CHAPTER 9

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

9.1 INTRODUCTION

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

9.2 RESEARCH PROCEDURE

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

9.2.1 The Goal and Objectives of the Study

The goal of the research study was:

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

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

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

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

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

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

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

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

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

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

9.2.2 The Sampling Strategy and Technique

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

9.2.2.1 The Pilot Study

9.2.2.2 Feasibility Of The Study

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

9.2.2.2.1 Pilot Test: Qualitative Study

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

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

9.2.2.2.2 Pilot Test: Quantitative Study

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

9.2.2.3 Description Of Population

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

9.2.2.3.1 Population: Qualitative Study

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

9.2.2.3.2 Population: Quantitative Study

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

9.2.2.4 Sample

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

9.2.2.4.1 Sample: Qualitative Study

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

9.2.2.4.2 Sample: Quantitative Study

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

9.2.2.5 Sampling

9.2.2.5.1 Sampling: Qualitative Study

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

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

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

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

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

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

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

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

9.2.2.5.2 Sampling: Quantitative Study

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

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

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

9.2.2.6 Data Collection

9.2.2.6.1 Data Collection: Qualitative Study

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

9.2.2.6.2 Data Collection: Quantitative Study

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

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

9.2.3 Ethical Issues

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

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

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

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

9.2.4 Problems Encountered

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

9.2.4.1 Time Factor

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

9.2.4.2 Resistance From Research Participants

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

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

9.2.4.3 Logistics

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

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

9.2.4.4 Death Of Respondents

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

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

9.2.5 Data Analysis and Interpretation

9.2.5.1 Data Analysis: Qualitative Data

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

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

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

9.2.5.2 Data Analysis: Quantitative Data

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

9.3 PRESENTATION OF EMPIRICAL DATA

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

9.3.1 QUALITATIVE DATA ANALYSIS

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

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

- Section A: Biographical Information

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

- Section B: Experiences of both infected and affected women

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

- Section C: The Role of EAP

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

9.3.1.1 Biographical Data

(Questions 1 to 3)

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

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

Table 1: Profiles of Respondents

9.3.1.1.1 Discussion of Data

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

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

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

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

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

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

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

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

9.3.1.2 Difficulties Experienced By Participants

(Question 4)

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

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

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

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

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

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

9.3.1.2.1 Feelings of Despair

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

9.3.1.2.2 Feeling of Despair - Infected participants

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

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

9.3.1.2.3 Feelings of Despair- Affected Participants

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

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

9.3.1.2.4 Discussion of Data

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

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

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

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

9.3.1.2.5 Difficulties Mentioned By Participants

9.3.1.2.6 Infected

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

9.3.1.2.7 Affected

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

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

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

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

9.3.1.2.8 Positive experiences

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

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

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

9.3.1.2.9 Stigmatisation

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

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

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

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

9.3.1.2.10 Time Lost Due To HIV And AIDS

(Question 5)

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

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

9.3.1.2.11 Duration of Absence

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

9.3.1.2.12 Stage Of Illness For Infected Women

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

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

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

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

9.3.1.2.14Discussion of data

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

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

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

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

9.3.1.3 Coping Strategies

(Question 6)

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

9.3.1.3.1 At Individual Level

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

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

9.3.1.3.2 At Corporate Level

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

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

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

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

9.3.1.3.3 Discussion of Data

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

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

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

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

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

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

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

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

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

(Question 7)

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

9.3.1.5 HIV And AIDS Related EAP Utilisation In The Workplace

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

The following are the themes for using EAP:

9.3.1.5.1 Counselling

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

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

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

9.3.1.5.2 Financial Support

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

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

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

9.3.1.5.3 Support With Practical Assistance

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

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

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

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

9.3.1.5.4 Home Visits

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

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

9.3.1.5.5 Medical And General Inquiry

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

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

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

9.3.1.5.5.1 Discussion of Data

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

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

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

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

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

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

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

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

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

9.3.1.7.1 Discussion of Data

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

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

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

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

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

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

9.3.1.8 Role of EAPs in Addressing the Needs of Affected Women

(Question 10)

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

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

9.3.1.8.1 Discussion of Data

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

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

9.3.1.9 Women's Perceptions of EAPs After Utilisation

(Question 11 and 12)

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

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

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

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

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

9.3.1.10.1 Stay away from gender specific programmes

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

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

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

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

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

9.3.1.10.2 Health Focus programme

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

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

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

- "Address issues of sexual abuse and harassment".

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

- "Advocate for disease management programmes where applicable".

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

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

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

9.3.1.10.3 More Support for EAP

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

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

9.3.1.10.4 Make EAP Visible

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

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

9.3.1.10.5 Other Creative Ideas

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

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

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

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

9.3.1.10.6 Discussion of Data

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

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

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

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

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

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

9.3.1.11 Summary and Conclusions of the Qualitative Data Analysis

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

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

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

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

9.3.2 QUANTITATIVE DATA ANALYSIS

9.3.2.1 Introduction

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

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

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

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

9.3.2.2 Section A: Demographic Analysis

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

9.3.2.2.1 Age of Respondents

(Question 2)

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

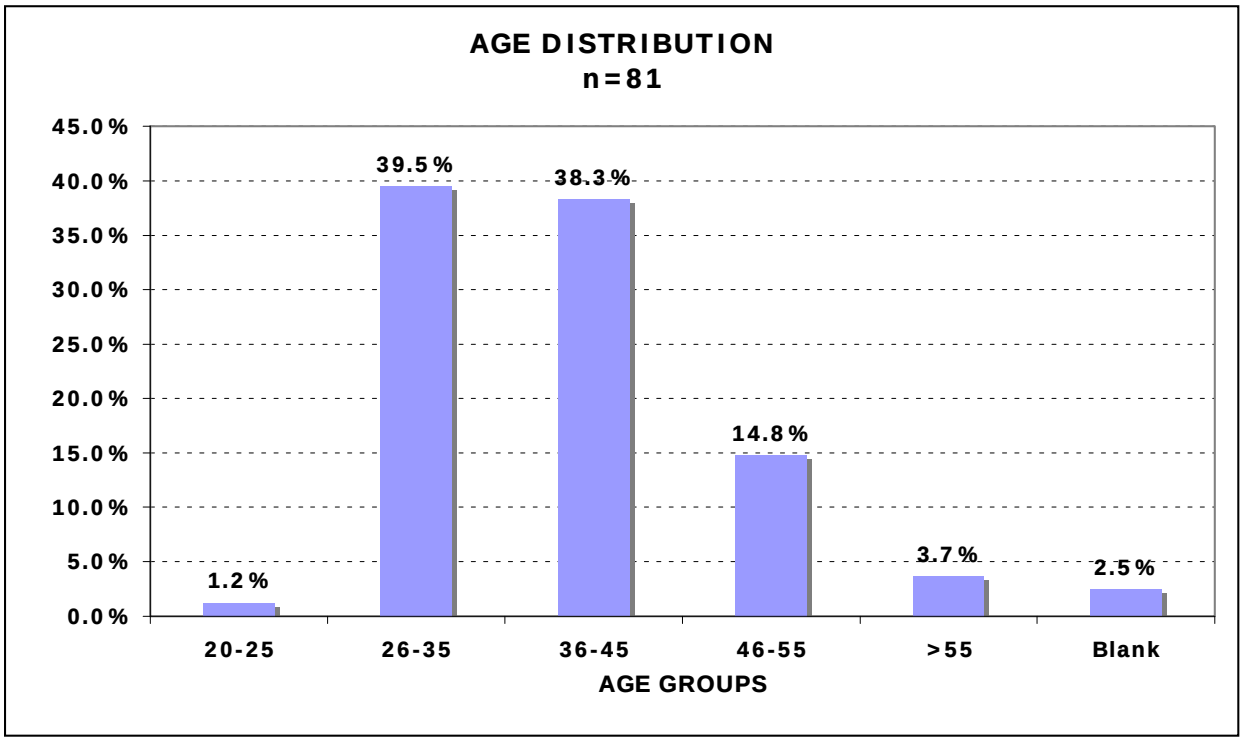


Figure 2: Age Distribution of Respondents

9.3.2.2.1.1 Discussion of Data

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

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

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

9.3.2.2.2 Position in the Workplace

(Questions 3 and 4)

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

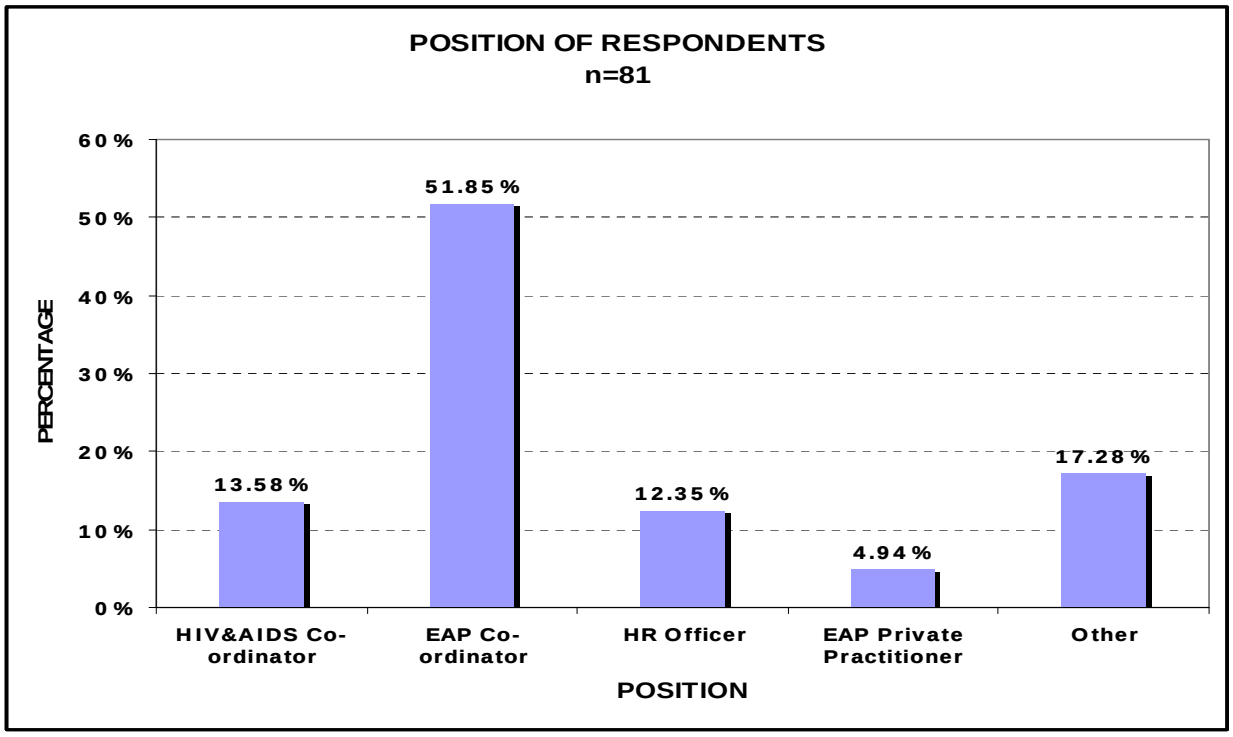
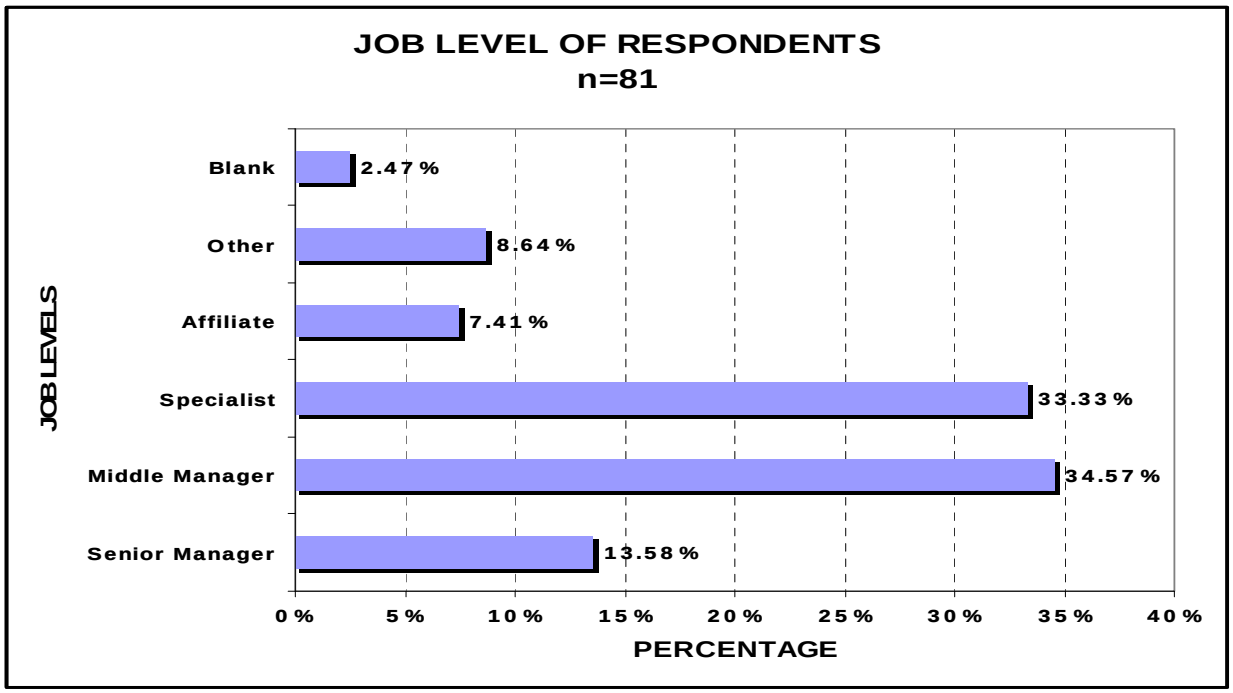


Figure 3: Position of Respondent

Figure 4: Job Level of Respondents



9.3.2.2.2.1 Discussion of Data

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

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

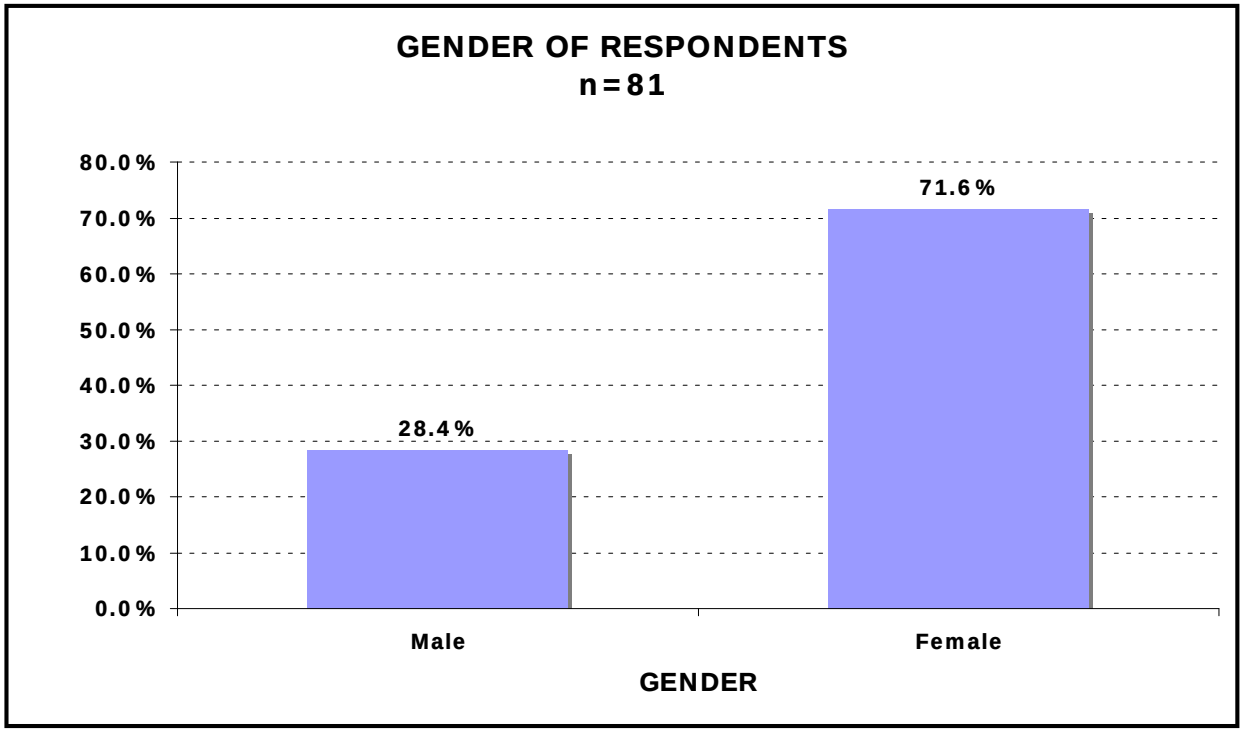
The researcher concludes from these responses that EAPs do not enjoy the influence that it deserves, given that the majority of the skills-base is within the middle management and specialist levels – which may be different from senior management level.

9.3.2.2.3 Gender of the EAP Practitioners

(Questions 5)

Question 5 required the respondents to indicate their gender.

Figure 5: Gender Profile of Respondents



9.3.2.2.3.1 Discussion of Data

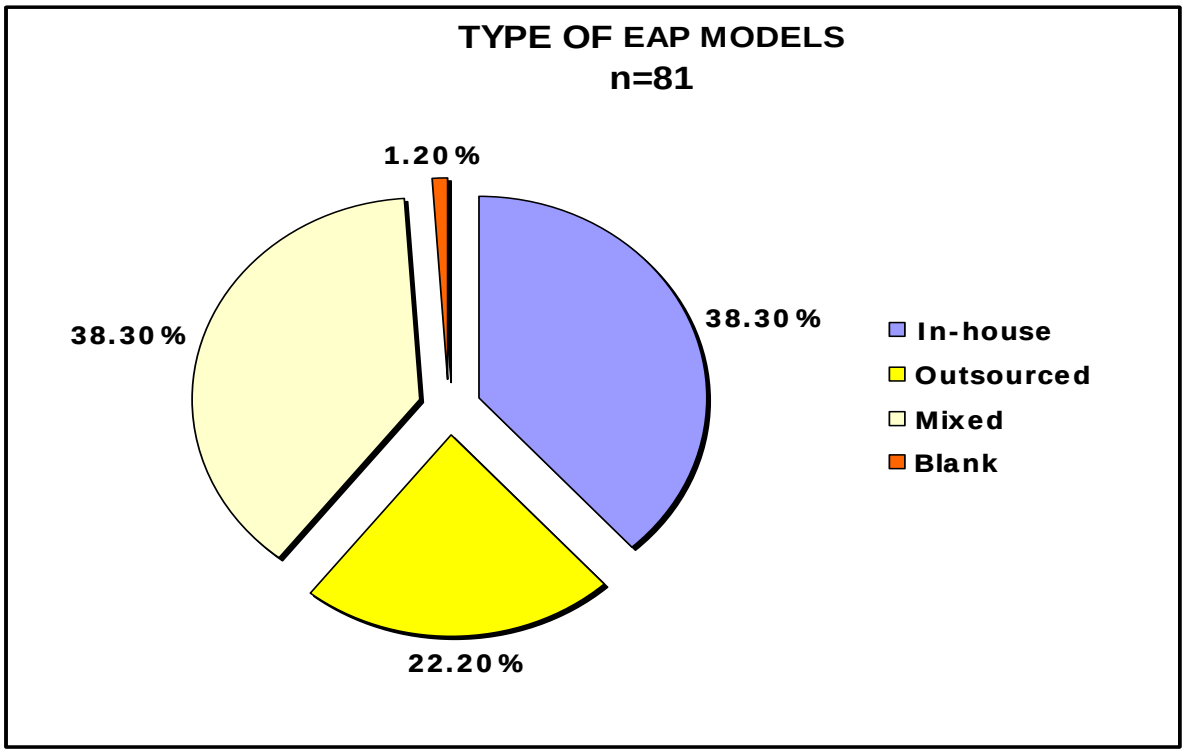
The majority of the respondents were female 71.6% and 28.4% were males. The responses above indicated that female practitioners dominated the EAPs in South Africa. Historically, the EAP and Occupational Social Work professions have inherited skills from the counselling profession, which has been largely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

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

9.3.2.2.4 Model Preference

(Question 6)

