

RequesterNote: ARIEL ill.dut.ac.za fax +2731-3732868 Tel 2731 373 2361
RequestedServiceType: COPY-NON-RETURNABLE

Ntuli T University of Zululand Makunga NV
Development and evaluation of intervention programs for HIV/AIDS persons in
the workplace : a phenomenological approach
; , 2002 2004
Volume / Issue:

Lending Unit: 5207
Name of Institution: University of Zululand
Return Address: Private Bag X1001, KwaDlangezwa, Mpangeni. 3886 South
Africa
Lender's Request ID:



3073419

Requesting Unit: P002
Requested: 20090226 Need Before: 20090319
Name of Institution: Durban University of Technology
Delivery Address: Mansfield Road, P.O. Box 953, DURBAN, 4001 South Africa
Delivery Service Description : Mail
Patron ID: 5207-Pillay Patron Name: Annetz Pillay Patron Contact Number(s):
0319104312/031312998

DEVELOPMENT AND EVALUATION OF
INTERVENTION PROGRAMS FOR HIV/AIDS PERSONS
IN THE WORKPLACE

BY

THANDEKA

NTULI

2004

**Development and evaluation of intervention programs
for HIV/AIDS persons in the workplace:
A phenomenological approach**

By

THANDEKA NTULI

A dissertation submitted in partial fulfilment of the requirements for the degree of Masters of Arts in the Department of Psychology, University of Zululand

SUPERVISOR: PROF N.V.MAKUNGA

FEBRUARY, 2004

TABLE OF CONTENTS

	PAGES
CHAPTER ONE: Introduction	1
1.2 Motivation for the study	2
1.3 Statement of the problem	3
1.4 Aim of the study	4
1.5 Hypothesis	
1.6 Value of the study	5
1.7 Definition of terms	
1.7.1 Human Immunodeficiency Virus (HIV)	
1.7.2 Acquired Immune Deficiency Syndrome (AIDS)	6
1.7.3 Infected persons	7
1.7.4 Workplace	
1.7.5 Intervention program	
1.7.6 Development and evaluation of a program	8
CHAPTER TWO: Literature review	9
2.1 Why address HIV/AIDS?	
2.2 Origins of HIV and AIDS	10
2.3 Progression of HIV to AIDS	11
2.4 HIV/AIDS and its stigma	13
2.5 Myths about HIV/AIDS	15

2.6 HIV/AIDS epidemic in South Africa	16
2.7 HIV/AIDS impact in the workplace	18
2.8 Intervention programs	25
2.9 Theoretical frameworks on HIV/AIDS	27
2.9.1 Theories on behavioural change	28
2.10 HIV/AIDS policies in the workplace	41
2.11 Development of HIV/AIDS intervention programs	44
2.12 Evaluation of HIV/AIDS intervention programs	49
CHAPTER THREE: Research methodology	50
3.1 The Study	
3.1.1 Aim of the study	
3.1.2 Research technique	
3.1.3 The Participants	51
3.1.4 Data Collection	52
3.1.5 Procedure	53
3.1.6 Scoring	
3.1.7 Data Analysis	
CHAPTER FOUR: Results and discussion	57
4.1 Phenomenological results	
4.1.1 Experience of infected employees	
4.1.2 Experience of professional nurses	61
4.2 Work policy documents	64

CHAPTER FIVE: Conclusion and recommendations	67
5.1 Conclusions	
5.1.1 Experience of infected employees	
5.1.2 Experience of professional nurses	
5.1.3 Intervention programs	68
5.2 Recommendations	70
5.3 Limitations	
REFERENCES	72

LIST OF TABLES

TABLES	PAGES
Table 1	57
Table 2	61
Table 3	64

LIST OF FIGURES

FIGURES	PAGES
Figure 1	22
Figure 2	46

APPENDICES

APPENDIX A - **Request to conduct research in the various
Organizations**


APPENDIX B - **Questions to HIV/AIDS infected employees**

APPENDIX C - **Questions to professional nurses**

APPENDIX D - **Questions to analyse organizational policies**

DECLARATION

I declare that this manuscript is my work and all the sources used or quoted have been indicated and acknowledged by means of references.



THANDEKA NTULI

FEBRUARY, 2004

ACKNOWLEDGEMENTS

Greater is He that is in me. Thank you Lord for your powers vested in me, again you have not failed me. You are a lamp unto my feet and my strength is in you.

I would like to say words of appreciation to my family for believing in me and standing by me in the toughest times. Tata, I know you would be proud of me. Gaba, I thank God for you, you are a strong lady. Wells (Bro Zet), you saw it coming I miss you.

To my supervisor, Prof N.V.Makunga I appreciate your patience and support during the difficult times in your life. Prof S.D.Edwards, 'ngibonga ubukhona bakho'.

I extend my deepest appreciation to all participants in this study from different organizations that I worked with. Your willingness and openness made this manuscript to be what it is.

Lastly, I would like to acknowledge myself with these words, "Thandeka Ntuli you've done it, yet the glory is still to be revealed".

DEDICATION

**This work is dedicated to my late father Solomon Fumbathile for
dreaming the impossible dream long before my own realization.**

ABSTRACT

The aim of this study was to determine whether intervention programs do enhance performance of HIV/AIDS infected persons in the workplace using a qualitative design. The study explored the experience of two categories of persons in the work environment i.e. professional nurses involved in administering the program and the HIV/AIDS infected persons as recipients.

Data was collected from each category in four organizations through in-depth interviews using the qualitative approach. The phenomenological method supports the assumption that an individual's experience is more valid and reliable as it gives a realistic picture that people can relate to and agree with the findings (Chasi & de Wet, 2002). Data collected from work policy documents was used to establish what programs were in place to deal with HIV/AIDS at organizational level.

The following conclusions were made:

- ◆ Intervention programs enhance work performance of HIV/AIDS infected persons
- ◆ Policies provide a guideline as to what strategies organizations use to deal with HIV/AIDS
- ◆ Monitoring and evaluation of intervention programs is essential in any organisation

CHAPTER ONE

INTRODUCTION

1.1 Introduction

In recent years there has been an increasing number of people diagnosed with HIV/AIDS (Human Immunodeficiency Virus and/or Acquired Immune Deficiency Syndrome) in South Africa. Referring to this issue Schlebusch (1990a) points out that one of the most severe public health problems of our times, particularly in Africa is HIV/AIDS. In support of this notion McEvoy (2000), notes that the life expectancy of people in Southern countries of Africa has been estimated to fall back to 45 years of age between 2005 and 2010 due to HIV and AIDS as compared to approximately 60 years in other countries.

The issue of HIV/AIDS, which was initially seen as the individual and family concern, has now also become a reality and a concern for the industry. Jordan (2002), alluded to this fact by expressing that companies in South Africa could lose about 15% of annual profits to HIV/AIDS by 2008 and suggesting that the total cost to the South African economy could soon be an annual reduction in the growth rate of between 0.3% and 0.4% at a cost of R167 billion. McEvoy (2000) also agrees that businesses are confronted with increased production costs and decrease in profits due to the HIV/AIDS impact as observed in increased absenteeism, deaths and costs of training new workers.

Given the nature of the disease and the stigma suffered by people with HIV and AIDS, it is not surprising that the infected employee if at work, might be so preoccupied with thoughts about his condition such that his output becomes affected. Facts are clear that HIV infections may cost companies between 2% and 6% of salaries a year (Jordan, 2002). Indeed, industries have been reported to suffer economically from the new infections of HIV/AIDS disease that are more prevalent in the 15 to 24 age group, which includes individuals who are in their most productive years, constituting current employees and a future hiring pool (Evian, 1991).

1.2. Motivation for the study

An HIV infected person is most likely to stay well for sometime, approximately 7 to 10 years before the AIDS phase develops and is thus able to continue with normal duties. Lately, however, this period has been reported to have dropped to approximately 4 years in South Africa, thus warranting urgent attention and intervention strategies to prolong the period. Jordan (2002) accepts that it would make sense for employers to pay for treatment to extend employee productivity.

According to Evian (1991), with good intervention programs, HIV infected persons could still continue with their daily activities. Thus, the present study explores the impact intervention programs in the workplace have on the performance of HIV/AIDS infected persons.

1.3. Statement of the problem

Working individuals spend most of their day at work. But the advent of HIV/AIDS suddenly presents employers with the dilemma of sustaining an employee who has been the best performer but now spends more time out of work rather than at work, attending doctors or even hospitalisation.

Lack of understanding both by employers and employees about HIV/AIDS could actually aggravate the condition, with the employee feeling threatened, isolated and indifferent. Evian (1991) reported courageous stories from HIV/AIDS infected persons about relationships that became enriched through caring, understanding and compassion. Thus it is important that they are supported rather than discriminated against.

In terms of client centered theory, it is argued that to help another person grow and change, requires a congruent relationship with the person, unconditional positive regard for the individual, and the communication of empathy from the helper to the helpee (Rodgers, 1957).

Psychosocial interventions have shown a positive impact on the quality of life of HIV/AIDS infected individuals on disease progression and factors related to improvement of health (Evian, 1991).

This research, therefore, is aimed at exploring whether intervention programs provided in the workplace have a positive impact on the performance of HIV/AIDS infected persons. Hence, this research is entitled “DEVELOPMENT AND EVALUATION OF INTERVENTION PROGRAMS FOR HIV/AIDS INFECTED PERSONS IN THE WORKPLACE.”

1.4. Aim of the study

The main aims of the present study are:

- To determine whether intervention programs at the workplace enhance the performance of HIV/AIDS infected persons.
- To determine the work performance of HIV/AIDS infected persons before and after an intervention program.

1.5. Hypotheses

- 1.5.1 Intervention programs for HIV/AIDS infected persons lead to better work performance.
- 1.5.2 There is a significant difference in work performance of HIV/AIDS infected persons before and after exposure to intervention programs.

1.6. Value of the study

The findings of the study will be of benefit to:

- Employees – increasing their self esteem knowing that employers are contributing towards their health and welfare in preventing the spread of HIV and AIDS.
- Employers – for being able to contribute positively in sustaining quality life for those affected and infected by HIV and AIDS, and also to the public health as a whole by promoting good lifestyle management programs
- Health professionals – in the form of research and as a method of intervention.
- Public – especially families and communities of those infected by the disease.

