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Leadership of Organisational Change in Successful HIV/AIDS Workplace Interventions

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Abstract

It is essential that business responds to the threat presented by HIV/AIDS, not only for economic sustainability, but for the sustainability of society at large. Consequently, the National Strategic Plan for HIV & AIDS and STIs for 2007- 2011 has called for the private sector's involvement in a multi-sectoral response. This research set out to validate the premise that strong and decisive leadership of large scale organisational change is required for a successful business response. The research also sought to identify the reasons for the change and the power bases employed.

The research was undertaken in two phases. Ten experts in the HIV/AIDS field were consulted to determine a judgemental sample of ten companies with successful HIV/AIDS workplace interventions. In-depth interviews were conducted with the manager responsible for HIV/AIDS at each company. The interviews were structured around organisational change, leadership and power base theories.

The change efforts were found to be motivated by a combination of a moral obligation and humanitarian conscience, and a persuasive business case. That large scale change was indeed required was only realised post event. The output of this research culminated in a model that can be applied in organisations that have implemented, or intend to implement, HIV/AIDS workplace interventions. The model illustrates the elements which have proven successful in HIV/AIDS workplace interventions. It comprises nine stages of change - four dimensions of the strategy for change and four factors that influence change and the leadership thereof.

Commitment from the most senior leadership in the organisation was identified as a prerequisite for success, with nine out of ten CEOs being mentioned by name with their contributions acknowledged. It was found that of the five power bases, Legitimate and Expert power were most commonly leveraged and that the use of Coercive/Punitive power to gain compliance was inappropriate in this context.

Declaration

I declare that this research project is my own work. It is submitted in partial fulfilment of the requirements for the degree of Master of Business Administration at the Gordon Institute of Business Science, University of Pretoria. It has not been submitted before for any degree or examination in any other University. I further declare that I have obtained the necessary authorisation and consent to carry out this research.

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Richard Alexander Douglas

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13th November 2008

Dedication

This research is dedicated to the families of my late friends Lulu Molobela and “Maybe” Kagongwe Khumalo, who, were it not for the ignorance around HIV and the awful stigma it wrongfully attracts, would still fill my life and the lives of others with love and laughter.

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1. Chapter 1 – Introduction to Research Problem

1.1. Introduction

South Africa has more HIV positive people than any other country on Earth. “The estimated 5.7 million [4.9million–6.6 million] South Africans living with HIV in 2007 make this the largest HIV epidemic in the world” (UNAIDS, 2008, p.40). In Africa, where an estimated twenty-eight million people are living with the HI Virus, the situation is dire. “Sub-Saharan Africa remains most heavily affected by HIV, accounting for 67% of all people living with HIV and for 72% of AIDS deaths in 2007” (UNAIDS, 2008, p.5). By 2010, 5.5 million people would have died from AIDS in South Africa alone (Bureau for Economic Research (BER), 2006).

The International Labour Organisation (ILO) (International Labour Conference, 2008) points out that the workforce is placed at increasing risk, with the epidemic disproportionately affecting people during their most productive years. The sustainability of the market is also at stake, as when people get sick they cease to be economically productive, they do not generate income and the little disposable income they have is spent on healthcare, with very little left to be spent on products and services. Consequently the private sector suffers from a dual blow of an under skilled workforce as well as a dwindling market. Njobe and Smith (2004) clearly articulate that business vulnerability and increased costs from the disease is unquestionable.

Business has no choice but to respond, which demands effective leadership of planned, comprehensive, organisational change initiatives that address HIV/AIDS in the workplace. In fact, leadership was the theme for World AIDS day in 2007, and ironically, ineffectual leadership and the lack of coordination in the response to the pandemic from both the public and the private sector have been cited as the primary causes for South Africa having the most severe HIV epidemic in the world, with the sixth highest prevalence (AIDS Foundation of South Africa, 2008).

The issue of HIV/AIDS has been examined at length in medical and scientific studies as well as economic studies, punctuated with copious statistics. Numerous studies have also been done on workplace programmes and the necessary elements of such. What has been absent is an empirical, behavioural study into organisational change and the leadership thereof and the requirements for this to be successful.

Goss, Pascale and Athos (1993) suggest that successful organisational change is not about changing what is, but rather about reinventing a new future. The future South Africa needs is one without the burden of AIDS. If business leaders champion large scale organisational change they can change the trajectory of South Africa's, and in fact the sub-continent's, HIV/AIDS crisis. "True leaders will avoid being lulled into complacency and instead will pursue evidence informed policies and programmes to reduce the epidemic's long-term toll" (UNAIDS, 2008, p.193).

1.2. Research Problem

Problem Definition

The challenge that presents itself is best summed up in the Millennium Development Goal 6, which provides that by 2015, the world will have halted and begun to reverse the global HIV epidemic (UNAIDS, 2008). South Africa, with the highest prevalence in the world, needs to address the crisis through an effective multi-sectoral response (NSP, 2007). Business is clearly an important role player, but to date the interventions undertaken by the South African business community have been inadequate. The approach has been unstructured and confused (Financial Mail, 2005). Some businesses however have intervened successfully. "There are companies with world class programmes, which contribute to the national effort in the fight against HIV/Aids" (Ngozwana in Mzolo, 2006, p.3).

How they achieved this and whether it can be attributed to the effective leadership of organisational change is the subject of this research. The research also examines the reasons for embarking on the change interventions and the power bases used in getting the organisation to comply.

1.3. Research Motivation

The impact of HIV/AIDS is pervasive in the South African community. The inevitable outcome, if an individual's status is ignored or unknown, is devastating. Worse still, the thought of someone dying of AIDS in the present day with the advent of effective Antiretroviral Therapy (ART), is both desperate and infuriating in its futility. Pursuant to the literature review for this topic, the researcher established that there is little documented about organisational change interventions in the response to the HIV/AIDS crisis, which provided the motivation for exploratory research into leadership of organisational change around HIV/AIDS. In addition, a practical motivation comes from the NSP's (2007, p.68) call for a multi-sectoral response. Leather, in UNAIDS (2008), says that the majority of people who are HIV-positive are at work, so the workplace is the ideal place to respond to HIV and AIDS.

It would bode well for the South African situation if more companies embraced the issue the way De Beers have, as the statement below illustrates:

> "In the face of this overwhelming reality, De Beers is committed to engaging with the challenge of managing HIV/AIDS in the workplace as an operative risk. We believe that the magnitude of this challenge calls for a concerted and coordinated effort in which the skills and resources of all key players - government, labour, business and civil society - are marshalled, inspired and led. Millions of lives literally depend on this collaboration and leadership" (Dickinson, 2006, p. 2).

Bloom in Taback (2006) indicates that it is the business approaches to HIV/AIDS that can actually take the epidemic out of the shadows, which is where it thrives, and present it out in the open so that it can be dealt with. This is supported by Roedy who feels that “HIV and AIDS is the defining moral issue of our time and businesses must play a critical role in the fight against the global spread of the epidemic. The business community is uniquely positioned to use our influence, resources and leadership to challenge stigma, promote prevention and facilitate treatment. There is no choice, no option. We must all be engaged and mobilized” (Taback, 2006, p.1).

The macroeconomic impact of HIV/AIDS on South Africa needs to be urgently addressed (BER 2006). “Using standard economic models, the best available evidence suggests that HIV is likely to reduce economic growth in high-prevalence countries by 0.5% to 1.5% over ten–20 years” (Piot in UNAIDS, 2008, p.23.) Njobe and Smith’s research (2004) places HIV/AIDS at its worst between 2009 and 2011.

The national prevalence is estimated to be 18.8%, and in terms of industry sectors the following prevalences have been reported:

Retail	10.5%
Agribusiness	23.7%
Manufacturing	14.0%
Media	10.2%
Utility	11.7%
Mining	23.6%

(UNAIDS, 2008, p.173)

The business sector urgently requires information and tools in order to be equipped for an effective response, which includes best practice methodologies for implementation as well insights into organisation behaviour. Revealing the critical success factors in interventions that are effective will provide this much needed information. Connelly

(2006) points out that few SMEs have actually implemented HIV/AIDS policies. The BER survey (Ellis and Terwin, 2005) showed that 77% of the mines, but only 58% of the financial services companies and a mere 50% of the manufacturers surveyed, have an HIV/AIDS policy in place. This would indicate that they could not possibly have effective workplace programmes in place. Davis (2005) rightly asks the crucial question – what is business' responsibility and why?

The World Economic Forum's annual Executive Opinion Survey (Porter and Schwab, 2007) measures the competitiveness of 131 countries in order to assist governments and other stakeholders to identify obstacles to economic growth. The South African business impact of HIV is one of the worst in the world, at 129th out of 131 economies. Interestingly, South Africa's best rankings are for strength of auditing and reporting standards (6th) and efficacy of corporate boards (4th). This prompts the need for HIV/AIDS targets to be made Key Performance Indicators for corporate boards, for standards to be promulgated and reporting on the standards made mandatory. Consequently, the impact on HIV/AIDS by business should improve.

Leather in UNAIDS (2008) says that although employers are now much more responsive to HIV issues than previously, workplace policies are not always implemented. "Some employers are responding, but others are not", he says. "They believe it is not their responsibility, they believe it is the responsibility of the health system or somebody else" (UNAIDS, 2008, p.173). The purpose of this research is to equip businesses, and in particular business leaders, with best practice organisational change methodologies and interventions around HIV/AIDS by illustrating those that have proved successful to date.

Insufficient literature is available on the role of business HIV/AIDS workplace interventions. The researcher's contribution to the body of knowledge in this area will, in part, address this deficit.

1.4. Research Scope

This research was limited to business' workplace HIV/AIDS workplace interventions in the broader context of the multi-sectoral strategic plan to address the crisis. Only successful interventions were considered. Within the context of successful interventions, only the leadership of change by senior management will be researched. The leaders concerned must have been responsible, in whole or in part, for championing the cause of HIV/AIDS in their respective businesses. The study was limited to large enterprises in the South African economy, across industry sectors. The population consists of profit-oriented businesses only; all other sectors fall outside the scope of this research. The research is not concerned with general Corporate Social Responsibility (CSR) initiatives but rather with internal HIV/AIDS workplace interventions.

2. Chapter 2 –Literature Review

2.1. Introduction

The literature review covers literature on HIV/AIDS addressing the current status of the epidemic, the imminent threat it poses to the country, the implication this has for business and the expectations and requirements placed on business in terms of a response. Literature surrounding theories of organisational change and the leadership thereof, the reasons therefore and the power bases that may be used, were also reviewed extensively. Broadly, these theories focus on the seminal work of:

- Beer and Nohria (2000) — The theory of change applied
- Kotter (1996) — The stages of organisational change undergone
- French and Raven (1959) — Power bases employed in the leadership thereof

2.2. HIV/AIDS – Situation Analysis in Africa and South Africa

The reality of the HIV/AIDS epidemic in South Africa presents both a social and an economic threat. According to the United Nations Development Programme (UNDP), HIV has inflicted the “single greatest reversal in human development” in modern history (UNDP, 2005). “In the countries most heavily affected, HIV has reduced life expectancy by more than 20 years, slowed economic growth, and deepened household poverty. In sub-Saharan Africa alone, the epidemic has orphaned nearly 12 million children aged under 18 years” (UNAIDS, 2008, p.13). The statistics are dire. “The estimated 5.7 million [4.9million–6.6 million] South Africans living with HIV in 2007 make this the largest HIV epidemic in the world” (UNAIDS, 2008, p.40)

A revitalisation of the response to HIV/AIDS globally is evident as supported by the UN Member States who, in 2006, reaffirmed the pledges made at the 2001 Special

Session, where they committed to taking extraordinary action to move towards universal access to HIV prevention, treatment, care, and support by 2010 (UNAIDS, 2008). This has placed a burden on business to play its part.

2.3. HIV/AIDS - The Threat to South African Businesses

Nattrass (2004) states that the AIDS pandemic in Southern Africa is not only a major public health crisis, but also a threat to economic development and social solidarity. Retarded economic development will perpetuate the crisis of unemployment and poverty in South Africa. The productivity of the workforce is rapidly declining with commerce and industry in desperate need for skills. “The HIV/Aids epidemic is increasingly being recognised as a serious threat to productivity and profitability by South African companies. Increased labour costs, changes in consumer spending and changes in the economic environment in which South African companies operate will have to be addressed by business if they are to survive the impact of the disease” (Mzolo, 2006, p.3).

The National Strategic Plan for HIV & AIDS and STIs (NSP) (2007) has called for a multi-sectoral response that requires business to play a major role in combating the disease. Jelley in Mzolo (2006) criticises the corporate response as often being a brand promotion exercise, with the actual outcome of any intervention considered less important than the perception and marketing of the benefits available to staff and their families. A real indictment is raised by Davies in Bloom, “The stark message from the Executive Opinion Survey is that businesses are doing too little, too late, in the battle against HIV/AIDS” (Bloom, Bloom, Steven and Weston, 2006, p.6).This is changing in South Africa with the business response to HIV/AIDS increasingly being understood to be an operational imperative. The BER’s survey (Ellis and Terwin, 2005) highlights the economic reality of HIV/AIDS in South Africa:

- Higher labour turnover
- Loss of experience, knowledge and skills
- Increased recruitment and training
- High absenteeism

The private sector faces mounting direct and indirect costs as a consequence of the unchecked pandemic. Medical and benefit payouts will increase, productivity will decrease as absenteeism and on the job morbidity continue to climb, cohesion in the workplace will deteriorate and knowledge and experience will be lost as people reach the stage where they are incapable of work and eventually die (Njobe and Smith, 2004). Business requires a clearer picture of how these costs, both quantitative and qualitative, can be mitigated by an effective programme. Njobe and Smith (2004) have documented the benefits that are realised when an effective programme is in place: The following table acts as a summary:

Table 1: Benefits of Successful HIV/AIDS Workplace Interventions (Njobe and Smith, 2004)

Costs – Direct and Indirect	Impact
Funeral Costs	Decrease
Death Benefits	Decrease
Vacant job positions resulting in lost profit	Decrease
Training Costs	Decrease
Salaries to staff in training	Decrease
Absenteeism	Decreases
Sick Leave	Decreases
On the job morbidity	Decreases
Morale	Increases
Motivation	Increases
Concentration	Increases
Skills pool	Increases
Teams stay together longer	
Schedules aren't disrupted	
Workforce discipline is maintained	

In the absence of interventions by South African business, the country will be reduced to a dysfunctional community with a disproportionate number of children, child-headed households and the elderly. Working age adults will essentially disappear. The market and a productive workforce that supports it will be dramatically eroded.

Cowlin in Dickinson (2006, p.38) states that "Today HIV and AIDS should really be regarded as a manageable chronic disease that can be treated cost effectively within a disease management programme." He notes "that the survival rate of patients who register with the programme when their CD4 count is 350 or higher is 98% over a 36 month period". The sooner companies can get their workforce educated on HIV/AIDS fundamentals, tested and onto treatment where necessary, the sooner they will benefit from lower absenteeism, higher workplace morale, improved and sustained skills transfer and the factors that would usually be expected in the absence of the burden of AIDS.

2.4. Factors that Constitute Successful Interventions by Business

The key theme surrounding the national response to HIV/AIDS is a coordinated, multi-sectoral response. Particularly with regard to interventions undertaken in South Africa, the UNAIDS country situation analysis (2008) states that these policies and interventions have not stemmed new HIV infections. In reality interventions to date have not produced adequate inroads into prevention, treatment and education.

Dickinson (2006) purports that a company's intervention will be considered successful if it has positive outcomes with regard to, *inter alia*:

a. A complete situation analysis

b. HIV/AIDS policy and procedures

c. Project plan targets and objectives

d. Effective information, education and communication

e. High proportion of staff undergoing voluntary counselling and testing (VCT)

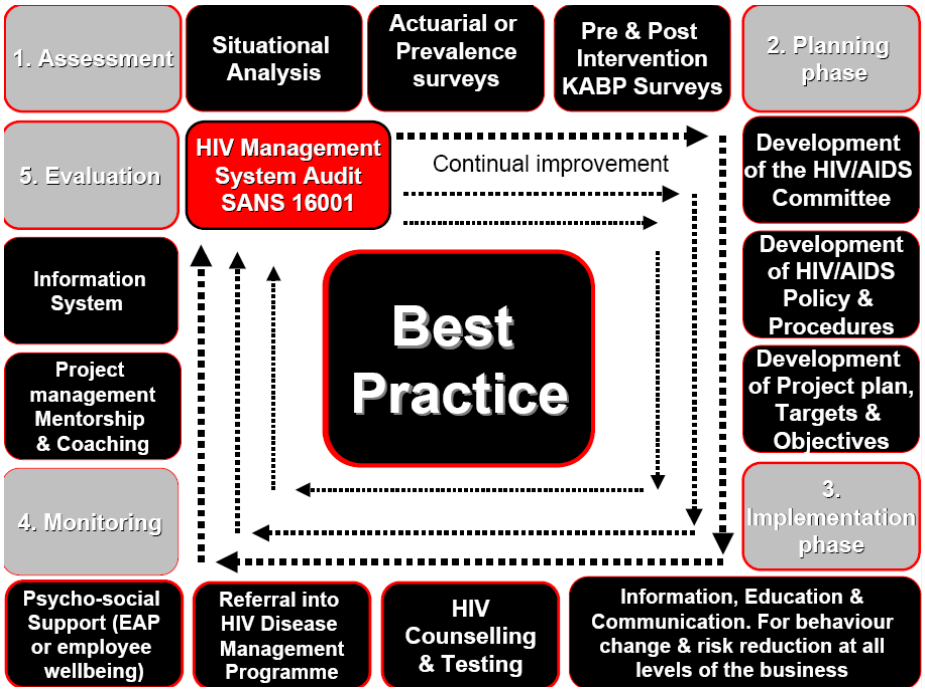
f. HIV disease management programme

g. Psycho-social support

h. Ongoing monitoring and evaluation

The figure below developed by Smith (2008) depicts graphically the various elements of a successful HIV/AIDS workplace intervention.

Figure 1 HIV/AIDS Policy – Best Practice (Smith, 2008).



What is evident, as researched by Cowlin in Dickinson (2006), is that we have been able to unequivocally show that companies that take an enlightened disease management approach to managing HIV and AIDS can reap the benefits of years of

productive service from HIV and AIDS positive employees. The survival rate of patients who register with the programme when their CD4 count is 350 or higher, is 98% over a 36-month period. However, the survival rate of patients who register with a CD4 count of less than 50 (full-blown AIDS) drops to 66% over the same time frame. In the worst case scenario, where patients with full-blown AIDS do not receive anti-retroviral therapy (ART), the survival rate at 24 months is zero. This supports the global consensus around the efficacy of treatment programmes. The statistics show that ART works, of this there is no question. When companies institute successful HIV/AIDS workplace interventions they will be able to maintain healthy and productive workforces.

2.5. Organisational Change

"The brutal fact is that about 70% of all change initiatives fail" (Beer and Nohria, 2000, p133). It is quite possible that HIV/AIDS workplace interventions have failed not because the objects of the programmes were in any way deficient or inappropriate, but because the approach to the change was wrong. Kegan and Lahey (2001) point out that there are employees who just won't change, and speak of a resistance to change that must be overcome.

This research looks at successful HIV/AIDS workplace initiatives as large scale organisational change interventions and it demonstrates how the principles and practice of organisational change can be used to ensure the ultimate success of such interventions. Knowing the outcomes required from an intervention is only part way to a solution (Cummings and Worley, 2005; Kanter, Stein and Jick,1999; Kotter, 1996; Covin and Kilmann, 1990). Engineering and realising the changes that result in those outcomes is crucial. For this reason the research aims to elucidate the critical elements of a successful change intervention. It is often in retrospect that one can identify the

success factors of change. Burke (2002) asserts that the change that occurs in organisations is for the most part not planned and most of it is gradual and evolutionary.

Three theory bases have been used, namely change strategies as described by Beer and Nohria (2000), Kotter's (1996) eight stages of successful organisational change and finally French and Raven's (1959) power bases. These are reviewed below in conjunction with additional literature on each topic.

2.5.1. Change Strategies

Beer and Nohria (2000) purport three change strategies. Theory E change is a hard approach to bringing about change and is largely economically driven, in contrast to Theory O change which is a soft approach focused on developing corporate culture and human capability through individual and organisational learning. In the past change was either: quickly create economic value for shareholders or patiently develop an open, trusting corporate culture long-term. What has emerged is the value of combining the "hard" and "soft" approaches. A combination of Theory E and Theory O change is common practice and often results in the most effective change, often accompanied by "big payoffs in profitability and productivity" (Beer and Nohria, 2000). Rousseau and Tijoriwala (1999) have identified three broad reasons for change, in addition to economic reasons, they list quality improvement and self-serving or political reasons as motivators for change.