Figure 6: Type of EAP Model



9.3.2.2.4.1 Discussion of Data

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

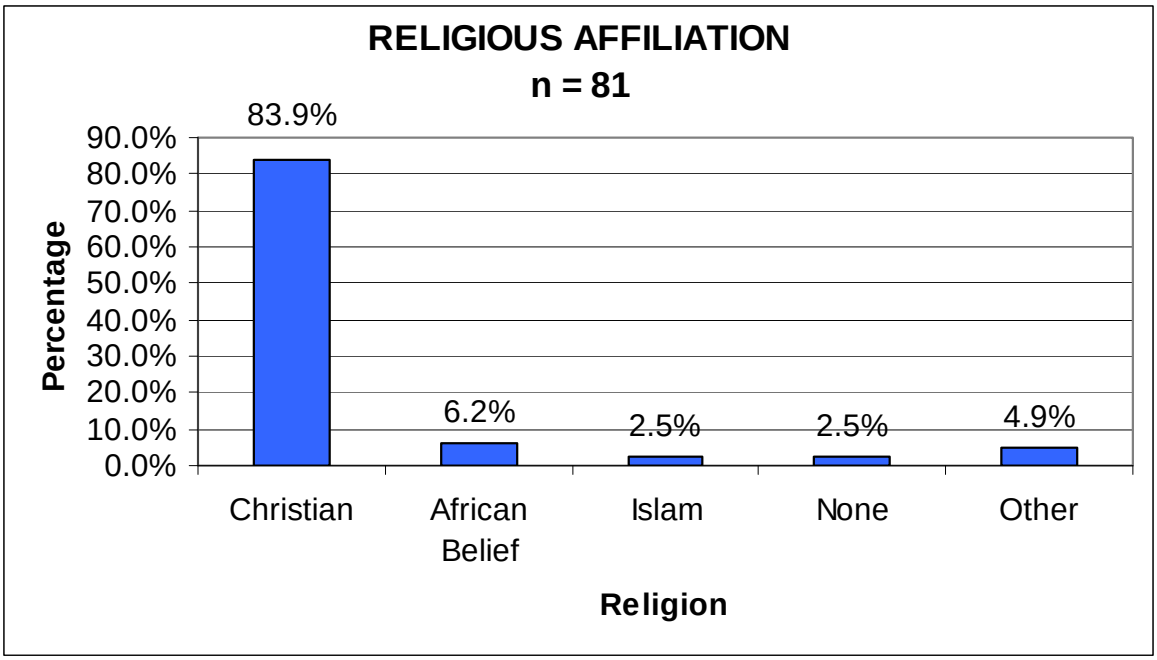
The choice of the respondents in the study indicated that in-house and mixed models are the preferred choices of EAP by those practitioners sampled at 38.30% respectively, with 22.20% outsourcing the function completely. In 1995 / 96, a survey by Harper (1996) of the top hundred companies in South Africa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

9.3.2.2.5 Religious Affiliation

(Question 7)

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

Figure 7: Religious Affiliation of Respondents



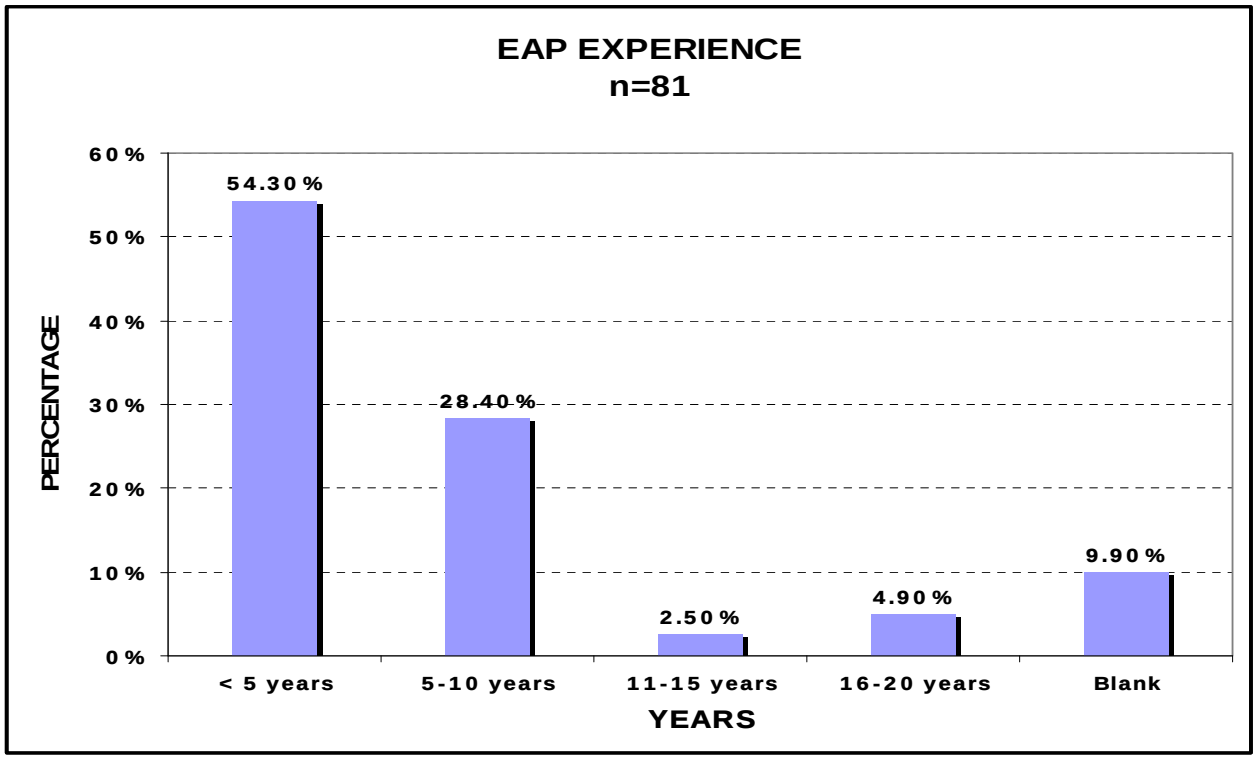
9.3.2.2.5.1 Discussion of Data

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

9.3.2.2.6 Duration of Work Experience of EAP Practitioner

(Question 8)

Figure 8: Experience of EAP Practitioner



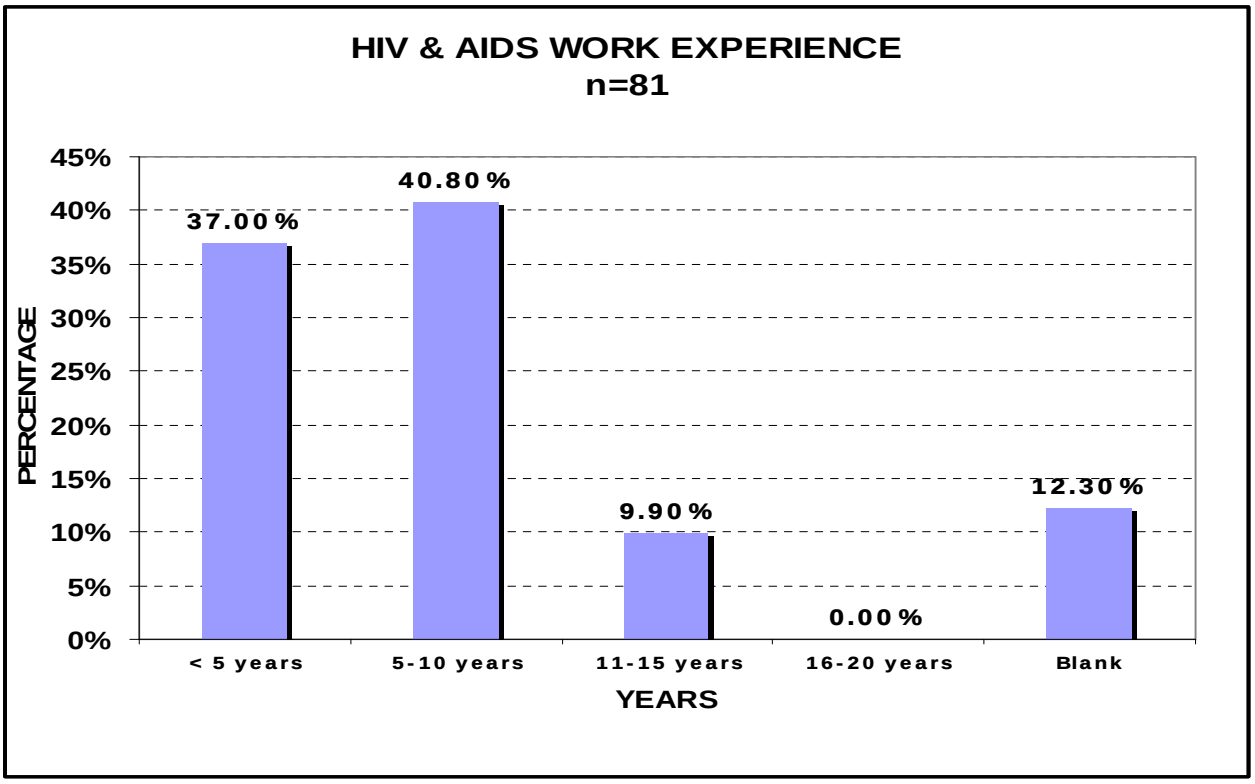
9.3.2.2.6.1 Discussion of Data

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

9.3.2.2.7 Work Experience in HIV and AIDS Field

(Question 9)

Figure 9: HIV and AIDS Work Experience



9.3.2.2.7.1 Discussion of Data

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

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

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

9.3.2.3 Section B: The Role of EAP

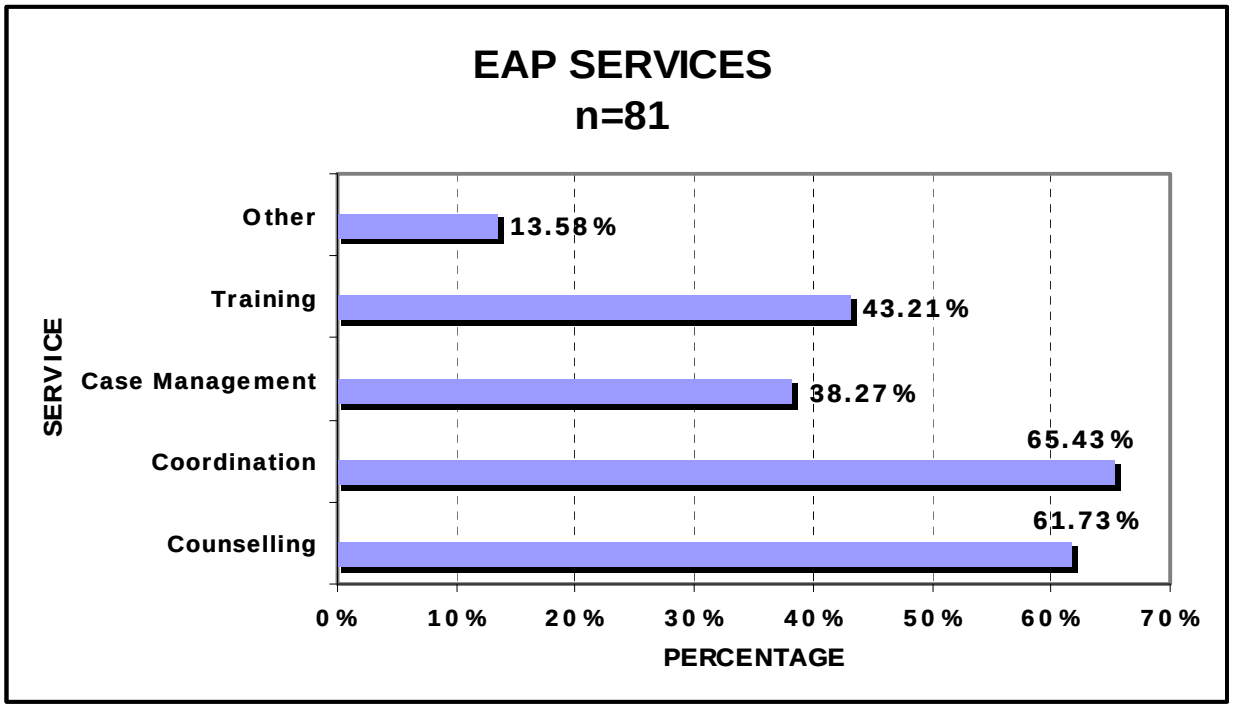
This section investigated the role of EAP involvement in HIV activities, including basic HIV prevalence. Some of the questions required multiple answers to the responses. Questions 10 to 28 are presented with figures 10 to 28 and discussed.

9.3.2.3.1 EAP Services Offered

(Question 10)

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

Figure 10: EAP Services Offerings



9.3.2.3.1.1 Discussion of Data

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

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

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

9.3.2.3.2 HIV and AIDS Prevalence in the Workplace

(Question 11 and 21)

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

Figure 11: HIV & AIDS Prevalence in the Workplace

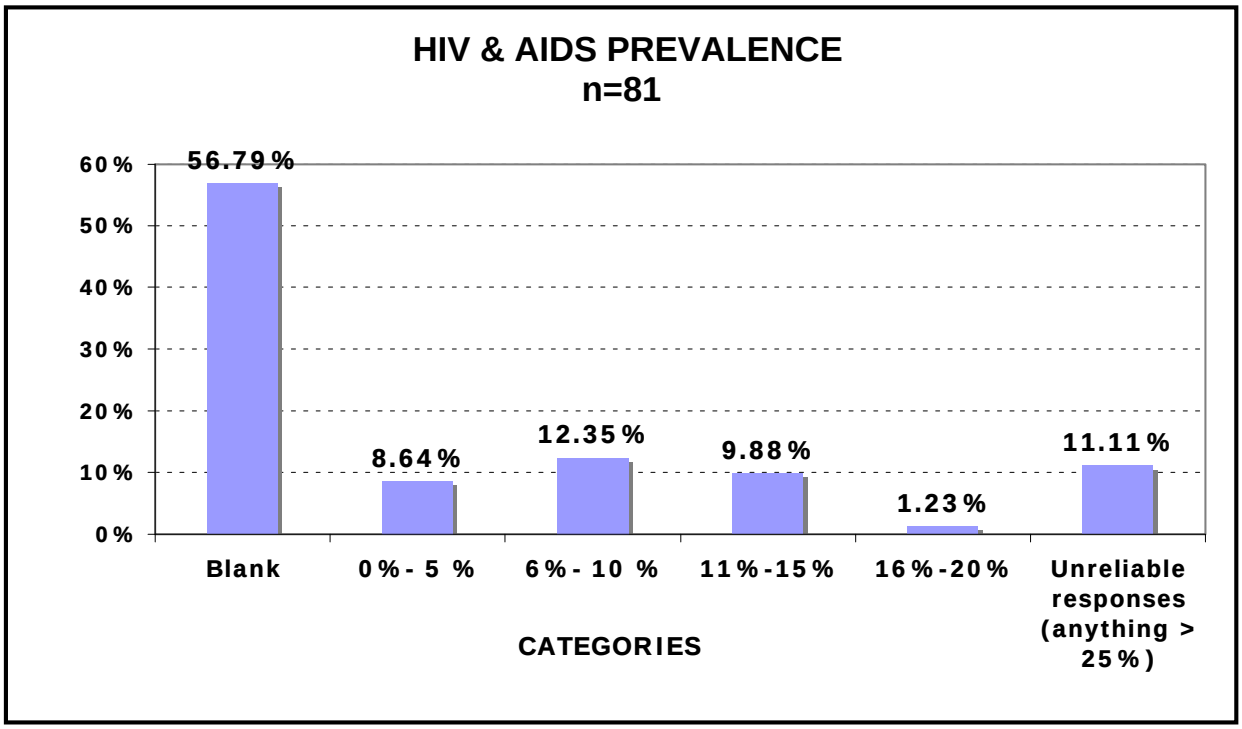
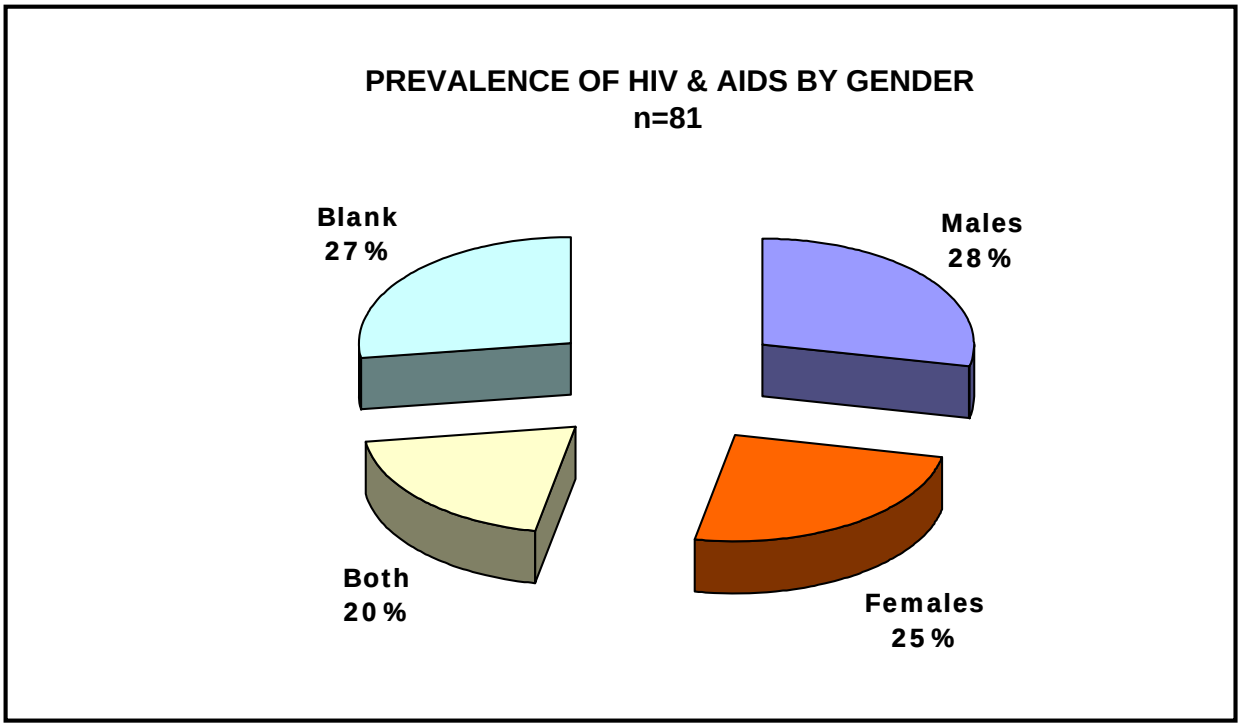


Figure 12: HIV and AIDS Prevalence By Gender



9.3.2.3.2.1 Discussion of Data

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

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

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

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

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

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

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

9.3.2.3.3 HIV and AIDS Programmes in the Workplace

(Questions 12 and 13)

