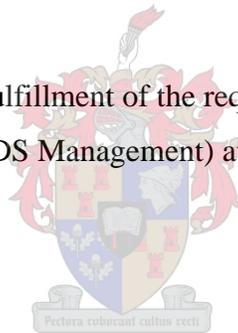


# **The Impact of HIV/Aids on Work Motivation in a Work Setting**

**Kefilwe Mmule Mokgoko**

Assignment presented in partial fulfillment of the requirements for the degree of Master  
of Philosophy (HIV/AIDS Management) at Stellenbosch University



Study leader: Prof JCD Augustyn

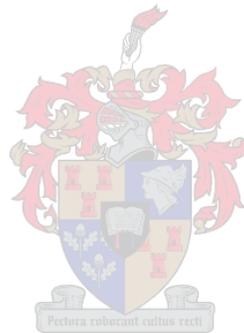
April 2006

***Declaration***

I, the undersigned, hereby duly declare that the work contained in this research document is my own work, and that I have not previously, in its entirety or in part submitted to another institution of higher learning for any form of educational qualification.

Signature:

Date:



## Summary

HIV/Aids are no longer just medical issues, they are psychological as well. This study aimed at exploring the impact that HIV/Aids has on employee work motivation. A survey design was used to find out what employees motivation levels were due to being diagnosed with HIV/Aids.

Individually administrated questionnaires through face to face interviews were used as a method of data collection. Fourty five employees living HIV/Aids were approached individually to participate. These respondents were identified from the database of the organisations Wellness programme.

The impact of HIV/Aids on workplaces with reference to the mining industry statistical background, understanding of work motivation and theories from various schools of thoughts, as well as the psychosocial impact of HIV/Aids are explored.

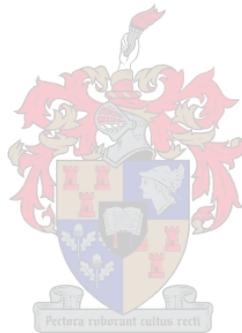
The research findings are presented graphically and discussed. It was found that HIV/Aids had a recognizable impact on employees living with HIV/Aids. Although the impact on actual production could not be measured in this study it is accepted that there is an impact. Generally, more efforts should be made to improve education levels of supervisors, managers, teams and general workplaces on disclosure, discrimination and stigma due to HIV/Aids. These result in great losses due to presenteeism (present but unfocused and unproductive).

The conclusion and recommendations derived from the study are provided lastly.

## Opsomming

Die impak van MIV/Vigs op die mynbousektor word in hierdie studie ondersoek. Die studie bevind dat MIV/Vigs 'n beduidende impak het op diegene wat MIV positief is. Die studie kon nie daarin slaag om die finasiele impak van die pandemie op die betrokke onderneming akkuraat te bepaal nie. Alle aanduiding is egter dat hierdie impak wel beduidend is.

Voorstelle word gemaak om die negatiewe effek van die pandemie op onderneming (byvoorbeeld werksafwesigheid ) aan te spreek.



## *Acknowledgements*

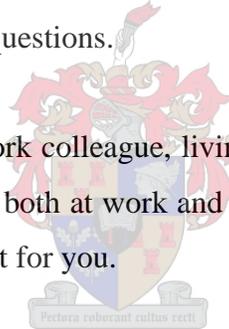
I am extremely grateful and thankful to a number of people who assisted me to ensure that this research study was completed:

To Phalakatshela my partner and friend for his moral support and love. Thank you for the encouragement and reminders on the importance of this research, even when times were tough. I love you very much.

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An extra special thank you to a work colleague, living with HIV – whom through going through challenges and difficulties both at work and at home as a result of his diagnosis, inspired this research. Much respect for you.



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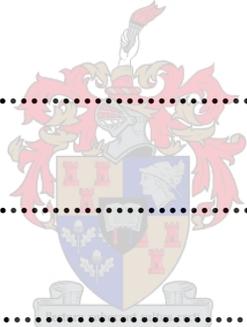
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## 1 INTRODUCTION

*“In Sub-Saharan Africa...HIV/Aids is considered as a state of emergency, which threatens development, social cohesion, political stability, food security, life expectancy and imposes a devastating economic burden.” (UN General Assembly Special Session on HIVAIDS, 2001)*

### **HIV/AIDS IN SOUTH AFRICA**

South Africa is said to have the highest number of people living with HIV, globally. Out of an estimated population of 40 million, 4.2 million are said to be living with HIV/Aids. This country (South Africa) is currently experiencing one of the most rapidly progressing HIV epidemics in the world. HIV prevalence among prenatal clinic attendees was reported to have increased twenty-fold over the past eight years to over 16 per cent in 1997. By the end of that year, it was estimated that 3 million people, over half of them women, were infected with HIV.

South Africa is a relatively prosperous country, with vast resources, modern and well-functioning physical infrastructure and a wealth of institutions. It is also a country of widespread and persistent poverty and deep inequalities – this is largely attributed to the legacy of legitimised racial discrimination that deprived the vast majority of communities’ access to basic life services and opportunities. Today, less than fifteen years after our historic transition to a fully representative democracy, that legacy remains deep and far-reaching.

In 1998, a Human Development Report (an annual report drafted by the United Nations Development Programme indicating where a country is development-wise, economically and socially) stated that South Africa enjoys one of the highest human development ratings among sub-Saharan African countries – at that point surpassed only, within the SADC region, by the Seychelles and Mauritius. In terms of economic performance measured through per capita income South Africa occupied the 80th position. However, when measured in terms of the Human Development Index (a combination of *per capita*

income, life expectancy and educational attainment) it fell nine places. By implication South Africa has been far less successful in translating economic performance into effective improvements in human development for almost its entire people across all income groups.

In recent years HIV/Aids has become a major contributor to these development challenges faced by this country. From the health perspective it is a serious concern because there is as yet no vaccine, no cure, and no directly accessible and affordable treatment for all who require it. HIV and subsequently AIDS tend to become almost fatal fairly due to a long incubation period between infection and illness.

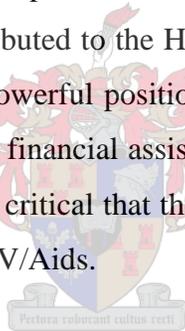
The determinants of the epidemic cannot be explained only in terms of individual risk taking behaviour. The causal factors are rather to be found in the poverty and deprivation experienced by most South Africans and in the social, economic and political alienation suffered by most of the population. These are a direct reflection of the social, political and economic history of the country. The spread of HIV and AIDS in South Africa is said to have been fuelled by among others the apartheid legacy of the migrant labour system, accompanying the spread of sexually transmitted diseases and the subordinate status of women in this country and the African continent in general. A survey published in March 2004 found that South Africans spend more time in funerals than they do having their hair cut, shopping or having a bar-b-q. It found that over twice as many people had been to a funeral in the past month as had been to a wedding. It is estimated that about 600 people in this country die of HIV-related illnesses each day.

Despite the high and rapidly rising prevalence of HIV in South Africa, very few people are 'open' about their HIV status. People who realise that they are infected with HIV are reluctant to seek support at any level; those who think they do not have HIV are reluctant to believe that AIDS is 'real' because of the invisibility of the epidemic. Projections of the path of the epidemic suggest that the overall prevalence of HIV will reach almost 25 per cent in the general population by the year 2010. By that year, life expectancy is projected to fall from the 68.2 years anticipated in the absence of the AIDS epidemic to

48.0 years. This has devastating implications both for the social structure of households and for their quality of life.

Human rights violations have contributed to the fear that surrounds HIV infection. For many, 'confidentiality' is a mechanism for self-protection. Unfair discrimination by employers, colleagues and communities has put so high a price on disclosure that most people are afraid to inform even their families or friends about their infection. Yet, examples from other parts of the continent demonstrate that the involvement of persons living with HIV/Aids is one of the most effective ways of combating the spread of the epidemic. Knowledge of your own HIV status is vital to the care and treatment and safety of others around us.

In recent years, the South African private sector has become more committed to humanitarian support, and has contributed to the HIV field substantially. In fact, it is the business sector that is in the most powerful position to effectively mobilise resources to respond to the epidemic. Apart from financial assistance, companies bring infrastructure, expertise, skills and experience. It is critical that these skills, resources, and expertise are harnessed to reduce the impact of HIV/Aids.



The high prevalence of HIV/Aids in South Africa poses major challenges for both government and the private sector and other civil society groups, who continue to do their utmost to curb the spread of the disease and help those affected by it. In the Limpopo Province, where De Beers Venetia Mine is situated, the HIV infection rate amongst women attending antenatal clinics in 2004 was 19.3%. Although this is considered the third lowest infection rate among the South African provinces, the rate has increased more than 30-fold since 1990, and continues to climb.

## **2 THE WORKPLACE CHALLENGE**

HIV/Aids are not merely growing health problems; they are a social and labour issue, which impacts on workers, enterprises/businesses and national economies. It is, without a

doubt, a workplace issue and a development challenge as much as it is a biomedical issue. Our weak economic base, high unemployment, poverty levels and the negative consequences of structural adjustments continue to aggravate this impact. Moreover, persons of working age comprise the majority of those infected with the virus. The detrimental effects of this will be manifested in areas such as: the supply of labour, the quality of human capital due to the loss of experienced workers, the greater social security demands placed on governments as well as poverty on households.

The HIV/Aids epidemic impacts on all spheres of life, and one of its most significant features is its concentration in the working age population (aged 18-49) to the extent that those with social and economic roles are greatly affected. HIV/Aids beats the world of work in numerous ways: it cuts the supply of labour and reduces income for many workers; increases absenteeism and raises labour costs for employers; valuable skills and experience are lost and more significantly than before - stigma and discrimination negatively affects production and workplace morale.

