GLOSSARY

HIV	Human Immune Virus
AIDS	Acquired Immune Deficiency Syndrome
CD4	A glycoprotein expressed on the surface of T helper cells
KAP	Knowledge, Attitude and Practice
EAP	Employee Assistance Programme
SABCOHA	South African Business Coalition on HIV and AIDS
GBC	Global Business Coalition on HIV and AIDS
HEARD	Health Economics and HIV and AIDS Research Division
VCT	Voluntary Counselling and Testing
SMME	Small Medium and Micro Enterprises

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CHAPTER 1

GENERAL ORIENTATION

1.1 INTRODUCTION

Counselling has become a symbol of an organisation that is taking care of its employee's health. An organisation offering counselling gains trust and knowledge among its employees and enhances creativity (Summerfield & Van Oudtshoorn, 1995). The Employee Assistance Programme (EAP) is a commonly accepted programme that provides counselling for employees and their families. It is based on a set of core skills and it has evolved partly from Occupational Social Work (OSW). Occupational social work is a specialised field of the social work profession. Its principles and background are inherent to generic social work. In some instances EAPs and OSW are used interchangeable in the workplace (Gilbert, 2005:11; Michael, Barak & Bargal, 2000; Kurzman, 1993). Some of the problems handled through EAPs include management of HIV and AIDS and support to infected and affected employees through psychological assistance. Of the employees receiving assistance is working women, who may either be infected or are caregivers.

1.1.1 The Role of EAP

EAPs in South Africa (SA) can be traced back to the early 1980s (Maiden, 1992: 2). Although EAPs is still a young field in South Africa, it has gained popularity to the extent that it has reached a degree of sophistication. According to Maiden (1992), EAPs in South Africa are generally staffed by professionals such as social workers, psychologists, nurses, medical officers, and labour-relation personnel. There are also an observable number of HIV and AIDS counsellors who are identifying with EAP counselling due to their roles in addressing the scourge of HIV and AIDS in the workplace. The range of problems that is presented to EAPs is often unique and diverse, unlike more traditional social work settings, where problems could be routine and predictable.

EAP practitioners never know what to expect, problems range from mental and emotional conditions with severe psychopathology and organisational stress, such as, absenteeism related to adverse conditions emanating from the employee's environment and poor performance (Berridge, Cary, Cooper & Highley-Marchington, 1997).

One of the major day-to-day problems addressed by EAP practitioners in South Africa, is Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). Unlike in the United States, where alcohol abuse in the workplace contributed to the development of EAPs, it would seem that in South Africa, EAP practitioners deal mostly with HIV and AIDS in the workplace.

1.1.2 HIV and AIDS

The global pandemic of HIV and AIDS is rapidly becoming the worst infectious-disease catastrophe in recorded history (Rosen, Vincent, Macleod, Fox, Thea, & Simon, 2004:317). HIV has different phases, namely, the asymptomatic phase, where symptoms of HIV are not visible and the symptomatic phase where the HIV symptoms are visible. It was projected that by 2008 in South Africa, 27% of the workforce will be AIDS ill (*Business Day Survey*…, 2001). HIV is the virus that breaks down the immune system within human bodies. This virus causes the condition known as Acquired Immune Deficiency Syndrome (AIDS), which is known as a collection of many infections in the body as a result of a weakened immune system caused by HIV (Crewe & Orkin, 1992:3).

The natural life cycle of AIDS begins when the individual is initially exposed to the virus. Not all exposed individuals will become infected; those that do acquire the virus seroconvert, meaning that they begin to produce antibodies specific to HIV that can be detected by laboratory tests. At this point, the virus begins to replicate, and flu-like symptoms may ensue approximately 2 weeks later (CDC, 2001). This illness is typically mild and self-limited, lasting only a week or two, but the virus continues to reproduce and accumulate within the host. The immune system begins rapidly producing greater

numbers of T-cells in order to maintain a steady state, and ultimately the virus is brought under limited control.

The virus is never eliminated, nor does it enter a latent state. It replicates at a 'set point' that is dictated by the initial immune response. This set point may determine the length of time the individual remains clinically asymptomatic. However, ultimately if the immunological response fails to match the infection's virulence, greater numbers of HIV particles accumulate, and the number of viable T-cells becomes diminished. Patients begin to experience symptoms and develop multiple ailments, including infections, metabolic complications, cancers, etc. (CDC, 2001).

Generally, HIV and AIDS are used interchangeably to mean the AIDS pandemic, however it has become common practice recently to emphasise the difference between the two conceptually. In this research HIV and AIDS are conceptually different. HIV is considered to be a virus and AIDS is the associated syndrome.

The HIV and AIDS pandemic has become a serious health and developmental problem in many countries around the world. The present scale of AIDS outstrips the worst case scenarios forecast by the UNAIDS a decade ago. Life expectancy in the world is estimated to be 49 years for males and 53 years for females (Dorrington, Johnson, Bradshaw & Daniel, 2006:1). The global overview of people living with HIV and AIDS in 2007 was estimated at 33,2 million and women living with HIV were estimated at 15,4 million (UNAIDS, 2007:1). According to UNAIDS, the estimates indicate a reduction of 16% compared to the estimate published in 2006 which was 39,5 million (UNAIDS/WHO, 2006).

There are arguments and assumptions regarding these estimates; as other reporters indicate that the reduction could be as a result of refined mathematical methodologies rather than pandemic trends (UNAIDS update, 2007), while others still maintain it is due to earlier estimates of incidences, prevalence, and mortality reports (UNAIDS/WHO, 2007). On the other hand, projections suggest that antiretroviral (ART) treatment could

have a significant impact on reducing the number of AIDS deaths per year (Dorrington *et al.,* 2006:1).

AIDS remains the leading cause of high mortality in Sub-Saharan Africa. Out of the 2,5 million estimated new infections in 2007, two thirds (68%) were reported to have occurred in Sub-Saharan Africa. There are currently an estimated 22,5 million people living with HIV in Sub-Sahara compared to the 20,9 million estimated in 2001. According to an UNAIDS update, it is reported that even if the prevalence is alarming in the Sub-Sahara region, the prevalence has declined from 5,8% to 5,0% (UNAIDS, 2007:8).

South Africa is the country with the largest number of HIV infections in the world. According to the Department of Health South Africa (2007) the prevalence of HIV among pregnant women has decreased by 1% from 30% to 29% in 2005 and 2006 respectively. It is important to note that the ratio of women to men remains stable globally, with women being mostly infected. South Africa is not an exception in this regard. There was an estimated 15,4 million women living with HIV in 2007 compared to the estimated 13,4 million in 2001 (UNAIDS 2007:8). This indicates that the decline of the infection rate is significant. In Sub-Saharan Africa, almost 61% of adults living with HIV in 2007 were women.

The Actuaries Society of South Africa estimates a current prevalence rate of 29,5% among people between the ages of 20 and 65 years – the most economically productive age bracket; many productive years and much investment in education and training will be lost due to HIV and AIDS absenteeism and deaths (ASSA, 2006). These deaths also have significant family consequences since most people in this age group are raising children, and assumed to be women and breadwinners.

The power imbalances between women and men in interpersonal relations contribute to this growing pandemic. According to the study done by the US Agency for International Development in 2001, the highest infection levels for women were in the 20 to 24 age group and the overall prevalence for women was marked higher than for men in the

same age bracket (Stover & Bollinger, 2001:10). In South Africa, it is reported that the prevalence for women is higher than that for men in the 15 to 34 age band while it is higher for men of older than 45 years (Dorrington *et al.*, 2006:ii). Among women, the rate is higher (at 32,5%) for the age group 25 to 29 years. Among men, the rate is reported to peak at slightly older ages, with 26,5% of those ages 30 to 34 years estimated to be infected (ASSA, 2006:9). According to the ASSA AIDS Committee (2006), the comparison between the ASSA model and the HSRC household prevalence survey, the modelled prevalence may be overestimated in the 25 to 29 age group for men and too low for women 55 and older (ASSA, 2006:9).

A study compiled by the Human Sciences Research Council (HSRC) and commissioned by the Safety and Security Sector Education and Training Authority on the impact and responses to HIV and AIDS in the private security and legal services industry in South Africa, has found that HIV prevalence in the private security industry is 15,9% and in the legal services industry 13,8%. Research was conducted among 2 787 participants from private security services in Gauteng, the Western Cape and KwaZulu-Natal, who agreed to be interviewed and of those, 2 224 agreed to an HIV test. In addition, 421 participants from the legal services sector, including lawyers, legal secretaries and clerks agreed to be interviewed and 341 also agreed to be tested for HIV. The study found HIV prevalence among men to be 17,3% compared to 12,3% among women In the security sector, while in the legal services sector HIV prevalence was slightly higher among women than men (14,4% *versus* 12,4%). The prevalence of women and men will always differ from one particular sector to another. For example in the security sector the nature of the work is such that it employs more men than women.

There has been a significant acknowledgement of the imbalance between women and men. All these challenges have a strong relationship with HIV and AIDS and its impact on women and gender relations. Due to the imbalances in the needs and experiences of South African women, the national Gender Policy Framework has developed an executive summary which highlights some of the key challenges as: violence against women, access to employment, economic empowerment, access to basic needs,

poverty and globalisation (Kornegay, 2002: ii). In addition to the reports, South African legislation through the Employment Equity Act is the only act that expressly refers to HIV and AIDS and protects employees against unfair discrimination on the basis of HIV status (Clause 5.3.1, Act No.54 (1)(a) of 1998).

Due to the Employment Equity (EE) legislation, most companies have made efforts to implement HIV and AIDS programmes in the workplace. The majority have HIV and AIDS programmes but still do not have a strategy that is focusing on the vulnerability of women in their prevention strategy. Therefore, it is important that innovative intervention strategies be devised to effectively address these problems that have a causal link to HIV and AIDS. Stroke (1994:121) hypothesises that the relationship between organisations and employees are and should be like a parent-child relationship where there is an inherent interdependent relationship. If this is true, working women who are HIV infected and AIDS affected should be able to feel a positive relationship within their place of work and experience support through the EAP.

1.2 MOTIVATION

AIDS has the potential to create severe economic impacts in many African countries and the world. It is different from most other diseases because the person does not become ill immediately and the AIDS pandemic strikes the most productive age group and it is fatal if left untreated.

The socio-political history in South Africa dictates a very radical, sensitive, and comprehensive EAP programme that will, according to Du Plessis (1992:29), look beyond a one-to-one clinical approach and acknowledge a history that has affected employees as families and community members. This background continues to impact on the prevention, awareness and education programmes that are initiated. Employees bring a diverse number of situational problems to the EAP; problems which affect them at home and in society (Kurzman, 1993). Socio- economic factors such as poverty, geographical relocation, and a lack of paternal support have been identified as potential

contributors to poor follow-up of treatment in a study conducted at Coronation Women and Children's PMTCT programme (Jones, Sherman & Varga, 2005). The same study identified that 57% of mothers were unemployed, 25% of fathers did not support their children and only 58% of the children remained resident in Johannesburg at the 12 month visit.

This study was first initiated as a result of the researcher's clinical interaction with employees at several companies in South Africa through an EAP service provider operating in Southern Africa, which has since then changed its name to Careways Group. The companies included, but were not limited to Coca Cola, Toyota and Makro. The researcher's encounters with employees highlighted the harsh realities of the HIV and AIDS pandemic, particularly as experienced by women from gender, socio-political and economic perspectives. Poverty, gender inequality and displacement as a result of conflict or natural disasters are all examples of social and economical factors that can enhance women's vulnerability to HIV infection. Secondly, the study was inspired by the two women who were living with HIV and were courageously in the forefront of HIV management in South Africa. These two women had been asked to assist in the development of an HIV policy and HIV awareness training in the company that the researcher was employed at in 2002. The two women helped with the problem formulation as they voluntarily highlighted the harsh realities of the impact of HIV among working women.

From a gender perspective, although both men and women are vulnerable to infection and disease, the impact of HIV and AIDS affects the two sexes differently, leaving women more prone to infection than men. To understand the gender perspective, one has to consider human behaviour as well as biological make up. Human behaviour is shaped by learnt behaviour and socialisation. Women tend to be socialised differently than men this influences their perception of themselves. From the perspective of biological make up, women are more vulnerable to HIV infection than men during unprotected sexual intercourse, their biological gender disposition, larger surface areas are exposed to contact and the vulnerability of mucous membranes which may get

damaged or broken (Kirby, 1999). In addition, women seem to be vulnerable to other Sexual Transmitted Infections (STIs), the presence of which greatly enhances the risk of HIV infection. STIs that bring on recognisable symptoms in men often are asymptomatic in women and therefore remain untreated (UNAIDS, 2000). It has been noted that in a mature epidemic, more women will be infected with an expected ratio of 1,2 to 1,3 infected women per man (Stover & Bollinger, 1999:6).

Some women never know that they are infected until they seek prenatal care during pregnancy. According to the Sentinel Surveillance System the prevalence among pregnant women in South Africa is 29,5%. The Sentinel Surveillance System has been able to provide data for estimating the extent of infection. The system operates in both urban and rural settings, which provide sites at antenatal clinics, where women are tested during pregnancy. Without this, it would have been very difficult to predict the extent of the infection among women (Department of Health, 2007).

The socio-political perspective is often influenced by economic and cultural factors. Poverty is one of the key factors that continue to hamper treatment and management of HIV and AIDS. South Africa has one of the world's highest incidences of murder and rape, with health activists suggesting that violent sexual crimes hamper efforts to combat the country's global third worst position for HIV positive infection. The majority of people who have limited access to treatment and services are the poor and women and women have a responsibility to care for those infected by HIV. For a long time, the debate regarding management of HIV and AIDS in South Africa has been largely influenced by the difference of opinion of politicians regarding the cause of HIV and AIDS. Employment equity measures are just few of the steps that will empower South Africans to have access to various treatment options. According to the Business Report (2008:12), Trevor Manual, the Minister of Finance, promised billions of rand in the Budget for 2008 to help curb a rampant HIV and AIDS pandemic, reduce poverty, and fight crime.

From an economical perspective, the effects of AIDS will be felt first by individuals and their families, then ripple outwards to businesses and the macro economy. The household earning impact begins as soon as a member of the household starts to suffer from HIV-related illnesses. The challenge of using one's disposable income to meet basic needs and healthcare comes to the fore. The challenge remains that the most important step for a business, in response to HIV and AIDS, is to get started on an HIV and AIDS programme. It is imperative that businesses take immediate action to lessen the economic and social consequences of HIV and AIDS both from the employer-employee responsibility perspective to the business risk mitigation perspective. EAPs in South Africa are well positioned to assist companies in implementing HIV and AIDS programmes, with guidance in terms of actions and best practices, especially because the EAP is the first stop for troubled employees.

This study is to a large extent informed by the uniqueness of South African trends of EAPs, the opportunity that the problems experienced by employees with HIV and AIDS pose to research and the business responses to the HIV and AIDS crisis in the workplace.

1.3 PROBLEM FORMULATION

Twenty years have passed since the isolation of HIV, the virus responsible for AIDS. Millions have been spent throughout the world on public education, and awareness, but despite this growing awareness, many South Africans are still confused and some still believe that AIDS does not exist. HIV and AIDS has become a political debate, which is affecting service delivery. According to Stover and Bollinger (1999:5), there is an estimated backlog of million housing units to be provided by the government and the planning process for the government in providing this housing is made more complicated, and thus more lengthy, through the impact of HIV and AIDS.

The adults who should reach their 40s and 50s are now in their 20s and 30s, and although some have already died, many more are already infected with HIV, which will then kill them before they reach their 50s (UNAIDS, 2000:50). Women are generally

known to be caregivers. It is predicted that a small number of young adults and women, the group that has traditionally provided care for both children and elderly will have to support large numbers of young and old people (SAP, 2003).

Care of the sick continues to be a responsibility of women within the family and due to lack of education especially when caring for the infected, women are more at risk. There is an assumption that women generally lack complete control over their lives and are taught from early childhood to be obedient and submissive to males. Whatever the exact dynamics, young women attain highest HIV infection levels at notably younger ages than young men. Violence against women is still the number one problem in South Africa. The high incidence of rape and girl-child sexual abuse is found to be contributing to the high rate of HIV infection among women. A survey conducted by the Department of Health in 2002 found that HIV and AIDS was most prevalent in women in the 20 – 24 age group, particularly among African women (National Gender Policy Framework, 2002:13).

The annual survey of women attending antenatal clinics by the Department of Health provides the most representative and reliable set of data concerning the HIV epidemic in South Africa. Almost one in three pregnant women attending public antenatal clinics were living with HIV in 2004 and trends over time show a gradual increase in HIV prevalence; however in 2006 trends have shown a decline in the women attending the antenatal clinics (UNAIDS, 2007). The majority of the women attending public sector antenatal clinics are black women; the survey results provide good coverage of pregnant black women. Unfortunately, the white, coloured and Asian population groups, as well as the wealthier part of the black population group, are underrepresented in this survey, as they tend to attend private clinics. The latest antenatal clinic survey (Department of Health 2007) revealed that 29,5% of women attending public sector antenatal clinics were infected with HIV by late 2007.

The ASSA 2002 model estimates suggest that ±19% of adults between the ages of 20 and 64 are currently infected with HIV. For the total population, the Actuarial Society of South Africa (ASSA) 2002 model estimates that roughly 11% or 5,08 million South Africans are HIV positive. The statistics is similar to the Statistics South Africa estimates, which is 10%. (Statistics *SA*…, 2005). Prof. Dorrington warns, "by 2010, despite interventions and treatments, we estimate that nearly 3,5 million South Africans will have died of HIV and AIDS related causes". (ASSA, 2006)

Companies in South Africa are finding ways to implement HIV and AIDS programmes. The term 'best practice for business' is still not well-defined. The SABS has developed standards as general guidelines to assist, encourage, and support organisations to implement minimum standards for an HIV and AIDS management system. The general requirements include processes of best practice, monitoring and evaluation standards, and resource management such as competence and training (SANS 16001:2007). Most approaches highlight programmes with comprehensive and integrated HIV and AIDS programmes in the workplace with maximised productivity and care for the infected. Despite the employment equity requirement, most companies still turn a blind eye to women issues especially in relation to HIV and AIDS.

The problem which contributed to the candidate's decision to undertake a study of this nature was primarily borne from the researcher's personal experiences in the service delivery of EAP to working women infected with HIV and AIDS or affected by AIDS and the reluctance of companies and medical aids in the 80s to provide unlimited health cover for infected employees. The problem can be summarized by a lack of scientifically obtained data on:

- The extent and nature of problems experienced by South African working women, resulting from being infected and/or affected by HIV and AIDS; and
- The role of the employee assistance practitioner in dealing with those working women infected and/or affected by HIV and AIDS – which may result in ineffective services provided to the identified target group with resulting negative consequences on their productivity and social functioning.

1.4 GOALS AND OBJECTIVES

1.4.1 Goals

The purpose of the research was to undertake an exploratory study and to examine the role of EAPs in addressing the problems experienced by working women who are infected or affected by HIV and AIDS in South Africa.

The goal of this study was to explore and describe the role of EAPs in addressing the difficulties experienced by working women, resulting from the impact of HIV and AIDS.

1.4.2 Objectives

The goal was further detailed into objectives, as listed below:

- To investigate the feelings and perceptions of HIV infected and affected working women in their working environment.
- To establish women's perceptions of the role of EAP regarding their situation.
- To investigate the type of HIV and AIDS counselling offered by EAP practitioners.
- To recommend intervention strategies for the workplace relevant to vulnerable women who are affected by HIV and AIDS.

1.5 RESEARCH QUESTION

It is the opinion of Brown (1981:35) that the orientation of the researcher's topic for social work research should come from day-to-day activities and interaction in the work situation. The problem that was investigated has been selected from the researcher's work experience as indicated above as part of the problem formulation.

What is the role of EAPs in addressing the difficulties experienced by working women in South Africa resulting from the impact of HIV and AIDS?

The research sub-questions to be addressed in this study were:

- What role, if any, does EAP play in supporting HIV infected and affected women in the workplace?
- What is the perceived role of EAP in supporting HIV infected and affected women?
- What is the perceived role of HIV infected women with regard to the effectiveness of EAP for HIV and AIDS in the work place?
- What are the difficulties of running a functional EAP service in the context of HIV and AIDS?
- What are the feelings of HIV and AIDS infected and affected women in their workplace?

In answering these questions listed above, the assumption remains that the EAP's response to infected and affected employees can determine negative or positive performance by employees.

1.6 RESEARCH APPROACH

This study was divided into two parts: a qualitative and a quantitative study. The research approaches to each section of the study are described hereafter.

Qualitative research data sometimes consists of verbal descriptions that answer questions about the phenomenon. Denzin and Lincoln, (1994: 2) define this research method as a multi-perspective approach (meaning utilising different qualitative and quantitative techniques for data collection) to social interaction aimed at describing, interpreting or reconstructing the interactions in terms of the meanings that the subjects attach to it. De Vos (1998:15) adds that a qualitative approach deals with the data that are empirically verbal, and a quantitative approach deals with data that is principally numerical. A theoretical framework for the qualitative study was developed from a literature review. Within the qualitative study a triangulation approach was applied for analysis of the data in order to enhance the quality of results through such cross verification.

From a qualitative point of view the research strategy enabled the researcher to investigate the dynamic process of drawing parallels between support offered by EAP practitioners and the difficulties experienced by HIV and AIDS infected and affected working women in their various workplaces in South Africa. De Vos (1998:358) claims that qualitative research seeks to understand phenomena and to gain in-depth information. A qualitative semi-structured interview schedule was conducted with infected and affected working women, being participants in the EAPs.

Quantitative research served to quantify information to support the respondent's descriptions. A questionnaire was administered to South African EAP practitioners. See paragraph one of page 26 for a detailed description of the sample. The data from the questionnaires complemented the semi-structured interviews with HIV and AIDS infected and affected working women.

According to De Vos (2005:362) 'triangulation' is used to designate a conscious combination of quantitative and qualitative methodology. In the context of this study, triangulation was used to refer to the use of different research methods that were used both for data gathering and analysis. For example, whereas questionnaires were used and interviews were conducted for data collection methods, data derived from both research instruments were triangulated in the analysis. Data triangulation means the use of more than one data source (De Vos, Strydom, Fouché & Delport, 2005:362).

1.7 TYPE OF RESEARCH

This study used applied research to contribute to the development of solutions for the problems experienced in EAP and HIV and AIDS counselling in the workplace. Rothery and Thomlison (in De Vos, 1998:8) define the goal of applied research as to develop solutions for problems and applications in practice. The expectation therefore, was that this research will add to the body of knowledge in respect of EAP practice and social work profession, which will be used to develop solutions to the problems related to HIV and AIDS. De Vos *et al.* (2005:41) expands applied research to mean professional

research. In this regards the paradigm is referring to the building scientific foundation for caring professions, which is the goal of this research.

The expected spin-off of this study was that the understanding and perceptions of working women regarding the role of EAP related to HIV and AIDS in the workplace will assist businesses to design and develop HIV and AIDS strategies which will help businesses to take immediate action to lessen the economic and social consequences of HIV and AIDS experienced by women in the workplace. According to the South African Employment Equity Act (no.55 of 1988), no person may unfairly discriminate, directly or indirectly, against an employee in any employment policy or practice, on one or more grounds of HIV status or their family responsibilities. The other spin-off is that women who would participate in this research would indirectly be reminded of their rights in terms of the Employment Equity Act.

1.8 RESEARCH DESIGN

According to Bloom (1982:10), a research design can be understood as the planning of any scientific research from the first to the last step. It is a blueprint or detailed plan for how a research study is to be conducted, a set of plans from which a researcher can select for the specific goals (De Vos *et al.*, 2005:82). Therefore the aim in research design is to align the research objectives with the practical considerations of the research process (Mouton, 1996:32). The purpose of exploratory research is to gain insight into a situation, phenomenon, community, or person (De Vos *et al.*, 2005:137). The need for such a study could arise out of a lack of basic information on a new area of interest.

Phenomenology design was used in this study. According to De Vos *et al.* (2005:270) the phenomenology design involves an approach which aims to understand and interpret the meaning that the subjects give to their everyday lives. HIV and AIDS can be described as a social problem that requires the researcher to enter into the subject's world, by conducting long interviews and making observations. Given the fact that the

researcher's aim was to explore, interpret and give a detailed description to the subject's experiences, it was therefore important to use interviews for the qualitative part of the study and questionnaire for quantitative part of the study. The phenomenological study through interviews and questionnaires have both assisted the researcher to build a base of theories that could further be validated in the future. This design further allowed the researcher to systematically collect data, which gave meaning, themes and general descriptions of the experience by the subjects.

1.9 RESEARCH PROCEDURE AND STRATEGY

1.9.1 Data Collection

Data was collected by conducting semi-structured interviews with 10-12 HIV infected working women (**Appendix 1**). This is complemented by conducting semi-structured interviews with 10-12 affected working women, currently involved in the EAP within various workplaces. In addition, quantitative data was collected through a questionnaire (**Appendix 2**) from EAP practitioners who were rendering EAP services in their workplaces. See section 1.11.2 for sampling. The EAP practitioners in this instance were case managers, EAP coordinators and EAP counsellors who are offering counselling to employees. With regard to the EAP practitioners, the focus was on their experiences and their perceptions about HIV and AIDS, the kinds of problems they deal with and the kinds of intervention strategies they have used in relation to HIV and AIDS counselling. The questions were fixed wording and in sequence of presentation as well as explanation was provided to give guidance on how to answer each question.

For the semi-structured interviews, the researcher targeted the questions at surveying the subjects' (infected and affected working women) experiences and perceptions of their conditions and the EAP services provided, the frequency of their utilisation of the service, their response to the quality of service received and their sense of how the service could be improved. According to Greeff (2002:306), an interview is a purposive discussion of a specific topic that highlights experiences and perceptions in a non-threatening environment.

Before collecting the data, the researcher wrote letters to various identified forums, such as EAPA SA, Uthingo Management (PTY) LTD and the Tsa Botsogo Centre, to introduce the study and obtain permission to do the study. During this time, the researcher also made contact with EAP practitioners during the regional monthly EAPA branch meetings. It was during this time that the researcher made protocol visits to some EAP sites and met with practitioners who linked the researcher with infected and affected working women identified for purposes of participation. The researcher worked with the EAP practitioners in order to conduct enumeration and sampling of key participants. Practitioners facilitated an initial meeting with all potential research subjects without identifying them to the researcher. The EAP practitioners only gave details of the identified women after the women displayed comfort in participating in the study. The researcher and the two research assistants then met with the women one by one to outline the research process and to arrange the semi-structured interviews.

The semi-structured interviews included questions with open- and closed questions. The semi-structured interview was based on an established schedule with fixed questions and themes that were important to the researcher (De Vos, 1998:298). The researcher and the research assistants ensured that all questions were answered, even though the questions did not necessarily follow the same sequence.

The researcher used research assistants that had basic HIV experience. One worked as a volunteer for an HIV training organisation and obtained a Social Work degree while the other one was an HIV peer educator at her work place and has since started her own HIV and AIDS training company in Botswana. The two research assistants were able to speak most of the South African Languages. To avoid bias, the participants were afforded the choice to express themselves in their mother tongue but they indicated comfort in answering the questions in English. The interviews for those who consented to tape recordings were recorded and notes were taken during the sessions.

1.9.2 Data Analysis

In analysing the data, the researcher understood that this was an ongoing process of examining information as it become available. Analysis should seek to identify similarities and differences. In this regard the strategy through interviews identified major themes that emerged form discussion and observations. The analysis technique was primarily text analysis. The researcher firstly went through all the transcripts to get the sense of the responses as a whole. The identified themes were put into major categories while noting subcategories within major categories. Similarities were identified and grouped. An independent coder who had experience in qualitative research was identified and asked to do open coding. Consensus was reached between the independent coder and researcher regarding the themes and categories which were included in this study.

Drawing from the HIV and AIDS strategies, as they are used in EAP, the researcher analysed the nature of the problems that respondents indicated they brought to the EAP, their perceptions of the service they received against the inputs of EAP practitioners in terms of what kinds of cases were brought to them and the kinds of intervention strategies the EAP practitioners used. On the basis of this, the researcher then was able to make recommendations on how the HIV and AIDS strategies in EAPs could be improved by drawing on participants' experiences. These recommendations are discussed later in the study.

Descriptive statistics for the structured questionnaires included graphs, tables and charts. The quantitative data was calculated manually through a computer-based programme, Microsoft Excel.

Data sources, which are indicated in the literature review of this research were compared to data from questionnaires and interviews and finally triangulated. According to Duffy (1993:143), theoretical triangulation involves the use of several frames of references or perspectives in the analysis of the same set of data, whilst methodological triangulation is the use of two data collection procedures within a single study.

1.10 PILOT STUDY

Since the research was at first at a generation level, its major aim was to pioneer a bottom line understanding of the core issues about this subject. Its focus therefore was descriptive and explorative in nature. Its results will contribute to a body of knowledge from which future research can be generated. Such research may be at post-doctoral level or conducted by other researchers in the field. A pilot test was conducted to test the data collection instruments for the two components of the study.

1.10.1 Pilot Test Of Questionnaire

After the approval of the structured interview schedule by the ethical committee, permission granted by all parties, i.e. Uthingo Management, Tsa Botsogo and EAPA SA, the researcher commenced with pilot testing of both the questionnaire with EAP practitioners and semi-structured interviews with infected and affected working women. Both the questionnaire and semi-structured interview schedule were self-developed and conducted in English. The interview was piloted with one infected woman at Uthingo Management (Pty) Ltd where the researcher was employed during 2002 to 2004 and one affected woman at Tsa Botsogo Centre. The two women did not form part of the overall study. A pilot study investigates the accuracy and appropriateness of any instrument that has been developed (Bless & Higson-Smith 1995:50). The pilot study measured whether the instrument reflected the real meaning of the concept that was under consideration. The pilot study was conducted to test reliability and whether the interviews would yield the same results each time. No problems were identified with the questions.

The questionnaires with EAP practitioners were tested among six registered EAPA members of the Egoli branch and were therefore excluded from the overall study. The researcher was a member of the Egoli branch and this testing site was chosen due to its accessibility. Testing the pilot questionnaires provided characteristics similar to those targeted group of respondents, namely case managers, EAP coordinators and EAP practitioners. A pilot test in this case assisted to minimise problems before the study was

conducted and allowed reformulation and redesigning of the questionnaire, which included spelling correction of ADS to AIDS; no changes were made to the content of the questionnaires. In addition, the consent form was changed to expand the study region to South Africa, instead of only Gauteng.

1.10.2 Literature Study

The literature study includes reviews of selected national and international literature on EAPs and HIV and AIDS in different contexts. Literature on EAPs is very rare; as a result the researcher relied on some of the outdated information, particularly the background on EAPs from United States of America where EAPs were primarily founded. The literature review has been an indispensable component of this proposal. It has familiarised the researcher with two research studies, which have already been done in this field, as well as with current research. In addition, the literature reviewed assisted in demarcating the boundaries of the research themes.

The literature review further provided information on the development of EAPs, current trends in EAPs in South Africa, and workplace initiatives regarding HIV and AIDS. Literature on community initiatives in other African countries gave insight when the researcher was formulating strategies that are culture-sensitive in relation to the South African scenarios. EAP improvement literature is vast and varied and as this study was concerned with explorative processes, the research focused on literature with regard to the causes of HIV and AIDS and understanding of current behaviour change strategies. Literature on women and gender was helpful in particular to determine the influence of gender to HIV and AIDS.

According to Bless and Higson-Smith (1995:23), the purpose of a literature review is to sharpen and deepen the theoretical framework of the research and to identify gaps in knowledge. The literature review in this study served to familiarise the researcher and other professionals with the latest developments in EAPs, HIV and AIDS.

The researcher used published reports, periodicals, unpublished theses, articles, journals, books, the Internet, presented seminar and conference papers and consultations with other experts in the field to provide a basis for a good literature review.

1.10.3 Consultation With Experts

1. Dr. Renate Volpe, Ph.D. – Chief Executive Officer of Leadership Culture Innovation. She is a specialist in culture change, leadership development and training. Dr. Volpe had shared her experience in the area of EAPs and current developments in the area of HIV and AIDS in South Africa. She assisted the researcher in shaping the questions regarding the strategic and leadership section in the quantitative research.

2. Mrs. Shirley Kenyon-Thompson, BA (SS), consultant to individuals, families and organisations and also a former lecturer at Wits University. Mrs. Kenyon-Thompson has assisted with the definition and theoretical background of an EAP. She had given ongoing input regarding EAPs as a consultant and an educator in the South African context. Her experience is in the field of occupational social work. Mrs. Kenyon-Thompson argues that there is a great difference between occupational social work and an EAP. An EAP's emphasis is on a clinical approach, while occupational social work is on all general employee problems. She also emphasised that occupational social work is a speciality and needs to be enhanced, while EAPs can be offered by anyone, including recovering alcoholics who were key role players in founding EAPs. She has maintained that an EAP cannot be professionalised.

3. Mrs. Glenda Noemdoe, MBA, former Director of The Careways Group provided input regarding organisational trends in the growth of EAPs and HIV and AIDS in South Africa. Mrs. Noemdoe has presented papers at national level in the field of EAPs and HIV and AIDS. Mrs Noemdoe believes that EAPs can play a very strategic position in shaping the companies' visions.

Dr Mokoena agrees with Mrs Noemdoe, he further maintains that the EAP professionals are doing little to position themselves in risk management and strategic decision-making of the current corporate SA, a role they must embrace. Dr Mokoena heads the Employee Wellbeing department in one of the South African public sectors.

1.10.4 Feasibility Of The Study

There is limited literature on EAPs available in South Africa. On the other hand, according to the recent survey by a South African auditing firm, the majority of South African companies are largely apathetic about the impending HIV and AIDS crisis (SAP, 2003:1). In view of this background, the researcher received cooperation from the EAPA SA, EAP practitioners, Tsa Botsogo and Uthingo to conduct research among their members and employees.

The under-explored field of EAPs in South Africa provided this study an opportunity to contribute towards the creation of new knowledge in this field. The researcher's ongoing contact with all the EAP providers in her professional capacity, and the EAP practitioners through the EAP Association, proved to have been the greatest strength of the study and made the practitioners accessible, as the researcher was able to give presentations about the study at various forums before distributing the questionnaires. Equally so, access to HIV infected and affected women was easy, as the majority of the respondents had disclosed their status within the various SA forums such as SABCOHA and the University of Pretoria monthly AIDS forum which the researcher attends regularly.

The expectation was that there should be a model as a framework to develop new skills and strategies to solve problems for the implementation of HIV and AIDS counselling in the workplace. This type of participation was exploratory, descriptive and had provided value to gain insight into the experience of infected and affected working women to improve HIV and AIDS counselling through EAPs.

The researcher provided EAPs in the company where she was employed and this had enabled her to be in touch with her research project on an ongoing basis, even in the post-research phase. In addition to the initial funding of R11 000 by the University of Pretoria, funding was provided by the researcher's employer, as there were benefits from the research results and the Skills Development Levy.

1.11 DESCRIPTION OF THE RESEARCH POPULATION

1.11.1 Description Of Population

According to Bless and Higson-Smith (1995:85), a population is the entire set of objects and events or group of people, which is the object of research, and whose characteristics could be determined.

1.11.1.1 Population: Qualitative Study

The qualitative study's population can be considered to be all the working women in South Africa who are affected or infected by HIV and AIDS and whom had participated in an Employee Assistance Programme offered by The Careways Group as a service provider.

1.11.1.2 Population: Quantitative Study

The population for the quantitative component of the study included all EAP practitioners who were registered with the EAP Association and who were members of EAPA – SA for the period 2005 - 2007. The EAP practitioners are all professionals who are employed as EAP counsellors, managers, coordinators, or consultants in their current employment and who are offering counselling to employees.

1.11.2 Sample

It is important to determine a sample that best represents a population so as to allow for an accurate generalisation of results and such a group is called a representative sample. Therefore a sample is a small portion of the total set of objects or persons which

together comprise the subject of the study (De Vos *et al*.,2005:194). EAP practitioners and HIV infected and affected working women served as a population in this study.

1.11.2.1 Sample Qualitative Study

From the identified infected and affected working women, 24 women were identified and volunteered to participate in the study (12 infected and 12 affected). Details of the biographical information, regarding the sample, are given in the qualitative section of the empirical data (see 9.4.2).

1.11.2.2 Sample Quantitative Study

According to the EAPA- SA database, 498 members are registered. The membership to the Association includes all professionals who are directly or indirectly involved in the field of EAP (see 9.2.2.1 and 9.5.2.2, Figure.3). Questionnaires were distributed at the EAP Annual Conference held in Durban in 2005, which was attended by 350 members inclusive of human resources managers and HIV and AIDS managers. Subsequently, questionnaires were emailed to the members who did not attend the conference and those who had never had the opportunity to receive the questionnaire at the conference. To avoid duplication of participants, the e-mailed questionnaire clearly specified that the questionnaire was applicable to only members who did not attend the Durban conference or did not receive the questionnaire at the conference. A total of 81 questionnaires were completed and returned. Details on the quantitative data are discussed in the empirical data section with specifics, e.g. biographical data (see 9.5.2).

1.11.3 Sampling Strategy

1.11.3.1 Sampling Strategy: Qualitative Study

According to (Bless & Higson-Smith, 2000:93), a larger sample allows the researcher to draw more representative conclusions. Random sampling is regarded as the only technique available that ensures an optimal chance of drawing a sample that is representative and accurate of the population from which it was drawn. Since this was a voluntary study, random sampling could not be applied in this study. This is often a problem that is encountered by most of the HIV and AIDS researchers. Issues such as

stigmatisation, fear, victimisation, isolation and labelling were considered as contributors of a small sample size. Therefore random sampling in this sample of HIV and AIDS infected and affected people was impractical. The researcher used non-probability sampling with purposive strategy for HIV and AIDS infected and affected women.

The in-depth study allowed the researcher to verify and probe issues that integrate HIV and AIDS programmes and EAPs with inter-organisational issues. Purposive sampling implied that the study was influenced to a large extent by the researcher's judgment of which research locations would best elucidate the focal research variables and parameters. Since the chosen research locations were impossible, the study focused on the available subjects of research due to the sensitivity around HIV and AIDS and the need for more voluntary interaction rather than coercive research inquiry. Snowball sampling further enhanced the purposive sample, particularly with participants recommending other known HIV infected and affected working women who then volunteered to participate in the study. In snowball sampling, the researcher collects data on the participants of the target population that can be located, and then seeks information from original participants that helps in linking the researcher with new participants. The process continues until the researcher reaches the targeted number of participants with identified characteristics. The characteristics that were important in the unit of analysis included race, age, and rank of employees (see qualitative section 9.4.2, Table 1). The researcher used all participants who had volunteered for the study.

1.11.3.2 Sampling Strategy: Quantitative Study

Questionnaires were distributed at the EAP Annual Conference held in Durban in 2005. Approximately 350 members attended the conference. De Vos *et al*:,(2005,196) provides the recommended number of respondents for a particular population to have a representative sample. For a population of five hundred the recommendation is a sample of 100 respondents.

The study was introduced at the conference at a plenary session where members were requested to complete the questionnaire. Only 126 conferences attendants accepted

and completed the questionnaire. From this initial distribution of 126 questionnaires to delegates at the conference, only 46 responses were received with 80 questionnaires unusable due to printing errors on two pages of the questionnaire. A convenient sample was used to determine this initial sample. A replacement sample of 80 was then implemented. These questionnaires were emailed to all EAPA-SA members and requested to complete. The e-mail message instructed that those who completed the questionnaire at the conference should not respond. Of the replacement sample, 35 responses were received. Thus a total of 81 questionnaires were completed and returned including the original 46 questionnaires.

The EAP practitioners' variables of experience in the field enriched both the quality of collected data as well as the fields of EAPs and HIV and AIDS (see quantitative section, par. 9.5.2, Figure 3, 4, 8 and 9).

1.12 ETHICAL ISSUES

De Vos *et al.* (2005:58) identifies the following ethical issues as important: avoidance of harm, informed consent, deception of respondents, violation of privacy or anonymity or confidentiality, actions and competence of the researcher, co-operation with contributors, release or publication of the findings, and debriefing of respondents.

Issues of privacy and confidentiality may somehow be compromised when one deals with a subject as sensitive as HIV and AIDS. The latter places significant challenges upon the researcher with regard to the sampling of research subjects, specifically the HIV and AIDS infected or affected. Any process related to this matter challenges confidentiality and privacy at the point of initial contact. The interviewer asked the respondents to provide written consent before conducting the interviews or completing questionnaires (**Appendix 3 and 4**). Honesty with regard to the process of research and its outcomes was useful in the process of building confidence and rapport with research subjects, the consent forms included the researcher's personal details and the research assistants always gave their details to ensure that they could be contacted later should the respondents wish to withdraw at any stage.

1.12.1 Confidentiality And Anonymity

The research was conducted in a secure and confidential environment. The issue of post-counselling was clarified with the women infected and affected by HIV and referrals were made back to their EAP where applicable. In some cases the interviewers offered follow-up sessions to ensure safety. Respondents were forewarned regarding feeling uncomfortable during interviews and the fact that they were afforded as much time they needed seemed to make them feel safe. The informed consent agreement reflected all aspects of confidentiality (Appendix 3 and 4).

Questionnaires that were completed by participants did not include their personal details such as ID numbers, names and addresses (Appendix 2). This was done to ensure confidentiality. Respondents were identified through numerical coded identification only. Anonymity on the questionnaires was ensured. Permission to use recordings was obtained, however to ensure no harm to the respondents, those who refused to be recorded were respected and they were not recorded. Participants are not reported by name or their workplace in any report or publication resulting from data collected in this study.

The research goals and purpose were explained in a competent manner, i.e. remaining sensitive to cultural differences, refraining from value judgment, and clarifying the reason openly and clearly. Social work is embedded in strong values of respecting the client. The same understanding was applicable to this research. As mentioned previously, the competency of the researcher and the assistants were pivotal to the study. The two assistants, one a professional social worker and the other one a peer educator and committee member at her workplace, conducted themselves with strong integrity and respect for the respondents. These provided ethical competence and respect of confidentiality.

1.12.2 Debriefing of Respondents

The HIV infected and affected respondents were offered debriefing sessions in an effort to deal with any feelings that may have been evoked during the interview. In addition they were referred back to use their EAP in their workplace. As mentioned above the telephone numbers of the researcher and research assistants were given to ensure they have further contact should that be necessary.

1.13 DEFINITION OF CONCEPTS

1.13.1 HIV and AIDS

The Public Health – Seattle and King County (2001: 1) defines HIV as the virus that attacks the human immune system and destroys the body's defences against disease, rendering it vulnerable to many infections and cancers that will not normally develop in healthy people.

HIV is a single stranded ribonucleic acid (RNA) virus, which breaks down the immune system of human beings. Transmission of HIV is through contaminated bodily secretions, which are primarily blood, semen and vaginal secretions and also breast fluids. (Crewe & Orkin, 1992:3). HIV can be seen as a small virus that is only found in human beings; it slowly weakens a person's ability to fight off other diseases by attacking white cells called T-cells.

According to the Oxford Dictionary (1995, 27) AIDS is a condition caused by a virus transmitted in the body fluids, marked by severe loss of resistance to infection and so ultimately fatal.

AIDS represents the end stage of HIV infection, when the immune system is severely depleted and the host is susceptible to significant morbidity. AIDS is defined by the following: CD4+ T-lymphocyte count below 200/L and/or development of specific indicator conditions, e.g. cytomegalovirus retinitis, Kaposi sarcoma, disseminated

histoplasmosis, pneumocystis carini pneumonia, and progressive multifocal leukoencephalopathy (CDC 2004:3).

AIDS, the accelerated infection of HIV, is a retrovirus that infects vital organs of the human immune system such as CD4+T cells and macrophages. In other countries such as Canada, AIDS is only diagnosed when the person infected with HIV is diagnosed with one or more of several AIDS-related opportunistic infections or cancers (Wikipedia- the free encyclopedia, 2007: 2)

AIDS can therefore be defined as the final stage of HIV. It is a collection of various infections that often attack the compromised body due to a weak immune system.

1.13.2 Employee Assistance Programme

The term Employee Assistance Programme traditionally refers to a confidential individual assistance and support services designed to help employees to cope with personal and social problems. The nature of these problems may vary and include chemical dependence, financial or legal difficulties, family disintegration and psychological and emotional disorders (*EAP*...,2007:1)

An EAP is defined by the Employee Assistance Programme Association (1999:4) as: “a work site-based programme designed to assist in the identification and resolution of productivity problems associated with employees impaired by personal concerns which may adversely affect employee job performance.” White and Dickson (1997:315) describes an EAP as a free, confidential phone counselling programme which aids employees and their immediate families in solving work–related issues and also offers face-to-face counselling if necessary.

These definitions imply that an EAP is a programme in which trained personnel identify and assist employees regardless of their rank when their job performance is affected due to either personal or job-related problems. Intervention may vary from counselling, referral, coaching, mentoring, and team building.

1.13.3 Employee Assistance Programme Practitioner

An Employee Assistance Programme Practitioner is an individual qualified by training or certification in the techniques of assessment of problems, particularly in respect of substance abuse, and of developing and implementing an intervention strategy. This includes, but is not limited to social workers, occupational health nurses and physicians, and volunteer peer referral agents trained in EAP (PSHCPD, 2006:1)

The term 'Employee Assistance Programme Practitioner' implies any counsellor who is directly involved in work place counselling of employees with either personal or work-related problems either as part of the organisation, or as a consultant. EAP practitioners are often used interchangeably with 'EAP professional'; as a result, for the content of this research, EAP practitioner will be used interchangeably to refer to all counsellors practicing EAPs in their workplace.

1.13.4 Occupational Social Work

Occupational social work is described "as a specialized field of social work practice which addresses the human and social needs of the work community–employer, trade union, job seeker and employee. Professional practitioners serve those preparing to enter or re-enter the world of work, as well as workforce participants (as union members or as employees), and the legitimate social welfare needs of labour and industrial organizations" (Kurzman & Akabas, 2005.1). It can therefore be said that occupational social work is a field of practice in which social workers attend to human and social needs of employees in the work milieu by designing and executing appropriate interventions in order to ensure healthier individuals and environments.

Du Plessis (1990) in (Maiden,1992:30) views industrial social work as a generic term, which refers to social work activities in the workplace. Since not all work settings can strictly be defined as industrial, for example commercial, retail, trade and union settings,

the alternative term 'occupational social work' is used to describe social activities in these settings.

Employee Wellness Programme as defined by Department of Public Services and Administration (DPSA), 2007:30) is a programme that "covers the traditional areas which addresses the entire spectrum of psychosocial stressors in the workplace in order to enhance individual and organisational wellness and ultimately productivity". DPSA does not offer a clear definition on what traditional areas of EAP are instead, the definition broadens wellness to include EAP, Wellness programme and Work life Programmes.

1.14 LIMITATIONS OF THE STUDY

- Even though the respondents were randomly selected, the findings are inconclusive and cannot be generalised to the larger population given the 81 response rate – therefore it remains a limitation of the study.
- Literature on History of EAPs is mostly outdated from research writing perspective but still relevant to the day- to- day principles of implementing EAPs in the workplace.
- Similarly the researcher found the literature on Gender and HIV and AIDS scarce and limited.
- Literature on HIV and working women was mostly limited to medical information.
- The researcher had hoped that the process of data collection would take 2 months, but it took 2 years to collect all the data due to work commitments. This made the analysis of data difficult, particularly as some people were interviewed in 2005 and others in 2007, a gap which made common themes and categories during the analysis difficult.
- Some of the respondents did not want to be recorded and as a result, this created inconsistency regarding data collection.
- Although Microsoft Excel was used in the study, its use was limited to calculation of quantitative data and no value was added as such for analysis and

interpretation of collected data - leaving the quantitative part of the study to be described as a descriptive survey.

- Family commitments made the planned time period unachievable because instead of three years, the study took 6 years to be completed; there were difficulties during the finalisation as some literature had changed and certain books were revised.

1.15 CONTENT OF THE RESEARCH REPORT

The research contained in this document is concerned with understanding the role that EAP plays in addressing the difficulties experienced by working women resulting from the impact of HIV and AIDS. The primary objective of the research is to investigate the feelings and perceptions of HIV infected working women in the workplace and establish EAP perceptions about them. A secondary objective of the research is to investigate the type of HIV and AIDS counselling offered by EAP practitioners and to recommend intervention strategies for the workplace relevant to vulnerable women who are infected by HIV and AIDS.

The study described in this document includes a literature survey, the aim of which was to understand the current conversations in the literature concerning women who are affected and infected by HIV and AIDS and the provision of EAP services, to identify an appropriate space to position this research. The literature review on concerning working women infected and affected by HIV and AIDS is developed by firstly giving a general background in the literature to women development in the workplace in Chapter 2, which is followed by a general description of HIV and AIDS in Chapter 3 and with particular focus on women in Chapter 4. The working environment is then explored in Chapters 5 and 7, giving a review of the impact of HIV and AIDS in the workplace and the response by business, both locally and internationally.

Chapter 6 provides insights to the opinions of various thought leaders on the difficulties experienced by working women infected and affected by HIV and AIDS. Chapter 8 is a review of EAP and their response to HIV and AIDS. The nature of the research is

exploratory and involved the development of an understanding of the role that EAP plays in addressing the difficulties experienced by working women resulting from the impact of HIV and AIDS. Chapter 9 presents the empirical research results of the study. The learning from this is further discussed in Chapter 9 with conclusions drawn and recommendations made in Chapter 10 describing interventions for effective EAPs in the support and delivery of a service to infected and affected working women.

CHAPTER 2

WOMEN IN THE WORLD OF WORK

"*Our liberation as a people cannot be complete unless the act of national liberation contains within it the genuine liberation of women."* (Oliver Tambo)

2.1 INTRODUCTION

A literature review on women studies indicates that before the turn of the 20th century, the majority of women died before the age of twenty-one. For those who lived longer, childbearing and childrearing consumed a significant part of the middle years. High school education was a rarity. Only about one-fifth of all adult women had paid employment, yet in the 1990s, increased life expectancy and reduced fertility have given women more time to work outside the home (Giele, 1993:32). However, it needs to be noted that currently nearly 60% of women are in the labour market. This chapter reviews the historical participation of women in the workplace, the factors that contributed to women entering the workplace, and current trends of women development in the workplace.

In 2001, the European Union had an employment rate for women at 54,8% (Duffield, 2002). In South Africa, data shows trends of a steady increase in female labour; in 2000 women represented 38% of the total labour force, up from 23% in 1960 and in 2006, Statistics South Africa reported an official unemployment rate of women at 30,7% in South Africa. The statistics however, suggest that women's roles in the workplace remain unequal in many respects. Women tend to be concentrated in service industries, such as administrative positions. In India about 60% of informal workers are women (Treacy, 2003).

2.2 WOMEN'S ROLES

Both men and women seek feelings of competence, self-esteem, contribution, being wanted and productive, and being in control of time and energy in the world of work. Earnings are crucial to both genders for personal and family support. A study by Dolbier, Soderstrom and Steinhardt (2001:469) revealed that self-leadership was positively related to an approach coping style aimed at eliminating or minimising the source of stress. According to Cory (1993) in Perkins (2000:57), the salary gap for both men and women have slightly closed in the last decade for American workers, but this is not due to the increase in women's salaries but due to the decline in men's salaries.

Women have been observed to have entered the world of work as far back as after World War II. In South Africa, black women entered the economic arena with greater prominence with the introduction of Black Economic Empowerment (BEE). Significant Black Women Organisations (BWOs) still lack prominence despite the BEE policy being explicit in its desire for women's economic empowerment. There have however been concerns that the implementation is very slow and that broad-based empowerment has not taken place. The boards of corporate South Africa are still noticeable lagging behind with only 7% women representation on these boards.

According to Giele's (1993:32) theory of life, traditional expectations are that women drop out of the labour force when they have young children. From 1900, educated women had to live in increasingly urban areas, where the majority of families were no longer based in rural areas. This is evident in five major dimensions that have affected women's roles:

- technological advancement and greater longevity;
- the development of a service economy;
- the changing structure of the family;
- educational improvement; and
- the re-emergence of feminism.

2.3 CHANGES IN THE WORKPLACE

For women, the improvement in both technology and health results in an increase in time available for other pursuits (Giele, 1993: 33). Labour-saving improvements such as running water, a gas or electric stove, a washing machine, refrigerators, prepared foods, etc. reduced the time needed for women's traditional housekeeping tasks. Along with this has been improved health, a key factor that caused a change in sexual behaviour. The developments with regard to contraception, that ultimately enhances a woman's right to choose an abortion, have also contributed to these changes.

However, in South Africa, the majority still live in rural areas and those women who are in urban areas, the majority of whom face educational and economic challenges. In the same vein, it is important to note that the South African government has been making efforts to re-address the historically extremely intolerable socio-economic situations of urban and poor rural women. The significant developmental changes include: access to water, free access to prenatal and postnatal care and child health. The recent introduction of the management of the HIV and AIDS epidemic, social grants, child maintenance, and the fight against domestic violence continues to assist in the eradication of poverty and related struggles of women.

2.4 DEVELOPMENT OF WOMEN

There have indeed been many developments since the 1970s to accommodate and develop women. This is evident in the shift in agriculture, heavy industry and manufacturing to a more service-oriented economy. Gradually, wives, mothers, and the middle-aged were accommodated to return to the labour force and were no longer required to leave work when they started families (Giele, 1993:34). During the 1980s economic restructuring became more widespread when men's jobs were threatened and the wife's capacity to tide a family over difficult economic times gained even further recognition and legitimacy than during the Great Depression. The decline in the average family income after 1973 also encouraged women to enter or remain in the labour market longer in order to maintain their families' standard of living (Schor, 1991). In

South Africa, skills development is part of the employment equity legislation that aims to educationally empower the previously disadvantaged, including women and those with disabilities.

2.5 CHANGING STRUCTURE OF THE FAMILY

In 1970 the labour force participation rate of married women with children under six years of age was 30%. By 1989 more than 60% of infants and more than 80% of pre-school children were receiving some care outside their own homes (Hayes, Palmer, and Zaslow, 1990). The changing economy had an impact on the structure of the family, the divorce rate rose and it was estimated that by the 1970s, 40% of marriages would have ended in divorce. There was an increasing number of single person households, mainly women (Giele, 1993:34).

2.6 EDUCATIONAL IMPROVEMENTS

By 1980, 20% of twenty-five year old women had completed four years of college. Another important development was the increased entries of women into so-called 'male' professions such as medicine and law, with admissions of women to professional schools rising from less than 10% before 1960 to nearly 30% by the 1990s (Hulbert and Schuster, 1993). Women's rising education levels have been closely linked to their increased participation in the labour force. According to Giele (1993:33), even as early as 1952, more than half of the college-educated women between forty-five and sixty-four years of age were in the labour force. According to Statistics South Africa (2003:1), the total number of employed people was stable between March and September 2003, at approximately 11,6 million with the informal sector accounting for a total employment among women at 19% and 8,8% women domestic workers. Continuing education programmes in a variety of settings from community colleges to universities have made it possible for women to combine further training with work and parenting (Chamberlain, 1988).

In contrast to the above observations, in the Tokyo Annual White Paper on National Life, the Tokyo government indicated Japan lagged far behind other countries in giving women opportunities outside the home (Crosby, 1991:7). The report stated there were no incentives for women to pursue career-track positions in corporate Japan, and there were few job opportunities and pay advancements. It is reported that the majority of men and women thought women encountered discrimination at work, and the average wage of women workers was only 63% than those of men, compared with 76% in the United States (Giele & Gilfus:1990:7). Apparently women who have children and quit work are not motivated to go back to a full-time job because they would not have put in the time to get a good wage, since Japanese employment practices require years of service before significant wage gains are made (Crosby, 1991).

A study by Sondhaus, Kurtz, and Strube (2001. 425) concluded that women show more positive attitude towards academic skills than men. The interaction found between body attitudes and academic interests, it revealed that men with positive identification with school subjects had significantly more positive body attitudes than women. They found that those men and women with a low level of academic interest showed no differential in body attitude. Studies with findings like these may reflect cultural injunction for women to be pretty but not smart (Wolf, 1991).

2.7 FEMINISM

A new women's movement brought forth two types of feminist groups, which developed an even stronger egalitarian ideology of gender roles. The more formal branch that included the Organisation for Women who challenged equal rights acts, such as equal pay, banning sex discrimination, and equal opportunity for education rights. The informal branch of the new feminist movement developed small consciousness-raising groups, which attacked sexism and discrimination in everyday life, including in the workplace - with emphasis that not only should women be treated equally at work and in the public sphere, but also that men be expected to perform an equal share of the child care and household (Gisele, 1993: 40).

McFadden (1998:56) argues that there is a difference between white feminism and African feminism. The latter according to her, has been in existence in pre-capitalist African societies. Her main point is that African feminist used strategies to resist patriarchal ideologies such as performing abortions in pre-colonial Africa without their partners knowing, formed women associations, and when they entered the world of work they were paid for their labour which challenged the myth that women are best suited for the kitchen and home, and real women work for free. These efforts have really encouraged more women in the workplace and their participation both in public office and corporate continue to increase. In South Africa 'pass laws' no longer exist in the post-apartheid democratic order; a result of the women's action in 1956. However, the women's petition included the fact that they will not rest until they have won fundamental rights of freedom, justice and security for their children.

In support of the development of women, a study of Columbia women found that the women who attended graduate school between 1945 and 1951 did not find full-time homemaking enriching and rewarding in their lives and were resentful of the women's movement. When they were given the chance in the 1950s, they moved into the labour force by converting their volunteer work into paid work and found the opportunity fully rewarding (Inhale, 1993:140). In 1972, women in the USA between fifty-four and sixty years of age, were asked whether they would pursue careers if given a second chance in life, two-thirds of Sears and Barbee's sample of the Term an gifted women said yes and 45% would take time off only to raise a family (Tomlinson- Kelsey, 1990:54).

Mills graduates of 1958 and 1960, interviewed in 1981, reported feeling depressed after childbirth and while caring for young children, and most of them - when they were in their forties - felt somewhat deprived if they were not in the labour force (Henson, 1993:190). A similar report (Schuster, 1990:211) stated that the gifted UCLA women of the class of 1961 all mentioned work when they described satisfying outlets for their abilities in the 1990s.

In a forceful affirmative action move, Norway now requires that in the next two years, 40% of the board members of the nation's 519 publicly traded private companies have to be women. At present the ratio is 16%. The penalty for non-compliance is the disbandment of the corporation. Surveys have shown that major European countries are lagging in promoting women to positions of power in business, and in achieving racial and ethnic diversity (Friday at Noon, 2006).

The South African government has made significant strides towards reaching its target of having 30% of its senior posts filled by women. Two years ago the government set itself a target to address gender equity. In March 2004, the South African Minister of Public Service Administration reported that 24,5% of management posts in the public service were occupied by women. Gauteng Province had out-performed all other provinces, having 29%, followed by Limpopo and Mpumalanga with 28% each.

The Minister stated optimistically that South Africa will now move up in the global ranking of women in parliament from 15th to 11th place in 2005, with 400 seats belonging to women in the National Assembly, which translates to 32,8% of parliament being women, compared to the 30% in 1999. Looking at the global competition of women in parliament, South Africa is behind Australia and slightly ahead of Germany, still leaving Rwanda in 1st place with 49% in the global league (The Star, 2002:2). Elliot (1999: 273) reports that women are strongly positioned for the future workforce; 7 out of 10 new jobs in the 1980s in USA were filled by women, 80% of women were having jobs in the service industries, compared to the 55% of men. Of these jobs, 34% resided in the higher-earning information and capital-intensive service industries.

Even though South Africa has made an effort in the advancement of women, the General Household Survey for 2006 indicates that there are still important gender differences in the percentage of people 20 years and older. 10,7% still has no formal qualifications; of these 8,6% is men and 12,6% women. This however shows improvement in the situation since 2002 when 9,9% was men and 14% women. Generally, the gap between men and women remains at 4% (Stats SA. 2007).

An interesting observation by Mtintso (1999) quoted by Jobson (2002: 43) presents a dilemma about visible participation of women. Mtintso (1999) asserted that the parliament in South Africa is so patriarchal and inferred that this status is so obvious that women are in danger of being swallowed by its culture, its ethos, values and priorities. Women instinctively fear being marginalised by raising things that are seen to be petty women's issues. They get afraid of moving against the mainstream and in that way find themselves compromising and promoting the very patriarchal agenda. According to the IPU Newsletter (1995), women face obstacles in the parliament, meaning parliament is as patriarchal as many other institutions in society. According to IPU (1995) preliminary findings of the experiences of women from all political parties stated that men in parliament were outwardly supportive of women, but were not genuine in their approval and were not proactive in their support.

The evidence of this struggle that women in parliament are experiencing makes a clear link between interrelationship and access of women to parliament, their participation, as well as gender transformation. From these examples, the assumption could be made that, women in various workplaces - whether it be politics or in parliament institutions, corporate or public sector - may have the same challenges. This therefore suggests that through strong participation of women in decision-making in the workplace, particularly as they are the only ones that can best articulate their needs, could yield positive results. Elliot (1999:273) challenges the EAP practitioners to familiarise themselves with gender education with the emphasis that in the 21st century, women will be the majority in the workplace, and will bring with them personal challenges arising from juggling responsibilities and making decisions.

2.8 WOMEN'S HEALTH

More women work and there are better strategies for facilitating a balance between work and family life. Five million of the 9,5 million women in the US in employment are aged between sixteen and forty-four. More than a quarter of mothers of children under five have part-time or full-time work, and more women with children of any age are returning to work (Murray-Bruce, 1990:280). In South Africa there is a recognised four months maternity leave and two months optional unpaid leave for pregnant women. The basic Conditions of Employment Act does not allow women to work four weeks before and eight weeks after childbirth, unless they have been given special permission to do so. Some of the reproductive and sexual health rights of women include:

- Contraception rights: All people, including women, have the right to decide whether or not to have children. All contraception methods, including termination of pregnancy and sterilisation, allow women to make this choice.
- An HIV infected woman is entitled to the same rights as other people and is protected under the equality right clause, which states that there may be no unfair discrimination directly or indirectly against anyone on any grounds including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age disability, religion, conscience, belief, culture, language and birth. However there is no specific Act for HIV and AIDS.
- In South Africa, HIV women attending antenatal clinic are closely monitored through home visits (guaranteed privacy and confidentiality) whether they follow the prescribed treatment.
- Some workplaces offer EAPs and make provision for employees to attend EAPs during work hours. This effort is to enable employees and women to address issues of mental health and stress that maybe present as a result of conflicts between work and home life. One of the primary sources of stress influencing the health of working women is the conflict between career and family roles. Work-family conflicts relate to the multiple roles that require energy and commitment.

2.9 SUMMARY

Women globally still seek a sense of belonging through work. Internationally, efforts are being made to reassure women of their roles in the workplace. However, workplaces still lack creating a conducive work environment for women. Women constitute the poorest group in South Africa and are more likely to be unemployed or underemployed. Kornegegay (2000:4) challenged the participants in a planning workshop at the office with regard to the status of women; the challenge being that to ensure that the South African macro economic strategy promotes an economic policy on various groups of people depending on class, race, age, gender, location and disability. Evidently, within the literature internationally, as presented above, women feel happy when they work, but even more, they feel empowered when there are supporting structures that encourage a balanced work and family life.

CHAPTER 3

HIV AND AIDS: A THEORETICAL OVERVIEW

3.1 INTRODUCTION

Much is known about the virus that causes AIDS, the ways in which it is transmitted, about the acute symptoms and the impact on the society. In addition, the statistical picture of HIV and AIDS at both national and international level is clear. This chapter aims to illustrate the basics of HIV and AIDS.