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

Figure 13: HIV and AIDS Programmes in the Workplace

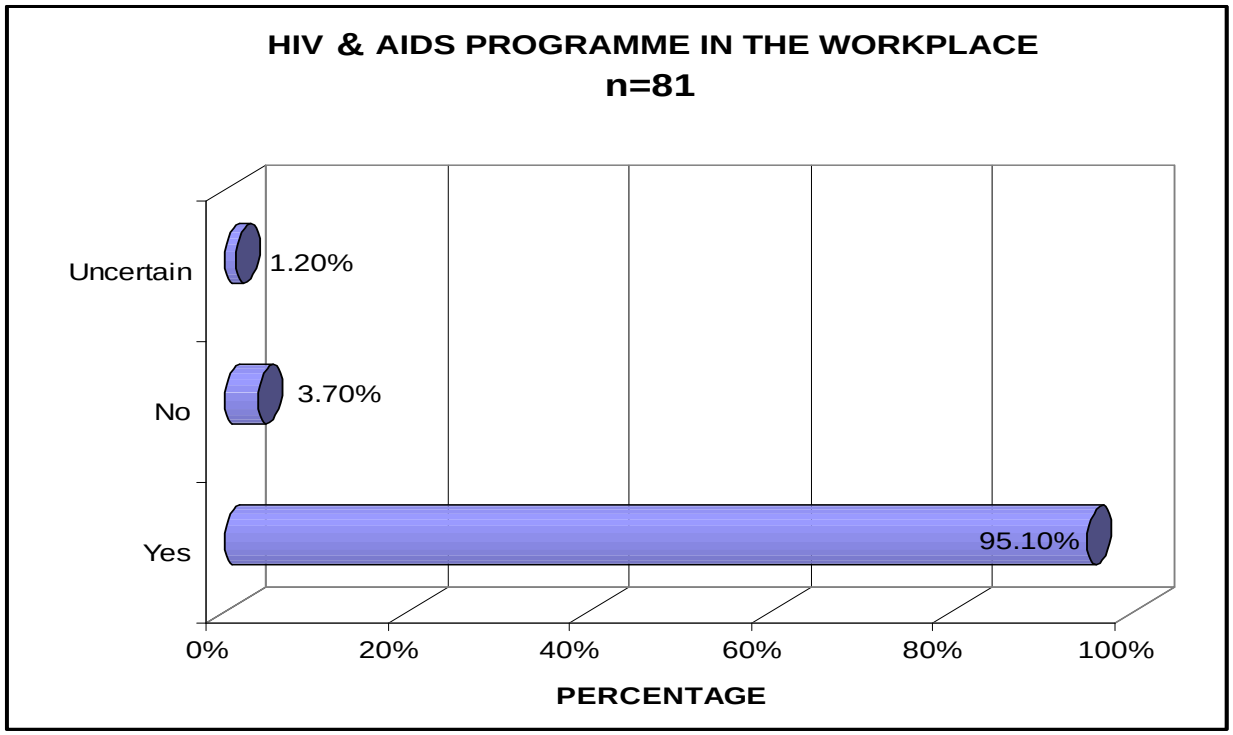
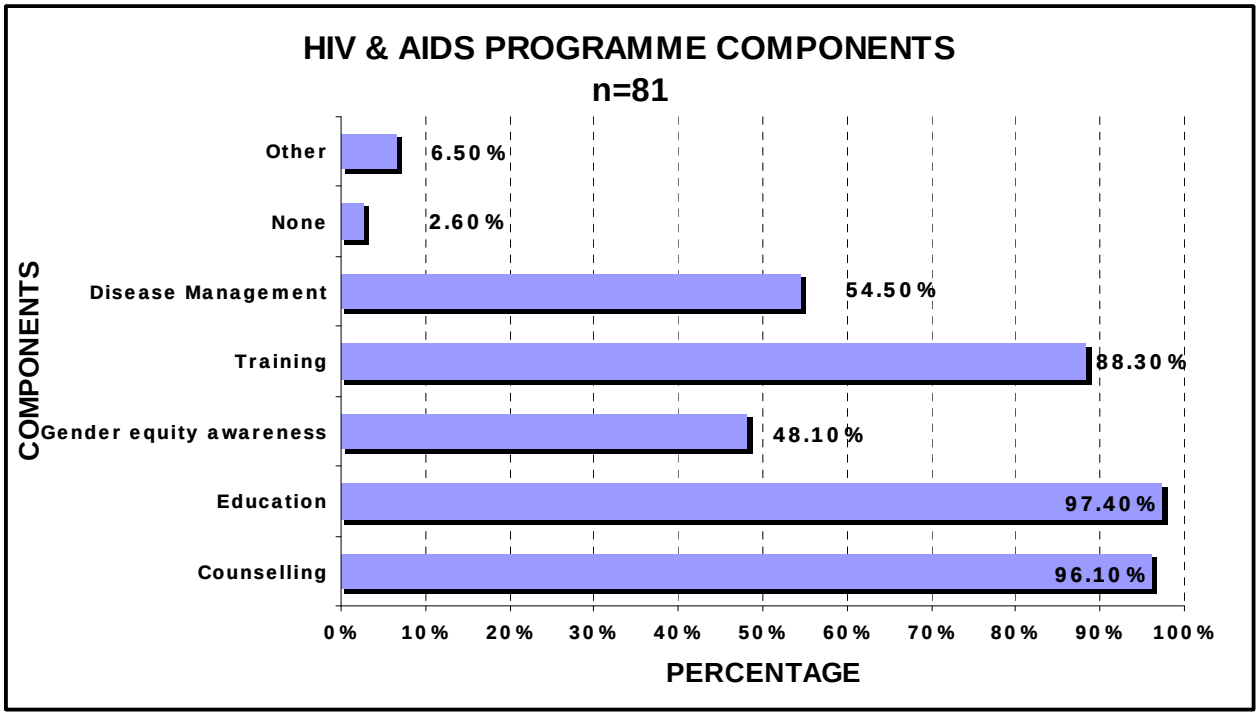


Figure 14: Components of HIV and AIDS Programme



9.3.2.3.3.1 Discussion of Data

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

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

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

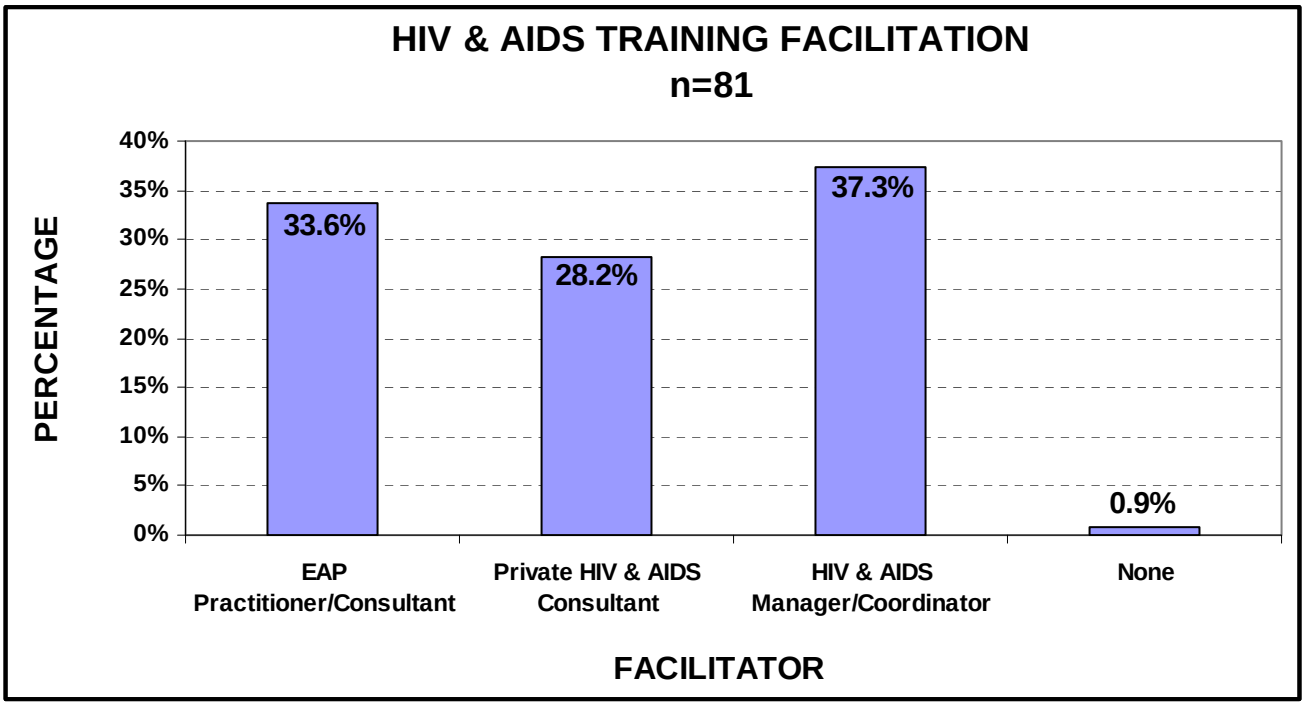
It is encouraging to see that gender equity awareness is also been offered by 48.10% of the respondents. Gender awareness addresses the issues of gender equity and awareness and can only assist in addressing gender imbalances, highlight gender sensitisation and introduce women empowerment initiatives.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

9.3.2.3.4 HIV and AIDS Training Facilitation

(Question 14)

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

Figure 15: HIV and AIDS Training Facilitation



9.3.2.3.4.1 Discussion of Data

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

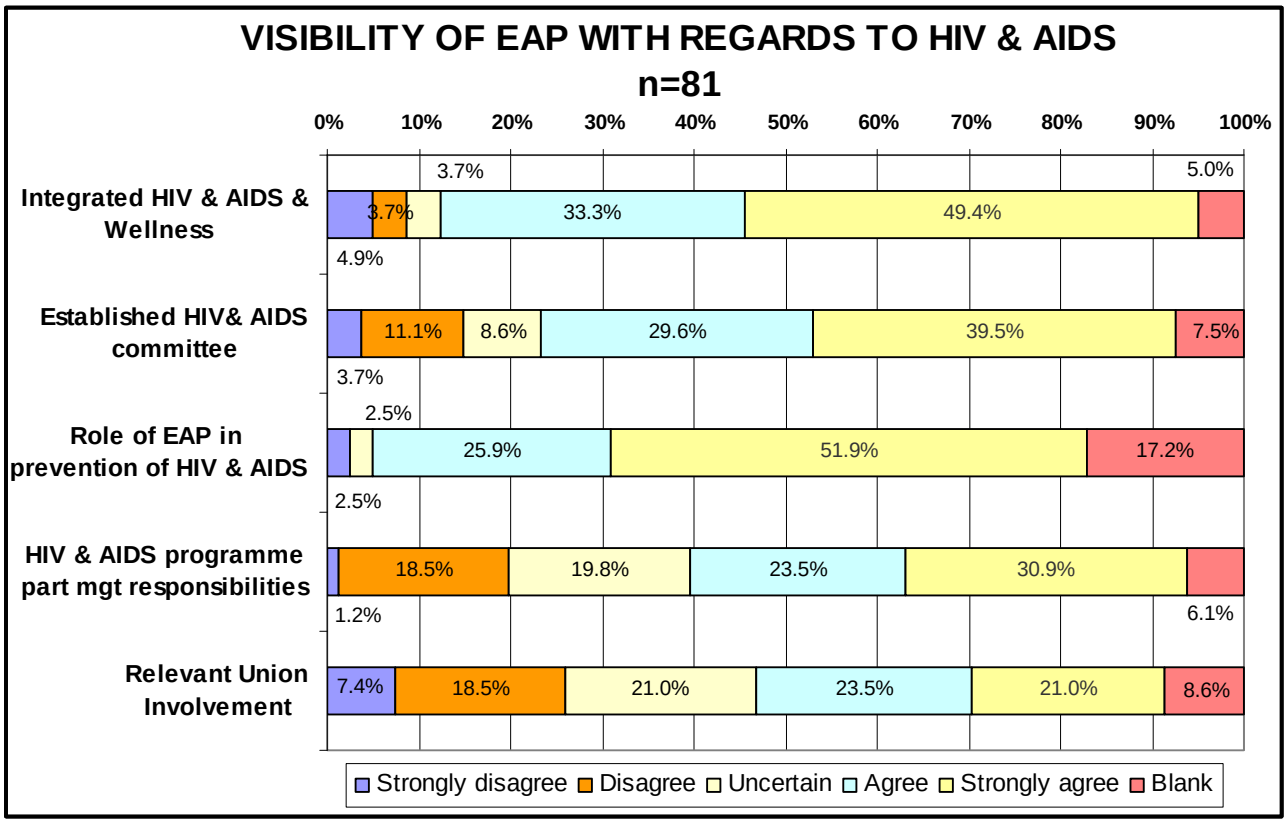
EAP programmes. These results do not in anyway show the impact of role differentiation to service satisfaction. The question investigated the role of EAP in the field of HIV and AIDS training, judging from the responses EAP practitioners are offering little training in this field. It can therefore be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

9.3.2.3.5 EAP involvement in HIV and AIDS

(Questions 15 to 19)

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

Figure 16: EAP Visibility



9.3.2.3.5.1 Discussion of Data

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

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

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

Question 21

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

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

(Questions 22 and 23)

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

Figure 17: How EAP addresses the needs of Infected Women

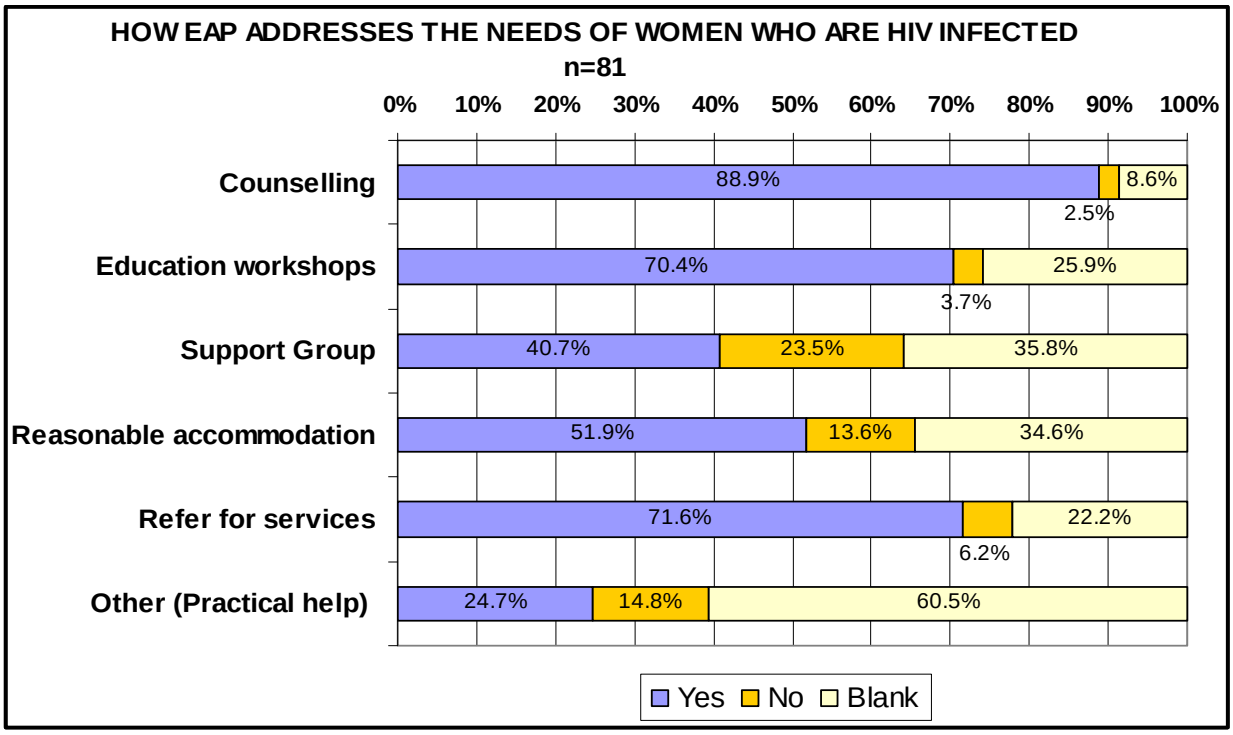
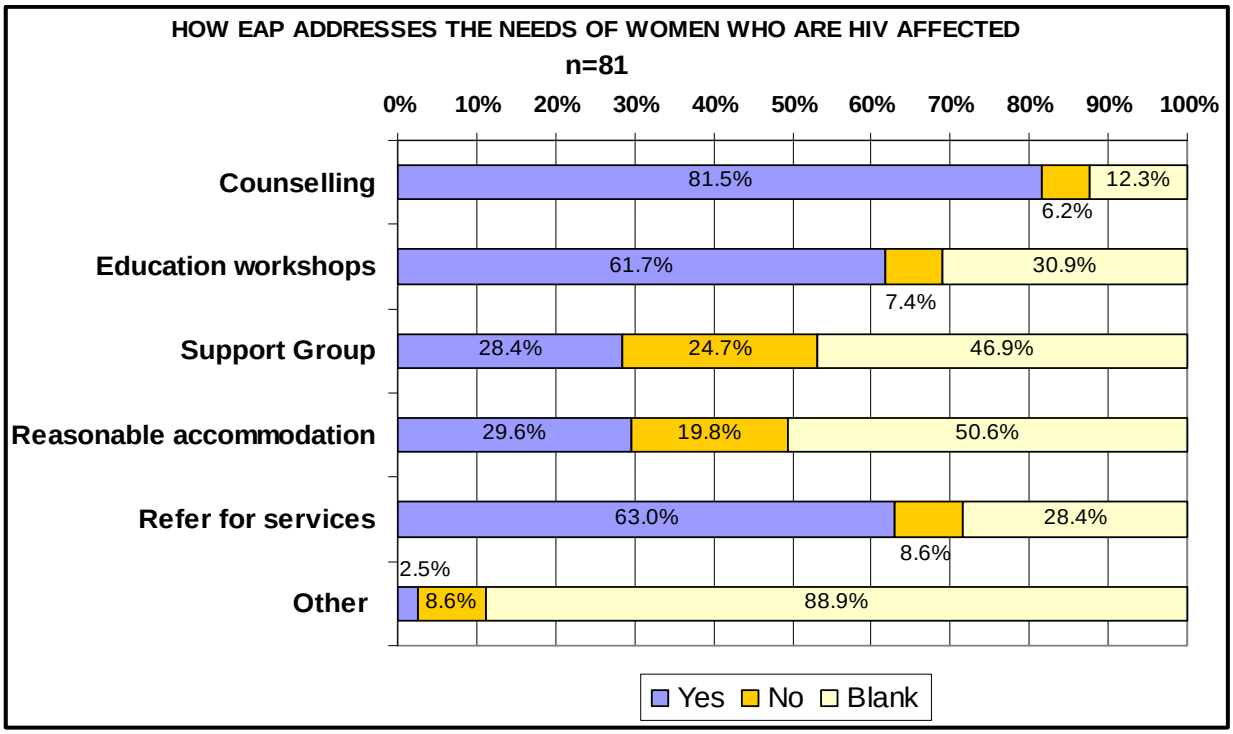


Figure 18: How EAP addresses the needs of affected women.



9.3.2.3.6.1 Discussion of Data

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

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

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

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

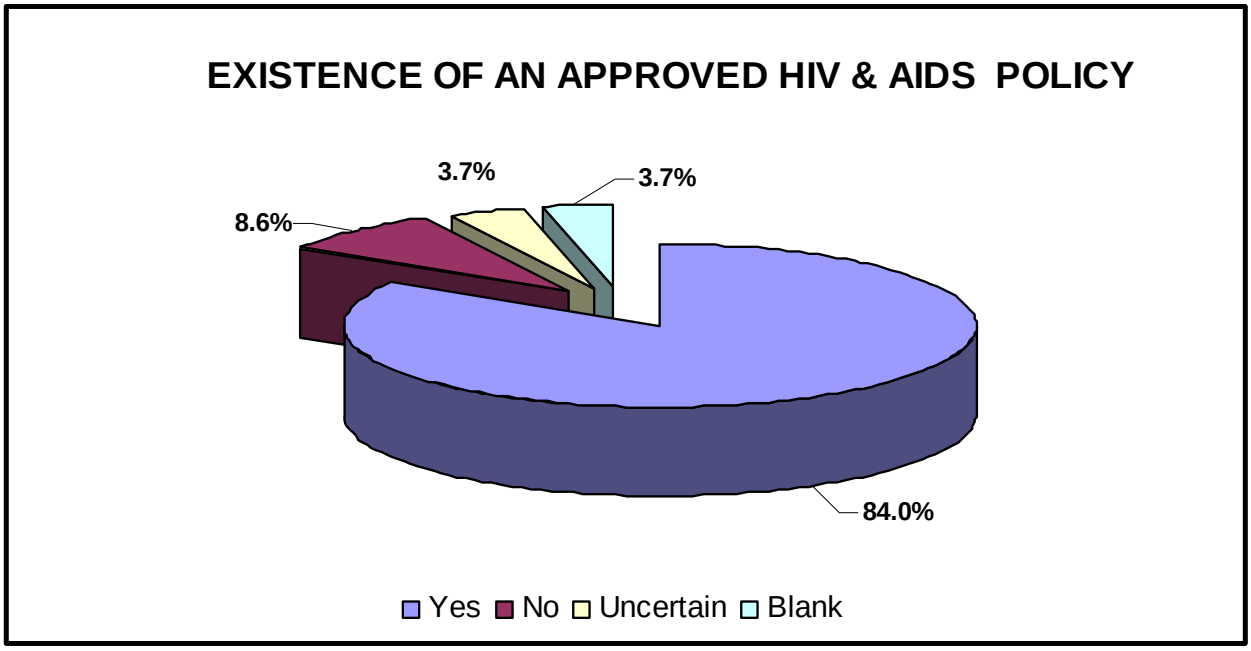
HIV and AIDS is a medical condition, thus it is not surprising that 71.6% respondents referred for HIV infected and 63.0% referred HIV and AIDS affected women for services. Referral for services is also an indication that EAPs are working together with other specialists in a multidisciplinary approach.

