

**SOCIO-BEHAVIOURAL AND STRUCTURAL CORE DRIVERS OF NEW HIV
INFECTION AS PERCEIVED BY EMPLOYEES AT DEPARTMENT OF
AGRICULTURE IN MOPANI DISTRICT, LIMPOPO PROVINCE**

By

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THESIS

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DEDICATIONS

This thesis is dedicated to my late parents, John and Julia Ngobeni, who used to teach me about the importance of education. I cannot omit also dedicating this study to my husband Mr. Bedwel Mathebula, for taking care of our children when I was not available for them because of this study; to my son-in-law, Pastor David Tibane, my beautiful daughters, Glenda, Amukelani, Bridget and Risima for their commitment to Christianity and their endless support throughout this research study. This thesis is also dedicated to my grandsons Lwazi David Tibane and Lwandile Blessing Tibane for offering the massage therapy and, their sense of humour kept me focused on my study.

DECLARATION

I declare that the thesis hereby submitted to the University of Limpopo, for the degree of Doctor of Philosophy in Social Work has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

Mathebula T.S (Mrs)

Date

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ABSTRACT

Despite the laudable progress on HIV and AIDS interventions encountered in South Africa, new HIV infection remains a challenge. Limpopo Department of Agriculture is not an exception as far as new HIV infections are concerned, regardless of the intervention efforts made. This study aimed at exploring on perceptions of LDA employees on social-behavioural and structural core drivers of HIV infection. Qualitative research methodologies were applied. A purposive sample of twenty participants (10 men and 10 women) was selected from Department of Agriculture, Mopani District, Limpopo Province. Constructivism and structuralism theoretical framework were used to navigate the study. Semi-structured, face-to-face interviews were designed. Data was collected through interviews, audio-recorded and transcribed. Eight steps of data analysis were followed as proposed by Creswell. Guidelines for the prevention of new HIV infection were developed.

Some of the major findings are that: the socio-behavioural core drivers that place all partners at risk of contracting new HIV infections is the Multiple Sexual Partnerships (MSPs). Age-disparate relationships in a workplace were also socio-behavioural drivers of new HIV infection. Young women and men who enter into age-disparate relationships have intention of obtaining permanent employment. Patriarchy was found to be amongst the structural core drivers of new HIV infections. The fact that men are not tested involuntarily is viewed as a structural barrier towards eliminating the spread of new HIV infections. Stigma has been also found to be a core driver of new HIV infections.

Some conclusions made are: MSPs is a closed sexual network system, characterised by “secrecy” and “trust”. Despite some reforms purporting to improve women’s status, patriarchal domination is still at its toll. Unsymbolised stigma remains a threat towards elimination of the spread of HIV infections. The major recommendations are that working women still require empowerment in number of areas of their social functioning, and the leadership involvement in the fight against the spread of new HIV infections.

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ARV	Antiretroviral
BRM	Behavioural Risk Management
CADRE	Centre for AIDS Development, Research and Evaluation
CD4	T-Lymphocyte cell bearing CD4 receptor
DPSA	Department of Public Service and Administration
EAP	Employee Assistance Programme
EHW	Employee Health and Wellness
FAO	Food and Agriculture Organisation
GBV	Gender-Based Violence
HAST	HIV and AIDS, STI and TB
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HSRC	Human Science Research Council
ICAS	Independent Counselling and Advisory Services
ICU	Intensive Care Unit
ILO	International Labour Office
IPCC	International Pentecostal Christian Church
IPHC	International Pentecostal Holiness Church
KAP	Knowledge, Attitude and Perception
KYE	Know Your Epidemic
KRA	Know Your Response
LDA	Limpopo Department of Agriculture

MA (SS)	Master of Arts in Social Science
MSPs	Multiple Sexual Partnerships
MTCT	Mother-to-Child Transmission
NSP	National Strategic Plan
OHS	Occupational Health and Safety
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PLWHA	People Living with HIV and AIDS
PMCT	Prevention of Mother-to-Child Transmission
RSA	Republic of South Africa
SADC	Southern African Development Community
SANAC	South African National AIDS Council
SMS	Senior Management Service
SDT	Self-Determination Theory
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TV	Television
UHC	Universal Health Coverage
UNAIDS	United Nations Program on HIV and AIDS
U.S	United State
VMMC	Voluntary Medical Male Circumcision
VCT	Voluntary Counselling and Testing
VSO	Voluntary Service Overseas
WHO	World Health Organization

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CHAPTER 1: GENERAL ORIENTATION OF THE STUDY

1.1. INTRODUCTION

The impact of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) pandemic is globally and nationally. South Africa has a generalised epidemic of HIV, driven largely by sexual transmission. In 2009 an estimated 17.9% of the adult population was living with HIV. This is estimated to be 5.63 million people, including women and 334,000 children (Summary on National Strategic Plan for HIV, STIs and TB 2012-2016:8). According to AIDS Foundation of South Africa, South Africa has the highest prevalence of HIV and AIDS compared to any other country in the world with 5.6 million people living with HIV, and 270,000 HIV related deaths recorded in 2011(UNAIDS 2013:2).

Recognizing the serious nature of HIV and AIDS and its impact on South Africa, the then Minister for Public Service and Administration Ms Geraldine Fraser-Moleketi initiated the impact and action project in January 2000 which aimed at ensuring that Public Service is able to sustain a quality service in spite of the progression of the AIDS pandemic (Public Service and Administration 2002:1). She further reiterated that as a single biggest employer in South Africa, with nearly 1.1 million public servants employed by approximately 140 government departments at national and provincial level, there is no doubt that the Public Service has a crucial role to play in mitigating the impact of HIV and AIDS as part of its overall focus on the health and well-being of its members. In terms of Public Service Regulation (2001: 24-26) the Head of Departments have been delegated with responsibilities to ensure that working environment support effective and efficient service delivery while, as far as reasonably possible, taking employees' personal circumstances, including disability, HIV and AIDS and other health conditions into account.

In response to the initiative of transforming the public sectors by the Minister of Public Service and Administration, Limpopo Department of Agriculture (LDA) started the implementation of Employee Health and Wellness (EHW) Programme in 2001. Guided by the Department of Public Service and Administration (DPSA) Framework on Employee Health and Wellness, the focus was mainly on bringing about changes in the wellbeing and the working environment in order to promote employees' health, accelerate service delivery and ultimately, increase high level of productivity. The response to HIV and AIDS during implementation was based on the understanding that the public interest is best served when the rights of those living with HIV and AIDS are respected, protected and promoted. The Public Service Regulations (2001) mandated the Head of Department to ensure that no employee or prospective employee is unfairly discriminated against on the basis of HIV status in any employment policy or practice. He or she should take appropriate measures to actively promote non-discrimination and to protect HIV employees from discrimination.

The researcher is of the opinion that EHW programme within LDA has advanced in its implementation, however; she cannot overlook the fact that witnessing new HIV infection during HIV, Counselling and Testing (HCT) conducted for the employees is a major challenge to the current applied prevention strategies. The primary strategy to prevent new HIV infection is by using a combination of biomedical, behavioural, social and structural interventions that will have the greatest impact in reducing the susceptibility and vulnerability to HIV infection (National Strategic Plan on HIV, STIs and TB 2012-2016). It is in response to this notion that the researcher aimed at exploring the perceptions of employees on socio- behavioural and structural core drivers of new HIV infection with the intention of promoting healthy behaviour, address norms and conduct that put them at risk for contracting new HIV infection.

1.2. PROBLEM FORMULATION

The Joint United Nations Programme on HIV and AIDS (UNAIDS) report on the global AIDS epidemic (2013) highlighted continued progress towards the global vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. However, the report also noted with caution, as well as signs of stagnating progress towards other targets such as the increase in sexual risk behaviours among young people; stigma and discrimination remain rife in many parts of the world.

Concurrently, a report by the Global Health Magazine (2013) attested that South Africa had made significant and laudable progress in the past five years. It further indicated that nearly one million South Africans had been receiving antiretroviral treatment; two-thirds of infected mothers had access to services to prevent transmission from mother-to-child, and new surveillance data indicated declining prevalence among children and youth, as well as higher rates of condom use. Despite the recent spate of encouraging news, the South African epidemic remains as daunting as ever. Prevention interventions have failed to gain traction with between 350,000 and 500,000 new infections still occurring annually (Global Health Magazine, 2013).

Limpopo Department of Agriculture (LDA) is not exceptional as far as new HIV infections are continuously being detected from employees during HIV Counselling and Testing (HCT) campaigns, despite the intervention efforts made by the Employee Health and Wellness (EHW) section within the Department. From the Employee Assistance Programme (EAP) case statistics and the sick leave analysis report conducted in the year 2010 within LDA it was evident that ill-health and incapacity leaves that results in absenteeism are the major threat of productivity in the Department.

The Global Health Magazine Report (2013) on the state of HIV and AIDS in South Africa stresses that the first step to mounting an effective prevention effort is to “know your epidemic” that enables one to “know the response”. The Voluntary Counselling and Testing Report compiled by Lebogang Lesedi consultancy in March 2010 at Limpopo Department of Agriculture outlined the identified risks of contracting new HIV infections as follows:

- Most of the employees were not using condoms;
- Some employees had multiple partners;
- Some employees did not know the HIV status of their partners;
- Some employees had sexually transmitted infections; and
- Were ignorant of the HIV infection prevention.

The findings of the report further revealed that from six workplaces in which Voluntary Counselling and Testing was conducted, 22 (Male=11; Female=11), that is 5% out of 508 (Male=248; Female=260) employees tested positive. It further showed that employees from age 30 to 59 and from both male and females were newly infected by HIV. The 2012-2013 annual HCT statistics in the same Department showed that out of 3998 employees from 38 workplaces that were covered, only 1095 (28%) employees underwent counselling and testing for HIV and 62 (6%) employees tested positive. If that new HIV infection trend continued, the social and economic structure of LDA was in jeopardy, and the degree of human suffering would increase significantly.

Based on the elusive epidemiological information within LDA, this study explored the socio- behavioural and structural core drivers of new HIV infection with the aim of addressing deeply entrenched and long established cultural, socio-economic and behavioural factors (National Strategic Plan for HIV and AIDS, STI and TB 2012-2016). There is a strong need to achieve a transition that will see fewer people newly infected than newly placed on treatment (UNAIDS 2010).

The Provincial Strategic Plan for HIV and AIDS, STI and TB (2012-2016) indicates that substance abuse, mobility and migration, multiple, concurrent and inter-generational sex were identified as social drivers of the dual epidemic in Limpopo Province. Added to these social drivers, the study will take into account the cultural practices, the persistence of stigma and discrimination experienced due to HIV status.

1.3. MOTIVATION FOR THE STUDY

The researcher was a coordinator of Employee Health and Wellness Programme in LDA, which is a health promoting programme. She had been further delegated by the Head of Department to provide appropriate education, awareness and prevention programmes on HIV and AIDS and other sexually transmitted infections for the employees, where possible, their families, and as far as possible, integrate those programmes with activities that promote the health and wellbeing of employees (Public Service Regulations, 2001).

Conducting awareness campaigns is a commonly used strategy to prevent new HIV infection. The shortfall of this strategy is that the employees participate less, the presenter is an expert and employees become passive recipients. The researcher was interested in engaging in a one on one approach, which can be benefiting in entering the employee's world of reality. The recent research literature on HIV and AIDS generated by UNAIDS (2013) and the findings by the Know Your Epidemic/ Know Your Response Summary Report (2011) have identified potential gaps that lead to the failure of arresting the new HIV infection. The researcher therefore argues that the identified gap is turned into an identified need to explore perceptions of LDA employees on socio-behavioural and structural core drivers of new HIV infection.

1.4. THE SIGNIFICANCE OF THE STUDY

A number of workplace HIV and AIDS research has been done, wherein the focus was mainly on evaluating the effectiveness and the impact of programmes in addressing the pandemic, as well as its impact on the infected individual and the organisation. Little, if not none, is known about perceptions of employees on socio-behavioural and structural core drivers of new HIV infection.

This study intrinsically bears an element of risk behaviour changing and the social conditions that drive the HIV epidemic. The findings from this study provided scientific evidence that will guide and enhance the Limpopo Department of Agriculture's response to the epidemic and; may also be extrapolated to other Departments where they might be experiencing similar challenges. Thus, the study was pursued for purposes of generating the knowledge needed to contribute in the social and public health research and in the country's response to prevention of new HIV infection.

1.5. THE PURPOSE OF THE STUDY

The aim of the study was to explore perceptions of LDA employees on socio-behavioural and structural core drivers of HIV infection.

1.6. THE OBJECTIVE(S) OF THE STUDY

The study aimed to achieve the following objectives:

- To understand the perceptions of employees with regard to the socio-behavioural core drivers of new HIV infections amongst them.
- To determine the perceptions of employees with regard to the structural core drivers of new HIV infections amongst employees.
- To examine the perceptions of employees in terms of stigma and discrimination due to HIV infection at the workplace.
- To develop a practice guideline on the prevention programmes of new HIV infections in a workplace.

1.7. LIMITATIONS OF THE STUDY

The following limitations of the study have been observed:

The study has provided more information on socio-behavioural and structural core drivers of HIV infection experienced by marriage partners, little information is known about single partners. The findings could have provided more information if attention was also given in exploring more of the applicability of the study to single partners.

Language was a barrier in some instances to obtain accurate information on the topic under investigation. Four languages, which are Xi-Tsonga, Se-Pedi, English and Tshi-Venda, were all used during the interview with the participants. The flow of communication and expression of ideas did not occur smoothly. This might have

compromised the accuracy of the information provided as well as the capturing by the researcher.

1.8. DEFINITION OF KEY CONCEPTS

The following are the definition of key concepts used in this study:

1.8.1. Socio-behavioral conduct

The socio-behavioural is a behaviour or conduct directed towards society, whereby a person demonstrates the ability to interact successfully within the environment of which each person is part. Examples of socio-behavioural core drivers of new HIV infection are sexual debut, multiple sexual partners, condom use, intergenerational relationships, alcohol and substance abuse. The concept bears the meaning is ascribed here for purposes of this study.

1.8.2. Structural

For purposes of this study the concept structural is the fundamental, tangible or intangible notion referring to the recognition, observation, nature, and permanence of patterns and relationships of entities. Examples of structural core drivers of HIV infections are mobility and migration, gender roles and norms, sexual abuse and intimate partner violence.

1.8.3. Core-Drivers

For purposes of this study, core-drivers are the main factors that influence or drive the outcome of the activity whose consequences are either rewarding or detrimental to the actor or to other people.

1.8.4. Perception

In this study perception is the organisation, identification, and interpretation of sensory information in order to represent and understand the environment.

1.8.5. Employee

For purposes of this study an employee means “any person who is employed in the Department of Agriculture, Mopani District in Limpopo Province.

1.9. OUTLINE OF THE RESEARCH REPORT

The research report consists of five chapters:

In this chapter, a general orientation of the study outlined the introduction, problem formulation, motivation, significance, aim and objectives, limitations of the study and definition of key concepts are provided.

Chapter 2 provides the applicable theoretical framework, the existing documented empirical research as well as legislation, policy, procedure and guidelines on implementing HIV and AIDS programme that assisted in guiding the findings of this study on the socio-behavioural and structural core drivers of new HIV infections amongst employees in Mopani district as perceived by the participants.

In Chapter 3 a detailed qualitative research methods applied for the purpose of this study is described.

The research findings, compared and contrasted with the existing body of knowledge on the investigated topic are presented and discussed in chapter 4.

The final chapter of the study outlines the summary, conclusions and recommendations of the research report.

1.10. SUMMARY

Chapter 1 of this study has introduced the impact of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome globally, nationally and provincially. The Joint United Programme on HIV and AIDS report on the global AIDS epidemic report (2013) outlined continued progress towards the global vision of zero new HIV infections, zero discrimination and zero AIDS related death. However, the report noted with caution, as is South Africa that prevention interventions have failed to gain traction of new HIV infection. HCT (2013) annual statistic in Limpopo Department of Agriculture confirmed the occurrence of new HIV infection despite the prevention effort made by Employee Health and Wellness Coordinators.

The researcher has identified and outlined four objectives addressed by the study. In order for the prevention strategies to succeed and ultimately to attain the 2030 vision, the researcher explored on the socio-behavioural and structural core drivers of new HIV infection as perceived by employees at Mopani district, Limpopo Province.

CHAPTER 2: LITERATURE REVIEW ON SOCIO-BEHAVIOURAL AND STRUCTURAL CORE DRIVERS OF NEW HIV INFECTIONS

2.1. INTRODUCTION

This chapter provides the existing documented research on the socio-behavioural and structural core drivers of new HIV infections. The literature review will focus on social constructivism and structuralism as theoretical frameworks, socio-behavioural and structural core drivers of new HIV infections, as well as legislation, policy, procedure and guidelines on implementing HIV and AIDS programme.

2.2. THEORETICAL FRAMEWORK ON SOCIO-BEHAVIOURAL AND STRUCTURAL CORE DRIVERS OF NEW HIV INFECTIONS

2.2.1. Social constructionism

Socio-behavioural and structural core drivers of new HIV infections may be understood from the social constructionism's perspective. Social constructionism is described as part of the movement in postmodernism in that it attempts to "replace the objectivist ideal with a broad tradition of on-going criticism in which all productions of the human mind are concerned" (Hoffman, 1990:1) and is inextricably linked to postmodernism as a set of lense that enforces an awareness of the way in which people perceive and experience the world (Hoffman, 1990). The terms constructivism and social constructionism had been used interchangeably in this study. Constructivism proposes that each individual mentally constructs the world of experience through cognitive processes processes while social constructionism has a social rather than an individual (Andrews, 2012).

In essence, social constructionism is the claim and viewpoint that the content of people consciousness, and the mode of relating to one another, is taught by the culture and society; all metaphysical quantities people take for granted are learned from each other (Owen, 1992). Based on this premise, the researcher argues that culture and society play a critical role on the individual's perception, interpretation and subsequent behaviour in relation to contracting new HIV infections.

Thus it is critical to understand, determine and examine the socio-behavioural and structural core drivers of new HIV infections as perceived by the employees, in order to develop appropriate strategies to address the new HIV infection at a workplace. In this regard, Webb (1997) also emphasised that in order to formulate legitimate prevention programmes and to make them truly place sensitive interventions suited to local conditions, analysis of the social constructions of HIV and AIDS are crucial. The discussion that follows includes a concise overview of these three assumptions underlying social constructionism thought.

2.2.1.1. Realities are socially constructed

Social constructionists argue that all knowing of reality requires an act of interpretation and there are no linear notions of causality for the explanation of events in "living systems" (Bateson, 1972). It is through the social interaction over time that people together construct their realities. Hence, social constructionists are concerned with meaning of interpretation, as it is the meaning that the persons involved attribute to events that determines one's behaviour. The researcher is therefore of the opinion of understanding, determining and examining the meaning of interpretations that the employees involved attribute to the socio-behavioural and structural functioning that drives the new HIV infections.

Furthermore, from the belief that reality is socially constructed, social constructivists also maintain that man's understanding of the world is historically and culturally specific. It is because the means people use to understand the world, such as categories and concepts, are all historically and culturally relative. As Burr (1995) argued that worldviews are not only "specific to particular cultures and periods of

history, they are seen as products of that culture and history, and are dependent upon the particular social and economic arrangements prevailing in that culture at that time". The researcher's frame of reference is that in order to understand the socio-behavioural and structural core drivers of new HIV infections, it is imperative to understand it in relation to an individual's historical and cultural context.

Laird (1993) ascertains that focusing on process rather than content brings about a radical shift in our way of viewing knowledge. People begin to see themselves as knowledge-creators. No one person or group can be said to exclusively possess this source of knowledge. Gergen (1994) attests that social constructionism is a reminder that all values, ideologies and social institutions are human-made. Because people cannot know the objective reality, all knowing requires an act of interpretation. It is through the process of social discourse that meanings are constructed.

Similarly, Barkhurst and Sypnowich (1995) concur that people are socially constructed beings because their identities are significantly shaped by social or cultural influences. In addition, people are viewed as participants in their own construction of reality. Social constructionists are interested in delineating the processes that operate in socio-cultural conduct of action to produce the discourse within which people construe themselves. Lock and Strong (2010) reiterate that social constructionism is concerned with meaning and understanding as the central feature of human activities.

Witkin (2012) attests that social constructionists do not assume a pre-existing world waiting to be discovered. They are more interested in the utility of descriptions than in their "truth". Concurrently, Holstein and Gubrium (2008) ascertain that the leading idea always has been that the world people live in and their place in it are not simply and evidently "there" for them. Rather people actively construct the world of everyday life and its constituent elements. The guiding principle of social construction is that humans cannot live alone. To envision human life is to envision relationships. Human's beliefs and feelings, what is found pleasing or displeasing, beautiful or ugly, right or wrong, are all the products of social relationships (Witkin 2012).

From the social constructivism's point of view, the researcher argues that HIV and AIDS programme in a workplace do not require only the expert knowledge for the programme to become effective, rather the engagement of employees in the construction of the reality of the social phenomenon, in this instance, the new HIV infection, by exploring on the socio-behavioural and structural functioning that can fuel the spread of the new HIV infection, since social constructionists acknowledge the equal engagement of research participant and researcher as co-creators of a shared reality.

2.2.1.2. Realities are constituted through language

The fundamental idea of social constructionism is that people in relationships construct the world and that; beliefs about reality are largely constituted by language. Social constructionists believe that speaking is not as neutral and passive as the positivists would have thought. Every time we speak, we bring forth a reality. Each time we share words, we give legitimacy to the distinctions that those words bring forth (Freedman & Combs, 1996). The way people think and the means people use, such as categories and concepts, in understanding the world are all provided by language. Furthermore, social constructionists argue that language and thought should not be viewed as two separate phenomena and that language provides the basis for all our thought (Burr, 1995). Hence, language is more than simply a way of expressing ourselves.

The researcher argues that language expresses thoughts, and thoughts are products of individual's life-world experiences. Thus to enter an individual's life-world experiences in regard to socio-behavioural and structural core drivers of new infection, an opportunity to share those experiences in the participants own language is of utmost importance. It is also notable that the meanings carried by the language are never fixed, but always open to questions, disagreement and potential conflict (Burr, 1995).

With reference to social constructivism's perspective, phenomena like HIV and AIDS exist because of the words that name them and render them visible and intelligible (Witkin 2012). HIV and AIDS is not any particular thing until it was given a name. To

represent a profound shift in thinking from a long-held view that language is a relatively transparent vehicle for representing reality that it reflects what is “out there”, the researcher perceived it as ideal to understand the naming and interpretations of socio-behavioural and structural core drivers of new HIV infections as perceived by employees and not as reflected by the existing documents on the research topic.

2.2.1.3. Knowledge is sustained by social processes

The modernists, such as behaviourists and advocates of empirical clinical practice uphold that it is the single individual who possesses the capacity to know the world and to act adaptively within it. If individual capacities and processes are functioning normally, the individual will confront life’s challenges as adequately as possible. When there are inadequacies in meeting these challenges, there is reason to believe that the capacities and processes become “malfunctioned” or “pathological” (McNamee & Gergen, 1992). Hence, it is the expert who carefully observes and deliberates, and who offers his or her conclusions about the adequacies and inadequacies of independently situated others. It is also the common individual who suffers from inadequacies, who may regain a fulfilling life by giving way to expert knowledge (McNamee & Gergen, 1992).

Social constructionists further describe knowledge as a human product, and is socially and culturally constructed (Ernest, 2012). Lock and Strong (2010) maintained that how people experience the world and make a sense of it is primarily the product of socio-cultural processes. Furthermore, these processes have their human roots in history than biology. It is more the case that knowledge and social action go together in development rather than that knowledge is separate from action and somehow informs it. Wittgenstein, 1953 (in Lock and Strong 2010) states that problems are solved, not by giving new information, but by arranging what we have always known. Facts are not neutral and out there waiting to be discovered. Instead,

such facts are constructed in fields of activities, and worked up into ideologies that benefit some people while disempowering others.

The researcher is of the opinion that employees are not passive absorbers of information, but active recipients and processors of information in a manner that fits with their value systems. Thus in order to understand the socio-behavioural and structural core drivers of new HIV infections as perceived by the employees, one has to understand them contextually in relation to cultural, societal and religious value systems.

2.3. EMPIRICAL STUDIES ON SOCIO-BEHAVIOURAL AND STRUCTURAL CORE DRIVERS OF NEW HIV INFECTIONS

The literature on socio-behavioural and structural core drivers of new HIV infection was also reviewed from the HIV and AIDS global, regional, national and provincial prevalence reports and from other related research studies done. Addressing social and structural barriers that increase vulnerability to HIV, STI and TB infection is one of the key objectives of the National Strategic Plan for HIV and AIDS, STIs and TB (2012-2016).

2.3.1. HIV and AIDS global prevalence

According to UNAIDS (2014) globally, 15 countries account for nearly 75% of all people living with HIV. Ensuring that people living with HIV in these countries have access to HIV treatment services is especially critical. At the end of 2013, there were 35 million [33.2 million–37.2 million] people living with HIV. This number is rising as more people are living longer because of antiretroviral therapy, alongside the number of new HIV infections, which although declining, is still very high.

An estimated 0.8% of adults aged 15–49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between regions and countries. There are 4 million young people 15–24 years old living with HIV, 29% of whom are adolescents aged 15–19 years. There are 16 million women aged

15 years and older living with HIV; 80% live in sub-Saharan Africa. The primary contributor to the scale of the epidemic in this region is heterosexual transmission and the increased vulnerability to and risk of HIV infection among adolescent girls and young women. The researcher has noted that the given statistics' age distribution by the UNAIDS (2014) global report ranges from 15 years and above. However, for the purpose of this study the participants' ages will range between 18 and 65 years old, which is the age of entry through internship programme and exit period in and out of the public service due to age retirement.

2.3.2. HIV and AIDS prevalence at sub- Saharan Africa region

Of the 35 million people living with HIV, an estimated 24.7 million are living in sub-Saharan Africa, nearly 71% of the global total. The sub-Saharan Africa is the region hardest hit by the epidemic. Nearly one in every 20 adults is living with the virus in this region. Almost 4.8 million people are living with HIV in Asia and the Pacific, although the regional prevalence of HIV infection is about one-seventeenth that in sub-Saharan Africa. In the Caribbean, 1.1% of adults were living with HIV at the end of 2013 (UNAIDS 2014).

Ten countries, namely Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe account for 81% of all people living with HIV in the region and half of those are in only two countries, which are Nigeria and South Africa. There are also more women living with HIV in sub-Saharan Africa than HIV-positive men; women account for 58% of the total number of people living with HIV. However, in other regions, more men are living with HIV than women, reflecting in part the fact that epidemics in these countries are primarily among populations such as sex workers and their clients (some of them migrants), gay men and other men who have sex with men, people who inject drugs and transgender people.

There are 2.9 million young people (aged 15–24) and more than 2.5 million people aged 50 years and older living with HIV in sub-Saharan Africa. Of the estimated 1.8 million people living with HIV who were affected by conflict, displacement or disaster in 2006, 1.5 million were living in sub-Saharan Africa. This number has since increased as the total number of people displaced has increased globally (UNAIDS 2014).

In sub-Saharan Africa, only eight male condoms were available per year for each sexually active individual. Among young people, condom access was even lower. Condom availability varies from country to country and can vary widely within a country, not necessarily aligned with HIV burden. The number of new infections in Eastern Europe and central Asia began increasing in the late 2000s after remaining relatively stable for several years since an initial peak in 2000. The region now has 0.6% of adults living with HIV (UNAIDS 2014).

The number of men who opted for medical male circumcision in the priority countries has tripled in the past two years. HIV prevention programmes for people who inject drugs, gay men and other men who have sex with men, sex workers and transgender people have shown results when such services are made available and community-led. Further, increased access to antiretroviral therapy, in combination with other HIV prevention services, is driving down new HIV infections. The trends in rising new infections are cause for concern in the Middle East and North Africa. Since 2001, new HIV infections in this region have increased by 31%, from 19 000 to 25 000. In Western Europe and North America, new HIV infections have increased by 6% (UNAIDS 2013:19). Subsequently, UNAIDS (2014) reiterated that there were 1.5 million new HIV infections in sub-Saharan Africa in 2013.

However, it is reported that new infections are on the decline. There was a 33% drop in new HIV infections among all ages in the region between 2005 and 2013 and a 19% reduction since 2010. The number of new HIV infections is falling in every country in the region except Angola and Uganda where increases were recorded. South Africa, the country with the largest number of people living with HIV, recorded the largest decline in new infections in absolute numbers, with 98 000 fewer new HIV infections than in 2010. Since 2010, the number of new HIV infections in Ghana decreased by 43% and by 41% in Malawi.

Despite gains in preventing new HIV infections, sub-Saharan Africa remains the region most severely affected, with nearly 1 in every 25 adults (4.4%) living with HIV. Three countries, which are; Nigeria, South Africa and Uganda represented almost 48% of the new HIV infections in the region, while there is an increase in the number of new infections in Uganda over the 2005-2013 period.

Generally, the number of people who are newly infected with HIV is continuing to decline in most parts of the world. There were 2.1 million new HIV infections in 2013, a decline of 38% from 2001, when there were 3.4 million new infections. In the past three years alone, new HIV infections fell by 13%. Among the 82 countries for which the data for determining trends are of sufficient quality, new HIV infections have declined by more than 75% in 10 countries and by more than 50% in 27 countries (UNAIDS 2014).

The researcher argues that although there is a gradual decline in new HIV infections in most parts of the world and South Africa in particular, the current tested new HIV infections are threat towards the attainment of the 20 year vision by 2030. This vision has been for South Africa that was launched by the South African President, Mr Jacob Zuma on the 1st December 2011, outlined as follows:

- Zero new HIV and TB infections;
- Zero new infections due to vertical transmission;
- Zero preventable deaths associated with HIV and TB; and
- Zero discrimination associated with HIV and TB (Limpopo Provincial Strategic Plan on HIV, STI's and TB 2012-2016:32).

There is now a growing momentum to set a target of “ending the AIDS epidemic” by 2030 with three possible sub targets related to: reducing new adult HIV infections and eliminating new infections among children; reducing stigma and discrimination faced by people living with HIV and key populations; and reducing AIDS-related deaths (WHO 2014). It is based on this notion that more intervention strategies of which; this study is one of those, should be in place in order to reduce new HIV infection.

While the majority of new HIV infections occur among adults above the age of 25, large proportion occurs among young women and adolescent girls. The issues faced by young women and adolescent girls, gender-based violence including sexual abuse, lack of access to education and health services, as well as social protection and how they cope with these inequities and injustices determine how able they are to protect themselves from HIV or to access antiretroviral therapy while they are young and move into adulthood.

The risks and choices they make are shaped by their early experiences and radical transformations are required to break these barriers. UNAIDS, therefore, recommends a major movement to protect adolescent young women. This clearly shows a failure to protect them and meet their sexual and reproductive health needs as they prepare for adulthood. In eastern and southern Africa, for example, adolescent girls in Mozambique had an HIV prevalence of 7%, which doubled to 15% by the time they were 25 years of age. In Lesotho, an HIV prevalence of 4% was recorded among adolescent girls, which increased to 24% among young women aged 20–24 years.

This pattern is repeated in almost every country in eastern and southern Africa. In West and central Africa, similar patterns are also observed, but at a slightly lower scale, indicating similar risk and vulnerability conditions for adolescent girls and women across the sub-region. Adolescent boys and young men are also impacted. In Nigeria, HIV prevalence among adolescent boys aged 15–19 years was already 2.9% (National HIV & AIDS Reproductive Health Survey 2012). However, in most countries, HIV prevalence among young men is much lower, suggesting a significant age differential in the sexual debut between women and men.

2.3.3. HIV and AIDS epidemic and response in South Africa

UNAIDS (2013) highlight a need to focus on local epidemics and populations. With strategic focus, programme investment becomes more efficient and delivers better-quality services that result in greater and better outcomes. Responses can be tailored to the local epidemics, giving customized service options according to the specific needs of the area or population. The drivers of the epidemic need to be examined, not just at the national level but also at the local level.

It is important to continue to collect and analyse data at the sub-national level, district by district, and in cities to identify areas of high incidence of HIV infection and the socio-behavioural reasons that contribute to people becoming newly infected with HIV. With local information, HIV services can be scaled up and saturated to meet community needs. Hence, the researcher was of the intention to explore the socio-behavioural and structural core drivers of new HIV infection to LDA employees.

According to the Know Your Epidemic/ Know Your Response Summary Report (2011), there are numerous methodological challenges in designing an appropriate package of interventions that match the epidemiological profile of a target population, in delivering that package at the population level as well as in measuring the combined rather than the single-intervention effect. Mkhize (2004) highlighted that many interventions failed miserably, because they were based on research done in the developed countries and thus did not take into account the socio-cultural context of people in developing countries.

In 2009, it was estimated that more than a 1000 people in South Africa become infected with HIV every day. Given that HIV is an infectious disease that is mostly sexually transmitted; these new infections in South Africa will continue to occur when there is sexual contact between HIV-negative and HIV-positive persons. The likelihood that unprotected sexual contact between HIV-negative and HIV-positive persons will occur is influenced by the sexual and relationship norms, alongside broader, more distal factors that modulate these social norms in South Africa.

Kalipeni, Oppong and Zerai (2007) found that poor knowledge about HIV and AIDS prevents the acceptance and understanding of dual and recombant infections, and the complications of elevated viral loads. Individual factors such as knowledge and confidence play, without doubt, a key role in sexual behaviour and thus also in the spread of HIV; however, these individual factors are shaped by a person's social context and are thus only part of this extremely complex problem.

According to the 2011 United Nations Political Declaration on HIV and AIDS, HIV prevention must remain the corner stone of the HIV response. To be optimally effective, prevention efforts should include combinations of behavioural, biomedical and structural programming approaches that focus on scale-up in geographic settings and populations at greatest risk of acquiring and transmitting HIV (UNAIDS 2013).

The report further indicates that as new biomedical tools rolled out, effective socio-behavioural and structural programmes will not only remain essential in their own right but are also needed to maximize the efficacy of biomedical approaches. Behavioural and structural programmes also help to overcome barriers to service uptake, such as social exclusion, stigma and inequity. In this regard, political commitment and strategic action are needed to reduce the number of adults who acquire HIV sexually (UNAIDS 2013).

Similarly, Webb (1997) holds that any approach which examines only some determinants while ignoring others are thus incomplete. If accuracy is to be maintained, conceptualisation of a situation must include all cultural, structural and behavioural factors. Jaquette and Summerfield (2007) concur that nearly every other welfare measure depends on health. Economies cannot prosper, democracies cannot flourish, and schools cannot function without healthy people. Health is defined by World Health Organization's 1946 constitution in Jaquette and Summerfield (2007) as a state of complete physical, mental, spiritual, and social-wellbeing and not merely the absence of disease or infirmity.

Findings in the Siyam'kela (2003), the Guidelines for the Workplace in HIV/AIDS and Stigma reveal that the workplace is considered an ideal setting for HIV/AIDS prevention programmes, as well as for the provision of treatment, care and support to employees infected and affected by HIV/AIDS. The researcher is of the opinion that in order for the workplace to be recognised as best, it requires a healthy workforce that is free from new HIV infection; hence there is a need for more efforts to be placed on prevention strategies.

It is based on this notion that the researcher decided to shift her focus from awareness campaigns as an intervention strategy, and rather adopt a research method as a strategy to seek out the employees' world of experiences by exploring their perceptions of the socio-behavioural and structural core drivers of new HIV infection.

An evaluation of the Limpopo Department of Agriculture's Employee Assistance Programme and HIV and AIDS programme was conducted by Independent Counselling and Advisory Services (ICAS) in 2006. A need analysis using the behavioural risk management Audit (BRM) and HIV and AIDS knowledge, attitude and practice (KAP) survey were employed (ICAS 2006). The findings of the KAP survey revealed that several knowledge indicators such as HIV and AIDS terminology, risk factors, prevalence and testing were explored in the study. Approximately, 71.5% participants responded that there is difference between HIV and AIDS. With regard to knowledge of risk factors on the transmission of HIV, less than 50% of the participants correctly identified the low risk behaviour. The majority (89.6%) answered correctly that one can ascertain an individual status through a blood test.

The negative attitudes and stigma associated with HIV and AIDS have shown to lead to fears of testing and finding out one's own status. Also, by classifying people infected with the virus as different and of lesser status, individuals themselves often perceive themselves as not vulnerable and distant from the disease. These

perceptions often lead to ignorance with regards to safe sex messages and prevention efforts.

2.4. SOCIO-BEHAVIOURAL CORE DRIVERS OF NEW HIV INFECTIONS

Socio-behavioural core drivers of new HIV infections are essential in the study of the spread of HIV. Waldo and Coates (2000) have highlighted how HIV prevention has been hindered by individual-level explanations of sexual behaviour, which have led to individual-level interventions which subsequently lead to individual-level change. Similarly, Campbell (2004) stated that the individual is most likely to come from projects in which people collaborate not only to change their own behaviour, but also to understand and challenge the social circumstances that place their health at risk.

It is further articulated that such interventions have failed to consider features of social context, which might either enable or hinder an individual's ability to act in a certain way. One of the sub-objectives of the prevention of new infection of HIV and TB as tabulated in the National Strategic Plan for HIV and AIDS, STIs and TB (2012-2016) is to implement a comprehensive national social and behavioural change

communication strategy with a focus on key populations. This must be aimed at increasing people's use of services as well as promoting constructive values, attitudes, (norms) and behaviour.

Behavioural theories emphasise the way in which behaviour is changed over time and ways in which individuals modify their behaviour (Slavin, 1994). According to the World Book (1992), behaviour is the way human beings and other organisms act, and in Psychology and other behavioural sciences, behaviour is how a person's actions fit society's idea of right or wrong. It results from a combination of many factors. Scientists and psychologists usually associate behaviour change with behaviour modification or behaviour therapy. Reber (2001), for example, defined behaviour modification as the process of changing a person's behaviour and that the term is generally used synonymously with behaviour therapy. Behaviour change according to Klein (1991) is a behavioural treatment to alter inappropriate behaviour.

Behaviour therapy can be defined as a group of therapeutic techniques aimed at the modification of maladaptive behaviour via application of learning principles (Hjelle & Ziegler, 1987). Behaviour can be changed through learning, conditioning, and communication. Learning and behavioural change learning is the process by which behaviour is changed as a result of experience and practice (The World Book, 1996). This means that learning can change behaviour. Behaviour theory maintains that most behaviour can be learned, given the appropriate environmental circumstances (Wicks-Nelson & Israel, 1984). Thus, like knowledge and attitude, behaviour modification occurs through conditioning and reinforcement. HIV and AIDS behaviour can therefore be modified by HIV and AIDS intervention as conditioning is one of the strategies in the intervention process.

Communication is an educational programme, which provides information about the need to change behaviour to avoid HIV and AIDS and a "means" programme, which provides the actual means for behaviour change as advocated by Ostrow

(1990). These educational programmes include awareness campaign in the form of presentations, debates and dialogues, posters and pamphlets. This behaviour change strategy is being implemented very often at Department of Agriculture in Limpopo since the researcher is the coordinator of HIV and AIDS, STI and TB (HAST) programme.

However, the researcher cannot overlook the fact that witnessing new HIV infections during HIV, Counselling and Testing (HCT) conducted with the employees is a major challenge to the current applied prevention strategies. Hence; she adopted the research method as a strategy to understand, determine and examine the perceptions of employees with regard to the socio-behavioural and structural core drivers of new HIV infections as well as stigma and discrimination due to HIV infection in their working environment from the constructivism' theoretical point of view.

In addition, the researcher argued that by engaging on one on one approach will be beneficial in entering the employee's world of reality and also creating a conducive environment that enhance behaviour change as affirmed by Springhall and Springhall, (1981) that meaningful behaviour change is brought about by the ability of a teacher/actor/researcher to arrange the proper sequence of reinforcement. Similarly, Wicks-Nelson and Israel (1984) cited that behaviour can be changed, given the appropriate environmental circumstances. The researcher argues that work environment in itself has the capacity to change behaviour of the individual.

Thus socio-behavioural core drivers of new HIV infections refers to those social, cultural, economic and behaviour that can aggravate the spread of new HIV infections. The behavioural and social determinants of new HIV infections is outlined in the Limpopo Provincial Strategic Plan on HIV, STIs and TB (2012-2016) as follows; sexual debut, multiple or concurrent sexual partners, condom use, intergenerational relationships, alcohol and substance abuse. Literature review has

been done on the selected social and behavioural drivers of new HIV infections that are relevant for the purpose of this study.

2.4.1. Multiple or concurrent sexual partners

The Know Your Epidemic/Know Your Response (KYE/KYR) summary report (2011) reiterated that sustainable reductions in new infections and the proportion of People Living with HIV (PLHIV) will require purposeful change of long standing sexual norms. Countries in Africa that have shown significant declines in HIV prevalence did so by reducing multiple sexual partnering. South Africa can emulate this prevention success by changing sexual behaviour and social norms about it (KYE/KYR Summary Report, 2011).

From the findings of the KAP survey conducted by ICAS (2006), approximately 76.8% participants reported having had one sexual partner in the last six months; 19.5% reported having had unprotected sex with several partners and 7.2% reported having had unprotected anal sex. This is indicative of a low infection risk. Slightly over 1 in 5 reported having 2 or more partners. The voluntary counselling and testing

(VCT) report compiled by the Lebogang Lesedi consultancy in March 2010 at Limpopo Department of Agriculture affirmed that some employees had multiple partners

Although infection is not confined to special “risk groups”, rates are highest among people with multiple sexual partners; the more the partners, the greater the risk. Prevention campaigns most often target people of marginal social status, such as prostitutes, migrant workers, and truck drivers, rather than high status officials, military officers, and businessmen. Since sex workers are frequently unable to refuse clients who reject condoms, behaviour change interventions must target men-wealthy, powerful men as working class men. Associating HIV and AIDS with morally stigmatized prostitution is a hindrance to prevention. The researcher argues that “it takes two to tango”. Hence, this study targeted the working class men and women who might be the silence role players in driving the new HIV infections.

A number of cultural practices such as polygene, levirate, widow cleansing, and bride price and their consequences for the rights of women make women more vulnerable to HIV infection. In some studies, being in a polygene marriage increases the risk of HIV infection. Mikell (2010) asserts that polygene remains a customary form of marriage in most cultures and is found in all social classes. Men also enjoy other types of multiple-partner sexual relations with varying degrees of social recognition. Thus many wives are at risk even if they have obeyed normative proscriptions regarding extramarital sex, which are imposed in some, but not all, central African cultures.

Johnson and Way (2008) affirm that women who were one of three wives in a polygyny marriage were over three times more likely to be HIV-positive than women who were the only wife in a marital union. Traditionally, successful men are expected to have many sexual partners which increase the risk that they will have intercourse with people who are HIV positive. For some men a major manifestation of

masculinity is their ability to have multiple partners (Caldwell, 2000). Kistner (2003) contends that having multiple partners is a status symbol, the yardstick by which masculinity, intelligence, and success are measured among one's male friends.

The mere suggestion of condom use can also spark off violence and, in Africa it is often closely linked to the tradition of the husband's family paying the bride-price to the wife's family. Joubert-Wallis (2008) asserts that the fact that the woman has been paid for (lobola), although it does not constitute an actual sale, puts her in an inferior position. This makes it extremely difficult for women to protect themselves against HIV. For women therefore, violence or a threat of violence is a huge impediment to refusing unprotected sex (Mumah, 2011).

As in other African studies most of the sexual relationships in Cameroon are male dominated, and female perceptions about their ability to refuse sex or the timing of sex, as well as negotiating condom use and fidelity are limited and vary by level of education (Mumah, 2011). Sex is regarded as part of the package that comes with marriage and is therefore regarded as an obligation on the part of the wives. Katherwara-Banda, Gomile-Chiaonga, Hendriks, Kachika, Mitole and Seodi (2005) contend that most women believe that their husbands have a right to demand sex, or they have low expectations of their right to control the terms of their sexual interactions.

Particular ideas about masculinity also support the discourse on male power. The idea that men cannot help having multiple sexual partners due to their uncontrollable drive for sex, or that a man has to prove his "manhood" by having many children and therefore has the right to object to the use of condoms are but two of the ideas surrounding masculinity. Traditionally it is accepted that men like a "melon seed have

to spread” by having more than one woman as a way of celebrating their masculinity. With the influence of modernisation, such historical conceptions have become totally unacceptable especially with the HIV and AIDS pandemic (Raditloaneng & Molosi 2014)

Campbell (2004) stated as examples for social constructivism that a man may choose not to act on information about the risks of HIV and AIDS due to the social construction of masculinity, which dictates that a “real man” should have sex with many women, and should not be afraid to take risks. A woman’s confidence to assert her rights to sexual health may be undermined in contexts where she depends on gifts from male sexual partners to support herself and her children. A young person’s motivation to attend a clinic for STIs may be reduced in a social context where adults (ranging from parents to nurses) refuse to acknowledge the existence of youth sexuality, and where STIs are heavily stigmatised. Campbell (2004) concludes that individuals are social creatures and society therefore plays a big role in the way which we behave.

An increasing body of literature on men and masculinity, Jaquette and Summerfield (2007) maintain that male dominance in family and community is not simply inherited from traditional social organization. Culturally constructed gender relations varied widely. In many pre-colonial societies, women held important religious and political offices, including village headships and chiefships. In other societies, women’s membership in corporate groups protected their access to resources, while collective retaliation sanctioned men who abused their power.

Collins in Joubert-Wallis (2008) alluded also that, not all men practise the same “type” of masculinity and many different constructions of male power exist. Results on the “women’s empowerment and sexual risk in Zambia” project conducted by Davis (2013) reveals that the nature of a woman’s relationship with her male partner is a crucial mediating variable in her sexual risk. It is further explicated that a positive partner relationship was associated with lower levels of violence and men’s sexual

risk behaviours. Ultimately, joint decision making by the woman and her partner was associated with lower risk for HIV.

According to UNAIDS (2014) interactive, socially empowering, community-based risk reduction interventions are needed to enable people to decide upon changes, support one another, and in effect change their culture. Deep, contextualized knowledge about beliefs and meanings of HIV and AIDS, and about the motivations, social pressures, and economic circumstances surrounding sexuality and health, is needed for prevention campaigns. The UNAIDS report on the global AIDS epidemic (2013) highlighted that HIV continues to be driven by gender inequalities and harmful gender norms that promote unsafe sex. The epidemic imposes a particular burden on women and girls. From the researcher's frame of reference, the behaviour change communication strategy which will be in a form of this study with employees at Limpopo Department of Agriculture will provide an opportunity of listening, hearing and understanding the socio-behavioural and structural core drivers of new HIV infections as perceived by them.

2.4.2. Condom use as a prevention strategy towards new HIV infections

Condom use has been identified as an effective strategy of prevention of preventing the spread of HIV infections. Views regarding the freely available condoms have differed widely and the debate has been charged with religious and moralist arguments. Approximately, 94.2% of participants felt that condoms should be freely available (ICAS 2006). However, it is reported that almost 1 in 3 never use condoms. The voluntary counselling and testing (VCT) report compiled by the Lebogang Lesedi consultancy in March 2010 at the Limpopo Department of Agriculture bears testimony. From the findings of the report it is outlined that most of the employees were not using condoms.

Mikell (2010) states that since development of a cure or vaccine will take many years, even decades, reduction of sexual risk, especially through regular condom

use, is needed to limit the epidemic. Information can raise awareness but seldom leads to widespread change in complexly motivated social behaviours, propelled by erotic desire, culturally constructed, freighted with moral values, and often silenced relations are among the most complex. The researcher is of the opinion that perceptions of employees on the use of condoms should be understood in relation to the language and meanings attached.

2.4.3. Voluntary medical male circumcision (VMMC) as a prevention strategy towards the new HIV infections

Voluntary medical male circumcision (VMMC) is one of the interventions proven to reduce the risk of acquiring HIV and other sexual transmitted infections among men. Mumah (2011) asserted that male circumcision has a protective effect in contracting the HIV infection and that uncircumcised men are four times likely to be HIV positive than circumcised men. Male circumcision was long practised by some cultures and it was a traditional norm for every man in that particular society. Provinces where traditional circumcision is practised like Eastern Cape, Mpumalanga and Limpopo, MMC levels were noted to be low (SANAC 2016).

In response to the prevention of new HIV infection among males, VMMC has being scaled up in the Republic of South Africa at both policy and programmes level in 2010 (SANAC 2011). The aim for such initiative was to reach 80% of HIV negative men aged 15-49 years by 2015 or 1.6 million men as recommended in the 2012–2016 NSP. However, it has been estimated through mathematical modelling by Njeumeli et al. in HSRC (2014) that 4.3 million VMMCs are needed in South Africa to achieve 80% male circumcision by 2015 which could avert more than 1 million HIV infections between 2011 and 2015.

SANAC (2016) alluded in the Enhanced Progress Report for National Strategic Plan on HIV, STIs AND TB 2012-2016 that since the inception of Medical Male Circumcision (MMC) in 2010, the national MMC programme has reached over 1 million men aged 15-49 years and about 3 million circumcisions were performed in the last five years. According to UNAIDS (2014) seven out of ten adult males have not yet had a chance to be circumcised in the 14 priority countries from where

reports are available. Increasing the participation of men and their uptake of HIV services is essential to protecting them and, in turn, their loved ones. Men are less likely to know their HIV status than women in most countries in the region and there are fewer men than women receiving HIV treatment.

The researcher infers that in order to address the spread of new HIV infection amongst LDA employees, the socio-behavioural and structural factors that hinders men to participate in MMC would have been explored. A successful AIDS response in the workplace is determined by the active participation of male employees in the HIV and AIDS prevention programmes.

A research study on circumcision knowledge, disinhibiting and timing, supported by the President's Emergency Plan for AIDS Relief (PEPFAR) (2013) was conducted in South Africa. The knowledge of HIV risk reduction benefits of male circumcision and levels of sexually disinhibiting among South African men, a subject on which little is known was explored.

A multi-stage, stratified random sample survey of 9,728 respondents was conducted in nine provinces of South Africa between April and August 2009. The survey was designed to be representative of 16-55 year old males and females. Of the 9,728 participants 4,437 (46%) were males. The question on circumcision status was answered by 4,353 men and 1,936 (42%) of those were circumcised. The prevalence of circumcision was significantly different by province. Limpopo (77%) and Eastern Cape (73%) had the highest prevalence of male circumcision. In these provinces, male circumcision is done for cultural reasons. The majority (67%) of circumcised men were circumcised in a traditional setting and 33% in medical setting. The 25% of men were circumcised before the age of 18 years.

From the survey conducted by HSRC (2014) higher percentage of black Africans (52.4%) having reported that they were circumcised compared to the other three race groups. With respect to locality type, males from both rural informal areas and urban informal areas reported significantly higher rates of male circumcision than those from both urban formal and rural formal areas. Provincial figures show that males in the

Eastern Cape and Limpopo have the highest rates of circumcised populations, followed by Mpumalanga and Gauteng. The Northern Cape and KwaZulu-Natal have the lowest percentages of circumcision. The rest of the provinces fall in between.

Circumcisions occur in many different settings which largely depend on cultural expectations and access to health facilities. For some people circumcision occurs in traditional settings or where certain cultural norms are observed and for others it is a purely medical procedure occurring in a health facility. The interviewers asked male participants to identify the places where they were circumcised. The results of the analyses show that the majority of participants reported that they were circumcised in traditional settings, followed by medical settings and very few said the procedure was done at home or elsewhere.

Analysis of data by age of the participant showed that young males were significantly more likely than all other age groups to have been circumcised in medical facilities. All older age groups were significantly more likely than the youth to have been circumcised in traditional settings. Analyses by race showed that whites were significantly more likely than any race group to be circumcised in medical facilities. Black Africans, in contrast, were significantly more likely to be circumcised in traditional settings. Indians or Asians had the highest rates of home circumcisions. Analyses by locality types indicated that living in a formal area was associated with circumcision in medical facilities whereas living in informal areas was associated (HSRC 2014).

Both men and women were asked whether they think male circumcision has health benefits and if so, what they are. Among both men and women, there was little knowledge about the HIV risk reduction benefits of male circumcision. For example, only 8% of both males and females combined knew that male circumcision reduces HIV risk. Most men in South Africa who are circumcised do so for cultural reasons.

Knowledge of the HIV risk reduction benefit is still very low, which may pose a challenge for MMC programmes as they scale up. However, circumcised men have similar sexual risk patterns to those uncircumcised. HIV communication programmes need to continue to promote MMC as a risk reduction method, but still promote condom use and reducing number of sexual partners.

In reference to the above exposition of gender roles, inequalities, gender based violence and medical male circumcision, the researcher is of the opinion that the significant aspect of socialization is the development of temperament which involves the formation of human personality along stereotyped lines of sex category (i.e. masculine and feminine) supplemented by sex role. In addition, sexual behaviour is almost entirely the product of learning from the social environment, where people are socialised into (male) aggressiveness or (female) passivity.

The researcher further argues that culture seems to have more influence in necessitating the importance of male circumcision. However, there is a need of intensifying the strategies to increase the knowledge of HIV risk reduction through MMC to the traditional leaders. The National Strategic Plan on HIV, AIDS, STIs and TB (2012-2016) asserts that the value of indigenous knowledge is acknowledged, and should also be part of the research agenda of SANAC, with particular emphasis on the use of traditional medicine for HIV and TB, and the efficacy of traditional circumcision in preventing HIV infection.

It is imperative for this study as well to explore the perceptions of employees on socio-behavioural and structural core drivers of new HIV infections with the intention of communicating and promoting healthy behaviours, addressing norms and behaviours that put them at risk of contracting new HIV infections such as MMC. The researcher further argues that while interpersonal relationships reflect social and cultural norms, gender roles are often seen as part of deeper societal-level political and economic structures of power and inequality. This form of inequality can be viewed as “structural violence”. Structural violence is a form of abuse that is based;

upon the connection between poverty and women's subordinate status (Katherwara-Banda et al., 2005).

2.4.4. Alcohol and substance abuse

Alcohol and substance abuse is rampant in the Limpopo Province especially in the farming and mining areas. Alcohol and substance abuse put people at the risk of HIV. The spread of human immunodeficiency virus (HIV), the virus that causes acquired immunodeficiency syndrome (AIDS), is not only a challenge to public health but also to the social and economic wellbeing of individuals, families, communities, and countries. With this in mind, one positive step toward reducing the transmission of HIV has included assessing the roles of risky behavioural patterns, including risky drinking, in the spread of the disease (Limpopo Provincial Strategic Plan on HIV, STIs and TB 2012-2016).

In Southern Africa the majority of HIV and AIDS transmissions occur through heterosexual contact and numerous studies have demonstrated evidence of an association between substance abuse and sexual HIV risk behaviours among men, women and adolescents (Harker-Burnhams, Musekiwa, Parry & London

2013). According to Parry and Pithey (2006) studies found that two adult community populations studied in Cape Town were more likely to engage in risky sex practices, characterised as sex with multiple partners and unprotected sex if they were methamphetamine or alcohol users. It has been suggested that heavy drinking patterns may influence sexual risk-taking by affecting judgment and reducing inhibitions, thereby diminishing perceived risk or excusing behaviours otherwise considered socially unacceptable.

A study conducted on drivers of the HIV epidemic, a look at the South African police service (SAPS) by Mutinta (2012) reveals that alcohol has been identified as a significant driver of the HIV epidemic in the SAPS. Police officers engage in alcohol abuse as a way of dealing with stress caused by the nature of their work. It is further explained that alcohol abuse influences police officers to engage in unsafe sex. It is argued that 75% of people in a drunken state find it difficult to use condoms during sex. The findings show that male police officers are more vulnerable than female officers to this particular problem because they consume more alcohol.

Similarly, a study by the Centre for AIDS Development, Research, and Evaluation (CADRE) found that alcohol intoxication impairs nearly every aspect of information processing, making it more likely that drinking police officers will engage in risky sexual activities (SABC News, 24 August 2011). In addition, it correlated heavy alcohol use with a lifetime tendency toward high-risk sexual behaviour. It is therefore possible to state that alcohol lowers inhibitions, diminishes the ability to assess risks, and may increase sexual aggression, a correlation which accounts for the measured relationship between alcohol and police officers' risky sexual activity (Mutinta 2012).

Barnett and Whiteside, (2006), Mccann, Harker-Burnhams, Albertyn, and Bhoola, (2011); Rose and Zweben (2002); Van Dyk (2005) asserted that a high prevalence of HIV infection is reported among individuals with substance-abuse problems as a result of greater sexually risky behaviour and infection through contaminated needles. The negative influence of substance use on the immune system; the delay in recovery from opportunistic diseases and interference with the absorption of nutrients during the treatment of HIV and AIDS, have also been confirmed. Given

that companies are already encountering increased labour costs as a result of 37% HIV-related absenteeism, the link with substance abuse places additional pressure on the business sector (Barnett & Whiteside, 2006).