Epidemics typically follow a path where the number of infections rises slowly at first and then rapidly once the pool of infected individuals exceeds a certain threshold. This process takes place when prevalence levels of once the majorities of susceptible individuals have become infected and, ultimately, begins to fall either because the development of natural resistance changes in behaviour, rising mortalities or the appearance of a cure.

The effects of HIV/Aids on mining industry can be categorized as follows: reduction in productivity, increased costs of mining and inability to reach targeted outcomes. Specifically these can be summarized as follows:

- Absenteeism due to ill employees, but also because workers take time off to care for their families who are ill and attend funerals;
- The morale of the workplace going down as the impact of the epidemic becomes clearer;

- Sick workers becoming less productive and unable to carry out more demanding mining physical jobs;
- Employers increasing the size of their workforce to provide for deaths during apprenticeship and because of absenteeism generally;
- As skilled mine workers become scarcer, increases in wages are inevitable for the limited pool available;
- The costs of health care, medical aid and hospitalisation are on drastic rise.

One of the salient attributes of an organisation is its power to motivate employees to influence their satisfaction levels. It is acknowledged that the giving or withholding of this can have a significant effect on productivity. The present study arises from personal observation as well as reports of poor job performance by a few employees who are living with HIV/Aids.

In order to provide a possible reason to the poor job performance, this research focuses on the lack of work motivation as a main source of influence on an employee living with HIV/Aids in a work setting. Central to this investigation is the role that the employee's expectancy and self-efficacy plays when an employee is faced with the challenges as a result of HIV/Aids.

In the past research undertook to determine what could be the possible sources of motivation for a person whose behaviour could be centered on death and the possibility of dying soon in a theoretical context and brings about certain behaviours. *Bandura (1994)* in his self efficacy theory once argued that anxiety arousal is affected not only by perceived coping efficacy but by perceived efficacy to control disturbing thoughts. This exercise was summed up in a proverb: "You cannot prevent the birds of worry and care from lying over your head. But you can stop them from building a nest in your head".

### **3 RESEARCH OBJECTIVES**

The objectives of this research paper will be to:

- Determine whether HIV/Aids has an impact on work motivation in a work setting
- Determine whether a theoretical relation between HIV/Aids and work motivation exists
- Explore the role that expectancy and self-efficacy plays in relation to HIV/Aids on an employee's work motivation resulting in satisfactory job performance.

### **4 THE HIV/AIDS APPROACH**

The medical fraternity has recently acknowledged that HIV/Aids is not only a medical issue, but a psychological one as well. Infection of the disease and its subsequent progression present people living with it a broad range of personal experiences to cope with and negotiate. Parallel to the medical stages that the virus follows, it has several psychosocial stages as well:

- Pre - HIV antibody testing: possibility of being infected
- Post - HIV antibody testing: knowledge of being sero-positive, asymptomatic stable CD4 count
- Falling CD4 count with or without symptoms and/or prophylactic medication: increasing viral load
- Severe medical illness: AIDS, deteriorating physical and mental functioning, pending and eventual death
- Restored feeling of well being with change in attitude regarding future.

Judging from the stages mentioned above, it cannot be underestimated that people living with HIV/Aids are expected to deal with strong emotional issues. Each of these stages can include a variety of emotional responses such as fear, shame, loss, grief, anger, depression, feelings of dependency and hope. For example fear can arise in the infected

person from the unpredictable nature of the disease. This fear can aggravate depression symptoms which would result in feelings of hopelessness, frustration and being overwhelmed.

HIV/Aids has also been called a disease of losses. Sadness is one outcome of experiencing repeated losses; these can also include the loss of a partner/s, friends, co-workers, mobility, strength, weight, appetite, and physical attractiveness, locus of control and social roles. Feelings of depression can be expected to surface as feelings of discouragement, rejections, and helplessness. If this depression is unresolved, a maladaptive coping strategy could result in extreme cases of substance abuse or attempted suicide. Added to these feelings can also be anger, which maybe directed at several targets simultaneously.

A person living with HIV may blame the following: themselves for getting infected resulting in physical loss, at one's support system for lack of understanding, empathy or compassion, at society for their rejection, the workplace for lack of adequate understanding and support, and the medical establishment for failing to find a cure. The need to stay in control can sometimes produce behaviours such as quarreling, arguing, complaining, or being demanding, resulting in high levels of stress, lack of trust and interest in life, work and those around them.

At any point along the HIV continuum, an individual can experience a crisis and the appearance of any symptom can trigger such a crisis (*Fishmen & Crawford, 1996*). They add that the majority of people living with HIV are able to manage their emotional disequilibrium without excessive emotional, behavioural, or interpersonal disturbance. However, which is a point of concern for this paper, Fishmen and Crawford also add that as many as 20% are able to manage their distress.

While individuals in both groups (i.e. those able to manage and those who do not do so well) recognize the threatening nature of the HIV/Aids disease. Those who become emotionally distressed can feel extremely vulnerable and less equipped to cope with the

challenges they face. In addition, feelings of helplessness and hopelessness are present along with cognitive distortions, misinterpretations and a lack of sense of control. According to *Hoffman (1996)*, research about which strategies are most adaptive has shown that active behavioural coping (altering the problem directly) were as a result of low mood disturbances and a higher self-esteem in recently HIV diagnosed gay men. Hoffman also asserts that cognitive-behavioural coping that is paired with the ability to take time out from thinking about having HIV can be adaptive, if one sets their mind to it.

This agrees with challenge posed by this paper, although no research yet exists to prove that employees living with HIV/Aids require extra effort of motivation – this is based on the argument that says – ‘the believe one holds about their own capabilities affects the effort they exert, the choices they make, the perseverance they can maintain in the face of obstacles, their thought patterns, their moods, and their stress levels’. *Bandura’s (1977) theory* described self-efficacy as a belief in one’s sense of control, one’s ability to perform some action or to control one’s behaviour or environment, to reach some goal or make something happen.

A person with an internal locus of control believes that things happen to him because of what he has done himself. This then contributes to making a person feel more in control over what happens to them (*Bee, 1994*). Research has shown that a person with a low-sense of self-efficacy and a higher feeling of hopelessness is more likely to become depressed, de-motivated, weak and as a result ill.

## **5 THE WORK MOTIVATION APPROACH**

### **DEFINING MOTIVATION**

Gleaning through a variety of psychology books, there is a general agreement that motivation is an internal state or condition (sometimes described as a need, desire, or want) that serves to activate or energise behaviour and give direction (*Kleinginna and Kleinginna, 1981*)

The internal state or condition that activates behaviour and gives direction;

The desire or want that energises and directs goal-orientated behaviour;

The influence of needs and desires on the intensity and direction of behaviour;

*Franken (1994)* adds to this definition that there needs to be arousal, direction, and persistent behaviour. Many of those in research are now starting to acknowledge that the factors that energise behaviour are to some extent different from the factors that provide for its persistence.

Many other contemporary authors also offered their definition of the concept of motivation. And they defined motivation as: the psychological process that gives behavior purpose and direction (*Kreitner, 1995*); a predisposition to behave in a purposive manner to achieve specific, unmet needs (*Buford, Bedeian, & Lindner, 1995*); an internal drive to satisfy a unsatisfied need (*Higgins, 1994*); and the will to achieve (*Bedeian, 1993*). For this paper, motivation is operationally defined as the inner force that drives individuals to accomplish personal and organizational goals.

## **THE WORK MOTIVATION THEORY**

Work motivation literature has been reviewed thoroughly at intervals of about a decade in the past century. *Brayfield and Crockett (1955)*, *Vroom (1964)*, and *Locke (1976)* each summarized the field extensively and observed the limited influence of motivation on work output. With so much disconfirmation from studies, it would seem that the presumed relation of work motivation and work performance should long ago have been left behind as a dead-end issue.

Nevertheless, continuing the tradition of once-a-decade revisits to the subject, *Iaffaldano and Muchinsky (1985)* updated the literature. One of their major contributions was that dissatisfaction seems to be consistently associated with higher levels of labour turnover. The argument was workers who are most dissatisfied also exhibit a higher frequency of absence. The explanation most frequently offered for this correlation is the likelihood that people escape, even if only temporarily, from unpleasant work circumstances. The correlations found, though, are typically moderate and by no means explain all of the

variability in observed absence or turnover rates. Many other factors are also influential here. Added to this argument is that turnover could be as a result many factors other than unhappiness in workplaces.

Dissatisfaction has occasionally been linked to poor health or longevity. Workers torn between making maximum work rates and observing the informal ceiling on output set by their work group have more ulcers. Work motivation was found to be the best single predictor of longevity against actuarial tables of mortality in another study. This research attempts to ask the question based on the above statements, whether workers have poor health because they are de-motivated, if they are de-motivated because their health is poor, or if both are the result of some other, unmeasured variable? An explanation could be that the relationship of health and longevity with work motivation can be demonstrated in various circumstances.

*Vroom (1964)* summarized his expectancy theory of motivation as ‘the strength of a tendency to act in a certain way depends on the strength of an expectancy that the act will be followed by a given consequence (outcome) and on the value or attractiveness of that consequence to the actor’. This expectancy, according to Vroom’s terminology represents an individual’s belief that a particular degree of effort will be followed by a particular level of performance. It is an effort performance expectation.