9.3.2.3.7 HIV and AIDS Policy

(Question 24)

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

Figure 19: HIV Policy



9.3.2.3.7.1 Discussion of Data

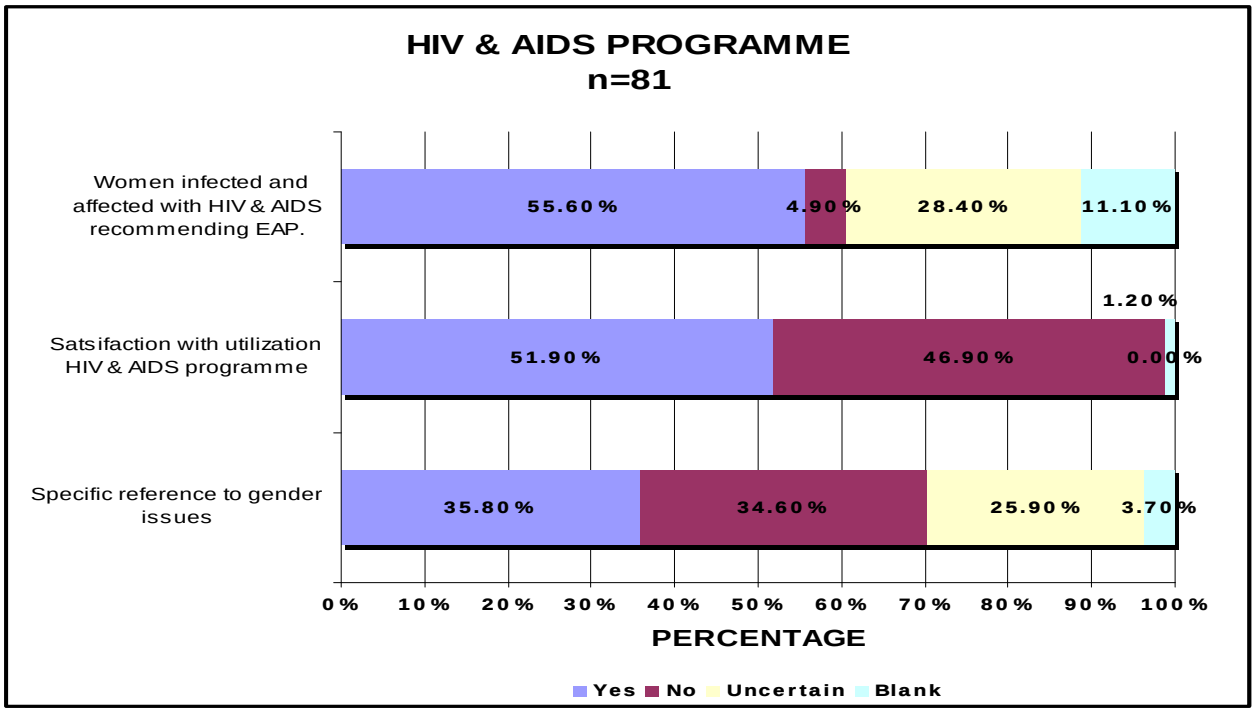
HIV and AIDS policy plays a very important role in the management of an HIV programme in the workplace. Furthermore an organization with an approved HIV policy demonstrates care for its employees and acknowledges the impact of HIV on its workforce. As illustrated in figure 19, eighty four percent of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

9.3.2.3.8 HIV and AIDS Programme

(Question 25, 27 and 28)

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

Figure 20: HIV and AIDS Programme



9.3.2.3.8.1 Discussion of Data

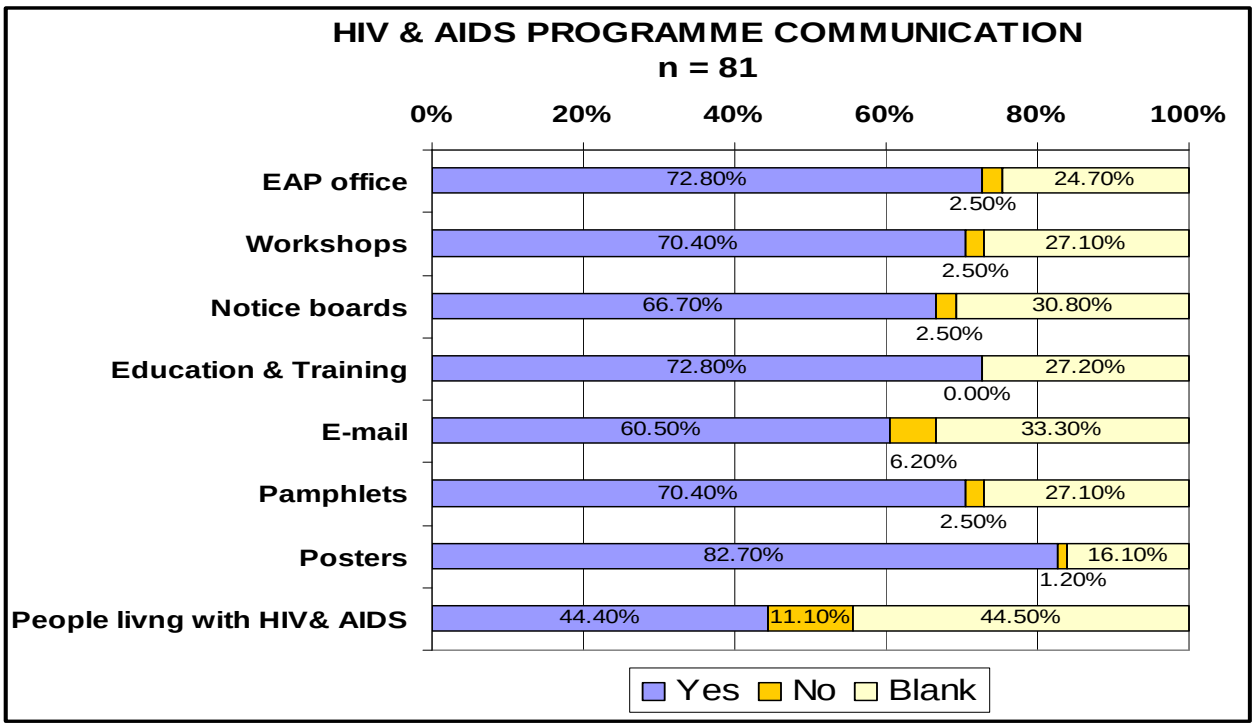
From the results above there seem to be mixed - responses regarding the special focus on gender issues regarding HIV and AIDS policy. At least 25.90% is still uncertain about the gender issues, which could suggest a lack of knowledge about their HIV and AIDS policy. It is encouraging to see that in evaluation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

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

9.3.2.3.9 HIV and AIDS Programme Communication

(Question 26)

Figure 21: Programme Communication



9.3.2.3.9.1 Discussion of Data

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

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

9.3.2.4 Section C: Difficulties Experienced by Women

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

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

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

(Question 29 and 30)

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

Figure 22: Difficulties as Experienced by Infected Women

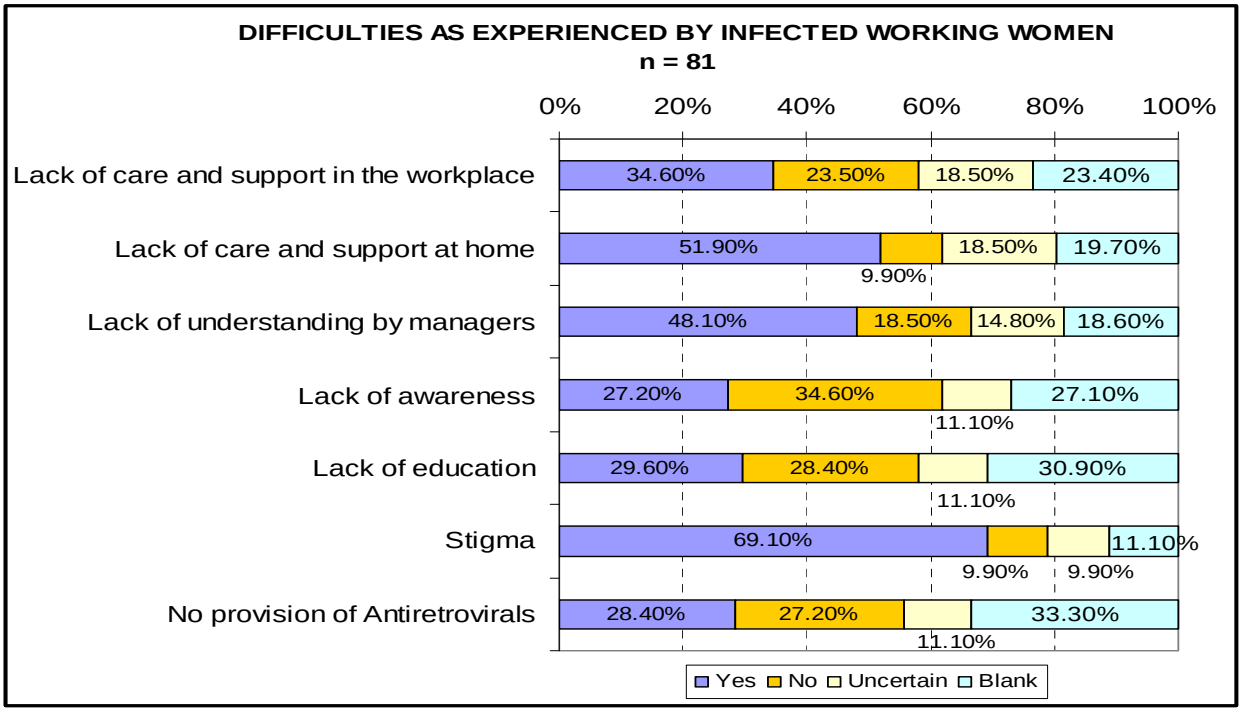
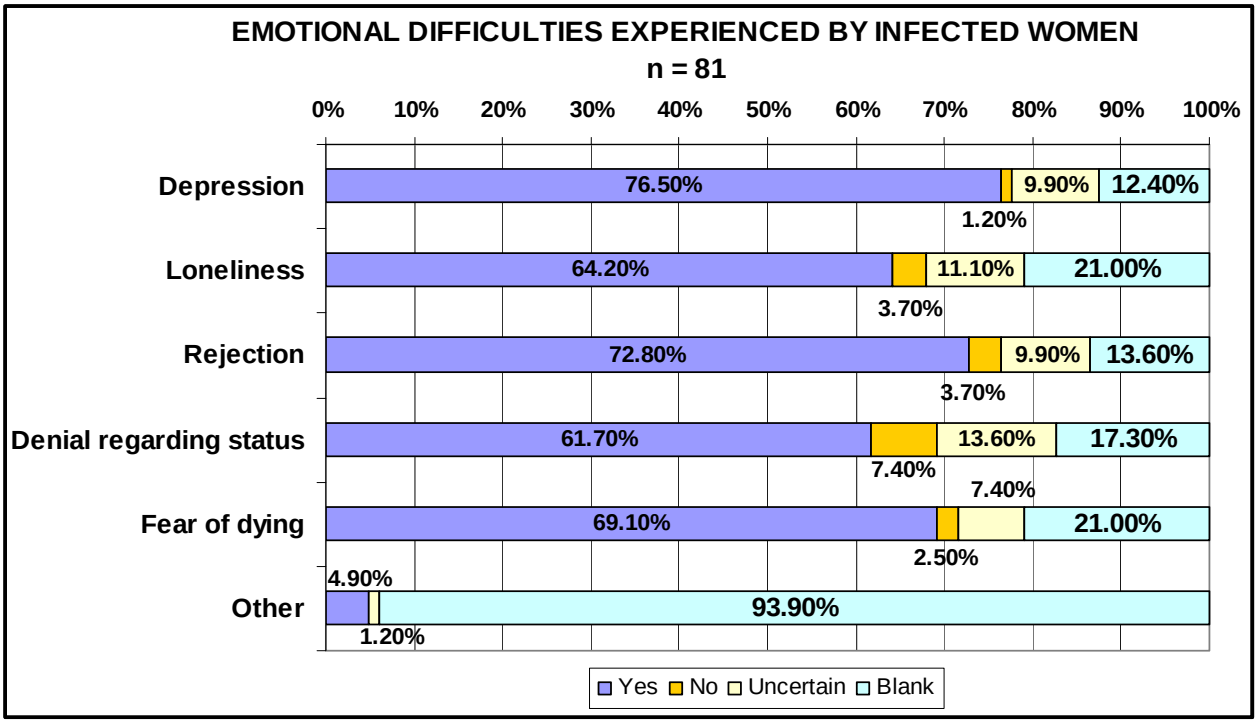


Figure 23: Emotional Difficulties Experienced by Infected Women



9.3.2.4.1.1 Discussion of Data

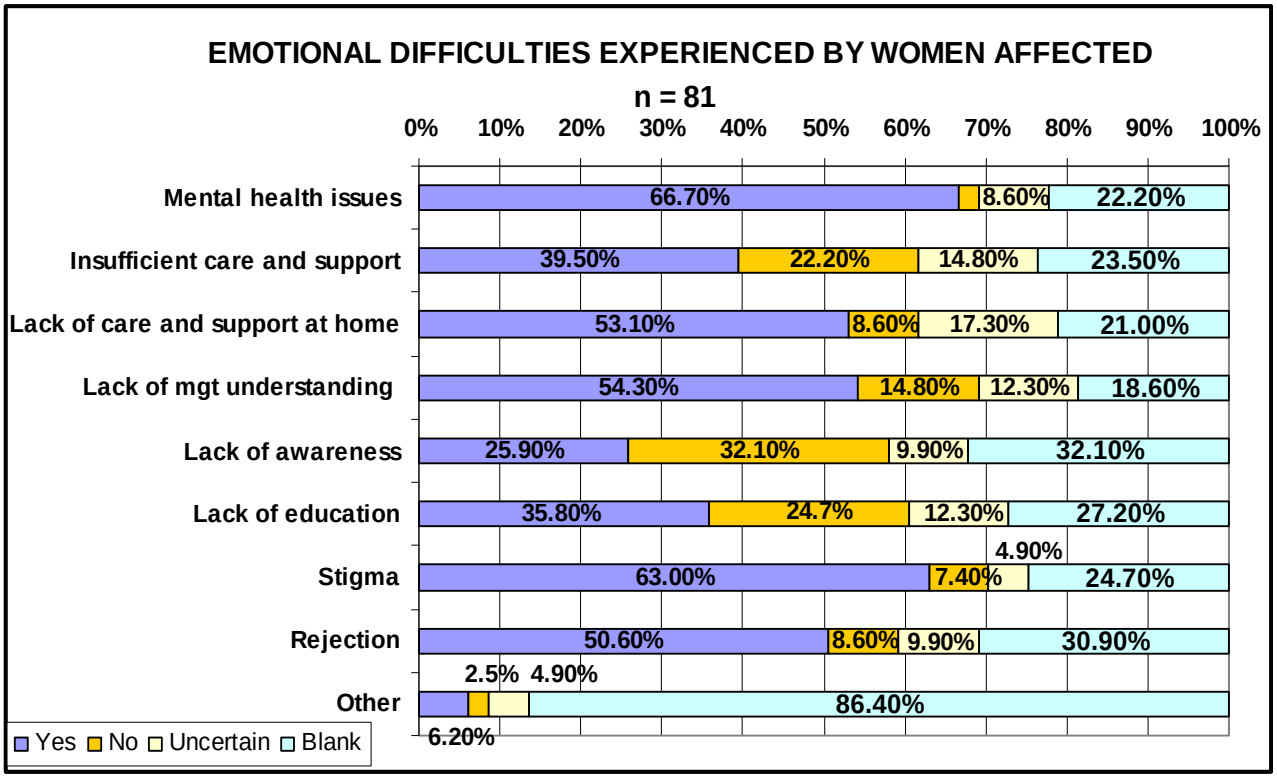
The information from the respondents were the collective experiences that the respondents had in respect of dealing with women infected with HIV and AIDS. The respondents affirmed that mental health issues are key challenges of women infected. Figure 23 showed that all the mental health issues are rated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

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

(Question 31)

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

Figure 24: Emotional Difficulties (Affected Women)



9.3.2.4.2.1 Discussion of Data

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

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

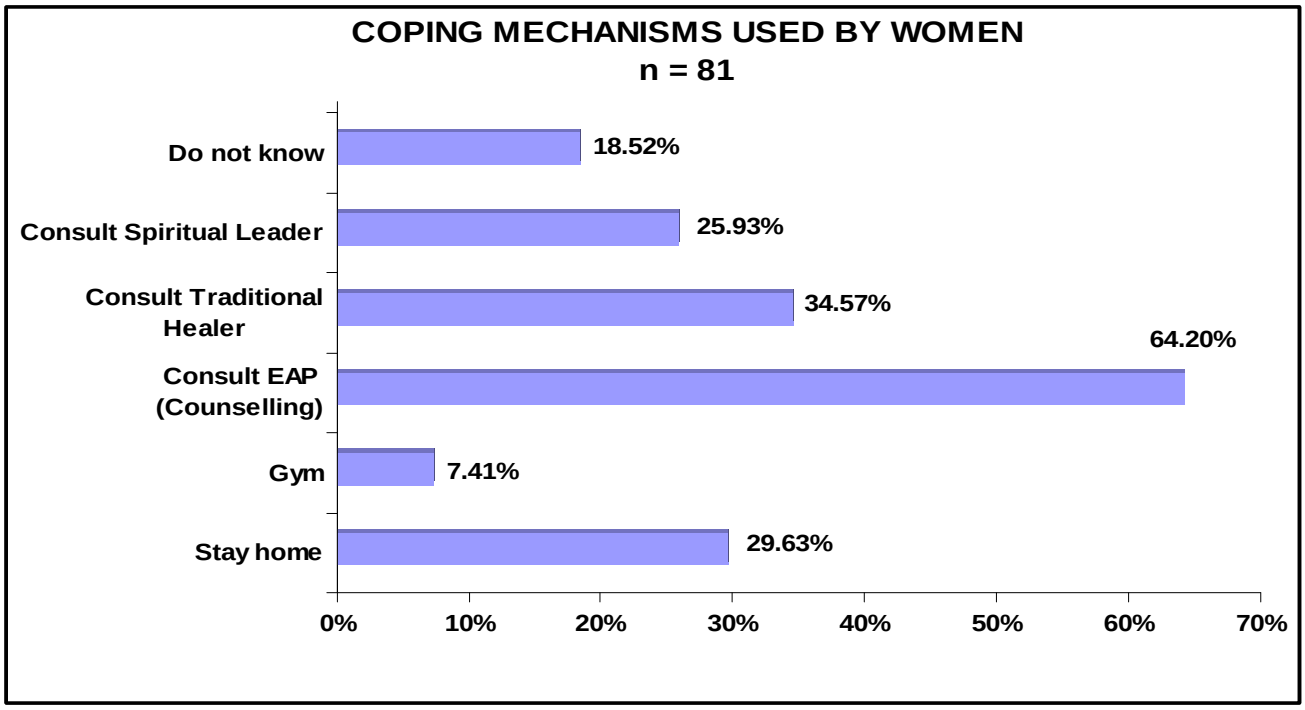
Similarly, stigma as a difficulty for HIV and AIDS affected women is indicated by 63.00% of the respondents, confirming research presented previously in Chapter 6. About 50.60% of the respondents confirmed that affected women experience rejection due to HIV and AIDS, of note is 30.90% left this section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

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

(Question 32)

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

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



9.3.2.4.3.1 Discussion of Data

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

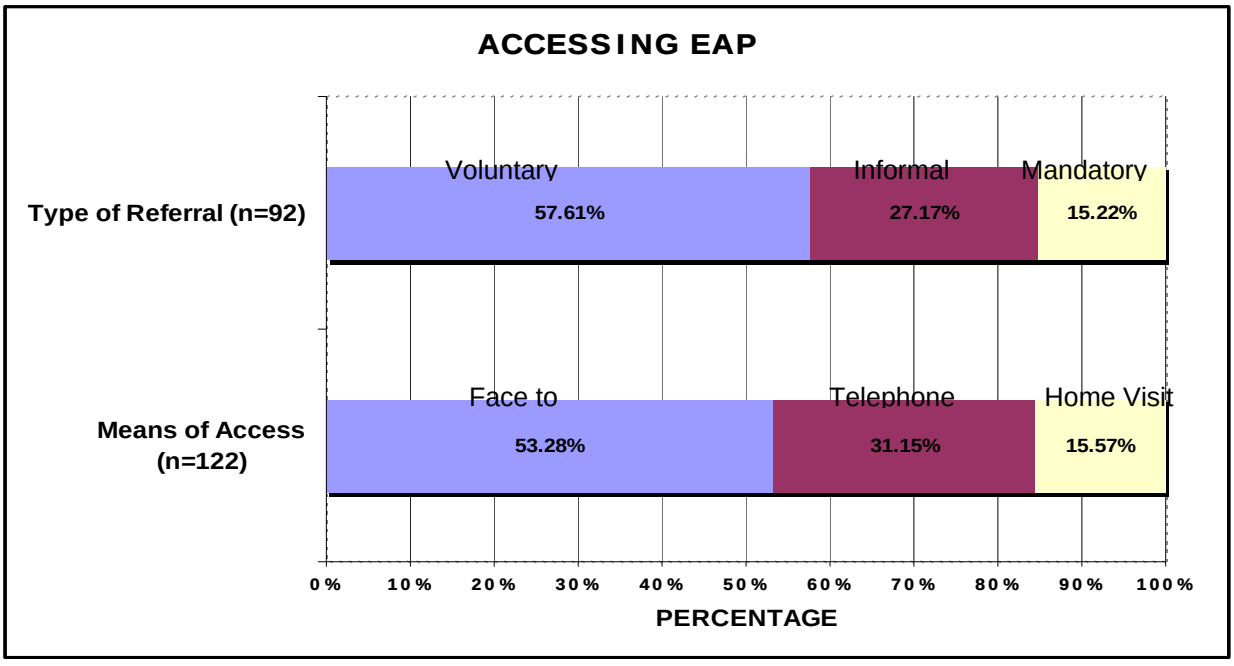
Only 7.41% of the respondents confirmed that women attend the gym. Gym is another financial commitment that needs to be budgeted for. The reason for low responses could be that indeed majority of the women could not make a financial commitment to this service. However, creative exercising initiatives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

9.3.2.4.4 Access to EAP Services

(Question 33 and 37)

