An evaluation of the efficacy of a HIV and AIDS management system in a multinational manufacturing organisation in KwaZulu-Natal

by

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Submitted in fulfilment of the requirements of the full degree of

Master of Technology: Nursing

In the Faculty of Health Sciences

Durban University of Technology

November 2011

Approved for Final Submission

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ABSTRACT

South Africa is currently at the epicentre of the AIDS epidemic with 5.6 million people living with HIV disease. The province of KwaZulu-Natal has the biggest burden with an antenatal HIV prevalence of 39.5% in 2010. It is estimated that 24.5% of South Africa's working age population is HIV positive.

Most infected people living with HIV in Africa are between ages 15 and 50 years which is the peak working age. AIDS now causes more deaths and suffering among the 18-44 year age group than any other disease. Organisations clearly present as one of the most effective and significant settings in which to respond to the epidemic. The effective management of HIV and AIDS within organisations is critical in order to reduce the negative consequences of the epidemic on the economy.

HIV and AIDS Management Systems (HAMS) within organisations have been implemented for approximately twenty years but they have been largely ineffective, mainly due to poor uptake of services. Therefore, there is a need for HAMS practice to be evaluated in relation to current best practice standards to ensure quality management, continual improvement and successful uptake of services.

This qualitative study evaluated one organisation's HAMS in relation to SANS 16001 and described employees' experiences of HAMS in this setting. The theoretical framework underpinning this study is the Deming cycle which is a well known quality management system methodology.

From the results of the study it was apparent that the organisation was aligned with most of SANS 16001 general requirements for HAMS. Employees experienced the intended benefits of prevention, treatment and support from the organisation's HAMS.

ACKNOWLEDGEMENTS

I dedicate this dissertation to all people living with HIV and AIDS.

I would like to acknowledge the following people without whom I would never have succeeded in completing this dissertation:

Mrs Penny Orton from the Durban University of Technology – thank you for your expertise on qualitative studies, assistance and ongoing support through all the challenges.

Doctor Shalini Singh from the Durban University of Technology – thank you for your support, technical knowledge and expertise in Quality Management which complemented my study.

Professor Kathleen Nokes from the City University of New York, Hunter College – thank you for your expertise, guidance and significant contribution.

Doctor Nokuthula Sibiya from the Durban University of Technology – thank you for your unwavering support. Your commitment to the education and progress of nurses is appreciated.

I thank the organisation for allowing me to undertake the study. A special note of thanks to all the participants of the study especially the HIV positive employees and Peer Educators who added real meaning to the study.

To my mentor Mr Jan Schlebusch, thank you for believing in me. My success is due to your support and passion for the organisation's HIV programme.

To the love of my life and husband, Clive Pillay; I realised my passion and dream because of your unconditional love, patience and support, thank you.
Nothing is achieved without the one who makes all things possible, our loving heavenly Father, Jehovah.

DECLARATION BY CANDIDATE

I, Mrs Annezt Louise Pillay;

We, Mrs Penny Orton, the supervisor and Dr Shalini Singh, the joint supervisor do hereby declare that in respect of the following dissertation/thesis:

An evaluation of the efficacy of a Human Immune-deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) Management System [HAMS] in a multinational manufacturing organisation in KwaZulu-Natal

(1.) As far as we know and can ascertain:
(a) no other similar dissertation/thesis exists.

(2.) all references as detailed in the dissertation are complete in terms of all personal communications engaged in and published works consulted.

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Signature of student	Date
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Signature of Supervisor	Date
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Signature of Joint Supervisor	Date

GLOSSARY OF TERMS

HIV and AIDS Management System (HAMS):

Part of an organisation's management system used to develop and implement its HIV and AIDS policy and manage its HIV and AIDS determinants. A management system is a set of interrelated elements used to establish policy and objectives and to achieve those objectives. The management system includes organisational structure, planning activities, responsibilities, practices, procedures, processes and resources (Standards South Africa, 2007:3). In this study, HAMS means the organisation's HIV and AIDS management system.

South African National Standard (SANS) 16001:

This standard specifies general requirements for HIV and AIDS management systems (HAMS). It is applicable to any organisation that wishes to establish, implement, maintain and improve an HIV and AIDS management system (Standards South Africa, 2007:i).

Continual Improvement:

A recurring process of enhancing the HIV and AIDS management system in order to achieve improvements in overall HIV and AIDS management performance consistent with the organisation's HIV and AIDS policy and procedures (Standards South Africa, 2007:3).

Organisation:

A business organisation that makes money by producing or selling goods or an association of persons trading for purposes of profit (Hornby, 2006:1).

Workplace:

It provides an environment that enables work to be done by workers that have knowledge of producing economic value. This environment provides workers with resources, training and physical well-being to promote productivity (Hornby, 2006:2).

Permanent employee:

In the context of the study, permanent employees work for the organisation and are paid by the organisation on a weekly or monthly basis. In addition to their salaries, they receive benefits like subsidised medical aid, paid annual leave, sick leave and contributions to a provident or pension fund. They are eligible to join a union.

HIV:

The Human Immune-deficiency Virus, a virus that weakens the body's immune system, ultimately causing AIDS (International Labour Organisation, 2001:ii).

AIDS:

The Acquired Immune Deficiency Syndrome, a cluster of medical conditions, often referred to as opportunistic infections and cancers for which, to date there is no cure (International Labour Organisation, 2001:ii).

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OVERVIEW OF THE STUDY

1.1 Introduction

The global workforce has lost 28 million economically active people to AIDS and an estimated 48 million workers will be lost by 2010 and 74 million by 2015 (International Labour Organisation, 2010:1). According to the International Labour Organisation (2010:2) the impact of HIV and AIDS threatens the fulfilment of the goal for decent work for all because the loss of workers leads to a decrease in labour force growth. This imposes a heavy burden on families, communities and economies due to slowed income growth (Statistics South Africa, 2010:6).

South Africa has endured the highest HIV prevalence rates in the world and has now entered its third decade of the epidemic (Evian, 2011b:1). Employees that were silently infected in the previous ten years are now likely to manifest with illness and death (Evian, 2007:1). Therefore, HIV and AIDS appears to be the biggest threat to South African industry. It has been noted by Shozi (2009 pers. comm. 11 September) that organisations are impacted largely because human resources are the biggest investment and the profits of organisations depend on people.

The organisation employs individuals (N=969) aged from 20 to 63 years (retirement age). This includes the age group that is greatest at risk for HIV, specifically those between 15 and 50 years of age which is the period in people's lives in which they are likely to be most sexually active (Barnett and Whiteside, 2002:3).

In addition, this industry contains a demographic profile of predominantly black employees who are particularly vulnerable to HIV infection due to lower income and literacy levels and the need to migrate from home to seek work (HIV and AIDS in South Africa, 2008:8; Barnett and Whiteside, 2002:2). For the ongoing sustainability of the organisation and the overall health of employees and their families, it is imperative that industry responds to HIV and AIDS.

HIV prevalence surveillance is a feature of the organisation's Human Immune-deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) Management System (HAMS) and has given the organisation data on the size, distribution and trends of the epidemic among its workforce. An initial HIV prevalence survey of permanent employees was conducted in July 2001 revealing a rate of 15.7%; follow up surveys were conducted in August 2004, September, 2007, and May 2011 which yielded decreasing rates of 16.2%, 14.2%, and 13.8% respectively (Evian, 2011a:4).

The organisation implemented an HIV treatment programme in 2003. Evian (2007:1) suggested that the organisation was one of the first organisations in South Africa to provide Anti-retroviral Treatment (ART) for its employees. Despite this benefit the organisation experienced poor registration of HIV positive employees on the HIV treatment programme which is explained further under Problem Statement.

The HAMS had never been evaluated against a recognised standard for continual improvement. The need for evaluation of HAMS is strengthened due to poor uptake of the HIV treatment programme and the economic downturn which warrants justification of expenditure.

Anti-Retroviral Therapy (ART) can offer people with HIV many more years of healthy and productive life and can mitigate against the potential impact of AIDS within organisations (Evian, 2007:1).

However there are challenges, which include diagnosing HIV infection among employees, enrolment on the HIV programme, ensuring that employees are adequately managed and adhere to therapy, and prevention and treatment of any drug toxicities and side effects. In addition, the organisation needs to intensify the prevention of new HIV infections (Evian, 2007:2).

The impact of HIV and AIDS has been well publicised which should be taken seriously if organisations are to be sustainable (Rosen et al, 2007:1).
Organisations can take control of the effects of HIV and AIDS on their business by implementing SANS 16001 which is a recognised HIV management system that is built on quality management principles to ensure that HAMS meets all customer requirements to deliver results.

This qualitative study evaluated HAMS in relation to SANS 16001, the intended benefits of HAMS, the experiences of HIV positive employees who are registered on the organisation HIV treatment programme and the experiences of HIV positive employees who are not registered on the organisation HIV treatment programme. The theoretical framework underpinning this study is the Deming cycle which is known as a quality management system methodology.

1.2 Problem Statement

HIV and AIDS Management Systems (HAMS) within organisations have been implemented for between 10 to 20 years without any auditable and certifiable standards and therefore HAMS are not seeing a good return on investment (Smith, 2009:1). Reports on HIV and AIDS management focus on activities rather than outcomes or impacts (SABCOHA, 2009b:3). Monitoring and evaluation of the implemented HAMS has therefore been difficult.

Out of a total employee population of 969 of this organisation, the HIV prevalence study in 2007 extrapolated that 141 (14.6%) employees were HIV positive (Evian, 2007:4). The organisation's 2009 HIV records revealed that 91 cases of the predicted HIV positive employees were known and 50 cases needed to be identified.

Of the 91 known cases, 41 were registered with Qualsa, 12 were managed by different medical aids with the assistance of the Clinic; 8 were managed by different medical aids without assistance of the Clinic; 3 had refused assistance; 5 were managed by government clinics; 18 had died; and 6 had left the organisation. A total of 15 eligible cases were managed outside of the organisation's contracted medical service.

In addition, a total of 990 HIV tests were conducted for the financial year of 2009. The number of HIV tests conducted for the first time was 320 and 670 HIV tests were repeated. A total of 50 employees tested HIV positive, however only 11 (22%) accessed services through the organisation's initiatives.

There is a need to explore the reasons why eligible employees are not accessing the available care and treatment since being tested HIV positive is an entry point to health care which decreases morbidity and mortality due to AIDS. The economic benefits to the organisation of providing care and treatment for HIV positive employees are increased productivity, savings on absenteeism and savings on disability and benefit claims (Rosen et al, 2007). This points to a fundamental need to evaluate HAMS against the SANS 16001 standard in order to better manage the outcomes of HIV interventions as good business practice.

1.3 Position of researcher

I am a Registered Nurse, Midwife, Community Nurse and Psychiatric Nurse. Additionally, I have a degree in Occupational Health Nursing which furnished me with adequate grounding in workplace health promotion models which I have applied successfully to occupational settings. My previous position was as a senior occupational health nurse in a large motor manufacturing organisation.

I am currently employed as an Employee Wellbeing Coordinator. Apart from my other responsibilities, I am the appointed HIV and AIDS coordinator for the organisation in which the research for this study was conducted. My primary responsibility is to implement training, give guidance, create awareness and manage the organisation's HAMS.

My inherent passion for HIV and AIDS, communication skills, experience from heavy manufacturing environments and fluency in the local isiZulu language and customs may have contributed to the success I have experienced in attaining high HIV Counselling and Testing (HCT) statistics in the last three organisations where I was employed.

The HCT statistics of the current organisation have increased exponentially since 2008 as a result of a concerted team effort. However, a new challenge arose when an increasing number of employees who were diagnosed HIV positive refused to be registered on the organisation's HIV treatment programme. This phenomenon concerned me since I have witnessed immune-compromised employees respond extremely well to Anti-Retroviral Treatment (ART), recover and return to work in order to support their families.

HIV is surrounded by stigma and myths which hinder living openly with the disease and accessing treatment and care. We need to change our attitude and stop viewing HIV and AIDS as a hopeless situation because there is now good news about HIV; it is a treatable infection and people with HIV now have a future (Evian, 2011b:6).

In my opinion, the HIV and AIDS coordinator is in an ideal position to describe HAMS and employees experiences on the organisation's HIV treatment programme because she is familiar with HAMS and HIV positive employees within the organisation.

I have been impacted by the effects of HIV in organisations and in society which has resulted in me adopting a humanistic view regarding the disease.

1.4 Statement of purpose

The purpose of this study is to evaluate HAMS in this organisation in relation to SANS 16001.

1.5 Research Objectives

- To evaluate the organisation's HAMS in relation to SANS 16001; and
- To describe the experiences of HIV positive employees.

1.6 Research Questions

1. Is the organisation's HAMS aligned to SANS 16001 in a paper manufacturing organisation?
2. What are the intended benefits of HAMS?
3. What are the experiences of HIV positive employees who are registered in the organisation's HIV treatment programme?
4. What are the experiences of HIV positive employees who are not registered in the organisation's HIV treatment programme?

1.7 Rationale for the Study

Evian (2011b:6) states that HIV and AIDS, together with malaria and Tuberculosis (TB), are now Africa's most severe and costly epidemic. The effective management of HIV and AIDS within workplaces is essential to reduce the negative consequences of the epidemic on the economy (Evian, 2007:2; Vass and Phakathi, 2006:5).

The organisation in which the research was conducted is situated in a location known as, 'the HIV and AIDS capital of South Africa' which has a high rate of poverty, poor health care systems and limited basic resources (Dickinson, 2006a:240; Whiteside and Lee, 2005:19). Thus ongoing monitoring and evaluation of HAMS is essential to mitigate the impact of HIV and AIDS in the workplace.

This research provided insight into how the HAMS was performing against a recognised standard in a specific organisation. It evaluated the strengths and weaknesses of the different elements of HAMS for continual improvement. The research described employees' experiences of HAMS which may have influenced treatment uptake and suggested methods to improve the organisation's HIV and AIDS treatment uptake. Findings of this research can be used to inform decision makers regarding factors that will improve HAMS implementation in this organisation.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

South Africa's history has made it a fertile ground for the spread of HIV (Barnett and Whiteside, 2002:3; Hamoudi, 2000:4). The South African political system was based on racial discrimination which was institutionalised and legalised after 1948 (Barnett and Whiteside, 2002:2). In 1990 the African National Congress (ANC) was unbanned and brought South Africa to its first democratic election in 1994 (Whiteside and Lee, 2005:6). When the new government came into power in 1994 it was confronted with many challenges and HIV did not seem to be a priority (Whiteside and Lee, 2005:6).

In 1994 the national antenatal HIV prevalence was 7.6% and 14.4% in Kwa-Zulu Natal (Department of Health, 2007b:9). An explosion in the HIV prevalence occurred during the 1990s with an estimated adult HIV prevalence of 19.94% at the end of 1999 (Barnett and Whiteside, 2002:11). The most rapid increase of diagnosed HIV in South Africa took place between 1993 and 2000, during which time the country was distracted by major political changes and the focus was on the transition from apartheid to democracy (HIV and AIDS in South Africa, 2008:2). By the second democratic election in 1999 the national antenatal HIV prevalence had risen to 22.4% (Department of Health, 2007b:9).

Campbell (2003:4) criticised the failure of the South African Government to develop a unified position about how to address the AIDS crisis in South Africa and failure to exercise strong leadership in this position. Alongside the previous President Mbeki's questioning of whether HIV really causes AIDS, the late health minister Manto Tshabalala-Msimang caused controversy by promoting nutrition rather than anti-retroviral drugs as means of treating HIV (HIV and AIDS in South Africa, 2008; Campbell, 2003:4). These views attracted widespread criticism, both within South Africa and the international community (HIV and AIDS in South Africa, 2008).

In contrast, the success in reducing the adult prevalence of HIV in Uganda to 5.4% in 2006 was as the result of a broad-based national effort backed up by high level political commitment to HIV prevention and care, including the personal involvement of President Yoweri Museveni (UNAIDS, 2008:43; Campbell, 2003:6). In 1987 Uganda's AIDS control programme formulated a five-year plan with the assistance of the World Health Organisation (WHO) with the main principles of the campaign being openness and frankness (HIV and AIDS in South Africa, 2008). This initiative showed that with the right political will and commitment a reduction in the prevalence of HIV can be realised.

The year 2009 saw a change in leadership in the South African government. President Jacob Zuma's approach to expand AIDS treatment was welcomed by activists and this marked a change from his condemnation in 2006 when he admitted at a trial for rape, of which he was acquitted, that he had unprotected sex with an HIV positive woman and then showered to cut the risk of infection (Govender, 2009:1). "Let today be the dawn of a new era," President Zuma said in drawing a line under the AIDS denialism of South Africa's recent past as he announced plans on 1 December 2009 to expand access to treatment for people living with HIV and AIDS and urged every citizen to help curb infection rates (Mbanjwa, 2009:1). Critics question whether these plans will be sustainable in light of the recent shortage of AIDS treatment in the Free State, staff shortages and failing financial resources (Mbanjwa, 2009:2) and a decline in funding from international donors.

2.2. Burden of HIV

2.2.1 International

The overall growth of the global AIDS epidemic appears to have stabilised.

UNAIDS estimated that that the number of people living with HIV worldwide in 2009 was 33.3 million compared to 26.2 million in 1999 which was a 27% increase. There were 2.6 million new HIV infections and 1.8 million HIV related deaths in 2009 (UNAIDS, 2010:23). This trend reflects a combination of factors, including the impact of HIV prevention efforts and the natural course of HIV epidemics (UNAIDS, 2010:20).

Although the annual number of new HIV infections has been steadily declining, this decrease is counterbalanced by the reduction in AIDS-related deaths due to the significant scale up of anti-retroviral therapy (UNAIDS, 2010:23). Therefore, with significant reductions in mortality the number of people living with HIV worldwide has increased.

2.2.2 In Africa

Sub-Saharan Africa continues to bear an inordinate share of the global HIV burden and is home to 68% of all people living with HIV, a total of 22.5 million and accounting for 72% of deaths in 2009 (UNAIDS, 2010:25). The proportion of women living with HIV has remained stable, at slightly less than 52% of the global total (UNAIDS, 2010:23). In Africa, AIDS kills ten times more people a year than war (Barnett and Whiteside, 2002:10). Although the rate of new HIV infections has decreased, the total number of people living with HIV continues to rise, mainly due to decreased mortality related to HIV treatment.

2.2.3 In South Africa

South Africa remains the area most heavily affected by the epidemic and is home to the world's largest population of people living with HIV – 5.6 million (UNAIDS, 2010:28). New indications show a slowing of HIV incidence accompanied by some signs of a shift towards safer sex among young people (UNAIDS, 2010:28). There is still no evidence of a decline in infections among pregnant women, where 29.4% of women accessing public health services tested HIV positive in 2009 (Department of Health, 2010a:3).

The national adult (15-49 years) HIV prevalence was 17.3 % in the mid-year population statistics for 2010 which is a slight increase from 17% in 2009 (South Africa, 2010:6). Evian (2011b:3) estimates that 25-40% of young adults are infected with HIV in South Africa.

2.2.4 In KwaZulu-Natal

The provincial antenatal HIV prevalence in KwaZulu-Natal (KZN) remained at 39.1% in 2005 and 2006 (Department of Health, 2009:11). In 2007 the figure decreased to 38.7% and remained at 38.7% in 2008 (Department of Health, 2010a:4). The South African government therefore claimed that the HIV epidemic was beginning to stabilize in 2007 (Department of Health, 2009:11). HIV and AIDS in South Africa (2008) argued that the epidemic was stabilising at a very high level. The antenatal HIV prevalence increased to 39.5% in 2009 and remained stabilised at 39.5% in 2010, which is still the highest in South Africa (Department of Health, 2011:8).

2.3 Demographic Impact

In South Africa the overall average life expectancy at birth had declined between 2001 and 2005 but has since increased partly due to the roll-out of anti-retroviral treatment. For 2010, life expectancy at birth is estimated at 53,3 years for males and 55,2 years for females (Statistics South Africa, 2010:6).

Women account for half of all people living with HIV worldwide and nearly 60% of HIV infections in Sub-Saharan Africa (UNAIDS, 2008:33). Whiteside and Lee (2005) stated that women are disproportionably infected by HIV and likely to die younger if untreated. As a possible consequence of the overall global economic downturn, intergenerational sex between older men and younger women underscored by gifts is on the increase which compounds this problem (UNAIDS, 2008:109). Women are more affected due to gender based violence and economic dependence on older men (UNAIDS, 2010:130).

In his study, Hunter (2001:11) found that the economic position of women intensifies the inequalities between men and women. Many women rely on multiple sexual partners to survive. Residents in KwaZulu-Natal stated that women are forced to have “one man for food, one for rent and one for clothes” (Hunter, 2001:23). This is also fuelled by the high social value some men place on having multiple girlfriends and polygamy is used to justify it whilst a very small amount of these relationships lead to marriage (Hunter, 2001:24).

In countries where HIV is primarily spread through sexual transmission, the peak of infection is 30-40 years because this is the age group that is more financially stable and can afford to have multiple sexual partners (Barnett and Whiteside, 2002:14). The peak ages of death are 5-10 years later without treatment intervention (Barnett and Whiteside, 2002:14). There is an increase in mortality of people mainly in their 20s, 30s and 40s due to being more sexually active than other age groups (Whiteside and Lee, 2005:2). These are the most economically productive years of adults and their illness or death inevitably reduces household income (Barnett and Whiteside, 2002:12; Hamoudi, 2000:4).

Kwa-Zulu Natal and Eastern Cape are two of the poorest provinces in South Africa (Lehutso-Phooko and Naidoo, 2003:4). The relationship between inequality, poverty and HIV and AIDS is observable (Barnett and Whiteside, 2002:13). Similarly Debswana, a Diamond mine in Botswana found that the highest HIV prevalence was in groups with the lowest skill requirements and income (Barnett and Whiteside, 2002:14).

2.4 South African response to HIV and AIDS

In 1992, the National AIDS Coordinating Committee of South Africa (NACOSA) was launched with a mandate to develop a national strategy on HIV and AIDS. In 1999, through a consultative process with stakeholders, a National Strategic Plan (NSP 2000-2005) was developed and has been the cornerstone of the response in mitigating the impact of HIV and AIDS. Its aim was to strengthen the implementation of the recommendations of the NACOSA Plan and review as well as enhance the national response to HIV and AIDS, Sexually Transmitted Infections (STIs) and Tuberculosis (TB). An assessment of the NSP 2000-2005 was carried out and its findings and recommendations were used to inform the NSP 2007-2011.

The NSP 2007-2011 has two primary aims which are to halve new HIV infections by 2011 and ensure that 80% of people living with HIV have access to treatment (Department of Health, 2007a:2). The plan has identified nineteen goals that are needed to reach the NSP's aims and these are structured under four key priority areas namely:

- prevention;
- treatment, care and support;
- research, monitoring and surveillance; and
- human rights and access to justice.

Each of the goals has specific objectives with intended interventions and annual targets for the period 2007-2011 (Department of Health, 2007a:3). However, Booth (2008) criticised the NSP for acknowledging that the major driver of HIV transmission in South Africa is heterosexual transmission but failed to link prevention measures to behavioural change or social change strategy.

South Africa has made remarkable progress in rolling out anti-retroviral (ARV) treatment, with the largest number of people enrolled on ARVs in the world. Approximately 56% of adults and children in need of ARVs are on treatment through the public sector as of 30 November 2009. By the end of November 2009, 833,653 adults and 86,270 children (under age 15) were on treatment which is an increase of 30% of children enrolled in ART and an increase of 26% in adult treatment from 2008 to 2009.

The South African ART programme reached 81% of children in need of ARVs in 2009 and 55% of adults in need; which has translated into fewer AIDS-related deaths (Department of Health, 2010b:44). Due to the limitations experienced by the public sector in providing ART, a need has arisen for organisations to offer treatment to infected employees to help facilitate national goals.

The primary goal of ART is to decrease the HIV viral load which is associated with decreased morbidity and mortality. The secondary goal is to decrease the incidence of HIV through an increase in HIV counselling and testing with more people knowing their status and practicing safer sex; reducing transmission in discordant couples (where one partner is HIV negative and the other partner is HIV positive) and reducing the risks of HIV transmission from mother to child (Department of Health, 2004:44). Studies reveal that ART lowers the rate of HIV transmission in heterosexual discordant couples (Thomas, 2010:1; Thaczuk and Carter, 2009:1). This suggests that ART reduces the community pool of HIV and decreases the transmission of HIV in general.

The National Anti-retroviral Treatment Guidelines were developed to set standards for the use of ART drugs in South Africa on which training and support programmes should be based (Department of Health, 2004:6). An effective ART programme requires more than just the drugs. Establishing adequate well-trained health care professionals, laboratory technicians, pharmacists and community workers is critical for the success of this programme (Department of Health, 2004:6). This will require finances which will increase the challenges for accessibility to ART.

2.5 Stigma and discrimination

AIDS-related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS (PLWHA) (HIV and AIDS stigma and discrimination, 2011:1). While there are many illnesses such as leprosy that have been severely stigmatised in the past, it is generally agreed that HIV and AIDS is the most stigmatised medical condition in the history of humankind (International conference on stigma, 2011:2).

It can result in people living with HIV and AIDS (PLWHA) being shunned by family, peers and the wider community; poor treatment in healthcare and education settings; and an erosion of rights and psychological damage (HIV and AIDS Stigma and discrimination, 2011:3).

In KwaZulu-Natal neighbours murdered Gugu Dlamini in 1999 for revealing her HIV positive status because they felt that she brought shame upon the community (Barnett and Whiteside, 2002:12). Stigma persists despite the estimation that 60-80% of African women with HIV had only one partner and were infected because they could not negotiate safe sex or prevent their partners from having additional sexual partners (Barnett and Whiteside, 2002:183; Kometsi, 2004:2).

Increasing evidence from UNAIDS (2010:112) contradicts the commonly held view that the vast majority of people newly infected with HIV in sub-Saharan Africa are infected as a result of unprotected sex with multiple partners. The evidence suggests that the majority of people newly infected through heterosexual transmission are infected within marriage or cohabitation and as heterosexual epidemics evolve, the numbers of discordant couples (where only one person is infected with HIV) increase and HIV transmission within long-term relationships increases (UNAIDS, 2010:112).

Fear of stigma and discrimination was cited as the main reason why people are reluctant to be tested, to disclose their HIV status or take anti-retroviral drugs (HIV and AIDS Stigma and discrimination, 2011:2; International conference on stigma, 2011:1; Okechukwu, 2007;2; UNAIDS, 2010:120). Several countries reported that stigma and discrimination in health care facilities adversely affect access to and the provision of services (UNAIDS, 2010:120). It was noted that some health care personnel are likely to discriminate against PLWHA and deny services to population groups at higher risk such as sex workers and men who have sex with men, or treat people who inject drugs as “delinquents” (UNAIDS, 2010:134).

Some PLWHA experienced a lack of confidentiality and reported receiving HIV testing without their informed consent (HIV and AIDS Stigma and discrimination, 2011; International conference on stigma, 2011; Okechukwu, 2007). Lack of confidentiality has been repeatedly found to be a problem in health care settings (HIV and AIDS Stigma and discrimination, 2011:3; International conference on stigma, 2011:2; Okechukwu, 2007:5; UNAIDS, 2010:126).

Stigma and discrimination was revealed to be a major obstacle to HIV counselling and testing, and treatment uptake in several workplace HIV programmes (Bhagwanjee, Govender, Akintola, Petersen, George, Johnstone and Naidoo, 2011:358; Dahab, Kielmann, Charalambous, Karstaedt, Hamilton, La Grange, Fielding, Churchyard and Grant, 2011:53; George et al, 2009:5; Phooko, 2009:2; Bhagwanjee et al 2008:274; Ramnarain, 2008:139; Dickinson, 2006a:246). A national research project by Conyers, Boomer and McMahon (2005:37) further suggest that HIV related employment discrimination is stigmatized more than other disability groups.

Stigma and discrimination around HIV and AIDS lowers the workforce morale resulting in workplace HIV programmes being undermined which prevents employees from being open about their status and accessing treatment and care (Dickinson, 2003:6). A less effective workplace HIV programme wastes resources and raises the cost of HIV and AIDS to the organisation (Dickinson, 2003:6). Organisations that link HIV status to employment or provide medical benefits that do not include proper treatment and coverage of HIV and AIDS are open to discrimination claims (Geffen and Blatt, 2003:4).

2.6 Impact of HIV on industry

Critics estimate that South African business and the country's economy are losing millions of Rands each year to HIV and AIDS (Van Schalkwyk, 2008:2). In contrast, a study of organisations in Sub-Saharan Africa and South Africa found that the average cost per employee lost to AIDS varied from 0.5 to 5.6 times the average annual compensation of the employee affected (Rosen et al, 2007:1).

The authors explained that this is a conservative estimate of the true cost because direct costs associated with morbidity, loss of productivity as a result of absenteeism, diminished performance when at work (so-called 'impaired presenteeism') and reduced productivity due to employee inexperience were harder to quantify because productivity could not be observed directly (Rosen et al, 2007:1).

Other direct costs were organisation benefits, increase in the size of the workforce and the overall cost of wages, increase in recruitment and training costs and the need to retrain and rehire workers (SABCOHA, 2009a:1; Rosen et al, 2007:2, Whiteside and Lee, 2005:22). Indirect costs to organisations were loss of morale among employees, poor labour relations and a reduction in customers and investors (SABCOHA, 2009a:2; Rosen et al, 2007:3; Dickinson, 2006:6).

The costs of employee benefits to the organisation, depending on conditions of employment such as a lump sum payment on death, a spouse's pension and a disability pension, increases due to increased mortality and morbidity from AIDS (Barnett and Whiteside, 2002:22; Naidoo, 2002:2). In South Africa many organisations offer group life insurance; if an employee dies in service the estate receives a multiple of annual salary. This is negotiated with the insurance organisation annually and can be altered to take account of actuarial calculations of cost (Barnett and Whiteside, 2002:5). If claims go up in any year premiums rise and employers and employees have the choice of paying more for the same cover or reducing benefits (Barnett and Whiteside, 2002:5).