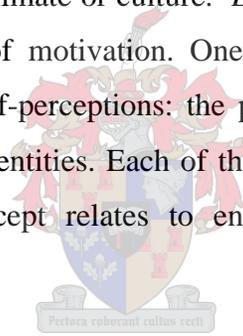
The expectancy theory posits that individuals choose among a set of behavioural alternatives on the basis of the motivational force of each alternative. It also asserts that motivation is based on people’s beliefs about the probability that effort will lead to performance (expectancy), multiplied by the probability that performance will lead to reward (instrumentality), and multiplied by the perceived value of the reward (valence). Expectancies can take the form of subjective probabilities. Suppose an employee is HIV positive and knows that death might not be in the far distance due to his state of health, he wants a promotion or recognition for his job. No matter how much effort he exerts, he perceives the probability of getting that promotion or recognition likely to be zero based

on his perception that the organisation might not see him as a long-term investment and his physical health might soon prevent him from reaching that goal.

This theory indicates that the following factors influence an employee's expectancy perceptions:

- Self-esteem
- Self-efficacy
- Previous success at the task
- Help and attitudes of a supervisor, subordinates or co-workers.

The above clearly indicates that Vroom's theory brings growing questions of the self in the motivation models, which do not explain the diversity behaviour found in organizational settings and their climate or culture. *Leornard, Beauvais & Scholl (1995)* proposed a self-concept model of motivation. One's concept of self, they argued is composed of four interrelated self-perceptions: the perceived self, the ideal self, one's self esteem, and a set of social identities. Each of these elements plays a crucial role in understanding how the self-concept relates to energizing, directing and sustaining organizational behaviour.



According to *Brown and Ghiselli (1995)* it has only been in the last few decades that the organisation has given significant recognition to workers as being humans. A set of circumstances was invariably expected to put together the same kind of reaction. *Viteles (1953)* has also identified the development of the "will to work" as industry's core problem in the utilisation of its manpower; *Maier (1955)* added to this debate by finally recognizing that there's a need for greater attention to problems of motivation and frustration by organisations.

It is well supported that negativity in human beings hides in many day to day conditions which we've come to accept as part of life today: stress, anxiety and worry are three of the biggest perpetrators. They can dump negative energy into the body, exhausting it and lowering its resistance. They can also be their own cause in that they propagate

themselves, i.e. the more stressed you are, the more anxious you become. The link between psychological stress and illness has become incorporated even into allopathic medicine. For employees that are living with HIV/Aids, their immune systems are already under enough strain due to the virus weakening the body and in most instances death is in the foremost of their minds. Yet it is believed that even in this extreme case, there exists a positive and a negative energy.

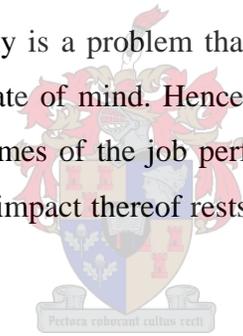
The capacity to exercise self-influence by goal challenges and evaluative reaction to one's own attainments provides a major cognitive mechanism of motivation. A large body of evidence shows that explicit, challenging goals enhance and sustain motivation. By making self-satisfaction conditional on matching adopted goals, people give direction to their behavior and create incentives to persist in their efforts until they fulfill their goals. Self-efficacy beliefs contribute to motivation in several ways: they determine the goals people set for themselves; how much effort they expend; how long they persevere in the face of difficulties; and their resilience to failures. When faced with obstacles and failures people who harbor self-doubts about their capabilities slacken their efforts or give up quickly. *Bandura (1994)* adds that those who have a strong belief in their capabilities exert greater effort when they fail to master the challenge. Strong perseverance contributes to performance accomplishments.

It is my believe, that people also rely partly on their somatic and emotional states in judging their capabilities. They interpret their stress reactions and tension as signs of vulnerability to poor performance. With employees living HIV/Aids it has been observed that in activities involving strength and stamina, they tend to indeed judge their fatigue, aches and pains as signs of physical debility. Mood also affects their judgment of their personal efficacy. True that positive mood enhances perceived self-efficacy, despondent mood diminishes it.

*Conway (1998)* adds that people's beliefs in their coping capabilities affect how much stress and depression they experience in threatening or difficult situations, as well as their level of motivation. Perceived self-efficacy to exercise control over stressors plays a

central role in anxiety arousal. People who believe they can exercise control over threats do not conjure up disturbing thought patterns. But those who believe they cannot manage threats experience high anxiety arousal. They dwell on their coping deficiencies. They view many aspects of their environment as fraught with danger. They magnify the severity of possible threats and worry about things that rarely happen. Through such inefficacious thinking they distress themselves and impair their level of functioning. Perceived coping self-efficacy regulates avoidance behavior as well as anxiety arousal. The stronger the senses of self-efficacy the bolder people are in taking on taxing and threatening activities.

Review of current knowledge asserts that organisations cannot assume that the existence of good plans and excellent work settings will result in an automatic undertaking of assigned tasks (*Flippo, 1984*). He contends that setting organisation members to go to work willingly and enthusiastically is a problem that has been compounded by various factors, such as an employee's state of mind. Hence it is crucial to be aware that good working conditions and the outcomes of the job performed somehow play a role in the role that an individual plays. The impact thereof rests on the individual's motivation and the organisation as a whole.



## **6 RESEARCH PROBLEM**

The research problem is initiated by the observation of the low motivation levels of employees who are living with HIV/Aids working for De Beers Venetia Mine.

The rate at which employees are living with HIV/Aids perform their duties seems to be deteriorating in respect of the expected output. The hypotheses can therefore be defined as follows:

P1: There is a relationship between HIV/Aids and an employees work motivation levels.

P2: There is a relationship between an employee living with HIV/Aids self- efficacy (What's in it for me) and the believe he holds about his current state and the ultimate choices he makes to exert effort in his performance.

In providing support for the relationship between HIV/Aids and work motivation the model provided by *Fishmen & Crawford (1996)* that those who become emotionally distressed believe that they are extremely vulnerable and feel less equipped to cope with the challenges they face. Thus a third hypothesis is summarized follows:

P3: If an employee doesn't believe he can be successful at a task or the employee does not see a connection between his activity and success or the employee does not value the results of the success, then the probability is lowered that the individual will engage in the required activity. From this perspective, expectancy must be high in order for motivation and resulting behaviour to be high.

## **7 RESEARCH METHODOLOGY**

### **A RESEARCH DESIGN**

A survey was conducted among a group of 45 employees at De Beers Venetia Mine, Limpopo Province - South Africa, in August and September 2005 as a method to assist in determining whether there is a relationship between HIV/Aids and an employee's motivation in a work setting, and whether there is an existing relationship between living with HIV/Aids and self-efficacy based on the believe an employee holds about his current state and the ultimate choices he makes to exert effort in his performance.

The organisation has a well established an HIV/Aids treatment programme since June 2003 for employees as well as their nominated spouses or lifetime partner who would have been diagnosed HIV positive through the Voluntary HIV Counselling and Testing service available on the mine.

The employee and spouse/lifetime partner would be referred to an accredited treatment doctor for further care and monitoring. An educational campaign through the disease management service provider\* was launched in January 2005, to give all employees information and create awareness on the role and value of the HIV/Aids Treatment Programme.

The sample comprised of a group of employees living with HIV/Aids, diagnosed at different time periods, currently working at De Beers Venetia Mine. Employees were individually approached by a dedicated Wellness coordinator to participate in the survey based on available data from company's Wellness programme accessible only to the coordinator (author of this paper).

A combination of both qualitative and quantitative research was used. The survey used an exploratory research technique. According to *Christensen (2001)*, the survey represents a probe into a given state of affairs that exists at a given time. *Christensen (2001)* further encourages that direct contact must be made with the individuals whose characteristics, behaviours, or attitudes which would be relevant to the investigation.

The method of inquiry used in this research forms part of experiential reality (discovering reality through personal experience). *Babbie (1992)* described two types of human inquiry, namely casual and probabilistic reasoning.

Casual reasoning is based on the assumption that future circumstances are caused by present ones, whereas probabilistic reasoning assumes that effects occur more often when causes occur than when the causes are present. Taking into account that this would be based on nonexperimental qualitative research, the methodology can be typified as human inquiry by means of probabilistic reasoning.

The limitations of this method were taken into account. This includes that direct contact has to be established, accurate data as well as the guarantee that information gathered

would not be used against individual participants. Without proper thought and work, critical information might be lost in the process.

## **B SAMPLING**

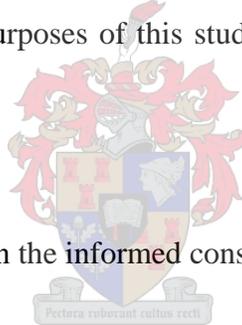
Because of the complexities and sensitivities of this research, the sample was selected on the basis of convenience, followed by a snowball sampling method which relied on referrals based on available data of the Wellness programme. The final sample consisted of 45 employees of De Beers Venetia Mine living with HIV/Aids. Responses were gathered over a period of eight weeks.

## **C ETHICAL RESEARCH PRACTICE**

Since social research is about the use of human beings as the subjects of study, it is indicated in Durrheim (1999:65) that researchers need to protect the rights and the welfare of the respondents. For purposes of this study, the following ethical issues into consideration.

Informed consent:

Respondents were requested to sign the informed consent form before they participated in the study.



Privacy, confidentiality and anonymity:

Respondents were respondents assured of privacy, confidentiality and anonymity so that they could provide the necessary information without fear. As indicated in Strydom (2002:67), these three aspects are synonymous. The identity of the respondents was also protected by making sure that questionnaires were completed anonymously.

## **D DATA COLLECTION**

Respondents were approached individually by the coordinator identified from available data. Individual appointments were scheduled and a face-to-face method, where personal, in-depth person-to-person structured interviews with the guidance of a questionnaire which was to be completed by all participants took place.

