Unrealised obligations: Implementing HIV and AIDS policy in a large international development organisation

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Declaration

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Abstract / Opsomming

This study presents a qualitative analysis of the dichotomy between official HIV and AIDS policy and its implementation in a Human Rights based, United Nations (UN) agency, located in South Africa. The study demonstrates that although HIV and AIDS policy is an intrinsic part of the commitment of this large organisation, the implementation of the policy, in the form of a Workplace Wellness Programme supported by budgetary resources, is weak and incomplete. The thesis integrates detailed vignettes in drawing attention to how personnel in the South Africa office perceive and experience the implementation of HIV and AIDS policy. Additionally, the voices of bureaucrats are also integrated in an effort to interrogate management attitudes and mindsets on matters of policy and treatment of staff. The study explores staff members' sense of being stigmatised and discriminated, when living with the virus and their responses to it. In this, I bring a personal perspective to the study, by relating my own views of living with a potentially life-threatening disease to the views of the participants in the workplace in which the study is conducted.

Classical Weberian and contemporary accounts of 'bureaucracy' and the organisational 'rule book' are drawn upon. It is argued that whilst the value systems and politics of managers in the United Nations system lead them to be defined as progressive, some of the practices within their own institutions are contradictory, indifferent and manipulative leading to the perpetuation of discrimination and anxiety amongst HIV-positive staff. Thus, human agency and ingenuity supersedes organisational structure and the rigour of organisational policies and rules. The contradictions highlighted necessitate a careful scrutiny of organisational dynamics, within the wider international development scenario, and organisational introspection within individual UN offices vis-à-vis HIV and AIDS policy implementation. It is envisaged that the study will induce the commissioning of a larger study carried out by an independent body and funded by the United Nations, enabling the validation and enhancement of the argument presented in the case study and provide more recommendations for the way forward for the United Nations.

Die studie verteenwoordig ’n kwalitatiewe ontleding van die digotomie tussen amptelike MIV en VIGS beleid en die implementering daarvan in ’n menseregte-gebaseerde, Verenigde Nasies geaffilieerde kantoor, gesitueer in Suid-Afrika. Die studie demonstreer dat alhoewel MIV en VIGS beleid ’n intrinsieke deel van die verbintenis van hierdie groot organisasie is, die implementering van dié beleid in die vorm van ’n Werkplek-welstandsprogram (WWP), gerugsteun deur begrotings-hulpbronne, swak en onvolledig is. Deur die aandag te vestig op die wyse waarop personeel in die Suid-Afrikaanse kantoor die implimentering van MIV en VIGS beleid beskou en ervaar, integreer die proefskrif gedetaileerde vinjette. Hierbenewens word stemme van burokrate ook geïntegreer in ’n poging om bestuurshoudings en sienswyses rakende beleidsake en die hantering van personeel ondersoekend te beskou. Die studie verken personeellede wat met die virus saamleef se gevoel van stigmatisering en vooroordeel, asook hul reaksie hierop. Deur my eie standpunt om met ’n potensiële lewensbedreigende siekte saam te leef in verband te bring met sienings van die deelnemers in die werksplek waarin die studie uitgevoer is, bring ek ’n persoonlike perspektief na die studie.

Daar word na klassieke Weberiaanse en kontemporêre beskrywings van ‘burokrasie’ en die organisatoriese reëlboek verwys. Alhoewel die waardesisteem en politiek van bestuurders in die Verenigde Nasies daartoe lei dat hul as hoogs progressief gedefinieer word, word daar aangevoer dat sommige van hul praktyke binne hul eie instellings teenstrydig, afsydig en manipulerend is, wat lei tot die voortsetting van diskriminasie en angs onder MIV-positiewe personeel. Dus, vervang agentskap en vindingrykheid organisatoriese struktuur en die stiptheid van organisatoriese beleide en reëls. Die teenstrydighede beklemtoon, vereis ’n noukeurige betragting van organisatoriese dinamika, binne die breër internasionale ontwikkelings scenario, en organisatoriese introspeksie binne individuele VN kantore vis-à-vis MIV en VIGS beleidsimplementering. Daar word in die vooruitsig gestel dat die studie die opdraguitvoering van ’n breër studie, befonds deur die Verenigde Nasies en onderneem deur ’n onafhanklike liggaam, teweeg sal bring wat die geldigheidsverklaring en uitbouing van die argument wat in hierdie gevallestudie aangebied word sal bevorder en wat verdere voorstelle sal verskaf rakende die weg vorentoe vir die Verenigde Nasies.

Acknowledgements

2008 has been a momentous year. I weathered cancer, four surgeries, 576 hours of chemotherapy and a PhD. Frightening as this list may appear it came not without its advantages. I lost a couple of kilograms which for the better part of my life appeared to be an unachievable ambition. Alas!!! It was a pyrrhic victory.

A crucial and more lasting benefit to my doctoral thesis accrued from the cancer with which I cohabited briefly. It privileged me with an insider's perspective of living with a potentially life-threatening ailment. Working with HIV and AIDS, this perspective was an incomparable gift to my thesis. My dear professor, adviser and friend Kammila Naidoo brought it to my notice in one of many wonderfully empowering feedback sessions. For that I am immensely grateful to Kammila. At the best of times, middle-aged academics are not the easiest to coach. Kammila did it with patience and determination and is largely responsible for my finishing the study.

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For my father and father-in-law who didn't live to see the completion of my thesis and my mother and mother-in-law who did and doted unabashedly. To my sister-in-law Vaishali Banerjee, who dropped everything and came when we needed her and my baby sister Sharmila Bhattacharya who completed her post-doctoral studies decades before I embarked on my PhD and who never ceased to extol the virtues of pain in the pursuits of health and intellect, I owe an immeasurable debt of gratitude.

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Glossary of Terminology and Acronyms

A glossary of terminology and acronyms used in the thesis is presented below. Many of the terms are used specifically in the context of HIV and AIDS and do not constitute regular idiom. Some of the key phrases are contextualized and explained in greater detail at the point at which they are introduced in the thesis.

- AIDS: Acquired Immune Deficiency Syndrome
- ARV: Anti-retroviral drugs. A form of medical therapy that controls the viral load in the human body
- Aston Group: A group of theorists from the University of Aston in Birmingham
- BER: Bureau for Economic Research
- CD4: T-cells are specialized white blood cells that play an important role in the body's immune system. These "helper" cells initiate the body's response to invading micro-organisms such as viruses.
- ECA: Economic Commission for Africa
- ECOSOC: Economic and Social Council of the United Nations
- GA: General Assembly of the United Nations
- GATT: General Agreement on Trade and Tariff
- GIPA[1]: Greater Involvement of People living with HIV and AIDS. It is a formal global movement
- HIV: Human Immunodeficiency Virus
- HR: Human Resources, an administration department in organisations
- HQ: Headquarters
- IFC: International Finance Corporation
- IDO: International Development Organisation
- ILO: International Labour Organisation

[1] I believe it is important not to label individuals or groups of individuals in acronyms. It is crucial for me to state my personal belief in the light of the fact that I will be using terms such as PLWHA or GIPA for convenience in this study.

- IMF: International Monetary Fund
- IOM: International Organisation for Migration
- MSF: *Medecins Sans Frontieres*
- NGO: Non-governmental Organisation
- PGC: Gewirth's Principle of Generic Consistency
- PLWHA: People Living with HIV and AIDS
- RCT: Rational Choice Theory
- SAA: South African Airlines
- SABCOHA: South African Business Coalition on HIV/AIDS
- SARS: Severe acute respiratory syndrome
- SC: Security Council of the United Nations
- Sero-positive: A person who has tested positive for HIV, the virus that may cause AIDS
- SIV: Simian Immunodeficiency Virus
- SSA: Short Service Agreement
- TAC: Treatment Action Campaign
- TB: Tuberculosis
- UIF: Unemployment Insurance Fund.
- UN: United Nations
- UNO: United Nations Organisation
- UNAIDS: The Joint United Nations Programme on HIV/AIDS
- UNDP: United Nations Development Programme
- UNEP: United Nations Environmental Programme
- UNESCO: United Nations Educational, Scientific and Cultural Organisation
- UNFPA: The United Nations Population Fund
- UNHCR: United Nations High Commission for Refugees
- UNICEF: The United Nations Children's Fund
- VCT: Voluntary Counselling and Testing
- VCCT: Voluntary and Confidential Counselling and Testing
- WFP: World Food Programme

- WHO: World Health Organisation
- WTO: World Trade Organisation
- WWP: Workplace Wellness Programme

Keywords

HIV, AIDS, International Development Organisation, Workplace Wellness Programme, United Nations, Bureaucracy.

Chapter 1- Problem, rationale and research concerns

1.1 Background and rationale for the study

The opening chapter landscapes the study by outlining the criticality of the research subject and the reason for its selection. In order to establish its relevance and importance, the study articulates the particular problem of HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) in South Africa and the vital role of international development organisations in the response to the epidemic.

HIV and AIDS is arguably the "greatest public health threat facing South Africa" (Mangcu 2008: 49-50). The severity of this threat to the nation makes the South African location of this study pertinent. Compounding the problem of the HIV epidemic in the country has been the relative apathy and "intransigence" of governments in South Africa. Early indication of the government's response to the HIV and AIDS epidemic in the country can be traced back to the apartheid years of the 1980s when the government "dismissed HIV/AIDS as a disease affecting homosexuals" viewing the epidemic as due retribution for "people regarded as wayward". Despite an egalitarian constitution that prescribes rights to people without discrimination of gender, race or sexual orientation, the apathetic approach persisted even beyond the apartheid years. According to Mangcu (2008: 50) even under Nelson Mandela's government HIV and AIDS responses were driven by a hetero-normative and homophobic paradigm, resulting in AIDS not receiving "as much attention as it warranted". By the time Mandela handed over the reigns of government to his successor Thabo Mbeki in 1999 the epidemic had already spread to "7 percent of the population" in South Africa. Between "denialism" and a recommended promotion of "beetroot, lemon and garlic" the Mbeki government drove Stephen Lewis, the United Nations Special Envoy in Africa to describe the incumbent South Africa government's HIV and AIDS responses as "obtuse, dilatory and negligent about rolling out treatment"

(http://www.kaisernetwork.org/health_cast/uploaded_files/Lewis%20Closing%20Speech.pdf). By 2005 HIV prevalence (in percentage terms) reported in the 2006 report released by UNAIDS (The Joint United Nations Programme on HIV/AIDS) rose to 18.8% in the age group 15-59 years.

The preceding paragraph establishes the significance of AIDS as a key issue in South Africa. It is therefore vital for international development organisations, such as the United Nations, who advise and support the national response to be consistent and proactive not just in their policy advice to the government in South Africa but in their own HIV and AIDS policy implementation. A relevant question that the study addresses is, 'Do international development organisations located in South Africa themselves implement the policies outlined by the International Labour Organisation and their own institutions?'

In order to lay a foundation for the study it is necessary to further establish the importance and immediacy of the subject of this thesis. The study seeks to demonstrate the proposition that although HIV and AIDS policies are an intrinsic part of the commitment of international development organisations such as the United Nations, the implementation of these HIV and AIDS policies in the form of Workplace Wellness Programmes (WWP) supported by budgetary resources is not comprehensive. Data that draws attention to the presence and management of HIV and AIDS in the workplace is also presented. As an area of sociological study, the thesis attempts to understand the bureaucracy and its management approach. It explores Weber's understanding of bureaucracy, his perspectives on interpretive understanding and social action. The thesis does however take the argument beyond Weber's assumption that, the highly formalised construct of a bureaucracy is underpinned by its inflexible rules and roles and that this is an absolute and definitive truth. It is against this discourse that the thesis presents the analysis that, it is the decision-maker's views, beliefs and self-interest that are key drivers of the selective and interpretive implementation of policy and the concomitant constraints.

The thesis breaks new ground in its presentation of the contradictions between a Human Rights based workplace policy and the lived-experiences of people who are supposed to be benefitting from the rights intentions of the policy. The study explores some staff members' feelings of stigmatisation and discrimination stemming from living with the virus and the response of some workplace colleagues to this fact.

This study is particularly relevant owing to the worldwide pandemic of HIV and AIDS. The enormity of the issue is evidenced in the UNAIDS publication, *Living in a world with HIV and AIDS* (UNAIDS/04.27E 2004: 46), which estimates that "as many as 5% of UN employees worldwide may be living with HIV". Interest in this study was sparked by the publication's projection that if the various agencies within the UN-system were to be pooled together and viewed as a 'country', it would feature among the top 30 countries most affected by the epidemic of HIV and AIDS. Further, in several of the agencies within the UN system, AIDS is the primary cause of mortality among employees. The same publication goes on to table some very revealing findings from a 2002 survey of UN employees about their outlook on the epidemic in the context of their own lives and workplace. The underlying finding of the survey was one of fear and lack of confidence in their organisation's HIV and AIDS policy. Twelve percent of employees feared that they were HIV positive and expressed reluctance to discover their sero-status, while 41% felt that any knowledge of a positive sero-status would lead to stigmatisation and discrimination. As many as 32% of staff members interviewed believed that their employers in the United Nations would not keep their sero-status confidential. Two percent of those responding to the same UN 2002 survey claimed to be living with the virus and "afraid to reveal their serostatus at work" (UNAIDS/04.27E 2004: 46).

According to another UNAIDS study with assumptions accepted by the UN Human Resources department, the total number of staff employed by the United Nations worldwide in 2004 was "56,619 fixed term staff members". The average HIV prevalence rate among the global UN workforce was estimated at "1.73%" (UNAIDS/IAAG (22)/06.4: 29). The numbers of UN staff and their dependants living with the virus are summarized in the table (Table 1.1) below. Results show that worldwide, as many as

3,500 UN staff members and their dependants (of a total of 257,616) could be living with HIV.

Table 1.1: Number of UN staff and dependants globally living with HIV

	Staff only			**Dependants only**		**Staff and dependants**	
	HIV prevalence	Total	Living with HIV	Total	Living with HIV	Total	Living with HIV
Fixed term	1.7%	56619	978	141548	1711	198167	2689
Contingency	1.7%	16986	293	42464	513	59450	807
Total UN staff	1.7%	73605	1271	184012	2224	257616	3495

The above figures are global statistics from 2004 (UNAIDS 2004: 46). They suggest that the total estimate of people living with the virus at the United Nations globally was estimated to be about 1.7%.

It should be noted that the above UNAIDS report offers the following rider:

> It should be cautioned that the above estimates are associated with a lot of uncertainty. The effect of HIV is different for people of different social class, age and sex and estimates should ideally be adjusted for these factors. However, in the absence of information on these factors, the estimates were based on assumptions that were agreed upon in consultation with Human Resources (UNAIDS/IAAG (22)/06.4: 29).

This cautionary rider explains the difference in the two different prevalence figures estimated in the above two studies of the United Nations system. While one suggests the figure may be 5% the other estimates it to be 1.73%. The difference between the two figures is not germane to this study. What is important is the understanding that both figures could be considered high and unacceptable from the moral and efficiency point of view. It is therefore vital for the United Nations to act urgently to fully implement its own HIV and AIDS policy.

The situation however looks quite different in a May 2006 VCCT (Voluntary Confidential Counselling and Testing) Report. The monitoring of HIV prevalence (in the May 2006 Report) was carried out among staff on a smaller, but more relevant, section of the UN in South Africa. The specific relevance lies in the fact that the May 2006 Report is located in the same workplace environment in which the fieldwork for this study is situated. The May 2006 VCCT Report found that 5.7% of all staff in the office were living with the virus. This variance in the global UN estimate and the South African UN estimate reflects the fact that countries like South Africa in Sub-Saharan Africa constitute the epicentre of the epidemic. According to a UNAIDS publication (UNAIDS 2007: 6) titled *AIDS Epidemic Update: December 2007*, the estimated number of deaths due to AIDS in 2007 was 2.1 million [1.9-2.4 million] worldwide, of which 76% occurred in sub-Saharan Africa.

The May 2006 VCCT Report, located in the milieu of the study, states that a total of "138 employees" attended the presentations designed to motivate staff to test for their status and "105 chose to undergo testing. In total, 105 employees underwent VCCT (52.5% of the total targeted employee base). Including two spouses, 107 individuals underwent VCCT. Six employees tested positive (5.7% HIV Prevalence)". It is important to bear in mind that only about half the targeted population actually agreed to undergo testing. It is possible, therefore, that among the population not available for the tests there was a large section of staff members who knew their HIV status and felt it unnecessary to undergo further tests. There may also have been staff members who believed that they might be HIV positive, but were emotionally ill-equipped to reveal their status to others, in particular their employer. By this assumption, it may be feasible to estimate that the actual number of people living with the virus could be at least double the UN quoted global average of 1.7%, or even higher if one accepts the hypothesis that it is possible that some staff members who know themselves to be HIV positive may find it unnecessary to test themselves again at a VCCT centre. Further, the proportion of staff members opting to test themselves endorses the earlier argument, based on the UNAIDS publication *Living with HIV and AIDS* (UNAIDS/042.7E 2004:46), that there is fear and

a mistrust of the manner in which organs of the UN system may be handling the presence of the virus in its own workplace.

It would not be presumptuous to assume, that in a Human Rights based and mandated structure like the United Nations system, the May 2006 Report (freely circulated within the system) would result in an active, comprehensive and committed response to an epidemic that is now in its third decade. However, a Progress Report (Johannesburg, 22 June 2004 – see Table 1.2) on HIV and AIDS in the UN workplace, circulated by ILO/AIDS (The AIDS unit of the International Labour Organization - ILO), draws attention to the disconnection between commitment and action (see Figure 1.1) on the HIV and AIDS workplace policy. This June 2004 Progress Report was conducted among a number of different international development agencies under the UN chapeau. The list of UN agencies participating in the 2004 Progress Report were from African countries located in Southern and Eastern Africa and included South Africa, making it important material for analysis.

Table 1.2: List of UN agencies participating in the ILO/AIDS study 2004.

Countries	UN Agencies
Ethiopia	ECA, IOM (International Organisation for Migration), ILO, UNDP (United Nations Development Programme), UNICEF (United Nations Children's Fund), UNESCO (United Nations Educational, Scientific and Cultural Organisation), UNFPA (The United Nations Population Fund), UNHCR (United Nations High Commission for Refugees), WHO (World Health Organisation)
Lesotho	UNDP
Mozambique	UNICEF, WHO
Tanzania	FAO, ILO, UNDP, UNICEF, UNESCO, WFP (World Food Programme)
South Africa	ILO
Zimbabwe	ILO, UNFPA, UNICEF, WHO, WFP

Source: ILO/AIDS Progress Report. Johannesburg 22 June 2004.

The following bar chart (Figure 1.1) is taken from the same ILO/AIDS Progress Report of June 2004. It demonstrates that, while almost 80% of the offices assessed by ILO had interagency work plans for dealing with HIV and AIDS, a little over half had budgets

available for the implementation of the workplan.

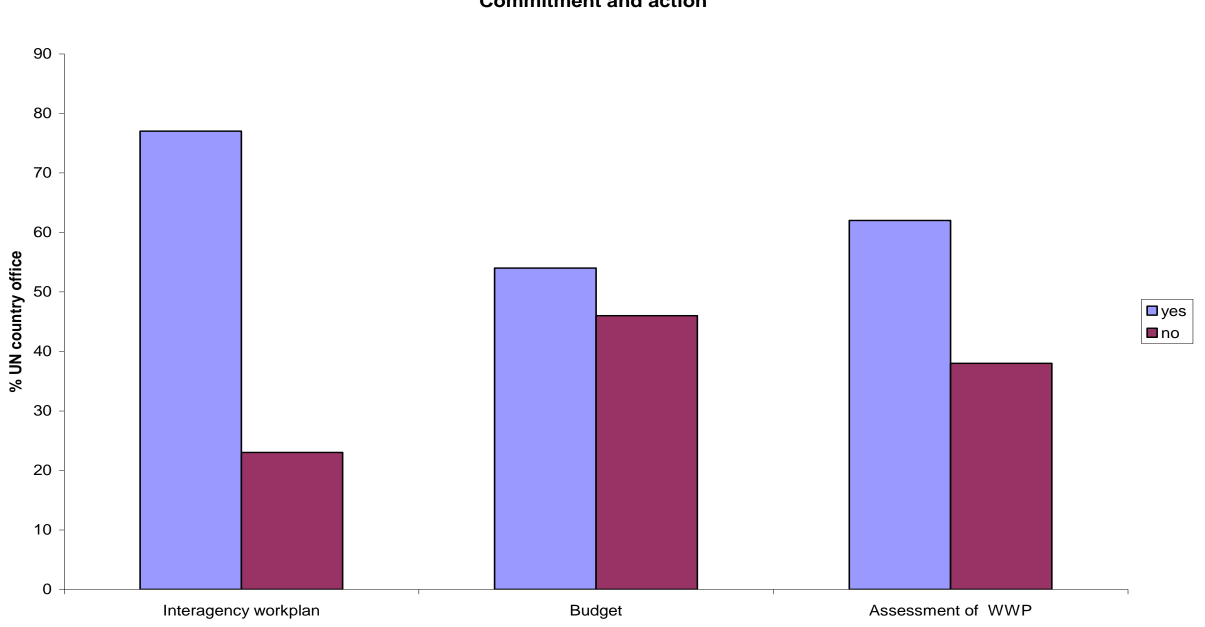

Figure 1.1: Rapid assessment of the implementation of HIV and AIDS workplace policies and programs in the UN Workplace in Eastern and Southern Africa.

The study (ILO/AIDS 2004: 3- 4) goes on to state that, 92% of United Nations Country Offices reported that they had adopted the 1991 UN Personnel Policy on HIV/AIDS[2]. A few of the agencies namely ILO, UNDP and UNICEF had even proceeded to internalise the policy, integrating it in their human resources policy framework, which they had adapted to the particularities of their organisations. Eighty-five percent of United Nations Country Offices were set up to provide healthcare services at the workplace for HIV and AIDS treatment, care and support, not just for staff members but also for their dependants living with the virus. Fifty-seven percent of the Country Offices reported that staff members, especially those on transitory contracts, were likely to fear disclosing their sero-status even at the risk of missing out on the possibilities of claiming health benefits. This 57% figure indicates that, though the policies are in the process of being implemented, some members of the workplace are confident enough about the HIV

[2] The key objective of the 1991 policy may be inferred to be the mitigation of the impact of HIV/AIDS on UN staff and their families. The four key policy areas are: a) preventive health measures b) voluntary counselling, testing, and confidentiality c) terms of appointment and service d) health insurance benefits programmes. The guidance notes address implementation in each of these areas.

workplace programme, to disclose their sero-status and request the benefits to which this entitles them. These statistics indicate the situation as it is manifested, but do not explain the dichotomy between policy and practice.

The recently designed Wellness Programmes in International Organisations are sometimes proactive (as indicated by the presence of prevention programmes), but are primarily reactive in nature to enable the organisation to manage the complex socio-medical consequences (stigma, discrimination and criteria based access to treatment) of contracting the virus.

As, Dr. Manto Tshabalala-Msimang, the former South African Minister of Health states:

> I can't say we have a roll-out because the plan has not been adequately costed. We are really not happy with the costing yet. (Mail and Guardian, 15-21 Aug. 2003 cited in Natrass 2004: 56).

The above quotation sums up the key concern of leaders, managers and decision-makers, attempting to address the challenges of implementing policies related to HIV and AIDS - the rational and logical inclination to balance the cheque book. Studies undertaken in the region by the Bureau for Economic Research (2001), ING-Barings (2000) and the Arndt-Lewis study (2000) all underline this key aspect of the impact of the epidemic. Although these studies are based on private sector organisations and not development organisations, it is pertinent to quote them (in the absence of similar studies from the development sector) to make a point on the increasing impact of HIV and AIDS on organisational structures, staff costs and budgets. These are areas of concern that are relevant and common, to both private and public sectors. The assumption is that the development sector, like the private sector, has to contend with finite resources and rising programmatic needs and administrative costs. As the former Secretary General of the United Nations, Kofi Annan, stated in a press release (SG/SM/7779/Rev.1 on 26 April 2001),

> … we need money. The war on AIDS will not be won without a *war chest*, of a size far beyond what is available so far. Money is needed for education and

> awareness campaigns, for HIV tests, for condoms, for drugs, for scientific research, to provide care for orphans, and of course to *improve our health care systems*. At a minimum, we need to be able to spend an *additional seven-to-ten billion dollars a year* on the struggle against HIV/AIDS in the world as a whole, over an extended period of time. It sounds a lot, and it is a lot. Somehow we have to bring about a quantum leap in the scale of resources available. But it is not at all impossible, given the amount of wealth in the world. In fact it is little more than one per cent of the world's annual military spending. We just have to convince those with the power to spend -- public and private donors alike -- that this would be money well spent.

