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MANAGEMENT OF HIV/AIDS PROGRAMMES AT THE WORKPLACE: A STUDY OF SELECTED ORGANISATIONS IN CHRIS HANI DISTRICT, EASTERN CAPE PROVINCE

By

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DECLARATION

I declare that "MANAGEMENT OF HIV/AIDS PROGRAMMES AT THE WORKPLACE: A STUDY OF SELECTED ORGANISATIONS IN THE EASTERN CAPE PROVINCE, CHRIS HANI DISTRICT" is my own work unless otherwise referenced or acknowledged. This dissertation has never been submitted or presented at any other university for the awarding of a similar or any other degree(s).

GETRUDE SHAVA

APRIL 2013

DEDICATION

I dedicate this work first and foremost, to the Man above (God Almighty) who gave me the strength, power and wisdom to realize my goals and dreams, for in Him, there is no failure. To my family, who stood by me through thick and thin and lastly, my late parents Jane and Major, I dedicate this to you, for teaching me to always thrive for excellence no matter how difficult and unfavourable the things may seem to be.

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ABSTRACT

The aim of the study was to investigate the management of HIV /AIDS programmes at the workplace in four selected organisations in Chris Hani District, Eastern Cape Province of South Africa. Four organisations were studied, two public organisations and two private organisations. With the use of triangulation method, two hundred employees were administered a semi- structured questionnaire while for (four) managers, semi structured in-depth interviews were conducted. The major findings of this study outline that all the four organisations studied have HIV/AIDS programmes and policies for their employees. However, there were no budget allocations for these programmes to be fully implemented for effectiveness. From the data, it can be concluded that HIV/AIDS has a negative impact on organisations' production like high training costs, high labour turnover and high absenteeism from work. This has been as a result of managers who did not put their total commitment towards HIV/AIDS management at their workplaces in the same way they have done to other core areas of businesses of their organisations. The study therefore recommends the management of these organisations to demonstrate a clear commitment to the HIV/AIDS management strategies by fully implementing the HIV/AIDS management programmes in their workplaces. It is very crucial for employees to see this commitment in a concrete form through non-discrimination and support for the people living with HIV/AIDS. Clear unambiguous commitment will go far in developing mutual trust between employers and employees and facilitate an atmosphere where people are willing to undergo VCT and to possibly disclose their status. Furthermore, managers are recommended to hire quality service providers to carry out intensive de-stigmatisation processes. This will create a supportive environment and adequately address the fears of employees about HIV/AIDS issues

at the workplace. All these recommendations will go a long way in assisting organisations achieve their strategic business objectives and reduce the negative impact of HIV/AIDS at their workplaces.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ART	Azidothyymidine
ASSA	Actuarial Society of South Africa
DMP	HIV/AIDS Disease Management
EAP	Employee Assistance Programme
GDP	Gross Domestic Product
HCT	HIV Counseling and Treatment
HSRC	Human Sciences Research Council
HIV	Human Immunodeficiency Virus
ICAS	Independent Couselling and Advisory Service
IDP	Integrated Development Plan
ILO	International Labour Organisation
PEPFAR	President's Emergency Plan For Aids Relief
PLWHA	People Living with HIV and AIDS
RNA	Ribonucleic acid
SABCOHA	South African Business Coalition on HIV/AIDS
SANAC	South African National AIDS Council
SPSS	Statistical Package for Social Sciences.
UNAIDS	Jointed United Nations Programmes on HIV/AIDS.
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation

CHAPTER ONE

GENERAL OVERVIEW OF THE STUDY

1.1 Introduction

This chapter presents the general overview of the study. The background of the study, the research problem, the hypotheses of the study, the outline of the chapters and the importance of having HIV and AIDS management programmes at the workplace are all presented in this chapter.

1.2 Background to the study

A workplace is a core centre for production of the needs of society. HIV/AIDS provides a critical threat to it. Therefore, there is need for management of HIV/AIDS programmes in workplaces to ensure healthy workplaces for quality production. HIV/AIDS constitutes a major setback to the development of South Africa in addition to causing tremendous sufferings in the society since it knows no gender, age or racial boundaries. According to Code of Good Practice on Aspects of HIV/AIDS Employment, it is still a disease surrounded by ignorance, stigma, prejudice and discrimination. The epidemic is maturing and prevalence rates still put South Africa squarely in the category of high prevalence countries (Chetty and Michel, 2005).

HIV/AIDS remains a continuing global challenge and is the world's leading infectious killer disease, with an estimated 2 million deaths occurring in 2008 alone. Even with improved treatment access, HIV remains a leading cause of death among young adults between 15 and 44 years of age (UNAIDS 2009). According to Bloomberg

(2010:2), statistics and numbers about HIV/AIDS globally paint an alarming picture of the world's health state and future well-being. For South Africa, the picture is equally serious with nearly six million people living with HIV and AIDS. South Africa has the world's largest population infected and affected by the disease. The impact of HIV/AIDS on society and its ripple effects are well documented, with the strongest call for action worldwide to stop the endemic by focusing on reducing new infections. For this reason, the Department of Health embarked on a national campaign to test 15 million South Africans by June 2011 (HSRC, 2010).

In April 2010 the South African Government launched a major counseling and testing campaign (HIV Counseling and Treatment)-HCT which marked a welcome change from South Africa's history of HIV. The HIV Counseling and Treatment was aimed at offsetting the problem of late or no diagnosis. This campaign has been built on the South African National AIDS Council endorsed theme for World AIDS Day 2009, which emphasised both the individual and collective responsibility of South Africans to stop new HIV infections, and provide treatment, care and support to people living with HIV. As such, workplaces are also encouraged to embark on HIV/AIDS programmes to promote the campaign.

The HCT campaign is a widespread strategy implemented in all health authorities whereby all South Africans are encouraged to interrogate the roles that they can play towards an effective national response to HIV and AIDS. To make sure that this can be achieved, HIV testing is free at all public health facilities where individuals have access to the highest level of quality service from testers and counselors, pre- and post-testing in a confidential manner and with informed consent. People are encouraged not to just test once, but to do it as a regular practice especially for

persons who are sexually active as a way of managing a healthy life style. Through this proactive approach the government of South Africa aimed to test 15 million people for HIV and reduce the HIV incidence rate by 50% by June 2011 (SANAC, 2010).

The global HIV burden remains enormous. At the end of 2008, an estimated 33.4 million people worldwide were living with HIV. That same year, some 2.7 million people became newly infected with the virus. More than 95% of all HIV-positive people are in low and middle income countries. According to WHO (2010), the global summary of the HIV/AIDS epidemic for December 2008 showed that 31.1 million adults were living with HIV, 2.3 million of whom were adults while 430 000 children under 15 were newly infected. In the same period, AIDS related mortality accounted for the deaths of 1.7 million adults and 280 000 children under 15 (WHO, 2009). These are alarming figures of deaths which require meaningful and consistent management of HIV/AIDS programmes by all organisations. But the question remains whether organisations really commit themselves to this responsibility.

According to WHO Regional offices in Africa, sub-Saharan Africa remains the region mostly heavily affected by the virus, accounting for nearly two thirds (67%) of all people living with HIV. Throughout the region, an estimated 60% of HIV infections are in women and 14 million children in this region under the age of 15 have lost one or both parents to AIDS (UNAIDS, 2009). In 2007, the total population of South Africa then estimated to be 47, 432,000, had an estimated 5,500,000 people, or 11.5 percent of the total population who were HIV positive (Parker, 2007:52). An estimated 5.7 million people were living with HIV/AIDS in South Africa in 2009, more than in any other country. It is believed that in 2008, over 250,000 South Africans died of AIDS (UNGASS, 2010).

Prevalence is more than 15 percent among those aged 15-49, with some age groups being particularly more affected. Almost one-in-three women aged 25-29, and over a quarter of men aged 30-34, are living with HIV (Statistics South Africa, July 2009). All these statistics have prompted the researcher to carry out this research in order to assist South African organisations to strategically control the epidemic through assessing the impacts and costs of having HIV programmes in the workplace and to assist those organisations that do not have these programmes thereby trying to create an atmosphere of retaining the workforce. Despite the fact that this epidemic has profound effect on the personal lives of employees and employers, it has also impacted on the organisational and economical lives (Dyk, 2005:416).

In response to these severe impacts, considerable capacity building and funding has been invested in developing HIV related workplace programmes. However the extent to which these programmes are being implemented and are benefiting the affected and infected employees have not been adequately studied. Therefore, the development of management of HIV/AIDS programmes at work is significant in promoting awareness, prevention and care among the already infected and the affected at the workplace. According to Dyk (2005:461), the workplace should be seen as a gateway to HIV prevention and the starting point for the care and treatment of people living with HIV/AIDS.

In many South African workplace setups, HIV programmes are available on paper with no practical implementation of the same. This can be supported by Welton *et al*. (2007), who stated that the effectiveness of many workplaces is unconfirmed. Monitoring and evaluation is limited, and the uptake of programme elements is weak,

partly due to the stigma surrounding the virus. Jansen (2004a) expressed the same views. He stated that while policies in South Africa are wonderful and are intended to provide an excellent and equitable service, there is a constant message in the literature that policy does not directly translate into practice on the ground. There are problems with the implementation and provision of resources (Lewin *et al*., 2004b). Care and support are not given to the infected and affected and this has led to absenteeism and discrimination among employees. Intervention programmes like nutritious meals are not even practiced in many organisations and one of the main reasons for that is the information gap between the top managers and the employees. According to SABCOHA Annual Report of (2007/8:10), it has been noted that nutrition is an effective but often neglected part of HIV treatment strategies which can play a key role in managing infection. Mafuya (2007:319) concluded that the lack of resources to effectively implement HIV/AIDS policies is the single biggest challenge thereby recommending an assessment of resources needs to be conducted so that it coincides with the implementation of the policies. Furthermore, Weston *et al*. (2007), noted the vacuum of leadership on HIV/AIDS at all levels of the public sector, from the highest level of government to HIV/AIDS managers, many of whom lack the skills and knowledge to run the programmes. Top management does not have adequate knowledge on how to manage the psychological climate of teams with members who have HIV/AIDS, and how to manage the culture of the organisation to prevent disruptions and discrimination. Hence the study seeks to close this gap by determining how workplaces manage, and how they should manage, HIV/AIDS programmes for consistence and effectiveness. More-so this study seeks to identify the effectiveness of workplace intervention programmes and how those particular activities benefit both the individual and the organisation which

in return will assist the government and other private sectors to plan strategically against the pandemic at the workplace, let alone the provision of stability in families.

1.3 Problem statement

The HIV/AIDS epidemic has presented a major social and developmental challenge in South Africa. Businesses in South Africa, like in other parts of the African continent, face many challenges in standing up to the needs of a global business environment, one of these being the scourge of HIV/AIDS. In South Africa, HIV/AIDS is thriving in an environment of poverty, rapid urbanisation, violence, illiteracy and destabilisation accompanied by ignorance, prejudice, discrimination and stigma. Transmission has been exacerbated by disparities in resources and patterns of migration from rural to urban areas. The rate of infection affects the socio-economic development negatively (Code of Good Practice on Aspects of HIV/AIDS Employment). A large amount of income is spent on health care. The household capacity to sustain itself is significantly reduced as infected members become economically inept. Many South African families are stretched to the limit, as they have to accommodate children whose parents have died from HIV/AIDS (SANAC, 2010).

According to Barnett and Whiteside (2006:270), HIV/AIDS has the potential to increase organisational costs over both the short and the long term. In South Africa, the government in partnership with other private sectors have been making, and are still making, efforts to fight the pandemic that has affected everyone whether directly or indirectly. South Africa has an excellent legislation but evidence of wide spread discrimination and stigma to people living with HIV/AIDS still exists (5th Southern

Africa AIDS Conference, 2011). AIDS related stigma has been expressed by employers and the employees through rejection, avoidance and violence against PLWHA. All this discrimination inflicts suffering on employees and interferes with attempts to fight the pandemic as well as causing some employees not to report for work thereby adversely impacting costs and production of organisations. Some employers have also terminated and refused employment once they have gained knowledge that an employee is infected by HIV.

This study seeks to promote acceptance and reduce stigmatisation and discrimination of employees affected and infected by HIV/AIDS at the workplace through investigating the management of HIV/AIDS programme and by assessing whether HIV/AIDS policies are implemented on sound information and taking into account the rights of everybody. More-so, the study seeks to improve business chances of success by focusing on programmes and policies that affect employees so as to improve morale in organisations as well as improving relationships between employees (both affected and infected) and management with regard to HIV/AIDS related issues at the workplace. Therefore this study is going to carry out an investigation into the management of HIV/AIDS programmes at the workplace in some selected organisations in the Eastern Cape.

1.4 Aims and objectives of the study

The aim of this study was to establish the existence, nature and extent of HIV/AIDS programmes in the workplace as a way of dealing with HIV/AIDS among employees. The study was guided by the following specific objectives:

- To determine the nature of HIV/AIDS programmes in selected organisations.

- To determine how workplaces manage their HIV/AIDS programmes for consistency and continuity.
- To determine the perception of employees of the organisations on the HIV/AIDS programmes.
- To determine the effectiveness of the workplace HIV/AIDS interventions programmes.

1.5 Research questions

The study sought to answer the following research questions:

- What HIV/AIDS management programmes exist in organisations?
- How are the HIV/AIDS programmes managed?
- How do the employees of the organisations perceive the HIV/AIDS programmes?
- How effective are the programmes in reducing the impact of HIV/AIDS on organisations?

1.6 Hypotheses

The following hypotheses guided this study:

- Employees have negative attitudes towards HIV/AIDS programmes at the workplace.
- HIV/AIDS interventions programmes are not effective.
- There is no difference between the public and private sector in the management of HIV/AIDS programmes.
- There is no impact of having HIV/AIDS programmes at the workplace.

1.7 Significance of the study

HIV/AIDS poses a threat to investment in the Eastern Cape as well as the rest of the country. Companies from abroad are skeptical of investing in a country where social responsibility exceeds the returns to investment. As is the case now, since HIV/AIDS affects mostly the economically active population group, this means a large amount of money will be used on training and replacement of personnel. Dyk (2005:416) adds that there is also a loss of productivity due to morbidity and mortality at the workplace. Therefore, this study's recommendations will enhance the proper development and promotion of management of HIV/AIDS programmes at the workplace which are vital in promoting awareness, prevention, and care among the already infected and affected employees at the workplace.

Furthermore this study seeks through its recommendation to make organisations aware of the benefits of implementing cohesive strategies of managing and treating the disease in the workplace. In this way, this will have a positive impact on organisations' economic benefits as managers will be able to handle sickness, absenteeism, loss of morale and grief in their departments. Proper management of HIV/ AIDS programmes can ensure that their productivity remains at an acceptable level for quite a number of years. It is also hoped that this study's findings will help organisations in reducing infection rate among employees through improving better management of HIV programmes and interventions in the workplace and also by building commitment in fighting this pandemic through education, awareness and counseling.

1.8 Delimitation and scope of the study

This study focused only on two selected public and two private organisations in Chris Hani District that have HIV/AIDS programmes in order to determine how they are managed, as well as determine their effectiveness. These organisations have been given pseudo names and identified as organisations A, B, C and D. Chris Hani District Municipality lies in the north-eastern part of the Eastern Cape Province. The district lies in a remote location along the N6, approximately 170 km from East London. There are eight local municipalities, namely Emalahleni, Engcobo, Inkwanca, Intsika Yethu, Inxuba Yethemba, Lukhanji, Tsolwana and Sakhisizwe Local Municipalities, and the District Management Area of Mountain Zebra Park. The major towns in the district are Queenstown, Middelburg and Cradock. In terms of transport networks, two national roads run through the area, namely the N10 and N6 connection routes.

The total population of Chris Hani District is about 810 300 people who live in an area that covers 37 111 km^2. Of the population, about 79% reside in rural areas while the remaining 21% are urban-based. The population density is 21.83 persons/km^2. Over 38.9% of the population in Chris Hani District is younger than 29 years of age. This shows that there is a need to implement youth development programmes, and for the most part, targeting women in stimulating nodal economic growth. Households headed by women constitute 53.5% of the population.

Moreover, there are also two primary and two secondary rail routes. There are vast distances to travel across the node. Many access roads remain unsurfaced, leading to lack of public transport. Some parts of the node are made up of parts of the former Transkei and Ciskei. The gross domestic product (GDP) per capita is 52.7% of the

Eastern Cape average. Investopedia online dictionary defines GDP as one of the primary indicators of a country's economic performance. It is calculated by either adding up everyone's income during the period or by adding the value of all final goods and services produced in the country during the year. Per capita GDP is sometimes used as an indicator of standard of living as well, with higher per capita GDP being interpreted as having a higher standard of living. Infrastructure provision revealed that 49% of households lack electricity while 54% lack piped water.

Moreso, the terrain of Chris Hani District has gradual step topography. Natural resources like two mountain ranges are found in the district, namely the Stormberg and Winterberg mountains. Most parts of the area lie between 500 m and 1 000 m above sea level. The District has a number of attractions that suggest that tourism could hold considerable potential for future growth. Furthermore, it offers abundant fertile soil and good veld quality, but the unequal distribution of rainfall limits the potential of some areas. The areas have high grazing potential and irrigation schemes with potential for expansion and also produce some of the highest quality milk in the country but there are limited processing facilities in the region.

The Chris Hani district economy is heavily reliant on community services so much so that without the employment opportunities offered by government, the regional economy would be in decline. General government services and community, social and personal services remain the most important sectors contributing to employment with 30% and 19% respectively. The wholesale and retail trade sector contributes 14% to employment and the contribution to employment by financial and business services amounts to 9%. The government (27%) is by far the largest contributor to the GDP of the node. The combined contribution that agriculture, manufacturing and

construction make to nodal GDP is less than that of government services of 27%. Indeed, the public sector in total (including community, social and other personal services) contributes 37% of Chris Hani's GDP.

The percentage of people employed within households, whether domestically or in self-employment, is of interest. The high level of employment in agriculture, households and trade indicate that the economy is still relatively underdeveloped. The reason for the high employment in trade and agriculture could be due to the fact that these industries are reliant on unskilled labour, which constitutes a large part of the district's workforce.

Unemployment is a major challenge, current unemployment levels are estimated to be about 57%, significantly higher than both the national unemployment rate, at 37%, and the provincial rate of 51%. Over 69.4% of households earn less than R9 600 per annum and live below the poverty line. Therefore there is high malnutrition and hunger index. With acute concentrations of hunger, poor households are forced to spend the greatest percentage of their incomes on food. Lack of facilities, equipment and properly trained staff, together with the low levels of household income, as well as the high teenage pregnancy rate, prevent parents from sending children to school.

1.9 Definition of terms

The following terms are defined as used in the study: workplace, employee, and HIV/AIDS programmes.

1.9.1 Workplace

According to the American Heritage Dictionary of the English Language (2000), a workplace is a place, such as an office or factory, where people are employed.

1.9.2 Employee

An employee is defined by the Collins English Dictionary (2003), as a person who is hired to work for another or for a business, firm etc., in return for payment.

1.9.3 HIV management programmes

These are programmes designed to prevent or reduce the HIV transmission including components such as awareness, education and trainings, condom distribution, treatment of sexually transmitted infections and peer education.

1.10 Chapter outlines

Chapter 1: General overview of the study

This is the first chapter and it highlights the background of the study and its significance. It encompasses the research aims and objectives, problem statement research questions and the hypotheses.

Chapter 2: Literature Review

This chapter entails the definitions of the main terms used in the study. The literature review is also found in this chapter as well as the theoretical framework of the research. The gaps from the literature review that need to be rectified by the current

research is also stated in this chapter as well as how to manage HIV/AIDS programmes at the workplace.

Chapter 3: Research Methodology

This chapter presents the research methodology, research procedures and research design, sampling, methods of data collection, trustworthiness of the research instrument and the ethical considerations and also limitations of the study.

Chapter 4: Presentation of Results and Discussion of findings

This chapter presents the results of the research, both quantitative and qualitative, as well as discussion of the findings of the study.

Chapter 5: Summary of findings, Conclusions and Recommendations

This chapter contains a summary of the results of the research, presentations of the conclusions and recommendations of the study. Finally, it presents areas for further research.

1.11 Conclusion

This research is of a great value for South African workplaces since HIV/AIDS is causing a serious threat to the economic expansion that has even led the government to draw its attention on awareness and promotion of HCT. This has also exacerbated by the African and world-wide statistics that picture South Africa as number one on HIV infection rate, HIV/AIDS related illnesses and AIDS deaths.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The previous chapter highlighted the general overview of the study, the problem statement as well as the objectives. This current chapter highlights and presents information on the theoretical framework, the literature review, information on the global views of HIV/AIDS and its prevalence in South Africa and South African workplaces, demographics of HIV/AIDS as well as the management of HIV/AIDS at the workplace.

2.2 Theoretical Framework

This study is anchored on the Human Relations Management theory in order to understand the management of HIV/AIDS at the workplace for the benefit of both the employee and the employer.

2.2.1 Human Relations Management Theory

The Human Relations Management theory (HRM) began in the Industrial Revolution where productivity was the focus of business. According to Encyclopedia of Business and Finance (2007), human relations is defined as fitting people into work situations so as to motivate them to work together harmoniously and it covers all types of interactions among people thus their conflicts, cooperative efforts and group relationships.

The HRM theory encompasses a rich and diverse tradition of models, techniques, research findings, and ideas that often trace their roots back to the Hawthorne Experiments conducted in the late 1920s which examined the effects of social relations, motivation and employees satisfaction on factory productivity. George Elton Mayo did different experiments at the workplace and his purpose was to explore the relationship between changes in physical working conditions and employee productivity. He discovered that employees who participated in scientific studies may become more productive because of the attention they receive from the researchers and he also noticed that the need for recognition, security and sense of belonging is more important in determining workers' morale and productivity than the physical conditions under which he works.

DuBrin (2007) argued that companies need their employees to be able to successfully communicate and convey information, to be able to solve conflicts and arrive at resolutions. So that everyone can maintain more compatible relationships. Furthermore, Mayo concluded that the worker is a person whose attitudes and effectiveness are conditioned by social demands from both inside and outside his discovery of the human factor, ushered in a new era in which workers' needs were acknowledged and met. The fundamental lesson that emerged from early research of employees who were put into control rooms suggested that employees who are given attention by management, who are treated as special, and who perceive their work as significant can become highly motivated and thus become more productive.

The HRM theory engaged directly with emerging understandings about the depth of personhood whereby more attention is given to individuals and their unique capabilities as a major belief for an organisation to prosper. Therefore, the

management of workers' needs like health and safety programmes, in this case "HIV/AIDS management", must be considered by organisations in order for them to be more productive. As a result, focus must be aligned to both satisfying the employer as well as the employee.

In a previous study Bowler (2007), used the UNAIDS cost impact model as a theoretical framework which shows the HRM theory by the way which it was designed where direct cost and indirect costs to employees were the first priority on the model followed by costs in productivity for the organisation. Bowler (2007) in his study focused on the potential that HIV management might have on the organisations whereas this study wants to close the gap by addressing the nature of programmes which exist in the organisations and the extent of how it is managed in dealing with the problem of HIV/AIDS for the benefit of both the employee and the organisation. This study wants to really find out if there are specific programmes in workplaces so that they can be compared to find the best method that can be recommended to other organisations including the perceptions of the employees about HIV/AIDS intervention programmes.

People are unique, you might provide an effective programme for them for example care and support but in their minds, beyond care and support, they might think of self-help projects so as to do away with the dependence syndrome. The organisations must know the needs of employees and their reactions to these interventions. Bowler (2007) was more concerned at the capacity in that case, and did not look at the emerging interventions and their impacts on people concerned; rather, it examined the feasibility of dealing with HIV management. This study examined what is happening on the ground, what are the procedural interventions

done in organisations in trying to manage HIV/AIDS in the workplace and their practicality in organisations. Furthermore the study wanted to find out what strategies of interventions are used by organisations; whether its advocacy or prevention.

2.3 Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

A few decades ago, a terrible disease, previously unknown to the human race, began to kill people in the most alarming and terrifying circumstances. It was as though a dreadful beast had entered the bloodstream of the human race. Wherever this microscopic beast appeared, it produced panic, fear, guilt, hysteria, accusations, terrible suffering and always, in the end, death. HIV/AIDS has become one of the most destructive plagues in history. It is a monster that threatens to destroy our society because it is changing the rules by which we live (Dyk, 2005:4). Crewe and Orkin (1992:3) defines HIV as a single stranded ribonucleic acid (RNA) virus, which breaks down the immune system of human beings and slowly weakens a person's ability to fight off other diseases by attacking white blood cells called T-cells.

According to Sipes and Sugarman (2006), the Human Immunodeficiency Virus is a retrovirus that causes AIDS in humans. In brief, HIV works by depleting the immune system of specific types of white blood cells, leaving the body unable to fight off infections. HIV, like all viruses, requires a living host to survive and replicate.

2.3.1 HIV Transmission

HIV transmission from person to person occurs via the direct contact with HIV infected fluid entering your body through your anus ,mouth, tip of your penis, small

cuts in your skin or vagina. Bodily fluids that contain high blood content, such as blood, semen, saliva, breast milk and vaginal secretions can directly transmit HIV to another person (Sipes and Sugarman, 2006).

Transmission can arise from such activities as accidental syringe sticks, the sharing of needles (including unsterile tattooing and piercings), and childbirth (mothers passing on HIV to the unborn child within the womb), unprotected sex (including oral and anal sex). HIV primarily infects vital organs of the human immune system such as CD4+ T cells (a subset of T cells), macrophages and dendritic cells. It directly and indirectly destroys CD4+ T cells which are required for the proper functioning of the immune system. When HIV kills CD4+ T cells so that there are fewer than 200 CD4+ T cells per micro liter of blood, cellular immunity is lost, leading to the condition known as AIDS. AIDS is the clinical diagnosis given to HIV–infected patients that also display AIDS-related illnesses and/or have a low white blood cell count (Dyk, 2005:10).

