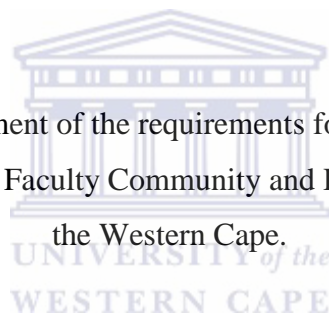


**GUIDELINES FOR THE DEVELOPMENT OF AN HIV/AIDS WORKPLACE
SUPPORT PROGRAMME FOR TEACHERS**

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A thesis submitted in fulfilment of the requirements for the degree of Philosophiae
Doctor in Social Work in the Faculty Community and Health Sciences, University of
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ABSTRACT

Managing HIV/AIDS in the workplace has become more important as more than 36million people living with the disease in the world are economically active (ILO, 2008). However, workplaces (public and private) have been slow in their responses including the education sector. More action and interventions are required to deal with challenges of HIV/AIDS in the workplace. This study came about as a result of this identified need and one of means of contributing towards fighting the scourge of HIV/AIDS especially in the workplace, education sector in particular.

Research suggests that HIV/AIDS impacts negatively on the education sector (HSRC, 2005; Cohen, 2002; Bennett, 2002; etc – check to confirm). The impacts on the education sector include infection and death of teacher leading partly to teacher shortages; supply and demand for education; quality of education is affected; heightened benefits or medical costs; etc.

The aim of this study was to develop guidelines for an HIV/AIDS support programme for teachers. In order to achieve this goal, Intervention Research: Design and Development model by Rothman and Thomas (1994) was adopted to guide the research process. Intervention research is a form of applied qualitative research utilized by researchers to design and develop interventions to ameliorate social problems.

Intervention research: design and development model has six phases and unique operational steps to follow in each phase. The researcher adopted the first three phases to facilitate the design of the guidelines to assist with development of a programme to support teachers.

Problem analysis and project planning is the first phase. In this phase, the aim was to understand the experiences of HIV/AIDS among teachers and in schools. Information was gathered from HIV/AIDS co-ordinators, principals, teachers living with HIV.

The second phase relates to information gathering and synthesis as a means to discover what others have done in the field to understand and address the problem under study. In order to fulfil this requirement/aim, literature review was conducted, and the visits to workplaces inside and outside of the country were undertaken.

Information gathered during phase one and two of the study was synthesised and informed the design of the guidelines to help develop HIV/AIDS support programme for teachers. This phase is referred to as design, the third phase of intervention research: design and development model. On completion of the design of the guidelines, these were evaluated for their implementation value using the evaluation model proposed by Thomas (1994). The evaluation of the guidelines was largely participatory allowing time for interacting with the information to stimulate discussion about the guidelines. Furthermore, the participants completed the evaluation schedule specifically developed for this purpose. The information gathered was then analyzed and arranged into themes which informed the development of the guidelines for an HIV/AIDS support programme for teachers.

The last section of the thesis draws conclusions on the research and research process and makes recommendations thereof in line with the conclusions, future research and limitations of the study. This thesis is therefore the result of engaging in various research activities.

KEYWORDS

HIV/AIDS

Workplace

Support Programme

Guidelines



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WESTERN CAPE

DECLARATION

I declare that “*Guidelines for managing HIV/AIDS in the workplace*” is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name: Thulisile Ganyaza-Twalo

Date: May 2010

Signed.....



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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

Across the world, it is accepted that HIV/AIDS impacts on all sectors of society. Different impacts are felt by individuals, families, communities, public and private institutions. The repercussions of not developing targeted interventions in response to these impacts could have enormous negative effects beyond these institutions to society at large. The study seeks to understand the dynamics and impacts of the disease as they are experienced in schools, and subsequently design guidelines for the development of an HIV/AIDS support programme for teachers.

The education sector is not immune from the effects of HIV/AIDS. Initial South African research on the impacts of HIV/AIDS on educators and the education sector (HSRC, 2007; Louw, Shisana, Peltzer & Zungu-Dirwayi, 2009) reveal collective factors, such as HIV infection, mortality, and absenteeism that impacts on the provision of quality education. What we see now in response to the impacts of HIV/AIDS on the education sector is a set of policies with minimal programmatic interventions putting research results into practice.

1.1.1 HIV/Aids in context

It is especially disconcerting that the AIDS pandemic has a direct impact on the South African workforce. Dickinson (2004) estimated then that 40% of the South African workforce was infected with HIV, and some reaching the AIDS stage.

The impact of HIV/AIDS on people of working age threatens to undermine the already weak skills base of the South African economy. The author further asserts that the difficulties in recruiting people with appropriate levels of skills and experience, along with the costs of such recruitment will be exacerbated by the less quantifiable impact of HIV/AIDS on levels of productivity as a result of absenteeism, lower performance due to illness, extra resources devoted to training, and the need to utilize less skilled or inexperienced workers in production and/or education and training.

A South African study on HIV/AIDS in the education sector conducted by the HSRC (2005) estimated that 12.7% of teachers were living with HIV. The estimated prevalence rate of 12.7% is higher than the latest national prevalence estimates of 10.6% (HSRC, 2009). The results of the HSRC study should caution the education policy makers and managers of subsequent negative impacts of the disease on the education sector. The education managers should also prepare the entire schooling system to manage HIV/Aids effectively in schools.

Even though the results for the Western Cape showed the lowest percentage of teachers living with HIV (1.1%), the impacts are huge considering the core functions and role of teachers, the investment that went into their training and qualification, and the high regard and need for highly qualified and skilled workforce in the country. It is therefore vital for the Western Cape Department of Education to act swiftly whilst the phenomenon is still arguably manageable.

The United Nations Millennium Development Goal (MDG) 6 calls for stopping and reversing the spread of HIV/AIDS. In response to this call, the South African government through the National Department of Health developed and produced the HIV & AIDS and STI National Strategic Plan (NSP) 2007-2011. The NSP provides universal guidelines to help fight the scourge of HIV/AIDS in the country mainly from a health perspective. Thus, guidelines aimed at addressing education sector specific HIV/AIDS related impacts are required and this study aims to develop such guidelines.

The targets for achieving this millennium development goal are:

- Have halted by 2015 or begun to reverse the spread of HIV/AIDS, and
- Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.

The first target mainly focuses on people between 15 and 24 years of age, which excludes most teachers. However, the second target is relevant for this study as teachers would certainly benefit from this provision.

The International Labour Organization (ILO) which is an international co-ordinating body on labour related matters has developed a Code of Practice that guides HIV/AIDS related interventions in the workplace (ILO, 2001). The Code of Practice subsequently influenced our country's Department of Labour's HIV/AIDS Technical Guidelines (Department of Labour, 2000). The aspirations espoused in these documents should filter down to, and be reflected in the education department's HIV/AIDS policy and programmes.



The ILO report (2008) estimates that 36million people of working age (15-64 years) are unable to work as a direct result of HIV/AIDS. This is an increment of about 10 million people from the 2005 estimates. Sub-Saharan Africa contributes 70% to these estimates. South Africa accounts for nearly 3.7million of economically active people who are HIV positive according to the report.

There are important gender dimensions which should be taken into cognisance when planning HIV/AIDS related interventions. For example, the HSRC (2009) found that more females than males are infected by HIV. Further, females in the age group 24-29 and 30-34 stood at 32.7% and 29.1% respectively compared to 15.7% and 25.8% for males in the same age groups. These results are significant for this study because many teachers would presumably fall within these age groups.

The aforementioned age groups represent people who have just entered the workforce or are becoming established in their work.

Teachers and the teaching profession are very important for the future economic development of the country. Education is a profession and an institution where transfer of knowledge and intellectual development begins or takes place. Citizens are thus highly dependent on this profession and education is of paramount importance to economic growth and development. HIV/AIDS poses a challenge to this vital role that the education sector can play. Teachers and learners alike are impacted negatively by this disease through infection and affection. Also, HIV/AIDS could potentially destroy human capital built over years and consequently weakens the capacity of workers to produce goods and services for the economy (Cohen, 1998 & 2002; Dickinson, 2004).

In 2002 the World Bank pronounced the adverse impacts of HIV/AIDS on both the supply and quality of education. It suggested that the impacts will manifest or culminate in teacher mortality and absenteeism. The loss of well qualified and experienced teachers coupled with the interruption of teaching programmes due to illness will reduce the quality of education (UNESCO, 2002: 27). The loss of most qualified and experienced teachers hence represents a serious threat to the quality of education. Also, the costs to the economy (and education sector) of absenteeism and reduced productivity may be higher than the costs of actual deaths (UNESCO, 2002: 25). HIV/AIDS will significantly reduce or slow the growth of the labour force and will create labour shortages in the education sector. The death of teachers to AIDS-related diseases and the time required (3-4 years) to produce teachers from institutions of higher learning contribute to teacher shortages.

1.1.2 Workplace Intervention Programs - EAPs

Workplace intervention programs such as Employee Assistance Programs (EAPs) are crucial in assisting employees with personal problems that impact on their work performance. Workers today face diverse problems simultaneously at times thus requiring whatever workplace based assistance available to sort them out.

EAPs have their origins in occupational alcoholism (Masi & Foster-Sanda, 2008) and have since evolved to cater for the diverse challenges that employees face. A disease like HIV poses major and diverse challenges for an infected person. These may include the trauma of diagnosis, declining health, health care costs, emotional and spiritual decline, and many more factors. Therefore, EAPs and their history of evolution and adaptability are best suited for use as a program to intervene with employees' personal challenges.

EAPs are set of policies and program procedures designed by which a work organization legitimately intervenes in identifying and treating problems of employees that impact or influence job performance (Holosko & Feit, 1988). As a set of policies, it means that the intervention programme can be designed to meet the diverse needs and challenges posed by HIV/Aids in the workplace. It is within this adaptability and resourcefulness that EAPs are crucial in any workplace.

The versatility of EAPs in terms of the delivery of services lends itself for greater utilization by employees. EAPs can be delivered internally or externally (Dickman et al., 1985) to meet the varying needs of the employees. The employer may also decide to use the combination of these modes of service delivery simultaneously to promote the psychosocial well-being of teachers.

In terms of the benefits EAPs provide for employees, they open up opportunities for workers to access health and wellness services in the workplace. These health and wellness services would among other services include access to medical treatment and trauma counselling. As regards the latter, trauma could affect both the recently diagnosed worker and fellow workers in the event of the death of a colleague.

When trauma occurs in any organization, health and productivity are usually compromised (Silberman, Kendall, Price & Rice; 2008). Therefore, it is critical for the employer to respond to trauma in the workplace in a manner that mitigates impacts on the general workforce.

Trauma could also relate to the death of a fellow who had Aids. Hoffman and Goya (2008) assert that an inadequate or absent response to an employee death can weaken or break the ties of trust and loyalty that enable other employees to remain engaged and productive in their work. With eventual mortality of an employee with Aids, is vital to work therapeutically with employees during the difficult work-life transition.

1.1.3 Role of the Social Work Profession

The social work profession has a crucial role to play in efforts to fight HIV/AIDS in the education sector. Social work has its grounding on social justice as it emphasizes the “person-in-situation” construct when defining its role (Swenson, 1998). Social work conceptualization of its functions lends itself to the promotion of social justice. Social justice promotes fairness (Rawls, 1993); the status of citizenship (Powell, 1999); social rights (Craig, 2002). Indeed, social work and social workers must assume a leading role in the promotion of these key principles.

Social exclusion and rejection often experienced by people living with HIV/AIDS is a pervasive phenomenon of human life. People who feel socially alienated or rejected are susceptible to a host of behavioural, emotional, and physical problems suggesting that human beings may possess a fundamental need to belong (Baumeister & Leary, 1995). Social exclusion is referred to as a denial or non-realization of civil, political, and social rights of citizenship (Room, 1995). This definition has affinity with the capability approach developed by Amartya Sen which calls for efforts to ensure that people have equal access to basic capabilities such as the ability to be healthy, well-fed, housed, integrated into community, participate in community and public life, and enjoy social bases of self-respect (Sen, 1992).

Social workers can, through advocacy role, advocate for the rights of people living with HIV/AIDS to access services necessary to enhance the quality of their lives.

1.2 PROBLEM STATEMENT

The management of HIV/AIDS in the workplace has become a priority for government and non-governmental organisations. Beyond policy formulation, support structures and preventative programmes are crucial considerations for the benefit of both the employer and the employees. This is especially so for the school settings where the goals of the Department of Education must be met. The needs of both learners and educators/teachers are in this regard interwoven. Social workers in the Department of Education, by virtue of the objectives of their profession, need to respond positively to enhance the lives of teachers and learners in the school setting.

The author/researcher undertook the study with an aim of designing guidelines for the development of an HIV/AIDS support programme for teachers. Critical to achieving this goal, the researcher had to understand, observe and design education specific solutions to the impacts of the disease in schools. An empirical study was conducted in order to understand the dynamics and experiences of HIV/AIDS by teachers, and the results of this activity are presented in chapter 3. It was also crucial for the study to understand what has been done elsewhere in response to this phenomenon. The gathered information was then synthesised and packaged into guidelines to help support teachers.

1.3 GOAL OF THE STUDY

The goal of this research was to:

“Develop guidelines for an HIV/AIDS workplace support programme to teachers”

1.3.1 Objectives of the Study

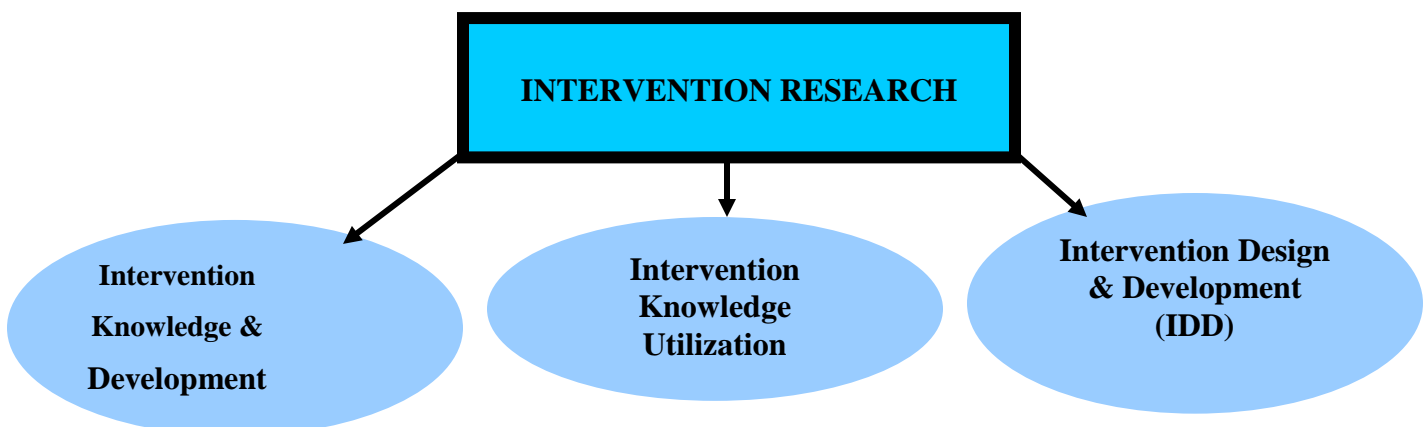
The following objectives were set in order to achieve the goal of this study:

- Explore perceptions and experiences of HIV/AIDS among teachers
- Gather information on HIV/AIDS in the workplace and identify successful elements of existing models.
- Observe practice models for workplace support to HIV infected and affected persons
- Develop guidelines using an adapted model of intervention research.

1.4 INTRODUCTION TO THE RESEARCH DESIGN AND METHODOLOGY

This study is conceptualized as falling within the genre of Intervention Research (Rothman & Thomas, 1994:4; & De Vos et al., 2002). Intervention research comprises of studies carried out for the purpose of conceiving, creating and testing innovative human services approaches to prevent or ameliorate problems, or to maintain the quality of life (Rothman & Thomas, 1994:). Social work and social science research is well placed to conduct this type of research as it is at the core of the social work profession and social science research to seek new innovations to enhance the quality of life of the people. According to the authors, intervention research has three facets as illustrated in figure 1.

Figure 1: Intervention Research and its three facets:



Within the paradigm of intervention research, this study is conceptualized to follow the Intervention Design and Development (IDD) approach. Rothman & Thomas (1994: 9) present an integrated design and development approach based on common features of developmental research, social research and development and other related approaches. In the IDD, six main intervention phases are identified i.e. 1) problem analysis and project planning; 2) information gathering and synthesis; 3) design; 4) early development and pilot testing; 5) evaluation and advanced development; and 6) dissemination. Each phase has distinctive steps or activities to be carried out to complete the work of each phase, and will be discussed in more detail in the following chapter on methodology.

Rothman and Thomas (1994:12) conceptualize IDD as a problem-solving process for seeking effective intervention and helping tools to deal with the given human and social difficulties. The authors further elaborate that unlike other types of problem-solving approaches, D&D is a process that is systematic, deliberate, and immersed in research procedures, techniques, and other instrumentalities. Thus the point of departure of the D&D approach is that it takes a real world problem and practical goal rather than a hypothesis to be tested or theory to be explored. For the purpose of this study, the researcher followed the first two phases and their operational steps as set out by Rothman and Thomas, 1994. The design and early development phase was adapted. An Adapted Intervention Research Model (AIR) by Strydom, Steyn and Strydom (2007) was considered appropriate for this study. Phase four (Development) and phase five (Evaluation) were applied to both develop the guidelines and evaluate them for their implementation value.

In the first phase: *problem analysis and project planning*, the goal was to elicit support and corporation necessary to conduct intervention research. In order to achieve the goals of this phase, the five operational steps were followed as proposed by the authors. These steps are: involving the clients, gaining entry and cooperation from the settings, identifying concerns of the population, analyzing the identified concerns or problems, and lastly setting goals and objectives.

Teachers infected and affected by HIV/AIDS were chosen to participate as the researcher believed that HIV/AIDS is one critical health issue that affects all in society including teachers. Qualitative information gathering methods were used to analyze their concerns, and concluded that the development goal of the design guidelines for developing an HIV/AIDS support programme for teachers was most relevant.

The second phase of Intervention Design and Development is *information gathering and synthesis*. The expected outcome is a list of functional elements of programmes that can be incorporated into the design of an intervention. This goal can be achieved by acquiring knowledge of programmes through integrating appropriate sources of information. A literature review and visit to identified companies and the Ugandan Ministry of Education and Sport were conducted.

The third phase of AIR model, *development* aims to develop guidelines based on data collected in the preceding phases. In this context, data collected in phases one and two of the original Intervention Research: Design & Development was used to inform the development of the guidelines.



The researcher finally evaluated the implementation value of the guidelines using guidelines proposed by Strydom et al. (2007). The findings of the evaluation are either incorporated into the guidelines or stated as recommendations in the last chapter of the thesis.

1.5 CONCEPT CLARIFICATION

Intervention Research, Intervention Design and Development: Intervention research falls within the genre of applied research (Rothman & Thomas, 1994). As a form of applied research, it explores relationships between conditions identified by clients as important. It has three facets to it, viz Intervention Knowledge Development; Knowledge Utilization and Intervention Design and Development (also referred as IDD in this study).

The latter (IDD) is utilized in this study, and it incorporates six interrelated phases. Only the first three phases were put into operation in the study.

Guidelines: Concise Oxford English Dictionary 11th Edition defines a guideline as a general rule or piece of advice. The Free Online dictionary defines guideline as a statement or other indication of policy or procedure by which to determine a course of action. From the above, it is a detailed guided plan and/or explanation for the course of action.

Teachers: According to the National Education Policy Act, 27 of 1996, an educator is defined as any person who teaches, educates or trains other persons at an education institution or assists in rendering education services or education auxiliary or support services provided by or in an education department but does not include any officer or employees as defined in section 1 of the Public Service Act, 1994. The word teacher is used here with the same meaning as an educator.

School/Education Setting: The National Education Policy Act, 27 of 1996 refers to school as a pre-primary, primary or secondary school. In defining an education institution, the Act refers to any institution providing education, whether early childhood education, primary, secondary or further or higher education, other than a university or technikon, and also an institution providing specialized, vocational, adult, distance or community education. The use of the concept “school” within the context of this study is confined to primary and secondary schools.

HIV: HIV is an acronym for Human Immunodeficiency Virus. It is a virus that is widely accepted to be the cause of AIDS. The World Health Organization (WHO) clinical staging of HIV is taken and accepted as the definition to be used in this study.

AIDS: According to WHO clinical definition of Aids, it is a term used to describe various clinical syndromes, specific opportunistic infections or malignancies that occur with HIV infection and signal those in whom advanced HIV infection has occurred (WHO, 2005).

Support Programme: The 11th edition of the Concise Oxford English Dictionary defines a programme as a set of related measures or activities with a long-term aim. It goes on to define support as giving assistance, encouragement or approval. This study combines the two definitions in referring to the support programme.

1.6 ETHICAL CONSIDERATIONS

- **Autonomy** – respecting the rights of participants, to participate voluntarily and with informed consent. Strydom in De Vos (2002:65) supports the view that informed consent becomes a necessary condition rather than a luxury or an impediment. He further asserts that emphasis should be placed on accurate and complete information so that subjects will fully comprehend the investigation and consequently be able to make a voluntary, thoroughly reasoned decision about their possible participation

Care was taken to ensure that informed consent was elicited from the research participants. All the participants signed a consent form which was simply designed to clarify the purpose of the study.

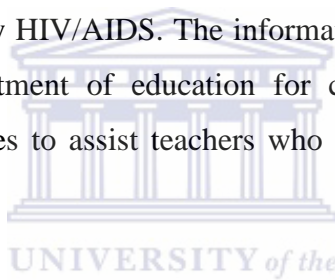
- **Nonmaleficence** – requiring the researcher ensured that no harm should be inflicted on research participants. Dane (1990:44) claims that an ethical obligation rests with the researcher to protect participants against any form of physical discomfort that may emerge, within reasonable limits, from the research project. It is also important for the researcher to be cognisant that participants may be harmed emotionally too, although this is very hard to detect or determine.

The HIV infected teachers who participated in the study were interviewed in places that were chosen by them and at times convenient for them. Some of these interviews were done over weekends in order to protect these teachers from possible harm that may arise as a result of this study. The identity of the teachers was kept confidential. In cases where teachers were identified as a result of the

snowballing technique, these teachers were assured of confidentiality on the day of interview. Their identities are not revealed anywhere in the writing up of this thesis.

In addition, the HIV positive teachers were told of resources close by to where they live in case counselling is required after the interview. The researcher also used her counselling skills and social work knowledge to deal with issues raised during the interview.

- **Beneficence** – designing a research project that will be of benefit to participants, future researchers, teachers and the education department and broadly to the larger society. It is the intention that this research will benefit teachers both infected and affected by HIV/AIDS. The information and/or results will be made available to the department of education for consideration when developing intervention programmes to assist teachers who may be infected or affected by this pandemic.



Strydom, in De Vos (2002:64-73), further identifies other ethical issues the researcher needs to be cognisant of during the research process.

- **Release or publication of the findings** – the ethical obligation rests on the researcher to ensure at all times that the investigation proceeds correctly and that no one is deceived by the findings. The author further suggests that participants should be informed about the findings in an objective manner, and should know that research findings will be published without impairing the principle of confidentiality and anonymity. The researcher presented the guidelines influenced partly by the findings to the teachers without mentioning names whatsoever.
- **Debriefing of participants** – debriefing sessions during which participants get the opportunity, after the study, to work through their experiences and its aftermath, are one way in which the researcher can assist participants and possibly

minimise harm (Judd et al. 1991: 517). This service was offered but the participants did not require debriefing.

1.7 LAYOUT OF THE THESIS

The reporting on the process followed in conducting the study is different from the traditional research reporting where the findings are presented and discussed followed by recommendations. Therefore, the thesis is organized and structured in such a way that it recognizes and follows the first three phases of Intervention Research: Design and Development (IR: DD) approach and their operational steps as suggested by Rothman and Thomas (1994). Thus, the thesis is divided into 4 sections in line with the selected phases as applied in the study. The first section sets the context for the study and comprises of this chapter (chapter 1). The second section focuses on problem analysis and project planning in line with the first phase of IR: DD. The third section is entitled information gathering and synthesis (IR: DD phase 2), whilst the fourth section is looks at the design and early development (IR: DD phase 3) of the guidelines. It then concludes by providing a summary, concluding remarks, limitations and recommendations for further research.

As an output of an intervention research process, it goes further by providing intervention guidelines to help develop an HIV/AIDS support programme for teachers. Consequently, this thesis adds value to social research by providing solutions in response to HIV/AIDS in the workplace (schools) which traditional research does not normally offer.

Section A: Context for the Study

Chapter 1, Overview of the Study. The introductory chapter covers the core concepts of the study; explains the rationale and motivation for the study; highlights the aims and objectives; presents the ethical considerations in the conduct of the study; and finally gives the layout of the thesis.

Chapter 2, Research Methodology. This chapter presents the methodological processes followed in this conduct of this study in detail.

Section B: Problem Analysis and Project Planning

Chapter 3, Teachers Experiences of HIV/AIDS in schools. It presents the findings regarding the teachers' perceptions and experiences of HIV/Aids in schools. The findings helped with understanding the problem better aided the process of setting goals and planning for the study.

Section C: Information Gathering and Synthesis

Chapter 4, Work and Wellbeing in the Workplace in the Presence of HIV/AIDS. It looks at and introduces the concepts of work and its meaning and wellbeing in the workplace.

Chapter 5, Workplace Intervention Models. This chapter provides information on selected workplace intervention models that could be utilized to assist employees with personal problems that impact on their levels of productivity.

Chapter 6, Observations of Intervention Programmes in South African Companies and Uganda. It looks at existing programmes or best practices focusing on what and how employees are assisted in their workplaces through programme interventions. It therefore presents information gathered from South African large companies and Uganda's Ministry of Education and Sport.

Section D: Intervention Design

Chapter 7, Guidelines for Developing an HIV/AIDS Support Programme for Teachers. The chapter synthesizes information from phase 1 and 2 of IDD. Thus, it provides a set of guidelines to help develop an HIV/AIDS support programme for teachers. It also provides information on the qualitative evaluation of the guidelines.

Section E: Conclusions and Recommendations

Chapter 8, Summary, Conclusions, and Recommendations. It presents a summary of the research process, concluding remarks and recommendations.



CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

The introductory chapter provided an overview of the study, its motivation and the goals and objectives of the study. Further, it introduced the research design and methodology to be followed. It also clarified concepts as applied in this study, and briefly outlined the ethical issues considered in the conduct of this study. Basically, the first chapter provided a blueprint that guided the execution of the study.

This chapter expands on the introductory chapter by providing detailed information on activities undertaken in line with the selected research approaches. It thus provides information on the rationale for choosing the methods and the approaches utilized in the study from inception through to completion.

It also serves to highlight the challenges faced in the field whilst conducting the study and how these challenges were dealt with as they arose or precluded in some instances.

2.2. INTERVENTION RESEARCH IN THE CONTEXT OF SOCIAL SCIENCE RESEARCH

Research is defined as a studious enquiry or examination, especially critical and exhaustive investigation or experimentation having for its aim the discovery of new facts and their correct interpretation, the revision of accepted conclusions, theories and laws in the light of newly discovered facts, or the practical applications of such new or revised

conclusions, theories or laws (Webster, 1961). Kerlinger (1986:10) defines scientific research as systematic, controlled, empirical and critical investigation of natural phenomena, guided by theory and hypotheses about the presumed relations among such phenomena.

The use of the word “science” in research denotes an existence of set laws that need to be followed in the conduct of research. Science is a social institution and a way of producing knowledge (Neuman, 2000:6-7). De Vos, Schulze and Patel (2005:3) expand on this definition by maintaining that science is (1) the knowledge of facts, phenomena, laws, and proximate causes gained and verified by exact observation, organised experiment, and correct thinking; also, the sum of universal knowledge; and (2) the exact and systematic statement or classification of knowledge concerning some subject or group of subjects. Further, science included faith in logical reasoning, an emphasis on experiences in the material world, a belief in human progress, and a questioning of traditional religious authority. From the above definitions, the researcher concludes that science is knowledge generated about phenomena, through the use of scientific and systematic methods of observation.



Social sciences can be viewed as those sciences that deal with a particular phase or aspect of human society or a study of people – their beliefs, behaviour, interaction and institutions (De Vos & Schulze, 2005:5). The authors further assert that they are sometimes referred to as soft sciences because their subject matter, human social life, is fluid, formidable to observe, and hard to measure precisely with laboratory instruments.

Professional research should be viewed within a professional context which ensures that the research process becomes a “knowledge-building enterprise” (Delport & De Vos, 2005:45). The authors thus argue that social work research should go beyond problem solving to building a theoretical base for the profession. In discussing the goals of professional research, Fouche and De Vos (2005: 89) highlight the goals as either basic or applied. The difference between the basic and applied research is that the former seeks to answer questions whilst the latter aims to solve specific policy problems or help

practitioners accomplish a task. In line with above-mentioned goals, the objectives could seek to explore, describe, explain, correlate, evaluate, intervene and encourage active participation during the research process.

Social science research can be viewed as a collaborative human activity in which social reality is studied objectively with the aim of gaining a valid understanding of it. Social research has two distinct approaches viz. quantitative and qualitative approaches. In his 1994 work on research design and approaches, Creswell provides the following distinctions between the two approaches:

- Quantitative research is referred to as the traditional, the positivist, the experimental or the empiricist paradigm.
- Qualitative research is termed the constructionist approach or naturalistic, the post-positivist or postmodern paradigm.

Quantitative research involves the use of methodological techniques that represent the human experience in numerical categories, sometimes referred to as statistics (Marvasti, 2004, and Creswell, 1994). Fouche & Delport (2005:73-74) quote Creswell (1994) who asserts that the quantitative research's main aims are to measure the social world objectively, to test hypotheses and to predict and control human behaviour.

Creswell (1994:1-2) summarizes quantitative research as an inquiry into social or human problems, based on testing a theory composed of variables, measured with numbers, and analyzed with statistical procedures, in order to determine whether the researcher is independent from that being researched, the research process is value free and unbiased, and is based on deductive processes. The qualitative paradigm in social research stems from an anti-positivistic, interpretative approach, is idiographic and thus holistic in nature, and aims mainly to understand social life and the meaning that people attach to everyday life (Fouche & Delport, 2005:73). The qualitative approach to research therefore seeks to understand authentic experiences of the phenomena under study from the perspective of the participants in their natural social settings. It is rooted in

phenomenology and its purpose is to construct a detailed description of the social reality. This social reality in the eyes of qualitative researcher is based on social interactions and socially constructed meanings of that interaction. This approach was employed in my research for analysing the problem of HIV/AIDS as experienced by teachers.

In his later work Creswell (2007:20-23) identifies four types of paradigms in research and defines a paradigm or a worldview as a basic set of beliefs that guide action viz.:

Post positivism: Researchers engaging in qualitative research using a belief system grounded in post positivism will take a scientific approach to research. This type of paradigm has elements of being reductionist, logical, an emphasis on empirical data collection, cause and effect oriented, and deterministic based on a priori theories. In terms of practice, post positivist researchers are likely to view an inquiry as a series of logically related steps, believe in multiple perspectives from participants rather than a single reality, and espouse rigorous methods of analysis, employ computer programmes to assist their analysis, encourage the use of validity approaches, and write their qualitative studies in a form of scientific reports, with a structure resembling quantitative approaches.

Social Construction: Researchers seek to understand the world in which individuals live and work. The goal of this approach is to rely as much as possible on the participants' views of the situation. In terms of practice, the questions become broad and general so that the participants can construct the meaning of the situation, a meaning typically forged in discussions or interactions with other persons.

Advocacy/Participatory: The basic tenet of this approach is that research should contain an action agenda for reform that may change the lives of participants, the institutions in which they live and work, or even the researchers' lives. In this paradigm, specific social issues help frame the research questions and the researchers collaborate with the research participants. Regarding the latter, the researcher may ask the research participants to help with designing the questions, collecting the data, analysing it, and shaping the final report of the research.

Pragmatism: Researchers holding this view focus on the outcomes of the research – the actions, situations, and consequences of inquiry – rather than antecedent conditions. In practice, researchers use multiple methods of data collection to best answer the research question, will employ both qualitative/quantitative data collection methods, focus on practical implications of the research, and emphasise the importance of conducting research that best addresses the research problem. In essence, this approach is practical in nature or focuses on what is best to achieve the research goals.

The choice of research paradigm, whatever the rules and procedures chosen, should be made on the basis of its appropriateness in answering the research questions of the study (Bryman, 1988; Punch, 1998; Mouton, 2001). In the first phase of this study, the researcher wanted to investigate the teachers' experiences of HIV/AIDS in schools. In order to get to the core of the teachers' experiences of the disease in schools, qualitative research methods of data collection were preferred and utilized in the study. Qualitative research provides detailed descriptions and analysis of the quality, or the substance, of the human experience. It mainly aims to understand social life and the meaning that people attach to everyday life (Berg, 1995; Fouche & Delport, 2002).

In summary, qualitative research views reality as subjective and multiple as seen by participants in the study, and the researcher is an objective observer but that the participants' views reflect their particular views and biases. Most importantly, the qualitative methods enabled and allowed for expression of experiences and solutions by the participants without external influence, and consequently enabled the researcher to gain a deeper understanding of the social phenomena.

In the context of this study, the researcher's primary goal was to design guidelines for the development of an HIV/AIDS support programme for teachers. The Intervention Design and Development (IDD) approach proposed by Rothman and Thomas (1994) was utilized as a framework for developing the guidelines. The Intervention Design and Development approach provides a structure in phases and operational steps to help design an

intervention to resolve an identified social condition or problem. In phase one of IDD, namely problem analysis and project planning, the researcher wanted to understand the experiences and impacts of HIV/AIDS on teachers in schools. In phases two and three, the researcher sought to understand how the problem was dealt with in other workplaces; and designed guidelines for an intervention following the synthesis of information from phases one and two.

2.3 INTERVENTION RESEARCH

Intervention Research came about as a result of collaboration between two pioneers in the field of development research, Edwin J. Thomas and Jack Rothman. The former focused on developmental research and utilization (DR&U), while the latter focussed on social research and development (SR&D). The combination of the two approaches to social research culminated into Intervention Research: Design and Development, mainly aimed the human service professions (De Vos, 2005: 392).

Intervention Research: Design and Development was designed with the intention of guiding research that will yield results that can be put into practice by administrators, practitioners and policymakers in the human services areas. The intervention research paradigm was therefore designed to provide an integrated perspective for understanding, developing, and examining the feasibility and effectiveness of innovative human services interventions. Intervention research is typically conducted in a field setting in which researchers and practitioners work together to design and assess interventions.

Rothman and Thomas (1994:8) identify three approaches in Intervention Research:

- Intervention Knowledge Development (IKD): This refers to empirical research to extend knowledge of human behaviour relating to human service intervention;

- Intervention Knowledge Utilization (IKU): This refers to the means by which the findings from Intervention Knowledge Development research may be linked to, and utilized in, practical applications; and
- Intervention Design and Development (IDD) referring to research directed towards developing innovative interventions.

The pioneers of this model identified six stages or phases of the intervention process referred to as design and development methodology. Each phase has distinct operational steps that need to be carried out in the process of intervention design.

The following graphic presents the six phases of IR: D&D

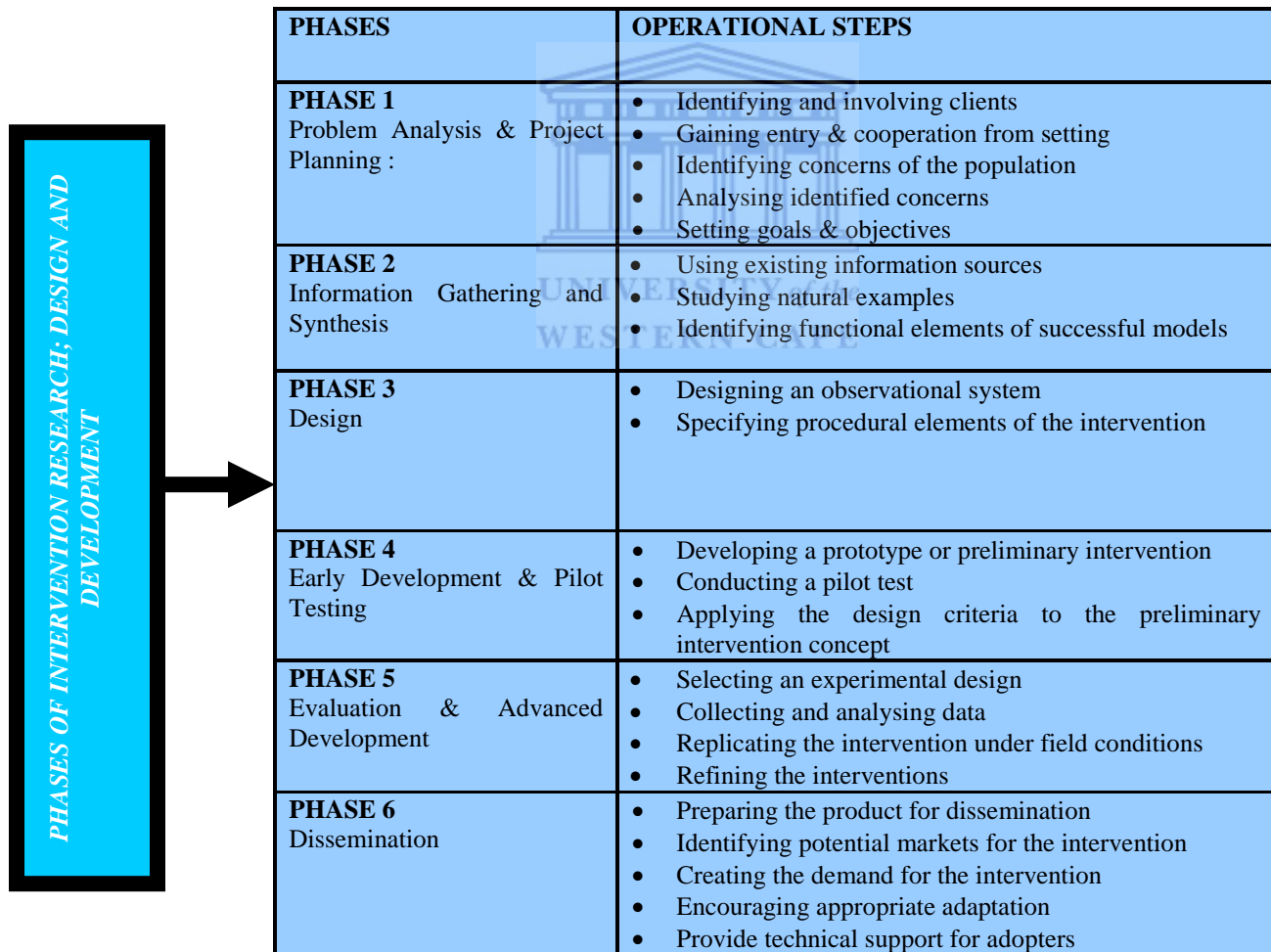


Figure 2.1: Six phases of Intervention Research: Design & Development by Rothman & Thomas (1994)

Recently, Strydom, Steyn and Strydom (2007: 329) propose an adapted model based on the needs of South African students. The Adapted Intervention Research Model consists of seven phases of which the first phase forces a researcher to conduct a preliminary study and make the necessary adaptations before the actual study is conducted. Also, it helps to clarify methodological issues right at the beginning. However at the time when the researcher initiated the study, the Intervention Design and Development model of Rothman and Thomas (1994) was deemed to be the most appropriate methodological framework available to structure and guide the conduct of this study.

With the increasing focus on evidence-based practice in social work, there is a need for research projects utilising models of design and development to produce findings relating to the outcome of interventions and, where applicable, the utilisation and dissemination of the new intervention. Richey and Klein (2007) however argue that in design and development research, the intervention should be evaluated, adapted and disseminated in order for the research to be classified as design and development research. The reality for many researchers is that the study often has to stand alone and its implementation becomes the responsibility of others. However, it is critical that the study goes far enough in phase three to demonstrate potential 'implementation value.

For this research, the operational steps of the first two phases of IR: D&D model of Rothman and Thomas (1994) were followed. For the design of the guidelines, the researcher found the suggested steps of the fourth and fifth phases of Strydom et al. (2007) most informative. The fourth and fifth phases of this model are called "Development" and "Evaluation" respectively. The authors imply that the programme development should be based on a synthesis of the outcome of the analysis of the needs of the participants and the information gathering phase. This is a major departure from the original IR: D&D which emphasises the design of an observational system and specifying elements of the intervention. The evaluation (phase 5) is concerned with the qualitative evaluation of the programme based on the needs of people in phase four. Critical to this phase is the presentation of the programme to ascertain its effects; data gathering by way of specific measuring instruments to gather the more quantitative data

from this phase of the project; data analysis; and report writing. This information would then be used to adapt and refine the programme to make it user-friendly. Figure 2.2 illustrates the researcher’s adapted model and operational steps followed in this study and the discussion that follows it further elaborates on these.

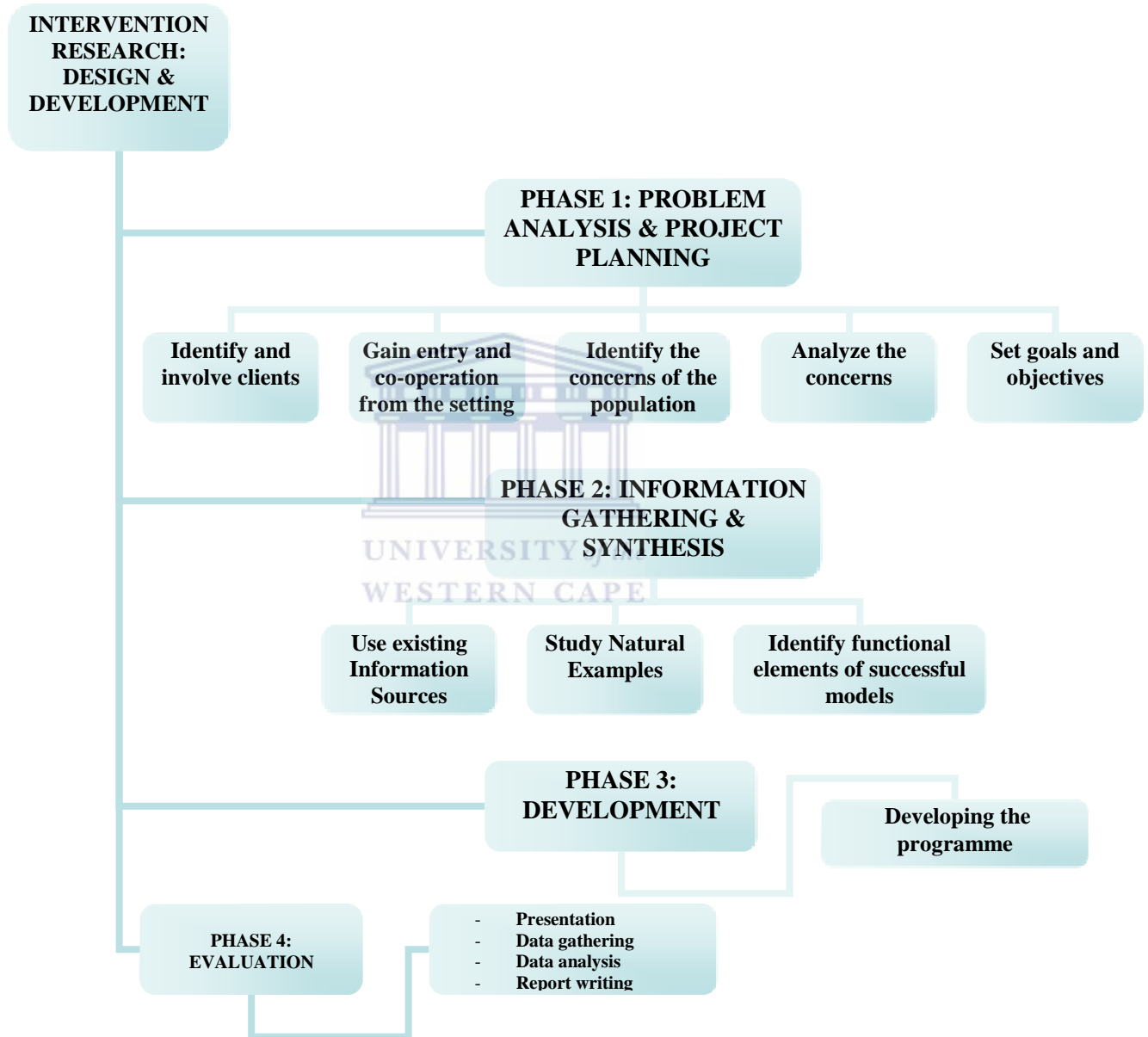
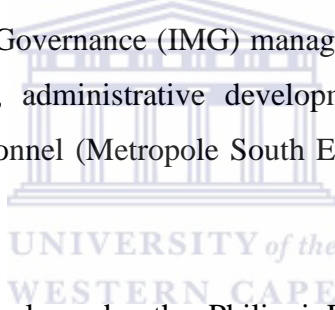


Figure 2.2: Adapted Intervention Research: Design and Development Model. [Adapted from Rothman & Thomas (1994) and Strydom, Steyn & Strydom (2007)]

2.4. RESEARCH SETTING (LOCATION OF THE STUDY)

The study was conducted in Cape Town in the Western Cape Province of South Africa. Cape Town is the cosmopolitan and the second largest city after Johannesburg in South Africa. The study focused on the schools under the Education, Management and Development Centre (EMDC): Metropole South. The researcher worked as a school social worker, and was constantly approached by teachers for assistance with HIV-related issues, hence the choice of this topic.

The yellow section of the map below depicts the EMDC: Metropole South where the study was conducted. The EMDC: Metropole South is one of the three urban EMDCs of the Department of Education. It has more than 220 schools/institutions supported by Institutional Management and Governance (IMG) managers, curriculum advisors, school psychologists, social workers, administrative development advisors, learner support advisors and office based personnel (Metropole South Education District website, April 2010).



Within Metropole South, schools under the Philippi East Education Support Centre (ESC) were selected for this study. The education support centre provided services to 56 schools. Out of the 56 schools, teachers from 40 schools participated in the study.

In terms of the community in which these schools are located, it is a poor community with high unemployment and low education.

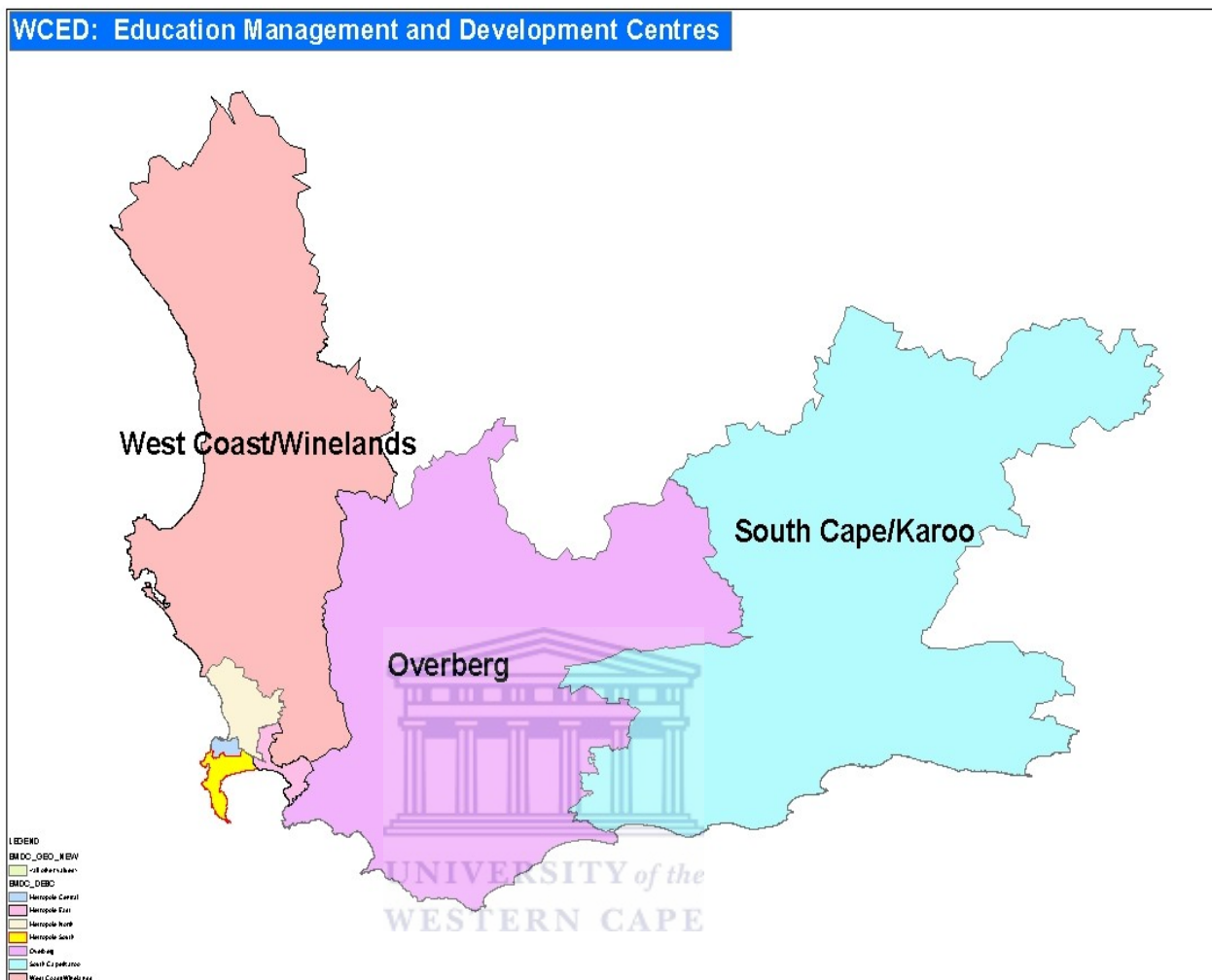


Figure 2.3: Map illustrating the 7 EMDCs of the Western Cape Education Department

2.5 IMPLEMENTATION OF INTERVENTION RESEARCH: DESIGN AND DEVELOPMENT PHASES

2.5.1 PHASE 1 OF IDD: PROBLEM ANALYSIS AND PROJECT PLANNING

As stated in the preceding chapter, one of the objectives of this study was to:

“Understand the experiences and the impact of HIV/AIDS on teachers at the school level”.

