ART on absenteeism for an unidentified company. It is clear that treatment interventions will have significant productivity benefits. Without ART absenteeism will increase at an increasing rate for the HIV cohort of workers.



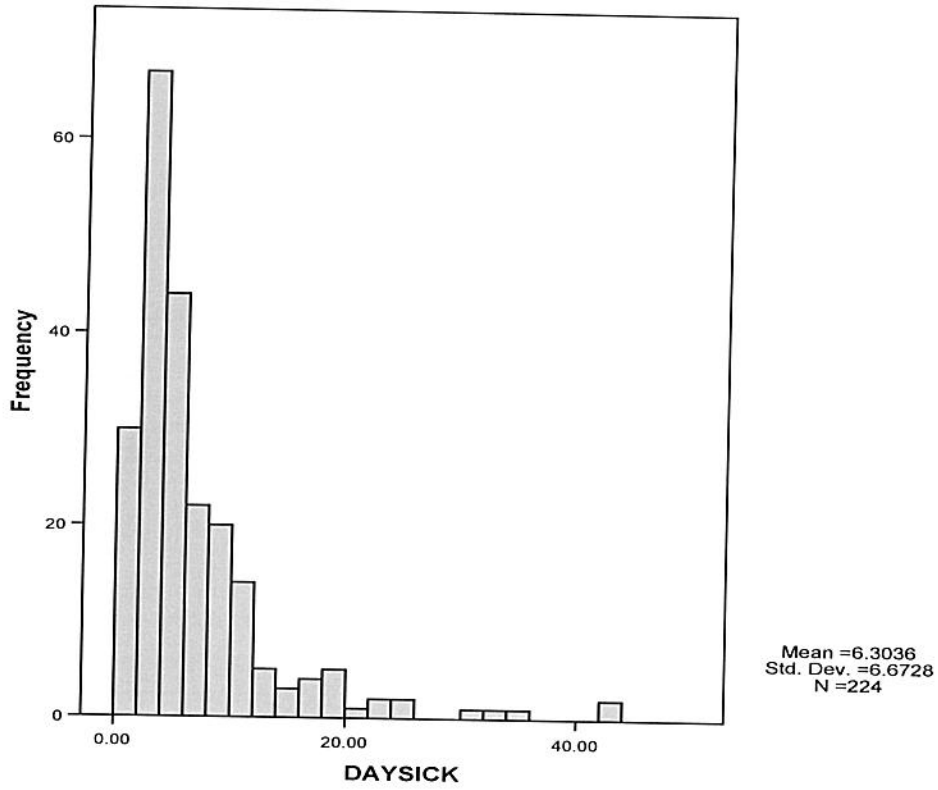
Source: Aurum Health 2006

Absenteeism due to ill-health for Limpopo-Department of Local Government and Housing workforce

Out of a sample of 1083 employees 20.7% took sick leave in 2006/7 financial year. The mean number of days sick was 6.3 days (min-max of 1-43 days) and a standard deviation of 6.67 days.

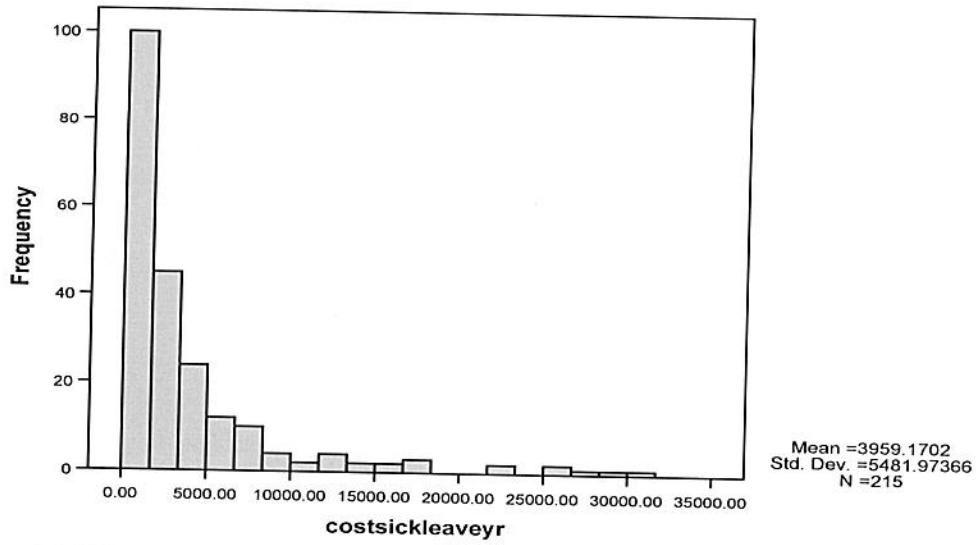
The cost of a day off sick was calculated using a working month of 20 days and the gross annual salary for each category of worker. The mean cost was R3 959.00 (ranging R 187.00 to R3 0111.00) per year. The total cost of days off due to ill-health was R851 221.60. Noteworthy is that this cost includes both costs associated HIV status and unknown status (includes HIV negatives). Figure 3 shows the distribution of sick days for all employees.