3.2 DEFINITION OF HIV AND AIDS

Acquired Immuno Deficiency Syndrome (AIDS) was first recognised in 1981 as a distinct medical condition by the Centre for Disease Control (CDC). A person infected with HIV is diagnosed with AIDS when the body's immune system breaks down and certain conditions or illnesses occur. HIV is a virus that attacks the body's immune system.

A person infected with HIV may not initially show any symptoms, but eventually, without effective treatment, the immune system will become very weak and the person will no longer be able to fight the illnesses. The Centre for Disease Control and Prevention (CDC) defines a person who has AIDS as being infected with HIV and having less than 200 CD4 cells per cubic millimetre of blood accompanied by health problems common in people with AIDS, which are called opportunistic infections (CDC, 2006). Healthy adults have CD4 and T cell counts of 1,000 or more.

HIV destroys white blood cells named the CD4+ T-lymphocytes, which are important to the body's immune system. When these cells are weakened or lost, the body becomes weak and is left vulnerable to opportunistic infections. The death of these blood cells is a consequence of the infection with HIV (National Research Foundation (NRF), 1986: 6). Opportunistic infections are illnesses that are caused by organisms that do not ordinarily cause disease in a person with a healthy immune system, such as tuberculosis,

pneumocystis carinii pneumonia, cervical cancers, herpes zoster, lymphoma and others (*World AIDS Day Website*…, 2007).

The Human Immuno-deficiency Virus (HIV) causes the acquired immuno-deficiency syndrome AIDS. There are different types and strains of HIV. Most people have the HIV-1 strain (type). A person can become infected with more than one strain. HIV attacks the body's immune system (natural defence system against disease) by destroying one type of blood cell (CD4 cells) that helps the body fight against and destroy germs.

CD4 cells belong to a group of blood cells called T-cells that also help the body fight disease. In the body, HIV enters these cells, replicates, and kills the healthy cells and leaves the body vulnerable against germs. When HIV overpowers enough CD4 cells or causes serious infections that do not normally make a healthy person sick, a person is then confirmed to have AIDS. The progression from HIV to AIDS is different from person to person, meaning some people live for 15 years or more with HIV without it developing into AIDS, while others develop AIDS faster. The exact explanation for progression from early HIV to AIDS is unknown. A number of factors are involved, including genetic susceptibility, co-infection with other viruses, age, and probably the resistance of HIV to anti-HIV drugs (Essex & Kanki, 1989:3).

3.3 HOW IS HIV TRANSMITTED?

HIV is transmitted through contact with certain body fluids or tissue of persons infected with the virus. HIV travels in the blood, semen, vaginal fluids, and breast milk of an infected person. The virus is transmitted through sexual contact (unprotected vaginal, anal and oral), by needle sharing, from mother to child during pregnancy, birth or after birth, through blood transfusion, tissue or organ donation.

The virus enters the body and attaches itself to host cells, which is known as the CD4 cells (or T-helper cells). The T-helper cells are the prime targets of HIV. In order for the person to be infected, the virus has to enter the body and attach itself to the CD4 cells. The process of the HIV infection and killing of the T4 cells is the process that starts the

infection. The infection begins as a protein on the viral envelope that attaches itself tightly to a protein known as CD4. The virus then merges with the T4 cell and transcribes its RNA genome into the double-strand DNA. The viral DNA becomes incorporated into the genetic material in the cell's nucleus and directs the products of new viral RNA and viral proteins, which combine to form new virus particles. These particles bud from the cell membrane and infect other cells. Finally, the viral protein circulates in the blood of people with HIV and makes the immune system weak (Redfield & Burke 1989: 3).

AIDS has become a social disease that can be defined as a social disease with its transmission related to certain identifiable forms of social behaviour, such as sex. The emphasis is also on behaviour change as the only way to prevent the spread of AIDS in the current event of absence of a medical cure. The two identifiable options to address behaviour, in the opinion of Jobson (2002:3), are reducing the number of sexual partners and increasing the use of condoms. Pool (1997:83) suggests that an understanding of the social, cultural, and economic contexts of the behaviour concerned is as important. He further adds that the relationship between knowledge and general causal models is essential, noting the following:

- Sexual behaviour and related attitudes.
- Knowledge and perceptions of AIDS.
- Local aetiologies and treatment-seeking behaviour.
- Social organisations, customs and norms.
- Underlying socio-economic factors.
- Coping with AIDS and its consequences.

There are symptoms and signs that identify a person who is HIV infected. During the first stage of HIV infection, the person is 'asymptomatic'. Asymptomatic means the person shows no symptoms of being infected. In this case, the only way to know if the person is infected is through a blood test. The second stage is called the symptomatic stage. The symptoms associated with this stage are fatigue, fever, swollen lymph glands, chronic

diarrhoea, meningitis, and weight loss. HIV may also result in symptoms such as neurological damage, and of the neurological complications, dementia is among the most severe and disabling (CDC, 1993: 2). Sometimes the presence of neurological complications may mimic psychological problems, posing difficulties in diagnosis. Women experience vagina yeast infections. This stage may last for several years, but it also may progress to severe, advanced illness in a matter of weeks or months. Through the introduction of drug therapy, the length of time can be extended before the person becomes seriously ill. The most advanced stage of HIV infection is the AIDS phase. This is the stage when the infected person has severe immune-suppression (less than 200 CD4 count).

3.4 STAGES OF HIV

The following description is a summary of the training manual developed by the researcher for the purpose of HIV training that is offered to various workplaces through consultation process. The manual is in a presentation format and the content was gathered from various research from newspapers and Internet sources, seminar and conference papers and interactions with experts in the field of HIV and AIDS over the past years.

3.4.1 Stage 1: HIV Infection

This stage comprises the first 6-12 weeks after acquiring the HIV-infection, until the body's initial immune response develops enough antibodies to reduce the amount of HIV in the body. During this period, people are highly infectious and the virus can then easily be passed on to others.

At this stage some people may develop a flu-like illness, called 'sero-conversion illness'. This occurs around the time the HIV antibody test converts from negative to positive, i.e. when the body has developed sufficient antibodies to be able to detect them with a blood test. It is probably caused by the activation of the immune system. Sero-conversion illness may present as follows:

- Fever, headache, malaise (general feeling of illness)
- Enlarged lymph nodes (glands of the immune system in the neck and groin)
- Skin rash
- Painful muscles and joints
- Sore throat

These symptoms usually disappear within a week to a month and are often mistaken for a simple cold or flu.

The period prior to sero-conversion is known as the 'window period'. During this period, antibodies are not detectable and a blood test may return a false negative result. This phase lasts two to twenty-four weeks after infection and most HIV tests will show negative results in this phase, although the person is already infected. This is a very dangerous period because people are infectious and are easily able to spread the virus, even though blood tests show that they are 'negative' (CDC, 2004).

Once antibodies are detected, the blood test result is positive and sero-conversion is said to have taken place. During sero-conversion, the antibody levels are very high. Levels drop much lower thereafter. Once the symptoms related to the sero-conversion illness disappear, the infected person may remain symptom-free and well for many years.

3.4.2 Stage 2: Asymptomatic Or Silent Phase

During this stage, an HIV positive person enters an asymptomatic phase, during which time he or she remains clinically healthy. This stage can last anything from three to seven years - sometimes up to 10 years. Although the infection is silent, the virus is continues its onslaught on the immune system, which is slowly deteriorating.

During this phase, the only indication that a person is infected with HIV would be by a positive HIV test. The person remains infective throughout this stage. This stage is associated with a CD4 cell count of 500 - 800 cells/mm^3 (CDC, 1993:4).

Most of the patients in this phase of the disease are unaware of their HIV infection and continue with their lives as normal. Those who become aware of their status, usually from screening during pregnancy, testing for blood donation or testing for insurance purposes, have to make a major social adjustment. A positive diagnosis usually causes an acute (sudden onset) emotional crisis for the person (and his/her family) and often results in depression. Psychological support in the form of counselling is often necessary.

3.4.3 Stage 3: Minor Symptomatic Phase

As the CD4 cell count reduces, a variety of minor complications begin to surface because of the weakened immune system. (Stage 3, characterised by minor symptoms, and stage 4, characterised by more serious symptoms are often discussed as one stage).

One of the first such symptoms experienced by many people infected with HIV, is lymph nodes (glands) that remain enlarged for more than three months, also called persistent lymphadenopathy (Crewe & Orkin, 1992).

Other symptoms often experienced months to years before the onset of AIDS include:

- A lack of energy
- Weight loss
- Frequent fevers and sweats
- Persistent or frequent yeast/thrush infections (oral or vaginal)
- Persistent skin rashes, dry and itchy skin
- Pelvic inflammatory disease that does not respond to treatment
- Short-term memory loss

- Children may have delayed development or 'failure to thrive'
- Fungal nail infections
- Recurrent mouth ulcers
- Recurrent throat infections
- Shingles (herpes Zoster)

As the virus spreads and CD4 cells are destroyed, the loss of these cells reaches a point where the CD4 count drops to as low as 350 cells/mm3. This marks the end of the minor symptomatic stage (Bendell, 2003).

3.4.4 Stage 4: Symptomatic HIV-Disease

About 5 to 8 years after infection, the immune system finds it increasingly difficult to sustain its defence against the HIV virus and the viral load progressively increases as the CD4 cell count decreases. Signs and symptoms of opportunistic infections now start appearing because the immune system is deteriorating. This period may continue for months or years but the infections gradually become more frequent and serious.

Symptoms are now more severe and may include the following according to (CDC, 1993: 12):

- Recurrent oral and vaginal thrush (Candida)
- Recurrent Herpes simplex infections (Fever blisters/cold sores)
- Herpes Zoster infections (Shingles)
- Hairy fungal growth of the tongue (Hairy leukoplakia)
- Chronic bacterial skin infections and other skin rashes
- Chronic diarrhoea
- Weight loss of more than 10% of the initial body weight
- Swollen lymph glands or shrinking of previously swollen glands
- Persistent and unexplained fevers and night sweats
- Reactivation of tuberculosis (TB).

The CD4 cell count during this stage may be between 150 and 350 cells/mm^3 (Hunt, 1996: 1283). These and other conditions can usually be treated effectively and the person can be kept in reasonably good health in between the bouts of illness.

3.4.5 Stage 5: Full-Blown AIDS

This is the final and most serious phase that is followed by death. By this time the immune system is severely weakened so that it cannot fight life-threatening diseases or cancers.

At this stage the imbalance between the CD4 cell count and the viral load, in favour of HIV, is significant. According to international guidelines, a person is said to have full-blown AIDS when the CD4 count drops below 200 cells/mm^3. The infected person now becomes vulnerable to serious opportunistic infections and some cancers. It is at this stage that the person moves from being merely HIV positive to having full-blown AIDS. Typical symptoms associated with this stage are:

- Chronic diarrhoea, nausea and vomiting
- HIV wasting syndrome (weight loss of more than 10% of body weight)
- Poor concentration and memory loss, often due to HIV encephalopathy

3.5 THE INTERNATIONAL EPIDEMIOLOGY OF AIDS

Ever since the AIDS pandemic was initially recognised in 1981, there has also been a realisation that AIDS is an unprecedented threat to global health. From analyses of both AIDS reports and sero-prevalence data, three broad and yet distinct patterns of AIDS have been recognised. According to Mann, Tarantola, and Netter (1992:34) three infection patterns of the AIDS virus are apparent worldwide. Research has identified the different pattern of AIDS:

Pattern One: The pattern that is known to be commonly and clearly visible in the USA among homosexuals. Pattern one is also found in South America, Western Europe,

Scandinavia, Australia and New Zealand, where about 90% of the cases are homosexual males or users of intravenous drugs.

Pattern Two: This is known to be primarily common among heterosexuals in Africa. It is also found in the Caribbean and some areas of South America where the primary mode of transmission is heterosexual sex.

Pattern Three: Typical in both homosexuals and heterosexuals and is found in Eastern Europe, North Africa, the Middle East, Asia and the Pacific. The epidemics in Eastern Europe and Central Asia have increased sharply in the past years. In 2007 150 000 people were newly infected with HIV (UNAIDS, 2007:39).

The first cases of HIV were identified as pneumocystis carini and the disease came to be called the Acquired Immuno Deficiency Syndrome (AIDS). In order to understand this new syndrome further research had to be undertaken. In the search to understand the syndrome, the virus that caused AIDS was identified and in 1983, this virus was named HIV. HIV is a retrovirus, meaning one of the first known viruses to transcribe DNA from RNA. The virus's existence depends on its attachment to the CD4 or T-helper cell. The virus reproduces itself and thereby destroys the body's immune system (Whiteside & Sunter, 2000:1).

In 1985, a second strain of HIV was identified and was called HIV-2. HIV-2 is common in West African countries while HIV-1 is prevalent in South Africa. The HIV-2 is the slower-acting virus; HIV-1 has nine different sub-types (Whiteside & Sunter, 2000:2). HIV can only be detected in the human body when HIV antibodies are present in the blood. To identify AIDS, the CD4 count and viral load have to be measured and when the CD4 counts falls below 200, people are regarded as having full-blown AIDS.

According to scientific research, there is no doubt that HIV causes AIDS. HIV, a virus that breaks down cells in the immune system, destroying the body's ability to fight infections and cancers, causes AIDS. According to the HIV and AIDS briefing papers

(2002:2), the virus is transmitted horizontally and vertically. Horizontal transmission occurs during either heterosexual or homosexual sexual intercourse without protection with an infected person. HIV is also transmitted through sharing of infected needles among drug users. Vertical transmission is said to occur between mothers and their children during or after pregnancy.

The epidemic has affected the world in many waves, with the first wave being HIV infection, followed by several years of waves of opportunistic diseases and lastly a wave of AIDS illness and death (UNIAIDS/WHO, 2006:80). Evidently the countries with the highest incidences have not as yet hit the highest peak of the AIDS death wave. The global prevalence of HIV has been published by AIDS update reports since 1998. This reporting system has helped measuring the trends of the epidemic in various continents and countries. The countries are required to give an annual update on the evolution of the epidemic in a uniform reporting guideline. The report is a joint UNAIDS and WHO initiative and is produced by the UNAIDS / WHO work group. So far these reports are the only updated and reliable reports (**See attached Maps, Appendix 13-15**). More than 6 800 persons become infected with HIV daily and 5 700 die from AIDS at a global level. There are varying reasons accounting to these infections, including inadequate access to prevention and treatment services.

According to the reports (UNAIDS / WHO Update, 2007), there are about 32,2 million people with HIV in the world, 2,5 million is the estimated number of adults and children with new infections and 2,1 million AIDS deaths. Clearly, all the estimates from those living with HIV, new infections and AIDS deaths, Sub–Saharan Africa is reported to be the highest on the list with 22,5 million living with HIV, 1,7 million new infections and of 1,6 million AIDS deaths compared to Oceania and Caribbean with the lowest figures at 75 000 and 230 000 with new infections and living with HIV respectively. Only 1 400 and 11 000 in Oceania and the Caribbean respectively are annually dying of AIDS. (**See Appendix 13-15).**

Swaziland and Botswana topped the list of countries with the highest prevalence rates, at 38,8% and 37,3% in 2003. However, at the end of 2007, South Africa clearly indicated an increase and stands at a 29% prevalence rate while both Botswana and Swaziland show a decrease rate to 25%. Life expectancy in Southern Africa, the world's hardest-hit region by AIDS, has dropped to 49 years for men and 53 for women, 13 years less than in the absence of AIDS (UNAIDS, 2006:17). Current global projections suggest that by 2015, the total population will be 115 million in each of the countries most affected by AIDS which is less than it would have been in the absence of AIDS.

At a macro level, the epidemic has impacted national economic growth in a number of countries. According to the UNAIDS (a) (2000:2), Tanzania experienced a 15% to 25% fall in GDP as a result of the AIDS epidemic in 1996. In Rwanda in 1995 an estimated 66% of public expenditure was directed towards HIV and AIDS patients. It is estimated that the impact on the workplace by 2020, including mortality, will reduce workforces globally by 11,5 million people (UNAIDS (b) (2000). Overall, Rwanda's epidemic has been stable in recent years with 190 000 people (UNAIDS, 2006:20) infected. According to the AIDS Watch, AIDS remains the most likely cause of death and days lost among 15 to 44 years old in Asia (Haldenwang, 2008: 1).

According to the U.S. Bureau of the Census, by 2010 in South Africa, more infants will be likely to die of AIDS than from any other cause (U.S. Bureau of the Census, 2004:85). In Zimbabwe, already twice as many infants are dying from AIDS than from any other cause (O'Grady, 2004:204). In Zambia, life expectancy has dropped to 35 years due to AIDS epidemics. It is estimated that in 2010, South African life expectancy will be 36 years (Census, 2004:7). HIV and AIDS have had a great impact on family income. Child labour is estimated to be on the increase, as well as a higher rate of survival sex among street kids (Reed, 2004:234). Zimbabwe's maize production was reported to have dropped by 61% because of AIDS-related losses in staff (UNAIDS (a) 2000:2). Kenya is estimated to loose 20% to 30% in their GDP by 2010 (Robalino, 2002: 14). In Thailand and Côte d'Ivoire, household income has been reported to decline by 40% to 60% when any family member is infected, but on the other

hand the national prevalence and trends on the HIV epidemic show a decline (UNAIDS, 2007:6). The epidemic in Thailand has largely evolved from the sex trade. Thailand attributes the decline of the infection rate to prevention efforts such as education. Thailand education campaigns have focused on decreasing the number of men buying sex and increased condom usage by men (UNAIDS, 2006:26).

Data collected by the European AIDS Treatment Group indicate that 104 countries have HIV-specific travel restriction. The restriction ranges from banning HIV positive people from entering for any reason to limiting them to length of time. According to Haldenwang (2008:2) the arguments regarding restriction involve the protection of public health and high costs associated with care, support and treatment. It is very disappointing that certain countries still have restriction on people living with HIV, in this researcher's opinion it is still discriminatory to put travelling restrictions on people living with HIV, given the fact modes of infection are clearly understood and travelling does not put risk to people that the infected persons come across.

3.6 THE SOUTH AFRICAN TRENDS ON AIDS

South Africa has reached the epicentre of the AIDS pandemic, with the country's first national household sero- prevalence indicating that 14,8% of the country's adult population (15 years and older) are living with HIV and AIDS (HSRC, 2002). South Africa is the country with the largest number of HIV infections in the world (UNAIDS, 2007:16). HIV prevalence collected from the latest antenatal clinic surveillance showed that HIV infection might be levelling off. The prevalence among pregnant women was at 30% in 2005 and 29,5% in 2006 (Department of Health, 2007: 3).

In South Africa, an estimated 6 million of 48 million people are living with HIV and AIDS. An estimated 18,8% of adults were living with HIV in 2005 (*Human Rights Watch Publications*…, 2001:1) and 600 die daily from HIV AND AIDS in the country. (UNAIDS, 2006:17). The UNAIDS HIV prevalence estimates, which describe the percentage of adult men and women living with HIV nationally, incorporates a variety of

HIV data, including gathered household HIV surveys and antenatal clinics. It was projected that by the year 2008, 500 000 people in South Africa would die and life expectancy will drop to 40 years by 2008 (AIDS Foundation of South Africa, undated). Trends in South Africa over time show a gradual increase in HIV prevalence (Department of Health SA, 2005), while household surveys with HIV testing in 2005 showed a lower infection rate. The household prevalence is unreliable as there is a high non-response rate of more than 40% (UNAIDS/WHO, 2006:17).

Lehohla, the Statistician General of South Africa, admitted that statistics on HIV and AIDS deaths are not readily available for South Africa. He explained that mortality data was collected from death notification forms that show that tuberculosis; influenza, pneumonia and cerebro-vascular diseases are the leading causes of mortality. He refused to be drawn on whether deaths caused by the abovementioned diseases could be HIV/ AIDS related, which is a non-notifiable disease. Between 1997 and 2002 mortality increased from 318 287 deaths to 499 268, representing an increase of 57%. Adult (15 years and older) deaths increased by 62% in the same period. A disturbing picture is the 106% increase in the mortality rate among the 20 to 49 age group (the most economically active) - from 121 548 deaths to 250 936. Infant mortality (four years and younger) has also showed a marked increase from 34 779 to 48 572. Lehohla, however, concedes that 'the data provides indirect evidence that the HIV epidemic in South Africa is raising the mortality levels of prime-aged adults in that associated diseases are on the increase' (Haldenwang, 2006:1).

The 6 million South African people infected translate into a prevalence rate of 11%, live in various South African provinces (Department of Health, 2006). The projections show that Kwa-Zulu Natal is the province with the highest prevalence rate of about 40%, the Western Cape is the lowest at 17% and Northern Cape and Limpopo are slightly higher than the Western Cape. The other provinces are expected to level off in the future.

According to the media, one unreleased report, commissioned by the Department of Health, found that 46% of patients in South African hospitals are HIV positive

(*Kaiser Foundation…*, 2004). Another report found that Johannesburg hospitals alone admit 100 full-blown AIDS cases daily (Basset, 2002; 1). The Chris Hani Baragwanath Hospital in Soweto recorded a 500% increase in HIV patients seven years ago (Cheek, 2001: 3).

The impact of HIV and AIDS seems to be exceeding the government capacity, with a high shortage of social workers and health workers (Majors, 2004:126) exacerbating the crises. The HIV infection figures show that the number of the people who are newly infected peaked in about 1998 and is now decreasing. According to the ASSA report, this is because the number of new infections has slowed down to the point where it nearly matches the number of people dying from AIDS (ASSA, 2006:3). An assumption could be drawn that education awareness is beginning to make a positive impact as the infection rate is stabilising.

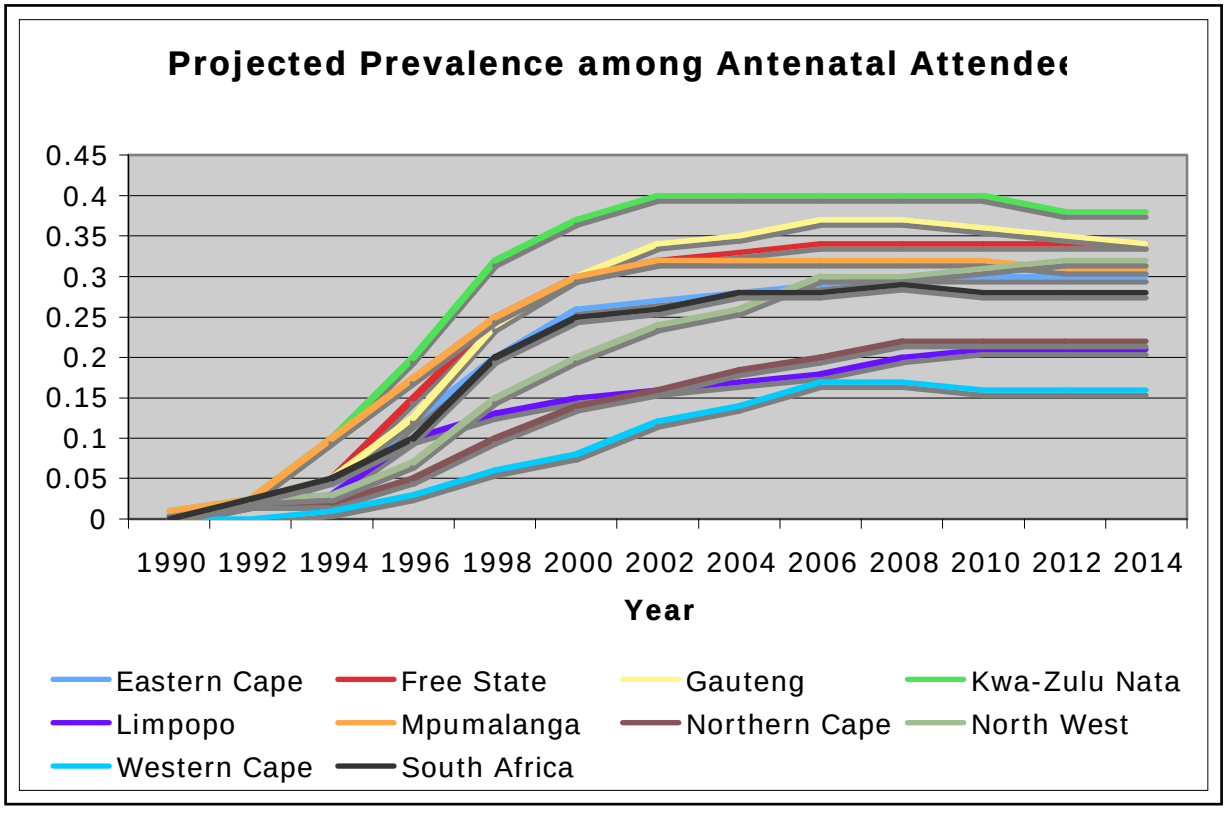
In addition, these projections indicate that anti-retroviral treatment could reduce 338 000 deaths a year, making anti-retroviral treatment one of the key strategic initiatives in AIDS management. According to the Department of Health, the National Strategic Plan (NPS) highlights commitment to give 80% of HIV-positive people access to ARV therapy by 2011.

The ASSA model (2006:1) projected that the HIV and AIDS epidemic in South Africa can be summarised as follows for 2015:

- 38 000 babies will be infected at birth;
- 527 000 uninfected people will become infected;
- 600 000 will be AIDS sick yearly; 3,5 million pre-AIDS sick and 225 000 on treatment;
- 737 000 dead;
- the prevalence will remain high in women;
- more than half of 15 years olds are not expected to survive to age 60.

HIV and AIDS has affected the South African population growth rate; however it is not expected to be negative for the country as a whole. A report by the human rights body Amnesty International (AI) indicated that the poor, rural women experience the impact of HIV pandemic as they face sexual abuse and discrimination. This could be further exacerbated by culture of violence and stigma. According to the ASSA model (2006), only Gauteng and the Free State are expected to show a negative population growth by 2015 and the growth will be due to the very low or negative net migration. Below is a graph by the ASSA model showing the plateau of the infection by percentage as per their estimated model. The graph shows that Kwa-Zulu Natal is the highest hit with about 40% and Western Cape the lowest at 17%.

Figure 1: Antenatal HIV Prevalence Projection by South African Provinces



3.7 SUMMARY

There is clear consensus that HIV leads to AIDS. There are identified stages of HIV that ultimately show that when the immune system is no longer able to fight infection, AIDS is inevitable.

The prevalence of HIV and AIDS in South Africa, and internationally, is still very concerning even though varying reports tend to give an improving situation with varying opinions on the decline of infections; this is mostly due to varied estimating modalities. The majority of the infected people are still women. Women are the majority accessing treatment through antenatal clinics through antenatal clinics.

CHAPTER 4

GENDER AND HIV AND AIDS

4.1 INTRODUCTION

Sexuality is generally considered to be about sexual development, reproductive health, interpersonal relationships, body image and gender issues. In an attempt to stay within the bounds of this study, this chapter will seek to highlight the vulnerability of women within this framework. It further highlights the impact of HIV and AIDS on women and gender influence within the society and workplace. The epidemic's interaction with gender inequality and social exclusion is revised.

There is an inextricable link between gender inequality and vulnerability to HIV and AIDS at every level. Gender inequality means unequal treatment for both sexes in all levels of society. Of people living with HIV and AIDS in South Africa, 65% are adult women between the ages of 15 and 49 years. According to the Daily News (2008:17), men make up half of the HIV positive population, but 70% of HIV positive people on treatment are women. Gender inequality renders women and girls socially and culturally vulnerable.

Gender "refers to the ideas that people have of what it is to be a boy or girl, man or woman, and what is masculine or feminine behaviour; how people are expected to behave simply because they are male or female" (The Gender Manual Consortium: 1999:22). According to Jobson (2000: 7) gender means "shared expectations and norms within a society about appropriate male and female behaviour, characteristics and roles." It is well known and accepted that men and women are different. For example HIV in men means an attack on their survival. Men, e.g. regard procreation as the extension of their surname, therefore the impact of HIV and AIDS (resulting in death) to them means the extinction of their surname. (Daily News, 2008: 2).

Gender ideas and norms reflect and influence the roles that women and men take on in daily life as well as their social status, economic, and political power. These ideas and expectations are acquired and sometimes taught by family members, friends, leaders, religious and cultural institutions, schools, workplaces and the media. The roles, status, and power on the other hand, affect an individual's risks of infection and the community's abilities to cope with HIV/AIDS and sexually transmitted infections (STIs). Ng'weshemi, Boerma, Bennett and Schapink, (1997:88) draw a distinction between sex and gender, stating that if people believe that female / male characteristics, abilities and behaviour are based only on sex / biological factors, they are likely to see the characteristics, abilities and behaviour unchangeable. However, if they understand that these aspects are determined socially by ideas and expectations, they are likely to learn that these dimensions can be changed.

However, a study on religious affiliation and attitudes in the prevention of AIDS by Begue (2001:571), indicates no significant gender differences on moral attitudes. The observation was that when religious belief and the type of social commitment are simultaneously taken into account, no gender differences exist. This may in part indicate that gender differences and moral attitudes might disappear if relevant factors known to be unequally distributed among gender, such as religion or social commitment, are held constant.

Women are disadvantaged in their roles and also in terms of their biological make up. In most of the South African cultures, gender empowers men and disempowers women. The imbalance between power and gender is exacerbated by culture of violence and stigma. This imbalance restricts women's sexual autonomy and expands men's sexual freedom. It may be accepted that a man can talk about sex and how he feels- often in a chauvinistic manner- while most communities will discourage women to have those discussions. If there is a discussion among women around sex, it will be regarding finding ways to satisfy the husband in particular. These discussions often contribute to girls' aspirations and the idealisation of motherhood.

In a study investigating men's feelings about infidelity, men reported that they would experience positive emotions to their partner's infidelity, possibly because that will give them a reason to get out of a relationship that was unsatisfactory already (Laak, Olthof & Aleva, 2003:548). This notion however indicates that men may not necessary deal with a women's infidelity well, a practice that is common among men. A study of Turkish students revealed that women, when dating, have more detailed future plans about relationships and families than men (Sakalli-Ugurlu, 2003:294). This perception, however, reinforces the stereotype with regard to a woman's dependency on a man.

Some of the gender stereotypes encourage women to be virgins when they get married and that men should be always one step ahead of their girlfriends in terms of sexual experiences. In the Zulu culture young girls will routinely undergo virginity tests. It can therefore be argued that these stereotypes encourage men's dominance, decisiveness, and authority over women, and women's acceptance, dependence, and compliance still remains strong in many cultures. The same findings that women tend to idealise family roles that encourage women's dependency on men, were noted in the study of Turkish students by Sakalli-Ugurlu (2003) about their attitudes towards women's compliance in romantic relationships.

Some of the cultural perspectives include putting demands on parenting and child bearing. A study in Northwest Tanzania has indicated that infertility may be indirectly associated with HIV infection. Infertile women suffered more marital break–ups and they also had a markedly higher prevalence of HIV (about 6,6% versus 18,2% women and men, respectively (AIDS, 1995: 913). These patterns are not only common in African countries but also in a country like India (UNAIDS, 2006:25).

Other cultures tend to give men freedom to be more sexually active while restricting female sexual activity. In some African cultures women become infected because of polygamy, and also by marrying their deceased husbands' brothers who are infected. In the event of HIV infection women are more likely to be blamed and rejected than men

would be. The irony being that some cultures actually encourages promiscuity among men as a sign of masculinity, while women are devalued in this regard.

Some of the factors placing women at risk of HIV infection as noted by Ng'weshemi *et al.* (1997:89) are:

- Blood transfusion during pregnancy complications;
- Male to female sexual transmission occurs more easily;
- The need for extra income can lead to unprotected sex with multiple partners;
- STIs in women are often less evident, and treatment may only be effected later;
- Young women are physically less mature and older women's vaginal mucosa thins, increasing the risk for HIV transmission.

In most cultures worldwide, when the male of a household becomes ill, the wife provides care and takes time off to take on additional duties to support the family. In the case of the wife falling ill, another woman may step in to care for her and take responsibility for AIDS affected children instead of the husband.

4.2 GENDER PERSPECTIVE ON WOMEN AND HIV AND AIDS

HIV and AIDS is a crisis for women. International statistics on AIDS reveal a greater impact of the pandemic on the lives of women. According to the GBC report on "In Good Company", the feminisation of HIV and AIDS is not only a humanitarian crisis but also an international emergency that can damage the economy in some countries. Females represent 41 % of the world labour force living with HIV and AIDS, this is so in particular to countries where the global economy relies on the female workforce for imported goods (GBC, 2008: 2).

In the Sub-Saharan Africa, 57% of adults infected are women, and 75% of young people infected are women and girls (Global Report (GRI), 2004:1). The report further states that women living with HIV were vastly out-numbered by men in the early years of the epidemic, however the opposite is true today. On average there are 13 infected

women for every 10 infected men - up from 12 infected women for every 10 infected men in 2002. One study of pregnant women in Rwanda found HIV prevalence rates of 38% of women whose spouses worked for the government, 32% of those with white-collar working spouses, 22% of army families and 9% of farmers (Bloom, 2001:59).

It is reported that in Russia, an estimated 860 000 people are living with HIV, women accounting for an increasing share of new HIV infections. In South and South-East Asia, women are accounting for just less than 30% of all HIV infections. In the United States of America approximately half of the 40 000 new HIV infections annually are African-American women. It is noted that AIDS is the leading cause of death for African-American women aged 25 to 34 (UNAIDS, 2004).

In Cambodia, like in many parts of the world, it is reported that women constitute a growing share of people living with HIV (an estimated 47% in 2003 compared to 37% in 1998). According to UNAIDS (2006: 27), a significant number of women are infected by husbands and boyfriends who have probably acquired the virus during paid sex. Sex work is also a driving factor in Ghana's epidemic where the HIV prevalence in women, attending antenatal clinics, has risen to just fewer than 4% (UNAIDS, 2006:22).

The difference in infection levels between women and men is even sharper among young people aged 15 to 24. The ratio ranges from 20 women for every 10 men infected in South Africa to 45 women for every 10 men in Kenya and Mali (GRI, 2004). In Cambodia and Thailand there are also indications of increasing HIV infections among street youth who use amphetamine-type stimulants (National Centre for HIV and AIDS, Dermatology and STIs, 2005). The trend in Russia is marked among young women, especially those in their late teens (15 to 20 years) and these accounted for more new infection cases in 2004, higher than young men in the same age group. According to the UNAIDS (2006:36), the contributing factors to the high infection rate among young women in Russia, was through injection as a result of drug use. Mobility and migrant work consistently increases vulnerability to HIV, especially for married women. Migratory

work is often linked with increased sexual networking for both men and women (Chirwa, 1997; Romero-Daza & Himmelgreen, 1998).

It has been estimated that by the year 2008, there will be 6 million South Africans infected with the virus and almost 1 million children under the age of 15 will have lost their mothers due to AIDS. Interestingly, and not surprisingly, the infection rates are noted to be high particularly in women and men of reproductive and of the economically active age group (Jobson, 2002: 4). In South Africa the vulnerable groups are predominantly young, black, and economically disadvantaged women. It can be argued that due to the last 14 years of democracy, most of the people in South Africa, particularly those who were previously disadvantaged, underwent various transitions, including freedom and empowerment. These changes however brought about various impacts including stress and adjustment on families.

According to research led by the HSRC on the incidence of HIV in South Africa, and published in the March (2007) issue of the South African Medical Journal, there is an 'alarming' increase in new HIV infections among young South African women, suggesting that current prevention strategies, such as condom use and abstinence programmes are failing to curb high-risk behaviour among teenagers and young adults.

The research, which sampled almost 16 000 South Africans, found that women accounted for 90% of all new HIV infections in the 15 to 24 age group. In the 20 to 29 age group, women were six times more likely to be HIV positive than men of the same age. People living in urban informal settlements 'had by far the highest incidence rates' at 5,1%, followed by those in rural informal areas (1,6%) and urban formal areas (0,8%). "These results suggest that poverty and education play a significant role in increasing vulnerability to HIV", said HSRC President, Dr Shisana (Haldenwang, 2007: 4). In addition, the gender inequality that is imbedded in many cultural traditions mean that the domestic burden of AIDS care is primarily on women because of their traditional roles as caregivers and homemakers. Not only is the intensive caring for the affected in this

compassionate undertaking for women a great burden, it also limits educational and economic opportunities for women and girls.

A study of HIV-related illnesses on families in Northern Zambia has revealed that when comparing household categories among female-headed household, male households and households taking care of people infected with HIV, among these groups, women supported an average of 3,6 orphans each - far more than male headed households (UNAIDS/WHO, 2006:85).

Women in domestic violence situations are more vulnerable to HIV and AIDS. Between 10% and 50% of women worldwide report physical assault by an intimate partner and in some situations assault involves sexual coercion and forced sexual compliance (UNAIDS, 2006:7). Other forms of violence against women include rape, sexual trafficking and slavery. Available evidence suggests that at least one in five of the world's female population has been physically or sexually abused at some time in their lives. Violence is a significant cause of both death and incapacity among women of reproductive age, and a greater cause of death than traffic accidents and malaria combined (Chin, 1990: 336).

Arranged marriages are well accepted in some cultures and in most cases HIV and AIDS testing is not required before the couple consummates the marriage. Physical violence, threats and fear of abandonment make the negotiation of the use of condoms and discussion about marital fidelity more difficult for women. HIV also affects women's fertility and could also contribute to spontaneous abortion. The UNAIDS report (2006:90) indicate that HIV reduces fertility level of women with 25% to 40%. Women who do not know their status are unable to take steps to prevent pregnancies.

A study by Laak, *et al.* (2003:545) revealed that women are annoyed by their partner's aggressive behaviour while men tend to be annoyed by their partner's sexual withholding. The study therefore supports the belief that women are at risk for HIV as their strategy in withholding sex may be met by aggressive response from their partners.

It should be further noted that if the couples are having marital problems, wives are likely to be more active than husbands in using strategies to maintain the marital relationship. When women are asked to imagine how they would react emotionally to their partner's emotional and sexual infidelity, women reported that they would feel repulsed, depressed, insecure, helpless and anxious (Shackelford, LeBlanc & Drass, 2000).

Women and girls in abusive relationships may have limited capacity to negotiate the terms and conditions of sex. Use of condoms may not be negotiable for them with their partners. HIV positive women who disclose their status are often at risk to violence from their intimate partners, family members, or community. The violence may range from emotional abuse to coerced sex and even to homicide. Sexual violence may increase the risk of HIV for women survivors, as the incidence of sexual violence is never negotiated. Forced or coerced sex creates a risk to trauma, which may be as a result of the torn skin of the vagina during dry or forced sex. To deal with these challenges, Director of Amnesty International (AI) suggests that the SA government should increase efforts to address the wider social and economical inequality, particularly assisting rural women and further suggesting a chronic illness grant to improve HIV-infected women's access to health services and treatment.

One of the contributing factors hampering HIV intervention is that in some part of the world young women are so marginalized that older men who take young lovers commonly help the girl's family by paying for their school fees and food. In South Africa teenage pregnancy is an important indicator of the situation of teenage girls and their lack of educational advancement. According to Stats SA Report 2008, in 2004, the main reason given by teenage girls for not attending educational institution and lack of educational advancement was teenage pregnancy, the number rose from 66 000 in 2002 to 86 000 in 2004.

No where in research is there an indication that the HIV prevalence among adult men and women is more or less the same; women are more infected than men, whether in Sub-Sahara, North-Africa, the Middle East, Asia, Eastern Europe and North America (UNAIDS, 2006:13). The risks for women are more likely to occur during a sexual encounter, while men generally have sex more often with the incidences of more sexual partners such as in the case of contacts with commercial sex workers and that is where their risk is highest. In some cultures women are found to be more at risk due to certain sexual intercourse practices, such as dry and rough sex. Men may prefer dry sex because they think that female vaginal fluids are unclean. Herbs or substances used for dry sex may be inflammatory, which may facilitate HIV transmission, although evidence is not conclusive. Heavy rubbing during dry sex may also cause sores in the mucous membrane and dry sex is also very risky as it may lead to bleeding and lesions, facilitating vulnerability to HIV.

Women are generally infected at an earlier age than men due to the fact that women have sexual contacts with men who are 5 to 15 years older than them. A study at Bugando Medical Centre in Tanzania analysed the admission data of 478 women and 581 men. The mean age of those admitted was 27,7 years for women and 28,8 years for men. The average age as having AIDS was 29,3 for woman and 32,6 years for men. The difference between the sexes became more pronounced when the ages of those who died in hospital were analysed. The average age of women who died with AIDS was 27,8 years and 33,8 years for men (Ng'weshemi *et al.*, 1997: 87). In Zambia 61% of all deaths between 15 and 59 occurred among women, and they were younger in age than men (UNAIDS, 2006:89). In some countries women are reported to live longer than men, however the AIDS epidemic has driven female life expectancy below that of men in four countries: Kenya, Zambia, Malawi and Zimbabwe (*UN Population Division*…, 2005). According to a UNAIDS report (2006:89), empirical evidence supports the existence of gender differences in mortality.

There is thus a link between HIV and AIDS and gender-based violence. For example, forced sex may directly increase the risk of HIV transmission as a result of physical trauma; violence or threats of violence may limit the ability to negotiate safer sex. Inadequacies in justice systems, particularly in South Africa, may discourage rape incidence reporting and subsequently seeking post-exposure prophylaxis. According to UNAIDS (2002:65) in a study in Vietnam, only 35% of women felt able to refuse their husbands sex, and a UNIFEM study on the impact of HIV and AIDS in Zimbabwe revealed that, even if women were educated about AIDS, their economic dependence on men left them feeling helpless to negotiate safer sex.

Marriage and long term monogamous relationships seem not to protect women from HIV. In Cambodia, about 13% of urban and 10% of rural men reported having sex with both a sex worker and his wife or steady girlfriend. In Thailand in 1999, a study found that 75% of HIV infected women were likely to be infected by their husbands. In some parts of African countries married 15 to 19 year old young women have higher HIV infection levels than unmarried sexually active females of the same age (UNAIDS, 2004:1).

The other contributing factor to gender and an increased risk of HIV infection among women has to do partly with social taboos regarding homosexual relations. Many men who have sex with men also maintain sexual relationship with women, who may be unaware of their partners' sexual lives. It is reported that in Ecuador a significant number of women with HIV were infected by their husbands or regular partners who acquired the virus during unprotected sex with other men (Montano, 2005: 58). Similarly, Colombia reports the same trends, namely that higher HIV infection levels have been found in groups of men who have sex with men (UNAIDS, 2006:44).

The explanations offered for the high rate of HIV infection among women in South Africa are:

- very high rates of sexually transmitted infections (STIs) are often with poor treatment success rates due to stigmatisation;
- the early age at which first sexual experiences occur (frequently under coercive conditions);
- a high number of concurrent sexual partners;
- violence against women and young girls;
- low levels of condom usage; and
- high poverty; mobility rate and low literacy levels (SA Health Review 2000).

4.3 THE UNITED NATION'S ROLE

In June 2001, the UN General Assembly Special Session (UNGASS) on HIV and AIDS and Human Rights, issued a Declaration of Commitment that acknowledged the link between gender and the AIDS pandemic. The declaration acknowledged that women and girls are affected by HIV and AIDS and demands commitment to address the gender dimensions of the epidemic through several measures. This declaration emanated from the central importance of human rights and fundamental freedoms to an effective AIDS response. The emphasis is on calling countries to enact legislation barring discrimination against people living with HIV and vulnerable population, among which women and children are mentioned.

Within the global pandemic of HIV infections there are many different epidemics, each with its own dynamics and each influenced by many factors including time of introduction of the virus, population density, and cultural and social issues. Effective management strategies depend on knowledge on all these factors. To control AIDS, an article in Pubmed (Lancet, 1996) strongly argues that countries must not only promote changes in individual behaviour, but also address social issues such as unemployment, rapid urbanisation, migration, and the status of women.

This list (**Appendix 9**) is a comprehensive guideline for addressing the gender inequality with regard to HIV and AIDS. In Africa, UNAIDS focuses on interventions at country level. Their goals are not different from the measures discussed above, with exception of the provision of access to testing, counselling, and drugs for HIV positive women (UNAIDS, 2000: 1). In keeping with these goals, In 2000, SA made a commitment to reducing child and maternal mortality and reversing the spread of HIV and AIDS by 2015. However, the National Strategic Plan (NSP) cautions that the Department of Health could exceed their budget by 20%, which poses a challenge for affordability and sustainability of the NSP.

4.4 SUMMARY

HIV and AIDS is a challenge for women. Gender inequality is the primary impediment to HIV and AIDS prevention. However, gender blindness is curable and continued education on gender issues is paramount. Any programme or policy regarding HIV prevention should address the issue of gender inequality and confront constructed gender roles. The UNAIDS needs to clearly articulate an HIV and AIDS framework from a gender perspective. An understanding of the factors that affect women is critical to any effective measure to contain the spread of HIV, and to deal with its effects on both women and men. The understanding of the vulnerability of women to HIV must be understood in the broader context of deeply embedded social and gender inequalities, which lie at the heart of women's inability to deal effectively with the risks and needs created by the epidemic. There is a need for recognition of the interaction between HIV infection, cultural values and the rights and needs of women.

CHAPTER 5

HIV AND AIDS IN THE WORKPLACE

5.1 INTRODUCTION

It makes business sense for companies and the public sector to be involved in solutions for HIV and AIDS management. Companies acknowledge that AIDS puts their employees, their families and global communities at risk, thus dictating a radical and urgent attention to a safe and supportive workplace, where HIV positive employees are encouraged to contribute to the country's economy. Unless the HIV prevalence of the company is known, little can be done to implement strategies and preventative measures. This chapter looks at the HIV prevalence in South African companies, the efforts and strategies by SA business to mitigate the scourge of HIV and AIDS, as guided by employment equity legislation and corporate social responsibilities initiatives. This chapter also looks at successes and failures.

5.2 THE PREVALENCE OF HIV AND AIDS IN THE WORKPLACE

The impact of AIDS is still not fully understood in the workplace. The lack of understanding of the dynamics involved in the disease itself seems to portray a bleak picture of HIV and AIDS in the workplace. This is primarily because there is little published information in the South African work environment on the impact of AIDS from an employee perspective, rather than from an organisational perspective. What is known, is that HIV and AIDS will have an effect on jobs in terms of job load, stress level, job satisfaction and performance, relationship with co-workers and may ultimately influence the employees' decision either to leave or stay with employers (Hall, 2004, 110).

HIV and AIDS has become the single most concentrated threat to human rights in developing countries. It is a threat as it links the business, health and economy together and calls for a crucial role for business. In South Africa HIV and AIDS has increasingly become the dominant issue on the corporate citizen agenda. The economic impact is already been felt by most business sectors. In South Africa alone a current prevalence rate of 23% is estimated among people between the ages of 20 and 65 years, the most economically productive age bracket (UNAIDS, 2006:99). The prevalence for women is higher than that of men in the 15 to 24 age band, but higher for men at ages over 45 (Dorrington *et al.,* 2006).

The impact of HIV and AIDS on the company is through loss of productivity, increased costs and impacts on employee morale. (See **Appendix 10**). In a study by Guinness, Walker, Ndubani, Jama, and Kelly (2003) of seven companies in Southern Africa, it is reported that the cost of death due to HIV and AIDS was twice for that of white-collar financial firms than manufacturing and transport companies. However in a study done by SABCOHA in 2005 in South Africa, it was discovered that not only financial sectors were impacted significantly by HIV and AIDS, other sectors such as mining, transport, and manufacturing sectors had experienced the heaviest impact of the pandemic (*BER/SABCOHA*…, 2005).

A report in the AIDS Watch (2008) have projected that AIDS deaths of employees in the South African workforce will soon exceed all other causes of death put together. Another estimate by Major (2004:141) is that 43 199 public servants will have died of HIV and AIDS between 1985 and 2020 and about 126 000 would have retired as a result of ill health related to HIV and AIDS while still employed by government. According to Fakier (2004:89) by 2010 15% of highly skilled employees will have contracted HIV and AIDS. A recent survey of insurance policy applicants found that even though HIV was more prevalent among unschooled labourers, more people holding degrees were infected with HIV than those with only matric (Pienaar, 2004). In Zambia two thirds of the deaths are reported to be among managers (d'Adesky, 2003).

Anglo American, a global mining and natural resources company have been actively involved in the struggle against HIV since 1990, after their first HIV case in 1989. With the current prevalence of 22%, they have now broadened their efforts to include strategies to deal with HIV and AIDS among their suppliers and the communities where they do business (*Perspective*…, 2006:27).

Simon, Rosen, Whiteside, Vincent, and Thea (2000:22) argue that the decline in productivity and increasing costs due to HIV and AIDS will make it expensive for a company to perform. As a result, a company can reduce costs rather than raising its price by investing in mitigating the risks of HIV and AIDS among employees in order to remain competitive. The loss of skilled labour due to HIV and AIDS is likely to reduce the competitiveness of South African companies internationally. A 2003 Sanlam survey of benefit funds found group risk benefits increased as an expense on average by 15% to 20% (Hassim, 2004:29), compared to the 1999 Old Mutual survey of 15 companies which found that six of the companies surveyed were reducing death and disability benefits (Major, 2004:128).

Restructuring employee benefits is an example of how most companies are shifting the cost burden of HIV and AIDS onto the employees. The transfer from defined benefit to defined contribution pension funds has become a common way to avoid costs related to HIV and AIDS (Stevens, 2001:14). The United Nations regard HIV and AIDS not only as a health issue but an issue that cuts to the core of business practice (UNAIDS, 2000:2). Given all these realities, the focus of sustainability reporting on HIV and AIDS has been seen as an important aspect of business and what companies are doing (Fakier, 2004:90).

In the annual survey conducted by Global Health Initiative (GHI) of the World Economic Forum, 46% of the 10 993 business executives in 117 countries expressed concerns that the threat of HIV continues to reduce the workforce and has an impact on their operations. The concerns seem to have risen significantly by 10% compared to the previous year, which was 36% (*Perspective*…, 2006:37).

While there is still uncertainty about the exact extent of the HIV and AIDS epidemic in South Africa, it is estimated that HIV prevalence rates would peak at 13,1% among health workers (ING Barings, 2000). Kalyegira (2000: 2) indicates that one in five South African nurses are HIV positive. Furthermore, healthcare workers take care of patients with HIV-related illnesses and run the risk of becoming infected (Hall, 2004:111).

A study by Pela (2004) projects that up to 250 000 public servants may die of AIDS by 2012. Another study indicates that about 40% of educators died of AIDS-related causes nationwide in South Africa in 2000 to 2001 and these losses are heavily felt in rural areas (UNAIDS Fact Sheet, 2002).

HIV and AIDS is posing a scourge on the SA National Defence Force, with 22% of the 60 000 strong defence force being reported HIV positive. (The Star, 2002). The South African Police Services (SAPS, 2000) estimated that 35% of its officers between the ages of 25 and 29 years, and 45% of its officers between the ages of 30 and 34 years will be infected with HIV by 2015. The above statistics of various public services shows the impact of HIV and AIDS on the government sector, the largest single employer in the country.

In a survey of NGOs by O'Grady (2004:212), four of the nine surveyed NGOs had lost staff members due to AIDS. The staff loss was felt in the area of service delivery as the remaining staff had to increase their workload. Funeral attendance was indicated as a major issue affecting most NGOs, especially in African countries where traditionally the family needed several days to hold ceremonies. Most NGOs rely on community capacity through volunteerism to carry out their community projects, thus the impact of AIDS on their work is heavy as the availability of volunteers is dependant on their health status. Furthermore, community activities take precedence to any meetings, thus it was reported that scheduled meetings were often cancelled at the last minute due to a concurrent funeral that requires attendance of most community members.

The type of employment, occupation, nature and organisation of work, skills level and shortages of particular skills are factors that may determine the impact that HIV and AIDS will have on employees.

The HIV and AIDS challenge manifests itself in the impact of unscheduled sickness absenteeism that can only be inferred to be caused by the impact of HIV. According to the South African Constitution, employees are not compelled to disclose their status. As a result, it becomes difficult for the employer to manage sick leave caused by HIV and quantify the cost. On the other hand, those employees that may be comfortable to disclose their status still find the culture in the workplace lagging in encouraging disclosure. These employees are often feeling vulnerable and fear discrimination, victimisation and stigmatisation.

The high prevalence of HIV necessitates multi-sector and global initiatives in an attempt to deal with the pandemic. Such include the launch of the Global Health Initiative (GHI) of the World Economic Forum in June 2006. The World Economic Forum has called for companies and governments in Africa to join hands to form private-public partnerships to address the challenge of HIV and AIDS. Details of these efforts will be discussed further later in this chapter under business response on HIV and AIDS.

5.3 THE IMPACT OF HIV AND AIDS IN THE WORKPLACE

The impact of HIV and AIDS in the workplace ranges from big business with both skilled and unskilled workers to small, medium and micro enterprises (SMMEs). The challenges and impacts are not only a human resources issue but it is now being classified as a business risk, as it is beginning to affect the supply chain of the business. According to Bowler's (2004) presentation at the Symposium Proceedings University of the Witwatersrand 2004, the impact of HIV and AIDS will affect productivity, competitiveness profitability of service and other human resources impacts that will be felt in the rate of absenteeism, accident rates deaths, early retirement, disability retirements, industrial disputes and emigration (**Appendix 10)**. These impacts are already been felt by most businesses in South Africa.

In South Africa there has been increased costs related to increased employee benefits in the form of group life insurance, pension, funeral benefits and medical aids increases. It is only as recent as 2006 that the medical aids have moved away from limiting coverage for people infected with HIV. The coverage is now being classified as chronic, and the cost of coverage is unlimited just like other chronic health diseases (Discovery Health Newsletter, 2008). In addition Discovery Health is now classifying HIV test under the basic tests that are not charged from an employee's savings account but risk account; this however excludes certain plans such as the Core and Key plans.

Another aspect of the impact is evident in the competition among skilled workers, which tends to contribute to the escalating remuneration costs. Currently in South Africa there is increased wage differentiation and the assumption is that the contributing factors, in addition to employment equity factors, is the impact of HIV and AIDS. These aspects bring staff movement that leaves the business and employees to adjust to these changes. The changes often manifest in declining employee morale, loss of experience, loss of skills and loss of workplace cohesion and loss of management time.

One of the interesting aspects of the impact of HIV and AIDS, discussed by Bowler (2004), is the fact that the impact could be so adverse that in some businesses credit may need to be written off as customers die and sales volumes reduce. Stein (2001) adds that these impacts could contribute to reduction in savings and reduced disposable income as expenditure shifts to health and funeral-related expenses. With the increase of interest rates, high costs of petrol and food, South African consumers are already feeling the pressure of juggling the priorities of health, funeral-related costs, and basic needs.

In a survey done by Bowler (2004) in the Nelson Mandela Metropolitan Municipal Area, 64% of the workplace claimed HIV and AIDS related deaths (N=14, N_1=22 265). The study explored the impact of HIV and AIDS in the organisations in the area; 14 workplaces responded of which 13 workplaces were in manufacturing and one in the service sector. Significantly, in one workplace, Bowler's (2004) results indicated

anecdotal evidence through medical aid tracking of HIV positive employees that once ill, death followed quickly.

The impact of dying employees present a challenge to those left behind to continue with the work. As a result it can be clearly argued that the higher the prevalence, the higher the stress level on both employees and health workers. A study by Hall (2004: 113) of nurses in South Africa, revealed an alarming prevalence in 93% female patients and just over 6% in male patients. A total of 1 922 interviews were conducted among professional nurses, and nursing assistants. The study indicated that the impact on the prevalence is affecting half of the respondents in performing their duties and poses a challenge on their own wellness and their own safety. The results indicated that the perceived risk of infection is high compared to the actual infection of other infectious diseases, such as Hepatitis B.

What is generally known is that HIV and AIDS has and will continue to have an impact on the workplace in terms of work load, stress levels, job satisfaction and performance. This will become predominant as the workplaces continue to foster the work environment where openness is encouraged and those disclosing not stigmatised.

5.4 SOUTH AFRICAN BUSINESS RESPONSE TO HIV AND AIDS

The response of corporate South Africa to HIV and AIDS has been slow, partial, and erratic and somehow guarded (Dickson, 2004:37). A study by the South African Business Coalition on HIV and AIDS (SABCOHA) in 2003, which focused on large companies in South Africa, reported that only 60% of the 25 largest companies in South Africa had HIV and AIDS policies or programmes (Bendell, 2003:13). Numerous workshops and conferences have been held to assist employers and trade unions to develop policies and programmes in assessing and planning to contain the risk, ensuring non-discrimination and awareness. Where the impact of HIV and AIDS is the most profound, SABCOHA, in a 2005 study by BER, found that workplace programmes are becoming more mature and integrated into broader wellness programmes. The 2005 study by SABCOHA was expanded to include the transport sector and still found that the results from the 2005 survey did not differ from the 2004 survey.

There is significant pressure on the business sector from various stakeholders, including government, to act on the HIV and AIDS issue. These pressures and regulations are shaping and speeding up the corporate agendas in South Africa. The stakeholders are demanding that companies not only look at their financial performance but also take greater responsibility for the social and environmental impacts of the business (Save the Children, 2002:19). In South Africa the government has published an extensive Code of Good Practice on key aspects of HIV and AIDS and employment to guide workplace policies and programmes (Code of Good Practice, 2000). With regard to the risk of HIV and AIDS, according to the King II Report on Corporate Governance (Institute of Directors, 2002:1), companies are required to disclose the company's HIV and AIDS strategy plan and related policies to address and manage the risk and potential impact of the disease on the company.

Following the release of the King II Report, the Johannesburg Securities Exchange (JSE) announced its intention to implement a JSE Social Responsibility Investment Index (Johannesburg Security Exchange, 2002:2). The index facilitates investment in companies with good records of social responsibility in all aspects of business including HIV and AIDS, health and welfare. It further measures what companies are doing with regard to HIV and AIDS and measure the risks as determined by economic, environmental and social development (Fakier, 2004:90). For the first time in the Deloitte's survey of 'The Best Company To Work For 2005' in South Africa, current topical issues in the workplace such as feedback on HIV and AIDS, and work / life balance were addressed.

The South African Global Business Coalition on HIV and AIDS (SABCOHA) was established in 1997, specifically to increase the numbers of businesses that fight AIDS, making business valued partners in the fight against AIDS. SABCOHA provides technical advice and advocacy support for business organisations and helps to develop formal partnerships. One of the successful tools developed by SABCOHA has been manuals on HIV and AIDS policy development, training for managers and labour

leaders, employee education and global strategies for global business (SABCOHA, 2006).

Some of the HIV and AIDS responses for businesses include Corporate Social Responsibility Programmes (CSR) and internal HIV and AIDS programmes. The companies with CSR programmes are often viewed as glossy programmes and are resented by employees with no internal HIV and AIDS programmes. In a survey by (Dickson, 2004:51), it is stated that while the HIV and AIDS committee were not opposed in principle to the company providing high-profile donations to well-known but distant HIV and AIDS projects, they pointed out that there are more pressing priorities and often more desperate need on the company's doorstep. Where companies are managing the impact of HIV and AIDS on productivity and cost, it is through internal HIV and AIDS policies and through peer education. Within the context of HIV and AIDS in the workplace, peer educators can be seen as a third channel of communication.

HIV and AIDS peer education is another method of disseminating HIV and AIDS information to employees. Since peer education programmes were started much earlier in many companies, the formalised version of these programmes began in 1997, and was modelled on a similar work-based programme run by the Zimbabwe AIDS Prevention Project in Harare (Bassett, 1998). The focus of the programme is to keep employees HIV negative and educate HIV positive employees on how to stay healthy. A study by Sloane (2004:269), evaluating HIV and AIDS peer education in South Africa, found the programmes to be ineffective and contributing little to improve Knowledge, Attitude, Behaviour and Practice (KABP) in the workplace.

Dickson (2004: 55) found that in large companies there has been significant mobilisation of peer education through stronger structures. Managers were involved and effectiveness, localisation and partnership with necessary resources were considered. In one of the medium-sized companies researched, management had not grasped the concept of peer education and had no plans to facilitate it. In the study by Stevens, Dickson and Mapolisa (2004:12), a case study of two companies in South Africa, it was

stated that the HIV and AIDS policy was clearly not a guiding document for employees. There was reference to training and peer education but nothing had happened two years later. These researchers did not find the policy document to be an operational policy that had the potential to inspire confidence in shareholders who would want to know that this endemic threat is being managed well.

Following the 2000 world summit on HIV and AIDS, the Global Reporting Initiative (GRI) was developed. The GRI HIV and AIDS framework is a process that involves multi-stakeholder collaboration (GRI, 2003:1). The main purpose of the GRI HIV and AIDS guideline document is to offer a framework for organisations to report on their HIV and AIDS policies and procedures, as well as performance regarding HIV and AIDS. It is too early to assess whether the GRI standardised format for reporting meets the needs of all stakeholders.

Dickinson (2004:71) identifies six aspects that drive companies to respond to HIV and AIDS. The drivers can be divided into two sections, which are *external* and *internal* driving forces. The external drivers are legal requirements and social pressures. The internal drivers are voluntary regulation, the business case, visibility and internal agents. He argues that the external drivers have been expanded within the corporate environment due to the weakness of the internal drivers. Legal requirements have helped companies to ensure compliance with the law. It is of interest to note that among those companies addressing HIV and AIDS in the workplace, they do so due to pressures such as high court rulings on HIV and AIDS-related cases, which are providing practical warning of no tolerance for discrimination and non-compliance. Such an example was employee who won a case after suing South African Airways (SAA) for discrimination based on his HIV and AIDS status when he did not get the position he had applied for because he tested HIV positive during the recruitment procedure. (AIDS Law Project, 2000:3 - The SAA case (‘A’ v SAA).

The pressure which is necessitated by the social crisis that HIV and AIDS poses to South Africa has been evident in the corporate social responses some of the companies

have made. The approach of companies until recently has been based on the visibility of those infected, and given the long incubation period of the virus; such approach according to Dickinson (2004:78) is reactive. Irrespective of the assurance by the company policies regarding non-discrimination, infected employees still find themselves in the vulnerable position and in fear of being directly targeted for downsizing processes. This response continues to make HIV and AIDS invisible.

Internal agents of HIV and AIDS in companies are often those with limited powers such as human resources junior staff. In cases where the champions have been leaders in the company, these cases relate to the person having been personally affected by the disease (Clark & Strachan, 2000:11). Trade unions in South Africa have been noticeably very active and vocal at national level with regard to policies and awareness. The Congress of South African Trade Unions (COSATU) has developed guidelines for shop stewards. The National Union of Mineworkers (NUM) and the South African Clothing and Textile Workers Union (SACTWU) have actively engaged employers on the issues of HIV and AIDS (Meeson, 2000; Bisserker, 2001; Petros, 2003).

According to an article by Lifeline, some organisations consider HIV and AIDS-related training to be too expensive, without considering the indirect costs of not educating themselves and their employees (*Management Today*…, 2004:46). Other companies in South Africa are recognising that the increasing poverty and inequality caused by the AIDS epidemic will undermine social, political and economic stability, ultimately leading to an environment that is not conducive for business. In South Africa while employees are beginning to fall ill from the HIV infection, companies are expected to assess their responsibility towards their employees, home based care and education interventions.
One of the most active areas in companies in dealing with HIV and AIDS has been that of employee benefits with specific reference to medical aids and pension fund benefits. However, the study by (Bowler, 2002: 25) in the Nelson Mandela Metropolitan Municipality, revealed that the major increase to employee benefit costs over the past four years were the costs of medical aids (83,3%) and pensions (66,6%) and can be attributed to HIV and AIDS. Of the attributed increases, 33% has been in life insurance

due to HIV and AIDS. Large companies such as Anglo American in South Africa have made the decision to respond to HIV and AIDS in a very comprehensive way, by the provision of anti-retroviral therapy to all its employees. According to a consultant at an HIV and AIDS Wits Symposium attended in 2004 at Wits University, this approach has put more pressure on other companies and it may not be relevant for all companies. The consultant assists companies in implementing sustainable development programmes (*HIV and AIDS Wits Symposium*…, 2004).