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

Figure 26: Accessing EAP Services



9.3.2.4.4.1 Discussion of Data

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

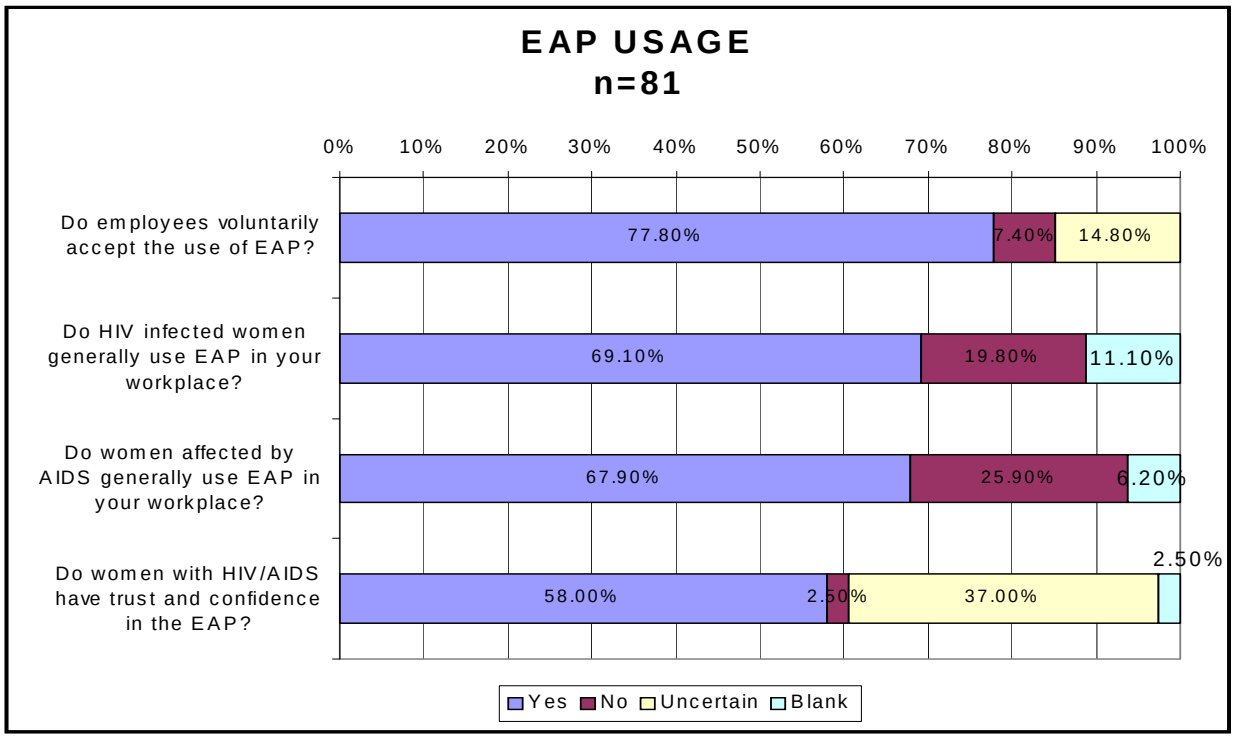
(voluntary referral) and access takes place on a personal basis. From the data, mandatory referral is low (15.22%) relative to informal and voluntary, further supporting the above assertion. The telephone counselling and home visits could be as a result of the person desiring greater confidentiality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

9.3.2.4.5 Utilisation Of EAP Services

(Question 34, 35, 36)

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

Figure 27: EAP Usage



9.3.2.4.5.1 Discussion Of Data

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

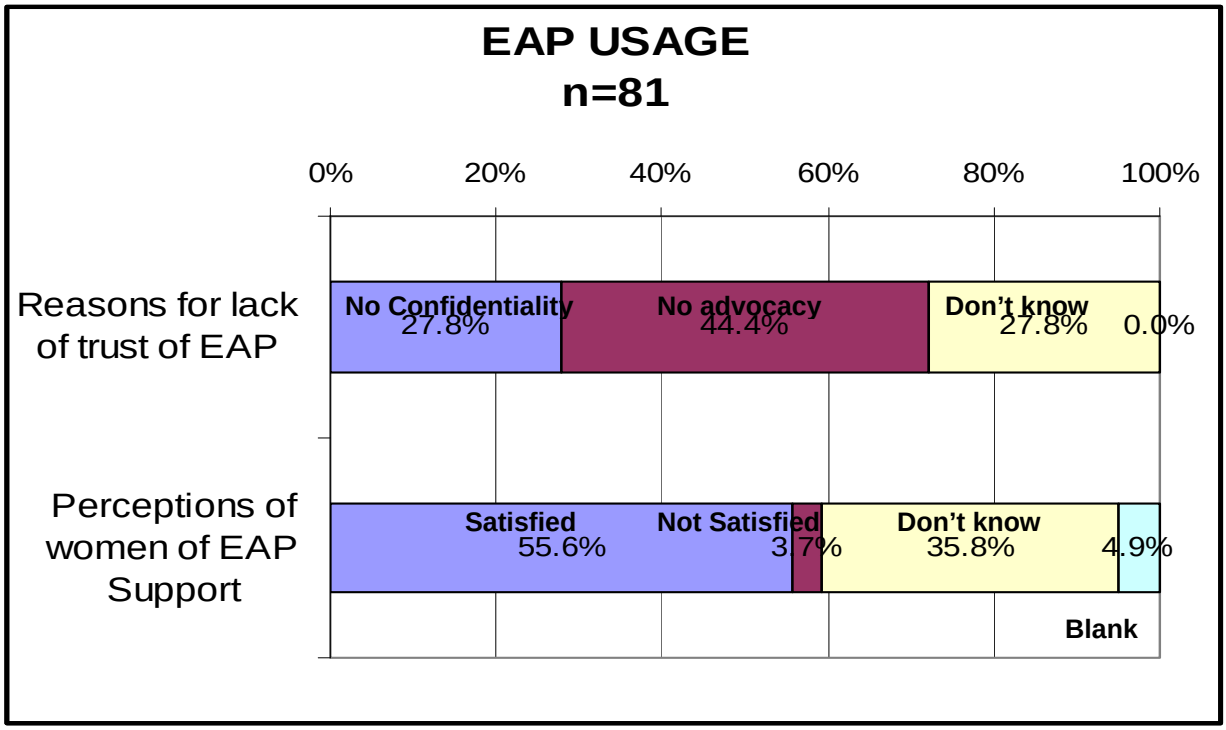
Research indicates that the majority of women with mental health issues irrespective of the illness are likely to seek help (About.com, 2006). Still about 25.90% of the respondents indicated 'No' to the use of EAP by women. It would have been interesting to find out what are the alternatives services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

9.3.2.4.6 Trust and Confidence In EAP

(Question 38, 39 and 40)

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

Figure 28: EAP Usage (Continued)



9.3.2.4.6.1 Discussion of Data

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

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

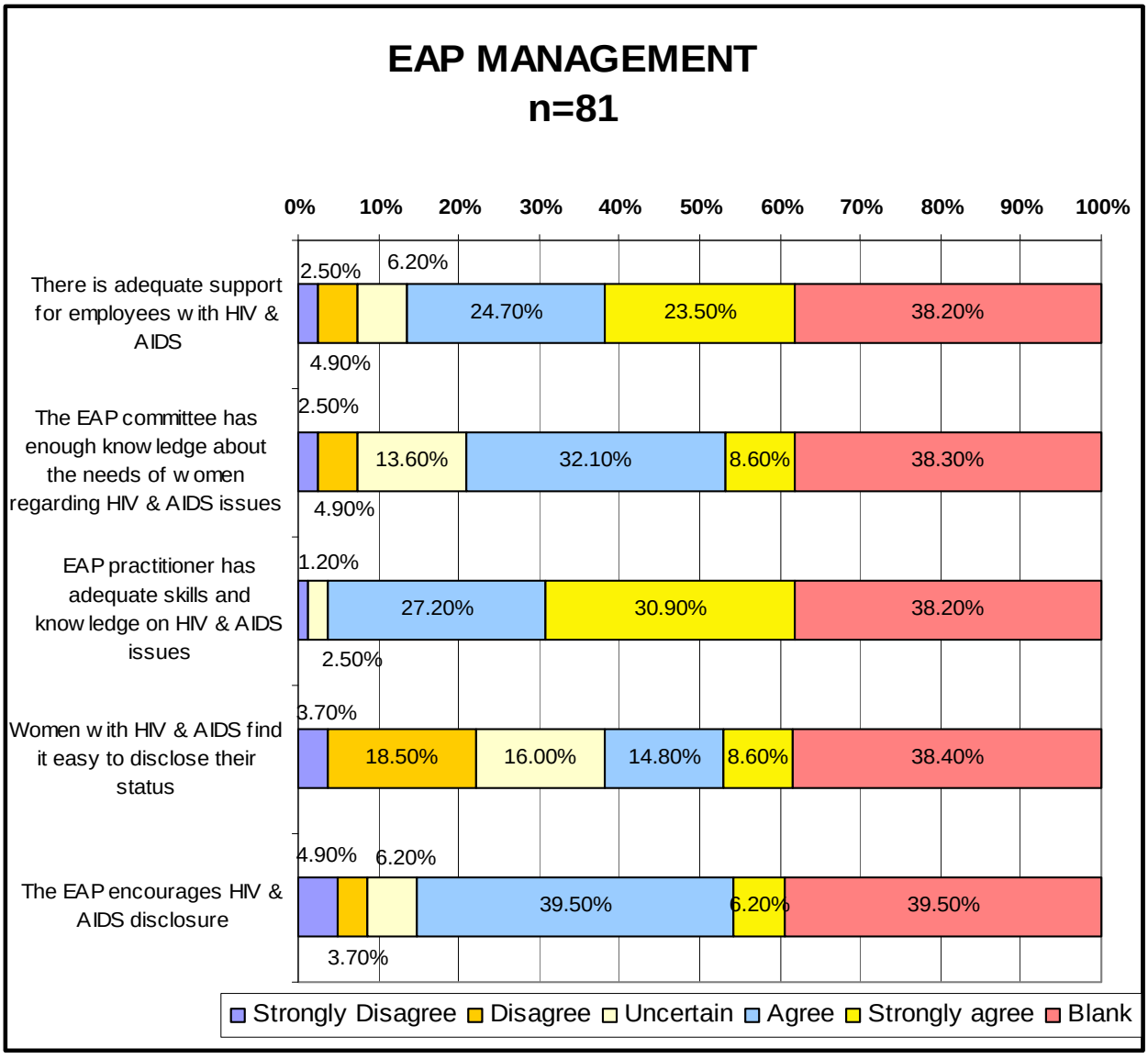
and level of work of EAP practitioners and the influence these aspects may have on decision making in the workplace (Figure 3 & 4) above. The argument was that if the EAP practitioners are in a position that can influence decision- making, there could be more advocacy for those accessing EAP, especially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

9.3.2.4.7 Reason for EAP Satisfaction

(Questions 41 to 46)

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

Figure 29: Reason for EAP Satisfaction



9.3.2.4.7.1 Discussion of Data

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

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

9.3.2.5 Section D: Strategic Planning

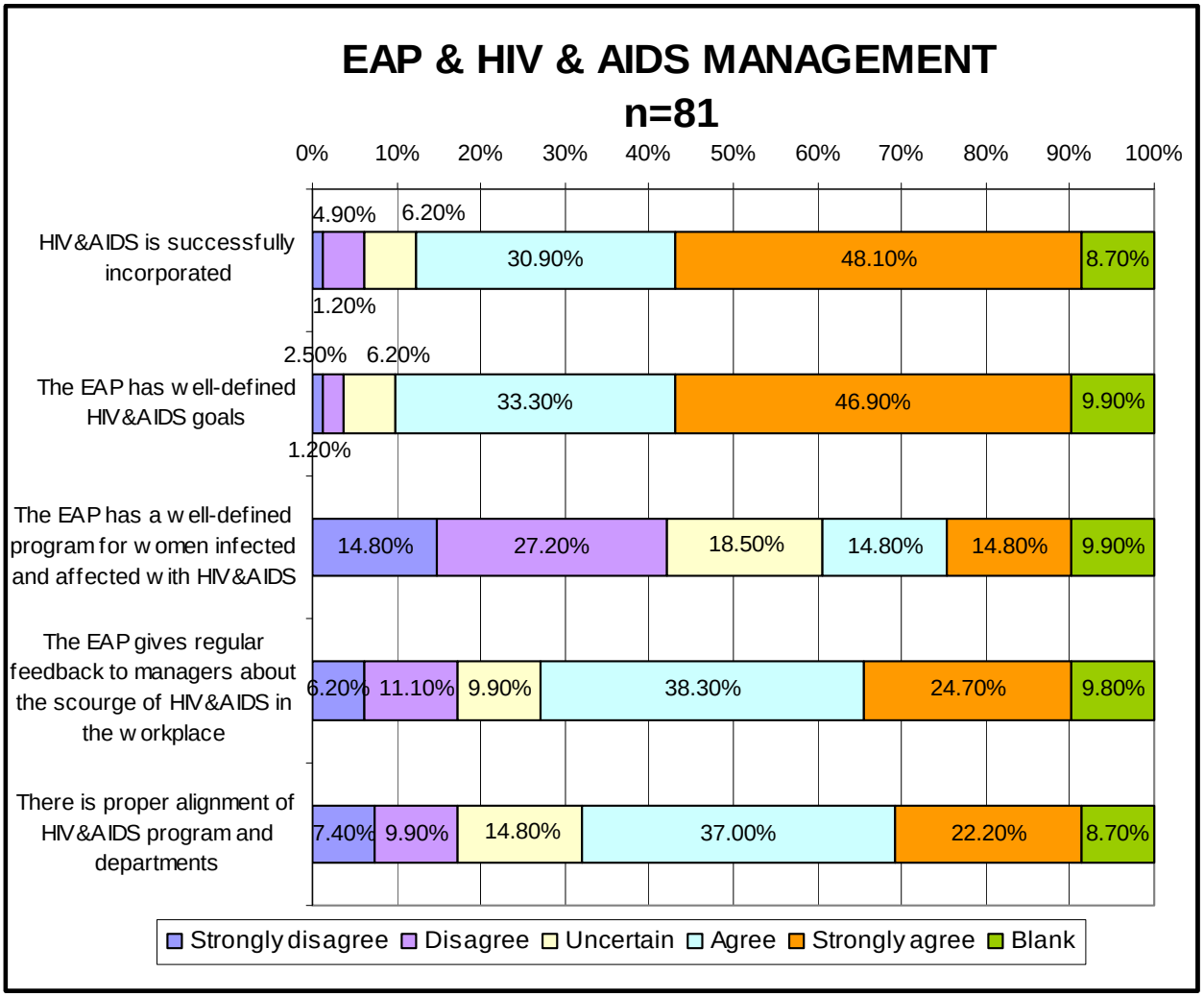
This section addresses the strategic need of the EAP programme. Strategic planning session for the sake of discussion and clarity is divided into two parts, namely, discussion and HIV and AIDS management, (Questions 47 to 51) and the role of management in HIV and AIDS programme (Question 52 to 61).

9.3.2.5.1 EAP and HIV and AIDS Management

(Question 47 to 51)

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

Figure 30: EAP and HIV and AIDS Management



9.3.2.5.1.1 Discussion of Data

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

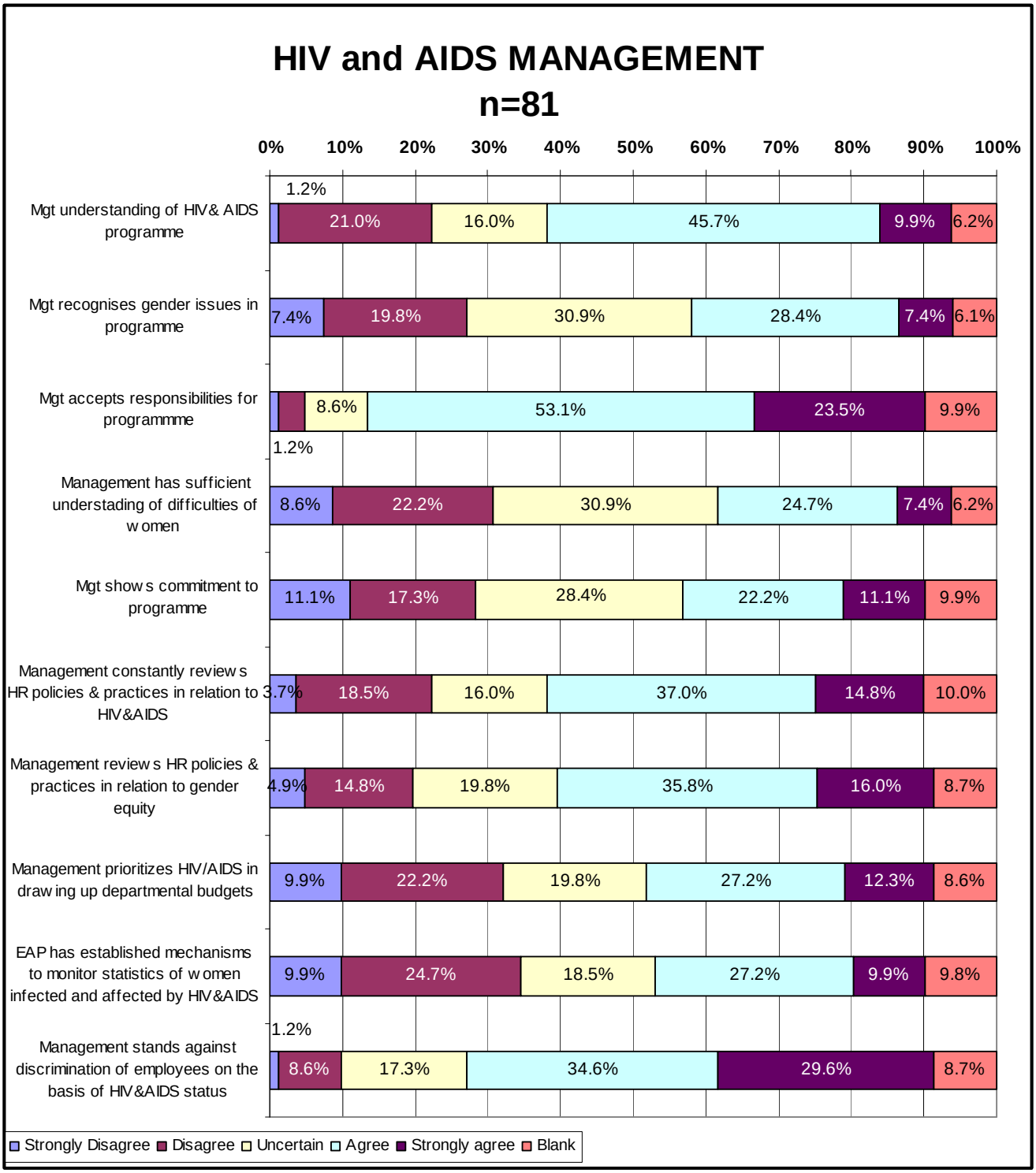
strategy execution is feedback and alignment. Feedback ensures that corrective measures can be taken to ensure that the strategy achieves it stated goals. From the responses, regular feedback (63.%) and alignment with departments (59.2%) are indicated as positive aspects of the EAPs facilitated by the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

9.3.2.5.2 The Role Of Management in HIV and AIDS programme

(Question 52 to 61)

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

Figure 31: HIV and AIDS Management



9.3.2.5.2.1 Discussion of Data

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

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

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

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

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

9.3.2.6 Section E: Leadership

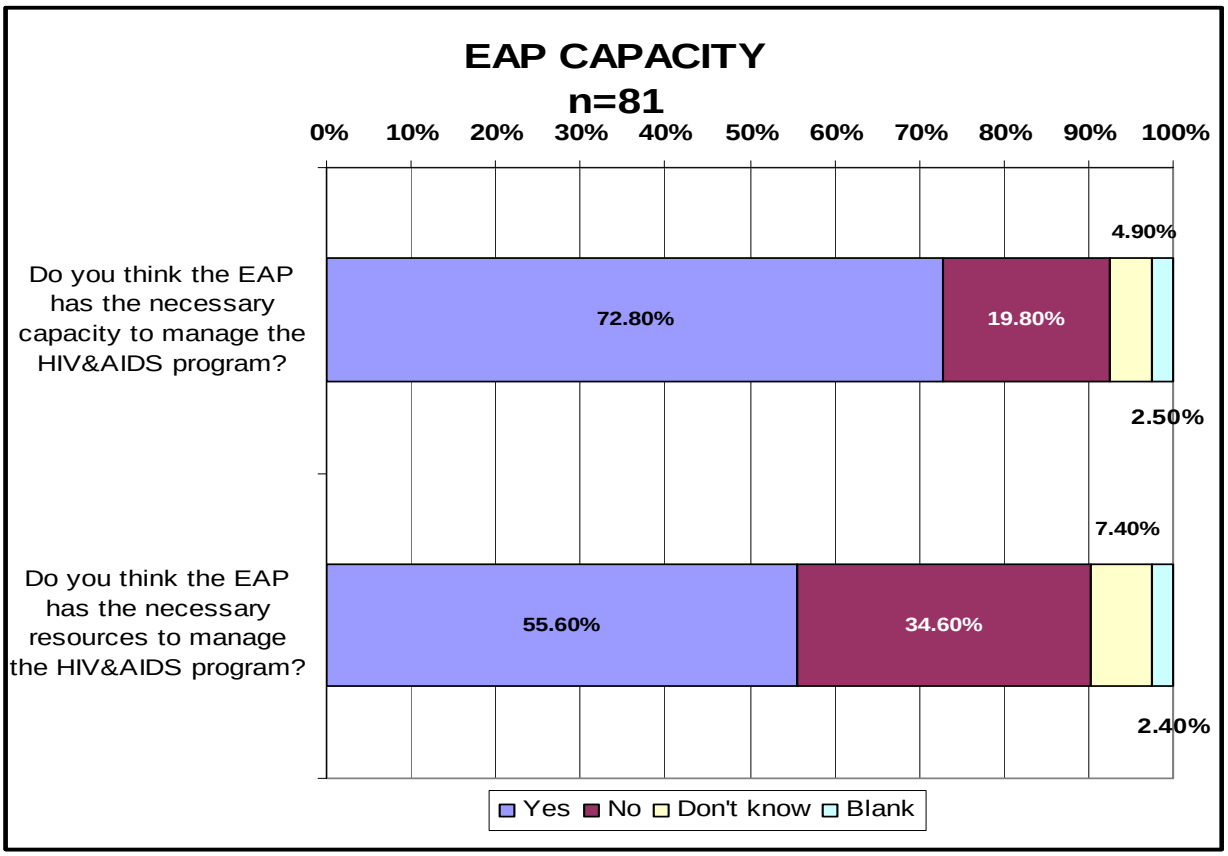
Section E investigated the role of EAP leadership in the HIV and AIDS programme.