Figure 3: Distribution of days sick. 2006/7 Financial Year



The cost distribution due to ill health follows the same pattern as the observed days sick taken.

Cost distribution due to ill health, 2006/7FY



The total figure could be more given the completeness of data and the fact that other days taken as normal vacation account were used to either access health services or recover.

Chapter 6: Discussion

In 1990, South Africa had an HIV prevalence rate of less than 1%, but by 1999, this had risen to 22,4%. The infection is spread unevenly between the provinces with the Northern Province at 12%, Gauteng 22%, Mpumalanga 30%, North West 21%, Free State 23%, KwaZulu–Natal 33%, Northern Cape 10% and Limpopo 15.6%. The figures show a dramatic and unparalleled rise in infections giving South Africa one of the fastest growing epidemics in the world. While the figures are dramatic and even shocking, the epidemic for most South Africans is still largely silent, as well as a hidden one. Comparing the figures and the response, it is possible to believe that one is dealing with different epidemics and perceptions.

Such high infection rates should have put the government and the population on high alert. Instead we are faced with a situation in which there is continual denial, where the population is well informed but has taken no steps to change its **behaviour**.

While the HIV/AIDS is being grappled with as outlined in the papers, there is a lack of coordination and commitment. This can be addressed by “breaking the silence”, facing the challenge and concerted action by government, organisations and communities at all levels to address issues in a concerted manner.

Research trends show that there is a need for an assertive, focused, goal – oriented approach in the context of a serious epidemic and emergency. There is a strong need for a paradigm shift from ‘managing’ risk at the point of sexual encounter to ‘managing contexts’ of risk, a shift from the national ‘generic’ approach to approaches tailored to context. Promoting the understanding of risk of exposure is critical as is the promotion and protection of human rights.

A big gap exists as quantitative studies provide a very good understanding of the ‘what is’ but a very poor understanding of ‘why’, with HIV prevalence seen as a problematic measure as it doesn’t allow for correlation between current sexual practices and HIV incidence. There is an overall poor understanding of HIV risk and factors underpinning HIV incidence and a need to expand the indicators to provide a clearer understanding of the risk. The gaps in the management of HIV/AIDS create opportunities to creatively look

at the early management of HIV to enable the employees to live longer and work productively and save the organisation money. A strong need exists to critically look at the dynamics to increase enrolment in disease management, to look at the role of incentives in this and an opportunity to address stigma.

The findings from this study are and should be cause for serious concern to managers of DLGH in particular. That at this stage of the country's experience with the HIV/AIDS epidemic, there exist a large number of workers who do not know and by extension would not use the recommended methods of prevention against HIV/AIDS.

The attitudes and perceptions of these workers, in spite of all the efforts to improve awareness and understanding of the syndrome, remain very much entrenched and negative.

If the majority of workers do not perceive themselves to be at risk of contracting the disease as was the case in this study, citing a number of ineffective myths, the challenge facing the country is enormous and the country may be in a very unfortunate situation of losing all the gains it ever achieved in the fight against the epidemic and in building the economy. The optimism prevailing about our growing economy may soon turn the 'smiling faces' of South Africans to 'wells of tears' as the virus continues unabated to masquerade amongst and maraud its citizens.

This cohort represents the economically active group in this country and in the context of the overwhelming poverty manifestations country-wide; their negligent behaviour has very profound implications to the rest of the populace of SA. All this poses a strong and direct challenge to the senior management of DLGH to make concrete intervention to improve awareness amongst its workers. A small intervention by DLGH as one component within the public sector, the biggest employer in SA, would go a long way in achieving the goals set by the country in its fight against this epidemic.

CONCLUSION:

This study with all its limitations was a major revelation for policy makers of DLGH. A number of consistencies with the general trends country-wide have been identified. There equally were some shocking findings and surprises though.

Amongst those who participated in the study, the majority was SePedi speaking males, at middle level employment and relatively well educated. These were in steady relationships but mainly with teenage partners and/or wives. From previous ante-natal care surveys and other studies, the teenage groups were found to be particularly vulnerable and at a relatively higher risk of contracting HIV and AIDS.

Knowledge:

The message about HIV and AIDS though heard by the majority, there was little understanding of the syndrome and in particular how a diagnosis of HIV and AIDS is and should be made.

Of much serious concern is the huge majority that does not know about the recommended methods of prevention and thus not using these, and some who believe that a cure for HIV and AIDS does exist.

Attitudes:

HIV and AIDS has directly affected many of DLGH employees through relatives, friends, colleagues, partners, etc.

There are worrying attitudes displayed towards the HIV positive individuals, including open confrontation and wanting to ostracise them.

Perceptions:

It is very disconcerting to discover that the risk of contracting HIV infection was not perceived for what it is, with a large majority not seeing themselves to be at risk, forwarding a number of reasons to justify this false sense of security (including prayers, being physically fit, etc).

