

**EVALUATION OF THE IMPLEMENTATION OF AN HIV/AIDS
WORKPLACE POLICY FOR FARM WORKERS: A CASE
STUDY OF
COUNTRY MUSHROOMS**

by

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DECLARATION

I, Monnakgotla Nakedi Margaret (student no 045775-66), declare that *EVALUATION OF THE IMPLEMENTATION OF AN HIV/AIDS WORKPLACE POLICY FOR FARM WORKERS: A CASE STUDY OF COUNTRY MUSHROOMS* is my own work, and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references, and that this work has not been submitted before for any other degree at any other institution.

SIGNATURE

15 FEBRUARY 2012

DATE

SUMMARY

Farm workers in South Africa have limited access to health care and health-related information. In this qualitative study, the implementation of a workplace HIV/AIDS policy was evaluated using data gathered through interviews and observation. It was found that, although the farm workers were knowledgeable about HIV and AIDS, this knowledge was insufficient. It was found that the lives of farm workers are deeply affected by HIV and AIDS. . It is also suggested that the agricultural sector is not yet able to deal effectively with HIV and AIDS and that, in this regard, urgent planning is needed in respect of HIV and AIDS policies and interventions.

KEYWORDS

Discrimination, epidemic, evaluation, farm workers, HIV and AIDS, implementation, policy, qualitative research, stigma, and VCT

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LIST OF ACRONYMS AND ABBREVIATIONS

AgriAIDS	Agricultural AIDS Organisation
AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral
AVERT	Averting HIV and AIDS – an international charity organisation
CD4	“Helper” T-lymphocytes in human blood
DOA	Department of Agriculture
DoH	Department of Health
EAP	Employee assistance programme
FAO	Food and Agriculture Organization of the United Nations
GDP	Growth Development Plan
HIV	Human immunodeficiency virus
HR	Human resources
HSRC	Human Sciences Research Council
ILO	International Labour Organization
IOM	International Organization for Migration
NGO	Non-governmental organisation
PEPFAR	President’s Emergency Plan for AIDS Relief
PHAMSA	Partnership on Mobility and HIV in Southern Africa
SABCOHA	South African Business Coalition on HIV and AIDS
SAMP	Southern African Migration Project
Sida	Swedish development agency
STIs	Sexually transmitted infections
TAG	Technical assistance guidelines
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNISA	University of South Africa
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing

WHO World Health Organization

CHAPTER 1: BACKGROUND TO THE STUDY

1.1 INTRODUCTION

Until recently, HIV and AIDS were considered mainly as health issues instead of as a developmental concern affecting social and economic life and the welfare of a society. HIV and AIDS cross social, political, religious, cultural and international borders. The manner in which societies organise and reproduce themselves have been, and continue to be, affected by the changing structure of populations with such changes being caused partly by the effects of HIV and AIDS (Webb & Bain 2011). South Africa has been severely affected by the HIV and AIDS epidemic and the agricultural sector is no exception (Zvomuya 2005). The South African government, through the Department of Health (DoH), has realised that there is a need to address the challenges posed by the epidemic in the various government sectors.

The global HIV infection rate estimate at the end of 2010 was over 40 million people with most AIDS-related deaths occurring in sub-Saharan Africa (UNAIDS 2010:2). In particular, the HIV epidemic is spreading rapidly among the youth and adults of working age (FAO 2009: 1–2). According to the World Health Organization (WHO) and the Joint United Nations Programme on HIV and AIDS (UNAIDS 2008), the estimated number of deaths in Southern Africa due to AIDS-related illnesses among people aged 15 to 34 years will be 1,8 million between the years 2010 and 2015 (AVERT 2007).

Alan Gelb (quoted in UNAIDS 2008), a World Bank economist for Africa, is of the opinion that the effect of HIV and AIDS has been even more devastating than the statistics suggest. He maintains that the economies of countries have been severely affected, as HIV and AIDS leads to increased mortality among young adults of economically productive ages and results in severe shortages of skilled person-power.

Despite extensive efforts on the part of the South African government to inform the public about the risks of HIV and AIDS, it would appear that behavioural changes are not occurring as expected (DoH 2008). For several years, and especially from 1993 to

2000, the HIV and AIDS epidemic in South Africa has gone unchecked as a result of the distraction of the political changes taking place in the country. Accordingly, valuable time has been lost during which prompt action and acknowledgement of the impact of the epidemic may, potentially, have lessened the severity of the epidemic (AVERT 2007). Combating the spread of new HIV infections relies, in part, on the correct implementation of prevention policies and programmes at both national and provincial levels.

1.2 BACKGROUND

The exact rate of HIV infections among South African farm workers is unknown because of this group's high mobility and their short stays on the farms where they work (FAO 2009:14). Farm workers are rarely able to access health services and, in addition, HIV and AIDS information campaigns which are specifically targeted at them are infrequent (FAO 2009:14).

According to the FAO (2009:1–4), South Africa is estimated to have lost seven million farm workers to HIV and AIDS since 1985. An estimated 15,7% of the farm workers employed in the Free State, Mpumalanga, KwaZulu-Natal and the North West were living with HIV in 2004 (FAO 2009:10). This implies that a high numbers of farm workers will be lost to AIDS-related deaths, will become too ill to work or will neglect their jobs in order to deal with family crises arising from the epidemic.

An impact assessment carried out in Kenya (Kenyan Ministry of Agriculture 2006), suggests that agricultural workers may have to resign from their jobs as a result of HIV and AIDS. The report also indicates that there will be a loss of skilled and experienced labour because of the HIV and AIDS epidemic and that more workers will have to be trained to keep up with the labour demand.

Within the context of HIV and AIDS, the South African Department of Agriculture (DOA) sees its responsibility to minimise the social, economic and developmental

consequences of HIV and AIDS within the sector by providing the leadership necessary to implement an HIV and AIDS policy (DOA 2008:4–6). One of the steps taken by the DOA has been to protect the rights of agricultural workers and other rural dwellers infected by HIV and also affected by HIV and AIDS.

The DOA's Communication Strategy (2008) is intended for all agricultural-sector workers throughout the country. The aim of the policy is to provide a framework for managing the impact of HIV and AIDS on the agricultural community. According to the DOA's Communication Strategy (2008:2), each farming sector should be responsible for setting up a farm workers' HIV and AIDS policy that maintains the minimum standards in accordance with the National HIV and AIDS policy.

The DOA's Communication Strategy (2008) for farm workers specifies the following:

- Farm workers and other rural dwellers have the right to equality.
- Confidentiality should be maintained for members whose HIV status is known and for those who voluntarily test and disclose.
- A non-discriminatory working environment should be created to ensure the ability to deal with HIV and AIDS in a sensitive and humane manner.
- Measures to prevent the spread of HIV infections should be put in place.
- Those individuals who are infected with HIV and affected by HIV and AIDS should be supported so that they may continue to work productively for as long as possible. Strategies to assess and reduce the impact of the epidemic in the workplace should be developed.

The policy further relies on the following Code of Good Practice (ILO 2007:4-32):

- All employers and employees and their respective organisations are encouraged to develop, implement and refine their HIV and AIDS policies and programmes to suit the needs of their workplaces.
- HIV and AIDS impact disproportionately on women and this should be taken into account in the development of workplace policies and programmes.

The DOA further stated (2008) that all registered farmers are to develop and implement their own HIV and AIDS policies and that these policies must be consistent with the Constitution of South Africa and the National HIV and AIDS policy.

According to the UNAIDS (2008:14), common problems identified by the DOA concerning the implementation of HIV and AIDS policies and programmes include the following:

- No appropriate training, awareness and educational programmes are provided for farm workers.
- The workload of HIV-infected workers is not taken into account.
- Farm workers who are infected with HIV and AIDS do not receive compensation to help them meet their medical expenses and they are also not placed in community programmes.

1.3 THE PROBLEM STATEMENT AND PURPOSE OF THE STUDY

In South Africa, HIV and AIDS threaten to have a severe effect on the pool of skilled and experienced farm workers, thus lowering morale and reducing productivity (FAO 2009). This study focuses on the way in which the farm workers deal with the implementation of HIV and AIDS policies and, in particular, the experiences of HIV-positive farm workers. It is, therefore, the aim of this study to discuss whether farm workers are aware of any policies in the workplace concerning HIV and AIDS. The study also aims to ascertain the extent to which they are involved in the implementation of the policy.

It is the purpose of this study to describe the knowledge and experiences of farm workers regarding workplace HIV and AIDS policies and programmes. The following questions were derived from this general purpose:

- Do farm workers have sufficient knowledge of HIV and AIDS to protect them against infection?
- Are new HIV infections prevented at farms as workplaces through information and training, and the implementation of universal methods aimed at protection against accidental exposure?
- Are farm workers living with HIV managed properly within the farming community?

1.4 RATIONALE FOR THE STUDY

Effective HIV and AIDS prevention programmes in the workplace are imperative for the future benefit of all South Africans. However, effective HIV and AIDS workplace policies, as well as the programmes, projects or other interventions stemming from such policies, depend on the participation and involvement of many different stakeholders. According to Tones and Tilford (1994:268–269), active community participation in workplace health promotion programmes empowers individuals both to achieve equity and to address inequalities. Both these factors (lack of empowerment and persistent inequality) are significant barriers to the realisation of health goals. The WHO (as quoted in Sidell, Jones, Katz, Peberdy & Douglas 2003:55) sees the engagement of farm workers in such programmes as an essential way of unlocking valuable knowledge, while UNAIDS (2008:16) argues that the success of HIV and AIDS workplace programmes is most likely to be maximised when such programmes are located within the broader community and social context, enabling and supporting health-enhancing behavioural changes.

Despite the importance of the involvement and participation of farm workers in workplace health promotion programmes, there is a lack of empirical evidence as regards the extent of the involvement required and the nature of any dilemmas encountered. Farm workers may have different reasons for participating in HIV and AIDS workplace programmes and these reasons may contribute to the success or

failure of such programmes. One of the challenges faced by HIV and AIDS policy makers is the way in which to evaluate such participation.

In view of the above, the rationale for this study was to investigate farm workers' knowledge of and involvement in the implementation of an HIV and AIDS workplace policy.

1.5 THE RESEARCH APPROACH SELECTED

A qualitative, exploratory research approach was selected and is directed at understanding the unique experiences of individuals in the social world by seeking to uncover shared meanings. Miles and Huberman (1994) maintain that qualitative research is relevant when the aim of the research is to study phenomena as they unfold in real-world situations. Accordingly, qualitative research seeks to uncover the meaning of social events and the processes based on the lived experiences from the social actors' point of view. Furthermore, since qualitative data is collected over a sustained period, this approach allowed the researcher to immerse herself in the daily world of the farm workers. Further details on the methodology selected for this study appears in Chapter 3.

1.6 THE SELECTED STUDY SITE

This research study was conducted at Country Mushrooms – a farm situated on the outskirts of Die Aalwyne Farm' in Bapsfontein, southwest of Bronkhorstspuit. Country Mushrooms was established in the 1980s and, since then, the farm has grown in size, as have most farms in the region. The farm's human capital has been severely affected by the impact of HIV and AIDS.

According to UNAIDS (2008), the impact of HIV and AIDS on the business sector may seriously hamper the ability of this sector to operate efficiently. A drastic decline in the effective labour supply could discourage foreign investment, and this would adversely affect South Africa's economic growth.

1.7 DEFINITIONS OF KEY CONCEPTS

A few related concepts are defined below, so that the assumptions made by the researcher and the general orientations of the study are made clear.

1.7.1 HIV and AIDS

HIV is an abbreviation for the term “human immunodeficiency virus”. This virus lives and multiplies in bodily fluids such as semen, vaginal fluids, breast milk, blood and saliva. HIV attacks the immune system and reduces the body’s resistance to all kinds of illness. It eventually weakens the body’s ability to fight sicknesses and causes death (Van Dyk 2005:4).

AIDS is an acronym for the term “acquired immune deficiency syndrome”. AIDS is a condition that causes the body’s defence system to become deficient, resulting in various life-threatening infections, known as opportunistic infections or diseases (Bayer & Fairchild 2006).

1.7.2 HIV and AIDS workplace programme

A workplace programme is an intervention aimed at addressing a specific issue within the workplace, for example, providing staff with access to a voluntary HIV counselling and testing programme. According to UNAIDS (2005:3), HIV and AIDS are critical workplace issues for many reasons, including the following:

- The stigma and discrimination associated with HIV and AIDS may threaten the fundamental rights of employees living with HIV.
- The loss of workers and their skills and experience may increase the burden on the remaining workforce, thus lowering morale and reducing productivity.

1.7.3 Qualitative data

Qualitative data consists of words and observations, and not numbers. Interpretations are required to bring order and understanding to the data. This process requires creativity, discipline and a systematic approach (Nelson, Treichler & Grossberg 1992).

1.7.4 Qualitative research

Qualitative research assumes that social reality is based on the definition and meanings that people ascribe to it, rather than being something that is externally present (Silverman 2005).

1.7.5 Implementation

Implementation is defined as a series of activities or steps which are undertaken in order to achieve a set of goals or missions (Swanepoel, Erasmus, Van Wyk & Schenk 2003:49).

1.8 CHAPTER LAYOUT

The dissertation is organised into the following chapters:

Chapter 1: Background information

Chapter 2: Literature review and theoretical background

Chapter 3: Research design and methodology

Chapter 4: Analyses of data

Chapter 5: Conclusions and recommendations

1.9 CONCLUSION

This chapter has introduced the reader to the research by providing a background to and rationale for the study. The purpose of the study, as well as the research problem statement, was discussed. A brief outline of the study site was presented and, finally, definitions of the terms used throughout this dissertation were provided.