1.7. Definition of terms

1.7.1 Human Immunodeficiency Virus (HIV)

Human Immunodeficiency Virus commonly known as HIV is the virus that causes AIDS. The HI virus lives and multiplies within living cells whilst attacking the immune system. Good Practice Note (2002) agrees that HIV attacks and slowly destroys the immune system by entering and destroying the cells that control and support the immune

response and system. The virus can be present in the body for several years before symptoms appear. Van Dyk (2001) describes two types of viruses presently associated with AIDS namely:

1.7.1.1 HIV-1

HIV-1 has higher infection rates and is found throughout the world but mostly in Central, East and Southern Africa, North and South America and Europe

1.7.1.2 HIV-2

HIV-2 although also dangerous presents with a gradual development of symptoms and is found mostly in West Africa

1.7.2 Acquired Deficiency Syndrome (AIDS)

Van Dyk (2001) defines AIDS as, "a syndrome of opportunistic diseases, infections and certain cancers" that leads to death. AIDS is a syndrome in that it is a collection of different conditions that manifest in the body when the virus undermines the immune system to the extent of actually compromising it so it cannot fight any pathogens invading the body. Thus a person is described as having AIDS when the immune deficiency caused by HIV is so severe that life threatening infections and/or cancer occur. These infections and/or cancer are called "opportunistic diseases" because they

take the opportunity to invade the body that already presents with a weakened immune system.

1.7.3 Infected persons

An infected person is someone who has been contaminated with micro-organisms (www.cogsci.princeton.edu/cgi-bin/webwn). An HIV infected person is an individual who is infected with an HI virus and thus presents with HIV antibodies but may not necessarily have AIDS. It may take quite some time before AIDS symptoms actually show up.

1.7.4 Workplace

Workplace is an environment that enables work to be done by workers that have knowledge of producing the economic value. This environment provides workers with tools, social connections and physical wellbeing to promote productivity. (<file://A:workplace.htm>)

1.7.5 Intervention program

A program is a “system of projects or services intended to meet a public need” (www.cogsci.princeton.edu/cgi-bin/webwn).

Intervention is the intentional involvement in a situation with the aim of bringing about beneficial change (Edwards, 2001). An intervention program therefore is a system of projects aimed at bringing about change by improving or preventing the situation from getting worse.

1.7.6 Development and evaluation of a program

Program development is a plan that is aimed at improving the quality and quantity of services while program evaluation refers to the assessment of how well the needs have been met by a program ([file: A program development and evaluation.htm](#)).

CHAPTER TWO

LITERATURE REVIEW

2.1 Why address HIV/AIDS?

Virtually unknown 20 years ago, HIV has infected many people. Approximately 40 million adults worldwide are currently HIV positive. Sub-Saharan Africa accounts for 70% of global HIV infections. It is further estimated that 2.3 million Africans died of AIDS in 2001. These figures will possibly increase to 50 million before the end of this decade (www.hivaids.co.za). According to the World Bank, AIDS is the leading cause of death in Sub-Saharan Africa and the fourth biggest killer globally (www.worldbank.org).

Infection rates continue to increase in developing countries with a high rate of poverty, poor health care systems and limited resources. The impact is not only through deaths but also on births in the population. Referring to this notion, literature points out that five million children have died of AIDS and half a million were born with HIV infection (www.oshc.dole.gov.ph/sp_aids.htm). The growth rate of around 1.7 % in 1999 is expected to fall to approximately 1.5 % by 2010 in South Africa (Love life, 2001).

2.2. *Origins of HIV and AIDS*

HIV/AIDS was first reported in the early 1980's as a mysterious 'gay disease' (Van Niftrik, 1991). Although the first case was reported in the United States of America in 1981, Africa was identified as the source of the disease. In the United States of America the disease presented among homosexual men as a rare form of pneumonia and Kaposi sarcoma (a form of skin cancer) that attacked the immune system. Later on another disease that undermined the immune system and also caused diarrhoea was identified in heterosexual people in Central Africa. This disease, which was referred to as 'slimming disease' in Africa, brought confusion to scientists as to what was its cause (Van Dyk, 2001). In 1983, the virus then known as the 'lymphadenopathy-associated virus (LAV) and Human T cell lymphotropic virus Type III (LTLV-III) was identified to cause the disease. The name of the virus was then renamed in 1986 to Human Immunodeficiency Virus (Van Dyk, 2001).

Dr Montagnier discovered HIV-1 in France in 1983. The following year Dr Gallo in the United States of America claimed to have discovered the virus, a factor that raised a lot of controversy. This resulted in a court case about 'alleged theft' by Dr Gallo from Dr Montagnier who claimed to have sent the virus to a colleague for research purposes. A compromise was then reached where both doctors were recognized as co-discoverers of the virus (Van Dyk, 2001).

The scientific explanation of HIV origin is that it crossed species barrier from animals such as chimpanzees and monkeys to humans through animal blood contamination. The virus was further spread by migration, socio-economic instability, drug use and exchange of blood products to the rest of the world (www.avert.org/origins.htm).

2.3 Progression of HIV to AIDS

When the HI virus infects a person it may take a period of approximately ten or more years before AIDS symptoms are displayed. Although the illness is initially acute, progression to the AIDS phase is actually gradual. An HIV infected person may not even be aware of his status till later when AIDS symptoms show up. The individual is referred to as HIV positive due to the presence of HIV antibodies that are mobilized as the body's immune response to viral invasion. Thus, the term "HIV positive" is related to the presence of these antibodies rather than the virus itself. The HI virus once in the body attacks the 'T' lymphocyte cells also known as CD 4 cells and overpowers them during the viral replication process. The body is then rendered defenseless as the immune system is weakened. The whole progression from the time of HIV infection is gradual as it includes stages when the virus lies dormant before killing the 'T' cells and when it starts multiplying (Van Dyk, 2001).

Mindel and Miller (1996) identified the following phases that lead to AIDS from the time of infection:

- *Seroconversion to HIV antibody*

This occurs within 2 – 12 weeks and is often asymptomatic but also varies with individuals. Primary infection is acute and may be accompanied by fever-like illness and even glandular appearances. The phase includes the ‘window period’, as the virus cannot be detected even with laboratory tests. HIV antibodies develop within a period of 3 – 6 months.

- *Asymptomatic phase*

This period occurs after seroconversion where the individual exhibits no symptoms of being infected. At this stage an individual who could have been alarmed by glandular fevers gets convinced of being healthy and even doubts or denies his HIV positive status. Therapeutic interventions offered within this period actually increase the individual’s life span.

- *Clinical phase*

Clinical conditions that are associated with a decline in the immune system develop. The infected person may present with symptoms such as weight loss, diarrhoea, shingles, fever, skin disease and thrush. Opportunistic infections (such as pneumonia, meningitis) and malignancies develop as a result of repeated infections and a decline from CD 4 cells. At this stage the individual is referred to as having AIDS and survival could take a period of up to 2 years varying with individuals and the type of infection or cancer.

2.4 HIV/AIDS and its stigma

Stigma is the biggest challenge in the fight against the spread of HIV and AIDS. The manner in which HIV/AIDS was introduced undoubtedly attached an enormous stigma to the disease. This attitude instead of helping prevent the spread of the disease seemed to create more divisions amongst the South African community. In South Africa HIV/AIDS was seen as a black person's disease and yet Blacks believed that the disease was a white person's strategy to destroy them as a nation (Van Niftrik, 1991).

The press continued to sensitize the nation in a more threatening and discriminatory manner by publishing reports that lacked evidence. For example, in one article it was claimed that if integration of other races into white areas were to be abolished, whites would not suffer from HIV/AIDS (Van Niftrik, 1991).

The private sector distanced itself from programs relating to HIV/AIDS and/or prevention of the disease. The business sector did not seem to realize where they featured in relation to the disease. Companies claimed that HIV/AIDS is not spread during the course of work and that it should be the concern of the infected, the affected family and the government (Greener, 1998).

Although people can still live with HIV/AIDS for many years, they have difficulty coping with the stigma attached to the disease. Reluctance to disclose one's HIV/AIDS status is associated with fear of rejection, denial, and ignorance ([file: A: Stigma and](#)

[HIV/AIDS in Africa.htm](#)). Silence, secrecy and shame surround HIV/AIDS due to its relation to sexual immorality as the cause. In support of this notion, Schenker and Nyirenda (<http://www.ibe.unesco.org>) point out that the “s” factors (shame, silence and stigma) are among the basic reasons behind continued HIV/AIDS fears, leading to denial, blame and discrimination, thereby delaying positive action.

The disease has inherited popular metaphors in different countries expressing perceptions about HIV/AIDS. The expression used in Swahili referring to the process of contracting AIDS is “stepping on an electric fence” ([file: A: Stigma and HIV AIDS in Africa.htm](#)). Amongst the Zulu’s in South Africa, people generally refer to the disease using euphemisms such as “amagama amathathu” or an unspoken language showing a sign of three fingers. These factors need to be recognized in the community, particularly in the workplace in order to address them (<http://www.ibe.unesco.org>). The first point of contact for a person who has been recently diagnosed as HIV positive is very crucial in perpetuating attitudes and beliefs in the population that lead to stigmatization.

HIV/AIDS epidemic is becoming visible, as more individuals are getting ill. The high mortality rate due to AIDS is now a reality for all sectors including government, industry and even communities. Thus, a joint effort to curb the spread of the disease seems a necessary strategy. Mandela (1997) supported this notion in his speech when he called for partnership between private sector and public health sector to jointly develop programs that prevent the spread of HIV and AIDS.

2.5 Myths about HIV/AIDS

One of the greatest threats to the realization of curbing the spread of HIV infection in South Africa are myths that people are confronted with in their communities that pertain to HIV/AIDS. In making decisions about life issues most infected and affected persons are influenced by these misconceptions. Accurate information is the key to understanding HIV/AIDS (<http://aids.about.com/cs/aidsfactsheets/tp/hivmyths.htm>).

Some of these myths that are identified by Swindells (2003) are given below:

- HIV/AIDS is limited to homosexuals, prostitutes and drug users.
- HIV/AIDS can be cured by having sex with a virgin and this has put children, girls and young women at high risk.
- AIDS can be cured by certain individuals like traditional healers and some doctors.
- Condoms are already infected by HIV by foreign countries with intent to kill Africans.

To a large extent, the spread of HIV and eventual development of AIDS can be partly attributed to traditional African beliefs and customs. Indications are that living in remote rural areas and informal urban settlements, in situations of poverty, people with HIV/AIDS have very limited access to services that they require. A consequence of this is that many HIV/AIDS affected individuals are not able to access information about their condition because of very limited formal education. Hence witches and sorcerers are usually blamed for illness and death in traditional African societies. HIV/AIDS is

associated and believed to be a result of witchcraft in such societies (Felhaber, 1997 in Van Dyk, 2001). In support of this notion, Boahene (1996) in Van Dyk (2001) expresses that many people in Africa do not regard their behaviour as a possible reason for HIV infection. Due to this misconception individuals do not appreciate the need to use HIV-preventative methods (Van Dyk, 2001).