Encouragingly though, the majority do believe in the protective capacity of condoms and they dismissed the myths about sexual intercourse with virgins as a cure.

Behaviours / Practices:

Consistent with other studies in SA, the majority were found to be sexually active, beginning their sexual experience during their teenage lives.

Worryingly though, the majority have or had multiple partners up to ten. Even more serious is that condoms were not used by this majority during these sexual encounters.

Male dominance in relationships including with decisions about condom use, was confirmed and these male partners would go to the extent of using force to have sexual intercourse without a condom.

Testing for the virus seemed to be acceptable by the majority but there still are some who would not go for testing and do not want to know their status. Fear of consequences of being HIV positive, including stigma there-of, was the main reason for them not wanting to know their status.

The workplace is not perceived to be particularly risky for contracting HIV by the majority, but again, possible protective methods are not known.

Even though minimal, discrimination against HIV positive workers is said to exist at DLGH.

Chapter 7: General/Broad Recommendations

Managing HIV/AIDS at the Workplace

1. HIV/AIDS Policy:

Policy guidelines and legislation make it clear that DLGH HIV/AIDS strategy needs to focus both internally (as an employer) and externally (as a public service provider), which together involves a process of mainstreaming HIV/AIDS into every function and service of DLGH. For a start DLGH has a policy in place which covers some of the basic objectives and principles, but with the survey results it will need a review so as to address the gaps that have been identified. A lot has been done already by the department but there's always room for improvement.

2. Workplace HIV/AIDS programmes:

Every workplace should develop and implement workplace HIV/AIDS programmes aimed at preventing new infections, providing care and support for employees who are infected or affected and managing the impact of the epidemic in the organisation. The nature and extent of a workplace programme should be guided by the needs and the capacity of each individual workplace.

It is further recommended that every workplace programme should attempt to address the following in cooperation with the sectoral, local, provincial and national initiatives:

- Training all workers about the syndrome and remove the existing myths
- Encourage Voluntary Counselling Testing
- Conduct Education and Training on HIV/AIDS
- Actively promote Condom distribution and use
- Encourage Health seeking behaviour for STI's and the use of universal infection control measures
- Create an environment that is conducive to openness, disclosure and acceptance amongst all staff
- Provide access to counseling and other forms of social support for people affected by HIV/AIDS
- Broader and regular education and HIV/AIDS prevention and awareness campaigns among the entire workforce

- Maximize the performance of affected employees through reasonable accommodation, such as investigations into the alternative sick leave allocation
- Develop strategies to address direct and indirect costs associated with HIV/AIDS in the workplace.

3. Stigma and Discrimination

The impact of HIV/AIDS in the workplace is hard to predict and quantify. The actual context of HIV in most work places is shrouded by stigma and discrimination. One study showed that the implications of the stigma, the ignorance and fear related to HIV/AIDS seemed to have a negative impact on the potential role employees could play in urging the organisation to come up with responsible answers to the disease.

Noting lack of data on the nature and extent of the discrimination, the Department of Health in January 2001, commissioned the Strategy and Tactics, in partnership with the AIDS LAW Project to conduct baseline research on HIV/AIDS with the following objectives:

1. Profiling the nature and extent of discrimination
2. Examining the impact of discrimination, particularly on health seeking behaviour
3. Identifying obstacles to creating a conducive climate for disclosure of HIV status
4. Developing a draft strategy to counter discrimination

4. Promoting a safe Workplace

An employer is obliged to provide and maintain, as far as reasonably practicable, a workplace that is safe and without risk to the health of the employees. (OHS Act no 85 of 1983). Every workplace should ensure that it complies with the provisions of the Occupational Health and Safety Act. Its policy should amongst others deal with the management of occupational exposure to HIV, including access to post- exposure prophylaxis.

5. Role of Stakeholders

Leadership:

Stakeholders in the organisation are perceived not to be playing a significant role in the decision to address HIV/AIDS proactively according to one study. The level of management involvement can be an indication of whether or not HIV/AIDS is perceived

as an economic risk to the organisation or not. In most companies, people without decision –making authority and often at low positions in the organization, are appointed by management to formulate HIV/AIDS policies or low budget prevention and awareness programmes.

Trade Unions:

In the perceptions of many stakeholders the trade unions performed weak in terms of monitoring companies for compliance with HIV/AIDS related laws. Trade union pressure is not seen as a reason for addressing HIV/AIDS in the workplace. They have the power to unite the interests of the employees, form a strong bargaining partner in their negotiations with the management and to organise collective strikes. To deal with these issues, they need to negotiate workplace policies and programmes on HIV and AIDS. Their demands must reflect what they know about HIV.

Workforce:

The workforce itself plays a role, in that employees come to the organisation with cultural and social baggage's obtained from interactions in other social contexts. Their interests and commitment outside the organisation are not necessarily in line with those of the company and can undermine, support, facilitate or complicate HIV/AIDS workplace responses. One study indicated that employees were not perceived as influential stakeholders when it comes to HIV/AIDS. It was found that within the companies, employees at all levels and of all backgrounds, from management to the work floor, contributed to a climate that is not conducive for disclosure in the workplace. People believe that stigma is the main reason people do not disclose in the workplace.