Apart from the plea for additional resources the UN Secretary General's statement (SG/SM/7779/Rev.1 on 26 April 2001) implies that resources exist in the "world" and that decision-makers need to enhance attention to the priority of HIV and AIDS responses and policy implementation.

Budgetary needs can only be properly appreciated in the context of the prevalence of this pandemic. As this study concerns the South African situation, the following statistics from the Bureau for Economic Research are pan-South African and demographic in nature. They relate to the South African population as a whole and are relevant to workplace scenarios across private, governmental and developmental sectors. The following bar chart (Figure 1.2) shows the high presence of HIV and AIDS among people in the relatively more productive age group, and its potential effect on the health of organisations:

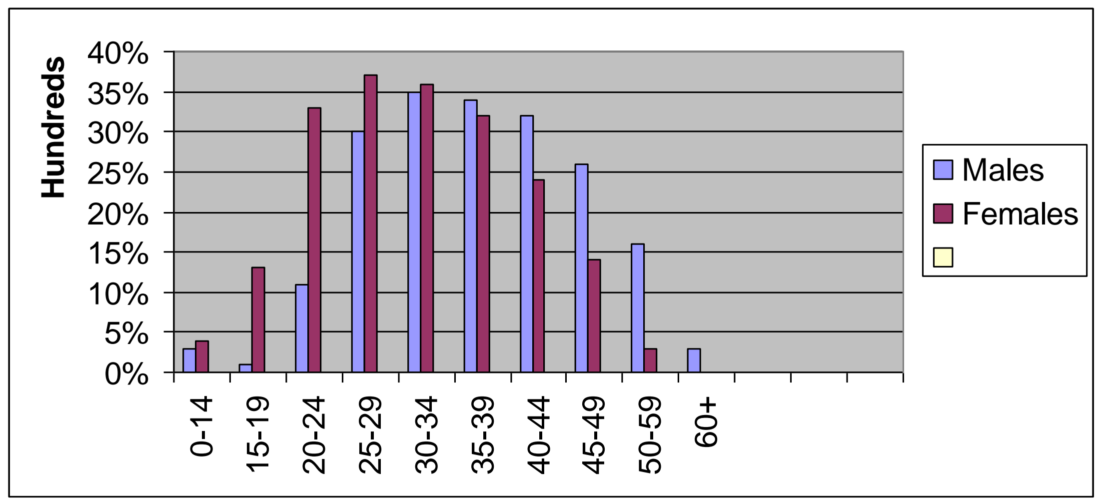

Figure 1.2: HIV prevalence by age group in 2003 (Source: Bureau for Economic Research).

The majority of people who are afflicted with diseases arising from the AIDS condition are in the economically productive age group of 25-49 years (Figure 1.2). According to the 2007 AIDS Epidemic Update, 18.8% of the adult[3] (aged 15-49) population in South Africa is living with HIV (UNAIDS/07.27E/JC1322E 2007: 11). AIDS-related deaths could quadruple over the next decade (BER 2003: 8-9), resulting in organisations needing "to increase contributions to pension, life, disability and medical benefits on account of the AIDS epidemic" (BER 2003: 11) in addition to the increase of direct costs due to absenteeism, training, recruitment, labour turnover and so on. These budget heads are relevant in the management of HIV and AIDS in all forms of workplaces, including development sector ones.

As the incidence of the epidemic accelerated in South Africa a little later than in other countries in the region, and as the median incubation period of the virus is about 8.5 years, the consequences of the epidemic are still to be fully felt in this country (BER 2003: 4). In the absence of suitable intervention, the morbidity (illness) and mortality (death) are likely to increase and the additional morbidity and mortality could raise organisational overheads even further.

On the one hand, managers heading organisations have to deal with the statistical progression of the epidemic; on the other, they have to deal with the implementation of organisational policy and the laws of the land. Some of these policies are relatively recent in the evolution of the organisations. For example, according to Kauffman and Lindauer (2004: 20-21) it is illegal to discriminate in South Africa on the basis of a person's health including a person's sero-status. While this would be considered a humane policy, it is important to consider that there is likely to be an associated "economic cost to such a law". Kauffman and Lindauer also observed that the "cost of hiring an HIV-infected worker was higher than the cost of hiring a worker with a sero-negative status". As a result of the costing issue, managers are left with the dilemma of choice between finding

[3] The UNAIDS 2007 AIDS Epidemic Update (UNAIDS/07.27E/JC1322E) categorises adults as aged 15 and above, while Chapter 2: Bill of Rights, Section 28.3 of the Constitution of South Africa, 1996 defines a child as "a person under the age of 18 years".

additional resources (for what could be perceived as a never-ending spiral of expenses) and shifting the burden to the staff or even the general population by replacing staff with technology. However, for managers of large international development organisations such as the United Nations, the options are rarely governed by economic considerations, though budgetary imperatives are, of course, a reality. The United Nations operating budgets globally are largely bank-rolled by United Nations Member states. The wealthier nations allocate a portion of their GDP to development and to support the UN operations globally. This takes some of the pressure, of managing the bottom-line, off the managers, who can then focus their efforts on managing their development agenda in support of countries and of regional institutions.

On the flip-side of the budgetary debate lies the argument that the advent of generic anti-retrovirals (ARVs) has sharply lowered the cost of medical intervention. According to Irwin (Irwin *et al*. 2003:75), in February 2001, an Indian generic drug firm, Cipla, offered to make generic versions of three leading ARV medications available in Africa. The total cost would be less than $1 a day per patient ($350 a year) through MSF, or $600 a year if the drugs were purchased by governments in Africa. Subsequent cuts reduced the price of generic ARVs still further, with the Indian firm Aurobindo offering one three-drug combination for $209 a year in mid-2002. These figures reflect a sharp drop in prices from a period as recent as the late 1990s, when according to Irwin (Irwin *et al*. 2003: 74) the annual costs of combination therapy in wealthy countries exceeded $20,000 per patient after the costs of laboratory tests and provider fees were factored in. This pricing (in today's world of generic drugs) makes the cost of treatment seem to be a reasonable investment when studied in the context of the implications of taking no action at all.

The above pricing figures remove cost as an excuse for non-action. United Nations organisations should be able to budget for the treatment both because the cost of intervention is lower in today's pricing context and because it is in the interest of the organisation to preserve the health of trained staff members in the organisation. Yet evidence shows that managers in the United Nations Organisations seem either unwilling or incapable of implementing the HIV and AIDS policies comprehensively, in their own

organisation. The sociological relevance of this study therefore lies in understanding this conundrum between stated commitment to the policy and the inadequate implementation thereof.

This conundrum, between commitment and implementation, poses the cardinal problem and begs the fundamental questions underlying this study:

> *1. How do personnel in a local office of a large Human Rights based bureaucracy perceive and experience the implementation of HIV and AIDS policy in the workplace?*
>
> *2. How does the Human Rights based bureaucracy, as exemplified by this South Africa case study, implement the HIV and AIDS policy in its workplace?*

These questions are discussed in greater detail, under the section *Key research questions*, in the chapter on *Research methodology* and addressed in the chapter on the *Rubric of the argument*.

The ILO HIV/AIDS study (2004) highlights the observation that, two decades into the epidemic, the development sector is still unable to fully implement its own policies in terms of staff and dealing with HIV and AIDS in a Human Rights context. It is thus necessary to take a fresh look at the policies and their implementation. The scenario outlined in the preceding section (1.1), underscores the importance of obtaining a conceptual understanding, of the dichotomy between stated HIV and AIDS policies of development organisations and the practical implementation within the system.

1.2 HIV and AIDS and its socio-medical impact on everyday life

The section[4] deals with HIV and AIDS as a socio-medical syndrome and provides a broad understanding of the characteristics of the virus and the epidemic that it has triggered. It has been included to help set the context of the study.

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[4] This section borrows significantly from a previous study carried out by this researcher (Bhattacharya 2003: 10-25). The contents have been modified, updated and enhanced for the purpose of this study.

The information booklet (UNAIDS/04.27E July 2004: 4) for United Nations staff members and their families defines HIV (Human Immunodeficiency Virus) as a virus that "attacks the body's immune system". It weakens the body's immune system, reducing its ability to ward-off opportunistic diseases such as TB (tuberculosis) and cancer. It is infectious and can be transferred from person to person (UNAIDS/04.27E July 2004: 4). If left unmanaged, the virus will gradually render the immune system ineffectual in its combat against secondary infections. This condition is called AIDS. AIDS is the acronym for Acquired Immune Deficiency Syndrome.

Each word in the acronym AIDS, ***A***cquired ***I***mmune ***D***eficiency ***S***yndrome, defines a characteristic of the virus that explains the manifestation of the AIDS condition and its *modus operandi* within the human body, as known to present-day medical practitioners and researchers. The word 'Acquired' indicates that the virus is *not* carried from one person to another through "casual contact" (Bhattacharya 2003: 10), like other viruses such as influenza, the SARS (Severe Acute Respiratory Syndrome) virus or the recently proliferating Avian influenza. The HIV virus can only be acquired as a consequence of the specific actions (outlined later in this section) of human beings. The fact that transmission of the virus requires precise human action distils the process of acquiring the infection down to choices and decisions made by human beings. The key implication is that halting and reversing the tide of the pandemic are within the control of individuals, communities and institutions. The phrase 'Immune Deficiency' highlights the fact that the virus affects the immune system of the host body making it increasingly less capable of warding off infections. The word 'Syndrome' makes the important point that AIDS is not a disease in itself, but a syndrome that affects the immune system. The syndrome of the failing immune system makes the body vulnerable to secondary infections, such as pneumonia, Karposi's sarcoma and tuberculosis (Whiteside & Sunter 2000:1).

If one analyses the syndrome by the above definition, it is clear that the phenomenon of HIV and AIDS is not merely a bio-medical condition but also a social issue where interpretations, choices, decisions and human action play a critical role in both the proliferation and prevention of the epidemic.

According to Whiteside and Sunter (2000: 1) the virus was discovered for the first time, as recently as 1979-80. It appeared as an unusual and inexplicable phenomenon since it was linked with the outbreak of a "cluster of diseases" not commonly seen up until that time, like pneumocystis carinii, which is normally spread by birds; and a rare form of skin cancer called Karposi's sarcoma. The virus was subsequently isolated and identified by scientists on both sides of the Atlantic in 1983.

Although the origin of the virus is unknown, it is commonly believed to have crossed the species barrier into humankind from monkeys. It is related to a number of Simian Immunodeficiency Viruses (SIV) found in Africa (Barnett & Whiteside 2002: 34-35). According to Ilifee (2006: 4), the Simian Immunodeficiency Viruses have crossed over the species barrier "from animal to human at least eleven times and probably more" and have taken on the characteristics of SIV common in the sooty mangabey species of monkeys found in Africa. The inadequacy of today's genetic tracking technology prevents tracing the virus on a "molecular clock" (Ilifee 2006: 6-7) in time and transmission due to the phenomenon of "recombination" (*ibid.*), which is the multiple infection of a person across virus strains. In the event of recombination, "viruses of different subgroups may enter the same cell and, in the process of integrating their genetic material with the host's, may produce a new strain of virus combining" genetic "elements from two or more subgroups. (SIV is subject to the same process, and the original Simian virus transmitted to humans as the ancestor of HIV-1 group M is itself believed to have been a recombinant form" (Ilifee 2006: 6).

Since Luc Montagnier's laboratory first identified the Human Immune Deficiency Virus in the early 1980s, there has been an effort to identify the origins of the epidemic. While the inadequate advancement of technology and the lack of adequate quantities of saved samples over the years prevent a conclusive determination of the dates, the

> "earliest convincing evidence of the Human Immune deficiency Virus (HIV) that caused the Acquired Immune Deficiency Syndrome (AIDS) was gathered in 1959 amidst the collapse of European colonial rule in Africa" (Ilifee 2006: 3).

It came from previously frozen blood samples and can be traced back to an unidentified man of African origin living in Kinshasa, at a time when the city was referred to as Leopoldville (*ibid.*). This however does not mean that the virus was not in circulation across continents and ethnic groups before 1959. According to Ilifee (*ibid.*), Luc Montagnier's laboratory in fact believed that the earliest known case was that of an American man who died in 1952 after being afflicted with fever, malaise, and pneumocystis carinii pneumonia which, at the time, was a rare form of pneumonia but one that subsequently afflicted other American AIDS patients. However, it was hard to conclude the man's condition accurately in the light of the fact that no blood samples had been stored for concomitant testing. The recorded symptoms merely confirmed suppression of the immune system, for which there could have been a host of medical explanations other than the immunodeficiency virus. This American man's case history was similar to that of a Canadian citizen of ethnic Japanese origin whose demise dates back to 1958 and that of an American of Haitian origin whose demise dates back to 1959, the following year.

As outlined in a previous study (Bhattacharya 2003: 4), there are, in human beings, two major strains of the virus which are categorised as HIV-1 and HIV-2. These strains each have multiple sub-strains. The dominant strain in South Africa and also globally is HIV-1, sub-strain-C. HIV-2 is found mainly in West Africa. According to Ilifee (2006: 4) this later strain occurs "between Senegal and Cote d'Ivoire" and is less virulent. This essentially means that the HIV-2 strain is less easily transmitted and "slightly less harmful than HIV-1" (Barnett & Whiteside 2002:28; Whiteside & Sunter 2000:2 cited in Bhattacharya 2003: 11). However, given the migration and mobility of populations, the HIV strains are no longer geographically isolated.

The earlier paragraphs underline two important characteristics. First, there is no racial or regional selectivity in the spread of the virus with early cases dating back to both Africa and the Americas and covering people of various racial origins. Second, the issue of migration is of significance to the largely mobile staff of international organisations, such as the United Nations, who often work in rotational and transferable posts and move from

one geographical location to another, potentially exposing them to different strains of the virus and potentially contributing to the creation of different sub-strains.

HIV is thus neither people nor country specific. As explained by Whiteside and Sunter (2000: 7-8), the virus itself survives and multiplies in the human body by attaching itself to two types of "host cells" in the human immune system. One type of cell is the CD4 cell, which organises the body's overall immune response to foreign bodies and infections. The other type of immune cell is called "macrophages". The task of these cells in the body is to "engulf" opportunistic diseases and ensure that the body's immune system is alerted to future opportunistic diseases entering the body. Once attached to these cells, the virus penetrates the wall of the host cell rendering itself safe from the body's own immune system. Once the virus is safely ensconced in the cell it both destroys the host cell and multiples, infecting other CD4 and macrophages cells in the human body. Through this process it slowly but steadily colonises the body and weakens the body's defence system until the human body falls prey to a host of diseases which the cells would normally fight off. In the case of the HIV-1 strain of virus, the "incubation period varies considerably but may last in adults for an average of nine or ten years – the period measured by a careful study in Uganda – before the immune system is so weakened that Aids supervenes" (Ilifee 2006: 8).

Current technology enables us to determine that a person is living with the virus, HIV positive or sero-positive, through the detection of HIV antibodies in the bloodstream. It is important to establish the clear distinction between being HIV positive and having AIDS. It is possible that a person who is HIV positive does not have the condition of AIDS. When a person living with HIV begins to display signs of a compromised immune system by falling prey to AIDS-defining indicants such as severe mouth sores, brain conditions and pneumonia, the person is categorised as having AIDS. In places where more sophisticated testing facilities are available, AIDS is defined by the CD4 count in the body. According to Barnett and Whiteside (2002: 32-34) a person normally has about 1200 CD4 cells per micro-litre of blood, while for a person diagnosed as living with AIDS, the CD4 count falls to 200 cells per micro litre of blood. At this level, the immune

system is seriously compromised and the body is unable to ward-off opportunistic diseases.

The reduced CD4 count renders the person living with the virus vulnerable to opportunistic infections and cancers that the body would normally be able to ward off. There are, according to Barrett-Grant *et al.* (2001: 22-24), five *stages* of the HIV infection. Each stage is characterised by specific symptoms and the risk of opportunistic infections that manifest themselves in the body during these stages. The stages and their symptoms are as follows:

At the *Primary stage,* a person usually sero-converts in the first weeks following infection and the HIV is detectable in the blood.
At the *Asymptomatic stage*, following the primary stage of infection, a person usually manifests no further symptoms for a protracted period of time, often years.
At the *Early symptomatic stage,* a person may develop mild symptoms of ailments such as shingles, swollen lymph glands and rashes.
At the *Medium symptomatic stage,* a person could become very ill without developing AIDS-defining illnesses.
At the Late symptomatic stage or AIDS, a person's ability to fend off opportunistic diseases is severely compromised. Any deficiency in early and effective treatment can cause severe long-term damage to the body, affecting such vital organs as the brain. Understanding the stages of the epidemic and the broad symptoms outlined above enables one to understand the possible signs that may stand out as signals of living with the virus and thereby provides a handle for an understanding of stigmatisation and discrimination in the workplace.

Table 1.3 shows the modes of transmission and the probability of HIV-1 infection per 1000 exposure:

Table 1.3: Probability of HIV-1 infection per exposure

Mode of Transmission	Infection per 1000 exposure
Male to Female, unprotected vaginal sex	1-2
Female to Male, unprotected vaginal sex	0.33 - 1
Male to Male, unprotected anal sex	5-30
Intravenous use of Infected Needles	3
Mother-to-child transmission	130 – 480
Exposure to contaminated blood products	900 - 1000

(Source: World Bank: 1997a:59 cited in Barnett & Whiteside 2002: 38 and Bhattacharya 2003: 12).

An important bio-medical analysis reported in the above table is that men are more likely to infect women than vice versa. So, women (far from being vectors of the virus) are biologically more vulnerable to infection than men. As Ann Biddlecom *et al.*[5] point out, in their article *Women, Gender and HIV/AIDS*, male sexual secretions, such as semen, are more viscous and carry a greater volume of the viral load than vaginal fluids, placing women at greater risk than men. Besides, a much larger surface area of a woman's vaginal mucous membrane is exposed during penetrative sex deepening the element of risk.

Exploring the bio-medical phenomenon, outlined in the previous paragraph, from a sociological perspective, because disease "epidemics are social processes" (Schoepf in Kalipeni *et al*. 2004:15), one can deduce that the biological vulnerability of women is compounded by social vulnerability on the part of women living in societies with weak social cohesion. According to Colvin (cited in Barnett & Whiteside 2002: 185), as many as 60-80 per cent of African women living with the virus have had only one partner, but have contracted the virus, nevertheless, because they have been unable to negotiate the terms of the sexual encounter with their male partners. Nor were they able to prevent their partners from engaging in other sexual encounters. This trend is not merely

[5] www.populationaction.org/**2015**/_pdfs/mag/58-69-HIV-**AIDS**.pdf: 66

prevalent in Africa. According to Marina Mahathir, the head of the Malaysian Council for NGOs (Non-Governmental Organisation) on AIDS,

"it is a fact not repeated enough that 90% of women who have been infected with HIV have only ever slept with one man in their lives, their husbands" (Barnett & Whiteside 2002: 185).

The reason for the vulnerability of married women, according to Kauffman (Kauffman & Lindauer 2004: 22-23), are the "informal institutions governing male-female relations". Kaufmann argues that women, who do not want to face stigma and want to stay connected with their partners tend to abide by community norms dictating female subservience. The cost of non-compliance with these informal norms could be more than ostracism. It could include "abuse" and "loss of financial support".

It is pertinent to briefly explore the concept of *institutions* (both formal and informal). According to Kauffman (Kauffman & Lindauer 2004: 19), institutions are themselves the "rules of the game". These institutions comprise "groups of individuals" who are both affected by the institutions and in turn attempt to affect them. Kauffman goes on to explain that though formal institutions have an important effect on society, informal institutions (such as traditions, norms and the personal ethics of individuals) sometimes have a larger impact on the behaviour and actions of individuals. As such, while women may be cognisant of the risk of contracting the virus from men who demand unprotected sex, when actually faced with the choice of safety and ostracism over risk and conformity, they "will", according to Kauffman, "choose not to break the local norms of subservience to men. The perceived social, physical and economic costs are simply too high" (Kauffman & Lindauer 2004: 23). Gugu Dlamini's case (outlined later in this chapter) highlights the vulnerability of women.

The South African Courts have had numerous opportunities to interpret the constitution on issues of HIV and AIDS and human dignity in the workplace. As Ngwena (2001: 56) articulates it,

> Irrespective of the unequal bargaining positions, the workplace becomes an environment in which employers are compelled to yield to the dictates of respecting human dignity, not treating job applicants and employees as mere expendable commodities. The Employment Equity Act of 1998 and the Code of Good Practices on Key Aspects of HIV/AIDS and Employment reinforces this constitutional imperative.

Charl Hoffmann, a South African Airlines cabin attendant, was denied employment based on his sero-status. This led to the landmark court trial, Hoffmann vs. SAA (South African Airlines) 2000, where the employers were adamant about the validity of their stand (Barrett-Grant *et al.* 2001: 39). Fortunately, the Constitutional Court of South Africa, in a unanimous judgement, supported the case of Charl Hoffmann and asked SAA to employ Hoffman as a flight attendant with effect from the date of the court order. In doing so the Constitutional Court overturned an earlier decision by the High Court in which the High Court had judged in favour of the airline.

According to Barrett-Grant *et al.* (2001: 39) people living with the virus in the workplace have been systematically exposed to stigma, discrimination and marginalisation. Society's response has induced many of them to conceal their sero-status for fear of prejudice, depriving them of possible assistance in treating and managing the virus.

In addition, according to Barrett-Grant *et al.* (*ibid.*) South Africa's apex court has sent a clear and unmistakeable signal regarding the stigmatisation and vulnerability of people living with the virus in the workplace. The SAA vs. Charl Hoffman ruling from the Constitutional Court (discussed above) has helped set the vision for policies and their implementation in organisations. The incidences of stigma and discrimination have made headlines resulting in the larger population being exposed to the issues and the views of both the court and the organisation. A rights based policy requires to be based on the needs of all its citizens, regardless of their sero-status.

Landmark judgements by the South Africa Court (such as Hoffmann vs. SAA, already mentioned) provide society with a Human Rights based perspective to people living with the virus in the workplace. It must also be understood that staff members and managers

are exposed to the discrimination of people living with the virus and form their own views in accordance with which they interpret policies. Community views on issues of people living with the virus in South African society and in the workplaces can be determined from the case of Gugu Dlamini, alluded to earlier. On 12 September 1998, a young community worker, Ms Gugu Dlamini, was lynched by a mob in South Africa after she had revealed her sero-positive status. The incident occurred in the township of KwaMashu, near Durban in the province of KwaZulu-Natal (Barrett-Grant *et al.* 2001:1, 37, Bhattacharya 2003: 24-25 and Kauffman & Lindauer 2004: 22-23). While little is known about her life, she "dared to think that she could, through herself, show the reality of this dreadful virus. Dlamini perished at the hands of those she thought she could help" (Kauffman & Lindauer 2004: 133). After her death, many were forced into the silence of shame and guilt (Kauffman & Lindauer 2004: 132-133) or driven into secrecy and denial by the fear of stigmatisation and unequal social interactions. Stigma intensifies the emotional strain and suffering of people living with the virus, and of their families and caregivers (Nyblade *et al*. 2003: 34). This compromises the opportunity of early intervention to manage the infection optimally and to prolong life.

Barnett and Whiteside (2002: 349) underline the importance of distinguishing between health and well-being. On the one hand the word 'health' focuses on the state of the body and its condition vis-à-vis disease and illness. 'Well-being', on the other hand, is a broader concept and "places emphasis on the social and economic origins of ill-being *(sic)*". In this definition, Barnett and Whiteside (2002:351) stress the importance of focussing on social interactions as a critical ingredient of well-being. That being the case, the management of stigma plays a vital role in the management of health and well-being in the response to HIV and AIDS, since stigma is a product of unequal social interactions that could lead to discrimination even in rights based international development organisations such as the United Nations. The findings of this study will later attempt to explore this phenomenon.

1.3 Conclusion

This chapter has sought to establish the importance and immediacy of the subject matter explored in the thesis. It broadly suggests that although HIV and AIDS policies are an intrinsic part of the commitment of international development organisations, the implementation of the policies in the form of resource allocations and the establishment of a viable WWP is both weak and incomplete. In addition, drawing on published reports the chapter argues that, decades into the epidemic, the development sector still appears to be unable to fully implement its own policies, making it necessary to take a fresh look at the policies and their implementation. It underscores the importance of obtaining a conceptual understanding, of the dichotomy between the stated HIV and AIDS policies of development organisations and their practical implementation within the system, articulated in the two key questions presented earlier in the chapter. This task is accomplished progressively in subsequent chapters, initially using literature available in the public domain and subsequently through the research findings of this study. As stated, the sociological relevance of the study lies in understanding the conundrum between commitment to policy and its implementation and also the way in which organisational responses to AIDS-affected personnel might offer a lens into emerging prejudices, discriminations and the occasional violation of human dignity.

