INVESTIGATION INTO THE QUALITY OF LIFE OF AN EMPLOYEE AFFECTED BY HIV/AIDS

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Assignment presented in partial fulfilment of the requirements for the degree of Master of Nursing Science in the Faculty of Health Sciences at Stellenbosch University

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March 2008
DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

One of the greatest challenges in the world today is fighting the HIV/AIDS pandemic. Life expectancy in developing countries, especially those in sub-Saharan Africa, decreased to 46 years while in developed countries the average life expectancy is 78 years. World Health Organisation (WHO) indicates that HIV/AIDS, now the world's leading cause of death in adults aged 15 to 59 years, is killing almost 5 000 men and women in this age group, and almost 1 000 of their children, every 24 hours in sub-Saharan Africa.

In South Africa today, employees operate in an increasingly complex legal environment with regard to HIV/AIDS in the workplace.

Despite the legal protection against employees affected by HI/AIDS and vigorous campaigns to combat HIV/AIDS in support of affected employees, the researcher has observed that management and co-workers show no compassion, empathy or understanding for the needs of these affected employees.

An in-depth literature review of quality of life was completed. The goal of this study was to investigate whether the quality of life of the employee affected by HIV/AIDS is adversely affected. The following objectives were set:

- To determine the family history of the employee affected by HIV/AIDS
- To determine occupational history of the employee affected by HIV/AIDS
- To determine the symptoms of the employee affected by HIV/AIDS
- To determine the effectiveness of the anti-retroviral treatment programme of the employee affected by HIV/AIDS

A descriptive qualitative research design using the case study method was applied to investigate whether the quality of life of the employee affected by HIV/AIDS was adversely affected.

The population of this study were HIV/AIDS-affected employees working at a food and beverage company. Ten employees who gave consent participated in the study. The trustworthiness of this study was assured with the use of Lincoln and Guba’s criteria of credibility, transferability, dependability and confirmability. A pre-test study was also
completed. All ethical principles were met. Data was collected through an interview using an interview guide designed for use in a semi-structured interview. Data analysed show that the basic needs of the employee affected by HIV/AIDS are not adequately met and that the employee therefore does not experience quality of life.

Recommendations include the improvement in public–private partnerships; in-service training and continuous refresher courses for all employees, supervisors and management; employee assistance programmes; involvement of church and communities; support circle; holistic approach in nursing care and further research.

The findings play a role in understanding the importance of remaining at work for as long as possible when one is affected by HIV/AIDS. The findings of this study further validate the concepts in basic needs and that QOL is perceived differently by each individual.
**OPSOMMING**

Een van die grootste uitdaginge ter wêreld tans is die stryd teen die MIV/vigs-pandemie. Lewensverwagting in ontwikkelende lande, veral dié in Afrika suid van die Sahara, het tot 46 jaar afgeneem. Die Wêreld Gesondheids Organisasie terselfdertyd bepaal dat die gemiddelde lewensverwagting in ontwikkelde lande 78 jaar. MIV/VIGS is nou die voorste oorsaak van sterfte onder volwassenes in die ouderdomsgroep 15 tot 59 jaar, en lei tot die dood van bykans 5 000 mans en vroue in hierdie ouderdomsgroep en bykans 1 000 van hul kinders elke 24 uur in Afrika suid van die Sahara.

In die hedendaagse Suid-Afrika moet werknemers in 'n toenemend komplekse regsomgewing funksioneer ten opsigte van MIV/VIGS in die werkplek. Ondanks die wetlike beskerming van werknemers wat deur MIV/VIGS geraak word en ernstige veldtogte om die pandemie te bekamp, het die navorser waargeneem dat die bestuur en kollegas geen deernis, empatie of begrip vir die behoeftes van hierdie werknemers toon nie.

'n Uitvoerige literatuuroorsig aangaande lewensgehalte is uitgevoer. Die doel van die studie was om te ondersoek of die lewensgehalte van die werknemer wat deur MIV/VIGS geraak is, benadeel word. Die volgende doelwitte is gestel:

- Om die familie geskiedenis van die werknemer wat deur MIV/VIGS affekteer is te bepaal
- Om die werk geskiedenis van die werknemer wat deur MIV/VIGS affekteer is te bepaal
- Om die simptome van die werknemer wat deur MIV/VIGS affekteer is te bepaal
- Om die doeltreffendheid van die anti-retrovirale behandelings program van die werknemer wat deur MIV/VIGS affekteer is te bepaal

'n Beskrywinde kwalitatiewe navorsings ontwerp volgens die gevalle studie metode is toegepas om te ondersoek of die lewensgehalte van die werknemer wat deur MIV/VIGS geraak is, benadeel word..

Die populasie van hierdie studie was werknemers wat deur MIV/VIGS geraak is wat by 'n voedsel-en-drankmaatskappy werkzaam is. Tien werknemers wat daartoe ingestem het, het aan die studie deelgeneem. Die betroubaarheid van hierdie studie is verseker
deur van Lincoln en Guba se kriteria vir geloofwaardigheid, oordraagbaarheid, betroubaarheid en bevestigbaarheid gebruik te maak. ’n Loodsstudie is ook gedoen. Daar is aan alle etiese vereistes voldoen. Data is ingesamel deur middel van ’n semi-gestrukturierde onderhoud waartydens daar van ’n onderhoud gids gebruik gemaak is. Die ontleiding van die data het getoon dat die basiese behoeftes van die werknemer wat deur MIV/VIGS geraak word, nie na behore vervul word nie, en dat die werknemer daarom nie lewensgehalte ervaar nie.

Aanbevelings sluit in die verbetering van privaat-openbare-vennootskappe; indiensopleiding en voortgesette opknappingskursusse vir alle werknemers, toesighouers en die bestuur; werknemerbystand en eweknie-opvoedingsprogramme; die betrokkenheid van kerke en gemeenskappe; ondersteuningsgroepe; holistiese benadering in verpleging en verdere navorsing.

Die bevindinge is belangrik om te toon dat die geraakte werknemers so lang as moontlik by die werk moet aanbly. Die bevindinge van hierdie studie beklemtoon die konsepte in basiese behoeftes en dat lewensgehalte verskillend ervaar word deur elke individu.
ACKNOWLEDGEMENTS

Thanks and praise to Almighty God for giving me the opportunity to undertake and complete this study.

My sincere thanks and appreciation goes to:

- Dr. Stellenberg, my supervisor to whom I am particularly grateful for her unfailing support and encouragement during an exciting but not always easy undertaking.
- To Wilhelmiene Poole, Stellenbosch University, Tygerberg Campus, for her invaluable assistance with the literature sources.
- My dear mom Audrey, Remona and Eugenia for encouraging, supporting and believing in me.
- My children: James, Vanencia, Bernadette and Jason for their undying support, love and understanding.
- Ruth Pearce for constant support and motivation
- Elsie Wagner for all her support during my studies
- Bernadette and Vanencia for typing.
- My colleagues and friend Sr. Gloria Mashao, Sr Barbara Hare and Colleen Shongwe for their help and continuous support.
- The Company and Human Resource Managers for emotional and financial support.
- Other competency managers for continued encouragement.
- Kiekie Mashaba and Walter Fakude for translation into vernacular.
- Ginny-Uren-Viner and Sally Mayhew for their ongoing support.
- All the employees who were involved without whom this study would not have been possible.
- T Haynes for editing.
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CHAPTER 1
SCIENTIFIC FOUNDATION OF THE STUDY

1.1 RATIONALE

One of the greatest challenges in the world today is fighting the Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) pandemic. It is estimated that of the 39.5 million people living with HIV worldwide in 2006, more than 63% are from Sub-Saharan Africa. In 2005 about 5.54 million people were estimated to be living with HIV in South Africa, with 18.8% of the adult population (15-49) and about 12% of the general population affected. Women are disproportionately affected; accounting for approximately 55% of HIV positive people. Women in the age group 25-29 are the worst affected with prevalence rates up to 40%. Among men older than 50 years an estimated 10% prevalence rate is found (Tulleken, 2008:114).

In South Africa Dorrington, Bradshaw and Budlender (2002:7) report that the mortality rate for adults as measured by the probability that an individual at the age of 15 years will not reach the age of 60 years \((45q_{15})\) is 43% for women, 56% for men and 50% for both sexes combined. It has been estimated that the life expectancy at birth for males is 50 years and females 55 years. This may ultimately influence the country’s economy adversely.

According to the report by Statistics SA on mortality and causes of death in South Africa between 1997 and 2003, an increase in deaths as a result of AIDS has been recorded for the age group 20 to 49 years. The statistics showed that the daily death rate soared by 57% between 1997 and 2002 while the population grew by 10%. According to data released by Statistics SA, 18 903 people aged 30 to 40 died in 1997, out of a total of 318 287 deaths. In 2002, 46 758 people in this age group died, out of a total of 499 268 deaths (Schoonakker, 2005:11). Tulleken (2008:180) predicted that by 2006 47% of all deaths will be as a result of AIDS.

The increase of the incidence of tuberculosis (TB) and pneumonia could be AIDS related as reported by researchers from the Medical Research Council (MRC) and
the University of Cape Town (UCT) because more than 60% of TB deaths were linked to HIV (Groenewald, Nannan, Bourne, Laubscher, & Bradshaw, 2005:198).

Despite the legal protection of HIV/AIDS affected employees and vigorous campaigns to combat HIV/AIDS in support of affected employees, the researcher has observed that management and co-workers show no compassion, empathy or understanding for the needs of these affected employees.

The Constitution of South Africa (Act 108 of 1996) protects the right to privacy of all individuals including employees who are affected by HIV/AIDS in the workplace. The Employment Equity Act 55 of 1998 ensures the promotion of a safe workplace, the absence of discrimination, and the protection against HIV testing without consent.

The employee affected by HIV/AIDS is further protected by the Labour Relations Act 66 of 1995 against unfair dismissal on grounds of a HIV positive status.


The researcher has observed that as soon as the affected employee became too ill to perform a full day’s work, the employee’s services would be terminated due to incapacity. The eighth principles of the International Labour Organisation and World Health Organization (2005:04) indicate “workers with HIV-related illness should be able to work in appropriate conditions for as long as they medically fit”. As with many other illnesses, people with HIV-related illnesses should be able to work as long as they are medically fit for available and appropriate work,

According to Hood and Leddy (2002:264), wellbeing is a subjective perception of vitality and feeling well which “can be described objectively, experienced and measured … and can be plotted in a continuum”. This continuum is presented in Figure 1.1.
An individual is a multidimensional entity, consisting of physical, psychological, social and spiritual components (Stellenberg, 1995:19). According to Anspaugh et al. (2003:3–7), wellness is a state of wellbeing. The basic concepts of wellness includes being self-responsible, having an ultimate goal, being a dynamic growing process, being able to make decisions on daily areas of nutrition, managing stress, being physically fit, applying preventive health care and ensuring emotional health.

Anspaugh, et. al. (2003:3–7), describe seven components of wellness:

- Physical – the ability to carry out daily tasks
- Social – the ability to interact successfully within the environment of which each person is part
- Emotional – the ability to manage stress and express emotions appropriately
- Intellectual – the ability to learn and use information effectively
- Spiritual – the belief in some supernatural force. It includes a person’s own morals, values and ethics.
- Occupational – the ability to achieve a balance between work and leisure time
- Environmental – the ability to promote health measures that improve the standard of living and quality of life.

Quality of life, according to the literature, is defined as “finding a balance between all the dimensions of one’s self and one’s life.” Quality of life can be experienced only to the degree that a person is able to develop such a balance (Mostert & Koekemoer, 2007:1). According to Stellenberg (1995:7) the quality of life of an individual is
based on the basic needs of the individual which include the physical, psychological, social and spiritual dimensions of the human being.

### 1.2 THEORETICAL APPROACHES

Maslow in Norwood (2005:2) describes five basic human needs which an individual will strive to satisfy in a specific order, from the basic physiological level, safety, belonging, esteem, to the highest level of actualisation. Man is never satisfied and is constantly striving to satisfy his needs which may fluctuate between these levels.

Orem’s theory of nursing describes “patients as care agents and defines the purpose of nursing as helping individuals to accomplish self-care that promotes health, facilitates peaceful death” (Foster and Bennett in George, 2002:127).

Roy’s theory of nursing postulates that man is a biophysical being in constant interaction with a continuously changing environment. Roy defines the goal of nursing “as the promotion of man’s innate and required mechanism for adaptation to situations of health and illness” (Galbreath in George, 2002:298).

