

CHAPTER 1: BACKGROUND AND MOTIVATION FOR RESEARCH

1.1 INTRODUCTION

The Acquired Immune Deficiency Syndrome (AIDS) is caused by the Human Immunodeficiency Virus (HIV) (Barrows, Gallo & Mulleady, 1996 as cited in Mclean & Moore, 1997). It is spread through unprotected sex, blood transfusion, organ donation, sharing of contaminated needles and syringes and or transfer from an infected mother to her child (eg while the child is still in the womb) (Bloor, 1995; Kohl & Miller, 1994; Mclean & Moore, 1997). HIV and AIDS are viewed throughout the world as the greatest crisis facing mankind (International Organisation of Employers, 2002; Mclean & Moore, 1997). Furthermore, HIV and AIDS are having an increasingly negative impact on the business world (International Organisation of Employers, 2002). It has become the fourth major cause of death worldwide and the major cause of death in Africa (UNAIDS, 2000a).

In 1995, 25 316 people had been diagnosed as HIV positive in the United Kingdom, while 11 500 had been diagnosed with AIDS (Mclean & Moore, 1997). As of December 1998, 688 200 people had been diagnosed with AIDS in the United States. Of them, 410 800 had died (Miller, 2000). A total of 650 000 to 900 000 people are thought to be living with HIV in the United States. The pandemic has had equally devastating infection rates in countries such as Kenya and Zambia, and cities such as Singapore (Clarke & Strachan, 2000; Lim & Loo, 2000). In South Africa, between 4,2 and 5 million are living with HIV/AIDS and there has been 245 000 AIDS related deaths from 1997 to 2002 (Steenkamp, 2002; UNAIDS, 2002a). The highest HIV/AIDS prevalence rates occurred in Kwazulu Natal, Gauteng, Free State and Mpumalanga (Department of Health, 2000). The World Health Organisation predicted that by the year 2000 HIV would infect about 30 to 40 million people worldwide (Mclean & Moore, 1997). UNAIDS confirmed these projections at the end of 2001 by estimating that about 40 million people were living with HIV/AIDS (UNAIDS, 2002a).

The HIV and AIDS pandemic affects the individual, the organisation, the economy and society as a whole through decreased gross domestic product per capita and life expectancy, increased

deaths, increased health care costs, loss of income, possible employee relations problems, discrimination in the workplace, and therefore also possible decreased job performance (Clarke & Strachan, 2000; Fesko, 2001a; Mclean & Moore, 1997; Miller, 2000). One in every 250 Americans will be affected by HIV or AIDS, 20% to 30% of the workforce in Africa will be infected and infected employees may live productive, symptom-free lives for more than ten years (Breuer, 1995; Clark & Strachan, 2001; Fesko, 2001b; Kohl & Miller, 1994). Furthermore, the majority of people infected with HIV or AIDS are between the ages of 20 – 44 years (ie during their prime working years) (Breuer, 1995; Lim & Loo, 2000; Mclean & Moore, 1997; Miller, 2000; UNAIDS, 2002b). Therefore, the aforementioned also imply that individual job performance could be negatively affected.

Despite the devastating impact that the pandemic has had, several advances have been made in the treatment of HIV and AIDS (Breuer, 1995; Fesko, 2001a; Lim & Loo, 2000). Therefore, HIV positive individuals are living longer and are maintaining healthy, productive lives (Breuer, 1995; Fesko, 2001a). Hence, they are still employed in the workplace. Furthermore, being able to make a meaningful contribution to the workplace is vital for the emotional wellbeing and economic needs of HIV or AIDS infected individuals (Fesko, 2001b).

It is thus evident that the prevalence of employees living with HIV or AIDS in the workplace poses many challenges to employers (such as increased labour turnover, absenteeism, discrimination, fear) (Breuer, 1995; Clarke & Strachan, 2000; Kohl & Miller, 1994; UNAIDS, 2002d). The workplace is considered an appropriate and important place to address the HIV and AIDS pandemic because people spend a large part of their life at work (Clarke & Strachan, 2000). Furthermore, assisting and supporting those who are HIV positive or living with AIDS could contribute towards their improved job performance, and thus organisational productivity. However, although many employers have implemented strategies to deal with the pandemic, several still continue to ignore its impact. Many of the strategies vary in nature and are often reactive (Kohl & Miller, 1994; Mclean & Moore, 1997). Furthermore, HIV or AIDS influences the infected employee and uninfected co-employees through feelings of fear, discrimination and workplace disruptions (Miller, 2000). In South Africa, legislation protects employees against unfair discrimination and unsafe workplaces (Employment Equity Act No, 55 1998;

Occupational Health and Safety Act, No 85 1993). However, incidents relating to discrimination and unsafe workplace practices involving HIV or AIDS infected individuals continue to take place within organisations.

Taking the impact of the HIV and AIDS pandemic into consideration, it becomes evident that organisations will be negatively influenced through the permanent loss or temporary incapacitation of their employees. As such, individual job performance and thus organisational productivity could also probably be negatively affected. There is therefore a need to ensure that effective workplace programmes are set in place to combat the HIV and AIDS pandemic, while ensuring maximum support and job performance of infected employees.

1.2 PROBLEM STATEMENT

1.2.1 The problem

While there is a need for workplace support programmes they are costly (Clarke & Strachan, 2000; Lim & Loo, 2000; Mclean & Moore, 1997). The costs include HIV and AIDS education, sick leave provisions and benefit policies, handling of job disruptions and retraining (Clarke & Strachan, 2000; Lim & Loo, 2000; Mclean & Moore, 1997). Furthermore, employees living with HIV or AIDS are looking for changes in the type of work, future career plans, health care benefits and fair treatment to ensure maximum mental and physical health. In contrast, employers are still profit driven, despite the HIV and AIDS pandemic, and therefore constantly attempt to improve productivity, while reducing costs.

A considerable amount of research exists regarding the impact of HIV and AIDS in the workplace and the influence of strategies implemented to deal with the pandemic (Breuer, 1995; Miller, 2000; UNAIDS, 2002b). Although research has identified the benefits (eg increased HIV and AIDS awareness, improved employer image, reduction in lost time, increased productivity) gained from implementing health care and or HIV and AIDS strategies, many employers have failed to do so (Lim & Loo, 2000; Mclean & Moore, 1997; Miller, 2000). This could be partly due to the fact that little of the research directly addresses the influence of

workplace support programmes (or specific workplace support activities) on the job performance of employees living with HIV or AIDS (ie lack of evidence supporting improved job performance). The research also does not directly address the influence of such workplace support programmes on individuals' job performance, through the influence on their self-concept or psychological contract.

There is therefore a need to determine the influence of workplace support programmes on the job performance of employees living with HIV or AIDS.

1.2.2 The research questions

In view of the above, the research question needs to provide an understanding of the influence of workplace support programmes on the job performance of individuals living with HIV or AIDS. To do the latter, the following sub questions must be answered:

- (1) What is the nature and organisational context of job performance?
- (2) What is the influence of stigmatisation and discrimination on individuals' decision to participate in workplace support programmes?
- (3) What is the influence of HIV or AIDS on the job performance of individuals living with HIV or AIDS?
- (4) What is the cost of HIV and AIDS to organisations?
- (5) What is the content of workplace support programmes?
- (6) What is the influence of workplace support programmes on individuals' job performance through the influence thereof on their self concept and psychological contract?
- (7) What is the influence of workplace support programme activities on the job performance

of individuals living with HIV or AIDS?

The answers to the above research questions should provide an understanding of job performance and the context within which it is performed, the cost of HIV and AIDS to organisations, the nature of workplace support programme activities and the influence thereof on the job performance of individuals living with HIV or AIDS. Specifically, the answers should provide an understanding of the nature and extent of influence that certain workplace support activities, or the lack thereof, have over others on the job performance of HIV or AIDS infected individuals. Furthermore, the answers should also provide an understanding of the influence of the provision or non provision of workplace support programmes on the job performance of HIV or AIDS infected individuals, through the influence thereof on their self-concept and psychological contract.

1.3 AIMS

1.3.1 General aim

To understand the influence of workplace support programmes on the job performance of employees living with HIV or AIDS.

1.3.2 Specific aims

The aims of this research are as follows:

- (1) To understand the nature and organisational context of job performance?
- (2) To understand the influence of stigmatisation and discrimination on individuals and their decision to participate in workplace support programmes.
- (3) To understand the influence of HIV or AIDS on individuals' job performance.

- (4) To understand the cost of HIV and AIDS to organisations.
- (5) To explore the content of workplace support programmes.
- (6) To understand the influence of workplace support programmes on individuals' job performance through the influence thereof on their self-concept and psychological contract.
- (7) To explore the influence of workplace support programme activities on the job performance of individuals living with HIV or AIDS.

1.4 THE PARADIGM PERSPECTIVE

1.4.1 Paradigm, disciplines and meta theoretical concepts

The research project will be approached from a humanistic paradigm. Humanists view individuals as being responsible and having the freedom to choose amongst the available options before them (Meyer, Moore & Viljoen, 1997). Individuals are seen as having inherent growth potential and are active participants in the journey toward their true potential (Bergh & Theron, 2002; Meyer et al, 1997). Furthermore, humanists study individuals as an integrated, but unique whole (Meyer et al, 1997).

The research will be conducted within the disciplines of organisational and personnel psychology (Bergh & Theron, 2002; Cascio, 1991). Organisational psychology focuses on the organisation as a system that consists of individuals, groups, structure and the dynamics which interact and mutually affect each other (Bergh & Theron, 2002). The purpose is to facilitate employee adjustment, satisfaction, productivity and efficiency. Personnel psychology involves recruiting, selecting, placement and training of employees while considering factors that could affect their utilisation (Bergh & Theron, 2002; Cascio, 1991).

Organisational behaviour, interpersonal behaviour and group dynamics are identified as applicable meta theoretical concepts (Ivancevich & Matteson, 1996).

1.4.2 Applicable behaviour models and theories

A model of the psychological contract will be used to illustrate the influence of the workplace support programmes on the job performance of employees living with HIV or AIDS (Robbins, Odendaal & Roodt, 2003). Rogers' Self-Theory will be used to illustrate the influence of workplace support programmes on the job performance of employees living with HIV or AIDS (Bergh & Theron, 2002).

1.4.3 Applicable concepts and constructs

The undermentioned concepts and constructs were derived from an extensive literature survey and are directly applicable to the research project.

1.4.3.1 Workplace support programmes

Workplace support programmes refer to all organisational activities, practices and policies implemented to manage HIV and AIDS in the workplace, thereby ensuring optimal utilisation and support of infected employees (Clarke & Strachan, 2000; Mclean & Moore, 1997). The activities, policies and practices include those that address discrimination, HIV and AIDS education, job accommodations, health care and insurance costs, privacy and counseling (Fesko, 2001b; Lim & Loo, 2000).

1.4.3.2 Job performance

Job performance is "the translation of potential into behaviour" (Bergh & Theron, 2002). It refers to the degree and quality of effort, initiative, co-operation, absenteeism, lateness, attainment of standards and commitment to the job displayed by the individual (Cronje, Hugo, Neuland & Van Reenen, 1995; Harrison, 1994; Ivancevich & Matteson, 1996).

1.4.3.3 Human Immunodeficiency Virus (HIV)

HIV is a retrovirus that can cause cancer, be relatively harmless or cause long-term degenerative diseases (ie HIV attacks the individual's immune system) (Bloor, 1995).

1.4.3.4 Acquired Immune Deficiency Syndrome (AIDS)

AIDS is caused by HIV which attacks the body's immune system, causing it to function progressively less effectively (Bloor, 1995; Green, 1994; Kohl & Miller, 1994; Nevid, Rathus & Greene, 1997).

1.4.3.5 Employer

An employer shall refer to any person that employs or provides work for any individual and remunerates that individual in exchange for work performed (Occupational Health and Safety Act, 1993).

1.4.3.6 Recent and relevant literature

Recent and relevant journals such as the AIDS Care, Journal of Psychology, Journal of Vocational Behaviour, Health and Social Work, Public Administration Review and Rehabilitation Counseling Bulletin will be consulted. Examples of articles include "Workplace experiences of individuals who are HIV positive and individuals who have cancer", "Disclosure of HIV status in the workplace", "How does HIV/AIDS affect African businesses" and "Report on the global AIDS epidemic" (Fesko 2001a, 2001b; United States Agency for International Development, 2001; UNAIDS, 2002a). The latter cover various aspects of HIV and AIDS and workplace support programmes, including their influence on employees living with HIV or AIDS and their job performance. Books such as "AIDS and the challenge to South Africa" and "Organisational behaviour" will be consulted to indicate the influence that HIV and AIDS and the work environment have on the employer and the employee. They also provide suggestions

regarding workplace support programmes and the influence on individuals living with HIV or AIDS.

1.4.4 Central theoretical statement

Workplace support programmes influence the job performance of employees living with HIV or AIDS.

1.4.5 Methodological convictions

An exploratory, qualitative research approach will be used because it allows for a greater understanding of phenomena and the relationships between them (Mouton, 1996; Mouton & Marais, 1991).

1.5 RESEARCH DESIGN

An exploratory, qualitative research design will be used for this research project. The exploratory approach will allow new insights to emerge as the influence of workplace support programmes on the job performance of HIV or AIDS infected employees is a relatively phenomena (Terreblanche & Durrheim, 2002). The qualitative approach will enable a more thorough understanding of the influence of workplace support programmes on the job performance of HIV or AIDS infected employees through identifying and categorising themes that emerge (Terreblanche & Durrheim, 2002).

1.6 TYPE OF RESEARCH

A qualitative approach will be used. Qualitative research enables the researcher to be more involved with the phenomena than with quantitative research (Mouton, 1996; Mouton & Marais, 1991). Qualitative research also allows that which lies behind a phenomenon to be uncovered and to provide more intricate detail that is not always possible by using quantitative methods (Strauss & Corbin, 1990). Qualitative research thus enables the researcher to interpret the data

and gain a deeper insight into the phenomena than is possible through using quantitative methods (Mouton, 1996; Mouton, 2001; Mouton & Marais, 1991; Neuman, 2000). Information will be obtained by using semi-structured interviews (Huysamen, 1995).

1.7 UNIT OF ANALYSIS

The individual will be the unit of analysis.

1.8 METHODS TO ENSURE RELIABILITY AND VALIDITY

A semi-structured interview schedule will be compiled with open and closed questions after a thorough literature review. The question wording, constructs and concepts will be formulated after a literature review and consultation with experts to ensure construct-, content- and face validity, and accuracy. All participants will be asked the same questions. The answers will be captured using an audiocassette and noting down respondents' answers on the interview answer blank. Informed consent will be obtained from participants prior to commencement of the interview. In addition, ensuring confidentiality and anonymity, confirming participants' availability before hand, establishing rapport and facilitating the interviews without expectations, perceptions or memory will ensure that reliability of results is enhanced (Christensen, 1997). The accuracy of self reported data regarding job performance, absenteeism and workplace support received will be increased where participants give informed consent to access these records or verify them with their employers. All employers will be asked the same questions, but different to those asked to participants. Using experts and existing literature to ensure that the appearance, content and constructs are accurate and relevant will enhance face-, content- and construct validity of the interview schedules (Gregory, 2000; Oppenheim, 1992).

1.9 RESEARCH METHOD

1.9.1 Literature review

The nature and elements of job performance will be determined through a literature review. This

includes how workplace support programmes influence job performance. The nature, conceptualisation and different type of activities, practices and policies that constitute a workplace support programme will be determined by a literature review. This includes the influence that a workplace support programme has on job performance through the self-concept and psychological contract.

1.10 INTERPRETIVE STUDY

1.10.1 Population and sample

The population will be individuals living with HIV or AIDS who reside within the Western Cape (Breakwell, Hammond & Fife-Schaw, 1995; Mouton, 1996). Specifically, it will only include individuals who are or have been employed during the period that they have been infected with HIV or AIDS. Due to the sensitivity regarding disclosure and HIV or AIDS infected individuals' willingness to disclose their status, the Hospitals, Clinics and Medical Practices in the Western Cape will serve as the sampling frame (Breakwell, Hammond & Fife-Schaw, 1995; Mouton, 1996). Participants will be conveniently selected from individuals living with HIV or AIDS who report as patients, on the basis of their willingness to be interviewed (Bless & Higson-Smith, 1995; Leedy, 1989). All participants will be asked the same questions (but different to those asked to their employers) that will generate information regarding workplace support programmes and the influence on job performance.

1.10.2 Measuring Instruments

A semi-structured interview schedule will be compiled. All participants will be asked the same questions. The responses will be captured using an audiocassette and noting down responses on the semi-structured interview schedule blank. Where applicable, ordinal, nominal and interval scales will be used to quantify responses (Babbie, 1990; Leedy, 1989; Oppenheim, 1996). The aforementioned will be used to provide an indication of the occurrence, nature and extent of workplace support programmes, and their influence on the job performance of employees living with HIV or AIDS (Bless & Higson-Smith, 1995; Oppenheim, 1992). Furthermore, a semi-

structured interview will be held with the employers of consenting participants to verify their job performance, absenteeism and workplace support received. The interviews should also provide an indication of the influence of stigmatisation and discrimination on participants' use of workplace support programmes.

1.10.3 Data collection

Data will be collected by interviewing all participants, using a semi-structured interview blank. The semi-structured interview blank will contain open and closed questions. Responses will be captured on an audiocassette and by noting down responses on the interview blank.

1.10.4 Data processing

Descriptive statistics (eg means, percentages, frequencies, categories) will be used to describe the sample and the impact of workplace support programmes on the job performance of employees living with HIV or AIDS (Babbie, 2001). The interview responses provided by the participants will be recorded using an audiocassette and field notes. The audiocassettes will be transcribed and compared to the field notes for accuracy. Thereafter, the data collected will be analysed through appropriate techniques (eg coding) to understand the influence of workplace support programmes on the job performance of employees living with HIV or AIDS, including the influence of stigmatisation and discrimination on participation in such programmes (Babbie, 2001; Christensen, 1997). Various techniques including identifying patterns and themes, counting, clustering and noting relations between data found will be used to analyse the data (Miles & Hubermann, 1994). This will allow for the generation of one or more hypotheses. The differences between individuals within the sample will also be explored. The themes will also be quantified to enhance their statistical value (Babbie, 2001; Miles & Huberman, 1994). It will also enable the research to explore the extent and nature of the influence of different types of workplace support programme activities on the job performance of employees living with HIV or AIDS.

1.10.5 Generation of hypotheses

Hypotheses surrounding the influence of workplace support programmes on the job performance of individuals living HIV or AIDS will be generated.

1.11 CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

1.11.1 Conclusions

The research will attempt to achieve the stated aims.

1.11.2 Limitations

The limitations of the research will be reported.

1.11.3 Recommendations

Recommendations will be made regarding the utilisation of the research results and areas for future research.

1.12 CHAPTER LAYOUT

The chapter layout is as follows:

- (1) Chapter 1: Introduction.
- (2) Chapter 2: Literature review: Job performance.
- (3) Chapter 3: Literature review: Workplace support programmes.
- (4) Chapter 4: Research design and methodology.

(5) Chapter 5: Findings and integration.

(6) Chapter 6: Conclusions, limitations and recommendations.

Now that the background to the research has been explained, the literature review will be discussed, starting off with the dependent variable (job performance).

CHAPTER 2: JOB PERFORMANCE

2.1 INTRODUCTION

The organisational context in which job performance is conducted will be the same context within which HIV and AIDS workplace support activities are implemented or from which they are excluded. Furthermore, the organisational context influences the nature and outcomes of job performance (Ivancevich & Matteson, 1996). Therefore, to understand the influence of workplace support programmes on the job performance of HIV or AIDS infected individuals it appears necessary to understand what job performance is and the organisational context within which it is conducted. Understanding the nature of the organisational context and individual job performance (including the determinants thereof, self-concept, psychological contract and the influence of HIV or AIDS on job performance) could provide an indication of those aspects that could also influence the provision and or influence of workplace support programmes on individual job performance.

The chapter will begin with the context in which job performance occurs. Thereafter, job performance will be discussed including the determinants thereof, Rogers' Self Theory, the psychological contract and the job performance of individuals living with HIV or AIDS.

2.2 ORGANISATIONAL CONTEXT OF JOB PERFORMANCE

2.2.1 Performance defined

On a macro level (eg organisational), performance involves the processing of inputs (eg energy, labour) into outputs (eg profit, number of units, benefits paid), according to certain quality and quantity specifications (eg level of customer satisfaction, total coldrinks sold), while attempting to achieve certain work goals (Williams, 1998; Roe, 1999). Performance can be viewed as a record of outcomes produced during a specific job, over a specific time (Bernardin, as cited in Williams 1998). Performance is directly related to the concept of productivity because of aspects such as efficiency, quality and effectiveness (Spangenberg, 1994; Williams, 1998). On a

micro level (eg individual), performance refers to the amount of effort, initiative, absenteeism, maintenance of standards and commitment displayed by individuals while performing the job tasks (Cronje et al, 1995; Harrison, 1994; Ivancevich & Matteson, 1996). The broader cultural context influences how job performance is defined and measured. Hempel (2001) found that Chinese and Western managers differ regarding the concepts, outcomes and appraisal of job performance. Whereas Western job performance focuses on organisational goals and is defined in terms of outcomes, Chinese business practices are grounded in tradition of maintaining family control over the business (Hempel, 2001). This includes tolerating poor job performance by family members. The Chinese also tend to emphasise individuals' personal character in defining job performance outcomes and evaluating job performance. Hence the Chinese focus on personal attributes whereas Westerners focus on skills and behaviours (Hempel, 2001).

Performance can thus be seen as a process during which effort is expended, over a period of time, to produce certain measurable products or services. Performance is also influenced by the broader cultural context.

2.2.2 Organisational mission, structure, strategy, goals, culture and climate

Job performance occurs within and is influenced by the context of organisational culture, climate, structure, vision, mission, strategy, goals and values (Ivancevich & Matteson, 1996; Kangis, Gordon & Williams, 2000; Roe, 1999; Schmidt, Shull & Schmitt, 2001; Spangenberg, 1994). Spangenberg (1994) discusses the implementation of a performance management system within organisations. He stresses the importance of congruence between the organisation's strategy, mission, culture, leadership values and the beliefs and the values of individual employees in performance management and organisational success. The organisation's vision is future orientated and indicates what it wants to be and whom it wants to serve (David, 1997).

The organisation's mission indicates its purpose, the critical areas of competence, core skills, customers, philosophy, values that lie behind the norms and behaviour standards and behaviour guidelines (Spangenberg, 1994). It also includes social responsibility to the community and wellbeing of employees (David, 1997). The organisation's strategies are the means by which it

will attain its long-term objectives (David, 1997). Williams (1998) supports this view and states that the vision, mission and strategy provides the organisation with a framework that helps direct it to where it wants to be in future. Once the vision, mission and strategy are finalised, goals are formulated at departmental, team and individual level and thus guide performance (Roe, 1999; Spangenberg, 1994; Williams, 1998). The organisation's structure is created with the aim to ensure that it is aligned with its strategy, thereby facilitating optimal goal attainment (Bounds, Dobbins & Fowler, 1995).

Organisations all have a unique culture and climate that distinguish them from other organisations and impacts on the way things are done and the interaction between its employees (David, 1997; Ivancevich & Matteson, 1996). Organisational strategy, climate, managerial values and culture have been found to influence individual behaviour, group and organisational performance (Kangis et al, 2000; Rogg et al, 2001; Wallace, Hunt and Richards, 1999). Kangis et al (2000) and Williams (1998) found a certain amount of linkage between organisation's climate and their performance (including individual job performance). The Burke and Litwin model also postulates that organisational and individual job performance are influenced by the organisation's mission, strategy, culture, climate and leadership (Kangis et al, 2000; Spangenberg, 1994). Jackson and Hinchliffe (1999) found that the Barnsley District General Hospital improved decision making, trust, communication and thus individual and organisational performance through developing a positive organisational culture. Furthermore, Kinnear and Roodt (1998) and Martins (2000) found that factors including work unit climate, task environment and management practices influence change and or trust within organisations. For example, poor management practices could hamper change efforts or reduce trust between individuals and management thus negatively affect organisational and individual job performance.

Job performance essentially refers to the application of effort to produce an outcome (eg cars sold) according to certain quality and quantity specifications. Job performance is carried out within an organisational context. The organisational context provides a framework within which work is executed. Research has shown that the organisational context influences individuals' job performance. A method of determining the influence of organisational context on individual job

performance is through managing and measuring performance.

2.2.3 Performance management and measurement

Organisational performance is measured continuously to determine whether or not it is effective and efficient (Spangenberg, 1994; Williams, 1998). Performance management on organisation and process levels includes setting and measuring goals, informing individuals about performance delivered and effective coordination (Spangenberg, 1994). At individual level, performance management includes managing their inputs, outputs, capacity, skills and feedback (Spangenberg, 1994). Goodson, McGee and Seers (1992) found that performance feedback clears up uncertainty, indicates the importance of various goals and clarifies performance expectations. Williams (1998) states that performance management begins and ends with the organisation's strategy. Hence measuring performance includes focusing on contributions to achieving strategic objectives, quality, quantity and customer satisfaction (ie internal and external). Yoon, Beatty and Suh (2001) found that internal customer satisfaction (ie employees) influenced the level of satisfaction experienced by external customers. Lau (2000) found similar results and concluded that a higher level of internal service quality increased employee satisfaction, customer loyalty and profits.

Harvey (1997) found that performance measurement processes must be adapted to allow for differences (eg culture, environment, and geographical distance between rater and ratee) where individuals are working in international environments. This could also imply that the manner in which individuals' performance is measured should differ according to the circumstances that influence them (eg health).

Measuring performance thus provides the organisation and the individual with an indication of how they are doing. Performance measurement also indicates areas that are negatively influencing individual and organisational performance. These areas should be changed if individual job performance is to be maintained or improved (eg work processes, culture, climate, individual experiences). Burke (1992), French and Bell (1999), Kinnear and Roodt (1998) and Lau (2000) support this view.

Now that the organisational context has been portrayed, the concept of job performance will be elaborated upon.

2.3 JOB PERFORMANCE

2.3.1 Individual job performance

On an individual level, job performance refers to the degree and quality of effort, cooperation, absenteeism, lateness, compliance with standards and commitment displayed by individuals (Cronje et al, 1995). It is the translation of potential into behaviour, can be viewed in terms of standards individuals must achieve in their work and it can be seen as the desired result of behaviour (Cascio, 1995; Cronje et al, 1995; Ivancevich & Matteson, 1996). Job performance depends on the individual's capacity, willingness and opportunity to perform. The direction, intensity and duration of effort expended by individuals influence the quality of their job performance (Ivancevich & Matteson, 1996).

Job performance includes a number of objectives (Ivancevich & Matteson, 1996). The objective outcomes can be measured and include turnover and absenteeism, personal behaviour outcomes and reflect the individual's reactions to the work (eg staying with the job or quitting due to physiological and health problems) (Hempel, 2001; Ivancevich & Matteson, 1996). The intrinsic and extrinsic outcomes (eg variety, autonomy, supervision) are related to individuals' actions and hence also influence their job performance (Ivancevich & Matteson, 1996). Finally, job satisfaction outcomes (eg pay, interesting job tasks, supervision) depend on how individuals view the outcomes and the level of intrinsic and extrinsic outcomes (Ivancevich & Matteson, 1996). Therefore, individuals will experience job satisfaction to the extent they are involved with the job, perceive the outcome to be equitable and the value they attach to the outcome (Ivancevich & Matteson, 1996).

The aforementioned outcomes include those that are important to the organisation and individual. By knowing, influencing and understanding the outcomes, organisations can monitor, maintain and even enhance individuals' job performance. Ho (2000) found that

management and the social environment affected job satisfaction, wellbeing (eg reduced stress) and performance of teachers at a junior school in Singapore.

Job performance can be described in many different ways. It can be described in terms of goals that individuals must achieve (Williams, 1998). Goals provide standards for performance management, guidelines for decision-making and planning, and they influence the organisation's structure (Spangenberg, 1994; Williams, 1998). Obtaining and maintaining commitment, participation, peer influence, incentives, self efficacy, expectancy and ability are important for goals to have a positive impact on job performance (Williams, 1998). Furthermore, individual goals must be congruent with department, function, process and organisational goals (Williams, 1998). Phillips and Gully (1997) found that individuals' goal orientation influences goal setting, self-efficacy and job performance.

Job performance can also be described in terms of behaviour that is relevant to achieving organisational goals (Williams, 1998). It is behaviour individuals' display to carry out their work. When linked to competencies, behaviour can be seen as visible evidence that shows whether or not individuals can perform the task (Williams, 1998). Competencies include characteristics, knowledge, skills and motives that are used to attain successful job performance (eg managerial competencies) (Stuart & Lindsay, 1997). Dobni, Zerbe and Ritchie (1997) state that employees' behaviour is vital to the overall organisational performance. They view performance in terms of behaviour repertoires. Behaviour repertoires are used to match the behaviours required from individuals with organisational goals and form the basis for training, performance measurement and improving productivity (Dobni et al, 1997). According to Hempel (2001), job performance can also be described in terms of personal attributions such as loyalty and obedience. Job performance is thus goals, behaviours, competencies or attributions that individuals attain or display while attempting to complete their tasks as efficiently and effectively as possible.