Beer and Nohria (2000) compare the hard and soft approaches along several key dimensions: goals, leadership, focus, process, reward system and use of consultants. Goals are largely economic based on organisational capability. Leadership is either the "old fashioned way: from the top down" (Beer and Nohria, 2000, 136), or it is getting

employees emotionally committed to improving the company's performance. Theory E's focus is on the "hardware" – the systems and structures, whereas Theory O is focused on building the "software" - culture, behaviour, attitudes and empowering employee teams. Progress is characterised by the achievement of specific targets and dates in Theory E, as opposed to the evolutionary and emergent process of Theory O. Rewards are either primarily financial incentives versus negligible financial incentives. External consultants are used heavily in Theory E and simply facilitate a process of discovery in Theory O (Beer and Nohria, 2000).

"Paradoxical as those goals may appear our research shows that it is possible to apply theories E and O together. The simultaneous use of E and O strategies is more likely to be a source of sustainable competitive advantage" (Beer and Nohria, 2000, p.138). The potential outcome of this joint strategy is best articulated by Norman in Beer and Nohria: "Our number one objective is to secure value for our shareholders and secure the trading future of the business" (2000, p.139).

The research aims to establish which theory, or combination of theories, is consistently more effective in bringing about the change required by HIV/AIDS workplace interventions. As a precursor to the stages of change, it is valuable to know why the change was initiated. The research will demonstrate which findings, across the successful cases, are consistent and whether recommendations can be made on the strength of these findings.

2.5.2. The Process of Organisational Change

Change is a process, fraught with the complexity of human behaviour. Achieving successful change requires a systematic approach. In his seminal work, Kotter (1996)

has listed eight stages that are required, in sequence, for change to succeed. These are presented below:

Establishing a Sense of Urgency:

A thorough understanding of the where the organisation is provides a realisation of the dire position and should be used to generate urgency. It determines what really needs changing (Dickout, 1997) and the magnitude of the threat posed to the organisation increases the likelihood of success of the intervention (Levy, 1986). Complacency prejudices the hope of success in a change intervention. Graetz (2000, p.251) points out that "the personal involvement of senior management signals the level of commitment to change and heightens the sense of urgency for change". Creating a sense of urgency is critical at the outset of a change intervention.

Creating the Guiding Coalition:

Coalitions of leadership, including operational leaders, need to be established and robust in order to overcome inertia in an organisation. Katzenbach (1996) asserts the need for a critical mass of change leaders in the middle of the organisation. Persuading leaders of the need for change in building coalitions is important in change interventions.

Developing a Vision and Strategy:

Vision provides guidance to the future state of the organisation. (Kotter, 1995; Collins and Porras, 1996). The vision and the strategy should be carefully formulated and clear. A leader's ability to articulate a vision is important in mobilising the support and energy for change (Levy, 1986). Vision is a vital ingredient for change. Without it, the initiative could disintegrate into a list of incompatible projects that can take the organisation in the wrong direction or nowhere at all (Kotter, 1995)

Communicating the Change Vision:

Communication of the change vision on an ongoing basis is a critical determinant in success. Cummings and Worley (2005); Kanter, Stein and Jick (1999); Kotter (1996) and Covin and Kilmann (1990), all consider communication of the vision as a critical step in the change process (see Table 3). It is better to over communicate, as the risk of under communicating is far greater as it encourages misinformation (Barnard, 1991). The message must be communicated repeatedly to sustain momentum (Graetz, 2000). “The dream or vision is the force that invents the future” (Kouzes and Posner, 1995, p10).

Empowering Broad-Based Action:

Involve people and overcome the obstacles to change, as the participation of large numbers of people assists in realising the change objectives (Kotter, 1995). Obstacles that prevent broad based participation must be removed. If key stakeholders are not onside, particularly at the middle and lower levels of management, they act as roadblocks to change, impeding the message of the change process to those within their span of control (Graetz, 2000). Kouzes and Posner argue that “grand dreams don’t become significant realities through the actions of a single leader. Leadership is a team effort” (1995, p.11), which involves empowering others. Another factor that reduces participation levels and involvement is described by Buchanan, Claydon, and Doyle as “initiative fatigue which may relate to disillusionment and cynicism in the face of forthcoming initiatives (often introduced at the apparent whim of senior managers)” (1997, p25).

Generating Short-Term Wins:

Short-term or quick wins assist in maintaining momentum and encouraging people, as without them too many people give up. These need to be proactively identified and

actively pursued (Kotter, 1995). Building small successes and gathering momentum can help a programme sustain itself (Holland, 1995; Kotter 1998). The change is energised when tangible benefits are in evidence, therefore tangible accomplishments must be highlighted (Collins, 2001). “Achieve small wins that promote consistent progress and build commitment” (Kouzes and Posner, 1995, p18).

Consolidating Gains and Producing More Change:

Given the credibility afforded by short terms wins, leaders of successful efforts should use this as a platform to tackle even bigger problems (Kotter, 1995). In the comparison that follows, Kotter stands alone on this point, but it is nonetheless a sensible and logical stage to learn from your experience and to use that to produce more change.

Anchoring New Approaches in the Culture:

Change sticks when it becomes ‘the way we do things around here’, and when it seeps into the bloodstream of the corporate body” (Kotter, 1995, p. 67) The change must be embedded in the culture and passed on to the next generation of managers and leaders, which includes the means to ensure leadership development and succession (Kotter, 1996). Kanter, Stein and Jick (1999) refer to reinforcing and institutionalising the change.

Kotter’s (1996) complete framework has been included in Appendix 1. In addition, Kotter (1996) has documented some of the reasons that change initiatives fail. The eight necessary stages are compared to the eight common reasons for failure in Table 2 below. Adjacent is insight into how this is relevant to HIV/AIDS workplace interventions.

Table 2 – Kotter's Relevance to Change Around HIV/AIDS (1996)

Required Stage (Kotter 1996)	Common cause of failure (Kotter 1996)	Relevance to research
1 Establishing a Sense of Urgency	Allowing too much complacency	"The workplace has become a silent battle ground as employers fail to realise the importance of adopting HIV/AIDS prevention and treatment programmes" (Mzolo, 2006, p. 4).
2 Creating the Guiding Coalition	Failing to create a sufficiently powerful guiding coalition	Piot (2007) illustrates the point "The sobering reality is that we will need to sustain an effective AIDS response over many decades. This will require sustained and exceptional leadership of all of us." This leadership will need the support of senior management.
3 Developing A Vision and Strategy	Underestimating the power of vision	The BER study (2006) reveals that GDP growth could be 0.5 percentage points lower than it would have been in the absence of HIV/AIDS. Leaders need to cast the vision of what the economy will look like with a coordinated intervention. The vision of an economy without the burden of AIDS.
4 Communicating The Change Vision	Under communicating the vision by a factor of 10 (or 100 or even 1,000)	The lead from government, in particular President Mbeki's interventions, resulted in widespread confusion, especially given that he took the dissidents' theory seriously, and was tantamount to under communicating the vision (Nattrass, 2003). Mixed messages, inconsistent communication and conflicting messages, as well as outdated information (especially around cost and effectiveness of treatment) and statistics, also equates to under communicating the vision.
5 Empowering Broad-Based Action	Permitting obstacles to block the new vision	Dissidents like Mbeki present an obstacle, saying that HIV doesn't cause AIDS and other quarters suggesting that it is not worth spending the money (Nattrass, 2003).
6 Generating Short-Term Wins	Failing to create short-term wins	Reddy and Swanepoel (2006) were able to demonstrate that over a two year period treatment costs fell by 30% to 40%. These and other statistics like them should be considered short term wins, supporting the cause for interventions.
7 Consolidating Gains and Producing More Change	Declaring victory too soon	With each change the impetus needs to be maintained to create even more change. "Instead of declaring victory, leaders of successful efforts use the credibility afforded by short term wins to tackle even bigger problems" (Kotter, 1995, p.66).
8 Anchoring New Approaches in the Culture	Neglecting to anchor changes firmly in the corporate culture	Organisation change on HIV/AIDS has to be entrenched in culture in order for behaviour around prevention and the eradication of stigma to be effective.

The work of other authors that outline the necessary stages for organisational change have been reviewed and compared in Table 3. Kotter (1996), describing the sequential process required for effective Organisational Transformation, is compared to Cummings and Worley's (2005) work as well as that of Kanter *et al* (1990) and the

research findings of Covin and Kilmann (1990). Table 3 summarises the organisational change literature to facilitate an easy comparison of the different stages purported by the various authors. In many cases there are common stages identified by all the authors, while some suggested stages required for change are only put forward by one or two of the authors. Each row of information represents similar propositions and/or findings. The greater the number of populated blocks per row, the greater the consensus on the course of action.

There are a number of essential stages required for successful organisational change. Cummings and Worley (2005) and Kanter *et al* (1999) propose ten stages, where Kotter (1996) proposes eight and Covin and Kilmann's (1990) findings can broadly be classified into seven elements required for successful change. The research will reveal whether all these stages are required for a successful HIV/AIDS workplace intervention, which stages are not critical, and whether there are additional stages required that are peculiar to HIV/AIDS interventions.

Activities contributing to Effective Change Cummings and Worley (2005)	8 Steps Kotter (1996)	10 Commandments Kanter, Stein and Jick (1999)	Empirical Findings Covin and Kilmann (1990)
		Analyse the organisation and its need for change	
	Establishing a sense of urgency	Create a sense of urgency	Recognition generally of a strong business-related need for change. It is imperative that people see that there is a definite need for change
Creating readiness for change and overcoming resistance to change		Separate from the past	
Vision - describing the core ideology	Developing a vision and strategy	Create a shared vision and common direction	Creating a shared vision
Constructing the envisioned future activity and commitment planning		Craft an implementation plan	The preparations and diagnosis are critical to success, thoughtful planning is required
Political - assessing change agent power identifying key stakeholders and influencing stakeholders	Empowering broad-based action	Line up political sponsorship	Encouraging employee participation. Involving employees from every part of the organisation. Soliciting commitment and visible support
	Generating short-term wins		
			Reward for change – rewards need to be linked to the desired change and they need to be consistent and occur in a timely manner

Table 3 – Tabular Comparison of Steps Required for Ef  **hange**

Activities contributing to Effective Change Cummings and Worley (2005)	8 Steps Kotter (1996)	10 Commandments Kanter, Stein and Jick (1999)	Empirical Findings Covin and Kilmann (1990)
Providing resources for change .			Make sure adequate resources are available for implementation and that there is adequate time for implementation
Building a support system for change agents		Develop enabling structures	
Developing new competencies and skills			
Communicate to overcome resistance to change	Communicating the change vision	Communicate, involve people, and be honest	Communication to be constant and broad based Communication of the programme goals and activities Communication of success stories from the change Frequent meetings for evaluation of the programme
	Consolidating gains and producing more change		
Reinforcing new behaviours	Anchoring new approaches in the culture	Reinforce and institutionalise the change	
Staying the course			

2.5.3. Power Bases

Power is a natural process in any group or organisation, however one needs to know how it is acquired and exercised in order to fully understand organisational behaviour. Understanding how power works enables one to be a more effective manager. (Robbins and Judge, 2007). Power refers to a capacity that A has to influence the behaviour of B so that B acts in accordance with A's wishes (Bass, 1990). There are a number of power bases, probably best described by French and Raven (1959) in their seminal work on social power bases, where they use a five fold typology for the various power bases that leaders have at their disposal:

Reward power - the ability to reward employees. People comply because doing so produces positive benefits. The benefits can be financial: incentives, pay or raises or non-financial: recognition or promotion, or better work assignments.

Coercive/Punishment power - expectation on the part of the employee that they will be punished by the leader if they fail to conform to the influence attempt. This is in fact the opposite to reward power (Robbins and Judge, 2007). It is based on the fear that something negative might occur if one fails to comply. This could include ridicule, exclusion, demotion or an inferior pay rise.

Legitimate power - the legitimate right to influence the employee where the employee has an obligation to accept this influence. The power is by virtue of one's structural position and one's authority within the hierarchy of the firm. Legitimate power is usually accompanied by an acceptance by members of the organisation of the authority of the leader's position.

Expert power - the extent of the knowledge or perception that the employee attributes to the leader within a given area. This is largely as a result of the leader's special skill,

expertise or knowledge. Expertise has become one of the most powerful sources of influence in the world (Robbins and Judge, 2007).

Referent power -,this has to do with admiration and respect. If I like, respect and admire you, you can exercise power over me (Robbins and Judge, 2007). It is the identification of the employee with the leader - the stronger the identification of the employee with the leader the greater the referent power of the leader over the employee.

Robbins and Judge divide power into formal power and personal power, with the formal powers being Reward power, Coercive power and Legitimate power. The personal powers are Expert and Referent power. Yukl (2006) proposes guidelines for using just three of French and Raven's powerbases: legitimate authority, reward authority and coercive power.

One of the major aspects of organisational change is power that leaders use to bring about the required change. The seminal work of French and Raven (1959) still stands - in order to get the organisation to comply with the change initiatives certain power bases or a combination of power bases must be employed. The research aims to reveal which power bases are more effective in soliciting the support of the organisations' employees. In addition, should any power bases prove to be wholly unsuccessful in producing the change, this will prove to be a valuable insight.

2.6. Leadership of Organisational Change

Piot (2007), in his speech to the international women's summit regarding HIV prevention and treatment, purported stronger and sustained leadership as the pre-eminent challenge with regard to HIV/AIDS on the African continent. In the South African context it would be appropriate for business leaders to follow the example set

by past president Nelson Mandela, who took the lead by disclosing that his son Makgatho died due to Aids-related factors. He has shown the way to South Africans struggling to break the stigma that still surrounds the disease in the country (South Africa Info, 2005). In particular, business leadership and senior management are being called to shoulder this responsibility. Whiteside and Sunter (2000) have stated that "this is a management and strategic issue."

Yukl (2006) says that one of the most important and difficult leadership responsibilities is leading change. Effective change requires certain skills and leadership styles. The leadership of change is a shared process involving different leaders at different levels (Shrock, 2004). Although top level involvement is essential to organisational change, the real change leaders, who affect how the majority of the people perform, come from middle and frontline managers (Katzenach, 1996).

Leaders, particularly narcissistic ones, often exhibit an intense desire to compete, while successful managers want to be winners (Maccoby, 2001). This can be used to the organisation's advantage in change interventions, by leveraging the fact that people are naturally competitive and that competition focuses people on goals. "People are naturally competitive; use that to your benefit as well. Competitive urges are part of instinct" (Davenport and Beck, 2001, p94).

2.7. Conclusion

The statistics in the review thus far are clear; HIV/AIDS presents a undeniable threat to our economy and society. With South Africa hardest hit, the response to the epidemic needs to be all the more rigorous. Nattrass (2004) points out that this goes beyond a health crisis and threatens economic development and social solidarity. Business has a vested interest in succeeding in the fight against HIV/AIDS, however to date they have contributed too little too late (Bloom *et al, 2006)*.

The premise of this research is that business' responses must transcend policy and programmes and embody large scale organisational change. The fact that over two thirds of change initiatives fail (Beer and Nohria, 2000) provides insight into the extent of the effort required for the success of an HIV/AIDS workplace intervention. Change is preceded by the reason for change, which is examined using the work of Beer and Nohria (2000) on Change Strategies. Is the change economic or based on organisational capabilities, or is it a combination of both?

The process of change and the leadership thereof is analysed using the seminal work of Kotter (1996) and supporting literature on the stages of the change process. It is widely accepted that a number of crucial stages, anywhere between seven and ten, are required in a change intervention to succeed. Leadership is of paramount importance and spans the whole change process. Piot (2007) calls for stronger and sustained leadership in this area, and yet Yukl (2006) points out that leading change is one of a leader's most difficult responsibilities.

French and Raven's (1959) power base theories are used to understand how power is used in an organisation to achieve the outcomes targeted. Here five power bases divided into formal power and personal power are used to understand this dimension of the change interventions, particularly surrounding HIV in the workplace.

3. Chapter 3 – Research Questions

From the literature review, three research questions have been developed. Broadly the questions relate to why companies decide to embark on HIV/AIDS workplace interventions. This topic is evaluated using Beer and Nohria's (2000) seminal work on the types of change. The stages required in the change process are then evaluated and compared to the eight steps that Kotter (1996) asserts are necessary for successful change. Finally, the power bases used to effect the change are considered in the light of French and Raven's (1959) influential work.

3.1. Research Question 1

Beer and Nohria (2000) refer to Theory E and Theory O change. Did the strategy for the successful HIV/AIDS workplace interventions exhibit Theory O or E change, or a combination of Theory O and E characteristics?

3.2. Research Question 2

Kotter (1996) advocates that eight stages, executed in sequence, are required for change to be sustainable. Did any or all of these stages, or any other possible stages, contribute to the success of the HIV/AIDS workplace intervention?

a) Did the leaders create sufficient urgency around the HIV/AIDS workplace intervention?
b) To what degree did the leaders utilise guiding coalitions?
c) How important was the development of a vision and a strategy for the organisation's HIV/AIDS intervention?
d) Did the leaders communicate the change vision and to what degree?

e) Were all members of the organisation empowered to take action in the fight against HIV/AIDS?

f) What role do short term wins play in bringing about a positive and sustained HIV/AIDS workplace intervention?

g) Did demonstrating the success of programmes build momentum and result in more change?

h) Were the initiatives anchored in the culture?

i) Were there any other relevant stages that can be identified?

3.3. Research Question 3

French and Raven (1959) refer to five power bases: Reward power, Coercive/Punishment power, Legitimate power, Expert power and Referent power. Which power bases were employed in the leadership of the organisational change required by the HIV/AIDS workplace intervention?

4. Chapter 4 – Research Methodology

The research design was qualitative and of an exploratory nature (Zikmund, 2003). Qualitative research attempts "to answer questions about the complex nature of phenomena, often with the purpose of describing and understanding the phenomena from the participants' point of view" (Leedy & Ormrod, 2001, p101).

This section describes the research method used. The research was undertaken in two phases, with the first phase involving interviewing ten experts in the field of HIV/AIDS to enable the researcher to identify the ten companies that were later used as the main sample for the research. In the second phase, in-depth interviews were conducted with the ten leaders responsible for the workplace interventions at the ten companies selected. They were interviewed in order to determine the critical success factors of leadership of organisational change in HIV/AIDS workplace interventions.

4.1. Phase 1 – Identifying Ten Companies That Are Acknowledged To Have Had Successful HIV/AIDS Workplace Interventions

4.1.1. Population

Zikmund (2003) describes population as any complete group that shares common characteristics. The population of relevance for this phase of the research consists of all experts in the field of HIV/AIDS from various sectors including government, NGOs, business, academia and the media. The individuals in the population need to be active in the field of HIV/AIDS and their opinions and perceptions would be widely acknowledged as being credible.

4.1.2. Unit of Analysis

The unit of analysis was the expert's perceptions of organisations and individuals that have led successful HIV/AIDS workplace interventions This was based on their exposure, familiarity and interactions with companies that have HIV/AIDS workplace interventions. It is important to mention that no formal models were used to evaluate whether the intervention was successful; this would require an independent study. Given the nature of the judgemental sampling method the unit of analysis was deemed to be sufficient.

4.1.3. Sampling Method and Size of Sample

"Judgement, or purposive, sampling is a non-probability sampling technique in which an experienced individual selects the sample based on his or her judgement about some appropriate characteristic required of the sample members. The researcher selects the sample to serve a specific purpose, even if this makes a sample less than fully representative" (Zikmund, 2003, p382). A sample of ten people was drawn on this basis, and these ten experts then identified the ten companies who formed the sample for the main study. Elements of snowball sampling in the selection of the sample was evident in that every individual consulted recommended others who they felt qualified as experts in the field.

The final sample of experts comprised:

1.	Alexis Apostolellis	HIV/AIDS research and consultancy
2.	Brad Mears	CEO of the South African Business Coalition on HIV/AIDS (SABCOHA)
3.	Brian Brink	Corporate health practitioner and lecturer on HIV/AIDS
4.	Dale Jackson	HIV/AIDS research and consultancy
5.	David Dickinson	Academic, HIV/AIDS research
6.	Elaine McKay	Corporate health practitioner

7. Linzi Smith	HIV/AIDS workplace standards and best practice consultant
8. Margie Sutherland	Academic, HIV/AIDS Research
9. Tracey Webster	HIV/AIDS Non-government organisation
10. Verity Hawarden	HIV/AIDS research and lecturer

In Table 4 below the results from the experts interviewed are presented. The names of the experts have been omitted and only the results are recorded (the numbered list above does not correlate to the results presented below).