This objective was realized by the implementation of the operational steps of the first phase of IDD research process: problem analysis and project planning. The objective also indicated that the researcher was primarily interested in the real life experiences of the participants and, as indicated in the previous discussion, qualitative methods were employed to identify and analyze the problem

It is the requirement of this first phase that a researcher engages in the following operational steps.

- Identifying and involving clients,
- Gaining entry and cooperation from the setting,
- Identifying the concerns of the population,
- Analyzing concerns or problems identified, and
- Setting goals and objectives.

Once the operational steps as proposed by the authors (Rothman & Thomas, 1994) were achieved, the researcher would have analyzed the problem and planned the project based on the desired outcomes by the teachers in this context. Rothman and Thomas (1994:9) advise that although the phases and operational steps are presented in a stepwise manner, the implementation most often does not realize as a rigid sequence of activities. In this study, identifying and involving participants for the research and gaining entry and cooperation from the setting happened simultaneously. The following sub-sections encapsulate the five steps mentioned above.

2.5.1.1 Identifying and involving clients and gaining entry and cooperation from the setting.

The national HIV prevalence in the general population and workforce; the researcher's observations as social worker in schools; and the relatively high HIV/AIDS prevalence

among educators motivated the need to conduct the study in this particular area, town and province.

According to De Vos (2005:396) gaining entry through key informants who have knowledge about local ways of doing things and gatekeepers who control access to the setting is crucial. The implication is that the researcher should know something about his/her clients, goals, policies and programmes. In this research this step was made easier by the researcher's knowledge of the EMDC: Metropole South and the Western Cape Education Department as she was previously employed there and received enquiries from teachers constantly. The researcher had daily contact with managers of the EMDC who in turn directed the researcher to the research directorate in Cape Town for access to any school in the Department of Education: Western Cape (WCED). Following an administrative process with the research directorate, the study was approved thus allowing the researcher access to schools at WCED.

Gaining access to the setting was critical and the researcher engaged in various activities to get permission from the education authorities. The following section describes the process used to gain entry to the setting and the population. The manner in which the activities are discussed is not done in a linear fashion but simply explains the activities that took place in the conduct of the research.

- **Gaining access to the setting (schools in the WCED)**

A presentation to the EMDC management on the proposed project was done by the head of Specialized Learner and Educator Support (SLES), Mrs Berenice Daniels (July 2005). Due to management constraints, the researcher could not present it herself. Permission for the study was thus obtained from the EMDC: South Metropole management. However, the researcher was referred to the research unit of the Western Cape Education Department for permission to conduct the study in schools under their jurisdiction, and the completion of formal documents.

WCED research unit director, Dr Cornelison was approached well in advance for permission to conduct the study and permission was granted on 24 June 2005 after completing the necessary administrative forms. This was mainly done to access schools under the jurisdiction of the Western Cape Education Department. A research proposal was submitted to the unit for scrutiny before permission could be granted.

- **Gaining access to the population and recruiting participants for the study**

This process of gaining entry was one of the challenges in conducting this research. Besides the administrative requirements for entering schools, which automatically gave the researcher permission to interview teachers, the researcher had to go through another administrative process at an EMDC level to elicit the teachers' participation in the study. A few presentations were done to teachers and principals in this regard to encourage their participation.

Gaining entry to the teachers also meant delineating the population of the study and recruiting teachers from all levels as participants in the study. The term population is a precisely defined body of people or objects under consideration for statistical purposes (Collis & Hussey, 2009). Critical to research is the precise definition of the population to be studied. In order to define population, a researcher specifies the units being sampled, the geographical location, and the temporal boundaries of the population (Neuman, 2003:216).

In this study, the population under study was teachers in the Western Cape Education Department falling under the Education Management and Development Centre (EMDC): South Metropole. Specifically, teachers in schools from the Philippi East Education Support Centre's catchment areas which cover lower Crossroads, Phillipi, New Crossroads, Nyanga and Gugulethu. The target population for the study was school managers, HIV positive teachers and other teachers who are HIV/AIDS co-ordinators in their schools.

School managers/principals from 13 schools were identified as an important group of people targeted for participation in the study. Through formal and informal engagement with the Head of Specialized Learner Support (SLES) at the EMDC: South Metropole, the researcher learnt that there are meetings specifically for school managers arranged by the EMDC management. These meetings became the target for promoting the study to the school managers. However, the limitation of this meeting is that they are only attended by EMDC management, and junior staffs were not permitted to attend. The researcher requested the Head of SLES to make the announcement about the study to the audience which she did successfully. This was gauged by the number of principals who were aware of the study and several even called the researcher asking to participate in it.

Principals were given the researcher's contact details if they wanted to participate in the study. Participation in the study was completely voluntary. A list of principals was then drawn up with representation from both primary and secondary schools.

HIV/AIDS co-ordinators (*from primary and secondary school*) in the area irrespective of their HIV status were also targeted for the study. The researcher presented the study with the purpose of recruiting these teachers to participate in the study. The first presentation was done to school-based HIV coordinators from the primary schools. They were also asked to write down their names on a form provided for such purpose if they wanted to participate in the study. Twenty-six names were on the list for participation in the study. The teachers were also given time to think about participating in the study. The researcher's contact details were also given in case teachers wanted to approach the researcher outside of the meeting.

A second presentation was done to another group of school-based HIV co-ordinators from secondary schools, of which sixteen teachers showed interest in participating in the study. Again teachers were given options to think about their decision to participate in the study, and the contact details left with them to contact me at a time most suitable for them. The researcher recruited 38 participants and they all ultimately participated in the study.

- **Recruiting Teachers living with HIV**

In order to develop guidelines to assist teachers infected with HIV/AIDS the researcher had to reach this particular hard to reach group. Teachers living with HIV are significant because they are able to provide firsthand information of their experiences; and they were regarded as a marginalised group in this study. Information about their experiences should influence interventions to assist these teachers. The researcher made presentations to all teachers with the view to gain support for the study from them. Contact details of the researcher were given out during these meetings for teachers to contact the researcher later if they wanted to participate in the study. This was done in order to conceal the identity of HIV positive teachers from their colleagues, thus protecting them from any abuse that may have arisen as a result of the disclosure of their HIV status.

Two known HIV positive teachers, who worked with the researcher during the departmental HIV/AIDS week, were approached individually to participate in the study. The study was presented to them and questions clarified. These teachers agreed to be part of the study. Using the snowballing technique, the researcher asked the teachers to recruit other teachers they knew who were living with HIV/AIDS to participate in the study. The researcher also requested the teachers to facilitate the process themselves so as to avoid any feelings of anger, conflict or betrayal that may have arisen as a result of her direct contact with them. At the time, each teacher knew about two teachers living with HIV/AIDS. Unfortunately, three teachers refused to take part in the study citing lack of emotional preparedness to confront and deal with their feelings. These teachers also found it difficult to even write down their responses to a set of questions prepared for this purpose. One teacher responded and wrote her responses and sent them to me.

In the light of the above-mentioned situation, the researcher felt it necessary to get more teachers living with HIV/AIDS to participate in the study. Contact was made with the HIV/AIDS program manager at the EMDC for possible teachers who could participate in the study. One female teacher responded, but failed to attend an interview session. The researcher's efforts to make contact with her failed, leading to her eventually having to be

dropped from the list of possible candidates. The researcher also tried to make contact with the SADTU national HIV/AIDS coordinator without any success. According to their office, there were no provincial coordinators for the programme within the union. This meant that the researcher could not proceed in finding more teachers living with HIV especially from this area.

- **Principals or School Managers**

The principals were mainly accessed through the presentation of the study in the principals' meetings. A number of principals indicated their interest in participating in the study. Their contact details, including the name of their schools were taken down. Consequently, these principals were contacted telephonically to set up interviews with them.

In total, 60 teachers were recruited and actually participated in the study. The number comprised of 42 teachers who are HIV/AIDS co-ordinators, 13 principals, and 5 teachers living with HIV. The researcher conducted focus group sessions with the 42 HIV/AIDS co-ordinators. Individual interviews were conducted with the principals, and in-depth interviews were conducted with the 5 teachers living with HIV.

2.5.1.2 Sampling method and sampling procedures

A sample comprises the elements of the population considered for inclusion in a study (Strydom & Venter, 2002) and is thus a subset of a population.

According to Neuman (2003), qualitative researchers rarely draw a representative sample from a huge number of cases to intensely study the sampled cases. The author further asserts that the qualitative method focuses less on a sample's representativeness or on detailed techniques for drawing a probability sample, but instead focuses on how the sample or small collection of cases, units or activities, illuminate social life. Therefore, the primary purpose is to collect specific cases, events or actions that can clarify and

deepen an understanding of the phenomenon under study. The study sample was thus determined and selected based on its relevance to the research topic rather than its representativeness. The researcher had to reach teachers irrespective of their status, HIV positive teachers, and school managers/principals. As far as the principals and teachers are concerned, volunteer sampling was the most appropriate for the purpose of this study. Volunteer sampling in the context of this study refers to participants who volunteered to participate after they have attended the information sessions

Regarding the recruiting of teachers living with HIV, the snowballing technique was utilised. Snowballing sampling is a method for identifying and sampling the cases in a network (Neuman, 2003:214), and often referred to as a multi-stage technique which begins with one or few units or cases and spreads out on the basis of links to the initial units or cases. Each unit or case is directly or indirectly linked to the original units or cases involved in the study. The researcher could not get more than the five HIV positive teachers referred to in this study using this technique. Many teachers simply pulled out by missing their appointments for interviews. The situation reflected the complexity of the disease, especially among teachers who are often given high status in communities and/or the stereotypes and myths perpetuated against teachers living with HIV.

2.5.1.3 Identifying and analyzing the concerns of the sample

The next step in the first phase of the research was to analyze how the participants experienced the problem of HIV/AIDS in their workplace/schools. Fawcett et al. (1994:31) list key questions that need to be considered in this regard, such as what is the nature between the ideal and the current; for whom is it a problem; and how are the individuals affected by the issue. In this study qualitative methods were used to identify and analyze the concerns of the participants.

2.5.1.3.1 Method of data collection

Creswell (1994) identifies three steps involved in data collection viz. (a) setting the parameters for the study, (b) collecting information through observations, interviews, documents and visual materials, and (c) establishing the protocol for recording information. Interviews and focus groups were chosen and used as a means of data collection in this study.

- **Use of interviews**

Interviewing is a dominant mode of data collection in both qualitative and quantitative research. Berg (1995) identifies three major categories of interviews, viz. standardized (formal), non-standardized (informal), and the semi-standardized (guided semi-structured) interviews. The standardized interview uses a formally structured schedule of interview questions. The rationale for the use of standardized interview is to offer each participant approximately the same stimulus so that responses to the questions, ideally, will be comparable. The assumption underpinning the use of standardized interviews is the notion that the interview instruments are sufficiently comprehensive to elicit information relevant to the study's topic from the participants.

The second category, which is non-standardized interview also known as informal interview, begins with the premise that the researcher does not know in advance what the necessary questions are (Berg, 1995:32). Consequently, researchers using this form of interview cannot predetermine fully a list of questions, resulting in them developing, adapting and generating questions and follow-up probes appropriate to the situation and the central purpose of the investigation.

The third category, semi-structured interviews, was utilized in this study for the personal interviews as well as the focus group interviewing. It involves implementation of a number of predetermined questions, with the interviewer being allowed the freedom to digress and probe far beyond the answers to the prepared and standardized questions

(Berg, 1995: 33). In all the interviews, the semi-structured schedules were designed to allow for further exploration of issues that arose out of the interviews.

Principals from 13 schools were interviewed to ascertain their experiences and/or management of HIV/AIDS in their schools. Of the 13 principals, 10 and 3 principals were from primary and secondary schools respectively. The numbers of principals interviewed is in proportion to the number of primary and secondary schools in the area.

In order to get a balanced perspective on the experiences of HIV/AIDS by teachers, interviews were also conducted with teachers living with HIV. Five teachers living with HIV participated in the study. Four of these teachers were interviewed and one teacher preferred to provide her story about her experiences of living with HIV without being interviewed. The latter teacher was provided with the interview schedule used when interviewing the other teachers living with HIV. The teacher's information was then included as part of other transcripts for analysis.

- **Use of focus groups**

A focus group is one of the popular data collection methods used in qualitative research. Historically, the focus group method has often been employed for market research and for what can be called *low-involvement topics* (e.g. preferred cigarette brand) in contrast to *high involvement topics* (e.g. promotion of safe sex, and HIV/AIDS). A number of researchers have recently shown that the method is indeed useful when investigating sensitive or high-involvement topics, such as sexuality (Overlien, Aronsson & Hyden, 2005), child bearing and welfare (Jarrett, 1993), or drug use (Agar and MacDonald, 1995). The researcher considered the study on HIV/AIDS among teachers to be very sensitive and one that would require a degree of sensitivity in choosing the form of data collection techniques. The recruited teachers had no knowledge of the HIV status of others and were willing to participate in focus groups. The focus group indeed stimulated interaction and participation. The focus groups assisted the researcher to access, explore and clarify sensitive information in ways that were less threatening to the participant (Webb & Kevern, 2001). The researcher realized that the focus groups gave the

participants a voice and a space to talk and ventilate their feelings about HIV/AIDS in schools.

Several researchers emphasize that the distinguishing feature of focus groups and the strength of the method is indeed the interaction among group participants, and that this interaction should be the main focus of study (Morgan, 1992, 1996; Kitzinger, 1994; Smith, 1995; Wilkinson, 1998b, 1999; & Smithson, 2000). The interaction gives the moderator and/or researcher the opportunity to study the process of collective sense making and to learn the language and vocabulary used by the participants (Frith, 2000).

The weaknesses of using focus group interviews as a form of data collection are presented by various authors (Morgan, 1996; Morgan & Spanish, 1984; Webb & Kevern, 2001). The authors allude to the role of the mediator/facilitator in producing focused interactions, the impact of the group itself on the data collected, and the impact of the group on its participants. Due to my experience in conducting focus groups, it was deemed unnecessary to elicit the assistance of a facilitator for the focus discussions.

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Five focus groups consisting of four groups of eight participants and one group with 10 participants were conducted. The number of the participants in a group session was deemed sufficient to hold a constructive group session. A group size of between six and 10 participants allows for full participation while eliciting a range of responses (Greeff, 2002). Morgan and Krueger, (1998) quoted by Greeff, (2002), mention that deciding on the right number of participants means striking a balance between having enough people to generate a discussion, but not having so many people that some feel crowded out.

Although authors like Kingry et al. (1990) suggest that the ideal is to conduct at least three group sessions, single two-hour group sessions were conducted with the teachers. This decision was influenced by consideration for the preferences of the participants. The teachers took the “time on task policy” of the department very seriously, and that needed to be accommodated in the process. Time on task meant that participants were

available only outside of working hours during the week. Care was taken not to place excessive demands on the teachers' time. .

The researcher chose to record the individual and group sessions with the consent of the participants. All participants were verbally informed of the researcher's intention to record the interviews in advance. In this way, the participants could choose whether to continue with the interview or withdraw from the process. In essence, the participants made a personal decision without persuasion to participate in the study. The researcher transcribed the first few recordings and converted them into text. While listening to the tapes, transcribing and reading the transcripts it was possible to identify areas for further exploration from the next group of participants. The researcher subsequently acquired the services of transcribers to convert more of the recorded data into text in preparation for analysis.

2.5.1.3.2 Method of Data Analysis

Qualitative research depends on the presentation of solid descriptive data, so that the researcher leads the reader to an understanding of the meaning of the experience or phenomenon being studied. In this study, large amounts of data were collected from a variety of participants through interviews and focus groups, posing a great challenge in analysing the collected data. Data-analysis is the process of bringing order, structure and meaning to the mass of collected data (De Vos, 2002:339), and the researcher dealt with ambiguous statements and the analysis of the responses was time consuming.

The key principle in analyzing qualitative data is that the depth and intensity of analysis are determined by the purpose of the study (Greeff, 2002). In addition, one of the specific objectives of the study was to understand the experiences and the impacts of HIV/AIDS on teachers at the school level, which is in line with the operational requirements of the first phase of IDD: problem analysis and project planning. A content thematic analysis was done to identify trends and patterns that reappear in the interviews and the focus groups.

Palmquist (1993) defines content analysis as a research method which examines words or phrases within a wide range of texts. By examining the presence or repetition of certain words and phrases in these texts, a researcher is able to make inferences about the philosophical assumptions of the audience for which a piece is written, and even the culture and time in which the text is embedded. Content analysis is therefore a technique for making inferences by objectively and systematically identifying specified characteristics of messages (Holsti, 1969 quoted in Babbie & Mouton, 2001). Content analysis was favoured for the study because it allowed the researcher an opportunity to make sense of patterns and themes that emerged from the data (Palmquist, 1993 cited in Babbie & Mouton, 2001).

The themes and sub-themes presented in chapter four are as a result of a vigorous data analysis using recognized qualitative data analysis techniques. Coffey and Atkinson (1996) argue that the analysis of qualitative data begins with the identification of key themes and patterns which are in turn dependant on processes of coding data. The authors also maintain that researchers need to be able to organize, manage, and retrieve the most meaningful bits of the data.



In the first stage of the content analysis, data was organized with the help of the Computer Assisted Qualitative Data Analysis Software (CAQDAS). Thereafter, further in depth analysis of narratives added to analysing of the experiences of teachers living with HIV and AIDS. I now focus on the computer assisted qualitative data analysis software used to manage and organize the data.

2.5.1.3.3 Data Preparation for Analysis and Narrative Content Analysis

The data was then entered into qualitative data analysis software programme called Atlas ti.

- **CAQDAS: ATLAS.ti**

Recent advances in computer technology have seen an increase in Computer-Assisted Qualitative Data Analysis Software (CAQDAS). ATLAS.ti was used to help with data organization and management for analysis. Through the use of this technology, the researcher drew themes and sub-themes from the data which were used in the development of the guidelines.

CAQDAS technologies like ATLAS.ti, offer scholars additional ways to conceptualize, manage and communicate their research (Lee & Esterhuizen, 2000; Gibbs et al., 2002 cited in Cousins & McIntosh, 2005).

- **Analyzing Narratives**

The use of computer assisted qualitative data analysis software (CAQDAS) does not come without disadvantages. The researcher learnt that CAQDAS helped with organizing the information for analysis but did not necessarily provide the depth of analysis required. The researcher decided to look at stories and meanings that are produced by data by manually re-visiting the data and themes to get to the core of issues as presented by the diverse group of participants in the study. This method of data analysis was mainly applied to stories of teachers living with HIV.

A process of content analysis or thematic data analysis based on Creswell's guidelines (1998) was undertaken. This involved the following phases and steps:

- Reading through all transcripts, in order to get a better understanding and sense of the teachers' experiences.
- Jotting down first impressions/ideas/concepts in the margin of the text.
- Organizing the data by means of coding and sorting data into themes and sub-themes of a chronicle.

- To understand the participant's construction of reality, the analysis moved beyond content analysis (what was said) to also note the structure and format of the "story" (how it was said). The way in which the experiences and perceptions were conveyed; their interpretations and reflections of the sequence of events and the expressions used to portrait the "story" helped to gain insight into participants' views (Coffey & Atkinson, 1996:83).
- Central generic themes (storylines) that emerged were therefore identified and reported on.

The findings of the problem analysis are reported in chapter 3, and effectively confirm the goal of this phase which can be summarised as the process understanding of the nature and complexity of the challenges experienced by the target group.

2.5.1.3.4 Data verification

Key to this process of data verification was checking for reliability and validity of the collected data. In verification of data, the researcher was guided by the use of validations suggested by Creswell (2007). This aim was achieved through different procedures:

- Triangulation – Data were collected from diverse sources to provide corroborating evidence and to shed light on the research problem;
- The use of technologies (tapes) to record interviews, and I used experienced transcribers to convert the recorded data into text that could be analysed.
- Peer review and external auditing by peers helped with examining the process and product of the account/report.
- Member checks: - The findings were presented to the participants for validation and checking of the interpretation of data in reporting.

By engaging in the above-mentioned activities, the researcher was able to deal constructively and objectively with the issues around trustworthiness.

2.5.2 PHASE 2 OF IDD: INFORMATION GATHERING AND SYNTHESIS

Phase two of IDD is about information gathering and synthesis. In order to fulfil the requirements of this phase, researchers are required to engage in defined operational steps (De Vos, 2005:399), and these are:

- Using existing information sources
- Studying natural examples, and
- Identifying functional elements of successful models.

The researcher engaged in the activities as espoused in the operational requirements mentioned above, and these are further discussed in the following section.

2.5.2.1 Using Existing Information

Access to existing information firstly meant to review the literature for published information on the issue of concern. A literature review usually consists of an examination of selected empirical research particularly relevant to the concern of the study (De Vos, 2005: 399). The author encourages intervention researchers to look beyond the literature of their field since societal problems do not confine themselves neatly to the various human and social science disciplines. Within the context of this study, literature review was conducted on core concepts and issues that could inform the development of the guidelines. To this end the researcher firstly reviewed the literature for the purpose of presenting a research-based rationale for workplace support programmes for employees. Chapter 4 therefore introduces the concepts of work and well-being in the workplace and this informs the rationale for the guidelines.

2.5.2.2 Studying Natural Examples

According to De Vos (2005: 399) *studying natural examples* is about observing how community members faced with the problem being studied have attempted to address it. Companies around Cape Town and Uganda's Ministry of Education and Sport were visited to ascertain how they assist employees/teachers with HIV/AIDS related issues.

The following discussion starts with an explanation of the process of gaining entry to local companies and to Uganda's Ministry of Education and Sport.

- **Gaining access to local companies who have implemented workplace assistance programmes**

The researcher identified companies known to have Employee Assistance Programmes in the city of Cape Town. These companies were purposefully selected and incorporated into the study. In purposive sampling, selected participants are chosen because they illustrate some features or process that is of interest to the study (Silverman, 2000: 104). Creswell (1998) asserts that purposeful selection of participants represents a key decision point in a qualitative study. Creswell further maintains that researchers designing qualitative studies need clear criteria in mind and need to provide rationale for their decisions. In this study, the researcher decided on big companies with well known and established, formal EAP that were considered successful. The researcher looked for typical and divergent data on these programmes. The researcher believed that an analysis and experiences of these programmes would enhance a programme to support teachers.

Initially, the researcher planned to have a once off meeting with representatives of the companies. The aim of that meeting would have been to present the whole study and to ask for voluntary participation in the study. Some companies preferred to first discuss the project with their employers and/or management before a decision was taken to participate in the study. The researcher experienced setbacks with the initial plan

resulting in plan B being implemented where the researcher went to each company and presented the study in an effort to gain support for the study.

Letters were sent to the respective companies requesting interviews with the programme managers. Follow-up telephone calls were made to strengthen the chances of getting permission for the interviews. Presentations on the overall study were done to various companies to support the study and further request permission to conduct the interviews. Only the employee assistance managers of companies that gave permission were interviewed about their companies' programmes. A total of five corporate and para-statal organisations in Cape Town were visited to observe their programmes or interventions to help HIV infected and affected employees. These companies were perceived by the researcher for having some of the best intervention programmes to assist employees infected and affected by HIV and AIDS.



- **Access to Uganda's Ministry of Education and Sport**

The researcher also received sponsorship following a submission of a written motivation to the programme research director, from the Human Sciences Research Council to visit Uganda. The trip was intended to learn more about experiences in that country and their responses to managing HIV/AIDS in schools. The information gained from this trip is incorporated into the study. Also, the information enriches the programmes to help teachers infected and affected by HIV/AIDS.

Uganda was the country of choice because of its reputation for bringing their HIV/AIDS incidence rates down through interventions. The Human Sciences Research Council had previous links with Makerere University, which facilitated easy access to information in that country.

The researcher also enquired from a psychology professor (Prof. Baguma) at Makerere University about the availability of services to support teachers infected and affected by HIV/AIDS in Uganda. The researcher discovered that there exists a comprehensive

programme aimed at teachers. The researcher believed that one could learn from their experiences, and would be able to fulfil the requirements of IDD phase. To structure and guide the process of observing their practice examples.

2.5.2.3 Identifying Functional Elements of Programmes

The researcher planned to do an adapted form of systematic review to identify functional elements of existing programmes. A systematic review refers to a scientific investigation with pre-planned methods and an assembly of original studies as their subjects. Systematic reviews are intended to synthesize the results of multiple primary investigations by using strategies that limit bias and random error. This plan however had to be adjusted due to a lack of formal and published information.

Various information data bases were consulted to try and retrieve peer reviewed articles/information; these included Medline, Cochrane Library, and EBSCOHOST. In addition, the researcher solicited the services of two librarians from the HSRC (Cape Town and Pretoria offices) to assist with information gathering.

In order to guide the librarians on the type of information to be gathered, a search guide was developed with the assistance of the study leader. The search strings/key words were: *HIV, AIDS, teachers, educators, intervention programmes, and workplaces*. The search yielded very limited results with articles not fitting the inclusion criteria. In addition to the above searches, the researcher searched the Cochrane and Campbell collaborations for relevant information. The search included the following search strings/keywords: *HIV/AIDS care and support; HIV/AIDS prevention; HIV/AIDS treatment, workplace*

The guide stipulated the inclusion and exclusion criteria to search for information. This guide was shared with the librarians and subsequently used for identification of relevant information.

The inclusion criteria were:

- All the programmes that responded to the HIV/AIDS epidemic in the workplace in the education sector would be included in the study. Teachers and lecturers were deemed a special group in the study hence a selection of workplaces that were educational settings was imperative. However, in the event of a lack of or limited studies done in an educational setting, the definition of workplace would then include any form of workplace whether business, public or otherwise. Such studies would be considered.
- Studies done within the past 20 years, meaning studies done from 1990 onwards, would be included in the study. It was felt that these studies would provide a wider view of issues that employers looked at to manage HIV/AIDS. Also, these studies would provide a better understanding of the evolution of workplace intervention programmes.
- Both qualitative and quantitative studies were included in the synthesis. It was felt that using the study type as a basis for inclusion/exclusion did not add any value to this study.
- Any programme intended to extend support to employees infected and affected by HIV/AIDS would also be included. This means that studies that focus on prevention, treatment, and care and support will definitely be incorporated into the synthesis. Also, guidelines based on evidence and good practice by world bodies (e.g. ILO, WHO, UNAIDS) on HIV/AIDS in the workplace were incorporated.
- Studies that attempted to evaluate workplace HIV/AIDS programmes would be included. These studies provide a critical analysis of the programme which will help enormously in providing information on what worked well or not with the programmes. Such information would assist in the design and development of the programme guidelines to support teachers. Also, such information would assist in learning from previous programmes and not include issues that did not work, or try and adjust others to suit an educational setting which this programme is aimed at.

- The scope of studies' selected for inclusion was not confined to studies done in South Africa, but across the African continent and the world. Inclusion of studies done all over the world helped with identifying innovations. Since there is no one way of managing HIV/AIDS in the workplace, broadening the scope could only assist in improving the guidelines developed through this study.

The researcher searched in the Campbell Collaboration database for information on reviews done on HIV/AIDS in the workplace encompassing prevention, treatment, care and support. In the Campbell Collaboration database, the researcher searched C2-SPECTR, C2-PROT and related trials registries; and the C2 RIPE library. A special look at the education (5 completed and 14 reviews in progress) and social welfare (13 completed and 32 reviews in progress) coordinating groups yielded no results, and these include completed reviews and reviews in progress.

It was thus not possible to conduct a formal systematic review of existing models and the selection of functional elements of the identified models because of the lack of scientifically documented evaluation of existing models. The researcher then adapted the requirements of this phase by conducting a literature review on issues related to HIV/AIDS in the workplace, specifically models of interventions. The focus was on theoretical information or evidence on the different types of programmes to assist with workplace related personal problems and/or experiences.

Google scholar search was also done to elicit information on HIV/AIDS workplace interventions. The keywords: *HIV/AIDS workplace interventions* were used in this search to get to the relevant documentation. The Google search led to the website of the Family Health International (FHI) which has publications on HIV/AIDS in the workplace.

2.5.3 PHASE 3: AN ADAPTED INTERVENTION RESEARCH MODEL (AIR): DEVELOPMENT

Phase 3 of IDD: Design was adapted to enable the researcher to develop these guidelines. The researcher used an adapted intervention research model suggested by Strydom, Steyn and Strydom (2007:337). The adapted model came about as a result of the authors' observations that researchers either combined or integrated various models in their work. The authors then believed that an adaptation of these models might serve a better purpose.

The fourth phase: Development is proposed in the adapted model. The authors propose that the programme should be developed from data derived from the data-analysis as well as from the results of the literature study on existing programmes. For the purpose of developing the programme guidelines, the researcher used information collected in phases 1 & 2 of the Rothman and Thomas intervention design and design model. The first phase was about collecting data from teachers and presenting the findings. The findings were used in order to gain insights and understanding of the problem under study as experienced by teachers. In phase 2, the researcher conducted a literature study, visits to local companies providing HIV and AIDS related assistance to their employees, and a visit to Uganda's Ministry of Education and Sport. The overall aim of all these activities was to understand and analyse existing programmes and eventually incorporate functional elements of these programmes and avoid repeating mistakes made by others.

2.5.3.1 Information Synthesis and Early Development of the Guidelines

As stated earlier, the researcher chose to adapt the requirement of phase three by synthesising the collected data (empirical and literature review) for early development of the guidelines.

- Information synthesis and early development, and
- Evaluation of the implementation value of the guidelines.

The Concise Oxford English Dictionary (2004:1461) defines synthesis as the combination of components to form a connected whole. This was achieved by combining information collected through literature review, and the empirical study (i.e. best practices, interviews and focus groups). The information from the literature review was used to inform the rationale for having a programme to support teachers infected and affected by HIV/AIDS. The information from the empirical study informed the design of the various elements of the guidelines. The overall output of the information synthesis process was the development of the guidelines which were then evaluated for their implementation value.

The next step was to evaluate the guidelines for their implementation value. The evaluation phase of Strydom et al. (2007:339) guided the evaluation process. Four steps are suggested to complete the requirements of this phase, i.e. programme presentation, data gathering, data analysis and report writing. In deciding on criteria for assessment, the researcher adopted criteria from Hartley (1985 & 1994). Although his work is aimed at evaluation of instructional texts, the participants in the evaluation sessions found the following criteria as most appropriated for an open discussions and also add some more of their own general views. Thematic content analysis (as for the data-analysis described in 2.5.1.3.3) was employed for the data-analysis.

The researcher held three evaluation sessions with the participants and newly appointed school based HIV/AIDS coordinators. There were 12 participants in each session, and accumulatively 38 participants evaluated the guidelines. In addition, the researcher tried to elicit the views and opinions of the managers but was unable to get them into a group. The researcher therefore elicited individual responses from managers who had were willing to look at the guidelines and make their own assessment of them. Only two out of the six managers responded and their opinions are included in the refinement of the programme guidelines.

The participants completed evaluation forms and the gathered information was analysed and findings incorporated in further developing the guidelines. The researcher also took

notes during the open discussion of these guidelines by the participants. The results of this process are reported in chapter 7 of this thesis.

2.6 SUMMARY

Embarking on this research process required specific social science methods to guide the scientific inquiry. The Intervention Research: Design and Development approach was used to guide the research process, therefore providing structure to this thesis.

The key concepts in social science research and research design, as it relates to intervention research, are provided and discussed. The discussion of these concepts served to provide clarity in their usage during the conceptualisation of the study.

The process followed in conducting this research is spelt out, e.g. operational steps in phases one to three. A rationale for only following the operational steps of the first three phases is provided and clarified.

This chapter therefore outlined and justified the methods and processes followed in conducting the study. It therefore serves as a prelude to the following chapters that present the outcomes of the operational steps of the three phases of the adapted Intervention Research: Design and Development model.

CHAPTER 3

TEACHERS' EXPERIENCES OF HIV/AIDS IN SCHOOLS

3.1 INTRODUCTION

The aim of this study was to design guidelines for an HIV/AIDS support programme for teachers. The development of the guidelines within the methodological framework of Intervention Research: Design and Development (IR: DD), requires an understanding of the nature and complexity of the challenges experienced by the target group, teachers in this context. Rothman and Thomas (1994) also suggest that IR: DD in particular is a form of applied research examining relationships between conditions identified by the clients as important and the personal or environmental factors that contribute to such conditions.

Several operational steps are critical to operationalizing the first phase (Problem analysis and Project planning) of Intervention Research: Design and Development. This chapter therefore is a direct response to the requirements of the operational steps for identifying and analyzing the concerns of the population. The rationale of this operational step is to understand the issues of importance to the population thus avoiding imposing external views of the problem and its solutions (Rothman & Thomas, 1994:29). The analysis of the identified conditions that teachers label as community problems is a critical aspect of this phase. The analysis of the identified concerns is infused in the presentation of the findings.

In order to understand the issues of importance to teachers regarding support for teachers infected and affected by HIV and AIDS, the researcher engaged in a data collection process through interviews and focus groups interviews with principals; focus group sessions with HIV/AIDS coordinators in their respective schools; and in-depth interviews with teachers living with HIV/AIDS, using a semi-structured interview guide. The methodology used for data collection is presented in chapter two.

The results of the content analysis of the data are presented thematically with sub-themes as they emerged from the questions posed to participants. The discussion of the results is structured according to these themes and sub-themes. Diverse and differing views of participants will be highlighted. Available published literature is compared with the findings after the discussion of each theme and the chapter is ended with a summary.

3.2 Presentation of findings: themes and sub-themes

The introductory open question asked was: ‘What is happening in schools with regard to HIV/AIDS and teachers?’ The question was asked to get to the inner views of teachers with regard to the extent and nature of HIV/AIDS among teachers in schools. It is worth noting that teachers responded to this question in terms of perceptions and experiences they have of HIV/AIDS related issues among teachers in their areas of work and it was not the intent to get representative views of teachers in the population. Information was gathered from principals, HIV/Aids co-ordinators and teachers living with HIV thus providing varying perspectives on teachers’ experiences of HIV in schools.

3.2.1 Findings Relating to the First Question: ‘What is happening in schools with regard to HIV/AIDS amongst teachers?’

Table 3.1: HIV/AIDS among teachers

THEMES	SUB-THEMES
3.2.1.1 Concerns about apparent HIV infections and deaths amongst young teachers <i>(Principals, school based HIV/AIDS coordinators and teachers living with HIV)</i>	
3.2.1.2 Adapting to trauma of diagnosis and lifestyle changes. <i>(teachers living with HIV and/or Infected participants)</i>	
3.2.1.3 Concerns about disclosure <i>(principals, HIV coordinators and HIV infected)</i>	3.2.1.3.1 Perceived advantages and disadvantages for disclosure <ul style="list-style-type: none"> • Perceived advantages • Perceived disadvantages 3.2.1.3.2 Reasons for disclosure 3.2.1.3.3 Barriers to disclosure
3.2.1.4 Stigmatization	3.2.1.4.1. Stigmatization by others 3.2.1.4.2 Self stigmatization 3.2.1.4.3 Perceived consequences of stigmatization

The following section is a detailed discussion of the themes and sub-themes identified in the above table.

3.2.1.1 Concerns about Apparent HIV Infections and Deaths of Young Teachers

The first theme that emerged from the analysis of the responses of the participants shows that principals and HIV coordinators' first concern is that young teachers seemingly get infected and die from AIDS related diseases. These statements and assertions were however not substantiated. This was largely due to lack of disclosures by the deceased teachers and subsequent rumours about the cause of death of these teachers as the following quotation suggests. However they supported their views by pronouncing their attendance of memorial and funeral services of teachers who succumbed to AIDS-related diseases and public disclosures at the funerals by families. Teachers also based their assumptions on observing physical changes linked to HIV infection and AIDS, especially loss of weight. Some teachers also base the assumptions on observing the rates of absenteeism from work. HIV positive teachers based their acknowledgement of teacher infections with HIV on experience, support and casual meetings when going for treatment and/or therapeutic sessions with the health professionals.

“We do attend funerals of teachers who have died because of AIDS-related diseases or complications. They are dying but before the teacher dies, maybe he/she was sick you know, and dies. We did not know what the problem was but when she dies and the rumour comes up that so and so teacher was infected, so it is really a difficult something. So we hear about it after he dies. You sometimes feel that “eish” that maybe if someone could have talked about it; maybe we were going to support him you know. Or maybe live longer and could not have died sooner”

The HSRC conducted a study to determine the prevalence of HIV among teachers. The study found that 12.7% of those interviewed were HIV positive (Shisana, Peltzer, Zungu-Dirwayi & Louw, 2005). The study also points out that the Western Cape Province accounts for 1.1% of this total percentage. The study concluded that the prevalence of infection for teachers was broadly comparable to the rest of the population. HIV prevalence is lower in the Western Cape than other provinces but is rising.

Deducing from the statements of participants, it can be concluded that there is a number of teachers who are infected with HIV and therefore will in future require support from the department of education as an employer.

The HSRC study (2005) also found that 1.1% of deaths among teachers in 2004 were AIDS-related. Again this is in line with the assertions of the participants that teachers are dying from AIDS-related diseases. Deducing from the responses of the participants and the findings of the 2005 HSRC study, it became clear that the schools are negatively affected and those teachers are not immune from the AIDS pandemic. This would mean that schools need to be turned into centres of care and support for teachers infected with HIV and affected by AIDS.

The finding in a study conducted in Malawi by Muula and Mfutso-Bengo (2005) suggested that it is customary in that country that at funerals, a relative of the dead person is allowed to speak to inform mourners regarding the cause of the death. The authors further suggest that the benefits of public disclosure of HIV/AIDS diagnosis of the dead person include the fact that all people who come to the funeral are 1) aware of the cause of death, and 2) the mourners will be able to appreciate that HIV and AIDS are real and that they can result in death.

“Most teachers just pass away without disclosing or telling the principal, it is just disclosed at the memorial or funeral service by their families”

HIV/AIDS threatens to destroy decades of investment in economic and social development (UNESCO, 2002). In addition, the investments in education are also threatened by the pandemic. The AIDS pandemic presents particular challenges to the education sector, not least by hindering its capacity to deliver quality education for all. The human resource base (teachers in this context) is increasingly eroding with about 12.7% of deaths were AIDS related (HSRC, 2005). The assumption here is that teachers would have been ill and away from school well before their death.

This implies that the rate of absenteeism due to illness among teachers is high. In 2005, 10.6% of public school teachers were hospitalized over the previous 12 months, implying absence from school due to illness (Rehle & Shisana, 2005).

Rehle and Shisana (2005) also found that 59.8% of teachers frequently visited health care practitioners in the previous five months, which the authors claim the statistical figure suggested that 75% of teachers have seen a practitioner in the last six months. Among HIV positive teachers, 17.1% were reported being away from work for more than ten days in the previous year compared the 13.8% of HIV negative teachers in the same study. It is therefore without doubt that teachers and schools are really in need of support to assist them to cope and deal effectively with the inevitable impacts of HIV/AIDS on teachers and the schools.

There is also a perception and concern among principals and HIV co-ordinators that HIV infects young teachers and this could lead to a generation gap in available teachers. Because of this perception that young teachers are mainly infected with HIV, there exists a general sense of urgency that the education department must do something to assist these teachers and mitigate the potential negative impacts of the pandemic on teachers and the education system. There is also a sense of urgency to do something because teachers are dying. The underlying tone was that teachers are perhaps not receiving the required assistance from the Western Cape Education Department.

“Something drastically needs to be done by the education department because HIV/AIDS is infecting the very, very young teachers. The young teachers so to speak, and if nothing is done there is going to be a generation gap. The department needs to do something seriously about it. Otherwise really teachers are dying out there”

The HSRC study found that the prevalence of HIV infection to be in the young age group of teachers, which is consistent with the assertion of participants in the study. Rehle and Shisana (2005) performed the estimates for the baseline scenario without ART, which also took into account the specific HIV age distribution of the educator population in

2004. The results of the estimates suggested that 8.3% (3 976/48 161) of HIV-infected educators, or 1.1% of the total educator population (356 749), died of AIDS in 2004. Almost half (48.7%) of the estimated 3 976 AIDS-associated deaths in educators were concentrated in the 35–44 age group. The results of this study suggest that young teachers, as asserted as well by the participants in this study, are dying from AIDS related diseases.

3.2.1.2 Adapting to Trauma of Diagnosis and Lifestyle Changes

Contrary to the responses of principals and HIV/AIDS coordinators, HIV positive teachers, although acknowledging that some teachers are infected with HIV and possibly dying from AIDS related diseases, were more concerned about how the disease has changed their lives and the implications thereof. HIV positive teacher professed that his priorities kept changing as a result of HIV infection. Knowing about the infection caused the teachers to look at priorities in their lives and rearrange their plans.

For the HIV positive teachers, learning about their HIV positive status came as a big blow such that HIV infection could be labelled as trauma. They initially perceived their future as very bleak and thought they would soon die from the disease. However, the introduction and availability of antiretroviral drugs (ARV) could bring hope with regard to living life longer. The teachers echoed a sense of despair and non-existence of hope that there is still more to life beyond infection with HIV. Sowell et al (1997) have found in a study on rural women with HIV that disclosure was their greatest concern. Fuelling the concern was deteriorating health status and wellbeing which caused preoccupation with dying. Similarly, the HIV positive teachers were concerned and preoccupied with the thoughts of dying.

“I saw my future as bleak” and the other teacher said “My priorities are changing every now and then. I do not know which is the best or the worst to apply for this traumatic infection. Since I was diagnosed I have been watching myself from morning to evening praying to God to spare me a life to live”

Literature on posttraumatic stress disorder following a diagnosis of a life threatening or highly stigmatized disease suggests that receiving a diagnosis of HIV is traumatic and may potentially cause or exacerbate existing mental health difficulties (Radcliffe et al., 2007; Stuber & Shemesh, 2006).¹ The quotes stated above simply confirm the views of these authors.

3.2.1.3 Concerns about Disclosures

Understanding the concerns about disclosure is important in managing HIV/AIDS in the workplace. Both principals and HIV co-ordinators are concerned with the lack of openness about the teachers' HIV status and its related factors such as lack of disclosure. Teachers still do not talk about HIV/AIDS, despite the assumed high levels of knowledge of the disease teachers possess. Seemingly, the situation therefore lends itself to the denial of the existence of the pandemic in the education sector or even infection of teachers with HIV. Anecdotal information from some teachers is indicating that some teachers prematurely leave the profession as a result of stress related to infection.

Disease progression theory suggests that individuals disclose their HIV diagnosis as they become ill because when HIV infection progresses to AIDS they can no longer keep it a secret (Talisman, 1995). Disease progression often result in deteriorating health and hospitalization, and the concerned person would have to explain their illness to others. Teachers may choose not to disclose to their colleagues because they do not see the need to divulge their HIV diagnosis to their colleagues while the sign and symptoms are minimal.

Kimberly et al, (1995) believe that the first step of the disclosure process is adjusting to the shock of diagnosis. The women in this study needed more time to make personal adjustments to their diagnosis before telling others. The duration of adjustment to the diagnosis may vary and ideally determines the time one would take to disclose the HIV

¹ Post-traumatic stress disorder is defined as a constellation of psychological and physiological symptoms that are persistent in some individuals who have been exposed to a traumatic event (Stuber & Shemesh, 2006).

sero-status to others. It might therefore be possible that the time and length of adjustment to the diagnosis by HIV positive teachers, with some even dying before telling others, could be construed as contributing to the lack of disclosure.

“There is very little talk about what is going on, only when a teacher dies then there is a rumour that the teacher was HIV positive.”

“In September last year, there was an ELSEN teacher who was servicing this school and another primary school; she died from AIDS related diseases. But HIV/AIDS is not something that we talk about or discuss. We forget about it. People are still in denial about it.”

The HIV positive teachers support the above views by noting that revealing an HIV positive status to other teachers is a risk taking exercise as there are no guarantees of confidentiality following a disclosure. However, there is an expectation and pressure from colleagues to disclose their HIV positive status. They also expressed lack of trust of colleagues in disclosing such vital personal information that may impact badly on them and their image given the current working environment in schools that is not conducive to such disclosures. Prevalent and enduring gossiping among teachers makes it unsafe to disclose one's HIV positive status to colleagues.

One way to conceptualize reasons for disclosure or non-disclosure is with the *consequences theory of HIV disclosure* (Serovich, 2001). This theory suggests that persons with HIV are likely to inform significant others once the rewards for disclosing outweigh the associated costs. It insinuates that as the disease progresses, stresses accumulate which result in the need to evaluate the consequences of disclosure.

It is at this time that an HIV positive person weighs the advantages and disadvantages of disclosing to others. The quote below supports the views expressed in the consequence theory.

“In the first place, it is not easy to disclose. It is like confiding things, to confide is a risk, and if you confide to somebody and you have that trust in that person and if the person goes out and tell other people about your problem, then that person is destroying you”

It would seem from the above quote that if a person deems that disclosing his/her HIV diagnosis might lead to the concerned person telling others without getting consent, they may find it difficult to disclose their HIV sero-positive status to colleagues. The environment is thus not conducive to disclosure if there is no guarantee of confidentiality.

The principals and HIV/AIDS co-ordinators observed ambivalence, in the presumed HIV positive colleagues, about disclosing the HIV status to colleagues. On the one hand they want their colleagues to disclose their HIV positive status so as to provide the necessary support to them. On the other hand, the very same teachers expressed concern over a lack of confidentiality and stigmatization of HIV positive teachers by fellow colleagues. Service (2001) asserts that disclosure is a necessary prerequisite for acquiring support, and revealing one's sero-status becomes an important mental health factor. The author further asserts that persons experiencing stress who also disclose feel better emotionally. Furthermore, suppressing thoughts or communication about difficult experiences can increase the likelihood of stress-related problems.

“Teachers do not disclose that they are suffering from HIV/AIDS”

It is alleged by both principals and HIV co-ordinators that their (ex)-colleagues kept silent about their HIV status to colleagues. This was largely due to inability of some teachers to maintain confidentiality. This reflects the persistent distrust about breaches of confidentiality that exists among teachers. The teachers in the focus group sessions seem to think that fellow teachers cannot be trusted as they may spread rumours about the status of another teacher.

“If a person has got a problem, I have an open door policy because some teachers off cause just come and talk to me about their problems because I am also hear to listen to

them and assist them because at the end of the day if I do not know what is bothering the teacher I will not be able to know why a teacher is behaving in a certain manner. So in this particular case, it is really difficult to go to this particular person I personally think teachers as professionals it seems it is an embarrassment when one comes to the principal and say I am suffering from this(HIV) and the colleagues will obviously say things.”

A perception exists among teachers and principals that HIV status disclosure following a test provides potential benefits for teachers and yet the level of disclosures among teachers remains low. In a social context where HIV/AIDS remains mysterious and HIV-related stigma prevails, decisions regarding disclosure may be influenced by concerns over possible negative influences (Yang et. al. 2006). Omar (2000) argued that disclosure often involved risk, particularly when the information revealed was potential embarrassment, negative or emotionally intense. The decision therefore to disclose HIV status involves a cognitive appraisal of negative consequences that is based on an individual's knowledge of HIV, attitudes towards HIV/AIDS or HIV-related behaviour and perceived social attitudes towards people with HIV. As expressed in the quotes above, it is insinuated that teachers do not disclose because the diagnosis with HIV is an embarrassment and also the perceived inability of colleagues to keep information confidential.

It has been found in this study that the disclosure of HIV status to colleagues and/or workplace created a big challenge for teachers, and some teachers resort to leaving the teaching profession. This finding is in line with Caulfield et al.'s (1994) finding that concern about disclosing HIV status at work created great stress for individuals and frequently caused them to leave their jobs rather than disclose their status. Concerns that may prevent an individual from disclosing at the workplace include fear of discrimination, harassment, and anxiety about losing health benefits (Hays et al., 1993). Another concern is the possibility of losing opportunities for advancement, because the individual's future might be viewed as tentative (Harmon, 1992). It is therefore

imperative to address these perceived fears by the teachers and help teachers to remain in the profession.

Only one HIV positive teacher disclosed his status to his principal, and it was because the teacher wanted to disclose his HIV status to all teachers in school. This teacher was however hindered from disclosing his HIV status to all teachers due to fear of lack of confidentiality. Two teachers made full disclosures to colleagues, and this was because their physical condition was deteriorating and there were rumours in the community that they were HIV positive. These teachers succumbed to pressure to disclose their status to their colleagues. Disclosing one's HIV status was also viewed as risk by one teacher because of prevalent hearsay and gossiping among teachers.