2.3.2 Determinants of job performance

Individual job performance is influenced by several factors. These include genetics, the muscle

system and job design (Bergh & Theron, 2002). Individuals' learning, perceptive and cognitive abilities together with their attitudes and values influence their job performance (Bergh & Theron, 2002). Therefore, to understand individuals' job performance in the workplace, it is necessary to understand the determinants of their job performance. According to Campbell (as cited in Williams, 1998) the following are essential determinants of job performance:

- (1) Declarative Knowledge (ie knowing what to do).
- (2) Procedural knowledge and skill.
- (3) Motivation (regarding amount of effort, level of effort and duration of effort).

The above determinants are influenced by individual differences in intelligence, personality, motivation, perception, demographics, attitudes and competencies (Bergh & Theron, 2002; Ivancevich & Matteson, 1996; Williams, 1998).

Individual job performance is enhanced or diminished by an interaction of individual and system factors (William, 1998). Factors that impede individual job performance include tools, equipment, work environment, time, policies and work processes (William, 1998). These factors could prevent the individual from delivering optimal performance (Williams, 1998). Simintiras, Lancaster and Cadogan (1994), Tietjen & Myres (1998), and Yamaguchi (2001) found that the task, work environment, relationship with co-workers, participation, management's concern, recognition and values influence job satisfaction, motivation and job performance of individuals. Williams (1998) argues that whereas factors impeding job performance influence individuals directly or indirectly, factors that enhance job performance do so indirectly. These factors influence the individual first (eg training and work redesign enhance declarative knowledge and motivation) and then job performance (Williams, 1998). Rummeler and Brache (as cited in Williams, 1998) discuss various factors influencing job performance. To them, adequate resources, clear standards, procedures, individual skills and knowledge, feedback and individuals' mental and physical capacity influence job performance. Williams (1998) notes that managers generally tend to attribute the causes of job performance to characteristics of the

individual rather than those in the work situation (eg poor facilities, unexpected interruptions). Spangenberg (1994) emphasises the need to understand the impact of individuals' work motivation on their job performance. To him needs (ie self actualisation), values, goals and intentions, influence individuals' job performance depending on their importance, appropriateness, variety, autonomy, satisfaction, feedback received and or recognition.

Roe (1999) states that job performance is influenced by general performance conditions (affect performance irrespective of individual's characteristics) and differential performance conditions (individual characteristics in which people differ). The general performance conditions include performance conditions of different tasks, the objective task (ie task specification), individuals' motivational state (eg commitment), competence, preparation of action (goal setting) progress on the task, demands on individuals' resources, emotional stability, working hours and social organisational factors (Roe, 1999; Spangenberg, 1994). Job performance can be expected to change if any of the general performance conditions are changed (eg working hours and knowledge level). For example, introducing frequent rest pauses could provide an opportunity to recover, particularly in tasks that require concentration and physical effort of lengthy periods. Numerous studies found that the aforementioned factors either enhanced or impeded job performance (Roe, 1999). Furthermore, Suliman (2002) found that committed individuals rated their job performance more positively than those who were less committed. Yoon, Beatty and Suh (2001) showed similar results. They found that job satisfaction improved individuals' job performance as well as customer satisfaction. Suliman and Iles (2000) and Yousef (2002) found that role conflict and ambiguity reduces job satisfaction, causes stress and reduces job performance and organisational commitment. Trust and organisational politics have also been found to reduce job satisfaction and commitment while increasing job stress (Poon, 2003).

The differential performance conditions are motivation (eg preferences, goals, values), performance capacity (eg ability), age and gender (Roe, 1999). The general performance conditions influence job performance directly while differential performance conditions do so indirectly (eg through job satisfaction, compatibility between individual and organisational goals) (Lau, 2000; Roe, 1999).

Personality has also been found to influence the job performance of individuals and teams (Bradley & Herbert, 1997; Lawsen, 1994; Phillips & Gully, 1997). Furthermore, job performance is also influenced to the extent that it is performed in teams (Ivancevich & Matteson, 1996; Roe, 1999). Strong group norms, conflict, group size, objectives and leadership can enhance or impede job performance (Bergh & Theron, 2002; Bounds et al, 1995; Ivancevich & Matteson, 1996). For example, Doorewaard, van Hootegem and Huys (2002) found that shared responsibility teams performed better than hierarchical teams. Bradley and Herbert (1997) found that the personality combination of teams can either enhance or impede its performance and thus also that of individuals.

The individual's job performance is determined and influenced by many factors internal or external to them (eg personality, needs, values and work environment). Some of these factors influence their job performance directly (eg work environment) and are not always under their control (eg task demands). Others influence job performance indirectly and are capable of being influenced by the individual (eg improved job performance by improved knowledge and ability through training). It is therefore vital that managers know and understand the factors that determine and influence individual job performance. This will enable them to create a climate that enhances job performance and design jobs that are clearly defined and satisfying. Furthermore, managers would achieve a better match between individual needs, abilities and values and that of the organisation and they would be able to adapt the working environment to enhance individuals' commitment and job performance. By doing this, managers could improve individuals' motivation, job performance and organisational performance.

The way individuals view themselves and the extent that there is congruency between this view and that which others have of them also has the potential to influence their behaviour, and thus also their job performance. Therefore, the self-concept will be discussed next.

2.3.3 Rogers' Self Theory

According to Rogers, all individuals have a unique frame of reference in terms of which they experience and interpret their environment (Nevid, Rathus & Greene, 1997). He believes that

individuals' environment influences them while they are striving to attain self-actualisation (Meyer et al, 1997). The ideal environment allows individuals to see themselves precisely as they are, while facilitating the attainment of their full potential (Meyer et al, 1997). However, in reality, certain significant others (eg supervisor) within the environment prescribe conditions of acceptance for individuals, which influence their behaviour (Meyer et al, 1997). The subjective way individuals experience their world influences the way they see themselves, their attitudes, relationships and how they cope in the workplace (Bergh & Theron, 2002; Meyer et al, 1997). The concept of the self is central to Rogers' theory. The self is individuals' perception of themselves, which is influenced by their perceptions, experiences and meanings that they attach to objects or events outside themselves (Bergh & Theron, 2002; Meyer et al, 1997; Nelson-Jones, 1988). The self is thus a picture that individuals have of themselves and although it is relatively stable, it is flexible and changeable (Bergh & Theron, 2002; Meyer et al, 1997; Nevid et al, 1997). The self-concept includes our self-esteem and self-identity: It indicates who we are and it directs and motivates behaviour (Bergh & Theron, 2002; Meyer et al, 1997).

The ideal self is that which the individual wants to become or have (Bergh & Theron, 2002; Meyer et al, 1997). It is individuals' view of their reality (Nelson-Jones, 1988). If individuals' present self-concept is congruent with their ideal self they are considered to be psychologically healthy (Meyer et al, 1997). Individuals also have a need for positive regard from others (eg approval, appreciation) and a need for positive self regard (eg self-esteem) (Meyer et al, 1997; Nevid et al, 1997). The need for positive regard is learned early on in life and reflects the internalisation of the values of others (ie conditions of worth) (Nelson-Jones, 1988). The internalised values include those that impede self-actualisation and influence the individual's psychological wellbeing (eg I must be HIV negative otherwise I am a not worthy of friendship) (Nelson-Jones, 1988). If the conditions of worth are internalised, they could reduce the individual's level of self-regard and prevent themselves from achieving their full potential (Nelson-Jones, 1988). The need for positive regard and the drive for self-actualisation influence individual behaviour (Meyer, 1997).

Individuals' self-concept is thus also influenced by their efforts to win approval of others and occurs when they incorporate the values of others into their self-concept to prevent rejection

(Meyer et al, 1997; Nevid et al, 1997). However, when individuals have experiences that are in conflict with their self-concept, they are unable to include them into their self-concept to fit their self-concept (Meyer et al, 1997; Nevid et al, 1997). Therefore, individuals may accept certain values, thoughts and behaviour of others, while disowning, distorting or ignoring that which is of value to them, just to be accepted (Meyer, et al, 1997; Nelson-Jones, 1988).

Individuals also have the freedom of choice to bring about change and realise their full potential (Meyer et al, 1997). For example, junior executives may ignore dishonesty, unfair practices or discrimination by senior executives, although all these values are important to them, just because they do not want to be seen as “rocking the boat”, and thus negatively affecting their chances for promotion. However, if they have opportunities to join the organisation’s competitors or consider their values as not negotiable, they might resign to preserve their self-concept and self-esteem.

Within the workplace, the self-concept could influence how individuals feel, think and act about themselves and the job. Thus it could also influence their job performance. Research regarding the self-concept has shown that self-esteem and self-efficacy influence individuals’ occupational choice (Betz, 1994). Individuals attempt to achieve a match between their self-concept and their ideal occupation, which is influenced by their self-esteem and self-efficacy (Betz, 1994). Individuals low on self-esteem could make incorrect choices (Betz, 1994). By implication those incorrect choices could prevent individuals from experiencing job satisfaction, self-actualisation, and influence their job performance. Geisler and Leith (1997) showed that self-esteem and self-efficacy, could influence job performance. Furthermore, during a study of soccer players’ penalty shots, they showed that the presence of others and level of anxiety could influence their ability to successfully kick penalties into the goal. Rogers’s theory focuses on the self as the driving force behind behaviour, which is flexible and influenced by the environment. As long as there is congruence between individuals’ current self-concept and the ideal self, they function normally. If there is incongruence, individuals could react abnormally, which could lead to a decline in job performance. Individuals’ self-concept is also influenced by their performance. Individuals’ self-concept is influenced by their need for positive regard from themselves and others. The above implies that individuals’ perceptions of their environment will influence their

job performance. Thus, organisations' culture, climate, the job, work relations and individual needs influence their self-concept and must be managed to ensure optimal job performance. Failure to do so could result in incongruence, lack of commitment and decreased job satisfaction. For example, Lee (2001) found that organisations that broke their promises to individuals reduced their commitment, job satisfaction and thus job performance. By implication, the broken promises may cause the individual to feel worthless and thus experience lowered self-esteem especially if the promise was vital to maintaining positive self-regard. For example, individuals who value being respected unconditionally, may experience rejection and lowered self worth, and reduced job performance, if they are rejected in the workplace due to a disease or illness, particularly where they believed the workplace to be supportive of who they are. Cassar (2001), Fesko (2001a) and Hunt et al (2003) show some support for this view.

Within the self-concept framework, individuals living with HIV or AIDS could experience tremendous stress and anxiety. This may result from the discrepancy between their real self (eg HIV positive, reduced capacity and stigmatised) and their ideal self (eg accepted, supported and healthy functioning). Coming to terms with being HIV positive has a profound impact on individuals. Some adjust very well while many more experience a wide range of distress including depression, bereavement, hostility, denial, anxiety, shock, withdrawal and guilt (Chippendale & French, 2001; Nowell & Van der Merwe, 2003; Strydom, 2003). The distress arises from fear, discrimination, unfulfilled dreams, realisation of mortality, loss of friends and hysteria that originate within the individual or which is perceived and experienced in the broader social environment (including the workplace) (Chippendale & French, 2001; Nowell & Van der Merwe, 2003; Strydom, 2003). Individuals' need for positive regard from others and the fear of rejection, loneliness and abandonment may prevent them from disclosing their HIV status (Nowell & Van der Merwe, 2003; Strydom, 2003). The self-esteem, self-worth and meaningfulness of infected individuals are affected on discovering their status. This has been evidenced by feelings of guilt, fear of others opinions and helplessness (Nowell & Van der Merwe, 2003; Strydom, 2003).

The resultant distress from the incongruency between the ideal and real self could hasten the decline in HIV positive individuals' health and ability to cope with the disease (Leserman,

Petitto, Golden, Gaynes, Gu, Perkins, Silva, Folds & Evans, 2000; Nowell & Van der Merwe, 2003). Stress has been shown to negatively influence the immune system whereas positive attitudes have been shown to improve longevity (Kelly & Kalichman, 2002; Leserman et al, 2000; Nowell & Van der Merwe, 2003).

Although returning to work is considered essential to the psychological health of HIV or AIDS infected individuals (including the self-concept) and thus considered a major achievement, there are several obstacles (Kelly & Kalichman, 2002; Nowell & Van der Merwe, 2003). The obstacles include stigmatisation, discrimination and a lack of support to be meaningfully integrated back into the workplace. The aforementioned could result in a decrease in job satisfaction, motivation, interpersonal relations and thus also decreased job performance (Nowell & Van der Merwe, 2003). Furthermore, they could sustain the incongruence between the real and ideal self. Depending on the individuals' values and need for positive regard, they may refrain from disclosing their HIV status and remain employed despite the negative impact on themselves, just to be accepted. However, they may also resign to avoid further distress that could result from disclosure in an intolerant organisation.

The most beneficial situation is where HIV or AIDS infected individuals are able to work in an organisation that is tolerant and supportive of them in all spheres. This situation does not only hold possible benefits to the individuals' self-concept and job performance, but also to the employers' productivity and profits (Fesko, 2001a; Greene, 1998; N'daba & Hodges-Aeberhard, 1998).

Another facet that is affected by the way employers treat individuals living with HIV or AIDS is the psychological contract.

2.3.4 The psychological contract

The psychological contract is an unwritten agreement that contains subjective, reciprocal expectations between individuals and their organisation regarding what each owes the other in the employment relationship (Ivancevich & Matteson, 1996; Lee, 2001; Marks, 2001; McDonald

& Makin, 2000; Rousseau, 2001). The psychological contract defines the behavioural expectations that are associated with every role in the organisation (Robbins et al, 2003). Cassar (2001) and Rousseau (as cited in McDonald & Makin, 2000) argue that the psychological contract can involve promises, obligations, beliefs or perceptions regarding what the parties involved owe to each other. Furthermore, the perceptions of the parties to the contract differ regarding the promises or obligations. Research has shown that the nature of the psychological contract is changing due to the changing world of work, globally and in South Africa (eg outsourcing, downsizing, fewer core employees, increased contingency workers) (Cassar, 2001; Lee, 2001).

Marks (2001) argues that the psychological contract is formed between individuals at multiple levels within the organisation, at individual, team and organisational level. There are two types of psychological contracts (Chrobot-Mason, 2003; Lee, 2001; McDonald & Makin, 2000). The first are transactional contracts and focus on economic exchanges for a specific period (temporary employment) and for specific tasks (Chrobot-Mason, 2003; Lee, 2001; McDonald & Makin, 2000). The second are relationship type contracts and are characterised by trust and commitment. They focus on ongoing relationships and indicate the tendency of the organisation to retain employees (Chrobot-Mason, 2003; Lee, 2001; McDonald & Makin, 2000). In general, research has found that psychological contracts change over time and include obligations such as promotions, fair treatment, trust, career development, long-term job security and support with personal problems (Chrobot-Mason, 2003; Ivancevich & Matteson, 1996; Lee, 2001; Shore & Tetrick, 1994). However, several studies have found that although psychological contracts tend to be a combination of transactional and relational types, they are changing towards a more transactional type (Lee, 2001; McDonald & Makin, 2000).

The psychological contract is crucial to the employment contract that regulates and guides behaviour and job performance (Lee, 2001; McDonald & Makin, 2000; Robbins et al 2003; Rousseau, 2001). It influences affective, normative and continuance organisational commitment and reduces uncertainty (Cassar, 2001; Lee, 2001; McDonald & Makin, 2000; Shore & Tetrick, 1994). A breach in the contract occurs wherever either party experiences that promises or obligations agreed upon, were not met (Cassar, 2001; Chrobot-Mason 2003; Marks, 2001).

There are several types of violations (Shore & Tetrick, 1994). Distributive violations include training and pay; procedural violations refer to procedural fairness and include fairness of layoffs; and interactional justice which refers to the quality of interpersonal treatment received when a procedure is implemented (trust is essential) (Shore & Tetrick, 1994). Several studies have found that a breach of the psychological contract leads to decreased job satisfaction, expressed feelings of resentment, decreased motivation, decreased commitment, increased cynicism, decreased trust, negative work behaviour, increased turnover, decreased organisational performance and law suites (Cassar, 2001; Chrobot-Mason, 2003; Lee, 2001; Marks, 2001; McDonald & Makin, 2000; Rousseau, 2001; Shore & Tetrick, 1994).

The psychological contract is a subjective, implicit agreement between the individual and the organisation concerning the expectations (eg trust, fairness) each has of the other. This contract is flexible and regulates individuals' behaviour, satisfaction and job performance. If it is violated it can have a negative impact on the individual and organisation. It is therefore in the interest of the organisation to ensure that it clarifies its expectations, and those of its employees, so that they can work towards honouring the psychological contract. Cassar (2001), Lee (2001) and McDonald & Makin (2000) argue that the job satisfaction, commitment and job performance of permanent staff, core staff or temporary employees can be maintained or enhanced through the effective management of individuals' psychological contract.

For example, individuals who value creativity, freedom, development, trust and fairness in striving toward self-actualisation would join organisations that they consider possess a psychological contract, which contains these values. Such individuals could experience a violation of the psychological contract if they experience organisational policies and practices that constrain their creativeness (eg too much regulation), promote unfair discrimination (eg unequal training opportunities or work assignments); or break trust (e.g laying off individuals due to their HIV status). This might cause them to voice their feelings, reduce commitment (and thus job performance) or even resign due to the extent of the contract breach. Violation of the psychological contract could bring about incongruence between their real and ideal self-concepts and their need for positive regard from others. The determinants of job performance, the self-concept and psychological contract are thus all factors that influence the job performance

of HIV or AIDS infected employees.

2.3.5 Job performance of employees living with HIV and AIDS

2.3.5.1 The impact of HIV and AIDS

It is estimated that 4,2 million individuals are living with HIV or AIDS in South Africa (ie 10% of the population) with a projected increase to 22% by the year 2010 (Nowell & Van der Merwe, 2003; Shisana, 2002). It is also projected that there will be about 2 million orphans due to the pandemic by 2010 and that life expectancy will decline from 64 to 47 years of age (Beeld, 1998 as cited in Strydom, 2002; Shisana, 2002; Whiteside & Sunter, 2000). The increase in orphans means that more individuals will enter the workforce generally unprepared as they could lack the required education, experience and general life skills that otherwise would have been provided through being raised in a normal family (Pharoah & Schönteich, 2003; Shisana, 2002; Strydom, 2002; Whiteside & Sunter, 2000).

Furthermore, the increasing number of HIV or AIDS related deaths is causing the consumer base to shrink and credit risks to increase, particularly in the younger, productive age groups (Bloom, Mahal & River Path Associates, 2001; HIV/AIDS and Southern Africa, 2002; Whiteside & Sunter, 2000).

A study convened by the JD group predicted that pandemic will cause its consumer base to decline by 18% by 2015 (Bloom et al, 2001; Christianson, 2001; Whiteside & Sunter, 2000). This situation has forced the JD Group to shift its market focus to less risky segments, including investing overseas (Whiteside & Sunter, 2000). Another study done by the South African Breweries (SAB) estimated that it would loose one percent of its potential earnings due to HIV and AIDS over the next 10 years (Impact on retail customer base, 2003). The overall South African economy will also be affected with an estimated decrease in the Gross Domestic Product by 17% and a shrinking, inexperienced labour force due to HIV and AIDS (Christianson, 2001; Pharoah & Shönteich, 2003; Whiteside & Sunter, 2000; USAID, 2001).

The impact of HIV and AIDS is thus tremendous, with the expectation that it will worsen even further in future. As such, the self-concept, psychological contract and job performance of HIV or AIDS infected individuals could also be negatively influenced one way or another. Therefore, organisations will need to provide support to employees infected with HIV or AIDS, and their families, if they want to ensure the availability of a competitive workforce. Failure to do so could negatively influence the individual, their families, their job performance, their employers and possibly the country.

2.3.5.2 Impact of HIV and AIDS on individual job performance

Individuals living with HIV or AIDS have many challenges to contend with in the workplace. These include discrimination, fatigue, loss of work, stigmatisation, reduced performance capacity, reduced disability and medical cover and difficulty in attaining career goals (Fesko, 2001a; Greene, 1998; Hunt, Niles, Jaques & Wierzalis, 2003; Lim & Loo, 2000). UNAIDS (2002b) projects that by 2005 six times as many individuals will die from AIDS in South Africa than from other causes. In addition, INGBARINGS (as cited in Naidu, 2001) predict that by 2005 one out of every 100 highly skilled individuals, about two out of every 100 skilled individuals and about two out of every 100 semi skilled individuals will die from AIDS related deaths. An HIV infection rate of between 13% and 32% of skilled or semi-skilled individuals compounds the latter situation. The severity of the situation is magnified when you consider that there is a shortage of highly skilled (currently only 10%) and semi-skilled (currently only 17%) individuals in the South African labour market (INGBARINGS as cited in Naidu, 2001; Quattek as cited in Heineken, 2001). Furthermore, Wöcke and Klein (2002) state that HIV and AIDS are an additional threat to a labour market that is constantly losing skills due to the brain drain. Rosen, Simon, Vincent, Macloed, Fox and Thea (2003) found that 39% of unskilled and semi-skilled workers and 14% of managers and supervisors of a specific South African organisation were living with HIV or AIDS. This implies that without strategies to retain, maintain or enhance the job performance of individuals living with HIV or AIDS, not only will their job performance and productivity decline, but the organisation and labour market will lose skills it can ill afford to do without. UNAIDS (2002c) concur with this view.

Furthermore, organisational strategies to manage HIV or AIDS infected individuals in the workplace vary from no action to integrated programmes including condom use, medical benefits and career management efforts (Breuer, 1995; Fesko, 2001b; Miller, 2000). Whereas a supportive environment helps HIV or AIDS employees maintain acceptable job performance, discrimination and rejection causes them to resign (Breuer, 1995; Fesko, 2001b). The latter can thus also imply reduced job performance.

Medical advances in the past few years have made it possible for HIV or AIDS individuals to live longer, productive lives (Hunt et al, 2003). Thus, such individuals are able to maintain previous levels of job performance while contributing to the organisation's bottom line for longer. Breuer (1995) states that with correct medical management, employees living with HIV or AIDS can make valuable contributions for years. Research by Rosen, Simon, Thea and Vincent (2000) support this view and add that South African organisations can extend the productive lives of HIV or AIDS individuals working for them through providing treatment and support to them. They show that the financial benefits (eg better productive life, less absenteeism, increases morale and longer working life) of such interventions outweigh the costs (eg medical expenses, lost productivity, training costs). In essence, they imply that the job performance of HIV or AIDS infected individuals could be maintained at previous levels, for longer, with correct workplace support strategy.

Just being able to work also has positive effects on individuals living with HIV or AIDS. The individual's sense of self worth, self-esteem and meaning are negatively affected upon being diagnosed with HIV or AIDS (Fesko, 2001b; Hunt et al, 2003; Vickers, 1997). Work plays an important role in individuals' core identity, self-esteem, organisational and family life (Fesko, 2001b; Vickers, 1997). Being able to continue to work provides meaning to an HIV or AIDS infected individual's life and provides a source of emotional support and psychological wellbeing (Fesko, 2001a; Hunt et al, 2003; Vickers, 1997). Furthermore, research has also shown that HIV or AIDS infected individuals are able to maintain productive lives and by implication good job performance (Breuer, 1995; Lim & Loo, 2000; Naidu, 2001; Rosen et al, 2000).

In terms of the self-concept theory, it could be argued that HIV or AIDS infected individuals would want to remain working as a way to live up to their ideal self: One that is healthy and able to make a meaningful contribution to the organisation. Unfortunately the real self may be at odds with the ideal self because of the extent to which the individual's health may have deteriorated. This may cause even more distress to a point where they realise that the attainment of the ideal self might not be possible. Being able to work for as long as possible, even with reduced responsibilities could at least contribute towards individuals living with HIV or AIDS maintaining a realistic view of their real self. It may even result in them adjusting their view of the ideal self that they want to attain. Furthermore, individuals living with HIV or AIDS may have a high need for positive regards of themselves and others. Not being able to contribute to the organisation or working in an environment which is not equipped to manage individuals living with HIV or AIDS in a supportive manner (eg discrimination, fear of infection) could cause even more anxiety and fear to these individuals. This would occur where the values of individuals living with HIV or AIDS (eg honesty, acceptance, fairness, support, trust, equal treatment) are incongruent with that of the employer in that it is perceived to be intolerant or unprepared for HIV or AIDS infected individuals.

Due to their need for positive regard, individuals living with HIV or AIDS may ignore their values and refrain from disclosing their status just so they will not be rejected. Research by Fesko (2001b), Hunt et al (2003) and Vickers (1997) found that remaining at work is required to maintain individuals' self-concept. They also found that individuals' decisions to disclose their HIV or AIDS status causes stress due fears of discrimination. The fear and distress caused by discrimination could thus also negatively influence individuals' job performance.

2.3.5.3 Impact of disclosure decisions on job performance

Of the challenges in the workplace facing individuals living with HIV or AIDS, the one that has the most far-reaching effects on job performance is the decision whether or not to disclose their HIV or AIDS status. One of the reasons for HIV or AIDS awareness education is aimed at improving individuals' understanding and knowledge of how the disease is spread or contracted (Breuer, 1995; Miller, 2000). A lack of understanding can lead to negative stereotyping that is

accompanied by rejection, violation, discrimination and even acts of violence against individuals living with HIV or AIDS. Research done by Lim and Loo (2000) and Fesko (2001b) support this view. Fesko (2001b) found that co-workers of HIV or AIDS infected individuals felt uneasy working near them. Some even believed that HIV or AIDS infected individuals should be fired the moment they show signs of disability (Fesko, 2001b). The aforementioned influences the decision of individuals living with HIV or AIDS to disclose their status, thus causing them anxiety, fear and tension (Breuer, 1995; Fesko, 2001b; Hunt et al, 2003; Vickers, 1997). It can therefore also be argued that the job performance of individuals living with HIV or AIDS could decline as a result of the anxiety and fear coupled to their decision to disclose.

Furthermore, the devastating effect of the HIV and AIDS epidemic throughout the world also adds to this fear. For example, the losses due to HIV and AIDS nearly crippled Ethiopian Military during the armed struggle (Gebretisae, 2002). The Ethiopian Defence Force (EDF) lost a large portion of its command group, forcing it to replace them with inexperienced soldiers (Gebretisae, 2002). In the South African Defence Force (SANDF), the current infection rate is between 17 to 23% (Heinecken, 2001; Heinecken, 2003). The loss of a soldier impacts on the whole platoon. This is due to the integration of functions performed by individuals, coherence and integrity that has to be rebuilt when a new member (s) joins the team (Heinecken, 2003). It is predicted that the SANDF could loose up to 25% of its middle ranks, thus placing it in a similar dilemma as the EDF. The pandemic will also influence the SANDF's force preparation, force employment, force sustainment and ultimately its ability to ensure national safety and security (Heinecken, 2001; HIV/AIDS in Southern Africa, 2001). The amount of HIV or AIDS related deaths has increased since the early 1990s (Dorrington, Bourne, Bradshaw, Laubser & Timaeus, 2001). For example, there were three and a half times more HIV or AIDS related deaths in the 25-29 year age group and two times more HIV or AIDS related deaths in the 30-39 year age group, in South Africa, in 1999/2000 than in 1985 (Dorrington et al, 2001). It is also estimated that there will be about 500 000 AIDS related deaths by 2010 (Williams, Gouws & Abdool Karim, 2000).

Whiteside and Sunter (2000) state that the effect of HIV or AIDS in South Africa will only peak around 2010. This will be accompanied by a loss in labour, skills and investment. Furthermore,

the current shortage of skills in South Africa will be aggravated even more (Naidu, 2001). UNAIDS (2000b) predict that within 10 years up to 25 000 mineworkers will die because of HIV and AIDS related illnesses. HIV and AIDS appear to cause increased absenteeism, reduced productivity, increased skills loss, decreased morale, increased disruptions and loss of supervisory skills (Naidu, 2000; Whiteside & Sunter, 2000; UNAIDS, 2000b; UNAIDS, 2002d; Van Wyk & Van Aardt, 2002). UNAIDS (2000b) argue that the smaller and informal sectors in South Africa will be hit harder because of the difficulty they will experience in replacing skilled and semi-skilled individuals. A study done on a South African sugar farm, from 1991 to 1998 found that 26% of the employees were HIV or AIDS infected (Naidu, 2001). Of these employees, only 53% were productive. Therefore, the remainder can be classified as unproductive and thus delivering unacceptable job performance.

Research by Breuer (1995) and Heineken (2003) has also indicated how HIV or AIDS impacts on individuals. Individuals living with HIV or AIDS have been found to suffer from memory loss, difficulty in integrating information and thus by implication also reduced job performance. The above known and projected impact of HIV and AIDS, and the ignorance surrounding the nature of the disease and how it spreads, creates an atmosphere that could prevent individuals from disclosing their HIV or AIDS status. Individuals' decision to disclose is further influenced by stigmatisation, fear experienced by uninfected employees, and workplace support (Fesko, 2001a; Lim & Loo, 2000). Research has shown positive and negative responses to individuals' decision to disclose their HIV or AIDS status, which include disruptions, discrimination law suites, low morale, reduced lost time, reduced stress and support (Fesko, 2001a; Lim & Loo, 2000; Miller, 2000). The latter all imply that individual job performance could be negatively affected, particularly in the absence of any means of workplace support.

Research by Fesko (2001a) and Vickers (1997) also indicated that while HIV and AIDS negatively influence individuals' job performance, advances in the treatment of the pandemic have allowed such individuals to live longer productive lives. It is also possible that they could be able to work for longer. Being able to work longer has positive effects on the overall psychological wellbeing of the HIV or AIDS infected individual, including positive self esteem and a sense of meaning.