4.1.4. Data Gathering

The experts were contacted via email and telephone, with nine of the ten experts being interviewed in person. They were asked which leaders and companies, in their opinion, had successful HIV/AIDS workplace interventions. The discussions also covered the broader scope of the main study and included input around the factors that constitute successful interventions. None of the experts requested that their responses be kept confidential.

4.1.5. Data Analysis

The responses from the experts were tabulated and the frequencies computed and then the companies were ranked accordingly. More than ten companies were identified, however not all of the companies made themselves available for interviews. Table 4 below shows an analysis of the recommendations, and ranks the companies to be selected for the sample, in descending order, according to the frequency with which they were identified by the experts.

Table 4 – Companies Identified as Having Had Successful HIV/AIDS Interventions

Company proposed for Main Study	Expert 1	Expert 2	Expert 3	Expert 4	Expert 5	Expert 6	Expert 7	Expert 8	Expert 9	Expert 10	Total
Anglo American	●	●	●	●	●	●	●	●	●	●	10
De Beers	●	●		●	●	●	●	●	●	●	9
Standard Bank		●	●	●	●	●	●	●	●	●	9
Anglo Coal	●	●		●	●	●	●	●	●	●	8
BMW SA	●	●	●			●	●	●	●	●	8
Mercedes Benz SA	●	●		●		●	●	●	●	●	8
SABMiller		●	●		●		●	●	●	●	7
ESKOM		●					●	●	●	●	5
Sappi		●						●	●		3
Telkom							●				1

4.2. Phase 2 – Main Study

4.2.1. Methodology

In-depth interviews were conducted with the ten leaders that championed the HIV/AIDS workplace interventions at the ten companies that were identified as having been successful. The objective of the interviews was to explore the reasons for the success of the HIV/AIDS workplace interventions in light of the organisational change efforts, the reasons therefore and the leadership thereof.

4.2.2. Population

The population of relevance for this research consists of all business leaders who have championed successful HIV/AIDS workplace interventions in South Africa. It must be noted that this population is not very large. In all the discussions with experts in the field, less than 30 companies were articulated as having had successful workplace interventions. This is in keeping with the point raised in the introduction that to date, the response by business at large to the HIV/AIDS epidemic has been poor (Bloom *et al,* 2006).

4.2.3. Unit of Analysis

The unit of analysis is the business leader's perceptions of what they did, or caused to happen, that contributed to, or resulted in, the success of their company's HIV/AIDS workplace interventions.

4.2.4. Sampling Method and Size of Sample

The sample drawn was ten individuals identified in the first phase of the research (see Table 4), which constituted judgemental sampling (Leedy and Ormrod, 2001). The sample comprises the ten individuals who made themselves available for interview out of all the companies recommended. Access is often a limitation in research of this nature, and the researcher was fortunate that only one company denied access. The companies in the sample represented the following industry sectors; Mining, Telecoms, Automotive Manufacturers, Public Utilities, Food and Beverage, Pulp and Paper and Financial Services. All the companies are large enterprises.

Given that the study only looked at successful interventions, which made the population of relevance very small, it was considered that ten individuals would be an adequate sample. The people that made up the sample were:

Joy Beckett	HIV/AIDS Manager – Operations – De Beers
Brian Brink	Group Medical Consultant – Anglo American plc
Jenni Gillies	GROUP HIV CONSULTANT – SABMiller plc
Natalie Mayet	General Manager - Health and Occupational Medicine - BMW Group South Africa
Ellenore Melrose	Regional Health and Wellness Manager – Sappi
Penny Mkalipe	Chief Medical Officer - Health & Wellness Department – ESKOM
Clifford Panter	Group Health & Safety Advisor – Mercedes-Benz South Africa (Pty) Ltd
Peter Philip	Head of Corporate Health – Standard Bank
John Standish-White	General Manager – Goedehoop Coal Mine – Anglo Coal
Wally Victor	Head SHE Corporate division and Employee Wellness – Telkom

4.2.5. Formulation of the Interview Guide

The interview guide, a copy of which is attached as Appendix 2, was compiled using the three frameworks that form the basis of the research questions. The guide was designed to facilitate a logical flow of thoughts around critical success factors at large, the motivators for change, identifiable steps in the change process and the power bases leveraged to realise the change objectives. At the outset on open ended question was asked so as not to distract the respondent by the constructs of the theory. This was followed by the motivator for change using the work of Beer and Nohria (2000) on Theory E and Theory O change. Kotter's (1996) eight stage process for creating major change was then explored using nine independent questions, and finally the guide covered the five power bases of French and Raven (1959).

In order to establish any critical success factors or obstacles to change not alluded to in the literature, or that may be specific to the case of HIV/AIDS workplace interventions, open ended questions were interspersed throughout the guide. . The in-depth interview results in a considerable amount of qualitative data that is incidental to the questions in the guide. In particular, the very first question was aimed at highlighting any factors which the interviewee deemed as critical in achieving success in the interventions. This was done to eliminate compartmentalising the respondent's thoughts and confining submissions to the theory frameworks alone The researcher wanted to optimise the information gained in this way.

Beer and Nohria (2000) on Theory E and Theory O change was distilled into tabular form that presented three options for each of the six broad categories that Beer and Nohria propose. This facilitated easy capture of the data as the interviewer could only mark one cell on each line of the table. The constructs of the theory were reworded in précis form and the specific subject of an HIV/AIDS workplace intervention was included. Each brief comment was elaborated on during the interview.

Similarly, Kotter's (1996) theory was reworded to bear relevance to the subject of HIV/AIDS workplace interventions and the constructs were reworded in question format in a manner that presented them as easily understandable to the respondents. The constructs that could best be captured on a continuum were designed using a Likert scale and those constructs that were better suited to qualitative discussion on the topic were phrased as open ended questions. A question to ensure completeness was asked at the end of this section, simply asking if there were any other items of relevance that the respondent felt warranted mentioning.

French and Raven's (1959) power bases were investigated using the constant sum scale technique (Churchill, 1986). The five power bases were summarised with key words that the researcher used as prompts to explain each one. This was displayed in a table with a column to record the results. It was anticipated that a combination of power bases would have been used and this allowed the respondent to assign a weighting to each power base in a manner that was not onerous or intimidating.

The guide aimed at soliciting responses from the interviewee that would support or refute the components of the theory. The literature on HIV/AIDS in South Africa, as it relates to South African business in particular, was used in conjunction with the theoretical frameworks to formulate questions that were relevant to the subject matter and that maintained the integrity of the tenets of the theory.

Each element of the theory is covered by at least one question in the interview guide. The guide was generated to prompt open discussion and sharing around the elements of change, leadership and power bases that were relevant to the interventions. The guide was not prescriptive and the researcher was able to provide additional depth and insight into the items in the guide given the broad knowledge gleaned from the literature reviewed. The guide provided structure and completeness with the benefit of ensuring the interviews were completed in the targeted one hour time period.

4.2.6. Data Gathering

A two-phase sampling methodology was undertaken, with ten experts being consulted to establish the companies which, in their opinion, had been successful in their HIV/AIDS workplace interventions. This resulted in a judgemental sample of ten companies for the main study: Anglo American, Anglo Coal, BMW SA , De Beers, ESKOM, Mercedes Benz SA, SABMiller, Sappi, Standard Bank, and Telkom.

The method employed to obtain the data was in-depth interviews (McCracken, 2005). The process involved interviews with the people responsible for the HIV/AIDS workplace interventions, predominantly the heads of the corporate health departments, occupational health departments and wellness departments or dedicated HIV/AIDS managers. The researcher met each individual personally and interviewed them for approximately one hour. A 12 question interview guide was utilised in order to give structure to the interview and to ensure that all the relevant data was ascertained for coding and content analysis post event. Nine of the ten interviews lasted at least an hour; these particular interviews were all conducted in person which provided greater depth and richness in the responses.

An interview guide, designed around the comprehensive literature review, was used to ensure maximum value from the interview process. The questions were made up of open ended questions, questions requiring a rating on a Likert scale, making selections from various options and a constant sum scale technique (Churchill, 1986) was used to solicit the most valuable response from the interviewee. (Interview guide attached as Appendix 2)

4.2.7. Data Analysis

Content analysis was used to analyse the data from the in-depth interviews. Content analysis is a detailed and systematic examination of the contents of a particular body of material. During this analysis, patterns, themes or biases are identified (Leedy and Ormrod, 2001).

In addition to patterns and trends, the consistencies within the sample were considered. The outcomes of this preliminary analysis were then mapped to Kotter's eight stage model in a form of coding. The interview guide was arranged around themes to facilitate easier coding of the data after the interviews were completed. All interviews were recorded on an audio device and, combined with the written notes from the interview, the researcher compiled a table with 34 fields for the coding of the data. These fields included the elements of the theoretical frameworks as well as emergent themes or factors that became evident during the interview process. A list of the descriptive field names are presented in Appendix 3.

The table was split into quantitative items, such as Likert scale scores and data that could be analysed with frequency tables, and into qualitative responses where the richness and depth of the submissions was recorded. Based on the content of the interviewees' submissions, the verbiage was captured in fields which represent themes established through the review of the literature. In addition, miscellaneous fields were used to record themes and content that had not been anticipated in the design of the interview guide or from the review of the literature. It took roughly three hours per interview to capture and code the data and to perform the analysis. The development of the spreadsheet was an iterative process and modifications were made as themes or patterns emerged, changes were made after each interview was captured.

4.2.8. Data Validity and Reliability

Internal validity is “the extent to which the design and the data that it yields allows the researcher to draw accurate conclusions about cause-and-effect and other relationships within the data” (Leedy and Ormrod, 2001). The internal validity of the data was preserved by avoiding leading questions and solicited responses through the discipline of asking open ended questions. External validity is not an objective of exploratory research of this nature as no inference was made to the total population.

4.2.9. Research Limitations

One of limitations that the researcher identified was the size and geographical distribution of the sample. Had time not been a constraint and geography not prohibitive, a countrywide sample would have been targeted. Consequently, the research was limited to a sample concentrated around Gauteng.

Further, only one person at each company, namely the person responsible for the intervention, was interviewed. Undoubtedly they would view their own programmes and successes differently from an impartial observer, which results in response bias (Zikmund, 2003) which is a limitation. A number of stakeholders that may have interpreted the situation differently and whose contributions may have been different are clearly excluded. Had more people been interviewed, a more accurate understanding of what truly happened in the organisation could have been established.

The problem was only looked at from the perspective of Beer and Nohria (2000), Kotter (1996) and French and Raven (1959). This theory is largely concerned with organisational behaviour and organisational development which limits the findings of the research to these fields and cannot shed light on the efficacy of the interventions

from a medical point of view for instance. There are indeed other lenses through which this problem can be viewed.

Aside from the above-mentioned limitations there were no other significant limitations to the research. The nature of problem is such that it promoted collaboration and sharing of information and tools for effectiveness.

5. Chapter 5 – Results

5.1. Introduction

The data was gathered through a process of in-depth interviews with each of the respondents. Notes were taken by the researcher throughout the interview and an audio recording was also made. The interviews were roughly an hour in duration. An interview guide comprising 12 questions structured around the Research Questions was used (refer to Appendix 2). The guide comprised open ended questions, questions requiring a rating on a Likert scale, making choices from various options and a constant sum scale technique was also used.

The notes and transcripts from the audio recordings were collated and captured on a spreadsheet where over 30 fields were populated with data (see Appendix 3 for descriptive field names). At this point themes and trends were identified and combined with the elements of the research questions. Content analysis was undertaken and certain elementary statistics were determined such as frequency distributions, ranges, means and medians.

Questions 1 and 11 (Appendix 2) were open ended questions that aimed to capture any elements of the change that could have been overlooked as a result of the fairly structured interview guide. The responses to these questions have been included in the most appropriate sections of the results presented below. Where the responses constitute something other than the elements of the research questions, these have been reported and analysed at the end under emergent themes and findings. The results presented below begin with Question 2 on the interview guide.

5.2. Change Strategies – Theory E and Theory O Change

Research Question 1: Did the strategy for the successful HIV/AIDS workplace interventions exhibit Theory O or E change, or a combination of Theory O and E characteristics (Beer and Nohria, 2000)?

Theory E change is understood to be motivated by pure economics; the bottom line profit impact of undertaking the change. Theory O change is the converse - it is change that is aimed at improving and enhancing the organisational capabilities of an organisation through focusing on people, their attitudes and behaviours and largely the qualitative or softer issues. Beer and Nohria's (2000) research revealed that in most cases a combination of E and O is evidenced.

In order to get the requisite depth of understanding around the change interventions, Beer and Nohria (2000) have categorised elements of the change into six broad topics: Goals, Leadership, Focus, Process, Rewards, and Use of Consultants. Per category and in aggregate the researcher aimed to establish whether Theory E, O or a combination of the two applied to change required for successful HIV/AIDS workplace interventions.

Question 2 in the interview guide (Appendix 2) was designed to answer Research Question 1, it aimed at establishing the frequencies with which respondents selected Theory E, Theory O or a combination across the six dimensions. The descriptions of the 18 options are presented in Table 5, taken directly from the interview guide with the sum of the actual responses scored against each option is displayed in bold type.

The question had the following precursor:

"There is always an underlying reason for change, a motivator of some kind. This can be purely economic: bottom line, business case, or profit incentive; or it can be a need to address the organisational capabilities of the firm, improved productivity through interventions targeting skills, attitudes and behaviours. Often both are used in combination. I would like to explore which of these it was by looking at the following dimensions that surround change: Goals, Leadership, Focus, Process, Reward systems and the use of consultants."

The objective of this question was to establish whether the change was Theory E, Theory O or a combination of the two. Each category was carefully explained to the respondent, the summary phrases on the guide were used as prompts for the interviewer, and during the interview more information was provided to ensure understanding on the part of the respondent. The three options were then presented and the respondent was asked to select only one item out of each of the three options per category on the table. The results have been totalled and presented below the relevant text in Table 5. The total line for each of the six categories represents the frequency with which that particular option was selected by each of the ten respondents; each line adds up to the maximum of ten.

Beer and Nohria (2000) describe six dimensions of change: goals, leadership, focus, process, reward systems and the use of consultants. The questions in the interview guide solicited separate answers for each of these dimensions and the selections supported either of the two types - Theory E change or Theory O change, or a combination of the two. The highest frequency associated with each type indicates which type was predominantly used in successful HIV/AIDS workplace interventions.

Table 5 – Results of Question 2 – Theory E and O Change

Theory E	Theory O	Combination
Goals		
Were your goals purely financial – not addressing HIV/AIDS would mean that in the long term the company would lose money?	Was your goal to develop a culture that embraces HIV/AIDS and the people affected by it ?	A combination of responding to HIV/AIDS while acknowledging that a failure to do so would ultimately impact shareholder value negatively?
0	**0**	**10**
Leadership		
Manage change from top down – little or no input from managers, employees or the unions?	Encourage participation from the bottom up, including emotional commitment to solving the problem at all levels?	Set direction from the top and engage the people from below?
3	**1**	**6**
Focus		
Emphasis on the physical systems and processes that would achieve the change. Outsourcing where necessary?	Build up corporate culture through a focus on employees' behaviour and attitudes, getting managers' buy-in?	Focus simultaneously on the hard (structures and systems) and the soft stuff like the culture and attitudes.
2	**1**	**7**
Process		
Did you implement a compelling and rigid plan and establish programmes with stringent dates and targets to achieve your objectives?	Did you experiment and allow the plan to evolve with input from employees, encouraging their ideas and subject to a number of iterative evaluations?	Did the plan have measurable targets but allow for spontaneity, innovation and change where necessary?
0	**2**	**8**
Reward System		
Did you motivate managers through financial incentives?	Did you motivate through commitment and convincing managers of the reality of the need?	Did you use a combination of getting buy-in but with financial incentives linked to success?
1	**5**	**4**
Use of Consultants		
Did consultants play a significant role, analysing the problems and shaping the solution?	Were consultants not used or only used to support management in shaping their own solutions?	Would you say that consultants provided expert resources to empower employees?
0	**4**	**6**

Table 6 provides a summary of the frequencies for ease of reference; each dimension is discussed independently below.

Table 6 Summary of Results – Theory E/Theory O Change

Theory E	Theory O	Combination
Goals		
0	0	10
Leadership		
3	1	6
Focus		
2	1	7
Process		
0	2	8
Reward System		
1	5	4
Use of Consultants		
0	4	6
Aggregate		
6	13	41

5.2.1. Goals

The data clearly indicates (ten out of ten) that the goals for the change were a combination of Theory E and Theory O change, a combination of both the compelling business case as well as the need to change attitudes and behaviours around HIV/AIDS in order to sustain the organisational capabilities. What makes this remarkable is that in not one instance was the goal purely profit motivated.

5.2.2. Leadership

The scores around leadership were divided, with the majority of respondents electing a combination of E and O, that is, the direction was set from the top but in consultation with the people below. There were only three instances where leadership was unequivocally top down.

5.2.3. Focus

The focus of the change intervention was largely a combination of E and O change with 70% of the respondents saying that they focus simultaneously on the systems and structures as well as on the softer issues such as culture and attitudes.

5.2.4. Process

With two exceptions, the process was notably a combination of plans having targets with a margin for spontaneity, innovation and change. The exceptions were toward a totally evolutionary process characterised by experimentation and consultation.

5.2.5. Reward System

By and large the use of rewards was not seen to be a significant part of the strategy. The use of rewards was evenly distributed between no rewards at all and the use, to a small degree, of financial incentives. In only one company was the use of financial incentives / rewards recorded. By and large, the change was not driven by financial incentives.

5.2.6. Use of Consultants

Here it is evident that some degree of capability in producing the change was vested within the organisation itself. It was either run totally in-house or external consultants were simply utilised for their expertise. In fact it was consistently acknowledged, by the majority of the respondents, that consultants were only relied on for their expertise.

5.2.7. In Aggregate

Beer and Nohria (2000) have identified six dimensions within their construct of three change strategies, this was detailed in 5.2.1 to 5.2.6 above. The total of the combined scores for each of the six dimensions, within each of the three strategies, provides an aggregate that indicates which strategies were in fact adopted by the organisations concerned. In aggregate the change strategy consistently applied was a combination of Theory E and Theory O change. Table 6 shows the aggregate score of 41 out of a possible 60; that is, 68% of the responses supported the presence of a combination of the two theories. Only 22% of the responses support pure Theory O change and a meagre 10% of the selections were in favour of pure Theory E change. This shows that there is both a profit motive contributing to shareholder value, as well as a compelling organisational capability dimension incorporating a moral obligation to do so.

5.3. The Process of Organisational Change

Research Question 2: Kotter (1996) advocates that eight stages, executed in sequence, are required for change to be sustainable. Did any or all of these stages contribute to the success of the HIV/AIDS workplace intervention?

In subsections 5.3.1 to 5.3.8 the results from each of Kotter's (1996) stages are presented. The research question from 3.2 is replicated along with a copy of the

question from the interview guide (please refer to Appendix 2 for the complete interview guide) as well as the Likert scale (where relevant). Where a Likert scale was used, the frequencies are recorded (in bold type) in the space where the interviewer would have placed his mark.

5.3.1. Creating a Sense of Urgency

Research question 2 a) Did the leaders create sufficient urgency around the HIV/AIDS workplace intervention?

Question 3 in the interview guide asked respondents to make a selection on a Likert scale, the number of responses related to each option on the scale are shown in bold type in the grid below. The question was worded as follows: *If you could give yourself a score out of 5 for the degree of urgency you created, how would you score?*

1 No Urgency	2	3	4	5 Tremendous urgency
		1	**4**	**5**

Only one respondent scored urgency below four - the remaining nine scored the urgency around the change above four. Five people scored it at five on the Likert scale and four people scored four.

A theme that becomes evident is the threat that an unsuccessful response to HIV/AIDS would pose to reputational risk. That is, the risk of damage to the organisation's reputation if the response to HIV/AIDS was viewed in a negative light. This was raised by five of the respondents. It can be said that the threat of reputational risk contributes to the sense of urgency.

5.3.2. Leadership and a Guiding Coalition

Research question 2 b) To what degree did the leaders utilise guiding coalitions?

Question 4 in the interview guide was an open ended question aimed at soliciting broad insights around the role of leadership and its importance. The following question on the interview guide acted as a prompt for the interviewer: *Can you describe what it takes from a leadership point of view to make this change happen? Who was involved? What roles did they play?*

In every case, bar one, the respondent mentioned the company boss by name and indicated that they had had a role to play. It was just the one company where the groundswell came from middle management responsible for health and safety. Their failure to mention anyone by name in senior leadership made the fact conspicuous by its absence, but reinforces the finding that only one company was successful without the impetus of senior leadership involvement.