The relationship between risk-taking, drinking, and HIV/AIDS risk is influenced by cultural and societal factors. For example, a study undertaken by WHO in eight countries found that inebriation was considered a culturally acceptable excuse for acting irresponsibly (including engaging in unsafe sexual activities) in Belarus, Kenya, Mexico, Romania, the Russian Federation, and South Africa. In Romania, this conceptualization was exclusive to men, implying that such behaviour was correlated with an assertion of masculinity (WHO 2011).

Research indicates that the relationship between alcohol and sexual conduct is context and community specific. Outcomes are likely to vary, depending on situation, gender, sexual and alcohol experiences, cultural norms and practices, drinking patterns, and individual physiological responses to alcohol. Expectations surrounding the effects of alcohol (forexample, the perception that alcohol enhances sexual arousal and performance) and personality traits associated with both drinking and sexual risk-taking (forexample, impulsive decision-making, stimulus- and sensation-seeking) may also influence unsafe sexual practices. The WHO study supports the assertion that in the Russian Federation there was a common misconception that a person without alcohol was incapable of engaging in sex (WHO 2011).

The researcher thus opines that research-based interventions that target these overlapping behaviours can provide a unique opportunity to address the drinking and risky sexual behaviours that are amongst the socio-behavioural and structural core drivers of new HIV infection. This kind of intervention will ultimately inform participants about the potential intersection of alcohol and HIV/AIDS and the merit of responsible drinking, thereby reducing problem drinking behaviours.

2.4.5. Inter-generational Sex or Age-disparate

The terms inter-generational sex and age-disparate relationships are similar, and thus are used interchangeably very often. Both terms generally refer to relationships in which the age gap between sexual partners is five years or more (Human Sciences Research Council 2014). The American Association of Sex Educators (1989) defines intergenerational sex as sex between two people of diverse ages. Although it is difficult to define 'very young' and 'very old' in this instance, some studies conceptualise the age as 10 years and above while others say 5 years and above. According to Oyediran, Odutolu and Atobatele (2011), intergenerational sex is similarly referred to as cross-generational sex or age-mixing or age disparate relationships.

Young people aged 15–24 years of age of either sex who had a sexual partner who was 5 years or older had a higher HIV prevalence than when they had a sexual partner within 5 years of their own age (Shisana, Rehle, Simbayi Parker, Zuma, Bhana, Connolly, Jooste & Pillay in HSRC 2014). Therefore, irrespective of one's own sex, age-disparate relationship with an older partner is generally a risk factor for HIV. In the survey conducted by HSRC (2014) the age differentials, that is, the difference in the ages between sex partners among adolescents aged 15 to 19 years were examined. The findings reveal that in 2012, 19.8% of respondents had a sexual partner who was more than 5 years older than they were. More interestingly, 33.6% of female adolescents aged 15 to 19 had partners who were more than 5 years older than they were compared to only 4.1% among their male counterparts.

Age-disparate relationships were more common in females than males, with females being between eight to nine times more likely than males to have older sexual partners. Furthermore, the association between age-disparate relationships and HIV status in the 15 to 19 years age group was also revealed. Overall, HIV prevalence

was higher in age-disparate relationships compared to when sexual partners were within the same age group.

Raditloaneng and Molosi (2014) mentioned that although women's biological make up can be blamed for the high risk of infection among girls and young women, sexual partnerships between older men and young girls can be blamed as there are sexual power dynamics involved that may not favour young girls involved in the partnership. For instance, they may be unable to negotiate safe sex due to skewed balance of power in intergenerational sex and the poverty- induced quest for the basics of survival. In Botswana, these relations are loosely termed 'sugar daddy/mummy' relations because of the age of people involved.

Barker and Ricardo (2005), Leclerc-Madlala 2008, Ramjee and Daniel (2013) indicate that relationships between young women and older men are common in the region as in many parts of sub-Saharan Africa and are associated with unsafe sexual behaviour and increased HIV risk. These relationships are largely premised upon material gain, with studies revealing that the greater the economic asymmetries between partners and the greater the value of a gift, service, or money exchanged for sex, the less likely the practice of safer sex (Leclerc-Madlala, 2009). In addition, Raditloaneng and Molosi (2014) maintain also that it should be noted that in some cultures, intergenerational sexual relations are a normal thing that is encouraged. Mostly parents may encourage intergenerational sex looking at its economic benefits for them and their daughters and in instances where a girl cannot consent; they may consent on her behalf as according to some cultural practices.

Literature reviewed further showed that throughout sub-Saharan Africa relationships between young women and older male partners were common, with an elevated HIV risks for young women in partnerships with men who are 5 or more (Ryan 2013; Society Diaries 2013 & Maughan-Brown 2016). Relationships with large differences

in age are associated with unsafe sexual behaviour, and low condom use (UNAIDS, 2014). The latest available data from South Africa show a national HIV prevalence of 5.6% among adolescent girls aged between 15 and 19 years, rising to 17.4% for young women aged between 20 and 24 years. However, HIV prevalence among adolescent boys was one-fifth that rate. One in every three (33.7%) sexually active adolescent girls is involved in an age-disparate sexual relationship with a sexual partner more than five years older. This compares to only 4.1% of adolescent boys who report the same behaviour (UNAIDS, 2014).

Psychologically, men and women who willingly have intergenerational sexual relationships may feel young and develop very high self-esteem backed by the fact that they are able to make a breakthrough across decades of age gaps. This individual psychological assertion of their attractiveness and “young” make them inflate their worth, especially if they can materially spoil their intimate partners with cash, cars and cell phones. Most studies assert that mainly young women and girls engage in intergenerational sex because their partners are able to spoil and provide for them (Mookodi, Ntshebe & Taylor 2004; Oyediran et al. 2011). The Society Diaries (2013) maintained that people stereotypically think that older men like dating younger women because of the following three primary reasons:

- Younger women may be more sexually attractive to them;
- They help older men to feel more youthful and,
- Lastly, younger women idolize older men and do not call them on their issues like an older woman will do.

The Society Diaries (2013) further cited Abraham Maslow’s five basic human needs, which are experienced at varying degrees by all humans. The survival need, which encompasses the need, to stay alive with food, clothing and shelter, but it also

includes the psychological needs to feel safe and secure. The researcher therefore opines that while younger women are often striving for meeting their basic needs and sense of security that an older man can provide, it is of great importance that they also consider the need for physical health such as prevention the spread of new HIV infection.

Raditloaneng and Moloisi (2014) assert that the types of sexual relationships involved in intergenerational sex are also silence in most cases; intergenerational sex goes unnoticed or underreported out of fear of public embarrassment, invasion of privacy by bringing the usually private matters of sexuality to the public domain. Silence among individuals, communities and nations may also be a sign of oppression as expressed by Freire (1973), that oppressed people have a “Culture of Silence” and lack voice to speak against societal injustice (Raditloaneng & Moloisi 2014).

From the findings of the workshops that were designed to raise the awareness of all women rights agencies in Botswana by Raditloaneng and Moloisi (2014), the following were revealed:

- Women engage in intergenerational sex account for a growing proportion of HIV and AIDS cases.
- Sexuality matters are not openly discussed with older people. Older men have the tendency to refuse to be tested and use age and anger to avoid it.
- There is a misconception that key actors in intergenerational sex, nicknamed “Sugar Mummies and Daddies” need each other to cleanse their blood by sex with relatively younger partners. Another risk perception in these relationships is that men perceive young partners to be more likely to be free from STIs and HIV, while young women often view older men as less risk-taking, more stable, and hence ‘safer’ partners (Madlala 2009).
- Culture makes it difficult for arranged marriages between older women to younger men. However, it is not clear what age difference is acceptable or tolerated if the woman is older than the man. Culturally women are old as long as they have children. Men do not age.

- There are instances of infidelity among women, though not culturally tolerated. Abuse is a factor in infidelity because the abused look for less violent partners than what they have, even if those partners may be of a different age.
- HIV and AIDS are more concentrated in marginalised communities and are worsened by conditions of poverty (socio-economic), class, and gender inequality, which aggravate indulgence in intergenerational sex.
- Young women often engage in unprotected forced/coerced sex, unwanted pregnancy with older men or boys their age, unsafe abortion, and substance abuse, put together, these increase exposure to HIV infection and AIDS.
- The act of forcing (or attempting to force) another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstances to engage in sexual behaviour against her/his will includes a wide range of behaviours from violent forcible rape to more contested areas that require young women to marry and sexually service men not of their choice.
- Coercive control is characterised by, firstly, behaviours intended to manipulate another and can be manifested in several ways, For example, an attack directed against another person's self-confidence or self-esteem (constant criticism, ridicule, accusations of infidelity or humiliation in public or in front of the children. Secondly, intimidation as a dimension of coercive control refers to behaviours intended to instil fear: subtle, but threatening "looks" or change in tone of voice, or more severe acts like swearing, screaming, or throwing things. Finally, coercive control was characterised by making unreasonable demands from another person due to self-entitlement to the spouse or the partner.
- Gender based-violence, sexual violence in particular, including intergenerational sex are some of the determinants of HIV infection during reproductive years. There are instances of rape across people of different ages: Older women raped by men in their twenties, and children raped by own biological and stepfathers.
- Intergenerational sex and materialism were identified as factors in predisposition to HIV and AIDS.

In contrast, Leclerc-Madlala (2009) highlighted that while many young women do find themselves in age-disparate relationships because of poverty or coercion, many play active roles in seeking and exploiting relationships with older men and do not perceive themselves as victims. Against such considerable potential benefits, any perceived risk of HIV is pushed aside in an effort to enhance and add meaning to life.

Based on the aforementioned reviewed literature on intergenerational sex that focuses mainly on young women between the age group of 15-24, the researcher is of the view that exploring on the participant's early age can assist in understanding the participant's social functioning in totality. In addition, she posits that the perceptions of male participants in this regard can be beneficial in understanding the socio-behavioural and structural core drivers of new HIV infections with the intention of addressing norms and behaviours that can put them at risk of contracting the infections on the one hand and promoting healthy sexual life style on the other hand.

According to the gap report by UNAIDS (2014) an independent study shows that, in South Africa, adolescents in families receiving a child support grant were 16% less likely to have had sex. Girls who received a grant earlier in their childhood had fewer pregnancies than those who received a grant later in childhood. The report further stated that recent reviews from other parts of sub-Saharan Africa indicate that cash transfers are a powerful tool for mitigating the risk for HIV. In combination with other HIV and social protection activities, cash transfers make an even greater contribution to HIV prevention, treatment, care and support outcomes. In nine of ten studies measuring sexual behaviour in Kenya, Malawi, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe, as well as in Mexico and the United States of America, cash payments had an HIV prevention effect (Baird, Chirwa, McIntosh & Ozler 2009; Ranganathan & Lagarde 2012; Cluver, Orkin & Pantelic 2013)

It is important to remember, however, that cash transfers alone will not stop all new HIV infections among adolescent girls and young women. In addition, this population must be provided with essential HIV prevention services that include sexuality

education, access to sexual and reproductive health services, HIV testing and counselling and access to HIV treatment. From the researcher's perspective, the same empirical findings of adolescent girls and young women who are involved on intergenerational sex can also be adopted to the women employees who are sexually engaged with their bosses in favour of promotion or in order to get extra cash that can supplement the monthly income in order to sustain themselves and their dependents.

The public service has an internship programme that intends on exposing young graduates, both males and females to acquire work experience and skills. These young graduates can also be vulnerable to intergenerational sex with an intention of looking for permanent employment in return.

2.5. STRUCTURAL CORE DRIVERS OF NEW HIV INFECTIONS

The structural approaches or structuralism seek to address deeply entrenched and long-established cultural, socio-economic and behavioural factors, such as economic inequality, gender inequality, marginalisation and lack of access to basic services, which are difficult to resolve in the short-term (NSP on HAST 2012-2016). Sociology Guide (2017) defines the concept structuralism as a way of thinking about the world that is predominately with the perception and description of structures of interrelated objects, concepts and ideas. Structuralism hinges on the view that society is prior to individuals. It employs the nature of social interaction as a patterned behaviour. The structuralism approaches are explained based on the two predominant concepts that are: social structure and social organisation.

2.5.1. Social structure

Murdock (1948) maintains that the notion of structure as embedded institutions and norms shape the actions of social agents is important, because it explains how structural determination occurs. Structural determination occurs when the actions of people and organisations are guided by the underlying structures in the social system. The proper functions of social structure depend upon proper assignment of roles and statuses. (Schneider 2017) define social structure as the orderly and patterned relationships between the elements of society. The integration and coordination of different parts of social structure depend upon conformity of social norms. The researcher argues that the orderly and patterned relationships amongst the employees in a workplace may either contribute or prevent the spread of HIV infection in a workplace. Parsons (1937) described four principles of social structures as follows:

Universalistic social values: These are values that are found almost in every society and are applicable to everybody.

Particularistic social value: These kinds of values are the features of particular societies and these differ from society to society. When the statuses are achieved on the basis of efforts, it means that such societies attach importance to achieve social values.

Universalistic achievement pattern: It refers to the combination of the value patterns which sometimes opposed to the values of social structure built mostly around kinship, community, class and race. The choice of goals by the individual must be in accord with the universalistic values. Pursuits are defined by the universalistic moral norms. Such a system is dynamically developing norms with an encouragement for initiative.

Particularistic achievement pattern. It combines achievement values with particularism. The primary criterion is not in universalistic term such as conformity to a generalised ideal or efficiency. Particularistic achievement pattern focussed on certain points of reference within relational systems itself or that are inherent in the situation. The emphasis on achievement leads to the conception of a proper pattern of adaptation which is a product of human achievement and are maintained by continuous efforts.

Firth (1971) defines social structure as well as a more permanent and continuous pattern of social reality whereas, social organization refers to the systematic ordering of social relations by acts of choice and decision. Individuals choose between alternative modes of behaviour and take decisions as they evaluate them according to their perceptions to the fulfilment of a goal which is set by the group they belong. Concurrently, Blau (1977) views social structure as composed of the different dimensions along which people are differentiated from one another. Among these may be wealth, education, gender, religion and political party. Societies vary in the number of dimensions involved in drawing distinctions, like their heterogeneity and the tendency of dimension to be ranked based on the inequality. They also vary in the degree to which ranking on one dimension predicts ranking on others.

DiMaggio (1987) argues that the tendency of societies to view expressive culture as divided among genres is determined by such structure features as social heterogeneity, the prevalence of weak ties, and the relative complexity of role structure in a society. The researcher is of the view that by exploring and understanding the distinct pattern of social structures and social organisation within the workplace, one would be able to identify the socio-behavioural and structural core drivers of new HIV infection amongst LDA employees.

2.5.2. Social organisation

Radcliff Brown (1940) and Firth (1971) define social structure as the arrangement of persons and social organisation as the arrangement of activities of two or more persons. In a social organisation all the participants of the organisation carry out activities assigned to them. This arrangement of activities of persons is the characteristic of the organisation. Thus, Radcliff Brown (1940) viewed an organisation as the arrangement of relationship that operates within the activities of an institution. The researcher posits that the way the social organisations are structured and function can also serve as a barrier towards the elimination of the spread of HIV infection in its employees.

Schur, Kruse and Blanck (2005), states that organisational norms and values identify the behaviour that appropriate and provide moral justification for organisation. Durkheim (2004) asserts that the maintenance of social organisation can be achieved when social differentiation is at minimal. In addition, Karl Marx analysed how social relations are structured to sustain inequalities in the society. Marx used the concept to denote the distribution of resources. Similarly, this study adopted structural approaches to understand the structural core drivers of new HIV infection in LDA. The study focussed on cultural norms and values, mobility and migration; gender roles, inequality, and gender-based violence as a structural core drivers of new HIV infections in LDA as perceived by the employees.

2.5.3. Cultural norms and societal values

According to the World Bank, July 2003 briefing notes on gender and development, some socio-cultural norms prevent both women and men from obtaining critical information about HIV and AIDS, For example, many societies have a culture of silence around sexual matters. Some women living with HIV also experience forms of institutional violence, including forced sterilization and forced abortion and the denial of voluntary sterilization or safe abortion services. Involuntary and coerced sterilization and abortion among women living with HIV occur in many countries. These practices have been reported in Bangladesh, Cambodia, Chile, the Dominican Republic, India, Indonesia, Kenya, Mexico, Namibia, Nepal, South Africa, the

Bolivarian Republic of Venezuela, Viet Nam and Zambia, among others (UNAIDS 2014).

Social and cultural norms, particularly around gender and behaviour that puts people at risk of HIV and TB must be challenged. According to UNAIDS (2011), declines in new HIV infections across the world have been spurred on by changes in behaviour among young people, sex workers and their clients, people who inject drugs, men and transgender people. This Day Report further elaborates that a combination of behaviour changes, including reductions in numbers of sexual partners, increases in condom use, and delayed age of first sex, have reduced new infections in several countries.

Socially constructed norms and values, which are constructed and reconstructed in interaction between people in social groups, deeply influence a person's choices or decisions. Due to the fact that norms, values and truths are socially constructed concepts, which differ in different communities/ settings, the truth or knowledge concerning the cause of the spread of HIV will be in different settings (Graham 1992). Social construction holds that there are no value-free actions or beliefs (Lock & Strong 2010). They are in favour of value transparency and exploring on how they function. It is also believed that the researcher must be attentive to the various perspectives that may exist on a topic under investigation.

The researcher therefore argues that participants' voices in this study will reflect a different assumptive world, thereby exposing values that are blended invisibly into the pervasive background of participants' social lives. The character of human thought cannot be understood as governed exclusively by the formal rules and categories of the propositional systems; rather explore the narrative structures human beings employ in their strivings to make sense (Barkhurst & Sypnowich 1995).

Berlin (1976); Shotter (2007); Lock and Strong (2010) assert that people's creations such as laws, institutions, religions, rituals, works of art, language, songs, rules of conduct and the like- are not artificial products created to please, or to exalt or teach

wisdom, nor weapons deliberately invented to manipulate or dominate people, or promote social stability or security. They are natural forms of expression, of communication with other human beings or with God. Consequently, the way to understand the perceptions of LDA employees on socio-behavioural and structural core drivers of new HIV infection is by attempting to enter the participants' world of experiences. Perceptions can also be understood by finding out on how do participants interpret their world, learning the rules and significance of their methods of expression, their myths, the form and idioms of their language, their interpersonal and sexual relationships.

2.5.4. Mobility and migration patterns

Decosas, Kane, Anarfi, Sodji and Wagner (1997) state that the spread of infectious diseases that are transmitted from person to person will follow the movement of those people. Brummer (2002) affirms that the epidemiology of HIV/AIDS is closely linked to the process of migration. Migration is defined as the movement of people from one place to another temporarily, seasonally or permanently, for a host of voluntary or involuntary reasons (Brummer 2002). Fages (1999) attest that migrants and mobile populations in general have played a significant role in the initial spread of HIV in the Southern African region. Fages (1999) further reiterate that the largely seasonal or temporary character of migration, with migrants returning home to their families on a regular basis; has facilitated the rapid spread of HIV infection. The conditions associated with migration increases the risk of acquiring HIV. Approximately 3% of people living in South Africa are estimated to be cross-border migrants (National Strategic Plan for HIV, AIDS, STIs and TB 2012-2016).

Decosas, Kane, Anarfi and Wagner (1997); Evian (1993) and Girdler-Brown (1998) emphasise that migrants experience many problems living in a new environment. This may influence their mental and physical health. High-risk behaviour such as sex with multiple partners is not solely the result of migration. It is also the result of alienation, of loneliness, of being separated from family and regular partners, and the breakdown of traditional family units. Women and men leave their familiar environment with traditional norms and values and the anonymity of being a foreigner can increase risky sexual activities.

Similarly, a research study conducted by Mutinta (2010) in the South African Police concurs that police officers working away from their families are removed from their social support structures, including families and regular sexual partners. As a result, they often feel lonely and bored, particularly when off duty, and this increases the likelihood of their engaging in risky sexual behaviour. The findings also show that police officers' wives are often left in difficult financial circumstances. Hence, they too are often driven by need and loneliness to find other supportive (sexual) partners, who also assume some of their financial obligations. Lurie (2002) attest that migrant men were four times likely to have a casual sexual partner than non-migrant men. Therefore, when coupled with an increase in unprotected sex, it is found that the frequent return of migrant workers to be an important risk factor for HIV.

The Limpopo Province plays host to external migrants from Zimbabwe, Botswana and Mozambique as it shares its borders with them. The HIV incidence is evident with the migration patterns especially for Vhembe, Mopani and Waterberg Districts (Limpopo Provincial Strategic Plan on HIV, STIs and TB 2012-2016). The researcher argues that some of the public servants in Limpopo Province, and probably in some other provinces, have been transferred involuntarily from one workplace to another due to organisational restructuring, which has a political connotation, while the physical, emotional, mental and social well-being of those employees were overlooked.

The researcher is also of the idea that in order to have an HIV free generation in the year 3030, HIV and AIDS should be a centre of all the developmental agendas of any family, organisation, country and a nation. Hence, it is necessary for the researcher to understand, determine and examine the perceptions of employees with regard to migration and mobility as one of the structural core drivers of new HIV infections.

From the researcher's frame of reference, an approach on preventing new HIV infection should no longer be in a linear-way of thinking. The focus should moved

away from the specific group of people who are referred to as key populations. A binocular vision of intervention should be pursued in order to view every human being as a social being in a social environment, who is in an influx state of a relationship. Moncrieff (2004) affirms that efforts that attempt to alter the sexual behaviour of individuals must acknowledge that behaviour is rooted and sustained through on-going relationships and exchanges within the individual social network. Individuals' attitudes and choices are influenced by the social and cultural norms that they observe and people therefore need not act autonomously.

2.5.5. Gender roles, inequality, and gender-based violence

Gender roles, inequality and gender-based violence are some of the structural core drivers of new HIV infections. Amongst the 2015 ten (10) key targets and elimination commitments outlined in the 2011 United Nations Political Declaration on HIV and AIDS by the United Nations, literature review on this study focussed more on two key targets which are more socio-cultural and structural in nature, which are:

The elimination of gender inequalities, gender based abuse and violence and, the increasing the capacity of women to protect themselves against HIV. From the World Bank (2003:1) gender and development briefing notes, it is asserted that economic dependency and insecurity is the core of the gender dynamics of HIV and AIDS. It is further reiterated that both married and unmarried women, their comparatively limited access to and control of economic assets increase the likelihood of their inability to negotiate safe sexual practises; exchanging sex for money; or in a relationship that they perceive to be violent or risky.

Female low social status is a reflection of pervasive gender inequalities that characterise most regions in Sub-Saharan Africa, which are manifested in low levels of employment, income and education, inadequate political representation and lack of access to resources such as health care, transport, housing and government bureaucracy (Gilbert & Walker 2002). Gender inequity is therefore one of the key variables contributing to the high transmission rate of HIV and other sexually transmitted diseases among women in the region (Katherwara-Banda et al., 2005).

Schuele and Berner-Rodoreda (2010) assert that traditionally, the gendered divisions of labour positions classify women as “homemakers” and men as “breadwinners”. Women take responsibility for the domestic affairs including household work and caring for children, the elderly and the sick. Generally the gender norms guiding women’s behaviour include being respectful, obedient, submissive and loyal to the husband. Men frequently control the family income. This means that women are often in economically dependent positions that imply lower status and unequal power relations that limit women’s influence on decisions regarding themselves and the family (Schuele & Berner-Rodoreda 2010). For many women, low income coupled with the culture of being economically dependent on men conversely fosters income generating initiatives that might put them at risk of HIV infection. According to the World Health Organization in UNAIDS (2014:142) there are four overarching approaches that can help to reduce women’s vulnerabilities to violence and HIV:

- Empowering young women through multi-sectoral approaches, for example through integration with economic empowerment interventions and possibly through engagement with families.
- Integrating services against gender-based violence into HIV services in a workplace, such as through addressing violence during HIV testing and counselling.
- Promoting and implementing laws and policies related to violence against women, gender equality and HIV, including developing and implementing national plans and policies to address violence against women as a component of the HIV response. Comprehensive sexual and reproductive health and HIV services must be integrated.

Some commercial sex workers resort to unprotected sex because of the higher economic gains that riskier practice yields. In the guidance note on gender based violence and livelihood interventions by Food and Agriculture Organisation (FAO) (2008) the concept commercial sex is defined as a particular kind of exchange relationship in which men and women exchange material benefits and sex. According to a recent study in Botswana and Swaziland, for women in sub-Saharan Africa, insufficient food for their daily needs is strongly linked to multiple (often

interdependent) risky sexual practices, sex exchange and inconsistent condom use which results in the increase in HIV transmission (FAO, 2008).

In certain circumstances, commercial sex linked to survival, that is in exchange for food or money for basic needs) can be considered a form of gender based violence; this may be the case of young girls who may be lured into early and short-term sexual relations by older men in exchange for food, money or school fee (FAO 2008). In discussing the poverty-driven selling of sex, some authors emphasise the importance of recognising that whilst millions engage in commercial sex work on a regular basis, even more people not commonly thought of as “commercial sex workers” find themselves needing to exchange sex for money or goods on an occasional basis (Collins & Rau, 2001: 14, Cohen, 1998: 6). Many mothers have been forced to turn to sexual transactions in order to obtain desperately needed money and in communities characterised by social inequalities, some older men with money procure sex from young females in exchange for gifts or spending money.

From the researcher’s point of view, employed women, ranging from the experiential learners to the full time working women are also vulnerable to engage themselves in commercial sex with their employers or bosses with the intention of getting a permanent post or a high level post if fully employed in order to increase the income. Based on this notion, the researcher therefore argues that this kind of a sexual behaviour is another structural pattern of gender based violence that fuel the spread of new HIV infections in a workplace.

It further indicates the need for a more focused discussion around the workplace setting with both men and women employees and the multiple strategies that are constituted for women survival in an increasingly difficult economic context should be developed. By exploring the perceptions of employees on social-behavioural and structural core drivers of new HIV infections will help the researcher to understand the viewpoints of the employees in regard to the risky sexual practices that have element of sexual harassment in a workplace environment and that can perpetuate new HIV infection.

A study in South Africa found that young women who experienced intimate partner violence were 50% more likely to have acquired HIV than women who had not experienced violence. The available data suggest that ever-married adolescent girls and young women aged 15–24 years are the most affected by spousal physical or sexual violence (UNAIDS 2014). There are approximately 880 million adolescent girls and young women aged 15–24 years worldwide. Despite making up 12% of the world's population this population is often left without a voice or control of their own bodies.

Gender-based violence and limited access to health care and education, coupled with systems and policies that do not address the needs of young people, are obstacles that block young women from being able to protect themselves against HIV, particularly as they transition into adulthood UNAIDS (2014). The World Bank (2003) gender and development briefing notes asserted that in many societies, gender norms and gender dynamics influence people's attitudes to sex, sexuality, risk taking and fidelity.

Schuele and Berner-Rodoreda (2010) provide a clear distinction between “sex” and “gender”. In this instance sex is defined as referring to biological characteristics that define a human as female or male whereas gender is defined as a social construct that differentiates the power, roles, responsibilities and obligations of women from those of men in society. Gender and gender relations are products of socially constructed roles and relationships, attitudes, values, behaviour and relative power and the influence society ascribes to the male and female on a different basis (Schuele & Berner-Rodoreda 2010).

People are born female or male but learn to be girls and boys who grow into women and men. It is this learned behaviour that makes up gender identity and determines gender roles (Turmen, 2003:412). Gender differences are fundamentally underpinned by power inequalities, which result in a subordination of women and their interest to a gender order that privileges men and is organized by male power (Greig, Peacock, Jewkes & Msimang 2008). According to UNAIDS (2014), women represent 50% of all adults living with HIV globally. However in the most affected region, sub-Saharan Africa, 59% of adults living with HIV are women. Almost 1000

young women are newly infected with HIV every day. Infection rates among young women are twice as high as among young men in sub-Saharan Africa.

Smith (2002) stated that the HIV/AIDS epidemic has been fuelled by gender inequality. Unequal power relations, sexual coercion and violence are the widespread phenomena faced by women of all age-groups, and have an array of negative effects on female sexual, physical and mental health. Similarly, the World Bank (2003) gender and development briefing notes further highlighted that the spread of HIV and AIDS is also fuelled by the key gender-based economical, socio-cultural, legal and physiological factors. In this regard, Schuele and Berner-Rodoreda (2010) maintain as well that HIV affects both women and men, however, there are important differences that stem from biological, social, cultural and economic factors that increase the susceptibility of women to HIV infection and their vulnerability to the impact of AIDS.

2.5.6. HIV and AIDS, human rights' violation and related stigma and discrimination

The second key targets and elimination commitments outlined in the 2011 United Nations Political Declaration on HIV and AIDS by the United Nations include amongst the 2015 ten (10) key targets the elimination of HIV-related stigma, discrimination, punitive laws and practices. Despite numerous efforts to change

public attitudes, the reality reflected in the literature is characterized by deeply ingrained social prejudice, stereotyping and stigmatization.

Stigma is defined by Goffman (1963) as an attribute that is significantly discrediting and in the eyes of society serves to reduce the people who possess HIV. Goffman further argues that the stigmatised individual is seen to be a person who possesses “an undesirable difference” which then leads to social devaluation and discrimination and, in turn, leads to human rights violations of the People Living with HIV and AIDS PLWHA and their families. According to the summary report on People Living with HIV Stigma Index in South Africa (HSRC, 2014) stigma cannot be understood without considering the factors such as poverty, gender based violence, social inequality, local norms and attitudes. Discrimination follows stigma, and it is the unfair and unjust treatment of an individual based on his or her HIV status.

Three types of stigma have been identified as follows:

- **External stigma:** It is done by others to PLHIV. It is displayed through attitudes or actions aimed at PLHIV, including insults, rejection, intolerance, stereotyping, discrimination and physical violence.
- **Internal stigma:** It happens when PLHIV begin to believe the negative things that those around them say or think. It can also be seen as thoughts or behaviour resulting from the person’s own negative thoughts about him/herself based on his/her HIV status.
- **Anticipated stigma:** It is the anticipation or the expectation that one will be treated differently or poorly because of the stigmatised identity of PLHIV as a group.

UNAIDS (2010) attests that numerous studies have linked HIV-related stigma with delayed HIV testing, non-disclosure to partners and poor engagement with HIV services. The report goes on to say that from the surveys conducted via PLWHA Stigma Index, people who experience stigma and discrimination report a range of negative effects, including loss of income, isolation from communities and inability to participate as a productive member of society. The consequences of lower male

uptake of HIV prevention, testing and treatment are more severe for women, who are reluctant to get tested or to access treatment services and often face violence, stigma and discrimination when they do reveal their HIV status to their male partners.

The infected individuals carry the burden of stigmatisation and suffer from isolation, abandonment, loss of social support and unemployment (Lippman, James & Frieson, 1993). Similarly Foreman and Lyra (2003) stated that experiences such as loss of family, friends, work and housing, verbal and physical abuse have been widely documented across social and political boundaries.

The findings of the KAP survey on the evaluation of the Limpopo Department of Agriculture's employee assistance conducted by ICAS affirms that in many instances, people living with HIV and AIDS are stigmatised and labelled to be promiscuous. Assumptions about deviant sexual practices are made and applied to the individual. A common belief is that people who engage in frequent partner changes or unusual practices deserve to contract HIV. HIV is therefore constructed as a moral punishment for past wrongdoings. Such attitudes do not only lead to discrimination but also sustain people's sense of invulnerability and distance to the issue, making prevention effort less effective (ICAS 2006:27).

The majority of the participants (77.1%) felt that people who practised sexual acts such as anal sex deserve to contract HIV. It appears that many employees attached strong moral and righteous values to the contraction of HIV, whereby the person infected with the virus is perceived as deserving the disease and being punished for socially unacceptable behaviour. In any scenario, attitudes such as these are of great concern and need to be urgently addressed in order to promote openness with regards to HIV and AIDS (UNAIDS 2014).

The People Living with HIV Stigma Index further demonstrates the significant impact of stigma and discrimination on the health and ability of people living with HIV to be active members of their community. On average, one in eight people living with HIV report being denied health services and one in nine is denied employment because of their HIV-positive status. An average of 6% reported experiencing physical assault because of their HIV status. People living with HIV who are members of key

populations face a double stigma because of their sexual orientation, gender identity, drug use or engagement in sex work (UNAIDS 2014).

In his speech at the 16th International Conference on AIDS and STIs in Africa, UNAIDS Executive Director Michel Sidibé said, “We need to be courageous enough to confront society’s wrongs. It is unacceptable that women and adolescent girls, sex workers, people who use drugs, migrants, prisoners, transgender people and gay men and other men who have sex with men are assaulted, violated, and murdered, and yet our conscience is not revolted, nor our sense of human dignity challenged. How can the world accept that some people have access to services while others are excluded because of race, social status, income and sexual orientation? We must reject this double standard wherever we encounter it. We must not be scared of radically reshaping our future” (UNAIDS 2011:7-8).

Nelson Mandela said, “The more we lack the courage and the will to act, the more we condemn to death our brothers and sisters, our children and our grandchildren. When the history of our times is written, will we be remembered as the generation that turned our backs in a moment of a global crisis or will it be recorded that we did the right thing?” (UNAIDS 2014:36) The researcher is of the opinion that stigma and discrimination are critical barriers that hinder employees to disclose their HIV status, to request permission from supervisors to visit their physicians as well as receiving the treatment via the workplace delivery post. The workplace environment becomes a stressor that precipitates the health condition of PLHIV.

Schuele and Berner-Rodereda (2010) maintains that stigma and discrimination associated with HIV and AIDS are major factors in preventing many, both men and women, from accessing health services. It is further explained that women might be more affected by stigma and discrimination than men because of social norms in relation to acceptable sexual behaviour of a “good woman”; yet men may be reluctant to go to a health clinic as the clinics are perceived to be for the women rather than for men and, seeking health services means acknowledging the fact of

being unwell, which may run counter to the gender expectation of being a strong who does not need a doctor. Such attitudes are socially constructed.

From the summary report of the people living with HIV Stigma Index, South Africa (2014) South Africa has made good progress in dealing with HIV related stigma and the levels of stigma are low when analysing instances of stigma independently of each other. The report shows that internalised stigma is a major challenge in South Africa with more than 40% PLHIV expressing feelings of internalised stigma.

People with disabilities often experience HIV and AIDS related stigma and discrimination. Family members, caregivers, employers and health-care providers fail to fully understand or appreciate the sexual and reproductive health needs of people with disabilities. People with disabilities are often neglected in HIV policy planning as well as wider health-care provisioning. Common misperceptions affecting public health planning include the belief that people with disabilities are sexually inactive or unlikely to use drugs or alcohol. People with disabilities experience all of the risk factors associated with acquiring HIV. They are often at an increased risk because of poverty, severely limited access to education and health care, and a lack of information and resources to facilitate safer sex. Often, they lack legal protection and are vulnerable to substance abuse and stigma.

Similarly; UNAIDS (2014) states that stigma, discrimination and other human rights violations against people living with HIV limit their access to HIV services. These violations also negatively affect their ability to lead full and dignified lives. Human rights violations affect people living with HIV in the workplace and affect their access to insurance, social security, housing and education. Sixty-eight per cent of countries have non-discrimination laws or regulations that specify protections for people living with HIV and AIDS Yet, stigma and discrimination towards people living with HIV and AIDS still happen despite these laws.

With reference to WHO (2014), the Universal Health Coverage (UHC) also refers to inclusion of all populations, in all circumstances, in all countries. UHC is about equity; it is about delivering health services according to need, and not according to financial power. It provides a framework for addressing health inequities, and ensuring that disparities in access to and uptake, coverage and impact of health services are minimised across populations.

Particular attention needs to be given to individuals and populations that are most vulnerable, at risk and affected, marginalised or underserved. Services should not discriminate against individuals or populations on the basis of sex, ethnicity, race, sexual orientation, socioeconomic status, age or beliefs. Policies, laws and regulations may be required to promote equity and prevent discrimination, and to give priority to vulnerable groups most in need of health services. Approximately, 65.2% participants indicated that they would be comfortable disclosing to family. Less than 1% reported that they would disclose to colleagues. The lack of confidence in colleagues is of concern and highlights the need for creating dialogue in the workplace to allow for open communication about HIV. Slightly over 1 in 3 maintained that they would not disclose to anyone (ICAS 2006).

According to the researcher's frame of reference, stigma and discrimination in a workplace fuel new HIV infections by hampering prevention and care efforts, sustaining silence and denial about HIV positive status. With reference to her experience as an employee wellness coordinator, the researcher observes further that workplace environment has not yet been fully harnessed to reach a stage in which individual and group of employees can freely disclose amongst themselves about their HIV status. Programmes within workplace settings should be intensified to sensitise and reduce stigma and discrimination between and amongst employees. Parallel to the intensification measures to reduce stigma and discrimination in the

workplace environment, psychosocial therapeutic interventions to eliminate internal stigma and increase positive perception towards self must be a priority.

2.6. THE STRUCTURAL IMPLICATIONS OF HIV AND AIDS IN A WORKPLACE.

According to the Department of Public Service and Administration (2008) HIV and AIDS have the following structural implications in a workplace:

2.6.1. Morbidity and absenteeism

As infected employees become ill they will take additional sick leave. The disruption of the organisation will be amplified when more qualified and experienced employees are absent. Increase in death will lead to increased absenteeism, as employees attend funerals for family members, friends and colleagues. Women employees due to their socially defined role as care givers will have to care for sick children and partners, which may involve time off from work.

2.6.2. Mortality or retirement

The loss of an employee requires an appropriate replacement to be appointed and trained. For highly qualified staff this is often difficult, particularly in developing economies with skills shortages. Training and recruitment are costly and disrupt operations.

2.6.3. Staff morale

The epidemic has a negative impact on morale in the workplace. There is a fear of infection and death, which may lead to increased suspicion of others as well as resistance to shouldering the additional responsibilities for colleagues who are off sick, away from work or newly recruited and not yet fully functional.

2.6.4. Demand for services

Demand for services, particularly health and welfare services have increased drastically. This has major implications if those relevant departments have enough

capacity. Section 17 of the Public Service Act, No.103 of 1994, provides that the power of discharge an officer or employees shall rest in the relevant executing authority, who may delegate that power to an officer, and the said power shall be exercised with due observance of the applicable provisions of the Labour Relations Act, No 66 of 1995. These provisions apply equally to employees with HIV/AIDS. An employee with HIV and AIDS may not be dismissed simply on the basis of their HIV status, but should be dismissed with due observance of the provision of the Labour Relations Act relating to dismissals for incapacity. With this regard, the Public Service Regulations, 2001 has been amended to incorporate new minimum standards on HIV/AIDS. These minimum standards contain mandatory guidelines to heads of departments (HODs) to ensure that:

- The working environment takes account of the personal circumstances of employees living with HIV and AIDS;
- Steps are taken to identify and reduce the risk of HIV transmission in the working environment;
- Steps are taken to manage occupational exposure to HIV and AIDS;
- Measures are taken to prohibit unfair discrimination and promote non-discrimination on the basis of HIV status or AIDS;
- HIV testing of a public servant is prohibited;
- HIV testing and counselling is encouraged;
- The confidentiality of HIV status is maintained;
- Health promotion programmes are introduced to deal with HIV and AIDS prevention, care and acceptance of people living with AIDS;
- Support for HIV and AIDS policies and programmes is established through allocating responsibilities, human and financial resources, structures and communication strategies; and
- Measures are put into place to monitor and evaluate HIV and AIDS policies and programmes (Public Service Regulations, 2001:24-26).

From the information alluded in respect of socio-behavioural and structural implications of new HIV infections at a workplace, the researcher deduce that not only the individual employees suffer the consequences of the new HIV infection,

but the organisational wellness is also at risk concerning productivity and its cost-efficiency.

2.7. LEGISLATION, POLICIES AND PROCEDURES AS A THEORETICAL FRAMEWORK ON SOCIO-BEHAVIOURAL AND STRUCTURAL CORE DRIVERS OF NEW HIV INFECTION

Below are the legislative framework, policies, procedures and guidelines that guides the implementation of the HIV and AIDS programme in a workplace setting.

2.7. 1. LEGISLATIVE FRAMEWORK ON HIV AND AIDS

2.7.1.1. The South African Constitution Act, No.108 of 1996.

Sections 4, 9 and 23 (1) of the Bill of Rights within the constitution protects the right of every person to amongst others, the right to equality and non-discrimination, dignity, privacy and fair labour practices. The relevant labour statutes are:

2.7.1.2. The Employment Equity Act, No 55 of 1998 which prohibits unfair discrimination based on HIV status and on HIV testing without Labour Court authorisation. If a department wishes to offer or require HIV testing in any circumstances, they must apply to the Labour Court for a court order granting permission to test employees for HIV. If granted, they must ensure that all HIV testing takes place:

- With the informed and voluntary consent of every employee;
- Following confidential and appropriate counselling; and
- With protection of the right to confidentiality.

2.7.1.3. Occupational Health and Safety Act, No 85 of 1993, which places a duty on all employers to ensure that, as far as is reasonably practicable, the working environment is safe and healthy for employees. Employees are required to provide safety equipment such as latex gloves to prevent the transmission of HIV during an accident involving a blood spill in the workplace.

2.7.1.4. Compensation for Occupational Injuries Act, No. 130 of 1993, gives every employee the right to apply for compensation if injured in the course and scope of their employment. This would include compensation for HIV infection if it can be shown that the employee was infected in the course and scope of the employment.

2.7.1.5. Draft code of good practice on key aspects of disability and employment. This code gives detailed guidelines on how to accommodate disabled employees, such as those with advanced HIV disease and how to adapt their working environments

2.7.1.6. Code of Good Practice on HIV and AIDS and the world of work as outlined in the government gazette No: 35435, 15 June 2012:8-9 provides the following guiding principles:

- Respect of human rights, fundamental freedoms and equality. The response to HIV and AIDS must be recognised as a contributing factor to the realization of human rights, dignity, fundamental freedoms, responsibility and equality for all, including workers and their dependants.
 - HIV and AIDS is a workplace issue and must be treated like any other serious illness or condition in the workplace. HIV and AIDS must be included among the essential elements of the national, provincial, local and sectoral response to the pandemic with full participation of all stakeholders.
 - Reduce HIV related stigma and unfair discrimination and promote equality of opportunity and fair treatment. Elimination of unfair discrimination remains a key principle for protection of the rights of individuals. There must be no unfair discrimination against or stigmatisation of workers on the grounds of real or perceived HIV status. It is the responsibility of every worker and employer to eliminate unfair discrimination in the workplace.
-
- Gender equality. Women and girls are at greater risk and more vulnerable to HIV infection and are disproportionately affected by HIV compared to men as a result of gender inequality. Women empowerment is a key factor in responding to HIV and AIDS and the world of work. Measures must be taken in the world of work to ensure gender equality, prevent violence and harassment, protect sexual and reproductive health and rights and involve men and women workers, regardless of their sexual orientation, in the HIV response.
 - The right to access and continuation of employment. Real or perceived HIV status is not a valid cause for termination of employment. Workers with HIV related illness must not be denied the possibility of continuing to carry out their work unless proven medically unfit to do so. As with many other conditions, workers with HIV and AIDS must be reasonably accommodated and be able to work for as long as medically fit. Medical examination should be limited to the capacity of a worker to perform the task(s) of a particular job.

- Prevention of all modes of transmission and TB is a fundamental priority for the country. The workplace must facilitate access to comprehensive information and education to reduce the risk of HIV transmission and HIV-TB co-infection and STI's.
- Treatment, Care and Support. Treatment, care and support services on HIV and AIDS must be accessible to all workers and their dependants. All workers must have access to affordable health services, social security, insurance schemes or other employment related benefits either through the employer, the State or non-governmental organisations. Programmes of care and support must include measures of reasonable accommodation in the workplace for persons living with HIV or HIV related illnesses.
- Testing, Confidentiality and Disclosure. Workers and their dependants must enjoy protection of their privacy, including confidentiality relating to their own HIV status or that of their co-workers. Workers must not be required to undergo HIV testing or other forms of screening for HIV unless found to be justified by the labour court. The results of HIV testing must be confidential and not endanger access to jobs, tenure, job security and opportunities for advancement.

2.8. INTERNATIONAL GUIDELINES FOR GOVERNMENT RESPONSE TO HIV AND AIDS

2.8.1. The UNAIDS HIV and AIDS and Human Rights International Guidelines (2006)

The International Guidelines on HIV/AIDS and Human Rights arose because of various calls for their development in light of the need for guidance for Governments and others on how to best promote, protect and fulfil human rights in the context of the HIV epidemic.

- The protection of human rights is essential to safeguard human dignity in the context of HIV and to ensure an effective, rights-based response to HIV and AIDS. An effective response requires the implementation of all human rights,

civil and political, economic, social and cultural, and fundamental freedoms of all people, in accordance with existing international human rights standards;

- Public health interests do not conflict with human rights. On the contrary, it has been recognized that when human rights are protected, fewer people become infected and those living with HIV and their families can better cope with HIV and AIDS;
- A rights-based, effective response to the HIV epidemic involves establishing appropriate governmental institutional responsibilities, implementing law reform and support services and promoting a supportive environment for groups vulnerable to HIV and for those living with HIV;
- In the context of HIV, international human rights norms and pragmatic public health goals require States to consider measures that may be considered controversial, particularly regarding the status of women and children, sex workers, injecting drug users and men having sex with men. It is, however, the responsibility of all States to identify how they can best meet their human rights obligations and protect public health within their specific political, cultural and religious contexts;
- Although States have primary responsibility for implementing strategies that protect human rights and public health, United Nations bodies, agencies and programmes, regional intergovernmental bodies and non-governmental organizations, including networks of people living with HIV, play critical roles in this regard.

The following guidelines are elaborated in UNAIDS (2006:17-19) in order to implement an effective, rights- based response.

- States should establish an effective national framework for their response to HIV which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV policy and programme responsibilities across all branches of government.
- States should ensure, through political and financial support, that community consultation occurs in all phases of HIV policy design, programme

implementation and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.

- States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.
- States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.
- States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.
- States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price.
- States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions.
- States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

2.8.2. The Southern African Development Community (SADC) Code of Good Practice on HIV and AIDS and Employment (1997)

Human Immunodeficiency Virus (HIV) infection and the Acquired Immune Deficiency Syndrome (AIDS) in the countries of the Southern African Development Community (SADC) and globally is a major health problem with employment, economic and human rights implications. As one response to this problem, the SADC Employment and labour sector has established the code on AIDS and employment on industrial relations standards which entails the following:

2.8.2.1. Education, awareness and prevention programmes

Information, education and prevention programmes should be developed jointly by employers and employees and should be accessible to all in the workplace. Education on HIV and AIDS should, where possible, incorporate employees' families.

2.8.2.2. Job access

There should be no direct or indirect pre-employment test for HIV. Employees should be given the normal medical tests of current fitness for work and these tests should not include testing for HIV. Indirect screening methods such as questions in verbal or written form inquiring about previous HIV tests and/or questions related to the assessment of risk behaviour should not be permitted.

2.8.2.3. Job status

HIV status should not be a factor in job status, promotion or transfer. Any changes in job status should be based on existing criteria of equality of opportunity, merit and capacity to perform the work to a satisfactory standard.

2.8.2.4. Workplace testing and confidentiality

There should be no compulsory workplace testing for HIV. Voluntary testing for HIV on the request of the employee should be done by a suitably qualified person in a health facility with the informed consent of the employee in accordance with normal medical ethical rules and with pre and post-test counselling. Persons with HIV or AIDS should have the legal right to confidentiality about their HIV status in any aspect of their employment. An employee is under no obligation to inform an employer of his/her HIV and AIDS status.

Information regarding the HIV status of an employee should not be disclosed without the employee's written consent. Confidentiality regarding all medical information of an employee or prospective employee should be maintained, unless disclosure is legally required. This applies also to health professionals under contract to the employer, pension fund trustees and any other personnel who obtain such information in ways permitted by law, ethics and the code or from the employee concerned.

2.8.2.5. Managing illness and job security

No employee should be dismissed merely on the basis of HIV status, nor should HIV status influence retrenchment procedures. Employees with HIV related illnesses should have access to medical treatment and should be entitled, without discrimination, to agreed existing sick leave provisions. HIV infected employees should continue to work under normal conditions in their current employment for as long as they are medically fit to do so. When on medical grounds they cannot continue with normal employment, efforts should be made to offer them alternative employment without prejudice to their benefits. When the employee becomes too ill to perform agreed functions, the standard benefits and conditions and standard procedures for termination of service for comparable life threatening conditions should apply without discrimination.

2.8.2.6. Occupational benefits

Government, employers and employee representatives should ensure that occupational benefits are non-discriminatory and sustainable and provide support to all employees including those with HIV infection. Such occupational benefit schemes should make efforts to protect the rights and benefits of the dependents of deceased and retired employees. Information from benefit schemes on the medical status of an employee should be kept confidential and should not be used by the employer or any other party to affect any other aspect of the employment contract or relationship. Medical schemes and health benefits linked to employment should be non-discriminatory. Private and public health financing mechanisms should provide standard benefits to all employees regardless of their HIV status.

2.8.2.7. Risk management, first aid and compensation

Where there may be an occupational risk of acquiring or transmitting HIV infection, appropriate precautionary measures should be taken to reduce such risk, including clear and accurate information and training on the hazards and procedures for safe work. Employees who contract HIV infection during the course of their employment should follow standard compensation procedures and receive standard compensation benefits. Under conditions where people move for work, government and organisations should lift restrictions to enable them to move with their families and dependents. People, who are in an occupation that requires routine travel in the course of their duties, should be provided with the means to minimise the risk of infection including information, condoms and adequate accommodation.

2.8.2.8. Grievance handling

Standard grievance handling procedures in organisations, in labour and civil law that apply to all workers should apply to HIV related grievances. Personnel dealing with HIV related grievances should protect the confidentiality of the employee's medical information.

2.8.2.9. Protection against victimisation

Persons affected by, or believed to be affected by HIV and AIDS should be protected from stigmatisation and discrimination by co-workers, employers or clients. Information and education are essential to maintain the climate of mutual understanding necessary to ensure this protection. Where employers and employees agree that there has been adequate information, education, and provision for safe work, then disciplinary procedures should apply to persons who refuse to work with an employee with HIV and AIDS.

2.8.3. The ILO Code of Practice on HIV and AIDS and the World of Work (2001)

- HIV and AIDS must be recognised as a workplace issue,
- Responses to HIV and AIDS must be based on the principle of non-discrimination Unfair discrimination occurs when an employee infected or affected by HIV and AIDS is treated differently due to their HIV status. This treatment is unfair as it impairs their fundamental human dignity.
- Gender equality must be pursued as part of any HIV and AIDS response;
- Every employee has a right to a healthy and safe working environment;
- Social dialogue between employers, workers, their representatives, government and PLWAs must take place on HIV and AIDS issues;
- There must be no HIV screening of job applicants or employees; every employee has the right of confidentiality regarding their HIV status. Many infected employees are afraid of disclosing their HIV status to others within

the workplace fearing that the information will not be kept confidential. A breach of confidentiality occurs when a person who is under legal or ethical duty to keep certain information to themselves, discloses the information without the consent from the owner of the information (Department of public service and administration 2016:23)

- Workers must be enabled to continue working for as long as possible;
- Workplaces must promote HIV prevention; and care and support should be provided to infected employees.

2.9. HIV AND AIDS POLICIES, PROCEDURES AND GUIDELINES

The introduction of a guide on the managing the HIV and AIDS in the workplace by all government departments is a broader response to manage the epidemic in South Africa (Department of Public Service and Administration 2001).

The objectives of the guide are to:

- 2.9.1. Contextualise the HIV and AIDS epidemic within the country as a whole, and within the public service in particular;
- 2.9.2. Identify key challenges to the public service in the context of HIV and AIDS;
- 2.9.3. Assist departments to plan, develop, implement and maintain HIV and AIDS workplace policies and programmes within a human rights and gender framework;

- 2.9.4. Provide practical guidance and information to departments on managing the HIV and AIDS epidemic; and
- 2.9.5. Promote the application of the minimum standards on HIV and AIDS as contained in the amended public service regulations, 2001 (Department of Public Service and Administration 2001).

2.10. SUMMARY

The global prevalence of the HIV and AIDS epidemic was presented. The sub-Saharan Africa is the region hardest hit by the epidemic. The core drivers of the new HIV infection need to be examined, not just at the national level, but also at the local level in order to explore the socio-behavioural and structural core drivers. Social constructivism and structuralism were theoretical framework mainly preferred for the study. Social constructionism was explained based on the three assumptions underpinned the theory. Social constructivism's premise is on the basis that culture and society play a critical role on individual perception, interpretation and subsequent behavior in relation to new HIV infection.

In view of constructionism theory, HIV and AIDS programme in a workplace requires equal engagement of research participants and a researcher as co-constructors of

the shared reality on socio-behavioural and structural core drivers of new HIV infection. Equally so, structuralism employs the nature of social interaction as a patterned behavior. Social structure and social organization predominant concepts of structuralism approaches. International and national legislation, policies and practices on the elimination of HIV and AIDS, human rights violation and related stigma and discrimination were extrapolated.

CHAPTER 3: RESEARCH METHODOLOGY

3.1. INTRODUCTION

In chapter 2 of this research report the researcher provided the applicable theoretical framework, the existing documented empirical research as well as legislation, policy, procedure and guidelines on implementing HIV and AIDS programme that assisted in guiding the findings of this study. Social researchers are concerned with what is going on and why it is going on as well as causal relationships between variables. In other words the studies are descriptive, exploratory or explanatory in nature. Social research requires a design or a structure before data collection or analysis can begin. Since the aim of this study was to explore perceptions of LDA employees on socio-behavioural and structural core drivers of HIV infection, in this chapter, a description of the research methodology employed in the process of collecting data will be furnished.

3.2. APPLICATION OF RESEARCH METHODS

A research methodology defines what the activity of the research is, how to proceed, how to measure progress and what constitute success (Denzin & Lincoln 2011:70). The methods followed in this study included the research approach, the research design, population, sampling and sampling techniques, methods of data collection, analysis and verification of the data obtained.

3.2.1. Research Approach

A qualitative research approach, which was exploratory in nature, was followed, as the researcher was of the opinion that qualitative research was best suited to explore and describe matters in which the departure point will be on the perceptions of LDA employees on social-behavioural and structural core drivers of HIV infection. In other words qualitative research approach attempts to study human action from the perspective of the social actors themselves (Mouton, 2001).

The researcher was of the opinion that qualitative approach was suitable for her study due to the following reasons entailed on the key features of the approach;

- The researcher had an opportunity to investigate on the perceptions of LDA employees on social-behavioral and structural core drivers of HIV infection in the participants' natural setting, which were various workplaces. The researcher regarded them as social actors within their workplaces.
- Donalek and Soldwisch (2004) asserted that a qualitative researcher seeks in-depth understanding of a phenomenon under study from the participants' point of view because participants are experts in the experiential worlds and are able to articulate and describe their experiences, perceptions and feelings until the researcher attains a full understanding of the phenomenon. The researcher was convinced that by engaging in an in-depth interview, participants would be able to provide a full description of their perceptions on socio-behavioral and structural core drivers of HIV infection among LDA employees.

- The researcher regards her study as a portrayal of the idiographic characteristic of qualitative research, in a sense that perceptions of participants were not viewed in isolation, but in context to their social environment.
- The study focused on the subjective perceptions of the employees on social behavioural and structural core drivers of HIV infection. Fouché and Delport (2002) speak of emic characteristic of the qualitative study, which implies that it derives from a subjective perspective.

3.2.2. Research Design

The researcher employed an exploratory, descriptive and contextual research design. In view of the fact that little has been known about socio-behavioural and structural core drivers of HIV infection amongst LDA employees, the exploratory mode of enquiry was relevant to be used for the attainment of the aim of this study (Grinnel 2001; Neuman 2006; Neuman 2011). A descriptive strategy of enquiry was also used as part of the research design because it paints a picture of specific details of socio-behavioural and structural core drivers of new HIV infection amongst LDA employees as perceived by participants.

Contextual studies seek to understand the social meaning and significance of an event or social action from the social context in which it appears (Neuman 2011). In the same way, social constructivism argues that all knowing of reality requires an act of interpretation and there are no linear notions of causality for the explanation of events in living systems (Bateson 1972). The researcher was therefore intended to gain an in-depth understanding of the socio-behavioural and structural core drivers of new HIV infection amongst LDA employees as perceived by the participants. The researcher successfully identified Department of Agriculture in Mopani District, Limpopo Province as the workplace of interest for conducting this study.