SPECIFIC RECOMMENDATIONS:

In order to effectively address the issues and/or challenges identified in this study the following are recommended to senior management of DLGH:

1. An HIV and AIDS policy must be reviewed and more emphasis and focus be put on de-stigmatising and demystifying HIV. An HIV and AIDS policy document must be made available and known through training, and visibly displayed to all levels of employees at DLGH.

2. HIV / AIDS should be a standing agenda point at all SBU meetings and LMF.
There should be visible top management buy-in and not simply lip service. concerted effort to train managers on HIV issues and how to deal with HIV infected employees, and mainstreaming HIV into the business.
Managers should take the lead and own HIV awareness sessions and not be reluctant in releasing subordinates to attend such sessions, otherwise lots of scarce resources are wasted on organizing events that do not benefit the organization.
Appreciable is the fact there are peer educators, but more need to be recruited from all divisions within the department. They should receive more acknowledgement and recognition for their existence and role, and be more empowered within the organization to deal with HIV / AIDS issues.
Peer educator training should be more structured and follow a fixed annual schedule or calendar to keep them abreast of recent developments within the HIV / AIDS fraternity.
An effective HIV and AIDS education must not solely be the responsibility of the Wellness division. For real impact, all senior management, line management and everybody at all levels should be involved and encouraged to take responsibility and ownership of activities with which they feel comfortable.
On-site VCT services, by a health practitioner with HIV, occupational and primary health care qualification should be made available on an on-going basis.
3. Constitutional and statutory obligations must be adhered to by all and at all times. Any form of discrimination against the HIV positive individuals is a serious violation of the constitution and must be urgently addressed.
4. Inadequate knowledge, perceptions, attitudes and behaviour by DLGH employees must be dealt with through awareness programmes, health promotion, Training / Access to information.

The critical issue is what to do and how, and not whether or not DLGH should implement some or all these programmes. The low turn-out for the survey explains the

low HIV prevalence which by all predictions is likely to be higher than what was established. The policy decision is whether something ought to be done now or in future when the cost to the employer and the family of workers are likely to be extremely high.

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Appendices

Appendix 1: Invitation Letter

Drs Ndamane Gaga Inc
37B Voortrekker Street
Polokwane

Mr/ Ms XX
Department of Local Government and Housing
Limpopo

Dear Mr/Ms XX

RE: HIV prevalence and KABP survey – Invitation letter

Doctors Ndamane and Gaga from Ndamane Gaga Inc cordially invite you to participate in a voluntary study that will be conducted on DLGH workers. Ndamane and Gaga Inc are medical doctors conducting health surveys in South Africa. They will be conducting a survey of DLGH employees to investigate the proportion of workers who are infected with HIV and to assess the workers' level of knowledge about HIV and AIDS and its prevention.

You have been selected through our processes to be one of the workers who will be tested for HIV and who will also answer the questions that will show us your level of your knowledge about HIV/AIDS and its prevention. The study will be conducted at _____ (venue) on _____ (date). The study team will be at the study venue from 07h00 in the morning until 17h30 in the evening. You are requested to bring and present this invitation letter with you on the study date mentioned above. You will be given detailed information about the study on your arrival at the study site and you will also be requested to sign a consent form should you agree to participate. An oral fluid specimen will be collected from you and this will be tested for HIV antibodies. The specimen will not be labeled with your name or any of your identifiers and therefore there is no way that the study team could link HIV test results with individuals. At the end of the study the study team will know how many workers are infected or not infected with HIV but won't know who is infected or not infected. All invited employees who are interested to know their HIV status will be referred to a VCT service that will be arranged specially for them. This service will be available on the same day as the study. It will operate separately and independently from the study. Through this service, you will receive pre-counseling, you will then be tested for HIV, receive

post-test counseling and then you will be told your test results at no cost to you; this will happen only to those who wish to know their HIV status.

You will be served tea and biscuits whilst you respond to a study questionnaire. The study procedures including oral fluid collection and completing the study questionnaire will take approximately one hour. You will fill in the questionnaire yourself, independently or the study team will assist you should you so wish. Should you wish to contact the study team for further enquiries about the study, kindly call the principal investigators:

Dr Ndamane cell: 0823426349 and Dr Gaga cel: 0825421022;

Tel: 012 322 6209

Fax: 012 322 6206 and

email: NdamaneGaga@webmail.co.za.

Yours sincerely

Dr Sisanda Gaga (Principal Investigator)

Appendix 2: Information Sheet

Good morning/afternoon. My name is ----- from Dr Ndamane Gaga Incorporated. Ndamane Gaga Inc is a company that conducts health surveys in South Africa. Our company will be conducting a survey of DLGH employees to investigate the number of workers who are infected with HIV and to assess the workers' level of knowledge about HIV and AIDS and its prevention. This investigation is commissioned by the DLGH management with the knowledge of and permission from the workers' union. I would like to invite you to participate in this study. The fact that the study is commissioned by the DLGH management with the knowledge and permission from the workers union does not automatically give us the right to carry out the study procedures on you without your permission. We would like you to take part voluntarily in this study.