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

South Africa is reported to be one of the countries with the highest number of people living with HIV and AIDS in the world (UNAIDS 2010). Dorrington, Johnson, Bradshaw and Daniel (2006) estimate that, during 2010, 5,7 million South Africans, 20% of whom were in the 20 to 64 year age group, were HIV positive, and that 380 000 people would have died of AIDS-related conditions by the end of 2010. Shisana, Rehle, Simbayi, Zuma, Jooste, Pillay-van-Wyk, Mbelle, *et al* (2009) report that there are an estimated 1 700 new HIV infections per day in South Africa.

Commenting on the effect of HIV and AIDS within the South African business context, Whiteside and Sunter (2000) note that the economic and labour impact of the spread of HIV infections in the workforce requires the urgent promotion of workplace health programmes to address HIV and AIDS. Noting that the workplace provides an ideal gateway to HIV and AIDS prevention and care, Van Dyk (2005) advocates the development of a six-stage integrated strategy to manage HIV and AIDS in the workplace.

The South African Business Coalition (SABCOHA) found that more than one-third of the companies surveyed indicated that HIV and AIDS had impacted negatively on labour costs and productivity and had led to increased labour turnover. As productivity falls, businesses, within both the public and the private sectors, will be faced with increased costs for overtime, recruitment and training. In addition, as a result of HIV and AIDS, many businesses are being forced to increase their spending on pensions, disability and medical benefits (Department of Health 2007; UNAIDS 2007). According to SABCOHA (2008), the South African business sector is becoming increasingly dedicated to humanitarian support and has made considerable contributions to the field of HIV and

AIDS. Moreover, businesses are in a powerful position to mobilise effective resources to respond to HIV and AIDS in the workplace.

HIV and AIDS health promotion programmes represent a key factor in forcing the South African workplace to respond to the dangers posed by the epidemic (Whiteside & Sunter 2000). However, as Whiteside and Sunter (2000) lament, it appears that HIV and AIDS health promotion programme efforts have not had the intended effect as the infection rate continues to rise. This observation by Whiteside and Sunter (2000) points to the need to reorganise the work environments in such a way that will add value to employees as well as help identify more effective HIV and AIDS health promotion models.

2.2 THE IMPACT OF HIV AND AIDS ON AGRICULTURE

The economy of Africa is primarily agrarian (UNAIDS 2007). The major effects of HIV and AIDS on agriculture include the serious depletion of human resources, diversion of capital from agriculture to patient care, loss of farming and non-farming income, as well as other psychosocial impacts that affect agricultural productivity (FAO 2009). Although the focus of HIV and AIDS programmes has been on the health sector, the disease has had a tremendous impact on the agricultural sector of developing countries. Coombe (2000:31) indicates that up to 80% of people in the most seriously affected countries rely on agriculture for their subsistence.

The agricultural sector is vitally important to most developing countries as it contributes substantially to GDP and is essential in terms of achieving food security (UNAIDS 2007). In addition, the impact of HIV and AIDS on this sector may increase poverty on a global scale because of a shortage of food supplies. .

As the pandemic robs countries of their most valuable assets, namely, their human capital, this will have a profound effect on the agricultural sector with not only the size of the labour force shrinking but its quality also suffering (UNAIDS 2007). In other words,

the impact of HIV and AIDS on the agricultural sector could seriously hamper its ability to operate efficiently. In addition, a drastic decline in an effective labour supply may discourage foreign investment and this, in turn, would affect the country's economic growth (UNAIDS 2007).

2.2.1 The impact of HIV and AIDS on the labour force

UNAIDS (2008:7) states that the HIV and AIDS "*pandemic is a powerful brake on economic growth*". The steady increase in HIV-infection rates has had a negative impact on agricultural production and food security in sub-Saharan Africa and also in South Africa.

According to Booysen, Geldenhuys and Marinkov (2003) the impact of HIV and AIDS on the South African economy means that the economy will decline by 5, 7% more by 2015 than it would have without HIV and AIDS. On the other hand, according to UNAIDS (2007), apart from the devastating effects of HIV and AIDS on the agricultural environment, estimates suggest that HIV and AIDS will also impact on the agricultural labour force in a number of ways. These are discussed in the following sections.

2.2.1.1 The size of the total labour force

It was only during the early 1990s that the human resource costs of the HIV and AIDS pandemic became apparent in agriculture (UNAIDS 2007); with agricultural sectors worldwide reporting a loss of productivity. Labour remains an important component of productivity in sub-Saharan Africa as a result of the limited use of machinery and an inability to purchase other farm inputs (FAO 2008). HIV and AIDS affect adults in their prime productive years and the resultant labour shortages will contribute to reduced productivity as a larger proportion of workers become affected by the pandemic (FAO 2008). Consequently, the effect of HIV and AIDS on the labour force means that the size of the labour force will decline.

2.2.1.2 *Average age of the labour force*

HIV and AIDS affect the age distribution of the labour force in the following three ways:

- It stimulates the entry of more young people and children into the labour market.
- It causes the withdrawal of older workers who are HIV positive and have become ill.
- It enables the greater retention of older workers who are not ill and also stimulates the entry of larger numbers of older workers who have to support families.

HIV affects the composition of each age group with the average age of the economically active population changing (Webb & Bain 2011).

2.2.1.3 *Child labour force*

The deaths of their parents mean that young children have to struggle for survival, with orphaned children and those whose parents are already sick often being forced to care for younger siblings, or to work to contribute to the household income.

2.2.1.4 *Skills profile of labour force*

The efficiency and productivity of a company is seriously jeopardised during the time it takes to replace workers, especially the more skilled and semi-skilled workers (UNAIDS 2008). In addition, it is often an extended period before the replacement workers are able to work at the same productive capacity as those who have been with the company for a longer period.

The socioeconomic impact of HIV and AIDS is assumed to be greater if the epidemic affects skilled workers more than it does those with fewer skills (UNAIDS 2008). Some studies argue that skilled workers are likely to be more susceptible to infection than those who are unskilled. According to these studies, skilled workers with a high level of

education are generally at a higher risk of HIV transmission, mainly because the improvement in socioeconomic status and the changes in life style that higher educational attainments make possible may be associated with behaviours that increase the risk of HIV infection (UNAIDS 2010). However, other research has found the highest HIV infection levels among unskilled and semi-skilled workers as compared to skilled workers.

2.2.2 Economic impact of HIV and AIDS on the agricultural sector

The workplace is being slowly brought into the foreground of the global response by the fact that “the majority of those likely to be affected by the virus are those who make up the bulk of the workforce at present (i.e. those aged between 20 and 49 years)” (Catalan, Sherr & Hedge 1997).

According to Gadd and Goss (as quoted in Catalan *et al* 1997):

Economists can predict the average costs for services for people living with AIDS. However, those direct expenses pale in comparison with the loss to society of the potential economic productivity of young people whose lives end prematurely. Add indirect costs generated by disruptions in social and economic activity caused by fear of contagion and the resulting price tag is astronomical.

However, either secluding or excluding HIV-infected employees in the workplace will, in the long term, be destructive to the business environment on many levels, as resentment and mistrust may infiltrate the workplace with employees sensing that their company is not taking an interest in their health and wellbeing. As morale decreases among workers, productivity and efficiency decline as well, thus resulting in a loss of profits (FAO 2008). It is, thus, impossible to ignore people living with the virus as they will, inevitably, constitute a greater and more significant part of the workforce. (Whiteside and Sunter 2000) conducted a study in one large company in South Africa on the impact of HIV and AIDS on the agricultural sector. The findings showed that

losses in terms of productivity, absenteeism, under-utilisation of equipment and the use of temporary staff all had a direct influence on the quality of control of products and services, leading to losses of reputation and, ultimately, to a reduction in customers (Whiteside & Sunter 2000).

The high rates of morbidity and mortality caused by HIV and AIDS result in increasing staff turnover, loss of skills, loss of tacit knowledge and declining morale (Barnett & Whiteside 2002), with training and recruitment costs escalating as a result of these increases in staff turnover and the loss of skilled workers. In addition, the business or economic sector may have to employ extra labour to cope with staff fluctuations and losses. An employer might attempt to train surplus workers with a view to counteracting the loss in employees caused by AIDS-related illnesses or deaths. However, this may result in the upward spiralling of overhead costs (Whiteside & Sunter 2000). Moreover, finding qualified workers to replace staff members who are no longer able to work may be difficult, especially in many of the developing regions (UNAIDS 2008).

Businesses are being subjected to the pressures of increasingly competitive national and global markets through globalisation and liberation of economies, combined with the demands from investors and consumers for increased productivity, efficiency, innovation and equality of products and services (UNAIDS 2008). In addition, pressures are mounting for businesses to be more responsible and accountable to their wider stakeholders, workforces, suppliers, communities, governments and general public. Recent initiatives include the work of the Partnership on Mobility and HIV in Southern Africa (PHAMSA) programme which is funded by the Swedish development agency (Sida). PHAMSA aims to reduce HIV incidence and the impact of AIDS among migrant and mobile workers and their families. PHAMSA commissioned a survey on HIV prevalence that was carried out on ten farms in the Hoedspruit area of the Limpopo Province in 2008. It found high rates of HIV prevalence among farm workers and mobile communities (IOM 2008)

2.3 RESPONSES TO THE IMPACT OF HIV AND AIDS

Most companies, the agricultural sector included, have been slow to recognise the threat to profits posed by HIV and AIDS. However, companies are now tending to pursue the following three basic strategies for mitigating this threat:

2.3.1 HIV-prevention interventions

It is the responsibility of companies to adopt a healthy, well-defined commitment to protecting and supporting their employees in the face of the rapidly growing epidemic (Catalan *et al* 1997). With its access to marketing, organisational resources and communication technologies and the ability to mobilise employees, the workplace is an ideal place in which to disseminate HIV and AIDS prevention messages (UNAIDS 2003). Educating workers to function as HIV and AIDS peer educators will enable workers to interact with each other both in the workplace and socially, thus providing them with the opportunity to influence one another's attitudes and behaviours and, therefore, reduce the number of new HIV infections. This will, in turn, enable employers to benefit from the continued presence of an existing and experienced workforce (Catalan *et al* 1997). Companies should develop a model for the prevention and management of HIV and AIDS that addresses local needs and requirements and which includes the following:

- Planning educational campaigns based on surveys in order to assess the level of HIV and AIDS awareness.
- Providing care, treatment and support to people infected with or affected by HIV.
- Monitoring statistical indicators, such as absenteeism, opportunistic infections and condom distribution in the workplace.
- Formulating an HIV and AIDS policy for the company.
- Implementing HIV and AIDS programmes within the company (UNAIDS 2003).

The management of the epidemic in the working environment may dramatically help reduce the spread of HIV and also place the focus on solutions that will result in the meaningful and sustainable upliftment of the workers, their families and society at large and, thus, improve quality of life (UNAIDS 2003).

2.3.2 Cost avoidance

As a result of HIV and AIDS, companies are having to spend more on health care to ensure that their labour force is able to work at maximum performance levels for as long as possible. It is important to note that companies also bear the brunt of increased medical and insurance costs, death benefits, and disability and pension payouts (UNAIDS 2008). Accordingly, companies are tending to avoid hiring new employees who are infected or who are thought to be in high risk groups, they are outsourcing production activities involving workers in high risk groups, or they are shifting from labour-intensive to capital-intensive technologies.

According to (UNAIDS 2008), one large South African company dissolved its shipping department and established its truck drivers as independent contractors so that the company would no longer be responsible for providing any benefits to drivers living with HIV, although its business will suffer if its distribution network is disrupted by high mortality among the drivers.

2.3.3 Shifting the burden to government and households

In an attempt to reduce the costs associated with HIV and AIDS, companies are effectively shifting these costs and the care burden onto households and government (UNAIDS 2010). Life insurance premiums and pension fund commitments for businesses are likely to increase substantially because of early retirements and deaths as a result of HIV and AIDS. However, this would undoubtedly be less of a concern for businesses if employees with HIV had either to pay for their own treatment, or rely on

publicly provided services. In the end, it is likely that households and extended families will have to bear the brunt of the costs.

Government and NGO health care facilities have already been overwhelmed by HIV and AIDS patients who occupy 70% of hospital beds. However, in view of limited government and NGO resources, individuals with HIV have no option but to turn to their own households for support and care (UNAIDS 2010).

2.4 STIGMA IN THE WORKPLACE

Dovidio, Major and Crocker (2000) define stigma as a *“process by which individuals with devalued physical, behavioural or medical attributes experience prejudice, discrimination, stereotyping and exclusion”*. In the majority of workplace settings, the WHO and ILO confirm that there

... Is no risk of acquiring or transmitting HIV between workers, from worker to client or from client to worker? Yet, despite the lack of risk of infection, people in many countries have been dismissed from their jobs, ostracised by their workmates, or tormented at the workplace because of fears about HIV and AIDS (UNAIDS 2008:8).

Prejudice and a lack of knowledge drive people to stigmatise and discriminate against people living with HIV. Studies have shown that prejudicial behaviour is sometimes triggered when employees disclosed their status to their employers or when confidentiality about an employee's status is breached (Dickson 2006). Employees who are known to be HIV positive often face stigma and discrimination from co-workers, supervisors and managers. This may take the form of dismissal from work, relocation to another position or having their job benefits limited (Dickson 2006).

However, the Constitution of South Africa provides for every person to have the right to equality and non-discrimination, privacy, fair labour practices and access to information (Whiteside & Sunter 2000).

2.5 GENDER INEQUALITIES AND HIV AND AIDS

The WHO (2007) views gender inequality and men's perceived sexual and economic superiority over women as central to HIV infection. According to the feminisation of poverty theory, women's power inequalities render them especially vulnerable to HIV infection (UNAIDS 2007). In a patriarchal culture men are seen as dominant both in the family as well as in society at large (Boonzaier 2003). The farming community in which the participants in the study live operates along such patriarchal lines, with the men making the important decisions for their families. In addition, men are seen as more intelligent than and superior to women.

