

**Factors influencing the utilization of voluntary counselling
and testing services amongst employees of the Lobatse
Town Council in Botswana**

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Abstract

In this study both qualitative and quantitative methods were used to find out to what extent the Lobatse Town Council employees used Voluntary Counseling and Testing (VCT) HIV and AIDS services, the reasons for using or not using the services, the preferred service providers reasons for choosing a service provider. Lastly recommendations were made on how the uptake HIV and AIDS VCT services could increased amongst the employees.

A sample of 200 respondents was selected from the employees of the Lobatse Town Council, and it was established that 65.5% of the respondents had used VCT. Females had a higher testing participation rates than males, white collar respondents had a higher testing participation than the blue collar respondents. There was a higher rate amongst the married than the single respondents and the older ages of 30 and above than the young ages of 29 years and under.

In the study it was also established that the majority of the respondents considered voluntary counselling and testing for HIV and AIDS as being important. However there were some groups that were more positive than others regarding the importance of testing. More females than males were positive regarding the importance of testing, and also amongst the employment categories the white collar respondents were more positive than the blue collar respondents regarding the importance of HIV and AIDS testing.

Furthermore it was established that the most important reason for testing amongst the employees that did test for HIV and AIDS was that they felt that they needed to undergo testing before they tested. The respondents that did not test for HIV and AIDS indicated that the most important reason for not testing was that they were scared the results could not be kept confidential.

The research also showed that the most preferred service provider was Tebelopele. Tebelopele was the most used and preferred service provider amongst both gender and age groups, all marital groups and the blue collar group in the employment categories. However, for the white collar group the most preferred service provider was the private practitioners. The most common reason for choosing a service provider was confidentiality and privacy.

Lastly, the research makes recommendations on what needs to be done to increase the uptake of VCT HIV and AIDS testing amongst the Lobatse Town Council employees. One of the recommendations is that there was a need to educate the employees of the Lobatse Town Council and that the education should be specific for each group. For example from the group discussion the participants felt that the reason to why males did not want to utilise HIV and AIDS VCT was because they lacked knowledge on the importance of testing. Also the respondents indicated that there was a need to remove stigma and discrimination through removing confidentiality attached to HIV and AIDS. It was also, recommended that the Lobatse Town Council formulate and implements a workplace policy on HIV and AIDS.

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Glossary of terms

Counseling - A confidential dialogue between a client and a trained counselor aimed at enabling the client to cope with stress and take personal decisions related to HIV and AIDS

Discrimination- any action, policies, or practices on the part of individuals, groups, or institutions that have the effect of denying other individuals or groups equal access to the society's resources and rewards (Curran & Renzitti, 1996)

Elsewhere- VCT service providers not in the Lobatse district

Industrial class- Low management and industrial class

Management- Middle management and High management

Service provider- Facilities both in the private and public health sector that provide the HIV and AIDS VCT services

Respondents- Sampled population that participated in the survey

Sexually active group- Under 30 year's olds

Stigma- It is a social label that disgraces and shames someone (Curran & Renzitti, 1996)

Stigmatization- process through which stigma is promoted

Tebelopele- HIV and AIDS testing center

Testing - Any form of testing designed to identify the HIV status of a person

Participants- Sampled population that participated in the focus group discussions

Voluntary - Acting willingly, not compulsory

List of Abbreviations and Acronyms

ACHAP- African Comprehensive HIV/AIDS Partnerships
AIDS- Acquired Immune Deficiency Syndrome
ARVT– Anti- Retroviral Therapy
BIDPA- Botswana Institute of Development and Policy Analysis
BOPA– Botswana Press Agency
CDC- Center for Disease Control
CSO- Central Statistics Office
DMSAC- District Multi-Sectoral Committee
EADCU – Epidemiology & Disease Control Unit
FHI- Family Health International
HIV - Immunodeficiency Virus
HPAEU –Health Promotion & Education Unit
HSRC- Human Science Research Council
ICFTU – International Confederation of Free Trade Unions
ILO- International Labour Organization
LTC – Lobatse Town Council
LUDC – Lobatse Urban Development Committee
MOFADP - Ministry of Finance and Development Planning
MOH- Ministry of Health
MOSP- Ministry of State President
MOLG- Ministry of Local Government
NAC- National AIDS Council
NACA- National AIDS Coordinating Agency
NSRHP- National Sexual and Reproductive Health Programme
PMTCT- Prevention of mother to child Transmission
STD- Sexually Transmitted Disease
TB – Tuberculosis
WHO- World Health Organization
UNAIDS- United Nations Joint Programme on AIDS
UNDP – United Nation Development Plan
VCT - Voluntary Counseling and Testing

1. Chapter One: Introduction

According to Lekoa (2004) Immune deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) is the worst phenomenon that has ever hit the human race. It is a holocaust, the black plague of the 21st century, reaching all continents, classes and races.

In Botswana the epidemic is considered to be a challenge that undermines the country's extraordinary achievement in development (Botswana Press Agency (BOPA), 2006a). A great deal of the country's developmental budget is directed towards HIV and AIDS. Currently, according to the Finance Minister, Gaolathe, the government is expected to spend at least 5.8 billion pula on developmental projects for the year 2006/2007. The state president's developmental projects have been allocated 21.3% of this amount 52% has been allocated for HIV and AIDS programs (BOPA, 2006b). In 2004/2005, HIV and AIDS programmes were allocated 56% of the state president's developmental project budget (Gaolathe, 2005).

According to Lekoa (2004), HIV and AIDS prevention programmes in Botswana are considered to be one of the main pillars in the fight against the disease, hence the introduction of HIV and AIDS Voluntary Counselling and Testing (VCT) services in all public health facilities and the creation of VCT centres (Tebelopele) in the country. It was reported that in 2003/ 2004 an average of 7821 females and 5678 males tested at the VCT centres per quarter (National AIDS Coordinating Agency, National AIDS Coordinating Agency (NACA), 2004). A similar trend was reported for the gender groups that tested at the public health facilities for the same year, in that 8156 females and 3261 males were tested (Lekoa, 2004). From the figures quoted it would seem that more females than males are making use of the VCT facilities. However, the gender difference for testing is reported to be declining, as in the first quarter of 2005, i.e. January to March, from the 15256 people who tested in the VCT centres in the country, 6735 were males. The females are nevertheless testing in higher numbers than their male counterparts. Also, the 20-24 year age group is reported to be consistently testing in larger numbers than the other age groups, as from the 181390 people who tested at the VCT centres from April 2004 to March 2005, 139991 were from that age group, followed by age group 25-29 with 11237 tested. Thereafter the number declines with age as it was reported that, from the 30-34 age group, 8432 tested, and 5868 tested for age group 35-39, followed by the 40-44 age group with 4414, and the 45-49 age group where 2985 tested. This number slightly increases for the age group 50 and above where 4398 people tested. A lower number of people testing from the age group below 20 were reported. For the 15-19 year bracket 2841 tested, while for the age bracket below 15 years 1224 tested (NACA, 2005; NACA, Central Statistic Office (CSO) and Other Development Partners 2005).

In Botswana the low utilisation of VCT services by males is of national concern. This raises the concern as recorded in the National Gender Programme, that the under-involvement of males in any health programme has a negative effect not only on themselves but also on their female counterparts. Botswana is a patriarchal country with men dominating the decision-making especially at the family level (Ministry of Health (MOH), 2002). Supporting this viewpoint, the mayor of Francistown, Billy asserted that the failure of men to test would inevitably result in men not supporting their counterparts to use the services (BOPA, 2006c). It was established through discussions with a focus group of women, that women believed that HIV and AIDS programmes, such as HIV testing or safer sex, will only be effective if these were initiated by men World Health Organization (WHO, AIDS/ Sexual Transmitted Disease (STD) Unit & Ministry of Health (MOH), 2004). Also, it has been reported that during the last quarter of the year 2005, 76% of people who died from the epidemic were males and this, according to President Mogae, was due to their reluctance to test (BOPA, 2005).

The under utilisation of a VCT service by some age groups is also of concern. Since all age groups are affected by the epidemic, the VCT services can be of benefit to them all. It was reported that in the first quarter of the year 2005, from the under 15 year olds who tested at least 26.7% were positive, and 19.5% for 15-19 age group, 32.0% positive for 20-29 age group, 42.1% for 30-39, and 32.9% for 40+ age group (NACA, 2005).

For the HIV and AIDS programmes to succeed, there is a need for all groups in the population, especially those in power, to be involved, otherwise, the Government's endeavour will be of no use.

The Lobatse Town Council (LTC) employees were studied to ascertain; firstly, if there is group biasness towards HIV and AIDS testing amongst the employees; secondly, if other demographic characteristics such as employment categories and marital status had a role to play in the decision to test or not to test; and thirdly whether other factors such as culture had a role to play. Also, the HIV and AIDS VCT service providers in Lobatse district were intended to be studied in order to establish the objectives and challenges of VCT services available to the employees and lastly to recommend the changes needed to increase the uptake of employees utilising the services. It would be helpful for the service providers to know what challenges are facing them and possible ways to improve so that they are able to increase the usage of the service by the employees. This would hopefully be applicable at the district level so as make the service more effective in the management of the epidemic.

1.1 Lobatse

Lobatse is one of the biggest towns in Botswana. The 2001 population survey indicated that it had a population of 26,050 in 2001 and the annual population growth rate was said to be 3.3%. The 2001 population survey also recorded the highest number of people within the 20-24 age brackets at 13.6%, 25-29 and 15-19 at 11.8% and 11.5% respectively of the whole population. Making 36.9% of the population between 15-29 years of age. The male population was recorded to be 14,205 with females 15,484 for a gender ratio of 47.8% for males and 52.2% for females. LTC, Lobatse Urban Development Committee (LUDC), & Ministry of Local Government (MOLG), 2003).

1.1.1 The HIV Prevalence Rate in Lobatse

HIV and AIDS is said to be one of the greatest concerns in the town. In 2001, it was reported that 2088 males and 3325 females of the 20-49 age bracket were HIV-positive. Furthermore it has been reported that in the same year, that 30% of the deaths that occurred at the hospital were as a result of AIDS. The HIV prevalence in Lobatse in 2001 was depicted to be 14.8% for males while for females it was 21.5% (LTC, LUDC, & MOLG, 2003). According to Hope and Gaborone (1999), the life expectancy in Lobatse at birth was 66 years in 1991 but projected to decline to 51 years in 2010.

1.1.2 Lobatse Town Council

The Lobatse Town council is one of the largest employers in the public sector in Lobatse, employing 1008 employees, of which 40% are males. According to G. Gagosi (personal communication, November 2005), the death rate among the employees for the past five years is reported to have been increasing each year for the last five years. She asserted that for the years 2001 and 2002 there were at least five to six deaths of which three out of five were HIV and AIDS related. From 2003 to 2005 the death rate is reported to have increased; for each year there were at least eight to nine deaths of which six were HIV and AIDS related.

1.2 Literature Review

A number of studies have been done on the importance of HIV and AIDS VCT services and barriers towards their usage by people in Botswana and outside the country (Chilisa & Bennel, 2001). However, little is available on the usage of HIV and AIDS VCT by Lobatse Town Council employees. The last study conducted on the employees of Lobatse Town Council was in 1999 by Hope and Gaborone. The study was titled "A strategic HIV/AIDS response plan for the town of Lobatse" and was intended to find out how the Lobatse district could develop the district plan on HIV and AIDS for the Lobatse District. The study was a qualitative study where researchers consulted the stakeholders and made recommendations on how the Lobatse Town Council

could develop its strategic plan towards the HIV and AIDS epidemic. Through the research, it was established that there was a need to sensitise and mobilise males to a greater extent for a more effective response to the HIV and AIDS epidemic. (Hope and Gaborone, 1999)

Various writers have written on the importance of HIV and AIDS VCT service, such as the Family Health International (FHI) (2002), who asserted that HIV and AIDS VCT was an important link between HIV prevention and HIV care and support. HIV and AIDS VCT promoted and sustained behavioural change, and it linked with interventions to prevent mother to child transmission, sexually transmitted infections and opportunistic infections. Also, it facilitated early referral to comprehensive clinical and community based prevention, care and support services, and provided access to anti-retroviral therapy (ARVT). They posited that it improved quality of life and may play an important role in reducing stigma.

However, it has been recognised that HIV and AIDS VCT especially in the Sub Saharan countries has had limited success due to problems such as the existence of attitudes and beliefs that act as psychological barrier towards its usage. Chilisa and Bennel (2001) had for example concluded through a study in Botswana, that there was a positive relationship between usage of VCT and those people who considered them being at risk of being infected with HIV and AIDS. Further issues concerning stigma, discrimination, confidentiality, and culture, were identified as factors that had an influence on the usage of HIV and AIDS VCT.

Chapter two discusses further some of the factors that have been found in various studies in the usage of HIV and AIDS VCT services. It includes the various models of VCT, their advantages and disadvantages, further it discusses the impact of HIV in Botswana, and highlights some of the steps that the country has taken to overcome the impact.

1. 3 Statement of the problem

VCT services are believed to be one of the most important tools in HIV and AIDS prevention and management. In Botswana, however it has been reported that there are different service usage rates for different groups, for example, gender and age groups, were not making use of the service at the same rate. Various studies try to explain the reasons why people are not fully utilising the VCT services, for example, Akinade (2002); Chiisa and Bennel(2001); Human Science Research Council (HSRC) (2002); Lipinge, Hofnie and Friedman (2004); Mark and Senak (2000);Simbayi (1999). The literature shows that various factors may lead to the low utilisation of the service and some of these factors are related to the individual and their psychological or socio- economic circumstances and some factors may be related to HIV and AIDS VCT service providers.

1.3.1 Aims and objectives

The aims and objectives were to study the Lobatse Town Council employees in order to establish, firstly, who has utilised or not utilised an HIV and AIDS VCT service and the reasons for accessing or not accessing VCT. Secondly to establish if there were preferred service providers and the reasons therefore. Thirdly, to make recommendations so as to overcome any difficulties with VCT, in order to help improve the take-up rate of Lobatse Town Council employees for VCT services. Although the results will only be generalisable to the employees of the Lobatse Town council, hopefully some of the recommendations are applicable to the broader community and as a result will lead to an improvement in the VCT take-up rate of Lobatse Town citizens.

1.3.2 The research questions

- 1) To what extent have Lobatse Town Council employees made use of a HIV and AIDS VCT service?
- 2) Have some groups, distinguished by gender, age, employment category, educational level or marital status, shown greater willingness than others to undergo HIV and AIDS VCT?
- 3) What is the motivation for testing and not testing?
- 4) Which are the preferred service providers and is there a group bias?
- 5) What motivates the choice of service provider?
- 6) What is the process by which the HIV and AIDS VCT service providers namely the clinic, Tebelopele, the hospital and private doctors, manage their service?
- 7) What flexibility exists within the service to accommodate the varying groups accessing the service with the emphasis on gender, age, and educational level?
- 8) Are the service providers meeting the HIV and AIDS VCT objectives? What are the successes, failures and challenges?
- 9) What are the recommendations for improving the HIV and AIDS VCT service within Lobatse?

1.4 Research Methodology

1.4.1 General approach

The nature of the research was descriptive. According to Mouton (1996) and Arkava and Lane (2003) a descriptive study attempts to describe the behaviour, opinions and attitudes of a sample group. Both qualitative and quantitative methods were used to collect data through the use of a survey questionnaire and focus groups on a sample of employees of the Lobatse Town Council. Interviews with the HIV and AIDS service providers were also organised, but were not carried out due to time constrained.

1.4.2 Population

It was intended to study two populations; firstly the Lobatse Town Council employees and secondly the VCT service providers in Lobatse. The population for Lobatse Town Council included all employees both management and industrial workers employed in Lobatse Town Council. The second population that was intended to be studied was of HIV and AIDS VCT service providers in the Lobatse District; the clinics, private practitioners, Tebelopele and the hospital.

1.4.3 Sample and sample selection

Probability and non-probability sampling was used to draw the samples for the study;

Sample A) Survey- Stratified random sampling was used to select 200 responses of the self-administered questionnaires from the 389 completed by the employees of the Lobatse Town Council. Gender and employment categories were used as the selection criteria.

Sample B) Group discussions -Systematic random sampling was used to select the participants for the male and females group discussions.

Sample C) HIV and AIDS service providers- Purposeful sampling was done to select the HIV and AIDS VCT service providers from each of the four categories operating in the Lobatse District.

1.4.4 Instrumentation and Data collection

Three measuring instruments were intended to be used as follows:

1. A self-administered questionnaire in English (Appendix 1) was distributed to all employees and responses were randomly selected from the returned questionnaire for the study. For, industrial class respondents Setswana questionnaires were also sent (Appendix 2). The responses made in Setswana were translated into English.
2. An interview guideline (Appendix 3) was used to direct the two focus group discussions. The discussions were held in Setswana and then transcribed and translated into English.
3. A semi – structured questionnaire (Appendix 4) was intended to be used for the HIV and AIDS VCT service providers' interviews.

1.4.5 Data Analysis

Different methods of data analysis were used for the different data types, qualitative and quantitative data, used in this study. The quantitative data collected from the self-administered questionnaire was captured and analysed in excel using descriptive and inferential statistics. The qualitative data from the focus groups was analysed using the content analysis method as proposed by Tesche as quoted in De Vos, Strydom, Fouche and Delport (1998).

1.4.6 Limitation of study

The survey questionnaire was sent to all 1008 employees of the Lobatse Town Council, 389 questionnaires were returned and from these the stratified sample of 200 was randomly selected. Although a sample of 200 is an adequate representation statistically, given the nature of HIV and AIDS there is likely to have been some self selection in the decrease from 1008 possible responses to 389 actual responses.

The results obtained from the survey are generalisable to the employees of Lobatse Town Council but not to the Lobatse population. The information collected from the focus group discussions was not generalisable either to the employees of Lobatse Town Council or to any other groups and is merely useful information. Some of the research questions that the researcher, initially planned to address through data collected from the face-to- face interviews with the selected VCT service providers in the district could not be addressed due to the lack of availability of the respondents and the limited time available to complete this project.

Another limitation is that the questionnaires were translated into Setswana and this may have led to the questionnaire losing what they were intended to capture. Also, some of the responses made in Setswana from the questionnaire and the focus groups discussions were translated into English, through this process important view points may have been lost as some words were difficult to translate. A language expert was engaged to try to minimize both these problems.

1.4.7 Ethics

Babbie (1992) recommended that it was crucial that before one undertakes a research project that one must be aware of the ethical issues with which one may be faced. HIV and AIDS is considered a particularly sensitive issue due to the nature of the stigma and discrimination surrounding the disease.

In this research the respondents were sent the questionnaire without their consent. This could be considered to be unethical. Ethically, respondents should volunteer to be part of a study. But this would have threatened the purpose of the study of generalising the results (Babbie & Mouton 2001). However, the respondents were allowed to decide whether to complete and return the questionnaire or not. According to Babbie (2001) and Mouton, fortunately, where voluntary participation is impossible, this norm can be violated as long as the other ethical norms are adhered to. In this case the respondents to the survey questionnaire were assured that their responses would be anonymous and kept confidential.

The focus group participants were given a choice as to whether they wished to participate or not, however their presence forfeited anonymity to the researcher but they were assured that their responses would be anonymous and confidential in the final results. The Service providers were given a choice as to whether they wished to participate or not however their presence forfeited anonymity to the researcher but they were assured that their responses would be anonymous and confidential in the final results.

1.4.8 Dissemination of Results

The study was done in partial fulfilment of the requirement for the Masters Degree in Labour Relations and Human Resources at the Nelson Mandela Metropolitan University, South Africa. A copy of the treatise was also given to the Lobatse Town Council where the research took place.

1.5 Thesis Outline

This research treatise contains the following chapters.

Chapter two: Literature Review - in this chapter a wide range of literature on HIV and AIDS VCT, HIV and AIDS, impacts of HIV and AIDS in Botswana and responses of the country to the epidemic, were consulted.

Chapter three: Research methodology- this section focuses on the research approach used, sampling, how data was collected and analysed.

Chapter four: Results and Discussion- the focus on this section is on tabulating, presenting and discussing the results of the study and relating the results to the research questions posed.

Chapter five: Conclusion and Recommendations- this section summarises the discussion of the results, links these results to the findings of other research studies, draws conclusions and makes recommendations.

Chapter Two: Literature Review

Various studies have been conducted on the importance of HIV and AIDS VCT in the fight against HIV and AIDS. Some of the studies, such as Mark and Senak (2000); and Corbett, Dauya, Matambo, Cheung, Makamure, Bassett, Chandiwana, Munyati, Mason, Butterworth, Godfrey-Faussett Hayes (2006), show that there are various factors that may inhibit the usage of HIV and AIDS VCT services. Corbett et al (2006) asserted that HIV testing was the key component of both HIV care and prevention, but the uptake was currently low. The studies make recommendations on how to enhance the usage of HIV and AIDS VCT services. In this section the researcher will outline some of the literature based on the issues discussed above and also discuss HIV and AIDS in the workplace. Furthermore, the section will highlight the impact of HIV and AIDS in Botswana, and the responses by the various stakeholders in the country towards the epidemic.

2. 1 HIV and AIDS and HIV and AIDS VCT

According to the President of Botswana, Mr Festus Mogae, the spread of HIV and AIDS world wide is astronomical (Masupu, Roels, Jimbo Gaolekwe, 2001). Mr, Juana Somavia, the director general of the International Labour Organisation (ILO) in support of the above has posited that “the HIV/AIDS epidemic is now a global crisis, and constitutes one of the most formidable challenges to development and social progress. In the most affected countries the epidemic is eroding decades of development gains, undermining economies, threatening security and destabilising societies. In sub-Saharan Africa, where the epidemic has already had a devastating impact, the crises has created a state of emergency. (ILO, 2001, p.iii) HIV and AIDS according to Barnett, Whiteside and Desmond (2000) has become the single largest cause of disease and death in Africa. According to the WHO more than 40 million people are reported to be living with HIV and AIDS. At the end of the year 2001, Sub Saharan Africa was the most seriously affected with over 28 million people including more than 1 million children reported to be living with HIV and AIDS. Eighty percent of all deaths and 75% of all new infections in the year 2001 were also in Sub – Saharan Africa United Nations Programmes on HIV and AIDS (UNAIDS) 2002.

Green and McCreaner (1989) posited that the number of cases of infection world wide was likely to continue to increase until there was a change in risky- behaviours amongst those at risk or there was an effective, cheap vaccine available which can cure the disease, since counselling and health education were the only tools available for the prevention of transmission of the disease. HIV and AIDS VCT is one of the measures that is used

internationally as a provision for counselling and education which is the basis of the prevention and care of HIV and AIDS. According to the Government of Botswana country report (2005) as quoted in the Ministry of State President (MOSP) & NACA (2005) VCT was an important strategy for both prevention and care and is recognised internationally. The report also indicates that HIV and AIDS VCT is found to be a cost effective strategy.

According to Van Dyk and Van Dyk (2003) HIV and AIDS VCT is the first step in the development of a comprehensive package of HIV services. They argue that it is necessary for the development of effective treatment, care, and support services, such as the prevention of mother to child transmission. Also, it is a preventive measure for tuberculosis (TB) and other opportunistic diseases. They further posited that it can reduce risky behaviour and prevent new infections. FHI (2002), also showed that VCT is an important link between HIV prevention and HIV care and support. They asserted that VCT promoted and sustained behavioural change, and also, it linked with interventions to prevent mother to child transmission, sexually transmitted infections and opportunistic infections such as TB, HIV and AIDS.

VCT entails volunteering for a blood test to establish whether there are HIV antibodies in the blood and whether the virus can be detected. The procedure includes receiving brief pre- and post-test counselling from trained professionals. The pre-test counselling is intended to prepare a person for the test and its possible outcome (Volberding, Lagakos & Koch, 1990). Post-test counselling involves supportive counselling, prevention strategies, medical advice and care (Stone, 2001). The aims of both “pre- and post-test counselling are to identify and clarify a person’s concerns and their risk of contracting HIV, and to check whether the individual understands how HIV is transmitted and how transmission can be prevented”(Diedericks 2003: p.63).

The FHI (2002) also posited that VCT facilitated early referral to comprehensive clinical and community based prevention, care and support services, and it also provided access to ARVT. They posited that it improved quality of life and may play an important role in reducing stigma. The following, figure 1, is a map illustrating how HIV and AIDS VCT is a link and an entry point for HIV and AIDS prevention and care.

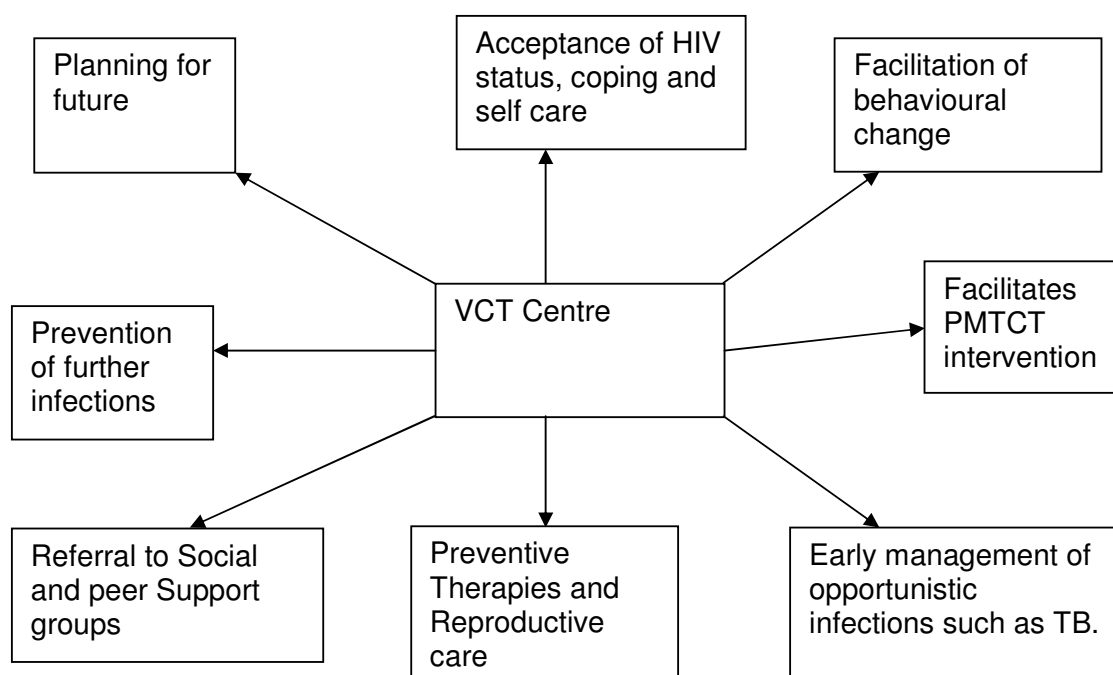


Figure 1: HIV and AIDS VCT as a link for prevention and care.