Considering the myths, traditional beliefs and misconceptions about HIV/AIDS, it became evident that the family structure was not a totally ideal situation for implementing HIV/AIDS intervention programs. The workplace seemed a suitable organized environment to implement a comprehensive HIV/AIDS program (Mason, 1995). Davies, Schneider, Rapholo and Everatt (1997) in Chetty (2002) support the fact that industry is an ideal place to implement HIV/AIDS prevention programs.

2.6. HIV/AIDS epidemic in South Africa

The HIV/AIDS epidemic in South Africa is amongst the fastest growing in the world. According to the United Nations, South Africa more than other countries in the world, has more people living with HIV/AIDS (www.hiv aids.co.za). The estimation is that around four million people in South Africa are currently infected. Approximately 15 % of adults between the ages of 20 and 64 are said to be HIV infected. The figure of 200,000 of persons living with AIDS is expected to rise to approximately a million by the year 2010 (Lovelifé, 2001 in Chetty, 2002). The epidemic is expected to have profound effects in the most developed part of Africa over the next 20 years.

Literature survey (www.hivaids.co.za) shows that 18% of employees in South Africa are already living with HIV/AIDS. The disease is most prevalent in the age groups of 15 – 49, which is the most economically active group. It appears that sexually and economically active South Africans are HIV positive. HIV/AIDS has been identified as a risk with negative implications to deter investment, whilst raising the cost of doing business in this region (Jelly, 2003).

A survey done in 2002 amongst antenatal clinic attendees, showed that the province of KwaZulu-Natal (KZN) was having the highest HIV/AIDS infection rate of 36.5%, followed by Gauteng with a rate of 31.6% and Free State standing at 28.8%. However, in the Nelson Mandela survey (2002) looking at a cross-section society, the prevalence was highest in Free State at 14.9%, Gauteng at 14.7% and Mpumalanga at 14.1%. KZN province was in the fourth place with a rate of 11.7% (www.laiveri.org/safrica/stats).

In spite of the difference in these studies it is clear that the prevalence of HIV/AIDS poses a threat to the social and economic development within the province. The KZN province has a population of approximately 9.2 million, which makes about 20 % of the total South African population (www.kzn-deat.govt.za). The social and economic impact of HIV/AIDS in this province will ultimately affect the economy of the country.

2.7. HIV/AIDS impact in the workplace

The HIV/AIDS epidemic affects every organization and indeed every business, big or small. The economic and social impact in Sub-Saharan Africa has been reported to be far more severe than previously thought and the impact will seriously undermine the development prospects of affected countries (ILO News, 2002).

The ability to increase global share within the manufacturing industry of developing countries such as South Africa is threatened by the impact of HIV/AIDS on the economically active population (Whiteside & Barnett, 1996 in Chetty, 2002). Supporting this notion Good Practice Note (2002) agrees that the social and economic impact of the disease is intensified by the fact that AIDS kills primarily young and middle-aged adults during their productive years. At the macro-level, by reducing the labour supply and disposable income, AIDS affects markets, rates of savings, investment and consumer spending. Although it is not easy to assess the economic impact of AIDS, studies suggest that the hardest-hit countries may forfeit 2% or more of GDP growth per year as a result of the epidemic (Good Practice Note, 2002). South Africa, the most developed country in Southern Africa is the hope of Africa in terms of economic development. Thus, the economic impact in this country has profound consequences in its neighbouring countries.

HIV/AIDS epidemic is one of the greatest challenges that business development in South Africa is faced with. Absenteeism, loss of productivity and cost of replacing

employees as a result of AIDS, threaten the survival of business and transformation of public sector (Government Gazette, 1998). The epidemic claims some of the best business leaders, managers and a great number of workers at all levels of the production system. HIV related absenteeism, loss of productivity and the cost of replacing workers threaten the survival of a number of businesses and industrial sectors in the increasingly competitive world market.

Illness and deaths from HIV/AIDS affect productivity in the workplace, and thus South Africa's competitive economic ability. The potential for economic growth has lately decreased by almost 2% per annum. To gain confidence in the international market South Africa has to produce better quality, improve on reliability and add value to the existing market (www.hivaids.co.za).

In striving for economic stability, the industry demands increased productivity and longer working hours that require physically and mentally fit individuals. Employees are often pressurized to perform at their best to meet up with these demands. The level of employee performance may be reduced by physical and psychological factors. The repercussions of a sick employee are delays in the production process, loss of quality and quantity in the final product. Employees standing in for sick colleagues are often overworked and exhausted producing poor quality and less quantity (www.kenyaweb.com).

At the micro level, the most common costs of HIV/AIDS to business are increased health care expenses, pension, death claims, retirement and other employee benefits. Research done by the Harvard Centre for International Health indicated that HIV infection might cost companies between 2 % and 6 % of salaries per annum (Love life, 2001). The employer not only has to pay for direct costs such as employee benefit but also indirect costs of absenteeism as a result of illness. Direct costs relating to HIV/AIDS include medical aid, sick leave, pension, and retirement. However, the greatest impact is felt through indirect cost of lost labour, decreased productivity and staff replacement as a result of increased worker absenteeism due to illness. (Greener, 1998)

Acott (2000) describes further impact on the economy as a result of a decrease in labour force and savings rates due to a shift in expenditure towards health care. Economic growth is affected also by the shift in government expenditure towards health care expenses. This increases deficit in budget whilst decreasing total investment. Increased government spending on HIV/AIDS not only impacts on health but also other departments like education as a result of reduced skilled labour and high unemployment rates. On the other hand, industry suffers the consequences of having to employ unskilled employees that need longer training periods. Economically, what affects the government and communities will eventually influence industries one way or the other and vice versa, either negatively or positively.

The industry has been mostly concerned with direct costs rather than indirect costs. However, due to alarming death rates, high rate of absenteeism and sick leave, companies are starting to feel the impact of the disease economically. Some employers and managers are still finding it hard to involve themselves in programs aimed at preventing the spread of the disease. Some of these companies are able to get away by reducing benefits, thus shifting some costs of the epidemic onto the public sector, which provides access of other services such as health care. During this process resources from government are diverted from other public services to enhance productivity in the business sector (Barkes-Ruggles & others, 2001).

The hidden costs of HIV/AIDS in the workplace are diagrammatically represented in Figure 1 below:

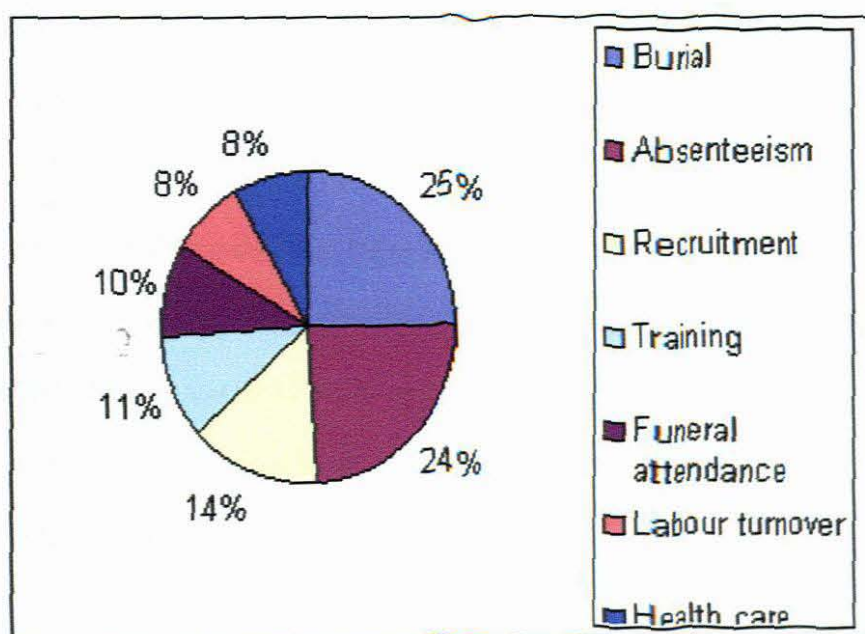


Figure 1. Hidden costs of HIV/AIDS in the workplace (adapted from the ETC Management Seminar, 2003)

In countries where the rate of HIV infection is high, the spread of AIDS devastates society through missed work, disability and deaths among the labour force. According to Keeton (2003), absenteeism, deaths and disability claims have increased in the year, 2003. When a sick employee dies a replacement becomes necessary. In a study

presented in a conference in Barcelona (2000), the difficulty of replacing both skilled and unskilled labour became more evident throughout Sub-Saharan Africa (ILO News, 2002). When skilled labour is lost valuable time is consumed by disrupted work schedules whilst organising replacements. The reality is that it might take longer to replace skilled labour resulting in decreased productivity (World Bank in <file:///A/articleP4.htm>).

The impact of HIV/AIDS on the individual, the workplace and on society is astonishing. Literature survey (Love life, 2001) shows that AIDS impacts more on unskilled labour than on skilled labour and that there is an increased mortality rate at work. The estimation is that around 15 % of highly skilled employees will have contracted HIV by 2010 (Love life, 2001).

It is estimated that 80% of working South Africans are HIV negative and thus it is imperative that this is kept that way whilst at the same time prolonging health and productivity of infected individuals. (Erica Barks-Ruggles in Keeton, 2003). The HIV/AIDS infected employee faces the challenge of coping with fatigue, physical pain, fear of death, low morale and poor performance. Organizations and employees require knowledge and resources to deal with issues like HIV/AIDS, and stressful situations, whilst bearing productivity in their minds (Midrand Graduate Institute, 2003).

According to the Government Gazette (1998), HIV/AIDS can be controlled in the workplace by developing a policy, intervention programs and wellness management

measures amongst other strategies. Health care and support, therefore, may help to reduce the spread of the disease and sustain the health of HIV positive workers. These programs would benefit the industry by increasing and maintaining worker productivity. Although both direct and indirect costs have raised awareness and concern within the business sector there is still a lack of a system in the measurement of HIV/AIDS impact on absenteeism and productivity in the workplace (Alan Whiteside cited in Keeton, 2003). In addition, the South African Business Coalition Against Aids feels that businesses do not have comprehensive programs towards prevention and awareness of HIV/AIDS in the workplace. This organization has since developed an instrument to measure and monitor the effectiveness of intervention programs. Forsythe (1999), however, comments about the difficulty of attributing the entire change of behaviour in employees to company intervention programs, as employees may have been exposed to other programs, for example through the media. In spite of these concerns a cost effectiveness analysis indicates a need for intervention by companies (Barks-Ruggles & others, 2001).