This chapter explains the rationale and importance for this study. The following chapter analyses existing literature on the sociology of organisations and bureaucracies, within the context of the rights based discourse on AIDS policies in the workplace.

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Chapter 2 – Literat[illegible]reaucracies and the rights based discourse on AIDS policies in the workplace

2.1 Introduction

This chapter attempts to capture some of the salient discourses in the public domain, related to the implementation of HIV and AIDS policies in international development organisations such as the United Nations system. It has been structured to lead, in a later chapter, to the contextualisation of the findings of the study and to a discussion of the literature reviewed. The chapter explores, discusses and illustrates some of the views and perspectives related to HIV and AIDS policies in international development organisations.

While much attention, in the chapter, has been paid to Weber’s contribution to understanding large bureaucracies, a range of insights and arguments on bureaucracies in general and the functioning of international development organisations in particular is also offered. Some of these insights and arguments also engage with Weber’s constructs of bureaucracy, in some instances challenging a few of his core ideas. The chapter also explores issues related to interpretation of policies that guide the management of AIDS in the UN system. The concepts used in this study have been presented in separate sections structured around homogeneous clusters of thought enabling seamless links with the findings introduced later in the thesis.

2.2 The sociology of organisations and bureaucracy

This study is located within the formal organisational structure of an international development organisation. This sub-section of the review of literature focuses on exploring organisational theories that offer analysis of the functioning of bureaucracies.

As Etzioni (1964) suggests, modern society is an organisationally structured construct. With growing social, economic and political demands, societies have become more and more complex:

> "Organizations are social units which pursue specific goals; their *raison d'etre* is the service of these goals. But once formed, organizations acquire their own needs, these sometimes becoming the master of the organization" (Etzioni 1964: 5).

Burgeoning urban metropolises, with their diversifying populations, needs and aspirations, are necessitating ever more effective coordination and management. As a result, the need for efficient and therefore organised action has gained momentum, giving rise to "a network of individual and social relationships through which [individuals] participate in society" (Thompson & McHugh 1990: 13), the modern organisation. These networks are the

> "fundamental building blocks of modern societies and the basic vehicles [of] collective action … [As such], organisations mediate the influence of individuals on the larger society" (Aldrich 2001: 5-6).

This phenomenon is also true in its converse, as organisations also monitor and calibrate the influence of the environment on individuals within the system.

The essential debate vis-à-vis organisations is not so much a debate as it is an evolutionary dialogue on organisations, as they metamorphose from Weber's bureaucracies (discussed in detail in the following subsection, titled, 'Weber's contribution to organisational theory') into new and varied forms designed to meet the changing needs and technologies of the time. Subsequent paragraphs track a set of evolutionary forms of organisations and attempt to demonstrate their effect on the United Nations bureaucracies.

Fulcher and Scott (2003) introduce a useful typology which is drawn upon in this section. However, the focus of this literature survey is not so much on the content of their analysis as it is on the study's assessment of how the UN as an organisation either matches or deviates from the basic characteristic of each form of organisation.

Fulcher and Scott (2003: 752-758) propose that Weber focused significantly on bureaucracies which he thought would, as a factor of their "technical superiority", remain the dominant management form. However, Weber (and later sociologists and contingency theorists who espoused his views) anticipated and tracked the evolution of "alternative forms" of management and organisation. Subsequent paragraphs will be dedicated to outlining these new forms of organisation.

As an insider to the United Nations system, I shall view the organisation in the context of some of the organisational forms Fulcher and Scott outline. In an attempt to bring out the characteristics more sharply, I have compared the UN as an organisation individually with each typology. The study also tracks possible changes in the United Nations bureaucracy that have enabled it to adopt some of the characteristics of alternate forms of organisation in its day to day function and management.

Organic Organisation: As a response to the assumed rigidity of bureaucracies, Burns and Stalker (1961 cited in Fulcher & Scott 2003: 752) heralded the advent of a more "flexible" form of organisation, than the bureaucracy, which they referred to as the "organic organization". In this form of organisation, jobs and roles evolved with the changing environment within the organisation and authority was exercised by specialists regardless of their location and regardless of the hierarchical stratification of seniority.

In the UN there are specialist advisors who have the authority to take programmatic decisions though much of the authority is still controlled by the bureaucratic management within the organisation. Thus, it has not been possible to experience any typically organic characteristics within the UN.

Mechanistic Organisation: This form of organisation is similar to bureaucracies in their hierarchical construct and "division of labour". These forms of organisation according to Fulcher and Scott (2003: 752) reflect the conflict between line management and experts within the system.

While the UN reflects the characteristics of a mechanistic organisation, there does not appear to be any significant and recurring conflict between managers and experts. It is more a mutually dependent and symbiotic relationship. The managers need the experts to run the system and to provide substantive advice to governments and civil society organisations, while the experts need the managers to establish their relevance and *raison d'être* within the organisation. However, there does appear to be a virtual firewall between the two functions. Not many experts seamlessly move to managerial roles within the organisation. Also, experts are usually paid from transient project budgets while the managers are paid from permanent and core organisational budgets. This inevitably results in a management-driven hierarchy within the system.

Network Organisation: This is a "radical and recent departure" from the conventional form of bureaucratic organisation. The significant departure from established forms of bureaucracies lies in an open structure, almost completely based on "information technology" (Fulcher & Scott 2003: 753) and computer networks. The structure links not only all internal staff and work flow, but also liaises seamlessly with external networks of suppliers and business associates. This method makes the institution of external sub-contracts much easier, enabling organisations to utilise external experts and consultants without dislocation and additional expenditure.

While the United Nations is far from being a fully fledged network organisation, it has both organically and systematically incorporated some aspects of the network organisation. For example in its efforts to move towards a learning network, it has e-learning courses to build the capacity of staff without moving them from their locations. The UNDP, for example, also has global e-networks on specialist subjects such as Capacity, Gender, Evaluation, HIV and AIDS. These e-networks encourage knowledge exchange among global staff that either have knowledge of the specialisation (which they can then share with other colleagues across the UN network) or use its services (providing colleagues with insight into matters such as procurement protocols, terms of reference and range of uses). These networks enable low cost and comprehensive

learning across continents, linking staff and managers to effective practices (adopted by other offices and branches of the organisation) and affording the opportunity to learn, understand and adopt best-fit practices. All a staff member has to do is post a query on the network and those on the global e-network who have relevant knowledge, experience or materials post a response on the network or offer a service. The UN system, like the system of network organisations is based more on bringing together needs and services rather than depending on bureaucratic mandate and bureaucratic coordination.

Virtual Organisation: This form of organisation takes network organisations a step further. It exists entirely on the virtual platform, even going beyond the physical structures of organisations that have computerised and networked extensively. Virtual organisation structures are particularly relevant for organisations the activities of which are primarily information, communication and financial data based.

The nature of UN work in areas, such as post-conflict development, poverty alleviation, reconstruction and peacekeeping, requires hands-on presence in countries, some of which do not even have strong and uniform computer facilities. This prevents the UN from adopting the characteristics of a virtual organisation.

Organisational Culture as a variant: Early organisational theorists assumed a certain global homogeneity of organisations. However, subsequent studies (Gouldner 1954; Crozier 1964; Clegg 1990 as referenced in Fulcher & Scott 2003: 754) demonstrate a global variation of organisations driven by national cultural practices. Clegg points out that Japanese organisations tend to involve less specialised and more flexible structures than organisations in the West. Chinese organisations in Taiwan tend to be radically different from either Japanese or western organisations in their propensity for family constructs. Classically, Chinese organisations are patriarchal systems led by the family head with key financial and managerial functions closely held and controlled by family members.

While UN agencies are more uniformly structured and centrally controlled, they do respect local and cultural sensitivities. The UN, for example, when located in an Islamic country, takes its weekly off-days on Fridays and Saturdays as is customary in these countries and tries to follow the national calendar for holidays. Female staff members of the United Nations agencies dress in hijab in Islamic countries such as Iran out of respect for the local customs of the country. However, these practices are cultural and often cosmetic in nature and do not pertain to changes in management structures.

Gender-equal Organisation: One of the primary criticisms of the bureaucratic form of organisation has been the patriarchal nature of its management. In the nineteenth century bureaucratic organisations were established in a primarily male-dominated society and reflected its nature. However, twentieth and twenty-first century organisations have steadily been attempting to balance the genders in management structures. But this has not always been easy since bureaucratic organisations have often had a preponderance of women in secretarial positions, effectively playing the role of "office wives" (Fulcher & Scott 2003: 755).

The UN agencies have been making serious efforts to bring in a strong gender perspective and balance the genders in their organisation. One of the United Nations largest UN development agencies UNDP has outlined a Gender Equality Strategy 2008-11[6], titled 'Empowered and Equal'. The document is grounded on the assumption that the objective of gender equality is an absolute and indivisible aspect of the UNDP human development goal.

UNDP, like many bureaucracies, has a patriarchal management and staff structure which it is by policy (outlined in the Gender equality Strategy 2008-11) attempting to redress "at all levels by 2010"[7].

[6] http://content.undp.org/go/topics/gender/?src=204576 (Accessed 1 July 2008).
[7] http://content.undp.org/go/topics/gender/?src=204576: 2008: 33. Accessed on 16 October 2008)

The following table (Table 2.1) demonstrates all the characteristics of gender inequality. Senior (66%) and middle management (65%) are male dominated. While support staff (a category which generally includes secretarial functions) tends to be female dominated at 58% reinforcing the stereotype of "office wives" (Fulcher & Scott 2003: 755).

Table 2.1: Male and female staff by category of job responsibility

Category	Total	Male	%Male	Female	%Female
Support Staff	3798	1592	**42%**	2206	**58%**
Junior Management	1912	1029	**54%**	883	**46%**
Middle Management	1740	1127	**65%**	613	**35%**
Senior Management	318	210	**66%**	108	**34%**
UNDP Global Workforce	7768	3958	**51%**	3810	**49%**

Source: IMIS/ATLAS November 2007[8]

Aldrich (1979, cited in Aldrich 2001: 2-4) comprehensively defines organisations as "goal-directed, boundary-maintaining, and socially constructed systems of human activity". This definition distils the *raison d'être* of organisations to three key characteristics and contextualises their "genesis and persistence", thereby differentiating them from other networks of people, such as "families and friendship circles". Other definitions of modern-day organisations such as those of Etzioni (1964), Meadows (1967) and Scott (1998) add characteristics,

> "such as deliberate design, the existence of status structures, patterned understandings between participants, orientation to an environment, and the substitutability of personnel" (Meadows 1967 & Scott 1998, cited in Aldrich 2001)

to Aldrich's definition by emphasising on the relationships and the environment. In the following paragraph, the characteristics of a large international development

[8] UNDP Gender Parity Report 2007, p. 16.

organisation, such as the United Nations, are outlined using Aldrich's three point definition[9].

It would be pertinent at this juncture to revisit Aldrich's three point definition of the modern day organisation in the context of the subject of this thesis, large international development organisations, such as the United Nations.

The ***goal*** orientation is fundamentally drawn from the United Nations Charter (discussed later in this chapter). All United Nations organisations endeavour to either deliver directly on the Charter, or within its mandate, the Charter serving as a more universal version of the corporate mission and vision statement.

The ***boundaries,*** Aldrich refers to as a defining factor, are in fact defined more sharply and significantly in international organisations like the United Nations than in commercial organisations. Upon appointment, staff members subscribe to the following oath of office or declaration by signing Form P.34 of the United Nations Staff Regulation 1.9:

> I solemnly swear (undertake, affirm, promise) to exercise in all loyalty, discretion and conscience the functions entrusted to me as an international civil servant of the United Nations, to discharge these functions and regulate my conduct with the interests of the United Nations only in view, and not to seek or accept instructions in regard to the performance of my duties from any Government or other authority external to the Organization.

As an oath of office, the UN declaration upon taking up office is not unlike the citizenship oath of countries such as the United States of America. Having been set up and managed by government bureaucrats, the United Nations system is, in many ways, structured like a national government, without the mandates and legitimacies of statehood.

Apart from contracts and identity cards issued to define the distinctions between different types of employment, United Nations employees are issued separate passports called

[9] As stated earlier, Aldrich (1979, cited in Aldrich 2001: 2-4) defines organisations as "goal-directed, boundary-maintaining, and socially constructed patterns of human activity".

Laissez Passer, which enable legal access (for staff members travelling on missions) to various countries across the globe, including South Africa. These privileges are legally accepted by the political dispensation of sovereign nation states. For example, select international staff members enjoy diplomatic privileges and tax exemptions of various sorts. They also have access to an independent banking system called the United Nations Federal Credit Unions (UNFCU). These characteristics of membership set the United Nations apart from other networks and organisations in the "environments" (Weber 1947 cited in Aldrich 2001: 3) creating a distinction of association. From a critical perspective, it can arguably be said that, apart from some specific situations such as conflict zones, these privileges are trappings of elitism and neo-colonialism unbecoming of a development organisation set up to serve "THE PEOPLES OF THE UNITED NATIONS" (Preamble to the United Nations Charter cited in *Basic Facts about the United Nations* 2000: 4).

Aldrich's third differentiating characteristic of the modern-day organisation is the presence of defined *activity systems* that enable the accomplishment of goals and organisational objectives. In the milieu of the United Nations and the context of this study, the *activity system* would be the policies that govern the organisation (specifically, the sub-set of policies governing the management of HIV and AIDS) and the organisational structure within which the policies are implemented.

The quintessence of the management system of the organisation is the 'administrative structure' which directly or indirectly influences the lives of people

> "exerting greater power over…lives. [The administrative structure] remain[s] a crucial meeting place of contending social forces … which generates and reflects contradictions and change" (Thompson & McHugh 1990: 14-15).

The centring and momentum of policies, management decisions, staff aspirations and environmental propulsion are not necessarily unidirectional, thereby generating the contradiction and change, Thompson and McHugh articulate. Later in the study (through the findings), these contradictions are explored in the context of the international

development organisation. The sociological perspective of organisations does not cast them as

> "simple mechanical tools doing the work of their creators. They are live collectivities interacting with their environments, and they contain members who seek to use the organisation for their own ends, often struggling with others over the content and allocation of the product" (Ness & Brechin 1988: 246-7)

giving the organisation a distinctive personality and character arising from the dialectics of these interactions (see Stacey, 1996; Scott, 2003) and the "power play" within organisations Etzioni (1964).

2.3 Weber's contribution to organisational theory

Dating back to 1918, and the formation of the League of Nations as part of the Treaty of Versailles, and through the next few decades, the evolution of bureaucratic development organisations has run parallel to the development of organisational theory. The evolution has been mapped in various literatures, from Weber's organising principles (1968; 1978) to Etzioni *Comparative Analysis of Complex Organizations* 1961 to Silverman the *Theory of Organizations* 1970 (Donaldson 1988: 1-2 / 114). "The origins of organization theory can [however] be traced largely to the appropriation of Weber's writings on bureaucracy" (Hancock & Tyler 2001: 65). In Morrison's (1995: 294) words: "his [Weber's] discussion stands alone as an independent investigation into the historical determinants of bureaucratic administration…" Weber's theorisation of bureaucracies is all the more relevant for this study since "the impetus for Weber's analysis came primarily from the organization of the state and the regulation of administrative employees" (Thompson & McHugh 1990: 69). Similar to international development organisations (which are the focus of this research project), these institutions were not-for-profit organisations and worked "within a framework in which command and task are based on authority derived from impersonal rules" (Thompson & Mc Hugh 1990: 69).

The bureaucracy, as a system of management, has however drawn criticism from "a number of empirical studies that used qualitative methods" to analyse its structure and dynamics (Selznick 1949, Gouldner 1954, Crozier 1964 cited in Donaldson 2001). Bureaucracies have also had criticism directed towards them from later day management experts such as Warren Bennis (1993: xii) who wrote, in an updated introduction to the 1973 classic edition of his book *Beyond Bureaucracies*, that

> [t]he organizations that thrive today are those that embrace change instead of trying to resist it. The old Weberian bureaucracies are simply too slow, too weighed down with intraorganisational agendas and priorities, to compete in a world where success goes to those who identify and solve problems almost before they have names (Bennis 1993: xii).

He goes on to say that bureaucracies are "doomed" because they either "do not work" or "do not work fast enough" (Bennis 1993: xii). Thompson and McHugh (1990: 177) have quoted Bennis (1966: 263) presenting a more comprehensively dismissive prognostication writing off bureaucracy "as a 'lifeless crutch that was no longer useful'".

Today, several decades since Bennis wrote his book, and since he made the prophetic statement (quoted in the previous paragraph), international organisations such as the Red Cross and Red Crescent, the United Nations, the Bretton Woods Institutions such as World Bank and the International Monetary Fund (IMF), imperfect though they be, exist as organisations with international acceptance operating under an international mandate in crisis situations in Sudan, Palestine, Afghanistan and Iraq, for example. Despite very difficult situations and the violent deaths of key staff members notably Margaret Hasan (Red Cross and Red Crescent) and Sérgio Vieira de Mello (United Nations), these organisations have the commitment and structural resilience to remain and work in crisis situations. Whilst they operate as modern bureaucracies, they cannot be dismissed as "doomed".

According to Hancock and Tyler (2001: 65), based on "realist ontology" the primary view of organisation theory has been that organisations can be "observed, measured and modified" as and when required. Bureaucracies constitute structured systems governed

by rules, roles, tasks and accountability. Gareth Jones (1995:113) sums up Weber's (1946, in 1968) "prescription" for the effectiveness of bureaucratic systems in terms of six principles. An attempt is made to interrogate these principles in a systematic fashion, though placing more emphasis on some principles over others:

Principle One: Bureaucracies are founded on the principle of "rational-legal authority" (Weber, 1968; Gareth Jones 1995: 113-119). This rational-legal authority that constitutes both the *raison d'être* and the power base of International Development Organisations, "gives them power independent of the states that created them and channels that power in particular directions" (Barnett & Finnemore 1999: 699). The rational-legal authority gives them a normative role in society and in the case of the UN in international relations, a role that has powers to prescribe, determine and direct the evolution of society. Barnett and Finnemore (*ibid.*) illustrate this normative role vividly when they state that,

> Bureaucracies, by definition, make rules, but in so doing they also create social knowledge. They define shared international tasks (like 'development'), create and define new categories of actors (like 'refugee' [and GIPA, the Greater Involvement of People Living With HIV and AIDS]), create new interests for actors (like 'promoting human rights'), and transfer models of political organization around the world (like markets and democracy).

In addition, Etzioni (1964), Barnett and Finnemore (1999) elaborate on the polarized manifestations of this normative role when they opine that

> "the same normative valuation on impersonal, generalized rules that define bureaucracies and make them powerful in modern life can also make them unresponsive to their environments, obsessed with their rules at the expense of primary missions, and ultimately lead to inefficient, self-defeating behavior" (Barnett & Finnemore 1999:699-700).

Principle Two: Roles within organisations are established on the basis of "technical competence", rather than "social status, kinship, or heredity…" (Weber, 1968; Gareth Jones 1995: 113-119). This leads to what Weber (1978: 225) refers to as the "tendency to 'levelling' in the interest of the broadest possible basis of recruitment in terms of technical competence".

Principle Three: Weber's (1968) third principle underlines the task-related responsibilities of employees in bureaucracies. This includes decision-making authority at different levels of management and the relationship of each employee and her/his role to other employees and their roles within the bureaucracy. All these characteristics are clearly specified in the organisational rule book.

Principle Four: Jones's (1995: 113-119) interpretation of Weber's (1968) fourth principle is that the organisation of tasks and roles within a bureaucracy are structured to ensure that lower offices are supervised and managed by a higher office. In Weber's words, "The organization of offices follows the principle of hierarchy; that is, each lower office is under the control and supervision of a higher one" (1964:331). , This risks leading to what Bennis (1993: 6) refers to as "conformity and 'group-think' ".

Principle Five: "Rules, standard operating procedures, and norms should be used to control the behavior and the relationship between roles in an organization…" (Jones 1995: 113-119; Weber, 1968). Weber argues that the influence of rules and administrative regulations is so unyielding that the authority to issue the orders necessary for the discharge of these duties is distributed in a stable way and is "strictly delimited by rules concerning the coercive means, physical, sacerdotal, or otherwise, which may be placed at the disposal of officials" (Eisenstadt 1968: 66). Weber (1978: 957-958) contends that despite the "monocratically organized" structure of bureaucracies,

> "The management of the office follows general rules, which are more or less stable, more or less exhaustive, and which can be learned... It involves jurisprudence, administrative or business management".

According to Weber, the objective discharge of business in a bureaucracy refers essentially to a discharge of business in accordance with calculable rules and without specific regard to the people concerned (Weber 1978: 975). Weber (*ibid.*) also states that,

> Bureaucracy develops the more perfectly, the more it is 'dehumanized', the more completely it succeeds in eliminating from official business love, hatred and all purely personal, irrational, and emotional elements which escape calculation.

Principle Six: Jones (1995: 113-119) defines Weber's (1968) sixth principle in terms of "administrative acts, decisions, and rules" which are usually articulated in writing. This then, according to Weber, proceeds to govern the actions of managers. The research will look for the influence of written regulations and policies related to HIV and AIDS and the degree to which the written rules are held by the bureaucracy as sacrosanct.

According to Thompson and McHugh (1990: 178) the Aston Group (a group of theorists from the University of Aston in Birmingham) developed a 'structural taxonomy' of bureaucracies based on the nature and control of workflow. Their typology of bureaucracies carried Weber's six principles (outlined above) forward though the development of three main categories:

> *Full bureaucracies* incorporate Weber's six principles articulated above and presume a high level of standardisation of activities. Authority is centralised and control is impersonal. A pure form of full bureaucracy does not, however, exist outside central government.
>
> *Workflow bureaucracies* have highly structured activities, but tend to be more decentralised in terms of authority within the hierarchical command framework. Such bureaucracies are characteristic of large manufacturing enterprises.
>
> *Bureaucratised structures:* Smaller branch plants or parts of local government manifest bureaucratised employment relationships with a low structuring of activities. Here, control is exercised on a more personal level (Thompson & McHugh 1990: 178).

On revisiting the characteristics of the United Nations, within the definition of Aldrich's three point definition[10] of the modern day organisation, it is clear that the United Nations is a *full bureaucracy* in its orientation, structure and management of workflow. This makes the Weberian perspective an important theory contextualising this study. However, as stated in earlier paragraphs and the next, the findings of this study may not comprehensively and completely concur with those of Weber.

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[10] As stated earlier, Aldrich (1979, as quoted in 2001: 2-4) defined organisations as "goal-directed, boundary-maintaining, and socially constructed systems of human activity".

The limitation of Weber's argument lies in his assumption that the rulebook is an absolute truth (what Weber [1978: 975] calls, "calculable rules") generating only one interpretation that guides decisions and actions in only one conceivable direction. It can be argued that some rules could, however, in themselves be open to multiple interpretations. Moreover, some rules may clash with the manager or decision-maker's beliefs, views or self-interest, resulting in managers rationalising their actions or decisions through a selective interpretation of the rulebook and in some cases the invocation of other rules that may serve as suitable in the pursuit of a decided course of action. Some of these actions may be driven by what Weber (*ibid.*) refers to as "purely personal elements". A hypothetical example serves to illustrate the point:

A senior manager (let us, in order to facilitate the use of pronouns, assume that the manager is a woman) is faced with the following situation: She is, by the rules of the organisation, required to finance complete medical care for all staff members. As a career-oriented manager her performance criteria for success also calls upon her to generate a wide variety of programmes and to mobilise adequate resources to fund all her programs and overhead expenses, including medical care for staff members. In this hypothetical example financial exigencies may result in the manager's career interest clashing with the organisational rules that she is obligated to uphold. If one were to apply Weber's understanding to the example, the manager in a bureaucracy would give primacy to the rules of the organisation and provide medical care for her staff. In so doing, she would either generate a shortfall in her budget or reduce the number of programmes she can generate in order to optimise the budget. However, through human ingenuity and innovation, she could arguably open up other options for herself. She could, for instance, reduce her staff overheads and re-direct some of the staff functions to programme consultants hired within project budgets, thereby reducing her office staff head count and, in turn, reducing her budget overheads. This action would reduce the number of people the organisation has to place on pension and medical care increasing the apparent financial viability of the office. This action could also, potentially, result in the manager being able to concentrate on generating a wide variety of programs and to mobilise adequate resources to fund them. This hypothetical action would demonstrate that

managers have, even within the confines of the rulebook, the flexibility to manipulate the system to fit their commitments. The essential point here is that rules in a bureaucracy are not necessarily infrangible, and human agency could play a very important role in rupturing the rigidity Weber has ascribed to the system, in partial contradiction, one might add, to his own theory of "instrumentally rational" "social action" (Weber 1978: 24). According to Weber, "instrumentally rational" social action is "determined by expectations as to the behaviour of objects in the environment and of other human beings. Weber sees these expectations as "conditions" or "means" of attaining the actor's desired objectives.