Redfield and Burke (1989) also explained how the virus works through a clinical point of view. They stated that the virus enters the body and attaches itself to host cells, which are known as CD4 cells (or T-helper cells). The T-helper cells are the prime target of HIV. In order for the person to be infected, the virus has to enter the body and attach itself to the CD4 cells. The process of the HIV infection and the killing of the T4 cells is the process that starts the infection. The infection begins as a protein on the viral envelope that attaches itself tightly to a protein known as CD4. The virus merges with the T4 cell and transcribes its RNA genome into double-strand DNA. The viral DNA becomes incorporated into the genetic material in the cell's nucleus and directs the products of new viral RNA and viral proteins, which

combine to form new virus particles. The particles bud from the cell membrane and infect other cells. Finally, the viral protein circulates in the blood of people with HIV and makes the immune system weak.

2.3.2 Stages of HIV infection before developing AIDS

2.3.2.1 First Stage: HIV infection

According to Ngwena (1999), the progression from HIV to AIDS follow four definable, though not immutable, phases. Broomberg (2010), the doctor and Chief Executive Officer of Discovery Health, stated that the earliest stage is right after one is infected, whereby HIV can infect cells and copy itself before the immune system has started to respond. In a manual presented by Jantjie (2009) in her study on challenges of HIV and experiences by working women, stressed that, this stage comprises the first 6-12 weeks after acquiring the HIV-infection, until the body's initial immune system responses develop enough antibodies to reduce the amount of HIV in the body. She added that during this period, people are highly infectious and the virus can then easily be passed on to others. The response at this stage is that people may develop a flu-like illness, (sero-conversion illness). This occurs around the time the HIV antibody test converts from negative to positive thus when the body has developed sufficient antibodies to be able to detect them with a blood test.

The Centre for Diseases Control and Prevention (2004) highlighted that the period to sero-conversion is known as the "window period" when antibodies are not detectable and a blood test may return a false negative result while person is already infected.

2.3.2.2 Second Stage: Asymptomatic/latent /silent phase

According to Ngwena (1999), this second phase is the asymptomatic or latent period whereby the hosts tests positive for HIV, but does not exhibit symptoms of disease, notwithstanding that the immune system is gradually being compromised. This phase may last for several years but there is no consensus on its precise duration. Jantie (2009) expressed that this stage can last anything from three to 7 years-sometimes up to 10 years. Though the infection is silent, the virus continues its onslaught on the immune system, which is slowly deteriorating. This stage is associated with a CD4 cell count of 500-800 cells/mm^3 (CDC, 1993).

2.3.2.3 Stage 3: Minor Symptomatic Phase

According to Ngwena (1999:98), the 3rd phase is a symptomatic phase whereby the host displays AIDS related symptoms but not the full measure of the disease. Crewe and Orkin (1992) highlighted that the symptoms experienced by many people infected with HIV are the lymph nodes (glands) that remain enlarged for more than 3 months, also called persistent lymphadenopathy. Other symptoms include night sweats, fever, thrush, chronic diarrhea, significant weight loss, persistent skin rashes short term memory loss, shingles and in children delayed development (Ngwena, 1999).

While hospitalisation may be required for the treatment of opportunistic infections in particular, the hosts remain able to work and carry out everyday activities. The duration of this phase is variable and may continue for several years (Ngwena, 1999). According to Bendell (2003), as the virus spreads the CD4 cell are destroyed

and the loss of these cells reaches a point where the CD4 count drops to a low as 350cells/mm^3.

2.3.2.4 Stage 4: Symptomatic HIV-Disease

About 5-8 years after infection, the immune system finds it increasingly difficult to sustain its defence against the HIV virus and the viral load progressively increases as to the CD4 cell count decreases. Sign and symptoms of opportunistic infections starts to appear as the immune system deteriorate (CDC, 1993).

2.3.2.5 Stage 5: Full Blown AIDS

Ngwena (1999) calls this phase a phase of “full blown AIDS related illness whereby it is the end stage in a continuum of AIDS-related illness. Janjtie (2009) stated that this stage is the final and most serious phase that is followed by death. The immune system is severely weakened so that it cannot fight life threatening diseases. This stage has an imbalance between the CD4 cell count and viral load. According to International guidelines, a person is said to have full blown AIDS when the CD4 count drops below 200 cells/mm^3

Once infected the host remains so infected for life. The discovery of AZT and protease inhibitors, which when used in combination reduce the viral load and retard the destruction of the immune system, making it feasible to reduce mortality and enhance the quality of life of PWAs. Today it is known that there are two types of HIV, namely HIV-1 and HIV-2 (Cotzee, 2006). Moreso, Ward (1998), explains these two type of viruses as very similar, but classify HIV-1 as more aggressive in causing

diseases. Apart from this difference in the viruses, scientists have now identified 11 subtypes of the HIV-1 virus and each type responds differently to a given treatment. Re-infection by another type could damage the immune system even more rapidly than infection by only one type (Janse, 2000). Cotzee (2006) mentioned that the effect of re-infection on the organisation and its control environment could thus be catastrophic, as people who are infected with different types subtypes become weaker more quickly and die fast.

Noting all the phases, tricks and challenges that are faced by infected people in this context of HIV/AIDS management at the workplace, it will be wise if workplaces can take serious cautions about this disease through implementing effectively HIV/AIDS programme so that they have healthy employees.

2.4 Global trends of HIV/AIDS

Coovadia and Hadingham (2005:1) state that globalisation affects all facets of human life, including health and well-being. In their study on globalisation and health, they stressed out that the HIV/AIDS pandemic has highlighted the global nature of human health and welfare and globalisation has given rise to a trend toward finding common solutions to global health challenges. Numerous international funds have been set up in recent times to address global health challenges such as HIV. However, in their study, Coovadia and Hadingham (2005), noted that despite increasingly large amounts of funding for health initiatives being made available to poor regions of the world, HIV infection rates are prevalence continue to increase worldwide. As a result, the AIDS epidemic is expanding and intensifying globally.

The world is becoming increasingly complex and the most serious challenges are global in nature. One of these global challenges identified by the Millennium Project (one of various environmental organisations focusing on HIV/AIDS) is the control and reduction of new and re-emerging diseases and immune micro-organisms (Glenn and Gordon, 2002). Over the past 27 years, nearly 25 million people have died from AIDS. HIV/AIDS causes debilitating illness and premature death in people during their prime years of life and has devastated families and communities (UNAIDS and WHO, 2009).Through unprecedented global attention and intervention efforts, the rate of new infection has slowed and prevalence rates have leveled off globally and in many regions (UNAIDS 2010).

Jantjie (2009) stated that HIV has become a serious health and developmental problem in many countries around the world. While Dorrington *et al*. (2006) found out that life expectancy in the world is estimated to be 49 years for males and 53 years for females. In 2007, the global overview of people living with HIV were estimated at 33.2 million, 15.4 million of them women (UNAIDS 2007:1). Despite the progress seen in some countries and regions, the total number of people living with HIV continues to rise. In 2008, global statistics revealed that about 2 million people died from AIDS, 33.4 million were living with HIV and 2.7 million were newly infected with the virus (UNAIDS, 2009). HIV infections and AIDS deaths are unevenly distributed geographically and the nature of the epidemics vary by region. The epidemic is abating in some countries and burgeoning in others where more than 90% of people live with HIV in the developing world (Kaiser Family Foundation, 2007).

Table 2.1:Trends in HIV Infections by Region

Region	No of people living with HIV (end of 1998) [39]	No of people living with HIV (end of 2003) [40]	% Increase 1998–2003
Sub-Saharan Africa	22,500,000	25,000,000	11%
South & South-East Asia	6,700,000	6,500,000	-3% [1]
Eastern Europe & Central Asia	270,000	1,300,000	381%
Western Europe	500,000	580,000	16%
East Asia	560,000	900,000	61%
Oceania	12,000	32,000	167%
North Africa & Middle East	210,000	480,000	129%
North America	890,000	1,000,000	12%
Caribbean	330,000	430,000	30%
Latin America	1,400,000	1,600,000	14%
TOTAL	33,372,000	37,822,000	13%

[1] this apparent decrease is due to inconsistencies in data collection methods between earlier and later years, as well as revised estimates by UNAIDS.

Source: Coovadia and Hadingham (2005 1:13)

Hussain (2004) noted that HIV prevalence is intensifying in most regions, with sub-Saharan Africa, Eastern Europe and Central Asia being the worst hit, accounting for approximately 79% of new infections between 1998 and 2003. Although the greatest number of people living with HIV are in sub-Saharan Africa, of equal concern is the growing epidemic in Central Asia.

The epidemiology of the disease differs between regions. It has been suggested that due to dissimilar patterns of sexual behaviour between Africa and Asia, the extent of the spread to the heterosexual population in Asia will be circumscribed. In most of sub-Saharan Africa, HIV spreads through an intricate web of relationships from sex workers to male clients to female spouses/partners. According to Peter Piot of UNAIDS, females in Africa generally report more sexual partners than their Asian counterparts (Cohen, 2004). In most of Central Asia transmission is virtually linear, from intravenous drug users to sex workers to male clients to female spouses/partners, with women tending to monogamy (Cohen 2004). The next decade will attest to the accuracy or error of this prediction. Rising prevalence is, however, not confined to developing countries, as an increase in the number of HIV infections is evident in all other regions except South and South East Asia (where inconsistencies in data collection methods have tended to skew the figures).

2.4.1 HIV epidemiological curve

An increasingly mobile global population exacerbates the risk of HIV transmission. The increasing volume of international travel contributes to the spread of sexually transmitted infections, including HIV (Rogstad, 2004). Refugee populations arising from areas of conflict, estimated by the United Nations High Commission for Refugees (2004) to number 9, 7 million worldwide, are at higher risk, as are internal migrants within countries, who oscillate between rural and urban milieux. According to the International Labour Organisation, at the beginning of the 21st century, 120 million workers worldwide were migrants (ILO, 2002).

Females are more at risk of contracting HIV than males. In 1997, women accounted for 41% of people living with HIV worldwide. This figure had risen to almost 50% by

2002. This gender-bias is especially apparent in sub-Saharan Africa, where the majority of those infected are women and girls. Widespread wars and regional conflicts in Africa escalate, by orders of magnitude, the risk of rape of women and girls. The low social status of women, risky sexual practices, and endemic poverty in Africa contribute to the spread of the disease. The impact on women is less marked in Asia (where 28% of those infected are women), although women's low socio-economic status renders them more susceptible to infection. Women's increased vulnerability to HIV infection is not confined to developing countries. Between 2001 and 2003, the percentage of HIV-infected who are women increased in North America from 20% to 25%, and in Oceania from 17% to 19%, suggesting that gender inequalities underpin the transmission of HIV (UNAIDS, 2004).

The impact of HIV mortality is greatest on people in their 20's and 30's; this severely distorts the shape of the population pyramid in affected societies. Projections indicate that mortality rates will increase: The UN predicts that, in seven selected countries in sub-Saharan Africa, 14 million AIDS-related deaths will occur between 1995 and 2025 (United Nations Population Division, 2003). UNAIDS projections indicate that, unless the AIDS response is greatly increased, populations in 38 African countries will decrease by 14% by 2025 (UNAIDS, 2004).

In sub-Saharan Africa, it is estimated that 12 million children have lost one or both parents to AIDS, a figure which is expected to increase to 18 million by 2010. Even in countries where HIV infections have plateaued, the number of orphans continues to rise due to the time lapse between infection and death of parents (UNAIDS 2004).

Coovadia and Hadingham (2005) concluded that the expansion of the AIDS epidemic across the globe has galvanized the global community into demonstrating

a willingness to challenge its unabated spread. The increasing mobilisation of resources aimed at mitigating the impact of the disease in developing regions of the world in particular holds numerous potential benefits on the course of the AIDS epidemic. Whether these benefits are realized or not depends on resources dedicated to addressing the global AIDS challenge being received by those in need. Globalisation brings with it many benefits in addressing the spread of HIV throughout the world. However, these benefits can only be realized if appropriate programmes are available in areas of need. As part of the generous supply of aid aimed at addressing problems specific to HIV/AIDS, attention needs to be paid to building capacity in recipient countries so that such funds may be effectively disseminated and the epidemic effectively curbed.

2.5 Trends of HIV/AIDS in Sub-Saharan Africa and in South Africa

The HIV/AIDS epidemic has had its profound impact to date in Sub-Saharan Africa. The region has the highest prevalence of HIV and AIDS in the world and the world of work is coming under constant threat as a result of this epidemic (Barnett and Whiteside, 2006). An estimated 22.5 million people were living with HIV in sub-Sahara at the end of 2009, including 2.3 million children (UNAIDS, 2010). During 2009, an estimated 1.3 million Africans died from AIDS. Almost 90% of the 16.6 million children orphaned by AIDS live in Sub-Saharan Africa (UNAIDS, 2010). Life expectancy gains over the past century have been halted and in some cases reversed in many of the hardest hit countries in sub-Saharan Africa, including Botswana, Lesotho, Malawi, Mozambique, Swaziland Zambia and Zimbabwe. South Africa has the highest number of people living with HIV/AIDS in the world. Women make up the majority of those living with HIV/AIDS in the region, and young people are at particular risk (UNAIDS, 2009). It was estimated by Census (2004) that in

2010, South African life expectancy will be 36 years. The epidemic has already posed serious development challenges for the region and has affected communities, families, livelihoods and numerous sectors of society. Most countries in the region are low-income and heavily or moderately indebted, according to the World Bank (2000). Other challenges faced include food insecurity, internal migration, and conflicts. Yet the epidemic is quite diverse throughout sub-Saharan Africa and, despite these challenges, there have been success stories, with some countries experiencing stabilization and even reduction in HIV prevalence (UNAIDS 2006).

The Global Fund and UN are continuing financing proposals addressing the needs of most at risk population. In fighting HIV/AIDS, the UN Formed The Joint United Nations Programme on HIV/AIDS (UNAIDS) which brings 8 UN agencies in a common effort to fight the epidemic (UNAIDS, 2004). Importantly, UNAIDS works to mobilize the UN system and to help bring focus and coherence to its activities against HIV/AIDS. The June 2001 UN General Assembly Special session on HIV/AIDS was calling for development of workplace policies that protect the rights and dignity of people living with HIV/AIDS in the workplace and to provide a supportive workplace environment free from discrimination and stigmatisation of those affected and or living on HIV/AIDS (UNAIDS, 2005).

The ILO also strengthens the global response to HIV/AIDS through mobilizing its tripartite constituents and partners and giving access to the workplace. Its primary objectives are to promote decent and productive employment for all in conditions of social justice and equality and to raise awareness of the economic and social impact of HIV/AIDS in the world of work, to help governments, employers and workers address HIV/AIDS through technical co-operation, training and policy guidance on

prevention, care and social protection and to fight discrimination and stigma related to HIV/AIDS (UNAIDS, 2003).Through the mobilization of the social partners and their extensive network of contacts, the code will be instrumental in helping to protect the rights and dignity of workers and their families and all the people living with HIV/AIDS.

Gender, economic imbalances and cultural practices are putting women to be more prone to HIV infection (PEPFAR, 2011). HIV/AIDS and poverty are closely intertwined in cause and effect. Massive male migration to work in mines, and young girls migrating to town to become sex workers, cultural practice and values that discriminates against women or use women are also contributing to the spread of disease (IFAD, 2001). According to (PEPFAR, 2011), in low and middle income countries worldwide HIV is the leading cause of death and disease in women in reproductive age (ages 15-44). In sub-Saharan Africa, 60% of those living with HIV are women. In the nine countries in Southern Africa most affected by HIV, prevalence among young women ages 15-24 years is on average, about three times higher than among men of the same age(UNAIDS,2006).These disparities are the result of biological structural, and cultural conditions that place women and girls at greater risk for acquiring HIV, such as gender norms that impact expectations and behaviors as well as differences in access to resources that limit prevention and mitigation of the disease.

South Africa has reached the epicenter of the AIDS pandemic; with the country's first national household sero-prevalance indicating that 14.8% of the country's adult population (15 years and older) are living with AIDS (HSRC, 2002). The prevalence of HIV among pregnant women was at 30% in 2005 and 29.5% in 2006 (Department

of Health 2007). According to the U.S Bureau of the Census, by 2010 in South Africa, more infants will be likely to die of AIDS than from any other cause (U.S. Bureau of the Census, 2004:85).

About 5.4 million people out of the total 48 million South Africans were HIV positive in 2006, a prevalence rate of about 11% while 600 00 people were estimated to be sick with AIDS related illnesses, 38 000 babies were infected at birth and around 26 000 through breastfeeding (Dorrington *et al*., 2006).

It is of particular concern that the HIV pandemic is becoming one of the most obstinate root causes of child labour as it exposes even more children to the hardships of child labour due to poverty, the burden of caring for family, the death of guardians fewer teachers and discrimination. The HIV/AIDS pandemic adds a new and tragic dimension to the problem of child labour in many countries around the world. Reed (2004: 234) traced that child labour is estimated to be on the increase, as well as a higher rate of survival sex among street kids Millions of children have been orphaned by the death of one or both parents from HIV/AIDS. Millions more will be (IPEC, 2003). Many of these orphans find security in the households of relatives. Others, however, drop out of school and look for work to survive. An especially harsh burden is placed on girls, who often have to provide care and household services for the entire family when a parent becomes ill or dies. Even children cared for by grandparents or other relatives may have to work to help provide income for guardians and siblings.

HIV/AIDS has a profound impact on growth, income and poverty in many countries. Economists estimate that the annual economic growth in half the countries of sub-

Saharan Africa will decrease radically as a direct result of HIV/AIDS. It has become a challenge for every workplace, no matter what size and nature of business to try and reduce the effect of HIV/AIDS among its own employees (Dyk, 2005:461) .This pandemic affects mostly younger people in any economy (ages between 15 and 49), this is the age group at the prime of their working career. Kehler (2007:20), indicates that in 2006, almost half (350 000) of the 740 000 deaths occurred were due to HIV/AIDS. Seventy-one percent of all deaths shown by the study occurred amongst 15-49 year olds which is the active population that is supposed to be in the workplace. For this reason the workplace must embark on management of HIV/AIDS programmes to reduce its effect on businesses.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) reveals that South Africa has the fastest growing HIV/AIDS epidemic in the world, with more people infected than in any other country (UNAIDS 2005). Market and customer profiles may also change with the growing HIV/AIDS epidemic. For example if an organisation provides services such as health care, the demand for the services could increase with AIDS epidemic, while the ability to provide services may be negatively affected due to the loss of key personnel such as nurses (Dyk, 2005:417). Organisations therefore should commit themselves in HIV/AIDS programmes in order to avoid costs in recruitment and training and encourage staff retention for continuity and consistency in service delivery.

Human Sciences Research Council (2005) estimated that 16.2% of the adult population (15-49) is infected with HIV in South Africa. With cure still remote, it is anticipated that the country has to deal with the epidemic for decades to come. An estimated 5.7 million people were living with HIV/AIDS in South Africa in 2009, more

than in any other country. According to UNGASS (2010), it is believed that in 2008, over 250 000 South Africans died of AIDS. National prevalence is around 11%, with some age groups being particularly more affected. Almost one in three women aged 25-29, and over a quarter of men aged 30-34, are living with HIV (Statistics South Africa, 2009). The age bracket that AIDS mostly targets is young adults and the number of premature deaths has risen significantly over the last decade from 39% to 75% in 2010 (UNGASS, 2010). The impact of the AIDS epidemic is reflected in the dramatic change in South Africa's mortality rates. The overall number of annual deaths increased sharply from 1997, when 316 559 people died, compared to 2006 when 607 184 people died. In 2006, 41% of deaths were attributed to 25-49 year olds, up from 29% in 1997 (UNGASS, 2010). These statistics show that AIDS is highly prevalent among workers in their most productive years.

Due to these devastating effects of HIV/AIDS, many families face financial hardship. One survey on HIV's impacts on households found that, 80% of the sample would lose more than half of their per capita income with the death of the highest income earner, suggesting a lingering and debilitating shock of death (Harrison 2009). According to a study by (Dickinson, 2005: 287), economic impact that is borne by individuals, households and communities as a result of an employed individual being infected or affected by HIV/AIDS is generally not considered. He highlights that there is evidence that the burden of the epidemic is taken up by individuals, their households and their communities as opposed to being shared between individuals, government and the private sectors. Any response by organisations need, if it is to provide a meaningful contribution to a national response is to approach HIV/AIDS from a strategic point. At the very least, this will involve reliable assessments of the impact of HIV/AIDS in the workplace, putting "best practice" responses in place that

respond to HIV/AIDS in the most effective manner and not simply shift the cost onto employees or other sectors of society (Dickison, 2005:288).

Thomas (2004:42) as cited in Petzer and Schoeman (2005:122) notes that whilst proactive strides in HIV/AIDS Workplace Programmes have been taken by big businesses and multi-nationals, the government and in particular local governments have been slow in this regard. One of the key challenges to successful HIV/AIDS programme planning and project is budget allocation. Some organisations prioritize other programmes and HIV/AIDS programmes are not looked at and always remain unfunded. Smith (2008:23) also highlights that the management of HIV/AIDS in the workplace has evolved over the past ten years. Large multinational employers have identified the components of a best practices workplace response. However she notes that the choice of service providers and the format of outsourcing should be closely matched to every employer's needs. She highlights four management phases of service providers that can assist in an organisation in its HIV/AIDS response and these include assessment, planning, implementation and monitoring, evaluation and auditing. Accordingly, phase one depends on an assessment of the risk that HIV/AIDS pose to sustainable business and on the subsequent specific needs of each organisation. In phase 2, HIV consultants assist to develop the company HIV policy and assist the organisation to develop a project plan or a strategic plan to implement the statements of the intent policy. Phase 3 is implementation which includes components of education and training, VCT, treatment and care, emotional, social support and palliative care. The last phase comprises of service providers that will offer mentorship, coaching and project management.

In her study, Smith (2008) stresses that if the organisation has not carried out an intensive de-stigmatisation process with the communication of their policy and procedures and educational intervention, the VCT uptake will be disappointing. She mentions that many organisations rush to do VCT without first creating a supportive environment and without adequately addressing the fears of their employees. She adds that many companies are offering HIV disease coverage for their uninsured employees to mitigate business impacts and to retain a healthy workforce but have decided not to offer antiretroviral treatment programmes to their employees because of the costs and because government now offers free ARVs at provincial hospitals and some Primary Health Care clinics.

Bowler (2007) studied the impact and management of HIV/AIDS in manufacturing workplaces of the Nelson Mandela Metropolitan Municipal area. The study found that the levels of disease in the sample were lower than for the adult population of the Eastern Cape. More to this, the impact of the disease on workplace costs and profitability had been surprisingly low. There was a high level of provision for access to health care and HIV-specific programmes, and management had reacted to contain the impact of ill-health and disease on the business environment. These results suggested that the unfolding of the epidemic was more complex than the various impact scenarios implied. In addition, the study also suggested that management interventions had the potential to contain impact and avert the predicted dangers. However this interpretation should be viewed with caution as the full impact of the disease might merely have been delayed and the progression of the disease might reveal greater impact in subsequent phases of the study. Because the sample studied was made up of medium and large workplaces, all in manufacturing, offering relatively stable working environment and 50% of the

workplaces were linked to transnational corporations, the results of the study could not be generalised to the workplaces of NMMM. Nevertheless, the results did suggest that similar sized and resourced workplaces might manage and contain the economic impact of the unfolding HIV and AIDS epidemic.

AIDS affects fundamental rights at work and in society as a whole. Discrimination on the basis of HIV/AIDS worsens existing inequalities in society, such as those based on gender and race. It creates a climate of blame and denial that cripples efforts to address the epidemic in the workplace and community. AIDS –related discrimination may include screening people for HIV infection for purposes of exclusion from work or promotion, breaches of confidentiality, or a refusal to adapt jobs at workplaces to the needs of workers with HIV/AIDS (ILO, 2005). Fundamental rights of workers living with and affected by HIV/AIDS include the right to work, training and promotion, the right to social protection and benefits ,the right to confidentiality regarding health status, and the right to reasonable alternative working arrangements.

HIV and AIDS is one of the major challenges facing South Africa today. Some two decades since the introduction of this disease in the general population, the epidemiological situation is characterized by very large numbers of people living with HIV and a disproportionate effect on particular sectors. AIDS causes the death of young and able-bodied people in the most productive part of their life. HIV in South Africa is transmitted predominantly heterosexually between couples, with mother-to-child transmission being the other main infection route (SANAC, 2010). The national transmission rate of HIV from mother to child is approximately 11%. In most instances the virus was transmitted from child's mother. Consequently, the HIV-

infected child is born into a family where the virus may have already had a severe impact on health, income, productivity and the ability to care for each other (UNGASS, 2010).

In April 2010 the South African Government launched a major counseling and testing campaign (HIV Counseling and Treatment)-HCT which marked a welcome change from South Africa's history of HIV. It aimed at offsetting the problem of late or no diagnosis. This campaign has been built on the South African National AIDS Council endorsed theme for World AIDS Day 2009, which emphasized both the individual and collective responsibility of South Africans to stop new HIV infections, and provide treatment, care and support to people living with HIV. As such, workplaces are also encouraged to embark on HIV/AIDS programmes to promote the campaign. According to the South African Government Information, 2011), Deputy President Motlanthe attended UN High Level meeting on HIV/AIDS on the 8-10th of June 2011 in New York ,United States of America to renew the political will and recommit to new targets in the fight against HIV/AIDS. Member states including South Africa had to identify challenges, recommend strategies and review progress and map the future course of the global AIDS response.