The goal attainment theory of King as described in George (2002:244–247) is derived from an open system of framework. Individuals comprise one type of system in the environment, called personal systems. Individuals interact to form small and large groups which compromise another type of system, called interpersonal systems. Groups with special interest and needs from organizations, which make up communities and societies are called social systems.

Kemppainen (1990:384) states the following regarding the concept of the self:

“The concept of perception is related to the concept of the self. Each personal system has a concept of the self. The diagnoses of HIV infection dramatically alter the perceptions in the personal system of the client and it also affects his self-image and self-esteem”. The concept of the self is decreased further by the initial negative responses that occur in the personal system of the affected employee. Body image, the picture that one has of one’s own body, is closely related to the concept of self. Therefore person worries about the possibility of disfigurement,
Neil (1994:36-40) describes the ideas and ideals inherent in Watson’s theory of human care nursing, basic beliefs and values namely:

- respect for the dignity of each person;
- the right and responsibility of each person to make informed choices concerning health;
- the belief that individuals possess inner resources to support self-healing; and that authentic caring relationships contribute to healing and health.

1.3 THE IMPORTANCE OF QUALITY OF LIFE IN AN INDIVIDUAL AFFECTED WITH HIV/AIDS

What impacts directly on the quality of life (QOL) of an individual with HIV/AIDS is the success with which an individual manages to live with this ongoing stressor. QOL has its origin in the field of oncology and is a relatively new concept in health-care research. In 1988, Frank-Stomborg concisely pointed out that “the value of cancer treatment is judged not only by survival but on the quality of that survival” (Grimes & Cole, 1996:691). It was soon realised that this concept had a broad application in the field of other chronic illnesses such as HIV/AIDS.

Although initial HIV research focused primarily on measuring the effectiveness of medical and pharmacological interventions (Hays & Shapiro, 1992:99; Lubeck & Fries, 1993:359; Wu & Rubin, 1992:251), there is a growing recognition that QOL is an important outcome for these employees (O’Keefe & Wood, 1996:275). What is self-evident for persons with HIV/AIDS, facing years of health decline and the escalating onset of debilitating opportunistic infections, is the importance of maintaining optimal QOL.

Grimes and Cole (1996:691) accurately point out how QOL has generally been conceptualised as a functional state rather than as a subjective construct that reflects attitudes and perceptions. A person’s ability to function effectively within a given role or life activity can be referred to as functional status. Although functional status is logically related to the pathology, progression and symptoms of the disease, there is sufficient evidence to argue that perceived QOL differs conceptually from a functional state. Satisfaction and pleasure in life can still be found even if daily functioning may

Reference to one gender also includes the other
be impaired. QOL therefore refers less to functional status and more to the subjective appraisal of wellbeing and level of satisfaction (Grimes & Cole, 1996:691).

The researcher currently functions as an occupational health practitioner at a particular food and beverage manufacturing company, at which she recorded six deaths due to HIV/AIDS-related diseases within the past nine years. Three of these deaths were recorded within one year. Currently 14 employees at this particular company are affected by HIV/AIDS. The average age of these employees is between 20 and 60 years, of which 15% are female and 85% male. This age group forms part of the economically active population of South Africa. These results also reflect the most sexually active time period of the life cycle.

1.4 PROBLEM STATEMENT

In the light of the above, and substantiated by the literature, the researcher believes that the quality of life of the employee affected by HIV/AIDS is adversely affected. The researcher poses the following research question as a point of departure for the purpose of this study: Is the quality of life of an employee affected by HIV/AIDS adversely affected?

1.5 GOAL OF THE STUDY

The goal of this study is to investigate whether the quality of life of the employee affected by HIV/AIDS is adversely affected.

1.6 OBJECTIVES

The study has the following objectives:

- To determine the family history of the employee affected by HIV/AIDS
- To determine occupational history of the employee affected by HIV/AIDS
- To determine the symptoms of the employee affected by HIV/AIDS
- To determine the effectiveness of the anti-retroviral treatment programme of the employee affected by HIV/AIDS
1.7 RESEARCH METHODOLOGY

1.7.1 Research Design

A descriptive research design using the case study method will be applied with a qualitative approach to investigate whether the quality of life of the employee affected by HIV/AIDS is adversely affected.

1.7.2 Population and sampling

The total population of 14 employees affected by HIV/AIDS at a food and beverage manufacturing company is included in this study. The researcher decided that the total population should be included in the study to provide richness and depth of the data collected. The validity of the study may also be supported.

The following criteria have been set:

- A positive HIV/AIDS status
- The ability to participate, i.e. employees' willingness to commit time to be interviewed and to share their experience with the researcher
- In the employment of the food and beverage manufacturing company.

1.7.3 Ethical considerations

At the beginning of each interview, an explanation of the study will be given and written consent to participate in the study will be obtained (Appendix B). The participants will be informed that they are not required to participate in the study, that they could stop the interview at any time or refuse to answer any questions, and that whether or not they participated will have no bearing on the care they receive. The participants will be assured of anonymity, and that, although some of the information they will provide may be published, their names will not be associated with the publication. Relevant permission was obtained from the Human Research Committee at Stellenbosch University and the food and beverage manufacturing company involved.
1.7.4 Instrumentation

For the purpose of this study an interview guide with some questions will be designed to ensure that the lived experience about each objective is explored.

1.7.5 Data collection

A semi-structured interview is planned with the use of a tape recorder to ensure that all data is captured with the use of an interview guide.

1.7.6 Validity testing of the research

The basic question of trustworthiness as described by Lincoln and Guba (1985:290) is critical as the researcher is required to persuade his audience that his research is worth paying attention to.

1.7.6.1 Credibility

To ensure that the raw data that will be collected is credible it will be cross checked by clinical experts in a similar clinical environment, and a nurse expert and research methodologist. The researcher will also check the data being collected back and forth with the participants to ensure that the information being collected is correct.

1.7.6.2 Transferability

Findings obtained in qualitative research are not always easy to transfer or generalise (De Vos, 2005:352) but it may be possible to generalise the findings obtained in this study or conduct this study under similar conditions at similar companies. As described by Eisner (1991:205) “…it is a retrospective generalization that can allow us to understand our past (and future) experiences in a new way”.

1.7.6.3 Dependability

The dependability of the study will be supported by an “inquiry audit” in which the reviewers may examine the process and the consistency of the research.

Reference to one gender also includes the other
1.7.6.4 Confirmability

To support the confirmability of the study and supported by Lincoln and Guba (1985: 320-321) the researcher will enhance her neutrality by providing an audit trail of well documented notes of the raw data collected, an analysis of the notes, the reconstruction and synthesis of the products, process notes, any personal notes and the preliminary developmental information.

1.7.7 Pre-test

A pilot study or pre-test will be conducted under similar conditions at a second clinic as the actual study to test the feasibility of the research design which would support the validity of the study.

1.7.8 Data analysis and interpretation

Data will be transcribed and categorised into common themes, ensuring consistency. As the categories of meaning emerge, the researcher will search for those that have internal convergence and external divergence.

1.8 RECOMMENDATIONS

Recommendations will be made based on the scientific findings of the outcome of this study. Recommendations will be made to the food and beverage company involved as well as policy makers in industrial health. The study will also be published in a scientific journal.

1.9 STUDY LAYOUT

1.9.1 Title

Investigation into the quality of life of an employee affected by HIV/AIDS

1.9.2 Chapter contents

The scientific foundation of the research project is presented in Chapter 1, which includes the rationale for the study, the theories and models related to the basic needs of individuals, the problem statement, objectives, research methodology and study layout. Chapter 2 contains a literature review on HIV/AIDS. Chapter 3
describes the research methodology applied in the project. In chapter 4 the interpretation and analysis of the data obtained in the research project are described. Chapter 5 presents the proposed recommendations, based on the outcome of the study.

1.10 SUMMARY

In this chapter, the rationale for and goal of this study were discussed, supported by the literature. The research methodology was described and the layout of the study presented.
CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

The quality of life (QOL) of an individual is determined by the success with which that individual manages to live with ongoing stressors.

The origin of QOL lies in the field of oncology. In 1988, Frank-Stomborg pointed out that “the value of cancer treatment is judged not only by survival but on the quality of that survival” (Grimes & Cole, 1996:691). Initial HIV research focused primarily on measuring the effectiveness of medical and pharmacological interventions. Currently however, a growing recognition that QOL is an important outcome is emerging. What is self-evident for persons with HIV/AIDS, facing years of health decline and the escalating onset of debilitating opportunistic infections, is the importance of maintaining optimal QOL (O'Keefe & Wood, 1996:88).

According to Stellenberg (1995:19), “[a]n individual is a multidimensional entity, consisting of physical, psychological, social and spiritual component’s”. Quality of life can be defined as “finding a balance between all the dimensions of one’s self and one’s life. Quality of life can be experienced only to the degree that a person is able to develop such a balance between work and life. In a recent study it was identified that work most often interferes with the workers personal lives Most stressors identified are related to the work environment (Mostert & Koekemoer, 2007:1).

2.2 CONCEPT OF QUALITY OF LIFE

Within the cost–benefit analysis of various therapeutic or rehabilitative measures, quality of life of the treated patients comes into discussion with increasing frequency. This term encompasses the effects of both disease and treatment on the subjective experience and functioning of the patient. Thus research into health-related QOL is essentially based on the subjective perception of health and disease from the patient’s point of view (Haverkamp, 1999:144). The classic criteria for success in medicine are prolongation of life, or the avoidance of side-effects from therapeutic measures. The term ‘quality of life’ focuses on the demand for rehabilitation or the
maintenance of a life worth living from the patient’s point of view (Peterman, Krischke and Deuchel in Peterman and Bergmann, 1994:29-41).

2.3 DEFINITION OF QUALITY OF LIFE

Quality of life research deals with empirical scientific examination of the question “How are you?” The analysis of this everyday question requires a multidimensional approach and is often much more difficult to achieve than appears at a first glance Eiholzer, U., Haverkamp, F., Voss, L., Hogrefe & Huber. (1999:144).

QOL encompasses the disease-specific – i.e. somatic/physical – medical realm and the functional status, that is coping in everyday life, restrictions, psychological adaptation such as affective or behavioural disorders, social adaptation and general satisfaction with life, as well as cognitive and developmental aspects Gotary, Korn, McCabe, Moore, and, Cheson (1992:575-579). QOL research tries to align itself with the holistic definition of health created by the WHO, which includes physical, psychological–cognitive and social factors alike, as described in Kozier, Erb, Berman, & Snyder, (2004:171).

2.4 QUALITY OF LIFE – A MULTIDIMENSIONAL CONCEPT

“QOL is a complex, abstract and multidimensional concept that is difficult to define and measure. [but may be] defined as the physical, emotional, intellectual or cultural satisfaction in a person’s everyday life” This concept, as used in health-care delivery, defines the standard by which outcomes for the total patient can be assessed (Bergner, 1989:S148-S156).

Quality of work life is defined as involving three major parts: occupational health care, suitable working time and appropriate salary. Being aware of their risks and rights the employer and employee can achieve a lot through mutual dialogue should the work pose a health hazard for the person. (Sotsiaalministeerium, 2004:1) Figure 2.1 shows the factors which include health, education, safety, family, work, psychological and spiritual components. These components are all interrelated, and should there be a disturbance in one the others may be affected.
2.5 MULTIDIMENSIONALITY OF HEALTH-RELATED QOL

The assessment of health-related QOL will be described in terms of each dimension listed in Figure 2.2.

Figure 2.2: Multidimensionality of quality of life (Arronson et al., 1988, 111:231–248)

Reference to one gender also includes the other
2.5.1 Disease specific status

Disease-specific status concerns the search for a link between the physical symptoms of a disease and the subjective QOL. The compensation mechanism might mask the effects of physical symptoms and the associated distress. Therefore a simple assessment of the physical health status may not necessarily be accompanied by a corresponding deterioration in quality of life (Spieth & Harris, 1996:175–193). The effect of medical treatment may influence people in ways that cannot be understood in terms of biological responses. However, some treatment may only be of benefit to QOL. The factors influencing QOL are weighed in treatment decisions and are a central concern in patient-provider communication (Rapkin and Schwartz, 2004:1).

2.5.2 Functional status

Functional status is understood as subjectively experienced coping and behavioural options in everyday life. It comprises stress and social adaptation. Functional status is not as much concerned with the objective measure of functional limitations but rather focuses on assessing the subjective view of the patient of his ‘functioning’. (Richards & Hemstreet, 1994, as cited in Eiholzer et al., 1999:146).