In non-agriculture organisations it was found that in their last two years of service, employees who died of AIDS or suspected of AIDS were absent from work between 18 and 50 days more than other employees which was equivalent to 1-3 months of lost working time over 24 months (Rosen et al, 2007:S41). Manual workers, for example tea pluckers, with HIV and AIDS were approximately 25-30% less productive over their last two years of service (Rosen et al, 2007:2).

A study in Kenya examined the impact of HIV and AIDS on productivity of workers who died from AIDS. In their last two years of life, they produced roughly one third less than the other workers (Fox et al 2003:3). It was proven that productivity declines as AIDS progresses.

2.7 The role of business in HIV and AIDS

Urbanization results in migration and mobility from rural to urban areas in search of employment which creates patterns of sexual behaviour and social interactions which are perfect for the spread of sexually transmitted diseases (STI) (Barnett and Whiteside, 2002:4). Infected men return to their home communities, often in rural communities with limited healthcare services, and local epidemics are established (Barnett and Whiteside, 2002:3).

Among the factors that increase individual susceptibility to infection are active or poorly treated STIs, the use of alcohol and high numbers of lifetime sexual partners (Barnett and Whiteside, 2002:3). This suggests that the risk of contracting HIV is higher amongst migrant workers who do not go home to their wives on a daily basis which implies that the prevalence of HIV within organisations in urban areas who employ migrant workers can potentially be increased.

An estimated two out of every three people living with HIV go to work every day thus making workplaces the ideal environment for tackling the epidemic as employers and employees are in an environment that makes the dissemination of information and education programmes possible (UNAIDS, 2008:2; Van Schalkwyk, 2008:4).

Business can play a leading role in alleviating the HIV and AIDS crisis by implementing an effective workplace HIV and AIDS management system (Geffen and Blatt, 2003). By effectively intervening in the epidemic, business can minimise its financial losses due to the epidemic, alleviate some of the burden on the public health sector and encourage government to better meet its Constitutional duties to protect life and dignity (Geffen and Blatt, 2003:3).

2.8 Workplace HIV and AIDS Management Systems (HAMS)

2.8.1 Historical background: mining industry

Debswana, Botswana's largest employer with 11 mining and related operations and the biggest contributor to Botswana's revenues through diamonds, formed a 50-50 partnership between South Africa's De Beers and the Botswana government to wage a multi-fronted fight against HIV and AIDS. The organisation came up with a programme called Aid for AIDS in 2002 which trained 200 employees from five mines as peer educators who were effective in educating employees. To combat HIV related deaths, Debswana has been providing Anti-Retroviral Therapy (ART) drugs since 2001 to employees, one spouse or partner and children (Mukumbira, 2003:2). The mine held an institutional audit that was considerably broader than an accountancy approach and enabled the organisation to respond to the potential impact on a wider front (UNAIDS, 2002:6).

As a result, Debswana became renowned as a global benchmark in responding to HIV and AIDS (UNAIDS, 2002:6) in the workplace. In February 2003 with funding from the American government, Botswana became the first country in Southern Africa to start providing free ART drugs and Debswana took advantage of these services. The advantage to the government was the increased access to ART without infrastructural and staff costs. According to the country's Heath Minister, Lesego Motsumi this collaboration was an excellent example of a public-private partnership (Mukumbira, 2003:2).

The De Beers group which is the largest diamond mining industry in the world recognised the need for a progressive and innovative approach to meet the threat posed by the HIV epidemic. The organisation has three shareholders comprising Anglo American (45%), Central Holdings (40%) and the Government of the Republic of Botswana (15%). De Beers received an International HIV and AIDS award from the Global Business Coalition in 2005 in relation to its HIV Counselling and Testing (HCT) services.

These services are available to De Beers employees, their spouses, contractors and where possible to community members. De Beers has a peer educator programme where volunteer employees engage their colleagues and encourage HCT. These programmes were enacted in partnership with the South African National Union of Mineworkers (Mining Weekly, 2005:1).

Anglo American has firmly maintained its position as a global corporate leader in the fight against HIV and AIDS since 1990 with an approach that balances prevention, care, support and treatment. Their focus is on outcomes rather than processes (Anglo American continues its global leadership in the fight against HIV/AIDS 2009). In June 2009, Anglo Coal South Africa was recognised as having the best organisational HIV and AIDS programme in the world by the Global Business Coalition on HIV and AIDS, Tuberculosis and Malaria at the organisation's Business Excellence Awards (Wyatt-Tilby, 2009:1).

2.8.2 Other organisations

Alexander Forbes' Direct AIDS Intervention (DAI) programme is an integrated programme that shifted from managing HIV and AIDS as a separate programme to the management of wellness in a more holistic approach which destigmatises HIV and AIDS and provides a broader perspective on the overall health of the workforce (Forbes, 2007:1).

The South African Business Coalition on HIV/AIDS (SABCOHA) strives to help organisations in their efforts to combat HIV and AIDS through workplace initiatives. Their Strategic Workplace HIV and AIDS programme aims to promote and facilitate strategic and practical responses to the impact of HIV and AIDS on business and counteract the relatively slow response by the private sector to the ongoing threat of HIV and AIDS (SABCOHA, 2009a:1).

2.8.3 Evolution of SANS 16001

The AIDS Management Standard (AMS) 16001 was a compliance standard developed by the National Occupational and Safety Association (NOSA) and Debswana to ensure a systematic way for business to address the HIV epidemic (AMS Initiative, 2003:1). AIDS Management Standard (AMS) 16001 provided specific requirements for the management of HIV and AIDS and was designed so that organisations could measure the performance of their HIV and AIDS programmes (AMS Initiative, 2003:2). In a telephone conversation on 14 February 2009, Smith stated that the standard had two major shortcomings in that it was oriented specifically to the mining sector and focused on the risk of employees becoming infected at work although it is well known that the majority of HIV transmissions occur outside the workplace.

This led to the development of the South African National Standard (SANS) 16001:2007 HIV and AIDS management systems-general requirements which is an adoption and rewrite of AMS 16001 by the South African National Standards Committee. It was based on the International Organisation for Standardisation (ISO) 9001 and ISO 14001, which is a quality management and environment standard series of management standards.

South African National Standard (SANS) 16001 is a management tool developed to assist organisations to establish, implement, maintain and improve their HIV and AIDS management systems by measuring the outcomes, impacts, performance and return on investment (Smith, 2009:4). It has been approved by the South African Bureau of Standards (SABS) (Standards South Africa, 2007:ii).

SANS 16001 audits are conducted on an annual basis by accredited lead auditors from Occupational Health and Safety Assessment Series (OHSAS) with certification issued every 3 years (Smith, 2009:3). Results of the audit can be measured against:

- the organisation's HIV and AIDS policy;
- HIV and AIDS management targets;
- objectives and success criteria; and
- other HIV and AIDS management performance requirements.

A major strength of SANS 16001 is that it is a South African Standard and it was designed to be compatible with ISO 9001, ISO 14001 and OHSAS 18001, thus granting organisations the opportunity to carry out integrated auditing against all four standards (Meyer, 2007:1). Another advantage associated with SANS 16001 is that it improved upon the weaknesses of AMS 16001 (Meyer, 2007:1). According to Smith (2010:5) other strengths of SANS 16001 are that it can help organisations to manage their HIV and AIDS related risks, improve HAMS operational effectiveness, reduce costs, increase employee confidence, achieve continual improvement of HAMS, and achieve national and international recognition.

There is a dearth of literature on the evaluation of the implementation of SANS 16001 within organisations (Smith, 2010:22). According to Smith (2009:7), problems encountered by SANS 16001 auditors include:

- management not having an adequate knowledge of HIV management;
- management forcing HIV co-ordinators to do 'window dressing' type interventions where they want to be seen doing something;
- no real commitment in leadership;
- departments driving ineffective interventions and working in isolation; and
- HIV coordinators with no decision making authority and having HIV management as only a percentage of their work responsibilities.

2.8.4 Codes of Best Practice

There exist several codes of best practice for developing effective HIV and AIDS management systems, each containing a set of principles to guide responses to the epidemic. The International Labour Organisation's (ILO) Code of Good practice on HIV/AIDS and the World of Work is a comprehensive guideline with a set of key principles (International Labour Organisation, 2001:12).

The first principle in the ILO code is the recognition of HIV and AIDS as a workplace issue that should be treated as any other serious condition within the workplace (International Labour Organisation, 2001:12). The code further states that the successful implementation of an HIV and AIDS programme requires cooperation and trust between employers, workers and their representatives and government (International Labour Organisation, 2001:13).

The code recommends that programmes should assess and reduce risks through education, prevention and counselling (International Labour Organisation, 2001:14), and that all programmes should be sensitive to gender, race and sexual orientation (International Labour Organisation, 2001:14).

In South Africa, the Employment Equity Act No.55 of 1998 Code of Good Practice on Key aspects of HIV/AIDS and Employment recommends that one of the most effective ways of reducing and managing the impact of HIV and AIDS within workplaces is through the implementation of an HIV and AIDS policy and programme (Department of Labour, 2000a:5).

The Code was developed to address aspects of HIV and AIDS within the workplace so as to enable employers, trade unions and government to actively contribute towards local, national and international efforts to prevent and control HIV and AIDS. This includes dealing with HIV testing, confidentiality and disclosure; providing equitable employee benefits; dealing with dismissals and managing grievance procedures (Department of Labour, 2000a:6).

The Code seeks to assist with the attainment of broader goals namely eliminating unfair discrimination within the workplace based on HIV status and promoting a non-discriminatory workplace in which people living with HIV or AIDS are able to be open about their HIV status without fear of stigma or rejection (Department of Labour, 2000a:7).

The HIV/AIDS Technical Assistance Guidelines (TAG) was developed to build on and assist with practical implementation of the Code of Good Practice on Key aspects of HIV/AIDS of 2000 and the Employment Equity Act No.55 of 1998. The purpose of the TAG is to set out practical guidelines for employers and trade unions on how to manage HIV and AIDS at the workplace (Department of Labour, 2003:iii).

The TAG states that the most serious public health problem in South Africa is the HIV and AIDS epidemic. It not only threatens the lives of employees and sustainability of employers, but has a significant impact on every workplace, the effective functioning of the labour market and the national economy as a whole (Department of Labour, 2003:iii). Organisations can take control of these effects on their business by implementing an appropriate management system (Singh, 2006:200).

In view of this SANS 16001 is identified as an ideal HIV and AIDS management system because it encompasses the above-mentioned best practise principles in its general guidelines for the establishment of HAMS with a philosophy of continual improvement to work towards best practice (Standards South Africa, 2007:i).

2.8.5 Relationship between Legislation and SANS 16001

The Labour Relations (Act No. 66 of 1995) protects employees against unfair dismissal. If an employee is dismissed because he/she has HIV or AIDS this dismissal is based on discrimination and is automatically unfair (Department of Labour, 1995:12). The employer can be taken to the Centre for Conciliation, Mediation and Arbitration (CCMA) or Labour Court and be forced to re-employ the employee or give him/her compensation stipulated by the Court.

When employees can no longer do their work, an employer should first investigate what the extent of the employee's capability to do their job is and what alternatives are available apart from dismissal. These alternatives can include extended sick leave without pay, adapted duties and possible means of accommodating the employee's disability. An employee who is no longer able to work must be provided with an incapacity hearing before they can be dismissed (Department of Labour, 1995:12).

The Employment Equity Act (No.55 of 1998) ensures that all employees are treated equally and that there is no discrimination in the workplace. The Act promotes equal opportunity by eliminating unfair discrimination and prohibits unfair discrimination (directly or indirectly) against an employee on the grounds of their HIV status.

The Employment Equity Act also prohibits medical testing to determine the HIV status of an employee, except in limited circumstances. HIV testing can only be done if it is approved by the Labour Court. The 'Code of Good Practice on Key Aspects of HIV/AIDS and Employment' is part of the Employment Equity Act and gives employers guidelines to implement the requirements of the Act (Department of Labour, 1998:14).

The Basic Conditions of Employment Act (No.75 of 1997) sets standards for employers on how many hours an employee may work in a week and how much leave they are allowed to have. Employees are allowed to take a total of six weeks paid sick leave every 3 years and employees with HIV and AIDS can take this leave just like any other employee in the organisation. Sick employees can ask employers to have more sick leave for less pay (Department of Labour, 1997:20).

The Promotion of Equality and Prevention of Unfair Discrimination Act (No.4 of 2000) also sees to it that there is no unfair discrimination in the workplace, especially with things like insurance. This means that an employee with HIV and AIDS must be treated in exactly the same way as all the other employees in the organisation in all matters (Department of Labour, 2000b:10).

The Occupational Health and Safety Act (No. 85 of 1993) stipulates that an employer is obliged to ensure that the risk of occupational exposure to HIV is minimised as far as is possible (Department of Labour,1993a:15).

The Compensation for Occupational Injuries and Disease Act (No.130 of 1993) ensures that if an employee is exposed to infected blood or body fluids as a result of a workplace accident and is infected with HIV, he or she may apply for benefits in terms of Section 22 (1) of the Act (Department of Labour, 1993b:18).

South African Law on HIV and AIDS is fragmented. According to Dickinson and Stevens (2005) there is no single piece of legislation governing HIV and AIDS within the workplace and the legal framework has resulted in a reactive rather than a proactive strategic approach. The drawback of no legal requirements imposed on organisations has resulted in no real commitment regarding HIV in most organisations (Smith, 2009:5; Dickinson and Stevens, 2005:2). SANS 16001 does not intend to increase or change organisations' legal obligations and is therefore not mandatory (Standards South Africa, 2007:i).

2.8.6 Evaluation of Workplace HIV and AIDS Management Systems (HAMS)

Most external audits found HAMS in South African organisations to be inadequate and based on outdated practices (Smith, 2009:20; Dickinson and Stevens, 2005:6; Nutbeam and Harris, 2004:2; Campbell, 2003:4; Barnett and Whiteside, 2002:23). It was confirmed in a report by Booth (2008:2) regarding South Africa's progress against AIDS that most HIV prevention strategies remain unfocussed, sub-optimal and unmonitored.

Health promotion programmes have educated people on the prevention of HIV but increasing infection rates reveal that knowledge on its own does not equate to behavioural change (Booth, 2008:4). A case study of large South African Corporations in the Chemical, Information Technology and Health Care Sectors similarly found that the response to HIV has been ineffective regarding prevention, treatment and there were issues of quality of care due to the generally fragmented nature of the corporate response to HIV and AIDS (Dickinson and Stevens, 2005:6).

An assessment of a workplace HAMS in the South African mining sector revealed significant concerns such as a lack of best practice sites and little evidence of a comprehensive strategy from their head office that integrated prevention and treatment interventions into a cohesive action plan (Ramnarain, 2008:167).

A study of organisations in Richards Bay and Empangeni found that the focus of most organisations was on prevention programmes which lacked strategies to sustain programmes for infected employees, and some organisations focused more on the provision of medication to treat HIV and AIDS (Ntuli, 2004:6). According to Dickinson (2006a:229) problems are encountered in HAMS because best-practice policies are not fully developed and management sometimes deliberately selects aspects of best practice that they wish to implement.

It is hoped that the above examples show that implementing and sustaining a successful HAMS is a challenge. Rosen et al (2007:6) declared that rigorous evaluation of the outcomes and sustainability of HIV prevention, care and treatment is now the highest priority on the AIDS and business research agenda. This need points to the urgency for organisations to implement suitable HAMS to deliver results.

2.8.7 Impediments to the uptake of HAMS within workplaces

Failures of effective HAMS have been attributed to AIDS champions being junior, (frequently, black managers or nurses); stakeholders not having an equal voice in decision making; relational challenges with unions due to a lack of consultation; confidentiality issues; race and legacies of apartheid (Phooko, 2009:1; Dickinson, 2006a:230). Dickinson (2006a:230) found that unskilled personnel in critical HIV line function positions are a contributing factor to programme failure.

Dickinson (2006a:231) contends that problems are encountered in HAMS when best-practice policies are not fully developed and management sometimes deliberately selects aspects of best practice that they wish to implement due to arbitrary views or a lack of HIV knowledge. His study of three medium-sized organisations highlighted management tendency to selectively implement best-practice components which contribute to programme failures, the most critical being the exclusion or downplaying of worker involvement (Dickinson, 2007:5).

Research has established that common barriers to HCT within workplaces are perceived violations of confidentiality by healthcare staff and doubts about the voluntary basis of HIV testing; coercion by wellness teams; organisational factors, including the visible group nature of the HCT campaign; denial; fear of a HIV positive result and discrimination in that event (George et al, 2009:5; Phooko, 2009:2; Bhagwanjee et al, 2008:274). In a study of a mining-sector workplace in South Africa it was found that in contrast to HCT uptake, there was a relatively low rate of enrolment in the HIV treatment programme (Bhagwanjee et al 2008:271).

Common impediments to HIV treatment uptake in several workplace HAMS included fears of being identified within the workplaces as HIV positive, which arose from perceived confidentiality violations on the part of health care staff as well as organisational factors they believed allowed easy identification of the programme users; limited time to attend the clinic; poor quality of post-test counselling and follow-up of HIV positive employees due to limited time; difficulties in coping with the diagnosis; traditional explanatory models of illness, which precluded medical care (George et al, 2009:5; Bhagwanjee et al 2008:274; Phooko, 2009:2; Ramnarain, 2008:139; Dickinson, 2006a:246).

Other concerns from a mining sector workplace study centered on levels of support from mine management and the head office who did not have a comprehensive action plan that aligned prevention and treatment initiatives, support of employees for the HIV and AIDS programme, relational challenges with the union, treatment and adherence issues, spousal HCT uptake, race, culture and sexism, and fear (Ramnarain, 2008:140).

Stigma was found to be the strongest predictor for not accessing HIV care and treatment which suggests that more work needs to be done to address stigma within workplaces and the community (George et al, 2009:7; Phooko, 2009:3; Bhagwanjee et al 2008:274).

2.8.8 Benefits of Successful Workplace HIV and AIDS Management Systems (HAMS)

The cost of each HIV positive patient registered on a South African mining wellness programme prior to commencing ART per annum was R1 700 and the cost of treatment per patient on ART was R18 000 per annum (Ramnarain 2008:134). Treating managers was found to be highly profitable by Rosen et al (2007:7) as they were expensive to lose and difficult to replace.

Data on the cost-effectiveness of HIV prevention in Sub-Saharan Africa and on ART indicate that prevention is 28 times more cost effective than ART (Marsielle, Fache and Kahn, 2002:1851). Researchers agreed that providing care and treatment for HIV positive employees reduces the financial burden of HIV and increases economic benefits (SABCOHA, 2009b:5; Newmarch, 2007:2; Geffen and Blatt, 2003:4). SABCOHA (2009a:1) similarly states that providing care and treatment for HIV positive employees can reduce the financial burden of HIV and AIDS by 40%.

These economic benefits are largely seen in increased productivity and morale, savings on absenteeism and termination costs (Geffen and Blatt, 2003:5). Increase in productivity and profits satisfy shareholders. Investors determine their investment strategies by favouring organisations that respond to HIV and AIDS in a socially responsible manner (Payne, 2002:3).

In a study of business funded HAMS it was found that organisations that combine HIV Counselling and Testing (HCT) with prevention and well supported, timely ART and treatments for Opportunistic Infections and Sexually Transmitted Infections (STIs) see substantial economic benefits (Geffen and Blatt, 2003:5). Daimler Chrysler reported saving up to R1.9 million by preventing new infections among its South African workforce. (Newmarch, 2007:1). Similarly, a study of forty factories participating in a Zimbabwean AIDS programme revealed a 34% lower rate of new HIV infections than compared to non-participating factories (Hyde, 2001:9).

Ramnarain (2008) established that the centralisation of HIV services which included the availability HCT, HIV treatment and care and pharmaceutical services resulted in cost and time saving since employees were able to access these services during working hours which afforded an opportunity for monitoring and evaluation of treatment efficacy.

Rosen et al (2007:5) argued that the benefits of workplace interventions to employers are largely unquantified due to the long time lag between prevention costs and prevention benefits. They agreed that organisations who provided medication to treat HIV and AIDS under strict conditions resulted in employees remaining at work for longer than otherwise expected. Benefits of effective HAMS in the workplace which are listed in several studies include continued good health of employees, reduced absenteeism, uninterrupted productivity and increased profit (Ramnarain 2008:176; Newmarch, 2007:6; Singh, 2006:200; Geffen and Blatt, 2003:7).

This literature review demonstrates that when suitable HAMS are implemented, rewards are delivered which strengthens the need for implementing a structured HAMS namely SANS 16001.

2.8.9 Elements for successful HAMS programmes

The critical elements for successful HAMS programmes are ongoing commitment from senior management to union level, implementation of an HIV and AIDS policy, identification and utilisation of peer educators, condom distribution and provision of STI treatment (Dickinson: 2003:2; Geffen and Blatt, 2003:4; Hyde, 2001:2).

Dickinson (2003:3) listed key elements that are necessary for successful workplace HIV programmes such as that it must be part of a wider workplace HIV and AIDS programme; unions must be fully involved in the design, governance, and implementation of workplace HIV programmes; confidentiality for those who do not want to disclose their status must be guaranteed and there must be access to advice and treatment for employees who test HIV positive.

When union representatives are fully involved in the workplace HIV programme, it promotes trust between the HIV committee and the union representative and between the representative and the employees. Union representatives are highly influential and employees trust them. Therefore, in implementing any new HIV policy, it is important to consult with unions or labour representatives because some of the best intentioned programmes have failed because employees' unions were not consulted (Geffen and Blatt, 2003:6).

Nutbeam and Harris (2004:4) recommend that HIV programmes are most likely to be successful when the exact nature of a health problem is well understood, the needs and motivations of the target population and the setting in which the programme is being implemented has been taken into account. For example the programme needs to take the culture and language of the clients into consideration as sociocultural issues are known to influence HIV-related stigma and HAMS uptake (Airhihenbuwa et al, 2009:426).

The adoption of a recognised standard such as SANS16001 can improve HAMS in a workplace setting because it includes the above-mentioned key elements for successful HAMS programmes (Smith, 2009:11; Standards South Africa, 2007:i).

2.8.10 Case study: Paper factory

This is the factory where the research was conducted, being referred to in this study as the 'organisation'.

The organisation's regional HIV and AIDS policy states in its preamble that it seeks to minimise the social, economic, development and health consequences of HIV and AIDS to the organisation and its employees; it commits to providing effective resources and leadership to implement an HIV and AIDS programme and aims to create a supportive and non-discriminatory working environment.

One of the policy's main principles is to protect employees with HIV and AIDS against unlawful discrimination (Organisation X HIV policy, 2010:1). In a telephone conversation on 3 April 2009 Melrose, the organisation's group Health and Wellness Manager stated that the organisation appointed an HIV programme coordinator, an HIV committee and peer educators to ensure that the policy is communicated to all employees and to ensure that HAMS is implemented as planned. The organisation's HIV committee compiled an HIV annual plan which identified the risks that increase the incidence of HIV within the organisation and developed objectives to mitigate these risks.

The HIV programme components included providing employees with Information and Education, HIV Counselling and Testing (HCT), confidentiality, Highly Active Anti-Retroviral Treatment (HAART) and HAART readiness training for HIV positive employees, Post Exposure Prophylaxis (PEP) in sexual assault, treatment of Sexually Transmitted Infections (STIs), Universal Precautions and appropriate support and counselling services (Organisation HIV policy, 2010:2).

Qualsa HIV unit was selected to manage the organisation's HIV treatment programme from 1 January 2003 for permanent employees regardless whether they are medical aid members (Johnson, 2003:1). The Qualsa HIV unit is a health risk specialist organisation which is based in Cape Town and administered by Metropolitan, an insurance organisation. When interviewed on 03 April 2009, Melrose stated that the treatment components and regimens are similar to other managed care organisations.

The following benefits are available to the organisation's HIV positive employees:

- Authorised ART within a budget of R11 000 per annum;
- Identified multivitamins for employees not on ART within a budget of R2 500 per annum;
- Treatment for prevention of mother to child transmission;
- Post exposure prophylaxis;
- Co-trimoxazole prophylaxis when indicated;
- HIV-related doctor consultations (three per year);
- Disease monitoring (pathology testing);
- Advice and counselling for employees;
- Expert telephonic support for treating doctors; and
- Access to preferred provider networks (pharmacy and pathology).

The organisation's Clinic assists with the uncomplicated treatment of HIV and AIDS with ART, reasonable treatment of side effects, opportunistic infections and referral to hospital or a specialist when needed. It has been noted by Melrose (2009 pers. comm. 3 April) that the Qualsa HIV Programme Treatment Protocols have been drawn up in consultation with experienced South African colleagues and based on current, internationally accepted treatment protocols.

The above details were included to describe the elements of the organisation's HIV treatment programme. The organisation's HIV treatment programme is made up of a team comprising of the organisation's in-house Employee Wellbeing Department, Qualsa HIV unit and the Clinic which is outsourced to a private medical practitioner.

2.9 Research models

Theoretical models help to stimulate research and the extension of knowledge by providing both direction and impetus (De Vos et al, 2005:25). The overall purpose of theoretical models is to make research findings meaningful and generalisable (Polit and Beck, 2004:118; Yin, 2009:26). Several theoretical models could have been used in this study but are limited as described below.

2.9.1 Evaluation model

According to Koortzen and Baloyi (2004:4) the evaluation model is an objective, scientifically sound and socially responsible method to evaluate organisational wellness programmes. It introduces monitoring of how well the programme is functioning, an assessment of the impact of the programme and an analysis of programme benefits.

The evaluation model consists of nine distinguishable phases. Each phase consists of a specific task or tasks which the evaluator needs to plan, identify or develop (Koortzen and Baloyi, 2004:5).

The nine phases are:

Phase 1: Determining the purpose of evaluation;
Phase 2: Identifying the stakeholders and their information needs;
Phase 3: Defining evaluation questions;
Phase 4: Conducting needs and evaluability assessments;
Phase 5: Identifying evaluation criteria;
Phase 6: Developing a full evaluation plan;
Phase 7: Implementing the plan;
Phase 8: Consolidating and reporting; and
Phase 9: Corrective action and re-planning.

This framework could have been adapted to suit the study but it seemed better suited to general wellness programmes. Based on a review of the literature, the researcher decided to rather evaluate the organisation's HAMS in a descriptive mode against a recognised South African standard namely SANS 16001.

2.9.2 Elaboration Likelihood model

Another model considered was the Elaboration Likelihood model because persuasion is a major part of all types of communication and messages are not effective if they are not persuasive to the target audience. It is based on the presumption that in order for someone's attitude towards a certain idea to change, there are two paths to persuasion, the central route and the peripheral route. The model was developed by Richard Petty and John Cacioppo in early 1980s.

The central route entails message collaboration and the message is very specific and provides all the relevant information. The central route is used to scrutinise ideas, determine the value and implications (Elaboration Likelihood Model 2010).

The peripheral route in the Elaboration Likelihood model involves ways to accept or reject a message without actually thinking about the issue. When an individual is not motivated or unable to process a message it is channeled through the peripheral route, using specific cues. Attitude changes for both routes differ significantly. The attitude change from the central route would be much more intense and deeper than the peripheral route, whereas the peripheral route is more superficial (Moore, 2001:1).

When the peripheral route is used to make decisions the change is temporary. When individuals take a central route to make decisions they are motivated and able to pay attention, which can lead to permanent change in attitudes (Wilcox et al, 2003:1). The two routes inclusive of the peripheral cues could have described how employees react to and take in HIV and AIDS treatment messages, and whether these messages result in positive attitude and behaviour change. However, the Elaboration Likelihood model seemed more suited to the evaluation of health promotion programmes.

2.9.3 Deming cycle model

The theoretical framework underpinning this study is the *Deming cycle* which was proposed by W.E. Deming in the 1950's. He recommended that business processes should be analysed and measured to identify sources of variations that cause products to digress from customer requirements. He suggested that business processes should be placed in continuous feedback loops so that managers can identify and change processes that need improvements. The commonly known Deming cycle has four steps: Plan-Do-Check-Act (PDCA) (Arveson, 1998:1):

1. Plan: Design or revise business process components to improve results;
2. Do: Implement the plan and measure its performance;
3. Check: Assess the measurements and report the results to decision makers; and
4. Act: Decide on changes needed to improve the process.

The International Organisation for Standardisation (ISO) 9001 promotes the adoption of a process approach when developing, implementing and improving the effectiveness of a quality management system to enhance customer satisfaction by meeting customer requirements (International Organisation for Standardisation, 2008:v). In view of this the ISO 9001 Process model which illustrates the process linkages was further adapted to evaluate employees' experiences in the study.

For an organisation to function effectively, it has to determine and manage numerous linked activities to enable the transformation of inputs into outputs which can be considered a process. An advantage of the process approach is the ongoing control that it provides over the linkage between the individual processes, their combination and interaction (International Organisation for Standardisation, 2008:v). This advantage was demonstrated in a study of one thousand organisations which revealed that ISO 9001 adopters had higher growth for sales and employment, and far lower deaths in comparison to non-adopters of ISO 9001 (Levine and Toffel, 2010:1).

The PDCA methodology can also be applied to all processes (International Organisation for Standardisation, 2008:vi). When used in a quality management system the process approach emphasises the importance of:

a) Understanding and meeting requirements;
b) The need to consider processes in terms of added value;
c) Obtaining results of process performance and effectiveness; and
d) Continual improvement of processes based on objective measurement.

The ISO 9001 Process model was based on the Deming cycle methodology which was used in this study to answer the research questions and evaluate the efficacy of HAMS, which is described in the Methodology section in Section 3.11. The ISO 9001 Process model provides a practical framework and relevant concepts within which the study can be described (International Organisation for Standardisation, 2008:vi).