A survey recently conducted by Markinor, across 130 small, medium and large Johannesburg Securities Exchange (JSE) listed companies in South Africa, reveals that only 45% of these companies have a fully documented HIV and AIDS policy and 59% of the companies are not aware of the HIV and AIDS prevalence within their workplace (*Succeed /Essential…*, 2004:5). Of the companies surveyed, 75% regard HIV and AIDS to be a long-term and not a current threat to the business, despite high statistical reports. The results reveal that 71% of the companies indicated that they have produced posters, 62% provided counselling for those infected, 61% distributed condoms, 53% had informal group discussions using HIV and AIDS literature, 46% hosted formal workshops by external experts, 45% supplied treatment for opportunistic infections and 44% provided treatment for STIs. It is noted in the study that 16% of these companies provided anti-retroviral medicine (ARVs) and 18% still intend to do so.

In South Africa there are few noticeable leading companies in addressing HIV and AIDS with the exception of sectors such as the mining sector, automotive manufacturers like Daimler-Chrysler and Ford, and Eskom. These sectors have been particularly transparent regarding HIV prevalence and have shown leadership and innovative approaches in developing strategies to manage the epidemic (Bowler, 2002:19). A number of surveys have indicated that the response of smaller companies lags behind (SABCOHA, 2004; Weiner & Mapolisa, 2003) these larger companies. A study of 80 small and medium enterprises (SMEs) with 20 to 200 employees in Gauteng in 2003, found that SMEs invest little in employee benefits and they did not view HIV and AIDS as a major impact on production costs (Connelly, 2004).

South Africa's big businesses have seen the impact of HIV and AIDS on small medium and micro enterprises (SMMEs) and their suppliers and for that reason they have extended their own HIV and AIDS programmes to these SMMEs. This strategy is an admission that by extending their programmes, it is an act of ensuring survival of the business as it is managing business risk. Illness and death of SMMEs' staff imposes costs along the supply chain of any business. Studies indicate that when large businesses worldwide use supply networks to address social issues, this yields more success in general and mitigates the continuous struggle of the SMMEs (Perspective, 2006:11).

Although media campaigns concerning AIDS have shown to have some impact on knowledge about the illness and the ways in which it is transmitted, they seem to have little impact on attitudes and behaviour. A study, measuring attitudes on AIDS, found that those who talk more frequently about HIV and AIDS and related issues will have more consistent attitudes than those who talk about it less frequently (Lalljee & Palmer-Canton (2001:87). However, it is important to note that the respondents may have been only those who have positive attitudes about AIDS; if the respondents had a mixture of those with positive and negative attitudes, the results may have been different. The results should be interpreted with caution.

More than 75% of the mines and financial services companies surveyed in the BER and SABCOHA study (2005), indicated that stigmatisation and discrimination has undermined the effectiveness of their HIV and AIDS programmes. Similarly, the study found out that stigmatisation and discrimination were of great concern to respondents in the wholesale, transport, manufacturing and building and construction sectors.

A study by Bowler (2004:27) evidently showed that in general companies in the Nelson Mandela Metropolitan Municipality had HIV programmes. The programmes were directed at prevention and care. Of these 92% ran awareness, education and training programmes and more than 80% claimed to monitor evaluate and review programmes.

Interestingly only 38% made female condoms available. Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC) an international organization with representation in SA has recently unveiled a practical and focused tool for mobilising business response to the feminization of HIV and AIDS. The practical tool provides replicable good practices that are focusing on workplace programmes for women, advocacy efforts and philanthropy, involvement of communities and leveraging their products and services. In this plan businesses are encouraged to disclose information about their supply chains and clearly articulate what they are doing. The three diseases, namely; HIV and AIDS, tuberculosis and malaria are treated broadly and treated as part of a full holistic health and wellness programme.

The following key themes and good practices are emphasized:

- Multi-sectoral partnership and diverse collaboration including all levels of government.
- Business leadership and commitment for workplace and community engagement
- Systems of effective monitoring and evaluation
- Community involvement
- Creative media such as art and sport to deliver information and education

In addition to efforts by the various South African business the South African Public Department under the Public Service Ministry, has developed the draft of employee health and wellness strategy framework to address the challenges of psychological and health issues, including HIV and AIDS, mother to child HIV transmission. The draft document focuses on four pillars of importance, namely: HIV and AIDS management, health and productivity management, wellness management and occupational hygiene and safety management (DPSA document, 2007: 30). In the minister's foreword: "the framework encourages a multi-sectoral response to HIV infection and wide-ranging impact of AIDS and other diseases on the workforce, and recognises the importance of individual health, wellness and safety and its linkages to organisational wellness " Fraser Moleketsi.

5.5 SUMMARY

The high prevalence of HIV and AIDS raises concerns among business leaders. Although there is much debate on whether the prevalence statistics available is the true picture of the real challenge, a number of surveys indicate latent crisis in the world of work. Companies are put under pressure from various sources to respond to the HIV and AIDS pandemic. For this reason the above literature indicates that many companies are taking responsibilities to mitigate the challenges of HIV and AIDS. It is however very difficult to gauge the efficacy of their response due to the potential competition that has been created by pressure and the publicity. Despite the value that can be derived from HIV and AIDS reporting, there are differing opinions about the value of the GRI framework as a reporting tool. Standards developed by GRI and SABS have a potential to give guidelines to proper reporting and monitoring, to currently minimise the inconsistency and incomplete reporting on these programmes.

CHAPTER 6

DIFFICULTIES EXPERIENCED BY HIV AND AIDS INFECTED AND AFFECTED WOMEN IN THE WORKPLACE

6.1 INTRODUCTION

Research has examined the particular stressors faced by women and the economic, social, and psychological costs of being female in the labour market and in the workplace. However, there is little information on the impact of HIV and AIDS on working women. There is an abundance of literature on the economic impacts of HIV on business which has spurned action globally (Reed, 2004:231), however there is little in terms of evaluation and empowerment programmes for working infected and affected women. This chapter provides an overview on the demands and stressors faced by women, with a focus on the HIV infected and affected women in today's workforce.

6.2 THE EFFECT OF HIV AND AIDS ON SOUTH AFRICAN WOMEN

There is still a tendency amongst researchers on HIV and AIDS to focus on the general impact of HIV and AIDS on the general population despite the reportedly high impact on women. With increasing number of women in to the world of work, this could be making a great impact on their roles as working women and caregivers. South African women are reportedly to be significantly affected by HIV. The explosive growth is noticeable in the extremely rapid increase in HIV prevalence among women attending antenatal clinics from 26,5% in 2002 to 29,1% in 2007, as discussed previously in Chapter Three. It is important to note that the statistics from antenatal studies only measure those women that are not a member of a medical aid or cannot afford private clinics. Those women who are attending private clinics are not counted in these statistics. It can be inferred that majority of women attending private hospitals are working women or women who are economically active or in a position to afford private hospitals. According to Majors (2004:136), in 1985 women accounted for 36% of the total workforce in the public sector. There was a noticeable rise to 41% by 1991

(Standing, Sender, & Weeks, 2002:158). In 2000, new female entrants in the public sector brought the total number of working women to about 55% (Public Service Commission (PSC), 2000:23) and this has been stable until 2004 (PSC, 2004).

According to Statistics South Africa, 53% of the employed labour force is married (Mutedi, 2003). A Human Science Research Council (HSRC) study conducted in 2002 by the Nelson Mandela Foundation showed that women aged 20 to 24 years had twice the HIV prevalence rate compared to young men in the same age group (NMF/HSRC, 2003:9). An estimated 3% of South African households in 2002 were found by the NMF/HSRC study to be child-headed, and the assumption is that most of these children are girls. Another study showed that in Zambia and Zimbabwe, for every 15 to 19 year old HIV infected boy, five or six girls in the same age group are infected (UNICEF, UNAIDS, WHO, 2002:17).

The South African Medical Research Council (MRC) indicated that death among women in South Africa, aged 20 to 49, rose by 168% between 1998 and 2003 (Reuter, 2004). A survey of HIV infected girls in Kwa-Zulu Natal Province showed that 10% of them reported their first sexual experience as forced rape (UNICEF, UNAIDS, WHO, 2004). With the risk of HIV and AIDS, women are the most vulnerable gender, especially in South Africa. According to Rape Crisis reports, South Africa has the highest *per capita* rate of reported rape in the world, indicating 115,6 for every 100 000 members of the population as of 1988 (Rape Crisis, 2003).

In a study of the development of high risk sexual behaviour by college students in 1996, it was found that during a three months time frame, about 49% (42 out of 86) of men and 64% (66 out of 103) of women have engaged in unprotected vaginal intercourse. Only 1 person reported using a condom (Scandell, Klinkenberg, Hawkes, & Sprinns, 2003:121). The study suggests that more women are engaging in high risk sexual behaviour than men. Jones (1996:23) indicates that HIV prevalence is growing the fastest among women. In a heterosexual relationship, it is easier for HIV to be transmitted from a man

to a woman than from a woman to a man, making women more vulnerable than men as discussed previously in a chapter discussing gender and HIV and AIDS.

In a pilot study by Bowler (2002:22), HIV prevalence per 1000 employees by gender, race and age for a sample of 20 HIV positive employees, showed that the prevalence is higher in female than males. Furthermore, it was higher in Africans than Coloureds and higher in the 25 to 34 year age group. The study was done in the Nelson Mandela Metropolitan Municipal area in the Eastern Cape in 2002. There was also an indication of only 20 HIV positive employees out of 1000 attending a wellness programme. A study in a rural area in the South African province of KwaZulu-Natal showed that of 13% of women, whose husbands worked away from home, two-thirds were infected with HIV (Morar, Ramjee, & Karim, 1998:23).

New approaches in HIV and AIDS programmes to lessen the vulnerability of women, includes efforts to keep couples together. A Norwegian relief agency working in Malawi hired and trained the wives of their drivers who frequently travel away from home to work as their ‘distribution’ assistants (James & Mullins, 2003:3). This effort is aimed at reducing the opportunities for highly mobile staff members to use their relaxation time for practicing risky behaviours. In addition, the programme generates a source of income for the family and is a programme that may be suitable for South African women.

HIV positive women experience many problems, including the absence of savings and other assets that cushion the impact of illness and death. These costs relate to the costs of drugs when available to treat opportunistic infections, transport costs to health centres, reduced household productivity through illness and diversion of labour to caring roles, loss of employment through illness and job discrimination, funeral and related costs. On the other hand, for a working woman, a compassionate undertaking for an affected family member can serve as a burden that can limit her economic opportunities (UNAIDS, 2006:90).

There is enormous strain on the capacity of women to cope with the psychosocial and economic consequences of illness, to such an extent that many families experience great distress and often disintegrate as social and economic units. When AIDS has eliminated the breadwinner who was the husband, the wife is often further exposed to poverty which then increases her chances of contracting HIV. This could be true in the cases of young women who will often be forced to engage in commercial sexual transactions, sometimes as casual sex workers, but often on an occasional basis as survival strategies for themselves and their dependants. The effects of this behaviour on HIV infection in women are only too evident and partly account for the much higher infections rates in young women who are increasingly unable to sustain themselves by other work in either the formal or informal sectors.

In a South African study in 1996, it was surprisingly reported that young girls think of short-term survival rather then long-term well-being. Short-term survival strategies often included exchanging sex for schooling, a job, money, or a roof over one's head. It is important to develop strategies that will protect young girls from the risks of HIV or premature death (Poku, 2001:198). The position of women in the current HIV and AIDS pandemic in South Africa is made precarious by the severe forms of stigmatisation that people who acknowledge their status currently have to face. The story of Laetitia (not her real name) as narrated by McGeary (2001: 48-50), symbolises that to acknowledge AIDS is to be branded as monstrous. Apparently, Laetitia was fired by her employer after falling sick in 1996. Following losing her job, her children were ashamed and frightened upon her disclosure, and her mother raged about the loss of money instead of Laetitia's health. The neighbour avoided her, young boys threatened to burn her house and seeking assistance from the police was not helpful. The story of Laetitia evidently shows the struggle of many working women who have families who do not understand the difficulties of women and employers who are in denial of the AIDS pandemic.

6.3 THE DIFFICULTIES EXPERIENCED BY HIV AND AIDS FEMALE CAREGIVERS

Caregivers are people who provide care for people with HIV and AIDS. Caregivers, who are mostly women by virtue of their caring role provide individual attention to bedridden

patients at their homes: feeding, washing and dressing them, reading to them, passing on health advice and offering companionship to help lessen their isolation (Irin PlusNews, 2008:1). Some are volunteers, while others receive a government stipend and others are family members of the infected. Caregivers in the content of family members, health providers and educators are discussed here.

There are several stressors experienced by caregivers such as care giving tasks, feelings of fear, and loss associated with each infection. In addition, there is social stigmatisation, loss of social support, feelings of rejection, and financial concerns. Dealing with uncertainty that surrounds HIV infection and AIDS is a stressor common to family caregivers (Brown & Powell-Cope, 1991; McGinn, 1996).

A study conducted by Gordon-Garofalo (2004:14) revealed that the most psychological stressors associated with HIV and AIDS were fear of contagion, stigmatisation, revelation of lifestyle, sense of helplessness, and grief. The most common stressors identified among family members were conflicts surrounding care and support provision. Gordon-Garofalo (2004:25) concluded that illness severity, suddenness of onset, and change in patient functioning were stressors as well. The impact on caregivers is determined by the severity of the illness. Therefore, the stressors could be grouped into two categories: the *primary stressors,* which are associated with care and household management and *secondary stressors*, which result from strains from primary stressors, i.e. financial, occupational, social, and emotional consequences.

Due to the stigma surrounding AIDS, spouses and partners are often reported to be anxious about discussing their needs with family and friends and thus becoming socially isolated. Gordon-Garofalo (2004:14) adds that uninfected partners also often feel resentment towards infected partners. Stigma attaches itself strongly to women because of the negative assumptions made about sexual behaviour risks, even when a woman has not engaged in any (UNAIDS, 2006:90). For infected women with a small baby, the fact that they are advised not to breastfeed their babies, puts a burden and causes them to carry the stigma around HIV and AIDS. In India, 90% of HIV positive women, who

were infected by their husbands, found themselves being subjected to more discrimination and stigmatisation than their husbands (ILO, 2003).

Individuals, not regarded as belonging to a high risk group, may also need assistance in coping with the epidemic. The care of patients with HIV-related disorders places stress on providers of care. Factors contributing to this stress include fear of contagion, prejudice against high-risks groups, unfamiliarity with AIDS, and the high prevalence of this disorder in some geographical areas, which limits training (Bowler, 2004).

Psychiatric intervention among caregivers includes education and offer opportunities to express their rational and irrational fears and despairs regarding the care of patients with HIV-related illnesses. The unwarranted fear in many caregivers of acquiring AIDS is determined in part by the ignorance, displacement, and the newness and uncertainty surrounding the AIDS pandemic.

The role of primary caregiver has a significant impact on women and their participation in the labour force. Perkins (2000:61) indicates that approximately 2,2 million people provide unpaid care to frail elders at home. Of those, 72% are women of 45 years or older, with an average age of 57. It is estimated that more women will quit their work for care-giving roles than those who continue to work, 20% will reduce working hours or take unpaid leave (Perkins, 2000). It has been well talked about in the South African media that the scourge of AIDS has affected the education sector. The challenges with the number of learners dropping out of school to support families who have been orphaned because of AIDS (most of them girls), threatens to erase the gains in education in the last ten years (Whitelaw, 2000). Educators teach learners that may frequently be absent from school to take care of ill family members.

Caregivers are likely to be overwhelmed by the high mortality rate and decrease in life expectancy. In countries such as Zambia and Zimbabwe, NGO staff members have taken several orphans and vulnerable children into their homes after their parents have died of AIDS (O'Grady, 2004:210). The task to care for dying children presents an

emotional, familial, societal, economic, and spiritual impact to the caregivers. Inside families, caregivers may be largely concerned about contracting HIV through casual contact, and outside the family, they might fear the gossip that can greatly affect the whole family and their social standing.

6.4 THE STIGMATISATION OF HIV INFECTED AND AFFECTED WOMEN

Theories on stigmatisation, such as sociological ones, highlight the reality that stigmatisation is the highest concern, because it is both the cause and effect of secrecy and denial, which can be seen as the catalyst for HIV transmission. According to (Rankin, Lindgren, Rankin & Ng'Oma, 2005: 4) the fear of stigmatisation limits the efficacy of HIV testing programmes across sub-Saharan Africa. The HSRC (2005:19) defines an HIV and AIDS stigma as an enduring attribute of an individual infected with HIV that is negatively valued by society. Alonzo and Renolds (1995: 304) on the other hand provide a more complex reading suggesting that a stigma is not merely an attribute, but represents a language of relationship as labelling one person as deviant - reaffirms the normalcy of the person doing the labelling.

6.4.1 Stigma

One of the theories on stigma is sociological theory. In sociological theory stigma is described as an attribute, behaviour or reputation, which is undermining an individual or group in a certain way (Ritzer, 2006: 16). The theory links stigma with stereotype and whether the person or group is accepted or rejected. The sociological theory implies that the society may establish the means to categorize and label the identified person or group and give them a social identity. In expanding sociological theory, (Falk, 2001:1) identifies two types of theories. Namely, existential stigma and achieved stigma. Existential stigma, implies a condition which the target of stigma either did not cause or over which the person has little control. He then defines achieved stigma as that which is earned because of behaviour or attitude and the person is blamed as having contributed to the cause that led to being labelled. Example of this behaviour is seen primarily in the social stigma that focuses on disease-associated with stigma. Such diseases are HIV

and AIDS, epilepsy, mental illness and disabilities. In studies involving these diseases, both positive and negative effects of social stigma have been discovered. In the work by the HSRC (2005:19) on theories of disease stigma, the definition of stigma is proposed as “an ideology that claims that people with a specific disease are different from normal society, more than simply through their infection with a disease agent.” There is a differing experience amongst people living with HIV and AIDS, some have reported that their stand on HIV disclosure have yielded positive results, whilst others have differed. The treatment of dehumanisation, often influences the decision of infected women to disclose or not to disclose their HIV status. Cases where there are designated hospitals or sections for access of HIV treatment can further reinforce the fear of stigma amongst HIV infected women. Despite increasing access to prevention of mother to child transmission initiatives, including anti-retroviral drugs, the perceived disincentives of HIV testing, particularly for women, largely outweigh the potential gains from available treatments in some countries, such as South Africa and Zambia (UNAIDS, 2007:241).

The study on the impact of HIV-related stigma by (Reece, Tanner, Karpiak and Coffey, 2007:73) revealed that the threat of social stigma prevented people living with HIV from revealing their status to others. Participants in their study with high HIV concerns proved to be 3.3 times more likely to be non-adherent to their medication regiment than those with low concerns. It is not surprising stigmatization is one of the greatest barriers of efforts against HIV prevention amongst women. The impact of stigma involves dehumanisation, threat and sometimes depersonalization of others, furthermore, this impacts on the HIV treatment and prevention as a whole. Therefore clinical care directed to women living with HIV should include consideration for patient sensitivity to social stigma.

It can therefore be conceptualized that stigma leaves people with a mark that in many instances they have no control over. The labelling can either contribute to stereotypes, discrimination or loss of status. In some cases it can even result into loss of self-esteem or cause identity issues. Levine and Van Laar (2004:11) postulate that stigma can dis-empower people and in some instances cause social injustices. An example of this is

that in certain Arabian countries and in Egypt, when people from other countries are found to be HIV positive they are deported back to their countries of origin, a practice that is not coherent with the United Nations' declaration (UNAIDS, 2004:55).

From the analysis of the definition of the societal theory above it can further be inferred that the pressure that is put on people who are labelled different such as in the case of HIV and AIDS could leave them with various mental health issues, particularly when they have no control over stigma that are attached to them.

Theories of stigma are further expanded by (Major & O'Brien, 2005:395) to include six dimensions, which give a better understanding of the challenge from one's personal responsibility viewpoint. The dimensions are classified as:

- Concealable stigma- which means the extent to which others can see the stigma
- Course of the mark- whether the stigma becomes more pronounced
- Disruptiveness- the degree to which the stigma affects social interactions
- Aesthetics – other's reactions to the stigma
- Origin – whether others think the cause was from birth, accidental or deliberate
- Peril- the visible impact the stigma has to others.

From these dimensions one can infer that stigma is necessarily not based on facts but on one's perception, belief and judgement of others. If the researcher's assumption is true, treatment of HIV should include a multidisciplinary approach where a person is viewed in totality, from the society they come from to the understanding of themselves. Research from HIV and AIDS has indicated these various stigma dimensions as common amongst women living with HIV and AIDS (UNAIDS, 2007:362). In some cultures, especially African cultures, the role of women have previously been generalized to one as equal to that of children. With the HIV epidemic the social stigma has worsened this perception. Women who have the burden of HIV and AIDS may feel that the stigmatization is transforming them from whole person to nothing. They may feel devalued whether in the workplace or in the society. The role of women in these cultures

and societies affect their identity and contribute to their level of self-esteem in a negative way.

Literature on the HIV and AIDS stigma tends to conflate the causes, functions and effects of stigmatisation and reveals a continuing tension between individual and social explanation for the phenomenon. Furthermore, the area of HIV and AIDS, as well as racism has conceptualised prejudice as a problem of individual ignorance.

Stigmatisation is part of the attitudes and social structure that set people against each other; it is with this background that the theory of stigmatisation is investigated against women's emotional status in relation to societal structures, including workplace interactions. Several examples are seen where fear of stigmatisation is contributing to women's behaviour during pregnancy and parenting. Fear is causing women to continue breast-feeding because the mothers do not want to arouse suspicion of their HIV status by using alternative feeding methods. HIV-related stigmatisation directly hurts people; individuals may be isolated within their family, hidden away from visitors, or made to eat alone (Nyblade, Pande, Marthus, MacQuarrie & Kidd, 2003:53). Stigmatisation can present itself in two forms: An internalised stigma, where the infected person becomes one with the illness and looses a sense of self, and an external stigma where the person is labelled by others. The combination of external and internal stigmatisation on the self may impose a heavy burden.

In Zambia, Tanzania, Zimbabwe and Malawi, experience of some women in the workplace is presented as a heavy burden, which is often a downward spiral marked by fatalism, self-loathing, and isolation from others (Rankin *et al.*, 2005: 2). Internalised stigma may perpetuate anxiety concerning infected or affected women given the perception of the community they live in. Women, sex workers, and youth are frequently blamed for bringing illness into the family. If we agree that these groups are generally disempowered due to perceptions and societal beliefs, then it can be argued that the burden on women is great, that the self-stigmatisation would therefore be potent, particularly if they have just learnt about their status. If the woman has low self-esteem,

she may already hold punitive views of HIV infection, which will then in turn be an emotional pain on her identity. This will then result in the third level of stigmatisation, which are multiple stigmatisations. Multiple stigmatisations are as a result of already existing prejudice and social stereotypes (HSRC, 2005:25). This is when different kinds of prejudice are added together. An example is when a woman experiences stigmatisation by virtue of being a single woman and being HIV positive.

In some African countries, husbands have beaten or abandoned wives thought to be HIV positive despite the fact that many women contract the virus from their husbands. (Rankin *et al.,* 2005: 4) In addition, it is acceptable in Nigeria that if a husband should die, the wife's in-laws may seize her inheritance (Alumbo, 2002: 117).

For working women, stigmatisation can place a burden on the family. The family may recognise that she may become increasingly unproductive and that caretaking will sooner or later draw one or more family members away from providing for the family. This will in turn put an economic burden on the family. The belief that the person will die anyway can cause a caregiver to give up on the person. In addition, in the workplace, stigmatisation may result in discrimination or outright removal from a job (Nyblade *et al.*, 2003: 53). According to an article titled "HIV/AIDS the caregiver" The following are some of the reasons why caregivers experience burnout (Health 24.com):

- Stigma associated with HIV and AIDS
- Secrecy and fear of disclosure among people with AIDS
- Over-involvement with people with AIDS and their families
- Personal identification with the suffering of people with AIDS
- "Difficult" patients
- The terrible plight of children
- A demanding workload
- A lack of support from superiors
- Financial hardships (of both patients and caregivers)
- Training and skills lacking

- Isolation and no support (especially of family members who are also caregivers).

6.5 THE EMOTIONAL PAIN OF WOMEN WITH HIV AND AIDS

Most literature on women living with HIV is focused on medical factors or obstacles faced by women living with HIV. There is therefore a need for theoretical and empirical literature exploring how women live and cope with HIV, which would include research on stress management, psychological make-up, and cognitive coping styles. According to the Nursing Times magazine, a domiciliary sister at St Christopher's Hospice, visiting a 41 year old with appalling physical problems, responded that the mental anguish and emotional pain are more overwhelming than physical pain. The blaming model of stigmatisation suggests that negative meanings are associated with disease and people who contract it, in order to totally allay anxiety about the risk of infection (HSRC, 2005:22). It is further postulated that blaming is a result of internalised pain and thus either projecting to others or splitting a psychological mechanism of reducing anxiety during crisis and stress.

At the same time, opportunities created by new treatments have created new, potentially stressful uncertainties. For example, people benefiting from treatments may worry that returning to work will jeopardise their receipt of health insurance and their chances of regaining disability entitlements, should their health again begin to deteriorate. In addition, contemplating having a baby might raise concerns that the demands of parenting could compromise one's health, which is generally argued as a medical risk in the medical literature on HIV and AIDS.

A new paper published by the UNAIDS-led Global Coalition on Women and AIDS, shows that when women have an income and a safe place to live, they are much more able to negotiate abstinence, fidelity, and safer sex. Economic security, the paper explains, is a major factor in enabling women to protect themselves from HIV infection. Today, however, of the 1,2 billion people living on less than US$1 per day globally, 70% are women. Women also represent almost 50% of all people living with HIV globally. According to the paper, securing property rights and inheritance rights for women and

girls has clear value in HIV prevention. Many promising initiatives are using microfinance and skills training to improve women's access to economic assets such as land, property, and credit to reduce their vulnerability to HIV. (Haldenwang, 2006:1).

Education is the most effective weapon against AIDS. HIV is transmitted mostly by behaviour that individuals can modify. AIDS is the leading cause of death among women and is preventable. The goal of prevention education must be to reach those individuals most likely to be at risk of infection (Jones, 1996:14), such as women and those who are in an abusive relationship. It is evident that women are most vulnerable both as homemakers, employees, and caregivers. It is the business sectors' challenge to address women's needs in the workplace and the next chapter will attempt to investigate workplace interventions by various corporations.

6.6 SUMMARY

Women, as wives and sex workers, are at risk of HIV transmission. As mothers, women must deal with the implications of HIV infection for their unborn children. As mothers, aunts, sisters, grandmothers, and daughters, women will have to care for the children orphaned by the epidemic. As caregivers, women bear the burden of caring for the sick and dying partners, children, relatives, and neighbours and attempt to hold the family unit together in the face of sickness and death. All these accounts evidently show the impact of HIV and AIDS on women. Compounded to the burden of HIV is the stigma associated with it. Stigmatisation continues to undermine treatment and intervention to reduce the risk of HIV among women. However, interventions should be geared towards empowerment of women faced with HIV at both individual and at an affected level as caregivers.

"We need to put the power to prevent HIV in the hands of women. This is true whether the woman is a faithful married mother of small children, or a sex worker trying to scrape out a living in a slum. No matter where she lives or what she does, a woman should never need her partner's permission to save her own life". (Bill Gates)

CHAPTER 7

THE ROLE OF EAP IN THE WORKPLACE

7.1 INTRODUCTION

This study investigates the role of EAP in relation to infected and affected women in the workplace. It is therefore important to outline the historical emergence of EAP, both internationally and locally. This chapter looks at the state of EAPs and key roles of workplace counselling.

7.2 EMPLOYEE ASSISTANCE PROGRAMME (EAP)

7.2.1 Definition

EAP is defined by the EAP Association of South Africa (2005:6) as a work site-based programme, designed to assist in the identification and resolution of productivity problems associated with employees impaired by personal concerns, but not limited to health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal concerns which may adversely affect employee job performance. Employee Assistance Programmes has been used as part of the business strategy to enhance employee functioning, loyalty, and performance in organisations around the world.

7.2.2 The Concept of EAP

Beidel, and Brennan (2006:36) refer to EAP practice as an approach with core technology dealing with:

- Identification of employees' behavioural problems on the basis of their job performance. The emphasis is on delineating job stressors.
- Provision of consultation with supervisors, managers, and shop stewards in assisting them with training regarding EAP utilisation and accessibility.
- Appropriate use of constructive confrontation.
- Development of linkages with external other community resources.

- The centrality of employees' alcohol problem as the focus of programme

In addition to change in the conceptualisation of EAP core technology, managing the HIV and AIDS scourge will be necessary within the framework of EAP. There has been a change in focus from earlier EAPs internationally. Van Den Bergh (2000:2) seeks to offer insight and pragmatic information on evolving themes for EAPs, which highlight the impact of changing workforce demography as it influences the need for workplace sponsored services which will assist caregivers and older workers. Secondly, the development of intervention skills broader than generic assessment and referral, to help organisations manage crisis, change and evolution.

De Jong and Miller (1995) and Saleeby (1997) encourage the use of concepts for a strength–based employee assistance intervention as empowerment, suspension of disbelief, dialogue and collaboration, membership, resilience healing and wellness and synergy. Strength employee assistance intervention can therefore mean finding opportunities of strengths in the clients. The opportunities may be formulated from the assumption that every environment is full of resources, trauma, illness and struggles that may be a resource of challenge, opportunity, and change. Every individual has strengths and clients are best served when they are experiencing the abovementioned challenges.

In addition, to keep up with the efforts in managing the HIV and AIDS scourge, it is the researcher's opinion that HIV and AIDS present with specific challenges that may require specific focus interventions in the workplace. For that reason the researcher proposes the addition of development of a comprehensive HIV and AIDS programme to be considered as one of the EAP's core technologies. This suggestion does not overlook the fact that core technologies include already interventions on health and welfare in a broader term, but the suggestion seek to enhance the technologies of EAPs and acknowledges the uniqueness of HIV and AIDS challenges.

7.3 HISTORICAL PERSPECTIVE OF EAP

An EAP is easily seen to be the descendant of a long life of programmes combining concerns for production and compassion. There are many reasons why companies adopt an EAP; some believe that helping employees solve their problems is good for workers as well as for the company, some use EAPs to avoid unionisation and retain control of the workforce.

An EAP is a work-based counselling programme that needs to be implemented strategically in order to impact on the life of employees. Involving key important people such as the Chief Executive Officer (CEO), the Chief Operating Officer (COO), and Unions is important to the success of an EAP.

7.3.1 International Perspective

The EAPs practiced internationally today, have their roots in the earlier Occupational Alcoholism Programme (OAP) model of 1940, established in the United States of America. These programmes were started during World War II. It was launched by the Kemper Group (USA) in 1962. Drinking was interfering with job performance, which in turn impacted productivity and ultimately economic efficiency. These OAPs saved companies money because of increased production and ultimately skilled workers were rehabilitated. The approach adopted was constructive confrontation, meaning supervisors were encouraged to confront employees with evidence of their unsatisfactory job performance, coach them on job improvement, encourage them to use employee assistance programmes and explain the consequences of continued poor performance. The assumption therefore was that the approach could be effective for other human problems, thus the establishment of EAPs.

In some countries, EAPs and occupational social work are seen to be one and the same discipline, due to the overlapping tasks. Some countries that have a strong background of occupational social work are still reluctant to introduce an EAP, or due to their culture do not accept EAPs. Such are France, Germany, Greece, Israel, Italy, Spain,

Switzerland, the Czech Republic, Korea, Norway, the Philippines, Portugal and Sweden. In other countries, the EAP concept is steadily growing and gaining momentum such as in Belgium, Ireland, India, Denmark, Jamaica, Mexico, Taiwan and the Netherlands (Masi, 2000).

Generally, EAPs are established in many countries and have started similarly as in the USA as a chemical dependency programme. Important to note is that in Brazil and India there is a strong cultural relevance and acceptance and Masi (2000) warns that one must not evaluate such services negatively. She noted that EAP in Brazil is more 'Brazilianized"; similarly in South Africa, there is call for a more "Africanised" EAP, Du Plessis in (Maiden, 2001:112). The emphasis is that business needs to parallel their culture with the socio-political changes. Countries that have seen the benefit of EAPs significantly include those with strong substance abuse incidents such as Puerto Rico, Bermuda, Russia, Jamaica and Trinidad and Tobago. In Singapore, EAPs is seen as a tool for enhancing both the individual and the workplace collectively to achieve their utmost potential. EAPs are seen as mechanisms for overcoming barriers that impact on personal and corporate success.

Interestingly, some of the South American and other countries that have implemented EAPs, have done so due to the existing USA companies in their countries. This raises a question whether they would have done so if they were no USA based companies. Johnson and Johnson, Levi Strauss, and other motor companies are examples of this phenomenon. Motorola in Japan has an interesting way of providing counselling to employees. They don't call it an EAP, but the psychologist is reimbursed whenever an employee has consulted. This could be similar to the Netherlands style, which tends to rely on existing EAP vendors. According to an EAP consultant at the 2007 EAP International Conference held in San Diego, California in October 2007, he found it common that in Bermuda there are no internal EAPs due to the fact that companies tend to have only a few employees as a result most of the EAP services are offered by consultants and through external models.

The countries that have strong EAPs include the USA, Canada, New Zealand, United Kingdom, Australia and South Africa. In these countries the EAP external models seem to be more popular. It is noted that currently in the United Kingdom, EAPs provide services to between 5% and 6% of the workforce, covering 1 285 000 employees (Berridge *et al.,* 1997). Today in the USA large corporations without an EAP, is the exception. From 1970 when the OAP was formed, to 1990, EAPs have progressed very positively, expanding emphasis on work-family balance, cultural diversity, and health promotion programmes. In addition, EAP staff members became expert consultants in critical incidence debriefing and the prevention of violence in the workplace, which was seen as effective during 11 September 2001, as reported by Maiden in a 2003 presentation, during a visit to the University of Pretoria in South Africa.

Sweden, even though the emphasis is not on EAPs, has identified the importance of HIV and AIDS education through the occupation social work programme. In Greece, Masi (2000) notes that there is a strong history of family norms, and interestingly, AIDS is viewed as a threat to the integrity of the Greek family and viewed as an outsider's problem. There is a strong proactive attempt at AIDS prevention, similarly in Jamaica the high prevalence of AIDS has necessitated an EAP that deals with the HIV and AIDS pandemic and substance abuse in a proactive way. In South Africa, employees are beginning to fall ill as a result of the HIV virus. Companies are expected to assess their responsibility towards their employees, home-based care, and education interventions.

7.3.2 South African Perspective

South Africa, like many other developing countries and the international world, is not unique with regard to problems in the workplace. Thus the concept and practice of EAPs are seen as vital in addressing workplace problems. EAPs were introduced in South Africa in the 1980s (Padiachy, 1996:44). Some of the first companies to introduce EAPs were the Chamber of Mines, Iron and Steel Corporation, which is now known as ArcelorMittal, Electricity Supply Commission, Alpha Limited, Everite (Fibre Cement Division), South African Breweries, Sabax and the Council for Scientific and Industrial Research. According to Du Plessis (1990: 246), there is no accurate information on

exactly how many EAPs there are in South Africa, however she cites Terblanche's study done in 1988 that 64 companies in an audit of companies with EAP in South Africa reported having an EAP. Currently, the implementation of EAPs is on the increase in South Africa. In 1995/96 a survey by Harper (1996) of the top hundred companies revealed that 42% companies had EAPs in the workplace. The study looked at the prevalence, model design, and services rendered. In 2005 it was estimated that about 65% of the top hundred companies surveyed have EAPs, ranging from internal to external models. In the 1980s, the preferred model was an in-house or coordinator model. There is a growing trend to outsourcing and combination / mixed models. In the 1980s there were only four recognised national service providers with a number of excellent regional players. Today, there are a higher number of service providers with even international recognised partners.

Due to the South African political history, counselling services are mostly run by NGOs and the emphasis on primary mental health services is high. Some companies still feel strong to involve primary mental health coordinators in dealing with problems experienced by employees, such as trauma debriefing and depression. One would therefore still find that employers would use service providers such as the Family and Marriage Society of South Africa (FAMSA), Lifeline, and The South African National Council for Alcohol and Drug Abuse (SANCA) for specialised services. SANCA has encouraged the development of counselling services for alcohol dependent employees by emphasising and publicising most importantly the hidden costs of alcohol abuse to organisations and that alcoholism is a treatable condition, Du Plessis in (Maiden, 2001:101).

EAPs in South Africa have been established for a variety of reasons, ranging from seeking alternative ways to manage poor performance to giving expression to the concept of internal responsibility and preventative approaches to crisis intervention (Du Plessis, 1990: 35). Due to the South African political history, an EAP often plays a role in encouraging trends, such as moving from an authoritarian culture to a more

participative one, from an exclusive to an inclusive style, from secrecy to transparency, from withholding to empowering, and a culture of ownership and belonging.

EAPs in South Africa are not only engaged in clinical or curative interventions, but have developed creative preventative programmes to address employee needs. The following are some of the programmes that various EAPs have introduced in companies in South Africa (Maiden, 1992:4):

- A development of a Visiting Wives Programme for miners by Anglo American Gold and Uranium Division's (West Rand Region), after it was found that miners were ill at home. This stemmed from a family-focused need and could be seen as a supportive approach type programme.
- The Chamber or Mines offers a wide range of EAP services to the mining industry. The services offered include assessment, diagnosis, and treatment, with emphasis on the core technology and incidence debriefing. Most South African companies offer similar kind of programmes, either through internal model or external models.
- The Electric Supply Commission of South Africa (ESKOM). ESKOM was one of the companies with a comprehensive HIV and AIDS programme in the early 1990s. Maiden's (1992: 2-7) observation was that the ESKOM programme tended to focus on education for all employees from rural and remote areas, including Zimbabwe, Mozambique and Botswana. This programme could be seen as a preventative approach type programme.

A study by Liebenberg (1990:21) makes two observations:

- That EAPs in South Africa have unique third world characteristics in that some of the facets are still complicated by issues such as malpractice liability, insurance, and clinical accountability.
- The second observation is that traditional patterns of EAPs in South Africa tend to focus mainly on early identification, and on treatment as a reactive rather than a proactive response. The strength of EAP in SA is that EAPs are empowered to identify problems earlier due to the problem identification skills that are inherent in

their social work background. Early problem identification precipitates good prognosis and a well-defined treatment plan.

These observations are in contrast with Maiden's observation that South African EAPs tend to be rather advanced and have developed rapidly and have become sophisticated in a short period (Maiden, 1992:2). Du Plessis (1990:35) adds that EAPs in South Africa are growing at an unprecedented rate, using both micro and macro perspective approaches. Harper (1999:12) reports that EAPs in South Africa evolved from internal social responsibility role changing social and legislative conditions within the workplace to being integral part of the business. Some of the changed issues include, among others, managing diversity, effective HIV and AIDS management, and managing transformation and affirmative action.

Many EAPs in South Africa are involved in bio-psychosocial health prevention and lifestyle disease management, in spite of the above observation in the study done by Terblanche (1992:27) where it significantly notes that EAPs in South Africa have just taken off, but are still not utilised to their fullest potential. The study suggests that EAPs in South Africa lack operational specifics, such as comprehensive training for managers, union representation, development of a sophisticated record keeping system that enhances confidentiality and staffing of the EAP by personnel with appropriate experience. It is the researcher's observation that it is becoming common practice in South Africa that EAPs, in addition to offering counselling are focusing on training and coaching of managers and employees in various workplace aspects. The training includes basic EAP referral, dealing with alcoholism and HIV and AIDS in the workplace, and life skills training.

A study done by Padiachy in 1996 made an observation that EAPs in South Africa were still applied predominately in blue-collar environments. Padiachy's study looked at the Standard Bank of South Africa Limited as a white-collar environment and the results were that Standard Bank has come to terms with the challenges of business and society and recognised that the establishment of an Employee Wellbeing Programme was a business imperative. (Padiachy, 1996:4).

Top problem categories in South African EAPs, as reported by Masi (2000: 134), include marital problems, depression, anxiety and suicide, financial problems, bereavement, gambling, hostility, domestic violence and rape, post-traumatic stress - related to violent crime, substance abuse and interpersonal workplace conflict.

There appears to be an emergence to broaden EAP in South Africa to include both employee psychosocial needs and organizational needs. The DPSA strategy document (2007:30) categorises the programmes into three:

- Employee Assistance Programme (EAP)
- Wellness Programmes (EWP)
- Work Life Programmes (WLP).

All three programmes even though they are defined differently it would seem that according to DPSA the focus is on service offerings that covers the traditional areas which addresses the entire spectrum of psycho-social stressors in the workplace in order to enhance individual and organisational wellness and ultimately productivity.

With the establishment of EAPs in South Africa, which then gave rise to formulation of EAP standards in 1996, it is hoped that EAP principles and ethics will be adhered to. The standards include the definition of EAP, core activities, and guidelines on evaluations.

7.4 REASONS FOR IMPLEMENTING EAP

There are two major reasons for EAP in the workplace. Firstly, the identification of social problems at work stemming from issues such as violence, strikes, high turnovers, high costs of recruitment, low productivity, the need to motivate workers towards greater productivity, counselling for personal, psychological or alcohol-related problems. Secondly, and the most important reason, is the employers' positive regard for employees. This could therefore be seen as the employers' social responsibility. If the

view is that employees experience problems at one point or the other in their lives, it will be therefore important to establish an EAP to address those problems so as to minimise problems and maximise profit. Sometimes these efforts are just more than internal initiatives but do enhance the company's image on an external basis.

Some companies see EAPs as integrating management concerns for productivity with humanitarian values, a management tool that reinforces the management principles, policies and procedures. A good EAP, established with union buy–in, reinforces the supervisor's responsibilities and create forums for employee debates. Dickman, Emener and Hutchinson (1985) emphasise that labour involvement is important to secure employee participation in any programme. The union's primary objective in the workplace is to look after the interests of employees. The union often has a strong background of social policy on a national level and ensures that the Human Resources Department implements key policies such as the Employment Equity Act, where the focus is on non-discrimination and equity.

The important reason for an EAP is to provide timely, professional help for employees whose personal problems are interfering with their work performance; such problems may not be limited to marital, HIV and AIDS, transport problems, day care problems, mental health, and work-related problems such as absenteeism, accidents, and conflicts in the workplace. Van Den Bergh (2000:2) suggests that EAPs in the 21st century should focus on human intervention strengths, rather than pathologies with emphasis on new paradigm words such as strengths, resiliencies, hardiness, empowerment and solution-focused approaches. Not many managers and union officials alike enjoy disciplinary processes. EAP offers an alternative to a misunderstanding of workplace processes and an EAP remains a better option to a disciplinary process.

7.5 THE TROUBLED EMPLOYEE

The term troubled employee will be used in this research as defined by 'those individuals whose personal problems such as HIV and AIDS; alcohol and drug addiction; marital difficulties; emotional distress preoccupy them to the extent that is on either own, or supervisors judgments, work performance is disrupted'. The term troubled employee is often used interchangeably with problem employees. Bruce (1990) defines a problem employee as an employee whose behaviour in the workplace causes reduced productivity and lowered morale for self, colleagues, or supervisors. An employee can be troubled by personal problems as major as death of a spouse or an HIV and AIDS infected family member. It is important that unless those troubles spill over into the workplace as behaviour that lessens effectiveness, that the employee will not be considered a problem employee.

The effect of one problem employee or troubled employee can change organisational goals. Problem behaviour of one employee will have a ripple effect that can destroy the productivity of every employee in a work unit. Employees do not often leave their troubles at home. The problems stay with them, haunt them and sometimes reduce work performance. Troubled employees are described by Bruce (1990) as the most difficult cases, as one must continuously deal with difficult and diverse challenges that often require control that most EAP practitioners have no expertise in. He further cites family problems as the major concern for escalating conflicts between work and family life; stating that 44% of the work force is female, and that 60% of those women have children under the age of six. In addition, some of the personal problems, which may be caused by employee deficiencies, include developmental issues, alcohol drug, emotional, financial, health care, legal, mental and physical issues. It has become common practise to define troubled employees not only as those with personal problems, but include those with several work-related problems such as discrimination, skill deficiencies, management style, sexual harassment, expatriate re-entry, job condition, job structure and role conflict.

With the call for more integrated EAPs, a need analysis of the company will guide where most of the programmes are needed. This will require cost benefit and workplace impact studies on various employee problems. The costs of mental health illness can add up to major costs annually, if not managed. Mental illness definition can be understood from a mental health perspective. Mental health is a term used to describe either a level of cognitive or emotional well-being. From the perspective of the discipline of positive psychology, mental health may include an individual's ability to enjoy life and maintain a balance between life activities and efforts to achieve psychological resilience (About.com, 2006).

The World Health Organisation (2001) argues that there is no 'official' definition of mental health. Cultural differences, subjective assessments, and competing professional theories all affect how 'mental health' is defined. This background therefore suggests that how an organisation is going to calculate the cost of mental illness on their workforce will primarily be influenced by their definition and their organisational culture. Therefore mental illness can be described as a state of the mind, thoughts, mood, or behaviour that causes distress which can result in a reduced ability to function psychologically, socially, occupationally, or interpersonally.

The methodology to calculate the costs of mental illness can therefore be formulated along the lines of subdividing the cost that results from a reduction of productive activity among the mentally ill; the cost of treating the mentally ill; the cost of illegal and other undesirable behaviour that can be attributed to the effects of mental illness; and the measurable and visible psychological loss indicators such as; fear, frustration, and despair which are often as a result of idleness and rejection.

Occupational mental health however is associated solely with the psychiatrically ill worker, whose symptoms interfere with his effective functioning on the job. In a broader sense, occupational mental health is concerned with thought, feeling, and behaviour - both healthy and unhealthy - as it occurs in the workplace, organisation, or as it relates

to the performance in a job. In a larger context, the mental health field deals with factors in the work environment, which supports mentally healthy behaviour as well as those that may be involved in triggering the development of symptoms of emotional disturbance.

Today we have begun to realise that a person cannot ignore either his concern with social, financial, and spiritual obligations or his very personal likes, dislikes, attitudes and temperamental traits when he comes through the office door or factory gates. EAP, for some companies is a component of Occupational health and Safety. The goal of occupational health or mental health in industry is therefore to promote and maintain the highest degree of physical, mental, and social well-being of all employees. The employee can be a bit fearful, a bit forgetful, a bit suspicious, a bit compulsive, irritable, and angry, and still be very much normal. When confronted by stress and strain in the form of worries, whether they precipitate in the home or at work, there may be an exaggeration of these particular traits. In a research involving the top 100 companies in South Africa, Harper (1999:4) identified that of the 42 companies who have EAP services, 45% were located in the Occupational Health. This according to Matlhape (2003: 32) tends to give EAP a health and health promotion focus to the exclusion of other broader organisational development issues affecting employees.

7.6 MODELS OF EAP

Whatever the reason for an EAP, the benefits are evident for both economic and humanitarian reasons. From the employee point of view the benefits may be summarised as cost effectiveness, i.e. reduction of health care cost and improvement of social functioning and self-esteem (Kurzman & Akabas, 1993:27).

On the other hand, from the company's point of view the benefits are:

- An EAP provides a mechanism that reinforces basic management practices.
- An EAP enhances corporate image.

- Measurable cost savings: this may be evident in measurable variables as reduced absenteeism, improved error judgment, and less late-coming.
- Minimises appeals, grievances, and arbitrations - especially when there is an improved relationship between union and management.

It is with these benefits in mind that a company considers a model that will address core issues and bear these benefits. Every model will distinguish clear functions for both the employer and the employees. The EAP model is the structure that the company uses to plan, design, and implement programmes to address the needs of the troubled employee. As a result, a need assessment and programme plan will assist in determining which model to use. The programme plan should be flexible enough to allow appropriate changes, which will yield to an intended goal and prove to be useful and valuable to the organization. (Warley, 2004:8).

There has been a rapid growth in the number of EAPs. This study will focus and narrow the models to only two as defined by Bruce (1990) as internal and external models. Organisational employees staff internal models, while personnel who are employed by an organisation that sells EAP services operate external programmes. The internal models are employers and union monitored while external models may be hot-line, consortium or contractor-driven. Union programmes may be totally union-operated and maintained. A union member may volunteer for the programme. Highlights of this model may be self-development activities, crisis intervention and peer confrontational.

The internal model (**Appendix 11**) is the one that is designed, implemented, and managed by the company's personnel. In this model, the employees either refer themselves or are referred and the counselling takes place onsite. The office is accessible and the cost for travelling and loss of time is minimal. The role of the counsellor is to perform case monitoring, aftercare, and job re-entry of employees and assist management in the planning of organisational functions. It is widely observed that confidentiality and anonymity are the two principal disadvantages of the internal programme (Bruce, 1990).

External models (**Appendix 12**) are models where many functions are provided by external agencies with various EAP specialists. There is a contract between the outside agency and the company. The advantage of this model could be that employees may feel comfortable to discuss their problem with someone who is not part of their company and feel their confidentiality is guaranteed. The external models often include hot-line services. There are currently a few major EAP service providers in South Africa, namely ICAS, Ndawo, The Careways Group, Leaders Culture Innovators and Agility. According to Sithole (2002:159), the external model is the most common model in South Africa and it seems to be yielding successful results to a successful EAP.

Both external and internal models may provide services for employee dependants. Assessment skills for practitioners include assessing dependent care as an underlying problem, even if the employee's presenting problem does not include care giving responsibilities. Given that EAPs offer structured limited sessions to most employees, the practitioner's knowledge of community resources, health care systems and community educational support services assist in addressing some of the complex issues related to dependant care. According to Hoffman (2002:29), a survey of EAP counsellors in New York found that less than one quarter of respondents had ever attended a seminar or training regarding dependent care. The recommendation therefore is that EAPs must provide their counsellors with comprehensive training that addresses practical skills building opportunities in identifying dependent care. Some of the dependent care issues may include care for people with HIV and AIDS and other life threatening diseases, parenting and child care, physical and mental health and issues relating to death and dying. The involvement of an EAP in dependent care may help in minimising the impact of dependant care stressors on employees.

Dr Volpe (CEO Leadership and Culture), one of the experts consulted in this study, believes that more has to be done to diversify the services offered through EAPs. She emphasised that given diversity in various countries, an EAP's core technology may no longer be applicable in its totality in the running of a day-to-day EAP. As such, she indicated that creativity is required to change employees' behaviour. This approach, she

said, it is not only one-on-one counselling, but could include diversity training, change leadership and identification of cultural strengths.

7.7 SUCCESS OF THE EAP

Whether the company chooses an internal or external model, the EAP needs to be well implemented. To yield a positive and successful EAP, Dickman *et al.,* (1985) advise that the company should consider a policy guideline, which recognises that problems are part of life for every employee. The company's policy should be informed by the core ingredients of a successful EAP, which are:

- Accessibility
- Training for managers and supervisors
- Management orientation
- Insurance coverage
- Broad service components, which covers all various employee problems
- Professional leadership
- Programme evaluation and follow-up
- Confidentiality and anonymity.

This researcher therefore concludes that when an EAP has been successfully implemented, the following will be indicators of some of the management benefits:

Popularity of the programme: When employees understand the referral procedures and believe in the confidentiality of the programme, they are likely to use the programme. The popularity may be promoted through intervention techniques, referral procedures, review, and alignment of policies and procedures**.**

Mobilisation role: When union and management work together cooperatively under the auspices of an effective EAP to help troubled employees, work morale tends to increase and apathy diminishes while there is a significant high turnover and low absenteeism. An effective EAP mobilises all stakeholders for high utilization.

Satisfactory feedback: It is important to allow employees who utilise EAP to give continuous feedback regarding service offered. When more challenged employees are helped, feedback by employees indicate timely assistance and positive wellness.

Enhanced productivity: EAPs are designed to reach intended goal of its existence in any organization. The goal of EAP is to restore employees to a more functional state after any personal or work related challenge.

Resilience building: The role of EAP is to give employee alternative option to problem resolution and offer skills that contribute to employee resilience, personal growth and empowerment.

7.8 SUMMARY

Motivations for providing human services in the workplace are related to cost savings, increased productivity and humanitarian reasons. EAPs emphasise the kind of programmes that offer a holistic approach focusing on physical, mental, and emotional wellness. Evidently, as seen in this chapter, there is little information and scientific research about EAP in South Africa. There are still conflicting debates about its development and effectiveness. It is however important to note that there is academic interest in the subject and enthusiasm among authors that EAPs in South Africa are here to stay.

There is a clear difference in the historical development of EAPs in the USA and EAPs in South Africa. The scope of EAPs in the USA focuses on broad interventions, while in South Africa the focus seems to be on individual interventions. The focus in the USA in the past was on alcohol programmes and in South Africa it looks like the focus will be on HIV and AIDS. As evidently noted, organisations have already in the 1990s been implementing HIV and AIDS programme. This means that HIV and AIDS had been identified as a threat to the business and prioritised as an integral part of the EAP programme. The next chapter takes a look at HIV and AIDS in the workplace as a responsibility of EAP.

CHAPTER 8

THE ROLE OF EAP IN ADRESSING ISSUES OF HIV AND AIDS INFECTED AND AFFECTED WOMEN IN THE WORKPLACE

8.1 INTRODUCTION

Drawing on the interrelationship between personal problems and job performance, the thrust of EAP lies in broadened EAP services; including problems that affect, or have the potential to impact negatively on an employee's job performance. An intervention that can reduce the stress, associated with high job strain, has the potential for immediate benefits. EAP clientele will include among others, risk populations, e.g. single parents, substance abusers, mentally ill workers, and persons with HIV and AIDS and family members of each of these groups.

8.2 HIV AND AIDS PROGRAMME

In South Africa, EAP practitioners have begun to assume a major role in the area of HIV and AIDS. A recent survey conducted by Markinor across 130 small, medium and large JSE Securities Exchange listed companies in South Africa, reveals that 59% of the companies are not aware of the HIV and AIDS prevalence within their workplace (*Succeed/Essential*…, 2004:5). The results indicated that only 62% of participating companies provided counselling for those infected in the workplace. One company's response to HIV and AIDS was evidently seen within the restructuring process whereby the wellness programme was designated as responsible for HIV and AIDS management (Steven, 2004:10). EAPs are involved in managing HIV and AIDS programmes, including designing and implementation of the programmes.

Three important aspects are training, education, and counselling of those infected and affected. In the area of HIV and AIDS risk prevention, Purcell, Degroff, and Wolitski (1998: 282) mirror this sentiment, suggesting that the first task of social workers (EAP practitioners in this case) is to assess risk behaviour. Valid assessment of high risk sexual behaviour related to HIV is important, because this information is used to

determine who receives education services and EAP interventions. It is suggested that individuals do not accurately self-report their sexual practices, especially behaviour related to HIV and Sexually Transmitted Infections (STIs). Under-reporting of high risk behaviour and over-reporting of protected sex have been found to occur more frequently in face-to-face interviews than in more anonymous conditions (Scandell *et al.*, 2003: 120). This could explain the EAP statistic reports presented at various local EAP conferences and during benchmarking sessions among various SA corporates. However, according to Du Plessis in (Maiden, 2001:115), statistics shared by EAP practitioners in a meeting held in Johannesburg in 1995, health issues such as HIV and AIDS and Sexually Transmitted Infections were on the increase. This means the EAP forums are platforms to discuss best practice and confidential statistics that are not otherwise discussed in the companies' published newsletters.

EAP and occupational social work use some of the frameworks and skills borrowed from psychiatry. With the impact of HIV and AIDS in the workplace, the treatment of employees in the environment with focus on casework is helpful. In addressing HIV and AIDS, practitioners face death and dying on an ongoing basis. In psychiatric management, the treatment of HIV and AIDS is treated and understood in causality with other mental health problems such as depression, grief responses, irrational guilt, diminished self-esteem and at times pronounced suicidal thoughts. This management requires psychological debriefing according to Lewis (2004:10). In most cases the symptoms are related to conscious and unconscious conflicts about how the disease was acquired. One of the common psychiatric interventions for patients with psychiatric disorders is the ability to create a structure for the patient. The importance of limit setting appropriate to the patient's current capacities, decrease unreasonable preoccupations, and reducing self-destructive behaviour can refocus the patient. Similarly, HIV and AIDS can first present in the form of cognitive or emotional symptoms, thus the need to follow structured counselling may be necessary. Warley (2004:8) encourages adoption of a pre-treatment model that uses quantitative and qualitative data collection methods: The model, which the researcher believes, is important in counselling of people living with HIV and AIDS includes the following theoretical frameworks:

- **Psychodynamic questions:** the technique that makes enquiry about the impacts of the client's past history as it affects the present and the hidden fears and anxieties.
- **Cognitive-behavioural queries:** the focus here is on the thoughts about self, others and the future.
- **Life model questions:** the enquiry is about phase of life, interpersonal processes and environmental barriers.
- **Solution- focused queries:** the focus here is about assessing the strengths and motivation of the client.
- **Psycho-education:** this process is important in particular to all clients facing life-threatening illness. The focus is understanding and acceptance of the illness.

It is not uncommon to find some AIDS patients remaining unreasonably hopeful about recovery, despite the presence of their fatal illness. In cases where denial in some patients has become so extreme that it interferes with the patient receiving medical care, it is recommended to confront the patient and treatment be instituted. The psychological problems caused by AIDS are psychosocial stressors particular to death and dying. These include ostracism by family, friends, and lack of a supportive social network. As more people are infected daily, the need for counselling by trained mental health professionals is growing. Most therapists can offer psychotherapy to treat grief, anxiety, depression, alienation, and avoidance behaviour. Although self-help groups and support groups are available, some individuals may have unique problems concerning confidentiality and anonymity preventing them to participate.

Persons who are HIV negative - but who are at risk for HIV infection - are often psychologically distressed, despite their HIV negative status. This may include individuals whose recent behaviour (intravenous drug use or unsafe sex) has placed them at risk of HIV infection. The distress, which is often acute, may be related to fear of pending test results. Stress may also result from the fact that the person must now alter their future behaviour to avoid infection. Providing counselling reduces the psychological problems and helps to prevent the spread of the disease.

8.3 HIV AND AIDS COUNSELLING IN THE CONTEXT OF EAP

Counselling is widely used as a strategy in health care and in the workplace (Summersfield & Oudtshoorn,1995: 55). Many people offer AIDS counselling, such as telephone counselling and / or face-to-face counselling. AIDS counselling has some very particular characteristics, but also shares many familiar resemblances with other forms of counselling. According to Burnard (1992), counselling people with AIDS involves counselling in three categories, namely: educational issues, advice, and psychological issues.

Nurses are one group that find themselves in the counselling role for HIV and AIDS patients. Klonoff and Ewers (1990) in Burnard (1992:11), administered a questionnaire to the nursing staff of a teaching hospital in the USA to determine sources of stress in caring for AIDS patients, to determine perceived sources of stress in being an AIDS patient and to investigate attitudes towards other various illnesses. This study revealed a number of factors related to increased stress, including: general concerns about the care of these patients; specific concerns in crisis situations; and concerns regarding the personal / social implications of caring for these individuals.

Another study in New Zealand by Will (1990) quoted by Burnard (1992: 14), was carried out to examine the nurses' attitudes to a wide range of matters relating to the management of patients and persons with AIDS. Prevention of HIV infection showed a strong support for public health measures and showed that most nurses believe AIDS patients should not be treated differently than other disease sufferers. The nurses' attitudes were that treating AIDS patients is not different from treating other patients.

Given this background regarding the attitude of nurses found in various studies, it is evident that nurses need to have education about HIV and AIDS, modes of transmission and become acutely aware of the vocabulary in the field. Advice is a form of counselling. Having AIDS is not an automatic indicator of a person's knowledge about it. Information about AIDS does not always change people's behaviour. Burnard (1992) emphasises

that counsellors should explore their own attitudes about believes related to AIDS before assuming the role of advisors.

Many writers on counselling have advocated a client-centred approach. This counselling style that advocates that the counsellor remains in the background while the client takes the lead in clarifying the problem and perceptions about the problem (Burnard, 1992:12). Counselling of HIV and AIDS patients may involve advice, confrontation, prescriptive mode and education, cathartic, catalytic and supportive approaches.

There are various psychosocial problems in AIDS counselling. An example of a psychosocial problem includes the client's own perception of himself / herself as a person with AIDS. In addition to the fact that the person has AIDS, they bring to the counselling sessions cultural beliefs, fears, anxieties, attitudes and mental health problems. After all these factors have been explored, issues of meaning, purpose, and dying may emerge.

AIDS counselling cannot be professionalised, particularly within the context of the medical and health professions. The aim of AIDS counselling is to encourage the person with AIDS to live as fully and as independently as possible. The emotional aspect of the person in AIDS counselling is important. HIV and AIDS people have a wide range of emotions, ranging from fear, guilt, anger, apprehension to worries about the likelihood of infecting others and future relationships. Burnard (1992:69) identifies the following emotions that are associated with the experience of having AIDS: shock, relief, anger, guilt, decreased self-esteem, loss of identity, loss of a sense of security, loss of personal control. Many people, including lay counsellors, religious leaders, and community volunteers who have been trained to work with HIV and AIDS people, can conduct AIDS counselling.

George, Green and McGreaner (1989) identifies the following counselling skills as important in counselling people living with HIV and AIDS:

- **Minimising Uncertainty**

The emphasis here is on the fact that HIV positive people have the right to know about their physical health. A therapist who becomes vague and evasive does not help people with life threatening diseases, but rather increases their mistrust and lack of confidence in the service offered. It is important that counsellors remain sensitive and confrontational.

- **Understanding And Correcting Misconceptions**

When a person is informed about his / her HIV positive status, checking misconceptions and clarifying myths set a good foundation for education. It is also important at this stage to reassure the person about confidentiality. Given the stigmatisation that accompanies HIV and AIDS, the emphasis on confidentiality is necessary.

- **Examining Personal Resources**

Examining personal information and who in the family needs to know about the HIV diagnosis and who does not, is important. Enquiring about housing, employment and finance will help prevent stress at a later stage. If work is an important part of the person's life, it may be important to discourage the person not to leave their work immediately. The person should be encouraged to consider options of limiting working hours. This will also largely depend on the kind of reasonable accommodating attitudes and support in the workplace.

- **Death And Dying**

Clients should not be forced to talk about the death or dying process. Gentle, tactful and sensitive enquiries are enough to ensure that the person understands the significance of the prognosis and who can answer questions pertaining to the disease. Death and dying should only be discussed when the client is ready. At the stage of death and dying, it may be important to discuss practical matters, such as

the will, children custody if necessary, the estate, etc. It may be advisable to link the client with community resources if any assistance falls outside the counsellor's area of expertise.

- **Developing A Sense Of Purpose**

Developing a sense of purpose aims to maximise the client's quality of life in a realistic way. Encourage the client to maintain realistic ambitions and alternative sense of purpose. The client with HIV and AIDS may feel that life is already over. It is important not to deny the difficulties the clients have, the feelings they are experiencing, as this may lead to alienation and isolation.

- **Choice And Dignity**

Most clients respond with realistic hope when their dignity is restored during counselling. HIV and AIDS can leave clients with a sense of dependency and unrealistic perceptions that they are not dignified. It may be important to encourage the client to exercise their choices in instances when it is necessary, particularly with regard to cultural and religious matters.

- **Setting Boundaries**

People with HIV and AIDS need to know whom they can rely on in cases of crises. This knowledge gives them a sense of security and privacy to their issues. Trust in the counsellor provides a sense of privacy. Refraining from over-involvement, over-helping and encouraging independence can only help the client's sense of boundaries and limits.