It is evident that HIV or AIDS affects the job performance of infected individuals (eg reduced productivity, increased absenteeism). However, medical advances in treatment strategies have made it possible for such individuals to live longer productive lives for up to 10 or 15 years after infection. At present, however, relatively few employers have policies in place to manage individuals living with HIV or AIDS in an environment in which the epidemic is spreading at alarming rates. This lack of HIV and AIDS workplace support is allowing highly or skilled individuals to either resign or perform less than satisfactory. As a result, individuals' self-esteem and self-concept are being negatively influenced and the labour force is losing skilled individuals which it can ill afford, due to such individuals resigning or being laid off. In addition, stigmatisation and fear of the non-infected, caused by a lack of information about the epidemic and the effects of the epidemic, results in discrimination against HIV or AIDS infected individuals.

The discrimination and rejection places individuals living with HIV or AIDS in a predicament of whether or not to disclose their status to colleagues and or management. The aforementioned factors hence combine to reduce the overall job performance of the individual and thus the organisation.

2.4 SUMMARY

Job performance is the behaviour or actions executed by individuals that lead to the attainment of goals, standards, quantities or other types of outcomes. Job performance is carried out within a specific organisational context, which directly or indirectly influences it. In particular, job satisfaction, motivation, absenteeism, productivity and commitment are influenced by the organisational culture, climate, strategy and structure, and therefore also job performance. The aforementioned are also important when considering the impact of the psychological contract on job performance as it has been viewed to be the driving force behind behaviour in the workplace. When the organisation is perceived to have broken this contract, employees could display job dissatisfaction, decreased commitment, low morale and decreased job performance. It is essential that the expectancies of each party to this contract be clarified, particularly in this time of contingency employment and constantly changing business environment. Some of the

individuals' expectancies that are contained in the psychological contract will include those that are important to maintain the self-concept (eg self-esteem, meaningfulness, self-actualisation).

The individuals' job behaviour is influenced by the self-concept. The extent that the work environment, occupation and task influence the job performance of individuals' will be determined by their drive for self-actualisation, need for positive regard, values and self-esteem.

Greater congruence between work environment and individuals' self-concept could result in increased job performance. The individual's personality, cognitive abilities and competencies also influence Job performance. This implies that organisations must create a culture that enhances individual job performance, while maximising the match between individual needs and capabilities and those of the organisation. The effectiveness of such efforts could be measured by implementing an effective performance appraisal system.

Individuals living with HIV or AIDS are encountered more and more in the workplace, due to advances in medicine. They are able to live longer productive lives, work longer, aspire to career goals and are capable of good job performance for extended periods of time. However, increasing costs, the dynamic business environment, fears regarding HIV and AIDS and lack of HIV and AIDS policies are hampering organisations' ability to effectively manage such employees. Furthermore, the self-concept of individuals living with HIV or AIDS could be negatively affected. These individuals could also experience a perceived breach in the psychological contract with the organisation. This could result in reduced motivation, stress and anxiety in these individuals and hence decreased job performance. Due to the high prevalence of individuals living with HIV or AIDS in the workplace, it is therefore necessary for employers to develop workplace support programmes that will improve or maintain the employees' job performance. This will enhance the long-term returns to the organisation as shown by Rosen et al (2000). Breuer (1995) puts it as follows: "Managing HIV/AIDS requires aggressive monitoring ... it requires a partnership among the manager, the employee... and other support people."

This chapter focused on job performance and the context within which it is carried out. The

factors that influence job performance such as the workplace environment, self-concept and HIV and AIDS were presented. The next chapter will focus on workplace support programmes and their influence on the job performance of individuals living with HIV or AIDS.

CHAPTER 3: WORKPLACE SUPPORT PROGRAMMES

3.1 INTRODUCTION

Organisations have a legal obligation to provide a safe and discrimination free working environment for all their employees, irrespective of their HIV or AIDS status. At the same time, the HIV and AIDS pandemic is spread through various factors and has vast cost implications to organisations, in addition to decreased job performance. Understanding the aforementioned aspects, could assist in understanding the influence of workplace support programmes (and specifically the activities contained therein) on the job performance of the individuals living with HIV or AIDS, including the extent of influence amongst the various activities.

Workplace support programmes can be seen as any action taken by an employer to prevent and reduce the impact of the HIV and AIDS pandemic on the individual and organisation. It includes education, condom supply, provision of medical benefits, psychological counseling, social support, reasonable accommodation in the workplace and drug therapy. It also includes actions to reduce discrimination and stigmatisation.

This chapter will begin with the employers' obligation to provide a safe working environment. Thereafter, the cost of HIV or AIDS to organisations, discrimination and stigmatisation due to HIV or AIDS, the nature of workplace support programmes and the influence of workplace support programmes on job performance of individuals living with HIV or AIDS will be discussed.

3.1.1 Employers' obligation to ensure a safe workplace versus discrimination

Employers find themselves arguably in a difficult position because of the possible trade-off between maximising profits and preventing unfair discrimination on the one hand and promoting harmony and the safety of individuals in the workplace on the other. The Employment Equity Act (1998) prohibits unfair discrimination on any basis including HIV status. The Act prohibits mandatory medical screening unless it is an inherent job requirement. Furthermore, if

organisations are found guilty of committing an offence regarding the aforementioned provisions they could be fined up to R900 000 (Employment Equity Act, 1998). Thus organisations have a legal obligation to treat all individuals fairly and reasonable (including those that are HIV positive).

The Occupational Health and Safety Act (1993) states that all organisations must provide and maintain a workplace that is safe and without risk to individuals' health. Organisations must also eliminate any hazards or potential hazards, provide training and instruction to enhance safety and health and take all precautions necessary to comply with the Act (Occupational Health and Safety Act, 1993). Organisations must also take all steps that are reasonably practicable to ensure the safety of individuals not working for the organisation. Organisations also have a duty to inform individuals of any hazard to their health regarding any work they perform (Occupational Health and Safety Act, 1993). Failure to ensure the safety and health of individuals internal or external to the organisation can lead to conviction and a fine of up to R50 000. The organisation is thus compelled to provide an environment that is safe and hazard free to all individuals it employs.

Herein lies the potential dilemma. It can be argued that while the employer has a legal, and even moral obligation to provide a supportive environment for employees living with HIV or AIDS it may well be creating an unsafe environment for HIV or AIDS negative individuals. Furthermore, certain professions and working environments (eg administration clerk employed in a supermarket) may have a lower degree of contact with infected individuals than others (eg ambulance crew, submarine crew) thus reducing the risk of infection (and vice versa). The aforementioned places the employer in a difficult position while it attempts to enhance the quality of work life through specific programmes, on its way to maximising profits. The specific programmes include safe and healthy work environments, opportunity for growth and security, protection of constitutional rights and social relevance and social responsibility (Bounds et al, 1995).

The difficulty arises because while organisations attempt to promote the health and safety of all individuals they could be inadvertently unfairly discriminating against some of them. For

example, how does an organisation comply completely with the Health and Safety Act regarding advising individuals of hazardous working conditions when it may not test the HIV or AIDS status of individuals unless ordered by the Labour Court (Employment Equity Act, 1998)? How does an organisation prevent discrimination, promote fair and meaningful utilisation or support individuals living with HIV or AIDS within the workplace if disclosure is mainly voluntary? Within the SANDF there is no mandatory HIV or AIDS testing and policies have been issued that prevent the mass exit of individuals who are medically unfit due to HIV or AIDS (Naicker & Engelbrecht, 2001; Heinecken, 2001; Heinecken, 2003). Furthermore, HIV or AIDS infected individuals within the SANDF must be managed to continue productive careers as long as their health permits. However, the Defence Act No, 42 (2002) states that medically unfit member's services can be terminated if they can't perform their duties or if the Surgeon General issues a certificate stating they are medically unfit (SANDF, 2000). At the same time, the SANDF is obliged to enforce the Occupational Health and Safety Act (1993) and meet its obligations in terms of the constitution. The latter is sometimes difficult when required to assist with international peacekeeping efforts because not all personnel comply with the medical requirements for such deployments due to them being HIV positive (Heinecken, 2001; Heinecken 2003). The difficulty lies in that the SANDF only becomes aware of the HIV status when individuals undergo pre-deployment medical examinations.

While the SANDF attempts not to discriminate against HIV positive individuals, inherent job requirements and medical standards for international deployment require an HIV negative status. In short, the controversy between not discriminating unfairly and promoting workplace safety is again evident.

From the above it is evident that without a sound strategy and policy regarding workplace support for HIV or AIDS individuals, the optimal balance between enhanced workplace health and safety and reduced unfair discrimination will not be achieved.

3.2 THE COST OF HIV AND AIDS TO ORGANISATIONS

The HIV and AIDS pandemic negatively affect organisations' financial position in various ways.

The effects of the pandemic have been divided into direct (eg benefit payments, increased loss of sales, recruitment costs) and indirect costs (eg decreased productivity, increased personal turnover, increased absenteeism) (Fraser, Grant, Mwanza & Naidoo, 2002; Rosen et al 2000 Rosen et al 2003; UNAIDS, 2001). Furthermore, direct costs related to increased expenditure and indirect costs lead to decreased income. Fraser et al (2002) studied the impact of HIV and AIDS on small and medium organisations. They found that amongst others health care costs and burial costs increased direct costs and increased absenteeism (more than 45% of absenteeism was due to illness/health) and staff turnover were among the factors that increased indirect costs. The research also showed that indirect costs were higher than direct costs (Fraser et al , 2002).

Research by Booysen and Molelekoa (2001) on the impact of HIV and AIDS on businesses in Welkom found that the average annual total cost of HIV and AIDS to organisations was about R236 million. If projected to 2010, the value of the annual HIV and AIDS costs was R2,4 billion per year. They found that the major HIV and AIDS cost components were employee benefits (53%), absenteeism (24%) and medical aid premiums (11%). Furthermore, they found that because the largest amount of deaths were amongst the semi-skilled and unskilled workers, the largest portion of the total HIV and AIDS costs could be attributed to them (ie just over half). They also found that the average cost per AIDS death increases with time as the skill level increases (eg cost per skilled individual is two and a half times and per unskilled worker is just over one times their average annual salary). Despite the increasing cost of HIV and AIDS to organisations, Fraser et al (2002) and Booysen and Molelekoa (2001) found that few of the organisations were willing to invest money to prevent AIDS related deaths. One reason was that some said that HIV and AIDS had not yet affect them.

The cost implications of the aforementioned to organisations and South Africa are enormous, considering the amount of current and potential skill that will be lost or remain undeveloped. It is estimated that by 2005 about 1 million children in South Africa will have lost their mothers due to the pandemic (Saloner, 2002). Many of these mothers will be single parents thus leaving children to grow up without parental nurturing, education and financial support (HIV/AIDS in South Africa, 2000, Pharaoh & Schonteich, 2003). The latter could negatively impact on the children's development, thus impeding their ability to take up a productive role in the workplace

later on in their lives. HIV and AIDS mainly infects individuals between the age of 20 to 44 and it is estimated that the average death of HIV or AIDS infected individuals is between 35 and 37 years old (Pharaoh & Schonteich, 2003; Saloner, 2002). The HIV and AIDS pandemic is thus hollowing out the productive core of the population.

Other studies have found that the cost of an HIV infection to an organisation can be three and a half times their annual salary bill. Furthermore, absenteeism due to HIV or AIDS can be as high as 54% of the organisations' costs, personnel attrition was six times the amount in the period 1999 – 2000 in the public service of a specific country and that the personnel turnover in the Southern African mining sector is estimated to increase by almost four percent per year (Rosen et al, 2003; UNAIDS, 2000b; UNAIDS, 2002a; UNAIDS, 2002b; UNAIDS, 2002c).

Kennedy (2002) studied the impact of HIV or AIDS on a South African colliery. She provides a critical evaluation of previous impact studies that were done on the impact of HIV or AIDS on the mining industry (Evian 2000 as cited in Kennedy, 2002). She states that while costs such as absenteeism (43% of a particular organisation's costs), funeral expenses (11% of organisations' costs) and personnel replacement costs have increased the reasons may not necessarily be related to HIV or AIDS. For example, leave records could not indicate leave taken due to HIV or AIDS related reasons; no changes were made to pension or provident funds to cover amongst others HIV or AIDS related funeral costs; and the age of the mine and advances in technology could account for increases or decreases in production (Kennedy, 2002). The latter mean that extraneous variables impact on the costs mentioned and need to be isolated if the exact impact of HIV or AIDS on organisations is to be determined. Despite this, the study sheds light on the costs affected by HIV or AIDS in the mining industry. For example, a certain employer spent R2,1 million on HIV and AIDS prevention and packages paid to individuals for termination on the grounds of incapacitation, as they did not belong to a pension fund. The costs were in excess of normal salaries. Supervisors found an increased negative impact of fatigued team members (presumed to be HIV or AIDS infected) on coal production and safety (Kennedy, 2002). She also found that the absenteeism costs totaled R5 036 395. Michael (2000) as cited in Rosen et al (2000) found decreases in productivity due to HIV or AIDS were as much as 50%.

Heinecken (2003) states that the South African Medical Health Services (SAMHS) does not have the funds, capacity or manpower at present to deal with the difficult, long term infections, such as HIV or AIDS on individuals in the SANDF. Furthermore, HIV or AIDS is placing an increased burden on the defence budget and the already strained Military Hospitals (Heinecken, 2003). The aforementioned will decrease the defence budget and thus prevent the SANDF from performing functions such as border-line patrols and humanitarian support without additional funds (Heinecken, 2001). Thompson and Marquart (1998) and Edwards and Tewksbury (1996) studied HIV and AIDS within the American Police. To them an increase in HIV or AIDS infections within the police, dealing with criminals who are HIV or AIDS infected (including those who may willfully want to infect officers through biting) and improved health and safety practices for officers who frequently dealt with high risk groups (eg drug addicts and prostitutes) raised concerns amongst officers. Furthermore about 40% of the officers felt that they had no or limited responsibility to act in situations that increased the risk of exposing them to HIV or AIDS (Thompson & Marquart, 1998). These factors could be implied to increase the cost already discussed if insufficient or inappropriate workplace support programmes were in place. For example, many state police organisations did not have an HIV and AIDS policy, some did not have any HIV or AIDS related training and where such training was provided the quality varied greatly (Thompson & Marquart, 1998). Furthermore, the cost to the organisation for replacing an individual who has died due to HIV or AIDS was found to be between R6501 and R25 000 depending on the level of skill and industry (Booyesen & Molelekoa, 2001; Kennedy, 2002).

The HIV and AIDS pandemic has also impacted on the mortality rate of organisations. Fraser et al (2002) found that more than 22% of 97 organisations surveyed had lost individuals through HIV/AIDS related deaths. Heinecken (2003) estimates that the SANDF will lose up to 25 % of the middle ranks (middle management) due to HIV or AIDS. Replacing these skills is more difficult in the SANDF than in the average private organisation. It usually takes 12 to 15 years to gain the relevant military and combat skills to function at that level (Heinecken, 2003). UNAIDS (2002) suggest that within the next 10 years about 25 000 mine workers will die every year due to HIV or AIDS. Projections have been made that indicate that five to seven million AIDS deaths will occur in South Africa by 2010 (Dorrington et al, 2001). Although this does not

focus on any specific industry, it is clear that employers will lose individuals and their skills that could adversely affect their core business delivery. Ultimately, a reduction in the human capacity to execute job performance related to specific organisational objectives could threaten the survival of organisations. This is even more inevitable if the organisations leave this pandemic unchecked. A study on a South African sugar mill indicated that 23% of the individuals it employs died due to HIV and AIDS during the period 1991 and 1998 (Naidu, 2001). A study found that small to medium organisations are more adversely affected than larger organisations, because they are not able to sustain the costs of the pandemic (eg financially and shrinking customer base) (Bloom et al, 2001; Christianson, 2001; Fraser et al, 2002).

The financial and human losses and costs resulting from the pandemic adversely influence individuals' job performance and organisational survival (Bloom et al, 2001; Christianson, 2001, Lamont, 2000; Whiteside & Sunter, 2000; UNAIDS, 1998; USAID, 2001). However, while some organisations are taking the initiative to implement workplace support programmes to combat the HIV and AIDS pandemic, fear, stigma and discrimination of infected individuals and other factors are hampering such efforts. There are also factors that promote the spread of the HIV pandemic. These factors also influence the individual and organisation and are discussed next.

3.2.1 Factors that promote the spread of the pandemic

There are many other factors that promote the spread and impact of the pandemic (Heinecken, 2001; Heinecken, 2003). These factors include political break down of law and order, instability, inequalities in income, geographically isolated populations, rapid urbanization, low education levels, migrant labour, war, conflict, intolerance and xenophobia, unemployment (particularly among women) and violation of fundamental rights (Heinecken, 2001; Heinecken, 2003; ILO, 2001; Kisoon, Caesar & Jithoo, 2002; Poverty and HIV/AIDS, 2001; Stigma, discrimination fuel AIDS pandemic, 2001; Susser & Stein, 2000; Williams et al , 2000). Different cultural levels and customs also need to be understood and respected (Maelase, 2002). If they are ignored prevention programmes may fail to achieve a reduction in the spread of the pandemic. The aforementioned factors create a fertile environment for the spread of the pandemic.

The HIV and AIDS pandemic has numerous direct and indirect costs including decreased profits, increased turnover, increased mortality and decreased life expectancy. The costs influence society, organisations and individual job performance (eg. carrying out extra responsibilities of those absent due to HIV illnesses, maladjusted HIV orphans who enter the workplace, ostracised HIV infected employees). The pandemic is further spread through factors including poverty, discrimination, stigmatisation, cultural differences and war.

However, stigmatisation and discrimination have a particularly negative impact on attempts to successfully combat the HIV and AIDS pandemic (Henderson, 1999; ILO, 2001). Within the broader social environment, and particularly in organisations, these factors tend to discourage disclosure and drive the pandemic underground. Individuals who disclosed their status have been shunned, ostracised and beaten (Henderson, 1999; ILO, 2001).

3.3 STIGMATISATION AND DISCRIMINATION DUE TO HIV OR AIDS

3.3.1 Stigmatisation due to HIV or AIDS

Policy Project SA, Pretoria University Centre for the Study of AIDS, USAID and Department of Health (2002) define stigma as “the subsequent action and feelings that result from labeling and/or the fears of labeling within the world of work...”. Thompson (1996) defines stigma as “shame or disgrace” while stigmatisation refers to “brand as unworthy or disgraceful”. Stigma due to HIV and AIDS in the workplace, and in the broader social environment, is due to fear, lack of information, misunderstanding of how the disease is transmitted and prejudice towards certain groups (eg immigrants, homosexuals) (Dussault, 1999; N'daba & Hodges-Aeberhard, 1998; Policy Project SA et al, 2002; South Africa – Stigma in the workplace, 2003; Stigma, discrimination fuel AIDS pandemic, 2001). It refers to irrational responses by co-workers and/or supervisors toward individuals living with HIV or AIDS (Nowell & Van der Merwe, 2003). The differences in cultural beliefs could also influence stigmatisation. Maelane (2002) found that African cultural views and beliefs regarding ancestors and witchcraft influenced individuals' attributions about the cause of HIV and AIDS and condom use. For example, Zulu men believe that wearing a condom hinders the foetus's development as it prevents the semen from reaching

it. This implies that HIV or AIDS infected men could be stigmatised for wearing condoms as they could be seen as preventing their unborn children from developing. Therefore, Maelane (2002) believes that unless these beliefs are respected and included in HIV and AIDS education, prevention efforts will not be successful. This also implies that these beliefs have the possibility of hindering workplace support programme efforts to reduce stigmatisation if they are not taken into consideration.

Stigmatisation impacts negatively on absenteeism, the psychological wellbeing and quality of life of employees living with HIV or AIDS; results in internalisation of stigma through increased work performance to hide the diseases affects and abstaining from sex; and strains employee relations (Lau & Wong, 2001; Policy Project SA et al, 2002). Employee relations in the workplace become strained because uninfected individuals fear working with infected employees, refuse to eat from the canteen where individuals working there are HIV positive, sharing office equipment with HIV or AIDS infected individuals or organisations sometimes refuse to serve HIV or AIDS infected customers (eg hospitals and nursing homes have refused to attend to HIV or AIDS infected individuals (Firmansyah & Kleiner, 1999; Health Systems Trust, 2003; Lau & Wong, 2001).

The stigmatisation leads to discrimination practices which prevents infected individuals from disclosing their status, using available workplace support programmes and thus promotes the spread of the pandemic. Furthermore, manifestations of stigma amongst individuals living with HIV or AIDS include reduced cognitive functioning, discrimination against their family, poor self-esteem, withdrawal and feelings of loneliness (Dane, 2002; Fesko, 2001b; Ford, Moore & Hollar, 2003; Policy Project SA et al, 2002). Stigmatisation does not only lead to the violation of fundamental rights, it also leads to perceived breaches of the psychological contract, unrealistic notions of the self-concept, hostility, anxiety, decreased commitment and reduced job performance (Dane, 2002; Firmansyah & Kleiner, 1999; Lau & Wong, 2001; Shore & Tetrick, 1994).

To ensure that the impact of the pandemic is reduced and thus the success of workplace support programmes on the job performance of individuals living with HIV or AIDS is enhanced,

employers must focus on the prevention of stigmatisation and discrimination. This view is supported by the Code of Good Practice: Key aspects of HIV/AIDS and employment (2001), Dussault (1999), ILO (2001), Lau and Wong (2001) and N'daba & Hodges-Aeberhard (1998). The silence regarding the pandemic must be broken and its consequences must be openly discussed before the real extent of infection can be determined and discrimination reduced (Strydom, 2002). Stigmatisation works hand in hand with discrimination. Hence it is important to understand HIV and AIDS related discrimination and its influence on infected individuals.

3.3.2 Discrimination due to HIV or AIDS

Unfair discrimination results when individuals are treated differently due to their real or perceived HIV status in a way that impairs their right to dignity, and is not based on inherent job requirements. It places burdens or disadvantages on such individuals or it limits or withholds access to benefits while these are freely available to others (Grant, Strode & Smart, 2002). Unfair discrimination on any basis, including an individuals' HIV or AIDS status is considered illegal in terms of the Constitution Act, No 108 (1996), Employment Equity Act, 1998 and the Labour Relations Act, No 66 (1995). The Promotion of Equity and Prevention of Unfair Discrimination Act, No 4 (2000) has also been passed. It deals with workplace issues not covered in the Employment Equity Act (1998) (eg it protects the rights of SANDF personnel who are not covered by the Labour Relations Act). In addition, the principle of non discrimination against HIV or AIDS infected individuals has been incorporated in several "codes of practice" and other documents (eg The South African Department of Labour's Code of Good Practice and HIV/AIDS Technical Assistance Guidelines (TAG), the ILO Code of Practice on HIV/AIDS and the world of work, Depart of Public Service and Administration's guide for managing HIV/AIDS in the workplace and the AIDS Review 2002 published by the Centre for the study of AIDS of the Pretoria University).

Current South African legislation also prohibits the testing of individuals to determine their HIV status unless the Labour Court justifies such testing (Employment Equity Act, 1998; South Africa: Stigma in the workplace, 2003). Unfortunately, despite the aforementioned legislation and codes of practice, discrimination continues against HIV or AIDS infected individuals.

Stigmatisation, ignorance, denial, fear and negative HIV and AIDS images portrayed by the media are some of the reasons for related discrimination (Dane, 2002; Dussault, 1999; Health Systems Trust, 1993; Policy Project SA et al, 2002; Stigma, discrimination fuel AIDS pandemic, 2001). This includes rejection and discrimination of friends of HIV and AIDS infected individuals and / or those who assist them. Jennifer Joni, an attorney for the AIDS law project put it this way, “We have the best legal framework but this hasn’t changed mindsets...I handle HIV/AIDS discrimination cases almost every day” (Health Systems Trust, 2003). There is still a belief that HIV or AIDS is something that happens to those who are promiscuous. This is the opinion of Terry Anderson who was diagnosed as HIV positive in 1999 (Health Systems Trust, 2003). He has been told by some of his staff and clients that he deserves to die and it is people like him that are causing the disease (Health Systems Trust, 2003).

The HIV and AIDS discrimination takes many forms. The most violent include physical attacks or even being murdered (Dussault, 1999). Such was the case with Gugu Dlamini from Kwazulu Natal. She disclosed her HIV status to her neighbour who beat her. She was eventually beaten to death by fellow villagers as she was accused of bringing shame to the community by disclosing her status. By implication her community was more scared of how they would be judged by knowing her status than the devastation that the disease can have by denying and not facing it. The discrimination is also directed toward children and family of HIV or AIDS infected individuals. Dane (2002) found that HIV or AIDS infected women advised their children not to discuss their mother’s illness at school for fear of what might happen to them. In the workplace, discrimination influences interpersonal relations with co-workers through being ostracised, isolated, shunned, judged and even dismissed (Firmansyah & Kleiner, 1999; Henderson, 1999; Lau & Wong, 2001). The discrimination can also be direct when an exclusion or preference is made on the basis of an individual’s HIV status (eg not employing HIV positive individuals) (HIV/AIDS TAG, 2002). Indirect discrimination includes not eating from a cafeteria that employs HIV positive individuals or granting benefits to individuals based on the amount of sick leave they use during a period (HIV/AIDS TAG, 2002).

While unfair discrimination is illegal, fair discrimination on the basis of inherent job requirements is not (Employment Equity Act, 1998). An inherent job requirement is a characteristic,

quality or capacity that is vital to the performance of the job (HIV/AIDS TAG, 2002). In *Hoffman v SAA* the court found that the individual's dignity and right to equality was impaired as he was found unsuitable for the position of cabin attendant on the basis of his HIV status (HIV/AIDS TAG, 2002). The SAA could not prove that an HIV negative status was an inherent job requirement (HIV/AIDS TAG, 2002). However, within the SANDF, an HIV negative status is an inherent job requirement aimed at ensuring its ability to fulfill its constitutional obligations (Heinecken, 2001). Failure to meet minimum medical health standards, including being HIV negative, can lead to the non-renewal or termination of individuals' employment contracts (Heinecken, 2001).

N'daba and Hodges-Aeberhard (1998) state that organisations carry out negative practices that have disastrous results for HIV or AIDS infected individuals. The negative practices include testing for HIV or AIDS at recruitment or during employment, lack of medical confidentiality by on-site medical professionals, dismissal due to HIV status, restriction of job benefits, difficulty in being hired and restriction of employment (Dane, 2002; Dussault, 1998; Lau & Wong, 2001; N'daba & Hodges-Aeberhard, 1998; Stigma, discrimination fuel AIDS pandemic, 2001). The HIV/AIDS TAG (2002) states that discrimination can be found in various organisational employment practices and policies including recruitment and selection criteria, appointments and appointment process, remuneration, working environment, job assignments, performance evaluation, dismissal and promotions. It also includes a refusal to deal with suspected or known HIV or AIDS infected individuals (eg patients, offenders, customers) (Edwards & Tewksbury, 1996; Firmansyah & Kleiner, 1999).

There have been increased calls for ethical guidelines for health professionals, particularly regarding the treatment of HIV or AIDS infected individuals (Oosthuizen & Verschoor, 2002). The focus is on amongst others confidentiality and the obligation to treat HIV or AIDS infected individuals. The real dilemma is the matter of confidentiality and the duty to disclose to a third party who is at risk of becoming infected if they are not made aware of their partner's status (Mielke, 2003). Mielke (2003) states that doctors are in an ethical dilemma between maintaining confidentiality towards the infected individual and the legal obligation to inform the partner so as to avert prosecution. He refers to the USA case of *Tarasoff* where a psychiatrist was found liable

for not advising the victim or the authorities of his patient's intentions to kill her.

The aforementioned negative practices must be taken into account when designing workplace support programmes so as to eliminate them. This will ensure a safe and healthy environment, build positive psychological contracts and facilitate the favourable development of individuals' self-concept. Together, these should therefore facilitate sustained or enhanced job performance.

Despite the abovementioned legislation and codes, cases of stigmatisation and discrimination continue to occur daily. To make matters worse, certain governmental policies and differences about HIV or AIDS within their ranks hinders effective management of the pandemic. For example, some states in the USA require that doctors must advise authorities of the names of those patients who test HIV positive (Dussault, 1999). Furthermore, there have been calls by the South African Government to make AIDS a notifiable disease which has been rejected by NGOs due to the negative consequences to those involved (Henderson, 1999). Such practices go against the individual's right to privacy, fuel stigmatisation and drive the disease further underground to the extent that HIV or AIDS infected individuals may abstain from treatment and disclosure (Dussault, 1999; Henderson, 1999). However, arguments in favour of such notification include the opinion that more openness will encourage progress (Henderson, 1999).

Lau and Wong (2001) used seven indicators to identify discrimination against HIV or AIDS infected individuals in the workplace. In Hong Kong, for example they found that 83,5% of organisations had no HIV or AIDS policy, 24,2% of organisations were aware of AIDS related legislation, 20% of the organisations dismiss HIV or AIDS infected individuals, and 41,1% perceived that other employees would resign if they became aware of an HIV positive co-worker. In South Africa, the SA Police Services require individuals to be subjected to a HIV or AIDS test prior to recruitment and at a cost (N'daba & Hodges-Aeberhard, 1998). Research by Fesko (2001b) and Vickers (1997) indicate that stigmatisation, fear and dismissal, hostility, discrimination, harassment and anxiety regarding loss of benefits and decreased opportunities for advancement were amongst the factors that prevented individuals from disclosing their HIV status. Seeking attention, social support, coping, enhanced self-esteem, concern about ability to handle workload were reasons why individuals did disclose their status (Fesko, 2001; Vickers,

1997). Consequences for not disclosing include anxiety, isolation, depression, withdrawal, lack of support systems and failure to use medical and psychological support available (Fesko, 2001b; Stigma, discrimination fuel AIDS pandemic, 2001; Strydom, 2002; Vickers, 1997).