9.3.2.6.1 EAP Capacity to lead HIV and AIDS Programme

(Questions 62 and to 63)

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

Figure 32: EAP Capacity



9.3.2.6.1.1 Discussion of Data

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

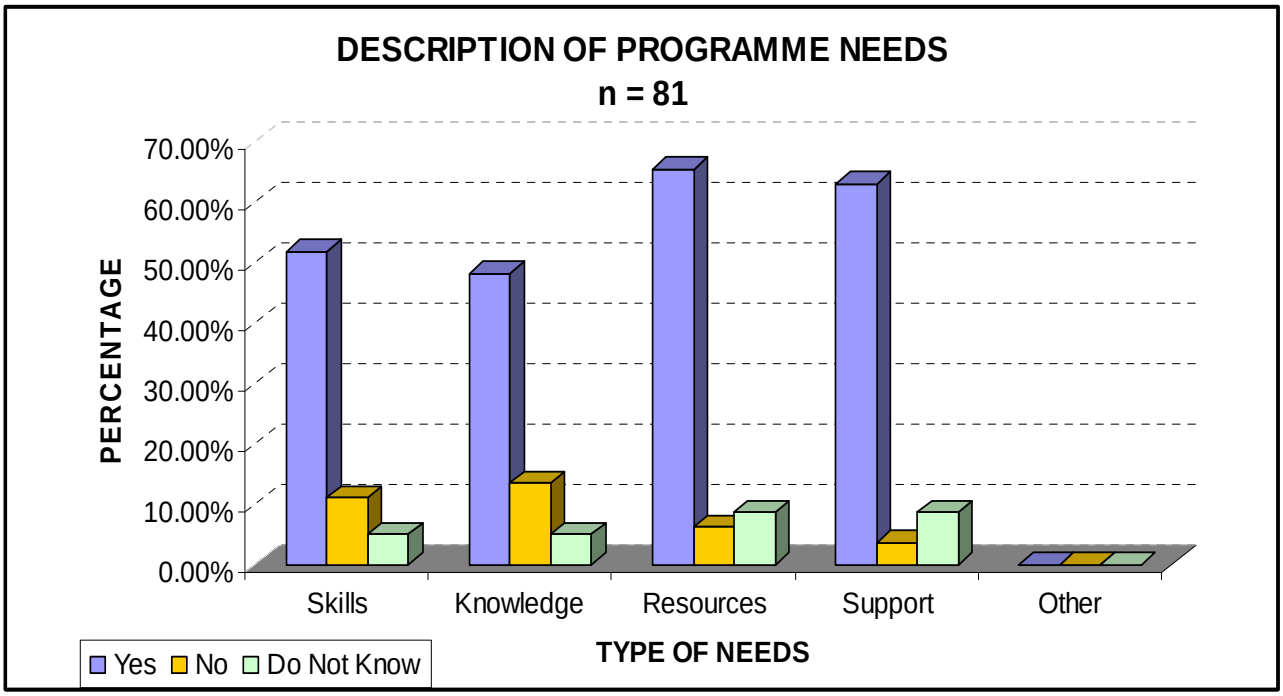
EAP function as an effective business partner and demonstrates its value practically to management.

9.3.2.6.2 EAP Programme Needs

(Question 64)

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

Figure 33: Description of Programme Needs



9.3.2.6.2.1 Discussion of Data

From the analysis of the responses, the respondents indicated that they have inadequate resources (28%), a confirmation of the perception indicated in the previous question. Approximately 28% of the respondents also felt that they had inadequate support in relation to EAP. Of particular note is the lack of sufficient skills and knowledge (44%) as a need of the EAP. Given the extent of experience that the respondents have indicated in previous responses (Figure 8 & 9), this raises the question whether the training that is provided to practitioners is adequate to facilitate the EAP.

9.3.2.6.3 Positive Experience in Providing HIV and AIDS Counselling Through EAP

(Questions 65)

In addition to the probing questions, the leadership section included a number of open-ended questions. These questions are of qualitative nature and served to supplement the quantitative responses. The questions attempted to capture responses that are potentially valuable.

Out of the 81 respondents, 49 (60.49%) indicated that they have positive experiences offering HIV and AIDS counselling through EAP.

The following are a selection of the responses obtained and are presented and grouped according to five themes.

- Professional fulfilment and satisfaction – 9.3.2.6.3.1.
- Integrated approach – 9.3.2.6.3.2.
- The EAP offers supportive service – 9.3.2.6.3.3.
- Gender role-modelling in counselling – 9.3.2.6.3.4.
- The positive impact of HIV disclosure – 9.3.2.6.3.5.

9.3.2.6.3.1 Professional fulfilment and satisfaction

"*Life is precious, I have great satisfaction to see how many employees just value the fact that they are alive and that I have been an important part of their life*"

The professional fulfilment and satisfaction is a very important aspect of the EAP practitioners. The responses below indicate that the EAP practitioners value their work and are happy when they make a difference in the employees' lives both male and females. The following are responses in a verbatim illustration:

- "When the HIV positive employees through EAP counselling move from denial to taking responsibilities for their own health"

- “When employees through greater understanding of policy begin to stand up against discrimination and highlight issues of policy importance”.
- “When HIV positive employees involve their family members in EAP counselling”
- "Health improvement of employees after intervention of the EAP”.

9.3.2.6.3.2 The Benefit Of The Integrated Approach Model

“ *As an Employee Wellbeing Manager, I’m responsible for health and safety programme, EAP, HIV programme and Absenteeism management. I have designed the five point strategy that addressed all aspects of employee well-being in an integrated model which gives me positive experience and is easy*”

- “An integrated approach offers various supportive one stop shop for employees”.
- “An integrated approach that allows quick process for HIV and AIDS destigmatisation”.
- “Through integrated approach the risk behaviours are identified and behaviour change strategies are easily implemented”.
- “An integrated approach deals with stigma in an effective manner’

The integrated model is a model that offers a supply chain of various services that are linked to employees’ wellbeing and improves their mental health. It would have been valuable if the above respondents had indicated what they meant by integrated model and services. There are varying aspects of an integrated model, however an integrated model should have services that are linked and are not conflicting in nature. This researcher will suggest an integrated model, in the recommendation section, that may guide other practitioners in their programme management.

9.3.2.6.3.3 EAP Counselling Offers Employee Support

“*Since offering HIV counselling through EAP, I have become more confident in my knowledge of HIV and EAP, particularly when I get feedback that EAP services are valuable, and appreciated by employees”*

- “Employees recommend EAP to their colleagues”
- “There is high utilization of EAP”
- “Employees enrol in the HIV treatment programme”
- “Employees verbalize having trust in the EAP”
- “Management indicate satisfaction about the programme”
- “Seeing more participation in Voluntary Counselling and Testing”.
- “When EAP is seen as practicing confidentiality”
- “Being available for employees 24hours through the EAP call centre”
- “When HIV infected and affected employees indicate better coping due to EAP support”

It is known in the marketing field that word of mouth is the best and sustainable strategy that locks in a client. Clients that are satisfied with the service are likely to recommend it to others. Judging by the responses above, it can only be concluded that where the employees show greater comfort with the level of confidentiality, the more accessible EAP is for employees and there is positive feedback from EAP users. EAP is a programme that adheres to certain core values such as treating employees with respect, dignity, practising confidentiality and giving employees trust. It would seem that that respondents have conducted themselves within the practices of EAP and have enjoyed offering EAP.

9.3.2.6.3.4 Gender Role Modelling

Interesting to note was the fact that women counsellors felt that their gender had a positive impact on women employees. “*Women employees have indicated feeling comfortable with me due to the fact that they could freely discuss issues of sex and sexuality without being embarrassed”*

- “Seeing women take responsibility for their own health when addressing women issues freely.”
- “Women being positive about their lives and willing to learn new ideas”.
- “Women verbalizing that they felt understood, supported and have a sense of purpose given that fact that they can identify with a woman counsellor”.

- " As an HIV positive EAP woman counsellor, I have seen my life change as I impact other women"

In a study by Gilbert (2006:11), women EAP professionals responded that EAP profession has not particularly been supportive to them during their career, they felt most EAPs in USA are still led by men. It is interesting to see that in a profession populated mainly by women, majority of men still hold leadership positions in countries such as the USA. The researcher believes that the role model identification in this study gives EAP women professionals an opportunity to launch themselves more and cease the opportunity to assist other women. A conclusion can therefore be drawn from these responses that women EAP practitioners understood and identified with the experience that the burden of home and family duties create as a disadvantage for women in the workplace.

9.3.2.6.3.5 The Positive Impact Of HIV Disclosure

"*It takes many sessions to encourage the employees to disclose their status, but when they do the perception of their colleagues and management changes positively*"

The respondents seem to suggest that when employees disclose their status, they make their work easier and offer them a positive experience. It can therefore be argued that non-disclosure has powerful secrecy, which not only weighs heavily on the HIV infected and affected but also on the EAP counsellors.

The following are the verbatim illustration by respondents:

- "HIV disclosure by employees gave rise to three publications of HIV/AIDS positive stories in my organization".
- "High participation of HIV positive employees in policy development".
- "When HIV positive employees are involved in HIV and AIDS education and awareness campaigns, employees tend to ask more questions and seem to give them respect".
- "Disclosure influences positive attitudes and challenges stereotypes and HIV myths"

- “Using employees living with HIV and AIDS has contributed to high participation in VCT”.
- “Greater understanding and tolerance with positive support from employees not infected”.
- “Open participation in workplace HIV and AIDS support groups”.
- “Disclosure has a greater sustainable impact as it makes it easier to link employees with community services”.

9.3.2.6.3.6 Discussion Of Data

The responses above seem to indicate that EAP practitioners have greater and positive experiences in offering EAP. A reasonable 60.49% respondents indicated various positive experiences that are evidently ranging from professional satisfaction to multiple service delivery and creativity. The service offered seem to be in line with the core business of EAP which is giving support to troubled employees. In giving support, it can be noted that when EAP practitioners encourage employees to disclose there is greater relieve and positive progress in achieving reasonable accommodation for employees. It is further noted that the process of encouraging HIV disclosure is a challenge but there is positive rewards once achieved, particularly for both the HIV infected and the EAP practitioners. The positive experiences from EAP practitioners also seem to suggest that integrated EAP model could be offering more than just counselling to employees and it is a recommendation that would need further investigation for the EAP future.

Of interest to note is the aspect of gender identification in the responses above. The results indicated that there is both greater satisfaction and appreciation from the EAP practitioners and the women being counselled in the study. Gender identification can yield greater positive results, however it needs to be noted that the opposite could be the case. Gender preference in counselling should not be imposed but an option should always be offered to the employees who seek EAP. Equally so not all HIV infected EAP practitioners are comfortable with offering EAP just because they have an HIV positive status. Their roles can present with counter-transference issues and interfere with their counselling. As much as in this study some felt that the fact that their HIV disclosure was

a positive experience for their EAP role, not all counsellors who are living with HIV can be assigned roles to be EAP practitioners. The responses above further suggest that there was greater satisfaction and acceptance when more employees attended support groups, however it can be argued that support groups can only achieve greater acceptance if there is open disclosures as anonymity can not be guaranteed. Greater support by colleagues can also be measured when there is open disclosure, open disclosure allows EAP practitioners to use those living with HIV and AIDS as champions during their internal company campaigns. It is been found that use of people living with HIV and AIDS is a tool for greater programme participation (WITS HIV/AIDS Symposium, 2004).

9.3.2.6.4 Negative Experiences Offering EAP

Similarly to question 9.3.2.6.3.5. above that explored positive experiences in offering EAP, respondents were asked if they had any negative experiences in offering EAP. The following responses are grouped into themes and discussed below. Out of 81 respondents 23 (28.40%) indicated negative experiences. It can therefore be argued that the majority of respondents have positive experience in offering EAP.

- Lack of management Support - 9.3.2.6.4.1
- Feeling of Frustrations - 9.3.2.6.4.2
- Lack of trust in EAP - 9.3.2.6.4.3
- Stigma as a barrier to EAP utilization - 9.3.2.6.4.4

9.3.2.6.4.1 Lack of Management Support

The respondents seem to indicate that there is insufficient management support which contributes negatively to their service delivery. It can be argued that lack of management support can impact negatively on the relationship between EAP counsellors and line managers. This can result in tension around advocacy, definition of confidentiality and performance management.

"*Noisy manager need proper training regarding EAP and HIV/AIDS management*"

- It is this researcher's experience that managers who have no understanding of confidentiality may demand that they be given feedback regarding employees' ill health. In some instances some managers would voluntarily disclose employees' status, assuming that telling the EAP counsellor is ok given the fact that EAP is governed by confidentiality. This behaviour tends to compromise the employees and violate their right to privacy.
- "Management in my organization are not supportive to employees who are HIV affected". "They tend to give impression that employees should leave their problems at home".
- "Sometimes management is in denial about the organization's state of affair regarding HIV and AIDS".

The two responses above seem to suggest that despite education on the value of EAP, some managers do not understand that employees bring to work their personal challenges. Employees sometimes find it difficult to separate their personal issues from work issues, thus introduction of EAP in the workplace to address these challenges. Importantly in workplaces were there is EAP, which is visible and accessible, this may yield a higher utilization rate.

9.3.2.6.4.2 Feelings of Frustration

"*It is very frustrating when HIV positive employees are not taking responsibility for their own health and at the same time the management is putting pressure on understanding what the employee's status is*"

- "Employees who give up and become depressed make EAP advocacy difficult"
- "Death of employees due to AIDS increase the challenges of HIV and AIDS management"
- "Employees who are resistant to enrol on the disease management programme"
- "Management that are reluctant to link counselling and treatment"
- "When employees are not adhering to treatment, their health become compromised"

- "Counter-transference issues are often experienced with employees with HIV and AIDS. Feeling empathetic to such an extent that practitioners becomes over involved".
- "HIV counselling poses an emotional burden on practitioners and this can be very traumatic at times".

As indicated above, it would seem that EAP in the workplace has a dilemma between advocating for employees and ensuring that there is business continuity. A correlation with Figure 28 which indicated 44.4% of respondents citing "no advocacy" for lack of trust in EAP. This can be a challenge especially for those EAP practitioners who are offering in-house EAP. Maintaining professional ethics and being loyal to the employer who is paying the EAP practitioner's salary and managing the performance can be a challenge. However, the skills in EAP counselling is to educate, support and empower employees, as a result EAP practitioners should maintain professionalism at all times.

In addition issues of transference and counter-transference are professional issues that need to be addressed through supervision and debriefing sessions. The responses above could be dealt with by providing compulsory supervision for EAP practitioners.

9.3.2.6.4.3 Employees' Lack of Trust in EAP

- "Employees sometimes doubt that EAP operates with confidentiality"
- "In some cases it takes many months to mediate between employees and management regarding issues such as reasonable accommodation and leave".
- "Employees believe EAP practitioners have no powers to influence organizational changes".

Indicated above are issues of concern, particularly as these responses are confirmed in Figure 28 previously, where 27% of the respondents indicated 'no confidentiality' in EAP. The responses above suggest that EAP practitioners are faced with pressures from management that may lead them to compromise their professional integrity, and possible lack of decision powers. These responses are confirmed previously as issues suggesting doubt by employees regarding trust and confidentiality.

9.3.2.6.4.4 Stigma As Barrier For EAP Utilization

In previous chapters the impact of stigma on programme success has been highlighted. Evidently, EAP practitioners also believe that stigma is impacting their counselling in a major way.

- "Employees do not want to take treatment because it affect their work attendance".
- "Stigma impacts on their relationship with their colleagues".
- "Negative attitudes are fuelled by stigma and fears".
- "Stigma contributes to non-disclosure".
- "Employees living with HIV have a perception that they are not been promoted due to their HIV status".
- "Denial plays a very important role to religious employees who are living with HIV"

9.3.2.6.4.5 Discussion Of Data

Lack of management support seems to be the greatest frustration for the majority of the EAP practitioners. Lack of management support, was indicated by all 23 respondents who completed this question. It would seem that the frustration, lack of trust and confidence and stigma issues are all linked in one way or the other to management support. The role of management buy-in is very important to the success of EAP. A lot of marketing and negotiation has to be done to ensure managers understand EAP principles in order to be able to work together to encourage employees to have trust in using the service. Clearly issues of stigma and lack of trust in EAP are important as they can serve as a barrier to EAP usage. From both the positive and negative experiences, below is a summary of the recommendations from the respondents.

9.3.2.6.5 Recommendations For Improvement Of EAP

Out of 81 respondents 28 (34.57 %) indicated recommendations for the improvement of EAP. There is a similarity in the recommendation to be discussed here and those provided in the previous discussion by the women in the qualitative section previously (see 9.3.1.11.1 to 9.3.1.11.5). To avoid repetitive discussions with previous

recommendations, the responses are discussed and grouped into various themes and will therefore be presented in a verbatim format.

- Training and workshops - 9.3.2.6.5.1
- Gender alignment programme - 9.3.2.6.5.2
- Integrate EAP programme - 9.3.2.6.5.3
- Health Focus Initiatives - 9.3.2.6.5.4
- EAP management - 9.3.2.6.5.5
- Debriefing Programme for EAP practitioners - 9.3.2.6.5.6

9.3.2.6.5.1 Training And Workshops

Previous responses by the practitioners indicated that they offer mainly HIV training and awareness. However the recommendation seemed to still indicate a need for more training. The respondents did not specify whether training should be targeting specific target group, such as management, employees of employees living with HIV and AIDS. This information would have guided this study recommendation had it been more specific.

9.3.2.6.5.2 Gender Alignment Programme

- “Identify specific needs from women themselves, but don’t segment programme for women specifically as it will stigmatize them”.
- “Policies should have a focus on gender issues”.
- “Sexual harassment policies to be integrated with other policies such as HIV/AIDS and disability”.
- “Capacity building and gender sensitization workshops for all employees”.

9.3.2.6.5.3 Integrate EAP Programme

- “Segment programme into Health, EAP, HIV/AIDS and incapacity”
- “Offer unlimited counselling session which will look at mental health issues, life management and medical issues”
- “Introduce and integrate spiritual counselling in the workplace”
- “Establish home-based care programme”

9.3.2.6.5.4 Health Focus Initiatives

"Condom distribution is an important aspect of prevention, however it is recommended that distribution of female condoms be made compulsory".

"Employers without compulsory medical aids should introduce treatment programme for their employees".

"Women to be encouraged to talk about health issues during women's day initiative and employers to encourage women to go for gynaecological checks ups".

9.3.2.6.5.5 EAP Management

It is up to EAP practitioners to make EAP visible and involve management participation. Furthermore, EAP practitioners need to know the prevalence of HIV in the workplace and make the statistics the visible.

- "Managers need to be given regular update regarding EAP progress and utilization to ensure that there is alignment of programmes in the workplace".
- "As much as HIV infected employees are being accommodated, it is also recommended that reasonable accommodation measures for affected employees be considered, particularly women who are care-givers".
- "More resources are needed to ensure that EAP manages and integrated EAP model approach".
- "Environmental accessibility that offers confidentiality, particularly in the case of in-house EAP. Involve employees in evaluating the EAP service before making decision to either outsource or maintain in-house".
- "Continuous marketing initiatives are necessary to encourage EAP utilization, confidence in EAP and sustainability of the programme".