Dealing with disclosures is also an important component of the programme to increase awareness and strengthen educational activities in an effort to fight the spread of the disease. Teachers can certainly play a crucial role in this fight. The guarantee of confidentiality seems to be the defining factor in disclosures. However, the values and status accorded to teachers also play a crucial part in whether teachers would reveal their status to the colleagues. The above factors need careful consideration and the spin offs from such a programme could be positive for the overall management of HIV/AIDS in the workplace.

The situation forces the department of education to look at employee benefits and how best these can be utilized to support the teachers infected with HIV. Seemingly in this study, there is an advocacy led by principals for boarding of teachers when the illness reaches the terminal stages. The lack of disclosures by teachers of their HIV positive status should be acknowledged as it continues to be a major obstacle in the fight against HIV/AIDS.

The researcher's difficulty in getting HIV positive educators to participate in the study despite using the snowballing technique to get to target group, was complicated by both selective or partial disclosure and stigma attached to the disease by the potential

respondents. On follow up, the potential respondents indicated their lack of readiness to talk about the illness and their experiences coupled with stigma and a sense of shame and guilt there were experiencing. The researcher's experience clearly shows how difficult it is to get teachers to divulge their HIV status due to both internal and external factors like stigma.

Indeed, the lack of or partial disclosures of one's HIV positive status makes it difficult to understand the extent of the pandemic, and most importantly how the disease plays itself out in the education sector. It also hinders and thwarts the efforts to effectively deal with impacts of the disease on the education sector. This is an issue that clearly needs careful attention from people developing programmes to support teachers infected by HIV and affected by AIDS. An enabling environment becomes crucial if support is to be given to teachers especially with regard to encouraging and facilitating disclosure of HIV seropositive status.

It was evident in the study that teachers do not necessarily disclose to the principal, which put principals in an awkward position in terms of accommodating teachers infected with HIV in the school setup. It implied that principals are not necessarily the persons that the HIV positive teachers disclose to. Assurance of confidentiality was cited as one of the determinants for disclosure, of which principals were perceived to be unable to provide guarantees for confidentiality.

3.2.1.3.1 Perceived Advantages and Disadvantages of Disclosure

- **Perceived Advantages**

One of the advantages of disclosure noted by the principals is better interaction and understanding of the teacher's problems and the offer of assistance where required. This would enable the school principal to better interact with the concerned teacher and in turn improve relations with the teacher and act accordingly within the "new" working relationship.

Although the principal indicated the need to divulge HIV sero-positive status, there is a sense that a committee consisting of other teachers might be the one providing support instead of the principal. This perception can be linked to the principals' expressed need for empowerment regarding counselling and management of HIV/AIDS at school.

“I think it will be much easier if one could come out so that he or she can get the necessary support from the committee because we do have a co-ordinator. I think it would be easier for her, the one being infected, to be given the necessary support although I know it is not something that is very easy to come out”

“If I could get the teacher to disclose, my dealings with the concerned teacher would be better. I would know how to work with the teacher”

The disclosure of HIV status is also viewed as a way of easing the burden on principals and the staff alike, and an opportunity for the infected teacher to receive the required support. It also provides an opportunity for the principal to understand the core of the problem thus better understand poor performance of a teacher as a result of the illness.

“I believe that if you do not perform optimally, you have problems. So it is very important as non-performance is affecting school work. If one has a problem one has to confide to the HOD, deputy principal so that we can understand exactly what the problem is with that teacher because when you understand the teacher's problem you also understand why the performance is not optimal. It's where you give this person support”

Contrary to the above-mentioned perceived advantages of disclosing as perceived by both principals and HIV/AIDS co-ordinators, the teachers infected with HIV saw disclosure as taking a risk of exposing themselves to many dilemmas including gossiping, lack of confidentiality and stigmatization. However, they too recognized the support received from fellow colleagues on revealing their HIV positive status. These teachers received emotional support from colleagues. One teacher mentioned being reminded by colleagues of deadlines and performance of important duties assigned to her.

“When you are HIV +, you become very forgetful and once I forget a teacher will remind me of expectations on certain dates for assessments for example. They always remind me two weeks before the time. So they work together with me”.

Another perceived advantage of disclosing HIV status was **provision of support** by sympathetic colleagues. Some of the HIV positive teachers who disclosed their HIV positive status to colleagues reported receiving emotional support from colleagues. The HIV positive teachers also expressed an understanding mainly by principals and heads of departments by allowing them time off to go for medical check ups and treatment. Beyond support received at school, the teachers also get support through the support groups that they attend.

“I do have support from a group of teachers called “HIV/AIDS awareness co-ordinators”, we are from different schools. We go to meetings and talk about AIDS related issues. In that group, it is not only HIV positive teachers who attend but a mix of teachers. In that group, I find love and people who understand HIV pandemic and people who know what they want. I also have lots of friends who support each other. So there is absolutely nothing challenging to me about support systems. Also I have friends around who are positive and supporting me well. My family as well, at least everybody seems to be there for me”

HIV/AIDS co-ordinators indicated that there is some improvement with some teachers disclosing their status but the number is still very small. There seemed to be an understanding though of the complex and difficult nature of HIV infection and AIDS, and related disclosing of one’s HIV status. This assertion in the improvement in teachers disclosing their HIV status is contrary to the feelings of principals who want teachers to disclose their HIV status so that they can be in a position to help. Principals feel that their hands are tied in terms of helping HIV positive teachers due to lack of disclosures. This implies that the teachers who disclose their HIV status are not necessarily disclosing to their principals.

- **Perceived disadvantages**

One of the expressed disadvantages of disclosing HIV status is rampant **gossiping** among teachers. Even though there is a call for teachers to disclose their HIV status, there is also a realization that teachers themselves do not make things easy for their colleagues to disclose because of gossiping and potential spread of rumours which could translate into a lack of confidentiality following disclosure. It should also be noted here that the HIV/AIDS co-ordinators were not sure about their reasons for wanting the other teachers to disclose their status. There was constant use of the word “support” without further explaining the meaning of it within this context. The following quote captures the views expressed by the HIV/AIDS coordinators.

“there are teachers who are HIV positive but the problem is that they cannot come out because they have got problems with other teachers who will go and spread the rumours wherever. So they become afraid of coming out and disclosing their status”

On the contrary, principals wanted teachers to disclose to 1) understand how these teachers are impacted by the disease, 2) accommodate teachers at school, and 3) enable and allow them to manage the schools effectively.

“I think my hands are cut off because I cannot just go to him/her and say what your problem is really? Teachers simply do not disclose their status to me as a principal. In this particular case, it is really difficult to go to this particular person. Even though I feel I want to go to this person and comfort her and say a few supporting words, but it’s difficult. Sometimes the teacher is valuable and goes out of the way to help learners or do tasks at school. It is said that it is upon the person to come and disclose, if the time has not yet come - that is killing, that is killing. I understand the issue of time but at the end of the day the person should not just keep quiet because by coming forward there are people and I am here to help people and the HIV positive teachers need assistance and support from others”

All the participants were left pondering on what might have been if a teacher disclosed his or her status to them. There was a sense that it is too late for those teachers who already passed on, and hinting that support could be provided if a teacher disclosed his or her status. The feeling was that the dead teachers failed to seize the opportunity for possible support, of whatever nature, that could have been provided to them by not disclosing their HIV status. It puts principals and teachers in an awkward position when the HIV status of a teacher is only revealed in a memorial or funeral service.

“I support my colleague but there is a difference now. Some teachers do disclose but really not most of them. Teachers are still struggling, but as you are saying that we have seen that there is something because of absenteeism that we are experiencing in our schools. Really you can see that there is something although people are not open to talk about their status.”

Some HIV/AIDS coordinators echoed a sense of bewilderment and despair at the lack of disclosures among teachers as reflected in the quotation below. The teachers also expressed a strong sense of hurt and emotion on the death of teachers to AIDS related diseases. Also, it could be that the teachers left behind by the dead teachers are consumed with guilt for not supporting their colleagues in their times of need. They described teachers as dying quietly without receiving any support due to lack of disclosures. The teachers lamented the need for teachers to disclose their HIV status so that the necessary support could be provided.

“Ayah, really this is a big problem, teachers do not talk and teachers are dying quietly. There is nothing they are saying and I really do not know why, I really do not know why. We also have schools where you will find that there are more than three teachers that already died of AIDS [related diseases]. There are schools we know for a fact that teachers have died and in all we still have a low percentage of teachers disclosing.

The reason why we can say this is because of what we have seen and the awareness given to us and the knowledge we have gained about the disease, then we able to say that this

one has been suffering for long, maybe you start to take that long illness and align it to one of the opportunistic diseases”

As much as there is an expressed need for disclosure of HIV sero-positive status, lack of **confidentiality** is regarded as one of the barriers in the battle against HIV/AIDS. The principals are pressing for HIV positive teachers to disclose their status so they could be in a position to offer support. Some principals also advocate for the teachers to rather disclose their status to them as opposed to friends where confidentiality is not guaranteed. However,

“I think that the problem lies there because if a teacher discloses to the friend, there is no guarantee that the friend will not tell someone else. Teachers in schools, some despise others. Instead of supporting, they will say words negative about this person and that is something that is happening in schools”.

HIV/AIDS co-ordinators implied that principals are not necessarily the right persons to disclose one’s HIV sero-positive status in schools because of their inability to maintain privacy. There was a lament from HIV coordinators that if the principals want to reveal the HIV status of a teacher, they must seek permission from the teacher concerned. The HIV positive teachers also supported this view.

“However, principals should keep the information confidential. If they need to tell someone else, then permission from the concerned teacher should be given”.

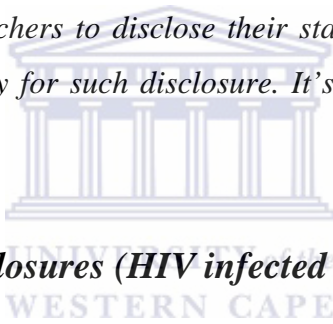
All the teachers in the study realized that schools are centres of gossip, which might cause HIV positive teachers to feel very uncomfortable disclosing their sero-positive status because confidentiality of information is not guaranteed.

“Gossiping is a daily occurrence in the schools and that teacher might really feel uncomfortable”.

It is really confusing to HIV positive teachers in a sense that they seem to understand the importance of informing colleagues, but confidentiality is yet again a crucial factor determining the disclosure to colleagues. However the insurmountable pressure put on teachers to disclose their HIV status is regarded as counterproductive when considering the emotional impact the knowledge of HIV infection may have on teachers and might not be emotionally ready to come out about their HIV status.

“If an HIV positive teacher discloses to me as a principal, I will be in a better position to know the needs of the teacher and I could support him or her in whatever way”

“Confidentiality is a big problem at schools. It is actually not guaranteed no matter how you look at it. Colleagues need to know about your status and within no time everyone knows. It puts pressure on teachers to disclose their status and at the time the teacher might not be emotionally ready for such disclosure. It’s a catch 22 situation really for me”



3.2.1.3.2 Reasons for Disclosures (HIV infected teachers)

Only three of the HIV positive teachers interviewed indicated that they had disclosed their status to their colleagues or principals. The first teacher saw a need to tell his colleagues to avoid them getting to know about his status from other people not working with them. The teacher also felt a sense of responsibility to let his colleagues know about his status. Beside these the teacher also felt a sense of obligation to do so because of the support that he received from his colleagues in general at school. The teacher was also definitely under tremendous pressure from outside forces to disclose his status to colleagues because of the rumours that were already going on in the community about his HIV positive status.

“I disclosed my HIV status because I was looking at the way of letting them know that I am HIV positive, letting them know that I was in this problem now. And not hear about it through the hearsay whereby it was going to be unfair on them to hear about it from

outside the school. They are working with me and are doing a lot for me. We are colleagues and working together. So I wanted to start with them first so they could hear about it from the horse's mouth"

In outlining reasons in support of disclosure, Mailer (2003) believes that disclosure would promote trust among colleagues, between teacher and the school manager, promote proper human resources management, and prevent speculation which could be harmful to the infected teachers.

"I was under a lot of pressure to disclose because this thing was going out in the community that I was sick and I was having this sickness and all those things. I did not have any problems telling them and I also did not have any problems with them accepting my status because I could see as well that they understood, believed me and they still assured me that they are still going to be friends with me. There were not going to be changes at all"

Contrary to the above, the other teacher disclosed his status to the school principal with a view to telling all the colleagues before being stopped by the principal from doing so. The principal voiced the concern about confidentiality that was not guaranteed if/when the teacher decided to disclose his status.

"The difficulty I experienced was around disclosure of my HIV positive status to colleagues. The difficulty was about my principal who said to me that she cannot see how I am going to disclose in front of all these people. She said that it is going to be difficult because other teachers are alcoholic and when they are enjoying themselves wherever they are, they would start talking about me and my status"

The third teacher disclosed her HIV positive sero-status because she could no longer hide it to colleagues. This was due to physical appearance changes, and secondly being absent from school for long periods due to illness. The teacher also remained away from school in order not to infect learners and colleagues with tuberculosis. The above situation

supports the views of progression theory as a reason for disclosing one's HIV positive status. Progression theory says that with the progression of the illness, one would be forced to explain his/her illness thus forcing a person to divulge his/her sero-positive status.

“I was very sick and I lost a lot of weight. Physically, one could see I was sick. I had all the opportunistic infections like TB, rash, thrush – you know these opportunistic infections. I stayed at home in order not to infect my learners and colleagues with TB especially. I only came back when I was put on treatment and feeling better. I was also at a stage where I could not infect anyone because of the treatment.”

3.2.1.3.3 Barriers to Disclosure

The high professional status accorded to teachers and the teaching profession by the community is presented as one of the barriers to disclosure by teachers. Seemingly teachers, by virtue of their acquired knowledge and status in the community, are expected to be vigilant at all times especially with illnesses that are classified to be the consequence of one's behaviour would affect one's health status eternally, such as HIV/AIDS. The community sentiments or perceptions about teachers and their position in the community/society play heavily on whether the infected teachers would disclose their HIV positive status.

“Yes, I think so it goes with the status as well because a teacher is regarded as a highly educated person so he/she must be able to know things that are going to affect his/her health so this one has no professionals, it is affecting people irrespective”.

The teachers feel embarrassed to reveal HIV positive sero-status to other teachers. This is potentially damaging to the status of the teacher and certainly creates an opportunity for gossiping by other teachers. This as a result of the well established perception and/or stereotypes in the community and perhaps in the teaching fraternity that HIV does not infect professionals like teachers.

“Well, I personally think teachers as professionals it seems it is an embarrassment when one comes to the principal and say I am suffering from this [HIV] and the colleagues will obviously say things. It is still regarded as a taboo thing. As a disease that cannot affect professionals, so that is why some teachers rather keep that within themselves”.

The above quote also points to the prevailing AIDS related stigma that still exists. Mailer (2003) asserts that stigma is exacerbated by attitudes that people have against HIV positive teachers. The negative attitudes emanate from the association of HIV positive status to promiscuity. These attitudes serve to perpetuate non-disclosure of HIV positive status thus making efforts to normalize and fight the disease very difficult.

Fesco (2001) has found in her study that the nature of work environment and co-workers was such that the workers could not share their diagnosis. A few studies concerned with disclosure in the workplace that have found that the majority of individuals did not tell their employers or co-workers (Simony, Mason & Marks, 1997; Sowell et al., 1997). When HIV positive individuals did tell people in the workplace, they were selective about whom they told and may not have disclosed to everyone (Sowell et al. 1997).

Problems with disclosure are compounded by the dilemma of who should be informed at school (Maile, 2003). The Western Cape Department of Education lacks a policy or a framework which school managers can use to facilitate disclosures. However, it would seem that the school principals are the persons to inform although it has been found in this study that the school principal is not necessarily the preferred person to disclose to in the school environment. The national department of education policy on HIV/AIDS for educators compels teachers to disclose their status, and disclosure to the third party be with a written consent of the concerned teacher, and unauthorized disclosure to a third person will give rise to legal liability. The policy is silent on who should handle disclosures at school.

The above findings and discussions on the issue of disclosure seem to indicate that dealing with disclosure is one important element to promote especially when trying to deal with HIV/AIDS in the workplace.

3.2.1.4 Stigmatization

Stigma and stigmatization are vital components in understanding the experiences of people regarding HIV and AIDS. Stigma lies at the core of winning the battle against the AIDS pandemic. This is because stigma influences the internal mental processes about the strong societal perceptions of the issue at hand, and decisions that people take about disclosing their HIV status (Cradle & Coleman, 1992). As it is known that HIV and AIDS are still highly stigmatized in South Africa, and this situation could lead to the preceding factors taking place at an individual level. Teachers perceive and experience HIV at various levels that are discussed next.

3.2.1.4.1 Stigmatization by Other Teachers

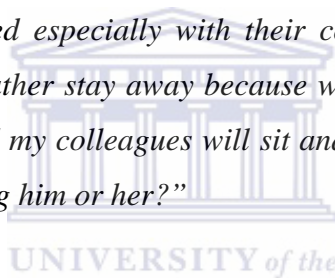
The data shows that stigmatization is one of the issues teachers infected by the virus have to deal with. The teachers in the focus group sessions felt overwhelmingly that HIV positive teachers are stigmatized by ignorant fellow colleagues who are insensitive to feelings and emotions of the infected teachers, and the complexities and challenges posed by the disease.

The teachers expressed how teachers who lose weight, as a result of other causes, are deemed HIV positive by other teachers. This misconception seems to be a major cause of the rumours and bad talking about the teachers. The situation seems to be a contributory factor to the lack of disclosures among teachers. There is a strong sense that teachers are stigmatizing other teachers without any medical proof of a person's HIV status or disclosure of HIV positive status. The teachers had a strong sense that teachers need to change their attitudes and are very stubborn. Without attitudinal change, teachers will continue stigmatizing their colleagues.

“One other thing is that at times we misjudge other people. Immediately when you see somebody dropping weight, maybe a person is dropping weight because he/she is facing stressful things. Just because we know that dropping weight is linked to an AIDS sufferer, you start talking bad about that person. Mom, such things you know. They do not disclose because of our attitudes, ayah, I think so. We do not want to change, we stigmatize people”

There is also a perception that a person who contracts HIV was sexually promiscuous. Because the contraction of HIV is strongly linked to sexual practices this makes disclosure even more difficult. The teachers lament that this is not always the case and there are other forms of contracting the disease that are often overlooked.

“Yes, they are feeling ashamed especially with their colleagues. That is what I have detected, so a person would rather stay away because what are my colleagues going to say, rather than disclosing and my colleagues will sit and gossip. How are they going to take that as a means of assisting him or her?”



“If you contract HIV you were sleeping around. That is the thing; you cannot just have HIV unless you were sleeping around. They do not look at other angles of contracting the disease. Uziphethe kakubi xa unje, mmm uziphethe kakubi xa kunje¹.

3.2.1.4.2 Self-Stigmatization

The teachers, especially the HIV/AIDS coordinators reckoned that the infected teachers also stigmatize themselves making it difficult for other teachers to support them in school. It was stated during interviews that the infected teachers tend to isolate themselves from others, and most importantly do not disclose their status to their colleagues. It is perceived that the infected teachers are also feeling ashamed of their HIV status, which might be due to factors mentioned in the preceding bulleted point above.

¹ Literally translates as “you carry yourself in a wrong manner if you find yourself in this situation”. However, this means the person was sexually promiscuous.

However, it was also noted that the school environment is still very hostile towards teachers infected with the virus hence some teachers find it extremely difficult to interact and share their plight with other teachers.

The existence of mistrust among teachers and colleagues hinders the HIV positive teachers from disclosing their HIV status and consequently leads to self-stigmatization.

“It is very difficult for me to come out because of stigma and how I am going to be treated by other educators. You find that although we are all working together, working in teams but there is still that mistrust among the staff members”

3.2.1.4.3 Perceived Consequences of Stigmatization

Stigmatization is so overwhelming for some HIV infected teachers, as described by one principal, that one of her staff members resigned from teaching due to fear of stigmatization. It is worrying to find that some teachers opt to leave such an important profession such as teaching because of AIDS-related stigma. It also seems that no matter how great the effort taken to convince the teacher to stay in the profession, the fear was just overwhelming and unbearable. Galvan et al. (2008) believe that HIV-related stigma is associated with a number of negative consequences including being labelled and stereotyped, separation from others, loss of social status, and being a recipient of actual discrimination and prejudice.

“I do not know how many times I tried to convince her to explore other avenues unlike just resigning but that was in vain. I think something was really growing, she was just running away from her colleagues not wanting to be seen. She should rather be seen whilst outside and not inside the school. So I think she thought that the only route she could take was just to exit”

A principal was heartbroken and hurt to see a seemingly bad physical condition of one teacher, who despite efforts to convince the teacher to stay in the profession took a

decision to leave. Stigmatization also seems to have another effect in terms of lowering the number of teachers who actually disclose their HIV positive status. The perceived high levels of gossiping among teachers further complicated the disclosure and/or lack of disclosure of positive HIV status.

“I met her and I was so heartbroken to see her condition (held her tears back really hurting), and what she said to me is that it was better for her to resign before her colleagues could find out. That was the end of the conversation. It is stigma I am talking about. She decided to leave the profession because she feared being stigmatized and I am very sad”

As reflected in one of the quotations, the HIV positive teachers are even scared of telling their principals because they are not sure whether the principal will tell other people about their status and/or medical condition. It also came out that HIV is still linked to death hence very difficult for some teachers to accept their medical conditions.

“I think that stigmatization contributes to this. And the teacher is really so scared to open up and not knowing if the principal is not going to tell somebody else perhaps about the problem. I am just speculating, because I do not know what really the issue is”

“I suppose they are not accepting the illness because the illness is connected with death, some people think if they are HIV they are going to die”.

Stigmatisation whether self imposed or by others, is rather crucial when designing a support programme within the context of the education department. Stigma takes two forms, perceived or enacted (Galvan et al., 2008). Perceived stigma refers to the subjective awareness of stigma, whereas enacted stigma refers to overt acts of discrimination and hostility directed at a person because of his/her perceived stigmatized status (Steward et al, 2008). The authors add the third dimension of stigma which centres around the extent to which stigma is internalized. Stigma has negative meanings applied to it through social interaction (Herek, 2004). Those stigmatized are accorded an inferior

status in community, and it challenges the coping strategies of the stigmatized group. For teachers, the situation could bring about conflicting ideas about their status in the community and lack of appreciation for their educational achievements.

Persons living with HIV encounter intense and often unrelenting psychological and social stresses over the course of the illness. Among these stresses is HIV-related stigma, which occurs at all phases of HIV disease and can interfere with coping and adjustment (Crandle & Coleman, 1992). With regard to the HIV/AIDS pandemic, HIV related stigma refers to prejudice, discounting, discrediting, and discrimination directed at people perceived to have HIV/AIDS, as well as individuals, groups and communities with which they are associated (Hongjie et al, 2006). The results reveal that stigma manifests in avoidance of contact with fellow colleagues and eventual resignation from teaching. Intuitively, the education system loses out on possibly experienced teachers. The public service yet again loses out on people with the requisite skills and expertise to carry out the mandate of the education department.

As Hongjie et al (2006) puts it, public stigma is the stigmatizing attitudes or reaction that the general population holds toward persons with HIV and their family members. The teachers fear to come out with their HIV status due to fear of the reaction and possible stigmatization by fellow colleagues. Although teachers are working as a collective, there seems to be an element of mistrust among them when it comes to HIV/AIDS-related issues in schools.

Understanding self-stigmatization and stigmatization by others is crucial in designing programmes to contribute towards the fight against HIV/AIDS. However, the results show that if the environment in the workplace is less stigmatizing and conducive to disclosures more people are likely to disclose their status. This in term will help with the normalization of HIV and AIDS in the workplace. It may also contribute towards improving the self-esteem of the affected workers. The possible spin off from this ideal situation is increased levels of productivity among workers.

AIDS stigma must be acknowledged and reduced to increase the rate of self-disclosure of the HIV positive status to significant others and thereby promote HIV prevention and HIV/AIDS care in a variety of settings worldwide (Kumar et. al. 2006).

3.2.2 Findings relating to the Second Question: What are the perceived impacts of HIV/AIDS in schools?

Table 2.2: Perceived impacts of HIV/AIDS in schools

THEMES	SUB-THEMES
3.2.2.1 Absenteeism and consequences	3.2.2.1.1 Increased workloads 3.2.2.1.2 Increased tensions between teachers 3.2.2.1.3 Work backlog, consequent impacts on children 3.2.2.1.4 Curriculum delivery and planning
3.2.2.2 Difficulties with policy application/implementation	3.2.2.2.1 Sick leave policy 3.2.2.2.2 Substitution of teachers

3.2.2.1 Absenteeism and Consequences

A teacher who is absent through illness or any other cause or who leaves teaching because of persistent illness is lost to children whom she/he would have otherwise taught (Bowers, 2001). Whether teachers take a volitional decision to stay absent from school or it is forced by the illness, the teachers’ absence from school must have an impact on children. Teacher absence may lower the quality of education and the children’s school experience may deteriorate.

All the participants reckoned that one of the most challenging issues posed by the AIDS pandemic in schools is teacher absenteeism. The continuous extension of sick leave by the concerned or possibly HIV positive teacher makes it difficult for the school principals

to plan properly to ensure that quality education is provided to learners. The situation therefore interferes with the planning and operational functions of the school.

“Absenteeism is a big problem. For example here at school, I have a teacher who was absent since June 2004 and she took leave for three months, then she kept on extending but there were symptoms if I can just be honest”²

Absenteeism due to illness is one of the major challenges schools face with the advent of HIV/AIDS. HIV-positive teachers are reported to be away from school for a prolonged period. However, it is only assumed that these teachers might be suffering from AIDS-related diseases, as teachers tend to keep their HIV status to themselves. Again, lack of disclosure of HIV sero-positive status poses difficulties in effective management of the disease in the school setting.

“Let us look at the extent of absenteeism. Maybe a certain teacher would be absent for two or three weeks and sometimes up to three months. Taking leave for quite a long time but it is not on my side to say that the teacher is suffering from HIV”.

Absenteeism of teachers due to illness brings about tensions and other related issues impacting on the operational functions of the school.

3.2.2.1.1 Increased Workloads

Absenteeism due to illness contributes to increased workloads of teachers present at school. The quotation below encapsulates the difficulties that principals face with regard to absenteeism superimposed on them by the AIDS pandemic. The principal here expresses the uncertainty regarding the wellness of the infected teacher and his/her ability to come to school on a regular basis. This uncertainty poses challenges with regard to finding someone to at least be with the learners in the event of the teacher’s absence. This

² Interview was conducted in the last quarter of 2005. The teacher must have been absent for about 18 months.

situation is especially difficult in the light of teacher shortages in schools. Furthermore, learners would be negatively affected by the absence of the teacher such that they may not receive quality education they deserve.

“I think of absenteeism because these teachers feel well today and tomorrow not well, so absenteeism is the most common problem. We can’t say he/she must come to school and that impact on children’s education. I do not know when they are going to be sick and I can’t even look for somebody who is going to sit in the classroom with the learners. The other thing is that we are short of staff now and in other schools as well, so I tend not to have somebody to look after those children and that subject the teacher is teaching”

The workload of the teachers increases with the absence of one teacher in a phase (i.e. foundation, intermediate or senior phases). Two classes are often merged and that seemingly causes irritation in the one teacher that has to accommodate the class of a sick teacher.

These quotations reflect the complexities around HIV/AIDS and absenteeism with an HIV positive teacher feeling helpless as life is dictated by the illness rather than the will to go to school. On the other hand, the remaining teachers feel the impact in increased workload as a result of teacher illness and/or absence from school. The principals are caught in the middle with having to accommodate both the infected and affected teachers and the challenges the situation poses on them.

“When classes are only two for one grade then it becomes a problem, no one will accommodate two different classes, sometimes teachers get irritated by looking after someone’s class as well as her or his class”

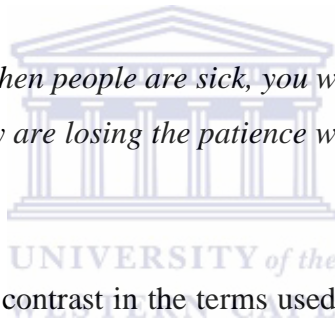
“I mean that since I have this illness sometimes I won’t be able to come to school especially if I am suffering from the consequences of this thing. The other teachers do not need to sympathize with me but when I am not well, I might not come to school everyday. Sometimes I will be done emotionally”

3.2.2.1.2 Increased tensions between teachers

Absenteeism due to illness potentially increases tensions between teachers as other teachers find themselves having to maintain bigger classes and monitor the increased numbers of learners.

“I do not think that it will be fair on the part of other teachers to have an extra burden of work that somebody else gets paid for. So I would encourage that teacher to either take an early pension or utilize sick leave that will be necessary. I think also that it will not be fair on the part of children for the person not to come to school when he is supposed to be there. When the illness has progressed, the person should then consider taking the necessary leave”

“There is a very big problem when people are sick, you will find that other teachers if are teaching in the same grade they are losing the patience when they have to look after their classes”



There was evidence of a sharp contrast in the terms used by principals and HIV-positive teachers to describe absence from work. The principals used the term “burden” put on other teachers whilst HIV-infected teachers used the term “time off” to refer to their absence from work, and as their “right” to go for checkups and treatment as deemed necessary by their doctors. These contrasting views certainly signal differences of opinion and potential tensions between HIV positive teachers and school principals. The principals especially expressed the “burden” as unfairness created by the absence of HIV-infected teachers because of the illness. They also professed that HIV positive teachers are paid to teach and therefore need to come to work.

“No, I do not think that it will be fair on the part of other teachers to have an extra burden of work that somebody else gets paid for”.

“It is my right as an HIV positive teacher to take time off and go for my monthly checkups and treatment. I do not think this should cause any problems for anyone at school”

Seemingly, some teachers also stay away from school without proper reporting as suggested by the quote below. The principal simply assumed that the teacher probably did not want to work and was not reporting for duty. This raises concern about the policy and its implementation at schools.

“He is always not coming to school and we thought he doesn't want to work but at the end now I had to ask him to come and have a report about him”.

3.2.2.1.3 Work backlog and consequent impact on children

Catching up with the curriculum is a daunting task for a teacher who is HIV positive who constantly has to be away from school due to the illness. The teacher expressed the difficulties in terms of going back to where he left off or just continues according to where he is supposed to be with the curriculum. Sometimes the teachers asked to fill the gap do not always teach the children, thus impacting negatively on children.

“The teacher keeps on asking somebody, and is left behind with his work and that affects the children and sometimes she needs to introduce the new lesson and go on with the work. Sometimes the learners need to write a test or exams at the end of the day. So you see, it also affects the children”

“Sometimes she does not teach my class the work I have given to her and when I come back I need to start from where I left so I do not do my work smoothly. Sometimes I have a break because I was sick and it means I must go back and teach the work I was supposed to do when I was sick. Sometimes I do not go back because I have to catch up with the curriculum”

3.2.2.1.4 Curriculum delivery and planning

The curriculum is the core of the education system and its implementation in developing the potential and capacity of learners to acquire knowledge that will eventually make them fully productive citizens. In South Africa, it is required of schools as institutions of learning and teaching to develop, work and plan together to implement the curriculum, and HIV/AIDS and consequent absence of teachers from school due to AIDS-related illnesses poses a huge challenge to this vision. A teacher who is constantly away from school, often for sustained periods misses out on planning which is the crucial activity for the delivery of curriculum in schools. Eventually, this would impact on curriculum delivery.

“The department requires teachers to work together when planning. When there is somebody who does not come to school she is going to miss the school planning”.

The Revised National Curriculum Statement (RNCS) introduced in 2001 came with a lot of changes that required all teachers to keep up with the changes in the delivery of the curriculum. Teacher absenteeism as a result of HIV/AIDS leaves these teachers with a huge task of catching up with the changing needs of the RNCS. The school managers are also left not knowing what to do. As the quote below implies, the teachers are battling with the demands of the RNCS and its related changes such that schools cannot afford teacher absenteeism. Teacher absenteeism as a result of HIV/AIDS simply exacerbates the problem or challenges facing teachers as far as curriculum delivery is concerned. Seemingly, absenteeism in general is an issue schools cannot afford especially with the changes brought about by the RNCS.

“We have to change the Revised National Curriculum Statement curriculum, we have to change the way we plan and the books that we use, all those things there is always changes, now tell me what happens when teachers are sick and absent from school looking at other problems”.

HIV/AIDS impacts negatively on teaching and curriculum delivery, and therefore there is a need to reinstall confidence and hope in teachers that despite the adverse impacts of the disease, teachers can still continue with teaching thus contributing to social and economic development of the young citizens of the country. This can only happen with support from the education department to imbue learning and development of teachers to enable them to deliver on curriculum. In this way, teachers will be in a position to find innovative ways to embrace curriculum demands whilst mitigating the impacts of teacher absenteeism as a result of HIV/AIDS.

The above discussion clearly shows that absenteeism puts a lot of strain on teachers and the education system at large. Work overload of other teachers due to absence of fellow colleagues through illness is evident in the results of the study. It would seem that the situation gives rise to irritation and tension among teachers as they have to constantly take care of the absent teachers' classes. Absenteeism certainly has policy implications especially when calculating the direct costs of the absences in monetary terms.

From the above remarks, it is clear that absenteeism is a major problem in the education sector and results in work overloading of teachers. Absenteeism has policy implications and needs to be dealt with cautiously and with sensitivity.

3.2.2.2 Difficulties with the Application of Policies

3.2.2.2.1 Sick Leave Policy

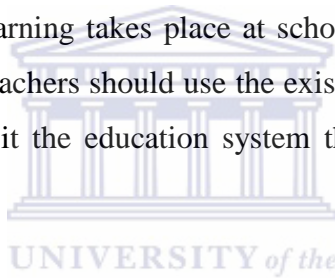
Sick leave is one of the benefits that teachers get as part of their employment package or benefits. The participants, especially the principals, alluded to the challenges and difficulties experienced in the implementation of this benefit in the time of HIV/AIDS in schools.

The principals especially, noted that some infected teachers are less productive due to the emotional and psychological strain the disease puts on a teacher. The principals displayed

uncertainty regarding whether to allow the teacher to stay at home whilst consciously knowing that there are learners who have to receive education.

“When the teacher is stressed by this illness you are unable to say to the teacher she must not come to school or she must stay at home ... there is also a classroom, where children are waiting for their teacher. The teacher cannot stay away for a week or two or three days, what about three days that the teacher was absent. And then you will find that maybe unless the teacher gets a leave of more than two weeks, then the school is allowed to employ someone in that teacher’s place but below ten days the school is not allowed to get a substitute teacher”.

Principals therefore find themselves in a dilemma of trying to accommodate the sick teacher whilst ensuring that learning takes place at school. As a result, some principals were of the opinion that sick teachers should use the existing medical benefits and/or use proper medical channels to exit the education system through medical boarding when terminally ill.



“It is very important for the teacher when terminally ill to rather take the option of boarding so that the teacher can have some financial security”.

The basis of this argument was on the impact the teacher’s prolonged absence from work due to illness has mainly on children whom the teacher is supposed to teach. It was also clear during the group session that the absence of teachers from work due to illness further impacts on the general school operations and curriculum delivery. Some teachers even mentioned the impact this has on their relations as colleagues.

“So I would encourage teachers to either take an early pension or utilize sick leave. I think also that it will not be fair on the part of the children, for this person not to come to school when he is supposed to be here. When the illness has progressed the person should then consider taking the necessary leave”.

“Those already infected, I think they could use sick leave or exit through medical boarding, but it is not easy”.

The difficulty in getting “substitute teachers” in the event of an ill teacher because of teachers in excess at the school exacerbates the problem. Teachers in excess³ are still a major problem in these schools especially when dealing with the direct impacts and/or challenges imposed on principals by HIV/AIDS. Principals also find it very difficult to tell teachers to come to school knowing that they are sick irrespective of challenges this pose on them. Even though principals are allowed to get teacher substitutes when a teacher is absent for two weeks, this is not always possible, and HIV positive teachers’ trend of absence is unpredictable as they may be away from school for two weeks but come back and only to find out that the teacher will be absent again.

“Let me go to areas that the policy does not cover. When a teacher is absent, there is a gap. A principal does not have an authority to prevent a teacher from being absent. There are times that I do not get substitutes from the department due to teachers being in excess. That [teachers in excess] is a major problem. Sometimes we do not qualify for substitutes.

The above issue as experienced by schools is a sharp contrast to the statements in the education department that there is shortage of teachers in schools. However, there was a general realization that there is a shortage in specific areas like mathematics and science. The excess of teachers in schools might therefore be areas not identified as scarce skills.

Contrary to the views expressed by the principals, HIV positive teachers view this benefit as inefficient in catering for their needs especially with attending to medical needs on a monthly basis. There was further support from HIV/AIDS coordinators that this benefit is insufficient. However, there was realization of the impact of absence of teachers due to illness on teaching and relations among teachers. HIV/AIDS coordinators were

³ “Teachers in excess” stems from the policy framework on learner teacher ratio together with numbers of teachers teaching a specific subject. In 2005, learner-teacher ratio was 32.8 learners to one teacher. If there is less learners to a recommended ratio, then a teacher would be deemed a “teacher in excess”. Another dimension to this is a situation where more than enough teachers are employed in a school qualified to teach the same subject. The extra teacher/teachers would be deemed “teachers in excess”.

ambivalent and torn apart concerning this issue as they were struggling to balance the needs of HIV positive teachers and the teaching responsibilities to be carried out by all staff members. It was clear from the discussions that this is a controversial and complex issue that needs care in its implementation.

3.2.2.2.2 Sub-theme 2: Substitution of teachers

The teachers identified gaps in the policy with regards to substitution of teachers who are sick. If a school has been identified as a school with teachers in excess, therefore that school cannot employ a teacher to substitute the sick one. This policy imperative puts the school principals in a predicament.

“Let me go to areas that the policy does not cover ... Now in high schools, we struggle because of subject specialisation which might not be the case in primary school.”

Adding to the above-mentioned dilemma, high schools specifically battle with the substitution of teachers due to subject specialisation. Teachers may be available but may not have the necessary subject specialisation required to fill a teaching post.

Presently, a sick teacher can only be substituted when absent for at least two weeks and this places a enormous challenges on the school principal and his/her management team and the teachers in general in terms of continuity with regards to the core business of the schools. In the meantime, the school has to find ways to teach all learners by way of accommodating them in other teachers' classrooms. However the participants' view of this is that it places an unfair burden on other teachers.

3.2.3 Findings relating to the Third Question: What strategies does your school use to mitigate the impacts of HIV/AIDS on your school?

Table 3.3: Mitigation Strategies

THEMES	SUB-THEMES
3.2.3.1 Reshuffling	
3.2.3.2 Care committees	

3.2.3.1 Reshuffling

Reshuffling is one strategy the schools employed in response to the challenges HIV/AIDS has imposed on them. Longman Dictionary of Contemporary English (2007) defines shuffle as an act of moving about. In this context, learners of a sick teacher are divided up into groups and sent to other teachers' classes as the quote below suggests.

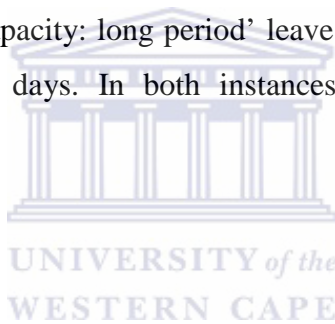
“We do some reshuffling by dividing learners among teachers”

“What we do, we always have to divide the class and give it to other teachers, like if the grade has 3 classrooms we take children of the sick teacher and divide it into half and give to the teachers. We always do that when a teacher is absent, but if it is two classrooms in one grade then we have to get somebody for the learners. We feel that the children need somebody in the classroom”

The participants also reckoned that this process is very difficult when there are only two classes in a grade because it means that one teacher in a grade is constantly overloaded. It was also reported that some teachers get irritated with the situation because of the increase in their workload and increased number of learners to look after during the course of the day. The irritation and tension among teachers is perceived as a direct consequence of the education department's policy on substitution of teachers, according to the teachers.

“That is a problem because the children are waiting for the teacher, now sometimes the teacher kind of speak to me or maybe another. For example we have three grade 1 classes and the teacher in one class is always ill and then you will find that the children are divided into other teachers’ classes and then it makes it better. When there are only two classes for a grade then it becomes a problem, no one will accommodate two different classes. Sometimes teachers get irritated for looking after someone else’s class as well as her/his class. Now the department has a problem because they do not allow schools to employ teachers even for one grade, but that person who is off-sick may be off for a couple of days or so, he/she will be behind with his/her work”

The Department of Education has a policy on incapacity defined as incapacity for short or long period. The ‘incapacity: short period’ leave applies when continuous leave is taken for less than 30 days. The ‘incapacity: long period’ leave applies when leave is taken for more than thirty consecutive days. In both instances the teacher has to complete designated forms.



3.2.3.2 Care Committees

The schools reported having different care committees that look at the different needs of the school community including teachers, administrative, support staff and learners. Depending on the target of the care committee, care is either aimed at teachers only or the broader school community. The care committees are divided into two such committees’ viz. school society, and HIV/AIDS and health committees.

- **School society**

Some schools opted for forming school societies with the aim of assisting each other with personal problems. These school societies are family-like structures to support one another in times of need. They are used as platforms for sharing personal and family-related problems encountered by the staff. In response to these support needs, teachers

are providing emotional and material support to their colleagues and learners and other support staff at the school.

By default, assistance related to HIV and AIDS is also provided through these committees. Currently, HIV/AIDS is a major issue for these committees as more and more teachers whether infected or affected by HIV/AIDS, come for support.

“We have a society at the school where if a person has lost a brother, a sister or anybody, we go to the family for prayers and support. We collect money to buy groceries to support the family. So we are a family, we talk about a lot of things from our homes. If somebody is sick from my home, the whole school staff will know that my mother is sick, so we behave as this one big family”

- **HIV/AIDS and health committee**

Teachers have also resorted to the formation of HIV/AIDS and health committees at schools that do not only look at teachers but also learners who are affected by the AIDS pandemic. These health committees focus on developing institutional strategies to assist every teacher and learner at the schools. The education department through the HIV/AIDS Life skills Programme directorate facilitated the formation of these committees. The aim of these HIV/AIDS committees was the development of school based intervention strategies to help the school community including teachers.

“In terms of preventative measures, the HIV/AIDS committee is expected to come up with strategies as to what we do within the school to offer support. What can we do as educators within the school to assist each other, maybe counselling sessions as educators. We should treat ourselves as if positive and that will make things easier for the infected teacher to come out and not isolate him or herself from others”

The schools took the opportunity to then assist teachers infected and affected by the AIDS pandemic. The very low number of teachers who actually disclose their status

hampers the efforts of the schools in the execution of their responsibilities and becoming hubs of care and support for teachers in particular. A question is raised therefore as to whether the disclosure of one's HIV status should precede the provision of support to the teachers in need.

“We have got a committee that is suppose to look after the health of the teachers and workers of the school and the health of the children, but it does not mean it is working very well because you will find that the people do not want to disclose”

The above discussion on the mitigation strategies employed by schools in coping with HIV/AIDS indicates that HIV and AIDS have serious implications for schools with regard to their core function of providing quality education for children.

The schools resort to or employ various methods and strategies in their mitigating efforts in response to effects of the AIDS pandemic on teachers. The impacts of HIV/AIDS on the education sector manifest in teacher sickness, absenteeism, attrition and mortality (Mobile Task Team on HIV/AIDS, 2006 & HSRC, 2005). The question asked here is how schools effectively mitigate the numerous impacts of HIV/AIDS on the education sector.

Mitigation strategies exist to control, treat and prevent HIV/AIDS and are a form of technology (including institutional organizations) (Mohiddin & Johnston, 2006) that schools need to adopt in order to achieve mitigation. The education sector could play a leading role in mitigating the impacts of HIV/AIDS on teachers. This could be done through various and well known strategies employed by states and organizations. These strategies include prevention, treatment, and care and support (e.g. ILO's Code of Good Practice, 2001). Prevention normally aims at changing individual and group behaviours through education; treatment, care and support strategies respond to the needs of those already infected with the HI virus and in need of treatment, care and support.

It is worth noting that the strategies schools employ operate at micro-level where the focus is mainly on assisting a sick teacher at school, and also accommodating learners of sick teachers. These strategies do not respond to the broader impacts affecting the education sector, but focus on the school and do not go beyond the boundaries of a particular school. The schools may argue that it is not their role to find strategies to deal with the broader impacts of HIV/AIDS on the education sector, but that of the education administrators. However, there is a definite need to assist teachers at school level with their health related problems.

The evidence in this study suggests that schools employ differing strategies to assist sick teachers and deal with other impacts of the AIDS pandemic at school level. One common approach or strategy constantly utilized by schools to ensure that teaching occurs even in the absence of some teachers due to ill-health is reshuffling of work. This normally takes a form of combining classes to accommodate learners of an absent teacher in another class.

The participants recognized the limitations of their capacity to mitigate the impacts of HIV/AIDS on the schools. Lack of sufficient resources like dedicated staff to provide counselling comes to the fore, and the limitation imposed on them by the education policies that are beyond their control in the effort to assist teachers. One such policy is the one that deals with the substitution of teachers in the event of absence of a teacher for a prolonged period.

The schools also showed some commitment to assist teachers infected with HIV and AIDS through the formation of HIV/AIDS health committees and school societies to support each other. The evidence also suggests that these committees are not well coordinated and respond only as needs arise.

3.2.4 Findings relating to the Fourth Question: What kind of support would teachers require for dealing with the impacts of HIV/AIDS?

Table 3.4: Required support for dealing with the impacts of HIV/AIDS

THEMES	SUB-THEMES
3.2.4.1 Psycho-social support	3.2.4.1.1 Counselling services 3.2.4.1.2 Service location
3.2.4.2 Training/Empowerment	
3.2.4.3 Access to treatment	

The participants expressed some views on the kind of support that they would require to be incorporated in a support programme. The expressed needs are based on their perceptions and experiences of what is going on in schools as far as the AIDS pandemic is concerned. This section therefore offers the views of the participants in the study.

3.2.4.1 Psychosocial Support

Psychosocial support is seen as one of the important factors in the interventions aimed at helping teachers living with HIV and affected by the AIDS pandemic. The views about the kind of support needed are discussed below. Social support refers to beliefs or evaluation that one has about the relationships in one’s life (Galvan et al. 2008). The authors assert that individuals with high levels of perceived social support describe themselves in more positive and less negative terms compared to others. Thus it allows individuals to deal more effectively with life stressors because they may believe that others will be there to help them in times of need.

3.2.4.1.1 Counselling Services

There was a general consensus among participants that counselling is one of the important services that need to be rendered to teachers. This need was linked to the realization that HIV/AIDS is still going to be around for a prolonged period. The need for

counselling services was also linked to trauma attached to the disease. Miller et al. (2006) suggest that receiving a diagnosis of a life-threatening illness is devastating, thus a person who has just been diagnosed with HIV/AIDS may experience depressive thoughts as they find it difficult to accept and adjust to their condition. Counselling helps in improving the level of HIV-related knowledge and contributes in reducing risky behaviours that makes a person susceptible to acquiring or transmitting HIV (Wiktor et al. 2004).

Since counselling is crucial in managing HIV, the participants therefore advocated for employment of counselling staff in the form of social workers and psychologists to provide this service. The participants reckoned that these professional groups are well-trained people and, by virtue of their unique training, they are equipped to deal with counselling issues. Thus, providing professional counselling services would maximize the counselling effects on the infected persons. The principals in particular saw themselves as sources of referrals for these services.

“I think that social workers and psychologists should be employed permanently so that they are available at all times. Anytime the teachers need them. When it comes to HIV/AIDS, people become so traumatized that they need to talk to somebody even at night if one so feels”

The availability of these professionals was another contested issue with some teachers wanting social workers and psychologist to be readily available at all times to assist teachers. This amounted to a service that is available 24 hours a day. Other participants wanted these professionals to work during school times or 8 hours per day.

“The counselling service provided to teachers will even curb suicide among teachers. Teachers will not be suicidal if they get help from these people 24hours a day. It should not only be up to 3 o’clock when the school ends, there should be people who are there even at night or on call to assist teachers”

The participants also felt that these professional people need to be employed permanently by the department of education. However, the participants were also pessimistic about the department of education's willingness to employ these professionals on a fulltime basis to provide this service. This view was largely based on past experiences of promises that the department of education had never fulfilled. In line with the permanent employment of these professionals, the participants differed on the location of the professionals or point of service. Others felt that they should be placed in the current education support centres while others want them based in schools and/or other centres specifically meant to provide services to teachers. Another debate ensued in the focus group sessions with some participants pushing for collaboration between the departments of education and health to ensure that HIV- and AIDS-related services are provided to teachers.

“The department should have people who counsel teachers. These people are readily available to provide services to teachers. I could refer the teacher for proper counselling so that the teacher can work towards accepting the illness”

HIV/AIDS is going to be with us for a very long time so I think that the department (of education) should have social workers and psychologists based at the schools and do this work on a fulltime basis”

The participants also require their own training on basic counselling skills to help enable them cope with their own emotions but also to be best positioned to offer initial and basic counselling to colleagues and learners when called upon. This view was strongly expressed by the principals even though they do not see this as their primary role. Counselling was also seen as an effective intervention to curb suicidal tendencies among teachers as a result of HIV.