Commenting on Weber, Morrison (1995: 299) states that the focus of bureaucracies on procedural matters serves to keep behaviour in check, ensuring predictability and reducing the possibility of conflict. This aspect of Weber's theory of bureaucratic control is partially at odds with his acknowledgement of human agency and social action in the *Methodology of the Social Sciences,* 1949. If one were to apply this principle of Weber to the context of the present study, a manager's decision in a bureaucracy would be driven by the letter of the rulebook rather than by human agency or the manager's own interpretation of the situation. While this research project captures evidence of formal rules and policies governing and directing processes, it also finds evidence of Weber's theory of interpretative understanding and social action (discussed in the following paragraph) in the manager's decisions and action, within international development organisations.

Weber's analysis of social action is compact in its articulation and constitutes a point of reference for this study. Weber argues that:

> Social Action, like all action, may be oriented in four ways. It may be:
>
> (1) instrumentally rational (*zweckrational*), that is, determined by expectations as to the behavior of objects in the environment and of other human beings; these expectations are used as "conditions" or "means" for the attainment of the actor's own rationally pursued and calculated ends;

(2) value-rational (*wertrational*), that is, determined by a conscious belief in the value for its own sake of some ethical, aesthetic, religious, or other form of behavior, independently of its prospects of success;

(3) affectual (especially emotional), that is determined by the actor's specific affects and feeling states;

(4) traditional, that is, determined by ingrained habituation (Weber 1978: 24-25).

The strength of Weber's analysis lies in the fact that he refrains from placing these action orientations in independent silos, and appreciates that the actions are often propelled by a combination of orientations. This flexibility, implicit in Weber's theory, is important for the current argument as complex HIV and AIDS issues such as sexuality, stigma, care and treatment constitute a complex combination of orientations. Weber's orientations are, however, not sufficiently exhaustive; they leave out the critical orientation of what Jon Elster refers to as, "belief formation and information-acquisition" (Turner 2000: 40). Beliefs play an important role in the framework of opinions and decisions. Mental models regarding issues of illness, death, treatment and care, as well as sexuality are firmly entrenched in and influenced by cultural practices and the worldview of a society. One of Jon Elster's key criticisms of Weber lies in Weber's overlooking of beliefs in his theory of social action. Elster (*ibid.*) says,

"… because of his [Weber's] neglect of strategic behavior he ignores the importance of *beliefs about beliefs* when several actors have to reach mutually interdependent decisions".

This is a crucial point for the present study – because whilst Weber's characteristics of bureaucracy are drawn upon as a starting point for analysis, the intersecting values and beliefs of decision-makers, which are disregarded in Weber's (1946) classic works, are afforded space and acknowledgement.
In other words, this study places the judgments, motives, "interpretive understanding" and actions of managers and staff under the spot light. It is pertinent to state that informed lassitude or non-action is seen as a product of considered decisions made by actors. This is based on the belief that a human being can have as precise a reason for action as for non-action or lassitude.

Having made a point about the importance of "interpretive understanding" and actions of managers and staff in this study, it is deemed necessary to make a comment on Rational Choice Theory (RCT). RCT is explored as an option over the next two paragraphs before the chapter reconnects with the discussion on Weber and other organisational theorists. Rational Choice Theory, as the name suggests bases itself on the rational choice of human beings with a motive of benefit or advantage. Sociologists such as Weber and Parsons have drawn on value-driven exchanges in the mainstream of their argument on social action while a select few such as George Homans (1961) have set out a basic framework of exchange theory grounded in assumptions that can be traced to "behaviourist psychology". He propagated the view that human behaviour, like animal behaviour, is determined by "rewards and punishments" (Scott 2000: 1). The fundamental source and point of all action, according to Rational Theorists, is the individual human being. They explain social institutions and social change as "the result and interaction of individuals" (Elster 1989: 13 cited in Scott 2000: 2).

While the role and importance of the individual is undeniable in the current study, this study assiduously steers clear of using the Rational Choice Theory because of its exclusive focus on the individual and the relationship between and among individuals from the perspective of behavioural psychology, which is too limited in scope for this study. The RCT tradition would view "institutions as temporarily 'congealed tastes' (Riker 1980), frameworks 'of rules, procedures, and arrangements' (Shepsle 1986), or 'prescriptions about which actions are required, prohibited, or permitted' (Ostrum 1986) (Powell & DiMaggio 1991: 8). This study, in contrast to the views of Riker, Shepsle and Ostrum approaches rules, procedures and arrangements as fundamental pillars of the organisation and the interpretations of managers and staff members as critical levers that propel or retard implementation.

Evolving from the *genre* of Rational Choice Theory, and better grounded in sociology, is more recent thought on organisation theory. While accepting the importance of RCT, end-of-the-millennium organisational theorists generate an approach that goes beyond it from the sociological perspective. Two current organisational theorists, Powell and

DiMaggio (1991:8), in the introduction to their book, *The New Institutionalism in Organisational Analysis* opine that, in

> the former [rational choice / game theoretic traditions] approaches institutions are the products of human design, the outcomes of purposive actions by instrumentally oriented individuals. But in the latter [regime theory and current organisation theory], while institutions are certainly the result of human activity, they are not necessarily the products of conscious design…. The new institutionalism in organisation theory and sociology comprises a rejection of rational-actor models, an interest in institutions as independent variables, a turn toward cognitive and cultural explanations, and an interest in properties of supraindividual units of analysis that cannot be reduced to aggregations or direct consequences of individuals' attributes or motives (Powell & DiMaggio1991: 8).

While Weber's theory of bureaucracy relevantly defines the broad framework of international development organisation/s in which this study is located, the theory needs to be re-interpreted, modified and evolved to make it relevant to today's bureaucracy. For example, in their modern form, bureaucracies have to negotiate contingencies and uncertainties both within the organisation and outside it. These are aspects that some latter day Contingency Theorists such as Burns and Stalker (1961), Hage (1965), Lawrence and Lorsch (1967) referenced in Donaldson (2001: 36) have brought into the dialogue on organisational theory.

Change and uncertainty are organic elements that are integral to today's bureaucracy of international development organisations, and often influence the interpretation and implementation of HIV and AIDS policy in the workplace. An attempt is made in this study to understand how, and if at all, the "mechanistic organizational structure" (Burns and Stalker as quoted by Donaldson 2001: 37) of present day international development organisations has evolved to deal with these uncertainties. Situations of high uncertainty are more efficiently (according to Burns and Stalker) and more innovatively (according to Hage) dealt with by decentralised organisations that have complex and participatory decision-making processes (synthesised from Donaldson 2001: 36-39).

> "Rather than getting embroiled in arguments for and against bureaucracy or any structural arrangements, Burns and Stalker were able to argue that both systems were suitable and rational for specific … situations" (Thompson & Mc Hugh 1990: 96).

It is safe to assert that today's international organisations cannot be typecast as either completely hierarchical or participatory. They evolve to respond to the needs of the times to survive, or they perish, like the League of Nations.

In the following section of the literature review, the structure and coping-mechanisms of international development organisations are explored, and their influence on decisions of policy implementation are highlighted. Since conventional wisdom would state that uncertainties are not simply internal, but also external, the argument also touches upon the role (if any) of external influences and dialogue (such as TAC -Treatment Action Campaign and the GIPA Movement on decisions made by managers for and in the organisations.

The Aston Group has labelled four key elements of bureaucracy theory. These elements (*Centralization, Specialization, Standardization and Formalization*) are examined in the context of HIV and AIDS policy implementation within the United Nations System. These elements are more fully explored later in the study in the context of the findings:

> *Centralization*: The hierarchy of the decision-making process, as it affects the implementation of an HIV and AIDS policy in the workplace is clear and centralized. In the United Nations Organisations, this centralization of policy implementation is designed to be set up within the larger mandates of the human resources department.
>
> *Specialization*: The division of labour within the United Nations system sets up specialist organisations, such as the ILO, to design the standard policy within the organisation. The human resources department carries out its implementation under the oversight of the country managers, deputy managers and department heads.
>
> *Standardization*: the level to which rules, roles and policies govern the organisation and its influence on HIV/AIDS-management in the workplace (modified and contextualized from Donaldson 2001: 63).
>
> *Formalization*: The level to which the rules and roles of standardization mentioned above have been codified and documented for easy reference of managers.

On the subject of *centralization*, the study explores the interplay of power between the managers of development organisations and the staff infected and/or affected by the epidemic, in the light of the theory that the

> mechanistic organization [of bureaucracies] is not only a structure but also a culture, in which subordinates are psychologically dependent upon their superordinates (Burns and Stalker 1961 as cited in Donaldson, 2001: 37).

Another important subtext of the analysis is the fact that senior managers and decision-makers within international development organisations are usually international staff members who are routinely transferred to other assignments in other countries. This turnaround of senior staff members implies a lack of local knowledge, needs and sensitivities among managers essential to informal decision-making. This study attempts to gather data on these aspects in staff and management orientation and on structural efficiencies as these relate to the implementation of policy.

On the subject of *standardization*, *formalization* and *specialization*, the Human Rights based policies and guidelines which govern the management of HIV and AIDS in the workplace and their interpretation by managers are explored. The development of policy and its implementation are different exercises requiring different processes. The focus in this study is not on the making of policy, but rather on its interpretation and implementation within the organisation.

In a sociological sense, the seminal research on institutions was, arguably, that conducted by Goffman and Foucault. Much of Goffman (1961) and Foucault's (referenced in Giddens 1986) work on institutions was grounded in bureaucratically managed systems. These bore broad hallmarks of the Aston Group's categorisation of bureaucracies. The institutional structures concerned were *centralized*, *specialized*, *formalized* and *standardized* institutions. Goffman and Foucault's studies were, however, largely conducted in institutions of incarceration, such as lunatic asylums, psychiatric wards and prisons. Being hugely specialised bureaucracies, these particular institutions follow procedures considered out of the ordinary in other systems. In reference to such institutions of incarceration, Giddens (1986: 155-6) points out that,

> "Interrogative procedures frequently transgress what for most of the population are regarded as legitimate 'information preserves' about the self and about the body".

They compile and record personal and private data about the inmates, normally considered a violation of personal privacy. These systems also dissolve the "boundaries between enclosure and disclosure". For instance, for professed security reasons, inmates may be expected to perform personal and private ablutions in public. As a result, there are no "back regions" or private spaces where inmates may spend private moments. Members of institutions studied by Goffman and Foucault have been reduced to levels of "childlike dependence" (Giddens 1986: 155-6) not seen in international organisations or development agencies like the United Nations.

On exploring other bureaucratic systems of management one would observe that there are tenuous similarities between bureaucracies such as the United Nations and bureaucracies such as the schools and academic systems studied by Hagerstrands (Giddens 1986: 134-5). These similarities include a clear and stated hierarchy between teachers and students, in the case of schools, and between management and staff, in the case of the United Nations. The teachers "usually have a back region to which they retreat, the staff room", where they are able to privately discuss and decide upon "tactics of coping" with teaching loads and student management issues. The managers in bureaucracies have their exclusively controlled and selectively accessed management retreats and boardroom sessions in which they are able to privately discuss and decide upon, among other things, staff-management issues. Further, both systems have their boards of governors who determine the institutional *raison d'être* and provide a system of checks and balances for institutional management. They both have associations (staff associations in the United Nations and student associations in schools) to give voice to issues that concern the staff or students (as the case may be).

These two systems do, however, diverge fundamentally in some ways. The school is a "'container' generating disciplinary power" with direct and punitive control exercised by teachers, while international bureaucracies do not define such rigid boundaries of control

absolutely. The most significant difference is the school's absolute control over time and space, a feature absent in international development bureaucracies such as the United Nations. As Giddens (1986: 135) describes it,

> "The school timetable is fundamental to the mobilization of space as co-ordinated time-space paths … like all disciplinary organisations, schools operate with a precise economy of time … [and] time enters into the calculative application of administrative authority".

Although hierarchical, the United Nations is constituted of policy advisors and programme managers who, within the overall mandate of the organisation have the freedom to adjust their own time and space. Working from home, for example, is an option available to United Nations staff members in select circumstances.

This exploration of literature pertaining to various types of bureaucracies, with highly polarised mandates, reveals that, while most bureaucracies share some broad similarities in characteristics, comparisons are not always fruitful tools of analysis. The findings in this study, therefore, steer clear of such comparisons.

2.4 International development organisations

Scholars have traced the genesis of international organisations to

> "numerous ancient leagues and assemblies that were aimed at warding off threats posed by formidable powers [such as the] cooperation among the lesser states confronting the imperial power of China and Rome" (Ziring, Riggs & Plano 2000: 4).

According to Ziring, Riggs & Plano (2000: 7), the

> "first examples of modern international organization were the river commissions [which go back to the 19th Century[11]] in Europe [and which] provided for extensive regulation of river traffic, the maintenance of navigation facilities, and the hearing and adjudication of complaints for alleged violations"

[11] Revised Convention on Navigation on the Rhine. Done in Mannheim, 17 October 1868; in force 1 July 1869. http://www.internationalwaterlaw.org/europe.html

of commissions' regulations. However the formalized construct of the international organisation, as we know it today, is very specifically a phenomenon of the twentieth century.

Two world wars in the first half of the twentieth century and countless deaths later, sovereign states realised the limitations of unilateralism and the need for equitable multilateralism as an arbiter of conflict and a stimulus for growth. As Paul Kennedy writes in his book the *Parliament of Man*,

> States, which had defined themselves from Thucydides to Bismarck by their claims to sovereign independence, gradually came together to create international organisations to promote peace, curb aggression, regulate diplomatic affairs, devise an international code of law, encourage social development, and foster prosperity (Kennedy 2006: xiii).

Fraught with the complex task of attempting to reconcile multilateralism and sovereignty, the development of international organisations is very much work-in-progress. And the location of this study is what Kennedy refers to as the "best-known and most ambitious of these bodies…the United Nations Organization" (*ibid.*).

For the purpose of this study, a definition and understanding of international organisations requires a prefaced contextualisation of its place within the umbrella concept of international regimes. An international development organisation is a unit or subset of what modern day organisational theorists call, "the concept of international regimes" (Krasner 1982:185). It is also vital to appreciate that the international development organisations referred to in this study are large institutions that nation states are willingly bound to for the facilitative function that they bring to the equation and despite the restrictions that limit the free action of nation states. As such,

> "institutions do not merely reflect the preferences and power of the units constituting them; the institutions themselves shape those preferences and that power" (Keohane 1988: 382 cited in Powell & DiMaggio 1991: 7).

As Powell and DiMaggio (1991:7) point out, scholars are questioning the rational actor approach to international institutions.

> Clearly many international institutions are not optimally efficient and, were they to be recognized de novo, would undoubtedly look quite different. Imperfect regimes survive nonetheless because sunken costs, vested interests, and the difficulty of conceiving of alternatives make it sensible to maintain them (Powell & DiMaggio 1991:7).

It is the dynamics of implementing an HIV and AIDS policy within the construct of these imperfect, yet resilient, institutions, which the fieldwork in this study explores. None the less, Powell and DiMaggio's (*ibid.*) belief that "sociological approaches to international institutions are better developed theoretically than empirically" is pertinent. The complexity of dealing with an epidemic such as AIDS, with its multifaceted associations of death, sexuality, stigma and discrimination, is also better served through sociological analysis than political and economic analysis, as sociological analysis is more encompassing and capable of spanning issues of policy and management structure on the one hand, and issues of rights and stigma on the other.

2.5 International regimes: Legitimacies, values and inconsistencies

Stephen Krasner's definition of international regimes is among the most acceptable definitions of the concept, with other organisational theorists such as Young (1986), Zacher (1987), Ness and Brechin (1988), Keohane (1988) and Powell and DiMaggio (1991) using it as a basic definition for their arguments. "Regimes" according to Stephen Krasner (1982:186)

> "can be defined as sets of implicit or explicit principles, norms, rules, and decision-making procedures around which actors' expectations converge in a given area of international relations" (Krasner 1982: 186).

In order to make the definition more specific and user friendly, Krasner goes on to detail the meaning of some of the keywords (principles, norms, rules and decision-making) that he uses. "Principles" he states,

> "are beliefs of fact, causation, and rectitude. Norms are standards of behavior defined in terms of rights and obligations. Rules are specific prescriptions or proscriptions for action. Decision-making procedures are prevailing practices for making and implementing collective choice" (Krasner 1982:186).

Despite the fact that international organisations are mandated with normative functions and the common goal of bringing stability to an international order, they have subtle differences in structure.

> Some of these international institutions (e.g., The United Nations or the World Bank) are formal organizations; others, such as the international regime for money and trade (the GATT or General Agreement on Trade and Tariffs) are complex sets of rules, standards, and agencies. Regimes are institutions in that they build upon, homogenize, and reproduce standard expectations and, in so doing, **stabilize the international order** (Powell & DiMaggio 1991: 6-7, original emphasis).

However, it is important to keep in mind that the "international order" itself is not constituted of a fixed environment, but a changing one requiring the organisation to change with it. Ness and Brechin (1988: 254) suggest that it

> is easy to see that the environment of the UN system has increased in size, heterogeneity, and instability since the UN was created. These changes suggest that the typically hierarchical structure of the organization may impede effective performance.

Lawrence and Lorsch (Ness & Brechin 1988: 266-7) showed that flat organisational structures performed better in a fluid and unstable environment than the hierarchical construct of a Weberian bureaucracy, like the United Nations system.

Most of the international development organisations that are significant players in today's context have come into existence in the last forty to sixty years following the ratification of the United Nations Charter in 1945. The Charter essentially sought to correct some of the imbalances triggered by the Second World War and to ensure that

> armed forces shall not be used, save in the common interest, and to employ international machinery for the promotion of the economic and social advancement of all people … (Preamble to the United Nations Charter cited in 'Basic Facts about the United Nations' [2000: 4]).

Among the key institutions created by the establishment of this new international regime was the United Nations and its many agencies such as Unicef, UNDP and UNFPA; the Bretton Woods institutions set up, in July 1944, with the objective of rebuilding the "shattered post war economy and to promote international economic cooperation" [12] through institutions and initiatives such as the International Monetary Fund (IMF), the International Finance Corporation (IFC) and the World Bank; the General Agreement on Tariffs and Trade (GATT), the later and more relevant reincarnation of which was the World Trade Organisation (WTO).

"Founding a new venture", as Aldrich (2001: 228) states

> "is risky business under any conditions, but especially so when entrepreneurs have few precedents for the kinds of activities they want to found".

It is important to interrogate Aldrich's statement in the light of the fact that given its size, multi-lateral mandate and global footprint, the United Nations can be considered a relatively nascent organisation. The United Nations officially came into being only on 24 October 1945 (United Nations 2000: 3) and is still evolving and reforming itself to maintain its legitimacy and relevance in a rapidly changing global environment. It had only one precedent (a failed one at that) in the form of the League of Nations. Established in 1919 after the First World War, with the objective of preventing further World Wars, the League of Nations closed offices after failing to prevent the Second World War, leaving its successor, the United Nations, with little to model itself on. It was confronted with the two problems Aldrich (2001: 228) believes emerging organisations face, those of learning and legitimacy.

The problem of 'learning' lay in the United Nations' need to define its role and discover approaches, methodologies and routines without the "benefit of role models" (Aldrich 2001: 229). While it would have learned from the mistakes of the defunct League of Nations, it had no successful prototype to emulate. Learning has been organic in nature, discovering itself in a changing environment through what Aldrich refers to as "organizational experimentation" (*ibid.*). HIV, for example, was discovered in the early

[12] http://www.brettonwoodsproject.org/background/index.shtml#01

80s (as already noted), but the 'ILO Code of practice on HIV/AIDS and the world of work' was only published and copyrighted in 2001 and the UN Secretary General's policy statement on Policy on HIV/AIDS in the workplace was only made in 2003 (United Nations ST/SGB/2003/18). The UN dealt with the epidemic both within its own organisation and globally as a pandemic and in doing so came upon its own policies.

The problem of 'legitimacy' lay in the United Nations' need to "establish ties with an environment that might not understand or acknowledge its existence" (Hannan & Carroll, 1992; Stinchcombe, 1965 cited in Aldrich 2001: 228). Suchman (1995a: 574 cited in Aldrich 2001: 229) defines the concept of organisational legitimacy as

> "a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions".

The criterion of legitimacy has been further sub-divided into two categories. Cognitive legitimacy refers to the acceptance of the organisation and its output as a presumed characteristic of the environment. Socio-political legitimacy refers to the organisation and its output's appropriateness in the environment as a moral body conforming to values and beliefs of the society it survives in and as a statutory body conforming to governmental rules and regulations.

Table 2.2 attempts to map the United Nations' HIV Policy in the workplace within the construct of Aldrich's categories of organisational legitimacy. This conceptualisation should assist in the analysis of the role and performance of the United Nations as a moral and regulatory authority:

Table 2.2: Mapping United Nations HIV policy in the workplace within the construct of Aldrich's categories of organisational legitimacy

Level of analysis	**Cognitive Strategies**		**Socio-political Strategies**	
	Learning	Cognitive legitimacy	Moral legitimacy	Regulatory legitimacy
Organisational level	The creation of a policy through exposure and experimentation	Link the policies to the UN Charter signed by countries in 1945 and subsequent Human Rights frameworks over following decades	Built on the United Nations' recognized role as gatekeeper of the Human Rights framework and the Economic and Social Council (ECOSOC)	Work within the framework of the UN Charter at one level and the constitutional framework of member countries within which the UN operates

Before examining the *raison d'être* of international organisations it would be pertinent to briefly note some of the common characteristics that Ziring, Riggs and Plano (2000: 8) outline to define recent international organisations such as the United Nations:

1. **Membership** is essentially reserved for "sovereign states".

2. **Treaty based** constitutions designed by multilateral consensus usually define the structure, scope and mode of operation.

3. A conference or *congress* usually constitutes the broad **policy making organ** of the organisation.

4. A *council* is usually set up to provide **executive authority** to the organisation.

5. A *secretariat,* run by a bureaucracy of civil servants, is usually established to **implement** the policies.

6. Decision-making is based on the principle of **egalitarianism.**

7. The **judicial authority** was sometimes incorporated in the treaty and sometimes, as in the case of the United Nations, linked to a special international court of justice.

8. Most have a **legal identity** that permits them to hold property and in some cases are covered by diplomatic immunities and privileges.

9. The **financial base** of the organisation necessary for its operation usually comes from the member states through a predetermined formula.

10. The **competence** of the organisation is determined by a focal area of intervention and is consequently staffed to deliver on its predetermined task.

11. The **decision-making** is usually carried out through the consensual drafting of treaties and resolutions and usually recommends action for some or all member states.

There are two broad, and somewhat polarised perspectives to the reason for the existence of these international organisations:

> From a "reductionist" or "realist" perspective, international organisations have no independent role or function in international affairs. They are merely extensions or instruments of state power. Unlike the more naturally developed nation states and governments, international organisations are artificially created by governments for the convenience of international cooperation and management. Designed for specific tasks, international organisations have no autonomous political will and consequently no political independence or existence (Heiskanen in Coicaud & Heiskanen 2001: 5).
>
> The "idealist" or "institutional" perspective, by contrast, sees international organisations as playing a role in international affairs that is independent of states and governments that brought them into being. Like states, international

> organisations are formal subjects of international law. They have an independent legal identity and can sue and in turn be sued within the scope of their functional immunity. Besides, they carry out functions that states are themselves incapable of carrying out. Consequently, international organisations must be understood as entities that not only have to be taken into account, but must also be accountable. (adapted from Heiskanen's chapter in Coicaud & Heiskanen 2001: 5).

The role of administering and facilitating international peacekeeping, stimulating growth and championing Human Rights without any formal authority to govern has resulted in

> many international organizations, and particularly international civil servants working within such organizations, view[ing] themselves as servants of the member states rather than their masters, and see as their main function the implementation of the decisions taken and the policies adopted by the representatives of these states … Nonetheless, it is hard to deny that from the perspectives of states that have, for instance, become targets of United Nations sanctions or other coercive measures approved by the Security Council, or that are on the receiving end of accusations by human rights organizations of alleged domestic human rights violations, or that are faced with the take-it-or-leave-it conditionality attached to IMF and World Bank credit and loan approvals, these international organizations are effectively exercising functions that verge on the governmental (Heiskanen in Coicaud & Heiskanen 2001: 7-8).