2.1.1 Importance of HIV and AIDS VCT services

VCT for HIV is important as it offers people the opportunity to test and once tested, individuals can access the appropriate services depending on their HIV status (FHI, 2002; ROB, 2004). Testing is important as those who test HIV-negative are counselled on how to stay that way, while those who test HIV-positive are counselled on how to live with the virus so that they may live a healthy life, and are counselled on how not to spread the virus, hence this could lead to behavioural change. Depending on their immune system they may be given treatment for prevention of certain infections, such as TB (MASA, 2002). Walker, Reid and Cornell (2004) asserted that TB was directly implicated in the epidemic, as people with HIV are susceptible to opportunistic infections of which TB is one. Because their immune systems are depleted, they are less able to fight off the disease and this was therefore a major cause of mortality

The effects of TB have led the Botswana government to adopt measures to prevent TB among HIV- infected persons. HIV positive persons are entered into TB preventive therapy to prevent them from developing active TB. This is crucial as the treatment can prolong a person's life; it helps prevent the spread of TB and helps the person to be healthier and carry on with a normal life. For pregnant women, who tested positive, they can be referred for Prevention of Mother to child transmission Therapy (PMTCT) in order to prevent their unborn children from being

infected (Epidemiology and Disease Control Unit (EADCU) & Health Promotion and Education Unit (HPAEU), 2005; Whiteside & Sunter, 2000).

Also, through VCT one can be given anti-retroviral drug therapy if necessary. The Anti-retroviral drugs reduce HIV mortality and morbidity, improve quality of life and prolong survival. The treatment is believed to be able to reduce the duration of acute illness and the risk of transmission of the virus. In Botswana the therapy was introduced in 2002. HIV-positive people with a CD4 count equal or less than 200 cell/mm³ are given the treatment as they are at risk of developing AIDS-related diseases and dying within a few months. The treatment is said to reduce these risks. Also, treatment is recommended to those people with severe or recurrent HIV-related diseases such as TB, wasting syndrome, and chronic diarrhoea. These patients, regardless of their CD4 count, are given the treatment. However, this is contrary to the international experiences especially western countries where the recommendation for the therapy is given to all those who tested positive and have a CD4 cell count below 350 cell/mm³. The Botswana government claims that the reasons for starting treatment for those with a CD4 cell count below 200 was that, it will be expensive as the demand for treatment will be too high if the cut off was made above 200 (Anabwani & Jimbo, 2004).

HIV and AIDS is said to be associated with stigma, discrimination, denial, rejection, and the isolation of infected and affected persons. Stigma and rejection are said to create an environment that has the potential for increased HIV infections. In Botswana, according to the 2002 Sentinel Surveillance, over 35 percent of the adults aged 15 – 49 years were HIV positive, but most of them did not know their HIV status, and this was possibly due to the fear of stigma (NACA et al, 2005). According to the FHI (2002) VCT can help reduce stigma. According to ROB (2004) this will happen as VCT provides an opportunity for people to know their status, and as more “ people know their HIV status and that knowledge becomes more commonplace and acceptable, stigmatisation due to one’s HIV status becomes less and less an issue” (p. 31). The importance of VCT is, therefore, that it can help “clients to understand the antibody test, to make more informed decisions by weighing up the pro and cons of having the test, to consider what might be their greatest concern if they were either HIV-positive or -negative, to access information about the personal, medical, social, psychological and legal implications of being diagnosed either HIV-positive or HIV-negative, and to prepare for difficulties they may face in future” (Stone, 2001: Pg 21). Hence Volberding et al (1990) have argued that VCT should be made accessible to all people.

However, Green and McCreaner (1989) identified a model that suggested that there were however disadvantages towards telling people of their HIV status if tested positive. The model suggested that there was a possibility that those infected and told the results may go out and intentionally infect other people. They say that this has been reported in many areas of the

world. However, the duo argues that the risk is outweighed by the advantages of people being told their status.

2.1.2 Barriers leading to the low utilisation of HIV and AIDS VCT services

Even though VCT can be beneficial to people, the low utilisation of this service is a prevalent problem all over the world (Mark & Senak, 2000). The studies below bring to light some of the reasons for the low utilisation, some factors related specifically to HIV and AIDS service providers and some related to people's perceptions and attitudes regarding HIV and AIDS testing.

According to the FHI (2002) there are many successful HIV and AIDS VCT programmes around the world, however, Rachier, Gikundu, Balmer, Robson, Hunt and Cohen (2004) argued that in Sub Saharan Africa, HIV and AIDS VCT was relatively new and was faced with various challenges. Below are some of the challenges and recommendations that were made in a three-day conference by the HIV and AIDS VCT counsellors from various Sub Saharan Countries. From the conference it was established that the counsellors in these countries needed training to at least a certificate level in general counselling before they specialised in HIV and AIDS VCT. Also, it was established that the HIV and AIDS VCT training should include client centred approaches where the focus is on the person as a unique and singular individual. Hence counselling should be made to address the individual needs and also the general needs of certain groups in society.

It was established that HIV and AIDS VCT centres in these countries needed to develop adolescent-friendly policies in order to facilitate young people testing. However the report did not specify the age groups it considered as young. It was suggested that the centres should be designed in a way that addressed the specific needs of youth appropriately, such as sex, drugs and sexually transmitted infections. It was established that the centres in these countries were gender insensitive as they did not address the needs of the women who were in subordinate positions. Hence it was recommended that the centres should give special attention to the needs of females, married and unmarried, young and old. Also it should address the issues of violence, abuse, rape and family planning. In addition it was suggested that the centres should also provide training in self-esteem and assertiveness for this group.

It was also established that there was a shortage of HIV and AIDS VCT services or centres in these countries especially in rural areas; hence they suggested that there should be a provision

of house to house HIV and AIDS VCT services in order to cover everyone. (Rachier, Gikundu, Balmer, Robson, Hunt and Cohen, 2004).

Last but not least, it was established that there was a need to have an effective referral system. It was recommended that those undergoing an HIV test and receiving either positive or negative results should receive further support over and above post-test counselling. For example, they may need to be referred to family planning programmes. Van Dyk and Van Dyk (2003) also posited that there was especially a need for support services or treatment for those people who tested positive, since it has been reported that some clients after being diagnosed HIV positive have experienced feelings of fatalism and depression, because they believed that they are doomed to death as there is no cure for the disease.

Some further recommendations can be found in the “VCT Toolkit: A Guide to Establishing VCT Services for HIV” published by FHI (2002). It serves as a guideline for the establishment of effective HIV and AIDS VCT services. The guidelines recommend that any country that wishes to provide the service should conform to the following:

- At a national level the guideline proposes that there should be a national policy, procedures and minimum standards for HIV and AIDS VCT services. Some of the minimum standard for the HIV and AIDS VCT services as suggested by the guidelines are addressed below.
 1. Staff: qualified counsellors should meet with a maximum of five clients a day at each site. Hence staffing levels should take these maximums into consideration.
 2. Space for the service: In order to ensure confidentiality and privacy the guidelines suggest that, there should be adequate space to provide the HIV and AIDS VCT service in a private and confidential manner. Hence the guidelines recommended that the HIV and AIDS VCT rooms, reception area and laboratory should appear attractive and comfortable to clients. In service centres where more than 10 people are attended each day, it recommends that there should be two counselling rooms, one laboratory space and one or two waiting areas.
 3. Equipment: The guideline recommends that quality equipment be used, especially in the laboratories. In addition there should be waste disposal facilities.

2.1. 2.1 Models of HIV and AIDS VCT service delivery

The FHI toolkit shows that there are various models of HIV and AIDS VCT service delivery and each have benefits and constraints. The models as recorded by The FHI (2002, p.7) are as follows:

Model	Benefits	Constraints
NGO	<ul style="list-style-type: none"> -Improved management due to limited focus. -Flexibility in staffing and clinic hours. -Quality easier to ensure 	<ul style="list-style-type: none"> - Contingent on outside funding -Potential for stigma as a stand- alone site.
Private Sector	<ul style="list-style-type: none"> -Need high quality to attract clients. -Perceived to be more private and confidential. -Responsive to clients needs 	<ul style="list-style-type: none"> -Inaccessible to the poor and uninsured
Integrated VCT services integrated into existing services, usually public sector	<ul style="list-style-type: none"> -VCT part of routine health services, thus normalising HIV and AIDS. -Direct referral to relevant HIV related care -Staff can provide services other than VCT. -High volume of potential clients 	<ul style="list-style-type: none"> - Dilution of other services and potentially lower quality VCT services. -Possible regulation disallowing the use of non-health care providers for counselling services. -Low motivation in public sector personnel -Quality assurance more difficult to implement -Long waiting times to be assisted -Possible client perception of poor quality of care
Mobile/outreach	<ul style="list-style-type: none"> -Improved access for population not using stand alone services or for rural population 	<ul style="list-style-type: none"> -Expensive -Difficult to ensure confidential services and follow up after post- test counselling. -Limited capacity.

2.1.3 Barriers to HIV and AIDS VCT services based on perceptions and attitudes

A survey done by the HSRC (2002) in South Africa, established that, though the majority of people knew about the importance and availability of VCT services, both counselling and testing, they were not willing to use the services, as they feared that they would be discriminated against and their social relationships would be adversely affected. Also, they were worried about how they would cope if they tested HIV-positive.

In another survey done in America, it was established that the majority of people did not want to undertake the test due to the reasons mentioned above and also they feared that they would be stigmatised if found to be positive. The disease was associated with homosexuality and drug users and hence those infected were suspected to be homosexuals or drug users (Mark & Senak, 2000). Also, it has been argued that the disease is more highly stigmatised than any other infectious disease that has ever existed. Also, people considered being diagnosed with HIV the same as being sentenced to death as there is no cure for the disease (Simbayi, 1999). The other reason for not testing established by the HSRC (2002) household survey was that most people had fears about confidentiality. They feared that their test results would not be safe as persons other than the doctor could access the test result. Hence, some people preferred testing at anonymous test sites where nobody would recognise them. Confidentiality as posited by Kenyon (in Chwaane, 2006) is very crucial in HIV and AIDS testing as for patients to trust health-care providers, they must be able to trust that the information they disclose would be kept secret. Kenyon stated that some people therefore preferred to test where they were not known as there would be more confidentiality.

The HSRC (2002) survey also found that people were not willing to use some VCT centres as they perceived them offering a low-quality service. They were not satisfied with either the facility or the staff employed there. The same results were found in Botswana by Chilisa and Bennel (2001) through a research survey carried out on the University of Botswana students. Chilisa and Bennel (2001), in their survey study, also revealed that most university students did not want to use the VCT Centres on campus as they feared that they would be marked as being HIV-positive. Since the place where the service was being provided was "marked" or stigmatised, people seen going in or out of the place were considered sick and this had adverse consequences for them.

A qualitative study carried out by MOH in Botswana also revealed that the VCT centres in Francistown and Ghanzi were stigmatised and people were therefore not using the service. Hence they recommended that the location where the VCT service is provided was important and they should not select places where people can easily determine who was visiting the centre. The report further indicated that HIV and AIDS programmes in Botswana were failing as most of them, such as HIV and AIDS VCT and PMTCT, were carried out in separate health

facilities that people were fearful of accessing since they did not want to be labelled sick. They further argued that stigmatisation and discrimination instilled fear and intolerance, which, in turn, are likely to drive people away from the programmes that are developed to prevent the spread of HIV and AIDS. The study also revealed that there was a strong gender bias in HIV and AIDS related stigmatisation. According to the research women and men were not dealt with in the same way when they are infected or affected by the epidemic. Women were reported to be more likely to be blamed even if they had been infected by their husbands. Women would be blamed for unfaithfulness even if it was the man who had been unfaithful (WHO, AIDS/STD Unit & MOH, 2004). This behaviour can inhibit the women from testing for fear of being blamed and stigmatised as being unfaithful. According, to Van Dyk and Van Dyk (2003), "since women are often blamed for bringing AIDS into the family, they tend to cope silently with this burden, without protecting themselves or their sex partners from further infection, and without accessing health care and support services. The reluctance to disclose their HIV positive status is therefore a major barrier to the successful implementation of HIV and AIDS VCT programmes. This self-imposed silence prevents people from reaping the important benefits of knowing their HIV status" (2003, p118).

Chilisa and Bennel (2001) in addition established that the low utilisation of VCT services may be due to the fact that the people were not aware of the service, or thought that the service was expensive. Through the HSRC survey (2002), it was also established that 40% of people in South Africa were not using the service as they thought it was not important. They believed that it was hopeless using the service as they would not be offered any medicine to cure them when tested positive as the disease was incurable. At the time of the study ARVT was not generally available in South Africa through the Public Health System.

Furthermore Chilisa and Bennel (2001) established a positive relationship between those people who perceived themselves as being at risk of getting HIV and utilising the VCT service. They argued that some of the students were not using the service as they said they were not engaged in any activities that exposed them to the virus. Therefore they considered themselves HIV-negative; hence they saw no reason to waste time by visiting HIV and AIDS VCT centres to be tested. On the other hand, those who perceived themselves as being at high risk, since they engage in activities that could expose them to the virus, used the service as they thought they may benefit from it. In Botswana, females were considered as being at risk as, the social or cultural factors reinforced practices such as the subordination of women in sexual relationships this increasing their vulnerability to HIV infection. These were exacerbated by the fact that often women were not able to make decisions about sex and lacked economic empowerment. The under 30 year's groups were considered to be more sexually active than the above 30 year olds. The younger age groups were said to be engaged in behaviors that could expose them to being infected. They were reported to have access to and abuse of

alcohol which is one of the practices that have contributed to the rapid spread of HIV and AIDS due to increased casual and unprotected sex. People with high levels of disposable income are at risk of HIV infection due to their ability to exert unfair pressure in pursuit of sex. The married people were also considered to be at risk as they did not want to use protection as once a partner uses protection, they would be accused of lacking trust (NACA 2004).

According to Solomon, Rooyen, Griesel, Gray, Stein and Nott (2004) many studies have shown that there was one variable, the perceived probability of a positive HIV test result, that was significantly associated with failure to return for post- test counselling and results. It was established in West Africa, that the HIV infected women were three times less likely to return for results than unaffected women. This therefore suggested that those who are more willing to receive test results were doing so because they had reasons to believe that it would be negative. Hence Mason (1990) as cited in Beardsell (1994) has suggested that people who are therefore unlikely to be infected are the ones who take the test, hence contradicting the work of Chillisa and Bennel (2001).

In Namibia, through a qualitative study, it was established that, although both males and females thought that mandatory testing should be imposed in order to stop people from unknowingly spreading the disease; they thought people did not want to test as they feared the outcome. But if mandatory testing was introduced, all people will be forced to test, and those positive will take precautions in order not to spread the virus. The male respondents, however, indicated that, although they agreed with mandatory testing, they thought it should only be imposed on females about to be married. This was because they thought more females than males were susceptible to the disease, not because of their biological makeup but rather because of their high-risk behaviour (Lipinge, Hofnie & Friedman, 2004).

According to Walker et al, (2004) an individual's belief system in a society has an impact on their understanding of health and their responses to their health conditions. Different people understand diseases differently; hence their responses will be different. There are those who use traditional reasoning while others used bio-medical reasoning. Those using a traditional reasoning are said to use their belief systems to understand the disease and therefore will use traditional ways to respond to the disease. For example, those who believe a disease was caused by supernatural forces will use a cultural way of responding to the disease. However, those using the bio-medical reasoning will use rational and scientific reasoning; hence they tend to respond rationally to the disease; for example, by using scientific methods. In Botswana, the Aids intervention programmes used to combat the epidemic are based on the western experiences; hence they adopt a bio-medical approach. However, Walker et al, (2004) established that through a life-skills education programme in primary schools in Kwa-Zulu Natal, the educators found that it was necessary to develop a culturally- sensitive

approach. Hence the programme formulators realised that the direct scientific approach used in health programmes such as those in Botswana were unhelpful and inappropriate.

Males in Botswana are said to be the decision-makers and active role-players in all aspects of life, but when it comes to sexual and reproductive health issues, they lag behind, especially on HIV and AIDS issues. The reasons for their passiveness are said to be attributed to their perceptions and attitude towards HIV and AIDS (MOH, 2002). This can be illustrated from the WHO, AIDS/STD Unit and MOH (2004) report, which gives an account of one respondent who was recorded as saying that her husband did not even want to talk about HIV and AIDS-related issues. This was because he believed that those who are concerned about the epidemic are those who are or have been unfaithful. The study also established that the reason for some men not using the HIV and AIDS VCT services was because men perceived using a health service as a sign of weakness, and health services were seen as a place for women. Also, some men are said to prefer traditional doctors rather than medical doctors. The most prevalent reason that was established by the research was that the HIV and AIDS programmes were stigmatised. Hence, the researchers recommended that there was a need to develop stigma reduction interventions, which should be gender-sensitive and especially targeted for men as they were less involved in such programmes (UNAIDS, 2000).

Through a qualitative and cross-sectional study done in similar field of HIV and AIDS stigma by Dr. Akinade of the University of Botswana, however, it was established that males were the group which suffered the least from HIV and AIDS stigmatisation compared to females and children. He attributed the reason to a culture that protects males more than females (Akinade, 2002).

2.2 HIV and AIDS in the workplace

According to the UNAIDS (2002), report HIV and AIDS dramatically affects labour, sets back the economic activity and social progress as it affects in particular, productivity, as the vast majority of people living with HIV and AIDS are the economically active population aged between 15 and 49. Lisk (2003) has posited that the fact that HIV and AIDS has its primary impact on the working age population means that those with important economic and social roles are prevented from making their full contribution to economic development. He also stated that in developing countries there was already lack of skills and there was loss of more skills due to HIV and AIDS, and this had a major impact on development. The ILO report according to Lisk (2003) has estimated that in ten to fifteen years time, the labour force will be between 10 and 30% smaller in higher prevalence countries as results of AIDS. Other studies on the impact of HIV and AIDS in the workplace can be found in Kelly, Parker and Gelb (2002) who through literature review established the effects of HIV and AIDS on operating profits of industries, workplaces and sectors.

The Global Compact Policy Dialogue on HIV and AIDS (2003, p.7) has quoted the Director General of ILO, Juan Somavia as saying that “two out of three people living with HIV and AIDS go to work everyday- it makes the workplace a vital entry point for tackling HIV/ AIDS”. According to Mwamadzingo (2003) workers, through their national and international organisations are instrumental in furthering the fact that the workplace must be seen as probably the most important and effective starting point in tackling the disastrous effects of HIV and AIDS. Some of the actions taken by the international organizations are for example as follows;

- At the 17th World Congress in Durban, South Africa, April 2000, the International Confederation of Free Trade Unions (ICFTU) adopted a resolution in favour of launching a trade union action programme against AIDS. The ICFTU identified three priorities for action; to adopt preventive measures, to mobilise against any form of discrimination and to press the pharmaceutical companies to lower their drug prices (Mwamadzingo, 2003)
- In September 2000 in Gaborone Botswana 120 participants from all over Africa decided in a Pan African conference to mobilise trade unions into actual participation against HIV and AIDS. (Mwamadzingo, 2003)
- In July 2000 in Accra, Ghanaian trade unions leaders in a seminar agreed to roles and responsibilities of all players, workers, employers, government, NGO's, civil society organisations and the international community in addressing the different aspects of HIV and AIDS to mitigate its effects in the world of work. The principle strategy included advocacy, campaigns, partnership building and inclusion of HIV and AIDS in collective bargaining agreements.

According to Somavia (2001), in ILO (2001), the ILO was committed to the fight against HIV and AIDS through 'The ILO code of good practice on HIV and AIDS and the world of work'. The code was seen as being instrumental in helping to prevent the spread of HIV and AIDS, mitigate its impact on workers and their families and also provided social protection to assist them to cope with the disease. He said that the code was to cover key principles, such as the recognition of HIV and AIDS as a workplace issue, “non- discrimination in employment, gender equality, screening and confidentiality, social dialogue, prevention and care and support, as the basis for addressing the epidemic at the workplace” (ILO, 2001, Piii). Some of the principles are further discussed below. The ILO guidelines provides practical guidance to governments, employers and workers as well as other stakeholders, to develop national and workplace policies to respond to the spread of HIV and AIDS and to mitigate its impact. The code applies to all employers and workers in the private sector and public sector and all aspects of work (Kabubi, 2006). Some of the aspects that the code suggests that workplace policies should address are as follows;

-Recognition of HIV and AIDS as a workplace issue

The code said that the epidemics should be treated like any other serious illness/condition in the workplace.

-Non discrimination

The code advocated that there should be no discrimination against workers or persons affected by or infected with HIV and AIDS. Discrimination and stigmatisation of people living with HIV and AIDS is seen as inhibiting efforts aimed at promoting HIV and AIDS prevention.

-Gender equality

It recommends that the gender dimensions of HIV /AIDS should be recognised as women are more at risk of being infected by HIV and AIDS. The females are more discriminated in issues relating to HIV and AIDS than the males hence there was a need to empower them in order to prevent the spread of HIV and AIDS infection.

-Social Dialogue.

The code recommends that for the HIV and AIDS policy to be effective there was a need for the cooperation of all stakeholders; employers, workers and their representatives and the government.

-Prevention

The code suggests that transmission of HIV and AIDS should be prevented and this could be achieved through changes in behaviour, knowledge, treatment and the creation of a non discriminatory environment.

In support of the code the Global Compact Policy Dialogue on HIV/AIDS (2003) stated that one way used to reduce HIV and AIDS impacts in the workplace was through the implementation of HIV and AIDS policies and programmes, however these policies and programmes are said to sometimes fail due for example, not being accepted by employees. According to Botswana Institute of Development and Policy Analysis (BIDPA) (2000), the formulation of an HIV and AIDS policy was an essential part of an adequate response to HIV and AIDS, as the policy provides an indication of norms and expectation in handling issues raised by HIV and AIDS. Furthermore the policies can guide both employees and managers and hence reduce conflict relating to HIV and AIDS issues in the workplace between the employees and management. The development and dissemination of a policy is said to build greater certainty and trust, which will enable employees to disclose HIV status and can allow for more active management of HIV and AIDS.

2.3 HIV and AIDS in Botswana and its Impact

Most literature in Botswana on HIV and AIDS is said to be devoted to the impact of the epidemic and the reason for this, according to a NACA report, is because the impact is phenomenal in all aspects and levels of Botswana society (NACA et al, 2005). Botswana is said to be amongst the countries hardest hit by AIDS. In 2003 there were an estimated 350,000 people living with HIV. This, in a country with a total population below two million, gives Botswana an adult HIV-prevalence rate of 37.3%, the second highest in the world after Swaziland. Life expectancy at birth fell from 65 years in 1990-1995 to 39.7 years in 2000-2005, a figure about 28 years lower than it would have been without AIDS. There were around 160,000 orphaned children living in Botswana in 2003, more than three-quarters of whom had lost a parent to AIDS. The number is projected to increase by 20% by 2010 if nothing is done to combat the epidemic (Oaitsi, 2005)

The Government's fiscal expenditure has been increased, as it spends more money on welfare services, catering for those affected and impacted by the epidemic. This is said to have increased public expenditure that is projected to rise from 17.1 billion, in 2003/04, to 25.5 billion in 2008/09. It has been indicated that the current expenditure of the government on health has increased from 5.65% in 1997/1998 to 6.5% in 2002/03 (Ministry of Finance and Development Planning (MOFADP), (2003).

The epidemic was first diagnosed in 1985 and since then HIV and AIDS has spread and the impact has been phenomenal. The epidemic was originally concentrated in the urban areas but quickly spread to the rural areas, hence reducing the infection rate gap between rural and urban areas (Ministry of Finance Development and Planning (MOFDP), 2003). The epidemic is assumed to be the leading cause of death in Botswana. In 2004 it was reported to have caused 68% of deaths, followed by TB, an HIV-related disease, with 20.6%. The impact of the epidemic on the country has been disastrous; hence the Government has adopted strategic action towards fighting the epidemic. The main programmes are measures to prevent the incidence of HIV and AIDS and reduce the impact of the epidemic on the country. The government has therefore adopted strategies to involve all stakeholders at all levels of the country in the fight against AIDS (NACA et al, 2005).

2.3.1 Botswana responses to HIV and AIDS

The government of Botswana has declared HIV and AIDS as a national emergency and has committed itself to an aggressive, comprehensive and expanded multi-sectoral and multi-level response to fight the epidemic in order to curb its impact. The government of Botswana started responding to the epidemic of HIV and AIDS in 1987. The government developed a Short Term Plan of Action that was developed in 1987 for two years after the first case of HIV and AIDS.

The Short Term Plan focused mainly on the screening of blood to eliminate the risk of HIV transmission through blood transfusion. The Short Term Plan was followed by the Medium Term Plan 1 for the years 1989 to 1993, which focused on the introduction of information, education and communication programmes. The National HIV /AIDS policy was developed in 1993 followed by the Medium Term plan II for 1997 – 2002, the Medium Term Plan II extended in many different directions to include education, prevention and comprehensive care including the provision of ARV. The plan involved many stakeholders who had been previously been excluded, with the overall aim, not only of reducing HIV infection and transmission, but also reducing the impact of HIV and AIDS at all levels of society (Fredrikson - Bass and Kanabus, 2005). The following are some of the programmes that the government and the private sectors have taken at both the National and District level in an endeavour to achieve the Medium Plan II

The government at national level has formulated different committees, councils and policies to fight the epidemic. Some of these are as follows;

- 1) The government has formed a National AIDS Council (NAC) that coordinates all HIV and AIDS activities in the country and advises the government on HIV matters. It consists of representatives of political leaders, some ministries and chiefs. The president of Botswana chairs the council and the Minister of Health is the vice-chairperson. The Assistant Minister of Local Government is also a member, and he provides a linkage between the central government and the district authorities. The secretariat of this council is NACA that is responsible for coordinating HIV and AIDS activities in the country (ROB, 2004).
- 2) The Government has produced a National policy that serves as a guideline to all the actors in HIV and AIDS prevention and care and this includes ministries, non government organisations, community organisations, parastatals and the private sector. The policy describes the role of national leaders, various governmental ministries, the private sector, non governmental and community based organisations, people living with HIV and AIDS and individual community members in the national response to the HIV and AIDS epidemic. Also, it provides mechanisms for resource mobilisation, allocation, monitoring and coordination of AIDS preventive and care activities in the country (MOH, 2004).
- 3) The MOLG, along with the MOH, are considered to be the key ministries for implementing the National HIV/AIDS strategic framework in the country (ROB, 2004). The MOLG is responsible for providing care and support to all those affected by the epidemic and also the prevention of more transmissions. According to the country's National Development Plan (NDP) 9, the ministry is responsible for mainstreaming HIV and AIDS into the development plans of the districts. In its endeavour, the ministry has formulated a policy

that requires the Local Authorities to implement HIV and AIDS and STD prevention care activities related to the health sectors, in collaboration with the MOH. Examples of such programmes are the HIV and AIDS VCT services, TB and ARVT programmes, all of which are offered free of charge to the citizens (Ministry of Finance, Development and Planning (MOFADP), 2003). The MOH in Botswana in 2002 produced a National Sexual and Reproductive Health Programme (NSRHP) that was intended to improve the sexual and reproductive health of all people in Botswana (MOH, 2002). The programme is said to have involved an extensive consultation with stakeholders and opinion leaders at both the national and district level. It was intended to reach out to adolescents and men, and make health services youth-friendly and gender-sensitive. The MOH argued that in Botswana, like other African countries, the health system and especially HIV and AIDS-related programme design were greatly influenced by women. The reason for this may be ascribed to the commonly-held view so well articulated by the Association of Commonwealth Universities who stated that women were:

“Physiologically, socially and economically more vulnerable to the impacts of HIV/AIDS than men...because of this, it is argued that all policies, programmes, and institutional practices that address HIV and AIDS must be designed with the needs of women in mind” (MOH, 2002, p. 30).