The participants raised a need for support ranging from counselling support through to treatment, good nutrition and training. Most prominent was a need for professional counselling of teachers living with HIV and AIDS. The rationale was for counselling to be provided to enable these teachers to accept the illness and disclose their HIV positive

status. This was regarded as one of the ways in which teachers can start with their emotional healing. The concept of counselling arises from a humanistic and client-centred approach, with counsellors attending to normal social, cultural and developmental issues as well as the problems associated with physical, emotional, and mental disorders (Wikipedia, March 2007). These are non-pathologizing views of the person in context. The vital ingredient is that counselling is a meeting between a therapist and a client which invites the creative possibilities of dialogue in finding the best possible solutions. Giving teachers an opportunity to use counselling as a way of helping them go through emotional and mental healing is vital.

3.2.4.1.2 Service location

The location of the professional staff to provide counselling services drew different views from the wider spectrum of the participants. Some participants were of the opinion that services should be located at the department of education's clinic or centre⁴ rather than the Education, Management and Development Centre (EMDC). The participants cited easy access to these centres compared to the EMDC, which is based in Mitchells Plain.

“I think that it will be easier to go to the education department's clinic or centre rather than the EMDC”

However, some participants wanted social workers to be placed right at schools. Besides providing counselling services, social workers are required to perform other tasks that will keep teachers busy when learners leave school after 14h00.

“I want social workers to be stationed here at school to look at such things”

The other motivation for social workers to be based at school was that of “keeping teachers busy”. This could be training over and above the counselling of teachers.

⁴ The education department's clinics or centres are satellite centres outside of the EMDC meant to be close to the schools with regard to service provision. These are not medical clinics or centres as would be understood in a normal context.

In essence, the teachers saw social workers as playing dual roles including counselling and training of teachers. The quote below suggests that teachers finish their work at 14h00 when learners leave the school and that there is a need to keep teachers busy until 15h30, which is the official time for teachers to vacate the school premises on a day.

“I think by having a person right here at school will make things easier because that person will not just sit but have tasks and sessions with people and keep teachers busy from 14h00-15h30. These social workers will be more knowledgeable than me on counselling issues”

3.2.4.1.3 Training and empowerment

The participants expressed the need for their own training and empowerment to enable them to deal with a variety of issues that the AIDS pandemic has imposed on them. The expressed training needs range from training on basic counselling skills, dealing with disclosures, and creation of a school environment that is conducive to encouraging disclosures at school.

There was a shared feeling that the school management team should be especially targeted for training on basic counselling skills. The HIV/AIDS coordinators felt that the school management teams are vested with the power to make reasonable accommodation within the school for teachers sick from AIDS-related illnesses. The training on basic counselling will help enable them to better apply these delegated powers to reasonably accommodate the sick teachers. On the contrary, the HIV positive teachers saw this as a need to enable the school management team to better understand the needs of an HIV positive teacher in order to accommodate them reasonably within the school system when the time comes.

The principals especially expressed the need to be trained on counselling skills with the view that they would be the first person teachers would disclose to at school. This is however not necessarily the case with HIV/AIDS co-ordinators feeling that the principals

cannot always be trusted with confidential information. Some principals fear that they neither have the necessary skills to counsel nor the confidence to do counselling if they were to be called upon to provide counselling to an HIV positive teacher.

“As a principal I am not empowered enough. I am not empowered I need to be empowered as to how to initially counsel someone”. “I do not have the skills and I would definitely need them to handle any situation. At the moment I would not know what to say or do. I really do not know how to handle this”

Despite feeling disempowered when it comes to HIV/AIDS, it does not seem that teachers approach their principals for assistance. There was fear of the first encounter with an HIV positive teacher coming out and seeking assistance from his/her principal.

In terms of HIV positive teachers coming to their principals for disclosure, the principals expressed uncertainty and lack of confidence in their ability to deal with such disclosures. This lack of confidence in their abilities is also complicated by the lack of a social environment in schools that is conducive to facilitating such disclosures.

“Hmm that is a difficult one because I do not think that I will be able to deal with teachers coming to me to disclose their HIV status to me. I will have a problem especially that no one has ever come to me about his/her status. I do not know how I would handle it”

The principals also identified lack of counselling skills as a major setback in the management of HIV/AIDS in schools. They however expressed hope that with training and exposure, that would enable them to better support teachers infected and affected by HIV/AIDS in schools.

“The social environment at schools is not conducive. Some of my colleagues [principal] are having the same problem that I am having, like the lack of necessary counselling

skills or how to handle this situation. Those who have teachers who are infected, they have problems at first and thereafter they are able to sort the problem”

Training and empowerment of teachers with HIV-related information was also identified as one of the most needed support service to teachers. Employee empowerment is important to the organizational change process because empowerment fulfils the individual's need for a sense of control (Kappelman, A. L. & Richards, C. T., 1996). An incremental and gradual implementation strategy is required on the road to full empowerment. The role of training in this process cannot be overemphasized since training is how the skills and knowledge necessary for effective empowerment are required. Teachers might therefore see training as one of the tools that would give them control over the pandemic by having the required skills they can use in times of need.

Alsop et al. (2006) define empowerment as a process of enhancing an individual's or group's capacity to make purposive choices and to transform those choices into desired action and outcomes. Feldman (2003) adds that empowerment is a process of making people feel valued by involving them in decisions, asking them to participate in the planning process, praising them, and continually providing adequate training and support. The essence of these definitions implies that empowerment connotes granting of ability to enable people to make informed choices that would translate into actions. The defining consequences of empowerment to the individual are a sense of fulfilment, greater motivation and heightened commitment (Feldman, 2003). The author further states that the expected organizational rewards include increased innovation, greater effectiveness and better performance.

3.2.4.2 Access to Treatment

The participants acknowledge the importance of medical treatment and access to it. This was in line with the view that medical treatment in the form of ARVs can prolong the lives of people living with HIV and AIDS. The participants therefore encouraged the

uptake of ARVs by the teachers when the infected teachers' illness reaches the appropriate stage.

“Medically, I think it is important because spiritually it is just the soul that is being cured, and then medically the body is given something to boost the mind. It is wise to take the ARVs as prescribed by the doctor when the time comes”

The provision of ARVs is seen as very important to assist teachers when the need arises. Preceding the provision of ARVs is the provision of counselling to the concerned teachers. However, the call for counselling sessions was linked to the creation of an enabling environment for HIV positive teachers to disclose their HIV sero-positive status.

“The provision of ART will assist a lot of teachers but also as I have said these teachers need to be counselled in such a way that they understand that they must disclose their HIV status”

Some participants advocated for the department of education to consider a separate medical scheme where teachers living with HIV could contribute towards to access the treatment over and above the normal medical aid schemes that teachers belong to. A financial contribution to this scheme would then be determined by the salary scale of the concerned teacher, but should vary according to salaries and levels of employment. The HIV/AIDS co-ordinators and HIV positive teachers proposed that the costs of treatment be split equally between the education department and the teachers.

Rehle and Shisana (2005) reported that 67.8% of teachers were members of a medical aid fund, suggesting that there is a portion of teachers without access to private medical assistance. From an economic point of view, teachers suggested a financial contribution on a proportional basis depending on a salary that one earns to determine the cost involved. This implies a further need for additional financial assistance to cope with medical costs. This is in line with the findings by Rehle and Shisana that financial

support (54.3%) was the second highest required support following treatment and care (at 55.6%) by teachers.

“The department can set up a scheme whereby the educators can contribute into. Assess the financial status and determine how much an educator can pay towards treatment and advice from dieticians because one cannot take ARVs without a proper diet”

Although access to treatment was lauded as essential in the management of HIV and AIDS mainly by HIV/AIDS co-ordinators and HIV positive teachers, the principals put the provision of counselling to teachers to accept their medical condition and enable infected teachers to disclose their HIV positive status as a priority.

All the participants were unanimous in supporting the view that the department of education should be in a position to provide treatment to teachers. This is a very unique finding as employers generally do not provide treatment. Employers generally prefer to co-fund medical aids than paying directly for treatment. It is also imperative to note that this request is expressed against the backdrop of free and government provided HIV treatment in health centres. This expression is also in line with the teachers’ reservation with the use of accredited public health facilities for HIV treatment.

Recognising that the direct payment of HIV treatment by employer may not materialise, teachers expressed the need for splitting the cost of treatment between teachers and the department of education. Teachers added that they should pay what is affordable by checking their financial status or pay according to their remuneration packages. In essence, they viewed payment of treatment costs on a sliding scale according to the teachers’ salary packages.

“For those teachers infected already the department of education should provide treatment whether the costs are split on a 50-50% basis between the department of education and the teacher concerned”

Access to treatment for teachers infected with HIV is one of the support requirements expressed by the teachers. The introduction of antiretroviral drugs greatly transformed the treatment of HIV and AIDS thus improving the quality and prolonging the lives of people infected with HIV. However, access to treatment does not only rely on the provision and availability of antiretroviral drugs through health facilities, but the awareness of HIV status and empowerment to seek treatment by the infected people.

As the vital component of treatment and care, teachers identified nutrition as one important component to prolonging the lives of people infected with HIV. Weight loss, wasting and malnutrition continue to be common problems in HIV despite more effective medications, and can contribute to rapid progression of the disease. This is where good nutrition plays a critical role with help in keeping the immune system strong, enabling the infected person to better fight the disease. Good nutrition also helps the body to better process the many medications taken by HIV positive people.

The South African National Guidelines on Nutrition for People Living with TB, HIV/AIDS and other Chronic Debilitating Conditions (Department. of Health, 2001), states that the HI virus itself has an effect on the nutrition of a person living with HIV/AIDS. It further states that the body reacts to the virus with an immune response that uses more energy and nutrients. This therefore suggests that when an immune system is weakened by HIV/AIDS, other infections start to occur and every new infection raises the need for nutrients and energy.

Realizing the importance of the role of nutrition in HIV/AIDS programming, in May 2006, the World Health Organization (WHO) secretariat took a resolution (WHO 57.14) urging Member States, as a matter of priority, to pursue policies and practices that promote, inter alia, the integration of nutrition into a comprehensive response to HIV/AIDS.

Lastly, people with HIV often find themselves in financial difficulties and struggle to pay for medical bills and expenses of an on-going treatment, nutritional foods and other

essentials to maintain quality of life, dignity and peace of mind. This forms part of a comprehensive plan to help support teachers infected and affected by HIV and AIDS. Teachers have found this to be their utmost need and are of importance when formulating guidelines for a support programme to support teachers.

3.3 summary and concluding remarks

- The study records that there are perceptions and experiences of teachers who are infected with HIV and experience AIDS-related diseases that eventually caused the death of some teachers. HIV positive teachers seem unable to seize the opportunity to get help and support from colleagues or the department of education as a result of their silence about their HIV positive status.
- The disclosure of HIV positive status proves to be a difficult matter for infected teachers. Disclosure of HIV status remains a highly stressful event for HIV positive teachers and they experience considerable emotional suffering as a result of diminished sense of self-worth. Lack of disclosure of one's HIV positive status is further complicated by the associated stigma, lack of confidentiality, distrust of colleagues, fear of potential discrimination, and other perceived negative consequences of disclosing. Perceived stigmatization and self stigmatization potentially inhibits the possibility of disclosing the HIV status by teachers.
- The perceived impacts of the AIDS pandemic manifest in various ways including absenteeism and increased workloads on other teachers, affect curriculum delivery and planning, and complicate the application of certain education policies like sick leave.
- Teachers and school principals use various coping mechanisms to avert the impact of the pandemic on education. These mitigation strategies are often reactive and implemented to deal with a situation at a particular moment and are not proactive or universal to all schools. Long-term mitigation strategies universal to all schools will have to be developed to ensure uniformity of interventions to assist teachers, both infected and affected by the AIDS pandemic.

Undoubtedly, there is a need for a support programme to address the issues that concern teachers around HIV/AIDS in schools if the education department is to fulfil its mandate of knowledge generation and the development of self-dependent, self-reliant and productive citizens, and to contribute towards the Millennium Development Goals on education. The following objectives thus need to be considered in developing a support programme based on the findings of the problem analysis:

- Develop targeted interventions to encourage disclosure, voluntary counselling and testing, ensure confidentiality of information, and dealing with stigmatization;
- Facilitate and provide opportunities for accessing HIV and AIDS related treatment;
- Contribute to increasing the confidence of principals and other teachers in dealing with HIV/AIDS through facilitating the training of teachers;
- Develop strategies to deal effectively with absenteeism; and
- Ensure the delivery of curriculum/education by reviewing policies that may hinder innovation in dealing with HIV and AIDS in the workplace.

CHAPTER 4

WORK AND WELL-BEING IN THE WORKPLACE IN THE PRESENCE OF HIV/AIDS

4.1 INTRODUCTION

The second phase of intervention research is broadly about studying what is and has been done before to deal a particular challenge. Mainly, information is collected through literature reviews and empirical work to fulfil the requirements of this phase. This chapter is a literature review on the concepts of work and well-being in the workplace in order to provide a rationale for developing an HIV/AIDS support programme for teachers. It is a direct response to the “development” goal and nature of the study.

Fawcett et al. (1994) identify two kinds of scholarship, viz. scholarship of discovery and that of integration, which are central in this phase of intervention research. The authors define scholarship of discovery as generation of new knowledge about behaviour/environment relations. The scholarship of integration refers to the establishment of linkages between concepts and methods of various disciplines.

This chapter introduces and examines the concepts of work and well-being in the workplace in the presence of HIV/AIDS in order to achieve the purpose of the two scholarships. A literature review and the discussion of the concept of work and its meaning for workers are presented. It explores the meaning that workers attach to their work, and how this meaning shapes one’s thinking and response to life changing events.

The chapter highlights the importance of wellness because it is critical for high level performance of employees. Employers need to be seen to be promoting wellness in the workplace in order to retain talented employees and maintain high levels of productivity. The chapter therefore seeks to demonstrate the importance of investing in the health and

wellbeing of employees. Information presented here will provide guidance in formulating the rationale for establishing workplace interventions to deal with the potential impacts of the disease in the education setting.

A discussion on the impacts of HIV/AIDS on the education sector is highlighted to understand the dynamics of the pandemic on this sector. The chapter also provides information on implications for social work, and ends by providing concluding remarks.

4.2 WORK AND WELLBEING IN THE WORKPLACE

Better health is central to human social, economic and mental functioning. Health makes an important contribution to economic benefits for companies and/or organizations as healthy people and workforce are more productive in their endeavours. The World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO Constitution, 1948). The above definition recognises bodily health, emotional and psychological well-being, which collectively promote the social well-being which allows an individual to function properly in society. Taking this broad definition of health, various concepts are discussed with a view to understand what could be done by workers to ensure health and well-being in the workplace. Concepts such as work and its meaning, psychosocial well-being, and organizational commitment are discussed in this section to help understand these concepts and their application in the debate around the promotion of health and well-being in the workplace.

4.2.1 Work and Meaning

The search for meaning at work has never been so important than it is today in the presence of HIV/AIDS. HIV/AIDS affects many people in their workplaces, and ironically. Therefore if meaning cannot be found in the workplace, people's ability to lead a fulfilling life is seriously impaired (Visser, 2006). This section is therefore dedicated to finding out what it means to work.

Work and working becomes central for a person's economic and social functioning. Thus workers engage in work activities for various purposes including the economic and social reasons and/or pure enjoyment in different settings of work, and other reasons pertinent to a person's life. Work therefore brings a sense of meaning and purpose in the lives of the working people. The workforce referred to in the context of this chapter is the workforce in professional and education work settings, as opposed to workforce in traditional agricultural settings where work was originally mainly done for survival.

Schultheiss (2006) argues that the meaning of work is embedded in people's lives and their social, familial and cultural contexts. A sense of embeddedness is therefore a feeling of belonging and being included in some sort of social network, thus indicating a subjective link with others as a social group. For teachers living with HIV, the school and colleagues represent a social network to which these teachers have a sense of belonging by virtue of their workplace and work. Following on Schultheiss' argument on the meaning of work, a lack of this sense of belonging may be interpreted by other teachers as isolation and a source of stress and internal conflict. Schultheiss believes that these interpretations are crucial in understanding the life context of the clients' presenting concerns and issues. Work, therefore cannot be separated from the clients' social, familial and cultural life contexts or presenting issues.

The work role promotes belonging by linking teachers to a work-defined community, a group with which one share interests and values. In this interaction with fellow teachers, a work culture is created that the teachers ascribe to by virtue of their association with a social grouping in the workplace. Therefore, work and work context cannot be separated from one's social functioning and belief system.

Schultheiss (2006) argue that an understanding of the unique meaning of work embedded within an individual's social, familial, and cultural context is needed to effectively comprehend the interdependence of work and family life and to guide an integrated therapeutic practice. Angers (2005) supports and expands this view by maintaining that the social context partly constitutes the meaning of work. It is important for a social

worker to understand the meaning attached to work by an HIV positive teacher or a teacher affected by HIV. This could be achieved through understanding the clients' conceptualization of the meaning of work, and the recognition of work as a potential source of connectedness or alienation that impacts on life functioning.

Oppermann (2004) found in her study that participants tended to ascribe meaning to work subjectively and objectively. The subjective meaning to work involves the explanation of how work and the kind of work a person performs define a person. Work on the other hand increases the person's self worth and fulfilment. The subjective meaning to work provides a materialistic way of looking at the meaning of work for an employee. The subjective meaning ascribed to work could also be linked to the value and status attached to work/job that one performs by society. If a position and work that one performs is held in high value and status by society it is likely to be seen as fulfilling.

The objective meaning used to define work describes how an individual may be limited to a budget each month, preventing him/her from having the freedom to spend money the way he/she would if not ill. Job security and stability can heighten a person's self-esteem and self-fulfilment. Teachers in South Africa are normally employed on a permanent basis thus providing job security. The onset of a life-threatening illness, which HIV/AIDS is, makes an indelible impact on an individual's identity and perceptions of the future. Fife (2005) believes that it is the meaning ascribed to a life-changing event that determines its significance and shapes individuals' responses. This is consistent with the sociological premise that the individual acts towards an event based on the meaning the event holds, which arises out of both the past and present social processes. It is plausible that differences in adaptation to life-threatening events, and variations in the impacts of a particular event on mental health may be at least partially understood in terms of personal meanings as they are shaped by the social context (Wheaton, 1990 & Taylor, 1983).

The significance of meaning making or search for meaning by individuals coping with loss and other traumatic events in their lives has been viewed on one's ability or inability to find meaning and the impact of this search on adaptation or outcome (Fife, 2005).

Thus finding meaning is about discovering a purpose in one's loss, and the explanations thereof are consistent with one's view of the nature of the world and the self if they are to be effective in the resolution of loss. HIV-infected teachers may try to find meaning to their traumatic event as it impacts on their identity and their status as educated or professional people in their communities. Fife (2005) therefore argues that the meaning attached to traumatic event refers to individual's unique perceptions of the world as they know it and the ways in which they perceive the event redefining their world, their place and therefore their personal identity. Meaning is thus integrally linked to identity, providing a basis for continuity between past and present. Meaning, as a fundamental dimension of human life, would assume a primary role in the individual's response to a traumatic event that represents a major life transition.

If infection with HIV is perceived to be a threat to job security, self-worth is likely to affect coping and adaptation, thus affecting one's view and meaning of work. Coping and adaptation to illness is inherently shaped by one's interpretation of the illness and impact thereof on work. Understanding this dichotomy and conceptualization of the event is crucial in assisting a person cope with the illness and shape her/his future in a positive manner.

Contextual meaning pertains to specific characteristics of the event and life circumstances that surround it as perceived by the individual, and it also includes a person's perception of others' responses to his/her roles as they are altered by events surrounding the event (Fife, 2005). Essentially, one constantly struggles to cope and adapt to required changes.

Magdoff (2006), taking a Marxist perspective on the meaning of labour suggests that work is central to human existence. This notion was further developed by Engels in his writings that labour "is the prime basic condition for all human existence". Along with the growing complexity of society, however, came private property, the separation of people into classes, and a social division of labour, all of which deeply altered the meaning of work. Magdoff (2006) identifies two types of the division of labour. The first

division of labour entails how the low-technology mode of production based on personal relations and production for use (rather than for exchange) gave way to the dominance of exchange, private property, and an increasingly rigid division of labour. This division of labour based on private property and exchange became the dominant characteristic of economic life. Ultimately, what kinds of jobs are available and how labour is divided are directly and indirectly determined by the self-interest of the owners and managers of capital.

The second identified division of labour involves the separation of mental and manual labour. This only served to engender and perpetuate differences among people. What is important in this analogy is that the objective elements creating and perpetuating divisions and sub-divisions of manual and non-manual workers - private property, exploitative class structures, and the state - are reinforced by a subjective, supportive social psychology and ideology that separates people and their work according to degrees of inferiority and superiority.

In today's world of work, workers constantly seek for meaning in the work they perform on a daily basis. Work provides more than just subsistence, it defines a person's status, provides satisfaction and a sense of self-worth, is a milieu in which social interactions and friendships develop, offers an activity around which to organize one's time (Perlman, 1982 in Akabas, 1997). The meaning is thus derived from interactions between a worker and fellow colleagues and the actual work environment.

Advanced medical technology has prolonged lives for many people living with HIV/AIDS. It has been estimated that there are 571 000 new HIV infections every year in South Africa (Rehle, 2005) resulting in these people facing a potentially bleak future consequent to acquiring the disease. The debilitating nature of the disease could see people living with HIV having to adjust their lives and constantly seek for new meaning in the work they do.

Work consisted of a set of activities hereditarily prescribed as part of a particular status position in the community. Indeed, one of the most distinguishing features of contemporary urban societies is the conscious expectation to derive meaning from work.

The separation of work from other realms of life has been erroneously interpreted by some as indicating that work is no longer a central life interest of modern man. The available evidence does not confirm this, for work continues to be the driving force giving direction and meaning to contemporary living. While it is true that work satisfaction tends to decrease with level of occupational skill, work still occupies a central role in the lives of most people. The primary reason for this is that there is no other activity which provides as much social continuity to life as does work. Certainly leisure has not yet replaced work as a central organizing principle of life. It is work, and not leisure, that gives status to the individual and his or her family.

St. Thomas Aquinas thought that work is the universal base of society, the real cause of differing social classes. The purpose of labour should be maintenance, not profit. Work is thus freed from hampering ideas of caste and is endowed with the greatest possible initiative. It becomes mobile, fluid, man-made rather than man-moulding, rationalized (Form & Naspw, 1962).

Havener tries to provide answers to the question “why work is not meaningful?” using three phases, viz formative, normative and integrative. The author believes that in the formative phase, any human social system is completely tangible. It originates as a purpose, a concept, an idea, a philosophy, a solution to a problem in someone’s mind. People then move to manifest it, give it forms and processes that accomplish its purpose. The normative phase is concerned with maximizing efficiency of the forms and processes it created thus maximizing predictability. This effectively means eliminating diversity and variance thus promoting control and conformity, and often discards the original intent as defined in the formative phase. The normative system is thus built for repetition, and overtly pushes creativity because creativity produces variance and decreases predictability.

The third and last phase is the integrative phase, which unifies the fragments of the normative phase by recognizing the system's original intent or purpose. It discovers why something exists and then redesigns the system, based on current conditions, to accomplish the original intent. The integrative phase transcends dualism by recognizing the original purpose and taking into cognizance the external benefactor outside to the system. In the education setting, the integrative model recognizes the teacher as the provider of information to learners who then benefit from the knowledge acquired during teaching. In order to embrace the integrative model, there is a need for a sense of purpose, grounded in the originating purpose, keenly focused on the other principal partner, and work towards the reconciliation of the antagonistic separation and reunification of parts into wholes. One could say that the integrative model to finding meaningful work is grounded on systems theory.

4.2.2 Psychosocial wellbeing in the workplace

The Psycho-Social Working Group (2000:5) defines psychosocial well-being of an individual with respect to three domains: human capacity, social ecology, and culture and values. These three domains are determinants of, and/or contribute to the psychosocial well-being of an individual, social connection and support.

Psychosocial well-being of both the individual and the communities of which they are members is thus seen to be dependant upon the capacity to deploy resources from these three core domains in response to the challenge of experienced events and conditions. These events and conditions could come from a variety of sources and could also be the HIV/AIDS pandemic in general, but more specifically in the workplace, as it influences individuals, and their families.

An individual's capacity to cope in stressful situations is also influenced by levels of self-esteem. Lorentz and Hinsz (1997) assert that employees bring different levels of self-esteem to the workplace, resulting from an individual's perception of competence, importance and control produced in the work setting. The authors also maintain that the

very act of performing the work-related behaviours or roles that demonstrate a person's skills and abilities essential for a job, influences the person's self-esteem. A high level of self-esteem serves to enhance one's ability to perform at a peak level, and it enhances one's ability to cope under stressful situations. Kitaoka-Higashiguchi (2003:37) indicates that individual level coping behaviours are generally ineffective in addressing most forms of occupational stress. It challenges a person living with HIV/AIDS to maintain a balance between work and family to enhance his/her social well-being. The support systems in and outside work setting that a person develops, maintains and utilises to his/her benefit contribute to the social well-being of the person. Human satisfaction at work is often the product of interaction between the individual worker's needs and the employer's needs and responses.

4.2.3 Organizational commitment to the wellbeing of the employees

The concept of organizational commitment is often applied to employees and their commitment to the organizations they work for. Organizational commitment is defined as having the core elements of loyalty to the organization, identification with the organization (pride in the organization and internalization of the goals of the organization), and involvement in the organization (personal effort made for the sake of the organization) (Lambert et al., 2005). The common thread through the various definitions and measures of organizational commitment is "the individual's psychological attachment to an organization, the psychological bond linking the individual and the organization (O'Reilly & Chatman, 1986).

The infection with HIV and consequent ill-health brings about a lot of uncertainty in the lives of many people (Hartley, 1998; Mathieu & Zajac, 1990; Meyer & Allen, 1997). The uncertainties are exacerbated by stressors related to the illness and being sick. Uncertainties and illness-related stressors may also lead, to a lesser degree, to job insecurities among a number of employees. Research has shown that job insecurity tends to erode employee commitment. The cost for the organization of hiring, training and

developing new employees is high (McAulay et. al. 2006). McAlay et al. (2006) identifies three components of work commitment, and these are:

- Affective commitment: refers to employee's emotional attachment to, identification with, and involvement in the organization. Employees are attracted to the organization because the organization satisfies their emotional needs.
- Normative commitment: refers to the employee's feelings of obligation to stay with the organization. These feelings result from the internalization of normative pressures exerted on an individual prior to entry. This type of commitment focuses on the employee's sense of duty.
- Continuance commitment: characterized by employee's feeling locked into a particular organization because of lack of external alternatives and the high costs they would incur upon leaving.

HIV/AIDS tends to interfere with the abilities (physical and sometimes mental) of persons infected with the virus to perform their work duties, especially in the late stages of the illness. The concepts of work ability and organizational commitment have been established along with the concept of occupational health. Toumi et. al. (2005) found that employee work ability and organizational commitment are associated with employees' mental well-being as well as company performance.

Teaching is one of the most stressful professions in South Africa to date. Various issues including integration of learners with disabilities (Swart, 2003), teachers working in gang infested areas (Reckson & Becker, 2005), changes in the education system (Myburgh & Poggenpoel, 2002) are among the most contributory factors to teacher burn out. HIV/AIDS is yet another stressor in the lives of infected teachers. These stresses manifest themselves in various ways such as absenteeism and alcohol abuse.

Lambert et al. (2005) introduce the concept of organizational justice which is concerned with distributive justice (employees' perception of fairness of outcomes), and procedural justice (perceived fairness of the process by which important decisions concerning

employees are made). The authors further argue that organizational justice affects job satisfaction and organizational commitment of employees. Job satisfaction is an affective response by an employee concerning his or her particular job in an organization, and this response results from worker's overall comparison of actual outcomes with those that are expected, needed, wanted, desired, perceived to be fair or just (Cranny et al., 1992). This is especially true for teachers who need support to help them cope with the impacts of the AIDS pandemic both personally and organizationally.

4.3 HIV/AIDS IN THE WORKPLACE/EDUCATION

HIV/AIDS has emerged as a very serious issue for the world of work. It is a threat to decent work and productivity because it threatens the rights of workers and invariably impacts on the workplace. People with HIV/AIDS are subject to stigmatization, discrimination or even hostility in the community and at work (ILO, 2000). ILO also maintains that individuals who suffer discrimination and lack of human rights protection are both more vulnerable to becoming infected and less able to cope with the burdens of HIV/AIDS. This situation should compel workplaces to address HIV/AIDS in a manner that protects and supports workers living with the disease.

Over the past decade, 'HIV/AIDS has been increasing and appears to have virtually overcome education, swamping it with a wide range of problems. These problems 'threaten to overwhelm the very fabric and structure of education organization, management and provision. A key contributory factor that is regularly highlighted is that education is 'person-intensive' and thus is likely to be particularly vulnerable to the epidemic.

It has been established that HIV/AIDS affects the supply of and the demand for and quality of education. Countries affected by HIV/AIDS experiences severe losses of the teaching forces due to teacher illness or death, the need to care for family, or transfers to other government or the private sector to replace personnel lost to AIDS (UNESCO, 2004). Teachers uninfected by HIV are often poorly equipped to deal with the impact of

the pandemic on their work. These dynamics place enormous strain on learning achievements, requiring reconsideration of what must be done to protect and support educational quality, and to maintain progress towards achievement of Education for All (EFA) goals. Educators need to ensure that education reduces risk and vulnerability while providing all learners a quality education that is meaningful in the 21st century. This is notwithstanding the fact that HIV-infected teachers also need support from education authorities to be able to provide quality education to learners.

It is argued that education personnel in sub-Saharan Africa (SSA) will be particularly badly affected by the AIDS epidemic because ‘for reasons that are not entirely clear, HIV sero-prevalence is very high among teachers and school administrators’ [UNICEF, 2000]. However, in a subsequent study by the HSRC (2005), it found an overall HIV prevalence among educators (12.7%) to be similar to that of the general population which stood at 11.8% then. The latest National HIV Prevalence, Incidence, Behaviour and Communication Survey put this figure at 11.9% showing no significant change in the overall HIV prevalence (HSRC, 2008:30-31). Infected teachers will eventually become chronically ill, resulting in marked increases in absenteeism and generally lower morale and productivity. However, the availability and consistent use of anti-retroviral drugs could change this scenario as more infected teachers on treatment should be able to continue in employment much longer and with less absenteeism.

A human resources base that is highly skilled, well educated, innovative, productive and equitable is one of society’s most important assets (Vaas, 2003 & Evian et al., 2004). Teachers are part of this important group of skilled and well educated people. Thus the care and support to teachers infected and affected by HIV/AIDS becomes crucial for achieving the constitutional mandate of the education department to ensure “education for all” in South Africa.

The human resource capacity, especially teachers in South Africa, may be contained in future given the scale and nature of HIV/AIDS and its morbidity and mortality effects. The engagement in work activities can be a very challenging activity for people infected

and affected by HIV/AIDS. The disease imposes stress on individuals and their families. The infection with the disease gives rise to a range of emotions and challenges for the workers. Thus the wellbeing of the workers in their interaction with the social and work environment is crucial in ensuring productivity, wellness and job satisfaction. Thus HIV/AIDS has a potential to severely affect the capacity of education and training to maintain and improve the skills of current and future human resources.

As a result of disproportionate prevalence of HIV infection among the economically active part of the South African population, economic studies predict a reduction in the number of productive adults in the 20-59 year age group and foresee implications for the supply and costs of labour (Arndt & Lewis, 2000: 858; HEARD, 1999). The limited studies have shown that HIV/AIDS in the education sector has impacts that relate to the supply and demand issues (Shisana, 2005; Human Resource Development Review, 2008).

4.3.1 Impacts on the workers/teachers

Education is 'person-intensive' and thus is likely to be particularly vulnerable to the AIDS epidemic (Bennell, 2002) with many teachers deemed vulnerable to HIV infection and its impacts, and its profound effects are concentrated in the education sector (UNICEF, 2000: 10). HIV/AIDS thus affects the education sector in many ways.

HIV/AIDS affects the education sector by continuously and rapidly **altering the workplaces** (Bennell [2002]; Vaas [2003]; Shisana et al [2005]) thus presenting a major challenge to employers and their employees. It changes the demographics of the workforce through illness and death, thus presenting new challenges for employers. Employers need to stay ahead of these challenges by using innovative ways to mitigate the impacts of the pandemic on the workplace. The education sector may see more young and inexperienced teachers taking up jobs that would otherwise be done by more experienced teachers in a situation where there was no HIV/AIDS.

HIV/AIDS impacts on the size of labour supply through increased **morbidity** (AIDS related diseases) **and mortality**. Thus, HIV infection prevalence and AIDS death trends provide an initial indication of the scale and potential impact on labour supply (Vaas, 2003). AIDS-related morbidity is expected to be one of the most serious impacts of the epidemic on school systems in Sub-Saharan Africa (Bennell, 2002). Sickness lowers teaching quality and results in higher rates of teacher absenteeism. Longer-term and persistent absenteeism is particularly disruptive because it increases the workload of other teachers and may disrupt the delivery of curriculum. The employment of substitute teachers to cover for the absent teachers could prove costly for the Department of Education because additional salaries will have to be paid.

Information on mortality rates among teachers has been unclear and mainly dependent on household surveys for estimation. This was the case in South Africa until research collaboration between the Human Sciences Research Council (HSRC) and the Nelson Mandela Foundation. The HSRC/Mandela study (2005) has found that 12.7% of teachers are infected with HIV, and an estimated 1.1% of teachers have **died** of AIDS related diseases in 2004. The 2010 Estimates of National Expenditure (ENE) for Vote 16: Higher Education and Training indicates the largest spending item is transfer payments to higher education institutions costing the department R17.5billion (ENE, 2010:316). The increased transfer payments support infrastructure renewal and academic programmes to improve graduate outputs and the efficiency and quality of teaching services.

Educators are arguably regarded as a **high-risk group**, being predominantly African and female, with an average age of 32 years (Bennell, 2002). The HSRC (2009:31) results showed high peaks in HIV prevalence in the age groups 25-39 years among females. For the age group 30-34 years which is where the high-risk group of teachers falls into, a peak of 29.1% was recorded. The high rate of infection among young and productive people is definitely concerning and requires interventions to prevent the continued infection with HIV within this group of people.

Over time - with the progression of the illness, increased morbidity and mortality will reduce the number of qualified and experienced teachers, thus constraining the capacity of the education sector to provide basic and further education, which is the springboard for higher education and skills training for labour supply. This in turn may constrain the flow as well as the quality of labour supply to other sectors of the economy.

4.3.2 Impacts on the workplace/schools

The impacts of HIV/AIDS on schools manifest themselves in various ways including absenteeism, attrition, morbidity and mortality. All these factors have a bearing on the education system and the provision of quality education.

4.3.2.1 Increased Absenteeism

Education is person intensive in order to enable to provide good education to the learners. It therefore requires that teachers be available to teach learners at all times. HIV/AIDS interferes with the availability of teachers to teach, thus hindering the ability of the education sector to deliver quality education. As Bennell (2002) puts it, “infected teachers will eventually become chronically ill”. The chronic illness of the teachers due to progression of the infection implies that schools will eventually experience absenteeism of teachers due to HIV/AIDS.

Absenteeism related to sickness, which measures the working population’s well-being and lost productivity, has emerged as an important indicator for social service professionals practicing in workplaces. A study conducted in the Netherlands on long-term sickness absence concluded that long-term sickness is an economic as well as a medical problem (Andrea et al., 2003). The study predicted economic costs amounting to billions of Euros for the provision of sickness absence benefits alone. Essentially, long-term sickness absence has substantial impact on costs as a result of lost productivity and teaching time.

Persistent and long-term absence from work is particularly disruptive in schools. Effective operational functions of the school are disrupted as a result of absenteeism. HIV/AIDS related absence affects human resources management, employee welfare, operations efficiency and customer relations (Family Health International, 2002). HIV/AIDS is therefore a factor that affects all managers, workers' representatives and employees as it is bound to affect the daily operational functions of the school.

UNESCO (2004) produced a report on HIV/AIDS, teacher shortage and curriculum renewal in the Southern Africa region in which it is claimed that persistent absenteeism due to AIDS is a serious problem affecting the productivity of teachers and the quality of education. The report went on to recommend that as many teachers as possible be trained (pre- and in-service training) on certain aspects including self-awareness and prevention.

4.3.2.2 Morbidity

The morbidity component of HIV/AIDS is rarely addressed by scientists. However, it is generally accepted that morbidity associated with HIV/AIDS will lead to less worker productivity. One of the reasons for the lack of scientific evidence measuring worker productivity is that productivity of an individual worker cannot be directly observed (Strauss & Thomas, 1998).

Fox et al. (1998) in their study of HIV/AIDS impacts on labour productivity among tea pluckers in Kenya have found that as HIV positive workers became sicker, they were physically less able to travel away from the estate. The study found that because the sick workers remained close to the workplace as a result of their inability to travel it increased their presence at work. This scenario is however unique to farming community and might not be the case in industrialized societies where workers stay far away from workplaces, or their places of work do not provide accommodation. Thus, although this study presents some evidence of increased productivity as a result of HIV/AIDS related morbidity, it is almost certainly an exception to the norm.

The HSRC (2005:43) findings illustrate contrary to the above. HSRC has found that 10.6% of public teachers reported having been hospitalised within a period of 12 months at the time of conducting its study. The finding implied that these teachers were absent from school due to illness. In addition, teachers (59.8%) were reported visited a health practitioner in the previous six months and concluding that the health of the teachers was poorer than that of the general population.

4.3.2.3 Mortality

One way of assessing the impacts of HIV/AIDS on the education sector is to focus on the direct effects of the social fabric aspects which are in them directly related to the functioning of the education systems (UNESCO, 2004). One such effect is teacher mortality leading to changes in the demographics of the teacher population. With the death of teachers from AIDS related diseases, new and inexperienced teachers will have to be recruited and mentored. The process of recruiting and mentoring new teachers would result in the education sector incurring more financial costs.

In Zambia, the scale and magnitude of the impact of HIV/AIDS was first appreciated in the late 1990s when the Ministry of Education reported a steep rise in the numbers of primary school teacher deaths from two per day in 1996 to more than four per day in 1998 (Grassly et al., 2003). During this time, serious loss of teaching time resulting from prolonged illness or erratic attendance was reported by parent associations. Every month, 100 Tanzanian primary school teachers are estimated to die from AIDS related illnesses (Rispel, 2006). In 2006 alone an estimated 45 000 teachers were required to replace teachers that succumbed to AIDS.

The death of teachers from AIDS related diseases comes at a time that many countries are working towards achieving their targets relating to the MDG on education, which is ensuring that girls and boys alike are able to complete the full course of primary education. The decrease in the number of available teachers to teach due to mortality would adversely affect the provision of quality education. If the education system is to

mitigate the impacts of HIV/AIDS on this sector, it is imperative that more teachers are trained to replace those who died from AIDS-related diseases.

4.3.2.4 The economic impacts

Literature suggests that with severe morbidity and mortality, HIV generally places a greater burden on workplaces and households. These are characterised by decreased and loss of productivity; decreased household income coupled with increased household expenditure; treatment and care for the infected; increased costs due to new training and hiring (Allison & Seely, 2004; Barnett, 2000/2; Bachmann & Booysen, 2004; Liu et al., 2004; Lopez-Bastida et al., 2009; Tekola et al., 2008).

In the workplaces, the economic burdens manifested in decreased and loss of productivity which is closely linked to the reduction in work capacity of the sick employees, attrition, and mortality (Liu et al., 2004; HSRC, 2005; Tekola et al., 2008). The HSRC (2005:53) reported that teachers were more frequently more than 10 days absent from work in that year – 13% and 12.6% for teachers from secondary and primary schools respectively.

With regards to productivity loss and reduction in work capacity, HIV infected employees became less productive and needed more time off-work especially as the disease progresses (Liu et al., 2004:1187). In essence, the amount of time in which the employees are unproductive is crucial to count the economic costs of the diseases to employers.

In reporting on permanent attrition among teachers in South Africa, the findings suggested that the proportion of attrition due to mortality rose significantly (HSRC, 2005). Further, the highest rates of attrition were noted in the Western Cape Province (6.5%) and mostly among females in the age group 55years and above. With attrition comes the recruitment and training of new teachers which may cause interruptions in teaching and place financial burden on the education sector. This may also be the case with mortality of teachers whether due to AIDS-related or other diseases.

The economic costs to employers include among others increased employment-based benefits. Liu et al. (2004:1186) are of the view that in addition to health insurance, employers provide for other benefits such as sick leave, life insurance, funeral expenses, and pension benefits. The authors suggested that in South Africa the benefits costs for employees with HIV infection would rise from 7% of the wage compensation in 1995 to 19% in 2005. This may be due to predicted increase in the number of employees who may contract the disease and the employers' commitment to mitigating the effects of the disease on the workplaces.

In their study in Kenya, Grassly et al (2003) have found that the economic impacts of HIV/AIDS on the education system relate to the following three aspects: 1) additional training of teachers to cope with teacher attrition, 2) salaries paid to teachers absent with HIV related illnesses, and 3) funeral costs contractually met by the Ministry of Education. What is crucial with the second point "*salaries paid to teachers absent with HIV-related illnesses*" is that the employer incurs costs in paying for substitutes for these teachers. The authors have also predicted then that the bulk of economic impacts of HIV/AIDS are likely to result from teacher absenteeism (71%), with most of the remaining impact caused by the loss of trained teachers (22%).

4.4 IMPLICATIONS FOR (OCCUPATIONAL) SOCIAL WORK

Quality education is a priority for South Africa and the world at large. The South African government works towards education for all as expressed in the White Paper on Education. Education is also one of the Millennium Development Goals launched by the United Nations and ratified by the South African government. Education is regarded as important and crucial for development in most countries. It is also through education that poverty can be reduced and eventually eradicated. It is without doubt that HIV/AIDS poses huge challenges on the education sector, and if left unabated the impacts are huge.

The situation calls on the social work profession to position itself in a way that its interventions make positive impacts on the lives of teachers both infected and affected by the AIDS pandemic. The term occupational social work conveys the evolution and settlement of this field of practice. The field covers policies and practice targeted at workers, under the sponsorship auspices of trade unions and employers, which are available at the workplace in the community, to individuals whose eligibility results from their status as workers or their dependent relationship to employees.

Work is significant in all aspects of assessment and intervention because it is a key aspect of personal functioning (Akabas & Kurzman, 1982) and a major influence on all family members (Germain, 1991). The workplace is a complex social milieu with formal and informal structures, rules, and decision-making processes. Understanding work as it creates stress or support for individual employees and their families is part of this dynamic assessment.

The world of work and its auspices, trade unions and employing organizations, have proved fertile ground for nurturing and expanding social work practice (Akabas, 1997). Occupational social work deals with all the practice and policy issues that link social welfare to the world of work, from employment to stress on the job, from policies on fringe benefits to efforts to establish an inclusive, balanced workforce, and from programmes that are designed exclusively for employees at specific work sites to service delivery systems that are based on partnerships between the world of work and community resources to provide facilities for child and elder care (Akabas, 1997).

Providing employee assistance in the workplace includes assessment and intervention processes that are well known to social workers in direct practice. In all social work settings, the processes rest on the application of basic principles, values, and techniques of practice modified by the setting.

The concept of fairness and justice are embodied within the organizing principle of social justice, and social justice is the primary focus and goal of social work (Weiss et al 2006;

Craig, 2002; Lambert et al., 2005). Flynn (1995) defines justice “as an embodiment of fairness (where people are dealt with reasonably), equity (whether similar situations are dealt with similarly), and equality (whether people and situations are dealt with in the same manner)”. The embodiment and integration of these concepts is crucial and in the centre of social work practice. Thus social workers need to strive for and promote social justice in their professional work with their clients.

Craig (2002) advocates for the application of the principles of social justice in the practice of social work in organizations and other settings where social workers practice their cause. Thus it becomes imperative for social workers to not only embrace fairness and justice for, in this context; teachers infected and affected by HIV/AIDS, but strive to ensure that fairness and justice are upheld in service provision. Social workers can promote social justice effectively by understanding the impact of social structures and policies upon service users, and must be actively involved in policy practice. Policy practice is the formulation of social policy and the introduction of policy change in large systems, organizations, communities, institutions and society (Figuera-McDonough, 1993; Weil, 1996; Ife, 1997; Denney, 1998).

Davies (1997) argued that the primary goal of social workers is to ensure that “life is more bearable for those whom others might prefer to forget or choose to condemn”, and Flynn (1995) argued that social service agencies must be structured in such a way to maximize social justice for clients. People living HIV/AIDS and teachers in particular constantly face challenges like potential discrimination and isolation in the event of disclosure of illness; hence social workers need to ensure that social justice prevails in the delivery of services to people living with HIV/AIDS.

Social workers should reposition themselves not as the agents of endless top-down government initiatives but as those working more explicitly with the excluded and deprived, that is, to find an appropriate and critical political distance from a position of being merely agents of change driven by government objectives (Craig, 2002). Social workers can certainly act as advocates and facilitators for those most on the margins of

the society. Social workers are bogged down on the cases they are working on thus neglecting the important call to engage in debates on social exclusion and the marginalization of vulnerable groups of our society, including people/teachers living with HIV/AIDS.

There is pressure on social workers to use evidence in support of their interventions in their settings. Evidence-based practice would involve the conscientious, explicit, and judicious application of best research evidence to a range of domains: clinical examinations, diagnostic tests, prognostic markers, and the safety and efficacy of interventions whose purposes may be therapeutic, rehabilitative, or preventative, with therapeutic interventions understandably getting most of the attention. However, evidence based practice does not replace expertise that a social worker should possess in the provision of social work services to the client system.

4.5 CONCLUSION

The focus of this chapter has been on examining the concept of work and well-being in the workplace in the presence of HIV/AIDS. The focus was also put on the role of social work in mitigating these impacts. In so doing, HIV/AIDS and its impacts were explored and seem to indicate that the impacts are potentially enormous. These impacts manifest in various ways including absenteeism, alcohol abuse, death and consequent recruitment of new and inexperienced teachers to perform tasks that would ordinarily be done by experienced teachers. Interventions are therefore needed to mitigate these impacts on teachers and the education system at large.

The concept of work and meaning were also discussed and stimulated debates on this matter. It is clear that people ascribe different meanings to the work they perform depending on the type and level of skill involved in the performing the job. Work seems to provide individuals with more than mere income for a living, it fulfils the sense of belonging to a social group, and enhances individuals' self-esteem as work provides new opportunities to master acquired skills. Self-actualization needs are met through

designing meaningful work. In essence, if work provides meaning and purpose, then work can fulfil the need for self-actualization. HIV/AIDS has the potential to undermine these fundamental human needs and it is argued that social work interventions can help address this problem.



CHAPTER 5

A REVIEW OF WORKPLACE INTERVENTION PROGRAMMES

5.1 BACKGROUND

The integration of employee health and wellbeing activities in the workplace and the attainment of a healthy workforce are imperative. The achievement of these imperatives maximize the employee potential, reduce time taken from work with stress-related illnesses and remain within the employment for longer with greater job satisfaction, as employees feel “valued” by their organization (MacKay et al., 2004).

Factors such as change, stress, employee engagement and performance loss affect wellness at work (Hillier, Fewell, Cann & Shephard, 2005). HIV/AIDS has in the recent past been one of the diseases affecting the workforce in a negative way. However, the management of HIV/AIDS in the workplace becomes crucial to minimize its potential effects on organizational performance. It is therefore crucial for employers to address disease related factors that affect the health and well-being of employees through the provision of wellness services to employees and their families with the view of creating and shaping a wellness culture in the workplace.

Workforce stability in the presence of HIV is important for the health and wellbeing of employees which consequently impacts positively on the employers. Intervening in the health and wellbeing of employees when required is crucial for bringing this stability in the workplace.

Hillier et al. (2005) concluded in their study that healthcare is not just a question of resource distribution, but also linked to the physical and social organization of economic production. Therefore, health should be regarded an investment that builds the economic infrastructure. The authors further concluded that organizational interventions should focus directly on the work environment rather than implicitly blaming the victims for experiencing problems. That is, the approach to quality of working life as a management issue, and stress and burnout as an organizational problem, not as an individual failing (Hillier et al., 2005). Therefore, health-related difficulties experienced by the employees should also be seen within the context of organizational health rather than individuals as liability to their places of work. In this way, collective responsibility by both employees and employers is fostered for the health of the workplaces.

Intervention Research: IDD's information gathering and synthesis phase recognizes the need to discover what others have done to understand and address the problem (Rothman & Thomas, 1994:32). In so doing, the researchers acquire knowledge that would be used and integrated in the design of an intervention programme. One of the suggested sources of information involves identifying functional elements of successful models. Therefore, the identification of functional elements of successful models forms the basis of this chapter.

The aim of this exercise is to analyze the critical features of the programmes and practices that have previously addressed the problem of interest (Rothman & Thomas, 1994:33). Though this section of information gathering and synthesis focuses on successful elements of programmes, it also embraces an analysis of unsuccessful programmes in order to look at elements that were functional and learning from the mistakes of these programmes.

In identifying functional elements of successful programmes in publications, it is suggested that critical questions are asked to fulfil the objectives of this section. The authors suggest that questions around the existence of models, policies and practices intended to address the problem in the research should be considered. Exploratory

questions are also encouraged to ascertain the effectiveness of programmes and the causes of failures in some programmes. All these questions should guide the researcher's programme design and develop activities.