Collins (2007) suggests that the power dynamic between men and women also occurs in their sexual relations and is an example of how the spread of HIV may be enabled. The discourse of power influences whether or not people practise safe sex. Men are perceived as powerful and, thus, have the right to decide what happens in a relationship. Accordingly, they are able to put both themselves and their partners at risk by having multiple sexual partners and by their refusal to use condoms (UNAIDS 2007).

Several factors work together to produce this perceived male power, as does the willingness on the part of the women to accept male decisions and behaviour. In the farming community targeted in this study, as in many others, women are more likely to be unemployed, to be less educated, and to have fewer and worse paid employment opportunities (UNAIDS 2007). They are, therefore, often dependent on men and, thus, they are forced to tolerate their behaviour, whatever that behaviour may be or whatever the consequences of that behaviour are. Particular notions about masculinity also support the discourse of male power (Collins 2007). The ideas that a man is not able to help having multiple sexual partners because of his uncontrollable drive for sex, or that a man must prove his 'manhood' by fathering several children and, therefore, has the right to object to the use of condoms are but two of the ideas surrounding masculinity (Collins 2007). In general, women are seen as the objects of men's sexual urges and

women tend to view sexual behaviour in terms of men's sexual needs and urges. Ensuring man's pleasure is experienced as an expression of commitment and love on the part of a woman (Collins 2007). According to an article in the *Mail and Guardian* (2006 p5), the pressures women face to have an unprotected sex and the belief that men are entitled to sex are enormously underestimated. Willig (1999) found that maintaining trust in a relationship requires strict censorship about what is communicated between the individuals and evidence of trust is offered by engaging in unprotected sex. A woman's request that a condom be used may be interpreted as a sign of infidelity or that the woman making such a request is HIV positive (UNAIDS 2008). Culturally, women are not supposed to talk openly about sexual matters with men. .

However, the structural gender inequalities and culturally condoned male sexual behaviours and sexual practices are harmful to both men and women, with the HIV and AIDS epidemic offering strong possibilities both in respect of transforming gender relations and in supporting greater democratic participation on the part of women (Baylies & Bujra 2000). Nevertheless, attempts to alter power relations are likely to be resisted by those in positions of dominance if such attempts threaten their position of relative privilege and access to resources (Baylies & Bujra 2000:194). According to UNAIDS (2007), men do not give up their male privileges and certainly not in situations of poverty and disempowerment.

Baylies and Bujra (2000) suggest that a way forward in the fight against HIV and AIDS may be to build on the existing organisational skills and practices of women. Research has shown that a lack of education and of access to assistance from social institutions imposes constraints on the options that poor women have (UNAIDS 2007). Socioeconomic status results in a difference in power, especially as regards economic resources and opportunities. Campbell (2003) adds that many of the social factors shaping the health-related behaviour of individuals are linked to the unequal distribution of both political and economic power.

2.6 THE VULNERABILITY OF YOUNG FARM WORKERS TO HIV AND AIDS

Farm workers are vulnerable to HIV and AIDS just as migrant workers in the mines and in the construction industry are (International Organization for Migration 2004). Despite the development of HIV and AIDS programmes in South Africa, there is still an increase in the HIV-prevalence rates among farm workers. The epidemic has, thus, created a clear need to prevent HIV infection among young farm workers. The loss of young farm workers as a result of HIV will cause a decline in the GDP of the country. Farm workers usually live in compound accommodation, tents or shacks which are unhygienic and overcrowded and which lack privacy (UNAIDS 2007:58). These factors all increase the farm workers' vulnerability to HIV and AIDS as they may become involved in transactional sexual activity in order to find alternative dwelling places. According to Webb and Bain (2011:31-33), inadequate wages for agricultural workers also increases their vulnerability to HIV and AIDS, as workers may be tempted to exchange sex for money.

A study conducted by the South African Migration Project (SAMP 2004) found that most foreign migrants working on South African commercial farms earn an average of between R10 and R33 per day (UNAIDS 2007:58). In addition, the agricultural sector employs many undocumented farm workers and migrants from across the borders who are reluctant to access the health services for fear of revealing their illegal work status to the authorities and risking deportation. According to Colvin (2000:335, 337–339), untreated sexually transmitted infections (STIs) in either partner increase the risk of HIV infection. The UNAIDS (2007:58) argues that the vulnerability of farm workers is enhanced by seasonal contracts which increase their mobility. In addition, the vulnerability of young farm workers is increased by deficiencies in their knowledge of HIV and AIDS prevention and the absence of HIV and AIDS programmes and STI services on farms.

2.7 KNOWLEDGE OF HIV AND AIDS

According to Barnett & Blaikie (1992) and the FAO (2009), knowledge of and attitudes and opinions towards HIV and AIDS are important factors to consider when designing information, education and prevention campaigns. Lovelife (2006) adds that the reason why the tide of HIV and AIDS infection is so difficult to stem in sub-Saharan Africa is the fact that so many people are not fully informed about HIV and AIDS and they have problems in interpreting the meaning of the disease and its causal factors. Barnett & Blaikie (1992) is of the opinion that the spread of HIV and AIDS is as a result of ignorance about the disease and that this ignorance is fuelled by a combination of factors such as poverty, prevailing attitudes towards sex and traditional practices.

Barnett, Whiteside and Desmond (2001:9) maintain that countries in sub-Saharan Africa should study their social and cultural settings and the way in which these impact on the spread of HIV and AIDS. Farmers could also play a role in curbing the spread of HIV by empowering farm workers not only with the correct knowledge about HIV and AIDS but also by helping them to think critically about the cultural and gender issues that may render certain people vulnerable to HIV and AIDS. This would, in turn, suggest that the farmers themselves should be equipped with the correct knowledge about the disease and also with the skills necessary to counsel farm workers and to address these issues with them.

2.8 HEALTH PROMOTION IN THE WORKPLACE

According to Campbell (2003), health promotion in the workplace was first practised by companies in the United States of America during the 1980s. This happened because American companies included insurance as a benefit for their workers. Employers were not able to cope with the escalating health costs and this compelled employers to find ways of keeping these costs low by ensuring the health of their employees. As a result, companies were forced to develop strategies which encouraged healthy lifestyles in their employees. Accordingly, health promotion programmes were introduced into companies with the goal of these programmes being to move employees towards a

state of optimal health. O'Donnell (2002) argues that health promotion programmes may have an effect on three levels. On the first level, they may enhance awareness; of health issues on second the level, they may motivate employees to change their lifestyles and, on the third level, which pertains to managers, they may create environments that support healthy lifestyles. Health promotion programmes are seen as a means of controlling employee benefit costs especially where state-funded health programmes are not available, for example, in North America, where the employers had to carry the costs of employee health insurance (Downey & Sharp 2007).

Health promotion programmes were seen as the most effective way of helping people to change their lifestyles and to move towards optimal health. These programmes were generally accepted by most organisations because they recognised the value of healthy work environments and health promotion in the workplace came to be regarded as management practice. Health promotion in the workplace not only makes business sense, but it also offers the possibility of reaching out to large numbers of the adult population in a constant setting over long periods of time (Whiteside & Sunter 2000). In addition, it provides a specific community with access to social support, while there are definite economic reasons for improving health and productivity in the working environment (Whiteside & Sunter 2000).

Bramford (1995) suggests that there is a need to implement health promotion programmes in the workplace because employees are not able to benefit from community-based health promotion programmes during working hours; and they have difficulty in accessing health practitioners during the day as they are busy working for eight hours a day. In the South African context, Huiskamp *et al* (2005) are of the opinion that the workplace is, increasingly, becoming an effective setting for health promotion because of the possibility of long-term interventions and evaluation and the social cohesion inherent in the workplace that enables peer pressure and support for conforming to healthy lifestyles.

Health promotion programmes in the workplace in South Africa have become a key focus in enforcing the implementation of the Occupational Health and Safety Act 85 of 1993, as well as the implementation of the HIV and AIDS Technical Assistance Guidelines (TAG) issued by the Department of Labour. The Occupational Health and Safety Act are concerned with the promotion of a safe work environment by preventing both accidents and exposure to hazardous chemicals at work. However, the educational activities that the Act regulates are limited to raising the awareness of both employers and employees with regard to environmental dangers. On the other hand, TAG is intended to provide employers, employees and trade unions with the information they require to address HIV and AIDS workplace issues and to address discrimination on the grounds of HIV status in line with the Employment Equity Act of 1998. There is no legal obligation for employers to provide health services in the workplace, although the provision of employee assistance programmes (EAPs) is fairly widespread and is recognised as being essential (Hooper 2004). HIV and AIDS education is provided as part of EAP services in government and in private organisations, with most businesses benefiting from such an intervention.

2.9 A THEORETICAL FRAMEWORK: THE EMPOWERMENT OF WORKERS

“Empowerment theory states that empowerment can be viewed both as a process, incorporating actions, activities, or structures, and as an outcome, suggestive of an achieved level of empowerment” (Nachshen s.a.:68). On an individual level, empowerment includes both the giving and receiving of assistance in a two-way process, which focuses on gaining control over one’s life. At the level of the organisation, empowerment involves those processes and structures which enhance goal-directed actions by members of the organisation while, at the broadest level, it reflects actions taken by stakeholders to improve life in the community (Minkler, Thompson, Bell & Rose 2001:786).

As a multilevel construct, empowerment is defined by MacDonald (2004:46) as an *“enabling process through which individuals and communities take control of their lives”*. As Wallerstein (1992:198) notes, empowerment is a *“social action process by which individuals, communities and organisations gain mastery over their lives in the context of changing their social and political environment to improve quality of life”*.

From the perspective of community-based interventions aimed at farm workers, these diverse levels of empowerment are unified by the belief that the primary goal of the community intervention is not to help individuals or communities to accept or to adjust to problems, but rather to help them develop the ability to change negative behaviour and prevent the spread of HIV. However, MacDonald (2004:49) believes that the participation and involvement of relevant people in the programme is not beneficial to either the providers or the service users if the programme does not support the empowerment process. Nevertheless, exploring each level of empowerment independently may assist us to understand both its characteristics and the processes within these different levels of participation and involvement. As noted above, this study focuses on the implementation of a HIV and AIDS workplace policy for farm workers.

Regardless of the level of empowerment being considered, Zimmerman (1995:44) suggests that there are three key factors involved, namely, participation, control and critical awareness. While participation and involvement are necessary conditions for empowerment, they are not sufficient because, apart from participation and involvement, it is essential that awareness and control also be achieved. Awareness and control include a person's belief in his/her ability to exert control over and to be involved in decision making (Zimmerman 1995:44).

For the purpose of this study, awareness and control also imply an understanding of the causes of HIV and AIDS. Critical awareness may be defined as the process through which an individual or group develops a desire for change (Campbell 2003). According to Perkins, Simnett and Wright (1999), critical awareness refers to the stage during which people become aware that a problem exists and decide to do something about it.

This occurs through participation in terms of which people become aware of their lack of knowledge of the way in which their social conditions may be undermining their wellbeing, although they do not perceive their own actions as capable of changing these conditions.

Campbell (2003:50) states that the first stage of critical awareness is an intransitive thought which is characterised by naïve thinking. In such a situation, people lack the knowledge that their “social condition undermines their wellbeing, and do not see that their actions as capable of changing this conditions”. The final stage involves “critical transitivity”. During this stage, people do have knowledge about certain issues and how to tackle these issues (Campbell 2003). Through participation in health awareness programmes offered at the farm, individuals may learn to think critically about their situations. Such critical thinkers are empowered to reflect on the conditions that shape their lives.

Participation is empowering as it increases the individual’s control over his/her life. Campbell (2003) defines control as “the development of confidence and the ability to act on a collective decision-making in favour of health-enhancing behaviour”, while MacDonald (2004) defines control as “people taking increased responsibility for managing their lives, relations and circumstances”. Both of these definitions suggest that powerlessness or lack of control over one’s destiny undermines people’s health. It is not important to note, however, that empowerment is not a service that may be delivered, nor is there a defined way in which to determine that an individual has been empowered.

Employers have a critical role to play in controlling the HIV and AIDS epidemic. In terms of the empowerment theory cited in MacDonald (2004:47), the participation and involvement of the farming community will equip participants with the power to take increasing responsibility for their lives and their circumstances. Attempts to encourage stakeholder participation tend to fail because organisations are not always very clear about the levels and types of participation required (Arnstein 1969). Limited

consultation, which offers few opportunities for actual participation, is likely to produce disillusionment. The participation of farm workers in the implementation of HIV and AIDS workplace programmes is necessary not only as a strategy for limiting HIV transmission, but also in terms of the way in which employers negotiate their responses to the HIV and AIDS epidemic.

2.10 CONCLUSION

This chapter discussed the impact of HIV and AIDS on agriculture and the economic impact of HIV and AIDS on various aspects of employment in both the agricultural and the business sectors. Thereafter, the response to HIV and AIDS from the agricultural sector and the business sector, as well as strategies adopted for mitigating the effects of HIV and AIDS were discussed.

CHAPTER 3: METHODOLOGY

3.1 INTRODUCTION

This chapter commences with a discussion of the qualitative approach chosen for this study. The research design of the study is then discussed. This discussion includes a general orientation to the study as well as a description of the data generation methods, the sampling strategies chosen, the data analysis and data interpretation; the strategies followed and the ethical considerations of the study.