Although there is no risk of HIV transmission through casual contact between workers in the workplace, there are concerns that are associated with the spread of HIV. These are known as the socio-economic determinants of HIV/AIDS, which include the following:

- Migrancy and migrant labour
- Single sex hostels
- Overcrowded housing
- Poor access to health care services

- Lack of recreation facilities
- High unemployment rate
- Exploitation of women and
- Factors related to poverty, such as Tuberculosis (TB)

Supporting some of the above issues Good Practice Note (2002) agrees that the mining industry in Southern Africa has relied for over a century on a system of migrant mine labour. The system demands miners to be absent from their families for an extended period while living in males' hostels at remote mine sites. Extended separation from families led miners to resort to alcohol and prostitution for entertainment. This latter pursuit has become lethal with the advent of the HIV/AIDS epidemic, making mining workers become HIV positive more than members of the general population.

According to Good Practice Note (2002) gender inequality, especially women's lack of economic empowerment, is an important factor in the spread of HIV/AIDS. Therefore, as companies operate in an increasingly diverse workplace and draw their workforce from different pools, they need to take into account the differing needs of men and women with respect to workplace HIV/AIDS strategies.

2.8. Intervention programs

An intervention program comprises of an intended effort to bring about change in behaviour. As shown in literature ([file: A behavioral approach.htm](#)), most studies

supporting theory-driven models of intervention have shown success on preventive strategies to reduce the spread of HIV/AIDS through change in behaviour. Behavioural change interventions on HIV/AIDS prevention, demand understanding of social, cultural and psychological factors that influence risky behaviours. The primary concern is to determine appropriate methods to change and maintain such behaviours. It is of further concern to discover intervention strategies that are aimed at reducing the negative impact of AIDS on infected individuals, their families, the community and the health care system. In addition to change in behaviour, Bernard and Krupat (1993) include change in cognition and gaining insight to methods of clinical intervention programs.

For effective intervention, programs should take into cognisance individual needs, organizational and government objectives. Studies (Schneiderman, 2001) undertaken to examine the effects of psychosocial interventions on HIV/AIDS infected persons showed a positive impact on mortality, disease progression and biological factors that improved an individual's health status. Interventions that focused on the support of life and experiential factors appeared effective in reducing stress. The conclusive findings indicated an improvement in the quality of life.

HIV/AIDS programs are aimed at assisting individuals in reducing the risk of exposure to HIV infection and prolonging life. An increasing interest has been noted lately from companies that want to establish HIV/AIDS programs in the workplace. Some companies are responding seriously to the epidemic to an extent of considering provision of treatment. However, provision of anti-retroviral treatment is one form of intervention

in contrast to a holistic program in which employees take responsibility towards wellness. The latter form of intervention is comprehensive and sustainable (Jelly, 2003). Early diagnosis and proactive health care to all employees is the first phase of intervention. The reality is that most HIV/AIDS infected persons learn of their status only towards the final stages i.e. approximately 6 to 7 years on average after being infected. The purpose of early intervention programs including education, counselling and testing is preventative. The ultimate goal is change of behaviour not only of HIV infected but also HIV negative employees (Jelly, 2003). The estimation is that approximately 90% of HIV infected employees are still healthy and asymptomatic. Lifestyle management programs help promote wellness whilst retarding the progression of the disease.

A study undertaken by the Center for International Health at Boston University about costs of businesses in South Africa, showed positive growth on investment when intervention programs were employed. In other words, the companies involved in the study saved some costs whether direct or indirect from prevention and treatment intervention programs (Barkes-Ruggles & others, 2001).

2.9. Theoretical frameworks on HIV/AIDS intervention programs

The role of theory is generally to describe factors that influence behaviour thus providing a direction on how to handle such factors. Theories therefore provide a framework that assists when designing intervention programs. (www.caps.ucsf.edu/theoryrev.html). Theories used in the development of HIV/AIDS

intervention programs have been drawn from diverse disciplines such as sociology, psychology and anthropology. Most HIV/AIDS intervention programs focus on behavioral change as a measure of prevention.

2.9.1. Theories on behavioral change

The primary goal here is to identify strategies of prevention aimed at reducing the risk of HIV transmission and prolonging life of an HIV/AIDS infected person. Development and testing of theories on behavioral change and maintenance is an effort towards primary and early prevention of HIV/AIDS.

Theories of behavioral change address different levels that include individual, interpersonal, community and environmental (including structural) factors. Programs are often developed based on a combination of factors from various theories ([File: A: Prevention%20Intervention.htm](#)). These programs support a healthy lifestyle, alleviation of psychological distress, and even providing access to treatment whilst promoting good coping strategies (www.caps.ucsf.edu/theoryrev.html).

2.9.1.1 Individual level

Individual level is considered the primary avenue to change behaviour and reduce risk of spreading HIV/AIDS infection. The challenge, however, is that of reaching to each and every individual to achieve this goal. Fishbein and Middlestadt (1989) in Van Dyk

(2001) support the fact that risky behaviours may not always change because of increased knowledge. There is more to be done above the supply of information on HIV/AIDS in order to change people's behaviour. Individual's intention to change including how much effort they can put contributes a lot to the process of change of behaviour. Thus the focus should also be on other characteristics such as perceptions and beliefs about the disease, self and others, values of preventive behaviour and cognitive functioning. However, intentions alone are not sufficient as they could be influenced by external factors. For an example, a wife could be willing to practice safe sex but this intention is hampered if the husband is not willing to use a condom.

Understanding individual decision-making process towards change of behaviour is an important exercise when dealing with the spread of HIV/AIDS. Prochaska and DiClemente (1984) in Van Dyk (2001) outline the following stages individuals undergo during the process of change of behaviour:

- Precontemplation – the individual is not aware about his/her behavioural problems and therefore has no intention of changing any behaviour
- Contemplation – the individual is aware of risky behaviour or problems that exist but has not yet made a decision to change.
- Action – the individual starts changing his/her behaviour even considering beliefs and conditions that affect behaviour
- Maintenance – the individual continues with the acquired behaviour, preventing any relapses until the problem is eliminated

Various models, some of which are outlined below, are often explored to understand what influences behavioral change in individuals.

Health Belief Model

The Health Belief Model was developed by Rosenstock in 1996 as an approach to predict preventive health behaviours and responses to such behaviours (Ogden, 1996). Originally, the model was only concerned about the individual without consideration of social context hence the revised version now includes the individual's social world.

This model assumes that an individual behaves according to the expectations of the outcome of a new practice. The Health Belief Model is one of the widely used models in HIV/AIDS campaign and awareness programs. For individuals to change behaviour they must first believe that:

- They are susceptible to a particular condition
- The condition is serious, in this case, “ AIDS kills”

Individuals should also consider the consequences of contracting the disease and the effects (including both positive and negative) of adopting new practices. The consequences not only affect infected individuals but also the family, community and others in various ways such as emotionally and financially. An individual should have an intention to change behaviour in order to change behaviour. This could be influenced by his attitude toward the behaviour or even perceptions about others such as colleagues, employer, family and community (www.caps.uscf.edu/theoryrev.html).

2.9.1.2 Interpersonal level

This level looks at how an individual's behaviour is influenced by social relationships and the environment.

Theory of reasoned action

Fishbein and Ajzen (Ogden, 1996), are the proponents of the theory for reasoned action, which combines individual's social norms and thought processing in order to address problems of interaction. The theory of planned behaviour that is derived from the theory of reasoned action may often be referred to interchangeably in discussions.

The model looks at how beliefs are turned into actions. The emphasis is on knowing an individual's behavioral intentions in order to predict behaviour and outcome of such behaviour.

Bernard and Krupat (1993) describe the three following factors that predict behavioral intentions as proposed by Fishbein and Ajzen:

- Attitude towards behaviour i.e. for an individual to intend changing behaviour it depends on the attitude about that behaviour. The intentions are influenced by what is considered to be the outcome and based on the evaluation of the outcome.

- Perceptions of social norms i.e. it is important for individuals to know what their significant others expect of them. They in turn feel pressurized and motivated to perform certain behaviours.
- Perceived control – the individual considers both internal and external factors that control behaviour. That is, the intention to change is due to the individual's ability to change behaviour. The theory of planned behaviour added this factor to the theory of reasoned action.

Learning Theory

The learning theory proposes that skills involved in a new behaviour are learnt through direct experience or observation of others' behaviour (<File://A:\Social%Learning%Theory.htm>) . The approach is concerned with changing unwanted behaviour through principles of **classical** and **operant** conditioning. Classical or respondent conditioning proposes that behavioural change is influenced by an alteration in circumstances that precede that behaviour. A change in behaviour is determined by a change in conditions leading to that behaviour (Barker, 1998).

Skinner developed the concept of operant conditioning that describes behaviour as a result of influence from circumstances that follow such behaviour (Barker, 1998). The principle of operant conditioning states that behaviour is likely to be continued or changed when subsequent environmental changes are rewarding.

Operant conditioning has been mostly adopted in the principle of learning about HIV/AIDS issues where people are often encouraged to behave in a desirable manner and receive positive reinforcements. The principle applies to both infected and non-infected so they can take safe precautions that prevent the spread of the disease. Bandura applied observational learning or modelling to behaviour modification (Barker, 1998). Social learning theory combines classical and respondent conditioning with observational learning. The principle of this theory is that people learn by observing others intentionally or accidentally. Observing others being rewarded for modified behaviour encourages others to change, while observing others being punished or failing encourages others to refrain from such behaviours (Bernard & Krupat, 1993).

In this approach HIV/AIDS infected persons are encouraged to disclose their status and even test publicly. The purpose is to de-stigmatise HIV/AIDS by observing what behaviour others engage in so they can model that behaviour. Other strategies include peer education programs and awareness programs that engage HIV positive individuals. Drama is another strategy that relays messages about HIV/AIDS issues. Behaviour rewarded in drama increases that behaviour amongst the audience and also increases self-efficacy.

Social learning theory adopts the view that changing behaviour is influenced by the person's interactions with others in the environment. Expectations and incentives determine behaviour. It is likely that behaviour will be repeated when one is expecting a

reward. Social relationships and the individual's belief that s/he is capable of changing behaviour promote change of behaviour (www.indiana.edu/aids).

The cognitive approach views behaviour as modified due to cognitive restructuring. The way an individual perceives a situation helps bring change in behaviour. The thought of implications of a situation influences an individual to change behaviour. Persuasive methods and live demonstrations redirect the way of thinking. This approach not only supports change of behaviour from observation and modelling but also an individual's capability towards performing the new behaviour. Intervention is an educational process aimed at changing one's thoughts, feelings and actions. Cognitive strategies on intervention include changes in attitude, awareness and dealing with irrational thinking (Barker, 1998). The cognitive approach views the behaviour and emotions of HIV/AIDS infected persons as based on how they perceive the disease including transmission and consequences. This approach teaches skills and trains individuals in dealing with issues that affect them emotionally, especially self-efficacy. HIV/AIDS infected individuals need these skills to cope with several issues in relation to life demands and AIDS related concerns such as stigma and discrimination.