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Research design

This chapter lays out the research design for this study. An overview of the methodology and methods will be given. It explains the data collection methods that were used to gather information to compare the organisation's HAMS in relation to SANS 16001 standard using the ISO 9001 Process model and to describe HAMS in this organisation.

A research design is the architectural backbone or blueprint that is utilised for conducting a study (Yin, 2009:26, Burns and Grove, 2005:48). Polit and Beck (2004:245) describe the research design as the overall plan for obtaining answers to research questions, including maximizing control factors that could interfere with the validity of the findings. It guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal. Skill is required in selecting and implementing a research design to improve the quality of the study and usefulness of the findings (Yin, 2009:27).

This was a qualitative study, with the aim of understanding the phenomena from the participants' view through the careful collection and analysis of qualitative materials that are narrative and subjective (Miles and Huberman, 1994:10). A qualitative design was chosen because qualitative studies result in rich, in-depth information that has the potential to unfold varied dimensions of employees' experiences of HAMS. It is important to look at the whole picture and understand the factors that inform HAMS uptake. Another feature of qualitative data is that it has a potential for revealing complexity; such data provides a rich and thorough description in a real context which have a ring of truth that has a strong impact on the reader (Miles and Huberman, 1994:10).

This qualitative study collected data at one point in time using a single case design that evaluated HAMS in relation to SANS 16001, and described the experiences of HIV positive employees (Polit and Beck, 2004:166). A case study is an empirical inquiry that investigates a phenomenon in depth and within its real-life context and is a phenomenon occurring in a bounded context (Yin, 2009:3; Miles and Huberman, 1994:11). A case study approach was chosen as the research strategy because it allows meaningful illumination and capturing of HAMS in its entirety. The greatest strength of a case study is the depth that is possible when a limited situation is being investigated (Yin, 1994:6). This study examined a single HAMS within a single organisation which was a paper factory.

The case protocol included the following qualitative methods to generate data:

- observations of a qualitative audit of the organisation's HAMS in relation to SANS 16001;
- documentary records of the organisation's HAMS files;
- Focus Group discussions;
- one-on-one interviews; and
- reflexive journal.

The South African National Standard (SANS) 16001 specifies general requirements for HAMS with the intention to assist organisations to establish, implement, maintain and improve an HAMS. The standard was based on the Deming methodology known as Assess-Plan-Implement-Monitor-Evaluate (APIME) (Standards South Africa, 2007:4).

3.2 Research model

The South African National Standard (SANS) 16001 is compatible with the International Organisation for Standardisation (ISO) 9001 (Standards South Africa, 2007:i). The International Organisation for Standardisation (ISO) 9001 is a process-based quality management system. The Deming cycle methodology was included in the ISO 9001 Process model as a means of process improvement (International Organisation for Standardisation, 2008:v). Therefore, the ISO 9001 Process model in Figure 1 was used to evaluate HAMS in this organisation and answer the research questions (International Organisation for Standardisation, 2008:vi; Standards South Africa, 2007:5).

The adapted ISO 9001 Process Model which included SANS 16001 general requirements has four phases:

1) The first phase begins with Management Responsibility which entails general guidelines for the establishment of HAMS. The next step is Documentation Requirements such as defining the HIV and AIDS policy, HAMS documentation, control of documents and records. This is followed by Planning which involves: establishing and maintaining procedures for HIV risk identification; legal and other requirements; HAMS objectives, targets and programmes; defining general responsibilities and authorities; appointment of a HAMS management representative; HAMS communication; operational control; and, impact mitigation and emergency preparedness.

2) The second phase is Resource Management which entails ensuring the availability of the necessary resources, competence training and awareness.

3) The third phase involves considering Employee Requirements that represents the customer which needs to be taken into consideration in order to improve the uptake of HAMS.

4) The fourth phase is Measurement, Analysis and Improvement of HAMS with a view to continual improvement through: evaluation of compliance; nonconformity; corrective action and preventive action; audit and management review. During this phase Employee Experiences that influence the uptake of HAMS need to be taken into consideration for continual improvement. The cycle is a continuous process which starts all over again (International Organisation for Standardisation, 2008:vi; Standards South Africa, 2007:4-13).

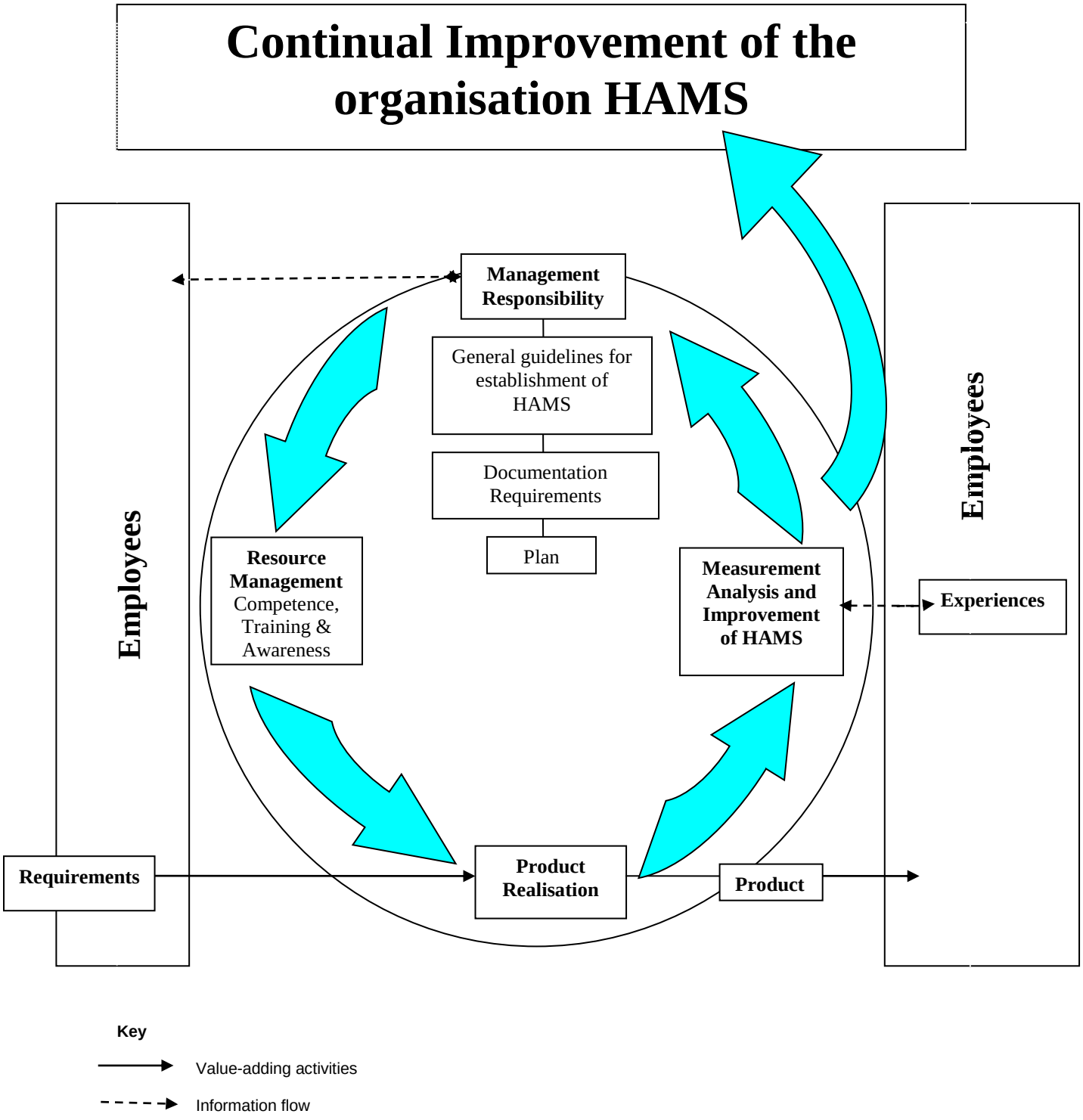

Figure 1: Adapted ISO 9001 process model (International Organisation for Standardisation, 2008:vi; Standards South Africa, 2007:5).

3.3 Study Setting

The organisation in which the research was conducted is a paper manufacturing organisation which was commissioned in 1954 (Hocking, 1987:5). This organisation was chosen for the study because it is believed to be typical of other manufacturing organisations in the same industry. The study of this particular HAMS is hoped to be informative because it is believed to represent a typical workplace HAMS since this organisation has sustained its HAMS for the past ten years.

Employees of this organisation are at high risk for HIV and the organisation is located within a high HIV prevalence area. The organisation employed 969 culturally diverse permanent employees and 600 contractors as at 2009 financial year end. The organisation was also selected for the study based on convenience because the researcher is employed by the organisation and has access to the participants. Written permission was sought from the management of the organisation to conduct the research after informing management of the research process involved (see Appendix A).

The geographical setting for this study is located midway between Durban and Richards Bay, and lies on the development corridor of the North Coast of KwaZulu-Natal. It is located on the major railway and road transportation route (the N2 national road) which links these two economic hubs. The area is arguably the only place along the coast where the development corridor and the shadow corridor of poverty meet. The establishment of the Dube Trade Port and King Shaka International Airport has lots of economic, social and employment implications for the municipality because of its location (Integrated Development Plan, 2009:10). Increased social connections are also a venue for HIV transmission so it is important to the overall economic impact of the area to control the HIV epidemic.

Areas of urbanisation in the municipality comprise Sundumbili, Mandeni, Tugela and Tugela mouth. Industrial development is concentrated in Isithebe. Informal settlements with limited to no infrastructional services occur on the periphery of the developed areas, within the Isithebe Industrial area and Sundumbili Township.

More than 60% of households do not have access to water and sanitation, especially three Tribal Authority areas. Access to electricity in the rural areas is lacking. Most of the 16 wards within the municipality have gravel roads which are in a poor state (Integrated Development Plan, 2009:11).

In 2007, the municipality total population was 138 736. The population distribution was as follows: 95.29% African Black, 0.48% Coloured, 2.43% Indian Asian, 1.81% White. The area has an unemployment rate of 48%, which is high. This is linked to a lack of skills, substance abuse and HIV and AIDS (Integrated Development Plan, 2009:12).

The organisation in which this research was conducted has reduced from four to three paper machines due to the current global recession and decrease in profits. The mill operates during regular office hours and four shift cycles to ensure that production continues 24 hours of the day.

One of the defining attributes of the organisation is its people. Relationships are at the heart of the success of the organisation. The organisation cares about its employees, customers, communities and all stakeholders who partner with them because they are passionate about people and the planet. Performance is another attribute of the organisation. The organisation strives for excellence and is high performing in the products they deliver. The values of the organisation are excellence, integrity and respect, which are in line with the attributes.

3.4 Target population

The target population was the entire permanent workforce which was 969 employees. There were 448 salaried employees (grade 3-11; the lower the grade the higher the position), 110 artisans, 252 grade A-C (skilled), 127 grade D-E (semi-skilled) and 32 grade F (unskilled).

The workforce is predominantly male 855 (87%). The race demographics were as follows: 605 African of which 124 were semi-skilled and 27 were unskilled; 13 Coloured; 169 White employees and 182 Indian of which 3 were semi-skilled and 5 were unskilled. The age demographics were as follows: 20-29 years = 273, 30-39 years = 276, 40-49 years = 204, and 50 years and above = 233.

3.5 Sample

3.5.1 Sampling strategy

In qualitative research there are no rules for sample size and the focus is on the quality of information obtained from the sample (Burns and Grove, 2005:52). According to Miles and Huberman (1994:27) a guiding principle in sampling is data saturation, which is sampling to the point at which no new information is obtained. If participants are good informants who are able to reflect on their experiences and communicate effectively, saturation can be achieved with a relatively small sample (Miles and Huberman, 1994:27; Polit and Beck, 2004:57). Therefore, in this study sampling was continued until data saturation occurred. The participants furnished sufficient information to answer the research questions.

Semi-structured interviews were conducted with four groups of participants (three focus group discussions and one-on-one interviews) using purposive sampling. Purposive sampling is frequently used by qualitative researchers and is based on the belief that the researcher's knowledge about the population can be used to select the sample members (Miles and Huberman, 1994:27).

In semi-structured interviews researchers prepare in advance a list of questions to be covered with each respondent. This technique ensures that researchers obtain all the information required, and gives participants the freedom to respond in their own words and provide as much detail as they wish, and offer explanations (Miles and Huberman, 1994:27). The list of questions included probes that were designed to elicit more information.

Polit and Beck (2004:342) state that people feel more at ease expressing their views when they share a similar background such as race/ethnicity, age, gender or experience. The organisation has adopted the Peromnes grading system which is based on specific criteria namely responsibilities, supervision and educational level. Two focus groups were selected according to grade levels for monthly and weekly paid employees.

Table 3.1 depicts the sampling framework for focus group 1 and 2. The participants per strata were selected from multiple computer enumerated listings from the organisation according to grade levels. This means that each employee had a chance of being selected for the sample (Polit and Beck, 2004:291).

Table 3.1: Sampling frame for focus group 1 and 2

Grade (Strata)	**Percentage of the population**	**Number of participants selected**
3-6 (monthly paid)	2.6%	1
7-10 (monthly paid)	28.5%	3
11-13 (monthly paid)	14.9%	2
Artisans (monthly paid)	11.3%	1
A-C (weekly paid)	26%	3
D-E (weekly paid)	13.1%	1
F (weekly paid)	3.3%	1

The third focus group consisted of the HIV committee members to promote a comfortable group dynamic and ensure representativeness of the sample. The HIV committee comprises of various categories of employees within the organisation who are responsible for facilitating HAMS namely:

1. Chairperson of the HIV committee who is the Finance Manager-Head of Department;
2. Personnel manager;
3. Human Resources Superintendent;
4. Communications officer;
5. Training officer;
6. Safety superintendent;
7. Professional nurse from the Clinic;
8. Full time union representative;
9. Part time union representative who is a stores assistant;
10. A peer educator who is a fitter;
11. Employee Well-being Assistant; and
12. Employee Well-being Coordinator.

One-on-one interviews were conducted with HIV positive employees. The HIV positive employees were known to the researcher and they were individually approached with an invitation to volunteer as a participant in the study.

3.5.2 Sample characteristics

The pilot study (N=3) included a white man and a black man and a black woman. Focus group one (N=7) included black men (n=3), black women (n=2) and white men (n=2) who were permanent monthly paid employees. Focus group two (N=6) included black men (n=5) and a black woman (n=1) who were permanent weekly paid employees. Focus group three (N=10) included black men (n=3), white men (n=3) and white women (n=4) who were members of the HIV committee (see attached Appendix E).

Two groups were included in the one-on-one interviews with HIV positive employees. One group (N=5) were registered in the organisation's HIV treatment programme and consisted of black men (n=3) and black women (n=2). The other group (N=5) were not registered in the organisation's HIV treatment programme and consisted of black men (n=5).

3.6. Data collection methods

3.6.1. Data collection and instruments

A major strength of case study data collection is the opportunity to use many different sources of evidence and address a broader range of issues which exceeds other research methods (Yin, 2009:2).

Table 3.2 depicts the research objectives that were addressed by each data collection instrument.

Table 3.2: Data collection matrix

Objective	**Instrument**
To evaluate the organisation's HAMS in relation to SANS 16001	Qualitative audit (see table 4.1)
To evaluate the organisation's HAMS in relation to SANS 16001	Document review checklist (see attached Appendix G)
To evaluate the organisation's HAMS in relation to SANS 16001	Focus group interview guides (see attached Appendix H)
To describe the experiences of HIV positive employees	Individual interview guides (see attached Appendix H)
To evaluate the organisation's HAMS in relation to SANS 16001	Reflexive journal (On audit trial CD)

Documentary records of the organisation's HAMS files such as minutes of the HIV committee meetings were thoroughly reviewed to identify central or recurring themes which were included in the document analysis of the study (on audit trial CD) . The most important use of documents is to provide specific details to corroborate or verify and enhance evidence from other sources.

If the documentary evidence is contradictory rather than corroboratory then the researcher needs to inquire further into the topic (Yin, 2009:40).

3.6.2 Reflexive journal

Self-reflexivity is the continuous process of self-reflection about one's own biases, preferences, and preconceptions (Polit and Beck, 2004:335, Miles and Huberman, 1994:66). Deliberation from my reflexive journal (kept for four years over which the research was conducted) helped me to identify problem areas in the research. The purpose of the reflexive journal was to help detect personal bias due to my own beliefs and values, role conflict, lack of neutrality which may have affected the focus group discussions, one-on-one interviews or the interpretation of the results which was discussed with my research supervisors. The reflection also covered issues on relationships.

Additionally, the journal included field notes documenting my observations during the interviews. In the interest of the examiners the raw data containing the transcripts of the interviews and field notes are attached in a CD Rom.

3.6.3 Focus groups

Focus groups were selected as a research tool because they enable the researcher to access information in an efficient manner and are useful in allowing participants to share their thoughts with each other (Polit and Beck, 2004:343). A focus group discussion is a carefully planned discussion designed to obtain perceptions on a defined area of interest in a non-threatening environment (De Vos et al, 2005:68).

A major advantage of a focus group is that it is efficient and allows the researcher to obtain the viewpoints of many individuals in a short time. Focus groups are usually stimulating and members react to what is being said by others, thereby potentially leading to richer or deeper expressions of opinion (Brink, 2003:159). In this way they spark off new ideas and consider a range of views before answering the researcher's questions (Brink, 2003:159). A disadvantage of focus groups is that some people are uncomfortable about expressing their views in the presence of a group (Polit and Beck, 2004:343).

Several writers have suggested that the optimal group size for focus groups is six to twelve people (De Vos et al, 2005:76). Focus Group 1 included seven salaried employees. Focus Group 2 included six weekly paid employees in order to ensure that lower level employees were able to talk openly and not be intimidated by higher level employees in the focus group.

Focus Group 3 consisted of ten members of the HIV committee. The HIV committee is a homogenous group that is believed to be representative of the sample, well informed and at ease to provide important insights about HAMS because they are comfortable in the group dynamic.

3.6.4 One-on-one interviews

One-on-one interviews were included in the methodology as some employees were not comfortable disclosing their HIV positive status in a group (De Vos et al, 2005:78). A pilot study was conducted with a participant who was registered with a private doctor. The first group of one-on-one interviews was conducted with five HIV positive employees who were registered in the organisation's HIV treatment programme. The second group of one-on-one interviews was conducted with five HIV positive employees who were not registered in the organisation's HIV treatment programme. Four participants were registered with private doctors. Two of these participants were initially registered in the organisation's HIV treatment programme and were dissatisfied. One participant was registered with a Provincial HIV treatment programme.

3.7 Ethical consideration

The research proposal was approved by the DUT Faculty of Health Ethics Committee prior to beginning the research project (see attached Appendix F). Permission was sought from the organisation's General Manager to conduct the study (see attached Appendix A and B). A letter of information and consent explaining how confidentiality will be maintained was signed by participants before commencing the discussions (see attached Appendix C). The full time union representative assisted with translation of the information and consent form, and the interview schedule, into isiZulu (see Appendix D).

The interview schedules were critiqued by faculty advisors from the Durban University of Technology (DUT) prior to the pilot study and some questions were simplified to facilitate better understanding of the interview questions by participants.

The researcher personally ensured that the consent forms were filed separately from the interview notes and recorded discussions to ensure that no links to individuals were made before interpretation of the results. The documents will be kept for five years by the researcher who will then personally destroy the documents by shredding them.

The participants had the right to decide voluntarily whether or not to participate in the study without the risk of penalty. They had the right to withdraw from the study at any time, and to refuse to give information or to ask for clarification about the purpose of the study (Brink, 2003:42).

The voice recordings conducted in isiZulu were translated into English by the researcher and back translated and verified through member checking as described under data analysis.

3.8 Trustworthiness

3.8.1 Construct validity

Triangulation is the use of multiple sources to draw conclusions about what constitutes the truth (Polit and Beck, 2004:432). To fulfil construct validity, a chain of evidence namely observations of a qualitative audit of the organisation's HAMS, records of the organisation's HAMS files, focus group discussions, one-on-one interviews and a reflexive journal were used to develop converging lines of inquiry, a process of data triangulation and corroboration (Yin, 2009:128). The conclusions are more likely to be convincing because multiple sources of evidence essentially provide multiple measures of the same phenomenon to converge (Yin, 2009:129).

3.8.2 Pilot study

A total of three employees were selected to participate in the pilot study; one from each employment strata to ascertain if the interview schedules were understandable and effective in obtaining information to fulfil the research objectives. The researcher established that the interviews were effective in obtaining the necessary information; therefore it was not necessary to make any further changes to the interview schedules. The pilot test interviews were included in data analysis of the study. In total, three focus group discussions as well as one group of one-on-one interviews with HIV positive employees in the organisation's treatment plan (n=5) and one group of one-on-one interviews with HIV positive employees not in the organisation's treatment plan (n=5) were conducted in order to access information.

3.8.3 Internal validity

The Deming model theoretical framework was used as an analytic framework because of its sequential links and the links can be analysed to determine whether a pattern match has been made in the case study to ensure internal validity. A reflexive journal was kept by the researcher from commencement of the research to identify potential problems in the research such as personal bias and was used to assist with deeper understanding of the interviews.

3.8.4 External Validity

Since the study is a single case study, the researcher referred to the original Deming cycle theoretical framework to show how data collection and analysis was guided. Researchers who design research studies within the same parameters can determine whether or not the case described can be transferred to other settings (De Vos et al, 2005:85).

The researcher had sessions with research supervisors to explore various aspects of inquiry for written or oral summaries of data collected, categories and themes that emerged and the researchers' interpretations of the data. Disconfirming data that challenged an emerging categorization was also facilitated through this process (Yin, 2009:129).

To ensure internal validity the interpretations of the focus group discussions and one-on-one interviews conducted were verified by the interviewees through member checking to ensure that the interpretations were correct (Polit and Beck, 2004:432).

3.9 Reliability

The goal of reliability is to minimise the errors and biases in the study (Yin, 2009:103). Reliability was addressed through the development of a separate database of raw data for independent inspection. The case study database was electronically developed by including raw data such as verbatim transcripts and the reflexive diary that were available for independent inspection (Yin, 2009:103).

'The general way of overcoming reliability is to make as many steps as operational as possible and to conduct research as though someone were always looking over your shoulder' (Yin, 2009:44). The research was conducted in such a way so that an auditor could in principle repeat the procedures and come to the same results.

3.10 Limitations of the study

Given that the study was conducted in one of the organisation's mill sites, caution is advised in making generalizations to all sites and other organisations. HIV and AIDS is a sensitive issue and participants of the study could provide information that is socially desirable. Participants of focus group interviews may succumb to socially desirable answers and discussions. Language has a limiting role in describing experiences. Although the researcher can communicate in isiZulu, translating some of the descriptions could provide some flaws which were minimized by verifying the relevant data analysis with the interviewees to ensure that the data and interpretations were correct.

CHAPTER 4

PRESENTATION OF RESULTS

4.1 Introduction

The purpose of data analysis is to organise, provide structure to, and elicit meaning from research data (Miles and Huberman, 1994:10). According to Polit and Beck (2004:52) data collection and data analysis in qualitative studies usually occur simultaneously as the search for themes and concepts emerge from the moment that data collection begins. Yin (2009:21) asserted that the analysis of case study evidence is one of the least developed and most difficult aspects of doing case studies. The objectives and design of the case study which reflect the research questions and review of literature guided the case study analysis (Yin, 2009:9). This was done by checking the thematic codes from the data against the research questions to ensure that the research questions were answered. Excerpts from the thick description were included in the study to enhance the report (Polit and Beck, 2004:52). In the final analysis stage, the researcher integrated the various themes to provide an overall structure.

The purpose of the study was to evaluate HAMS in relation to SANS 16001, and described the experiences of HIV positive employees. The sample realization included:

- observations of a qualitative audit of the organisation based on SANS 16001;
- documentary records of the organisation's HAMS files;
- three pilot interviews;
- three focus group discussions;
- ten one-on-one interviews; and
- an on-going reflexive journal.

Thematic analysis was structured by the theoretical framework which was the Deming cycle and the research objectives. Data analysis began concurrently with the collection of research data. Data analysis consisted of three concurrent flows of activity: data reduction, data display, and conclusion drawing/verification (Miles and Huberman, 1994:10-11). Data reduction involved reading all the transcripts, field notes and reflexive diary many times, selecting, focusing, simplifying, abstracting, and transforming the data. Data was organised into tables to help with identification and interpretation of emerging themes. As recurring themes, patterns and integrations emerged possible explanations and propositions were initiated which were not finalised until the end because findings were continually integrated.

A rich and thorough description of the research setting was done. Extracts from the focus group discussions and one-on-one interviews were quoted in the analysis so that the analysis reflected the thoughts and concerns of the participants (Polit and Beck, 2004:573). Conclusions emerged from the analysis which answered the research objectives and questions, and were reached taking into consideration current literature and the theoretical framework.

The researcher's experience in health promotion programmes in occupational settings and nursing background was used to better understand the meaning of the data and gain insights into the meanings.

The researcher was sensitive to relationships within the data by considering possible alternative or rival interpretations for the findings and took into consideration methodological or other limitations that could affect the results (Yin, 2009:127). For example interview participants said that they believed that HIV results were kept confidential within the organisation yet when probed further some participants said that they underwent an initial HIV test outside the because they feared that the confidentiality of their HIV results would be breeched.

The recorded interviews have been transcribed verbatim. The researcher put in continuous efforts to check the accuracy of transcription data by listening to the recorded interviews whilst doing a cross-check (Polit and Beck, 2004:589). The transcribed voice recordings key concepts were written in the margins of the transcripts as memos (De Vos et al, 2005:88).

Each section included a category to facilitate the retrieval and comparison of all the data marked with the same code that are examples of the same action, setting, strategy, meaning, emotion, and interest. The raw data was then organised according to the Deming cycle framework. Each category was indexed in the raw data. The data was arranged in a matrix format. Themes emerged from the data and were used to interrogate and extend the theoretical framework. Each main theme has categories which were displayed in separate columns for each respondent. Immersion in the data and familiarisation with it helped raise issues for investigation and helped develop insights and interpretation (Gibbs, 2007:120).

4.2 Research Question #1: Is HAMS aligned to the SANS16001 standard?

4.2.1 Quality management comparison

Data was obtained by the researcher from the report of a qualitative external audit that was based on SANS 16001, and documentary records of the organisation's HIV committee meeting minutes for two years (2008 and 2009). Central and recurring themes were identified.

Table 4.1: Qualitative audit of organisation's HAMS in relation to SANS 16001

SANS 16001 Standard			Organisation's HAMS
1.		HIV and AIDS management system requirements	
	1.1	General guidelines for the establishment of an HAMS (Based on Deming Methodology: Plan-Do-Check-Act)	
	1.1.1	Overview for compliance:	
		a) Define and document the scope of its HAMS;	Outlined in section 3.1.1.b).
		b) Establish, implement, maintain and improve the HAMS;	Outlined in section 3.1.1.c,d and e).
		c) Eliminate or minimize risk to employees and the immediate community who might be exposed to HIV infection due to the presence of the business and its practices;	Risks outlined in HAMS documentation under section 3.2.2. and implemented by persons identified in section 4.4. and with resources clarified in section 5.

SANS 16001 Standard			Organisation's HAMS
		d) Assist infected and affected employees with access to treatment, care and support;	The organisation has an HIV support group in place since August 2008 for HIV infected employees. The Employee Well-being (EWB) Coordinator offers counselling, support and referral for employees and immediate dependants. The Clinic offers treatment and monitoring of HIV infected employees.
		e) Assure itself of its conformity with its stated HIV and AIDS policy;	The organisation assures conformity of its stated HIV and AIDS policy through measurement and analysis of as discussed under section 6.1. and 6.2.
		f) Demonstrate compliance with this standard by:	The organisation demonstrates compliance by:
		1) Making a self-determination and self-declaration;	Having made a self-determination and self-declaration in the HIV and AIDS policy;
		2) Seeking confirmation of its conformance by parties having an interest in the organisation, such as customers;	Obtaining confirmation of its conformance by parties having an interest in the organisation such as interested customers;
		3) Seeking confirmation of its self-declaration by a party external to the organisation, or	Obtaining confirmation from an external auditor as indicated in section 6.4;
		4) Seeking confirmation/ registration of its HIV and AIDS management system by an external organisation.	Obtaining confirmation from an external auditor as indicated in section 6.4.

SANS 16001 Standard			Organisation's HAMS
	1.2	Documentation requirements	
	1.2.1	HIV and AIDS policy.	• The organisation's HIV and AIDS Regional policy was initiated in 2000 and revised in 2003 and January 2010 in consultation with union representatives. The policy is located in the Employee Well-being (EWB) Master Policy file. • The organisation's HIV related risks were documented in the HAMS 2009 annual plan which is explained under section 3.2.2. • The policy is established, documented, implemented and maintained. • Includes a commitment to comply with applicable legal and other requirements that relate to HIV and AIDS management. • Includes a commitment to prevention of work-related exposure to HIV and AIDS. • Includes a commitment to provision of information, education, communication and a variety of preventative measures. • Includes a commitment that HIV infected employees will be protected against unlawful discrimination and practices. • Includes that reasonable precautions will be taken to ensure confidentiality regarding the HIV status of any employee. • Non-discrimination, disciplinary measures, employee benefits, confidentiality and disclosure is further outlined in the Management Standard for HIV/AIDS Management Programme. • Includes a commitment that the policy will be communicated to all employees.

SANS 16001 Standard			Organisation's HAMS
			• The policy states that it will be reviewed on a regular basis to take account of the progression of the epidemic, developments in medical care and its impact on employee benefits. <u>Gaps identified</u> • The policy needs to include the nature and scale of the organisation's HIV and AIDS related risks in order to be appropriate. • The policy did not include commitment to continual improvement. • The policy did not include commitment to behaviour change communication. • The policy did not address non-discrimination in recruitment, performance evaluation criteria, disciplinary measures, dismissal, testing, disclosure and death benefits. • The supply of ARVs was not clear • Did not include communication of the HIV policy to relevant stakeholders, employees' spouses, life partners, orphans and immediate family.
	1.2.2	HIV and AIDS management system documentation.	• HAMS documentation makes reference to HIV and AIDS policy. • The relevant HIV related risks of the organisation were identified and objectives to mitigate those risks were documented in the HAMS annual plan for 2009 namely stigma and denial, substance abuse, migrant workers and contractors. The plan is reviewed annually and filed in the HAMS Master file.