The MOH argued that there was a need to “increase activities targeted at sexually-active males because of their own health risks and the potential effect of their sexual behaviour on the reproductive health of their partners” (MOH, 2002, p47). The programme produced guidelines which were to help the health services or programmes to be more effective and of higher quality. As per the guidelines, the services must be organised as follows:

- They must be in an accessible location.
- They must be organised in such a way that one does not wait long to be helped.
- They must be held on clean premises.
- The environment must be seen to be able to provide privacy and confidentiality.
- The facility must be equipped with the right quality equipment that is fully maintained.
- There must be communication between the service provider and clients.
- Service providers must have knowledge and be able to practice their skills.

- Clients should be given a chance to make informed decisions with the assistance of the service providers.
 - They must be gender-sensitive and must be able to arrange that the person is attended to by a person of the same gender.
- 4) The employees in the public sector are eligible to join an optional medical scheme offered by the government. The government contributes 50% while an employee contributes the other 50%. This enables employees to access the paid private health facilities for any health service they may require (ROB, 2005).
 - 5) In 2003 the MOH indicated that there were sixteen hospitals, two hundred and sixty-five clinics, and eight hundred and ten mobile stops in the public health sector of the country. All these provide free HIV and AIDS programmes such as the HIV and AIDS VCT services (except for one hospital which is a mental hospital). Treatment for TB and other opportunistic diseases is also provided in the public health sector facilities.
 - 6) According to the MOH, routine testing was introduced after it was realised that people were dying of the epidemic although ARVT was available. Also, pregnant women were not entering into PMTCT programmes to prevent their unborn children from being infected. The programme was introduced in all public health facilities in 2004. All clients visiting the public health sector regardless of whether they went there for HIV testing or not, are pre-test counselled on the importance of HIV testing, however clients can refuse to be tested. Those who agree to be tested for HIV have their blood sample sent to the laboratories and have to wait at least two weeks for the results. When they come for the results they are post-test counselled and those who are HIV positive are given appropriate treatment (NACA et al, 2005).

2.3.1.1 Non Governmental Responses

Different Non-Governmental organisations have also volunteered to assist the country in the fight against AIDS. Also, private practitioners are available and some have HIV and AIDS programmes.

- 1) VCT centres are an example of non-governmental organisation (NGO) attempts to fight against the epidemic. In 1995 the US Centre for Disease Control and Prevention (CDC) and the Botswana Government began a collaboration called BOTUSA, to work on public health research and programmes to combat TB as well as HIV and AIDS. BOTUSA has grown substantially since 2000 and has managed to build 16 HIV and AIDS VCT centres known as TEBELOPELE. These centres provide HIV and AIDS

testing with pre- and post-test counselling. If a person is detected as having the virus, they are referred to a public health facility (MOH, 2004).

- 2) With the support from the African Comprehensive HIV/ AIDS partnerships (ACHAP), and Bill and Melinda Gates foundation, the government has managed to introduce an ARVT programme since 2002. When it was introduced it was offered at four sites in Botswana - Francistown, Gaborone, Serowe and Maun. Currently it is being offered in all major public health facilities such as the hospitals and major clinics. The service is free.
- 3) There are also private practitioners in the country, with a private hospital in Gaborone.

2.4 Lobatse and HIV and AIDS

HIV and AIDS in Lobatse is considered to be a serious problem. In 1988, 11 cases were reported in Lobatse and by 1999 the number had increased to 750. It was also reported that in 1999 from 132 pregnant women tested for HIV and AIDS, 23% were reported positive, while 35% of the 71 men with STDs were HIV positive. In 2000 30% of deaths among the hospital patients were reported to be as a result of HIV and AIDS. The most affected were young people, the productive age groups of both males and females. In 2001, it was reported that 2088 males and 3325 females of the 20-49 age bracket were HIV-positive. The HIV prevalence in Lobatse for males was depicted to be 14.8% while for females it was 21.5% in 2001 LTC, LUDC & MOLG, 2003). The life expectancy at birth in Lobatse was 66.7 years in 1991 and was expected to decline to 51 years by 2010 (Hope & Gaborone, 1999).

2.4.1 Lobatse District responses

According to the Lobatse Urban Development plan 2: 2003 – 2009, the provision of health care services in Lobatse is a shared responsibility of MOLG through the Lobatse Town Council and the MOH. According to the plan, the aim of Lobatse district is to strengthen preventive measures by control of disease, and the development, design, and provision of information, education and communication materials which are relevant to the district needs regarding health issues. Some of these activities are achieved through the provision of health service facilities and the distribution of condoms.

There is a multi sectoral AIDS committee (District Multi- Sectoral AIDS Committee) (DMSAC), which is charged with the implementation of HIV and AIDS prevention and care strategies in accordance with the National policy on HIV and AIDS. There is one public hospital under the MOH that provides a variety of HIV and AIDS programmes. There are six clinics under the MLG in the district, which provide HIV and AIDS VCT services, ARV and treatment for opportunistic diseases (LTC, LUDC & MLG, 2003).

The private practitioners are considered to be part and parcel of the health care system in Lobatse. There are five private practitioners in Lobatse, and two dental clinics and services provided at these private practitioners are for the patients account. There is one NGO centre which offers free HIV and AIDS VCT services called, Tebelopele. (LTC et al, 2003).

2.4.1.1 Lobatse Town Council responses

According, to G. Gagosi (personal communication, November 2005) the death rate among the employees of the Lobatse Town Council for the past five years is reported to have increased each year for the last five years. She asserted that for the years 2001 and 2002 there were at least five to six deaths of which three out of five were HIV and AIDS related. From 2003 to 2005 the death rate is reported to have increased for each year there were at least eight to nine deaths of which six were HIV and AIDS related.

The Lobatse Town Council works within the National Policy on HIV and AIDS, 1998. However the Lobatse Town Council does not have a workplace policy that it has formulated but has developed a mission statement and activities that are guided by the National Strategic Framework. This plan is however not made specifically for the employees of the Lobatse Town Council. The strategic plan was derived from consultation with all stake holders in the district and in the mission statement the Lobatse Town Council committed itself to the radical reduction of HIV infection, the provision of total care, support, and treatment services through active involvement of all stakeholders, and the dissemination of HIV and AIDS information to all people in the district. The goals towards the achievement of the mission are;

- Prevent HIV and AIDS transmission through:-
 - Increasing access to, and utilisation of VCT services throughout the district.
 - Expanding Prevention of Mother to Child treatment and to encourage wider participation of women and their families, especially men, in the programme.
 - promoting proper use and disposal of condoms.
- Provide treatment, care and support, through :-
 - Encouraging wider participation in care and support and treatment programmes such as the home based care.
- Manage and ensure effective co- ordination, monitoring, and evaluation of all HIV and AIDS activities in the district by:-
 - Strengthening the capacity of the DMSAC
- Ensure the provision of a strengthened legal and ethical environment through:-
 - Enforcing the implementation of the national Aids policy and Code of Conduct on HIV and AIDS.

In the Lobatse Town Council workplace the employees are provided with education, e.g. the importance of testing, through workshops, morning prayers and pamphlets and flyers from the

clinics. Also, condoms are placed in all workplace offices and toilets for employees. The Lobatse Town Council provided stop order facilities for all employees who are interested in joining the medical aid schemes.

2.5 Some of the challenges facing HIV and AIDS VCT services in Botswana

The MOFDAP (2003) has indicated that the major problem facing the public health sector was a shortage of resources. For example, the ARVT programme's greatest challenge is said to be the critical shortage of skilled personnel to carry out the programme. It was reported that in 2001-2002 the country was short of fifty-two nurses in all its health facilities.

It has also been reported that another problem faced by the service providers is that there is a proliferation of counselling programmes leading to counsellors who are not adequately trained being employed by HIV and AIDS VCT service providers. There is no central body or council put in place to see that training done for counsellors at all levels of qualification is in line with the formal training required at a degree level (WHO, AIDS/STD Unit & MOH, 2004).

2.6 Conclusion

The above literature review gives an insight into what may be some of the reasons causing the low utilisation of HIV and AIDS VCT in different parts of the world. Some of the reasons given by the literature indicate that people did not want to use the HIV and AIDS services as they fear they will be discriminated against and stigmatised if found to be HIV-positive, or, if they are seen using the HIV and AIDS services, as they will be marked as being sick. Also, some people did not utilise the HIV and AIDS services as they were not aware of its availability, others were scared of knowing their status as they feared death, and some thought it was of no use as there was no cure. Some were scared that there was a lack of confidentiality in the VCT service providers. The other reasons advanced were that people did not want to use the service as they thought they were not at risk of being infected as they were not engaged in behaviours that exposed them to being infected. Also, culture or belief systems are said to be one of the factors that may lead to the low utilisation of the HIV and AIDS services.

The literature review also, gives an insight into the impact of HIV and AIDS in Botswana and also, shows some of the action taken by the country, at a national and district level, in an attempt to be responsive to the epidemic. The literature also, shows some of the factors that influence the low utilisation of HIV and AIDS services in Botswana. For example, The HIV and AIDS VCT services in Botswana are said to be stigmatised, some groups especially women are said to be discriminated and stigmatised if found to be infected and this tends to make them unlikely to test. Another reason is that the health systems in the country are said to be more suitable for females than males and hence this discourages males from using the health

facilities in general and HIV and AIDS services specifically. Botswana culture is said to play an important role in influencing behaviour and is said to be one of the reasons that influences the decision not to test for HIV and AIDS. This is especially relevant for males. The literature also shows that the utilisation of HIV and AIDS VCT services was biased towards different groups in Botswana. More females than males, the young age groups than old aged groups, the high level of disposable income earners than low levels of disposable income earners, and the married than singles, utilised the service than their counterpart groups. The literature also, established some of the challenges facing health services in the country and some of these challenges for example the lack of qualified HIV and AIDS VCT counsellors may contribute to the low utilisation of HIV and AIDS VCT services in the country.

However when it comes to Lobatse little or no research has been done on the utilisation of HIV and AIDS VCT services amongst the Lobatse Town Council employees. Hence this research is an opportunity to find out what is happening in Lobatse and which of the personal and service provider issues seem to be influencing the decisions to test or not test. The research will give an insight into the usage of HIV and AIDS VCT services.

3. Chapter Three: Research Methodology

3.1 Introduction

This study was to understand the extent of the usage of the HIV and AIDS VCT service by different groups of employees of the Lobatse Town Council. The groups were characterised by age, gender, employment category, education level and marital status. The aims were, firstly, to establish who accesses or does not access HIV and AIDS VCT and the reasons for accessing or not accessing VCT. Secondly, to establish if there were preferred service providers and the reasons therefore. Thirdly, to make recommendations to overcome any difficulties with HIV and AIDS VCT so as to improve the take-up rate amongst the employees of Lobatse Town Council. The research questions formulated to achieve this were as follows:

- 1) To what extent have Lobatse Town Council employees made use of HIV and AIDS VCT service?
- 2) Have some groups, distinguished by gender, age, employment category, educational level or marital status, shown greater willingness than others to undergo HIV and AIDS VCT?
- 3) What is the motivation for testing and not testing?
- 4) Which are the preferred service providers and is there a group bias?
- 5) What motivates the choice of service provider?
- 6) What is the process by which the HIV and AIDS VCT service provider, namely the clinic, Tebelopele, the hospital and private doctors, manage their service?
- 7) What flexibility exists within the service to accommodate the varying groups accessing the service with the emphasis on gender, age, and educational level?
- 8) Are the service providers meeting the HIV and AIDS VCT objectives? What are the successes, failures and challenges?
- 9) What are the recommendations for improving the HIV and AIDS VCT service within Lobatse?

3.2 General Approach

This study was a descriptive one and both qualitative and quantitative data were used to find out the reasons that motivated the Lobatse Town Council employees to test or not to test, their preferred HIV and AIDS VCT service provider and the reasons for choosing or not choosing that service provider. The study was also intended to find out the challenges, successes and recommendations of HIV and AIDS VCT service providers in the Lobatse District.

Quantitative data was collected through a self-administered questionnaire that was distributed to all Lobatse Town Council Employees. Qualitative data was collected through two focus group discussions held with selected Lobatse Town Council employees.

A face- to- face interview with selected HIV and AIDS VCT service providers was also planned but was not carried out due to time constraints. The research questions, numbers 6, 7 and 8, that were to be addressed by the interview findings were therefore not addressed and have not been written up in Chapters 4 and 5.

3.3 Population

The study was conducted in the Lobatse District in Botswana. Two populations were intended to be studied, the Lobatse Town council employees and the HIV and AIDS VCT service providers in the Lobatse district. Below is a brief description of the two populations.

3.3.1 Lobatse Town Council Employees

During the month of June 2006, the Lobatse Town Council had a population of 1008 employees. Of the overall population, 40% were males and 60% were females. The employees were divided into two employment categories that of, permanent and pensionable staff and industrial class staff employees, who are the daily-paid workers. The permanent and pensionable staff were further divided into three categories, i.e. management, middle management and lower management.

Table 1 below shows the population by employment category and gender.

Table 1 - Employees of Lobatse Town Council by employment category and gender

Employment categories	Gender				Total	
	Males		Females			
	Number	%	Number	%	Number	%
Management	20	2.0%	50	5.0%	70	6.9%
Middle Management	50	5.0%	101	10.0%	151	15.0%
Lower Management	101	10.0%	177	17.6%	278	27.6%
Industrial Class	232	23.0%	277	27.5%	509	50.5%
Total	403	40.0%	605	60.0%	1008	100%

3.3.2 HIV and AIDS VCT Service Providers

The population of the service providers were all the HIV and AIDS VCT service providers in the Lobatse Town Council District. The following Table 2 shows the different types of service providers in the Lobatse District during the month of June 2006.

Table 2: HIV and AIDS VCT Service providers in the Lobatse district

Categories	Service provider	Number
Public Health System	Clinics	6
	Hospital	1
Private	Tebelopele	1
	Private practitioner	5

3.4 Sampling and Selection

According to Babbie (1992) and De Vos (2002) it is sometimes impossible, impractical or expensive to study all members of the population that are of interest; hence there is a need to sample the larger population. Sampling is when one selects some of the elements from the population with the intention of finding out something about the population from which they are taken (Judd, Smith & Kidder, 1991).

Due to reasons espoused above, samples were taken from the employees of the Lobatse Town Council for the focus group discussions, and a sample was selected from the questionnaire responses. Also, a sample was selected from the service providers in the Lobatse District. The samples and sample selection are further discussed below.

3.4.1 Lobatse Town Council Employees

3.4.1.1 Survey

A self-administered questionnaire was distributed to all employees as it was felt that, if distributed to all employees, a sufficient workable number would be returned completed. According to the MOH (2002), reproduction and sexual issues, HIV and AIDS included, were still considered as a taboo subject among some Batswana. The researcher therefore anticipated that some employees would not be comfortable in answering the questionnaire and thus there might have been a low response rate if a sample of respondents were selected to complete the questionnaire. Although all the employees were sent the questionnaire to complete, not all employees responded. From the 1008 employees, 389 responses were collected. Of these, 125 were disqualified as the respondents did not complete the questionnaire as required. Of these 125, 38 questionnaires were returned without any responses, 57 respondents did not show whether they have been tested for HIV and AIDS or not, and 30 respondents answered sections A and B only. The remaining 264 (389 -125) responses were used for stratified random sampling. The reason that only completed questionnaires were used was because this has been recommended by writers such as Babbie (1992), who asserted that incomplete questionnaires that contain many missing responses might introduce error during data capturing. Therefore the questionnaires were scrutinised and only completed questionnaires were included in the set for stratified random sampling.

The Table 3 below shows the responses that were collected and disqualified by employment category by gender.

Table 3- Number of questionnaires collected by employment category and gender group

Employment category	Gender					
	Males			Females		
	Number of responses collected	Number of responses disqualified	Responses used	Number of responses collected	Number of responses disqualified	Responses used
Management	8	-	8	17	-	17
Middle Management	21	10	11	49	14	35
Lower Management	51	20	31	58	15	43
Industrial Class	87	35	52	98	31	67
Total	167	65	102	222	60	162

From the completed questionnaires, 200 responses were selected using stratified random probability sampling. Stratified random sampling was used to obtain a greater degree of representation than could be obtained by simple random sampling. The two characteristics considered important for stratification were gender and employment category. The number of questionnaires randomly selected per strata is shown in Table 4 below and accurately represent the gender and employment categories as shown for the population in Table 1 above.

Table 4- Numbers of questionnaires selected by employment category and gender

Employment Category	Gender				Total	
	Males		Females			
	Number	%	Number	%	Number	%
Management	4	2.0%	10	5.0%	14	7.0%
Middle Management	10	5.0%	20	10.0%	30	15.0%
Lower Management	20	10.0%	36	18.0%	56	28.0%
Industrial Class	46	23.0%	54	27.5%	100	50.0%
Total	80	40.0%	120	60.0%	200	100%

3.4.1.2 Focus Groups

Two focus groups were selected, one from the females and one from the males. It was ensured that for each group each employment category was represented (see Table 5 below). More participants were selected from the lower management and industrial class, since within

the employee population, there are more employees in these employment categories (see Table 1). Selection was done by dividing the employees list in males and females and then into employment categories (see, Table 1). Within each strata, names were randomly selected by systematic sampling. Each potential participant initially selected was contacted by telephone to establish if they were interested in volunteering to participate in a focus group.

Table 5- Focus groups samples by employment categories and gender

Category	Gender		Total
	Males	Females	
Management	1	1	2
Middle Management	1	1	2
Lower Management	3	3	6
Industrial Class	6	6	12
Total	11	11	22

The Table 6 below shows the number of participants by employment category and gender who finally attended the focus group discussions:

Table 6 - Number of focus groups participants by gender and employment category

Employment Category	Gender	
	Males participants who attended	Females participants who attended
Management	1	1
Middle management	1	1
Lower management	1	1
Industrial class	4	2
Total	7	5

3.4.2 HIV and AIDS VCT Service Providers

Sampling for the service providers was done through purposive sampling. From each service provider, one respondent was approached; for the six clinics, the matron for all clinics; for the HIV and AIDS VCT centre, Tebelopele, the head of the centre; for the public hospital, the matron of the hospital, and for the private practitioners, one of the private doctors.

3.5 Instrumentation

Three methods of data collection were used in this study, i.e., a survey questionnaire, a focus group discussion guide and face-to-face interview guide.

3.5.1 Survey questionnaire - Lobatse Town Council employees

The questionnaire was developed in English (see Appendix 1) and then translated into Setswana which is the national language of Botswana (see Appendix 2). This was because

most of the respondents from industrial class though knowing how to read and write, do not understand English. The responses written in Setswana were translated into English by the translator who is a colleague of the researcher.

The questionnaire was divided into five sections: Where appropriate the questionnaire made use of a five point Likert scale. The following outlines the information areas of the questionnaire and the theme each section addressed.

Section A: Demographic information

In this section, the respondents' demographic characteristics were established, i.e. age, gender, marital status, education level and employment category were established. The differentiation was important as respondents may differ in respect of their views towards issues due to their differing demographic characteristics.

Section B: This section intended to establish the reasons why it is important to test for HIV and AIDS, to establish important attributes of a HIV and AIDS VCT service provider, and whether the respondents have tested for HIV and AIDS or not.

Those who established that they had not been tested were to complete Sections C and E, while those who have tested were to complete Sections D and E. The sections are further discussed below.

Section C: This section intended to establish the reasons why the respondents had not tested for HIV and AIDS. Also, to establish which HIV and AIDS VCT service provider they would choose if they were to test and to further find out the reasons for their preference.

Section D: This section intended to establish for those respondents who had tested for HIV and AIDS their feelings and concerns before they were tested, and if their concerns were realized. Also, it intended to establish the respondents' HIV and AIDS VCT service providers of choice, the actual service provider used and the reasons for the choice. In addition, this section intended to find out whether the respondents tested in Lobatse or elsewhere and whether they received pre- and post- test counseling. The level of satisfaction of respondents with the HIV and AIDS service providers was also to be established.

Section E: Open-ended questions

In this section, the researcher intended to find out what the general reasons for people not testing might be, and what could be done to encourage more people to test. According to Babbie (1992), the rationale for this is to get the respondents to think and it also helps as some responses could have been overlooked in structured questions.

3.5.2 Focus groups – Lobatse Town Council Employees

Focus group discussions were used to establish the perceptions of male and female groups of employees on the role of culture in HIV and AIDS VCT. Focus groups, according to De Vos, Strydom, Fouche and Delpont (1998), can be used for three basic reasons, one of which is to supplement other sources of data in studies, especially surveys. The surveys used in this research did not give much detail on cultural issues. Culture, according to Curran and Renzetti (1996), plays an important role in the behaviour of people, and, according to Babbie (1992); Rubin and Babbie (1997); Powers, Meenaghham and Toomey (1985) culture could only be understood through an interactive approach such as focus group discussions.

A question guideline was used by facilitators to direct the discussion (Appendix 3).

The participants from each group were asked to discuss the cultural issues that might prevent the gender group from testing for HIV and AIDS. Secondly the participants were asked to list ways in which people could be encouraged to test for HIV AND AIDS.

3.5.3 Face-to-face interview - Lobatse Service Providers

A semi-structured questionnaire, which is also called a guideline, was prepared (Appendix 4). The guideline was divided into 2 sections, which were as follows:

Section A: Demographic information

In this section, the respondents' occupation, length of service, qualifications, age and gender were to be established.

Section B:

Different questions were to be asked to establish the service providers' objectives on VCT, and what they had achieved, not achieved and reasons for the failures and successes. They were also to be asked to comment and recommend ways that could help improve the VCT services in Lobatse District so as to increase the numbers of people testing.

3.6 Data collection

The following outlines the activities that took place for the collection of data. Prior to the distribution of the questionnaires, a letter requesting permission to carry out the survey in the Lobatse Town Council was sent to the Chief Executive Officer. The letter identified the researcher and the reasons for the research. Furthermore, the letter served to ask for permission to use the council facilities for the group discussions (Appendix 5). A letter from the supervisor was attached, which introduced the researcher and outlined the research objectives

and aims. Included was a letter ensuring confidentiality (Appendixes 6 & 7). Permission was granted to conduct the research (Appendix 8).

3.6.1 Survey questionnaire

The self-administered questionnaire, letter from Chief Executive officer granting permission to researcher and an introductory letter (Appendix 9) were sent to all employees in the Lobatse Town Council through the internal mail. Two questionnaires were sent to all industrial class employees, one was in English and the other was in Setswana. The completed questionnaire was to be put in a box placed outside personnel office.

The questionnaires were sent out on the first day of the Month, July, and respondents were given two weeks to complete the questionnaire. However on the closing date, only 20 completed questionnaires were collected. The closing date was then extended for one more week from the initial closing date. This was done by sending letters to all the employees through the internal mail (Appendix 10). However, the response rate was still low after the second closing date had passed with only five additional questionnaires being collected. The researcher then invited all respondents that had not yet returned the questionnaires on the day of the closing date, for lunch (Appendix 11). This was to lure the employees to complete the questionnaire. Lunch was organised three days after the extended closing date. Invitation letters to all respondents were sent out, inviting them for lunch and all respondents were asked to bring along the questionnaire they had been sent. Lunch was organised in the Lobatse Town Council District premises during lunch break. During this period, the respondents were asked to complete their questionnaires and place the completed questionnaire in the provided sealed box. Thereafter they were served with lunch. This proved to be successful as during that period 364 of the responses were collected.

3.6.2 Focus Groups

The selected participants were telephoned and informed about their selection for the focus groups, and told of the other participants that were selected and what would be required of them. This was to ensure that the selected respondents knew what would transpire during the focus group discussion and who would be present. This gave the prospective participants a chance to decide if they wanted to participate in the discussion and it also gave the researcher a chance to reselect another participant if turned down, so as to ensure that an adequate number would be secured for the discussions. Most importantly, they were informed that this was voluntary and that they could always withdraw from participating in the focus group discussion if they wanted to and that the information collected from the discussion would be kept confidential. Also, they were informed that the discussions would be recorded. They were also informed that further information in a form of a formal invitation letter would be sent to

them. The purpose of the letter was to formally invite the participants to the focus groups discussions informing them of the time and venue of the discussions (Appendix 12). The letter from the Chief Executive Officer granting permission for the research was also attached (Appendix 8). All these steps were done following De Vos et al's (1998) prescription of what information was necessary to prepare the participants for the focus group discussion.

Initially it was intended that the results of the survey would be shared with the participants; however, this was not achieved. At the time the group discussions were held, the responses from the survey were insufficient as only 20 had been collected. The focus group discussion could not be postponed as the researcher had limited time, due to study commitments in South Africa.

Although all participants who were initially selected, confirmed that they were willing to attend the group discussions, and were reminded of the discussion the day before, 10 participants did not attend the discussions. On the day of the discussions, 2 were reported sick, while the other 8 were on "claimed" official trips. The meetings were held after work in the Lobatse Town Council District premises.

The focus discussions were facilitated by a male (researcher's colleague) for the male group and the researcher for the female group. Before the group discussions, the researcher briefed the male and female groups, informing them of the aims and objectives of the research and explaining further their role. The invitation letter was also read to the participants to ensure that they clearly understood why they had been invited. They were further told of the usage of the tape recorder and the voluntary aspect of the participation. The males were further introduced to the male facilitator. A tape recorder was used to record the discussions and the facilitators also took notes during the meetings. Setswana was used during the focus group discussions.

3.6.3 Face-to-face interviews

The selected HIV and AIDS VCT providers were sent an introductory letter explaining to them the reasons for the research (Appendix 13). A confirmation letter from the supervisor was attached to assure them that the study was for academic reasons and the information collected would be kept confidential (Appendix 14). The introductory letter also served as a request for an appointment for the interview, and it requested that a tape recorder will be used if they agreed to be interviewed; if not, the researcher would write down the responses (See Appendix 13).

Due to time constraints the researcher was unable to carry out the interviews with the identified service providers. The dates that the service providers could accommodate researcher were after the researcher had travelled back to South Africa to resume studies. Therefore this section of the research was not completed.

3.7 Data capturing and data analysis

Different methods of data analysis were used to analyse qualitative and quantitative data. The following section briefly discusses the different methods used for the different data collected.

3.7.1 Survey Questionnaire

The data collected was captured and statistics computed in MS Excel. Where appropriate four group characteristics have been used for analysis; gender, employment category, age and marital status. Descriptive statistics included percentages, frequencies, means and standard deviations. T-tests were used to determine the statistical differences based on sample means. The level of statistical significance was set at $\alpha=0.05$ and the level of practical significance was determined using Cohen's d where:-

Intervals	Effect
$0.0 < d < 0.2$	Small
$0.2 < d < 0.8$	Moderate
$d < 0.8$	Large

The qualitative data collected from the open ended questions was coded in order to create data that could be analyzed; the process involves identifying similar responses from the questionnaires then grouping them together. Responses were allocated numbers according to the theme they belonged to. The themes were then analyzed into frequency counts and percentages.

3.7.2 Focus Group Discussions

The recorded focus group discussions for both males and females were transcribed into Setswana and later on translated into English by the translator. Thereafter the researcher followed Tesch's approach as quoted by De Vos et al (1998) and the following took place:-

- The researcher listened to the tape and transcribed all the discussions and, in so doing, was getting a sense of the whole.
- The researcher made use of the Excel spreadsheet to write all the interpretation relevant to the study. Two categories were made for the two research questions that were addressed in these discussions. For each group discussions, a spreadsheet was made. The researcher took one discussion and wrote down the different topics that were raised during the discussion for each category.
- Different themes for each topic were written down; topics that had the same theme were grouped together.
- An employee of the Lobatse Town Council, who specialises in research, was used to validate the data collected by the tape recorder that was transcribed and the coding.