The fear and ignorance caused by the pandemic thus creates a vicious cycle of discrimination and non-disclosure, which causes anxiety and suspicion in HIV positive and negative individuals. Furthermore, it hampers efforts to combat the pandemic and drives it underground. Stigmatisation and discrimination can become costly to organisations, particularly regarding legal suits brought against them (Nowell & Van der Merwe, 2003). If one views the discrimination from the point of view that organisations have an obligation to create a safe, healthy working environment (Occupational Health and Safety Act, 1993) one could believe that such practices constitute fair discrimination. The increasing number of employees and clients living with HIV or AIDS makes it extremely difficult for employers to uphold their duty to inform, protect and enhance individuals' knowledge and or health and safety against hazardous working environments, including HIV and AIDS. However, promoting a safe working environment does not mean promoting or advocating discriminatory practices. It involves assuming that any individual may be infected with HIV or AIDS and therefore manage the possible risks of infection through contact measures (HIV/AIDS TAG, 2002; ILO , 2001).

The transmission of HIV in an office environment is negligible and individuals who are employed in high-risk occupations (eg medical personnel, police, and armed forces) are covered in their health and safety policies (Firmansyah & Kleiner, 1999; Occupational Health and Safety Act, 1993). Furthermore, numerous authors have found that education awareness, prevention measures, workplace support programmes, safety precautions and prevention of discrimination are the most effective ways to combat the pandemic (Code of Good Practice: Key aspects of HIV/AIDS and employment, 2001; Dussault, 1999; Firmansyah & Kleiner, 1999; HIV/AIDS, TAG, 2002; Ndaba & Hodges-Aeberhard, 1998).

It therefore becomes clear that discrimination is not necessary to ensure occupational health and safety. Furthermore, the right to safety is not placed above the right to dignity or privacy as guaranteed in the Constitution (1996). Dussault (1999) put it as follows: "Although the stigma

of HIV or AIDS is tied to ignorance, informing people about the virus is not enough to eradicate it ... has to be accompanied by serious education about discrimination ... we must not forget that the disease is the enemy, not the people who have it”.

Kisoon et al (2002) discusses a rights based approach in overcoming the HIV and AIDS pandemic. Essentially they state that the violation of basic human rights has worked with other conditions to spread the pandemic. To be effective, all efforts must be based on principles that guarantee the infected individuals basic rights. Numerous resolutions, charters, legislation and training have been formulated nationally and internationally to facilitate the guarantee of the rights based approach (eg the international guidelines published by the office of the High Commissioner for Human Rights published in 1996; Employment Equity Act, 1998) (Kisoon et al, 2002). However, the reality is that fear, denial and ignorance surrounding the HIV and AIDS pandemic complicates efforts to counter the impact. Tensions between individuals who suspect each other of being HIV positive; no policy due to lack of the pandemics' impact on organisations; careful disclosure of individuals' HIV status; hap-hazard interventions; or perceived general lack of need for HIV or AIDS policies have resulted in organisations only taking limited or no actions to address the pandemic (Booyesen & Molelekoa, 2001). In effect, organisational interventions of the latter kind contribute to discrimination and even the spread of the pandemic (Edwards & Tewksbury, 1996; Firmansyah & Kleiner, 1999; Fraser et al, 2002; Heinecken, 2001; Kisoon et al, 2002; Lau & Wong, 2001).

Poverty, instability, mobility of the population, discrimination and stigmatisation aggravate the spread of the HIV and AIDS pandemic. Stigmatisation and discrimination against HIV or AIDS infected individuals are a result of fear, ignorance and misunderstanding. Stigmatisation and discrimination are manifested in many ways including being branded unworthy, shunned or being physically attacked. It also includes negative actions against families and friends of individuals living with HIV or AIDS. Stigmatisation and discrimination result in physical and psychological distress amongst HIV positive individuals, denial, failure to disclose, avoidance of workplace support programmes, spread of the pandemic and increased costs (direct and indirect). While organisations are compelled to provide a safe and healthy work environment, they must do so in a manner that prevents unfair discrimination (including the protection and non-

discrimination against HIV positive individuals).

To ensure that discrimination and stigmatisation are prevented and that the quality of work life, and thus the job performance of HIV or AIDS infected individuals in the organisation are enhanced, it is essential that workplace support programmes are designed and implemented. Such programmes must create an environment that promotes acceptance and support to individuals living with HIV or AIDS while eradicating stigmatisation and discrimination.

3.4 THE NATURE OF WORKPLACE SUPPORT PROGRAMMES

The HIV and AIDS pandemic knows no boundaries and has no preferred race, gender, income group or population. It is a disease that is threatening the foundations of our society, organisational survival and therefore individual job performance. It does this by incapacitating arguably the most important organisational resource: The workforce. Only through a combined effort from all sectors of society, and perhaps particularly employers, will South Africa and other countries be able to counter the devastating impact of the pandemic. It means developing and implementing workplace support programmes that will provide HIV or AIDS education, prevention of new infections and actions to support infected individuals to maximise their quality of life, and thus productivity. This view is supported by the Code of Good Practice: Key aspects of HIV/AIDS and employment (2001), Fraser et al (2002), ILO (2001) and N'daba & Hodges-Aeberhard (1998). Kisoon et al (2002) states that a holistic, rights-based approach is required to respond successfully to the pandemic: A checklist.

While it is acknowledged that an integrated approach is required to address the pandemic, many organisations only have superficial interventions or none at all. The main reason for the latter is that their business has not yet been affected at this stage. Lim and Loo (2002) found that 70% of organisations in their research had no health care programmes of any kind. Booyesen and Molelekoa (2001), Breuer (1995), Fraser et al (2002) and Kohl and Miller (1994) found similar results. Booyesen and Molelekoa (2002), for example, found that only a quarter of the organisations they surveyed were willing to budget funds for HIV/AIDS programmes. Part of the reason why organisations don't implement HIV and AIDS policies or funding also involves

the difficulty in clearly attributing HIV and AIDS as the sole cause of a decline in organisational and individual job performance. Kennedy (2002) studied the impact of HIV and AIDS on the coal mining industry in South Africa. She found that amongst others age of the mine, location, geological composition of the site, improvement in technology, incorrect reasons for sick leave and lack of records relating to HIV and AIDS related health costs masked the real impact of the pandemic. Unless accurate ways could be found to isolate the exact impact of the pandemic on the organisation, the actual input will be difficult to determine (Kennedy, 2002). She does add, however, that HIV and AIDS are now beginning to impact on the coal mining industry. The lack of organisational action could be attributed to denial of the effects of this pandemic. However, failure to implement strategies to manage HIV and AIDS could lead to decline in individual health, job performance, organisation productivity and profits, and even closure. Therefore, to counter this it is essential that organisations develop workplace support programmes to manage the HIV and AIDS pandemic. The South African federation for Mental Health states that organisations that promote their employees wellbeing improve their own position and the output of their employees (Harvey, 2000).

3.4.1 Principles of workplace support programmes

The International Labour Organisation (ILO) has stipulated several key principles for managing HIV and AIDS in organisations (ILO, 2001). The principles include treating HIV and AIDS like any other serious illness; prevention of stigmatisation and discrimination; gender equality; prevention of the spread of HIV and AIDS by adhering to occupational health requirements; improving trust and dialogue between organisations, government, individuals and other representatives; confidentiality; protection of human rights and dignity; no compulsory testing at recruitment; prevention, education; full participation in policy development; and access to acceptable, care and support for HIV or AIDS infected individuals (ILO, 2001).

These principles have been adopted by the South African Department of Labour, the Department of Public Service and Administration, the SANDF, SANLAM, Daimler Chrysler South Africa and BMW South Africa in their HIV and AIDS policies or codes of practice (Code of Good Practice: Key aspects of HIV/AIDS and employment, 2001; Grant et al, 2002; HIV/AIDS

programme, 2003; HIV/AIDS TAG, 2002; ILO, 2001; Milestones for BMW, 2003; Naicker & Engelbrecht, 2001). While these codes and policies do not directly impose legal obligations on organisations, the legislation on which they based does (eg Basic Conditions of Employment Act, Employment Equity Act Labour Relations Act).

3.4.2 Composition of workplace support programmes

Workplace support programmes must focus on internal organisational responses to the pandemic and external measures aimed at the environment within which it operates (HIV/AIDS TAG, 2002). Workplace support programmes must include a prevention programme, a wellness programme, co-ordination mechanisms and management strategies (HIV/AIDS TAG, 2002; Morris, Wilkinson, Stein & Cheevers, 2001).

The effective management of HIV and AIDS within organisations requires an integrated strategy (HIV/AIDS TAG, 2002). It involves formulating a HIV and AIDS policy; reviewing all organisational policies, procedures and programmes; consulting with all stakeholders to identify clear responsibilities; integrating HIV and AIDS activities into the core function of the organisation; and reaching consensus on key concerns (Code of Good Practice: Key aspects on HIV/AIDS and employment, 2001; HIV/AIDS TAG, 2002; ILO, 2001; Morris et al, 2001). Furthermore, the management of HIV and AIDS in the workplace must include an understanding and assessment of the impact of the pandemic on the organisation, and long and short term actions aimed at reducing the pandemic's impact (HIV/AIDS TAG, 2002; ILO, 2001; Morris et al, 2001). The organisation's HIV and AIDS policy should balance its needs with those of the individuals it employs.

3.4.3 HIV and AIDS policy and committee

For HIV and AIDS to be managed effectively, employers should establish a policy that covers the key issues while being concise, but comprehensive. Furthermore, the policy must provide clear objectives and responsibilities; indicate monitoring and evaluation mechanisms; provide an outline and framework; set behaviour standards; and indicate what benefits are available

(HIV/AIDS TAG, 2002; ILO, 2001). Morris et al (2001) demonstrated, during a study on a South African sugar mill, that the establishment of a workplace committee was the most effective way to manage organisational responses to the HIV and AIDS pandemic. The committee was comprised of representatives of management, unions and occupational health care personnel. The committee addressed the concerns of all role players and was responsible for the implementation and planning of HIV and AIDS programmes and policy within the sugar mill (Morris et al, 2001). In general, the committee must include representatives from top management, supervisors, training department, human resource, occupational health and safety and infected individuals (HIV/AIDS TAG, 2002; ILO, 2001; Morris et al, 2001). The committee must facilitate continued dialogue between all role players, have clear roles and responsibilities and decision making powers (HIV/AIDS TAG, 2002; ILO, 2001; Morris et al, 2001).

The HIV and AIDS committee should review applicable national legislation; assess the impact of the pandemic on the organisation; establish services currently available (internal and external); draft a HIV and AIDS policy; clarify human resource issues (eg job security, benefits, reasonable accommodation of symptomatic individuals); and compile a budget and plan of action (ILO, 2001). The HIV and AIDS committee should also disseminate the policy and action plan to the lowest levels, monitor the impact of the policy and carry out a regular review based on the results achieved (ILO, 2001). Furthermore, the committee should ensure that the policy is based on the needs and capacity of each workplace and is integrated into all policies, procedures and practices (eg training, budgeting) while upholding the rights of individuals (HIV/AIDS TAG, 2002; ILO, 2001; Kisoona et al, 2002; Morris et al, 2001).

The SANDF has implemented its HIV and AIDS programme, “MASIBAMISANE” under the management of a broad committee structure (Engelbrecht, 2002; Naicker & Engelbrecht, 2001). The structure consists of advisory and co-ordinating committees at top management down to units on the ground through HIV and AIDS workplace programmes (Engelbrecht, 2002; Naicker & Engelbrecht, 2001). The committee functions according to the guidelines already mentioned. (Engelbrecht, 2002; Naicker & Engelbrecht, 2001). BMW South Africa, SANLAM, Daimler Chrysler South Africa and De Beers have established a HIV and AIDS task force and or policy, similar to that found in the research of Morris et al (2001), to manage the HIV and AIDS

pandemic within the organisation (Health Systems Trust, 2003; HIV/AIDS programme, 2003; Impact on retail customer base, 2003; Milestones for BMW, 2003; Sanlam, 2003).

Other South African organisations that have implemented some kind of workplace support programme are ABSA, AFROX, Anglo American, Pick n' Pay, JD Group, Eskom, Gold Fields, Johnic, Ford, SA Breweries and BP (AIDS threat sparks business into action, 2001; Christianson, 2001). The HIV and AIDS committees could therefore be seen as the main vehicle for ensuring that national and international codes and legislation regarding the successful management of the pandemic are carried out at organisation level. Unfortunately many organisations have not taken aforementioned actions, as already stated (Booyesen & Molelekoa; 2001, Frazer et al, 2002; Green, 1998; Lim & Loo, 2000).

3.4.4 Activities included in workplace support programmes

The nature of the activities included in workplace support programmes varies from distribution of materials (eg condoms and literature) to comprehensive multilevel organisational wide interventions (eg Daimler Chrysler South Africa) (Fraser, et al, 2002; Morris et al, 2001; N'daba & Hodges-Aeberhard, 1998).

The workplace support programmes aim to prevent or reduce new infections and provide treatment care and support to infected individuals and their families (Grant et al, 2002; HIV/AIDS TAG, 2002; ILO, 2001). The HIV and AIDS prevention programmes generally include awareness education and training (eg assessment of risk, displays, distribution of pamphlets, information about transmission); eliminating discrimination and promoting disclosure; STI prevention and treatment; voluntary counseling; encourage health promoting behaviour for STDs; and establish unbiased confidential testing (including pre and post test counseling) (Code of Practice: Key aspects of HIV/AIDS and employment, 2001; Fraser et al, 2002; Grant et al, 2002; HIV/AIDS TAG, 2002; ILO, 2001; Kisoon et al, 2002; Morris et al, 2002). The success of prevention efforts depends on adhering to a rights based approach, preventing new infections, changing high-risk behaviour and supporting prevention initiatives

(Grant et al, 2002; HIV/AIDS TAG, 2002; Morris et al, 2002). Therefore, continual monitoring and evaluation is vital.

The HIV and AIDS workplace support programme prevention activities can be provided within the organisation (eg talks by on-site medical personnel, peer education) or by external sources (eg training instructors, using national AIDS programmes), using various methods of training (eg posters, industrial theatre, talks by infected individuals), while recognising diversity (Fraser et al, 2002; N'daba & Hodges-Aeberhard, 1998). The HIV and AIDS workplace support programme activities are aimed at reducing HIV and AIDS related mortality; improving quality of life of infected individuals and maximising infected individuals job performance. They also aim to maintain health for longer and promote disclosure and acceptance (Grant et al, 2002; HIV/AIDS TAG, 2002; ILO, 2001; Kennedy, 2002).

Workplace support programme activities include access to medical benefits (eg provision of anti-retroviral drugs (ARVs), equity in access to benefits); reasonable accommodation for infected individuals to maintain their productivity; access to counseling (eg on-site, referrals, time off to attend external counseling) and other forms of social support (eg ensure family members are covered, funeral benefits); helping infected individuals and their families cope with the extra financial, emotional and other demands; and helping infected individuals with planning for the future (Grant et al, 2002; HIV/AIDS TAG, 2002; ILO, 2001; Kennedy, 2002). Legal advice, privacy and confidentiality and grievance resolution mechanisms are also included (Grant et al, 2002; HIV/AIDS TAG, 2002; ILO, 2001; Kennedy, 2002).

Organisations have implemented many workplace support programme activities including awareness and prevention programmes; HIV and AIDS policy and code of conduct; early retirement benefits; alternate working arrangements (eg less strenuous work with same pay, reduced working hours); and medical care (eg full cover of medical expenses, counseling) (Breuer, 1995; Edwards & Tewksbury, 1996; Fraser et al, 2002; Kennedy, 2002; Morris et al 2001; N'daba & Hodges-Aeberhard, 1998). They also found that organisations were taking future directed actions to counter the impact of the pandemic on the supply of human resources. The actions included multi-skilling, training of replacement workers, streamlining work

processes and training individuals to handle HIV or AIDS infected clients. Organisations such as the SANDF, BMW South Africa, Daimler Chrysler South Africa, De Beers and SANLAM have implemented comprehensive HIV and AIDS workplace support programmes (Health Systems Trust, 2003; HIV/AIDS programme, 2003; Milestones for BMW, 2003; Naicker & Engelbrecht, 2001; Sanlam, 2003). Ford et al (2003) found that vocational rehabilitation is important to assist HIV or AIDS infected individuals address work related concerns (eg psychosocial concerns, effects of medication) and return to work. Employment has been positively correlated to the health (mental and physical) of employees living with HIV or AIDS (Chammas & McReynolds as cited in Ford et al, 2003; Fesko, 2001b; Goodman as cited in Fesko, 2001b). Ford et al (2003) state that vocational rehabilitation professionals must help infected individuals make decisions about returning to work (eg part time versus full time); help them understand the factors that will influence their decision to return to work (eg influence of the mediation, discrimination, stress management); and rearrange their work area (eg use of footrests). Such counseling can be provided by the organisations as part of the workplace support programme.

Kohlenberg and Watts (2003) discuss how group vocational counseling can reduce negative perceptions; vocational concerns and anxiety thereby assisting HIV or AIDS infected individuals in making the correct vocational choices. This is also important for maintaining a realistic self-concept. By discussing these concerns with a vocational counselor, for example, individuals will be in a position to reduce the incongruency between the real and ideal self through considering these factors instead of denying them. Once again, this type of counseling could be included in the organisation's HIV and AIDS workplace support programme.

While many employers have implemented some kind of HIV and AIDS workplace support programme, there are many more in South Africa that have not simply because they don't see the need. The latter is coupled to them currently not being affected by the pandemic. However, if the predictions by Whiteside and Sunter (2000) regarding the manifestation of the real impact of the pandemic in South Africa are accurate, then such employers are at great risk. Employers might not be able to cope with the impact of the eventual explosion of the pandemic if they continue to refrain from creating appropriate strategies to prevent the spread of HIV and AIDS.

Failure to implement HIV and AIDS workplace support programmes could lead to a decline in consumers due to a poor public image and reduced competitive edge due to a loss of skilled infected individuals, and also decreased job performance. Implementing HIV and AIDS workplace support programmes could improve the quality of life, job performance, self-concept, self-esteem and organisational commitment of individuals living with HIV or AIDS due to the reinforcement of a positive psychological contract. Implications for the organisation include possible productivity improvements, skill retention, increased profits, favourable public image and reduced training and recruitment costs. Naidoo (2001) put it as follows: “The extent to which a firm is affected from a demand perspective will be determined by the number of customers who fall ill...the number of customers who die because the firm will have to spend money on acquiring new customers...loyalty...price elasticity demand... and the income elasticity of demand”.

Currently, there is no known cure for HIV or AIDS. Despite the fear and anxiety it creates, relatively less costs can be incurred to prevent infections and improve the quality of life of the infected when compared to those that will have to be incurred to deal with the viciousness of a full-blown, mature AIDS pandemic (Lim & Loo, 2000).

Workplace support programme activities vary from prevention education to vocational counseling that enables employees living with HIV or AIDS to return to work. Unfortunately, many employers have only implemented limited workplace support programmes or none at all.

The influence of workplace support programmes will be discussed now that the HIV and AIDS committee and the nature of workplace support programmes have been elaborated upon.

3.5 INFLUENCE OF HIV AND AIDS WORKPLACE SUPPORT PROGRAMMES ON JOB PERFORMANCE

Much research has been done on the benefits of either individual interventions or comprehensive workplace support programmes. However, none focus directly on the influence of such programmes or interventions on the job performance of individuals living with HIV or AIDS.

Despite this, it is possible to draw conclusions from the research results as it applies to individual job performance.

Rosen et al (2000) and Rosen et al (2003) studied the cost of organisational HIV and AIDS prevention and treatment programmes in relation to the benefits that would accrue. They found that prevention programmes only cost between \$10 and \$15 per individual while achieving substantial reductions in new infections. They also found that ARV therapy, counseling and other psychosocial interventions lead to an extension of the average number of productive years of infected individuals, thus increasing the return on their investment and decreasing associated costs. By implication it is thus also highly possible that such individuals would at least also maintain or improve on their levels of job performance.

Through prolonging the productive lives of HIV or AIDS infected individuals, the negative impact on morale is reduced, managers spend less time coping with employee deaths and have more time to create and implement strategies focused on dealing with the pandemic (Rosen et al, 2000; Rosen et al, 2003). Booysen and Molelekoa (2001) found similar results. They found that extending the working life of infected individuals will improve productivity, reduce labour turnover and reduce the current value of the cost per death. However, they also found that only 25% of the organisations were willing to allocate funds to HIV and AIDS workplace support programmes in their future budgets. Despite this, seven at least stated that they were willing to spend some money to avert AIDS deaths. Booysen and Molelekoa (2001) provide examples of the greater savings that can be achieved by averting HIV or AIDS related deaths in relation to funeral costs.

Pick n' Pay and Daimler Chrysler have implemented the treatment of HIV or AIDS infected employees (AIDS threat sparks business into action, 2001; Christianson, 2001; Connelly, 2002). Pick n' Pay reported a reduction in the cost of ARV treatment from between R1 and R2 million to R300 000. Similarly, Daimler Chrysler reported that the treatment costs of their Aids for AIDS scheme reduced rapidly from R2400 per month after the first twelve months (AIDS threat sparks business into action, 2001; Christianson, 2001; Connelly, 2002). The savings were achieved through lower absenteeism, reduced recruitment and training costs and training and

recruitment were higher than treatment costs (AIDS threat sparks business into action, 2001; Christianson, 2001; Connelly, 2002).

Greene (1998) and Kennedy (2002) found that workplace support programmes (eg zero tolerance of HIV or AIDS related discrimination, workplace accommodations, multi-skilling the workforce) increase productivity, decrease safety costs through increased use of automation, reduces absenteeism, reduces accident costs and injuries and increases morale. Another successful workplace support programme is the Lesedi project that began in 1996 (Whiteside & Sunter, 2000). It involved the Harmony Gold Mining Company's workplace support programme that included treatment for STDs, sexual health promotion, counseling and promotion of condom use (Whiteside & Sunter, 2000). In 1999 they showed and estimated 46% decrease in new HIV infections and a reduction in associated expenditure from R2, 34 million to R 268 000 as a result (Whiteside & Sunter, 2000). Several studies have also been done on the effectiveness of several activities of workplace support programmes albeit as stand-alone activities not necessarily directly part of a workplace support programme (eg counseling, treatment for AIDS Dementia Complex and support). Andrews (2000), Baraldi (2000), Chippendale and French (2001), Gregory and Gibbs (2002), Kelly and Kalichman (2002), Leserman et al (2000), Mason (1997) and McIntyre (2000) have individually reported the benefits attached to at least one of the aforementioned activities. The benefits include prolonged healthy functioning, emotional coping, reduced HIV or AIDS related suicide, reduced mother to child transmission, increased adherence to drug treatment programmes, enhanced quality of life and enhanced functioning. The aforementioned could also again imply a certain degree of improvement in job performance.

Although it can be implied from the latter that the job performance of HIV or AIDS infected individuals can also be increased due to workplace support programmes, the exact extent and which combination of activities are most effective does not seem to be clear. This could be part of the reason why although research has shown the overall benefits of implementing HIV or AIDS workplace support programmes, many organisations still have not done the same. This could simply be because research results have not shown specific improvements in the job performance of HIV or AIDS infected individuals as a result of such programmes, but rather ones that are implied. Furthermore, research on the overall benefits of workplace support

programmes appears to be scarce and that which does exist does not measure gains to the organisation or individual job performance from alternate work arrangements, a non-discriminatory workplace or from psychological and psychosocial activities. It has also been stated earlier that organisations are also still somewhat reluctant to allocate funds in the budget to implement workplace support programmes.

However, more importantly though, research has shown that although certain factors (eg new technology) can mask the impact of HIV and AIDS, individual and organisational job performance can benefit from such programmes. It also implies that individuals' self-concept and psychological contract can be positively influenced by the benefits derived from implementing workplace support programmes. Therefore, implementing workplace support programmes makes sense to improve organisational performance, individual self-concept, psychological contract and individual job performance, while reducing costs, discrimination and stigmatisation. Legal suites and resultant costs from cases made against the organisation could also be reduced. It should also be remembered, however, that an impact study should be done prior to the implementation of such programmes to clearly exclude factors that could mask the impact of the pandemic, thus possibly causing inappropriate or misdirected workplace support programme activities.

There are many employers that do HIV or AIDS related research and publish results, provide advice and or training that organisations can use when designing their workplace support programmes. The organisations include UNAID; USAIDS; Health Economics and HIV/AIDS Research Division (HEARD), BMR and the Centre for the Study of AIDS of Pretoria University. It must also be remembered that workplace support programmes should be culturally sensitive otherwise they could fail. Maelane (2002) has shown that cultural difference must be considered when planning interventions otherwise they will fail.

3.6 SUMMARY

Workplace support programmes refer to any activity or combination of activities undertaken by employers to prevent the spread or reduce the influence of the pandemic on the organisation and

individual job performance. Although employers may find themselves in an ethical dilemma between not discriminating against HIV or AIDS infected individuals and maintaining a safe and healthy workplace, there is evidence that suggests that the two can be achieved without the compromise of the other. The pandemic has many costs to the employer and individual. For the employer the costs are divided between an increase in direct and indirect costs. For the individual the costs are mental, physical and financial. The pandemic reduces the size of the available work force, increases the amount of AIDS orphans, increases mortality while reducing life expectancy, reduces the nation's GDP and hollows out an already depleted supply of skills in certain occupational areas and levels. It therefore also implies individuals' job performance could also be affected.

Two of the major costs that result from the HIV and AIDS pandemic are arguably stigmatisation and discrimination. Despite the protection offered by the law and various policies and codes of conduct against HIV and AIDS related discrimination many infected individuals are still being affected. The latter prevents infected individuals from disclosing their HIV or AIDS status, which drives the pandemic underground while fanning its spread. Discrimination and stigmatisation negatively influence infected individuals' self-concept and psychological contract. The main reasons still appear to be a lack of understanding of how the disease is spread, anxiety, fear, unsafe sexual behaviour and even cultural differences. However, many employers are trying to reduce the incidence of discrimination and stigmatisation.

The key to overcoming the pandemic is a multi intervention workplace support programme that is fully integrated into all organisational levels, processes, policies and procedures. Such a workplace support programme is generally managed by a committee representative of all role players, and is funded through the organisation's strategic budgeting process. The workplace support programme should include the promotion of disclosure and acceptance, prevention and wellbeing programmes and management strategies to ensure continual effectiveness. The specific activities are varied and include provision of drug treatment therapies, counseling and reasonable accommodation at the workplace. While the programmes involve an initial increase in organisational costs, the long-term benefits are even greater. The benefits include improved psychological health of infected individuals (including a realistic self-concept), improved

productivity and job performance, organisational commitment, positive psychological contract, reduced organisational costs and absenteeism, and increased long term organisational survival.

It is important to note that it is not always possible to determine the exact impact of HIV and AIDS on the organisation, and thus on individual job performance, or the exact influence of workplace support programmes because of factors (eg new technologies) that mask the affects of both. However, there is general support that the various workplace support programme activities reduce the influence of the pandemic on individuals, thus improving or implying improved job performance.

3.7 SUMMARY OF LITERATURE REVIEW

Job performance refers to the actions or behaviours that employees execute with the aim of attaining certain outcomes. Job performance is carried out within a specific organisational context that influences the quality of job performance that is delivered. HIV and AIDS form part of the organisational context due to their prevalence throughout society, including the workplace. HIV and AIDS influence employers and individuals through financial costs, mortality, losses, discrimination and stigmatisation. Specifically, within the workplace, these factors could influence job performance directly, through the individual's self-concept and through the psychological contract. To minimise the negative influence of HIV and AIDS on individual job performance, multifaceted workplace support programmes should be integrated and implemented at all levels. The activities should include education, prevention and wellbeing components aimed at reducing the influence of the pandemic on the organisation as a whole, and thus also on individual job performance. This is particularly important in the light of advances in the treatment of the disease on the one hand that prolongs the life of infected employees and the shrinking availability of certain skills on the other. The literature review suggests that having workplace support programmes could enhance the retention and job performance of HIV or AIDS infected employees, thereby reducing staff turnover, related costs and increasing profitability.

Unfortunately there is little research that shows the direct influence of workplace support

programmes on the actual job performance of individuals living with HIV or AIDS. This research aims to explore the latter.

To carry out the research, the sample, method and design must be established. Therefore these will be elaborated upon in the next chapter.

CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION

The chapter will begin with the research design. During this part the type of research, unit of analysis, methods for ensuring reliability and validity and research ethics will be elaborated upon. Thereafter, the research method will be discussed. The population sample, sampling technique, measuring instruments, data collection methods, data capturing methods and data analysis and method will be discussed in that part.

4.2 RESEARCH DESIGN

4.2.1 Type of research and unit of analysis

4.2.1.1 Type of research

Studies regarding certain workplace support activities have found that amongst others, productivity and morale increase while absenteeism decreases (Greene, 1998; Kennedy, 2002). However, no research could be found that specifically focuses on the influence of workplace support programmes on the job performance of employees living with HIV or AIDS. Therefore, because of a lack of research in this regard, an exploratory, qualitative approach was adopted to gain an understanding of the influence of workplace support programmes on the job performance of employees living with HIV or AIDS (Bless & Higson-Smith, 1995; Mouton, 1996; Mouton & Marias, 1991).