3.2.3. Population

A population is described as an entire group of elements, persons or objects that meet the study criteria (Denzin & Lincoln, 2005). Rubin and Babbie (2010) and Neuman (2011) define population as the theoretically specified aggregation of the study. In this study the specified population is regarded as employees who are

employed by Limpopo Department of Agriculture at Mopani District. Mopani District is constituted by four Municipalities. The sample was initially planned to be drawn from the two municipalities due to the financial constraints. However, a third municipality was added on in order to reach a point of saturation of the data collected.

3.2.4. Sampling

Participants were drawn from Giyani, Greater Letaba and Greater Tzaneen municipalities in Mopani District, Limpopo Province. Purposive sampling method has been decided upon to select a sample of participants because of its natural element of allowing the researcher to purposely and deliberately select the sample that would enable her to generate the data that could lead to the answer of the research question (Leedy & Ormrod 2010; De Vos, Strydom & Delpont, 2011).

The sample was constituted by twenty participants as opposed to the thirty participants proposed in the initial plan of the study. Conventionally in qualitative research, sampling takes place until the point of saturation is reached. In simpler terms, the researcher selects and interviews participants until the data can no longer offer any new information (Patton, 1990; Thietart, 2007). In addition, Creswell (2007) recommends that 20 to 30 participants can be included in order to develop a well-saturated theory. Therefore, the selected sample size was justifiable for the purpose of this study.

The criteria for inclusion in the sample have been highlighted in the initial plan as follows:

- Male and female participants between age 18 and 35.
- Male and female participants between age 36 and 54; and 55-65 were included in the study.

The researcher's decision was influenced by Erikson (1959) model of eight stages of development. She selected only three last phases of life that were relevant for her study, which are intimacy vs isolation, constituted by young adult between age category 18-35; generativity vs stagnation characterised by middle-age adult of 36-54 and integrity vs despair, comprises of older adult between the ages of 55-65.

3.2.5. Method of data collection

The researcher conducted a pilot study beforehand with one employee in her workplace to assess the effectiveness of the interview guide. In this regard Strydom (2002) states that a pilot study is indeed a prerequisite for successful execution and completion of research project. The exercise assisted the researcher to identify and correct errors that might arise in the actual project. Berg (2004) and Silverman (2013) concur that once researchers have developed the instrument and are satisfied with the general wording and sequencing of questions, they must pretest the schedule to try out different styles of questioning prior to the main study .

Rubin and Babbie (2010) describe qualitative interviewing as a way of finding out what others feel and think about their worlds. It is with this notion that the researcher visited participants' workplaces in order to gather data through semi-structured one-on-one or face-to-face interactive method. Participants were given an opportunity to

narrate their perceptions on socio-behavioral and structural core drivers of new HIV infection amongst LDA employees.

This interview method provided the researcher with greater flexibility in a sense that she managed to follow up interesting avenues that emerged in the interview, which varied from participant to participant (Grinnell 2001; Greeff 2011). Ritchie and Lewis (2005) affirmed as well that individual interviews provide opportunity for detailed investigation of people's personal perspectives, for in-depth understanding of personal context within which the research phenomena are located, and for very detailed subject coverage.

An interview guide with a set of pre-determined open-ended questions aided the researcher to direct the interview as commended by Welman, Kruger and Mitchell (2011). The researcher in this study perceived the employees as experts in their lives and proposed that interviews be interactional, where both the researcher and participant were equal partners.

Interviews were conducted in the language of the participants. In Limpopo Province, the spoken languages are mainly Northern Sotho, Xitsonga and Venda. However, Xitsonga speaking employees mainly dominates in Mopani District. This has placed the researcher in an advantageous position since she also speaks Xitsonga. The researcher successfully applied interviewing techniques that she acquired during the theoretical and practical orientation to the MA (SS) Mental Health study to gain an in-depth understanding of the socio-behavioural and structural core drivers of new HIV infection amongst LDA employees (Meadows 2003; Babbie 2007).

In reference to the proposed plan, the researcher perceived the diverse language as an opportunity to interact with diverse cultures that can generate a broad spectrum of information that can lead to the attainment of the aim of this study, which was to explore the perceptions of LDA employees on social-behavioural and structural core drivers of HIV infection. However, in Greater Letaba most participants were speaking Sepedi and one was speaking Tshivenda of which she has chosen to be interviewed in English. The flow of communication and expression of ideas were compromised

as indicated under limitations of the study in chapter 1.7, which might have barricaded the accuracy of the information collated. In instances where the researcher and the participants were not getting along in terms of language, the interview was switched to English by both the researcher and the participants.

At the end of the interview, the hand written notes and the audio-recorded interviews were handed over to the professional translator to transcribe the information from the language of the participants to English. Fossey, Harvey, McDermott, and Davidson (2002) assert that note-taking and audio-recording is useful when used together because it provides a holistic analysis of the information and gives detail to specific components of the interviews. The transcription of data was aimed at assisting the researcher to carry out the process of analysis since the study had to be reported in English.

3.2.6. Data analysis

Marshall and Rossman (1999) define data analysis as the process of bringing order, structure, and interpretation to the mass of collected data. In analysing data, the desire is to transform them into meaningful findings. Similarly, Fossey et al. (2002) define qualitative data analysis as a process of reviewing, synthesising and interpreting data to describe and explain the phenomena or social worlds being studied. Data analysis is aimed at seeking meanings which people attach to their life experiences.

According to Alston and Bowles (2003) qualitative research is flexible in that during the data collection process, important emerging themes can be identified to allow the researcher to get more information on a particular aspect until such aspect becomes saturated and there are no more new information generated. This was confirmed by De Vos, Strydom, Fouché, and Delport (2005) when they postulated that data analysis in qualitative research does not wait until the data collection process is

complete as it is done in quantitative research; instead it starts during the data collection process.

For the purpose of analysing data of this study, the researcher followed the eight steps as proposed by Tesch (in Creswell, 2009) to analyse data. This entailed the following:

- The researcher read all transcripts carefully in order to get a sense of the whole, while jotting down some ideas that could be themes and sub-themes.
- She chose one transcript which was on the top of the pile to read it and try to find an underlying meaning of what she was reading and wrote thoughts in the margin as they came.
- After several transcripts had been read, the researcher made a list of all topics identified. The topics were clustered according to similarities that were marked as major topics, unique topics, and left overs.
- The list of marked topics was abbreviated as codes, as the codes were written next to the appropriate segments of the text. While using this preliminary organising scheme, the researcher checked if new themes and sub-themes were emerging.
- The researcher found the most descriptive wording for the topics and turned them into themes. Topics that were related to each other were grouped in order to reduce the total list of themes.
- She then made a final decision on the abbreviation for each theme and wrote them down in alphabetical order.
- Data material that belongs to each theme was assembled in one place and a preliminary analysis was then performed. When the process was completed, the researcher presented the results of the study (complemented by a literature control) in chapter 4.

Instead of using the independent coder to do quality check of the analysis as planned initially, the researcher resorted in using peer reviews to conduct data verification in order to ensure that the research methods were accurate and credible. Two of her former colleagues have obtained their PhD degrees in social sciences and have experience in qualitative research methods. Their inputs assisted the

researcher to think critically about the thematic structure she developed as well as the coding decision she made.

3.2.7. Reliability, validity and objectivity

Reliability is generally understood to concern the replicability of research findings and whether or not they would be repeated if another study, using the similar methods, is undertaken; while validity refers to whether the researcher is investigating what he or she claims to be investigating. Terms like reliability and validity in data verification are relative to the quantitative research methods, and in qualitative research, these terms are replaced by such terms as accuracy, confirmability of findings, trustworthiness, consistency and credibility (Ritchie & Lewis 2005; Salkind 2012).

According to Creswell (2009:196), data verification in qualitative research means a process of checking the accuracy and credibility of research findings from the standpoint of the researcher, verification for qualitative research differs from that of quantitative research as qualitative research seeks to describe accurately the

experiences of the phenomenon under natural settings. Guba's model of ensuring the trustworthiness of qualitative data (in Krefting, 1991) comprises of four characteristics, namely: the truth value, applicability, consistency and neutrality. These four characteristics have been used as follows in this research project for the purpose of data verification:

3.2.7.1. Truth-value

Truth-value asks how confident the researcher is with the truth of the findings based on the research design, informants and the context in which the study was undertaken. It is concerned with whether the findings of the study are a true reflection of the perceptions of the study participants (Krefting, 1991:214). This is termed as credibility which is established through a number of methodological strategies. In order to ensure that the findings are a true reflection of the participants' perceptions, the researcher used the following methodological credibility strategies:

Interviewing techniques. The researcher used various interviewing techniques during the interview. For example - tracking, empathizing, probing, reframing, paradoxical interviewing, verbal and non-verbal expressions and summarizing in order to enhance the credibility of the study.

Triangulation. Triangulation is a strategy that seeks to establish the credibility of findings by comparing multiple perspectives for mutual confirmation of data (Ritchie & Lewis 2005; Krefting 1991; Bless, Higson-Smith & Sithole, 2013). The researcher employed the method of triangulation of data sources to compare data collected from three age categories of participants who participated in this study. From the three groups of participants the researcher was able to compare the multiple perspectives for mutual confirmation and contrasting of data that was essential to inform the findings. During triangulation data sources like from theoretical frameworks and empirical research findings were also compared during data analysis process to cross-check data and the interpretation.

Peer examination. Krefting (1991) indicates that peer examination is a strategy that involves discussing the research process and findings with the researchers who are conversant and have experience with qualitative methods to share understanding

and to debrief about problems that are encountered during the research process. The researcher consulted with other researchers also conducted qualitative research in order to share understanding about the research methods applied in the study and the challenges she encountered during the study endeavor.

3.2.7.2. Applicability

Applicability refers to the extent to which the findings can be applied to other contexts and settings or to other groups (Krefting 1991:216). Krefting (1991) further indicated that in qualitative research, applicability does not necessarily seek to generalise findings to a larger population because the research is conducted in a natural setting of individuals with few controlling variables. Applicability is thus established through the strategy of transferability or fitness. Transferability is achieved when the research findings fit into contexts other than that of study situation which have some degree of similarity (Krefting 1991).

As far as applicability is concerned in this study, the researcher provided dense background information of the research methodology followed in exploring the employees' perceptions on socio-behavioral and structural core drivers of new HIV infection in Limpopo Department of Agriculture. The researcher is of the opinion that by doing so, some HIV and AIDS coordinators in different workplaces, can check the transferability of the findings in the similar social phenomenon such as the prevention of the spread of new HIV infection through addressing the socio-behavioral and structural core drivers of such spread in the workplace environment.

3.2.7.3. Consistency

Krefting (1991) states that consistency is achieved when the study is replicated using the same participants or similar context and still produces the same findings. In qualitative research, consistency is defined in terms of dependability. The researcher established the dependability of the results using two strategies. Firstly, the

researcher provided a dense description of the exact research methods of data collection, analysis and interpretation. Secondly, she conducted a code-recode procedure as outlined by Krefting (1991) to assess consistency. The researcher recorded the same data after two weeks and compared the results to check consistency.

3.2.7.4. Neutrality

Krefting (1991) indicates that neutrality refers to the extent to which the research procedures and findings are free from bias. In qualitative research, neutrality of the data is given more emphasis than neutrality of the researcher and it is established through the strategy of confirmability. The researcher employed credibility strategies to establish the truth value and applicability of the findings. Neutrality was also achieved through the guidance of the study promoter who followed up on decisions taken for each phase of the study.

3.3. ETHICAL CONSIDERATION

Ethics according to Grinnell and Williams (1990) is defined as a discipline concerned with what is good and bad or right and wrong or with moral duty and obligations. According to Mouton (2001) and De Vos, Strydom, Fouche and Delport, (2011) ethics is a set of moral principles that is suggested by an individual or group, is subsequently widely accepted, and offers rules and behavioral expectations about the most correct conduct towards experimental participants, employers, sponsors, other researchers, assistance and students. To this end all researchers, regardless of research designs, sampling, techniques and choice of methods, are subjected to ethical considerations (Gratton & Jones, 2010). As a social worker registered with the South African Council for Social Services Profession (SACSSP), the researcher was obliged to take into cognisance her personal and professional limitations. The following ethical principles were embraced:

3.3.1. Ethical clearance

A request to conduct the research study within LDA was made in a form of a memorandum as per prescribed standard of the Department and submitted to the Head of Department for approval. Approval was granted unconditionally (cf. Annexure E). The rationale behind the whole process was to inform the management about the purpose of the research project, a description of the research design, the researcher's roles and responsibilities and more importantly, to gain access as management has a major influence on opening and closing of the gate (Feldman, Bell & Berger 2003; Miller & Glassner 2004). Similarly, ethical clearance was granted by the Turfloop Ethical and Research Committee (TREC).

3.3.2. Informed consent

Yegis and Weinbach (2002); Welman, Kruger and Mitchell (2011) state that being informed means that participants should have a fairly clear understanding of what it means to them to participate in a particular study; whilst consent refers to a written agreement between the researcher and the participant to participate in a particular study. In ethical terms participants in this research project were approached about the study with an explanation of what the study was all about; how the information would be used and what was to be expected. The intention of audio –recording the interviews was brought to the fore and permission was obtained for this purpose. The researcher informed them about the team members who would have an access to all the recordings. No participant was forced to cooperate in the study, participation was voluntary.

3.3.3. Confidentiality

The researcher safeguarded the privacy of participants as well as their identity by using pseudonyms in order to ensure their anonymity and avoid the tracing back to them of any information shared during the interview. It has been noted by Yegidis & Weinbach (2002) that data should be edited before disseminating its findings to remove all names of participants and replace them with pseudonyms to ensure that there should be no association of data with any of the participants. Real names were erased and replaced by alphabetical references. Confidentiality of information was maintained by storing the recorded information in a locked safe place. The stored information was accessible only to the researcher, the peers who reviewed the research methods and verified the research findings, the professional translator and the study's supervisor. All recordings will be destroyed as soon as the study is completed in line with Mark (1996).

3.3.4. Protection from harm

Harm may include emotional as well as physical harm (Babbie 1998; Strydom 2002). The study might place stressful, embarrassing and unpleasant situation for the participants. Neuman (2011) further states harm to self-esteem of participants. The researcher informed the participants about the emotions that might be triggered during the interview process. They were at liberty to make decisions on whether to continue or withdraw from the interview during such encounter. Although some became emotional in the process, no one decided to withdraw as the researcher demonstrated the ability to attend on those emotions and none was referred for counselling to EAP practitioners or any helping profession. Physical harm according to Neuman (2011) includes basic safety concerns. The researcher did assess the surrounding environmental settings in which interview took place to ensure that participants are not exposed to any potential safety hazards.

3.4. Summary

This chapter provided a description of the qualitative research methods applied in this study. The research design, population, sampling and sampling techniques, methods of data collection, analysis and verification of the data obtained provided the in-depth information that accurately addressed the intended aim of the study. The professional background that the researcher possesses contributed a great deal in remaining focused on the selected qualitative research methods and the adherence on the ethical principles have led to the attainment of an in-depth understanding of the socio-behavioural and structural core drivers of new HIV infection as perceived by employees at the Department of Agriculture in Mopani district, Limpopo Province.

CHAPTER 4: PRESENTATION, ANALYSIS AND INTERPRETATION OF EMPIRICAL FINDINGS

4.1. INTRODUCTION

This chapter presents findings, analysis and interpretations of the empirical study on the socio-behavioural and structural core drivers of new HIV infection as perceived by employees at Department of Agriculture in Mopani district within Limpopo Province. The predominant languages are the Xitsonga, Sepedi, and TshiVenda. People's languages, philosophies and world views should be taken into consideration when conducting a sociological study, as it is through these constructs that people make sense of themselves and their world (Mkhize, 2004).

The research question in this study was: “what are the perceptions of employees with regard to the socio-behavioural and structural core drivers of new HIV infection amongst themselves?” Thus to respond to the research question, the study aimed at exploring on perceptions of LDA employees on socio-behavioural and structural core drivers of new HIV infections. Added to these key drivers of the new HIV infections, the study took into account the exploration of perceptions on stigma and discrimination as one of the human rights violation of people living with HIV and AIDS towards the access of health services, thus contribute towards the spread of HIV infection.

In order to realise the objectives of this study, purposive sampling method had been decided upon to select a sample of participants because of its natural element of allowing the researcher to purposely and deliberately select the sample that would enable her to generate the data that could lead to the answer of the research question (De Vos, Strydom & Delpont, 2011). The sample was composed of twenty participants as opposed to the thirty participants proposed in the initial plan of the study.

Conventionally in qualitative research, sampling takes place until the point of saturation is reached. In simpler terms, the researcher selects until the data can no longer offer any new information (Patton, 1990). In addition, Creswell (2007) recommends that 20 to 30 participants can be included in order to develop a well-saturated theory. The researcher thus ended up selecting twenty participants instead of thirty as there was no longer new information that was brought forth by the participants during the interview. The sample size was therefore justifiable for attaining the aim of the study. The criteria for inclusion in the sample have been highlighted in the initial plan as follows:

- Male and female participants between age 18 and 35.

- Male and female participants between age 36 and 54; and 55-65 were included in the study.

A pilot test was conducted with an employee who was not part of the sample size to pretest the effectiveness of the interview guide beforehand. The researcher was satisfied with the results yielded by the pilot test; hence she proceeded to implement the same interview guide with the rest of the participants (Strydom 2002; Silverman 2013). The data collection process lasted for two weeks. Participants were audio recorded after obtaining permission from the participants. The audio-recorded and short-hand written notes were translated from Xitsonga and Sepedi into English. The researcher is also a Xi-Tsonga speaking person and more conversant in Sepedi. She made use of a professional translator to translate what the participants articulated in their home language into English language.

The researcher employed Tesch's eight steps (in Creswell 2009) of data analysis to analyse the data collected from twenty (20) participants. This entailed the following:

- The researcher read all twenty transcripts carefully in order to get a sense of the whole, while jotting down some ideas that came into her mind.
- She chose one transcript which was the most interesting, shortest and the one on the top of the pile to read and try to find an underlying meaning of what she was reading and wrote thoughts in the margin as they came.
- After all twenty transcripts were read, the researcher made a list of all topics identified. The topics were clustered according to similarities that were marked as major topics, unique topics, and left overs.

- The list of marked topics was converted into codes written next to the appropriate segments of the text. While using this preliminary organising scheme, the researcher saw if new categories and codes were emerging.
- The researcher found the most descriptive wording for the topics and turned them into categories. Topics that were related to each other were grouped in order to reduce the total list of categories. Inter-relationships between categories were shown by lines.
- She then made a final decision on the abbreviation for each category and gave alphabets to these codes.
- Data material that belonged to each category was assembled in one place and a preliminary analysis was performed. Once this process was completed, the chapter in which the research findings were presented (complemented by a literature control) commenced.
- Finally, she recorded the existing data.

From the above highlighted process of data analysis, five themes with sub-themes and categories emerged as reflected in table1 (cf. page 103). The findings had been presented according to the outlined themes and illustrated by direct quotations from the transcribed interviews that were contrasted with the existing theories and previous literature in order to establish the credibility and trustworthiness of the study.

4.2. DEMOGRAPHIC PROFILE OF THE RESEARCH PARTICIPANTS

Table1 that follows presents the demographic data of the sample (employees at Department of Agriculture in Mopani district within Limpopo Province); who participated in an exploratory study on socio-behavioural and structural core drivers of new HIV infections as perceived by them.

4.2.1. Demographic profile of the research participants

Table 1 Demographic profile on the research participants

Participants	Gender	Age at the time of conducting the research	Nature of work	Work period in public service	Last HIV test done
A	Female	39	Administration	7 years	2 months
B	Male	60	Administration	29 years	24 months
C	Female	33	Administration	5 years	1 month
D	Female	58	General Assistance	33 years	6 months
E	Female	53	General Assistance	34 years	1 month
F	Female	54	General Assistance	30 years	1 month
G	Female	56	Animal health technician	33 years	2months
H	Male	33	Scientist production	13 years	12 months
I	Female	24	Internship	6 months	Never tested
J	Male	33	Scientist production	13 years	12 months
K	Female	36	Scientist production	7 years	1 month
L	Male	40	Administration	7 years	24 months
M	Male	48	Animal health technician	25 years	48 months
N	Male	41	Agricultural Advisor	4 years	1 month
O	Male	25	Internship	6 months	6 months
P	Male	37	Agricultural advisor	7 years	3 months
Q	Male	56	Administration	34 years	24 months
R	Female	36	General assistance	4 years	3 months
S	Female	47	Administration	26 years	1 month
T	Male	55	General assistance	29	3 months

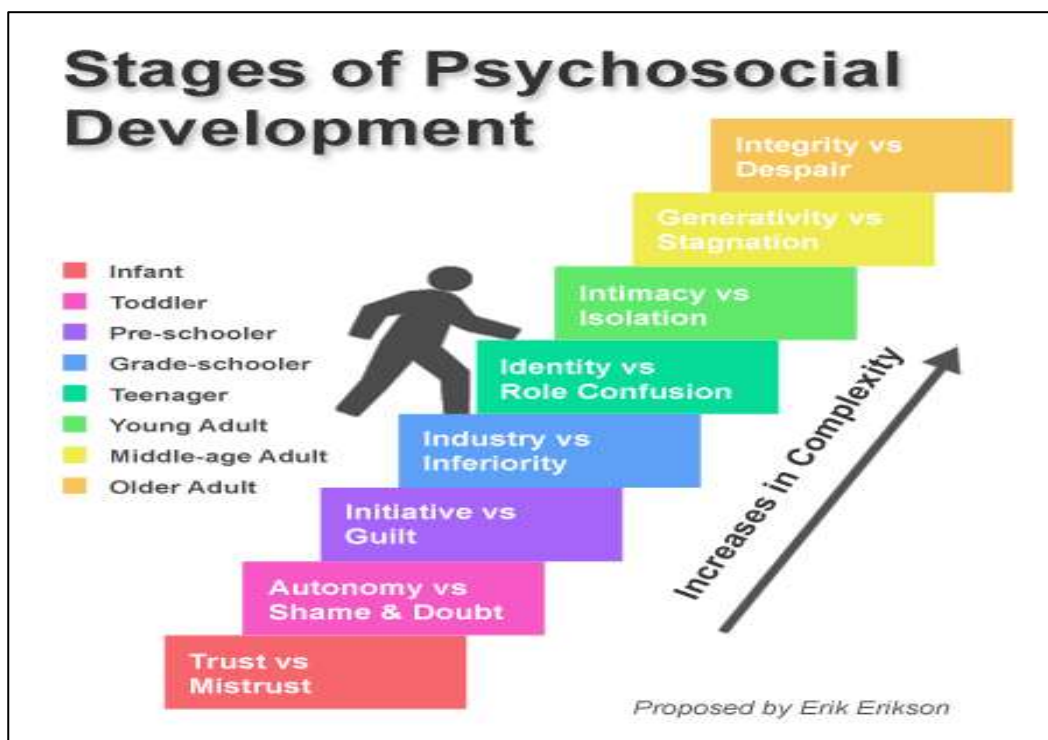
It is evident from table 1 that 10 males and 10 females took part in this study. It is therefore imperative to note that the findings of this study are not the product of the researcher who would have played the role of an “expert” but of an interactional communicational process that took place between the researcher and the participants who were the co-constructors of the body of knowledge in regard to the socio-behavioural and structural core drivers of new HIV infections.

This approach is cited against social constructivism which maintains that the inter-subjectivity of people that constructs the meanings of the world and the self, understanding the people’s interpretations of the world and of the self should no

longer be based on “professional knowledge” which is derived from a coherent and solid structure of positivistic assumption. Instead, knowledge is derived through a communication process in which the people co-construct the meaning with the experts (McNamee & Gergen, 1992; Ernest, 1999; Lock and Strong 2010).

The participants were classified into three age groups that according to Erikson (1959)’s Stages of Development as shown in diagram 1. The last three developmental stages, which are young adult, middle-age adult and older adult, were applicable for the selection of participants between the ages of 18 - 35; 36 - 54 and 55 – 65.

Diagram1. Erik Erikson’s stages of psychosocial development (McLeod 2017).



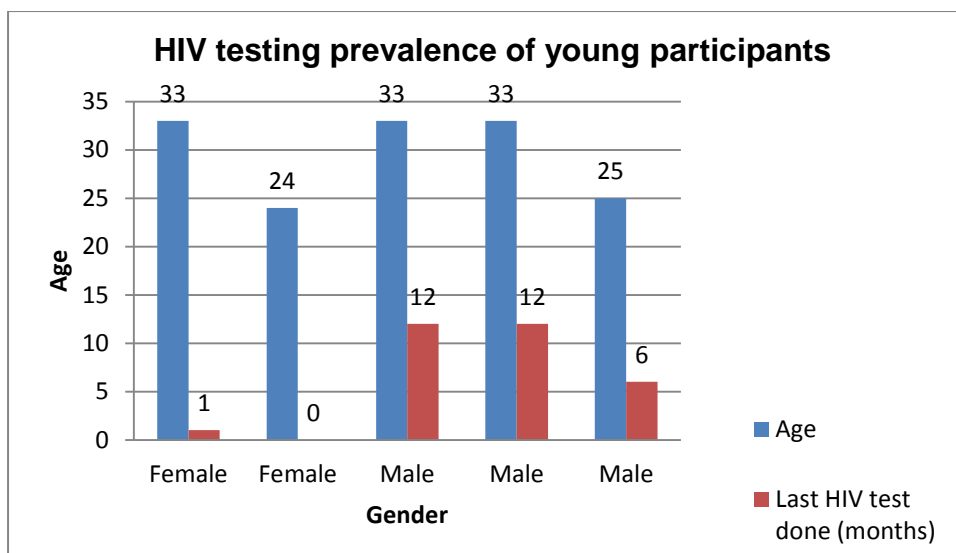
The first group of participants in this study were in the stage referred to as “intimacy versus isolation” according to Erikson (1959), stages of development. This is a developmental stage in which a young adult of age between 18 and 35 seeks deep intimacy and satisfying relationships, but if unsuccessful, isolation may occur. It is generally known that some young women who entered public service through the Internship Programme are vulnerable to enter into sexual intimacy with their mentors in a workplace, with a hope of getting job favours in return.

A study on transmission networks and risk of HIV infection in KwaZulu-Natal, South Africa found that sexual partnering between young women and older men, who might have acquired HIV from women of similar age, is a key feature of the sexual networks driving transmission (The Lancet 2017). Unemployment is another structural driver of the epidemic among young women. Statistics South Africa (2013) reported that youth aged 15-34 are unemployed, education or training rate 30% since 2012, highest rate recorded at 33,5% in 2013. A core package of interventions applicable to this age group is crucial to reduce both socio-behavioural and structural drivers of new HIV infections in a workplace.

4.2.2. HIV TESTING PREVALENCE OF YOUNG ADULT PARTICIPANTS

The column chart 1 depicts the gender, age and the last HIV test done by five young participants who fall within the first age category of 18 to 35.

Column chart 1. HIV testing prevalence of young adult participants



Column chart 1 demonstrates that the last HIV test done by this group at the time of conducting the study varies from 0 to 12 months. A young female participant, aged 24 has never tested for HIV; two participants, a male and female did their HIV test in the past six months while the other two males did their last test a year ago. South African National HIV Prevalence, Incidence and Behaviour Survey (2012) findings affirms that females aged 20 to 34 are amongst the key populations that are at a higher risk of HIV exposure. Concurrently, HSRC (2012) asserts also that adolescent girls and young women in South Africa are up to 8 times more likely to be infected with HIV than their male peers.

UNAIDS (2014) reveals that there are 2.6 million-3.4 million young people aged 15-24 living with HIV in sub-Saharan Africa. It was also affirmed during the launch of National Campaign For Young Women And Adolescent Girls, the She Conquers Campaign at Pietermaritzburg in South Africa on the 24th of June 2016 that over 7000 new HIV infections every week among young women globally and almost 2000 new HIV infections occur among young women and adolescent girls aged 15–24 in South Africa each week, a rate of two and a half times among males of the same

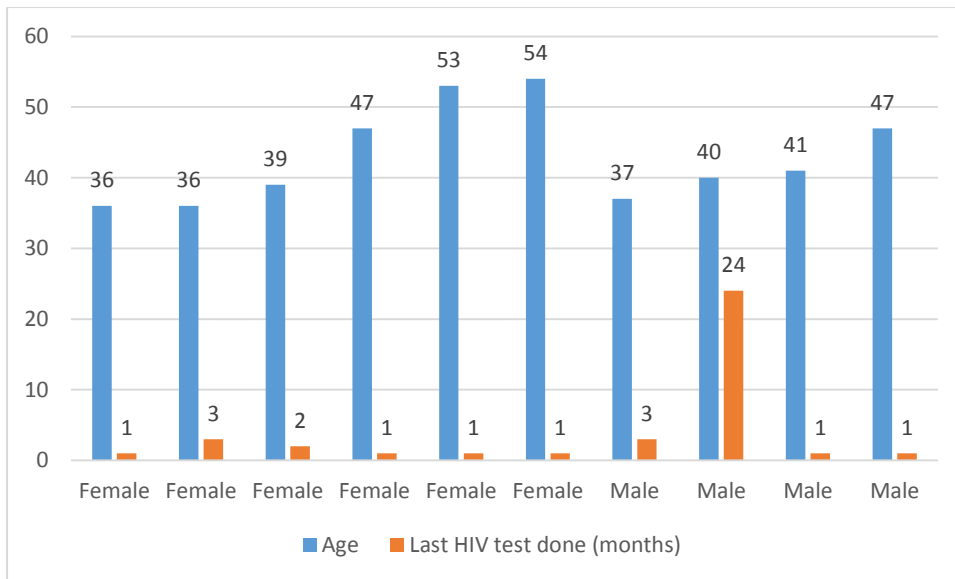
age (UNAIDS 2016). The Enhanced Progress Report on National Strategic Plan on HIV, STIs and TB (2012-2016) attest that HIV prevalence among girls and young women aged 15-24 in national surveys has consistently been found to be many times higher in comparison to boys and young men in the same age groups, contributing over 30% towards new HIV infections (SANAC 2016).

The researcher infers that the Public Service has young women and male employees who fall within this age category who are still anxious to go for HIV test, thus do not know their HIV status. The risk for not knowing the HIV status by this age group is that they may be more likely not to make informed decisions in regard to their social and behavioural life style that may either contribute towards the spread of HIV infection or contract new HIV infection. Therefore, HIV and AIDS prevention programmes in a workplace should also be tailored to address the socio-behavioural and structural core drivers of new HIV infection that are peculiar for young women and their male partners between age 18-35, whom the government and/or departments might have invested in those young employees through financial aid such as bursaries, National Student Financial Aids Scheme (NSFAS), the acquired skills and knowledge through mentorship and trainings offered during this developmental period.

4.2.3. HIV TESTING PREVALENCE OF ADULT PARTICIPANTS

The second age group of ten participants that were between age 36 and 54 and their HIV testing trends are represented in the column chart 2.

Column chart 2. HIV testing prevalence of adult participants



This group of participants comprised of four males and six females. This is a larger group when compared with other two groups, mainly because the majority of LDA employees fall within this age category of middle adulthood. Hence, they were easily accessible for the purpose of this study. According to Erikson's (1959) developmental stages, this stage is referred to as middle-aged adult, characterised by "generativity versus stagnation". The people in this stage take greater responsibilities and control in their work career, family and in society. However, if a person does not experience a sense of contribution to the world, an expression of stagnation may result.

Table1 (cf. page 93) elucidates as well that the participants' work period in public service range from 4 to 34 years. Amongst the group, only two participants, a male and female who were 4 years experienced, while the rest were above 4 years. The researcher infers therefore that most of the group participants were experienced, skilled and knowledgeable about their job mandates; also that they could be eligible

to be mentors of the first group. A mentor is defined as an individual with a reasonable degree of seniority above five years of experience in the particular work division, entering a developmental relationship with the less skilled individual employee to achieve personal growth, greater efficacy, productivity and effectiveness within an organisation (The Public Service Mentorship Programme 2006).

With reference to this age group, the findings suggest that the HIV prevalence has significantly increased from 2005 to 2012 wherein Mpumalanga, KwaZulu-Natal and the Free State have always been among the top three provinces with the highest HIV prevalence. Limpopo as well experienced a significant increase in HIV prevalence in 2012 as compared with 2005 (HSRC 2014). Furthermore, females remain at higher risk of contracting HIV infection and are 1.6 times more likely than males to be HIV positive since they are at their prime reproductive age (HSRC 2014). The researcher posits that women at this age category are vulnerable to contract HIV infections, thus the socio-behavioural and structural drivers that contribute to contracting and/or to spreading further the HI virus should be mitigated and addressed by HIV and AIDS workplace programmes.

Column chart 2 shows further that eight of these ten participants (which is 6 women and 2 men) did the HIV test within 3 months at the time of conducting this study; while the other two (which is 2 men) did the last test between 24 and 48 months. The researcher gathers that the majority of female participants in this age category test for HIV regularly and make informed decision about their sexual behaviour as compared to male participants. These participants have a sense of responsibility and self-determined to have control over the socio-behavioural and structural determinants of new HIV infection, therefore at a lesser risk of contracting the new HIV infection and of being the agent of transmitting the infection. She further argues that the skills, knowledge and experience possessed by this group are preserved for the betterment of production by their employer.

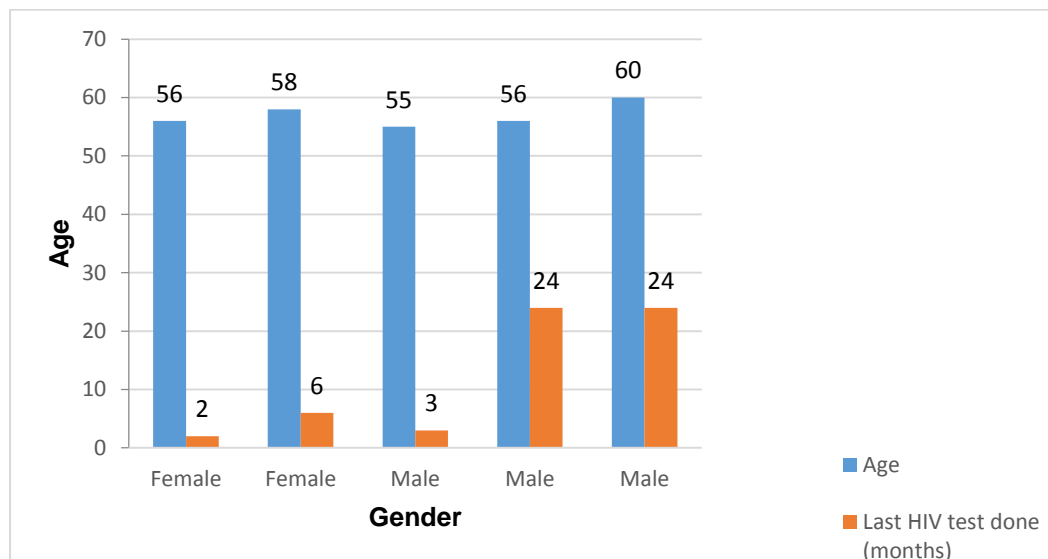
Despite the satisfactory results of this group, the two male participants who did the last HIV test in the past 24 and 48 months is a worrying factor. These two employees were aged 40 and 48, of which they are still far from considering early or old age retirement. HIV and AIDS intervention programmes should also target male

employees in order to address the socio-behavioural and structural drivers that hinder men to participate in HCT on the one hand and fuel the spread of the new HIV infections on the other hand.

4.2.4. HIV PREVALENCE OF PARTICIPANTS AT LATER ADULTHOOD STAGE

The final group of five participants, presented in column chart 3 comprised of three males and two females who were at their later adulthood phase, aged between 55 and 65. This developmental stage is characterised by “integrity versus despair” in accordance to Erikson’s (1959) stages of development.

Column chart 3. HIV prevalence of participants at a later adulthood age



From the column chart 3, it is reflected as well that three of these participants did their HIV test within 2 months and 6 months, and the other two, who were both male participants tested last in 24 months, which are similar results found in the second group of middle-aged male participants. According to South African National HIV Prevalence, Incidence and Behaviour Survey (2012), HIV prevalence in older people is based on smaller numbers, mainly because HIV is not as prevalent in older people as it is in persons of reproductive age (HSRC 2014).

It is commonly believed that people in this age category are no longer sexually active, therefore, perceived as not susceptible to contract the new HIV infection. It is maintained that perception of risk is considered the first stage towards behavioural change from risk taking to safer behaviour. It is expected that once individuals perceive themselves to be susceptible to a disease, they are more likely to take

prevention measures. Results of the study conducted on perceived susceptibility to HIV infection show that participants who were 50 years and older were more likely to believe that they would either probably or definitely not be infected with HIV (HSRC 2014).

The researcher posits that the latter group of participants are employees who can exit public service due to early or old age retirement. This age group is the cream of the department, an inspiration to the first and second group categories and a resource to the society whom they are about to join when retired. However, given these quality characteristics of this age group can be a misleading factor to assume that men in this age category are trustworthy or HIV-free.

She further contends that it should be noted that some men at this age category are involved in the sugar daddy/mummy phenomenon (cf. Chapter 2, pp.39). Similarly, Jones (2006), Nkosana and Rosenthal (2007) maintained that men perceive young partners to be more likely to be free from STIs and HIV, while young women often view older men as less risk-taking, more stable, and hence 'safer' partners. Madlala (2009) affirms that a risk perception in the intergenerational relationship is that men perceive young partners to be more likely to be free from HIV.

Erikson (1959) stages of development affirm that this is a last stage of life wherein some people reflect back on their lives with feelings of contentment and fulfilment, having led a meaningful life and valuable contribution to society. Others may have a sense of despair during this stage, reflecting upon their experiences and failures. The perceived HIV risk at this age category is that of age-disparate relationships when such men can fall into a relationship with women either the first or second group category. Harling (2014) mentioned that irrespective of one's own sex, age-disparate relationship with an older partner is generally a risk factor for HIV.

The researcher deduces also that the age disparity between the participants in this age category with the first category indicates that some employees can be fit to be the parents of their own colleagues in that particular workplace. It is based on this notion that by presenting the findings on the demographical data of these three

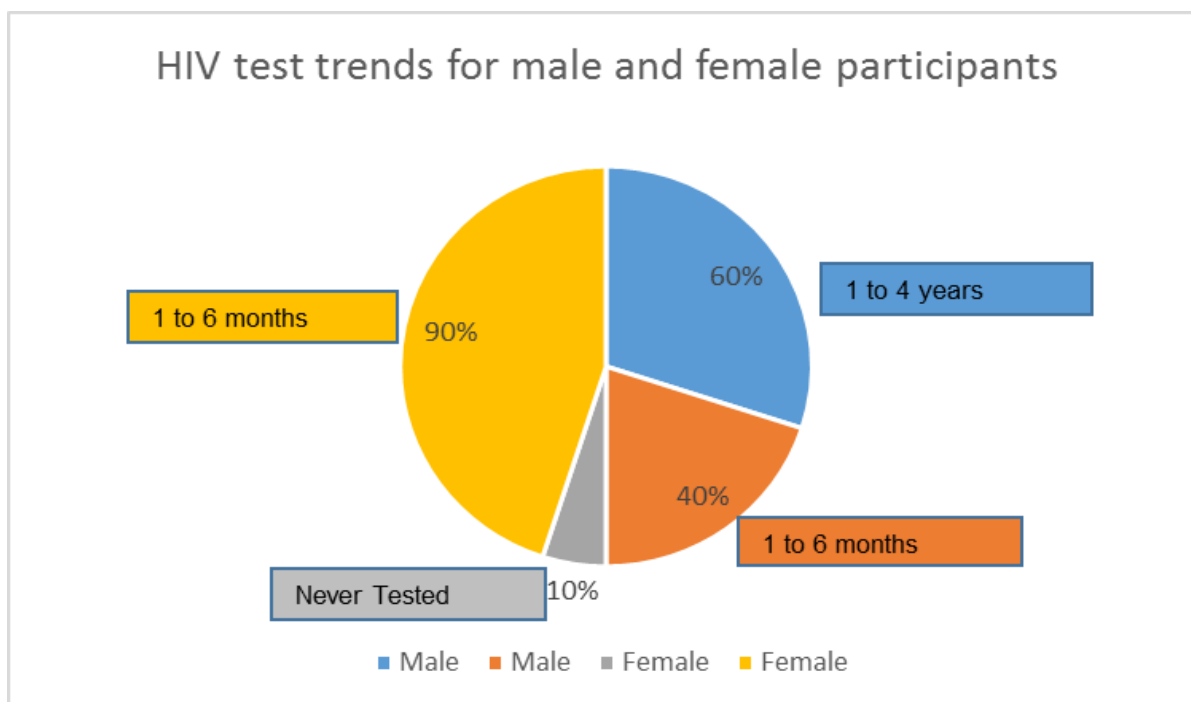
categories of participants enabled one to explore on the socio-behavioural and structural core drivers of new HIV infections in the workplace.

Table1 highlights as well the nature of work that participants do, which are: administrative functions, animal health technicians; agricultural advisors, internship programme; scientist production and general assistance. The Occupational Health and Safety Act, No 29 of 1996, places a duty on all employers to ensure that, as far as is reasonably practicable, the working environment is safe and healthy for employees. Chapter 4, Part 3 (55) (2) (a) of Public Service Regulations equally stipulates in respect of occupational exposure, that a head of department shall identify units or employees within the department that, due to the nature of their work, are at high risk of contracting HIV infections or any other diseases and take reasonable steps to reduce the risk of occupational exposure to HIV or any other disease.

Employees are required to be provided with safety equipment such as latex gloves to prevent the transmission of HIV during an accident involving a blood spill in the workplace. In accordance to the researcher's standpoint, knowing the job functions of the employees will assist in analysing whether the job's specific functions can predominantly expose the employees to contract new HIV infections in his/her line of duty, which bears a structural driver of new HIV infection. Intervention strategies to properly address the occupational exposure to HIV infections would be in place.

4.2.5. HIV TEST TRENDS FOR MALE AND FEMALE PARTICIPANTS

Pie Chart 1: HIV test trends for male and female participants



The data provided in Pie-chart 1 shows the HIV test trends for twenty participants in terms of gender. In April 2010, South Africa launched a national HCT campaign with the goal of promoting HIV counselling and testing and screening for TB (UNAIDS 2012). In the Global AIDS Response Progress Report (2012), South Africa concurred that coverage of HIV Counselling and Testing (HCT) increased substantially from 2005 to 2010. It is clear from the pie chart 1 that 40% of male employees did the last HIV test in between 1 and 6 months; while 60% of those male participants tested in between 12 and 48 months.

These findings attest that few men participate in HCT campaigns and also that they do not utilise HCT services that are offered by health facilities. South African National HIV Survey (2012) attested that HIV-testing refusal rate was higher among males than among females. DiCarlo, Mantell, Remien, Zerbe, Morris, Pitt, Abrams E. J., and El-Sadr (2014); Fleming, Colvin, Peacock and Dworkin (2016) concurred that in Lesotho, men have lower HIV testing rates, less contact with HIV clinical settings and less knowledge of HIV prevention than women.

It is also affirmed by Camlin, Ssemmondo, Chamie, EL Ayadi, Kwarisiima, Sang, Kabami, Charlebois, Petersen, Clark, Bukusi, Chen and Kanya (2016) that the entrenched male gender norms acted against men's participation in testing. Care-

seeking in general is often viewed as counter-normative for men and clinics were said to be seen by men as female spaces. The lack of knowledge about one's HIV status results in a risky sexual behaviour that fuel the spread of HIV to their partners. The socio-behavioural and structural factors that hinder some men to test for HIV in a workplace should be challenged.

It is also reflected in pie-chart 1 that 90% of female participants have last tested for HIV in 1 to 6 months, while another 10% of the female participants have never tested their HIV status at the time of conducting this study. Adolescent girls and young women are the most vulnerable group to contract new HIV infections, following the underlying socio-behavioural and structural elements that perpetuate the contraction of new HIV infection. The HSRC (2012) study found the highest HIV incidence for females aged 15-24.

From the findings, the researcher thus infers that several female employees are more likely to participate regularly in HIV Counselling and Testing (HCT) in contrast to male employees. However, it is noted that few of these female employees still show reluctance to test for HIV. National HIV Communication Survey (2009) affirms that sexually active women are more likely than sexually active men to have had an HIV test in the last year of the survey. Similar results of the workshop designed to raise the awareness of all women rights agencies in Botswana by Raditloaneng and Molosi (2014), attest also that older men have the tendency to refuse to be tested and use age and anger to avoid HIV tests. In contrary to these findings, the results from this study assert that few male employees do regularly test for HIV, while the majority test for HIV sometimes, while few do test regularly. In contrast, several female employees test regularly, however it is noted that few of them have never tested for HIV.

From the participants' responses and the resultant processes of data analysis by the researcher, the following main themes emerged:

Theme 1: Employees' knowledge about HIV and AIDS

Theme 2: The socio-behavioural core drivers of new HIV infections

Theme 3: The structural core drivers of new HIV infections

Theme 4: HIV and AIDS related stigma and discrimination in a workplace

Theme 5: Strategies and guidelines to prevent new HIV infections in a workplace.

4.3. OVERVIEW OF THEMES, SUB-THEMES AND CATEGORIES

In the remainder of this chapter, five themes with their accompanying sub-themes, categories and sub-categories as reflected in table 2 will be presented and confirmed by providing direct quotations from the interviews conducted with twenty employees in Limpopo Department of Agriculture about the socio-behavioural and structural core drivers of new HIV infection as perceived by the employees.

Table 2 Themes, sub-themes and categories

4.3.1. THEME 1: EMPLOYEES' KNOWLEDGE ABOUT HIV AND AIDS	
Sub-themes	Categories
4.3.1.1. Knowledge and understanding of HIV and AIDS	
4.3.1.2. The mode of transmission	4.3.1.2.1. Sexual intercourse and contact with HIV infected blood
	4.3.1.2.2. Mother-to-child transmission HIV infections
	4.3.1.2.3. Contact with body fluids of someone who is HIV positive
4.3.1.3. HIV progression to AIDS	4.3.1.3.1. Symptoms of HIV infections to AIDS stage
	4.3.1.3.2. Treatment of HIV and AIDS
4.3.2. THEME 2: SOCIO-BEHAVIOURAL CORE DRIVERS OF NEW HIV INFECTIONS	
4.3.2.1. Multiple sexual partners	4.3.2.1.1. Women in marriages
4.3.2.2. Intergeneration or Age-disparate relationships	4.3.2.2.1. Desperation for promotions and job opportunities
	4.3.2.2.2. Desperation for material gain by young men
4.3.2.3. Substance abuse	
4.3.3. THEME 3: THE PERCEPTIONS OF EMPLOYEES WITH REGARD TO STRUCTURAL CORE DRIVERS OF NEW HIV INFECTIONS	
4.3.3.1. Cultural norms and societal values	4.3.3.1.1. The role of socialisation
	4.3.3.1.2. Polygyny
	4.3.3.1.3. Gender based violence
4.3.3.2. The working environment	4.3.3.2.1. Employees performing technical duties
	4.3.3.2.2. Migration and mobility
	4.3.3.2.3. Department's residential houses
	4.3.3.2.4. Departmental events
4.3.3.3. Gender equality	4.3.3.3.1. Women in managerial positions
	4.3.3.3.2. Gender equality and domestic violence
4.3.3.4. Departmental HIV and AIDS policy	4.3.3.4.1. HIV Counselling and Testing
	4.3.3.4.2. HIV and AIDS policy popularity
4.3.4. THEME 4: THE PERCEPTIONS OF EMPLOYEES WITH REGARD TO HIV AND AIDS RELATED STIGMA AND DISCRIMINATION IN A WORKPLACE	
4.3.4.1. Disclosure of HIV status to a colleague	
4.3.4.2. Disclosure of HIV status to a supervisor	
4.3.4.3. Disclosure of HIV status to EAP Professional	
4.3.4.4. Disclosure of HIV status to significant others outside the workplace	
4.3.5. THEME 5: THE EMPLOYEES SUGGESTED STRATEGIES AND GUIDELINES TO PREVENT NEW HIV INFECTIONS IN A WORKPLACE	
4.3.5.1. Departmental strategy should be responsive to HIV and AIDS	
4.3.5.2. Leadership role	
4.3.5.3. Strategies to scale-up and strengthen the HIV Counselling and Testing should be developed	4.3.5.3.1. Employees should be sensitised on human rights and its gender-based violence.
	4.3.5.3.2. HCT strategies should be accurate
	4.3.5.3.3. HCT intervention should adopt a holistic approach approach
	4.3.5.3.4. Adopt HCT rewarding strategies
4.3.5.4. Capacitate employees on self-efficacy	

4.3.1. THEME 1: EMPLOYEES' KNOWLEDGE ABOUT HIV AND AIDS

This theme and its accompanying sub-themes as well as categories presented in this section were derived from the information articulated by the participants. Although this study focused on the socio-behavioural and structural core drivers of new HIV infection as perceived by employees at Department of Agriculture in Mopani District, Limpopo Province, participants often reflected on their own experiences in regard to the research topic.

Social constructivists assume that speaking is not as neutral and passive as the positivists would have thought. Every time a person speaks, he or she brings forth a reality. Each time words are shared, legitimacy to the distinctions that those words bring forth is given (Freedman & Combs, 1996). From the social constructivist's point of view, individuals create and interpret the social context in which HIV is spreading. Webb (1997) states that there are two basic forms a community's perception of HIV and AIDS can take on, the first being knowledge of the disease, method of transmission, and the progression of the disease. The following sub-themes emerged during data analysis process:

- Knowledge and understanding of HIV and AIDS
- The mode of HIV transmission
- The progression of HIV and AIDS

4.3.1.1. Knowledge and understanding of HIV and AIDS

In sharing the knowledge of HIV and AIDS, amongst fifteen participants some chose to demonstrate understanding of the two concepts by providing the definitions of HIV and AIDS concepts while others, provided an explanation of how the concepts differ as well as how they relate by indicating the progression process from HIV to AIDS phase. It has emerged from their narratives that some have knowledge and understanding about HIV and AIDS, by providing the full definition of the two concepts, while others indicated that they could not differentiate between HIV and AIDS. The following excerpts illustrate this fact:

“HIV is the Human Immune Deficiency virus and AIDS is the Acquired Immune Deficiency Syndrome”

“It means Acquired Immune Deficiency virus. When the person is having AIDS he is on a stage where the immune system is no longer functioning well, the infected person loses weight, coughs and opportunistic infections like TB result. In order to know one’s HIV status one needs to go for HIV test, which is done through testing the blood sample”

“HIV is a virus that infects a person by fighting against the immune system. The symptoms of HIV infections are weight loss, diarrhoea, rash around the mouth and others”

“AIDS are sicknesses which result due to HIV infection”

Ernest (1999) asserts that knowledge and social action go together in development rather than that knowledge being separate from action and somehow informs it. Lock and Strong (2010) state that problems are solved, not by giving new information, but by arranging what had always been known.

It is on the basis of this supposition that the researcher contends that any knowledge that is shared about HIV and AIDS reflects the punctuation of the meanings in relation to the socio-behavioural and structural core drivers of new HIV infections as perceived by the participants. Keeney (1983), a system theorist, highlights that an individual’s punctuation of experience or event is largely based on his or her epistemology.

The Basics of Philosophy defines epistemology as a study of the nature and scope of knowledge and justified belief. Therefore, the researcher asserts to a point that a successful intervention strategy to prevent the spread of new HIV infections in a workplace environment; depends on the engagement into the interactional processes of co-constructing and co-evolving of new meanings and realities attached on the social, behavioural and structural drivers of new HIV infections amongst LDA employees in Mopani District.

The said approach invites all HIV and AIDS programme implementers and decision makers to refrain from playing a role of a “patient-doctor”, “therapist-client”, an “expert-observer and “researcher-participant” in order to make progress towards the zero new HIV infection 20 year vision by 2030 for South Africa that was launched by President Jacob Zuma on the 1st December 2011 through addressing the socio-behavioural and structural core drivers of new HIV infections in a workplace. The approach further benefits all role players, including HIV and AIDS coordinators, health professionals and others in the interactional process as they are also social beings, functioning in various social and structural systems.

The researcher further maintains that it is not only through social interaction that people together construct their reality as contemplated by social constructivism, but that prior knowledge acquired, whether scientific or non-scientific that a person values, plays a significant role in how a person interprets and attaches meaning on HIV and AIDS pandemic. It was evident from the results of this study that few participants could not provide a clear knowledge and understanding of what HIV and AIDS is. It emerged from the five participants’ narrative accounts that some refer to HIV as a thing, a syndrome and infectious disease that kills. The excerpts below confirm:

“...I cannot really differentiate between HIV and AIDS; to me the two are more or less the same”

“HIV is one of the syndromes that can be transmitted through sexual intercourse without using protection”

“What I know is that it is either I abstain to have sexual intercourse or I condomise if I can’t abstain”

“HIV is an infectious disease that kills if not taken care of...”

“HIV is a thing that affects people through sex, wounds, not using protective clothing like hand gloves and through using the same tooth brush”

From the narrative accounts few participants who are at the middle adulthood stage and are employed as general workers could not differentiate between HIV and AIDS. Similar findings from two KAP surveys conducted in the Limpopo Department of Agriculture found that the majority of the participants knew the difference between HIV and AIDS (ICAS 2006; Shipalana 2009). Educational background has been mentioned in this study to be one of the determinants of the level of understanding of HIV and AIDS. In order to address the socio-behavioural and structural core drivers of new HIV infections, the intervention strategies should be designed in a manner that could able to reach out even employees who have obtained lower level of education.

The researcher thus is of the opinion that the basic knowledge about HIV and AIDS should serve as a point of departure of communicating understanding of the perceptions of employees on socio-behavioural and structural core drivers of the new HIV infections. It is maintained that the country has slid backwards in the important work of communicating messages on HIV prevention. The population’s knowledge of the basics of HIV prevention has declined from 2008 to 2012 (Global AIDS Report for South Africa 2012). Lowest knowledge levels were found amongst older people aged 50 years and older, black Africans and individuals residing in the urban informal areas as well as among four key populations at higher risk of HIV exposure as were identified by this survey (HRSC 2014).

UNAIDS (2012) affirms also that sound knowledge about HIV and AIDS is an essential pre-requisite for adoption of behaviours that reduce the risk of HIV transmission. The new survey on HIV education progression, regression or stagnation assert as well that education is the foundation for the success of all HIV programming and the very fact of being educated in itself reduces vulnerability to the virus, as it promotes self-esteem, assertiveness and economic independence (UNAIDS 2013). The researcher thus deduces that the participants who do not show an understanding of what HIV and AIDS are, are more likely to be at a risk of adopting behaviours that might increase vulnerability of contracting new HIV infection due to their insufficient knowledge about the virus.

4.3.1.2 The mode of HIV transmission

All participants, including the few who could not provide the full definition of HIV and AIDS, demonstrated their knowledge and understanding by explaining on how HIV infection is transmitted. The following three modes of transmission emerged from this sub-theme:

- Sexual intercourse and contact with HIV infected blood
- Mother-to-child transmission HIV infections
- Contact with body fluids of someone who is HIV positive.

4.3.1.2.1. Sexual intercourse and contact with HIV infected blood

The findings of this study are that sexual intercourse and blood contact are the most common mode of HIV transmission. All participants were conversant with these two modes of HIV transmission. The researcher extracted some few quotes articulated by the participants:

“HIV is a virus which is transmitted through sexual intercourse with someone who is HIV positive”.

“HIV is a viral organism that is contracted through unprotected sexual intercourse, contact open wounds with someone who is HIV positive if protective clothing is not worn”

“HIV is a virus that is contracted during unprotected sexual intercourse, blood contact...”

“HIV and AIDS are infectious diseases that are transmitted from one person to another through sexual intercourse if one does not condomise. It may happen accidentally that I felt pity to assist someone who got injury and bleeding without taking precautionary measures. It would be unbelievable to me by the time I learned that I have contracted HIV infection”

“HIV infection is transmitted through blood contact, unprotected sex...”

“You can contract HIV infection by having sexual intercourse and by coming into contact with blood that is HIV positive. You can protect yourself through condomising and putting on hand gloves when taking care of someone who is sick”

The findings concur with some research findings that sexual transmission is the most common transmission of HIV and AIDS. UNAIDS (2012) asserts that HIV epidemics are perpetuated primarily through sexual transmission of infection. Similarly the review of the South African HIV epidemic report affirms that HIV epidemic in South Africa is clearly driven by heterosexual and same sex transmission between men having sex with men (Frazer-Hurt, Zuma, Njuho, Chikwava, Slaymaker, Hosegood & Gorgens 2011). Burnhams, Musekiwa, Parry and London (2013) cited also that the majority of HIV/AIDS transmissions in Southern Africa occur through heterosexual contact. The researcher infers that the acquired knowledge about sexual and blood transmission of HIV infections results in the reduction of socio-behavioural and structural factors that fuel the spread of new HIV infection.