SANS 16001 Standard			Organisation's HAMS
			• Objectives and targets to mitigate the risks is documented in the HAMS annual plan. • HIV related education is outlined in the HAMS objectives and planned Health Topics for 2009 is linked to the Health Calendar and reviewed annually. It is filed in the HAMS Master file.
	1.2.3	Control of documents.	• The organisation has reviewed and updated documents namely HIV Counselling and Testing (HCT) forms for adequacy prior to use which is filed in the HAMS Master file. The forms are reviewed when necessary. • Ensures that changes to and revision of documents are identified. • Ensures that documents remain legible and readily identifiable. • Relevant versions of applicable documents are available at points of use on the organisation Health and Well-being shard drive. • Documents of external origin necessary for planning and operation of HAMS are identified and distribution controlled by the Regional Health and Well-being manager.
	1.2.4	Control of records.	• The organisation has established and maintained records necessary to demonstrate compliance with requirements of its HAMS and the SANS 16001. • Ensures that records remain legible, identifiable and traceable.

SANS 16001 Standard			Organisation's HAMS
			• The clinic and EWB stores files in filing cabinets. Clinic files for employees that are deceased, retired, terminated or resigned are stored in the administration block for a period of 40 years under lock and key. • The organisation has established, implemented and maintained procedures for the identification, storage, protection, retrieval, retention and disposal of records with regard to confidentiality.
2.		Planning	
	2.1	Identification of HIV and AIDS determinants and evaluation of related risks.	• The organisation has established and maintains procedures for on-going identification of HIV and AIDS determinants and other factors within the defined scope of the HAMS that it can control and influence that promote the possibility to HIV. • A Knowledge, Attitude and Practices (KAP) survey was conducted in 2005. An HIV prevalence survey was conducted by Dr Evian in 2001, 2004, 2007 and 2011. The survey is conducted periodically. • An actuarial assessment of the impact of HIV and AIDS on the organisation was conducted in 2006. • The associated risks are evaluated at the organisation's HIV committee meetings to identify those that can have a significant impact on the performance of HAMS. • Risk evaluation includes activities of all persons having access to the organisation including contractors and community and social factors.

SANS 16001 Standard			Organisation's HAMS
			• Significant risks are taken into account when establishing, implementing and maintaining its HAMS. • Risk evaluation includes routine and non-routine activities and facilities at the organisation. • Documents results of the risk assessment process in the HAMS annual plan and keeps the information up to date.
	2.2	Legal and other requirements related to HIV and AIDS.	• The organisation has identified applicable legal and other requirements and rights applicable to HAMS in the organisation's HIV and AIDS policy. • Determined how these requirements apply to the organisation's HIV determinants and risks • The organisation has taken these requirements into account when establishing, implementing and maintaining its HAMS. • The organisation communicates relevant legal and other requirements to employees and interested parties through presentations of its HIV and AIDS policy.
	2.3	HIV and AIDS management system objectives, targets and programmes.	• The organisation has established, implemented and documented appropriate HAMS objectives and targets. • The organisation has taken into account its risks, legal and other requirements when setting targets and objectives. • The objectives and targets are measurable and consistent with the HIV and AIDS policy and includes commitment to continual improvement.

SANS 16001 Standard			Organisation's HAMS
			• The organisation has established, implemented and maintained programmes for achieving its objectives and targets. • The programme includes designation of responsibility and means for achieving objectives and targets. • The organisation technological options, financial, operational and business requirements and views of interested parties have been considered. <u>Gaps identified</u> • Specific time frames for achieving the set objectives and targets were not included in 2008 and 2009 HAMS annual plan.
	2.4	Responsibility and authority.	
	2.4.1	General.	• Roles and responsibilities are documented regarding the EWB coordinator, clinic personnel, peer educators and EWB committee members and filed in the HAMS Master file.
	2.4.2	HAMS representative.	• A top management representative (Head of Finance Department) has been appointed as the HIV committee chairperson and is the HAMS representative. • The HAMS representative reports to top management on the performance of HAMS for review and made recommendations for improvement in 2008 and 2009.

SANS 16001 Standard			Organisation's HAMS
			• The HAMS representative ensures that the views of employees and other interested parties are taken into account regarding HAMS.
	2.4.3	HAMS communication.	• The organisation has established and maintained procedures for ensuring that pertinent HIV and AIDS management system information is communicated to employees through the internal Communication Link and integrated with the annual Communication Plan from the head office of the organisation. • The Peer Educators (PE) and HIV committee members inclusive of union representatives are consulted and informed regarding the planned HAMS which are documented in the monthly HIV meeting minutes and located in the EWB file. • They are also involved in the development and review of policies and procedures to manage internal and external risks of exposure to HIV. • The results of the HIV prevalence surveys were communicated directly to interested parties and employees through a management brief document in December 2007 and filed in the HAMS Master file. • The employees are represented when decisions are made at the HIV committee by union representatives and PE. • The PE and HIV committee members are consulted before any changes that affect HIV and AIDS impact on the organisation are implemented.

SANS 16001 Standard			Organisation's HAMS
			• The employees are informed of the identity and function of the EWB coordinator, HIV committee chairperson and peer educators in the organisation through the internal Communication Link. • Employees are informed on how to access HIV and AIDS care and treatment through the Communication Link, EWB section presentations and PE. <u>Gaps identified</u> • To develop a communication procedure that will address the receiving, and documenting of, and responding to relevant communication from external interested parties. • The organisation needs to decide whether to communicate its HIV and AIDS-related risks to external parties and document the decision.
	2.5	Operational control and impact Mitigation.	• The organisation has identified and planned operations associated with HIV and AIDS determinants and related risks namely stipulating procedures for HCT and Disposal of Biohazardous Waste. • These procedures were communicated to relevant employees and contractors during in-service training, which was documented and filed in the HAMS file. • Health Topics and HIV awareness drives linked to the Health Calendar and Meeting Topics for the peer educators training planned for the year encompasses wellness management.

SANS 16001 Standard			Organisation's HAMS
	2.6	Emergency preparedness and response.	• The organisation has established and maintains emergency and response procedures for incidents and occupational emergency situations namely First Aid and Disaster Management located in the Safety policy file. • Quality control of sensitivity and specificity of HIV rapid tests, HIV storage temperatures and competency of employees using test equipment is outlined in the HCT procedure which is communicated with relevant employees. • The organisation procedures relevant to HAMS namely quality control of the medical service provider and disposal of biohazardous waste is periodically audited by external auditors as outlined in section 6.4. • A post-exposure prophylaxis (PEP) procedure in the event of sexual assault of employees is available in the EWB Master Policy file. • PEP for occupational exposure to HIV is available from the clinic and the clinic standard operating procedure is filed in the EWB Master policy. • The clinic sister has a list of peer educators and clinic personnel trained on universal precautions and disposal of biohazardous waste in the clinic training file.

SANS 16001 Standard			Organisation's HAMS
3.		<u>Resource Management</u>	
	3.1	Resources.	• Management has ensured the availability of resources necessary to establish, implement, maintain and improve the HIV and AIDS management system. Resources include human resources, technology and financial resources. (R450 000 was budgeted for the HIV and AIDS annual budget in 2009. The budget spread sheet was filed in the HAMS Master file.)
	3.2	Competence, training and awareness.	• HIV and AIDS awareness education needs were identified and employees whose work involves risk of exposure to HIV were assisted to become competent in Infection control, First Aid and Disaster Management training. A copy of completed training is filed in the HAMS Master file and Safety policy files. • The Peer Educators (PEs) are trained on 3 levels namely initial, intermediate and merit level by an external accredited trainer and copy of the certificates are filed in the HAMS Master file. • Monthly meeting topics for the PEs' training planned for the year was based on PE needs which were which were partly identified by the PE trainer. • Training needs for outstanding clinic personnel namely HCT training, Tuberculosis, Sexually Transmitted Infection and HIV and AIDS management, Adherence counselling and Peer Educator training was identified and planned.

SANS 16001 Standard			Organisation's HAMS
			Gaps identified • Make employees and contractors aware of importance of conformity to HAMS policy and procedures and potential consequences for noncompliance.
4.		Measurement, analysis and Improvement of HAMS	
	4.1	HIV and AIDS management system monitoring and measurement.	• The organisation has in place a monthly HIV committee meeting to establish, implement and maintain procedures to monitor and measure the impact of its HAMS on a monthly basis. The HIV committee meeting is documented in minutes and forwarded to the Group Wellness manager.
	4.2	Evaluation of compliance.	• The organisation has established, implemented and maintains procedures for periodic monitoring and evaluation of compliance of HAMS to international best practices and other requirements as explained under section 6.4. • Records of periodic evaluations are kept in the HAMS Master file.
	4.3	Nonconformity, corrective action and preventative action.	• The organisation has established, implemented and maintains procedures for dealing with actual and potential nonconformities and take corrective and preventative actions through action plans to identified gaps which is recorded in the HIV committee meeting minutes. • The HIV committee investigates nonconformities and implements appropriate actions to avoid recurrences as documented in the minutes.

SANS 16001 Standard			Organisation's HAMS
			Gaps identified • The organisation needs to record and review effectiveness of results of corrective and preventative actions taken and ensure that necessary changes are made to HAMS documentation.
	4.4	Audit	• An internal evaluation audit tool to evaluate the organisation's HIV and AIDS programme implementation bi-annually was established by the Group Health and Wellness manager. The records are filed in the HAMS Master file and available to management and other stakeholders. The audit results in 2008 was 82% and 2009 was 85%. • An integrated ISO audit is conducted at four yearly intervals. Certification for Occupational Health and Safety Management System (OHSAS) 18001:2007 was obtained in 2009, Certification for International organisation for Standardisation (ISO) 9001:2008 obtained in 2009 and ISO 14001:2004 in 2009. An external, registered and independent ISO integrated auditors undertook the evaluation.
	4.5	Management review.	• Top management reviews HAMS through monthly mill review feedback and biannual feedback is given to the Group Human Resources Director to ensure continuing suitability, adequacy and effectiveness. An annual feedback session is presented to the Group chairperson by the Group Health and Wellness Manager.

SANS 16001 Standard			Organisation's HAMS
			• Input to reviews include results of audits and evaluation of compliance to legal and other requirements. • Communications from interested parties including complaints, the extent to which objectives are met, status of corrective and preventative actions are included. <u>Gaps identified</u> • Reviews to include assessing opportunities for improvement and the need for changes and recommendations to HAMS objectives and targets and the HIV and AIDS policy. • Reviews to include follow-up actions from previous management reviews, changing circumstances including legal and other requirements within the scope of HAMS. • Outputs from management reviews need to include decisions and actions relating to changes to the HIV and AIDS policy, objectives, targets and other elements of the HAMS, consistent with the commitment to continual improvement.

4.2.2 Summary of findings for Research Question #1 using the ISO 9001 organising framework

4.2.2.1 The organisation's strengths

4.2.2.1.1 Management responsibility

Results of the qualitative audit (Section 4.2.11) revealed that the organisation has a good systematic process in place because it complied with most of SANS 16001 general requirements for HAMS.

The HAMS system documentation was fully compliant to SANS 16001. The planned objectives to mitigate the identified risks to HIV were discussed throughout the minutes and the achieved objectives were ticked off on the HIV annual plan which was in conformance to the SANS requirement to maintain documented HAMS objectives and targets. The organisation was fully compliant with control of documents and records.

The organisation implemented an HIV treatment programme in 2003. The organisation identified HIV and AIDS determinants, evaluated its related risks by arranging a Knowledge, Attitude and Practices (KAP) survey in 2005, and HIV prevalence surveys in 2001, 2004, 2007 and 2011. An actuarial assessment of the impact of HIV and AIDS on the organisation was conducted in 2006. The organisation was fully compliant with legal and other requirements related to HIV and AIDS and mostly compliant to HIV and AIDS management system objectives, targets and programmes.

The organisation's HIV committee meeting minutes revealed that the organisation was in conformance to SANS risk evaluation recommendation to include community and social factors by hosting meetings with the local traditional healers association, visiting local Governmental and Non-Governmental (NGO) Organisations and engaging in outreach projects for community upliftment.

For planning requirements the organisation complied fully with general organisational responsibility and authority, and appointment of a HAMS representative. The organisation's HIV committee meeting minutes revealed that the HAMS representative who is the chairperson of the HIV committee had one-on-one sessions with Peer Educators (PEs) to take their views into account and for individual support which resulted in successfully motivating PEs. The organisation was mostly compliant to HAMS communication.

The organisation has established and maintained procedures for ensuring that pertinent HIV and AIDS management system information is communicated to employees through the internal Communication Link and integrated into the Regional HIV and AIDS Annual Communication Plan. The HIV committee meetings documented that the health topics annual plan which included HIV education was communicated in the internal Communication Link as planned. Monthly HIV related presentations by PEs and EWB were recorded as occurring in the sections.

Employees were informed of the identity and function of the peer educators in the organisation through the internal communication and PEs were presented with training certificates during the General Manager's quarterly review meetings. PE photo frames were also put up in the sections.

For operational control and emergency preparedness and response the organisation scored full compliance. The HIV committee meeting minutes documented that the Group Health and Wellness manager sent an e-mail commending the exceptional teamwork resulting from the in-service training conducted by EWB regarding HCT and infection control for the clinic personnel.

4.2.2.1.2 Resource management

The organisation achieved most requirements for resources, competence, training and awareness. The records of the HIV committee meeting minutes revealed that the organisation's management supported HAMS and the PE programme. The PE year end function, nomination for recognition prizes and individual sessions with the HIV committee chairperson for individual support resulted in PEs rating management and the HIV committee as giving them optimal support which was a significant improvement from 2007.

The PE training report from an external accredited trainer rated the unit as a model for the PE programme and recommended that other organisations within the organisation group utilise the organisation for internship. The report outlined that PEs were given maximum management support in terms of resources and they are active with new methods of invoking audience participation regarding HIV education in the organisation. The Group Wellness Manager communicated that the organisation's PE meeting was leading other organisations within the organisation group. An EWB assistant position was successfully motivated and appointed. The EWB assistant reported to the committee on activities such as supporting the PE with their responsibilities, section presentations and home visits for HIV positive employees on disability.

4.2.1.2.1.3 Employee requirements

The SANS 16001 does not include employee requirements. The International Organisation for Standardisation (ISO) 9001 Process model that was used as a theoretical framework for this study included employee requirements as the next phase.

The ISO 9001 quality management system recommends that the organisation needs to determine requirements by the customer in order for delivery of the product (International Organisation for Standardisation, 2008:12).

According to the HIV committee meeting minutes the organisation considered the need for confidentiality of HCT and carried out alterations at the Clinic to ensure appropriate consultation rooms were built to promote confidentiality of HCT in compliance to legal requirements.

HIV related education and the HIV and AIDS policy communication were recorded throughout the HIV committee minutes as a need. This was implemented during multi-disciplinary team meetings, section green area meetings, inductions, training sessions, health day campaigns and PE "role plays" on stage at the canteen.

Since 2008 an Anti-Retroviral Therapy (ART) readiness course has been made accessible to employees and contractors through a local Non-Governmental Organisation since 2008 to improve the adherence of ART by affected employees. The support for HIV positive employees was identified as a need by the HIV committee. An HIV support group was launched in 2008 and continues to be sustained.

4.2.1.2.1.4 Measurement, analysis and improvement of HAMS

The organisation achieved monitoring and measurement, and evaluation of compliance requirements for HAMS. There was partial compliance to nonconformity, corrective action and preventive action. The HIV committee minutes documented that nonconformities were investigated and appropriate actions were implemented to avoid their recurrence. For example the Clinic personnel required that employees who refused HIV Counselling and Testing (HCT) were to sign for refusal and be referred to EWB. The union representative communicated that employees were not happy with the requirement to sign refusal of HCT. The professional nurse agreed that employees would no longer be required to sign refusal of HCT which resolved the concern.

The organisation attained requirements for auditing. An external, independent and registered ISO integrated auditor evaluated HAMS and the Clinic in 2009. Results revealed documented commendation for the organisation's HAMS annual plan and self-audit. In conclusion, the organisation achieved the majority of SANS 16001 general requirements as revealed by the qualitative audit.

According to the ISO 9001 process model, to achieve employee satisfaction the organisation needs to monitor employee perception to ascertain whether the organisation has met employee requirements. Employee experiences influence the uptake of HAMS and therefore need to be taken into consideration for continual improvement of HAMS. Positive feedback was received from employees for HIV presentations during health campaigns and section presentations which was a recurring theme throughout the organisation's HIV committee minutes.

A recurring theme of commendation for a phenomenal uptake of HCT since 2007 was noted throughout the HIV committee meeting minutes. The Group Wellness Manager confirmed that the organisation's HCT statistics were the highest in the organisation group when a total of 850 employees underwent HCT in support of World AIDS Day in November 2008.

4.2.2.2 Organisation's Weaknesses

4.2.2.2.1 Management responsibility

Observations of the qualitative audit revealed that the HIV policy did not include the nature and scale of the organisation's HIV and AIDS related risks. The policy did not include commitment to continual improvement and behaviour change communication. Non-discrimination in recruitment, performance evaluation criteria, disciplinary measures, dismissal, testing, disclosure and death benefits were not addressed in the policy. The supply of ARVs during and after employment was ambiguous. Communication of the HIV policy to relevant stakeholders, employees' spouses, life partners, orphans and immediate family was not included.

The HAMS self-audit conducted in 2009 confirmed that there was a gap in management training related to HIV and AIDS policy resulting in a score of 31% for management and 40% for supervisors. The HIV committee meetings documented that there was a concern that the policy should be communicated to all employees and plans to improve this was discussed.

Findings revealed that specific time frames for achieving the set objectives and targets were not included in the HAMS annual plan for 2008 and 2009 as required for HIV and AIDS management system objectives, targets and programmes.

A short coming was identified with HAMS communication, as there was no documentation of a decision by the organisation to communicate its HIV and AIDS-related risks to external parties. A communication procedure was not in place to address the receiving, and documenting of, and responding to, relevant communication from external interested parties.

Whilst the organisation has established and maintained procedures for HAMS communication, the HIV committee minutes documented that some requirements of the Regional HIV communication annual plan were not practical such as the communication officer was required to interview employees who have disclosed their HIV status whilst no employees had disclosed their HIV status in the organisation.

4.2.2.2.2 Resource management

Competence, training and awareness of Human Resources are a requirement of SANS 16001. The organisation's HAMS self-audit identified a short coming in the clinic personnel training requirements namely Tuberculosis (TB) protocols, Sexually Transmitted Infection (STI) protocols, treatment of HIV and AIDS conditions. A turnover of three professional nurses on the HIV committee was documented during a period of two years in the HIV committee meeting minutes.

Findings revealed that there was no documented evidence of the organisation making employees and contractors aware of the importance of conformity to the HAMS policy and procedures and potential consequences for noncompliance.

4.2.2.2.3 Employee requirements

A client satisfaction survey for HAMS was not in place at the time of the research.

4.2.2.2.4 Measurement, analysis and improvement of HAMS

Whilst the HIV committee investigated nonconformities and implemented appropriate actions, findings revealed that corrective actions were not documented for all complaints. The effectiveness of corrective and preventative actions was not reviewed. For example the HIV committee meeting minutes revealed that the union requested for an IsiZulu speaking doctor to be available during office hours for employees because of transport problems.

An external, independent and registered ISO integrated auditor evaluated HAMS and the Clinic in 2009. An observation regarding a concern of confidentiality of medical files that were accessible at the Clinic reception area was documented. This was consistent with a recurring theme of confidentiality concerns documented in the HIV committee minutes. For example, employees were not comfortable with the fact that the medical surveillance files which included HCT forms were accessible to all Clinic personnel.

A concern about confidentiality and the manner in which HCT was offered by some clinic personnel was documented in the HIV committee minutes. A union representative complained that when he declined HCT he was told, “you are at work now and you do not know what your wife is doing at home”. The personnel manager planned to discuss the complaint with the clinic management. However, there is no record of feedback to the HIV committee regarding resolution of this complaint. The EWB assistant similarly reported that employees who underwent an HCT with him expressed a concern that their HIV status would not remain confidential at the Clinic.

A new issue regarding the colour coding of HIV positive patient files was raised in the HIV committee minutes, whereby coloured dots on files represented certain chronic medical conditions including HIV. A meeting was held between management and they decided to continue with the colour coding. The union representative argued that this practice was a form of discrimination and expressed dissatisfaction. It was documented at the next HIV committee meeting that all colour coding would be removed from medical files.

Whilst the HCT statistics uptake showed a phenomenal increase, the HIV committee minutes documented that there was a concern that the majority of employees (88%) who tested HIV positive did not register on the organisation's HIV treatment programme. The union representative was of the opinion that the lack of HIV treatment uptake was the result of the colour coding of medical files. The professional nurse assured that follow up of these employees would occur. However, this was not reported on in subsequent minutes.

Top management scored poorly with regard to assessing opportunities for improvement and the need for changes and recommendations to HAMS objectives and targets and the HIV and AIDS policy. Reviews did not include follow-up actions from previous management reviews. The outputs from management reviews did not include decisions and actions relating to changes to the HIV and AIDS policy, objectives, targets and other elements of the HAMS to attain continual improvement.

In review of employees experiences concerns of confidentiality, fear of stigma and discrimination of HIV positive employees were a common theme throughout the HIV committee minutes.

4.3 Research Question #2: What are the intended benefits of HAMS?

Data was obtained via three focus groups. The data was analysed and major themes and sub-themes were identified.

4.3.1 Main Theme 1 – Prevention of HIV

Table 4.2 represents sub-themes and analyses that emerged regarding Main Theme 1.

Table 4.2: Main Theme 1 – Prevention of HIV.

Sub-theme	Analysis	Words of the participants
Information and education.	All focus group participants agreed that they experienced an intended benefit of HIV related information and education.	"*The internal communication…from when it started up until now, there's a frequent uh kind of contact with regards to kind of programmes that are available, where we can go and seek help." (Sakhile, Focus Group 1, 20 September 2010).* *"People see counsellors and they get educated about HIV and then they talk and discuss and it then depends on the person after a discussion that he can continue with HIV testing. That how he gets information of whether he has it or not, and get assistance and continue with life". (Yvonne, Focus Group 2, 21 September 2010).*
	Information on the prevention of HIV, re-infection and healthy lifestyle was reported to have been received from the HAMS by the Focus Group participants.	*"The company has peer educators that make people aware of HIV and how it is contracted." (Yvonne, Focus Group 2, 21 September 2010). "A person gets knowledge about how the virus is transmitted and what to do to avoid it. If you have this disease then you can infect your wife…but since we are educated we can prevent that by…having one partner only." (Khunene, Focus Group 2, 21 September 2010).*

Sub-theme	Analysis	Words of the participants
		"We are really educated well…taught that you must not…re-infect yourself and get more sick. You learn how to use a condom...learn that HIV is not only transmitted through sex but also through blood so if you helping someone without gloves you can also get it." (Samuel, Focus Group 2, 21 September 2010).
	An HIV committee member was of the opinion that that HIV related information and education was of a higher level than other organisations.	*"We hold regular health days…publish in the the Communication Link on how to keep safe…offer…female and male condoms… organisation employees are much more (.) knowledgeable where HIV is concerned than other companies." (Bernice, Focus Group 3, 8 September 2010).*
	A peer educator was of the opinion that the increase in HCT uptake was as a result of training.	*"I do a lot of training in the sections…if you look the test that we do…uh how the numbers…it's growing and I think by doing this training and going to people to come forward, go for a test." (John, Focus Group 3, 8 September 2010).*
	An HIV committee member alluded that to the fact that on-going information and education was required.	*"If I must go for an AIDS test, it's telling me they don't know enough about HIV and AIDS…we have a lot of work still to do in educating people." (Maureen, Focus Group 3, 8 September 2010).*
HIV Counselling and Testing (HCT).	As a result of health promotion activities all participants were aware that HCT was accessible within the organisation.	*"We…were many from the section. We were taught…the more you stay…not knowing your status, it will be diagnosed very late where treatment may not help you and your soldier cells will be very low…it's where I took a decision to get tested." (Vusi, Focus Group 2, 21 September 2010).*

Sub-theme	Analysis	Words of the participants
	The organisation rewarded employees when they tested for HIV, which contributed to attracting employees for HCT.	*"We were given T-shirts if people come and get tested, I didn't have to ask who's been there, I could see this one is wearing a VCT, they have been tested…something is happening." (Ted, Focus Group 1, 20 September 2010).* *"The…drives…getting people to understand that they should be tested…was the success story for the company. If you look at the numbers of people who did come to actually find out what their status were, uh I think that was a a huge plus for us." (Piet, pilot study, 11 September 2010).*
	Findings revealed that the majority of Focus Group 1 participants were not offered an HCT during their annual medicals.	*"…why can't they do testing when you do you're doing your annuals?" (Danny, Focus Group 1, 20 September 2010). "Never ever been offered, never been asked." (Danny, Focus Group 1, 20 September 2010).* *Another participant confirmed, "No." (Lucas, Focus Group 1, 20 September 2010).*
	Some participants were offended by the manner in which they were offered HCT.	*"They asked me…if I was testing every six months, every year depending on your activities, it's voluntary so I told them, thank you." (Ted, Focus Group 1, 20 September 2010).*
	Some employees chose to test for HIV with their private doctors due to anonymity.	*"If it's within the company…although there's all the confidentiality clauses in place…you just feel a bit more vulnerable. Whereas if it's your own private doctor and it's off site…you feel a little bit more protected and more sheltered, and it's your own private business…" (Frederick, Focus Group 3, 8 September 2010).*

Sub-theme	Analysis	Words of the participants
	Other reasons for opting out of HCT included denial and fear of a positive result.	*"Many do not trust themselves because their lifestyle of which if he comes here, a lot might come out." (Vusi, Focus Group 2, 21 September 2010). "Another person knows himself that he is not ready for it, if it is found that he is positive then he cannot accept it." (Vusi, Focus Group 2, 21 September 2010).*
	Hearing loss attributed to HIV raised trust issues.	*"One of the old men...was having problem about the hearing loss. They just eh pronounced that it is not related to noise, before taking him to a specialist. At the end it was eh discovered that it's still related to (..) uh to to the noise…It would…be difficult now to disclose at the medical centre your status." (Obed, Focus Group 1, 20 September 2010).*
	A participant experienced anxiety regarding answers to the HCT pre-test counselling questionnaire.	*"The whole event itself is also quite stressful …need to now prepare yourself, what are they gonna ask me, what am I gonna tell them, I'm not gonna tell them this and that…and where and what I've done and all that kinds of stuff." (Lucas, Focus Group 1, 20 September 2010).*
	Findings revealed that HCT was not integrated into general health awareness screening.	*"At the end it uh might look at …HIV as an isolated issue, out of which uh we are missing a big picture...I think it's…good…to look at these other support uh diseases which you can eliminate…we'd like to see more of…so they can go have check-ups." (Sakhile, Focus Group 1, 20 September 2010).*
	A participant argued that confidentiality of HIV results might be breeched.	*"If it can be like that, the number for the employees who will be participating will be less. Who is at the back can (.) uh can see…it (results)." (Obed, Focus Group 1, 20 September 2010).*

Sub-theme	Analysis	Words of the participants
	Results revealed that despite the organisation's initiatives in the HAMS some employees opted out due to a perceived fear of stigma.	*"I think the company has done a lot…we've got Peer Educators who go out there and talk…to make them feel comfortable and come forward and disclose about their status…and test but still I don't think it's enough…I don't know…What more can be done?" (Joyce, pilot study, 27 August 2010).* *"…the reasons why…people are not going for testing is the stigma aspect of it." (Ted, Focus Group 1, 20 September 2010).*
Confidentiality.	A committee member identified that it was critical for HIV positive individuals to know that their results will be kept confidential.	*"I was quite impressed when I came here in terms of what they actually do…and the assistance…Overall it's confidentiality, and I think in terms of that it's critical um for an individual who does test possible positive to know that, A, there's someone he can talk to, and B, that whatever is spoken about will remain confidential" (Cathy, Focus Group 3, 8 September 2010).*
	Participants agreed that HIV results were kept confidential within HAMS.	*"I know that we can be tested. I know uh that all that that information is kept very confidential, which we appreciate, and I also know that there is support…" (Lucas, Focus Group 1, 20 September 2010).*
		"Whatever they are saying to the EWB members there is treated confidentially…. also the HIV Committee itself, everything that's discussed on the meetings is treated uh as confidential as possible." (Joyce, pilot study, 27 August 2010). *"I think that the programme is going well. We never heard of any person being gossiped about just because it leaked that somebody is HIV positive." (Yvonne, Focus Group 2, 21 September 2010).*

Sub-theme	Analysis	Words of the participants
		"Things here are confidential even if someone is supported you won't know…they can keep secrets. You cannot even see a person who has a problem because of the way in which they get support." (John, Focus Group 2, 21 September 2010).
	Despite agreeing that there was confidentiality within the HAMS, a perceived fear of breech in confidentiality existed.	*"You don't feel comfortable talking to another person or to a total stranger, so that's why I feel that they are scared to come forward and talk about this." (Joyce, pilot study, 27 August 2010).* The participant later confided to the researcher that she was diagnosed HIV positive since 2002 and is on ARVs with a private practitioner.
		"*There is that fear that if it is found you are HIV positive maybe there are people in the company who might know, because I live my life with them for the whole week. I spent most of my time with them…I am one of those who ran away and tested in Durban and came back after three months to test here." (Vusi, Focus Group 2, 21 September 2010).*
	A fear of breech in confidentiality resulted in HIV positive individuals not seeking health care.	*"He will become suspicious that we may find a way to find it out that he has got maybe...it's fear." (Khunene, Focus Group 2, 21 September 2010).* *"Even if this thing is killing him, he won't…they do not trust the how confidential things are." (Sthembiso, Focus Group 2, 21 September 2010).*
	Involuntary disclosure precludes health care.	"*I've heard some people talking…a lot of inside the people mill who (…) are on ARV's…they are talking about their WEIGHT and stuff like that, so it's not right."* (Joyce, pilot study, 27 August 2010).