This chapter is therefore structured in such a way that it presents information on 1) the review of workplace intervention policies, programmes, and approaches, and 2) the functional elements of intervention models. Therefore, this chapter brings out issues on managing the disease in the workplace that should be considered and utilized in designing intervention guidelines.

5.2 REVIEW OF WORKPLACE INTERVENTION POLICIES, PROGRAMMES AND APPROACHES

Due to lack of published information on research-based programmes and programme evaluations, the researcher decided to discuss relevant information for the purpose of this research which relates to policies, approaches and programmes/models. The review provides an opportunity to enhance the understanding of key policy and programmatic issues for managing HIV/AIDS in the workplace.

Available literature on managing HIV/AIDS in the workplace highlights key factors that should inform these efforts, including policies and components of programmes. This literature review unpacks the key or critical factors and characteristics that inform and are crucial for management of HIV in the workplace.

5.2.1 HIV/AIDS Workplace Policies

One of the landmarks in the fight against HIV/AIDS was the declaration adopted by the United Nations committing itself to slowing down the social catastrophe created by the AIDS pandemic. The UNGASS Declaration of Commitment, adopted by the UN General Assembly's Special Session on AIDS in June 2001, recognized the importance of a

legislative framework for establishing and defending basic principles concerning HIV/AIDS in the workplace. The Declaration included the following target:

“By 2003, develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS and those at the greatest risk of HIV/AIDS, in consultation with representatives of employers and worker, taking account of established international guidelines on HIV/AIDS in the workplace”

The International Labour Organisation (ILO) developed a code of good practice document in response to the call and the declaration to help fight the scourge of HIV/AIDS in the workplace. In terms of the scope of the legislative framework proposed by the ILO, the policy framework should try to ensure the widest possible application of laws which do cover HIV/AIDS, including the informal sectors. This was proposed in the light of the observation made that legislative frameworks cover relations only in the formal sector.

The ILO code of practice contains fundamental principles for policy development and guidelines from which concrete responses can be developed. Key principles of the code of practice include non-discrimination and employment security; confidentiality; healthy and safe work environment; social protection; prevention; care and support; gender equality and social dialogue. Many workplace policies and programmes try to incorporate some of these fundamental principles.

An HIV/AIDS workplace policy sets the overall framework within which programmes are developed (Vaas & Phakathi, 2006: 21). In the South African context, the Department of Labour has published the HIV/AIDS Technical Assistance Guidelines (also known as Code of Good Practice) for employees, employers and trade unions on how to manage HIV/AIDS in the workplace.

The code, like other codes of good practice, suggests key legal and policy components that guide implementation in the workplace based on the following principles:

- Eliminating unfair discrimination and promoting a non-discriminatory workplace,
- Testing, confidentiality and disclosure,
- Promoting a safe working environment,
- Compensation for occupational infection with HIV,
- Employee benefits, and
- Dismissals and grievances.

The above are legal and policy issues within which intervention programmes are shaped in the South African context.

Since the development of the guidelines for managing HIV/AIDS in the workplace by the Department of Labour, Vaas (2004: 5) found that surveys conducted by four different research institutions produced varying results with regards to private sector companies with HIV/AIDS policies in place ranging from a low of 26% to 85% of respondents. The smaller companies were found to be lagging behind the larger companies as far as the development of HIV/AIDS policies in the workplace.

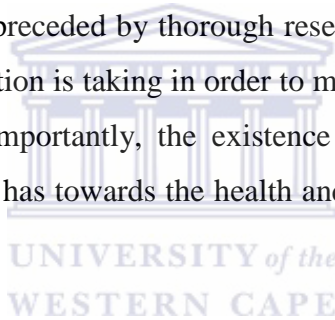
Companies within the mining, financial, transport and manufacturing sectors, policy development and communication are relatively undertaken. The results showed that more than 80% of the financial services companies and 60% of the mines surveyed have an HIV/AIDS policy in place. Fifty two per cent of transport companies and 47% of manufacturers surveyed have policies, while less than a third of the wholesalers, building and construction companies and vehicle dealers have implemented an HIV/AIDS policy. Only 12% of retail respondents reported having HIV/AIDS policies in place (SABCOHA, 2005).

It is encouraging to note that by 2005 the vast majority of companies had HIV/AIDS policies in place that were also communicated to their employees, meaning that policies can only be effective if they are communicated to employees. Furthermore, SABCOHA cautioned that policies should not be static documents, but should be constantly reviewed

and updated in order to remain effective. The successful and continual communication of a company's HIV/AIDS policy is the major driver of workplace programmes.

Critical to the awareness of the HIV/AIDS policies is its communication and marketing to the workforce. Communication and marketing of these policies creates broader understanding and awareness of such policies and expectations thereof. If the institution fails to market the policies to the broader workforce this may lead to failure of such programmes not because they are ineffective but merely because of the lack of awareness of their existence.

The existence of workplace HIV/AIDS policies provides an opportunity for allocating resources to ensure the success of the policies. However, the development of workplace HIV/AIDS policies should be preceded by thorough research on the needs of employees and the direction that an institution is taking in order to make it responsive and successful in its implementation. Most importantly, the existence of such policies points to the commitment that the employer has towards the health and welfare of employees affected by HIV/AIDS.



Policies have to be translated into programmes which are discussed below. SABCOHA (2005) reported that company programmes were based on the following critical issues:

- A voluntary counselling and testing programme,
- An HIV/AIDS workplace awareness programme,
- An HIV/AIDS care, support and treatment programme, and
- Provision of anti-retroviral therapy at the workplace.

These critical programmatic issues mentioned above are discussed in the next section in more detail.

5.2.2 Key Programmatic issues

In order to effectively manage HIV/AIDS in the workplace, consideration should be given to the following programmatic issues:

5.2.2.1 Prevention

One of the critical factors to consider when managing HIV/AIDS in the workplace is prevention. When referring to prevention, many studies focused on prevention of the transmission of HIV to other persons. Thus prevention strategies are geared towards the prevention of HIV transmission. However, the researcher takes a view that prevention is an all encompassing concept which in this context also embraces those living with HIV and taking into cognizance their needs in the workplace.

At the core of prevention strategies is consideration of factors that make the lives of people living with HIV difficult. Thus improving the quality of life of people living with HIV in the workplace should be at the centre of all prevention strategies or programmes. The key to improving the quality of life of people living with HIV in the workplace is finding and identifying those factors that affect them and seek to reduce or eliminate their impact on the affected individual and consequently the employer.

Workplace discrimination has been identified as one of the barriers for people requiring re-entry into the workforce (Brooks, Martin, Ortiz & Veniegas, 2003 & 2004), and a consequence of widespread social stigma (Conyers, Boomer & McMahon, 2005: 37). These authors further assert that HIV/AIDS related discrimination is often related to pre-existing stigma which makes individuals with HIV/AIDS particularly vulnerable to discrimination. HIV/AIDS discrimination could also be linked directly to the characteristics of the illness itself, with a primary focus on the fact that it is potentially a fatal infectious disease with no cure (Conyers et al., 2005). Misapprehension about communicable diseases has led to pernicious myths about those affected by the illness, resulting in social isolation. With regards to HIV/AIDS, many people harbour unfounded

fears about their risk of infection through casual contact despite public health awareness campaigns and guidelines that clearly characterize this risk as infinitesimal.

Conyers et al. (2005: 44-46) categorized the types of workplace discrimination into six sub-sets which include job acquisition and advancement, quality of work environment, employee benefits, union, demotion and discipline, and job termination. The job acquisition and advancement subset speaks to hiring/employment, reasonable accommodation and training. The quality of work subset consists of terms and conditions of employment and harassment. The benefits subset includes general work benefits and insurance benefits. The union subset relates to the failure of the labour unions to adequately represent the interests of persons based upon disability status. The demotion and discipline subset involves the actual demotion; assignment to less desirable duty, shift or location; discipline; or suspension because of disability status. Finally, the job termination subset includes allegations of discharge, constructive discharge and layoffs. The prevalence of the above types of discrimination against people living with HIV requires acknowledgement of their existence before adequate and effective management to improve the quality of life of people living with HIV in the workplace can be achieved.

The South African HIV/AIDS related policies⁵ prohibit discrimination against people living with HIV/AIDS when applying for jobs. The laws confer protection against discrimination in employment, access to basic employee benefits including health care benefits. Also, these laws make various provisions which may effectively improve the quality of health and life of people living with HIV/AIDS in the workplace.

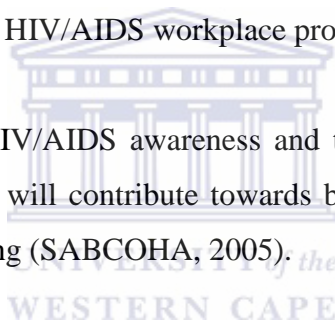
Workplace discrimination is closely associated with HIV disclosure in the workplace. Fear of discrimination, harassment, work related health concerns, job skills concerns, work accommodation concerns, and anxiety about losing health benefits may prevent individuals from disclosing their HIV status in the workplace (Conyers et al., 2005; Fesko, 2001; Martin et al., 2003). Therefore, deciding on disclosing one's sero-positive HIV status is often tainted by certain individual concerns and risks, particularly when the

⁵ Department of Labour. Technical Assistance Guidelines for managing HIV/AIDS in the workplace.

revealed information is potentially embarrassing, negative or emotionally intense (Martin et al., 2003; Omarzu, 2000). This means that a decision to disclose HIV status involves a cognitive appraisal of negative consequences based on the individual's knowledge of HIV, attitudes towards HIV/AIDS or HIV-related behaviour and perceived social attitudes towards people with HIV.

Prevention of opportunistic infection is generally more important for the workforce than the transmission of the disease to others. Although occupational transmission of HIV may occur, especially among health professionals who are exposed to the blood of workers who are injured on duty, for the general workforce, the likelihood of HIV transmission in this way is very low. Prevention of opportunistic infection and/or diseases is achieved by ensuring access to treatment. The following section looks at treatment as another component of a comprehensive HIV/AIDS workplace programme.

Also, programmes focus on HIV/AIDS awareness and training to enhance employees' knowledge which, it is hoped, will contribute towards behaviour change and uptake of voluntary counselling and testing (SABCOHA, 2005).



5.2.2.2 Treatment

HIV positive people require a range of support services, and access to health care services is a major need for HIV positive people (Brooks et al., 2004; Erns et al., 2004). The health care and support services relate to medical treatment, ongoing medical check-up and counselling services, prevention of further infections and transmission, and reducing vulnerability.

Further, PLWHA express health concerns related to working and the work environment. The concern is over the stress of work which would in turn affect their health (Brooks et al., 2004: 762). PLWHA often visit healthcare centres to test for viral load and possible review of treatment and if they are unable to test, it can potentially affect their health

status. Access to health care services that meets the health care needs of people living with HIV/AIDS becomes crucial for improving the health of the employees.

Advances in the treatment of AIDS have extended and improved the lives of people living with HIV/AIDS. Brooks et al. (2004: 764) assert that the indices of quality of life have shown concurrent improvement, including positive changes in general health, energy levels and physical functioning. People living with HIV/AIDS who expected their health to decline now have a substantially prolonged lifespan and improved quality of life as a result of treatment. Treatment for HIV would therefore imply access to more effective treatments, especially highly active anti-retroviral therapy (HAART) regimens. The remarkable success of the anti-retroviral therapy regimens and their ability to achieve durable suppression of HIV replication, have transformed HIV infection into a chronic manageable disease (Baer & Roberts, 2001: 116).

It is widely accepted that advances in treatment therapy have improved the health and prolong the lives of people living with HIV. Arguably, their quality of life is substantially improved too. Quality of life includes the physical, mental and social wellbeing and the diversity of aspects ranging from direct symptomology and daily functioning to work performance and emotional status (Baer & Roberts, 2001: 117). When referring to treatment regimens and quality of life, the importance of adherence to treatment cannot be ignored. The success and effectiveness of HAART requires high levels of adherence to medication (Baer & Roberts, 2001; Holzemer, 2000). Failure to adhere to the prescribed treatment regimens may result in incomplete viral suppression and the development of drug resistant viral strains (Altice & Friedland, 1998; Bright, 1999; Holzemer et al., 1999), both of which may have serious consequences for the patient.

Ongoing counselling for people living with HIV is a crucial element of their continuous HIV treatment. Counselling can focus on various aspects including physical, psychological and social areas of life (Orsulic-Jeras et al. 2003), promoting adherence (Baer & Roberts, 2001), and fostering psychosocial wellness (Medland et al., 2004) for improving quality of life and ongoing functioning.

The results of a study by SABCOHA (2005) indicated that about 40% of companies surveyed were providing or offering anti-retroviral therapy at the workplace which is considered crucial in the management of HIV/AIDS in the workplace. To some degree, it may serve to reduce employee absenteeism, thus allowing employees to continue with their duties knowing that they are going to be taken care of. It also increases employee commitment and psychological attachment to the employer.

5.2.2.3 Care and support

The Family Health International (2002) states that “improving access to HIV/AIDS care and support services helps de-stigmatize HIV, improves the demand for voluntary counselling and testing services, and allows for early management and prevention of infectious diseases and sexually transmitted infections among both HIV-positive and negative people. Likewise, the provision of these services creates opportunities for HIV prevention. Also, there is a need for synergistic programming that links HIV prevention with care and support. Strengthen levels of care and support taking into cognisance affordability and feasibility in the short-term which should be maintained in the future. Strategies and standards must guide the allocation of resources and the implementation of HIV/AIDS care and support in the education department.

FHI Comprehensive HIV/AIDS care and support includes:

- medical and nursing care,
- access to appropriate diagnosis,
- treating and preventing opportunistic infections, including TB,
- managing HIV related illnesses and palliative care,
- Antiretroviral therapy,
- Socioeconomic support to families, orphans, and vulnerable children,
- Human rights and legal support,
- Community involvement,
- Care for caregivers, and

- Referral mechanisms.

The following discussion looks at what is done to assist employees manage HIV/AIDS in the workplace.

- **Peer Education**

Peer education is a widely used tool in the response against HIV and AIDS, and typically involves training and supporting members of a given group to effect change among members of the same group (Dickinson, 2006: 324). Among the stated advantages of peer education is the ability to access people living with HIV or vulnerable to infection. This access is both physical and socio-cultural with peer educators able to communicate effectively because they understand the language and patterns of communication of those whom they seek to influence.

Considerable guidance is available to employers responding to HIV/AIDS in the form of guidelines and codes, which provide key steps and actions to follow. The South African Department of Labour in its *“Technical Assistance Guidelines”* states that the core of HIV/AIDS education and training is the use of peer educators who have either volunteered or been nominated to conduct HIV/AIDS education sessions (DoL, 2003: 59). The guidelines further state that peer educators should have important qualities such as maturity, empathy and good communication skills, and they should be highly motivated and respected. This implies that the peer educators should be people who are mature enough and highly motivated to take up this responsibility.

There is substantial literature on peer education within the context of HIV/AIDS, which identifies critical issues such as cultural specificity, characteristics of what constitutes peer status, appropriate involvement in the programme that they participate within, and the degree to which they influence peers, but none of this literature addresses these issues within the world of work (Dickinson, 2006). Thus research on these issues as they apply in the workplace has to be done.

- **Counselling and Testing**

HIV counselling and testing is a key component of both prevention and care (Corbett, Dauya, Matambo, Cheung, Makamure, Bassett, Chandiwana, Munyati, Mason, Butterworth & Godfrey-Faussett, 2006: 1006). Workplace based HIV counselling and testing initiatives have a potential to access a high number of adult employees who may otherwise not go for these services where they live. Corbett et al. (2006: 1007) have found in their assessment of 26 businesses that an uptake of VCT with on-site rapid testing was significantly and substantially greater than voucher uptake (i.e. referral), demonstrating the high potential of rapid HIV testing and counselling at the workplace when this is linked to basic HIV care. The same authors' further report a low VCT uptake offered off-site compared to on-site uptake of VCT. This means that on-site VCT seems to get better support than treatment. This is a significant finding for wellness managers in their efforts to provide HIV services to employees.

- **Confronting Stigma (Normalizing HIV & AIDS)**

Stigma related to HIV/AIDS manifests in various ways. Stigma is expressed through social ostracism and personal rejection of People Living with HIV/AIDS (PLWHA), discrimination against them, and laws that deprive them of basic human rights (Herek, 1999), and social marginalization (Ware, Wyatt & Tugenberg, 2006). A concern with stigma is that it is often perpetuated against unpopular groups disproportionately affected by the local epidemic. In South Africa, people expressed negative attitudes towards PLWHA (HSRC, 2005).

Stigma and AIDS-related stigma are associated with a variety of social, psychological and demographic elements. Younger and better educated persons consistently manifest lower levels of AIDS stigma than older persons and those with lower levels of educational achievements (Herek, 1999). In explaining the social psychology of HIV/AIDS, Herek (1999:1109) asserts that because the primary mode of HIV transmission is due to behaviours that are widely considered voluntary and immoral,

PLWHA are regarded by a significant portion of the public as responsible for their condition and consequently are stigmatized.

Herek (1999: 1109) also maintains that stigma is associated with illnesses and conditions that are unalterable or degenerative, and putting others in harm's way. All the above factors are likely to provoke stigma and anger among people because of the perceived lethality and transmissibility of a deadly disease. These factors should be taken into consideration when devising programmes to confront stigma related to HIV/AIDS. These should however be adapted to suit the circumstances or environment and the intended target group for the programme.

People living with HIV/AIDS (PLWHA) often experience intense and unrelenting psycho-social pressure during the course of the illness. One form of this pressure is stigma related to HIV. Chesney and Smith (1999: 1163) suggest that stigmatization is a factor that contributes to delays in HIV testing. Unfortunately, HIV testing is the only way that a person can determine his or her status. Delays in such testing could have potentially negative impacts on people who might be infected but do not know their HIV status.

The reduction of stigma associated with HIV and AIDS is recognized as an important component of any HIV/AIDS or workplace wellness programme. Stigma drives the disease underground rendering many responses ineffective (Dickinson, 2006: 333). The assertion suggests that stigma could have serious negative effects especially when those stigmatized avoid social encounters because of the fear of disclosing their status and discrimination. It is this reason that Dickinson (2006:334) asserts that the reduction of stigma and fear around HIV and AIDS is critical to any effective response to HIV/AIDS.

The Integrated Model of Health Promotion developed by Abel, Rew, Gortner and Delville (2004: 512) depicts the influence of a number of factors on the management of the health of persons living with HIV/AIDS. The model, which integrates social,

cognitive, behavioural, and immunological theories, attempts to capture the complexity of care related to living with HIV/AIDS.

The model suggests that emotional disclosure through a writing intervention assists individuals to reorganize their perceptions of the meaning of the HIV/AIDS diagnosis and requisite treatment, and thus to experience psychological, physiological and behavioural health benefits. The use of integrated models such as this one could be of immense help to people living with HIV/AIDS.

5.3 REVIEW OF FUNCTIONAL ELEMENTS OF WORKPLACE INTERVENTION PROGRAMMES

5.3.1 Introduction

This section presents an overview of workplace intervention programmes aimed at assisting employees with various personal and health related problems. There are various workplace intervention programmes of this nature, and the idea here is to present the most prominent ones in order to provide an overview of the range of programmes and interventions to assist employees. The aim is to describe these programmes based on themes such as their objectives, rationale, types of services and other issues that arise out of these programmes.

HIV and AIDS are the greatest health crisis South Africa has seen in recent times. HIV prevalence among persons between the ages 15-49, which forms the core of the workforce stood at 16.2% in 2005 and up to 16.9% in 2008 (HSRC, 2005 & 2008). The infection prevalence in this age group is slightly higher than overall national infection rate which stands at 10.8% in 2005 and 2008 respectively (HSRC, 2005 & 2008). The infection rate among workers therefore poses a threat to the core of the workforce, and consequently the workforce's ability to contribute to the generation of wealth for the country.

Another study by Colvin, Connolly and Madurai (2007: 15) showed variations in HIV prevalence among employees in the public and private sector. The study found that a total of 3500 out of 32015 employees were HIV positive, translating into 10.9% HIV prevalence rate in the South African workplaces. Although not statistically significant, the study also found higher HIV prevalence rates in men (11.3%) compared to women (9.8%).

In contrast, the HSRC study (2005) found that the prevalence among females was twice that of males with 20.2% compared to 11.7%. This is cause for concern, especially in the context of this study because the teaching profession is female-dominated in this country. An HSRC study (2005) found that 12.7% of educators who gave specimens for HIV testing were HIV positive.

The above-mentioned studies indicate an arguably higher HIV prevalence rate in the South African workforce. Thus programmes to assist employees are essential to deal effectively with HIV/AIDS in the workplace. Workplace intervention programmes are commonly used by employers to assist their employees suffering from a wide array of personal problems that impact on their ability to work effectively and produce good results. The following section focuses on the workplace intervention programmes to assist employees with personal and health related issues that could be adopted and adjusted accordingly to deal with matters related to HIV/AIDS in the workplace.

5.3.2 Workplace Intervention Programmes

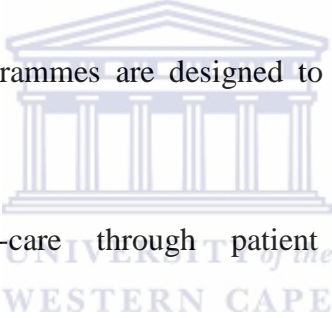
Workplace intervention programme is an umbrella concept/term encompassing varied intervention programmes designed to assist employees with their health and/or personal problems that may hamper their productivity and wellness. The following section looks at the different workplace intervention programmes utilized by employers to assist their employees. A brief synopsis of each intervention programme is provided to understand how employees are assisted with their personal and health related problems by their employers.

5.3.2.1 Disease Management Programme

Disease management emphasizes prevention of disease related exacerbations and complications using evidence-based guidelines and patient empowerment tools (Gillespie & Rossiter, 2003). Disease management programmes can help manage and improve the health status of a defined patient population over the entire course of the disease.

Centres for Medicare and Medicaid Services and the Disease Management Association of America define disease management as a system of co-ordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are substantial. Disease management also evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

The disease management programmes are designed to achieve the following specific goals:

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- Improve patient self-care through patient education, monitoring and communication,
 - Improve physician performance through feedback and/or reports on patient progress in compliance with protocols,
 - Improve communication and coordination of services among patient, physician and disease management organization, and other providers, and
 - Improve access to services, including prevention services and prescription drugs as needed.

The following are some of the functions of the disease management programmes:

- Identify patient populations,
- Use evidence-based practice guidelines,
- Support adherence to evidence-based medical practice guidelines by providing practice guidelines to physicians and other providers, reporting on patients

- progress in compliance with protocols, and providing support services to assist the physician in monitoring the patient,
- Provision of services designed to enhance patient self-management and adherence to patient's treatment plan,
 - Routine reporting and feedback to the healthcare providers and to the patient,
 - Communication and collaboration among providers, and between the patient and the patient's providers, and
 - Collection and analysis of process and outcome measures, along with the system to make necessary changes based on findings of the process and outcome measures.

Gillespie and Rossiter (2003:347) claim that the disease management programmes are used widely for many chronic diseases. These programmes were adopted by managed care plans because of a general movement toward preventive health, the reduced cost of obtaining data to implement disease management interventions, and a desire to improve the coordination of care that has become more complex to deliver. The initial efforts of disease management included simple tools such as reminders to patients for diagnostic and monitoring tests (Gillespie & Rossiter, 2003).

These reminders were designed to ensure adherence to complicated medication regimens. Disease management programmes were then enhanced with the introduction of customized health education materials and self-care manuals to help patients better understand their disease and promote empowerment. Clinical protocols for disease specific care were developed and implemented, followed by extensive case management interventions for high cost illnesses to help reduce or limit future cost. These were ultimately refined and packaged together as the early disease management programme. To date, what constitutes a disease management programme varies widely, and how each disease is managed needs to be tailored for the provider and patient.

The following table presents the types of disease management programmes, and provides a brief description of each type.

Table 5.1: Type and description of Disease Management Programmes

Type	Description
1. Pay for performance	This approach establishes new rules for scope of practice or referrals and involves non-traditional providers in the care of patients with specific diseases. The service providers are paid a special fee contingent upon improving health outcomes or lowering costs.
2. Centres of excellence	Focus on particular disease episodes for high-cost, high volume diseases and select a network of hospitals, physicians, and other providers who are already organized to receive the prospective, bundled payment per episode of care.
3. Health outcomes partnership approach	This approach is applied to an existing fee-for-service primary care case management programme.

Source: Gillespie & Rossiter, 2003:348

According to Gillespie and Rossiter (2003), the identified limitations of these programmes relate to huge data infrastructure which exposes them to inadequacy making it impossible to properly identify disease management populations. Data and infrastructure limitations can affect research design which in turn can affect appropriate analysis and understanding of the impact of the disease management.

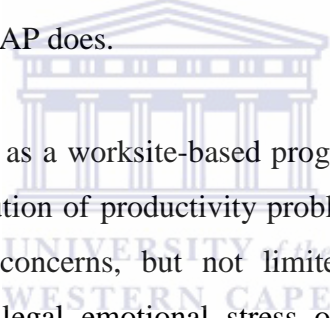
5.3.2.2 Employee Assistance Programme

EAPs are employer funded resources offered to employees and, often, to their families (Kirk & Brown, 2003:138). The concept of Employee Assistance Programme (EAP) has been used to refer to various strategies employed by companies and service organizations aimed at assisting employees with wide-ranging social and personal problems affecting

their work and their performance. Historically, the focus of these EAPs has largely been that of mediating the personal problems experience by employees and their immediate family members.

The premise of an employee assistance programme is to protect the stability of the industry and the community from high human and financial costs that arise from absenteeism, lateness for work, poor productivity and high staff turnover caused by health or social problems. Employee assistance programmes are also seen as protecting the most valuable asset, the employees, in the company and/or institutions. Without the contribution of the employees towards the sustainability of the business and/or service, production is likely to go down.

There is no single definition of an EAP, and various authors seem to provide various definitions to explain what an EAP does.

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- EAPA-SA defines EAP as a worksite-based programme designed to assist in the identification and resolution of productivity problems associated with employees impaired by personal concerns, but not limited to: health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal concerns which may adversely affect employee job performance (revised March 2005).
 - EAP is an employer funded resource offered to employees and, often, to their families. The core service offered by an EAP is generally professional assessment, referral, and short-term counselling directed at personal, family and work-related problems that might interfere with worker performance and/or health (Kirk & Brown, 2003: 138).
 - Berridge and Cooper (1994: 5) define EAP as a programmatic intervention at the workplace, usually at the level of the individual employee, using behavioural science knowledge and methods for the recognition and control of certain work and non work-related problems (notably alcoholism, drug abuse and mental health) which adversely affect job performance, with the objective of enabling the individual to return to making her or his full work contribution and to attaining full functioning in personal life.

- Masi (1997) concluded that EAP is a method of intervention that focuses on the decline in job performance, not on the nature of the employees' problems, to restore the worker to full productivity.

From the above definitions, it can be concluded that EAP is an employer funded, workplace based, pragmatic intervention to assist employees experiencing personal problems, which interfere with job performance, to reach full productivity and functioning, thus helping both the individual and organization achieve the desired goals of their core business. The above definitions recognize that EAP as an approach is not a haphazard form of intervention but as an intervention strategy that uses professional people with scientific knowledge and methods to help intervene with employee problems. However, Roman and Blum (1988) expand on these definitions by viewing EAPs as a Personnel/Human Resource Management tool which has considerable potential for reducing uncertainty in the general management of employees. The authors go further to view EAPs as part of the performance-management and control activity in an organization's Personnel/Human Resource Management system and contribute to the attainment of the organization's goals. This definition recognizes both the individual/employee and the organizational elements involved in the process of building a better functioning workforce for the benefit of the organization.

In the absence of a single clear definition of EAP, various authors, including the above, mention a common group of core components, including the provision of confidential assessment, counselling, and therapeutic services for employees and dependants experiencing a wide range of personal, emotional and psychological problems, with a telephone help-line for advice and information on domestic, legal, medical and financial matters (Arthur, 2000; Employee Assistance Professionals Association, 1994 & 2005; Kirk & Brown, 2003; Masi, 1997). EAP has become an umbrella term that includes HIV/AIDS interventions. In all, it is a broad service provided to employees with personal problems perceived to be interfering with their work and productivity that could impact on the operational functions of the organization and/or company.

The main **goal or characteristic** of the EAP is to help employees before their personal concerns affect their job performance. Although use of the term ‘assistance’ within the name employee assistance programme suggests a *reactive* intervention when an employee is experiencing some form of personal problem that interferes with work performance, today’s EAPs have moved beyond this to incorporate *proactive* or preventative measures to deal with issues perceived as having the potential to impact of work performance and thus company profits. EAPs are said to provide a ‘management tool’ to improve workplace performance and productivity, and respond to critical incidents (Arthur, 2000).

EAPs have to respond to a broad constituency of workers, and often their family members, with services that provide diverse care for a range of presenting problems in addition to their focus on rehabilitation of alcohol and drug abusers (Akabas, 1999). The author further asserts that the service agenda of most EAPs is broader and can be adapted to suit any personal and workplace condition.

Programmes offer counselling to those experiencing marital problems or difficulties with children, those needing help with finding day care or those making decisions concerning elder care for a family member. Some EAPs have been asked to deal with work environment issues. Their response is to give help to families adjusting to relocation, to bank employees who experience robberies and need trauma debriefing, to disaster crews, or to health care workers accidentally exposed to HIV infection. Assistance in coping with “downsizing” is supplied, too, to both those laid off and the survivors of such layoffs. EAPs may be called on to assist with organizational change to meet affirmative action goals or to serve as case managers in achieving accommodation and return to work for employees who become disabled. EAPs have been enlisted in preventive activities as well, including good nutrition and smoking cessation programmes, encouraging participation in exercise regimes or other parts of health promotion efforts, and offering educational initiatives that can range from parenting programmes to preparation for retirement.

Table 5.2 Types of models and their descriptions

Model	Description
Onsite/internal model	The on-site/internal model is one in which the entire EAP staff is employed by the company. It can be housed physically in or away from the company worksite. Managers sometimes prefer this model because of the belief that on-site programmes provide service at a lower cost, with increased control, greater identification of alcoholic employees, increased supervisory and medical referrals and more positive acceptance by the unions.
Offsite/external model	The off-site/external model is one in which a firm is contracted to provide the EAP staff and services. This model is viewed as providing better accountability, lower legal liability, and ease of programme start-up and implementation. This model is preferred by managers because of the belief that the programme can foster an employee confidence in the confidentiality of the programme. In addition, a contractual relationship need not be long-term.
Combination model	Uses the combination of the above-mentioned models with some staff that normally conduct initial assessments and screening and then refer to appropriate services.

The 1990s brought new challenges for the EAP field. Increasing health care costs accelerated the development of managed care and the re-orientation of EAPs towards health benefits.

There are various assumptions put forward by authors on the **rationale** for funding EAPs by the employers. The following section examines these assumptions and the rationale for funding such EAPs.

Improved Productivity

There exists an assumption that EAPs will result in improved productivity through outcomes such as reduced absenteeism, increased morale and lower turnover (Kirk & Brown, 2003; Harper, 1999). Improved productivity also depends on equity and/or equitable exchange between what employees invest in their relationship with the organisation and what they receive back in return is a key element in the employee-organisation relationship (Geurts, Schaufeli & Rutte, 1999: 253). The provision of EAP

services by the employer could be other means of promoting and achieving equity with the employees.

- Cost containment

The motivation for implementing EAPs in the workplace is not purely a charitable or humanistic concern of organizations, but also the containment of health care related costs. Health care monies need to be well managed so as not to exceed the budget. The health care costs manifest either directly through the company contributing financially for health services provided to employees or through the high insurance/medical aid premiums that the employers also contribute to. Kurzman (1997) suggests that EAPs are increasingly likely to be one element in a multiphase approach to employers' containment of health care costs. EAPs are therefore challenged to actively become part of the solution in containing the costs of health care.

- Organizational Change

Organizational change is one of the important elements to look at when assisting troubled employees. This comes with the assumption that workplaces are, among other things, sources of stress that challenge and test employees' coping mechanisms, probably on a daily basis. As Walsh (1982) noted, "while EAPs that are oriented principally toward organizational effectiveness or productivity continue to administer emotional first-aid to employees they scoop out of the rapids, they should also move upstream in search of explanations for why so many tumble in." This institutional perspective is valuable to a work organization because it addresses the possibility of prevention, which generally leads to a far less costly human resource solution. However, it should be noted that prevention results are often experienced in the long-term thus requiring patience in anticipating outcomes. Kurzman (1997) argues that occupational social workers and EAPs need to embrace both the delivery of professional human services and the promotion of progressive social change in organizations.

5.3.2.3 Wellness Programme

Wellness programmes emerged as a manifestation of the growing national interest in disease prevention and health promotion (Conrad, 1987). Consequently, health promotion has become an active part of corporate health care policies.

Wellness is a concept often emphasized by alternative or complementary medical systems, where it is viewed as distinct from the concepts of prevention and treatment of disease (Watt, Verma & Flynn, 1998). Conrad (1987) defines wellness as “a conscious and deliberate approach to an advanced state of physical and psychological/spiritual health.” Watt, Verma & Flynn (1998: 225) define a wellness programme as a structured intervention focused on achieving wellness in the physical, psychological or spiritual realm. Their focus on engaging the inner resources of each individual as an active and conscious participant in the maintenance of his or her own health. Such programmes share the goal of encouraging self-care and are purported to help patients recover some control over their health and health care.

These programmes are frequently aimed at patients with chronic illnesses, and the desired outcome is an improvement in the patients’ quality of life, which is considered a global measure of health or well-being based on perceptions, illness experience and functional status (Watt et al. 1998). Wellness therefore incorporates socio-cultural, psychological and disease-related factors. Watt et al. (1998) further assert that wellness programmes use a patient centred, multidisciplinary approach and may shift service from institutions to the community and from physicians to allied health professionals, meaning that wellness programmes may contribute to preventive health care thus reducing health service usage and decrease the number of physician visits.

Worksite health promotion is a combination of educational, organizational and environmental activities designed to support behaviour conducive to the health of employees and their families (Parkinson et al., 1982). Conrad (1987) adds that in effect, worksite health promotion consists of health education, screening, and/or intervention

designed to change employees' behaviour in order to achieve better health and reduce the associated health risks. These programmes range from single interventions to comprehensive health and fitness programmes.

The benefits of worksite health promotion have included improvements in productivity and absenteeism, increased employee morale, improved ability to perform and the development of high quality staff; reduction in benefit costs, such as decreases in health, life and workers compensation insurance; reduction in human resource development costs, such as decreased turnover and greater employee satisfaction and improved image for the corporation (Conrad, 1987). In essence, the employees attend these programmes at their own time before and after work or during lunchtime (Conrad, 1987). It would seem like there is restriction in terms of the times that employees can make use of the services. It may therefore limit and hamper the use of these services.

Worksite health promotion as a widespread corporate phenomenon only began to emerge in the 1970s and has developed largely outside the medical care system with little participation by physicians (Conrad, 1987). The author adds that the dominant stated rationale for work-site health promotion has been containing health care costs by improving employee health. Reducing absenteeism, improving employee morale, and increasing productivity are also important corporate rationales for worksite health promotion (Herzlinger & Calkins, 1986; Davis et al., 1984). Hidden absenteeism can be very costly, especially when skilled labour is involved (Clement & Gibbs, 1983 in Conrad, 1987). Improved morale is expected to reduce turnover, increase company loyalty, and improve workforce productivity (Bellingham, Johnson and McCauley, 1985).

Corporate wellness programmes are long-term organizational activities designed to promote the adoption of organizational practices and personal behaviour conducive to maintaining or improving employee physiological, mental, and social well-being (Ho, 1997). The rationale for the introduction of these programmes includes the following:

- A need to contain rising health costs,
- Increased competition and technological changes leading to negative effects on employee health or well-being by increasing the likelihood of overwork, work stress, job dissatisfaction, and accidents, and
- Greater access to adults compared to other community programmes, reasonable stability of the target population, presence of organizational structures and management to support the programmes, the ability to provide preventive medical services at lower costs, and opportunities to develop and provide more comprehensive, integrated health programmes than those possible through traditional medical care and public health institutions (Opatz, 1994).

The perceived benefits of wellness programmes and their practices are based primarily on the reported experiences of participants and advocates of the wellness ideology (Watt et al., 1998). The subjective nature of this evidence limits its value in determining the usefulness of wellness programmes.

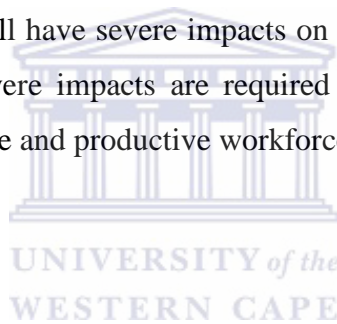
A workplace wellness programme ideally consists of three components: prevention, recognition, and assistance. The combination of these elements in a wellness programme suggests the comprehensiveness of these programme, which if implemented effectively can serve to improve the quality of life of employees with wellness problems. Also, workplace wellness programmes have been proven to reduce absenteeism, and add to the health and longevity of participants. They are instrumental in keeping people or employees on a healthy living path.

5.4 CONCLUSION

There exists a variety of workplace intervention programmes that employers could utilize depending on the employers' rationale and attitude to the quality of care and cost implications for the company. These programmes are all intended to improve the quality of life of individuals but differ in focus and approach. An approach that an institution adopts will be determined by the needs of both the employer and employees.

The complexity of HIV/AIDS requires a comprehensive programme that takes into consideration the wider impacts of the pandemic beyond an individual to their families as well. This thinking incorporates not only those who are infected with the virus but also those who are affected by the diseases it produces. The high cost of treating a person living with HIV (using ARVs) has implications for the corporate health benefits likely to be provided for employees. Thus, employers have to invest in their employees' health and welfare by adopting cost effective strategies to reduce health care costs. Employers in South Africa should also note that ARVs are freely available from government healthcare centres.

Since HIV/AIDS impacts can be severe on the workforce and employers, without appropriate interventions, it will have severe impacts on the economy. Therefore, efforts to mitigate the potentially severe impacts are required at workplace levels where the target is the economically active and productive workforce.



CHAPTER 6

OBSERVATIONS OF SELECTED PRACTICE EXAMPLES OF INTERVENTION PROGRAMMES IN SOUTH AFRICAN COMPANIES AND UGANDA

6.1 INTRODUCTION

When engaging in intervention research processes with an aim of developing intervention, it is critical to observe elements of other programmes. The role of the researcher would be to analyse the critical features of the programmes and practices that previously addressed the problem. This chapter presents information on the researcher's observations of practice examples of programmes to assist employees with HIV/AIDS related matters in the workplace.

Rothman and Thomas (1994: 32) assert that this phase can be achieved by means of searching computerized data bases for selected empirical research, reported practice and innovations relevant to the particular concern being studied (De Vos et al., 2005:399). The ultimate outcome of this phase would be a list of apparently functional elements that can be incorporated into the design of the intervention. The researcher therefore chose to visit South African companies and Uganda's Ministry of Education and Sport, and the results of these visits are presented here.

6.2 RESULTS OF INFORMATION GATHERING AND OBSERVATION OF EXAMPLES OF INTERVENTION PROGRAMMES

6.2.1 South African Corporate and Para-Statal Companies

Five South African companies and para-statal organisations were visited for the purpose of collecting information on the services provided to their employees in an endeavour to support them with AIDS related issues at the workplace. Due to a confidentiality agreement signed between the researcher and the companies concerned, companies' identities are not revealed in this chapter and the whole thesis. The companies included in the study represented the insurance, transport and telecommunications industries.

6.2.1.1 Approach to services: internal vs external service provision

Some companies have adopted a combination of internal and external services. The role of internal and external service providers is distinct. Internal service involves promotion of the EAP: HIV/AIDS in the workplace programme to the broader employees of the company. The programme involves awareness-raising through organized activities/events, internal communication (intranet, information leaflets, newsletters, and peer education). The EA practitioner also addresses staff at their meetings, including organized labour union meetings.

In other companies, the designated person is expected to conduct initial assessment of the presenting problem and refer clients to community service providers. It is therefore required of this designated person to have knowledge of existing community and governmental programmes and/or agencies providing specific programmes to refer employees appropriately. This meant that the designated person has to establish and maintain networks with community organizations and government institutions at all times.

In other instances, the EA practitioner works in close collaboration with the occupational health services. Identified and voluntary employees coming for a service are referred to the occupational health practitioner whose responsibility is also to refer an employee to appropriate services. Normally, the referral point in this case is the outsourced services of the company.

6.2.1.2 Outsourced Services

The companies also outsourced certain services to external service providers. It is believed that the outsourcing of these services will ensure confidentiality, and promote the use of these services by the employees. The external service providers were expected to provide the companies with statistical information on the number of employees utilizing the service on a monthly basis.

The downside of this service is that the companies are only provided with statistics of persons who attended the programme in a month. This system does not allow the companies' management to really understand the extent and the dynamics of HIV/AIDS as it plays out in the workplace. The companies may lack necessary information on the qualitative issues related to HIV/AIDS in the workplace, thus affecting their response to the epidemic in the workplace.

The following discussion focuses on the services outsourced to external service providers.

- **Voluntary Counselling and Testing**

All companies investigated promote and encourage voluntary counselling and testing by the employees. The companies embarked on various campaigns through the internal EAP practitioners and communication channels in a company to encourage employees to support this venture. The promotion of this service is done in order for the companies to know the extent of the HIV/AIDS in the company and also to enrol the employees into

the Disease Management Programme provided by the companies. It was not clear from the managers how the selected companies ensured confidentiality of information, and whether it was voluntary to enrol in such a disease management programme.

It was noted that these campaigns are not highly successful when done on the company premises. It is therefore recommended that VCT campaigns be done at company premises to encourage employees to go for VCT and not necessarily have it done on the spot. The success of the campaign also depended on the marketing of the campaign to the targeted audience rather than a general campaign. The targeted marketing seemed to have played a critical role in determining the success of the campaign.

- **Counselling**

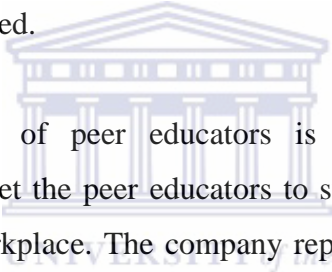
All company employees are entitled to a stipulated number of counselling sessions which are paid for by the companies. The norm in these companies for counselling sessions was between 6-8 sessions a year, and thereafter the employees use their own medical aid benefits or other company medical support for those employees who are not affiliated to any medical scheme. It is important to note that the companies are also concerned with the welfare of those employees who are not members to any medical scheme by extending these services to them without having to pay from their own salaries.

The companies also extend the counselling services to family members of their employees. This is in recognition that family members are also affected when a family member is ill. However, this service is very short-term one as in a once off session for assessment of the presenting problem and referral of the family to an appropriate service provider.

- **Training**

The companies contracted external service providers to formally train managers on managing HIV/AIDS in the workplace, and managing absenteeism effectively. Managers

are expected to handle HIV/AIDS related matter in a sensitive and sensible manner hence their training. For example, managing absenteeism in the workplace should be done in a sensitive and sensible manner as some employees may be absent for pure health related reasons linked to the progression of the illness. It also serves to allow for an employee to be accommodated within the course of work as the disease progresses. The Trade Unions were said to be suspicious when a company wants to reasonably accommodate the employees' needs, e.g. by redeployment, as this is viewed as another form of trying to rid the company of employees who are deemed unproductive due to illness. This therefore means that reasonable accommodation of ill employees has to be handled with caution and care and having the interest of the employee at the core of the decision making process. Engaging the union representatives in programme planning might improve the understanding of the employer's intentions but needs to be handled with discretion if confidentiality is to be maintained.



Internal or in-house training of peer educators is prominent in the companies investigated. The aim was to get the peer educators to support their colleagues (mainly affected employees) in the workplace. The company representatives held a strong view that many HIV positive employees did not coming out about their HIV status in the workplace. Internal staff support groups were started in many companies but fell flat as employees never utilized them. It was acknowledged that the stigma attached to HIV/AIDS plays a role in this situation. The companies however do not have programmes to deal with stigma attached to HIV/AIDS in the workplace although they did acknowledge that this was highly desirable.

The in-house training also focuses on the induction of new employees to understand the vision, mission and philosophy of the companies with regard to HIV/AIDS in the workplace. The induction programme is also geared towards making new employees aware of available services and benefits the company provides to their employees.

6.2.1.3 Disease Management Programme

As part of company's medical scheme benefits, the employees infected with HIV are enrolled into a Disease Management Programme which focuses on medical assessment including CD4 counts. Through this programme, an HIV infected employee is followed up medically and put on treatment when necessary. In some instances, companies pay for these services, which are not necessarily part of the normal medical benefits. This service is therefore viewed as over and above the normal medical benefits employees receive.

6.2.1.4 Marketing of the programme

The companies use various methods to market their services to employees infected and affected by HIV and AIDS. These marketing methods include Open Days; lunch time presentations; internal communication via intranet or company website; forums including labour and peer educator forums, task teams or wellness committees and staff meetings; newsletters and magazines, posters and leaflets; and other launches.

There is a range of marketing activities to promote HIV/AIDS related activities and campaigns, but there was a feeling that these marketing methods are somehow not effective as far as increasing VCT intake thus making it difficult to ascertain and determine the extend of the AIDS pandemic in the workplace. This statement suggests that increasing VCT intake would enable the employer to understand how much HIV is present in the workplace. This would be so if many employees actually go for testing. However, this would be problematic if only a few employees go for testing.

6.2.1.5 Programme Evaluation

The programme evaluation is a major weakness in the companies' intervention programmes. None of the companies visited had formal evaluation of their comprehensive HIV/AIDS programme. As a result, it is difficult for the companies to

measure the success of their internal programmes. For awareness-related activities, the companies rely mainly on the turn-out to these events. However, the turnout alone does not mean that employees are fully aware of HIV/AIDS related issues especially with regards to prevention and living with HIV for those already infected.

As far as the services provided by the external service provider, companies receive statistics. However, the information is only on the number of people who utilized the service in a particular month. The challenge is that the information does not give the companies any in-depth information about the extent and nature of HIV/AIDS in the company to help them plan appropriately in future.

6.2.2 Uganda's Ministry of Education and Sport

6.2.2.1 Grounding of HIV/AIDS in the workplace programme on policy

Uganda's response to HIV/AIDS is based on a National Strategic Framework that is governed by multi-sectoral approach to HIV. One of the purposes of the Ugandan Strategic Plan for HIV/AIDS was to bring to the fore the active involvement of all stakeholders in the planning, management, implementation, monitoring and evaluation of HIV/AIDS interventions over the 2000/1 – 2005/6 period (National Strategic Framework, 2000/1-2005/6). This comes with the recognition and realization that the effectiveness of the programme will be guided by the involvement of all stakeholders.

All the stakeholders, including the education sector, have very clear and defined roles and responsibilities within the overarching national strategic framework or policy. The education sector is also mandated to come up with those interventions that are best suited within the mandate of the education sector. The education sector thus assesses its comparative advantages and defines its intervention areas along the identified parameters. One of the key components within Uganda's education sector strategic plan is the workplace policy and programmes to intervene appropriately as far as HIV/AIDS in the workplace is concerned.

The National Strategic Plan focuses on the following:

- Dealing with the increasing number of orphans as a result of the death of one or both parents to AIDS-related diseases
- Adverse impacts on the economy, and
- Realizing the role played by various sectors and line ministries in HIV prevention, care and mitigation of the socio-economic impacts of the pandemic.

From the National Strategic Plan for HIV/AIDS, an Education Sector Policy on HIV/AIDS was developed. This is an all encompassing policy that looks at HIV/AIDS related issues that impact on learners, employees, managers, administrators, and other providers of education in all public and private, formal and non-formal learning institutions at all levels of the education system in the republic of Uganda (Uganda Education Sector Policy on HIV/AIDS, 2004).

The key principles underlying the Education Sector Policy on HIV/AIDS are:

- Approaches: multi-sectoral approach to development and in the fight against HIV/AIDS; mainstreaming HIV/AIDS into policies, procedures, practice and programming; involvement of people living with HIV/AIDS; and recognition of people affected and displaced by conflict, disasters and other emergencies in any HIV/AIDS response.
- Rights: HIV/AIDS Education sector policy to recognize and uphold the rights of all people with the sector with a special focus on marginalized and vulnerable groups and those with special needs; universal access to HIV/AIDS information; access to treatment and care; protection from discrimination and stigma; and care for orphans and vulnerable learners.
- Resources and access: promote resource mobilization to ensure that budgetary provisions are made for HIV/AIDS interventions; and strive for equitable allocation of resources for HIV/AIDS interventions.

- Practice: observation of the right of privacy and confidentiality; no compulsory HIV testing; institutions in the education sector are required to develop and enforce HIV/AIDS workplace policies; and the promotion of safe learning environment.

The development of the HIV/AIDS Workplace Policy was in direct response of the Education Sector HIV/AIDS policy which in turn responded to the National Strategic Plan for HIV/AIDS 2000/1-2005/6. The HIV/AIDS Workplace Policy is therefore a basic component of the entire comprehensive HIV/AIDS policy for the education sector. Its main purpose is to ensure a consequent and equitable approach to the prevention of HIV/AIDS among employees and the comprehensive management of the consequences of HIV/AIDS, including care and support of employees living with HIV/AIDS (Uganda, 2004). The policy also makes provision for the immediate families of the employees to be provided with appropriate services when the need arises.