Communications approach

Barker (1998) describes the communications approach as comprised of three aspects:

- Syntax, which refers to grammatical rules of language

- Semantics that relates to meaning of words
- Pragmatics, which is a study of behavioural effects of communication

Communications approach relates to all types of behaviour as communicative. It is not possible not to communicate. Barker (1998) further explains the relationship between behaviour and communication in a statement, “one cannot not communicate”. An individual is communicating all the time through his behaviour. The approach looks at the relationship of those that are communicating and how communication affects behaviour.

Watzlawick (Barker, 1998) the proponent of pragmatic communications, views change as occurring in two phases:

- First order change, which is a result of conscious decisions to do something differently
- Second order change that involves a change in attitude or reframing a situation to perceive things differently

Pragmatic communication has been the most used strategy for the prevention of HIV/AIDS with emphasis on behavioural change. Pragmatic communication uses strategies like metaphors and paradox to give another meaning about HIV/AIDS. The aim is to create awareness and educate the communities about their responsibility in preventing the spread of the disease. The communicator’s ultimate goal is to change the receiver’s thoughts (Chasi & de Wet, 2002). The focus of communication is generalised

i.e. it is not specific to infected persons. Although a lot of public awareness has been established around information on how it must be prevented, yet the figures of HIV/AIDS pandemic continue to escalate.

Phenomenological approach

Phenomenology is derived from the word 'phenomenon' that refers to appearance. Phenomenological psychology, a study of phenomena draws from phenomenological philosophy. The origin is based on the philosophy of existence relating to an individual's experience of being-in-the-world. The phenomenological theory describes each individual as being-in-the-world, which is a unique experience (Spinelli, 1989).

Husserl, though not the founder of phenomenology did a lot of investigation on intentionality of consciousness so as to give meaningful experience (Vaille & Hatting, 1989). He noted how minimal self-consciousness was during experiences. An individual only becomes conscious of the self once the experience has been completed.

According to this approach an individual's behaviour is determined by the meaning given to a subjective experience of a situation. All individual experiences are the bases of knowledge and behaviour. Behavioral change is a result of conscious experience and meaning attached to it. A phenomenological intervention is 'an intentional effort to bring about change' (Edwards, 2001).

The phenomenological approach states that individual experiences of the world are unique due to their focus that is directional and referential. Spinelli (1989), describes the phenomenological method as composed of the following steps:

- The individual sets aside any bias or prejudice of things, suspending any assumptions or expectations about the situation. The focus is on the immediate experience of a person rather than assumptions or expectations. All experiences are thus considered as initially valid.
- The second step looks at the analysis of immediate experiences that takes description rather than theoretical explanation as the point of focus. A concrete descriptive analysis of subjective variables that constitute an experience is done.
- The last and third stage ensures that the described items are treated as having equal value rather than any hierarchical manner of importance. This provides an analysis of experience with less prejudice

Phenomenological enquiry or investigation provides a distinction in the actual experience (*straightforward* experience) as it occurs and the interpretation given to that experience (known as *reflective* experience). The phenomenological viewpoint allows an individual to experience the event and describes it once it has occurred. The aim is to determine the meaning of the experience for the person involved in such an experience. In phenomenological investigation *naïve* descriptions of an experience are collected using in-depth unstructured interviews. Phenomenological interviews seem to provide a valid and reliable picture about the reality of experiential investigations. Chasi and de Wet (2002) support this notion in that, readers can easily relate with the findings of such

an investigation. Descriptions of direct experiences are recorded as they occur. The researcher teases out the structure of consciousness based on the experience in order to describe that experience. Vaill and Hattig (1989), outline three sources from which the researcher can generate descriptions of experiences:

- Data from researcher's self reflections, used as a preparatory step in gathering data from participants so as to be aware of any preconceptions
- Data from participants, which is the focus of research, collected as naïve descriptions of their experiences
- Data gathered from experiences outside the research e.g. other research articles

The process of data gathering provides the researcher with a collection of descriptive experiences of the topic being investigated. The researcher ends up with a lot of data on experiential descriptions, which needs to be analyzed in order to make sense of the study. During the data collection process the researcher is also able to learn about the experiences.

Phenomenological approach on HIV/AIDS intervention is meaningful because of subjective experience for that individual. The meaning of an individual's experience of an intervention program plays an important role in determining any behavioral changes. Although not commonly used, phenomenological interventions are valid for providing reality and subjective experience which others can relate to. However, Kant, a philosopher, argues that it is only possible to know the thing as it appears to us, as it is beyond our ability to understand the experience as it occurs. General or universal

meaning can only be derived from the individual experiences. Another concern about reflective experience is that it describes the experience by use of language, which may not give a true picture of an experience, as it occurred (Spinelli, 1989).

During the language transformation process of naïve descriptions expressed in concrete language of the subject into a psychological perspective of the phenomenon, some discrepancies may be noted. The researcher should be conscious not to impose his theoretical expectations while describing the subjects experiences. Certain themes may appear to be unrelated and therefore rejected (Vaille & Hatting, 1989). Although the researcher is more interested in structures that seem to have a common appearance, the greatest temptation is that of completely ignoring themes that are incoherent (Stones, 1986).

Both Van Kaam and Giorgi (Vaille & Hatting, 1989), advocate use of judges who will agree to the transformed meaning as coherent with the psychological expression. Giorgi encourages reflection and imaginative variation as thought processes that help deal with difficulties of language transformation. The researcher, through mental experimentation, explores all possible meanings given in a description.

2.9.1.3 *Structural and policy level*

Theories at this level are concerned about how the environment impacts on health issues including policies and economic conditions. These theories deal with conditions that

affect normal functioning of workers in such organizations as may be further influenced by the environment and society (www.caps.ucsf.edu/theoryrev.html). Companies formulate policies that stipulate how they want to deal with certain issues such as HIV/AIDS, disabilities, safety and security. Policies therefore outline what intervention programs the organization plans to follow and what strategies to use. Decisions to formulate such policies are based on country laws and policies, and policies within the business sector.

Grounded level theory

Grounded theory is an inductive technique developed for health – related topics by Cylaser and Strauss in 1967 (http://www.fortuneity.com/greenfield_grizzly_432_rra.htm). The term “grounded” means that the theory developed from the research is grounded or has its roots in the data from which it was derived. Grounded theory is based on symbolic interaction theory that holds many views in common with phenomenology (http://www.fortuneity.com/greenfield_grizzly_432_rra.htm). Within the field of health sciences, grounded theory has been used most often in studying areas where there has been minimal research and in gaining new insight into previously researched areas. Hence, it becomes an inductive method of gaining knowledge.

A grounded level theory was developed from the work of two sociologists who wanted to bridge the gap between theory and empirical research. The researchers were trying to answer important questions or assumptions they had about a phenomenon that were not



yet properly identified. Research can be used as a form of intervention. In the case of grounded level theory, a theory is expected to be the outcome of collected data, rather than the beginning of research. The purpose is to identify and describe possible relationships between concepts. The grounded theory is often employed to collect data from historical records and through interviews and observations (Leedy, 1997).

In grounded theory design all stages of research occur at the same time i.e. data collection, coding and analysis (Leedy, 1997). During the continuous process of data comparison between categories the researcher identifies any relationship between concepts in order to develop a theory for the research.

2.10. HIV/AIDS policies in the workplace

An AIDS policy is defined as a document that stipulates a company's commitment, obligations and response to the impact of HIV/AIDS in the workplace (Small & Strode, 1995).

Dancaster and Jamieson (1991), proposed three ways in which an employer can address HIV/AIDS issues in the workplace:

- Protect worker's rights and dignity of persons living with HIV and AIDS. The workplace policy should be non-discriminatory so as to accommodate workers with HIV/AIDS. It is essential that the policy of an organization does not allow discriminatory action in the provision of services and employment.

As noted in literature (www.oshe.dde.gov.ph/sp_aids.htm) for persons applying for employment, mandatory testing for STD/HIV/AIDS should be prohibited except in certain cases where testing is necessary to protect public safety. For employed persons, those with STD/HIV infection and HIV related illness should be entitled to the same rights and employment opportunities as other employees. Most people affected by STD/HIV want to continue working, thus they should be given the opportunity to be productive in a supportive occupational setting. Those with STD/HIV/AIDS need to be treated with the same compassion as other persons suffering from any incurable disease.

- Negotiate terms of employment in situations in which AIDS related problems arise. Persons with HIV – related illness should be able to work as long as they are physically fit and medically cleared.
- Address HIV/ AIDS issues such as education and treatment of infected employees. Employees need to receive a comprehensive HIV/AIDS education program.

The following are some of the advantages of having a policy:

- A policy shows a clear stance by the company including employees and managers, with regard to the rules and approach
- it outlines social commitment by the company
- it provides consistency in tackling HIV/AIDS issues

- it sets out support structures that are made available to employees

Most companies have realized the need to have policies on HIV/AIDS in order to address the problem of HIV and AIDS at work. However, there have been some companies that argue for not having a written policy. The concern is about the limitations imposed by having a workplace policy program. Dancaster and Jamieson, (1991) outline the following as some reasons against having a policy:

- Shift of responsibility to the government and media to educate the public including employees
- Unease at dealing with HIV/AIDS issues
- Lack of awareness about the impact of HIV/AIDS in industry
- Believing that information will be used against the company

The present researcher, however, agrees with the need to set up policies in the workplace mainly for uniformity in caring for employees and also because this shows commitment by the company. Policies of course do not serve a purpose if they are not reviewed periodically therefore they should be set up with an open mind. Companies should consider what is relevant and of benefit to their employees.

A policy should portray the company's stance to the HIV/AIDS epidemic including prevention and management in the workplace. All employees should be made aware about the policy. According to Davies et al., in Chetty (2002), an HIV/AIDS policy program in the workplace should cover the following:

- Personal issues that include management of infected employees, HIV testing, and employee benefits
- Program issues, including prevention programs such as risk reduction, awareness, education, wellness management, counselling, and infection control programs. These should be linked with other programs internally and externally from the workplace.
- Monitoring and evaluation issues, which include baseline information, how to monitor such programs, risk analysis, impact assessment, reasons for monitoring, indicators for monitoring and evaluation of programs.
- Legal issues that include formulation of such policies around principles of non-discrimination, equality, confidentiality and medical ethics.

Organizational policies often state which intervention programs have been set up by the company to curb the spread of HIV/AIDS in the workplace.