An obvious trend emerged whilst exploring the issue of leadership, as nine people mentioned their CEO/MD by name, that is, the ultimate leader of the organisation was identified as being personally associated with and responsible, at least in part, for the success of the change intervention. The leaders identified are recorded below.

- Standard Bank –Jaco Maree, Simpiwe "Sim" Tshabalala
- SABMiller – Graham Mackay
- Anglo Coal – Tony Trahar
- De Beers – Nicky Oppenheimer
- Sappi – Eugene Van As
- Anglo American – Gavin Relly and Tony Trahar

- BMW SA – Ian Robertson, Managing Director
- Mercedes Benz SA – Jurgen Schrempp (Global Chairman) and Christoph Köpke (South Africa)
- ESKOM – Steve Lenon and Mpho Letlape

Passion emerged as a character trait embodied by all of the respondents. Without exception every person interviewed was passionate, and to this I add optimistic. Everyone was positive and optimistic about the impact their interventions would have on the trajectory of the epidemic.

5.3.3. Vision and Strategy

Research question 2 c) How important was the development of a vision and a strategy for the organisation's HIV/AIDS workplace intervention?

Question 5 in the interview guide also required a Likert scale selection which was used to determine the importance of the development of a vision and strategy in an HIV/AIDS workplace intervention, the number of responses related to each option on the scale are shown in bold type in the grid below. The question posed was: *How important was the development of a vision and a strategy for the organisation's response to HIV/AIDS?*

1 Vision not important	2	3	4	5 Vision critically important
	1	**2**	**2**	**5**

Five respondents scored Vision and Strategy at five, with two choosing four and two ranking it three. Only one respondent felt Vision and Strategy was not important and scored it as low as two. Those that scored this less than five felt that the Vision and the Strategy were not that important but that the communication thereof was critical.

5.3.4. Communication of the Vision

Research question 2 d) Did the leaders communicate the change vision and to what degree?

Question 6 in the interview guide required responses on a Likert scale, the number of responses related to each option on the scale are shown in bold type in the grid below. The question was phrased "*Was the communication of the change vision important and to what degree?"*

1 Communication not important	2	3	4	5 Communication critically important
				10

Overwhelmingly, communication of the vision and strategy emerged as critical for the success of an HIV/AIDS workplace intervention. A score of five, indicating that communication was critically important, was unanimous.

HIV/AIDS fatigue was something that came to light as a reality facing the challenge around communication. Eight out of ten respondents' felt that their target audiences were experiencing what can best be called HIV fatigue. The message of HIV/AIDS has been bombarding people for so long that they have tired of hearing it. This poses an added challenge to the communication efforts in that there is an obstacle to overcome in getting the message across.

A further observation around the communication of the vision and strategy was to keep the message simple. Again seven out of the ten respondents mentioned this.

5.3.5. Empowerment and Participation

Research question 2 e) Were all members of the organisation empowered to take action in the fight against HIV/AIDS?

Question 7 in the interview guide, "*Can you describe the levels of participation/involvement across the organisation in the fight against HIV/AIDS?"* probed the importance of participation in a successful response to HIV/AIDS in the workplace.

1 Participation low	2	3	4	5 Participation extremely high
		3	**1**	**6**

Six respondents scored participation as five on the Likert scale, with one respondent ranking it at four and the remaining three scoring participation at three. Eight out of ten respondents said that involving the unions as part of a broad based strategy was important. It signifies the participation of organised labour and eliminates a potential obstacle by garnering the unions' support at the outset.

5.3.6. Quick Wins

Research question 2 f) What role do short term wins play in bringing about a positive and sustained HIV/AIDS workplace intervention?

Question 8 in the interview guide was an open ended question directed at finding out what, if any, quick wins were realised in the process of change. A content analysis was performed on the responses to the questions: *"Did you identify and go for any 'low hanging fruit' or 'quick wins'? Did you focus on small successes along the way? What impact did this have?"*

Seven out of ten respondents went for quick wins in their interventions and identified them as such. Content analysis of the qualitative responses to this construct revealed that treatment and testing were the most popular quick wins. Treatment can be procured and is simply a financial decision. It did not prove difficult, although there are challenges, to get people onto treatment. By the same token, VCT is a fairly mechanical process requiring lots of planning and creative communication, but getting it established and reaching measurable targets is viewed by many respondents to be a quick win. It is visible and as uptake improves it helps to give the programme momentum.

5.3.7. Consolidate and Produce More Change

Research question 2 g) Did demonstrating the success of programmes build momentum and result in more change?

Question 9 in the interview guide was open ended and read: *"Assuming success didn't all just come at the end, did you consolidate the success along the way and use that in any way in the broader initiative? What impact did this have on momentum and sustainability?"*

Ten out of ten respondents said that consolidating gains, learning from the various elements of the intervention and applying those learnings to the way forward were essential to the success of the interventions. It was evident that success breeds success, and the celebrating the success stories maintained the impetus of the interventions. Also evident was interdepartmental learning and sharing that contributed to organisation wide success.

The responses revealed that an HIV/AIDS workplace intervention has two distinct parts, the programmatic element for which there are numerous established best practice models, and then there is the behavioural and attitudinal change component around awareness and education and which is long-term in nature.

5.3.8. Anchor Change in the Culture

Research question 2 h) Were the initiatives anchored in the culture?

Question 10 in the interview guide, the last of Kotter's (1996) Eight Stages, read: "*Can you describe what this change has meant to [Company Name]? Has the initiative remained in management hands or is it more pervasive than that? (Are the initiatives now anchored in the culture?)*"

Seven out of ten are confident that the response to HIV/AIDS is embedded in the culture, with the remaining three feeling they are almost there. Again, in the three that feel it is not yet in the culture, they have set themselves idealistic standards which the researcher doubts they will ever satisfy.

5.4. Power Bases

Research Question 3: French and Raven (1959) refer to five power bases: Reward power, Coercive/Punishment power, Legitimate power, Expert power and Referent power. Which power bases were employed in the leadership of the organisational change required by the HIV/AIDS workplace intervention?

The researcher set out to establish which power bases were used in order to realise the objectives of the HIV/AIDS workplace intervention. A constant sum scale technique was used to determine the spread of the power bases used. Respondents were asked to divide 100 beans between the five power bases that the researcher described to them.

In this section the table used to record the data in the interview guide (please refer to appendix 2 for the complete interview guide) is replicated to demonstrate how the respondent was taken through the weighting process. The scores of each respondent are then displayed in tabular form in Table 7. Summary data in the forms of Mean, Median and Ranges are then presented in Table 8 detailing the distribution of the data.

Figures 2 to 4 are useful for interpretation of the data given that they provide a pictorial view.

Question 12 in the interview guide was presented as follows:

There is research that suggests there are five types of power, I've described them briefly below. If you had 100 beans to allocate between the power bases that best describe you - how many would you give to each:

Reward Power – you were able to give special benefits or rewards to people and were able to trade favours with them.	Beans
Coercive/Punishment power – you could make things difficult for people if they did not comply, they did things because they didn't want to anger you.	Beans
Legitimate power – people complied with your will because of your position of authority and job responsibilities.	Beans
Expert power – you had the experience and/knowledge that earned people's respect, they valued your judgement.	Beans
Referent power – People like you, want to be positively associated with you and therefore enjoy doing things for you, they want to please you.	Beans
	100 Beans

Table 7 overleaf shows each respondents score from the table in question 12 on the interview guide, essentially indicating the power bases used and the weighting of each. Each line totals 100 given that the respondent was asked to allocate 100 beans across the five power bases. There are no strong frequency patterns evident from the table - the only significant trend in this section of the detail shows that Coercive power is either zero or very low. (Please refer to Appendix 4 for a graphical depiction of the distribution of the responses.)

Table 7 – Results of the Constant Sum Scale Exercise

	Legitimate Power	Expert Power	Referent Power	Reward Power	Coercive Power
Respondent 1	70	30	0	0	0
Respondent 2	80	10	0	0	10
Respondent 3	35	20	5	30	10
Respondent 4	33	33	33	0	0
Respondent 5	20	30	10	20	20
Respondent 6	25	20	30	15	10
Respondent 7	0	30	60	10	0
Respondent 8	10	45	45	0	0
Respondent 9	60	20	20	0	0
Respondent 10	5	30	5	50	10

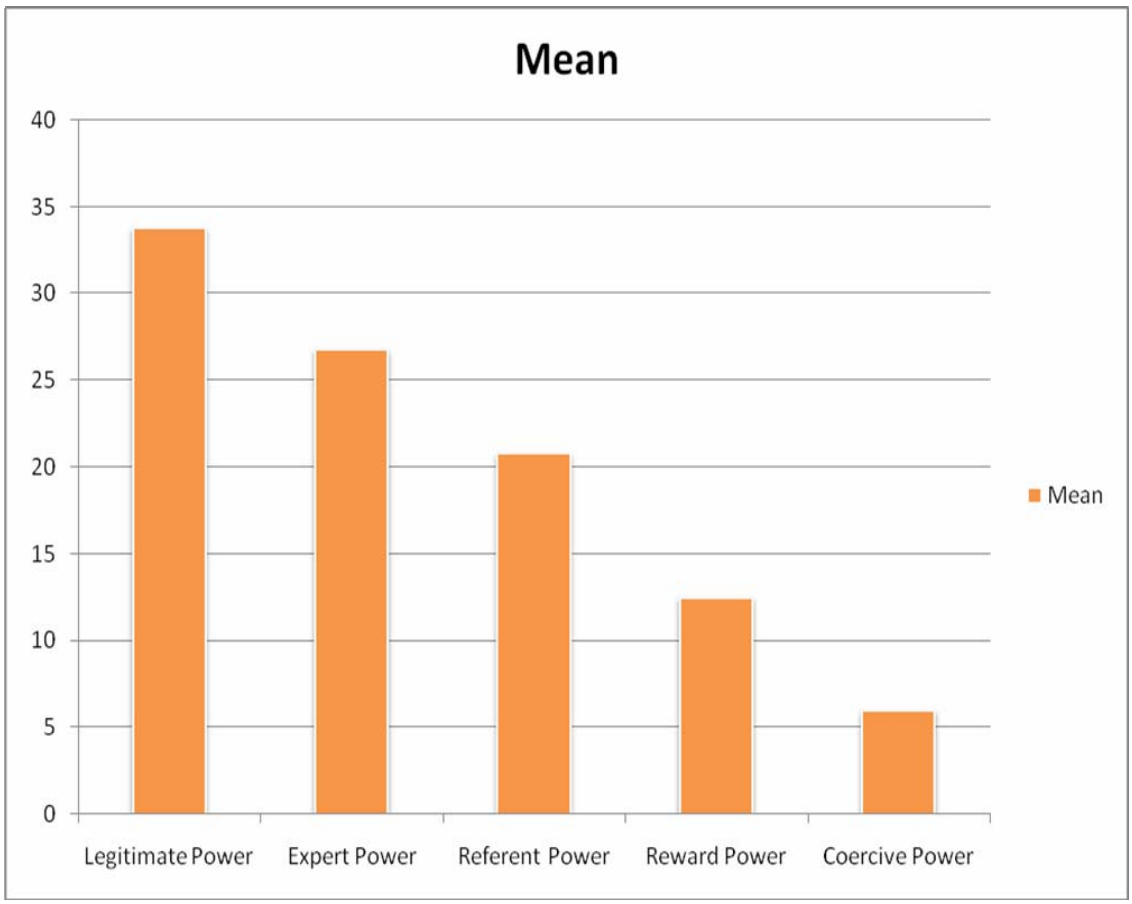
Table 8 provides information on the distribution of the powerbase scores. The central point estimates and the range assist in identifying the weightings of each power base in relation to the others. They have been arranged from most heavily weighted to the least heavily weighted, from left to right.

Table 8 – Distribution of the Results of the Constant Sum Scale Exercise

	Legitimate Power	Expert Power	Referent Power	Reward Power	Coercive Power
Mean	34%	27%	21%	13%	6%
Median	29%	30%	15%	5%	5%
Min	0%	10%	0%	0%	0%
	to	to	to	to	to
Max	80%	45%	60%	50%	20%

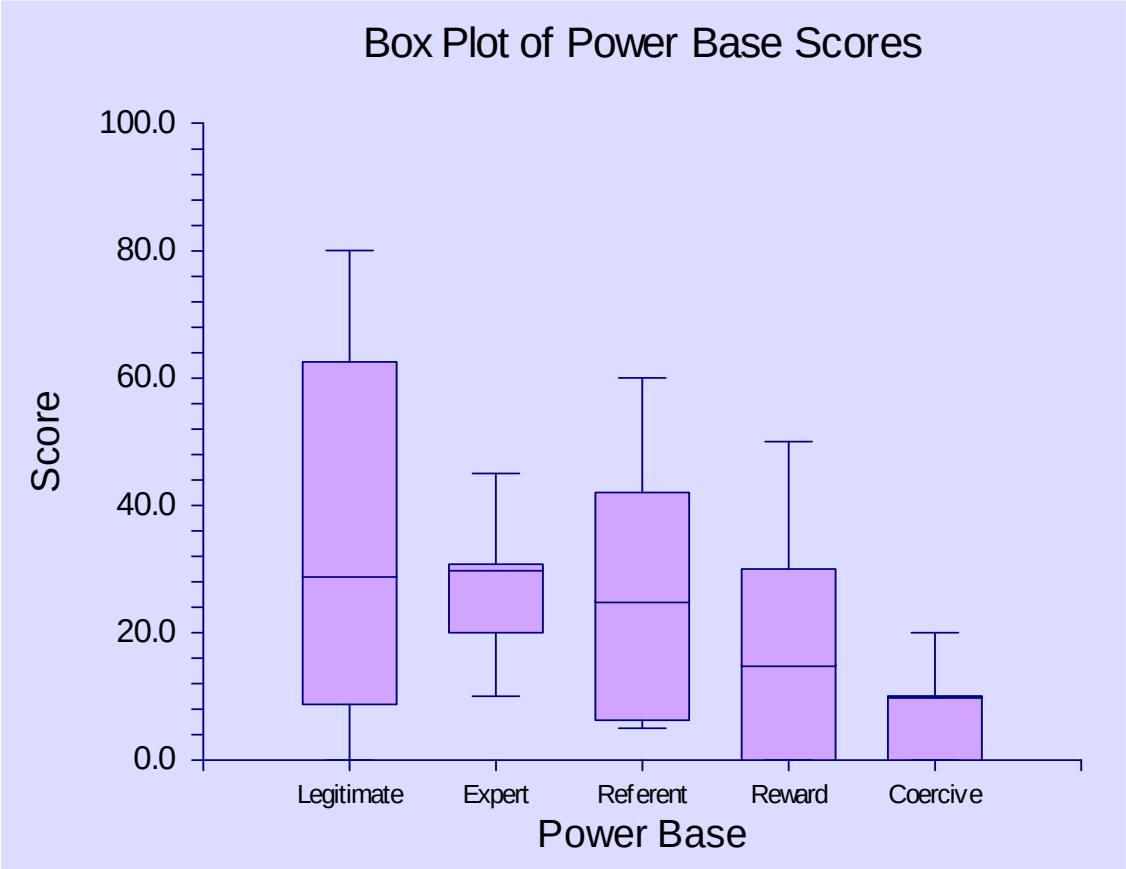
The mean provides the best measure of the central point given the data collection methodology. This is shown graphically in Figure 2.

Figure 2 – Mean Distribution of Power Bases



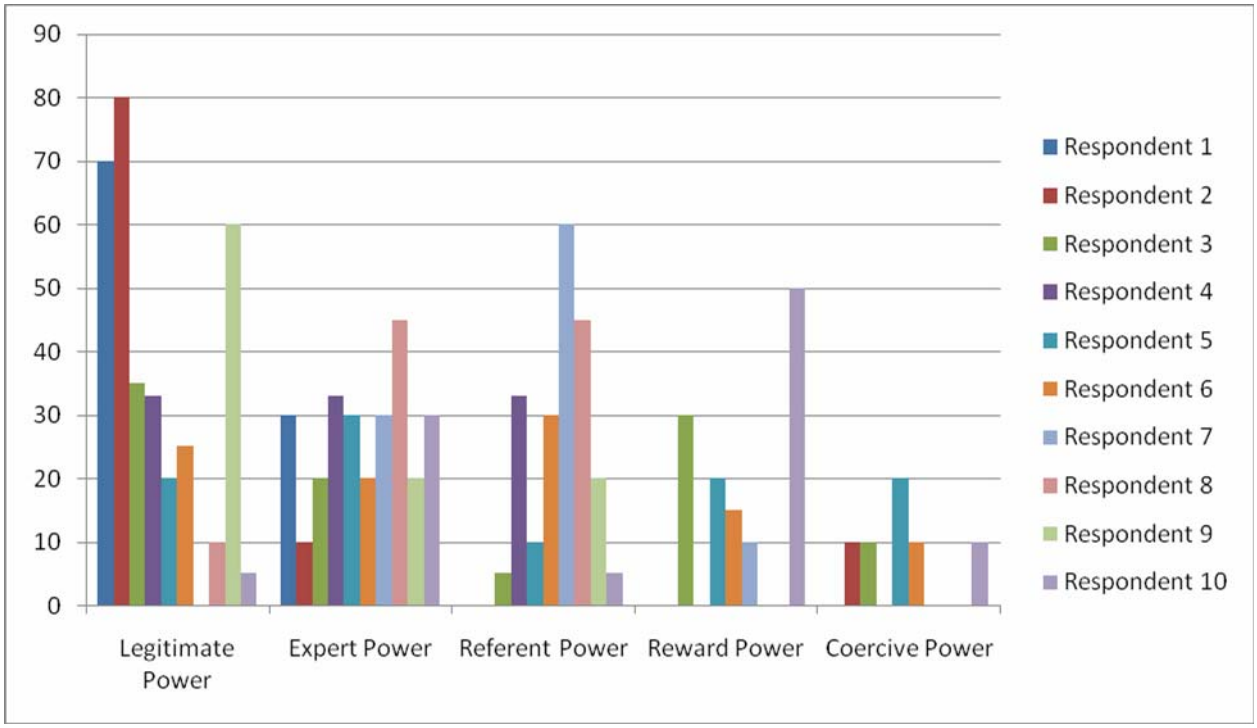
A box plot provides a useful depiction of the distribution of the respondents' scores. It shows the range and the median and the rectangle represents the inter-quartile range (50% of the response around the median). In Figure 3 below, note how the scores for Expert and Coercive power are clustered close together, with Referent and Reward power having a broader spread, and finally Legitimate power, with the highest mean (Figure 2), having the broadest distribution of scores.

Figure 3 – Box Plot of Power Base Scores



In order to depict the scores per power base graphically. The ten respondents are grouped adjacent to one another, by power base, in Figure 4 They have been arranged from most heavily weighted to least heavily weighted, from left to right.

Figure 4 How Respondents Scored by Power Base.



5.5. Emergent Themes and Findings – Elements of Change Specific to HIV/AIDS Workplace Interventions

Incidental to the interview guide questions and as a part of the wider discussion in each interview, a number of themes that fall outside of the ambit of the theory emerged. These were solicited by open ended questions right at the start of the interview and part of the way through (please refer to the complete interview guide in Appendix 2).

The open ended question asked at the outset of the interview intended to establish, without bias or prompting, what the respondent felt was critical to the success of the intervention. These responses were not expected to be limited to any one of the research questions and may well have provided answers to all of them. The respondents were encouraged to take the time to consider the question at length and comment freely. To draw out information the interviewer allowed uncomfortable silences to motivate the respondents to offer more.

Question 1 in the interview guide was designed as a catch all, open ended question and was phrased as follows: "*By way of introduction, knowing what you know now about leading change in the area of HIV/AIDS – what advice would you give others?"*

Following on from this question, and from the incidental discussions that arose during the interview, the following findings came to light:

- Eight respondents could identify either a defining moment, a personal experience or a watershed event that catalysed the need for an intervention
- Seven out of ten articulated that the response to HIV/AIDS was an operational or business imperative
- Six of ten respondents said that you cannot focus on just one thing, there is no silver bullet, you have to do everything all the time. Keeping everything in tension and not losing focus in any area, such is the nature of the inter-dependencies within the response
- Six out of ten respondents raised the issue of human rights, confidentiality and trust
- Six out of ten of the companies house the HIV/AIDS workplace interventions within a broader wellness programme

After the eight questions posed around Kotter's (1996) eight steps, the following open ended question was asked and it related specifically to Research Question 2 i) Were there any other relevant stages that can be identified?.