9.3.2.6.5.6 Debriefing Programme for EAP practitioners

It is important to note that the EAP practitioners do acknowledge the impact of HIV and AIDS on their own wellbeing. In the negative experiences discussed in 9.3.2.6.4 above, EAP practitioners indicated being over involved and feeling the burden of HIV and

counselling. It is therefore, not surprising that they are recommending debriefing programmes.

9.3.2.6.5.7 Discussion of Data

The recommendation from the qualitative and quantitative section of the study will be integrated in the discussion and will form part of the summary and recommendation section in chapter 10. Clearly the EAP practitioners argue that training and workshops are still needed for both EAP and HIV and AIDS education. Of interest to note is the gender alignment recommendation. It will be important to further encourage EAP forums to discuss and investigate the aspect of an EAP Integrated Model, what it means and what it involves.

CHAPTER 10

SUMMARY AND RECOMMENDATIONS

10.1 INTRODUCTION

AIDS as a disease, impacts all races and genders. However, the impact has evidently been felt more by women due to both their biological make-up and social and gender pressures. EAPs and EWPs in the workplace are counselling and strategic programmes that seek to address the impact of HIV in the workplace through counselling, training and awareness and disease management programmes. It is exciting to see that businesses have strategically formulated good practices focusing on feminisation of HIV and AIDS. Literature on the feminisation of HIV and AIDS by GBC is a great example of the acknowledgment of the vulnerability of women with regards to HIV/AIDS and workplace programmes. In the previous chapter the researcher presented the research results obtained through the interview schedule and questionnaire. In this chapter, the focus is on the researcher's conclusions according to the objectives, as well as the researcher's recommendations.

- Chapter 1 provided an introduction to the study, which included the study rationale, research methodology and suggested analysis of the data. The motivation of the study was to focus on HIV and AIDS and EAPs as the research project, followed by problem formulation. The goals and the objectives were identified and the research question formulated. The description of the research approach was discussed, followed by the type of research, research design, research procedure and strategy. The pilot study was discussed, as well as the research population including sampling methods. Ethical issues were discussed and the chapter ended by outlining the sequence of the subsequent chapters in the thesis. Given that this research focused on women, the introduction gave a background on the emergence of the role of women in the workplace. This study makes a contribution to the social work profession and the HIV field as it represents a baseline investigation in the integrated

strategies of EAP and HIV and AIDS. The summary on chapter one is discussed below:

10.2 RESEARCH OBJECTIVES

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

The study objectives included:

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

The findings as discussed both under qualitative and quantitative reflected the description of the women's experiences, perception and difficulties. The results from the survey indicated similarity between the experiences of infected and affected women ranging from mental health difficulties, including depression, feeling of despair, stigmatization and they had missed work due to HIV related challenges both as infected and affected. Similarly, quantitative findings reflected mental health issues with depression, lack of support from home and from work as challenges with HIV and AIDS.

The following research question was formulated to guide the process of this research project:

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

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

- What role, if any, does EAP play in supporting HIV infected and affected women in the workplace?
- What is the perceived role of EAP in supporting HIV infected and affected women?
- What is the perceived role of HIV infected women with regard to the effectiveness of EAP for HIV and AIDS in the workplace?
- What are the difficulties of running a functional EAP service in the context of HIV and AIDS?
- What are the feelings of HIV and AIDS infected and affected women in their workplace?
- In answering these questions listed above, the assumption remains that the EAPs response to infected and affected employees can determine negative or positive performance of employees.

Findings from the research question indicated that women received support from EAP in the form of counselling and in other practical ways such as home visits and referral to support resources. Generally women are satisfied with the role of EAP and they will recommend EAP to others. Training and counselling are highly ranked by EAP as the role of EAP in HIV and AIDS. Management seem to be taking responsibility in prioritizing HIV and AIDS initiatives. However the EAP practitioners indicated a balanced capacity needs in the following areas: skills, knowledge, resources and support.

Valuable information and improved insight were obtained due to the research project and these insights are presented in the form of a general summary, conclusions, and recommendations below.

The researcher draws the following conclusions that chapter one demonstrated focus of the study through the following statements:

- The combined qualitative and quantitative research approach was important as this enabled the researcher to draw information on the process and the aim of the study

from a sample of the population by using an interview schedule and questionnaire to supplement literature and the research goal.

- Applied research selected for this study proved to be suitable as the study was a problem solving process which added a knowledge base to the social work profession and applied research will assist to develop solutions to the problems related to HIV and AIDS and EAPs.
- The phenomenological study design was used to gain insight into the difficulties experienced by HIV infected and affected women in the workplace and the role of an EAP.

10.3 LITERATURE REVIEW

Summary of all the chapters are discussed below with recommendations by the researcher based on the literature reviewed previously.

10.3.1 HIV and AIDS

The impact of HIV and AIDS is discussed in detail from Chapter 3 to Chapter 7. The essence of these chapters was on the theoretical background of HIV and AIDS and the influence of gender perspectives on women who are HIV infected and affected and the difficulties HIV affected or infected women's experiences in the workplace.

10.3.2 Difficulties Experienced By HIV Infected And Affected Working Women

The chapter on the difficulties for women infected by HIV and affected by AIDS highlights the plight of women in society. Women face socio-economic challenges and psychological struggles both in society and in the workplace. Culture has an influence on the perception of society and business and further complicates the livelihood of the infected and affected women.

10.3.3 EAP in the Workplace

Chapters 8 and 9 highlighted the role of EAPs and the value that EAP counselling brings in the workplace. The importance of HIV counselling is addressed. These two chapters identify the origin of EAP and revise the international presence of EAP in various countries.

10.3.4 Literature Review Conclusions

- The above chapters confirmed that HIV is a pandemic and as such a crisis for the world and the business world. Furthermore, it was established that there are clear HIV and AIDS definitions, the methods of transmission are defined and understood, and the socio-economic links of the disease were discussed.
- Women are the most affected by HIV and AIDS. International statistics on AIDS revealed the greater impact of the pandemic on the lives of women. In Sub-Saharan Africa, 57% of adults infected are women and 75% of young people infected are women and girls (Global Report (GRI), 2004:1).
- Women are most vulnerable to HIV from a social, biological, and economic perspective. The Human Science Research Council (HSRC) study in 2002 and the Nelson Mandela Foundation showed that women aged 20 to 24 years had double the HIV prevalence rate as compared to the young men in the same age group (NMF/HSRC, 2003:9).
- The crisis of HIV and AIDS has necessitated the collaboration of international partners, business and government in the management of HIV and AIDS.
- Care for employees, education and awareness are the most recognised interventions in the workplace.
- Stigmatisation and gender inequality complicates the management of HIV and AIDS among women.
- Women as caregivers experience financial and psychological burdens due to HIV and AIDS.
- Historically, EAPs focused on the troubled employee. However, an EAP in the workplace currently focuses on education, training and other wellness programmes that facilitate the engagement of employees.
- EAP is facing the challenge of managing HIV and AIDS as a significant medical condition in the workplace. Goplerud (2006:20), identifies four common medical / behavioural conditions as depression, anxiety / stress, alcohol abuse and the catch-all category of marital or relationship problems faced by EAPs.
- The concept of an integrated approach has shown momentum and has proven to be a preferred choice by many businesses. According to Goetzel and Ozminkowski

(2006:25), an integrated approach to workplace health and productivity got started in 1987 and the initial approach was in the areas of absence management, disability management and workers compensation. In South Africa, an integrated approach yields benefits from disability management, counselling in the workplace, absenteeism management and HIV and AIDS programmes. Because of this integration, more EAPs prefer the external models and combined models of EAPs.

- HIV and AIDS counselling acknowledges the burden of death and dying and the impact this has on the counsellors.

The researcher concludes that literature has informed this study in the following ways:

- There has been a significant effort to include women in the workplace.
- Working women gain self esteem and confidence by assuming roles in the workplace.
- Awareness about HIV and AIDS has grown and general understanding regarding the cause of HIV and AIDS has improved.
- Gender perceptions influence the transmission of HIV and AIDS.
- Gender wise, women are the most affected by HIV and AIDS as partners and caregivers.
- The impact of HIV and AIDS in corporate South Africa is clearly felt.
- Corporate South Africa through business against HIV and AIDS and the King II Report have put strategies in place to mitigate the scourge of HIV and AIDS in the workplace.
- EAPs in the workplace are addressing the needs of the employees from a troubled employee perspective
- A greater number of EAPs are integrating various programmes to address business objectives and employee needs.

10.3.4.1 Literature Review Recommendations

- Business people, human resource practitioners including EAP professionals, should continuously position themselves as professionals with HIV knowledge and relevant counselling and handling skills in order to confidently develop preventative and supportive strategies to mitigate HIV and AIDS.
- Given the fact that stigmatisation and gender inequality seem to be the biggest barriers for HIV and AIDS prevention, individual empowerment should be encouraged. To support GBC proposed seven-point plan, the three diseases, namely; HIV and AIDS, tuberculosis and malaria should be integrated in a wellness model and treated as part of a full holistic health programme.
- Multiple strategies are important in the workplace, including behaviour change and spiritual and cultural support systems. Leadership workshops with emphasis on respect for fundamental values of humanity that are embedded in culture and spirituality.
- Businesses should position themselves financially to support HIV-related research projects, even though it has recently emerged that Eskom is withdrawing its commitment on AIDS research (Sunday Times, 23, March 2008).
- Studies on the psyche of working women should be encouraged. According to Global Business Coalition on HIV and AIDS, Tuberculosis and Malaria (GBC) the fight against HIV and AIDS cannot be won without addressing the impact of the pandemic on women.
- Working women in senior positions should be empowered to mentor women who are working and living with HIV and AIDS. Women's day forums should be used practically to disseminate HIV and other health education, address domestic violence and recognise success of their female staff, who have made a difference in leadership and human capital areas with specific reference to change management and attitudes.
- Employment equity initiatives should be positioned to empower women regarding policies and equity issues in the workplace. Retention strategies for women including those living with HIV and disability should be aligned.

- The value of EAPs in the integrated approach is important, however it is equally important that the employees' confidentiality is not compromised in the process. Specifically, surveys such as behaviour change and risk behaviour surveys should be conducted by private consultants and reported only through EAP offices.
- EAPs should play a more strategic role in evaluating and monitoring the impact on EAPs and HIV to reflect return on investment for the workplace. Various measurable indicators such as KAP surveys and leave analysis could be linked to strategies to develop work-life programmes. Results indicated that EAPs are not using these measures to evaluate their HIV programmes.
- Multiple communication tools should be used to improve the EAPs' utilisation, enhance the reputation of EAPs in the workplace and empower women in particular to deal with work-life-family balance through disclosing their status and needs.
- Mediation and dispute resolution are required in EAPs and HIV and AIDS programmes to provide an opportunity to work more closely with management. Encouraging rewards for de-stigmatising and disclosures efforts.

Based on a combination of literature review and this study the researcher concludes that the following summary key points are important consideration for further research:

- Further research on the impact of HIV on working women is important, specifically with reference to their enhanced capacity to make decisions about their illness and legal rights.
- Research has indicated that female condoms are effective in empowering women as a preventative method. Companies should invest in distributing female condoms to address specific needs of women.
- Research on the evaluation of EAPs in South Africa is long overdue, given that there is limited research on EAPs in South Africa.
- The next phase of EAPs and HIV research should test the strategies on integrated wellness programmes.

- Future studies are recommended regarding interventions aimed at helping women living with HIV and AIDS to cope with stigmatisation, disclosure, and discrimination. It is suggested to use the support group model as an experimental study whereby one group includes participants who share skills and experiences and the other group receives counselling. This model will best be used as an internal model for business managing their employees living with HIV and AIDS. The model would have to first establish through disclosure exercise the prevalence of HIV amongst women employees.

10.4 QUALITATIVE STUDY

The goal of this study was to explore and describe the role of the EAP in addressing the difficulties experienced by working women, resulting from the impact of HIV and AIDS. In total, 24 respondents participated in the qualitative part of the research study. The respondents answered the research questions that were posed to them during one-on-one structured interviews.

10.4.1.1 Demographic Details: Qualitative

- All respondents were women aged between 23 and 49.
- The majority (20) were African.
- They were all South African.
- Almost all were working (22), with 2 unemployed at the time of the actual interview.
- Mixed representation of various work levels.

10.4.1.2 Difficulties Experienced As A Result Of HIV and AIDS

Working women in this study generally experienced difficulties with disclosure and negative experiences with colleagues, which included discrimination and lack of support from colleagues and family. The experiences of women ranged from mental health difficulties to such as depression, feeling of despair, loneliness and stigmatization.

10.4.1.3 Stigmatisation

General experience of stigmatisation was identified as the greatest barrier of treatment and care and future strategic interventions were suggested.

10.4.1.4 Lost Time

Increased absenteeism is one of the key results of the impact of HIV and AIDS in the workplace. The impact of HIV and AIDS was felt equally by infected and affected and women in the workplace. Women missed work due to ill health or family responsibility roles. The majority of time lost by infected women accounted to more than three months for each one of them.

10.4.1.5 Addressing the Difficulties Experienced By Women through EAP

An EAP is very important in the workplace. Most respondents verbalised receiving positive added value by the EAP in their working lives. The value of the EAP was experienced in very practical ways ranging from counselling, financial assistance, home visits and medical assistance. Given the value of an EAP, most women felt EAPs should not only focus on counselling, but rather on change management including policy implementation and management training. Counselling remained the most valued aspect of EAP amongst infected and affected working women. On the contrary, the responses by EAP practitioners did not demonstrate that counselling was the most valued EAP intervention. The researcher therefore recommends that EAP continue to offer counselling given the value it provides as per the responses of the participants. However, it is important that an investment be made to train practitioners in leadership courses to enable them to make strategic levels.

10.5 QUANTITATIVE STUDY

Chapter 11 of this study described the quantitative findings in detail. The sample included 81 respondents (EAP practitioners) of EAPA-SA throughout South African regions.

10.5.1 Demographic details: Quantitative

- Majority of respondents were aged between 26 and 45 years.
- The majority of the respondents (71.6%) were females.

- The majority of the respondents (83.9%) were Christians.
- Experience in an EAP and HIV ranged from 5 to 10 years.
- The majority (51.85%) was EAP coordinators and were in the middle management level (34.57%) and specialist level (33.33%). Only 13.55% were in the senior level).

10.5.2 Role of EAP

- The two most preferred EAP models are an in-house model and mixed model (both 38.30%);
- EAP service offerings included coordination (65.43%) and counselling services (61.73%). Training is offered at 43.21% and therefore evidently recommended by respondents (see 9.3.2.6.5 of the recommendations).
- The response on HIV prevalence was inconclusive, 56.79% respondents did not complete the question and 11.11% indicated a percentage over 25%, which is regarded as unrealistic. This was confirmed by the literature review in chapter 5, which looked at the prevalence of HIV among companies in South Africa.
- The majority of companies (95.10%) have HIV and AIDS programmes.
- The HIV and AIDS programmes mostly offer counselling (96.10%), education (97.40% and training (88.30%). Education entails awareness and information sharing on HIV and AIDS, this is normally measured through KAP surveys. Training refers to formal training on HIV and AIDS which may range from one to five days and can be divided into two parts, targeting all staff or managers only. Evidently, programmes are moving towards offering on diseases management (54.50).
- Only 48.10% of the HIV and AIDS programmes offer gender equity awareness.
- There is not much difference in who facilitate HIV and AIDS training. Majority (37.3%) of the HIV and AIDS programmes are facilitated by HIV and AIDS managers / coordinators and 33.6% are by EAP practitioners / consultants and 28.6% private consultants.
- Forty nine percent of the HIV and AIDS programmes are integrated with wellness programmes.
- Only 39.5% have established HIV committees.

- The majority (51.9%) indicated that EAPs are playing a role in HIV and AIDS management.
- Management is still not taking responsibility in HIV prevention. Only 30.9% indicated that management sees HIV management and programmes as their responsibility.
- Twenty one percent strongly agreed that unions are actively involved in HIV and AIDS programmes.
- The workplace is still male dominated as discussed in Chapter 1. Given the representation of women in the workplace, it is not surprising that the prevalence of HIV is highest among males at 28% and evidently most respondents did not know the prevalence in their workplace
- The majority indicated that EAPs address the needs of *infected* women in the workplace and do so through counselling and education. (88.9% and 70.4% respectively);
- EAPs address the needs of *affected* women through counselling and education at 81.5% and 61.7% respectively.
- The majority (84%) of the companies have an approved EAP policy.
- Few respondents gave specific reference to gender issues in their programme (35.8%).
- It is encouraging to see that the respondents are satisfied with the utilization level of the HIV and AIDS programmes However there is not much difference with the unsatisfactory responses (46.9%).
- The perceptions of respondents 55.6% are that the women would recommend EAPs to others.
- The common methods of HIV and AIDS education in the workplace in the order of majority to least favoured are posters (82.7%), EAP office and education and training (72.8% respectively), workshops and through pamphlets (70.4% respectively), notice boards (66.7%) and emails (60.5%). Only 44% use people living with HIV and AIDS in the context of HIV and AIDS education dissemination. The need for use of people living with HIV and AIDS is indicated under recommendation (see 9.3.2.6.3.5 positive impact of HIV disclosure).

10.5.3 Difficulties Experienced By Women

- The majority of women infected and affected by HIV and AIDS experience stigmatisation (69.1% and 63.% respectively), followed by lack of care and support at home (51.9% and 53.1% respectively) and lack of understanding by managers (48.1% and 54.3% respectively).
- The majority of infected and affected women struggle with mental health issues with depression being common (76.5% amongst infected and affected women)
- The majority of women affected and infected by HIV deal with their difficulties by consulting EAPs (64.2%) and do so through face to face consultation (53.28%).
- The most preferred referral regarding HIV and AIDS (57,61%) is voluntary referral.
- The results indicate that EAP is generally accepted and is voluntarily used by employees in South African work place (77.8%).
- Women affected and infected by HIV generally use EAPs (67.9% and 69.1% respectively).
- Fifty eight percent respondents indicated that women have trust and confidence in the EAP. About 55,6% of the respondents agree that women are satisfied with EAPs, those who do not agree cited no advocacy (44.4%) and no confidentiality (27.8%). Of note was 27,8% whom indicated “did not know” the reason for lack of trust.
- Even though EAP practitioners have adequate EAP skills and knowledge (58.1%) they still indicate need for skills and knowledge (44%).
- Clearly from the qualitative and quantitative responses, women find it difficult to disclose their HIV status. Qualitative results attribute the reasons to stigmatisation and lack of support from managers. According to the quantitative study, 22.2% disagrees and strongly disagrees with the statement that women with HIV find it easy to disclose their HIV status, despite the fact that a large percentage (45.7%) of the respondents indicated that the EAPs encourage HIV and AIDS disclosure.

10.5.4 Strategic Management

- Forty eight percent of the respondents' feel the HIV and AIDS programme is successfully incorporated in the workplace.
- A large percentage (46.9%) indicated that EAP has well-defined goals regarding HIV and AIDS.
- Most workplaces do not have well-defined programmes for women infected and affected with HIV and AIDS- confirmed by 42% of the EAP practitioners.
- The majority (63.%) agrees and strongly agree that EAPs give regular feedback to managers about the scourge of HIV and AIDS.
- The majority (59.2%) is of the opinion that workplace programmes have proper alignment with HIV and AIDS programme and other relevant departments.
- Less than 5% agree that management has sufficient understanding of the HIV and AIDS workplace programme due to the effort by the EAP office.
- The majority is uncertain about management's perception of the importance of gender issues regarding HIV and AIDS in workplace programmes.
- The majority (76.6%) indicates that they encourage management to see HIV and AIDS programmes and management thereof as part of responsibilities.
- Just less than 50% of respondents indicate that management has sufficient understanding of difficulties of women infected with HIV and AIDS.
- A small percentage (33.3%) agrees and strongly agrees that management has shown ongoing commitment to HIV and AIDS programmes for women.
- The majority (51.8%) feel that management reviews HR policies and practices in relation to gender equity.
- Only 39.5% indicate that management prioritises HIV and AIDS in drawing up a departmental budget.
- A small percentage (37.1%) agrees and strongly agrees that EAP has mechanisms to monitor statistics of women infected and affected by HIV and AIDS.

- Majority 64.2% agree and strongly agree that management takes a stand against HIV and AIDS discrimination of employees.

10.5.5 Leadership

- The majority (72.8%) agree that an EAP has the capacity to manage HIV and AIDS in the workplace.
- Only 55.6% agree that EAPs have the necessary resources to manage HIV and AIDS.
- In order of importance, the following are the EAP needs; resources (63%), support (60%), skills (50%) and knowledge (48%).
- In general, most respondents indicated positive experiences in running an EAP. The experiences included professional fulfilment and satisfaction, use of integrated approach model, the EAP supportive service offering, gender role modelling and the positive impact of HIV disclosure.

The negative experiences which need further intervention approach for the future of EAP includes: lack of management support, feeling of frustration, lack of trust in EAP and stigma as a barrier to EAP utilization.