The aim of this investigation is to inform the development of an HIV and AIDS intervention programme within an employee health and wellness programme for the DLGH workers. The Department of Labour recommends that every workplace should have an HIV and AIDS policy which will create a "supportive environment so that HIV infected employees are able to continue working under normal conditions in their current employment for as long as they are medically fit to do so". This is also done to "protect HIV infected people's human rights and their dignity". At times, other employees are affected through infected relatives though they are not infected with the virus. This affects the performance and the productivity of the employee and therefore intervention programmes at a workplace could offer a supportive environment and help the relatives to understand and manage the disease better.

Study procedures – what is expected of you?

You are given this information sheet to read (or to be read to you), and you are expected to ask all the questions that will help you understand the aim of the study, the procedures and how this will benefit you. Once you are satisfied with the answers, you will decide whether you would like to participate or not. Should you agree to participate you will be requested to sign a written consent form. Participation in this study is important to address the study purpose and your participation will be highly appreciated. You have the right to refuse to participate should you decide so. Your refusal will not disadvantage you in anyway regarding your job, your work benefits or any other services that may emanate from this process.

The study procedures are in two parts as follows:

Part 1: You will be tested for HIV infection. The study nurses will collect a specimen of saliva from your mouth. The saliva specimen will then be sent to a laboratory where it will be tested for HIV antibodies using rapid test. The process of collecting a saliva specimen will not cause you any discomfort or harm. Your name or employee number will not be used to label your specimen and once your specimen is put amongst other specimen we won't know which is yours. In order for the laboratory to know that the specimen was sent by our company, a unique bar-coded number will be used to identify the specimen. The bar-code will not be linked to you. This is called anonymous testing, we don't want to know who is infected or not infected; we only need to know how many workers are infected. You will not be told your test results since we won't know ourselves. If you are interested in knowing your HIV status, you will be referred to the voluntary counseling and testing (VCT) site which is specially set up to service the study participants. At VCT, health providers will pre-counsel you, test you for HIV, then post-counsel you before giving you your test results. Because our testing is anonymous, we won't be counseling you before taking for your saliva specimen.

Part 2: You are required to complete and respond to a questionnaire (see copy) which will be given to you and will take you approximately 45 minutes to complete. You can complete the questionnaire on your own, independently whilst enjoying a cup of tea and biscuits. Should you wish, the study nurses will assist you to complete the questionnaire. We would like you to respond to the questionnaire to the best of your ability and answer all questions. You will not write your name on the questionnaire; we will again put the same bar-code on your questionnaire as the saliva specimen. This will only tell us that the test results belong to the person who completed this questionnaire; again we won't know who that is.

Who will access the study information?

The study data is the property of Ndamane Gaga Inc and is strictly accessible to the study team during the study period. Both the workers' union representatives and the management will have no access to this information; it is strictly confidential. The study data will be analysed and used by the study team to write a report. The study results will be communicated to the DLGH management and the workers and will report on overall results, not on individuals. Once the study is completed, the study data will be kept locked in a steel cabinet, with the keys kept strictly by the study PI for a period of five years; thereafter it will be destroyed.

What are the benefits of participating?

At an individual level in a short term, study participants will have an option of knowing their HIV status should they so wish. There is a Voluntary Counseling and Testing service that is set up specifically for all selected employees who agree to participate in this study but is operating separately from the study. If you agree to participate and after completing the study procedures, you will be referred to VCT where you will receive pre-test counseling, you will then be tested and post-test counseled before receiving your results. You will also be referred to an employee assistance programme that supports all employees who need assistance at your workplace. In a medium to long term the benefits will be to all employees once the company institutes an HIV and AIDS intervention programme. You will not receive any money or job favours by participating in this study.

What are the disadvantages of participating?

There are no serious disadvantages known to us that you'll experience by participating in this study. You will be inconvenienced with your time, as the study procedures will take approximately one hour to complete. The study procedures are neither uncomfortable nor invasive. You may feel uneasy with some of the questions in the questionnaire. These should not deter you from participating or answering. The information will be treated with great confidentiality.

What else should you know?

It is important for you to know that this study is voluntary and that you are free to withdraw at any time should you decide to. Remember also that your name won't be appearing on both the questionnaire and on HIV test results. If you decide to refuse to participate, your refusal will not be used against you at your work place. The process is made such that we won't even know who participated and who refused. I would like to reaffirm that we will appreciate your participation very much as this is important for informing plan of action to institute an employee health and wellness programme in your company.