The question read: "*Is there anything else that happened in your intervention that you would consider a critical factor in its success?"* The following emerged:

- All ten respondents felt that measurement, metrics, monitoring and evaluation were important in the success of their interventions

6. Chapter 6 – Discussion of Results

6.1. Introduction

Chapter 6 integrates the theories on change strategies, leadership of organisational change, and power bases and the results of the interviews. The findings, as they relate to HIV/AIDS workplace interventions laid out in Chapter 5, are used to answer the Research Questions in Chapter 3, which are interpreted in light of the literature. This discussion will prove useful to managers in the private sector as they embark on, or improve, their own HIV/AIDS workplace interventions.

The discussion of the results follows the same structure as that used in Chapter 5. Each section and sub-section relates directly to the data presented in the corresponding section in the preceding chapter.

6.2. Change Strategies – Theory E and Theory O Change

Research Question 1: Did the strategy for the successful HIV/AIDS workplace interventions exhibit Theory O or E change, or a combination of Theory O and E characteristics (Beer and Nohria, 2000)?

The results from the research presented in 5.2 above do indeed support the premise by Beer and Nohria (2000) that, in most successful cases, the drivers for change are a combination of the business case and the need to develop and enhance the organisational capabilities of the company. This is discussed under the six dimensions detailed in their article.

6.2.1. Goals

Support for a combination of Theory E and Theory O change in the goals category was undisputed and is evident in the data presented in Table 6 and section 5.2.1. The overwhelming feeling was that it was a combination, as when asked to make a selection every respondent acknowledged that the goals were a combination of Theory E and Theory O.

One respondent pointed out that the health and wellness department was able to quantify benefits as it prepared a comprehensive, undisputed business case and was able to demonstrate the Rands and Cents' implication. This was the only inference to a purely business case decision and even so the respondent chose a combination when pressed for an answer. Not one organisation embarked on the change for purely economic reasons.

Most felt that an HIV/AIDS workplace intervention was not just about the money but rather about the people. There are skills at risk, particularly in Africa, which are very difficult to replace. This affects the capabilities of the organisation. Skills and attrition issues constitute very real organisational capabilities issues. John Standish-White echoes these sentiments, saying that it is not just for economic benefit. He highlights that the business case gets the leadership to listen, however there is a prevailing, fundamental moral obligation to do something. One cannot just sit back and let people die. The moral imperative and ethical responsibility justifies the need for compassion.

The key here is that the driver of change is not one or the other, but rather a clear combination of both. Businesses need to give due consideration to the cost/benefit decision while considering the moral imperative and the soft issue implications of the decision regarding their response. It is unlikely that the goal for change will ever be exclusively economic in nature.

6.2.2. Leadership

Table 6 reflects that a disparity around the dimension of Leadership exists. Succeeding in this endeavour is not straightforward or easy, as attested by Yukl (2006). One company advocated an undisputed top down approach with a step change driven by decisive direction from the top. The senior leadership in this case dictated the way change would take place, people were made accountable and the results followed. It came to light that in the mines the General Manager (GM) is “God” and the change was driven from the top-down.

Other companies indicated urgency from the top, with senior management acting first and fast, and that only recently was there a groundswell from the bottom. This was indicative of a combination of the two Theories.

On the Theory O end of the spectrum, one company exercised an almost exclusively bottom-up approach. The response was characterised by partnering; there was a groundswell from the bottom and leadership just steered it. This was the only instance of pure Theory O change under the leadership category and it was most definitely driven from a grassroots level. Beer and Nohria point out that “employees distrust leaders who alternate between nurturing and cut throat corporate behaviour” (2000, p134) It is important that leaders of change are consistent in the approach they choose and do not vacillate between the two.

The insight gleaned from this is that at times senior leadership needs to be decisive and dictatorial, particularly to generate action and create momentum. However, the intricacies and sensitivities around HIV/AIDS workplace interventions in particular, demand that there is substantial and comprehensive consultation with all stakeholders. Business leaders need to recognise when to act decisively and when they need to defer to the process of consultation.

6.2.3. Focus

Table 6 clearly shows the distribution of the responses to the focus dimension of the change intervention. In this regard there was a balance between the priority given to systems and structures and that given to the attitudinal and behavioural issues presented by the intervention. A singular focus on physical systems and processes, essentially hands-off, was only evident in two cases. In one, the respondent felt that there was a commitment to focussing on the soft issues but in actual fact they did not really succeed and in retrospect it can be said that the soft issues were neglected.

By and large it was a combination of Theory E and Theory O change. The respondents felt that, as important as structures and systems are, organisations must not ignore the soft issues around attitudinal and behavioural change. People need to be won over and persuaded. Creating awareness and changing behaviour was seen to be by far the hardest thing to achieve. One respondent felt it should extend to managers having to know how to handle someone who discloses to them that they have HIV.

Those responsible for interventions should observe that ignoring either the hard stuff - the systems and processes, or the soft stuff - the behavioural and attitudinal factors, could lead to adverse consequences. The two need to be held in tension and the balance delicately maintained.

6.2.4. Process

Table 6 indicates what the process definitely is not; it is not a compelling and rigid plan with stringent targets and inflexible delivery dates. The process is in fact flexible, with room for innovation and creativity, subject to the discipline of enforced targets, metrics and deadlines. The field of HIV/AIDS is young and rapidly changing and as such the programmes and approaches are very dynamic. One respondent described the

process as iterative: as he learned, he was able to develop the process and fine tune it. Another called the process evolutionary. The process dimension falls convincingly within the ambit of a combination of Theory E and Theory O change and is subject to change and not cast in stone, where learnings from more experienced business units were appropriated.

The plans have to be flexible and responsive to adjust to each environment and learning from mistakes was common. Treatment for instance is easier to plan for, quantify, evaluate and monitor. The attitudinal and behavioural matters around prevention and community need to be far more spontaneous and require responsiveness to the environment.

There must be room for innovation. Evaluation should be based on outcomes - essentially the quality of the programme outcomes and not the sophistication of the programme itself. Processes must be changed in response to the feedback from the environment.

6.2.5. Reward System

Table 6 shows that the reward system dimension is the one that has a strongest bias to pure Theory O. What is being considered in the theory is a substantial financial reward in terms of metric linked financial incentives. For the most part the companies interviewed were not in favour of substantial financial rewards. The majority of cases were either Theory O, where no rewards were used and compliance was secured through convincing managers and getting their commitment, and a combination of Theory E and Theory O, where persuasive measures and some form of financial incentives were employed. Covin and Kilmann (1990) advocate the need for rewards that are linked to the desired change, which are consistent and occur in a timely manner.

The one company that did elect to use rewards did so aggressively. It was a conscious decision to use rewards to motivate the desired behaviour, and the respondent revealed that managers get a financial incentive to comply with the HIV/AIDS programme.

To a lesser degree, a number of the companies used trivial rewards to ensure that the implementation of elements of the programme was successful. For instance, to get people to test, go for training, or to get people educated, they were rewarded for their participation. This is considered as part of communication and marketing of the initiatives and does not fall within the sphere of this construct.

In one form or another, targets for HIV/AIDS initiatives appeared in managers' metrics. Examples include the percentage of the workforce tested in the financial year, the percentage of HIV positive staff registered in a managed health care programme, the percentage of spouses that are HIV positive and are registered on a managed health care programme, and the ratio of peer educators to employees. Some companies with HIV/AIDS related KPIs said that where there haven't been measures linked to incentives then the change has not been as pervasive or successful.

A broad insight around rewards and financial incentives is that organisations must interrogate the resultant behaviour from that which is being rewarded. Often what is rewarded has the propensity to drive the wrong behaviour and may not be sustainable.

6.2.6. Use of Consultants

Table 6 shows that consultants were used primarily for their expertise and not as surrogates for an internal capability. The time dimension of an HIV/AIDS workplace intervention should be raised at this stage. It is long-term and costly and the study showed that every successful company interviewed had developed some capability

within its own structures. Not one company researched outsourced the entire intervention.

Four of the ten companies represented typical Theory O behaviour where consultants were concerned. Their use was extremely limited and predominantly where unique expertise and leading edge knowledge was concerned. One concern raised was consultants' tendency towards quick fixes versus the objective of efficacy for the long-term. This company only relied on consultants for support and the consultants were used for impact assessments, cost/benefit analysis and prevalence surveys. Another company used a service provider for record keeping and statistics.

The companies that advocated a combination of Theory O and Theory E change used consultants for their expertise while building on their own capabilities. This facilitates getting the best people for the job and knowledge of best practice and is used to empower the employees of the company who then develop internal capabilities. A substantial part of the change intervention was always retained in-house.

6.2.7. Conclusion to Research Question 1

The last row in Table 6 represents a total or aggregate figure across the six dimensions. When viewed collectively, the data across the six dimensions points unequivocally to a combination of Theory E and Theory O change. This indicates that there is a profit motive while being mindful of the fact that this is necessary for the sustainability of the organisations' capabilities and for the simple reason that it is the right thing to do. It shows that decisive leadership and effective structures and systems are required but that it is also necessary to support organisational capabilities through attention to attitudinal, behavioural and cultural factors. The process requires measurements and evaluation and monitoring but not at the expense of flexibility, creativity, innovation and spontaneity which are critical and should not be

compromised. This should all be achieved with discipline around deadlines and deliverables. It illustrates that rewards of some kind can be beneficial, and that consultants should be prevailed upon for their expertise where the expertise is not present within the organisation itself.

This compelling evidence should encourage managers to focus on both the hard and soft issues - neither should be neglected. It is only in the areas of leadership and focus that actions, more typical of Theory E change, prove successful. Conversely, it was only the dimension of rewards where a typical Theory O practice was evidenced. The fact that in aggregate only 10% of the responses across all the dimensions suggested Theory E is evidence to suggest that the motivation for change cannot be justified by economic incentive alone.

6.3. The Process of Organisational Change

Research Question 2: Kotter (1996) advocates that eight stages, executed in sequence, are required for change to be sustainable. Did any or all of these stages contribute to the success of the HIV/AIDS workplace intervention?

In section 5.3, detailing the answers to Research Question 2 the data shows that all of Kotter's (1996) eight stages are required for change to be realised in an HIV/AIDS workplace intervention. In addition, there are certain elements of change that are significant that Kotter does not cover and these have been included following the discussion on the eight stages.

6.3.1. Creating a Sense Of Urgency

Section 5.3.1 presents the results on creating a sense of urgency. The scores on the Likert scale were all high (nine scored four and above), with the consensus being that urgency must be created for an intervention to gain momentum. The difficulty with generating urgency around HIV/AIDS is the length of time it takes for the final, fatal outcome of the disease to take place. As public knowledge grows and the epidemic approaches a mature stage, generating urgency has become increasingly possible. It would appear that Kotter (1996) is correct in suggesting that this is required at the very outset of an intervention.

Kanter *et al* (1999) believe that analysing the organisation and its need for change should be the first step in a change intervention. This is particularly relevant for an HIV/AIDS workplace intervention, as an analysis of prevalence and incidence contributes significantly to the sense of urgency. Gillies at SABMiller said the statistics galvanise companies into responding. When the prevalence stats are revealed, things happen. At some companies, leadership made HIV/AIDS their top priority which created the required sense of urgency. Understanding the epidemic builds urgency, as does believing that something can be done, and that the tools exist to stop the AIDS epidemic.

Urgency was heightened when the Department of Labour promulgated their code of good practice and with the Declaration of Commitment signed in 2001 at the UN General Assembly Special Session on HIV/AIDS (UNGASS). Urgency was also stimulated in the automotive sector by the thought that Germany may not wish to manufacture vehicles in South Africa if the risk of HIV/AIDS was perceived to be too high.

To quote Brink in Bloom *et al* (2005, p.4) in the Preface to the World Economic Forum (WEF) report, *Business and HIV/AIDS: Commitment and Action*.

> "HIV is a very smart virus. It attacks human weakness, both biological and behavioural. It targets the core of our human defences–the immune system. It infiltrates through the most secret route –our human sexuality and sexual behaviour. It exploits the power imbalance of human gender and exposes the weakness of relationships in our society. Unlike SARS, it is covert and insidious in its operation, taking an average of nine to ten years before manifesting as a disease with 100% mortality. Humans are quite complacent about small changes over a long period of time. We are much more adept at responding to crises than planning for the long term. That is why SARS failed and HIV continues to thrive."

A trend that emerged from the study is that reputational risk creates urgency; this was evidenced at more than half the companies. At one company negative publicity and potential reputation damage resulted in sudden urgency; this particular event was a catalyst in the change process.

Business must create a sense of urgency at the outset of a change intervention in order for it to have any hope of success and for that success to be realised in an acceptable timeframe. This is an important task for the leaders in the organisation to undertake and is only likely when the leadership truly understand the implications of the epidemic.

Research Question 2 a) can be said to have been answered in the affirmative, the leaders did create sufficient urgency around the HIV/AIDS workplace interventions.

6.3.2. Leadership and a Guiding Coalition

Section 5.3.2 reflects that nine out of the ten companies researched indicated that commitment from senior leadership was a critical success factor. As Ramsingh and van Aardt observe, “Leadership has proven to be one of the most important aspects influencing the successful implementation of the policy. One of the most notable complaints regarding unsuccessful policy implementation is that senior management do not provide their commitment and support, at the same time, the support of the head of the department, and the commitment of senior management in HIV- and AIDS-related events have been identified as one of the main reasons for success” (2006, p.191).

There was just one anomaly where the presence of a guiding coalition was not obvious, where no individuals or offices in the organisational hierarchy were mentioned, and where there was no evidence to suggest a personal motivation or concern. This would be an exception to the rule. (See Appendix 5 for verbatim responses.)

It was interesting to note that almost all of the respondents mentioned the CEO or Chairman by name, unsolicited. This gesture was interpreted as demonstrating the personal involvement of the most senior leader in the organisation. The fact that the individuals were singled out and named is significant. Graetz (2000) speaks of how this intensifies urgency. These leaders led by example. As Kouzes and Posner rightly assert, “leaders model the way through personal example and dedicated execution” (1995, p.13)

That everyone was passionate was an observation across the board. The spin-off of passion is urgency; an impassioned plea has a far greater impact on the organisation at large. It requires a sizeable emotional investment and is accompanied by drive, commitment, resolve and optimism. “A leader who is optimistic can roll with the

punches, seeing an opportunity rather than a threat in a setback. Such leaders see others positively, expecting the best of them. And their "glass half-full" outlook leads them to expect that changes in the future will be for the better" (*Goleman et al*, 2002, p.255). Optimism was encountered in every encounter in both phases of the study and is an important observation. As Goleman *et al,* (2002) relate, a pessimist dwells on what is wrong and in so doing loses hope, while an optimist keeps going despite difficulty by holding in mind the satisfaction to come when the goal is met. Goleman *et al* add that, "Leaders who stay optimistic and upbeat, even under intense pressure, radiate the positive feelings that create resonance" (2002, p.47).

Passion was pervasive: at senior management, middle management and right through to implementation level. Passion breeds the courage to take on the tough tasks ahead (Goleman, Boyatzis and McKee, 2002). Business must recognise that passion is an indispensable requirement for the employees and agents of the company that are responsible for the HIV/AIDS response. More importantly, this passion must reside at the highest level of the organisation, "What makes the difference is finding passion for the work, for the strategy, and for the vision - and engaging hearts and minds in the search for a meaningful future. Leaders should find a way to get executives emotionally engaged with each other and with their visions, and see to it that they begin to act on those visions" (Goleman *et al,* 2002, p.239). Brink, who has been involved in the fight against HIV since the 1980s, related the story of how a security guard at the doors the Anglo American head office in Johannesburg wore an armband, demonstrating his participation in the campaign running at the time, and a gold badge with the HIV/AIDS ribbon which signified that he was one of the first people to test. "I do it all for that one person, and every other one that gets this message."

Passion is an unequivocally critical element of successful interventions. It is noted that it is difficult to replicate passion; difficult but nonetheless essential. "Leaders can't ignite

the flame of passion in others if they don't express enthusiasm for the compelling vision of their group" (Kouzes and Posner, 1995, p11).

Research Question 2 b) can be answered in the affirmative, a guiding coalition in leadership, comprising the CEO and other board members, most notably the Human Resources Director, was present in the organisations studied.

6.3.3. Vision and Strategy

Section 5.3.2 shows the broad spread of the scores around the need for a vision and strategy. It would indicate that vision and strategy are important, but not the most important thing on the change agenda. One observation suggested that this is largely why the response to date has been tactical and not strategic. There was nothing to suggest a strategic intent but rather a tactical, reactive response. Cummings and Worley (2005), Kanter *et al* (1999) and Covin and Kilmann (1990) all refer to a shared vision. It is only Kotter (1996) who incorporates the strategic dimension. The vision most commonly articulated was one of an AIDS- free future with the four zeros: zero new infections, zero deaths, zero positive babies and zero discrimination. (See Appendix 5 for verbatim responses.)

A strategic envisioning will undoubtedly contribute to the success but this was not the case in the companies researched. It would be fair to say that in the future a more strategic envisioning would engender even greater effectiveness and success. The consequences of this would be further reaching and more deeply felt. As the risk of the epidemic is understood, and the efficacy of treatment takes hold, a less reactive and more strategic response will be required of business.

The answer to Research Question 2 c) is that vision and strategy are important, but not the most important element of the intervention.

6.3.4. Communication of the Vision

Section 5.3.4 shows every respondent scoring communication as critically important. Philip said six out of five and Standish-White jokingly said nine out of five. Communication has emerged as the most important element of an intervention. It is absolutely critical and must remain dynamic and responsive to changes in the environment and be aligned with developments in the field of HIV/AIDS. The communication must also be contextually relevant. “The key issues influencing the success and failure of the implementation of the HIV and AIDS policy which were repeatedly emphasised include leadership and Communication” (Ramsingh and van Aardt, 2006, p.191).

One challenge facing communication initiatives is HIV fatigue, described by Buchanan, Claydon, and Doyle as initiative fatigue (1997). People are tired of the HIV message. The message has to be reinvigorated and reenergised as complacency sets in - especially as the programmes start to work and it is no longer as visible. When the sense of urgency is gone it is difficult to sustain the commitment of line management. Success takes away the urgency however the passion of leadership can assist in igniting this.

To keep the message simple and straightforward was an emergent theme. “The main issues influencing the effective communication of the policies and programs are clarity and the ability to be understood, conciseness and interaction and participation” (Ramsingh and van Aardt, 2006, p.192). Issues should not be overcomplicated and bureaucracy should be removed. Ramsingh and van Aardt (2006) feel there is an information overload regarding HIV and AIDS and that the policies are often too complex and not compiled in a manner that makes them easy to comprehend.

The communication must be fun - one respondent spoke of a carnival atmosphere. The consensus was rather to over communicate, make it interactive, and engage people.

Companies must communicate that the organisation is winning against AIDS. “The main issues influencing the effective communication of the policies and programs are clarity and the ability to be understood, conciseness and interaction and participation” (Ramsingh and van Aardt, 2006, p.192). (See Appendix 5 for verbatim responses)

The communication strategy must be at the forefront of the intervention. Implementers must ensure creative, varied, dynamic, engaging communication that is simple and relevant. Covin and Kilmann (1990) advocate communication of success stories from the change. This has had very positive impacts on HIV/AIDS workplace interventions. Examples would be people who disclose their status and are living positively with HIV and the stories of how people get well. As fatigue sets in it is imperative that leaders and implementers breathe life into their interventions through effective communication.

Research Question 2 d) can be answered in the affirmative, the communication of the vision emerged as the most important element of the intervention.

6.3.5. Empowerment and Participation

Section 5.3.5 shows the distribution of the respondents’ scores on a Likert scale. The metrics surrounding HIV/AIDS workplace interventions target 100% participation in both VCT and disease management programmes. When questioned regarding participation a number of the respondents were not satisfied with less than 100% and consequently felt they could not score participation too highly. It became evident as the interview process progressed that it was not that the respondents felt that participation was not important, but rather that they felt that their organisations had not achieved the levels of participation that they ideally would have liked.

In discussing one of the businesses researched by Beer and Nohria, participation was identified as a hallmark of Theory O. “Every effort was made to get all its employees

emotionally committed to improving the company's performance" (2000, p.136). This contrasts to Theory E where goals are set with little involvement from lower level management and employees. Overall the value of participation to the success of the intervention was undisputed; it was just that some had set the bar extremely high.

The observation around the involvement of unions is key - broad based involvement in the intervention is required, including organised labour and government, NGOs and civil society at large. Another form of involvement centred around champions and peer educators who engaged the workforce at the grassroots level. Kanter, Stein and Jick (1999) speak of developing enabling structures: peer educators, champions programmes and wellness centres are considered to be enabling structures. The solution begins with reaching individuals and engaging them. As one respondent shared: there has to be a transition from "What is being done about it?" to "What can I do about it?" It has to be personalised - everyone must know their status and know where the clinics are, -from the CEO to unskilled labour. As can be seen in the discussion on wellness programmes in 6.5, a successful approach to encouraging participation was through a broader wellness programme.