8.4 SKILLS FOR COUNSELLORS HELPING PEOPLE AFFECTED BY HIV AND AIDS

The following skills have been compiled by the researcher from various research reports over the years of experienced and are continuously tested and used by the researcher when counselling employees living with HIV and AIDS.

8.4.1 Ability to overcome Health Worries

It is important to educate caregivers about People living with HIV and AIDS (PWA) and the disease itself to avoid misconceptions. It may be difficult to care for a PWA when experiencing nagging fears about one's own health. The caregiver needs to be reassured about what is possible and what is not.

8.4.2 Role Reversal

In the case of role reversal, the caregiver needs to be taught how to cope with the changes, such as taking more charge, be more assertive and take responsibilities for more practical matters if this was the role of the PWA. In the case of couples, the roles may fluctuate and it is important that open communication regarding who may survive the other do happen. Children may also be involved in these communications and planning.

8.4.3 Dealing With Betrayal

In the case of couples, issues about who infected who may be raised. Allowing the client to ventilate and own their feelings may be essential. Verbal expression of feelings is often enough to ease the deep sense of hurt, pain and blame. It is important to remain neutral and not to take sides, as this will not help the client to move on. Listening and reflective feelings will alleviate anger and blaming.

8.4.4 Handling Sexuality Issues

Couples may not know how to deal with their sexual needs initially. Education on sexual matters, i.e. how to create enjoyment and the importance of safer sex is essential. It normalises their sexual needs and empowers them to take responsibility. Counsellors should always recognise the couple's need for intimacy and help them to realise it through safer methods.

8.4.5 Adjustment to Multiple Issues

Multiple issues may include loss of income, grieving in advance of the death of the PWA, accommodation and some family fun activities. This may often become a reality to the caregiver when the PWA's health starts to decline. As with other serious illnesses, such as cancer, heart disease or stroke, HIV can be accompanied by depression, an illness that affects mind, mood and behaviour. Depression undermines people's ability to deal with the problems of everyday life. It will be a mistake to assume that prolonged or intense depression is natural. It is reported that one in three persons with HIV may suffer from depression (*Dbsaalliance.org*:.., 2005). When assessing the mental status of a PWA, it is important to look for symptoms of depression as identified by the American Psychiatric Association (1987).

8.4.5.1 Affective Symptoms

Affective symptoms are symptoms of mood and mental status. The following signs steps should guide the counsellor in identifying the patient's mood symptoms:

- Ask about moods, especially over the past few weeks.
- Enquire about changes in enjoyable activities. Things often seem pleasurable. It may be important to ask how this aspect has been during the last two weeks.
- Enquire about a loss of libido; distinguish fear and loss of interest.
- Enquire about irritable moods and emotional instability. Usually the depressed person would report being more easily upset than usual.

8.4.5.2 Cognitive Changes

Depressed people see themselves usually as worthless and unlovable this may result in a loss of self-esteem. They look at themselves in a negative way and highlight their shortcomings. Sometimes they tend to be neglectful regarding their appearance. It is important to enquire how they feel about themselves. Typical related symptoms are:

- Feeling of failure;
- Loss of hope; the future often looks bleak in their minds and eyes;

- Difficulties in concentrating;
- Forgetfulness.

8.4.5.3 Somatic Symptoms

Somatic symptoms are symptoms that are experienced by the patient as real, even if there is no medical confirmation or a diagnosis of sort.

- Look for changes in sleep patterns.
- Assess eating disturbances and food appreciation.
- There may be multiple physical complaints, e.g. headaches, joint pains, and / or stomach problems.

8.4.5.4 Behavioural Symptoms

When people are infected, everything seems like too much effort to do. People with depression may feel less energetic than usual. They would often do less than they used to do.

8.4.5.5 Suicidal Tendencies

Many people who are depressed contemplate suicide at one point or another. The dangerous time for suicidal people is usually the time when they just come out of a depression. Green (1989: 4) identify the following steps to take in consideration when counselling people with depression:

- **Putting things in perspective**

  It helps to clarify depression symptoms to the client, reassure them that depression does not last forever and help them to focus on the future. Reassure them that depression is treatable.

- **Sorting out problems**

  Assess what is causing the depression and help the client to sort out the problem. Once this is sorted out the client may feel better.

- **Increasing activity**

Helping the client to focus on activities that bring pleasure may defocus attention on the problems at hand. This may also help the person to find new activities that help to focus more on future plans.

- **Identifying inaccurate thoughts**

Challenging the client's inaccurate thoughts may empower them to take responsibility for their emotions and life. This skill could be applied by asking the client to write down their views and thoughts.

- **Working with the family**

This is one of the most important aspects when counselling depressed people. The family's understanding, support, and encouragement help the depressed person in the process of a speedy recovery. Should the depressed client not improve after family intervention, psychiatric intervention should be considered.

8.5 SPIRITUAL COPING MECHANISM FOR WOMEN WITH HIV AND AIDS

There have been various changes in the world of work to make the workplace a friendlier place for employees and to enhance job performance. Evidently, in the late 1990s, workplaces became faith-friendly, incorporating policies that respected all religions through leave policies accommodation. Studies indicate that this in turn encourages workplaces to allow employees to live their lives openly and bring the value of their spiritual identities, their souls and their faith to the workplace, making it for them a great place to work at (Miller, 200513).

Research on other life-threatening illnesses has indicated that individuals often turn to religion and spirituality to cope (Dein & Stygall, 1997, Demi, Moneyham, Sowell & Cohen 1997). It can be assumed that spiritual awareness contributes to lower levels of psychosocial distress as it provides a sense of meaning in the face of threat to existence. On the other hand, it is reported that an individual, battling with a life-

threatening illness, use religious coping in complex and variable ways, making it difficult to identify the mechanisms by which it operates (Smith & Hill, 1993).

Pargament (1997) suggests that prayer allows expression of anger and disappointment, emotions that are common among HIV positive women, particularly upon knowing their status. On the other hand it is suggested that prayer assists one in repairing damaged relationships, letting go of the past, achieving a sense of closure and provides hope of an ultimate victory (Carson *et al.,* 1990). There is however a view that some clinicians see spirituality as detrimental to emotional functioning and believe that it fosters passivity, dependency and denial (Jenkins & Pargament,1995:131). Studies indicate that HIV is associated with greater religiosity and spirituality among HIV positive and HIV negative partners of men with AIDS (Folkman, Chesney, Cooke, Boccellari, & Collette 1994:746). Qualitative research regarding spirituality is needed to give conclusive evidence of the role it plays as a coping mechanism of those with life-threatening illnesses in general. The use of spirituality-based coping has been found to be prevalent among women. Studies have consistently indicated a greater use of spiritually-based coping activities among samples of women than in samples of gay men (Demi *et al.,* 1997:173) and (Potts, 1996:16). Faith can be a source of solace and nurture and healing in difficult times, such as when one has just been diagnosed with HIV.

When the usual human coping resources are ineffective or are threatened, as in the case of a life threatening disease such as HIV and AIDS, spirituality may be an available resource. Drawing from the perspective of Pargament (1997), spirituality may help individuals conserve meaning and transform their sense of significance through integration of the stressor into existing definition of self, thus providing a greater sense of control and aiding in psychological adjustment.

In a study by Simoni, Martone and Kerwin, (2002:137) that aimed at examining spirituality and its correlation to spiritually-based coping among women with HIV the researcher found that spirituality and spiritually-based coping mechanisms may lead to better well-being. Furthermore, the study concluded that women who feel better

psychologically are more optimistic and appreciative regarding spirituality in their lives. The study however found that there was a high level of depressive symptomatology, which suggested counsellors should pay more attention to suicidal ideation in the group.

The best way forward regarding spiritual counselling would be for a workplace to develop policies that help create faith-friendly cultures in the workplace. Employees need to be given permission to bring their whole being to work. According to Miller (2005:15), companies that allow this perspective in the workplace are likely to avoid major accidents and become better places to work

Even at a professional level, faith and work are leadership issues and can make such difference in the executive coaching and mentoring (Miller, 2005:14). Increasingly, leadership training and seminars tend to emphasise inherent spiritual values such as respect for individuals, care, sharing and improved relationships. Some religious beliefs play an important role in encouraging greater tolerance of, and respect for employees. McAninch (2006:16) highlights that understanding spirituality is essential in addressing any traumatic event, including dealing with HIV and AIDS, particularly because every incidence has social, political, and spiritual impacts. He encourages EAP professionals to be comfortable talking about the spiritual dimension, as it can be a major factor in the recovery of workers.

8.6 PHYSCHOSOCIAL IMPACT OF HIV AND AIDS ON COUNSELLORS

There is a perception that health workers are able to cope with all related health matters. However, studies indicate that coping in the work environment is difficult for nurses because of lack of support from employers and most of the health workers do not have access to any form of official support such as counselling for work-related stress. A study in Uganda among health workers showed the same results indicating inadequate counselling and lack of facilities and equipment (Mungherera, Van der Straten, Hall, Faigeles, Fowler & Mandel, 1997; Hall, 2004:111). Bateman (2001: 3) reported that since 1999, the Health Professions Council of South Africa has had an increase in cases of alleged impaired doctors.

Bateman describes “impaired”, as a mental or physical condition, or abuse of substance, which affects the competence, attitude, judgment, or performance of a health professional. It can be assumed that the impairment may be related to lack of support, which then ultimately leads to stress in the workplace. A study by Hall (2004:113) in South Africa found that confidentiality of a patients’ HIV status posed challenges to health professionals in their work. Evidently in Hall’s study, the stigma attached to HIV and AIDS in communities led to an influx of very ill patients. Nurses then found themselves taking care of terminally ill patients, who were becoming increasingly taxing as dying patients generally need supplementary support.

A study by Aiken and Sloane (1997a) in Hall (2004:111) found that the organisational form of the unit and hospital in which AIDS care is provided has a significant impact on the emotional exhaustion experienced by nurses. HIV work is extremely intense and difficult. Counsellors and EAP practitioners are constantly exposed to people who are in an intense emotional state. To protect themselves from becoming overburdened and incapacitated, counsellors develop a variety of ways to cope. One mechanism is to create and maintain an emotional and cognitive thinking process that gives the counsellor a sense of invulnerability; seeing the client as different from himself or herself enables the counsellor to work with the client. It is noted that some counsellors would then skip all the emotional counselling and concentrate on the medical and educational aspects of the disease and ending up lecturing rather than listening to the client (Fowley, Rosenthal, & Levine, 1990:286).

Nurses, like EAP professionals, found themselves having an additional load of counselling added to their daily work routine due to the HIV and AIDS challenge. Hall (2004:110), in a study about the challenges HIV and AIDS poses to nurses in the work environment, found that the secrecy surrounding the disease reduces nurses’ productivity, confronts them with ethical issues and hinders them from curbing the spread of HIV and AIDS. O’ Grady (2004:205) agrees that the lack of disclosure of HIV is the compounding difficulty in managing HIV and AIDS. Similarly, EAP practitioners

face ethical dilemmas about high sick leave rates of employees with HIV and AIDS and assisting managers to manage productivity and create reasonable accommodating environments for sick employees. In a survey of NGO managers in South Africa in 2002, several senior managers reported difficulties to cope with managing employees with long-term illness (James & Mullins, 2003:4).

Psychosocial support has been evidently documented to be one of the most effective tools of assisting HIV and AIDS patients in gaining access to antiretroviral treatment. In South–East Asia and in many other countries, there is considerable evidence of the psychological benefits of self-help clubs for HIV infected and affected people (UNAIDS, 2002:158).

Research suggests that EAPs should be moving towards integrating resources. Kramer and Ricket (2006:23) stress that by incorporating resources, EAPs can both validate health and productivity services while also providing a strong growth product on EAPs. Kramer and Ricket (2006:24) suggest the following components to be included in the integrated programme offering:

- Tracking and administration of employee absences.
- A toll-free “Life Enhancement Line”.
- A health risk assessment.
- Employee group interventions.
- Organisational effectiveness interventions.
- Employee interventions.
- Return on investment analyses.

8.7 SUMMARY

HIV and AIDS counselling present difficulties for most EAP practitioners, due to the fact that it is a new field of counselling. The ethical dilemma of confidentiality and workplace management of HIV and AIDS is a continuous problem for most practitioners. It is therefore very important that EAP practitioners be abreast of new changes and education on HIV and AIDS as they remain in the forefront of the management of the pandemic. Employees need comprehensive care regarding HIV and AIDS management, as well as understanding and creation of reasonable accommodating environments for employment opportunities. EAP practitioners are the best advocates to assist employees. However, there is limited information on HIV and AIDS counselling by EAP practitioners, which necessitates future research and studies in this area. In addition, spirituality and spiritually- based coping should be explored as part of a strategy of identifying and bolstering cultural strengths, particularly in relation to HIV and AIDS.

CHAPTER 9

EMPIRICAL RESULTS ON THE ROLE OF THE EAP IN ADDRESSING THE DIFFICULTIES EXPERIENCED BY WORKING WOMEN RESULTING FROM THE IMPACT OF HIV AND AIDS

9.1 INTRODUCTION

In this chapter the researcher aims to discuss the empirical research results including the research methodology, ethical issues relevant to the study, problems encountered and a detailed presentation of the empirical data collected. The research findings are then discussed based on the analysis of the data collected. The transformation of the world of work in the 21st century has seen the acceleration of the pace of integration of women into the workplace. The world of work however presents challenges for women who are the ones most affected by HIV and AIDS. The global overview of people living with HIV and AIDS in 2007 was estimated at 33,2 million whilst women living with HIV was estimated at 15,4 million and children under 15 years was estimated at 2,5 million. (UNAIDS, 2007:1). In Sub–Saharan Africa, HIV and AIDS prevalence in 2007 was estimated at 22,2 million people living with the disease. It is estimated that about 6 million people were living with HIV and AIDS in South Africa at the end of 2006. According to the Department of Health South Africa (2007), the prevalence of HIV among pregnant women has decreased from 30% to 29% from 2005 to 2006.

9.2 RESEARCH PROCEDURE

In this section the researcher describes the choice of the research methodology, the objectives of the study, as well as the choice of the study population and sample used in both the qualitative and quantitative methods of data collection, including data collection procedures such as the pilot study results.

9.2.1 The Goal and Objectives of the Study

The goal of the research study was:

To explore and describe the role of EAPs in addressing the difficulties experienced by working women, resulting from the impact of HIV and AIDS.

The following objectives were formulated in order to achieve this goal:

- To investigate the feelings and perceptions of HIV infected and affected working women in their working environment.
- To establish women's perceptions of the role of EAP regarding their conditions.
- To establish the extent of HIV and AIDS counselling offered by EAP practitioners.
- To recommend intervention strategies relevant to vulnerable women who are affected by HIV and AIDS.

The above goals and objectives necessitated the formulation of the following research question and sub-questions that guided the study:

What is the role of an EAP in addressing the difficulties, experienced by working women in South Africa, resulting from the impact of HIV and AIDS?

- What role, if any, does an EAP play in supporting HIV infected and affected women in the workplace?
- What is the perceived role of an EAP in supporting HIV infected and affected women?
- What is the perceived role of HIV infected women with regard to the effectiveness of an EAP related to HIV and AIDS in the workplace?
- What are the difficulties of running a functional EAP service in the context of HIV and AIDS?

- What are the feelings of HIV and AIDS infected and affected women in their workplace?

In addressing these research questions, an exploratory research methodology was adopted by the study with the purpose of identifying and describing difficulties, behaviour and feelings experienced by infected and affected working women and identifying if there is any relationship with the role that EAP plays in the workplace.

The researcher made an effort to develop solutions regarding a specific work-related psychological and social problem and therefore an applied research approach was appropriate (De Vos *et al.*, 1998:8). It is envisaged that the understanding of the difficulties experienced by women affected by HIV and AIDS in the workplace will assist corporate SA and the EAP community to design and develop strategies to address these difficulties and maximise working women's work performance.

This study used a combination of qualitative and quantitative, research methods. The data from research was then triangulated and conclusions were drawn from data analysis. De Vos *et al.* (2005: xvi) states that a qualitative approach deals with data that is empirically verbal, and a quantitative approach deals with data that is principally numerical. According to De Vos (2005:362) 'triangulation' is used to designate a conscious combination of quantitative and qualitative methodology. In the context of this study, methodological triangulation was used to refer to the use of different research methods (qualitative and quantitative) which were used both to study a single topic being "the impact of HIV and AIDS on working women". In addition these two methods were used for data gathering and analysis. For example, whereas questionnaires and interviews were conducted for data gathering, data derived from these research methods were triangulated in the analysis.

9.2.2 The Sampling Strategy and Technique

For the qualitative study an initial pilot study was undertaken. The sampling strategy and technique for the quantitative and qualitative parts were then considered under the categories of population, sample and sampling strategy.

9.2.2.1 The Pilot Study

9.2.2.2 Feasibility Of The Study

Before collecting the data, the researcher wrote to the EAPA-SA President to obtain permission to conduct the study and obtain access to their database of registered practitioners **(Appendix 5)**. Additional letters were written to Uthingo (PTY) LTD and Tsa-Botsogo Centre for access to implement the pilot test **(Appendix 6)**.

9.2.2.2.1 Pilot Test: Qualitative Study

Upon the approval of the structured interview schedule by the Research Proposal and Ethics Committee of the Faculty of Humanities of University of Pretoria, a pilot test was conducted with two respondents who were not part of the main study. One respondent was interviewed at Uthingo (Pty) Ltd and one at Tsa-Botsogo Centre. No problems were identified with the questions, except that one respondent was no longer working at the employer where she had utilised an EAP. The interviews were conducted in English.

The only adjustment made was on the consent form. The wording used was changed to reflect that the study was conducted in South Africa rather than Gauteng.

9.2.2.2.2 Pilot Test: Quantitative Study

For the quantitative survey, six questionnaires were distributed to the Egoli branch of the EAPA–SA chapter and the only adjustments made were spelling corrections; no changes were made to the content of the questionnaire. The six practitioners who were selected for the pilot test were excluded in the overall study sample

9.2.2.3 Description Of Population

The population for the two studies are discussed in detail below.

9.2.2.3.1 Population: Qualitative Study

The qualitative study's population can be considered to be all the working women in South Africa who are affected or infected by HIV and AIDS and who had participated in an Employee Assistance Programme offered by The Careways Group as a service provider or in the EAP in house at various South African workplaces.

9.2.2.3.2 Population: Quantitative Study

The population for the quantitative component of the study included all EAP practitioners who were registered as members of EAPA- SA in 2005 to 2007. The EAP practitioners are all professionals who are employed as EAP counsellors, managers, coordinators, or consultants in their current employment and who are offering counselling to employees. The register of the conference attendants was 350 in 2005, excluding non conference attendants from various EAPA- SA chapters. During the writing-up of this research, the current EAPA- SA membership in 2007 was 498.

9.2.2.4 Sample

EAP practitioners and HIV infected and affected working women served as a sample in the two parts of the study.

9.2.2.4.1 Sample: Qualitative Study

From the identified infected and affected working women, 24 women volunteered to participate in the study (12 infected and 12 affected).

9.2.2.4.2 Sample: Quantitative Study

There were 498 members of EAPA SA. According to De Vos *et al*. (2005, 196) for a population of 500, the sample size is required to be 25% of the population which is 100 respondents. For this study the number of respondents were 81, which equals 23% of the total conference attendants.

9.2.2.5 Sampling

9.2.2.5.1 Sampling: Qualitative Study

Random sampling would ensure an optimal chance of drawing a sample that is representative. Participation in the qualitative study was voluntary, therefore random sampling could not be applied. This is often a problem that is encountered by most of the HIV and AIDS researchers. Issues such as stigmatisation, fear, victimisation, isolation and labelling were considered as contributors of a small sample size.

A purposive sampling strategy was used for the qualitative sample. Purposive sampling, according to Strydom and Venter (2002:207), is based entirely on the judgment of the researcher as the sample is composed of elements, which contains typical attributes of the population.

Purposive sampling implied that the study had been influenced to a large extent by the researcher's assessment of which research locations would best elucidate the focal research variables and parameters. Since the chosen research locations were few, the study focused on the available subjects of research due to the sensitivity around HIV and AIDS and the need for more voluntary interaction rather than coercive research inquiry. The following criteria for purposive sampling was used:

- Working women living in South Africa employed by South African Companies using in-house EAP or outsourced EAP providers (The Careways Group and ICAS).
- Women had to be either infected or affected by HIV and AIDS.
- Had to have participated in EAP or currently attending EAP in 2005 and registered with EAP-SA in 2007.
- Some women were used to the researcher, others recommended by EAP practitioners whilst other recommended by women who participated in the study.
- All women participated voluntarily.

The researcher used working women that she knew and who had agreed to be interviewed for the study. This was further extended to working women recommended by EAP practitioners after confidentiality issues were resolved between the practitioners and the women in question. The women voluntarily contacted the researcher to participate in the study. Some of the women that were initially interviewed also

recommended other women to participate in the study. The latter also voluntarily contacted the researcher.

- First level: During presentations about the study the EAP practitioners indicated they would link the researcher with working women who have disclosed their status and would likely participate in the study (convenient sample).
- Second level: The researcher contacted the identified EAP practitioners for a follow-up on prospective participants (snowball sample)
- Third level: The women were briefed by the EAP practitioners regarding the study and provided them with the researcher's contacts for voluntary participation.
- Fourth level: The researcher met with the women one on one before the actual interview to ascertain voluntary participation. At this stage the women also informed other women about the study and participated voluntarily (snowball sample).
- Fifth level: The same process was followed as from level one, again with women recommended by the participants. At this stage interviews commenced with all participants. When the number of 24 was reached the researcher did not allow more women to participate. The women who participated initially were advised to recommend both HIV infected and affected working women and the process continued simultaneously.

In summary, the researcher used a non-probability sampling technique with a purposive strategy for HIV and AIDS infected and affected women. The initial group of women interviewed was a convenient sample. This group referred other women to be interviewed. The second group was a snowball sample.

9.2.2.5.2 Sampling: Quantitative Study

The researcher introduced the study at an EAP Association Conference in 2005 in Durban South Africa. This was South Africa's 7th Annual conference and was held on 7th to 9th September 2005 at the Hilton Hotel. The theme of the conference was 'Growing the Profession in the 21st Century" - Maximising behavioural health and productivity through joint EAP, human resources, organisational labour and management synergy.

The attendants included EAP practitioners, HR specialists, organisational development managers and labour specialists.

The conference registry indicated 350 attendants including non-EAP practitioners. During a plenary session the researcher introduced the research study and requested EAP practitioners to participate and distributed the questionnaires to those who indicated. From the initial distribution of 126 questionnaires to delegates at the conference, only 46 responses were received with 80 questionnaires unusable due to printing errors on two pages of the questionnaire. The sample was based on a convenient sample of the attendants at the conference. A replacement sample of 80 was then implemented using a non-probability sampling method. These questionnaires were emailed to the members who were listed in the database of all EAPA-SA chapters, i.e. Jacaranda, Egoli, Mpumalanga and Western Cape. The e-mail requested that members who had completed the questionnaire at the conference to refrain from responding. This was done to avoid duplication of participants. Of the replacement sample, 35 responses were received. Thus a total of 81 questionnaires were completed and returned.

9.2.2.6 Data Collection

9.2.2.6.1 Data Collection: Qualitative Study

For the purpose of the qualitative part of the study, interviews were held according to a semi-structured interview schedule to elicit responses regarding the women's feelings and experiences about HIV and AIDS and an EAP in the workplace. The aim was to get an in-depth description of the subjects' personal experiences. From a qualitative perspective, the research strategy enabled the researcher to investigate the dynamic process of drawing parallels between support offered by EAP practitioners and feelings of HIV and AIDS infected and affected working women in their various workplaces in South Africa.

9.2.2.6.2 Data Collection: Quantitative Study

The quantitative research approach was used to quantify information to support the respondents' descriptions. In the quantitative survey questionnaires were used and were

randomly administered to EAP and HIV counsellors- all delegates at the EAPA-SA conference held in Durban in 2005 where there was representation from all South African regions. All delegates became members automatically after registration since the conference registration fee included the membership fee for a year. The data from the questionnaires complemented the semi-structured interviews. An analysis of the collected data is presented later in this chapter.

9.2.3 Ethical Issues

To deal with the ethical aspects, such as those identified by Strydom (De Vos *et al., 2005*:57) as avoidance of harm, informed consent, deception of respondents, violation of privacy, actions and competence of the researcher, co-operation with collaborations, release or publication of the findings and debriefing of respondents, the researcher explained the purpose and the benefits of the research to all participants. Each aspect was handled as follows:

- All participants and respondents were asked to participate in the research project by requesting each of them to provide a signed informed consent form to be interviewed or to complete the questionnaires **(Appendix 3 and Appendix 4**). This was done to address the issue of privacy and confidentiality, including publication of the research. Problems were encountered with this aspect and will be discussed below in the relevant section on problems that were encountered.
- Respondents' names were not used in this research, or the companies they work or worked for. Identification numbers were allocated to the respondents with no compromise to their identities. A tape recorder was used only with the respondents' consent.
- The name of the researcher and the research assistants used in this research project were revealed at all times to ensure trust and the telephone number of the researcher was given in all cases.
- The respondents and participants were informed that the final document would be sent to EAPA-SA, and that the document will be accessible in South African

Libraries. In addition respondents were informed that all documents will be kept confidentially and stored in a safe cabinet at the University of Pretoria for 15 years to allow any later verification of research.

- Due to the sensitivity of the research, all women were offered a debriefing session and were referred back to their EAPs where applicable.

9.2.4 Problems Encountered

A number of problems were encountered during the data collection process. These are listed below and discussed in further detail.

9.2.4.1 Time Factor

The researcher was hoping that the process of data collection would take two months, but it took 2 years to collect all the data, due to work commitments. This made the analysis of data difficult, particularly as some were interviewed in 2005 and others in 2007, a gap for shared feelings and experiences.

9.2.4.2 Resistance From Research Participants

Some of the respondents were concerned about confidentiality, particularly when they expressed their reservation about the EAP in their own workplace and they were concerned about victimisation.

This happened, despite the researcher's explanations of the benefit of the study especially as an empowerment tool regarding employment equity issues and non-discrimination. Some respondents requested that the interviews should not be recorded, but were comfortable with the interviews.

9.2.4.3 Logistics

As indicated previously, respondents were afforded a comfortable venue of their choice. In the case of those respondents who opted for a restaurant setting for interviewing

purposes, some of them seemed to be very restrictive due to the noise levels and the fact that they were in a public place.

9.2.4.4 Death Of Respondents

At the time of the analysis of the data, two of the respondents had already died. As in any normal situation, this highlighted the realities of HIV and AIDS pandemic to this researcher. One of these respondents was on medication and seemed to be in good health during the time of the interview.

In summary, the important elements to research design have been discussed with the ethical aspects and problems also being highlighted. Based on this, the data analysis process was undertaken.

9.2.5 Data Analysis and Interpretation

9.2.5.1 Data Analysis: Qualitative Data

The researcher used text analysis in analysing the qualitative data. This was primarily enforced by the fact that analysis of data was an ongoing process of examining information as it arrived. The researcher went through all the transcripts to identify themes, and note similarities, differences and recurring ideas. According to De Vos *et al.* (2005:337), descriptive statistics are those, which summarise patterns in the responses of people in a sample. The units of meaning were put into major categories while noting the sub-categories and the researcher drew conclusions that reflected problems identified by the study.

Drawing from the HIV and AIDS strategies as they are used in EAP, the researcher analysed the nature of the problems that participating women indicated they had brought to the EAP practitioners attention, their perceptions of the service they received against the inputs of EAP practitioners in terms of what kind of cases were brought to them and the kinds of intervention strategies they used. Open coding is part of analysis that involves the naming and categorising of phenomena through close examination of data

(Grinnell, 1993:271). Each section will be discussed according to the different questions asked. The biographical section will be presented in a table and the other sections will be discussed according to themes. The results will not be presented with direct quotations. In addition to the availability of the transcripts, the tapes that were used are available on request.

9.2.5.2 Data Analysis: Quantitative Data

This section displays the quantitative results in graphs and charts, while the descriptive statistics for the semi-structured schedules include tables and a discussion of the open questions. On the basis of this, the researcher were then able to make recommendations of how HIV and AIDS strategies in EAPs could be improved, drawing on participants' experiences. Data sources, through literature review as in previous chapters of this research document, are compared with data from questionnaires and interviews and triangulated in this chapter. According to Duffy (1993:143), theoretical triangulation involves the use of multiple theories or perspectives in the analysis to interpret a single set data. Quantitative data collected was calculated manually using Microsoft Excel software package and qualitative data was analysed by identification of themes.

9.3 PRESENTATION OF EMPIRICAL DATA

The presentation of the data obtained in the study is divided into the two components of the study: qualitative and quantitative.

9.3.1 QUALITATIVE DATA ANALYSIS

The qualitative data was collected through semi-structured interviews (Appendix 1) and the data was analysed by developing themes from the respondents' answers from the interviews.

The interview questions were divided into 3 sections and these sections are discussed in detail below:

- Section A: Biographical Information

  The section relates to biographical data on each respondent. The information requested related to age, race and job level.

- Section B: Experiences of both infected and affected women

  This section is best described by questions 4 to 6. The questions aimed to probe the experiences and feelings of the infected and affected women as well as their coping mechanisms.

- Section C: The Role of EAP

  This section is best described by questions 7 to 14. The questions aimed to understand the usage of EAP by the infected and affected women, the experiences that they have in respect of EAP and suggestions for improvements of EAP services.

9.3.1.1 Biographical Data

(Questions 1 to 3)

The first section of the interview schedule represented biographical information of the respondents. The purpose of the biographical details is to serve as a verification tool that the respondents complied with the sampling criteria. This information is presented in Table 1 below.

Respondent	Race	Age	Job Level/Description	Status
1	African	37	Junior/Unemployed	6 years HIV+
2	African	27	Junior/	5 years HIV+
3	African	32	Middle/Project Manager	9 years HIV+
4	African	30	Junior/Administration	3 years HIV+
5	African	33	Middle/Professional	5 years HIV+
6	African	36	Middle/Manager	10 years HIV+
7	White	49	Middle/Manager	9 years HIV+
8	Indian	34	Junior/Executive Assistant	6 years HIV+
9	African	33	Middle/Professional	4 years HIV+
10	African	29	Junior/Call centre agent	6 years HIV+
11	African	46	Junior/Chef	6 years HIV+
12	Coloured	23	Junior/Call centre agent	HIV+
13	African	36	Junior/Banker	Affected
14	African	37	Middle/Marketing	Affected
15	African	46	Junior/Teller	Affected
16	African	37	Manager/Senior	Affected
17	Coloured	48	Manager/Middle	Affected
18	African	39	Director/Senior Mgt	Affected
19	African	35	Senior/Manager	Affected
20	African	33	Middle/Manager	Affected
21	African	30	Junior/Administration	Affected
22	African	41	Middle/Specialist	Affected
23	African	39	Middle/Specialist	Affected
24	African	37	Junior/Unemployed	Affected

Table 1: Profiles of Respondents

9.3.1.1.1 Discussion of Data

Purposive sampling was used and as a result the researcher ensured that the criteria for selection matched the respondents, for example, the respondents had to be working women, using or had used EAP services. The researcher ensured that the sample was composed of elements which contained most characteristics which are typical attributes of the population (De Vos *et al*., *2005*:194). There were two women who had just been unemployed for one to two months as they lost their jobs during the time when the

appointment with the researcher was secured. Table 1 indicates the age range of women to be between 23 and 49 years. According to (UNAIDS, 2002) estimated adult prevalence of HIV was 20% amongst 15 – 49 years old. Department of Health (2007,16) estimated that there was a significant decline in prevalence in the 15 to 24 years age group, but HIV prevalence has increased among women above 30 years old, once again the most economical age group. The statistics indicate that education and awareness amongst the younger age group is more successful than the older age group that was infected five to 10 years ago. Given the fact that HIV affects anyone and has no racial boundaries, it was interesting to note that the majority of the women who agreed to participate were African. The majority of the women interviewed (almost 98%) were Africans with only one White respondent, one Indian and two Coloured research participants. This could be a reflection of the perception in South Africa that HIV affects different race groups differently and certain race groups tend to dissociate themselves from the pandemic. The rate of HIV is highest among Africans in South Africa and Sub-Saharan Africa. The biased reporting resulting in discrimination against Africans has angered most African leaders and those involved in AIDS programmes (Evian, 2000:3).

According to a pilot study by (Bowler, 2002:22), HIV prevalence per 1000 employees, by gender, race and age for a sample of 20 HIV-positive employees, showed that the prevalence is higher in females than males and higher in Africans than Coloured. There is a myth that HIV only affects Africans and gay men and this blaming model perpetuates stigmatisation and discrimination, for example, Joffe's work has shown that some Africans in South African blame Western scientists for HIV and AIDS, while some White heterosexual British men blame Blacks for the disease (quoted in the HSRC, 2005: 28).

As per Table 1 on page 113, participants 1 to 12 are HIV infected women and participants 13 to 24 are affected by HIV and AIDS. The job levels of the HIV infected women reveal that 7 are at an entry or junior level with only 5 respondents at middle to senior levels. Among affected participants, 8 participants are either at middle to senior levels and only 4 at a junior level. It is the researcher's opinion that the job level of

infected versus affected clearly reflects that the impact of HIV and AIDS on the education and career progression in the workplace varies. Those affected have clearly progressed, whilst those infected still are at lower levels. The reason could also be that women who are at senior levels are still not comfortable to disclose their status or participate in research on HIV and AIDS. Eight of the affected in this study are in the middle to senior level, this confirms the theory that HIV and AIDS affect anyone irrespective of their status and level of work. It is predicted that by 2010 people will be knowing someone close to them infected by HIV or living with AIDS either in work place or living with as a family member.

Women are generally the most impacted by HIV given their biological, cultural, and economic status. Research however, indicates that the low social status of women in many societies encourages discrimination, domestic and sexual violence, coercion and psychological abuse (UNAIDS, 2000a: 4). Women who have access to education are more likely to be empowered to negotiate for their rights. Similarly, in the workplace, women who are in high level positions are more likely to have a positive self-esteem, have access to education and have more decision-making power and negotiation power for workplace benefits. Given the fact the majority of women infected with HIV in this study are not at senior level fails to confirm the argument above. Chapter 2 has painted a background on the dynamics of women and their role in the workplace. A study by Dolbier *et al.* (2001.469) revealed that self-leadership was positively related to an approach in coping styles aimed at eliminating or minimising the source of stress. Women's rising education levels have been closely linked to their increased participation in the labour force. If the argument is true, the more women infected or affected by HIV and AIDS who become comfortable with disclosure, the more there will be progress in the management of HIV amongst working women.

Mtintso (1999) has argued in Jobson (2002: 4) that visible participation of women in the workplace and the South African Parliament in particular, have presented them with an uneasiness to address women's needs with the fear of being marginalised and seen as raising petty women's issues. This therefore suggests that if women who are in

parliament are perceived to be struggling with these issues, working women who are infected or affected by HIV should face greater challenges, given the stigma around HIV and AIDS. It can therefore be argued that a job level *per se* does not give a woman any bargaining power to address women-related needs or difficulties.

9.3.1.2 Difficulties Experienced By Participants

(Question 4)

Only when the feeling of the infected differ from the affected, then the discussion will be divided to highlight the difference, otherwise where the two groups share feelings, the experiences, perception and feelings will be grouped.
The researcher has divided the data into themes as they emerged from the data analysis, namely:

- feelings of despair ; 9.3.1.2.1.
- difficulties; 9.3.1.2.2.
- time lost, due to HIV and AIDS; 9.3.1.2.3.
- coping strategies – 9.3.1.2.4.

In this section, the researcher intended to explore the respondent's experiences and difficulties, if any, in the workplace. In the past, the highest number of infected cases was found to be men; however, research indicates that women are showing increasing levels of infection. In 1999, women accounted for 49% of new infections and more than 50% of AIDS-related deaths (UNAIDS (a), 2000:3) while in 2007, 15,4 million were reported living with HIV (UNAIDS, 2007:1).

Chapter 6 highlighted some of the difficulties experienced by women infected or affected by HIV and AIDS. HIV infection has an impact on women's health, physical and mental well-being, raises the risk of mother-to-child transmission, affects their ability to be mothers and in some cases it has been perceived to limiting career and employment opportunities (UNCSW, 1999: 13). The researcher is of the opinion that - like people with disabilities, substance abuse and other chronic diseases such as cancer - women infected and affected with HIV experience the same feelings, difficulties and

stigmatisation. According to research discussions, numerous direct and indirect causal factors have been linked with the impact of HIV on women. Preventative methods such as female condoms have shown to be effective and empowering women, but they are inaccessible and expensive.

The following themes emerged from the respondents' feelings, difficulties, and experiences:

9.3.1.2.1 Feelings of Despair

The feelings are divided into key words as indicated by participants verbatim as summarized as feelings that suggest a feeling of despair. A feeling of "very difficult" was indicated both by infected and affected.

9.3.1.2.2 Feeling of Despair - Infected participants

" *You don't understand, I felt mad when I discovered I'm HIV positive, but after accepting my status and disclosing to my friends, I felt nobody wanted to be with me and it was like every body was avoiding me." "Sometimes I'm angry, mad and sometimes I just feel sad or nothing and I just wish I was dead to escape the shame*"

- Very difficult, mad, anger, sad, fear, depressed, resentful, isolated, shame, regrets, and acceptance.
- Only 2 women who are infected expressed suicidal ideation at one stage of the disease.

9.3.1.2.3 Feelings of Despair- Affected Participants

"*A feeling of depression and betrayal overwhelmed me, and instead of feeling sympathetic I felt angry…, angry at the world, angry with AIDS, and angry at the health services." "My mother was a nurse and got infected whilst working at Hospital and knowing my mother as a Christian woman, she was infected in the call of duty whilst attending to a patient with HIV"*

- Depression, regrets, isolated, fear, very difficult, shock, sympathy, sadness, numbness, hurting for family, traumatic, secrecy, denial, betrayal, and acceptance.
- Only 1 respondent felt suicidal.

9.3.1.2.4 Discussion of Data

As with other chronic illnesses, such as cancer, strokes and heart diseases, it is evident that HIV is also accompanied by depression and feelings of despair. As the immune system deteriorates, a variety of complications start to take over both physically and mentally and these complications could take a toll on an individual's mental status, leaving them depressed as the disease increasingly affect their physical state negatively. It is in the opinion of the researcher that treatment of depression in the context of HIV and AIDS could present multiple problems given the contra-indicators in the treatment regimes. Suicidal ideation, a state of hopelessness is common among people struggling with chronic illnesses. There is a strong link between depression and suicide. Depression is a serious medical condition that affects thoughts, feeling and the ability to function in everyday life (DBSA,1999:1). Treatment has however enabled many people including women living with HIV to lead fuller, more productive lives.

Anger seems to be a common feeling amongst participants in this study. It is expressed in words as anger or feeling mad. This feeling is common amongst people struggling with death and dying where it is defined as one of the stages of death and dying. Similarly, the affected women also experienced anger towards the infected family member and the disease itself. It can only be concluded given the ranges of feelings indicated by participants that HIV was taking a toll on already struggling working women in this study.

Much so it can be argued that for those who are predisposed to depression, HIV can exacerbate the psychological state and leave them with the feeling of despair. Research indicates that women are more prone to depression than men, also women are more comfortable to talking about their feelings openly than men. This study did not probe

whether the women were depressed before knowledge of their status or their family members' status. This could have helped in drawing conclusions whether depression was caused by the impact of HIV and AIDS or the women where predisposed to depression. The researcher therefore proposes a study that will look at the relationship between Depression and HIV and AIDS amongst working women.

9.3.1.2.5 Difficulties Mentioned By Participants

9.3.1.2.6 Infected

- The participants indicated that they felt extremely uncomfortable, sensed negativity and indifference by colleagues. *"People talk behind your back", "you become aggressive and lose yourself", "You become scared to disclose*".
- Of concern was that the participants indicated they experienced victimisation, lack of support and indicated career concerns. "*The disease silences you",* "*sometimes work duties get taken away from you as if you are incompetent*", The women expressed that at time they felt they were forced to disclose HIV status to get special benefits such as leave or time off and medication.

9.3.1.2.7 Affected

The difficulties experienced by the affected participants were indicated as follows:

- The participants indicated problems with HIV disclosure of their family members, they confirmed that HIV was creating a financial burden for them. In other instances the respondents expressed that they felt blaming and judgemental attitudes by those around them. "*You tend to take over the responsibilities for the infected person*" ….."*You feel ashamed as if you are the one infected".*

- A general response by the affected participants was that of Lack of support by managers and colleagues and that caring for the HIV infected family was career limiting. When the reason for the career limiting was probed further, the respondents expressed that the fact that they missed work affected their prospects of career growth.

- Participant 19's mother died of AIDS and she felt strongly that the mother was infected attending to infected patients. At the time of interview participant 19 was still struggling with bereavement.

9.3.1.2.8 Positive experiences

Despite the impact of HIV and AIDS in the lives of the participants, both infected and affected respondents highlighted positive experiences.

- Participant 1,6, 7 and 18 mentioned the following:
  ''*Great support from colleagues and CEOs, got positive attention, afforded as much time off as needed for bereavement reasons*"…. "*Received telephone calls from my colleagues to check on how I was doing".*

Positive responses indicate that little efforts of support by colleagues to women infected and affected by HIV and AIDS is a great source of support. It can therefore be argued that when support may reduce the level of shame and isolation.

9.3.1.2.9 Stigmatisation

Various responses were given regarding stigmatisation. All 24 participants have reported that HIV and AIDS is a disease that has a stigma attached to it. They expressed, either feeling stigmatised, or perceiving that others are stigmatised or there were behaviours related to stigmatisation which hurt them. It is important to note that stigma can be a direct behaviour and attitude by others but also can be a perception by those who felt they are victims of stigma, this is called self-stigmatisation. The interpretation was made that not all women were stigmatised due to HIV and AIDS. Evidently there were those who instead enjoyed positive experience and support by colleagues and CEO. In line with studies done in the area of HIV and stigma, this study confirms that stigma has a great impact on the women infected and affected and the overall management of HIV and AIDS in the workplace.

In a study by BER and SABCOHA, stigmatisation and discrimination were indicated as a great concern by the participants in the wholesale, transport, manufacturing, building

and construction sectors. More than 75% of the mines and financial services surveyed in South Africa also indicated that the stigma related to the disease undermined the effectiveness of their HIV and AIDS programmes.

According to (UNAIDS, 2006:86), stigmatisation is one of the worst consequences of the HIV and AIDS pandemic. Similarly, a SABCOHA/BER (2005) study found stigmatisation to be the barrier in the uptake of VCT and treatment; as a result SABCOHA's efforts since their research have focused strongly on how to overcome stigmatisation in the workplace (SABCOHA Annual report 2005/2006:6). The HIV-related stigma consists of negative attitudes towards those infected or suspected of being infected with HIV and those affected by AIDS such as family of people living with HIV. A survey of literature about stigmatisation was presented in Chapter 6 of this study.

9.3.1.2.10 Time Lost Due To HIV And AIDS

(Question 5)

In order to discuss these aspects better, the respondents have been divided into:

- Duration of absence
- Stage of illness for infected women
- Stage of illness for the loved ones of the affected women

9.3.1.2.11 Duration of Absence

Based on the responses, participants 6, 7, 8, 9, 10, 11,12,13, 14, 15, 17 and 18 were absent from work for more than three months. According to AIDS Watch (2008:1), AIDS remains the most likely cause of workdays lost among 15 to 44 year old Asian employees.

9.3.1.2.12 Stage Of Illness For Infected Women

Participants 5, 6, 9, 11 and 12 indicated that they missed worked shortly after being diagnosed with HIV. Participants 5, 6, 9, 10, 11 and 12 missed work after reacting to the medication in the first three months of commencing treatment regiment.

9.3.1.2.13 Stage of Illness for the family Members of the Affected Women

The following are the times that necessitated absenteeism of the affected women:

- Participant 17 and 18 needed to take time off from work during the time when their family member infected by HIV deteriorated to the AIDS phase. The process needed time to organize home-base care and adhoc caring and visits to the hospital. According to UNAIDS (2004,32), AIDS has created young widows who have dependant children, which limits their ability to contribute optimally to the work force and earn an income. It is the researcher's impression that this dilemma may present a challenge for many working women who have to balance work and family responsibilities and be expected to compete at the same level with those with less caring responsibilities.
- In the case of participants 18, 20, 21 and 24, the only time they took off was during the death of their family members. The process needed time off from the time the family died until a week after the funeral. The women reported a very frustrating time of being involved in the funeral logistics, including meetings with the deceased's place of work and funeral parlours. They indicated avoiding missing work due to care of infected family member, that is why they could only take time of during this time of death in the family.
- Only one (Participant 15) resigned from work to take care of her brother after using up all her leave days. She indicated that she had used up all her leave and was left with no option but to resign. The impact of HIV and AIDS here is seen as detrimental in this particular respondent's career. As it has been indicated in the previous chapters, HIV and AIDS can indirectly affect one's career and job opportunity. A report by (UNAIDS, 2004, 32) indicated that in some instance, girls in Africa have been taken out of school to provide home-based care. The educational challenge which would in turn become a barrier for educational advancement and limit economical opportunities for these girls and women. As long as women and girls who are affected by HIV and AIDS are unable to earn an income and exercise their rights to education and health, progress on AIDS front has not been achieved.

9.3.1.2.14Discussion of data

All 24 participants reported having missed work due to various reasons ranging from ill health, family responsibilities, and lack of financial means. A Coronation study found that the contribution of socio-economic problems for women during follow-up HIV treatment were issues such as financial support, father's support, primary caregivers and place of residence. Of the 176 women interviewed in the Coronation Study, 101 (57%) were unemployed. In addition, of the 176 children in the Coronation study lived with a primary caregiver other than their mother, this mostly being a grandmother, and 44 of the fathers had no contact at all with their children (Jones *et al.*, 2005). The Coronation study indicates the multiple challenges of caring for people with HIV and AIDS, including children.

The length of absences ranged from 5 days to 3 months. In addition, participants 7, 9, 18, and 19 indicated they often took half days leave as they were afforded time to attend to doctor's appointments. Participant 5 indicated she missed work due to depression rather than HIV. Participants 7 and 9 indicated that even though they have missed work they try their utmost to avoid missing work as they fear that colleagues will find out about their status. The SABCOHA 2005 study indicates that with regard to economic consequences of HIV and AIDS, a slightly larger percentage of the companies reported that HIV and AIDS has led to lower labour productivity and increased absenteeism, and loss of experience and skills compared to the previous surveys (AIDS Guide 2007:153). It can therefore be argued that caregivers of the infected family member suffer not only the burden of compassionate caring but the impact of HIV can also limit their educational and economic opportunities. Some of the practices on career growth and succession planning are quantifiable measures such as trends on absenteeism versus availability and willingness to work as an indicator for reliability. For this reason absenteeism can have an impact on the career opportunities of people caring for the infected families.

The BER/SABCOHA study (2005) found between 16% and 23% of the transport companies, mines, manufacturing and construction companies foresee the appointments of additional employees to compensate for the impact of HIV and AIDS on labour productivity, absenteeism and mortality. In South Africa, various companies such as the mining industries are investigating measures to deal with absenteeism and these include, but are not limited to investing in machinery and equipment to reduce their dependency on labour in preparation for future loss of productivity..

The question on whether women ever missed work, did not in detail explore the relationship between time lost and stage of the disease. The participants volunteered responses, however as a result some did not give answers relating to stage of the disease and absenteeism. The question was seeking to understand the impact of HIV on the respondents' work performance. Probing the relationship between stage of the illness and absenteeism would have enriched the data, in the sense that conclusions would be drawn regarding the stage of the illness and strategic planning for employees infected and affected with HIV an AIDS. An example could be that if the results indicated that the length of absence from work during early diagnosis is shorter that the absence in the last stage of illness, then it would be necessary for the workplace to apply reasonable accommodation and proper workload planning.

9.3.1.3 Coping Strategies

(Question 6)

The participants seem to indicate that there are benefits in disclosing HIV status, whether infected or affected by HIV and AIDS. One participant said, "*disclosure is the secret to a successful and positive living, when I disclosed my status, I felt accepted by my colleagues and my manager now gives me attention"…*she further respondend that she feels confident to take her medication in public and does not feel shy to educate people about why she is taking HIV medication. Coping strategies were grouped according to the themes of individual and corporate levels.

9.3.1.3.1 At Individual Level

At a personal level, the women indicated that they use the following strategies for coping with the disease. Acceptance, disclosure, women empowerment, increase in support systems, take care of others, normalise the disease, telephone calls. It is the opinion of these women that when they increase contacts with others, talk about their challenges and disclose their status, the strategies lessen their pain about HIV and AIDS.

The participants indicated that phone calls from colleagues and friends contribute to them feeling they are loved and they belong. Based on Maslow' Hierarchy of needs (Chapman, 2001:4), self-actualization, self esteem needs, belongingness and physiological needs, it can be concluded that people are more motivated to take responsibility and live positively when they are acknowledged, noticed, affirmed and validated.

9.3.1.3.2 At Corporate Level

Strategies at a macro level seem to be recommended by women infected and affected as effective strategies. The following are the key coping strategies in the workplace that women indicated improve their coping level. HIV confident workplace, awareness and education, promoting non-discrimination initiatives through policies in the workplace, manager's empowerment, more leave.

Participant 6 has been promoted to head the HIV/AIDS programme at her workplace after disclosure. This is indicative of a caring workplace, and the power of disclosure. In her words she said, " *the fact that I am the project manager for the HIV/AIDS programme, gives me the coping strategy to live by example, in my lifestyle and behaviour... I do what I love and I continue to research more about HIV and AIDS so that I can be ahead of my colleagues and grow to be an expert."*

The researcher however cautions that not all HIV infected employees can assume the responsibility of being HIV programme managers. It is common practise to assume that

if one is HIV positive they will best manage the HIV programme, similarly in the case of people living with disabilities or recovering from alcohol abuse. As much as participant 6 has had a positive experience in this role, participant 3 resented the fact that just because she was HIV positive she was offered the role of managing the programme which she otherwise would not have chosen as role in the workplace. She felt overwhelmed and burdened as a woman living with HIV and managing the programme and the burden contributed to her changing her job. Out of 24 participants only one participant (Participant 20) did not indicate any coping strategies.

9.3.1.3.3 Discussion of Data

The researcher identified that the participants have similar experiences as other groups of people with chronic illnesses. The similarities of experiences are evident in the disease, and the role that get assigned to them in their workplaces. In some instances the participants admitted to have experienced discrimination and isolation due to HIV and AIDS. Research indicates HIV infected women often feel isolated and experience stigmatisation and shame (Chung & Magraw, 1992:891). There were common feelings such as shock, fear, anger and ultimately acceptance. The researcher is of the opinion that HIV and AIDS presents working women with feelings of not coping, even though after disclosure there was an impression that they experienced a sense of relieve. Shameful behaviour was observed throughout most interviews, with reference to cultural and religious values and blaming.

Unlike what research suggests (Chung & Magraw, 1992:894), none of the participants expressed feelings of anxiety and confusion regarding sexual activity. Participants 7 and 18 indicated they felt indifferent about sex and have no sexual interest. Mabel, not her real name, was a woman living with HIV and quoted as having said that “just because one has been diagnosed to be HIV positive, it does not mean one should stop feeling sexually attractive”. She further said “safer sex should not be a clinical discussion during counselling but a recommendation by a counsellor as a basic need for people living with HIV” (*HIV/AIDS Leadership*…, 2007:36).

Difficulties reported included experiences with disclosure. The decision to disclose emanates either from lack of workplace support or from positive workplace support. Even in very close relationships, disclosure seems to be a difficult experience. A Coronation study found that, of the 176 mothers interviewed, only 117 reported that they had disclosed their HIV status to the child's father (Jones *et al.*, 2005).

In addition to negative attitudes by colleagues in the workplace, there was evidence that HIV and AIDS creates a financial burden. Psychosocial problems of women with AIDS and HIV infection are under-recognised and the economic, personal and social resources to meet their needs are often inadequate (Chung & Magraw, 1992:894). It is noted that the financial effects of HIV and AIDS results in families to overextend their borrowing capacity (*African Journal,* 2004:42). For those participants that are at senior level and are affected, particularly participants 16, 17 and 18, expressed a high expectation and pressure from family members to take care of the financial responsibilities of the infected family member based on the impression that they can afford to do so financially. This, according to them, put a great burden on their financial responsibilities.

Experiences of participants reveal that whether one is HIV infected or affected, the impact in the workplace ranges from victimisation, coerced disclosure, career changes and / or positive support. Most of the infected and affected women have to cope with stigmatisation, suffer family disruption and peer or colleague relationship challenges (*Clinical Nursing…*, 1993: 245). Similarly, to care for the elderly and other care-giving roles, the role of a primary caregiver has a significant impact on women and their participation in the labour force. Perkins (2000:61) indicates that approximately 2,2 million people provide unpaid care to frail elders at home. Of those, 72% are women at age 45 and older, with an average age of 57. It is estimated that an increasing number of women will quit their work for care-giving roles and of those who continue to work, 20% will reduce their working hours or take unpaid leave just to care for family (Perkins, 2000: 62). Literature previously highlighted in this research study, has shown

that the great responsibilities HIV caregivers endure to make life meaningful for loved ones that are infected by HIV is in many various ways.

Stigmatisation is a social phenomenon, which has significant impact on the life experiences of individuals both infected and affected by HIV (Uys, 2000:160). The participants expressed stigmatisation as a social issue in a very emotive manner. There was an element of psychological distress and lack of understanding as they indicated they experienced stigmatisation. Each participant gave a unique impression of their stigmatisation experiences, which ranged from stigma-related to health, religious values, blaming, power and profession or status in the workplace. It is in the researcher's opinion that stigmatisation is experienced by different people in different ways, given one's childhood or cultural background, power or status and financial position with regard to affordability, or the role in the workplace or society. When their experiences on stigmatisation were explored, an argument was made to the fact that both infected and affected find it difficult to separate self-stigmatisation and actual stigmatisation. The comments made by them included perception about their colleagues, that they avoided them or talked behind their backs, despite the fact that they had not disclosed their statuses. Only participants 3 and 5 had disclosed their status.

The impact of HIV and AIDS is evident in corporate South Africa through high absenteeism and family responsibility leave. Disclosure remains a concern for both infected and affected individuals in the workplace. There are still mixed feelings regarding disclosure. Though disclosure is encouraged depending on the workplace response, this action could either be a source of punitive behaviour or a supportive environment. The infected women at an individual level expressed feelings of relief, but at a corporate level they felt discriminated against and felt mixed support regarding their status. Disclosure is one of the difficulties experienced by women in the workplace. Women fear losing their jobs, being ostracised, that their children will be rejected, but more so, they fear being judged (*African Journal…,* 2004:42).

9.3.1.4 The Role Of EAPs For Women In The Workplace In Relation To HIV And AIDS

(Question 7)

The role of EAPs is very important related to workplace support and performance improvement. The role of EAPs is similarly important in managing workplace trauma (Biedel & Brennan, 2006: 29) and addressing psychiatric disorders (Terman, 2007:10). HIV and AIDS is a workplace challenge and needs to be incorporated in the EAP service offering and managed accordingly. In South Africa, EAP practitioners have begun to assume a more significant role in the area of HIV and AIDS. The role of EAPs has been broadened to focus not only on counselling, but to include strategic interventions such as health risk management with focus on awareness, training and HIV and AIDS disease management. This section investigates the role of the EAP within the context of the difficulties which have already been highlighted at the beginning of this chapter. The researcher wishes to explore the support participants received from an EAP. This would include aspects such as whether they have utilised the EAP, does the EAP address their difficulties and was it helpful, and is it visible in their workplace. In addition, the aim was to explore the extent into which the EAP differentiates with regard to gender issues for HIV management.

9.3.1.5 HIV And AIDS Related EAP Utilisation In The Workplace

According to one of the criteria of the sampling strategy, participants were required to have used an EAP or counselling services in the workplace. Even if some did not call it an EAP, as they worked for small medium and micro –enterprise (SMME) companies, they were referred for counselling outside the workplace.

The following are the themes for using EAP:

9.3.1.5.1 Counselling

- When the participants first found out about their status or their family member's status, all the participants used counselling.

- Participants 9 and 12 used counselling during the time when they had acute stress and were diagnosed with suicidal ideation as they had just learnt about their HIV status.
- Counselling was used when work performance was impacted. The participants were either referred formally or informally by their managers - Participants 4, 5, 9 and 13. They also indicated fearing death with the exception of participant 13.
- Counselling was used when an absenteeism pattern was noted by the managers - Participants 1, 8, 12, 15 and18
- Participant 13 used counselling for couple counselling including her husband
- Counselling during bereavement time and the session was attended with family - Participants 13, 19 and 23.
- Participant 19 felt very angry that her mother died from the scourge of AIDS working as a nurse in a hospital and was still attending EAP at the time of the interview.

Counselling is very important for people living with HIV and AIDS. Research indicates the need to emphasise the importance of going for counselling not only before and after the HIV test, but also when living with HIV and AIDS (UNAIDS, 2000:3). Counselling can serve as a support system, particularly when women have to balance work and family responsibilities. Women indicated that counselling helped them to clarify and understand their HIV status, their family members' challenges living with HIV and general education on HIV and AIDS. It further provided them with a realistic expectation about the future, gave them the space to cry, express themselves, and talk about their fears without feeling judged.

9.3.1.5.2 Financial Support

It is noted that the financial effects of HIV and AIDS can lead families to over-extend their borrowing capacity to such an extent that they often find themselves at the mercy of micro-lenders (*African Journal,* 2004:42): On a positive note, only 4 out of 24 participants significantly suffered financial difficulty.

- Over-extended borrowing capacity in this study was evident as indicated by Participants: 11, 13, 17 and 24.

- Only one infected woman (Participant 11 above) indicated over-extended borrowing. It is not surprising that the majority with extended borrowing were affected women. This confirms the responsibilities of caring for those infected as financial burden to caregivers. The women as caregivers indicated taking cash advances from work after the EAP negotiating assistance for them. The significant role of EAP indicate the advocacy role of EAP, but also this role helps clients not to over borrow as the EAP are in position to help the women not to take loans more that they can cope with.

9.3.1.5.3 Support With Practical Assistance

The participants indicated that they needed support, and it was offered in many ways including the following:

- Disclosure to family members: Participants 1, 3, 6, 7, 8, and 11. Disclosure can be a challenging process, particularly given the fact that HIV and AIDS still carries stigma and discrimination. In some cultures, HIV status is associated with punishment from God and can bring shame and judgement on the family, for this reason people living with HIV may need assistance to facilitate disclosure to their families.
- Parent–child preparedness: Participants 2 and 10 talked about the difficulties of talking to their children about HIV and AIDS. They indicated that they have found themselves avoiding television programmes on HIV and AIDS, particularly watching with their children. The issue of child preparedness can be complicated by fear of death and dependency. Children are dependent on their parents and knowing that the parent is sick or seeing them sick can provoke emotions and anxiety about death and dying.
- Special leave advocacy: Participants 10, 14 and 15 given the fact that they had disclosed their status to their EAP practitioners, they found the role of EAP in advocating and negotiating flexible leave arrangement very helpful.
- Nutritional advice: Participant 4 received advise from EAP regarding nutrition and healthy eating. In addition, nutritional menus were introduced through the

organisation canteen to benefit not only HIV infected employees but as a healthy lifestyle programme.

Various practical help strategies have proven to be valuable to many people living with HIV and AIDS. In addition to what is indicated above, practical assistance for caregivers could include emotional support, instruction on how to safely prepare the body after death of the infected and funeral arrangements (UNAIDS, 2000:3). Where applicable, all counsellors should have knowledge about nutrition. HIV and AIDS information recommends food that is high in fat and proteins, as AIDS patients are known to experience weight loss.

9.3.1.5.4 Home Visits

Home visits serve as an extension of support for any caring organisation. In these cases home visits were coordinated through the EAP office. The following are some of the response in addition to practical assistance from EAP.

- Home visits were requested by participants due to financial difficulties and ill health: Participants 1, 2, 5, 9, 10, 11, 15 and 24. It is not surprising that in some instances the participants could not afford to go to EAP due to financial challenges.
- EAP practitioners accompanying the women to the home-based care centre to visit their families: Participants 13, 17, 18 and 23. Support can be demonstrated in many ways, like in this case, the women needed the EAP practitioners to support them in kind through the emotional times.
- Participants 13 and 18 felt supported during the funerals of their family members. EAP practitioners attended their family member's funeral.

9.3.1.5.5 Medical And General Inquiry

- The stage when to start medication is sometimes a challenge for people living with HIV as indicated by participants 1 to 12. A discussion about medication was mentioned by participant 3 and 7 as a discussion that is needed by any one infected with HIV. There are varying debates about antiretroviral treatment, some

believe that it has toxic effects whilst others have seen a very positive result since using treatment. Given this background, the researcher agrees with respondent 3 and 7 that people living with HIV should feel comfortable to discuss treatment and seek advise not only from EAP but from the doctors prescribing treatment.

- Enquiry was made by participants regarding pros and cons of child bearing “Can I have a child”: Participants 3 and 5 indicated even though they understood the medical concern regarding pregnancy and HIV and AIDS, they needed counselling to make decisions about starting a family. They felt that the EAP was very helpful in respecting their wishes and openly allowing them the decision powers regarding their own health.

9.3.1.5.5.1 Discussion of Data

Home visits by EAP practitioners seemed to be valued by people living with HIV and AIDS and their families. In addition, medical care and advice, including transport to hospital, emotional support and basic needs (food, shelter and supplies) are important (UNAIDS, 2000:7). In the opinion of the researcher it is important that counselling combines care with emotional support and education on HIV prevention and infection control. The fact that the majority of EAP practitioners have training in counselling assists in preventing the exposure of infected and affected women to the risk of suicide or destructive behaviours. The importance of counselling by professionals ensures ethics such as confidentiality and respect for the client, which ensures a sense of privacy.

9.3.1.6 EAP Support For Women Infected Or Affected By HIV And AIDS (Question 8)

Generally, the participants indicated positive support. However, the participants indicated that there was no focused attention to women in particular. The participants recommended women empowerment initiatives, particularly due to the vulnerability of women and promotion of employment equity goals. Participant 16 indicated that much attention is given to infected employees as opposed to affected employees. A Human

Science Research Council (HSRC) study in 2002 by the Nelson Mandela Foundation showed that women aged 20 to 24 years had double the HIV prevalence rate as compared to young men in the same age group (NMF/HSRC, 2003:9). In light of this background, the argument could be that more women are infected by HIV than men. However, these responses in this study suggest that working women living with HIV experience the impact of HIV in their personal and working life.

In addition, according to HIV transmission risks, women are biologically more susceptible to HIV infection than men. Despite this alarming statistic, corporate South Africa still does not make a special effort to understand women issues. The reason may be that women in these workplaces are involved in decisions regarding women health and have recommended against special health programmes for women. Most participants felt comfortable that the workplace does not differentiate programme offering in terms of gender, as this will further stigmatise them. However, Participants 3, 6, 16 and 18 are in support of gender differentiation for HIV and AIDS programmes.

9.3.1.7 Role of an EAP in Addressing the Needs of HIV Infected Women (Question 9)

The following items are grouped in themes and are indicated as a direct impact by the EAP:

- EAP is a counselling programme. Based on this, the role of counselling has had a positive role on the women interviewed. The women indicated that the best support for them is the fact that EAP is available on a 24 hours basis for them in the workplace. In addition the women felt counselling helped them in setting realistic goals and providing hope for the future.
- For the women who had disclosed their status to EAP, they felt EAP had the negotiation skills to mediate between them and their managers regarding reasonable accommodation and flexible work arrangement and leave. In addition the women appreciated the role of EAP in sourcing support resources for assistance with wills and disclosure to families.