Exploratory research involves the use of interviews, literature reviews, is flexible and open, hypothesis are formulated from the results and it usually leads to insight and understanding of the phenomena being researched (Mouton, 1996; Mouton & Marais, 1991). Qualitative research allows the researcher to interpret concepts and constructs in a number of ways, thus facilitating a greater depth of understanding (Mouton, 1991). In qualitative research the context within which the phenomena occur is be taken into account, the researcher is able to observe behaviour when

and as they take place, unexpected events are recorded and hypothesis emerge during the course of the study (Mouton & Marais, 1991). Furthermore, an exploratory, qualitative research approach allows for a greater understanding of the relationships between the phenomena (Mouton, 1996; Mouton & Marais, 1991). The reason is that the researcher is more involved with the phenomena than with quantitative research (Mouton, 1996; Mouton & Marais, 1991). Qualitative research also allows that which lies behind phenomena to be uncovered and provides more intricate detail that is not always possible by using quantitative methods (Strauss & Corbin, 1990). Qualitative methods of collecting data include semi or unstructured interviews, observations or being a participant observer (Mouton & Marais, 1991). Qualitative research thus enables the researcher to interpret the data and gain a deeper insight into the phenomena than is possible through using quantitative methods (Neuman, 2000).

Despite the advantages of a qualitative research approach, there are also disadvantages. The disadvantages include ambiguous meaning of concepts, researchers' influence on results because of their involvement in observations and the lack of precision or structure that are present in quantitative measures (Mouton & Marais, 1991). The research attempted to prevent the influence of the aforementioned disadvantages through steps taken to ensure reliability and validity as discussed below.

4.2.1.2 Unit of analysis

The individual served as the unit of analysis. Therefore, individuals living with HIV or AIDS formed the unit of analysis for this research.

4.2.2 Reliability and validity

4.2.2.1 Reliability

Participants were interviewed using a semi-structured interview blank that was compiled in English (ie a separate one respectively the for participants and their employers). Reliability was ensured in various ways. Firstly, participants' availability was confirmed prior to conducting the

interview. Prior to the interview, the reasons and nature of the research were explained individually to all participants, thus establishing rapport. All participants that were or had been employees and all participants that were employers or supervisors were asked the same questions, respectively. Furthermore, written informed consent was obtained from all participants prior to the commencement of the interview. An example of the informed consent form is contained in Appendix A. Allocating numbers only to participants' completed interview blanks and keeping them in a locked cabinet ensured anonymity and confidentiality. Interviews were facilitated as far as possible without expectations, perceptions or preconceived ideas. Lastly, interpreters were used where participants could not speak or understand English language.

4.2.2.2 Validity

Construct validity was ensured through a thorough literature study of the constructs used within the semi-structured interview schedules. Checking to see that questions asked were in line with the research aims ensured content and face validity. Face validity of the interview schedules was also enhanced through the ordering of questions and overall layout. Furthermore, the interview schedule was given to social workers, medical practitioners, human resource practitioners and academic personnel for scrutiny. Scrutiny by the aforementioned individuals resulted in changes to the interview schedules that further enhanced validity.

4.2.3 Research ethics

Although all research projects are bound to ethical principles as contained in Bless and Higson-Smith (1995) and Mouton (2001), research relating to HIV and AIDS requires an extra emphasis. The reason for extra emphasis on ethics relates to the devastating impact of stigmatisation and discrimination on individuals living with HIV or AIDS. Therefore, every effort was made to ensure confidentiality, anonymity, informed consent and wellbeing of all participants. To achieve this, the first step involved obtaining approval from the medical practitioners, hospital management, local health authorities and ethics committees where relevant. Appendix B and C are examples of letters requesting authority from a local authority and ethics committee to

conduct the research. Appendix D is an example of authority obtained to conduct the research. Thereafter, at the time of the interview, informed consent was obtained from participants before the interview commenced. The informed consent form was divided into two parts. The first part focused on consent to take part in the research project and to have participants' responses captured on an audiocassette. The second part required participants to provide an indication of their willingness for their employers to be interviewed. Participants who consented to be interviewed were not obliged to provide consent for their employers to be interviewed. Furthermore, participants were free to terminate the interview at any stage.

Finally, debriefing and mechanisms of referral were established and utilised during the research project. The debriefing and referral mechanisms were established and utilised to reduce the possibility of participants being traumatised or to treat those who did. The research method will be explained next.

4.3 RESEARCH METHOD

4.3.1 Population sample and sampling technique

The population was individuals living with HIV or AIDS residing within the Western Cape (Breakwell, Hammond & Fife-Schaw, 1995; Mouton, 1996). Hospitals, clinics and medical practices in the Western Cape served as the sampling frame. The sample consisted of individuals living with HIV or AIDS who were patients or employees of the aforementioned organisations. The participants had to be employed or have been employed during the period that they had been living with HIV or AIDS. Participants were conveniently selected from those who reported as patients or who were employees of the specific medical organisation, on the basis of their willingness to be interviewed (Bless & Higson-Smith, 1995; Leedy, 1989). A total of 34 participants were interviewed. Of the 34 participants only 12 gave consent for their employers or supervisors to be interviewed. Only 10 of the 12 employers or supervisors were interviewed, as the remainder was not available.

Table one contains the gender, race and marital status details of the sample. Of the sample 22 were females and 12 were males. The sample contained 26 blacks, six whites and two coloureds. Furthermore, 30 of the participants were divorced, single or widowed. The groups within the sample that had the highest figures regarding people living and working with HIV or AIDS were blacks, women and single individuals.

Table 1

Race, gender and marital status

	Male				Female				
Marital status	Married	Divorced	Single	Widower	Married	Divorced	Single	Widow	Total
Race	Married	Divorced	Single	Widower	Married	Divorced	Single	Widow	Total
Black	2	1	3	0	2	1	15	2	26
Coloured	0	0	0	0	0	0	2	0	2
White	0	1	5	0	0	0	0	0	6
Total	2	2	8	0	2	1	17	2	34

The sample is comprised of individuals from different occupations, at different job levels and in different sectors. Of the sample, 26 were ordinary workers, five were managers, two were supervisors and one was a director. Furthermore, of the sample 27 work or had worked in the private sector, six work in the public sector and one works in the non-governmental organisation sector. From this sample it is thus also evident that the majority of individuals living HIV or AIDS are employed in the private sector and at the level of worker. Tables two and three contain details regarding sector and job level.

Table 2

Sector and job level

Job level	Sector	Non governmental organisation	Private	Public	Total
Director		0	1	0	1
Manager		1	3	1	5
Supervisor		0	1	1	2
Worker		0	22	4	26
Total		1	27	6	34

Table 3

Occupation and job level

Job level	Director	Manager	Supervisor	Worker	Total
Occupation					
Teacher	0	0	0	1	1
Domestic worker	0	0	0	6	6
Public relations officer	0	0	1	0	1
Fish trimmer	0	0	0	1	1
Security guard	0	0	0	2	2
Gardener	0	0	0	2	2
Farm worker	0	0	0	1	1
Sales official	0	0	0	2	2
Electricity checker	0	0	0	1	1
IT consultant	0	0	0	1	1
Printer-fitter	0	0	0	1	1
Chef	0	0	0	2	2
Logistic clerk	0	0	0	1	1
Youth coordinator	0	1	0	0	1
Barman	0	0	1	0	1
Theatre sister	0	0	0	1	1
Senior administration officer	0	1	0	0	1
HED manager	0	1	0	0	1
Gallery administrator	0	1	0	0	1
Financial manager	0	1	0	0	1
Cleaner	0	0	0	2	2
Consultant	1	0	0	0	1
Theatre technician	0	0	0	1	1
Personal assistant	0	0	0	1	1
Total	1	5	2	26	34

Most of the sample was employed (33) while only one was not. Of those employed, 24 had been employed for less than five years and only four had been employed for more than 10 years. The mode of the sample's age was 30 to 35 years of age. Furthermore, 28 of the participants were between 20 and 40 years of age, which is considered to be the most productive years of an individual's life. A total of 27 of the participants had been HIV positive or living with AIDS for five years or less. Furthermore, the highest age interval of the sample was 50 to 55 and the highest interval for an individual either HIV positive or living with AIDS was 15 to 20 years. Tables four to six contain the details regarding the sample's age, period of employment and period of being HIV positive or living with AIDS.

Table 4

Age

Years	Frequency	Percentage
20 – 25	3	9
25 – 30	9	35
30 – 35	13	74
35 – 40	3	83
40 – 45	3	91
45 – 50	2	97
50 – 55	1	100

Table 5

Period of employment

Years	Frequency	Percentage
0 – 5	24	70
5 – 10	6	88
10 – 15	3	97
15 – 20	0	97
20 – 25	1	100

Table 6

Period HIV positive or living with AIDS

Years	Frequency	Percentage
0 – 5	27	79
5 – 10	6	97
10 – 15	0	97
15 – 20	1	100

A total of 10 participants' employers were interviewed. Table seven contains the details regarding the sector and industry of the employers that were interviewed. Most of the employers (eight) were in the private sector.

Table 7

Employers' sector and industry

Sector	Private	Public	Non governmental	Total
Industry or service				
Education	0	1	0	1
Information technology	1	0	0	1
Printing and media	1	0	0	1
Medical health services	1	0	0	1
Health support services	1	0	0	1
Accounting and auditing	1	0	0	1
Community service	0	0	1	1
Domestic services	2	0	0	2
Arts and culture	1	0	0	1
Total	8	1	1	10

The sample thus comprises of individuals from various occupations, sectors, job levels and different periods of employment and unemployment. The sample consists of individuals from both genders and from most of the racial groups. On the whole, the sample is relatively young, mostly in the productive part of their life and has been HIV positive or living with AIDS for a

relatively short to medium period of time. Furthermore, the majority of the participants' employers that were interviewed were located in the private sector.

Now that the population sample and sampling technique have been described, the measuring instruments will be elaborated upon.

4.3.2 Measuring instruments

Two semi-structured interview schedules were compiled. The first was used to interview sampled participants. The second was used to interview employers of participants who gave their consent.

4.3.2.1 The semi-structured interview schedule for sampled participants

The schedule used to interview the sampled participants was structured to provide information that would achieve the research aims. The interview schedule contained 25 questions and each interview lasted about 50 minutes. The first part of the interview contained questions regarding biographical details, which assisted in describing the sample. The second part focused on the influence of workplace support programmes on job performance. Therefore, mainly open-ended questions were formulated to obtain information regarding specific matters. The answers to the questions would then provide a greater understanding of the influence of workplace support programmes on the job performance of employees who were HIV positive or living with AIDS. The participants' responses were captured on a blank interview schedule and on an audiocassette. The semi-structured interview schedule is included as Appendix E. A transcript of a completed interview is contained in Appendix F.

The questions were constructed to provide information as follows:

- (1) Questions 1a to c

Question 1a was aimed at obtaining participants' understanding of what workplace support

programmes meant to them. Obtaining the participants' understanding would also provide an indication of what kind of support they expected from their employer. Questions 1b and c were aimed at understanding how and if an employer managed HIV and AIDS in the workplace, and the type of workplace support activities that were made available to employees. Knowing how employers managed HIV and AIDS in the workplace and the type of support they provide would contribute to understanding the influence thereof on the job performance of participants. All the questions were thus aimed at obtaining an overview of the state of workplace support available to employees that were HIV positive or living with AIDS, including what employees understood by the term.

(2) Questions 2a to k

The questions were aimed at obtaining an understanding of the influence of the consequences of disclosure or non-disclosure, within the workplace, on individuals' self-concept, including an understanding of the self-concept as a result of being HIV positive or living with AIDS. In other words, the questions sought to obtain an understanding of the influence of being HIV positive on the individual's self-concept and how the consequences of disclosure or non disclosure enhanced or inhibited the self-concept. The questions also focused on obtaining an understanding of how the consequences of disclosure (eg reaction by peers, supervisor or employer) influenced individuals' psychological contract and ultimately their job performance. Questions 2a to e focused on individuals who have disclosed in the workplace. Questions 2f to k focused on those who had not disclosed, including the possibility of being suspected of being HIV positive. The consequences of disclosure or non-disclosure thus involved behaviour and reactions by employers, peers or supervisors. The reactions or behaviours would indicate support or rejection of employees that were HIV positive or living with AIDS. The participants' response to the support or rejection would indicate how the psychological contract, self-concept and ultimately job performance were influenced.

(3) Questions 3a to c

The questions focused on understanding the influence of illnesses related to living with HIV or

AIDS on job performance. It included the influence of resulting employer, supervisor and peer behaviour on participants themselves and their job performance.

(4) Questions 4a to c

Whereas the questions 2a to k indirectly elicited workplace support received, questions 4a to c focused directly on the type of support provided. The questions were aimed at understanding the type of workplace support provided. The latter included the influence of disclosure or non-disclosure on participants' use of such support.

(5) Questions 5a to d

The questions aimed at obtaining an understanding of the influence of using workplace support programme activities on participants' job performance. The understanding of the influence on job performance included the influence on participants' self-concept and psychological contract as far as it related to job performance. Question 5d focused on understanding the influence of certain specific workplace support activities on participants' job performance.

(6) Question 6

The question was aimed at obtaining any general comments regarding workplace support provided and the influence on job performance, which might increase the understanding even further.

4.3.2.2 *Semi-structured interview for employers*

A semi-structured interview was conducted with employers or supervisors of consenting participants. The aim was to obtain a more thorough understanding of workplace support programmes made available to employees who were HIV positive or living with HIV, and the influence thereof on their job performance. The interview also enhanced the accuracy and clarity of responses provided by the participants. The interviews were conducted with employers only

once participants had given their written consent. There were 10 questions and each interview was about 30 minutes in length. The interview questions are contained in Appendix G. A transcript of a completed interview is contained in Appendix H.

Now that the measuring instruments have been explained, data collection process will be explained.

4.3.3 Data collection process

The actual process of data collection took place over four and a half months. Prior to commencing interviews, medical practitioners, medical clinics and hospitals were conveniently selected and telephoned regarding their patients' and employees' participation in the research project. A written request including a research proposal, proof of university registration and proposed measures to protect confidentiality were forwarded where the aforementioned medical organisations displayed an interest. The access to patients was only granted once the management of the medical organisations mentioned had given their written approval. The approval also included obtaining approval from an ethics committee. In the case of this research, the Research Ethics Committee of the University of Cape Town (UCT) granted approval.

Once general approval was granted, arrangements were then made with the personnel at the aforementioned medical organisations to determine from their patients and staff if they would be willing to participate. The arrangements included explaining the criteria that patients and staff must fulfill. Once the personnel had obtained patients' and employees' initial consent they were referred to the researcher.

Of the 19 medical organisations approached, 12 agreed to make their patients and employees available as possible participants. Furthermore, the majority of participants came from private medical practitioners and Local Authority day hospitals. Where participants had consented for their employers or supervisors to be interviewed, the arrangements were made after conclusion of the interview with them. A total of 34 patients or employees and 10 employers or supervisors were interviewed. On average, six interviews were conducted per week and were conducted at

various towns or suburbs. Table eight and nine respectively, contain the type of medical organisations that were conveniently selected and the amount of participants obtained.

Table 8

Type of medical organisation

Medical organization	Agreed to participate	Declined to participate	Total
Private hospital	2	5	7
Government hospital	2	2	4
Local authority day hospital	4	0	4
Specialist medical institutes	1	0	1
Private medical practice	3	0	3
Total	12	7	19

Table 9

Total participants per medical organisation

Medical organization	Patients	Employees	Total
Private hospital	0	1	1
Government hospital	5	0	5
Local authority day hospital	11	0	11
Specialist medical institutes	5	0	5
Private medical practitioner	12	0	12
Total	33	1	34

An exploratory, qualitative research design was used for the research project. Measures were taken to enhance validity and reliability, which include asking the same questions to all participants and ensuring construct validity through a thorough literature research on constructs used. Measures were taken to ensure confidentiality including obtaining informed consent prior to interviews. The participants' sample was conveniently selected from patients and employees of medical practitioners, medical clinics and hospitals in the Western Cape who gave their informed consent. The majority of the participants were black or female, were in the 30 to 35 year age bracket and had been HIV positive for five years or less. A semi-structured interview

was used to interview participants and employers or supervisors of those who gave their consent. The questions in each interview were aimed at obtaining an understanding of the influence of workplace support programmes on the job performance of employees who were HIV positive or living with AIDS. Of the 19 medical organisations that were approached, only 12 consented to allow their patients or staff to participate. Finally, the majority of the participants came from the Local Authority day hospitals and private medical practices.

4.3.4 Data analysis

The research data were analysed by using the process of coding. Coding enables the researcher to organise and manage large sets of data, allowing for quick retrieval and meaningful dissection, while keeping the relations between the parts intact (Miles & Huberman, 1994; Neuman, 2000). In coding, data are broken down, conceptualized and then put back together in new ways (Strauss & Corbin, 1990). Coding also enables the researcher to notice the phenomena being studied, collect examples of the phenomena and find commonalities, patterns, structure and differences amongst the data (Miles & Huberman, 1994; Strauss & Corbin, 1990). The process of coding involves several stages. The stages are open coding, axial coding and selective coding (Strauss & Corbin, 1990). Furthermore, the process can be enhanced by creating a start list of codes prior to analysing the data, based on the research questions, key variables and research aims (Miles & Huberman, 1994).

During open coding, observations, paragraphs or sentences are analysed, broken down and each given something that indicates or represents a phenomenon (Strauss & Corbin, 1990). The aforementioned results from data being questioned, conceptualized, labeled and grouped into categories (Strauss & Corbin, 1990). With axial coding, data are reviewed again, but with the aim to put them back together so that connections and relationships between the data can be identified (Strauss & Corbin, 1990). Selective coding involves selecting the central phenomenon, obtaining examples of categories or themes, validating the relationships between categories or themes and filling in those that require further refinement (Miles & Huberman, 1994; Strauss & Corbin, 1990).

The coding process used during this research is as follows:

(1) Start list of codes

A start list of codes relating to the influence of workplace support programmes on the job performance of individuals living with HIV or AIDS was created prior to analysing the participants' or employers' responses to the semi-structured interviews. This was done by reviewing the literature that was gathered and extracting possible categories and themes. The start list of codes was revised and updated during each pass of the data, where required.

(2) Open coding

During the first pass, the data contained in the participants' and employers' responses were scrutinized, broken down, examined, themes were located and labels were assigned to them, based on the start list of codes and new ones that emerged (Miles & Huberman, 1994; Neuman, 2000; Struass & Corbin, 1990). The aforementioned involved reading through each participant's completed interview schedule, identifying common themes or categories, comparing them to the start list of codes and each other, and then grouping them into common categories or themes. Thereafter, the employers' responses were subjected to the same process. In addition, categories and themes that emerged from the participants and employers were compared with each other and grouped according to appropriate categories or themes, where relevant. The aforementioned process produced themes or categories that related to the influence of workplace support programmes on the job performance of HIV or AIDS infected individuals, applicable to the research aims.

(3) Axial coding

Axial coding involved going through the data a second time. The focus then shifted more to the initial coded themes where they were grouped into smaller sets. The aim was to make connections between data through analysing possible causes, interactions and conditions. From the latter, themes or ideas were organised and the axis of key concepts was identified (Miles &

Huberman, 1994; Neuman, 2000; Struass & Corbin, 1990). The aforementioned was done by reviewing the responses of the participants and employers while looking for interactions, causes and conditions, first within their individual groupings and then between them. The initial themes and grouping of themes were also revised and amended. As a result, central themes and their interaction, causes and conditions that were applicable to the influence of workplace support programmes on the job performance of HIV or AIDS infected individuals emerged.

(4) Selective coding

The data and previous codes were scanned to selectively identify cases that illustrate the themes. This was done by reading through the participants' and employers' responses and selecting sentences or paragraphs that illustrated the themes, causes, interactions and or conditions. Thereafter comparisons and contrasts of the data were made, by going through the data until no further new insights emerged (Neuman, 2000).

The coding process thus resulted in a number of themes with causes, conditions, consequences and interactions that would permit an understanding of the influence of workplace support programmes on the job performance of individuals living with HIV or AIDS.

Now that the research design and research method have been discussed, the data results will be discussed and integrated.

CHAPTER 5: FINDINGS AND INTEGRATION

5.1 INTRODUCTION

The findings were obtained from analysing the participants' responses and that of their employers, where consent was given for them to be interviewed. The chapter will begin with the influence of HIV and AIDS on individual job performance. Thereafter the nature and content of workplace support programmes will be elaborated upon. This will be followed by an exploration of the influence of discrimination and stigmatisation on individuals' decision to use workplace support programmes provided. Thereafter, the influence of workplace support programmes on individual job performance will be elaborated upon. Finally, the findings of the interpretive research will be integrated with that of the literature review.

5.2 FINDINGS: CENTRAL THEMES

5.2.1 The influence of HIV and AIDS on individual job performance

Most of the participants (22) indicated that HIV and AIDS related treatment, illnesses or ailments had negatively influenced their job performance. The factors influencing individual job performance can be grouped into three broad areas. The broad areas are absenteeism, standard of work and physiological and psychological factors. Absenteeism and standard of work appeared to influence job performance directly as they potentially reduced the amount of time available to perform work or the quality of the task at hand. The physiological and psychological factors are thought to influence job performance indirectly, through their affect on absenteeism and standard of work.

Of the aforementioned 22 participants 18 indicated that their absenteeism had increased, thus affecting their job performance. Absenteeism consisted mainly of increased sick leave, followed by an increase in time off to rest, obtain medication or to receive professional assistance. The time off included periods that were authorised and those that were not (eg extra unofficial rest breaks and poor time-keeping). More than half of absenteeism was due to sick leave. Hence the

findings suggest that absenteeism negatively influences job performance through a reduced amount of time available to carry out the work. The following are examples of participants' responses (participant and or their employer):

- (1) "She asks time off to go to the doctor or chemist" and "I am panicking as I have already used up more than my 12 days sick leave per year".
- (2) "I have been off on two months sick leave in the last 12 months".
- (3) "After he disclosed his sick leave rose by 50%" and "...the first year I needed medication every four weeks...I drained all my sick leave".
- (4) "I was off sick or came late for five months because of the sickness and tests at the clinic".
- (5) "I was off work from 15 September 2003 to 29 October 2003" and "He has been off on two months paid sick leave".
- (6) "She started arriving late two or three months ago...she has been off for three weeks".

The participants' standard of work was the next aspect of job performance that appeared to be negatively influenced by HIV or AIDS. The decline in standard of work took the form of reduced quality and quantity. Of the 22 participants, 19 indicated that the quality and or quantity of their work had declined due to HIV or AIDS related reasons. Tasks were either not completed, were performed in part or not completed on time. Examples of participants' (participant and or employer) responses are as follows:

- (1) "She becomes slower...she starts something and leaves it half way" and "Sometimes I become so tired, I leave for tomorrow what I can't do today".
- (2) "I had no strength to fetch the tools" and "His job performance decreased due to the

medication”.

- (3) “His performance has dropped mainly at night” and “There are only three mechanical guys...it is difficult to get a replacement when I am off sick suddenly”.
- (4) “His job performance started to drop...he failed to submit certain reports”.
- (5) “It takes longer to do things...sometimes I work slower”.
- (6) “Her telephone answering voice deteriorated...she sounded depressed”.
- (7) “In my previous job I was off a lot”
- (8) “I am not so strong as before...then I must rest” and “She was a good worker then her job performance decreased because of the illness”.

The findings thus suggest that HIV and AIDS influence absenteeism and compliance with work standards that are coupled to individuals’ job performance. The negative influences on absenteeism and standard of work appear to be related to physiological and or psychological affects of HIV and AIDS. Of the 22 participants who indicated that HIV or AIDS had negatively influenced their job performance (ie absenteeism and or standard of work), 19 stated that they had experienced at least two physiological and or psychological factors that had negatively influenced their job performance. Only three of these participants stated specific factors that caused them to become sick (eg reduced CD 4 cell count, Tuberculosis) while the other 19 simply stated that they had become sick due to HIV or AIDS. Most of the 22 participants (ie 20) stated that fatigue was the main physiological or psychological influence on their job performance. Participants indicated that decreased strength (nine), stress and anxiety (eight), mood swings (seven) and medication side effects (four) relating to HIV or AIDS also had a negative influence on job performance. Furthermore, 14 of the 20 participants indicated that their job performance appeared to be negatively influenced by fatigue in combination with decreased strength, mood changes, stress and/or anxiety.

Hence the findings suggest that fatigue is one of the main physiological effects of HIV and AIDS on job performance. When fatigue is experienced with other physiological or psychological factors, it is possible that job performance could be negatively influenced even further (ie due to reduced compliance with work standards or increased absenteeism).

Most of the 34 participants held occupations that involved exerting physical effort, completely (18) or in part (six), to perform their jobs (eg domestic servants, labourers, chefs, printer-fitter, theater sister). Furthermore, 12 of the participants that had occupations that involve mainly physical work indicated that HIV or AIDS related physiological and psychological factors had negatively influenced their job performance. The remaining participants (10) held occupations that involved little or no physical effort (eg financial manager, logistic clerk). Furthermore, five of the participants held occupations that involved little or no physical work and indicated that HIV or AIDS related physiological and psychological factors had generally not negatively influenced their job performance. The latter suggests that the influence of physiological and psychological effects of HIV and AIDS on job performance could also depend on the type of occupation.

A small portion of the 22 participants (three) stated that while they had experienced a combination of physiological and or psychological factors, together with increased absenteeism, their overall job performance had remained the same. Examples of participant responses are as follows:

(1) “The problem is outside the class...I am not able to do the extra mural activities anymore because I have arthritis in my joints from the medication” and “Before she could contain the class, now the children are less well managed...she used to become aggressive with her colleagues”.

(2) “Sometimes (twice a week) I get tired or drowsy at work”.

(3) “Sometimes I feel like I am a zombi, like I am on drugs because of the medicine...I then sleep one to two hours while on night shift” and “He forgets a bit more...goes off at his

colleagues...is more tired, particularly on night shift”.

- (4) “Sometimes I get headaches...and get tired at work”.
- (5) “I get more tired especially in the afternoons”.
- (6) “I am getting tired and forgetting quite a lot” and “She is a lot slower and gets more tired”.
- (7) “She seemed destitute and very sad...I would not add more responsibilities to her as she is not physically able to do more yet”.
- (8) “Sometimes I get so stressed...I loose control and feel tired”.
- (9) “I had no energy...I was not relaxed...I got angry with other staff”.

The remainder of the 34 participants (12) stated that HIV or AIDS had not affected their job performance in any way. They stated that they had either used the same amount of sick leave and time off as before or none at all, and they had been HIV positive for between zero and five years. Furthermore, amongst them five had recently started a new job, were recovering from other medical conditions (eg injury, stroke) or were pregnant. It is therefore possible that HIV or AIDS does not affect individuals and their job performance early on. It is also possible that the influence of HIV or AIDS on job performance can be masked by other factors.

The research suggests that HIV and AIDS influences an increase in absenteeism and a decrease in the standard of work produced by people who were HIV positive or living with AIDS. Physiological and psychological factors such as fatigue and side effects of the medication appear to negatively influence job performance through decreased compliance with work standards or a rise in absenteeism. Furthermore, the results suggest that HIV or AIDS mainly influence performance in jobs requiring the exertion of mainly physical effort. Finally, it is also possible that HIV or AIDS does not influence the individual during the early years and that other factors

(eg pregnancy) can mask the influence of HIV or AIDS on job performance. Similar results were obtained by Breuer (1995), Fesko (2001a), Greene (1998), Hunt et al (2003), Lau and Wong (2001), Lim and Loo (2000), Kennedy (2002) and Rosen et al (2000). Table 10 contains the details of the influence of HIV or AIDS on individual and job performance in respect of the 22 participants who had indicated that they had been affected.

Table 10

Influence of HIV and AIDS on the individual and job performance

Participant no	Area influenced												Total
	Absenteeism		Psychological and physiological						Standard of work				
	Increased sick leave	Increased time off	Medication side effects	Fatigue	Forgetfulness	Reduced strength	Stress/Anxiety	Mood swings	Quantity down	Quantity same	Quality down	Quality same	
1	X	X	X	X	X	X	X	X	X		X		10
2		X		X	X	X	X		X				6
4				X					X				2
5				X		X			X				3
7	X		X	X			X			X		X	6
8	X			X			X	X	X			X	6
9	X			X			X	X	X				5
10	X			X		X			X				4
11	X	X	X	X	X		X	X	X		X		9
12	X			X		X			X				4
14	X	X		X		X			X				5
19				X						X	X		3
20	X			X		X				X	X		5
21				X						X	X		3
22	X	X		X					X			X	5
25	X			X	X	X			X			X	6
26	X								X		X		3
27		X		X	X					X		X	5
28	X	X		X	X		X	X	X		X		8
31	X	X		X		X		X	X		X		7
32							X	X		X		X	4
34	X		X	X						X		X	5
Total	15	8	4	20	6	9	8	7	15	7	8	7	114

5.2.2 Nature and content of workplace support programmes

5.2.2.1 *Employee expectations regarding workplace support programmes*

Participants' responses regarding their understanding of the term "workplace support programme" were based on their interpretation. Hence it was assumed that their responses would also indicate their expectations regarding such support. Almost all participants expected some form of workplace support from their employer. Two broad categories of expectations regarding workplace support programmes emerged.