2.11. Development of HIV/AIDS intervention programs

The purpose of developing preventive intervention programs is to educate individuals and empower them with necessary life-skills. The ultimate goal is to prevent the spread of HIV/AIDS and to care for those infected and affected by the disease. Development and evaluation of intervention strategies prevent physical, psychological and social consequences of HIV/AIDS infection. Therefore, an overview of cognitive, emotional and social factors that influence those concerned should be considered during the process

of program development and evaluation ([file:///A/behavioral%20approach.htm](#)). All three components link with the individual's intentions towards changing behaviour, which indicate how much effort and commitment is required to make it a success. People may not only want to change behaviour for their sake but also to please others such as partners, friends and family. Thus including the individual's intentions, attitudes and ability to change his/her behaviour in intervention programs promotes a positive outcome (Van Dyk, 2001)

Figure 2 below gives an overview of cognitive, emotional and social factors that should be included when developing a program (Ajzen, 1991 in Van Dyk, 2001).

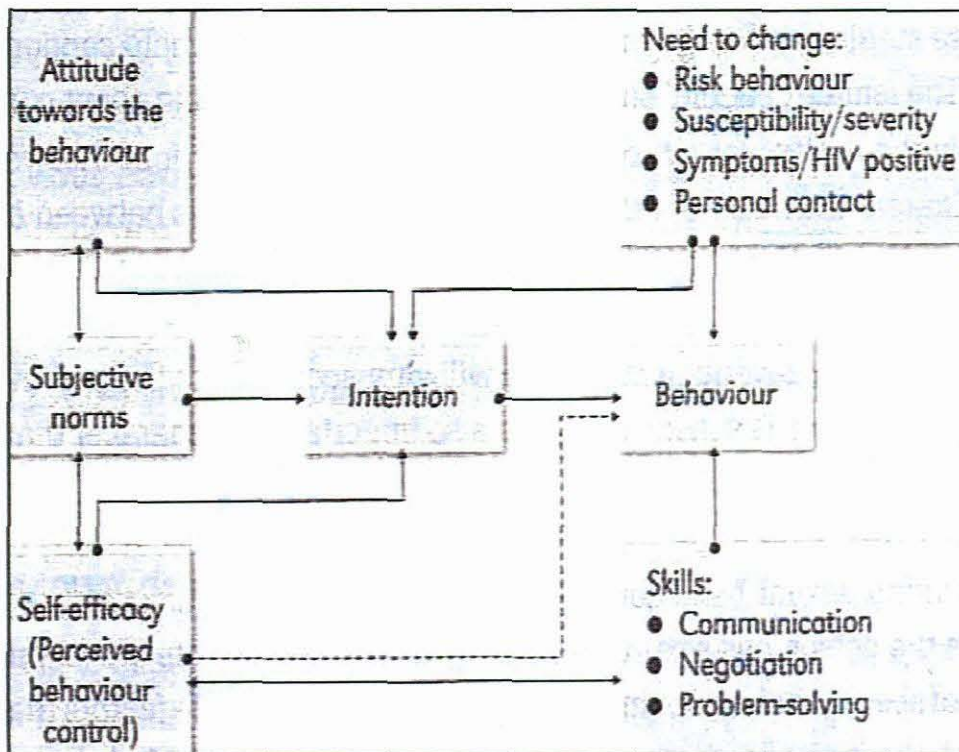


Figure 2. Factors influencing behavioural change

The World Health and International Labour Organizations have set out guidelines to deal with HIV/AIDS issues in the workplace. WHO (2000a) in Van Dyk (2001) outlines the following principles and strategies that need to be considered when developing prevention programs:

- National support

The support of all stakeholders i.e. politicians including government, leaders (e.g. community leaders), private sector, especially business, plays a major role during this process i.e. their views on HIV/AIDS and policies of dealing with the disease. The development of programs should be seen as a comprehensive effort by government, private sector, non-governmental and community based organizations to prevent the spread of HIV/AIDS. WHO (1992: p 8) supports this notion stating that, “all sectors of society must be mobilized in support of national AIDS programs providing education, counselling and care”

- Peer support

Support of each other especially HIV/AIDS infected and affected persons is a worthwhile experience and this could be in the form of a support group and, or peer education. Peer education programs are motivational and often give meaning.

- Participation of HIV/AIDS infected persons

Involving HIV/AIDS infected persons in a program is a subjective process as individuals gain first hand experiences from others in the form of personal experiences or stories. The experiences are a reality and provide a valuable resource. The program becomes relative and people take pride once they have been involved in developing something.

- Multicultural practices

Different cultural practices should be considered including traditional and religious beliefs, language and values for any program to be meaningful otherwise the program may be seen as for certain individuals and not for them.

- Empowerment

Through provision of certain life-skills, individuals are able to deal with important life issues such as perceptions, finances, stress, family and emotions. These skills could benefit people at all contextual levels whether at work and even in communities.

- Condom distribution

Condoms should be made available freely to all individuals. Distribution in a discreet manner that avoids embarrassment from other colleagues is often recommended.

- Human Rights

A rights-based approach in the workplace usually helps to deal with any form of stigma and discrimination to avoid any victimization. One should be aware of possible stereotypes and ensure that those infected are empowered to deal with these. Organizational policies should be clear on how to deal with such stereotypes and discrimination and what benefits do employees have especially in relation to HIV/AIDS infected employees. Individuals should be made aware of their human rights including health rights, labour laws, government responsibility towards citizens especially poverty, education and improvement of social structures.

- Volunteer Counselling and Testing
- Volunteer testing has become the important strategy to prevent the spread of HIV/AIDS through early intervention

2.12. Evaluation of HIV/AIDS intervention programs

Evaluation of a program refers to assessing the effectiveness of such a program. Seedat, Duncan and Lazarus (2001) outline two purposes for program evaluation. The researcher considers issues around development of such a program, the type of issues people are faced with and how they deal with such issues. Collected information may then be used to develop a theory. Secondly, evaluation analyses issues about the implementation and end results of the program i.e. whether these are according to the initial plan. Evaluation of programs may also be used to identify problems and provide solutions to problems around HIV/AIDS issues.

Program development and program evaluation go hand in hand. When information has been collected from an evaluation process it may be used to develop a theory that will further be used towards developing a program. During the program-planning phase it is important to indicate how the program be monitored and evaluated to measure its impact.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter outlines the research design that was used by the researcher to collect data. It is the responsibility of the researcher to choose a suitable method to gather information for the research undertaken.

3.1 *The Study*

3.1.1 *Aim of the study*

The main aim of the present study was to determine whether intervention programs enhance the performance of HIV/AIDS infected persons in the workplace. The idea here was to see whether there are any differences in the performance of participants after being through an intervention program.

3.1.2 *Research technique*

The qualitative approach was found to be the most appropriate to use in this study. Qualitative research deals with shared stories that enable the researcher to understand what others experience in certain situations. Qualitative research looks at the broader perspective including the reason why people do certain things (Leedy, 1997). The

phenomenological approach and grounded level theory were used for the present study. The purpose of the phenomenological investigation was to gain subjective experience from participants so as to understand a particular phenomenon or behaviour in question. Similarly, the grounded theory approach explored how people define reality and how their beliefs are related to their actions.

3.1.3 The Participants

The sample for the present study was drawn from organizations in and around Richards Bay and Empangeni. Four organizations were chosen namely, Bell Equipment, Mondi, National Ports Authority and the University of Zululand. In the present study sampling was purposive since the researcher dealt with those subjects who met the purpose of the study.

The study involved eight participants from the four organizations mentioned above. The sample comprised of two categories of participants, that is, those who were recipients of the HIV/AIDS program within the workplace and those who were administrators of the program. The two categories were as follows:

- Four HIV/AIDS infected employees (one from each company). These participants were selected with the help of nurses administering the intervention program
- Four professional nurses (one from each organization) who were involved as administrators of HIV/AIDS intervention program. These nurses worked at

clinics within the different organizations and were selected because of their involvement and experience with the intervention program

3.1.4 Data Collection

To collect data, face-to-face interviews were undertaken. A telephonic interview was later arranged with one participant when it became difficult to meet with him due to time constraints.

The researcher asked the participants to share in detail their experiences about the intervention programme. Interviews focused on understanding the themes described by participants about their experiences of the program and the meaning of being involved in a workplace intervention. The main question to all participants was, ‘What was your experience of being involved in the HIV/AIDS intervention program?’ The researcher asked further questions for clarification purposes as opportunity arose in relation to:

- The effect of such a program
- Client’s performance

Work policies were also used to identify programs that organizations were involved in and to help monitor and evaluate such programs. The purpose here was to identify what strategies organizations used in dealing with HIV/AIDS epidemic. The ultimate goal of this exercise was to help review intervention programs towards further development.

Copies of policy documents were collected from the different participating organizations. The focus of data gathering from the policy documents was:

- Availability of a policy document and when formulated
- Intervention programs supported by each organization
- Opportunity to review policies

3.1.5 Procedure

Permission was requested from the organizations where research was to take place. Ethical commitment especially with regard to informed consent, confidentiality and anonymity throughout the process was maintained. A good rapport was established with the personnel department and the clinic supervisor to help in identifying the possible participants. Professional nurses did the initial debriefing with HIV/AIDS infected employees, which was then followed by the researcher's interviews.

3.1.6 Scoring

The researcher did scoring and coding of collected data. Information on scored data is further reported and discussed in Chapter 4.

3.1.7 Data Analysis

To make sense out of collected data the following analysis was done.

3.1.7.1 *Phenomenological research analysis*

The aim was to determine the meaning of the experience for the person who had the experience (Vaile & Hatting, 1989). The process of data analysis followed in this study was based on the process developed by Van Kaam and Giorgio (Vaile & Hatting, 1989).

Van Kaam introduced six steps to analyze data in phenomenological research:

- Step 1- Classification of data into categories

A list containing all the different statements from descriptions made by participants was compiled. The researcher determined the frequency of appearance of items on descriptive statements

- Step 2 - Reduction and linguistic transformation of structured experiences into precise terms

The researcher transformed data from the original language used for descriptions into meaningful statements. This step included re-describing the experience from a different perspective so that it related to the research topic in a precise manner

- Step 3 - Elimination of inherent statements

Descriptions and any other statements that are not compatible with the topic under investigation were excluded from the list made during step 1. Any redundant material was eliminated

- Step 4 - The first hypothetical identification

When classification, reduction and elimination processes had been completed a hypothetical description of the experience was made.

- Step 5 – Application

The hypothetical description was tested to see if it was applicable to the investigation. The aim was to detect relevance of descriptions to the topic under investigation by either adding or eliminating relevant and irrelevant data respectively. This process was repeated several times till the researcher was satisfied about the applicability of the hypothesis

- Step 6 - Valid identification

The hypothetical description was accepted as a valid description of the experience that was relevant to the research topic

Both Giorgi and Van Kaam agree that original descriptions of experience need to be broken down and transformed into meaningful units, which are transformed into psychological expression to make a general description (Vaile & Hatting, 1989).