He was asked to follow the same steps taken by the researcher to ensure that the analysis was objective.

- Afterwards, the researcher and the independent researcher met to compare the variables and categories. Where they had differences they went back to the notes and tried to reach a consensus.

3.8 Sources of error

During data collection, sources of error were realized from the following:-

It must be established that most of the respondents completed their questionnaires in the presence of the researcher, i.e. during lunch; this may have influenced the respondent's responses.

The focus groups for both males and females were facilitated by colleagues who may have been younger in age and senior in employment position, to most of the respondents. This might have influenced the respondents' behavior.

The researcher anticipated that HIV and AIDS may still be considered as sensitive amongst the employees and hence instead of sampling the respondents for the survey the questionnaire were sent to all employees. On return the responses were instead sampled and this therefore may not be representative as it would have if the respondents were sampled from the whole population.

The face-to-face interviews with the VCT service providers had to be cancelled due to time constraints. This affects the research as some of the research statements and questions that the researcher aimed to address were not achieved.

The survey questionnaire was sent to all 1008 employees of the Lobatse Town Council, 389 questionnaires were returned and from these the stratified sample of 200 was randomly selected. Although a sample of 200 is an adequate representation statistically, given the nature of HIV and AIDS there is likely to have been some self selection in the decrease from 1008 possible responses to 389 actual responses.

As stated in chapter one the results obtained from the survey are generalisable to the employees of Lobatse Town Council but not to the Lobatse population.

The information collected from the focus group discussions was not generalisable either to the employees of Lobatse Town Council or to any other groups and is merely useful information. Some of the research questions that the researcher, initially planned to address through data collected from the face-to-face interviews with the selected VCT service providers in the district could not be addressed due to the lack of availability of the respondents and the limited time available to complete this project.

Another limitation also mentioned in chapter one is that the questionnaires were translated into Setswana and this may have led to the questionnaire losing what they were intended to

capture. Also, some of the responses made in Setswana from the questionnaire and the focus group discussions were translated into English, through this process important view points may have been lost as some words were difficult to translate. A language expert was engaged to try to minimize both these problems.

3.9 Conclusion

In this study qualitative and quantitative methods were used to collect data for the research from the employees of the Lobatse Town Council. A survey was used to collect quantitative data and qualitative data was collected from the group discussions. Face-to-face interviews that were intended to be held with the HIV and AIDS VCT service providers were unfortunately not held. The data collected from the survey was analysed using descriptive and inferential statistics and the qualitative data was analysed using Tesch's approach to content analysis. In the subsequent chapter detailed information of the findings of the research will be given.

4. Chapter Four: Results and Discussion

4.1 Introduction

This chapter depicts the results that were obtained from the self administered questionnaires and focus group discussions. The chapter is divided into three sections. Section one gives the results of the questionnaires, section two the focus group discussions and section three discusses the results of both the survey questionnaire and the two focus groups in relation to the research questions.

4.2 Results from the survey

The results obtained from the survey are presented according to the format of the questionnaire, starting with the sample profile for the respondents, followed by the results from each section of the questionnaire.

The demographic data given for the sampled population is gender, employment category, age, marital status and education level.

The results are reported for the total sample and where appropriate by group for purposes of comparison.

The employment category that was divided into four sub categories in the questionnaire is combined to form two sub categories for reporting purposes. The management and middle management are combined to form the white collar category since these two sub-categories are very similar and the lower middle management and industrial class employment sub categories are combined to form the blue collar category since these two sub-categories are also similar. However the two employment categories white collar and blue collar are different from each other in that those in the white collar category had more skills, more authority and earned more than those in blue collar category.

The age category that was divided into eight sub-categories in the questionnaire is combined into two sub categories for reporting purposes. Category one is those aged 29 years and under and group two those aged 30 years and above.

The married and cohabitating sub categories were combined to form the married category as in both situations a person would be staying with a partner.

The education level that was divided into four sub-categories in the questionnaire is combined into two for reporting purposes. The educational levels of "no qualification" and "primary qualification" were combined and "secondary" and "tertiary level" was combined. However, for purposes of comparison it was felt that these sub categories were adequately represented by the blue collar employment category which corresponds to the sub category where the respondents either had no formal education or had a primary education and the white collar

employment category which corresponds to the sub category where most respondents had secondary and tertiary qualifications.

In sections B, C and D of the questionnaire the respondents were asked to agree or disagree with statements on a five point Likert index. For interpretation purposes, strongly agree and agree responses were combined for an overall positive response to a statement, and the same approach applies to strongly disagree and disagree responses for an overall negative response to a statement. The average represented the response rate of those that were neutral about the statement. The information is presented in Table form for each section. Descriptive statistics is presented for each item in a section and where appropriate a summated score for all the items of each section are presented in the Table. This information was analysed further to identify if there were gender or employment categories differences for the overall (summated index) and/or individual statements in each section. Due to inadequate sample sizes a Chi-square test could not be conducted to test the significance of the difference between groups either gender groups or employment categories. Instead a t-test was used based on sample mean scores and the results are reported in a Table form. Cronbach's coefficient was used to confirm the reliability of the items.

4.2.1 Demographic information

Table 7- The demographic profile of the sampled population

Demographic Information of sampled population n=200		Frequencies (f)	Percentages %
Gender	Females	120	60.0
	Males	80	40.0
Age	29 and under	43	21.5
	30 and above	156	78.5
Marital status	Married	96	48.0
	Single	104	52.0
Employment categories	White collar	44	22.0
	Blue collar	156	78.0
Educational level	No or primary qualification	23	11.5
	Secondary or tertiary qualification	177	88.5

The gender ratio of 60% females and 40% male and the employment category ratio of 22% white collar and 78% blue collar were determined by the sample selection and are representative of the total population of the employees in the Lobatse Town Council. Within the sample, the majority, 78.5%, were either 30 years or older, 52.0% were single and 88.5% had some formal education.

Table 8 - Females and males within the sample by age, marital status, employment category, and educational level

Demographic Information		Females % (n= 120)	Males% (n= 80)
Age	29 and under	21.7	21.3
	30 and above	78.3	78.8
Marital status	Married	45.8	51.3
	Single	54.2	48.8
Employment category	White collar	25.0	17.5
	Blue collar	75.0	82.5
Educational level	No or primary qualification	10.8	14.7
	Secondary or tertiary qualification	89.2	87.5

The majority of respondents from both the females and males were aged 30 years and older and similarly the majority had formal qualifications. However more females, 54.2%, were single than males, 48.8%.

Table 9 - Employment categories within the sample by gender, age, marital status, and educational level

Demographic Information		White collar % (n= 44)	Blue collar% (n= 156)
Gender	Females	68.2	57.7
	Males	31.8	42.3
Age	29 and under	2.3	22.3
	30 and above	95.5	77.7
Marital status	Married	56.8	45.5
	Single	43.2	54.5
Educational level	No or primary qualification	0.0	14.7
	Secondary or tertiary qualification	100	85.3

The majority of respondents from both employment categories were aged 30 years and above. However, the white collar respondents (95.5%) had more respondents in this age category than blue collar respondents (77.7%). More of the respondents from white collar (56.8%) were married than blue collar respondents (45.5%). Respondents from both categories were educated, 100% of white collar respondents had qualifications, whereas, for blue collar, 85.3% had qualification and 14.7% had no or primary qualification.

4.2.2 Perceived importance of reasons for testing for HIV and AIDS

The respondents were asked to agree or disagree (5 point Likert) with six reasons for testing for HIV and AIDS. This was to establish what level of importance the respondents attached to testing overall and to establish if any particular reason might be more compelling than the rest.

Descriptive statistics for the six items and a summated score for the six items combined are presented in Table 10. Item analysis confirmed the reliability of the summated score with a Cronbach's coefficient alpha of 0.88.

Table 10 - The perceived importance of reasons for testing for HIV and AIDS for the sample

	n=200				
	Low	Average	High	Mean	SD
Get counseled on how to live if not infected	5.5%	3.0%	91.5%	4.40	0.90
Get counseled on how to live if infected	6.0%	2.5%	91.5%	4.34	0.94
Protect your partner from infection	6.5%	5.0%	88.5%	4.34	0.98
Plan for the future	9.0%	4.0%	87.0%	4.16	1.09
Get treatment	16.0%	4.0%	80.0%	4.04	1.36
Live a healthier life	13.0%	10.5%	76.5%	4.00	1.20
Summated score	5.0%	8.0%	87.0%	4.21	0.86

All of the reasons mentioned in Table 10 were perceived as important by the respondents. The three most important were that a person could protect the partner from infection and could get counselled on how to live if infected or not infected by HIV and AIDS and the least important was to live a healthier life. The respondents were asked to state any other reasons that may be important for HIV and AIDS testing; 25% of the respondents, indicated that testing for HIV and AIDS was important as one could avoid re - infection, protect the unborn child, live longer, and thus reduce death rates.

The information in Table 10 was analysed further to identify if there were gender or employment categories differences in the perception of the overall importance of testing or for any of the individual statements. The frequencies are presented in Table 11 for gender and Table 13 for employment categories and the mean, standard deviation and tests of significance in Table 12 for gender and Table 14 for employment categories.

Table 11 - The perceived importance of reasons for testing for HIV and AIDS for the sample by gender

	Females (n=120)			Males (n=80)		
	Low	Average	High	Low	Average	High
Get counseled on how to live if not infected	4.2%	1.7%	94.2%	7.5%	5.0%	87.5%
Get counseled on how to live if infected	3.3%	1.7%	95.0%	10.0%	3.8%	86.3%
Protect your partner from infection	5.0%	4.2%	90.8%	8.8%	6.3%	85.0%
Plan for the future	7.5%	3.3%	89.2%	11.3%	5.0%	83.8%
Get treatment	15.8%	2.5%	81.7%	16.3%	6.3%	77.5%
Live a healthier life	10.8%	10.0%	79.2%	16.3%	11.3%	72.5%
Summated Score	3.0%	7.0%	90.0%	8.0%	10.0%	83.0%

The results are presented in descending order of importance for the male group. All the reasons mentioned in Table 11 were considered important by both females and males however for each reason the females showed a higher level of agreement that the issue was important. Due to inadequate sample size a Chi square test could not be conducted to test the significance of the difference between the gender groups. Instead a t- test was used based on sample mean scores and the results are reported in Table 12.

Table 12 - Tests of significance for the differences between gender groups regarding the reasons for testing for HIV and AIDS perceived as important

	Females (n=120)		Males (n=80)		Significance (bold)
	Mean	SD	Mean	SD	
Get counseled on how to live if not infected	4.48	0.83	4.26	0.99	t(198)=1.70, p=0.090
Get counseled on how to live if infected	4.51	0.80	4.09	1.07	t(198)=3.18, p=0.002, Cohen's d=0.46
Protect your partner from infection	4.45	0.94	4.16	1.01	t(198)=2.05, p=0.041, Cohen's d=0.30
Plan for the future	4.26	1.08	4.01	1.08	t(198)=1.57, p=0.117
Get treatment	4.09	1.38	3.95	1.35	t(198)=0.72, p=0.473,
Live a healthier life	4.11	1.19	3.84	1.22	t(198)=1.57, p=0.119
Summated score	4.32	0.79	4.05	0.94	t(198)= 2.15, p=0.033, Cohen's d= 0.31

From Table 12 above it is apparent that there were significant differences between the gender groups; females were significantly more positive than males with regards to the importance of testing for HIV and AIDS for the statement that one could get counseled on how to live if infected, to protect your partner from infection and the overall importance of testing.

Table 13 - The perceived importance of reasons for testing for HIV and AIDS for the sample by employment category

	White Collar (n=44)			Blue collar (n=156)		
	Low	Average	High	Low	Average	High
Get counseled on how to live if you are infected	2.3%	2.3%	95.5%	7.1%	2.6%	90.4%
Get counseled on how to live if you are not infected	2.3%	2.3%	95.5%	6.4%	3.2%	90.4%
Protect your partner from infection	2.3%	2.3%	95.5%	7.7%	5.8%	86.5%
Plan for the future	2.3%	0.0%	97.7%	10.9%	5.1%	84.0%
Get treatment	13.6%	0.0%	86.4%	16.7%	5.1%	78.2%
Live a healthier life	4.5%	2.3%	93.2%	15.4%	12.8%	71.8%
Summated Score	2.3%	0.0%	97.7%	5.8%	10.3%	84.0%

The results are presented in descending order of importance for the blue collar group. All the reasons mentioned in Table 13 were considered important by both white and blue collar groups however, for each reason the white collar group showed a higher level of agreement

that the issues presented in the Table were important. The three most important reasons given were that one could get counselled on how to live if infected or not infected and also, one could protect your partner from being infected.

Due to inadequate sample size a Chi square test could not be conducted to test the significance of the difference between the employment category groups. Instead a t-test was used based on sample mean scores to test the significance of the difference between the employment category groups and the results are reported in Table 14.

Table 14 - Tests of significance for the differences between employment categories regarding the reasons for testing for HIV and AIDS perceived as important

	White collar (n=44)		Blue collar (n=156)		Significance (bold)
	Mean	SD	Mean	SD	
Get treatment	4.48	0.83	4.26	0.99	t(198)=1.70, p=0.090
Plan for the future	4.51	0.80	4.09	1.07	t(198)=3.18, p=0.002, Cohen's d=0.46
Live a healthier life	4.45	0.94	4.16	1.01	t(198)=2.05, p=0.041, Cohen's d=0.30
Protect your partner from infection	4.26	1.08	4.01	1.08	t(198)=1.57, p=0.117
Get counseled on how to live if you are infected	4.09	1.38	3.95	1.35	t(198)=0.72, p=0.473,
Get counseled on how to live if you are not infected	4.11	1.19	3.84	1.22	t(198)=1.57, p=0.119
Summated score	4.32	0.79	4.05	0.94	t(198)= 2.63, p=0.009, Cohen's d= 0.45

From Table 14 above it is apparent that there were significant differences between the white collar and blue collar groups; white collar respondents were significantly more positive than blue collar with regards to the importance of testing for HIV and AIDS in order to plan for future and living a healthier live and the overall importance of testing.

4.2.3 Important attributes of VCT Service Providers

The respondents were asked to agree or disagree (5 point Likert) with ten important attributes of an HIV and AIDS VCT service provider. This was to establish what the respondents considered as important attributes for an HIV and AIDS VCT service provider, the overall level of importance the respondents attached to the attributes of an HIV and AIDS VCT service provider and to establish if any particular attribute might be more compelling than the rest. Descriptive statistics for the ten items and a summated score for the ten items combined are presented in Table 15. Item analysis confirmed the reliability of the summated score with a Cronbach's coefficient alpha of 0.89.

Table 15- The perceived Importance of attributes of an HIV and AIDS VCT service provider for the sample

	n=200				
	Low	Average	High	Mean	SD
To be made comfortable when counseled	1.5%	4.0%	94.5%	4.50	0.67
Proper counseling services	2.0%	7.0%	91.0%	4.47	0.76
Cleanliness	3.0%	8.0%	89.0%	4.39	0.80
There should be privacy so that no one can tell that I am being tested for HIV	6.1%	5.1%	88.9%	4.37	0.94
Quality equipment	3.0%	9.5%	87.5%	4.35	0.83
Do not have to wait too long for assistance	3.5%	10.5%	86.0%	4.31	0.84
Competent staff	4.0%	10.0%	86.0%	4.27	0.85
To be told results at the same time as the test	3.5%	11.5%	85.0%	4.30	0.83
To get treatment if found HIV+	10.5%	5.0%	84.5%	4.21	1.12
The staff would treat information as confidential	9.0%	11.5%	79.5%	4.18	1.06
Summated score	1.0%	5.5%	93.5%	4.33	0.63

All of the attributes mentioned in Table 15 were perceived as important by the respondents. The two most important attributes were to be made comfortable when counselled and proper counselling services. The least important attribute was that the staff would treat information as confidential. There was an open ended question that required the respondents to add any other attribute of a service provider that they perceived important and that was not included in the list, however, the respondents did not make any additional comments.

This information was analysed further to identify if there was a gender and employment category difference in the perception of the overall importance of the attributes of an HIV and AIDS service provider or for any of the individual statements. The frequencies are presented in Table 16 for gender and Table 18 for employment categories and the mean, standard deviation and tests of significance in Table 17 for gender and Table 19 for the employment categories.

Table 16- The perceived importance of the attributes of an HIV and AIDS VCT service provider for the sample by gender

	Females (n=120)			Males (n=80)		
	Low	Average	High	Low	Average	High
To be made comfortable when counseled	0.0%	3.3%	96.7%	3.8%	5.0%	91.3%
There should be privacy so that no one can tell that I am being tested for HIV	5.0%	5.9%	89.1%	7.6%	3.8%	88.6%
Cleanliness	2.5%	6.7%	90.8%	3.8%	10.0%	86.3%
Proper counseling services	0.0%	5.8%	94.2%	5.0%	8.8%	86.3%
Competent staff	2.5%	10.8%	86.7%	6.3%	8.8%	85.0%
Do not have to wait too long for assistance	2.5%	8.3%	89.2%	5.0%	13.8%	81.3%
Quality equipment	0.8%	7.5%	91.7%	6.3%	12.5%	81.3%
To get treatment if found HIV+	10.0%	3.3%	86.7%	11.3%	7.5%	81.3%
To be told results at the same time as the test	3.3%	8.3%	88.3%	3.8%	16.3%	80.0%
The staff would treat information as confidential	8.3%	10.8%	80.8%	10.0%	12.5%	77.5%
Summated score	0.0%	2.5%	97.5%	2.5%	10.0%	87.5%

The results in Table 16 are presented in descending order of importance for the male group.

From Table 16 above it is noticeable that all of the attributes presented in the Table were

considered important by both males and females. However, for each attribute the females were more positive than the males about the importance of the attributes for HIV and AIDS VCT service provider, there are also differences in the ranking of what males see as important and what females see as important.

Due to inadequate sample size a Chi square test could not be conducted to test the significance of the difference between the employment category groups. Instead a t-test was used based on sample mean scores to test the significance of the differences between the gender groups and the results are reported in Table 17 below.

Table 17- Tests of significance for the differences between gender groups regarding the importance of the attributes of HIV and AIDS VCT service provider

	Females (n=120)		Males (n=80)		Significance (bold)
	Mean	SD	Mean	SD	
Cleanliness	4.46	0.77	4.29	0.84	t(198)=1.48, p=0.140
Proper counseling services	4.56	0.61	4.33	0.92	t(198)=2.16, p=0.032, Cohen's d=0.31
Do not have to wait too long for assistance	4.42	0.75	4.15	0.93	t(198)=2.23, p=0.027, Cohen's d=0.32
The staff would treat information as confidential	4.29	1.02	4.00	1.11	t(198)=1.91, p=0.57
Competent staff	4.34	0.80	4.16	0.92	t(198)=1.46, p=0.147
Quality equipment	4.49	0.71	4.14	0.95	t(198)=3.01, p=0.003, Cohen's d=0.43
To get treatment if found HIV+	4.28	1.13	4.09	1.10	t(198)=1.21, p=0.228
To be told results at the same time as the test	4.40	0.78	4.15	0.87	t(198)=2.11, p=0.036, Cohen's d=0.31
To be made comfortable when counseled	4.62	0.55	4.33	0.79	t(198)=3.07, p=0.002, Cohen's d=0.44
There should be privacy so that no one can tell that I am being tested for HIV	4.43	0.91	4.28	0.99	t(196)=1.10, p=0.272
Summated score	4.43	0.53	4.19	0.75	t(198)=2.66 p=0.008, Cohen's d=0.38

From Table 17 above it is apparent that there were significant differences between the gender groups. The females were significantly more positive than the males about the following attributes of an VCT HIV and AIDS service provider; proper counseling services, not having to wait too long for assistance, quality equipment, being told results at the same time as the test and being made comfortable when counseled and in the overall importance of the listed attributes.

Table 18 - The perceived importance of the attributes of an HIV and AIDS VCT service provider for the sample by employment category

	White collar (n=44)			Blue collar (n=156)		
	Low	Average	High	Low	Average	High
To be made comfortable when counseled	2.3%	2.3%	95.5%	1.3%	4.5%	94.2%
Proper counseling services	2.3%	2.3%	95.5%	1.9%	8.3%	89.7%
Cleanliness	2.3%	4.5%	93.2%	3.2%	9.0%	87.8%
There should be privacy so that no one can tell that I am being tested for HIV	6.8%	0.0%	93.2%	5.8%	6.5%	87.7%
Quality equipment	2.3%	4.5%	93.2%	3.2%	10.9%	85.9%
To get treatment if found HIV+	13.6%	6.8%	79.5%	9.6%	4.5%	85.9%
Competent staff	9.1%	2.3%	88.6%	2.6%	12.2%	85.3%
To be told results at the same time as the test	4.5%	11.4%	84.1%	3.2%	11.5%	85.3%
Do not have to wait too long for assistance	4.5%	4.5%	90.9%	3.2%	12.2%	84.6%
The staff would treat information as confidential	11.4%	9.1%	79.5%	8.3%	12.2%	79.5%
Summated score	2.3%	2.3%	95.5%	0.6%	6.4%	92.9%

The results in Table 18 are represented in descending order of importance of the blue collar group. The respondents from both the employment categories considered all the attributes as being important and the most important for both groups was to be made comfortable when counselled and proper counselling services, the least important was that the staff would treat the information as confidential. Due to inadequate sample size a Chi square test could not be conducted to test the significance of the difference between the employment category groups. Instead a t-test was used based on sample mean scores to test the significance of the differences between the employment category groups and the results are reported in Table 19.

Table 19 - Tests of significance for the differences between employment categories regarding the importance of attributes of an HIV and AIDS VCT service provider

	White collar (n=44)		Blue collar (n=156)		Significance (bold)
	Mean	SD	Mean	SD	
Cleanliness	4.55	0.79	4.35	0.80	t(198)=1.46, p=0.145
Proper counseling services	4.57	0.76	4.44	0.76	t(198)=1.03, p=0.307
Do not have to wait too long for assistance	4.41	0.95	4.28	0.80	t(198)=0.89, p=0.374
The staff would treat information as confidential	4.18	1.15	4.17	1.04	t(198)=0.05, p=0.962
Competent staff	4.27	0.97	4.27	0.82	t(198)=0.02, p=0.981
Quality equipment	4.45	0.79	4.32	0.84	t(198)=0.94, p=0.346
To get treatment if found HIV+	4.09	1.33	4.24	1.06	t(198)=- 0.76, p=0.446
To be told results at the same time as the test	4.34	0.94	4.29	0.80	t(198)=0.37, p=0.711
To be made comfortable when counseled	4.50	0.76	4.50	0.65	t(198)=0.00, p=1.000
There should be privacy so that no one can tell that I am being tested for HIV	4.52	0.98	4.32	0.93	t(196)=1.23, p=0.219
Summated score	4.39	0.73	4.32	0.61	t(198)= 0.66, p=0.507

There are no significant differences between the two employment categories as shown in Table 19 above, with regards to the perceived importance of the attributes of an HIV and AIDS service provider

4.2.4 HIV Testing

The respondents were asked to indicate if they have tested for HIV and AIDS or not, if they have tested they selected Yes and if not they chose the No response. Tables 20 and 21 below show the results for the sample and by demographic characteristic.

Table 20- The participation rate of respondents who have tested for HIV and AIDS overall and by gender and employment categories

Have you tested for HIV and AIDS	Overall % (n= 200)	Gender		Employment Categories	
		Females % (n=120)	Males% (n=80)	White collar% (n=44)	Blue collar% (n= 156)
Yes	65.5%	71.7%	56.3%	81.8%	60.9%
No	34.5%	28.3%	43.8%	18.2%	39.1%

From Table 20 above, the majority of respondents have tested for HIV and AIDS (65.5%). In the gender and employment categories more females, that is 71, 7% have tested whereas only 56.3% of males have tested and 81.8% of the white collar employees have tested compared with 60.9% of the blue collar employees.

Table 21- The participation rate of respondents who have tested for HIV and AIDS overall and by age and marital status

Have you tested for HIV and AIDS	Overall % (n= 200)	Age		Marital Status	
		29 and under% (n=43)	30 and above% (n=157)	Single% (n=104)	Married% (n=96)
Yes	65.5%	58.1%	67.5%	63.5%	67.7%
No	34.5%	41.9%	32.5%	36.5%	32.3%

From Table 21 above more respondents from the 30 and above age group, 67.5%, than the 29 and under, 58.1%, had tested for HIV and AIDS and more married respondents, 67.7%, had tested than the single respondents, 63.5%.

4.2.4.1 Reasons given for not testing for HIV and AIDS

The respondents who had not tested for HIV and AIDS were asked to complete Section C of the questionnaire and to agree or disagree (5 point Likert) with ten possible reasons for not testing for HIV and AIDS. This was to establish the respondents overall response to the possible reasons and to establish if any particular reason might be more compelling than the rest. Descriptive statistics for the ten items and a summated score for the ten items combined are presented in Table 22. Item analysis confirmed the reliability of the summated score with a Cronbach's coefficient alpha of 0.91.

Table 22 – Reasons for not testing for HIV and AIDS by respondents who did not test for HIV and AIDS

	(n=69)				
	Low	Average	High	Mean	SD
I am scared the results will not be kept confidential	36.2%	10.1%	53.6%	3.26	1.53
I do not need to undergo VCT testing	40.6%	7.2%	52.2%	3.23	1.63
I am scared of discrimination	37.7%	11.6%	50.7%	3.19	1.59
I am scared of being stigmatized	40.6%	8.7%	50.7%	3.14	1.62
I am scared of knowing my status	43.5%	13.0%	43.5%	2.99	1.61
I am scared that my family and friends will reject me	50.7%	5.8%	43.5%	2.78	1.61
I am scared of dying	47.8%	10.1%	42.0%	2.87	1.62
I am scared my partner will reject me	40.6%	17.4%	42.0%	2.97	1.48
I am scared that my job will be threatened	52.2%	7.2%	40.6%	2.78	1.62
I am not aware of any VCT centers	72.7%	6.1%	21.2%	2.15	1.44
Summated score	42.0%	23.2%	34.8%	2.94	1.15

The results in Table 22 are presented in a descending order. Table 22, above shows that the majority of the respondents that did not test for HIV and AIDS were aware of the HIV and AIDS VCT service providers (72.7%). There is low level of agreement among respondents with the statements in Table 22. The highest scores were found for two reasons; one that said that the reason for not testing for HIV and AIDS was that the respondents that did not need to test for HIV and AIDS (52.2%) and the second that the respondents were scared that their results will not be kept confidential (53.6%). Half of the respondents (50.7%) indicated that they were scared of stigmatisation and discrimination. The least important reason why the respondent did not test for HIV and AIDS was that they were not aware of any VCT centres (21.2%). Overall, only 34.8% of the respondents felt that the possible reasons given were important considerations for not testing and 42.0% felt that they were not. However, the respondents did not give any other reasons in the section that they were asked to indicate if they had any additional reasons for not testing for HIV and AIDS.

This information was analysed further to identify if there were gender and employment category differences in the perception of the overall reasons for not testing for HIV and AIDS or for any of the individual statements. The frequencies are presented in Table 23 for gender and Table 25 for employment categories and the mean, standard deviation and tests of significance in Table 24 for gender and Table 26 for the employment categories.