6.2.2.2 Statement of commitment

Ugandan Ministry of Education and Sport states and commits to:

- Recognizing the seriousness of the HIV/AIDS epidemic.
- Providing leadership to implement an HIV/AIDS Workplace programme.
- Ensuring a workplace that guarantees a non-discriminatory environment for persons affected by HIV/AIDS, and encourages HIV positive employees to disclose their HIV status.
- Developing and implementing an HIV/AIDS policy in consultation with all employees.
- Minimizing the social and economic consequences to MoES, including affiliated para-statal, commissions, schools, colleges and institutions.
- Ensuring an HIV/AIDS workplace policy that is compliant to existing laws in general and regarding HIV/AIDS in Uganda, and to the ILO Code of Practice on HIV/AIDS and the world of work.

6.2.2.3 Research on the need for HIV/AIDS interventions in the workplace

Ugandan Ministry of Education and Sport conducted a baseline research with a focus on knowledge, attitudes and practice, also known as KAP survey. Following the results of this survey, a decision was taken by this ministry to collaborate with the ministry of health culminating in the development of a network model concept to investigate and define the kinds of entry points for access to care and support for everybody including teachers.

6.2.2.4 Aspects of the programme

- **Behaviour Change Agents**

The behaviour change agents are generally also known as “peer educators”. The behaviour change agents are based at schools, and each school has at least one behaviour change agent in the staff establishment. The plan is to have a minimum of three behaviour change agents per school because their staffing levels are high in many schools. The Ministry also recognized that the transfer of teachers to other schools leaves an important gap if the teacher being transferred is the trained behaviour change agent. Hence the need to train and place at least three behaviour changes agents per school.

As the name suggests, one of the main focus areas is working with teachers towards behaviour change. The behaviour change agents do not only work on trying to influence behaviour change, but also act as hubs of knowledge where they distribute information in the staff rooms, to families of the teachers and also do general advocacy work promoting positive behaviour.

- **Support Groups**

These groups consist of teachers living with HIV/AIDS who mainly experienced stigma and stigmatization in their schools. They share their experiences which are formulated

into case studies, which are in-turn used in the training of other teachers. The focus of these groups is dealing with self-enacted stigma, which prevents teachers from disclosing their HIV status and leaves them in isolation. The Ministry also recognized that the externally given stigma is decreasing and is no longer a major challenge. Teacher groups were established because it was assumed that teachers can better motivate others, thus developing and instilling a collective sense of togetherness.

The Education sector approach to managing HIV/AIDS in the workplace is done through 'mainstreaming', i.e. infusing various intervention methods, which are deemed useful in the sector. One example of the mainstreaming of HIV/AIDS activities in schools is that the secondary school budgets should reflect resources committed to HIV/AIDS interventions. The school and the board of governors are held accountable for ensuring that some school budget and resources are committed towards this cause. By so doing, the Ministry of Education is trying to nurture the pre- and in-service training so that teachers begin to accept and embrace a diagnosis of HIV because the disease is still viewed as threat to humanity, and to convince teachers that the education sector is centrally placed to turn around the AIDS pandemic.

- **Outreach**

The outreach component of the HIV/AIDS in the Education sector programme refers to the extension of the HIV/AIDS services not only to the teachers but also to their children and families. The Ugandan Ministry of Education and Sport took a holistic approach to the HIV/AIDS programme hence the extension of services to children and families of the teachers. The service takes the form of counselling and referral for services in the public health care system.

- **Referral System**

The referral system has been a problem because the Ministry has not developed its own referral system. The teachers mainly refer themselves and follow the Ministry of Health systems for service delivery.

The Ministry encourages every teacher to do a personal risk assessment facilitated by the counsellors or behaviour change agents. This is based on a principle that “everyone needs counselling”. It is hoped that the personal risk assessment will enable teachers to take decisions to seek the right services at the right time, where they will be able to change their behaviours within the workplace and in the community. Behaviour change related to changing behaviours that would put teachers at risk of contracting HIV, e.g. multiple partners and unsafe sex. Peer counsellors or behaviour change agents make referrals to the public health care centres. Peer counsellors are people of high integrity and dignity, possess counselling skills and able to maintain confidentiality. The peer counsellors undergo vigorous screening and training to enable them to perform these duties.

The challenge with this system of referrals is that the Ministry of Education and Sport is unable to get statistics on the teachers on treatment or receiving some sort of service. At the time of the research, the Ministry was in the process of conducting a survey together with the Ministry of Health to determine the state of HIV/AIDS in the education sector.

- **Collaboration with other Ministries**

The Ministry of Education and Sport had difficulty getting many teachers to take up services available to them. The majority of teachers utilized public health services and a need existed to get to those teachers. They believed that this would enable them to understand the extent of the AIDS pandemic in the education sector. The Ministry of Education and Sport reached an agreement with the Ministry of Health to work together. The Ministry of Health was to provide the education ministry with information on teachers infected and affected by HIV/AIDS choosing to use their services. The

information was gathered through the entry points to the Health Ministry. The agreement also included efforts to allow teachers to receive preferential treatment when coming for services so that they could return to their duties at schools with minimal delay. This intervention indicates that teaching is regarded as an essential service that needs to be protected.

The Ministries of Gender, Labour and Social Development were viewed as crucial partners in the development of HIV/AIDS interventions in the Education sector as these Ministries were already providing services to employees infected and affected by HIV/AIDS. These Ministries had already developed generic guidelines which the Ministry of Education adapted in formulating its HIV/AIDS programme.

- **Network Model**

Within the network model, a school is placed within a health service provision community. The schools are thus required to conduct a profile of existing services in the catchment area. The schools are also required to update this information on a regular basis so that community services could be used effectively for the benefit of the school community. In this way, schools are trying to address access to services that are at close proximity to the school.

However, the Ministry has learnt that teachers do not want to use health services within the school localities because of some challenges. One of these challenges is sitting in the same queue with learners, parents and other community members for the same service. This is exacerbated by the fact that while teachers are still held in high regard in the communities where they teach, HIV is associated with promiscuity and immorality.

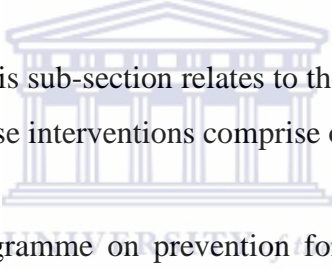
In order to overcome the problem, they introduced the system of cost-sharing where the Ministry and the teacher share the costs for services. The teacher is allocated a counsellor that is available 24 hours a day and can be accessed at any time, as the need arises. This helped to fast track service delivery to teachers who share the costs.

Another model is that of a separate window for teachers in a public health care facility. Although teachers are attended to without having to pay for services, the process of receiving assistance takes a while longer compared to the cost-sharing model.

The other model is the use of Non-Governmental Organizations (NGOs), Faith Based Organizations (FBO) and mission hospitals to provide care for the teachers. This model seems to provide easier access than public/government facilities. Teachers and staff from the ministry are referred to these facilities where there are also fewer conditions. Teachers also make sure that they negotiate appointments and days they for follow-up services.

6.2.2.5 Kinds of interventions / focus areas

The information presented in this sub-section relates to the different types of programmes provided to assist teachers. These interventions comprise of the following elements:

- 
- Treatment focused programme on prevention for infected or affected teachers. Prevention takes the form of teacher training and the use of behaviour change agents to impart knowledge and information on to teachers at school.
 - Life-skills programme aimed at learners but seen as a way that teachers will get more information and enhance their knowledge of HIV/AIDS as well. Learners are taught life-skills to empower them with knowledge and skills to cope with peer pressure and hopefully help them with decision making that will prevent them from contracting the disease.
 - Curriculum review for primary education to include HIV/AIDS in teaching. The plan is to have the curriculum reflecting on HIV/AIDS so that the disease is part of everyday teaching at schools. The move is also around tertiary institutions developing modules on HIV/AIDS. Tertiary institutions are considered to have been very slow in incorporating HIV/AIDS in the teaching curricula.
 - Induction programme to the workplace HIV/AIDS programme for new teachers entering profession or public service. This is meant to educate new teachers about

available services and the Ministry's expectations from teachers concerning HIV/AIDS. New teachers are also informed about government policies around HIV/AIDS so that they are well informed on these policies and the expectations thereof.

- Workload rationalization programme aimed at teachers in the late stages of the illness. Workload rationalization is often referred to as “reasonable accommodation” of teachers who find it hard to perform their duties as a result of the illness. This programme is also aimed at those teachers who care for sick family members. Work is rationalized to accommodate the needs of these teachers within the school.
- Early retirement on medical grounds subject to following the set rules of the Ministry. Early retirement on medical grounds is a provision available to all public servants and this programme simply makes it easier for HIV positive teachers to retire early on medical grounds.

6.2.2.6 Evaluation of services

The Ministry of Education and Sport established a monitoring and evaluation programme for the HIV/AIDS in the workplace programme. The Ministry defined indicators and some of the indicators are about the extent of access to health care services by teachers. This information was collected at facility level which will provide the Ministry with information on the number of teachers seeking services or service penetration levels by the teachers.

6.3 SUMMARY AND CONCLUSION ABOUT THE MODELS

Following an examination of the companies' and the Ugandan Ministry of Education and Sport's programmes, the following aspects are identified as critical elements of the programmes:

6.3.1 Companies

Firstly, a combination of internal and external services that compliment each other was found useful. The internal services served to conduct initial assessments, facilitate internal communications, and channel referrals to external service providers. External service providers specifically dealt with interventions directed at the individual in the form of medical treatment, examination and monitoring of CD4 counts. However, a key component that was lacking with the external service providers was the provision of qualitative information to help managers plan effectively for the management of HIV/AIDS in the workplace. Their main focus was providing quantitative data about the use of services. The provision of only qualitative information may be as a direct consequence of the contractual agreement between the employer and the external service provider.

Secondly, the focus on counselling the employees living with HIV/AIDS was useful. Counselling sessions allowed individuals to deal with personal and emotional issues related to the illness. However, this service is not extended to families compared to Ugandan Ministry of Education and Sport.

Thirdly, training aimed at managers is one of the more useful elements of the HIV/AIDS in the workplace programme. This helps managers to become aware of issues and enable them to act sensitively. It also helps with the actual management of the disease as it impacts on the workplace.

Lastly, the marketing of the programme to the employees enables them to make better use of the available services.

6.3.2 Uganda Ministry of Education and Sport

- Monitoring and evaluation

The establishment of the monitoring and evaluation programme for HIV/AIDS in the workplace should be very useful. It is useful in order to first monitor the activities of the Ministry. Monitoring of the activities continuously will assist in identifying whether the programme is delivering on its plans early in the implementation process. On the other hand, the evaluation component serves to ascertain the impact of programme on the target group.

- Induction programme

The induction programme is not only crucial for the new employees, but also the existing employees to be aware of available services. The intake into such an important programme could increase as a result of the induction programme.

- Workload rationalization

The ILO advocates for reasonable accommodation of people living with HIV and AIDS in the workplace. Workload rationalization is one way to assist teachers infected by HIV, and perhaps reaching an AIDS stage according to the WHO staging of HIV/AIDS. However, workload rationalization needs to be carefully implemented in order to prevent any tensions that may arise from workload rationalization among teachers.

- Collaboration with other service providers

From the Ugandan experience, collaboration with other health-care service providers, private or public was the crucial element of the programme. This is especially beneficial to the teachers and the Ministry where resources are limited. This is one of the innovative ways of utilizing available resources to effect maximum impact.

- Use of behaviour change agents

Behaviour change agents, otherwise known as peer educators, allow teachers to interact with other teachers. It provides a sense of belonging and understanding of fellow teachers' social conditions thus giving them an ability to respond accordingly. Whether teachers would trust behaviour change agents with confidential information about a disease that has high morality issues involved depends on the approach taken. In the Ugandan context, teachers came up with this concept and showed commitment to help colleagues.

6.4 CONCLUSION

In conclusion, HIV/AIDS workplace programmes are seen as one of the many intervention programmes available to assist employees infected and affected by HIV and AIDS. The delivery of HIV/AIDS workplace programmes takes various forms including the use of internal and external services.

There are various types of services to employees infected and affected by HIV/AIDS. Together, these services provide comprehensive support to employees. The variety of services allows for employees to choose the type of service they want to use for a specific purpose.

However, there are some challenges faced in the delivery of HIV/AIDS workplace programmes. One of these is increasing the uptake of programmes and another is their evaluation. An increased uptake would mean that the services are responsive to the needs of employees. On the other hand, an evaluation of these services would serve to ensure that the employers are aware of the extent and nature of the problem and respond accordingly.

CHAPTER 7

GUIDELINES FOR DEVELOPING AN HIV/AIDS SUPPORT PROGRAMME FOR TEACHERS

7.1 INTRODUCTION TO THE PROCESSES AND OUTCOMES FOR DESIGN AND DEVELOPMENT

Intervention Research: Intervention Design and Development (IR: IDD) identifies two critical phases that lead to the design of an intervention programme. The first phase involves *problem analysis and planning*, and its main aim is to elicit the necessary support and cooperation to enable a researcher to conduct intervention research. Subsequently, it enables the researcher to analyze the problem from the perspective of the research participants. The second phase is about *information gathering and synthesis*. At the core of this phase is discovering what others have done to understand and address the problem, HIV/AIDS in the workplace in this context. The key characteristic of this phase is not “reinventing the wheel”, but the researcher’s ability to extract and incorporate functional elements of the observed programme into the design of a new intervention.

According to Rothman and Thomas (1994), design is the third phase of IR: IDD, and the product of this phase is an intervention which may include a strategy or a programme. However, the design and development phases were adapted according to the adapted model proposed by Strydom, Steyn and Strydom (2007:338). The authors suggest that development should be based on the results of the problem analysis and information gathering processes and evaluated for refinement. This chapter focuses on the development and evaluation phases of the adapted IR: IDD. As such, it provides the refined guidelines for developing an HIV/AIDS support programme for teachers. The discussion that follows presents a summary of the outcomes of the first two phases.

The summary brings together the core issues emanating from these two phases that influenced the design of the guidelines for the development of an HIV/AIDS support programme in schools. Further, it outlines the steps taken in the early development and pilot testing of the guidelines which facilitated further refinement of the guidelines.



7.2 PROCESSES AND OUTCOMES OF THE RESEARCH THAT INFORMED AND GUIDED THE DEVELOPMENT OF THE GUIDELINES

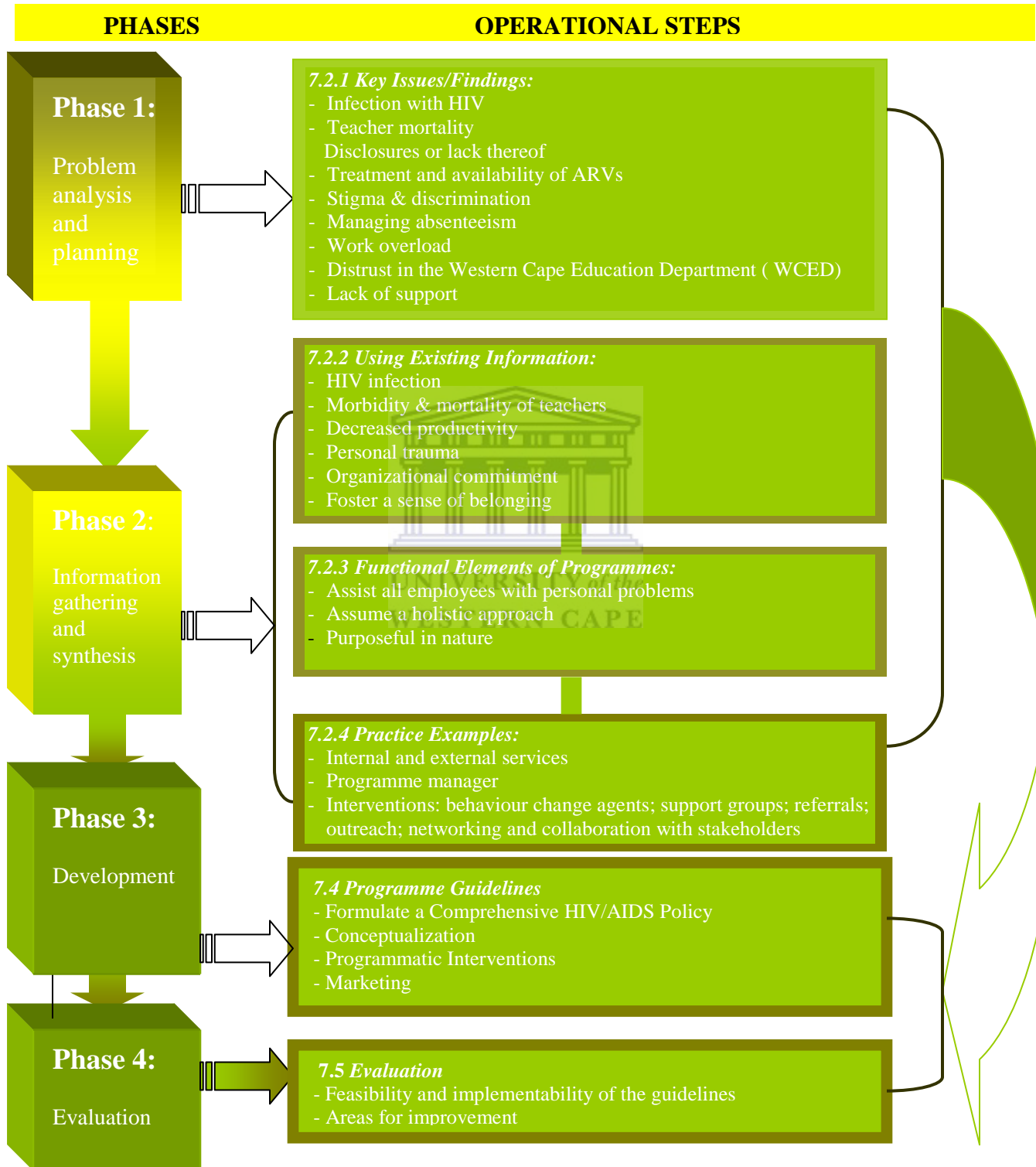


Figure 7.1: Summary of processes and outcomes

In the following discussion the key findings that emerged from first two phases that informed the development of guidelines are presented. Following this discussion the outcome of the development is presented in 7.4.

7.3 KEY ISSUES EMANATING FROM THE FIRST TWO PHASES

7.3.1 Phase 1: Problem analysis and project planning

The critical factor in the first phase of the study was to identify and involve clients, gain entry and co-operation from the setting (see chapter two), identify the concerns of the population, analyze the identified problems, and lastly set goals and objectives. Chapter four presents issues of participants' perception and experiences of HIV/AIDS among teachers. This sub-section thus summarizes the general findings from the problem analysis and planning phase as depicted in table 7.1. These factors have to be considered in an HIV/AIDS programme in an educational setting.

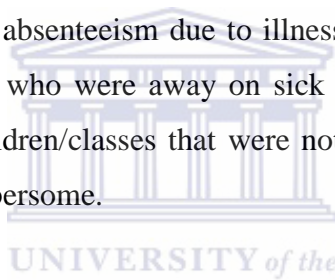
Infection: The continued occurrence of new HIV infections in teachers, coupled with the progression of the illness, affects the management and operational functioning of schools, and traumatizes the infected teachers and their colleagues. HIV infection thus has a psychological impact on all teachers.

Disclosures and lack of disclosure: Generally, teachers prefer not to disclose their HIV positive status to colleagues as a result of a perceived antagonistic school environment towards infected teachers. Because many teachers do not disclose their HIV positive status, principals are less able to help them. The lack of preparedness, mainly as a result of incapacity and lack of knowledge and skills, manifests in hostility and antagonism between teachers.

Stigma: This reinforces the tendency for non-disclosure of an HIV positive status to managers and colleagues and drives the disease underground, hindering prevention and care efforts. Also, it entails discrimination of teachers infected with HIV.

Absenteeism: Prolonged leave of absence not only affects the quality of teaching, it makes it difficult to substitute sick teachers. Principals often do not know how long a teacher would be absent from school as the sick leave is only reviewed and submitted to the principal just before a teacher is due back at school. Also, the education department's substitution policy has stringent guidelines for appointment of substitute teachers which do not necessarily allow for assessment and use of sick leave patterns as motivation for a substitution of a teacher.

Work overload: As a result of absenteeism due to illness, other teachers are overloaded with work. However, teachers who were away on sick leave also complained of work overload as a result of the children/classes that were not taught in their absence, and it becomes administratively cumbersome.



Distrust in the WCED: Based on past experiences, teachers expressed distrust in the education department and its ability to keep its promises. The consequence of this is the dented image of the education department and a sense of distrust in the department by teachers.

Lack of support: Teachers generally felt unsupported by their school managers and the the education department at large. Support also related to the department being a caring organisation of which this is lacking according to teachers.

7.3.2 Phase 2: Information Gathering and Synthesis

The researcher engaged in three operational steps to fulfil the requirements of this phase, viz. using existing information, identifying functional elements of programmes, and

studying practice examples. The findings are presented in detail in chapters 4-6. The following summarizes the key issues that arose out of each phase.

7.3.2.1 Using Existing Information

Chapter three presents a review of literature on the rationale for employers to support their employees. This section encapsulates pointers to the rationale for employer-initiated services to support employees.

The literature suggests that investing in the *health of the employees is crucial* as it is central to economic and social functioning of persons. A consequence of such investment is increased productivity. From an organizational perspective, the issues of HIV infection and mortality of teachers are thus of crucial concern for employers.

Secondly, it is critical to *enable employees to find meaning in their work* which in turn is partly the reason for their existence. When this meaning is found, it is likely to enhance the employee's ability to lead a fulfilling life, foster a sense of entrenchment and belonging to a caring organization. *Adaptation to instances of loss and trauma* is associated with finding meaning in work. As such, it is important to create an enabling environment in schools for teachers to find meaning in their work even under the cloud of the HIV/AIDS epidemic.

Thirdly, there is a need for employers to promote and contribute *towards the psychosocial well-being of an employee*. Improved psychosocial well-being of employees increases their capacity to confront challenges, find ecological balance, and entrench support for the culture and values of their employers. Consequently, individuals' coping capacity is enhanced with high levels of self-esteem.

Fourthly, employers should direct their efforts towards *facilitating commitment to the organization by employees*. This commitment to the organization relates to individual's psychological attachment to the organization and increased ability to perform the

required work. The employees' work ability and organizational commitment are *associated with the employees' mental well-being*.

Lastly, perceived *social justice* is the ultimate achievement in facilitating commitment to the organization. It relates to perceived fairness of outcomes and processes by which decisions concerning employees are made. The employer should thus constantly strive for fairness to facilitate and improve employee trust and commitment to the organization.

In addition to the above-mentioned issues, the literature recognizes the impacts of HIV/AIDS on the education system and the need to mitigate these impacts. Also, teachers are poorly equipped to deal with the impact of the pandemic on their work which subsequently affects learning outcomes.

There is broad consensus that the loss of teachers to AIDS-related diseases affects the supply of, and leads to a shortage of teachers. Factors such as the insufficient supply of teachers combined with the inability of the institutions of higher learning to produce a sufficient number of teachers; consequent inability to provide full attention to learners; and increased levels of tension and stress among teachers make it even more important to manage HIV/AIDS in schools.

Teachers are a valuable asset to society because they have specific skills which are in demand and represent one of the better educated segments of the population. By implication, they need to be protected, cared for and harnessed to perform their duties at a high professional level. This means that support has to be provided within the available resources to enable teachers to perform their work professionally and effectively, especially within the context of HIV/AIDS.

7.3.2.2 Functional Elements of Programmes

The focus of work in this operational step is gathering and analyzing critical features of the observed programmes and published work. The outcome of this process is the

identification of potentially useful elements of the interventions. Due to lack of publicized information on HIV/AIDS in the workplace programmes, the researcher then critiqued the existing intervention models like EAP and disease management programmes.

The following discussion presents the key issues that make these programmes functional and perhaps successful when correctly or effectively implemented. These functional elements include the following.

Policy: The programmes respond to an HIV/AIDS workplace policy developed by the company. These policies have stated goals and objectives. The sub-programmes are thus guided by these goals and objectives.

The policies clearly state the target group for the programme, generally all employees of the companies. In addition, policies clearly state the scope of interventions. The scope of interventions usually relates to the extension of services to families of the employees.

The policies reflect the company's or the department's commitment to assisting all employees. This also serves to portray a positive image about the company/department to the employees and potential employees.

Structure: Structures are created within the organogram of the department/organization to effectively manage the disease in the workplace. The programme usually has a manager or coordinator to communicate or market the programme to employees and assess and refer cases to external service providers. The manager also acts as a liaison person between the company and the external service providers.

In instances where the company adopts an internal approach to service provision, the manager still assesses and refers to internal approach for specific services. Thus, the manager is responsible for networking with community organizations and garnering their support for the benefit of the employees.

Intervention Approaches: Internal, external or combination (internal and external) services are utilized to achieve the stated goals of the programme. Internal and/or external approaches have advantages and disadvantages when used in isolation. The tendency is thus to use both internal and external services in combination in order to compliment each other's weaknesses.

Programme Content: Programmes consist of various sub-programmes including prevention, treatment, care and support to all employees. The aim of the prevention sub-programme is mainly to control accidental and new infections and spread of the disease in the workplace. This aim is achieved through education and raising the levels of awareness. Since accidental infection during the performance of work is unlikely to occur in the education sector, emphasis should on empowering teachers with knowledge on the modes of transmission with a view to preventing new infections.

With regard to treatment, infected and eligible employees are enrolled into disease management programme where employees access treatment with the initial financial support of the employer. This financial support comes in the form of medical aid as a benefit to all employees of the company. In the public sector, emphasis is on linking employees with public health care centres for treatment.

Care and support relates to availability of specialized services for a variety of issues affecting employees during the progression of the illness. Access to ARVs is one such benefit that may be made available to employees. However, access to ARVs comes as a package which includes monthly medical check-ups and screening for CD4 count and the degree adverse drug effects. Care and support also relates to other employee benefits such as sick leave.

Monitoring and Evaluation System: In instances where there is monitoring of interventions and the use thereof, the external service provider is required as part of the

contract to statistical information to the employer on a monthly basis. This information is used to determine the uptake and impact of the service.

All the above factors contribute to the success and effectiveness of the programmes to assist employees infected and affected by HIV/AIDS.

7.3.2.3 Studying Practice Examples

The researcher visited various companies and para-statal organisations around Cape Town and Uganda's Ministry of Sport and Education to observe and learn from programmes to manage HIV/AIDS in the workplace. The following key issues emerged and in turn influenced the design of the guidelines.

- *Companies and Para-statal Organisations*

The companies' approach to service provision reflected both the use of *internal and external services*. With regards to *internal services*, the company takes full responsibility for provision of services by staff specifically employed tasked with this work. The concerned coordinator/manager would be mainly responsible for *promoting and marketing the programme* to the employees of the company. The programmes are promoted mainly through internal communication, special events, and trade union activities.

Among other activities, the programme *managers conduct initial assessments of the presenting problem and refer accordingly to the external service providers*. These service providers are either directly linked to the company through outsourcing of the service, or indirectly linked to the company and are community based non-governmental organizations and public services. In the case of indirectly linked organizations, it means that the programme manager must establish and maintain good working relations with the community based organizations for the benefit of the company's employees.

With regards to external or outsourced services, the programme manager interacts with the external service provider regularly. The external service provider is also expected to provide *monthly statistics on service utilization*. This information is used to gauge the utilization of the programme, and quality assurance. It is also believed that the use of an external service provider ensures confidentiality, thus increasing the likelihood of service utilization by the companies' employees.

External services are mainly used for medical treatment and follow-up services. The outsourced services also include voluntary counselling and testing (VCT), therapeutic counselling, training, and the disease management programme. These services are packaged and provided to all employees and their immediate family members.

The limitation of the workplace programmes was the lack of formal ways of monitoring and evaluating the success and effectiveness of the programmes, thus making it difficult for the companies to ascertain and understand the scale and impacts of the disease on employees and the companies.

- *Uganda's Ministry of Sport and Education*

The Uganda Ministry of Sport and Education's HIV/AIDS programme is *grounded on the country's National Strategic Framework for HIV/AIDS*. The framework requires that all stakeholders are involved in planning, management, implementation, and monitoring and evaluation of HIV/AIDS interventions in the country. Taking the cue from this national strategic framework, the Ministry's HIV/AIDS workplace programme is inclusive in all the facets mentioned in the national strategic framework. It means that the Ministry's HIV/AIDS in the workplace policy and approach has its grounding on the broader national framework.

The policies also promote certain key principles which include *a multi-sectoral approach to development; human rights; mobilizing resources and promoting access; and*

observation of the right to privacy and confidentiality in their practice. These principles are the cornerstones of the Ministry's HIV/AIDS in the workplace programme.

The following functional aspects of the observed Ugandan HIV/AIDS in the workplace programme informed the guidelines.

- Use of “*behaviour change agents*” otherwise known as peer educators who are school based, with a special focus on working with teachers towards behaviour change to reduce new infections, and act as hubs of knowledge through information giving.
- *Support groups* constituted and run by teachers living with HIV/AIDS who work towards stigma reduction.
- *Outreach*: this is done through extending services to the teachers' children and families.
- *Referral*: their approach is to encourage teachers to make use of public services on their own. The ministry has contributed to the creation of conducive and friendly visits by organizing special services for teachers.
- *A Network model* where schools are required to conduct a profile of existing services in the areas where they are based. This model promotes interaction between the school and local organizations, thus decreasing dependency on the Ministry of Education for services.
- *Collaboration with other key ministries* such as health, for the purpose of gathering statistics on teachers using private health services in order to gain a better understanding of the scale of the epidemic in education.

The focus areas of their HIV/AIDS intervention programme are treatment, life skills, curriculum review, induction of new teachers, workload rationalization, and early retirement on medical grounds. The Ministry has an established monitoring and evaluation programme based on collectively defined indicators.

7.4 GUIDELINES FOR DEVELOPING AN HIV/AIDS SUPPORT PROGRAMME IN SCHOOLS

This section presents the outcome of the study i.e. guidelines for developing an HIV/AIDS support programme in schools. Further, some tips on operationalizing the proposed guidelines are provided.

Figure 7.2 presents the guidelines for developing an HIV/AIDS support programme in schools. The steps presented here should act as guides for managers responsible for executing an HIV/AIDS support programme in schools. The guidelines would help in initiating and/or refining an existing programme to assist teachers with AIDS related support issues.



7.4 Guidelines for Developing an HIV/AIDS Support Programme for Teachers

7.4.1 Formulate a Comprehensive HIV/AIDS Policy

It is crucial to formulate an HIV/AIDS policy in schools which serves to guide interventions to support teachers infected and affected by the disease.

7.4.1.1 Rationale and Objectives of the policy

One of the critical features of an HIV/AIDS policy is the statement of what the policy aims to achieve and the reasoning behind the policy. The rationale and objectives can be stated in terms of interventions to employees and/or in a form of what the policy seeks to achieve.

7.4.1.2 Principles

It is important to state key principles on which the policy and the support programme is based. Principles such as justice, promotion of wellness – healthy lifestyle, confidentiality, and recognition of the impacts of HIV/AIDS on the education sector are some of the principles that underline the policy and programme.

NB! Engage all stakeholders .

7.4.2 Conceptualization

When a policy is formulated and interventions are required, it is important to understand and define the problem. ‘What is the extent of the problem?’, ‘How does the disease manifest itself in schools?’, and ‘What are the impacts of HIV/AIDS in schools?’, are some of the questions that should be asked to understand and define the problem.

- Conduct needs analysis
- Importance of teacher orientation

Once the problem is understood and defined, it is crucial to choose an appropriate mode of service delivery. Internal, external and combination mode of service delivery can be chosen to provide the required services to teachers. Important to decide on the delivery mode (internal/external/combination) and the type of programme (EAP, Disease Management, Health Promoting, Awareness)

7.4.3 Decide on Programmatic Interventions

Some elements of an HIV/AIDS support programme in schools:

- Prevention

The objectives of the prevention component of the programme are to:

- Prevent new infections and spread of the disease
- Reduce stigma and stigmatization (by self and other)
- Minimize or mitigate the impacts on the workforce and the core business of the organization.

- Treatment (access to health services and ARVs; mental health promotion)
- Management Capacity Building (manage absenteeism & disclosures; and other policy related issues)

Critical to continuously market the programme to the target group
NB! See section on marketing.

7.4.4 Marketing

- Ensure throughput through consistent marketing
- Marketing strategies (electronic, print, campaigns)
- Procure the services of a marketing specialist to develop a marketing strategy

7.4.5 Monitoring and Evaluation

- Develop indicators
- Design an M&E plan
- Determine frequency of evaluation
- Report and disseminate results

Phase 3: Development

Figure 7.2: Guidelines for developing an HIV/AIDS support programme in schools

7.4.1 Formulate a Comprehensive HIV/AIDS Policy

The formulation of a workplace policy is essential to direct programmatic interventions and resources. Thus the policy acts as the basis for developing programmatic interventions to support teachers infected and affected by HIV/AIDS. It is thus critical to consider certain and specific issues when formulating a comprehensive HIV/AIDS policy in schools and the following section focuses on these issues.

Before an HIV/AIDS policy in schools is formulated, the process must be driven by the responsible person. An HIV/AIDS in the workplace *programme manager* needs to be appointed to drive such a teacher support programme. The first draft of the Western Cape Education Department HIV/AIDS policy is not specific about the responsible person, and this may derail the implementation of the department's plan as no one takes the final responsibility for driving the department's HIV/AIDS in the workplace programme. The programme manager should preferably have a social work or clinical psychology background. In terms of utilizing existing expertise within the education department, the programme manager can work closely with the HR team, heads of Specialised Learner and Educator Support (SLES) and social work. Because of the nature of their training, social workers and psychologists possess counselling and training skills that may be required by the programme manager in executing the workplace HIV/AIDS support programme. Alternatively, the manager could refer people to qualified practitioners in the external services.

In formulating a school HIV/AIDS policy, all *organizational stakeholders* must be involved from the beginning. Thus a team representative of all stakeholders needs to drive the policy formulation process under the leadership of the programme manager. The stakeholders would include teachers, the school management team (principal, deputy principal, heads of department), school governing body (SGB) member, HR department, and representatives from the EMDC and WCED head office.

It is critical at this stage to base the policy on identified HIV/AIDS phenomena. However, if this policy is the first ever policy for schools then the formulation of such a policy can be guided by and based on national policies on HIV/AIDS in the workplace. If it is a review of an existing policy, then it is critical to formulate an HIV/AIDS in the workplace policy that is based on well understood and defined problem related to HIV/AIDS as experienced by teachers.

Following an extensive consultative process and engagement with the stakeholders, the policy must state what it intends to achieve. This must be presented as a policy statement. For example, the statement can read as follows:

“The HIV/AIDS workplace policy of the Western Cape Department lays the foundation on which to develop a programme to support teachers living with and affected by the disease and bring stability to the education system”

Such a policy statement points to the direction in which the WCED wants to move with regard to HIV/AIDS in the workplace support programme.

The policy should also reflect the *organization’s commitment* to assisting teachers to enhance their productivity in the midst of HIV/AIDS. By so doing, the Western Cape Education Department is likely to promote commitment, increase loyalty and a sense of belonging among teachers. Since the education system is person intensive, it is crucial that the education department is seen to be caring for its valuable assets, the teachers, by providing services that respond to the impact of the AIDS epidemic on teachers, and, more broadly, the education system as a whole.

An HIV/AIDS policy should have a clearly defined *scope of intervention*. It should state whether it is concerned with teachers only, or also extends its scope to include the families of the infected and affected teachers. Such scoping will clarify any misunderstandings about who the policy covers. Scoping and decisions reached should be

based on thorough scanning of the environment, and balancing of employee and school needs. Such equilibrium can only be achieved through negotiated consensus between the stakeholders.

An HIV/AIDS policy must be linked to and/or based on *national (and international) policies, guidelines and protocols* to manage HIV/AIDS in the workplace. Examples of such policies are the National Strategic Plan 2007 - 2011, the Department of Labour's Technical Guidelines for Managing HIV/AIDS in the workplace, and the ILO Code of Good Practice. Documents like these should serve as guides for developing an HIV/AIDS policy in schools and/or workplaces.

It is important for the HIV/AIDS policy to state *how the department intends to intervene* with the epidemic. This intention or desire is put in a statement form rather than laying down the programmes. Thus, this becomes a *policy statement* rather than an actual articulation of intervention programmes.

This policy should also influence the programme developed to support teachers infected and affected by HIV/AIDS in schools. As such, it is critical to first develop a policy, and the programme then realizes the values and aspirations of the policy.

7.4.1.1 Rationale and Objectives of the Policy

The *rationale* of the policy is to promote the wellbeing of both the teachers and the education system, with HIV/AIDS as a critical component of a broader wellness programme. With this rationale for the policy comes recognition of the symbiotic relationship between employees and the organization.

The objectives of an HIV/AIDS in the workplace policy should embrace the following four broad issues:

- Mitigate HIV/AIDS impacts on schools,

- Promote justice and human rights,
- Promote mental health and human capacity to cope and adjust, and
- Increase organisational commitment.

Mitigate HIV/AIDS Impacts on Schools: In mitigating the HIV/AIDS impacts on schools, the authorities must look at bringing stability with regards to the demographics of the workforce, and managing absenteeism among other factors. As stated earlier, education is person centred and as such prolonging the lives of teachers and retaining teachers in the education system for as long as possible is crucial for reducing the impact of HIV/AIDS in schools.

Justice and Human Rights: Justice and human rights speak to the principle of fairness in managing HIV/AIDS and related matters at schools. In this context, it relates to enhancing job security among teachers infected by the disease. Job insecurity works on an individual's psyche and may interfere with their ability to maintain peak performance. Furthermore, consistency and fairness need to be applied especially as it concerns promotional opportunities for all teachers.



Also, it is important for teachers to access HIV/AIDS-related services, hence the programme needs to be fully resourced. This means that the WCED must invest finances, human resources, goods and services in the programme.

Justice and human rights also relates to the promotion of decent work where employee benefits are provided for and correctly interpreted and implemented by managers. Care should be taken to prevent abuse of these benefits by both employees and employers in their implementation.

Mental Health and Human Capacity: These two components are interlinked and crucial in managing HIV/AIDS in the workplace. The programme must promote mental health to enable teachers to cope with the trauma of diagnosis and loss of colleagues. Since the diagnosis of HIV impacts psychologically, a programme must seek to enhance the self-

esteem and worth of the teachers. With high self-esteem and enhanced self-worth, teachers would be more confident in performing their work with the knowledge of appreciation and recognition by the employer.

Organizational Commitment: The provision of the required HIV/AIDS related services at WCED is likely to change the perception of teachers regarding the current generally negative image of the department. A more positive perception of the department is likely to develop if it were seen as being a caring organization and this, in turn, is likely to increase organizational commitment. Teachers' loyalty to the department would be increased, and the sense of belonging enhanced in the process.

7.4.1.2 Principles

An HIV/AIDS intervention programme should be based on the following principles:

Social Justice – equality and non-discrimination: The principle of social justice in the management of HIV/AIDS in the workplace is crucial. Self development and self determination are key concepts in promoting social justice especially within the context of HIV/AIDS. Self-development relates to the institution's capacity to actualize the needs of teachers living with and affected by HIV/AIDS.

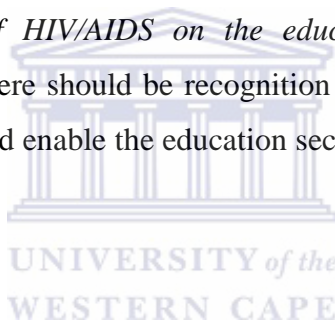
Self-determination is the ability to participate in determining one's action and the condition of one's action (Eggleston, 2004). Self-determination therefore is equated here with social inclusion. People living with HIV/AIDS, and as a vulnerable and marginalized group, need to be included in directing the course of action and self-determination, which is a requirement for promoting social justice.

Self determination and development combined will promote social justice especially for people living with HIV/AIDS who are very often stigmatized and isolated by their communities. The schools should thus seek to advocate for justice for these teachers.

Promote Wellness – “healthy lifestyle”: Promoting wellness is a key factor in managing HIV/AIDS in the workplace. The concept of wellness encourages engagement in activities that promote good health, and the psychosocial wellbeing of the employees.

Confidentiality: The policies should promote and encourage confidentiality of personal information about the medical condition of an employee who discloses his/her HIV status whether to the school managers or fellow teachers. Thus, the interventions should strive to protect the rights of people infected by HIV through committing to and enforcing the principle of confidentiality. The programme managers should note that whilst it is not acceptable to breach confidentiality without permission from the concerned person, it may be a stumbling block in implementing a support programme for teachers.

Recognition of the impact of HIV/AIDS on the education sector: From policy to programmatic interventions, there should be recognition of the impact of HIV/AIDS on the education sector. This would enable the education sector to take decisive steps to deal with HIV/AIDS in schools.



7.4.2 Conceptualization

This is the crucial stage of the guidelines, thus a programme manager should be appointed to drive this process. In addition, it is important to engage all stakeholders in the conceptualization phase.

7.4.2.1 Understand and Define the Problem

Every intervention programme begins with an identified problem for resolution. However, it becomes critical to understand and define the identified problem before an intervention is designed to resolve it. The process of understanding and defining the problem will help the department of education in various ways:

- Maintain focus on resolving the identified problem effectively.

- Assist in gaining the better understanding of the phenomenon, how it is experienced, and the scale of the problem, thus enabling the organization to respond accordingly.
- Provide insights on which to base an HIV/AIDS policy in the workplace.

The process undertaken to understand and define the problem helps the manager to get to the core of the pandemic by gaining a deeper insight into the problem and its dynamics at school level. Thus, the objective and the challenge are to get the required information that would assist in gaining insight into the dynamics of the disease. A deeper understanding which leads to the understanding and definition of the problem would require the following to be done by the programme manager:

- Needs Assessment/Analysis

An intervention programme in response to a phenomenon or epidemic like HIV/AIDS is essential and should be preceded by a process of needs assessment/analysis as expressed by the target population. Therefore, a needs analysis or profiling of the problem must be conducted as a necessary prerequisite for designing an intervention.

Critical to the needs assessment process is an analysis of both the needs of individual teachers and the education department as they relate to HIV/AIDS management. Thus the needs of the various stakeholders need to be embraced in the design and development of such an intervention programme.

Assessment involves the process of data collection, exploration, organization, and analysis of relevant information for use in making decisions about the nature of the problem and what is to be done about it (Compton, Galaway & Cournoyer, 2005). This requires a scientific research process to produce information that can be organized and analyzed to make it useful for decision making and intervention.

Specific information would then be required to help understand and define the HIV/AIDS epidemic in schools. The programme manager, together with the team, would have to decide on and determine the type of information required to enable the department of education to intervene accordingly. For example, information on where the disease is most prevalent (e.g. specific age groups, locations); how teachers are affected; how schools are currently responding to the disease may be information that the department may require. By so doing, the department would gain an understanding of the unique features of the target group. By understanding these unique features, the department would therefore respond accordingly and with certainty.

This information can be elicited from various sources. The information can be sourced from focused groups, surveys, the human resources department and published information. The department can either make use of its own staff or procure services from external providers. to source information that would assist it with the conceptualization of an HIV/AIDS in the workplace programme. The education department will have to decide on the person or organization that would conduct a needs analysis for them.

- Importance of Teacher and Organization Orientation

Both teachers and the organization are important stakeholders in effective implementation of an HIV/AIDS programme in the workplace. This programme will have to take into consideration the needs of the teachers, by allowing teachers time to articulate their needs as they experience them without placing any judgement on them. The programme manager must decide whether to do this internally or outsource the service.

As far as the organization is concerned, an independent researcher should conduct an ability survey by looking at how the organization is organized through its structures, the type and skills of personnel that exists, and affordability of such a programme.

7.4.2.2 Choose an Appropriate Service Model

Choosing a service model that fulfils the identified programmatic interventions is crucial. A service model generally reflects what an organization perceives to be important and how it should intervene to address the identified problem. Thus, the chosen service model would reflect the organization's mentality, the scale and impacts of HIV/AIDS and its way of resolving the perceived problems.

Mode of service delivery: There are various models that could be utilized to deliver services to teachers. These modes of service delivery include internal, external and combination of internal and external services. The internal mode of service delivery would entail using internal resources or employing people to manage the programme internally without the services of an external service provider. The external services relate to procurement of external service providers to manage the programme. The use of external service provider would mean complete outsourcing of the services to external service providers. The combination of internal and external services allows for use of internal resources whilst outsourcing certain elements of the programme.

Type of programme: Various types of programmes are available to meet the needs of teachers and WCED. The programme can be called an Employee Wellness Programme (EWP) or Employee Assistance Programme (EAP) in order to avoid possible stigmatization of teachers if it were called an AIDS programme. Such programmes are generally known to be comprehensive programmes aimed at the total welfare of employees and they can be adapted to specific circumstances.

The goal is to choose a service model that would best address the stakeholders' concerns and desires, and subsequently achieve the desired goals.

In choosing a service model, decisions have to be made with regards to the following:

- Stakeholder views and expressed needs

Section 7.3 summarizes the concerns expressed by various categories of teachers which should guide the process of selecting a model best suited to provide services to teachers. It is imperative that the service model chosen must be able to address the teachers' views and expressed needs and concerns as packaged solutions.

Also, the teachers' preferences on how the service should be provided are critical for choosing a service model, and the success of the entire HIV/AIDS in the workplace programme. This information can be gathered from teachers using various data collection methods and/or procedures. The information can be gathered qualitatively through focus groups and in-depth interviews with special groups; and/or quantitatively through surveys.

Internal resources or the services of an external service provider could be procured following the organization's procurement procedures to obtain the above mentioned information requirements. However, it is important to be clear on the type of data that is required, which should also guide the target group from which the data would be collected. For example, if the organization requires information on the training of principals to enable them to manage disclosures at school, it only makes sense to gather data from principals who will be targeted for such training.

Clarity is required on how the collected information will be utilized. In this instance, data would be necessary to enable the programme manager and the team to gain deeper insight into the needs of the stakeholders, and to enable them to select and apply an appropriate service model.

Whilst it is important to consider the views and needs of teachers in the selection of the service model or programme, it has to be balanced with available resources or what the

department of education can afford and is capable of providing. Realism forms the basis for taking a reasonable and well informed decision. The required resources would include among others financial and human resources. It is important to note that these resources may be readily available within the WCED or they would have to be planned and budgeted for. This means that some of the desired goals may not be fulfilled immediately but later, and that the situation would then force the stakeholders to be realistic in terms of what is immediately possible, and what could be done later.

- Organizational audit

Following on the above argument for human resources, it is important to conduct an organizational audit to understand the functioning of the organization in its entirety. The exercise is good also for gaining more knowledge of various structures within the organization, how they work, how their services can be pulled together to assist with the implementation of an HIV/AIDS programme in the workplace, and most importantly achieve maximal benefits with the available resources. The model can thus be chosen in order to close gaps in the existing organizational structures and the services they provide.

- What best works in the field

The chosen model should be partly influenced by what works best in the field because these are often based on tested intervention methods. This information can be gathered through the external service provider who will conduct research on behalf of WCED. This component should therefore form part of the terms of reference that go out when procuring research services.

- Available resources (financial and human)

In choosing a service model, consideration of available resources (financial and human) is critical. An internal audit must be done to ascertain the available and/or availability of resources, and gaps or challenges. The internal audit will help in decision making in

determining whether to provide services internally or outsource certain elements of the programme.

The audit process should be preceded by a costing exercise to determine viability of the chosen model to assist teachers infected and affected by HIV/AIDS. Such costing has to be done thoroughly to inform decision making.



SOME TIPS ON OPERATIONALIZING:

POLICY FORMULATION

- Make sure that all key stakeholders are involved and obtain their support and commitment to a programme to assist teachers with HIV/AIDS related issues. Stakeholders include representatives of teacher trade unions; representatives of WCED management; SGBs; potential implementers; and importantly, teachers living with HIV.
- Establish a working team from this group to drive policy formulation. Make sure that this team meets regularly and has well defined tasks to complete within a certain timeframe. So that their work is purposeful with timeframes.
- Policy must be precise and reflect the thinking of all stakeholders.

DECIDING ON SERVICE MODEL

- Allow for choice in a variety of models. Research and thorough analysis must be done on various models, and how they work.
- The team must reach a consensus on the model which will work best for WCED, internal or external or combination of aspects of internal and external models. If the combination model is chosen, then define which aspects of these models would be used.

7.4.3 Decide on programmatic interventions

At this stage, it is imperative to decide on programmatic interventions based on the findings of empirical inquiry, analysis of best practices, and literature. Some practical suggestions for operationalizing the components of the programme are offered.

7.4.3.1 Prevention

The empirical results of this study and observations from best practices indicate that prevention is critical to managing HIV/AIDS in the workplace. Prevention is a pertinent and key feature of HIV/AIDS programmes, thus it becomes the cornerstone of the programmes to manage the illness in the workplace.