3.2 METHODOLOGICAL ORIENTATION

The nature of the research topic demanded a qualitative research approach focused on exploring and understanding attitudes in the workplace. The research was, therefore, qualitative in nature and based on personal, in-depth interviews and observations. The paucity of research on the subject determined the nature of this study, with the research being conducted as a knowledge-building exercise. The researcher viewed the study as a learner rather than as an interpreter. The research design was structured to be exploratory.

The study was descriptive in nature and captured individual, emotional discourses. In this regard, the researcher, before commencing with the study, consulted various sources to help her to gain an understanding of the world of the farm worker. The International Organization for Migration (IOM) (2003) is a proponent of immersing oneself in the research environment and in the life world of the subjects. In addition to reading about the social worlds of farm workers, the researcher gathered field notes by observing the interaction between the research participants and their colleagues and by visiting different sections of the workplace in order to experience the life of the workers. The various notes gathered via these sources of information (literature reviews and observational notes) provided a framework for understanding how the farm workers occupy themselves and the type of the world in which they live. This broader understanding of farm workers was sought in order to provide an insight into the type of

conditions under which they work and how they interact with one another (see literature review).

3.3 THE RESEARCH DESIGN

A research design is a type of mind map which the researcher follows in order to achieve his/her goal and objectives. According to Babbie (2005:87), the research design is a process that involves a set of decisions regarding the topic of a research study, the population and the methods for gathering and analysing the data. Research may be conducted to serve exploratory, descriptive or explanatory purposes (Adler & Clark 2008; Babbie 2005).

Grounded theory offers a methodology well suited to understanding the type of social phenomenon which is the focus of this research (Hancock 1998; Ryan & Bernard 2006). Two of the most common data-collection techniques described in grounded theory are interviews and observation (Hancock 1998; Pope, Ziebland & Mays 2000). This study made use of personal interviews with the participants in a purposive sample, and also utilised an interview schedule as a research instrument. The interview schedule was chosen in preference to a formal questionnaire because it offers flexibility, which is a hallmark of qualitative research (Holloway 2003).

Meeting the participants face to face gave the researcher an opportunity to view the farm and to witness the participants' working environment. This, in turn, enabled a process of direct observation on the part of the researcher, which would not have been possible if the researcher had used telephone interviews or posted the questionnaires to the respondents.

The study made use of constant comparative analysis, an important feature of grounded theory which allows emergent data to guide the research process (Hancock 1998). The data analysis was accomplished using the classic grounded theory methods of theme analysis and the building of a codebook (Neuman 2003:120)

3.3.1 Selecting a site and gaining access

The researcher chose a farm in Bronkhorstspuit as the field site as she was familiar with the area and was aware that it would yield rich data on a web of social relations within a rural workplace. In order to gain access to the farm, the researcher approached Country Mushrooms, a farm in Bapsfontein, southwest of Bronkhorstspuit. A number of interviews with the farm officials followed. The aim of these interviews was to provide the necessary orientation for understanding both the working world of the farm worker and, in the case of the informal settlement dwellers near the farm, the living arrangements of the participants. Informal interviews were conducted with the human resources (HR) official, a shop steward and a number of farm workers prior to selecting the site.

3.3.2 The presentation of self and roles in the field

Neuman (2003) maintains that it is essential that a field researcher is conscious of the presentation of self in the field. At the start of this research study, the researcher assumed the role of observer as participant (Junker 1960 as quoted in Neuman 2003:357) as she had a known, overt role as a researcher in the workplace and had had limited and formal contact with the research participants. At times, however, she adopted the role of participant as observer (Junker 1960 as quoted in Neuman 2003:357) as she engaged as a member of the team with the participants in the Tswana language and also asked questions.

The researcher is a middle-aged, educated, African female who speaks four African languages fluently, namely, Tswana, North Sotho, isiZulu and Southern Sotho. In this study the researcher conducted interviews on personal and emotionally overwhelming issues with a cross-section of the farm worker participants. This presented the researcher with an ethical dilemma. However, the researcher ensured that she approached the study with great caution while bearing in mind, as Babbie (2008:317) points out, that reactivity may occur in such studies as the research participants may

react to the characteristics of the researcher. The researcher remained vigilant as regards harming the participants in any way while, at the same time, she took care not to allow her feelings of empathy to contaminate the quality of data. The researcher struck a balance between obtaining in-depth information, while remaining careful not to push the participants to reveal more than they were prepared to divulge. In addition, she respected the decisions of the participants if they did not feel comfortable answering certain questions for reasons of their own.

3.3.3 Focusing and sampling

Country Mushrooms was purposefully chosen as the research site and the case study for this study. After observing this workplace for a few days, the researcher realised that she would have to select a sample of interviewees with whom to conduct in-depth interviews and that this purposeful sample would have to be chosen to include a cross-section of the workers. Accordingly, the researcher decided to interview twelve farm workers – six males and six females – in the first round of interviews. In view of the fact that the aim was to find a representative sample, the researcher used non-probability sampling. The participants for this study were selected in accordance with the following criteria:

- All the participants were farm workers at Country Mushrooms.
- The participants were all above 18 years of age.
- The participants were all willing to participate in the study, and to be interviewed.

During the sampling stage it was felt undue pressure may be exerted on a farm worker if the researcher were present when the farm worker was asked to take part in the research and so an HR officer asked potential participants if they would be willing to participate. Two farm workers refused to be interviewed while two others agreed, but refused to be audio-taped. The researcher regarded the fact that some workers refused to take part in the study in a positive light as this allayed the fear that the workers who gave their consent had done so because they felt under an obligation to do so.

Approximately four months after the initial interviews, a second round of interviews was conducted with ten of the original twelve participants. These additional interviews were conducted between January and March of 2006. Two of the initial participants had left the farm after being declared unfit for work as a result of HIV and AIDS related illnesses. The researcher was, therefore, fortunate to be able to re-interview those participants who had been interviewed in the first round of interviews and who were prepared to be re-interviewed.

In terms of language, the group included two isiZulu speakers, six Northern Sotho speakers, one Setswana speaking woman and one Southern Sotho speaking man.

3.3.4 Collecting data via face-to-face interviews

The preliminary discussions and observations were important in order to provide context for the life worlds of the farm workers. Based on these preliminary discussions and the observations, as well as the literature review, the researcher devised an interview schedule in English, comprising four main, open-ended questions and 25 sub-questions in accordance with the researcher's goal and objectives. The aim of this interview schedule was to guide the flow of the interviews (see Appendix 1). The field interviews were kept flexible, thus enabling the researcher to focus on certain themes, as well as allowing participants the opportunity to discuss any related issues they deemed important.

The initial twelve interviews were conducted towards the end of 2005 over a period of approximately three months. Each interview took between one and one-and-a-half hours. During these interviews the participants were given the opportunity to talk freely about the subject, although there was some prompting on certain HIV and AIDS issues. The researcher acted as the interviewer and the interviews were designed in such a way that the individual participants were able to tell their stories in their own words, without time or information constraints. The interviews, which were recorded in the form of process notes and a tape recorder, were conducted in four African languages,

namely, Setswana, IsiZulu, Southern Sotho and Northern Sotho. Follow-up interviews were held and recorded in both audio form and in the form of process notes.

Babbie (2005:318) recommends that researchers make full and accurate notes of what transpires during interviews and also what has been directly observed. In this study, the researcher accurately recorded the interviews in the form of process notes in journals immediately after each interview for the purpose of further analysis and interpretation. Follow-up interviews were later conducted and also recorded in the form of process notes and audio tapes. Certain specific themes were explored although the participants were also given the time and opportunity to speak about things they deemed important.

All the interviews were audio-taped, except in the case of two participants who did not want their responses audio-taped. In these instances the researcher took detailed notes. Notes were also made during all the other interviews.

During the second round of ten follow-up interviews, the conversations were generally much longer than had been the case with the first interviews. The researcher reread the transcripts of the first interviews shortly before the second interviews and this enabled her to pick up on specific aspects that required clarification (Neuman 2003:391). Although the process of setting up the second interviews was, at times, frustrating, the second interviews were, generally, more fruitful than the first because most of the farm workers were far more relaxed compared to the first time the researcher had interviewed them. The interviews were conducted in offices that offered a certain amount of privacy and, also, the researcher was by now more familiar to the participants.

3.3.5 Observation

According to Neuman (2003), one of the first characteristics of a qualitative orientation is the emphasis on the social context of the phenomenon to be researched. Accordingly, the researcher, before commencing with the study, consulted various

sources to help her understand the world of the farm worker. In addition to reading about the social worlds of farm workers, the researcher gathered field notes by observing the interaction between the research participants and their colleagues, and by visiting the different sections of the workplace in order to experience the life of the workers. The various notes gathered via these sources of information (literature review and observational notes) provided a framework for understanding how the farm workers occupy themselves and the type of world in which they live.

3.3.6 Data quality, validity and reliability

According to Polit and Beck (2006), credibility ensures that findings are in accordance with the reality of the participants, that is, how true the findings of the study are within the context in which the study was conducted. In this research study, steps were taken to improve and evaluate the credibility of the data obtained as it is essential that quality data be presented to ensure confidence in the truth of the data. These criteria for the establishment of credibility were honoured through discussions with the supervisor who acted as an external auditor to check veracity in the data generated and in the analysis. The supervisor as an auditor commented extensively on the data-generating steps and on the plausibility of the emerging findings.

The researcher enhanced and protected the credibility of the data gathered by allowing the research participants to relate their experiences as farm workers regarding the implementation of a HIV and AIDS workplace policy. Neuman (2003:249) explains that *“field researchers depend on what members tell them. This makes the credibility of members and their statements part of reality that field researchers take into account as they evaluate credibility”*.

The researcher transcribed the interviews as soon as possible after the interviews had been conducted and checked and rechecked the transcriptions and coding. The researcher made every effort to meet the criterion of vividness by producing thick and

faithful descriptions, and by reflecting on whether the findings addressed the stated objectives of the study in a convincing way.

3.3.7 Data analysis and interpretation

After conducting the first twelve interviews, the researcher transcribed the interviews fully within a week after the interviews had been conducted. In transcribing the interviews the researcher made no attempt to “tidy up” the interviews – grammatical errors, peculiar expressions, pauses, interruptions and so on were not edited out of the transcripts. Since the interviews had been audio-taped, it was possible to listen to the tapes repeatedly in order to ensure that the transcripts were reliable (Silverman 2005:222–223). The comments or the field notes made during the interviews were also incorporated into the transcripts at this stage. The audio-tapes were handed over to an independent and professional transcription organisation called Datafer.

The process of “open coding” then followed, during which initial labels were assigned to the data in order to locate the main themes (Neuman 2003:442). The initial interview schedule used had dictated the main themes of the interviews, but these themes were adjusted and refined after the actual data had been obtained. After these initial themes had been identified the follow-up interviews with ten participants were planned. It had been possible to formulate tentative themes using the first twelve interviews, and these themes were explored in greater detail during the follow-up interviews. These follow-up interviews covered more ground and were in greater depth as compared to the first twelve interviews. The researcher also audio-taped these second interviews and then transcribed them.

After the follow-up interviews, the initial codes were reviewed in order to identify the key concepts. The process of re-examining the themes, identifying the sub-themes and combining certain themes took place after the second round of interviews. Selective coding then followed, during which the entire collection of transcripts was perused with

the aim of finding all possible data related to the final themes and sub-themes (Neuman 2003:444).

3.4 ETHICAL CONSIDERATIONS

Liamputtong and Ezzy (2005:42) state that one of the concerns of ethics committees is the potential of qualitative studies to cause distress to participants. In this study the researcher adhered to the relevant ethical principles. The following sections discuss some of the ethical principles to which the study adhered:

3.4.1 Confidentiality and informed consent

The ethical principle of confidentiality and informed consent emphasises that every person has the right to privacy. In this study a consent form was devised (see Appendix 2) and handed to each participant prior to the commencement of the interview. The form stated that each participant was taking part in the research voluntarily and that the participant had been adequately informed about the aims and purpose of the topic under examination. In addition, the consent form stated that all names and personal details that had the potential to identify the participants would be withheld during the reporting of the results.

The consent forms were locked in the researcher's confidential documents safe to which nobody has access. After the process of data collection, pseudonyms were used to protect the real identities of the participants. The data that had been collected was password protected in the researcher's personal computer to ensure that the participants' identities were protected. All data (signed consent forms, notes taken during observations, names of participants, audio-recordings, transcriptions, and analysis files) will be kept in a safe and only destroyed 5 years after the degree has been conferred.

3.4.2 Fair treatment

According to Polit and Hungler (1995), participants have the right to be treated fairly and objectively before, after and during their participation in the research. The process of fair treatment includes the following:

- Participants are not discriminated against. In this study those individuals who were interested were given the opportunity to participate. All the participants were employed at the same company.
- Participants who decline to participate or who withdraw from the study should not be subjected to any prejudicial treatment
- All the participants agree to be freely available to the researcher should it be necessary to clarify any information.

It is important to note that all of the above points were taken into consideration prior to commencing the study. In addition, these points were clarified to all the participants before the interviews commenced.

3.4.3 No harm

In this study every effort was made to ensure that there were no known risks or harm to any individual who participated in the study. However, in any cases of psychological or emotional upset, provision was made to offer counselling to the participants. According to Polit and Beck (2006:144), the psychological consequences of participating in a study are usually subtle and, thus, require close attention and sensitivity. In order to avoid psychological trauma it was also made known to the participants that they were free to leave out any question that they felt uncomfortable in responding to.

3.4.4 Freedom to decline or cease participation

No participant was coerced to participate in this study. In other words, participation was voluntary as it was accepted that people have freedom of choice. If an individual chose not to be involved in the study, then that was acceptable to the researcher. Similarly, if

any participants wished to terminate their presence midway through the research, they were permitted to do so. Thus, in order to fulfil this ethical principle, the researcher had informed all the participants of their right not to participate in the study or to terminate a session if they so wished.