Sub-theme	Analysis	Words of the participants
		"*You will find others saying, we are fetching treatment with so and so, some are scared of things like that." (Yvonne, Focus Group 2, 21 September 2010).*
	The colour coding of HIV positive employees files resulted in frustration and a feeling of racism amongst employees.	*"Dots on HIV positive employees' files were for the clinic staff's benefit…some employees…questioned eh the dots on their files. Employees are FED UP with the medical centre. There is that stigma that HIV is eh a Black man's disease." (Obed, Focus Group 1, 20 September 2010).*
	Feelings of mistrust existed amongst employees and the union regarding the Clinic.	*"I don't trust the guys in the medical centre..." (Zizile, Focus Group 1, 20 September 2010). "There is no trust between the medical centre and the union…friction because of unfair decisions against the company employees." (Khunene, Focus Group 3, 8 September 2010).*
	Participants related receiving actual complaints of breech in confidentiality.	*"Eh some years…ago I'm up pushed by four ou's, they tested at medical centre…they are HIV positive…I use for the fact to history…If everyone ask me…about the testing…I would say…I can test any time but not at the medical centre…I assume that they can leak whatever information…" (Obed, Focus Group 1, 20 September 2010).*
	Concerns of confidentiality issues existed regarding the handling of medical files.	*"Two years ago (.) a lady at eh a section after finishing the annual checkup, the file was there, someone came and pinch it…after she was requested to do the HIV test. Eh (.) that means, once you leave your file…someone can go there and take the file, and check (.) your status." (Zizile, Focus Group 1, 20 September 2010).*

Sub-theme	Analysis	Words of the participants
		"When you look at the files and how they're being handled at the medical centre and…the access that more than one person has…to that file…is a concern…" (Lucas, Focus Group 1, 20 September 2010). *"If I go there to do my medical, you find that eh our files is lying there on the reception…even me I can…open the files and find confidential things." (Zizile, Focus Group 1, 20 September 2010).*
	Personnel from the Clinic living amongst employees resulted in trust issues.	*"Some of the employees who are working there, they stay with us in the township, if you know my status like it or not…he will tell somebody. Although he or she has signed a confidentiality, but he will tell somebody." (Obed, Focus Group 1, 20 September 2010).*
Peer Educators.	A participant revealed that the organisation's HAMS was initially ineffective until the creation of the peer education programme.	*"A lot of effort went into the…HIV programme but wasn't very effective at that stage…until we decided to do things differently to mobilise the programme by creating legs on the floor"* which on further probing was revealed as "*the peer educator system…that are the ears and hands on the floor…which is the crux of the programme." (Piet, pilot study, 11 September 2010).*
	Participants were satisfied with the quality of PE training.	*"The quality of training we getting here…it's very good it's quite very good, I'm telling you if we look at the works that we're doing, it shows." (Ricky, Focus Group 3, 8 September 2010).* *"They know and understand what's going on, and they've been trained properly." (Lucas, Focus Group 1, 20 September 2010).*
Anti-Retroviral (ARV) treatment.	Participants were aware of the provision of ARV treatment for employees by the organisation.	*"I also know that there is support for the guys in terms of the (.) um in terms of your status, anti-retrovirals is available." (Lucas, Focus Group 1, 8 September 2010).*

Sub-theme	Analysis	Words of the participants
		"If the organisation…promised, they've said if you test and you are a permanent employee then it will be put you on the programme for anti-retroviral treatment and support. (Ted, Focus Group 1, 8 September 2010).
	The organisation referred employees for Highly Active Anti-Retroviral Treatment (HAART) readiness training.	*"We also send each patient that does test uh positive…for HAART readiness training, which helps to prepare them in terms of the process going forward so they know what needs to be expected. (Cathy, Focus Group 3, 8 September 2010).*
	HIV positive employees who registered on the organisation's HIV treatment programme are perceived to have benefited.	*"I think also there are…people who uh have been registered to uh receive this uh ARV treatment...ja they do get all the proper care." (Joyce, pilot study, 27 August 2010).* *"It's obviously up to the employee to use those benefits and to understand them …once you've acknowledged that…they get good assistance." (Rowen, Focus Group 3, 8 September 2010).*
	The stages of grieving, traditional beliefs, alcohol abuse and fear of the commitment of taking ARVs and side effects were attributed to the poor uptake of the HIV treatment programme.	"*If you're told you are HIV positive that shock, it's a very traumatic event…I've been finding that the people need time to work…the trauma of finding out they're HIV positive." (Maureen, Focus Group 3, 8 September 2010).* *"I believe there's still is a lot of cultural hinges onto this…a lot of these people believe that the sangomas will treat them and cure them." (Piet, pilot study, 11 September 2010).* *"They rather believe in traditional healers, that's why they go to them uh maybe that's just a way of uh keeping their uh status safe instead of coming to the company doctors." (John, Focus Group 3, 8 September 2010).*

Sub-theme	Analysis	Words of the participants
		"Another stumbling is alcohol…consuming more alcohol than what they should…people get braver and then they think, you know I can go through this on my own." (Piet, pilot study, 11 September 2010). *"Your body will react…get swollen, getting fat and other things…male in newspaper, he found himself developing breasts after having started taking treatment…some are scared of that eish!" (Sthembiso, Focus Group 2, 21 September 2010).*
		"If…you have started taking treatment you cannot not stop…maybe he is not ready to take treatment and is scared that he may stop." (Samuel, Focus Group 2, 21 September 2010).
	Despite the intended benefits of the organisation's HIV treatment some employees on medical aid chose to register on a private HIV programme.	*"I've encountered people…who are positive and are on medical aid….people who are on treatment, who are happy…and they have chosen not to follow the route of the benefits that the company…provides." (Maureen, Focus Group 3, 8 September 2010).*
Employee Wellbeing (EWB) and the Clinic.	Participants recognised EWB as a source for information, advice, guidance and support regarding HIV.	*"They uh know that there is EWB…where they can get…advice and guidance…they know they can always get help…on how they can handle or or protect themself or their families uh from getting infected." (Joyce, pilot study, 27 August 2010).* *"There is EWB that help people with problems…we are assisted as this man has mentioned, even in your family, you can say it without fear." (Samuel, Focus Group 2, 21 September 2010).*

Sub-theme	Analysis	Words of the participants
	The HIV committee agreed that the Clinic personnel provided support through follow up of patients.	*"In terms of support from the clinic...they're dealing with the patients in terms of following up, and make sure that we do not have any defaulters in the programme." (Cathy, Focus Group 3, 8 September 2010).*
	Follow up of HIV positive employees by the Clinic personnel was not adequately utilised.	"*We try to get follow-up within twenty four hours…you get excuses…that range from, I'm busy at work to I'm going on holiday or whatever and they just never come back and that's sad because you never know where they go from there." (Bernice, Focus Group 3, 8 September 2010).*
Home visits.	Support was extended to employees and their families in their homes.	*"They also go to an extent that they even visit the people, the families of those people that are infected or are affected just to give support to those uh families." (Joyce, pilot study, 27 August 2010).*
	An article which was published in the internal communication regarding home visits that were conducted had a positive impact.	"*We've seen some picture where the homes they visited…one of the stories where we even saw the big lunch that they prepared for the team...so it was showing a very good support and if you see the people happy when they see the team coming from the company." (Ricky, Focus Group 3, 8 September 2010).*
HIV support group.	Although an HIV support group existed only some employees utilised the service due to stigma and a perceived fear of breech in confidentiality.	*"There is support group…they may end up coming because maybe some are thinking like me before testing here that somewhere somehow the information that I am positive will leak whereas there is nothing like that." (Vusi, Focus Group 2, 21 September 2010).*

Sub-theme	Analysis	Words of the participants
HIV committee.	The HIV committee was identified as being effective in implementing the organisation's HAMS.	*We've got a committee which I think is functioning quite well. In terms of the interventions that we do…there's regular health interventions." (Cathy, Focus Group 3, 8 September 2010).*
	A Peer Educator acknowledged support of PEs by the HIV committee members.	*"We've got…a Shop Steward,…PRO, clinic staff…EWB…so the organisation's doing very well, and they're giving us time, we do this during work hours…we've got a Manager here who's doing the interviews with…every Peer Educator, to find out what are their feelings about the Programme and…you need help you go to the manager." (Ricky, Focus Group 3, 8 September 2010).*
	One-on-one interviews with the HIV committee chairperson proved effective in motivating PEs.	"*They're going very well, it just (..) takes a few minutes to chat to everyone to see how they're going, how they're involved in the community and in the mill…" (Rowen, Focus Group 3, 8 September 2010).* *"The feedback that we get from the Peers after they've seen the chairman is… they feel encouraged that he takes the time to listen to their concerns…he's supportive of them and they go away feeling empowered…" (Maureen, Focus Group 3, 8 September 2010).*
Peer Educators.	The PEs were identified as a main source of support for employees.	*"Probably the most important part of that is the support component…cause you know it's a very difficult type of thing…to live with…that's what the peer educators are involved with…" (Lucas, Focus Group 1, 20 September 2010).* *"In terms of the success and the wellness of the individual. I think in terms of the support that they get from your Peer Educators, it's almost a little bit of an outlet." (Cathy, Focus Group 3, 8 September 2010).*

Sub-theme	Analysis	Words of the participants
	PEs were actively involved in offering support to employees and their families.	*He even asked me to even go to his house to speak to his family and his children so well we do, and some of the Peer Educators I hear too that they so confidently going to assist the employees in their houses."* (Ricky, Focus Group 3, 8 September 2010).
	A PE experienced opposition from his foreperson when he attempted to fulfil his PE responsibilities which affected his morale.	*"You send the mail for the meeting…for this date…you forward it to your superior…he tells you, no I can't release you for this. He always finds an excuse we don't have people, we're busy, the machine is down…we are here to make paper, we are not employed for PE work which has nothing to do with the business."* (Lucas, Focus Group 1, 20 September 2010). *"Ja, this I feel it. NEVER got that support…"* (Lucas, Focus Group 1, 20 September 2010).
No discrimination.	Management believed that there was a decline in stigma and discrimination.	*"We have achieved a lot. Breaking barriers was a major achievement and people are coming forward to test…It's not a huge issue now to talk about HIV, which four five years ago was like a scandal and this is not the case anymore…"* (Piet, pilot study, 11 September 2010).
	Education resulted in the decline of discrimination.	*"…with the education that is given through the Peer Educators… informing…the team leaders…when a person is infected…when they follow the doctor's prescription…they can still work effectively like anybody else…they have to accept everyone no matter what."* (Ricky, Focus Group 3, 8 September 2010). *"…this programme was conducted here…by EWB…you can say it without fear…encourage kids not to discriminate against HIV but be careful if a person has a cut..."* (Sithembiso, Focus Group 2, 21 September 2010).

Sub-theme	Analysis	Words of the participants
	Focus Group 1 participants believed that there was no HIV related discrimination within the organisation.	*"People are getting out of their shell thinking …so discrimination to be honest on the shop floor, I haven't seen personally…" (Ted, Focus Group 1, 20 September 2010). "I don't hear anything." (Sakhile, Focus Group 1, 20 September 2010).*
	Focus Group 2 participants confirmed that stigma and discrimination perpetuated amongst lower grade employees.	*"I heard them say, Hey! Did your'll see Khunene? He has AIDS…I showed myself and I asked him who told him that I had AIDS…he pretended to be looking for papers...It was popular belief that I had HIV/AIDS." (Khunene, Focus Group 2, 21 September 2010).*
		"Nje it is a joke, if you are sick how you are dying of AIDS!" (Yvonne, Focus Group 2, 21 September 2010). *"…I was wearing size 32 and now I am 36 someone said, no Yvonne the treatment is good for you…If you gaining weight, you are taking treatment. If you getting thin…are you stressed or is it AIDS? AIDS is always mentioned." (Yvonne, Focus Group 2, 21 September 2010).*
	Another participant also believed that stigma still existed amongst employees.	*"If you…disclose your status…people just look at you…they monitor you on day to day basis, seeing if you, when are you getting sick, and are you are you at work on that day." (Joyce, pilot study, 27 August 2010).*
	Stigma and discrimination was identified as a major barrier to accessing care and treatment for HIV.	*"These are the things that frighten people here in the company." (Samuel, Focus Group 2, 21 September 2010).* *"That is why employees are scared of testing." (John, Focus Group 2, 21 September 2010).*

Sub-theme	Analysis	Words of the participants
	Findings revealed that the organisation was supportive and did not discriminate against HIV.	*"If the company gets that you are sick, it does not dismiss you…it gives you help that will make you continue to live more days. It does not say because you have been working here, you are going to change…no you stay in your job you continue to get help, get treatment." (Sthembiso, Focus Group 2, 21 September 2010).* *"…this company…train you on how you should live…does not dismiss you…if your sickness is so severe, you can get disability." (Samuel, Focus Group 2, 21 September 2010).*
	Some senior employees did not support the Organisation's HAMS due to racial undertones.	"*There is a white misconception that HIV is a Black man's disease...there is horrible racism still here, the general consensus is that they will never support a programme for Black people but they wouldn't openly oppose it." (Maureen, Focus Group 3, 8 September 2010).*
	Participants agreed that they experienced the intended benefit of the organisation's HAMS through PE presentations.	*"The Peer Educators are doing a great job…with their role plays and uh distributing the condoms, showing how to use them…the information that they give…it's enough for the people…to…know what's going on uh with this HIV/AIDS..." (Joyce, pilot study, 27 August 2010).*
	A participant narrated the benefit of PE advice whilst workers were discussing HIV.	*"The peer educator said that we should call HIV correctly by its name as HIV straight…not say 'this thing', but to say HIV to show that we…talking about something that exists and we know it...It helps us as employees to know that HIV exists and not fear HIV." (Yvonne, Focus Group 2, 21 September 2010).*

Sub-theme	Analysis	Words of the participants
	An employee benefitted from disclosing his HIV status to a PE.	"…*later he came back to me and he said, listen here the teaching you gave me, now I'm feeling much better and the doctors told me now I'm not going to use a lot of tablets." (Ricky, Focus Group 3, 8 September 2010).*
Minimised impact of HIV.	Participants agreed that the organisation benefitted from minimising the impact of HIV on its employees.	*"This thing is working two way. The organisation need the employees …to make production…and the organisation have to take care of the life of the employees." (Obed, Focus Group 1, 8 September 2010).* *"They're really doing a lot of good work…in the long term if you can pick it up earlier, it means the impact on the business is low, so there is a benefit to the company as well." (Cathy, Focus Group 3, 8 September 2010).*
	Participants were aware of the impact of HIV on the organisation.	*"If organisation workers are fully aware that they have this disease…it helps because if they do not know, more workers will die…and that replacing a person, training that person, all things like that costs a lot to a organisation." (Khunene, Focus Group 2, 21 September 2010).* *"You can't just keep re-training…if you train somebody, and (..) that person has to die now of AIDS, it's, it's not necessary." (Danny, Focus Group 1, 8 September 2010).*
	Participants related that the results of previous HIV prevalence surveys indicated that the organisation's HAMS was effective in minimising the impact of HIV.	*"The last um saliva test survey…seen an adjustment in the numbers of of prevalence of HIV." (Frederick, Focus Group 3, 8 September 2010).* *"There has been a turn…with the younger generation as….they aren't scared of getting treated or knowing their status and making adjustments." (Frederick, Focus Group 3, 8 September 2010).*

Sub-theme	Analysis	Words of the participants
		"I'm involved in a company now with a HIV prevalence rate of 42%. It's nowhere near that in this company, and I think we're achieving that by giving the people information and by teaching them…and by offering such a great programme." (Bernice, Focus Group 3, 8 September 2010).
	Participants believed that the organisations long-term commitment to HIV has ensured their sustainability.	*"Benefits are…less absenteeism, less people off sick, (…) uh hopefully a more efficient um workforce. (Rowen, Focus Group 3, 8 September 2010).* *"I think the company has done a wonderful job …starting a long time ago in terms of HIV and AIDS…this is something that can't be achieved over night…they've gone a long way to make sure that we are where we are today as a company." (Frederick, Focus Group 3, 8 September 2010).*

4.3.2 Main Theme 2 – Treatment of HIV

Table 4.3 represents sub-themes and analyses that emerged regarding Main Theme 2.

Table 4.3: Main Theme 2 – Treatment of HIV

Sub-theme	Analysis	Words of the participants
Anti-Retroviral (ARV) treatment.	Participants were aware of the provision of ARV treatment for employees by the organisation.	*"I also know that there is support for the guys in terms of the (.) um in terms of your status, anti-retrovirals is available." (Lucas, Focus Group 1, 8 September 2010).* *"If the organisation…promised, they've said if you test and you are a permanent employee then it will be put you on the programme for anti-retroviral treatment and support. (Ted, Focus Group 1, 8 September 2010).*

Sub-theme	Analysis	Words of the participants
	The organisation referred employees for Highly Active Anti-Retroviral Treatment (HAART) readiness training.	*"We also send each patient that does test uh positive…for HAART readiness training, which helps to prepare them in terms of the process going forward so they know what needs to be expected. (Cathy, Focus Group 3, 8 September 2010).*
	HIV positive employees who registered on the organisation's HIV treatment programme are perceived to have benefited.	*"I think also there are…people who uh have been registered to uh receive this uh ARV treatment...ja they do get all the the proper care." (Joyce, pilot study, 27 August 2010).* *"It's obviously up to the employee to to use those benefits and to understand them …once you've acknowledged that…they get good assistance." (Rowen, Focus Group 3, 8 September 2010).* *"Your body will react…get swollen, getting fat and other things…male in newspaper, he found himself developing breasts after having started taking treatment…some are scared of that eish!" (Sthembiso, Focus Group 2, 21 September 2010).* *"If…you have started taking treatment you cannot not stop…maybe he is not ready to take treatment and is scared that he may stop." (Samuel, Focus Group 2, 21 September 2010).*
	Despite the intended benefits of the organisation's HIV treatment employees on medical aid chose to register on a private HIV programme.	*"I've encountered people…who are positive and are on medical aid….people who are on treatment, who are happy…and they have chosen not to follow the route of the benefits that the company…provides." (Maureen, Focus Group 3, 8 September 2010).*

4.3.3 Main Theme 3 – Support for HIV positive employees and HAMS

Table 4.4 represents sub-themes and analyses that emerged regarding Main Theme 3.

Table 4.4: Main Theme 3 – Support for HIV positive employees and HAMS

Sub-theme	Analysis	Words of the participants
Employee Wellbeing (EWB) and the Clinic.	Participants recognised EWB as a source for information, advice, guidance and support regarding HIV.	*"They uh know that there is EWB…where they can get…advice and guidance…they know they can always get help…on how they can handle or protect themself or their families uh from getting infected." (Joyce, pilot study, 27 August 2010).* *"There is EWB that help people with problems…we are assisted as this man has mentioned, even in your family, you can say it without fear." (Samuel, Focus Group 2, 21 September 2010).*
	The HIV committee agreed that the Clinic personnel provided support through follow up of patients.	*"In terms of support from the clinic...they're dealing with the patients in terms of following up, and make sure that we do not have any defaulters in the programme." (Cathy, Focus Group 3, 8 September 2010).*
	Follow up of HIV positive employees by the Clinic personnel was not adequately utilised.	"*We try to get follow-up within twenty four hours…you get excuses…that range from, I'm busy at work to I'm going on holiday or whatever and they just never come back and that's sad because you never know where they go from there." (Bernice, Focus Group 3, 8 September 2010).*
Home visits.	Support was extended to employees and their families in their homes.	*"They also go to an extent that they even visit the people, the families of those people that are infected or are affected just to give support to those uh families." (Joyce, pilot study, 27 August 2010).*

Sub-theme	Analysis	Words of the participants
	An article which was published in the internal communication regarding home visits that were conducted had a positive impact.	"*We've sawn some picture where the homes they visited…one of the stories where we even saw the big lunch that they prepared for the team...so it was showing a very good support and if you see the people happy when they see the team coming from the company." (Ricky, Focus Group 3, 8 September 2010).*
HIV support group.	Although an HIV support group existed only some employees utilised the service due to stigma and a perceived fear of breech in confidentiality.	*"There is support group…they may end up coming because maybe some are thinking like me before testing here that somewhere somehow the information that I am positive will leak whereas there is nothing like that." (Vusi, Focus Group 2, 21 September 2010).*
HIV committee.	The HIV committee was identified as being effective in implementing the organisation's HAMS.	*We've got a committee which I think is functioning quite well. In terms of the interventions that we do…there's regular health interventions." (Cathy, Focus Group 3, 8 September 2010).*
	A Peer Educator acknowledged support of PEs by the HIV committee members.	*"We've got…a Shop Steward,…PRO, clinic staff,…EWB…so the organisation's doing very well, and they're giving us time, we do this during work hours…we've got a Manager here who's doing the interviews with…every Peer Educator, to find out what are their feelings about the Programme and…you need help you go to the manager." (Ricky, Focus Group 3, 8 September 2010).*
	One-on-one interviews with the HIV committee chairperson proved effective in motivating PEs.	"*They're going very well, it just (..) takes a few minutes to chat to everyone to see how they're going, how they're involved in the community and in the mill…" (Rowen, Focus Group 3, 8 September 2010).*

Sub-theme	Analysis	Words of the participants
		"The feedback that we get from the Peers after they've seen the Chairman is… they feel encouraged that he takes the time to listen to their concerns…he's supportive of them and they go away feeling empowered…" (Maureen, Focus Group 3, 8 September 2010).
Peer Educators.	The PEs were identified as a main source of support for employees.	*"Probably the most important part of that is the support component…cause you know it's a very difficult type of thing…to live with…that's what the peer educators are involved with…" (Lucas, Focus Group 1, 20 September 2010).* *"In terms of the success and the wellness of the individual. I think in terms of the support that they get from your Peer Educators, it's almost a little bit of an outlet." (Cathy, Focus Group 3, 8 September 2010).*
	A PE experienced opposition from his foreperson when he attempted to fulfil his PE responsibilities which affected his morale.	*"You send the mail for the meeting…for this date…you forward it to your superior…he tells you, no I can't release you for this. He always finds an excuse we don't have people, we're busy, the machine is down…we are here to make paper, we are not employed for PE work which has nothing to do with the business." (Lucas, Focus Group 1, 20 September 2010).* *"Ja, this I feel it. NEVER got that support…" (Lucas, Focus Group 1, 20 September 2010).*
No discrimination.	Management believed that there was a decline in stigma and discrimination.	*"We have achieved a lot. Breaking barriers was a major achievement and people are coming forward to test…It's not a huge issue now to talk about HIV, which four five years ago was like a scandal and this is not the case anymore…" (Piet, pilot study, 11 September 2010).*

Sub-theme	Analysis	Words of the participants
	Education resulted in the decline of discrimination.	*"…with the education that is given through the Peer Educators…informing…the team leaders…when a person is infected…when they follow the doctor's prescription…they can still work effectively like anybody else…they have to accept everyone no matter what." (Ricky, Focus Group 3, 8 September 2010).* *"…this programme was conducted here…by EWB…you can say it without fear…encourage kids not to discriminate against HIV but be careful if a person has a cut..." (Sithembiso, Focus Group 2, 21 September 2010).*
	Focus Group 1 participants believed that there was no HIV related discrimination within the organisation.	*"People are getting out of their shell thinking …so discrimination to be honest on the shop floor, I haven't seen personally…" (Ted, Focus Group 1, 20 September 2010).* *"I don't hear anything." (Sakhile, Focus Group 1, 20 September 2010).*
	Focus Group 2 participants confirmed that stigma and discrimination perpetuated amongst lower grade employees.	*"I heard them say, Hey! Did your'll see Khunene? He has AIDS…I showed myself and I asked him who told him that I had AIDS…he pretended to be looking for papers...It was popular belief that I had HIV/AIDS." (Khunene, Focus Group 2, 21 September 2010).* *"Nje it is a joke, if you are sick how you are dying of AIDS!" (Yvonne, Focus Group 2, 21 September 2010).* *"…I was wearing size 32 and now I am 36 someone said, no Yvonne the treatment is good for you…If you gaining weight, you are taking treatment. If you getting thin…are you stressed or is it AIDS? AIDS is always mentioned." (Yvonne, Focus Group 2, 21 September 2010).*

Sub-theme	Analysis	Words of the participants
	Another participant also believed that stigma still existed amongst employees.	*"If you…disclose your status…people just look at you…they monitor you on day to day basis, seeing if you, when are you getting sick, and are you are you at work on that day." (Joyce, pilot study, 27 August 2010).*
.	Stigma and discrimination was identified as a major barrier to accessing care and treatment for HIV.	*"These are the things that frighten people here in the company." (Samuel, Focus Group 2, 21 September 2010). "That is why employees are scared of testing." (John, Focus Group 2, 21 September 2010).*
	Findings revealed that the organisation was supportive and did not discriminate against HIV.	*"If the company gets that you are sick, it does not dismiss you…it gives you help that will make you continue to live more days. It does not say because you have been working here, you are going to change…no you stay in your job you continue to get help, get treatment." (Sthembiso, Focus Group 2, 21 September 2010).* *"…this company…train you on how you should live…does not dismiss you…if your sickness is so severe, you can get disability." (Samuel, Focus Group 2, 21 September 2010).*
	Some senior employees did not support the Organisation's HAMS due to racial undertones	"*There is a white misconception that HIV is a Black man's disease...there is horrible racism still here, the general consensus is that they will never support a programme for Black people but they wouldn't openly oppose it." (Maureen, Focus Group 3, 8 September 2010).*

4.4 Research Question #3: What are the experiences of HIV positive employees who are registered on the organisation's HIV treatment programme?

Data was obtained from the five one-on-one interviews with HIV positive employees registered on the organisation's HIV treatment programme. The data was analysed and major themes and sub-themes were identified.

4.4.1 Main Theme 1 – Benefits

Table 4.5 represents sub-themes and analyses that emerged regarding Main Theme 1.