The key objectives of the prevention programme are:

I. Prevention and awareness

One of the key objectives of this programme is prevention through consistent education and empowerment of teachers. The aim is to ensure that teachers' level of awareness of HIV/AIDS is raised, in such a way that it would lead to behaviour change and prevent them from contracting the virus. Information alone does not automatically lead to behaviour change, thus the role of behaviour change agents/peer educators, departmental social workers and psychologists should be accentuated.

Central to prevention and awareness is averting a situation where teachers prematurely retire from the education system as a direct result of an HIV positive diagnosis and physical changes linked to the progression of the illness. The counselling services and educational campaigns run by peer educators, social workers and psychologists in collaboration with teacher trade unions will help in de-stigmatizing the disease, and create a sensitive and empowering working environment. Of utmost importance is the role played by the school management team in managing disclosures, promote confidentiality, and facilitating a less hostile and an enabling working environment for all teachers.

In prevention and awareness efforts, care should be taken not to discriminate against some teachers on the basis of their sero-positive HIV status. In line with the Department of Labour's technical guidelines on HIV/AIDS in the workplace, the WCED must avoid discriminating against teachers living with HIV during the recruitment process. Likewise,

promotional opportunities should be available to all teachers irrespective of their HIV status. Therefore, principals and recruitment teams should be constantly reminded of these factors when engaging in a recruitment drive and evaluating the annual performance of teachers as part of the department's performance appraisal system which is linked to incentives for good performance.

Teachers living with HIV could play a crucial role in the prevention and awareness drives or campaigns organized by the department. Through the educational awareness campaigns, they can motivate and facilitate disclosures by teachers, act as support systems to those who divulge their sero-positive HIV status, and become school based peer educators. Thus they are valuable assets to the department in efforts to reduce the incidence of HIV/AIDS among teachers.

As part of the prevention and awareness campaigns, the department of education will have to identify and target areas where HIV is most prevalent among teachers for its prevention efforts. For example the Human Sciences Research Council (HSRC) has conducted an HIV/AIDS prevalence study in the education sector, and information from this study could be utilized to determine these areas and intervene accordingly. However, areas and schools where prevalence is low or unknown should also form part of the awareness campaigns. The content may be different but care should be taken to avoid singling out or stigmatizing certain areas and schools making HIV/AIDS an issue for some rather than for the whole Western Cape Education Department.

Some prevention and awareness strategies include awareness campaigns; staging events on specific days of the year; use of peer educators and peer education; and collaboration with trade unions that have influence on a large number of unionized teachers. These educational campaigns have to be aimed at facilitating and strengthening behaviour change. The focus on behaviour change through education is in line with commonly accepted norms and research-based evidence that the key to curbing the spread of the disease is through education.

II. Reduction of stigma and stigmatization

Stigma is one of the key areas for consideration in managing HIV/AIDS in the workplace. Ware et al. (2006) concluded that stigma is the origin of working tensions between social and health interests. What this means is that stigma leads to social marginalization and fear of disclosure which in turn affects help or health seeking behaviours of those infected by the disease.

The former issue (*social marginalization*) often leads to loneliness which signals the desire for connection. In this case, the focus needs to be on infected and affected teachers and to seek integration of these two groups to enable harmony to supersede diversity. The results of this study show that the latter issue (*fear of disclosure*) has led to some teachers leaving the profession prematurely. The programme should try and prevent teachers from leaving the profession prematurely, and other factors that prevent teachers from disclosing their sero-positive HIV status, and so on.

The key to *stigma reduction* is a shift in mentality that traps the infected people in isolation, and the uninfected teachers from perpetuating social stigma. This can be achieved through education, sensitivity and orientation towards the plight of the infected teachers. The aim would be to promote social cohesion which encourages consensus between teachers, and broadly the general community. One way to reduce stigma is meaningfully engaging HIV infected teachers on school based activities. It is essential to change the attitude of teachers (HIV positive teachers included) and the attitudes of communities towards teachers living with HIV/AIDS.

III. Minimize or mitigate the impacts of HIV/AIDS on the teaching workforce and the core business of the organization

Absenteeism and prolonged absence from work due to illness are just some of the issues that impact on the cost of providing education and quality of education that learners receive. Thus, the need exists to minimize or mitigate the impacts on the education

sector. This would require policy change and/or review by the Department of Education, and the following discussion presents some of the suggested policy changes.

Medical/Leave Benefits: Teachers infected with HIV often take time off to attend to medical matters related to their illness on a monthly basis. Currently, school managers are given discretion to decide whether a teacher can go for monthly medical check-up. Teachers need to know that it is permissible for them to go for monthly medical check-ups, but it has to be done in a structured way.

Absenteeism: Uniformity is required in managing absenteeism in schools. Absenteeism in this context relates to medically evoked absenteeism of which many sick teachers stay away from school for a prolonged time. The situation leaves the school managers without knowledge of whether they should employ other teachers in the place of those who are sick. The current education policy on teacher substitution is rendered useless in the midst of HIV/AIDS. Principals are not always sure about when a teacher would come back to work. Also, a long time elapses before a teacher substitution takes effect due to administrative requirements and processes.

It is difficult to pre-empt the length of absence in teachers infected with HIV due to the nature of the illness and the fact that there is no cure for the disease. Recovery depends on how strong ones' immune system is which is already comprised by the illness. Thus, it should be required of sick teachers to provide the department with sick certificates stating the length of absence to enable the principals to plan for the anticipated period of absence.

The following *strategies* can be used to prevent the spread of HIV/AIDS in schools as workplaces:

Employment of assistant teachers: Teachers who prolong their absence from work due to illness leave a gap in terms of available teachers, and thus the provision of education to learners. Currently, the department has a policy for schools to employ substitute teachers

in an event where a teacher would be absent for two consecutive weeks. However, the administrative process takes a long time before a substitute teacher is employed. It is recommended that the department expedite the administrative process to ensure that substitute teachers are employed promptly.

Alternatively, assistant teachers could be employed at each school to help manage the problematic administrative situation. This would mean that teachers would be readily available to fill in for absent teachers without losing teaching time. This scenario may cause some difficulties for these teachers if they have to stand in for various teachers, teaching various subjects. This should be dealt with at the beginning so that it is clear these teachers will be generalists and their position requires flexibility.

Voluntary Counselling and Testing (VCT): VCT is one method used to encourage people to learn their HIV status. A good feature of VCT is its voluntary nature, thus no one is forced to take an HIV test. No laws of the country would be broken, either for employment purposes or otherwise, when a teacher volunteers to be tested. Also, because counselling before and after testing is part of the service, it includes plans for supporting those who are tested. Upon knowing about one's HIV status, a person is provided with an opportunity to act accordingly to either prevent him/her from contracting the disease or live life positively with HIV.

When a teacher's HIV status is positive, assurance is required that the teacher would be provided with the necessary support, and that their vertical progression will not be hindered by virtue of their HIV status.

VCT must not only be done on specially organized events but rather available for teachers at anytime and when it is convenient for them to take an HIV test. This means that the service must be available at all times. Also, the environment must be safe for teachers to receive the results, especially when the test results are HIV positive.

Constant messages must be passed on to teachers regarding the availability of the service, using the department's internal communication systems and other methods deemed suitable for such marketing of the service (also see section on programme marketing).

Behaviour Change Agents: Behaviour Change Agents (otherwise known as Peer Educators in South Africa) is the concept used in Uganda. These are mainly HIV infected teachers who dedicate their working lives to helping other teachers through information giving and awareness. As the name suggests, their main aim is to change behaviour with the view to reducing HIV infection. Their main modes of influencing behaviour change are pragmatic education, forming support groups and distribution of HIV/AIDS health promotion material. Basically, they act as hubs of knowledge for the teachers and schools. Most importantly, they feed information back to the Ministry's HIV/AIDS in the workplace programme manager. Therefore, a forum of behaviour change agents and departmental managers would have to be established.

Where possible, each school must be covered by a behaviour change agent, preferably based at the school. It is important to note that these behaviour change agents conduct this work over and above their normal teaching responsibilities. Thus, there is no need to employ additional staff members to do this work, which would have financial implications for the Department of Education.

In order to compensate for utilizing existing teachers, it is important to ensure that suitable motivated teachers are recruited, and are thoroughly trained on HIV/AIDS in the workplace matters to enable them to be effective in the conduct of their work. Recognition or appraisal of their efforts must be considered and appropriately rewarded.

Firstly, the emphasis should be on recruitment procedures which ensure that the best suited behaviour change agents are utilized for the programme. Secondly, these agents need to be thoroughly trained and continually supported to enable them to conduct their work effectively, and with enthusiasm.

7.4.3.2 Treatment

Treatment and its availability and access are vital for managing HIV/AIDS in the workplace. It is becoming known and accepted that medical treatment (ARVs) prolongs lives and maintains a fairly good health status for infected persons. Treating infected teachers when required becomes very important for the education department in its endeavour to provide quality education.

Access to health services: Access to health services entails deciding on having a service point of its own or entering into partnership with public health centres. Access to health services also means access to treatment through public or private means and the monthly medical check-ups.

If the department decides to establish its own health care centre, it would obviously have financial and human resource implications. It means the recruitment of diverse qualified staff to provide the service. The professionals would provide services ranging from counselling, medical treatment, and nutrition among other things. Also, these professionals would have to be reimbursed accordingly, provide a suitable environment for provision of such services. This means sourcing equipment to perform duties, providing them with a building with offices/room that would also promote confidentiality when serving teachers.

Further, the department will have to consider the location of the service centre. In deciding on the location of the health centre, it is important to take into consideration confidentiality, location and physical accessibility of the centre, and related matters like the mode of transport that could be use to enable such accessibility.

In an instance where the department chooses to enter into partnership with public health centres, it has to consider the promotion of confidentiality. Confidentiality is the crucial factor for teachers in deciding about utilization of health services.

Throughput should be considered and is critical for enticing teachers to make use of the public service. Throughput relates to time spent at the clinic, quality service and preferential treatment by medical staff in service provision. Consensus will have to be reached between the education department and the department of health to ensure that teachers receive privileged treatment at certain predetermined times when visiting local health care centres.

Anti-retroviral drugs/therapy: It was noted earlier in this section of the chapter that access to health services means access to treatment and consequent mandatory monthly check-ups. As far as treatment is concerned, teachers who are eligible for treatment (ARVs) must receive such medication to enhance their health status. The required treatment can either be accessed via public or private health institutions.

The anti-retroviral drugs are available from public health institutions so long as the teachers meet the stipulated government norms for enrolment into the treatment programme. However, private services would require that the concerned persons have available funds to pay for them. An additional top up or levy payment for accessing ARVs through medical schemes is recommended. This means that a portion of the benefits would be set aside for accessing anti-retroviral treatment.

Networking with other relevant departments: The WCED can facilitate collaboration with other departments like the Department of Health to enable teachers to receive preferential treatment when visiting health care centres. Teachers could thus receive prompt service, allowing them more time for their teaching duties, minimizing impacts on the provision of quality education.

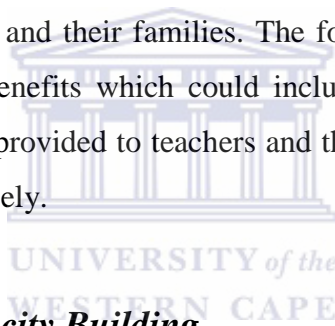
Outreach: This can be achieved by establishing teacher support groups in clusters of schools in specified areas. These support groups could be run by the school based peer educators with the support of the district office officials (e.g. social workers and psychologists). The clustered support groups would decide on the frequency of meetings

and topics that are relevant and of interest to them. Speakers on various topics could be invited to present in a workshop or lecture.

- Other health and wellness related services

Mental Health Promotion: Teachers have to deal with loss of colleagues at their schools and other neighbouring schools and requires counselling services to deal with the associated trauma. Bereavement counselling would play a critical role in facilitating and enabling the healing process. Mental health promoting events can be organized and duly promoted to all schools/teachers.

Care and support: Another key service is the extension of care and support to HIV infected and affected teachers, and their families. The focus would be on providing the necessary general employee benefits which could include medical and leave benefits. Counselling services could be provided to teachers and their families in order to manage the illness properly and effectively.



7.4.3.3 Management Capacity Building

In sub-section 7.3.1, various concerns as expressed by principals when trying to analyze the problem are outlined. In summary, the principals' concerns suggest that capacitating school managers is fundamental in managing HIV/AIDS in the workplace. The managers need to be able to utilize both their management skills and the department's policies to mitigate the immediate and long-term impacts of the disease on the functioning of schools.

The following are programmatic elements crucial for capacitating the principals in managing HIV/AIDS in schools:

Managing absenteeism: Managing absenteeism should be one of the key focus areas in empowering and capacitating managers to allow them to manage schools effectively.

This could be achieved through training principals on utilizing the education department's policies, such as the sick leave and boarding on medical grounds for very sick teachers.

Managing HIV/AIDS in the workplace requires firm leadership that would display innovation in the performance of its duties. This would mean that managers would have to be given space to exercise their duties in a manner that would accommodate challenges imposed on them by the disease. For example, principals could encourage teachers under their leadership to take an early retirement, boarding on medical grounds, or employ any other strategies as deemed fit for the situation.

The managers would have to be trained on technological systems and their use for managing absenteeism. This technological system could be installed by the department and linked to schools for their own analysis on absenteeism trends and advice teachers accordingly.

Managing disclosures: There are various reasons in favour of disclosure of HIV status, not only by teachers, but by the society at large. These reasons include knowledge about the extent of the disease, and who is infected and affected most. This information would help in directing interventions, and prevent or mitigate impacts on individuals, families and communities.

The teachers and consequently the education system would certainly also benefit from such disclosures. The education department via principals should thus encourage disclosure of HIV positive status by teachers and intervene accordingly.

The results of this study indicate that principals are not usually the first person teachers disclose to. However, they play a critical role in providing a reasonable accommodation of teachers infected and affected by HIV/AIDS in schools. Furthermore, principals could play a critical role in getting teachers to disclose their status, and can be a source of

information with regards to a number of teachers leaving with HIV. Thus, they have to be capacitated to manage disclosures.

Policy issues: The Department of Education has policies that serve to guide principals and teachers with regards to benefits, including medical benefits and others. The principals should be trained on correct interpretation and innovative implementation of these as a way of dealing effectively with HIV/AIDS at schools.

The substitution policy requires review especially within the context of HIV/AIDS and its impacts on the functioning of the schools.

Medical boarding is another mechanism that must be used with a degree of sensitivity to enable schools to appoint teachers in the place of terminally ill teachers. The schools would in this case not have to wait longer before appointing a replacement. The medical boarding process could be done parallel to the recruitment process as well.



SOME TIPS ON PROGRAMMATIC INTERVENTIONS

PREVENTION

- Stage awareness campaigns organized by social workers and psychologists in collaboration with teacher trade unions
- Peer educators at each school constantly organizing school based awareness activities

TREATMENT

- Access to treatment is crucial, emphasis must be placed on collaboration with other important stakeholders e.g. Department of Health, Medical Aid Schemes
- Because CD-4 count and nutrition are important in managing HIV, must allow teachers time to attend monthly check-up and promote healthy lifestyles

MANAGEMENT CAPACITY BUILDING

- Train school management team on the department's policies that would apply in managing HIV/AIDS in schools and allow for innovative implementation of these.

NB! These interventions should not be perceived as additional work for teachers but must be integrated into their normal work.

7.4.4 SOCIAL MARKETING

Of concern to any organization is marketing of a programme to ensure programme throughput. Throughput defined as success in getting the target group to use the programme for their benefit and that of the organization. Thus, marketing (programme communication) lies at the core of the success of the programme. The aim is to communicate the programme to reach the intended group, even those in remote places of the organization. Therefore, the objective is to increase the number of people using the programme in the workplace.

Kotler & Andreasen (1995) indicate that marketing for non-profit organizations, like for profit organization should be based on three principles:

Customer orientation (client focus): Customer orientation, which the researcher refers to as client focus, refers to the way in which an organization understands the needs of the target group or clients. Thus, a programme is in response to an identified need which has to be satisfied for the programme to succeed. This approach fits in well with an HIV/AIDS in the workplace programme. Due to the nature of the illness and its diverse impacts, it becomes critical to first understand the progression of the illness, its impacts on an individual and eventually the school in this context. These factors would then influence the contents of the programme.

However, the organization should be realistic in terms of fulfilling the identified needs. The fulfilment of the needs should be in line with the available resources to satisfy such needs. Therefore, the needs to be fulfilled by the organization can be classified according to priorities and staggered over the years instead of trying to achieve everything at once. Such staggering and prioritization can be achieved through working together with the employees targeted by the programme.

Systems orientation: Systems orientation refers firstly to the integration of the marketing activities, and secondly to organizational integration/principles of co-operations. This

approach is premised on the recognition of various components or segments of the organization that can work together in achieving programmatic goals using their unique expertise. These would include the human resources, finance, public relations and information communication departments. It realizes that the organization's success lies in the strength and total commitment of these components of the organization.

Goal orientation: In contrast to profit organizations where the primary goal is maximum profit, non-profit organizations' aim at an effective and efficient service to the community. It implies maximizing

The above-mentioned principles are suggested as guidelines for the marketing of a programme to maximize its benefits for both the employees and the organization.

Marketing is a business concept used with an aim of making potential customers aware of a product and value with a view to make profit. This concept is applicable in the social and health science but not with a view to make profit but to ensure penetration of a programme by people it is designed for. Various definitions of the concept are provided by various authors.

Stellefson & Eddy (2008), taking a health perspective, refer to marketing as an organizational function and a set of processes for creating, communicating, and delivering value to customers and for managing customer relationships in ways that benefit an organization and its stakeholders.

The definition suggests mutual benefits of marketing to all stakeholders. Critical to marketing an HIV/AIDS in the workplace programme is effective communication of such a programme to the broader spectrum of employees in the education system. An HIV/AIDS programme can be marketed in the following ways:

Electronically: Technology proves to be one of the methods used by companies (see chapter 5) to communicate its programmes. Electronic information alerts sent to staff

members via the organization's information and communication technology effectively markets the organization's programme to the employees. However, this method has its own challenges. It is only effective when all employees have access to computers and emailing facilities. The weakness is that not all employees can be reached using this method alone.

The human factor also comes in when using this system as a method of communicating with employees. Some employees may not open their emails or ignore such notices completely. The challenge is ensuring that employees open their emails and act upon them. Therefore, it should be used as a complimentary way to reach the employees.

Staff awareness campaigns: Another method of marketing the programme is through staff awareness campaigns. These take a form of presentation to trade union or staff association meetings by the programme managers. It is assumed in this method that employees are organized and can be reached through such unions or organizations. The risk is excluding those that are not members of such employee organizations.

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Internal print media: Some organizations use pamphlets and posters to advertise their policies. The pamphlets are placed in strategic points or areas in the organization. The assumption is that the employees will actually read the pamphlets and posters. This kind of advertisement is sometimes referred to as "in your face" advertisement.

The aim is to bombard the employees with information that is around them in their work areas, information they can see daily. However, there is no guarantee that the employees will read the pamphlets or act upon the information presented in them.

Thus, it is argued here that a combination of marketing methods is useful to reach various groupings of people in an organization.



SOME TIPS ON SOCIAL MARKETING:

- Essential to note that teacher levels of awareness on HIV/AIDS and related matters is high. They have reached saturation point.
- Hire social marketing specialist to develop a marketing strategy from a social perspective
- The marketing specialist to help coin messages that would capture teachers' attention and remind them of crucial issues around HIV/AIDS.

EXAMPLES OF SOCIAL MARKETING FOR HEALTH AND WELLBEING:

1. Kotler, P. & Lee, N. 2007. Social Marketing: Influencing Behaviors for Good. 3rd Edition.
2. Manoff, K. R. 1985. Social Marketing: New Imperatives for Public Health.
3. Kotler, P.; Roberto, N. & Lee, N. 2002. Social Marketing: Improving the Quality of Life. 2nd Edition.



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7.4.5 Monitoring and Evaluation

A key to the success of the programme is monitoring and evaluation of its activities and achievements. Kozma (2005) asserts that within a resource constrained environment, measuring impacts should be at the centre of anyone's agenda. Otherwise, who will invest in a programme that does not yield the intended results? Also, how are the impacts of a programme measured? Monitoring and evaluation provides systems for measuring such impacts. This section provides guidelines for monitoring and evaluating a programme in an education setting.

The monitoring and evaluation of an HIV/AIDS programme in the workplace must be conducted for the following reasons:

- *Determine the utilization of the programme by the broader employees*

It is important for organizations to determine whether a service provided to employees is actually utilized by the employees. Otherwise it becomes wasteful expenditure for the

organization. If employees utilize a service, it could mean that it responds to the needs of the employees and that they attach value to such a programme. This alone may justify continuing the service, although the efficacy of the programme should also be evaluated.

- *Determine and maintain relevance of the programme*

Any programme provided to employees or the public should be tested for its relevance to the issues it intends to address. Be it treatment, education or prevention components of the programme. The aim is to keep the programme relevant to the needs of employees through constant monitoring. Relevance of the programme also speaks to broader government or country requirements as far as dealing with the challenge of HIV/AIDS, not only in the workplace but in the broader society. So, an HIV/AIDS programme in the workplace should go beyond only considering the needs of employees but be cognisant of broader country initiatives in confronting the scourge of the disease.

- *Continuous alignment of the services to the needs of the employees*

It is important that services are aligned to the needs of employees. The process of aligning services to needs would require the Department of Education to be in touch with the teachers, understand their experience of the disease on a daily basis, and understand the impacts thereof on the entire education system. This could be achieved through thorough analysis of monthly statistics in terms of the utilization of the programme, understand what teachers mostly go for or require from the service. These are some of the key indicators of the success of the programme in delivering on the needs of the teachers.

The aim is to align the services to the actual needs of the employees. Linking to the above discussion, they encourage alignment to make HIV/AIDS programmes relevant to the workforce.

- *Value for money*

Any employer would like to get value for money invested in a service. The aim would thus be to maximize benefits for employees, and subsequently for the department through a stable teacher workforce that is able to provide quality education.

- *Total Quality Management*

The premise for and/or essential fundamentals of monitoring and evaluating programme is that the monitoring and evaluation systems are designed to enhance the quality of designed interventions to ameliorate social/educational problems. If the quality of the programme is not evaluated, it lends the programme to stagnation and failure. Thus, quality of the programme is essential to its success.

- *Identify Weaknesses for Rectification*

Monitoring and evaluation is associated with checking that the delivery of articulated plans is on track and that the specified outcomes are achieved; developing management information systems that can provide responsive, valid and useful information for assessing programme delivery and outcome; providing evidence through which managers can report on the achievements to funding agencies and other stakeholders; and developing mechanisms by which programs can be fine-tuned on the basis of the findings (Owen, 2007). This aforementioned extract points to the importance of monitoring programmes for delivering on plans and their intentions.

Monitoring and evaluation should be framed so that it provides evidence-based information that would assist managers with making decisions about the impacts of the programme. It is crucial for programme evaluators to gain consensus on what needs to be assessed together with the programme implementers. This consensus will lead to a negotiated evaluation plan that will produce the desired results on completion of the evaluation.

The information presented in the subsequent sub-section is mainly based on literature, since the observed programmes lacked this vital monitoring and evaluation element. This is additional information that should assist with the monitoring and evaluation of the success of an HIV/AIDS support programme.

7.4.5.1 Develop Indicators

Fundamental to monitoring and evaluation is indicator development. It is essential and critical that indicators are developed during the planning phase of programme implementation as they provide measuring mechanisms for the performance of the programme. Kozma & Wagner (2005) define an indicator as a piece of information which communicates a certain state, trend, warning or progress to the audience. In this context, the audience is the decision makers who would normally have influence on the running of the programme. Thus monitoring and evaluation gives the decision makers options based on the best information that can be gathered to support one or another decision (Kozma & Wagner, 2005). As the information gathered and analyzed will be used for decision making, it is important to select indicators for measurement. Selecting indicators is a challenging exercise for evaluators. Kozma & Wagner (2005) categorise indicators as input or outcome indicators.

Input indicators refer to the activities that one puts into a programme in order to achieve a certain outcome. And an outcome indicator is a consequence of input indicators, modified by processes inherent in the application of the intervention. For example, if an input indicator for an HIV/AIDS programme is training, then the outcome indicators would be increase in levels of HIV/AIDS knowledge. An evaluator needs to think carefully about the type of information that would be needed to come to a conclusion about increased levels of HIV/AIDS knowledge. Thus, selecting an indicator requires thinking about the right questions to ask, and the best method of data collection. Therefore, in terms of recruitment a person with research experience would generally be required to conduct effective monitoring and evaluation.

7.4.5.2 Designing a Monitoring and Evaluation Plan

Monitoring and evaluation provides an opportunity for learning and feedback throughout the planning and implementation stages of a programme, and it also includes an assessment of results at the end, as related to the original objectives (James & Miller, 2005). Thus, key to assessing the results of a programme is developing an evaluation plan which should provide vital information on successes and weaknesses.

Two stages in designing a monitoring and evaluation plan, viz. 1) choosing the method of study, and 2) selecting monitoring and evaluation indicators are suggested by James & Miller (2005). The method of study is influenced by the kind of information required to elicit the necessary information (quantitative or qualitative data). Underpinning any monitoring and evaluation activity is determination and selection of variables to be measured. Critical to the selection of these variables is the definition of the variables by those conducting the monitoring and evaluation exercise.

7.4.5.3 Determine Frequency of Evaluation

A key to successful monitoring and evaluation of a programme is determining the frequency of evaluation. Monitoring reports can be provided monthly in order to keep track of activities done in line with the programme plans. It has been established in this study that statistical information is provided to companies regarding throughput but the information is only for ascertaining the level of use of the programme by the employees. The statistical information is however not useful for evaluating the service. As a result, companies are unable to ascertain the quality and effectiveness of the programme. Therefore, the monitoring activity should be based on set or standard questions to provide the organization with useful information that could be used to identify areas for intervention within the programme implementation. Beyond monitoring is an evaluation of the programme.

An evaluative inquiry of the programme can be done after a year in medium term projects, as this would allow assessment of milestones after defined intervals. The aim of this evaluative inquiry is to provide feedback on progress, and to identify weaknesses which should be dealt with promptly.

The nature and depth of information required from this exercise is determined by the approach used to collect and analyze data (quantitative or qualitative). Thus, a range of data collection methods can be used, including questionnaires, surveys and case studies.

7.4.5.4 Report and Disseminate Results

Reporting in this context refers to reporting progress on key issues or a report as an output of an evaluation process. The aim is to provide information at intervals regarding achievements and assessment of the programme against set goals. Dissemination of results would entail the manner in which the results of the study are disseminated to the broader stakeholders of the organization and this in turn may lead to measurable outcomes such as changes in policy.

In producing a report, the researcher and stakeholders decide from the beginning of the process on the issues to be monitored and evaluated. The composite indicators provide a structure for reporting and compilation of the report.

Further, the person or persons conducting the monitoring and evaluation exercise need to formulate a strategy for dissemination of the results considering the various stakeholders to the process. The results of the monitoring and evaluation exercise can be disseminated through presentations to managers and employees in their trade union or staff association, publishing of the report for internal consumption or producing information pamphlets.



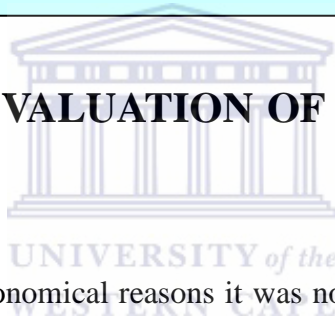
SOME TIPS ON MONITORING AND EVALUATION:

- Vital to reach agreement on indicators
- Must have predetermined frequency and/or timeframes
- Monitoring and evaluation should preferably be done by an external person/expert or organization

RECOMMENDED READINGS:

1. Estrella, M.; Blauvert, J.; Campilan, D.; Geventa, J.; Gonsalves, J.; Guijt, I.; Johnson, D. & Ricafort, R. 2000. Learning from Change: Issues and Experiences in Participatory Monitoring and Evaluation.
2. Kusek, J. Z. & Rist, C. R. 2004. Ten Steps to a Results-Based Monitoring and Evaluation System: A Handbook for Development Practitioners.
3. WHO. 2002. Healthy Cities Initiative in the African Region: An Evaluation Manual.

7.5 QUALITATIVE EVALUATION OF THE PRELIMINARY GUIDELINES



For practical, logistical and economical reasons it was not possible to pilot the proposed guidelines in selected schools. Strydom et al. (2007) suggest a programme presentation, data gathering, data analysis, and report writing to complete this phase.

The main aim of this qualitative evaluation was to get the participants' perceptions on the feasibility and the utilization value of the guidelines for the development of an HIV/AIDS support programme for teachers. In deciding on criteria for assessment, the researcher adopted the assessment criteria by Hartley (1985 & 1994). Although his work is aimed at evaluation of instructional texts, the participants in the evaluation sessions found the following criteria as most appropriated for open discussions and to add some more of their own general views.

The guidelines were presented to the groups of teachers and newly appointed HIV/AIDS co-ordinators through power-point presentations. There were about 12 participants in each session, and accumulative total of 38 participants evaluated the guidelines.

Critical to presentation of the guidelines was gathering data in relation to the implementation value of the guidelines. The researcher noted down all critical factors expressed by the teachers in evaluating the implementation of the guidelines. This information is presented below this section. Furthermore, the participants completed the evaluation form.

The collected information was analysed and structured into themes that emerged from the data. The following sub-section presents the views of the participants with regard to the implementation value of the guidelines.

7.5.1 Feasibility and Implementability of the Guidelines

Themes that emerged in relation to implementability of the guidelines are:

The participants believed that the programme prototype indeed *responds to the needs* of the teachers. Teachers said they have long been waiting for such a programme to be provided by the Western Cape Education Department. However, they pointed out that it requires the commitment of education managers to succeed. However, there were some participants who suggested that the implementation of these guidelines can only succeed with the support of teachers; for example, teachers disclosing their sero-positive HIV status. As such, the success of the implementation of these guidelines depends on the contributions and commitment of both teachers and managers at district and head office levels of WCED.

Responses from numerous teachers suggest that the guidelines would *contribute to the achievement of the overall strategy and core business of the WCED*. They believed that the guidelines will contribute towards improving the quality of education, especially

when the infected and affected teachers receive the necessary support and care. However, there was concern that top managers do not show commitment to implementing the existing policy and that the proposed guidelines are at risk of becoming another “great intellectual effort” that is not implemented by the top managers.

With regards to feasibility of the guidelines, most teachers felt that the guidelines are implementable and practical. Furthermore, the involvement of all stakeholders (e.g. teachers, principals, office based staff and managers across the board) is vital for these guidelines to be effectively implemented. Some teachers believed that some aspects of the guidelines would be difficult to implement. For example, with regards to the substitution of teachers the participants were of the view that the top managers would make it difficult to implement these guidelines because the delivery of curriculum is more important than managing HIV/AIDS in schools. The successful implementation of these guidelines would thus require a mind-shift by regarding HIV/AIDS as one of the top priorities for the education system.

The guidelines were viewed as easy to understand and user friendly. However, they would have to be piloted first to further strengthen them followed by training of all stakeholders to enhance their understanding before implementation by managers. Teachers and school management teams would have to understand them in order to enable them to utilize the wellness programme based on these guidelines.

Most teachers felt that the guidelines are *comprehensive* enough to cover considerations on all levels. However, the School Governing Bodies (SGBs) were identified as a special group that did not feature in the intervention guidelines.

The guidelines were found to be *systematic*, and respondents felt that they will improve the education department’s response to HIV/AIDS.

All the teachers interviewed believed that there is a need for these guidelines and agreed to *support* the wellness programme if implemented. However, the wellness programme

based on these guidelines has to be marketed properly and effectively to all teachers and office based staff. Marketing will have to be done frequently. Also, sufficient human and financial resources have to be invested in the programme.

Some teachers doubted the *WCED management's support for and commitment* to implementing a wellness programme based on these guidelines even though it is a necessity. Some of the reasons mentioned a possible barriers to implementing these guidelines included 1) the fact that they are not about the delivery of curriculum; 2) perceived lack of care for people infected and affected by the disease; and 3) the guidelines do not come from a sufficiently senior person.

Some teachers believe that the *implementation of a wellness programme based on these guidelines may not be financially feasible*. The reasons for this are that HIV/AIDS in the workplace is not a priority; and wastage of funds on non-essentials by the department. The WCED would therefore need to prioritize issues of importance to education, and those that directly impact on the provision of quality education including HIV/AIDS. Also, the decision on funds that go into HIV/AIDS in the workplace should not be left at the discretion of the provincial department but ring-fenced at national level for provinces.

Although the guidelines are lauded as useful and essential to assist the WCED with the development of a wellness programme to support teachers, the following were identified as possible barriers to successful implementation of such a wellness programme. These are divided into school and departmental levels.

At school level, the following factors will make implementation difficult:

- Lack of buy-in from principals,
- Lack of commitment from district officials especially with regards to monitoring and support of the implementation of the guidelines,
- Former model C schools who still view HIV/AIDS as an issue for Black and Coloured schools,

- Overloading of teachers and principals and unwillingness of teachers to volunteer their time and services,
- Ignorance among teachers and principals,
- Lack of trust and stigmatization issues , and
- Lack of support to teachers who disclose their HIV status.

At departmental level:

- Lack of will from top management,
- Negative management attitude,
- Lack of timeframe for implementation and adherence to the set timeframe,
- Some officials are regarded as gatekeepers,
- Lack of commitment to the plight of people living with HIV/AIDS,
- Confusion about an accountability, and
- WCED is generally perceived as a non-caring organization with little concern for the well-being of teachers.



7.5.2 Areas for Improvement

Areas identified for improving the guidelines are summarised below but are discussed further in the next chapter on conclusion and recommendations chapter.

- HIV/AIDS as a human rights issue
- Relief teaching system
- Make available and allocate a number of posts to needy districts to deal with chronic absenteeism
- Extended leave for teachers at terminal stage of their illnesses
- Support provided to office based staff
- Education of WCED top management on the importance of dealing with the challenges imposed by HIV/AIDS on schools

- Research on the extent of HIV/AIDS in schools in affluent areas. It is believed that there is a lot of resistance from these schools because they do not know the extent of HIV/AIDS in their areas
- Training of teachers and principals
- Do more on prevention and encouraging disclosures to neutralize stigmatization of the people living with HIV/AIDS

7.6 CONCLUSION

The chapter presented guidelines for managing HIV/AIDS in the workplace with an emphasis on the education sector. The aim is to help the schools and the education department to effectively manage the impacts of the disease on the functioning of the school and provision of quality education to learners.

These guidelines should assist schools and the education department in national endeavours to fight HIV/AIDS and its impact on the education system and the country at large.

As the title suggests, these are guidelines and should be seen as a means to an end rather than an end in them. Thus, they can be used in combination with other well tested guidelines or to supplement what already exists in the department. The guidelines are designed to contribute to other efforts to fight HIV/AIDS in schools and the country in general.

Also, the chapter presented information on the evaluation of the guidelines by the teachers and managers. These issues need to be considered by programme managers and factored into the programme to assist with the management of HIV/AIDS in the workplace, the schools in this context.

CHAPTER 8

SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

8.1 INTRODUCTION

Intervention Research, as a form of applied research, promotes an understanding of individual and community conditions and contributes to their improvement (Rothman & Thomas, 1994). The implications are that an intervention researcher would come up with an intervention model to help mitigate and/or combat an identified problem. This means that, and as indicated in chapter 1, this report therefore deviates from the traditional research report of presenting findings and discussions thereof, so as to better reflect the flow of, and the implementation of the operational steps of the selected phases of IR: D&D.

This study was conceptualised within the genre of Intervention Research, and in particular the Design and Development approach. The nature of the IR: D&D model requires that an outcome of the empirical and literature studies be transformed into an intervention model to ameliorate a social condition identified in the study. Within the context of this study, the results of empirical study and review of literature are presented in sections A and B, and comprises chapters three to six. The findings were then condensed into guidelines for developing an HIV/AIDS support programme for teachers presented in section C (chapter 7) of the thesis.

Given the nature of and processes followed in this study, this chapter thus provides the summary of the research processes, concluding remarks of the outcomes in relation to the goal and objectives of the study, the methodology, and the identified strengths and limitations of the study. Lastly, recommendations are offered for future research in accordance with the identified limitations of the study.

8.2 SUMMARY OF THE RESEARCH PROCESSES AND OUTCOMES

8.2.1 The Goal and Objectives of the Study

The goal of the study guided the research process. The goal was to design guidelines for the development of an HIV/AIDS support programme for teachers. Thus, the research output would be the design of such guidelines to assist in developing an HIV/AIDS support programme for teachers. This goal was achieved through engaging in various activities as suggested in IR: IDD model by Rothman & Thomas (1994).

The first phase of this process involved engaging teachers in exploring their perceptions and experiences of HIV/AIDS among teachers and in schools. The findings of this activity are presented in chapter three, and are verified against literature. The process of engaging in this activity enabled the researcher to better understand and get to the depth and dynamics of the disease as experienced by teachers. However, information from teachers alone was not enough to inform the design of the guidelines.

In addition to collecting information from teachers, information was gathered from various other sources. These activities included a literature review on work and meaning of work which served to inform the rationale for developing and/or establishing an HIV/AIDS in the workplace support programme. A review of literature was also done on the type of workplace programmes to give effect to the structure and mode of intervention/delivery that could be utilized to support teachers infected and affected by HIV/AIDS. At this point, the researcher was still faced with the challenge of understanding the impacts and dynamics of the disease in the workplace and how the infected and affected are assisted by their employers.

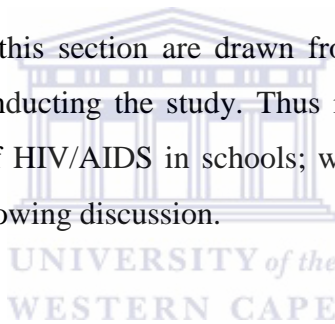
To further enhance the understanding of HIV/AIDS phenomena in the workplace, the researcher considered what was been done elsewhere to support employees in the workplace. Information on workplace practices was gathered from various companies in

Cape Town and the Ministry of Education and Sport in Uganda. The findings on these practices are presented in chapter 5 of the thesis, and were also incorporated into the guidelines.

Finally, the gathered information was synthesized and structured into guidelines to help develop an HIV/AIDS support programme for teachers, which also served as an output of the Intervention Research: Design and Development processes. Also, as the foundation for future intervention design and development efforts especially around HIV/AIDS in the workplace with a special focus on the education sector.

8.3 CONCLUSIONS RELATING TO FINDINGS

The conclusions presented in this section are drawn from processes and activities the researcher engaged into in conducting the study. Thus information about the teachers' experiences and perceptions of HIV/AIDS in schools; workplace models; and observed practice models inform the following discussion.



8.3.1 Teachers' Experiences and Perceptions on HIV/AIDS among Teachers and Schools

The schools (in the area of this study) are certainly under severe pressure from the impacts of the disease. This is evident in the continued infection of young teachers coupled with the death of teachers, absenteeism and tensions among teachers which points out to the potentially devastating effects of the disease on the schools in the long-term. Unless drastic steps are taken to support teachers and mitigate the impacts of HIV/AIDS in schools, the scale of the problem will escalate and will make it even more difficult to overcome.

Building on the above conclusion, there is a need to help teachers infected with HIV live positively with the disease, help other colleagues cope with the impacts of the diseases, and strengthen the capacity of the school management teams to deal effectively with the

impacts of the disease as they relate to the daily operational functioning of the school and provision of quality education thereof.

The quality of education and the calibre of learners the education systems purports to produce are potentially negatively affected by the disease. Care should to be taken to ensure the provision of quality education through creating a dynamic work environment where innovation in managing the disease at school, the Education Management and Development Centre, and head office levels can be displayed. This also requires innovation in implementing the existing education policies by managers.

According the teachers, the current Employee Wellness Programme of the Western Cape Department does not respond to their needs, and is not properly and effectively marketed to encourage usage by the intended group of teachers. Therefore, a focused intervention crafted in collaboration with teachers is required. In addition, vigorous and targeted marketing would help increase awareness and usage thereof.

Fighting the impacts of the disease on the education requires a paradigm shift especially by top education managers through investing in programmes and activities that would change the image of the department as far as promises made to teachers, and the provision of wellness services to teachers. In order for this to happen, HIV/AIDS in the workplace should be prioritised and given the attention and commitment it requires.

Deducing from the teachers' experiences of HIV/AIDS in schools in the Philippi East area of the EMDC, the education system at these schools is in crisis. The premature retirement and death of teachers to AIDS related diseases; teacher shortages and subsequently work overload, trauma and psychological impact of losing colleagues all contribute to the crisis situation teachers painted in this study. Commitment from all education stakeholders to dealing with the challenges of HIV/AIDS in education is fundamental. This commitment will come with the realization that HIV/AIDS is an education challenge, and that all stakeholders can play a meaningful role in mitigating the impacts of this disease in schools.

8.3.2 Workplace Intervention Models

HIV/AIDS and/or wellness programmes respond to a set of policies developed and adopted by the employer. Thus, it is crucial to develop such policies to make it compulsory for the employer to establish such a programme and provide the requisite services accordingly.

There exists various workplace intervention programmes, ranging from Disease Management, Employee Assistance, and so on. Depending on the orientation of the employer, the employer may choose pure medical approach or seek to demystify or reduce stigma attached to certain programmes by assuming a perceived neutral approach/programme like the EAPs.

Within the identified programmes above, a range of services could be provided depending on the identified areas of need. The range of services could provide for treatment, care and support to employees. At the core of these programme is to strive for the programmes to be as comprehensive as possible to give employees a wider choice but also respond to various elements of employee needs.

8.3.3 Observations of Practice Models

There is a general commitment displayed by employers to invest in the welfare of its employees. As such, programmes are developed and services provided to employees based on the identified area of need. Thus, engaging employees in determining the type of services provided to them becomes crucial for the success of the programme.

It is imperative to develop an HIV/AIDS workplace policy to guide interventions. However, the policy should be grounded not only on internal core business strategy but encapsulate external trends and developments nationally and internationally.

In providing the HIV/AIDS or health and wellbeing related services, it is crucial to diversify these services to allow for choice to be made by the employees in terms of which services to utilize and at what stage of the experience of a wellness problem or challenge experienced.

The success of the programme also depends on the external to which internal and external stakeholders are involved in the provision of services. Thus, the programme should aim also at involving stakeholders to ensure utilization, monitoring and evaluation of the programme.

8.3.4 Strengths of the Study

Due to the participatory nature of the study in collecting data to understand the phenomenon and what has been done before to tackle it, the study was able to get to the dynamics of the disease as experienced and play out in schools, and get firsthand experience of some best practices.

HIV/AIDS is one of major challenges in the social sciences in terms of finding ways and means to prevent and manage it. Social science research has been confined to understanding social and behavioural elements of the disease with the view to finding programmatic solutions (HSRC, 2002 & 2005). This study has gone beyond understanding the social and behavioural elements of HIV/AIDS to developing guidelines for managing it in the workplace. As such, it builds on the studies to understand the dynamics of the disease into provision of solutions to the challenges

The data gathering process to understand the problem and how some companies or organizations have responded to the pandemic involved **a range of methods**. These included the following:

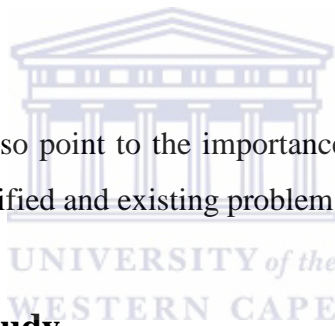
- Interviews with a range of teachers, viz. HIV positive teachers, principals, and HIV/AIDS co-ordinators whose HIV status was unknown. This helped the

researcher to gain knowledge of these teachers' experiences of this disease and their needs thereof. The study was inclusive as possible as far as the various categories of teachers in schools.

- Best practices which included visits to companies around Cape Town and Uganda's Ministry of Education and Sport. The information helped with the understanding of how organizations have responded to the challenges of HIV/AIDS in the workplace.
- Literature review and/or synthesis focused on existing models that could be used as intervention approaches to dealing with HIV/AIDS in the workplace.

These forms of data collection combined coupled with diversity **in the sources** of information strengthened the study as far as prerequisite information to facilitate the development of the guidelines.

The above-mentioned issues also point to the importance and relevance of this study in providing a solution to an identified and existing problem in the education sector.



8.3.5 Limitations of the study

The confinement to a specified area together with the qualitative nature of the study, its findings cannot be generalised to other schools in the Western Cape. However, the results of the study contributed to initial initiatives to deal with the impacts of the disease on teachers. Also, the study gave opportunity to teachers infected and affected by HIV/AIDS in finding solutions that are specific to the education sector.

Even though the study is qualitative in nature meaning that the quantity is not a concern as far as the number of participants in the study, it is crucial to get more teachers living with HIV to determine the course action in efforts to manage HIV/AIDS. With more teachers living with HIV participating in a study will serve to enhance our understanding of the specific needs of these teachers.

Upon reflection on the processes followed in conducting the study, the researcher is of the view that a study of this nature requires more human, time and financial resources. For example, the study could not be piloted which would have enabled an on-field experimentation to provide for better evaluation of the guidelines.

The guidelines developed through this study are aimed at teachers in schools. They exclude other allied workers in the education sector. This is so even though the actual guidelines can be adapted and implemented in other work environments.

8.4 RECOMMENDATIONS

The recommendations presented here are based on the conclusions made about the study. These recommendations should inform future research, especially studies utilizing the intervention design and development approach to intervention research. This section is divided into two sub-headings which comprise recommendations relating to future research and the limitations of the study.



8.4.1 Relating to future research

Extension of this study: This study focused in a small area (Philippi East) a bigger study to extend to the whole Western Cape or the country to allow the concerned education department to understand the dynamics of HIV/AIDS as they play out in schools. This research study should further guide the Western Cape Education Department in its interventions in schools with a special focus on teachers.

Study evaluating these guidelines: The researcher suggests that the Western Cape Education Department commission a study to evaluate the implementation of the guidelines following piloting in certain schools in the Cape Town region.

Departmental commitment: One of the key concerns during the evaluation of the implementation value of the guidelines was commitment of managers to implement a

programme based on these guidelines. The development and establishment of an HIV/AIDS support programme for teachers should be prioritized and done as a matter of urgency as the impacts thereof are devastating for the education system. As such, the researcher intends to make presentations to decision makers in education, which are the national Minister of Education and the provincial Member of the Executive Committee on Education.

Stigma and stigmatization: Stigma and stigmatization came out as one of the crucial elements that seem to hinder effort to manage of HIV/AIDS from the teachers' side. Innovative ways to deal with stigma and stigmatization are thus fundamental for effectively dealing with the challenges of HIV/AIDS among teachers. The researcher thus recommends that the Department of Education intensify its stigma reduction campaigns to enable teachers to infected and affected by HIV to embrace it and those colleagues who live with it. In this way, premature retirement would be reduced.

Piloting of the guidelines: Due to financial, time and related constraints, the guidelines could not be piloted during the course of this study. Such piloting would help in evaluating certain aspects of the guidelines, adapt and refine the entire guidelines. It is thus recommended that the guidelines be piloted by the Western Cape Education Department in some schools in Cape Town.

Focus on teachers living with HIV: In addressing HIV/AIDS related problems facing teachers, including teachers living with HIV, it is crucial to involve them, let them speak for themselves and direct interventions to help them. A study that focuses purely on understanding the experiences of teachers living with HIV with a view to either refine these guidelines or redesign relevant programmes would be highly recommended.

8.5 CONCLUSION

The goal of this study was to “develop guidelines for an HIV/AIDS support programme for teachers”. This goal was therefore met by engaging in various research activities that

facilitated the design of the guidelines. The completion of this thesis is testimony to this fact.

Intervention Research, Design and Development approach was used to conduct the study. In following the requirements of this model, teachers including HIV/AIDS co-ordinators, principals and teachers living with HIV were interviewed with a view to understand the problem and plan accordingly. As part of design process, the researcher reviewed literature on best practices and visited some companies and Uganda's Ministry of Education and Sport. Information gathered was used to develop various sections of the guidelines. The implementation of the phases and their operational steps with adaptations to phase 3 (Design) enabled the researcher to design the guidelines thus meeting the goal of the study. The research approach and methods used were thus appropriate for this study.

The researcher recognises that HIV/AIDS still poses a major challenge to workplaces and the development of these guidelines is one of the first steps to fighting the disease within a work setting. The effort put into this research made the researcher realise that the education sector in particular would require serious commitment to fighting the disease by all stakeholders. The guidelines are not in themselves an end but rather a means to an end. They provide one of the initial efforts aimed at assisting employees infected and affected by HIV/AIDS.

It is the intention of the researcher to market these guidelines to the education authorities in the Western Cape Education Department. The researcher is optimistic that these guidelines will assist the Western Cape Department of Education in its efforts to manage HIV/AIDS in schools especially as part of the wellness programme.

BIBLIOGRAPHY

Abel, E.; Rew, L.; Gortner, E. & Delville, L. 2004. Cognitive reorganization and stigmatization among persons with HIV. *Journal of Advanced Nursing*, 47(5): 510–525.

Agar, A. & MacDonald, J. 1995. Focus groups and ethnography. *Human Organization*, 54(1): 78-89.

Akabas, S. H. 1999. EAP handbook. *Consad Research Corporation*. New Jersey: Prentice-Hall, Inc.

Akabas, S. H. 1997. Employee assistance programmes. Accessed at www.ilo.org/encyclopeadia/?doc&nd=857400242&nh=1, in June 2009.