3.4.5 Trust

In view of the qualitative nature of the study the issue of trust or rapport between the participants and the researcher was also of importance. The researcher used consent forms (see Appendix 2) that were completed by all the participants after the forms had been explained to them by an HR officer. On the consent forms it was made clear to the farm workers that they were entitled to withdraw from the study at any time, and that their real names would not be linked to their views. On completion of the study these consent forms will be destroyed so as to protect the identities of the participants.

3.5 CONCLUSION

This chapter has highlighted the background to the research methodology. The chapter introduced the exploratory qualitative research design and provided a brief discussion of sampling, data collection methods, data analysis and interpretation and validity and adherence to ethical principles. In the next chapter the researcher deals with the research findings and the interpretation of these findings.

CHAPTER 4: FINDINGS

4.1 INTRODUCTION

In this chapter, the findings which emerged from the transcription, translation, coding and analysis of the data are presented. In this respect, Dorinne Kondo (1990:43) comments on the need for research narratives to focus on *“the ways people construct themselves and their lives – in all their contradiction, and irony – within discursive fields of power and meaning, in specific situations, at specific historical moments”*. She adds that it is the role of the reflective researcher is to *“trace the parameters, the limits and possibilities of our located understandings ... animated by an openness to otherness”* (Kondo 1990:86).

In order to put into practice the insights she had gained from Kondo's writing the researcher spent an extended time at the research site – first merely observing and writing notes in her research journal and then participating in some of the activities on the site, accompanying research participants to the nearest health care facility, formally interviewing the nurse at this facility and informally conversing with the group before commencing with the formal data collection. These steps were essential to developing a contextual background to the data as the researcher, as an urbanite, was not completely familiar with the rhythms and flavours of life in a semi-urban, farming environment. In the data presented in this chapter, the researcher uses some of these background notes in an attempt to present the voices of the rural research participants and to address what Lather (2002:199–227) refers to as *“the otherness that always exceeds us”*. To this end, this chapter is organised as follows:

- A profile of the research site and brief profiles of the research participants
- The socioeconomic backgrounds of the research participants
- The themes which emerged from the interviews and the data analysis
- Conclusion

4.2 A PROFILE OF THE RESEARCH SITE AND BRIEF PROFILES OF THE RESEARCH PARTICIPANTS

The following profiles are presented in order to provide some insights into a variety of factors relating to, *inter alia*, the research setting and its idiosyncrasies and the profiles of the research participants as gleaned from the researcher's observational notes.

The research setting is semi-rural, and the proximity of the available health care facilities is disproportionate to the physical distance and location of the farm workers' residences and/or workplaces. Virtually all of the farm workers have had little exposure to formal education, and many have worked on the farms from an early age. The farm workforce includes several undocumented immigrants from neighbouring African countries who have left their families behind, thus creating grounds for pervasive spousal infidelity. During the course of data collection, it soon became apparent that the selected research participants did visit the local clinic. In order to ascertain further the condition of the clinic and the nature of the health care services it provided, the researcher visited the facility to validate/invalidate the remarks made by the research participants.

In comparison with other spheres of health research, the field of HIV and AIDS among farming communities has been under researched (see Netangaheni 2008 for similar conclusions). For the purposes of this study, primary documents were sourced from the Bapsfontein clinic, and a personal interview was conducted with the primary health care worker – a nurse. The total absence of any clear prevalence data for HIV infection and AIDS cases at the research site, that is, data disaggregated to the particular population at risk at a sub-district level, reflects the need for greater administrative coordination between the local, district and provincial healthcare structures, as this would enhance the capacity of national health departments to deliver sustainable services to the public. In the section below, short impressions of and backgrounds for each of the research participants are presented in the same order in which the respondents were recruited for participation in the study. However, in the presentation of direct quotations, all

individually identifiable links have been removed to honour the guarantee of complete confidentiality made to the research participants.

The first interviewee was a man, aged 34 years, who worked at the site as a packer. He was a frail, slight man with a nervous disposition. His speech was unclear and his voice tended to trail off at the end of his sentences. This was particularly evident when he said something which he felt might not be to the liking of his supervisor should the latter ever find out. He had lost his partner and child as a result of AIDS-related illnesses and tended to live a reclusive life. When the researcher asked him if he had friends he responded *“Well, I do not have friends.”* Then, as an afterthought, he added: *“The colleagues are, you can say, are my friends ... because I sometimes ... I need to share my pain.”*

The second interviewee was a 39-year-old woman who held an administrative job. She was responsible for issuing equipment from the storeroom. She was confident and articulate and seemed to be extremely comfortable in her job. She talked about being “drawn” into her work. In a moment of candid insight she even told me: *“I have grown ... learning from other people, because they come in with a completely different angle to what you experienced.”*

The third interviewee was a 28-year-old male who was the groundsman (or groundskeeper). Since the nature of the job meant that he did not have a fixed office space or workstation, he mingled with the other workers in the open. His working conditions are physically demanding and entail working in the open for long hours. He was mild-mannered and revealed that he had a mentor within the organisation to whom he went for assistance. This mentor was an older woman, whom he regarded as a caring mother figure. He reported that she treated him like a son and confided that he was drawn to the emotional comfort that this provided. He was a religious person who went to church on Sundays.

The fourth research participant was a woman aged 48 years who worked as a packer. She was softly spoken, but confident and articulate. She was also open and frank in her discussions and did not shy away from sensitive questions. The fifth interviewee, also 48 years old and also female, was the most energetic and loquacious of all the interviewees. Also working as a packer, she took great pride in her work and was extremely hard working.

Interviewee number six was a 50-year-old female who worked as a picker. She was slightly apprehensive and seemed mildly irritated with the interview process, although she had given consent to participate. She often did not respond in words, but rather gesticulated or gave brief responses. Her reactions were very similar to the reactions of the seventh interviewee, a 48-year-old male who was also employed a picker and who did not volunteer information easily.

The final three interviewees, one woman and two men, were all aged between 42 and 50. The 42-year-old woman worked as a packer and was calm, composed and articulate. She talked about hope as the emotion underpinning her life. The 48-year-old male, employed as a picker, was mild mannered, but spoke openly and frankly about his many sexual relationships. In the course of the interview, he disclosed that he is living with HIV. The 50 year old male was shy and difficult to interview. He appeared tired and possibly depressed. He was reluctant to speak to the researcher, wanting to know how much time it would take. Despite the fact that the interview was conducted in a private setting with a door which could be closed, he left the door open throughout the interview. He occasionally turned his head slightly away and looked out of the office window. This had the effect of emphasising to the researcher that he was uncomfortable in discussing the subject matter, although he had volunteered to be interviewed.

4.3 BIOGRAPHICAL CHARACTERISTICS OF INTERVIEWEES

A brief biographical description of each interviewee is presented below. The respondents are referred to as first, second, etc interviewee in order to protect their confidentiality.

The first interviewee was a 48 years old male. He had grown up in Mozambique. During the previous year he had become extremely ill and had been forced to take leave. He had tested positive for HIV but was not on ARVs at that time of our interview. Approximately eight months after leaving work he was able to return on a part-time basis.

The second interviewee was a 39 year old female who had grown up in Limpopo province where the family lived in one dwelling. Her father had worked as a security guard for a government department but he had died from tuberculosis (TB) when she was in Grade 6 (Standard 4). She had not been able to continue with her schooling after her father's death as her mother was not able to pay the school fees. Her dream of becoming a teacher had been shattered.

The third interviewee had lived with his wife, his three children and his parents for a period of five years. His parents were not in good health – his father's leg had been amputated because of an illness and his mother suffered from high blood pressure. Both his parents had worked on the same farm before he started working there. His six siblings had grown up in the Free State with his uncle. There had been a total of sixteen people living in his uncle's house. He believed that his uncle had favoured his own children and described his childhood as "terrible." He had never lived with his own parents until they had become too weak to look after themselves and had moved in with him five years previously. This third interviewee was 28 years old at the time of the interview.

Similar views were expressed by the fourth interviewee in that she had also not been raised by her parents. She was still single with four children and in her late forties. Her

elderly parents were still living in Bushbuckridge in the Limpopo province. In her view she never had fun as a child and she had had a difficult upbringing. Her wish of becoming a nurse one day had never been realised.

The fifth interviewee was in her late forties and worked as a packer at the farm. She would have liked to become a nurse but poverty had meant that she had not been able to finish school. She lived with her partner and three children on the farm.

The sixth interviewee was a 56 year old female who had grown up in Mpumalanga (Sabie) province. She had started working on the farm when she was a teenager. Her ambition had been to become a teacher but, because of financial constraints, she had not even been able to go beyond Grade 3 (Standard 1). Nevertheless, she believed that the support she received from her family, friends and the workforce made her work worthwhile.

The seventh interviewee had been born in 1961 although he maintained that his passport erroneously stated that he had been born in 1954 in Mozambique. He had married a South African woman and had four children with her. When he was growing up, his family had members of the Old Apostolic Church and he was still an active member. He stated that he was bringing up his own children in a religious environment. The church appeared to play an important social function in his life as church affairs were the only other activity in which he participated that provided a social network besides his work and family.

The eighth interviewee had grown up in Limpopo province and had worked on several farms before she joined Country Mushrooms. She had come to Gauteng province with her partner of 2 years. She described herself as having adjusted to her current work. She liked her job but would like to go back home to her family. She was 42 years old at the time of the interviews

The ninth interviewee was a male in his fifties who had worked at various farms before coming to Country Mushrooms. He was articulate and communicative during the interview and describes himself as having a love of people, especially women. He had grown up in Mthatha as an only child and had never gone to school. However, he had learnt to write his name and last name while employed as a farm worker.

The last interviewee was a 48 year old male who had grown up in Limpopo province. He had married according to customary law and had several children. He had never had the opportunity of going to school and, as a result was unable to read and write although he was able to make a cross to indicate his signature.

4.4 THE SOCIO-ECONOMIC BACKGROUNDS OF THE RESEARCH PARTICIPANTS

The farm chosen for this study is typical of workplaces in the agricultural sector of Gauteng province. The farm is situated on the outskirts of “Die Aalwyne farm” in Bapsfontein, south-west of Bronkhorstspuit. This farming district is characterised by rural infrastructural underdevelopment and disproportionate access to health facilities as compared to urban or metropolitan areas. In a discussion with the health care provider at the local clinic, the researcher found that those socioeconomic factors that often render people vulnerable to HIV-infections, for example, poverty (FAO 2002), were rife in the area. In addition, behavioural factors, and in particular, unprotected sex and multiple sex partners, were also problems that predisposed the inhabitants of this area to HIV-infections. Under sub-heading 2.6 in Chapter 2 of the dissertation, the researcher discussed the issue of the vulnerability of farm workers to HIV-infection. Moreover, the easy availability of alcohol in the area, and the absence of recreational and other social amenities, completed a scenario in terms of which the farm workers, as a socioeconomic category, and their lifestyles could possibly, if urgent action were not taken, remain confined to the inevitable status of an underclass or cohort rendered extremely vulnerable to HIV and AIDS.

4.5 THEMES EMERGING FROM THE INTERVIEWS AND THE DATA ANALYSIS

This study focused on the evaluation of the implementation of an HIV and AIDS policy at Country Mushrooms. The following seven themes emerged from the analysis of the participants' responses:

4.5.1 Knowledge and perceptions of vulnerability to HIV infection

4.5.2 Preventing HIV infection

4.5.3 Perceptions of treatment for HIV and AIDS

4.5.4 Perceptions of VCT and workplace-based HIV and AIDS programmes

4.5.5. The impact of HIV and AIDS on the farm

4.5.6. Possible solutions to the problems caused by HIV and AIDS in the farming community

4.5.7 Discussion of the impact of the inadequate access to health care facilities

4.5.1 Knowledge and perceptions of vulnerability to HIV infection

As discussed in Chapter 2 of the dissertation, ascertaining the levels knowledge of HIV and AIDS is an important first step in any consideration of an HIV and AIDS workplace policy. All of the participants were able to link HIV infection with AIDS. In addition, the research participants indicated that HIV-infection is incurable, fatal and transmitted through sexual intercourse. This implied that the farming personnel, employees and community members had some form of understanding regarding HIV and the main modes of transmission of the virus. However, there is still a dire need for simplified education and training. Although some of the statements did not constitute proper descriptions of HIV, they did, at least, indicate an understanding that HIV causes AIDS, and not vice versa, for example:

AIDS is a combination of diseases. [Interviewee No 1]

It is a serious disease. [Interviewee No 2]

It is an incurable disease. [Interviewee No 3]

It is a killer disease. [Interviewee No 4]

AIDS is caused by unprotected sex. [Interviewee No 5]

However, not all of the research participants were knowledgeable about the transmission and preventive factors related to HIV infection. For example:

I heard people talking about HIV and AIDS but I don't know how it gets into a person. They say it starts as something like a small disease and ends up being AIDS. There is a need to find "muti" (*traditional medicine*) to cure AIDS. [Interviewee No 6]

HIV and AIDS gets into people in different ways... one example is that when we sit together talking, you may find that my saliva gets through your mouth and you get AIDS. [Interviewee No 7]

You can also get AIDS by sharing a glass of water with someone else, especially if it used without being washed. [Interviewee No 8]

You can also get AIDS through sexual intercourse. The way I heard is that you can get AIDS through unprotected sex, like having sex without a condom and your blood contact can give you AIDS. [Interviewee No 1]

If people use one toothbrush they can get AIDS. [Interviewee No 2]

It may, thus, be concluded that ignorance about the disease's aetiology is still an important risk factor for some of these respondents. However, awareness and knowledge does not necessarily translate into appropriate preventative behaviour, as the quotations from the interviews below indicate. The following are some of the combined narrative responses from the group:

Do not know or do not believe that there is anything. [Interviewee No 6]

That we can do to avoid infection. We can only protect ourselves by using condoms and, apart from that; there is nothing we can do. It is not possible to abstain from sex, we try, but it is difficult. If you abstain your man will get another woman and chase you away [Interviewee No 4]

None of the research participants knew what the acronyms "HIV" and "AIDS" denoted. Some were also not able to differentiate between HIV and AIDS, and believed that HIV and AIDS referred to the same disease. Some notion of the manifestations and symptoms of the disease were given by the participants. Some of the verbatim responses are given below to illustrate this point:

It is a virus that affects a person who will be said to be having AIDS.
[Interviewee No 5]

Any disease can come to you and grow bigger. The person (sufferer) becomes thin and eventually dies [Interviewee No 1]

4.5.2 Preventing HIV infection

After devoting some time to the discussion of HIV and AIDS, the researcher guided the respondents to consider the way in which HIV infection may be prevented. The discussion was immediately dominated by one prevention strategy only, namely, the use of condoms. Most of the respondents expressed negative views about the use of condoms, for example:

Condoms are important but we don't trust them. [Interviewee No 3]

These condoms are perceived to be AIDS carriers. [Interviewee No 1]

I have never used a condom in my life. [Interviewee No 8]

The only problem with condoms is the oil and the worms on it.
[Interviewee No 6].