Table 23 - Reasons for not testing for HIV and AIDS by respondents that did not test by gender

	Females (n= 34)			Males (n= 35)		
	Low	Average	High	Low	Average	High
I am scared the results will not be kept confidential	58.8%	8.8%	32.4%	14.3%	11.4%	74.3%
I am scared of being stigmatized	67.6%	2.9%	29.4%	14.3%	14.3%	71.4%
I am scared of discrimination	61.8%	5.9%	32.4%	14.3%	17.1%	68.6%
I am scared of knowing my status	67.6%	8.8%	23.5%	20.0%	17.1%	62.9%
I am scared that my job will be threatened	76.5%	5.9%	17.6%	28.6%	8.6%	62.9%
I am scared my partner will reject me	64.7%	11.8%	23.5%	17.1%	22.9%	60.0%
I am scared that my family and friends will reject me	73.5%	0.0%	26.5%	28.6%	11.4%	60.0%
I do not need to undergo VCT testing	47.1%	5.9%	47.1%	34.3%	8.6%	57.1%
I am scared of dying	70.6%	2.9%	26.5%	25.7%	17.1%	57.1%
I am not aware of any VCT centers	83.9%	3.2%	12.9%	62.9%	8.6%	28.6%
Summated score	67.6%	17.6%	14.7%	17.1%	28.6%	54.3%

The results in Table 23 are represented in descending order of importance of the male group. The results from Table 23 show that the females were in disagreement with most of the statements than the males regarding reasons for not testing. The males who were mostly in agreement with the statements and their most important reason for not testing was that they were scared that their results will not be kept confidential (74.3%) and were also scared of stigmatization (71.4%) and discrimination (68.6%). For females the most important reason for not testing was that they did not need to undergo an HIV and AIDS VCT test (47.1%). There was no other additional information given on the reasons for not testing.

Due to inadequate sample size a chi -square test could not be conducted to test the significance of the difference between gender groups. Instead a t- test was used based on sample mean scores and the results are reported in Table 24.

Table 24 - Tests of significance for the differences between gender groups regarding the reasons for not testing for HIV and AIDS by the respondents that did not test

	Females (n=34)		Males (n=35)		Significance (bold)
	Mean	SD	Mean	SD	
I do not need to undergo VCT testing	3.03	1.75	3.43	1.50	t(67)=- 1.02, p=0.312
I am scared of knowing my status	2.24	1.44	3.71	1.45	t(67)=-4.26, p=0.000, Cohen's d=-1.03
I am scared of discrimination	2.47	1.58	3.89	1.28	t(67)=-4.09, p=0.000, Cohen's d=-0.99
I am scared of being stigmatized	2.35	1.57	3.91	1.27	t(67)=-4.54, p=0.000, Cohen's d=-1.09
I am scared the results will not be kept confidential	2.59	1.58	3.91	1.17	t(67)=-3.97, p=0.000, Cohen's d=-0.96
I am scared of dying	2.21	1.47	3.51	1.50	t(67)=-3.65, p=0.001, Cohen's d=-0.88
I am scared my partner will reject me	2.29	1.43	3.63	1.24	t(67)=-4.15, p=0.000, Cohen's d=-1.00
I am scared that my family and friends will reject me	2.09	1.50	3.46	1.42	t(67)=-3.89, p=0.000, Cohen's d=-0.94
I am scared that my job will be threatened	2.00	1.33	3.54	1.52	t(67)=-4.49, p=0.000, Cohen's d=-1.08
I am not aware of any VCT centers	1.74	1.21	2.51	1.54	t(64)=-2.24, p=0.028, Cohen's d=-0.55
Summated score	2.31	0.98	3.55	0.96	t(67)=-5.30, p=0.000, Cohen's d=-1.28

From the Table 24 above, there were significant differences between females and males with regard to agreement with the reasons why they did not want to test for HIV and AIDS. More males than females agreed with the suggested reasons for not testing, except for the reason that they did not need to go for HIV and AIDS testing.

Table 25- Reasons for not testing for HIV and AIDS by respondents that did not test by employment category

	White collar (n=8)			Blue collar n= 61		
	Low	Average	High	Low	Average	High
I am scared the results will not be kept confidential	50.0%	12.5%	37.5%	34.4%	9.8%	55.7%
I do not need to undergo VCT testing	50.0%	0.0%	50.0%	39.3%	8.2%	52.5%
I am scared of discrimination	50.0%	12.5%	37.5%	36.1%	11.5%	52.5%
I am scared of being stigmatized	50.0%	12.5%	37.5%	39.3%	8.2%	52.5%
I am scared of knowing my status	50.0%	25.0%	25.0%	42.6%	11.5%	45.9%
I am scared that my family and friends will reject me	75.0%	0.0%	25.0%	47.5%	6.6%	45.9%
I am scared my partner will reject me	50.0%	25.0%	25.0%	39.3%	16.4%	44.3%
I am scared that my job will be threatened	75.0%	12.5%	12.5%	49.2%	6.6%	44.3%
I am scared of dying	50.0%	0.0%	50.0%	47.5%	11.5%	41.0%
I am not aware of any VCT centers	87.5%	12.5%	0.0%	70.7%	5.2%	24.1%
Summated score	62.5%	25.0%	12.5%	39.3%	23.0%	37.7%

The results for Table 25 are represented in descending order of importance for the blue collar group. From Table 25, respondents from both the employment categories were aware of the VCT centres. However there were more respondents from the white collar (87.5%) than blue collar (70.7%) who were aware of the service. In every instance, except for the statement “I am scared of dying” more blue collar respondents agreed with the statements than the respondents from the white collar employees. The majority of the blue collar respondents showed that they did not want to test for HIV and AIDS as they were scared their results would not be kept confidential, they did not need to go for testing, were scared of stigmatisation and discrimination. For the white collar respondents the important reasons for not testing were because they were scared of dying (50.0%) and also, they thought they did not need to go for testing (50.0%).

Due to inadequate sample size a chi -square test could not be conducted to test the significance of the difference between the employment categories. Instead a t- test was used based on sample mean scores and are reported in Table 26.

Table 26 - Tests of significance for the differences between employment categories regarding the reasons for not testing for HIV and AIDS by respondents that did not test

	White collar (n=8)		Blue collar (n=61)		Significance (bold)
	Mean	SD	Mean	SD	
I do not need to undergo VCT testing	2.75	1.91	3.30	3.05	t(67)=-0.89, p=0.312
I am scared of knowing my status	2.50	1.51	3.05	1.63	t(67)=-0.90, p=0.369
I am scared of discrimination	2.88	1.64	3.23	3.05	t(67)=-0.59, p=0.558
I am scared of being stigmatized	2.88	1.64	3.18	1.63	t(67)=-0.50, p=0.620
I am scared the results will not be kept confidential	2.88	1.64	3.31	3.05	t(67)=-0.76, p=0.452
I am scared of dying	2.88	1.81	2.87	1.63	t(67)=-0.01, p=0.992
I am scared my partner will reject me	2.38	1.30	3.05	3.05	t(67)=-1.21, p=0.230
I am scared that my family and friends will reject me	1.88	1.36	2.90	1.63	t(67)=-1.72, p=0.090
I am scared that my job will be threatened	1.88	1.13	2.90	3.05	t(67)=-1.71, p=0.091
I am not aware of any VCT centers	1.63	0.74	2.22	1.63	t(64)=-1.11, p=0.273
Summated score	2.45	0.88	3.01	1.17	t(67)= -1.29, p=0.200

However although Table 25 shows that there are differences between the employment categories, the differences are not statistically significant as indicated in Table 26 above.

4.2.5 Preferred HIV and AIDS VCT service provider for respondents that have not tested for HIV and AIDS

The section below shows which would be the preferred HIV and AIDS VCT service provider for those respondents who had not tested for HIV and AIDS. This section gives the overall information and for the various groups. In addition the reasons for choosing the service provider are also given. The various types of HIV and AIDS VCT service providers were listed in the questionnaire and the respondents chose which service provider they preferred. The results are shown in Table 27 for gender and employment categories and Table 28 for age and marital status groups. The respondents that did not test for HIV and AIDS were further asked further to indicate the reasons for preferring that service provide and these results are shown in Table 29 below.

Table 27 - Preferred service providers overall by gender and employment categories for those respondents that have not tested for HIV and AIDS

Service Provider	Overall % n=69	Gender		Employment Category	
		Females % n=34	Males% n=35	White collar% n=8	Blue collar % n= 61
Private Practitioner	34.8	41.2	28.6	37.5	33.3

Tebelopele	50.7	47.1	54.3	62.5	50.0
Clinic	8.7	5.9	11.4	0.0	10.0
Hospital	5.8	5.9	5.7	0.0	6.7

Table 28 - Preferred service providers overall and by age and marital status groups for those respondents that have not tested for HIV and AIDS

Service Provider	Overall % n=69	Age		Marital status	
		29 and under % n=18	30 and above % n=51	Single % n=38	Married% n=31
Private Practitioner	34.8	27.8	36.0	27.0	41.9
Tebelopele	50.7	50.0	52.0	51.4	51.6
Clinic	8.7	11.1	8.0	13.5	3.2
Hospital	5.8	11.1	4.0	8.1	3.2

From Table 27 and Table 28 the majority (50.7%) of respondents that did not test for HIV and AIDS preferred HIV and AIDS VCT service provider Tebelopele, regardless of gender, employment category, age and marital status.

Table 29- Reasons for preferring service providers by respondents who have not tested for HIV and AIDS

	Overall % n=69	Gender		Employment Category	
		Females % n=34	Males % n=35	White collar % n=8	Blue collar% N= 61
There is confidentiality	42.0	47.1	37.1	75.0	26.2
You get results faster	23.2	29.4	17.1	0.0	26.2
Closer to where I live	14.5	5.9	22.9	12.5	14.8
It is Free	11.6	11.8	11.4	12.5	11.5
No body could tell that I will be going for an HIV test	8.7	8.8	8.6	0.0	9.8
There is quality staff	4.3	2.9	5.7	0.0	4.9
I will be made Comfortable when Counseled	2.9	2.9	2.9	0.0	3.3

From Table 29 above, overall confidentiality was the most important attribute that motivated respondents to choose a service provider and was the most important attribute for females, male and white collar respondents. However, for blue collar respondents the speed of the results was important.

4.2.6 Sentiments held before testing by respondents that have tested for HIV and AIDS

The respondents were asked to agree or disagree (5 point Likert) with nine sentiments they may have before they went for testing for HIV and AIDS. This was to establish the overall level of concern that they had before testing and to establish if any particular concerns might be more compelling than the rest. Descriptive statistics for the nine items and a summated score

for the nine items combined are presented in Table 30. Item analysis confirmed the reliability of the summated score with a Cronbach's coefficient alpha of 0.92.

Table 30 - Sentiments before testing by respondents that have tested for HIV and AIDS

	(n=131)				
	Low	Average	High	Mean	SD
I needed to undergo VCT testing	9.9%	6.9%	83.2%	4.12	1.12
I was scared of knowing my status	18.3%	12.2%	69.5%	3.78	1.26
I was scared of being stigmatized	19.8%	12.2%	67.9%	3.75	1.26
I was scared of discrimination	23.7%	10.7%	65.6%	3.68	1.31
I was scared the results would not be kept confidential	22.9%	13.7%	63.4%	3.57	1.34
I was scared my partner would reject me	24.4%	12.2%	63.4%	3.61	1.42
I was scared that my family and friends would reject me	30.5%	6.9%	62.6%	3.50	1.48
I was scared that my job would be threatened	31.3%	6.1%	62.6%	3.47	1.51
I was scared of dying	27.5%	11.5%	61.1%	3.53	1.43
Summated score	19.1%	16.8%	64.1%	3.67	1.06

There was a high level of agreement by the respondents that they had experienced all the concerns mentioned in Table 30 above before they went for testing for HIV and AIDS. The most important concern was that most respondents that tested for HIV and AIDS thought they needed to test, (83.2%) and the least important concern was that they were scared of dying (61.1%). The respondents were asked to add any additional concerns regarding testing which they considered important but the respondents did not add any other concerns.

This information was analysed further to identify if there were gender and employment category differences in the perception of the overall sentiments which the respondents that tested for HIV and AIDS had before testing for HIV and AIDS or for any of the individual statements. The frequencies are presented in Table 31 for gender and Table 33 for employment categories and the mean, standard deviation and tests of significance in Table 32 for gender and Table 34 for the employment categories.

Table 31 - Sentiments before testing by respondents that have tested for HIV and AIDS by gender groups

	Females (n= 86)			Males (n=45)		
	Low	Average	High	Low	Average	High
I needed to undergo VCT testing	20.9%	16.3%	62.8%	4.4%	4.4%	91.1%
I was scared of knowing my status	24.4%	11.6%	64.0%	13.3%	4.4%	82.2%
I was scared of being stigmatized	29.1%	11.6%	59.3%	11.1%	8.9%	80.0%
I was scared of dying	26.7%	15.1%	58.1%	17.8%	6.7%	75.6%
I was scared my partner would reject me	36.0%	7.0%	57.0%	20.0%	6.7%	73.3%
I was scared that my family & friends would reject me	34.9%	7.0%	58.1%	20.0%	6.7%	73.3%

I was scared the results would not be kept confidential	32.6%	14.0%	53.5%	11.1%	17.8%	71.1%
I was scared that my job would be threatened	20.9%	16.3%	62.8%	24.4%	4.4%	71.1%
I was scared of discrimination	24.4%	14.0%	61.6%	22.2%	8.9%	68.9%
Summated score	20.9%	22.1%	57.0%	15.6%	6.7%	77.8%

The results for Table 31 are presented in descending order of importance for the male group. From Table 31 above, there is a difference between the females and males in regards to the sentiments they had before they tested for HIV and AIDS. Before testing males were more concerned than females for all the possible concerns listed. The most important was that they thought they needed to undergo testing for HIV and AIDS (91.1%). Due to inadequate sample size a chi -square test could not be conducted to test the significance of the difference between the employment categories. Instead a t- test was used based on sample mean scores and are reported in Table 32 below.

Table 32 - Tests of significance for the differences between gender groups regarding the sentiments before testing for HIV and AIDS by respondents that have tested for HIV and AIDS

	Females (n=86)		Males (n=45)		Significance (bold)
	Mean	SD	Mean	SD	
I needed to undergo VCT testing	4.03	1.27	4.29	0.76	t(129)=-1.23, p=0.220
I was scared of knowing my status	3.69	1.35	3.96	1.07	t(129)=-1.16, p=0.247
I was scared of discrimination	3.70	1.37	3.64	1.21	t(129)=0.22, p=0.827
I was scared of being stigmatized	3.66	1.37	3.91	1.02	t(129)=-1.07, p=0.286
I was scared the results would not be kept confidential	3.49	1.46	3.73	1.05	t(129)=-1.00, p=0.321
I was scared of dying	3.40	1.53	3.80	1.18	t(129)=-1.55, p=0.124
I was scared my partner would reject me	3.56	1.46	3.71	1.34	t(129)=-0.59, p=0.559
I was scared that my family and friends would reject me	3.37	1.56	3.73	1.30	t(129)=-1.33, p=0.186
I was scared that my job would be threatened	3.37	1.58	3.67	1.35	t(129)=-1.06, p=0.289
Summated score	3.59	1.10	3.83	0.96	t(129)=-1.25, p=0.214

Table 32 above indicates that there were no significant differences between the males and females in regards to the sentiments that they may had before they tested for HIV and AIDS.

Table 33 - Sentiments before testing for HIV and AIDS of respondents that have tested for HIV and AIDS by employment categories

	White collar (n= 36)			Blue collar (n=95)		
	Low	Average	High	Low	Average	High
I needed to undergo VCT testing	8.3%	13.9%	77.8%	10.5%	4.2%	85.3%
I was scared of knowing my status	11.1%	11.1%	77.8%	21.1%	12.6%	66.3%
I was scared of being stigmatized	13.9%	11.1%	75.0%	22.1%	12.6%	65.3%
I was scared of discrimination	13.9%	8.3%	77.8%	27.4%	11.6%	61.1%
I was scared the results would not be kept confidential	22.2%	5.6%	72.2%	23.2%	16.8%	60.0%
I was scared that my family and friends would reject me	25.0%	5.6%	69.4%	32.6%	7.4%	60.0%

I was scared my partner would reject me	16.7%	8.3%	75.0%	27.4%	13.7%	58.9%
I was scared that my job would be threatened	25.0%	2.8%	72.2%	33.7%	7.4%	58.9%
I was scared of dying	16.7%	13.9%	69.4%	31.6%	10.5%	57.9%
Summated score	11.1%	13.9%	75.0%	22.1%	17.9%	60.0%

The results for Table 33 above are represented in descending order of importance for the blue collar group. From Table 33 above, both employment categories had high level of agreement that they needed to go for testing, however more respondents from blue collar employees thought so. On every other concern there was a higher level of agreement from the white collar employees than the blue collar employees. More respondents from white collar were scared of knowing their status than those in the blue collar. Also, important concerns among white collar employees were that they were scared of discrimination and stigmatisation.

Due to inadequate sample size a chi -square test could not be conducted to test the significance of the difference between the employment categories. Instead a t- test was used based on sample mean scores and are reported in Table 34 below.

Table 34 - Tests of significance for the differences between employment categories regarding the sentiments before testing for HIV and AIDS by respondents that have tested for HIV and AIDS

	White collar (n= 36)		Blue collar (n=95)		Significance (bold)
	Mean	SD	Mean	SD	
I needed to undergo VCT testing	4.22	1.07	4.08	1.15	t(128)=0.65, p=0.519
I was scared of knowing my status	4.19	1.04	3.62	1.31	t(128)=2.05, p=0.020, Cohen's d=0.47
I was scared of discrimination	4.14	1.15	3.51	1.34	t(128)=3.18, p=0.014, Cohen's d=0.49
I was scared of being stigmatized	4.08	1.16	3.62	1.28	t(128)=2.05, p=0.063
I was scared the results would not be kept confidential	3.83	1.34	3.47	1.33	t(128)=3.18, p=0.182
I was scared of dying	4.00	1.29	3.36	1.44	t(128)=2.05, p=0.023, Cohen's d=0.46
I was scared my partner would reject me	4.03	1.18	3.45	1.47	t(128)=3.18, p=0.040, Cohen's d=0.41
I was scared that my family and friends would reject me	3.83	1.46	3.37	1.47	t(128)=2.05, p=0.117
I was scared that my job would be threatened	3.86	1.46	3.33	1.50	t(128)=3.18, p=0.075
Summated score	4.02	1.00	3.53	1.05	t(128)= 2.37, p=0.019, Cohen's d= 0.47

There are significant differences between the white collar and blue collar respondents regarding the sentiments they had before they tested for HIV and AIDS as indicated in Table 34 above. More white collar employees than blue collar employees were concerned of knowing their status, were scared of discrimination, of dying, and of rejection by their partner and overall the white collar seemed more concerned than the blue collar employees.

Table 35 and Table 36 show whether the sentiments that the respondents that tested for HIV and AIDS had before testing were realised or not.

Table 35 - Respondents indicating pre HIV test concerns realised by gender and employment category

Were concerns Realised.	Overall % n= 131	Gender		Employment categories	
		Females % n=86	Males % N=45	White collar % n=36	Blue collar % n= 95
Yes	13.7	7.0	26.7	13.9	13.7
No	86.3	93.0	73.3	86.1	86.3

Table 36- Respondents indicating pre HIV test concerns realised by age and marital status

Were concerns Realised.	Overall % n= 131	Age		Marital status	
		29 and under % n=25	30 and above % n=106	Single % n=66	Married% n=65
Yes	13.7	12.0	14.2	10.6	16.9
No	86.3	88.0	85.8	89.4	83.11

The concerns that the respondents had before testing, overall and regardless of gender, employment category, age or marital status were not realised for most of the respondents who tested for HIV and AIDS.

Table 37 - Realised concerns by respondents that have tested for HIV and AIDS

Realised concerns	Overall % n= 18	Gender		Employment category	
		Females % n=6	Males % n=12	White collar % n=5	Blue collar% n= 13
Partner rejected me	3.1	3.5	2.2	8.3	1.1
I was mistreated at work	11.4	15.1	4.4	16.7	9.5
My family rejected me	2.3	2.3	2.2	2.8	2.1

The most common concern amongst the eighteen respondents that indicated the concerns they had were realised, was that the respondents were mistreated at work. This was experienced to a greater extent by females than males and by white collar than the blue collar respondents.

4.2.7 Preferred HIV and AIDS VCT service provider by the respondents that have tested for HIV and AIDS

Table 38 and Table 39 below show the HIV and AIDS VCT service providers preferred by the respondents that have tested for HIV and AIDS by gender, employment category, age and marital status and Table 40 and Table 41 show the actual HIV and AIDS service providers that were used for testing by the respondents that have tested for HIV and AIDS by gender,

employment category, age and marital status. The reasons for choosing an HIV and AIDS VCT service provider are reported in Table 42.

Table 38 - Preferred HIV and AIDS service providers by respondents that have tested for HIV and AIDS by gender and employment category

Preferred Service Provider	Overall % n= 131	Gender		Employment categories	
		Females % n=86	Males % n=45	White collar % n=36	Blue collar % n= 95
Private Practitioner	29.0	27.9	31.1	58.3	17.9
Tebelopele	45.0	41.9	51.1	30.6	50.5
Clinic	14.5	17.4	8.9	5.6	17.9
Hospital	11.5	12.8	8.9	5.6	13.7

Table 39 - Preferred HIV and AIDS service providers by respondents that have tested for HIV and AIDS by age and marital status groups

Preferred Service Provider	Overall % n= 131	Age		Marital status	
		29 and under % n=25	30 and above % n=106	Single% n=66	Married% n=65
Private Practitioner	29.0	8.0	34.0	24.2	33.8
Tebelopele	45.0	72.0	38.7	48.5	41.5
Clinic	14.5	12.0	15.1	15.2	13.8
Hospital	11.5	8.0	12.3	12.1	10.8

The respondents that have tested for HIV and AIDS indicated that the service provider of choice was Tebelopele. This was the common preference amongst females, males, both age groups and both married and unmarried and the blue collar respondents. The white collar respondents would have preferred private practitioners. Private practitioners were the second choice of service providers the overall respondents looking, across the group breakdown for females, males, the over 30s, singles and married. However, for white collar employees Tebelopele was second choice; the blue collar respondents could have chosen a clinic or private practitioner and the 29 years old and under would have preferred the clinic over and above a private practitioner.

Table 40 - The HIV and AIDS VCT service providers used by respondents that have tested for HIV and AIDS by gender and employment category

Chosen Service Provider	Overall % n= 131	Gender		Employment Categories	
		Females % n=86	Males % N=45	White collar % n=36	Blue collar% n= 95
Private Practitioner	20.6	19.8	22.2	38.9	13.7
Tebelopele	51.9	50.0	55.6	47.2	53.7
Clinic	14.5	17.4	8.9	8.3	16.8
Hospital	13.0	12.8	13.3	5.6	15.8

Table 41 - The HIV and AIDS VCT service providers used by respondents that have tested for HIV and AIDS by age and marital status.

Chosen Service Provider	Overall % n= 131	Age		Marital Status	
		29 and under % n=25	30 and above 29 % n=106	Single % n=66	Married% n=65
Private Practitioner	20.6	12.0	22.6	19.7	21.5
Tebelopele	51.9	72.0	47.2	53.0	50.8
Clinic	14.5	8.0	16.0	13.6	15.4
Hospital	13.0	8.0	14.2	13.6	12.3

The actual HIV and AIDS VCT service provider that was used by the majority of respondents that tested for HIV and AIDS was Tebelopele. Overall this was greater than the numbers that would have chosen Tebelopele and this was evident for each of the groups except for the 29 year olds and under where the same (72.0%) used Tebelopele as indicated this as their preference. In most instances Tebelopele was used instead of the private practitioner

Table 42-Reasons for choosing the service providers by respondents who have tested for HIV and AIDS

Reasons For choice	Overall % n= 131	Gender		Employment Categories	
		Females % n=86	Males % N=45	White collar% n=36	Blue collar class % n= 95
There is privacy and confidentiality	37.6	38.5	35.5	58.6	30.0
Its free	30.6	37.2	13.3	21.4	33.8
There are trained officers	11.1	6.4	23.3	3.6	13.8
No one knew I was going for HIV test.	6.5	7.7	3.3	3.6	7.5
Did not have to wait long to get assistance.	6.5	7.7	3.3	3.6	7.5
They offer better service	4.6	1.3	13.3	3.6	5.0
Equipments are of high quality	4.6	3.8	6.7	3.6	5.0
Close to home	4.6	5.1	3.3	0.0	6.3
Spouse forced me to go there	2.8	2.6	3.3	3.6	2.5
I get treatment do not have to be referred to other services.	1.9	2.6	0.0	0.0	2.5
Friends advice me to use the service	0.9	0.0	3.3	0.0	1.3
No reason	0.9	1.3	0.0	3.6	0.0

Privacy, confidentiality and no cost were the reasons that most respondents considered in deciding which service provider to use.

4.2.8 The geographical district of the service provider chosen by respondents that have tested for HIV and AIDS

The following section discusses the areas in which the HIV and AIDS VCT service providers that were used by the respondents that have tested for HIV and AIDS were located; Lobatse or elsewhere. The results are shown in Table 43. Also, this section establishes the extent of pre and post- test counselling services that were provided for the respondents and this is shown in Table 44.

Table 43- The geographical district of the service provider chosen by the respondents that have tested for HIV and AIDS

Service Provider chosen	Overall % n= 131	Gender		Employment Categories		Age		Marital Status	
		Females % n=86	Males % N=45	White collar % n=36	Industrial class % n= 95	29 and under % n=25	30 and above % n=106	Single % n=66	Married% n=65
Lobatse	45.0	43.0	48.9	44.4	45.3	40.0	46.2	45.5	44.6
Elsewhere	55.0	57.0	51.1	55.6	54.7	60.0	53.8	54.5	55.4

The majority of respondents had chosen service providers outside Lobatse district.

Table 44- The number of respondents that received pre- test and post -test counselling from the HIV and AIDS service provider in Lobatse and elsewhere

Counselling provided	Overall N= 131		Lobatse n= 59		Elsewhere n=72	
	Yes	No	Yes	No	Yes	No
Pre-test counselling	93.9	6.1	94.9	5.1	93.1	6.9
Post test counselling	85.5	14.5	89.8	10.2	81.9	18.1

The majority of the respondents were given pre- test and post counselling whether outside or in Lobatse. However, more respondents were given pre test counselling than post counselling. The pattern was evident in both Lobatse and elsewhere. In addition more respondents who tested elsewhere than in Lobatse indicated that they did not receive any pre test and post- test counselling.

The level of satisfaction that the respondents had with the service provider is shown in Table 45 below. The results of Table 45 are from the section of the questionnaire where the respondents that have tested for HIV and AIDS were asked to agree or disagree (5 point Likert) with eleven statements showing the level of satisfaction with the HIV and AIDS services they received when testing for HIV and AIDS. This was to establish the overall level of satisfaction the respondents had when testing and to establish if any particular reason might be more compelling than the rest. Descriptive statistics for the eleven items and a summated score for the eleven items combined are presented in Table 45. Analysis confirmed the reliability of the summated score with a Cronbach's coefficient alpha of 0.92.