This method offered the advantage of allowing clarity on any ambiguity in the questions that were asked and opportunity to probe even further in instances where inadequate answers were provided. This method, like *Christensen (2001)* indicated, generally gave higher completion rate and more complete information.

Each employee was assigned a time slot at a dually agreed venue; clear consideration was given to the fact that respondents required assurance that their involvement was to remain voluntary and anonymous. The meeting venue had to be largely dictated to by the participants. Although participants had agreed to fill in the questionnaires as well as be interviewed, their signatures were required as proof of their consent to participate.

#### **E CONFIDENCE LEVELS AND MARGINS OF ERROR**

A sample of 45 De Beers Venetia Mine employees out of a population of 145 employees projected to be living with HIV/Aids from a recently conducted VCT campaign (where over 90% of employees participated, calculated at a total of 933 staff complement) provides a confidence level of 90%, a level considered acceptable in this kind of research with a margin of error of 9.8%, where 10% is acceptable for research of this nature.

#### **F CONSIDERATIONS AND LIMITATIONS**

Although there were no major problems or limitations concerning the study, the potential obstacle to good data collection is considered, and every measure taken to counter any problems, all research takes place within the constraints of reality. Efforts were deliberately taken to assess and reduce these limitations.

The researcher is confident that the results are adequately representative and that this study has achieved its objectives.

#### **G MEASUREMENT TOOL**

A customized survey instrument has been used which contained a total combination of 30 questions and statements as well as employee demographic questions. All the questions and statements were positively worded, and they were all answered on a 5 point *Likert*

rating scale (1 being “strongly disagree” and 5 being “strongly agree”, with a “can not say” option included. Thus the higher the scale the more positive or favourable the response. The *Likert* scale in this instance was used to measure respondent’s personal attitudes.

1 = Strongly disagree

2 = Disagree

3 = Can not say

4 = Agree

5 = Strongly agree

### **The questionnaire:**

The questionnaire was divided into three sections:

Section 1: Aimed at collecting demographical information of respondents

Section 2: Assess the psycho-social implications of HIV/Aids on the employee

Section 3: Assess the impact of HIV/Aids on work environment and work relations

For section 1 responses were collected and reported based on the initial diagnosis as well as the current state of health, to determine if this could be an additional contributing factor to the current work motivation level. For purposes of collection based on individual responses, respondents were not divided into groups, however level of health was used as a measure, assuming that views would differ from person to person based for the most part on working conditions as well as organizational culture/climate and their perceptions thereof.

Sections 2-3, participants were requested to give their views indicating whether they agree or disagree with the statements on a five point scale. Each degree of agreement or

disagreement was given a numerical value from one to five. Participants were required to rate each question or statement on the questionnaire.

To the extent that it was possible, academic jargon in the questionnaire was avoided.

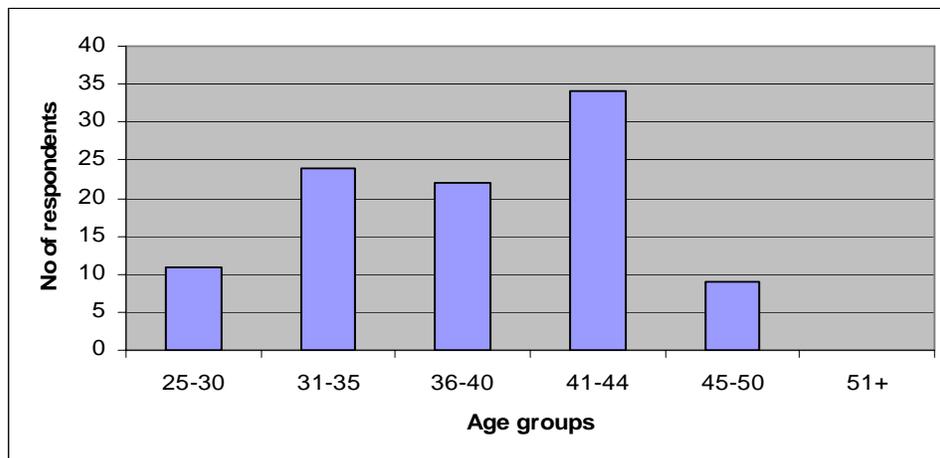
## 8 RESULTS

A total of 45 responses were gathered during a period of eight weeks. All participants filled in the questionnaires and were individually interviewed in the process. The results and responses were however grouped and are summarized and discussed below:

### 8.1 SURVEY DEMOGRAPHIC BACKGROUND

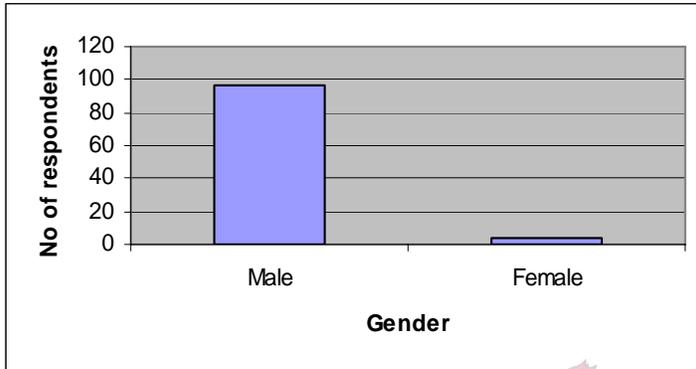
#### **Figure 1**

Figure showing details of age groups of employees who participated in the survey. In the survey, over 33% of respondents were in the 41-44 age group and 11% were in the 25 - 30. There were respondents from the over 51 year's age group, which gave a clear indication that the majority of the working group at De Beers Venetia Mine is largely 25 - 45.



**Figure 2**

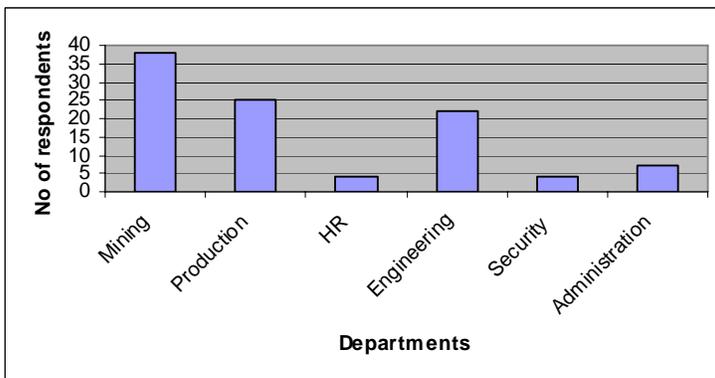
Figure showing details of respondents in terms of gender who participated in the survey. Of the gender distribution, 96% of participants were male employees and only 4% were females. This is also a clear indication that the mining industry is a male dominated environment with over 92% of the total number of employees at De Beers Venetia Mine being males.



**Figure 3**

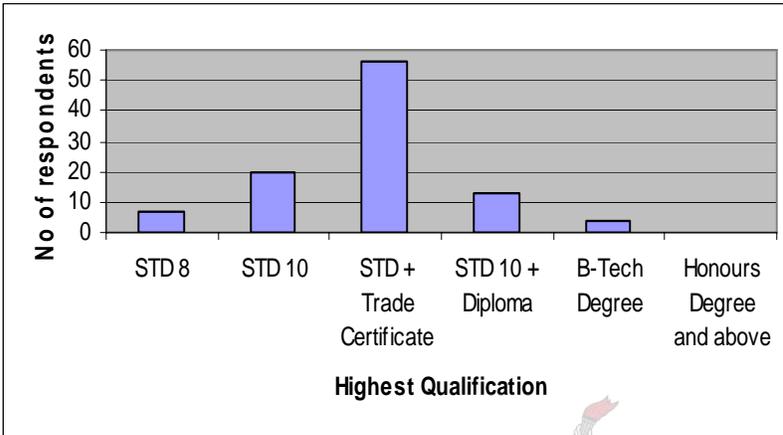
Figure detailing the various departments existing on the mine and the representation thereof in the survey. The figure outlines specific departments, where we are able to make a clear comparison between participants working within the administration (mostly described as office bound) in comparison to those working directly in mining jobs (mostly described as lauding, hauling and plant based) on a daily basis.

According to the figure below, over 38% and 25% of respondents work in the mining and production sections respectively, whereas only 7% and 4% work in the administration and human resources sections respectively of the company.



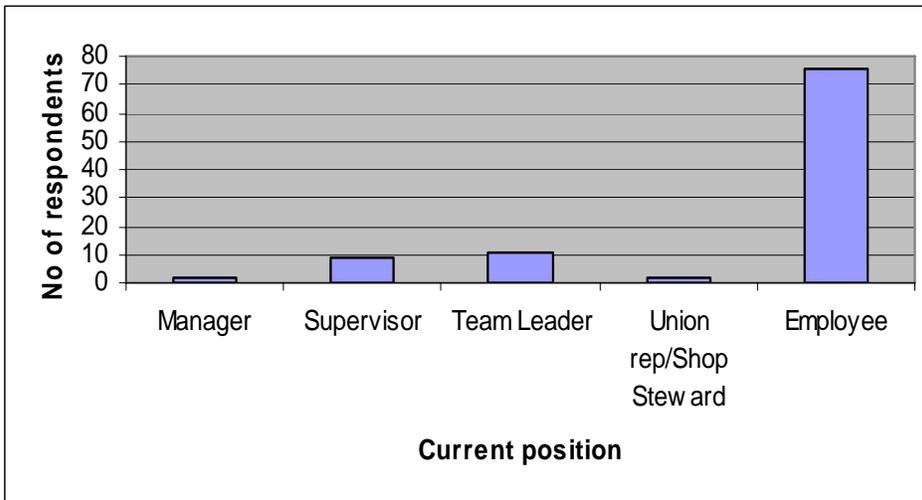
**Figure 4**

Figure describing the qualification levels of the participants from the survey. According to figure 4, 56% of the respondents were in possession a trade certificate, while only 4% were in possession some form of a university degree. Only 7% of the respondents had a qualification below STD 8 (Grade 10).