I can't agree to sleep with a man who uses a condom. I will just tell him, I don't use that thing. [Interviewee No 4]

The majority of the male respondents reported that they felt uneasy at demonstrations of male and female condoms at the clinic or in the workplace. To them, protected sex was the equivalent of an *"invasion of privacy"* and a *"besmirching"* of their *"traditionally endowed genital supremacy"*. It is acceptable that men have multiple sex partners, as this is perceived as part of their culture and as a sign of manhood. Some of the workers are in informal partnerships which involved living together, possibly because *lobola* had not yet been paid. According to one woman it is not possible to abstain from sex as, if you abstain, your man will find another woman and chase you away. A frequent

misconception among the respondents appeared to be that condoms themselves are carriers of HIV and AIDS and, therefore, they should not be used. The women also indicated that their husbands or partners either did not like condoms or that they had not considered using them. In terms of other preventive strategies, such responses as *“HIV and AIDS can be treated by abstaining, condomising or by using ARV treatment if you are already infected with the virus”* denoted misconceptions about ART and about the difference between prevention and treatment.

The above narrative statements indicate that there is some form of awareness about HIV and AIDS among some members of the farming community; although they are not necessarily able to articulate the technical and medical aspects. It is, thus, clear that the farming community needs more formal HIV and AIDS prevention and treatment training interventions so as to enable them to differentiate between the two terms. The participants obviously experienced some difficulties as regards their understanding of HIV and AIDS and there are also misconceptions regarding the two issues. Country Mushrooms, the other farm owners and the district and provincial health authorities have a moral responsibility to ensure that their employees, as well as those in their care, are aware of the impact and effect of HIV and AIDS. As discussed in Chapter 2, knowledge is the key to success to any challenge in South Africa.

Prevention will be effective only if people come out, disclose their status and talk openly about their illness so that the reality and severity of the pandemic may be clearly understood. In other words, HIV and AIDS prevention measures will be clearly understood and taken seriously only if the messages come from the infected people themselves. As alluded to in Chapter 2, the stigma attached to the HI-virus forces people to hide their condition and to shy away from public places because of their fear of blame and rejection, thus rendering the process of effective prevention difficult, if not impossible.

4.5.3 Perceptions of treatments for HIV and AIDS

In Chapter 2 the researcher noted that the full empowerment of workers includes helping them understand the causes, aetiology and treatment options related to HIV and AIDS. Such critical awareness is regarded as a prerequisite for behavioural change. The research participants expressed the following pessimistic views regarding the treatability of HIV and AIDS:

It is not curable but the treatment makes people feel better.
[Interviewee No 6]

There is no cure or treatment. [Interviewee No 5]

There is no cure, but there are medications that are taken by HIV-positive people in order for them to live a longer life. [Interviewee No 4]

No, there is no cure for AIDS. The only thing is to take care of yourself and accept the way you are... there are ARVs which help but do not cure HIV and AIDS. [Interviewee No 2]

These narrative statements reveal that the participants understood there is, at present no cure, but that ARVs may prolong life. The discussion then moved to the overall management of HIV and AIDS. In this regard, the responses of some of the respondents demonstrated a fear of people living with HIV and also disrespect for their human rights, for example: *“The government should take care of people living with HIV and AIDS and ensure that they do not engage in unprotected sex.”*

Some of the respondents clearly placed their trust in the ability of both Western and traditional medicine, for example:

If the traditional and Western doctors can join hands, they could perhaps come up with a cure for this killer disease that is destroying our nation. Cooperation between the two groups will be vital if we want to succeed in the comprehensive treatment and management of HIV and AIDS. [Interviewee No 1]

Scientists, doctors, traditional healers must work jointly and quicker than they are doing now. HIV and AIDS seem to be the most politicised health problem. [Interviewee No 5]

Other respondents made the following references to the socioeconomic context of HIV and AIDS:

Countries that are poorer will be deeply affected by HIV and AIDS because there would be not enough resources to fight the pandemic. [Interviewee No 3]

The farming community have to use some of their profits against the HIV and AIDS problem. [Interviewee No 7]

The government alone could not succeed in fighting this epidemic...The private sector has to play an active role concerning the management of HIV and AIDS. [Interviewee No 2]

As a result of the prolonged and unsuccessful efforts to find a cure for HIV and AIDS, societies have resorted to preventive efforts as an alternative way in which to fight the epidemic. Prevention is clearly the only option in view of the fact that there is, at present, no cure. Health information messages and the use of contraceptives such as condoms are believed to be ways in which to curb the spread of the epidemic by reducing the new infection rates which have eroded most families and left others destitute.

The respondents indicated that they were aware of the existence of the disease and they were able to provide compelling descriptions of the signs and symptoms of the virus. However, they were also clearly experiencing some difficulties and there were misconceptions regarding HIV and AIDS. Given the existing situation, there is an obvious need for the farming community and other stakeholders to cooperate in order to confront the challenge of HIV and AIDS. Building coalitions is important in order to bring together the diverse groups that are already committed to fighting the HIV epidemic and to enable them to draw in others who are not yet fully convinced. These groups could include sections of government, including the National HIV and AIDS Secretariat or coordinating body, the National HIV and AIDS Council or inter-ministerial committee, the HIV and AIDS units in certain ministries, civil society groups that are already active and often include one or several national umbrella organisations, associations of people living with HIV and AIDS and a wide assortment of multilateral, bilateral and international non-governmental agencies. To support the process, these various individuals and institutions could be engaged as members of task forces, inter-agency working groups led by government and other national actors. Country Mushrooms and other farm owners have a moral responsibility to empower their employees by ensuring that they are made aware of the impact and effects of HIV and AIDS.

The researcher asked the respondents to consider HIV testing as a first step to education and, if necessary, referral for treatment. One of the research participants only has been tested for HIV. In terms of health-seeking behaviour among farm workers, it was found that many of the participants were very reluctant to be tested for HIV and it is probable that very few were aware of their status. An extremely common feeling expressed in the words *“What you don’t know won’t harm you.”*

Access to treatment in the case of HIV and AIDS is a process which commences with knowledge of one’s HIV status. However, in view of the fear, denial and silence surrounding the disease, such knowledge of one’s status becomes threatening and people are reluctant to be tested for HIV. People choose to live without the knowledge

of their HIV status because they are afraid of being labelled and rejected should they be found to be HIV positive.

The majority of the research participants indicated that they would prefer to go for HIV testing at places other than government clinics because they felt that the prevailing attitudes at such clinics meant that if you tested positive, you would, inevitably, die. When asked to explain what they meant the respondents explained that, in their view, government clinics do not provide proper counselling, caring attitudes and confidentiality about people's status.

The absence of a cure and the fact that antiretroviral treatment will probably prolong life for a certain period only also made some of the research participants hesitant to be tested. This is indicated in the following statement:

We are afraid because we can be told that we are HIV positive. Once you discover you are HIV positive, you will think a lot and will have a difficult life. You think of death in 4 or 5 years' time or maybe 10 years and feel haunted by the disease. [Interviewee No 6]

Some people avoid testing because they fear dying. This fear is exacerbated by the fact that, according to popular conception, HIV and AIDS are strongly associated with death. Accordingly, people prefer not to know their status rather than live with a death sentence. Another reason associated with people's unwillingness to be tested is a fear of the psychosocial consequences of testing positive for HIV, because the diagnosis may lead to a loss of social status, discrimination and domestic violence.

These negative perceptions about VCT and governmental health care facilities may act as powerful deterrents to the utilisation of VCT. As indicated earlier in this chapter, the researcher had visited the local clinic, observed the running of the facility and conducted an interview with the nurse on duty. The fears about poor counselling, uncaring attitudes

and lack of confidentiality were certainly not borne out by the researcher's visit to the clinic.

Access to health care, which includes treatment, care and support, is one of the basic human rights enshrined in the Constitution of the Republic of South Africa (Act 108 of 1996). Prevention, care and support are, thus, components through which the impact of HIV and AIDS may be mitigated.

The clinic mentioned in this study offered VCT services. The number of patients presenting daily for VCT ranged between 10 and 18, while the number of counsellors employed varied between one and five, depending on the geographical location of the clinic. The counsellors had to attend a 10-day VCT training course. It was also reported that they received additional training through workshops from time to time to update their skills and knowledge.

The counsellors' responsibilities include offering VCT pre-counselling, testing and post-test counselling. The group counselling of pregnant mothers at the antenatal clinics, as well as general health talks, is also conducted by the counsellors while the clinic nursing sister acts as a mentor to the counsellors. The interviewees reported that patients requesting VCT were attended to on the same day and in a matter of hours and, thus, it was clear that none of the respondents felt that patients were forced to wait for lengthy periods before being counselled. In addition, no one indicated that the patients who presented themselves for testing were ever turned away because of staff shortages.

Patients who tested positive for HIV were immediately sent to Tembisa Hospital to have blood samples taken to test their CD4 counts. The researcher deduced from her observations at the clinic that the clinic staff was adhering to the "Batho Pele" principle (serving our people with pride) of the new government initiative.

In terms of the confidentiality of an HIV status, most of the research participants indicated that they believed that disclosure was a personal decision. Certain of the

interviewees were of the opinion that such disclosure may be necessary to enable the HIV-positive person to receive assistance and to access the necessary health and social services. Some of the research participants believed that disclosure would be treated as confidential if the person was tested at his/her workplace but, as indicated earlier, some of the interviewees had negative views about confidentiality at the governmental VCT clinics.

4.5.4 Perceptions of VCT and of workplace-based HIV and AIDS programmes

The researcher directed the discussion to focus on workplace-based health programmes, as also indicated in Chapter 2 in the discussion of health promotion in the workplace. In this regard, the participants all indicated that, since they had started work at Country Mushrooms, they had not seen or heard of any health-related training being offered at the workplace. Instead, the only form of health-related training offered was offered at the local clinic and one home-based care NGO located in the Bronkhorstspuit area. From the researcher's point of view, this is an indictment against Country Mushrooms and is almost tantamount to neglect.

When asking the respondents about an HIV and AIDS workplace policy, the following response was given by one of the respondents:

I think if they (Country Mushrooms) have such a policy, it would make everybody very much aware. The issue of HIV and AIDS involves us all Some things that people do (like the traditional healers) are dangerous, like using the same razor for different clients. So, Country Mushrooms must play their part. They cannot just hire people and watch them when they die of AIDS. It would be very helpful to the employees and their families if employers played a part. Besides,

employers stand to benefit from healthier employees. I suppose that, in general, it would also help them from paying non-stop death benefits

Some of the respondents indicated that they had heard about Country Mushrooms' HIV and AIDS policy from the clinic nurse who conducted HIV and AIDS awareness and testing. However, all the research participants claimed that they had no idea of the type of assistance Country Mushrooms provided to employees who were either infected with HIV or affected by HIV and AIDS. Furthermore, none of them had participated in the drafting of such a policy nor had they ever seen a copy of it. The participants also revealed that there was no HIV and AIDS committee in place nor were there any workplace representatives. When asked why this was so, one of them responded: *"Because this issue is a sensitive one."*

In terms of HIV and AIDS education and awareness campaigns conducted at the workplace, the research participants referred to two education and awareness interventions, one conducted in 2003 and another in 2005 – both had included a saliva HIV-prevalence test – and that an HIV and AIDS survey had been conducted in 2005. In terms of the consequences of these interventions, the research participants stated that they believed that several of the workers had gone for VCT in response to the wish expressed by the farm owner that he required them to go. This was to enable him to make future plans in anticipation of the impact of the disease on the farm. Some workers had been motivated to go for VCT by the owner's promise that people who tested HIV positive would be moved to "lighter jobs" as needed. However, some of those who went for VCT did not fetch their test results. Nevertheless, many workers, including most of the interviewees, had not been persuaded by the owner's appeal to go for VCT because of their fear of being tested.

It was felt that, beyond these interventions, the farm workers had not heard, seen or knew anything about HIV and AIDS in the workplace and that more interventions were needed in order to allay the workers' fear about being tested. There was clearly a lack of trust in management's promises because the farm workers had not seen the HIV and

AIDS policy in black and white. This, in turn, raised doubts about the reliability of management's promises regarding HIV and AIDS. The participants also reported that they had not ever seen anyone being moved to "lighter jobs" and, thus, they doubted that this would happen.