- Practical and tangible support was felt by the women in the form of financial assistance, home visits and telephone calls.
- In addition to above, the women indicated that the EAP practitioners were a vital resource for linking them with specialists and community support such as in the case of home-based care.
- Updated information on HIV and guidance with treatment was always available for them through the EAP office and the organization's internet based services. It was indicated by one of the participants that the resource has been helpful during the time when her children were doing school projects on HIV and AIDS.
- The women felt that EAP role could be evident in the adherence to policy issues against discrimination. The impression was that EAP is not doing much in this area. The limited input by EAP in policy issues may be contributing to stigma and difficulties in disclosure as indicated by women as the major issues impacting the HIV and AIDS programmes.
- Participant 3 indicated that in addition EAP practitioners should be able to motivate for work flexibility to allow treatment adherence by giving time off for treatment appointments.

9.3.1.7.1 Discussion of Data

The above were raised by the participants as their perceptions of an EAP and its role in their workplace. It is the researcher's opinion that the participants are generally aware of EAPs and that the practitioners are helping them in their personal capacities and with referrals. Research indicates that EAP's function is an objective gatekeeper and bridges the gap between employees' needs and treatment providers (Brooks, 2001:8). EAP is a resource that is well-positioned in the workplace to develop strong referral systems for HIV infected and affected women due to the understanding of confidentiality. Literature further indicates that setting up a workplace structure requires coordination with hospitals, clinics, Voluntary Counselling and Testing (VCT) centres and support agencies and collaboration with local traditional and spiritual healers. In keeping with research best practice, it can be argued that South African EAPs are operating within best practice standards. There is however, still a need for the EAPs to play a mediation

role and promote policy reinforcement. Literature on HIV and AIDS support through an EAP highlights the following as important aspects of an EAP's impact:

- counselling;
- care at home;
- care costs;
- workplace support;
- strong referral systems; and
- training on HIV and AIDS.

Given the discussion above, it needs to be understood that EAPs' history is rooted in EAP core technology, thus a caution needs to be exercised when running an EAP, project owners need to delineate the EAP core functions and HIV/AIDS programme needs. General HIV and AIDS counselling can range from individual to family counselling and individual to multidisciplinary counselling. There are generally no limitations to service offering. Sessions can continue over an above limited and prescribed EAP sessions that can range from 6 to 8 sessions per event. Constraints can therefore arise under the counselling that is offered through EAP in the workplace, where the EAP policy, core function, company culture and strategy dictate EAP that has its roots from EAP core technology. In this case the programme will be designed to be short-term problem solution focused and operate under company's customized strategy.

The responses above indicate that EAP in South Africa is offering an eclectic services ranging from counselling to home visitations. The reason could be that majority of the EAP practitioners are staffed by social workers who have their counselling background from social work education where service offerings may include home visits or this is merely a humanitarian value inherent in most of South African called "Ubuntu." Ubuntu is a value that has its understanding from an act of kindness that goes beyond prescribed standards and style of doing things. The responses confirm this argument made by Masi (2000) previously under the literature review that warns that one must not evaluate such services negatively. Even though most EAPs in various countries are historically

established similarly as in the USA as a chemical dependency programme, the programmes have evolved by following countries diversity and cultural influences. Masi (2000) noted that EAP in Brazil is more 'Brazilianized"; similarly in South Africa, there is a call for a more "Africanised" EAP, as emphasised by Du Plessis in (Maiden, 2001:112).

9.3.1.8 Role of EAPs in Addressing the Needs of Affected Women

(Question 10)

The following was indicated as positive impacts by EAPs for affected respondents:

- Similarly to the infected women, the affected women appreciated counselling in the workplace. They received EAP counselling in the form of bereavement, dealing with guilt and blame and focusing them to accept the status quo.
- In addition, the women felt their knowledge and education about HIV and AIDS was enriched by the EAP.
- Support is the cornerstone of EAP. In addition to the emotional support, affected women experienced support in the form of reasonable accommodating measures and policy issues.
- One of the EAP core technology function is resource referral. Equally so, the affected women were referred to specialists for targeted services when necessary.

9.3.1.8.1 Discussion of Data

Similarly to the infected women, affected participants feel there is evidence that the EAP is visible in the workplace. Counselling is indicated as the visible role that was played by the EAP, followed by HIV and AIDS awareness and education. In addition, support offered through home visits and treatment advises was appreciated by both infected and affected research participants. Of significance to note was, the fact that some of the EAP practitioners and committee members attended the funerals of their family members was an action valued by women affected by AIDS. It is of cultural importance to Africans when support is shown through practically means or mere attendance of a funeral ceremony.

In cases where reasonable accommodation was given in the form of time flexibility, the women indicated they themselves showed effort in ensuring that they work hard to ensure productivity and replace time lost. It can be argued that when flexible time is offered to employees struggling either with family responsibility tasks or care of family, employees tend to show appreciation by ensuring that they maintain high performance. This is also relevant to cases of employees with disabilities. In a study by Mathaphuna (2007:162), it was argued that when there is advocacy for people with disability in the workplace, the action contributes to them enjoying their work. It can therefore be concluded that advocacy for employees contributes to high retention and skills attrition in the workplace.

9.3.1.9 Women's Perceptions of EAPs After Utilisation

(Question 11 and 12)

Out of 24 respondents, 4 felt the experience was negative and that the EAP is only effective regarding counselling but is not visible and effective to change management issues. EAP is a counselling programme which offers short-term problem resolution to employees, therefore its main focus is to help employees identify and resolve personal concerns. Judging from the responses, it can therefore be concluded that EAPs are achieving the intended goal and aims of the EAP core functions, which is counselling employees and assisting them to identify and resolve personal concerns. Twenty respondents were very happy with the EAP and indicated they will recommend participating in the EAP to others. The satisfactory responses further indicate that EAP is well received. Participants 3, 5, 6, 10, 13, 14 and 16 believe strongly in an EAP, recommend EAPs for employees regularly and participants 5, 10, 13 and 14 serve as EAP committee members or peer educators in their workplace. In a survey by (Dickson, 2004:51) peer educators reported resentment to the fact that their companies tend to provide high-profile donation to well-known but distance HIV and AIDS projects, while there are more pressing priorities and often more desperate needs on the company's doorstep.

Where companies are managing the impact of HIV and AIDS on productivity and cost, it is through internal HIV and AIDS policies and through peer education that a difference can be made. Within the context of HIV and AIDS in the workplace, peer educators can be seen as a third channel of communication. The HIV and AIDS peer education is another method of disseminating HIV and AIDS information to employees. Similarly EAP committee members are a channel for communicating the importance of EAP and visibility of services offered. This study bore this contrast to the feeling of HIV/AIDS peer educators discussed above, since the participants in this study indicated positive identification with EAPs in the workplace.

9.3.1.10 Recommendations - EAP for Women Infected/Affected by HIV and AIDS (Question 13 and 14)

Many of the recommendations made by the participants are in line with the recommendations in the HIV and AIDS briefing paper, titled 'towards earth summit' (2002), which divided recommendations into various sections, such as governmental interventions; NGOs, private sectors and international institutions. The majority of the recommendations fall under the private sector section emphasising long-term business plans, enhancing traditional rights, safety nets and workers' rights, business coalitions and awareness raising.

***The following are itemised themes in a verbatim format as recommended by the respondents and grouped by the researcher*:**

9.3.1.10.1 Stay away from gender specific programmes

- "EAPs should not only focus on women, but should include all infected and affected employees regardless of gender".
- "EAP should offer skills and training on HIV and AIDS". Despite research indicating that there is ongoing education and training, and supported by some of the participants above, women indicated a need for more education on HIV and AIDS.

The rationale could be that as long as there is not yet cure for HIV, ongoing education and training is required for information update.

- "HIV and AIDS to be de-stigmatised by encouraging disclosure and protecting those who disclose through retention initiatives". There seem to be a need for disclosure, and the rational could be disclosure facilitated support and ease the burden of HIV and AIDS.

- "Advocate for use of both female and male condoms". In South Africa, male condoms are accessible and are distributed through public distribution means. Female condoms are recommended as an empowering tool for women, however female condoms are not freely accessible.

- "Establishment of support groups". Support group will allow participants an opportunity for shared experiences. Similar to Alcohol anonymous, support groups serve as a process that facilitates healing and increases support for both infected and affected.

9.3.1.10.2 Health Focus programme

- "EAP should offer empowerment skills for women regarding sexual rights".

- "Empower infected and affected individuals to mentor others who have just found out about their status".

- "Encourage disclosure and normalise HIV and AIDS as a manageable disease".

- "Address issues of sexual abuse and harassment".

- "Encourage treatment, especially in cases of rape incidences".

- "Advocate for disease management programmes where applicable".

- "Men should be encouraged to disclose and EAP should influence legislation to deal with those who infect others knowing their status".

- "Encourage going for VCT on a quarterly basis".

- "Encourage good nutrition habits".
- "Encourage in-house health facilities for easy access to treatment".

9.3.1.10.3 More Support for EAP

Not all the recommended strategies are feasible for a functional EAP.

- "More resources for Wellness Programmes such as a larger staff component and teams". As much as for EAP to be an effective business partner, this aspect is relevant, however more resources may only be considered inline with the organizational strategy and strategy intent.
- "Encourage multidisciplinary teams with accessibility to specialists". In keeping with EAP historical definition, EAP is a short-term problem resolution programme. Multidisciplinary approach may not fit in with the EAP core technology. A strong referral network is necessary to address this need.
- "The role of EAP should be to mediate for better job opportunities for the infected and affected". This recommendation should be looked at within the equal opportunity for all employees including people living with HIV and AIDS. The principles on retention and succession planning should apply equally to all.
- "HIV and AIDS should not be seen as a black disease but an illness that affects all races". This statement seems to suggest that there is a mixed perception about HIV and AIDS in South African workplaces. More education should address this and maybe use of people living with HIV from both black and white communities should be considered.

9.3.1.10.4 Make EAP Visible

- "EAPs should improve their marketing strategies and aim to be visible".
- "EAPs must be positioned at an executive level".
- "Empower women to manage their finances".

- "Management training on EAP and HIV and AIDS".

9.3.1.10.5Other Creative Ideas

- "Focus on women's day events to target HIV education".
- "Monthly email messages on current research such as new preventative strategies (e.g. microbicides) for women". (this suggestion was given by participant 3,8 and 19 in 2007 before the debates about the efficacy of microbicides was questioned). Microbicides is an formulation gel that can be applied vaginally or rectally which has been investigated by researchers as a possible HIV prevention strategy. A review of pre-clinical and clinical research on this formulation has yielded 118 studies of which 73 pre-clinical and 45 clinical. Clinical research included phase 1 and 11 safety studies whilst phase 111 was efficacy studies. Clinical trials of both phase 1 and 11 have found microbicides to be safe and well tolerated, however phase 111 have not demonstrated efficacy in preventing HIV transmission. As reported in the Lancent Infectious Diseases Report by Cutler and Justman (2008:685), microbicides clinical trials face scientific and ethical issues given choices, potential viral resistance and inclusion of HIV infected participants. It can therefore be suggested that until conclusive results have been achieved on the efficacy of microbicides, caution should be exercised in recommendation of this possible HIV prevention strategy tool.
- "Support groups involving family members".
- "Advertise real stories and cases".
- "Merge EAP committees with peer educators".
- "Benchmark actions with other role-players in the HIV and AIDS field".
- "Parent–child or mother-daughter workshops on gender and HIV and AIDS".

Participants 3, 4, 10 and 18 had praises for their workplace programmes and suggested that their EAP managers should look into presenting their programmes for best practice

reasons at various EAP conferences. Most participants felt very strongly that the EAPs are not marketed well. EAP is still seen as a programme for the weak and troubled only. Phillips (2006: 18) agrees that EAPs are not often positioned well to serve the organisation's strategic vision and goals. He recommends that EAPs should clearly outline service delivery options in order to attract those that need it through communication, pamphlet promotions, and programme branding. It should be customised to meet unique needs at both organisational and departmental levels.

Best practice on marketing and selling EAPs emphasise that a clear understanding of one's EAP is key in positioning the EAP (Beidel & Brennan, 2006: 27). Every EAP coordinator or manager must make an effort to evaluate their EAP's strengths, weaknesses, values and beliefs. In doing so, one will have a better strategic focus to position, brand and sell the EAP to employees and management. Identifying key people and decision-makers in the workplace is the beginning of a relationship that will give rise to a supportive and integrated EAP which will make the marketing process easy (Beidel & Brennan, 2006: 28).

9.3.1.10.6 Discussion of Data

Increasing numbers of companies are integrating EAP services, including health, work-life balance programmes, HIV and AIDS programmes, disability programmes and counselling. By integrating these services, employers began to discover that some workers were sometimes using multiple benefits inappropriately. Integrating services is not only a turning point for cost savings, but it also enhances productivity, improves the employees' level of health and help address absenteeism. With the evolution of an EAP from an internal work-site based model to outsourced models, the programme can offer a more holistic approach to training, behaviour change and responsive strategies to mitigate any workplace problems (Maynard, 2006:29).

The participants indicated the role of the EAP as important and that they received value in utilising the EAP in their workplace. However, they have also indicated that the EAP is sometimes invisible and 10 of the participants evidently used EAP only after referral by

their managers through the organizational referral system and when their managers noted much absenteeism. It was interesting to note that some participants benefited from various EAP services: 6 participants used EAPs for practical help, while 8 participants benefited from home visits and valued the visits. In addition, the participants valued the fact that their colleagues attended the funeral ceremony of their family members. It is common value in the African culture to show support through attendance of the funeral during bereavement time. Attending a funeral symbolises support in times of need.

It is in the researcher's opinion that an EAP's role is not only limited to counselling and training. As much as various practitioners are creative and proactive in EAP marketing in their workplace, participants still indicated that the EAP is not visible and management needs empowerment and training to manage HIV and AIDS or to facilitate referrals. All the HIV affected respondents, with the exception of one, have used EAPs for bereavement counselling after the death of their family members. This raises a question of the need for debriefing sessions for counsellors dealing with death and dying. Research indicates that AIDS counselling contributes to high stress levels among counsellors (Klonoff & Ewers (1990) in Burnard (1992:11). In avoiding counter transference issues, it is noted that some counsellors would then skip all the emotional counselling and concentrate on the medical and educational aspects of the disease and end up lecturing rather than listening to the client (Fowley *et al.*, 1990: 286).

There was general agreement that an EAP is an important programme acknowledging that employee's health and personal issues should be mitigated to increase work satisfaction. From the recommendations regarding improvements, various initiatives are already in place in the workplaces. However stigmatisation, disclosure, training, management and empowerment remain the strong key recommendations. It remains a central theme that stigmatisation is a barrier for programme visibility and HIV and AIDS should be de-stigmatised. Recently, South Africa has seen an emergence of prominent leaders talking openly in radios, television and various forums in South Africa, about their family members who have died due to AIDS related reasons. These include, but

are not limited to former President Nelson Mandela, Inkatha Freedom Party President, Mangosuthu Buthelezi and recently, South African Football Association Head, Mr Irwin Khoza.

9.3.1.11 Summary and Conclusions of the Qualitative Data Analysis

The 24 participants are working women who have used EAP in their workplaces. This study reveals that HIV and AIDS affect women at different ages and different work levels. The study further shows that the majority of infected women are at lower levels whilst the affected women in this study are mostly at a senior level. Both groups of women have similar experiences and suffer various difficulties ranging from feeling of despair to practical work-related difficulties. The majority of women in both groups have missed work due to HIV and AIDS, however it cannot be concluded that the fact that they missed work was directly linked with specific stage of their illness or those of their family. The question in the study was probing the impact of HIV on work attendance and absenteeism. The study further revealed that women infected and affected by HIV appreciate the role of EAP, however the aspects that were most appreciated seems to be those practical aspects that were offered by EAP over and above EAP core functions. The researcher therefore concludes that in order to integrate EAP and HIV/AIDS programme, it is important to understand that EAP is defined by its core technology function, but in the same vein, the EAP can be customised to suit the company and country values and culture, In South Africa the term can be called Africanising as defined by Du Plessis in (Maiden, 2001:112).

The involvement of women in the EAP functions as committee members affirms the satisfactory level of women regarding the role of EAP. The recommendations in this study highlight mixed opinions from women regarding HIV programme designed considering gender difference. Clearly those women who have disclosed their status tend to agree that the programme should give special attention to women needs, however those who have not disclosed, tend to fear discrimination and stigma. The researcher concludes that disclosure is the key for proper planning and reasonable accommodation. Without disclosure, women may remain disempowered to address issues of discrimination and stigmatization in the workplace.

However it is also important that EAP practitioners are empowered to advocate for those who disclose and put into places strategies that seek to rid barriers against disclosures. The mixed responses for and against disclosure indicate that stigma regarding HIV still exists and the aspect of disclosure can only be managed when workplaces become HIV and AIDS confident. It is the researcher's impression from the responses in this study that EAP workplace programmes in South Africa have moved beyond counselling as HIV and AIDS education and training are in place and yielding positive results.

Finally, judging from the recommendation by respondents, South African women who are infected and affected by HIV and AIDS have a clear understanding of HIV and AIDS. The recommendations are in line with general HIV and AIDS education. The researcher therefore concludes that when people are empowered they tend to take responsibility not only for their illness but also for those around them.

9.3.2 QUANTITATIVE DATA ANALYSIS

9.3.2.1 Introduction

Quantitative data was collected through a questionnaire (Appendix 2) and was calculated manually, using Microsoft Excel software.

The structured questionnaire was divided into 5 sections and these sections are discussed in detail below:

- **Section A**: Demographic Analysis
  The section relating to demographic analysis is best described by questions 2 to 9. Information derived from the responses to these questions are illustrated in Figures 2 to 9.
- **Section B**: The Role of the EAP
  This section is best described by questions 9 to 28. Information derived from the responses to these questions are illustrated in Figures 10 to 20.
- **Section C**: Difficulties experienced by women with HIV and AIDS in the workplace. This section is best described by questions 29 to 41. Information derived from the responses to these questions are illustrated in Figures 21 to 27.

- **Section D**: Strategic planning
  This section is best described by questions 47 to 61. Information derived from the responses to these questions are illustrated in Figures 28 to 30.
- **Section E**: Leadership
  This section is best described by questions 62 to 67. Information derived from the responses to these questions are illustrated in Figures 31 and 32.

9.3.2.2 Section A: Demographic Analysis

A total of 206 questionnaires were distributed to EAP professionals, and 81 respondents completed and returned the questionnaires. Demographic information included on the questionnaire was: age, gender, religious affiliation, position and level at work, type of EAP model used within organisation, length of EAP experience and work experience in HIV and AIDS. The demographic analysis is discussed in detail with emphasis on data collected from questions 1 to 9 as illustrated in figures 2 to 9 below.

9.3.2.2.1 Age of Respondents

(Question 2)

The respondents were requested to provide their age. Figure 2 graphically indicates the age distribution of all the respondents.

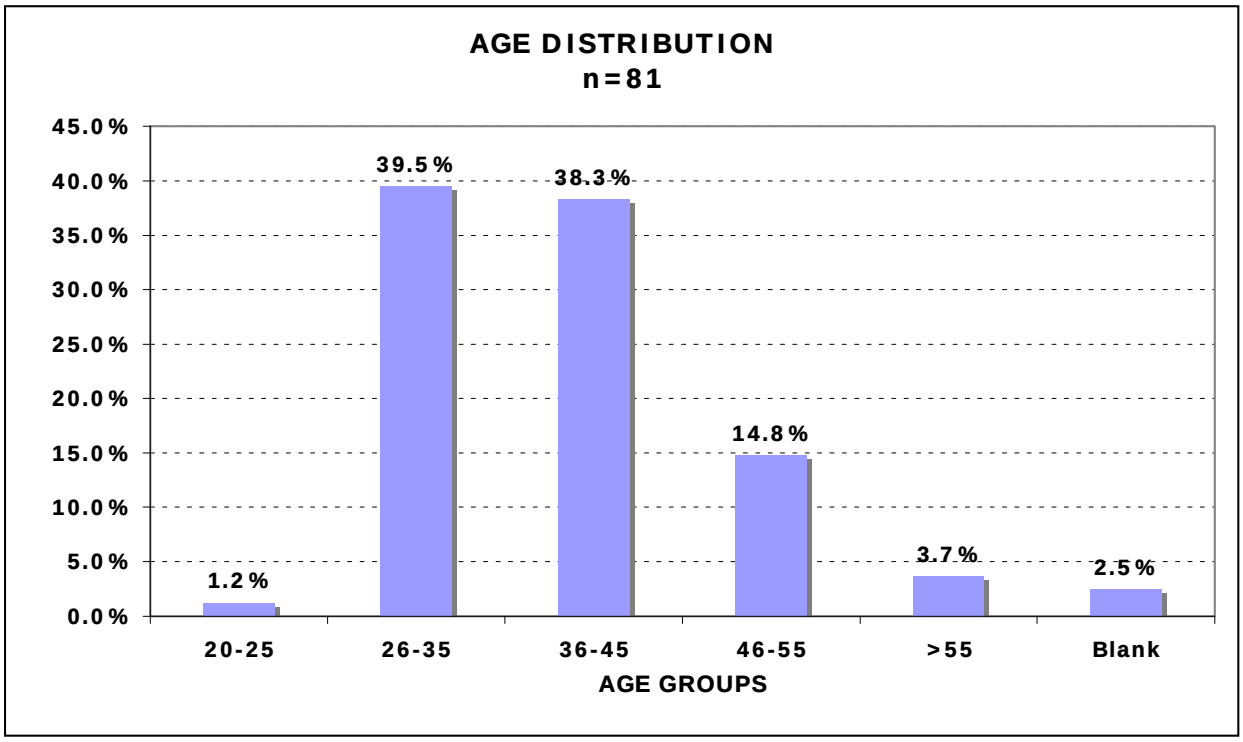


Figure 2: Age Distribution of Respondents

9.3.2.2.1.1 Discussion of Data

The question on age was open-ended. The data was collated and categorised into intervals to facilitate analysis. The majority of the respondents fell in the age bracket 26 to 35 years (39.5%) and 36 to 45 years (38.3%). In South Africa the working age is 18 years and the retirement age for women is 60 years and 65 years for men. The age distribution above indicates that the EAP practitioners represented the general working profile of South African industry. From the sample of the survey, of interest is the low number of EAP practitioners that are represented in the age group 20 to 25 year olds. A possible explanation for this phenomenon in the age group could be that EAP practitioners initially are still developing a career that would lead to running EAP in their organisations. It could be implied that the EAP practitioners have the working experience to cover the youngest to the oldest worker. An assumption can therefore be made that age can have either positive or negative impact on the counselling offered to a client.

Of interest would be to explore whether age has any impact on the level of counselling offered to women infected or affected by HIV and AIDS, particularly as the mode of transmission is primarily through sexual intercourse, as different generations have different perspectives on sex. In South Africa in certain cultures, the topic of sex is a taboo subject, thus raising another issue relevant to the discourse. Furthermore, the issue of the gender of the counsellor, which is discussed under question 5, could be another concern.

The practitioners played different roles in their respective organisations ranging from co-ordinator to managing or consulting.

9.3.2.2.2 Position in the Workplace

(Questions 3 and 4)

Questions 3 and 4 relate to the level of work and position occupied in the workplace by the EAP practitioner. These two questions are interrelated and thus are discussed under figures 3 and 4 as demonstrated in bar graphs below.

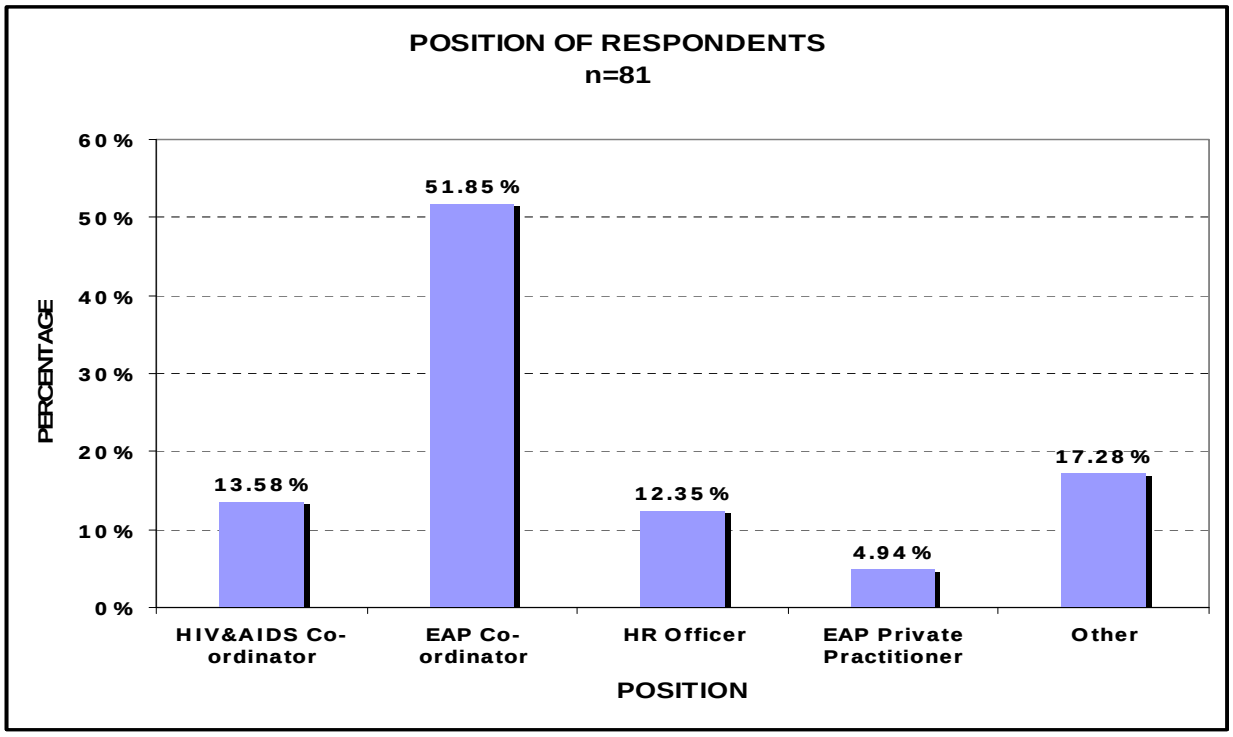
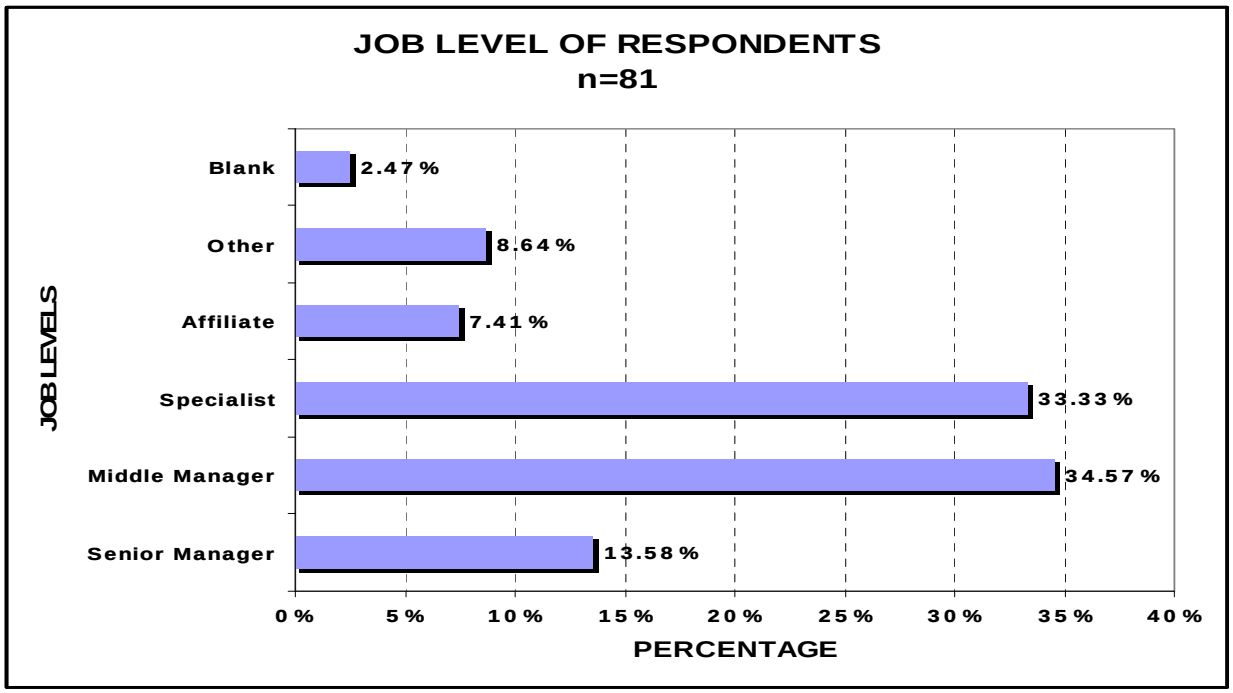


Figure 3: Position of Respondent

Figure 4: Job Level of Respondents



9.3.2.2.2.1 Discussion of Data

Considering question 3, the position of practitioners in the organisations, the majority of the respondents indicated that they perform the role of EAP co-ordinators (51.85%). The category labelled as 'other', as indicated by the respondents, mainly included wellness managers and health and safety managers (17.28%). When considering question 4, the majority of the respondents are in a middle management position (34.57%) and specialist position (33.33%). In South African business, with its largely hierarchical structures, position determines the decision-making power a person has in an organisation.

Based on the organisations particular organograms, specialist skills could find themselves operating at a senior level but not necessarily having decision-making power. The position and level at which the EAP practitioner finds him or herself largely determines the ability to influence the objectives and implementation of EAP in the organisation. Specialist positions in EAP in corporate South Africa falls within the lower and middle levels and may differ from one organisation to the other, depending primarily on the size. It is concerning to see that only 13.58% of the respondents were at senior level. When one considers that HIV and AIDS is one of the major risks facing the South African economy, the expectation would be for a greater number of decision makers at senior level in organisations to provide strategic guidance in this regard.

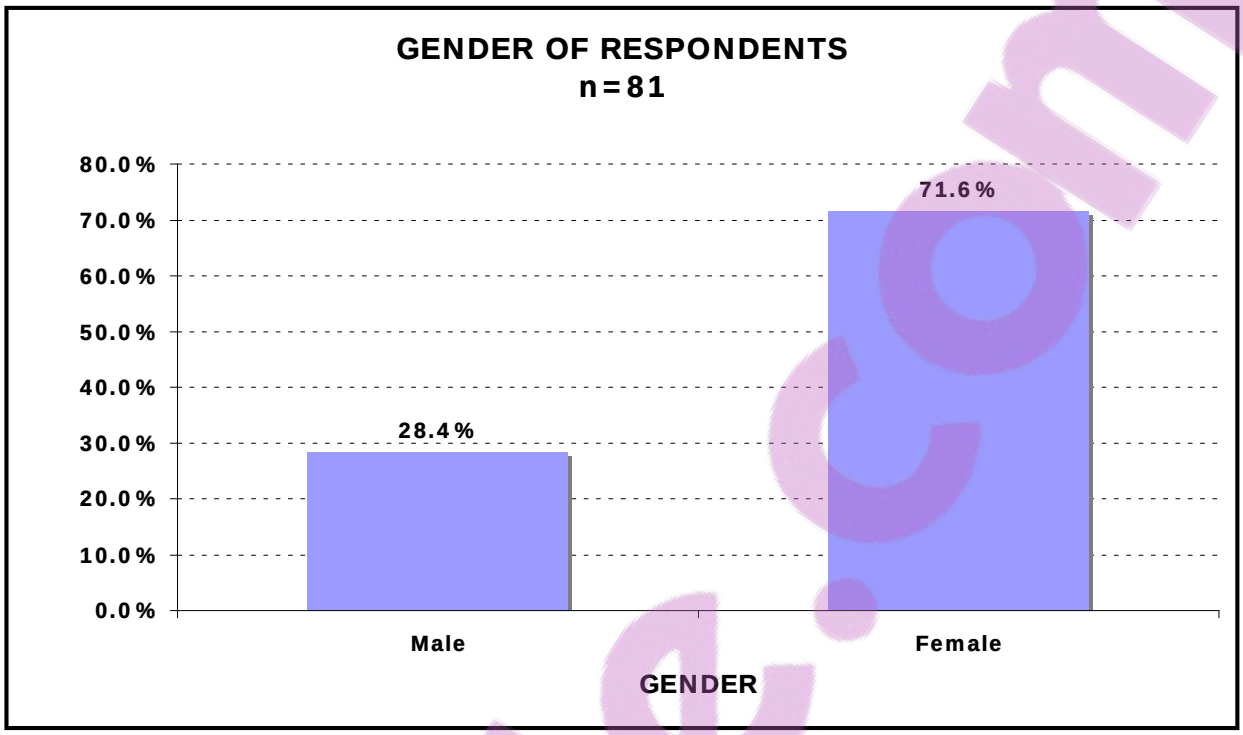
The researcher concludes from these responses that EAPs do not enjoy the influence that it deserves, given that the majority of the skills-base is within the middle management and specialist levels – which may be different from senior management level.

9.3.2.2.3 Gender of the EAP Practitioners

(Questions 5)

Question 5 required the respondents to indicate their gender.

Figure 5: Gender Profile of Respondents



9.3.2.2.3.1 Discussion of Data

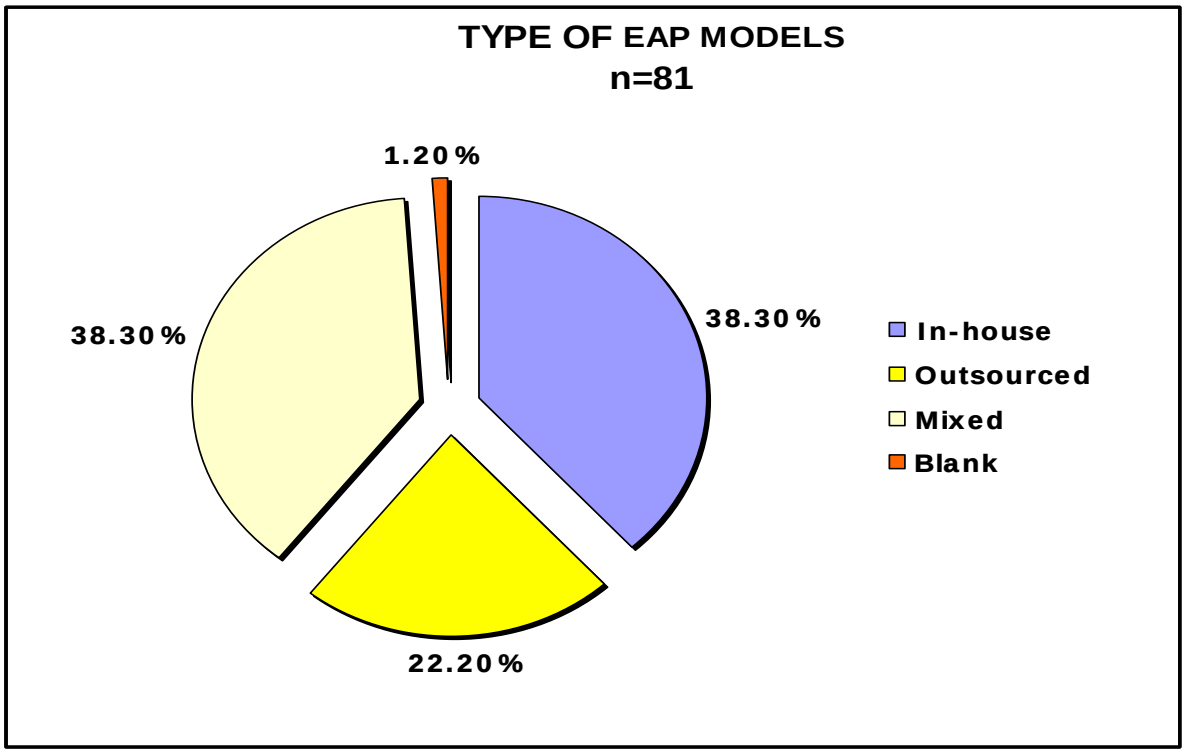
The majority of the respondents were female 71.6% and 28.4% were males. The responses above indicated that female practitioners dominated the EAPs in South Africa. Historically, the EAP and Occupational Social Work professions have inherited skills from the counselling profession, which has been largely dominated by female professionals and got to be known as the “pink collar” field. This has however changed in the 20th century with the emergence of counselling in the workplace where there was no limitation to social work profession and the need to help the troubled employee included the use of predominantly recovering alcoholics (Gilbert, 2006:11). It is this researcher’s assumption that the majority of the counsellors (recovering alcoholics) were men given the workplace gender profiles in the 20th century. According to Gilbert (2006) in USA, EAP is still dominated by men and the reasons range from the inherent issues around women working part-time as they have to balance work and family responsibilities to limited opportunities for women, whilst men easily take leadership from their inherent socialization influences. In South Africa it is common practice

amongst the external EAP models to offer employees the option regarding gender preference when seeking counselling. It can therefore be concluded that this preference can contribute in EAP professional choice for men, given the demand for EAP and gender preference in the future. The psychodynamic theory, however indicates that gender preference does not affect the quality of counselling offered by counsellors, instead the quality of counselling is influenced by experience, skills and ability to connect and built a client-counsellor relationship (Summerfield & Oudtshoorn, 1995). This question did not explore whether gender had any impact on counselling offered to women infected or affected by HIV and AIDS – which could be seen as a limitation, valuable information could have been gained.

9.3.2.2.4 Model Preference

(Question 6)

Figure 6: Type of EAP Model



9.3.2.2.4.1 Discussion of Data

Every EAP model will distinguish clear functions for both the employer and the employees. The EAP model is the structure that the company uses to plan, design, and implement a program to address the needs of the troubled employee. The EAP has evolved mainly from internal, worksite-based model to an outsourced, managed care delivery model which has tend to focus not only on counselling but on education, prevention and early intervention (Vineburgh, Ursano, Gifford, Benedek & Fullerton, 2006:14). The pie chart in figure 6 demonstrated the visibility of various EAP models in South Africa.

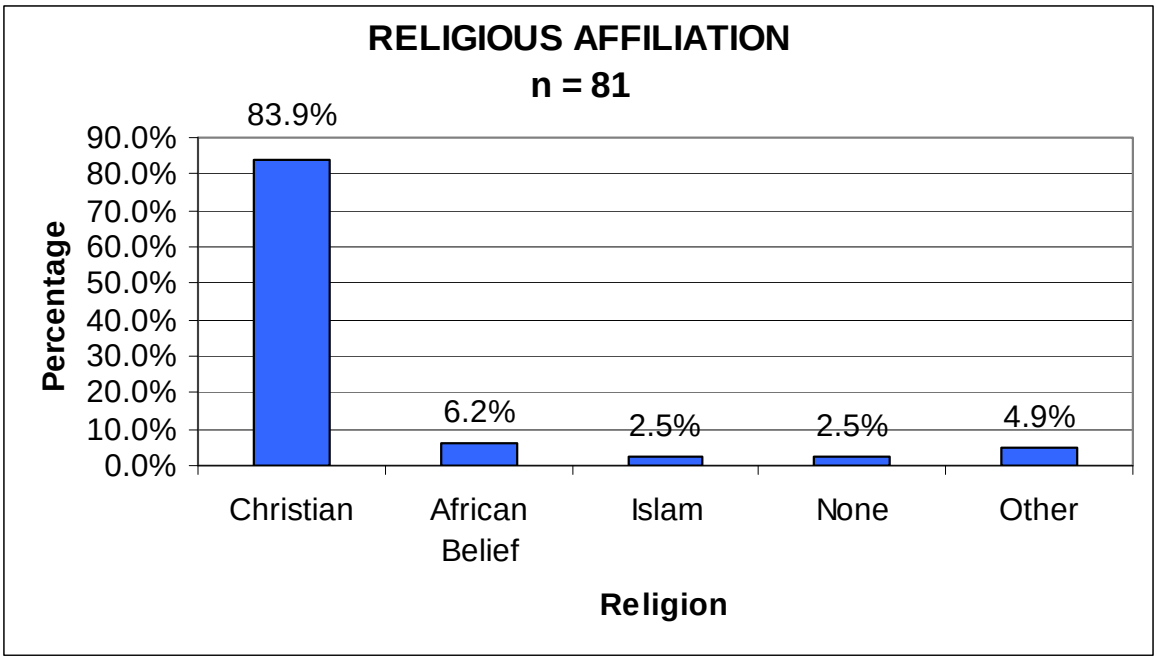
The choice of the respondents in the study indicated that in-house and mixed models are the preferred choices of EAP by those practitioners sampled at 38.30% respectively, with 22.20% outsourcing the function completely. In 1995 / 96, a survey by Harper (1996) of the top hundred companies in South Africa revealed that 42% companies had EAPs in the workplace. The study looked at the prevalence, model design and service. The data from the responses showed no clear preference for a particular model. This could be as a result of the unique position that EAP has as a growing field of expertise within organisations and in the country. Organisations are most probably developing positions that would best suit the skills and competencies it requires to implement EAP with a view to the organisational culture and needs.

9.3.2.2.5 Religious Affiliation

(Question 7)

Question 7 investigated the religious identification of the practitioners. Religion and spirituality can plan a role in counseling and service delivery.

Figure 7: Religious Affiliation of Respondents



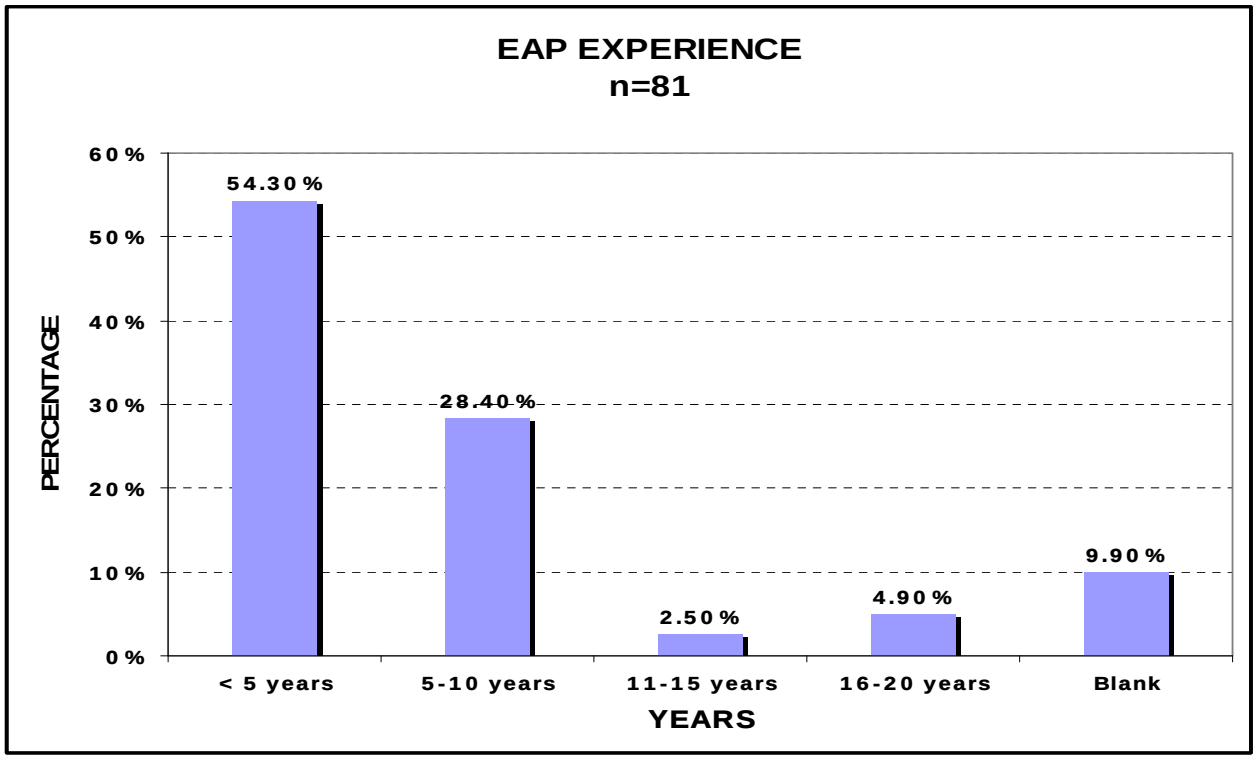
9.3.2.2.5.1 Discussion of Data

The majority of the respondents were Christians at 83.9% and there was no significant difference between other religious choices. What is not known is whether the respondents' religious experiences had any impact on the EAP offering. As discussed in the literature review previously, spirituality plays an important part in the lives of people infected and affected by HIV and AIDS. Spiritual counselling encourages workplaces to allow employees to live their lives openly and bring the value of spiritual identities, their souls and their faith in the workplace, making it great place to work for employees (Miller, 200513). Research has shown that people with a spiritual belief tend to cope better when faced with challenges (Simoni, Martone & Kerwin, 2002; Dein & Stygall, 1997; Pargament,1999). In contrast, the principles of counselling encourages counsellors to stay away from spiritual counselling as this could be viewed as imposing one's belief on the client. Whether the respondents used their spirituality during counselling with women counselled was not explored. The influence of spiritual counselling by EAP practitioners would have been an interesting dimension to explore given support of literature on this aspect of counselling.

9.3.2.2.6 Duration of Work Experience of EAP Practitioner

(Question 8)

Figure 8: Experience of EAP Practitioner



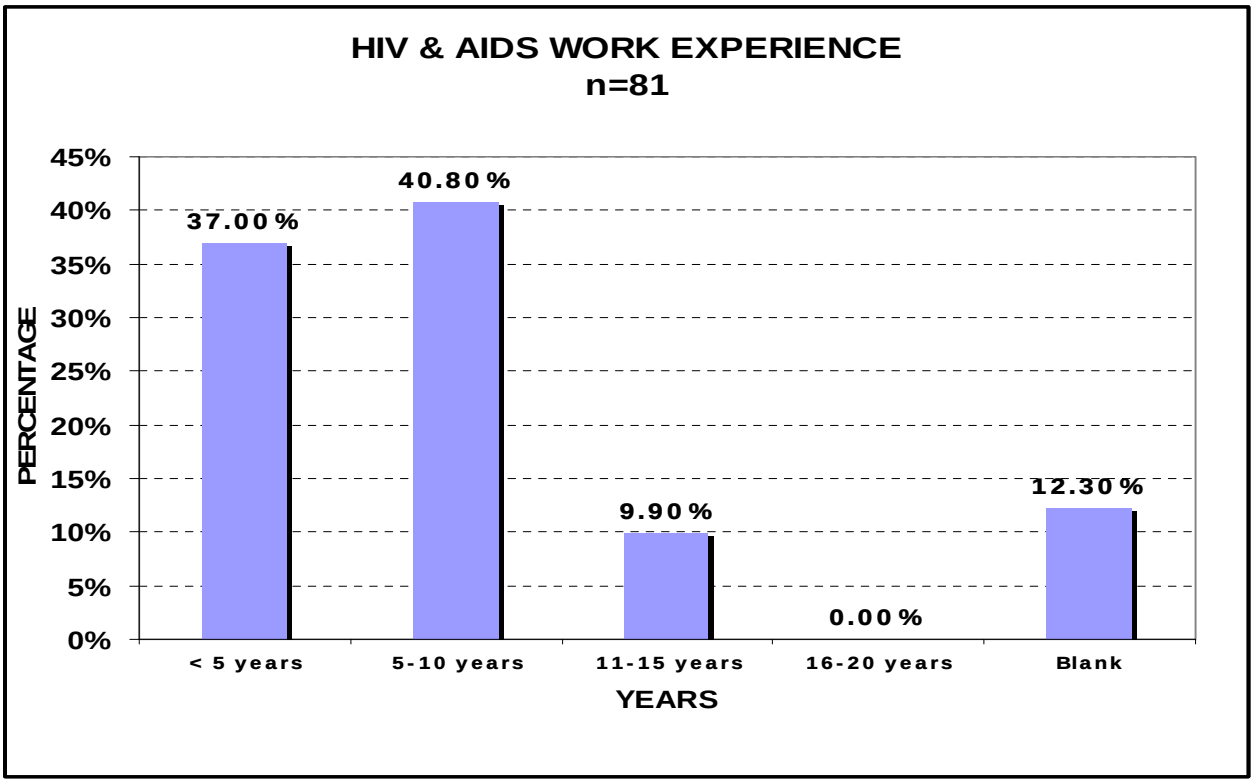
9.3.2.2.6.1 Discussion of Data

The data for 'years of experience in EAP' was analysed and grouped in intervals as indicated above in Figure 8. From the responses, the majority (54.30%) of respondents have less than 5 years experience in EAP. As EAP is a programme that includes counselling services, thus special skills and knowledge are essential in delivery of the programme. The assumption is that in addition to technical professional experiences, skills and knowledge can be achieved through years of experience and interaction with peers in the field. In this field one's reputation and integrity is enhanced by the breadth and depth of one's experiences in the field. The responses above indicate that the South African workforce is staffed with EAP practitioners with reasonable experience in their field of work.

9.3.2.2.7 Work Experience in HIV and AIDS Field

(Question 9)

Figure 9: HIV and AIDS Work Experience



9.3.2.2.7.1 Discussion of Data

From the collation of the data relevant to question 9, the majority of the respondents indicated that they have more than five years work experience in HIV and AIDS. The most acquired experience is up to 15 years. Since the AIDS pandemic was recognized in 1981 (Mann *et al.,* 1992:35*)*, information on HIV and AIDS over the years has evidently been made available through media, scientific research and community and business support structures (UNAIDS/WHO Update, 2007). HIV and AIDS work experience in this study was not limited to counselling but included all aspects of HIV and AIDS experience such as education and awareness, policy formulation and advise on psychological issues as defined by Burnard (1992:11) previously in chapter 8 of the literature review.

Drawing from the research indicated here, the researcher made the conclusion that the respondents' experiences were coherent with the 26 years since the recognition of the onset of the AIDS pandemic. When comparing the responses to question 8 and question 9, there was a relatively good correlation between the experiences that the respondents have related to EAP and HIV and AIDS work experience. Notably, the experience in the EAP field, which was less than 10 years equated to 77.8 % of the respondents whilst 87.7% of the respondents indicated having experience in HIV and AIDS work experience. It is most likely that due to the high HIV and AIDS prevalence in South Africa, EAPs have made attempts to address the HIV and AIDS issues in the organisations.

It can thus be argued that South African employees are in the hands of competent and experienced practitioners, making the analysis by Maiden (1992: 2) true that EAP in South Africa has developed much faster and has gained a sophisticated level to look beyond a one-on-one clinical approach as highlighted by Du Plessis in (Maiden,1992:29).

9.3.2.3 Section B: The Role of EAP

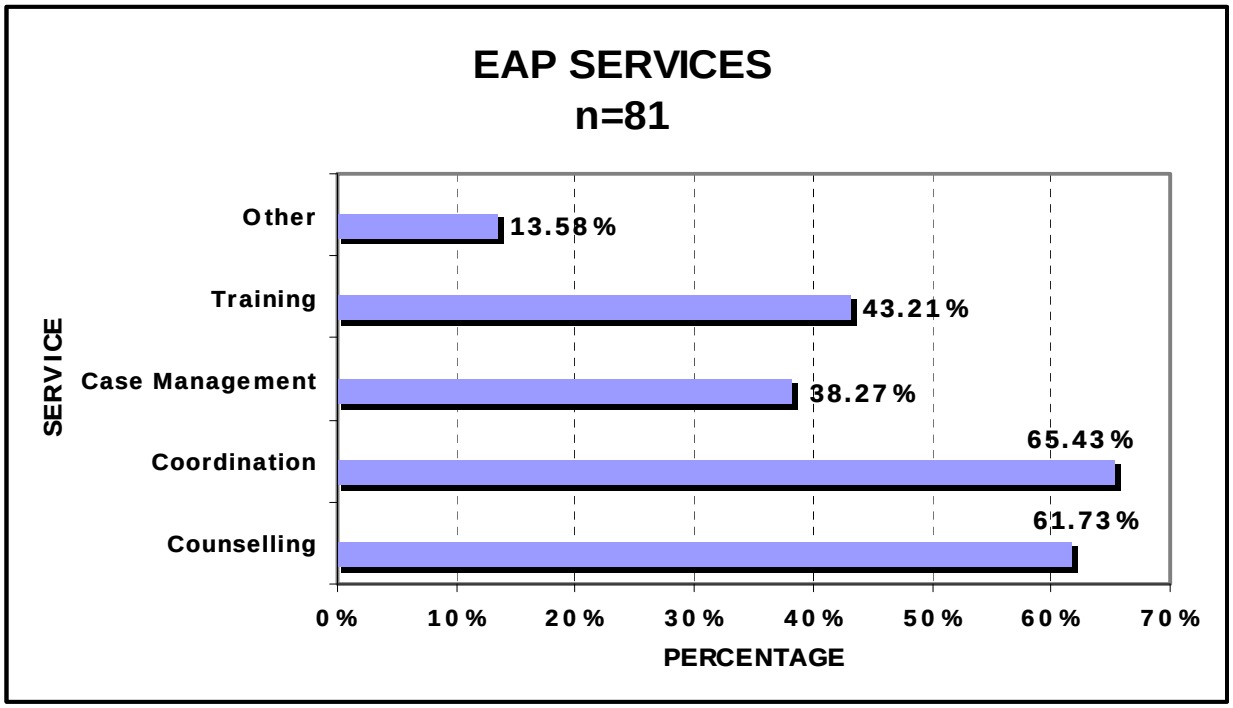
This section investigated the role of EAP involvement in HIV activities, including basic HIV prevalence. Some of the questions required multiple answers to the responses. Questions 10 to 28 are presented with figures 10 to 28 and discussed.

9.3.2.3.1 EAP Services Offered

(Question 10)

Question 10 investigated the type of services offered by EAPs in South Africa. The respondents were expected to indicate multiple answers where necessary.

Figure 10: EAP Services Offerings



9.3.2.3.1.1 Discussion of Data

There were 180 responses by the 81 respondents on the various services offered. As it was evident that EAPs in South Africa offer various services, the question provided for multiple answers. Overall co-ordination and counselling remained the most popular aspects within the EAP service offering. This is borne out by 65.43% (coordination) and 61.73% (counselling) of the respondents indicating this. As counselling is the primary service offered by EAPs, the researcher expected counselling to have been offered by all the respondents.

Of particular interest is the relatively strong score attributed to other services such as training (43.21%) and case management (38.27%). An explanation and assumption for this could be that EAP services in these areas are offered predominantly by EAP consultants in the outsource EAP model or in their private capacity. The 13.28% that indicated ‘other’ as an option mainly included home visits and referral to home-based care. Home visits are common professional practices borrowed from social work

practices, and the diverse South African communities value these practices. The responses further indicate that EAPs in South Africa have gained a level of sophistication and that practitioners are putting their HIV and AIDS experiences into practice.

9.3.2.3.2 HIV and AIDS Prevalence in the Workplace

(Question 11 and 21)

Question 11 and question 21 are both discussed here as they are interrelated. The two questions investigated the prevalence of HIV in the workplace. Question 21 however investigated the prevalence amongst females and males. The data from the two questions is illustrated in Figures 11 and 12 below.

Figure 11: HIV & AIDS Prevalence in the Workplace

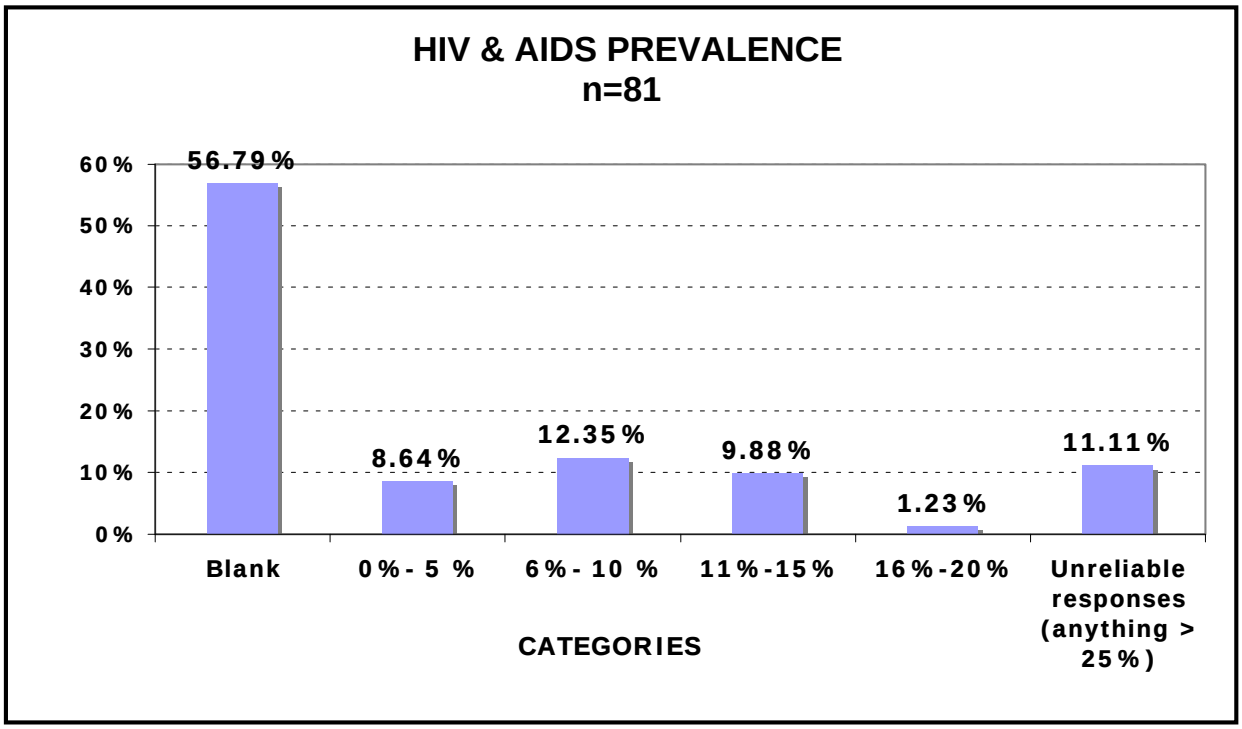
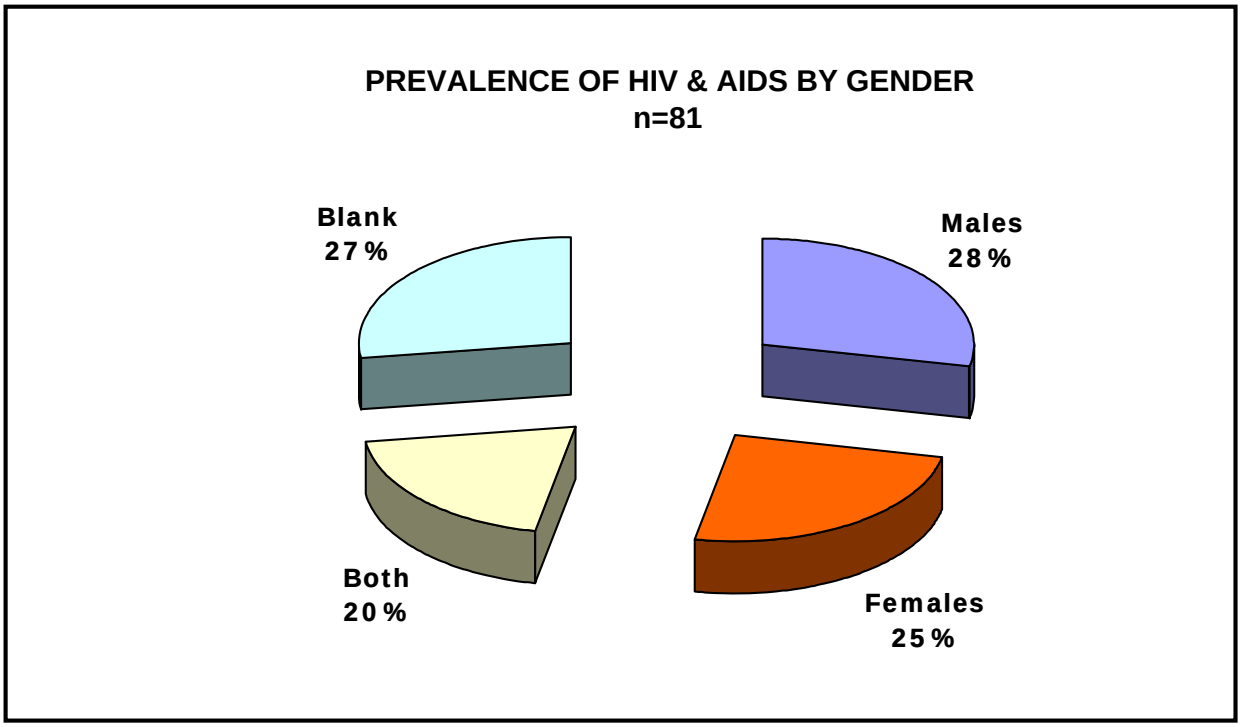


Figure 12: HIV and AIDS Prevalence By Gender



9.3.2.3.2.1 Discussion of Data

Figures 11 and 12 above indicated the perception of the respondents with regard to HIV prevalence in their workplace. What is disconcerting in these results from figure 11 and 21 is that despite the responses previously reflecting respondents experience in HIV and AIDS as satisfactory (see figures 8 and 9), 56,79% of the respondents in question 11 did not complete the question and 11.11% indicated a percentage greater than the norm in the HIV research prevalence. This prevalence, grouped as (anything over 25%) in figure 11 above, is regarded as unreliable in this study as a value between 30% to 100% is higher than norm in the country. It is unlikely that any organization will have a prevalence of over 25%, given that the acceptable known prevalence through the Antenatal Surveillance Statistics was estimated at 29% by end of 2007 and it is calculated at a national level. The South Africa mining industry is known to have the highest HIV prevalence at 31% in the workplace (SABCOHA/BER, 2006). The

researcher therefore concludes that any prevalence indicated at over 25% in this study is considered to be unreliable given that the organizations represented here are unlikely to have a prevalence rate more than that of the antenatal prevalence and mining industry in South Africa.

From both questions, the blank responses on prevalence rates in the organisations could be attributed to:

- The respondents genuinely did not know the prevalence in their workplace;
- The respondents did not want to reveal their workforce HIV prevalence;
- There are no formalized standards of tracking VCT results on an annual basis;
- The respondents have not started the process of testing their workforce despite that VCT is one measure of understanding prevalence in the workplace;
- Respondents had unreliable results on VCT as employees are reluctant to participate in these VCT drives;
- Respondents were specialists or consultants that do not serve a particular organisation.

If the above reasons were true, the responses raise a question on the technical knowledge of respondents with regard to HIV and AIDS measurements standards. VCT and KAP surveys are commons measurements used to track the knowledge and prevalence of HIV in the workplace, thus it is expected that the practitioners who are involved in the HIV and AIDS field should have been alert to these measurements and may have used them as reliable tools. The question did not explore whether the respondents used measuring techniques. The SABS has developed a technical assistance tool to assist workplace with measuring and evaluation standards for any HIV and AIDS workplace programme (South African Bureau of Standards, 2007:5).

The responses above also reflected a higher percentage of prevalence to be amongst male (28%) than females (25%) in this study. According to the employment equity report (2007) South African labour force reflects a higher number of gender disparity still in

2007, despite strong emphasis on employment equity measures. The result could be a true reflection of the HIV prevalence in the workplace, given that the majority in the workplace are still males. However the South African national prevalence indicates that the majority of the HIV infected are women. It has to be noted that the national prevalence is made of both working and unemployed women.