The first category can be called environmental acceptance. Environmental acceptance generally refers to the creation of a stigma and discrimination-free workplace that unconditionally accepts and supports employees who are HIV positive or living with AIDS. Examples of activities are being treated as any other person with a chronic illness, education of employers and individuals indirectly affected by the pandemic (colleagues, family), eradication of discrimination, demonstrated understanding, employer's trust, being treated as a normal person and no rejection. Participants regarded unconditional support and understanding, respectively, as the main environmental acceptance activities required. Of the participants 18 expected only environmental acceptance. The second category of workplace support programmes expected can be called practical support. Practical support generally referred to professional assistance in coping and living with HIV or AIDS. Examples of activities are referrals to professionals for assistance, counseling, support groups, advice, financial support, information on new medications available, benchmarking assistance provided and involvement with research into new medicines. Advice and counseling were the main practical support activities expected followed by the provision of medication (through medical aid, subsidised by employer or supplied by employer). Eight of the participants indicated an expectation of only practical support.

Five of the participants had an expectation of a combination of practical and environmental workplace support programme activities to assist them in living with HIV or AIDS. The remaining three participants did not provide any response.

The findings thus suggest that most of participants had expectations of workplace support programmes that primarily focus on environmental acceptance of individuals who are HIV positive or living with AIDS, although practical support and a combination of the two were expected to a lesser extent. Therefore, the findings suggest that participants at least expect workplace support programmes to create an atmosphere that promotes disclosure and acceptance. The literature review produced similar findings, although sometimes indirectly. Specifically, Grant et al (2002), HIV/AIDS TAG (2002) and ILO (2001) identify principles and guidelines that must be included in workplace support programmes, which are similar to those mentioned above, for them to be effective. It is thus possible to infer that the aforementioned principles and guidelines were as a result of expectations of those living with HIV or AIDS.

5.2.2.2 *Management of HIV and AIDS*

Only seven of the participants indicated that their employers had either a formalised policy and or committee that managed HIV or AIDS within their organisation. Most of the respondents (16) indicated that their employers had no HIV or AIDS policy or committee while eight indicated that their employer had some sort of informal management process (eg informal awareness, advice and monitoring). Finally, three of the respondents indicated that they were unsure as to whether or not their employer had any policy or committee to manage HIV or AIDS in the organisation as they had not seen or heard any official communication in that regard. The employers in the private sector also included private households who employed domestic servants or gardeners. Only four participants of the latter mentioned employers had some means of managing HIV and AIDS in the workplace (ie informal). In general, employers who had implemented some means of managing HIV or AIDS in their organisation indicated that they felt responsible for doing so or valued the employees for their loyalty and or good performance. Examples of the aforementioned are as follows:

- (1) “We support her emotionally and with her work. She is gifted and is always passionate about her work and actively involved. Even more so now”.
- (2) “They said to me that they are happy with my work and trust me. They said they value

me and want me to live a normal life and will see to my health.”

(3) “He has always been a good worker and friend. I would not have this garden if it were not for him. We are happy to do it”.

(4) “She has been here a long time. She is reliable and I can trust her. If we do not support her she would die”.

(5) “She is a very good worker. I feel morally responsible as she will die without support”.

(6) “I realised she was becoming ill. She was always very reliable and duty bound. We are all fond of her. She needs more”.

(7) “Creating a supportive environment, one that is HIV friendly and helps people remain productive”.

Some employers (ie seven with formal policies and eight with informal policies) appear to have realised the benefits of managing HIV and AIDS in their organisations, particularly regarding the retention of valued employees, and felt obligated to them. However, most of respondents’ employers had either not implemented a means of managing HIV and AIDS in the organisation (sixteen) or if they had, it was not effectively communicated (three). The reasons provide by the participants are as follows:

(1) “I am the first case” or “There have not been any cases before”.

(2) “My employer does not care about his workers”, “She is focused on the reputation of her business” or “His business interests come first”.

(3) “She does not want to hear about HIV”, “They don’t talk about it”, “Only a small piece on HIV in our newsletter” or “He will fire me if he finds out”.

(4) “They just tolerate me”, “Headquarters is only waking up now”, “The nature of the disease is not well known” or “She will blame me if anything happens to them as she did when my uncle got TB”.

(5) “A policy has only being formulated now” or “The policy is new”.

(6) “They can’t afford it” or “They are one of the few who can afford it”.

The findings suggest that ignorance, lack of willingness to communicate or denial appears to be the main reason why employers have not implemented mechanisms to manage HIV and AIDS in the workplace. Furthermore, some employers (across all sectors) still appear to only focus on the bottom-line while others have only recently begun to take action.

It thus appears that some employers still believe that they are not or will not be affected by the HIV and AIDS pandemic. A few respondents indicated that employers are not able to afford the management of HIV and AIDS. While this may be true, there are several actions that employers can take which do not involve the outlay of capital. For example, they could refer employees to local clinics, obtain information regarding support networks and living with HIV and create a stigma free environment. The research findings thus suggest that employers are still ignoring the influence or potential influence of HIV and AIDS, and the necessity to counter it. Despite the latter, there were employers that had implemented HIV and AIDS policies and or committees and were thus considered in a positive light by the respondents involved.

It is thus suggested that employers that don’t have an HIV and AIDS policy or committee, albeit informal, risk not being able to deal effectively with the negative influence that the pandemic can have on the individual and organisation. Furthermore, it is also suggested that employers will be unable to satisfy their employees’ expectations regarding support for individuals living with HIV or AIDS where they do not have a comprehensive or any sort of mechanism to manage HIV and AIDS in the workplace. Booyesen and Molelekoa (2001), Frazer et al (2002), Green (1998) and Lim and Loo (2000) showed similar findings in that most of the employers had either no or very limited workplace support available for individuals that were living with HIV or AIDS. In one

study (Lim & Loo, 2000) it was found that 70% of employers had no health care programme at all while in another (Booyesen & Molelekoa, 2001) it was found that only a quarter of employers surveyed were prepared to budget for HIV and AIDS programmes.

5.2.2.3 *Workplace support programmes*

Literature indicates that the general nature of workplace support programmes should include awareness, education and training and interventions to change high-risk behaviour (eg assessment of risk, information about transmission). It also includes eliminating discrimination and promoting disclosure; STI prevention and treatment; voluntary counseling; establish unbiased confidential testing (including pre and post test counseling); and the provision of a range of support activities to assist individuals that are HIV positive or living with AIDS (Code of Practice: Key aspects of HIV/AIDS and employment, 2001; Fraser et al, 2002; Grant et al, 2002; HIV/AIDS TAG, 2002; ILO, 2001; Kisoon et al, 2002; Morris et al, 2002).

The findings indicated that only seven of the participants' employers had a formal HIV and AIDS committee or policy and a combination of workplace support activities to manage the influence of the pandemic in the workplace. However, only five of the aforementioned employers (and thus five out of 34 participants' employers) had a HIV and AIDS policy and a combination of support activities that correspond with the general contents of workplace support programmes as mentioned at the start of this section. In the latter instance, the support activities provided appeared to focus on promoting acceptance, voluntary testing, general support, awareness and prevention. Furthermore, eight participants' employers had an informal mechanism to manage HIV and AIDS although there was no formal written policy. The workplace support provided appeared to focus on practical support (eg payment of medical costs, adjusted workload), advice, emotional support and acceptance. Of the participants' employers that had an informal HIV and AIDS policy, half were in public sector organisations or private business, while the other half were private households. The latter mentioned employers provided a comprehensive workplace support programme that included assistance with medical costs, adjustment of work load and hours and advice on healthy living.

The findings also indicate that 16 of participants' employers appeared to have no mechanisms in place to manage HIV and AIDS nor much workplace support programme activities that specifically focused on managing the influence of the pandemic in the workplace. In fact, of these participants, four indicated that their employer had provided no policy or any type of support for employees who were HIV positive or living with AIDS. The overall findings suggest that the workplace support that was provided focused on general support provided to all employees (eg sick leave) and on promoting acceptance, with little emphasis on prevention and awareness.

Three of the participants indicated that it was unclear whether or not their employer had an HIV and AIDS policy or committee. One of them worked for an employer that had no specific workplace support programme for HIV positive individuals, although sick leave was provided. Another of these participants had an employer that had a comprehensive range of workplace support programme activities that focused on the criteria as stipulated at the start of this section. Examples of responses concerning workplace support provided are as follows (participants and or their employers):

- (1) "We support her emotionally and with her work" and "They accept me, provide medical aid that includes ARVs...hold an AIDS awareness week each year in September".
- (2) "They always say that if I am sick I must buy my own medicine".
- (3) "They take good care... they give classes to understand HIV...they support HIV...have a free medical clinic, social worker".
- (4) "I don't know how they support people who are HIV positive...no one talks about it".
- (5) "No they don't give me support".
- (6) "They are there for me...pay all my medical costs and treatment...are caring and supportive".

(7) “Psychological support, counseling, awareness workshops...no policy...not enough is done for those who are already HIV positive” and “The organisation has education programmes although not well known...counseling...give him time off during work to go to gym...I talk to him and give emotional support”.

(8) “We talk to him...pay 75% of his ARVs...give him time off to go to the doctor...encourage him”.

(9) “They have counseling and testing...counseling for the family...clinic with a department for HIV...give you advice”.

(10) “They do nothing. I don’t hear anything. They give information about HIV in our news letter”.

(11) “They are doing nothing at present. They only work-shopped a policy yesterday. I get 36 days sick leave over three years and they subsidise my medical aid payments as with other employees”.

(12) “They don’t manage HIV in the workplace. There is nothing for the workers. I get sick leave and they pay part of my medical aid fees”.

Whereas most of participants indicated environmental acceptance as the main type of workplace support programme required, employers provided mainly practical benefits. Furthermore, the benefits seem to be the same as those available to all employees and not specially tailored for those living with HIV or AIDS. It is suggested that the lack of a clear policy to manage HIV and AIDS in the workplace could cause or perpetuate dissatisfaction as interventions implemented may be inappropriate or may not be implemented at all. Furthermore, employers could therefore also be viewed as insensitive. As one respondent put it “She seemed to know a bit about the virus...but did not seem to care enough...she dismissed me”. The findings appear to suggest that on the whole neither participants’ expectations regarding emotional support nor practical

support have been satisfied to the extent expected. The literature revealed similar results (Fraser et al, 2002; Kennedy, 2002; Kohl & Miller, 1994).

5.2.2.4 Length of time using workplace support programmes

Only 10 of the participants gave an indication of length of time that they had been using workplace support programme activities provided. The mean length of time that the latter participants had been using the workplace support programmes was 18 months. The range was between four months and 36 months. All of the latter participants have been HIV positive for between zero and five years.

Tables 11 and 12 contain the details regarding workplace support programmes and activities provided and the way employers manage HIV and AIDS in the workplace, respectively.

Table 11

Workplace support programmes

		HIV and AIDS policy or committee						
		None		Informal	Formal	Not sure		Total
		12	4	8	7	1	2	34
Workplace support programme activities provided								
Emotional support and acceptance	Employer, supervisor and or colleagues	5		8	6		1	20
	Work friends only	3	0	0	0	0	0	3
Contribution to medical costs/medical aid	Full	0	0	4	0	0	0	4
	Subsidised	2	0	1	0	0	0	3
Medical aid	ARVs	2	0	2	3	0	1	8
	No ARVs	2	0	0	2	0	0	4
Provision of ARVs		0	0	2	1	0	0	3
On-site medical personnel		0	0	0	1	0	0	1
On-site medical facilities		0	0	0	0	0	2	2
Financial support		0	0	3	0	0	0	3
Adjusted benefits		0	0	2	2	0	0	4
Funeral benefits		0	0	0	1	0	0	1
Counseling		0	0	1	5	0	2	8
Advice		1	0	4	1	0	0	6
Support to those affected		0	0	1	0	0	1	2
Medication (not ARVs)		0	0	2	1	0	0	3
Voluntary counseling and testing (VCT)		0	0	0	6	0	1	7
Externally managed HIV/AIDS programme		0	0	0	1	0	0	1
Sick leave		11	0	7	7	1	2	28
Time off		4	0	7	1	0	0	12
Adjusted work load/hours		5	0	5	2	0	1	13
HIV and AIDS education or awareness		2	0	0	6	0	2	10
Other (eg food, transport)		0	0	4	2	0	1	7
No specific HIV/AIDS support activities		0	4	0	0	1	0	5
Total		37	4	53	48	2	14	158

Table 12

Management of HIV and AIDS in the workplace

Management of HIV and AIDS	Sector			Total
	Private	Public	Non Governmental	
Policy and or committee	4	2	1	7
Informal	7	1	0	8
None	13	3	0	16
Not sure	3	0	0	3
Total	27	6	1	34

In general, the workplace support programme activities provided appear to vary quite vastly amongst the participants' employers regarding scope and content. Although the majority of participants received at least some type of workplace support activity it was not to the extent as presented in, for example, the ILO guidelines (ILO, 2001). The main areas of workplace support provided appeared to focus on sick leave, assistance with medical costs, emotional support and acceptance, adjusted working conditions and time off (in that order). Less support appeared to focus on prevention, coping (advice and or counseling), assistance to those affected by but not HIV positive or living with AIDS and elimination of unsafe behaviours.

There also appeared to be only a small percentage of employers who had a comprehensive workplace support programme, inclusive of a formalised HIV and AIDS policy. The findings suggest that employers that had a formal or informal policy to manage HIV and AIDS in the workplace generally provided better support activities than employers who did not. The findings therefore also suggest that most employers do not have adequate support programmes in place and may also lack sensitivity regarding employees' actual needs. The results suggest further that many employers still appear to deny the actual or potential effects of the pandemic on individual job performance or their organisations.

Finally, the findings suggest a possibility of participant dissatisfaction because employers appear to be providing mostly practical benefits while participants indicated an expectation of environmental acceptance type support programmes.

5.2.3 Discrimination, stigma and the use of workplace support programmes

The findings suggest that distrust in the employer and a fear of workplace discrimination is stopping participants from disclosing at work, thus preventing them from accessing support that might be available. Half of the participants indicated that they had not disclosed their status to their current employer. Of these participants, however, three had disclosed to a colleague. The fear of possible or repeated discrimination (ie job loss, poor confidentiality, rejection) and a lack of trust in the employer were the main reasons. Furthermore, it is suggested that the participants' responses also indicate that those who had not disclosed experienced stress and anxiety. A few participants stated that the fear of being treated with pity prevented them from disclosing. They perceived pity as being unhealthy. To them pity caused them to become depressed, overwhelmed or dependent, thus preventing healing. Hence, being pitied can be seen as a kind of stigmatising. Some of the aforementioned participants indicated that they would only disclose when their job performance would start to be affected by the disease. The aforementioned fears were also the main reason for this. All participants who had not disclosed their status reported being treated and accepted as normal healthy individuals, thus reinforcing their behaviour. Examples of participants' responses are as follows:

- (1) "I don't trust her...I am scared she will fire because I am HIV...she is scared that it will spread that there is a staff member at the crèche that is HIV".
- (2) "The whole firm will know if you tell one person...they will start to treat you badly".
- (3) "I will tell them when I am sick and can't work...they might treat me bad...I am afraid".
- (4) "I fear they may laugh behind my back or talk about me to other people".
- (5) "Sometimes they say don't go with him...don't touch him he has blood here".
- (6) "I don't want to be the centre of attraction...treat me normally" and "If I am treated as ill I will become negative, constantly reminded of this thing...treating me as normal helps with

healing”.

- (7) “I feel scared...I know that I will be rejected”.
- (8) “I am scared that I might also loose this job”.
- (9) “Most fear being fired and do get fired”.

The other half of the participants stated that they had disclosed to their employer. Of them, a few only made limited disclosure once again due to a lack of trust. Just over half of those who had disclosed stated that they had done so because they trusted their employer. The remainder stated that they disclosed due the possible impact of HIV or AIDS related illnesses on their job performance. In general the findings suggest that most of the participants that had disclosed received empathy and were accepted and supported by their employers, albeit that the support was limited in many cases. The findings also suggest that participants who disclosed were relieved and less anxious. Examples of responses are as follows (participants and or their employer):

- (1) “She trusts this company”.
- (2) “I feel that there are people who care and love me”.
- (3) “I am relieved. If they did not accept me I would have accepted it with difficulty”.
- (4) “I felt relieved that I have disclosed”.

Two of the participants reported that their employment was terminated after disclosing their status. Examples of participants’ responses are as follows:

- (1) “They betrayed me...I disclosed to her and she said she would support me, but instead I was fired...I have taken them to the CCMA”.

(2) “I was fired from my old job because of my HIV”.

Seven of the participants had not disclosed and specifically indicated that they would not use workplace support programmes provided as they did not trust the expertise or confidentiality of the system. Examples of participants’ responses are as follows:

(1) “I decided not to use that which was offered as I don’t trust the confidentiality of the system”.

(2) “I don’t use the support as I don’t trust them to use the support in an ethical manner”.

(3) “The doctor did not know the side effects of the medicine...she (the doctor) does not know enough”.

(4) “They support HIV...here is a medical clinic...social worker...I don’t want them (the clinic) to know...I don’t trust them”.

It is suggested that the distrust, rejection, fear of discrimination and being pitied (stigmatised) are the main reasons why individuals refrain from disclosing to their employer. It is therefore also suggested that employees that do not disclose because of the aforementioned reasons will also not use workplace support programmes for the same reasons. In contrast, however, trust and acceptance displayed by the employer is suggested to promote disclosure and the use of workplace support programmes provided. It is therefore suggested that all workplace support programmes should include the promotion of acceptance and disclosure for them to be successful in positively influencing individuals living with HIV or AIDS, and particularly their job performance.

The literature review revealed similar results. Discrimination and stigmatisation were found to cause individuals to hide the effect of the disease, not use support available and or strain employer-employee relations (Dane, 2002; Lau & Wong, 2001; Policy Project SA et al, 2002). In one study (Lau & Wong, 2001) 20% of organisations surveyed stated that they would dismiss

HIV or AIDS infected employees.

5.2.4 The influence of workplace support programmes on individual job performance

5.2.4.1 Influence of workplace support programmes on the individual's self-concept

The findings suggest that participants' main reactions to discovering that they were HIV positive were denial, depression, disbelief, fear, shock, anxiety and anger. Blame, feelings of hopelessness, shame and guilt were experienced to a lesser degree. Most of the participants (19) reported that they experienced a combination of at least two or more of the aforementioned reactions, while all reported at least experiencing one. It is suggested that discovering that you are HIV positive has a negative influence on your perception of your real and ideal self, highlighting incongruencies between the two, thus causing stressful reactions.

Examples of responses are as follows:

- (1) "I wanted to kill myself...I did not want to take my treatment".
- (2) "I keep saying that I might not reach 2010".
- (3) "It stressed me...I blamed myself".
- (4) "I was depressed...the psychological pain was unbearable".

Furthermore, it is suggested that participants' reasons for non-disclosure (eg lack of trust, fear of discrimination) enhance the stress experienced by them as they represent conditions of worth and conditional acceptance. It is suggested that the fear and lack of trust in the employer reinforce a negative self-perception (eg powerless, not able to be real self, worthless) and thus could hamper self-acceptance and effective coping.

In contrast however, the reasons for disclosure (eg employer trust, acceptance, and empathy)

suggest unconditional acceptance, diminishing the incongruency and stress experienced, thus assisting self-acceptance and coping.

Examples of participants' responses are as follows:

- (1) "I am not a secretive person, I get uncomfortable if I lie...I want to tell her (employer) but I feel like a little child in front of her...I am scared...she is suspicious of me".
- (2) "I would feel better if I could tell them, but now I feel I have no choice but to keep my secret".
- (3) "I would be happy if they know...if they know, I can be free".
- (4) "I don't want to hide it...I want to tell them, but he don't care about the people".
- (5) "If they (employer) did not accept me I would not have got through this. I would accept this (HIV) with difficulty".
- (6) "Before I talked I felt embarrassed and used to be alone. Now I feel normal...it makes it easier now that I talk (at work)".
- (7) "They are very kind, I feel happy and I feel I can welcome this (HIV)".

Most of participants (20) indicated that the workplace support received from colleagues, supervisors and or employers had positively influenced their self-concept. Participants included being able to disclose and receive acceptance within the workplace as workplace support received (half of the participants had disclosed). Of the mentioned participants, almost all reported an increase in self-acceptance, improved self-esteem, feeling good about themselves and or experienced a sense of being accepted and loved by their employer and or colleagues. They indicated that receiving workplace support positively influenced their ability to cope with and accept the disease. Furthermore, they reported that workplace support had positively

influenced their healing, reduced anxiety and stress and minimised feelings of guilt.

Examples of participant responses are as follows (participants and or their employer):

- (1) “I feel accepted...they were so worried (about me)...I feel strong as a person”.
- (2) “I have a low self esteem...their support encourages me”.
- (3) “I feel more confident...I feel good about myself...I could deal with it (HIV status) better”.
- (4) “I feel fine...I forget about this thing” and “He has gained in confidence”.
- (5) “I feel much stronger...I used to be alone...they make me feel good...now I feel normal”.
- (6) “Their support has not really changed my attitude about myself”.
- (7) “I feel appreciated...it makes me feel well...it makes me feel good about myself”.
- (8) “I feel very positive and relieved...I don’t feel I need to hide anything from them”.

A few of the aforementioned participants (three) indicated that despite the support provided by their employers, they still felt that they had “something to prove”. They gave responses such as, “Subconsciously I suppose I still have something to prove” and “I force myself to work even though I am tired”. It is suggested that these participants could be internalising the fear of rejection and discrimination through working hard to hide any affects of the disease that may arise.

The findings therefore suggest that workplace support could assist individuals accept themselves, despite their HIV status, thus facilitating congruence between the real and ideal selves through

unconditional support. The findings also suggest that despite the possible positive influence of workplace support programmes, some employees were still not completely at ease with their real self. It is thus suggested that HIV and AIDS workplace support programmes should be flexible enough to allow individuals to choose the support they require, thus facilitating their acceptance of their status and themselves, without disempowering them. It is thus suggested that where individuals are offered workplace support programmes that accept and support them unconditionally, they are able to accept themselves, thus enabling them to deliver acceptable job performance (ie due to reduced stress, increased confidence and encouragement).

The remainder of the participants (14) indicated that the lack of workplace support programmes had negatively influenced their self-concept. Furthermore, almost all of the latter mentioned participants had not disclosed due to distrust in their employer or fear of discrimination. Stress, anger and anxiety, feeling trapped or putting up a front and forcing oneself to work harder despite being weak were the main negative influences on the participants' self-concept. Feeling down, denial and guilt were experienced to a lesser degree. It is therefore suggested that a lack of workplace support programmes contributes towards promoting conditional acceptance and reinforces the incongruence between individuals' real and ideal self.

Examples of the participants' responses are as follows:

- (1) "I keep saying I wish I could tell them and that they could understand me, but if I tell them I won't be free...they think I will infect them".
- (2) "I felt punished because now I am loosing my job...she was just trying to make me feel better, but actually she betrayed me".
- (3) "It's hurting me, she promised me help but she just wanted me to go away, I felt abandoned" and "Now I sometimes feel tired but I tell myself that I must be strong".
- (4) "If I need support, I won't approach them. I will deal with the issues and rather keep it a secret in the workplace".

(5) “I feel they won’t appreciate me even if I work hard and sometimes I want to tell somebody but I realise I can’t...nobody cares about anybody”.

(6) “I feel sad because I keep lying, it’s not me...I keep trying to do things but I can’t and I feel bad everyday because I can’t”.

(7) “I am showing them I can do this job even though they don’t know my status because if I don’t have this job I won’t have food on the table”.

(8) “I am not feeling OK about it because I want them to know...I try force myself so that they don’t see I am sick”.

The findings suggest that the participants’ ideal self is one that can be unconditionally accepted despite their HIV or AIDS status, thus freeing them to be their real self (living with HIV or AIDS). Furthermore, it is also suggested that while individuals work within an environment of conditional acceptance (only accept HIV negative individuals) they will continue to push themselves beyond their actual capabilities, and put up a front, just to be accepted as normal individuals. The latter seems to create anxiety within the individual, as the lack of workplace support programmes (including being accepted unconditionally) appears to enhance the incongruence between the real and ideal self. The findings also seem to suggest that employers only view HIV negative as normal, thus allowing individuals living with HIV or AIDS to perceive themselves as abnormal, even unworthy. It is therefore suggested that where workplace support programmes are absent or insufficient (including a HIV intolerant environment) individuals living with HIV or AIDS could generally experience increased incongruency between their real and ideal self, and possibly decreased job performance.

The findings suggest that individuals living with HIV or AIDS experience amongst others anxiety, stress and depression as they come to realise their vulnerability and incongruence between their real and ideal self. The presence of a workplace support programme, inclusive of a HIV tolerant environment, is suggested to positively influence the individual’s self-concept through unconditional acceptance and positive regard. It is further suggested that such support

reduces individuals' anxiety and stress and enhances congruency between their real and ideal selves, while enabling them to experience unconditional positive regard. It is thus suggested that the job performance of the latter mentioned employees will also improve. However, the findings also suggests that a lack of a workplace support programme (inclusive of an intolerant HIV environment) hampers individuals in experiencing congruence between their real and ideal selves, while increasing their need for unconditional positive regard. The incongruence appears to contribute to amongst others the experience of stress, depression and anger and feelings of being trapped or putting up a front (not the true self). It is therefore also suggested that the lack of a supportive environment (inclusive of a lack of a workplace support programme) could also negatively influence job performance due to the negative influence on the individual's self-concept (eg stress, anxiety, self blame, feeling powerless).

The literature review provided similar findings. For example, Chippendale and French (2001), Kelly and Kalichman (2002), Nowell and Van der Merwe (2003), Strydom (2002) and Strydom (2003) found that coming to terms with HIV or AIDS and obstacles in the work environment regarding HIV and AIDS (eg discrimination and lack of support) negatively influence infected individuals' self-concept and thus also their job performance. However, a supportive environment could assist the individuals in coming to terms with their HIV or AIDS status, and thus enhance their self-concept and job performance.

5.2.4.2 The influence of workplace support on individuals' psychological contract

Half of the participants appeared to display a positive attitude toward their employer because of the workplace support that they had received. In particular, participants indicated that they felt more positive, satisfied, grateful, committed, motivated, loyal and or trusting toward their employer because of the workplace support provided. Participants indicated that acceptance, general and emotional support and understanding, concern for employee wellbeing, equal benefits for all employees and or a general understanding of individuals' needs displayed by employers were the main reasons for their positive attitude toward their employers. Furthermore, a large portion of the latter mentioned participants stated that they would terminate their service if their employer discriminated against them or treated them poorly in any way.

Examples of participants' responses are as follows (participants and or their employer):

- (1) "I feel loved and accepted. If they did not accept me I would become frustrated and stay at home".
- (2) "It shows that my employer takes care of HIV people. I would like to continue to work for them because they know their people's needs".
- (3) "I feel nice towards my colleagues and supervisor".
- (4) "I feel like not staying out of work or relaxing. I want to do more for my employer".
- (5) "One definitely tends to be more loyal because I am accepted. There is no discrimination in my benefits due to my HIV status".
- (6) "I would not want to work for another place now. Without their support I would not have got through it" and "He was more than just an average worker. We all care about his wellbeing and encourage him".
- (7) "I feel very happy about him and his wife. I won't leave them. I work with my own heart for him".
- (8) "I know there are people who care and love me. I am glad it happened in the hospital (employer)".
- (9) "It was very good to find they are accepting me. They were not running away. I respect them more. It has made me feel a little more indebted to them".
- (10) "I admire them for doing it. It's wonderful. There is a level of empathy and understanding that is pervasive. They care".

(11) “There is a greater understanding and now because of this psychological bond. I work so much harder. If they were not so caring I would do what I have to and not go to the “nth” degree” and “We manage to create an internal system through understanding and compassion”.

The other half of the participants appeared to display a negative attitude toward their employers, as they had not received any support from them. In particular, participants indicated dissatisfaction with the nature or quality of workplace support provided, distrust, disappointment, decreased loyalty, anger, resentment and or decreased commitment towards their employer as reactions to the lack of any or insufficient workplace support programmes. Insufficient or ineffective support (ie for those living with HIV and AIDS or those affected by HIV or AIDS), discrimination and non-acceptance, lack of empathy and or a lack of HIV and AIDS awareness education appeared to be the main reasons why participants had a negative attitude toward their employer. There were also several participants that were somewhat disappointed with certain areas of workplace support provided by their employers, due to differing expectations, although they were satisfied with them in general. Examples of responses are as follows (participants and or their employer):

(1) “There should be more people visiting and talking to the school or counseling, and not only wait until September. The current leave policy does not allow you to be off for more than three days at one time, then you must go back to work”.

(2) “I feel angry towards her. She let me down. I feel more threatened and uncomfortable. She must be educated about HIV first, but she does not allow these things”.

(3) “Employers should go for counseling about AIDS or read about it. Then it will be good”.

(4) “Not enough is done for those who are already HIV positive. It’s more preventative”.

(5) “Putting up posters is a great start but it’s not enough. They don’t do enough to educate the industry. You are just a number”.