Table 45- The level of satisfaction with the HIV and AIDS VCT service provided

	n=131				
	Low	Average	High	Mean	SD
I was satisfied with the overall service	3.1%	3.8%	93.1%	4.32	0.79
I received helpful information	3.8%	3.1%	93.1%	4.36	0.81
The facility was clean	1.5%	6.1%	92.4%	4.35	0.73
The counselor made me comfortable	3.1%	6.9%	90.1%	4.35	0.86
I was satisfied with the counseling service	5.3%	5.3%	89.3%	4.24	0.87
The equipment was of good quality.	3.8%	8.4%	87.8%	4.31	0.84
The staff was competent	4.6%	7.6%	87.8%	4.25	0.90
I was attended to promptly	6.1%	6.9%	87.0%	4.20	0.92
My information was treated with confidentiality	5.3%	8.4%	86.3%	4.28	0.94
I was able to get my results straight after the test	12.2%	3.1%	84.7%	4.18	1.08
No one was able to tell that I was going for HIV testing	8.4%	9.9%	81.7%	4.12	1.07
Summated score	3.1%	3.8%	93.1%	4.27	0.70

The results for Table 45 above are represented in descending order of importance by respondents. The respondents that have tested were satisfied with the service they received from the VCT service providers. The majority of respondents that tested for HIV and AIDS indicated that they were satisfied with the overall services, they received helpful information, facility was clean and they were made comfortable when counselled. This information was analysed further to identify if there was a difference in the overall level of satisfaction between respondents that tested elsewhere or in Lobatse district or for any of the individual statements. The frequencies are presented in Table 46 below.

Table 46- The level of satisfaction with the HIV and AIDS VCT services received in Lobatse and elsewhere

	Lobatse (n= 59)			Elsewhere (n=72)		
	Low	Average	High	Low	Average	High
I was satisfied with the overall service	5.1%	5.1%	89.8%	1.4%	2.8%	95.8%
I received helpful information	5.1%	3.4%	91.5%	2.8%	2.8%	94.4%
The facility was clean	3.4%	5.1%	91.5%	0.0%	6.9%	93.1%
I was satisfied with the counseling service	8.5%	3.4%	88.1%	2.8%	6.9%	90.3%
The counselor made me comfortable	5.1%	1.7%	93.2%	1.4%	11.1%	87.5%
My information was treated with confidentiality	8.5%	6.8%	84.7%	2.8%	9.7%	87.5%
I was attended to promptly	5.1%	6.8%	88.1%	6.9%	6.9%	86.1%
The equipment was of good quality.	8.5%	1.7%	89.8%	0.0%	13.9%	86.1%
No one was able to tell that I was going for HIV testing	10.2%	11.9%	78.0%	6.9%	8.3%	84.7%
The staff was competent.	5.1%	3.4%	91.5%	4.2%	11.1%	84.7%
I was able to get my results straight after the test	8.5%	3.4%	88.1%	15.3%	2.8%	81.9%
Summated score	5.1%	3.4%	91.5%	1.4%	4.2%	94.4%

The results in Table 46 above are sorted in descending order according to the elsewhere group. Respondents that have tested in Lobatse district and elsewhere were satisfied with the overall services. However respondents that tested outside the district were more satisfied with the overall services than those that tested in Lobatse.

The respondents did not give any additional comments regarding the service provided in response to the open ended questions asking for any additional comments.

4.2.9 Reasons why people were not testing for HIV and AIDS and recommendations on how to make more people test for HIV and AIDS by respondents.

This section shows results that were obtained from the open ended questions where all respondents were asked to indicate the reasons why people were not testing for HIV and AIDS and what they thought needed to be done to encourage more people to test for HIV and AIDS.

Table 47 - Barriers toward testing

	n=118
There is discrimination and stigmatization of HIV and AIDS	37.3%
People lack education on HIV and AIDS, they do not know the importance of testing, no knowledge on Aids. They see it as being witch craft)	15.3%
People do not want to know their status,	10.2%
Service centers are too far from people, hence not easier to access.	10.2%

People do not believe that AIDS exist, but rather that it is witchcraft.	6.8%
Talking about Sexual issues is a taboo.	6.8%
There is no encouragement or support for testing from partners or family	4.2%
There is lack of confidentiality from the service providers	3.4%
Service centers close early, hence there is no time for testing.	2.5%

Discrimination and stigmatisation were identified as the most important barriers to testing (37%). Lack of information was seen as the second most important (15.3%).

Table 48 - what needs to be done to make more people test for HIV and AIDS

	n=112
People must be educated	50.0%
Stigmatization and discrimination should be removed	9.8%
Consulting times should be increased.	8.0%
There should be home visits	7.1%
People should be given incentives to test	6.3%
Compulsory testing should be introduced	6.3%
There should be increased confidentiality	5.4%
Aids should be treated just like any diseases	5.4%
The service providers must be able to make follow ups on those positive.	5.4%
Two entrances, for going in and out (these should be far apart, and people getting out should not be seen. Their facial expression may say it all).	3.6%
After been tested positive, you should be given AIDS cure	2.7%
Increase more private practitioners	0.9%
Trained and qualified staff should be recruited	0.9%
There should be group sensitive, age, marital status, gender when one is been counseled.	0.9%

Majority of the respondents saw education as the solution that can make more people test.

4. 3 Group discussions

4.3.1 Group discussion participants profile

For the female group discussions 5 participants attended, 2 were from white collar employees and 3 from blue collar employees. For the male participants 2 were from white collar employees and 5 from blue collar employees. This is shown in Table 6 below.

Table 49 - Number of focus groups participants by gender and employment category

Employment Category	Gender	
	Males participants who attended	Females participants who attended
Management	1	1
Middle management	1	1
Lower management	1	1
Industrial class	4	2
Total	7	5

4.3.2 Results of the group discussions

The results of the group discussions are reported in two sections; the first section addresses the results from the female discussions and the second section the results from the male discussions. Each section is further divided into two with each subsection answering one of the two main questions that were asked.

4.3.2.1 Results from the female group discussions

1. What were the cultural reasons that prevented females from testing?

-Females were scared of testing for HIV and AIDS as they were scared that they would be found positive, since they are subservient to males who engaged in risky behaviours. One participant was quoted saying “ Banna ba tlisa bolwetsi ka go robala le mongwe le mongwe kwa ntle ga lelwapa, ba tlisa bolwetsi ka boitshawaro jo, mme ka mmonna ele tlhogo ya lelwapa, mosadi o tshwanetse go modirela se a sebatlang, le fa a lemoga a itsenya bolwetse”(Mens' behaviour of sleeping around brings the disease home by sleeping around outside the home, women have to do as men ask as they are head of the family even if putting themselves at risk)

-Females culturally were blamed for bad things that happen in the family, hence they are scared to test, since if found positive, females would be blamed for infecting the partner even if it is the man who infected the woman. One participant is quoted as saying “Mosadi lelata, fa sengwe se senyega ke ene, fa bolwetsi botla lapeng gatwe ke mosadi, lefa ene ele monna o tlišitseng bolwetsi mo lapeng” (A women is a servant, if anything goes wrong she is blamed, if the disease 'comes' home she is blamed even if the disease is brought home by the man)

2. What could be done to make more women test?

- Males needed to be educated on the importance of testing. One participant was quoted as saying, 'Banna ga baitse sepe ka botlhokwa ba go itlhatlhoba baitsa balekane ba bone goitlhatlhoba" (Men do not know anything about the importance of testing, hence prevent their partners from testing)

-AIDS should be treated like any other disease, hence confidentiality must be removed. This would help reduce the stigma attached to AIDS. One participant is quoted as saying, “bolwetsi jo ke bolwetsi fela jaaka bongwe le bongwe, jaanong a botsewe jaaka bolwetsi bongwe le bongwe. A go sanne le sephiri fela jaaka fa motho a tsenwe ke kankere, se seka thusa mo go hokotseng batho go supywa ka menwana”(this disease must be treated like any other disease. When one is infected there should be no confidentiality, just like if one has cancer. This will help reduce people pointing fingers at each other)

4.3.2.2 Results from the male group discussions

1. What were the cultural reasons that prevented males from testing?

-To use a health service may be considered as a sign of weakness. One participant was quoted as saying “ ke lefelo la basadi le bana, e seng banna tota” (It’s a women and children’s place, not meant for real men)

- Male promiscuity is culturally accepted. One participant was quoted as saying they were allowed to have a ‘second’ or ‘small house’; hence they lived risky lives, and so were scared to test as they may be infected “ ka setso monna ke monna fa a na le ntlo e nnyenyane, jalo he, se sedira gore ba taboge mo, mme basa kgalemelwe. Se sedira gore ba robale gongwe le gongwe go sena bothata, mme kana jaanong batshaba goitlhatloba ka batshaba gore ba katswa ba lwala” (Culturally a man is a man if he has ‘a small house(s), hence he can sleep anywhere he likes, without being made to stop. This makes them scared to test as they know that they may be infected)

2 . What could be done to make more males test?

- Males should be educated on the importance of HIV. One participant is quoted as saying, (Banna ga bantsi ka bothokwa ba go itlhatloba”(Males do not know about the importance of testing)

-Testing kits like the pregnancy testing kits should be provided, so that one could test in the privacy of their house and there would be more confidentiality. One respondent was quoted as saying, “ Bolwetsi jo bo masisi, go tlhokahala sephiri se sentsi, jaanong fa o ya kwa ngakeng ga gona sephiri, kefa fela reka nnelwa dilo tse ditshwanang le pregnancy kits, se se ka dirang gore batho baitlhatlobe mo sephiring, se seka dira gore batho bale bantsi baitlhatlobe”(the disease is very sensitive, there is a need for privacy and confidentiality, if you go to the Doctors, there is no privacy or confidentiality. There is therefore a need for kits like the pregnancy test kits where one can test in privacy of their home).

4.4 Discussion

This section combines both the research findings from the survey and the two focus group discussions. The results of the research findings are discussed in relation to the research questions.

1. Research questions 1 and 2

To what extent have Lobatse Town Council employees made use of an HIV and AIDS VCT service? Have some groups, distinguished by gender, age, employment category, education level and marital status, shown greater willingness than others to undergo VCT?

The majority of the respondents (65.5%) from Table 20 have submitted themselves to HIV and AIDS tests. Among those who tested, 65.6% were females while 34.4% were males translating into a female participation rate of 71.7% and a male participation rate of 56.3%. Table 20 shows that for the employment categories, of those who tested 27.4% were white collar while 72.5% were blue collar employees translating into a white collar respondent participation rate of 81.8% and a 60.9% participation rate among the blue collar respondents. In Table 21 it was established that for the age groups of those who tested 19.1% were 29 years and under while 80.9% were 30 years and above translating into 29 years and under respondent participation rate of 58.1% and a 67.5% participation rate among the 30 years and above respondents. For the marital status, groups of those who tested 50.4% were single while 49.6% were married translating into a single respondent participation rate of 63.5% and a 67.7% participation rate among the married respondents.

2. Research question 3

What is the motivation for testing and not testing?

a) Reasons for testing as perceived by all the respondents

Table 10 shows that majority of respondents (87.0%) perceive HIV and AIDS testing as being important. The two most common important reasons were; to get counselled on how to live if not infected (91.5%) and, to get counselled on how to live if infected (91.5%). Among the gender groups, HIV and AIDS VCT were perceived as important as depicted by Table 11. The females showed a higher level of agreement regarding the importance of HIV and AIDS VCT (90.0%) than the males (83.0%). Among the females, the three most important reasons for HIV and AIDS VCT were; to get counselled on how to live if infected (95.0%), to get counselled on how to live if not infected (94.2%) and to protect their partner from infection (90.8%). Among the males, the same three reasons were cited as the most important reasons for HIV and AIDS VCT were, to get counselled on how to live if not infected (87.5%), to get counselled on how to live if infected (86.3%), to protect partner from infection (83.8%). Table 12, shows that the females significantly regarded all the reasons for testing for HIV and AIDS as more important than the males

($t(198) = 2.15, p = 0.033, \text{Cohen's } d = 0.31$). There was a significant difference for some individual reasons for the importance of HIV and AIDS VCT with females seeing the reason as

more important than males . This were counselled on how to live if infected ($t(198)=3.18$, $p=0.002$, Cohen's $d=0.46$) and protecting partner from infection ($t(198)= 2.05$, $p=0.041$, Cohen's $d= 0.30$).

Table 13 shows that for the employment categories, both the white collar and blue collar respondents considered testing for HIV and AIDS as important. However the white collar, respondents (97.7%), was more positive than the blue collar (84.0%) on the importance of testing for HIV and AIDS. The most important reasons for testing for the white collar were to 'plan for future (97.7%), and getting counselled on how to live if not infected' (95.5%) and getting counselled if infected (95.5%). Amongst the blue collar the most important reasons for testing for HIV and AIDS, were to get counselled on how to live if infected, (90.4%) and to get counselled if not infected (90.4%).

Table 14 shows that the respondents from the white collar employment category differed significantly on the overall importance of these reasons for testing for HIV and AIDS from the blue collar employment category ($t(198)= 2.63$, $p =0.009$. Cohen's $d= 0.45$). The individual reasons that the two employment categories differed with were to plan for future ($t=(198)=3.18$, $p=0.002$, Cohen's $d= 0.46$) and to live a healthier life ($t(198)=2.05$, $p=0.041$, Cohen's $d= 0.30$). The result above shows that HIV and AIDS VCT is considered important by respondents. However there were group biasness, gender and employment categories, regarding the perceived importance of HIV and AIDS VCT services. Females were more positive than the males, also the white collar respondents were more positive than the blue collar.

b) Concerns expressed by the respondents that had tested for HIV and AIDS

Table 30 shows that respondents that tested for HIV and AIDS had overall agreement with the concerns before testing of 64.1%. The most common concern was that they felt that they needed to go for HIV and AIDS testing (83.2%).

Table 31 shows that the males (77.8%) had more concerns before testing than females (57.0%). The three most common concerns amongst the males were that they felt they needed to undergo for HIV and AIDS testing (91.1%), they were scared of knowing their status (82.2%) and they were scared of being stigmatised (80.0%). The common concerns among the females before testing were that they were scared of knowing their status, (64.0%), were scared that their jobs would be threatened (62.8%), and needed to undergo HIV and AIDS testing, (62.8%). However, as shown in Table 32, there were no significant differences on the concerns before testing between the gender groups.

Table 33 shows that between the employment categories, the white collar respondents (75.0%) had more overall concerns than the blue collar respondents (60.0%). The most common concern amongst both the blue collar and the white collar respondents was that they thought

they needed to undergo testing, (85.3% and 77.8% respectively) White collar employees were also scared of knowing their status (77.7%) and were scared of discrimination (77.8%).

Table 34 shows that the respondents from the white collar employment category were significantly more concerned before testing for HIV and AIDS than the blue collar employment category ($t(128)=2.37$, $p=0.019$, Cohen's $d= 0.47$.) The individual reasons where white collar employees were significantly more concerned were; scared of knowing their HIV and AIDS status $t(128)=2.05$, $p=0.020$, Cohen's $d= 0.47$ and scared of discrimination ($t(128)=3.18$, $p=0.014$, Cohen's $d= 0.49$), scared of dying ($t(128)=2.05$, $p=0.023$, Cohen's $d= 0.46$.) and scared that they would be rejected by partner ($t(128)=3.18$, $p=0.040$, Cohen's $d= 0.41$).

Tables 35 and 36, show that the majority (86.3%) of respondents indicated that the concerns that they had were not realised. The most common realised concern was that the respondents were mistreated at work (11.4%). This was more common amongst the females and amongst the white collar respondents.

In conclusion the respondents that have tested for HIV and AIDS before testing had concerns regarding testing for HIV and AIDS. The most common concern was that they needed to undergo HIV and AIDS testing. There was group biasness towards some concerns and more males than females had more concerns. The white collar was more concerned than blue collar. However, the majority of the respondents showed that most of the concerns they had before testing were not realised. Being mistreated at work was the commonest concern that was realised for the respondents that indicated that the concerns they had before testing were realised.

c) Concerns expressed by respondents that had not tested for HIV and AIDS

Table 22, shows that the most important reasons for not testing for HIV and AIDS for the respondents that did not test for HIV and AIDS, were that they were scared that the results would not be kept confidential, (53.6%), while 52.2% perceived that they did not need to undergo testing and 50.7% were scared of discrimination and (50.7%) were scared of being stigmatised. The same reasons discrimination and stigmatisation, from Table 47, were indicated as common barriers that prevented people from testing. (37.3%) Table 23, shows that there were a lower number of female respondents (14.7%) that agreed with the statements than the males (54.3%). The most common reasons for not testing for males were that they were scared that the results would not be kept confidential (74.3%) and that they were scared of stigmatisation, (71.4%). More males (57.1%) than females (47.1%) thought they did not need to go for testing. Table 24 shows that the males were significantly more concerned overall regarding testing for HIV and AIDS than females ($t(67)= -4.409$, $p =0.000$, Cohen's $d= 0.99$.) Females were significantly less concerned than males on the below listed concerns for not wishing to test than males: I am scared of knowing my status ($t(67)= -4.26$, $p= 0.000$, Cohen's

$d = -1.03$), I am scared of discrimination $t(67) = -4.09$, $p = 0.000$, Cohen's $d = -0.99$, I am scared of being stigmatized $t(67) = -4.54$, $p = 0.000$, Cohen's $d = -1.09$, I am scared the results will not be kept confidential $t(67) = -3.97$, $p = 0.000$, Cohen's $d = -0.96$, I am scared of dying $t(67) = -3.65$, $p = 0.001$, Cohen's $d = -0.88$, I am scared my partner will reject me $t(67) = -4.15$, $p = 0.000$, Cohen's $d = -1.00$, I am scared that my job will be threatened $t(67) = -4.49$, $p = 0.000$, Cohen's $d = -1.08$, I am not aware of any VCT centers $t(64) = -2.24$, $p = 0.028$, Cohen's $d = -0.55$, and I am scared that my family and friends will reject me $t(67) = -3.89$, $p = 0.000$, Cohen's $d = 0.94$)
The only exception is that there was no significant difference between males and females in the need to undergo testing ($t(67) = -1.02$, $p = 0.312$).

There were cultural factors that were identified through the focus group discussions which influenced the behaviour of females and males regarding testing. The female participants established that some females refused to undergo testing because they feared that due to the behaviour of their male partners, they might be HIV positive. The females were also scared of testing because if found positive they would be blamed for bringing the disease home as women were culturally blamed for everything at fault in the family. The male participants felt that most men believe that due to their risky behaviours, they might already be HIV positive. Hence, they were scared that the test may confirm their suspicions; therefore they were scared of testing. They were also be scared of using Health services as they did not want to be seen as being weak. Also, the males were seen from the two group discussions that they lacked education on the importance of testing.

From Table 25, both the white and blue collar respondents had a low agreement for reasons for not wanting to test. Overall score of respondents who agreed with the statements from the white collar respondents was, 12.5% and 37.7% of blue collar respondents. The most common reasons for not wanting to test for HIV and AIDS from the white collar was that 50.0% of the white collar felt they did not need to undergo testing, and 50,0% also were scared of dying. From the blue collar the four most common reasons for not wanting to test was that they were scared that the results would not be kept confidential,(55.7%), they did not need to undergo testing (52.5%), were scared of discrimination, (52.5% and were scared of being stigmatised (52.5%). Although the blue collar employees showed more agreement with the concerns there were no significant differences overall or on individual items between the two employment categories (Table 26).

Table 30 shows that 83.2% of the respondents that have tested for HIV and AIDS felt they needed to test, of those that did not test for HIV and AIDS 52. 2% felt they did not need to undergo testing(Table 22).

The respondents that did not test for HIV and AIDS were motivated by various reasons and some of the reasons were culturally motivated and some were behavioural influenced. There

was group biasness for reasons of not testing. More males than females were in agreement with statements regarding reasons for not testing and the blue collar employees were more in agreement with the statements than the white collar employees.

3. Research question 4

Which are the preferred service providers and was there a group bias?

a) Preferred service providers amongst the respondents that had not tested

Table 27, shows that the majority (50.7%) of respondents that did not test for HIV and AIDS preferred Tebelopele, an NGO, as a service provider. The second preferred (34.8%) service provider was the private practitioner. The least was the Hospitals (5.8%). Amongst the gender groups the preferred service provider was Tebelopele, males (54.3%) and females (47.1%). The second preferred service provider was Private practitioners with 41.2% for females and 28.6% for males. The least preferred service provider by both the gender groups was the hospital. For the employment categories, Tebelopele was also the most preferred service provider. However more respondents from the white collar (62.5%) than the blue collar (50.0%) preferred Tebelopele. The second preferred service provider by the employment categories were the Private practitioners. No respondents from white collar preferred the clinic or the Hospital and for the blue collar the least preferred was the Hospital.

Table 28 shows that the preferred service providers for the respondents that did not test for HIV and AIDS by age and marital status groups was Tebelopele; the 29 years olds and under, 50.0%, 30 and above, 52.0% and single 51.4% and married 51.6%. The second preferred service provider was the Private practitioners with 29 years old and under, 27.8% and 36.0% for 30 years and above, and for the single 27.0% and 41.9% for the married. The least preferred service provider for 29 years old and under was the hospital with 11.1%, and 4.0% for 30 years and above, and for the single 8.1% and 3.2% for the married.

In conclusion, Tebelopele was the most preferred service provider amongst the respondents that did not test for HIV and AIDS. The second preferred service provider was the private practitioners. The public service providers were the least preferred.

b) Preferred service providers amongst those respondents that had tested

Table 38 shows the majority (45.0%) of respondents that tested for HIV and AIDS preferred, Tebelopele, followed by Private practitioners with, 29.0%. The least preferred service was the Hospital. For the gender groups, Tebelopele was the most preferred service provider, followed by private practitioners. For the employments categories, there were differences in the

preferred service provider, the white collar employment category preferred service provider was the private practitioner with 58.3% and second best preferred service provider was Tebelopele, with 30.6%. Whereas for the blue collar the preferred service provider was Tebelopele (50.5%) and the second preferred service provider was the Private practitioners and clinic (17.9%).

Table 39, shows that there were differences in the preferred service providers between the age groups.

Table 39 shows that the most common preferred service provider for both age groups and married and single respondents was Tebelopele. The second preferred service provider for the 29 olds and under was the clinic (12.0%) and the least preferred service providers were the private practitioner and the Hospital (8.0%). Whereas the second most preferred provider for the 30 year old and older were the private practitioner (34.0%). For both the single and married respondents the private practitioners were the second best preferred service providers with the Hospital being the least preferred.

In conclusion amongst the respondents that have tested for HIV and AIDS the first preferred service provider was Tebelopele and this was common amongst the gender, age groups and marital status groups. However for the employment categories the first choice among the white collar employees was the private practitioners followed by Tebelopele. The second preferred service provider for most groups were the private practitioners.

c) The actual service provider used by the respondents that had tested

Table 40 depicts that the most common used service provider used by respondents that have tested for HIV and AIDS was Tebelopele (51.9%). The second most used service provider was the private practitioner with 20.6%. The least used service provider was the hospital (13.0%). Table 40 also shows that amongst the gender groups the most used service provider was Tebelopele for both females 50.0% and males 55.6%. The second most used service provider amongst the gender group was the private practitioner, for females 19.8% and males 22.2%. The least used service provider by females was the hospitals with 12.8%, while for males it was the clinic with 8.9%. Also from Table 40 amongst the employment categories Tebelopele was the most used service provider, with 47.2% for white collar and 53.7% for the blue collar respondents. The second most used service provider for the white collar were the private practitioners (38.9%), while for the blue collar it was the clinics with 16.8%. The least used service provider for the white collars was the hospital (5.6%), while for the blue collar it was the private practitioner (13.7%).

Table 41, shows that amongst the age groups Tebelopele was the most used service provider for the 29 years and under (72.0%), and for 30 years and above 47.2%. The second most used service provider for the 29 year olds and under was the private practitioners (12.0%) and both the clinic and the hospital were the least used service providers at 8.0% each. For the 30

years and above the second most used service provider was also the private practitioner (22.6%) and the least used service provider for the 30 years and above was the hospital with 14.2%. From Table 41, the most used service providers by both singles and married was Tebelopele: single (53.0%) and married (50.8%). The second most used service provider by the two marital status groups was the private practitioners, married 21.5% and single, 19.7%. The least used service providers for the single (13.6%) was the clinic and the hospital. For the married respondents the hospital was the least used (12.3%).

In conclusion the most used service provider amongst the respondents that have tested for HIV and AIDS was Tebelopele and the second used service provider was the private practitioner. This was common amongst the gender, marital and age groups. Whereas for the employment category the most used service provider was Tebelopele for both groups. However the second used service provider for blue collar were the clinics, while for white collar it was the private practitioners.

d) Geographic location of the service providers used by the respondents that had tested

Table 43 shows that the most used HIV and AIDS service providers were outside Lobatse district, 55% of respondents indicating that they used the services elsewhere while 45% used the service providers in the Lobatse district. This was common amongst all the gender, age, marital status and employment category groups. This shows that the service providers in Lobatse are less utilised when compared to the service providers outside Lobatse.

4. Research question 5

What motivates the choice of HIV and AIDS VCT service provider?

Table 15 shows that three common attributes of a service provider considered important by respondents were to be made comfortable when counselled (94.5%), followed by being given proper counselling services (91.0 %) and cleanliness (89.0%). The least important attribute was that the staff would treat information as confidential (79.5%).

From Table 16 there were various attributes considered important by both males and females. Both males (91.3%) and females (96.7%) rated "to be made comfortable when counselled" The least important attribute for both gender groups was that the staff would treat information as confidential 80.8% for females and 77.5% for males.

Table 17 shows that the females were significantly more positive regarding the attributes required for a service provider than the males ($t[198]= 2.66, p= 0.008, \text{Cohen's } d= 0.38.$). The males and females also differed on some of the individual attributes considered important such as receiving proper counselling services ($t[198]= 2.16, p=0.32, \text{Cohen's } d= 0.31$), not having to

wait too long for assistance ($t[198]= 2.23, p= 0.027, \text{Cohen's } d= 0.32$), service provider having quality equipment ($t[198]= 3.01, p= 0.003, \text{Cohen's } d= 0.43$), To be told result at the same time as the test ($t[198]= 2.11, p= 0.036, \text{Cohen's } d= 0.31$) and to be made comfortable when counselled ($t[198]= 3.07, p= 0.002, \text{Cohen's } d= 0.44$). The female were more positive regarding the above mentioned attributes than the males.

Table 18 shows that to be made comfortable when counselled was the most important attribute for both white collar (95.5%) and blue collar (94.2%) respondents. For the white collar respondents 'proper counselling services' were equally important (95.5%). The least important attribute for both employment categories was 'the staff would treat information as confidential' (79.5%).

Table 19 however shows that there were no significant differences between the two employment categories in what they considered important attributes for HIV and AIDS services providers.

Table 29 shows the majority (42.0%) of respondents that did not test for HIV and AIDS, indicated that the reason for preferring a services provider was because they felt there was confidentiality. This was also common amongst those that have tested for HIV and AIDS where 37.6% indicated that the reason for choosing the services provider was because they consider there was privacy and confidentiality(see Table 42).

Amongst, the gender groups, for both those that have tested for HIV and AIDS and those who have not tested, (Tables 42 and 29 respectively), the most common reason for preferring a HIV and AIDS service provider or using a HIV and AIDS service provider was because they felt there was confidentiality. Table 29 shows that the white collar respondents that have not tested for HIV and AIDS, indicated that the reason for preferring a services provider was confidentiality (75.0%). For blue collar respondents from Table 29 (26.2%) indicated confidentiality but an equal number showed that the reason for preferring a service provider was that one could get results faster.