South Africa is suffering one of the worst HIV and AIDS epidemics in the world. The impact of HIV and AIDS within a society stems from the increased premature morbidity and mortality of primarily the most economically active segment of the population. While the economic and social impact is readily evident at the individual and household level, the unfolding at other levels within society, namely the organisational, the sectoral and the macro levels, can be slow, complex and often difficult to predict. The predictions vary from the minimal to the catastrophic and the

analysis is often speculative and based on numerous assumptions because there is a lack of data due to the lack of adequate research at micro level (Bowler, 2007:72). According to Code of Good Practice on Aspects of HIV/AIDS Employment online (2005), it is recognized that HIV/AIDS epidemic will affect every workplace, with prolonged staff illness, absenteeism, and death impacting on productivity, employee benefits, occupational health and safety, production costs and workplace morale. So this code stresses that one of the most effective ways of reducing and managing the impact of HIV/AIDS in the workplace is through the implementation of an HIV/AIDS policy and programme. Addressing aspects of HIV/AIDS in the workplace will enable employers, trade unions and government to actively contribute towards local, national and international efforts to prevent and control HIV/AIDS.

2.6 HIV in the Eastern Cape Province

Different provinces in South Africa experience different levels of HIV infections and AIDS related deaths. This illustrates the fact that the epidemic is in different stages of development in each province and that a different approach to addressing the epidemic in each province is necessary to stem the course of new infections and deaths. The epidemic is still growing in the Eastern Cape Province. The province is among those provinces that are still experiencing high numbers of new infections relative to AIDS deaths leading to rapidly growing HIV prevalence rates (Nicolay, 2008). The Eastern Cape is experiencing the third largest epidemic (730 000 HIV positive people) and are relatively young and rapidly growing epidemic. Only 44% of those in need of treatment are accessing it in the Eastern Cape (Nicolay, 2008). Table 2.2 illustrates Eastern Cape HIV/AIDS statistics.

Table 2.2: Eastern Cape HIV and AIDS statistics

Whole population	11%
Antenatal clinic estimate	29%
Adults (ages 20-64)	20%
People living with HIV	729,000
New HIV infections(over the year)	81,000
AIDS deaths(over the year)	44,000
Total people in need of ART (mid-year)	111,000
Total people accessing ART (mid-year)	49,000
Accumulated AIDS deaths	277,000
New infections per day	223
New deaths per day	120

Source: **Nicolay (2008:4)**

As Table 2.1 shows,

- The Eastern Cape has the third largest number of HIV positive people in the country.
- A total of 730 000 people (11%) of the population) and one in every 5 adults are estimated to be HIV positive in 2008.
- The epidemic in the Eastern Cape has not reached a mature phase yet and is still growing rapidly with new infections double the number of AIDS related deaths.
- An estimated 110 000 people are in need of antiretroviral treatment in 2008 with around 44% having taken up treatment.

ASSA Model 2003 estimated the population of Eastern Cape in 2006 to be about 6.67 million. About 10% of the population (667 000) over the age of two years were

living with HIV of whom 81 000 were newly infected in 2006. The ASSA Model also estimated that there were 226 000 0rphans in the Eastern Cape Province, of these, 124 00 were orphaned as a result of AIDS.

Daily Dispatch of 29 September 2011, reported that the number of children growing up with no parents in the Eastern Cape has doubled in the last 5 years, from 352 000 to 701 000. This is according to a paper recently released by the National Department of Social Development which has revealed how poverty and unemployment in most rural Eastern Cape has deviated the family structure. The huge number of orphans has added strain to already cash-strapped orphanages and place of safety. The government said the South African family was under threat from poverty, unemployment, unwanted pregnancies, HIV/AIDS and absence of parents and domestic violence.

2.7 The impact of HIV and AIDS within Chris Hani district

According to Chris Hani District Municipality IDP review (2011-2012:20), HIV and AIDS affect local economic development as well as health and all other infrastructure and service delivery. HIV and AIDS affect all community members through illness and death associated with the disease. Key community members become ill or spend time caring for others, resulting in a change of household composition, with women, the youth and the elderly assuming ever greater burdens (IDP Review 2011-2012). The district may also provide infrastructure that will be redundant in the future as the demand decreases because of the impact of HIV and AIDS. Therefore, if the impact of HIV and AIDS is not addressed in all municipal programmes and services,

its effects on the population will result in further poverty, which may lead in turn to an increase of infected and affected people.

2.8 HIV in the Public and Private Sectors of South Africa

Over the past decade, employers in the private and public sectors of South Africa have been increasingly concerned about the impact that HIV epidemic may have on their operations. The potential impacts of HIV-related mortality and morbidity include decreased productivity, rising production costs and a higher employee turnover. At the same time, employers have been under increasing pressure to respond to the epidemic by providing prevention and treatment services. In order to determine the extent of the impacts and to plan for the future, many organisations have undertaken HIV prevalence studies on their workforces. Obtaining data on the epidemiology of HIV allows an organisation to conduct human resource and cost-impact planning, enables it to anticipate treatment and support requirements, facilitates the implementation of prevention measures, and allows the impact of workplace HIV interventions to be monitored over time. As a result of concerns regarding the confidentiality of company information and potentially negative publicity, however, most research in this field is not published (Colvin et al 2007:S4).

The appearance of HIV/AIDS has compelled workplaces to focus on worker health since there is an obligation on workers to remain productive in the generation of goods and profits. However, workplaces vary in their levels of willingness to assume responsibility for worker health and the resources to make such provision and moreso, while workplaces may be willing to provide health and income protection, a rising tide of ill health and disease may compromise their ability to provide such

service (Bowler 2007:73). Bowler (2007) embarked on a longitudinal study to explore the unfolding manifestation, progression, impact and management of HIV/AIDS in workplaces in the Nelson Mandela Metropolitan Municipality for the period 2000-2010).The research sought to provide micro-level information describing the impact of the management responses to the changing levels of disease and death associated with the progression of the HIV and AIDS epidemic.

Using the UNAIDS cost impact model of 2000, there could be indirect costs linked to increased absenteeism, accident rates, early retirement, disability retirements, industrial disputes, declining employee morale, loss of experience, skills, workplace cohesion and demands on management time. There might be increased direct costs related to employee benefits such as group life insurance, pensions, funeral benefits and medical aid. Costs could be incurred to run HIV/AIDS programmes and further costs might emerge in the form of taxation for increased government spending on health and welfare. There might be increased replacement and training costs as employees died or retired early and additional employees might be needed to cover absenteeism.

HIV/AIDS interventions in the South African private sector are largely led by corporate with extensive access to financial resources, and information and knowledge networks (Vass, 2008). Thus, local studies show consistently that small companies tend to lag behind in the management of the epidemic and access to HIV/AIDS services, while medium-sized companies performed relatively better in this regard. A study conducted in 2004 showed that while 96% of large corporates and 64% of medium-sized companies had HIV/AIDS policy, only 17% of small companies had the same (Vass, 2008:3). While the existence of a policy does not necessarily

reflect effective governance, it does indicate a written commitment to a set of principles and procedures, an essential step in the management of the HIV/AIDS impact. Further, both the International Labour Organisation Code of Practice on HIV/AIDS and the world of Work and the South African Code of Good Practice: Key aspects of HIV/AIDS and employment promote the development of work-based HIV/AIDS programmes to facilitate the protection of employee rights and delivery of HIV/AIDS prevention programmes, care, treatment and support. However, the successful attainment of these objectives requires appropriate institutional and governance capacity within workplaces. This is especially relevant to SMEs, who often suffer resource and capacity constraints in HIV/AIDS management. There are concerns that HIV/AIDS will impact on South African workplaces. Private sector companies, notably insurance groups, appear to have been most active in assessing the effects of HIV/AIDS in the workplace. The workforce is an important target group for HIV prevention activities. Economically active persons, as a sector of the population, can be viewed as being at risk of contracting HIV due to their disposable income and ability to afford multiple sexual partners (Mapolisa *et al*, 2005).

There is a wide variation in the number of people in different sectors of society who are infected. For example sectors with mobile/migrant workforces, like the mining and transport sectors, have high levels of infection (Bowler, 2007:73). Sectors and workplaces differ in availability of basic health and income security support systems and have different levels of resilience to the impact of increased illness and death. The appearance of HIV/AIDS has compelled workplaces to focus on worker health since there is an obligation on workers to remain productive in the generation of goods and profits. However, workplaces vary in their levels of willingness to assume responsibility for worker health and the resources to make such provision and

moreso, while workplaces may be willing to provide health and income protection, a rising tide of ill health and disease may compromise their ability to provide such services (Bendell, 2003).

A study conducted by Cleary *et al*. (2008) on the burden of HIV/AIDS in the public health care system indicated that the HIV/AIDS pandemic in South Africa influences all spheres of the economy and society as a whole, impacting on macro-economic, micro economic, social and psychological levels. The same study also concluded that the provision of public health care for HIV/AIDS patients is under severe pressure as a result of funding constraints, shortages of health care personnel and infrastructure deficiencies, and that it is becoming more and more evident that the private health sector should contribute more toward addressing the HIV/AIDS problem. Connely and Rosen (2005) are of the opinion that the implementation of HIV/AIDS programmes by employers could contribute significantly to addressing and managing the negative impact of HIV/AIDS in the workplace. The results of the study that sought to determine the extent of the negative impacts of HIV/AIDS in the workplace on firm efficiency and firm competitiveness on the South African manufacturing industry, indicated that larger firms tend to implement HIV/AIDS programs much faster than small and medium-sized firms, and that many Human resource departments at firms were not convinced of the potential effectiveness of HIV/AIDS programmes and that especially small and medium -sized firms lacked the urgency to invest scarce resources in order to address the potential negative impacts of HIV/AIDS (Van Zyl and Lubisi, 2009:1).

According to Van Zyl and Lubisi (2009:1), on their research on the extent of the negative impact of HIV/AIDS in the workplace on firm efficiency and firm

competitiveness, it has been proven in the research that HIV/AIDS is starting to exert a serious negative impact on the level of firm efficiency (skills levels, labour productivity, labour costs and production costs and ultimately on firm competitiveness, sales, prices and profitability. They stress out that HIV/AIDS programmes and the human resource base of firms require a greater level of effective management in order to limit the extent of the negative impacts of HIV/AIDS. Efficiency levels were also affected negatively by HIV/AIDS.

2.9 The demographic impact of HIV/AIDS

AIDS is a fatal disease caused by the Human Immunodeficiency Virus (HIV), a virus that is mainly acquired through heterosexual intercourse. HIV/AIDS primarily affects adults in their economically most productive years and does not spare the elite. Not only adults are affected by diseases, many children are also becoming infected by the disease. In South Africa, as many as 280 000 children under 15 years old were living with HIV at the end of 2007 (UNAIDS, 2008). The epidemic is already widespread, particularly in the developing world, and there is as yet no cure for the disease. These characteristics suggest that HIV/AIDS could be the most devastating disease man has ever faced, not only in terms of its demographic consequences, but also in terms of the economic implications of the epidemic for countries with severe epidemics. Ellis *et al*. (2003:1) did a research to quantify the economic impact that the HIV/AIDS epidemic will possibly have in South Africa over the next 10-15 years investigated by means of macro-econometric model of South African economy. The analysis was based on a set of HIV/AIDS inclusive and exclusive demographic projections for South Africa for the period up to 2015. Given this objective, the first step was to obtain estimates of the current level of HIV infection in South Africa, as

well as projections of the demographic impact of the epidemic over the next 15 years. The main source of information concerning the HIV epidemic in South Africa is an annual survey of pregnant women attending public antenatal clinics conducted by the Department of Health. The latest antenatal clinic survey revealed that 24.8% of women attending public sector antenatal clinics were infected with HIV by late 2001 and that HIV prevalence is still increasing. Demographers use estimates from the antenatal clinic survey in combination with assumptions with regard to HIV infection rates in the sub-groups of the population not covered by the survey (e.g. men and people who are not sexually active) to develop demographic models to project the future course of the epidemic. Two generally accepted HIV/AIDS models exist in South Africa, namely the Doyle model of Metropolitan Life and the model that was developed by Professor Rob Dorrington and the Actuarial Society of South Africa (ASSA), (Abt Associates and Metropolitan Life, 2000).

In the labour force by skill category, this research stresses that the HIV/AIDS epidemic will have a disproportionate impact on the labour force, with approximately 15% of South Africa's total labour force already infected with HIV. HIV prevalence among the total labour force is projected to reach 26% by 2015, while AIDS prevalence could rise to 4.4%. Semi- and unskilled workers are the most susceptible to the epidemic. HIV infection rates for semi- and unskilled workers, as well as skilled workers, are projected to peak above 25%. Even for the relatively less infected highly skilled labour force category HIV prevalence rates are projected to reach 18% by 2015 (Ellis *et al*., 2003). Furthermore, the low unemployment rate for highly skilled labour implies that there is a small "reserve pool." of highly skilled labour in South Africa, so that a skilled worker will be more difficult to replace in the event of an AIDS death than an unskilled worker. The impact on population growth is dramatic to say

the least and even more so for the working age population. By slowing the growth in the labour force, HIV/AIDS will have an adverse impact on the production potential of the economy (Ellis *et al*., 2003:10). Similarly, AIDS deaths will reduce the absolute number of consumers compared to a no-AIDS scenario, which should have a negative effect on final consumption expenditure (FCE) by households.

AIDS related illnesses and deaths of managers, employees and their family members will have a significant impact on business. Moreso from the results of this study by Ellis and others, it is expected that companies will need to increase their contributions to pension, life, disability and medical benefits on account of the AIDS epidemic. While it is certain that the AIDS epidemic will lead to an increase in the cost of providing benefits for most companies, it is difficult to determine the magnitude of these direct costs to companies over an extended period of time. The reason for this is that some companies will attempt to shift a large proportion or even all of the increased cost to the employees. Should companies succeed in restructuring their risk benefits so that employees carry a larger share of the responsibility, a proportion of the direct costs of HIV/AIDS will be absorbed by employees who will have to increase their own benefit contributions (and hence reduce their personal savings or expenditure on other consumer products and services), accept lower benefits or opt out of schemes altogether (Ellis *et al*, 2003:12).

2.10 Effects of HIV/AIDS in organisations

Despite the fact that this epidemic has profound effect on the personal lives of employees and employers, it has also impacted on the organisational and

economical lives. Dyk (2005:416) highlights the effects of HIV/AIDS in the workplace as:

> Increasing cost of employee benefits as well as insurance costs, declining in profit of organisations, lower quality of product and services, increased number of accidents due to fatigue and illness, loss of productivity due to high morbidity, absenteeism and mortality in the workplace, decrease in work performance when HIV/AIDS results in the death of an experienced skilled worker whose skills are difficult and expensive to replace, a culture of stigma and fear of infection, further lowering staff morale as employees refuse to work with colleagues infected with HIV and also increased absenteeism as employees take time off to care for the sick family members or to attend funerals of friends, colleagues or family members who have died with AIDS.

The macro-economic impact of HIV/AIDS in South Africa study also indicated that, there will be higher government expenditure due to HIV/AIDS in such a way that increased morbidity and mortality among employees will bring about substantial direct and indirect costs for the government as an employer. Like private sector companies the government will need to increase its contributions to pension, life disability and medical benefits of its employees on account of the AIDS epidemic. Within the workplace, increased mortality and morbidity will affect worker efficiency, raise costs, reduce productivity and compromise profitability and the delivery of goods and services (Whiteside, 2005). However, the extent of the impact of HIV/AIDS related mortality and morbidity is influenced by the number of people infected, the term of death, the skills levels of those infected and the available support systems. As in the case of direct costs to the private sector, it was assumed

that only skilled and highly skilled employees are covered by medical and other benefits. They assumed the government will carry 50% of the direct costs increases due to HIV/AIDS and that employees would have to be responsible for the other half.

One of the most visible consequences of the epidemic will be increase in the number of people seeking medical care. The financial strain on the public health sector will be severe, not only as a result of the sheer number of people seeking health care, but also because health care for AIDS patients is more expensive than for most other conditions. HIV/AIDS epidemic will also put pressure on the government's fiscal position. Higher employment costs and health care expenditure by the public sector implies higher government consumption expenditure and an increase in foster care grants for AIDS orphans boosts government transfers to households (Ellis *et al*, 2003).

According to Rothberg and Huyssteen (2008:335), on their research on "employee perceptions of the Aid-for AIDS disease-management programme", it is estimated that 18-20% of South Africa's more than 5 million HIV- positive individuals are formally employed. Disease management programmes for these employees vary in scope and sophistication, with service provided by the employer, or the third-party specialist disease managers, or through medical schemes. Their study surveyed 215 HIV-positive employees in two organisations contracted to the Aid for AIDS (AfA) disease management programme through their in-house medical aid schemes. The two organisations differed in their overall approach to HIV and AIDS: one mainly relies on on-site access to voluntary counseling and testing (VCT) and AfA's management of registered HIV-positive employees, while the other has invested in and actively developed a comprehensive programme that also extends to families

and the community as well as links employees to the AfA programme. Responses received from 28 of the 215 employees surveyed indicate the fear of disclosure of one's HIV status, stigmatisation and ignorance of the value of therapy are reasons for late registration with the AfA programme or non-utilization of other available support programmes. Respondents mentioned that confidence in the employer's ability to maintain confidentiality was also an issue. All respondents stated that their HIV status was known to their partners and/or families, while about one- quarter (28.5%) answered that fellow workers and/or management were aware of their status. Almost 40% felt that the employer should ideally be aware of an employee's HIV-positive status but did not believe that under current circumstances management would keep the information confidential. Some 21% felt that disclosure would affect their chances of promotion or would result in termination of employment, 25% were of the opinion that their HIV status had (assumed or actually disclosed) had impacted on opportunities for promotion or had resulted in other forms of discrimination in the workplace. Respondents' important suggestions for change included on-site educational and awareness programmes for management personnel and staff in order to reduce HIV discrimination and stigmatisation, information directed at HIV-positive employees publicizing the benefits and effectiveness of medical treatment, support groups for HIV positive employees and management personnel to engage with HIV-infected employees who are willing to take an active role in staff education and the development of workplace policies and programmes. Notably, the management in both environments rated the utilization of programmes by employees as sub-optimal. From the survey, it is evident that one organisation has been active and even progressive in supplementing the AfA programme with a range of educational and health promotional activities including engagement beyond

workplace), while the other organisation offers employee-support programmes but has been less active.

South Africa has an estimated HIV prevalence of at least 5.5 million cases (UNAIDS, 2006). Given that the national figure for formal employment is in the region of 8.3 million (The South African Department of Labour Online, 2005), of which some 11% are likely to be HIV-positive (Colvin *et al*., 2007), it is apparent that in more than 80% of cases (i.e. among unemployed and self-employed patients) the costs of HIV Management will be largely borne by the public sector, supported by contributions from donors, funding agencies and out of pocket payments by patients. The formally employed will generally be covered by the employers for HIV-related care, through either in –house health care programmes or health insurance with a registered and regulated medical aid scheme. In both cases HIV screening, counseling, treatment, monitoring and evaluation components will be outsourced to third parties to a greater or lesser extent. Mahajan (2007), found widely varying workplace HIV/AIDS policies and programmes with different levels of sophistication. Furthermore, Mahajan *et al*, (2007) review of large companies and selected sectors led them to conclude that the effectiveness of workplace policies and programmes is difficult to assess, and further research is urgently needed.

The challenges of coordinating, rationalizing and tracking the corporate sector's approaches to management of the HIV epidemic have been taken up by the South African Business Coalition on HIV and AIDS (SABCOHA) (2008), while several non-profit specialist organisations, such as Right to Care (2006) and the Aurum Institute for Health Research (2008), engage in activities ranging from consulting to on-site clinical research. Low participation and programme uptake has also been a concern

for AID for AIDS AfA, a specialist health risk management company based in Cape Town, South Africa, which for the past decade has provided HIV/AIDS consulting and management services for corporations and medical aid schemes. Responses received from 28 of the 215 employees surveyed indicate the fear of disclosure of one's HIV status and of stigmatisation are reasons for late registration with the AfA programme or non-utilisation of other available support programmes. Respondents mentioned that confidence in the employer's ability to maintain confidentiality was also an issue. Respondents' important suggestions for change included on-site educational and awareness programmes for management personnel and staff in order to reduce HIV discrimination and stigmatisation, information directed at HIV-positive employees publicizing the benefits and effectiveness of medical treatment, support groups for HIV positive employees and management personnel to engage with HIV-infected employees who are willing to take an active role in staff education and the development of workplace policies and programmes.

2.11 HIV/AIDS in South African workplaces

The AIDS pandemic originated approximately twenty years ago (Dickinson 2003:26). Its origin is uncertain. At this stage the HI virus responsible for AIDS continues to spread. Currently the highest levels of prevalence (infection) and the largest numbers of HIV+ individuals are in sub-Saharan Africa, South Africa being a leader (Dinkinson, 2003). While knowledge of HIV/AIDS and its prevention is often good, there is frequently a failure or reluctance to act on this knowledge where the primary transmission route is sex; infection is embedded within powerful human drives and resilient cultural norms (William *et al*, 2000). It has proven extraordinarily difficult to change behavior with a view to reducing infection (UNAIDS, 1999). Despite this,

understanding of HIV/AIDS remains central to any response. HIV prevalence in South Africa is measured by actuarial extrapolations of tests carried out in state antenatal clinics on an annual basis. The estimated incubation period of the HI virus in South Africa is 6-8 years. A key concern for companies is that AIDS, because of its sexual transmission affects those of working age (Dickinson, 2003).

A multitude of response guidelines were generated through international organisations. The International Labour Organisation issued HIV and AIDS policy and programme guidelines for workplaces supported by international labour conventions that advocated fair labour practice and safe and healthy working environments. For employers, the international emphasis on corporate governance promoted responsible leadership, accountability to stakeholders and the need to achieve a balance between the interests of individuals, the organisations and society (ILO, 2001). The containment of rising levels of the disease and the associated costs within a workforce, the surrounding community and the labour market requires strategies and support mechanisms from a range of social actors. Workplaces are uniquely positioned to have an impact on the factors influenced health and mitigating against disease and epidemics(ILO 2001 as cited in Bowler 2007:72).

Dickson *et al*, (2005:287) did a research on management responses to HIV/AIDS in South African workplaces focusing on minimizing direct labour costs, rather than comprehensively addressing the impact of AIDS will have on the company and its employees. A baseline national cross-sectional study of 383 companies, each with more than 50 employees was carried out. Issues of HIV/AIDS policies, responsibility for workplace programmes, and perceived and measured impact of HIV/AIDS and the response of companies were reported. Findings from this survey were compared

with results from four other surveys viewing HIV/AIDS in companies. In line with other surveys, the findings indicate limited responses on the part of the workplaces. Lack of measurement reflected widespread strategic failure on the part of South African management which resulted in a de facto shift of workplace responsibility for the burden of the disease onto individuals, communities and society. The response to HIV/AIDS by managers in South African companies was uneven and poor. Only some 58% of companies surveyed reported having an HIV/AIDS policy and some 44% of these did not know what their policies were based on, if anything. Although there appears to be an encouraging amount of involvement of workers in policy development, this appears to be one dimensional and potentially weak. Certainly, it appears that very few companies distribute their policies to employees. Business leaders have not responded adequately by strategically costing the comprehensive impact of HIV/AIDS on their companies (Dickinson, 2005:296).

However, this failure to measure or to anticipate will not exempt companies from the impact of AIDS. Moreso, intervention at the workplace was not enough. There has to be monitoring and evaluation, which would determine the effectiveness and quality of the programmes in place. It appeared as if managers are doing something, yet there is a lack of focus, strategy and responsibility. Finally, what these data reveal in an indirect manner is the haphazard manner in which the private sector is passing on the burden of responsibility to individuals, households and society. The companies in this sample were not choosing a comprehensive set of prevention activities, nor are they incorporating HIV/AIDS into their strategic management activities.

Having reviewed the available literature on the economic impact of HIV/AIDS, it appears as though researchers have not reached consensus on the impact of

HIV/AIDS on economic growth estimates of the impact of HIV/AIDS on countries with advanced epidemics range anywhere between a reduction of 0.1 and 4.4% points in the average annual GDP growth rate over the next 10 to 20 years. Even for South Africa, projections seem to diverge whereas Arndt and Lewis (2000) project that per capita income levels will be lower due to AIDS, the ING Barings study suggests that per capita income may rise significantly (Ellis *et al*, 2003).

The impact of the HIV/AIDS epidemic goes far beyond the household level. Firms and businesses may also be affected as HIV infected people are usually in the prime working years and are involved in the process of production. If HIV prevalence reaches a high level in a country or within a firm, the impact of the disease may be dramatic for the business or firm involved. Many companies have undertaken studies on the impact of AIDS on their workforce and productivity. Unfortunately, the results of most of the studies are not available to the public. Nevertheless, the few studies whose results are available point to a serious impact of HIV/AIDS on companies in some settings and to the potential for the effects to grow rapidly as the epidemic advances. Therefore this study seeks to really find out if there are specific programmes in the organisations so that they can be compared to find out the best method that can be recommended to other organisations for the equal benefit of both the employee and the organisation. The study also seeks to look into what is really happening on the ground, what are the procedural interventions done in organisations in trying to manage HIV/AIDS in the workplace and their practically in organisations as well as finding out if employee needs are met according to their expectations concerning HIV management programmes.

2.12 The impacts of HIV/AIDS in the workplace

The impact of HIV/AIDS is being felt in the country as a whole, and the workplace is no exception. With infection rates still on the increase, departments must be prepared to deal effectively with HIV/AIDS so as to maintain high productivity and service delivery levels whilst avoiding discrimination of those infected or affected. Partnerships between government and the private sector have to be forged in order to develop and implement policies and programmes that are aimed at combating the spread of the virus and mitigating the impact of the AIDS pandemic (Department of Public Service and Administration, 2002). HIV/AIDS has the potential of creating severe economic impacts if it is left unmanaged. The mere fact that it affects people in their most productive age is a cause for concern. Within workplaces where many employees are infected, the impact of HIV/AIDS will be experienced in many ways, such as morbidity and absenteeism. As the infected become ill, they will take additional sick leaves. This will disrupt the operation of the organisation for which they work. The disruption will be amplified when the more qualified and experienced employees are absent. Increases in deaths 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. HIV-related absenteeism, loss of productivity and the cost of replacing workers lost to AIDS threaten the survival of businesses and industrial sectors in the increasingly competitive global market. HIV AIDS does not only affect workers. By claiming a large part of the urban population with disposable income and by impoverishing families and communities, it also affects the market base of African businesses. According to Fasset statistics, workers within the Fasset sector are relatively young,

with 63% of workers 35 years old/younger, only 4% are in the age category of 56-65 years. The average age varies for the different occupational groups (Fasset, 2005).