9.3.2.3.3 HIV and AIDS Programmes in the Workplace

(Questions 12 and 13)

Question 12 investigated whether there was an HIV and AIDS programme in the workplace, whilst question 13 enquired the components of this programme. In question 13 multiple answers could be chosen by the respondents. The results from the responses are presented in figures 13 and 14 below.

Figure 13: HIV and AIDS Programmes in the Workplace

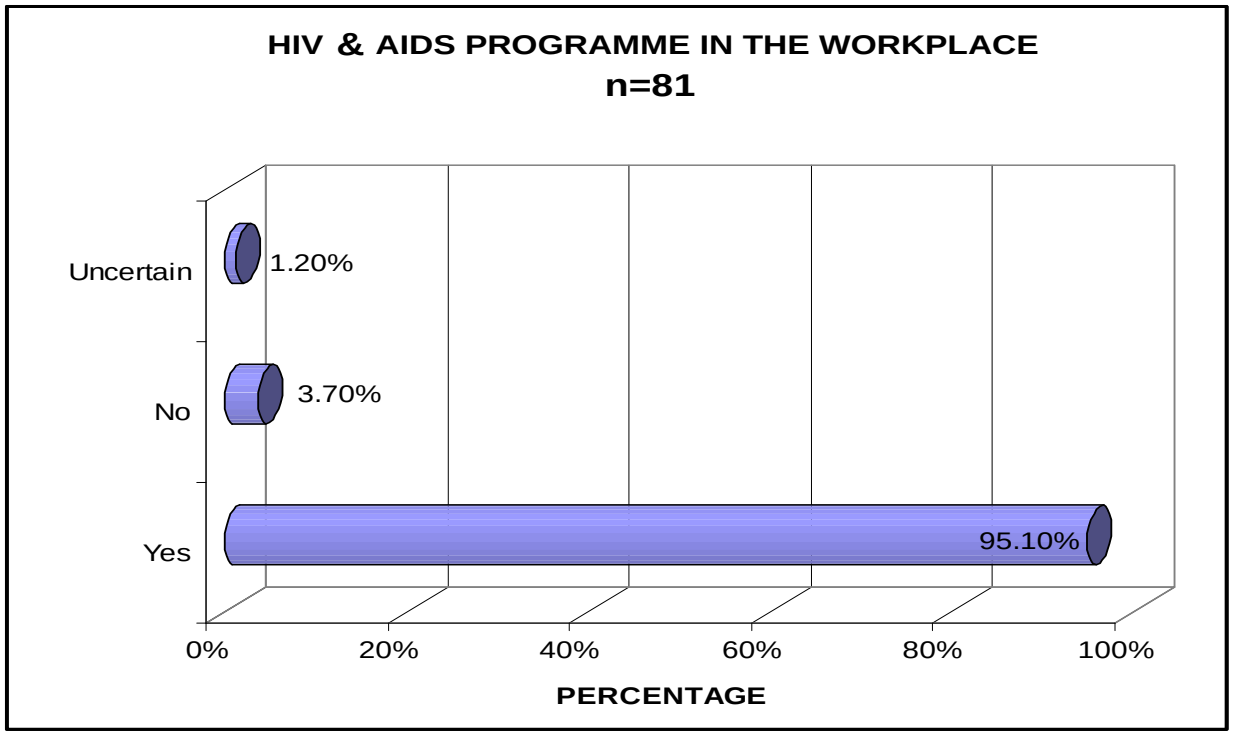
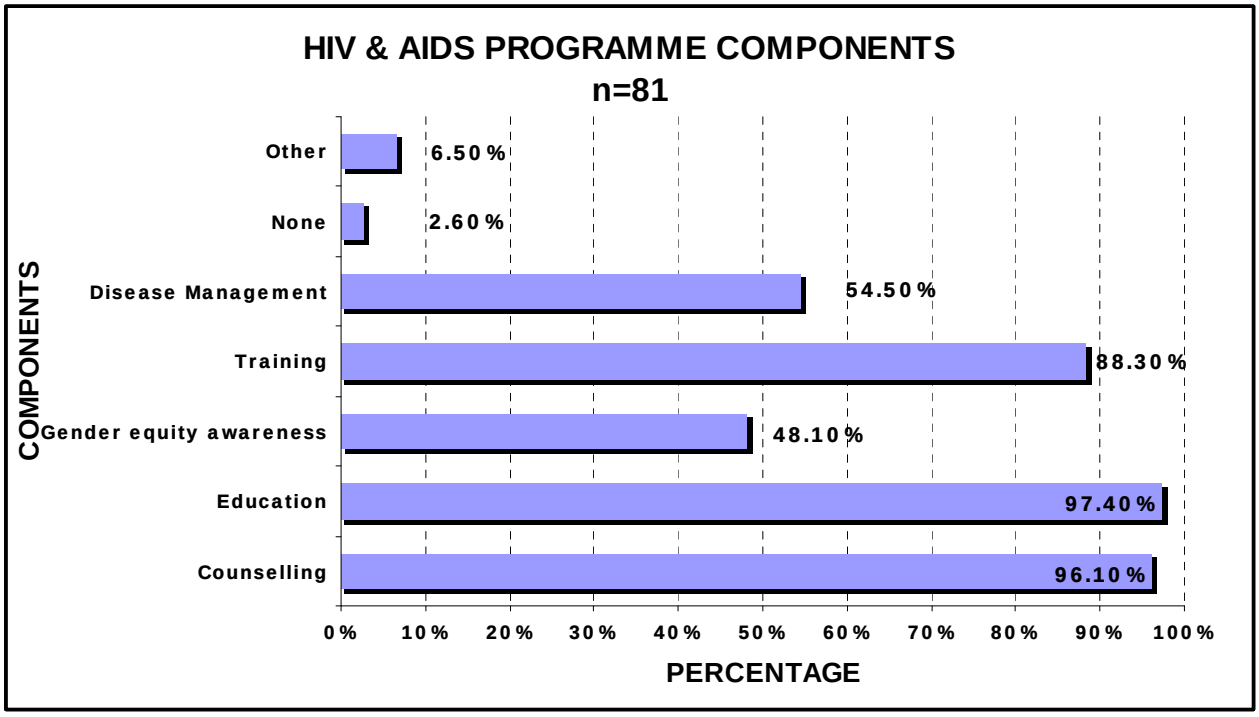


Figure 14: Components of HIV and AIDS Programme



9.3.2.3.3.1 Discussion of Data

In addition to the EAP services, the majority of companies surveyed (95.10%) offer HIV programmes to their employees. When compared to the findings of research undertaken by HEARD and reported in the annual report of SABCOHA 2005/2006, this finding warrants further investigation. The HEARD research indicated that companies operating in labour intensive environments with low profit margins, could not afford to establish comprehensive HIV and AIDS treatment programmes. SABCOHA indicated that these programmes would take an advocacy role to influence policy change and better treatment. From figure 14 of this study, companies concentrate on counselling (96.10%) and clearly HIV education is mostly offered by the majority in this study (97.40 %). This is in line with the SABCOHA findings and it also shows the progress made since the research surveyed by Succeed / Essential (2004:5), which found that 62% of companies provided counselling for those infected. According to Reed (2004:238) HIV and AIDS initiatives in South Africa are led by initiatives that involve training and education. It is

not surprising that majority of the respondents have indicated training as an HIV and AIDS offering. Training on HIV and AIDS issues has become a key component in many workplaces in South Africa. Majority of the training would occur around World AIDS Day where employers would declare their commitment in mitigating the scourge of HIV and AIDS. Disease management and provision of treatment initiatives have only been taking momentum since 2004. Evidently the momentum is reflected by the responses in this study at 54.50% of those offering disease management. Most medical aids offer disease management programmes with unlimited cover. This action was a joint effort advocated by HIV and AIDS activists, legal activists and government. In addition, Treatment Action Campaign (TAC) played a very important role negotiating a national treatment plan for people living with HIV and AIDS in South Africa including medical aid benefits (Mapolisa, Schneider & Stevens, 2004:170).

As this study was undertaken over the period 2005 to 2007, the results do not conclusively show that the outcome of 95.1% is a result of the efforts and commitment of SABCOHA as described in their annual report. The results however indicated a growing commitment by companies to move beyond counselling and that programmes are moving into the regime of training and treatment. This is a significant indicator that HIV and AIDS maybe starting to get the required due attention from organisations.

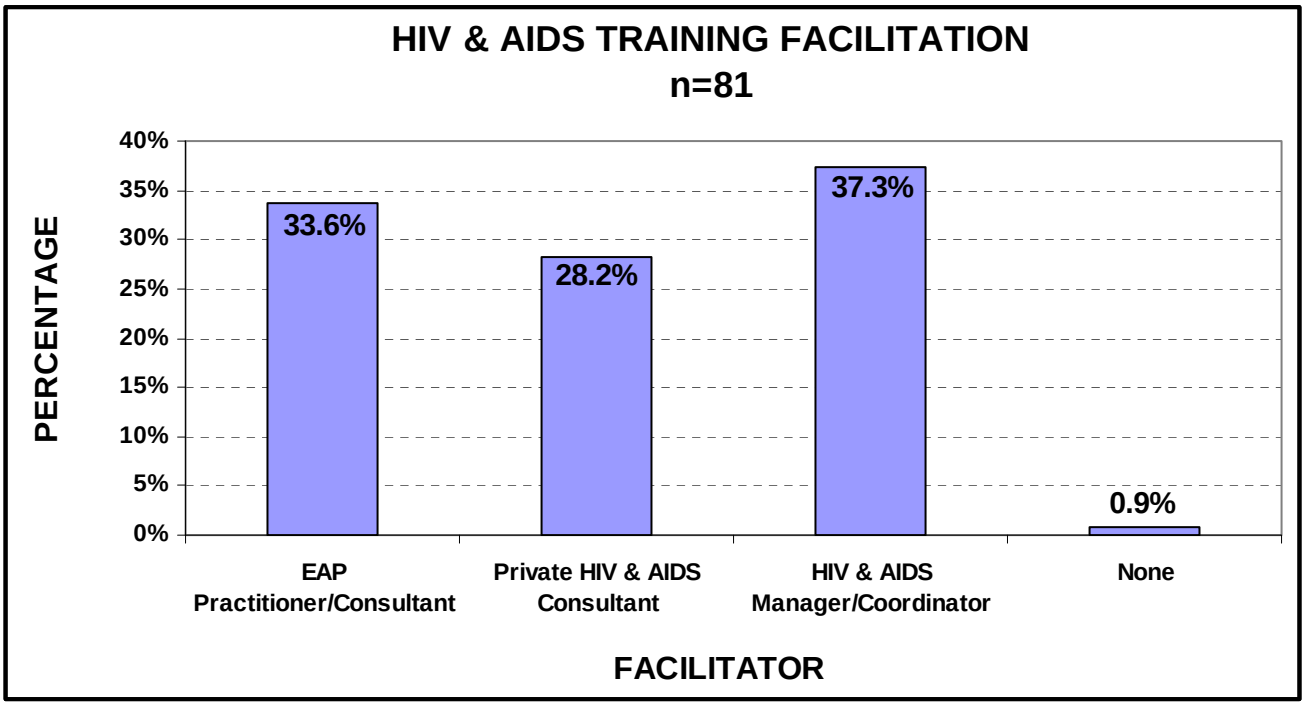
It is encouraging to see that gender equity awareness is also been offered by 48.10% of the respondents. Gender awareness addresses the issues of gender equity and awareness and can only assist in addressing gender imbalances, highlight gender sensitisation and introduce women empowerment initiatives. Companies such as Anglo America in South Africa are leading efforts in integrating women's health issues as part of their HIV and AIDS strategy. Anglo American provides comprehensive reproductive health services including education, testing, counselling, family planning and maternity care (Leadership in HIV and AIDS, 2008:37).

9.3.2.3.4 HIV and AIDS Training Facilitation

(Question 14)

The question investigated the role of EAP practitioners in relation to HIV training. The results are presented in Figure 15 below. The respondents could give multiple answers. For these types of questions, frequency distributions were developed and illustrated graphically.

Figure 15: HIV and AIDS Training Facilitation



9.3.2.3.4.1 Discussion of Data

Training plays a key role in the HIV and AIDS programme interventions. Most companies (37.3%) use HIV and AIDS managers for HIV and AIDS training interventions. Where companies are able to do this, this provides more ownership and control of the programme, as the managers are able to gauge the level of interaction on a more personal basis. However, the minority (28.2%) of the companies use outside consultants or EAP practitioners (33.6%) to run these programmes- this could be as a result of the lack of internal capacity and the reliance of companies in outsourcing their

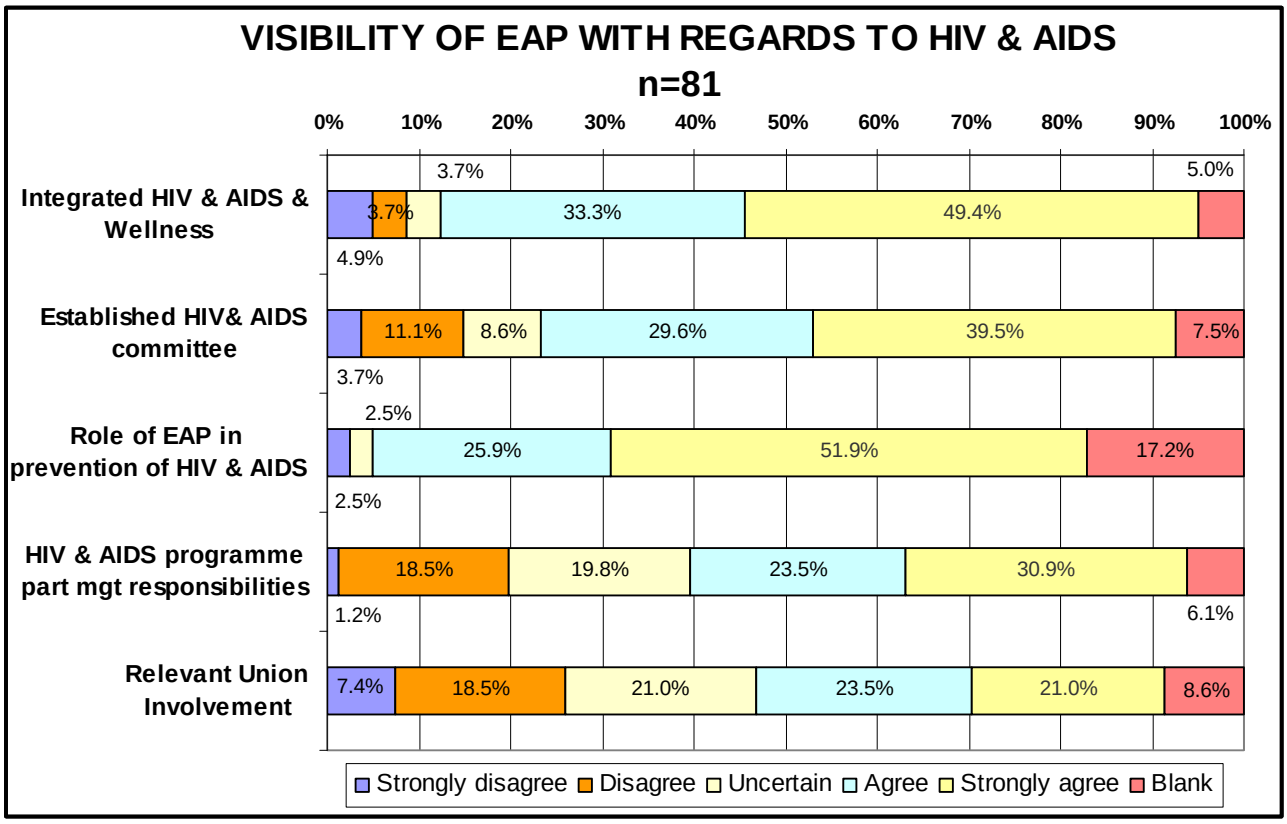
EAP programmes. These results do not in anyway show the impact of role differentiation to service satisfaction. The question investigated the role of EAP in the field of HIV and AIDS training, judging from the responses EAP practitioners are offering little training in this field. It can therefore be argued that for EAP practitioners in South Africa the focus area is largely on counselling.

9.3.2.3.5 EAP involvement in HIV and AIDS

(Questions 15 to 19)

The above questions probe the visibility of EAP and are grouped and discussed together under figure 18 below. Frequency distributions for each question were developed from the responses and illustrated graphically for ease of interpretation.

Figure 16: EAP Visibility



9.3.2.3.5.1 Discussion of Data

Based on the data collated and illustrated in Figure 16, the role of EAPs is focused on HIV and AIDS prevention and support programmes (51.9% of the respondents). According to the Harvard Business Review (February, 2003), educational programmes of the companies surveyed produced no clear benefit. Of interest is the perspective from respondents that 49.4% strongly agreed and 33.3% agree to the integration of HIV and AIDS and Wellness programmes making the total of 82.7%, a clear majority of integrated service. The majority of the respondents (29.6% and 39.5% which equals 69.19%) also agreed or strongly agreed to the establishment of HIV and AIDS committees as visible demonstration of the implementation of these programmes. Of particular interest is the respondents' view that the HIV and AIDS programme is a part of management's responsibilities. In the South African environment, the focus or agreement to union involvement probably stems from the role that unions play in social issues. Despite the role of COSATU and the Treatment Action Campaign (TAC) which

aimed at negotiating a national treatment plan for people living with HIV and AIDS, a study by Mapolisa, Schneider and Stevens (2004:170) found that the role of union involvement in the workplace in terms of HIV intervention is very limited. They attributed their conclusion to the stewards' limited knowledge on HIV and AIDS and that the stewards are not well versed in the language used to convey concepts regarding HIV and AIDS.

Question 20 resulted in a numbering error whereby question 20 was mistakenly not numbered and included.

Question 21

Question 21 was discussed under Figure 12 above together with question 11 which dealt with the prevalence of HIV in the workplace.

9.3.2.3.6 Manner in which EAP Addresses the needs of Infected and Affected Women

(Questions 22 and 23)

Questions 22 and 23 investigated the role of EAP with regard to the needs of both infected and affected women. The two questions, even though they addressed different groups, are discussed here together under Figure 17 and 18 to indicate similarities and differences.

Figure 17: How EAP addresses the needs of Infected Women

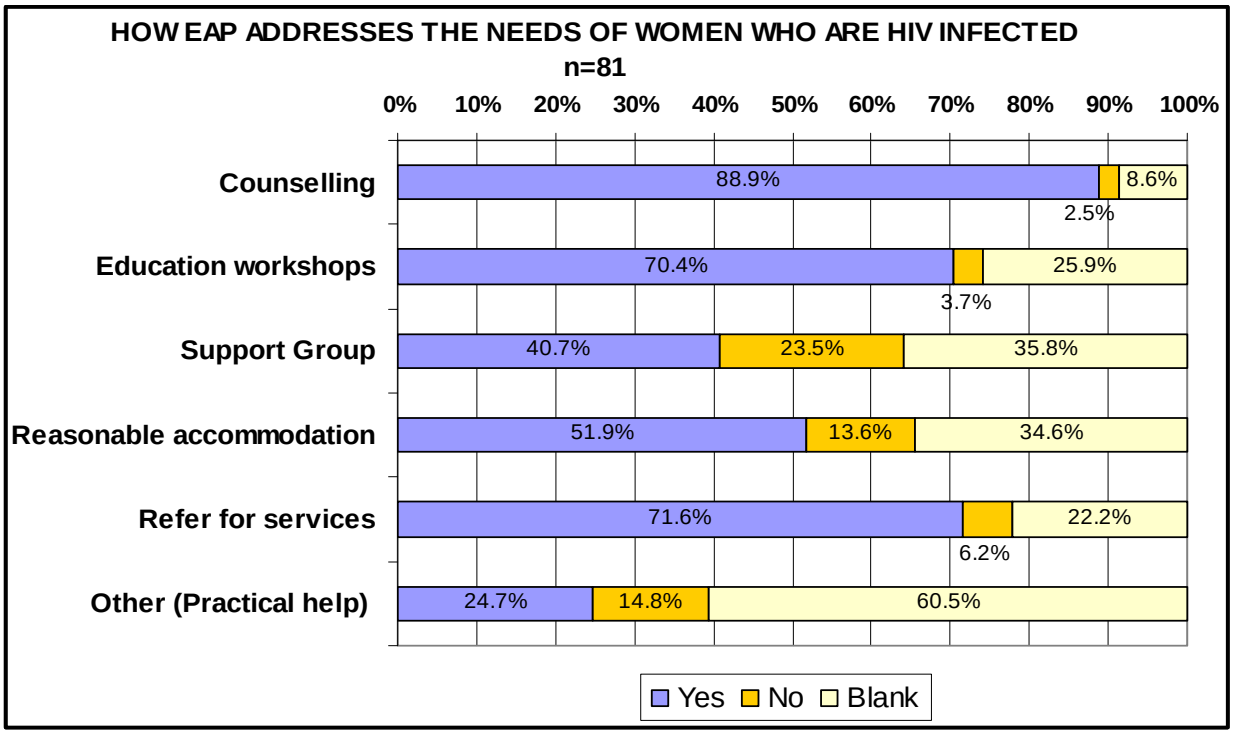
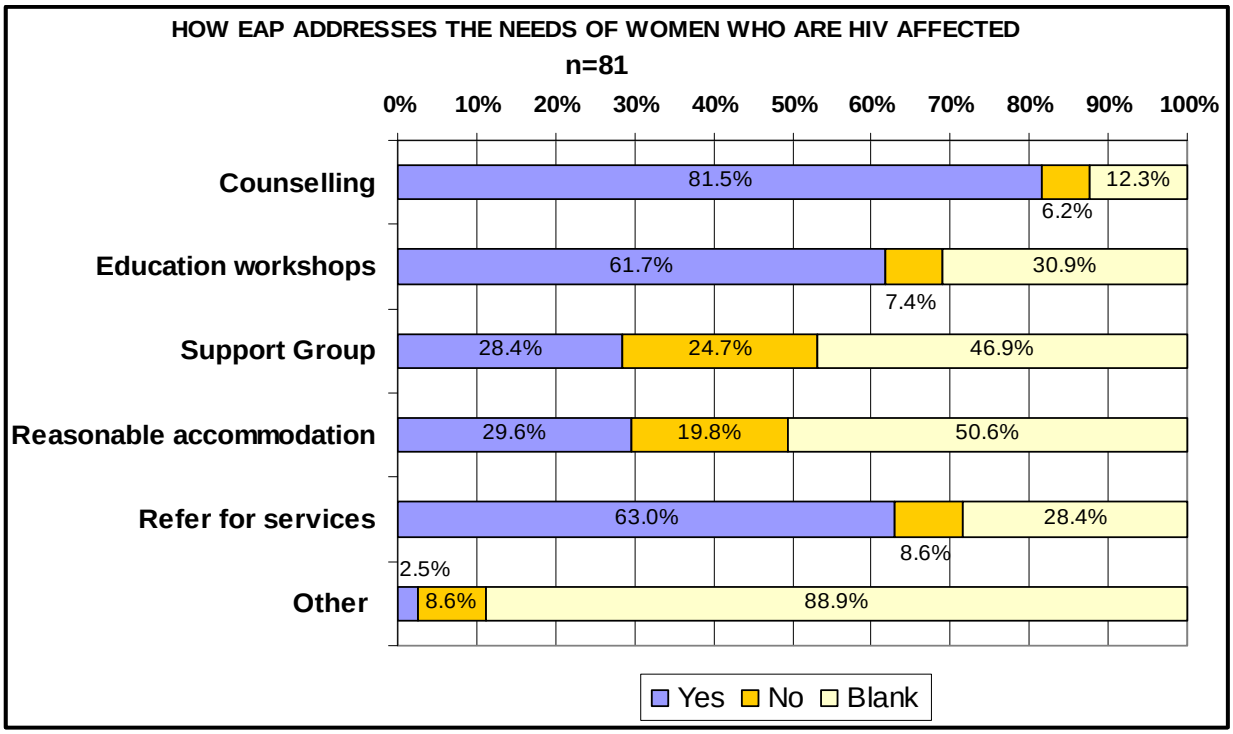


Figure 18: How EAP addresses the needs of affected women.



9.3.2.3.6.1 Discussion of Data

The mechanisms used to address the needs of infected and affected women by the majority of EAP programmes are similar when one considers the use of counselling, educational workshops and referral for services. However the aim of any programme should be to also encompass elements of practical help and reasonable support. From the above, the responses (24.7%) indicate that infected women tend to receive more assistance than affected women (2.5%) in practical help. The fact that women receive practical help is encouraging when one considers the level of sophistication of the programmes. The responses indicate that there is a potential need to assess further how EAP addresses the needs of affected women and address the current shortcoming.

Figures 17 and 18 illustrate above that EAPs in South Africa are clearly using counselling (88.9% for infected) and 81.5% for affected in addressing the needs of working women. Similarly, education and workshops ranked high for both infected (70.4%) and affected (61.5%). As indicated in the literature review some companies such as Eskom in South Africa have long being involving HIV training and counselling in their EAPs. In addition to providing education and counselling, studies show that employees' risk of HIV infection is reduced when companies provide treatment for sexually transmitted diseases which increase the risks of HIV, such as but not limited to herpes and gonorrhea (*Harvard Business Review*…, 2003).

It will seem that support groups were used more by the HIV infected (40.7%) women than HIV and AIDS affected women (28.4%). The common known concern about support groups amongst HIV infected people are lack of confidentiality and anonymity. As reported during HIV workshop at Uthingo (PTY) LTD, by (Makhalemele, 2003) support groups can not guarantee that attendants may not disclose the status of others attending, equally so the group doesn't protect the anonymity of its members. Despite confidentiality agreements there could be cases where the privacy of others is compromised.

Reasonable accommodation means the extent in which EAP practitioners position EAP to extend services to make special consideration in kind for women's needs. Once again responses indicated that infected women are reasonable accommodated by majority of the respondents at 51.9% whilst in the case of affected women only 29.6% respondents are noted.

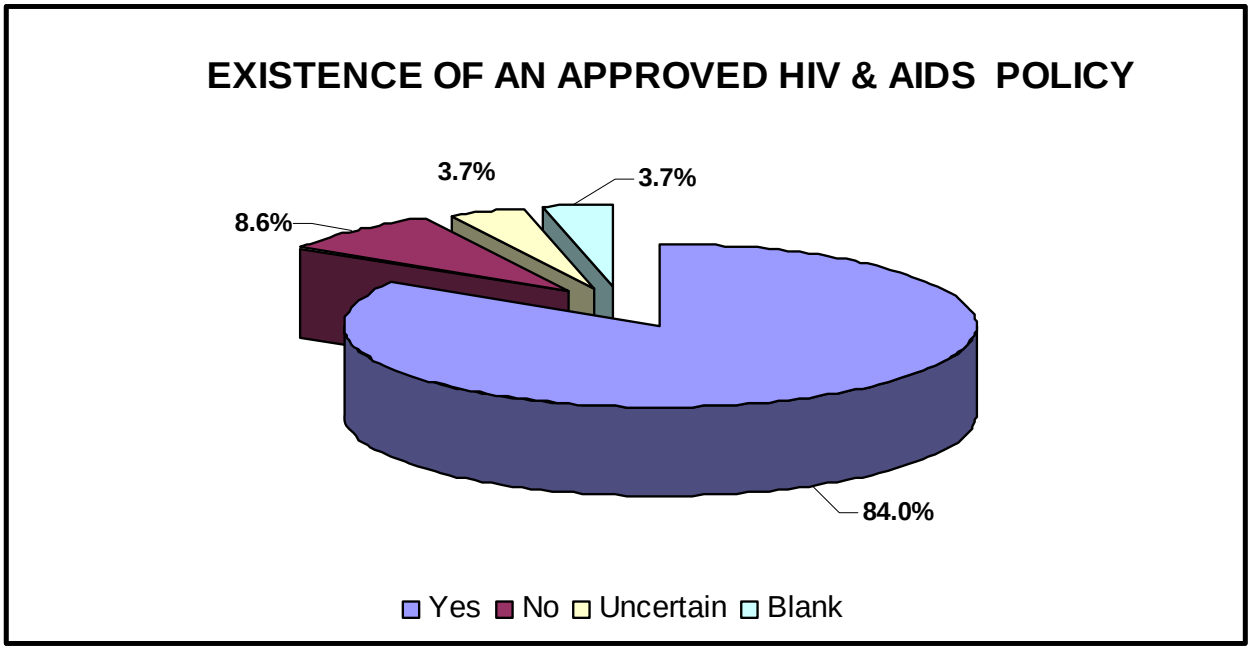
HIV and AIDS is a medical condition, thus it is not surprising that 71.6% respondents referred for HIV infected and 63.0% referred HIV and AIDS affected women for services. Referral for services is also an indication that EAPs are working together with other specialists in a multidisciplinary approach.

9.3.2.3.7 HIV and AIDS Policy

(Question 24)

This question's objective was to understand whether the organisations have a specific policy in respect of HIV and AIDS. Policy is an important component in any organisation as it provides a framework for the organisation to address a need or threat or to manage its resources to achieve a set objective. A well-developed policy that is implemented judiciously has the potential to provide the organisation a means to achieve its goals through the development and implementation of strategies and tactics relevant to these goals.

Figure 19: HIV Policy



9.3.2.3.7.1 Discussion of Data

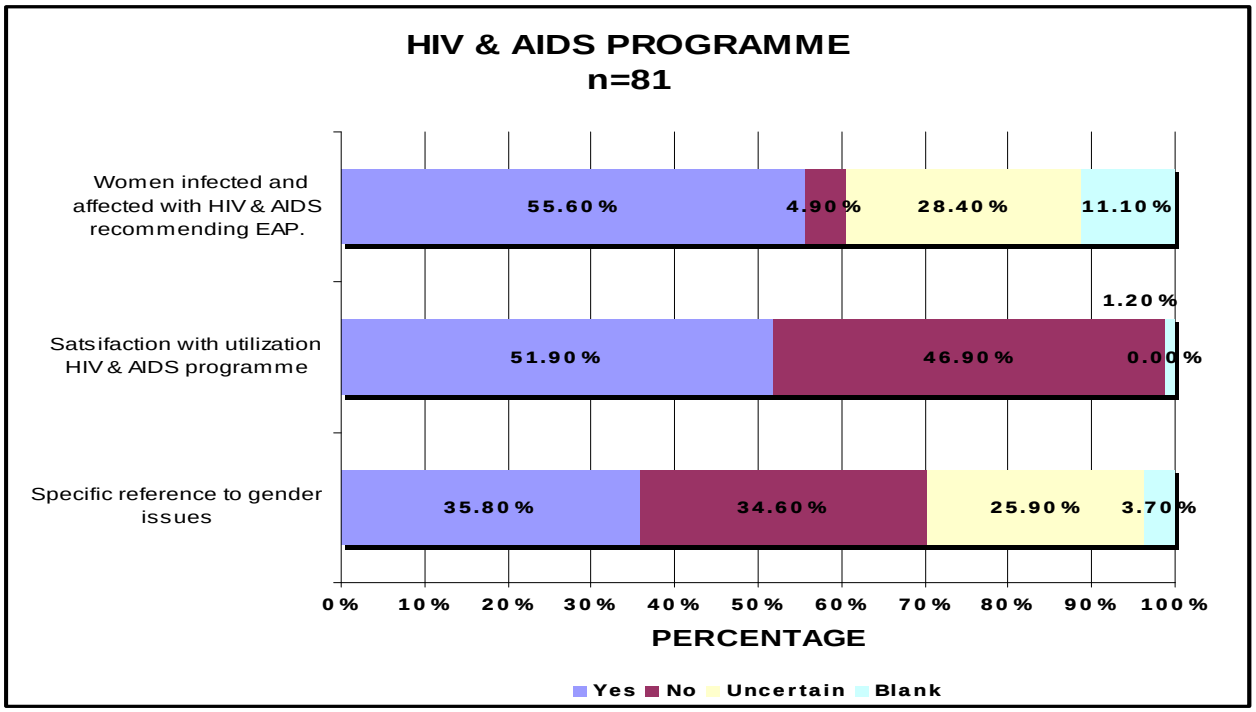
HIV and AIDS policy plays a very important role in the management of an HIV programme in the workplace. Furthermore an organization with an approved HIV policy demonstrates care for its employees and acknowledges the impact of HIV on its workforce. As illustrated in figure 19, eighty four percent of respondents confirmed their organizations have an approved HIV and AIDS policy. It is still a concern that amongst respondents who are EAP practitioners 3.70% is uncertain whether their organizations have an HIV and AIDS policy and 3.70% did not complete the question. The only argument to be made here may be that the 3.70% are the practitioners in private practice who are not working for specific organizations. Equally so, the 8.60% who indicated not to have an HIV and AIDS policy could be due to the same reasons or their organizations may not have an HIV and AIDS policy. Reed (2004:240) argues that even though HIV and AIDS policy is important, keeping policy available and accessible is necessary to encourage individual employee to learn their status and to be cognisant of their rights. HIV and AIDS policy is certainly one of the tools for effective HIV strategy.

9.3.2.3.8 HIV and AIDS Programme

(Question 25, 27 and 28)

Given the relationship between question 25, 27 and 28, the three are combined and the responses are presented below in figure 20, to highlight the link. The questions required definite answers: yes, no, uncertain.

Figure 20: HIV and AIDS Programme



9.3.2.3.8.1 Discussion of Data

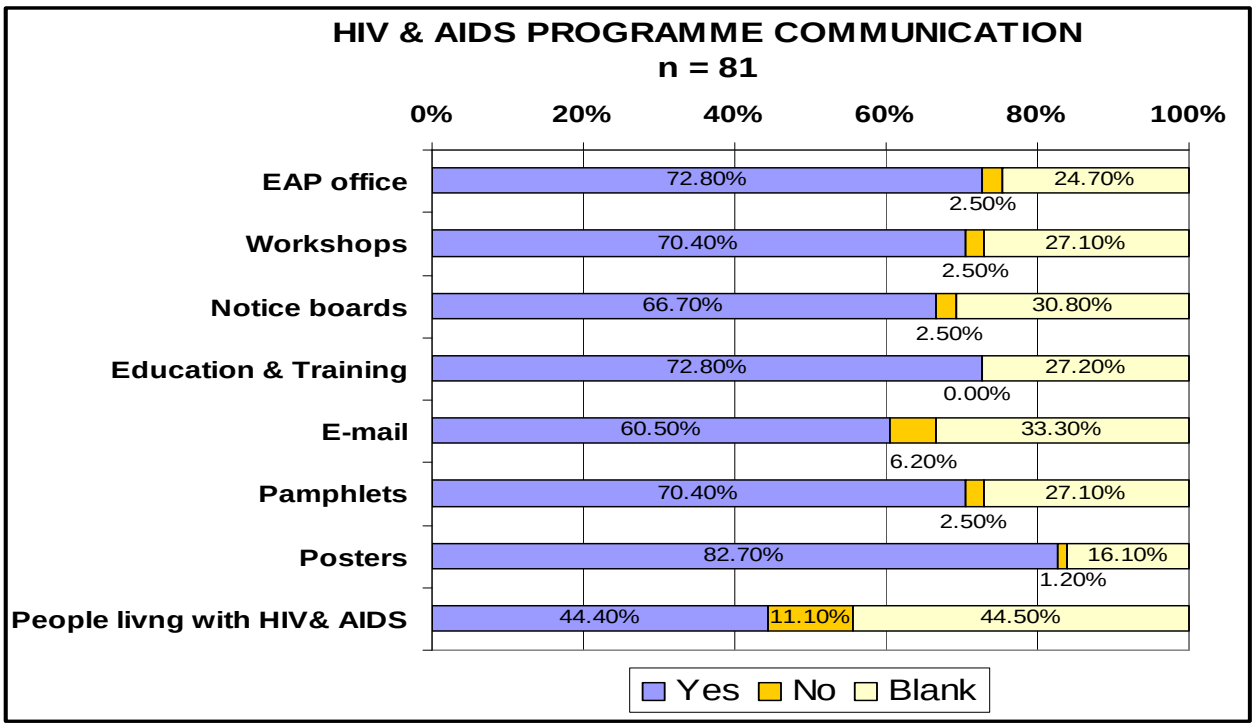
From the results above there seem to be mixed - responses regarding the special focus on gender issues regarding HIV and AIDS policy. At least 25.90% is still uncertain about the gender issues, which could suggest a lack of knowledge about their HIV and AIDS policy. It is encouraging to see that in evaluation of the service offered by EAP nearly 55.60% of their programme users would recommend the EAPs to colleagues. This reflects the satisfactory level amongst users, i.e. nearly 1 out of every 2 users are satisfied with the EAP programmes.

The question did not probe the quality control measures used by the EAPs in the workplace, this then indicates the perception of the respondents as EAP practitioners who are service providers and maybe subjective. Just over 51.90% of the respondents indicated that they were satisfied with the utilisation level of the HIV and AIDS programmes. This is a disappointing result in that the expectation is that utilization of EAP would be higher considering the great needs that EAP should service in any organisation. It is normal practice to expect high utilization in any service delivery programme and EAP is not an exemption given the risk of HIV and pandemic. This is an aspect that should be explored further to understand what are the factors that contribute to these results.

9.3.2.3.9 HIV and AIDS Programme Communication

(Question 26)

Figure 21: Programme Communication



9.3.2.3.9.1 Discussion of Data

HIV and AIDS activities are communicated in companies using a variety of communication channels. The most popular communication strategies in order of preference include: posters (82.70%), through EAP office and education/ training at 72.80%, respectively; workshops and pamphlets (70.40%, respectively, notice boards 66.40% and emails 60.50%. These traditional channels are well used by the respondents as indicated by the responses in Figure 21.

Of interest is the low usage of using people living with HIV and AIDS. Making use of people to share their experiences through testimonial reference is a powerful medium that needs greater exploitation. According to Reed (2004:239) the value of using people living with HIV as speakers during workshops is important, at the same time, Reed cautions that when using people living with HIV it is important to match the level of education of those living with HIV with that of employees being targeted.

9.3.2.4 Section C: Difficulties Experienced by Women

This section in seeking to address the goal and objectives of the study demonstrates the difficulties that women are experiencing and what they bring to EAP. Question 29 was a multiple option question. The respondents could indicate more than one item suggested. The responses were collated into a frequency distribution and the results are illustrated in figure 22 below. Question 30 will be discussed together with Question 29 as they relate to each other in terms of difficulties experienced by women infected with HIV and AIDS.

9.3.2.4.1 Difficulties Experienced in the Workplace by HIV and AIDS Infected Women

The questions investigated difficulties experienced by both infected and affected women and the responses are compared below:

(Question 29 and 30)

Question 29 and 30 are discussed together under Figures 22 and 23 below.

Figure 22: Difficulties as Experienced by Infected Women

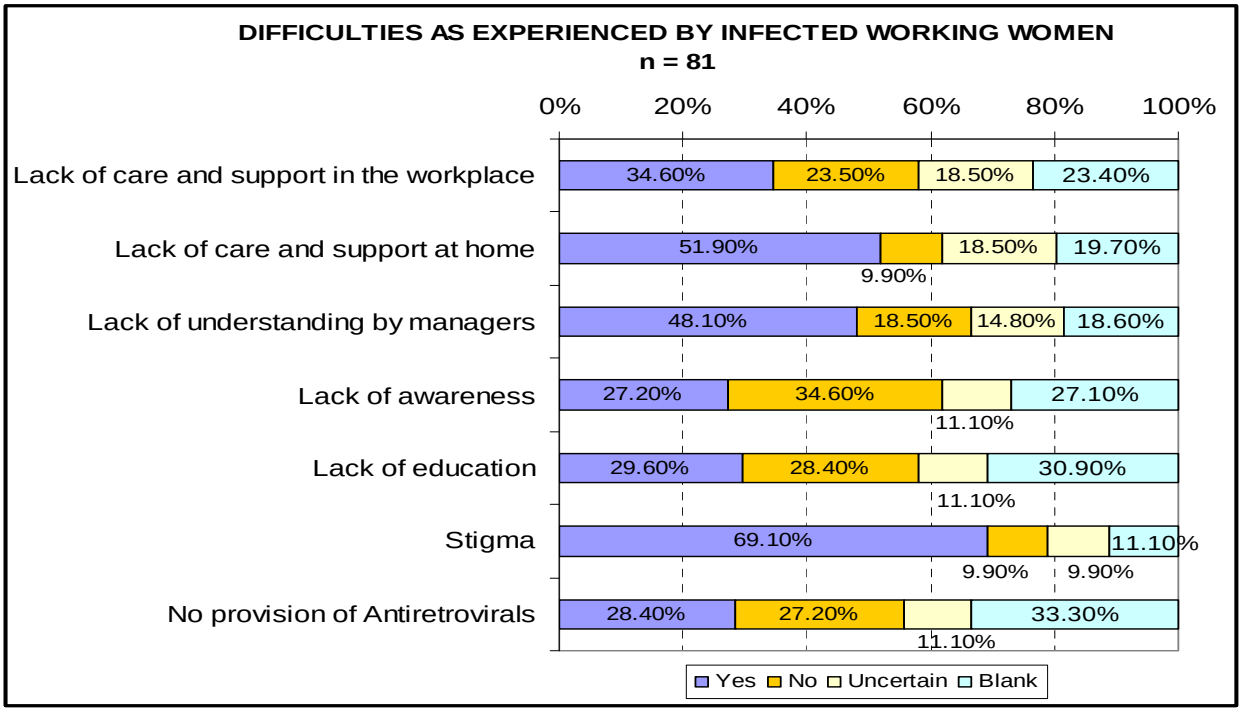
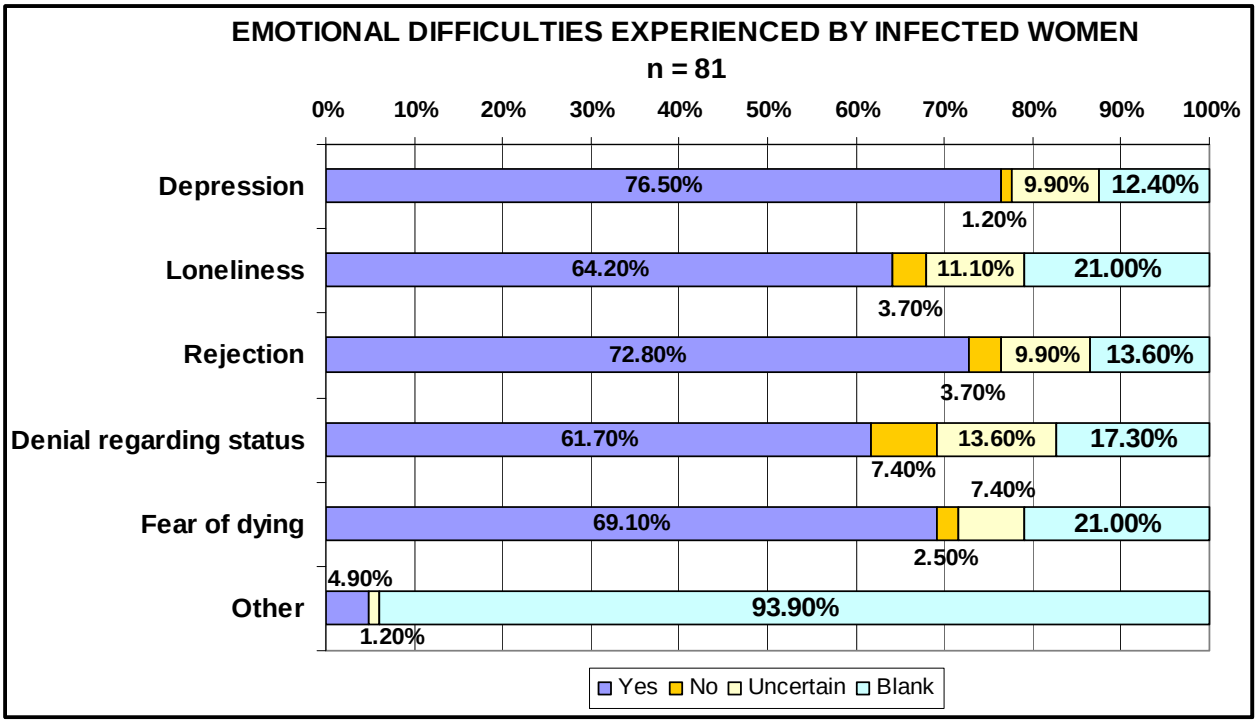


Figure 23: Emotional Difficulties Experienced by Infected Women



9.3.2.4.1.1 Discussion of Data

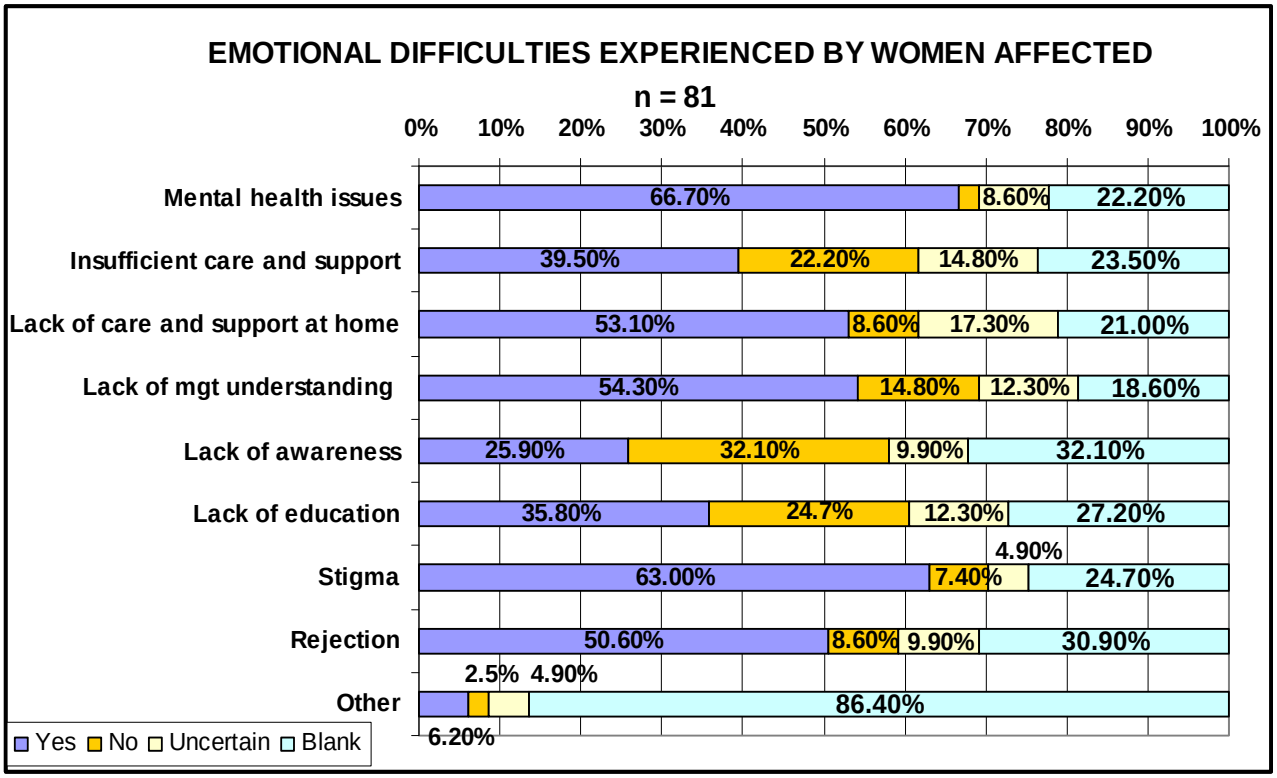
The information from the respondents were the collective experiences that the respondents had in respect of dealing with women infected with HIV and AIDS. The respondents affirmed that mental health issues are key challenges of women infected. Figure 23 showed that all the mental health issues are rated by over 60% of the respondents as difficulties experienced by women infected by HIV and AIDS. Furthermore over 50% of the respondents indicated lack of support at home for infected women as an important difficulty that these women needed to overcome. The respondents also indicate that lack of care / support in the workplace and lack of support from managers is experienced regularly by infected women. This could be attributed to the risks that materialise when women disclose their status. Disclosure could thus either lead to positive or negative outcomes for the person in terms of support both at home and at the workplace. Of particular interest is the lack of provision of anti-retrovirals as a difficulty when one considers the extensive rollout of these programmes nationally. Most organisations have recognised that this aspect is an important practical help component of their programmes, even if they do not provide the anti-retrovirals themselves they can assist in the access to these. Since 2005, medical aids have been classifying HIV and AIDS under chronic diseases, making chronic benefit with unlimited cover for infected members accessible.

9.3.2.4.2 Difficulties Experienced in the Workplace by HIV and AIDS Affected Women

(Question 31)

The question investigated the perception of the EAP practitioners with respect to the experiences that the affected women have and whether these differ with those of the infected women.

Figure 24: Emotional Difficulties (Affected Women)



9.3.2.4.2.1 Discussion of Data

Stigmatisation, rejection and mental health issues are ranked high as the major difficulties experienced by women infected and affected by HIV and AIDS. Mental health issues include depression, anxiety, and bereavement for these women are indicated by 66.70% of the respondents. As discussed previously under 6.3 of chapter 6 in (page 89.), HIV and AIDS contribute to high mental health difficulties for women who are caregivers of people with HIV and AIDS. The mental health issues present in the form of stress and depression (NRF, 1986:151). It is this researcher's view that HIV and AIDS will have implications on mental health issues of individuals, families and communities in South Africa. This is in light of the disintegration of family values and cultures that were previously intact. People with HIV and AIDS tend to be isolated and experience shame and loneliness that contributes to depression and thus leaving them vulnerable to mental

health. It is therefore argued that given the magnitude and pervasiveness of HIV, the mental health issues will be far greater than the sum of the parts.

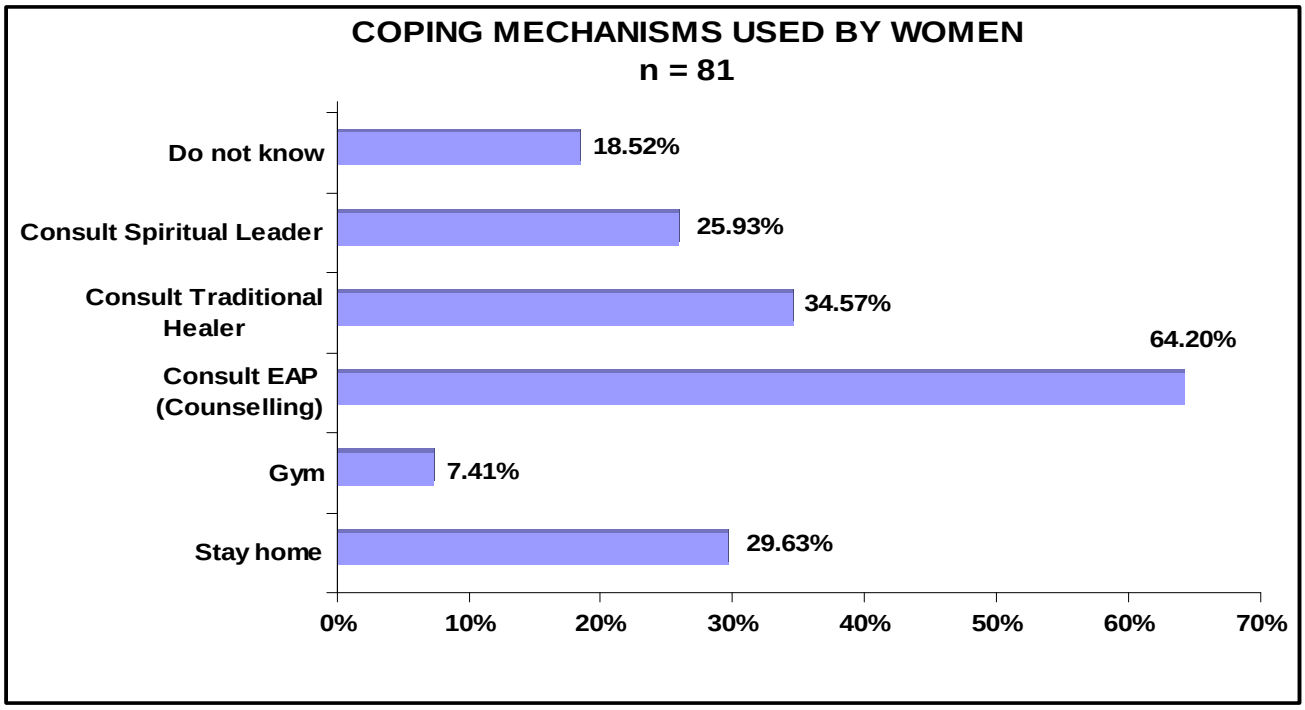
Similarly, stigma as a difficulty for HIV and AIDS affected women is indicated by 63.00% of the respondents, confirming research presented previously in Chapter 6. About 50.60% of the respondents confirmed that affected women experience rejection due to HIV and AIDS, of note is 30.90% left this section blank, indicating uncertainty about this issue. Over 50% of the respondents indicated lack of support at home for both affected and infected women as a difficulty. Lack of care / support in the workplace and lack of support from managers are also difficulties experienced regularly by both affected and infected women. The responses indicate that both infected and affected women have similar plights when considering the difficulties they face. Less than 40% (25.90% and 35.80%, respectively) agrees that lack of awareness and education is a difficulty shared by women affected by HIV and AIDS.

9.3.2.4.3 Coping Mechanism used by Women Infected and Affected with HIV and AIDS

(Question 32)

Question 32 looked at the coping strategies of women infected with HIV and AIDS. The respondents could provide more than one answer to the question.

Figure 25:Coping Mechanisms by Women Infected /Affected with HIV and AIDS



9.3.2.4.3.1 Discussion of Data

The majority of the respondents indicated that women in the workplace deal with HIV by accessing EAPs (64.20%) and only 29.63% indicated the stay-at-home option. Spirituality plays an important role in the lives of women infected and affected with HIV thus the respondents indicated that women would either consult traditional healers (34.57%) or spiritual leaders (25.93%). Research indicates that traditional healers are principle careers in many developing countries (UNAIDS (a), 2000:4). The researcher is of the opinion that traditional healers could assist in adherence to cultural practices and values that may serve as preventative strategies, like abstinence and basic hygiene practices. The researcher also believes that undermining traditional healers' medicinal knowledge, access to biological resources or cultural / spiritual rights, can directly influence the community's ability to deal with HIV and AIDS. Spiritual and traditional leaders have an important role to play in giving guidance and advice, which is generally accepted within societies that traditionally hold these leaders in high esteem.

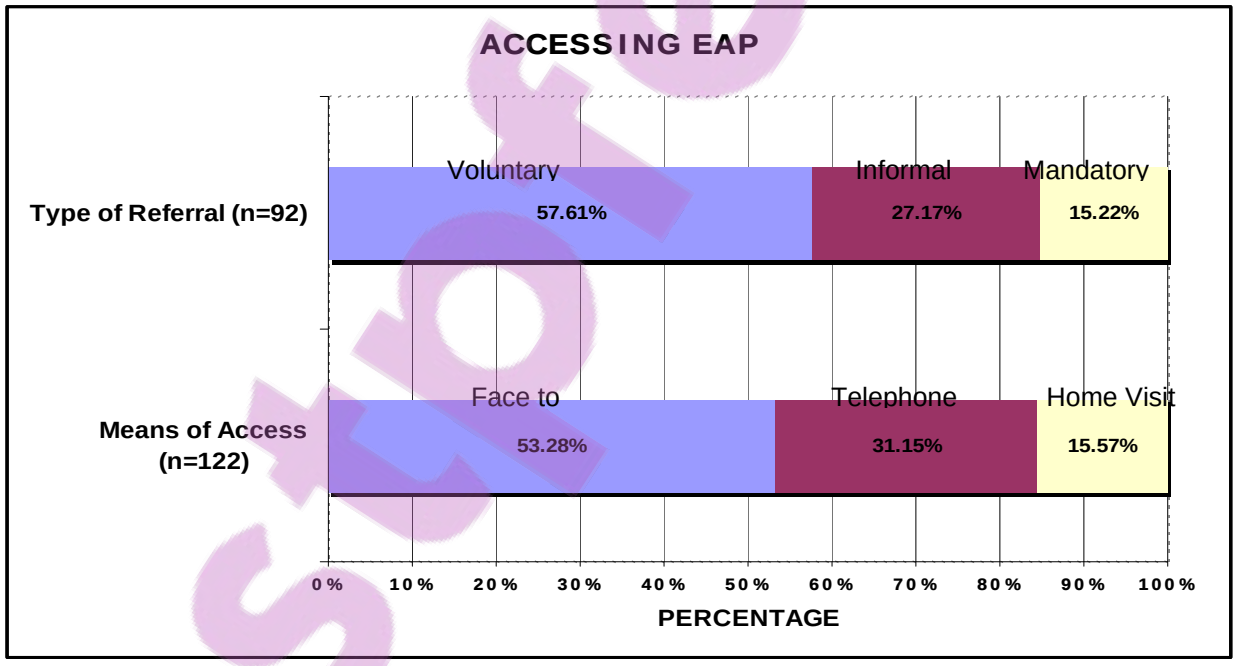
Only 7.41% of the respondents confirmed that women attend the gym. Gym is another financial commitment that needs to be budgeted for. The reason for low responses could be that indeed majority of the women could not make a financial commitment to this service. However, creative exercising initiatives that do not require financial commitment such as walking and jogging can be recommended.

9.3.2.4.4 Access to EAP Services

(Question 33 and 37)

The questions investigated the accessibility of EAP to women in both groups as a support system in the workplace. The answers for question 33 are given in multiple form and the results from questions 33 and 37 are illustrated in figure 26 below.

Figure 26: Accessing EAP Services



9.3.2.4.4.1 Discussion of Data

Based on the responses, most women are voluntarily referred to EAP (57.61%) and this access takes place through face-to-face counselling in the workplace (53.28%). This indicates the central role EAP plays in the well being of these women: it is accessible

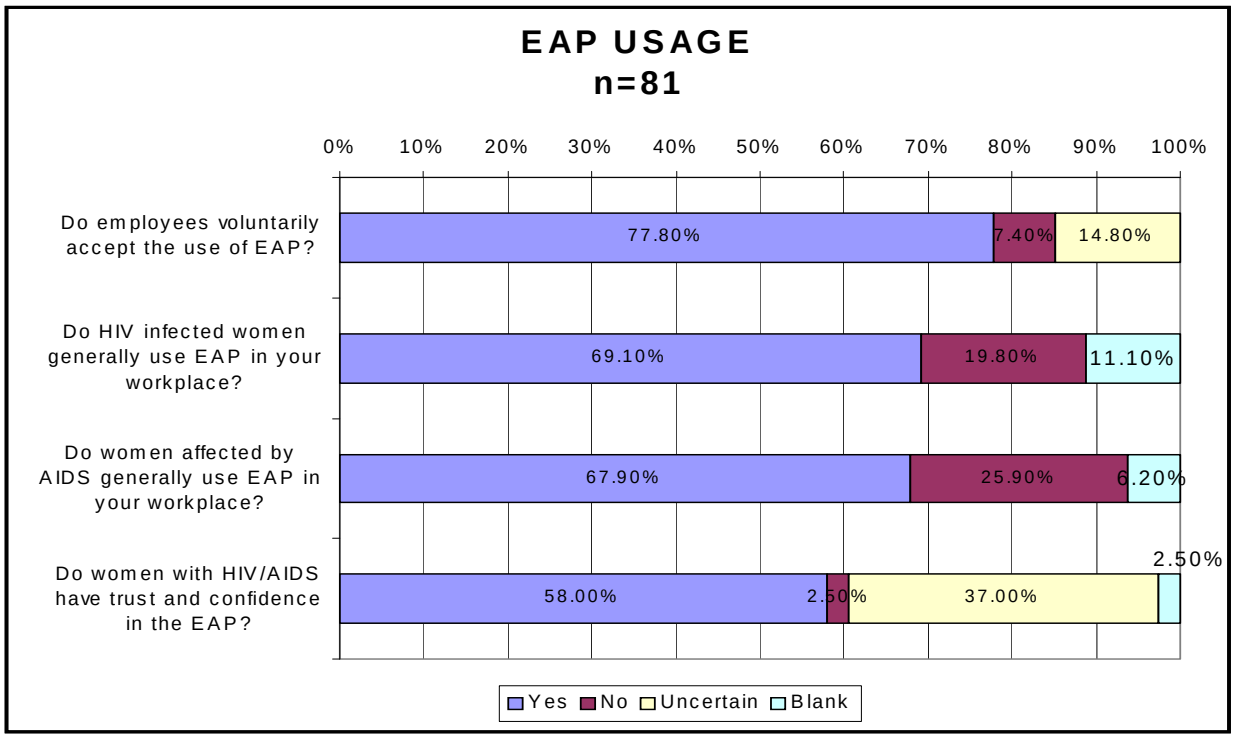
(voluntary referral) and access takes place on a personal basis. From the data, mandatory referral is low (15.22%) relative to informal and voluntary, further supporting the above assertion. The telephone counselling and home visits could be as a result of the person desiring greater confidentiality or may have been during the time when the employee was on sick leave. About 1 out of every 2 women would opt for telephone counselling or home visit despite both these services not being common in EAP in South Africa. Home visits are common in social work practice in South Africa.

9.3.2.4.5 Utilisation Of EAP Services

(Question 34, 35, 36)

The questions required a definite yes or no answer. The results of the above questions are grouped and illustrated in figure 27 below.

Figure 27: EAP Usage



9.3.2.4.5.1 Discussion Of Data

The majority of respondents (77.80%) indicated that employees generally accept the use of EAP. When EAP is well marketed and position as a one of the important support service for employees, employees are likely to use the EAP with ease. Managers who refer employees and generally market EAP amongst employees tend to also afford employees time to attend the sessions. Equally so, the respondents indicated above that both HIV infected (69.10%) and affected (67.90%) women use EAP in the workplace. Women are generally comfortable to seek help when they have challenges.

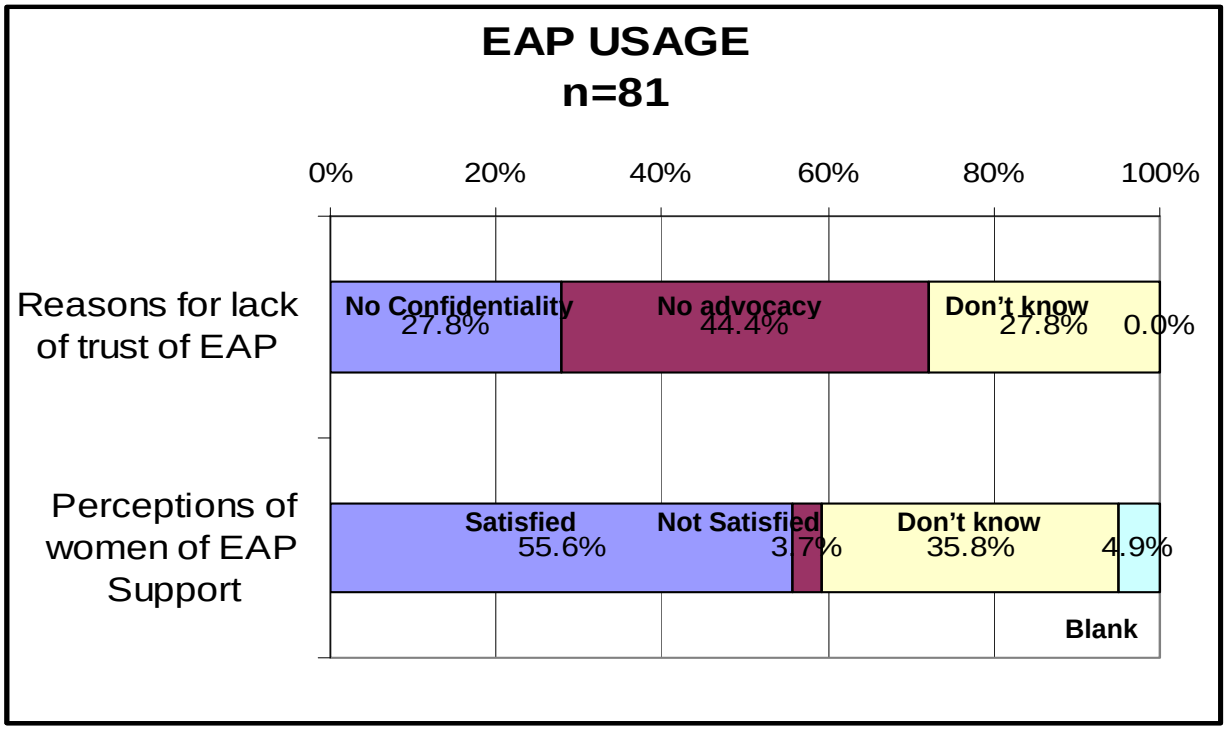
Research indicates that the majority of women with mental health issues irrespective of the illness are likely to seek help (About.com, 2006). Still about 25.90% of the respondents indicated 'No' to the use of EAP by women. It would have been interesting to find out what are the alternatives services that the women rely on in dealing with their challenges. Over half (58%) of the respondents indicated women have trust and confidence in EAP. Approximately 38% that indicated uncertain may have done so as a result of lack of evaluation systems that would help ascertain service satisfaction.