One company was exemplary in its participation endeavours: the union was involved from the outset, the company consulted from bottom-up and included medical staff, medical aids, managers, academics, and workforce representatives. This resulted in broad based input; it took a year to design their programme. This is the example set for business in general; broad based participation of all stakeholders is a prerequisite to success and the higher the participation the better the result.

Research Question 2 e) can be answered in the affirmative, employees were empowered with the aim of ensuring broad based involvement.

6.3.6. Quick Wins

Section 5.3.6 records the findings around the question on quick wins. The data supports quick wins as a critical element of change. The quick wins went beyond treatment and testing and included having achievable targets. As one respondent said and which is supported by Holland (1995) and Kotter (1998), “celebrate the low figures and then raise the bar.” By virtue of the problem, implementers should focus on the outcomes that, for all intents and purposes, can be bought, i.e. VCT, treatment and Prevention of Mother to Child Transmission (PMTCT). This is, or can be, made visible and tangible as Collins (2001) puts it, and is far easier to achieve than behavioural change which is overwhelmingly difficult to achieve and virtually impossible to measure.

Realising quick wins is made possible by a focus on the elements of the programme and not the programme as a whole. Focus on the small things as Kouzes and Posner, (1995) advise. As mentioned in 5.3.6 these quick wins must be visible, communicated and used to build momentum. The obvious ones, identified above, must be proactively identified and actively pursued (Kotter, 1995). The change is energised when tangible benefits are in evidence, therefore tangible accomplishments must be highlighted (Collins, 2001). “Achieve small wins that promote consistent progress and build commitment” (Kouzes and Posner, 1995, p18).

Implementers should be cognisant of the objection raised to quick wins: that HIV/AIDS is not the kind of intervention where there are quick wins; one needs to work on everything all the time. It is sensible to target quick wins but not at the expense of any of the other vital elements of the broader initiative.

The answer to Research Question 2 f) is that short term wins play an important role in sustaining the momentum, morale and commitment to the HIV/AIDS workplace interventions.

6.3.7. Consolidate and Produce More Change

The data presented in section 5.3.7 is unanimous in its corroboration of the need to consolidate the lessons learned and to create more change. This stage refers to continual improvement and building on the learnings from the intervention to date. The positive learnings must be implemented while the negative are discarded. Each success was seen as the genesis for the next component of change. The knowledge is most often transferable across departments and can come from all BUs, even internationally. The successful components are transferred and then modified to ensure appropriateness for the specific context. This addresses the dynamism of an intervention in the rapidly changing field of HIV/AIDS. Replicating successes has been a hallmark of HIV/AIDS workplace interventions. (See Appendix 5 for verbatim responses)

The value of quick wins is undisputed, however as Katzenbach (1996) points out, there is a risk that celebrating the quick wins can detract from the ongoing and long-term focus of the intervention. Declaring victory too soon based on intermediate success could derail an intervention. It is of paramount importance that organisations consolidate the success and use this to generate even more change.

Research Question 2 g) can be answered in the affirmative, demonstrating the success of programmes sustained momentum and encouraged more change.

6.3.8. Anchor Change in the Culture

Section 5.3.8 shows that the majority of the respondents felt that the intervention is taking hold in the culture of the organisation. It must be said that all of the companies interviewed considered themselves to be in the early stages of the intervention, such is the expected timeframe of an HIV/AIDS workplace intervention. Consequently it is difficult to commit to saying that the objectives are anchored in the culture, although across the board this would be the objective of the intervention. The ownership of intervention ultimately needs to reside in the organisational fabric, and should be the "way we do things around here" (Kotter, 1995). Kanter *et al,* (1999) believe that it must be institutionalised. (See Appendix 5 for verbatim responses)

The objective for businesses in their response to HIV/AIDS should be for the tenets of the response to become cultural in the long-term. If stigma and discrimination and the resultant secrecy that is an obstacle to progress in combating HIV/AIDS is ever to be eradicated, the response to the epidemic will have to be pervasive in companies and embedded in the cultural fabric of the organisation

Research Question 2 h) can be answered in the affirmative, albeit the interventions were not yet complete, there was evidence to suggest that the interventions were taking root in the cultures organisations.

6.3.9. Conclusion to Research Question 2

The inquiry into whether all stages of the Kotter Model apply to successful HIV/AIDS workplace interventions confirms that all eight stages are necessary. The answer to Research Question 2 i) reveals that one additional element proves valuable in augmenting the eight stages, that is, the presence of measurements and metrics. Consequently, the model developed as an output of this research, lists nine essential elements for HIV/AIDS workplace interventions to be successful.

6.4. Power Bases

Research Question 3: French and Raven (1959) refer to five power bases: Reward power, Coercive/Punishment power, Legitimate power, Expert power and Referent power. Which power bases were employed in the leadership of the organisational change required by the HIV/AIDS workplace intervention?

The results of the investigation into the powerbases used by leaders in the leadership of HIV/AIDS workplace interventions are presented in Table 7 and Table 8 and they are depicted graphically in Figures 2, 3 and 4. The discussion of the results will reveal that it is only Expert power and Legitimate power that really feature as effective power bases in interventions of this nature.

6.4.1. Reward Power

Table 8 shows that the use of Reward power is not significant. On average it would make up 18% of the power used. The median is closer to 15% which is more realistic given the one outlier who said that Reward power would make up 50% of the power leveraged.

Leaders should refrain from trying to leverage Reward power in HIV/AIDS workplace interventions. This is due in large part to the fact that rewards can motivate the wrong behaviour as well as the fact that it is deemed inappropriate given the significant humanitarian reasons for the response.

6.4.2. Coercive Power

Table 8 and Figures 2, 3 and 4 all show very demonstrably that Coercive power is seldom used in interventions of this nature and where it is used it forms a negligible proportion. This is an important result as it demonstrated that this power base should not be used at all. The insight here is for management to avoid the use of coercive power and where it is used, it should be incidental and once-off.

6.4.3. Legitimate Power

Figure 2 shows that Legitimate power has the highest mean and shares the position of the highest median (Table 8 and Figure 3) with Expert power. This would indicate that this is one of the most important power bases to use. This is supported by Robbins and Judge (2007), who say that of the formal power bases, Legitimate power is the one that has the most significance.

A powerful lesson lies in this finding, as compliance with the intervention's initiatives is largely due to the fact that the boss, by virtue of his authority and office, simply requested that employees comply. It is a challenge to those who hold high office and leadership positions in organisations, as their contribution could contribute significantly to the success or failure of an intervention.

6.4.4. Expert Power

Figures 3 and 4 show the uniformity of the use of Expert power in HIV/AIDS workplace interventions. Expert power has the highest median score with a mean (Table 8 and Figure 2) that is only just second to Legitimate power. This is the only one of the two personal power bases that is truly effective in HIV/AIDS workplace interventions.

Research suggests that personal sources of power are in fact most effective (Robbins and Judge, 2007).

Consistently, about a third of the power that leaders leverage is Expert power. HIV/AIDS is an information intensive field with a great deal to know and it is important that leaders are well informed.

6.4.5. Referent Power

Figures 2 and 3 show that after Expert power, Referent power is the third most common power base exercised. There is a lot more variability around the mean and as a result it does not carry the equivalent significance to that of Expert power.

The recommendation for leaders comes in the form of a caution - do not place too much reliance on the fact the people like you as a means of getting them to comply with your wishes and with the requirements of an intervention. Referent power is a personal powerbase (Robbins and Judge, 2007) and it is either present or absent - there is little one can do in the short-term to change this. Expert power can on the other hand be developed fairly rapidly and is much safer to rely on.

6.4.6. Conclusion to Research Question 3

In answering Research Question 3, the power bases that were leveraged in HIV/AIDS workplace interventions were Legitimate power, Expert power, and to a lesser degree, Referent power. The use of Reward power proved insignificant and the use of Coercive power was seen to be negative. The significance of Legitmate power places the onus squarely on leadership and managements shoulders, as a consequence of the positions of authority. More people in positions of authority will engender more success in the intervention. Expert power is the most significant and this should be cultivated by enhancing the knowledge of leaders on the subject of HIV/AIDS.

6.5. Emergent Themes and Findings – Elements of Change Specific to HIV/AIDS Workplace Interventions

The in-depth interview, by design, is rich in qualitative data, much of which departs from the themes and constructs on which the Research Questions were based. These emergent themes and findings are indeed a vital part of exploratory research. For ease of reference and consistency the researcher has recorded the findings from the open ended questions as well as findings that emerged from incidental discussion in this section termed.

The data from questions 1 and 11 in the interview guide that were presented in 5.5 were combined and discussed together in this section. Augmenting this section was information volunteered by the respondents at other points in the interview.

- Catalysts, watersheds, defining moments, and personal experience were clustered together and have been identified as a factor common to successful interventions. This element was present in eight of the ten responses. (See Appendix 5)

- That it is an operational imperative and needs to be understood as such is also very important for the change to be successful. It is good for business to get it right - it should be part of the day to day risk management. It is more than a “nice to have”; it is an operational imperative and forms part of sustainability. If a company does not manage HIV they will fail to have business continuity. HIV should form part of every business continuity discussion. Covin and Kilmann’s (1990) recognition of the strong business-related need for change supports the finding that HIV/AIDS workplace interventions are an operational imperative.

- That there is no one thing that you can focus on was a consistent comment by all the respondents - one needs to be mindful of a multitude of elements. All aspects must be linked all the time as nothing operates in isolation. Every angle must be tried in a combination of all initiatives which are then capitalised upon. According to Mayet said there is no one factor - no magic bullet.

- Trust was seen as a crucial tenet of an HIV/AIDS workplace intervention. To this add the importance of confidentiality and the fact that the human rights foundation is fundamental. Kanter *et al* (1999) describe a step that suggests organisations must separate from the past. Apartheid created a huge degree of distrust with many people viewing a response to AIDS as a ploy to prevent Blacks from procreating. In addition there are many myths, and one of them is that condoms carry the virus. Stigma and discrimination, and consequently shame, promote the secrecy that stands as the paramount obstacle to fighting the epidemic. This can be addressed through vigilant observance of confidentiality, building and maintaining trusting relationships and a broad based paradigm shift with regard to the disease and its implications. It is not in business' nature to be mindful of these soft, human behaviour issues, but they cannot be ignored if interventions are to have any hope of success. The research supports Kanter *et al* who advocate the need to escape the constraints of the past.

- Making HIV/AIDS part of a broader wellness/wellbeing programme emerged as a factor in the success of the intervention. For instance testing is now done during annual and routine check ups. Drives include wellness weeks where everything including HIV testing is done. Health in general is focused on, with programmes concentrating on wellness (including financial wellness), stress management advice and other support opportunities such as for divorce counselling, information on depression, substance abuse, and even career

guidance. Some are taking it to an existential model where they explore our reason for being - why does one want to live?

In response to Research Question 2 i), there was one element of the successful change interventions that was common across all respondents:

- Measurement and metrics, monitoring and evaluation proved crucial to the success of an intervention as measurements drive behaviour. A number of the respondents referred to the surveys on prevalence and other issues, which were done at the outset of the change. Kanter *et al* (1999) list as their first step the need to analyse the organisation's need for change. Covin and Kilmann (1990) speak of diagnosis which, for all intents and purposes, is a baseline measurement. Little is evident in the literature on ongoing measurement and yet this has proved to be a convincing success factor. (See Appendix 5 for verbatim responses). The inclusion of metrics as a necessary element of HIV/AIDS workplace interventions is convincingly supported by the research findings.

6.6. A Leadership and Organisational Change Model for HIV/AIDS Workplace Interventions

The output of this research culminates in a model that can be applied in organisations that have implemented, or intend to implement, HIV/AIDS workplace interventions. The model is presented in Figure 5 and illustrates the elements required which have proven successful, in HIV/AIDS workplace interventions. The Model comprises nine stages of change - four dimensions of the strategy for change and four factors that influence change and the leadership thereof.

The nine stages critical to successful HIV/AIDS workplace interventions are presented in the centre of the diagram. Research Question 2 explored the required stages of

change and the findings show that all of Kotter's (1996) stages are critical, however an additional stage, referred to in this report as Metrics, has emerged. The sequence in which they are presented is a sensible sequence but it is not prescriptive. This follows from the theory and the research findings which demonstrate that urgency should be created at the beginning and that the outcomes should be entrenched in the culture at the end. That is not to say that urgency is not required throughout, nor does it suggest that the other elements need necessarily follow on from one another in a strict sequence. All the elements should be considered and exploited throughout the intervention, with different emphases at different times. This is supported by the finding that one cannot focus on just one thing, but that all aspects need to be kept in tension at all times.

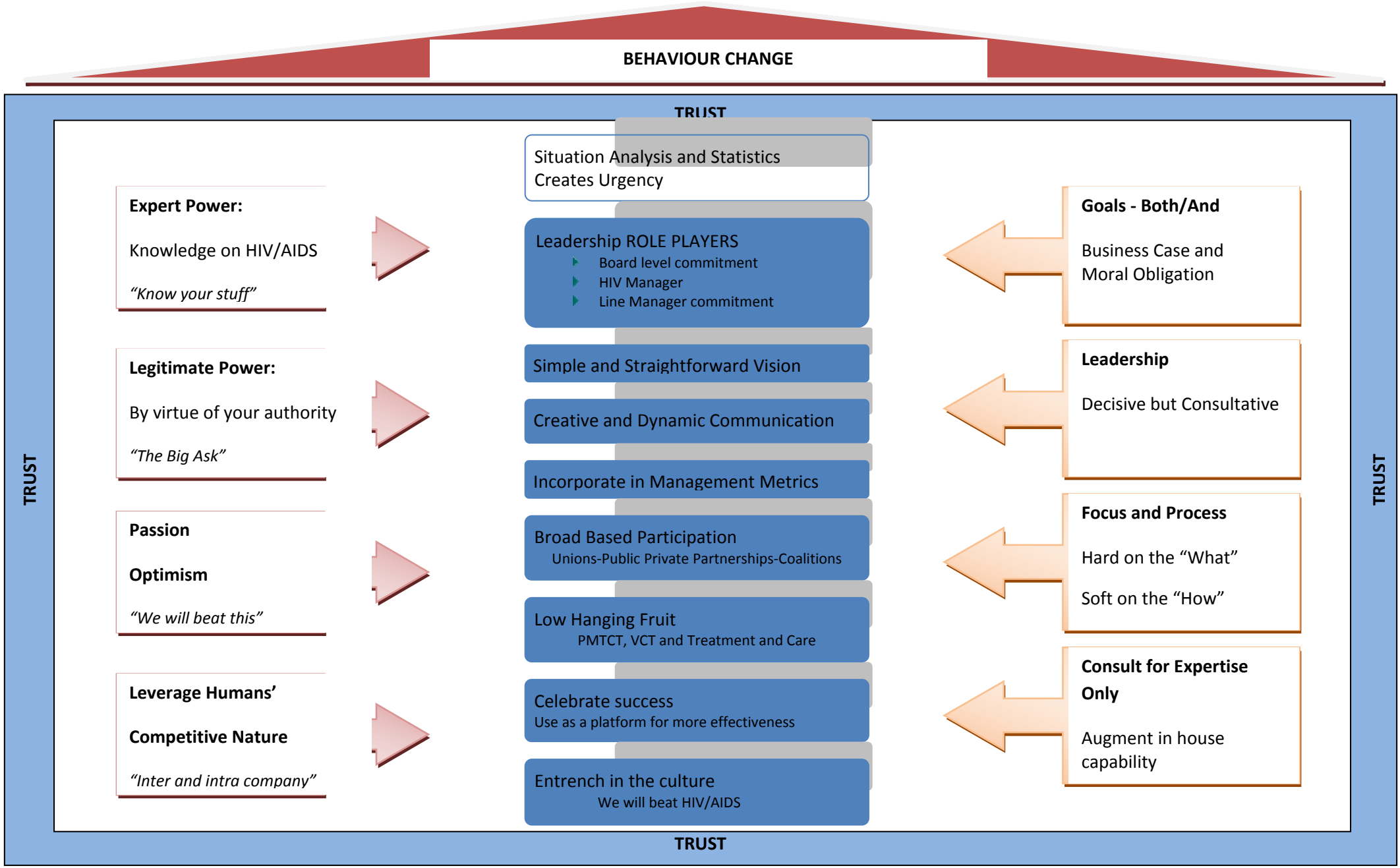
Four broad dimensions of the strategy for change are shown to influence the nine stages. In the interest of simplicity, Beer and Nohria's (2000) six dimensions have been adapted to include only those dimensions relevant to an HIV/AIDS workplace intervention. The findings from Research Question 1 show that the use of rewards does not play a significant role in the success of an intervention. In addition, the dimensions of focus and process have considerable commonality and as a result are combined into one dimension. The model implies that these four strategic dimensions have a significant impact on the success of the intervention. The goals must be a combination of the business case and the moral imperative to intervene. Leadership needs to be decisive when the situation merits, but committed to a consultative process on the whole. Cognisance must be given to the hard issues of deadlines and deliverables but in an atmosphere of flexibility and responsiveness. And lastly, the organisation must develop capabilities within its ranks and only draw on the expertise of consultants to augment their knowledge and capacity.

On the left hand side of the diagram, the two significant power bases and other leadership traits that influence the success of an HIV/AIDS workplace intervention are shown. The power bases perceived to be most effective, as discovered through Research Question 3, are Expert and Legitimate power. These are combined with the influence of passion and optimism, as well as the impetus that leveraging people's competitive nature has on the success of an intervention. The greater the extent of these factors on the left, the more successful the intervention is likely to be. Expert power can be developed by improving leadership's knowledge on HIV/AIDS. Legitimate power can be strengthened by enlisting more senior members of the organisation in the leadership coalition. Passion and optimism are more difficult to create but the magnitude of their presence will influence the success of the intervention directly. Finally it has been shown that the inherent nature of human beings to compete can be used to leverage success, both within and between companies.

All this is must be achieved in an environment of confidentiality and trust. The ultimate outcome of which will be the behavioural change required to: prevent new infections, prevent mother to child transmission, eradicate stigma and discrimination, improve the up take of VCT, enrol more people in treatment management programmes, prevent people from getting sick and dying and ultimately to win in the battle against HIV/AIDS.

The model overleaf (Figure 5) illustrates the necessary elements for business to consider when embarking on, or seeking to improve workplace HIV/AIDS interventions.

Figure 5. Essential Leadership and Organisational Change Elements for Successful HIV/AIDS Workplace Interventions



7. Chapter 7 – Conclusion

In this chapter the major findings of the research will be discussed. In addition, recommendations are made and ideas for future research are listed.

"Achieving the many political commitments made on HIV will require stronger leadership, building on recent successes, taking account of lessons learnt, increased financial resources, improved coordination of effort, and effective action to address societal determinants of HIV risk and vulnerability" (UNAIDS, 2008, p12).

As the threat of complacency looms large, leadership must take stock of the long term realities surrounding the impact of HIV/AIDS. Prevention and behavioural change are vital and, by their very nature, require a long term perspective. There is a perception that workplace interventions are losing momentum as weariness sets in. As the quick wins of testing and treatment are dispatched, the hard work of long-term imperatives sets in, however impetus cannot be forsaken. As DeBeers point out, "Business must remain vigilant and maintain momentum" (DeBeers in Dickinson, 2006, p.3). "Leadership means avoiding the temptation to 'wish the epidemic away' once progress in the response begins to be reported. Leaders on HIV recognise that the epidemic is a generations long challenge that requires persistence, vision, and flexibility; in short, HIV leadership means planning for the long-term" (UNAIDS, 2008, p.193).

7.1. Recommendations

Figure 5 presents a model of essential leadership and organisational change elements required for successful HIV/AIDS workplace interventions. It is this model which provides the basis of the recommendations. The ultimate objective of an intervention of this nature is behavioural.

The nine elements of change begin with establishing, through situation analysis and statistics, the risk that the organisation faces and using this to create urgency around the response. Leaders at three levels - on the board (preferably championed by the CEO or Chairman), at the HIV/AIDS Manager level and then at the operational level, must be involved. A simple vision must be created and substantial energy and resources must be invested in communicating this vision creatively and effectively. The emergent elements critical for workplace interventions were metrics, including the HIV/AIDS related elements in management metrics and KPIs. As many stakeholders as possible must be involved in the process, and there should be broad based engagement with employees, the unions, the community, the government through public/private partnerships, and coalitions with other companies. This must be an inclusive process in every respect. To build and sustain momentum elements of the programme and not the programme at large must be focused on. Short term wins at the outset would mean delivering on the elements of the programme that can be procured, such as VCT, PMTCT and treatment. Successes should be celebrated and the learnings used as a foundation on which to build more change. Finally, it should be the ultimate aim of every organisation to have this intervention entrenched in the organisation's culture. All of this must be done in an environment of trust, the value of which cannot be stressed enough. Every effort must be made to ensure that trust is preserved and that confidentiality and human rights are sacrosanct.