Themes evident from the described experiences are explored and discussed in Chapter 4.

3.1.7.2 Grounded level theory analysis

Data from work policy documents was analysed according to the method of coding outlined in Leedy (1997):

- Open coding

Data was first broken down into units, examined and compared to each other then organised into categories

- Axial coding

Data was organised in a new manner so as to make connections between categories from open coding

- Selective coding

The researcher selected core categories systematically validating the decision based on relationships and comparison with other categories. These are further discussed in Chapter 4.

CHAPTER FOUR

RESULTS AND DISCUSSION

This chapter presents results with comments from the phenomenological and grounded theory investigations based on collected data. The identified themes from the subject's descriptions of experience are outlined for the reader's meaningful understanding of the study. Examples are quoted where necessary to justify the researcher's findings. The researcher also discusses the possible theory formulated from data collected from organizational policies.

4.1 Phenomenological results

4.1.1 Experience of HIV/AIDS infected employees

Table 1. Themes from infected employees

Thematic categories	No of responses	Percentage
Positive about life	4	100
Gained strength	4	100
Gained confidence	2	50
External locus of control	3	75
Scope for improvement	3	75
Negative thinking	1	25

Positive about life

All participants described their experiences of being involved in the program as positive.

This was concluded from the following descriptions:

- “I have been on treatment for three months but can already see the difference”
- “ I am pleased company is helping us and can carry on working”
- “ I am happy the company is doing this, I have seen people dying before without any help”
- “Now, I have an opportunity to do things I’ve always wished for. I’m getting married before end of this year”

Gained strength

All participants experienced improvement both in their health status and in work performance. This was deduced from the following comments:

- “ I was sick but now can do my job well”
- “I used to get help from my colleagues. I would take long to do only half of my job, not anymore things have improved. I have also gained weight”
- “ Although not long taking treatment I have not been sick ever since”
- “ I feel strong physically actually I have gained weight”

Gained confidence

Fifty percent of participants seemed to have gained enough confidence as observed with the process of disclosure:

- “I talk about it freely to my colleagues, they can’t believe when they see me”
- “I am past the stage of being emotional. Disclosing was the best thing that happened to me”

The other half were still concerned about issues relating to confidentiality and anonymity. When the present researcher was talking to one participant on the telephone arranging for an interview, it was apparent that the participant was not free to talk at home. He requested to transfer the call to where he could express himself freely.

Locus of control

Most employees agreed that external help mostly keeps them going and able to cope with life stressors. This included health professionals and family members. Only one participant believed in internal self control.

Scope for improvement

Three participants felt there was a need to extend the program by including spouses and adding other programs like nutrition. The concern about spouses was that of dealing with guilt feelings of benefiting from the program whilst their partners were still suffering. Due to their experience of being-in-the-world, participants were faced with the dilemma of either continuing or discontinuing with the program based on guilt feelings.

One participant also felt managers were not involved in the program especially in terms of support. This was observed from the following comments:

- “Managers think we are the only ones who get sick”
- “Don’t supervisors get sick from this disease or we mustn’t know about them?”

Negative thinking

Although there was one participant with negative thinking this was related to one section of the program. He expressed his concerns towards taking treatment for ‘the rest of his life’. This was overruled, however, by other benefits of being on treatment and being part of the program.

4.1.2 Experience of professional nurses

Table 2. Themes from nurse's experiences

Thematic Categories	No. of responses	%
Provides hope	4	100
Encouraging	4	100
Worthwhile and satisfying	4	100
Disappointing & discouraging	4	100

Provides hope

The experiences of professional nurses described the workplace HIV/AIDS program as providing hope for employees. The descriptions were based on awareness and education programs that focus on preventative measures without provision for those already infected. This was evident in various ways in descriptions given by all participants as quoted in the following examples:

- “The response has been good since we started the program, it’s wonderful that the company is doing something for employees”
- “ It gives hope that they can still earn a salary”

Encouraging

The theme of encouragement was based on the increased numbers of employees coming forward for voluntary testing and others that are able to benefit from the entire program in various ways. Previously, the issue of stigma and discrimination has made most employees reluctant to come forward and be associated by any means:

- “Good compliance is assured. An employee who was given sick pension is doing so well he might come back to do casual work”
- “Employees have been coming voluntarily for testing, response is good”

Worthwhile and satisfying

Most participants described the progress since intervention as satisfying in terms of health status and work performance. Improvement was justified based on increased CD 4 count¹, decrease in viral load², weight gain and physical appearance:

- “Employees on the verge of taking sick pension are able to go back to full duties. They regain their strength from general weakness”
- “They are seldom away from work and remain productive for longer periods. The rate of absenteeism has decreased”

¹ CD 4 count refers to lymphocyte count assessing immune system

² viral load refers to number of viral particles in a sample of blood plasma

- “Some have jobs that are quite demanding and yet are able to sustain their duties when on treatment”
- “It is not only useful for those infected but everyone affected. I have also gained a lot from the program”

Disappointing and discouraging

Although the program was seen as encouraging there was some ambivalence. Analyzing this discourse meant that there is a need to extend the services and to encourage more involvement of employees:

- “Behavioral change is still a problem. There are those who still have more than one partner and are reluctant to use condoms”
- “Emotionally, they tend to be very sensitive to issues that relate to planning of life goals. Including close family members especially spouses would be holistic”
- “In the early stages two died due to poor compliance and it was very late i.e. in the last stage of the disease when they got into the program”
- “We need to go beyond talking and motivation; people have other things in their minds than being educated on AIDS. Maybe we need to work with other organizations and include programs like nutrition and food supplements.”

4.2 Work policy documents

Table 3 gives a summary of categories picked up during analysis of work policy documents from the four participating organizations.

Table 3. Categories from work policy documents

Category	Responses	Percentage
Availability of policy document	4	100
Intervention programs:		
Awareness & Education	4	100
Voluntary Counselling & Testing (VCT)	4	100
Wellness Management	3	75
Anti-retroviral treatment (ART)	3	75
Incapacity management	4	100
Provision for review of policy	4	100

Availability of policy documents

All participating organizations had HIV/AIDS policies in place showing commitment in preventing the spread of the disease in the workplace. Analyzing policy documents gave the researcher an overview of what programs were of importance to the organizations.

Intervention programs

Intervention programs varied with the different organizations. The focus of all organizations was on education and awareness programs. Voluntary counselling and testing (including pre and post testing) has been included as part of intervention. Seventy five percent of the participating organizations included wellness management and anti-retroviral treatment in their intervention programs

Incapacity management

Incapacity management showed what plans each organization had for employees who were unable to perform their duties and their benefits thereof. All organizations outlined non-discriminatory practices and benefits for HIV/AIDS infected employees relating to sick leave, medical aid, and pension and retirement funds.

Provision of review

All organizations had provisions made for the process of monitoring and evaluation of policies. This possible review of policies was seen as important for companies to keep updated with research and changing times and as part of the development process of HIV/AIDS policies.

From this exercise the researcher identified strengths, gaps and opportunities to further develop workplace HIV/AIDS programs. In this process categories from different policy documents were compared to help identify whether there was a need for further development in relation to intervention programs. All participating organizations had HIV/AIDS policies in place and intervention programs to deal with the spread of the disease. Although prevention strategies were applicable both in the workplace and at home there was a gap in managing and sustaining HIV/AIDS infected persons. However, all organizations were clear in the management of any disability as a result of the disease, including benefits for the infected employees. The focus of most organizations was on the role of treatment with lack of emphasis on wellness management.

Intervention strategies lacked the integration of spouses and close family members in other programs such as treatment and wellness. There was also no clear involvement of organizations in HIV/AIDS prevention programs in communities. Results from the phenomenological investigation and from the grounded theory analysis were combined to provide conclusive findings and recommendations for this study. These are discussed in the following chapter.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

This chapter discusses conclusions that were drawn from the findings of the study. The conclusions of the study then come up with recommendations for further investigation.

5.1 Conclusions

5.1.1 Experience of HIV/AIDS infected employees

All participants described their experience as positive about life since their involvement with the program. They also felt that they have gained strength based on weight gain and improvement in their performance. Other experiences such as confidence, external locus of control and scope for improvement varied with individuals. This meant that some of these experiences could be the focus of improvement strategies for intervention programs in future.

5.1.2 Experience of professional nurses' experience

Although the experiences were unique for each individual, underlying themes were common to all of the participants. They provided positive and negative but constructive descriptions of their experience with the intervention programs.

On a positive note, participants described experiences of hope, encouragement, worth, and satisfaction since being involved with the program. Experiences relating to work performance were mainly determined by physical appearance of an infected person including weight gain or loss. The rate of absenteeism, which eventually affects organizational productivity, was used to indicate levels of individual sickness.

Participants expressed their feelings of disappointment and discouragement about the intervention program. This experience was associated with the behaviour of employees that were not taking full advantage of available services of the program. The other concern was that of resistance to change of behaviour by some infected individuals.

5.1.3 Intervention programs

The aim of this study was to determine whether intervention programs enhance work performance on HIV/AIDS infected persons. Qualitative designs were used to provide an opportunity for individuals to describe their direct experiences and analyze policy documents. The experiences provided a valid and reliable picture about the individuals' feelings on HIV/AIDS intervention programs. This makes it easy for individuals to identify with the reality of the disease (Chasi & de Wet &, 2002). Experiences are said to provide access to direct knowledge of subjects. Stones (1986), recommended that experiences of subjects be included in research as part of research data.

Intervention programs on HIV/AIDS infection in the workplace seem to play a big role in preventing the spread of the disease. The findings from the individuals' experiences

revealed benefits of these programs to the advantage of employers. Both the professional nurses and HIV/AIDS infected persons described experiences of reduced rates of absenteeism, illness and increased productivity.

Using the grounded theory, HIV/AIDS policy documents were analyzed. The aim of analyzing organizational policies was to try and answer the following questions:

- What policies are available to deal with HIV/AIDS in the workplace?
- How do organizations respond to HIV/AIDS?
- Do policies relate to the employee's work performance?

Although all organizations involved in the study had HIV/AIDS policies in place, the findings conclude that they need to come up with strategies to extend their intervention programs. To provide comprehensive intervention programs a holistic approach is necessary. The focus of most organizations was on prevention programs and this lacked details of strategies to sustain the programs for those who were already infected. The focus of other organizations was rather on the provision of antiretroviral treatment. It is however important that individuals use treatment in conjunction with other programs such as nutrition and wellness. HIV/AIDS intervention programs should involve a multi-sector team in order to provide a balanced program. Ante-retroviral treatment is said to be one form of intervention and therefore cannot be used independently of other programs (Jelly, 2003).