**Figure 5**

Figure describing the position levels held by participants currently within the organisation. In terms of the level of work, 76% of the respondents were ordinary workers of the organisation, whereas 11% of the respondents were team leaders with one form of responsibility or other. There was an equal participation at 2% of both what is classified as supervisors as well as union representatives or shop stewards.



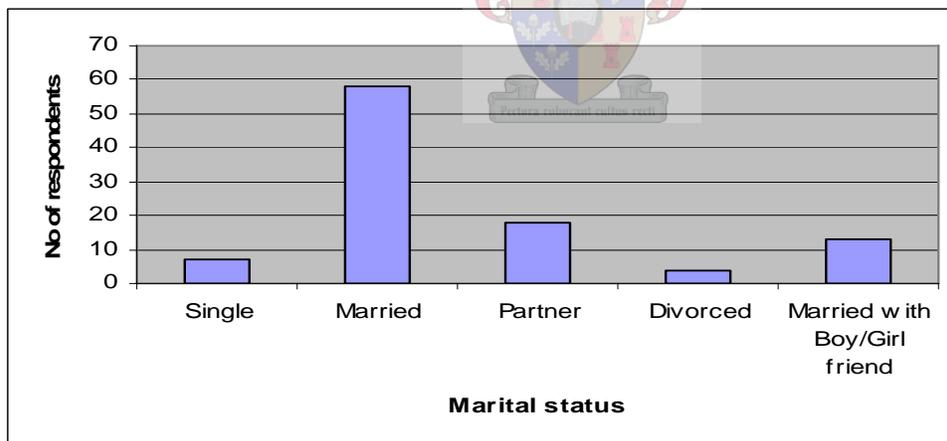
**Figure 6**

Figure describing the marital status of employees who participated in the survey.

More than half of the respondents at 58% indicated that they were married, while only 7% indicated that they were single. Interesting to note that 13% of the participants declared that while they were married they also had a regular boyfriend or girlfriend that they had interaction with on a regular basis and in some instances more than they had with their spouses.

Only 4% of the participants were divorced or in a process of getting divorced – but separated, half of these indicated that the disclosure of their HIV status contributed largely to the disputes as blame and guilt played a major role.

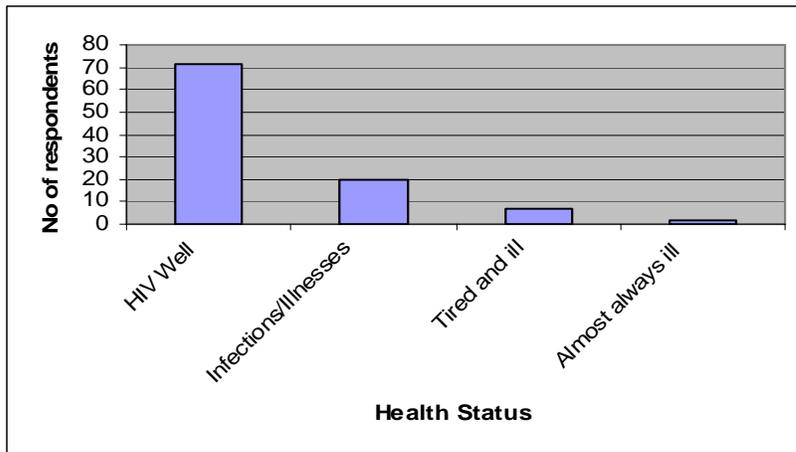
Experience in surveys has shown that the definition of ‘girlfriend’ or ‘boyfriend’ is highly subjective and may refer to someone one has known for a few days, weeks or even years. It is recommended that these figures be read with this broad definition in mind.



**Figure 7**

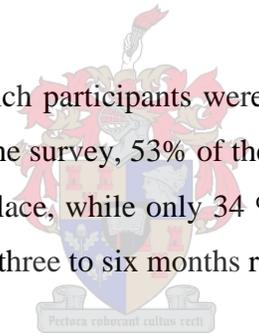
Figure describing the current health status of employees who participated in the survey. According to the responses from the survey, 71% of the participants were at the point of the survey HIV positive but were very well and felt nothing wrong with them (HIV well),

while only 7% of them were often tired and ill. Only 2% were almost always ill and off work regularly.

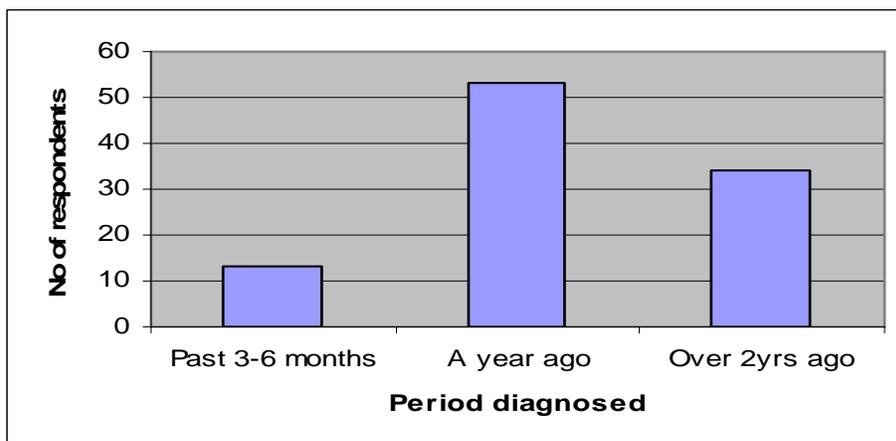


**Figure 8**

Figure outlining the period at which participants were initially diagnosed HIV positive. According to the responses from the survey, 53% of the respondents were diagnosed over a year ago of this survey taking place, while only 34 % and 13 % were diagnosed more than two years ago and in the past three to six months respectively.



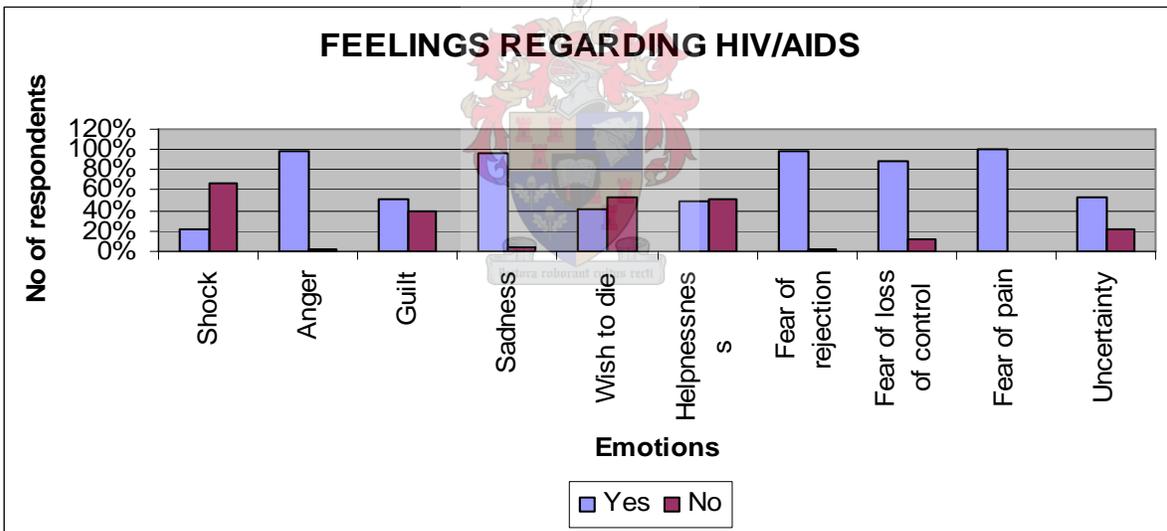
This is was also clear from the interviews that were held as respondents demonstrated their individual interpretation of the meaning of their HIV/Aids diagnosis. While the majority of respondents indicated that they viewed HIV/Aids as a life threatening disease, a few had limited knowledge about the virus and could only base it on information obtained from hear say.



**Figure 9**

Figure describing the most outstanding feelings regarding HIV/Aids. The figure below depicts the respondents emotions towards HIV/Aids, 22% indicated that they were shocked initially when they received their diagnosis, while over 98% state that they were still angry and sad about their HIV status. Contrary to popular views, 53% of respondents indicated clearly that they do not wish to die, while only 5% did not give their views on the matter.

According to the responses, 51% of the respondents did not feel at all helpless because of their HIV status, whereas all the participants (100%) had some fear of pain; 53% had some form of uncertainty while 25% of the respondents did not give their views on the matter. As many as 98% had a fear of being rejected in one way or the other, while 89% had a sound fear of loss of control.



## 8.2 DISCUSSION FROM KEY FINDINGS ON SECTION 2

From sections 2 and 3, respondents were asked questions and given statements aimed at assessing their attitudes and perceptions regarding various incidences or workplace experiences in relation to HIV/Aids. These were geared towards determining the level of impact that HIV/Aids might have on their work environment.

These sections required participants to choose on a five point scale – enquiring about their ‘comfort level’ in dealing with typical HIV-related situations they face on a daily basis.