The importance of having HIV/AIDS programmes at the workplace is clear because most affected people are within the working age. According to a UNAIDS Report (2007), of the over 40 million people living with HIV/AIDS, at least 26 million are workers aged 15 to 49, in the prime of their working lives. This has led to increased demand on spending for health and social welfare and increased costs of insurance benefits for households. Companies have reported a doubling of medical expenses since employees who fall ill have to receive medical care (UNAIDS, 2007). Moreover mortality or retirement negatively impacts the organisations. The impact of the death or retirement of an infected employee is similar to morbidity, although the problems are permanent. 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. Staff morale is also affected by the HIV pandemic in the organisations (Fasset, 2005).

The epidemic has a negative impact on morale in the workplace. There is 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 (Fasset , 2005). As the epidemic spreads, employers and employees will feel the impact as the cost of employee benefits increases. Furthermore demand for services, particularly health and welfare services, is likely to increase dramatically. This will have major

implications for departments that provide these services and even more so if they already face capacity constraints or are short staffed (Fasset, 2005).

2.13 The workplace's response to HIV /AIDS epidemic

In South Africa, there are concerted efforts to fight the pandemic involving the Government, Non-Governmental Organisations, and the Private Sector. In the Private Sector HIV/AIDS workplace programmes are in place and organisations like DeBeers, BMW South Africa, and Daimler Chrysler South Africa provide their employees with Hyper-Active Antiretroviral treatment (Nyemba 2008:16). Effective management of HIV/AIDS in the workplace requires an integrated strategy that is based on an understanding and assessment of the impact of HIV/AIDS on the specific workplace. The strategy must focus on short and long term measures required to deal with and reduce this impact (Dyk 2005:462). In South Africa HIV and AIDS has increasingly become the dominant issue on the corporate citizen agenda (Jantjie, 2009).

With the high rate of infection recorded in previous literature, South African businesses need programmes in place that will help manage the impact of HIV/AIDS on their operations and well-being of their employees. According to an estimate by Majors (2004), 43 199 public servants will have died of HIV/AIDS between 1985 and 2020 and about 126 000 would have retired as a result of ill health related to HIV/AIDS while still government employees. In SMME organisations, (SABCOHA, 2009/10), noted that small, medium and micro enterprises may not have the infrastructure or the capacity to develop HIV/AIDS workplace programmes. The reason being that, these companies are often suppliers or vendors to large

organisations which already have work place programmes in place and want to see an extension of the business sector response to HIV/AIDS through their supply chains. SABCOHA, which seeks to empower companies to initiate workplace responses to HIV/AIDs epidemic, created the SMME HIV /AIDS Capacity Development Programme aiming to build capacity, ensure systems strengthening and providing access to VCT and treatment for vendors of corporate companies.

The workplace provides an ideal gateway to HIV/AIDS prevention and care. The workplace has its own culture that connects its workers. Although staff members come from varying social backgrounds and cultures, speak different languages and follow different traditions, employers and employees all share the same organisational culture in which they have the same visions, follow the same guidelines and adhere to the same rules. The organisational culture is thus an equaliser, offering a consistent platform from which a comprehensive HIV/AIDS plan can be implemented (Dyk, 2005).

2.14 Fighting and managing HIV /AIDS at the workplace

A particularly pertinent aspect for the business environment is that infection levels are very high among young, economically active persons. This will not only influence consumer power but has an overwhelming effecting on the workforce and is thus a major threat to the achievement of strategic business objectives and related business risks, forming a great concern for management. Responding to HIV/AIDS in the workplace is essentially about managing the issue as a business risk that is having accurate and relevant information about the epidemic, monitoring progress knowing or predicting the risk and addressing the risks through management.

Firmansyah and Kleiner (2005) indicated that, the International Labour Organisation (ILO) and the World Health Organisation (WHO) both agree that occupational health and safety in Africa needs strengthening. In support of this realization are the need to maintain and promote workers' health and working capacity. The fight against HIV/AIDS in the workplace is a continental priority. HIV/AIDS can be fought through workplace intervention programs. According to Pinder (2006), HIV/AIDS intervention programs refer to the techniques that have been adopted by workplaces in trying to curb the impacts of the HIV/AIDS pandemic in the workplace.

All organisations should either have or be working towards a comprehensive HIV/AIDS workplace programme, such a program according to the Workplace Program Policy (2005), should provide education and awareness in the workplace, counselling, health care, promote condom distribution and use, accommodations, compensation, death benefits, mechanisms for dealing with HIV/AIDS related grievances, implement fair employment practices, provide care and support in the workplace and community involvement. Workplace intervention programs include the following:

2.14.1 Awareness

There are a number of large scale communication campaigns related to raising awareness of HIV and AIDS as well as broader health-related issues for example HCT campaign introduced by government in 2010, Khomanani, meaning 'caring together', ran since 2001 and was the health department's premier AIDS-awareness campaign. It uses the mass media to broadcast its messages including radio announcements and the use of situational sketches on television, Soul City and Soul

Buddy. Effort, time and, when necessary, money must be invested in HIV/AIDS education and training. Making people aware of the disease and its implications, including its devastating impact, how to prevent its transmission and how to tackle its stigma, is an important step in fighting the disease. Get outside help by inviting local clinics, AIDS organisations and other educational groups to talk to your team about personal lifestyle, preventing and dealing with HIV/AIDS (Fasset, 2005:22). Research has shown that high levels of awareness around HIV/AIDS are only the first step towards changing behaviour. Recognising personal vulnerability, developing efficacy (ability and skills to change behaviour) and adopting supportive social norms are also necessary for effective and sustained behaviour change. Examples of awareness activities include:

- The distribution of AIDS ribbons for staff to wear, this serves as a constant reminder of the reality of HIV/AIDS and the need to care for and support PLWAs
- Distribution of pamphlets on HIV/AIDS
- Arranging talks by PLWAs
- Celebrating World AIDS Day in the workplace; and
- Holding a video session on an HIV/AIDS related topic. (Department of Public Service and Administration, 2002:80)

2.14.2 Peer Education

Is one of the best methods used to combat HIV/AIDS in the workplace? Peer education involves selecting appropriate company members and then training them in HIV/AIDS awareness and prevention. They in turn, educate their fellow employees (Fasset, 2005:22). The focus of the peer education programme is to keep employees

HIV negative and educate HIV positive employees on how to stay positive (Jantjie, 2009). Peers are people in the workplace who are similar to one another in age, background, job roles, experience and interests. People are more likely to listen to and follow the advice of their peers. Peers also have greater influence on each other than non-peers, a significant factor in lending credibility to behaviour-change messages. With specific training and support, peer educators (workers) can effectively carry out a range of HIV/AIDS education and other prevention activities with their co-workers (Rau, 2002:47).

According to SABCOHA Annual report for (2009/10), it is estimated that 150 000 trained peer educators and peer education is still considered a vital prevention component of any workplace programme, the key to unlocking behaviour change. However SABCOHA (2009/10), has realised that the lack of support, debriefing and mentorship for peer educator programmes and resulting in the burnout of peer educators. In an effort to address these challenges and assist peer educators to perform optimally in workplace and community environments, SABCOHA developed a programme which essentially looks to establish a national support network for peer educators. The concept of peer communication is central to effective responses to HIV/AIDS (UNAIDS, 2000) as cited in Dickinson (2003). Because our responses and our vulnerability to HIV/AIDS is embedded within group attitudes and behaviours, effective understanding of the disease and changing behaviour is best achieved through discussion with peers. Successful peer educator initiatives therefore consist of a cross section of the company's employees in terms of occupational level as well as demographic characteristics, such as race, age, and gender. This closeness to all levels of the company, combined with enthusiasm to

address the issue, provides a powerful line of communication into the workforce that management alone – simply cannot replicate.

2.14.3 Open Communication and Compensation

Employers, unions and workers' representatives must communicate HIV/AIDS policies to employees in simple, clear and unambiguous terms and continue to demonstrate their support for HIV/AIDS prevention and care efforts. Communication of clear messages will reinforce established business practices, assure consistent implementation of the policy and reinforce low-risk worker (including sexual) behaviours (Rau, 2002:38).

According to Lethbridge (2004), employees working in vulnerable environments whose work make them to get direct contact with human blood, compensation is the best programme that they need, thus, Workmen's compensation for work related accidents and injuries, prophylactic treatment for risk exposures is important. For those who are affected by the impacts of the pandemic, paid compassionate leave in the event of the death of spouse or immediate family will be of great importance.

2.14.4 Support Groups

Employees living with HIV/AIDS or who have a dependent /close friend with HIV are likely to find support groups as an important psychological boost. Public service organisations can encourage staff to form/join support groups, either in the workplace or the community. In several private sector firms, peer support groups have been an important feature for infected and affected employees. These groups

provide some financial and much emotional support to co-workers who are living with HIV/AIDS or who have relatives living with HIV/AIDS (Department of Public Service and Administration, 2002).

2.14.5 Dealing with stigma

Zelnick and Donnel (2005) suggested that a supportive, non-discriminatory work environment can greatly help HIV positive individuals and their families cope with the disease. People who are HIV positive or related to someone who is infected often experience a hostile reaction from relatives, co-workers, and friends. A workplace that does not tolerate discrimination against employees and openly supports HIV/AIDS prevention and care efforts will help reduce stigma surrounding the disease. The support groups described above have contributed to a fuller understanding of HIV/AIDS among all employees. Dickinson (2003:40) stressed that, HIV/AIDS is a heavily stigmatised disease. This is largely due to the fact that it is sexually transmitted, loading with moral and cultural judgements. He further stated that, even when such judgements can be put aside, sex remains for many people an embarrassing topic that is difficult to discuss openly (Dickinson, 2003). The absence of a cure for AIDS and the even greater ignorance of the positive steps that infected individuals can take to remain healthy makes HIV/AIDS a feared disease and reinforces its stigmatised status. Such stigma is independent of the workplace, being generated from wider social values and the nature of the disease. Therefore it is essential for an organisation that an environment be created in which employees living with HIV/AIDS are able voluntarily to divulge his/her status without fear of discrimination or retribution. Such an environment will assist management not only to

support the employee where possible, but importantly also to manage the human resource implications.

2.14.6 Condom use and Distribution

An important component of workplace prevention programs is distributing condoms to men and women. Regular and correct condom use is essential in preventing HIV or STIs. Condom use in South Africa is growing with the percentage of those using a condom during their last sexual encounter increasing from 27% in 2002, 35% in 2005 to 62% in 2008 (HRSC, 2009). Younger people show the highest rates of condom use which bodes well for the future of prevention, and could explain the decline in HIV prevalence and incidence among teenagers and younger adults (HRSC, 2009). The 2009 National Communication Survey on HIV/AIDS also found that 15% of married men and women used a condom at last sex compared to 74-83% men and 55-66% of women who had casual sex or one night encounters, identifying the need for prevention programmes to further target married couples. According to South Africa's progress report on declaration of commitment of HIV/AIDS, in 2007, 256 million male condoms were distributed by the government, down from 376 million in 2006. Over 3.5 million female condoms were distributed in 2006 and 2007. A major focus of worker education and prevention sessions is likely to be on the importance of regular and proper condom use. Distributing condoms to employees support and reinforces HIV education and prevention activities. Almost all organisations that permit condom distribution have found favourable responses from employees, both men and women. Condoms can be distributed by peer educators or through dispensing machines.

2.14.7 HIV Testing, Counselling, and Support

Breuer (2005: 164), said that, without information and coaching, the HIV- positive employee or job applicant faces a daunting journey through an employment minefield of unanticipated and illegal personal questions, nosy application forms, discriminatory supervisors, unworkable policies and unrelenting anxiety. However Breuer (2005), noted that with good vocational counselling, the client's anxiety level, like the viral load, will register, "undetectable" most of the time.

Organisations are strongly discouraged from mandating HIV Testing of employees or applicants. Voluntary, informed and confidential testing of employees and their partners is central to employee HIV prevention programs. There is growing evidence that Voluntary HIV testing and counselling is an important tool in prevention. Individuals who seek their HIV status are usually motivated to learn more about the disease and how they can protect themselves and their sexual partners. Where HIV testing is conducted, it is essential that people tested receive pre-test and post-test counselling so that they understand the nature of the test and its implications. According to Gillis (1994:2) cited in Dyk (2005:174) counselling is defined as "a facilitative process in which the counsellor, working within the framework of a special helping relationship, uses specific skills to assist clients to develop self-knowledge, emotional acceptance, emotional growth, and personal resources". Nattrass (2004), noted that although most employees do not see the value of counselling, an HIV/AIDS workplace program should include counselling and to encourage positive attitude towards counselling there should be qualified professional staff on sit, approved counsellors, referrals, also employees should be provided with time off for counseling at the community clinic, testing days should be arranged with local clinic,

and the workplace should also provide counselling for family members. Summerfield and Van Oudtshoom (1995) stressed that an organisation offering counselling gains trust and knowledge among its employees.

2.15 Conclusion

To mount a comprehensive response to the epidemic, it is important for organisations to foster cooperation between all the relevant role players within the company as well as with other stakeholders at local, sectoral, provincial and national levels. Ideally, workplaces should establish and participate in a multi-sector HIV/AIDS network in which expertise and resources can be shared. The workplace has the potential to become the key delivery point for information on prevention, prevention methods, treatment and care of working adults. The workplace also has the potential to reach a much wider circle than just its employees. It can also influence the welfare of the families and communities relating to individual workers. By encouraging open discussions and providing compassionate programmes for prevention, care and support, the workplace can help alleviate the community's suffering as well as its fear of HIV infection. It can work towards reducing stigma and discrimination both inside and outside the workplace (Dky, 2005:471-472).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The previous chapter presented literature review on HIV/AIDS on a global perspective, regional and in South Africa and how it affects the workplace and how it can be management in workplaces. This current chapter focuses on the methodology used during this research. Research methodology encompasses, the methods and techniques by which data are collected, where and from whom these data are collected as well as the sample size used (De Vos, 2005:168). It covers research design, population, sampling procedures, data collection instruments, data analysis procedures and ethical issues of the research.

3.2 Research design

A research design is a plan, structure, and strategy of investigation so conceived as to obtain answers to research questions or problems (Kumar, 2005:84). According to (Shafeek, 2009), a research design refers to set of fundamental beliefs, in lieu of a worldview which delineates the nature of the world and the individual's place in it, and the variety of probable relationships to that world" for an individual. Hofstee (2006) contends that in the research design section the researcher should name and discuss the overall approach to be used to test the research statement. The study utilized both quantitative and qualitative approaches. Thus, triangulation which is a powerful technique that facilitates validation of data through cross verification from two or more sources as well as increasing credibility of the results was used for this

study. This research sought to predict the impact of HIV/AIDS programmes on the working population at the workplace. Qualitative research method is the collection of non-numerical data and for this study, it was direct observation Secondary data from documents and other sources also constituted another source of data.

3.3 Qualitative research

Qualitative research is defined as the research about person's lives, lived experiences, behaviours, emotions and feelings as well as organisational functioning, social movements, cultural phenomena and interactions between nations (Mboyane, 2006). It also seeks a better understanding of complex situations and it is often explanatory in nature and the observations are used to build theory from the ground up. It is also concerned with attempting to accurately describe, decode, and interpret the meanings of phenomenon occurring in their normal context (Mboyane, 2006). Data was collected from a small sample using direct observations. Then it was analysed using words, as it is deduced from narratives and individual quotes of the interviewed and observed subjects. Organisations' HIV/AIDS policy documents were used as well as attendance registers for data analysis. Qualitative research design that was used in the study, enabled the researcher to evaluate the experiences and perceptions of employees on HIV and AIDS management at the workplace as well as experiences and perception of management (employers) in managing HIV and AIDS programmes in the workplace for consistency and continuity as well as evaluating on its effectiveness for the benefits of both the company and the employee. This has got advantages of obtaining more realistic feel of the world and providing a holistic view of the phenomena under investigation (Neill, 2007).

3.4 Quantitative Research

Quantitative research refers to an investigation of a phenomenon by testing a theory that can be measured numerically and analysed statistically (Shafeek, 2009:79). It seeks explanations and predictions that will generalize to other persons and places with intention to establish, confirm, or validate relationships and to develop generalisations that contribute to theory. Neil (2007) states that the major strengths of quantitative research are that measurement are reliable, valid and can be generalized. This study was both qualitative and quantitative in nature as semi-structured questionnaires and semi-structured in-depth interview schedules were used in the collection of data. Questionnaires were self-administered with closed and open-ended questions covering the following areas personal details, HIV/AIDS workplace policy, absenteeism, HIV intervention services, perceptions of management, recommendations and opinions. Quantitative data was analysed using SPSS Software. Age, gender and marital status were analysed quantitatively. Descriptive data has been presented using frequency tables, cross tabulations, bar graphs and pie charts. Quantitative is appropriate in this study because the issues of HIV and AIDS at the workplace have been studied by other researchers hence a substantial body of literature exists.

3.5 Population, sample, and sampling procedures

The population, sample and sampling strategy or procedures are described.

3.5.1 Population

Population is the identifiable objects or elements of interest to the researcher and pertinent to the information problem. According to De Vos (2005), population is a term that sets boundaries on the study units and it refers to individuals in the universe who possess specific characteristics. In this research the population referred to all employees and employers of the public and private organisations within the study area; that is Chris Hani District Municipality. However, investigating the views of an entire population is not always possible due to various factors such as time constraints, financial constraints and availability of researchers (Mnyanda, 2006). Therefore for manageability, a representative sample was identified for data collection in this study.

3.5.2 Sampling procedures

Sampling is the technique used to identify a subset of the population which is representative of the entire population in the process of data collection. According to Arkava and Lane (1983:27) as cited in Strydom (2005) a sample comprises elements of the population considered for actual inclusion in the study. It can also be described as a subset of measurement drawn from the population in which the study is interested in. For this study, four organisations were studied, two public organisations (organisations A and B) and two private (organisations C and D) in Chris Hani District of the Eastern Cape Province. Chris Hani was chosen because no such study has been conducted in this district. Therefore it was purposefully selected. The two private and two public organisations were purposefully selected to avoid randomly selecting one type of organisation. Two hundred respondents were used as the study sample, 50 respondents from each organisation. The employees were first stratified and then respondents were randomly selected so that the sample

will be representative. This gave every employee an equal opportunity of being included in the sample. However, four employers and/or those heading such organisations constituted another sample representing their organisations. These four employers heading the organisations were purposefully selected too.

3.6 Sampling strategy

There are two main methods for sampling which are known as probability and non-probability. This study used probability sampling. Tustin *et al*. (2005:344) defines probability sampling as a plan in which everyone in the population has a chance of being included in the sample and non-probability sampling as instances in which the chances of selecting members from the population in the sample are unknown. In this study the two private and two public organisations were purposefully selected to avoid randomly selecting one type of organisation. Two -hundred respondents were used as the study sample, fifty respondents from each organisation. The employees were first stratified according to age and then randomly selected so that the sample will be representative. This gave every employee an equal opportunity of being included in the sample representing their organisations. However, the four employers and/or those heading such organisations constituted another sample representing their organisations. These four employees leading the organisations were purposefully selected too.

Before collection of data one must first stage and determine the actual size of the sample needed, and this calls for determining the size of the confidence interval first (Gray 2006:85).This is the range of figures between which the population is expected to lie. For this study, the confidence interval was set at 4%, and 91% of the

population pick a particular answer. This means that we are confident that between 87% (91-4) and 95% (91+4) of the entire population would have picked that answer. Larger samples enables researchers to draw more representation and more accurate conclusions, and to make more accurate predictions than in smaller samples, although this is more costly (Bless and Higson 2000:93 as cited in De Vos, 2005:195).

3.7 Sampling error

A common cause for sampling error lies with sampling frame (Gray, 2006:116).The members in the sampling frame have to be easily identifiable to avoid under-coverage or over-coverage. Under –coverage is where the sampling frame excludes possible respondents and over-coverage is where the sampling frame includes more respondents even such as do not qualify for a particular study. In this very study to avoid either of these two only employees from four selected organisations were eligible to be respondents of this study.

3.8 Data Collection Instruments

The principal instruments of data collection were two set of instruments: semi-structured questionnaires and semi-structured in-depth interview schedule which were mostly adopted from those of Bello *et al*, (2010). One semi-structured instrument (questionnaires) was designed for employees of both public and private organisations and the in-depth interview schedule for employers and/or heads of these organisations. However, there are some disadvantages on this method, that is, it is very expensive and time consuming. Furthermore, the presence of the

interviewer may hinder the respondents' ability to answer the questions freely especially when sensitive information is required therefore likely to have biased answers.

The employees' questionnaire had seven sections. All research questions were covered thus the management of HIV and AIDS in the workplace, employees perceptions about these programmes and effectiveness of these programmes in reducing the impact of HIV and AIDS in the workplace. The questionnaire had the following sections:

Section A covered the personal details for the respondent (employee of the organisation.

Section B contained information on absenteeism.

Section C entailed information on HIV and AIDS workplace policy.

Section D included benefits to employees when it comes to HIV and AIDS programmes at the workplace.

Section E covered information on HIV and AIDS services within the workplace, treatment, care, support and prevention programmes.

Section F gave information on perceptions of management's response to HIV and AIDS and/or support of PLWHA in the workplace.

Section G was soliciting information on recommendation, opinions and suggestions.

On the employers' semi-structured interview guide, the following made up the different sections:

Section A contained employees" statistics and HIV/AIDS management.

Section B covered information on how HIV/AIDS management are managed (response to and impact of HIV/AIDS).

Section C was based on benefits to the employee.

Section D sought information on recommendations, opinions and suggestions.

3.9 Data Collection Procedures

There are many ways of collecting data in research. To collect the required data, a questionnaire with interviews schedule was used which was completed prior to the visit by the interviewer. According to the new dictionary of Social Work (1995:51) as cited in De Vos (2005:166) a questionnaire is "a set of questions on a form which is completed by the respondent in respect of a research project". The researcher in this study made use of personal interviews which allowed face-to-face interactions with the employer and employees of four selected organisations in Chris Hani District in order to have a better understanding of questions and issues raised in the questionnaire. This enabled even the respondents to have a greater opportunity to ask for clarity on the questions that they do not understand. This research consisted of two set of instruments; semi structured questionnaires and an in-depth interview schedule though mostly opened in-depth interview schedule were used in collecting data from employees and employers of the four selected organisations respectively.

The respondents were interviewed for approximately 15 to 30 minutes and the data collection took the researcher one and half months to complete. The advantages of using semi-structured interview approach are that it increases response rate because the researcher will be present to clarify ambiguous questions and all questions will be answered. It also has a distinct advantage of enabling the

researcher to establish rapport with potential participants and therefore gain their cooperation. These interviews yield highest response rates.

3.10 Pre-testing the instruments

De Vos (2005:171-172) argues that in all cases it is essential that newly constructed questionnaires, those in their semi-final form, be thoroughly pilot-tested before being utilized in the main investigation. This ensures that errors of whatever nature can be rectified at little costs. No matter how effective the sampling or analysis of the results, ambiguous questions lead to non-comparable responses, leading questions lead to biased responses and vague questions lead to vague answers. In this regard, Babbie (2004:256) as cited in De Vos (2005) recommends that it is better to ask people to complete the questionnaire than to read through it looking for errors. All too often, a question seems to make sense on a first reading, but it proves to be impossible to answer. In this research eight respondents were used to test the questionnaires in Chris Hani District who were not part of the study. Mbonyane (2006) indicated that the process of pre-testing helps to identify areas of the research tool that need changes. Only after the necessary modifications have been made following the pilot test the questionnaire was administered to the whole sample of 200 respondents. However, it must be stated that the in-depth interview schedule was not piloted as there are few private organisations in this district.

3.11 Data Analysis

The data of the research were analysed quantitatively and qualitatively. The researcher made use of the Statistical Package for the Social Science (SPSS) to

analyse quantitative data. These data were presented in the forms of frequency distribution, tables, bar graphs and pie charts where percentages formed the principal basis of comparison amongst the variables that were analysed. Apart from the statistical data analysis method, qualitative data from in-depth interviews and observations were analysed according to themes that emerged during brief direct observations and from the discussions with the participants. Some of the key findings were subjected to statistical analysis using chi-square and t-test in order to test the four hypotheses that were postulated in chapter one of this study.

3.11.1 Data Coding

Data is often coded before storage. Coding is the process of combing the data for themes, ideas and categories and then marking similar passages of text with a code label so that they can easily be retrieved at a later stage for further comparison and analysis (Gibbs and Taylor, 2010). In this study data was coded using themes that emerged from the discussions.

3.11.2 Fieldwork

This term “fieldwork “ according to Mouton (2003:110), as cited in (Sumbulu, 2010) refer to that part of research process in which the researcher has to leave his /her office, study, or computer and enter the real world in order to collect, select and analyse data. To reach respondents, the researcher had to make appointments first with the employers them visit the organisations. There were some ethics and values that had to be taken into consideration by the researcher upon gaining entry in the organisation. Research ethics refer to a set of moral principles guided by an

individual or group, widely accepted and offer rules and behavioural expectations about the most correct conduct towards experimental subjects, thus employees and employers of the organisations. Some of the ethical issues are discussed below.