4.3.1.2.2. Mother-to-child transmission (MTCT) of HIV infections

Out of twenty participants, only three participants from the first age category of 18-35 communicated about mother-to-child transmission as another mode of transmitting HIV infection from the mother to the new born baby. Amongst these three, two were men. These results indicate that young men and women are familiar about this mode of HIV transmission. The extracts below attest:

“HIV infection is transmitted through blood contact, unprotected sex and mother-to-child transmission”

“...you can get HIV through unprotected sex, exchange of blood and mother to child transmission”

“HIV is transmitted through mother- to- child”

The researcher presumes that only few participants have knowledge about the MTCT; which is HIV infection transmitted from the mother to the child during the birth of the child. The researcher argues that the attainment of the 20 year vision; amongst others, the zero new infections due to vertical transmission by 3030 for South Africa that was launched by President Jacob Zuma on the 1st December 2011 might not be possible if 70% of young employees who are at a child-bearing age do not have an idea on how to prevent the vertical transmission of HIV infection from the mother to the child (Limpopo Provincial Strategic Plan on HIV, STI's and TB 2012-2016).

The risk for mother-to-child transmission can be reduced significantly by the complementary approaches of providing antiretroviral drugs (as treatment or as prophylaxis) to the mother and antiretroviral prophylaxis to the infant and using safe delivery practices and safer infant feeding (UNAIDS 2012). The researcher further argues that mother-to-child transmission is less known and understood by the majority participants. Although this mode of transmission seems to be biomedical, it has a structural bearing effect of driving the new HIV infection to the child if policies and guidelines on Prevention of Mother to Child Transmission (PMCT) of HIV are not adequately implemented.

4.3.1.2.3. Contact with body fluids of someone who is HIV positive

The contact with the fluids of someone who is HIV positive has been communicated by participants as another mode of transmitting HIV infection. This knowledge and understanding was communicated by only two participants as highlighted below:

“It is a virus that is contracted during the contact with bodily fluids like vomits and diarrhoea when taking care of the HIV positive sick person”

“HIV is transmitted through blood contact and bodily fluids from unprotected sexual intercourse”

From the two extracted verbatim accounts above, it is evident that only few of the participants had knowledge that having contact with bodily fluids of someone who is HIV positive can expose one into a risk to contract HIV infection, while some of those participants do not have that relevant knowledge. The bottom line of the transmission is only if there is a cut through which blood can pass. This finding is worrisome since some employees also have a role to take care of their sick family members. The utilising of hand gloves by this group of participants during this critical moment is also a question. It is of the researcher’s opinion that the majority of employees are not well conversant about prevention of occupational HIV infection due to injury on duty. In this notion, employees should be educated about occupational health hazards that can be structural core drivers of new HIV infection in a workplace.

4.3.1.3. HIV progression to AIDS

When sharing the knowledge and understanding about the progression of HIV infection to AIDS, two categories emerged from the employees' narratives as follows:

- Symptoms of HIV infections to AIDS stage and
- Treatment of HIV and AIDS

4.3.1.3.1. Symptoms of HIV infections to AIDS stage

Some employees went to an extent of explaining on how the HIV progresses to AIDS stage, which is more biomedical. The story lines below testify:

“When the virus has progressed to AIDS, the symptoms become visible...”

“If not taking care of oneself when tested HIV positive, you end up experiencing various opportunistic infections like diarrhoea, develop sores, loss of weight and appetite”

“HIV kills white blood cells, CD4 counts go low, you get weak and then fall sick, lose appetite and make ways for opportunistic diseases like TB”

“When a person is having AIDS, he is at a stage in which the immune system is no longer functioning well; the infected person loses weight, coughs and opportunistic infections like TB results”

It is evident that only few participants are informed about this mode of spread of HIV infection. Olowookere, Fatiregun and Adewole (2012) state that currently a large percentage of the Nigerian population has good and accurate knowledge about all aspects of the HIV and AIDS epidemic, unfortunately, the knowledge has not resulted in appreciable changes of attitude. It is found that over 90% of students possessed good knowledge about HIV progression but only 16.6% reported to have used condoms for protection during sexual intercourse (Olowookere et al. 2012).

The researcher concludes that it is not always lack of knowledge that leads to the vulnerability of contracting new HIV infection, but attitude, social norms, values and structural factors such as gender equality, legislation and policies also have a contributing role.

4.3.1.3.2. Treatment of HIV and AIDS

The new Actuarial Society of South Africa (ASSA) 2008 and 2011 model estimates maintains that there is a substantial downturn in AIDS related mortality in recent years, with annual number of AIDS deaths reduced from about 257,000 in 2005 to about 194,000 in 2010. This is largely due to the expansion of the ART programme (UNAIDS 2012:52). The South African National HIV Survey (2012) concurs that the immediate benefits of ART provision are already evident in the large reductions of AIDS deaths among people living with HIV (HSRC 2012). Few participants communicated their knowledge about the treatment of HIV and AIDS. The knowledge on the CD4 cells count, the adherence on treatment and the prognosis for HIV and AIDS was communicated as per utterances below:

“...when the CD4 counts become lower than 500, the person starts to take treatment”

“HIV cannot be cured but it can be controlled by taking treatment provided by the Department of Health”

“The person takes ARVs as supplements to boost the CD4 cells”

“Currently there is no cure and vaccine for HI virus”

The findings of this study demonstrate that few participants understand that there is no cure for HIV and AIDS. However, there is a treatment that one can take in order to prolong his/her life. South Africa has scaled up the coverage of antiretroviral therapy in 2015. The results of this intervention strategy in the rapidly developing countries, has preserved and strengthens the health and well-being of the adolescents and working age adults on which the future economic growth depends (UNAIDS 2015).

Despite the achievements the country has made in scaling up of ARVs and the knowledge that people have about the importance of adhering in ARVs, the stigma associated in taking ARVs remains a barrier towards the prevention of the spread of new HIV infection. One of the participants in the study by Mona (2012) attested that she had not yet disclosed her HIV status and having to constantly ask for permission from her employer to visit the health care facility was a challenge.

Some employees who are HIV positive and on treatment face a dilemma as they have to comply with their clinic appointments and if they have not disclosed this becomes a challenge as they have to make up lies every time they have to go to the clinic. The researcher asserts that effective adherence to HIV treatment can be enhanced by a non-stigmatised and non-discriminatory working environment that promotes the shared norms, values and moral obligation in reducing the further spread of new HIV infection. The social capital theory support the idea of upholding moral obligations and norms, social values and social networks as critical in enhancing adherence to HIV treatment (Putnam1995). It has been found that adherence to ARVs suppresses the viral load. The more the viral load is suppressed the lesser the risk for secondary transmission of HIV infection.

4.3.2. THEME 2: SOCIO-BEHAVIOURAL CORE DRIVERS OF NEW HIV INFECTIONS

Amongst the objectives of this study, understanding the perceptions of employees with regard to the socio-behavioural core drivers of new HIV infection amongst them was the key of this study. From the social constructivist's point of view, the psychosocial construction of the disease where beliefs relating to its origins and aetiology, risk perception and attitudes toward infected individuals are incorporated into the perception. Webb (1997) reiterate that, in order to formulate legitimate prevention programmes and to make them truly place sensitive interventions suited to local conditions, analysis of the social constructions of HIV and AIDS are crucial. The guiding principle of social construction is that humans cannot live alone. To envision human life is to envision relationships. Human's beliefs and feelings, what is found pleasing or displeasing, beautiful or ugly, right or wrong, are all the products of social relationships (Witkin 2012).

The analysis of how participants constructed their perceptions with regard to the socio-behavioural core drivers of new HIV infections have given rise to three sub-themes with relevant categories reflected as follows:

- multiple sexual partnerships (MSPs) as core drivers of new HIV infections
- Intergenerational or Age-disparate relationship
- Substance abuse

4.3.2.1. Multiple Sexual Partnerships (MSPs)

MSPs are widely held to be one of the primary drivers of the HIV epidemic, especially in sub-Saharan Africa, where about two thirds of the world's HIV-positive population live and more than 70% of all new HIV infections occurred in 2008 (Lancet 2011). The Know Your Epidemic/Know Your Response (KYE/KYR) Summary Report (2011) reiterated that sustainable reductions in new infections and the proportion of People Living with HIV (PLHIV) will require purposeful change of long standing sexual norms.

The majority of participants from the three age categories perceived MSP as behaviour that places all partners at a risk of contracting new HIV infections, whereas few of them affirm that MSP reduces the spread of HIV infection. Chen, Jha, Stirling, Sgaier, Kaul, and Nagelkerke (2007) conducted a systemic review of 68 epidemiological studies in sub-Saharan Africa on infected individuals and an uninfected control population. The study found that besides paid sex, STIs, and HSV-2, multiple sex partners are a significant HIV transmission factor.

The review of the South African HIV epidemic postulates that there is some indication of an increase over time in the proportion of 16-55 year old men who reported MSPs in the past 12 months (UNAIDS 2011). Similarly, the South African National HIV Survey (2012) shows the results for young men and women participants aged 15 and older who reported having had more than one sexual partner in the past 12 months.

There is an inverse relationship between age and multiple sexual partnerships with a higher percentage of younger participants reporting that they had had more than one sexual partner in the past 12 months compared to older participants. Overall, significantly higher percentages of males reported that they had more than one sexual partner in the last 12 months consistently compared to females. Among those aged 50 years and older for males the rates peaked in 2005, decreased in 2008 and then increased slightly in 2012. Corresponding peaks for females who had multiple sexual partnerships were 8.8% in 2002 for those 15–24 years old, 4.0% for those 25–49 years old, and 0.8% for those aged 50 years and older. It is important to note that the rate for females aged 50 years and older who had multiple sexual partnerships stabilised at 0.8% over the period of the past two surveys (HSRC 2012). This literature review denotes that some of the participants from the three age categories of participants were involved in MSPs although at different levels.

The majority of participants also perceive MSPs as a socio-behavioural driver to the spread of new HIV infection. The extracted lines from their narrative accounts concur:

“The first partner did not stick to me alone, and then the HIV infection circulates between us. It should be one man, one woman”

One of the participants elaborates explicitly how MSPs increase the chance of contracting HIV infection. *“When you engage in a sexual relationship with a man who is not yours, you must know that it is more or less the same when you have shared a bed with more than one person. Multiple partnership increases the chance of contracting HIV infection by all people involved in the partnership”*

The circular pathway of transmitting HIV infections amongst the sexual partners seems to be a characteristic of MSP behaviour; which increases the probability of contracting the new HIV infection. A male participant narrates his perception as follows:

“Personally, I do not like and promote the idea of multiple sexual partnerships. The second partner that you are involved with will be having her previous history of sexual partners whom you do not even know their HIV status. Obviously, you are putting your life and the life of your spouse at a risk of contracting HIV infection”

The principle of circularity has been explained in systems theory as referring to interdependency of elements in a given interaction. In this principle there is no cause and effect. There is no beginning and no end in a circle, therefore the ‘why’ question should be avoided (Watzlawick 1967). In addition, Maturana (1975) describes the circular nature of a living system by stating that if the organization of the living system is circular then the living system is organizationally closed. By implication, organizationally closed living systems are autonomous systems, therefore, not dependent on input or information from outside the system.

The researcher therefore argues that the spread of HIV infection in a workplace or community may become circular in nature if there is sexual interdependency amongst the employees as members of the system. In this instance, the element of “secrets” that maintains closure and sustains the autonomous function of the MSPs network or system may result in not opening to any given information with regard to HIV and AIDS or any information that is in contradiction with the values of that particular MSP system.

Brebner (2007) concurs that due to the smaller size of the population, it is very likely that sexual partners are shared either at the same time, or in serial relationships. As a result, if one individual within the circle becomes infected, it is likely that several other individuals may be infected because of contact with that initial partner.

Lancet (2011) affirms that multiple sexual partnerships, in contrast to serially monogamous sexual partnerships, are thought to allow an increased rate of spread of HIV by linking up what would otherwise be discrete sexual networks in time and space. In contrast, only one participant in this study perceives multiple sexual partners as a behaviour that does not place all partners at a risk of contracting new HIV infections if you know each one’s HIV status. He maintained:

“There is no problem about having multiple sexual partners provided you all know each one’s HIV status...if it is not like that; do not even think of involving yourself in that kind of partnership”

The participant’s account emphasises the need for responsibility and openness between multiple sexual partners about one’s HIV status. The researcher argues that disclosure of one’s HIV status is still a challenge to many people in South Africa due to factors like fear of losing a sexual partner, stigma and discrimination. The study conducted by Magwaza (2009) attest the main reason for nondisclosure as fear of discrimination, and the need for self-protection.

Thus the researcher infers that there is likelihood that people who engage in MSPs do not know the HIV status of their sexual partners and, if safe sex is not practised, there is a high risk of contracting, spreading and re-infection of HI virus. The study further reveals culture as having both the social and structural element of driving the spread of HIV infections; hence its structural effect has been outlined again in theme 3 of this chapter 4. Culture is defined as the attitudes, behaviour, beliefs, customs, habits, language, and values that are characteristic of a group, society, or organisation in a particular place and time, the accumulated knowledge of which is passed to the next generation through socialisation (Free online dictionary). Mkhize (2004) affirms as well that culture refers to a knowledge that is passed on from one generation to another within a given society, through which people make sense of themselves and the world. It incorporates language, values, assumptions, norms of behaviour, ideas about illness and health.

Culture has been found in this study as a contributory factor that leads to the spread of new HIV infection by promoting multiple sexual partnerships. Campbell (2004) concurs that a man may choose not to act on information about the risks of HIV and AIDS due to the social construction of masculinity, which dictates that a “real man” should have sex with many women, and should not be afraid to take risks. It is perceived that by having more than one woman as a way of celebrating their masculinity. An older female community leader in a study by Brebnor (2007:101) attests: *“A man who has more than one sexual partner receives praise in society. My*

husband (who is now deceased) once told me that he had to have extra-marital affairs. He said: "what would everybody think if I only had one woman? What kind of a man do you think I am?"...I ended up taking care of at least four of his children who were born outside our marriage"

Similarly, Schuele and Berner-Rodoreda (2010) affirm also that in many societies "manliness" and "masculinity" is often closely associated with having multiple sexual partners and negative attitudes towards condom-use, which seem to hold true for both heterosexual men and men who have sex with men. Some participants highlighted the cultural idioms that emphasize the approval of men to practise multiple sexual partnerships. However, they further condemn such behaviour because of its negative outcomes on the spread of new HIV infection.

"In Xi-Tsonga, a man may have more than one sexual partner. There is an idiom expression which says: "wanuna a hi tuva kuri a nga haha a ri yexe" (meaning that a man is not a dove that he can fly alone). However; the consequences for flying up with more than one partner are not good. From the three women that you are in love with, one might not be trustworthy. If one has contracted HIV, consequently the other three parties will be infected as well. The man will contract and transmit to the poor two innocent women".

Another revelation is that there are "good" and "bad" naming of both men and women who practise multiple sexual partnerships. The following utterances attest to the fact: *"Ethnically I am a Mo-Pedi. In my culture it is accepted for a man to have more than one sexual partner. If you are a man it is approved; but, if you are a woman it is disapproved. If I can cheat my partner I will be called by names such as "sefebe" (a tart, or a woman of loose morals). Conversely, if a man cheats he is being praised and called "sekhokho" (which means a boss or a great one).*

A SexInfo online affirms that the gender dichotomy of "good woman" and "bad woman" also plays a role in Ba-Tswana culture. Females who utilise their rights to sexual freedom can often be labelled promiscuous and are blamed for the spread of HIV infection. It is apparent in the findings that participants in this study share certain common cultural values about MSPs which are more in favour of men. It should also be noted that some men and boys who defy such norms around masculinity might be

experiencing societal sanction, stigma and bad naming such as “sisi” (meaning that he is a lady) or “mpara” (a Se-Pedi word refers to coward).

The researcher argues that although the empirical findings and the literature reviewed found the rate of MSP to have increased in men, this study indicates that the majority of female participants perceive some women to demonstrate a seductive behaviour that entice men to engage in sexual relationship with them. Some female participants concur that women have ways to avail themselves to men for sexual relationship purposes. Below are the shared testimonies:

“...another challenge is that some men and women who are both working are having “roll-ons”, I mean boyfriends and girlfriends and they keep it secret. We are aware of such behaviour by our colleagues. They do not only fall in a sexual relationship with colleagues in the same department, but with employees from other departments”

“...as a woman you keep on making endless requests from a man such as...buy me lunch...after two minutes...buy me cold drink...you make unnecessary phone calls, those are signals that you are making all efforts to have him for you”

“A woman’s sincere actions lure a man’s heart. In our Venda language we say: “munna u kungea nga mato” (meaning that a man’s heart is won by the woman’s sincere actions).

“These days’ women also give cues of proposing to men. My belief is that when I asked an amount of R50.00 from a man, honestly it is a way to tell him that I love him...”

“...in those olden days a married woman was so respected by everybody; but nowadays they are the ones who avail themselves to men. Men are weak when it comes to sex, they can’t resist a woman who avails herself. In most instances men are not the ones who initiate intimate relationship, but it is us women...buy me a cold drink...”

“Men are not the only ones who behave like that; there are some women who went all out to hunt for male partners in order to satisfy their sexual desire

From the feminist point of view, women are freed from being the passive member in the initiation of a relationship; it is now acceptable for women to pursue guys for a date, dress sexily and desirable and to act sexually assertive in a relationship, which the colleagues pronounce as a sex manipulative game. The feminists point out that the fact that women reach the stage of desire to live in committed relationships earlier than men has created a culture of women chasing men (Nino 2006). Leclerc-Madlala (2009) affirms that young women may be powerless as regards safer sex negotiations, but they often have a high degree of control over partnership formation and choosing the number and types of partners with whom they become involved. This was also confirmed to be true by one male participant who lamented his personal experience as follows:

“I remember when I started working; one lady told me that she wants to sleep with me without a condom and I refused. Her intention was to get impregnated by someone who is working...she wanted financial security for her child”

The researcher argues that women are not passive role players in MSPs, but have a potential to initiate in the formation MSP which she becomes part. Based on the alluded results, the researcher posits that such women demonstrated the potential to make such a relationship, thus such capability can also be applied in negotiating practising safe sex with the opposite sexual partner, which places both of them at less risky situation of either contracting or spreading the HI virus.

4.3.2.1.1. Women in marriages

The results of this study indicate that women in a marital relationship suffer the adverse impact of MSPs, which is contracting the new HIV infections. Mikell (1997) asserts that men also enjoy other types of MSPs relations with varying degrees of social recognition. Thus many wives are at risk even if they have obeyed normative proscriptions regarding extramarital sex, which are imposed in some, but not all,

central African cultures. Parikh (2007) affirms that the greatest risk of HIV infection for married women is the extramarital sexual activity of their husbands.

Rombo (2009) also highlighted that the risk of HIV infection for married women increases if the marriage is customary, polygynous marriage, or remarriage. Rombo (2009) further mentioned that multiple sexual partners characterize all these marriages, in which protected sex is least likely to be practised. A study by Pebody (2013) attests that marriages in Malawi are characterised by gender inequalities that marriages itself is a risk factor for HIV infection in women. Mashangwa (2016) asserts as well that, more women in Zimbabwe have a higher HIV and AIDS prevalence rate than men. Married women lack the choice and power to control their sexual and reproductive health, could not negotiate for safe sex. Most women blamed their husbands' non-monogamy for their HIV infections. Some women participants shared similar perceptions:

“We married women; we are at a higher risk of contracting the virus. Our partners do not accept to use protection through condomising during sexual intercourse”

“Women are at a greater risk of contracting the new HIV infections, more specifically we women who are in marriage. If you are not married I think you are at a safer side, if it was me I would choose to abstain”

One woman who lost her husband felt to be at liberty from contracting HIV infection and decided not to get married again. One of the women testifies:

“One like me I have lost my husband, so I feel very much relief because I have chosen to stay alone without involving myself in another relationship with any man”

Rombo (2009) affirms *that* remarriage following divorce, separation and widowhood is the greatest risk factor for HIV infection in both Ghana and Kenya. The conflicting results to these findings was provided by South African National HIV Prevalence, Incidence and Behaviour Survey, (2012) that individuals who were married had a considerably lower HIV incidence rate than did survey participants who were living together with a sexual partner and those who were single (HSRC, 2014). The

researcher infers that social and structural factors are the core drivers of HIV infections in most women in marriages.

It is shown by this study that a behaviour of “keeping a secret” of one’s engagement in MSPs places an innocent marriage partner into a risk of contracting HIV infection.

“Once a person cheats, the risk for contracting HIV infection is high because one cannot confide to the other partner about his cheating behaviour...and would find it difficult to introduce protection”

“A marriage which is full of secrets of extramarital affairs is more likely to experience HIV infection and domestic violence because there will be pinpointing of fingers of who has infected the other with HIV”

“...what is happening currently men married one wife and have a second lover outside the marriage, which is very risky that one can contract the infection and spread to the other partner very easily”

4.3.2.2. Intergenerational or Age-disparate relationships

According to Oyediran, Odutolu and Atobatele (2011), intergenerational sex is similarly referred to as cross-generational sex or age-mixing or age disparate relationships. The terms intergenerational sex and age-disparate relationships are synonymous, thus used interchangeably very often. Both terms generally refer to relationships in which the age gap between sexual partners is five years or more (HSRC 2014). Participants relate on how intergenerational relationships manifest in a workplace. From their perceptions in this regard, two categories emerged as follows:

- Desperation for promotions and job opportunities
- Desperation for material gain

4.3.2.2.1. Desperation for higher positions and job opportunities

Employed women, ranging from young women in the Internship Programme to permanently employed women are prone to engage in transactional sex with their bosses or supervisors with the intention of getting a permanent post or a promotion to a higher position. The following utterances serve as a reference:

“Some young women avail themselves sexually to male senior managers with intentions that they will be promoted to higher positions if opportunities come”

“...the same applies to women who are closer to their male supervisors they are being hooked in having sexual intercourse with them with the false impression that they will be promoted into the higher post”

In discussing the poverty-driven selling of sex, some authors emphasise the importance of recognising that whilst millions engage in commercial sex work on a regular basis, even more people not commonly thought of as “commercial sex workers” find themselves needing to exchange sex for money or goods on an occasional basis (Collins & Rau, 2001: 14, Cohen, 1998). The Second National HIV Communication Survey (2009) attests that more employed people were involved in transactional sex in the past year than unemployed people and students.

Leclerc-Madlala (2009) concurs that transactional sex and materialism were identified as factors in predisposition to HIV/AIDS. Additionally, a qualitative study with the fishing communities in southern Malawi found that transactional sex occurred in a form of “fish-for-sex” networks, where female fish traders exchange sex with fishermen for better access to fish or more favourable prices, and gift giving within relationships (MacPherson, Sadalaki, Njoloma, Nyongopa, Nhwazi & Mwapasa 2012). By controlling the means of production, the power dynamics in the exchanges favour, and can make it difficult for women to negotiate condom use.

According to the World Health Organization in UNAIDS (2014) many women who earn low salaries coupled with the culture of being economically dependent on men, conversely foster income generating initiatives that might put them at risk of HIV infection. Young women who are on Internship Programme are at a risk of contracting new HIV infection. A young woman, who is on internship programme lamented:

“...as a young girl, when you arrive in a new work environment, every guy would want to associate himself with you, even those that are married. To me it means that these men are taking advantage of each and every intern who arrives in this workplace”

Her (the young woman participant above) perception is confirmed by a male participant who voiced out as follows: *“Some men and young men have tendencies of falling in love with interns from each and every group that is recruited yearly. Those ones even boast about such behaviour. I remember at some point, a certain manager who is my supervisor told me that he has fifteen girlfriends within one local municipality. The very same supervisor has a relationship with a young lady whom I am supervising. It became so difficult for me to function effectively in such kind of a working environment, as his girlfriend was no longer cooperating with my instructions. It impacted on service delivery negatively”*

Leclerc-Madlala (2003) indicates that men often view these relationships as transactional and are not willing to use condoms when they have given their young partners a valuable gift or service. Age-disparate sexual relationships as a strategy gains viability and meaning for young women within the context of existing economic structural conditions and prevailing gender and power relations in southern Africa. Such relationships are nested within a common system of socio-sexual networking that includes the normative elements of multiple and concurrent partnerships and the semiotics of sex-money transfers. The extracts below bears as a reference:

“Employees are getting sexually involved with young girls who are in internship programme. We just feel sorry for these young girls and we can’t advise them since they feel to be over the moon, they are untouchable”

“Young women, who are in internship programmes like me, may be anticipating job opportunities before the end of internship. At the end of the internship period we might experience desperation of exiting the work environment and become vulnerable to the deceptions by our supervisors to have sex with them with the expectation that we will be offered permanent posts. One of my friends is still getting a salary although her contract has ended, just because she has an affair with her boss”.

Glynn et al., (2001); Kelly et al., (2003) and Longfield et al., (2004) indicate that relationships between young women and older men are common in the region as in many parts of sub-Saharan Africa and are associated with unsafe sexual behaviour and increased HIV risk. These relationships are largely premised upon material gain, with studies revealing that the greater the economic asymmetries between partners and the greater the value of a gift, service, or money exchanged for sex, the less likely the practice of safer sex (Luke, 2003; Wojciki, 2005).

According to the gap report by UNAIDS (2014) an independent study shows that, in some other parts of sub-Saharan Africa cash transfers are a powerful tool for mitigating the risk for HIV. In combination with other HIV and social protection activities, cash transfers make an even greater contribution to HIV prevention, treatment, care and support outcomes.

The new emerged sexual behaviour that can contribute towards the spread of new HIV infection is the “blesser-blessee” phenomenon. eNCA South Africa 26 May reported that the blesser phenomenon has gone viral, with many women looking for older men to sponsor their expensive lifestyle. However, men, some of whom are married, may be blessing more than one woman. A 27 years old Amanda Cele who was a “blessee” of two prominent business men for more than a year also reported that she can no longer settle for dating someone who is broke. She further mentioned that she knows that most of the blessers are not looking for relationships and that they will never leave their wives for a “blessee” (City Press, 01 June).

From the researcher’s perspective, the cash transfer seems to have been taking another form of transactional sexual behaviour that involves all three later life stages of development according to Erikson (1959). Poverty, lack of employment and low salary income are the key drivers this kind of transactional sexual behaviour that has placed both young men and women at a risk of contracting new HIV infection.

4.3.2.2.2. Desperation for material gain by young men

In African culture it is accepted that a woman should get married to a man who is older than her and not vice-versa. Raditloaneng and Molosi (2014) confirm that culture makes it difficult for arranged marriages between older women to younger men. It is also articulated by participants that the age difference should not be too disparate, and that a woman must not be older than a man. Rather, a man must be older (Raditloaneng & Molosi 2014). Peter Masanda in Parent24 (2012) affirms that the focus is mainly on older men dating younger girls and forget older women dating younger men or boys (parent24:1012).

This kind of intergenerational relationship has been given names that described the kind of sexual relationship between older women and younger men, where older women are referred as “Sugar mamas” and younger men as “Ben 10s”, after the TV cartoon character. There is a myth that key actors in intergenerational sex, nicknamed “sugar mummies and Daddies” need each other to cleanse their blood by sex with relatively younger partners (Raditloaneng & Molosi 2014). Similarly, this study found that young men are engaged in intergenerational relationships with older women; which is traditionally uncommon. Concurrently, some participants expressed their perceptions as follows:

“In this workplace there are women who want young blood, the “Ben 10s”. The “Ben 10s” want material things from the sugar mamas. Young men do not concentrate on the consequences of their actions”.

“Successful women have also brought their own fashion of falling in love with young boys. They spoil these young boys by maintaining them financially and materially. They go to an extent of providing the boy’s parents with groceries and other gifts so that they can accept them. These young ones are too materialistic, they are not aware that they are exposing themselves to a risk of contracting HIV infection and other sexually transmitted infections from these older women.

Supporting the findings above, Raditloaneng and Molosi (2014) cited Karl Marx's theory that the fundamental proposition of historical materialism is premised in the materialist conception that throughout human history, economic factors determine and motivate how people exist. Whatever they do in their quest for existence is motivated by material wealth. It is not the consciousness of men that determines their existence, but their social existence that determines their consciousness.

Young men advance their willingness to intergenerational sex even at workplace to the older women whom they are working with. One of the participants shares her personal experience...*“even these young boys whom we are working with, they will utter statements such as...mama you excite me, can I come and stay with you? So...if you are a foolish woman you can find yourself falling in love with a boy who is of the same age with your fourth born child”*.

Another participant concurs with the findings by sharing her experiences while she was studying at tertiary institution...*“I had a friend at the university who met another woman at a hiking spot and offered him a lift. That woman exchanged her cellular phone numbers and she started to call him continuously and make appointments to meet him. The woman succeeded in winning my friend's heart and he left the campus to stay in the house of that woman in town. He came to school driving that woman's car and he couldn't even bother to answer on our calls...”*

The relevance of historical materialism to the spread of HIV and AIDS amongst young generation in Botswana is that young people are motivated by materialism in the form of cars, cash, and cell phones. This posits that history of human societies is made as a result of struggle between different social classes rooted in the underlying economic base. Adolescents, especially girls, and to a lesser extent boys, are attracted to partners who can relatively provide for their well-being (Raditloaneng & Molosi 2014).

The intergenerational relationship is also described to be mutually benefitting in that young men are looking for material benefits, while old women are relieving boredom and benefitting from the company of those young men. This was reported in this manner...*“Young men on the other hand contract HIV infection from divorced, widows, single and high profile women who feel boredom and loneliness”*. A divorced woman who is dating a man 14 years younger than her told that initially she was uncomfortable about the age difference but the young man was a source of comfort for her, he cares and loves her (Parent24).

4.3.2.3. Substance abuse as core driver of the new HIV infections

In her foreword, Minister of Social Development, Ms Bathabile Dlamini states that alcohol and substance abuse continue to ravage families, communities and society. The youth of South Africa are particularly hard hit due to increase in the harmful use of alcohol and the abuse of illicit drugs (National Drug Master Plan 2013-2017). The Minister further indicated that alcohol and drugs damage the health of the users, and are linked to rises in non-communicable diseases including HIV and AIDS (National Drug Master Plan 2013-2017).

The majority of the participants asserted also that substance abuse can contribute to unsafe sexual activities and as a result to new HIV infection. It reduces people's commitment to practise safe sex as illustrated in the following excerpts:

“People who are under the influence of alcohol are more likely not to practice safe sex. They are vulnerable to hang around with girls who are also drunk. Neither one nor both of them will think about using protection when engaging in a sexual intercourse. If by chance they remembered; using the protection correctly is another question”

“...alcohol can get you to make mistakes that you had not intended to...the person might find him/herself sharing the same bed with his sister or brother and failing to

explain the next morning how did it come about. In such instances, no one might have thought of using a protection”.

When a person is under the influence of alcohol, human values and morals like respect are suppressed. Old and young men and women engage in unplanned sexual intercourse. The use of condom under such circumstances seems to be questionable. According to Pithey (2006) it is found that two adult community populations studied in Cape Town were more likely to engage in risky sex practices, characterised as sex with multiple partners and unprotected sex if they were methamphetamine or alcohol users.

The same results were found in the study presented at the 4th South African AIDS Conference, 31st March-2 April 2009 in Durban which reported that some of the participants had engaged in alcohol use and drugs before sex in the past month, had multiple sex partners in the last three months and reported to non-condom use at the last sex (HSRC 2009). An individual commits certain sexual activities with a person unintentionally, and subsequently suffers remorse and embarrassment when sober.

The following narrative account confirms:

“...you find a person waking up at someone’s house and claims that he/she thought it was the partner. It has happened in our township I am not telling a story, a mother of a certain girl engaged in sexual activity with her daughter’s father-in-law unaware after they were drinking together. The next day in the morning they woke up together from the same bed. It was an embarrassment to both of them and to their children. I commented that if it was me, I would instantly quit drinking alcohol”

“Alcohol fuels the spread of HIV infections. Someone who is drunk cannot make appropriate judgements. He or she does not care whom she engages in a sexual act with; and the HIV status of the opposite partner is unknown to each other. They use to utter foolish words such as...if I die; I die...He neglects himself and think that he will be like a soldier dying in a war”

“Those who drink alcohol are at a greater risk of contracting HIV infections. Although I have never tasted alcohol, but observing those who drink, I could see they think and do things differently when they are drunk as compared to when they are sober. They behave strangely when drunk and behave well when sober. Others don’t even know their way home, they get lost. If such a person is a woman, do you think the group of boys can leave her without gang raping her?”

Psychosocial challenges experienced by both men and women are perceived to be amongst the contributing factors for the drinking behaviour. Some participants mentioned the frustrations experienced by women and marital conflict experienced by men as factors that drive them (men and women) to the drinking spots, a communal drinking environment that precipitates the probability of engaging in an unintended sexual activity.

“...those frustrated old women are there to seduce young boys. Young girls work on attracting those old men who run away from their homes to avoid continuous fight with their wives. Since there is a loud sound of music and people are drunk, no one cares about who does what? Can you see that kind of environment? Even those who think they are gentlemen, when they leave the spot; they pack group of girls in their cars and leave with them. Ahhh...there is no life where there is alcohol...”

It is assumed that some men do not experience sexual desire when drunk, thus they are less likely to engage in sexual intercourse. Contrary to this assumption, one participant states that his husband delights in having sex when he is drunk. *“Haaa...kwini laa...hi la swi lavaka kona!* (Loosely translated from Xitsonga language, which implies that sexual desire is very high when people are drunk). *My husband was drinking alcohol and I knew that on that day there is no other way... (She laughed out loudly) He would not sleep without...”* However, Shakespeare affirms that alcohol provokes the desire but takes away the performance. Therefore it sets him on and takes him off (The New Age online 2016).

Some participants negate that alcohol contributes to the spread of new HIV infections. A personal experience has been shared by one participant that him and other men whom he drink alcohol with enjoys to be together, used to play indigenous game and sing church songs in order to relieve boredom. It is further illustrated that the sense of responsibility is still possessed despite the fact that he is drunk.

“I do drink and I feel good when I am drunk. We do not drink where there are women; we club together as men only. We play casino and muruba, sing church choruses and hymns. We relieve boredom when we drink alcohol, but at 20h00 I am in my house. I only drink during weekends, but during the working days I do not drink”.

Professor Wim van den Brink from the University of Amsterdam concurs that alcohol is a social lubricant and that moderate use of alcohol makes people happier, more social and less inhibited when it comes to sexual engagement (The New Age Online 2016). It is also mentioned that people behave differently when drunk. The following narrative accounts by some participants confirm this:

“Liquor or alcohol makes a person to have sexual desire, but to some sexual desire decreases. If you drink responsibly I don’t think there is any harm or in any way you can contract HIV infection”

“The people whom I know that they drink alcohol, they just fell asleep when drunk. How will they perform the activity, because everything should start from the mind, if there is nothing in the mind, nothing can happen”

“...sexual intercourse and alcohol does not go along. Those ones they establish a relationship when they are sober. You cannot draw an “S” (a metaphor which implies that one cannot engage in a sexual activity) when you are drunk”.

Barnett and Whiteside (2006), Mccann, Harker, Burnhams, Albertyn, and Bhoola, (2011); Rose and Zweben (2002); Van Dyk (2005) differ with these findings by emphasising that a high prevalence of HIV infection is reported among individuals with substance-abuse problems as a result of greater sexual risky behaviour and infection through contaminated needles. In Southern Africa the majority of HIV/AIDS transmissions occur through heterosexual contact and numerous studies have demonstrated evidence of an association between substance abuse and sexual HIV risk behaviours among men, women and adolescents (Burnhams, Musekiwa, Parry & London 2013).

Some churches are perceived by as “hot spots” for spreading new HIV infections by few participants. Rombo (2009) states that Protestant Christians have the highest odds of being infected with HIV. Catholics, Muslims, and those who do not have any religious affiliation follow them in descending order. Compared to Protestant Christians, individuals who identify as belonging to other religions have relatively reduced odds of being infected, with Catholics having a marginal difference from protestant Christians.

Some of the participants perceive religious people to be the most vulnerable to contract new HIV infection. The excerpts below refer:

“In the community in which I reside, people who drink alcohol are not actively engaged in sexual intercourse. Those who love engaging in sexual activities are those who are hiding in churches”

“Most of the pastors are hiding at church but have multiple relationships. The people, who are at risk, are those who are in the church. Women confide their problems to pastors at the end those pastors take advantage of them”.

“Those who are inside churches even fall in love amongst themselves”

Some participants perceive the workplace as an environment, which by chance offers some employees an opportunity to perform secretly engage in sexual activities in the course of their duties. The following narrative accounts emerged:

“There are some field work employees who go to shebeens and bottle stores during working hours. Those employees go to an extent of hiding themselves so that they should not be identified by fellow colleagues. They even have sexual relationship with shebeen queens and other women who keep the spot hot or attractive for the customers”.

To sleep away from home due to work-related reasons has been perceived as another opportunity for some employees to engage in unacceptable sexual activities that might result in the contraction of HIV infections. This is what has been said by some participants:

“You really get to know the true colours of employees when they are out for workshops or any event that led them to sleep away from home. Others don’t even want to go on pension even though they are over 65 years, because they are scared that they are losing freedom of having multiple partner relationships”

“...we sometimes go out for workshops and sleep over. Like recently we were at Skukuza, known as Kruger National Park. Employees were heavily drunk. They started misbehaving and ended up sleeping with one another”

Another participant affirms that some employees who are perceived as dignified and loyal to their families choose to engage in sexual activities during official working hours in their offices.

“Respectful men and women will have sexual intercourse in their offices during working hours because to maintain their good character to their families, they should keep time of returning home. They perform the activity with an attitude to say: “let me start in the office and I will finish at home”.

From these results, the researcher deduces that some employees have a potential to fulfil their sexual desire by engaging in sexual activities by any chance during the course of work, within and outside of their work scope.

4.3.3. THEME 3: STRUCTURAL CORE DRIVERS OF NEW HIV INFECTIONS

The structural approach seek to address deeply entrenched and long-established cultural, socio-economic and behavioural factors, such as economic inequality, gender inequality, marginalisation and lack of access to basic services, which are difficult to resolve in the short-term (NSP on HAST 2012-2016). There has been growing recognition of the importance of interventions that seek to address the structural forces that underpin much HIV vulnerability.

Radcliffe-Brown (1940) in his presidential address “on social structures” defines the concept structure as an arrangement of parts of components related to one another in some sort of larger unity. In the social structure the ultimate components are human beings in relation to one another while the social organisation is concerned with arrangement of activities.

Levi-Straus (2005), a structuralist states that societies are seen as being structured according to the underlying rules. Each given culture forms the world according to different structures of meaning, which include patterns of cultural norms, values, myths, religion and beliefs strata. Thus, through exploratory nature of this study on the structural core drivers of the new HIV infections amongst LDA employees as perceived by them, four critical sub-themes, reflective of social and cultural norms, values, networks, structures and prescripts have emerged as follows:

- Cultural norms and societal values
- The work environment
- Gender equality
- Departmental HIV and AIDS policies

4.3.3.1. Cultural norms and societal values

From a social science perspective, social norms are rules about behaviour that reflect and embody prevailing cultural values and are usually backed by social sanctions. Values are ideas held by individuals and groups about what is desirable, proper, good or bad (Auerbach, Parkhurst & Caceres 2011). Cultural norms and values are social patterns that regulate relationships and interactions among members of the society, providing guidelines to achieve the defined goals. Therefore, the researcher acknowledges for the purpose of this study that norms and values are core structures of any given society.

Most participants perceive some cultural norms as promoting the spread of new HIV infections, while such perceptions did not exist among few participants. Cultural norms are seen as occurring through societal values and norms on gender roles that drives the spread of new HIV infections. (FAO, 2007) states that the type and extent of gender based violence reflect the attitudes, beliefs and practices of their own society/culture, and often increase in a situation of humanitarian concern. While some cultural norms and practices do empower and protect women's human rights, traditions, customs and religious values are often used to justify or even encourage violence against women (FAO, 2007).

4.3.3.1.1. The role of socialisation

Socialisation is defined as a process by which the social order is involuntarily and coercively transferred unto a person, beginning as a new born baby. According to Michael (2015) socialisation is initiated when agents of socialisation, like doctors and nurses begin by categorising the new born baby as male or female. The socialisation continues at home where parents become responsible in training their children in the ways of gender and social class.

The primary role of socialization by parents and guardian during childhood and teen hood upbringing is mostly valued by participants as having played an important social role in their latter lives. Some of the participants attest:

“...later in life, some of us maintain those norms and values acquired during our early childhood ...in a nutshell I can say that we are principled. I have been raised by my maternal grandmother. She was tough like a man. She has built up a man out of me and I am so grateful about that”

It is also told that family has a responsibility of proving support in re-shaping one's morals and values in case deviation occurred in regard to sexual immorality. The following narrative accounts bear testimony:

“Those that were brought up in good families, they taught their children that sex before marriage is unacceptable. Even when you get pregnant and you were unfortunate to get married, like me, my parents continued their role to groom me about how to live a decent life being a young single mother. They refrain from letting me to reject myself and loosen the morals which I was taught during my upbringing. You earn dignity and respect due to how you handle yourself, not about your marital status”

It is emphasised by the excerpt below that the behaviour that is displayed reflect the family from where one originates:

“An employee who is coming from the home background in which things were not well such as lack of respect, obviously that employee would behave in an unacceptable manner at work such as engaging in sexual activities with different employees”

“...we are from various family backgrounds and we have been raised differently. Some men do not care to propose love even though they are aware that you are married”

From the narrative accounts, participants affirm that their current sense of self in respect to their sexual behaviour is grounded from the norms and morals acquired from their parents. Muir (1991) ascertains that individuals functioning are affected by political, economic, and legal structures which; form the norms and institutions of their society. Efforts that attempt to alter the sexual behaviour of individuals must acknowledge that behaviour is rooted and sustained through on-going relationships and exchanges within the individuals' social network. An individual's attitudes and choices are influenced by the social and cultural norms that they observe and people therefore need not act autonomously (Moncrieff, 2004).

Similarly, Mahlangu (2012) in her study on understanding sexual abstinence and HIV risk reduction strategies in urban Xhosa adolescent girls reveals that the theme of firm grounding speaks to the older girls' descriptions of their strong values that guided their thoughts and behaviours, as if the girls were the authentic originators of these ideals bears as a reference. Based on this finding, the researcher infers that family norms, beliefs, morals and values learned are critical in shaping constructively or destructively to the future behaviour of an individual in general and to the sexual behaviour specifically in later life. Thus to challenge specific sexual behaviour, is to challenge the deeply rooted social norms and values that embedded in such risky sexual behaviour that results in spreading further the HI virus or contracting new HIV infections.

Some female participants cited as well the influence that primary socialisation being an element of structural core driver of HIV infections have towards women.

"We grew up respecting a man because we were told so. Since we grew with that mentality, even today a man is perceived as a head of the family; we have to live under his authority and nothing else. If you don't submit, you are inviting a fight. When you test HIV positive and you give a report to the man, you will be accused of being the one who has brought your sickness in the house".

It is also revealed that the societal norms and values that determine the relationship between a man and woman place a man in a decision-making position while a woman has to play weak. The following excerpt proclaims:

“Women are helpless because they have to submit to their husbands. Since it has been declared long time ago that a man is the head of the family, so most of the decisions are made by them. Men have to approve or disapprove the use of a condom as well...we as women are usually compromised for the sake of keeping peace in the marriage”.

“When we were still young, we were taught that it is conjugal rights for a man to demand sex from his wife at any time he feels like. There were no HIV infections during those days. So if I start to introduce condom now, it is a challenge and a threat to our marriage”.

Kathewara-Banda et al., (2005) attest to the fact that some women believe that their husbands “have a right to demand sex, or they have low expectations of their right to control the terms of their sexual interactions”. Schuele and Berner-Rodoreda (2010) concurs that men frequently control the family income. This means that women are often in economically dependent positions which implies lower status and unequal power relations that limit women’s influence on decisions regarding themselves and the family.

The researcher argues that some women who are at work are victims of patriarchal system, which is the prime structural obstacle to women advancement in negotiating safe sex and become vulnerable to contract HIV infection. Bhasin (2006) defines patriarchy as the power relationships by which men dominate women, and to characterise a system whereby women are kept subordinate in a number of ways. So patriarchy is a system of social structures and practice in which men dominate, oppress and exploit women.

Another participant stated that culturally HIV and AIDS topic is something that cannot be openly discussed. The culture of “being silent” about the scourge is perceived as a behaviour that promotes the spread of new HIV since men cannot be challenged about their sexual behaviour. She maintained:

“Our African culture perpetuates such submissiveness among women and domination of men in the relationship. Our culture is silent about the HIV epidemic and its rapid spread within the society”.

From the presented narrative accounts by the participants, the researcher argues that although some women are aware of the risk of contracting HIV infection embedded in the cultural principles that determine their marriages, they still feel helpless in this present time in making any effort to protect themselves against the contraction of HIV infection. In order to make a success of changing the long standing sexual norms that perpetuate the spread of new HIV infection, intervention strategies should not only aim at empowering women in a workplace, but also the inclusion of partners, their boy and girl children.

Another structure of society that is perceived to have played a role in shaping the morals of young girls to become responsible women, thus reducing the vulnerability of contracting HIV infection is the rite. A rite is a ceremonial ritual which is observed when in a young girl experiences menstruation for a first time. It is believed to be a sign of growing up. Girls are taught to be careful in their conduct and relationships with others. The traditional initiators form an important group in the society through which reproductive health messages can be passed on to young girls (Moyo & Muller, 2011).

One of the female participants affirms:

“When we were still children, we used to play with boys until we reached about sixteen years and not knowing that we can talk about sexual relationships matters. A young girl and boy were not friends like it is nowadays. Even at school, girls would have their own company and boys theirs. A young girl was taken for girls’ initiation school immediately she starts experiencing menstrual periods, wherein she was taught on how to behave herself while waiting for a right man to marry her. It was the school coordinated by elder women. It was very good”

From the researcher’s frame of reference, there are certain societal norms and values that can be acknowledged to be playing a valuable role in prevention of the spread of new HIV infection amongst young men and boys. Those societal norms and values should be pursued, upheld and integrated in any intervention strategies aimed at addressing the prevention of socio-behavioural and structural core drivers of new HIV infection amongst young men and women employees in a workplace.

4.3.3.1.2. Polygyny

Polygyny is defined as a form of marriage in which a man may have more than one wife (Social Science Dictionary 2008; New World Encyclopedia 2015). Johnson and Way (2008) affirm that women who were one of three wives in a polygynous marriage were over three times more likely to be HIV-positive than women who were the only wife in a marital union. Additional studies, such as Esu-Williams, (2000); NiiAmoo Doodoo and Ampofo, (2001); Dada-Adegbola, (2004), Bove and Valeggia, (2009) have established polygyny as a risk for women in terms of HIV infection. For every additional woman that a man marries, the risk of infection within the marriage increases. Because condom-use is minimal within marriage, women in polygynous marriages are also at high risk of contracting HIV and AIDS indirectly from co-wives engaging in extramarital sex.

Polygyny is not a new form of marriage, but it has been a widespread historical occurrence (Polygamy in Africa 2015). In affirmation, New World Encyclopedia (2015) states that polygyny was accepted in ancient Hebrew society, in classical China, and in Islam. It has been accepted in many traditional African and Polynesian cultures. Cultural practices such as polygyny and its consequences for the rights of women make women more vulnerable to HIV infection (Mikell 1997).

The majority of female participants and few male participants stated that the current generation does no longer value marrying more than one wife, however; engaging in secret relationships has gained momentum. A male participant attests:

“It is not a taboo in a Lemba culture to marry more than one wife on condition that a man should agree with his wife before the second or third marriage. However; the attitude by the current generation towards this issue is gradually changing. What is happening currently is to have secret lovers outside marriage, which is also risky that one can contract the infection and spread to other partners very easily”

Three female participants supported the idea by saying: *“...there is a Xi-Tsonga idiom which says: “wanuna i nh’wembe, wa nava” and in Se-Pedi it is like: “monna ke thaka, o a naba” (it means men, like a melon seed have to spread), he is not restricted to have many wives. He can even get married to hundred wives if it pleases him like King Solomon in the Bible. However, that idiom is out of place nowadays, the nation is dying because of such cultural beliefs”*

“There is a saying in Xi-Tsonga language that a man spreads out like a melon seed; it is not applicable in the current generation because of its adverse effects”

“Yesterday doesn’t come again and today has its troubles. The cultural belief that a man is allowed to marry many wives...hiii (what?)...it does no longer apply in nowadays. Long time ago a man could have six or seven women and they were living healthy life, even hospitals were few because there were few diseases.”

Similarly, Auerbach (2011) affirms that through human's actions and meaning they bring to those actions, they are constantly creating and recreating social norms and values. Thus society is perceived as not static, but in a constant change. Raditloaneng and Molosi (2014) concur also that traditionally it is accepted that men like a "melon seed have to spread" by having more than one woman as a way of celebrating their masculinity. However, with the influence of modernisation, such traditional conceptions are being challenged by feminists, especially with the HIV and AIDS pandemic.

In contrast to the findings, the study by Reniers and Watkins (2010) found a negative ecological relationship between polygyny and HIV prevalence. The study elaborates further that polygyny creates small isolates of concurrent partnerships in which the virus is trapped until one or more of the (infected) spouses starts a new relationship. Similarly, a presentation by Cily Tabane at 2010 HSRC seminar series on polygyny practices amongst the Batswana concurs that participants felt that culture has protected people from the spread of HIV and AIDS. The woman in polygynous marriage will know that she can only have sexual relationship with her partner within that specific marriage.

Few of the participants in this study hold similar idea with the Se-Tswana idiom that a man is like a bull and should not be confined to one pasture (Tabane & Delport 2010), and perceive polygyny as a kind of customary marriage that curbs the spread of HIV infections. A male participant, who is married to two wives, attests:

"I have two wives. We go together being three to get tested... My wives became my sisters, my mother and friends. As a man left alone from my parents, I am without siblings, they do a very wonderful job in my life; they are like my cushions... during those years I had one wife; I became naughty and impregnated another woman. I and my wife decided to pay lobola to the second wife, because if not, the same temptation would have happened again that can lead me to contract the HIV infection"

The researcher is of the opinion that polygynous marriage is recently gaining momentum among some African men since prominent figures, who have potential influence in the nation, like the current President of South Africa Jacob Zuma, the king of Zulu nation Goodwill Zwelithini and the Swati king Mswati married more than one wife. Amongst other polygynous marriages, is that of a prominent South African business man from KwaZulu-Natal, Mr Milton Mbhele who is married to four wives at the same time, featured in the Sowetan newspaper, September 23, 2009 as well as another business man Mr Mandla Gcaba, a nephew to President Jacob Zuma, is married to three wives (Tabane & Delport 2010).

One of the biggest churches in South Africa known to be supporting polygynous marriages is the International Pentecostal Holiness Church (IPHC) confirms before the commission investigating the commercialising of religion that, it was not the church's policy to allow a man to take more than one wife. It is upon the church members to decide (Sowetan, January 31, 2009). Some religions approve polygynous marriage. This kind of the marriage structure can also be perceived as another form of marriage that protect its network members from contracting or spreading HIV infection outside its network system.

The researcher posits that some of the prominent figures who are at the later adulthood stage are entering into polygynous marriages with young women who have positive perception about polygyny. A 24 year old young woman participant who is not yet in a marriage supported the idea that marrying another wife might be a better move of preventing the risk of contracting HIV infection. Her utterance below illustrates:

"It is hard to accept and witness your husband marrying another woman, but I think it is much better than him having more girlfriends outside the marriage".

The relations of polygyny as a structural factor to HIV vulnerability is complex, and sustained progress in HIV prevention requires a better understanding of the social dynamics and strata embedded in such risky behaviour.

4.3.3.1.2. Gender-Based Violence (GBV)

GBV contributes to HIV and sexually transmitted infection vulnerability through disempowerment of women by men. Most women who are HIV positive were subjected to the inhumane practice. Violence or being threatened with abuse prevents women from negotiating for safer sex and often these women do not even have a choice to abstain. The researcher infers that it is not only women who experience GBV, but men as well. Women and men who are vulnerable and scared of their violent partners may not be in a position to demand condom use.

According to the Enhanced Progress Report on National Strategic Plan on HIV, STIs and TB 2012-2016, a two-province study conducted in 2010 found that both women and men perpetrated and were victims of physical violence by a partner, with victimisation in the past month being twice as high among women in comparison to men (SANAC 2016). As a result of abusive behaviour of their partners most women may be afraid to go for counselling and testing, disclosing after a positive diagnosis and will not even seek treatment even when they know they are HIV positive (VSO, 2012; SANAC 2016). In such a marital relationship, refusing sex, inquiring about other partners, or suggesting condom use have all been described as triggers for intimate partner violence (UNAIDS 2012).

The Human Science Research Council (2014) affirms that there is a relationship between violent behaviour on women and HIV infection. This relationship operates through a variety of direct and indirect mechanisms, for example; a fear of violence may keep women from insisting on condom use by a male partner. The difficulty in introducing a condom and commodification of women in a marriage was expressed by some female participants from the three group categories.

"...there was no HIV and AIDS and no condom by the time we got married. So, when I want to introduce a condom now it becomes a challenge and a threat to your marriage. A man will overpower you physically and with words as well; to a point where he doesn't ask you politely, you are his asset"

"Currently women are trying to negotiate for the use of condom, but men have the final say to approve or disapprove"

“... using a condom is perceived as a barrier to procreation. I am married to another kind of a person, if I bring a condom home he will want to know why”

“According to my perception and based on what I heard, most men don’t agree to use protection”. They will say: “when I marry you I was not using protection when we had sex, maybe you are the one who is not trustworthy at your workplace”

Women in marriage seem to have less or no voice in exercising protection from new HIV infection by using a condom. Schuele and Berner-Rodoreda (2010) support that the mere suggestion of condom use can also spark off violence and in Africa, is often closely linked to the tradition of the husband’s family paying the bride-price to the wife’s family. This makes it extremely difficult for women to protect themselves against HIV. The Global AIDS Response (2012) attests that people above 50 and married people are least likely to report condom use.

The researcher argues that practising safe sex through condomising should be perceived as a mutual protection by both parties. Therefore any HIV and AIDS condom promotion programmes should also target men in the workplace as well as in the community. Similar findings by South African National HIV Prevalence, Incidence and Behaviour Survey (2012) reveals significant higher percentage of males than of females reported that they consistently used condoms.

The same survey further reported that consistency of condom use decreases with age: youth aged 15-24 years reported the highest percentage of condom use every time with their most recent sexual partner, followed by adults aged 25-49 years, while the elderly (aged 50 years and older) reported the lowest rate of consistent condom use. Some working class women lost hope in negotiating safe sex with a fear of losing their partners. The researcher posits that some working class women are also at a higher risk of contracting new HIV infection from their partners. Therefore, in order to reduce the risk of contracting new infection among working women, continuous education and empowerment in practising safe sex is critical in a workplace.

The Global AIDS Response Progress Report in South Africa (2012) reiterate also that single people who are not married or cohabiting and young people reporting multiple sexual partners are most likely to report using condoms. In contrast with the above findings, the study conducted in Nigeria by Olowookere, Fatiregun and Adewole (2012) states that the group of students voiced out that the use of condoms hindered their sexual satisfaction; caused health problems and reduced sexual interest; therefore, those students were not willing to use condoms. The researcher infers that practising of safe sex through the use of condoms remains a challenge to some people in all age groups and across marital status. Therefore, in order to address the structural core drivers of new HIV infection, GBV and its human right dimension should be mitigated in a workplace.

4.3.3.2. The working environment

The Occupational Health and Safety Act, No 29 of 1996, places a duty on all employers to ensure that, as far as is reasonably practicable, the working environment is safe and healthy for employees. Employers are required to provide safety equipment such as latex gloves to prevent the transmission of HIV during an accident involving a blood spill in the workplace. Public Service Regulations, 2016, Chapter 4, Part 3 (53) provides as well that a head of department shall establish and maintain a safe and healthy work environment for employees of the department and a safe and healthy service delivery environment for members of the public.