9.3.2.4.6 Trust and Confidence In EAP

(Question 38, 39 and 40)

These questions are follow-up questions to 34, 35 and 36 above and are grouped and are illustrated below in figure 28.

Figure 28: EAP Usage (Continued)



9.3.2.4.6.1 Discussion of Data

Of those who do not accept the use of EAP, the highest responses indicated above in Figure 28 is lack of advocacy by the EAP. The responses above give a split between issues of confidentiality and 'do not know'. The reason could be that EAP still does not have a quality management system that includes evaluation measures to test the satisfaction level of their clients. This may result in the practitioners delivering the service being unable to determine appropriate feedback.

Confidentiality is a very important aspect of the EAP service. Reasons for the perception of a lack of confidentiality would have been an interesting insight to explore in the study. In particular to establish which EAP model experiences this lack of confidentiality. From Figure 28, women who used EAP, 55.6% of the respondents indicated they were satisfied with the service that they received from their organisations. Forty-four percent of the respondents indicated that EAP practitioners did not advocate for them for various services. There is a notable correlation to the argument made earlier regarding position

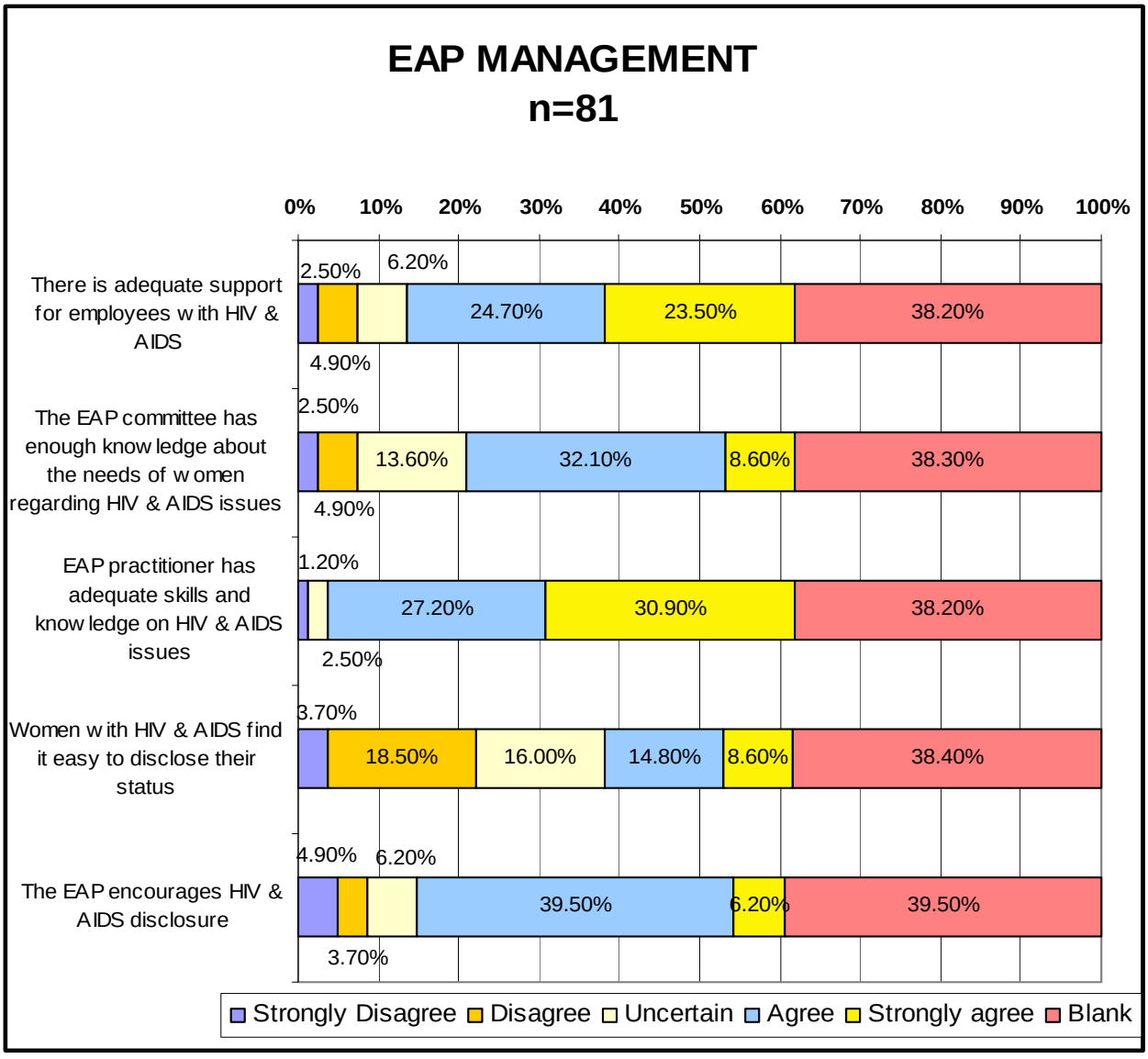
and level of work of EAP practitioners and the influence these aspects may have on decision making in the workplace (Figure 3 & 4) above. The argument was that if the EAP practitioners are in a position that can influence decision- making, there could be more advocacy for those accessing EAP, especially in the event of a need for reasonable accommodation.

9.3.2.4.7 Reason for EAP Satisfaction

(Questions 41 to 46)

Respondents were required to complete questions 41 to 46 in order to establish the level of EAP satisfaction. The questions used a five point likert scale to assess the perception of the respondents requiring them to answer the statements and to indicate if they agree or disagree with the statements. The responses were collated, a frequency distribution for each statement was developed and these are illustrated graphically below.

Figure 29: Reason for EAP Satisfaction



9.3.2.4.7.1 Discussion of Data

Based on the responses, a large proportion of the responses from question 41 to 46 were left blank (39.50%). Of the ones that did respond, most of these responses were positive in that they agree that management played a role in the different dimensions of the EAP programme. The blank responses could indicate that the EAP programmes were having difficulty in making themselves visible to both management and winning the confidence of employees. From the positive responses, what was noted was the number of EAP practitioners 58.10% (27.20% and 30.90%) that indicated, as a self-assessment,

that they had adequate skills and knowledge to address HIV and AIDS issues. This indicated a level of confidence in dealing with matters related to HIV and AIDS. However, the same set of respondents indicated that they perceived women living with HIV and AIDS as having difficulty with disclosure of their status (22.2%). It can therefore be argued that despite the women's difficulties in disclosing their status, the EAP practitioners' level of competence in handling their difficulties may yield positive results in assisting the women. It is also important to bear in mind that the confidence that women have in the EAP may differ in the confidence women have in the management of their companies.

9.3.2.5 Section D: Strategic Planning

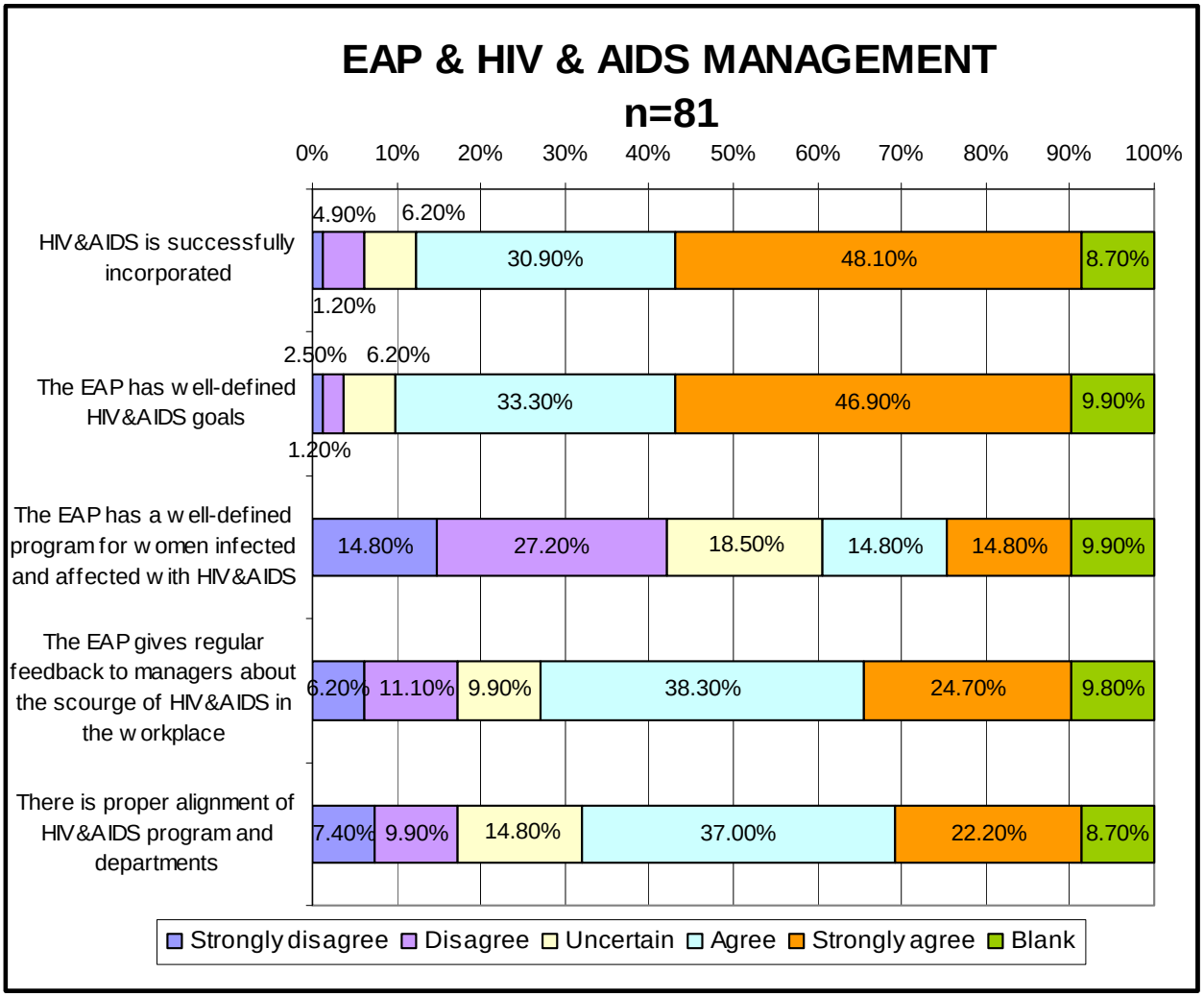
This section addresses the strategic need of the EAP programme. Strategic planning session for the sake of discussion and clarity is divided into two parts, namely, discussion and HIV and AIDS management, (Questions 47 to 51) and the role of management in HIV and AIDS programme (Question 52 to 61).

9.3.2.5.1 EAP and HIV and AIDS Management

(Question 47 to 51)

Similar to the previous 5 questions, Questions 47 to 51 used a five point likert scale to assess the perception of the respondents requiring them to answer the statements and indicate if they agree or disagree with the statements. The responses were collated, a frequency distribution for each statement was developed and these are illustrated graphically below:

Figure 30: EAP and HIV and AIDS Management



9.3.2.5.1.1 Discussion of Data

The respondents indicated a positive response (greater than 50%) on all the dimensions of EAP and HIV and AIDS except for the dimension of support for women infected and affected by HIV and AIDS which is 42% (combines disagree and strongly disagree) of the respondents. This could be as a result of the EAP programmes not discriminating in the services it delivers to its clients- i.e. women are not singled out for special treatment. The responses indicated that most respondents (79.00% of agree and strongly agree) view that EAP has successfully incorporated HIV and AIDS into its services and that EAP has well defined goals in respect of HIV and AIDS (80.2%). An important aspect of

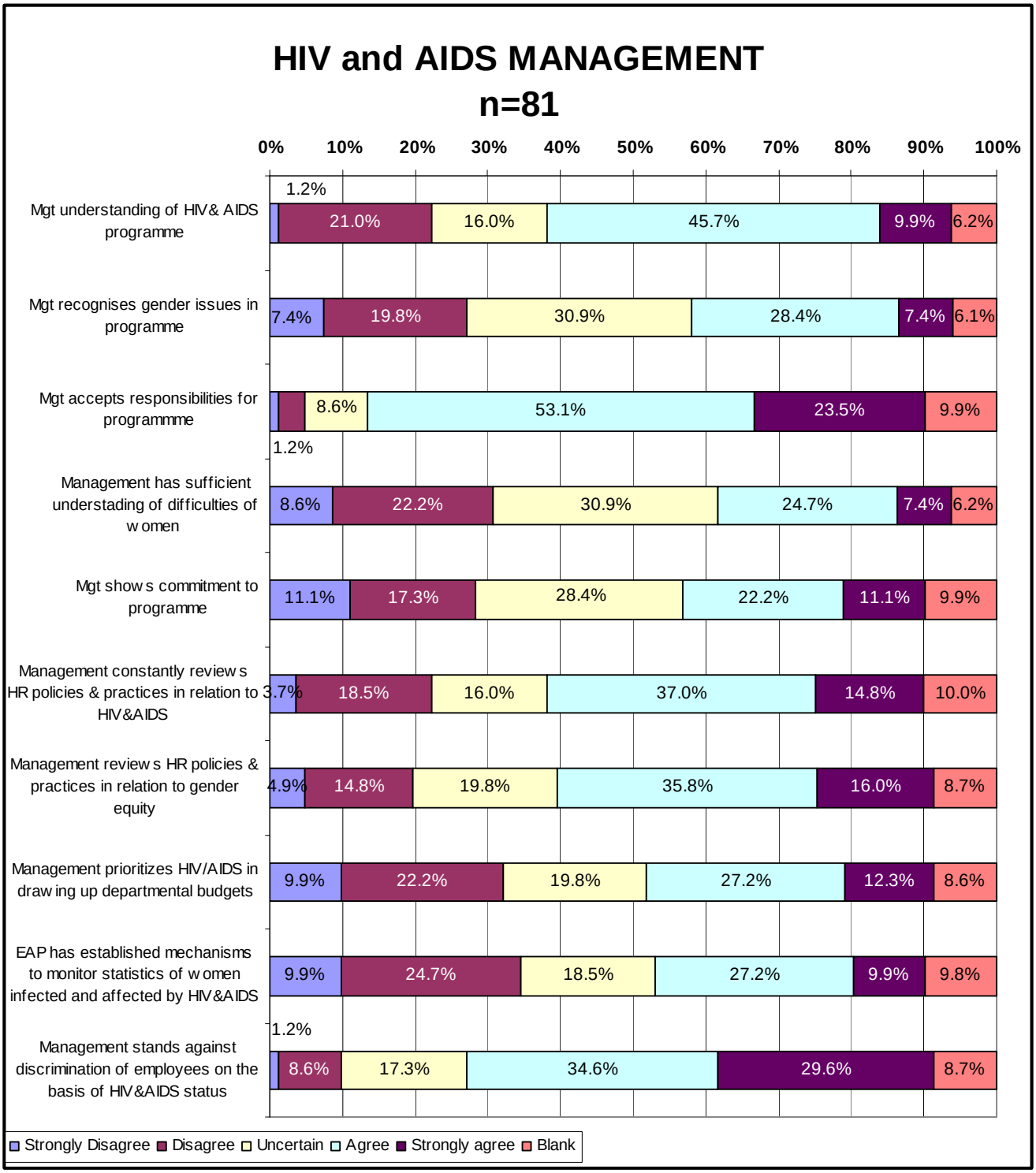
strategy execution is feedback and alignment. Feedback ensures that corrective measures can be taken to ensure that the strategy achieves it stated goals. From the responses, regular feedback (63.%) and alignment with departments (59.2%) are indicated as positive aspects of the EAPs facilitated by the respondents.

9.3.2.5.2 The Role Of Management in HIV and AIDS programme

(Question 52 to 61)

Similar to the previous questions, Questions 52 to 61 used a five point likert scale to assess the perception of the respondents requiring them to answer the statements and indicate if they agree or disagree with the statements. The responses were collated, a frequency distribution for each statement was developed and these are illustrated graphically below.

Figure 31: HIV and AIDS Management



9.3.2.5.2.1 Discussion of Data

The data presented in Figure 31, collated from the responses, indicates that management in companies are taking responsibility to prioritise HIV and AIDS workplace programmes. Approximately 55.6% of the respondents agree and agree strongly with the statement that management has sufficient knowledge of HIV and AIDS whilst 76.6% confirmed that management is encouraged by EAPs to see HIV and AIDS workplace programmes as part of their responsibilities. These positive responses provide encouragement in that EAP is perceived by management to be an appropriate vehicle to address HIV and AIDS issues in the workplace. Whether management themselves are involved in HIV and AIDS knowledge transfer and encourage referral of employees to use the EAP services available is still another matter. Under half of the respondents (33.3%) as combined agree and strongly agree, indicated that management shows commitment to the programme and (64.2%) stands against discrimination of employees who are HIV. Protection of employees against discrimination is a human rights issue and failure to do so violates the employee's human rights, more importantly a company that has clearly outlined non-discrimination on the basis of HIV status is aligned with the South African constitution. This is a good leadership and corporate citizenship.

Other functions that are important in ensuring that policies remain relevant and are receiving due attention from management is the process of reviewing and making the necessary budgets available to a particular programme. Of the respondents, 51.8% agree that management consistently reviews HR policies and practices in relation to HIV and AIDS and that management reviews policies with regard to gender issues (54.8%).

Just over half (54.8%) feel that management is prioritising a budget for HIV. The issue of budgeting is not seen to be totally positive, as other respondents indicated that the budgets provided are inadequate or the process did not take place (33.1%). Of particular interest is the mixed responses that the respondents had in respect of the EAPs establishing mechanisms to monitor women infected and affected by HIV and AIDS. Of those who responded, 37.1% agree and strongly agree with the statement whilst 34.6%

disagrees and strongly disagrees. According to these responses, the issue of HIV and AIDS and gender seem to be a sensitive issue in the workplace. Majority of the organizations do not seem to give a clear differentiation. Only recently has Anglo America in South Africa taken a strategic decision to embark on comprehensive programme to integrate women health with HIV and AIDS programme. According to (Leadership in HIV and AIDS, 2008:36) gender equality and promoting the human rights of women is the cornerstone of Anglo's AIDS policy.

The above responses clearly indicate that the majority of the companies' management in South Africa have made significant progress in HIV and AIDS management. Similarly, there is understanding of policy issues and efforts are made to prioritise education and budgets. According to the researcher there is however a great need to see how management is practically demonstrating these strategic inputs, particular as the responses agreeing and strongly agreeing with management commitment to the programme is under 50%, the wish will be to see the current responses of 33.3% growing to 100% in the future.

9.3.2.6 Section E: Leadership

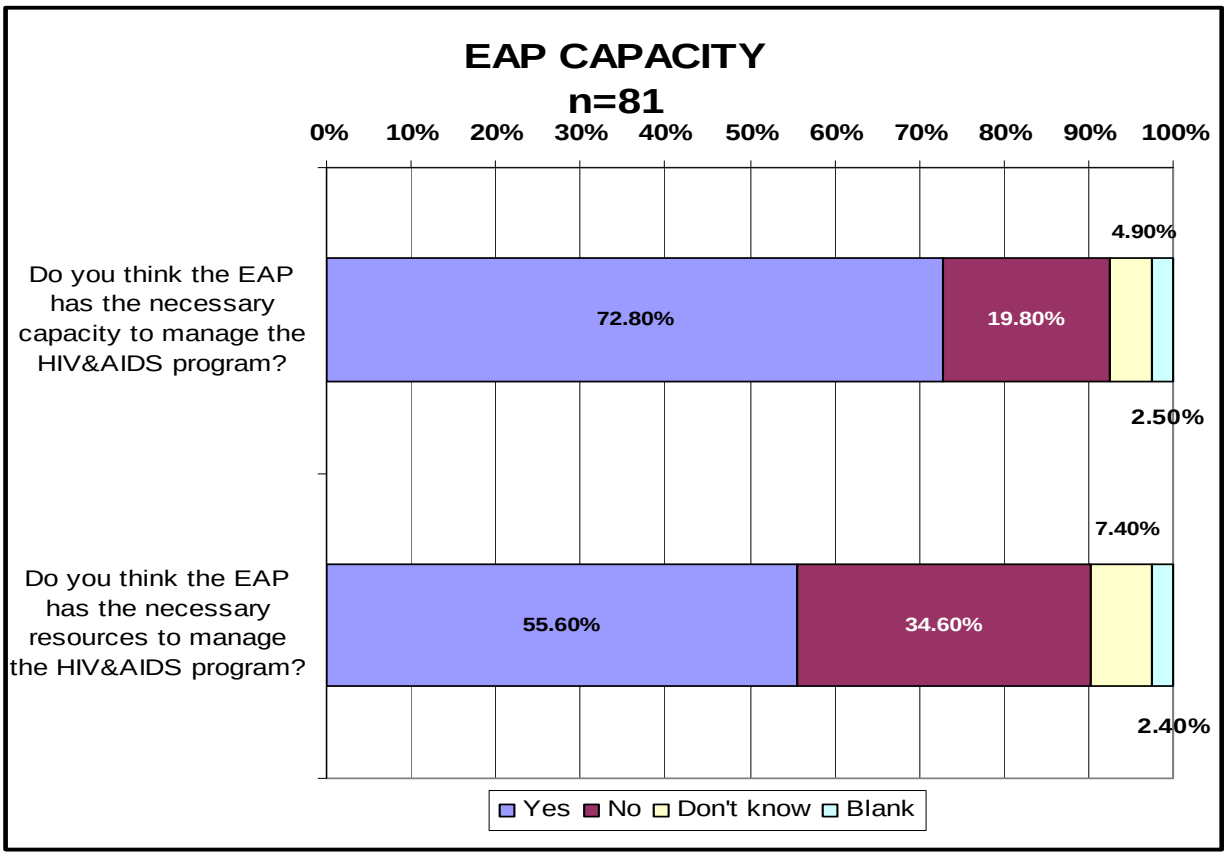
Section E investigated the role of EAP leadership in the HIV and AIDS programme.

9.3.2.6.1 EAP Capacity to lead HIV and AIDS Programme

(Questions 62 and to 63)

The responses to questions 62 and 63 were collated and are illustrated in figures 32. The questions explored the capacity of EAPs and the resources required to make EAP effective and influence leadership.

Figure 32: EAP Capacity



9.3.2.6.1.1 Discussion of Data

The respondents indicated that EAP has the necessary capacity and resources to manage HIV and AIDS programmes. The responses were above 50% for both metrics considered. This confirms the questions previously relating to the abilities of the respondents (Figure 29). However, 34.60% of the respondents still felt that they were inadequately resourced to manage HIV and AIDS through the EAP. For an EAP to function effectively, resources are key. The results are in line with the responses of the women in the qualitative responses previously (See paragraph two on page 144). Similarly, the women indicated more resources as recommendation for an effective EAP. The extra resources can be provided given the staff complement, if the request is aligned with organisation strategy. EAP needs to market and position the importance of

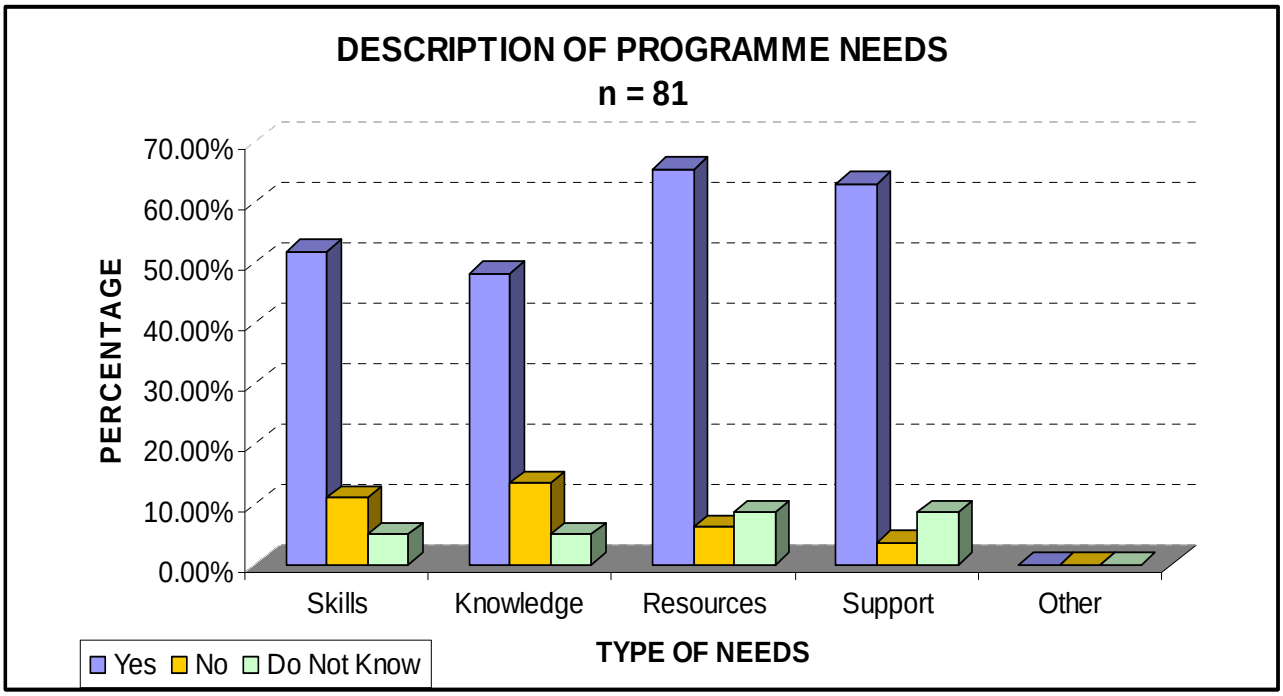
EAP function as an effective business partner and demonstrates its value practically to management.

9.3.2.6.2 EAP Programme Needs

(Question 64)

Question 64 aimed to provide a description of the programme needs. The respondents could indicate as many programme needs options as provided in the question. The responses are indicated in figure 33 below.

Figure 33: Description of Programme Needs



9.3.2.6.2.1 Discussion of Data

From the analysis of the responses, the respondents indicated that they have inadequate resources (28%), a confirmation of the perception indicated in the previous question. Approximately 28% of the respondents also felt that they had inadequate support in relation to EAP. Of particular note is the lack of sufficient skills and knowledge (44%) as a need of the EAP. Given the extent of experience that the respondents have indicated in previous responses (Figure 8 & 9), this raises the question whether the training that is provided to practitioners is adequate to facilitate the EAP.

9.3.2.6.3 Positive Experience in Providing HIV and AIDS Counselling Through EAP

(Questions 65)

In addition to the probing questions, the leadership section included a number of open-ended questions. These questions are of qualitative nature and served to supplement the quantitative responses. The questions attempted to capture responses that are potentially valuable.

Out of the 81 respondents, 49 (60.49%) indicated that they have positive experiences offering HIV and AIDS counselling through EAP.

The following are a selection of the responses obtained and are presented and grouped according to five themes.

- Professional fulfilment and satisfaction – 9.3.2.6.3.1.
- Integrated approach – 9.3.2.6.3.2.
- The EAP offers supportive service – 9.3.2.6.3.3.
- Gender role-modelling in counselling – 9.3.2.6.3.4.
- The positive impact of HIV disclosure – 9.3.2.6.3.5.

9.3.2.6.3.1 Professional fulfilment and satisfaction

"*Life is precious, I have great satisfaction to see how many employees just value the fact that they are alive and that I have been an important part of their life*"

The professional fulfilment and satisfaction is a very important aspect of the EAP practitioners. The responses below indicate that the EAP practitioners value their work and are happy when they make a difference in the employees' lives both male and females. The following are responses in a verbatim illustration:

- "When the HIV positive employees through EAP counselling move from denial to taking responsibilities for their own health"

- “When employees through greater understanding of policy begin to stand up against discrimination and highlight issues of policy importance”.
- “When HIV positive employees involve their family members in EAP counselling”
- "Health improvement of employees after intervention of the EAP”.

9.3.2.6.3.2 The Benefit Of The Integrated Approach Model

“ *As an Employee Wellbeing Manager, I’m responsible for health and safety programme, EAP, HIV programme and Absenteeism management. I have designed the five point strategy that addressed all aspects of employee well-being in an integrated model which gives me positive experience and is easy*”

- “An integrated approach offers various supportive one stop shop for employees”.
- “An integrated approach that allows quick process for HIV and AIDS destigmatisation”.
- “Through integrated approach the risk behaviours are identified and behaviour change strategies are easily implemented”.
- “An integrated approach deals with stigma in an effective manner’

The integrated model is a model that offers a supply chain of various services that are linked to employees’ wellbeing and improves their mental health. It would have been valuable if the above respondents had indicated what they meant by integrated model and services. There are varying aspects of an integrated model, however an integrated model should have services that are linked and are not conflicting in nature. This researcher will suggest an integrated model, in the recommendation section, that may guide other practitioners in their programme management.

9.3.2.6.3.3 EAP Counselling Offers Employee Support

“*Since offering HIV counselling through EAP, I have become more confident in my knowledge of HIV and EAP, particularly when I get feedback that EAP services are valuable, and appreciated by employees”*

- “Employees recommend EAP to their colleagues”
- “There is high utilization of EAP”
- “Employees enrol in the HIV treatment programme”
- “Employees verbalize having trust in the EAP”
- “Management indicate satisfaction about the programme”
- “Seeing more participation in Voluntary Counselling and Testing”.
- “When EAP is seen as practicing confidentiality”
- “Being available for employees 24hours through the EAP call centre”
- “When HIV infected and affected employees indicate better coping due to EAP support”

It is known in the marketing field that word of mouth is the best and sustainable strategy that locks in a client. Clients that are satisfied with the service are likely to recommend it to others. Judging by the responses above, it can only be concluded that where the employees show greater comfort with the level of confidentiality, the more accessible EAP is for employees and there is positive feedback from EAP users. EAP is a programme that adheres to certain core values such as treating employees with respect, dignity, practising confidentiality and giving employees trust. It would seem that that respondents have conducted themselves within the practices of EAP and have enjoyed offering EAP.

9.3.2.6.3.4 Gender Role Modelling

Interesting to note was the fact that women counsellors felt that their gender had a positive impact on women employees. “*Women employees have indicated feeling comfortable with me due to the fact that they could freely discuss issues of sex and sexuality without being embarrassed”*

- “Seeing women take responsibility for their own health when addressing women issues freely.”
- “Women being positive about their lives and willing to learn new ideas”.
- “Women verbalizing that they felt understood, supported and have a sense of purpose given that fact that they can identify with a woman counsellor”.

- " As an HIV positive EAP woman counsellor, I have seen my life change as I impact other women"

In a study by Gilbert (2006:11), women EAP professionals responded that EAP profession has not particularly been supportive to them during their career, they felt most EAPs in USA are still led by men. It is interesting to see that in a profession populated mainly by women, majority of men still hold leadership positions in countries such as the USA. The researcher believes that the role model identification in this study gives EAP women professionals an opportunity to launch themselves more and cease the opportunity to assist other women. A conclusion can therefore be drawn from these responses that women EAP practitioners understood and identified with the experience that the burden of home and family duties create as a disadvantage for women in the workplace.

9.3.2.6.3.5 The Positive Impact Of HIV Disclosure

"*It takes many sessions to encourage the employees to disclose their status, but when they do the perception of their colleagues and management changes positively*"

The respondents seem to suggest that when employees disclose their status, they make their work easier and offer them a positive experience. It can therefore be argued that non-disclosure has powerful secrecy, which not only weighs heavily on the HIV infected and affected but also on the EAP counsellors.

The following are the verbatim illustration by respondents:

- "HIV disclosure by employees gave rise to three publications of HIV/AIDS positive stories in my organization".
- "High participation of HIV positive employees in policy development".
- "When HIV positive employees are involved in HIV and AIDS education and awareness campaigns, employees tend to ask more questions and seem to give them respect".
- "Disclosure influences positive attitudes and challenges stereotypes and HIV myths"

- “Using employees living with HIV and AIDS has contributed to high participation in VCT”.
- “Greater understanding and tolerance with positive support from employees not infected”.
- “Open participation in workplace HIV and AIDS support groups”.
- “Disclosure has a greater sustainable impact as it makes it easier to link employees with community services”.

9.3.2.6.3.6 Discussion Of Data

The responses above seem to indicate that EAP practitioners have greater and positive experiences in offering EAP. A reasonable 60.49% respondents indicated various positive experiences that are evidently ranging from professional satisfaction to multiple service delivery and creativity. The service offered seem to be in line with the core business of EAP which is giving support to troubled employees. In giving support, it can be noted that when EAP practitioners encourage employees to disclose there is greater relieve and positive progress in achieving reasonable accommodation for employees. It is further noted that the process of encouraging HIV disclosure is a challenge but there is positive rewards once achieved, particularly for both the HIV infected and the EAP practitioners. The positive experiences from EAP practitioners also seem to suggest that integrated EAP model could be offering more than just counselling to employees and it is a recommendation that would need further investigation for the EAP future.

Of interest to note is the aspect of gender identification in the responses above. The results indicated that there is both greater satisfaction and appreciation from the EAP practitioners and the women being counselled in the study. Gender identification can yield greater positive results, however it needs to be noted that the opposite could be the case. Gender preference in counselling should not be imposed but an option should always be offered to the employees who seek EAP. Equally so not all HIV infected EAP practitioners are comfortable with offering EAP just because they have an HIV positive status. Their roles can present with counter-transference issues and interfere with their counselling. As much as in this study some felt that the fact that their HIV disclosure was

a positive experience for their EAP role, not all counsellors who are living with HIV can be assigned roles to be EAP practitioners. The responses above further suggest that there was greater satisfaction and acceptance when more employees attended support groups, however it can be argued that support groups can only achieve greater acceptance if there is open disclosures as anonymity can not be guaranteed. Greater support by colleagues can also be measured when there is open disclosure, open disclosure allows EAP practitioners to use those living with HIV and AIDS as champions during their internal company campaigns. It is been found that use of people living with HIV and AIDS is a tool for greater programme participation (WITS HIV/AIDS Symposium, 2004).

9.3.2.6.4 Negative Experiences Offering EAP

Similarly to question 9.3.2.6.3.5. above that explored positive experiences in offering EAP, respondents were asked if they had any negative experiences in offering EAP. The following responses are grouped into themes and discussed below. Out of 81 respondents 23 (28.40%) indicated negative experiences. It can therefore be argued that the majority of respondents have positive experience in offering EAP.

- Lack of management Support - 9.3.2.6.4.1
- Feeling of Frustrations - 9.3.2.6.4.2
- Lack of trust in EAP - 9.3.2.6.4.3
- Stigma as a barrier to EAP utilization - 9.3.2.6.4.4

9.3.2.6.4.1 Lack of Management Support

The respondents seem to indicate that there is insufficient management support which contributes negatively to their service delivery. It can be argued that lack of management support can impact negatively on the relationship between EAP counsellors and line managers. This can result in tension around advocacy, definition of confidentiality and performance management.

"*Noisy manager need proper training regarding EAP and HIV/AIDS management*"

- It is this researcher's experience that managers who have no understanding of confidentiality may demand that they be given feedback regarding employees' ill health. In some instances some managers would voluntarily disclose employees' status, assuming that telling the EAP counsellor is ok given the fact that EAP is governed by confidentiality. This behaviour tends to compromise the employees and violate their right to privacy.
- "Management in my organization are not supportive to employees who are HIV affected". "They tend to give impression that employees should leave their problems at home".
- "Sometimes management is in denial about the organization's state of affair regarding HIV and AIDS".

The two responses above seem to suggest that despite education on the value of EAP, some managers do not understand that employees bring to work their personal challenges. Employees sometimes find it difficult to separate their personal issues from work issues, thus introduction of EAP in the workplace to address these challenges. Importantly in workplaces were there is EAP, which is visible and accessible, this may yield a higher utilization rate.

9.3.2.6.4.2 Feelings of Frustration

"*It is very frustrating when HIV positive employees are not taking responsibility for their own health and at the same time the management is putting pressure on understanding what the employee's status is*"

- "Employees who give up and become depressed make EAP advocacy difficult"
- "Death of employees due to AIDS increase the challenges of HIV and AIDS management"
- "Employees who are resistant to enrol on the disease management programme"
- "Management that are reluctant to link counselling and treatment"
- "When employees are not adhering to treatment, their health become compromised"

- "Counter-transference issues are often experienced with employees with HIV and AIDS. Feeling empathetic to such an extent that practitioners becomes over involved".
- "HIV counselling poses an emotional burden on practitioners and this can be very traumatic at times".

As indicated above, it would seem that EAP in the workplace has a dilemma between advocating for employees and ensuring that there is business continuity. A correlation with Figure 28 which indicated 44.4% of respondents citing "no advocacy" for lack of trust in EAP. This can be a challenge especially for those EAP practitioners who are offering in-house EAP. Maintaining professional ethics and being loyal to the employer who is paying the EAP practitioner's salary and managing the performance can be a challenge. However, the skills in EAP counselling is to educate, support and empower employees, as a result EAP practitioners should maintain professionalism at all times.

In addition issues of transference and counter-transference are professional issues that need to be addressed through supervision and debriefing sessions. The responses above could be dealt with by providing compulsory supervision for EAP practitioners.

9.3.2.6.4.3 Employees' Lack of Trust in EAP

- "Employees sometimes doubt that EAP operates with confidentiality"
- "In some cases it takes many months to mediate between employees and management regarding issues such as reasonable accommodation and leave".
- "Employees believe EAP practitioners have no powers to influence organizational changes".

Indicated above are issues of concern, particularly as these responses are confirmed in Figure 28 previously, where 27% of the respondents indicated 'no confidentiality' in EAP. The responses above suggest that EAP practitioners are faced with pressures from management that may lead them to compromise their professional integrity, and possible lack of decision powers. These responses are confirmed previously as issues suggesting doubt by employees regarding trust and confidentiality.

9.3.2.6.4.4 Stigma As Barrier For EAP Utilization

In previous chapters the impact of stigma on programme success has been highlighted. Evidently, EAP practitioners also believe that stigma is impacting their counselling in a major way.

- "Employees do not want to take treatment because it affect their work attendance".
- "Stigma impacts on their relationship with their colleagues".
- "Negative attitudes are fuelled by stigma and fears".
- "Stigma contributes to non-disclosure".
- "Employees living with HIV have a perception that they are not been promoted due to their HIV status".
- "Denial plays a very important role to religious employees who are living with HIV"

9.3.2.6.4.5 Discussion Of Data

Lack of management support seems to be the greatest frustration for the majority of the EAP practitioners. Lack of management support, was indicated by all 23 respondents who completed this question. It would seem that the frustration, lack of trust and confidence and stigma issues are all linked in one way or the other to management support. The role of management buy-in is very important to the success of EAP. A lot of marketing and negotiation has to be done to ensure managers understand EAP principles in order to be able to work together to encourage employees to have trust in using the service. Clearly issues of stigma and lack of trust in EAP are important as they can serve as a barrier to EAP usage. From both the positive and negative experiences, below is a summary of the recommendations from the respondents.

9.3.2.6.5 Recommendations For Improvement Of EAP

Out of 81 respondents 28 (34.57 %) indicated recommendations for the improvement of EAP. There is a similarity in the recommendation to be discussed here and those provided in the previous discussion by the women in the qualitative section previously (see 9.3.1.11.1 to 9.3.1.11.5). To avoid repetitive discussions with previous

recommendations, the responses are discussed and grouped into various themes and will therefore be presented in a verbatim format.

- Training and workshops - 9.3.2.6.5.1
- Gender alignment programme - 9.3.2.6.5.2
- Integrate EAP programme - 9.3.2.6.5.3
- Health Focus Initiatives - 9.3.2.6.5.4
- EAP management - 9.3.2.6.5.5
- Debriefing Programme for EAP practitioners - 9.3.2.6.5.6

9.3.2.6.5.1 Training And Workshops

Previous responses by the practitioners indicated that they offer mainly HIV training and awareness. However the recommendation seemed to still indicate a need for more training. The respondents did not specify whether training should be targeting specific target group, such as management, employees of employees living with HIV and AIDS. This information would have guided this study recommendation had it been more specific.

9.3.2.6.5.2 Gender Alignment Programme

- “Identify specific needs from women themselves, but don’t segment programme for women specifically as it will stigmatize them”.
- “Policies should have a focus on gender issues”.
- “Sexual harassment policies to be integrated with other policies such as HIV/AIDS and disability”.
- “Capacity building and gender sensitization workshops for all employees”.

9.3.2.6.5.3 Integrate EAP Programme

- “Segment programme into Health, EAP, HIV/AIDS and incapacity”
- “Offer unlimited counselling session which will look at mental health issues, life management and medical issues”
- “Introduce and integrate spiritual counselling in the workplace”
- “Establish home-based care programme”

9.3.2.6.5.4 Health Focus Initiatives

"Condom distribution is an important aspect of prevention, however it is recommended that distribution of female condoms be made compulsory".

"Employers without compulsory medical aids should introduce treatment programme for their employees".

"Women to be encouraged to talk about health issues during women's day initiative and employers to encourage women to go for gynaecological checks ups".

9.3.2.6.5.5 EAP Management

It is up to EAP practitioners to make EAP visible and involve management participation. Furthermore, EAP practitioners need to know the prevalence of HIV in the workplace and make the statistics the visible.

- "Managers need to be given regular update regarding EAP progress and utilization to ensure that there is alignment of programmes in the workplace".
- "As much as HIV infected employees are being accommodated, it is also recommended that reasonable accommodation measures for affected employees be considered, particularly women who are care-givers".
- "More resources are needed to ensure that EAP manages and integrated EAP model approach".
- "Environmental accessibility that offers confidentiality, particularly in the case of in-house EAP. Involve employees in evaluating the EAP service before making decision to either outsource or maintain in-house".
- "Continuous marketing initiatives are necessary to encourage EAP utilization, confidence in EAP and sustainability of the programme".

9.3.2.6.5.6 Debriefing Programme for EAP practitioners

It is important to note that the EAP practitioners do acknowledge the impact of HIV and AIDS on their own wellbeing. In the negative experiences discussed in 9.3.2.6.4 above, EAP practitioners indicated being over involved and feeling the burden of HIV and

counselling. It is therefore, not surprising that they are recommending debriefing programmes.

9.3.2.6.5.7 Discussion of Data

The recommendation from the qualitative and quantitative section of the study will be integrated in the discussion and will form part of the summary and recommendation section in chapter 10. Clearly the EAP practitioners argue that training and workshops are still needed for both EAP and HIV and AIDS education. Of interest to note is the gender alignment recommendation. It will be important to further encourage EAP forums to discuss and investigate the aspect of an EAP Integrated Model, what it means and what it involves.

CHAPTER 10

SUMMARY AND RECOMMENDATIONS

10.1 INTRODUCTION

AIDS as a disease, impacts all races and genders. However, the impact has evidently been felt more by women due to both their biological make-up and social and gender pressures. EAPs and EWPs in the workplace are counselling and strategic programmes that seek to address the impact of HIV in the workplace through counselling, training and awareness and disease management programmes. It is exciting to see that businesses have strategically formulated good practices focusing on feminisation of HIV and AIDS. Literature on the feminisation of HIV and AIDS by GBC is a great example of the acknowledgment of the vulnerability of women with regards to HIV/AIDS and workplace programmes. In the previous chapter the researcher presented the research results obtained through the interview schedule and questionnaire. In this chapter, the focus is on the researcher's conclusions according to the objectives, as well as the researcher's recommendations.

- Chapter 1 provided an introduction to the study, which included the study rationale, research methodology and suggested analysis of the data. The motivation of the study was to focus on HIV and AIDS and EAPs as the research project, followed by problem formulation. The goals and the objectives were identified and the research question formulated. The description of the research approach was discussed, followed by the type of research, research design, research procedure and strategy. The pilot study was discussed, as well as the research population including sampling methods. Ethical issues were discussed and the chapter ended by outlining the sequence of the subsequent chapters in the thesis. Given that this research focused on women, the introduction gave a background on the emergence of the role of women in the workplace. This study makes a contribution to the social work profession and the HIV field as it represents a baseline investigation in the integrated

strategies of EAP and HIV and AIDS. The summary on chapter one is discussed below:

10.2 RESEARCH OBJECTIVES

The goal of this study was to explore and describe the role of the EAP in addressing the difficulties experienced by working women, resulting from the impact of HIV and AIDS.

The study objectives included:

- To investigate the feelings and perceptions of HIV infected and affected working women in their working environment.
- To establish women's perceptions of the role of EAPs regarding their situation.
- To investigate the type of HIV and AIDS counselling offered by EAP practitioners.
- To recommend intervention strategies for the workplace, relevant to vulnerable women who are affected by HIV and AIDS.

The findings as discussed both under qualitative and quantitative reflected the description of the women's experiences, perception and difficulties. The results from the survey indicated similarity between the experiences of infected and affected women ranging from mental health difficulties, including depression, feeling of despair, stigmatization and they had missed work due to HIV related challenges both as infected and affected. Similarly, quantitative findings reflected mental health issues with depression, lack of support from home and from work as challenges with HIV and AIDS.

The following research question was formulated to guide the process of this research project:

What is the role of EAP in addressing the difficulties experienced by working women in South Africa, resulting from the impact of HIV and AIDS?

The research sub-questions to be addressed in this study were:

- What role, if any, does EAP play in supporting HIV infected and affected women in the workplace?
- What is the perceived role of EAP in supporting HIV infected and affected women?
- What is the perceived role of HIV infected women with regard to the effectiveness of EAP for HIV and AIDS in the workplace?
- What are the difficulties of running a functional EAP service in the context of HIV and AIDS?
- What are the feelings of HIV and AIDS infected and affected women in their workplace?
- In answering these questions listed above, the assumption remains that the EAPs response to infected and affected employees can determine negative or positive performance of employees.

Findings from the research question indicated that women received support from EAP in the form of counselling and in other practical ways such as home visits and referral to support resources. Generally women are satisfied with the role of EAP and they will recommend EAP to others. Training and counselling are highly ranked by EAP as the role of EAP in HIV and AIDS. Management seem to be taking responsibility in prioritizing HIV and AIDS initiatives. However the EAP practitioners indicated a balanced capacity needs in the following areas: skills, knowledge, resources and support.

Valuable information and improved insight were obtained due to the research project and these insights are presented in the form of a general summary, conclusions, and recommendations below.

The researcher draws the following conclusions that chapter one demonstrated focus of the study through the following statements:

- The combined qualitative and quantitative research approach was important as this enabled the researcher to draw information on the process and the aim of the study

from a sample of the population by using an interview schedule and questionnaire to supplement literature and the research goal.

- Applied research selected for this study proved to be suitable as the study was a problem solving process which added a knowledge base to the social work profession and applied research will assist to develop solutions to the problems related to HIV and AIDS and EAPs.
- The phenomenological study design was used to gain insight into the difficulties experienced by HIV infected and affected women in the workplace and the role of an EAP.

10.3 LITERATURE REVIEW

Summary of all the chapters are discussed below with recommendations by the researcher based on the literature reviewed previously.

10.3.1 HIV and AIDS

The impact of HIV and AIDS is discussed in detail from Chapter 3 to Chapter 7. The essence of these chapters was on the theoretical background of HIV and AIDS and the influence of gender perspectives on women who are HIV infected and affected and the difficulties HIV affected or infected women's experiences in the workplace.

10.3.2 Difficulties Experienced By HIV Infected And Affected Working Women

The chapter on the difficulties for women infected by HIV and affected by AIDS highlights the plight of women in society. Women face socio-economic challenges and psychological struggles both in society and in the workplace. Culture has an influence on the perception of society and business and further complicates the livelihood of the infected and affected women.

10.3.3 EAP in the Workplace

Chapters 8 and 9 highlighted the role of EAPs and the value that EAP counselling brings in the workplace. The importance of HIV counselling is addressed. These two chapters identify the origin of EAP and revise the international presence of EAP in various countries.

10.3.4 Literature Review Conclusions

- The above chapters confirmed that HIV is a pandemic and as such a crisis for the world and the business world. Furthermore, it was established that there are clear HIV and AIDS definitions, the methods of transmission are defined and understood, and the socio-economic links of the disease were discussed.
- Women are the most affected by HIV and AIDS. International statistics on AIDS revealed the greater impact of the pandemic on the lives of women. In Sub-Saharan Africa, 57% of adults infected are women and 75% of young people infected are women and girls (Global Report (GRI), 2004:1).
- Women are most vulnerable to HIV from a social, biological, and economic perspective. The Human Science Research Council (HSRC) study in 2002 and the Nelson Mandela Foundation showed that women aged 20 to 24 years had double the HIV prevalence rate as compared to the young men in the same age group (NMF/HSRC, 2003:9).
- The crisis of HIV and AIDS has necessitated the collaboration of international partners, business and government in the management of HIV and AIDS.
- Care for employees, education and awareness are the most recognised interventions in the workplace.
- Stigmatisation and gender inequality complicates the management of HIV and AIDS among women.
- Women as caregivers experience financial and psychological burdens due to HIV and AIDS.
- Historically, EAPs focused on the troubled employee. However, an EAP in the workplace currently focuses on education, training and other wellness programmes that facilitate the engagement of employees.
- EAP is facing the challenge of managing HIV and AIDS as a significant medical condition in the workplace. Goplerud (2006:20), identifies four common medical / behavioural conditions as depression, anxiety / stress, alcohol abuse and the catch-all category of marital or relationship problems faced by EAPs.
- The concept of an integrated approach has shown momentum and has proven to be a preferred choice by many businesses. According to Goetzel and Ozminkowski

(2006:25), an integrated approach to workplace health and productivity got started in 1987 and the initial approach was in the areas of absence management, disability management and workers compensation. In South Africa, an integrated approach yields benefits from disability management, counselling in the workplace, absenteeism management and HIV and AIDS programmes. Because of this integration, more EAPs prefer the external models and combined models of EAPs.

- HIV and AIDS counselling acknowledges the burden of death and dying and the impact this has on the counsellors.

The researcher concludes that literature has informed this study in the following ways:

- There has been a significant effort to include women in the workplace.
- Working women gain self esteem and confidence by assuming roles in the workplace.
- Awareness about HIV and AIDS has grown and general understanding regarding the cause of HIV and AIDS has improved.
- Gender perceptions influence the transmission of HIV and AIDS.
- Gender wise, women are the most affected by HIV and AIDS as partners and caregivers.
- The impact of HIV and AIDS in corporate South Africa is clearly felt.
- Corporate South Africa through business against HIV and AIDS and the King II Report have put strategies in place to mitigate the scourge of HIV and AIDS in the workplace.
- EAPs in the workplace are addressing the needs of the employees from a troubled employee perspective
- A greater number of EAPs are integrating various programmes to address business objectives and employee needs.

10.3.4.1 Literature Review Recommendations

- Business people, human resource practitioners including EAP professionals, should continuously position themselves as professionals with HIV knowledge and relevant counselling and handling skills in order to confidently develop preventative and supportive strategies to mitigate HIV and AIDS.
- Given the fact that stigmatisation and gender inequality seem to be the biggest barriers for HIV and AIDS prevention, individual empowerment should be encouraged. To support GBC proposed seven-point plan, the three diseases, namely; HIV and AIDS, tuberculosis and malaria should be integrated in a wellness model and treated as part of a full holistic health programme.
- Multiple strategies are important in the workplace, including behaviour change and spiritual and cultural support systems. Leadership workshops with emphasis on respect for fundamental values of humanity that are embedded in culture and spirituality.
- Businesses should position themselves financially to support HIV-related research projects, even though it has recently emerged that Eskom is withdrawing its commitment on AIDS research (Sunday Times, 23, March 2008).
- Studies on the psyche of working women should be encouraged. According to Global Business Coalition on HIV and AIDS, Tuberculosis and Malaria (GBC) the fight against HIV and AIDS cannot be won without addressing the impact of the pandemic on women.
- Working women in senior positions should be empowered to mentor women who are working and living with HIV and AIDS. Women's day forums should be used practically to disseminate HIV and other health education, address domestic violence and recognise success of their female staff, who have made a difference in leadership and human capital areas with specific reference to change management and attitudes.
- Employment equity initiatives should be positioned to empower women regarding policies and equity issues in the workplace. Retention strategies for women including those living with HIV and disability should be aligned.

- The value of EAPs in the integrated approach is important, however it is equally important that the employees' confidentiality is not compromised in the process. Specifically, surveys such as behaviour change and risk behaviour surveys should be conducted by private consultants and reported only through EAP offices.
- EAPs should play a more strategic role in evaluating and monitoring the impact on EAPs and HIV to reflect return on investment for the workplace. Various measurable indicators such as KAP surveys and leave analysis could be linked to strategies to develop work-life programmes. Results indicated that EAPs are not using these measures to evaluate their HIV programmes.
- Multiple communication tools should be used to improve the EAPs' utilisation, enhance the reputation of EAPs in the workplace and empower women in particular to deal with work-life-family balance through disclosing their status and needs.
- Mediation and dispute resolution are required in EAPs and HIV and AIDS programmes to provide an opportunity to work more closely with management. Encouraging rewards for de-stigmatising and disclosures efforts.

Based on a combination of literature review and this study the researcher concludes that the following summary key points are important consideration for further research:

- Further research on the impact of HIV on working women is important, specifically with reference to their enhanced capacity to make decisions about their illness and legal rights.
- Research has indicated that female condoms are effective in empowering women as a preventative method. Companies should invest in distributing female condoms to address specific needs of women.
- Research on the evaluation of EAPs in South Africa is long overdue, given that there is limited research on EAPs in South Africa.
- The next phase of EAPs and HIV research should test the strategies on integrated wellness programmes.

- Future studies are recommended regarding interventions aimed at helping women living with HIV and AIDS to cope with stigmatisation, disclosure, and discrimination. It is suggested to use the support group model as an experimental study whereby one group includes participants who share skills and experiences and the other group receives counselling. This model will best be used as an internal model for business managing their employees living with HIV and AIDS. The model would have to first establish through disclosure exercise the prevalence of HIV amongst women employees.

10.4 QUALITATIVE STUDY

The goal of this study was to explore and describe the role of the EAP in addressing the difficulties experienced by working women, resulting from the impact of HIV and AIDS. In total, 24 respondents participated in the qualitative part of the research study. The respondents answered the research questions that were posed to them during one-on-one structured interviews.

10.4.1.1 Demographic Details: Qualitative

- All respondents were women aged between 23 and 49.
- The majority (20) were African.
- They were all South African.
- Almost all were working (22), with 2 unemployed at the time of the actual interview.
- Mixed representation of various work levels.

10.4.1.2 Difficulties Experienced As A Result Of HIV and AIDS

Working women in this study generally experienced difficulties with disclosure and negative experiences with colleagues, which included discrimination and lack of support from colleagues and family. The experiences of women ranged from mental health difficulties to such as depression, feeling of despair, loneliness and stigmatization.

10.4.1.3 Stigmatisation

General experience of stigmatisation was identified as the greatest barrier of treatment and care and future strategic interventions were suggested.

10.4.1.4 Lost Time

Increased absenteeism is one of the key results of the impact of HIV and AIDS in the workplace. The impact of HIV and AIDS was felt equally by infected and affected and women in the workplace. Women missed work due to ill health or family responsibility roles. The majority of time lost by infected women accounted to more than three months for each one of them.

10.4.1.5 Addressing the Difficulties Experienced By Women through EAP

An EAP is very important in the workplace. Most respondents verbalised receiving positive added value by the EAP in their working lives. The value of the EAP was experienced in very practical ways ranging from counselling, financial assistance, home visits and medical assistance. Given the value of an EAP, most women felt EAPs should not only focus on counselling, but rather on change management including policy implementation and management training. Counselling remained the most valued aspect of EAP amongst infected and affected working women. On the contrary, the responses by EAP practitioners did not demonstrate that counselling was the most valued EAP intervention. The researcher therefore recommends that EAP continue to offer counselling given the value it provides as per the responses of the participants. However, it is important that an investment be made to train practitioners in leadership courses to enable them to make strategic levels.

10.5 QUANTITATIVE STUDY

Chapter 11 of this study described the quantitative findings in detail. The sample included 81 respondents (EAP practitioners) of EAPA-SA throughout South African regions.

10.5.1 Demographic details: Quantitative

- Majority of respondents were aged between 26 and 45 years.
- The majority of the respondents (71.6%) were females.

- The majority of the respondents (83.9%) were Christians.
- Experience in an EAP and HIV ranged from 5 to 10 years.
- The majority (51.85%) was EAP coordinators and were in the middle management level (34.57%) and specialist level (33.33%). Only 13.55% were in the senior level).

10.5.2 Role of EAP

- The two most preferred EAP models are an in-house model and mixed model (both 38.30%);
- EAP service offerings included coordination (65.43%) and counselling services (61.73%). Training is offered at 43.21% and therefore evidently recommended by respondents (see 9.3.2.6.5 of the recommendations).
- The response on HIV prevalence was inconclusive, 56.79% respondents did not complete the question and 11.11% indicated a percentage over 25%, which is regarded as unrealistic. This was confirmed by the literature review in chapter 5, which looked at the prevalence of HIV among companies in South Africa.
- The majority of companies (95.10%) have HIV and AIDS programmes.
- The HIV and AIDS programmes mostly offer counselling (96.10%), education (97.40% and training (88.30%). Education entails awareness and information sharing on HIV and AIDS, this is normally measured through KAP surveys. Training refers to formal training on HIV and AIDS which may range from one to five days and can be divided into two parts, targeting all staff or managers only. Evidently, programmes are moving towards offering on diseases management (54.50).
- Only 48.10% of the HIV and AIDS programmes offer gender equity awareness.
- There is not much difference in who facilitate HIV and AIDS training. Majority (37.3%) of the HIV and AIDS programmes are facilitated by HIV and AIDS managers / coordinators and 33.6% are by EAP practitioners / consultants and 28.6% private consultants.
- Forty nine percent of the HIV and AIDS programmes are integrated with wellness programmes.
- Only 39.5% have established HIV committees.

- The majority (51.9%) indicated that EAPs are playing a role in HIV and AIDS management.
- Management is still not taking responsibility in HIV prevention. Only 30.9% indicated that management sees HIV management and programmes as their responsibility.
- Twenty one percent strongly agreed that unions are actively involved in HIV and AIDS programmes.
- The workplace is still male dominated as discussed in Chapter 1. Given the representation of women in the workplace, it is not surprising that the prevalence of HIV is highest among males at 28% and evidently most respondents did not know the prevalence in their workplace
- The majority indicated that EAPs address the needs of *infected* women in the workplace and do so through counselling and education. (88.9% and 70.4% respectively);
- EAPs address the needs of *affected* women through counselling and education at 81.5% and 61.7% respectively.
- The majority (84%) of the companies have an approved EAP policy.
- Few respondents gave specific reference to gender issues in their programme (35.8%).
- It is encouraging to see that the respondents are satisfied with the utilization level of the HIV and AIDS programmes However there is not much difference with the unsatisfactory responses (46.9%).
- The perceptions of respondents 55.6% are that the women would recommend EAPs to others.
- The common methods of HIV and AIDS education in the workplace in the order of majority to least favoured are posters (82.7%), EAP office and education and training (72.8% respectively), workshops and through pamphlets (70.4% respectively), notice boards (66.7%) and emails (60.5%). Only 44% use people living with HIV and AIDS in the context of HIV and AIDS education dissemination. The need for use of people living with HIV and AIDS is indicated under recommendation (see 9.3.2.6.3.5 positive impact of HIV disclosure).

10.5.3 Difficulties Experienced By Women

- The majority of women infected and affected by HIV and AIDS experience stigmatisation (69.1% and 63.% respectively), followed by lack of care and support at home (51.9% and 53.1% respectively) and lack of understanding by managers (48.1% and 54.3% respectively).
- The majority of infected and affected women struggle with mental health issues with depression being common (76.5% amongst infected and affected women)
- The majority of women affected and infected by HIV deal with their difficulties by consulting EAPs (64.2%) and do so through face to face consultation (53.28%).
- The most preferred referral regarding HIV and AIDS (57,61%) is voluntary referral.
- The results indicate that EAP is generally accepted and is voluntarily used by employees in South African work place (77.8%).
- Women affected and infected by HIV generally use EAPs (67.9% and 69.1% respectively).
- Fifty eight percent respondents indicated that women have trust and confidence in the EAP. About 55,6% of the respondents agree that women are satisfied with EAPs, those who do not agree cited no advocacy (44.4%) and no confidentiality (27.8%). Of note was 27,8% whom indicated “did not know” the reason for lack of trust.
- Even though EAP practitioners have adequate EAP skills and knowledge (58.1%) they still indicate need for skills and knowledge (44%).
- Clearly from the qualitative and quantitative responses, women find it difficult to disclose their HIV status. Qualitative results attribute the reasons to stigmatisation and lack of support from managers. According to the quantitative study, 22.2% disagrees and strongly disagrees with the statement that women with HIV find it easy to disclose their HIV status, despite the fact that a large percentage (45.7%) of the respondents indicated that the EAPs encourage HIV and AIDS disclosure.

10.5.4 Strategic Management

- Forty eight percent of the respondents' feel the HIV and AIDS programme is successfully incorporated in the workplace.
- A large percentage (46.9%) indicated that EAP has well-defined goals regarding HIV and AIDS.
- Most workplaces do not have well-defined programmes for women infected and affected with HIV and AIDS- confirmed by 42% of the EAP practitioners.
- The majority (63.%) agrees and strongly agree that EAPs give regular feedback to managers about the scourge of HIV and AIDS.
- The majority (59.2%) is of the opinion that workplace programmes have proper alignment with HIV and AIDS programme and other relevant departments.
- Less than 5% agree that management has sufficient understanding of the HIV and AIDS workplace programme due to the effort by the EAP office.
- The majority is uncertain about management's perception of the importance of gender issues regarding HIV and AIDS in workplace programmes.
- The majority (76.6%) indicates that they encourage management to see HIV and AIDS programmes and management thereof as part of responsibilities.
- Just less than 50% of respondents indicate that management has sufficient understanding of difficulties of women infected with HIV and AIDS.
- A small percentage (33.3%) agrees and strongly agrees that management has shown ongoing commitment to HIV and AIDS programmes for women.
- The majority (51.8%) feel that management reviews HR policies and practices in relation to gender equity.
- Only 39.5% indicate that management prioritises HIV and AIDS in drawing up a departmental budget.
- A small percentage (37.1%) agrees and strongly agrees that EAP has mechanisms to monitor statistics of women infected and affected by HIV and AIDS.