Table 4.5: Main Theme 1 – Benefits

Sub-theme	Analysis	Words of the participants
Information and education.	Participants registered on the organisation's HIV treatment programme verbalised benefiting from information and education.	*"The information…is very positive. You get everything…financial wise, health wise, everything is in place." (Daniel, one-on-one interview, 29 November 2011).* *"The way EWB provides us with information it's very good cause even if you are not at work…phone you …then you can see how this information can help you." (Nelly, one-on-one interview, 10 September 2011).*
	Participants related experiencing improvement in their health after implementing information from EWB.	*"EWB…discussing a lot of things…asking about my wife…they join us…taking the medication on the same medical." (Daniel, one-on-one interview, 29 November 2011).* *"As a foreman…We getting it on the e-mails…so that's how I got it." (Watson, one-on-one interview, 5 November 2011).* *"EWB advised me to go to the clinic…I went there and then I started my treatment. And I'm feeling well now. (Watson, one-on-one interview, 5 November 2011).*

Sub-theme	Analysis	Words of the participants
	A participant verbalised that he received information from EWB which assisted him with improving his lifestyle, disclosure and adherence to ART.	*"I saw one video one guy was hiding it so that uh nobody will know at home…when you when you're taking the treatment you must be open to your family…they…reminding…you must eat healthy food, then the treatment will work". (Bobby, one-on-one interview, 8 September 2011).*
	Employees attitude towards HIV were influenced by education within the organisation resulting in an increased HCT uptake.	*"I think as information is more exposed to everyone…attitude has changed… even the ratio of testing I think since has gone up than before." (Nelly, one-on-one interview, 10 September 2011).*
	More information on benefits of early HCT and treatment was requested.	*"…meetings with employees like just to explain that…you…need to go test blood…because if you know your status, I think that's a relief…you can start taking the treatment…It's a disease…if you got HIV, it's not that you'll die now…make every employee to be aware of it..." (Bobby, one-on-one interview, 8 September 2011).*
HIV Counselling and Testing (HCT).	Participants were aware and supportive of HCT within the Organisation.	"*If you know your status and then the EWB advise you where you supposed to go. And then they never chasing you away. They still keep you working." (Daniel, one-on-one interview, 29 November 2010).*
	Participants understood that HCT was voluntary.	*"Up to people to say that (.) they accept the challenge that they given by the company." (Daniel, one-on-one interview, 29 November 2010).*

Sub-theme	Analysis	Words of the participants
	Findings revealed that the Peer Educators were instrumental in promoting HCT campaigns to meet set targets.	"*They spread the word around the sections…campaigns where it invites people…they have a target…the peer educators…encourage people to go for testing." (Nelly, one-on-one interview, 10 September 2010).*
	A participant who was referred by a PE registered on the HIV treatment programme.	"*I found out that I was positive… and from there we did um my viral load and CD4 count…EWB told me about Qualsa so that I can register…qualify for free medication." (Nelly, one-on-one interview, 10 September 2010).*
	A PE who is a foreperson actively promoted HCT resulting in a successful uptake in his department.	*"I encourage them just to just to know your status. When you are right keep it safety…if you are positive it's not end of the road. You supposed to change the way of living…then you can live longer…All my shift crew I think err ninety percent came for…HIV testing." (Daniel, one-on-one interview, 29 November 2010).*
	Some employees are resistant to HCT.	*"The guys they do talk when they're outside something like, hey I won't test or something." (Bobby, one-on-one interview, 8 September 2011).*
	Perceived fear of breech in confidentiality precluded HCT.	*"Some are afraid that maybe they are gonna be exposed that they are HIV positive…they don't know that it's confidential. So that's why maybe they scared to come forward." (Watson, one-on-one interview, 5 November 2010).*
Confidentiality.	Participants agreed that confidentiality was maintained within the organisation's HAMS.	*"I always come to EWB and…WHATEVER we speak it remains private." (Zelda, one-on-one interview, 27 October 2011).*

Sub-theme	Analysis	Words of the participants
		"When I'm coming to…EWB office…never heard anything about me…our…HIV committee. No one can spreading all these things to say that I'm positive I'm what. So I believe that it's confidential." (Daniel, one-on-one interview, 29 November 2010).
	The naming queues in the public clinics influenced a participant to register on the organisation's treatment programme.	*"If we attend this EWB Programme…get counselling…this confidentiality, hey I haven't experienced something that hey maybe the EW…went and talk about us…" (Bobby, one-on-one interview, 8 September 2011).* *"Nurse will come and say; uh queue for the TB…She'll not like say for whatever they came…you can see that this person looks a bit sick. So definitely you gonna conclude. So I decided no let me go to the company clinic not the public ones." (Zelda, one-on-one interview, 27 October 2011).*
	Employees were not coerced into disclosure and experienced support during the disclosure process.	*"It is confidential…no one that is forced to disclose. Everyone is given a choice to disclose." (Nelly, one-on-one interview, 10 September 2010).* *"I've disclosed to my foreman and my other colleagues…my mother…they always encourage us that it's up to you when you ready to disclose…there is no pressure." (Nelly, one-on-one interview, 10 September 2010).*
	A participant experienced that his HIV status was initially kept confidential by the professional nurse.	*"I think there is a confidentiality at the company EWB, Peer Educators. I'm talking about what I've seen. When I started treatment eh it was confidential…with the professional nurse." (Watson, one-on-one interview, 5 November 2011).*

Sub-theme	Analysis	Words of the participants
	A participant did not approve of the Clinic personnel concealing his ARVs because he was comfortable with his HIV status.	"*They open all medication for you. But before it came with the box…I don't mind…It's a part of my life that thing. So I don't bother myself about anyone who can see that the box is for (…)." (Daniel, one-on-one interview, 29 November 2010)*.
Peer Educators.	A participant was of the opinion that PE training was adequate.	*"I think Peer Educators are trained." (Watson, one-on-one interview, 5 November 2011).*
	Man-to-man training was afforded to some male PE which empowered a participant to effectively assist male employees.	*"Men are clay soil they taking long to absorb something…on that man-to-man (training) we learn a lot how can we to face that… attitude…People….come and ask me…they have their problem…even the(.) .uh people that are older than me." (Daniel, one-on-one interview, 29 November 2010).*
	A foreperson observed the PE in his section being very helpful and actively promoting HCTs.	*"The guy is very helpful…Peer Educators…doing a very good job…they are encouraging each and every employee to go and test…so that they can know about their status." (Watson, one-on-one interview, 5 November 2011).*
	A participant confirmed that PE presentations were being done.	*"There are some presentations done in this section." (Watson, one-on-one interview, 5 November 2011).*
	A PE who is a foreperson reminded employees to take their ARVs timeously.	*"I knows…guys uh that are HIV positive in my section…I look after for them. Ask him…do you remember what's the time? He knows that when I'm asking the time…he go and take his medication." (Daniel, one-on-one interview, 29 November 2010).*

Sub-theme	Analysis	Words of the participants
	A participant who had a bad experience with the late EWB assistant had trust issues with PEs.	*"I always had a fear…are these all people professional? Do they know how to keep some other peoples secrets or everything? I still wonder…I know some of them they are but I'm not sure." (Zelda, one-on-one interview, 27 October 2011).*
	The progress in HIV knowledge amongst employees was attributed to PEs which affirms the effectiveness of PE.	*"It's fine to have peer educators. Because some people especially all the people they were blank about HIV and AIDS…So you know someone who can explain to them using their language that they understand better." (Zelda, one-on-one interview, 27 October 2011).*
	A participant was of the opinion that the young PEs were intimidated by older employees.	*"I believe the…young guys are scared to to talk to the older guys, they feel like maybe uncomfortable…attitude…what this Ou knows…I don't know how this programme will work within the Section, cause some of the guys are young." (Bobby, one-on-one interview, 8 September 2011).*
Highly Active Anti-retroviral Readiness Training (HAART).	Participants benefited from HAART training.	*"The course was excellent. And they even teach us how to take treatment. When to take it and we must not miss it." (Watson, one-on-one interview, 5 November 2011).*
	A participant advised that HAART training was essential before commencing ARVs.	*"Before I started my medication they spoke to me…I knew what I was dealing with…I think it's best to attend (..) uh the course first (..) because some issues arise…if side effects and everything." (Zelda, one-on-one interview, 27 October 2011).*
	HAART prepared participants for ARV side effects which promoted adherence.	*"Sometimes I was vomiting when taking the treatment…So I carried on taking the medication…up until my body agreed that I'm on medication." (Watson, one-on-one interview, 5 November 2011).*
Anti-retroviral (ARV) treatment.	A participant attributed the reason he is alive was due to ARVs.	*"That's my medication. That's part of my life. That's why I'm living because of that medication." (Daniel, one-on-one interview, 29 November 2010).*

Sub-theme	Analysis	Words of the participants
	A participant who defaulted ARVs improved and returned to work after adherence.	*"As time goes on I took the treatment…tested my blood. They…told me hey I'm doing well…with me taking it continuously…helped me a lot…can see I'm recovering…I must still take it so that I recover more." (Bobby, one-on-one interview, 8 September 2011).*
	A participant reported no side effects and experienced a decline in opportunistic infections.	*"I haven't had any side effects...when the time goes on I got used to the treatment the symptoms disappeared even the flu…so far the treatment is keeping me well." (Nelly, one-on-one interview, 10 September 2010).*
Cost saving and convenience.	Participants experienced convenience when utilising the organisation's HIV treatment programme.	*"I saving a lot cause we just jump on the car park…It's easy for us. Even when I'm vying to the shopping mall…I go straight…and take my medication. (Daniel, one-on-one interview, 29 November 2010).* *"Ja I will say it was convenient because I …don't DRIVE to Stanger. I don't drive to Empangeni to collect medication. It's just here. It's delivered here…whenever ( ) uh I want it I get it." (Watson, one-on-one interview, 5 November 2011).*
	Participants were allowed to collect ARVs during working hours which depicts management's support.	*"I may not have time to go…cause of the shifts I am working but…I can excuse myself…go to our clinic and fetch the medication…even…lunch time you can go there and return to work." (Nelly, one-on-one interview, 10 September 2010).* *"Because…it's closer to me…I don't need…to go somewhere far to get my treatment, even if…I'm at work I…ask my Supervisor…I need…to go fetch my treatment…then they allow me to go." (Bobby, one-on-one interview, 8 September 2011).*

Sub-theme	Analysis	Words of the participants
	Participants experienced cost saving benefits.	*"When you are sick when you got no cash you can go straight there…that's why I tell them say (.) uh take your medication right here." (Daniel, one-on-one interview, 29 November 2010).*
	Participants were informed when their ARVs arrived.	*"At the public clinic you wait (..) a long time to fetch treatment meanwhile here it is convenient…they phone you to inform you that your treatment is there." (Nelly, one-on-one interview, 10 September 2010).* *"They sending a message on my phone to say that they dispatched your medication." (Daniel, one-on-one interview, 29 November 2010).*
	A participant was impressed that the Clinic personnel honoured appointments which saved time.	*"Other doctors you'll make (..) 10 o' clock appointments…when you go there there are people…You have to wait up until all those people are finished…but there, they are professional…If you don't have an appointment, there are people who have made an appointment. You will…wait for their appointments." (Zelda, one-on-one interview, 27 October 2011).*
	Easy accessibility to the Clinic was experienced by participants.	*"I had access to the medical centre at any time of the week unless maybe it's a weekend…Sisters don't work the weekend…even if you…off…you can go easier…and fetch your treatment." (Bobby, one-on-one interview, 8 September 2011).*
Support.	PE were identified as a source of support for employees.	*"The Peer Educators they do a tremendous job…they just err encourage the people to be tested and then trust people to be behaving right…stop people to be doing wrong things…just guiding the people the right way. (Daniel, one-on-one interview, 29 November 2010).*

Sub-theme	Analysis	Words of the participants
	Support group members benefitted through sharing information and experiences.	*"The support group err…Ja they benefit." (Daniel, one-on-one interview, 29 November 2010).* *"It gives us more knowledge…we…share some ideas and experiences especially in this disclosure part cause most of us it's not easy to just disclose but if ever you…speak to people who understand the very same language…it will be easy…if I can take step one and step two maybe I can arrive at step five." (Nelly, one-on-one interview, 10 September 2010).*
	Support group members supported one another through their experiences.	*"…the other lady she asked…how do you …start taking ARV's? How did you do it? The support group is very important…that's where you share experiences. I didn't know we were on the same page…you'll be surprised that haibo I'm not the only one." (Zelda, one-on-one interview, 27 October 2011).*
	Support extended outside the support group.	*"Even later that day the other lady she sent me an sms saying; this is not our battle sister. God will see us through…through the support group all will be fine." (Zelda, one-on-one interview, 27 October 2011).*
	A participant benefitted from motivational speakers who visited the support group.	*"Some of the guys they come with different experience or something in that support group…we get visitors from outside. The guys that got experience…they give us support too…help us a lot." (Bobby, one-on-one interview, 8 September 2011).*
	A participant received information material and support during a home visit.	*"…It's not that I'm an only person that is taking the treatment…if you can get an information like that saying the Doctor is taking an HIV treatment…they even tell you what to eat, what not to eat. How to live a healthy life…I was so happy." (Bobby, one-on-one interview, 8 September 2011).*

Sub-theme	Analysis	Words of the participants
	Participants that experienced home visits responded that they found it to be beneficial and supportive.	*"Came to, to my house…helped me and my family a lot…We are living a normal life…My wife…has accepted that I'm HIV positive… she's still treating me the way…through EWB counselling…" (Watson, one-on-one interview, 5 November 2011).* *"I've received a home visit. I was shocked too when I got (laugh) that, but hey I was happy. That's when I knew, hey, it's not that I'm alone or something…that's when I knew…got support." (Bobby, one-on-one interview, 8 September 2011).*
	Participants agreed that they received support through EWB counselling.	*"Me and my co-ordinator…discuss about…how am I coping…also come to you now and again. Sometime you feel…this person is really pestering me…you end up seeing…what is making me fail to be so concerned about my life so to be with people like this it is very nice." (Nelly, one-on-one interview, 10 September 2010).* *"I do go for counselling and it helps. Especially…at some stage nje besides eh your problems about the HIV you have some other problems…so it's easy to go and talk about any problem you might have." (Zelda, one-on-one interview, 27 October 2011).*
	A participant experienced support from EWB and the Clinic.	*"I got that support from…the EW Programme…medical centre…got Sisters like, giving me counselling…ask you if you got a problem like a hey like eating healthy ….when last…you take the treatment, they even give you condoms." (Bobby, one-on-one interview, 8 September 2011).*
	A participant was dissatisfied when she was refused STI treatment by the Clinic in error.	*"How can the company…give us medication for vitamins and ARVs…more expensive than STI treatment? …I ended asking a lady who was working at the [public] clinic to find me something for that moment…" (Nelly, one-on-one interview, 10 September 2010).*

Sub-theme	Analysis	Words of the participants
	Participants were impressed with the organisation's support through HAMS.	*"I got the support even in the management…the company…put on the table just offering me that how they look after for me…I'm impressed about what the company…did for us." (Daniel, one-on-one interview, 29 November 2010).* *"With the treatment I'm taking, I'm feeling healthy…must…test so that they'll get support from the company, because the company is willing to help us… recover or stay healthy." (Bobby, one-on-one interview, 8 September 2011).*
	A participant who disclosed her HIV status to her colleagues experienced a lot of support.	*"…I was like eish let me take my pills for HIV then she just laughed then…I had to tell sisi I am not joking. I am HIV positive…She was so supportive…she will phone and ask me Nelly have you eaten, did you take your medication." (Nelly, one-on-one interview, 10 September 2010).*
	A foreperson played a pivotal role in an employee's recovery.	*"When I was sick…my foreman…told me…if you got a problem you need to go…EW Programme…helped me a lot because I ended up uh being like on disability….Foreman…told me…if you…doing… physical job that that needs power…not feeling well…tell me I will put other guys on that job...he read…about this support groups how they help employees to recover." (Bobby, one-on-one interview, 8 September 2011).* *"With my foreman too because your superior it's like he's like a mother…knows you when you got a problem…without his support hey I don't think I would have managed." (Bobby, one-on-one interview, 8 September 2011).*

Sub-theme	Analysis	Words of the participants
No discrimination.	Participants responded that they didn't experience discrimination regarding their HIV status within the organisation.	*"I never seen it…discrimination...But at the end of the day they accept now and they understand the thing." (Daniel, one-on-one interview, 29 November 2010). "They never chasing you away. They still keep you working." (Daniel, one-on-one interview, 29 November 2010).* *"...You are just treated like normal person. Eh there's no there's no…discrimination…" (Watson, one-on-one interview, 5 November 2011).*
	A participant related that she felt protected from discrimination by the organisation.	*"But the company itself, no. I think I've been more than protected. I don't even know what can I say." (Zelda, one-on-one interview, 27 October 2011).*
	Results revealed that employees supported HIV positive employees.	*"They not talking negatively about people who are infected…most of the people they are supportive to those people who are HIV infected." (Watson, one-on-one interview, 5 November 2011).*
	Although a participant experienced support as a result of involuntary disclosure, he felt internal stigma.	*"...some…talk good…like hey, look at Bobby, he's healthy and all. But these other Ou's (say) why you don't take treatment or something…when they see…somebody getting sick, they…(say) why don't go speak to somebody maybe you get healthy." (Bobby, one-on-one interview, 8 September 2011).*
	A PE related that her PE presentations changed the negative attitude of her foreperson.	*"…a foreman who used to say bad things about HIV positive people but when the time goes I was in the section doing my presentations and he ended understanding more better about HIV people and I once… told him that some other people who were affected by…things he say…then he ended up cooperating very well (smiling)." (Nelly, one-on-one interview, 10 September 2010).*

Sub-theme	Analysis	Words of the participants
	Despite participants agreeing that no discrimination existed within the Organisation shame, stigma and silence still perpetuated.	*"If everyone was so open about HIV like sugar and other diseases (..)hh. I don't think there will be any problems. The other thing that I think is killing us a lot is that we are so like we are secretive." (Nelly, one-on-one interview, 10 September 2010).*

4.4.2 Main Theme 2 – Barriers

Table 4.6 represents sub-themes and analyses that emerged regarding Main Theme 2.

Table 4.6: Main Theme – Barriers

Sub-theme	Analysis	Words of the participants
Fear.	Participants revealed that employees did not register on the HIV treatment programme because they feared discrimination.	*"Maybe one will say...if I go (..) uh for the treatment …for the company thing. Eh (…) if my employer knows…I just don't want people to know…Maybe some times that it can affect my work." (Zelda, one-on-one interview, 27 October 2011).* *"Maybe they scared that maybe they will chasing away…That's why the people who are scared of that." (Daniel, one-on-one interview, 29 November 2010).* *"They are afraid that maybe if I use company services my status will be known." (Zelda, one-on-one interview, 27 October 2011).*
	A participant did not participate in the HIV prevalence survey because he feared that his employment would be affected.	*"…we had that uh spewing test …I doubting myself to do it because, I wasn't sure whether they'll be taking our names or what, because it will affect my position at work or something like that..." (Bobby, one-on-one interview, 8 September 2011).*

Sub-theme	Analysis	Words of the participants
	Employees feared involuntary disclosure at the Clinic whilst fetching ARVs.	*"The guys are…scared…if people…saw this guy here is taking treatment…to the medical centre, it's not that…you're alone one day, maybe you'll find other guys there." (Bobby, one-on-one interview, 8 September 2011).*
	Employees preferred to access an HIV programme where they were unknown.	*"…The other people will say, no (..) I don't wanna go to Mandeni. I don't wanna go to any company clinic. Let me just go to Durban where no one knows me." (Zelda, one-on-one interview, 27 October 2011).*
	Some employees feared that they might be HIV positive.	*"We do attend…these bars…maybe you are drunk…You take a lady…to your room, you don't think about using a condom… …you start doubting yourself, hey, did I contract HIV? Some of the guys…scared to going to test cause they don't know what to expect." (Bobby, one-on-one interview, 8 September 2011).*
	Participants related that fear existed regarding knowing one is HIV positive, the challenge of disclosure, commitment to taking ARVs and death.	*"Other people were scared to to face the sequences of their life…" (Daniel, one-on-one interview, 29 November 2010).* *"Some of the guys they're like scared maybe if they know that they got HIV, hey to disclose to their family…" (Bobby, one-on-one interview, 8 September 2011).* *"…she has to start the ARV's now. But she's afraid…She is still doubting." (Zelda, one-on-one interview, 27 October 2011).* *"You know the guys they then they got a th th that mind of hey, I'm like hey, I'll be dying now." (Bobby, one-on-one interview, 8 September 2011).*

Sub-theme	Analysis	Words of the participants
	Fear was linked to internal stigma and guilt.	*"…I think it's a natural fear…you know if you have done something wrong…If people look at you. You'll think that maybe that they'll see it's YOU that has done something wrong…" (Watson, one-on-one interview, 5 November 2011).*
	A participant who was afraid to access the HIV programme experienced that he benefitted himself.	*The experience I can say uh regarding HIV programme…I heard about it…I was also scared to come forward. But since um (…) that was the way uh I was gonna be helped. I had to approach EWB as I did…it's very helpful. (Watson, one-on-one interview, 5 November 2011).*
Stages of grieving.	Denial results in HIV positive individuals not seeking healthcare and dying.	*"I've seen people who have died because of denial. Yes lots, lots even from my family. My cousins, they've passed on because of denial." (Zelda, one-on-one interview, 27 October 2011).*
	A participant confessed that fear delayed his seeking help.	*"I tested…I got that I was HIV infected. So um I was scared to come forward for about a year and I started to getting sick." (Watson, one-on-one interview, 5 November 2011).*
	Non-disclosure, despair and fear of dying results in loss of the will to live.	*"It's like if you are HIV positive it's your own thing and you don't want anybody to share it with you you have to die alone. Anyway because you are dying so what's the use of getting help." (Nelly, one-on-one interview, 10 September 2010).*
	Non-disclosure leads to stress which lowers immunity and results in opportunistic diseases.	*"…we are quick to get opportunistic diseases because we hide things and you end up with stress." (Nelly, one-on-one interview, 10 September 2010).*

Sub-theme	Analysis	Words of the participants
	A participant feared that death was imminent every time she had an ailment.	*"When something small happens you have flu then you get stressed thinking now I am going to be bedridden, HIV is now taking me and panic." (Nelly, one-on-one interview, 10 September 2010).*
	The participant eventually accepted her status and viewed HIV as a chronic illness.	*"Haai me sisi I know that I will die…To be HIV positive is the same as if I have cancer, sugar or I have BP like ANY OTHER diseases." (Nelly, one-on-one interview, 10 September 2010).*
	Acceptance resulted in a participant taking responsibility and seeking help.	*"I knew that if…I don't take action I might die and my children and my wife will suffer… that's why I said no. I better take treatment because it's the only way it's gona help me." (Watson, one-on-one interview, 5 November 2011).*
	Disclosure goes hand in hand with acceptance.	*"I have accepted my status in such a way that (.) uh if I see that person, (swallowing) is very close to me...I don't mind to disclose." (Zelda, one-on-one interview, 27 October 2011).*
	Counselling and disclosure promotes acceptance of HIV and reduces anxiety.	*"…a lot of things that have helped me…having proper counselling. Opening it up. Where you have to tell someone…That was (…) one big step. It was HUGE. After that it was like HEY I was relieved." (Zelda, one-on-one interview, 27 October 2011).*
	Disclosure provides an opportunity for support and the feeling of not being alone.	*"…If a friend can come and share this…why can I can't I accept it and just be free and talk freely about it…it came to a point where I knew that I'm not the only one." (Zelda, one-on-one interview, 27 October 2011).*
Confidentiality.	A barrier to registering on the organisation's HIV treatment programme was a perceived fear of breech in confidentiality.	"*Maybe it's because of confidentiality. Maybe they scared…people will at the clinic they will see that they are HIV positive. And then they will go on gossiping about their names." (Watson, one-on-one interview, 5 November 2011).*

Sub-theme	Analysis	Words of the participants
	Employees feared that the organisation's doctor might divulge their status to the organisation.	*"Other people they have got that negative attitude…cause it's a company doctor… some way…communicate with the HR like." (Daniel, one-on-one interview, 29 November 2010).*
	Employees perceived a lack of confidentiality at the clinic because of inappropriate probing by personnel.	*"People still have THAT in their minds that there is no confidentiality in the clinic and everybody will see me going there and will know…cause the lady if you go to clinic and ask for the sister she will ask you what you want from the sister." (Nelly, one-on-one interview, 10 September 2010).* *"…most of the people they are scared to go…to the clinic…asking questions...people don't want to…tell they are HIV positive." (Watson, one-on-one interview, 5 November 2011).*
	A participant was unhappy that his status was divulged when he was referred to a paramedic.	*"When I started treatment eh it was confidential…since sister XX is not there…referred to somebody else who doesn't know your status…So you have to explain…that's not confidentiality…I'm also not happy going that side." (Watson, one-on-one interview, 5 November 2011).*
	Employees feared that the Clinic personnel living amongst them might divulge their status.	*"…at the public clinic that we have around our place there is this thing that the people that are working there they go back in the community and talk about people. I think that even at this clinic the same thing will happen." (Nelly, one-on-one interview, 10 September 2010).*
	Involuntary disclosure resulted when seen consulting with a particular professional nurse.	*"…maybe you'll find other guys there…they see…he's coming out with a packet of tablets or something…if you…go see a certain Sister, then they know…he's taking…HIV treatment." (Bobby, one-on-one interview, 8 September 2011).*

Sub-theme	Analysis	Words of the participants
Alcohol abuse.	Alcohol was less stigmatising than HIV.	*"I did disclose to them…I had a problem with alcohol…my colleagues telling me hey Bobby if you got a problem, you must try and stop." (Bobby, one-on-one interview, 8 September 2011).*
	Alcohol abuse resulted in risky behaviour and precluded HCT.	*"…the HIV…virus…it starts…in a bar…you start doubting yourself, hey, did I contract HIV or what? Some of the guys they even scared to going to test cause they don't know what to expect." (Bobby, one-on-one interview, 8 September 2011).*
Turnover of professional nurses.	A turnover of professional nurses resulted in a participant being dissatisfied with the organisation's HAMS.	*"since sister XX is not there…I'm also not happy going that side. Because I've been referred to somebody else who is not even a a a a trained nurse." (Watson, one-on-one interview, 5 November 2011).* *"I went there for my medication. (Sigh) …they said no my medication is not there…there's no follow up in terms of delivering the medication to the clinic…I was so worried …maybe this nurse doesn't care about my life.." (Watson, one-on-one interview, 5 November 2011).*
Anti-retroviral (ARV) treatment side effects.	A participant mistook opportunistic infections for side effects of ARVs.	*"I had an experience of these side effects, hey that's when I knew, hey this Programme, it's not right for me…I thought maybe TB the tablets are giving me side effects…I had uh a diarrhoea…the Doctor told me, hey I'm not taking the treatment uh quite well...I ended up having shingles." (Bobby, one-on-one interview, 8 September 2011).*
Stigma and discrimination.	Employees feared participating in the organisation's HAMS due to fear of discrimination.	*"Maybe they scared that maybe they will chasing away. You know people like. That's why the people who are scared of that." (Daniel, one-on-one interview, 29 November 2010).*

Sub-theme	Analysis	Words of the participants
		"…saliva survey…Cause I think the guys, (.) is like when they know, hey I'm HIV…I'll lose my job or…position at work, maybe they'll give me another position…I think here, with that too, (..) that's why the guys, they're scared of testing. (Bobby, one-on-one interview, 8 September 2011).
	Fear of being ostracised by employees existed due to stigma.	*"Are afraid ja hey what people will say about me if I disclose." (Nelly, one-on-one interview, 10 September 2010).* *"…in our minds I think there is this thing that okay if someone is positive it's just because they were sleeping around. So if I disclose to them I'm HIV positive they will see aw this one was sleeping around." (Nelly, one-on-one interview, 10 September 2010).*
	Employees experienced stigma and isolation by colleagues due to involuntary disclosure.	*"…when you're within the Section and… you're getting sick…your body's getting thinner or you're getting sick…they do suspect that hey this guy here hey maybe he got HIV. Some…guys they…try …not to be closer to you." (Bobby, one-on-one interview, 8 September 2011).* *"I once heard some rumours. But I think those people they were just guessing…I know for a fact that they didn't know a thing …But I didn't take it very well. You see it disturbed me… (Zelda, one-on-one interview, 27 October 2011).*
	A participant experienced discrimination when his colleagues refused to use his tools and left him to work alone.	*"…the foreman he ended up buying us like individual tools so that there'll be no… discrimination…I did explain…the tool that I'm using…the guys here they don't want to use it…you're doing a graff (work) the guys they ended up…leaving you on your own…" (Bobby, one-on-one interview, 8 September 2011).*

Sub-theme	Analysis	Words of the participants
	A participant did not internalise external stigma because she accepted her status.	*"I received…an anonymous call…who said… they said…you are HIV positive…So I said…if they think that I have it, it's fine…If they don't have it, it's their luck…I was a bit cross…But after that I'm cool, nje. I'm fine. It just doesn't get into me…You see I've accepted my status." (Zelda, one-on-one interview, 27 October 2011).*
	Participants experienced that employees had derogatory names for HIV thus discouraging disclosure.	*"There is stigma cause if they see a person sick they will be like hey looks like HIV 'Iqocks' (nickname for HIV) caught him…you hear how they talk about others you think eish if I can disclose to them what will happen to me?" (Nelly, one-on-one interview, 10 September 2010).* *"…even someone can tease…especially in us as a youth I I don't know whether it has became as a…theme…Whenever people are fighting…they say, oh well you've got AIDS or you are HIV positive…" (Zelda, one-on-one interview, 27 October 2011).*
	A participant stopped consulting with professional nurses because she experienced discrimination by a professional nurse.	*"…she was not nice nje at all…when I came there…she was cross…She was cheeky…She said, Hey no no not at this time…after some time…she checked on my file. And then she saw it's written the time…she never like apologized as in like she was meaning it you see." (Zelda, one-on-one interview, 27 October 2011).* *"…I felt like she was discriminating me… for a while nje I was not okay with seeing sisters because (.) uh I don't know if all of them will be like her you see. Up until I got counselled…" (Zelda, one-on-one interview, 27 October 2011).*

Sub-theme	Analysis	Words of the participants
	A participant related that employees that attended EWB were labelled as being HIV positive.	*"Some people…I think that in their minds that everyone has seen me that I am going to EWB…it is about HIV meanwhile at EWB it is not about HIV only…So people have this thing ah if I go to EWB people will see me going down there so they will think that I have HIV." (Nelly, one-on-one interview, 10 September 2010).*

4.5 Research Question #4: What are the experiences of HIV positive employees who are not registered on the organisation's HIV treatment programme?

After a comparison of themes from five one-on-one interviews with HIV positive employees who are not registered on the organisation's HIV treatment programme, two main themes emerged from the data and will be discussed below.

4.5.1 Main Theme 1 – Benefits

Table 4.7 represents sub-themes and analyses that emerged from the data regarding Main Theme 1.