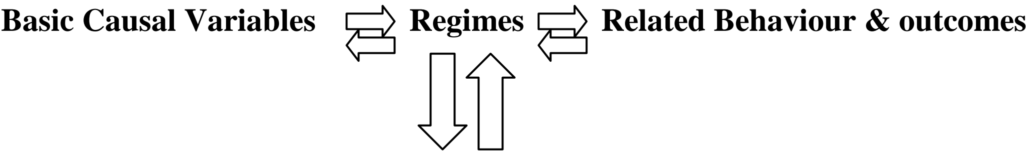
It is however inaccurate to state categorically that, international organisations perform functions that can be characterised as governmental. Whether they do or not largely depends on the differing perspectives of states sponsoring an action from those on the receiving end of it. Each instance is different and each international organisation seeks its own specific outcome. Moreover, differences of opinion can be polarised in the context of sanctions and peace-keeping interventions and sometimes less so in the context of aid and development interventions (Heiskanen in Coicaud & Heiskanen 2001: 7-8).

According to Krasner (1982: 189), regimes constitute a set of catalytic variables among such basic causal factors as power and self-interest and the related outcomes of multilateral cooperation and harmony. The following figure by Krasner (Spring, 1982: 189) represents such inter-relationships graphically:

Basic Causal Variables ⇨ Regimes ⇨ Related Behaviour & outcomes

Figure 2.1: Causal relationships

According to Krasner, regimes neither arise of their own accord nor are they considered ends in themselves. They are not solely by-products of state needs and interventions, but play very distinct and particular roles in multilateral issues. If as Krasner's argument suggests, regimes are not purely epiphenomenal or secondary structures serving as by-products of primary organisational structures, but are distinct and even normative players in themselves, it is important then to focus on the internal mechanics of the units within the regime (the international organisations) for consistencies of policy and implementation. It is my understanding that a graphic conceptualisation, with a focus on internal mechanics of international organisations, would look like Figure 2.2, based on a modification of Figure 2.1 by Krasner (Spring, 1982: 189):



International Development Organisations

Figure 2.2: Causal relationships: Modified to include international development organisations

The thrust of this study is, as already argued, sociological rather than political in nature. Thus it aims to determine a wider model of engagement and action that facilitates an understanding of how HIV and AIDS policies are instituted and implemented within the internal structures of international organisations. The research moves the focus from a political and corporate *modus operandi,* towards the power equations, social actions, interpretations and, more especially in this study, to relationships that facilitate and inhibit the implementation of HIV and AIDS policy, in the "organized social space" (Fligstein 2001: 15) within which international organisations operate.

Unlike commercial, private sector organisations, which are inward-looking and which operate largely for themselves and their shareholders, international organisations are mandated to operate for an external community of nation states. Jean-Marc Coicaud (in Coicaud & Heiskanen 2001: 519) points out that, their (International Development Organisation's) institutional mandates include three things, providing countries with a

meeting point for negotiations, establishing laws for multilateral engagement, extending technical and political assistance in areas such as security and development. As a manifestation of this multilateral mandate, Coicaud observes that the legitimacy of international organisations was sought on the basis of a set of externally codified values. In the context of the United Nations, these values are fundamentally inspired by the UN Charter and are codified more specifically in various conventions, such as the Convention on the Rights of the Child (CRC) or the Convention on the Elimination of Discrimination against Women (CEDAW), developed by specialist UN agencies. However, being a normative body and an unbiased arbiter demands a certain consistency of values and positions in areas of policy development and implementation, not just externally (with its clients, the nation states) but internally (within its own system) too. This project seeks to understand the consensuses and conflicts, the disagreements and negotiations, the breakdowns and breakthroughs that fuel the dynamic social exchanges that in turn drive the implementation of HIV and AIDS policy in the internal workplace.

The following section will sharpen the focus of the chapter from a generic analysis of international development organisations to an understanding of the United Nations as an international development organisation.

2.6 The United Nations as an international development organisation

Before turning to the main focus of the thesis (HIV and AIDS), in the context of fundamental Human Rights (as enshrined in the UN Charter, discussed above), it is pertinent to explore the sociology of international development organisations, with specific reference to the United Nations, in some detail.

The term ‘United Nations’ has been attributed to Franklin D Roosevelt and was first used officially in the *Declaration by United Nations* of 1 January 1942, during the Second World War, when 26 countries united in their pledge to fight the Axis Powers (World War II, fought between 1939 and 1945, was primarily a conflict between the Axis Powers [Germany, Italy, Japan, Hungary, Romania, Bulgaria] and the Allies [the main countries

being U.S., Britain, France, USSR, Australia, Belgium, Brazil, Canada, China, Denmark, Greece, Netherlands, New Zealand, Norway, Poland, South Africa, Yugoslavia]) [13].
The UN Charter was signed on 26 June 1945 in San Francisco by 50 attending nations. Poland, which was not represented at the San Francisco conference, later signed to make up the original 51 signatories of the UN Charter that brought the United Nations into existence. However, the United Nations only officially came into existence on 24 October 1945, when the UN Charter was ratified by China, France, USSR, UK and the USA (subsequently constituting the Permanent Five on the Security Council) and a majority of the other signatories (Adapted from United Nations 2000: 3).

The Charter (United Nations 2000: 4-5) is the "constituting instrument" of the United Nations organisation. It outlines the rights and obligations of member states and establishes the major "procedures" and "organs" of management. The Preamble to the Charter "expresses the ideals and common aims of all the peoples whose governments joined together to form the United Nations" (*ibid.*). It articulates the faith of member states in fundamental Human Rights and the "dignity and worth of the human person, in the equal rights of men and women" (*ibid.*). It also reaffirms its commitment to "employ international machinery for the promotion of the economic and social advancement of all peoples" (*ibid.*). The commitment to Human Rights and the "advancement of all people" is a significant point to take note of, as it will serve as a yard stick for performance assessment on the issue of implementing HIV and AIDS policies in the workplace.

The purpose of the organisation set out in the Charter helps to define its core mandate: "to maintain international peace and security; To develop friendly relations among nations based on respect for the principle of equal rights and self-determination of people; To cooperate in solving international economic, social, cultural and humanitarian problems and in promoting respect for human rights and fundamental freedoms; To be a centre for harmonizing the actions of nations in attaining common ends" [14]

[13] http://www.infoplease.com/ipa/A0001288.html Accessed on 25 October 2008.
[14] http://www.un.org/aboutun/basicfacts/unorg.htm (Accessed on 25 October 2008).

According to the United Nations Web page on basic facts about the UN[15], the United Nations is a significantly large organisation with a budget of "$2,535 million" in the years 2000-2001. The primary funding source for the organisation is generated from the Member States, at a level sanctioned by the United Nations General Assembly. The organisation's Finance section on Global Policy[16], states that the United Nations and its agencies and funds expend approximately $20 billion per year, which translates to approximately "$3 for each of the world's inhabitants". This is considered a meagre sum compared to the budgets of most national governments and is just a tiny fraction of the world's military spending. These figures enable one to envisage the complexity of the United Nation's situation vis-à-vis funding, prioritisation and operations.

Set up by the governments of member states, the United Nations system loosely replicates governmental bureaucracies with the Secretary General being accorded the protocol of a Head of State and United Nations Resident Coordinator in a country accorded the status of an Ambassador. However, its powers are not commensurate with national governmental bureaucracies (see Table 2.3). Kofi Annan (2000: xvi) defines the type of organisation the United Nations is and its power, authority and role as an international bureaucracy:

> "The United Nations has no independent military capability, and very modest funds. Its influence derives from the force of the values it represents, its role in helping to set and sustain global norms and international law, its ability to stimulate global concern and action, and the trust inspired by its practical work on the ground to improve people's lives. The effectiveness of the United Nations in all these endeavours depends on partnerships: among governments, civil society groups and the private sector, and most of all among people reaching across lines that might otherwise divide".

The structure of the United Nations is also outlined in the Charter, which established six principal organs of management: the General Assembly (GA), the Security Council (SC), the Economic and Social Council, the Trusteeship Council, the International Court of Justice and the Secretariat. The wider UN System is even larger and encompasses 15

[15] http://www.un.org/aboutun/basicfacts/unorg.htm (Accessed 29 June 2008).
[16] http://www.globalpolicy.org/finance/index.htm (Accessed 29 June 2008).

agencies and several programmes and bodies. The United Nations programmes (such as UNDP, UNEP [United Nations Environmental Programme], UNICEF and UNFPA) and the specialised agencies (such as ILO, FAO, WHO, and UNESCO) report to the ECOSOC Council which "plays a key role in fostering international cooperation for development and in setting priorities for action" (United Nations 2000: 6).

Table 2.3: United Nations system organogram: United Nations 2000

The United Nations System

Principal Organs

Trusteeship Council

Security Council

Subsidiary Bodies

- Military Staff Committee
- Standing Committee and ad hoc bodies
- International Criminal Tribunal for the former Yugoslavia (ICTY)
- International Criminal Tribunal for Rwanda (ICTR)
- UN Monitoring, Verification and Inspection Commission (Iraq) (UNMOVIC)
- United Nations Compensation Commission
- Peacekeeping Operations and Missions

General Assembly

Subsidiary Bodies

- Main committees
- Human Rights Council
- Other sessional committees
- Standing committees and ad hoc bodies
- Other subsidiary organs

Advisory Subsidiary Body

- United Nations Peacebuilding Commission

Programmes and Funds

- **UNCTAD** United Nations Conference on Trade and Development
  - **ITC** International Trade Centre (UNCTAD/WTO)
- **UNDCP**[1] United Nations Drug Control Programme
- **UNEP** United Nations Environment Programme
- **UNICEF** United Nations Children's Fund
- **UNDP** United Nations Development Programme
  - **UNIFEM** United Nations Development Fund for Women
  - **UNV** United Nations Volunteers
  - **UNCDF** United Nations Capital Development Fund
- **UNFPA** United Nations Population Fund
- **UNHCR** Office of the United Nations High Commissioner for Refugees
- **WFP** World Food Programme
- **UNRWA**[2] United Nations Relief and Works Agency for Palestine Refugees in the Near East
- **UN-HABITAT** United Nations Human Settlements Programme

Research and Training Institutes

- **UNICRI** United Nations Interregional Crime and Justice Research Institute
- **UNITAR** United Nations Institute for Training and Research
- **UNRISD** United Nations Research Institute for Social Development
- **UNIDIR**[2] United Nations Institute for Disarmament Research
- **INSTRAW** International Research and Training Institute for the Advancement of Women

Other UN Entities

- **OHCHR** Office of the United Nations High Commissioner for Human Rights
- **UNOPS** United Nations Office for Project Services
- **UNU** United Nations University
- **UNSSC** United Nations System Staff College
- **UNAIDS** Joint United Nations Programme on HIV/AIDS

Other UN Trust Funds[7]

- **UNFIP** United Nations Fund for International Partnerships
- **UNDEF** United Nations Democracy Fund

Economic and Social Council

Functional Commissions

Commissions on:

- Narcotic Drugs
- Crime Prevention and Criminal Justice
- Science and Technology for Development
- Sustainable Development
- Status of Women
- Population and Development

Commission for Social Development

Statistical Commission

Regional Commissions

- Economic Commission for Africa (ECA)
- Economic Commission for Europe (ECE)
- Economic Commission for Latin America and the Caribbean (ECLAC)
- Economic and Social Commission for Asia and the Pacific (ESCAP)
- Economic and Social Commission for Western Asia (ESCWA)

Other Bodies

- Permanent Forum on Indigenous Issues (PFII)
- United Nations Forum on Forests
- Sessional and standing committees
- Expert, ad hoc and related bodies

Related Organizations

- **WTO** World Trade Organization
- **IAEA**[4] International Atomic Energy Agency
- **CTBTO Prep.Com**[5] PrepCom for the Nuclear-Test-Ban-Treaty Organization
- **OPCW**[5] Organization for the Prohibition of Chemical Weapons

International Court of Justice

Specialized Agencies[6]

- **ILO** International Labour Organization
- **FAO** Food and Agriculture Organization of the United Nations
- **UNESCO** United Nations Educational, Scientific and Cultural Organization
- **WHO** World Health Organization

World Bank Group

- **IBRD** International Bank for Reconstruction and Development
- **IDA** International Development Association
- **IFC** International Finance Corporation
- **MIGA** Multilateral Investment Guarantee Agency
- **ICSID** International Centre for Settlement of Investment Disputes

- **IMF** International Monetary Fund
- **ICAO** International Civil Aviation Organization
- **IMO** International Maritime Organization
- **ITU** International Telecommunication Union
- **UPU** Universal Postal Union
- **WMO** World Meteorological Organization
- **WIPO** World Intellectual Property Organization
- **IFAD** International Fund for Agricultural Development
- **UNIDO** United Nations Industrial Development Organization
- **UNWTO** World Tourism Organization

Secretariat

Departments and Offices

- **OSG**[3] Office of the Secretary-General
- **OIOS** Office of Internal Oversight Services
- **OLA** Office of Legal Affairs
- **DPA** Department of Political Affairs
- **DDA** Department for Disarmament Affairs
- **DPKO** Department of Peacekeeping Operations
- **OCHA** Office for the Coordination of Humanitarian Affairs
- **DESA** Department of Economic and Social Affairs
- **DGACM** Department for General Assembly and Conference Management
- **DPI** Department of Public Information
- **DM** Department of Management
- **OHRLLS** Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States
- **DSS** Department of Safety and Security
- **UNODC** United Nations Office on Drugs and Crime

- **UNOG** UN Office at Geneva
- **UNOV** UN Office at Vienna
- **UNON** UN Office at Nairobi

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NOTES: Solid lines from a Principal Organ indicate a direct reporting relationship; dashes indicate a non-subsidiary relationship.

1 The UN Drug Control Programme is part of the UN Office on Drugs and Crime
2 UNRWA and UNIDIR report only to the GA
3 The United Nations Ethics Office and the United Nations Ombudsman's Office report directly to the Secretary-General
4 IAEA reports to the Security Council and the General Assembly (GA)
5 The CTBTO Prep.Com and OPCW report to the GA
6 Specialized agencies are autonomous organizations working with the UN and each other through the coordinating machinery of the ECOSOC at the intergovernmental level, and through the Chief Executives Board for coordination (CEB) at the intersecretariat level
7 UNFIP is an autonomous trust fund operating under the leadership of the United Nations Deputy Secretary-General. UNDEF's advisory board recommends funding proposals for approval by the Secretary-General.

2.7 AIDS in the United Nations system and the Humans Rights discourse

Equity and Human Rights underpin the laws and policies that govern development organisations in twenty first century South Africa. Documents, such as the *South African Constitution* (1996) and *The ILO Code of Practice on HIV/AIDS and the world of work: its implementation in the UN workplace* (2004)[17], demonstrate that this is so. These policies are expected to be put into practice by the managers of the organisations. The level of implementation, however, does not always reflect the stated objectives of the policy, as is amply visible in the ILO/AIDS assessment of HIV and AIDS workplace policy implementation within the United Nations Development agencies in the Southern and Eastern Africa sub-region (Fig 1.1: Rapid assessment of the implementation of HIV and AIDS workplace policies and programmes in the UN workplace in Eastern and Southern Africa). It demonstrates that nearly 80% of the agencies assessed in the report have work plans to implement HIV and AIDS policies. A little over 50% have, however, provided the budget to execute the work plan that will implement the policy, and even fewer offices have set up a WWP. Both work plans and budgets form part of policy implementation. Whether this is driven by constraints of resources or the opinions of managers is one of the primary questions of the study (see section 3.9).

It is pertinent also to review certain aspects of the HIV and AIDS policies (such as universal access to treatment, stigma free workplace and discrimination free actions on the part of the management) in the context of them being Human Rights as opposed to moral perspectives. According to Gewirth (1982: 64), for these moral perspectives to be considered Human Rights, they would need to pass the tests of “universality and practicability”. To be considered universal, the right needs to be

> a right of all persons against[18] all persons: all persons must have the strict duty of acting in accord with the right, and all persons must have the strict right to be treated in the appropriate way. Thus all persons must be both the agents and the recipients of the modes of action required by the right (*ibid.*).

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[17] http://www.ilo.org/public/english/protection/trav/aids/publ/compliance.pdf Accessed on 25 October 2008.

[18] I would emphasise the relational aspect of the word “against” (Gewirth 1982: 64) rather than the confrontational aspect of its meaning since the fulfilment of the rights for one group may not necessarily imply the impingement of the rights of others.

This definition tends to suggest a hierarchy of Human Rights. As Gewirth points out, one set of rights, such as the rights to life and freedom of movement fulfil the requirement easily on grounds of universality. Another set of rights such as the right to be relieved from economic starvation or severe economic deprivation remains conditionally relevant only for those in starvation or deprivation. If this definition were to be applied strictly to the policy of providing access to ARV treatment in organisations, it would not be considered a Human Right, since only some people (those living with the virus) would have the right and some people (those in positions of institutional authority and in control of budget allocations) would have the obligation to fulfil the right.

On Gewirth's criteria of "practicability" as a criteria for the fulfilment of rights, the right of access to treatment would appear to fall short as a comprehensive right, since all organisation's, at all times, do not necessarily have the resources to fulfil the right. It may not be considered practical, by duty bearers, to deliver to all those in need. However, Gewirth provides a decidedly categorical rider to the criterion of practicability in his statement that, "this objection need not concede that the right… is universal only in a 'weaker' sense" (*ibid.*).

In applying Gewirth's (1982: 30) Principle of Generic Consistency (PGC)[19] to the issue of access to treatment, it must be stated that the lack of universal need for ARV treatment does not mitigate the importance, need and right of people to receive treatment when they are infected. The application of Gewirth's argument would recommend organisations to take positive action towards reallocating budgets "to the extent of their available resources" *(ibid.)*.

In his chapter, *The Basis and Content of Human Rights*, Gewirth (1982: 65) argues that there is a "considerable distance" between the issues of non-uniform financial resources and equitable distribution of available resources. It is therefore important not to use the

[19] Gewirth advocates the need to "Apply to your recipient the same generic features of action that you apply to yourself" (Gewirth 1982: 30).

former as an excuse for not attempting to deliver the later. The obligations of duty bearers under the Principle of Generic Consistency (PGC), according to Gewirth (1981: 135),

> "cannot be escaped by any agent [duty bearers in the context of my study] by shifting his [or her] inclinations, interests or ideals, or by appealing to institutional rules whose contents are determined by convention".

This is a crucial position in the context of this study, since it advocates the view that

> the agent must hold that he has rights to these features simply insofar as he is a prospective purposive agent; he rationally must accept that his recipients also have these rights insofar as they too are prospective purposive agents (Gewirth 1981: 135).

In summary, the manager or duty bearer in the organisation should understand that a right that is due to himself or herself should be equally due to all others serving in the organisation. The issue of practicability is negated by the argument that, the right or facility, in being available to select staff members, should be available to all others in the same workspace.

A significant detail in Gewirth's argument of universality and practicability is that it is not a matter of all rights' holders having the same right at the same time and to the same degree of immediacy. Nor is it a matter of duty bearers fulfilling all rights at all times to the fullest extent of the need. It is, as Gewirth (1982: 65) states it,

> rather a matter of everyone's having, as a matter of principle, the right to be treated in the appropriate way when he [or she] has the need, and the duty to act in accord with the right when the circumstances arise…. And he [or she] has the ability to do … [within the] consideration of cost to himself [or herself].

An important element of rights' fulfilment is the obligation of duty bearers, who are tasked to deliver on their obligations. This is an important element of the rights discourse as it directly pertains to the role of the managers of international development organisations. The word 'obligatory' might lead us to assume its meaning in its very literal and absolute sense, as being something that is both morally and legally binding. However, Gewirth in his essays on the justification and application of Human Rights (1982) has drawn a few very fine distinctions that merit articulation in this thesis.

Gewirth has (in a theoretical sense) removed the sense of an absolute compulsion from the concept of the obligations of duty bearers. On the one hand, he writes about "descriptive obligations" as being

> "required by some institution; but the person making the statement may not himself [or herself] accept the institution or its purposes as right or justified" (Gewirth 1982: 260-261).

He illustrates this definition with the vivid example of a black South African in apartheid South Africa as accepting the existence of certain obligations according to the law, but robustly opposing any obligation to fulfil it. On the other hand Gewirth refers to "prescriptive" obligations as being obligations that go beyond the mere acknowledgement of the obligations existence but a vigorous "advocacy or endorsement" *(ibid.)* of it.

Gewirth (1982: 262-263) explains the concept of obligations a step further when he draws a fine distinction between "tentative" and "determinative" obligations.

> A tentative obligation is one, [Gewirth articulates] that obtains only within a context which has not itself yet received successful justification; it hence does not determine what one's 'real' obligations are, that is, what is justifiably required of one, or what one ought to do. A determinative obligation, on the other hand, determines what is justifiably required of one, what one ought to do. Unlike a tentative obligation, it is already justified, and hence does not need to await justification (or disjustification) from some further set of considerations *(ibid.)*.

When viewing HIV and AIDS policies and their implementation in international development organisations, it is important to do so in the context of the rights the HIV Policy contains and attempts to deliver to its work force. In a sub-chapter on the importance of positive rights, Gewirth (1996: 31-33) articulates the view that a

> "human society based on positive human rights requires not only that persons refrain from coercing or harming one another but also that they help one another"

in an attempt at both self-realisation and the realisation of the larger community in which one is based.

Gewirth's view that "persons refrain from coercing or harming one another but also that they help one another" brings the spotlight clearly on the role of the organisation and its

managers in this study. Another view that does so is Rawls's difference principle (Kelly 2001: 61-66). Rawls interprets the difference principle as a "principle of distributive justice" *(ibid)*. But as this principle opens up a variety of possibilities, including some that do not conform to Rawls's principle of justice, he articulates key criteria and preconditions. Rawls claims that the principle is

> subordinate to both the first principle of justice (guaranteeing the equal basic liberties) and the principle of fair equality of opportunity. It works in tandem with these two prior principles and it is always to be applied within background institutions in which those principles are satisfied (Rawls cited in Kelly 2001: 61).

Both Gewirth and Rawls's views are relevant to this sociological study on two counts. First, because they underline the mandate of the managers in international development organisations such as the United Nations to assume responsibility for providing staff with the basic rights of equality of liberty and opportunity. It follows that a person living with the virus and working in the organisation should receive equal treatment with those living either sero-negative or living undetected (either to themselves or to the work community at large). Secondly, if there is to be a differential treatment, (since Rawls's principle works in tandem with the principle of equality), it needs to be a positive one, instituted to redress any particular imbalance. As Rawls states in illustration,

> "if men, say, have greater basic rights and greater opportunities than women, these inequalities can be justified only if they are to the advantage of women and acceptable from their point of view" (Rawls cited in Kelly 2001: 65).

These principles are therefore used as yardsticks to analyse the performance of the organisation and the actions of managers who are authorised to represent the organisation's best interest.

It would be an oversight not to mention the counterpoints to Rawls's view that constitutes Sandel's (1998) arguments on *Liberalism and the limits of justice*. Sandel provides a robustly argued counterpoint to Rawls's principle of difference in his chapter titled, *Meritocracy versus the Difference principle* (Sandel 1998: 72-77). According to Rawls, the concept of "moral worth" does not enter the equation until the principles of justice are already delivered upon. However, Sandel argues that,

> "[s]ince no virtue has antecedent, or pre-institutional moral status, the design of institutions is open with respect to the qualities it may prize. As a result, the intrinsic worth of the attributes a society elicits and rewards cannot provide a measure for assessing its justice, for their worth only appears in the light of institutional arrangements to begin with".

Writing in the early-AIDS era of the nineties, Sandel overlooks the complexities that constitute worth and ability, in a world living with HIV.

A person living with the virus may have all the necessary qualifications for the job and still be unjustly discriminated against under the presumption of a projected later-day inability. Sandel's theory allows for managers to make moral judgments and use them as yardsticks to determine worth. This is where Rawls's theory of justice (despite being developed in a pre-AIDS society) stands the test of time by insisting on the basic right of equality. Unlike Sandel, Rawls refrains from bringing in riders such as meritocracy. Although Sandel's argument can be legitimately applied in many situations and cases (such as the skills criteria of "fleet-footedness" over "loquaciousness" in a "hunting society" (Sandel 1998:76)), to my mind, it lacks the universality of the Rawlsian approach.

Apart from the view of the policy in the context of equality and justice being basic Human Rights, it is also important to unpack the policy in the context of its socialisation within a community. Risse and Sikkink (Risse, Ropp & Sikkink: 1999: 5), in an essay on 'The socialization of human rights norms', break the process of socialising Human Rights into a three-step process. At the first level there is the "instrumental adaptation" of the policy. At this level, it is instituted as a policy that defines rights and obligations. At the second level a process of "moral conscience raising, argumentation, dialogue, and persuasion" defines the course, before the third (and final) level, which is defined by a process of "institutionalization and habitualization". When this third level is achieved the HIV and AIDS policy may be considered to have been socialised.