In contrast, Grimes and Cole state that QOL has generally been conceptualised as a functional state rather than as a subjective construct that reflects attitudes and perceptions. A person’s ability to function effectively within a given role or life activity can be referred to as functional status. Although functional status is logically related to the pathology, progression and symptomatology of the disease, there is sufficient evidence to argue that perceived QOL differs conceptually from a functional state. Satisfaction and pleasure in life can still be found even if daily functioning may be impaired (Grimes & Cole, 1996:691).

2.5.3 Psychological adaptation

Psychological adaptation comprises individual forms of psychological impairment such as depressive moods due to disease-related worries (Peterman et al., 1994:35). A research methodology problem results from the fact that the available psychological tests and questionnaires often do not have the necessary sensitivity to
differentiate between occasional or slight problems and serious stress, or between inadequate psychopathological abnormal adaptations (Eiholzer et al., 1999:146).

In many respects life is what an individual makes of it. The personal psychological attitude defines the level of satisfaction of an individual’s life. Therefore an optimist will see the positive side whilst a pessimist will only see the negative side of a situation. Thus the same environment is perceived differently. This means that environmental or material change is a poor method of optimisation. It is crude global changes that can make life seem worse – even if most like the change. Thus one’s concentration on the psychological aspect should prove beneficial, in the fulfilment of those personal goals that lies behind most definitions of QOL (Lucas, 2002:2).

2.5.4 Social adaptation
Social adaptation comprises the ability to develop and maintain appropriate social relationships. The social adaptation may be operationalised, e.g. by the assessment of the number and quality of social relationships (Aaronson et al., 1988: 111).

2.5.5 General contentment with life
Overall satisfaction with life comprises a general view of ones own life situation and the evaluation of the different stresses and resources (Arronson et al., 1988, 111). QOL may refer to the objective achievement by certain persons of attributes and skills that are highly valued in culture, such as intellectual ability, physical capacity, emotional stability, artistic and technical skills, and the capacity to form and enjoy social relations.

In addition to medical evaluation, the assessment of health-related QOL can be used in an evaluation of an individual response to different forms of therapy, including psychological counselling. Furthermore, it can serve as a basis for comprehensive cost–utility analysis. The anticipated QOL might influence decision making with respect to withholding or withdrawing the so-called aggressive therapy (Bullinger & Ravens, in Seiberer, 1995: 44).
### 2.6 QUALITY OF LIFE AND ETHICAL CONSIDERATIONS

HIV/AIDS is strongly associated with sexual behaviour, illicit drug use, and physical decline and death, and therefore bears a social stigma (Kozier et al., 2004:77). The principles of confidentiality, patient/client autonomy, beneficence (do no harm) and justice (fair treatment) is all ethical issues surrounding HIV/AIDS.

According to Langley in Stellenberg and Bruce (2007:958), Evian (2003) states that when caring for a person affected with HIV/AIDS the following applies:

- All patients/clients should receive the usual respect, dignity, sensitivity and empathy
- The moral values of the affected individual should not be judged
- Strict and absolute confidentiality must always be adhered to
- No individual may be refused treatment because of his status
- Respect their right to privacy at all times
- When testing for HIV, the individual has the right to an informed choice, including the right to refuse testing

One cannot disregard the social and historical circumstances in which an individual lives but these do not change the justification of morality and ethics. We have to remember that outcome prediction, QOL assessment and also cost efficiency were not taught in medical schools, nor were they emphasized in post-graduate training. However, they are among our most important tools for meeting the challenges of today and of tomorrow.

The Conference on Quality of Life in Severe Burns held in Prague focused on two goals:

- The first was to remind that the primary aim of burn care is to save the life but survival is not a subtle enough indicator of success. Decisive is the subsequent QOL, which is influenced by scar formation and the individual stress response of the patient, though multiple subjective factors play an important role in a positive or negative way.
- The second was to stimulate awareness of ethical problems and of possible legal consequences. With the development of the biosciences, the sum of
individual requirements in medicine has become much higher than society can provide. However, it would be expected that health-care professionals will be influenced in their decision making not only by the constraints of the law or those of professional bodies but by their own moral principles and values. (Kdnigova, 2000:1)

2.7 FACTORS AFFECTING QOL IN INDIVIDUALS AFFECTED BY HIV/AIDS

Following a study of the stressors and stress of being HIV positive, Thompson, Nanni, & Levine (1996:14) concluded that QOL might be improved by interventions that help individuals to have a sense of autonomy and optimism in their lives and by programmes that reduce conflict with significant others.

According to Coetzee (2001:40):

Ensuring optimal QOL in people living with HIV and AIDS is a key objective that requires careful consideration and focused research. It would further facilitate the identification of individual needs and concerns and directly inform much needed care plans/programmes.

Numerous variables have been shown to correlate with QOL to a lesser or greater extent. These variables are discussed below.

2.7.1 Coping Styles

Following the initial appraisal of a stressful situation – in this case a HIV diagnosis – and the subsequent appraisal of one’s resources to cope with it, a specific coping strategy is utilised (Schruers & De Riddes, 1997:221). Lazaras and Folkman (1984:114) define coping as “constantly changing cognitive and/or internal demands that are appraised as taxing or exceeding the resources of the person”.

The following coping styles will be discussed here:

- active versus passive coping
- problem-focused versus emotion-focused coping
- escape or avoidance coping – including denial

Reference to one gender also includes the other
Certain patterns of QOL outcomes have emerged within the clusters of problem-focused and emotion-focused coping. The use of problem-focused coping strategies – such as effective stress management and perceived control – seems to have a significantly positive influence on and show a positive correlation with improved QOL in HIV/AIDS-affected people. Conversely, an absence of these attributes has been found to have a significantly negative effect (Chidwick & Borrill, 1996:20).

Swindles et al. (1999:40) refer to a longitudinal study of 138 HIV-infected patients in Nebraska confirmed by Friedland et al. (1996:30) in which improved QOL was associated with problem-focused coping, while emotion-focused coping, avoidant coping, hopelessness, loss of motivation and negative feelings about the future were predictors of poorer QOL.

Passive coping, on the other hand, has not only been linked to poorer QOL but also to the clinical progression of HIV to AIDS (Byrnes et al., 1997:35). Moneyham et al. (1998:351-362) investigated the effectiveness of active and passive coping strategies in a sample of 264 women. Active coping, which included activities such as seeking social support, managing the illness and engaging in spiritual activities, appeared to serve a protective function in that emotional distress decreased with greater use of active coping, even as physical symptoms increased. Passive coping, as indicated by avoidance behaviour, had no such protective effect against emotional distress. Interestingly, the use of avoidance coping decreased and active coping increased, suggesting that active coping is more likely to be used as levels of physical symptoms rise.

In a four-year longitudinal German study, 43 subjects reported on their QOL depressive reactions and coping styles. A decrease in evasive-regressive coping in favour of enhancement of emotional palliative and goal-oriented coping strongly predicted improved QOL (Brieger, 1996:51). Furthermore, escape-avoidance coping has been associated with symptoms of psychological distress (such as depression and self-blame), an external focus of control and consequently an overall reduced QOL (Chidwick & Borrill, 1996:36).

Denial as a form of escape-avoidance coping has been the subject of much research and deserves a more in-depth exploration. Denial can be viewed, however, as an
adaptation response that allows the individual to cope with an initial shock while buying time to make the necessary cognitive adjustment (Coetzee, 2001:8).

Coping is not a static or inflexible phenomenon but a continuous and constantly changing process whereby the individual takes the necessary steps to deal with stress (Coetzee, 2001:8). HIV/AIDS thus represents a complex host of ever fluctuating stress. Poor QOL shows a strong correlation with certain mental adjustment subscales. Grassi et al. (1993:45) found an association between lower fighting-spirit scores, greater hopelessness and elevated psychological morbidity. Fighting spirit was found to be the most adaptive end of the continuum with helplessness/hopelessness the least adaptive.

Social support has been a strong focus of the stress-outcome paradigm within the subjective conceptualisation of QOL for HIV-positive patients (Coetzee, 2001:12). Folkman (1984:417) refers to social support as a coping strategy. He describes it as “the active participation of significant others in individuals’ stress management efforts.” It has also been suggested that social support is dependent on coping, implying that social support follows as a result of an individual’s way of coping (Vaux, 1990:507-518). Within this context, it might be possible to integrate models of coping and support such as:

- problem-focused coping and instrumental support;
- emotion-focused coping and emotional support;
- perception-focused coping and informational support (Friedland et al., 1996:25).

In an attempt to find a theoretical framework for understanding the role of coping and social support in chronic illness, authors have referred to the transactional stress-coping model proposed by Lazarus and Folkman (1984) as described in Coetzee (2001:15).

2.7.2 Stigmatisation

Social prejudice and stigmatisation are commonly regarded as the root of social isolation experienced by those suffering from HIV/AIDS. Already in 1992, the World Health Organisation (WHO) declared discrimination one of the pivotal concerns in
developing a social policy for HIV/AIDS. This was supported locally by Lindegger and Crewe (1997:24), who anticipated the need for a comprehensive mental policy regarding HIV/AIDS – a policy that nurtures non-discrimination, fosters respectful and empathetic environments and enhances QOL (Strebel & Lindegger, 1998:16).

Despite numerous efforts to change public attitudes, the reality reflected in the literature is characterised by deeply ingrained social prejudice, stereotyping and stigmatisation. Lutgendorf, Antoni, Ironson, Starr, Costello, Zuckerman, Klimas, Fletcher, Schneiderman, (1994:217-235). It is not surprising then that stigmatisation has been identified as one of the major stressors and obstacles in the lives of HIV-positive individuals and those close to them (Lindegger & Wood, 1994:14).

The infected individuals carry the burden of stigmatisation and suffer from isolation, abandonment, loss of social support and unemployment (Lippmann et al., 1993:24). The socio-economic consequences of the illness lead to further marginalisation, with devastating social and political consequences (Lindegger & Wood, 1994:12).

The fear of being stigmatised has been found to increase the individual’s sense of isolation and lack of control (Meredith et al., 1997, as cited in Coetzee, 2001:18). The withdrawal, silence and isolation caused by stigmatisation deprive the individual of opportunities for much needed support from families, friends and health staff, which complicates matters further. In a Tanzanian study of 611 HIV-positive individuals, Lie and Biswalo (1996: 285-296) identified that fear of rejection, shame and guilt prevented individuals from informing significant others of their status. Living with the fear of rejection is an ongoing psychological stressor and often leads to the adoption of avoidant coping strategies such as denial. The secrecy surrounding an HIV diagnosis reinforces the discourse of silence. Fear of discrimination not only prevents individuals from accessing potential support structures but also from seeking timeous help from health-care systems (Coetzee, 2001:18).

2.7.3 Depression

Living with an HIV diagnosis constitutes an ongoing strain which predisposes the individual to depression. Periods of increased vulnerability have been identified as
occurring shortly after diagnosis as well as during periods of increased physical symptoms (Thomson, Nani & Levene, 1996, as cited in Coetzee, 2001:19).

Most research shows that a decline in health often signals the onset of a myriad of psychosocial stressors, such as loss of employment. These stressors also have an adverse effect on the individual’s psychological wellbeing and mood. In a report on anxiety and depression among HIV-infected heterosexuals in India, Chandra, Ravi, Desia and Subbakrishna (1998:401-409) found the presence of AIDS in the spouse to be a factor associated with increased emotional distress, and furthermore identified pain, poor family relations and concurrent alcohol abuse as of equal significance. They found depression among 40% of individuals within four to six weeks after diagnosis.

As pointed out by Thompson et al. (1996:18), the levels of depression and anxiety among HIV-positive individuals often do not fall within the range of clinical diagnosis. Even though this indicates an ability to cope with the stress of infection, it has a notable impact on the QOL of the individual and should therefore be targeted as a significant point of intervention.

2.7.4 Socio-Economic and Socio-Cultural Factors

Within the multicultural South African population, where socio-demographic factors are deeply interwoven with a socio-political history characterised by complex and unequal power relations, it becomes a research priority. The local emerging pandemic profile not only reflects a strong association with poverty (Karim, 1998:15-25; Tallis, 1998:) but confirms the notion that those who are marginalised by social prejudice, discrimination, economic inequalities and political injustice are indeed most vulnerable to the disease (Crewe, 1992:25).

In their study of health-related QOL, Cunningham et al. (1998a, as cited by Coetzee, 2001:23) conclude that access to care predicted better physical and mental outcomes. Friedland et al. (1996:30) found higher income to be positively related to improve QOL in a sample of 120 HIV-positive adults. However, unemployment was high even amongst the healthy and well-educated respondents.