Table 4.7: Main Theme 1 – Benefits

Sub-theme	Analysis	Words of the participants
Information and education.	A participants health improved after implementing education.	*"I've learned…about taking tablets…even my CD4 count has went up…I'm feeling more better…it has benefited me in order to stay cautious… and doing things right." (Thomas, pilot study, 8 September 2010).*
	Information and education promoted the acceptance of HIV.	*"Till I got more understanding of HIV and AIDS management…if you look after well yourself you can live…much longer. So it's to accept and it's like any diseases…" (Siyabonga, one-on-one interview, 9 November 2011).* *"They need to be educated nje." (Stanley, one-on-one interview, 28 October 2011).*

Sub-theme	Analysis	Words of the participants
	A participant observed that information and education decreased stigma and discrimination.	*"…since they haven't experienced it…a person thinks that if they sit with someone who has the virus obviously they will also be infected. In the way that I see things happening…when a person knows that they keep their distance from you…but with learning about the virus some they just don't mind." (Nelson, one-on-one interview, 5 November 2010).*
	A participant expressed benefiting from the experience of a person living with HIV during World AIDS Day.	"*…I learn a lot…I asked him about how he survived from full blown AIDS to what he is now with such a high CD4 count so I learnt a lot from him." (Nelson, one-on-one interview, 5 November 2010).*
	A participant did not receive HIV communication due to no section meetings.	"*It's in the bush here you have to see for yourself." (Stanley, one-on-one interview field notes, 28 October 2010).*
	A participant was of the opinion that one-on-one education regarding HIV would be more effective.	"Call one by one person…going through it with everybody within the mill…maybe the people will understand…if you're taking a group of people teaching them…some will understand, some won't understand." (Thomas, pilot study, 8 September 2010).
	Results indicated that more education on HIV was required to decrease on stigma.	*"Try and educate people more about that so that it can maybe sink in their heads it's not about how many people you slept with. You can be a virgin and be active once…you get infected with HIV." (Nelson, one-on-one interview, 5 November 2010).*
	Results indicated that line management needed education on the psychosocial aspects of HIV.	*"The management…I don't feel maybe they understand clearly…how people feel…after hearing…they are positive…they see the person is sick they don't…refer him that time to the doctors. Some they even let him come to work whether they see this person is sick." (Thomas, pilot study, 8 September 2010).*

Sub-theme	Analysis	Words of the participants
	Older employees had a misconception that HIV affected younger people.	*"Some say I'm happy because hey I'm old now you see I don't go anywhere…Some say like me… If you…still want some cherries you ( ) uh must use some condoms." (Norman, one-on-one interview, 25 November 2011).*
HIV Counselling and Testing (HCT).	Participants were of the opinion that the HCT programme was effective; however some employees did not access HCT.	*"I would say it is effective…even though not everybody…come forward…because again they are (..) not comfortable…exposing their…HIV related illnesses." (Sipho, one-on-one interview, 10 November 2010).*
	The quality of HCT and rewards for undertaking an HCT was successful in improving the uptake of HCT.	*"It's becoming a very high level…testing… they get something like a T-shirt." (Norman, one-on-one interview, 25 November 2011).* *"People start going because there are…give aways. It's right the T-shirts and bags…It draws other people a lot…It also made me very happy honestly." (Nelson, one-on-one interview, 5 November 2011).*
Confidentiality.	Most participants agreed that they received the intended benefit of confidentiality within the organisation's HAMS.	*"Ja only through the EWB office…they are caring they know how to do follow up…speak private matters…kept confidential…if something is upsetting you…that is the only place that you know you can cough it out safely and your stress levels are less." (Stanley, one-on-one interview, 28 October 2011).* *"The things that I experienced is that the person who is employed at EWB, you are able to talk to her and she knows how to keep your information to herself and confidential." (Stanley, one-on-one interview, 28 October 2011).* *"The way EWB keep the thing…everything is keep private even though…there is somebody you know about his or her status…everything is just…keep quiet…every time." (Norman, one-on-one interview, 25 November 2011).*

Sub-theme	Analysis	Words of the participants
	A participant who transferred from the organisation's HIV treatment programme believed that confidentiality only existed in the EWB office.	*"Everything in…the company is confidential…I do have a positive but (..) uh only me and maybe in the EWB (..) uh knows that. And even my foreman…the previous one was knew about it and he kept it between him and me." (Norman, one-on-one interview, 25 November 2011)* *"…off sick… twice a week or more…from disability…he asked me why…I told him everything…he promised me…that would be between him and me…he responded positive." (Stanley, one-on-one interview, 28 October 2011).*
	Participants who disclosed their status to their foreperson experienced support.	*"When we have a green area meetings maybe once or twice a week…shared information between our colleagues... sometimes easily to understand something with the people at your same level..." (Siyabonga, one-on-one interview, 9 November 2011).*
Peer Educators.	A participant who was a trained PE described how he disseminated HIV related information.	*"That was more for educational…were beneficial…people tend to be shy…it won't see as many people it as (..) you'll think people need to know…people don't want to .(..) associate with any of that." (Sipho, one-on-one interview, 10 November 2010).*
	Although PE presentations were beneficial some employees avoided these due to stigma.	*"I can't say nothing err anything about that. Because I only seen their T-shirts and I never sat with one of them." (Norman, one-on-one interview, 25 November 2011).*
	Whilst a participant was aware of PEs he didn't experience a presentation.	*"I learnt a lot…the food err about my weight…how to keep my body fit you see. Ja I learnt a lot by this side and then I gain it [weight]." (Norman, one-on-one interview, 25 November 2011).*

Sub-theme	Analysis	Words of the participants
Highly Active Antiretroviral Readiness Training (HAART).	A participant expressed that he benefited from HAART.	*"Ja it has benefited me because (..) now I understand how what's the dangers of not taking tablets, skipping them, all those things." (Thomas, pilot study, 8 September 2010).*
	A participant understood the dangers of defaulting ARVs.	*"Ja it was really right in such a way that I wish that doctor my could be my family doctor with the way in which he explains things. (Stanley, one-on-one interview, 28 October 2011).*
	The manner in which the doctor from the local NGO presented the course facilitated easy understanding.	*"I believe people who are under programme they are doing well…I'm not the only one who's HIV positive in the mill but people they are doing well." (Siyabonga, one-on-one interview, 9 November 2011).*
Anti-retroviral (ARV) Treatment.	A participant believed that employees on ARVs benefited.	*"Maybe the husband is working for the company he's taking treatment here and his wife…is taking treatment… somewhere else…it's better if they can take the treatment on the same place in order, the people whose offering help…understand…their problems." (Thomas, pilot study, 8 September 2010).*
	Results revealed that there was a need for the organisation's HIV treatment programme to be extended to employee's spouses.	*"…you get support in a way that you end up living. They give you reason that life still goes on and hope. From EWB ja." (Nelson, one-on-one interview, 5 November 2011).* *"…when I got problems…been help helpful to me…The support (..) uh through the EWB." (Thomas, pilot study, 8 September 2010).* *"The support that I have especially that my wife still we were not married at that time. And I was scared to tell my mother…EWB…helped me a lot." (Siyabonga, one-on-one interview, 9 November 2011).*
Support.	Participants agreed that they received support through EWB counselling.	*"We had visits uh I think that was just at the time when I was sick. Yes, I would say it was it was beneficial, helpful..." (Sipho, one-on-one interview, 10 November 2010).*

Sub-theme	Analysis	Words of the participants
	A participant who experienced home visits benefitted.	*"I…did receive uh help …communicating with medical staff (..) there has been a lot of advice…things like counselling and understanding uh (..) the disease…" (Sipho, one-on-one interview, 10 November 2010).*
	A participant experienced that the Clinic personnel were supportive and helpful.	*"Basically all what we know about the medi it come from the EWB office but not from the medical staff…we know that it's a clinic next to the company they offered the health service to the company. But I still belief they are not exposed to employee." (Siyabonga, one-on-one interview, 9 November 2011).*
	Presentations from the clinic were required to promote their services.	*"…indirectly the section was supporting me. Even if I was in the hospital so I think company supportive." (Siyabonga, one-on-one interview, 9 November 2011).* *"…[Foreman] responded positive…he said, …everyone has his own thing that makes him sick which doesn't mean that…will…kill you quickly…" (Stanley, one-on-one interview, 28 October 2011).*
	Participants experienced support regarding their status within the organisation.	*"The company has helped a lot of people…through the EWB…So I think …don't changing this method…everything will be coming okay I think so." (Norman, one-on-one interview, 25 November 2011).*
	Results revealed that the organisation was supportive of HIV positive employees and the internal structures for support were effective.	*"I haven't heard of any cases where individuals have been discriminated against as a result of being HIV positive in the company…during my past 26 years…" (Siyabonga, one-on-one interview, 9 November 2011).* *"I haven't had any bad experience (..) because um I haven't told anybody about my status…" (Thomas, pilot study, 8 September 2010).*

Sub-theme	Analysis	Words of the participants
No discrimination.	Participants responded that they didn't experience discrimination within the organisation as a result of their HIV status.	*"After my disability…I can't say the company discriminate me because I've been promoted two times…I went on my studies. I finished my N6 diploma. I carry on with them at B Tech." (Siyabonga, one-on-one interview, 9 November 2011).*
	A participant related that he received study assistance and was promoted after being diagnosed HIV positive.	*"…they just generalise if somebody's sick (..) and uh possibly they share information as to how to can help…somehow. So uh my other understanding is that people now look after themself." (Siyabonga, one-on-one interview, 9 November 2011).*
	Involuntary disclosure resulted in the support of some HIV positive employees.	*"I didn't hear another person say…I know of sure…that this person is positive. According to the stats…there is a percentage …positive…there is no one specific identified which means that no they do keep their promise." (Siyabonga, one-on-one interview, 9 November 2011).*
	The organisation fulfilled confidentiality and non-discrimination as pledged in the HIV policy.	*"I think education that's been going around both nationally and within the company, does help people to understand…this disease so as a result there's not much of (..) a gossip as such of individuals." (Siyabonga, one-on-one interview, 9 November 2011).*
	A participant was of the opinion that education decreased stigma and discrimination.	*"They all (..) uh err feel ashamed and then…some say hey we must we must… be aware of that thing." (Norman, one-on-one interview, 25 November 2011).*
	A participant admitted that shame and stigma still existed despite awareness on HIV.	*"They all (..) uh err feel ashamed and then…some say hey we must we must… be aware of that thing." (Norman, one-on-one interview, 25 November 2011).*

4.5.2 Main Theme 2 – Barriers

Table 4.8 represents sub-themes and analyses that emerged from the data regarding Main Theme 1.

Table 4.8: Main Theme 2 – Barriers

Sub-theme	Analysis	Words of the participants
Fear.	Results revealed that employees did not register on the Organisation's HIV treatment programme because they feared stigma.	*"I think (..) uh the only thing that can be there …people are scared that their status will be revealed." (Nelson, one-on-one interview, 5 November 2011).* *"I haven't heard anything about anyone's status that they are positive and stuff…It's just nje that there are those fears nje." (Nelson, one-on-one interview, 5 November 2011).* *"It that people haven't accepted their status. They are afraid that they will be laughed at." (Stanley, one-on-one interview, 28 October 2011).*
	Fear precludes HCT and access to care and treatment.	*"Ja it's fear, (..) and some people are even having fear of even testing you see (..) so they can't even access anything, so they're even scared or starting testing you see." (Thomas, pilot study, 8 September 2010).*
	A belief existed that the knowledge of being HIV positive results in stress which hastens death.	*"The fact that you know actually kills itself ja, you end up accepting that you are going to die…the whole system gives up. (Sipho, one-on-one interview, 10 November 2010).*
	A participant related that witnessing sick people dying of AIDS was a fearful reminder that he would be next.	*"…it was on the television programmes when they show these dramas of people who have …AIDS…who's VERY sick. If that goes through your mind that one day I will be like that like that person it's hurtful…It's frightening." (Siyabonga, one-on-one interview, 9 November 2011).*

Sub-theme	Analysis	Words of the participants
Stages of grieving.	Fear experienced after being diagnosed HIV positive is accompanied by shock.	*"The people…got this thing in their mind that maybe you once you get scared you get the shock maybe you found that you positive…" (Thomas, pilot study, 8 September 2010).*
	Denial results in depression, despair and illness.	*"I was saying to admit…you feel that now life is ending and you are getting sick…Denial jaaa." (Nelson, one-on-one interview, 5 November 2011).* *"Many people they don't accept HIV and they think that if you have this disease it's the end of your life." (Stanley, one-on-one interview, 28 October 2011).*
	A participant who was in despair became financially irresponsible.	*Because first time when I (..) diagnosed that I'm HIV positive. (..) My financially behaviours change and I was using all of my finance, my savings…I was looking like I'm dying tomorrow. (Siyabonga, one-on-one interview, 9 November 2011).*
	Blaming oneself and others is a barrier to acceptance.	*"On my opinion to discovering on yourself it means to accept what you have better than blaming somebody. Said why I have the virus? Who I got it from?" (Siyabonga, one-on-one interview, 9 November 2011).*
	The stages of grieving is a process until acceptance is attained.	*"…it is difficult to admit. I am not saying that it is right not to admit but it is difficult it takes time after time then you learn to live with it." (Nelson, one-on-one interview, 5 November 2011).*
Confidentiality.	Two participants reported that the Clinic personnel divulged HIV results.	*"I remember it's quite a while ago…some of the medical staff…used to release…confidential information to some people who did not need to know." (Siyabonga, one-on-one interview, 9 November 2011).*

Sub-theme	Analysis	Words of the participants
		"…I was working at the reception…at that time it was when that HIV and AIDS started …individuals name were made to known…to the outside people who were not involved in the…medical treatment as such..." (Sipho, one-on-one interview, 10 November 2010).
	A participant changed to a private doctor after his HIV status was divulged.	*"That was only reason that made me change or not to continue with the clinic because they …revealed my HIV status to the community...The employees at the medical centre are unable to keep things confidential at work." (Stanley, one-on-one interview, 28 October 2011).*
	A participant did not register on the organisation's HIV treatment programme due to knowledge of colour coding of HIV positive employees files.	*"…because of what I knew…Files of individuals who are HIV positive…sticker…indicating that there is no confidentiality at the medical centre." (Sipho, one-on-one interview, 10 November 2010).*
	Perceived fear of breech in confidentiality, stigma and discrimination precluded accessing the organisation's HAMS.	*"Some people believe that (..) be known to the public again the information will be spread all over the mill and their reputation goes down the drain." (Sipho, one-on-one interview, 10 November 2010).* *"It was fear of information that might be leaked to the company. Maybe I might be discriminated…" (Norman, one-on-one interview, 25 November 2011).* *"…the problem with, for the people is…they are (..) they are scared somebody will see, will know the result maybe the person who's testing them will tell the results I don't know." (Thomas, pilot study, 8 September 2010).*

Sub-theme	Analysis	Words of the participants
	Employees chose to utilise private doctors because they felt safer that their status would remain confidential.	*"Some people believe that uh their illness …is their own business…so they prefer going to their private doctors." (Sipho, one-on-one interview, 10 November 2010).* *"It was fear of information that might be leaked to the company. Maybe I might be discriminated. That's why I went through on a private doctor...a lack of trust to the company..." (Norman, one-on-one interview, 25 November 2011).* *"…I was just…want to make it private confidential…I just I don't like you see everybody to know..." (Norman, one-on-one interview, 25 November 2011).*
	Participants were not comfortable with the Clinic personnel who were married to employees.	*"People from. here and people from the clinic they know each other…some have husbands and wives there…if…a wife tells a husband…it will go all over the mill…" (Norman, one-on-one interview, 25 November 2011).* *"…you see when a person is going to be tested by that person maybe he or she knows outside the mill (..) maybe a relative or family friend, (.) that's why they don't trust...most of them." (Thomas, pilot study, 8 September 2010).*
	Involuntary disclosure resulted when employees did not join queues, saw the professional nurse and left with a lot of medication.	*"…if you go there…there is a group...they all see…you are not taking…this form…not seeing the doctor…you are following the sister maybe you are…taking some…anti-retroviral." (Norman, one-on-one interview, 25 November 2011).* *"...if someone is near me who went for annual check-up and I came for my treatment he will know that on the annual check-up list this person was not there." (Stanley, one-on-one interview, 28 October 2011).*

Sub-theme	Analysis	Words of the participants
		"…my friend…told me that hey the way they are doing this thing…not…coming out to in the front door with err a lot of (..) uh tablets you see…He was complaining about that thing. But err long time ago." (Norman, one-on-one interview, 25 November 2011).
	Results revealed that there is a need for suitably trained Clinic personnel that are committed to confidentiality.	*"It needs to have the people who have confidentiality and have been trained properly nje and not speak that I saw you." (Stanley, one-on-one interview, 28 October 2011).*
	A participant recommended that forepersons need to sign a confidentiality document to deter confidentiality violations.	*"…the foremen must train them again…so that they can sign that they…will not divulge confidential information if they divulge confidential information they will get into trouble…So that…you are assured that …it is not easy for him…to disclose..." (Stanley, one-on-one interview, 28 October 2011).*
Traditional medication.	Some African employees believe in traditional medication which precludes western medication.	*"…we the Africans sometimes (..) we believe more (..) on uh on this uh this African treatments you see…traditional treatment." (Thomas, pilot study, 8 September 2010).*
Stigma and discrimination.	HIV positive employees did not access the HIV support group due to stigma.	*"…if a person can be assisted individually and not as a group you know. Individual makes people more comfortable. But as a group it will really make people really uncomfortable even though you know these classes by five are positive but still it makes things very difficult." (Nelson, one-on-one interview, 5 November 2010).*

Sub-theme	Analysis	Words of the participants
	Involuntary disclosure whilst taking ARVs resulted in stigma.	*"…maybe a person sees a person maybe taking some tablets…some people don't hide things you see…you'll hear some people saying hey, he was saying this and that you see…Telling people this person's got…AIDS you see." (Thomas, pilot study, 8 September 2010).*
	Participants revealed internal stigma when they kept distancing themselves from HIV.	*".well in the past when this thing came up and this disease HIV and AIDS it was something really scary…They just look and suspect…because of your physical appearance…no one can actually guarantee that you will be safe (..) ja because of the way that you pick these things up, ja." (Sipho, one-on-one interview, 10 November 2010).*
	A participant who was initially registered on Organisation's HIV treatment programme changed to a private doctor after he experienced discrimination from the Clinic Doctor.	*"…Dr XX was very cruel to me…He said…last week you were here and you come here again. You don't know that it's Friday today. It's month end you don't want to…work? No no sir I'm feeling very weak today…he say there is nothing to do (..) uh with you. I give you … treatment…and…you can be ready to…die…I…didn't like to go to the medical centre…Dr XX…arranged …temporary disability…" (Norman, one-on-one interview, 25 November 2011).*
	Employees used derogatory names when referring to HIV thus perpetuating stigma and discouraging disclosure.	*"…among us as the workers sometimes it happen…they called names. Like…uya tracker…Z3…it's just a name they call people who have this virus…" (Siyabonga, one-on-one interview, 9 November 2011).*

Sub-theme	Analysis	Words of the participants
	A participant experienced labelling and discrimination as a result of involuntary disclosure thus lengthening his grieving process.	*"…I was very sick. So the rumours were moving around said they can see him. He is positive. Err, it's like, Ah Siyabonga is sick. He not gonna make it…Even people who were like friends they try to avoid me. Because you still discovering yourself and then you find hate by what they say." (Siyabonga, one-on-one interview, 9 November 2011).*
	A participant did not register on the organisation treatment programme because he feared discrimination by the organisation.	*"Not specifically reason but () err I was fear for my future with the company. If the company knows that I'm HIV positive whether which I would like to." (Siyabonga, one-on-one interview, 9 November 2011).*
	Employees accessing EWB are labelled as being HIV positive or alcoholic.	*"Like if people they see somebody going to EW Office they just assume that you are HIV positive or you got a drinking problems." (Siyabonga, one-on-one interview, 9 November 2011).*

CHAPTER 5

DISCUSSION AND RECOMMENDATIONS

5.1 Introduction

With the current turmoil and increasing competitiveness in the international economy, the management of most organisations are embarking on cost cutting measures to ensure the survival of their businesses. Managing HIV and AIDS in the workplace is often viewed as non-essential and it is difficult for management to justify expenditure on a quality management system such as SANS 16001. However, it could prove to be more costly to organisations to disregard the value of implementing a quality management standard such as SANS 16001. Apart from marketing, other benefits of SANS 16001 implementation are improved operational effectiveness of HAMS, improved quality, increased employee confidence, employee satisfaction, increased production, cost reduction, continual improvement of HAMS, and national and international recognition (Levine and Toffel, 2010:2; McGuire and Dilts, 2007:19; Meyer, 2007:2; Smith, 2010:18).

5.2 Overview of the research findings

The findings are discussed in relation to themes and subthemes which emerged from the data that was integrated. The proceeding headings were common features from the one-on-one interviews and focus group discussions.

Information and Education

Information and education is an important aspect of HAMS which emerged in the study. Information and education promoted disclosure, adherence to Anti-Retroviral Therapy (ART) and improved health.

Employees' attitudes towards HIV were influenced positively which resulted in an increased HCT uptake, and decreased stigma and discrimination. Introduction to HIV and AIDS Education (2011:4) and the UNAIDS Global report (2010:122) similarly demonstrated that HIV education plays a vital role in reducing stigma and discrimination, and helps HIV positive employees to live healthily and stay employed.

A favourable conclusion can be drawn from the effectiveness of information and education implemented during section presentations, health day campaigns, Peer Educator (PE) 'role plays' and counselling sessions. It is worthy to note that these findings are consistent with Carr-Hill et al (2002:3) who recommended that the best way to deal with HIV is through prevention efforts that influence behaviour and values.

In spite of this, results indicated that line management needed education on the psychosocial aspects of HIV. This is significant because Cameron (2009:12) suggested that since HIV is overwhelmingly a sexually transmitted disease people still poorly understand the intensity, intimacy, embarrassment and shame experienced when coping with the diagnosis. This emphasizes the need to continue improving HIV related information and education.

HIV Counselling and Testing (HCT)

The quality of HCT and rewards for undertaking HCT during campaigns improved the uptake of HCT within the organisation. This finding is consistent with Bhagwanjee et al (2008:272) who attained that running campaigns promotes HCT.

In addition, Bhagwanjee et al (2008: 272) supported that quality pretest counselling is useful in prompting employees to reflect on their risk behaviours and creates awareness of the importance of knowing one's HIV status.

Despite the successful uptake of HCT not all employees participated largely due to a perceived fear of a breach in confidentiality, stigma and discrimination.

Ford et al (2008:7) and Kranzer et al (2011:8) shared a common view that the most frequently reported barriers to HCT were concerns about confidentiality, stigma and discrimination.

A gap was revealed in the organisation's HAMS when participants disclosed that they were not offered HCT during their annual medicals at the Clinic. This is concerning because an opportunity was missed to include HCT as part of general health screening to normalise HCT. Richter (2006:12) similarly recommended routine offering of HCT by health care providers because it is more effective and wide-ranging in getting people tested.

It is noteworthy that Bhagwanjee et al (2008:271) and Corbett et al (2006:1005) identified HCT as one of the most cost-effective HIV and AIDS interventions because it serves as a crucial precursor to HIV treatment interventions for infected individuals and assists uninfected individuals maintain their HIV negative status by reducing high-risk sexual behaviour. In addition, recent research by Kranzer et al (2011:8) recommended that due to the continuous risk of infection of sexually active individuals in high prevalence settings HIV testing should be conducted more frequently than annually. It can be concluded that regular HCT is necessary to minimise the impact of HIV on the organisation.

Peer Educators (PEs)

The research showed that the organisation's HAMS was more effective with the commencement of the peer education programme. This is significant because employees relate better to their peers. Introduction to HIV and AIDS Education (2011:6) has a similar view that Peer Education is effective in reaching and educating people because it is a less formal method of educating, and people relate better to their peers.

Current literature further suggests that Peer Education is a widely used component of HIV prevention programmes and is often part of a larger, more comprehensive approach to HIV (Dickinson, 2009:2; Van Schalkwyk, 2008:5; Dickinson, 2006b:4).

Participants revealed that PEs were active with education and promotion of HCTs in the sections. PEs were actively involved in extending support to employees and their families. This finding is consistent with a study of five large South African organisations which revealed that the vast majority of Peer Educators conducted formal presentations and had informal discussions with employees and the community (Dickinson, 2006b:4).

It is noteworthy that a barrier to benefitting from PE presentations was perceived stigma. Beukman (2011:4) highlighted in a workshop by the South African Business Coalition on HIV/AIDS (SABCOHA) that stigma is the monster that has the potential to destroy workplace HIV programmes and PEs were identified as having a vital role to play in challenging stigma and discrimination.

A favourable conclusion can be drawn regarding the effectiveness of the organisation's PE programme in promoting HCT and changing attitude and behaviour. Review of some studies similarly revealed that Peer Education in combination with other prevention strategies were effective in changing attitude and behaviour (Dickinson, 2009:3; Van Schalkwyk, 2008:5; Dickinson, 2006b:6; UNAIDS, 1999:19).

Dickinson (2006b:7) correspondingly reported that the activity of workplace peer educators was extensive and extended beyond formal company programmes and was acknowledged as a major contribution to the national response to HIV and AIDS. Therefore the PE programme was identified as a necessary component of the organisation's response to HIV.

Anti-Retroviral Therapy (ART)

The study revealed that HIV positive employees benefitted from ART because it kept them alive, decreased opportunistic infections and improved health which enabled some to return to work from disability.

This is due to the primary benefits of ART being viral load suppression, immunological recovery, reduced morbidity and mortality, decreased opportunistic infections, improved quality of life and decreased HIV transmission (Evian, 2011b:149).

It is worth considering that the results revealed a need for the organisation's HIV treatment programme to be extended to employees' spouses. Kumarasamy et al (2010:178) and Mahajan et al (2007:S1) similarly supported couple-based interventions because they increased adherence to ARVs and contributed to increased workplace HIV treatment programmes.

Participants that were registered on the organisation's HIV treatment programme benefitted from accessibility, convenience, time and cost saving due to the close proximity of the Clinic. Participants revealed that they were allowed to collect ART during working hours which was an indication of managements' support for the organisation's HAMS. These findings were consistent with those of Corbett et al (2006:1006) who shared the common view that convenience and accessibility appear to have critical roles in the acceptability of HCT and HIV treatment uptake.

A favourable conclusion can be drawn in that there were benefits associated with organisation providing ART for its HIV positive employees. Rosen et al (2007:7) held a similar view that organisations who provided medication to treat HIV and AIDS under strict conditions resulted in employees remaining at work for longer than otherwise expected.

Researchers agreed that providing care and treatment for HIV positive employees reduces the financial burden of HIV and increases economic benefits (SABCOHA, 2009:5; Newmarch, 2007:5; Geffen and Blatt, 2003:3).

Support

The Clinic was outsourced to provide an Occupational Health and Primary Health Care service. The study revealed that the Clinic personnel were supportive and helpful to HIV positive employees.

This finding is favourable as Mahajan et al (2007:56) and Bhagwanjee et al (2008:271) who stated that amongst the factors associated with improved uptake of HIV treatment programmes was the support of HIV positive employees by health professionals.

Results revealed that following up of HIV positive employees by the Clinic personnel was not fully utilised due to fears of stigma and discrimination and the stages of grieving. George et al (2009:4) and Bhagwanjee et al (2008:273) similarly revealed that the stages of grieving delayed health seeking behaviour and advised stringent follow up of HIV positive employees for the successful uptake of HIV treatment programmes.

Employee Well-being (EWB) was identified as a source for advice, guidance and support. Participants were assisted with disclosure which reduced anxiety. A study of African American women similarly revealed that disclosure increased access to support which improved the quality of life and decreased depression (Vyavahakar et al, 2011:78). It can be concluded that disclosure provides an opportunity for support and acceptance.

Participants who belonged to the organisation's HIV support group revealed that they benefitted from information and supported one another through their experiences. In a similar way the benefit of support groups for people living with HIV and AIDS was revealed to be deceased isolation, increased disclosure, improved mental health and increased opportunities for support (Vyavahakar et al, 2011:80; Airhihenbuwa et al, 2009:427). Although participants benefitted from the support group the study revealed that there was minimal utilisation of the organisation's HIV support group due to fear of stigma and discrimination.

The study revealed that HIV positive employees who were ill experienced support through home visits by EWB which had a positive impact. Studies of the impact of home visit interventions similarly revealed that these visits resulted in positive outcomes for HIV positive individuals because it allowed for psychosocial assessment, addressing of problems and improved adherence to ART (UNAIDS, 2010:120; Maron et al, 2008:1; Diabate and Dossou, 2004:1).

Participants revealed that they were satisfied with the organisation's support of HAMS and it motivated them to register on the organisation's HIV treatment programme and adhere to treatment. Therefore a favourable conclusion can be drawn regarding the effectiveness of the organisation's support of HIV positive employees in ensuring employee satisfaction. Bhagwanjee et al (2008:275) supported the finding that support is one of the motivating factors for ART uptake and adherence.

Barriers to accessing the organisation's HIV treatment programme

Despite the intended benefits of the organisation's HIV treatment programme the study revealed a poor uptake due to the stages of grieving, alcohol abuse, fear of the commitment and side effects of ART, traditional beliefs, concerns of confidentiality, and fear of stigma and discrimination. Airhihenbuwa et al (2009:426); George et al (2009:5) and Bhagwanjee et al (2008:274) similarly revealed that the stages of grieving, traditional beliefs, alcohol abuse, fear of ART side effects, disclosure, stigma and discrimination were an impediment to HIV treatment programmes.

This finding revealed an unfortunate situation as immune-compromised employees failed to access the benefits associated with ART from the in-house programme. However, it is noteworthy that the participants who were not registered on the organisation's HIV treatment programme were registered on an external HIV treatment programme.

Confidentiality

A favourable conclusion can be drawn from the majority of participants who related that they experienced the intended benefit of confidentiality within the organisation's HAMS. Dickinson (2003:4) stated that confidentiality for those who do not want to disclose their status must be guaranteed for the success and uptake of HIV workplace programmes.

In contrast, a concern of the confidentiality of HIV positive employees' status was the second most recurring theme in the study. Phooko (2009:3) and Dickinson (2006:8) warned that failures of effective HAMS were due to relational challenges with unions and confidentiality issues.

It is concerning that that five participants revealed a breech in confidentiality by Clinic personnel which discouraged registration on the organisation's HIV treatment programme. In addition, an HIV positive employee's hearing loss was wrongfully attributed to HIV resulting in trust issues. These findings were consistent with George et al (2009:5), Phooko (2009:3), Bhagwanjee et al (2008:274), Ramnarain (2008:126) and Dickinson (2006:8) who found that common impediments to HIV treatment uptake in several workplace HAMS included fears of being identified within the workplaces as HIV positive, which arose from perceived confidentiality violations on the part of health care staff and fear of stigma.

The colour coding of HIV positive employees medical files perpetuated feelings of mistrust which contributed to the poor uptake of the organisation's HIV treatment programme. The study revealed that employees feared a breach in confidentiality because of involuntary disclosure whilst collecting ARVS at the Clinic, a lack of trust of the organisation's Doctor, a high turnover and inappropriate probing by Clinic personnel, and Clinic personnel living amongst employees in the community.

Bhagwanjee et al (2008:274) similarly established that the reasons for poor uptake of HIV treatment programmes were perceived violations confidentiality mainly by healthcare staff, specific clinic days for HIV patients and difficulties in collecting medication privately which made it easy to identify patients (Kranzer et al, 2011:7).

Lack of confidentiality has been repeatedly found to be a problem in health care settings which discourages access to health care (Introduction to HIV and AIDS Education, 2011:6; International conference on stigma, 2011:2; Okechukwu, 2007:65; UNAIDS, 2010:124). This supports the notion that the organisation needs to take more cognizance of the concerns of confidentiality to improve its HAMS.

Stigma and discrimination

Fear of stigma and discrimination as barriers to employees accessing the benefits of the organisation's HAMS were the most recurring themes in the study. Participants revealed that despite the organisation's efforts in promoting HAMS it was insufficient in influencing all employees to participate in the organisation's HAMS due to stigma. Bhagwanjee et al (2008:274) and Airhihenbuwa et al (2009:427) had similar views that concerns of stigma and discrimination were impediments to HCT and HIV treatment uptake.