Akabas, S.H. & Kurzman, PA. 1982. Work, workers and work organizations: a view from social work. (Eds). New Jersey: Prentice-Hall, Inc.

Allison, E. H. & Seeley, J. A. 2004. HIV and AIDS among fisherfolk: A threat to 'responsible fisheries'? *AIDS Care*, 17(6): 688-697.

Alsop, R.; Bertelsen, M. F. & Holland, J. 2006. Empowerment in practice: From analysis to implementation. Washington DC: The World Bank.

Altice, F.L. & Friedland, G.H. 1998. The era of adherence to HIV therapy (Editorials). *Annals of Internal Medicine*, 129: 503-505.

Andrea, H., Beurskens, A. J. H. M., Metsemakers, J. F. M., Van Amelsvoort, L. G. P. M., Van den Brandt, P. A., and Van Schayck, C. P. Health problems and psychosocial work environment as predictors of long term sickness absence in employees who visited the

occupational physician and/or general practitioner in relation to work: A perspective study. *Occupational Environmental Medicine*, 2003: 60.

Angers, M. 2005. Work and the meaning conferring context of the clubhouse. Accessed at www.iccd.org/iccd_library/8th/10angers.htm.

Arndt, C. & Lewis, J.D. 2000. The macro implications of HIV in South Africa: A preliminary assessment. Paper prepared for the International AIDS Economics Network Symposium, Durban: 7-8 July 2000.

Arns, P. G., Martin, D. J. & Chernoff, R. A. 2004. Psychosocial needs of HIV-positive individuals seeking workforce re-entry. *AIDS Care*, 16(3): 377-386.

Arthur, A. R. 2000. Employee assistance programmes: the emperor's new clothes of stress management? *British Journal of Guidance and Counseling*, 28(4): 549-559.

Babbie, E. & Mouton, J. 2001. *The practice of social research*. Cape Town: Oxford University Press.

Bachmann, M. O. and Booyesen, F. L. R. 2004. Relationship between HIV/AIDS, income and expenditure over time in deprived South African households. *AIDS Care*, 16(7): 817-826.

Baer, M. B. & Roberts, J. 2001. Complex HIV treatment regimens and patient quality of life. *Canadian Psychology*, 43(2): 115-121.

Barnett, T. 2002. HIV/AIDS impact studies 11: Some progress evidence. *Progress in Development Studies*, 2 (3): 219-225.

Barnett, T., Whiteside, A. & Desmond, C. 2001. The social and economic impact of HIV/AIDS in poor countries: A review of studies and lessons. *Progress in Development Studies*, 1(2): 151-170.

Baumeister, R. F. & Leary, M. R. 1995. The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*, 117(3): 497-529.

Bellingham, R. D., Johnson, D. & McCauley, M. 1985. Wellness in the workplace. In Conrad, P. 1987. Wellness in the workplace: Potentials and pitfalls of work-site health promotion. *The Milbank Quarterly*, 65 (2): 255-276.

Bennell, P. 2003. The AIDS epidemic in sub-Saharan Africa: Are teachers a high-risk group? *Comparative Education*, 39, (4): 493-508.

Berg, B. 1995. Qualitative research methods for the social sciences. Massachusetts: Allyn & Bacon.

Berridge, J. R. & Cooper, C. L. 1994. The employee assistance programme: Its role in organizational coping and excellence. *Personnel Review*, 23(7): 4-20.

Bowers, T. 2001. Teacher absenteeism and ill health retirement: A review. *Cambridge Journal of Education*, 31(2): 135-157.

Bright, C. D. 1999. Antiretroviral therapy for HIV infection: A review of current medications and therapies. *Journal of American Optometric Association*, 70: 355-383.

Brooks, R. A., Martin, D. J., Ortiz, D. J. & Veniegas, R. C. 2004. Perceived barriers to employment among persons living with HIV/AIDS. *AIDS Care*, 16 (6): 756-766.

Bryman, A. 1988. Quantity and quality in social research. London: Unwin Hyman.

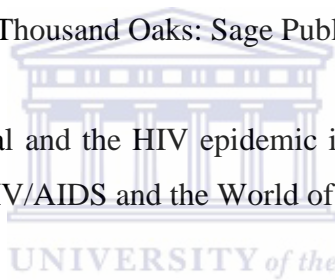
Caulfield, M. S., Carey, C. S. & Mason, C. Y. 1994. Project employ: Rehabilitation services facilitating employment on individuals with HIV/AIDS. *American Rehabilitation*, 20(3): 12-16.

Chesney, M. A. & Smith, A. W. 1999. Critical delays in HIV testing and care: The potential role of stigma. *The American Behavioral Scientist*, 42(7): 1162-1174.

Clement & Gibbs. 1983. Employer consideration of health promotion programs: financial variable. In Conrad, P. 1987. Wellness in the workplace: Potentials and pitfalls of work-site health promotion. *The Milbank Quarterly*, 65 (2): 255-276.

Coffey, A. & Atkinson, P. 1996. Making sense of qualitative data: Complementary research strategies. California: Thousand Oaks: Sage Publications.

Cohen, D. 2002. Human capital and the HIV epidemic in sub-Saharan Africa. Working Paper 2. ILO Programme on HIV/AIDS and the World of Work. Geneva: ILO.



Cohen, D. 1998. Poverty and HIV/AIDS in sub-Saharan Africa. HIV and Development Programme. Issue Paper no. 27.

Collis, J. & Hussey, R. 2009. Business research: A practical guide for undergraduate students. 3rd Edition. Palgrave MacMillan, London.

Colvin, M., Connolly, C. & Madurai, L. 2007. The epidemiology of HIV in South African workplaces. *AIDS*, 21(3): 513-519.

Compton B., Galaway, B., & Cournoyer, B. 2005. Social work processes (7th ed.). Pacific Grove, CA: Brooks/Cole Publishing.

Concise Oxford English Dictionary. 2004. 11th Ed. New York: Oxford University Press Inc.

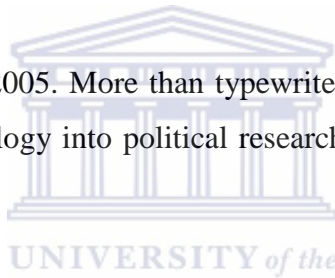
Conrad, P. 1987. Wellness in the workplace: Potentials and pitfalls of work-site health promotion. *The Milbank Quarterly*, 65 (2): 255-276.

Conyers, L., Boomer, K. B. & McMahon, B. T. 2005. Workplace discrimination and HIV/AIDS: The national EEOC ADA research project. *Work*, 25: 37-48.

Corbett, E. L., Dauya, E., Matambo, R., Cheung, Y. B., Makamure, B., Bassett, M.T., Chandiwana, S., Munyati, S., Mason, P.R., Butterworth, A. E. & Godfrey-Faussett, P. 2006. Uptake of workplace HIV counselling and testing: A cluster-randomised trial in Zimbabwe. *PLoS Medicine*, 3(7): 1005-1012.

Cornelison, Dr. Head of Research. Western Cape Education Department: Head Office.

Cousins, K. & McIntosh, W. 2005. More than typewriters, more than adding machines: Integrating information technology into political research. *Quality & Quantity*, 39: 581-614.



Craig, G. 2002. Poverty, Social Work and Social Justice. *British Journal of Social Work*, 32: 669-682.

Crandle, C. S. & Coleman, R. 1992. AIDS-related stigmatization and the disruption of social relationships. *The American Behavioral Scientist*, 42 (7): 1162-1174.

Cranny, C. J., Smith, P. C. & Stone, E. F. 1992. Job satisfaction: How people feel about their jobs and how it affects their performance. Lexington Books: New York.

Creswell, J. W. 2007. Qualitative Enquiry and Research Design: Choosing among five approaches. Thousand Oaks, CA: Sage Publications.

Creswell, J. W. 1998. Qualitative enquiry and research design: Choosing among five approaches. Thousand Oaks, CA: Sage Publications.

Creswell, J. W. 1994. *Research Design: Qualitative and Quantitative Approaches*. California: Thousand Oaks, CA: Sage Publications.

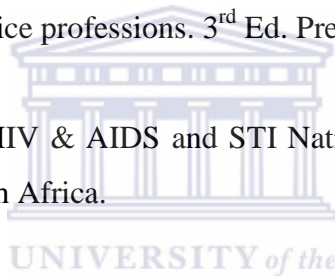
Dane, F. C. 1990. *Research Methods*. Belmont: Thomson Brooks/Cole Publishing Co.

Davies, M. 1997. (ed). *The Blackwell Companion to Social Work*, Blackwell, Oxford.

Davis, M. K., Rosenberg, D., Iverson, D. C., Vernon, T. M. & Bauer, J. 1984. Worksite health promotion in Colorado. *Public Health Reports*, 99(6): 538-543.

Delpont & De Vos 2005. Professional Research and professional practice. In De Vos, A. S. Strydom, H., Fouche, C. B. & Delpont, C. S. L. 2005. *Research at grassroots: For the social sciences and human service professions*. 3rd Ed. Pretoria: Van Schaik Publishers.

Department of Health. 2007. *HIV & AIDS and STI National Strategic Plan 2007-2011*. South Africa. Republic of South Africa.



Department of Health. 2001. *South African National Guidelines on Nutrition for People Living With TB, HIV/AIDS and Other Chronic Debilitating Conditions*.

Department of Health. 2000. *HIV & AIDS and STI National Strategic Plan 2000-2005*. Republic of South Africa.

Department of Labour. 2003. *HIV/AIDS Technical Assistance Guidelines*. Cape Town: Formeset.

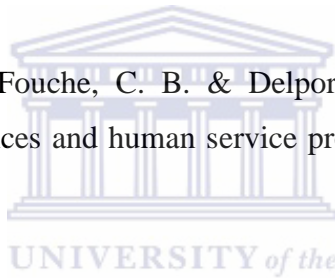
De Vos, A. S. 2005. Scientific Theory and Professional Research. In De Vos, A.S., Strydom, H., Fouche, C. B. & Delpont, C. S.L. 2002. *Research at grassroots: For the social sciences and human service professions*. 2nd Ed. Pretoria: Van Schaik Publishers.

De Vos, A. S. 2002. Qualitative Data Analysis and Interpretation. In De Vos, A.S., Strydom, H., Fouche, C. B. & Delpont, C. S.L. 2002. Research at grassroots: For the social sciences and human service professions. 2nd Ed. Pretoria: Van Schaik Publishers.

De Vos, A. S., Schulze, S. & Patel, L. 2005. The sciences and the professions. In De Vos, A. S., Strydom, H., Fouche, C. B. & Delpont, C. S. L. 2005. Research at grassroots: For the social sciences and human service professions. 3rd Ed. Pretoria: Van Schaik Publishers.

De Vos, A. S., Strydom, H., Fouche, C. B. & Delpont, C. S. L. 2005. Research at grassroots: For the social sciences and human service professions. 3rd Ed. Pretoria: Van Schaik Publishers.

De Vos, A.S., Strydom, H., Fouche, C. B. & Delpont, C. S.L. . 2002. Research at grassroots: For the social sciences and human service professions. 2nd Ed. Pretoria: Van Schaik Publishers.



Dickinson, D. 2004. Corporate South Africa's response to HIV/AIDS: Why so slow? *Journal of Southern African Studies*, 30 (3): 627-649.

Dickinson, D. 2004. Medium-sized companies, many stakeholders: The sociology, psychology and political economy of HIV/AIDS responses in three manufacturing companies. HIV/AIDS in the workplace: Symposium Proceedings. University of the Witwatersrand.

Dickinson, D. 2006. Smokescreen or opening a can of worms? Workplace HIV/AIDS peer education and social protection in South Africa. *African Studies*, 65(2): 321-342.

Dickman, J.F. & Emener, G.W. & Hutchison Jr., W.S. 1985. Counselling the troubled person in industry: A guide to organisation, implementation and evaluation of employee assistance programs. Illinois, USA: Charles C. Thomas Publishers.

Employee Assistance Professionals Association of South Africa. 2005. Standards for Employee Assistance Programmes in South Africa. Pretoria.

Eggelston. 2004. Procedural Justice in Young's Inclusive Deliberative Democracy. *Journal of Social Philosophy*, 35(4): 544–549.

Estrella, M.; Blauvert, J.; Campilan, D.; Geventa, J.; Gonsalves, J.; Guijt, I.; Johnson, D. & Ricafort, R. 2000. Learning from change: Issues and experiences in participatory monitoring and evaluation. London: Intermediate Technology Publications Ltd.

Evian, C., Fox, M., MacLeod, W. Slotov, S. J. & Rosen, L. Prevalence of HIV in workforces in Southern Africa: 2000 – 2001. *South African Medical Journal*, 94 (2): 125-130.

Family Health International. 2002. <http://www.hivpolicy.org/biogs/HPE0019b.htm> in July, 2009.



Fawcett, S. B.; Suarez-Balcazar, Y.; Balcazar, F. E.; White, G. W.; Paine, A. L.; Blanchard, K. A. & Embree, M. G. 1994. Conducting intervention research: The design and development process. In Rothman, J. & Thomas, E. J. (Eds), *Intervention Research: Design and Development for Human Service*. New York: Haworth.

Fesko, S. L. 2001. Disclosure of HIV status in the workplace: Considerations and strategies. *Health and Social Work*, 26(4):235-244.

Fife, B. L. 2005. The role of constructed meaning in adaptation to the onset of life-threatening illness. *Social Science and Medicine*, 61: 2132-2143.

Fifer, A.; Henschen, K.; Gould, D & Ravizza, K. 2008. What works when working with athletes. *The Sport Psychologist*, 22: 356-377.

Figueira-McDonald, J. 1993. Residence, dropping out, and delinquency rates. *Deviant Behavior*, 14(2): 109-132.

Feldman, B. 2003. Employee Empowerment: Does it work? Accessed at <http://www.steven.arruda.com/ArrudaLiterature%20Review.htm> in February 2009.

Flynn. 1995. Social justice and social agencies. In Edwards (Editor in Chief), *Encyclopedia of Social Work*. 19th Edition. 1: 95-100. Washington, D.C.: NASW Press.

Fox, M. P.; Rosen, S.; MacLeod, W. B.; Wasunna, M.; Bill, M.; Foglia, G. & Simon, L. S. 2004. The impact of HIV/AIDS on labour productivity in Kenya. *Tropical Medicine and International Health*, 9 (3).

Fouche, C. B. & de Vos, A. S. 2005. Problem formulation. In De Vos, A. S., Strydom, H., Fouche, C. B. & Delpont, C. S. L. 2005. *Research at grassroots for the social sciences and human service professions*. 3rd Ed. Pretoria: Van Schaik Publishers.

Galvan, F. H., Davis, E. M., Banks, D. & Bing, E. G. 2008. HIV stigma and social support among African Americans. *AIDS Patient Care*, 22(5): 423-436.

Germain, C. B. 1991. *Human Behaviour in the social environment: An ecological view*. New York: Columbia University Press.

Geurts, S. A., Schaufeli, W. B., Rutte, C. G. 1999. Absenteeism, turnover intention and inequity in the employment relationship. *Work & Stress*, 13 (3): 253-267.

Gibbs, G. R. & Friese, S. 2002. The use of new technology in qualitative research. In Cousins, K. & McIntosh, W. 2005. More than typewriters, more than adding machines: Integrating information technology into political research. *Quality & Quantity*, 39: 581-614.

Gillespie, J. L. & Rossiter, F. L. 2003. Medicaid disease management programs: Findings from three leading US state programs. *Dis Manage Health Outcomes*, 11 (6): 345-361.

Grassly, N. C., Desai, K., Pegurri, E., Sikazwe, A. Malambo, I., Siamatowe, C. & Bundy, D. O. P. 2003. The economic impact of HIV/AIDS on the education sector in Zambia.

Accessed at:

<http://hivaidsclearinghouse.unesco.org/search/resources/Economic%20Impact%20submitted.doc> in August 2009.

Greeff, M. 2002. Information Collection: Interviewing. In De Vos, A. 2002. *Research at Grassroots: For the Social Sciences and Human Service Professions*. Pretoria: Van Schaik Publishers.

Harmon, L. 1992. AIDS in the workplace. In Seligson, M. S. & Peterson, K. E. (Eds). *AIDS prevention and treatment: hope, humor and healing*. New York: Hemisphere.

Harper, T. 1999. Employee assistance programming and professional developments in South Africa. *Employee Assistance Quarterly*, 14(3): 1-18.

Hartley J, 1985. *Designing instructional text*. London: Kogan.

Hartley J, 1994. *Designing instructional text*. London: Kogan.

Hartnett, S. 2003. Kenya's traditions and AIDS collide. *American Nurses Association*, 103(10): 42.

Havener, C. Why most work isn't meaningful: Why companies can't attract and retain talented people and how if call all change. Accessed at http://www.tracc.com.au/docs/publications/Meaning_of_Work.pdf in January 2010.

Hays, R. B., McKusick, L., Pollack, L., Hilliard, R., Hoff, C., & Coates, T. J. 1993. Disclosing HIV sero-positivity to significant others. *AIDS*, 7, 425 – 431.

HEARD. 1999. Annual Report: The health economics and HIV/AIDS research division. Accessed at www.heard.org.za/downloads/heard-annual-review-1999.pdf in January 2010.

Herek, G. 1999. AIDS and stigma. *The American Behavioural Scientist*, 42 (7): 1106 - 1116.

Herzlinger, RE. & Calkins, D. 1986. How companies tackle health care costs: Part 111. *Harvard Business Review*, 64(1): 70-80.

Hillier, D., Fewell, F. Cann, W. & Shephard, V. 2005. Wellness at work: Enhancing the quality of our working lives. *International Review of Psychiatry*, 17(5): 419-431.

Ho, J. T. S. 1997. Corporate wellness programmes in Singapore: Effect on stress, satisfaction and absenteeism. *Journal of Managerial Psychology*, 12 (3): 177-189.

Hoffman, C. & Goya, B. 2008. Responding to Deaths of Faculty Staff and Students at UC, Berkeley: An Integrated Approach. *Journal of Workplace Behavioral Health*, 22 (2): 161-175.

Holosko, M. J. & Feit, M. D. 1988. Evaluation of Employee Assistance Programs. New York: The Haworth Press, Inc.

Holzemer, WL; Bakken Henry, S; Portillo, CJ; Miramontes, H. 2000. The Client Adherence Profiling-Intervention Tailoring (CAP-IT) Intervention for Enhancing Adherence to HIV/AIDS Medications: A Pilot Study. *Journal of the Association of Nurses in AIDS Care*, 11(1).

Holzemer, W.L., Corless, I.B., Nokes, K.M., Turner, J.G., Brown, M.A., Powell-Cope, G.M., Inouye, J., Henry, S.B., Nicholas, P.K. & Portillo, C.J. 1999. Predictors of self-reported adherence in persons living with HIV disease. *Aids Patient Care STDs*, 13: 185-197.

Human Sciences Research Council. 2008. Human resources development: Education, employment and skills in South Africa. Cape Town: HSRC Press.

Human Sciences Research Council/Nelson Mandela Foundation. 2005. South African national HIV prevalence, HIV incidence, behaviour and communication survey. Cape Town: HSRC Press.

Human Sciences Research Council. 2007. The health of our educators: A focus on HIV/AIDS in South African public schools. Cape Town: HSRC Press.

Human Sciences Research Council. 2009. South African National HIV prevalence incidence, behaviour and communication survey: A turning tide among teenagers? Cape Town: HSRC Press.

Human Sciences Research Council. 2005. Educator supply and demand in the South African public education system: Integrated report. Cape Town: HSRC Press.

Hongjie Liu, Zhi Hu, Xiaoming Li, Stanton, B., Naar-King, S. & Hongmei Yang. 2006. Understanding interrelationships among HIV related stigma, concern about HIV infection, and intent to disclose HIV serostatus: A pretest-posttest study in a rural area of Eastern China. *AIDS Patient Care and STDs*, 20(2): 133-142.

Ife, J. 1997. Rethinking Social Work: Towards Critical Practice. Longman, Melbourne.

International Labour Office. 2008. HIV/AIDS and Work: Global Estimates, Impact and Response. Switzerland: Geneva.

International Labour Office. 2004. HIV/AIDS and work: Global estimates, impact and response. Switzerland: Geneva.

International Labour Office. 2001. Code of Good Practice. Switzerland: Geneva

International Labour Organization. 2000. HIV/AIDS: A threat to decent work, productivity and development. Document for discussion at the special high-level meeting on HIV/AIDS and world of work. Switzerland: Geneva

Judd, C. M., Ryan, C. S. & Park, B. 1991. Accuracy in the judgement of in-group and out-group variability. *Journal of Personality and Social Psychology*, 61: 366-379.

James & Miller. 2005. The Impact of ICTs in Education for Development: A Monitoring and Evaluation Handbook. In Wagner, D., Day, R., James, T., Kozma, R., Miller, J. & Unwin, T. Monitoring and Evaluation of ICT in Education Projects: A Handbook for Developing Countries. Washington, DC: The World Bank.

Kalichman, S. C. 1995. Understanding AIDS: A guide for mental health professionals. American Psychological Association. Washington DC.

Kappelman, A. L. & Richards, C. T. 1996. Training, empowerment, and creating a culture for change. *Empowerment in Organizations*, 4 (3): 26-29.

Kerlinger, F. N. 1986. Foundations of research. New York: Holt, Rinehart & Winston Publishers.

Kimberly, J. A., Serovich, J. M., Greene, K. 1995. Disclosure of HIV positive status. *Family Relations*, 44 (3): 316-322.

Kingry, M.J., Tiedje, L.B. & Friedman, L. 1990. Focus Groups: A Research Technique for Nursing. *Nursing Research*, 39(2): 124-125.

Kirk, A. K. & Brown, D. F. 2003. Employee assistance programs: A review of the management of stress and wellbeing through workplace counseling and consulting. *Australian Psychologist*, 38(2): 138-143.

Kitaoka-Higashiguchi, K. 2005. Causal relationship of burnout to medical accident among Psychiatric Nurses. *Journal of Japan Academy of Nursing Science*, 25: 31-40

Kitzinger, J. 1994. The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health and Illness*, 16(1), 103–121.

Kotler P & Andreasen A 1995: Strategic Marketing for non-profit Organizations. Prentice Hall, Engelwood Cliffs New Yersey

Kotler, P. & Lee, N. 2007. Social Marketing: Influencing Behaviors for Good. 3rd Edition.

Kotler, P.; Roberto, N. & Lee, N. 2002. Social marketing: Improving the quality of life. 2nd Edition.

Kozma, R. B. 2005. National policies that connect ict-based education reform. *Economic and social development*, 1(2): 117-156.

Kozma, R. B. & Wagner, D. A. 2005. Core indicators for monitoring and evaluation studies in ICTS for education. Accessed at www.infodev.org/en/Publication.286.html

Kurzman, P. A. 1997. Employees assistance programs: Towards a comprehensive service model. In Kurzman, P. A. & Akabas, S. H. 1997. *Work and Well-Being: The Occupational Social Work Advantage*. Washington, DC: NASW Press.

Kusek, J. Z. & Rist, C. R. 2004. Ten steps to a results-based monitoring and evaluation system: A Handbook for development practitioners.

Kumar, A., Waterman, I., Kumari, G. & Carter, A. O. 2006. Prevalence and correlates of HIV serostatus disclosure: a prospective study among HIV-infected post-parturient women in Barbados. *AIDS Patient Care and STDs*, 20 (10): 724-732.

Lambert, E. G., Cluse-Tolar, T., Pasupuleti, S., Hall, D. E. & Jenkins, M. 2005. The impact of distributive and procedural justice on social service workers. *Social Justice Research*, 18 (4): 411-427.

Lee, R. M. & Esterhuizen, L. 2000. Computer software and qualitative analysis: trends, issues and resources. *International Journal of Social Research Methodology*, 3(3): 231-243.

Liu, G. G., Guo, J. J. & Smith, S. R. 2004. Economic costs to business of the HIV/AIDS epidemic. *Pharmacoeconomics*, 22(18):1181-1194.

Lopez-Bastida, J., Oliva-Moreno, J., Perestelo-Perez, L. & Serrano-Aguilar, P. 2009. The economic costs and health-related quality of life of people with HIV/AIDS in the Canary Islands, Spain. *BMC Health Services Research*.

Accessed at www.biomedcentral.com/1472-6963/9/55 on the 11 May 2010.

Lorentz, N.R. & Hinsz, V.B. 1997. The Cognitive Antecedents of Task-Related Self-Esteem. *Social Behavior and Personality*, 25(4), 401-408.

Louw, J., Shisana, O., Peltzer & Zungu-Dirwayi, N. 2009. Examining the impact of HIV & AIDS on South African educators. *South African Journal of Education*. 29: 205-217.

MacKay, C., Kelly, L, & McCaig, R. H. 2004. Managing standards and work-related stress in the UK: policy background and science. In Hillier, D., Fewell, F. Cann, W. & Shephard, V. 2005. Wellness at work: Enhancing the quality of our working lives. *International Review of Psychiatry*. 17 (5): 419-431.

Magdoff, H. 2006. The meaning of work: A Marxist perspective. *Monthly Review*, 52-64.

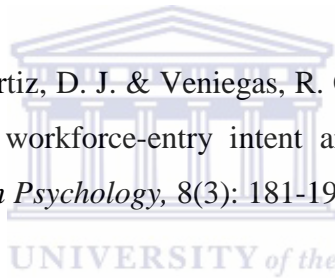
Maile, S. 2003. Legal aspects of the disclosure of HIV serostatus by educators. *South African Journal of Education*, 23(1): 78–83.

Manoff, K. R. 1985. Social Marketing: New Imperatives for Public Health.

Masi, D. A. 1997. Evaluating employee assistance programs. *Research on Social Work Practice*, 7 (3): 378-390.

Masi, D. A. & Foster-Sanda, S. 2008. Why College Binge Drinking is Relevant to EAPS. *Journal of Workplace Behavioral Health*, 1555-5259, 23 (4): 381-394.

Martin, D. J., Brooks, R. A., Ortiz, D. J. & Veniegas, R. C. 2003. Perceived employment barriers and their relation to workforce-entry intent among people with HIV/AIDS. *Journal of Occupational Health Psychology*, 8(3): 181-194.



Marvasti, A. B. 2004. *Qualitative Research in Sociology*. Sage Publications Ltd, London.

Mathieu, J. E. & Zajac, D. 1990. A review and meta-analysis of the antecedents, correlates and consequences of organizational commitment. *Psychological Bulletin*, 108: 171-194.

McAulay, B. J., Zeitz, G. & Blau, G. 2006. Testing a “Push – Pull” theory of work commitment among organizational professionals. *The Social Science Journal*, 43.

Medland, J., Howard-Ruben, J. & Whitaker, E. 2004. Fostering psychosocial wellness in oncology nurses: Addressing burnout and social support in the workplace. *Oncology Nursing Forum*, 31 (1): 47-54.

Metropole South Education District Website. Accessed on the 10 April 2010.

Meyer, J. P. & Allen, N. J. 1997. *Commitment in the Workplace: Theory, Research and Application*. Thousand Oaks, CA: Sage Publications.

Miller, T. W.; Bousaada, K. E.; Rodriguez, L. R.; Maggio, T. & Chadwick, J. 2006. Health focused education and counselling for a patient diagnosed as HIV positive. *The Internet Journal of Allied Health Sciences and Practice*, 4(3).

Mohiddin, A. & Johnston, D. 2006. HIV/AIDS mitigation strategies and the State in sub-Saharan Africa: The missing link? Accessed at <http://www.globalizationandhealth.com/content/2/1/1>

Morgan, D. L. 1996. Focus Groups. *Annual Review Sociology*, 22: 129-152.

Morgan, D. L. & Spanish, M. T. 1984. Focus Groups: A New Tool for Qualitative Research. *Qualitative Sociology*, 7(3): 253-270.

Mouton, J. 2001. *How to Succeed in Your Master's and Doctoral Thesis*. Van Schaik Publishers, Pretoria.

Muula, A. S. & Mfutso-Bengo, J. M. 2005. When is public disclosure of HIV seropositivity acceptable? *Nursing Ethics*, 12(3): 288-295.

Myburgh, C. P. H. & Poggenpoel, M. 2002. Teachers' Experiences of Their School Environment: Implications for Health Promotion. *Education*, 123(2).

National Education Policy Act, 27 of 1996. Republic of South Africa.

National Treasury. 2010. *Estimates of National Expenditure*.

Neuman, W. L. 2000. *Social research methods: qualitative and quantitative approaches*. 4th Edition. Boston: Allyn & Bacon.

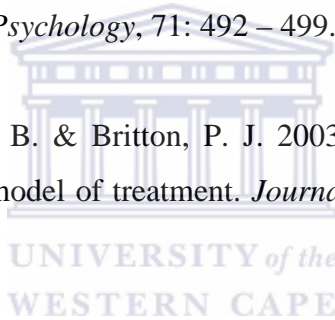
Omarzu, J. 2000. A disclosure decision model: Determining how and when individuals will self-disclose. *Personality and Social Psychology Review*, 4 (2): 174-185.

Opatz, J. P. 1994. Economic Impact of Worksite Health Promotion. *Medicine & science in sports & exercise*, 26 (80): 1070.

Opperman, J. D. 2004. Interpreting the Meaning Individuals Ascribe to Returning to Work after Traumatic Brain Injury: A Qualitative Approach. *Brain Injury*, 18 (9): 941-955.

O'Reilly, C. III, and Chatman, J. 1986. Organizational commitment and psychological attachment: The effects of compliance, identification, and internalization of pro-social behaviour. *Journal of Applied Psychology*, 71: 492 – 499.

Orsulic-Jeras, S., Shephard, J. B. & Britton, P. J. 2003. Counseling older adults with HIV/AIDS: A strength-based model of treatment. *Journal of Mental Health Counseling*, 25(3): 233-244.



Overlien, C., Aronsson, K. & Hyden, M. 2005. The Focus Group Interview as an Indepth Method? Young Women Talking about Sexuality. *International Journal of Social Research Methodology*, 8(4): 331-344.

Owen, JM. 2007. Program Evaluation: Forms and Approaches. 3rd Edition. Guilford Press, New York.

Parkinson, R. S. & Associates (eds). 1982. Managing health promotion in the workplace. Palo Alto: Mayfield.

Peltzer, K., Shisana, O., Udjo, E., Wilson, D., Rehle, T., Connolly, C., Zuma, K., Letlape, L., Louw, J., Simbayi, L., Zungu-Dirwayi, N., Ramlagan, S., Magome, K., Hall, E. &

Phurutse, M. 2005. Educator Supply and Demand in the South African Public education system: Integrated report. Cape Town: HRSC Press.

Psychosocial Working Group. 2000. Psychosocial Intervention in Complex Emergencies: A Conceptual Framework.

Punch, K. F. 1998. Introduction to Social Research: Qualitative and Quantitative Approaches. London: Sage Publications.

Radcliffe, J., Fleisher, C. L., Hawkins, L. A., Tanney, M., Kassam-Adams, N., Ambrose, C. & Rudy, B. J. 2007. Posttraumatic stress and trauma history in adolescents and young adults with HIV. *AIDS Patient Care*, 21 (7): 501-508.

Rawls, J. 1993. The law of peoples. *Critical Inquiry*, 20 (1): 36-68.

Reckson, B. & Becker, L. 2005. Exploration of the narrative accounts of South African teachers working in a gang-violent community in the Western Cape. *International Journal of Social Welfare*, 14(2): 107-115.

Rehle, T. & Shisana, O. 2005. The impact of antiretroviral treatment on AIDS mortality: A study focusing on educators in South African public schools. Cape Town: HSRC Press.

Republic of Uganda. 2004. Education Sector Policy on HIV/AIDS.

Republic of Uganda. 2001. HIV/AIDS Workplace Policy for Education and Sports Sector. Revised National Curriculum Statement. Government of Uganda: Department of Education.

Richery, R. & Klein, J. D. 2007. Design and Development Research. Lawrence Erlbaum: New Jersey, USA.

Rispel, L. 2006. Education Sector Response to HIV/AIDS: Learning from Good Practices in Africa. London: Commonwealth Secretariat, Academy for Educational Development and Human Sciences Research Council (HSRC).

Roman, P. M. & Blum, T. C. 1988. Formal intervention in employee health: comparisons of the nature and structure of employee assistance programs and health promotion programs. *Social Science & Medicine*, 26(5): 503-514.

Room, G. 1995. Beyond the threshold: The measurement and analysis of social exclusion. Great Britain: Polity Press.

Rothman, J. & Thomas, E. J. 1994. Intervention Research: Design and Development for Human Service. New York: The Haworth Press.

SABCOHA. 2005. The impact of HIV/AIDS on selected business sectors in South Africa. University of Stellenbosch: Bureau for Economic Research.

Schultheiss, D. E. P. 2006. The Interface of Work and Family Life. *Professional Psychology: Research and Practice*, Vol. 37 (4), 334-341.

Sen, A. 1992. The political economy of targeting. Accessed at http://www.adatbank.ro/html/cim_pdf384.pdf . 24 May 2010.

Serovich, J. M. 2001. A test of two HIV disclosure theories. *AIDS Education Preview*, Vol. 13(4):355-364.

Shisana, O., Peltzer, K., Zungu-Dirwayi, N. & Louw, M.A. 2005. The Health of our Educators: A focus on HIV/AIDS in South African Public Schools. Cape Town: HSRC Press.

Silberman, A., Kendall, J. W., Price, A. L. & Rice, T. A. 2008. University Employee Assistance Program Response to Traumas on Campus. *Journal of Workplace Behavioral Health*, 1555-5259, 22 (2): 91-109.

Simoni, J. M., Mason, H. R., & Marks, G. 1997. Disclosing HIV Status and Sexual Orientation to Employers. *AIDS Care*, 9, 589-599.

Sowell, R. L., Lowenstein, A., Moneyhem, L., Demi, A., Mizuno, Y., & Seals, B. 1997a. Resources, stigma, and patterns of disclosure in rural women with HIV infection. *Public Health Nursing*, 14, 302-312.

Stellefson, M. & Eddy, J. M. 2008. Health Education and Marketing Processes: 2 Related Methods for Achieving Health Behavior Change. *American Journal of Health Behavior*, 32(5): 488-496.

Steward, W. T., Herek, G. M., Ramakrishna, J., Bharat, S., Chandy, S., Wrubel, L. & Ekstrand, M. L. 2008. HIV-related stigma: adapting a theoretical framework for use in India. *Social Science & Medicine*, 67(8): 1225-1235.

Strauss, J. & Thomas, D. 1998. Health, nutrition and economic development. *Journal of Economic Literature*, 36 (2): 766-817.

Strydom, H., Steyn, M. M. & Strydom, C. 2007. An adapted intervention research model: Suggestions for research and practice. *Social Work*, 43(4): 341.

Strydom, H. & Venter, L. 2002. Sampling and Sampling Methods. In de Vos, A. S. 2002. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. 2nd Edition. Pretoria: Van Schaik Publishers.

Strydom, H. Ethical aspects of research in the social sciences and human service professions. In De Vos, A. S. 2002. *Research at grassroots: For the social sciences and human service professions*. 3rd Edition. Pretoria: Van Schaik Publishers.

Stuber, M.L. & Shemesh, E. 2006. Post-traumatic Stress Response to Life-Threatening Illnesses in Children and their Parents. *Child and Adolescent Psychiatric Clinics of North America*, Vol. 15 (3), 597–611. Accessed at <http://repositories.cdlib.org/postprints/1802> in May 2009.

Swart, E., Engelbrecht, P., Oswald, M. & Eloff, I. 2003. Including Learners with Intellectual Disabilities: stressful for teachers? *International Journal of Disability, Development and Education*, 50 (3): 293-308.

Swenson, C. 1998. Clinical Social Worker's Contribution to a Social Justice Perspective. *Social Work*, 43(6): 527-537.

Taylor, S.E. 1983. Adjustment to Life-Threatening Event: A Theory of Cognitive Adaptation. *American Psychologist*, 38, 1161-1173.

Tekola, F., Reniers, G., Haile Mariam, D., Araya, T. & Davey, G. 2008. The economic impact of HIV/AIDS morbidity and mortality on households in Addis Ababa, Ethiopia. *AIDS Care*, 20(8): 995-1001.

Toumi, K., Vanhala, S., Janhonen, M. & Nykyri, E. 2005. Employees' work ability and company performance: A follow-up study in the metal industry and in retail trade. *International Congress Series*, 1280: 234-237.

UNESCO. 2008. Good Policy and Practice in HIV & AIDS and Education. Booklet No. 1, 2nd Edition. Paris: UNESCO.

UNESCO. March 2006. Expanding the Field of Enquiry: A Cross-Country Study of Higher Education Institutions' Responses to HIV and AIDS. Paris: UNESCO.

UNESCO. 2004. Education sector global readiness HIV & AIDS survey. Policy implications for education & development. UNAIDS Inter-agency Task Team. Accessed at <http://unesdoc.unesco.org/images/0014/001446/144625e.pdf> in March 2009.

UNESCO. 2002. Towards African Response: UNESCO Strategy for HIV/AIDS and Education in Sub-Saharan Africa 2002-2007. Paris: UNESCO.

UNGASS. 2001. Declaration of Commitment on HIV/AIDS. Switzerland: United Nations.

UNICEF. 2000. AIDS epidemic update. Switzerland: UNAIDS/WHO.

UNICEF/UNAIDS. 2005. A call to action: Children the missing face of AIDS. UNICEF and UNAIDS.

Vaas, J. 2004. Policy versus reality: A preliminary assessment of the SA code of good practice on HIV/AIDS and key aspects of employment. In HIV/AIDS in the workplace: symposium proceedings. Centre for Health Policy Johannesburg: Centre for Health Policy, School of Public Health, University of the Witwatersrand, 308-325.

Vaas, J. 2003. The Impact of HIV/AIDS. *HRD Review*. Cape Town: HSRC Press.

Vaas, J. & Phakathi, S. 2006. Managing HIV in the workplace: Learning from SMEs. Cape Town: HSRC Press.

Visser, W. P. 2006. From MWU to solidarity: A trade union reinventing itself. *South African Journal of Labour Relations*, 30(2): 1–27.

Walsh, D. C. 1982. Employee assistance programs. *Health and Society*, Vol. 60(3): 492-517.

Ware, N.C.; Wyatt, M. A. & Tugenberg, T. 2006. Social Relationships, Stigma and Adherence to Antiretroviral Therapy. *AIDS Care*, 18(8): 904-910.

Watt, D., Verma, S. & Flynn, L. 1998. Wellness programs: a review of the evidence. *Canadian Medical Association Journal*, 158 (2): 224-230.

Weil, M. 1996. Community building: building community practice. *Social Work*, 41(5): 481-499.

Weiss, I., Gal, J. & Katan, J. 2006. Social Policy for Social Work: A Teaching Agenda. *British Journal of Social Work*, 36: 789-806.

Webb, C. & Kevern, J. 2001. Focus Groups as a Research Method: A Critique of Some Aspects of Their Use in Nursing Research. *Methodological Issues in Nursing Research*. Blackwell Science Ltd.

Webster's third international dictionary. 1961. London: Bell & Sons.

Wheaton, B. 1990. Life Transition, Role Histories, and Mental Health. *American Sociological Review*, 55: 209-223.

Wiktor, S. Z.; Abouya, L.; Angoran, H.; McFarland, J.; Sassan-Morokro, M.; Tossou, O.; Coulibaly, D.; Caulibaly, I. M. & Greenberg, A. E. 2004. Effects of an HIV counseling and testing program on AIDS-related knowledge and practices in tuberculosis clinics in Abidjan, Cote d'Ivoire. *International Journal of Tuberculosis and Lung Disease*, 8(4): 445-450.

WHO. 2006. Towards Universal Access by 2010. Switzerland: WHO.

WHO. Nutrition and HIV/AIDS. Report by the Secretariat. Fifty Ninth World Health Assembly. Switzerland: WHO.

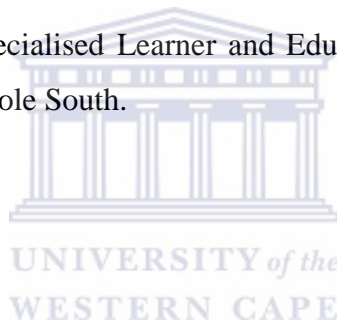
WHO. 2002. Healthy Cities Initiative in the African Region: An Evaluation Manual. Switzerland: WHO.

WHO. 2005. Interim WHO Clinical Staging of HIV and HIV/AIDS case definitions for surveillance: African Region. Switzerland: WHO.

Yang, H., Li, X., Stanton, B., Fang, X., Lin, D. & Naar-King, S. 2006. HIV-related knowledge, stigma, and willingness to disclose: A mediation analysis. *AIDS Care*, 18(7): 717-724.

OTHERS

Daniels, B. 2005. Head of Specialised Learner and Educator Support (SLES). Western Education Department: Metropole South.



APPENDIX A

INTERVIEW SCHEDULE: PRINCIPALS & GROUP SESSION

The following question guided the interviews:

1. What are the teachers' experiences of HIV/AIDS in Schools?
2. What are the impacts of HIV/AIDS in schools?
3. How is HIV/AIDS managed in schools?
4. What are the strategies schools use to mitigate the impacts of HIV/AIDS?
5. What is the required support to deal with the impact of HIV/AIDS?



APPENDIX B

INTERVIEW SCHEDULE: TEACHERS LIVING WITH HIV/AIDS

The following question guided the interviews:

1. What are their experiences of HIV/AIDS in schools?
2. What are the impacts of HIV/AIDS in schools?
3. How are they affected by their own sero-positive HIV/AIDS status?
4. What kind of support would they require to manage the illness?



APPENDIX C

PROGRAMME EVALUATION INSTRUMENT

Programme Manager

Company/Organization Name:

1. Description of the structure of the Employee Assistance Program (EAP)
2. Description of the operating environment of the EAP
3. Description of the EAP processes
4. Evaluation of the EAP



APPENDIX D

Information and Consent Form

Development of a Support Programme for Teachers within the Context of HIV/AIDS

University of the Western Cape/ Human Sciences Research Council

Programme Manager

My name is Thulisile Ganyaza-Twalo, a PhD student in the Social Work department at the University of the Western Cape. I also work for the Human Sciences Research Council as a PhD intern. I am conducting research to investigate the functional elements of your Employee Assistance Programme (EAP) and how it supports your employees. This study is part of a project aimed at developing a support programme for teachers within the context of HIV/AIDS.

I am interviewing managers responsible for the Employee Assistance Programmes in their organizations/companies. Your organization/company has been identified and included in the study, and I would appreciate your participation. For the purpose of this part of the study, I will focus on the functional elements of your programme and use the information to develop guidelines for further development of programmes to support teachers within the context of HIV/AIDS.

Your organization/company has been selected on the basis that it has an EAP and your knowledge and experiences can guide the development of the support programme for teachers within the context of HIV/AIDS. The interview will not take longer than an hour, and I would like your permission to record our conversation. Only the researcher and my two supervisors (from UWC & HSRC) will have access to the transcripts of the tape recordings. The transcripts from the recordings will be destroyed after the analysis has been done and the report completed.

The information will be presented in such a way that it will not be possible to link any statement to a particular individual or organization/company. An acknowledgement of your organization/company's participation will be made in the report.

You are not obliged to take part in the study thus your participation in this study is entirely voluntary, and if you refuse there will be no adverse consequences for you or your company/organization. You can also withdraw from the study at any time. However, we believe that your contributions to the study will be very helpful. If you agree to participate, you may stop me at anytime and tell me that you do not want to go on with the interview. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way.

If you have any questions or concerns about this study, you are welcome to call Prof. Susan Terblanche, Study leader, Dept of Social Work, UWC, at (021) 959 2011 or Prof John Seager, Co-study leader and Research Director, Human Sciences Research Council, at (021) 466 7908.

	Yes	No
Do you have any questions or concerns?	1	2
Will you participate in this study?	1	2

CONSENT: I sign my name to indicate that I agree to participate in this study as explained to me by the researcher

Respondent		Signature		Date	
Researcher		Signature		Date	

CONSENT FOR TAPE RECORDING OF THE INTERVIEW

CONSENT: I have agreed to allow the interview to be tape-recorded in this study as explained by the researcher concerned.

Respondent		Signature		Date	
Researcher		Signature		Date	

An extra copy of the consent form is for you to keep.

APPENDIX E

Information and Consent Form

Development of a Support Programme for Teachers within the Context of HIV/AIDS

University of the Western Cape/ Human Sciences Research Council

Teachers

My name is Thulisile Ganyaza-Twalo, a PhD student in the Social Work department at the University of the Western Cape. I also work for the Human Sciences Research Council as a PhD intern. The aim of the study is to develop guidelines for an HIV/AIDS workplace support programme for teacher.

I would like you to assist me in understanding the dynamics of HIV/AIDS in schools. The information would be incorporated in the development of the HIV/AIDS workplace guidelines for teachers. Your participation is appreciated.

The individual interview will last for an hour. For group sessions, the groups will be limited to two hours. I wish to ensure the participants of confidentiality. The interviews and group sessions will be recorded and the transcripts of interviews will be kept safely and destroyed following the analysis and completion of the report.

The information will be presented in such a way that it will not be possible to link any statement to a particular individual or organization/company. An acknowledgement of your organization/company's participation will be made in the report.

You are not obliged to take part in the study thus your participation in this study is entirely voluntary, and if you refuse there will be no adverse consequences for you or your company/organization. You can also withdraw from the study at any time. However, we believe that your contributions to the study will be very helpful. If you agree to participate, you may stop me at anytime and tell me that you do not want to go on with the interview. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way.

If you have any questions or concerns about this study, you are welcome to call Prof. Susan Terblanche, Study leader, Dept of Social Work, UWC, at (021) 959 2011 or Prof John Seager, Co-study leader and Research Director, Human Sciences Research Council, at (021) 466 7908.

	Yes	No
Do you have any questions or concerns?	1	2
Will you participate in this study?	1	2

CONSENT: I sign my name to indicate that I agree to participate in this study as explained to me by the researcher

Respondent		Signature		Date	
Researcher		Signature		Date	

CONSENT FOR TAPE RECORDING OF THE INTERVIEW

CONSENT: I have agreed to allow the interview to be tape-recorded in this study as explained by the researcher concerned.

Respondent		Signature		Date	
Researcher		Signature		Date	

An extra copy of the consent form is for you to keep.

APPENDIX F

MOTIVATION TO UNDERTAKE A STUDY TRIP TO UGANDA

Social Work Department
University of the Western Cape
Bellville
7500
February 2006

Human Sciences Research Council
Pleinpark Building
83-103 Plein Street
Cape Town
8000

Dear Prof. John Seager

Re: Motivation to undertake a trip to Uganda

As part of my PhD study I have to engage in three phases of data collection: (1) interviews and focus group sessions, (2) extensive literature review, and (3) visit to sites (locally and internationally) with existing HIV/Aids support programmes for employees. It is within the context of the third phase of data collection that I need to undertake a trip to Uganda. The aim of the visit is to study both functional and less functional aspects of their programme to assist in the design and development of our programme to support teachers.

I have just learnt that the Flemish Inter-university Council (VLIR) will finance a flight tickets to Uganda but I will need to cover subsistence for 4 days.

This visit provides an opportunity for policy comparison in terms of HIV/Aids related intervention programmes in the workplace between the two countries and will obviously contribute to the completion of the PhD.

It is in the light of the reasons outlined above that I request the HSRC: URED to finance accommodation, subsistence and taxi costs which will amount to not more than R6,000.

Yours truly

Ganyaza-Twalo, Thulisile

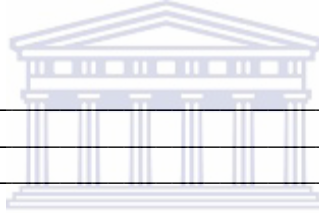
APPENDIX G

Guidelines for Managing HIV/AIDS in the Workplace Presentation to the Western Cape Education Department Evaluation/Feedback Form

1. Feasibility of the proposed programme guidelines. Please explain your answers where possible.

Do the programme guidelines respond to the needs of the teachers and those of WCED?

Do these programme guidelines contribute to the achievement of the overall strategy and core business of WCED?



In your view, are the guidelines implementable/practical? Please explain your answer.

WESTERN CAPE

Are the guidelines easy to understand?

Are the guidelines comprehensive enough to cover considerations on all levels?

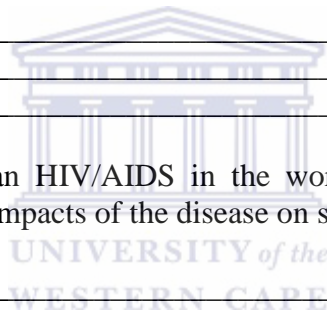
Are the guidelines systematic?

Will the teachers support such an HIV/AIDS in the workplace programme?

Will WCED management support such an HIV/AIDS in the workplace programme?

Is it financially feasible to implement the HIV/AIDS in the workplace programme guidelines?

Will an implementation of an HIV/AIDS in the workplace programme following these guidelines mitigate the impacts of the disease on schools?



What are the factors that will make implementation difficult?


School level:

Department level:

2. Areas for improvement

Please identify areas for improvement on the aspects of the programme guidelines. Please make suggestions on how these could be improved.

3. Any other suggestions on the guidelines



The logo of the University of the Western Cape, featuring a classical building facade with columns and a pediment, with the text "UNIVERSITY of the WESTERN CAPE" below it.