10.5.6 Summary of Combined Qualitative and Quantitative Study

Both qualitative and quantitative analysis highlighted the following key points:

- HIV infected and affected working women have difficulties due to their circumstances in the workplace. These difficulties are experienced in the form of psychological, practical work-related issues and disclosure and stigma.
- Qualitative and quantitative results informed this study that there is still mixed experiences regarding HIV disclosures thus creating problems for effective HIV management.
- Both in qualitative and quantitative analysis, the need for EAPs to assume a mediation role between employees and their managers has emerged strongly.
- Management is taking responsibility to manage HIV and AIDS in the workplace.

- Majority of respondents and participants confirmed that South African workplace has approved HIV and AIDS policy and EAP practitioners were involved in the development of the HIV and AIDS policy.
- South African EAP practitioners did not demonstrate in this study knowledge of the HIV prevalence in the workplace. There was a co-relation between lack of prevalence statistics and strong fear of disclosure by participants.
- This study demonstrated that there was high utilization of EAP services, however it was also noted that lack of confidentiality and trust in EAP was hampering HIV management.
- Both qualitative and quantitative results indicated that the role of EAP in major decision making was necessary.
- Both studies suggested that attention should be given to women issues but not in terms of HIV and AIDS service delivery. Such attention includes women condoms and empowerment initiatives.
- Both from qualitative and quantitative results there is a recommendation for integrated EAP and HIV model to address a supply chain of services to all HIV infected and affected employees.

10.6 RECOMMENDATIONS

Drawn from the literature review previously discussed and summary of the empirical data above, the researcher makes recommendations to address the problem investigated which includes difficulties experienced by working women, the EAP programmes in the workplace and management of HIV and AIDS in South Africa. EAPs in the workplace can only gain reputation if the professionals have respect for the client, suggesting strong adherence to EAP guiding principles and professional ethics. From the findings and recommendations given by respondents it is evident that EAPs are doing much to address the difficulties experienced by women infected and affected by HIV and AIDS. This researcher is satisfied that EAP is addressing the difficulties of women at an individual level through counselling which is EAPs' area of expertise. However much still have to be done to position EAP and make it visible both in terms of

levels of work and strategic difference. This section incorporates some of the recommendations received from both qualitative and quantitative respondents.

10.6.1 Integrated EAP Model

- The qualitative results under part one of this study indicated that the EAPs are very supportive to the working women's individual needs but lack changing powers to the corporate decisions making. This was further supported by results in the quantitative data that reflected the need for capacity, support, skills and knowledge when they were asked to indicate their resource needs. According to Goetzel and Ozminkowski (2006:25) the concept of an integrated approach to EAP started in 1987. However in South Africa, integrated approach is a new concept. The integrated approach as recommended by the researcher will mean a one-stop shop supply chain of multiple services that are linked and analysed. The thrust of the researcher's rationale for the integrated approach model is derived from the fact that EAP's core technology functions are encompassing three main focus areas: Health, Wellness and Productivity.

- The programmes to be linked will include functions from preventative health and wellness, safety programme, leave and absenteeism, chronic benefit access, incapacity and disability, HIV/AIDS and EAP. When all these programmes are linked, information of employees can be accessed through a limited access point. Information could be used for analysis, monitoring, strategic planning and other purposes relevant to employee's benefit. The integrated approach is an approach that looks at the employee as a whole person, regardless of the programme accessed. The link in programmes monitors the level of programme utilisation and addresses service duplication quickly and easily. Programmes that are not integrated and are provided by various providers tend to be duplicated and can be a costly affair. Providers will never highlight the duplication of services, as they are interested in their revenue. The integrated approach further provides the synergy benefit to the programme owners and preventative approach to employee's challenges. So far the integrated model seem to be the best in

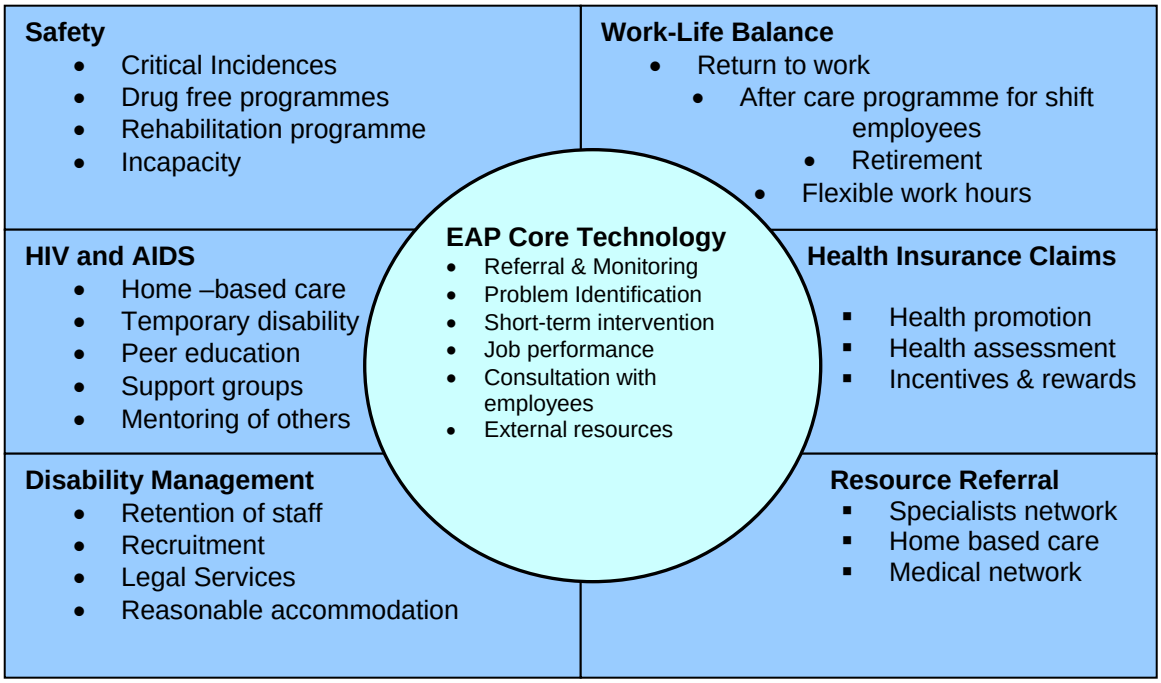
providing efficient and effective service delivery and uses the language understood by the businesses, which is risk management.

The Benefits of an Integrated Model:

1. Absenteeism can be monitored and fed into the disability management and equity.
2. Presenteeism can be tracked and EAP can leverage employee performance through work life balance and other innovative work shadowing programmes.
3. Employees with chronic illness and HIV can be put on temporary disability benefit.
4. EAP can use return to work programme to encourage affected employees to significantly show gains in productivity.
5. Compensation claims can be speedily processed and rehabilitation programmes can form part of return to work programmes.
6. Wellness initiatives such as stress and conflict management trainings will serve as preventative tools for EAP challenges

An EAP integrated model will enhance the profile of EAPs in the workplace. It will assist in establishing linkages between gender programmes, disability programmes and harassment policies. The model will strengthen strategic decisions, as the results in this study seemed to indicate that the EAPs have a very weak position in this regard and are not visible. Overall, the model will identify risks emerging from personal and environment factors and target intervention in a proactive manner. Similarly EAP will facilitate relationship building between the business and employee and may transform the company into product-focused business. Through this model the researcher has no doubt, EAP can remain on the cutting edge as an business partner in investment gain due to health, wellness and productivity interventions. Below is an illustration on the researcher's recommended integrated approach model as adapted from Beidel and Brennan (2006: 36).

Figure 34: Best Practice Requires EAP Involvement



(Adapted from Beidel *et al*., 2005:36)

10.6.2 Women Focused Initiative

Many theories indicate that cultural barriers put women in a vulnerable position. According to the researcher, implementing women programmes focusing on HIV and AIDS will not only result in good programme utilisation, but rather perpetuates stigmatisation and discrimination - as were the findings from the participants living with HIV and AIDS in this study (see 9.3.1.2.9). These results were further supported by results from the quantitative findings (Figure 22, 24 and 29). The recommendation on women focused initiatives should not be focused on HIV as women feel this will stigmatize them, but instead already existing programmes in the organization which will highlight and integrates the following issues:

1. Empowerment workshops for women addressing issues of confidence, self-actualisation, encouraging life-skills and mentoring programmes.
2. Support groups for mothers and daughters to be developed to address issues around sexual harassment, empowerment skills and myths about sexual education. These support groups to be attended outside the workplace.
3. Real-life stories to be encouraged as stories of courage and tangible rewards to be used to encourage disclosures. Forums to celebrate success intervention for women by women living with HIV and AIDS in the organisations. Incentives to include but not limited to the following:
    - Incentives to include flexible work time
    - Working from home options
    - Aftercare programmes for children of women wanting to make up time lost during difficult times and shift working mothers.

10.6.3 National Business and Community Forums

1. Companies, communities, academic sectors and government should collaborate to find ways to reduce the spread of HIV and AIDS among women. Forums with these sectors to be held quarterly with presentations on research, strategies and success.
2. Discussion forums and dialogues to be established to discuss issues around culture and stigmatisation, evaluating the importance of traditional and religious strategies with reference to education and care of women living with HIV and AIDS.
3. While strategies to combat HIV and AIDS are improving and recent medical advancements in prevention and care have been considered, much work is still to be done in the area of disclosure and discrimination. Joint efforts by the business sector, academic environments and government should be considered.

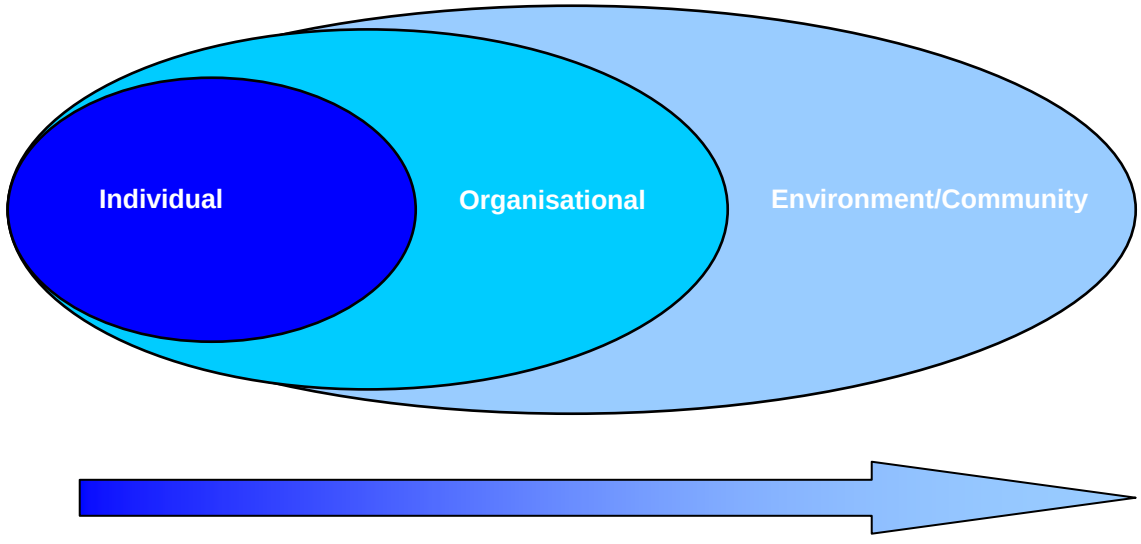
4. South African businesses should learn from other African countries such as Uganda and Botswana in the areas of behaviour change strategies and treatment planning. An example could be that educational sessions should be included during funeral agendas in the case where death is AIDS-related.

The researcher proposes a business and community model which can be called the engagement strategy. The model should be an integrated business model focusing on both internal and external approaches. The model would be applicable to the organization's employees and their family members first.

The following is a recommended strategy process and is illustrated in Figure 35 below:

1. Establish the prevalence of HIV amongst women in the organization. (Transparency regarding HIV profiles)
2. Procurement of services from people living with HIV and AIDS and SMMEs (first priority to be given to family members of employees).
3. Develop enterprise programmes where community people living with HIV can be supported and empowered (target the communities where majority employees reside).

Figure 35: Engagement Strategy



10.6.4 Business Approach To HIV And AIDS Programmes

- The EAP's visibility and management must involve more resources, good reporting and visible HIV statistics in the workplace. Clearly from the results it was evident that the EAP do not have clear understanding of the HIV prevalence in the organisations they worked for.
- EAPs should be more integrated with strong capacity building and must be in alignment with gender programmes. A practical example as suggested by the Director of Amnesty International is that a chronic illness grant be encouraged to improve HIV infected women's access to health services and treatment and not to be terminated as their CD4 improves as is the case currently.
- The introduction of spiritual counselling with a focus on acceptance and support from infected and affected people should be considered. In the same vein, debriefing sessions for EAP professionals should be compulsory and EAP should be encourage to embrace their spirituality.
- EAPs should be champions of the organisation's vision and goals, particularly in the area of risk management and change management using multidisciplinary assessment of social, economic and cultural / spiritual aspects to contribute to the development of behaviour change strategies.
- Managers to be encouraged to take more leadership role, and consequence management to be considered for non-compliance on policies which promotes non discrimination. Consequence management entails the process of managing employees with the emphasis on taking responsibility for the consequences of their action.

The above recommendations would need further research exploration and experimentation, however this can be achieved through collaborative efforts between people living with HIV and AIDS, businesses efforts, communities forums, EAP

interventions, spiritual and cultural inputs and lastly through patience, tolerance and values of respect and humanity.

10.6.5 Standardise EAP Education

According to the EAPA-SA requirements, it is important that those involved in EAP conform to the standards of EAP that are guided by EAP core technology. A module on HIV and AIDS will add professional knowledge and skills to the profession and core technology. In addition, the University of Pretoria offers a certificate in EAP to allow those involved in the field of EAP to practice EAP within the EAP standards, the certificate is only to assist with the understanding of EAP and it does not guarantee professional competency. In 2001 University of Pretoria introduced two masters programmes for non- social workers and professional social workers. Both programmes offer theory, practical and research in EAP. Through these two masters programmes, EAP professional competency can be enhanced.

In the South African workplaces there is no prerequisite counselling experience required for an EAP coordinator role. The reason could be that companies rely on external models for actual counselling of employees. For the sustainability of EAP profession, EAPA-SA standards need to be enforced and a certain level of competency need to be standardized through tertiary requirements. In doing so, this will assist employers in South Africa to align their position requirements with the professional standards.

The USA has made so much progress in the area of EAP, so much so that in some states, the progression is evident in that EAP certification is offered to all employees at a particular level of their responsibilities. The two years certificate was introduced at the university medical centre in Texas, USA. The two years certificate is offered to all employees who have a supervisory control over employees. According to Tiner (2006:25) the certificate was introduced not only to heighten supervisors' and managers awareness of EA services but to help them better understand how to use the EAP as a vital tool in dealing with troubled employees.

10.6.6 Limitations of the Study

- Literature is available on women and HIV and AIDS, especially regarding feelings, difficulties, and work struggles, however there is limited literature on working women and HIV and AIDS. The focus on literature on HIV and AIDS is on medical information, infection rate but not on workplace and HIV women infected or affected.
- Unavailable statistical information on the prevalence of HIV among working women in South Africa. The only available statistics are through antenatal studies, and the Nelson Mandela Household studies, which do not reflect working women who are members of a medical aid and who have access to private hospitals. This limitation was also evident when analysing quantitative data, as most respondents did not indicate the HIV prevalence of their work force according to gender; therefore it was difficult to quantify the data rendering some of the findings inconclusive.
- The limitations identified are that some findings, such as the various organisational HIV and AIDS prevalence are inconclusive and cannot be generalised to the larger population.
- Research on the efficacy of EAPs in South Africa was unavailable and as a result there was limited information to justify the integration of HIV and AIDS programmes with EAP. EAPs in South Africa have largely not been scientifically evaluated.
- The study was aimed at only interviewing working women, but during the implementation of the study two women were retrenched, making it very difficult to exclude them because the researcher only learnt about the retrenchment during the process of the interview.
- The aim was to collect quantitative data only in Gauteng. However, since the pilot study yielded only a few responses, it was necessary to include all practitioners in various South African regions. This was achieved during the EAP Durban Conference in 2005. Due to the limited response, questionnaires were further distributed via email to practitioners outside Gauteng.

- The Durban Conference was attended by EAP practitioners who are active in the EAP field. This resulted in difficulties excluding professionals who are not practising EAP practitioners, rendering some results inconclusive. 17,3% of respondents indicated 'other' to the question asking about job position and 12,3% of respondents are Human Resources professionals.

10.7 GOALS AND OBJECTIVES

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

Table 2: Achievements of Goals of Study

OBJECTIVE	ACCOMPLISHMENTS
1. To investigate feelings and perceptions of HIV infected and affected working women in the working environment.	Chapters 2-9 highlighted how this objective was achieved through various discussions using South African literature. The role of the business sector and EAPs and counselling models. In addition, the qualitative results clearly demonstrated feedback from women infected and affected by HIV and AIDS, which confirmed the assumption that women infected and affected with HIV have feelings and perceptions regarding their needs in the workplace. The feelings included a list with the majority being negative feelings, i.e. feelings of depression, suicidal ideation, issues of stigmatisation. This was also confirmed by the quantitative data in that the majority of the respondents indicating counselling women around depression and stigmatisation. Clearly stigma is still a barrier for disclosure in organisations that were represented in this study.

2. Establish HIV infected / affected women's perceptions of the role of EAP regarding their situation.	This objective was achieved through the presentation of a detailed discussion in Chapter 10, presenting the qualitative and quantitative findings of the study. The study explored the role of EAPs during difficulties experienced by women in the workplace in relation to HIV and AIDS. The established perception of women about an EAP is that an EAP is supportive at an individual level though counselling, practical help and through home visits. In the event where HIV programme is incorporated within the EAPs, training and awareness have been valuable. The findings have clearly showed that there EAP need to play a strategic role in the organisations, however much resources, skills and knowledge are needed to ensure that this happens. The strategic position needs to tackle issues such as discrimination and stigmatisation, which have been reported by women as barriers to their HIV disclosures. EAP has to be positioned strategically to ensure women have confidence in the service and feel supported enough to disclose their statuses.
3. To investigate the type of HIV and AIDS counselling offered by EAP practitioners.	Similarly to the above, this objective was achieved through qualitative and quantitative research of which the findings are presented in Chapter 10. Women receive face-to-face counselling which focuses on psychological empowerment, home visit support and bereavement counselling. The practitioners have provided individual counselling, couple counselling and crisis intervention as part of EAP to women infected and affected by HIV and AIDS. The counselling offered

	was provided through internal and external EAP models.
4. To recommend intervention strategies for the workplace relevant to vulnerable women who are affected by HIV and AIDS.	This objective was achieved through a detailed presentation of the conclusion, summary and recommendations in Chapter 10. The recommendations presented are a collaboration of women's *verbatim* inputs, recommendations from EAP practitioners, the researchers' analysis of research recommendations and input drawn from literature reviews. The key results here is that EAP should continue to offer counselling to employees. This researcher has proposed an integrated model which will focus not only on counselling but on empowering women through already existing programmes, incorporating three diseases, HIV/AIDS, tuberculosis and malaria in the effort to destigmatise HIV and AIDS. EAP to be professionalized to ensure EAP principles are standardised, monitored and evaluated. Partnership through business, academics and community forums to fight the scourge of HIV and AIDS. EAP to incorporate spiritual, cultural and scientific processes in supporting employees in the workplace.

10.8 CLOSING REMARKS

No words can adequately portray the impact of the HIV and AIDS pandemic on economic growth, developmental prospects, political stability, and generally on the lives of people around the world. HIV is a chronic health condition. Just like any other chronic health condition, lack of management of the condition can lead to death. HIV however, has become a pandemic that has been complicated by stigmatisation and discrimination. Workplace efforts to mitigate the scourge of HIV and AIDS have

necessitated multi-level strategies, including EAP interventions. An EAP is a workplace programme that has over the years proven to assist workplaces with interventions for troubled employees.

Employees infected and affected by HIV and AIDS are equally troubled in the workplace, and EAPs have played an important role in addressing their needs and difficulties. Little has been done to address specific needs of women infected and affected by HIV and AIDS. However, EAP efforts have been made to assist all employees irrespective of gender, as clearly seen in the research results. The majority of the responses, both qualitative and quantitative, indicated that the EAP is addressing the needs of infected and affected employees through education and awareness training and disease management programmes.

Given the level of stigmatisation that still exists in the workplace, HIV programmes should continue to address employees' needs and difficulties from this perspective with specific understanding and acknowledgement of the fact that women are more affected and are specifically vulnerable to HIV infection. From a micro perspective, EAPs should empower women to take responsibility for their own health. From a macro perspective level, workplace programmes should encourage management input to have an integrated EAP and HIV and AIDS programme.

As this was a first level study on women, HIV and AIDS and EAPs, there is a need to build on this study and research the interrelationship further. This study could not particularly establish that women's difficulties are definitely due to the fact that they were women, but instead, there was a strong link found between these difficulties and HIV and AIDS.