- Majority 64.2% agree and strongly agree that management takes a stand against HIV and AIDS discrimination of employees.

10.5.5 Leadership

- The majority (72.8%) agree that an EAP has the capacity to manage HIV and AIDS in the workplace.
- Only 55.6% agree that EAPs have the necessary resources to manage HIV and AIDS.
- In order of importance, the following are the EAP needs; resources (63%), support (60%), skills (50%) and knowledge (48%).
- In general, most respondents indicated positive experiences in running an EAP. The experiences included professional fulfilment and satisfaction, use of integrated approach model, the EAP supportive service offering, gender role modelling and the positive impact of HIV disclosure.

The negative experiences which need further intervention approach for the future of EAP includes: lack of management support, feeling of frustration, lack of trust in EAP and stigma as a barrier to EAP utilization.

10.5.6 Summary of Combined Qualitative and Quantitative Study

Both qualitative and quantitative analysis highlighted the following key points:

- HIV infected and affected working women have difficulties due to their circumstances in the workplace. These difficulties are experienced in the form of psychological, practical work-related issues and disclosure and stigma.
- Qualitative and quantitative results informed this study that there is still mixed experiences regarding HIV disclosures thus creating problems for effective HIV management.
- Both in qualitative and quantitative analysis, the need for EAPs to assume a mediation role between employees and their managers has emerged strongly.
- Management is taking responsibility to manage HIV and AIDS in the workplace.

- Majority of respondents and participants confirmed that South African workplace has approved HIV and AIDS policy and EAP practitioners were involved in the development of the HIV and AIDS policy.
- South African EAP practitioners did not demonstrate in this study knowledge of the HIV prevalence in the workplace. There was a co-relation between lack of prevalence statistics and strong fear of disclosure by participants.
- This study demonstrated that there was high utilization of EAP services, however it was also noted that lack of confidentiality and trust in EAP was hampering HIV management.
- Both qualitative and quantitative results indicated that the role of EAP in major decision making was necessary.
- Both studies suggested that attention should be given to women issues but not in terms of HIV and AIDS service delivery. Such attention includes women condoms and empowerment initiatives.
- Both from qualitative and quantitative results there is a recommendation for integrated EAP and HIV model to address a supply chain of services to all HIV infected and affected employees.

10.6 RECOMMENDATIONS

Drawn from the literature review previously discussed and summary of the empirical data above, the researcher makes recommendations to address the problem investigated which includes difficulties experienced by working women, the EAP programmes in the workplace and management of HIV and AIDS in South Africa. EAPs in the workplace can only gain reputation if the professionals have respect for the client, suggesting strong adherence to EAP guiding principles and professional ethics. From the findings and recommendations given by respondents it is evident that EAPs are doing much to address the difficulties experienced by women infected and affected by HIV and AIDS. This researcher is satisfied that EAP is addressing the difficulties of women at an individual level through counselling which is EAPs' area of expertise. However much still have to be done to position EAP and make it visible both in terms of

levels of work and strategic difference. This section incorporates some of the recommendations received from both qualitative and quantitative respondents.

10.6.1 Integrated EAP Model

- The qualitative results under part one of this study indicated that the EAPs are very supportive to the working women's individual needs but lack changing powers to the corporate decisions making. This was further supported by results in the quantitative data that reflected the need for capacity, support, skills and knowledge when they were asked to indicate their resource needs. According to Goetzel and Ozminkowski (2006:25) the concept of an integrated approach to EAP started in 1987. However in South Africa, integrated approach is a new concept. The integrated approach as recommended by the researcher will mean a one-stop shop supply chain of multiple services that are linked and analysed. The thrust of the researcher's rationale for the integrated approach model is derived from the fact that EAP's core technology functions are encompassing three main focus areas: Health, Wellness and Productivity.

- The programmes to be linked will include functions from preventative health and wellness, safety programme, leave and absenteeism, chronic benefit access, incapacity and disability, HIV/AIDS and EAP. When all these programmes are linked, information of employees can be accessed through a limited access point. Information could be used for analysis, monitoring, strategic planning and other purposes relevant to employee's benefit. The integrated approach is an approach that looks at the employee as a whole person, regardless of the programme accessed. The link in programmes monitors the level of programme utilisation and addresses service duplication quickly and easily. Programmes that are not integrated and are provided by various providers tend to be duplicated and can be a costly affair. Providers will never highlight the duplication of services, as they are interested in their revenue. The integrated approach further provides the synergy benefit to the programme owners and preventative approach to employee's challenges. So far the integrated model seem to be the best in

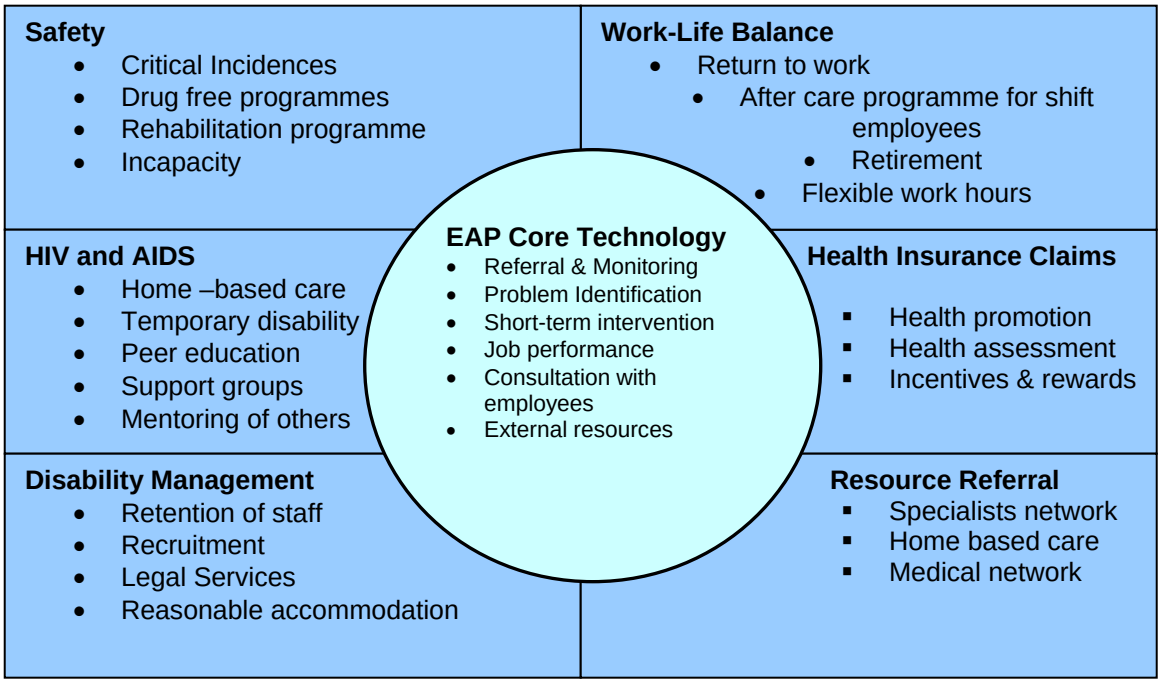
providing efficient and effective service delivery and uses the language understood by the businesses, which is risk management.

The Benefits of an Integrated Model:

1. Absenteeism can be monitored and fed into the disability management and equity.
2. Presenteeism can be tracked and EAP can leverage employee performance through work life balance and other innovative work shadowing programmes.
3. Employees with chronic illness and HIV can be put on temporary disability benefit.
4. EAP can use return to work programme to encourage affected employees to significantly show gains in productivity.
5. Compensation claims can be speedily processed and rehabilitation programmes can form part of return to work programmes.
6. Wellness initiatives such as stress and conflict management trainings will serve as preventative tools for EAP challenges

An EAP integrated model will enhance the profile of EAPs in the workplace. It will assist in establishing linkages between gender programmes, disability programmes and harassment policies. The model will strengthen strategic decisions, as the results in this study seemed to indicate that the EAPs have a very weak position in this regard and are not visible. Overall, the model will identify risks emerging from personal and environment factors and target intervention in a proactive manner. Similarly EAP will facilitate relationship building between the business and employee and may transform the company into product-focused business. Through this model the researcher has no doubt, EAP can remain on the cutting edge as an business partner in investment gain due to health, wellness and productivity interventions. Below is an illustration on the researcher's recommended integrated approach model as adapted from Beidel and Brennan (2006: 36).

Figure 34: Best Practice Requires EAP Involvement



(Adapted from Beidel *et al*., 2005:36)

10.6.2 Women Focused Initiative

Many theories indicate that cultural barriers put women in a vulnerable position. According to the researcher, implementing women programmes focusing on HIV and AIDS will not only result in good programme utilisation, but rather perpetuates stigmatisation and discrimination - as were the findings from the participants living with HIV and AIDS in this study (see 9.3.1.2.9). These results were further supported by results from the quantitative findings (Figure 22, 24 and 29). The recommendation on women focused initiatives should not be focused on HIV as women feel this will stigmatize them, but instead already existing programmes in the organization which will highlight and integrates the following issues:

1. Empowerment workshops for women addressing issues of confidence, self-actualisation, encouraging life-skills and mentoring programmes.
2. Support groups for mothers and daughters to be developed to address issues around sexual harassment, empowerment skills and myths about sexual education. These support groups to be attended outside the workplace.
3. Real-life stories to be encouraged as stories of courage and tangible rewards to be used to encourage disclosures. Forums to celebrate success intervention for women by women living with HIV and AIDS in the organisations. Incentives to include but not limited to the following:
    - Incentives to include flexible work time
    - Working from home options
    - Aftercare programmes for children of women wanting to make up time lost during difficult times and shift working mothers.

10.6.3 National Business and Community Forums

1. Companies, communities, academic sectors and government should collaborate to find ways to reduce the spread of HIV and AIDS among women. Forums with these sectors to be held quarterly with presentations on research, strategies and success.
2. Discussion forums and dialogues to be established to discuss issues around culture and stigmatisation, evaluating the importance of traditional and religious strategies with reference to education and care of women living with HIV and AIDS.
3. While strategies to combat HIV and AIDS are improving and recent medical advancements in prevention and care have been considered, much work is still to be done in the area of disclosure and discrimination. Joint efforts by the business sector, academic environments and government should be considered.

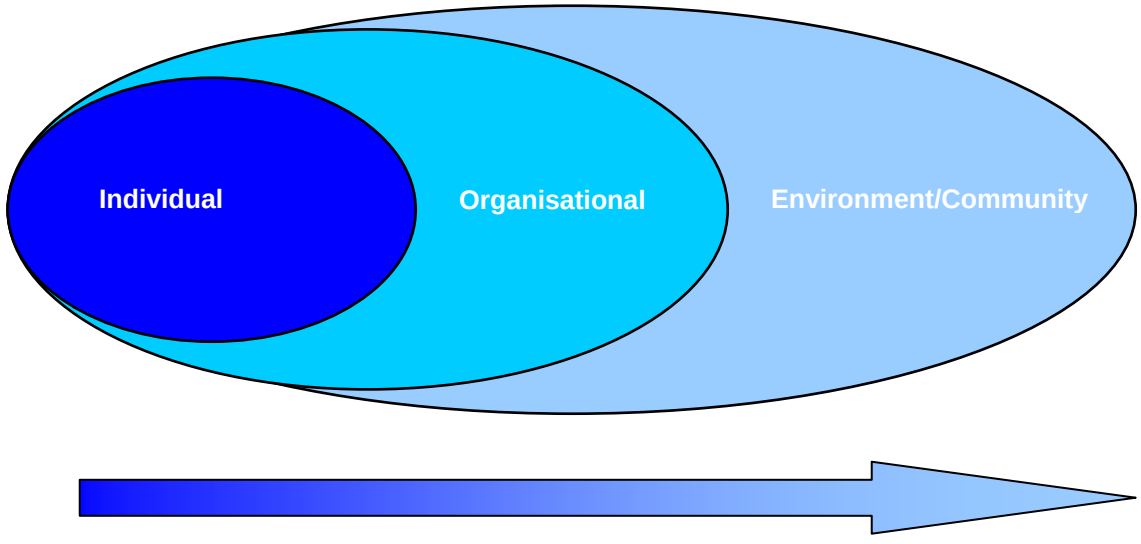
4. South African businesses should learn from other African countries such as Uganda and Botswana in the areas of behaviour change strategies and treatment planning. An example could be that educational sessions should be included during funeral agendas in the case where death is AIDS-related.

The researcher proposes a business and community model which can be called the engagement strategy. The model should be an integrated business model focusing on both internal and external approaches. The model would be applicable to the organization's employees and their family members first.

The following is a recommended strategy process and is illustrated in Figure 35 below:

1. Establish the prevalence of HIV amongst women in the organization. (Transparency regarding HIV profiles)
2. Procurement of services from people living with HIV and AIDS and SMMEs (first priority to be given to family members of employees).
3. Develop enterprise programmes where community people living with HIV can be supported and empowered (target the communities where majority employees reside).

Figure 35: Engagement Strategy



10.6.4 Business Approach To HIV And AIDS Programmes

- The EAP's visibility and management must involve more resources, good reporting and visible HIV statistics in the workplace. Clearly from the results it was evident that the EAP do not have clear understanding of the HIV prevalence in the organisations they worked for.
- EAPs should be more integrated with strong capacity building and must be in alignment with gender programmes. A practical example as suggested by the Director of Amnesty International is that a chronic illness grant be encouraged to improve HIV infected women's access to health services and treatment and not to be terminated as their CD4 improves as is the case currently.
- The introduction of spiritual counselling with a focus on acceptance and support from infected and affected people should be considered. In the same vein, debriefing sessions for EAP professionals should be compulsory and EAP should be encourage to embrace their spirituality.
- EAPs should be champions of the organisation's vision and goals, particularly in the area of risk management and change management using multidisciplinary assessment of social, economic and cultural / spiritual aspects to contribute to the development of behaviour change strategies.
- Managers to be encouraged to take more leadership role, and consequence management to be considered for non-compliance on policies which promotes non discrimination. Consequence management entails the process of managing employees with the emphasis on taking responsibility for the consequences of their action.

The above recommendations would need further research exploration and experimentation, however this can be achieved through collaborative efforts between people living with HIV and AIDS, businesses efforts, communities forums, EAP

interventions, spiritual and cultural inputs and lastly through patience, tolerance and values of respect and humanity.

10.6.5 Standardise EAP Education

According to the EAPA-SA requirements, it is important that those involved in EAP conform to the standards of EAP that are guided by EAP core technology. A module on HIV and AIDS will add professional knowledge and skills to the profession and core technology. In addition, the University of Pretoria offers a certificate in EAP to allow those involved in the field of EAP to practice EAP within the EAP standards, the certificate is only to assist with the understanding of EAP and it does not guarantee professional competency. In 2001 University of Pretoria introduced two masters programmes for non- social workers and professional social workers. Both programmes offer theory, practical and research in EAP. Through these two masters programmes, EAP professional competency can be enhanced.

In the South African workplaces there is no prerequisite counselling experience required for an EAP coordinator role. The reason could be that companies rely on external models for actual counselling of employees. For the sustainability of EAP profession, EAPA-SA standards need to be enforced and a certain level of competency need to be standardized through tertiary requirements. In doing so, this will assist employers in South Africa to align their position requirements with the professional standards.

The USA has made so much progress in the area of EAP, so much so that in some states, the progression is evident in that EAP certification is offered to all employees at a particular level of their responsibilities. The two years certificate was introduced at the university medical centre in Texas, USA. The two years certificate is offered to all employees who have a supervisory control over employees. According to Tiner (2006:25) the certificate was introduced not only to heighten supervisors' and managers awareness of EA services but to help them better understand how to use the EAP as a vital tool in dealing with troubled employees.

10.6.6 Limitations of the Study

- Literature is available on women and HIV and AIDS, especially regarding feelings, difficulties, and work struggles, however there is limited literature on working women and HIV and AIDS. The focus on literature on HIV and AIDS is on medical information, infection rate but not on workplace and HIV women infected or affected.
- Unavailable statistical information on the prevalence of HIV among working women in South Africa. The only available statistics are through antenatal studies, and the Nelson Mandela Household studies, which do not reflect working women who are members of a medical aid and who have access to private hospitals. This limitation was also evident when analysing quantitative data, as most respondents did not indicate the HIV prevalence of their work force according to gender; therefore it was difficult to quantify the data rendering some of the findings inconclusive.
- The limitations identified are that some findings, such as the various organisational HIV and AIDS prevalence are inconclusive and cannot be generalised to the larger population.
- Research on the efficacy of EAPs in South Africa was unavailable and as a result there was limited information to justify the integration of HIV and AIDS programmes with EAP. EAPs in South Africa have largely not been scientifically evaluated.
- The study was aimed at only interviewing working women, but during the implementation of the study two women were retrenched, making it very difficult to exclude them because the researcher only learnt about the retrenchment during the process of the interview.
- The aim was to collect quantitative data only in Gauteng. However, since the pilot study yielded only a few responses, it was necessary to include all practitioners in various South African regions. This was achieved during the EAP Durban Conference in 2005. Due to the limited response, questionnaires were further distributed via email to practitioners outside Gauteng.

- The Durban Conference was attended by EAP practitioners who are active in the EAP field. This resulted in difficulties excluding professionals who are not practising EAP practitioners, rendering some results inconclusive. 17,3% of respondents indicated 'other' to the question asking about job position and 12,3% of respondents are Human Resources professionals.

10.7 GOALS AND OBJECTIVES

The **goal** of this study was to explore and describe the role of the EAP in addressing the difficulties experienced by working women, resulting from the impact of HIV and AIDS.

Table 2: Achievements of Goals of Study

OBJECTIVE	ACCOMPLISHMENTS
1. To investigate feelings and perceptions of HIV infected and affected working women in the working environment.	Chapters 2-9 highlighted how this objective was achieved through various discussions using South African literature. The role of the business sector and EAPs and counselling models. In addition, the qualitative results clearly demonstrated feedback from women infected and affected by HIV and AIDS, which confirmed the assumption that women infected and affected with HIV have feelings and perceptions regarding their needs in the workplace. The feelings included a list with the majority being negative feelings, i.e. feelings of depression, suicidal ideation, issues of stigmatisation. This was also confirmed by the quantitative data in that the majority of the respondents indicating counselling women around depression and stigmatisation. Clearly stigma is still a barrier for disclosure in organisations that were represented in this study.

2. Establish HIV infected / affected women's perceptions of the role of EAP regarding their situation.	This objective was achieved through the presentation of a detailed discussion in Chapter 10, presenting the qualitative and quantitative findings of the study. The study explored the role of EAPs during difficulties experienced by women in the workplace in relation to HIV and AIDS. The established perception of women about an EAP is that an EAP is supportive at an individual level though counselling, practical help and through home visits. In the event where HIV programme is incorporated within the EAPs, training and awareness have been valuable. The findings have clearly showed that there EAP need to play a strategic role in the organisations, however much resources, skills and knowledge are needed to ensure that this happens. The strategic position needs to tackle issues such as discrimination and stigmatisation, which have been reported by women as barriers to their HIV disclosures. EAP has to be positioned strategically to ensure women have confidence in the service and feel supported enough to disclose their statuses.
3. To investigate the type of HIV and AIDS counselling offered by EAP practitioners.	Similarly to the above, this objective was achieved through qualitative and quantitative research of which the findings are presented in Chapter 10. Women receive face-to-face counselling which focuses on psychological empowerment, home visit support and bereavement counselling. The practitioners have provided individual counselling, couple counselling and crisis intervention as part of EAP to women infected and affected by HIV and AIDS. The counselling offered

	was provided through internal and external EAP models.
4. To recommend intervention strategies for the workplace relevant to vulnerable women who are affected by HIV and AIDS.	This objective was achieved through a detailed presentation of the conclusion, summary and recommendations in Chapter 10. The recommendations presented are a collaboration of women's *verbatim* inputs, recommendations from EAP practitioners, the researchers' analysis of research recommendations and input drawn from literature reviews. The key results here is that EAP should continue to offer counselling to employees. This researcher has proposed an integrated model which will focus not only on counselling but on empowering women through already existing programmes, incorporating three diseases, HIV/AIDS, tuberculosis and malaria in the effort to destigmatise HIV and AIDS. EAP to be professionalized to ensure EAP principles are standardised, monitored and evaluated. Partnership through business, academics and community forums to fight the scourge of HIV and AIDS. EAP to incorporate spiritual, cultural and scientific processes in supporting employees in the workplace.

10.8 CLOSING REMARKS

No words can adequately portray the impact of the HIV and AIDS pandemic on economic growth, developmental prospects, political stability, and generally on the lives of people around the world. HIV is a chronic health condition. Just like any other chronic health condition, lack of management of the condition can lead to death. HIV however, has become a pandemic that has been complicated by stigmatisation and discrimination. Workplace efforts to mitigate the scourge of HIV and AIDS have

necessitated multi-level strategies, including EAP interventions. An EAP is a workplace programme that has over the years proven to assist workplaces with interventions for troubled employees.

Employees infected and affected by HIV and AIDS are equally troubled in the workplace, and EAPs have played an important role in addressing their needs and difficulties. Little has been done to address specific needs of women infected and affected by HIV and AIDS. However, EAP efforts have been made to assist all employees irrespective of gender, as clearly seen in the research results. The majority of the responses, both qualitative and quantitative, indicated that the EAP is addressing the needs of infected and affected employees through education and awareness training and disease management programmes.

Given the level of stigmatisation that still exists in the workplace, HIV programmes should continue to address employees' needs and difficulties from this perspective with specific understanding and acknowledgement of the fact that women are more affected and are specifically vulnerable to HIV infection. From a micro perspective, EAPs should empower women to take responsibility for their own health. From a macro perspective level, workplace programmes should encourage management input to have an integrated EAP and HIV and AIDS programme.

As this was a first level study on women, HIV and AIDS and EAPs, there is a need to build on this study and research the interrelationship further. This study could not particularly establish that women's difficulties are definitely due to the fact that they were women, but instead, there was a strong link found between these difficulties and HIV and AIDS.

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APPENDIX 1

SEMI-STRUCTURED INTERVIEW (WORKING WOMEN)

INTERVIEW SCHEDULE FOR HIV AND AIDS INFECTED AND AFFECTED WORKING WOMEN

Section A – Biographical Information

1. How old are you? ……

2. What is you race group? ……

3. What is your job level? .....

Section B

Difficulties experienced by women infected or affected by HIV and AIDS

4. HIV AND AIDS is a disease that is not clearly talked about in the communities and workplace. Kindly share with me you personal difficulties, feeling and experiences in your workplace as an HIV infected or affected woman?

……
……
……
……
……

5. Have you ever missed work due to HIV and AIDS related difficulties? If so how did that make you feel?
.....
.....
.....
.....
6. What will make it easier for you to cope with your difficulties relating to HIV and AIDS in your workplace?

……
……
……
……

Section C - The role of EAP

EAP is a confidential Programme that offers help to employees when they have personal or work related problems.

7. Have you ever used EAP for HIV and AIDS related difficulties?

……
……
……
……..
8. What role (if any) does EAP play in supporting HIV and AIDS infected and/or affected women in your company?

……
……
……
……
……
……

9. How does EAP address your needs as an employee who is HIV infected? **Applicable to those infected only.**

……
……
……
……
……

10. How does EAP address your needs as an employee who is HIV and AIDS affected? **Applicable to those affected only.**

……
……
……
……
……

11. What kind of experiences (positive and /or negative) have you had in using EAP in your company?

……
……
……

12. What impact did the experiences you outlined (under 11 above) have on your overall perception of EAP in your company?

……
……
……
……

13. What improvements (with specific reference to HIV and AIDS) would you like to see in the running of EAP for women in your company?

……
……
……
……

14. Any additional comments?

……
……
……
……
……

Thank you for taking the time to respond to these questions

APPENDIX 2

STRUCTURED QUESTIONNAIRE (EAP PRACTITIONERS)

THE ROLE OF THE EAP IN ADDRESSING THE DIFFICULTIES EXPERIENCED BY WORKING WOMEN RESULTING FROM THE IMPACT OF HIV AND AIDS.

QUESTIONNAIRE TO EAP PRACTITIONERS

Permission for your participation in this study has been granted by the EAPA President. The researcher guarantees all participants that information collected will solely be used for the purpose of this study. You are guaranteed that the information will not be used in a manner that will be damaging to you or your company. It will solely be used to enhance programme management. You are therefore requested to answer the questionnaire with honesty, and to the best of your knowledge.

It will take you about twenty minutes to complete this questionnaire. The questionnaire is divided into 5 sections. Please complete the appropriate section by marking your response with an X in the space provided.

Thank you, for your time in completing this questionnaire.

PARTICIPANT INFORMATION:

1. Respondent number	**For Office Use**

SECTION A

2. How old are you?.....years

3. Position

HIV & AIDS coordinator/manager	1
EAP coordinator/practitioner/consultant	2
Human resources officer	3
EAP private practitioner/affiliate	4
Other, specify	5

4. Level

Senior manager	1
Middle management	2
Specialist	3
Affiliate	4
Other, specify	5

5. Gender

Male	1
Female	2

6. EAP Model

In-house	1
Out-sourced	2
Mixed	3

7. What is your religious affiliation

Christian	1
African believe	2
Islam	3
None	4
Other, specify	5
Not sure	6

8. How long have you been offering EAP?.....years

9. What are your HIV and AIDS work experiences?.....years

SECTION B: THE ROLE OF EAP
This section investigates the role of EAP with regard to women with HIV and AIDS in the workplace

10. What kind of EAP services do you offer?

counselling	1
coordination	2
Case management	3
Training	4
Other, specify	5

11. What is the HIV and AIDS % in your workplace? ……..

12. Does your workplace have HIV and AIDS programme?

Yes	1
No	2
Uncertain	3

13. If you answered 'yes' above, what does your HIV and AIDS workplace programme offer to manage HIV AND AIDS?

	Yes	No	Uncertain
Counselling	1	2	3
Education	1	2	3
Gender equity awareness	1	2	3
Training	1	2	3
Disease management	1	2	3
None	1	2	3
Other, specify			

14. Who conducts or facilitates the HIV and AIDS trainings / workshop?

EAP practitioner/consultant	1
Private HIV and AIDS consultant	2
HIV and AIDS manager/coordinator	3
None	4

These questions probe the visibility of EAP with regards to HIV and AIDS

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
15. HIV & AIDS policy is integrated with other wellness policies and programmes.	1	2	3	4	5
16. There is an established HIV & AIDS committee.	1	2	3	4	5
17. EAP plays a major role in HIV & AIDS prevention and support programmes.	1	2	3	4	5
18. Management sees the HIV & AIDS workplace programme as part of their responsibilities.	1	2	3	4	5
19. The relevant unions are actively involved in HIV & AIDS workplace programme.	1	2	3	4	5

21. The Percentage of HIV and AIDS in your company is highest among?

Males	1
Females	2
Both	3

22. Does EAP address the needs of women who are **HIV infected** through the following?

	Yes	No
Counselling	1	2
Education workshops	1	2
Support group	1	2
Reasonable accommodation regarding leave and work time	1	2
Refer for services	1	2
Other, specify	1	2

If you answered yes for other, please specify what kind?
……
……

23. Does EAP address the needs of women who are **HIV affected** through the following?

	Yes	No
Counselling	1	2
Education workshops	1	2
Support group	1	2
Reasonable accommodation regarding leave and work time	1	2
Refer for services	1	2
Other, specify	1	2

If you answered yes for other, please specify what kind?
……
……

24. Does you company have an approved HIV and AIDS policy?

Yes	1
No	2
Uncertain	3

25. Does your HIV and AIDS programme give specific reference to gender issues?

Yes	1
No	2
Uncertain	3

26. Are HIV and AIDS activities communicated throughout the company?

	Yes	No
EAP office	1	2
Workshops	1	2
Notice boards	1	2
Education and training	1	2
email	1	2
Pamphlets	1	2
Posters	1	2
Use of People living with AIDS	1	2

27. Are you satisfied with the utilization of the HIV and AIDS programme in your workplace?

Yes	1
No	2
uncertain	3

28. After assisting women infected and affected with HIV and AIDS, what are their responses when asked whether they would recommend EAP to anyone?

Yes	1
No	2
Uncertain	3

SECTION C:
This section probes the difficulties experienced by HIV and AIDS infected and affected working women

29. What are the difficulties experienced by women **infected with HIV?**

	Yes	No	Uncertain
Lack of care and support in the workplace	1	2	3
Lack of care and support at home	1	2	3
Lack of understanding by Managers	1	2	3
Lack of awareness	1	2	3
Lack of education	1	2	3
Stigma	1	2	3
No provision of antiretrovirals	1	2	3
Other, specify			

30. What are the emotional difficulties experienced by women **infected** with HIV?

	Yes	No	Uncertain
Depression	1	2	3
Loneliness	1	2	3
Rejection	1	2	3
Denial regarding their status	1	2	3
Fear of dying	1	2	3
Other, specify			

31. What are the difficulties experienced by women **affected** with HIV and AIDS?

	Yes	No	Uncertain
Mental health issues (depression, bereavement, etc)	1	2	3
Insufficient care and support in the workplace	1	2	3
Lack of care and support at home	1	2	3
Lack of understanding by managers	1	2	3
Lack of awareness	1	2	3
Lack of education	1	2	3
Stigma	1	2	3
Rejection	1	2	3
Other, specify	1	2	3

32. How do women with HIV in your workplace deal with difficulties related to their illness?

Stay home	1
Go to the gym	2
Consult EAP for counselling	3
Consult traditional healer	4
Consult spiritual leader	5
Do not know	6

33. How do women infected and affected by HIV and AIDS access EAP?

Face to face counselling on site	1
Office off site, but still in walking distance	2
Public transport to EAP centre	3
Telephone contact	4
Home visits by the EAP practitioners	5

34. Do employees voluntarily accept the use of EAP?

Yes	1
No	2
Uncertain	3

35. Do **HIV infected** women generally use EAP in your workplace?

Yes	1
No	2

36. Do women **affected** by **AIDS** generally use EAP in your workplace?

Yes	1
No	2

37. What type of referral is mostly noted by EAP regarding women infected and affected by HIV and AIDS?

Voluntary (self referral)	1
Informal referral (friend or family member)	2
Mandatory referral (management)	3

38. Do women with HIV & AIDS have trust and confidence in the EAP?

Yes	1
No	2
Uncertain	3

39. If you answered no, what are the reasons indicated by women regarding their answer?

EAP has no confidentiality	1
EAP practitioner lacks empathy	2
No advocacy for the employees infected and affected with HIV & AIDS	3
Do not know	4

40. What are the perceptions of infected and affected women regarding EAP support?

Satisfied	1
Not satisfied	2
Do not know	3

41. If you answered satisfied above please answer the following.

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
42. There is adequate support for employees, with HIV & AIDS.	1	2	3	4	5
43. The EAP committee has enough knowledge about the needs of women regarding HIV & AIDS.	1	2	3	4	5
44. EAP practitioner has adequate skills and knowledge on HIV & AIDS issues	1	2	3	4	5
45. Women with HIV & AIDS find it easy to disclose their statuses.	1	2	3	4	5
46. The EAP encourages HIV & AIDS disclosure.	1	2	3	4	5

SECTION D: STRATEGIC PLANNING

EAP and HIV/AIDS Management

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
47. HIV & AIDS is successfully incorporated.	1	2	3	4	5
48. The EAP has well-defined HIV & AIDS goals.	1	2	3	4	5
49. The EAP has a well-defined program for women infected and affected with HIV & AIDS.	1	2	3	4	5
50. The EAP gives regular feedback to managers about the scourge of HIV & AIDS in the company	1	2	3	4	5
51. There is proper alignment of HIV & AIDS programme and departments	1	2	3	4	5

The Role of Management in HIV and AIDS Programme

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
52. Management has sufficient understanding of the HIV & AIDS workplace programme due to EAP.	1	2	3	4	5
53. Management sees the importance of gender issues regarding HIV & AIDS in the workplace programme.	1	2	3	4	5
54. Management are encouraged by the EAP to see the HIV & AIDS workplace programme as part of their responsibilities.	1	2	3	4	5
55. Management has sufficient understanding of the difficulties of women infected with HIV & AIDS experience.	1	2	3	4	5
56. Management has consistently shown on-going commitment to HIV & AIDS programmes for women.	1	2	3	4	5
57. Management constantly reviews human resources policies and practices in relation to HIV & AIDS.	1	2	3	4	5
58. Management reviews human resources policies and practices in relation to gender equity	1	2	3	4	5
59. Management prioritizes HIV & AIDS in the drawing up of departmental budgets.	1	2	3	4	5
60. EAP has established mechanism to monitor the statistics of women infected and affected by HIV & AIDS.	1	2	3	4	5
61. Management stands against discrimination of employees on the basis of HIV status.	1	2	3	4	5

SECTION E: LEADERSHIP

62. Do you think the EAP has the necessary **capacity** to manage the HIV & AIDS programme?

Yes	1
No	2
Do not know	3

63. Do you think the EAP has necessary **resources** to manage the HIV & AIDS programme?

Yes	1
No	2
Do not know	3

64. Which of these best describes your programme needs? (**Tick box of choice for each of the variables).**

	Yes	No	Do not know
skills	1	2	3
Knowledge	1	2	3
Resources	1	2	3
Support	1	2	3
Other, specify			

65. What **positive experiences** (if any) have you had in offering HIV & AIDS counselling through EAP? …….. ……. 66. What **negative experiences** (if any) have you had, in offering HIV & AIDS counselling through EAP? ……. ……. 67. What improvements (with specific reference to HIV & AIDS) would you **recommend** in the running of EAP for women in your company? …… …… …….	

Thank you for taking the time to respond to these questions

APPENDIX 3

LETTER OF INFORMED CONSENT (WORKING WOMEN)

Faculty of Humanities
Department of Social Work and Criminology
Fax 012 420-2093 Tel 012 420-2325

INFORMED CONSENT FORM TARGET GROUP:WORKING WOMEN

Participant's Name: …….. Date: …….

Informed Consent

1. ***Title of Study: The role of the Employee Assistance Programme (EAP) in addressing the difficulties experienced by working women resulting from the impact of HIV and AIDS.***
2. **Principal Investigator:** Tumi Jantjie, University of Pretoria, Pretoria
3. **Purpose of the study:** To investigate the role of EAP in addressing the problems experienced by working women who are infected and affected by HIV and AIDS in Gauteng.
4. ***Procedures:*** In this study, you will be asked questions about your age, your work history, family history, health history, your feeling and concerns about EAP services provided at your workplace. The interview will be recorded and will take 45 minutes. This interview will be scheduled at your own convenient time and place.
5. ***Risks and Discomforts:*** *You may feel uncomfortable being interviewed and may start crying but you will be afforded rest and breaks as much as you want. You will not be pressurized to answer any question that makes you uncomfortable.*
6. ***Benefits:*** There are no direct medical benefits but you are afforded a chance to talk about your condition with another EAP practitioner. The study will help researcher to gain a better understanding of the role of EAP in HIV and AIDS counselling.
7. ***Participant's Rights:*** You may withdraw from participating in this study at any time. You are free not to answer any question that makes you uncomfortable. Your refusal to participate will in no way jeopardize your future participation or use of the EAP in your workplace.

8. ***Confidentiality:*** The result of the interview will not be identified by your name or company. The result may be published in professional journal or presented at professional conferences but your identity will not be revealed at any time.

9. ***Persons to contact: If you want to*** **talk to anyone about this research study because you think you have not been treated fairly or think you have been hurt by participating in the study, or you have any other questions about the study, you should call the principal investigator, Tumi Jantjie at 083 7972455 any time during the day or night time or the promoter, Prof L S Terblanche at 012 420 3292.**

I ……., understand my rights as a researcher subject, and I voluntarily consent to participation in this study, I understand what the study is about and how and why it is being done. I will receive a signed copy of this consent form.

_____ _____
Subject's Signature **DATE**

_____ _____
Witness to Consent if Unable to Read or write **DATE**

_____
Signature of Investigator

APPENDIX 4

LETTER OF INFORMED CONSENT (EAP PRACTITIONERS)

Faculty of Humanities
Department of Social Work and Criminology
Fax 012 420-2093 Tel 012 420-2325

INFORMED CONSENT FORM TARGET GROUP: (EAP Practitioners)

Participant's Name: …….. Date: 8/09/2005

Informed Consent

1. ***Title of Study: The role of the Employee Assistance Programme (EAP) in addressing the difficulties experienced by working women resulting from the impact of HIV and AIDS.***
2. **Principal Investigator:** Tumi Jantjie, University of Pretoria, Pretoria
3. **Purpose of the study:** To investigate the role of EAP in addressing the problems experienced by working women who are infected and affected by HIV and AIDS in South Africa.
4. ***Procedures:*** You will be given a questionnaire about your feelings/attitudes about HIV and AIDS counselling in the workplace. The questionnaire will take 20 minutes to be completed.
5. ***Risks and Discomforts:*** *N*o known medical risks or discomforts are associated with the completion of this questionnaire.
6. ***Benefits:*** The results of this study will help the EAP practitioners to understand their expected roles in dealing with HIV and AIDS infected/affected women in the workplace.
7. ***Participant's Rights:*** You may withdraw from participating in this study at any time.
8. ***Confidentiality:*** The result of the questionnaire will not be linked to your name or the company where you are employed. The results may be published in a professional journal or presented at professional conferences but your identity will not be revealed at any time.
9. ***Persons to contact: If you want to*** **talk to anyone about this research study because you think you have not been treated fairly or think you have been hurt by participating in the study, or you have any other questions about the study, you should call the principal investigator, Tumi Jantjie at 083 7972455 any time during the day or night time or my promoter, Prof. L S Terblanche at 012 420 3292.**

I ……, understand my rights as a researcher subject, and I voluntarily consent to participation in this study, I understand what the study is about and how and why it is being done. I will receive a signed copy of this consent form.

_____ _____

Subject's Signature **DATE**

_____

Signature of Investigator

APPENDIX 5

LETTERS TO EAPA AND TSA-BOSOGO CENTRE

14 January 2004

P.O.Box 2455

Rivonia

2128

The EAPA President
Private Bag 11166
Hatfield
0028
South Africa

Re. Permission to Conduct Research on EAPA members

My name is Tumi Jantjie. Ph.d Student registered with Pretoria University in the Department of Social Work. I'm currently conducting research with the title " the role of EAP in addressing the difficulties experienced by working women resulting from the impact of HIV and AIDS". This letter serves as a request to be able to conduct both a pilot and research study using your members as subjects in the study.

Sincerely

Tumi Jantjie

0837972455

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

14 January 2004

P.O.Box 2455

Rivonia

2128

The CEO
Tsa- Botsogo Centre
132 Fox Street
East Wing Second Floor
Johannesburg CBD
South Africa

Re. Permission to Conduct Research on your Members

My name is Tumi Jantjie. Ph.d Student registered with Pretoria University in the Department of Social Work. I'm currently conducting research with the title " the role of EAP in addressing the difficulties experienced by working women resulting from the impact of HIV and AIDS". This letter serves as a request to be able to conduct both a pilot and research study using your members as subjects in the study.

Sincerely

Tumi Jantjie

0837972455

APPENDIX 6

EAPA CONSENT LETTER

INTERNATIONAL EAP ASSOCIATION
LABOR • MANAGEMENT • CONSULTANTS
SOUTH AFRICA CHAPTER

PRESIDENT: P.A.Bhoodram; V.PRESIDENT:N. Motloung; SECRETARY: P.Masango
Tel: (012) 420 4848; Fax: (012) 420 2093; Cell: 083 247 9908; E-mail: pmasango@postino.up.ac.za

EAPA SA
P. O. BOX 11166
Hatfield
0028

2004-02-02

TO WHOM IT MAY CONCERN.

This serves to confirm that Tumi Jantjie is authorised to interview EAP practitioners that are registered with EAPA SA. This will be done with their informed consent and confidentiality will be maintained at all times.

Kind regards

P.A.Bhoodram
PRESIDENT: EAPA SA

APPENDIX 7

TSA- BOTSOGO CONSENT LETTER

QuickTime™ and a
decompressor
are needed to see this picture.

APPENDIX 8

UTHINGO CONSENT LETTER

APPENDIX 9

UNITED NATIONS DECLARATION OF COMMITMENT

Table 3: United Nations Declaration of Commitment

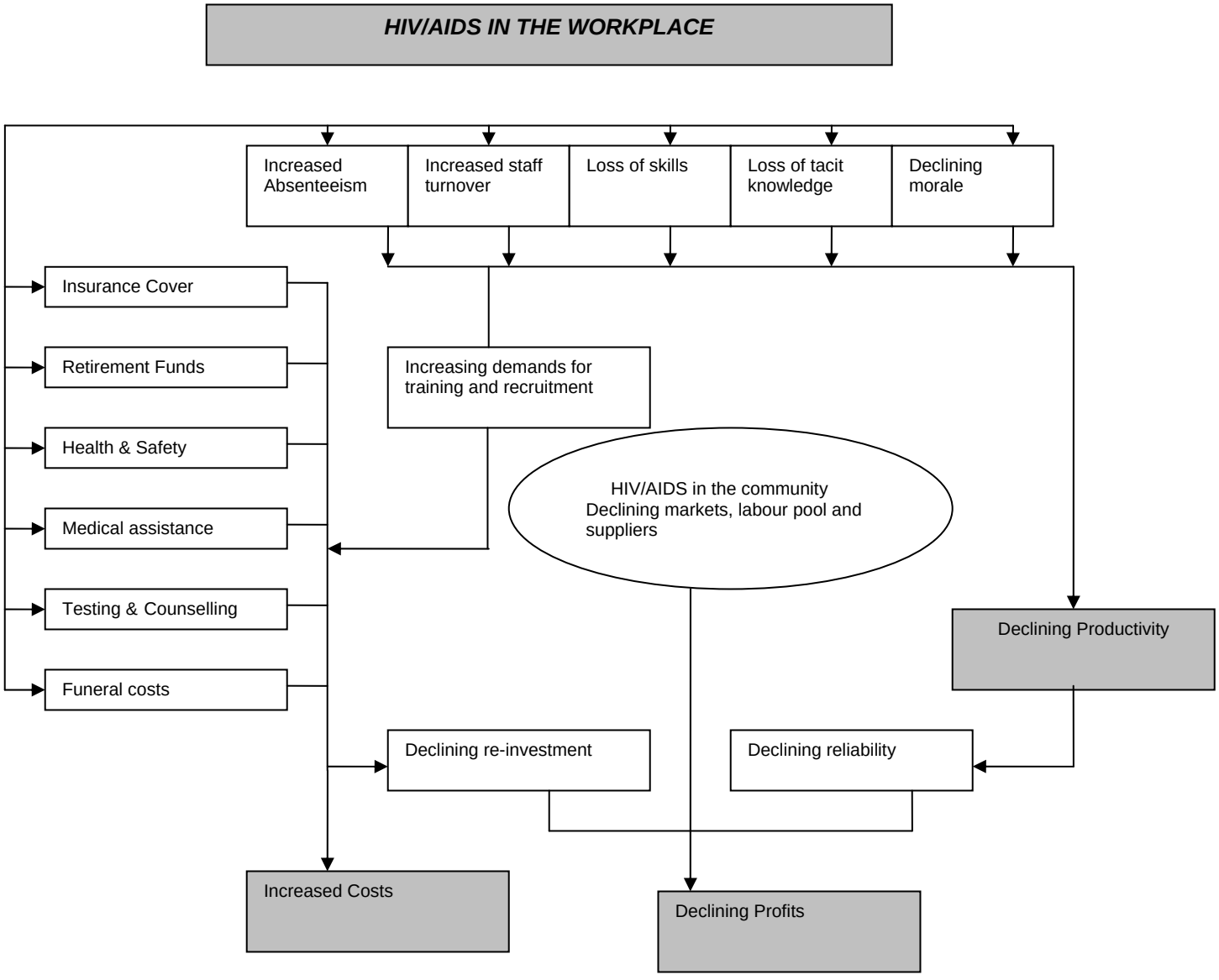
- **Promote advancement of women and their human rights**
- **Promote shared responsibility of men and women to ensure safer sex**
- **Empowering women control relating to their sexuality including protecting themselves from HIV infection**
- **Provide adequate access to health care services including reproductive health care services**
- **Provide prevention of infection that promotes gender equality within a culturally and gender sensitive framework**
- **Eliminate all forms of discriminations and violence against women and girls, including harmful traditional and customary practices**
- **Addressing factors that increase vulnerability to HIV infection such as underdevelopment, economic insecurity, poverty discriminations social exclusions illiteracy and all types of sexual exploitation of women, girls and boys.**
- **Recognizing the importance of the family in reducing vulnerability to HIV infection**
- **Ensuring safe and secure environments, free of violence and rape, especially for your girls**
- **Expanding youth-friendly information and sex education**
- **Strengthening reproductive and sexual programmes**
- **Provide special assistance to children orphaned by HIV and AIDS**

UNAIDS, June 2001

APPENDIX 10

CORPORATE HIV AND AIDS IMPACT

Figure 36: Corporate HIV AND AIDS Impact

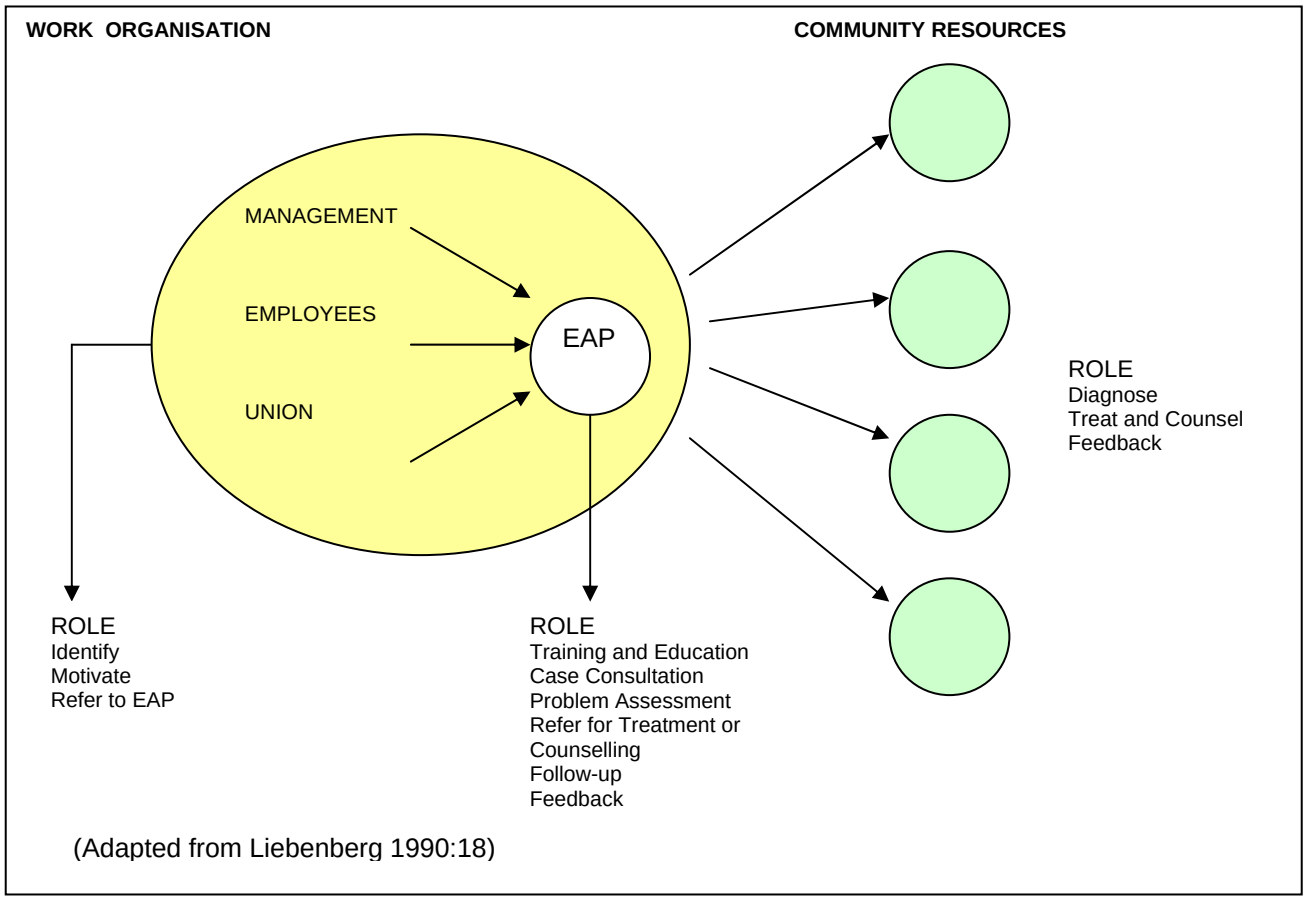


(Adapted from UNAIDS, 2000)

APPENDIX 11

INTERNAL EAP MODEL

Figure 37: Internal EAP Model

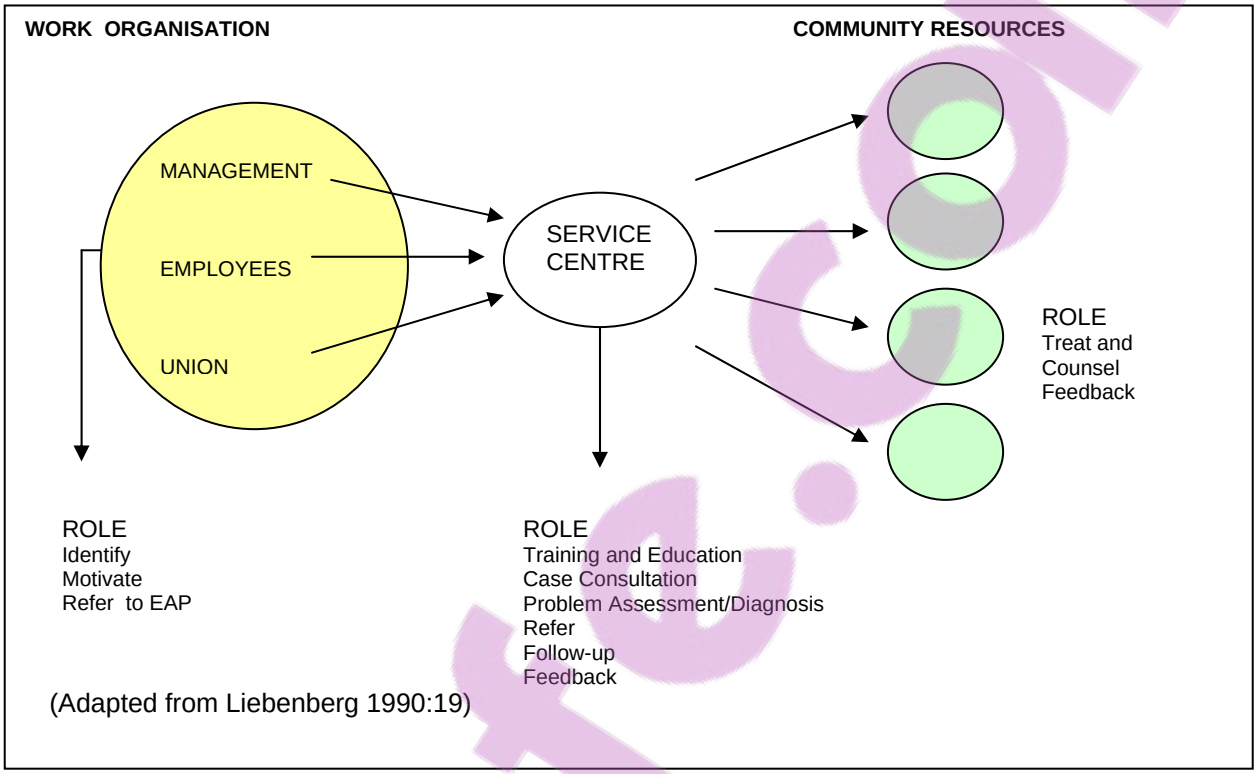


(Adapted from Liebenberg 1990:18)

APPENDIX 12

EXTERNAL EAP MODEL

Figure 38: External EAP Model

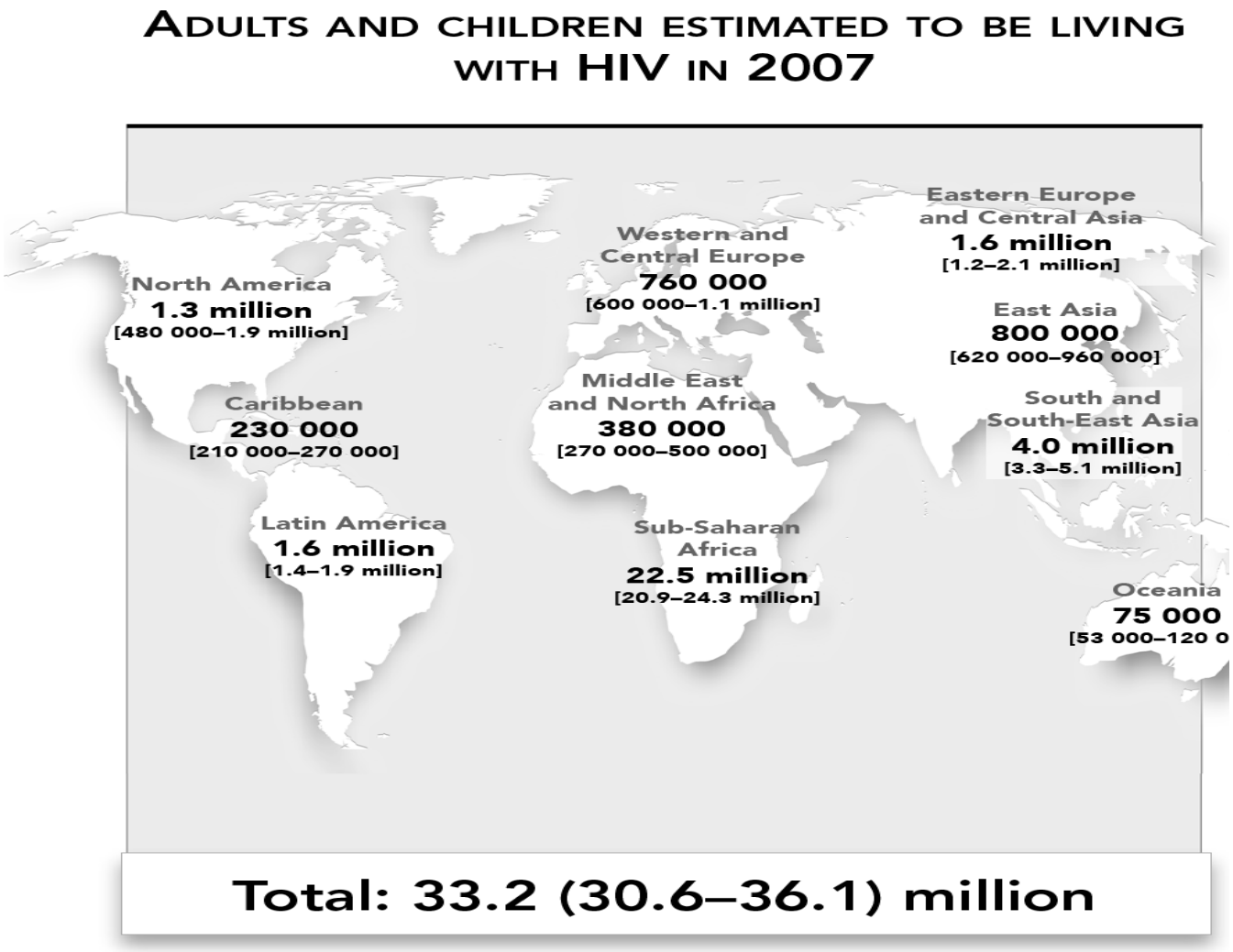


(Adapted from Liebenberg 1990:19)

APPENDIX 13

ADULTS AND CHILDREN LIVING WITH HIV IN 2007

Figure 39: Map of Adults and Children Living with HIV (2007)



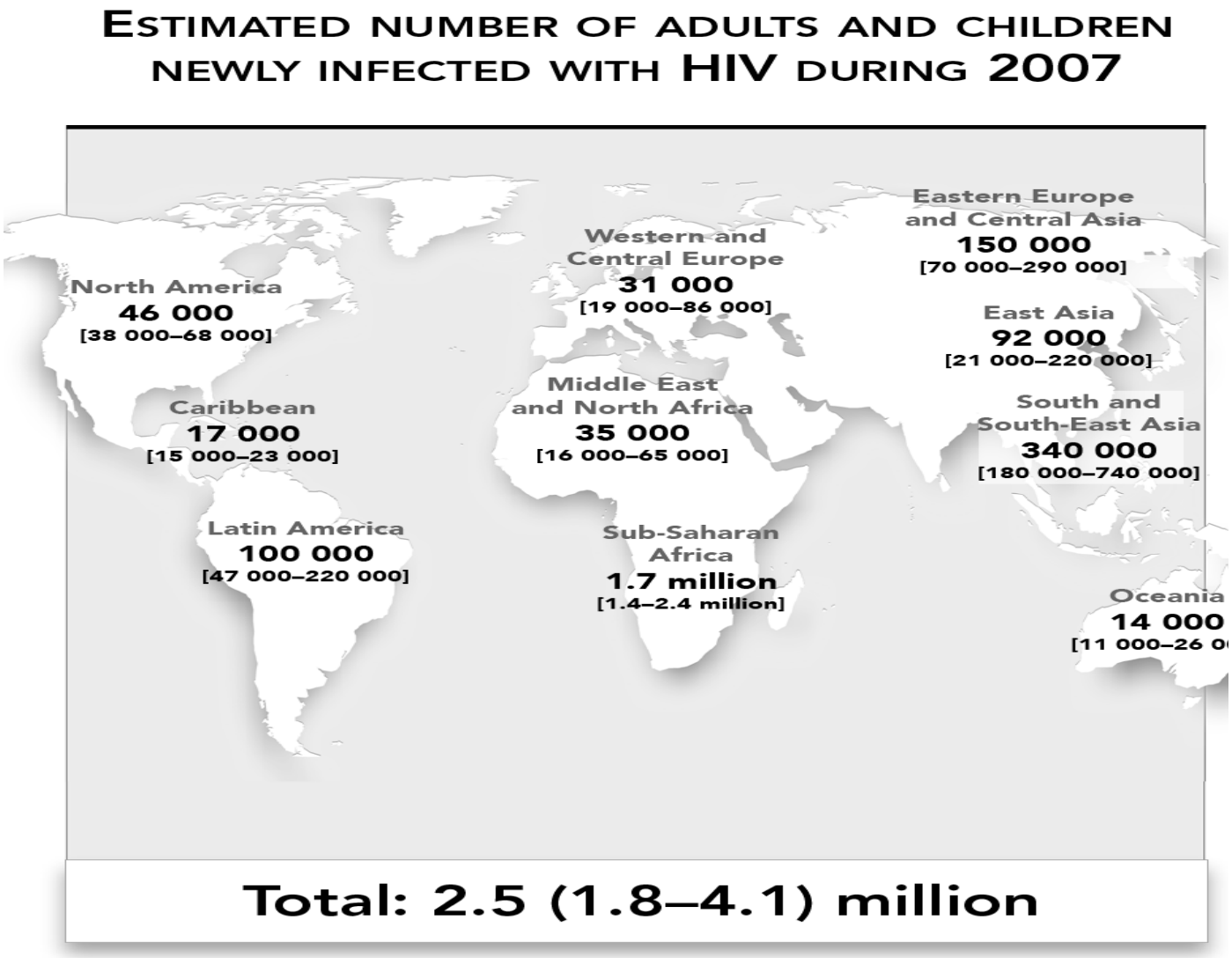
UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

World Health Organization

APPENDIX 14

NEW INFECTIONS OF ADULTS AND CHILDREN WITH HIV DURING 2007

Figure 40:: Map of New infections of Adults and Children with HIV during 2007



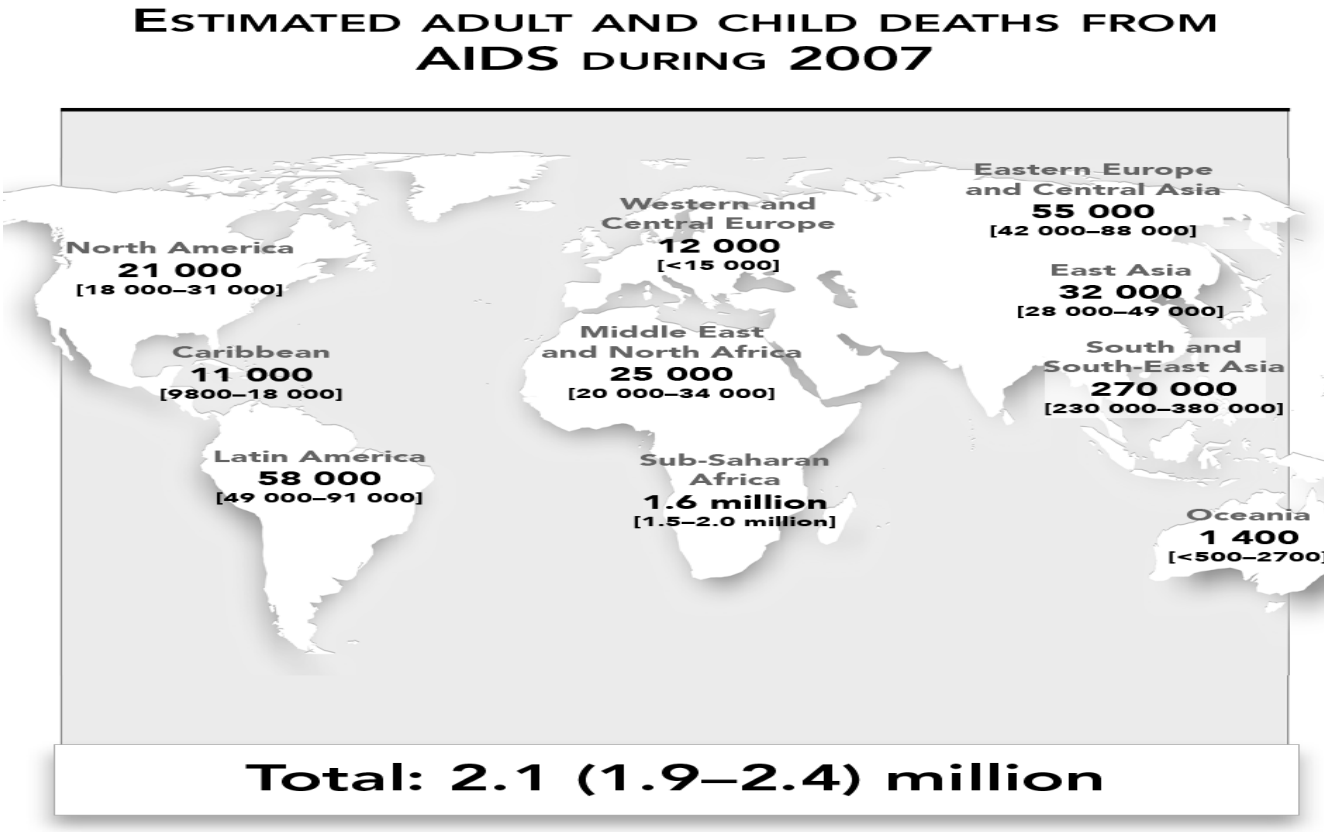
UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

World Health Organization

APPENDIX 15

ESTIMATED ADULT AND CHILD DEATHS FROM AIDS DURING 2007

Figure 41: Map of Estimated Adult and Child Deaths from AIDS during 2007



UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

World Health Organization