Whilst management and the higher income participants believed that no discrimination of HIV positive individuals occurred within the organisation, lower income participants perceived that stigma and discrimination was perpetuated. This is disquieting because fear of stigma and discrimination was cited as the main reason why people are reluctant to be tested and disclose their HIV status or take anti-retroviral drugs (Introduction to HIV and AIDS Education, 2011; International conference on stigma, 2011; UNAIDS, 2010; Okechukwu, 2007).

In addition, UNAIDS (2010) states that stigma makes AIDS the silent killer and is a chief reason why the AIDS epidemic continues to devastate societies worldwide. It can therefore be concluded that stigma and discrimination promotes the spread of the AIDS epidemic.

Results revealed that some participants experienced isolation, stigma and discrimination by colleagues as a result of involuntary disclosure. This is concerning because UNAIDS (2005) highlighted that in addition to being a violation of human rights in itself, discrimination directed at people living with HIV or those perceived to be infected, leads to violation of other human rights such as rights to health, dignity, privacy, equality before the law, and freedom from inhuman, degrading treatment or punishment.

The study revealed that fear was linked to internal stigma and guilt resulting in nondisclosure and not seeking treatment. This finding is consistent with Cameron (2010:12) who wrote that many Africans experience stigma so intensely that they prefer to die rather than to be diagnosed or treated for HIV as a result of internalised feelings of shame, self-revulsion and dread. Morrison (2006:3) emphasized that the consequences of HIV related stigma and nondisclosure is it inhibits people from seeking care, support, treatment and impedes people from using protection during sex which leads to increased transmission, morbidity and mortality.

It is worth considering that the participants who were not registered on the organisation's HIV treatment programme revealed internal stigma when they kept distancing themselves from HIV by referring to HIV as *'this thing, this disease'.* These results commensurate with the views of Cameron (2010:12) pertaining to the effects of internalised stigma which is more destructive and leads to withdrawal, depression, prevents disclosure and affects health-seeking behaviour. Stigma has therefore been correlated with poorer mental health (Holzemer et al, 2007:541*).*

A favourable conclusion can be drawn with regard to the effectiveness of the organisation's HIV treatment programme because participants who were registered on the programme appeared to be coping better and exhibited higher self-esteem than their counterparts. This validates the benefits of support when employees access the available services.

Some participants revealed that that they stopped accessing the organisation's HIV treatment programme after experiencing discrimination from the Clinic Doctor and other Clinic Personnel. This finding is consistent with the views of UNAIDS (2010) who reported that several countries experienced that stigma and discrimination in health care facilities adversely affect access to the provision of services. In a study by Ford et al (2008:7) it was similarly found that some participants perceived healthcare staff, whether receptionists or clinicians as generally rude or disrespectful of patients.

Airhihenbuwa et al (2009:427) warned that the negative roles of health care providers are an enabler in HIV related stigma. The above examples are of note because it demonstrates that registering employees on the organisation's HIV treatment programme does not mean that they automatically stay in the programme. This emphasizes the need to keep employees satisfied regarding the organisation's HIV treatment programme.

The study revealed that some senior employees did not support the organisation's HAMS due to a misconception that HIV is a Black person's disease. This finding was consistent with Guma, Henda and Petros (2005:1) who ascertained that there is still a belief that HIV is a problem of another group with certain characteristics including race which perpetuates stigma. This exposes a risk that certain employees felt that they were unaffected by HIV which the organisation needs to try to mitigate because no one is immune to HIV.

A favourable conclusion can be drawn from findings that revealed that the organisation was demonstrably supportive and did not discriminate against HIV positive employees. However fears of stigma and discrimination were revealed to be the main reason for exclusion of employees from accessing the benefits of the organisation's HAMS. This underscores the need for the organisation to address stigma and discrimination. Various authors suggest that continued HIV education may be one important strategy in the eradication of stigma coupled with programmes and disciplinary measures that are proactive in addressing stigma (Holzemer et al, 2005:541-542; UNAIDS, 2005:34; Dickinson, 2006;7).

5.3. Conclusion

Findings of the study revealed that the organisation was aligned with most of SANS 16001 general requirements for HAMS. Employees experienced the intended benefits of prevention, treatment and support when they accessed the organisation's HAMS. However the main impediments to accessing the organisation's barriers were revealed to be concerns of confidentiality and fears of stigma and discrimination.

HIV positive employees who were registered on the organisation's HIV Treatment Programme experienced benefits such as information and education, HIV Counselling and Testing (HCT), confidentiality, Peer Educators, Highly Active Anti-retroviral Readiness Training (HAART), Anti-retroviral (ARV) treatment, cost saving and convenience, support and no discrimination. The barriers they experienced were a lack of confidentiality, turnover of Clinic personnel, and perceived stigma and discrimination.

HIV positive employees who were not registered on the organisation's HIV Treatment Programme experienced benefits from the organisation such as information and education, HIV Counselling and Testing (HCT), confidentiality, Peer Educators, Highly Active Anti-retroviral Readiness Training (HAART) referred by EWB, Anti-retroviral (ARV) treatment through medical aid, support and no discrimination. The barriers they experienced were lack of confidentiality, and perceived stigma and discrimination.

Results revealed that the organisation did not discriminate against HIV positive employees. Participants who were registered on the organisation's treatment programme had accepted their status and were coping better emotionally and physically in comparison to participants who were not registered on the organisation treatment programme. These findings were consistent with Mlobeli (2007) who affirmed that participants who were well informed and those who were members of HIV support groups reported that they are coping with the illness and they are open about their HIV status.

It can be concluded that education efforts have been remarkably successful at the organisation in bringing about a change in attitudes.

UNAIDS (2010) confirmed that although progress has been noted, HIV-related stigma and discrimination are still highly prevalent globally and are not yet being sufficiently addressed. This underscores the need for business to urgently scale up comprehensive programmes that build capacities of HIV-related service providers, address stigma and discrimination, and empower employees affected by HIV. It can be inferred that the organisation can address the gaps in its HAMS by implementing the South African National Standard (SANS) 16001 which is a recognised HIV management system that is built on quality management principles to ensure that it meets all employee requirements to deliver results.

5.4 Recommendations

- to propose the adoption of SANS 16001 as a management tool for the organisation as good business practice;
- to address non-discrimination in recruitment, performance evaluation, disciplinary measures, dismissal, testing, disclosure, the provision of ARVs and death benefits in clear unambiguous terms to gain employees confidence in the HIV policy;
- aim for 100% communication of the HIV policy to employees and relevant stakeholders;
- develop a communication plan for employees who don't have access to e-mail or section meetings to promote HIV education;
- insourcing and retaining of skilled professional nurses for continuity of care;
- outsourcing an isiZulu speaking occupational medical practitioner to promote employee satisfaction and diversity management;
- consider moving the Clinic back into the factory premises to promote accessibility, and prevent employees from being questioned when they need to fetch ART;
- to review the accessibility of medical files at the Clinic reception area;

- ensure that medical files have no identification indicating the HIV status of employees;
- ensure that HIV positive employees who fetch ART on specific days or at specific times cannot be identified;
- initiate client satisfaction surveys at the Clinic;
- top management to have the responsibility for assessing opportunities for improvement and making recommendations regarding HAMS objectives and targets;
- the HIV committee to take corrective actions for all HIV related complaints and review their effectiveness;
- target supervisors and management for education on the psychosocial aspects of HIV;
- aim for 100% HCT participation and target employees who never tested before;
- offer provider initiated HCT during annual medicals to normalise testing for HIV;
- employees HIV status to be shared only with personnel directly involved in the management of the employee's health namely the professional nurse, EWB personnel and the doctor;
- review HCT pre-test counselling questionnaire to prevent discomfort;
- stringent follow up, counselling and support of HIV positive employees through the stages of grieving to enable successful registration with the organisation's HIV treatment programme;
- embark on stigma reduction programmes to address stigma and discrimination through leadership and ongoing education especially targeting management and lower income employees;
- educate employees on the different roles and responsibilities of the professional nurse and EWB to prevent stigma when accessing these services;
- investigate costs for extending the organisation's HIV treatment programme to employees' spouses to improve adherence; and
- focus on keeping employees that are registered on the organisation's HIV program satisfied to realise the full benefits of the programme.

5.5 Future research

If the organisation implements the recommendations made from this study then further research is recommended on the impact of these changes and employee satisfaction of the organisation's HAMS. An avenue for further research exists on how to decrease involuntary disclosure during the collection of ART in the organisation. Given that the research was limited to a selected organisation, the opportunity arises for further research in this regard on a wider scale with other organisations with established HAMS.

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LIST OF APPENDICES

Appendix A: Letter requesting permission to conduct research

17 Talbot Road
Mandeni
4490
20 October 2009

Mr L. Kruyshaar
General Manager
Mandeni
4490

Dear Sir

Request permission to conduct research study at Mill Site until 2010

I, Annezt Louise Pillay am employed at the Mill in the Human Resources Department as the Employee Well-being Co ordinator. I am currently finalising my research proposal in full compliance for a Master's Degree in Technology - Nursing with the Durban University of Technology. I have gratefully received assistance for a study loan from the company for this purpose since 2008. The area of my intended research is to describe the company HIV and AIDS Management System (HAMS) in relation to the SANS 16001: 2007 (South African National Standard: HIV and AIDS management systems general requirements) and to describe employees' experiences on the company HIV Treatment Programme.

The study will require purposive sampling. Three Focus Group discussions will be held with the EWB committee and other employees. Semi structured one-on-one interviews will be conducted with HIV positive employees. Confidentiality will be maintained throughout the duration of the research. The company's name will not be mentioned in the study; reference will only be made to a multinational paper manufacturing company in KwaZulu-Natal.

This letter seeks to establish if the management will allow this research to be conducted in the Mill until 2011. Once the research is completed comprehensive feedback will be made available to management and the EWB committee with the intention to inform decision makers on factors that will improve the company HAMS.

Your favourable consideration of my request will be greatly appreciated.

Yours faithfully

A.L. Pillay (Mrs)

Appendix B: Letter of informed consent from the selected organisation

19 November 2009

Mrs A Pillay
Coy No: 819708
EWB Co-ordinator
Human Resources

Dear Annezt

PERMISSION TO CONDUCT HIV AND AIDS MANAGEMENT SYSTEM RESEARCH STUDY

It is with pleasure that permission is hereby granted for you to carry out the research study described in your letter dated 20 October 2009 on the following conditions:

(1) The findings, results and/or conclusions of this research must be written and published in such a way that the personal identity of any natural person to which this research relates is not identified by name or is otherwise identifiable;

(2) The findings, results and/or conclusions of this research must be written and published in such a way that is not identified by name or is otherwise identifiable as being associated with this research; and

(3) You will deliver a true and complete copy of your research thesis and/or other final report to Regional Health and Wellness Manager (currently) on behalf upon completion of this research, which may be retained by

Yours faithfully,

[redacted]

GENERAL MANAGER

NEM/cm/HRM_LET_0001_A PILLAY_APPROVAL FOR STUDIES

Appendix C: Letter of information and consent to participate (English)

Title of the Research Study: An evaluation of the efficacy of a HIV and AIDS management system in a multinational manufacturing organisation in KwaZulu-Natal

Principle Investigator: Annezt Louise Pillay [Company Employee Well-being (EWB) Coordinator]

Supervisor/Co-supervisor's name: Penny Orton

Brief introduction and purpose of the study: HIV programmes at the workplace have been implemented for approximately fifteen years and the results have been largely ineffective. Even the best HIV programmes can be a lost investment if there is poor uptake of the services. Therefore, management systems need evaluation against a recognized standard to ensure continual improvement. The aim of the study is to describe the company HIV and AIDS management system (HAMS) within the SANS 16001: 2007 (South African National standard: HIV and AIDS management systems-general requirements). Research questions will be answered such as: Do the employees experience the intended benefits of the company HAMS? What are the experiences of HIV positive employees on the Company HIV Treatment Programme?

Outline of procedures: The Focus Group discussion will comprise of five to seven salaried or five to seven weekly paid employees. It should take between 30 minutes to one hour to discuss the semi-structured questions in the group. Feel free to ask for clarity of questions at any stage. It may be necessary to have a second group discussion for more information. The results of the study will be made available to the company management and the EWB committee. The discussion will be recorded electronically with your permission, because it will allow a fuller record of the discussion in comparison to notes.

Risks or discomforts to the subject: There are no risks involved. The semi-structured questions and the informed consent letter are available in isiZulu if necessary. We hope that this will make you comfortable to give your honest opinions.

Benefits: This study will enable the company to better meet the needs of employees with regards to prevention of HIV infection and provision of quality care for infected employees. Your comments will enable the company to improve the HIV programme which will benefit employees' health and promote company sustainability.

Reason/s why the subject may be withdrawn from the study: You may choose to withdraw from the study at any time without any consequences to yourself.

Costs of the study: There are no costs to you.

Confidentiality: The discussion is completely confidential. You are required to sign an informed consent on this page to participate in the study. The researcher will personally file the consent form separately to ensure that no links to individuals are made before interpretation of the discussion results.

Persons to contact in the event of any problems or queries:
Supervisor Penny Orton; Contact no: 031 – 3732537
Head of Department Moeti Kware; Contact no: 031 – 3732809

Statement and agreement to participate in the research study**:**

I _____ ID number _____
have read this document in its entirety and understand its contents. Where I have had any questions or queries, these have been explained by A.L Pillay to my satisfaction. Furthermore, I fully understand that I may withdraw from this study at any stage without any adverse consequences and my future health care will not be compromised. I therefore, voluntarily agree to participate in this study.

Subjects name _____Subjects signature:_____

Date: _____

Researcher's name: _____Researchers signature:_____

Date: _____

Witness name: _____Witness signature: _____

Date: _____

Indicate your demographics by marking the appropriate box with an X

i. Male ☐

Female ☐

ii. Age

20 – 29 years ☐

30 – 39 years ☐

40 - 49 years ☐

50 + years ☐

iii. Job Grade

Grade 3 – 6 ☐

Grade 7 – 10 ☐

Grade 11 – 13 ☐

A – C band ☐

D – E band ☐

F band ☐

Unskilled ☐

iv. Marital status

Single ☐

Married ☐

Divorced ☐

Widowed ☐

v. Race

Black (African) ☐

Asian (Indian) ☐

Coloured ☐

White ☐

Appendix D: Letter of information and consent to participate (Isi-Zulu)

Isijobelelo incwadi yolwazi nemvume

Isihloko socwaningo olutadishwayo: Ukubuyekezwa kwempumelelo ngokuphathwa kohlelo lwe HIV ne Aids enkampanini enezizinda eziningi emhlabeni zokukhiqiza e KwaZulu-Natal

Uqobo lwenhloli: Annezt Louise Pillay (Umhleli Wezenhlalakahle Yabasebenzi Enkampanini)

Igama lomphathi: Penny Orton

Isingeniso esifushane kanye nenhloso ngesifundo

Izinhlelo ze HIV ezindaweni zokusebenza zaqala eminyakeni elinganiselwa kweyishumi nanhlanu futhi imiphumela ayizange igculise neze. Ngisho nezinhlelo ezinhle ze HIV zingaba ukulahlekelwa uma kunokuphathwa okungekuhle kwezinhlelo.Ngalokho ukuphathwa kwezinhlelo kudinga ukubuyekezwa, ziqhathaniswe nemigomo ebekiwe ukuze kuqinisekiswe ukuthuthuka okuqhubekayo. Inhloso yalokhu kufunda, ukuhlaziya izinhlelo zokuphathwa kwe HIV ne Aids (HAMS) ngaphakathi kwe SANS 16001:2007(nemigomo yezwe ye Ningizimu ne Afrika, nezidingo ezejwayelekile zokuphathwa kwe HIV ne Aids).Imibuzo yocwaningo iyophendulwa, isibonelo: Ngabe izipiliyoni zabasebenzi zihlose ukuzuzisa kwi HAMS yenkampani? Yiziphi Izipiliyoni zabasebenzi abaphila ne HIV ngezinhlelo zamakhambi e HIV enkampanini?

Ukukhanyisa nge nqubo: Kungathatha isikhathi esilinganiselwa phakathi kwemizuzu engamashumi amathathu kuya kwi hora elilodwa ukuphendula imibuzo ehlelwe ngokungaphelele. Zizwe ukhululekile ukubuza ukuze uthole ingcaciselo yemibuzo noma yinini. Kungaba nesidingo sokuba nenxoxo yesibili ukuze kutholakale ulwazi oluningi. Imiphumela yalokhu kutadisha iyonikwa abaphathi benkampani kanye ne komitini le EWB. Inxoxo iyoqoshwa ngokomoya ngemvume yakho, ngokuba kuyonikeza ukuxoxa okuphelele uma kuqhathaniswa namanothi.

Ubungozi noma ukunganethezeki ngesihloko: Abukho ubungozi obubandekayo. Imibuzo ehlelwe ngokungaphelele kanye nencwadi yemvume equkethe kuyatholakala ngesizulu uma kunesidingo. Sethemba ukuthi lokhu kuyokwenza unethezeke ukunikeza imibono yakho eyiqiniso.

Imivuzo: Lokhu kutadisha kuyokwenza inkampani ikwazi ukuhlangabezana nezidingo zabasebenzi mayelana nokuvikela ukungenwa I HIV kanye nokubhekelela izinga eliqotho lokunakekela abasebenzi esibangenile. Imibona yakho iyokwenza inkampani ikwazi ukuthuthukisa izinhlelo ze HIV eziyozuzisa izimpilo zabasebenzi kanye nokwenyusa uzinzo lwe-Nkampani.

Isizathu noma izizathu, kungani isihloko singakhishwa kwisitadi: Ungakhetha ukuphuma kwisitadi noma ngasiphi isikhathi ngale kwezinqinamba kuwe.

Izindleko zokutadisha: Azikho izindleko kuwe.

Imfihlo: Inxoxo iyimfihlo ngokuphelele. Kudingeka ukuthi usayine incwadi yemvume equkethe kulelikhasi ukuze ube yinxenye yokutadisha. Umcwaningi yena uqobo uyofaka efayeleni ifomu lemvume ngokwehlukana ukuze kuqinisekiswe ukuthi akukho ukuthintana nomuntu okwenzekayo ngaphambi kokutolikwa kwemiphumela yenxoxo.

Abantu ongabathinta uma kunesigameko sanoma iyiphi inking noma imibuzo:

Umphathi u Penny Orton; inombolo athintwa kuyo: 031- 3732537
Inhloko ye- Diphathimenti Moeti Kware; inombolo athintwa kuyo: 031-3732809

Isitatimende kanye nesivumelwano sokuba yinxenye yokutadisha ucwaningo:

Mina_____Nombolo kamazisi_____

Usuku_____

Ngilifundile leliphepha eliqukethe umbhalo ngokugcwele futhi ngiyakuqonda okulishoyo. Lapho engike ngaba nemibuzo khona yanoma yiluphi uhlobo noma ukungaqondi, lokho ngikuchazelwe ngu A.L. Pillay nganeliseka. Ukwelula mbijana, ngikuqonda ngokugcwele ukuthi ngingakwazi ukuphuma kulokhu kutadisha noma ngasiphi isikhathi ngale kwemiphumela engemihle nokuthi ikusasa lokunakekelwa kwempilo yami angeke kubekwe encupheni. Mina ngalokho, ngiyavuma ngokuzinikela ukuzibandakanya nalokhu kutadisha.

Igama _____ Isibophezelo_____

Usuku_____

Igama Lenhloli_____Isibophezelo ye nhloli_____

Usuku_____

Igama likafakazi_____Isibophezelo ka fakazi_____

Usuku_____

Khombisa ukuthi ukusiphi isigaba ngokufaka u X ebhokisini elefanele

i. Wesilisa ☐

Wesifazane ☐

ii Iminyaka yokuzalwa

20- 29 weminyaka ☐

30- 39 weminyaka ☐

40- 49 weminyaka ☐

50 nangaphezulu weminyaka ☐

iii. Isigaba sezinga leholo

Isigaba 3- 6 ☐

Isigaba 7- 10 ☐

Isigaba 11- 13 ☐

Isigaba A- C ☐

Isigaba D- E ☐

Isigaba F ☐

Abangenakhon ☐

iv. Isimo Somshado

Uwedwa ☐

Ushadile ☐

Wehlukanisile ☐

Washonelwa ☐

v. Ubuhlanga

Womnyama (Wase Afrika) ☐

Wase Ndiya ☐

Ikhalathi ☐

Omhlophe ☐

Appendix E: Demographics of participants

Demographics of Participants for Pilot Study				
Pseudonyms have been given to the participants				
Date	Number	Personal Details	Grade	Focus Group/ Interview
26-Aug-10	1	White male 50+ married	3 - 6	Focus Group 1
27-Aug-10	2	Black female 30-39 Single	7 - 10	Focus group 3
08-Sep-10	3	Black male 30-39 Single	A - C	One-on-one Interview

Demographics of Participants for Focus group 1				
Stratified Random Sampling				
Date	Number	Personal Details	Grade	Focus Group/ Interview
20-Aug-10	1	Black male 30-39 Married	11 – 13	Focus Group
20-Aug-10	2	Black female 30-39 Single	11 – 13	Focus Group
20-Aug-10	3	Black female 40-49 Single	7 – 10	Focus Group
20-Aug-10	4	White male 30-39 Married	11 – 13	Focus Group
20-Aug-10	5	Black male 30-39 Married	7 – 10	Focus Group
20-Aug-10	6	White male 30-39 Married	7 – 10	Focus Group
20-Aug-10	7	Black male 30-39 Married	11 – 13	Focus Group

Demographics of Participants for Focus group 2				
Stratified Random Sampling				
Date	Number	Personal Details	Grade	Focus Group/ Interview
21-Sep-10	1	Black male 20-29 Single	F	Focus Group
21-Sep-10	2	Black male 50+ Married	A – C	Focus Group
21-Sep-10	3	Black female 20-29 Single	D – E	Focus Group
21-Sep-10	4	Black male 20-29 Single	A – C	Focus Group
21-Sep-10	5	Black male 50+ Married	A – C	Focus Group
21-Sep-10	6	Black male 20-29 Single	A – C	Focus Group

Demographics of Participants for Focus group 3				
HIV committee				
Date	Number	Personal Details	Grade	Focus Group/ Interview
08-Sep-10	1	White female 40-49 Married	11 – 13	Focus Group
08-Sep-10	2	Black male 50+ Married	11 – 13	Focus Group
08-Sep-10	3	White male 50+ Married	7 – 10	Focus Group
08-Sep-10	4	White male 40-49 Divorced	3 – 6	Focus Group
08-Sep-10	5	Black male 40-49 Married	11 – 13	Focus Group
08-Sep-10	6	Black male 30-39 Single	11 – 13	Focus Group
08-Sep-10	7	White female 30-39 Single	7 – 10	Focus Group
08-Sep-10	8	White female 20-29 Married	Contractor	Focus Group
08-Sep-10	9	White male 40-49 Married	7 - 10	Focus Group
08-Sep-10	10	White female 30-39 Married	7 - 10	Focus Group

Demographics of Participants for One to One Interviews				
Employees registered on the Organisation HIV Treatment Programme				
Date	Number	Personal Details	Grade	Focus Group or Interview
08-Sep-10	1	Black male 30-39 Married	11 – 13	Interview
10-Sep-10	2	Black female 30-39 Married	A – C	Interview
27-Oct-10	3	Black female 20-29 Single	11 – 13	Interview
05-Nov-10	4	Black male 40-49 Married	11 – 13	Interview
29-Nov-10	5	Black male 40-49 Married	7 - 10	Interview

Demographics of Participants for One to One Interviews				
Employees not registered on the Organisation HIV Treatment Programme				
Date	Name	Personal Details	Grade	Focus Group or Interview
10-Nov-10	1	Black male 50+ Married	7 – 10	Interview
28-Oct-10	2	Black male 30-39 Single	11 – 13	Interview
25-Nov-10	3	Black male 30-39 Married	A – C	Interview
05-Nov-10	4	Black male 20-29 Single	A – C	Interview
09-Nov-10	5	Black male 30-39 Married	7 – 10	Interview

Appendix F: Ethics clearance certificate

DURBAN UNIVERSITY of TECHNOLOGY

Faculty of Health Sciences

ETHICS CLEARANCE CERTIFICATE

Student Name	A. L. Pillay	**Student No**	20423233
Ethics Reference Number	FHSEC 013/10	**Date of FRC Approval**	17 MAY 2010
Qualification	Maters in Technology : NURSING		
Research Title:	Case study of a workplace HIV and AIDS management system in a multinational paper manufacturing company in KwaZulu-Natal		

In terms of the ethical considerations for the conduct of research in the Faculty of Health Sciences, Durban University of Technology, this proposal meets with Institutional requirements and confirms the following ethical obligations:

1. The researcher has read and understood the research ethics policy and procedures as endorsed by the Durban University of Technology, has sufficiently answered all questions pertaining to ethics in the DUT 186 and agrees to comply with them.
2. The researcher will report any serious adverse events pertaining to the research to the Faculty of Health Sciences Research Ethics Committee.
3. The researcher will submit any major additions or changes to the research proposal after approval has been granted to the Faculty of Health Sciences Research Committee for consideration.
4. The researcher, with the supervisor and co-researchers will take full responsibility in ensuring that the protocol is adhered to.
5. ***The following section must be completed if the research involves human participants:***

	YES	NO	N/A
❖ Provision has been made to obtain informed consent of the participants	X		
❖ Potential psychological and physical risks have been considered and minimised	X		
❖ Provision has been made to avoid undue intrusion with regard to participants and community			X
❖ Rights of participants will be safe-guarded in relation to: - Measures for the protection of anonymity and the maintenance of Confidentiality.	X		
- Access to research information and findings.	X		
- Termination of involvement without compromise	X		
- Misleading promises regarding benefits of the research			X

[redacted]
SIGNATURE OF STUDENT/RESEARCHER — 21/5/2010 DATE

[redacted]
SIGNATURE OF SUPERVISOR/S — 21.05.2010 DATE

[redacted]
SIGNATURE OF HEAD OF DEPARTMENT — 25/05/2010 DATE

[redacted]
SIGNATURE: CHAIRPERSON OF RESEARCH ETHICS COMMITTEE — 26/05/2010 DATE

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Appendix G: Document summary form

(*Adapted from Miles & Huberman, 1994, pp. 54-55)

Name or Type of Document:

Document No.:

Date of Document:

Event or Contact with which Document Is Associated:

☐ Descriptive

☐ Evaluative

☐ Other

Page #	***Key Words/Concepts***	***Comments: Relationship to Research Questions***

Brief summary of Contents:

Significance or Purpose of Document:

Is There Anything Contradictory About Document?

☐ Yes

☐ No

Salient Questions/Issues to Consider:

Additional Comments/Reflections/Issues:

Appendix H: Focus group and individual interview guides

Development of instruments for data collection based on Research Objectives, Audit results, Documentary evidence, HIV and AIDS Policy and Theoretical Framework

Focus group discussion 1 Interview schedule with representative employees selected according to grade levels

Objectives	Questions	Tools	Interview Schedule Questions /Probes
1. To evaluate the organisation's HAMS in relation to SANS 16001	2. What are the intended benefits of the Company HAMS? 3. Do the employees experience the intended benefits of the Company HAMS?	Focus Group 1 Discussion Schedule	• Can you tell me about the Company HIV programme? Probe: What do you know about it that you would like to share with me? • What are the intended benefits of the Company HIV programme? • Do you think that employees are benefiting from the Company HIV programme?

Focus group discussion 2 Interview schedule with HIV committee members

Objectives	Questions	Tools	Interview Schedule Questions /Probes
1. To evaluate the organisation's HAMS in relation to SANS 16001	2. What are the intended benefits of the organisation HAMS? 3. Do the employees experience the intended benefits of the organisation HAMS?	Focus Group 2 Discussion Schedule	• The company, through implementation of its HIV policy and programme seeks to minimise the consequences of HIV to its employees. Do you think they are achieving this? • What are the intended benefits of the company HIV programme? • Do you believe that employees receive the intended benefits of the HIV programme? Explain

Group 1 Semi-structured one-on-one interview schedule with HIV positive employees registered on the Company HIV Treatment Programme

Objectives	Questions	Tools	Interview Schedule Questions /Probes
2. To describe the experiences of HIV positive employees	3. What are the experiences of HIV positive employees on the organisation HIV Treatment Programme?	One-on-One Interview Schedule for HIV positive employees that are on the organisation HIV treatment Programme	• The company through its HIV policy states that it aims to create a supportive and non-discriminatory working environment which will be achieved by protecting employees with HIV against unlawful discrimination. Can you tell me what has been your experience in the company? • Can you talk about your experience regarding the company HIV programme (Probe: Are you aware of the availability of counselling, testing and confidentiality, Anti-Retroviral Treatment (ART) and a readiness course for ART?) • What made you chose to access the company HIV treatment programme? (Probe: Are there any cost or time savings?) • How do you think the company can improve the uptake of the HIV treatment programme? • Why do you think other employees do not access the company HIV treatment programme?

Group 2 Semi-structured one-on-one interview schedule with HIV positive employees ***not*** registered on the Company HIV Treatment Programme

Objectives	Questions	Tools	Interview Schedule Questions /Probes
2. To describe the experiences of HIV positive employees	3. What are the experiences of HIV positive employees on the organisation HIV Treatment Programme?	One-on-One Interview Schedule for HIV positive employees that are not on the organisation HIV treatment Programme	• The company through its HIV policy states that it aims to create a supportive and non-discriminatory working environment which will be achieved by protecting employees with HIV against unlawful discrimination. Can you tell me what has been your experience in the company? • Can you talk about your experience regarding the company HIV programme (Probe: Are you aware of the availability of counselling, testing and confidentiality, Anti-Retroviral Treatment (ART) and a readiness course for ART? • What made you decide not to access the company HIV treatment programme? (Probe: Are there any reasons for this?) • How do you think the company can improve the uptake of the HIV treatment programme? • What would you like to see the company doing differently which might encourage more people to access treatment and care through the company HIV treatment programme?