Reference to one gender also includes the other
2.7.5 Gender

Determinants such as socio-economic dependence, level of education, relationship status, role as family caregiver and culturally supported gender roles have been considered as gender-specific antecedents to QOL (Coetzee, 2001:24).

Sarna et al. (1999:139) conducted an exploratory descriptive study to describe QOL in a sample of 44 pregnant women with symptomatic HIV/AIDS. QOL was measured every two months over a four-month period. A significant improvement in QOL on the physical and psychological scales was found during this period. However, the most prevalent description in these women’s lives were in the psychological domain, with married women being more vulnerable to descriptions in QOL (QOL) over time. Sowell et al. (1997:25) found a similar correlation between marital status and QOL. The authors suggest that anxiety and distress could be subscribed to the additional demands of a marital relationship while having to cope with a debilitating illness.

Evidence suggests that gender, in conjunction with socio-demographic and other variables, play a significant role in the experienced QOL of HIV-positive individuals. A clearer understanding of how these factors impact on QOL and the needs and expectations of men and women would enable health-care workers to individualise support strategies aimed at enhancing QOL through the course of the disease. (Coetzee, 2001:27).

2.7.6 Disease Progression

A decrease in T4 cell and total lymphocyte count has been seen as significant predictors of disease progression and the development of AIDS. Several studies have investigated positive predictors of these immune measures as a way of exploring health-related QOL. In a sample of 11 asymptomatic homosexual males, high life-stressor impact and a passive coping style were positively related to deterioration in immune measures and consequently also reduction in QOL. Goodkin et al. (1992b:20; 1992a:26) confirm that an active coping style has a deterrent effect on the loss of natural killer cell functions and subsequently on disease progression.

Reference to one gender also includes the other
2.8 SUMMARY

In this chapter, an in-depth literature review regarding quality of life was conducted, specifically discussing the concept, its definition, its multidimensionality, factors influencing QOL and ethical considerations related to the individual affected by HIV/AIDS.
CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION
This chapter describes the research methodology that was followed to ensure that the goal and objectives set for the study were attained. Mark (1996:366) states that this part of the research should provide an answer to the question of how the population were defined and what sampling method was employed. Included in this chapter will be the research design implemented, the selection of the target population, sampling, data gathering, how the validity was ensured, conducting the pilot study and data analysis.

3.2 GOAL OF THE STUDY
The goal of this study was to investigate whether the quality of life of the employee affected by HIV/AIDS was adversely affected.

3.3 OBJECTIVES
The following objectives were set for this study:

- To determine the family history of the employee affected by HIV/AIDS
- To determine occupational history of the employee affected by HIV/AIDS
- To determine the symptoms of the employee affected by HIV/AIDS
- To determine the effectiveness of the anti-retroviral treatment programme of the employee affected by HIV/AIDS

3.4 RESEARCH QUESTION
The researcher posed the following research question as a point of departure for the purpose of this study: “Is the quality of life of an employee affected by HIV/AIDS adversely affected?”

Reference to one gender also includes the other
3.5 RESEARCH DESIGN

A descriptive qualitative research design using the case study method was applied with a qualitative approach to investigate whether the quality of life of the employee affected by HIV/AIDS was adversely affected.

According to Labuschagne (2003:1) qualitative research emphasises the properties, the state and the character of the phenomena. In qualitative research processes and meanings are rigorously examined, but not measured in terms of quantity, amount or frequency. It produces a wealth of data about a smaller number of people and cases. Qualitative data provide depth and detail through direct quotation and careful description of detail of situations, events, interactions and observed behaviours (Labuschagne, 2003:1).

3.6 POPULATION AND SAMPLING

In purposive sampling a particular case is chosen because it illustrates some feature or process that is of interest for a particular study but this does not simply imply to any case that has been chosen (Silverman, 2000:104).

Purposive sampling is based entirely on the judgement of the researcher, in that a sample is composed of elements that contain the most characteristic, representative of typical attributes of the population. Researchers using this strategy of interpretive enquiry will mainly utilise participant observations and long interviews (with up to ten people) as methods of data collection (De Vos, 2005:202, 270).

For the purpose of this study a purposeful sample was chosen as the total population of 14 employees affected by HIV/AIDS working at a food and beverage manufacturing company was included in this study. The researcher decided that the total population should be included in the study to enhance the depth and richness of the data obtained and to improve the validity of the study. However, only 10 interviews were successfully completed as four employees indicated that they were not willing to share their experiences. According to De Vos (2005:270), ten participants are adequate for a sample in qualitative research.

The following criteria were set:

Reference to one gender also includes the other
• A positive HIV/AIDS status
• The ability to participate, i.e. employees’ willingness to commit time to be interviewed and to share their experience with the researcher
• In the employment of the food manufacturing company

3.7 ETHICAL ASPECTS

The following can be regarded as some guidelines for social work research as suggested by the Code of Ethics of the National Association of Social Workers (Williams et al., as cited in De Vos, 2005:67).

• The possible consequences for research participants should be considered.
• It should be ascertained that the consent of participants is voluntary and informed, without any implied deprivation or penalty for refusal to participate, and with regard to participants’ privacy and dignity.
• Participants should be protected from unwarranted physical or mental discomfort, stress, harm, danger or deprivation.
• As far as the discussion of evaluation of services is concerned, it should only be done for professional purposes and only with people directly and professionally involved.
• All information received about participants should be treated confidentially.
• The researcher should take credit only for work actually done in direct connection with scholarly and research endeavours and should give credit to contributions made by others.

Ethical decision making requires that complex decisions be made. The curriculum of human sciences students, for example, should make provision for creating an opportunity for students to grapple with both ethical and legal dilemmas in a safe and supportive environment. In this manner a personal approach to ethical decision making is formed by every prospective human sciences worker (Zakutansky & Sirles, 1993:344).

Ethical issues come to the fore in human sciences research when conflict arises between the values of the community in matters such as freedom and privacy and scientific methods that are aimed at generating data of the highest quality (Singleton
et al., 1988:456). Cwikel and Cnaan (1991:115) state in this regard that an ethical dilemma arises if the researcher chooses one form of conduct and respects a certain moral principle but transgresses another. Dane (1990:58) states that the final responsibility rests with each individual researcher to eventually present a study that meets all ethical requirements.

Permission to conduct a research project of this nature was obtained from the Committee for Human Research of Stellenbosch University and the food and beverage company involved. Personal consent was further obtained from the employees who voluntarily participated in the research project. The purpose and aims of the study were conveyed to all those concerned in the process of acquiring permission to conduct the research project and when consent was obtained from the HIV/AIDS-affected employees.

Interviews were conducted personally by the researcher and in private. The HIV/AIDS-affected employee was assured of total anonymity and confidentiality. At the beginning of each interview, an explanation of the study was given and written informed consent to participate in the study was obtained. The consent was given in the language of choice, namely English, Sesotho or SiSwati (Appendix B). The participants were informed that they were not obliged to participate in the study, that they could stop the interview at any time or refuse to answer any questions. Furthermore, they were assured that whether or not they participate will have no bearing on the care that they receive. The participants were assured of anonymity and the fact that, although some of the information they provide would be published, their names would not be associated with the publication.

3.8 INSTRUMENTATION

An interview guide (Annexure A) was designed for use in a semi-structured interview.

According to Lofland and Lofland (1984) as described in Hoepfl (1997:6) an interview guide or “schedule” is a list of questions used by the interviewer to explore during each interview. According to Soy (1996:5) a guide is used to ensure uniformity and consistency in the data that is collected, which could include facts, opinions, and unexpected insights.
The researcher documented all data as the participant described their lived experiences. The outline of the interview guide (Annexure A) consisted of the following sections:

- Demographics
- Family history
- Occupational history
- Symptoms
- Anti-Retroviral Programme

3.9 DATA COLLECTION

In this study, an in-depth semi-structured interview was conducted with the participants to collect the required data about the lived experience of the participants affected by HIV/AIDS. Although the researcher planned to record the interview, the participants objected to the use of a tape recorder. The participants indicated that it was sufficient for the researcher to make notes. Furthermore, the interview guide was used as a guideline for the collection of the data as participants did not respond spontaneously to discussion. They constantly required the researcher to pose a question to illicit adequate reaction and response. The duration of each interview was about an hour.

3.10 VALIDITY TESTING OF THE RESEARCH

Validity of qualitative studies refers to the extent to which data provides insight, knowledge and understanding of the meaning, attributes and characteristics of people under study. Validity is concerned with confirming the truth of findings (Le Compte & Goetz in Brink 2000:124).

Trustworthiness as described by Lincoln and Guba (1985:290) was assured as follows:

3.10.1 Credibility

The raw data that was collected was cross checked by clinical experts in a similar clinical environment, a nurse expert and research methodologist. The researcher
also checked the data being collected back and forth with the participants to ensure that the information being collected was correct.

3.10.2 Transferability

As described in paragraph 1.7.6.2, the findings obtained in qualitative research are not always easy to transfer or generalise (De Vos, 2005:352) but it may be possible to generalise the findings obtained in this study or conduct this study under similar conditions at similar companies. As described by Eisner (1991:205) “…it is a retrospective generalization that can allow us to understand our past (and future) experiences in a new way”.

3.10.3 Dependability

The dependability of the study was supported by an “inquiry audit” during which a research methodologist especially focused in qualitative research examined the process and the consistency of the research together with a nurse expert and clinical nurse practitioner in the field.

3.10.4 Confirmability

The confirmability of the study was supported as described by Lincoln and Guba (1985: 320-321) by the following: the researcher maintained her neutrality by the provision of an audit trail of well documented notes of the raw data she collected, an analysis of the notes, the reconstruction and synthesis of the products, the process notes, all personal notes and the preliminary developmental information.

3.11 THE PILOT STUDY / PRE-TEST

According to de Vos (2005:331) in qualitative research it is critical to complete a pilot study to allow the researcher to focus on specific areas or to test specific questions which may have been ambiguous or unclear.

According to Singleton et al. (1988:290), the pretesting of a measuring instrument consists of “trying it out on a small number of persons having characteristics similar to those of the target group of respondents.” According to Monette et al. (1998:9), a pilot study can be regarded as a small-scale trial run of all aspects planned for use in
the main inquiry. Mitchell and Jolley (2001:13–14) add that a pilot study helps the researcher to fine tune the study for the main inquiry. Substantiated further Bless and Higson Smith (2000:155) provide what is perhaps the most encompassing definition of the pilot study: “A small study conducted prior to a larger piece of research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate”.

For the purpose of this study a pilot study was conducted. The researcher requested a colleague who works with the employees of a food manufacturing company to interview one of her clients on the quality of his life using the interview guide. The following results were obtained in this pre-test: Firstly, the participant did not accept the tape recorder. Secondly, the participant did not express himself well due to his custom of not making eye contact, and withheld a lot of information on feelings and experiences. The researcher then conducted an interview with one of her employees who did not form part of the study. Similar problems were experienced and the interview guide had to be redefined. After corrections were made, the researcher proceeded with the data collection.

3.12 LIMITATIONS OF THE STUDY

The research study has the following limitations:

- The total population of employees affected by HIV/AIDS were males of African descent only.
- Cultural aspects such as not making eye contact with the researcher were dominant.
- HIV/AIDS is not easily accepted as a chronic medical condition.
- The researcher could not obtain consent for the use of a tape recorder during the interviews.

3.13 ANALYSIS AND INTERPRETATION

According to Patton (2002:432) describes qualitative analysis of data as transforming data into findings. This process involves minimising the volume of raw data, sorting the good data from the more trivial data, identifying significant patterns and constructing a framework for communicating the findings.
The raw data obtained in this study were examined for completeness and accuracy. Data were categorised into common themes, ensuring consistency. As the categories of meaning emerged, the researcher searched for those with internal and external divergence, testing for emergent understanding and searching for meaning in the data.

3.14 SUMMARY

In this chapter, the research methodology was described, which included the research design implemented for the purpose of this study, ethical considerations, validity-testing strategies applied, data collection, and data analysis and interpretation.
CHAPTER 4
DATA ANALYSIS, INTERPRETATION AND DISCUSSION

4.1 INTRODUCTION

This chapter provides descriptive information about the study of experiences as described by employees affected by HIV/AIDS working at a Food and Beverage Company. The narrative will assist the researcher to understand the case study as a qualitative research method using thoughtful retrospection.