In general, the participants were deeply suspicious of and seriously doubted the reliability of the saliva tests. This had resulted from an incident where an employee had received conflicting results from the test. This incident was retold often and had confirmed the workers' fears and suspicions about HIV testing. The researcher asked whether there may not, perhaps, be rational reasons for such conflicting results, for example, the efficacies of different test procedures or when a person is tested during the so-called window period. This did not help to further the discussion on this matter, as the interviewees had never been informed about this and they were not aware of or know what the window period referred to. In addition, the saliva test incident had caused great confusion as the workers had been told that HIV could not easily be transmitted through saliva. This misconception is an important indicator of the technical difficulties involved in HIV and AIDS education.

After the HIV-prevalence survey in 2005, Country Mushrooms had made E-pap and soya-based foods available to its workers because of their nutritional value and immune-boosting effects. While most of the participants admitted that the workforce continued to buy these products for general use, the general perception was that these foodstuffs were stigmatised because they were linked to a positive HIV status.

There was a mixed response from the respondents as to whether participation in the prevalence survey should have been either compulsory or voluntary. The controversy arose from differing interpretations of the practical implications of confidentiality as regards HIV status and the dynamics of HIV disclosure. Some of the respondents felt that there was no clarity as to what would happen to a person who was already living with HIV and also to a person who would have found out that he/she was infected with HIV. The belief was expressed that, if a person were HIV positive, then that individual

should approach someone they trusted in management to disclose their HIV status as the reason behind, for example, absenteeism. The view was that if a person were to have access to treatment, then the company had to be made aware of his/her status as, without this awareness, the “positive” worker would be fighting a losing battle. This is a reason why the company had introduced the E-pap and soya-based foodstuffs for their nutritional value and immune boosting affect; but the way in which the two foodstuffs had been advertised was continuing to make people suspicious and to associate these foodstuffs with HIV status. The opposing view was that this amounted to “forced” disclosure because it should remain an individual’s choice as to whether or not to keep their status confidential because of possible discrimination and stigmatisation. The respondents felt that there was still a high level of mistrust among the workforce as regards the introduction of the two foodstuffs.

One of the misconceptions was that, if a worker bought E-pap and soya-based foodstuffs, this meant that the worker was automatically disclosing his/her status to the rest of the workforce. It appeared that beyond these interventions, the workers had not heard, seen or knew anything about HIV and AIDS in the workplace and that more interventions were needed to allay the workers’ fear of being tested. This raises doubts as to the reliability of management promises in connection with HIV and AIDS. This perception is formed due to inadequate knowledge indicated by low levels of risk assessment and a lack of any studies into behaviours or conditions amongst the workforce.

4.5.5 Impact of HIV and AIDS on the farm

Section 2.2 in Chapter 2 of the dissertation is devoted to an exploration of the impact of HIV and AIDS on the agricultural sector. The participants were asked the following question: *“In your opinion, are there HIV and AIDS problems here at the farm?”* The responses provided by the research participants revealed that they found it difficult to express the impact of and the extent to which HIV and AIDS was affecting their lives on the farm. They indicated that they were aware of labour shortages when some workers became sick and were unable to work during bouts of illness for example:

I think it (*absenteeism*) has picked up a little bit. I cannot say the percentage, maybe a slight increase ... All I can say is that, from what I've noticed, people are not as strong as they used to be...Also, funerals have increased a lot ... usually of family members...they come and ask for help ... this has increased in the last 3 to 4 years.

When exploring this point further, issues such as increased farm worker absenteeism, reduced productivity, production losses, failure to meet deadlines and farm worker shortages were mentioned. HIV and AIDS were also reported to be affecting staff morale as a result of the psychological impact on non-affected staff and because of the tensions created in the workforce by the disease. Many of the research participants felt that, although there were high numbers of AIDS-related deaths on the farms, the families of some of the deceased would not admit to the truth. Some employees tended to blame HIV and AIDS on witchcraft by stating that they had been bewitched.

Although not part of the sample, the researcher decided to confirm these perceptions about HIV and AIDS with the farm owner. His verbatim response was:

I do not want to guess what percentage of people is infected with AIDS but I'm sure that, if I take a guess of more than 40%, I will not be too far off. Not necessarily all of them are affected, work-performance-wise, but a percentage of them are ... what we see is that this performance is going down, down, down, on average. If you ask them, to a lot of them it is because the people are sick. And you have some people, mostly your more educated ones as far as AIDS is concerned; they talk about a 'slow puncture'. They call somebody with AIDS a slow puncture ... But they will tell you it is things like TB, or he's got a skin problem, he's got a problem with his blood ... they sometimes call it 'his blood is dirty or he's got an internal problem.

HIV and AIDS is a disease that thrives on a lack of understanding and misinformation. The fact that it was estimated (UNAIDS 2008) that there were approximately 40 million people worldwide living with HIV and AIDS at the end of 2010, is primarily the result of a lack of knowledge on the nature of the disease and how to prevent it, as well as a lack of knowledge regarding proper treatment that would enable people infected with the virus to remain healthy and productive for a long time.

With the emergence of HIV and AIDS came the stigma attached to the disease. Stigma was also a factor in the first years of the HIV and AIDS pandemic when it was seen as a mechanism in terms of which to reform morally unacceptable behaviours. Accordingly, HIV and AIDS is a devalued physical, medical and behavioural attribute with those infected displaying clearly visible bodily symptoms. In addition, it is considered to be a contagious disease which may be transmitted if certain precautions are not followed, while its association with opportunistic diseases such as TB also makes it a feared condition because of its ability to be transmitted to other people. Those infected are, therefore, rejected and avoided because of the fear of contamination. If a person is known to have or is suspected of having a contagious disease such as HIV and AIDS, he/she will be identified as different and labels will be attached to him/her with such labels tending to take some form of metaphor – as highlighted in the paragraph above, for example, “*he has a slow punch*” – which are, in turn, influenced by people’s experiences from which they draw information in order to make such judgements. People then tend to search for negative attributes which these people possess so as to justify the attachment of labels to them.

Many farm owners are worried about the effect of HIV and AIDS on their farms but, at the same time, they perceive the epidemic as a distant problem and they appear to have taken little, if any, action to prevent infection among their workers or put in place any support mechanisms for the affected workers. One explanation for this lack of initiatives on the part of the farm owners may be that they themselves lack any knowledge of appropriate interventions. It has also to be said that there seems to be a poor attitude among farm owners towards the HIV and AIDS problem and very little

interest in the issue. The farm owner in the study reported that *“If a farm worker falls away, he is easily replaceable. AIDS has had little effect on us due to the fact that we do not do specialised work, people are easily trained in what they have to do, and the effect on business is very little”*.

The farm owner also reported having noticed an increase in the number of deaths among his staff members. He said:

You find more people attending clinics and taking sick leave than in the past but I ... wouldn't say alarmingly so. What we do find, though, is people really becoming really ill and dying. I can confirm 3 HIV deaths in the last three years, but I suspect there are a lot more. You will find that people come and resign. We ask them, why do you want to resign? They say, 'Look, I'm tired, I want to go home and rest' ... This is not necessarily an AIDS thing but you find this happening more and more. And then you hear 3, 4, 5 months later, you hear that they died ... we sometimes find that a lot of these people, they haven't had themselves tested but they have a very good idea, so they resign, they take their money, they go home and they die. Where you find the most deaths is your men aged 35 and up. That's where we tend to get most of our deaths

The farm owner is referring to individuals who are active and who are in their most productive years. As alluded to in Chapter 2, available literature shows that social capital or community-related factors may play a key role in the susceptibility of individuals or groups living in informal areas (squatter camps), with most such areas appearing to have higher HIV-prevalence rates than other geographical locations (UNAIDS 2008)

The perceptions of the farm owner about people hiding their HIV-positive status were borne out by the responses of the research participants who confirmed that:

Most of us who are HIV and AIDS affected do not disclose it for fear of being shunned by other people and families. People will no longer love you like before

In other words, those infected decide to keep the condition to themselves and avoid situations where the condition may be recognised. These people pretend to be healthy and without problems, despite the fact that they are suffering and they are stressed by the disease. However, this secrecy becomes a coping mechanism which enables them to keep the condition to themselves for fear of being labelled.

These reactions also appear to be closely linked to the stigma attached to HIV and the fact that people are reluctant to speak openly about the disease. It also seems to be common and accepted practice that workers who fall ill leave the farm to die at home and to be buried in their villages. This hidden impact of HIV and AIDS on the farm workers was described by one of the interviewees as follows:

I can't really tell the truth about the danger of HIV and AIDS on this farm, since we never heard anyone telling us about someone who died or is infected with HIV on the farm .People are buried at their villages and most of them die of unknown illnesses

HIV and AIDS are treated with fear within communities and families because anyone who is infected is viewed as guilty and is blamed for contracting the disease. Farm workers who are living with HIV believe that the only way in which to avoid blame and rejection is to keep quiet and pretend that the condition does not exist. They often feel that they have done something wrong or they have angered the gods and they deserve to be punished for contracting the disease.

4.5.6 Possible solutions to the problems caused by HIV and AIDS in respect of the farming community

The interviewees were asked to consider possible solutions to the problems caused by HIV and AIDS in respect of the farming community. Given the empowerment framework that underpins this study (see Chapter 2), it was important to gauge the workers' own suggestions for addressing the problems caused by HIV and AIDS in the farming community. The solutions offered included educational interventions, for example:

Bring a trainer.

The most important part is to educate our people about the reality of HIV and AIDS.

The people on the farms must be treated equally. They must get education on HIV and AIDS.

People must be given HIV and AIDS pamphlets. Those who are infected by HIV must be taught to follow treatment as usual and must use condoms during sex.

The fact that a number of respondents indicated the need for a full-time HIV and AIDS trainer on the farm makes it abundantly evident that they regard training for both farm workers and farm owners as desirable such training interventions should not be ignored or overlooked any further, especially in view of the fact that HIV and AIDS is still viewed as a serious threat within the farming community.. Given the situation the suggestion that a full-time trainer be appointed on the farm should not be taken lightly, particularly as such an appointment would help alleviate the manpower shortage indicated by management. A further solution offered related to action on the part of either the state or the farm management, for example:

In my opinion, I think our manager should ask someone to come and teach people about HIV and AIDS every month because most of the people in the farming community are not aware of the disease and most people are coming from disadvantaged areas

Put a notice board up saying: Don't sleep around

Farm workers must not keep their girlfriends in the workplace

Health and welfare officials must visit to distribute condoms

There is clearly a need for cooperation between the farming communities and other stakeholders so that the challenge of HIV and AIDS may be confronted. Farm owners have an obligation to work with government departments, especially the Department of Health and Social Development and relevant NGOs in the management of HIV and AIDS. A third suggestion related to the establishment of a climate of tolerance and acceptance, for example:

The community must try to accept those who are infected by HIV and affected by HIV and AIDS.

My solution is like a slogan: 'One man, one wife'. If you fail to do that, you can condomise or abstain. But, most important, is to have one man or one wife and believe that God will help us.

Implement a one wife, one life policy.

The respondents were clearly of the opinion that there is a need to empower the farming community with basic knowledge and information which could help them in the event of anyone in the community becoming infected. In Chapter 2, the basic tenets of worker empowerment were detailed. From the data gathered, the researcher thus

concludes that the workers also need to be empowered to embrace behavioural and attitudinal changes. In addition, lack of family and community support for HIV and AIDS positive individuals often leads to fatalistic psychosocial stress and unnecessary illness.

The researcher also asked the interviewees to indicate who should take a leading role in implementing the suggestions. The most striking feature that emerged from the range of possible solutions offered by the interviewees was the fact that the responsibility for implementing solutions should not devolve on any one stakeholder in particular. Instead, all of the agents in the farming community were regarded as instrumental as possible candidates, including the farm owner, Country Mushrooms as an organisation, local, district and provincial public health care authorities and the farm workers themselves. These social actors were viewed as playing a critical role in the formulation, development and implementation of a meaningful and comprehensive HIV and AIDS policy for farm workers.

4.5.7 Discussion of the impact of the inadequate access to health care facilities on the workers' daily lives on the farm

The extreme vulnerability of farm workers in South Africa was discussed in Chapter 2 of this dissertation. Therefore it came as no surprise to find that a depressing picture emerged from the collective statements of the majority of farm workers, who felt that, insofar as their "health care rights" were concerned, they were not part of mainstream society. In this regard they used adjectives such as: "*neglected*," "*unwanted*," "*ostracised*" and "*cheated*" to describe the way they felt about their treatment by both Country Mushrooms and the public health care system. They justified their conception of health rights by referring to infrastructural development in other non-farming communities and regarded such "*unequal development*" as a "*new form of discrimination*". Access to adequate health care offered by the public health care system was categorised as follows:

1. *Distance to the only available facility:* The clinic was far from the farm and this was compounded by the costliness of the scarce public transport facilities, thus presenting problems as regards physical access. There were two mobile health care clinics only which were infrequently available to all the farming communities.
2. *The range of health care services provided:* The Bapsfontein clinic was neither well staffed nor sufficiently well equipped to cater for various illnesses, for example, TB. In addition, ambulance services were virtually nonexistent so that desperately ill people sometimes died while waiting for an ambulance to be dispatched from Tembisa Hospital which is some 58 kilometres from Bapsfontein. There were no doctors at the clinic while volunteers, for example, from the home-based NGO, complemented the health care staff providing services to the farming communities. Community-based HIV and AIDS prevention and health care education campaigns were both few and irregular, while Country Mushrooms did not provide workplace-based health care education and training by peer educators.

The frustration experienced as a result of these issues is demonstrated in the following extracts from the interviews:

There are many expectations, but few people to fulfil those expectations. On the other hand, the provincial (health) department will tell you there is not enough funding from the national (health) department. So, it all comes to funding. If there is no money to pay people, they go to other countries like Australia and England. But we still have to do the job. Our people are dying. The local farm owners and companies must also play their part.