3.12 Ethical Considerations

The study was dependent on the use of human subjects for completion. Treating research participants ethically matters not only for the welfare of the individuals themselves but also for continued effectiveness of behavioural science as a scientific discipline (Stangor, 2007:41). Social workers increasingly realize that the recognition and handling of ethical aspects are imperative if successful practice and research are the goal (De Vos 2005:56).

3.12.1 Informed consent

The ethical considerations of social sciences research was strictly observed including informed consent as well as respect for human dignity and especially as the research was dealing with sensitive issues of HIV and AIDS that instills fear of death to many. Obtaining informed consent implies that all possible or adequate information on the goal of the investigation, the procedures which will be followed during the investigation, the possible advantages, disadvantages and dangers to which respondents may be exposed, as well as the credibility of the researcher, be rendered to potential subjects or their legal representatives (Williams *et al*., 1995:30) as cited in De Vos (2005:59).

3.12.2 Voluntary Participation

The respect and protection against danger of subjects was strictly observed. No subjects were forced to disclose their HIV/AIDS status, in addition to that, no subjects were coerced or forced to participate in the study, if he or she was not comfortable with the matter under study. Respondents were encouraged to participate out of their own will or permission. Participation was voluntary and the signing of consent forms served as a proof that the respondents were freely participating. The research aims and purpose were explained before the collection of the data. Research subjects therefore, gave a voluntary and thorough or reasoned decision about their possible participation.

3.12.3 Anonymity and Confidentiality

In essence, anonymity and confidentiality was strictly adhered to during and after the study and during dissemination of findings. No individual was mentioned by name in reporting the results. An informed consent process informed the participants about the nature of the research and protected participants' rights to confidentiality and their ability to terminate involvement in the study at any time. The questionnaire was kept with confidentiality and destroyed after completion of the research. They were informed of one person thus the supervisor of the research, that he is the only person who will get the results but their names remaining anonymous. Since the topic under investigation involves information on people's personal details like age and marital status and personal perceptions on HIV/AIDS management, in-depth interviews were employed whilst maintaining participant anonymity and confidentiality.

3.13 Limitations of the study

During data collection process, some few challenges were faced by the researcher and the most important one was the budget issue. The researcher did not have a funder to sponsor for the travelling expenses, printing of questionnaires and refreshments. More-so some respondents were scared to participate when they had of HIV/AIDS. However, through clear explanation of the study they end up freely cooperating. The standard time set per interview schedule was exceeded however this was a blessing in disguise since more and more information was obtained from the respondents. Furthermore, the study included four organisations of the Chris Hani District which led the results to be difficult to generalize since organisations are different and are in different towns and environment in the Eastern Cape Province, some might have different or better way of HIV/AIDS Management in their workplaces.

3.14 Conclusion

This chapter has presented the research methodology used in this research to collect data. These include research design, population, sampling data collection methods, data analysis, validity and reliability and lastly ethical considerations to be observed in social science research. The study followed both qualitative and quantitative research methods. The next chapter covers the details of data analysis, presentation of results and discussion of findings.

CHAPTER FOUR

PRESENTATION OF RESULTS AND DISCUSSION OF FINDINGS

4.1 Introduction

The preceding chapter on research methodology only gave a brief background on how data was going to be analysed. Therefore this chapter presents the comprehensive analysis and interpretation of quantitative and qualitative data collected on the management of HIV/AIDS programmes at the workplace .Quantitative results are presented in form of descriptive statistics and qualitative results are presented according to the themes that emerged from the direct observations. The chapter also contains discussion of findings of the study.

4.2 Presentation of quantitative findings

Quantitative data for this study were collected using questionnaires. The quantitative data present biographical information of employees of the organisations studied. Their biographical information encompasses gender distribution of the respondents, their ages, educational qualifications, marital status, number of years in service and their type of contract. The main aim of the study was to find out the management of HIV/AIDS in the workplace for effectiveness and the employees perceptions about the programmes.

4.2.1 Biographical information of the respondents

The study results displays that 68 percent of the respondents were female and while 32 percent were male. This indicates that there is an improvement of affirmative action campaign in organisations studied. It shows that women are empowered and this will assist them to become independent. According to Dunkle *et al*, (2004), disempowerment of South African women revealed by such high levels of rape and domestic abuse is a factor in the country's HIV epidemic. So if women become empowered they will be in a position to negotiate safer sex and reduce the transmission of the HIV virus in the workplace and outside the workplace.

Women now have access to socio-economic opportunities. Men though few in the workplace-are susceptible to infection because of having multiple –partners (Nyemba, 2008:27). Economically active persons, as a sector of the population, can be viewed as being at increased risk of contracting HIV due to their disposable income and ability to afford multiple sexual partners. The individual's socio-economic status determines their ability to attract sexual partners particularly in case of men (Dickinson *et al*., 2005:287). Some spend long time away from their immediate families and they end up engaging in sexual activities with women in their workplace. Dickinson *et al*. (2005) argue that at the same time, wage earners may be supporting numerous people within their families and households. Their sudden exit from the formal economy, including their loss of employment benefits has a ripple effect beyond the individual. Therefore, to manage HIV/AIDS at the workplace, the organisations can raise awareness through educational programmes on gender equity, behaviour and attitude towards HIV/AIDS.

On the ages of respondents, Table 4.1 shows that 19 (9.5%) of the employees participated were in the 21-24 age group ,47 (23.5%) respondents were in the 25-

30 age group, 45 (22.5%) were in the 31-35 age group, 37 (18.5%) respondents were in the 35-40 age group and 52 were in the 41+ age group.

The results shows that, a higher percentage of employees(45%) are falling in the age group ranging from 21years to 35 years and only 26 percent being over 41. Amongst the respondents, there was no-one ranging from the age of 16-20. Considering these results, it will be a good cause for organisations if HIV/AIDS programmes at the workplace can be managed consistently and effectively in order to maintain a healthy workforce for quality production. If the HIV programmes are correctly implemented, employees will be well-versed and work on improving their behaviours, attitudes and responsibilities towards the disease for their own benefit and of the community at large as well as the benefit of their employer. Principally, the disease affects people during their most productive years of life (Coetzee, 2006:185). Using the participatory forum theatre to explore HIV/AIDS issues in the workplace, Durhen and Nduhura (2003) state that HIV prevalence rates climbs amongst the key economically active age group of 15-49 year olds. Furthermore, Durhen and Nduhura stressed that can business with a high number of HIV positive employees can expect reduced productivity, increased operating costs, a loss of trained and experienced workers, and depressed profits. Therefore it is high time organisations must look into the HIV interventions programmes to avoid loss of employees in their business.

Table 4.1: Age of respondents

Age	Frequency	Percentages
16-20	0	0
21-24	19	9.5
25-30	47	23.5
31-35	45	22.5
35-40	37	18.5
41+	52	26
TOTAL	**200**	**100**

Figure 4.1 below indicates that all employees that participated in the study have attended school with educational qualification ranging from pre- matric to degrees. In some organisations studied, they need starting from matric and a national certificate for one to be on the entry point of being recruited for a job. Nonetheless, some organisations need National diplomas and degrees depending on the post that one would have applied for and that post will need specific requirements. Figure 4.1 further indicates that 40% of employees interviewed had degrees closely followed by 37.5% with diplomas. That 5 percent consisted of those with pre matric results.

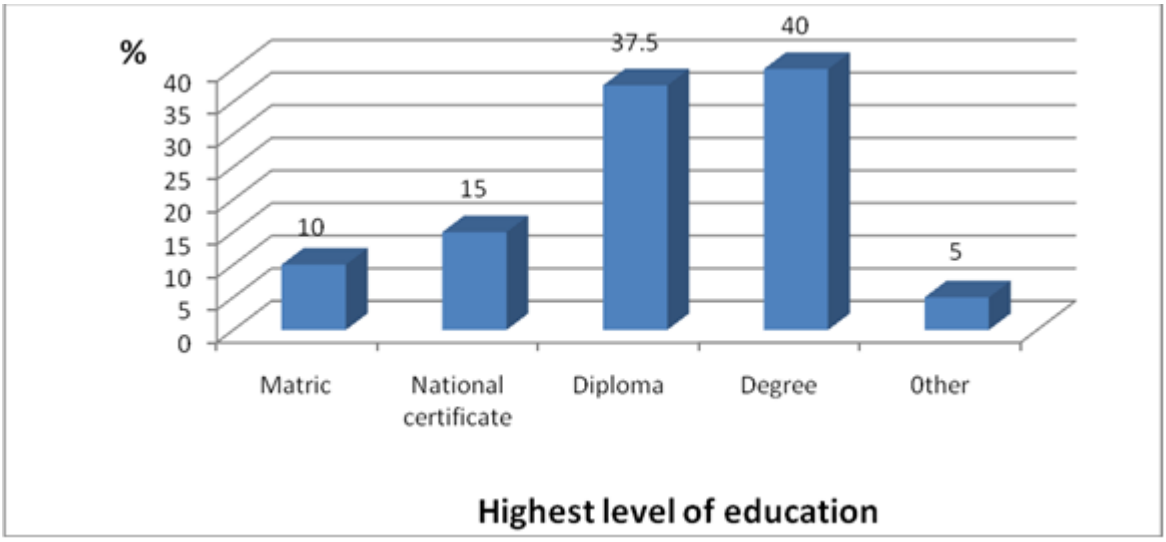

Figure 4.1: Highest level of education attained by respondents

Figure 4.2 illustrates that 37.5% of the respondents were never married, 42.5% were married, 5.5% were divorced, 2.5% were widowed, 4% were separated and 8% were cohabiting. It can be deduced from the study that, a large number of employees who participated in the study were married. Thirty-seven point five percent said that they were never married. Though not married, most of them confirmed that they were involved in sexual relationships. This puts them on high chances of contracting the disease because they will engage in multiple sexual relationships as this is common among African men and women. This can be supported by empirical evidence that has demonstrated that women's lower power coupled with high male control in intimate relationships is generally associated with increased HIV risky behaviours and infection (Dunkle *et al*., 2004). The 42.5% are married and these are in stable relationships which will reduce the transmission of the virus. However, married women find themselves contracting the virus from their husbands due to culture that puts them on a platform of not being able to negotiate safer sex. This can be supported by Kehler (2007), who stated that the gender system prevalent in South Africa fosters power imbalances that facilitates women's risks for sexual assault and

sexually transmitted infections, and that existing power and control disparities in relationships create a context for men to have multiple partners and fuel their reluctance to use condoms.

Kehler (2007) further stated that the patriarchal paradigm prescribes women's lower status and therefore, impacts significantly on the choices that women can make in their lives especially with regards to when, with whom and how sexual intercourse takes place. However in this study women are beginning to regain their appropriate place in society and are taking responsibility for their lives since they are now economically independent. In the present era of HIV/AIDS, the power imbalance between the sexes in the cultural context carries a novel sense of urgency. Women have become especially susceptible to the disease as a result of their limited power in sexual encounters, despite the assurance of the right to reproductive autonomy enshrined in the Constitution (Mswela, 2009). Five point five percent were divorced, 2.5% were widowed and 8% were cohabiting. Those widowed/divorced might have been as a result of HIV/AIDS, unfortunately this study failed to ask whether employees who were widowed/divorced –could be as a result of HIV/AIDS. Ngwena (1999:99) concluded that, unless there is a drastic change in sexual behavior, the evidence is sadly, that South Africa is headed for the worst case scenario, with prevalence rates probably reaching 27% of the sexually active population by 2010.

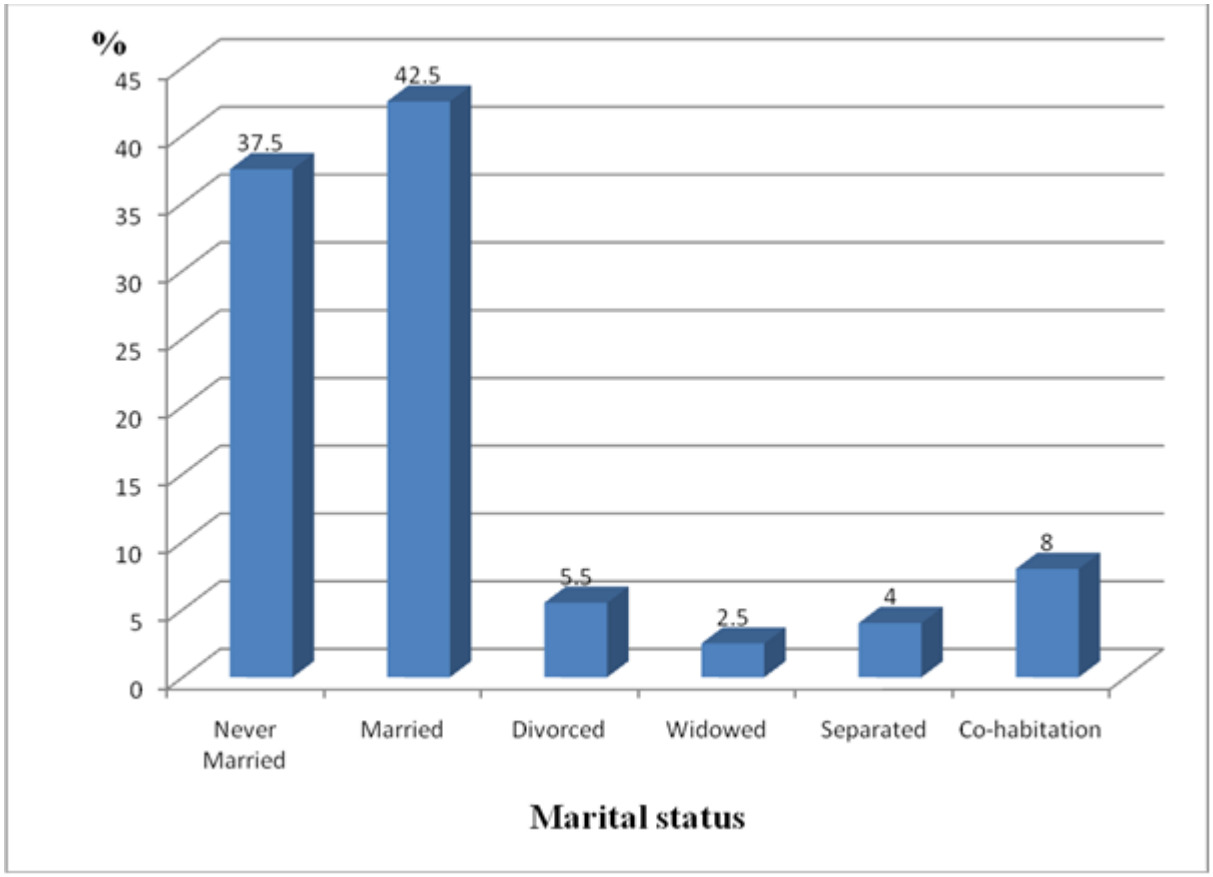

Figure 4.2: Marital status of respondents

Respondents were asked to indicate the number of years that they have in the organisation and Figure 4.3 illustrates their responses. Seventy-five employees highlighted that they had between 0-5 years' work experience within their respective fields, 30% were having experience ranging from 5-10 years, 20% were ranging from 10-15 years, 7.5% were ranging from 15-20 years and only 5% that is only 10 people studied have 20 years and above in the field.

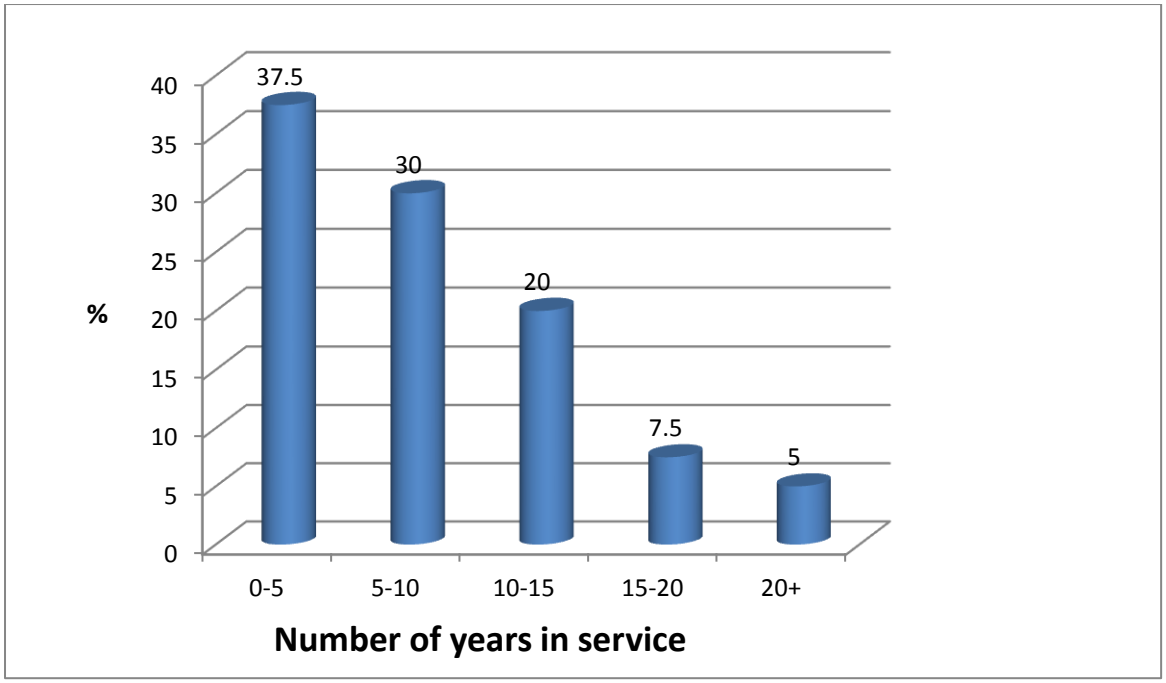

Figure 4.3: Number of years of service

The respondents were also asked about their type of contracts that they hold within their respective organisations and Figure 4.4 depicts that 91% of the respondents participated were employed permanently in their organisations, 5% were temporarily employed and 4% were employed on other bases not stated in the questionnaire. They were further asked if absent from work due to illness can affect their work, and 150 employees(75%) said yes it can affect their work and 50 employees (25%) said that it does not.

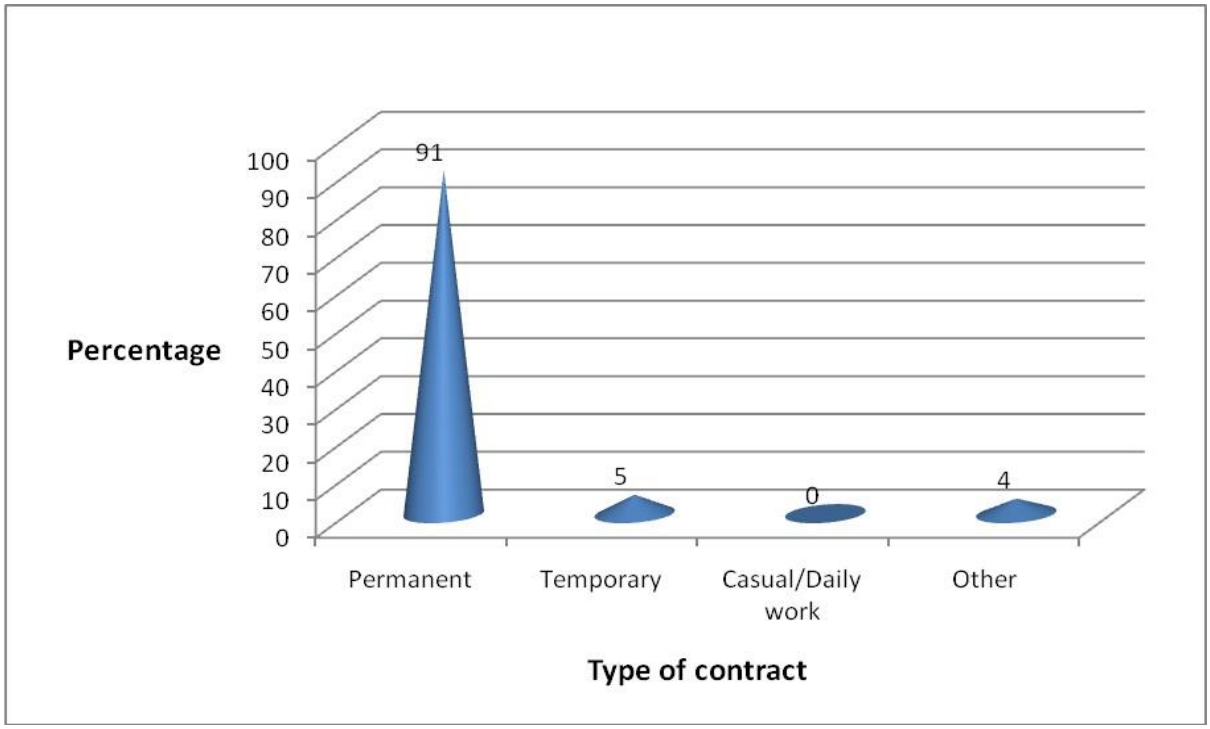

Figure 4.4:Type of employment held by respondents

In every organisation, at any one time or the other, employees may be absent from work for one reason or the other.Abseenteeism is the greatest problem faced by organisations (Barnett and Whiteside, 2006). Employees in this study were asked on what happens in their organisations if they are absent from work due to reasons other than ill-health. Figure 4.5 shows that 9% of the respondents agreed that there was no promotion, 30% of the respondents stated that there were salary cuts,18% highlighted that no other leaves were given and 43% indicated some other reasons on the effect of being absent from work due to other reasons than ill-health. According to a study undertaken in 2005, commissioned by AIC Insurance, companies are losing as much as a month's work each year for every employee with advanced HIV/AIDS. The very same study also showed that the absenteeism rate for people living with HIV/AIDS was three times higher than that of people not infected with the virus.On average,people living with HIV/AIDS were absent 32 days a year, genetrally divided into four stints of about eight days each.

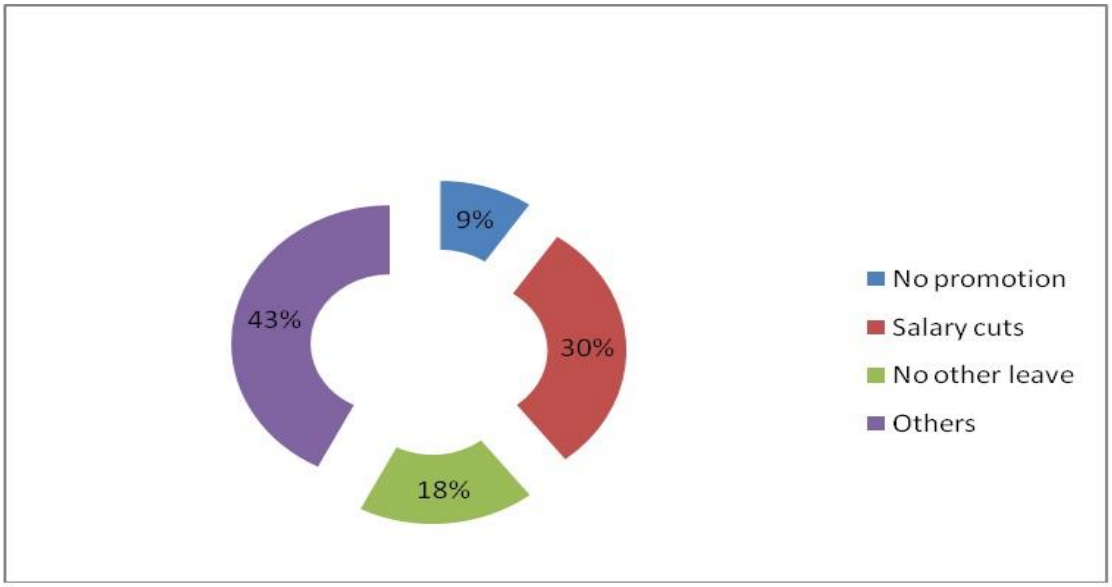

Figure 4.5:Effects of absenteeism from work due to reasons other than ill-health

4.2.2 Nature of HIV/AIDS programmes at the workplace

Concerning the existence of HIV/AIDS policy/programme in the workplace, 188 employees (94%) said they had an HIV/AIDS policy at their workplace and 12 employees said they did not have it (6%). A large number 151 of employees (75.5%) who participated in this study supported the idea of an HIV/AIDS policy at the workplace and 49 employees (24.5%) did not support it. The employees were further questioned if their employer's current HIV workplace policy is adequate and 104 respondents (52%) agreed that it is adequate and 96 respondents (48%) stated that it was not adequate.

Table 4.2 illustrates that the respondents were asked if HIV awareness programmes in their organisations were effective and 46 percent agreed whereas a 29.5% were not certain .They were further asked if there is an disciplinary action taken against those who discriminate against PLWHA in their workplace and 63% agreed and this can show that the is reduction in terms of discrimination in the workplace due to

HIV/AIDS status. Moreso a higher number (74%) agreed that they are encouraged to go for VCT at their workplace. When it comes to hiring of doctors and counselors to do counseling at the workplace, 46% agreed that counselors are hired and 33% did not agree with the statement.

Table 4.2: Some employee responses on HIV/AIDS programmes

Variables	Responses				
	Strongly Agree	**Agree**	**Uncertain**	**Disagree**	**Strongly Disagree**
HIV awareness effectiveness	6.5	39.5	29.5	14.0	10.5
disciplinary action	17.5	45.5	25.5	8.5	3.0
VCT for employees	19.5	55.0	12.0	8.5	5.0
Hiring of doctors and counselors	11.5	34.5	21	15.5	17.5

Knowing your HIV status is very important for one inorder to prevent HIV/AIDS or taking treatment if one is infected .The respondents were further asked for a place they would prefer to do an HIV test. Figure 4.6 illustrates that 70% would go to other places not mentioned like their own private or family doctor, 20% would prefer to take up an HIV test at a clinic, 5% at the hospital and the other 5% at a private facility. None would be tested at the organisations since all the four organisations studied do not have their own clinics as one of the HIV/AIDS management programme.This can cost the organisations in terms of time spent outside the workplace by employees who will go to look for private facility for testing.