Table 42, shows that for the respondents that have tested for HIV the white collar respondents showed that the most common reason for choosing a service provider was because they felt there was confidentiality(58.6%) whereas for the blue collar respondents the most important reason was that the service was free (33.8%).

In conclusion there are various factors that may motivate respondents for choosing a service provider. The results show that there were some attributes considered important for a service provider and the most common amongst the respondents was to be made comfortable when counselled, and this was common amongst the gender groups and the employment categories. Confidentiality was one of the factors considered important when choosing a service provider by the respondents and this was common amongst all groups. Getting results faster and cost

were some of the factors that were taken into consideration when choosing a service provider and this was common amongst the blue collar respondents.

5. Research question 6, 7, and 8

These research questions, 6, 7 and 8 are not discussed in this chapter, as already indicated in previous chapters, face to face interviews with the service providers that were to address these research questions were not administered due to time constraints.

6. Research question 9

What are the recommendations for improving the VCT service within Lobatse?

The respondents that tested in Lobatse and elsewhere show that they were satisfied with the overall service given by the HIV and AIDS service providers they used in each district. Table 45 shows that the majority (93.1%) of respondents that tested for HIV and AIDS were satisfied with the overall services and information they received from the service providers. Table 46 shows that a higher level of satisfaction was experienced from the district outside Lobatse, (94.4%) than in the Lobatse district (91.5%). The respondents that tested in Lobatse showed that they were satisfied as they were made comfortable when counselled (93.2%). For those that tested outside Lobatse the majority were more satisfied with the overall service, 95.8% than those within Lobatse (89.8%).

Table 44 shows that majority (93.9%) of respondents that did test for HIV and AIDS received pre- test counselling and the majority (85.5%) of respondents that did test for HIV and AIDS received post- test counselling. The number of respondents that received both pre-test and post-test counselling was higher for those testing in Lobatse than outside the district. The majority (50.0%) of respondents that answered the open questions which are tabulated in Table 48 indicated that to make more people test there was a need to educate people. From the males and females focus groups discussions the same was established. However, the participants recommended that there was a need to educate the males on the importance of testing. The female participants also, recommended that HIV and AIDS should be treated like any other disease, and there should be no confidentiality regarding the disease. They felt that confidentiality caused the stigma and discrimination associated with HIV and AIDS. While the male participants felt there was a need to increase confidentiality by introducing testing kits that will allow people to test in privacy of their houses.

In conclusion the results show that there was a high level of satisfaction experienced by the respondents that tested in Lobatse and outside. Those that tested in Lobatse were more

satisfied with being made comfortable when counselled while those that tested outside were more satisfied with the overall services. Pre test and post test counselling were provided by the service providers both in Lobatse and outside. However, more respondents that tested in Lobatse than outside Lobatse were provided with pre test and post test counselling.

Respondents indicated that there was a need to educate people in order to make more people test, and also, to remove stigma and discrimination through removing confidentiality attached to HIV and AIDS. However the males believed that there was a need to increase confidentiality.

4.5 Conclusion

In this chapter the researcher presented results from the survey and focus groups discussions for both males and females. The results were further discussed in relation to the research questions, and these are summarised below.

The majority of respondents have utilised HIV and AIDS VCT services. There is group bias in utilising HIV and AIDS services with more females than males; more white collar than blue collar; more 30 year olds than the young ages of 29 years and under and more married than single respondents having tested. The respondents were motivated by various reasons to test or not to test. Those that tested for HIV indicated that though they had test for HIV and AIDS, they had concerns before testing and these were more common amongst the males and the blue collar respondents. The respondents that did not test for HIV had concerns regarding testing and these were more common amongst the males than females and amongst the blue collar than the white collar respondents. Culture played a role in influencing people to test or not to test.

The most preferred service provider was Tepelopele followed by private practitioner and the least were the public service providers. This was common amongst most groups except for the white collar respondents who preferred private practitioners seconded by Tebelopele. Whereas, for blue collar the private practitioners were the least preferred service provider. Various factors are considered when choosing a service provider, and the commonest was to be made comfortable when counselled, there should be confidentiality; speed of receiving results and the cost were considered.

The respondents indicated that there was need to remove stigma and discrimination in order to make more people test. Also, they indicated that more people can be made to test by being educated, Confidentiality was one of the factors that were shown to be playing an important role, and the males thought there was a need to increase confidentiality in order to make more people test, while the females thought otherwise.

In the next chapter, Chapter 5, the results are discussed in relation to the findings of other researchers as outlined in the literature review. It is indicated where the results of this study

support or contradict other studies. Recommendations are made for further research and for improving the up-take of HIV and AIDS VCT within the district of Lobatse.

5. Chapter Five: Recommendations and conclusions

The following chapter outlines the conclusions and recommendations derived from this study in relation to the aims and objectives of this study. The recommendations suggest what future studies are needed and also what needs to be done in order to increase the utilisation of HIV and AIDS VCT services within the Lobatse Town Council sphere of authority.

5.1 Conclusions

The following are conclusions derived from the study and are linked to the literature.

5.1.1 Who utilised the HIV and AIDS VCT service providers and the reasons therefore

According to Chilisa and Bennel (2001) there is a positive relationship between those people who perceive themselves as being at risk of getting HIV and AIDS and the utilisation of the HIV and AIDS services. According to NACA (2004) report the high risk groups in Botswana are the females, people with high levels of disposable income, the young ages, 29 years and under and the married. From the results, (Table 20) there was a higher testing participation rate amongst females than males. This was also a reflection of what is happening nation wide (NACA, 2004; Lekoa, 2004). From the employment categories, there is a higher testing participation rate amongst the white collar respondents than the blue collar respondents, and a higher rate amongst the married than the single respondents. However Table 21 also shows that amongst the age groups the older ages of 30 and above have a higher testing participation rate than the young ages of 29 years and under whereas the opposite would have been expected. The results from this research shows that for females; higher income earners; and the married confirm Chilisa and Bennel's (2001) theory to some extent, as from the results the majority of respondents that tested are considered to be at higher risk than the groups that did not test. However, the results from the age groups contradict Chillisa and Bennel's theory of a positive relationship. The results rather support, Mason's (1990) theory as cited in Beardsell (1994) who asserted that those who perceive themselves to be HIV and AIDS positive were less likely to undergo testing, hence proposing a negative relationship.

HIV and AIDS testing according to the FHI (2002); and ROB (2004), is important as it offers people the opportunity to test and once tested, individuals can access the appropriate services depending on their HIV status. Testing is important according to MASA (2002) as those who test HIV-negative are counselled on how to stay that way, while those who test HIV-positive are

counselled on how to live with the virus so that they may live a healthy life, and are counselled on how not to spread the virus, hence this leads to behavioural change. The results in Table 10 show that the employees perceived HIV and AIDS testing as important, however there were some groups that were more positive than others regarding importance of testing. In Table 11 amongst the gender groups the females were more positive than the males regarding the importance of testing and also amongst the employment categories the white collar respondents were more positive than the blue collar respondents regarding HIV and AIDS testing. It is therefore not surprising that females and white collar employees have higher testing participation rates than males and blue collar respondents.

Also, the results show that the most important reason for testing amongst the employees that did test for HIV and AIDS was that they felt they needed to undergo testing before they tested (Table 30), and this may have been influenced by the perception of the importance of testing (Table 10). However amongst those that did not test (Table 22) the most important reason for not testing was that they were scared that the results will not be kept confidential. Their most important concerns hence are different from the concerns that those respondents that tested had before testing.

However, as recognised by Mark and Senak (2002) even though VCT can be beneficial to people, there is an indication that some people have not utilized the HIV and AIDS service. Amongst the Lobatse Town Council employees, it is evident that some employees have not tested for HIV and AIDS and this was more prevalent amongst the males, blue collar, 29 years and under, and singles.(Table 20 and 21).

From the literature various reasons have been given as to why people did not want to test, and the results from the survey and focus group discussions support some of the reasons. The results of this study shows that the majority of respondents were aware of the importance of testing but some did not test as they were scared of being stigmatisation and discrimination, and according to Simbayi (1999) HIV and AIDS was a more stigmatised disease than any other disease. According to a research done by the HSRC (2002) in South Africa, those people who were HIV and AIDS positive were more often discriminated. Stigmatisation and discriminations are factors that are seen as preventing people from testing. In this research stigmatisation and discrimination were one of the factors that were identified as a barrier for HIV and AIDS testing (Table 48).

According to the literature, an individual belief system in a society has an impact on a persons understanding of health and their responses to their health conditions (Walker et al, 2004)., In Botswana the MOH (2002) has posited that reproduction and sexual issues are still considered as a taboo amongst some people in Botswana. This was illustrated by WHO, AIDS/STD Unit and MOH (2004) report that one female respondent was recorded that her husband did not even want to talk about HIV and AIDS. It is evident from the rate of responses amongst the

employees of Lobatse Town Council that HIV and AIDS may be perceived as a taboo as from the 1008 questionnaire that were distributed only 20 were collected on the first closing dates.. The closing dates were postponed twice. 389 responses were received but from these 125 were disqualified. From the disqualified, 57 did not answer if they had tested or not. Also, of the 22 employees that were invited and who also confirmed that they would attend the focus group discussions, only 11 turned up.

Confidentiality is another factor which is identified as a barrier to HIV and AIDS testing amongst the employees of Lobatse Town Council and this was in support of the HRSC (2002) results, where it was found that one of the reasons why people in South Africa did not test for HIV and AIDS was because they feared lack of confidentiality. In this study the majority of respondents that did not test for HIV and AIDS indicated that the reason they did not test for HIV and AIDS was because they were scared that the results will not be kept confidential (Table 22). The results are also in support of Keyon in Chwaane (2006) who indicated that in order to get confidentiality respondents tested in areas that they were not known and in this research more respondents tested outside the Lobatse district than in the district where they work.

However the results from the females group discussions agree that HIV and AIDS is being stigmatised, hence are in agreement with Simbayi (1999). However they suggested that the stigma was caused by the confidentiality attached to HIV and AIDS, hence contradicting Keyon in Chwaane (2006) who stated that there was a need for people to have access to confidentiality when dealing with HIV and AIDS.

5.1.2 Preferred HIV and AIDS VCT service providers and reasons thereof

The FHI (2002) has proposed that integrated service providers found in public sector have a high volume of potential clients, but from the results from this study the public service providers, namely the clinics and the hospitals were the least preferred and the least used service providers. Tebelopele a specialist HIV and AIDS testing service provider was the preferred service provider amongst those that did not test (Table 27); the most used service provider amongst those that did test (Table 40) and the most preferred service provider amongst all the groups that did test (Table 38) with the exception of the white collar employees where though the majority used Tebelopele the majority preferred private practitioners. This may imply that the private sector in Botswana is expensive hence supporting the ROB (2005) who pointed out that the major challenges of private practitioners was that they were expensive and also the FHI (2007) who stated that the private practitioners were inaccessible to the poor and uninsured.

The FHI (2002), and MOH (2002) have proposed some of the guidelines that are necessary for a service provider in order to be effective, for example, there must be qualified staff and there should be adequate space which will allow for privacy and confidentiality. Confidentiality

according to Kenyon as cited by Chwaane (2006) is crucial to HIV and AIDS testing as people are said to only want to test if they know that their results will be kept confidential. However from this research the most important attribute for choosing a service provider according to the respondents was 'to be made comfortable when counselled' (Table 15). Whereas confidentiality was considered the least important attribute hence contradicting Kenyon. The female participants from the group discussions argued that confidentiality caused stigma. However the males participants from the male focus group discussions considered that confidentiality was needed to increase the rate of people testing and also from the survey (Table 23) a high number of males that did not test for HIV and AIDS showed that the reason for not testing was because they were scared that the results will not be kept confidential, hence agreeing with Kenyon. However from the survey amongst the males the attribute considered the least important for a service provider was staff treating information as confidential, refer to Table 16. The results however were contradicting each other as the results from the survey shows that the most common reasons for choosing a service provider was because there was confidentiality and privacy.

The common reason for choosing a service provider for the blue collar was because it was for free, therefore supporting Chillisa and Bennel (2001) who stated that one of the reasons people did not use a service provider was because they thought it was expensive. This is also supporting information for the issue of private practitioners in the paragraph above.

5.1.3 What needs to be done to increase uptake amongst the employees of Lobatse Town Council?

The low utilisation of HIV and AIDS VCT services in Botswana is of national concern (MOH, 2002). According to Billy as quoted by BOPA, (2006c), the low utilisation of HIV and AIDS VCT services by males does not only affect the males but may inevitably result in females not testing. The results from this research show that there was a lower participation rate in HIV and AIDS testing amongst males as compared to the females. There is therefore a need to increase the number of males that test. From both the females and males group discussions it was established that the reasons why males did not want to utilise HIV and AIDS VCT was because they lacked knowledge on the importance of testing, therefore there is a need for males to be educated on the importance of testing and this may make them test in greater numbers. Also stigma may be reduced amongst the males as from the results the males were more concerned of being stigmatised and discriminated. This could be achieved as recommended by ROB (2004) making more males to test as when "people know their status and that knowledge becomes more common place and acceptable, stigmatisation due to ones status becomes less and issue" (p31).

The education that is provided must be made specific for each group and must be made to empower each group especially females so that they are able to make decisions regarding their health.

There is a need to ensure that the service providers in Lobatse provide the pre- test and post-test counselling as from the results of this study the employees showed that the most important attribute of a HIV and AIDS service provider was being counselled if infected or not infected refer to Table 15. Hence if there is no counselling testing would not be effective and this may prevent people from testing.

However it should be noted that in some instances post-test counselling may not be provided as the client may test but not go back to get the results and hence not receive post-test counselling. This has been illustrated by some studies in Solomon, Rooyen, Griesel, Gray, Stein and Nott (2004), where it was found that those people who tested but considered themselves HIV and AIDS positive were three times less likely to go back for results hence missing out on post- test counselling.

Ensuring confidentiality is considered to be one of the crucial attributes that will encourage people to test (Kenyon as cited by Chwaane, 2006). From the results the males indicated that the reason why they preferred a service provider or used it was because there was confidentiality refer to Tables 29 and 42. According to the FHI (2002), one of the benefits of a private sector provider was because it provided more confidentiality and privacy; however the service is not accessible even to the groups that would have preferred to use it (Tables 38 and 40). There is therefore a need for this service to be made more accessible to employees.

5.2 Recommendations

The following are some of the recommendations of what can be done to increase the uptake of utilisation of HIV and AIDS VCT services and future studies that need to be undertaken in relation to this study.

1 Lobatse Town Council employees

a) There is a need for Lobatse Town Council to formulate a workplace policy that will show its commitment towards the fight against HIV/AIDS. The council must ensure that in its formulation it will include the employees in order to ensure that the policy will have greater relevance and that there will be greater acceptance of the policy from employees. According to the Global Compact Policy Dialogue on HIV and AIDS (2003) workplace policies mostly fail as employees do not accept the workplace policies. The workplace should ensure that it takes into consideration the guidelines provided by ILO and also is formulated towards the achievement of the National strategic plan II goals.

b) There is a need for further studies to establish the perceptions of the employees of Lobatse Town council on HIV and AIDS. Their perception may prevent them from knowing and understanding HIV and AIDS and this may be detrimental to the fight against the disease amongst the employees. This study could form part of the participation of employees in the formulation of the HIV and AIDS policies and programmes discussed above.

2 Lobatse Town Council as a service provider

The DMSAC committee need to be evaluated in order to establish its effectiveness as it is an important committee that links all the HIV and AIDS services together and monitors their activities in the district.

5.3 Research

1. Further research is needed to establish the effects of confidentiality on the fight against HIV and AIDS as it is evident from the research that there are differing perceptions on confidentiality and its impact on HIV and AIDS testing. This will help in establishing if HIV and AIDS needs to be treated with confidentiality as it is now and if there was a relationship between stigma and confidentiality.

2. This research did not address some of the research questions namely the following;

- what was the process by which the VCT service provider, the clinic, VCT Centre, the hospital and private doctors manage their service?

-What flexibility existed within the service to accommodate the varying groups accessing the service with the emphasis on gender, age, employment categories and marital status?

Lastly to establish if the HIV and AIDS VCT service providers were meeting the HIV and AIDS VCT objectives and also to find out their success, failures and challenges?

This research should be completed since this would help establish the strength and weaknesses of HIV and AIDS service providers in Lobatse and also make recommendations on how they can improve in order to increase the uptake of people to test.

3. The public services, the clinic and hospital are the least used services there is therefore a need to investigate what is required of them to make increase their uptake.

References

Akinade, E. A. (2002) HIV/ AIDS related stigma and its curtailment in Botswana. Gaborone. University of Botswana.

Anabwani, G. & Jimbo, W. (2004). *Botswana Guidelines on Anti-Retroviral Treatment: 2005 Version*. Gaborone. MOH.

Arkava, M.L. & Lane, T.A. (2003). *Beginning Social Work Research*. Boston: Allyn & Bacon.

Babbie, E. & Mouton, J. (2001). *The Practice of Social Research*. Cape Town: Oxford University Press.

Babbie, E. (1992). *The Practice of Social Research* (6th Ed.). Belmont: Wadsworth Publishing Company.

Barnett, T., Whiteside, A. & Desmond, C. (2000). *The Social and Economic Impact of HIV/AIDS in Poor Countries: A Review of Studies and Lessons*. Geneva, UNAIDS.

Beardsell, S. (1994). *Should wider HIV testing be encouraged on the grounds of HIV prevention?* AIDS Care, 6, 5-19.

Botswana Institute of Development and Policy Analysis (BIDPA),(2000). *Review and Evaluation of HIV /AIDS Related data for an expanded national response to the HIV/AIDS Epidemic in Botswana*. Gaborone: United Nation Development Plan (UNDP).

Botswana Press Agency (BOPA) (2006a February 10). *Molomo fights HIV/AIDS with zeal*. Botswana Daily News, p8.

Botswana Press Agency BOPA (2006b February 7). *Govt does more with less.* Botswana Daily News, p2.

Botswana Press Agency BOPA (2006c February 15). *Tebelopele encourages couples to test.* Botswana Daily News, p21.

Botswana Press Agency BOPA (2005 December 2). *Mogae urges men to join AIDS fight.* Botswana Daily News, p2.

Chilisa, B. & Bennel, P. (2001). *The impact of HIV/ AIDS on the University of Botswana: Developing a comprehensive strategic response.* Faculty of Education: University of Botswana.

Chwaane, T. (17 February, 2006). *Laws impeding HIV/AIDS testing.* Mmegi, p6.

Corbett, E.L., Dauya, E., Matambo, R., Cheung, Y.B., Makamure, B., Bassett, M.T., Chandiwana, S., Munyati, S., Mason, P.R., Butterworth, A.E., Godfrey-Faussett, P. & Hayes, R.J. (2006). *Uptake of Workplace HIV Counselling and Testing: a cluster- randomised trial in Zimbabwe.* Downloaded on 06/12/2005 from Pubmed web at <http://www.ncbi.nlm.nih.gov>.

Curran, D. J & Renzetti, C.M. (1996). *Social Problems: Society in Crisis* (4th Ed). Allyn and Bacon: Boston.

De Vos A.S., Strydom, H., Fouche, C.B. & Delpont, C.S.L. (ed) (1998). *Research at Grassroots: A Prime for the Caring Professionals.* Pretoria: Van Schaik.

De Vos (ed) (2002). *Research at Grassroots: A Prime for the Caring Professionals.* Pretoria: Van Schaik.

Diedericks, A. (2003). *University students' HIV/ AIDS knowledge, information, sexual behaviour and perceptions of Voluntary Counselling and Testing.* Faculty of Health Science: University of Port Elizabeth (in partial fulfilment of the Degree Magister Artium).

Epidemiology & Disease Control Unit & Health Promotion & Education Unit (EADCU & HPAEU) (2005). *TB: Questions & Answers.* Gaborone: Ministry of Health.

Family Health International (FHI) (2002). *VCT Toolkit: A guide to establishing Voluntary Counselling and Testing Services for HIV*. www.fhi.org. retrieved on 04-05-2006.

Fredrikson-Bass, J. & Kanabus, A. (2005). *HIV and AIDS in Botswana*. Downloaded on 9 December, 2006, from <http://www.avert.org>.

Gaolathe, B. (2005). *Budget Speech*. www.gov.bw Retrieved 02-03-2006.

Global Compact Policy Dialogue on HIV /AIDS (2003), Geneva, International Labour Office. Retrieved from Worldwide Web on 9 December 2006. <http://www.ilo.org>.

Green, J. & McCreaner., A. (ed) (1989). *Counselling on HIV Infection and AIDS*. Boston: Blackwell Scientific Publication.

Hope, K.R. & Gaborone, S. (1999). *A strategic HIV/AIDS response plan for the town of Lobatse*. Gaborone: Report presented for UNDP Botswana Field Office.

Human Science Research Council (HSRC) (2002). *Nelson Mandela/HSRC study of HIV/AIDS. South African National HIV prevalence, behavioural risks and mass media. Household survey*.

International Labour Organization (ILO), 2001. *Code of practice on HIV/AIDS and the world of work*. Geneva: International Labour Office.

Judd, C.M., Smith, R.E. & Kidder, H.L... (1991). *Research methods in Social Science*. New York: Jovanovich College Publishers.

Kabubi, N. (2006). *An investigation of employee perceptions on the impacts of HIV and AIDS Policies and Programmes in the Directorate of Public Service Management in Botswana*. A project submitted in partial fulfillment of the requirements for the degree of Magister Artium in Faculty of Arts, Nelson Mandela Metropolitan University.

Kelly, K., Parker, W. & Gelb, S. (2002). *HIV/AIDS, Economics and Governance in South Africa: Key issues in Understanding Response. A literature Review*. USAID. Downloaded 9 December, 2006 from Worldwide Web <http://www.cadre.org.za>.

Lekoa, L.C. (2004). *Reaching out with anti-AIDS strategies for women and girls*. Paper presented to the United States for World Aids Day, 30 November, 2004. Retrieved 03-03-06 from www.allafrica.com.

Lipinge, S., Hofnie, K. & Friedman, S. (2004). *The relationship between gender roles and HIV infection in Namibia*. University of Namibia Press: University of Namibia. Issue Number 8.

Lisk, F. (2003). *Workplace Action on HIV/AIDS: Identifying and Sharing Best Practice*. Geneva International Office. Retrieved from the Worldwide Web on 9 December 2006. <http://www.ilo.org>.

Lobatse Town Council, Lobatse Urban Development Committee & Ministry of Local Government (LTC, LUDC & MOLG), (2003). *Lobatse Urban Development Plan 2: 2003-2009*. Gaborone: Botswana Printers.

Mark, S. & Senak, J.D. (2000). *HIV/AIDS and the law*. New York: Plenum Press.

MASA (2002). *The 100 most-asked questions about HIV/AIDS and ARV Therapy*. Gaborone: MOH & ACHAP (Pamphlet).

Masupu, K., Roels, T., Jimbo, W. & Gaolekwe, S.M. (December 2001). *Botswana 2001, HIV sero-prevalence sentinel survey among pregnant women and men with sexually-transmitted infections. A technical report*. Gaborone: NACA.

Formatted: Dutch
(Netherlands)

Ministry of State President and NACA (2005). *2005 progress report of the national response to the UNGASS declaration of commitment on HIV /AIDS*. Gaborone: NACA.

Ministry of Finance and Development Planning (MOFADP), (2003). *National Development Plan 9 2003/04-2008/9*. Gaborone: MOFADP.

Ministry of Health (MOH), (2002). *National Sexual and Reproductive Health Programme Framework*. Gaborone: Family Health Division, Ministry of Health.

Mouton, J. (1996). *Understanding Social Research*. Pretoria: J. L. Van Schaik.

Mwamadzingo, M. (2003). *HIV and AIDS at the workplace – the workers' response*. ILO Addis Ababa, retrieved 9 December 2006 from Worldwide Web <http://www.avert.org>.

National AIDS Coordinating Agency (NACA), (2004). *National Quarterly Report (April – June 2004)*. Gaborone: National AIDS Coordinating Agency, Ministry of State President.

NACA (2005). Republic of Botswana. National AIDS Coordinating Agency (NACA), Ministry of State President, Botswana, HIV/AIDS. Response Information Management System (BHRIMS) January to March report. Downloaded May 2006 from <http://www.naca.gov.bw/document>.

NACA, CSO & Other Developmental Partners (2005). *Botswana AIDS impact survey ii: Statistical Report*. Gaborone: CSO.

Oaitsi, N. (2005). *How many people in Africa are infected with HIV: HIV and AIDS in Botswana*. www.avert.org Retrieved 03-04-2006.

Powers, G.T., Meenaghham, T.M. & Toomey, B.G. (1985). *Practice focused research*. New Jersey: Prentice Hall.

Rachier, C.O., Gikundu, E., Balmer, D.H., Robson, M., Hunt, K.F. & Cohen, N. (2004). *The meaning and challenge of voluntary counselling and testing for counsellors –report of the Kenya Association of Professional Counsellors Conference for Sub-Saharan Africa*. Journal des Aspects Sociaux du VI/SIDA. Vol. 1 No 3 (p 175-181).

Republic of Botswana (ROB), (2004). *Botswana National Strategic Framework for HIV/AIDS 2003-2009*. Gaborone: Pyramid Publishing.

ROB (2005). *Botswana Public Officers Medical Aid Scheme*. Gaborone Associated Fund Administrators.

Rubin, A. & Babbie, E. (1997). *Research methods for social work*. Pacific Grove, CA: Brooks/Cole.

Simbayi, L. (1999). *Aids Awareness and Sexual Behaviour in South Africa*. New York: Hawthorn Press.

Solomon, V., Van Rooyen, H., Griesel, R., Gray, D., Stein, J., & Nott, V. (April 2004). *Critical Review and Analysis of Voluntary Counseling and Testing*. Durban: Health System Trust. Downloaded December 9 2006 from <http://www.hst.org.za>.

Stone, C. (2001). *Socio-political and psychological perspectives on South Africa*. London: Nova Science.

UNAIDS (2000). *Protocol for the identification of discrimination against people living with HIV and AIDS*. Geneva, Switzerland: UNAIDS.

UNAIDS (2002). *Report on the global HIV/AIDS epidemic*. Geneva: United Nations.

Van Dyk, A. & Van Dyk, P.J. (2003). "What is the point of knowing?": *Psychological barriers to HIV/AIDS Voluntary Counselling and Testing programmes in South Africa*. South African Journal of Psychology: 33(2). p118-125.

Volberding, P.A., Lagakos, S.W. & Koch, M.A. (1990). *Zidovudine in asymptomatic HIV infection*. New England Journal of Medicine, 322, 941-949.

Walker, L., Reid, G. & Cornell (2004). *Waiting to Happen: HIV/AIDS in South Africa - The bigger picture*. Cape Town: Double Storey Books.

Whiteside, A.W., & Sunter, C. (2000). *AIDS: The challenge for South Africa*. Cape Town: Human & Rousseau.

WHO, AIDS/STD Unit & MOH (2004) *Report of the study on Stigma and Stigmatization Associated with HIV/AIDS in the Health Sector In six selected Districts in Botswana*. Gaborone: MOH.

Appendix 1- Self administered questionnaire in English

**Lobatse Town Council
Employee Questionnaire**

This questionnaire is anonymous. Please do not write your name or employee number on this document
Please note that the responses are confidential and cannot be used to identify individuals.
Please note that certain questions are sensitive but we ask you be entirely honest in your responses.