The study shows that some of the employees are perceived to be at risk of contracting HIV infections while on line of duty by virtue of their work. Four categories arose on this sub-theme are outlined as follows:

- Employees performing technical duties.
- Migration and mobility
- The departmental residential houses.
- Departmental events

4.3.3.2.1. Employees performing technical duties

Employees performing technical duties are those employees who are skilled to assist communities who do either animal or crop farming subsistence for the betterment of their life and to grow the economy of the country through farming. In essence, those employees are implementing the core business of LDA. Some participants viewed this group of employees to be at a higher risk of contracting HIV due to the structural nature of their duties.

Employees doing technical duties are working more independently with minimal oversight from the supervisors. This arrangement provides some of these employees with ample time of engaging in risky life-style behaviour within their scope of work which expose them in a risk of contracting HIV infection. The following narrative accounts were highlighted:

“We have little supervision. We are on our own in most of our working time. As part of monitoring you bring along a report that is signed by the client to your supervisor. In that way it is believed that you have done your work effectively”

“The nature of our job is mostly field work. It is conducted outside the office. We have much time working in the community. If we were cars, we should have been placed tracking devices to monitor our conduct when outside the office. Some of our colleagues are not behaving well out there”

“Technical employees, who are commonly known as responsible for animal and crop production, are mainly field workers. We really don't know what is going on when they are outside their offices. They work more independently from their supervisors. There is a rumour that from field work they have much time of doing their personal affairs, including drinking alcohol and socialising with their girl or boy friends during working hours”

The researcher is of the opinion that although employees' work is community-based, the head of department has little control over the health and safety of the working environment when employees are working out in the field. However, employees have duties and obligations as stipulated in Section 14 (a) of the OHS Act that every employee take a reasonable care for the health and safety of himself and others. Section 14 (b) of the Act elaborates further that every employee shall carry out any lawful order given to him and obey the health and safety rules and procedures laid down by his employer or by any one authorised by his employer.

The researcher posits also that it is the behaviour or conduct of some employees rather than the work design that can drive them to contract HIV infection while on line of duty. In this instance the employer does not have any bearing in any injury occurred or diseases that are contracted out of the mandated scope of work. The study found that some employees are perceived to be at risk of being seduced for sexual relationship by their clients in return of service favours. The excerpt attests:

“Agricultural advisors work very closely with the emerging farmers; they socialise and get attracted to them...they throw themselves to us. Generally speaking it is difficult to resist that temptation”

Another participant elaborated further by disclosing the kind of relationship which their clients envisaged other than the working relationship:

“We come across some challenges out there in the field. Some young female farmers are proposing love from us... (loughing)...one needs to be firm and openly say that it won't be possible. Other men say that it is an opportunity to be proposed by a woman”

In the event of such challenges faced by the employees who are doing field work, one participant, who is not a field worker, but doing administration, indicates that the same challenge of being lured in sexual relationships during the course of work is possible to anyone, however; one has a potential to overcome those challenges.

“It is possible that I can contract the infection due to the nature of my job. I am working with suppliers who are moneyed. There are a lot of temptations in that you can be hooked in an unplanned sexual relationship. I am defeating this temptation because I told myself that I am here for work and nothing else. When they offer me their money I frankly told them that my employer is paying me for the service I am offering them”

In this case the employee is a recipient of a service on behalf of the employer; however the service provider has an intention of obtaining preferences for his/her business through engaging in a sexual relationship with the employee. The researcher argues that the underlying motive of some employees, who fall in a trap of engaging in a sexual relationship with either their clients or service providers, is due to the material or capital gain and the behaviour can also be referred as “corruption”. Thus the researcher cannot rule out the fact that commercial sex work commenced in a workplace within the scope of work and that is the bottom line for contracting new HIV infection by some employees.

Some employees emphasised that employees have to retain the sense of responsibility and take account on their own behaviour. The theoretical implication of these participants’ perception is the behaviour change model on reducing the socio-behavioural and structural core drivers of new HIV infection should not only concentrate to factors at the interpersonal/network level, institutional and structural level, but the focus should also be at an individual level wherein, elements such as individual’s self-determination and self-responsibility should be a point of focus in any intervention that intend to prevent the spread and/or the contraction of new HIV infections.

Thus, the consequences of the actions taken should not be shifted to anyone else other than oneself. The following extracts relate:

“The key is not the amount of supervision, but it is the amount of the accountability and responsibility that one demonstrate when performing his duties out there in the community”

“With regard to the nature of their work, I think that employees who are field workers are at a risk of contracting new HIV infection. However, the person’s behaviour depends on the character of that person. If you are disciplined enough; work environment does not have much influence on your behaviour”

“I think as employees we are the ones who are supposed to have a bigger role to take responsibility over our life”

“It is not an external pressure that forces a person to behave unacceptably, but it is the individual’s internal forces that results into such an unacceptable behaviour. People justify and hide their behaviour behind number of complaints, the power to decide on the action is within the person”

“I would also urge my colleagues that the best treatment is to take responsibility of our own behaviour. We have seen that our brothers, sisters and relatives have passed away due to AIDS, so we should consider ourselves fortunate when our department takes responsibility of conscioutising us”

The researcher acknowledges that the South African response to HIV and AIDS was initially at an individual level intervention such as the biomedical approach. The individual and support group therapy contributed in a significant change on addressing HIV and AIDS, although at a steady pace. However, review of such approach was considered to include the high level connection (which is the social, economic, behavioural and structural factors) through the adoption of the combination and multi-sectoral approach as outlined by the NSP on HIV, STIs and TB 2012-2016.

She further recognises the success of the multi-sectoral approach in the reduction of the spread of HIV infection in the country, however, the National stakeholders are of the view that addressing social, behavioural and structural core drivers of HIV, STIs and TB infections need to be tightened up, while the provincial representatives concur that addressing the socio-behavioural and structural drivers of HIV was crucial to prevention, yet there was little adequate consensus on the best approaches to ensure impact (SANAC 2016). Therefore, addressing social and structural drivers of the new HIV infection is currently one of the goals of the five years National Strategic Plan on HIV, STIs AND TB 2017-2022. The researcher posits that there is a need for multi-level or ecological approach in preventing the spread and contracting of new HIV infections in the workplace.

4.3.3.2.2. Migration and mobility

Migration and mobility of people have a profound effect on the spread of HIV and AIDS infection. Fages (1999) affirm that migrants and mobile populations in general have played a significant role in the initial spread of HIV in the Southern African region. Brummer (2002) as well asserted that the epidemiology of HIV/AIDS is closely linked to the process of migration. Migration is defined as the movement of people from one place to another temporarily, seasonally or permanently, for a host of voluntary or involuntary reasons (Brummer 2002). Concurrently, the Medecins Sans Frontieres (2012) migrant populations are very vulnerable to HIV and TB and are at a higher risk of being infected.

In response to this structural core driver to the spread of HIV infection, the Enhanced Progress Report on National Strategic Plan on HIV, STIs and TB 2012-2016 mentioned that SANAC has established a national forum as well as a technical working on migrant and mobile population (SANAC 2016). Weine and Kashuba (2012) maintain that while some migrant and mobile workers were able to bring their wives or families with them to the labour stations, logistical and financial constraints left many men separated from their families. Away from their families, labour migrants missed their wives and children, the emotional and practical support which could help them to cope with the loneliness and stresses of migration and mobility.

The study further revealed that men who migrated without their wives and/or families exhibited more risky sexual behaviours.

“Here in the department we have colleagues who are coming from far away and they are squatting in the department’ residential houses. These fellow colleagues are not staying with their families, but due to boredom after working hours and on weekends, they resorted in staying with fiancées. They are at risk of contracting HIV infection because they keep on changing women”

“Those employees who joined us here, they live in these departmental residential houses nearby (using her finger to point some houses built next to the work place), they change women like hell. Men are lazy to cook, clean and do the washing for themselves. They rely on their girlfriends for that purpose, and those girlfriends depend on them for financial benefit.

Family separation due to migration also affected wives who were left behind by their husbands. In comparing the Chinese wives of migrants to Chinese wives of non-migrant men, migrant wives had higher rates of multiple partnering, higher rates of HIV infection and lower rates of condom use (Weine and Department of Psychiatry, University of Illinois 2012).

4.3.3.2.3. The departmental residential houses

It has also transpired in this study that due to post-apartheid restructuring system of public service, number of employees from former homelands were involuntarily relocated from their former workplaces to certain areas of work. Some areas of relocation were far away from their families. They had to reside at the arranged departmental residential houses, next to their workplace, which seemed to be more affordable than renting or buying a house of their own.

Those departmental residential communal houses were perceived as some of the structural factors that expose some LDA employees to a risk of HIV infections. Some of the participants elaborated:

“Some years back some employees were moved from their workplaces to other workplaces. They were forced to relocate due to the fact that they were told that they were on excess, their posts were no longer vacant in the existing work structures Thus, if they want to continue working they should be ready to relocate. They had no options; if they choose not to relocate it means they should have lost their jobs”.

“Those employees who joined us here, they live in these departmental residential houses nearby (using her finger to point some houses built next to the work place), they change women like hell. Men are lazy to cook, clean and do the washing for themselves. They rely on their girlfriends for that purpose, and those girlfriends depend on them for financial benefit. Hahahaaa... (She lough loudly), Tsonga people use to say: “xandla famba, xandla vuya” (meaning that when you give someone something you expect to receive something in return from that person) and the Zulus’ say: “I zandla zi ya gezana” (This implies that for the one hand to be washed, it should first wash the other one)”.

In this instance the researcher contends that the departmental communal houses that are allocated to some employees are not meant to be family units, but they are more or less similar with the former apartheid housing structures that were poorly equipped and dilapidated hostels that resulted in the destruction of the fabric of society. Relevant to this study, in a form of escalating the socio-behavioural and structural drivers of the spread of new HIV infection to the employees and to some people within the vicinity of those departmental dwelling houses.

One of the psychological determinants of risky behaviour displayed by migrant employees is loneliness and boredom. One participant affirms:

“Here in the department we have colleagues who are coming from far away and they are squatting in the department’ residential houses. These colleagues are not staying with their families, but due to boredom after working hours and on weekends, they resorted in staying with fiancées. They are at risk of contracting HIV infection because they keep on changing women”

Cacioppo, Fowler and Christakis (2009) concurs that people who are lonely tend to be linked to others who are lonely, an effect that is stronger for geographically proximal than distant relationship. In the same way, Mutinta (2010) ascertain that in the South African Police, police officers working away from their families are removed from their social support structures, including families and regular sexual partners. As a result, they often feel lonely and bored, particularly when off duty, and this increases the likelihood of engaging in risky sexual behaviour.

The researcher argues that loneliness precipitates the formation of new social network with its unique norms and values which may exacerbate the spread of new HIV infection. The structural pillars of the apartheid economy continue to buttress the current neoliberal agenda of the current government with intent to increase a healthy and long life for all South African citizens through, amongst others, addressing the socio-behavioural and structural core drivers of new HIV infections. Therefore, in order to address the socio-behavioural and structural drivers of new HIV infections in the workplace, there is a need to revisit the existing policy on the departmental residential housing structures which depicts the remnants of apartheid regime which according to Marxism, was only interested in the labour force of the working class only.

It became apparent as well in this study that there are illegally constructed shacks within the departmental residential areas with the provision of accommodating non-employees within the area, which is perceived as a structural issue with the accompanied socio-behavioural drivers of the new HIV infection amongst employees. A woman participant expounds:

“There are lot of shacks constructed in the department’s residential area just right here around this workplace. Employees from different departments, everyone lives as he or she is pleases, although it is the Department of Agriculture’s residential houses. Some who live there are already on pension but they continue to stay there with girlfriends. Some residents are working at retail shops but they are staying at the residence. There is no control of the ins and outs. We have lost a colleague due to HIV related illness who was residing there”

From the excerpt, the researcher infers that the construction of unauthorised shacks in the departmental premises is a structural driver of HIV infections. Its implication is like that of a “broken windows theory” proposed by James Wilson and George Kelling in 1982 that used as a metaphor for disorder and incivility within a community to subsequent occurrences of serious crime (McKee 2013). If a window is broken and left unrepaired, people walking by will conclude that no one cares and no one is in charge. In terms of “broken windows theory”, little things matter. If there is no policy that regulates the departmental residential area there is the probability that non authorised people will keep on invading the area in one way or another as no one cares about such a conduct (City of Missoula 2013).

Some participants further explained that another group of employees who are most vulnerable to new HIV infections are those who are placed at the redline gates. The redline gates area demarcated areas that are meant to impound the crossing over of animals or meat from the area which has been declared having certain animal diseases to a non-declared area. The following excerpts concur: *“I am mostly concerned about those who stay in the residential houses and those who work at the redline gates are of no exception. At the redline gates those employees are targeted by women from the neighbourhood. Their lifestyle is not good, even their health is questionable”*.

“Employees who are working at redline gates are the ones vulnerable to contract HIV infection. The department has built houses for them just next to those redline gates. Women from surrounding villages avail themselves to these employees, stay permanently with them. By virtue of their jobs those employees are at risk of contracting HIV infection as they do not have their wives close to them”

With reference to the two narrative accounts, the researcher posits that any behaviour, whether constructive or destructive is motivated by a certain need in accordance to Maslow’s hierarchy of needs. According to the Cambridge Dictionary of Sociology by Turner (2006), needs are often invoked to explain human behaviour but there is little agreement on what needs people have beyond the purely physiological ones of food, sleep and shelter to anything more complex such as sexual gratification or a desire for achievement with cultural variation in how such putative needs are expressed and met.

Although the employees referred to have an element of being involuntarily migrated from their original families to the place of work, and the local women who targeted those employees, the researcher affirms that the alleged sexual behaviour by both role players, is motivated by what Maslow refers to as the biological and physiological needs, which include, amongst others, sex, the safety needs, referring to need of protection and stability, need for belonging and loved, esteem and self-fulfilment (Chapman 2001; Neel Burton 2012 & Norwood 2016).

Thus for the optimal functioning of the individual employee, which is self-actualisation according to Maslow, the first two basic needs, which are biological and physiological needs and the safety needs should be appropriately considered in case of employment or redeployment as one of the strategic intervention by the employer towards fighting against the spread of new HIV infection. Rogers in Grobler, Schenck and Mbedzi (2013) affirm that behaviour is basically the goal directed attempt of the organism to satisfy its needs as experienced in the field as perceived. This implies that all behaviour, however odd it may appear to an observer, has been motivated by a particular need. For example, a need of sense of belonging, sexual needs, safe

and security can lead a man or woman to seek for an opposite sexual partner in order to address such a void.

However, the researcher is of the opinion that in the process of addressing such identified need, the individual has a potential to determine the value and risk attached to the envisaged behaviour. Therefore, in order to understand the socio-behavioural and structural core drivers of new HIV infection in a workplace, it is important that a strategy for new appointees and/or transferred employees should be developed in order to proactively understand them as an organised whole and adopt appropriate interventions that can also address the covert norms and behaviours that might be a risk to contract new HIV infections.

4.3.3.2.4. The departmental events

Some of the departmental events that are hosted within the department are viewed as contributing towards the spread of the HIV infection in a workplace. Consumption of alcohol particularly by some young employees is one of the characteristics of those specific events. Those events are end of the year party, extension officers' conference and young farmers' inspiration awards. Three of the participants mentioned the use of alcohol during departmental events as the catalyst of the behaviour that subjects some young men and women employees in an act of contracting new HIV infection.

“During the end of year party, employees bring along liquor, both young men and women indulge in drinking until late, where everyone has left the spot to their respective places. Our poor female colleagues will find themselves waking up from their male colleagues without remembering exactly what happened a night before. We would have not been there, but the rumours spread so fast because men do boast that...I am done with that one...it is very embarrassing and humiliating as a woman. Do you think she was in a position of negotiating safe sex...myself I don't think so...”

From the researcher's frame of reference, the relationship between young men and young women is mutual. The relationship started before the drunken state by both of them. They went through certain processes up to the last act of engaging into a

sexual intercourse. In this case the researcher infers that the young women made a decision to attend a year party, to choose a company to hang around with during the party time and to engage in a sexual intercourse with the male colleague.

“During the extension officers’ conference that the department holds annually, women took wine. When a woman is under the influence of wine, she has a desire of engaging in sexual activity. They become vulnerable to having sexual intercourse indecisively with their male colleagues whom they never thought that they can behave in such a manner when not drunk”

The researcher infers that men might have the same experience with alcohol as Shakespeare affirms that alcohol provokes the desire but takes away the performance. Therefore it sets him on and takes him off (The New Age online 2016).

“I anticipate risk of contracting HIV infection by colleagues during the social events that take place at the end of year. Employees use to take alcohol in such occasions. Some of us who are not consuming alcohol we leave very early; we are not sure of what should have happened after we left”

Brebnor (2009) maintains that on the field trip around Tobago there was a need for several vehicles to accommodate the large number of travellers. On the tray of one van was a cooler bag filled with beers and rums. At every other village, the vehicles would stop and the drivers would each take a drink. From the rough calculations, each driver had approximately 15 cans of beer throughout the course of the day, while driving. This type of drinking, particularly when on field trips or other similar get-togethers, was normal to these field workers.

The researcher argues that consuming of alcohol during departmental functions, more especially in the event wherein such employees buy alcohol for themselves, the conduct may be considered as having nothing to do with the employer. However, the consequences of such behaviour may have a bearing on the employer in the long run. Thus policies that address substance abuse in a workplace should be transparent and be brought to the knowledge of all employees.

Erasmus, Claassen and du Toit (2012) concur that employees consuming alcohol during working hours seem to be a problem which is on the increase, with a resulting increase in problems for the employer. Erasmus et al. (2012) further state that this type of a behaviour constitutes misconduct and that employers should have a company or workplace policy in place, that has been communicated to all employees, regulating the consumption of alcohol on company premises, and also off company premises, where it might have impact adversely on the employer, the employees, or the employee's ability to perform his/her duties.

Some participants perceive the extension conferences as of no value for money as it is viewed as not ultimately having a goal of achieving the departmental strategic objectives.

"...these young male employees seem to be too fast about life. Most of them are single, I have observed them during extension conferences, all municipalities come together to hold a conference. Those young men and women are untouchable (meaning that engage in a sexual relationship). The intimate relationship took place only for that moment and end up when that two days conference closes. From my assessment the extension conference is time consuming and money wasting. It is a sort of a social gathering that does not have an ultimate goal of achieving the strategic objectives of the department. The event was supposed to be of one day and not two days"

It has been evident also that not only young men and women employees that displayed behaviour that might be risky to contract new HIV infection, but adult employees as well had intentions to lure some fellow employees who are the highest authority within the Department. The following excerpt refers:

"If you want to see the lifestyle of LDA employees, come to the events like extension conferences, you will see. I hate the extension conference to the last degree. In that event women employees become live stock in an auction, they do come with their

nails polished, heads braided with expensive brazilian hair and parading with new clothes taken on credit at Queens Park, Truworths and other expensive clothing shops. Their intention is to be chosen by big shots during those conferences”

Another participant reveals that the time schedule in which the events are planned to take place is also a precipitating factor towards the behaviour that leads to the risk of contracting HIV and AIDS by employees.

“The department has annual functions or events such as the women and youth farmer awards that take place mainly in the evening. Wines are served and other employees bring their own strong drinks to entertain themselves during those events. First of all the evening time in which the event is hosted, is a precipitating factor for employees to engage in a risky sexual behaviour. Secondly, the liquor that employees consume drives the urge to behave differently than one used to be when sober”

4.3.3.3. Gender equality

The principle of gender equality is enshrined as a fundamental right in the Constitution of South Africa (1996) and since 1994 there have been major advances for women in certain areas, most notably in the political and legal spheres. Despite the progress made in the implementation of the Beijing Declaration Platform⁴ in respect of gender equality, it is found that women are still occupying low managerial positions (Nino 2006). UNAIDS (2012) attest to the fact that South Africa has very high levels of inequality in wealth and income, and this remains a significant factor in South Africa’s HIV response (UNAIDS 2012).

The abuse of power and gender inequality is the underlying causes of exploitation. The abuse occurs when the disparity of power is misused to the detriment of those women employees who cannot negotiate or make decisions on an equal basis. Lack of education, information and access to services, economic inequalities and control over resources, as well as inappropriate or inexistent policies, laws and institutions are factors that contribute to people’s vulnerability to gender-based violence in a workplace (FAO 2007).

Additionally, the South Africa's National Policy Framework for Women's Empowerment and Gender Equality prepared by the Office on the Status of Women affirms employed women are concentrated in low-paying occupations. Of the African women employed, one-fifth (21%) have clerical or sales jobs. One in twenty-five (4%) are in the professions while 11% are in the semi-professions. In terms of industry, only 10% of employed African women and 12% of all employed women have jobs in manufacturing compared to 16% of all employed men. Women in general account for only 25% of all managerial positions. This attests to the fact that inequality is entrenched in the South African social structure and this legacy is bound to linger on for some time.

In the same way, this study found economic inequalities manifested in a form of women occupying lower positions are perceived as a structural core driver for some women to be infected with HIV infection. These women subject themselves for sexual abuse by their bosses due to desperation for promotion to higher positions. Some male and female participants narrate their account:

“Some people get infected because they want promotions. I am not reporting anyone here. Some of my colleagues do not have appropriate qualifications, but because they sleep with bosses, they are promoted to higher ranks. Some got infected as a result of infidelity, some for the love of money”

“The same applies to women who are closer to their male supervisors, they are being seduced in having sexual intercourse with them with the false promise that they will be promoted into the higher positions. Some people get their higher posts as a result of that act...”

“I said some women are opportunists. If the manager is very close to me, I only see an opportunity of getting a higher post. All employees want to be close to the manager. Men have a tendency of saying that they are the ones who are being

seduced by women. Everyone wants to see herself on top positions since the present government is addressing the occupation discrepancies related to gender”

“Poor women are throwing themselves to the senior and executive management with the intention of getting higher positions. They tend to forget that there might be only one position that is available and it cannot be available for all. In such instances the poor woman contracts the HIV in vain. Women are aware about the processes of recruitment and selection for the post, but because they don’t have necessary qualifications they have false hopes that expose them to a risk of contracting HIV infection”.

The researcher deduces that the “glass ceiling’ factor coined by the Wall street Journal (1986) is still applicable in the sense that women still find it harder to climb the ladder to the high paying ranks (Strategic Framework for Gender Equality within the Public Service 2006-2015). The invisible barrier that stands between women and their ascent to higher positions such as employment policies, regulations and performance evaluation systems tend to be gender-biased and skewed.

Strong negative views about women’s inability to assume leadership positions add further barrier. All these kind of challenges faced by a woman in a workplace has an aggravating factor to some women who are placed at low paying ranks to become victims of sexual exploitation by their superiors, which is a detrimental behaviour that drives to the contracting of HIV infection in a workplace. The researcher is also of the opinion that although some women in a corporate world of employment may be empowered to protect themselves, there are some who resort in risking their morals and values by engaging in sexual activities with their superiors in anticipation.

The system exploits and dehumanises working women as sex commodities or tools for trade. From the persuasion of the Marxist, women’s liberation becomes a measure of society’s general emancipation, a part of the superstructure, or an important aspect of the class struggle (MacKinnon 1982). The researcher argues that women’s emancipation denotes an achievement of a political struggle, yet in a real sense, some women at the world of work are still faced with economic equalities,

sexual exploitation, humiliation and exposure to risky behaviours to contract HIV infection.

4.3.3.3.1. Women in managerial positions

There are perceptions that some women who are economically sustained and hold the managerial positions have made it through engaging in sexual affairs with their bosses. It is noted that there are selection and recruitment criteria for the potential candidates, however; management authorities have a way of manipulating the system in order to favour their own interest. Two participants asserted;

“The truth about the person lies in the heart of that particular person. Most women who occupy high positions did not get those positions lawfully, but through selling their bodies. Women, who are successful in the tendering business, got those tenders through extending sexual favours to their benefactors. Most of them are successful financially but poor physically and emotionally because their health is being challenged by having infected by HIV. People value material things more than their dear lives. All these unacceptable and immoral acts operate underground because it is illegal, but as the bearer, you have a life time wound”

A male participant attests:

“... most women in higher positions, got those positions corruptly, including through engaging in a sexual relationship with the big shots at work. Nowadays if you refuse to have sexual intercourse with your boss you will stay in the same position until you retire”

It is reported that in Bangladesh sexual harassment at the workplace is another form of sexual exploitation wherein many women workers are thrown out of their job when they are not willing to give in to the demands of their bosses (Sultana 2011). The implementation of Gender Equity Act in addressing the economic disparities between men and women is accompanied by the exposure of some women into sexual

exploitation by the dominant male authority in a workplace, which; place them on the hand at a risk to contract new HIV infection.

One participant mentioned that recruitment and selection procedures are in place within public service; however measures are being manipulated in order to favour specific individuals who are targeted for the post by management, regardless of whether they meet the minimum requirements or not.

“Women are exposing themselves to sexual abuse by men who are at higher positions with the expectations that they shall be promoted to the next level. That practise was happening during the former homelands era. Nowadays just forget. There are policies and procedures to follow for recruitment, selection and appointment. If you don’t meet the requirements there is no way that you can be given a post. Although those requirements are being relaxed and manipulated to accommodate someone whom management might have interest on, but people are doing that at their own risk. We refer that conduct as corruption”

According to the researcher’s opinion, the more employees perceive that some women attained higher positions due to sexual exploitation, the more economic injustice is perpetuated in regard to the distribution of equitable share in wealth and income, and such a conduct is corrupt, which means that corruption is endemic. The phrase, “The fish rot from the head is sometimes used to express the idea that all problems in the company can be traced back to its leaders, and that the rot filters down to the employees (Peter, 2008). Thus corruption with regard to recruitment, selection and appointment in job vacancies expose some employees to vulnerability of contracting HIV infection to their potential bosses.

The aforementioned results of the study unfold two incidents of some working women. They are those whom still encounter challenges in occupying high positions and those who have already attained the higher positions. These two groups have a common element of engaging in a risky sexual activity in the process which makes them vulnerable to HIV infection. In contrast, some participants opine gender equality to have minimised the risk to spread the HIV infection. The following excerpt refers:

“Women are the ones who are given preference for the high positions to close the discrepancy between men and women caused by apartheid regime. Men are afraid to propose women of a higher rank. In this way I do not see in what way those women can be lured in a risky sexual behaviour”

“When I perceive gender equality issue, I think the government has considered greatly empowering women, which led to the decrease of the spread of HIV infection. During the apartheid regime when men were occupying high positions, some of them were taking advantage of women at lower positions by engaging in a sexual intercourse with them, with the hope that they will be given promotions”

The associate director of the IPPR Dalia Ben-Galim, mentioned that feminism has delivered some professional women, while other women have been left behind. Many advances for women at the top have masked inequality at the bottom (The Guardian 2013, 31 March). From the researcher’s point of view, gender equality has not yet adequately addressed the inequality gaps between men and women in a workplace.

4.3.3.3.2. Gender equality and domestic violence

Gender equality is viewed as 50/50 (affirmative action in regard to equal pay for equal work regardless of gender) by some participants. The principle of gender equality according to them has led to a shift of gender roles between husband and wife. This shift of gender roles is being viewed to be in favour of the wife by placing her in an economical and intellectual domination in relation to decision-making. This

kind of a relationship makes the woman's husband to feel helpless and becomes a passive player in the relationship.

It is narrated that such a relationship encourages betrayal and increases the chances of engaging in private sexual relationship by both, the wife and the husband.

"In this democratic government women are being considered for higher positions. If a woman is placed in a higher position and she earns more than her husband, it becomes a problem at home. The man feels very much intimidated and inferior. The woman views the man as incompetent and boring. She will start to associate herself with men that she views as at her equal. They attend meetings together and talk the same strategic language. The couple in such a marital relationship is at risk of contracting HIV because the extramarital behaviour is kept secret. They also experience difficulties in introducing the condom"

Another participant attests on how gender equality has offered women to exercise their power in a marital relationship, which also results in determining the sexual obligations.

"Gender equality contributes to domestic violence and the spread of HIV infection. Recently, women exercise their power control unbearably at their homes. There are number of challenges, even in bed at night. Our wives sleep with their tights on, so that you must not bother to touch her and ask for sex. Men are afraid of the law nowadays. They resort to go and have fun outside because at home he has lost control. He becomes happy when he is with the girlfriend than when he is with his wife"

A woman participant also affirms that gender equality or what is referred to as 50/50 has reviewed the gender roles in a marital relationship, which in turn yielded marital conflict or violence characterised by a man feeling powerless, helpless, loss of control and insecure; whereas a woman feels powerful, sense of autonomy and in control and secured.

“50/50 fuels the spread of new HIV infection because women do not want to be under the control of man’s authority anymore. So there would be no idea that I raise that a man or my husband will take it seriously into his heart. The same applies to me, I won’t take my husband’s ideas seriously without scrutinising them as I know that I am independent in number of ways. Men sometimes attempt to submit because they buy favours from the working wife. They are scares as well that we will run to the police to report them. So they feel unsafe”

Another woman participant asserted that gender equality has fuelled the spread of HIV in a marital relationship. She also brought out that 50/50 or gender equality should not be applied at home and that a woman should be submissive to her husband.

“A man is a head of the family and it will always be like that. Women should be submissive regardless of their economic status. 50/50 takes place at work, but at home it does not apply. If it is practised, it causes a man to go out and look for those who can put him in a rightful place. The woman on the other hand relate sexually with those she thinks are of her standards. In those instances, both partners are at a risk of contracting HIV infection”

The researcher argues that economic empowerment has an element of liberating the person’s mind from slavery towards the abusive relationship that is underlined by manipulation of economic or coercive power in a marital relationship. It also places women in a viable position to speak for herself and in a less position of contracting new HIV infection. However, there are some men and women who perceive gender equality as contributing to the vulnerability of contracting and spreading of HIV infection and justifying the extra-marital affairs as a solution for meeting the marital needs which is not fulfilled by the legitimate marriage.

In this regard the researcher deduces that gender norms emanating from the patriarchal family socialization are still predominant in some working men and women and they serve as a barrier towards the elimination and prevention of the socio-behavioural and structural drivers of the spread of new HIV. Thus it might pose a challenge to the HIV and AIDS programme coordinators towards the implementation of the prevention of socio-behavioural and structural core drivers of new HIV infections in a workplace. However, the researcher acknowledges the pursuit of gender equality as a structural change with the positive effects in the fight against gender based violence with its HIV and AIDS dimensions. In the same way, the President of South Africa, Jacob Zuma reiterated in the ANC January 8 statement, 2017 that women of this country throughout the ages, have proven to be strong and resilient in the face of challenges and triumphs. *“Mmangwana o tshwara thipa ka fa bogaleng”* (Mothers catch or hold a knife by its sharp edge).

4.3.3.4. HIV and AIDS workplace policies

The employment law handbook defined workplace policy as a set of rules and principles that aim to guide managers and workers' conduct in the workplace. Thus HIV and AIDS workplace policy provides the framework for action to reduce the spread of HIV and AIDS and manage its impact. This study found that some participants viewed the HIV and AIDS workplace policy positively and for others it was the opposite. The following perceptions were narrated: *“Policies are good, the problem is with the end users of those policies”*.

There is a provision of HIV and AIDS policy in the workplace which guides the implementation of the programme and the prevention strategies for the further spread of HIV infection. It is noted that the employer is adequately implementing the programme, however; employees are the ones who are not keen in taking precautionary measures. The three participants alluded:

“The employer is making an effort to make people become aware; employees themselves are the ones who are promoting the spread of HIV infection. If the employer provides condoms in a workplace, what more do we expect? The ball is in our court, we may decide to play it or not”.

“The employer is doing his best in creating awareness; the danger is only the ignorance of the employees. They are well informed about HIV and AIDS, but people think that there are those who are meant to contract HIV infection and not them”

“The employer is implementing the HIV and AIDS programme in the workplace. The ball is in the court, we have been given knowledge and skills on how to play it. It is up to the employees to play their role to ensure that they are safe and also saving the life of their beloved ones”

Although the majority of the participants affirm the availability and popularity of HIV and AIDS policy in the workplace, some maintain that there are still limitations in the principles encompassing the HIV and AIDS policy. The following reveals:

“I think the employer’s policies are making a difference but not that huge of preventing the spread of HIV infection. I commend the strategy of bringing along HIV ambassadors in the workplace when creating HIV and AIDS awareness in the workplace. Voluntary disclosure should be encouraged because the more I am silent about my HIV positive status, the more I spread”

HIV and AIDS policy is seen to have its limit as long as it is not integrated as part of the strategic plan of the department.

“Departmental policies are silent about HIV and AIDS. Those policies must be integrated at the strategic level. Even in the structure of the department, HIV and AIDS programme must be visible and not be hidden inside other programmes”.

Another limitation of the policy is for it not to be given a consideration in instances where an employee supposed to be transferred on conditions.

“Some years back some employees were moved from their workplaces to other workplaces. They were forced to relocate due to the fact that they were told that their posts did no longer exist in the structure, if they want to continue working they should be ready to relocate. They had no options; if they choose not to relocate it means they should have lost their jobs”.

4.3.3.4.1. HIV Counselling and Testing (HCT)

Voluntary counselling and testing provides the information necessary to make informed decisions about the future and to protect one’s own health and that of loved ones (Wilson, 2003). The Khomanane Brochure (2005) on voluntary counselling and testing (VCT) explains VCT as the process that is followed when a person wants to find out if he/she is infected with HIV. Voluntary means that persons decide on their own whether or not they will be tested, and they have a chance to discuss the HIV/AIDS test results with a trained counsellor about the HIV/AIDS results and its implications. It is confidential and the results cannot be discussed with anyone else, but only with the concerned person in private.

The Global AIDS Response Progress Report (2012) of the Republic of South Africa highlights the new guidelines in February (2010) of South Africa’s policy on voluntary counselling and testing that was expanded to include a number of new components. The components include a revision of counselling protocols as well as a shift for HIV Counselling and Testing (HCT) to be offered by health providers on any patient’s visit to any health facility for any ailment. Provider-initiated HIV counselling and testing remains voluntary but it places an obligation on the health care workers to explain to patients the importance of knowing one’s HIV status and of testing regularly for HIV as part of a normal health seeking behaviour (UNAIDS 2012).

Despite the new initiative of HIV Counselling and Testing by the South African government, some participants still perceive the concept of “voluntary” participation as a structural barrier towards eliminating the further spread of new HIV infection in the country. Both men and women participants affirm that HIV testing should be a standard requirement for each and every citizen in the country.

The possibility for compulsory testing is being cited by the compulsory testing of a pregnant woman as an example. The following extracts bear references:

“We must do away with the idea of voluntary testing. If this country wants to have an HIV and AIDS free generation, there should be involuntary counselling and testing. If infants and children are entitled for vaccines and immunization, youth and adults should go for HIV test in every three months as a prevention strategy for further spread of HIV and AIDS”.

“Yes. I am against the idea of voluntary testing. Why can you give people to make a choice to decide whether to test for HIV or not. It must be an obligation that every citizen of this country should test for HIV. Why pregnant mothers are being tested for HIV. The same men who impregnated the woman should be subjected under the similar test. Should it be women only subjected to such emotional circumstances? Let men be tested for statistics purposes even if he is not interested to know his HIV status”.

It is also perceived that men hardly go for an HIV test; instead they use the HIV test results from their spouses to conclude their HIV status.

“Testing for HIV should be made compulsory. We, as women are still oppressed. When I am pregnant I am obliged to test for HIV, what about the person whom I made with this child? Government should ensure that we all go for HIV test, pregnancy or no pregnancy! Men do not want to consult, the time they consult and test for HIV status is when they are critically ill. Can the government wait for that period; meanwhile the HIV is being spread day in and day out? No; they cannot talk of human rights while people are at a risk of contracting HIV. Let each and every couple go together for counselling and testing”.

The researcher is of the opinion that AIDS education is not internalised by some men. The principle of “voluntary” testing is a human rights issue, however; it raises some questions and concerns by the bearers and observers of that human right. It is also perceived by some women that the principle is very lenient to the male counterpart regardless that HIV and AIDS testing to pregnant mothers is conducted at the best interest of promoting the health of the pregnant mother and that of the unborn child, although there is no strategy for men who impregnated their female partners to go through HCT.

It is found that male involvement strategy into the PMTCT programme was initiated with positive outcomes such as greater use of ARV therapy, higher acceptance of post-test counselling, increases spousal open communication about HIV and sex safe practice (Addis, Mesfin, Yonas, Zemenu, Markos, & Ambachew 2015). The study further indicates that even though there is positive impact on the uptake and adherence on to PMTCT regimens especially when men accompany their partners, evidence indicates that only few men accompany their female partners for antenatal care with a rate of 3.2% in Malawi (Addis, et al. 2015). A study by Zenebe, Gebeyehu, Derseh and Ahmed (2016) confirms that there are several programmes promoting male involvement in HIV counselling and testing during their wife’s pregnancy as part of PMTCT, but only few men heeded the call. Zenebe et al. (2016) further alluded that the study shows the prevalence of male involvement in HCT to be optimal.

The researcher posits that the provider-initiated HIV counselling and testing and other programmes aimed at reaching men for HCT seems to be yielding insufficient results. The principle of voluntarism supercedes all the initiated efforts. The honours of whether to go for HIV test or not lie with the individual. So, there is a need for an open discussion or dialogue on HIV and AIDS issues such as voluntary testing as stipulated by the International Labour Organisation (ILO) Code of Good Practice on HIV and the World of Work (2001).

4.3.3.4.2. HIV and AIDS workplace policies popularity

Contrary to what some participants alluded to about being aware of the HIV and AIDS policy, some acknowledge the existence of the policy, but confirm that they are not aware about the content of the policy because they do not take initiatives to read and familiarise themselves with those policies. Hence a proposal by some of the participants that continuous awareness on HIV policy should be made.

“Policies are just guidelines that guide us on how to deliver the services. You know if you want to hide something from a black man, write it in a book. You know I am black and I am not afraid to say that we black people are lazy to read. We want someone to read for us. We only read if the document is about the salary adjustment. HIV and AIDS information is about our life. We are not working about papers. You see policies are written on papers. One should be there to continuously create awareness on policies until we internalise them. We have many policies written on papers in this department, but we do not know those policies. When a man is working in Gauteng for example, is it good for him and his family to send them money only or, it is good for him and his family to come back home with the money? The later question I believe can get more votes. So, let the same metaphor be applied to policies and other HIV and AIDS prescripts”

“We as agricultural technicians, we are so relaxed and more comfortable about not knowing the legislations that govern our work and mandatory to us on our implementation of services. The employer’s policies on HIV and AIDS are available, but developing oneself in mastering and implementing those policies is an individual’s choice”

“I haven’t seen or heard about HIV and AIDS policy. I would appreciate if I can be provided with such policy.

The researcher infers that although some employees acknowledge the existence and knowledge of HIV and AIDS workplace policy, and have understanding that employees have responsibility of acquainting themselves with such policies, there are some who think that the department has many policies, which is not easy for one to go through. Thus a call is made for the custodian of the policy to continuously create awareness on HIV and AIDS workplace policy. She further posits that if employees lack knowledge on the principles embodied in the policy, their human rights can be easily violated and perpetuates as well the risk of new HIV infection. Continuous awareness on HIV and AIDS workplace policy would address the lack of knowledge as a structure barrier towards eliminating the spread of new HIV infection.

4.3.4. THEME 4: PERCEPTIONS ON HIV AND AIDS RELATED STIGMA AND DISCRIMINATION IN A WORKPLACE

The second key targets and elimination commitments outlined in the 2011 United Nations Political Declaration on HIV and AIDS by the United Nations include amongst the 2015 ten (10) key targets the elimination of HIV-related stigma, discrimination, punitive laws and practices. Despite numerous efforts to change public attitudes, the reality reflected in the literature is characterized by deeply ingrained social prejudice, stereotyping and stigmatization (Parker & Aggleton, 2003; Mawar, Sahay, Pandit & Mahajan, 2005).

Stigma is defined by Goffman (1963) as an attribute that is significantly discrediting and in the eyes of society serves to reduce the people who live with HIV. Goffman further argues that the stigmatised individual is seen to be a person who possesses “an undesirable difference” which then leads to social devaluation and discrimination and, in turn, leads to human rights violations of the People Living with HIV and AIDS (PLWHA) and their families. The summary report on People Living with HIV stigma Index (2014) elaborates further that discrimination follows stigma, and it is the unfair and unjust treatment of an individual based on his or her HIV status.

The findings of Stigma Index study further outlined three types of stigma, which are:

- **External stigma:** It is done by others to PLHIV. It is displayed through attitudes or actions aimed at PLHIV, including insults, rejection, intolerance, stereotyping, discrimination and physical violence.
- **Internal stigma:** It happens when PLHIV begin to believe the negative things that those around them say or think. It can also be seen as thoughts or behaviour resulting from the person's own negative thoughts about him/herself based on his/her HIV status.
- **Anticipated stigma:** It is the anticipation or the expectation that one will be treated differently or poorly because of the stigmatised identity of PLHIV as a group.

While all the three types of stigma were demonstrated in this study by most of the participants (see page 184-185), the researcher infers that stigma and discrimination have both social and emotional impact on employees. This study, in support of several literature that many individuals who choose to be open about their HIV status within the workplace do so in order to obtain support from their employers, supervisors and colleagues. Access to appropriate treatment and care for people who are HIV positive is a basic human right. Stigma and discrimination prevent PLWHA from accessing HIV and AIDS programmes such as counselling and testing, treatment and adhering to such therapy once they initiate it (Tomaszewski, 2012).

Employees narrated different perceptions with regard to HIV and AIDS related stigma and discrimination in a workplace. The followings are sub- themes in regard to stigma and discrimination due to disclosure of HIV and AIDS at different levels of working relationship:

- Disclosure of HIV and AIDS status to a colleague
- Disclosure of HIV and status to a supervisor
- Disclosure of HIV status to EAP Professional

- Disclosure of HIV status to significant others outside the workplace
- Attitudes towards an HIV positive colleague

4.3.4.1. Disclosure of HIV and AIDS status to a colleague

Some participants confirmed that they can open up about their HIV positive status to their colleagues, some mentioned that they cannot while some emphasise that they can disclose on conditions. One male participant indicated the importance of disclosing to a colleague by relating his personal experience when he disclosed to a colleague that he was diagnosed with prostate cancer, which is one of the life-threatening diseases if not taken care of in time.

“Yes, for example; when we (me and my wives) are going for testing, I have disclosed about the chances of having prostate cancer, I also disclosed to a colleague. I educated him and encouraged him about the significance of going for prostate cancer screening”. HIV and AIDS should be perceived and treated like any other ailments like cancer, diabetes, high blood pressure which people are free to talk about without fear of stigma and discrimination.

The ability to disclose about one’s HIV status to a colleague demonstrates an element of caring by protecting the spread further spread of HIV in case one experiences injury on duty. One participant attest:

“Yes, here in our sub-directorate we are only four. In a case of an injury, it is important to alert them to take precautions when they offer me assistance”

The importance of alerting one another to take precautions was also emphasized by another participant:

“Yes, so that she should know and it will be an eye opener for her to take precautions in order to prevent the chances of the spread of the infection. It is hot now, if I can collapse here, she won’t leave me, and she will assist to pick me up or provide any first aid measures”

In reference to the above excerpt, the researcher argues that HIV infection cannot be transmitted to someone who assists in resuscitating a collapsed colleague. However, precautions should be taken in case of bleeding in the course of incident regardless of disclosure or non-disclosure of the HIV status by a colleague. Employees are required to provide safety equipment such as latex gloves to prevent the transmission of HIV during an accident involving a blood spill in the workplace (Occupational Health and Safety Act, No 85 of 1993).

Disclosure does not only benefit the colleague, but it is also a mutual benefit that the disclosing employee receives moral support in case of any health related emergency that may be required. The two participants narrate:

“Yes; my colleagues can assist me, may be in reminding me about the time of taking my medication. If I do not have a car of my own and something urgent came up that will need assistance with transport my colleagues will be able to understand the need for urgent intervention and assist accordingly”

“Yes, I think opening up about my status will assist me in times of need. I would need to visit my doctor from time to time. It may happen that I accidentally collapse or get injured; my colleagues should be able to assist me carefully”

A participant in the study conducted by Mona (2013) attest that having to ask for permission to go to the clinic was not easy as she has not disclosed to his employer. Some employees who are HIV positive and on treatment face a dilemma as they have to comply with their clinic appointments and if they have not disclosed this becomes a challenge as they have to make up lies every time they have to go to the clinic. Furthermore, some participants who were employed felt that it was crucial for them to disclose to some of their colleagues as they needed to be reminded about taking their medication.

Disclosure or non-disclosure of HIV status is determined by the created meaning an individual attaches about the perceived world of reality (being HIV positive) after the disclosure. Social constructivism as well as are concerned with meaning of interpretation, as it is the meaning that the persons attributes to events that determines one's behaviours. The researcher argues that if the outcomes of disclosure are perceived as more meaningful by the one who discloses, the concerned person is more likely to disclose his HIV status than the one who anticipates meaningless outcomes of disclosure.

One of the participants highlighted some of the positive meanings attached to disclosure that can also give courage to continue disclosing without fear of stigma and discrimination.

“Yes. I do not have any problem in disclosing my HIV status. People are afraid to come out, with me I don't care, people will talk today and tomorrow is another topic. It is like the headlines of the media or newspapers”

A better understanding about the psychological impact of disclosure and non - disclosure is also a key on the decision that the person makes

“Yes; if you keep a problem within yourself and not share it, you will die of stress”

Another benefit of disclosure that was outlined in this study is the inherent character of self-determination that one should uphold and perceive himself/herself as having a potential to live a healthy life despite the HIV status. One participant confirms:

“I would be bold to share my status because I believe that HIV and AIDS will never kill me and I refuse to be killed by AIDS. I am going to die because it would be the right time for me to pass from this world”

A small proportion of participants felt that people who disclose their status will feel a sense of relief or that disclosure will send a message to others infected with HIV or affected by HIV/AIDS that open discussion and disclosure is safe (Magwaza 2009). The researcher argues that disclosure to a colleague creates a platform of openness, support and protecting fellow colleagues from the new HIV infection. Rogers in Grobler, Schenck and Mbedzi (2013:21) states that the organism reacts to the field as it is experienced and perceived. The perceptual field is, for the individual reality. The perception about the meaning attached on disclosure is an individual matter as alluded above. Thus, when some participants perceived disclosure to a colleague positively, half of the participants perceived it negatively based on the meanings attached on life after disclosure, which concurs with anticipated stigma (see page 181). The following findings bear a reference:

- An individual's HIV status is not a workplace issue, but a personal matter
- Workplace environment is perceived not to be conducive for one to disclose his/her HIV positive status because of gossips and change of attitude of colleagues towards the person living with HIV positive
- Lack of confidentiality that manifests in a form of gossips.

The following uttered statement relates: *"I cannot disclose to a colleague because they will spread the news that I am HIV positive. There is no guarantee that my HIV status will be kept safe"*

Chapter 4, part 3 (55) (5) of Public Service Regulations (2016) stipulates that in respect of confidentiality and disclosure, all employees shall treat information on an employee's HIV status or any other medical disease or condition as confidential and shall not disclose that information to any other person without the employee's written consent. Employees should be educated that breaching of confidentiality on a colleague's HIV status without his written consent is unlawful and a sanction against such a conduct should be instituted.

One participant indicated a need for a conducive environment to be created for disclosure *“No; the workplace is not a conducive environment wherein you can share your personal matters”*

A female participant emphasised non-disclosure to everyone except her partner: *“Absolutely no...I can disclose only to my partner, not even to my children, parents or whosoever. Other people are not well informed about HIV and AIDS, like my mother cannot read nor write. What she knows is that HIV and AIDS kills. Immediately I delivered that news to her, I would have killed her”*

Fear to be gossiped as one of the anticipated stigma was also mentioned:

“No...employees are good in gossiping. You share such sensitive news with one colleague, the following morning the whole workplace will know. They treat you as if they care, but they stabbed you in the back when you are not around”

“No, I can't. The reason is that if I disclose may be you can go and spread the information that I am HIV positive. People are not trustworthy”

“No, if I tell my colleague, I will even quit my job because they will spread the news, I will feel ashamed”

Internal stigma was also demonstrated by an effort of tracking on how HIV infection came about. One participant told:

“No, it is not an easy thing to do. First you would assess on how did it came about that you contract HIV virus”

“Eish...eish...it is so difficult...immediately you share your status, some will change their relationship towards you. They will develop some attitudes. It is not easy”

The findings of the survey conducted by Shipalana (2009) on the knowledge, attitudes and practices on HIV/AIDS among peer educators in the Limpopo Department of Agriculture, affirm that the majority of the participants believe that HIV and AIDS should not be discussed as it is regarded as a private matter. Similar findings by Magwaza (2009) stipulate that some of the participants felt that disclosure or nondisclosure is matters of individual choice.

The negative consequences of disclosure about one's HIV status are more anticipated than the positive consequences. These participants are constructing their own reality of how life would be in a workplace after disclosure relative to the current workplace culture which they form part. In the light of these findings on the disclosure of HIV status to a colleague, the researcher is of the idea also there is a probability that number of employees who are HIV positive in a workplace kept the HIV positive status secret because they do not trust on the workplace environment in which they co-constructed.

Magwaza (2009) found that the main reason for nondisclosure is fear of discrimination, and the need for self-protection. Participants reiterated that trust is a critical element that forms the basis of whether to close or disclose the HIV positive status to a colleague. The narrative accounts below attest:

“It depends on the trust and the nature of the relationship that we may have”

“Yes, provided I trust that colleague”

Trust is one of the critical elements which a person seeks to consider first before he could identify whom to disclose to. The act of disclosure requires the trust that the HIV positive individual will not be victimised, stigmatized or rejected after disclosure (Law, Gogolishvili, Globerman & Rueda 2013).

“Yes, I can disclose my HIV status in order to reduce stress. I can choose the person whom I trust not the one who will say “As you see her she is positive”. Talking to someone helps me live well. I won’t even mind if my confidentiality can be breached, it would be the problem of the person who breached it. Myself I would have achieved my ultimate goal of disclosing my HIV status, which is; to be stress free”

4.3.4.2. Disclosure of HIV status to a supervisor

Like disclosure to the colleague, this study reveals that some participants will consider disclosing to their supervisors while some could not and some can do conditionally. Disclosure of an individual’s HIV positive status in the workplace is at present rarely taking place because of its negative consequences. However, some participants also perceive positive results in disclosing to a supervisor at the workplace if the environment is a safe, confidential and supportive one.

Disclosure of one’s HIV status may enable the employee to gain the necessary support from colleagues and employers and to access medical care (Open Society Foundation for South Africa, 2009). Some employees in this study point out that they would prefer to disclose their HIV status to their supervisors. The following attest:

“Yes, because he is supposed to support me in terms of sick leaves... it might happen that my sickness progresses up to the point where I fail to deliver some assigned duties. It is my supervisor who will facilitate the provision of reasonable accommodation in case of disability due to my ill-health”

The Code of Good Practice on HIV and AIDS and the World of Work (2012) states that workers with HIV and AIDS must be reasonably accommodated and able to work as long as medically fit. Keeping the HIV positive status secret from the supervisors may result in elevating the stress level and aggravates ill-health condition of the employee. Some participants relate:

“There is no need to hide; it can be an added stress to me”

“Yes, I can disclose my HIV positive status to my supervisor. If I keep it secret, I am aggravating the seriousness of my health condition” Another participant added: *“Yes, in case I am supposed to go and collect my medication, my supervisor must know and provide support in my condition”*

The Labour Relations Act No 66 of 1995 protects employees against unfair labour practices such as pre-employment HIV counselling and testing. Employees who disclose their HIV status in the workplace should do so out of their own volition. The study by Mona (2014) found that the most popular employees to disclose to were the supervisors so that they could allow them to comply with their clinic appointments, some were forced by ill health to disclose, some needed support and some just wanted to be free.

There was a general consensus amongst the participants that good relationship with the supervisor prior to disclosure serves as a gate way for disclosing one’s HIV status. Support and understanding is more anticipated in the event of disclosure.

“Yes, I relate very well with my supervisor. She would be there to provide support in terms of all administrative requirements such as completion of sick leaves”

“Yes. In my case I have a good relationship with my supervisor. I am open to her in number of personal issues and the same applies to her”

Two participants mentioned that their disclosure of HIV status to the supervisor will be based on how they relate at work level and on the professional behaviour of the supervisor. *“It depends on my relationship with my supervisor. I don’t think disclosure is necessary”*

*“If my supervisor behaves well, without harassing or even ridiculing me on my status; by harassing me I mean if he or she will not make funny comments about me like...
“...she is doing this and that...because of the kind of sickness that she is having”*

The nature of a working relationship between the supervisor and the supervisee serves as a basis for disclosure or non-disclosure of one’s HIV status in a workplace setting as alluded above. It is highlighted in the responses by some participants that were accompanied by anger and emotions when they express themselves that they cannot share their HIV status to their supervisor.

“It is a no for the supervisor, unless they got into the ICU while I will be unconscious and read my hospital file. Other colleagues visit the hospital to come and see the condition so that they can spread the information at work. I will tell my mother that I don’t want any colleague to visit me where I will be hospitalised...for me a colleague’s telephonic support can be enough”

“No...what applies to the colleague, applies to the supervisor”

“I can’t. The level of trust is not good. We only have a working relationship and personal issues are a “no go area”

“To hell...even if the sun can rise; if you come to differ with him/her, she will use your HIV status to fight you back”

In most instances, negative feelings like anger, emotions, self-blame and blaming others represents the feelings of internalised stigma. The results of self-reported feelings or internalised stigma were reported from a sizeable proportion of people living with HIV and AIDS who took part in the study by the HSRC (2015). From the narrative account by the participants above, the researcher deduces that there is poor relationship with their supervisors. Poor working relationship in a workplace is a structural factor that may contributes to the employees living with HIV to comply on the clinic appointments, disclose on their HIV status and to form part of the support group in a workplace. Such a working relationship does not encourage openness, acceptance, care and support for employees with HIV or any other diseases as contemplated in Chapter 4, Part 3 (55) (6) (c) of the Public Service Regulations (2016).

4.3.4.3. Disclosure of HIV status to EAP Professional

Employee Assistance Programme (EAP) Professional is a designated person based on the prescribed qualification, specifically social work or psychology who assists employees with personal problems and/or work-related problems that may impact their job performance, health, mental and emotional well-being (EAPA-SA 2011). The key principles of EAP are confidentiality, respect, genuiness, honesty, trust and competency. With these principles, it is believed that employees will have confidence on the services such as counselling, that is rendered by EAP Professional.

The researcher was the EAP Professional for all the Department of Agriculture Local Municipalities within Mopani District. From her experience, 1 out of 10 employees that tested HIV positive disclosed on their HIV status. Contrary to this experience, the majority of the participants in this study mentioned that they would prefer to disclose their HIV positive status to the EAP Professional for counselling, advice and emotional support. One male participant referred to a confidential medical condition he was diagnosed with, which he managed to disclose:

“Yes, I can disclose my HIV status as I did when I learned about my prostate cancer results I consulted professionals for counselling and support”

“Yes, even you (referring to the researcher) I can tell you now if I am HIV positive”.

Various reasons mentioned for disclosure to the EAP Professional includes the need for moral support and professional opinion. *“Yes, I can. They can provide me with moral support”*

“EAP Professionals are supposed to know in order to provide advises either to me or my supervisor when there is a need”

“It is a yes for EAP Professional advises”

“I can disclose to everyone whom I think there is a need for me to do so. People who are living with HIV positive have fear of the unknown. They stigmatised themselves. With me I am not ready to do that in case I am tested HIV positive”

The majority of participants have demonstrated confidence in disclosing to the EAP Professional. However, few of the participants emphasised that disclosure can be done conditionally. It will be based on assurance of confidentiality and trust established with the EAP Professional. *“Yes, my disclosure to an EAP Professional will be done only if confidentiality will be maintained. One may never know, maybe one day you will need their assistance”*

“Disclosure in this regard will be based on the assurance that the information shared will be treated in confidence. I think I can need professional guidance”

Similarly, the study conducted by Magwaza (2009) confirms that some participants would prefer to disclose only under certain circumstances. Another finding by this study is that some participants prefer to test the trustworthiness of the helping professional by narrating wrong information during the initial phase of the sessions. Such kind of behaviour is done in good faith of protecting oneself and to test if the EAP Professional can keep the shared information in confidence.