On the one hand the strategy for change has an impact the elements of change. This begins with employing a combination of Theory E and Theory O change. The salient points include goals being both economic and motivated by the moral obligation. Leadership must be both decisive and consultative, the process must be vigilant about outcomes but flexible on how these are achieved, and capabilities must be developed in-house with consultants being used for their expertise to augment the organisation's knowledge and proficiency.

Finally, certain power bases, leadership traits and behavioural constructs influence the effectiveness of the change. Most notably, the value of knowledge is leveraged through Expert power, while the obligation is placed on leadership given that the most effective power base is Legitimate power. The traits that leaders must embody are passion and optimism, which have a significant influence on the success of the interventions. An interesting observation was the effect that people's competitive nature has on success, individuals, departments and companies and this should be leveraged for success.

7.2. Future Research Ideas

Given the limitations of the research described in Chapter 4, the researcher has identified the following areas to be researched in the future. The research problems presented below would provide a sensible extension of the exploratory research undertaken in this study:

- Divisional /business unit responses – research the critical success factors that make one mine/mill/brewery successful and others not.
- Leadership of organisational change in the HIV/AIDS workplace interventions of small and medium enterprises.
- Research how organisations sustain successful HIV/AIDS workplace interventions, maintaining momentum and positive outcomes.
- The efficacy of corporate wellness programmes and their impact on HIV/AIDS, in particular looking at the benefits of incorporating the HIV/AIDS workplace interventions as part of the broader wellness programme.
- Quantitative study into the companies that have workplace programmes and what these programmes consist of.
- The Role of organised Labour / Unions in the fight against HIV/AIDS.

7.3. Conclusion of the Research

This exploratory research provides a framework for the leadership of HIV/AIDS workplace interventions. South Africa has been exposed to the worst burden of the global epidemic and the response, across all sectors, has been inadequate. By applying the learnings of this research, business leaders will be better positioned to lead successful HIV/AIDS workplace interventions.

The purpose of this research was to establish how companies that were identified as having succeeded in HIV/AIDS workplace interventions achieved this. It examined whether this could be attributed to the effective leadership of organisational change, which change strategies were employed and which power bases were used

The research shows that large scale organisational change is indeed required for the response to HIV/AIDS to be effective. It shows that this change is driven by a combination of the business case as well as a moral imperative, which is closely linked to organisational capabilities. It should be noted that in no way was the incentive to change purely economic.

The research reveals that workplace interventions should include nine essential elements of change, eight of which are supported by the literature and one that emerged from the research. Urgency, a guiding leadership coalition, vision and strategy, communication, empowerment and participation, realising quick wins and anchoring the change in the culture are well documented stages, with the emergent element being measurement and metrics. These nine elements, combined and employed concurrently, contribute significantly to the success of the intervention.

Finally, the research demonstrates that Legitimate power and Expert power are most commonly leveraged to realise the change objectives. It is also evident that Coercive or Punitive power should be avoided in interventions of this nature.

These findings have been condensed into a model for leadership of the organisational change required for successful HIV/AIDS workplace interventions. As a result, it is submitted that this research has made a useful contribution to the knowledge base on this subject. The research will prove valuable to those business leaders who wish to initiate HIV/AIDS interventions in the workplace as well as to those who perceive their endeavours in this area to be ineffective. Most importantly, the research should demonstrate that, notwithstanding all the intricacies, complexities, trials and difficulties, it is most certainly possible to succeed in workplace responses to the HIV/AIDS epidemic.

‘A LEADER IS A DEALER IN HOPE’

Napoleon Bonaparte

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9. Appendices

Appendix 1 – The Eight-Stage Process of Creating Major Change

Appendix 2 – Interview Guide

Appendix 3 – Fields Used in Content Analysis

Appendix 4 – Graphs of Power Base Distribution

Appendix 5 – Responses by the Interviewees

Appendix 1

The Eight-Stage Process of Creating Major Change

1 ESTABLISHING A SENSE OF URGENCY
Examining the market and competitive realities
Identifying and discussing crises, potential crises, or major opportunities

2 CREATING THE GUIDING COALITION
Putting together a group with enough power to lead the change
Getting the group to work together like a team

3 DEVELOPING A VISION AND STRATEGY
Creating a vision to help direct the change effort
Developing strategies for achieving that vision

4 COMMUNICATING THE CHANGE VISION
Using every vehicle possible to constantly communicate the new vision and strategies
Having the guiding coalition role model the behaviour expected of employees

5 EMPOWERING BROAD-BASED ACTION
Getting rid of obstacles
Changing systems or structures that undermine the change vision
Encouraging risk-taking and non-traditional ideas, activities, and actions

6 GENERATING SHORT-TERM WINS
Planning for visible improvements in performance, or "wins"
Creating those wins
Visibly recognising and rewarding people who made the wins possible

7 CONSOLIDATING GAINS AND PRODUCING MORE CHANGE
Using increased credibility to change all systems, structures, and policies that do not fit together and do not fit the transformation vision
Hiring, promoting and developing people who can implement the change vision
Reinvigorating the process with new projects, themes, and change agents

8 ANCHORING NEW APPROACHES IN THE CULTURE
Creating better performance through customer- and productivity-oriented behaviour, more and better leadership, and more effective management
Articulating the connections between new behaviours and organisational success
Developing means to ensure leadership development and succession

Appendix 2

Universiteit van Pretoria
University of Pretoria

GORDON INSTITUTE OF BUSINESS SCIENCE

Interview Guide

Company *Company Name*

Interviewee *Person Interviewed*

Date *Date Interviewed*

I am researching leadership of the organisational change that surrounds successful HIV/AIDS workplace interventions. To this end I have prepared the interview guide that follows and I would be grateful if you would indicate your consent to doing this interview by checking the box below. Further, if you are prepared to have your name and surname disclosed in my research report please will you also check the appropriate box. If you have any concerns, please contact me or my supervisor.

Richard Douglas (Researcher)
rdouglas@uti.co.za
078 803 0121

Prof. Margie Sutherland (Research Supervisor)
sutherlandm@gibs.co.za
011 771 4000

☐ I consent to being interviewed

☐ I consent to my Name and Surname being disclosed in the final research report

Introduction

1. By way of introduction, knowing what you know now about leading change in the area of HIV/AIDS – what advice would you give others?

Types of Change

2. There is always an underlying reason for change, a motivator of some kind. This can be purely economic, bottom line, business case, or profit incentive; or it can be a need to address the organisational capabilities of the firm, improved productivity through interventions targeting skills, attitudes and behaviours. Often both are used in combination. I would like to explore which of these it was by looking at the following dimensions that surround change: Goals, Leadership, Focus, Process, Reward systems and the use of consultants .

Goals	Were your goals purely financial – not addressing HIV/AIDS would mean that in the long term the company would lose money? ☐	Was your goal to develop a culture that embraces HIV/AIDS and the people affected by it ? ☐	A combination of responding to HIV/AIDS while acknowledging that a failure to do so would ultimately impact shareholder value negatively? ☐
Leadership	Manage change from top down – little or no input from managers, employees or the unions? ☐	Encourage participation from the bottom up, including emotional commitment to solving the problem at all levels? ☐	Set direction from the top and engage the people from below? ☐
Focus	Emphasis on the physical systems and processes that would achieve the change. Outsourcing where necessary? ☐	Build up corporate culture through a focus on employees' behaviour and attitudes, getting managers' buy-in? ☐	Focus simultaneously on the hard (structures and systems) and the soft stuff like the culture and attitudes. ☐
Process	Did you implement a compelling and rigid plan and establish programs with stringent dates and targets to achieve your objectives? ☐	Did you experiment and allow the plan to evolve with input from employees, encouraging their ideas and subject to a number of iterative evaluations? ☐	Did the plan have measurable targets but allow for spontaneity, innovation and change where necessary?. ☐
Reward system	Did you motivate managers through financial incentives? ☐	Did you motivate through commitment and convincing managers of the reality of the need? ☐	Did you use a combination of getting buy in but with financial incentives linked to success? ☐
Use of consultants	Did consultants play a significant role, analysing the problems and shaping the solution? ☐	Were consultants not used or only used to support management in shaping their own solutions? ☐	Would you say that consultants provided expert resources to empower employees? ☐

8 Stages of Change

Described below are eight stages that are expected for change to be sustainable, please indicate if any or all of these stages contributed to the success of your HIV/AIDS workplace intervention?

3. If you could give your self a score out of 5 for the degree of urgency you created, how would you score?

1 No Urgency	2	3	4	5 Tremendous urgency

Comments:

4. Can you describe what it takes from a leadership point of view to make this change happen? Who was involved? What roles did they play?

5. How important was the development of a vision and a strategy for the organisation's response to HIV/AIDS?

1 Vision not important	2	3	4	5 Vision critically important

Comments:

6. Was the communication of the change vision important and to what degree?

1 Communication not important	2	3	4	5 Communication critically important

Comments:

7. Can you describe the levels of participation/involvement across the organisation in the fight against HIV/AIDS?

1 Participation low	2	3	4	5 Participation extremely high

Comments:

8. Did you identify and go for any ‘low hanging fruit’ or ‘quick wins’? Did you focus on small successes along the way? What impact did this have?

9. Assuming success didn’t all just come at the end, did you consolidate the success along the way and use that in any way in the broader initiative? What impact did this have on momentum and sustainability?

10. Can you describe what this change has meant to *Company Name*? Has the initiative remained in management hands or is it more pervasive than that? (Are the initiatives now anchored in the culture?)

11. Is there anything else that happened in your intervention that you would consider a critical factor in its success?

12. There is research that suggests there are five types of power, I've described them briefly below. If you had 100 beans to allocate between the power bases that best describe your approach to HIV/AIDS workplace interventions - how many would you allocate to each:

Reward Power – you were able to give special benefits or rewards to people and were able to trade favours with them.	Beans
Coercive/Punishment power – you could make things difficult for people if they did not comply, they did things because they didn't want to anger you.	Beans
Legitimate power – people complied with your will because of your position of authority and job responsibilities.	Beans
Expert power – you had the experience and/knowledge that earned people's respect, they valued your judgement.	Beans
Referent power – People like you, want to be positively associated with you and therefore enjoy doing things for you, they want to please you.	Beans
	100 Beans

Appendix 3

Fields Used in Content Analysis

The following fields were used to analyse the content of the data. Each field was divided into a quantitative section where appropriate and into a Qualitative section where most of the responses were coded.

Beer and Nohria's Theory E and Theory O

Goals

Leadership

Focus

Process

Reward System

Use of Consultants

Kotter's 8 Steps

Urgency

Leadership - guiding coalition

Vision and strategy

Communication

Participation and involvement

Quick wins

Consolidating gains and producing more change

Anchored in culture

Other critical success factors

French and Raven's Power bases

Reward power

Coercive power

Legitimate power

Expert power

Referent power

Emergent themes/constructs

Personal experience/defining moment

Buy in support by senior leadership - CEO/Chairman mentioned

Catalysts, watersheds, defining moments

Other

HIV fatigue

Measurement, metrics, monitoring and evaluation

Operational imperative

No one thing

Reputational risk

Trust and confidentiality

Wellness/wellbeing programme

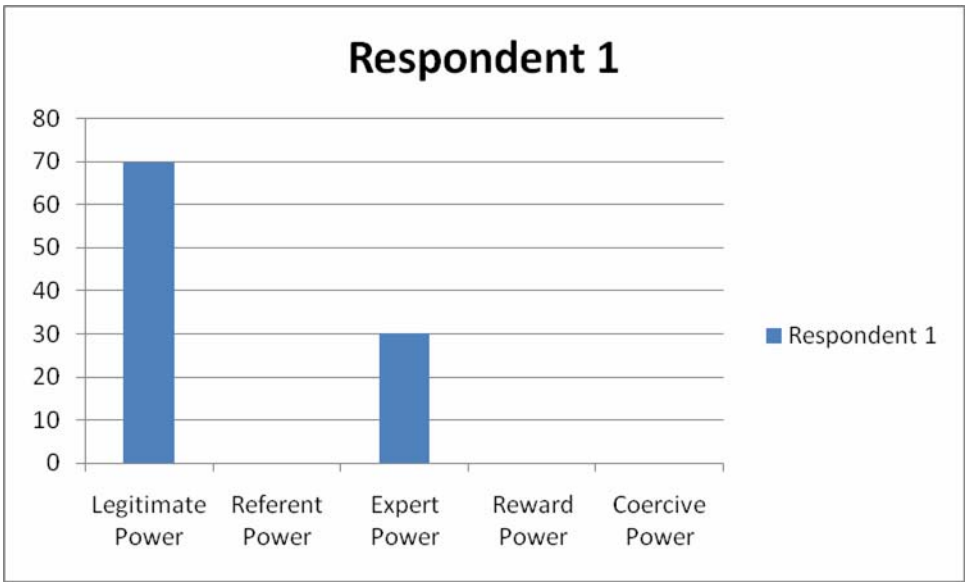
Passionate

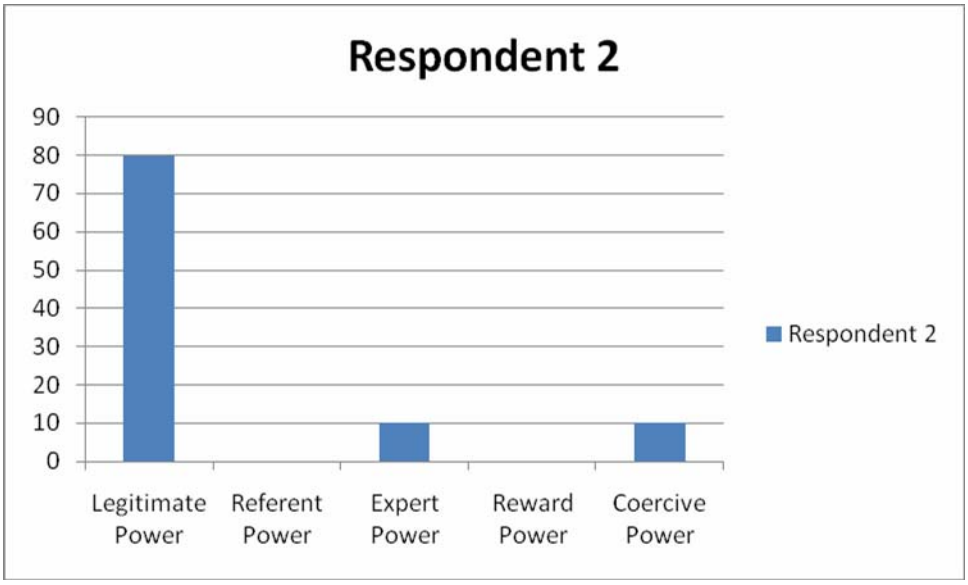
Simplicity of the programme and the communication