## Section 2: Results

In my work environment no one knows that I have HIV

Q1	SD	D	Can not say	A	SA
In my work environment no one knows that I have HIV	8	3	2	18	14

Thirty two of the forty five respondents indicated that no one in their work environment, with the exception of the VCT clinic staff or people that tested them for HIV knew that they had HIV. Two of the respondents were not confident whether or not there were people that could possibly be in knowledge about their HIV status.

Sometimes I feel guilty I have HIV

Q2	SD	D	Can not say	A	SA
Sometimes I feel guilty that I have HIV	12	8	3	15	7

When asked whether they have any guilt feelings regarding their HIV status, twenty two participants had varied levels of agreement that at times they felt guilty that they have HIV/Aids. Three respondents declared that they were unable to whether they do feel guilty or not.

Telling someone at work that I have HIV is risky

Q3	SD	D	Can not say	A	SA
Telling someone at work I have HIV is risky	8	6	0	25	6

As many as twenty five respondents felt that disclosing their status to someone they work with is very risky, while six respondents strongly felt it was not risky. From the interviews this was attributed to a lack of trust within the work environment as well as lack of clear policy outlines on non consented disclosure. Surprisingly eight respondents disagreed that there was any risk in disclosing one's status within their work environments; and this was attributed to the understanding of their rights and clear knowledge of the company's HIV/Aids policy.

People with HIV lose their medical privacy at work once they disclose their status

Q4	SD	D	Can not say	AS A	SA
People with HIV lose their medical privacy at work once they disclose their status	5	4	4	21	11

Again, like the previous question (Q3) most respondents were uncomfortable with disclosing their HIV status as they perceived this to contributing to a loss of internal medical privacy. From interviews participants indicated that their experiences with the medical facility in the past have lead to lack of trust in the system. Five of the respondents expressed a different view, largely attributed to the level of knowledge of the organisations' policies and procedures regarding disclosure of medical records without consent and felt they were more concerned about being well than 'who says what'.

It is easy to avoid my work colleagues than worry about telling someone I have HIV

Q5	SD	D	Can not say	A	SA
It is easy to avoid my work colleagues than worry about telling someone I have HIV	3	2	0	10	30

More than half of the respondents indicated they would prefer to avoid their work colleagues than having to disclose their HIV status to them; thirty respondents indicated they would not be comfortable to disclose their HIV status to their work colleagues.

Same as the responses from question 3, a majority of employees were confident that it would be risky to disclose to anyone at work.

I worry that my supervisors may judge me when they learn I have HIV

Q6	SD	D	Can not say	A	SA
I worry that my supervisors may judge me when they learn I have HIV	1	5	6	20	13

Thirty three of the respondents had varying feelings of agreement that their supervisors would be judgmental of them if they knew that they had HIV/Aids. From the interviews respondents indicated that they felt the maturity levels at supervisory levels within the organisation were not at all ready to understand and accommodate a subordinate who was living with HIV/Aids. Six of the respondents felt that their relationships with their supervisors were very distant to the level they could not guess what the reactions would be.

I feel I am not as good an employee as others because I have HIV

Q7	SD	D	Can not say	A	SA
I feel I am not as good an employee as others because I have HIV	7	21	1	9	7

Twenty eight of the respondents indicated that although they were HIV positive, they still feel as adequate employees as they were before. It was concerning that seven respondents strongly felt that they were not as good employees because of the HIV status. This was largely attributed to physical health and regular absenteeism or being moved from the job they were originally employed to do to that which was considered light duty, which in essence meant doing menial work as they reported.

Since learning that I have HIV, I feel set apart and isolated from the rest of the workforce

Q8	SD	D	Can not say	A	SA
Since learning that I have HIV, I feel set apart and isolated from the rest of the workforce	9	20	0	12	4

Twenty nine respondents felt that they were still part of the greater workforce even though they were HIV positive. While sixteen respondents from the interviews expressed the view that the attention that the organisation, media and the country at large is giving to HIV/Aids at times makes them feel isolated from the workforce, as those that had a ‘special disease’. One respondent expressed a view that he felt if he does disclose to his colleagues he felt he would be would be treated like the one with “that disease”.

Some seniors avoid discussing my performance/future opportunities once they know I have HIV.

Q9	SD	D	Can not say	A	SA
Some seniors avoid discussing my performance/future opportunities once they know I have HIV	6	14	0	19	6

Twenty five of the fourty five respondents believed that their seniors avoided at all costs having a discussion with them regarding their performance or career development. Six of the respondents disagreed with the statement and indicated that there had been history to this avoidance and it could not be attributed to HIV/Aids, more so because they were confident that their seniors had no knowledge of their current HIV status as a result it could not be a factor but rather other workplace disputes. However it concerned them that should the supervisor realize that they are HIV positive, it could be used to their disadvantage.

I care about my work performance regardless of my HIV status

Q10	SD	D	Can not say	A	SA
I care about my work performance regardless of my HIV status	19	3	0	8	15

It was concerning that almost half; twenty two of the respondents did not care about their performance at work. From the interviews respondents indicated that they have other things that they considered more critical to worry about than their performance at work. The strongly felt that they have their lives and health to worry about more than their performance at work. Nineteen of the respondents indicated that they were still concerned about their performance at work and the results they produced.

Since learning I have HIV I worry about my performance at work

Q11	SD	D	Can not say	A	SA
Since learning I have HIV I worry about my performance at work	21	3	0	4	17

Twenty one of the respondents attributed a large percentage of their worry about their performance at work to their HIV status. From the interviews a majority of those sharing that view indicated that since their diagnosis their attention has been focused on worries regarding general health, death, and their children and to what will happen should they die more than worry about their performance at work since their diagnosis.

Some work colleagues who know or suspect I have HIV have grown more distant

Q12	SD	D	Can not say	A	SA
Some work colleagues who know or suspect I have HIV have grown more distant	14	19	0	6	6

Respondents indicated with great confidence that they did not feel that their work colleagues were at all growing or have grown distant from them on the suspicion that they could have HIV. Six of the respondents strongly disagreed and in the interviews indicated that since their colleagues have observed a change in physical health they have experienced some distance. One of the respondents attributed this to ignorance about facts of HIV/Aids transmission as well as the workplace HIV/Aids policy.

Colleagues have told me that future work prospects are minimal because of my current health conditions

Q13	SD	D	Can not sat	A	SA
Colleagues have told me that future work prospects are minimal because of my current health conditions	6	12	0	14	13

More than half of the respondents agreed that their colleagues have indicated that a person's career prospects or possibilities of a promotion or development programme are minimal should their health status found to be questionable. Surprisingly when asked in the interviews how they were told, a majority indicated that they had heard from a colleague who had heard from another work colleague that if a person has HIV, the company makes a plan to either retire them on the grounds of ill health or being unfit to do the job, but one or other reason is used to retire them. Only three of the participants who agreed, indicated that these views were based on an observation of a colleagues who had regular illness episodes.

When seniors learn that I have HIV, they will look for flaws in my character

Q14	SD	D	Can not say	A	SA
When seniors learn that I have HIV, they will look for flaws in my character	5	8	1	20	11

Thirty one of the respondents felt that their seniors will be judgmental and look for mistakes in their work on a regular basis if they knew that they had HIV, this was also attributed to a lack of trust in the system and a dissatisfactory organizational culture. Only thirteen respondents felt that they could confidently say that this would not be case.

Sometimes I feel too ill to work, but I come to work for fear of losing my job

Q15	SD	D	Can not say	A	SA
Sometimes I feel too ill to work, but I come to work for fear of losing my job	8	10	0	22	5

It was concerning that more than half of the respondents, twenty seven indicated that at times they felt too ill to work but they come to work for fear of not wanting to be regarded as those that are abusing the sick leave system. Another concerning factor was that six of the respondents who agreed indicated that sometimes they come to work and sit in their working area or tea room most of the time because they would be too ill to work (presenteeism). Noting that this was an unsafe act and risky, they strongly emphasized their fear to losing their jobs.



## COMMENTS

Although a majority of respondents reported that in their knowledge no one in their work environment (department or work area) had knowledge that they had HIV, they reported suspicions of information leaks. This was clearly indicated when many reported their distrust in the confidentiality of the internal medical system. It was concerning that one of the respondents working within the medical system also had issues and concerns regarding confidentiality issues of the system.

There is some evidence that employees diagnosed with HIV experience many emotional responses identified in people fearful of a terminal illness. They also reported how they had to go through the process of denial, shock, and anger, and a feeling of guilt about

their infection or anger towards those they believed infected them and could not acknowledge having the disease and are in denial of its likely consequences.

From the comments of the interviews it was clear that even though many respondents did not feel isolated from the rest of the workforce due to their HIV status, there was evidence of withdrawal associated with HIV/Aids which could be as a result of uncertainty or apprehensiveness about how work colleagues might react.

From the majority of responses, it was clear that many participants felt that HIV/Aids posed a threat to their lives, goals, expectations, and significant relationships; hence a majority of the employee respondents are reluctant to admit their diagnosis to their seniors or supervisors and even work colleagues.

Despite high levels of knowledge, it is clear that the issues facing HIV positive employees vary in accordance with the disease process, including whether the disease is symptomatic. The differences were so clear in that employees that were diagnosed in the past 3-6 months were more concerned about death and dying, and whether they worried about others knowing their status. They had fears of rejection by colleagues, supervisors and seniors which lead to a lot of anxiety.

While respondents who have been diagnosed more than two years ago worried about control issues as they thought more about their physical wellbeing and the potential loss of physical control. Self-efficiency, active involvement in their careers and decisions relating to their work increased. There was a strong feeling of worth and their performance at work regardless of their HIV status, as they felt they had already suffered through the process of denial and wanted to move on with their lives after some period. Many felt that HIV was presenting them with the opportunity to want to contribute more and their development, regardless of the challenges they face as a result of the organizational culture.