Two female participants attest: *“To the EAP professional...I can disclose my HIV status to them only because they are professionals. Truly speaking I am not giving correct personal information to service providers during wellness day activities. It is my strategy of protecting my image in case results do not go well”*

“EAP professional, you have to know what kind of person he/she is, and if you can trust them. When I want to tell someone confidential information, I start telling him or her false information and wait for two weeks to see if there won't be the spread of those news”

A similar finding was evident in the study by Brebnor (2007) wherein a community member was asked about whether she used a condom during her last sexual encounter. She said that she did and few days later, she confessed that she had lied about her answer. Few of the of the participants hold to the idea that HIV status is a personal matter and that, they have potential to face the reality of being HIV positive. Therefore, they perceive no need to share with EAP Professional as they view themselves as capable to handle any challenge they may encounter in regard to their HIV status. The following responses assert:

“No...I still believe that my HIV status is personal”

“No, I am very strong emotionally; I don't think I will need counselling”

“It will depend. I have to apply my mind if really I need that counselling”

It is imperative as EAP Professional to understand and respect the choice that an employee has made. Rogers (1987) states that the system has a tendency of self-preserving to any information that is in discrepancy with itself. However, a mechanism must be created to encourage openness, acceptance and support for employees to disclose their HIV status within the workplace.

4.3.4.4. Disclosure to significant others

When people discover that they are HIV positive, one of the first thing to do is to decide whether to tell family or friends because of the stigma associated with HIV/AIDS and the potential for discrimination, people with HIV and AIDS have to be careful about whom they tell (De Bruyn, 1998). It is evident in this study that there are significant others outside the workplace whom employees would prefer to disclose to about their HIV status. Those are mainly their partners, children and parent(s), specifically a mother.

It became apparent also in the study by Mona (2013) that participants carefully identified the first people to disclose to their HIV status. Again, sexual partners and spouses featured more prominently than any other individual. Disclosure of one's HIV status to a sexual partner or spouse is critical as it plays a major role in curbing the spread of HIV. Five female participants in this study also affirm:

“Once I am done with counselling, I will only tell my partner and continue taking treatment. With the rest...I would rather keep it a secret until I die”

“The first person to know my status would be my partner, then the professional help”

“I use to share my HIV test results with my husband; although he does not want me to go for HIV test but I go either”

“...I can disclose only to my partner, not even to my children, parents or whosoever”

“... the first one to discuss with I am sure it will be my husband. The next person to share with is my mother”. Mothers were very popular as well and some indicated that they disclosed to their children and siblings (Mona 2013).

A male participant also concurs that his wife would be a preference to disclose to about his HIV status. *“... I can disclose to my wife. We usually go along to test for our HIV status”*

Mona (2013:231) shows that most men chose to disclose to their wives or partners, who are very supportive and encouraging. The majority of the participants indicated that they had disclosed their HIV status to their husbands/wives/partners and also to their children and affirmed that they felt empowered when disclosing their HIV positive status to the significant others (HSRC 2014).

No person lives in isolation. Everybody interacts with others, and what is of great significance is the perception of the interactions with people whom are perceived as important and form part of the self (Rogers 1987). Witkin (2012) affirms that humans cannot live alone. To envision life is to envision relationships. The researcher argues that in order to prevent the new HIV infection in the workplace, the significant others of the employees should be considered in any HIV and AIDS intervention programmes that are implemented in a workplace environment.

4.3.4.5. Attitudes towards an HIV positive colleague.

Stigma and discrimination towards people living with HIV and AIDS remains a major barrier to effective HIV prevention, as well as to the provision of treatment, care and support. Participants were asked on the attitude portrayed by colleagues towards a fellow colleague who is living with HIV. Some, as narrated below, attest that a positive attitude was demonstrated towards colleagues who were living with HIV and AIDS. Colleagues provided care and support by sharing the meal together and in terms of ensuring that they adhere to medication. Participants attest:

“Their attitude is good. They give necessary support to colleagues who are infected with HIV; they eat and live with them”

“In this office, we do support one another, some of our colleagues are on treatment and they are in a good state of health currently”

“Attitude should be good. The person must not be treated like they are sick, but should be treated like any other person, not to be side lined”

A reference of how well they relate was made also to some of their deceased colleague, who died of HIV and AIDS related sickness.

“I have just heard that there was an employee who passed away because of HIV and AIDS. The employees were concerned that the deceased wouldn’t have passed away if he/she followed the prescribed treatment. To me it meant that they care about each other”

“Our colleague who is now deceased was never treated differently because of his HIV positive status, he was treated as the same colleague we had before the status”.

“Employees were also supportive to our deceased colleagues. I have not experienced any negative attitude to isolate our fellow colleagues”

State resources, such as vehicles and working hours are being allocated to visit a sick employee in order to send a message of care and provide emotional support. One participant relates:

“Employees were so very supportive to him. There was a time where he was hospitalised in Polokwane provincial hospital, government vehicles were authorised to transport some of the employees to Polokwane just to go and provide emotional support to our colleague. There was no gossiping, we have been taught that we treat people living with HIV and AIDS with respect and dignity”

Although it is clear that support and care was demonstrated to colleagues who are living with HIV and AIDS and to the ones who already died, some employees voiced out fear of being gossiped about by fellow colleagues as one of the barriers that hinder disclosure about one’s HIV status in a workplace (cf. page 181). An estimated half of the participants asserted that employees living with HIV and AIDS suffer the negative attitude displayed towards them by fellow colleagues.

“Our employees here (workplace) talk too much; they like the grape vine and they can start to spread the news, before the end of the business day every employee would know. That might be the reason many employees are not coming out to share about their HIV status”.

“When they are with you, employees act as if they care. They buy your face and back bite you. The person with HIV infection is perceived otherwise. Employees are not disclosing their HIV positive status because they are afraid to be bad mouthed”.

Similar fear of potential stigma like being talked, harassed, verbally insulted and physically assaulted was reported by some participants in the study by HSRC (2014).

“HIV and AIDS are still viewed as something that should be kept secret. Employees are still afraid to come out and share about their HIV status in a workplace because they might be called by names and be viewed as stupid”.

Some participants also shared their negative experiences on the attitude portrayed by some of their colleagues towards fellow employees living with HIV and AIDS in a workplace. *“I remember one colleague of mine was tested HIV positive during the period of my appointment. When other colleagues realised that we are working very close, they called me in private and warned me that I must be careful because that colleague of mine is HIV positive”.*

One participant also affirms: *“Employees’ attitudes were bad towards the colleague who is living with HIV. I remember they even stopped to put their water in the refrigerator. Now that colleague of ours is healthy because she is on medication, colleagues got used to her and they have accommodated her as one of them regardless of her HIV status”.*

A personal experience of discriminating a colleague was alluded to by two participants: *“I have witnessed what I am telling you (the researcher), two women here were friends, they drink alcohol together, and they would sneak out of work together. One of them tested and told the friend, the friend came to me and asked “if someone is positive would you share a meal with them?” The following week she stopped coming with lunch box because she didn’t want to share with the friend”*

“Some employees do not accept HIV positive people, they do not give support. The institution is so small that news spread very fast”

This study has found another type of stigma which the researcher refers to as unconscious or unsymbolised stigma. This is a kind of a stigma that manifests itself in the speech of a person involuntarily. The person is convinced that he/she is against stigma and discrimination, in contrast to that belief, the person talks discriminatingly and stigmatising speech or language. Unsymbolised stigma was evident when some participants whose responses were against stigmatising their fellow colleagues living with HIV and AIDS in the workplace. These are some of the statements:

“Some of our colleagues are gradually losing weight but they don’t tell us what went wrong. They are scared that we are going to remind them to slow down in life.”

From the statement, it is also evident that losing weight, withdrawal and isolating oneself is associated with being HIV positive. It is assumed as well that only people who demonstrated multiple-sexual behaviour are vulnerable to contract HIV infection.

“No one disclosed the status in our workplace, but you just become observant when a person changes drastically by withdrawing and isolating himself, becomes lonely and loose weight”

“Many of those that we are suspecting to have HIV infection, their lives weren’t in order, they don’t disclose to protect themselves from being stigmatised and lose an opportunity of being proposed or loved again”

It is perceived that some people who are living with HIV and AIDS have poor listening skills. *“I consider praying beforehand so that he or she can be able to listen to my conversation, because some people who are living with HIV and AIDS cannot listen when you talk to them. So by praying, I request God to assist my colleague to accept his or her HIV status so that he/she continues to live a longer life”*

It is also perceived that employees who are not taking part during awareness campaigns are HIV positive. *“Those whom we think are HIV positive don’t even attend awareness sessions when offered in a workplace. It is so difficult to reach them out. So how will they be educated about their rights and the healthy eating diet? They are the ones who close the door for their freedom”*

One of the stereotyped views is the idea that loss of hair by young girls is a sign of being HIV positive. The excerpt attests: *“Young girls are sick nowadays, they have even lost their hairs to show that they are HIV positive, because they engage in sexual activity with old men”*

Similar to loss of weight, gaining weight is perceived as a sign that someone is on antiretroviral treatment *“... more especially those who look fresh, meanwhile they are on ARV treatment, you won’t suspect them having HIV. Those that look much fresh are the ones that are HIV positive”*

According to Rogers (1987) theoretical proposition 13 states that behaviour may, in some instances be brought about by organic experiences and needs that have not been symbolised. Such behaviour may be inconsistent with the structure of the self. In such instances, the behaviour is not owned by the individual (Grobler, Mbedzi & Schenck 2013). Employees, peer educators, supervisors and HIV and AIDS Coordinators might have been trained and empowered in fighting against stigma and discrimination in a workplace. However, it is necessary to address the unsymbolised stigma that involuntarily manifests either verbally or non-verbally in the day to day interaction with people living with HIV and AIDS.

The researcher argues that employees have their own reasons that make sense to them why they do not participate on HIV and AIDS initiated programmes in the workplace. Rogers (1987), a social constructivist, maintains that every individual's world is subjective, in order to understand it should be viewed in terms of that individual's frame of reference. Therefore, judging and condemning those who are non-participating on the programme might be a social barrier towards the prevention of the spread of new HIV infection.

4.3.5. THEME 5: GUIDELINES TO PREVENT NEW HIV INFECTIONS IN A WORKPLACE

Socio-behavioural and structural core drivers of new HIV infection call for strategic approaches in order to prevent new HIV infection amongst employees in LDA and reach the 2030 vision for Zero HIV infection in South Africa. These are the guidelines to prevent new HIV infections in the workplace as narrative accounts of the participants:

4.3.5.1. Departmental strategy be responsive to HIV and AIDS

HIV and AIDS programme is considered as a support function to the core business of various departments, hence in the organisational structure the programme is mostly placed under Human Resource Management. Priority in terms of allocation of resources, including human resource is given to the core functions of the department. As a result, the effective and efficient implementation of HIV and AIDS programme in terms of the National Strategic Plan on HIV and AIDS, STIs AND TB is being compromised and foremost, the health and well-being of the employees is also undermined.

In Limpopo Department of Agriculture, HIV and AIDS programme is coordinated at head office and district level. Twenty-five municipality offices and the respective service centres do not have HIV and AIDS Coordinators. This kind of structural weakness resulted in inadequate delivery of health promotion programmes to employees who constitute the majority of the staff establishment of the department.

The following narrative accounts show dissatisfaction on the recent approach of service delivery as far as health promotion service is concern:

“The only challenge is that the health services are not offered sufficiently. At least if it can be provided once quarterly”

“I suggest that a visit once a month to conduct awareness can suffice. While in churches there are conferences to revive one another, even this programme it needs continuous revival”

“There should be an awareness campaign at least once in a quarter. Just to keep on reminding employees about HIV and AIDS”

A Similar finding of the inequitable distribution of human resources was highlighted in the study conducted at Limpopo Department of Economic Development, Environment and Tourism by Ramoloko (2012) that out of 9 positions on the approved departmental structure for workplace HIV and AIDS programme, only 3 were filled. This suggests that there is a shortage of staff which had a negative bearing on the implementation of the workplace HIV and AIDS policy and programme. With this regard, the DPSA minimum standards on HIV and AIDS require a head of department to allocate adequate human resources and funding for the workplace HIV and AIDS programmes (South Africa, DPSA 2002). Similarly; Chapter 4 Part 3(6) (c) of Public Service Regulation 2016 states that in respect of a health promotion programme in a workplace, a head of department shall allocate adequate human and financial resources to implement the provisions of this regulation, and, where appropriate, form partnerships with other departments, organisations and individuals who are able to assist with health promotion programmes.

According to the systems model, if the inputs such as finance, staff and material are inadequate, the overall implemental process will be affected as well as the outputs, outcomes and impacts. It can therefore be argued that as long as the departmental strategic/structural response on HIV and AIDS in terms of allocation of sufficient budget and human capacity is not properly aligned, the department is far from eliminating the spread of new HIV infection in the department and contributing to the South Africa's long-term vision of achieving zero new HIV and TB infection by 2030.

4.3.5.2. The management authorities should play a leadership role

Leadership is defined as a process by which a person influences others to accomplish an objective and directs the organisation in a way that makes it more cohesive and coherent (Northouse, 2007). Amongst the principles of leadership the U.S. Army (2003) is to set an example, be a good role models for the employees by not only hearing what they are expected to do, but also become the change they want to see (Sigh Marwaha, 2014). It is commonly found that management authorities hardly partake in any HIV and AIDS event arranged in a workplace

Addressing aspects of HIV and AIDS will enable employers, trade unions and other stakeholders to actively contribute towards arresting HIV infection by preventing the further spread and the contracting of the new HIV infection. The Lancet (2011) states as well that substantial changes are needed to achieve a more targeted and strategic approach to investment in the response to HIV and AIDS epidemic that will yield long term dividends. However, this kind of approach seems to be far much reaching by workplace response due to the less involvement of management in the implementation of the programme as related by some participants:

“Our SMS (referring to senior management) should participate in HIV and AIDS events to encourage all employees. SMS normally don't attend. I just think they might be having their own education session done aside, but it will be good if they become part of us because they are more influential”

“It is only employees from the lower ranks who attend awareness sessions and participate in HIV and testing. These big bosses are less concerned”.

“The management should be part of HIV and AIDS programme. If they do not take the programme seriously, how could we?”

The proposed Treatment Adherence Model, developed in the study by Mona (2014) asserts as well that community leaders and workplace managers need to lead by example, in that if they want their subordinates to take HIV seriously they need to volunteer to be counselled and tested themselves, so that their subordinates can be able to realize the importance thereof. It is in the view of the researcher that efficiency in prevention of the new HIV infection in a workplace can be reached through management and trade union mobilisation’s active involvement throughout the phases of the programme.

4.3.5.3. Strategies to scale up and strengthen the HIV Counselling and Testing should be developed.

The Global AIDS Response Progress report (2012) in Republic of South Africa highlights the new guidelines in February 2010 of South Africa’s policy on voluntary counselling and testing that was expanded to include number of new components. The components include a revision of counselling protocols as well as a shift of HIV Counselling and Testing (HCT) to be offered by health providers on any patient’s visit to any health facility for any ailment. Thus it is pursued as one of the country’s response to HIV and AIDS to intensify the provision of HCT that aimed at arresting the HI Virus, linking those who are HIV positive with the treatment care programmes and as a prevention strategy for the further spread of new HIV infection.

Minister of Health, Dr Aron Motsoaledi affirms in his foreword that the South African Government has embarked on a deliberate effort to scale up and strengthen the quality of HCT at all health and non-health facilities (National HIV Counselling Guideline 2015). Provider-initiated HIV counselling and testing remains voluntary but it places an obligation on the health care worker to explain to patients the importance of knowing one’s HIV status and of testing regularly for HIV as part of a normal health seeking behaviour (UNAIDS 2012).

The evidence-based models which include expanding of HCT through targeting specific groups such as couples, adolescents, men and others seem to be partially effective. In order to prevent mother-to-child transmission of HIV, pregnant women should be tested as early as possible in each pregnancy. Based on the findings of the suggested strategies on HCT provided by the participants, various guidelines emerged and elaborated as follows:

4.3.5.3.1. Employees should be sensitised on human rights and its gender-based violence

Some of male and female participants in this study voiced out that HCT should be mandatory not only to pregnant mothers, but also to every South African citizen.

“In a number of occasions women are the ones who go for testing and the man thinks that when I am tested negative he is also HIV negative, when I am tested positive he will say: “it is you who is positive, myself I am fine” Let our country wake up and take a firm decision that will assist in reducing the spread of HIV amongst its citizens”

Women are not only subjected to test for HIV when they are pregnant, but they also participate voluntarily during HCT activities that are coordinated at workplaces as compared to their male counterpart. Another woman participant concurs:

“The department should enforce that all employees test for HIV. HCT should be mandatory. Women are the ones who mostly go for testing but only few men test for HIV at a workplace”

A call for a proactive initiative in engaging men in health promotion programmes such as HCT is raised by a male participant: *“Government should ensure that we all go for HIV test, pregnancy or no pregnancy! Men do not want to consult, the time they consult and test for HIV status is when they are critically ill. Can the government wait for that period; meanwhile the HIV is being spread day in and day out?”*

4.3.5.3.2. HCT strategies should be accurate

Insufficient service providers who conduct HCT during the workplace HCT campaigns are amongst the challenges experienced by the coordinators of the HIV and AIDS programme. Employees are compelled to wait anxiously for their turn to be tested. Others are able to tolerate such long processes but some are not. One female participant suggested that men's forum meetings can be a link for accessing male employees to participate in HCT. *"HCT should be coordinated especially for male employees during their men's forum meetings. They may be having pride that they won't participate where women are or not tolerating to wait for their turn in a testing line"*. For an HCT programme to achieve ultimate goals, availability of sufficient trained staff by relevant stakeholders can improve utilization of HCT services by both men and women employees in the workplace. The researcher argues that different components of the employees require different HCT approaches in order to gain an entry point to address the spread of new HIV infection in the workplace.

4.3.5.3.3. HCT strategy should adopt a holistic approach

The human rights issue of voluntary testing was found to be at odds with the right to life if one partner is placed at the risk of contracting HIV infection by the infected partner *"No; they cannot talk of human rights while people are at a risk of contracting HIV. Let each and every couple go together for counselling and testing"*. One of the priority areas of HCT guidelines is the need to prioritize counselling and testing of couples and testing of family members of the infected person (National HIV Counselling Guideline 2015). One participant affirms as well:

"I think our families should be part of the awareness campaigns and wellness screening that we receive here at work. When I shared with them about the health education that we are receiving here at work, they get shocked because they don't have access to such information. They can be the beneficiary of the information so that it can be easy for us when we apply what we have learned at home"

It is therefore argued that HCT interventions in a workplace should holistically consider the inclusion of employees' partners and family members in order to address the social and structural core drivers of new HIV infection in the family of an employee. Since HIV and AIDS is a developmental issue, the approaches in the workplace should be developmental rather than clinically addressing an individual employee only.

4.3.5.3.4. Adopt HCT rewarding strategy

A male participant suggested a best strategy which the department previously adopted and had proven to have encouraged maximum participation in HCT by male employees.

“Number of male employees tested their HIV status after the introduction of the incentives of cooler bags. They were reluctant to test before but, seeing that employees who were tested for HIV were given a six cans cooler bag, they all came for testing. Let that strategy proceeds because employees will get to know their HIV status and on the other hand, the employer will able to retain and maintain the healthy workforce in the department”

Self-determination theory (SDT) affirms that certain factors such as rewards for good behaviour (such as HCT) motivate clients to follow health care providers' instructions and sanctions also play a critical role in ensuring that they comply and change behaviour accordingly (Deci & Ryan, 2000). The most central distinction in SDT is between autonomous motivation and controlled motivation. Autonomous motivation comprises both intrinsic motivation and the types of extrinsic motivation in which people have identified with an activity's value and ideally will have integrated it into their sense of self (Deci & Ryan, 2002). When people are autonomously motivated, they experience preference; or a self-endorsement of their actions as with the person with self-efficacy mentioned in below in this study.

Controlled motivation, in contrast, consists of both external regulation, in which one's behaviour is a function of external contingencies of reward or punishment, and there are also regulations, in which the regulation of action has been partially internalized and is energized by factors such as an approval motive, avoidance of shame, contingent self-esteem, and ego-involvements. When people are controlled, they experience pressure to think, feel, or behave in particular ways. In the light of the findings and the theory presented, the researcher argues that provision of rewards in a form of incentives during HCT campaign is a constructive intervention strategy that can yield maximum participation of both males and female employees. Ultimately, there are positive results of behaviour modification in regard to social and behavioural core drivers of new HIV infection.

4.3.5.4. Employees should be empowered on self-efficacy

In contrast to the findings on the need for involuntary testing (cf. page 213), some of the participants articulated the importance of self-efficacy in making right choices about one's own life. Self-efficacy refers to perceived capabilities for learning or performing actions at designated levels (Bandura 1994). Self-efficacy plays a role in self-regulation of motivation and actions. A dialogue that seeks to promote responsibility for knowing one's HIV status, knowing one's partners' status, preventing new HIV and secondary infection as well was facilitated to bring together various national stakeholders in the introduction of the theme: "I am responsible...We are responsible...South Africa is taking responsibility" (SANAC, 2010). Some of the participants emphasized the importance of knowing oneself. It is asserted that if you know yourself much better there is no one who can persuade you to commit an act that is against your will. The followings accounts have unfold:

"I think us as employees are the ones who are supposed to have a bigger role to take responsibility over our life".

"It is not an external pressure that forces a person to behave unacceptably, but it is the individual's internal forces that result into such an unacceptable behaviour.

People are justifying and hiding their behaviour behind a number of complaints. The power to decide on the action is within the person”.

“I would also urge my colleagues that the best treatment is to take responsibility of our own behaviour. We have seen our brothers, sisters and relatives have passed away due to AIDS, so we should consider ourselves fortunate when our department takes responsibility of conscioutising us”.

“Life is about making choices. I don’t think you can be persuaded to do things that you were not ready to do. If so, it means you do not know who you are”.

4.4. DISCUSSION OF THE RESEARCH FINDINGS

Tesch’s eight steps (in Creswell 2009) of data analysis were pursued to analyse the data collected from the participants. Participants were ten males and ten females classified into three developmental phases, namely intimacy versus isolation, generativity versus stagnation and ego integrity versus despair according to Erikson (in McLeod 2013). They were young adults whose ages ranged between 18 and 35, middle-aged adults between age 36 and 54 and later adulthood phase of the age between 55 and 65.

During intimacy versus isolation developmental phase, young adult begin to share themselves more intimately with others, explore relationships leading toward longer-commitment with someone other than a family member. Successful completion of this stage can result in happy relationships and a sense of commitment, safety and care within a relationship. The study confirmed that a young woman (24 years old) who fell within this age category had never tested for HIV, while the other four participants tested for HIV within 6 and 12 months (cf. page 94). The fear to know one’s status is one of the barriers of testing for HIV. The stigma attached to employees with HIV hinders some employees to participate in HCT.

Girls and young women are amongst the key vulnerable populations to contract new HIV infections. Adolescent girls and young women in South Africa are up to 8 times more likely to be infected with HIV than their male peers. In response to the risk inherent in this stage of development, the government has launched a three years National Campaign for young women and adolescent girls, the She Conquers Campaign in Pietermaritzburg, South Africa on the 24th of June 2016 as a prevention strategy to fight against the spread of new infection to this target group. The workplaces should follow the same approach in order to address the socio-behavioural and structural core drivers of new HIV infection amongst employees within this age category.

The second group of participants in the middle adulthood stage comprised of four males and six females. This was a larger group when compared with other two groups, mainly because the majority of LDA employees fall within middle adulthood. Hence, they were easily accessible for the purpose of this study. According to Erikson's (1959) developmental stages, this life phase is characterised by "generativity versus stagnation". People in this stage take greater responsibilities and control in their work career, family and in society. If a person does not experience a sense of contributing to the world, expression of stagnation may result.

The participants' work period in public service ranged from 4 to 34 years. Amongst the group, only two participants, a male and female were 4 years experienced, while the rest were above 4 years. Therefore, the researcher would agree with Erikson in MacLeod (2017) that most of the group participants were experienced, skilled and knowledgeable about their job mandates that they can be eligible to be mentors of the first group. With reference to this age group, literature revealed that Limpopo Province, amongst the three top Provinces (Mpumalanga, KwaZulu-Natal and the Free State) has also experienced a significant increase of HIV prevalence from 2005 to 2012 (HSRC 2014). Furthermore, females remain at higher risk of contracting HIV infection and are 1.6 times more likely than males to be HIV positive since they are at their prime reproductive age (HSRC 2014).

The study found that eight of those ten participants (which were 6 women and 2 men) did the HIV test within 3 months at the time of conducting this study; while the other two (which is 2 men) did the last test between 24 and 48 months. The majority of female participants in this age category tested for HIV regularly and make informed decision about their sexual behaviour as compared to male participants. Those participants demonstrated a sense of responsibility and self-determination. It is therefore assumed that they have control over the socio-behavioural and structural determinants of new HIV infection, therefore at a lesser risk of contracting the new HIV infection and of being the agent of transmitting the infection in a workplace.

Despite the satisfactory results of this age category, two male participants who did the last HIV test in the past 24 and 48 months was a worrying factor. Norms and values around gender roles seem to be a contributory structural factor for some men not to participate in HCT. Exploring on those structural core drivers of HIV infection will enable HIV and AIDS coordinators to strategize on interventions for maximum participation of male employees during HCT campaigns.

The final group of five participants were at their later adulthood phase of the age between 55 and 65, comprised of three males and two females. This developmental stage is characterized by “integrity versus despair” in accordance to Erikson’s (1959) stages of development. Three of those participants (one male and two females) did their HIV test within 2 months and 6 months, and the other two male participants tested last in 24 months, which is also not commendable.

According to HSRC (2014) HIV prevalence in older people are based on smaller numbers, mainly because HIV is not as prevalent in older people as it is in persons of reproductive age. A female participant also believed that her husband is no longer sexually active, therefore, perceived him not susceptible to contract the new HIV infection. The researcher agreed with Jones (2006); Nkosana and Rosenthal (2007), Madlala (2009); that people at this age category are less likely to test for HIV because they see themselves as not vulnerable to contract HIV infection. However, the risk perception in the inter-generational relationship is that men perceive young partners to be more likely to be free from HIV, while young women often view older men as less risk-taking, more stable, and hence ‘safer’ partners.

Perception of risk is the first stage towards behavioural change from risk taking to safer behaviour. It is expected that once individuals perceive themselves to be susceptible to a disease, they are more likely to take prevention measures. It is crucial to explore on the perceptions towards socio-behavioural and structural core drivers of new HIV infection among employees with intent to modify risky behaviours.

The perceived HIV risk in this age category is that of age-disparate relationships when such men can fall into a relationship with women either in the first or second age category as Harling (2014) asserted that irrespective of one's own sex, age-disparate relationship is generally a risk factor for HIV. In both three age categories, there were some employees who did not test HIV regularly, which was an indication that employees in all age categories are vulnerable to HIV infection.

The HIV testing trends revealed that 90% of women tested for HIV regularly, while 10% never tested. Whereas only 40% of men tested for HIV regularly and 60% tested in the last 12 to 48 months, lack of knowledge about one's HIV status results in a risky sexual behaviour that fuels the spread of HIV. Knowledge and understanding about HIV and AIDS was discussed with participants. Needless to say regular testing for HIV confirms knowledge about HIV and AIDS; and some participants demonstrated their knowledge and understanding of the disease by providing the full definition of the two concepts, while others indicated that they could not differentiate between the two.

Educational background has been mentioned in this study as one of the determinants of the level of understanding of HIV and AIDS. An effort to understand the basic knowledge that employees have about HIV and AIDS should serve as a point of departure in any intervention to address the socio-behavioural and structural core drivers of the new HIV infections.

Most participants explained the modes of transmission and the process of progression from HIV to AIDS stage. The most common modes of transmission known by the majority of the participants is through sexual intercourse without practising safe sex with someone who is HIV positive and through blood contact. The least known mode of transmission by the majority of the participants was through MTCT. It was explained mainly by few in the first category of young men and women participants.

Although this mode of transmission seems to be biomedical, it has a socio-behavioural impact on contracting the new HIV infection if the pregnant employee is not practising safe sex during pregnancy regardless the medical advice that she might have been provided with during her antenatal period, and structural bearing of vertical transmission of HIV infection to the child if policies and guidelines on Prevention of Mother to Child Transmission (PMCT) of HIV are not adequately implemented. Participants who did not show an understanding on PMCT are more likely to be at a risk of adopting behaviours that might increase vulnerability of contracting new HIV infection due to their insufficient knowledge about the virus.

Few participants understood that there is no cure for HIV and AIDS. That notwithstanding, there is a treatment that one can take in order to prolong one's life. ARVs are used largely to achieve this. Despite the achievements the country has made in scaling up ARVs, the knowledge that people have about the importance of adhering to ARVs and the stigma associated with taking ARVs remains a structural barrier towards the prevention of the spread of new and secondary HIV infections. Mbonu and van den Borne (2009), as well as Mhode and Nyamhanga (2016) affirmed in their studies that different forms of HIV related stigma among people on ART were experienced by participants, included internal, external, verbal, social and perceived stigma associated with taking ARVs. Effective adherence to HIV treatment can be enhanced through a non-stigmatised and non-discriminatory work environment that promotes shared norms, values and moral obligation in reducing the further spread of new HIV infection.

An elevated and highly regarded cultural practice of having multiple sex partners among African men is a contributing factor to the spread of new HIV infection. In affirmative, Schuele and Berner-Rodoreda (2010:8) maintained that in many societies "manliness" and "masculinity" is often closely associated with having multiple sexual partners and negative attitudes towards condom-use, which seems to hold true for both heterosexual men and men who have sex with men.

Some participants also concurred that men who practise multiple sexual partnerships are associated with “good” naming such as “sekhokho” (which means a boss or a great one), meanwhile a woman who displayed the same sexual behaviour is belittled by being called “sefebe” (a tart, or a woman of loose morals). A SexInfo online affirms that the gender dichotomy of “good woman” and “bad woman” also plays a role in Ba-Tswana culture.

Females who utilise their rights to sexual freedom can often be labelled promiscuous and are blamed for the spread of HIV infection. Cultural practise of MSPs is promoting risky sexual behaviour amongst men, which in turn has an adverse impact on their partners. Most female participants and one male participant perceive some women to demonstrate seductive behaviour. Women are freed from being the passive member in the initiation of a relationship according to Feminist theory. It is now trendy for women to pursue guys for a date, dress sexily and act seductively, which fellow employees pronounce as a sex manipulative game. Women who demonstrate the potential to make such an initiative of the relationship may use such capability to negotiate safe sex with the sexual partner, which with reference to the researcher’s opinion it is the socio-behavioural strategy that can liberate most women from gender based and domestic violence that aggravate the risk to contract new HIV infection amongst women in and outside the workplace environment.

Multiple sexual partnerships have been viewed by the majority of the participants from the three groups as the socio-behavioural core drivers that place all partners at a risk of contracting new HIV infections. Being that as it may, there was only one young male participant in this study who perceived having multiple sexual partners as a behaviour that does not place all partners at the risk of new HIV infections provided they do know each one’s HIV status.

Some women in marriage suffer the adverse effect of MSPs, which is contracting the new HIV infections. In marital relationships protected sex may be least likely to be practised. MSPs are characterised by an element of keeping the (secondary and subsequent) relationship “secret” from each member of the MSPs system. By so doing members tend to be naïve and trust their partners thereby loosening measures of exercising protection during sexual intercourse. These findings also suggest that it is not men only who engage in MSPs, but some women engaged in MSPs.

The circular pathway of transmitting HIV infections amongst the sexual partners in a workplace is another characteristic of MSP behaviour; which increases the probability of contracting the new HIV infection. The principle of circularity has been explained in systems theory as referring to interdependency of elements in a given interaction. In this principle there is no cause and effect. There is no beginning and no end in a circle, therefore the ‘why’ question should be avoided (Watzlawick, Beavin & Jackson 1967). Therefore, the researcher inferred that the spread of HIV infection in a workplace may become circular in nature if there is sexual interdependency amongst the employees as staff members of the organizational system.

In this instance, the element of “secrets” found in this study maintained closure and the autonomous functioning of the MSPs network or system which may result in closing up to any given information in regard to HIV and AIDS or any information that is in contradiction with the values of that particular MSPs system. It is also suggested that any intervention aimed at addressing MSPs as a socio-behavioural driver of HIV infection, should consider system theory’s principles of “circularity” an “autonomous” nature of the MSPs in order for its members to open up for HIV and AIDS information, which is essential for the prevention of the further spread of new HIV infection amongst employees.

Intergenerational or age-disparate relationships in a workplace were also alluded to. Such relationships are intricately linked to the need for job opportunities, the desperation for higher positions and associated material benefits which predispose young men and women in Internship to engage in risky behaviour. The “sugar mummies” and “sugar daddies” intergenerational relationships have been a long practice in society. However, the new emerged sexual behaviours that exist in age-disparate relationships are the commonly known as “blesser-blessee” and the “Ben 10s” (after the TV cartoon character) phenomena, which aimed at sponsoring the expensive lifestyle of young men and women are mainly threats to address the socio-behavioural and structural drivers of new HIV infection in and outside the workplace.

Financial constraints are the key drivers of this kind of transactional sexual behaviours that place both young men and women at a risk of new HIV infection. The inter-generational relationship is also described as mutually benefitting in that young men are looking for material benefits, while older women are relieving boredom and benefitting from the company of those young men.

The anomie of the organizational structure as Durkheim (1994) would call it was reflected in the instances whereby some permanently employed men and women who were at low occupational ranks also engage in transactional sex with their bosses or supervisors with the intention of getting permanent posts or promotions to higher positions. Durkheim spoke about an organization being structured by offices or echelons, one on top of the other, arranged in terms of authority and power while Max Weber (1978) spoke of bureaucracy which is characterized by the presence of impersonal positions that are earned, rule governed decision making, professionalism, chain of command, defined responsibility and bounded authority. Such a structure, in terms of organisational theory, may be abused as it happens in the research site under discussion.

Anomie in this study has been found where Employment Equity has little effect in appropriately advancing most women in the corporate world. It is important to note that whilst millions engage in commercial sex work on a regular basis, even some employees whom not commonly thought of as “commercial sex workers” find themselves needing to exchange sex for promotions, money or goods on an occasional basis, which is a socio-behavioural core driver of the spread of HIV infection in a workplace. One of the guiding principles of Code of Good Practice on HIV and AIDS and the World of Work is that, women empowerment is a key factor in responding to HIV and AIDS and the world of work. Measures must be taken in the world of work to ensure gender equality, prevent violence and harassment, protect sexual and reproductive health and rights and involve men and women workers, regardless of their sexual orientation in the HIV response.

Substance abuse is viewed by the majority of the participants as one of the socio-behavioural drivers of the spread of HIV infections since it is associated with MSPs and reduces people’s commitment to practise safe sex. Few participants stated that some men do not experience sexual desire when drunk, thus they are less likely to engage in sexual intercourse. However, the view was opposed in that, Shakespeare affirms that alcohol provokes the desire but takes away the performance. Therefore it sets him on and takes him off. The researcher agrees with Mccann, Harker, Burnhams, Albertyn, and Bhoola, (2011); Erasmus et al. (2012); Burnhams, Musekiwa, Parry & London (2013) that substance abuse has a profound impact in driving the spread of HIV infection amongst employees. Employees consuming alcohol during working hours seem to be a problem which is on the increase, with a resulting increase in problems for the employer. This type of behaviour constitutes misconduct.

Institutions like workplaces are viewed to be areas that are hot in spreading HIV infections amongst its members. In the workplace, field workers with minimum supervision are at a risk of new HIV infection through engaging in MSPs in their line of duty. Some employees who are perceived as dignified and loyal to their families choose to engage in sexual activities during or after official working hours in their offices. The used condoms that are usually spotted around the workplace premises are evidence to the allegations. Sleeping away from home due to work-related commitments has been perceived as another opportunity for some employees to engage in unacceptable sexual activities that might result in the contracting of HIV infections.

Like socio-behavioural drivers of new HIV infection, structural core drivers were also deliberated. Societies are perceived as being structured according to different echelons, which include patterns of cultural norms and values, myths, religion and beliefs strata. There are some women who have been raised and socialised from the patriarchal family system. They still uphold the patriarchal norms and values that determine the power relationships by which men dominate; oppress and exploit women, and women are kept subordinate in a sense that they adhere to the culture of “silence” to an extent that issues of HIV and AIDS or negotiating safe sex are not discussed in such a relationship.

Efforts to alter any individual’s norms and values that may seem to put women or other employees at risk of contracting HIV infections, must take into consideration that despite some reforms purporting to improve women’s status, there are the remaining of patriarchal domination with the interlinked forces of traditional norms and values instilled during primary socialisation. Thus to prevent the socio-behavioural and structural core drivers of the new infection resulting from the patriarchal structure, continuous awareness sessions targeting and empowering women is essential.

In a sexual relationship that is characterised by gender based violence, most women experience difficulty in introducing a condom and are being treated as commodity by their husbands. According to Marxist feminist, practising safe sex should be remarked as mutual protection. Therefore any HIV and AIDS condom promotion programmes should also target men in the workplace as well as in the community in order to reduce the spread of the new HIV infection with its gender based violence dimensions.

It was found in literature that working class women are economically empowered and in a position to protect themselves by insisting on the use of condom. In contrast, some women participants mentioned that they cannot stand a risk of losing their partners over the battle of practising safe sex. This is an indication that some working class women are also experiencing a challenge of negotiating safe sex with their partners, thus remain vulnerable of contracting HIV infection.

Polygyny is another form of marriage, which is practiced by some men to marry more than one wife. The majority of participants, both men and women disapprove the practice of polygyny as it is viewed as aggravating the spread of HIV infection in the polygynous marriage network. Marrying more than one wife is viewed as a behaviour that is no longer valued in this era of HIV and AIDS, but some men have resorted to multiple sexual relationships, which also bears the same risk as polygyny of contracting and spreading new HIV infection if safe sex is not practised.

In contrast, polygyny is perceived as gaining momentum among some African men since prominent figures, who have potential influence in the nation like President of South Africa Jacob Zuma, the king of Zulu nation Goodwill Zwelithini, the Swati king Mswati. South African businessmen from KwaZulu-Natal, Mr Milton Mbhele and Mr Mandla Gcaba, a nephew to President Jacob Zuma married more than one wife. Polygyny is mainly characterised by age-disparate relationship in which prominent figures who are at their middle and later adulthood stage entered into a polygynous marriage with young women who have positive perception about polygyny.

A 24 year old young woman participant, who had never tested for HIV, supported the idea that marrying another wife might be a better move of preventing the risk of contracting HIV infection. Young women in the workplace may envisage entering into a polygynous marriage, thus strategies designed to address young women in a workplace with regard to the prevention of spread and contracting of new HIV infection should also take this structural element into account.

Employees whose job functions are mostly performed in the communities such as Agricultural Scientists, Agricultural Advisors, Animal Health and Crop Production Technicians are seen to be at risk of contracting new HIV while on the line of duty. Minimum supervision was one of the elements perceived to provide employees with an ample time of engaging in risky sexual behaviour while at work. Seduction by their clients is another factor that was mentioned by the majority of participants. However, a female participant stated that the same challenge of being lured to sexual relationships during the scope of work perceived to be possible to anyone. The underlying motive of some employees, who fell in traps of engaging in sexual relationship with either their clients or service providers is corruption based on the pursuit of material or capital gain.

Few male participants emphasised the need for employees to retain the sense of responsibility and taking account of their own behaviour. Although South Africa's response to HIV and AIDS has moved from the micro level of individualising the approach to a macro-level of combination approach that encompasses interventions that address the socio-economic, behavioural and structural core drivers of the epidemic, some participants emphasised that the onus to contract or spread the HI virus lies on the individual himself/herself.

The Post-apartheid restructuring system of public service through redeployment has been realised to have a profound impact on the spread of HIV infection amongst the employees by the majority of participants. Involuntary relocation from their former workplaces and leaving their families and regular sexual partners behind to certain allocated areas of work is a structural element which might have predisposed some of the employees to contract the HIV infection. Those employees were accommodated in arranged departmental residential houses, next to their workplace, which seemed to be more affordable than renting or buying a house of their own. The psychosocial effects accompanied the relocation such as the feeling of loneliness and boredom and the tendency to be linked to others who are lonely, an effect that is stronger for geographically proximal than distant relationship are another driving force behind the spread of HIV infection (Cacioppo, Fowler and Christakis, 2009).

Another aggravating circumstance is the lack of regulatory policies on those departmental residential houses, which keep the door open for unauthorised people to invade the area in one way or another as no one cares about such a conduct. The building of unauthorised shacks in the departmental residential premises is an indication of the lack of control over the area and the residents. Its implication is like that of a “broken windows theory”, which is a metaphor proposed by James Wilson and George Kelling in McKee (2013) for disorder and incivility within a community to subsequent occurrences of serious crime.

Implicitly, the departmental communal houses that are allocated to some employees are not meant to be family units, but they are similar to the former apartheid poorly equipped and dilapidated hostel structures that resulted in the destruction of the fabric of society, relevant to this study, in a form of escalating the socio-behavioural and structural drivers of the spread of new HIV infection to the employees and to some community members within the vicinity of those departmental dwelling houses.

Employees working at the red-line gates are also perceived as most vulnerable to contract the new HIV infections. They target some women from the nearby community who avail themselves for sexual relationship purposes. However, sexual relationships are viewed as mutually benefitting as determined by the parties. Any behaviour whether constructive or destructive, is need-oriented according to Maslow's hierarchy of needs. The biological and physiological needs, which include, amongst others, sex, the safety needs, referring to need of protection and stability, need for belonging and loved, esteem and self-fulfilment were found to be the reasons for the manifestation of the kind of sexual behaviour to employees stationed at the redline gates.

For the optimal functioning of the individual employee, the employer should appropriately consider the employee's need for self-actualisation, which entails the satisfaction of physiological and the safety needs in case of employment or redeployment as one of the strategic intervention towards fighting against the spread of new HIV infection. Employees should be assisted beforehand to determine the potential value and risk attached to the envisaged sexual behaviour.

Departmental events like extension officers' conference, farmers' awards and end of year parties are viewed as hot spots for employees to either contract or spread the HIV amongst themselves. Consumption of alcohol and the subsequent engagement in sexual intercourse by some young male and female employees have been stated to be the characteristics of those specific events. Most female participants were of the idea that consumption of alcohol provokes the sex drive for both men and women whereas most male participants stated that consumption of alcohol takes away the desire to have sex for men.

As it has been discussed before (cf. page 133), substance abuse is a socio-behavioural core driver of HIV infection amongst employees during the aforementioned departmental events. In those situations, young women employees are not victims of the circumstances as regarded by the majority of female participants, but the researcher saw them as decision makers who demonstrated their ability by deciding to attend the events, consume alcohol with the specific employees who fitted well with them and such mutual understanding led to the event

of sexual intercourse, which is a social driver to spread or contract new HIV infection if safe sex was not practised.

The same may apply to some male and female employees whose departments temporarily send them away to attend meetings, workshops or trainings and perceive the privilege as an opportunity to engage in sexual behaviour that might lead to the spread or contracting of new HIV infection. Drinking of alcohol during departmental functions and/or in an area declared as a workplace, more especially in the event wherein such employees buy the alcohol for themselves; is viewed as an employer's less concern behaviour. However, the consequences of such behaviour have an impact on the employer in the long run. The study provided a schematic presentation of the process flow of the contribution of departmental events to be the structural core drivers of HIV infection in amongst LDA employees.

Despite the progress made in the implementation of the Beijing Declaration Platform⁴ (1995) in respect of gender equality, women are perceived to be still holding low managerial positions in South Africa. The high levels of inequality in wealth and income remains a significant structural driver that may contribute to the spread of HIV infection in a departmental workplace and a challenge as well to the workplace response on HIV and AIDS. The majority of participants confirmed that some women who occupied lower positions subject themselves to be abused sexually by their bosses due to desperation for promotion to higher positions. It is further stated that the selection and recruitment criteria for potential candidates are being followed for compliance with the prescripts, however; those processes are being manipulated by managerial authorities in order to favour their own interests.

Attainment of higher positions due to sexual exploitation demonstrates the economic injustice in regard to the distribution of equitable share in wealth and income, which seems to be an occurring endemic corruption in the departmental workplace. This conduct fitted so well with a metaphor which says: "The fish rots from the head" to express the idea that all problems in the organisation or workplace can be traced back to its leaders, filters down to its citizen.

HIV and AIDS workplace policy provide the framework for action to reduce the spread of HIV and AIDS and manage its impact. Although few participants appreciated the way HIV and AIDS programme is coordinated in the department and think that it is the responsibility of every employee to take get acquainted with such policies. The majority emphasise that the department has many policies of which is not easy for one to go through each and every policy, thus a call for the custodian of the policy to continuously create an awareness on the HIV and AIDS policy.

Lack of knowledge about the principles embodied in the policy contribute to a structural driver to contract the new HIV infection due to occupation injury, and not knowing the human rights as a person leaving with HIV infection may also results to the socio-behavioural and structures factors that drive the further spread of HIV infection in and/or outside the workplace. The stigma and discrimination, which serve as a barrier towards the fight of the spread of new HIV infection might be the results of the lack of knowledge of HIV and AIDS policies.

The probability of disclosing HIV status in a workplace was assessed based on disclosure to the colleague, supervisor, EAP and significant others outside the workplace. The study found that disclosure or non-disclosure about HIV status is determined by the created meaning an individual attaches about the perceived world of reality (being HIV positive) after the disclosure. If the outcomes of disclosure are perceived as more meaningful by the one who discloses, the individual person is more likely to disclose about the HIV status than the one who anticipates meaningless outcomes of disclosure.

Half of the participants mentioned that they would prefer to disclose to colleagues because the ability to disclose about one's HIV status to a colleague demonstrates an element of caring by preventing the spread further spread of HIV in case one experiences injury on duty. Disclosure does not only profit the colleague, but it is also of mutual benefit in that the disclosing employee receives the moral support in case of any health related emergency that may be required and that; a better understanding about the psychological impact of disclosure and non-disclosure is also a key on the decision that the person makes.

The other half of the participants perceived disclosure to a colleague negatively based on the presuppositions that an individual HIV status is not a workplace issue, but a personal matter; workplace environment is perceived not to be conducive for one to disclose his/her HIV positive status because of gossips and change of attitude of colleagues towards the person living with HIV positive, which is an indication of lack of confidentiality in a workplace environment.

There was consensus amongst the participants that a good relationship with the supervisor prior disclosure serves as a gate way for disclosing one's HIV status. Some participants pointed out that they would prefer to disclose their HIV status to supervisors if support and understanding is more anticipated. With reference to disclosure to the EAP Professional, the majority of participants asserted that they would prefer to disclose their HIV positive status to the EAP Professional for counselling, advice and emotional support.

Contrary to the findings, since the researcher was the EAP Professional for all the Department of Agriculture local municipalities within Mopani District, from her experience, few of the employees tested HIV positive in those local municipalities came out to seek professional help. It seems as if it is easier to pursue the support systems within the workplace before the actual experience of being HIV infected. Support throughout the process of disclosure is necessary. Few participants emphasised that disclosure to the EAP Professional can be done conditionally. It will be based on assurance of confidentiality and trust established with the EAP Professional.

Another finding is that some participants prefer to test the trustworthiness of the helping professional by narrating wrong information during the initial phase of the sessions. Such kind of behaviour is done in good faith of protecting oneself and to test if the EAP Professional can keep the shared information confidential. Lack of professional discipline by HIV and AIDS coordinators might be a barrier towards disclosure of HIV status that fuels the spread of new HIV infection in a workplace.

There are significant others outside the workplace whom employees would prefer to disclose to about their HIV status. The preferred significant others mentioned by most participants are mainly their partners (wife or husband), children and parent(s), specifically a mother. No person lives in isolation. Everybody interacts with others, and what is of great significance is the view of the interactions with people whom are seen as important and form part of the self ((Rogers 1987). In order to prevent the socio-behavioural and structural core drivers of new HIV infection in the workplace, the significant others of the employees should be considered in any HIV and AIDS intervention programmes that are implemented in a workplace environment.

Positive attitude towards employees living with HIV and AIDS in a workplace was indicated by half of the participants, while the other half see the attitude as bad. Positivity of the attitude was provided in a form of care and support by using state resources, such as vehicles and working hours to visit a sick employee who are hospitalised. Emotional support was displayed through sharing the meal together and in terms of ensuring that they adhere on medication. An estimated half of the participants asserted that employees living with HIV and AIDS suffer the negative attitude displayed towards them by fellow colleagues.

HIV stigma index in South Africa (2014) revealed three types of stigma, identified as external, internal and anticipated stigma. Unconscious or unsymbolised stigma related attitude was found in this study. This is a kind of a stigma that manifests itself in the conversation of a person involuntarily. Unsymbolised stigma was evident when some participants whose responses were against stigmatizing their fellow colleagues living with HIV and AIDS in the workplace uttered statements like:

- employees who are not taking part during awareness campaign are HIV positive
- Those who look fresh, meanwhile they are on ARV treatment, you would not suspect them having HIV. Those that look much fresh are the ones that are HIV positive

- I consider praying beforehand so that he or she can be able to listen to my conversation, because some people who are living with HIV and AIDS cannot listen when you are talking to them.

Rogers' (1987), theoretical proposition 13 explain unsymbolised stigma as that behaviour, in some instances be brought about by organic experiences and needs that have not been symbolised. Such behaviour may be inconsistent with the structure of the self. In such instances, the behaviour is not owned by the individual (Grobler, Schenck & Mbedzi 2013). Employees, peer educators, supervisors as well as HIV and AIDS Coordinators might have been trained in fighting against stigma and discrimination in a workplace, However, it is necessary to identify the unsymbolised stigma that spontaneously manifest either verbally or non-verbally in the process of HIV and AIDS intervention programmes.

Participants suggested strategies and guidelines which can assist in preventing the spread of new HIV infection. It is commonly found that management hardly take part in HIV and AIDS events arranged in a workplace. Leadership role efficiency in prevention of the new HIV infection in a workplace can be reached through management and trade union mobilisation's active involvement throughout the phases of the programme. Some participants in this study opined that HCT should be mandatory not only to pregnant mothers, but also to every South African citizen.

Insufficient service providers who conduct HCT during the workplace HCT campaigns were amongst the challenges identified by the participants. Employees are compelled to wait anxiously for their turn to be tested. Others are able to tolerate such long processes but some are not. For an HCT programme to achieve ultimate goals, availability of sufficient trained staff by relevant stakeholders can improve utilisation of HCT services by both men and women employees in the workplace, which is an entry point for knowing one's HIV status and be linked with the antiretroviral therapy if need be. Thus put the further spread of HIV into a halt.

A call for proactive initiative in engaging men in health promotion programmes such as HCT was raised in this study. One of the priority areas of HCT guidelines is the need to prioritise counselling and testing of individuals, couples and family members of the infected person. HCT interventions in a workplace should holistically consider the inclusion of employees' partners and family members in order to address the social and structural core drivers of new HIV infection in the family of an employee.

The provision of incentives during HCT campaigns is a constructive intervention strategy that yields maximum participation of both males and female employees and ultimately results in a behaviour modification with regard to social and behavioural core drivers of new HIV infection. Self-determination theory (SDT) affirms that certain factors such as rewards for good behaviour (such as HCT) motivate clients to follow health care providers' instructions and sanctions also play a critical role in ensuring that they comply and change behaviour accordingly (Deci & Ryan, 2000). The SDT theory should be pursued in a workplace in order to promote maximum participation relevantly to men who found to be less participating in workplace HCT campaign.

CHAPTER 5: SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.1. INTRODUCTION

This chapter will briefly summarise, conclude and make recommendations pertaining to the study. The presentation of these activities will revolve around the five themes which emerged during the data analysis process.

5.2. SUMMARY

The research problem was formulated on the basis that the South African HIV and AIDS epidemic remains as daunting as ever. Prevention interventions failed to gain traction with between 350,000 and 500,000 new HIV infections occurring annually (Global Health Magazine, 2013). Limpopo Department of Agriculture (LDA) was not exceptional as far as new HIV infection is concerned. Despite the intervention efforts made by Employee Health and Wellness (EHW) section within the Department, HIV Counselling and Testing (HCT) statistics showed that new cases of HIV infections are still occurring. Therefore, the study served as a response on the prevention effort to reduce vulnerability to new HIV infection faced by Limpopo Department of Agriculture employees, by exploring the socio- behavioural and structural core drivers of new HIV infection with the aim of addressing deeply entrenched and long established cultural, socio-economic and behavioural factors (National Strategic Plan for HIV and AIDS, STI and TB 2012-2016).

In order to realise this aim the researcher employed a qualitative research approach, which was best suited to understand, determine and examine the perceptions of employees with regard to the socio-behavioural and structural core drivers of new HIV infection amongst LDA employees and the stigma and discrimination attached on HIV and AIDS. Case study was pursued to generate data directly from the sample of twenty employees purposely and deliberately selected from three municipalities within Mopani District. Face-to-face interviews, aided by an interview guide was preferred by the researcher at the participants' workplaces to explore on socio-behavioural and structural core drivers of new HIV infection as perceived by them.

The existing literature on the socio-behavioural and structural core drivers of new HIV infections and the theoretical framework that guided the study was reviewed and documented. For the purpose of analysing data of this study, the researcher followed the eight steps as proposed by Tesch (in Creswell, 2009), relevant emerging themes were identified and the researcher got more information on socio-behavioural and structural core drivers of new HIV until data became saturated.

The findings were confirmed by the narrative accounts of participants, compared and contracted with the existing body of knowledge. In the opinion of the researcher, the qualitative research approach, design and methodology adhered to provided findings that promoted understanding on socio-behavioural and structural core drivers of HIV infections amongst LDA employees as perceived by them.

5.3. CONCLUSION

In pursuing the aim of the study, which was to explore perceptions of LDA employees on social-behavioural and structural core drivers of HIV infection, the conclusion of the study were drawn from the findings and they are presented based on the following objectives:

5.3.1. THE PERCEPTIONS OF EMPLOYEES WITH REGARD TO THE SOCIO-BEHAVIOURAL CORE DRIVERS OF NEW HIV INFECTIONS AMONGST THEM

Perceptions of employees were understood based on the identified themes that emerged from the findings on the socio-behavioural core drivers of new HIV infections amongst LDA employees. The socio-behavioural core drivers of new HIV infection brought to the forth were: Multiple sexual partnerships (MSPs), Intergenerational relationships or Age-disparate and substance abuse in a workplace environment.

5.3.1.1. Multiple sexual partnerships (MSPs)

MSPs have been viewed by all participants, except one young man, as a socio-behavioural driver of new HIV infection among LDA employees because of its circular pathway of sexual interdependency amongst the employees who are members of the sexual network systems. It is characterised by an element of “secrecy”. Married women were considered as victims of MSPs, in a sense that they tend to trust their husbands and loosen measures of exercising protection during sexual intercourse. This study didn’t explore much on MSPs with single women, of which the researcher acknowledges it as a weakness of the study.

On the basis of the information provided, the researcher concluded that MSPs is a closed sexual network system, autonomous, not dependent on input and information from outside as it is characterised by “secrecy” on the one side of the coin and “trust” on the other side of the same coin. In this kind of sexual relationships safe sex practice is rarely discussed, which place some party members vulnerable to contract HIV infection or give others a platform to spread the HI virus.

Some female participants and one male participant mentioned that men are seduced by some female employees and their clients in a workplace. Culturally, it is discouraged that a woman proposes love from a man. Women are freed from being the passive member in the initiation of a relationship according to Marxist Feminist theory. It is based on this theory that the researcher concluded that women who demonstrate the ability for sexual initiative and advancement of erotic relationship, demonstrate assertiveness, autonomy and courage. These are amongst the essential qualities that enabled a woman to negotiate practising safe sex, which place both of them in a less risky situation of either contracting or spreading the HI virus.

Few female participants stated that MSPs is being observed from some employees whom are being sent away from home to attend meetings, workshops or trainings. Some employees whom are regarded as dignified and loyal to their families choose to engage in sexual activities during or after official working hours in their offices. The used condoms that are usually spotted around the workplace premises were evidence to the allegations.

Based on the described presuppositions, the researcher concluded that MSPs is practised by some employees in a workplace setting and within the scope of work. Some of them do condomise as proven by the used condoms, but that does not rule out the fact that there might be others who are not practising safe sex. The researcher concluded that all employees, regardless of social status, educational background, religious affiliation and other attributes, are eligible to contract or spread HIV infection in a workplace environment.

5.3.1.2. Inter-generational or Age-disparate relationships

Desperation for career advancement into higher positions, job opportunities and material gain were found to be the precipitating factors for young men and women to engage in age-disparate relationships, a risky behaviour that fuels the spread of HIV infection in amongst employees. Interns, on internship programmes were the most victims of inter-generational relationships in the workplace environment. The so called “sugar mummies; sugar daddies”, “blesser-blessee” and the “Ben 10s” (after the TV cartoon character) are social phenomena adopted by the society to normalise and promote inter-generational relationships which drivers of new HIV infection amongst employees. The risk with inter-generational behaviour is that the sexual relationship pattern cut across all age categories in a workplace.