2.8 The morality of managing the virus in the workplace

It seems pertinent at this stage to briefly dwell on the issue of “moral conscience”, proposed by Risse and Sikkink. Extrapolating Risse and Sikkink’s statement, one can argue that, apart from the responsibility of implementing the HIV policy, managers also face the moral prospect of supporting a person socially, medically and financially, who has been disadvantaged by society’s response to an epidemic. Referring to the responses of the average German citizen to the treatment of Jewish people by the Nazi regime, Norman Geras (1998: 28) says,

> “[i]f you do not come to the aid of others who are under grave assault, in acute danger or crying need, you cannot reasonably expect others to come to your aid in [a] similar emergency; you cannot consider them so obligated to you”.

Geras refers to this as “the contract of mutual indifference” (Geras 1998: 28). It horrified Geras that people could actually see injustice unfold in front of their eyes and go back to their homes and lead normal lives. It is preferable, however, to take Geras’s insight and present it from an action-oriented perspective. As human beings in a society, as colleagues in a workplace, we have a *contract of mutual empathy*, in which we have the responsibility to empathise and support those around us in need, to the best of our ability. The suggestion is that this would create a momentum for positive social change, as advocated in the United Nations Charter.

Opining from a practitioner’s perspective, Jonathan Mann (Mann, Gruskin, Grodin & Annas 1999: 224) argues that

> “issues of human rights inherently and inevitably put the person concerned with rights at odds with… [the] sources of power” within the system, making the “challenges of response… ever more difficult”.

The reasons are simple. On finding rights issues in contradiction to their considered decisions and actions, Managers of the system, the duty bearers, would either conceal (from public and transparent scrutiny) or openly acknowledge and repress the action, depending on the level of unilateral authority, immediacy and public opinion the authority felt inclined or able to deal with. Thus posing the “challenges of response”,

Mann refers to. Michael Ignatieff propounds an opinion that reinforces Mann's thoughts. "No authority whose power is directly challenged by human rights advocacy is likely to concede its legitimacy" (Ignatieff 2001: 56). His opinion implies opposition and confrontation between the holding power base and Human Rights advocacy when there is disagreement on principles and values. However, Ignatieff makes a somewhat basic and simple point on the confrontation between obvious and visibly polarised value systems. All disagreements are not necessarily acknowledged and articulated as so. The power equation is more complex when the disagreement and challenge (between duty bearers and holders) are subtle and unacknowledged. This is so because it does not permit the obvious convenience of arbitration between clearly opposing viewpoints. Readily acceptable surrogate issues are used as proxy, completely obfuscating the real point of opinion and therefore the real reason for the disagreement. A smoke screen is generated through the reinterpretation of facts and issues. In the rule-book governed bureaucracy that is the international development organisation there seem to be numerous avenues available in the numerous policies that govern the system. Theoretically, those in power, while accepting Human Rights policies as determined, might sometimes, driven by other considerations, seek to dilute the execution of the policy. If carried out with a degree of efficiency such practices could remain unnoticed for long periods of time.

Half a century after its proclamation, the Universal Declaration of Human Rights has entered the language of policy. In its design and in the forum of its presentation it wields a certain power over governments and organisations the world over. In a facetiously titled chapter (Allen 2003: 129), *Proximity and Reach: Were there Powers at a Distance before Latour?* John Allen[20] articulates a view that might explain the far-reaching influence and power of the Declaration of Human Rights on current policies and legislation. He *(ibid.)* says, "The idea that power assumes extensive reach into the lives of those not present or draws distant others closer into its ambit is not one we should be complacent about." Referring to Latour's argument, Allen goes on to say,

> it was possible to dominate others at a distance through the mobilization and translation of what he [Latour] referred to as 'circulating traces'; that is, virtually

[20] John Allen refers to Bruno Latour's contention that "microbes didn't exist before Louis Pasteur rendered them 'visible'" (Allen 2003: 129).

> any element, entity or piece of documentation that can be inscribed or re-presented in some way so as to hold the mobile world 'out there' constant (Allen 2003: 129).

In the larger analysis, the study will attempt to re-enforce the importance and influence of the rights base of the policy and the significant influence that it wields (half a century into the future). The study will also attempt to understand whether, left to the interpretations of managers on the ground, the HIV and AIDS policies are able to "hold the mobile world 'out there' constant" (Allen 2003: 129).

2.9 Interpretations guiding decisions of managers: Rational and reasonable options

On the subject of interpretations that guide the decision-making of managers, Natrass, Rawls and Sidley (Sidley 1953: 560 as cited in Rawls 1993: 49 and Natrass 2004: 191) have analysed specific distinctions between the 'rational' and 'reasonable':

> knowing that people are rational we do not know the ends they will pursue, only that they will pursue them intelligently. Knowing that people are reasonable where others are concerned, we know that they are willing to govern their conduct by a principle from which they and others can reason in common; and reasonable people take into account the consequences of their actions on others' well being.

Managers are rarely, only rational or only reasonable. Both characteristics exist in varying degrees, as part of a continuum. As such, actions often mask intentions. It is also important to "recognize the burdens of judgment" (Rawls 1993: 54) that the managers have to carry in their decision-making. Paltiel's observation about economics in the context of the implementation of HIV and AIDS policy in the workplace is pertinent here: He says, "economics is an efficiency driven science with no moral compass with regard to equity and compassion" (as cited in Natrass 2004: 36). Further underlining Paltiel's contention is a recent study on 'the impact, meaning and challenges of work'. The authors, Timmons and Fesko (2004) , observe that people living with the virus are "living longer" and "productive lives", making it important to "shift [the] approach from managing an immediate medical crisis to managing a chronic, long term health issue".

While the direct extrapolation of this understanding could induce a 'rational' manager in the private sector to infer that long term medical overheads result in budget inefficiencies, and would therefore need to be addressed as such, it is not a matter of concern for the manager in a non-profit development organisation, where economic criteria do not constitute performance evaluation criteria.

It is also important at this juncture to highlight that a positioning statement, dated August 2002, by the Global Business Coalition (GBC) on HIV/AIDS on the subject of pre-testing for HIV[21], adopts the view that while it is important to take into account the "concern for productivity, profitability, shareholder interests and employee well-being" managers should "refrain from adopting and implementing pre-employment HIV testing". The GBC position on pre-employment testing categorically states that:

> Pre-employment testing usually fails to achieve its desired results of significantly reducing HIV prevalence in a workforce. This would be especially true when implemented within the 16-20 year old age group in Africa (a cohort commonly targeted for recruitment by many extraction companies) as HIV peak prevalence occurs in an older age group.
>
> Pre-employment testing has not demonstrated any reduction in risk-taking behaviors to reduce HIV infection rates once employed. In fact, compulsory pre-employment testing would likely discourage existing employees from coming forward for voluntary counseling and testing (VCT) for fear of discrimination and stigmatization.
>
> Scrutiny of multinational corporations - particularly the treatment of their workers - has dramatically increased. Executives and shareholders have recognized the impact of sound corporate social responsibility on not only a company's public image but its bottom line. The impact of pre-employment testing on the international reputation of companies could be drastic and costly[22].

[21] http://info.worldbank.org/etools/docs/library/49153/Pre-employment%20Test%20final.doc Accessed 2 July 2008.
[22] HIV Pre-Employment Testing: The Global Business Coalition on HIV/AIDS http://info.worldbank.org/etools/docs/library/49153/Pre-employment%20Test%20final.doc Accessed 25 October 2008.

The above position, adopted by the Global Business Coalition, rationally negates any perceived advantages that managers may feel accrue from pre-testing for HIV as a productivity and profitability measure. The positioning statement[23] is that,

> "[n]o data or evidence exists to show that HIV pre-employment testing is economically feasible or will reduce prevalence in the workplace".

The statement also goes on to advocate policies "based largely upon peer advocacy on current practices, consideration of Human Rights tenets, and knowledge of legal requirements". A Human Rights based approach, in order to be successful, will require an understanding and belief among managers that HIV is a reality in our society and can be better managed if it is mainstreamed into the fabric of the organisational response.

2.10 Exploring possible reasons for slow policy implementation

In a study featured in SAfAIDS News (March 2004 Vol. 1), Mapolisa and Stevens show how the setting up of policies are often the simplest and most immediate responses of private sector organisations to HIV and AIDS within a workplace. In their study of 302 workplaces, 52.5% reported work-place policies on HIV and AIDS in their organisations, but a mere 28.4% reported the union's involvement in the "policy development process" and an even scarcer 8% reported staff dissemination of the policy. While this study implies a disjunction between policy and practice, it deals with implementation only at the Union level without extending the scope of the study to the individual organisations. The same disjunction is evidenced in a more direct fashion in the ILO/AIDS progress report, where the issue of 'care and support' is viewed as a contradiction of "principles vs. contractual status":

> For all agencies, national staff[24] (65-85% of local staff) has the same access to health insurance as international staff. 17 % of the UN country offices reported

[23] HIV Pre-Employment Testing: The Global Business Coalition on HIV/AIDS http://info.worldbank.org/etools/docs/library/49153/Pre-employment%20Test%20final.doc Accessed 25 October 2008.

[24] UN staffers are either national (citizens on the country in which they serve) staff or international (foreign national passport holders). The terms and nature of the contracts differ.

> total medical insurance coverage for their staff. For the majority of UN country offices, medical insurance coverage varies and depends on type and length of contract. Short-term or temporary staff with a contract of less than three or, in some cases, six months may have more limited health insurance entitlements, with dependants not automatically covered, although there may be the option for the staff member to cover them voluntarily (ILO/UNAIDS 2004: 4).

The above extract underlines the fact that, despite the rights based policy of access to care and support; some UN personnel do not (as a result of the nature and longevity of their contract) have cover for medical contingencies.

At this juncture it would be pertinent to turn the lens briefly to the private sector and review some of studies conducted in that sector. This would also provide the opportunity to understand some of the private sector responses and perspectives to HIV and AIDS policy-implementation. Both the Mapolisa and Stevens study (based in the private sector) and the ILO/AIDS report (based in the non-profit development environment of the United Nations) demonstrate some similarities, such as gaps between policy and practice in both commercial and development organisations; and a step-by-step weakening of momentum, as organisations move from policy to practice. However, as the demand for commitment and resources increases, the similarities are neither sufficiently significant nor compelling enough to permit cross-referencing between the two systems of management with such sharply differing operational bases.

Mark Donovan (as cited in Theodoulou 1996: 68-87), in an article on the Ryan White Act[25] and the social constructions of people living with the virus, establishes the "connection between pervasive stereotypes and public policy-making". He refers to the 1993 Schneider and Ingram study as a

> parsimonious model of policy-making that holds that both the justifications for and the substance of public policies can be broadly predicted by understanding the social construction and political power of the groups being targeted by a given policy (Theodoulou 1996: 69).

[25] Ryan White Comprehensive AIDS Resource Emergency (CARE) Act 1990 in the USA was a landmark act because it was the first comprehensive piece of legislation that mandated the access of treatment to PWHA. It did however exercise yardsticks of deservedness, resulting in children being categorized as "innocent victims" and therefore more deserving of treatment than "injection drug users" or "gay men" (modified from Theodoulou ed. 1996: 75-82).

Relevant for this present study is the link he makes, in a bi-polar map, between social constructions of various "hypothetical" population segments (such as gay people, people living with the HIV and AIDS virus, intravenous drug users etc.) and their relative power to "exert some leverage on the policy process" (Theodoulou 1996: 70). What is important is that he demonstrates that, despite the shift in focus from "risk groups" to "risk behaviors", people living with HIV and AIDS (PLWHA) are categorised, labelled and judged. However, while Donovan's analysis is lucid in its linkage between social construction and public policy, it falls short of actually explaining the dichotomy between policy and implementation. The relation between stereotyping of people living with the virus (with its consequent disempowerment) and policy implementation is an important sub-text of this study. It directs the study to explore the influence of stigmatisation and discrimination as possible reasons for the slow policy implementation. While much has changed in the decade and a half between the Ryan White Act and this present study, stigma and discrimination continues to be a key factor in the epidemic.

A Horizons Report (Hutchinson 2003: 4) finds that the fear of social exclusion and derision often prevents workers from revealing their sero-status and accessing workplace services. Another Horizons Report (Stewart *et al.* 2002: 4), already quoted, adds that, HIV and AIDS program staff have put forward the view that VCT facilities at the workplace are not being accessed by workers because of fears of HIV-related stigma and discrimination. They also state, that those living with the virus prefer to keep a positive HIV status secret until they are so ill that they have no choice but to reveal their status. Stigma and discrimination as a potential retardant to policy implementation is significant, in the context of benchmarks set by the ILO guidelines on care and support, espoused by development organisations. The 'ILO Code of Practices' recommends that,

> "Solidarity, care and support are critical elements that should guide a workplace in responding to HIV/AIDS. Mechanisms should be created to encourage openness, acceptance and support for those workers who disclose their HIV status, and ensure that they are not discriminated against or stigmatized" (ILO 2003: 27).

Since managers' decisions are not made in a vacuum, the interplay and leveraging possibilities of power are analysed in this study. Power necessarily includes both agency and structural components in relation to the individual on whom the control is exercised. An important aspect of this study is the relational aspect of power. As Foucault (1990: 93) points out, in his analysis of the relational nature of power, the omnipresence of power lies not just in its potential of "consolidating everything under its invisible unity" but because it is:

> produced from one moment to the next, at every point, or rather in every relation from one point to another. Power is everywhere; not because it embraces everything, but because it comes from everywhere (Foucault 1990: 93).

Moving from the 'what' of power to the 'how', it is important to explore the power dynamics of human agency at one level, as "a … [potential] to get things done, a facility to secure certain goals", and at another level, "as a means of constraint, 'leverage' over others. The difference between them is perhaps best understood by contrasting the 'power to' side of things with that of the "power over dimension" (Allen 2003: 51). As Allen explains it, one approach offers the possibilities of cooperative gain and collective action through partnership and alignment, while the other seeks to "gain at the expense of another" (*ibid.*). Articulating the positive aspects of power, Wrong describes it as "a force … that … traverses and produces things … induces pleasure, forms of knowledge, produces discourse … [and has the] generalized capacity to bring about outcomes, par excellence" (Wrong 2002: xxiii). Outlining the manipulative aspects of power, Max Weber (as cited in Wrong 2002: 21) propounds the view that, "[i]n general, we understand by 'power' the chance of a man or a number of men to realize their own will in a social action even against the resistance of others who are participating in the action". Similarly, later-day sociologists, such as Lasswell and Kaplan (Wrong 2002: 21), refer to the intimidating and manipulative characteristics of power as "the process of effecting policies of others with the help of (actual or threatened) severe deprivations for nonconformity with policies intended". What all the definitions of power from Weber to Lasswell and Kaplan, to Foucault or even Wrong and Allen fail to capture clearly, is the prevalence of the invisible and concealed characteristics of power, where a subject has

been manipulated and discriminated against without any clear idea of why he or she has been so manipulated. However, both Wrong (1997: 221) and Allen (2003: 51-52) in their definitions of agency, refer to this phenomenon as the difference between the "power to" and the "power over". The ILO/AIDS bar-chart, in Figure 1.1 of this study, demonstrates both uses of power. The power exercised to implement a work plan and budget as vis-à-vis the basic authority over the function. As the bar-chart demonstrates, in some offices of the United Nations, the process of work plan, budget and WWPs have progressed considerably, while in other offices they are slow and/or at a standstill. The recently designed Wellness Programmes at the United Nations are sometimes proactive in nature (with the prevention programmes), but primarily reactive in nature to enable the organisation to manage the complex socio-medical consequences (stigma, discrimination and criteria based access to treatment) of contracting the virus.

In a society evolving and redefining itself in a world living with HIV and AIDS, it is necessary to understand not only power "asymmetries" and their consequences, but also the "degree of imposition and constraint" (Allen 2003: 27) that surfaces in a "multiplex" (Horowitz 1990: 12) management-staff relationship, which constitutes "more than one type of exchange". Four aspects of power-hierarchy outlined by Horowitz (1990: 13) are considered in this study:

> Rank: an individual's position in the prestige hierarchies of a group.
> Dominant: an individual with superior power in a relationship.
> Dependant: an individual with inferior power in a relationship.
> Stratification: the distribution of valued resources in a social group.

Foucault (1990) depicts power as "pervading all social relations" in the form of a micro-political system which exercises itself "from innumerable points … Power is everywhere, not because it embraces everything but because it comes from everywhere". Foucault's (*ibid.)* assertion that power is not centralised occasionally deepens the challenge of locating the source and origin of a particular action, as is discussed later in this study. The dynamics of power, as already inferred, involve those wielding the power and those subjected to it. In the context of the workplace, this signifies management, on the one hand, and general staff members, on the other.

It is difficult to centre a study on the interaction of managers and staff without referring to the Marxian dialectics of management-staff relationships. However, it is important to keep in mind the caveat that, "a basically societal level theory, Marxism, is being made to do work for which it was not devised, that is the explanation of organizations" (Donaldson 1988: 124). What compounds the relevance of Marx's theories, in the context of this study, is the economic aspect related to the domination of sources of production and profit, a phenomenon absent in the non-profit environment of an international development organisation, such as the United Nations. Although managing the budget is integral to staff management, the focus in this study is on workplace policy implementation, within the confines of an international development organisation and with regard to the HIV and AIDS pandemic.

2.11 Policies that guide the management of AIDS in the United Nations system

Policies are the means to administer situations with equity and consistency. They provide guidelines for the management of situations. For that reason, it is essential to explore some of the policies that govern the management of HIV and AIDS in the United Nations. However, before doing so, it is pertinent to observe that policies are in themselves inadequate tools without the staff and management who breathe life into them and convert the mandates and promises, embodied in the policies, into reality. The pivotal role of staff and management in the implementation of policy makes it important to understand their actions, inactions and decisions as drivers in the process and key stakeholders in the outcome.

The United Nations Policy on HIV and AIDS is enshrined in a document called, *An ILO code of practice on HIV/AIDS and the world of work* (ILO: 2001). Launched in June 2001 by the Director General of ILO, Juan Somavia, it has since formed the bases of numerous policies both in the private sector and the development sector. Somavia maintains that the document seeks to address current problems and to anticipate

consequences that arise from the epidemic and its impact in the workplace (ILO 2001: iii). This document thus forms the basis of the United Nations Policy on HIV/AIDS in the workplace (United Nations ST/SGB/2003/18).

Four key principles articulated by ILO to protect the rights and productivity of staff living with the virus are listed below. These principles provide a criterion for the analysis of the domestication of AIDS workplace policies in international development organisations and shed light on the actions and opinions of staff and managers in implementing the policy and their interpretation of it. The principles selected and cited in accordance with numbering in the ILO code, focus primarily on key issues of concern that surfaced in the interviews undertaken for the thesis:

> **4.2. Non-discrimination**
> In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention.
>
> **4.6. Screening for purposes of exclusion from employment or work processes**
> HIV/AIDS screening should not be required of job applicants or persons in employment.
>
> **4.7. Confidentiality**
> There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with the ILO's code of practice on the protection of workers' personal data, 1997.
>
> **4.8. Continuation of employment relationship**
> HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illnesses should be able to work for as long as medically fit in available, appropriate work (ILO 2001: 3-4).

The important point that the ILO guidelines make is that HIV, like many other serious and chronic medical conditions, should be mainstreamed, without the marginalisation and discrimination that the policy anticipates and the interviewees in this study articulate. The above mentioned principles outlined by the International Labour Organisation (ILO) find

echo in the United Nations HIV Policy launched by the Secretary General in 2003, in which he says that,

> "The United Nations is committed to providing a supportive workplace for its employees, regardless of their HIV status. To achieve this, we must have an environment that promotes compassion and understanding and rejects discrimination and fear" (United Nations ST/SGB/2003/18 2003:1-5).

In order for us to attain the target of a compassionate workplace free of discrimination, the Secretary General reinforced the Organisation's commitment to the United Nations Personnel Policy on HIV/AIDS (see annex). This policy has since guided (and, according to the Secretary General, will continue to guide) the United Nations' efforts in the development and implementation of programmes concerning HIV and AIDS in the workplace:

> (a) United Nations staff and their families will have access to information about treatment and support, including how and where to obtain voluntary confidential counselling and testing, and antiretroviral drugs. The costs of these services and drugs will continue to be met to the maximum amount provided for by the medical insurance schemes in which staff are enrolled;
>
> (b) Staff members will not be required to undergo HIV testing as a condition for obtaining health insurance coverage;
>
> C. **Terms of appointment and service**: Pre-recruitment and employment prospects
> 7. Under this heading, the following provisions apply:
> • The only medical criterion for recruitment is fitness to work.
> • HIV infection does not, in itself, constitute a lack of fitness to work.
> • There will be no HIV screening of candidates for recruitment.
> • AIDS will be treated in the same manner as any other medical condition in considering medical classification.
> • HIV testing with the specific and informed consent of the candidate may be requested if AIDS is clinically suspected.
> • Nothing in the pre-employment examination should be considered as obliging any candidate to declare his or her HIV status.
> • For any assignment in a country that requires HIV testing for residence, the requirement must appear in the vacancy notice.
>
> **Continuity of employment**
> 8. Under this heading, the following provisions apply:
> • HIV infection or AIDS should not be considered as a basis for termination of employment.

• If fitness to work is impaired by HIV-related illness, reasonable alternative working arrangements should be made.
• United Nations staff members with AIDS should enjoy the same health and social protection as that afforded to United Nations employees suffering from other serious illnesses.
• HIV/AIDS screening, whether direct (HIV testing), indirect (assessment of risk behaviours) and/or questioning about tests undertaken should not be required.
• Confidentiality regarding all medical information, including HIV/AIDS status, must be maintained.
• There should be no obligation on the part of the employee to inform the employer regarding his or her HIV/AIDS status.
• Persons in the workplace affected by, or perceived to be affected by HIV/ AIDS, must be protected from stigmatization and discrimination by co-workers, unions, employers or clients.
• HIV-infected employees, and those with AIDS, should not be discriminated against, including with regard to their access to and receipt of benefits from statutory social security programmes and occupationally-related schemes.
• The administrative, personnel and financial implications of these principles under terms of appointment and service should be monitored and periodically reviewed.

D. **Health-insurance benefits and programmes**
9. Health insurance coverage should be available for all United Nations employees regardless of HIV status. There should be no pre- or post-employment testing for HIV infection.
10. Health insurance premiums for United Nations employees should not be affected by HIV status. No testing for HIV infection should be permitted with respect to any health insurance scheme (United Nations ST/SGB/2003/18 2003:1-5).

The United Nations HIV policy has translated the principles of the ILO Code of Practice directly into actionable clauses related to employment and medical coverage, providing what one would imagine, constitutes clear guidelines, not just of action, but also of perspective.

The Bill of Rights forms the guiding principles on which the courts of South Africa make their decisions. The workplace HIV and AIDS policies, too, take their inspiration from a number of these rights. To give a few examples, the WHO/ILO guidelines on HIV/AIDS in the workplace echo the Bill of Rights in all its clauses. The following matrix (Table 2.4), establishes the linkages between globally accepted workplace guidelines and the

South African Bill of Rights, with a commentary on the implication of some of these guidelines on the HIV policy of organisations managing a work force.

Table 2.4: Linkages between the WHO/ILO guidelines and the South African Bill of Rights and the potential consequences

WHO/ILO guidelines on HIV/AIDS in the workplace[26]	The South African Bill of Rights[27]	Observations
Informing the employer: There is no obligation on the part of the employee to inform the employer about his or her status.	Section 14: Everyone has the right to privacy.	
Access to services: Employees and their families should have access to information and other educational programmes.	Section 32: Access to information: Everyone has a right to access any information that helps the person to protect his or her rights.	
Benefits: HIV-infected people should not be discriminated against and should have access to all the standard Social Security benefits and occupationally related benefits.	Section 27: Everyone has the right to access health care services, social security and other suitable social assistance.	The mandates of Sections 27 and 32 attempt to address the issues of discrimination against staff members, either living with or perceived to be living with the virus, by articulating the rights of people and the responsibilities of duty bearers.
Continuation of employment: A person living with the virus should be permitted to work as long as the person is fit to do so.	Section 22: Every citizen has the right to choose their trade, occupation or profession freely	

Section 27 of the South African Constitution (The Constitution of the Republic of South Africa: Act 108 of 1996) stipulates that the State must take:

[26] The contents of this column have been taken from, *International Nursing Review*. 41, 1, 1994: 10. The WHO/ILO guidelines are often espoused by international development organizations such as UNDP, UNICEF as policy guides for HIV and AIDS.
[27] The contents of this column have been taken from a manual entitled, 'HIV/AIDS and the law. A Resource Manual'. 2nd edition (2001: 83).

> **reasonable** legislative and other measures within its **available resources**, to achieve the **progressive realisation** of each of these rights (The Constitution of the Republic of South Africa: Act 108 of 1996, Section 27. Also cited in the Resource Manual 2001: 76).