- (6) “She said I was a good worker. I thought she was only trying to make me feel better because then I lost my job. I felt betrayed. I lost trust. They did not appear to care enough”.
- (7) “I feel bad towards them. They are out of order. They should have been in the forefront, but they always lag behind”.
- (8) “There is not enough support from my employer”.
- (9) “I am not satisfied. It’s hurting me because I must pay for the doctor myself. I must try and get another job”.
- (10) “They don’t deal with my feelings. I feel not trusted. They want to choose the doctor for me. They think for me. I feel like a guinea pig because it’s the first time they deal with a person who is HIV positive. I am disappointed with them”.
- (11) “He thought that we must do more, but we have more than bent over backwards. We must be consistent. However, we have set up a meeting to determine realistically we he wants and what we can give”.

The findings suggest that the provision of applicable and adequate workplace support programme activities can have a positive influence on the psychological contract of employees that are living with HIV or AIDS. In this study, participants viewed acceptance, general and emotional support and understanding, concern for employee wellbeing, equal benefits for all employees and or a general understanding of individuals’ needs as important workplace support activities. The findings also suggest that employees could display increased commitment, motivation, trust and loyalty because of employers satisfying the workplace support expectations that are perceived to form part of the psychological contract. It is further suggested that employees’ perception of fulfilled psychological contract expectations will also positively influence their job performance. However, it is also suggested that where there is a perceived difference in expectations regarding workplace support, between the individual and employer, or if the workplace support is inadequate or absent, the individual’s psychological contract will be

negatively influenced. The reactions that appear to occur in response to a perceived breach of the psychological contract include distrust, anger, decreased commitment and loyalty and decreased morale. It is thus also suggested that in such instances the job performance of individuals living with HIV or AIDS could also be negatively influenced. It is therefore suggested that employers that have applicable and adequate workplace support programmes will contribute toward improving the psychological contract of employees living with HIV or AIDS and thus also their job performance. The literature review did not produce findings directly relating to the influence of specific workplace support programmes on the psychological contract of individuals living with HIV or AIDS. However, the literature review did find that being able to work, being accepted, satisfaction of the psychological contract and being treated as others increases morale, commitment, job performance and emotional coping of those infected with HIV or AIDS (Baraldi, 2000; Chrobot-Mason, 2003; Greene, 1998; Kennedy, 2002). Therefore, the literature appears to support the research findings.

5.2.4.3 The influence of workplace support programmes on individual job performance

Just over half of the participants (18) indicated that they had received varying degrees of support from their employers. The aforementioned also included participants who were unsure of whether or not their employer had a mechanism to manage HIV and AIDS. All of the latter mentioned employees indicated that the receipt of workplace support from their employers had positively influenced their job performance. Improved job performance appeared to be mainly due to increased strength, improved health, increased productivity, rejuvenation and or improved interpersonal relations. An increase in motivation through applying extra effort and initiative was the next positive influence on job performance that was stated by participants. Maintenance of previous levels of job performance, commitment, decreased absenteeism, improved coping and reduced stress and anxiety (in that order) were also indicated as being positive influences on the job performance of employees living with HIV or AIDS. Examples of participant responses are as follows (participants and or their employer):

- (1) “There is now an improvement in her work. She is more relaxed and not aggressive anymore”.

(2) “The quality of my work has stayed the same. I want to do more for my employer. I do things today even if she says leave it for tomorrow”.

(3) “After talking to me he seems to feel better. The support may assist him in increasing his job performance”.

(4) “I have always taken pride in my work. Now to maintain the standard is hard, but my job performance has improved” and “After we encouraged and supported him his job performance improved but not to the level it was before he became sick. But last night again he was like a steam roller: He produced two and a half work loads”.

(5) “I told him you saved my life. I push myself. My work is better” and “He is twice the employee he used to be because he realises that we saved his life. His job performance has improved beyond the original level”.

(6) “They gave me more responsibility. I want it that way. My job performance is the same. If I feel not wanted my job performance might not be as good. I would just do the basic”.

(7) “I want to do more for them because they make me feel so happy. Even if I can’t, I try to do more” and “Her work is fine. I don’t want to treat her as an invalid”.

(8) “I have a greater sense of pride. I take work a step further”.

(9) “I am always trying my best everyday. If they did not treat me nice I would not work as before” and “She is much calmer and at ease. Her attendance is now 100%. She is more committed and loyal because of the support”.

The remainder of the participants (16) indicated that they had not received any assistance from workplace support programmes or if they did, they were not satisfied with that which was provided. Their responses suggest that their job performance had been negatively affected by the lack of any or sufficient workplace support programmes for individuals that are living with HIV

or AIDS. Forcing oneself to work harder due to fear of job loss or rejection, increased stress and anxiety, decreased motivation and commitment (through decreased performance, possible resignations or only doing the bare minimum) and frustration were reported as being the main negative influences on job performance. Examples of participant responses are as follows:

- (1) “They won’t appreciate my work I do. Sometimes I feel I must just work to get it done. She does not want to hear about it (AIDS)”.
- (2) “I could improve my job performance if they know about AIDS and support me”.
- (3) “I force myself to do the work. If I don’t do my job I will lose my job”.
- (4) “I am not satisfied. It’s hurting me because I must pay for the doctor myself. I must try and get another job. I just earn a living”.
- (5) I feel frustrated. I sacrificed two years without pay for them. If there were another job I would leave now. I am only staying with them because of the income”.
- (6) “I try force myself so that they don’t see that I am tired”.
- (7) “She said she was prepared to put her side of the business on the line as I was a good worker. Then I lost my job. I lost trust. I felt betrayed. I am angry now”.

The findings suggest that employers can directly and positively influence the job performance of employees living with HIV or AIDS through providing appropriate workplace support programmes. The findings thus suggest that workplace support programmes can positively influence mental and physical health, strength, productivity, commitment, motivation and absenteeism, thus improving job performance. However, the findings also suggest that providing no or insufficient workplace support programmes could negatively influence the job performance of employees living with HIV or AIDS. It is suggested that frustration, commitment, motivation, staff turnover and psychological health could be negatively affected where there is insufficient or

no workplace support programmes, and thus also decrease job performance. Therefore, it is suggested that employers should provide workplace support programmes to maintain or improve individual job performance, including motivation and commitment. The literature review produced somewhat similar findings. For example, workplace support programmes were found to improve and or extend the working life of infected individuals, improve morale and productivity, reduce absenteeism and enhance quality of life (Leserman, 2000; Rosen et al, 2000; Rosen, 2003; Whiteside & Sunter, 2000).

The participants identified workplace support programme activities that had and or which could positively influence their job performance. The workplace support activities stated by the participants can be grouped into two main categories as was the case with their expectations already discussed. The two categories are environmental acceptance and practical benefits. Participants identified non-discrimination, acceptance, no stigmatisation, education and awareness training, being treated as a normal person, being treated with dignity and respect, empathy and understanding as the activities involved with environmental acceptance. The practical benefits identified are payment of medical costs, counseling, guidance, advice, VCT, flexi-time, affordable medicines, financial support and the provision of ARVs. Most of the participants (18) stated that environmental acceptance would have the most positive influence on job performance although a combination of practical benefits and environmental acceptance activities was important. Whereas 19 of the participants had preferred the aforementioned combination, only 10 of them had actually received such workplace support programme activities, which had positively influenced their job performance. The findings thus suggest a discrepancy between support expected and that which was received.

A further 10 participants stated that environmental acceptance and practical benefits were equally important, thus workplace support programmes should contain a combination of the two. Of these participants six had actually received such support while the remainder had not. The remaining five of the participants stated that although a combination of environmental acceptance and practical benefits was important, affordable medication (including ARVs) and payment of medical costs were considered to be more important for positively influencing job performance. The reason offered was that individuals at lower income groups would not survive

without financial or other support to obtain the medications required to treat the disease. Four of the participants who gave the latter response were unable to afford their medication on their current income. However, all were receiving environmental acceptance type of workplace support.

Examples of participant responses are as follows:

- (1) “We must tell the people that anyone can get this thing. If people understand and have the right attitude we can be safe. If this can happen I would work much better”.
- (2) “Accepting me with my disease is much more important than money or medicine. If I am not happy my health will not improve. But with happiness because of the way you treat me, I will get hope for tomorrow”.
- (3) “I suppose emotional support would be more important. If there were no emotional support no other support available would mean much although a combination would be important”.
- (4) “Deal with the stigma. If only industry can get more involved with education, treatment and making medication more affordable” and “Money to get medicine is not important. Support from work and home is important for happiness. I would rather die happy than have medicine and be unhappy”.
- (5) “A combination of emotional support and other support would be ideal to improve job performance”.
- (6) “A combination of acceptance, no discrimination and other benefits, like sick leave, is important. However, it may differ from person to person”.
- (7) “Medical costs are equally important as acceptance. They will let me work better, but if they are not there I will report them”.

(8) “A combination of medical expenses, time off work and acceptance is important. However, the importance of which part would depend on your salary position. It would make me go the extra mile if the company gave that support”.

(9) “The financial costs first, then the other type of support and acceptance. If I was struggling and the support was not there, it would influence my job performance”.

The findings suggest that HIV and AIDS workplace support programmes that emphasise environmental acceptance to create a discrimination free atmosphere within the organisation are preferred. However, the findings suggest that workplace support programmes should contain a practical benefits and environmental acceptance component. The findings also suggest that the exact balance between the two would differ from person to person. Level of income was suggested to influence the individual’s preference of the degree of combination between the two. Therefore, the findings suggest that HIV and AIDS workplace support programmes can influence the job performance of individuals living with HIV or AIDS. The findings also suggest a discrepancy between what individuals expect in the form of support from their employer and what they receive. It is suggested that such discrepancies can further negatively influence job performance. Furthermore, it is suggested that employers should base the nature and content of workplace support programmes on individuals’ needs, to ensure maximum satisfaction of employee expectations, while maintaining flexibility regarding the support provided. Although the literature review did not reveal specific combinations or activities that are directly related to improving infected individuals job performance, it did provide general support that workplace support of such individuals could enhance their overall functioning and thus job performance (Gregory & Gibbs, 2002; Whiteside & Sunter, 2000).

Employees who discover they are HIV positive experience a variety of feelings and emotions that influence how they see themselves (their self-concept). It is suggested that the self-concept held by individuals living with HIV or AIDS is reinforced or altered by the factors that prevent or promote disclosure, as they could also represent conditions of worth. It is further suggested that sufficient and appropriate workplace support programme activities contribute towards congruence between the real and ideal selves. However, a lack of such support reinforces the

incongruence and conditional acceptance. The lack of or provision of insufficient workplace support programme activities is also suggested to influence the psychological contract. The findings suggest that the presence of appropriate workplace support programme activities increases the chances of employers being viewed in a positive way while the absence thereof increase the chances of them being viewed in a negative light. It is thus suggested that workplace support programme activities influence job performance indirectly through individual's self-concept and psychological contract by influencing their motivation, commitment and or psychological wellbeing. Direct influences of workplace support programmes on job performance include increased strength, output and health. Furthermore, while a combination of environmental acceptance and practical benefits are included in workplace support programmes, most of the participants appear to prefer support that focuses mainly on environmental acceptance. However, the exact balance of workplace support programme activities will differ among individuals. It is suggested that income level could influence the combination of workplace support programme activities preferred.

In general, participants felt the provision of workplace support programmes positively influences job performance while the absence of such support decreases job performance. Furthermore, it is suggested that discrepancies between the type of workplace support programme activities provided and that which is expected, could lead to dissatisfaction and decreased job performance. It is therefore suggested that employers should provide workplace support programmes that are based on individuals' needs, are flexible, applicable and focus on improving individuals wellbeing and job performance.

5.2.5 Summary

The interpretive research findings suggest that HIV and AIDS influences the job performance of individuals who are HIV positive or living with AIDS through an increase in absenteeism and a decrease in the standard of work. Physiological and psychological factors such as fatigue, stress and side effects of the medication appear to negatively influence job performance through decreased compliance with work standards or a rise in absenteeism. Furthermore, the findings suggest that HIV and AIDS mainly influence performance in jobs requiring the exertion of

mainly physical effort. The findings suggest further that it is also possible that HIV and AIDS does not influence the individual during the early years (therefore also not job performance) and that other factors (eg pregnancy) can mask the influence of HIV and AIDS on job performance.

Participants' expectations regarding workplace support programmes centred around two broad groupings namely, environmental acceptance (eg the creation of a stigma and discrimination-free workplace) and practical support (eg advice and counseling). Most of the participants had expectations of workplace support programmes that primarily focus on environmental acceptance of individuals who are HIV positive or living with AIDS although practical support or a combination of the two were expected to a lesser extent. Therefore, the findings suggest that participants at least expect workplace support programmes to create an atmosphere that promotes disclosure and acceptance.

Most of the respondents (16) indicated that their employers had no HIV and AIDS policy or committee while some (eight) indicated that their employer had at least some sort of informal management process (eg informal awareness, advice and monitoring). Only seven of the employers had either a formalised policy and or committee that managed HIV and AIDS within their organisation. The remainder of the respondents (three) were unsure as to whether or not their employer had any policy or committee to manage HIV and AIDS in the organisation or workplace. The findings thus suggest that employers are still ignoring the influence or potential influence of HIV and AIDS, and the necessity to counter it. It is thus also suggested that employers that don't have an HIV and AIDS policy or committee, albeit informal, risk not being able to deal effectively with the negative influence that the pandemic can have on the individual and organisation. It is also suggested that they would not be able to satisfy their employees' expectations in this regard.

Whereas the most of the participants indicated environmental acceptance as the main type of workplace support programme required, employers provided mainly practical benefits. It is suggested that the lack of a clear policy to manage HIV and AIDS in the workplace could cause dissatisfaction as interventions implemented may be inappropriate or may not be implemented at all. Furthermore, employers could therefore also be viewed as insensitive. The findings appear

to suggest that on the whole neither participants' expectations regarding emotional support nor practical support have been satisfied to the extent expected.

The findings suggest that distrust, rejection, fear of discrimination and being pitied (stigmatised) prevent individuals from disclosing to their employer, and thus also prevent them from using workplace support programmes. However, trust and acceptance displayed by the employer is suggested to promote disclosure and the use of workplace support programmes provided.

Workplace support programmes, inclusive of a HIV tolerant environment, appear to positively influence the individual's self-concept through unconditional acceptance and positive regard. However, a lack of a workplace support programme (inclusive of an intolerant HIV environment) appears to hamper individuals experiencing congruence between their real and ideal selves, while increasing anxiety, stress and their need for unconditional positive regard. It is therefore suggested that participants' job performance could also be influenced due to concomitant factors such as stress, anxiety or feeling worthless.

The findings suggest that employees' perception of fulfilled expectations regarding workplace support could positively influence their psychological contract and also their job performance. However, where there is a perceived difference in expectations regarding workplace support, between the individual and employer, or if the workplace support is inadequate or absent, the individual's psychological contract and job performance could be negatively influenced. The findings suggest that employers can directly and positively influence the job performance of employees living with HIV or AIDS through providing workplace support programmes. However, the findings also suggest that providing no or insufficient workplace support programmes could negatively influence the job performance of employees living with HIV or AIDS.

The overall findings suggest that HIV and AIDS workplace support programmes that emphasise environmental acceptance to create a discrimination free atmosphere within the organisation are preferred. However, the findings also suggest that workplace support programmes should contain a practical benefits and environmental acceptance component. The exact balance

between the two would differ from person to person. Level of income is suggested to influence the individual's preference of the degree of combination between the two.

5.3 INTEGRATION OF LITERATURE REVIEW AND RESEARCH FINDINGS

The literature review revealed that job performance involves various facets including the attainment of objectives and producing quantifiable outcomes. Job performance is performed within a specific environment, which includes a particular culture and climate that is unique to the organisation. The literature review found several factors within the workplace that influence individuals' job performance, and thus that of individuals living with HIV or AIDS (eg work environment, relationship with co workers, satisfaction, working hours). Furthermore, the literature has shown that organisational climate, culture, practices and policies influence the organisation and also the individuals, and their job performance. The results of the interpretive research also suggest that aspects of the employers' organisation culture and climate, policies, and practices influence the job performance of HIV or AIDS infected individuals. The aspects include perceived breach of the psychological contract (unfulfilled employee expectations), discrimination and stigmatisation by colleges and supervisors, absence or lack of a HIV and AIDS workplace support policy or strategy, decreased self-concept due to conditional acceptance and insufficient or inappropriate workplace support programme activities. The interpretive study also showed, by implication, that job performance involves many aspects that could be influenced by HIV and AIDS. Specifically, participants who were living with HIV or AIDS worked in various sectors, at various levels and held occupations from a domestic servant to consultant or financial manager.

The literature review revealed that HIV and AIDS continues to have devastating effects on society, and thus also on organisation and individual job performance at all levels. Specific factors such as increased mortality, decreased life cycles, increased AIDS orphans, increased resignations, increased individuals living with HIV or AIDS that are in their prime production phase of their lives and loss of critical skills negatively influenced employers and job performance of individuals living with HIV or AIDS. Furthermore, the literature review found that organisations faced various cost implications due to the HIV and AIDS pandemic, including

increased medical, production and employee replacement costs. According to the literature review, the cost implications were the reason why some organisations had not implemented workplace support programmes.

The literature review also found that factors such as poverty, discrimination and stigmatisation fuel the spread of the pandemic. This was because individuals living with HIV or AIDS did not or could not access the support available because a lack of financial means or because they did not disclose for fear of discrimination. The interpretive research findings supported this view to some extent, as 12% of the respondents received no support from their employers. It is thus possible to infer that the individuals may not be in a position to afford the proper treatment, and could thus unknowingly spread the pandemic. Furthermore, certain participants actually stated that the latter could have occurred had it not been for the support from their employer.

Apart from the aforementioned effects on job performance, the literature review and interpretive research findings suggest that HIV and AIDS influence individuals' job performance negatively through increased absenteeism, fatigue, decreased physical strength, forgetfulness, anxiety, stress, medication side effects, decreased productivity (quantity and quality) and mood swings. Furthermore, actual discrimination (past experiences) or the fear of discrimination and or stigmatisation appeared to decrease trust displayed toward employers and enhance anxiety and stress experienced by individuals living with HIV or AIDS, but who had not disclosed to their employer. The interpretive research findings found that HIV and AIDS appear to mainly influence performance in jobs requiring the exertion of mainly physical effort. Furthermore, the literature review and interpretive research findings suggest that it is possible that HIV and AIDS do not influence the individual during the early years (therefore also not job performance). The literature review and interpretive study (Kennedy, 2002) found that it is also possible that other factors (eg pregnancy, starting a new job, technology) can mask the influence of HIV and AIDS on job performance.

The literature review and interpretive research findings suggest that a comprehensive workplace support programme should be implemented to reduce the influence of HIV and AIDS on individuals, and thus also on job performance and the organisation. Furthermore, awareness,

prevention and support to individuals living with HIV or AIDS should be the main areas within such support programmes. The interpretive research found that most of the participants (18) had expectations of workplace support programmes that focused primarily on environmental acceptance of individuals who are HIV positive or living with AIDS (eg the creation of a stigma and discrimination-free workplace, HIV and AIDS education). However, practical support (eg advice and counseling) or a combination of the two was expected to a lesser extent. Although the literature review did not directly find which activities were preferred it did indicate that prevention of discrimination and providing workplace support for infected employees were important to improve their quality of life and job performance. Unfortunately the results of the literature review and interpretive research found that while some employers have a formalised policy, committee to manage HIV and AIDS in the workplace and or a comprehensive workplace support programme, the majority do not. The interpretive research also found that in some instances it was not clear whether or not the employers had a policy or committee to manage HIV and AIDS in the workplace. The interpretive research also found that some employers managed HIV and AIDS in the workplace, although there was no formal mechanism to do so.

The literature review, and to a some extent the interpretive research, indicated that to be effective, an HIV and AIDS policy should be integrated into all the employer's processes and practices, while being aligned to all relevant legislation and involve individuals living with HIV or AIDS. Furthermore, the literature review and interpretive research found that prevention of discrimination, education and voluntary testing should be part of a workplace support programme to enhance its effectiveness and reduce discrimination. The literature review and interpretive research also identified provision of medication (including ARVs), medical aid, counseling, assistance with medical costs, accommodating working conditions and support for families among the activities to include in workplace support programmes. The interpretive research findings found that whereas most of the participants indicated environmental acceptance as the main type of workplace support programme required employers provided mainly practical benefits. It is thus suggested that the lack of a clear policy to manage HIV and AIDS in the workplace could cause dissatisfaction as interventions implemented may be inappropriate or may not be implemented at all.

Despite legislation prohibiting discrimination the literature review and interpretive research found that many individuals living and working with HIV or AIDS have experienced discrimination or face the possibility of discrimination due to their status. The discrimination and stigmatisation included job loss and or being treated differently. Furthermore, the literature review revealed that employers have a legal obligation to create a safe working environment. However, it is suggested this should be done in a way that it does not discriminate against individuals because of their HIV or AIDS status. The basic assumption should be to treat everyone as being HIV positive and then manage safety accordingly. The research found that the negative influence of discrimination include failure to disclose at work, dismissal, decreased job performance, strained employee relations, increased stress and anxiety and refusal to utilise workplace support programmes provided. The interpretive research found that distrust, denial, rejection, fear of discrimination and being pitied (stigmatised) were reasons that prevented individuals from disclosing to their employer, and thus also from using workplace support programmes (half of the participants had not disclosed for the aforementioned reasons). However, trust and acceptance displayed by the employer were provided as reasons that would promote disclosure and the use of workplace support programmes provided, and possibly improvements in job performance (half of the participants had disclosed for the aforementioned reasons).

The interpretive research found that some individuals would only disclose their HIV status at work to gain access to support or where they suspect a drop in their job performance. Furthermore, the interpretive research found that failure to disclose appeared to increase anxiety, isolation and depressed mood, and possibly decrease job performance.

The literature review and interpretive research found that individuals' view of their self-concept could influence their behaviour, self-worth perceptions, acceptance and job performance. The research findings suggest that workplace support programmes, inclusive of an HIV tolerant environment, appear to positively influence the individual's self-concept through unconditional acceptance and positive regard. However, a lack of a workplace support programme (inclusive of an intolerant HIV environment) appear to hamper individuals in experiencing congruence between their real and ideal selves, while increasing anxiety, stress and increasing their need for

unconditional positive regard. The findings therefore appear to suggest that participants' job performance was also be influenced positively or negatively, depending on the presence or lack of any or sufficient workplace support programmes, including an HIV tolerant environment. It is suggested that this would possibly be due to concomitant factors such as stress, anxiety, acceptance, unconditional positive regard or feelings of worth.

The literature review suggested that organisational climate and culture influence individual job performance. Furthermore, the psychological contract between employees and employers exists within and is affected by the organisational climate and culture. The literature review and interpretive research findings therefore also suggest that satisfied employee expectations (ie workplace support programmes) could positively influence their psychological contract and also their job performance (eg increased trust, motivation, commitment). However, the interpretive research findings also suggest that where there is a perceived difference in expectations (ie regarding workplace support), between the individual and employer, or unfulfilled expectations (ie inadequate or absent workplace support), the individual's psychological contract and job performance could be negatively influenced (eg reduced commitment, resignation, minimum job performance). It is also suggested that a weak psychological contract, resulting from unfulfilled expectations regarding workplace support programmes, could also lead to an increase loss of already scarce skills.

The literature review and interpretive research findings suggest that employers can directly and positively influence the job performance of employees living with HIV or AIDS through providing workplace support programmes. Furthermore, the literature review and interpretive research findings suggest that providing no or insufficient workplace support programmes could negatively influence the job performance of employees living with HIV or AIDS.

The interpretive research findings suggest that workplace support programmes appear to positively influence the job performance of individuals living with HIV or AIDS through increased strength, improved health, increased productivity, rejuvenation, improved interpersonal relations and increased motivation. The positive influences include maintaining or increasing previous levels of job performance, increasing commitment, decreasing absenteeism, improving

coping and reducing stress and anxiety (in that order). However, the interpretive research findings also suggest negative influences on job performance due to not providing workplace support. The negative influences were forcing one to work harder due to fear of job loss or rejection, increased stress and anxiety, decreased motivation and commitment (through decreased performance, possible resignations or only doing the bare minimum) and frustration. Finally, the literature review, and to a limited extent the interpretive research findings, suggest that employers can reduce HIV and AIDS related costs (eg production costs, absenteeism) through investing in workplace support programmes which positively influence job performance.

The overall findings suggest that HIV and AIDS workplace support programmes that emphasise environmental acceptance to create a discrimination free atmosphere within the organisation are preferred to positively influence job performance. However, the findings also suggest that workplace support programmes should contain a practical benefits and environmental acceptance component. The interpretive research findings suggest that the exact balance between the two would differ from person to person (eg due to differences in level of income).

5.4 HYPOTHESES

The following hypotheses are put forward:

(1) HIV and AIDS do not always influence the individual's job performance during the early years after infection. The literature review and interpretive research found that individuals who are living with HIV or AIDS were not always negatively affected by the disease early on. The literature review indicated advances in medical treatment as a possible reason. The interpretive research findings found that 35% (12) of the sample had been infected for between zero and five years but reported that their job performance (and their health in general) had not been affected in any way.

(2) Fear of discrimination and stigmatisation influence individuals' decision to disclose their HIV and AIDS status and thus their use of workplace support programmes. The literature review and interpretive research found that discrimination and stigmatisation influence individuals'

decision to use workplace support programmes provided. The interpretive research found that half of the participants had not disclosed to their employers, as they did not trust them. Of the latter employees, seven (21% of the sample) specifically indicated that they would not use the support programmes offered by their employer as they did not trust the confidentiality (implying a fear of possible discrimination).

(3) The extent of the influence of HIV and AIDS on job performance is dependent on the nature and type of work involved. The interpretive research found that 35% (12) of the sample performed jobs that involved mainly physical work and experienced several physiological (eg fatigue) and psychological (eg stress) factors. A total of 29% (10) of the sample performed jobs with almost no physical work. Of the 10, half stated that neither them nor their job performance had been negatively influenced by HIV or AIDS related physiological or psychological factors. The research by Booysen and Molelekoa (2001) and Kennedy (2002) also appear to show some support to the hypothesis. They conducted studies in organisations that performed mainly physical work (sugar mill and colliery, respectively) and found that fatigue resulting from HIV or AIDS negatively impacted on infected individuals' productivity.

(4) Workplace support programmes influence job performance through influence on the individuals' psychological contract and self-concept. The literature review and interpretive research appear to support this hypothesis. Greene (1998), Leserman et al (2000), McIntyre (2000) and Rousseau (2001) indicate that workplace support programmes and or fulfilled expectations thereof could improve or maintain a positive self-concept and or psychological contract. The interpretive research found that half of the participants were more positive, committed to and satisfied with their employer as a result of the workplace support that they had received. The participants that had received no workplace support displayed frustration and a negative attitude toward their employers as result thereof.

(5) The provision of appropriate workplace support programmes has a positive influence on the job performance of individuals living with HIV or AIDS. The literature review and interpretive research appear to support this hypothesis. The interpretive research found that just over half of the participants received some form of appropriate workplace support and that their

job performance had been positively influenced as a result. The employers of these participants who were interviewed also supported this hypothesis. The participants that received no or unsatisfactory support reported frustration and decreased job performance. Christianson (2002), Kennedy (2002) and Whiteside and Sunter (2000) found somewhat similar results. They found that absenteeism decreased and morale and productivity increased when workplace support programmes were implemented.

Now that the results have been analysed and integrated, the conclusions, limitations and recommendations will be presented.

CHAPTER 6: OVERVIEW OF FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

The HIV and AIDS epidemic is possibly the worst threat facing mankind today. It has no known cure. It is cutting into every sphere of society leaving no individual, group or organisation unaffected. It is hollowing out mainly the younger adults in the prime of their productive lives, and perhaps more importantly the next generation of future leaders and employees through an increase in child mortality and orphans. At the same time the pandemic is consuming resources which in some instances are already overstrained. Within South Africa, the influence of HIV and AIDS on organisations, individuals and the broader society has been devastating. However, the worst is yet to come. It is forecast that the actual impact of the pandemic will only be felt by the year 2010 when five to seven million individuals currently HIV positive become ill with full-blown AIDS (Dorrington et al, 2001). Furthermore, the average life expectancy has also reduced due to the affects of the pandemic. Organisations exist within this broader society and are thus at the heart of pandemic's impact, and arguably at the heart of bringing the pandemic to a manageable level, if not eradicating it. Individuals living with HIV and AIDS perform jobs within the organisational environment to ensure, amongst other things, their own and their employers' financial survival and growth. Therefore, putting workplace support programmes in place does not only contribute to the social responsibility for combating the pandemic, but it makes business sense because of the effects on bottom line results.

Unfortunately many organisations still have either no, limited or inappropriate mechanisms in place to deal with the pandemic, despite the advances in medical treatments that could prolong and enhance employees' productive lives. As such employees who are HIV positive or have full-blown AIDS are not able to improve their quality of life, and thus also their job performance.

This study focused on gaining an understanding of the influence of workplace support programmes on the job performance of individuals living with HIV or AIDS. By doing so it is

hoped that employers will see the benefits of implementing such programmes on job performance as well as consequences if they don't.

The chapter will commence with an overview of the findings and conclusions. Thereafter the limitations of the study, recommendations and areas of future research will be discussed.