In dealing with employee performance there were no clear guidelines in relation to intervention programs. Emphasis was rather on potential benefits and management of disability should the employee be unfit for work. The focus of intervention programs was on preventing the spread of disease and looking after the infected employees in the workplace. The findings showed that some improvement in the work performance of HIV/AIDS infected employees occurred with exposure to intervention programs. Organizational policies based on collected data from documents provide a guideline on what strategies organizations had in place to deal with the issue of HIV/AIDS.

5.2. Recommendations

Based on the discussions and literature review the following recommendations came up:

- Further research to evaluate the effectiveness of intervention programs in the workplace
- An investigation to include experiences of uninfected employees
- A quantitative design to determine the difference in performance before and after intervention
- Developing therapeutic intervention programs based on experiences of HIV/AIDS infected persons

5.3. Limitations

Experiences from a phenomenological viewpoint make it difficult to generalize findings to a large population. This is one of the limitations of a phenomenological investigation.

Language has a limiting role in describing experiences. Although the researcher and HIV/AIDS infected employees were able to communicate in the same language, translating some of the descriptions could provide some flaws.

The other limitation in this study was that of being unable to obtain direct experiences of HIV/AIDS infected employees before involvement in intervention programs. As the research participants were already included in such programs, they had to describe their experiences before being involved in the program and after exposure to the program. The researcher acknowledges that it would have been of great value to collect data about these experiences at appropriate and relevant intervals.

REFERENCES

Acott,D. (2000). *The economic impact of AIDS in South Africa: a critique of the demographic methods used in the ING-Barings report of April 2000, and their implications.* [File://A:articleP4.htm](#)

Barker,P. (1998). *Basic Family Therapy (4th ed).* North America: Oxford University Press

Barks-Ruggles & others (2001). Conference Report: *The Economic Impact of HIV/AIDS in Southern Africa.* www.brookings.edu

Bernard, L.C.& Krupat E. (1993). *Health Psychology:Biopsychosocial Factors in Health and Illness.* United States of America: Harcourt Brace College Publishers

Chasi,C.T & de Wet, G. (2002). *Kierkegaardian Pointer on Communication for Prevention of HIV/AIDS.* AIDS and literature conference abstracts: <http://bwenglish.tripod.com>

Chasi, C.T & de Wet, G. (2002). *A Phenomenological Study for the HIV/AIDS Communication Dilemma.* AIDS and literature conference abstracts: <http://bwenglish.tripod.com>

Chetty, (2002). *Combating AIDS/HIV Spread In the Workplace:A Case Study Of The Durban Clothing Industry*. Master's Dissertation, University of Natal.

Dancaster, L and Jamieson, E. (1991). *AIDS Analysis Africa (Southern African Edition)*
1 (4)

Edwards, S.D. (2001). Phenomenology as intervention. *Indo-Pacific Journal of Phenomenology*, 2 p1-10

ETC Management seminar –Copyright (2003)

Evian, C. (1991). *Aids in the workplace in Southern Africa*. Halfway House:
Russel Friedman Books.

File://A:articleP4.htm. (2000). *Section One: The Macroeconomic Impact*

File://A:behaviourl approach.htm. *Intervention programs*

File://A:Prevention%20Intervention.htm. *HIV Prevention Toolbox: Intervention Strategies*

File://A:Social%20Learning%20Theory.htm. *HIV Prevention Toolbox: Social Learning Theory/Social Cognitive Theory*

File://A:Program development & evaluation home.htm. *Program Development and Evaluation*

File://A:Stigma and HIV/AIDS in Africa.htm). *Stigma and HIV/AIDS in Africa*

File://A:workplace.htm. *Workplace: Performance diagnostic*

Forsythe, S. (1999). Cost Effectiveness of HIV/AIDS Interventions: Why Don't Policy Makers Listen? *SAfAIDS News*. (17) 3

Greener, R. (1998). The impact of HIV/AIDS on companies in Botswana. *AIDS Analysis Africa (South Africa Edition)* (8) 6, p6-10.

Good Practice Note (2002). *HIV in the workplace*

Government Gazette (1998). December 11, 402 (19603)

http://aids.about.com/cs/aidsfactsheets/tp/hiv_myths.htm *HIV/AIDS: Top 10 HIV/AIDS Myths*

http://www.fortuneity.com/greenfield/grizzly_432_rra.htm. *Basics of Qualitative Research*

<http://www.ibe.unesco.org>. *Global Curriculum Bank for HIV/AIDS Preventive Education*

http://www.oshc.dde.gov.ph/sp_aids.htm

International Labour Organization (2002). ILO says HIV/AIDS impact on African development “underestimated”: Says shift needed now. *ILO News, July 11*.

Jelly, S. (2003). Why it pays to fight HIV/AIDS: Time and ignorance are the real enemies – risks associated with the disease can be managed. *Sunday Times Business Times, July 20 p.8*

Jordan, B (2002). Aids: it’s not just lives we want to save, but businesses. *Sunday Times Business Times, May 12, p.3*.

Keeton, C (2003). Finally, business faces up to HIV/AIDS reality. *Sunday Times Business Times, November 23 p.6*

Love life (2001). *Impending Catastrophe Revised: an update on the HIV/AIDS epidemic in South Africa*. Hendry J. Kaiser Family Foundation p.2

Leedy, P.D. (1997). *Practical Research: Planning and Design*. Ohio: Prentice-Hall

Mandela, N. (1997). AIDS: Facing up to the Global Threat - A text of an address to the World Economic Forum. *AIDS Analysis: Southern African Edition* 7(6)

Mason, B. (1995). AIDS Programs in the Workplace: a Case Study (Part 2). *AIDS Analysis Africa: Southern Africa Edition*. (5) 6

Mc Evoy, P. (2000). *Heightening awareness of HIV/AIDS in Caribbean region*.
St. Thomas: Satellite.

Midrand Graduate Institute (MGI) (2003). Responding to the growing need for counsellors. *City Press*, November 23

Mindel, A. & Miller, R. (1996). *AIDS: A pocket book of diagnosis and management* (2nd ed). London: Oxford University Press

Ogden, J. (1996). *Health Psychology: A textbook*. Philadelphia: Open University Press

Rodgers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-103.

Schlebusch, L. (1990a). (Ed.). *Clinical health psychology. A behavioural medicine perspective*. Johannesburg: Southern Book Publishers.

Schneiderman, N. (2001). Health psychology: psychological and behavioural aspects of chronic disease management. *Annual Review Psychology*: [www. findarticles.com](http://www.findarticles.com)

Seedat, M. ;Duncan, N. & Lazarus (2001). *Community Psychology: Theory, Method and Practice South African and Other Perspectives*. Cape Town: Oxford University Press

Small M. and Strode A.(1995). The challenge to the Industry: Developing a company AIDS policy. *The Thinking Person's AIDS Awareness Magazine: Positive Outlook 2 (3)*

Spinelli, E.(1989). *The Interpreted World. An introduction to phenomenological psychology*. London: Sage

Stones, C.R. (1986). Phenomenological praxis: A constructive alternative in research in psychology. *South African Journal of Psychology*, 16 p.117 – 121

Swindells, S. (2003). Myths blunt Africa's fight against AIDS. <http://www.alertnet.org/printable.htm>.

Vaille, R.S. and Hatting, S. (1989). *Existential-phenomenological perspectives in psychology: Phenomenological Research Methods*. New York: Plenum Press

Van Dyk, A (2001). *HIV/AIDS Care & Counselling: A mutidisciplinary approach (2nd ed)* Cape Town: CTP Book Printers

Van Niftrik, J. (1991). *The Pandemic and the Press. AIDS Analysis Africa (Southern African Edition)*. (1) 4

WHO (1992) *1991 Progress Report: Global Program on AIDS*. Geneva: WHO

www.avert.org/origins.htm. *The Origin of AIDS & HIV, and the First Cases of AIDS*

www.avert.org/safricastats.htm. *HIV and AIDS Statistics for South Africa*

www.caps.ucsf.edu/theoryrev.html. *What is the role of theory in HIV prevention*. Center for AIDS Prevention Studies: AIDS Research Institute

www.cogsci.princeton.edu/cgi-bin/webwn. *Current events*. Princeton University

www.hivaids.co.za. *The Impact of HIV AIDS on Productivity in South Africa: AIDS is no longer a disease that happens to somebody else*

www.indiana.edu/~aids (1995) Rural Center for AIDS/STD Prevention Banner. *Behaviour Change Models For Reducing HIV/STD Risk*. Fact Sheet: No.3

www.kenyaweb.com. *Impact of HIV AIDS: Aids Awareness*

www.kzn-deat.govt.za_econ/indicators.html. *KWAZULU-NATAL Dept of Economic Development and Tourism: Overview of KZN Economy*

www.worldbank.org. *HIV/AIDS*

APPENDIX A

Dear Sir/madam,

Permission to conduct research

Permission is here requested to conduct research in your company. The study is on **development and evaluation of intervention programs for HIV/AIDS infected persons in the workplace**. Information requested would be about the experience with the program from two categories of employees' i.e. the professional nurse involved in the program and that of the infected employees. The purpose of this study is:

- To determine the effectiveness of intervention programs in relation to performance
- To identify gaps in existing programs with the aim of improvement
- To encourage other employees' involvement in the program

The research would benefit the company by helping develop these intervention programs with the purpose of improving employees' performance.

Thanking you in advance.

Yours sincerely,

T. Ntuli (Intern psychologist)

University of Zululand

APPENDIX B

Questions to HIV/AIDS infected employees:

1. Uzizwa unjani lokho waqala kolu hlelo losizo nokuvikela isandulela kanye nesifo sengculazi?

1.1 Ngabe luvusizo kangakanani lolu hlelo?

.....
.....

1.2 Lukhona yini ushintsho ekusebenzeni kwakho lokho wangena ohlelweni?

.....
.....

APPENDIX B

Questions to HIV/AIDS infected employees (English version):

1. What is your experience of being involved in the HIV/AIDS intervention program?

1.1 What is the effect of this program?

.....
.....

1.2 Has there been any change in performance at work?

.....
.....

APPENDIX C

Questions to professional nurses:

2. What is your experience of being involved in the HIV/AIDS
intervention program?

2.1 What is the effect of this program on performance of infected employees?

.....
.....

2.2 Has there been any change in work performance?

.....
.....

APPENDIX D

Questions to analyze organizational policies:

1. Does the organization have an HIV/AIDS policy?

.....
.....

2. What intervention programs does the company have in place?

.....
.....

3. Does the policy relate to employees' work performance?

.....
.....