### 8.3 DISCUSSIONS FROM QUESTIONS ON SECTION 3

My current work environment encourages me to do my best and perform

Q1	SD	D	Can not say	A	SA
My current work environment encourages me to do my best and perform	8	13	4	13	7

Twenty respondents indicated that their work environment allowed them to perform their level best at work, although the work environment was largely described as a physical work environment which included equipment, machinery and required extra efforts on safety. Thirteen respondents indicated that the culture of the organisation did not allow people to do their best in their work performance.

I feel free to talk to my supervisor when and if necessary

Q2	SD	D	Can not say	A	SA
I feel free to talk to my supervisor when and if necessary	22	11	0	11	1

A large number of respondents indicated that they are unable to discuss with their supervisors when and if they needed too. This was clear indication that communication between supervisors and employees is perceived as not effective. In the interviews a larger majority of the respondents attributed to this lack of communication to the entrenched culture of junior and seniority within work environments. Respondents indicated that the culture does not allow subordinate and supervisor relations to grow beyond instruction giving and instruction taking. One respondent indicated that due to the good relationship that she has with her supervisor, she feels very free to talk to her supervisor.

I am usually given credit for work well done

Q3	SD	D	Can not say	A	SA
I am usually given credit for work well done	12	17	3	9	4

Thirteen participants indicated that they were not given credit for any work that they do by their supervisors. From the interviews many participants attributed this to the culture of the organization. It is discouraging to note that three participants from the comments of the questionnaire indicated that over the past year they have chosen to focus on other life related matters that they viewed more critical than focus on receiving credit for work well done; their health was a specific mention.

I am currently a motivated employee

Q4	SD	D	Can not say	A	SA
I am currently a motivated employee	13	15	0	14	3

More than half of the participants, twenty eight indicated that they are not at all motivated and satisfied with their current jobs. The degree at which this was at could not be determined. Ten of the participants indicated that they are demotivated by a number of life changing events which contribute to their work levels of motivation. Those that reflected demotivation, felt less empowered, they felt they had nothing to strive for because of a perceived lack of recognition and general development. In discussions participants indicated that the level of lack of motivation could be attributed to the low levels of health in that period (both physical and psychological) and their surroundings.

I am doing something worthwhile in my job

Q5	SD	D	Can not say	A	SA
I am doing something worthwhile in my job	15	10	0	13	7

Twenty of the participants felt that they are doing something that they consider worthwhile in terms of their job. Surprisingly twenty five of the respondents indicated that they disagreed that they were doing something that they considered worthwhile in their jobs. This was attributed to lack of visible recognition for jobs well done.

I feel appreciated by my company regardless of my HIV status

Q6	SD	D	Can not say	A	SA
I feel appreciated by my company regardless of my HIV status	14	7	0	19	5

Twenty four of the respondents felt that the company in its entirety appreciates them as employees regardless of their HIV status. Fourteen of the respondents strongly disagreed with the view that the company shows no appreciation; however many of the respondents who had a different view felt HIV/Aids was not the sole contributor.

I have the opportunity to participate in all decisions that affect my work regardless of my HIV status

Q7	SD	D	Can not say	A	SA
I have the opportunity to participate in all decisions that affect my work regardless of my HIV status	13	13	0	15	4

Twenty six respondents indicated that they were not given the opportunity to participate in decisions that affected them. From the interviews participants agreed that this was largely attributed work culture that they find themselves in. Nineteen respondents indicated that they felt they were being offered the opportunity to participate in decisions that affected their work regardless of their HIV status; this was attributed to the relationship between supervisor and to employees in his team. One respondent felt due to his continuous absence because of illness, he was being denied these opportunities.

I want to continue working for the company for as long I can

Q8	SD	D	Can not say	A	SA
I want to continue working for the company for as long I can	3	9	0	21	12

A larger majority of the respondents, thirty three indicated that if their health permits they wanted to continue working for the company for as long as they could. Twelve of the respondents had a different view. Where they gave a view that if they had other options they would not work for the company until a certain period. Three of the participants attributed this view to their current state of health.

My section's management is interested in my well-being

Q9	SD	D	Can not say	A	SA
My section's management is interested in my well-being	8	20	1	12	4

It was concerning that twenty eight of the respondents felt that the management within their organizations were not interested in their well-being, specifically which did not relate to work safety. While only sixteen of the participants agreed that their management had some form of interest in their health and well-being based on the introduction of the Wellness programme.

The physical work conditions in my area are enabling me to do my job

Q10	SD	D	Can not say	A	SA
The physical work conditions in my area are enabling me to do my job	10	12	2	11	10

Twenty one of the respondents agreed that the physical working conditions in their area enabled them to do their jobs safely. Twenty two of the respondents felt that their working conditions were not enabling them to their jobs, these were attributed to their physical health in comparison to the extend of physical work that was required in their daily jobs. A large percentage of these views were expressed by many of those working in the mining and production environments on a daily basis.

I trust and respect my supervisor

Q11	SD	D	Can not say	A	SA
I trust and respect my supervisor	21	9	0	6	9

An overwhelming majority, thirty agreed that they did not trust and respect their supervisors. Only fifteen of the respondents indicated that they had trust while they still had some reservation. This agrees with the view that many respondents expressed when looking at the respondents views on disclosure to someone within their work environment.

My supervisor helps me with problems that occur in my job

Q12	SD	D	Can not say	A	SA
My supervisor helps me with problems that occur in my job	10	12	1	16	6

Twenty two of the respondents indicated that their supervisors do not assist them with problems at work. Equally twenty two respondents agreed that their supervisors do assist them with their problems that they experience at work only because targets must be met, and not because they wanted to. One of the respondents indicated from the interviews that his view might be extremely subjective as it would be based on the changes in their relationship in the past few months due to his regular absenteeism and sick leave; as a result the relations have soared.

My supervisor regards me as a valuable member of the team

Q13	SD	D	Can not say	A	SA
My supervisor regards me as a valuable member of the team	12	11	7	10	5

Twenty three of the respondents had a different view to the fact that their supervisors regards them as an integral part of their work environment. This was attributed largely to the culture of the organisation, where rewards and recognitions are not transparent and are subjective. Surprisingly as many as seven respondents did not give their views to this question, which was attributed to a none existing relationship between them and their seniors.

My personal development is important to my supervisor

Q14	SD	D	Can not say	A	SA
My personal development is important to my supervisor	8	11	4	9	13



Nineteen of the respondents felt that their personal development was not important to their supervisors, while four respondents indicated that their development is not important to their supervisor but they know that it is important to the organisation as it impacts directly on the opportunity to meet production targets, regardless of their current state of health. Twenty two respondents had varying levels of agreement, that their seniors and not necessarily supervisors showed some form of interest in their development.

I am satisfied with my current job

Q15	SD	D	Can not say	A	SA
I am satisfied with my current job	11	20	3	8	3

Thirty one of the respondents indicated that they were not happy with their current jobs, while only eleven indicated that they were happy with the jobs that they were in currently. A majority of the thirty one respondents indicated that there were various factors that contributed to their dissatisfaction which included their state of health, relations with seniors, the culture and lack of motivating factors within the organisation.

## **COMMENTS**

From the responses of the participants there appears to be excellent understanding of what their developmental needs are, as well as what they considered could assist in appreciating their work environment. A majority of respondents' made continuous reference to the impact that organizational culture had on various aspects of their work environments. The lack of trust in systems, unclear policy issues on disclosure and protection for those disclosing were some of the aspects named.

Many of the respondents did not differentiate between the terms culture and climate. Instead, they represented different, but overlapping interpretations of the same phenomenon. The concept of organizational culture was to describe configurations of attitudes and perception by organisation members that, in combination reflect a substantial part of the context of which they are part and within which they work. The attitudes and perceptions are usually conceived of as being structurally realist, deductive or based on survey methods.

There is some evidence that motivation has an influence on productivity, and the respondents indicated that supervisors need to understand what motivates employees to reach peak performance. Many agreed that it is not an easy task to increase employee motivation because they themselves respond in different ways to their jobs and their organization's practices, with HIV as a contributing factor it was clear that it contributed to a recognizable extent to these low levels of motivation.

The supervisor (at times the motivator) was regarded as a highly influential and contributing factor to motivating employees to higher levels of productivity. The fact that

the maturity, knowledge and understanding levels of supervisors on matters regarding HIV/Aids and how to interact and deal with an employee living with HIV/Aids was a great concern and required great improvement.

## 9 CONCLUSION

*“Beyond the enormous suffering of individuals and families, South Africans are beginning to understand the cost in every sphere of society ...*

*The severity of the economic impact of [HIV/Aids] is directly related to the fact that most infected persons are in the peak productive and reproductive age groups. AIDS kills those on whom society relies to grow the crops, work in the shops and factories, run the schools and hospitals and govern nations and countries ...”* (President Mandela, World Economic Forum (1997)

Drawing from the results and interpretation from the quantitative and quality analysis, the following conclusions can be made: Although not much research has been conducted to test if there is a relationship between HIV/Aids and work motivation in the past, the study has highlighted the importance of attending to the emotions that an employee living with HIV/Aids goes through such as guilt, shock, sadness and uncertainty. The survey has revealed a vulnerable workforce, who have begun to confront HIV/Aids in their personal and work lives, and yet feel ill-equipped to deal with themselves and others effectively.

That employees with HIV disease can continue to be productive, contributing members of the workforce in a supportive workplace. Also, as employees get to understand the implications of the diagnosis – with time they learn to adjust and interesting work becomes more of a motivator.