Having received this information, do you have any questions you'd like to ask? *(Allow the participant to ask any questions she may have).*

Now that you have asked all the questions (or you have no questions to ask) kindly read the consent form on the next page

Appendix 3: Participants' Consent form

I have read, understood and satisfied with the information contained in the information sheet/ the information sheet has been read and explained to me (*delete where not applicable*). I understand that my participation in the study is voluntary and I'm not forced to participate; I have the right to refuse or withdraw at anytime should I decide so. I also understand that I will be tested for HIV infection and that I will not be given my test results. Should I want to know my status, I will be referred to a parallel VCT service where I will get counseling and then tested. I also understand that the information I have given in this study will be used strictly for the study purposes and will only be accessed by the Ndamane Gaga Inc personnel. I understand that there is no direct benefit to me as an individual in the form of money or job favours.

Declaration of agreement (tick where appropriate)

(N.B: If the respondent is not willing to participate and ticks 3 below, thank him or her and allow him/ her to leave without signing the form)

1. I am willing and agree to test for HIV
2. I am willing and agree to complete the study questionnaire
3. I am not willing and will not take part in the study
(If 3, then say: thank you for your time and Good bye)

The part below is applicable only to those employees who are agreeing to participate and have ticked 1 and 2 above.

Name of employee _____

Signature _____

Date _____

Witness (name) _____

Signature _____

Date _____

Appendix 4: Ethics clearance

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HSRC Research Ethics Committee

FWA Registration: Organisation No. 0000 6347

IRB No. 00003962

www.hsrc.ac.za

11 January 2007

Dr Sisanda Gaga

Drs Ndamane Gaga Inc

771 Schoeman Street

Arcadia

Pretoria

Dear Dr Gaga

Ethics clearance of HSRC Protocol REC 2/18/10/06: HIV prevalence rate and KABP survey of employees for the Department of Local Government and Housing, Limpopo Province

Thank you for your application for ethics approval of the above study. This was considered by the Research Ethics Committee at its meeting on 22 November 2006.

Ethics clearance of the study is granted, and the Committee wishes you success in your research.

Yours sincerely,

Prof. D R Wassenaar PhD

Chairperson: HSRC REC

Appendix 5: KABP Questionnaire

KABP SELF COMPLETION QUESTIONNAIRE DEPARTMENT OF LOCAL GOVERNMENT AND HOUSING-LIMPOPO

STUDY QUESTIONNAIRE ON KNOWLEDGE, ATTITUDES, BEHAVIOUR AND PRACTICE AROUND HIV AND AIDS

You are kindly invited to take some time and complete the attached questionnaire on knowledge, attitudes, behaviour and practices around HIV. The questionnaire is completely anonymous; do not write your name on it or any other information that identifies you. Kindly **answer all questions** in all the sections of this questionnaire to the best of your ability. It will take you about 45 minutes to complete the questionnaire. Should you need any assistance, please feel free to ask for assistance from any member of the study team.

Please answer the questions by circling the number corresponding with your choice.
Example:

What did you have for breakfast this morning?

Mealie pap	①
Toast	2
Other – please specify	3

Please note that the questionnaire is printed back-to-back and has questions on both the front and back of each page.

Your participation and honesty in completing this questionnaire will assist your employers (Department of Local Government and Housing) to develop an appropriate employee health and wellness programme that will be responsive to your health needs.

I would like to take this opportunity and thank you for agreeing to participate in this study.

SECTION A: DEMOGRAPHIC INFORMATION

1. Employment category

(Eg. Communication Services)

...../2

2. Level (Between 1-16)

...../3

3. Sex

Male	1
Female	2

 /4

4. How old are you?

.....years /5

5. Marital status

Married	1	
Not married but living together	2	
Single, never married	3	
Divorced/widowed	4	
Other (please specify)	5	/6

[If married and/or living together with partner]

6. How long have you been together with your partner? (Eg. 12 years 3 months)

Years	Months	/7
-------	--------	----

7. How old is your partner?

.....years /8

8. Educational status

No education	1	
Primary (Grade 1-6)	2	
Secondary (Grade 7-10)	3	
Matric (Grade 11-12)	4	
Tertiary (Ns, diploma, university)	5	/9

9. Job description

(Eg. Communication Analyst)

...../10

10. What is your home language?

English	1	
Sepedi	2	
Xitsonga	3	
Tshivenda	4	
Other (please specify)	5	/11

SECTION B: KNOWLEDGE ABOUT HIV AND AIDS

11. Have you heard of HIV?

Yes	1
No	2

 /12

[If no, go to question 15]

12. If yes, what is HIV?

 /13

13. How can you tell that one has HIV?

 /14

14. How does one get infected with HIV?

 /15

15. Have you heard of AIDS?

Yes	1
No	2

 /16

[If no, go to question 18]

16. If yes, what is AIDS?

 /17

17. How can you tell that one has AIDS?

 /18

18. Do you know of any person who has HIV or AIDS?

Yes	1	
No	2	/19
		/18

[If no, go to question 21]

19. If yes, how do you know about his/her HIV or AIDS status?

/20

20. What is your relationship with this/these persons? [Tick as many responses as apply]

Sibling	1	
Partner	2	
Relative	3	
Friend	4	
Colleague	5	
Someone from community	6	
Just people I saw on TV/heard from media	7	/21

21. Do you know of any person who died of AIDS?

Yes	1	
No	2	/22

[If no, go to question 23]

22. If yes, what is your relationship with this/these persons? [Tick as many responses as apply]

Sibling	1	
Partner	2	
Relative	3	
Friend	4	
Colleague	5	
Someone from community	6	
Just people I saw on TV/heard from media	7	/23

23. Where do you normally get information about sexually transmitted infections (STI's), HIV and AIDS? [Give your five most common sources]

1.
2.
3.
4.
5.