Analysis is a reasoning strategy with the objective of taking a complex whole and resolving it in parts. By means of analysis the constant variables of factors that are relevant to the understanding of the phenomenon or event are isolated (Mouton & Marais, 1990:102–103).

Tesch (1990:154–156) proposes the following eight steps for data analysis:

- The researcher ought to get a sense of the whole by reading through all of the transcriptions carefully. During this time ideas could be written down as they arise.
- The researcher selects one interview – for example the most interesting, the shortest, the one on top of the pile – and goes through it asking “What is this about?” and thinking about the underlying meaning in the information. The researcher writes thoughts that emerge in the margin.
- When the researcher has completed this task for several respondents, a list is made of all the topics. Similar topics are clustered together and formed into columns that might be arranged into major topics, unique topics and leftovers.
- The researcher takes the list and returns to the data. The topics are abbreviated as codes and the codes written next to the appropriate segments of the text. The researcher tries out this preliminary organising scheme to see whether new categories and codes emerge.
- The researcher finds the most descriptive wording for the topics and turns them into categories. He endeavours to reduce the total list of categories by grouping together topics that relate to each other. Lines are drawn between the categories to show inter-relationships.
• The researcher makes his final decision of the abbreviation for each category and alphabetises the codes.
• The data material belonging to each category is assembled in one place and a preliminary analysis is performed.
• The researcher recodes existing data if necessary.

The process of data analysis described above is supported by De Vos (2005:334), who maintains that the following steps are critical:

• Planning for recording of data
• Data collection and preliminary analysis
• Managing or organising the data
• Reading and writing memos
• Generating categories, themes and patterns
• Coding the data
• Testing the emergent understandings
• Searching for alternative explanations
• Representing and visualising, i.e. writing a report

4.2 RESULTS OF DATA ANALYSIS

The data of each participant were identified by the use of codes between 1 and 10. It should be noted that the participants did not spontaneously volunteer information about their experience as an employee affected by HIV/AIDS but only when they were prompted to answer a question. The data will therefore be discussed according to the semi-structured interview guide used during the interview and through the categorising process. The notes made on each question were studied; common themes and subthemes were identified according to the categories.

A. CATEGORY: DEMOGRAPHICAL DATA

The biographical data obtained indicated that all the participants are still economically active, their ages ranged between 34 and 52. All participants were male which was described as a limitation as the females objected to participate in the project. All the males were married and have children.

Reference to one gender also includes the other
Most of the participants (7) had no allergies, the remaining three had allergies for certain foodstuff but specific details could not be obtained about medications or injections. The participants were all able to communicate in English and do speak a second language either Sesotho (3) or Siswati (7).

The participants indicated that they are Christians and do attend a church

*Primary caregiver*

Asked about who their primary care giver is (3) indicated that their wives are the primary giver but (3) of the participants indicated that their doctor is the primary caregiver, while (4) indicated that both their wives and doctor are the primary caregiver. This is important to determine as the progression of the disease may warrant the caregiver to take a more prominent role in the care of the affected employee, this would preferable be the wife, who is probably available daily.

When asked about their secondary caregiver this varied between the mother, wife and doctor.

**B. CATEGORY: HISTORY**

*Theme B1: Diagnosis*

The employees were asked about when they were diagnosed as HIV positive. However (2) could not remember when this diagnosis was made. This could be attributed to a phase of denial. It is critical for the nurse to support the patient / client / employee when a diagnosis of HIV positive status is made. As described by Kubla Ross (1969) in Stellenberg & Bruce (2007:942) a patient may enter a phase of denial and may never reach the level of acceptance. The patient may also fluctuate between these phases of anger, denial, bargaining, depression, grief and acceptance. It is the duty of the nurse to support the patient through these phases as described by Kubler Ross to reach a level of acceptance.
Theme B2: What was your indication for getting tested?

Various reasons were given by the participants for getting tested ranging between voluntary testing (3), through awareness campaigns in the workplace (3) and physical problems (4). Table 4.1 shows the reasons given for getting tested for HIV.

Awareness talks about HIV and getting tested in the workplace should be an ongoing practice as employees do become aware about this problem and it appears that some of the workers associated their physical problems with the possible status of being HIV positive when they developed “unusual” physical problems.

Table 4.1: Indication for getting tested

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I got a sore on my penis”</td>
<td>1</td>
</tr>
<tr>
<td>Loss of strength “and my skin had an eruption that I did not understand nor did I like it”</td>
<td>1</td>
</tr>
<tr>
<td>“Rash on my arms and knees shaking. Sleepy all the time and body aching”</td>
<td>1</td>
</tr>
<tr>
<td>“I started with blood in my stools and anus, my anus was itchy and I had a sore throat. I consulted and doctor told me my whole system inside is full of sores”</td>
<td>1</td>
</tr>
<tr>
<td>“Nothing. Only to be aware so that I can get help”.</td>
<td>1</td>
</tr>
<tr>
<td>“They were talking about testing here at work so I go to test”</td>
<td>1</td>
</tr>
<tr>
<td>“We were encouraged by the clinic to know our status”</td>
<td>1</td>
</tr>
<tr>
<td>“Became very ill and had to be admitted to hospital, was coughing, losing weight and treated for TB and abscesses”</td>
<td>3</td>
</tr>
</tbody>
</table>

Theme B3: Have you disclosed your status to any other person besides the researcher and the doctor?

Table 4.1 shows that three of the participants have not disclosed their status to anyone. However, participants who have indicated that they have disclosed their status indicated fear of losing credibility among family, friends and colleagues. The role of the employer and clinic nurse is critical in this regard that the employee is protected against discrimination and the fear they may have of becoming socially isolated. “Because the people will not like me anymore. They will throw me out of work and tell me to move away from home”
Table 4.2: Disclosure

<table>
<thead>
<tr>
<th>Response</th>
<th>To whom</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Wife and a friend who is HIV positive</td>
<td>None</td>
</tr>
<tr>
<td>Yes</td>
<td>A friend who is also a colleague</td>
<td>“I am not prepared to tell anyone else as I am afraid that they will not understand. Although I use a condom with my wife”</td>
</tr>
<tr>
<td>Yes</td>
<td>Wife</td>
<td>“When I told my wife she asked me where I got it from. I told her I don’t know. I requested her to go for a test and she tested positive. I was concerned about dying at an early age … we accepted it although my wife was always the one going away and sleeping out”</td>
</tr>
<tr>
<td>No</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Wife</td>
<td>“So that the family must not be affected more. At work I want to keep it confidential so that no one can use the illness against me”</td>
</tr>
<tr>
<td>No</td>
<td>None</td>
<td>“Because the people will not like me anymore. They will throw me out of work and tell me to move away from home”</td>
</tr>
<tr>
<td>Yes</td>
<td>“Wife and a friend of mine from church who works with home-based care people”</td>
<td>“I give him a lot of booklets we get from clinic about the disease”</td>
</tr>
<tr>
<td>Yes</td>
<td>Wife</td>
<td>“For her to understand my condition”</td>
</tr>
<tr>
<td>Yes</td>
<td>Wife</td>
<td>“My wife was having a baby and she tested positive and I was asked to be tested.”</td>
</tr>
<tr>
<td>No</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

C. CATEGORY: FAMILY HISTORY

Theme C1: Have you always lived at the present address?

Table 4.3 shows that the majority, 8, of the participants are still living at their original homes. An important aspect to explore is to determine whether the employee still feels safe and secure in his home environment. As described above in Table 4.2 employees are fearful of being isolated. “Because the people will not like me anymore. They will throw me out of work and tell me to move away from home”

Table 4.3: Living at same address (N=10)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>8</td>
</tr>
<tr>
<td>No, have relocated due to work transfer</td>
<td>2</td>
</tr>
</tbody>
</table>

Reference to one gender also includes the other
Theme C2: What do your parents do for a living?

Table 4.4 shows that the majority of the participants are from a low socio-economic background. The majority, 9, of parents are labourers. Determining the socio-economic status of the employee and his family provides the employer/clinic nurse with the required information whether the employee is able to financially care for himself, his family and possibly his parents as well. With an underlying physical problem poverty may severely compromise the individual’s health. Money is required for visits to the doctor, clinic, purchasing fruit and vegetables and to provide for their families. The immune system of the employee is affected by HIV and with increase work pressure and poverty the health of the employee may be further compromised.

Proactive measures and support programmes could be introduced in the workplace to support these clients.

<table>
<thead>
<tr>
<th>“Parents are labourers”</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I grew up with my aunt and her husband because they could not have children of their own.”</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 4.4: Parents’ livelihood N=10)

Theme C3: Do you have brothers and sisters? Where do they live and do you see them often?

Table 4.5 shows that minimal support exists among the families of the participants. Eight of the participants have either a brother or sister or both; however, only one indicated that they are a big family who visit each other. To enjoy quality of life all basic needs should be met which includes family support especially for an employee who is affected by HIV. The employer/clinic nurse should become aware of these needs as additional support in the workplace and an understanding working environment may promote an improvement in health decreasing possible negative feelings which may impact on work attendance.
Table 4.5: Cross-tabulation between siblings and age (N=10)

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of siblings</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>5</td>
<td>No comment</td>
</tr>
<tr>
<td>39</td>
<td>3</td>
<td>“Live near home but we don’t see much of each other”</td>
</tr>
<tr>
<td>46</td>
<td>0</td>
<td>No comment</td>
</tr>
<tr>
<td>49</td>
<td>0</td>
<td>No comment</td>
</tr>
<tr>
<td>49</td>
<td>3</td>
<td>“Hardly hear from my brother but I get along with my sisters”</td>
</tr>
<tr>
<td>49</td>
<td>0</td>
<td>“I am the only child. I don’t know my stepsister but I know my stepbrother”</td>
</tr>
<tr>
<td>50</td>
<td>6</td>
<td>“All my brothers and sister are doing well except for my eldest sister who has cancer”</td>
</tr>
<tr>
<td>52</td>
<td>0</td>
<td>“We are one big family. All of us we visit around our homes”</td>
</tr>
<tr>
<td>53</td>
<td>3</td>
<td>“I last saw them a week ago”</td>
</tr>
<tr>
<td>53</td>
<td>6</td>
<td>“I am the firstborn. They are all living in their own dwellings”</td>
</tr>
</tbody>
</table>

**Theme C4: How many children / grandchildren do you have? Where do they live? Do you see/talk to them frequently?**

Table 4.6 shows that all participants have children. Nine have children 18 years old or younger and therefore have financial responsibilities towards their families. Minimal support is received from the children. Employers /clinic nurse should ensure that a thorough assessment is made of every employee and to be aware of these financial responsibilities. As the disease progresses employees may not meet all their work obligations and without the required support in the workplace employees may lose their much needed jobs. As indicated above in table 4.2 employees are fearful for others to know their status as they fear losing their jobs. “…They will throw me out of work and tell me to move away from home”

Table 4.6: Children

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of children ≤18yrs</th>
<th>Younger than 18 years</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>1 out of wedlock</td>
<td>“They are concerned about my ill health”</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>2</td>
<td>“I hardly see them, only when the one son needs money”</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>3</td>
<td>“All live with me plus my grandchild”</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>2 with first wife</td>
<td>No</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>------------------</td>
<td>----</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>3</td>
<td>“My daughters are big now and they live on their own and I think they don't like me anymore. Maybe they know I have the disease”</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>2</td>
<td>“My children have their own wives and I have four grandchildren. They like sweets and they always visit me”</td>
</tr>
<tr>
<td>9</td>
<td>0</td>
<td>3 with two other women</td>
<td>“I did not hear from the two when they moved with their mother to Johannesburg. One of my children is 23 years old and I must still pay maintenance of R300 as he is unemployed”</td>
</tr>
<tr>
<td>10</td>
<td>2</td>
<td>1</td>
<td>No</td>
</tr>
</tbody>
</table>