SECTION A

DEMOGRAPHIC INFORMATION

Please answer the following questions by circling the number corresponding to the most appropriate options.

Gender	Female	1
	Male	2
Age	Under 20	1
	20-24	2
	25-29	3
	30-34	4
	35-39	5
	40-44	6
	45-49	7
	50+	8
Highest qualification	None	1
	Primary	2
	Secondary	3
	Tertiary	4
Marital Status	Married	1

	Single	2
	Cohabiting	3
Job Band	Higher Management	1
	Middle Management	2
	Lower Management	3
	Industrial Class	4

SECTION B

For the following statements, please circle the number that best represents your opinion by using the following key.

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

	SD	D	N	A	SA
1. Testing for HIV is important because one can then:					
1.1 Get treatment	1	2	3	4	5
1.2 Plan for the future	1	2	3	4	5
1.3 Live a healthier life	1	2	3	4	5
1.4 Protect your partner from infection	1	2	3	4	5
1.5 Get counseled on how to live if you are infected	1	2	3	4	5
1.6 Get counseled on how to live if you are not infected	1	2	3	4	5
1.7 If you have any other reason(s) why testing for HIV is important, please specify:					

2. The following are important attributes for a VCT service provider					
	SD	D	N	A	SA
2.1 Cleanliness	1	2	3	4	5
2.2 Proper counseling services	1	2	3	4	5
2.3 Do not have to wait too long for assistance	1	2	3	4	5
2.4 The staff would treat information as confidential	1	2	3	4	5
2.5 Competent staff	1	2	3	4	5
2.6 Quality equipment	1	2	3	4	5
2.7 To get treatment if found HIV+	1	2	3	4	5
2.8 To be told results at the same time as the test	1	2	3	4	5
2.9 To be made comfortable when counseled	1	2	3	4	5
2.10 There should be privacy so that no one can tell that I am being tested for HIV	1	2	3	4	5
2.11 If you have any other requirements for a VCT service provider, please specify:					

- | | | | |
|---|--------------------------|-----|---|
| 3 | Have you tested for HIV? | Yes | 1 |
| | | No | 2 |

If you answered “No” to 3 above please answer **Section C** If you answered “Yes” to 3 above please answer **Section D**

Section C

Indicate how each of the following reasons for not testing applies to you by circling the most appropriate number on the 5 point scale

	SD	D	N	A	SA
1.1 I do not need to undergo VCT testing	1	2	3	4	5
1.2 I am scared of knowing my status	1	2	3	4	5
1.3 I am scared of discrimination	1	2	3	4	5
1.4 I am scared of being stigmatized	1	2	3	4	5
1.5 I am scared the results will not be kept confidential	1	2	3	4	5
1.6 I am scared of dying	1	2	3	4	5
1.7 I am scared my partner will reject me	1	2	3	4	5
1.8 I am scared that my family and friends will reject me	1	2	3	4	5
1.9 I am scared that my job will be threatened	1	2	3	4	5
1.10 I am not aware of any counseling centers	1	2	3	4	5
1.11 If you have any other reasons for not testing, please specify:					

- | | | | |
|-----|---|----------------------|---|
| 2 | If you were to choose a VCT service provider, which one would you choose? | Private Practitioner | 1 |
| | | Tebelopele | 2 |
| | | Clinic | 3 |
| | | Hospital | 4 |
| 2.1 | Please explain why you would choose that service provider | | |

SECTION D

1. Indicate how each of the following statements applied to you before you went for testing by circling the most appropriate number on the 5 point scale

	SD	D	N	A	SA
1.1 I needed to undergo VCT testing	1	2	3	4	5
1.2 I was scared of knowing my status	1	2	3	4	5
1.3 I was scared of discrimination	1	2	3	4	5
1.4 I was scared of being stigmatized	1	2	3	4	5
1.5 I was scared the results would not be kept confidential	1	2	3	4	5
1.6 I was scared of dying	1	2	3	4	5
1.7 I was scared my partner would reject me	1	2	3	4	5

- | | | | | | | |
|------|---|---|---|---|---|---|
| 1.8 | I was scared that my family and friends would reject me | 1 | 2 | 3 | 4 | 5 |
| 1.9 | I was scared that my job would be threatened | 1 | 2 | 3 | 4 | 5 |
| 1.10 | If you had any other concerns about testing please specify. | | | | | |

2. Were any of the concerns you had about testing realized? Please specify.

- | | | | |
|-----|---|----------------------|---|
| 3.1 | Which service provider would be the provider of choice? | Private Practitioner | 1 |
| | | Tebelopele | 2 |
| | | Clinic | 3 |
| | | Hospital | 4 |
| 3.2 | Which service provider did you choose? | Private Practitioner | 1 |
| | | Tebelopele | 2 |
| | | Clinic | 3 |
| | | Hospital | 4 |

3.3 Please explain why you chose that service provider?

- | | | | |
|-----|---------------------------------------|-----------|---|
| 4. | Where did you go for HIV testing? | Lobatse | 1 |
| | | Elsewhere | 2 |
| 5.1 | Did you receive pre test counseling? | Yes | 1 |
| | | No | 2 |
| 5.2 | Did you receive post test counseling? | Yes | 1 |
| | | No | 2 |

- | | | | | | | |
|------|--|-----------|----------|----------|----------|-----------|
| 6. | Regarding the VCT services provided: | SD | D | N | A | SA |
| 6.1 | I was satisfied with the counseling service | 1 | 2 | 3 | 4 | 5 |
| 6.2 | I was satisfied with the overall service | 1 | 2 | 3 | 4 | 5 |
| 6.3 | The facility was clean | 1 | 2 | 3 | 4 | 5 |
| 6.4 | I received helpful information | 1 | 2 | 3 | 4 | 5 |
| 6.5 | The counselor made me comfortable | 1 | 2 | 3 | 4 | 5 |
| 6.6 | My information was treated with confidentiality | 1 | 2 | 3 | 4 | 5 |
| 6.7 | I was attended to promptly | 1 | 2 | 3 | 4 | 5 |
| 6.8 | No one was able to tell that I was going for HIV testing | 1 | 2 | 3 | 4 | 5 |
| 6.9 | The equipment was of good quality. | 1 | 2 | 3 | 4 | 5 |
| 6.10 | I was able to get my results straight after the test | 1 | 2 | 3 | 4 | 5 |
| 6.11 | The staff were competent. | 1 | 2 | 3 | 4 | 5 |

6.12 Any other comments that you wish to make about the service provider? Please specify:

SECTION E

You may have thoughts about HIV testing that are not covered in the questionnaire above. The section below asks a few more questions and gives you the opportunity to add your own thoughts.

Please answer the question by writing down the answers in the space provided

1. What are the reasons why people do not want to test?

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2. What can be done to make more people test?

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3. Please add any additional information that you think is important regarding VCT

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.....
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Appendix 2- Self administered questionnaire in Setswana

**Lobatse Town Council
Employee Questionnaire**

Posoloso e, e sephiri, se kwale leina kana nomore ya gago ya bodiredi.
Itse gore karabo tse o difileng di tlaa tsewa ele sephiri, jalo he, karabo tsa gago ga dinke di diriswe go supa gore ditswa mo go mang. E la tlhoko gore dipotso dingwe di katswa di ama maikutlo, mme fela rekopa gore di a rabiwe ka botlalo le bo ammaaruri.

SECTION A

DEMOGRAPHIC INFORMATION

Please answer the following questions by circling the number corresponding to the most appropriate options.

Bong	Female	1
	Male	2
Dingwaga	Under 20	1
	20-24	2
	25-29	3
	30-34	4
	35-39	5
	40-44	6
	45-49	7
	50+	8
Thutego	None	1
	Primary	2
	Secondary	3
	Tertiary	4
Nyalo	Ke nyetswe	1
	Ga ke na molekane	2
	Ke nna le mongwe mme re sa nyalana	3
Job Band	Higher Management	1
	Middle Management	2
	Lower Management	3
	Industrial Class	4

SECTION B

Supa ka go thekeletsa nomore e o dumalanang le mogopolo wa teng. Dikai tse dif a tlase di supa se nomore e se emetseng.

6. Ga ke dumalane fela thata.
7. Ga ke dumelane
8. I Kefa gare
9. Ke a dumelana
10. Ke a dumelana fela thata

	SD	D	N	A	SA
1. Go itlhatlhobela bolwetse jwa HIV go botlhokwa ka motho o:					
1.1 O kgona go bona kalafi e e lebaneng	1	2	3	4	5
1.2 O kgoana go rulaganyetsa isago.	1	2	3	4	5
1.3 O kgona go tshela botshelo jo bo itekanetseng.	1	2	3	4	5
1.4 O kgona go sireletsa molekane wa gagwe mo go tsenweng ke bolwetsi	1	2	3	4	5
1.5 O bona bo gakolodi jwa go tshela ka mogare fa a na le mogare.	1	2	3	4	5
1.6 O bona bo gakolodi jwa go itsheretsa mo go tsenweng ke mogare fa a tlhatlobilwe mme ga fitlhelwa a sena mogare.	1	2	3	4	5
1.7 Fa ona le mabaka mangwe a supang botlhokwa jwa go itlhatlhoba, mme a sa kwalwa fa go dimo, a kwale fa tlase fa.					
2. Fa tlase fa ke se se tlhokafalang go re ba ba neelang thuso ya VCT ba tshwanetse go nna le sone.					
	SD	D	N	A	SA
2.1 Bophepa	1	2	3	4	5
2.2 Bogakolodi jo bo maleba	1	2	3	4	5
2.3 Motho ga a diegelwe go neelwa thuso.	1	2	3	4	5
2.4 Maduo ame ga a nke a itsiwe ke mongwelemongwe. A tla etsiwe fela ke nna le mogakolodi.	1	2	3	4	5
2.5 Bodiredi jwa VCT ba tshwanetse go itse tiro	1	2	3	4	5
2.6 Di dirisiwa tse di diriswang e tswanetse go nna tsa boemo jo bo kwa godimo that.	1	2	3	4	5
2.7 K etshwanetse go bona kalafi molefelong le le fang VCT fa ke fitlhelwa kena lemogare wa HIV.	1	2	3	4	5
2.8 Ke tswanetse go bolelelwa maduo a tlhatlhoba gone foo, fa ke sena go itlhatlhoba.	1	2	3	4	5
2.9 Ke tshwanetse go gololesega fa ke ile bogakoloding.	1	2	3	4	5
2.10 Fa ke ya goitlhatlhobela mogare wa HIV, lefelo leo le tshwanetse go nna fa ope a sa kakeng a itse gore ke ile go itlhatlhobela mogare.	1	2	3	4	5
2.11 Fa one le se o akanyang gore se a tlhokafala mo felong le lefang VCT, mme se sa kwalwa fa godimo, sekwale fa tlase.					
3. A o itlhatlhobetse mogare wa HIV?				EE	1
				Nyaa	2

Fa karabo ya gago e le nnya mo potsone e fa godimo araba karolo ya **section C**. Fa karabo ele ee, araba karolo ya **section D**.

Section C

Supa gore a mabaka afa tlse a go tlhoka goitlhatlobela mogare wa HIV a supa mabaka a gago a

go tlhoka go itlhatloba. Supa se ka go thelkeletsa nomore e o dumalanang le yone.

1. Ga ke dumalane fela thata.
2. Ga ke dumelane
3. Kefa gare
4. Ke a dumelana
5. Ke a dumelana fela thata

		SD	D	N	A	SA
1.1	Ga go tlhokafale gore nkaitlhatlobela mogare wa HIV.	1	2	3	4	5
1.2	Ke tshaba goitse seemo same mabapi le HIV.	1	2	3	4	5
1.3	Ke tshaba go kgethololwa fa ke fitlhelwa kena le mogare.	1	2	3	4	5
1.4	Ke tshaba go bidiwa ka maina fa ke fitlhelwa kena le mogare.	1	2	3	4	5
1.5	Ke tsoga gore maduo ame ga a nke a tsshware e lesephire same.	1	2	3	4	5
1.6	Ke tshaba go swa.	1	2	3	4	5
1.7	Ke tshaba gore molekane wame o tla ntatha fa nka fitlhela ken a le mogare wa HIV.	1	2	3	4	5
1.8	Ke tshaba gore ba lelwapa le ditsa; a tsame bat la ntatha fa nka fitlhela ken a le mogare wa HIV.	1	2	3	4	5
1.9	Ke tlhobaela gore tiro yame e ka senyega.	1	2	3	4	5
1.10	Ga keitse kwa go itlatlobelwang teng mogare wa HIV.	1	2	3	4	5
1.11	Fa ona lemabaka mangwe a supang gore keeng osa itlhatlobela mogare, a kwale fa.					
2	Fa one o ka itlhopela lefelo la goitlhatlobela mogare wa HIV, one o ka ya kae?	Private Practitioner				1
		Tebelopele				2
		Clinic				3
		Hospital				4

2.1 Supa gore mabaka e le eng one o ka dirisa lefelo leo.

SECTION D

Supa ka go thekeletsa nomre e o dumelang gore e supa mabaka a gore pele oya go itlhatloba one o na leone. 1. Indicate how each of the following statements applied to you before you went for testing by circling the most appropriate number on the 5 point scale

		SD	D	N	A	SA
1.1	Ken e ketshwanelwa ke go ya goitlhatloba.	1	2	3	4	5
1.2	Ken e ke tshaba goitse seemo same sa HIV.	1	2	3	4	5
1.3	Ken e ke tsaba kgetololo.	1	2	3	4	5
1.4	Ken e ke tshaba go bidiwa ka main.	1	2	3	4	5
1.5	Ken e ke tshaba gore maduo a me a tla itsewe ke mongwe le mongwe.	1	2	3	4	5
1.6	Ken e ke tshaba loso.	1	2	3	4	5
1.7	Ken e ke tshaba gore molekane wa me o tla ntlogala.	1	2	3	4	5
1.8	Ken e ke tshaba gore balosika le ditsala ba tla ntatla.	1	2	3	4	5
1.9	Ken e ke tlhobaela gre tiro yame etla ntshenyegela.	1	2	3	4	5
1.10	Fa one ona le tlhobaelo ngwe ya goitlhatloba e supe.					

2. A tlobaelo e oneneg ona le yone e diragafetse fa o sena go itlhatloba? e kwale fa tlase.

3.1	O ka itlhopela go itlhatlobela kae mogare wa HIV?	Private Practitioner				1
		Tebelopele				2

		Clinic	3
		Hospital	4
3.2	One wa itlhatlobela kae mogare wa HIV.	Private Practitioner	1
		Tebelopele	2
		Clinic	3
		Hospital	4
3.3	Ka goring one wa go itlhatlobela koo?		
4.	O itlhatlhobetse kae mogare?	Lobatse	1
		Elsewhere	2
5.1	A o ne wa bona bogakolodi pele o itlhatlhobela mogare?	Yes	1
		No	2
5.2	A o ne wa bona bogakolodi morago fa o itlhatlhobela mogare?	Yes	1
		No	2
6.	Mabapi le tiroso ya VCT:	SD	
6.1	Ke itumeletse bogakolodi jo ke bo nneetsweng.	1	2 3 4 5
6.2	K eitumeletse thuso yotlhe e ke ennetsweng.	1	2 3 4 5
6.3	Lefelo lene le le phepha.	1	2 3 4 5
6.4	Ke neetswe kitso e mosola.	1	2 3 4 5
6.5	Mogakolodi one a dira gore ke gololesege fa a nneala bogakolodi.	1	2 3 4 5
6.6	Maduo a me ane a sirelesegele.	1	2 3 4 5
6.7	Ke bone thuso ka bofefo.	1	2 3 4 5
6.8	Ga gona ope o oneng a kgona go bona gore keya go itlhatlhobela mogare wa HIV.	1	2 3 4 5
6.9	Di dirisiwa e nee le tsa maemo a a kwa godimo.	1	2 3 4 5
6.10	Ken e ka kgona go bona maduo ame ka pele morago ga goitlhatloba.	1	2 3 4 5
6.11	Bodiredi bone boitse tiro ya jone.	1	2 3 4 5
6.12	A gona le kakgelo e o botlang go l dira ka thuso e o e boning kwa oneng o itlhatlhobelang teng. Tlhalosa ka botlalo.		

SECTION E

O katswa o na le dikakanyo ka go itlhatlobela mogare wa HIV tse re sa di supang fa godimo, karolo e e gofa sebaka sa go supa dikakanyo tsagago.

Araba dipotso tse dilatelang ka go kwala mo ditselaneng tse tse difilweng.

1 Ke eng se se itsang batho go itlhatlhobela mogare wa HIV?

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

2 Go ka dirwang go ngoka batho go itlhatlhobela mogare wa HIV?

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

3 A gona le kakgelo nngwe e o batlang go e dira mabapi le tiriso ya VCT.

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

Appendix 3 - An interview guideline for focus group discussions

1. What are the cultural factors that may influence males (females) not to use HIV and AIDS services?

2. What could be done to make males (females) test more?

Appendix 4- An interview guideline for the HIV and AIDS VCT service provider

SECTION A

Service Provider	Clinic	Tebelopele	Hospital	Private Practitioner
	1	2	3	4
Gender			Male	Female
			1	2
Age	20-29	30-39	40-49	50+
	1	2	3	4
Qualification				
Occupation				
Length of service				

SECTION B

Preamble

Lobatse District has formulated and implemented different HIV/Programmes intended to fight the HIV scourge. Different sectors, both private and public sectors, have adopted more or less the same objectives for the programmes in their endeavour to respond to the epidemic. One of these programmes is the VCT service.

Question

The facilitator will share the initial results of the Lobatse Town council employees and ask to comment.

Questions

1. What are your VCT objectives?
2. Have they been achieved?
3. How?
4. If they have not been achieved why?

Preamble

Different service providers may have differing processes put in place to administer the service. The process followed may lead to the success or failure of the process. Ideally the process of VCT includes the following:

1. Pre-test counselling, which entails the following:
 - Explanation of what that HIV test is and the purpose of testing.
 - The meaning of negative and positive results, including the implication of results.
 - Assessment of personal risk of HIV infection.

- Safer sex and strategies to reduce risks.
 - Coping with a positive result and identification of support services.
 - An opportunity for decision making about taking the HIV test.
2. Post-test counselling:
- This is provided when one receives the result and the following takes place
- Feed-back and understanding of results, and
 - What needs to be done?

Different service providers may have varying processes for different reasons.

Questions

1. What VCT process do you use in your facilities?
2. Why?
3. Is it effective?
4. How?
5. Do you have different processes for different groups of the society, e.g. gender, age, etc?
6. What are they?
7. In your own opinion, what makes a VCT service successful?

Preamble

Different service providers are faced with differing or same challenges and needs.

Questions

What are challenges facing your service in terms of?

- Staff.
- Facility.
- Equipment.

What needs to be done to address these challenges?

In your opinion, what needs to be done to develop the VCT programmes in order to increase the employees' uptake?

Appendix 5 – Letter to the Chief executive Officer from the researcher

Port Elizabeth Nelson Mandela Metropolitan University
Village 5, flat 11b
Post graduate village

Reference no: US 106507

Chief Executive
Lobatse Town Council
Lobatse

UFS: Chef Personnel Officer.

Re: Permission to interview Lobatse Town Council Employees

I am an employee of Lobatse Town Council and currently I am doing a Master's programme in Labour Relations and Human Resources at the Nelson Mandela Metropolitan University in South Africa. In partial fulfilment of the Master's programme, I am required to submit a treatise. In previous discussions held with Mrs, Mopedi (Matron) in December last year, it was agreed that my research project could be on the usage of VCT services by the Lobatse Town Council employees. I hope that you will be in agreement with this suggestion.

I attach a letter from my supervisor Jennifer Bowler together with a brief outline of the proposed research objectives.

This, therefore, serves as a request to be allowed to carry out the study with the employees. 300 employees will be requested to complete a self administered questionnaire, after working hours, while 20 employees will participate in group discussions which will also be held after hours. Permission is also sought to use the LTC premises for the discussions.

Thanking you in advance for your assistance.

Yours faithfully

Lorato Komanyane
Senior Personnel Officer(us:106507)
lukomanyane@yahoo.co.uk
Cell No. 0783609723

Appendix 6-Letter from Supervisor to Chief executive officer

CEO
Lobatse Town Council
Lobatse
18 May 2006

To Whom it May Concern

Lorato Komanyane is a Masters student in the Labour Relations and Human Resources Unit at the Nelson Mandela Metropolitan University in Port Elizabeth, South Africa. As part fulfillment of her master's programme she is required to produce a research treatise. The research area that she has chosen is a study on HIV and AIDS in the workplace.

The proposed title of her treatise is "Factors influencing the use of VCT services in the Lobatse Town Council, Botswana."

The results are published as a master's treatise and will become part of the international library system.

Confidentiality may be of concern. Lobatse Town Council may wish to reserve the right to be identified by name dependent on the outcome of the research. In this case the title of the treatise could be changed to "Factors influencing the use of VCT services in a public sector workplace in Botswana." and all reference to the name of the council and individuals would then be omitted in the text.

As a student of the Unit Lorato Komanyane is bound by the rules of confidentiality when dealing with any information. It is customary for students, when dealing with sensitive information, to be required to sign a confidentiality agreement. Attached please find such an agreement for Lorato Komanyane. If you have any queries or concerns regarding the above please contact the undersigned.

Yours faithfully
Jennifer Bowler
Co-ordinator Honours programme and HIV and AIDS Research
Labour Relations and Human Resources Unit,
Nelson Mandela Metropolitan University

Email address Jennifer.Bowler@nmmu.ac.za

Telephone: 027 41 5042362

Fax: 027 41 5042825

Cell: 0834635285

Appendix 7-Letter assuring confidentiality from researcher

June 2006

To Whom it May Concern

Lorato Komanyane is a Masters student in the Labour Relations and Human Resources Unit at the Nelson Mandela Metropolitan University in Port Elizabeth, South Africa. As part fulfillment of her master's programme she is required to produce a research treatise. The research area that she has chosen is a study on HIV and AIDS in the workplace.

The proposed title of her treatise is "Factors influencing the use of VCT services in the Lobatse Town Council, Botswana."

The results are published as a master's treatise and will become part of the international library system. Please indicate if you are willing to have your name and the name of the institution mentioned in the treatise or if you prefer to remain anonymous.

As a student of the Unit Lorato Komanyane is bound by the rules of confidentiality when dealing with any information. It is customary for students, when dealing with sensitive information, to be required to sign a confidentiality agreement. Attached please find such an agreement for Lorato Komanyane.

If you have any queries or concerns regarding the above please contact the undersigned.

Yours faithfully
Jennifer Bowler
Co-ordinator Honours programme and HIV and AIDS Research
Labour Relations and Human Resources Unit,
Nelson Mandela Metropolitan University

Email address Jennifer.Bowler@nmmu.ac.za
Telephone: 027 41 5042362
Fax: 027 41 5042825
Cell: 0834635285

Appendix 8- Letter granting permission from Chief executive-

Our Ref: US: 10645
Your ref:

20th June 2006

Lorato Komanyane
Senior Personnel Officer
Lobatse Town Council

Dear Madam

PERMISSION TO UNDERTAKE RESEARCH

Permission is granted for you to undertake your study in Lobatse Town Council and to utilize its premises.

Yours faithfully

APPENDIX 9- Introduction letter for the survey respondents

Nelson Mandela Metropolitan University
Port Elizabeth
Village 5, Flat 11

Date-----

To -----

Lobatse Town Council

-----Department

As a student at the abovementioned institution, I am required to carry out a research project in partial fulfilment of my Master's programme. The questionnaires attached are instruments used to collect data for the research I am undertaking.

The research is a survey intended to find out the factors that are contributing towards the utilisation of VCT services by different groups of employees in Lobatse Town Council.

You are requested to complete the questionnaire attached. Please be assured that your responses will be anonymous and will be treated as confidential.

The completed questionnaire must be put in a sealed box by the administration office before or on the -----2006.

For any clarification please do not hesitate to call me at the telephone number given below or email me.

Thanking you in advance.

Yours faithfully,

Lorato Komanyane

lukomanyane@yahoo.co.uk

Cell No. 0783609723

Appendix 10- Closing date extension letter for the survey respondents

19-06-2006

To: Lobatse District Council staff

From: Lorato Komanyane
Senior personnel Officer
Lobatse Town Council

Re: SUBMISSION OF QUESTIONAIRES

This serves to inform you that the closing date for submission of completed questionnaire have been extended from the 19th June 2006 to 10th July 2006. You therefore requested to complete the questionnaire and drop it in the sealed box by the personnel office.

Thank you for your cooperation.

Yours

Lorato Komanyane.

Appendix 11 - – Letter inviting survey respondents for lunch

10-07-2006

To: All Lobatse Town Council staff

From: Lorato Komanyane
Senior personnel officer
Lobatse Town Council

Re: INVITATION FOR LUNCH

You are kindly invited for lunch on the 13th July 2006 in the conference room at 13:00hrs. Please bring along the research questionnaire that was sent to you by myself.

See you there.

Lorato Komanyane.

Appendix 12- - Invitation letter for the focus group discussion participants

Nelson Mandela Metropolitan University
Port Elizabeth
Village 5, Flat 11
Post graduate village
Date-----

To -----
Lobatse Town Council
-----Department

As a student at the abovementioned institution, I am required to carry out a research in partial fulfilment of my Master's programme.

You have been randomly selected to participate in one of the two focus discussion. You may be aware of the questionnaire regarding the utilisation of VCT services that was distributed to approximately 300 Lobatse Town Council employees to find out the factors that are influencing utilisation of VCT services, and reasons for selecting a VCT service provider. In order to compliment the results of the survey we wish to have two discussions; one with a group of females and another with a group of males.

This is a voluntary; therefore you can decline the invitation. Should you agree to participate, you are requested to come for the discussion on the ----- 2006 at the ----- at 17:00 hrs.

For any clarification please do not hesitate to call me at the telephone number given below.

Thanking you in advance.

Yours faithfully,
Lorato Komanyane
lukomanyane@yahoo.co.uk
Cell No. 0783609723

Appendix 13- Letter to the HIV and AIDS VCT service providers

Nelson Mandela Metropolitan University
Port Elizabeth
Village 5, Flat 11
Post graduate village
Date-----

To: Matron (Clinics)
Officer in Charge-Tebelopele
Private Practitioner
VCT Programme coordinator- Athlon Hospital

I am an employee of Lobatse Town Council and currently doing a Master's programme in Labour Relations and Human Resources at the Nelson Mandela Metropolitan University in South Africa. In partial fulfilment of the Master's programme, I am required to submit a treatise. My research is on the usage of VCT services by the Lobatse Town Council employees. I attach a letter from my supervisor Jennifer Bowler together with a brief outline of the proposed research objectives. A survey has been done on the employees to find out the reasons why people are testing, or not testing, reasons for choosing a service provider and level of satisfaction of the VCT services they have experienced in Lobatse.

As a service provider, I would like to interview you further to discuss the above and find out the challenges that you are facing and recommendations for the development of the services. This will hopefully help in the development of the VCT service providers in Lobatse and increased utilisation of users.

Furthermore, if you accept to be interviewed, I request that I be allowed to record the interview. A follow up of this letter will be made through the phone in order to make the appointment for the interview.

For any clarification please do not hesitate to call me at the telephone number given below.

Thanking you in advance.

Yours faithfully,

Lorato Komanyane
lukomanyane@yahoo.co.uk
Cell No. 0783609723