Misunderstandings, interruptions in productivity can result when HIV-infected colleagues are viewed as having only rights and managers as having only responsibilities. Although HIV/Aids many argue should be regarded as any other chronic disease, this research study has shown that the psychological and physical implications of this illness on

employees does at times make it 'the disease'. Its effects on the fortunes of business: reduced working hours, high rates of absenteeism, low motivation for employees to work, reduced productivity or poor performance due to health, increased health bills and most of all stigmatization and discrimination.

Just as we should not rely on a similar patchwork of ideas to govern employees' behavior in sexual harassment situations, we should not allow it to inform their behavior around HIV/Aids disease, which is still so widely misunderstood. Our long-term and short-term responsibility to all our employees is to provide education about how HIV/Aids is not transmitted, even if such training is not required in our industry or area as compulsory training. There are some misperceptions and myths that place people at risk for HIV infection. These need to be addressed creatively during education and counselling.

Major educational programmes are needed to alter the very vulnerable position of many employees, together with an upgraded condom distribution programme and a transformation of the medical services into a friendlier and more accessible service, especially for the care of STDs and VCT.

Aspects of clear guidelines on HIV/Aids policies are also an issue. The lack clearly stipulated actions to be taken against those refusing to work with those infected and isolation issues are great concerns by employees living with HIV. The absence thereof increases the anxiety and lack of interest in disclosure, thus impacting on the confidence levels on the internal systems.

## 10 RECOMMENDATIONS

*“Let’s put in the dustbin the idea that simplistic solutions will end this epidemic. Single interventions are ineffective without an enabling environment and broader action.”*

*(Peter Piot, Intl AIDS Conference, Durban 2000)*

The following actions are being recommended as a start to enhance a motivating and positive culture for employees both infected and affected with HIV/Aids at De Beers Venetia Mine in future:

- A comprehensive corporate HIV/AIDS intervention strategy focusing on two major goals:
- Educating the organisation with emphasis on the supervisors on how to work and manage employees living with HIV/Aids, and
- Managing and containing the possible negative effects of HIV/AIDS on the individual, through providing comprehensive psychological support
- Accordingly, the objectives of such an intervention are to equip people with necessary knowledge, but also to address attitudes and practices regarding the following:
- Top management to buy into the living with HIV/Aids supervisory skills programme, in line with the company wellness programme. Aimed at educating and providing line managers with the tools and skills of working with employees living with HIV/Aids. Conduct a critical job analysis studies to assist with identifying critical jobs that will influence job succession programmes. In consultation with all stakeholders, draw up job enlargement policy and procedures for employees who will require to be moved from their original jobs due to

physical health, such that these might also be jobs that make a meaningful contribution to the organisation.

- All employees (both supervisors and employees) must live by the set organizational rules and values.
- Enhance current development programmes, and develop proper career paths for all employees
- Enhance communication with workforce by sharing as much information as possible with employees at the hop floor
- Fair performance and reward systems for all employees
- Improve motivation programmes



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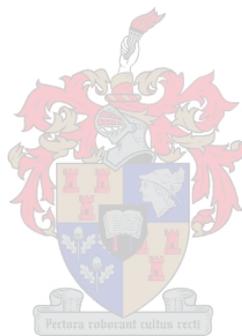
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## APPENDICES

K.....

### Questionnaire

#### Section 1: Demographics and special data

Kindly complete the following info by marking with an X

##### 1.1. How old are you?

25-30	31-35	36-40	41-45	45-50	51+
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##### 1.2. Are you a man or a woman?

Man	Woman
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##### 1.3. Which department do you currently work for?

Mining (O/E)	Production (O/P)	HR	Engineering	Security	Administration
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##### 1.4. What is your Patterson band (scale)?

B	C	D	E
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##### 1.5. What is your highest qualification?

STD 8	STD 10	STD 10 + Trade Certificate	STD 10 + Diploma	B-Tech Degree	Honours Degree and above
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##### 1.6. Which of these best explains your current position?

Manager	Supervisor	Team leader	Union Rep/ Shop Steward	Employee
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**1.7. Which of the following describes your current relationship?**

Single	Married	Regular Boyfriend/Girlfriend	Divorced	Married with Boyfriend/Girlfriend
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**1.8. Which best describes your current health status?**

HIV Well	Infections/Illnesses	Tired and ill	Almost always ill
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**1.9. When were you first diagnosed?**

Past 3-6 months	A year ago	More than 2 years ago
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**1.10. When you received your HIV diagnosis, indicate which of the feelings below best describes your emotional reaction (Mark appropriate answer with an X)**

	YES	NO
Shock		
Anger		
Guilt		
Sadness		
Wish to die		
Helplessness		
Fear of rejection		
Fear of loss of control		
Fear of pain		
Uncertainty		

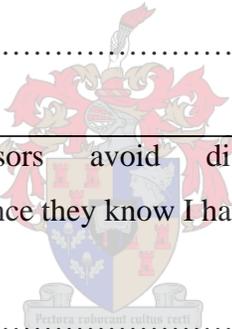
## Section 2: Social and Emotional Aspects of HIV/Aids

The following set of questions asks about some of your feelings, opinions and emotions. Kindly mark the letters that go with your answer. There are no right or wrong answers, feel free to write comments as you go through the questions. Please do your best to answer each question.

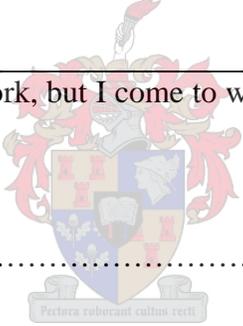
Strongly Disagree (SD)    Disagree (D)    Can not Say ( C)    Agree (A)    Strongly Agree (SA)

	SD	D	C	A	SA
2.1. In my work environment no one knows that I have HIV .....	SD	D	C	A	SA
2.2. Sometimes I feel guilty that I have HIV .....	SD	D	C	A	SA
2.3. Telling someone at work I have HIV is risky .....	SD	D	C	A	SA
2.4. People with HIV lose their medical privacy at work once they disclose their status .....	SD	D	C	A	SA
2.5. It is easy to avoid my work colleagues than worry about telling someone I have HIV .....	SD	D	C	A	SA

2.6. I worry that my supervisors may judge me when they learn I have HIV .....	SD	D	C	A	SA
2.7. I feel I am not as good an employee as others because I have HIV .....	SD	D	C	A	SA
2.8. Since learning that I have HIV, I feel set apart and isolated from the rest of the workforce .....	SD	D	C	A	SA
2.9. Some seniors/ supervisors avoid discussing my performance/future opportunities once they know I have HIV .....	SD	D	C	A	SA
2.10. I care about my work performance regardless of my HIV status .....	SD	D	C	A	SA
2.11. Since learning I have HIV, I worry about my performance at work .....	SD	D	C	A	SA
2.12. Some work colleagues who know/suspect I have HIV have					



<p>grown more distant</p> <p>.....</p>	SD	D	C	A	SA
<p>2.13. Colleagues have told me that future work prospects are minimal because of my current health conditions</p> <p>.....</p>	SD	D	C	A	SA
<p>2.14. When my seniors/supervisors learn that I had HIV, they will look for flaws in my character</p> <p>.....</p>	SD	D	C	A	SA
<p>2.15. Sometimes I feel too ill to work, but I come to work for fear of losing my job</p> <p>.....</p>	SD	D	C	A	SA



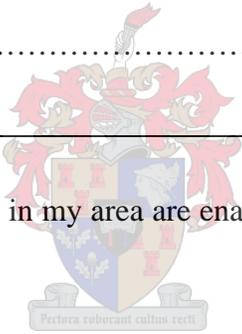
### Section 3: Work Relations Impact

The following set of questions asks about some of your experiences, feelings and opinions on your work environment. Kindly mark the letters that go with your answer. There are no right or wrong answers. Please do your best to answer each question.

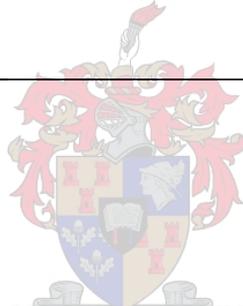
Strongly Disagree (SD) Disagree (D) Can not say ( C) Agree (A) Strongly Agree (SA)

	SD	D	C	A	SA
3.1. My current work environment encourages me to do my best and perform .....	SD	D	C	A	SA
3.2. I feel free to talk to my supervisor when and if necessary .....	SD	D	C	A	SA
3.3. I am usually given credit for work well done .....	SD	D	C	A	SA
3.4. I am currently a motivated employee .....	SD	D	C	A	SA
3.5. I am doing something worthwhile in my job .....	SD	D	C	A	SA
3.6. I feel appreciated by my company regardless of my status					

.....	SD	D	C	A	SA
3.7. I have the opportunity to participate in all decisions that affect my work regardless of my HIV status .....	SD	D	C	A	SA
3.8. I want to continue to work for the company as long as I can .....	SD	D	C	A	SA
3.9. My section's management is interested in my well-being .....	SD	D	C	A	SA
3.10. The physical work conditions in my area are enabling me to do my job .....	SD	D	C	A	SA
3.11. I trust and respect my supervisor .....	SD	D	C	A	SA
3.12. My supervisor helps me with problems that occur in my job .....	SD	D	C	A	SA
3.13. My supervisor regards me as a valuable member of the team	SD	D	C	A	SA



.....					
3.14. I trust and respect my supervisor .....	SD	D	C	A	SA
3.15. My personal development is important to my supervisor .....	SD	D	C	A	SA
3.16. I am satisfied with my current job .....	SD	D	C	A	SA



**END OF QUESTIONNAIRE**

**THANK - YOU**