**Theme C5: Aspects related to health and Illness**

Table 4.7. shows that three of the participants do not have the strength to do any chores or gardening around the house. Three indicated that they are well and fit. Seven have indicated that they still have hope for the future. Employers could support the employee with the hope they have to still want to do as many things as possible. No discrimination should prevail in the workplace so that employees may still strive to be promoted in the work place. “Like to change my standard of work, upgrade myself”, “God to strengthen me so that I can continue to work and work and work, build a nice house for my family…” Table 4.7 shows that the participants still have the will to live and enjoy life; this is shown by the variety of activities undertaken by the participant. “Working in the garden, planting vegetables for use at home”; “Eating the right foods and road work” (jogging) but there are participants who have indicated that they have lost the will to live. The occupational nurse and employer’s role in this regard is emphasised to support the employee from diagnosis throughout the disease process and to adapt the work. “Too weak to work” Heavy work like lifting heavy stuff” “Continue to do a good job. I don’t want to be fired or changed. People talk at work and they tell my supervisor stories I do not know about”. These fears should be allayed.
<table>
<thead>
<tr>
<th>Code</th>
<th>Sub theme: Responsibilities before illness</th>
<th>Subtheme: Relaxation before illness</th>
<th>Subtheme: Limitations as a result of illness</th>
<th>Subtheme: Current greatest pleasure</th>
<th>Subtheme: Things you would like to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>“Well and fit”. Does everything around</td>
<td>Gospel music. Plays soccer. Plays with child</td>
<td>“Well and fit. I do everything”</td>
<td>“Eating the right foods and road work” (jogging)</td>
<td>“Like to change my standard of work, upgrade myself”</td>
</tr>
<tr>
<td>2</td>
<td>“Working in the garden, planting vegetables for use at home”</td>
<td>“Usually sit together and have a chat over weekends”</td>
<td>“Because I was worried a lot at first it caused me to lose strength and interest in everything”</td>
<td>“Family unity”</td>
<td>“God to strengthen me so that I can continue to work and work and work, build a nice house for my family”</td>
</tr>
<tr>
<td>3</td>
<td>“I used to do everything that needed to be done: cleaning of the house, garden work”</td>
<td>“Watch TV, soccer, any sport e.g. wrestling”</td>
<td>“When I was ill I could not jog; now I can and I even play soccer”</td>
<td>“Braaivleis with cool drinks, no alcohol”</td>
<td>No comment</td>
</tr>
<tr>
<td>4</td>
<td>“I extended my house. Now I do gardening”</td>
<td>“I am around the house chatting with family. I do have friends but I do not drink anymore”</td>
<td>“I cope well with my job at work and anything at home”</td>
<td>“I do not have any pleasure since I have been diagnosed. I accepted my condition”</td>
<td>“All is well at work and then I repair fridges at home as a hobby and income generating”</td>
</tr>
<tr>
<td>5</td>
<td>“Helping my wife in cooking, maintaining the garden etc.”</td>
<td>“I’m never sick”</td>
<td>“I still do everything”</td>
<td>“I live like Before, no changes in me”</td>
<td>“To work the normal work which I always do”</td>
</tr>
<tr>
<td>6</td>
<td>“Too tired to work at home”</td>
<td>“ Goes to church, dance and listen to jazz music”</td>
<td>“Prevents me from doing my job properly because I’m stressed”</td>
<td>Nothing</td>
<td>“Just to continue working”</td>
</tr>
<tr>
<td>7</td>
<td>“I’m like my parents: I love to work in the garden, plant vegetables in the field”</td>
<td>“Nothing. I do not have friends because of my work and gardening. Sometimes I sit with my parents”</td>
<td>“Nothing. I still do everything myself”</td>
<td>“What pleasure? I have a disease and I must look after myself”</td>
<td>“Continue to do a good job. I don’t want to be fired or changed. People talk at work and they tell my supervisor stories I do not know about”</td>
</tr>
<tr>
<td>8</td>
<td>“I’m not always sick. I can still do my duties around the</td>
<td>“Go to the mall and just walk around, take children to”</td>
<td>“Heavy work like lifting heavy stuff”</td>
<td>“Seeing all the love around my house and my family and”</td>
<td>“Continue to work until the day I retire. I want to join the”</td>
</tr>
</tbody>
</table>
D. CATEGORY: OCCUPATIONAL HISTORY

Theme D1: Education and training

Table 4.8 shows that the majority 7 of the participants are labourers and therefore are of a low socio-economic level. Socio-economic level comprises of income, occupation and educational level (Stellenberg, 2000:63).

<table>
<thead>
<tr>
<th>Code</th>
<th>Subtheme: Highest standard</th>
<th>Subtheme: Type of training</th>
<th>Subtheme: Where trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>High school 5</td>
<td>On the job, semi-skilled 3</td>
<td>Trained at work 10</td>
</tr>
<tr>
<td>2</td>
<td>Primary school 4</td>
<td>On-the-job training as labourer 7</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>No schooling 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Theme D2: Occupation, health status, leave and wife’s occupation

Table 4.9 shows that the majority (8) of participants were labourers before diagnosis and 7 are still labourers. The role of the employer is to ensure that support is given in the workplace for these employees as their jobs are in most cases physically demanding. With an underlying disease that will gradually decrease the physical strength of the employee adaptations to the workload is required for the employee who is affected with HIV/AIDS. Workers should feel secure and safe in the work environment and should not fear that they may lose their jobs as they grow weaker.
Table 4.9: Occupation

<table>
<thead>
<tr>
<th>Subtheme: First job</th>
<th>Subtheme: Type of work before illness</th>
<th>Subtheme: Last job before illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labourers 7</td>
<td>Labourers 8</td>
<td>Labourers 7</td>
</tr>
<tr>
<td>Semi-skilled 3</td>
<td>Semi-skilled 2</td>
<td>Semi-skilled 3</td>
</tr>
</tbody>
</table>

Table 4.10 shows that one of the participants has been “boarded”, one is sickly and eight are still healthy. The majority of their wives are working but are supportive towards them. This table also describes the fears the employees have of losing their jobs. “I want to stay at work so I keep healthy. I do not want to lose my job”. Refers to “friends who goes off sick and claim that they are bewitched”. As described above in theme D2 employers should be supportive of their employees.

Table 4.10: Health status, leave and wife’s occupation (N=10)

<table>
<thead>
<tr>
<th>Subtheme: Health status</th>
<th>Subtheme: Leave</th>
<th>Subtheme: Occupation of wife</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 states he’s been medically boarded</td>
<td>2 had more than 4 months sick leave</td>
<td>7 wives working</td>
</tr>
<tr>
<td>8 states they never ill and 1 reports to be sickly</td>
<td>3 spent their leave at home</td>
<td>3 are housewives</td>
</tr>
<tr>
<td>“I want to stay at work so I keep healthy. I do not want to lose my job” Refers to friends who goes off sick and claim that they are bewitched</td>
<td>2 states “no holiday leave taken because of work pressure”</td>
<td></td>
</tr>
</tbody>
</table>

Theme D3: Management support

Table 4.11 show that there are participants who fear disclosure and isolation, that this may lead to losing their jobs or general support from co-workers and management. All except one are pleased that the company is providing support regarding their treatment. Again the fear and possibly anger surfaces, it appears that the employees have this problem on their minds constantly “…Because they are not aware of my status I do not have a problem but I won’t tell anyone. If they ask I will get very angry” “…What will I do should I lose my job and need treatment?”

Reference to one gender also includes the other
Table 4.11: Management Support

<table>
<thead>
<tr>
<th>Code</th>
<th>Subtheme: Facilities at work with reference to treatment programme</th>
<th>Subtheme: Your feelings about the employer who pays for your treatment</th>
<th>Subtheme: Team Leaders’ support – should they know?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>“Presently my work surrounding is still safe”</td>
<td>“I thank the employer. If it was not for the employer I would not be able to afford”</td>
<td>“I do not think there is an environment for me to disclose my status as yet; I believe that could change”</td>
</tr>
<tr>
<td>2</td>
<td>“Have set times to go for treatment”</td>
<td>“I’m happy about it a lot. Personally I will not be able to afford the treatment”</td>
<td>“I have never had a problem. They were all supportive and hoping that I could become better and come back to work. I’m not aware of any gossip”</td>
</tr>
<tr>
<td>3</td>
<td>“I am not at work. I was disabled before I started on treatment”</td>
<td>“I believe its right. I am very happy about it. It prolongs one’s life. I would have been dead a long time ago”</td>
<td>“When I was at work management was very supportive”</td>
</tr>
<tr>
<td>4</td>
<td>“What will I do should I lose my job and need treatment?”</td>
<td>“I am happy that the company is paying”</td>
<td>“Because they are not aware of my status I do not have a problem but I won’t tell anyone. If they ask I will get very angry”</td>
</tr>
<tr>
<td>5</td>
<td>“Yes, I am happy and satisfied with the setup”</td>
<td>“I feel fine”</td>
<td>“No, because I did not discuss my status with them”</td>
</tr>
<tr>
<td>6</td>
<td>“I am very happy for the programme”</td>
<td>“I’m happy the company is paying”</td>
<td>“Nobody knows. I haven’t disclosed my status”</td>
</tr>
<tr>
<td>7</td>
<td>“I am on the wellness programme. I am still well even though I have the disease”</td>
<td>“I thank them. I think it is good”</td>
<td>“My supervisor is good to me. I think he likes me. I do my work and not worry anyone. I go for breakfast; I make sure I come back in time”</td>
</tr>
<tr>
<td>8</td>
<td>“Management came with a good plan to give us this treatment otherwise we would all die of this disease”</td>
<td>“I feel good. Management looks after me and all of us”</td>
<td>“Everybody gives good support but they always say that we must be careful of witchcraft”</td>
</tr>
<tr>
<td>9</td>
<td>No comment</td>
<td>No comment</td>
<td>No comment</td>
</tr>
<tr>
<td>10</td>
<td>“All is well. I am happy”</td>
<td>“I am happy the company is paying for my treatment”</td>
<td>“Because they are not aware of my status I do not have a problem”</td>
</tr>
</tbody>
</table>

Reference to one gender also includes the other
**Theme D4: Activities of daily living**

Table 4.12 shows that participants are content with their daily living. It appears that contentment except for one who indicated that he is now excited to get up and go jogging everyday. This participant has been medically boarded and therefore has time in the morning. The majority get up at 04:00 to go to work, which starts at 06:00. Two have expressed that they have to work hard to keep their jobs. One indicated that he does not know what the day holds and therefore has no plans, living for the moment. From these clauses it can be concluded that the support in the workplace is not as it should be. To the question if you had a choice how will you spend tomorrow one of the participants show the insecurity he has about tomorrow. “I don’t know what to say. I don’t know what is going to happen during the rest of the day”

<table>
<thead>
<tr>
<th>Code</th>
<th>Subtheme: How do you organise your day?</th>
<th>Subtheme: What is your daily schedule like now?</th>
<th>Subtheme: If you had a choice how would you spend tomorrow?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>“On and off. Awake at 04:20. Go to bed at about 10:00. Like to watch wrestling”</td>
<td>“Not changed”</td>
<td>“I don’t know what to say. I don’t know what is going to happen during the rest of the day”</td>
</tr>
<tr>
<td>2</td>
<td>“Get up 04:00. Take easy when getting up and then go to work”</td>
<td>“Same as above, nothing much”</td>
<td>“I will still choose to work as this helps to exercise my body”</td>
</tr>
<tr>
<td>3</td>
<td>“When I was ill I just watched TV, used the toilet and went to sleep. I used to sleep a lot. I walk for 10 minutes and then after that I feel weak and feel like sleeping”</td>
<td>“Now I am excited at 06:00, road work (jogging), garden work, meals and rest”</td>
<td>“I would like to go on vacation”</td>
</tr>
<tr>
<td>4</td>
<td>“During week goes to work. I do not like sitting in the lounge at work”</td>
<td>Nothing has changed</td>
<td>“Nothing much really. I’m quite happy with my life”</td>
</tr>
<tr>
<td>5</td>
<td>“As usual I talk to my two drivers, come to work and go to bed about 11 pm. It’s normal. I sleep well”</td>
<td>“Every morning to drink my tablets and eat well and fruits”</td>
<td>“Spend time with my family”</td>
</tr>
<tr>
<td>6</td>
<td>“Wake up and have breakfast and treatment and go to work”</td>
<td>Stressful day at work</td>
<td>Would like to relax with his family, not to have so much stress</td>
</tr>
<tr>
<td>7</td>
<td>“My days are always the same. I wake up at 04:00 and go to bed at 9 pm. I must work hard everyday to keep strong and healthy”</td>
<td>“It is the same, I don’t want it to change”</td>
<td>“The same like everyday”</td>
</tr>
<tr>
<td>8</td>
<td>“I get up at 04:00 to be on time at work. I work hard so during the</td>
<td>“The same. It was a lot slower when I was ill”</td>
<td>“I want to be old self again; strong, strong,</td>
</tr>
</tbody>
</table>

Reference to one gender also includes the other
Table 4.13 shows that all the participants have symptoms of opportunistic infections ranging from minor to more serious complaints, as described in Table 4.22. Symptoms of concern are that many are having trouble remembering and this could pose a problem in the workplace as it becomes a hazard for accidents. The majority are depressed, followed by feeling nervous and anxious and finding it difficult to sleep. Participants' expressed that they felt light headed and, five felt a loss of energy and tired. These clinical manifestations are an indication that the employees are in need of physical support in the workplace, social support and psychological support. If there is an imbalance in one of these dimensions the QOL of the individual is adversely affected.