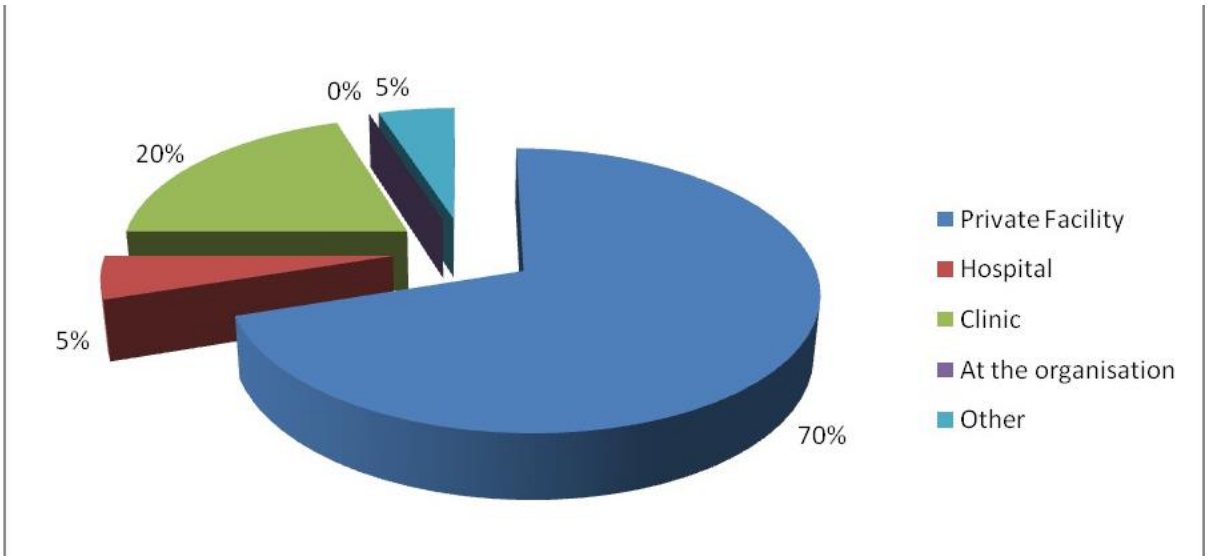

Figure 4.6:Testing facilities for HIV/AIDS

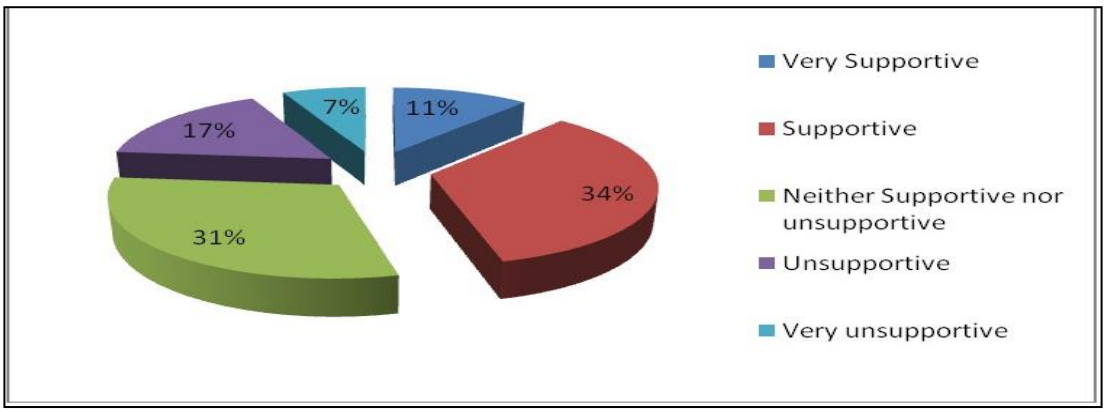

Figure 4.7: Management's support on HIV/AIDS management programmes

Furthermore, Figure 4.7 shows that 6% of the employees agreed that that the management of the organisation were very responsive in dealing with issues of HIV/AIDS in the workplace,11% said they were responsive, 30% highlighted that management is neither resposive nor unresponsive, 35% agreed that they were unresponsive and 18% said that the management were very unresponsive.

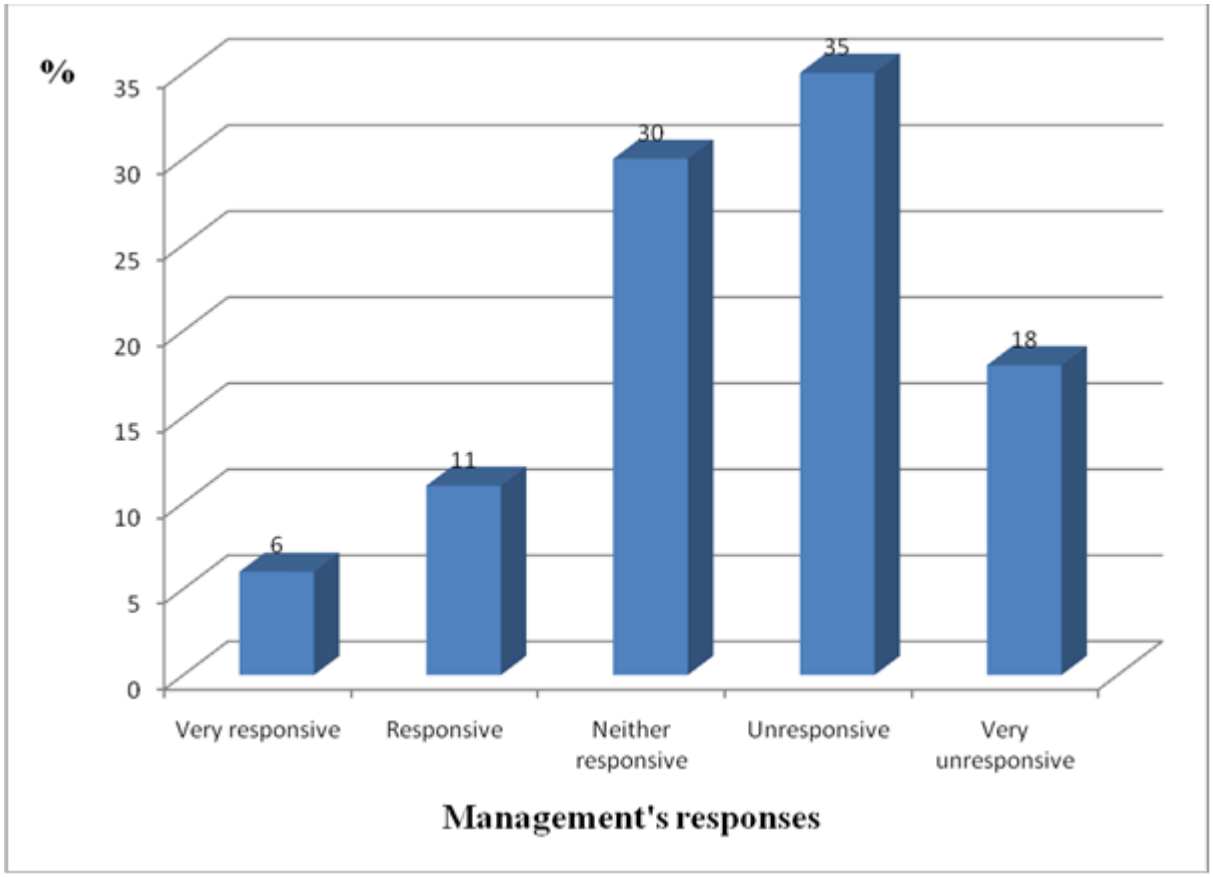

Figure 4.8:Employees views on management's responses to HIV/AIDS issues

Figure 4.8 illustrates that 17% of respondents thought that managers were very unsupportive to PLWHA in the organisation, 31% thought they were neither supportive nor unsupportive, 34% thought that they were supportive, 11% thought that they were very supportive and 7% thought that they wre very unresponsive.

Management is more likely to perceive an impact of HIV/AIDS when death or disability from the disease has occurred , rather than the mere knowledge of HIV positive workers whose productivity may not yet be affected (Mapolisa et al, 2005). In this study, Figure 4.9 depicts that 5% of the respondents agreed that the management of the organisation have been very committed in making the HIV/AIDS activities or programmes they have implemented in the workplace, a success, 11%

agreed that they were committed, 25% of the respondents agreed that they were neither committed nor uncommitted and 59% said they were uncommitted

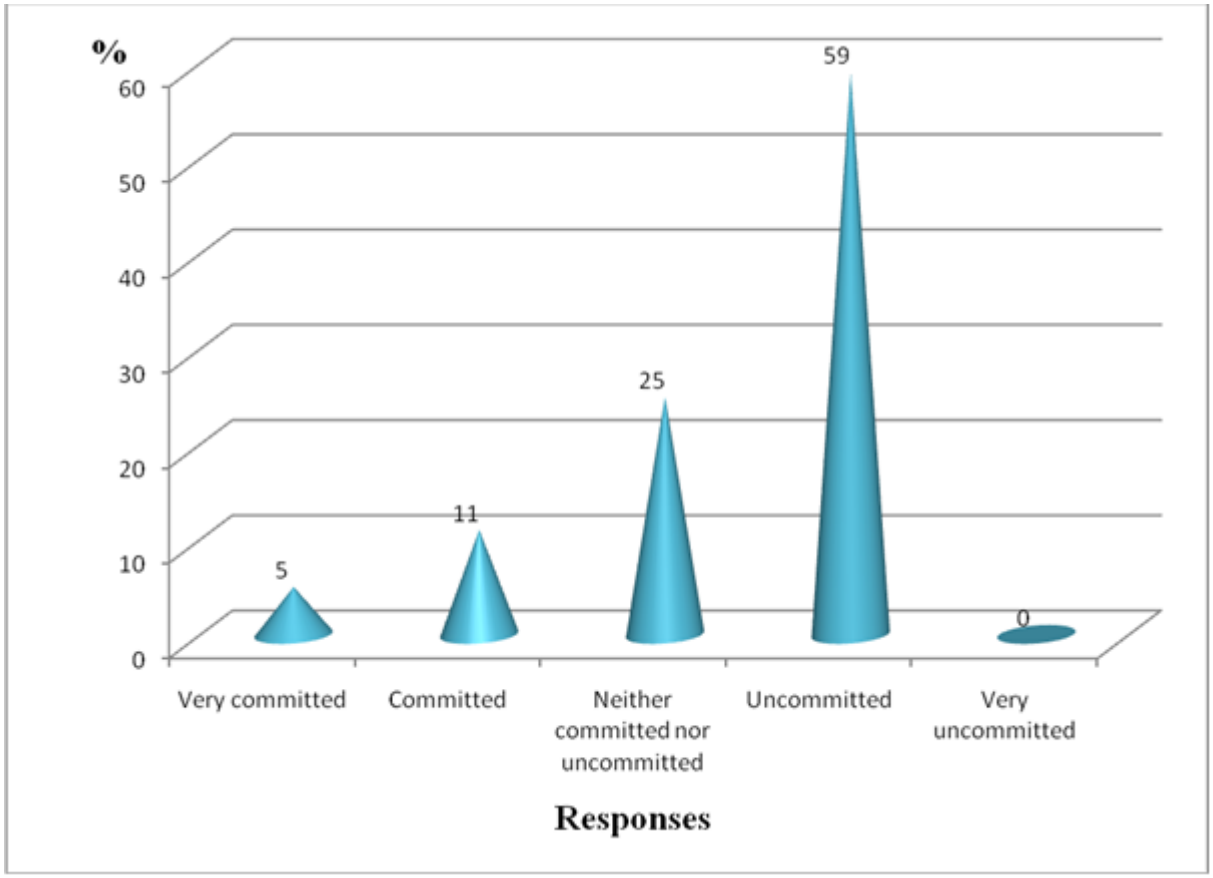

Figure 4.9: Employees views on management's commitment to HIV/AIDS management issues

4.3 Employees perceptions on HIV/AIDS at the workplace

The respondents were asked if they can work next to someone who is HIV positive and 192 employees (96%) agreed that they can work next to someone who is HIV positive and only 8 people (4%) said they do not want to work next to someone who is HIV positive.This suggests that many employees are now accepting the epidemic and are ready to fight stigma and discrimination in their workplaces and this can be realised when employers or managers take a leading role and in supporting HIV/AIDS in their workplaces.They were further asked if the treatment of HIV/AIDS

positive people is fair in their organisations and 27% agreed while 73% did not agree. The main reason of not agreeing was that most of the employees participated in the study stated that, most employees do not disclose their status and its difficult to conclude that HIV positive employees are fairly treated. However it can be deduced from the question that they were further asked if they know someone who has been forced by the employer to take an HIV/AIDS test. A large number thus 198 of the employees (99%) said that they do not know of anyone forced to take an HIV test by the employer while only 2 employees (1%) said they know. Therefore it can be generalised from these results that employers were not forcing their employees to take an HIV test which is a good conduct of the codes of good practice on HIV Management at the workplace.

Figure 4.10 depicts that 10.5% of the respondents have an obstacle of using a condom due to religious beliefs, 8.5% due to culture, 22% due to their spouses, 18% due to suspicion and 43% were having other reasons not mentioned.

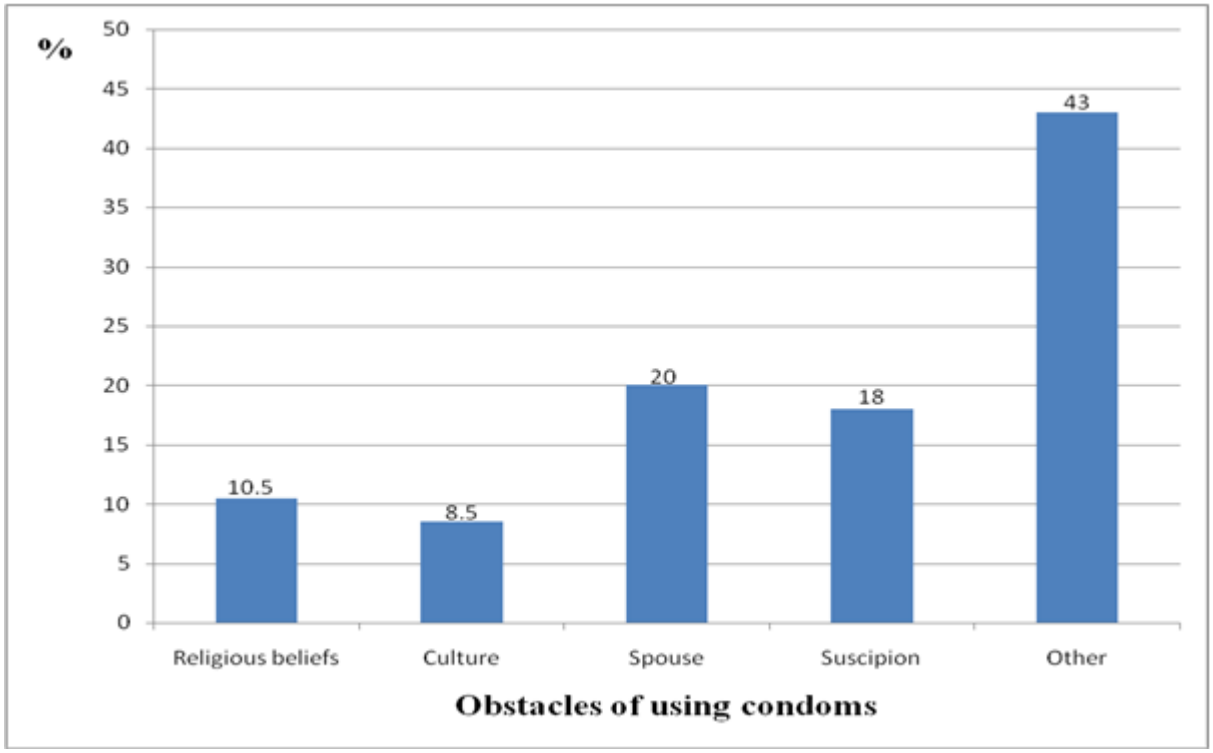

Figure 4.10:obstacles of using condoms

Figure 4.11 indicates that 17.5% support the idea of HIV/AIDS policy at their workplace because they say it boost their self-esteem, 65.5% argued that it reduces stigmatisation, 7% argued that it promote support to those with low morale and 10% have other reason. Other employees were having other reasons of not supporting the idea of a policy at the workplace; 1.5% did not support their reason leading to low self-esteem, 3% argued that it lead to stigmatisation, 87.5% maintained that it lead to discriminination and 8% said that it lead to labelling.

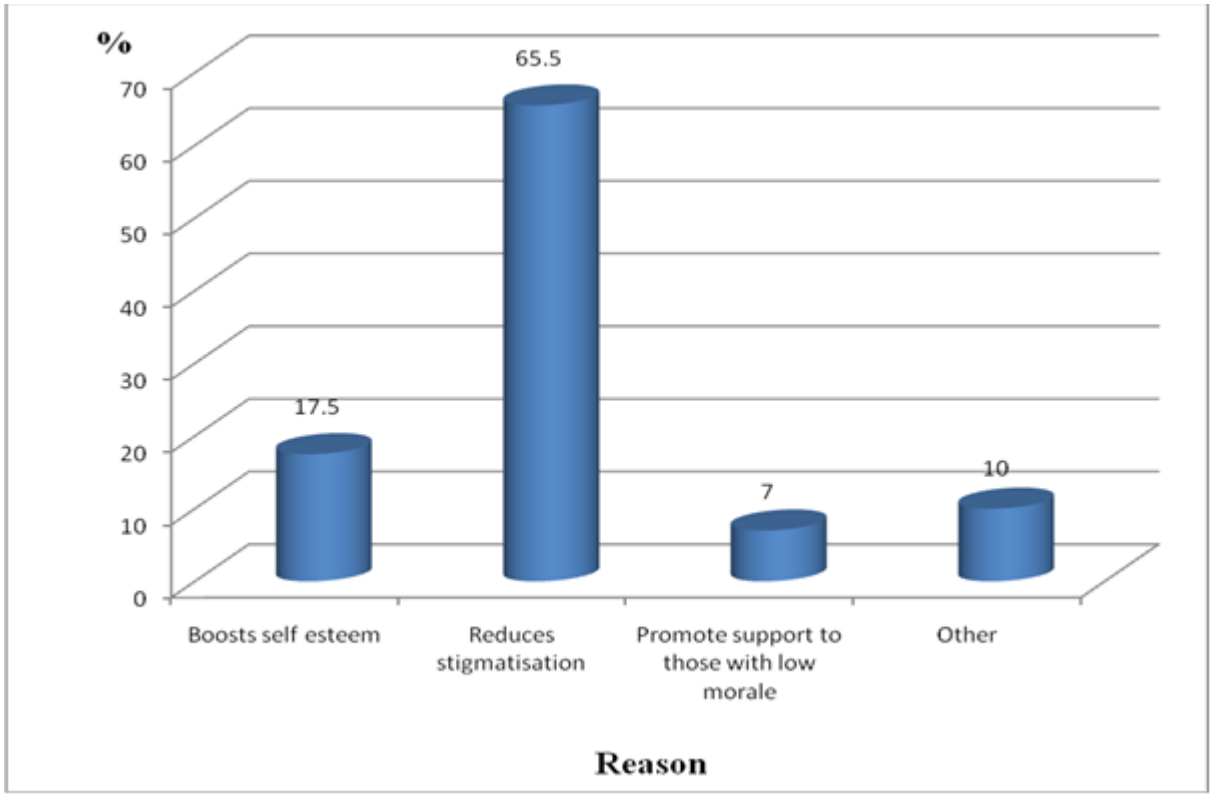

Figure 4.11: Reasons for support of HIV/AIDS policy at the workplace

In addition, Figure 4.12 shows that 19.5% of respondents viewed the main weakness of HIV/AIDS programme in the organisations as lack of support from top management, 35% saw it as lack of interest among employees, 8.5% viewed this as lack of specialists support, 20% as lack of information and 17% had viewed in other ways.

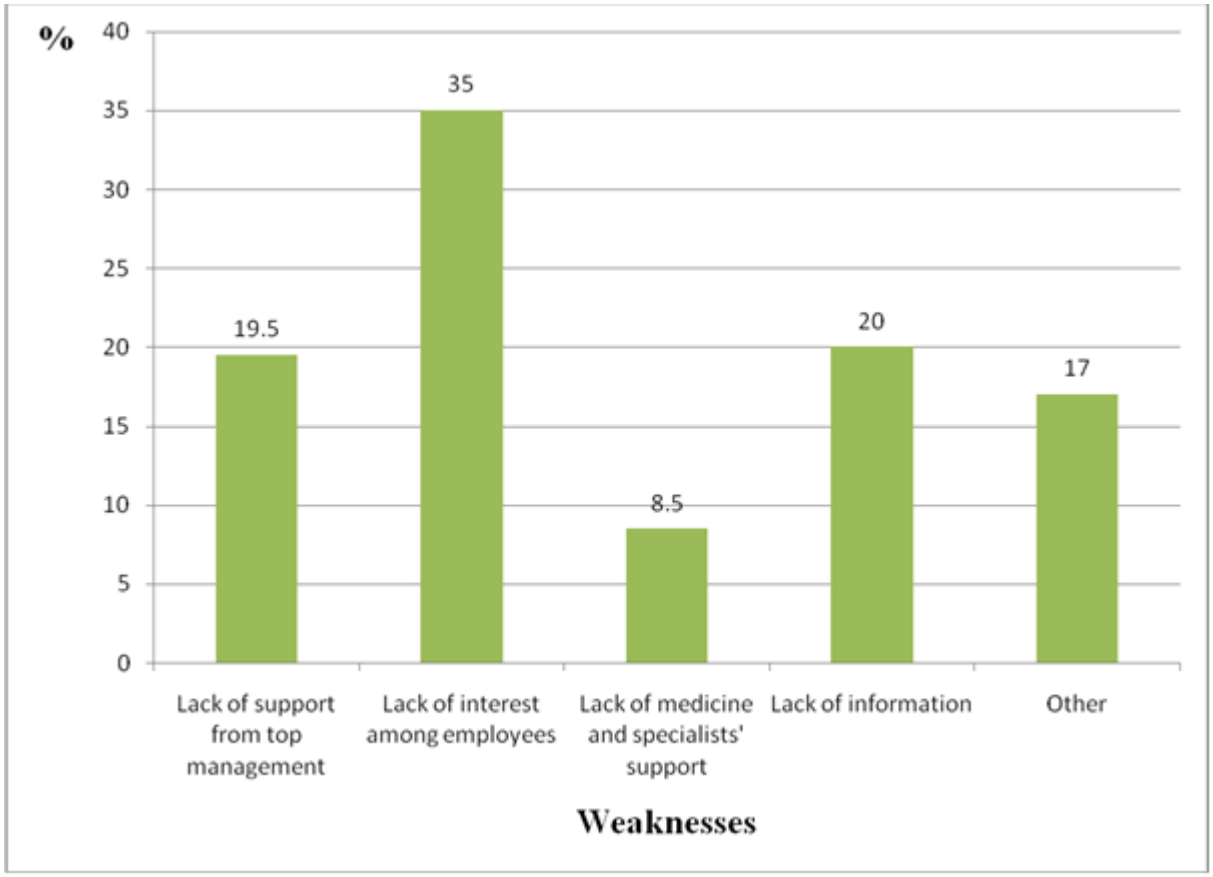

Figure 4.12: Weaknesses of HIV/AIDS programmes at the workplace

Table 4.3. Statistical analysis: The Chi-square results

peerEduc	condom	shun	offer	arvs	knowledge	noEffect
84.850[a]	70.500[a]	180.000[a]	86.650[a]	121.000[a]	115.650[a]	171.850[a]
4	4	4	4	4	4	4
.340	.620	.860	.630	.250	.210	.920

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 40.0.

The chi-squared one-variable test was used in this study and it serves a purpose similar to the binomial test, except that it can be used when there are more than two categories to the variable. Thus, if one wants to determine if the number of people in each of several categories differs from some predicted values, the chi-squared one-variable test is appropriate. The test statistic output gives the value of the chi-square statistic (84.850 in the peer education variable), the degrees of freedom (df) (4 in this example), and the p value is given on the last line of the output. In the peer output, the p value is 0.340. In the study, the first hypothesis was stated as: employees have a negative attitude towards HIV/AIDS programme at the workplace. In this case, the p value (0.340) is greater than α (0.05) so we do not reject H0. That is, there is sufficient evidence to conclude that the proportions of the attitudes of people towards HIV/AIDS programmes are not different. This means that we do not reject the H0 and conclude that employees have a negative attitude towards HIV/AIDS programmes. This has been as a result of lack of support from management If we look at all our variables above the p values are all greater than 0.05, also supporting or indicating negativity towards HIV programmes. The second hypothesis was HIV/AIDS intervention programmes at the workplace are not effective. The p value is greater than 0.05, so we do not reject H0 and conclude that HIV/AIDS programmes are not effective.

Group Statistics

	VAR00001	N	Mean	Std. Deviation	Std. Error Mean
Relevant	1.00	100	1.69	.465	.046
	2.00	100	1.27	.446	.045

α=0.05

One of the hypotheses of the study was to find out if there no difference in the management of HIV/AIDS programmes between the public and private sector. An independent samples t-test was used to compare the mean score on some continuous variable for two different groups of subjects. An independent sample t-test tells whether there is a statistically significant difference in the mean scores of two groups. In statistical terms it's testing the probability of the two sets of scores that are coming from the same population. An independent samples t test was conducted to compare the self-esteem scores for public sector employees and private sector. There was a significant difference in the scores for the Private (M=1.69,SD=0.465) and Public (M=1.27,SD=0.446); t(198)= 6.518. The results show that there is a significant difference in the impact of HIV/AIDS interventions programmes between the Public and Private sector with the IMPACT being high on the private as compared to the public. The last hypothesis was to find out if there is no impact of not having HIV/AIDS programmes at the workplace and from the results (t= 6.518; df=198), the p value is less than 0.05, so we reject H0 and conclude that there is an impact of not having HIVAIDS programmes at the workplace.