6.2 OVERVIEW OF FINDINGS

6.2.1 The influence of HIV and AIDS on individual job performance

The literature review and interpretive research found that HIV and AIDS is influencing individual job performance in many ways within the organisation. Furthermore, job performance consisted of many aspects and was carried out in an organisational context, which also influenced the outcome thereof. The literature revealed that HIV and AIDS inflicted huge costs on organisations including staff turnover, loss in production and decreased morale. Furthermore, it is envisaged that the negative impact will increase in future. On an individual level, HIV and AIDS were found to negatively influence individuals' overall health and capacity to perform their job tasks. The effects include anxiety, decreased strength, fatigue, and decreased standard of job performance. In particular, the research found that individuals doing mainly physical work appeared to experience a greater negative influence on their performance than those whose work had none or very little. The findings also revealed that the organisational context negatively influenced job performance of HIV or AIDS infected individuals, including a decreased self-concept, violated psychological contracts and reduced commitment, where there was discrimination and or no or insufficient workplace support. Where the aforementioned factors were present, infected individuals' job performance, self-concept and psychological contract remained the same or improved. The research findings also indicated that individuals who were HIV positive did not always experience ill health due to the virus, particularly in the early years after infection. Furthermore, several factors masked the effects of HIV on job performance and there have been medical advances that prolong the individuals' productive life.

It is therefore evident that the job performance of individuals living with HIV or AIDS could be

negatively affected where organisations fail to eradicate discrimination and fail to implement workplace support programmes. Therefore, to reduce the negative influence of HIV and AIDS on the job performance of individuals living with the disease organisations should implement a comprehensive, appropriate and needs based strategy and workplace support programme. Although guidelines exist for the formulation and management of HIV and AIDS workplace support programmes, none have been legislated in an effort to aid the eradication of the pandemic. Therefore, it is suggested that the lack of legislation compelling organisations to implement workplace support programmes could also negatively influence job performance of infected individuals. It is thus suggested that if the guidelines indicated in the HIV/AIDS TAG (2002) and ILO (2001) were legislated, thus obliging organisations to implement workplace support programmes, the influence of the pandemic on individuals' job performance could possibly be reduced even further. In addition, national and provincial authorities should publish the results and benefits achieved by organisations that have implemented such programmes. The latter could assist in promoting the provision of workplace support programmes even further.

6.2.2 Discrimination and stigmatisation

The research found that discrimination and stigmatisation continue to occur within the workplace despite the existence of legislation that clearly prohibits such actions. The presence of discrimination and stigmatisation was found to negatively influence individuals' self-concept, psychological contract and job performance. Furthermore, individuals living with HIV or AIDS would not use workplace support provided where they experienced or perceived the presence of discrimination and or stigmatisation. Some individuals even suggested resigning rather than remaining with organisations that tolerated discrimination and stigmatisation. It can be argued that in such cases it is possible that infected individuals could even add to the spread of the pandemic as they may not receive the treatment that they otherwise might have. The research also found that where individuals distrust confidentiality or fear discrimination and stigmatisation, they would probably not disclose their HIV status, and therefore also not use support that may be available. In contrast, however, the research found that a non-discriminatory environment enhanced individuals' positive self-concept, commitment, job performance and utilisation of the support that was provided. The research also found that eradication of

stigmatisation and discrimination needed to be addressed if workplace support programmes were to be successful. Therefore, such efforts should be included in workplace support programmes and policies. It is therefore evident that measures to eradicate or prevent discrimination should be included in workplace support programmes to enhance their utilisation and effectiveness in combating the pandemic, and enhancing individual job performance. Furthermore, although various legislation prohibit discrimination and stigmatisation of infected employees, no legislation exists that covers only the management of HIV and AIDS in the workplace and ways to eradicate or prevent discrimination. It is suggested that such legislation could enhance the effectiveness of workplace support programmes, and thus also individual job performance.

6.2.3 Nature and content of workplace support programmes

The research found that while some organisations had comprehensive workplace support programmes, many had either none or limited support for individuals living with HIV or AIDS. Furthermore, many employers had no mechanism to manage HIV or AIDS related matters within their organisation. The interpretive research found that employees experienced a breach of the psychological contract and decreased commitment where employers had inappropriate or no workplace support programme in place. Matters such as awareness education, prevention and support to those living with HIV or AIDS should be included in workplace support programmes. Furthermore, the interpretive research found that most of the participants seemed to prefer workplace support programmes that focus on achieving environmental acceptance firstly (ie remove discrimination and stigmatisation, awareness education) or at least be combined with practical benefits (eg medical aid). Furthermore, the interpretive research found that workplace support programme activities focused mainly on practical benefits whereas participants seemed to prefer those related to environmental acceptance. The discrepancy between expected and provided workplace support appeared to cause frustration and dissatisfaction amongst participants. Therefore, to be effective, HIV and AIDS workplace support programmes should be flexible, needs based, appropriate, integrated into all benefits, processes and levels within the organisation and developed involving all role players, including individuals living with HIV or AIDS. Furthermore, legislating the provision of workplace support programmes could ensure that at least employers provide a baseline level of support to individuals living with HIV or

AIDS.

6.2.4 The influence of workplace support programmes on individual job performance

The research findings indicate that the provision of workplace support programmes positively influence individuals' self-concept, psychological contract and job performance. Specifically, the influences included increased morale, commitment, reduced stress and anxiety and willingness to do more than what is required. However, the lack of any or sufficient workplace support programmes appeared to have the opposite affect including frustration, anger and decreased job performance. From a business perspective, the research implies that investing in HIV or AIDS infected employees is beneficial to individual and organisational growth and performance. Furthermore, the interpretive research indicated that workplace support programmes that contain environmental acceptance (eg non-discrimination, acceptance) had a greater influence on the job performance of individuals living with HIV or AIDS. However, workplace support programmes should at least be a combination of environmental acceptance and practical benefits (eg change in job, reduced working hours) to positively influence the job performance of individuals living with HIV or AIDS. Therefore, to improve the job performance of individuals living with HIV or AIDS, organisation should implement workplace support programmes that have an appropriate combination between environmental acceptance activities and practical benefits. Furthermore, legislating the provision of workplace support programmes could stipulate minimum requirements regarding content, prevention of discrimination, responsibility for the overall management of such programmes, and could possibly enhance job performance.

6.3 CONCLUSIONS

The HIV and AIDS pandemic continue to negatively influence our society, employers, and individuals and their job performance. Despite the negative influence, individuals living with HIV or AIDS are able to live longer productive lives due to medical advances, and are thus able to contribute to bottom line results. However, while many employers are supporting their employees who are infected, there are many more that are not. Those who have workplace

support programmes in place are experiencing improved individual job performance and productivity while those that have yet to do so are not. Therefore, to reduce the negative influence of HIV and AIDS on the job performance of infected employees organisations should implement a comprehensive, appropriate and needs based workplace support programme. Furthermore, the guidelines as indicated in the HIV/AIDS TAG (2002) and ILO (2001) could be legislated, thus obliging organisations to follow them when implementing workplace support programmes, thereby possibly reducing the influence of the pandemic on job performance even further. To be effective, workplace support programmes should be flexible, needs based, appropriate, integrated into all benefits, processes and levels within the organisation and developed involving all role players, including employees living with HIV or AIDS. Furthermore, legislating the provision of workplace support programmes could ensure that at least employers provide a baseline level of support. Such workplace support programmes should eradicate or reduce discrimination and stigmatisation together with providing practical support to infected individuals. Therefore, to improve the job performance of individuals living with HIV or AIDS, organisations should implement workplace support programmes that have an appropriate combination between environmental acceptance activities and practical benefits. Finally, national and provincial authorities could publish results and benefits achieved by organisations that have implemented such programmes, in an effort promote the advantages that can be achieved, particularly regarding job performance.

6.4 LIMITATIONS

6.4.1 Language

English was the language used to conduct the interviews. However, a large portion of the participants did not speak English as a first language. It is therefore possible that questions were incorrectly interpreted despite the researchers' efforts to translate or have someone else translate the questions for participants. As a result, it is possible that the answers may contain deficiencies.

6.4.2 Generalisability

The research approach is qualitative and therefore the findings will not be able to be generalised to the broader population.

6.4.3 Disclosure to employers

Most of the employers were not interviewed, as participants had not disclosed their HIV or AIDS status to them or if they had, they were not comfortable with them being interviewed. This could affect the research findings as the employers may have provided additional insight into understanding the influence of HIV or AIDS on job performance, but which is now lacking.

6.4.4 Quantification of the influence of workplace support programmes

The quantification of the influence of workplace support programmes on job performance was not done as the research was focused on exploring and understanding this relationship. Therefore, the actual size of the influence of workplace support programmes on the job performance of individuals living with HIV or AIDS is not known.

6.5 RECOMMENDATIONS

The following is recommended to enhance the influence of workplace support programmes on the job performance of individuals living with HIV or AIDS:

- (1) Increased national and local government efforts to make the influence of HIV and AIDS known to employers (of any nature or size), particularly how it will affect their bottom line, including individual job performance. This could be achieved through partnerships between business and government, measuring the effects of workplace support programmes implemented on job performance and publishing the results. The aforementioned could lead to best practices specific to certain industries, occupations and or job levels.

(2) Increased efforts by employers to accept personal responsibility for their employees' health and wellbeing. This could be achieved by making HIV and AIDS a strategic imperative and implementing comprehensive workplace support programmes, including appropriate policies. Such programmes should be preceded by a thorough needs analysis. They should be integrated into all organisational processes and levels, contain a range of appropriate benefits, be flexible, affordable, formulated according to the ILO guidelines and involve all role-players, particularly individuals living with HIV or AIDS. Such support programmes should also focus on the capabilities and career options of individuals living with HIV and AIDS to ensure effective placement, utilisation, sustained motivation and maximum job performance.

(3) Increased efforts should be taken by employers to promote awareness, disclosure and acceptance of HIV and AIDS through attending workshops, seminars and presenting on-site education sessions for all employees.

(4) Increased multi-sectoral involvement in initiatives to combat the pandemic, particularly focussing on workplace support programmes and ways that they can be used to achieve this.

(5) Legislation of the employers' obligation to implement workplace support programmes, including a minimum baseline level of support that could reduce or eradicate discrimination and enhance individual quality of life, and thus their job performance.

6.6 FUTURE RESEARCH

In view of the above it is recommended that future research examine the following:

(1) The quantitative extent of the influence of workplace support programmes on the job performance of individuals living with HIV or AIDS, including the influence of such programmes on work that is mainly physical and that which is not.

(2) The influence of the absence of legislation directly enforcing employers to provide workplace support programmes on their efforts to do so voluntarily, and the influence thereof on

job performance.

- (3) The extent of the influence that the provision of workplace support programmes has on the quality of life of individuals living with HIV or AIDS.

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APPENDIX B

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October 2003

Community Health Services
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Dr N. Slinger

**AUTHORITY TO INTERVIEW HIV/AIDS INFECTED PATIENTS/STAFF FOR
MASTER DEGREE RESEARCH**

I am currently completing my thesis for a master's degree in Industrial Psychology at UNISA. The topic of my thesis is, "The influence of workplace support programmes on the job performance of HIV/AIDS infected employees".

The study aims to explore the influence of workplace support programme activities on individuals' job performance. The empirical part of the study will be conducted on HIV/AIDS infected individuals in the Western Cape.

I have decided to focus on HIV/AIDS infected individuals who utilise hospitals, clinics and where possible organisation's within the Western Cape.

My research follows a qualitative approach. Therefore, I intend to interview participants according to a semi-structured interview schedule and verify job performance and absenteeism records with their supervisors.

Due to the sensitivity surrounding the disclosure of ones HIV/AIDS status and the associated experienced or feared discrimination I will make every effort to ensure participant anonymity. I undertake to maintain the confidentiality of records perused, ensure no names or any identifiable characteristics/information of participants are used and to obtain written informed consent from all participants prior to interviewing. A copy of the consent form is attached. I am also registered at the HPCSA as a student psychologist (No PS 0065846). Furthermore, I have enclosed a copy of my research proposal (chapter one) and proposed form concerning informed consent.

I intend commencing the interpretive research during the second week in October 2003 for submission for examination on 28 November 2003.

I request authority to utilise HIV/AIDS infected patients or staff at the Community Health Service Centre as participants for my research.

Your assistance in this matter will be greatly appreciated.

M.S. CLOETE

Enclosure 1: Research Proposal: Chapter One

2: Consent Form

APPENDIX C

Cell no: 0834444315
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October 2003

Groote Schuur Hospital
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Prof T. Zabow

ETHICS COMMITTEE APPROVAL TO INTERVIEW HIV/AIDS INFECTED PATIENTS/STAFF FOR MASTER DEGREE RESEARCH

My letter dated 6 October 2003 and discussions between you and I, today, refer.

I undertake to do the following to ensure that the anonymity, confidentiality and welfare of research participants are protected and ensured:

Only patients and or staff that attend the Groote Schuur outpatient HIV clinic and Lung Institute run by Prof Maartens will be used to recruit possible research participants.

I will only approach patients or staff attending the above once Prof Maartens has told them about the research project and they grant their consent to participate.

Once a patient or staff member has indicated willingness to participate I will arrange to see them at the location where they attend as a patient, with the consent of Prof Maartens. The interview will only commence once I have explained the exact nature and reason for the research to the

participant, obtained his/her written informed consent (see attached form) and explained that they are free to terminate participation when ever they choose.

Participants may use whatever alias they choose when signing the consent form and may also only indicate initials to increase confidentiality.

The interview schedule used does not contain particulars that will enable the participant to be identified.

All interview schedules and consent forms are kept under lock and key.

I also undertake to ensure that no names or any other information that could possibly identify participants will be included in my thesis and article that is eventually published.

Observe the participant's behaviour and reactions during the interview.

Debrief and normalise participants at completion of the interview, prior to their departure.

Where required (I will ask participants), arrange follow up sessions with me under the supervision of a registered industrial psychologist (Mr R Barnes), refer participants to specialist HIV/AIDS counselors at ATTIC and or provide them with contact information regarding the toll-free AIDS help line.

I undertake to take all precautions necessary to protect the welfare of research participants and the integrity of Groote Schuur hospital. Furthermore, the letter of authority by Prof Maartens is attached.

I request the ethics committee approval to interview staff and or patients that attend either of the above sections as part of my research.

Your assistance in this matter will be greatly appreciated.

M.S. CLOETE

Enclosure 1: Consent Form

2: Letter by Prof Maartens

APPENDIX D

APPENDIX E**INTERVIEW SCHEDULE: WORKPLACE SUPPORT PROGRAMMES AND THE INFLUENCE ON HIV/AIDS INFECTED INDIVIDUALS' JOB PERFORMANCE****INTRODUCTION**

The HIV/AIDS pandemic has been identified as the greatest threat facing human beings today. The pandemic affects all spheres of society and the workplace is no different. The effect in the workplace is felt in many ways including increased absenteeism, personnel losses, costs, skills loss, declining morale and decreased productivity. The effects of the pandemic are exacerbated by the negative impact of AIDS related discrimination and stigmatisation, which tend to drive the pandemic underground. This occurs because those infected do not disclose their status for fear of the consequences within the broader society and also the workplace. To counter the effects of the pandemic, organisations have implemented workplace support programmes, which include a variety of activities. However, it is not clear which activities or to what extent they influence HIV/AIDS infected individuals, and thus their job performance.

PURPOSE OF THE INTERVIEW

To understand the influence of workplace support programmes on the job performance of HIV/AIDS infected individuals.

CONFIDENTIALITY, ANONYMITY AND INFORMED CONSENT

All information provided in response to questions asked will be treated confidentially. The utmost care will be taken to ensure that participants remain anonymous. Therefore, names or any other form of identification will not be recorded or attached to the responses provided. You are also requested to provide your written informed consent to partake in this interview, by completing the form provided.

THANK YOU

Thank you for participating in this research project.

INTERVIEW QUESTIONS

BIOGRAPHICAL DETAILS

Gender	M		F		Race		AS		B		C		W	
Age	15 – 20	20 – 25	25 - 30		30 – 35	35 – 40	40 – 45		45 – 50	50 – 55		55 – 60		
Marital status	Married				Single				Divorced					
Occupation	Sector													
Job level	Director	Deputy Director		Assistant Director			Senior Manager		Manager	Supervisor		Worker		
Currently Employed: Length of service	0 – 5		5 – 10		10 – 15	15 – 20	20 – 25		25 – 30	30 - 35		35 – 40		
Currently Unemployed	0 – 5		5 – 10		10 – 15	15 – 20	20 – 25		25 – 30	30 - 35		35 – 40		
HIV positive/ AIDS (years)														
Medical institution	Medical clinic			HIV/AIDS clinic			Hospital			Private practice				
Type	Pvte	LA	Govt	Pvte	LA	Govt	Pvte	LA	Govt					
Affiliation	Patient								Employee					

GENERAL QUESTIONS

1.a. What do you understand by the term “workplace support programme”?

1.b. How does your employer manage HIV/AIDS in the workplace? (Policy/committees)

1.c. What type activities does your employer make available to support employees living with HIV or AIDS in the workplace?

2.a. How did you react or feel when you discovered that you were HIV positive?

2.b. Have you disclosed your HIV/AIDS status to anyone at your workplace (eg. friends, superiors or colleagues)?

Yes	No
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If yes, please answer the following questions

2.c. How has their behaviour and/or reactions toward you been affected as a result of your disclosure? (before and after disclosure)

2.d. How do you feel about yourself as a result of their reaction or behaviour toward you?

2.e. How has the resulting reaction or behaviour by them influenced you and your job performance?

If no, please answer the following questions

2.f. What are your reasons for not disclosing?

2.g. How do you feel as a result of not disclosing your status (in general and about yourself)?

2.h. Does/did anyone at work suspect that you were/are HIV positive (friend, colleague, supervisor)?

2.i. How has their behaviour and/or reactions toward you been affected as a result of their suspicions? (before and after you perceived them to be suspicious)

2.j. How has the resulting reaction or behaviour by them influenced you and your job performance?

2.k. How has not disclosing your HIV/AIDS status influenced your job performance?

3.a. How has your job performance been influenced as a result of HIV/AIDS related illnesses (eg. absenteeism, productivity, goals, targets, errors, accidents, physical ability, concentration)?

3.b. How do your peers/colleagues/superiors/friends at work behave toward you as a result of your changed job performance?

3.c. How has their behaviour toward you influenced you and your job performance?

4.a. What workplace support programme activities have you used or been made available to you?

4.b. How has not disclosing your status at work influenced your use of support made available to Employees living with HIV or AIDS by your employer?

4.c. How long have you been partaking in workplace support programme activities?

5.a. How has partaking/not partaking in workplace support programme activities influenced your job performance and / or you personally?

5.b. Has the availability/non availability of workplace support programme activities influenced your feelings toward your friends/peers/colleagues/supervisors and how (which activities)?

5.c. Has the use/non-use of workplace support programme activities influenced your feelings toward your friends/peers/colleagues/supervisors or employer and how?

5.d. Has any specific workplace support programme activity (ies) had more or less influence on you/your job performance than any other? What are they and why?

6. General Comments

APPENDIX F**INTERVIEW SCHEDULE: WORKPLACE SUPPORT PROGRAMMES AND THE INFLUENCE ON HIV/AIDS INFECTED INDIVIDUALS' JOB PERFORMANCE****INTRODUCTION**

The HIV/AIDS pandemic has been identified as the greatest threat facing human beings today. The pandemic affects all spheres of society and the workplace is no different. The effect in the workplace is felt in many ways including increased absenteeism, personnel losses, costs, skills loss, declining morale and decreased productivity. The effects of the pandemic are exacerbated by the negative impact of AIDS related discrimination and stigmatisation, which tend to drive the pandemic underground. This occurs because those infected do not disclose their status for fear of the consequences within the broader society and also the workplace. To counter the effects of the pandemic, organisations have implemented workplace support programmes, which include a variety of activities. However, it is not clear which activities or to what extent they influence HIV/AIDS infected individuals, and thus their job performance.

PURPOSE OF THE INTERVIEW

To understand the influence of workplace support programmes on the job performance of HIV/AIDS infected individuals.

CONFIDENTIALITY, ANONYMITY AND INFORMED CONSENT

All information provided in response to questions asked will be treated confidentially. The utmost care will be taken to ensure that participants remain anonymous. Therefore, names or any other form of identification will not be recorded or attached to the responses provided. You are also requested to provide your written informed consent to partake in this interview, by completing the form provided.

THANK YOU

Thank you for participating in this research project.

INTERVIEW QUESTIONS**BIOGRAPHICAL DETAILS**

Gender	M		F ✓		Race		AS		B ✓		C		W					
Age	15 – 20		20 – 25		25 – 30		30 – 35 ✓		35 – 40		40 – 45		45 – 50		50 – 55		55 – 60	
Marital status	Married				Single				Divorced				Widow ✓					
Occupation	Domestic worker						Sector						Private dwelling					
Job level	Director		Deputy Director		Assistant Director				Senior Manager				Manager		Supervisor		Worker ✓	
Currently Employed: Length of service	0 – 5		5 – 10		10 – 15 ✓		15 – 20		20 – 25		25 – 30		30 – 35		35 – 40			
Currently Unemployed	0 – 5		5 – 10		10 – 15		15 – 20		20 – 25		25 – 30		30 – 35		35 – 40			
HIV positive/ AIDS (years)	0 – 50 ✓		5 – 10		10 – 15				15 – 20		20 – 25		25 – 30					
Medical institution	Medical clinic				HIV/AIDS clinic				Hospital				Private practice					
Type	Pvte		LA ✓		Govt		Pvte		LA		Govt		Pvte		LA		Govt	
Affiliation	Patient				X				Employee									

GENERAL QUESTIONS

1.a. What do you understand by the term “workplace support programme”?

“Your employers to be there for you and to help you if you have got a problem, even if you are HIV positive”.

1.b. How does your employer manage HIV/AIDS in the workplace? (Policy/committees)

“They accepted it. They manage very well because if I got a problem I talk to them and they understand”.

1.c. What type activities does your employer make available to support employees living with HIV or AIDS in the workplace?

“The most important is that they help me with the treatment (drugs) from the chemist. I pay half

and they pay half. If I don't feel well they will always tell me to take it easy and rest. They advise me to eat healthy and take me to the doctor when I need to go. They also give me time off to see the doctor. They don't have a problem".

2.a. How did you react or feel when you discovered that you were HIV positive?

"In a way I wasn't shocked. I have been reading newspapers and listening to the radio so I was aware of the symptoms. When I got sick I realised something was wrong with me. It was a bit of a shock to me. I hated myself for not using protection as I knew what the media says about AIDS. I was a bit upset with myself".

2.b. Have you disclosed your HIV/AIDS status to anyone at your workplace (eg. friends, superiors or colleagues)?

Yes	No
✓	

If yes, please answer the following questions

2.c. How has their behaviour and/or reactions toward you been affected as a result of your disclosure? (before and after disclosure)

"She treats me the same way as before me and her became aware of my status. She treats me in a way I can't describe. She told me not to give up hope. She is very supportive. She says that there are others also becoming infected and that I am not alone".

2.d. How do you feel about yourself as a result of their reaction or behaviour toward you?

"I feel that she appreciates me, even now that I am HIV positive. Some days I am not well and the way she treats me makes me feel well, not sick. She always asks me in the morning how I am doing. I feel good about myself even though I am sick".

2.e. How has the resulting reaction or behaviour by them influenced you and your job performance?

“Sometimes I am so tired that I can’t do some things. She says I must take things easy, not to be too hard on myself. I do put in more because sometimes I can’t cope during the day. I work overtime to catch up with my work. I want to do more because they make me feel happy in their home”.

If no, please answer the following questions

2.f. What are your reasons for not disclosing?

Not applicable.

2.g. How do you feel as a result of not disclosing your status (in general and about yourself)?

Not applicable.

2.h. Does/did anyone at work suspect that you were/are HIV positive (friend, colleague, supervisor)?

Not applicable.

2.i. How has their behaviour and/or reactions toward you been affected as a result of their suspicions? (before and after you perceived them to be suspicious)

Not applicable.

2.j. How has the resulting reaction or behaviour by them influenced you and your job performance?

Not applicable.

2.k. How has not disclosing your HIV/AIDS status influenced your job performance?

Not applicable.

3.a. How has your job performance been influenced as a result of HIV/AIDS related illnesses (eg. absenteeism, productivity, goals, targets, errors, accidents, physical ability, concentration)?

“I am getting tired. I forget quite a lot, but I am always at work even if I don’t feel well. I think that if I stay away Mrs “Y” will think that I am lazy to come in that day. It is sometimes difficult to lift my arms and legs as they get painful and tired when I walk a lot”.

3.b. How do your peers/colleagues/superiors/friends at work behave toward you as a result of your changed job performance?

“She is not funny at all. For example, yesterday I forgot to put the telephone back after a fax came in for her. She understood. She adjusts my amount of work to my current state of health, but I work the same hours. I don’t have to do everything”.

3.c. How has their behaviour toward you influenced you and your job performance?

“I feel bad because I know I was a hard worker. Sometimes I feel useless. They get people in to wash the windows because I can’t. I try to work harder”.

4.a. What workplace support programme activities have you used or been made available to you?

“Those already mentioned plus rest time when I need it. They also fetch my medicine from Goodwood for me”.

4.b. How has not disclosing your status at work influenced your use of support made available to Employees living with HIV or AIDS by your employer?

Not applicable.

4.c. How long have you been partaking in workplace support programme activities?

“Since 2002”.

5.a. How has partaking/not partaking in workplace support programme activities influenced your job performance and / or you personally?

“It makes me feel proud. Makes me give more than I used to because they really make me happy because if they never helped me with the drugs I would never be able to afford it. I always try to make them happy, as much as they make me happy. I never want to say no. I always want to help them. If I wasn’t a good worker maybe they would have let me go”.

5.b. Has the availability/non availability of workplace support programme activities influenced your feelings toward your friends/peers/colleagues/supervisors and how (which activities)?

Sometimes I feel guilty because they are doing too much for me. I want to do more for them. I am very happy here. The children also accept me even though they know my status”.

5c. Has the use/non-use of workplace support programme activities influenced your feelings toward your friends/peers/colleagues/supervisors or employer and how?

Not applicable.

5.d. Has any specific workplace support programme activity (ies) had more or less influence on you/your job performance than any other? What are they and why?

“Providing medicine is important. However, if they provided me with medicine and were nasty to me I would look for something else. It is not nice if people change when you are sick and don’t treat you the way they used to because of your status. Although being accepted is more important than receiving the medicine, I might have kept up with her nastiness if I could not afford the medicine, as I might die without the medicine”.

6. General Comments

“I think if one does not feel that you get good care from your employer it will make you not happy and you won’t feel good. It will have a negative affect on your work. My friends who have disclosed were treated badly and they feel unwanted”.

APPENDIX G

EMPLOYER OR SUPERVISOR INTERVIEW SCHEDULE

1. What is the nature and type of workplace support programme activities offered to employees who are HIV positive or living with HIV?

2. Describe the employee's job performance before he/she became HIV positive.

3. Describe the employee's job performance after becoming HIV positive, but before disclosure.

4. Describe the employee's job performance after disclosing his/her status.

5. Describe the employee's absenteeism before he/she became HIV positive and disclosed.

6. Describe employee's absenteeism after he/she became HIV positive and disclosed.

7. Describe employee's job performance before he/she was given workplace support.

8. Describe employee's job performance after he/she was given workplace support.

9. Has any specific workplace support programme activity (ies) had any more or less influence on the employee's job performance than any other? Describe them and their influence.

10. General comments

APPENDIX H

EMPLOYER OR SUPERVISOR INTERVIEW SCHEDULE

1. What is the nature and type of workplace support programme activities offered to employees who are HIV positive or living with HIV?

“In the initial stages we took her to the doctor and clinics. We made telephone calls for advice. She took a while before she told us. I suspected it. I still take her to the doctor and hospital. I pay a third of the cost of her tablets. The job keeps her going. I have a good friend that provides me with advice. If she can’t work because she is tired I will give her a day off, it’s up to her. I don’t want to make her feel like an invalid. I treat her like anybody else otherwise she dwells on it which does more harm than good”.

2. Describe the employee’s job performance before he/she became HIV positive.

“Before she became HIV positive she worked fine, except when she got TB and lost weight suddenly”.

3. Describe the employee’s job performance after becoming HIV positive, but before disclosure.

“She started to become forgetful. She became a bit slack, although it’s nothing that I am not pleased with. She becomes slower and tired, but the overall quality is still fine.”

4. Describe the employee’s job performance after disclosing his/her status.

“Same as question three”.

5. Describe the employee's absenteeism before he/she became HIV positive and disclosed.

"She was very reliable. She used to be off maybe twice a year before".

6. Describe employee's absenteeism after he/she became HIV positive and disclosed.

"In the middle of 2002 she was off for a week. She is also off one day per month to go to the doctor and clinic. However, she puts in extra hours. She has been here a long time. I can trust her. She comes in some days even when she is not well. I am glad she disclosed. Now she can get help".

7. Describe employee's job performance before he/she was given workplace support.

"Her job performance is fine. She is working like normal. She just gets headaches and forgets".

8. Describe employee's job performance after he/she was given workplace support.

"If we did not support her after disclosure she would have been dead. She was going one way as her CD four count was very low. Now I would think her job performance is fine".

9. Has any specific workplace support programme activity (ies) had any more or less influence on the employee's job performance than any other? Describe them and their influence.

"Both medication and emotional support are important. Medication is important as it prolongs life. If I don't assist I am basically saying that she will die. If you treat people differently it becomes all consuming. We are supportive, listen to her, talk to her and give her a lot of empathy".

10. General comments

"I told her that she must be responsible with her health (eg wear gloves)".