It is thus concluded that young women and men entered into age-disparate relationship with older employees who has an age gap of five years and above with an intention of obtaining permanent employment in return. Therefore, unemployment, which is also in a structural form and limited opportunities for career advancement fuel the spread of HIV amongst employees.

5.3.1.3. Substance abuse

Substance abuse has been regarded as one of the socio-behavioural core drivers of the spread of new HIV amongst LDA employees by the majority of the participants. Consumption of alcohol and subsequent engagement in voluptuous relationship particularly by some young employees has been observed during departmental events like extension officers’ conference, farmers’ awards and end of year party. Young women employees were perceived to be victims of sexual abuse by some female participants, thus remain vulnerable to contract new HIV infection. Few participants from the last age category were of Shakespeare’ idea, that alcohol arouses sexual desire but take away performance.

In this instance, it is concluded that both young employees are active partners who entered into a mutual understanding that eventually resulted in sexual interaction. The ability to make decisions to attend the events and to consume alcohol with specific fellow employees demonstrated a sense of autonomy and self-determination. To consume alcohol during departmental functions and/or in an area declared as a workplace, more especially in the event wherein such employees buy the alcohol for themselves and the conduct is seen as an employer's less concern behaviour, however, it constitutes a misconduct in terms of the ILO Code of Good Practice on the management of alcohol and drug related issues in the workplace (ILO 2005). It also seems as if there is no management of substance abuse policy in place, and if any; its implementation is inadequately enforced. On the basis of the information provided, the study's first objective is fully attained.

5.3.2. PERCEPTIONS OF EMPLOYEES WITH REGARD TO THE STRUCTURAL CORE DRIVERS OF NEW HIV INFECTIONS AMONGST EMPLOYEES

The researcher derived her conclusions from the study's findings emerged as sub-themes of structural core drivers of new HIV infection amongst LDA employees. Employees' perceptions were determined from the following structural sub-themes: culture manifested in a form of norms and values, gender-based violence and polygyny; organisational restructuring; work design and gender equality.

5.3.2.1. Societal norms and values

Societies are perceived as being structured according to different echelons of meanings, which include patterns of cultural norms and values, myths, religion and beliefs strata. Some working women who have been raised and socialised from the patriarchal family system, still uphold the patriarchal norms and values that determine the power relationships by which men dominate; oppress and exploit women, and women are kept subordinate in a sense that they adhere to the culture of "silence" as mentioned under MSPs (cf. page 118-121), to an extent that issues of HIV and AIDS or negotiating safe sex are not discussed in such a relationships.

The primary role of socialization by parents and guardian during child and teen hood upbringing was mostly valued by most participants as having impacted their latter lives positively. The above findings led to the conclusion that despite some reforms purporting to improve women's status, there are the remnants of patriarchal domination with the interlinked forces of traditional norms and values instilled during primary socialisation which; some women found them fit well with their self-structure regardless its negative effect on the spread of HIV infection. Societal norms and values learned at an early life-phase critically shape the individual employee's behaviour either constructively or destructively in general and to the sexual behaviour specifically in later life. Explicitly, some societal norms and values have a contributory role in preventing the spread of new HIV infection while others elevate the spread of new HIV infection.

5.3.2.2. Gender-based violence

In a sexual relationship that is characterised by gender based violence, most women experience difficulty in introducing condom and are being treated as sex commodity by their partners. There is a relationship between violence behaviour on women and HIV infection. This relationship operates through a variety of direct and indirect mechanisms, for example; a fear of violence may keep women from insisting on condom use by a male partner. Some studies found that economically empowered women are in positions to protect themselves by insisting the use of condom as they are less economically dependent on men. Contrarily to the findings, some women participants reiterated that they cannot stand a risk of losing their partners over the battle of practising safe sex.

In conclusion, certain working class women are still subjected to various forms of gender-based violence. As they hopelessly participate in a condom free sexual engagement, metaphorically, those women are assisting to keep a window opened for HI virus to gain an entrance in the relationship. The use of a condom is one of the primary preventions of the spread of HIV infection. Engagement in an erotic relationship should be perceived as a mutual responsibility by both partners, as ascertained by young male participant that some young women refuse to practise safe sex with intention of conceiving child by a man who is employed as a licence to access cash transfer through maintenance orders.

5.3.2.3. Polygyny

This is another form of customary marriage whereby some men marry more than one wife. The existing body of knowledge and the findings of this study affirmed that traditionally it is accepted that men like a “melon seed have to spread” by having more than one woman as a way of celebrating their masculinity. Se-Tswana idiom maintains that a man is like a bull and should not be confined to one pasture. Majority of the participants, disapprove the practice of polygyny as it is viewed as a core driver of the spread of HIV infection in the polygynous network system. It is also regarded as no longer classic to marry more than one wife at this era of HIV and AIDS. Certain studies found a negative ecological relationship between polygyny and HIV prevalence. It is elaborated further that polygyny creates small isolates of concurrent partnerships in which the virus is trapped until one or more of the (infected) spouses start a new relationship.

The researcher concluded that polygyny has gained impetus in South Africa since prominent figures, who have potential influence in the nation practise the culture of polygyny. This form of marriage is envisaged by young women in a workplace due to the economic value attached on it as compared to other forms of marriages. It is one of the cash transfers and safety net through which young people found capital security and escape the reality of poverty and unemployment faced by the some of South African youth.

Further conclusion made was based on idea that when polygyny creates small isolates of concurrent partnerships in which the virus is trapped, more women versus one man found themselves trapped in and remain vulnerable to contract HIV infection. Hence, the validation those women are more vulnerable to contract HIV infection than men.

5.3.2.4. Organisational restructuring

Post-apartheid restructuring system of public service through redeployment has resulted in some of the employees to involuntarily relocate from their former workplaces, leave their families and regular sexual partners behind. The psychosocial effects experienced due to relocation, the allocated dilapidated residential communal houses, the building of unauthorised shacks in the departmental residential premises and the lack of policy that regulates on those departmental residential houses are all described by some participants as structural challenges that contributed to the spread of new HIV infection amongst the employees.

The researcher therefore, draws into a conclusion that there are still structural pillars of the apartheid economy that continue to batter the current neoliberal agenda of the current government which aimed at increasing a healthy and long life for all South African citizens by creating a health and safety working environment that prevent the spread of new HIV infections. James Wilson and George Kelling's metaphor of "broken windows theory" proposed by James Wilson fitted well in this structural driver since when a broken window is left unrepaired, people walking by will conclude that no one cares and no one is in charge. If there is no policy that regulates the departmental residential area there is the probability that non authorised people will keep on invading the area in one way or another as no one cares about such a conduct. It is further concluded that people who are lonely tend to be linked to others who are lonely, an effect that is stronger for geographically proximal than distant relationship.

5.3.2.5. Work design

Most participants indicated that employees who are performing technical duties such as extension officers, animal health scientists and crop production scientists are at risk of contracting HIV while online of duty. Young male participants view themselves as exposed to seductive behaviour demonstrated by their clients (young women farmers) who are looking for favours in respect to the service offered, and with reference to favours on being selected for winning wards like, young farmer and female awards. This behaviour has been viewed as another state of corruption in a workplace, which one of the structure issue in South Africa which indirectly is said to be more visible in the tendering industry whereby women who are in the industry are engaged in sexual relationship with an intention of being awarded a tender.

Insufficient supervision of field workers provided autonomy to some technical employees at the fields to remain independent and some abuse the independency by being promiscuous and spent working hours consuming alcohol in shebeens. Few participants stated that there is a need for self-determination and responsibility over one's action that can results in the spread or contraction of new HIV infection while online of duty. Autonomous motivation according to self-determination theory asserted that when people are autonomously motivated, they experience preference; or a self-endorsement of their actions.

The researcher has concluded that there are some employees who are self-motivated to have identified with an activity's value and ideally integrated it into their sense of self. There are some employees who cannot do on their own, but need an external regulator to motivate the desired outcomes, which is the accepted behaviour that can prevent one from contracting or spreading the new HIV infections in amongst LDA employees.

5.3.2.6. Gender equality

Despite the progress made in the implementation of the Beijing Declaration Platform⁴ (1995) in respect of gender equality, the majority of participants attested that economic inequalities, in a form of women occupied lower positions is a reality in LDA and that remains a structural core driver of the spread of HI virus since some women subject themselves for sexual exploitation by their bosses due to desperation for promotion to higher positions. Another perception raised in this study is that some women who are economically sustained and hold the managerial positions have made it through engaging in sexual affairs with their bosses. It is noted that authorities have a way of manipulating the recruitment and selection system in favour of their own interest.

The researcher concludes that this is another form of workplace sexual harassment, similar to what was found in the study conducted in Bangladesh wherein many women workers were thrown out of their job when they were not willing to give in to the demands of their bosses. The implementation of Gender Equity Act in addressing the economic disparities between men and women is accompanied by the subjection of some women into sexual exploitation by the dominant male authority in a workplace, which; expose both employees at a risk of contracting HIV infection.

In agreement with Dalia Ben-Galim, associate director of the IPPR (The Guardian 2013, 31 March), it is further concluded that many advances for women at the top have masked inequality at the bottom. Some women occupying lower ranks are vulnerable for sexual exploitation in a workplace. This kind of workplace sexual conduct is less or not reported at all as it has an element of consensual agreement and stigma. The more the conduct is kept secret, the more it is likely to repeat itself, possibly with different victims, which lead to rampant spread of new HIV infection.

5.3.3. PERCEPTIONS OF EMPLOYEES IN TERMS OF STIGMA AND DISCRIMINATION DUE TO HIV INFECTION AT THE WORKPLACE

The participants' perceptions were examined based on the probability of disclosing their HIV positive status to a colleague, supervisor, EAP Professional and significant others outside the workplace environment.

5.3.3.1. Disclosure to a colleague

Half of the participants mentioned that they would prefer to disclose to colleagues, while the other half would not prefer to disclose. The first group would do so because they would like to protect colleagues in case they assist during injury on duty, expect moral support in case of any health related emergency and to relieve stress by disclosing the status. The other group of participants would choose not to disclose based on the presuppositions that HIV status is not a workplace issue, but a personal matter; gossips and change of attitude followed the disclosure.

Those perceptions have led to conclude that disclosure or non-disclosure about one's HIV positive status is determined by the created meaning an individual attaches about the perceived world of reality (being HIV positive) after the disclosure. If the outcomes of disclosure are perceived as more meaningful by the one who discloses, the individual person is more likely to disclose about the HIV status than the one who anticipates meaningless outcomes of disclosure.

5.3.3.2. Disclosure to a supervisor

There was a general consensus by all participants that good relationship with the supervisor prior disclosure is a basis for one to disclose HIV status. Majority of participants pointed out that they would prefer to disclose their HIV status to their

supervisors if support and understanding is more anticipated. Few participants emphasised that they will neither disclose nor allow them to visit them at the hospital. It is concluded that a perceived positive relationship between supervisors and subordinates paves an environment of trust, acceptance and support latter when each of them is experiencing psychosocial and physical challenges.

5.3.3.3. Disclosure to EAP Professional

Some of the participants asserted that they would prefer to disclose their HIV status to EAP Professional for counselling, advice and emotional support. Few male participants emphasised that disclosure to the EAP Professional can be done on conditions based on surety of confidentiality and trust established with the EAP Professional; while some insisted that one's HIV status remains personal. Some prefer to test the trustworthiness of the EAP Professional by providing wrong identical information to professional nurses during HCT. Such kind of behaviour is done in good faith of protecting him/herself and to test if the health and social professionals can able to keep the shared information in confidence.

Employees have confidence to seek help from the EAP Professional who demonstrate professional values in a workplace. Lack of trust and poor rapport between an employee and the EAP Professionals and health practitioners may results in poor relationship, accompanied by wrong information that will lead to wrong intervention in addressing HIV stigma and discrimination in a workplace.

5.3.3.4. Disclosure to significant others

There are significant others outside the workplace whom employees would prefer to disclose to about their HIV status. The preferred significant others mentioned by most participants are mainly their partners (wife or husband), children and parent(s), specifically a mother. It is therefore concluded that if an employee is not intending to disclose to anyone in a workplace does not imply that he/she see no value for disclosing, but preference would be given to some significant people whom are most valued.

5.3.3.5. Attitude towards employees living with HIV

Positive attitude displayed towards employees living with HIV and AIDS in a workplace was indicated by half of the participants, while the other half described the attitude as bad. HIV and AIDS stigma index conducted in South Africa revealed three types of stigma, identified as external, internal and anticipated stigma. This study found another form of stigma referred to as “unconscious” or “unsymbolised” stigma related attitude, named from Carl Rogers’s thirteenth propositions which maintains: “Behaviour may, in some instances, be brought about by organic experiences that have not been symbolised. Such behaviour may be inconsistent with the structure of the self, but such instances, the behaviour is not owned by the individual”. This kind of a stigma manifests itself involuntarily in the speech of a person who is convinced that he or she is against stigmatising and discriminating colleagues based on their HIV positive status.

Based on the exposition of findings above, the researcher concluded that the attitude displayed by other employees towards fellow employees living with HIV serves as a yard stick of determining as whether it will be safe or not, to disclose in a workplace. Employees who perceive the working environment as non-judgemental and non-discriminatory, trustworthy and supportive are more likely to feel comfortable to disclose about their HIV status. Unsymbolised stigma may be a threat towards the elimination of the spread of new HIV infections amongst employees as it operates unconsciously by employees and probably by HIV and AIDS programme coordinators and implementers such as health practitioners, peer educators, EAP practitioners and other professionals who qualified and well trained in the field of stigma and discrimination.

5.3.4. DEVELOP PRACTICE GUIDELINES ON THE PREVENTION PROGRAMMES OF NEW HIV INFECTIONS IN A WORKPLACE.

The suggested guidelines for implementation of prevention programmes on the spread of new HIV in a workplace are provided.

5.3.4.1. Departmental strategy should be responsive to HIV and AIDS epidemic

HIV and AIDS programme is considered as a support function to the core business of various departments, hence in the organisational structure the programme is mostly placed under Human Resource Management. Priority in terms of allocation of resources, including human resource is given to the core functions of the department. As a result, the effective and efficient implementation of HIV and AIDS programme in terms of the National Strategic Plan on HIV and AIDS, STIs AND TB is being compromised and foremost, the health and well-being of the employees is also flouted. In LDA, HIV and AIDS programme is coordinated at head office and district level. Twenty-five municipality offices and their respective service centres do not have HIV and AIDS Coordinators. This kind of structural arrangements resulted in inadequate delivery of health promotion programmes to employees who constitute the majority of the staff establishment of the department.

The success of intervention programmes to address socio-behavioural and structural core drivers of new HIV infection in a workplace depends on the availability of adequate human capacity, sufficient budget and capital resources. There is a need for reframing the perception of HIV and AIDS programme as an isolated programme that functions independently from other core mandates of the department.

5.3.4.2. Integrated departmental induction strategy should be in place

A proactive response on socio-behavioural core drivers of new HIV infection to any new employee in a workplace invite for an induction on HIV and AIDS beforehand to determine the potential value and risk attached to the envisaged sexual behaviour. Therefore, as a mitigating strategy for further spread of new HIV infection in a workplace, HIV and AIDS programme should be integrated in the departmental induction programme and implementation must be ensured and enforced by all relevant stakeholders within the department.

5.3.4.3. Establish a linkage strategy of graduate Interns with job opportunities

Alternative strategies to economic emancipation of young men and women who have finished their internship programmes by linking them with public works extended programmes and other formal job opportunities can serve as a basis for preventing vulnerability towards the socio-behavioural and structural core drivers of new HIV infections to this age category.

5.3.4.4. Management authorities should play a leadership role

Senior management hardly take part in HIV and AIDS events such as HCT and awareness campaigns arranged onsite. Leadership testing on HIV by the President of South Africa has found to have yielded maximum participation during HCT campaign in 2010. Leadership efficiency in preventing the spread of new infection in a workplace can be reached through management and trade union mobilisation's active involvement in the programme.

5.3.4.5. HCT strategy should be developed

Some male and female participants suggested that HCT should be mandatory to all South African citizens for statistical purposes as it is done to pregnant women. Intolerance for male employees to wait for a long time, queuing to be tested makes them to end up not testing for HIV. On the basis of this suggested strategy, the researcher concludes that employees are no longer in tolerance of some of the human rights applicable to HIV testing. To be kept waiting on a queue for one's turn to be tested might raise the level of anxiety in the event of wondering about the outcome of the results. Insufficient provision of professional nurse and trained health workers to provide HCT necessitate such long queues for HCT, which is a potential barrier for maximum participation on HCT and towards reaching a considerable number of male employees. One of the priority areas of HCT guidelines is the need to prioritize counselling and testing of couples and testing of family members of the infected person. HCT in a workplace is only offered to an individual employee, which sometimes the intervention becomes ineffective if the partners do not know their HIV status. The provision of incentives to those participated in HCT campaign is a constructive intervention strategy previously yielded maximum participation by both males and female employees.

5.3.4.6. Employees should be empowered on self-efficacy

Self-efficacy refers to perceived capabilities for learning or performing actions at designated levels. Some of the participants articulate the importance of self –efficacy in making right choices about one's own life. Self-efficacy plays a role in self-regulation of motivation and actions. A dialogue that seeks to promote responsibility for knowing HIV status, knowing partners' status, preventing HIV new and secondary infection as well was facilitated to bring together various national stakeholders in the introduction of the theme: "I am responsible...We are responsible...South African is

taking responsibility (SANAC 2010:10). Some of the participants emphasized the importance of knowing oneself. It is asserted that if you know yourself much better there is no one who can be persuaded to commit an act that is against your will.

5.3.4.7. Provision of psychotherapy prior HCT

Besides the coordinating role of HCT in the workplace, Employee Health and Wellness Coordinators have a crucial role of providing counselling or therapeutic sessions as part of psychosocial therapy intervention. Most of those EHW coordinators are professionals who have registered with the recognised statutory bodies in South Africa. They are trained in counselling and some have specialised within the field of psychosocial and mental health therapy. The anxiety and other psychosocial stressors that hinder some young employees and others to test for HIV status should be addressed in advance through the wellness management programme. A workplace proactive response that will facilitate and enhance maximum participation in HCT is recommended.

5.3.4.8. Men's forum should be establishment and/or strengthened in a workplace

It is commonly believed that men are more comfortable to share deep matters that affect them in a forum that consists male only. Men forum may serve as a platform to reach out men on health related matters and other psychosocial matters that affect them. HIV and AIDS with the attached issues such as HCT could be introduced in the forum's agenda.

5.3.4.9. Disclosure within the workplace

Disclosure or non-disclosure of one's HIV status is determined by the created meaning an individual attaches about the perceived world of reality (being HIV positive) after the disclosure. If the anticipated outcomes of disclosure are perceived as more meaningful by the one who discloses, the individual person is more likely to disclose about the HIV status than the one who anticipates meaningless outcomes of disclosure. A supportive working environment should be created wherein employees feel more comfortable and safe to disclose their HIV status. The following practice guidelines were made in regard to disclosure to the supervisor, EAP Professional and the significant others:

- **Supervisor**

Disclosure to the supervisor depends on the nature of the relationship that an employee has with the supervisor. If the relationship is perceived as good, an employee is more likely to disclose than the one who perceive it as bad. Empowerment programme on disclosure is recommended. Further recommendations are made on the implementation of organisational wellness programmes in a workplace as per DPSA Employee Health and Wellness framework in public service.

- **EAP Professional**

Employees have confidence to seek help from the EAP Professional who demonstrates professional values in a workplace. Lack of trust and poor rapport between an employee and the EAP Professional may produce poor relationship characterised by distorted information by employees that results in an inaccurate intervention. Two principles that are corner stone of Employee Health and Wellness

services are confidentiality and voluntarism. There are ethical principles that govern different helping professions such as respect, self-determination, non-discrimination and others that should be upheld at all times.

- **Significant others**

If an employee is not intending to disclose the HIV status to anyone in a workplace, it does not imply that he/she see no value for disclosing, but preference would be given to some people who are significant in the life of the employee. In order to prevent the socio-behavioural and structural core drivers of new HIV infection in the workplace, HIV and AIDS intervention strategies should also be extended to accommodate immediate family members of employees. The significant others play a major role of providing the department an opportunity to reach out for after care support in case the individual employee is on ill-health leave.

5.3.4.10. Programmes to deal with stigma and discrimination

Stigma and discrimination displayed by some employees towards a fellow employee who is living with HIV serves as a baseline on whether is it safe or not to disclose in a workplace. Addition to the three identified stigmas by the Stigma Index in South Africa, this study found another form of stigma referred to as “unconscious” or “unsymbolised” stigma related attitude which led to the conclusion that such kind of a stigma may be common in a workplace, of which; HIV and AIDS programme implementers such as health practitioners, peer educators, EAP practitioners and other professionals are not exceptional.

One of the most characteristic and perhaps one of the most important challenges in intervention is the bringing into awareness the experiences and perceptions which people have not been conscious of. Unsymbolised stigma must be brought to the attention of all employees and HIV and AIDS coordinators. This kind of stigma inherently possess thought provoking element of self-introspection that can probably results in reframing, reconstructing one’s perspective about workplace HIV and AIDS

stigma. Carl Rogers asserts that psychological adjustment or reconstruction of the self exists when people become aware of all their experiences, made decisions whether they should maintain or change their selves.

5.3.4.11. Recognise HCT and its human rights dimension

On the basis of the findings on HCT presented in theme 5 of this study, the researcher extracted the following as sub-guidelines:

- With reference to the conclusion that employees are no longer in tolerance of some of the human rights applicable to HIV testing like voluntary testing, of which made a call for involuntary counselling, HIV and AIDS implementers should ensure that no employee of the department is compelled to take HIV test unless consented, and unless the Labour Court declared such testing as justifiable in terms of Employment Equity Act, No 55 of 1998. However, dialogues and discussions on such a topic is encouraged in a workplace.
- HCT in a workplace is only offered to an individual employee, which sometimes the intervention becomes ineffective if the partner does not know his/her HIV status. One of the priority areas of HCT guidelines is the need to prioritize counselling and testing of couples and testing of family members of the infected person. Therefore, there is a need for workplace holistic HCT programme that also integrate family members.
- Insufficient provision of professional nurse and trained health workers to provide HCT is one of the causes for employees to wait long queues for their turn to partake in HCT, which becomes a barrier towards reaching greater number of male employees on HCT. Sufficient deployment of trained health workers by relevant stakeholders should be pursued to speed up HCT processes.
- The provision of incentives to those participated in HCT campaign is a constructive intervention strategy previously yielded maximum participation by both males and female employees. Based on the conclusion that the

withdrawal of incentives used to encourage HIV testing material has led to sub-minimal participation, mainly by male employees, the researcher recommend that a budget for HIV and AIDS programme promotion is essential for the attainment of the goals and objectives set by National Strategic Plan on HIV, AIDS, STs and TB responsive in the country.

5.3.4.12. Decentralisation of HIV and AIDS programmes

HIV and AIDS programmes should be decentralised and be coordinated at least up to the Local Municipalities level in order to effectively and efficiently prevent the spread of new infections amongst LDA employees.

5.4. RECOMMENDATIONS

The following are the recommendations made based on the concluded findings on the four objectives of the study.

5.4.1. Workplace dialogue on MSPs

A dialogue engaging employees on MSPs topics such as “MSPs as a closed sexual network system”, or “secrecy” versus “trust” in MSPs sexual network system where employees can able to share their views, interrogate the norms and values associated with MSP and reflect back on their behaviours.

5.4.2. Women empowerment

The researcher arrived at the recommendations that working women still require empowerment in number of areas of their social functioning outlined as follows:

- They should be encouraged to express their feelings and their thoughts with regard to sex issues that affect them.

- Any effort that attempt to alter women' sexual behaviour should pay attention on the norms and values that may seem to put them or others at risk of contracting HIV infections.
- Women should also support each other throughout in order to create a strong voice against gender based violence that dehumanizes a dignity of a woman, perpetuate the spread of HIV infection.
- Financial life skill should be pursued to address transactional sex behaviour in a workplace
- Employment equity forum and other stakeholders should form part of recruitment and selection to monitor corruption and ensure that EEA is correctly implemented.
- It is further recommended that the remnants of patriarchal domination with the interlinked forces of traditional norms and values instilled during primary socialisation which has a negative impact on the spread of HIV infection should be challenged.

5.4.3. Continuous promotion of condom use

The researcher concluded that all employees, regardless of social status, educational background, religious affiliation and other attributes, are eligible to contract or spread HIV infection in a workplace environment. In the light of this conclusion, the researcher recommends the continuous promotion of the condom use as well as condom use demonstration in all HIV and AIDS related programmes and during mainstreaming of HIV and AIDS activities in the core business of the department.

5.4.4. Marriage enrichment programmes

Polygyny has been concluded as another form of marriage which is gaining momentum to some African men and women since prominent figures in South Africa, who have potential influence in the nation practise polygyny. Young women in a workplace may envisage entering into a polygynous marriage due to the value attached to this kind of marriage as compared to other forms of marriage. Marriage

enrichment programme in a workplace is recommended to engage young women and men in open discussions on marriage matters in order to make informed decisions in relation to the envisaged marriages.

5.4.5. A decent departmental family units houses

The researcher recommends for the eradication of the dilapidated departmental/government houses that are the remnants of structural pillars of the apartheid economy and replace them with the decent houses that will be able to accommodate immediate family members in order to minimise a risk of contracting and spreading the HI virus.

5.4.6. Effective Implementation of Employment Equity Act, 1998 (Act No 55 of 1998 as amended)

EEA should be appropriately implemented in accordance to the prescripts. Employment equity forum should monitor the implementation of the Act. All service beneficiaries and relevant stakeholders should be consulted and entitled for feedback as contemplated by the Employment Equity Regulations (2014). Employees should be conversant about the Employment Equity Policy of the department.

5.4.7. Workplace policies

With reference to the findings and conclusions made about the departmental housing structures, the consumption of alcohol during the departmental events and sexual exploitation in a workplace, the researcher recommends that the following workplace policies be developed, popularised, implemented and monitored.

- **A departmental housing policy**

A clear policy that provides all the housing rules that shall governs the occupants. The monitoring system of the policy must be in place in order to ensure compliance on the policy. Residents should be familiar with the policy in order to identify their roles and responsibilities in respect to the given policy.

- **Substance abuse policy**

The employer should have a workplace policy in place, that has been communicated to all employees, regulating the consumption of alcohol on workplace premises, and also off premises, where it might have impact adversely on the employer, the employees, or the employee's ability to perform his/her duties as constituted he development and implementation of the substance abuse policy in accordance to ILO

- **Workplace sexual harassment policy**

Women occupying lower ranks are the victims of sexual exploitation in a workplace. This sexual conduct is less or not reported at all as it has an element of consensual agreement. The more the conduct is kept on silence, the more it is likely to occur, possibly with different women, which results in high probability of spreading and contracting the HIV infection. It is affirmed that in Bangladesh sexual harassment at the workplace is another form of sexual exploitation wherein many women workers are thrown out of their job when they are not willing to give in to the demands of their bosses. A workplace sexual harassment policy should be developed and popularized.

5.4.8. Leadership involvement

Leadership efficiency in preventing the spread of new infection in a workplace can be reached through management and trade union mobilisation's active involvement in the programme. An establishment of HIV and AIDS committee that consists of all

relevant stakeholders and SMS members is recommended as per Chapter 4, Section 55 (6)(d) of Public Service Regulation, 2016.

5.4.9. A mainstreamed Departmental Strategic response on HIV and AIDS epidemic

A mainstreamed HIV and AIDS programmes into the core mandate of the department is crucial for employees to access appropriate HIV and AIDS services as stipulated also in Chapter 4, Section 55 (1) of Public Service Regulation, 2016.

5.5. Recommendations for further research

The conclusions arrived at in this study presented avenues for future research. The following recommendations for further research are proffered:

- This study has explored and described the socio-behavioural and structural core drivers of new HIV infection as perceived by employees at Department of Agriculture in Mopani district within Limpopo Province. The results of the study cannot be generalised to other contexts and settings. In view of this it is recommended that similar qualitative studies should be conducted in other workplace contexts in order to generate broader and more comprehensive workplace response on the prevention of socio-behavioural and structural core drivers of HIV infection amongst the public servants.
- Assumptions on males not testing HIV status regularly and the underlying reasons were made. An in-depth qualitative research to explore on this area would add a great value in workplace response on HCT services.

- The study has explored much the socio-behavioural core drivers of new HIV infection on women in marriage, a research on the same topic that focus on single women is recommended.
- More research on stigma and discrimination is critical until the workplace is declared a non-discriminatory environment in regard to HIV and AIDS.

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ANNEXURE A: SEMI-STRUCTURED INTERVIEW GUIDE

Title: An exploratory study on socio-behavioural and structural core drivers of new HIV infection as perceived by employees at Department of Agriculture in Mopani District within Limpopo Province

1. Biographical Information

Each participant will be asked to provide the following information:

- Gender, Age, Workplace, nature of work, period of time on that specific job.

2. Knowledge on HIV and AIDS

- 2.1. Tell me what you know about HIV infection.
- 2.2. Do you know your HIV status? If yes, when have you last tested?
- 2.3. Can you share about the significance of testing for HIV?

3. Socio-behavioural Core Drivers

- 3.1. Which factors contribute to the spread of HIV amongst LDA employees
- 3.2. What role does gender has in spreading of HIV amongst LDA employees.
- 3.3. Is there any way that female employees in LDA can be vulnerable to contract new infection?
- 3.4. Is there any way that male employees in LDA can be vulnerable to contract new infection?
- 3.5. What are the risk factors that can lead female employee to contract HIV infection?
- 3.6. What are the risk factors that can lead male employee to contract HIV infection?
- 3.7. What is your opinion about having multiple partners?
- 3.6. Is having multiple partners has any impact in increasing HIV infection? Please substantiate your answer.
- 3.7. What do you think about substance abuse and HIV infection?
- 3.8. What is your perception in regard to the life style of LDA employees in general?
- 3.9. What strategies do you suggest can be put in place to prevent the new HIV infection in LDA employees?

4. Structural Core Drivers

- 4.1. Do your employer's policies contribute in any way to its employees' vulnerability to contract HIV infection?
- 4.2. Does your job predispose you to HIV infection? If yes, motivate.
- 4.3. How gender inequality in LDA can contribute in the spread of new HIV infection?

- 4.4. What is your employer doing to address new HIV infection within the workplace?
- 4.5. What could your employer do differently to address new HIV infection in the workplace?

5. Stigma and discrimination

- 5.1. Would you disclose an HIV status to your colleague? Please motivate your answer.
- 5.2. Would you disclose your HIV status to your supervisor? Please motivate your answer.
- 5.3. Would you disclose your HIV status to the EAP Professional? Please motivate your answer.
- 5.4. How will you respond to a colleague when disclosing his/her HIV positive status to you?
- 5.5. How should colleagues behave towards a fellow colleague who has disclosed the HIV positive status?
- 5.6. How are the attitudes of employees in your department towards an HIV positive colleague?
- 5.7. How best can stigma and discrimination be addressed in your workplace?

ANNEXURE B: VUHUNDZULUXERI BYA XITSONGA BYA NKANERISANO

Nhloko mhaka: Vulavisisi byo enta hi matikhomelo na vulawuri bya milawu ya le ntirhweni leyi yi nga van a ka xiphemu xo engetelela ku tluletana hi xitsongwa-tsongwana xa HIV eka vatirhi va ndzawulo ya swa vurimi va xifundza xa Mopani eka xifundza-nkulu xa Limpopo.

1. Matimu ya vangheleleri

Mungheleri un'wana na un'wana u ta vutisiwa swivutiso leswi landzelaka:

Rimbewu, malembe, laha u tirhaka kona, muxaka wa ntirho, malembe eka ntirho wolowo.

2. Vutivi hi xitsongwa-tsongwana xa HIV na AIDS

- 2.1. Unga ndzi byela ku ri u tiva yini hi vuvabyi bya xitsongwa-tsongwana xa HIV?.
- 2.2. Xana u tiva xiyimo xa wena mayelana na vuvabyi bya HIV? Loko yi ri “Ina”, Xana u kamberisile rini ro hetelela?
- 2.3. Xana unga kota ku byela va n’wana hi nkoka wa ku hlahluvisa vuvabyi bya HIV?

3. Matikhomelo lawa ya nyanyisaka ku andza ka xitsongwa-tsongwana xa HIV

- 3.1. Hi wihi nhlohletelo lowu endlanga kuri vuvabyi bya HIV byi andza eka vatirdhi v aka Murimisi?
- 3.2. Xana rimbewu rona ri na nhlohletelo wihi eka ku andzisa vuvabyi bya xitsongwa-tsongwana xa HIV eka vatirhi v aka ndzawulo ya vurimi?
- 3.3. Xana kun a ndlela leyi vatirhi va xinuna va ndzawulo ya vurimi va nga kumaka hi yona vuvaby bya xitsongwa-tsongwana xa HIV?
- 3.4. Hi tihi timhangu leti nga endlaka kuri vatirhi vaxisati va le ka ndzawulo ya vurimi va tluleriwa hi vuvabyi bya xitsongwa-tsongwana xa HIV?
- 3.5. Xana ku van a vuxaka bya masangu na vanhu vo tala swi nga va swi nyanyisa ku andza ka vuvabyi bya xitsongwa-tsongwana xa HIV? Seketela mavonela ya wena.
- 4.6. Xana u hleketa yini hi xitsongwa-tsongwana xa HIV na ku va xilovekelo xa byalwa?
- 4.7. Xana mavonelo ya wena hi wahi mayelana na matikhomelo ya vatirhi va ndzawulo ya vurimi?
- 4.8. Hi tihi tindlela leti leti mi vonaka onge ti nga tirhisiwa ku sivela ku tlulela ka vuvabyi bya xitsongwa-tsongwana xa HIV?

5. Vumbiwa bya matirhelo leby byi nga andzisaka vuvabyi bya xitsongwa-tsongwana xa HIV

- 5.1. Xana milawu ya vulawuri ya muthori ku va nga van a ndlela leyi yi nga anddzisaka vuvabyi bya HIV?
- 5.2. Xana ntirho wa wena wu nga ku veka ekhombyeni r ova u tlulela hi vuvabyi bya xitsongwa-tsongwana xa HIV?
- 5.3. Swi nga endlekisa ku yini ku ku pfumala ku ringana eka rimbewu eka ndzawulo ya vurimi swi nyanyisa ku endza ka xitsongwa-tsongwana xa HIV?
- 5.4. Xana muthori wa wena u endla yini ku sivela ku andza ka xitsongwa-tsongwana xa HIV eka vatirhi va Ndzawulo?
- 5.5. Hi wahi magoza lawa mathori a nga ma endlaka ku sivela ku tlulela ka xitsongwa-tsongwana entirhweni?

6. Xihlawu-hlawu hikwalaho ka vuvabyi bya xitsongwa-tsongwana emitirhweni

- 6.1. Xana u nga paluxa xiyimo xa wena xo van a xitsongwa-tsongwana xa HIV eka mutirhi kulobye? Seketela nhlamulo ya wena.
- 6.2. Xana u nga paluxa xiyimo xa wena xo van a xitsongwa-tsongwana eka mupfuni wa wena entirhweni. Seketela nhlamulo ya wena.
- 6.3. Xana u nga paluxa xiyimo xa wena xo van a xitsongwa-tsongwana eka mutirhi loyi a langutaka ta rihanyu na kuhlayiseka ka vatirhi eka ndzawulo ya swa vurimi.
- 6.4. Xana unga yi tikisa ku yini mahka ya loko mutirhi-kuloni a paluxa xiyimo xa yena xa vuvabyi bya xitsongwa-tsongwana xa HIV eka wena?
- 6.5. Xana va tirhi kulobye va fanele ku tikhoma njhani eka mutirhi kuloni loyi a nga paluxa hi vuvabyi bya xitsongwa-tsongwana xa HIV eka ndzawulo ya swa vurimi?
- 6.6. Xana vatirhi va n'wi tekisa ku yini mutirhi kuloni loyi a nga paluxa xiyimo xa yena xa HIV?
- 6.7. Xana xihlawuhlawu hi vuvabyi bya xitsongwa-tsonwana xi nga leterisiwa ku yini entirhweni?

ANNEXURE C: INFORMED CONSENT FORM

Participant's name:

Date:

Researcher: Thandy Shirley Mathebula

Institution: University of Limpopo

Informed Consent

1. **Title of the Study:** Socio-behavioural and structural core drivers of new HIV infection as perceived by employees at Department of Agriculture in Mopani District, Limpopo Province.
2. **Purpose of the Study:** The purpose of the study is to develop an in-depth understanding of the perceptions of LDA employees on socio-behavioural and structural core drivers of HIV infection.
3. **Procedures:** I will be involved in the semi-structured interview, whereby I will respond to the interview guide. The interview will take approximately one to one and half hour.
4. **Risks and Discomforts:** There are no known risks and discomforts associated with the project.
5. **Benefits:** The results of the study will assist my employer to address the challenge of employees contracting HIV with the intention of enhancing and promoting the well-being of employees, and ultimately, increase productivity.
6. **Participant's Rights:** I may withdraw from participating in the study at any time.
7. **Financial Compensation:** I understand that there is no financial compensation for participating in this study.
8. **Confidentiality:** In order to record exactly what I say in the interview, audio recorder will be used. I understand that the identity of the participants will be kept confidential.

I understand my rights as a research participant, and voluntarily consent to participation in this study; I understand what the study is about and how and why it is being done. I will receive a signed copy of this consent form.

Participant's Signature

Date

ANNEXURE D: VUHUNDZULUXERI BYA XITSONGA BYA MPFUMELELO WO NGHENELELA EKA VULAVISISI

Vito ra Mungheneleri:

Siku:

Mulavisisi: Thandy Shirley Mathebula

Ndzawulo: Univhesiti ya Limpopo

Mpfumelelo wo paluxeka

1. **Nhloko-mhaka ya vulavisisi:** Vulavisisi bya nkambisiso hi matikhomelo na vumbiwa lebyi nga na nhlohotelo eka ku khomiwa hi vuvabyi bya xitsongwa-tsongwana eka vatirhi va ndzawulo ya vurimi hi mavonelo ya Vangheneleri eka ndzawulo ya vurimi, exifundzeni xa Mopani, eka xifundza-nkulu ya Limpopo.
2. **Xikongomelo ya vulavisi:** Ku twisisa hi vuenti mavonelo ya vatirhi va ndzawulo ya swa vurimi mayelana na matikhomelo na nsimeko wa vulawuri lowu nga na nsusumeto wo khumiwa vuvabyi bya xitsongwa-tsongwana.
3. **Procedures:** Ndzi ta nghenelela eka mburisano lowu lulamisiweke. Nzi ta hlamula swivutiso leswi swi nga tekaka kwalomu ka awara na hafu.
4. **Swikavanyeto leswi nga va ka kona:** Ku hava swikavanyeto leswi swi fambanaka na vulavisisi lebyi.
5. **Mbuyelo:** Mbuyelo wa vulavisisi lebyi wu ta pfuna muthori ku lwisana na vuvabyi bya xitsongwa-tsongwana xa HIV hi xikongomelo xo tlakusa xiyimo xa rihanyu xa vatirhi no tisa ntshovelo wa le henhla.
6. **Timfanelo ta Vangheneleri:** Ndzi nga tshika ku nghenelela nkarhi wun'wana na wun'wana.
7. **Ku ririsiwa hi mali:** Ndzi twisisa ku ku hava ku ririsiwa hi mali ku va ndzi nghenelela eka vulavisisi lebyi.
8. **Xihundla:** Ku va ku kandziyisiwa leswi ndzi nga ta swi vula, ku ta tirhisiwa xo kandziyisa marito. Ndzi twisisa ku ri timhaka hinkwato ti ta va ti sirhelelekile, na swona ti vekiwile hi vukheta.

Ndzi twisisa timfanelo ta mina tani hi Mungheneleri, na kona ndzi nghenelela hi ku swi tsakela. Ndzi twisisa xikongomelo xa vulavisisi lebyi. Ndzi ta kuma mufanekiso wa mpfumelelano lowu.

Nsayino wa Mungheneleri

Siku

ANNEXURE E: REQUEST FOR APPROVAL TO CONDUCT RESEARCH STUDY



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF AGRICULTURE

MEMORANDUM

TO : HEAD OF DEPARTMENT

FROM : EMPLOYEE WELLNESS AND SPECIAL PROGRAMMES

REFERENCE : S.9/3/2

SUBJECT : REQUEST FOR APPROVAL TO CONDUCT A RESEARCH STUDY IN LIMPOPO
DEPARTMENT OF AGRICULTURE, MOPANI DISTRICT

DATE : 12 MARCH 2015

ENQUIRIES : MATHEBULA T.S

1. PURPOSE

To request approval:

- 1.1 To conduct a research study in Limpopo Department of Agriculture at Mopani District.

2. DISCUSSION AND MOTIVATION

I am a Deputy Manager for Employee Wellness, Human Immune Deficiency Virus (HIV) & Acquired Immune Deficiency Syndrome (AIDS) Program employed by the Department of Agriculture in Limpopo Province with effect from the 1st of January 2008 to date. I am placed at Head Office as a coordinator of HIV, AIDS; Health & Productivity Management Programme.

SUBJECT: REQUEST FOR APPROVAL TO CONDUCT A RESEARCH STUDY IN LIMPOPO DEPARTMENT OF AGRICULTURE, MOPANI DISTRICT

From the epidemiological information on HIV and AIDS interventions done in LDA, this study will serve as a response on the prevention effort to reduce vulnerability to new HIV infection faced by Limpopo Department of Agriculture employees, thereby exploring on the socio-behavioural and structural core drivers of new HIV infection, with a focus of addressing deeply entrenched and long established cultural, socio-economic and behavioural factors as mandated by the National Strategic Plan for HIV and AIDS, STI and TB 2012-2016. With specific reference to the "Getting to zero 2011-2015 UNAIDS", there is a need to achieve a transition that will see fewer people newly infected than newly placed on treatment. The Limpopo Department of Agriculture encourages employees to upgrade their studies in order to keep abreast with new developments of the organization and the sector.

Based on the above eluded information, I therefore took an initiative to register as a part-time doctoral student with the Department of Humanities at the University of Limpopo in order to embark on a research study which will focus on this topic: "**Socio-behavioural and structural core drivers of new HIV infections as perceived by employees at the department of agriculture in Mopani district in Limpopo province**". The purpose of the study is to explore perceptions of LDA employees on socio-behavioral and structural core drivers of new HIV infection. The targeted population is Mopani District and the sample will be drawn from employees at service centres and redline gates.

As a registered social worker with the South African Council of Social Service Profession (SACSSP), I am consciously aware of the ethical principles that need to be taken into consideration in order to safeguard the wellbeing of all participants. The findings of the study will enable the researcher to formulate practise guideline or a model that can inform effective and efficient prevention strategies of new HIV infections by the programme implementers within the Department. Furthermore they will contribute to the body of knowledge of HIV and AIDS research conducted within the Province.

SUBJECT: REQUEST FOR APPROVAL TO CONDUCT A RESEARCH STUDY IN LIMPOPO DEPARTMENT OF AGRICULTURE, MOPANI DISTRICT

3. LEGISLATIVE IMPLICATION

The request to further my studies and to apply for approval to conduct the research study in the Department is supported by:

- Skills Development Act
- Employee Health and Wellness Strategic Framework for the Public Service.
- National Strategic Plan for HIV and AIDS 2012-2016

4. ORGANIZATIONAL/HR IMPLICATION

As an employee of the Department, studying on the behavioral and structural core drivers of new HIV infection as perceived by employees will directly have positive contribution to my work and career development. This will also add value to my knowledge and skills towards enhancing service delivery.

5. FINANCIAL IMPLICATIONS

I will be financing all the cost incurred for the proposed research project during the period of my study.

6. ATTACHMENTS.

- Proof of registration acceptance to the University of Limpopo for 2015 academic year.

7. RECOMMENDATIONS

It is recommended that approval be granted to conduct a research study at the Department of Agriculture in Mopani District, wherein employees will be interviewed in relevant to the proposed topic.

Submitted for consideration


.....

Mathebula T.S
Deputy Manager: Employee Wellness Management

2015/03/12

Date:

Recommended/ not recommended


.....

Motswi S.V
Senior Manager: Employee Wellness and Special Programmes

12/03/2015

Date:

Recommended/ not recommended


.....

Netshifhere N.D
General Manager: Human Resource Management

16/03/15

Date

Approved/ not approved


.....

Maisela R.J
Head of Department

2015-03-16

Date

ANNEXURE F: RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE



University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 2212, Fax: (015) 268 2306, Email:noko.monene@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

MEETING: 06 May 2015

PROJECT NUMBER: TREC/32/2015: PG

PROJECT:

Title: Socio-behavioural and structural core drivers of new HIV infections as perceived by employees at the Department of Agriculture in Mopani District in Limpopo Province

Researcher: Ms TS Mathebula

Supervisor: Prof SL Sithole

Co-Supervisor: N/A

Department: Social Work

School: Social Sciences

Degree: PhD in Social Work


PROF. TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: REC-0310111-031

Note:

- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
- ii) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa

ANNEXURE G: LETTER FROM THE EDITOR

Language Quality Assurance Practitioners

Mrs KA Goldstone Dr PJS Goldstone

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17 June 2017

TO WHOM IT MAY CONCERN

We hereby certify that we have language-edited the doctoral thesis/dissertation of Ms T.S. Mathebula entitled: **THE SOCIO-BEHAVIOURAL AND STRUCTURAL CORE DRIVERS OF NEW HIV INFECTIONS AS PERCEIVED BY EMPLOYEES AT THE DEPARTMENT OF AGRICULTURE IN MOPANI DISTRICT, LIMPOPO PROVINCE**

We are satisfied that, provided the changes we have made are effected to the text, the language is of an acceptable standard, and is fit for publication.

Kate Goldstone
(Rhodes) BSc (Stell.) SATI No: 1000168
Language

Dr Patrick Goldstone BA
DEd (UPE) UPE

Practitioner (1975-2004) NMMU Language Practitioner (2005)

ANNEXURE H: MANWALIWA A VHADZHENELELI

Dzina la vhukuma li a shanduka u itela vhutsireledzi

Mudzheneleli A

Muṭodisisi: Kha vha mbudze nga ha tsumba dwadze dza HIV

Mudzheneleli A: Ndi vhulwadze vhune ha pfukela nga kha vhedzekani, zwilonda na u sa shumisa zwiambaro zwa tsireledzo zwingaho sa magilavu a tsireledza zwanda, u shumisa bulatsho ya mano na munwe muthu.

Muṭodisisi: Vha a divha vhuimo havho ha HIV? Arali phindulo I ee, vho guma lini uya u ṭola?

Mudzheneleli A: Ee! Ndi ṭola misi yoṭhe mu si huna mishumo ya u ṭola fhando mushumoni. Duvha le nda ṭola lwa u fhedza hovha hu dzi 2 Khubvumedzi 2015

Muṭodisisi: Zwi sumbedza u ṭola HIV kha vhone hu tshipiḽa tsha vhutshilo havho; vhangadzumbululela vhu ndeme ha u ṭola kha vhanwe vhatshu?

Mudzheneleli A: Ee ndiḽo ita ngauralo; na kerekeni vha shumisani nan ne vha a ṭuṭuwedza vha uri vha ṭola, na fhando mushumoni sa mu si ndi mudededzi wazwo.

Muṭodisisi: Ndi dzifhio mbuno dzine vha vhona unga dzia dzhenelela kha u phadadza HIV kha vhashumi vha LDA?

Mudzheneleli A: Athi khavha na ngoho uri vhangavha vhatshi shumisa zwi tsireledzi zwa vhudzekani.

Muṭodisisi: Ndi zwifhio zwithu zwine mbeu ya ita vhutambe-tambe ha phadadza HIV kha vhashumisani vha LDA?

Mudzheneleli A: Vhafumakadzi vha khomboni khulwane tshiitisi hu mbumbeo ya vhudzimu havho. Arali nda nga ḡi dzhenisa kha zwa vhudzekani ndi songo ḡi imisela na munḡa, ndi nga ḡi vha na fuvhalo zwine zwa nga ita uri ndi be malofha. Arali mufarisi wanga ana tshitshili tsha HIV, hezwo zwi nga ita uri ndivhe khomboni nga u kwamana ha malofha nga kha vhudzekani. Khombo inḡe ndi ya mu si ndi mufumakadzi ndi tshi ḡi sendedza kha munḡa; ri mbo ḡi thoma u farina-farana, zwine zwa bveledza lutamo lwa zwa vhudzekani. Ndi zwine zwa ita uri u tambudzwa ha vhudzekani hu dzhie ndango. Zwi ḡi fana na vhafumakadzi vhane vha vha tsini na vhahulwane vhavho mushumoni vha vhanḡa vha a kungea u dzhenelela kha zwa vhudzekani navho hu na mafulufhedziso a si one a uri vhaḡo vhahudza mushumoni uya kha poso khulwane. Vhanwe vhatu wana poso khulwane nga mvelelo idzo dzo raloho.

Muḡoḡisisi: Vhufhura uho ho ima nga tshivhumbeo-ḡe?

Mudzheneleli A: Miḡwahani yo fhiraho mishumo yo raloho yovha yo anda vhukuma vhunzhi ha vhatu vho wana mishumo ya poso khulwane ngau dzhenelela kha zwa vhudzekani na vhahulwane vhavho mushumoni. Fhedzi, zwazwino a zwongo tsha leluwa. Ndi shuma kha fhethu ha vha u thola huna mitevhe ine ya tevhelwa kha u thola.

Muḡoḡisisi: Zwine vha khou amba zwone ndi zwa uri vhafumakadzi avha tsha ḡi dzhenisa kha zwa vhudzekani na vhahulwane vhavho mushumoni nga nḡhani ha uri u hudza a hu tshavha zwanḡani zwa vhahulwane mushumoni, fhedzi huna ndaotewa dzine dza tea u tevhedzwa.

Mudzheneleli A: Eee; maḡuvha-ano zwithu zwo raloho a zwo ngo tsha ḡala, nga uri u si na ḡhoḡea dza dipuloma kana digiriyi a u nga koni u ḡi wana u khou nangiwa kha zwau thola. Hu na u khwinifhadzwa.

Muḡoḡisisi: Hu na nḡila I ne vhashumi vha tshifumakadzini vha LDA vha nga vha na u sa pfesesa kha kontiraka ntswa ya u kavhiwa?

Mudzheneleli A Khasho dza dzi nyonyoloso dzi a tshimbidziwa zwavhuḡi fhano mushumoni, pfunzo I khou bvela phanḡa, thaidzo I ne yavha hone kha vhashumi ndi u sa vha na ndavha.

Muḡoḡisisi: Arali ndi tshi khou vhapfa zwavhuḡi zwine vha khou amba ndi uri vhashumi vho ḡivhadzwa na hone vha na nḡivho nga ha dwadzhe tshifu, fhedzi

thaidzo yavho ndi u sa vha na ndavha. Ndi tshini tshine tsha ita uri usa vha na ndavha hu bvele phanda uya nga u pfesesa havho?

Mudzheneleli A: Munwe anga kha di humbula uri ukavhiwa nga Dwadzhe-tshifu a zwonga itelwa u bvelela kha nne, fhedzi hu na vhatu vho khetheaho kana vho nanguludzwaho vhanane vho tewa ngau kavhiwa.

Mutodisisi: Vho amba nga uri vho tsivhudzwa nga-ha Dwadzhe-tshifu, ndi tshini tshine tsha nga disa mvelaphanda ya uri vha kavhiwa nga Dwadzhe-tshifu uya nga u talukanya ha vho?

Mudzheneleli A: Rihe vhafumakadzi vho malwaho; ri khomboni khulu yau kavhiwa nga hetshi tshi tshili. Vhafarisi vhashu avha tangedzi u shumisa tsireledzo kha u di dzhenisa kha zwa vudzekani. Vhafhindula fhedzi nga ndila ya vhu di arali ndi tshibva u tola mvelelo dzanga dza HIV dzi tshi amba uri ndo kavhiwa, zwino-ha rado kona u tevhela tsivhudzo dza madokotela kana vhaongi uri ri di tsireledze u thivhela u kavhiwa na u ri huvhe na vhutshilo vhulapfu. Vhanha avha fulufhedzei na hone a huna zwine wa nga zwi ita sa mufumakadzi.

Mutodisisi: Vha khou mbudza uri vhafumakadzi vha a tamba tshipida tsha u khwathisa mbingano dzavho?

Mudzheneleli A: Eee, mvelele kana tshaka dzashu dzi kombetshedza u di nekedzela ho raloho kha siya la vhafumakadzi na u vhusa ha vhanha kha vhuledzani. Mvelele yo fhumula nga-ha HIV na mvelaphanda ya u phadalala kha tshitshavha. Kha lushaka lwa Vha-Shangaan, mu si mufumakadzi o maliwa u lavhelelwa uri a bveledzise u beba ha vhana. Hezwo u shumisa tshireledzo zwi vhonala sa thivhela-mbebo. Ndo maliwa kha muhwe muthu, arali nda nga disa tsireledzo hayani u do toda u divha uri ndi ngani. Ndi nga divhadza tsireledzo fhedzi mu sin di tshi divha uri u khou ita zwa vhuledzani nga nda ha mbingano yashu, fhedzi nga ndani ha khombo l dzo, ndi a ofha u thoma divhadza thoho l dzo.

Mutodisisi: Huna ndila dzinwe dzine vhashumi vha vhanha vha LDA vha vha na u sa pfesesa kha ndila ntswa ya u kavhiwa?

Mudzheneleli A: Ahuna tshanduko kha zwe nda amba malugana na vhafumakadzi. Zwine zwa bvelela kha vhafumakadzi zwi bvelela na kha vhanha. Vhafumakadzi vhanwe vha kunga vhanha nga ndila dzine vha ambarisadzone u fana na u zwikete zwipufhi na rokho dzau vhonadza zwa ngomu. Zwi a konza kha vhanha u di langa kha nyimelo yo raloho.

Muṭodisi: Zwinga konadzea hani u thivhela u kunga vhanṅa kha nyimele dzo raloho mishumoni?

Mudzheneleli A: Vhafumakadzi vha tea u funziwa ngaha mambarele o teaho a uya mushumoni. Mufumakadzi o ṭhandavhuwaho u dzulela u humbula uri ndi ufhio muledza une a khou u rumela nga mambarele awe kha ḍuvha lo imaho ngauri. Kha vhaḍi vhudzise mbudziso dzingaho sa hedzi “ndia vhonala zwavhuḍi naa... hone tshimiswa tshanga...mvelelo dzanga...? Zwino mi si yoṭhe humbula nga-ha masiandoitwa a maambarele au. Zwine vhatu vha fhindulisa zwone ḍuvha ilo nga maambarele a u vha u fha ṭhonifho kana zwiṅwe-vho, zwibva kha uri muthu o ḍi vhonadza hani nga maambarele fhedzi.

Muṭodisi: Ndi vhufhio vhuḍipfi vhaho ngaha vhane vhavha na vhuledzani na vhatu vhanzhi?

Mudzheneleli A: Muthu u tea uḍi badekana na muledzani muthihi. Arali vhatshi balelwa u fulufhedzea, khwine vhatu ḍitsireledza. Maḍuvhani a kale, uvha ma vhaledzani vhanzhi sa munṅa zwovha zwo ṭhanganedzwa. Maḍuvha-ano maitete o raloho ana khombo khulu. U ita khuwelelo ngaha tsireledzo na kha mahosi hune havha na vhakaha na vhakegulu vhane vhavha na ṭhuṭhuwedzo kha vhana vhavho. Avho vhovha vhatshi amba nga maitete a kale ngau topola maipfi angaho sa: “Vha khou mbona, khotsi anga vhovha vhana vhafumakadzi vha-ṅa. Vhana avho vha mbo ḍi tevhedza maitete a zwe vho-makhulukuku vhavha vhatshi ita. Rine vhashumi vha fhano kha Zwavhulimi (Agriculture) ri na mashudu nga uri ro funzea, vhatu ngei nṅa vha khomboni khulu; miṅwaha ya fuṭhanu na ya nṅa ya vhafumakadzi vha kha dzilafho nge vha pfukiselwa nga vhafunani vhavho vhe vha kavhiwa nga HIV mu si vhe kha ḍivha mishumoni na hone vho ḍi dzhenisa kha zwa vhananyana vhe vhavha vha khou ṭoḍana na masheleni. Vhaṭhanga na vhone vhatshi kavhiwa nga HIV ubvaa kha vhatu vho lovhelwaho nga vhafarisi vhavho, vha songo malwaho na avho vha u hola masheleni a nṅa vha vhafumakadzi, vhane vhavha a vhuludu na u vha vhe vhoṭhe, vha pfukisela ukavhiwa kha vhafarekani navho vhaṭhuku. A vho vhafumakadzi vha kuga vhaṭhanga vhaṭuku ngau vhafhuredzela nga dzimpho na masheleni. Vhoṭhe vha miṅwaha ya zwigwada zwoṭhe vha khomboni khulu. Zwi ṭoḍa phaṭhutshedzo dza Mudzimu, ndi nga tshilidzi tshawe uri munwe hango kavhiwa nga hetshi tshifhinga.