4.4 How organisations can improve the effectiveness of HIV/AIDS programmes at the workplace in terms of:

4.4.1 Employee participation

Most employees from both public and private sector suggested that to improve the effectiveness of HIV/AIDS programmmes at the workplace,

- management must provide intensive training on HIV/AIDS awareness and motivate employees.

- Employees must be linked with enough resources inorder to implement the programme.
- Motivational speakers must be hired and present HIV/AIDS issues.
- Mobilization of employees to form and join support groups for both affected and infected.
- Employees must be encouraged to speak one language and not stigmatising others.
- Every employee must be given a task to do and be included in planning and decision making.
- Employees must be workshopped on HIV/AIDS policy and HIV/AIDS programmes.

4.4.2 Management

One said, "*managers must be equiped first on HIV management programmes so that they can assist employees"*

Employees also suggested that, when management do the budget of the organisation, there must also prioritize HIV/AIDS management budget.

Others suggested that managers must be enforced by lawamakers and policy makers to take the matter of HIV/AIDS management in the workplace as a serious issue.

Moreso the employees urged managers to do constant monitoring of the programme and bringing in new information and updates on HIV/AIDS issue.

Furthermore,some were of the opinion that managers must make sure that the policy is accessible to every employee.

4.4.3 Generating employees interest

Most employees suggested that they must be flooded with incentives and more prevention information. *One stated that 'promotional material like T-shirts written information about HIV//AIDS must be provided for us by the organisation'*

Some suggested that they need to be rewarded and reinforced by being given certificates of appreciation if they attend HIV/AIDS programmes so that they will continue having a high spirit of implementing the programme.

Other employees in a public sector organisation added that HIV/AIDS programme must not stay with HR or the Provincial office but rather be distributed to all levels of employees so that everyone is equipped and owns it.

Moreover, some were of the opinion that employees must visit hospitals and talk with those infected and affected so that they will face reality and be able to deal with HIV/AIDS infected and affected in their own workplaces. And also inviting PLWHA to do presentations.

Furthermore, other employees suggested that the HIV/AIDS programmes will be effective if they take the leading role. Some suggested that tours, games and drama activities on HIV/AIDS iniated by employees can create a great difference in managing HIV/AIDS.

4.4.4 Seek specialists knowledge when designing and implementing the program

On this sub-theme the employees suggested that the organisations must hire professionals with intensive knowledge on issues of HIV/AIDS to run the programmes.

Others suggested that the EAP representative of the organisation must link employees with resourcess so that it will assist them as well as the wider community.

Some suggested that when impementing the program, all the role players must fully participate and accomodate rather than give an HIV/AIDS policy compiled by HR without consultation or involvement of all employees both infected and affected.

Generally, employees are willing to participate in these programmes if management provides full support. In one public sector, they argued that the policy is there within their organisation and has not been fully implemented. They suggested that the organisations must hire someone who specifically stands for HIV/AIDS issues among employees. The employees further highlighted that its high time organisations must look deeply into the costs and impacts of not implementing the programme effectively before it is too late for the benefit of the organisations and its workers.The policies are in place but in some areas of the sectors it has never started to be implemented and its even worse when it comes to HIV/AIDS programmes in the workplace.

4.5 Presentation of qualitative findings for the managers (employer)

The study was further aimed at qualitative analysis that was done through the use of in-depth interviews with managers. Four managers were interviewed thus 3 females

and one male. The analyses of their responses were presented according to themes that emerged during discussion as stated below**.** Like other challenges in the contemporary business world, HIV/AIDS is a factor that companies must now reckon within their planning operations. HIV is now a factor that affects all managers, workers' representatives and employees. HIV also affects Human Resource Management, employee welfare, operation efficiency and customer relations. Implementing workplace HIV/AIDS program has been proven to be the only source of accurate information employees have about HIV/AIDS (Keba, 2011).

This part of the chapter is going to analyse the findings from management/employers. It analyses how organisations fund the HIV/AIDS programmes, programmes that are available and how they are implemented for the benefit of the employees. Two private organisations and two public were the nature of the organisations studied. All the four organisation were given pseudo names organisation A and B were public and C and D were private. It has been discovered that a greater number of employees working in these organisations are female as compared to male population. This shows there is gender balance in terms of employment though their income is still low due to the positions that they are occupying. The population in the study ranges from 20 years of age and above. And the larger population is between the 25-49 age bracket (economic active population). This means that all the organisations studied are on high risk of contracting the disease since they are sexually active and some still do not use condoms yet they share partners as the results have shown it previously that most of them were never married.

Four managers were interviewed and all of them agreed that HIV/AIDS is negatively impacting their organisations in terms of costs related to absenteeism, loss of

experienced and skilled workers, recruitment and training costs, lowering of labour productivity and reduce the growth of an organisation. Indirectly, HIV is leading to an increase in the demand for public health care and welfare grants for orphans, all of which will put upward pressure on the government's budget deficit. All the management employees confirmed that all their employees have seen the doorway to school some with pre matric results, some diplomas and some degrees. Organisation A and B employees have degrees and in organisation C and D (private) most of their workers have national certificates and diplomas with a small number with degrees. However in all the organisations, there are general workers who do cleaning jobs with limited education. Some dropped out in grade 6, 7 and 8 respectively. This shows that with education and trainings of HIV/AIDS being implemented in the organisations, there will be a great change since most of the employees have gone through learning process and they will adopt and change their behaviour in trying to prevent HIV/AIDS in the workplace.

4.5.1 Introduction of HIV/AIDS management programmes at the workplace

The introduction of HIV/AIDS management programmes for the employees at the workplace was said to have been introduced 15 years back. The managers also stated that the introduction of HIV/AIDS management was prompted by South African Government Legislation. This initiative was said to be as a result of many researches that has been done that put South Africa on number one in Sub-Saharan Africa and the rest of the world where HIV infection is spreading fast and had high mortality rate and deaths as a result of HIV/AIDS. And it has been realised that it has a potential to impact economy and production of an organisation whether public or private. Dickinson et al. (2005:287) highlighted that, the workforce is an important

target group for HIV prevention activities. Economically active persons, as a sector of the population, can be viewed as being at increased risk of HIV due to their disposable income and ability to afford multiple sexual partners. Therefore this triggered the introduction of HIV/AIDS management programmes at the workplace.

4.5.2 Sponsoring of the HIV/AIDS programmes at the workplace

The managers were asked how their organisations get sponsorship for HIV/AIDS programmes and the managers from organisation A and B stated that the sponsorship comes from government though the government had failed to budget for the programme. They stated that they have no funds to run the programme effectively. This shows that there has been no follow up from SANAC and other responsible boards in monitoring the implementation of HIV/AIDS programmes at the workplace as well as evaluating the programmes. External support has been given to organisation, A and B from private companies like Nedbank and Old Mutual when they do wellness programmes twice or thrice a year. It is not an everyday thing so there is no consistency. In organisations C and D the sponsorship is internally from the organisations and from external donors and they are doing much better in terms of programmes as compared to organisations A and B that are public sectors.

4.5.3 Management of HIV/AIDS programmes at the workplace

All the four managers were interviewed to find out the programmes or intervention methods that are currently available in their organisations. Organisations A and B had only two programmes that are functioning, thus condom distribution and HIV/AIDS workplace awareness programmes that is implemented on wellness days.

They both stated that some of their employees once get training on HIV once–off so that they can assist infected and affected employees. But these two managers stated that sometimes condoms are not found in their workplaces after they are finished and sometimes some condoms get expired because employees will not be taking them. In organisation C and D, their managers stated that four programmes were functional in their organisations, these include, a nurse for occupational health and safety, training on HIV/AIDS, HIV/AIDS workplace awareness programmes and counseling services for workers living with HIV and AIDS. Most of these programmes are 24 hours-online services. Organisation C does have EWP (Employee Well-Being Programme) where it can help in providing free therapy through an independent professional counseling organisation such as Independent Counseling and Advisory Service (ICAS) as well as supporting staff affected and infected by HIV/AIDS. A simple service like condom distribution was not found in any of these two organisations even at the time of visit and the managers said that they do not have such a programme though it has seen as best method that has reduced HIV infection and STDs in South Africa.

Many companies hesitate to undertake an HIV/AIDS program because they believe they do not have the needed funds and expertise. The solution is that they must partner with other companies to design a workplace program, train and support staff, provide medical commodities and access program effectiveness Conspicuous leadership which entails willingness by senior managers and board of directors to speak out on HIV/AIDS prevention and care regularly and frankly at the workplace will lead to control of the spread of the disease (Keba Africa, 2011). Managers were also interviewed on how they were managing the current programmes for consistency and all of them stressed that they have done nothing to watch over the

consistency of these programmes. And their reasons for not doing anything was the fact that they did not know what was expected of them and not having any tool or standard framework to manage and monitor the progress of these HIV programmes at their workplaces. This clearly shows that management has been not doing justice on the programme. More focus had been given to production than the health issues of the workforce. The managers are therefore recommended to act through seeking more knowledge and information on how to run these programmes in their workplaces.

So evaluation of these current programmes has not been done to make sure it is benefiting the employees of the organisation and the organisation itself. There was no monitoring of the programmes as stated above thereby not having evaluation as well. One manager stated that most of these programmes are not functional in her workplace and therefore it becomes difficult to evaluate. However, it is high time all the employers from all organisations could rise up and seriously engage in HIV programmes in a way that they do with organisations' production and profits. And through this, HIV infections will be reduced since a workplace is seen by other researchers as a gateway to successful HIV/AIDS prevention, care, treatment and support.

All the organisations studied were confirmed by their management that they do not have their own clinic. The managers highlighted that the reason of not having a clinic was that they have many service offices and branches therefore it will be difficult and costing for the government or private sector to build a clinic in every centre in the Eastern Cape and South Africa as a whole. Therefore they stated that they make use of government clinics and some of their employees with their different medical AIDS opt for private clinics of their own choice.

4.5.4 Impact of HIV/AIDS programme and their effectiveness

Absenteeism and productivity were raised by all the managers as currently having a greater negative impact in their respective organisations. They stated that they are not sure whether absenteeism is as a result of HIV/AIDS since most of their employees do not disclose their status to them. And managers have no right to force the employee to disclose his/her status if s/he is not willing to. If employees do not come up for work, employers have to delegate others to cover up for them but they said it affect productivity since that one person will not finish in time two jobs at one time. According to Human Capital Management (2006/7), in 2005, South Africa was said to be losing an estimated R12 billion a year due to absenteeism, of which R 1.8 billion and 2.2 billion could be attributed to the effects of HIV/AIDS.

The programmes implemented were said to be effective to those with interest. But as raised earlier, programmes in organisation A and B has not been effective because not much has been done except those wellness programmes that are done so often and condom distribution that is not consistent. In organisation C and D, the mangers think that the programmes are effective since there is a lot of privacy through on-line services though they have not monitored, measured and evaluated it. Two managers from organisation A and B were not sure whether the impact of HIV/AIDS has decreased in their organisations since the introduction of HIV programme as they have realised for themselves that no justice have been given to the programme and they need more knowledge to rectify this. From organisation C and D, their managers thought that since the introduction of the programme HIV/AIDS rate has decreased because they said they have given their employees 24 h online service that has programmes and is confidential. Though some employees do not disclose,

they believe somehow, the workers who accessed the services have benefited however this need to be analysed and evaluated not relying on assumptions.

Services/intervention methods that must be in every workplace include clinic, HIV/AIDS awareness, HIV/AIDS care and suport, couselling services to workers living with HIV and AIDS, nurse for Occupational Health and Safety, independent employee driven HIV and AIDS programmes or activities (peer educator), trainings on HIV and AIDS, condom distribution and Anti-retroviral treatment. On the public organisations studied, most of these programmes are not being implemented.Both organisations were on similar positions. In one organisation most awareness have been done by employees to the community not to themselves as staff. In another there is one representative for HIV/AIDS programmes but she focuses mainly on learners than staff. Condom distribution was once functional in these workplaces whereby the health Department was distributing them but now they say no condoms are available in their workplaces.

All organisations under study do not offer Anti-retroviral since they do not have clinics or specialists for that duty. Peer educators were there who were once trained in HIV /AIDS issues but the employees stated that they are doing nothing and some have forgotten that they are peer educators since they said they were trained once on the HIV prevention programme. An EAP is available in our organisation but her office is in the provincial level and she is only found in wellness programme and she serves the whole province. At local and district levels, there is no EAP.

However in the private sectors that participated, operation is a bit different. They do not have all the programmes but they have 24 hour online counsellors and a toll free number where they get couselling care, and support whenever needed,they do have

a nurse for occupational health and safety and also condom distribution though they stressed that its not constant. During the time of data collection, only one organisation had condoms that had expired. So the employees' family and spouse do not have access to these services since most of them exist on paper not on a practicality level. Absence of HIV prevention services show weakness in the organisations as it shows failure to adhere to the demands of the national policies which would therefore indicate a gap that need to be closed so that workers are not left exposed to risk unnecessarily. Dickinson (2003:45) stated that having an HIV policy is one thing, but that turning such a policy into a reality requires much more than a document. Even policies backed by an appropriate programme may not be sufficient to ensure an adequate response in the area of HIV/AIDS. Because of the stigma, fear, denial, and discrimination that surrounds HIV and AIDS there needs to be a pro-active engagement with all the employees using multiple-but above all, peer-based –channels of communication.

Thus, policy and programmes need to be closely aligned with on-going processes in which knowledge, attitudes and ultimately behavior are shifted through continuous debate and discussion within employee groups. He further highlighted that, such an approach requires the mobilization of grassroots structures-notably peer educator groups and unions- that are able to engage fellow employees using their own languages, understandings, and group identities.

4.5.5 Budget allocation

When it comes to budget allocation, all the managers were crying saying that in their yearly financial budget, there is no money allocated specifically for HIV/AIDS

programmes to employees. In organisation A, the budget allocation is for the community based projects and awareness campaigns for PLWHA in the community as well as orphaned children resulted from HIV/AIDS. In organisations B, C, and D, there are some occasions where they give a hand in form of food parcels to identified individual families affected and infected by HIV/AIDS. Therefore the organisation have no access to purchase or offer Anti-retroviral drugs/treatment to employees who are infected whenever needed, instead employees make use of their medical Aid option to get ARVs and some are supplied by government hospitals. If HIV programmes were budgeted for, it was going to save time for the organisation and increase productivity since employees will be surrounded by services thereby not travelling far distances to get medication.

All the manager believe, there has been a change in the way employees view HIV/AIDS in their organisation since the introduction of HIV/AIDS programmes since their employees talk about the disease and participate in wellness programmes. Some are even doing voluntary counseling and testing in those sessions. However, they feel there are some who still do not want to hear about the disease due to fear and stigma attached to it. The managers also mentioned that those employees who are no longer fit for their usual jobs can be given an alternative job as per the terms of their HIV /AIDS policies. When an employee is no longer able to work, in organisation A and B, the employee will be given incapacity leave and in organisation C and D they also give leave or pension funds if the employee is no longer able to work.

When employees need to cope with depression or stress caused by HIV/AIDS, organisation A manager stressed out that the employee can receive counseling from

the EAP in the provincial office, in organisation B the HIV/AIDS employee whose office is in the district will assist hundreds and hundreds of employees and for organisation C and D, they both use their on-line counselors and it promotes confidentiality and anonymity. In these four organisations, they confirmed that they have peer educators who were once trained to help other employees. However they have not been visible and seen actively doing their work. The manager suggested that they need to be equipped more by specialists so that they can perfectly carry out their duties.

All managers supported that there will be reduced labour turn over, improved productivity, reduction of absenteeism, low retaining costs and high employee benefits to their organisation derived by implementing the HIV/AIDS programme. Lastly, to improve the effectiveness of the HIV/AIDS programmes at the workplace, managers suggested that, if they can unite with their employees when designing the programme it will be effective since everyone will be honouring it. Another suggestion was of funding, they recommended the government to review their strategy in line with budgeting so that there will be enough resources to support the programmes at South African workplaces. Specialists and improvement in communication between employees and employers were suggested as other important key points to effective HIV/AIDS management since specialists will have deep knowledge on the disease and with unity they will stand and fight this epidemic. Generally managers felt that if they do justice and pay attention to this call of fighting HIV/AIDS at the workplace, they will be conquered to this fearful disease that has caused havoc in the workplaces. Connelly and Rosen (2005) are of the opinion that the implementation of HIV/AIDS programmes by employers could contribute

significantly to addressing and managing the negative impact of HIV/AIDS in the workplace.

4.6 Conclusion

The findings of the research were discussed in this chapter, so the coming chapter will make conclusions of the study and make recommendations for future research for other researchers with interest in this field.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This final chapter intends to supply information on the summary of findings of the whole study, conclusions, recommendations and areas for further research.

5.2 Summary of Findings

This study was conducted with the main aim of finding out the HIV/AIDS management programmes that exist in organisations selected, how these programmes are managed for consistency, how employees of the organisations perceive these HIV/AIDS programmes as well as the effectiveness of the programmes in reducing the impact of HIV/AIDS in the organisation.

The study was conducted in four selected organisation in the Eastern Cape Province in South Africa under Chris Hani District Municipality. Two private sectors and two public sectors were studied for variability in trying to avoid bias. Organisations A and B were public thus government owned and organisations C and D were private (non-governmental). The study used a sample of 204 respondents, 200 respondents responded to self-administered questionnaire and 4 managers used in-depth interviews from a semi-structured interview guide.

The research problems emanates from the fact that HIV/AIDS epidemic has presented a major social and developmental challenge in South Africa. Businesses in South Africa like their counterparts on the continent face many challenges in standing up to the needs of a global business environment, one of these being the scourge of HIV/AIDS. The rate of infection affects the socio-economic development negatively (Code of Good Practice on Aspects of HIV/AIDS Employment). A large amount of income is spent on health care. The household capacity to sustain itself is significantly reduced as members infected become economically inept. Many South African families are stretched to the limit, as they have to accommodate children whose parents have died (SANAC, 2010). According to Coetzee (2006), a particularly pertinent aspect for business environment is that infection levels are very high among young economically active persons. This will not only influence consumer power but has an overwhelming effect on the workforce and is thus a major threat to the achievement of strategic business objectives and related business risks, forming a great concern for management. Therefore it is vital to look into the management of HIV/AIDS programmes in the workplace for the benefit of both the employer and the employee. According to the literature that was reviewed, it can be noted that HIV/AIDS is becoming a serious threat in the workplace that can negatively impact the economy of South Africa since it is affecting the young, vibrant economically active persons.

The workplace provides an ideal gateway to HIV/AIDS prevention and care. The workplace has its own culture that connects its workers. Although staff members come from varying social backgrounds and cultures, speak different languages and follow different traditions, employers and employees all share the same organisational culture in which they have the same visions, follow the same

guidelines and adhere to the same rules. The organisational culture is thus an equaliser, offering a consistent platform from which a comprehensive HIV/AIDS plan can be implemented (Dyk, 2005:462).Therefore there is need to find out and to suggest improvement where there is a need to have effective and consistent HIV/AIDS management programmes in the workplace for the benefit of the employer and the organisation.

5.2.1 Major Findings

The findings of the study shows that all the four organisations studied have HIV/AIDS programmes and policy for their employees in their workplaces. The organisations have similar policy aims of ensuring consistent and equitable handling and management of employees with HIV/AIDS, ensuring that the impact of HIV/AIDS is managed in a manner that is consistent with the current legislation and also understanding that HIV and AIDS is a progressive but treatable chronic illness with social economic and human rights implications. Moreso, in the four workplaces studied, the scope of their policies include non-discrimination whereby employers or employees will not discriminate against an employee on the basis of their HIV status, as long as the person is capable of performing the inherent requirements of the job.

Furthermore, the employees do not have to disclose their status this means they have a right to confidentiality and privacy regarding their health status. In the case of alleged discrimination or victimization of employees with suspected or confirmed HIV status, the grievance procedure may be implemented and if necessary after due process, disciplinary measures to deal with such HIV-related discrimination will be

taken. Education, training and awareness are implemented in these organisations so as to provide support to employees infected by HIV/AIDS. The shortfall within the policy that needs to be rectified is the inclusion of affected employees because whether infected or affected, when it comes to absenteeism, the organisations suffer. In all the four organisations on average 2 days sick leave and or family responsibility leave for caring for PLWA or attending funerals were taken.The attendance registers for organisations were assessed inorder to find out the rate of absenteeisn at work. Two public organsations were found to be having many employees taking sick leaves of 2 constant days a week . From organisation B, some employees were taking a one week sick leave in a month and in organisation A, some were on incapacity leave which means they were temporary unfit to work. In the two private organisations, absenteeism was also there but it was lower as compared to the public organisations.There were some workers ,who were taking sick leaves twice a month ,however the managers were not sure whether these employees were infected by HIV/AIDS or not since workers are not forced to disclose their illnesses or sicknesses. By the end of the year ,a manager from organisation A reported that all the 34 days sick leave days and 5 family responsibilty leave days will be exhausted as well as the 22 working days annual paid leave days. One manager from public organisation B , commented that, the employees who always exhausts all their leaves are always the same. Most of the employees' reasons for taking family responsibility were to attend funerals of a family member or friend who had passed on.

Absenteeism from work poses a big threat to profitability as well as competitiveness in any organisation. From the research findings absenteesim is high at the workplace among employees who go out to seek medical attention from private facilities ,some is due to caring for PLWA at home and funeral attendance. Most employees

take family responsibilility leaves and some take infected take sick leave and this will lead to loss of labour and productivity thereby increasing costs in medical schemes and costing the government billion of rands. The 150 (75%) respondents who agreed that absenteeism from work affect their work stated that when, they are not present at the workplace, it overburdens other employees since they have to cover up for their work. However some disagree stating that, they will find the work allocated for them pending waiting for them if the work needs a specific special skill.However for some common work which can be done by anyone, they will find that others have covered their work already. So when they were asked about the effect of absenteeism from work,to them the effect was little since they will find their work covered. From my observation, I think employees are ignorant to the effects of absenteeism at their organisations. One of the public organisation studied was an educational sector ,and with the absence of an educator in a classroom definitely poor results will be yielded . In another public organisation that deals with individuals ,groups and communities with different needs, backlogs due to absenteeism will eventually affect government's main mandate of effective service delivery and better life for all. Even its mission of creating a better life for all with be shattered.

In addition, the findings of the research shows that implementation of HIV/AIDS programmes at the workplace is not very effective. The main reason being the managers are poorly responding and are not fully committed to HIV/AIDS programmes at the workplace. Employees are willing to participate in HIV/AIDS programmes if the organisations' management is ready to seriously implement the programmes.

Budget allocation for the programme has been another burning issue. Most organisations' management studied prioritised the core business of their organisations than HIV programmes. Employees participated in the study argued that their organisations does not consistently sponsor training activities on HIV/AIDS prevention organisation A and B stressed that they only have an Employee wellness sports day once or twice a year where presentations on HIV awareness, care and protection methods are being shared by employees from GEMS (Government Employee Medical Scheme). On those occasions the employees also highlighted that voluntary couselling and testing will be done to employees and also encouraged to know their status The public sector also partner with independent sectors like Nedbank and Old Mutual to sponsor these activities.

However the employees highlighted that these activities are being done once or twice a year. They further argued that their organisations have good designed workplace programmes/policy yet most of the time it is not implemented. Dickison (2005 :290) stated that having an HIV/AIDS policy is in itself not a sufficient indicator that a workplace response is underway. Information on what policies are based on, on what is involved in developing them and how has it been communicated to employees help us understand the extent to which a policy is a "real" document rather than merely a piece of paper. Unless managers are enlightening, the disease will slowly and silently kill the organisations' workforce and production.

In the organisations studied, there isn't much benefit to employees infected by HIV/AIDS and some of the reasons were of the less response, commitment and support from the employer/management. This has led to many employees not disclosing their status and not willing to know their status. In public sectors, support is given by other colleagues if one dies with HIV/AIDS. However many employees

stated that it has been rare to hear the family stating the cause of death of their relative as a result of HIV/AIDS. So, mostly other employees just support each other even if the real cause of the death is not stated to them. Those with GEMS will also chose an option of benefits that will allow them to be provided with medication for HIV/AIDS. Those without Medical Aid scheme, get their treatment from government hospitals for free since organisations do not have a nurse for occupational health and safety and a clinic in their workplaces. In public organisation A, they have a service called HIV/AIDS where they provide counseling, care and support to people living with HIV/AIDS as well as the affected in their communities. They can also sometimes provide food parcels as a way of promoting a healthy nutrition. In other organisations nothing much has been done to the community. In this organisation, awareness campaigns and educational workshops are also being conducted to make the community aware so that there will be “zero-zero infections, zero discriminations and zero AIDS related deaths” as stated in 2011 theme of the year.

Moreso, in the other organisations studied especially private, employees who develop life threatening diseases are encouraged to review their benefits and contact the medical aid in order to register and from programmes which apply to their medical condition. In case of HIV/AIDS, the HIV/AIDS Disease Management (DMP) is available to HIV positive employees who are members of Bankmed and subject to them enrolling on the programme. All the information on this programme will be confidential. Neither that organisation, nor line managers will have access to this information. In case of those not using Bankmed, there are other similar programmes offered by other medical aids for employees who are not members of Bankmed. 24 hour online service is also available for employees of the two private sectors studied specifically for their company employees that provide necessary counseling whenever needed by the employee.

The private organisations are offering better services as compared to the public .The research findings indicate that there were several initiative in place, including the staff policy and an employee well-being programmes which incorporates the counselling services of ICAS (Independent Couselling and Advisory Service) to assist and support staff affected or infected with HIV/AIDS.