This stance both commits and empowers decision-makers to decide upon a time frame of the roll out of measures and the allocation of resources, based on their best judgment. While this section of the South African Constitution might appear to give managers both options and opportunities to shift the burden of care away from the system, the sheer visibility of the epidemic and pressures on governments to deliver empowering AIDS legislation keeps the lens firmly trained on managers and policy makers. The TAC for the roll-out of ARVs and the subsequent government policy implementation is a case in point. If one were to have keyed-in the term, "TAC anti retroviral campaign results" on Google (as at 11.20AM on 14 August 2007) it would have yielded 50,100 results in 0.2 seconds.

It is also important to note that the South Africa Constitution, ILO Code of Practice and the United Nations AIDS Policy (referred to above) are in perfect synergy with one another, as demonstrated in the articles outlined earlier in this section. This context will, later in the thesis, provide the necessary focus to assess the actions of managers and staff on the subject of HIV/AIDS Policy implementation in the workplace.

James Slack (2002: 354-370) in a study entitled *Zones of indifference and the American workplace: The case of persons with HIV/AIDS* deals with the rights of people living with the virus and what "can happen with the work setting to thwart or facilitate the intent of this piece of legislation". The study refers to the concept of "area of acceptance" or "zone of indifference". The zone, as Slack defines it, covers issues that are "relatively non-controversial and, hence, provide little room for intense debate and disagreement" (Slack 2002: 354-370). It is his view that the wider this band is the more comfortable the employees. He also propounds that the "emotional baggage … of shock, fear, and depression" (Slack 2002: 366) that goes with the detection of one's status during the asymptomatic stage results in the narrowing of the zone of indifference, for those living with the virus. The emotional baggage reduces the perceived safe zones, thereby

narrowing the band. This thesis attempts to determine what effect the level of implementation of the HIV/AIDS policy within the United Nations system has on the well-being and perspectives of staff vis-à-vis the policy.

2.12 Conclusion

Chapter two captures central issues, theories and arguments related to the implementation of HIV and AIDS policies in international development organisations, as articulated in the public domain and in contemporary academic literature. The chapter examines sociological and historical descriptions of organisations and their functioning, and integrates key concepts and typologies. Whilst the broad approach to the presentation of organisational analysis is eclectic, particular attention is paid to Weber's classical works on the dynamics and coherence of bureaucratic systems.. Contemporary understandings of organisations as "goal-directed, boundary maintaining, and socially constructed systems of human activity" are explored and adapted to the international development environment. The chapter takes the position that international development organisations are and have been significant players in the last 40 to 60 years and proceeds to investigate the learnings and legitimacies of the United Nations and Bretton Woods institutions. From the macro setting of institutions and their structures and mandates, the chapter moves towards managerial responses within the organised social spaces of Human Rights based workplaces. Thus, the chapter explores the instrumentality, adaptability and moral conscience of managers in international development organisations, who are charged to implement HIV and AIDS policies in the workplace.

The central purpose of this chapter is to offer a detailed literature survey on how large organisations active in international politics can be analysed, understood and criticised. The numerous assumptions reviewed reveal a particular 'gap' that the study has been positioned to address empirically, viz. the question of how bureaucratic structure and the logic of "calculable rules" co-exists, or engages with, the evolving interpretations and applications of decision-makers in these challenging times. Later chapters search for answers on the issue of the moral conscience and agency of managers. They attempt to

offer insights into the role of managers in implementing or inhibiting HIV workplace policy and the reasons behind such actions.

Chapter 3 - Research methodology and research questions

3.1 Introduction

The practice of qualitative research has, as Denzin and Lincoln (2003: 1) described it, "a long, distinguished, and sometimes anguished history in the human disciplines". The anguish they ascribe, in part, to the colonial antecedence of the early qualitative researchers who were "colonists long before they were anthropologists" (Denzin & Lincoln 2003: 2). They refer to, what can only be summarised as the white male gaze of the anthropologist working in an alien setting, well meaning, misguided and somewhat distant from the culture it surveys. In today's post-colonial era, some of these extreme and exploitative differences are greatly reduced. However, the importance of empathy with integration into the lives of the people and subject being researched are still issues of significance. While "there is no way to stuff a real-live person between the two covers of a text" (Denzin as cited in Schmitt, 1993: 130 and Silverman 2004:129), it is important for the researcher to create an intimacy and empathy with the participants[28] in order to capture the essence of the phenomenon being investigated.

I make the above point to contextualise my own gaze in the study. I have, variously, worked with the United Nations system since the early 1990s, directly within it since 2001 and very specifically in the milieu being researched since January of 2003. I personally know the participants as colleagues and some as friends. I share an element of trust with the participants of the study and believe that my gaze is that of an insider to both the organisation and the subject of the study. It is however unrealistic to assume a complete absence of power dynamics or negation of prior knowledge and familiarity with the organisational environment and history. Though my responsibilities in the organisation are more professional than administrative, my position as a senior member

[28] I use the words 'interviewee' and 'participant' interchangeably in this study to refer to the participants of the qualitative research whom I interviewed and observed as my primary source of data.

of the team may have influenced the participants' approach to the interview. It is possible that they may have been either more reticent to answer some questions or more vocal in venting their anxieties. Some of the interviewees were also at my level in the organisation and a few senior. Having quoted sections of interviews at length, in following chapters, I have left the reader to judge any power dynamics implicit in my relationship with the participants.

As a result of being an insider, to the social setting and subject matter, it is expected that this study will be richer for the inclusion of subjective and interpretive insights. Drawing on my intimate knowledge of the milieu, I chose the subject of the research, invited the participants (many of whom I knew personally prior to the interview), raised questions, analysed the findings and crafted the thesis. Strauss and Corbin (1998: 43) point out that researchers these days understand the impossibility and, if I may add, limitation of a disconnected objectivity. I am, however, cognisant of the desirability to balance a nuanced connectedness and sensitivity towards the subject matter and participants in the study with a critical distance. The important interposition is to prevent the encroachment of extreme subjectivity into the matter. With this caveat in place, I underline the importance of my own gaze both as a close colleague of many of the participants and an insider to the mindset of a person who has intimately encountered the vicissitudes of living with a life threatening illness. Apart from the relevance of my personal testimony vis-à-vis the study, it is important for me to carefully locate and contextualise my experience in a manner that I hope will have wider implications in the overall response to HIV and AIDS, specifically in the workplace.

3.2 Methodological approach

This study is exploratory in nature and designed to understand what I conjecture to be the dichotomy between policy and implementation of HIV and AIDS policies. I have attempted to capture 22 individual stories, perspectives and emotional considerations. In general the findings have been structured to do justice to the rich material captured. As

such, the testimonies are quoted in detail to give the reader a sense of, not just the issues in question, but also the emotional landscape in which they play themselves out. The study captures both the experiences of living with the virus and managing the virus in the United Nations workplace from the lenses of both staff and managers. I have been mindful of Puttergill's (2008: 159) caution that research should not merely be a "passive description, mirroring experiences", leaving the voices of the participant to stand alone without interpretations and annotations. I have attempted to highlight and provide commentary on the quotes in the data analysis, draw conclusions in the summary and provide recommendations for the way forward.

The primary method of research in this thesis has been Participant Interviews (PI). However, the study also has an element of Participant Observation (PO) since the researcher seeks to make sense of the personal testimony of participants and the manner in which these testimonies interact with one another through active participation and continued observation. In this sense, the trajectory of the research goes beyond the classical case study that might assume a single-minded focus on distance and objectivity. It does so by bringing the researcher into the framework of the analysis, since the content and context of the study is "profoundly linked to the individual history of the [participant observer]" (Silverman 2004: 17). As Silverman proceeds to point out, the narrative approach ensures that the researcher is "not unfairly remove[d]" from the text when his or her experience is relevant to the study. It is with this in mind that I have made it a point to ensure that the voice of the participant is duly represented in the findings of the study, despite the length of some of the quotes.

Crucial in framing the context, PO as a concept comes with many definitions that coalesce to give it meaning. John van Maanen (1996 cited in Genzuk 1999) described it as a method where a "single investigator" lives with the subject, as a participant of the study, for a year or more and where the investigator stimulates the findings partly as participant and partly as observer. My presence in the organisation and research fulfils both criteria.

Marvin Harris and Orna Johnson (cited in Genzuk 1999) describe the concept of Participant Observation as "a portrait of a people", while David Fetterman (1998 as cited in Genzuk 1999) describes it as "the art and science of describing a group or culture". The emerging point is that PO is a legitimate social research instrument of investigation that provides an intimate and involved experience for the investigator.

The PO based approach supplements the primary data gathering method of interviews by offering this study the spontaneity of realism. I was able to listen, observe and review behaviour and opinions as they unfolded. As an insider to the organisation it was natural for me to discuss issues related to AIDS and the workplace providing this study with the advantages of a more natural and instinctive exchange with participants. PO, as an approach, also affords the advantages of a syllogistic and discovery-driven approach that is not bound by the rigours of proving assumptions and hypotheses. Such an approach would come with its blinkers of vested interest.

The participant observer, however, is not without his or her dilemma. In a seminal work titled, *The Vulnerable Observer: Anthropology that breaks your heart*, Ruth Behar (1996: 2) ponders the quintessential quandary of the participant observer when she deliberates the complexity of drawing a line between the empathetic participant and the dispassionate observer. Behar (*ibid.*) is trapped in the trauma of indecision when,

> … as a storyteller opens her heart to a story listener, re-counting hurts that cut deep and raw into the gullies of the self, do you, the observer, stay behind the lens of the camera, switch on the tape recorder, keep pen in hand? Are there limits – of respect, piety, pathos – that should not be crossed, even to leave a record? But if you can't stop the horror, shouldn't you at least document it?

Behar's final question in the above quotation firmed my resolve that this study should in the long run be both, the stories of the people in the UN work space, as they negotiate the complexity of living with and in the context of the epidemic, and the stimulus for a more proactive and uniform implementation of the HIV and AIDS policy in the workplace. It is to retain the purity of the voices of the participants that I have quoted many of them extensively in the findings; the purpose is to table their stories in their words and not the

researcher's paraphrasing thereof. I have done so to enhance the authenticity of my presentation and the reader's empathy for the participants and HIV-related issues they deal with in the workplace.

The findings in this study come together as a montage constituted of different perspectives and testimonials on the staff's experiences with the organisation's HIV and AIDS policy and its implementation. As Denzin and Lincoln describe it, in a

> montage, several different images are superimposed onto one another to create a picture. In a sense, montage is like pentimento, in which something that has been painted out of a picture (an image the painter "repented," or denied) becomes visible again, creating something new. What is new is what had been obscured by a previous image (Denzin & Lincoln 2003: 6).

As evidenced in the next chapter, the study is a montage which uses the testimonials of participants to "create a clearly defined sense of urgency and complexity" (Denzin & Lincoln 2003: 7). Interpretations of these varied images emerging from the testimonials, as also the insights and reflections generated from being a participant observer facilitate the development of the larger tale of the montage.

3.3 Data collection format

The primary sources of data were 22 personal in-depth Participant Interviews. In going about the interviews, this researcher used a variety of commonly used enquiry-techniques outlined by Murray Thomas (2003: 63-66): "loose-question[s], tight-question[s], converging-question[s], and response guided" questions.

The data collection approach has been primarily response-driven resulting in interviews of both differing length and questions. However, the questions used have been both open-ended and closed in nature, coming together in what Holstein and Gubrium have referred to as *active interview*. The active interview technique has been used as a tool during data collection, because in this kind of interview the interviewee is an active producer of meaning, thereby enriching my own analysis of the interviews. In more traditional

models of interviewing, the interviewee is perceived as the source of information, material and emotions.

In the active interview method, the interviewee participates in “a concerted project for producing meaning” (Holstein & Gubrium 1997: 121 as cited in Gray 2003: 95). Interpretation has not been dictated. The aim was to provide an environment conducive to the production of the range and complexity of meanings that address relevant issues” (Gray 2003: 95) in this study. The varied lengths of interview and the differing trajectories of each conversation is an indicator that the meaning construction process did not adopt the conventional process of the interviewer asking x number of questions and recording the related responses in an entirely pre-determined fashion. As an employee of the organisation and insider to the United Nations system, I set out for the interviews with the perception that it was unlikely I would be able to operate as wall-paper, an unnoticed presence for the participant. This made the dialogue “unavoidably interactional and constructive – in a word … **active**” (Holstein & Gubrium cited in Silverman 2004: 143). I was careful, though, not to lead people into offering me what they might have thought I wanted to hear. By constantly prodding, I gave interviewees sufficient opportunity to reflect, talk and reaffirm their views and arguments. This was a conscious strategy intended to counteract the subjective influence of my ‘insiderness’ and the interviewees knowledge of me and my beliefs.

I chose to go with personal in-depth interviews rather than the other valid qualitative technique, focus group discussions, for basic reasons. I used a researcher’s discretion to opt out of focus group interviews, because I would have been able to cover a lot less ground in terms of depth and diversity of issues had I opted for focus group interviews. Whilst a large group of people might have resulted in multiple and diverse opinions on each issue, the opportunity to explore a particular opinion in some depth would have been weakened. In addition focus group interviews would have yielded more considered rather than spontaneous responses from participants, owing to exposure to alternate views and so leading to a tendency to contextualise and modify responses. As some of the interviewees were known to be living with the virus, I was able to provide confidentiality

and even the freedom to discuss cases that might involve colleagues. Focus group discussions, even with skilled moderators facilitating the dialogue, risk compromising confidentiality and sacrificing personal-control over the interview.

3.4 Interview sample

The sample selected permitted an overview of discourses on the topic, as the participants came from one umbrella organisation, the United Nations. The participants in the study were thus stakeholders in a coherent universe.

The selection of participants was based on pre-selected criteria:

Geographical proximity: All participants were available in the geographically contiguous cities of Johannesburg and Pretoria in the Gauteng province of South Africa. They were all, directly or indirectly, working with the United Nations system selected for the study. (One participant living with the virus lost her job with the organisation. I tracked her down at a satellite township of Pretoria, and obtained both her consent and her testimony).

Accessibility: The availability for interviews on HIV and AIDS related research required more than mere geographical accessibility. Suitable participants had to be located and their consent obtained. All participants volunteered for the interview. They were informed that it was for a thesis on the implementation of HIV and AIDS policy in the United Nations workplace and that their past or present engagement with the United Nations workplace and the HIV and AIDS policy made them ideally suited candidates for the study. They were assured that confidentiality would be maintained and that their names would not be disclosed in the study. They all agreed to participate in face-to-face depth interviews.

Sample size: At the time, the office in which the study is located had approximately 80 personnel (with various contracts ranging from regular to temporary) employed in workplace, 22 of whom agreed to participate. This constituted 27.5% of the work force making it a robust sample.

The sampling of 22 participants was representative[29] and non-random. It represented men (ten participants) and women (twelve participants) in roughly equal proportions, management (including senior management), professional (advisory positions without administrative responsibilities) and non-management. The representation included both permanently contracted staff and temporary staff members and constituted the consensual representation of staff openly living with the virus. The remaining staff members among the interviewees were either unaware of their status or sero-negative. I sought and obtained permission to undertake the study from the required level of authority in the organisation.

The findings, in keeping with the trend in qualitative studies, are not intended to be generalisable, though, as Thomas (2003: 88) argues, researchers are sometimes not content with restricting their interpretations to the finite pool of their study and feel the urge to extrapolate the findings to a larger universe. For example, one may carry out a research study among matriculates at Crawford College in Pretoria, but attempt to apply the conclusions to the larger universe of all students graduating from the matriculate batch of all schools in the province of Gauteng. While some international development organisations may have similar experiences, the findings of this study may not be uniform across all institutions. From a personal standpoint, I both feel the urge to extrapolate the findings of the study and understand the severe limitations of doing so. My hope therefore is that the findings become relevant to contexts beyond the case study, and that they stimulate a larger and more representative study.

[29] I use the term representative, not in a statistical sense, but to mean that I sought to ensure diversity (gender, functional, contractual) with the overall objective of obtaining a width and depth of thought and opinion on the subject matter.

3.5 Data collection method and fieldwork practice

According to Marshall and Rossman (cited in Babbie 2001: 278), in a field research the researcher can approach the participants in various ways. The interviewer could be a "full participant" immersed in the environment going about the same activities as the participants on a daily basis. Davis (cited in Babbie 2001: 279) refers to this approach as "the Convert" or a researcher "going native". In my case, I was a native to the milieu even prior to the study and continued to be so throughout the tenure of the study. At the other end of the spectrum the interviewer could be a "complete observer" delinking from any involvement in the activities of the subject. Davis (*ibid.*) referred to this as "the Martian", implying complete alienation to the environment. Since Marshall and Rossman (1995) view the approaches on a continuum, according to them, the interviewer could feature anywhere on the scale of the continuum, adopting a mix of approaches.

As the participants were known to me and knew of me, I approached them as a colleague and complete insider to their activities. Though I clarified to all participants that the interviews were not official but directed towards an academic outcome, it is important to reflexively acknowledge, once again, that I may not have been able to fully distance myself from my official position as a senior professional in the organisation. This is a crucial submission since it is possible that some participants may have intentionally used the interviews to voice general frustrations with UN personnel policies and their implementation to someone they may perceive as having access to senior management. In Davis's terminology, I approached them as a "native", which naturally came with its own equations of power. It was relatively easy for me to access participants for the study and they were comfortable discussing the issues of HIV in the workplace with a colleague. Given the complex nature of the subject matter, I ensured first that I had obtained their consent for the interview. The consent is recorded on tape at the beginning of all the interviews and transcribed in the MS Word format. I secondly, ensured that I had secured their availability for the interviews and scheduled them for an interview at a mutually convenient time. Further, I made sure that I had provided them with a brief of the

objective and outline of the initiative, so that they could feel comfortable with the process.

3.6 Interview approach

According to Steiner Kvale (cited in Babbie 2001: 292) the interviewer is faced with the option of approaching the participant either as a "miner" or as a "traveler". As a "miner" the researcher approaches the interview with the assumption that the participant has specific information and it is the assumed task of the interviewer to drill deep in order access the information. As a 'traveler', by contrast, the researcher sets out with a clean slate. Interviewers are not pre-determined but encountered in passing and the conversations are entirely open-ended with the participants telling their own story. I set out for each interview with a clear agenda and yet I maintained flexibility in my exploration. This guided, yet exploratory, dialogue enabled me to ensure that I did not miss out on an unanticipated and relevant line of thought. I attempted to mix open-ended questions with focused inquiries and follow-up questions. I attempted to guide the conversation to stay within the ambit of the subject matter, using a loosely structured interview guide which covered my broad information and data needs. The interview guide, available in the annexure to the thesis, was clustered into categories and sub-categories to facilitate a non-linear line of inquiry. The categories were also flexible and designed to accommodate emerging lines of thought as I carried out the interviews using a generative approach to the inquiry.

Interviews may simulate a "normal conversation" (Babbie 2001: 292-293). Comforting as that is for both the interviewer and the interviewee, it is important for the interviewer to remain alert to the possibility of the conversation meandering into irrelevant and counterproductive terrains. It is expedient in such situations to retain the comfort and casual flow of conversation while redirecting it to specific areas of inquiry in the event of the conversation straying. Like the "aikido master" (Babbie 2001: 292), the interviewer

should be careful not to counter the participant but merely pick up on an aspect of the conversation and use it to redirect the conversation back on track.

John and Lyn Lofland (cited in Babbie 2001: 293) have a solution to this. They suggest the interviewer assume the persona of the "socially acceptable incompetent", a well-meaning and interested person who is unaware of the situation as it stands and needs it to be explained. It was, however, neither feasible nor realistic for me to assume the persona of the "socially acceptable incompetent", in the light of the fact that I was known to be a staff member of the organisation and, in many cases, a direct colleague of the participants. I engaged them in a guided conversation, interfacing with them on a largely listening and enquiring role.

I approached the interviews with a few broad areas of inquiry and allowed space for active listening. The interview lengths were not pre-determined thereby permitting a dialogic approach. Each interview took between one and a half to three hours. Since I was acquainted with the participants, I was viewed as an insider and common stakeholder of the policies in question. This enabled me to maintain a non-judgemental space for the interview.

3.7 Interview setting

The interviews were conducted in the privacy of an office and recorded using a dictaphone (with the permission of the interviewee). The office had a glass panel which permitted visual sighting from the outside corridor but the door was kept shut, to prevent the conversation from being heard from the outside. A person approaching the room would have been seen before he or she reached the door. Four participants opted to be interviewed away from the office. They were interviewed in a residential lounge, with a glass door which was kept shut. None of the doors, either in the office or the lounge, were ever locked at the time of the interview. The participants were advised that they could

conclude the interview at any stage they chose to, without the need to give the researcher a reason for doing so.

We sat together at a round table, on two separate and identical chairs. The purpose was to avoid the potentially negative consequences of power seating that comes from rectangular seating arrangements or higher and more comfortable seating for the interviewer. The air-conditioning was calibrated for comfort and tea was offered. One participant had to be ferried to the interview venue from the office and dropped back and another participant was reimbursed for transport to and from the interview location.

As the recordings and transcripts will validate, I was careful not to register any judgemental reactions to the participant responses. I attempted to use my familiarity with the participants and knowledge of the culture of the workspace to enable spontaneity in dialogue. Comfort with the interviewer and the environment to candid dialogue and open testimonies.

While the interview guide was pre-planned, it was used largely as a guideline for discussion and expression, rather than a rigid sequence of questions.

As already noted, the interviews were recorded on a digital Dictaphone. This was then handed over to an independent and professional transcription organisation which transcribed the interviews and provided the outputs on A4 size sheets in double-spacing format.

3.8 Key research questions

The key research questions the study explores can be distilled down to two basic areas of inquiry:

1. How do personnel in a local office of a large Human Rights based bureaucracy perceive and experience the implementation of HIV and AIDS policy in the workplace?

The findings attempt to distinguish between the perceptions of management and staff in relation to the organisation's HIV and AIDS policies. It investigates management perceptions of performance and prioritisation vis-à-vis macro-performance outcomes and staff health, wellbeing and sustainability.

The findings also interrogate the perceptions of staff vis-à-vis the implementation of HIV and AIDS policy in the workplace and their feelings of being stigmatised and discriminated.

2. How does the Human Rights based bureaucracy, as exemplified by this South Africa case study, implement the HIV and AIDS policy in its workplace?

The study attempts to understand how the bureaucracy in question, operates in practice. It investigates the extent to which ideal-typical depictions of efficiency and commitment to the rulebook are subscribed to and implemented across the board.

3.9 Data construction and analysis

According to Thomas (2003: 81), the analysis of any research project comprises two stages: "the descriptive and the interpretive". This study integrates both stages. In an effort to keep the richness of the participant's views intact, I have quoted relevant sections of their testimonials extensively in the descriptive section of the analysis. In the interpretive sections, I have attempted to explore the stories of the participants and look deeper into the intentions and drivers of the participants' views and actions.

There was a temptation, in the study, to determine "causation" and to understand why things happen the way they do and what the implications are. I have however refrained from looking into the crystal ball and attempting any predictive analysis. I neither had the material to do justice to that nor was it germane to my study. I have focused my efforts

on facilitating a deeper understanding of the situation as it stands and enabling managers and staff of organisations, who read the study or sections of it, to turn the lens towards themselves. The larger objective is to enable managers and staff to review their views and actions and if pertinent evaluate what, if anything, they would do differently.

To facilitate easy access, relevant sections of the interviews focussed on key-concept clusters based on the areas of inquiry. Driven by my experience in working on AIDS and having been employed with the organisation since 2001, I used my knowledge and experience of the subject to pre-determine some areas of inquiry. These concepts were structured into the broad interview schedule and used to stimulate discussions. Other concepts inserted themselves into the conversations through the feedback of participants. The broad clusters of concepts are highlighted in the appendix of this study.

For the expediency of analysis, I shall not be using the cluster of key-concepts (outlined in detail in the appendix) to structure the presentation of findings. The cluster-of-concepts enabled me to structure my thoughts ahead of the interviews, but were not designed to facilitate reporting. However, the concepts have been used in the analysis. The findings, tabled in the following chapter, will be structured around themes discussed in the literature review and emerging in the interviews. They will also attempt to capture, in a rich tapestry of stories, the elements introduced in the cluster of key-concepts.

3.10 Ethical considerations

Bringing Paul Cozby's (1985: 207) opinion into my position on ethical issues, I would propound that advancement in the field of science has resulted in outputs both positive and negative. Nuclear science, for example, has beneficial outputs in medical sciences and destructive outputs in the area of military armaments. In the same way, laser science has guided surgeons to precision life-saving surgery, but also facilitated the development of bombs that are often used for the destruction of infrastructure and human lives. Similarly, research injudiciously carried out in the field of social sciences could trigger

problems of a socio-psychological nature. For example, the breach of confidentiality of people living with the virus could precipitate the traumas of stigma and discrimination. It is therefore vitally important to anticipate and cater for the maintenance of strict ethical standards, in order to protect the participants of researches in the social sciences. This caution is crucial, since the striving for meaning could risk infringement of the participants' Human Rights.