Muṭodisi: Vhuḍipfi havho ndi vhufhio ngaha u tambudzwa nau kavhiwa ha HIV?

Mudzheneleli A: Kha tshitshavha tshine nda dzula khatsho, vhathu vhane vha nwa mahalwa a vhana zwiṅungo zwau ḍi dzhenisa kha zwa vhudzekani. Avho vhane vha funa u ḍi dzhenisa kha zwa vhudzekani ndi avho vhane vha dzumbama dzikerekeni.

Muṭoḍisisi: Vha zwi ḍivha hani?

Mudzheneleli A: Mu si vho kambwiwa vha a eḍela. Vha ḍo kona hani u bveledza nyito ngauri zwoṭhe zwi tea u thoma u bva muhumbuloni, arali hu si na tshithu muhumbuloni, ahuna tshine tsha ḍo bvelela nguvhoni. Avho vhane vhavha ngomu dzikerekeni, vha ita zwau funana nga tshavho.

Muṭoḍisisi: Nga maipfi ayo, zwine vha khou amba ndi zwauri halwa avhu khou shela mulenzhe kha u phadladza u kavhiwa huswa ha HIV.

Mudzheneleli A: Uya nga kuvhonele kwanga, Eee, vhudekani nahalwa azwi tshimbilelani. Havho vha bveledzisa zwa vhuledzani mu si vha songo kangwa. Vha nga si kone u ola tshifanyiso tsha “S” mu si muhumbuloni wavho hu na fomo ya sekhula.

Muṭoḍisisi: Ndi vhufhio vhuḍipfi havo malugana na vhutshilo ha vhashumi vha LDA ngau to angaredza?

Mudzheneleli A: Vhaḍi fara zwavhuḍi, kana zwi khou itiswa nga zwipiḍa zwa vhuḍifari. Na avho vhathu vhane vho kavhiwa nga HIV, vhaḍi fara zwavhuḍi mushumoni, Ndito sa ḍivha mu si vhe nḍa ha vhupo ha mushumo.

Muṭoḍisisi: Nga nḍa ha zwipiḍa zwa vhuḍifari zwine zwa bvelela misi yoṭhe, ndi dzifhio mbuno dzinwe dzine vha vhona unga dzi nga thivhela nḍila ntswa dza u kavhiwa nga HIV kha vhashumi vha LDA?

Mudzheneleli A: U dala luthihi kha nwedzi u ita zwipiḍa zwau ṭola. Musi vhe dzikerekeni huna miṭhangano u vusulusana, na dzi khasho I dzi dzi tea u bvela phanḍa u vusulusa.

Muṭoḍisisi: Uri milayo ya vhatholi huna hune ya dzenelela kha vhuḍifari ha vhatholiwa khau kavhiwa nga HIV?

Mudzheneleli A: Milayo ya Zwiimiswa yo fhumula ngaha Dwadzhe-tshifu. Heyo milayo I ambiwa fhedzi kha zwipiḍa zwa zwikili. Nakha zwivhumbeo zwa zwiimiswa, zwipiḍa zwa Dwadzhe-tshifu zwi tea u vhoneala husini u dzumbiwa nga ngomu ha khasho dzinwe. Ndi vhona unga muhasho wa DWADZETSHIFU u tea u ḍiimisa nga yoṭhe na mukovhe wayo dzi ifice dza mimasipala.

Muṭoḍisisi: Uri mushumo wavho ua vha dzikusa kha u kavhiwa nga HIV? Arali phindulo I Eee, khavha ṭhandavhudze.

Mudzheneleli A: Sa HR kileke ana avha na vhudifhinduleli hau thola na u pfukisasela, vhashumi vha vhanha vha nga di fulufhedzisa u zwa nguvhoni hu u itela mushumo, zwine zwinga kha di kundelwa u konadzea nga nthani ha milayo ine ya tea u tevhedzwa.

Muṭodisisi: Ndi zwifhio zwine mutholi a khou ita u pfumbudza ngaha u kavhiwa huswa ha HIV mishumoni?

Mudzheneleli A: Mutholi u lwisa nga nungo dzothe u pfumbudza nau tsivhudza, u rangaphanda uṭola ha HIV mishumoni. Ndi vhona unga riṅe sa vhashumi ndi riṅe vha ne ra tea u di dzhenisa kha u thogomela matshilo ashu.

Muṭodisisi: Vha nga dzumbulula mvelelo dzavho dza HIV kha mushumisani na vho? Khavha thandavhudze phindulo yavho.

Mudzheneleli A: Athinga dzumbululi kha mushumisani ngau vhaḍo phaḍalaadza vhoimo hanga. Ahuna vhungoho uri mvelelo dzanga dzi ḍo tsireledzwa Mu si ndo fhedza nga u ṭoliwa, Ndi ḍo vhudza mufarisi wanga nda bvela phaḍa na u nwa dzilafho. Khwine nditshi nga dzumbu tshiphiri uswika nditshi lovha.

Muṭodisisi: Vha nga dzumbulula mvelelo dzavho dza HIV kha mutholi wavho? Khavha thandavhudze phindulo yavho.

Mudzheneleli A: Kha mutholi hai, nga nḍa ha mu si vho dzhena ICU bha vhala faila yanga. Vhashumi vhanwe vha dalela vhuongelo u toḍa u vhona u itela uri vha phaḍaladze mafhungo mishumoni. Ndi ḍo vhudza mme anga uri athi ṭodi mushumisani na-nṅe atshi dalela hune nda ḍovha ndo ongiwa hone. Mutakalo wa mutholiwa u tea langa uri ndi kha maga afhio ane mushumisani a tea u dalelwa kha tshifhinga tsha mu si a siho mishumoni nga nthani ha vhulwadze. Kha nṅe u khuthadza nga lutingo nga mushumisani zwi ḍovha zwo luga.

Muṭodisisi: Vha nga dzumbulula mvelelo dzavho dza HIV kha vha-EAP? Khavha thandavhudze phindulo yavho.

Mudzheneleli A: Kha vha-EAP, Eee ngauri ndivha vhulangi. Muthu wau thoma u ḍivha mvelelo dzanga hu ḍovha mufarisi wanga, haḍo kona-ha uvha thuso ya zwa vhulangi. U amba ngoho athi kho u fha vhuṭanzhi ngaha mafhungo anga kha mihasho mu si hu kha maḍuvha a zwa dzinyonyoloso. Ndi nḍila yanga yau di tsireledza u itela u tsireledza muimo hanga u itela mu si mvelelo dzi songo tshimbila zwavhuḍi.

Muṭodisisi: Vhaḍo fhindula uri mini kha mushumisani navho mu si atshi bvisela khagala mvelelo dzawe kha vhone?

Mudzheneleli A: Ndinga thusa u tšutšuwedza uri aye u tšoliwa na uri a lavhelele mafhungo awe e a a dzumbulula atshi dovhha o tsireledzeaho.

Mungheneleri B: XI-Tsonga

Mulavisisi: U tiva yini hi vuvabyi bya xitsongwa-tsongwana?

Mungheneleri B: Vuvabyi bya xitsongwa-tsongwana I vuvaby lebyi tlulelaka hi timhaka ta swa masangu loko ku nga tirhisiwi swo tisirhelela, na hi ku cincana ka tingati loko ku ri timbanga kumbe ku vaviseka. Vuvabyi lebyi bya dlaya loko munhu a nga byi takeri nhlokweni. Munhu u tiva xiyimo xa yena hi tlhelo ra xitsongwa-tsongwana ntsena loko a kamberise ngati ya yena. Vana, va aka tiko na vanhu etikerekeni va fanerile ku dyondziwa hi vuvabyi lebyi. Lava va nga byona va fanerile ku landzelela swiletelo swa vutshunguri.

Mulavisisi: Xana u tiva xiyimo xa wena xa rihanyu mayelana na xitsongwa-tsongwana? Loko nhlamulo yi, u kamberiwile rini?

Mungheneleri: Ina, a ku ri 2013

mulavisisi: Mi nga hi byela nkoka wa ku kamberisa vuvabyi xitsongwa-tsongwana.

Mungheleri B: Tani hi loko ndzi ri mufundhisi ekerekeni, Ndzi tala ku tsundzuxa nhlengeletano hi nkoka wo kamberiswa na ku tirhisa swo tisirhela. Vanhu va tshembela ngopfu eka masingita va tshika na ku teka maphilisi. Ekerekeni ya hina hi tala ku rhamba va ndzawulo ya rihanyu ku ta dyondzisa vantshwa na vana va xikolo xa sonto hi vuvaby bya xitsongwa-tsongwana. Milawu ya tiko-nkulu yi fanerile ku tiyisisa ku vuvaby lebyi bya xitsongwa-tsongwana by dyondzisiwa na le swikolweni. Tikereke na tona a ti tsundzuxi nhlengeletano hi vuvabyi lebyi.

Mulavisisi: I yini lexi xiendlaka kuri vuvabyi bya xitsongwa-tsongwana byi andza eka vatirhi va ndzawulo ya swa vurimi.

Mungheleri B: I ndlala, loko munhu a nga tirhi, ngopfu-ngopfu vavasati, swiendla ku va tihoxela eka vavanuna. Hi mikarhi yin'wana, swiendla hi nshekelelo lowu wanuna a wu endlaka eka vavasati. Mitolovelole leyo ku twala rito ra wanuna ntsena, wansati u fanele ku titsohata yi khombo swinene. Vana lava pfumalaka va ta huma ku ya lava

vavanuna lava nga va xavelaka swakudya. Hi ndlela ley va nga hlangana na khombo ro tluletiwa xitsongwa-tsongwana.

Mulavisisi: Mbewu ya rixaka yi tlanga xiphemu muni eka ku andzisa vuvabyi bya xitsongwa-tsongwana.

Mungheleri B: Vavanuna vo tala va vabya, ngopfu-ngopfu lava va nga na vuvabyi bya chukele, a va ha koti ku enerisa vasati va vona hi swa masangu. Xiyimo lexi xi nga endla ku wansati a endla swa masangu ehandle ka vukati bya yena. Hi ndlela leyi a koka vuvabyi bya xitsongwa-tsongwana. Vavanuna va n'wana va sindzisa ku nyikiwa masangu hi mikarhi hinkwayo, kambe wansati wa kona a nga koti ku fikelela swilaveko leswi. Hi ndlela yoleyo wanuna u teka ndlela yo handla swa masangu eswihundleni. Loko ku ri na nkinga hi vukati bya vona swa fanela ku va va pfulekelana ku lulamisa xivangelo.

Mulavisisi: Xana swa olova ku va wanuna a humela erivaleni hi nkinga ya yena ya swa masangu?

Mungheleri B: A swi olovi. Mina ndzi na vasati vambirhi, hi fambe swin'we ku ya kamberwa vuvabyi bya xitsongwa-tsongwana. Hi vunharhu bya hina hi tlhela hi dyondzisa na vana va hina hi vuvabyi lebyi.

Mulavisisi: Mi swi kotise ku yini ku vana vulawuri ka vuxaka byo tani endyangwini wa wena?

Mungheneleri B: Vasati va mina va hundzuke vamakwerhu, va manana na vanghana va mina. Tani hi loko ndzi lo sala ndzi ri swanga endyangwini w aka hina, vasati va mina va tlanga ndzima yikulukumba swinene evuton'wini bya mina. Va fana na ximbuwetelo eka mina. Vana va mina van'wana va kona se va tekile vavasati, hi hlangana hinkwerhu ekamareni yo wisela, hi va tsundzuxa hi nkoka wa ku tisirhelela na ku kamberwa vuvabyi.

Mulavisisi: Ndzi tsakile loko u humelerise erivaleni mhaka yo teka vasati vambirhi. Ku twisisa loko ku nga kona I ku wanuna kumbe wansati loyi a rhandzanaka na munhu wo hundza un'we I le khombyeni ro tlulerwa hi vuvabyi bya xitsongwa-tsongwani. Mi ri yini hi mhaka leyi?

Mungheneleri B: Eka malembe lawa ndzi nga va na nsati un'we, a ndzi tala ku van a vunghanu bya masangu na vavasati ehandle ka vukati ku fikela laha ndzi nga tikisa loyi a ndzi tiyiva na yena. Mina na nsati wa mina hi kaneriwa ku swa antswa ku va ndzi lovola, ku va nsati wa vumbirhi ku sivela ku ya emahlweni na vuganga ehandle ka vukati bya mina. Sweswi vasati va mina I vadyondzisi. Va yisiwile hi mina exikolweni xo dyondzela ntirho. Ndzi majaha ya nkombo na nhwana un'we. Va kurisiwile kahle ehansi ka nawu. Xikwembu xi kahle na kona ndzi katekile. Vafundhisi vo tala va tumbela hi kereke, kambe va ha endla swa vugangu ehandle ka vukati bya vona. Vavasati va aneka timhaka ta vona eka vafundhisi, aha emakumo va tlhelaka va tikombelela vuxaka bya swa masangu eka vavasati volavo.

Mulavisisi: Hi wahi mavonelo ya wena hi matikomelelo ya vatirhi va ndzawulo ya swa vurimi hi ku angarhela?

Mungheleri B: Va tirhi vo tala eka ndzawulo leyi va le ka malembe yo khalabya, a va ha ri ka rivilo hi swa masangu. Hi ndlela yoleyo a va ha ri khombyeni ro hlangana na xitsongwa-tsongwana. Hi vona va ngheneleka eka ku tikamberisa vuvabyi lebyi, loko vantshwa va tsutsumela kule no tikamberisa. Ku fanele ku endliwa ndlela yo endla ku vantshwa va tikamberisa.

Researcher: Xana ku nga va ku ri na ndlela leyi vatirhi vaxisati va la ka Murimisi va nga tluleriwaka hi vuvabyi lebyi?

Mungheneleri B: Ina. Mutirhi loyi a humaka endyangwini wo va hava nawu, ku fana no xixima, swi le rivaleni ku matikhomelo ya mutirhi yoloye a ya nga amukeleki na le ntirhweni, ku fana na ku endla timhaka ta masangu na vatirhi-kulobye hi ku hambana-hambana. Khombo ro hanganyela hofisi I ku vatirhi va tolovelana ku hundzisa mpimo ku fikelela laha va sungulaka vuxaka bya masangu. Vanhu van a ntolovelo wo tisola loko swilo swi onhakile.

Mulavisisi: Muthori wa n'wina u endla yini ku lulamisa timhaka ta ku andza ka xitsongwa-tsongwana laha entirhweni?

Mungheneleri B: Ku tsundzuxana na ku dyondzisana hi vuvabyi lebyi ku fanele ku humelela hi mikarhi hinkwayo. Ku dyondisa a ku humeleri hi ku enerisa laha

ntirhweni. Vatirhi va hina vo tala va tirhela ehandle, mi kuma ku a va fikeleriwi hi tidyonzo hi ku va va vatirhela ehandle. Van'wana va kona, kambe a va lavi ku nghelela hi tinhlamuselo leti ti tivaka hi vona va ri voxo. Milawu ya tiko-nkulu wa hina yi fanele ku herisa mhaka yo kamberiwa hi ku rhandzu, kambe xi va xiboho leswo munhu un'wana na un'wana a kamberiwa.

Mukambisisi: Swi languteka onge mi ri ririmi leri tirhisiwaka loko ku ri na ku lemukisana hi tidyondzo a ri amukeriwi hi va tirhi va malembe ya le henhla. Hi yini ndlela leyi nga tirhisiwaka ku fikelelela ntlawa lowu wa vatirhi handle ko lwisana na matshemba ya vona.

Mungheneri B: Ma tiva Machangana a va hlangani na ririmi ro vulavula hi ku tshikilela. Van'wana va hina va tirha na va kon'wana na maxaka. Loko ti dyonzo leti a to dyondzisiwa hi mitlawa ya rimbewu. Mina ndzi xiphemu xa nhlango wa vavanuna laha hi dyondzisaka hi mixaka yo xanisa va vasati, na ku u mutsakisa njhani nsati wa wena.

Mukambisisi: Xana mi twa mi hlayisekile loko mikanela timhaka mi ri vavanuna ntsena?

Mungheneri B: Kahleee! xikombiso, eka nhlango lowu a hi ri na wona ku nga ri khale, n'anga ya vutshunguri by xilungu u vurile ku loko wansati a tsakile na ku tshuxeka hi vuxaka by yena na nuna wa yena, u ta humesa moya, ku kombeta ku u le hansi ka vuhlayiseko byo tshembeka.

Mukambisisi: Xana hi yini ndlela leyi vatirhi va xinuna laha ka ndzawulo va nga kumaka ha yona xitsongwa-tsongwana?

Participant B: Loko ndzo vulavula ku tikeriwa ka mina xi kahle na kona ndzi katekile ayelana na vukati bya mina na mutirhi-kulorhi wa xisati, a nga va a vona ku ri nkateko w ova a ndzi onga hi tlhelo ra swa rirhandzu. U ta tikarhatela ku ndzi chavalela, na mina ndzi humbeka mano ku fikelela laha hi tikumaka se hi endle swa masangu, ku nga ri hi ku tiyimisela.

Mukambisisi: Xana mi nga va miehleketa yini hi ku tirhisa swidzidziharisi na vuvaby lebyi bya xitsongwa-tsongwani?

Mungheneri B: Ku na ndyangu wun'wana ndzi wu tivaka wu nga na vana va ntlhanu va tshamaka na kokwana wa vona. Vana lava va veleka va nga languta endzhaku. Sweswi se i khumenhungu ya vona, hi timhaka to lava na mudende wa vana. Vanhu va ndyangu wolowo va hanya hi ku nwa byalwa. Ndzi teke na n'wana un'we wa jaha

ku mu hlayisa. N'wana loyi a tikhome kahle, kambe hi ku famba ka nkarhi a cinca mahanyelo.

Mukambisisi: Milawu leyi vekeriveke vatirhi ku tirha hi yona yi nga van a xiyave eka ku hundzisela mavaby ya xitsongwa-tsongwani?

Mungheneleri: Milawu ya matirhelo yi kahle, Xiphiso xi na va tirhisi va milawu yoleyo.

Mukambisisi: Xana ntirho wa wena wu nga va wu ku veka ekhombiyeni ro kuma vuvabyi bya xitsongwa-tsongwana? Seketela nhlamulo ya wena.

Mungheneleri B: Ee. Ndzi tirha hi ku langutela nhundzu ya muthori. Mikarhi yin'wana hi yisiwa ka dyonzo ta le mitirhweni, ku etleriwa kona. Ku fana na sweswi, a hi ri Skukuza, laha va ku vitaka "Kruger National Park". Van'wana va vatirhi kulobye a va popiyiwile swinene. Loko va twa byala va ku hetelele ku van a ku endla timhaka ta masangu. Valanguteri lavakulu na vona va le khombiyeni ro sariwa endzhaku hi vanhwanyana hi xikongomelo xo nyikiwa ti poso ta le henhla.

Mukambisisi: Xana mi nga palaxu xiyimo xa n'wina hi tlhelo ra xitsongwa-tsongwana eka mutirhi kulobye?

Mungheneleri B: Ina. Xikombiso, loko mina na vasati va mina hi ya tikamberisa, madokodela van di byerile ku ndi nga van a khombo ro van a mbvukuzana lowu khomaka marhanga ya vununa. Ndzi fike ndzi vikela mutirhi-kulobye. Ndzi tlhele ndzi mu dyondzisa hi vuvabyi lebyi, na ku mu hlohletela ku ya kamberwa na yena.

Researcher: Xana lonkulukumba wa wena unga mu paluxela xiyimo xa wena mayelana na xitsongwa-tsongwana? Ndzi kombela u seketela hlamulo ya wena.

Mungheneleri B: Ina. I fanerile ku ndzi seketela loko ndzo tshika ndzi vabyile. Lonkulu wa mina hi ntirho wa fana na manana, tatana na ndyangu wa mina. Hi le ka rivilo ro tsutsuma rendzo rin'we ra ntirho. Ku miyela na xihundla xa xiyimo hi tlhelo ra xitsongwa-tsongwana swi khumba na matirhelelo. Swi nga endleka ku vuvabyi byi kula ku fikela laha ndzi tsandzekaka ku tirha. I lonkulukumba hi ntirho loyi a nga ta vona ku ndzi nyikiwa mitirho yo ringanela. A ku na xilaveko xo ndzi tumbeta xiyimo xa mina, swi nga ndzi tshkelela.

Mulavisisi: Mulanguteri wa rihanyu na ku hlayiseka ka vatirhi yena ke, mi nga n'wi byela?

Mungheneleri B: Ina. Loko ndzi ta tiva xiyimo xa mina xa mbvukuzana ya marhanga ya xinuna, ndzi yile ka hofisi ya ku langutela rihanyu ra vatirhi ku ya vulavurisiwa.

Mulavisisi: U nga hlamula yini loko mutirhi kulobye a ku paluxela hi xiyimo xa yena xa xitsongwa-tsongwana.

Mungheleri B: Ndzi nga museketela, ndzi mu komba rirhandzu handle ka ku va ndzi mu ahlula.

Mulavisisi: Vatirhi-kuloni vona va fanele ku ti khoma njhani ka mutirhi loyi a nga paluxa xiyimo xa yena hi tlhelo ra vuvaby bya xitsongwa-tsongwana?

Mungheleri B: Va fanele va museketela, va murhandza, va mu hlohletela ku hanya rihanyu lerinene, va tlhela va nga muhlawuri. Leri I vhlwa ra jika-jika. Hinkwerhu ka hina hi le khombyeni ro kuma xitsongwa-tsongwana. Hi yona mhaka hi fanele ku seketelana.

Mulavisisi: Matikhomelo ya vatirhi-kuloni ya njhani eka mutirhi loyi anga na vuvabyi bya xitsongwa-tsongwana?

Mungheleri B: Laha ntirhweni ha seketelana. Van'wana va vatirhi-kulobye va teka tiphilisi, na kona va le ka xiyimo xo tsakisa hi ta rihanyu.

Mulavisisi: Hi fikile emakumu ya ku vulavurisana ka hina. Ndzi khensa nkarhi wa n'wina na miehleketo leyi mi nga hi chumbutela yona.

Mungheleri B: Ndzi khensile na mina ku va ndzi nghenelerile a ka ku vulavurisana ka muxaka lowu. Ndzi tshemba ku mavonelo ya mina ya ta tsariwa eka tibuku letikulu ku pfuna rixaka.

Motseakarolo C- Sepedi

Monyakishishi: Mpotse se o se tsebang ka kokwanahloko ya HIV.

Motseakarolo C: HIV ke tswaetso ya go tsena ka thobalano. E ka go feta go gonggwe le go gonwe, e ka ba mosomong, mo kotsing o sa tsebe gore e ya go fetela gob age osa ihlokomele. HIV ga e fole, fela e ka laolega ka diokobatsi go tswa go lefapha la maphelo.

Monyakishishi: O tseba seemo sa gago sa HIV. Ge eba oa se tseba, ke neng la mafelelo mo o tserego diteko?

Motseakarolo C: Ee, ka nako yela re keteka letsatsi la basadi ka September 2015.

Monyakishishi: O ka re hlathollela bohlokwa bjago tsea diteko tsa HIV?

Motseakarolo C: Ee, motho wa mathomo o ke tlogo bolela le yena ke molekane waka. Yo a latelago e tlabo motswadi waka. Wa mafelelo e tla ba bagwera baka.

Monyakishishi: Mpotse gore ke eng se se dirago gore o bolele le bona bao o ba kgethilego?

Motseakarolo C: Ke nagana gore go bohlokwa go bolela le molekane w aka ka gobane ge e legore ke swaeditse ke kokwanahloko, go molaleng gore le yean o swaeditse. Kgona galo ya gore o swaeditse e godimo. Motswadi waka ke bolela le yena gore ge e le gore seemo s aka sa maphelo se a theoga, o tla kgona go nhlokomela. O swanetse go tseba gore a kgone go tsea magato a go se fetele ke kokwanahloko. Bagwera baka bona, ke nagana gore ke hloka batho ba ke tla bolelang le bona go imolla bohloko. Ka go dira bjalo, ke tshepa gore ke tla kwa bokaone.

Monyakishishi: Ke di karolo tse dife tse difetetsang kokwanahloko ya HIV mo bashoming ba LDA?

Motseakarolo C: Bashomi ba technical, bao ba tsebegago ka go hlokomela tsa bolemishi, ba berekela ntle ka nako ye ntshi. Ga re tsebe gore go direga eng ka bona ge ba tswela iofising. Ba shoma ba le noshi bas a hlokomelwe ke bagolo ba bona.

Go na le mabarebare a gore ba na le nako ye ntshi ya go dira maratapelo, go swana le go nwa madila le go bapadishana le mekaola ya bon ka nako ya moshomo. Ka mokgwa o ba shomang ka gona, ba kotsing ya go fetela ke kokwanahloko ya HIV, Efela maitshwaro a motho a laelo ke semelo sa gagwe. Ge o kgona go itswara, mokgwa wa moshomo o kase laole maitshwaro a motho.

Monyakishishi: O gopola bjang ka bao ba hlokang maitshwaro?

Motseakarolo C: Bao go molaleng gore ba bothateng bja go sweats ke HIV ka gore ga gona o a le kang go ba busha tseleng ya nnete.

Moyakishishi: Ke karolo efe ye e leng gore bonna gob bosadi bo a e tsea ka go fetetsa kokwanhloko ya HIV go bashomi ba LDA?

Motseakarolo C: Mo moshomong ga gona kgethologanyo meshomong ya banna le basadi. Ge ba go thapile go dira moshomo o itseng, o swanetsetse go shoma ka mo go swanetseng, o kaba monna goba mosadi. Ka go le lengwe ge re fihla malapeng a rena, banna ban a le maatla go feta basadi. Bann aba bantshi ga ba berekishi dikgotlopo.ge ban a le bakaola ka ntle go lenyalo, go na le kgonagalo e ntshi ya go fetelwa ke HIV goba go e fetetsa go mosadi wa gagwe.

Monyakishishi: O leka go mpotsa gore se banna ba se bolelang se agelwa legora, bolela ka boripana gore se se hlolwa ke eng?

Motseakarolo C: Basadi ga ba hwetse thuso ye e lekaneng ka gore ba swanetse go ikokobetsa go banna ba bona. Go tloga lebakeng la kgale, monna ke hlogo ya lapa, le diphetho di tsea ke bona. Sa bobedi, ge ke motshepa kudu, ga ke nagane gore a ka nyaka bakaola.. Basadi ba a leka go boledishana le banna ba bona ka go berekisha dikgotlopo, efela banna ke bona ba tseago sephetho sa gore ba a dumela goba ga ba dumele.

Monyakishishi: O ra gore basadi ba palelwa ke ganetsa diphetho tsa banna?

Motseakarolo C: Nkare rena basadi gantshi re dumela se sengwe le sengwe gore gobe le khutso ka lapeng.

Monyakishishi: Go sa tlo ba le khutso ka morago ga go hwetsa gore o swaeditswe ka kokwanahloko ya HIV?

Motseakarolo C: (O a sega) Ee, e tswela pele.

Monyakishishi: Go na le mokgwa o e leng gore basadi ba LDA ba ka ba kgatelelong ya go swara ke HIV?

Motseakarolo C: Basadi ba LDA ban a le maitshwaro a mabotse.

Monyakishishi: Go na le mokgwa o e leng gore banna ba LDA ba ka ba kgatelelong ya go swara ke HIV?

Motseakarolo C: Banna ba LDA, nka se bolela ka bona go swana le basadi; gantshi ba na le mekaola ka ntle ga lenyalo. Ba ba kotsing ye kgolo ya go swaetswa ke HIV. Bann aba bantshi ba palela ke o gana ge ba tshepishwa tsa thobalano, efela, basadi ba kgona go gana.

Monyakishishi: O nagana eng ka goba le balekane ba bantshi?

Motseakarolo C: Ge monna a eba le balekane ba mmalwa, ga a sa kgona go kgotsofatsa molekane wa gagwe ka gae. Mosadi o ba kotsing e kgolo ya go swaetsa ke HIV ka gore monna a ka se tsogile a mmoditse gore ona le mekaola. Ka nako eo, monna a ka se tsebe gore o swaeditse, a tswelapele ka go se berekishe kgotlopo mosading wa gagwe.

Monyakishishi C: A goba le balekane ba bantshi go ka oketsa tswaetso ya kokwanahloko ya HIV?

Motseakarolo: Ee, batho ba bantshi ba swaetswa ka nako e tee. E re kef e mohlala: “Ge monna a na le mekaola/balekane ba bararo ke gore, mosadi wa gagwe le bakaola babedi, ge o mongwe gare ga bona ka moka a na le kokwanahloko ya HIV, gora gore ba bangwe ba bararo ba kotsing ya swaetswa ke kokwanahloko HIV”.

Monyakishishi: O ka tla ka manka a mafe go fokotsa swaetso ya HIV mo moshomong?

Motseakarolo C: Go swanetse ga ba le ditshemodisho ga tee ka kotare. Ka mehla bashomi ba gopotswe ka HIV le AIDS. Ba lefapha la maphelo ba be le seabe, bashomi ba hlohleletswe go tsea diteko. Babagolo mo moshomong ga ba tsenele ditshedimsho. Ke gopola gore ba na le ditshedimsho tsa bona ka thoko, efela go ka swanela ge ba ka tsea karolo le bashomi k age ba na le influence.

Monyakishishi: A eka ba moshomo wa gago o go bea kotsing ya HIV? Ge go le bjalo, hlohleletsa.

Motseakarolo C: Ee, g eke sa hlokomele. Ke shoma ka difaele ka PMDS, le dikonopo tsa tsona, di ka go ripa monwana o tee, moshomimmogo a ka leka go thusha ka ntle ga go itshireletsa, gomme a ba kotsing ya go swaetswa. Go swanetse

go ba le ditshedimosho ka go shoma ka ofising, Di First Aiders ba trainiwe, ba phele bale komana madula a bapile ka go thusha ge gona le dikgobadi moshomong.

Monyakishishi: Go se lekalekane ga banna le basadi mo LDA go ka ba le seabe bjang go godisheng tshwaetso ya kokwanahloko ya HIV?

Motseakarolo C: Basadi ba bantshi ba thapilwe mo meshomomg ya fase. Go molaleng gore basadi ba go senyalwe, ba ban aba babedi gob aba bararo ba ka se kgone go hlokomela bana ba bona ka tshelete e nnyane. A ka robala le monna o mongwe le mongwe gore a mo thushe ka tshelete gopola gore mosadi o a ka se kgone go boledisha go berekisha kgotlopo ka gore a nyaka tshelete. Ke bone basadi ba bantshi ba isha ban aba bona theshiari ka tshelete ya mekaola ya bon efela ka morago ge ban aba thoma go shoma ba thusha ka gae, mahelo a mmago bona ga a sa kgotsofatsa k aba ka la go gola ga kokwanahloko ya HIV.

Monyakishishi: Mong moshomo o dira eng go fokotsa tswhaetso ya kokwanahloko ya HIV mo moshomong?

Motseakarolo C: Ditshedimosho ka HIV le AIDS, matsatsi a wellness, dithlathlobo tsa malwetsi, keteko ya leatsatsi la basadi bjalo, bjalo. Go na le perekishano ya meshomo go ba lefapha la maphelo le GEMS.

Monyakishishi: Ke eng se mong moshomo a ka se dirang go fokotsa tshwaetso ya kokwanahloko ya HIV mo moshomong?

Motseakarolo C: Ge lefapha le ka hlohleletsa gore bashomi ba tsee diteko tsa tsa HV. HCT e ame motho o mongwe le o mongwe. Basadi ke bona ba tseago diteko ka mehla mola banna ba rothela. Ditshedimosho tsa banna di swanetse go ba HCT. Ba ka na ba ba na le makoko a go bontsha basadi gore le bona ka tsea diteko.

Monyakishishi: O ka bololla seemo sa gago sa HIV go modirishane mmogo le wena. Ka kgopelo hlohleletsa karabo ya gago.

Motseakarolo C: Ee, re ba bane fela lefaphaneng la la PMDS. Ge go k aba le kotsi, go bohlokwa go sebotsa ba bangwe go ihlokomela ge ba thusha.

Monyakishishi: O ka bololla seemo sa gago sa HIV go mogolwane wa gago moshomomg. Ka kgopelo hlohleletsa karabo ya gago.

Motseakarolo C: Go tla ya ka gore re tlwaelane go kae? A ke bone go hlokega.

Monyakishishi C: O ka bololla seemo sa gago sa HIV go moshomi wa EAP. Ka kgopelo hlohleletsa karabo ya gago.

Motseakarolo C: Ee, ge e le gore ditaba tsa gona e tla ba sephiri. O ka se tsebe, mohlomongwe ka letsatsi le lengwe o k aba hloka.

Monyakishishi: O ka tsea bjang moshomi mmogo wa gago ge a bololla go wena gore o na le kokwanahloko ya HIV go wena?

Motseakarolo C: Ke tla kgotsa, efela ke tla leka go mo fa thekgo, ke tla e dira sephiri ka gobane ditaba tsa mohuta di nyaka tshepagalo.

Monyakishishi: Bashomi mmogo ka wena ba ikwa bjang ka moshomi yo a swaeditsego ke kokwanhloko ya HIV?

Motseakarolo C: Moshomi ga a swanela go swara bjalo ka motho wa go lwala. O swanetse go swarwa bjalo ka motho o mongwe le o mongwe. A seke a phaelwa ka thoko.

ANNEXURE I: PARTICIPANTS TRANSCRIPTS IN ENGLISH

Real name changed for confidentiality purposes

Participant A

Researcher: Tell me what you know about HIV infection

Participant A: It is a thing that affects people through sex, wounds and not using protective clothing like hand gloves, using the same teeth brushes.

Researcher: Do you know your HIV status? If yes when have you last tested?

Participant A: Yes. I test always when there are wellness activities here at work. The last time I tested was on the 2nd September 2015

Researcher: It seems testing for HIV is a lifestyle to you; can you share about the significance of testing for HIV with others?

Participant A: Yes I will; even at the church fellow employees encourage them to test, even here at the workplace since I am a peer educator.

Researcher: Which factors do you think contribute to the spread of HIV amongst LDA employees?

Participant A: Not quite sure if employees practise safe sex.

Researcher: What role does gender have in spreading of HIV amongst LDA employees?

Participant A: Women are at a high risk due to the nature of their private parts. If I sleep with a man when not yet ready I might experience a cut that might lead to bleeding. If my partner is HIV positive, that could me to a risk because of blood contact during sexual intercourse. Another danger is when I as a woman bring myself closer to a man; we begin to touch each other, develop interest to an extent that

someone could realise that hmmm...these people can even fall into temptation of having sexual intercourse. That is where the issue of sexual harassment come into place at work. The same applies to women who are closer to their male supervisors they are being hooked in having sexual intercourse with them with the false promise that they will be promoted unto the higher post. Some people get their higher posts as a result of that act.

Researcher: How false is that promise?

Participant A: Some years back that conduct was rife and many received their promotions after they have slept with their bosses. However, currently it is no longer easy. I am working at recruitment section under human resource section there are processes to be followed.

Researcher: What you are saying is that women are currently less engaging in sexual activities with their bosses mainly because promotion is no longer the boss's decision, but there are recruitment and selection procedures to be followed.

Participant A: Yes; nowadays such conduct is minimal, because if you don't have the required diploma or degree you won't stand a chance of being short listed. There is fairness.

Researcher: Is there any way that female employees in LDA can be vulnerable to contract new infection?

Participant A: Wellness programmes are well coordinated here in our department, education is on-going, the problem lies with the employees is just ignorance.

Researcher: If I hear you clearly what you are saying is that employees are well informed and have adequate knowledge about HIV and AIDS, but their challenge is ignorance. What is it that is driving this ignorance according to your understanding?

Participant A: One thinks that HIV and AIDS are not meant to be acquired by me, but there are certain or specific people who are meant to contract the infection.

Researcher: You mentioned that you are well informed about HIV and AIDS, what is it that can lead you to contract HIV and AIDS according to your view?

Participant A: We married women; we are at a higher risk of contracting the virus. Our partners do not accept to use protection through condomising during sexual intercourse. They only respond positively if may be I am from testing and my results are HIV positive, then we have to follow the doctors or nurses's advices that we

should condomise to avoid re-infection and to prolong our life-span. Men are not faithful and there is nothing that you can do as a woman.

Researchers: Are you telling me that women are passive role players in their marital relationship?

Participant A: Yes, our culture perpetuates such submissive in the side of women and dominion for men in the relationship. Our culture is silent about HIV epidemic and its rapid spread within the society. In Shangaan culture, when a woman is married is expected to procreate, give birth to children. Thus using a condom is perceived as a barrier to procreation. I am married to another kind of a person, if I bring a condom home he will want to know why. I can only introduce a condom only when I know that he is having extramarital affairs outside our marriage, but without those incidences, I am afraid to start the topic.

Researcher: Is there any way that male employees in LDA can be vulnerable to contract new infection?

Participant A: There is no difference to what I said in regard to women. What applies to the female also applies to the male. Some women attract men by the way they dress like mini-skirts and see through dresses. It is difficult for men to resist seduction.

Researcher: How best can men seduction be prevented at workplaces?

Participant A: Women must be taught on a proper dress code when going to work. A matured woman must always think of what message is she sending through her attire on that specific day. Ask yourself questions such as “am I representable... what about my organisation...my profession...? Then every time think about the consequences of your dress code. The way people respond to you that day in terms of giving you respect or otherwise, it is based on how one has presented herself to them through dress code only.

Researcher: What is your opinion about having multiple partners?

Participant A: A person must stick on one partner. If you fail to remain faithful, simply condomise. In the olden days, having extramarital affairs as a man was acceptable. Nowadays such behaviour is very risky. Creating awareness on condomising even at tribal authorities where there are old men and women who are influential to their children. Those ones used to refer back then behaviours by uttering phrases like: “Do you see me, my father used to have four wives. Those children emulate what their forefathers use to behave. We employees here at Agriculture we are so fortunate to be educated, people out there are at a higher risk; 50 year old and above old women are on treatment infected by their spouses who contracted HIV while they were still at work and they were involved with young school girls who were hunting for money. Young men on the other hand contract HIV from widows, single and high profile women, who feel boredom and lonely, then transfer the infection to their young partners. Those women attract young men by bribing them with gifts and money. All age groups are at high risk. It just needs God’s grace, it is by his mercy that one is not infected at this moment.

Researcher: What do you think about substance abuse and HIV infection?

Participant A: In the community which I resides, people who drink alcohol are not actively engaged in sexual intercourse. Those who love engaging in sexual activities are those who are hiding in churches.

Researcher: How do you know?

Participant A: When they are drunk they fell asleep. How will they perform the activity, because everything should start from the mind, if there is nothing in the mind, nothing can happen in bed. Those who are inside churches, they even fall in love amongst themselves.

Researcher: In other words, what you are saying is that alcohol is not contributing to the spread of new HIV infection.

Participant A: According to my perception, yes, sexual intercourse and alcohol does not get along. Those ones they establish a relationship only when they are sober. You cannot draw an “S” symbol when you are in your mind is on a circular form.

Researcher: What is your perception in regard to the lifestyle of LDA employees in general?

Participant A: They behave so well, or it is because of the wellness programme. Even those who are HIV positive, behave well in the work place, I am not sure about when they are outside the work environment.

Researcher: Besides the awareness programmes that are on-going, what other strategies do you suggest can be put in place to prevent the new HIV infection in LDA employees?

Participant A: Visit once a month to conduct awareness. While in churches there are conferences to revive one another, even this programme it needs continuous revival.

Researcher: Do your employer’s policies contribute in any way to its employees’ vulnerability to contract HIV infection?

Participant A: Departmental policies are silent about HIV and AIDS. Those policies must be integrated at the strategic level. Even in the structure of the department, HIV and AIDS programme must be visible and not be hidden inside other programmes. I suggest that the HIV & AIDS section should be a stand-alone programme with its own budget in all the districts and municipality offices.

Researcher: Does your job predispose you to HIV infection? If yes, motivate.

Participant A: As an HR Clerk who is responsible for recruitment and transfers, male colleagues may promise someone to sleep with in exchange of a post, which might not be happening because of procedures to be followed.

Researcher: What is your employer doing to address new HIV infection within the workplace?

Participant A: The employer is doing his best in offering education and awareness, coordinate HIV testing and counselling in a workplace. I think us as employees we are the ones who supposed to have a bigger role to take responsibility over our life.

Researcher: Would you disclose an HIV status to your colleague? Please motivate your answer.

Participant A: I cannot disclose to a colleague because they will spread my status. There is no guarantee that my information will be kept safe. Once I am done with

counselling, I will only tell my partner and continue taking treatment. I would rather keep it a secret until I die.

Researcher: Would you disclose an HIV status to your supervisor? Please motivate your answer.

Participant A: No for the supervisor, unless they got into the ICU and read my file. Other colleagues visit the hospital to come and see so that they can spread the information at work. I will tell my mother that I don't want any colleague to visit me where I will be hospitalised. Employee health and wellness should also regulate under what conditions a colleague should be visited during his or her period of being absent to work due to ill-health condition. For me a colleague's telephonic support can be enough.

Researcher: Would you disclose an HIV status to the EAP professional? Please motivate your answer.

Participant A: To the EAP professional, yes because they are professionals. The first person to know my status would be my partner, then the professional help. Truly speaking I am not giving correct personal information to service providers during wellness day activities. It is my strategy of protecting my image in case results didn't go well.

Researcher: How will you respond to a colleague when disclosing his/her HIV position status to you?

Participant A: I can assist her by encouraging that she goes for counselling and also assure him/her that the information she shared with me shall be treated confidential.

Researcher: How are the attitudes of employees in your department towards an HIV positive colleague?

Participant A: Attitudes are good. They give necessary support to colleagues who are infected with HIV; they eat and live with them.

Participant B

Researcher: Tell me what you know about HIV infection.

Participant B: HIV is an infectious sickness that kills if not taken care of. One knows about his HIV status when he goes for blood test. Children have to be educated, the community and in churches people should be educated. Those who are infected must follow the treatment accurately. It is contracted through having sex without protection, exchange of blood through open wounds.

Researcher: Do you know your HIV status? If yes when have you last tested?

Participant B: Yes, around 2013

Researcher: Can you share about the significance of testing for HIV?

Participant B: As a preacher, I used to tell the congregation to go and test for HIV and to condomise continuously. People believe mostly in miracles and leave out taking the treatment. In church we also invite nurses to provide awareness, especially to sunday school and youth. Government policies should ensure that HIV and AIDS should form part of the school curriculum. Church sermons should also address this pandemic in their teachings.

Researcher: Which factors contribute to the spread of HIV amongst LDA employees?

Participant B: Poverty, when a person is not working, more especially women, they throw themselves to men. Sometimes it is the pressure from the man, the culture that the man has a voice and he is the head of the family therefore the woman has to submit, is dangerous. Children who lost parents, may not have food, so they go to the streets and find old man to support them, hence they get infected with HIV.

Researcher: What role does gender have in spreading of HIV amongst LDA employees?

Participant B: Most men are sick, more especially those with sugar diabetes, their sexual performance drop gradually that may result unto their wives going out to find sexual satisfaction. Another cause to the spread of the virus is domestic violence. Some men demand sex continuously from their wives and out to find that those women don't have that much capacity to meet the man's sexual demands. In such instances a man resorted to go out and has multiple partners. When there is a problem they don't share and discuss that problem, one of them just decides to go out. You must have an open communication.

Researcher: Is it an easy task for a man to communicate with his wife about his sexual challenges?

Participant B: It is very easy. The easiness is like for example; I have got two wives, we go together being three to get tested and the three of us also teach our kids.

Researcher: How have you managed to have such kind of a relationship with your family?

Participant B: My wives became my sisters, my mother and friends. As a man left alone from my parents, I am without siblings, they do a very wonderful job in my life, they are like my cushions. My children are already married, we all gathered in our lounge with their wives and I advise them about the importance of testing for HIV.

Researcher: I am happy that you came out clearly that you have two wives. There is an understanding or a belief that a man who is having more than one partner or a woman who is in love with a man who has more than one partner are all at risk to contract the virus. Does having multiple partners have any impact in increasing HIV infection?

Participant: During those years I had one wife; I became naughty and impregnated another woman. I and my wife decided to pay lobola to the second wife, because if not, the same temptation would have happen again that can lead me to contract the HIV infection. Both of them are teachers and I am the one who took them to school to further their studies. I have seven boys and one girl; they are all well groomed and well mannered. God is good and I am blessed. Most of the pastors are hiding at church but have multiple relationships. The people who are at risk, are those who are in the church. Women confide their problems to the pastors; at the end those pastors take advantage of them.

Researcher: What is your perception in regard to the lifestyle of LDA employees in general?

Participant B: Most employees in Department of Agriculture are at an old age and no longer sexual active. They are at less risk. They are the ones who participate in HIV Counselling and testing, while youth run away from testing. An effort and strategy to reach out the youth in agriculture should be in place.

Researcher: Is there any way that female employees in LDA can be vulnerable to contract new infection?

Participant B: Yes, An employee who is coming from the home background in which things were not well such as lack of respect, obviously that employee would behave in an unacceptable manner at work such as engaging in sexual activities with different employees in such a workplace. The danger of sharing offices create an environment wherein employees get used to one another to an extent that they end up having interest on each other and involve themselves in sexual activities without any future plans of such a relationship. People use to regret while the damage has already occurred.

Researcher: What is your employer doing to address new HIV infection within the workplace?

Participant B: Awareness and education must be on going. Education is not sufficient in LDA, most of our employees are field workers, and the moment the awareness is conducted some are not available. Some are within the vicinity of the workplace, but they choose not to participate because of reasons that are known to them. Adults feel like awareness is insulting when the effective use of condom is demonstrated. The departmental policies or other legal prescripts should enforce participation by making HIV testing compulsory or involuntary.

Researcher: It seems as if you are saying that the language that is used during awareness campaigns is not acceptable to adult employees in the department, what method do you suggest can be acceptable to reach out every age group without violating their belief system?

Participant B: You know Shangaan are very sensitive to strong languages, some are working with their in-laws and relatives, some of the words are not acceptable to be spoken in the presents of everyone, a separate conversation such as grouping females and males separately, might yield fruitful results. Myself I am a member of men's forum; in those forums we discuss deeper issues that affect us as men. They

also taught us about various forms of women abuse and about how to take care of your partner and entire family.

Researcher: Are you feeling much safer and comfortable to share your ideas when you are only men.

Participant B: Definitely! For example, the recent men's forum that we had, another doctor indicated that when a woman is happy and comfortable with you, she will puff, shows you how safe she feels to be under your headship (Participant B...laugh and the researcher laugh as well).

Researcher: Is there any way that male employees in LDA can be vulnerable to contract new infection?

Participant B: Yes, if I am experiencing marital problems and share with my female colleague, she might see an opportunity to have me as her partner. She will go all out to comfort me and by so doing, I got caught in a net and ended up in making love with her, meanwhile it was not intended to happen.

Researcher: What do you think about substance abuse and HIV infection?

Participant B: There is one family that I know; there are five children who are staying with their grandmother. Those children continuously give birth and ended up being eighteen in the house for the sake of getting child support grant. That family survived through drinking alcohol. We even decided to foster one boy. That boy was good at first but due to adolescent stage, he changed his behaviour.

Researcher: Do your employer's policies contribute in any way to its employees' vulnerability to contract HIV infection?

Participant B: Policies are good, the problem is with the end users of those policies.

Researcher: Does your job dispose you to HIV infection? If yes, motivate.

Participant B: No, I am dealing with the goods at work. However; we sometimes go out for workshops sleep over, like recently we were at Skukuza, known as Kruger national park, employees were heavily drunk, they started misbehaving and ended up sleeping with each other. Senior management as well are at a risk of being targeted by young ladies who are desperate for promotions.

Researcher: Would you disclose an HIV status to a colleague? Please motivate your answer.

Participant B: Yes, for example; when we (me and my wives) are going for testing, I have disclosed about the chances of having prostate cancer, I also disclosed to a

colleague. I educated him and encouraged him about the significance of going for prostate cancer screening.

Researcher: Would you disclose an HIV status to your supervisor? Please motivate your answer.

Participant B: Yes, because he supposed to support me in terms of sick and ill-health leaves, my supervisor is like my mother, father and my family, we are on the race of work-life together, non-disclosure affects service delivery. It might happen that my sickness progresses up to the point where I failed to deliver some assigned duties; it is my supervisor who will provide reasonable accommodation as well. There is no need to hide; it can be an added stress to me.

Researcher: Would you disclose an HIV status to the EAP professional? Please motivate your answer.

Participant B: Yes, when I learned about my cancer prostate results I consulted professionals for counselling and support.

Researcher: How will you respond to a colleague when disclosing his/her HIV positive status to you?

Participant B: I can be supportive, show him/her love, without judging or criticizing.

Researcher: How should colleagues behave towards a fellow colleague who has disclosed the HIV positive status?

Participant B: They should be supportive, show them love, encourage them, educate in terms of food, and not isolate them. This is a venting wheel, all of us we are at risk of contracting the infection, so hence there is a need to support each other.

Researcher: How are the attitudes of the employees in your department towards an HIV positive colleague?

Participant B: In this office, we do support one another, some of our colleagues are on treatment and they are in a good state of health currently.

Researcher: We have come to an end of our interview. I thank you for your time and ideas that you shared with me.

Participant B: I am so grateful as well to have participated in the interview. I believe my ideas shall be written in the journals that can be read by everybody to assist our nation.

Participant C

Researcher: Tell me what you know about HIV infection.

Participant C: HIV infection is transmitted through blood contact, unprotected sex and mother to child transmission.

Researcher: Do you know your HIV status? If yes when have you last tested?

Participant C: No, I am scared to test.

Researcher: What makes you scared?

Participant C: I have a partner who is unfaithful to me. I am scared that I might have already contracted the virus from him.

Researcher: Can you share about the significance of testing about HIV?

Participant C: I sometimes share with my partner, he used to test for HIV very often, but with me...ee...I am afraid.

Researcher: Which factors contribute to the spread of HIV amongst LDA employees?

Participant C: It is because of ignorance, people do know but they don't act...like myself (with laughter).

Researcher: When have you started your internship?

Participant C: I am now six months.

Researcher: For those six months you joined the department, what is your perception in regards to the lifestyle of LDA employees in general?

Participant C: What I have observed is that employees like gossiping about each other and they are too judgemental, like I cannot feel comfortable to disclose my

status to them if I discovered that I am HIV positive. So I would be afraid to be judged.

Researcher: From your experience as an intern in this department, is there any way in which you can be at risk to contract new HIV infection here at your workplace?

Participant C: If one is not careful yes.

Researcher: Can you explain further what do you mean about one not being careful?

Participant C: When you arrive in a new work environment, every guy would want to associate himself with you, even those that are married. To me I think that they are taking an advantage to each and every intern who arrives here.

Researcher: What advice do you think you can give your fellow interns?

Participant C: I can advise them that sexual relationships in a workplace do not work. You need to have self-introspection that what is it that attracts men on you; like it might be the way you behave?

Researcher: How do you feel when each and every male colleague come and propose love to you?

Participant C: I am feeling uncomfortable, it makes me to assess my conduct or the impression I am sending to these men, and I ask myself is it love or it is lust that these men are having on me.

Researcher: You spoke about a behaviour that may be attracting to men; can you share with me such behaviours?

Participant C: We are relating very closely with our colleagues, but the relationship should be within limits. If for instance when you greet each other you hugged; or as a woman you keep on making an endless requests from a man such as “buy me lunch...after two minutes...buy me cold drink...you make unnecessary phone calls”. Those are signals that you like that guy and you are making all attempts to have him for you.

Researcher: From your own perspective, what led such behaviour from the young girls?

Participant C: They seek attention, money and want to fit in a certain company or group of specific people.

Researcher: What role does gender have in spreading of HIV amongst LDA employees?

Participant C: Culturally men has been raised up with that mentality that they are men and it is accepted by society that they can go as they wish to play around. When they come back to their wives they don't use protection when engaging in sexual intercourse.

Researcher: What is your opinion about having multiple partners?

Participant C: Ethnically I am a Pedi. In my culture it was acceptable for a man to have more than one wife. The current generation rarely marry more than one wife, but they have girlfriends. If you are a man it is approved, but if you are a woman it is disapproved. If I cheat my partner I will be called by names such as: "sefebe" a belittling word which means that you are a prostitute, but if a man cheats he is being praised and called him "sekhokho" meaning a boss or great one.

Researcher: Does having a concubine contributes to the spread of new HIV infections?

Participant C: I think it expose more risk to all parties involved, because the girlfriends do not have any strings attached to that relationship. In this instance he or she might have been in another relationship. So, can you see the chain in which the person finds himself in without being aware that he is part of that hidden chain? It is hard to accept and witness your husband marrying another woman, but I think it is much better than him having girlfriends.

Researcher: From a young girl of your age I am so pleased that you share our deep thoughts on the topic under discussion.

Participant C: Thank you. I think life at the University has groomed me to understand myself. I have learned and grown from number of mistakes. I believe that when one enters the work life, he/she should know what he/she wants for the future. At work men who have been working for number of years they would be very far materially, and they use those materials to win you. So, if you don't know who you are and what you want you may fall into a trap.

Researcher: What role does gender inequality contributes in the spread of new HIV infection?

Participant C: Young women, who are in position of being interns like me, may be anticipating job opportunities before the end of internship. During the end of the internship programme we might experience desperation of exiting the work environment and become vulnerable to the deceptions by our supervisors to have sex with them with the impression that we will be offered permanent posts. One of my

friends is still getting a salary although her contract has ended, just because she has an affair with her boss.

Researcher: What do you think about substance abuse and HIV infection?

Participant C: Alcohol does contribute in the spread of HIV and AIDS. When you are under the influence of alcohol you lose control over your own behaviour and behave irresponsibly by not using protection. Another risk is that you are more likely to have sex with the person who is not your partner, and you regret when sober. Girls who indulge in drinking alcohol they provide sex in exchange of getting a beer. Men are afraid to propose love from women who are at a higher rank than themselves. Those women resorted to seducing young men by giving them money in exchange of sex and buying alcohol so that they can become brave to stay in that relationship. This kind of behaviour puts a young man at a risky situation in that his life will revolve around the life of that woman. I had a friend at the university who met another woman at a hiking spot and gave her a lift. That woman exchanged her numbers, she started calling him continuously and ending up winning him. The friend of mine left the campus to stay in the house of that woman; he came to school driving that woman's car. Fortunately he managed to complete his studies and they are together full time as wife and husband. He is no longer answering calls from his friends.

Researcher: The story seems to have a happy ending, but the risk of contracting HIV in that kind of a relationship is not known I guess so.

Participant C: That's the truth. His success in having an intimate relationship with a woman older than him has encouraged young men of his age to follow the suit. However; their autonomy is being robbed. They are being overprotected by those

“sugar mamas”, treated like kids by these women; they do everything for them. So they are denied an opportunity to grow and become matured.

Researcher: Do your employer’s policies contribute in any way to its employees’ vulnerability to contract HIV infection?

Participant C: I am not sure. I haven’t seen any awareness campaign on HIV since the past six months I joined this department.

Researcher: What you are telling me is that the employer’s initiative to prevent the spread of HIV in a workplace is not enough to the employees.

Participant C: Yes. I think six months is too much for no provision of HIV and AIDS awareness initiatives.

Researcher: Would you disclose an HIV positive status to your colleague? Please motivate your answer.

Participant C: No; the workplace is not a conducive environment wherein you can share your personal matters.

Researcher: Would you disclose an HIV status to your supervisor? Please motivate your answer.

Participant C: The same applies to the supervisor

Researcher: Would you disclose an HIV status to the EAP professional? Please motivate your answer.

Participant C: No

Researcher: How will you respond to a colleague when disclosing his/her HIV positive status to you?

Participant C: I still believe it is personal. However; if a colleague feels like disclosing, I will avail myself to listen and provide necessary support.

Researcher: How should colleagues behave towards a fellow colleague who has disclosed the HIV positive status?

Participant C: I have just heard that there was an employee who passed away because of HIV and AIDS. The employees were concern that the deceased wouldn’t have passed away if he/she followed the prescribed treatment. To me it meant that they care about each other.

Researcher: I believe we have come to the end of our interview. Let me take this opportunity to thank you for having volunteered to contribute in this research by sharing your ideas and knowledge