As employers of farm workers here, nothing stops them from educating their employees. For instance, condom distribution does not require a nurse to come to their workplaces.

Employers cannot shift the blame for their incompetence. I think the law requires that they ensure that workers' working environment is safe and healthy.

As you know, many professional nurses are leaving the country for greener pastures. HIV and AIDS require specialised knowledge.

There is a shortage of doctors. We only have a doctor coming once a week to the clinic... The mobile clinic service is not yet as helpful as expected. There are other areas outside Bapsfontein that need to be serviced by the two mobile clinics. You can see for yourself that the distance they have to travel is long. In addition to other services like antenatal care, the increasing HIV and AIDS duties are too much for few people.

We try to work with NGOs to help us. They are sometimes better funded than the public health system.

NGOs such as AgriAids are PEPFAR and/or USAID funded but, as a result of the remoteness of many of the farms, they are unable to reach large numbers of farm workers. The prevention of new HIV infections among farm workers has been less successful (AgriAids Newsletter no14, June 2011).

4.6 CONCLUSION

This chapter presented the major findings of the study according to the themes which emerged during the data analysis. It emerged from the study that the research participants believe that they need more formal HIV and AIDS prevention, treatment and training interventions. In addition, they are still experiencing some difficulties regarding their understanding of the disease and there are also certain misconceptions about HIV

and AIDS. However, an analysis of all the responses and statements given by the farm workers, irrespective of variables such as country of origin, cultural beliefs, gender, material status, educational background and socioeconomic status, indicate that they are, indeed, aware of the existence of the disease.

In the next chapter these findings will be amplified to inform the conclusions drawn and the recommendations of the study.

CHAPTER 5: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The purpose of the study was to evaluate of the implementation of an HIV and AIDS workplace policy for farm workers. The aim of this chapter is to provide a summary of the findings and to discuss the general conclusions and recommendations of the study, with specific emphasis on a summary of the major findings, the limitations of the study, and suggestions for further research into HIV and AIDS as well as recommendations for policy and practice relating to the virus.

5.2 SUMMARY OF THE FINDINGS

This section presents a summary of the major findings.

5.2.1 Knowledge and perceptions of vulnerability to HIV infection

It appeared that many of the respondents interviewed possess an extremely basic knowledge of HIV and AIDS. They seemed to have picked up information from various sources, including the clinic nurse, radio, television and printed materials. However, their knowledge appears to be somewhat superficial and it is likely many have picked up fragments of information but have never been given a complete picture of the disease. The fact that few respondents report having formally received HIV and AIDS information strengthens this hypothesis.

A picture emerged of this community as one which is characterised by a basic knowledge about the disease and where beliefs in traditional healing methods are rife. Although the respondents did possess some knowledge about HIV and AIDS, gaps were noted in workplace strategies for reducing vulnerability to HIV infection. The research participants all believed that educational efforts to increase awareness of HIV

and AIDS were essential but would not be sufficient to bring about change in their own lives and in their willingness to be tested for HIV and AIDS.

5.2.2 Preventing HIV infection

The research respondents indicated that they felt that they were at risks either of becoming infected with the HI-virus or that they were already infected. They also reported that they did not trust their sexual partners. However, despite the perception of high risk, they had never discussed condom use nor actually used condoms with their current sexual partners. This mismatch between knowledge and behaviour among the respondents is difficult to explain. Why are so many of them prepared to engage in casual and unsafe sex despite the fact that they appear to be equipped with sufficient knowledge about protection against the disease and transmission of the virus? In line with what has been mentioned earlier, this may be related to the fact that the HIV and AIDS 'message' has not been fully internalised and that, because of scant information, HIV and AIDS remains a distant problem. Moreover it may be related not only to their limited knowledge of HIV and AIDS, but also to problems in translating their knowledge of HIV and AIDS into action. Such action would include how to act in sexual relationships and the degree of control that they feel they are able to exercise in these relationships.

5.2.3 Perceptions of VCT and of workplace-based HIV and AIDS interventions

In terms of health-seeking behaviour among the research respondents, it was found that they were extremely reluctant to be tested for HIV. They also felt that the emphasis on confidentiality had unintended negative consequences by creating an atmosphere of secrecy that may increase the stigma attached to the disease. Accordingly, it is highly likely that very few are aware of their status with a common feeling being expressed in the words *"What you don't know won't harm you"*. The respondents reported that access to adequate health care centres was difficult with the clinics and hospitals being at some distance from the farms. This problem was compounded by the costliness of the scarce public transport. In addition, VCT services are not available at public clinics

during weekends, there are delays regarding testing and long waiting lists between times of testing.

5.2.4 The impact of HIV and AIDS on the farm

The research participants revealed that they found it difficult to express the impact of and the extent to which HIV and AIDS had affected their lives on the farm. They indicated that they are aware of labour shortages arising when some workers became sick and were unable to work during bouts of illness. Many of the research participants felt that, although there were high numbers of AIDS-related deaths on the farms, the families of the deceased would not admit to that fact. Some of employees blamed HIV and AIDS on witchcraft, saying that they had been bewitched.

Based on the research findings, the researcher came to the conclusion that the lives of participants had been deeply affected by HIV and AIDS. In addition, HIV and AIDS are having a negative impact on agricultural production and rural livelihoods in Southern Africa. Its toll on the productive age group is robbing the economy in general and smallholder farmers in particular of the much-needed, energetic labour force. Two decades of action against the epidemic have revealed that the fight against HIV and AIDS should be multisectoral, involving the integration of strategies aimed at prevention, treatment, care and mitigation.

5.3 LIMITATIONS OF THE STUDY

This study was conducted using a sample of ten farm workers (men and women). The researcher identified the limitations discussed in the following sections:

5.3.1 Study site

The study site was restricted to a specific farm. It is, thus, not possible to generalise the results of this study to other farms throughout the country as they apply specifically to a single farm.

5.3.2 Racial distribution of the respondents

All the participants in this study were black women and men and, thus, no other population group was represented in this study. Accordingly, it is not possible to generalise the interpretation of the findings from this study to other racial groups. The researcher had selected this group as a result of its vulnerability to the socioeconomic challenges associated with HIV and AIDS.

5.3.3 Illiteracy of the respondents

There was a high level of illiteracy among the participants and none of them has progressed beyond Grade 12. This constituted a challenge to them as their knowledge of HIV and AIDS was extremely limited.

5.4 STRENGTHS OF THE STUDY

Although the study has not offered new insights into the issues of HIV and AIDS, its findings are, nevertheless, in line with the findings of other researchers. The main implication of the findings of this study is that HIV and AIDS remains a serious problem with no cure envisaged within the foreseeable future. It is essential that this fact be taken into account in any efforts to address HIV and AIDS. However, the findings from this study highlighted the fact that, in order to promote and facilitate behavioural change among the farming community in general, it is necessary to implement effective programmes designed to alter the beliefs and attitudes of this community. The existence of a policy will guide health care interventions as well as health education programmes and, possibly, reduce new transmissions. An HIV and AIDS policy may, therefore, serve as a tool in the management of HIV and AIDS and assist farm workers in preventing the disease, thus limiting further infections.

5.5 SUGGESTIONS FOR FUTURE RESEARCH

Based on the findings of this study, the researcher would like to propose that further studies be conducted in the following areas:

- Implementation of a behavioural change communication strategy.
- Advocacy and technical assistance programmes targeting farm workers.
- Development of care and support programmes on farms.

5.6 RECOMMENDATIONS FOR POLICY AND PRACTICE

The researcher would like to make recommendations to the following groups of people for policy and practice purposes:

5.6.1 Mismatch between policy priorities and government budget

A mismatch between policy priorities and government budget may result in some policies and programmes not being effective. This problem arises partly as a result of inadequate resources being allocated by the government, as well as a lack of costing in respect of policy implementation plans. There is a need for government to prioritise those social-structural factors that lead to persistent inequality in the budget and increase budgetary allocation to the mitigation of HIV and AIDS.

5.6.2 Foster care by institutions and families

Care and support begins in the family. The number of unproductive family members may increase as a result of fostering children or of hosting and caring for HIV-infected relatives who, typically, return to rural areas to avoid the social biases to which they are subjected in more heavily populated urban areas. These realities endanger both short- and long-term household food security and financial solvency. It is, therefore, important that the government arrange for the lower cost and non-institutional care of orphans.

5.6.3 Policies encouraging school attendance, plus curriculum reform

Parents affected by HIV and AIDS have less time to instruct their children in a variety of skills, including how to farm. As a result of the gender division of labour and knowledge, the surviving parent is frequently not able to transfer the skills of the deceased parent to the next generation. Children are sometimes left orphaned and, thus, schooling of any kind becomes completely out of the question.

As with so many of the labour-related impacts of HIV and AIDS, the training of new human capital can be planned in advance and problems relating to the training needs and labour productivity of the surviving children and adults in household affected by HIV and AIDS can be anticipated. Otherwise policies would need to be devised both to encourage school attendance and to modify the curricula to incorporate the intergenerational training that is no longer available in the home.

5.6.4 Social safety nets or humanitarian programmes

Social safety initiatives should focus on increasing the productive capacity of both farmers and communities and reducing dependency, including any adverse impact that aid may have on local production. It is imperative that those funders who are involved in humanitarian programmes such as HIV and AIDS programmes make funds available for projects and programmes that are aimed specifically at preventing HIV and AIDS and addressing the impact of the disease.

5.7 CONCLUSION

This study has produced significant data relating to both HIV and AIDS and the general conditions of farm workers. The active involvement of all stakeholders is required in preventing HIV and AIDS as well as addressing its socioeconomic impact. Finally, the findings of this research study highlight the need to conduct more research into this particular topic.

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APPENDIX 1: THE INTERVIEW SCHEDULE

Hello, my name is Nakedi Margaret Monnakgotla, I am interested in farm workers and, specifically, in your experiences regarding HIV and AIDS in the workplace. Is there anything you would like to ask me before we start?

Own identity:

Tell me who you are.

Tell me about your current daily life and living arrangements.

Tell me about your life here on the farm.

Where do you live?

With whom do live?

Your history as a farm worker.

When did you start working on the farm?

How old were you at that time?

Your life before the farm.

Tell me about your childhood.

With whom did you live? Name different people at different times.

1. Knowledge.

- What do you know about HIV and AIDS?
- What is HIV?
- What causes AIDS?
- How does a person become infected?
- How does your body fight germs such as HIV?
- In your opinion, is HIV and AIDS a problem on the farm?

- What is an HIV test?
- Is there a cure for HIV?

2. How did you get to know about HIV and AIDS?

- Do you believe everything you hear or read about HIV and AIDS?
- Is there anything particular which you do not believe?
- Do you believe that traditional healers are able to cure HIV?
- Is it true that a man will be cured of HIV if he has sex with a virgin?
- Does a condom protect a person from becoming infected?
- Do you know how to use a condom correctly?

3. Human rights

- What are you feeling towards people living with HIV and AIDS?
- Do you believe that people living with HIV are responsible for their disease and they get what they deserve?
- Would you work with a farm worker infected with HIV and AIDS?
- Do farm workers who are either HIV positive or have AIDS have rights?
- If yes, what rights do they have?
- If no, why do you think that they do not have rights?
- What makes women, in particular, vulnerable to HIV?

4. Safety

- Do you regard your farm as being safe from HIV infection?
- What do you consider having HIV and AIDS as a risk?
- In your opinion what should farm workers do to avoid contracting HIV and AIDS?
- Do you know any farm workers who have received HIV and AIDS education?
- Do you have time allocated for the passing of HIV and AIDS information on your farm?
- Are there HIV/AIDS awareness/education programmes for farm workers?
- In your opinion what should be done to reduce the spread of HIV and AIDS?
- In your opinion what should be done as regards managing infected and affected farm workers on the farm premises?
- Do you have an HIV and AIDS workplace policy on your farm?

- If yes, who selected the committee?
- Do you think that the policy may improve the lives of farm workers?
- Do you think that the policy will help people who are already infected to obtain treatment?

5. Issues of self.

- Define yourself. Who are you? How would you introduce yourself to a stranger?
- How would you introduce yourself to someone whom you want to impress?
- How would your introduction have changed over the years?
- How do people/friends/colleagues introduce you? Is this their perception of you? Is it correct? How has this changed over the years?
- Do you like the way in which you introduce yourself? Would you like it to be different? How?
- Have you ever encountered hostility? When?
- Have you ever felt hostile? When?
- Do you believe that you are discriminated against? Give examples.
- Do you believe that this could change? How?
- Give an example of discrimination.

APPENDIX 2: CONSENT FORM

Hello, my name is Nakedi Margaret Monnakgotla and I am currently working towards a Masters degree in Sociology.

My research focuses on an evaluation of the implementation of a HIV and AIDS workplace policy for farm workers. I would like to interview you by asking you a few questions regarding general information on HIV and AIDS and, specifically, on your experiences as regards a HIV and AIDS workplace policy for farm workers. Should you agree, I shall record our conversation on audiotape? The interview will take approximately one hour. I would like to conduct two follow-up interviews with you in the near future. Your participation in this research is voluntary and you may refuse to answer any questions.

The management of Country Mushrooms is aware of and has given their consent to this research. Your name will not be linked with the information you provide. The results of the interviews will, however, be communicated to Country Mushrooms, but no specific details will be linked to specific individuals.

Consent

I, Nakedi Margaret Monnakgotla, will not implicate any individuals by discussing the details of our conversation.

Signed..... Date.....

I understand that my views and the information I provide in this conversations will not be linked to me personally.

I agree to take part in the research

I agree that our conversation may be recorded

Signed..... Date.....

†

I agree that our conversation may be recorded †

Signed.....

Date.....