Furthermore, from the findings some employees do not use condoms. This can be an indicator though of the reason why there are still new infections and which means there is still a bigger number of the population that are still at risk of contracting the disease, probably an issue of cultural practices in the Eastern Cape for instance the unequal gender balances and low income rates which forces most women to be vulnerable to abuse.

Some of these employees raised different reasons why they have an obstacle of using condoms which include religious beliefs, culture, spouse, and suspicion of promiscuity between sexual partners. In some cultures, for example Xhosa culture women do not have that power to negotiate safer sex especially if they are married. They do not use condoms because they trust one another and no one will suspect one another of having extra marital relationships. However the higher number of employees participated in the research has never been married. Some were having other reasons other than the ones stated, saying that they want to do the real sex and have the feeling or sexual gratification of what they will be doing without using condoms. This means that organisations need to teach more and emphasise more on protection especially use of condoms that has reduced the HIV infection rate in many countries.

The findings of the research also states that programmes of HIV at the workplace were supported by employees as some perceived that it boosts self-esteem, reduce

stigmatisation, absenteeism a well as promote support to those with low morale whereas to some it was a bad idea since they argued that its leads to labeling, discrimination, stigmatisation and low self-esteem. Most of the employees support the idea of HIV/AIDS policy in their workplaces and are now aware of the disease since it is being spoken everywhere through all forms of communication. Their knowledge of HIV/AIDS has been also enhanced through the organisation when presentations are being done. However there are some employees who still engage in risky behaviours which put them on high risk of HIV infection.

Some employees were uncertain since in their workplace people do not disclose due to fear of being stigmatised so they do not have an experience of someone living openly with HIV/AIDS. Companies have an unparalleled opportunity to tackle head on the stigma and discrimination that enabled the virus to spread often unchecked, over the last 25 years (Keba, 2011). South African Government Agency (2012), stated that where workers are free from stigma and discrimination on the basis of real or perceived HIV status, they and their dependents benefit from improved access to HIV education, information, treatment, care and support at the national and workplace levels. For HIV/AIDS programmes to be effective in the workplace, most employees felt that, a clinic must be there in an organisations, nurse for occupational health and safety as well as a shop steward responsible for HIV and AIDS so that training, awareness, care, support and treatment will be constantly implemented in order to manage time accurately as well as maximising production. And most of the employees would want these services to be free not to be paid for from their monthly income.

5.3 Conclusions

The main purpose of the study was to investigate the management of HIV/AIDS programmes at the work place. Considering the findings of the research, it can be concluded that though organisations studied do have HIV/AIDS policy and HIV/AIDS programme, they are not effective. This has been as a result of management or employers who do not pay much attention to HIV/AIDS issues in their own workplaces. Therefore managers have a crucial role in global fight against the epidemic particularly within their own workplaces by engaging in HIV/AIDS sensitization, providing counseling and testing, condom distribution, access to care and treatment, support for responsible sexual behaviour among employees and support for appropriate policies to address HIV/AIDS related situations that may arise at the workplace.

Budget constraints has also led to unsuccessful HIV programmes in workplaces, so organisations need to source financial resource support for prevention and care programs within the workplace and surrounding communities while having a commitment to sustain HIV programmes overtime in order to fight HIV/AIDS at the workplaces. Serious commitment must be shown by private and public sector organisations to effectively implement and manage HIV/AIDS programmes in the workplace in order to promote production and health workforce (Coetzee, 2006). Moreso, with maximum recognition and support from the managers, employees are willing to fight the epidemic in their workplace. So a workplace is seen as a gateway to HIV prevention.

5.4 Recommendations

- Employers are encouraged to hire quality service providers to carry out an intensive de-stigmatisation process with the communication of their policy and procedure and educational interventions and also first creating a supportive environment and adequately addressing the fears of employees for an effective HIV/AIDS management in the workplace.
- The management should demonstrate a clear commitment to the HIV/AIDS management strategy. It is very crucial to employees to see this commitment in a concrete form through non-discrimination and support for the people living with HIV/AIDS. Clear unambiguous commitment will go far in developing mutual trust between employers and employees and facilitating an atmosphere where people are willing to undergo VCT and to possibly disclose their status.
- Willingness by management employees and employers to speak out on HIV /AIDS prevention and care regularly and frankly at the workplace will lead to control of the spread of the HIV/AIDS epidemic.
- When developing HIV/AIDS policy and programmes for implementation maximum participation by employees both infected and affected, senior management, HIV committees, HIV occupational health and safety practitioners, trade union shop stewards, HIV consultants, actuaries epidemiologists, behavioural scientists and auditors is encouraged. Involvement of all these people enables everyone to have a sense of belonging and responsibility and able to account for any outcome.
- Law and policy makers must and some responsible authorities like SANAC are recommended to strengthen workplace HIV prevention efforts.

5.5 Areas for further research

- Since organisations do have HIV/AIDS programmes and policy on paper (theory) not in practice (action), future researchers must focus on how best can implementation of HIV/AIDS programmes done in the workplaces.
- Future research must also focus on assessment of the availability of resources required in the organisation in the process of effective implementation of HIV/AIDS policy and programmes in the workplace.
- How best employers can be engaged so that they can balance and value the needs of the employees in a way that they values production and profits all in the name of managing HIV/AIDS in the workplace and beyond.

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APPENDIX 1: COVER PAGE

MANAGEMENT OF HIV/AIDS PROGRAMMES AT THE WORKPLACE: A STUDY OF SELECTED ORGANISATIONS IN THE EASTERN CAPE PROVINCE.

University of Fort Hare
Together in Excellence

University of Fort Hare
P. Bag x1314
5700
Alice
RSA
Tel: 0840330029

You are kindly requested to fill out the semi-structured interview schedule prior to the visit by the interviewer, who will go through it with you. Please complete this semi-structured interview schedule as honestly and constructively as possible. The information received in this research will be used for academic purposes only and your responses will be kept in strict confidentiality. No answer is correct or wrong. The success of this study depends on your co-operation. The University of Fort Hare wishes to thank you for your anticipated co-operation.

MANAGEMENT OF HIV/AIDS PROGRAMMES AT THE WORKPLACE: A STUDY OF SELECTED ORGANISATIONS IN THE EASTERN CAPE PROVINCE.

Introduction

I am undertaking a research on "Management of HIV/AIDS programmes at the workplace in selected organisations in the Eastern Cape Province". The study will investigate the nature of HIV/AIDS programmes that exist in selected organisations in the Eastern Cape Province and also identify how effective the programmes are in reducing the impact of HIV /AIDS as well as determining how employees of the organisation perceive the HIV/AIDS programmes and how HIV/AIDS programmes are managed. Four organisations will be studied, two private and two public.

There are no known direct benefits associated with your participation in this research. However, the data the researcher shall collect will enable her to provide the relevant stakeholders, including policy makers, law makers and Department of Health, a basis for informed decision regarding policy that may lead to overall improvement of management of HIV/AIDS programmes in the private and public sector when it comes to HIV/AIDS issues in the workplace and beyond. The results of this semi-structured interview schedule will be communicated to yourself during subsequent dissemination activities.

This semi-structured interview schedule will take approximately **15 to 30 minutes** to complete. It is important to note that the answers to all these questions will remain confidential: neither you nor your organisation will be identified by name in reporting the results. Anonymity will be maintained throughout the study and dissemination process. The semi -structured interview schedule with your answers and the accompanying signed consent form, which will be removed from the semi-structured interview schedule prior to data collection to ensure your confidentiality, will be securely kept for some period of time pending when they will finally be destroyed.

Your participation is entirely voluntary and a national service. You are however free to decline to answer any specific question if you feel the information is too sensitive or personal. You are also at liberty to tell the interviewer that you no longer wish to participate in the interview and that your responses should not be used for the research so that the semi-structured interview schedule with your consent form will be destroyed with no consequences. Should you agree to participate, you need to sign the informed consent form. You are free to refuse to participate in the survey if you wish.

Should you require any additional information concerning this study, you are welcome to contact me on the following number below:

Ms G.Shava:0840330029

APPENDIX 2

CONSENT FORM

Name of the Organisation	
Location of the Organisation	
Position of Executive providing answers[1]	
Name of Interviewer	
Date of interview	

Note 1: Use the following codes: 1. Manager
2. Employee

RESPONDENT:

I, _____

[FULL NAME OF RESPONDENT IN BLOCK LETTERS]

	CHECK]	
• have read and understood all the above information;	Yes	No
• was given the opportunity to discuss this information and to ask questions;	Yes	No
• volunteer to take part in this study;	Yes	No
• confirm that I have received a copy of this consent form	Yes	No

Signature of respondent: _____ Date: _____

Respondent chose not to sign consent form ☐

INTERVIEWER:

I,_____

[FULL NAME OF INTERVIEWER IN BLOCK LETTERS]

	[CHECK]	
• have explained the nature and purpose of the study to the respondent in full;	Yes	No
• confirm that I have given the respondent a copy of this consent form	Yes	No

Signature of interviewer: _____Date:_____

Nature of organisation: _____

APPENDIX 3

University of Fort Hare
Together in Excellence

SEMI- STRUCTURED IN-DEPTH INTERVIEW GUIDE FOR MANAGEMENT

SECTION A: EMPLOYERS' STATISTICS AND HIV/AIDS MANAGEMENT PROGRAMMES

Q1. What is the nature of your organisation (Private/Public)?

Q2. How many male and female employees does your organisation employ?

Sex	**Number**
Male	
Female	
Total	

Q3. How many employees fall under these age groups?

Age group	**Number**
15-24	
25-29	
30-34	
35-39	
40-44	
45+	

Q4. How many employees fall under the following educational categories?

Education	**Number**
None	
Matric	
National Certificate	
Diploma	
Degree	
Other(specify)	

Q5. When did your organisation introduce an HIV/AIDS management programme for the employees at the workplace? _____

Q6. How is the sponsoring of the HIV/AIDS programmes (Internally in the organisation, External donor, Government, South African National AIDS Council, Others)?

_____

_____

Q7. Who prompted the introduction of an HIV/AIDS policy at your organisation (Government Legislation, Employee Pressure, Collective Bargaining Agreement, Trade Unions Pressure, Management Initiative, etc)?Explain

_____

_____

_____

SECTION B: HOW ARE THE HIV/AIDS MANAGEMENT PROGRAMMES MANAGED (RESPONSE TO AND IMPACT OF HIV/ AIDS).

Q8. Which of the following HIV/AIDS programmes and related interventions have your organisation implemented, i.e. which of these programmes or interventions are currently available in the organisation?

Programme	Tick (√) ONE appropriate response	
	Yes	**No**
(a) Nurse for occupational health and safety		
(b) Shop Steward responsible for HIV and AIDS		
(c) Training on HIV and AIDS		
(d) Voluntary counselling and testing (VCT)		
(e) HIV/AIDS workplace awareness programme		
(f) HIV/AIDS care and support programme		
(g) Counselling services for workers living with HIV and AIDS		
(h) Condom distribution		
(i) Antiretroviral treatment		
(j) Independent employee driven HIV and AIDS programmes or activities		
(k) Other (please describe below)		

Q9. How are these current management programmes managed for consistency? Please explain.

Q10. How do you evaluate these current management programmes to make sure that it is benefiting the employees of the organisation and the organisation itself?

Q11. Does your organisation have its own health clinic? Explain

---

Q12. To what extent do you think HIV/ AIDS currently impact your organisation **(**Absenteeism, Employee morale, Labour Turnover, Training Costs, Productivity, Accidents due to fatigue/illness, etc)**?** Explain

---

Q13. Have the HIV/AIDS programmes being implemented so far have been effective? Explain

---

Q14. Do you think that the impact of HIV/AIDS has decreased since the introduction of HIV programme? Explain.

Q15. Is the budget allocation on HIV/AIDS adequate? Explain

Q16. Does the organisation have access to purchase Anti-retroviral drugs whenever the need arises? Explain

---

SECTION C: BENEFITS TO EMPLOYEES

Q17. Do the HIV/AIDS programmes in the organisation benefit every employee? Explain.

Q18. Has there been an attitude change in the way employees' view HIV/AIDS in the organisation since the introduction of awareness programmes? Explain

---

Q19. Does the organisation offer Antiretroviral treatment for all employees who are infected with HIV/AIDS? Explain

---

Q20. Does the organisation provide specialists to help employees cope with depression or stress caused by HIV/AIDS? Explain.

Q21. Did the employees participate in the implementation of HIV/AIDS programmes? Explain.

Q22. Does the organisation offer assistance if a close member of an employee dies of AIDS? Explain

---

Q23. Does the organisation offer any assistance when employees retire from the organisation if they are infected with HIV/AIDS? Explain.

Q24. Does the organisation offer alternative duties for employees who are no longer fit for their usual jobs? Explain.

Q25. Does the organisation provide HIV/AIDS programmes to the community around? Explain

---

Q26. Does the organisation provide training for employees to be peer educators/counsellors? Explain

---

SECTION D: RECOMMENDATIONS AND OPINIONS

Q27. Which of the following benefits does your organisation derive by implementing the HIV/AIDS programmes in your organisation **(**Reduced labour turnover, Improved productivity, Reduced absenteeism, Low retaining costs, High employee morale, etc)?

Q28. Which suggestions do you think will improve the effectiveness of HIV/AIDS programmes at the work place? **(**Management and employee participation in designing the HIV, AIDS policy/programme, Adequate funding, if not available combine the program with another organisation or seek external donations, Effective communication between the management and employees on issues to do with HIV/AIDS programme, Seek specialists knowledge when designing and implementing the program/policy**)** Explain

……

……

……
……

Q29. If you have any more suggestions, please feel free to express them in the spaces provided.

……
……
……
……

Your time and participation is greatly appreciated.
Thank you

MANAGEMENT OF HIV/AIDS PROGRAMMES AT THE WORKPLACE: A STUDY OF SELECTED ORGANISATIONS IN CHRIS HANI DISTRICT, EASTERN CAPE PROVINCE.

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Together in Excellence

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5700
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You are kindly requested to fill out the questionnaire prior to the visit by the interviewer, who will go through the questionnaire with you. Please complete this questionnaire as honestly and constructively as possible. The information received in this research will be used for academic purposes only and your responses will be kept in strict confidentiality. No answer is correct or wrong. The success of this study depends on your co-operation. The University of Fort Hare wishes to thank you for your anticipated cooperation.

MANAGEMENT OF HIV/AIDS PROGRAMMES AT THE WORKPLACE: A STUDY OF SELECTED ORGANISATIONS IN CHRIS HANI DISTRICT, EASTERN CAPE PROVINCE.

Introduction

I am undertaking a research on "Management of HIV/AIDS programmes at the workplace in selected organisations in the Eastern Cape Province". The study will investigate the nature of HIV/AIDS programmes that exist in selected organisations in the Eastern Cape Province and also identify how effective the programmes are in reducing the impact of HIV /AIDS as well as determining how employees of the organisation perceive the HIV/AIDS programmes and how HIV/AIDS programmes are managed. Four organisations will be studied, two private and two public.

There are no known direct benefits associated with your participation in this research. However, the data the researcher shall collect will enable her to provide the relevant stakeholders, including policy makers, law makers and Department of Health, a basis for informed decision regarding policy that may lead to overall improvement of management of HIV/AIDS programmes in the private and public sector when it comes to HIV/AIDS issues in the workplace and beyond. The results of this questionnaire will be communicated to yourself during subsequent dissemination activities.

This semi-structured interview schedule will take approximately **15 to 30 minutes** to complete. It is important to note that the answers to all these questions will remain confidential: neither you nor your organisation will be identified by name in reporting the results. Anonymity will be maintained throughout the study and dissemination process. The semi-structured interview schedule with your answers and the accompanying signed consent form, which will be removed from the semi – structured interview schedule prior to data collection to ensure your confidentiality, will be securely kept for some period of time pending when they will finally be destroyed.

Your participation is entirely voluntary and a national service. You are however free to decline to answer any specific question if you feel the information is too sensitive or personal. You are also at liberty to tell the interviewer that you no longer wish to participate in the interview and that your responses should not be used for the research so that the semi-structured interview schedule with your consent form will be destroyed with no consequences. Should you agree to participate, you need to sign the informed consent form. You are free to refuse to participate in the survey if you wish.

Should you require any additional information concerning this study, you are welcome to contact the researcher.

Ms G.Shava:0840330029

ANNEXURE 4

University of Fort Hare
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QUESTIONNAIRE FOR EMPLOYEES OF THE ORGANISATION

Tick **(✓)** in the appropriate box (es) where applicable

SECTION A: PERSONAL DETAILS

Q1. Gender

1. Male ☐
2. Female ☐

Q2. Age

1. **16-20** ☐
2. **21-24** ☐
3. **25-30** ☐
4. **31-35** ☐
5. **35-40** ☐
6. **41+** ☐

Q3. Have you ever attended school?

1. Yes ☐
2. No ☐

Q4. If your answer to **Q3 is Yes**, what is the highest level of education have you completed in school?

1. Matric ☐
2. National Certificate ☐
3. Diploma ☐

4. Degree ☐

7. Other (specify) _____

Q5. What is your current marital status?

1: Never married ☐

2: married ☐

3: Separated ☐

4: Divorced ☐

5: Widowed ☐

6: Cohabitation ☐

Q6. How long have you been working for this organisation? _____

Q7. What type of contract do you have at the moment?

1. Permanent contract (1 year or more) ☐

2. Temporary contract (less than 1 year) ☐

3. Casual / daily work ☐

4. Other (specify) _____

SECTION B: ABSENTEEISM

Q8. Are there occasions when you become so ill that you are absent from work?

1. Yes ☐

2. No ☐

Q9. In the past year, how many days on average were you absent from work due to the following reasons?

Reason of absence	**Average no. of days**
Normal leave	
Sick leave	
Funeral attendance	
Caring for PLWA	
Sick but not on sick leave	
Family responsibility leave[1]	
Short-time leave[2]	
Compassionate leave	

Other (specify)	

Notes: 1. family responsibility leave is given when someone has to take time off to attend to some family responsibilities such as care for a sick family member, marriage, etc. This is different from compassionate leave which is normally given to someone to attend to funeral arrangements of a dead family member. Funeral attendance means taking time off to attend to funerals of other persons other than family members.

2. Short-time leave refers to when a worker is asked to temporarily take leave because the organisation is experiencing period(s) of low purchase order of its products.

Q10. How does absence from work due to other reasons than ill-health affect your work?

1. No promotion ☐
2. Salary cuts ☐
3. No other leave ☐
4. Other (specify) _____

Q11. Do you think being ill has an effect on your productivity?

1. Yes ☐
2. No ☐

Q12. If your answer to **Q11 is Yes**, what is the effect like?

1. Little ☐
2. Moderate ☐
3. Severe ☐

SECTION C: HIV AND AIDS WORKPLACE POLICY

Q13. Does your organisation have an HIV and AIDS policy/program?

1. Yes ☐
2. No ☐

Q14. Do you think that your employer's current HIV and AIDS workplace policy is adequate?

1. Yes ☐
2. No ☐

Q15. If your answer to **Q 14 is No**, where do you think there is need for improvement? (These responses are not to be read to the respondent but are expected possible multiple responses to be ticked)

1. Non-discrimination in hiring ☐
2. Non-discrimination in promotion/training ☐
3. Maintenance of confidentiality ☐
4. Transfer to other jobs on account of HIV and AIDS ☐
5. Additional sick leave for people living with HIV and AIDS ☐
6. More prevention information ☐
7. More treatment ☐

8. More care and support ☐
9. Other (specify) _____

Q16. Do, or have, people living openly with HIV and AIDS play/played an important role in the introduction of HIV policy and programmes?

1. Yes ☐
2. No ☐

Q17. If Yes to **Q16**, what kind of role did they play?
_____
_____
_____
_____

Q18. Does your organisation sponsor any training activities on HIV/ AIDS prevention and treatment?

1. Yes ☐
2. No ☐

Q19. If your answer to **Q18** **is** **Yes**, describe these activities
_____
_____
_____
_____

Q20. Are the HIV/AIDS management programmes offered at your organisation relevant to the benefit of you as an employee?

1: Yes ☐

2: No ☐

Indicate your choice by putting an "X" in the appropriate block provided

(1) = Strongly agree
(2) =Agree
(3) =Uncertain
(4) =Disagree
(5) =Strongly Agree

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Q21. HIV awareness programmes conducted in the organisation are very effective.					
Q22. There is disciplinary action against employees who unfairly discriminate against, people who are HIV positive.					
Q23. Employees are encouraged to go for voluntary counselling and testing of HIV/AIDS.					
Q24. The organisation hires doctors and counselors to help employees who are infected with HIV/AIDS.					

SECTION D : BENEFITS TO EMPLOYEES

Q25. Where would you go for a test?

1: Private facility ☐

3: Hospital ☐

4: Clinic ☐

5. At the organisation ☐

6: Other (specify) _____

Indicate your choice by putting an X in the blocks provided

	Strongly agree	**Agree**	**Uncertain**	**Disagree**	**Strongly disagree**
Q26. Some employees were sent for training in order to help their fellow employees as peer educators/counselors.					
Q27. I always use a condom whenever l have casual sex					
Q28. People in the organisation do not shun working with HIV infected people					
Q29. The organisation does not offer any form of assistance to families of employees who have died of HIV/AIDS					
Q30. The organisation provides Anti-retroviral drugs for employees who are suffering from AIDS.					
Q31. My knowledge about HIV/AIDS has been enhanced through the HIV/AIDS program.					
Q32. The AIDS awareness programmes offered by the organisation have no effect on employees					
Q33. The organisation is doing its best to help employees who are suffering from HIV/AIDS.					
Q34. The HIV/AIDS program benefits everyone in the organisation.					
Q35. The organisation has community programmes for people living with HIV/AIDS.					
Q36. The organisation offers support if a close member of an employee dies.					

Q37. Condoms are easily available at the workplace.					

SECTION D: HIV AND AIDS SERVICES: TREATMENT, CARE/SUPPORT AND PREVENTION

Q38. I will now ask you various questions regarding the services, programmes and activities provided in the workplace in respect to HIV and AIDS related issues (tick [˩]in the appropriate box (es). **Ask by Column**

Service, intervention or activity	**(a)** Is [service] available in your organisation?		**(b)** Is [service] provided to staff free of charge?		**(c)** Does spouses or family of staff have access to [service]?		**(d)** If YES, is [service] provided free of charge to your spouse or family?		**(e)** Do you participate or make use of [service]?		
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	If No, give reason for not using the
(a) Clinic											
(b) HIV/AIDS awareness											
(C) HIV/AIDS care and support											
(d)Counselling services at workplace to workers living with HIV and AIDS?											
(e) Nurse for occupational health and safety											
(f) Independent employee driven HIV and AIDS programmes or activities											
(g) Shop Steward responsible for HIV and AIDS											
(h) Training on HIV and AIDS											
(i) Condom distribution											
(j) Antiretroviral treatment											
(k) Other (Please specify)											

Note: Please make sure you complete the responses for all listed services and/programmes

Q39. Of the services or activities noted in **Q38** above that are **NOT** currently available in your workplace, which particular THREE do you feel are MOST IMPORTANT and you would like to see provided in the workplace?

1._____

2._____

3._____

Q40. Would you be willing to pay to access these services in the workplace?

1. Yes ☐
2. No ☐

SECTION F: PERCEPTION OF MANAGEMENT'S RESPONSE TO HIV AND AIDS AND/OR SUPPORT OF PLWHA IN THE WORKPLACE.

Q41. How responsive do you think management of your organisation has been in dealing with issues of HIV/ AIDS in the workplace?

1. Very responsive ☐
2. Responsive ☐
3. Neither responsive nor unresponsive ☐
4. Unresponsive ☐
5. Very unresponsive ☐

Q42. How supportive do you think are managers in your organisation of PLWHA?

1. Very supportive ☐
2. Supportive ☐
3. Neither supportive nor unsupportive ☐
4. Unsupportive ☐
5. Very unsupportive ☐

Q43. How committed has management of your organisation been to making the HIV / AIDS activities or programmes they have implemented in the workplace, a success?

1. Very committed ☐
2. Committed ☐
3. Neither committed nor uncommitted ☐
4. Uncommitted ☐
5. Very uncommitted ☐

SECTION E: RECOMMENDATIONS AND OPINIONS

Q44. Would you work next to someone who is HIV positive?

1: Yes ☐

2: No ☐

Q45. Do you think people who are positive in this organisation are treated in a negative way because of their status?

1: Yes ☐

2: No ☐

Explain your answer above

_____

_____

_____

Q46. Do you know of anyone who has been forced to take an HIV Test by the employer

1: Yes ☐

2: No ☐

Q47. The obstacle which l have in using a condom is **:**

1. Religious beliefs ☐
2. Culture ☐
3. Spouse ☐
4. Suspicion ☐
5. Other(specify_____

Q48. Do you support the idea of HIV/AIDS programmes at the workplace (Yes/No)

Q49. If you answer to Q48 is **Yes**, give the main reason why you support it.

1 .It boost self -esteem ☐

2 .Reduces stigmatisation ☐

3. Promote support to those with low morale ☐

4.Other (specify_____

Q50. If you answer is No to **Q48**, tick one main reason why you do not support it

1: Leads to low self-esteem ☐

3: Lead to stigmatisation ☐

4:Lead discrimination ☐

5.Lead to labelling ☐

Q51.The main weakness of the HIV/AIDS program in my organisation is

1: Lack of support from top management ☐

2. Lack of interest among employees ☐

3: Lack of medicine and specialists support ☐

4. Lack of information ☐

5: Other (specify) _____

Q52.Give suggestions on how your organisation can improve the effectiveness of HIV/AIDS programmes at the work place in terms of:

1: employee participation

---

2 : Management support

3: generating employee interest

4: Seek specialists knowledge when designing and implementing the program.

5: Other (specify)

Q53. If you have any more suggestions, please feel free to express them in the spaces provided.

……
……
……
……
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……
……
……
……

Thank you for your time and cooperation