Table 4.13: Symptoms

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue or loss of energy</td>
<td>5</td>
</tr>
<tr>
<td>Fevers, chills, sweats</td>
<td>5</td>
</tr>
<tr>
<td>Feel dizzy or light headed</td>
<td>5</td>
</tr>
<tr>
<td>Pain/numbness/tingling in hands/feet</td>
<td>4</td>
</tr>
<tr>
<td>Trouble remembering</td>
<td>5</td>
</tr>
<tr>
<td>Nausea and vomiting</td>
<td>3</td>
</tr>
<tr>
<td>Diarrhoea or loose stools</td>
<td>2</td>
</tr>
<tr>
<td>Feel sad, down, depressed</td>
<td>9</td>
</tr>
<tr>
<td>Feel nervous, anxious</td>
<td>6</td>
</tr>
<tr>
<td>Difficulty falling or staying asleep</td>
<td>6</td>
</tr>
<tr>
<td>Skin problems – rash, dryness, itching, shingles</td>
<td>3</td>
</tr>
<tr>
<td>Cough or trouble catching breath (breathless, short of breath)</td>
<td>4</td>
</tr>
<tr>
<td>Headaches</td>
<td>4</td>
</tr>
<tr>
<td>Loss of appetite or a change in taste of food</td>
<td>5</td>
</tr>
</tbody>
</table>
Bloating, pain or gas in stomach 6
Muscle aches or joint pains 4
Problem having sex, e.g. loss of interest, lack of satisfaction 3
Changes in the way body looks, e.g. fat deposit, weight gain 2
Problems with weight loss or gain 4
Hair loss or changes in the way hair looks 1
Other symptoms:
  Just feel sick 4
  Too slow and feel week 1

F. CATEGORY: ANTIRETROVIRAL PROGRAMME

Theme F1: How do you rate your life and overall QOL?

Table 4.14 shows how the participants rate their lives and whether they have quality of life. One gave no comment on both questions. The majority rated their lives as good or excellent. QOL could be rated subjectively as described by Grimes and Cole (1996:691) in paragraph 1.3. Satisfaction and pleasure in life can still be found even if daily functioning may be impaired. QOL therefore refers less to functional status and more to the subjective appraisal of wellbeing and level of satisfaction.

<table>
<thead>
<tr>
<th>Code</th>
<th>Subtheme: How do you rate your life?</th>
<th>Subtheme: Overall QOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No comment</td>
<td>No comment</td>
</tr>
<tr>
<td>2</td>
<td>Fair</td>
<td>Don’t know</td>
</tr>
<tr>
<td>3</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>4</td>
<td>Excellent</td>
<td></td>
</tr>
</tbody>
</table>

Theme F2: Treatment programmes

Table 4.14 shows that most of the participants are satisfied with their treatment partners. Many are on ARV treatment and two indicated that they are participating in a wellness programme. Two of the participants are visiting a prophet for treatment and two are on neither ARVs nor participating in a wellness programme.

Reference to one gender also includes the other
Table 4.15: Treatment programmes

<table>
<thead>
<tr>
<th>Subtheme: What can you tell me about the service from treatment partners?</th>
<th>Subtheme: What treatment programme are you on?</th>
<th>Subtheme: Do you visit the sangoma, prophet or herbalist?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No comment</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Not happy</td>
<td>Wellness</td>
<td>Prophet</td>
</tr>
<tr>
<td>Good</td>
<td>ARV</td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Theme F3: Company contributions**

Table 4.16 shows that, when asked what more the company can do to make their lives easier at work and at home, participants requested that the company continue to support the treatment programme. Participants also show fear that this support may be lost. One participant has indicated that he would appreciate a lighter job and one would just like to keep his job. Again the fear of losing their jobs was expressed “Keep my job” “It is not nice to be ill and out of work as you cannot fend for your family”. This is a psychological disturbance and if this persists the employee may be affected physically, socially and spiritually as supported by the literature in paragraph 1.1.

Table 4.16: Possible company contributions

- “Continue helping with the treatment”
- “Extend my house and have a proper home”
- “Take me back as a worker, even casual work”
- “No comment”
- “Give me lighter work”
- “Keep my job”

**Theme F4: Anti-Retroviral Treatment Programme**

The anti-retroviral programme is having a positive effect on the employees who is receiving treatment as expressed by two employees respectively. “I am well, I am excited, life is good and it is good to be alive” “I feel well as long as I get treatment” Table 4.17 shows comments about the treatment being received.

Reference to one gender also includes the other
Table 4.17: Comments

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>“It is not nice to be ill and out of work as you cannot fend for your family”</td>
</tr>
<tr>
<td>“I am well, I am excited, life is good and it is good to be alive”</td>
</tr>
<tr>
<td>“My circumstances cause me to be depressed. I would like to see a therapist to help to get a win-win situation”</td>
</tr>
<tr>
<td>“I feel well as long as I get treatment”</td>
</tr>
</tbody>
</table>

4.3 DISCUSSION

In this chapter, the study data were analysed and interpreted. The process of data analysis described by De Vos (2005:334) and set out in Section 4.1 was followed.

4.3.1 Goal

The goal set for this study was to investigate whether the quality of life of the employee affected by HIV/AIDS is adversely affected. This goal is successfully investigated as the various categories and themes have identified that the need in the various dimensions are not always met. QOL is adversely affected if there is an imbalance in these needs namely physical, psychological, spiritual and social.

4.3.2 Objectives

The objectives set for the purpose of this study were met, namely:

- To determine the family history of the employee affected by HIV/AIDS
- To determine occupational history of the employee affected by HIV/AIDS
- To determine the symptoms of the employee affected by HIV/AIDS
- To determine the effectiveness of the anti-retroviral treatment programme of the employee affected by HIV/AIDS

4.5 SUMMARY

In this chapter, the management, analysis and interpretation of data were discussed. The goal and objectives set for this study were investigated successfully and findings have been discussed and tabled.
CHAPTER 5
RECOMMENDATIONS

5.1 INTRODUCTION

Quality of life is defined as the “physical, emotional, intellectual or cultural satisfaction in a person’s everyday life. (Bergner, 1989:27).” This concept as used in health-care delivery defines the standard by which outcomes for the total patient can be assessed (Bergner, 1989:27).

5.2 BASIC NEEDS OF THE EMPLOYEE AFFECTED BY HIV/AIDS

The basic needs of the employee affected by HIV/AIDS are not met adequately. Research shows that job-loss is highly stressful and can be characterised as a form of bereavement. Stress is known to affect physical health further down the line as a result of chronically increased levels of anxiety (Stellenberg, 2000:66).

Therefore the following is recommended:

5.2.1 Public–Private Partnerships

Public–private partnerships need to be strengthened to address the problem of lack of continuation of treatment and support should an employee become unemployed. The affected individual’s fear will decrease if he knows what tomorrow will bring – not only regarding his illness but also regarding the continuation of support for treatment. Individuals should be given the reassurance as continuous high levels of stress have a detrimental effect on the body.

5.2.2 In-service training and continuous refresher courses

Fear, intimidation and isolation are some of the most important problems of the individual affected by HIV/AIDS. As one of the participants put it, “So that the family must not be affected more. At work I want to keep it confidential so that no one can use the illness against me” A second participant described disclosure as “I am not prepared to tell anyone else as I am afraid that they will not understand (Table 4.2.).

Reference to one gender also includes the other
Researchers believe that men fear VCT (Voluntary Counselling and Testing) and that a positive status will be disclosed through testing. Consequently stigmatisation will follow. “Surveys have also suggested that some men see no value in knowing their HIV status, viewing such knowledge as a burden” (Pembrey, 2007:5). The participants' reasons for getting tested for HIV are presented in Table 4.1. Three of the participants had tested voluntarily while the majority were tested after they presented with symptoms of ill health.

The researcher recommends that the employer should create an environment where the employee could feel safe enough to disclose his status to his immediate supervisor and any colleague close to him. “Let us give publicity to HIV/AIDS and not hide it, because [that is] the only way to make it appear like a normal illness” (Mandela’s eldest son dies of AIDS, 2005).

Table 4.1 shows that three of the participants had not disclosed their status to anyone. However, participants who have indicated that they have disclosed their status also indicated fear of losing credibility among family, friends and colleagues. Continuous education and refresher courses should be introduced to educate all employees, supervisors and management about the disease and factors promoting quality of life for individuals affected by HIV/AIDS.

Table 4.12 shows that three participants do not have the strength to do any chores or gardening around the house; however, seven have indicated that they still have hope for the future. Employee assistance programmes (EAPs) should support this hope.

5.2.3 Employee assistance programmes

When the data is cross-referenced, it is evident that the employees affected by HIV/AIDS are still in various stages of the grieving process as described by Küblia Ross i.e. denial, anger, bargaining, depression, and acceptance (Brysiewicz in Stellenberg and Bruce, 2007:942; Kozier et al., 2004:1035).

Despite the wellness programme offered by the company, the affected employees were not taking the programme seriously as signs of denial surfaced when asked when they were diagnosed with HIV. Table 4.2 shows that two of the participants did not remember when this diagnosis was made. This could be attributed to a phase of
denial. One of the participants indicated that he is never sick. “Because they are not aware of my status I do not have a problem, but I won’t tell anyone. If they ask I will get very angry.” This statement shows the underlying anger in this individual.

Participants are also paranoid about their condition as they fear isolation, discrimination and witchcraft. “I want to stay at work so I keep healthy. I do not want to lose my job. I refer to friends who go off sick and claim that they are bewitched” (Table 4.2.). “My daughters are big now and they live on their own. I think they don’t like me anymore. Maybe they know I have the disease” (Table 4.6).

Although one of the participants indicated that he has accepted his condition, he also refused to disclose his status for fear of what will happen to him. The introduction of employee assistance programmes should be mandatory for the specific support of employees affected by HIV/AIDS. This will provide psycho-social services according to the need of infected individuals. It should also be mandatory that all affected individuals should be referred to a psychologist, as support should be provided with the grieving process.

5.2.4 Involving the church community

Despite the fact that all participants indicated that they attend a church, they did not indicate whether the church community was providing adequate support. One of the individuals indicated that he provides the church with booklets and pamphlets on HIV/AIDS (Table 4.11). The researcher recommends that the Church should be more open on issues of HIV/AIDS and support educational programmes.

5.2.5 Support Circle

Support for employees affected by HIV/AIDS is limited. They need to be equipped with skills to enlarge their support circle to include a friend, a neighbour, a friend at church, or even a member of a home-based care organisation. Table 4.5. shows that there is minimal support among the families of participants. Eight of the participants have one or more siblings; however, only one indicated that they are a big family who visit each other.
5.2.6 Holistic approach in nursing care

A holistic approach is required when managing the employee affected by HIV/AIDS namely physically, socially, psychologically and spiritually. It must be noted that an employee is not only a member of the workforce but belongs to a family, community and society at large. The nursing curriculum should emphasise the holistic management of the employee affected with HIV/AIDS.

5.3 FURTHER RESEARCH

The researcher recommends that further research in QOL of employees is conducted in occupational health nursing, both with a quantitative and qualitative approach. The predominant aim of doing research on QOL is to contribute to quality assurance in the public/private health system and improving medical services for patients, with special consideration of their interests and subjective experience. “It can be said that ensuring optimal QOL in people living with HIV and AIDS is a key objective that requires careful consideration and focused research. It would further facilitate the identification of individual needs and concerns and directly inform much needed care plans/programmes” (Coetzee, 2001:40).

5.4 SUMMARY

This chapter dealt with recommendations based on the findings of the study. As indicated the basic needs of the employee affected by HIV/AIDS are not met adequately.
CHAPTER 6
CONCLUSION

In this study, the meaning of the lived experience of employees affected by HIV/AIDS was uncovered through the use of the descriptive qualitative approach applying the case study method. The occupational health nurse should take the lead in caring for a person with HIV/AIDS as a member of a community. (Van Rensburg in Stellenberg & Bruce, 2007:1022).