/24

24. Of the sources you have given above, which one do you believe in and trust the most?

/25

25. Why do you believe and trust the source you've given in question 24 so much?

/26

26. From what you know, how can a person prevent him/herself from getting infected with HIV? [Tick as many responses as you think are correct]

Do not have sex at all	1
Use condoms during sex	2
Do not have sex with prostitutes	3
Do not have sex with homosexuals	4
Do not have sex with many partners	5
Have one faithful partner	6
Avoid blood transfusion	7
Avoid kissing	8
Seek protection from a traditional healer	9
Do not drink too much alcohol	10
Do not share needles	11
Avoid STI infections	12
Do not share razors	13
Avoid frequent change of partners	14

/27

27. Have you heard about Voluntary Counselling and Testing (VCT)?

Yes	1	/28
No	2	
Not sure	3	

[If no or not sure, go to question 30]

28. If yes, do you know where you could get VCT services in your home or work area?

Yes	1	/29
No	2	
Not sure	3	

[If no or not sure, go to question 30]

29. If yes, where do you get VCT services in these areas?

1.	/30
2.	
3.	

30. Can HIV and AIDS be cured?

Yes	1	/31
No	2	

[If no, go to question 32]

31. If yes, what do people use to cure AIDS?

	/32

32. What makes people living with HIV to live longer and have good quality life? [Tick as many responses as you think are correct]

Anti-retroviral medication (ARV's)	1	/33
Good nutrition	2	
Praying and believing in God	3	
Traditional healers cure AIDS	4	
Use of vitamin supplements	5	
Exercise or physical activity	6	
Accepting one's status, caring for one's self and good support systems	7	
Don't know	8	

SECTION C: ATTITUDES AND BELIEFS

33. How do you rate your risk of getting infected with HIV?

No risk at all	1	/34
Small	2	
Moderate	3	
Great	4	

34. Why do you think you have the risk you mentioned above?

	/35

35. Do you believe that having sexual intercourse (that is, putting one's penis inside a vagina) with virgins or children cure HIV and AIDS?

Yes	1	/36
No	2	

36. Why would some people believe sexual intercourse with virgins or children cures HIV and AIDS?

37. Do you believe that using a condom will protect you from getting infected with HIV?

Yes	1	/38
No	2	

38. What do you think is the best way to care for people sick with AIDS? [Tick as many responses as you think are correct]

Train family members to take good care of their people	1	/39
Train community workers to care for them	2	
They should be cared for at special homes	3	
Government should build more hospitals to hospitalize them	4	
Other (please specify)	5	

SECTION D: PRACTICES AND BEHAVIOURS

39. Have you ever had voluntary (meaning that you wanted to/you gave your consent) sexual intercourse?

Yes	1	/40
No	2	

[If no, go to question 51]

40. Have you had sexual intercourse in the past 12 months?

Yes	1	/41
No	2	

41. If no, why not?

I do not currently have a partner	1	/42
I have not had the opportunity	2	
I'm worried about getting HIV	3	
Other (please specify)	4	

42. At what age did you start having sex?

.....years /43

43. How many people have you had sex with in your lifetime?

1-3	1	/44
4-6	2	
7-10	3	
More than 10	4	

44. Do you use a condom when having sex?

Yes, with every sex act	1	/45
Yes, sometimes	2	
I used to but not anymore	3	
I never use a condom	4	

45. If your answer in question 41 is 2 or 3 or 4, explain why.

	/46

46. If you use a condom sometimes, with whom do you (a) use or (b) not use condoms?

(a) Always use with	(b) Do not use with
1.	1.
2.	2.
3	3
/47a	/47b

47. Did you use a condom the last time you had sex?

Yes	1	/48
No	2	

48. In your sexual relationship, who decides whether you should use a condom or not?

I decide	1	/49
My partner decides	2	
We talk about it and decide	3	

49. If your partner were to say no to condom use, what would you do?

	/50

50. From where do you get condoms? [Tick as many responses as apply]

Nearest clinic	1
Workplace	2
Buy from shops/garages and other outlets	3
From friends	4
My sexual partner always brings condoms	5

51. Have you ever suffered from a smelly or unpleasant discharge from your genital organs?

Yes	1	/52
No	2	
Don't know	3	

[If no or don't know, go to 54]

52. If yes, what did you do about it? [Tick as many responses as apply]

Sought treatment from GP	1
Sought treatment from clinic	2
Sought treatments from traditional healer	3
Treated it myself	4

 /53

53. If you answered 4 in question 52, please explain how you treated it?

 /54

54. Have you ever been tested for HIV?

Yes	1
No	2

 /55

[If no, go to question 57]

55. If yes, when last did you test for HIV?

Last 12 months	1
Last 36 months	2
More than 3 years ago	3

 /56

56. Are you planning to test for HIV again in future?

Yes	1
No	2

 /57

57. [If no to question 54] Do you want to know whether you are infected with HIV or not?