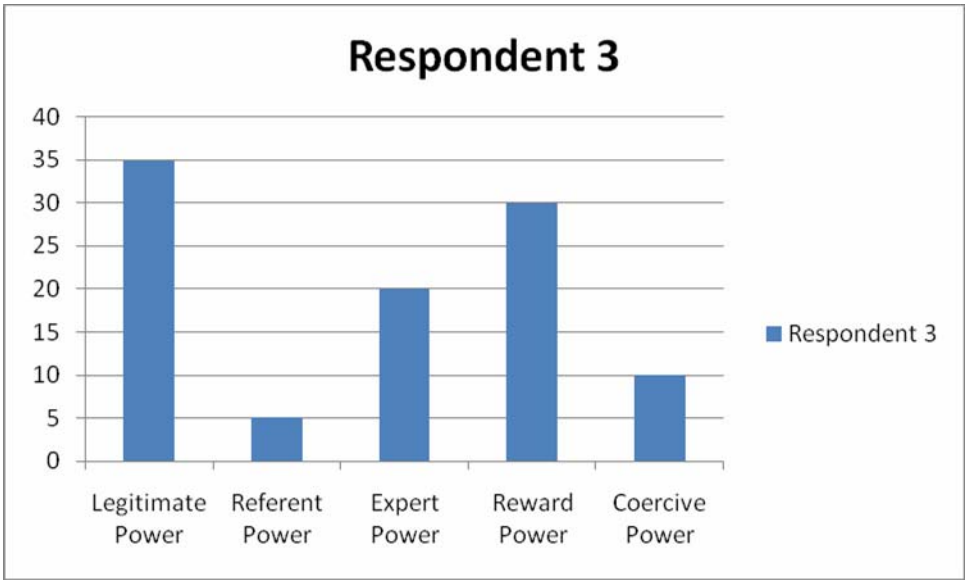
Union involvement

Appendix 4

Graphs of Power Base Distribution



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35
30
25
20
15
10
5
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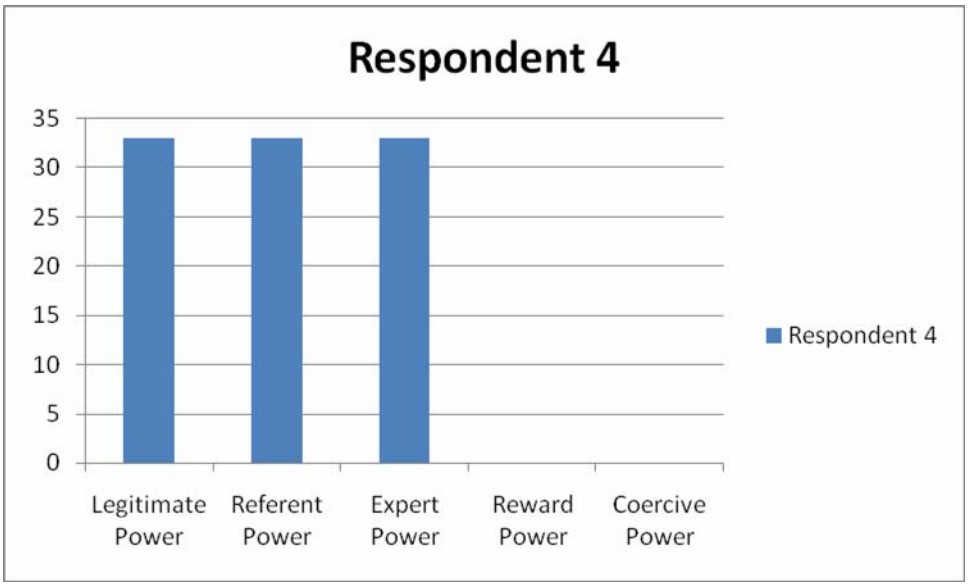
Legitimate Power
Referent Power
Expert Power
Reward Power
Coercive Power
Respondent 3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25
20
15
10
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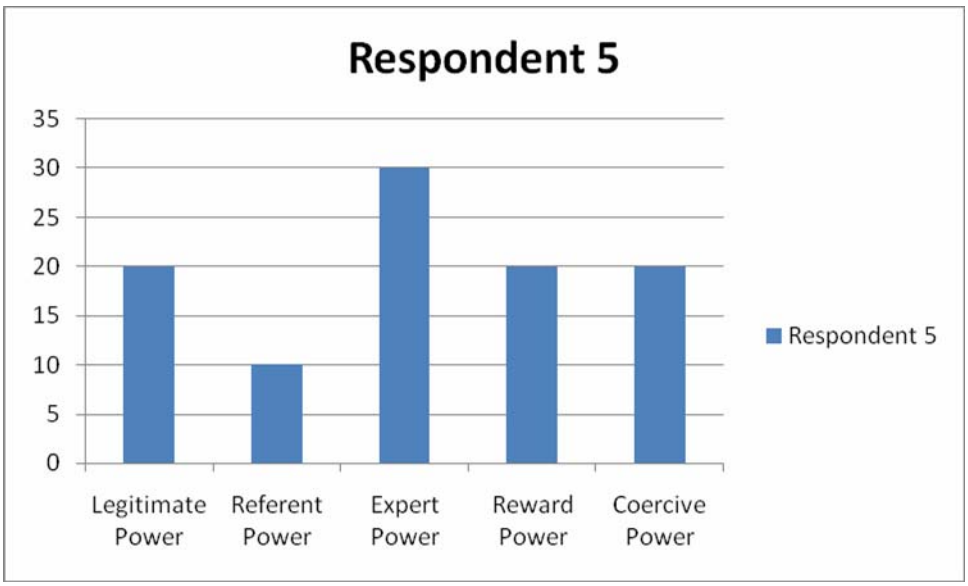
Legitimate Power
Referent Power
Expert Power
Reward Power
Coercive Power
Respondent 4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15
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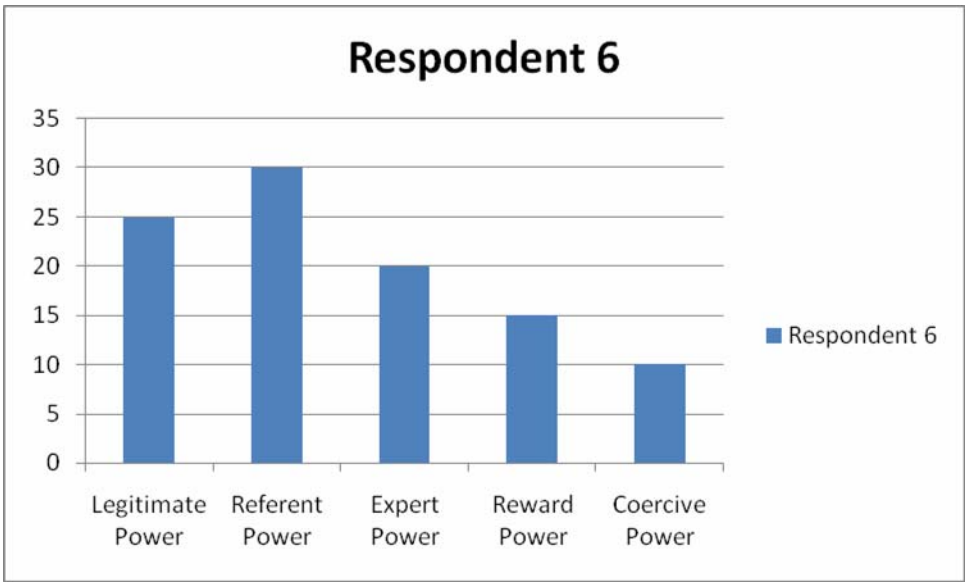
Legitimate Power
Referent Power
Expert Power
Reward Power
Coercive Power
Respondent 5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15
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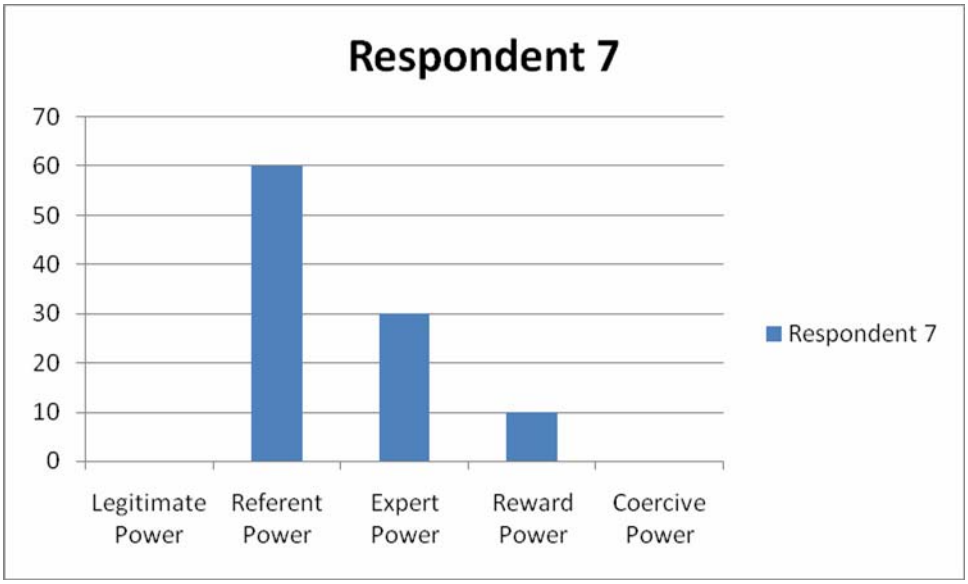
Referent Power
Expert Power
Reward Power
Coercive Power
Respondent 6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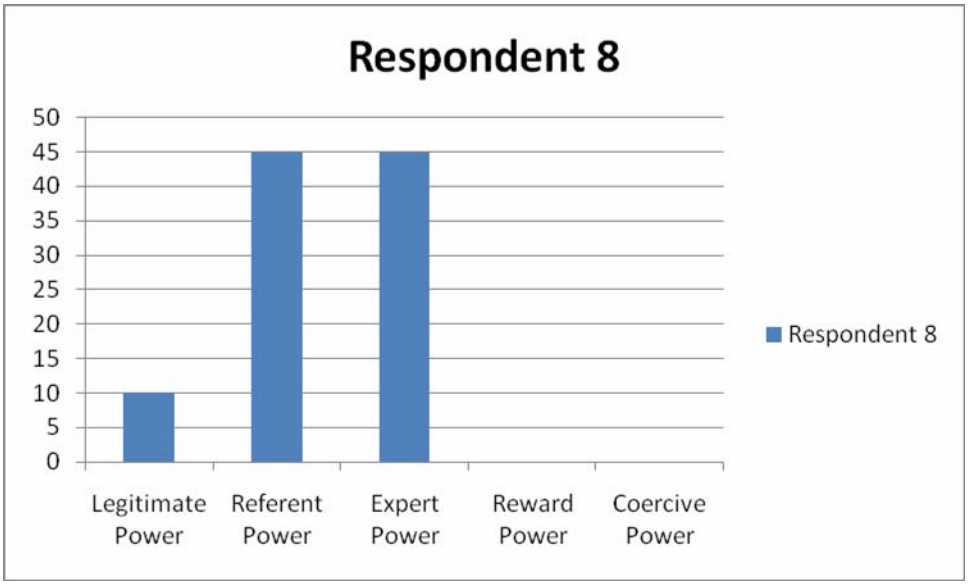
Legitimate Power
Referent Power
Expert Power
Reward Power
Coercive Power
Respondent 7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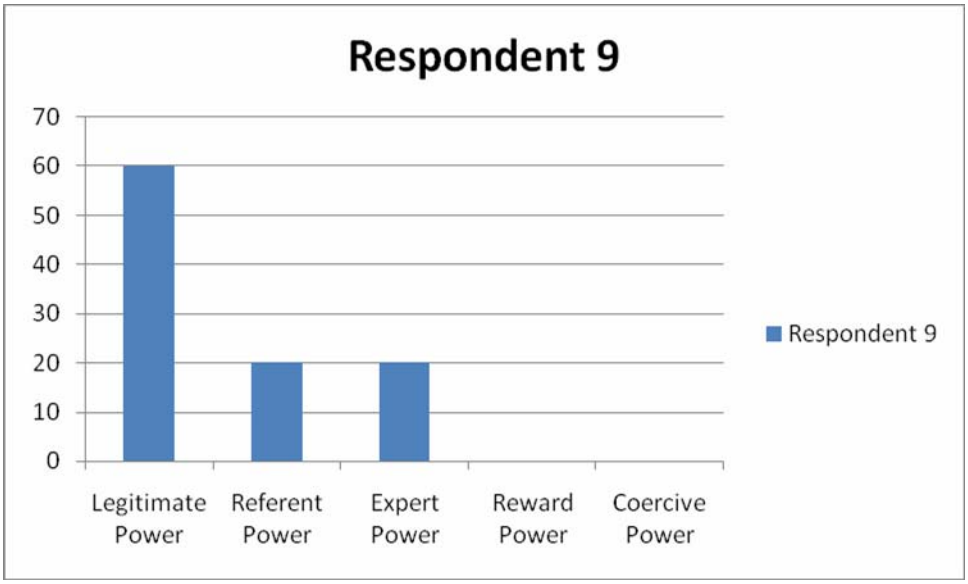
Referent Power
Expert Power
Reward Power
Coercive Power
Respondent 8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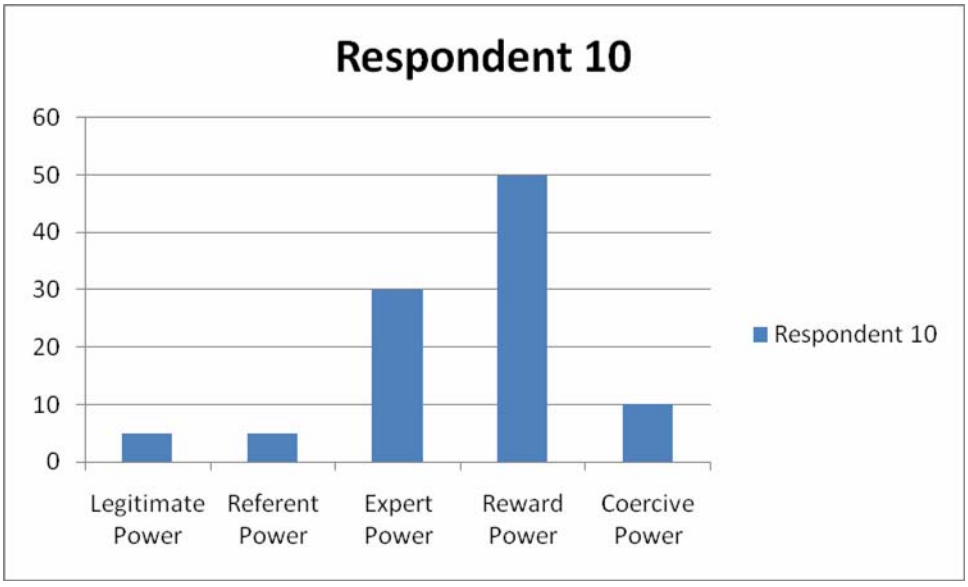
Legitimate Power
Referent Power
Expert Power
Reward Power
Coercive Power
Respondent 9


Respondent 10
60
50
40
30
20
10
0
Legitimate Power
Referent Power
Expert Power
Reward Power
Coercive Power
Respondent 10

Appendix 5

Responses by the Interviewees

Many of the responses from the interviews provide a depth of insight into the reality of HIV/AIDS workplace interventions that will prove useful to those embarking on or looking to improve their own interventions. These responses have been recorded below. The researcher has withheld the names of the respondents where it was felt that inclusion would not add significant value or could be construed as incriminate the respondent.

6.3.2. Leadership

The comments of the respondents assist in driving home this premise.

- Leadership has to be unambiguous and clear, a leadership trio at the most senior level.
- "First thing for a successful response is leadership's commitment and it must be 100%, visible and felt leadership." This leadership must act on what they see.
- Lead by example. Support people who have spoken about their status.
- Line management in production were critical. They had to support this on a day to day, operational level.
- Uganda operation which is a leadership flagship, leadership is critical and they rely on their leadership in every country.
- Leadership needs to be broad based - get the unions involved, get the shop stewards involved.

- Personal satisfaction and acknowledgement is what motivates the leader. The fact that they have achieved something worthwhile, i.e. saving lives is an incredible motivator! Recognition and awards motivate employees to do more.

- You have to have the buy in from the decision makers and senior leadership. Standish White reiterated that leadership must be visible.

- Broad leadership involvement, executives, interested parties, staff members the union, all engaging in a very consultative approach. All concerns of all stakeholders were given due consideration, and ultimately a team of experts was used to distil the information and generate policy and programmes. HIV/AIDS was considered a strategic objective, of the seven strategic drivers, HIV/AIDS was not negotiable.

- The most senior people – owners and management –set and drove the agenda and this leadership has been unwavering, promoting, advancing and standing behind the response to managing and mitigating the HIV/AIDS risk.

- You can't have just one person, ownership of the need must vest in a coalition of stakeholders, senior and middle management and experts alike. The boss knew what he was talking about when it came to HIV/AIDS, he was informed, he had read about it.

- The HR Director drove the process very hard, leadership cared and wanted to know the details. Getting this ownership and commitment at the highest level made the rollout much easier. The initiative came from the top.

- Overcome resistance from middle management. They have so many objectives to manage, work at getting them to take ownership. Not enough to just have top

management involvement - you have to have ownership at a middle management level, this is one of the biggest challenges.

- Leadership has to be engaged. "When you say who - for me it is the CEO, the very top, without exception." Board support is a critical success factor.
- A champion is essential.
- If you are leading the initiative you must have knowledge, it is imperative, social and economic in general, and business implications in particular.
- Money is not the limiting factor in the aids response, it is human initiative and leadership that makes the difference.
- Lead from the front.
- The need for a policy and programme was initiated at board level. The managing director (MD) drove the programme.
- One leader used every forum, public and private to talk about AIDS.
- HIV/AIDS was on the board agenda and on management's agenda and progress was reported.
- This imperative was driven as hard as any other in the organisation, there was almost competitive ownership of making a difference.
- Leadership must build trust, this is crucial, people must feel secure under their leadership.
- Leadership must be prepared to take Initiative, they must be prepared to be the first mover, daring to be different and challenging the conventional wisdom.

6.3.3. Vision and Strategy

When commenting on vision and strategy the following was mentioned, these are extracts from the respondents comments:

- No new infections, no deaths, no positive babies. Clearly articulated at the outset.
- Six out of five – vision is very important. Critical.
- The vision was important - but the vision needs to be simple and communicable. The vision/message was concise. Everyone must be able to understand it and it must be consistent.
- The vision is fundamental and it is a country without a burden of HIV.
- Three Zeros. No new infections, no HIV+ babies, No getting sick and dying.
- Caring for people is the company vision, employee centric – this was not a specific vision for HIV/AIDS.
- A vision for employee wellbeing. Healthy = productive. Not a specific vision cast for HIV/AIDS. There was a component of HIV/AIDS in one of their campaigns - a vivid description of the future. Care for employees and their family members, an AIDS free future.
- The Vision forms part of the broader organisational vision.

6.3.4. Communication of the Vision

This element of change received ten out of ten, the verbatim responses are included below:

- Tuesday is AIDS day. Stats every day. Part of every safety discussion. Send the message home with payslips, use posters, movies, theatre, story boards, a page in every newsletter and publication. Have to keep the initiative alive.
- Creative, needs based, designed around the context. Knew the audience. Tailored message. Example of the speedometer in the canteen, communication is massive, it must be fun.
- One respondent spoke of a carnival atmosphere, rather over communicate, must get the message across. You have got to communicate that we are winning with AIDS.
- The person originally appointed to manage HIV/AIDS at one company was in fact a communications practitioner.
- Communication must be positive. Communication must be audience specific. Have to persuade people and get understanding not just tell people or explain the mechanics of the system.
- Listen to people, really understand what's going on. More you talk about it the better the understanding. Ensure it is consistent and aligned across the company.
- At one company, managers are required to discuss HIV/AIDS for five minutes in all their staff meetings. Communication was key and the challenge of creating relevant, audience specific messages, catering for those with standard one

education to a nuclear physicist, with due consideration for generational factors and having to combat myths and overcome obstacles to the truth. She told of the need to celebrate successes."Everyone wants to be associated with winners." But be open and honest, communicate the failures.

6.3.7. Consolidate and Produce More Change

Submissions from those interviewed are listed below:

- Momentum does seem to be coming at the end. Learnt from each intervention and consolidated the learning and used that as a starting point for further change
- Learnings that are coming out of Africa, and there are lots and how can we use these in the global programme to develop programmes in emerging epidemic countries e.g. Russia, India, Latin America.
- One mine has learned from the other. Five principles were transferred from Greenside to Goedehoop. They get tweaked and modified and customised and contextualised to get the best outcomes for that particular mine but they are always building. Interdepartmental competitiveness is a reality, they look at how well that shaft is doing, inter business units, then leveraged of the success of Goedehoop to get other mines to tow the line. Other group companies are encouraged by the success stories, move the successful champions to facilitate the transfer of the success. Use it positively, look at what is being done not what is not being done.
- De Beers learnt a lot from Anglo American in the early stages of their programme development which was a major benefit to De Beers. Refined some of the treatment guidelines, broadening adherence compliance with regard to treatment. Have innovated based on what they have learned. Always building on the learning. Repositioned the initiatives. Alignment with global best practice. e.g. milk formula for Prevention of Mother to child Transmission (PMTCT), C-Section deliveries. Now

using the workplace programme to influence the development of the community programme.

- At Sappi the learning started in Forestry, when it works somewhere it gets transferred. Success in a BU is convincing, no longer theory. Demonstrates what works. Makes it tangible if someone else in the organisation is succeeding.
- Competition among the managers and engineers to meet the programme targets was identified as a fortuitous outcome and was common across a number of respondents. Engineers are very competitive, so are sales and marketing people.
- Success breeds success. Replicate the successes to other mines.
- Telkom aims at being a learning organisation adopting a continuous learning approach, an action learning approach, implement learnings in the next initiative. Learnings are recorded and documented. Keep the good discard the bad.
- Celebrate successes, communicate these and this builds momentum and sustainability.
- ESKOM learned, when they made mistakes they changed. Mkalipe described it as a journey to get to the HIV programme they have today. They experimented with different things, some worked some didn't.

6.3.8 Anchor Change in the Culture

Comments from the respondents:

- At Standard Bank commitment to the principles around an effective response to HIV/AIDS is becoming embedded in the culture, it is being embraced through the vision and values.
- It is now part of culture at SAB, even at the highest level. This is verifiable through the KABP survey that looks at qualitative issues, changes is attitude, knowledge, fears, behavioural change.
- At Anglo Coal it was first the rewards just got people to test but then it got ingrained in the culture and people tested without reward because the appreciated the value of VCT and knowing your status. Standish-White doesn't believe it is in the culture yet. He feels there is room for improvement.
- Beckett at De Beers admitted that it was hard to measure, they haven't had a change or Organisation Design (OD) specialist that has monitored this longitudinally, in fact it was never intended to be an OD intervention, as with most of the companies studied it was not an overt change management initiative. It is becoming anchored in the culture in that most De Beers employees see this as an operational risk. Not every person has bought into it but by and large De Beers personnel know that HIV/AIDS is something that we work at.
- At Sappi It is now part of culture, the programme will not be compromised if Melrose or coordinators leave, it is pervasive, the people are running with it.

- Brink at Anglo American feels it is still owned by management, it is not yet embedded in the culture.

- At BMW SA it is not just a programme the vision and ownership is entrenched in the organisation. Importantly, it was broad based at the beginning, it has always been owned at the grassroots.

- At Mercedes Benz SA it is definitely cultural, supported by an internal customer satisfaction survey and an employee satisfaction index survey. HIV/AIDS programme forms an important part of why employees work for Mercedes Benz, they say they are proud and communicate this externally.

- The workforce has taken ownership and it is spilling out into the community, the masses have been mobilised. Mkalipe related that PEPFAR funded training for lay counsellors, they expected 100 applicants, they received 2000.

6.5 Emergent Themes and Findings – Elements of Change Specific to HIV/AIDS Workplace Interventions

Catalysts, watersheds, defining moments, and personal experience

Submissions from those interviewed are listed below:

- Philip had a very personal experience, referred to this as the Damascus moment, for him this was hospice work. He says you have to be the change, walk the talk. It must be from the heart, one needs to be affected.
- Standish-White had a staff member who went to Lesotho, he even sent a driver to take him there, and the man never came back.
- A defining moment at SAB was getting the Strategic Assessment Matrix (SAM), HIV is one of the ten trends and part of the sustainable development strategy.
- At De Beers, moving from programmatic to operational risk was a defining moment.
- At Anglo American, deciding to provide treatment was a watershed, Brink recalls the date without a thought, 6 August 2002. Brink had a personal experience in his housekeeper's family.
- Victor identifies the defining moment as being where understanding was achieved and no longer someone else's disease/problem.
- Mayet said Government's inertia was a catalyst and so BMW SA took the initiative.
- Panter acknowledges the public private partnership with GTZ in Germany was a catalyst that helped reinvigorate the organisation. In November 2000 Mercedes Benz South Africa held an international two day workshop at the plant in East

London. This was a watershed event. Internal and external stakeholders from the company globally, experts and advisors.

- Mkalipe was a GP in Soweto, she had seen what HIV does. The frustration of people not knowing and the futility of it all spurred her to action.

Measurement and metrics.

Submissions from those interviewed are listed below:

- One respondent was of the opinion that monitoring and evaluation can be used to maintain the urgency.
- Statistics are vital and form the basis for measurement and metrics.
- Monitoring and evaluation appears to be an important part of maintaining the momentum of the interventions.
- Measure outcomes, identify a few indicators and measure them.
- Measurement is essential. KPIs. Have targets and stretch targets. Evaluation is based on three pillars: Implement, Improve, Impact.
- Detailed record keeping and measurements are vital, know the risk, begin with establishing prevalence.
- Good governance – reporting in the annual report is now required and this has a positive impact on the outcomes of the interventions as it is a form of accountability.

- One respondent specifically articulated monitoring and evaluation as being a critical success factor.
- It was part of the bonus measurements.