The value of this study lies in the fact that it gives an understanding of how the participants perceive and experience QOL. The findings play a role in understanding the importance of remaining at work for as long as possible when one is affected by HIV/AIDS and that the ARV Programme is beneficial to the employees. The findings of this study further validate the concepts in basic needs and that QOL is perceived differently by each individual.
REFERENCES


Byrnes, D., Antoni, M., Goodkin, K., Ironson, G., Asthana, D., Efantis-Potter, J.,


Reference to one gender also includes the other


Compensation of Occupational Injuries and Diseases Act 130 of 1993. Section 22(1) Cape Town, Government Printers


Reference to one gender also includes the other


Labour Relations Act 66 of 1995. Sections 187(1) (f) and 188(a) (1). Cape Town, Government Printers


Reference to one gender also includes the other


Reference to one gender also includes the other


Tesch, R. (1990) Qualitative research: analysis types and software tools. Bristol, Farmer.


*Reference to one gender also includes the other*


## Annexure A: Interview guide for use in a semi-structured interview with employees who are affected by HIV/AIDS

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home language</td>
<td></td>
</tr>
<tr>
<td>Primary Caregiver</td>
<td></td>
</tr>
</tbody>
</table>

| Secondary Caregiver | |
| When were you diagnosed HIV positive | |
| History: what was happening to you at the time of the test | |
| Have you disclosed your status to any one? | |
| Yes, to whom? | |
| No, why not? | |
| Medications | |

### FAMILY HISTORY

1. Have you always lived at the present address? If no, where did you live before you moved here?  
2. What did your parents do for a living?  
3. Do you have brothers and sisters? Where do they live? Do you see/talk to them often?  
4. I understand that you have children/grandchildren. Where do they live? Are they married? Do you see/talk to them frequently?  
5. Before you got sick, what were your duties/responsibilities around the house?  
6. Before you got sick, what did you do for fun or relaxation with your spouse, children, grandchildren, and friends?  
7. What are the most important things that your illness has prevented you from doing?

Reference to one gender also includes the other
8. At the present time what brings you the greatest pleasure?

9. What are the things you would most like to do now?
   - Work
   - Self-care
   - Leisure

**OCCUPATIONAL HISTORY**

1. What is the highest standard you passed?

2. What work were you doing before you got ill?
   How did you get started/interested in that line of work?

3. What sort of training/education was involved?

4. Where did you get your training?

5. What was the first job you had? What jobs did you have after that?

6. What was the last job you had before you became ill? What did your job actually entail?

7. Did you work up until you got sick?

8. How long have you been medically boarded?

9. Tell me about your leave?
   Do you have any leave or sick leave left?
   When were you last on annual leave? Where did you spend your leave?

10. Do the facilities here at work satisfy your need now that you are on this type of treatment? Where/what do you think needs attention? Tell me more about it.

11. How do you feel about the employer having taken responsibility to pay for your treatment?

*Reference to one gender also includes the other*
12. Can you talk about your manager/supervisor/team behaviour towards you since you started getting ill? What do you think we should do to get more support from them?

13. How long have you been medically boarded?

14. Were you still active in these activities until you became ill?

15. Since you became ill, what jobs have been the most difficult to give up?

16. What bothers you the most about the jobs you have had to give up?

17. What type of work is/was your spouse involved in?

18. How did you organize your day? Start from the time you got up each morning and tell me everything you did before you went to bed.

19. What is your daily schedule like now?

20. If you had your choice, how would you like to spend tomorrow?

## Symptoms

- Fatigue or loss of energy
- Fevers, chills, sweats
- Feels dizzy or light headed
- Pain/numbness/tingling in hands/feet
- Trouble remembering
- Nausea and vomiting
- Diarrhoea or loose stools
- Feel sad, down, depressed
- Feel nervous, anxious
- Difficulty falling or staying asleep
- Skin problems – rash, dryness, itching, shingles
- Cough or trouble catching breathe [breathless – short of breathe]
- Headaches
- Loss of appetite or a change in taste of food
- Bloating, pain or gas in stomach
- Muscle aches or joint pains

*Reference to one gender also includes the other*
Problem having sex e.g. loss of interest, lack of satisfaction
Changes in the way your body looks e.g. fat deposits, weight gain
Problems with weight loss or gain
Hair loss or changes in the way your hair looks
Other symptoms

22. In general would you say your life is: excellent, very good, good, fair, poor.
23. What can you tell me about the service you receive from our treatment partners?
24. What treatment are you on presently?
25. Why did you opt out of the Wellness/ARV Programme
26. Do you visit an herbalist, sangoma, prophets?
27. If yes, why?
28. What are your wishes for the future?
29. What more can the company do to make your life easier here at work and at home?
30. What can you say about the overall quality of your life at this stage?
Annexure B: Concept information and consent document

TITLE OF RESEARCH PROJECT / STUDY.

Investigation into the Quality of Life of an Employee affected by HIV/AIDS.
Reference Number: ………………………………………………….

Declaration of the participant:
I, the undersigned,……………………………………………………………………..
(Participant)
ID………………………………………………………………..

A. I confirm that:
I, the participant have been invited to participate in the above research project/study undertaken by the Department of Nursing, University of Stellenbosch.

It was explained that:

2.1 An investigation is being undertaken into the Quality of life of an HIV/AIDS affected employee in a Food and Beverage Manufacturing Industry. The purpose of this study is to gain knowledge about the Quality of Life of these employees. This will enable management to implement appropriate intervention strategies aimed at enhancing HIV/AIDS related QOL.

2.2 My participation includes the following:

2.2.1 An interview only will be conducted with me during which, personal questions will be asked and a tape recorder will be used to capture all the information which will be transcribed verbatim. No blood or further intervention of such nature will be carried out. Tapes will not be shared by anybody other than the supervisor of the study and possibly a translator. The researcher will destroy the tapes on completion of the research. Anonymity will be maintained throughout the research.

2.2.2. My participation will not have negative implications for me.

Reference to one gender also includes the other
1. I have been informed that although the results of this study are to be published I will remain anonymous.

2. All information obtained from me will remain confidential, but will however, be used in a thesis for a masters degree and in professional scientific journals.

3. I have been informed that I may withdraw from the study at any time if I so wish to.

4. My participation in the study is not linked to any form of financial gain. However, it will contribute to the better care of other affected employees.

5. An English/Swathi/Sotho explanation of the above information was given to me by the researcher. I was given the opportunity to ask questions and all my questions were answered satisfactorily.

6. I understand that this study will have no financial implications for me.

B. I hereby agree voluntarily to participate in the above project/study.

Signed/Confirmed at .................................................................
on.....................................2005

.................................................................

Participant’s Signature
Statement by Researcher

I, ..........................................................................................declare that I:

1. Explained the information contained in this document to

Mr/Ms. ................................................................. (participator)

2. Requested him/her to ask questions if uncertainty did exist about any aspect of this document.

3. That this discussion took place in English / Swathi / Sotho

4. Dr / Mr / Ms .................................................................

Signed at ..............................................................on..........................2005

.................................................................

Researcher.

Reference to one gender also includes the other
Sihloko setifundvo luhlolo

Luhlolo kwetesimo sempilokumsebenti lotsintsekile ngengculazi enkampanini yetekwenta kudla

Reference Number

Sifungo semngeleli waleleihlolo

Mina, ...................................................................................................................................................
(Longenele)

Umatisi................................................................................................................................................

A. Ngiyavuma kwekutsi:

1. Mina ngienyiwe kungenela letifundvo luhlolo lwabemyango lebahlengikati enyuvesi yase Stellenbosch

2.1 Kucacisiwe kwekutsi:

2.2 Kwentiwa kweluhlolo kutesimo sempilo kumsebenti ekampanini yetekwenta kudla lotsitsekilo ngengculazi. Injong yaletifundvo kuthola lwati ngetesimo sempiol salaba basebnti. Lokhu kuyoyenta bapatsi enkampanini bakhone kuvela netibonellelo noma tinsita tekucacisa ngengulazi mayelana nesimo setempilo.

Kungenelela kwamikufaka naku lokulanzelako:


2.2.2. Kutibandakanya kwami angeke kwaba nemiphumelo lemibi kimi.
1. Ngatisiwe kutsi nanoma miphimelo yaloluhlolo itobhalwa ngayo, angeke kwavetwa kwekutsi ngingubani.

2. Lonke lwati lelitfolwe kimi lutoba yimfihlakalo kodwa litawusethentiswa kutifundvo nasetincwadzini tescience.

3. Ngatisiwe kwekutsi ngisamisa kungenelela leliphenyyo uma kusifiso sami.


B. Ngiyavuma ngokutinikelela kutibandakanya kulolumhlolo.

Signed/Confirmed at .................................................................
on.................................2005
Lokuphuma kumseshi

Mine,................................................................................nqiyaqiniseka kwekutsi mine:

1. Nqimuchazele ku Mnu/Nks.................................................................(Lonqenele luhlolo)

2. Nqimucelile kwekutsi akululeke abute lapho anagvisisi khono kulokuckutfwe nqulombhalo.

3. Lokubonisana nekukhulimasa kweniwe nqe Swathi

4. Dkt/Mnu/Nks........................................................................................

Isayinwe e ..........................................................ngamhla..........................2005

…………………………………………………………

Meshi

Isayinwe yaqinesekwa e.................................................................
nqamhla..........................2005

Lotibandzakanyayo

Reference to one gender also includes the other
CONCEPT INFORMATION AND CONSENT DOCUMENT

Nyakišišo ka tša bophelo bja mošomi yo a amago ke HIV/AIDS mo industereng yo go dirwa dijo

Reference Number.................................................................

Maekamo a mo tšea karolo

Nna..............................................................................................

......

ID.

A. Ke kgonthišiša gore:

1. Nna ke memilwe go tšea karalo mo projekeng ya Department of Nursing University of Stellenbosch

2. Ke ilwe ka tlhalošetswa gore:

2.1 Dinyakišišo di ilwe tša dirwa go ya ka maphelo a batho bao ba amegago mo ditabeng tša HIV/AIDS mo dikhampaning tšeo di dirago dijo. Maekemišetšo a di thuto tše ke go hwetša tsebo ka maphelo a batho ba. Tsebo ye e tla thuša dimenegere gore ba kgone go tla le leano le le kaone la go lwantsha leoba le la HIV/AIDS.

2.2. Go tšea karolo gaka go akaretša dilo tše dilatelago:

2.2.1. Ke tla botšišwa diputšišo e bile batla šomiša segatišo lentšu (tape recorder) Gore ba kgone go hwetša ditaba ka go fela. Ditiko tša maddii ka se dirwe. Ditaba tše di gatišitšwego di ka se fewe motho mang kapa mang. Moithuti o tla phumula ditaba tše di gatišitšwego ge a feditše ka dithuto tša gagwe

2.2.2.

1. Ke bile ka tsebišwa gore dipoelo tsa dithutho tše ditla gatišwa dipampiring ebile leina laka le ka se tsebje.

Reference to one gender also includes the other
2. Ditaba ka go fela digatišitšwego di kasa phatlalatšwe, empa ditla šomišwa mo dithutong tše phagamego.

3. Ke tsebišitšwe gore nka tlogela go ba karolo ya dithuto tše ge ke nyaka nako efe kapa efe.

4. Go tšea karolo gaka ga go na mopotso. Eka ba tselete go ba eng. Se selego bohlokwa ke gore e tlathuša batho bangwe bao barago le mathatha a bolwetši bjo.


6. Ke a kwišiša ka botlalo gore dithutho tše dirwago a dina maputso wago swana le tšhelete.

B. Ke a ekana go ya ka thato yaka go tšea karolo projekeng e.

Kgonthisiša mo

……………………………………………………………………………………………………..ka di …………………2005

……………………………………………………………………………………………………..

Motšea karolo o sayina mo
Statement by Researcher

Nna……………………………………………………………………………………..ke a ikana gore ke

1. Tlhalošetlitšè mo tšea karolo ka botlalo ka ditaba tše dingwadilasego mo pampering ye.

Mr/Ms…………………………………………………………………………………….. (motšea karolo)

2. Ke mo kgoptšè gore a botšišo dipotšišo mo sa kwišišego gona.

3. Gone poledišano ya rena e bile ka sesotho

4. Dr / Mr / Ms ……………………………………………………………………………………………

Sayino mo…………………………………………………………………………………………2005

………………………………………………………………………………

Researcher.

Moithuti sayina mo……………………………………………………………………………………………………ka di………………………………2005

………………………………………………………………………………

Motšea karolo o sayina mo.

Reference to one gender also includes the other