Yes	1
No	2
Not sure	3
I know my status	4

 /58

58. [To all respondents] Why would you want /not want to know your HIV status?

 /59

59. Do you ever talk about or discuss HIV and AIDS issues?

Yes	1	/60
No	2	

[If no, go to question 63]

60. If yes, who do you normally talk to or discuss with [Tick as many responses as apply]

My partner	1	/61
My siblings	2	
With everyone in my family including parents	3	
Relatives	4	
Friends	5	
Colleagues	6	
Church leader	7	
Health providers	8	
Anyone in community	9	

61. How helpful do you find these talks/discussions?

Not helpful at all	1	/62
Somewhat helpful	2	
Helpful	3	
Very helpful	4	

[If response above is (1), then go to question 63]

62. In which way are these talks/discussions helpful?

	/63

63. If you were to discover that one of your friends is infected with HIV, what would you do? [Tick as many responses as apply]

Ask him/her about his/her HIV status	1	/64
Wait until he/she tells you when he/she is ready to do so	2	
Tell his/her family about his/her status	3	
Warn his/her partner about his/her status	4	
Stop being friends with him/her	5	
Maintain friendship	6	
Give him/her all the support he/she needs	7	
Warn other people around him/her to be careful around him/her	8	

SECTION E: HIV/AIDS AND THE WORKPLACE

64. Is there any type of work in your organization you believe is likely to put workers at risk of contracting HIV?

Yes	1	/65
No	2	

[If no, go to question 67]

65. If yes, what job is this?

	/66

66. What would you suggest your employer does to protect the workers you think are at risk?

	/66

67. Do you know of any incident of an employee who had been treated unfairly because he/she is infected with HIV or has AIDS at your workplace?

Yes	1	/68
No not to my knowledge	2	
Not sure	3	

68. Did you get tested for HIV or asked about your HIV status when you first come to work for your company?

Yes	1	/69
No	2	
Not sure	3	

69. Have you or any other employee ever been asked about your/his/her HIV status at work?

Yes	1	/70
No	2	

70(a) Do you believe your workplace respects the rights of employees as far as their health status is concerned?

No, not at all	1	/71
Yes, to some extent but not completely	2	
Very well, employees' rights are highly respected	3	

70(b) If answer is 1 or 2, please explain.

/72

71. Does your workplace have an HIV and AIDS policy?

Yes	1	/73
No	2	
Not sure	3	

[If no or not sure, go to 74]

72. If yes, do you know and understand the contents of this policy?

Yes	1	/74
No	2	

73. If yes, can you explain the four main issues that it addresses?

1.
2.
3.
4.

/75

74. What would you advise the DLGH to do in order to ensure that all employees are aware, know and understand the company's HIV and AIDS policy?

/76

75. Are there any HIV, AIDS or STI education programmes at your workplace?

Yes	1
No	2
Not sure	3

 /77

76. Are there any employees trained to educate other workers about STI's, HIV and AIDS?

Yes	1
No	2
Don't know	3

 /78

77. Are there any materials in the form of pamphlets, booklets, films, etc. that are given out at the workplace that help inform workers about HIV?

Yes	1
No	2
Don't know	3

 /79

78. Are there any common rooms or facilities where workers sit during lunch or tea breaks and read or get informed about life skills as well as STI's, HIV and AIDS?

Yes	1
No	2
Don't know	3

 /80

79(i) Are there any HIV and AIDS support groups that give support and educate both infected and affected workers at work?

Yes	1
No	2
Don't know	3

 /81

79(ii) Are there any HIV and AIDS support groups that give support and educate both infected and affected workers in the community?

Yes	1
No	2
Don't know	3

 /82

80. At your workplace, what are the three main sources of information about STI's, HIV and AIDS?

1.
2.
3.

81. If you were infected with HIV, would you disclose your HIV status to your manager?

Yes	1
No	2

 /84

82. From your experience, how would your decision in question 81 benefit or disadvantage you as an infected employee?

Benefits:	
Disadvantages:	

 /85
/86

83. What suggestions or advice do you have that could help reduce HIV and AIDS stigma at your workplace?

 /87

84. So far, are you happy with the manner your workplace handles HIV and AIDS issues?

Yes	1
No	2

 /88

85. In your opinion, what would you like to see DLGH management do to show its support and commitment to fighting and combating HIV at the workplace?

 /89

Thank you for completing this questionnaire !!