Ethical issues in an HIV and AIDS linked study are a given, particularly one which contains conversations with people living with the virus. Like in any other area of inquiry but more so, considerations of Human Rights and well-being automatically emerge. Many ethical considerations naturally appear in different areas of both this chapter and the chapter on the findings. I have, however, attempted to collate a few of the ethical considerations of this study and bring them together under this sub-section.

Informed consent: I ensured that the participant was given an accurate brief of the intentions and objective of the study. This was provided both at the time of soliciting the brief and further recorded on dictaphone at the outset of all interviews (as noted earlier). They appear in the transcript at the beginning of every interview. All interviews were based on a "clear and fair agreement with the research participant" (Cozby 1985: 198). Participation was voluntary and participants had the flexibility to decline the interview or change their mind at any stage and were reassured that their true names would not be used in the study to protect privacy.

Stress Mitigation: All interviewees were, as already stated, informed at the outset that they had the "freedom to decline to participate in or to withdraw from the research at any time" (Cozby 1985: 198). The setting, as noted, was arranged for comfortable interaction through the use of relaxed and equitable seating arrangements. As a colleague who was (to varied degrees of closeness) acquainted with the participants, I was able to keep an instinctive track on the comfort and stress meter with the objective of detecting and eliminating any "undesirable consequences for the participant" (Cozby 1985: 199).

Protection of Confidentiality: The study paid due respect to the Right of Privacy for all, coded under Section 14 of the Bill of Rights. The Right provides for a person living with the virus to, "… keep that information to yourself" (Barrett-Grant *et al.* 2001:83). To protect the confidentiality rights of participants their names have been changed and specific biographical details avoided. To my knowledge the identities of the participants were available only to the primary supervisor and me.

The premise of confidentiality is a paramount feature of the study. The study will be available in the University library and accessible to the staff and students of the University of Pretoria. Prudence exercised in the wider dissemination of the study will add an additional filter to enable confidentiality and prevent misuse of the material.

For reasons of confidentiality the names and contact details of the interviewees will not be placed in the public domain and will be retained with the researcher and supervisor. The use of pseudonyms to identify participants anticipates and rectifies the problem of resorting to the dehumanising option of giving them alphabetic references. Pseudonyms enable us to relate to the participants as people. The functional and psychographic profiles of each participant have been outlined and placed in an annexure of the thesis.

The *nom de guerre* for each participant has been selected randomly and follows no similarity to the original name, except the gender. Though all participants did not belong to one homogeneous religious or race group, the researcher has been careful not to register the participant's racial and religious origin. As such, one religion (in this case Christianity) was chosen and pseudonyms generated based on the chosen religion[30]. This approach is vital to strengthening the issue of confidentiality, outlined earlier in this chapter.

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[30] I chose Christian pseudonyms because Christianity is the most practiced religion in the province and country in which the study is located. I do so to protect the identity of participants by giving them a generic set of names.

3.11 Conclusion

This chapter establishes the importance of a qualitative, subjective study. It outlines the use of active interview techniques strengthened by reflection and the use of a montage of narratives of staff members both living with the virus and in the context of it, in the workplace of an international development organisation. With respect to the sensitive nature of the study, the chapter registers the efforts of the researcher in establishing confidentiality of content, procedural ethics and participant comfort in the interviewing process. Vitally, this chapter sets the framework for the following one, by elaborating on the key-questions guiding this study and its approach to acquiring an in-depth understanding and meaningful data. Particular attention has been paid to the researcher's insiderness and the implications of this for the study: familiarity creates the conditions for potentially richer interpretive insights but efforts have to be made to ensure that undue influences and power dynamics are kept in check. Trust, sensitivity and empathetic participation were essential elements steering the interviews and defining the construction of the montage of testimonials.

The strength of the methodology of this piece of research lies in the complete immersion of the researcher in the subject matter and milieu of the study. The intimacy of the researcher with the subject matter and the time spent with participants enables a deeper understanding of the culture of the organisation. Its limitation, arguably, lies in what Ann Gray (2003:15) refers to as the representativeness of the study in "scale and breadth". Since the study focuses on "specific examples", in a specific organisation, at a specific point in time, it cannot easily lend itself to general claims.

As already suggested, I believe the relevance of the study will lie in its ability to serve as a pilot and inspiration for larger and broader research on the subject. I also hope that it will provide a platform for introspection among managers and staff of international development organisations the world over.

Chapter 4 - Rubric of the argument: Analysis and reflection

4.1 Introduction

While the literature review has been about theoretical constructs and conceptual models for analyses, the findings are about human beings and the manner in which they experience HIV and AIDS policy implementation in the micro-context of their work lives in an international development agency in South Africa. Simultaneously, the analysis and reflections in this section also demonstrate management responses, as agents of policy implementation. As explained in the previous chapter, my situation as an insider in the organisation and the use of the PO based approach has facilitated intimacy of conversation and spontaneity of participant response stimulating lengthy dialogue, relevant aspects of which have been embedded in this section. The effort has been to interrogate and elicit the nuances of participants' views adding to the authenticity of the study

This section attempts to bring to the research findings the "vulnerable" (Behar 1996) gaze of an observer placing himself (in this case the researcher) in the shoes of the subject. Clifford Geertz articulated a similar sentiment when he wrote, "You don't exactly penetrate another culture...You put yourself in its way and it bodies forth and enmeshes you" (cited in Behar 1996: 5). As a researcher, I am fortunate to have been embedded in the milieu of the study and to being one with its people and policies. My endeavour has been to balance observational intimacy with critical distance in my narration and analysis of the complex testimony of people living with the virus and managing it in a large international development organisation, the United Nations.

I have maintained an exploratory style in the presentation of the findings, without attempting to cast it in the mould of a single argument at the outset. The findings are developed in separate sub-sections and argued in relation to conceptual models that I have examined in the literature review.

I have consciously quoted the testimonials at length for a number of reasons. First, it is crucial in a qualitative study to capture the voices of the participants rather than depend on second-hand paraphrases of actual conversations. Related to the importance of presenting the authentic voices of the participants is the issue of validity. With extensive presentation of the content of the conversations, it is possible to better monitor the veracity and plausibility of my interpretations of these conversations. Many of the issues presented in the findings could be potentially contentious, as they place the decisions and actions of specific colleagues under scrutiny. It is, therefore, critically important to present detailed verbatim accounts to ensure fairness of representation.

As a researcher revisiting the transcripts retrospectively, the extensive quotations enabled me to dwell in the moment in which the thoughts were expressed and be one with the journey that the participants made through their testimonials. An insider to the organisation and part of the milieu of the study I was sensitive to the testimonials, empathising with participants' views at one level and partaking in the construction of meaning at another level. As the Vietnamese Buddhist monk Thich Nhat Hanh urged, one must be careful not "to sacrifice the *journey* for the sake of the *arrival*" (cited in Behar 1996: 161). The "*journey*" in the context of this thesis is the observation of participants through detailed one-on-one interviews, resulting in the expression of emotions and experiences of the participants as they opened themselves up to lend substance to the study. The "*arrival*", is the reflection and analysis of the data in the form of findings. I have, in the data analysis and presentation of the findings, attempted to do justice to both the journey and the arrival through the authentic and in-depth presentation of the testimonials. The testimonials and their analysis have, subsequently, been organised by me under sub-heads that summarise the emerging thought. The testimonials presented are sometimes lightly edited for readability.

I conclude the section on the findings of the study, by bringing together the various findings in a single thread of argument by revisiting the research questions outlined earlier in the study. The findings are presented below.

4.2 Manifestation of policy: Emerging dichotomies

The significance of any finding pertaining to the contradiction between HIV policy and its implementation, in international development organisations such as the United Nations, is rooted in Gewirth's concept of universality and practicability. He argued (as detailed in the literature review) that it is not a matter of all rights holders having the same right at the same time and to the same degree of immediacy. Nor is it a matter of duty bearers fulfilling all rights at all times to the fullest extent of the need. It is, as Gewirth (1982: 65) states, a matter of principle that everybody has the right to be universally "treated in the appropriate way" when the need arises and those in authority have the duty to act in accordance with the right, within the constraints of feasibility and cost, when they have the ability to do so.

The analysis and qualitative interviews establish a tension between policy and practice. The directive of the UN Personnel Policy on HIV and AIDS and the manner of its implementation in the workplace is not consistent. There are clear written regulations and policies related to HIV and AIDS. These policies and guidelines, endorsed by the Secretary General of the United Nations, are designed to guide managers in their engagement with HIV in the workplace. However, despite the rule based operations of bureaucracies, the written rules are far from sacrosanct. As one of the interviewees, Lydia, observed, "The implementation of the policy … does not reflect fully the spirit in which the policy was intended when it was introduced".

The United Nations Personnel Policy on HIV/AIDS specifically mandates the protection of personnel, specifically stating that,

> Persons in the workplace affected by, or perceived to be affected by HIV/AIDS, must be protected from stigmatization and discrimination by co-workers, unions, employers or clients (United Nations ST/SGB/2003/18).

This is further corroborated by the United Nation's Secretary General in his Bulletin dated 1 December 2003. In it he publicly and unequivocally states that,

> "The United Nations is committed to providing a supportive workplace for its employees, regardless of their HIV status. To achieve this, we must have an environment that promotes compassion and understanding and rejects discrimination and fear" (United Nations ST/SGB/2003/18).

Despite the published policies and public articulations of the United Nations, the implementation of HIV policy in various units and organisations of the UN system in South Africa remains inconsistent. This is illustrated below in some of the testimonies gathered in the field research.

Among the interviewees for the study was Maud, a former employee, who is understood to have lost her job following her detection as a person living with the virus. The case, as articulated by the employee, demonstrates evidence of discrimination, fear of stigma and a lack of transparency in the recruitment process. Despite working in an organisation which promotes both compassion and understanding with the overall objective of rejecting discrimination and fear, Maud felt constrained to discuss her HIV status with either peers or superiors in the organisation while she was employed there. This is what she had to say on the subject:

> MAUD: [When] I started [in the year] 2000, I was not aware that I was positive, I only found out in 2001 but since …. they were not treating them [people living with the virus] that good, so I felt that I could not tell them that [I was HIV positive], that is why I was unable to talk to anyone about it.
>
> SHIVAJI: [anyone] in the organisation?
>
> MAUD: Yes.

The following segment of Maud's account outlines the manner in which HIV is sometimes dealt with in the organisation.

> MAUD: … they were trying to restructure the organisation. So all our posts were restructured, we had to apply again; I do not know what they called it.
>
> SHIVAJI: Re-profiling?

> MAUD: Yes, re-profiling. In the re-profiling you had to apply again for your post and the other posts in case you do not get your post. We all went for those interviews. Fortunate[ly] for me I got the HR [Human Resources] Assistant post, but at the time I was the Admin. Assistant and I was working with Mr B[31] as his secretary/PA - assistant. Okay. I apply and I did not get that one that I was working on but I was able to get the HR Assistant post.
> I qualified and got the highest marks for the HR [post].No one was close to me, so they gave me that position but then I was only due to start in 2002 in February … as an HR assistant. At that time there was no registry clerk, there was no travel assistant, so I ... had to do those three posts until they were filled so that I can move to my other post.
> Okay, I signed the contract … and they said I am only going to qualify if my medical examination was going to come and it will be according to their standards ….

[It is important to at this juncture of Maud's testimony to briefly invoke the UN HIV policy to enable the reader to compare the principles of the policy with the unfolding testimony. The policy states that,

- HIV infection does not, in itself, constitute a lack of fitness to work.
- There will be no HIV screening of candidates for recruitment.
- AIDS will be treated in the same manner as any other medical condition in considering medical classification (United Nations ST/SGB/2003/18)].

> MAUD (continues): Okay, I went for the first test but then it was not clear. That is when there were other tests which they could not be clear on, so it was sent to [HQ - Headquarters] Medical, I do not know what they call it, and it came back and they said I had to do other tests. I went three times to the doctor ... Dr A [name withheld for reasons of confidentiality]. And the last time when I went to him…that was when I found out that I was ... HIV positive. Maybe that is why my medical things were not that much clear... He said: no, do not worry; it will not affect you because they do not have a right to, like, not give you this because they have already given it to you. It is just for them to know how to treat you and blah, blah, blah. Okay, I was able to, you know, talk to him confidently because he told me I should not worry about it.
>
> Okay, we talked about it and then he wrote that I had TB at the time, but I was not that much sick, but it was on me, the TB, and I was taken to him in fact. Okay, Dr A told me that he will write a letter, a motivation. Okay.

[31] Name withheld for reasons of confidentiality

> It went to [HQ], when it came back, that is when, I do not know what, the standards that they used, but I got something that, I got a [medical] standard what was low, so they said they could not give me the post any more because I do not qualify because of the medical examination.
>
> And the other thing they said: I worked for more than six months; at the [organisation] they said the policy…that they use…a person cannot work for more than six months before getting the clear medical examination. I worked for more than six months; they would not give me the salary, so I could not continue for the seventh month. Even though they gave me a 1 year contract, I could not continue, that is what they told me. And that is when they gave me a copy of that policy, just showing me that I could not work for more than six months. But before I did not know about it. They only gave it when the six months was over and I could not contest it.

It is clear from the testimony above that Maud was neither empowered with clear and complete knowledge of the policies governing her case nor with the decision-making process followed by the organisation in evaluating and managing her case. She was selectively exposed to organisational rules without being provided a comprehensive picture of the process and decisions of the organisation vis-à-vis policy for the re-recruitment of qualified staff members. For instance, they told her that she could not work for more than six months without a medical clearance. Yet they did not tell her what the medical condition was and why it did not qualify her for continuation in the post she was selected for and already serving successfully. The manipulation of rules evident in Maud's case is corroborated in the testimony of another interviewee. Lydia tells us about a haemophilia colleague living with the virus.

> LYDIA: And discrimination, when it happens, is mainly …through acts of omission not through acts of commission. And there are also rules which have not gone through the …evolution that is …critical for the workplace wellness programme policy to be completely implemented and …efficient. For example, while there is … a rule that says that employees will not be discriminated on the basis of their status, at the same time there is also a rule that...asks the employee to certify that the employee is in mental and physical health well enough to carry out his or her duties. Now these two points are contradictory at a point in time when…a positive person falls ill. Because at that point in time the person may not be in a position to carry out his or her duties to the full extent possible and over a period of time. It is not a short thing. It is not like two days or three days, it might be for a longer period of time. So it has happened within the organisation that a particular employee, while that employee was hired by the organisation with full knowledge of the employee's positive status, but the employee was not

> given a better contract because, the awarding of that contract required the employee to attest to the fact that the employee was in full physical and mental health. Now this employee was a haemophiliac and therefore could not certify to that and so the employee did not get that contract. Now this is clearly a situation where there are confusing legalities and … personnel employment rules … have not been sorted out because this person was HIV positive, essentially because he or she was a haemophiliac and so the organisation hired him knowing it [the status of the person] but at the same time the organisation penalised this person, not because this person was positive, but [because] the person had another illness [which was] responsible for the person's… positive status. So it is a very confused thing. And the organisation has not worked it through… However, because … smoothening the process and clarifying these laws or rules, takes a period of time, this particular person was penalised and therefore the short answer is that this person was discriminated against.

It is important to point out at this juncture that Lydia's testimony suggests a tension between the perceived need for efficiency and the humane treatment of staff members. My understanding is that the organisation's assessment of the case is not always consistent with the policy and the selective use of HIV and other policies are sometimes used to obstruct and hinder the implementation of policy. A lack of transparency is one of the tools of control and manipulation. Much of the testimony reviewed above demonstrates that staff members, in contravention of Gewirth's principle of universality and practicability, are denied both the right to transparent information and the right to be treated appropriately when detected to be living with the virus.

All the testimonies were not about job loss on account of HIV. Leon, for instance, retained his job and was put on medical coverage. However, even when the staff member is retained on a temporary fixed term contract and medically covered for HIV treatment, as in the case of Leon, he/she loses both salary and medical coverage for two weeks every year. This two week break is designed to interrupt the continuity of the contract. While the rule may have been incorporated to safe guard the organisation from labour disputes, it compromises the staff's medical coverage and also his means of livelihood. The interruption in pay could prove risky to the health of the staff member, who needs to maintain continuity of treatment. According to the testimony:

> LEON: … So you can see that if something bad happens, or if I commit an act whereby… [I do] not get along with the condition, I might be asked to leave or the office might not … give me contracts again because I am working on a TFT [Temporary Fixed Term] basis, which is a …. temporary staff. So my contract is being renewed every year. My … contract means that I work for eleven months and then I break for two weeks and then the office might decide if they do need me in the office, they should renew my contract. That is what is keeping me unstable because this time, towards the end of my contract, I just stress up wanting to know… if my performance was better. Will I be able to get recommendation that my contract be renewed?
>
> SHIVAJI: And those two weeks [when the staff member is required to take a break between contracts] … you do not get paid?
>
> LEON: I do not get paid for … those two weeks. I am not covered because I do not have a contract …. I have to make sure that I have the medication that can take me during the two weeks until I come back to the office you know, and there is never that I can see that my contract is renewable, you know, there is no way I am seeing that it is going to be renewed. It is a temporary fixed term contract.

The Temporary Fixed Term (TFT) mode of contract for local staff that Leon is employed on is designed for organisational convenience. It covers the staff member's medical bills while in service. However, it does not do so after the staff member retires from the organisation. This, in an organisation which has other modes of contract that cover staff members, who have completed a mandatory number of years of service, to medical benefits on retirement. I believe that this lack of a level playing field fosters vulnerability among staff living with the virus and risks manipulation by managers running the organisation and implementing HIV policy.

One of the fundamental principles of the 'Policy on HIV/AIDS in the workplace' is the importance of maintaining the confidentiality of tests and test results. The policy states that

> "[s]pecific procedures must be developed by United Nations bodies to maintain confidentiality with respect to negative as well as positive results from an HIV test, including whether such a test has been taken. Only the person tested has the right to release information concerning his or her HIV Status" (United Nations ST/SGB/2003/18 2003: 4).

The principle of confidentiality needs to be backed with careful implementation within organisations to prevent the kind of leaks evident in the testimony of Caitlin:

> SHIVAJI: Do you know of any cases, and I do not need names, anywhere in the system, where people who are living with the virus have been disadvantaged in any way by a particular decision?
>
> CAITLIN: Well, the one is that someone's contract was under review for renewal and that person had to go for a medical. That person knew that he was HIV positive and then the medical came back …, and I cannot remember exactly the details, but reflecting that that person would need to go for an HIV test and the person said well I am living with HIV. So not a problem and it came back from the head quarter office that that person's contract should not be renewed. The person subsequently fought and the contract was renewed and so I think that did happen. When people do medicals they are not supposed to be checked for HIV but in fact they are tested and the reason that we know that is that the tests were sent to someone else's desk who then … told.

Caitlin's testimony alludes to the influence of headquarter offices (located outside the country) in the decision making of local managers. The participant was not at the level of the organisation where she was likely to know for sure that such was the case or indeed if that was the reason given. However, it draws attention to staff perceptions of the management's ability to manipulate a situation. Her testimony also makes reference to the power of human agency both in the management attempt to rescind the person's contract and the person's empowered actions to fight successfully for a contract renewal. Caitlin's person stands out in contrast to Maud who timidly accepts the situation and moves on.

In an earlier study (Bhattacharya 2003) undertaken by the researcher in the same organisation, it was found that

> [t]his is not the only occasion when managers have demonstrated a disinclination to invest in sero-positive staff. Judith was fully qualified for a six month international training programme in Eastern Europe, but someone else was sent in her place. Someone with fewer qualifications, but whose sero-status was presumed to be negative, prompting Judith to say, 'I do not have a future in the department'. Judith felt that her presence in the department was, in her own words, a 'politically correct' gesture, but a gesture nevertheless. She said in the interview, '… they never thought that I would give them more than what they

> were expecting from me'. The overwhelming feeling was one of being under-valued: 'There is a career path, but then I think my status could be an obstacle' (Bhattacharya 2003: 94).

Using the Rawlsian approach, I would opine that a person living with the virus in the organisation should receive equal treatment with those living either sero-negative or living un-detected (either to themselves or to the work community at large). Secondly, if there is to be a differential treatment, (since Rawls's principle works in tandem with the principle of equality) the differential treatment should, ethically, be a positive one, instituted to redress any unfair imbalances. As Rawls (cited in Kelly 2003: 65) illustrates,

> if men, say, have greater basic rights and greater opportunities than women, these inequalities can be justified only it they are to the advantage of women and acceptable from their point of view.

Using these principles as yardsticks of organisational performance and managerial interventions, the study finds that the basic rights of those living with the virus are not protected uniformly, as the examples provided by Maud, Leon and Caitlin illustrate.

Transgressions of policy implementation are not necessarily just about job losses or access to expensive medication and treatment; they sometimes take the form of poor information exchange or strategically designed contracts. An efficient information exchange program would result in enlightened staff members who know their rights and responsibilities. In the United Nations HIV Policy launched by the Secretary General in 2003, Kofi Annan stated that,

> The programmes will continue to ensure that … United Nations staff and their families will have access to information about treatment and support, including how and where to obtain voluntary confidential counselling and testing, and antiretroviral drugs (United Nations ST/SGB/2003/18 2003:1-5).

Yet, staff members, even those who presumably work in the area of HIV and AIDS like Seamus and Lorenzo, had this to say,

> SEAMUS: Even though we are in the HIV/AIDS group in a major international development organisation, I have always been quite surprised at how little we

> have been made aware of the HIV/AIDS policies that exist in the organisation. I do not think that I have necessarily been as productive as I could have been in terms of seeking out what exactly the policy is and in what ways … it cater[s] to the needs of staff. But certainly in no way has it been something that is prominent or on display in terms of activities, in terms of programmes that are very real …. that allow staff members every day, or at least even once in a while, to think that this is obviously a workplace policy that keeps our needs in mind. I think part of that has to do with us being an organisation in a bit of flux and many of those policies are in the process of being in force now and I think especially in the area of workplace policy. In the last couple of months there has been a shift but in general, in terms of the policy, I feel like it is something that exists on paper that has not really filtered into the day to day practice of workers.

And Lorenzo, a senior and experienced HIV and AIDS Project staff member, wasn't even aware of a concerted HIV and AIDS Policy in the workplace. He had this to say:

> SHIVAJI: As far as HIV and AIDS policies are concerned, are you aware of the existence of an HIV and AIDS policy in your organisation? How much of it has been implemented and what are your opinions on the policy itself and the implementation?
>
> LORENZO: I am not sure whether there is a specific [name of organisation] policy but I know there is a policy which may have been adopted or subscribed to by the Agency. The degree of implementation really is, I believe very mixed.
>
> SHIVAJI: Would you elaborate on that?
>
> LORENZO: Or very limited.
>
> SHIVAJI: Would you elaborate on that too?
>
> LORENZO: Except the recent work that colleagues have started, really I do not think there was any workplace policy that was being implemented in practice. At the [office] at the [another office] for instance, they used to have condom programmes and the like.
>
> SHIVAJI: Okay just to go back to your reference to the recent workplace programme activity, were you present at the intervention and what, what was your basic takeout on it, what do you think the strength of that programme was?
>
> LORENZO: The approach was very good, particularly to people who may not have know well about HIV AIDS the transmission and the prevention mechanisms and factors that predispose people to susceptibility of infection, the simplicity I think was very good.

SHIVAJI: Tell me, what was the turnout like for the programme?

LORENZO: It was very well attended by both by staff and management also.

SHIVAJI: Okay and now is that the general trend? Do all HIV and AIDS related programmes have the same turnout? There was a sensitisation workshop sometime back, was there a difference in the turnout?

LORENZO: I do not really remember the earlier event.

Lorenzo also makes a claim of organisational inability and lack of foresight as a possible impediment to policy implementation. This is his argument:

SHIVAJI: And what is your opinion on this separation of contract for people doing similar work in the same workspace?

LORENZO: I think there should be very good reasons for issuing different types of contracts. The span of the work differs as the skill requirements differ and the institution needs flexibility to change the staff profile depending on its needs. Because of that and I think the institutions should retain some such flexibility. But even if it brings them [employees] for a shorter term, I think the benefits can be across the board. You bring a person for three months, let him have health insurance, let him access the services that the rest of the staff access. The financial implications may not be that significant, but when the contract ends, the benefits will also cease to exist.

SHIVAJI: How, why does the organisation do that?

LORENZO: Sincerely, it may not have been thought through very carefully. I think the goodwill does exist on the part of the organisations, but it may not have been thought very carefully and of course the implications are very small. If you have a consultant he picks a condom or two every other day, just like everybody else, it will not be significant, but the problem from the point of the staff is once the contract ceases to exist, those benefits will not exist. If you put him on ARVs and the contract comes to an end at the end of three months, you cease to give him ARVs and you generate ARV resistant.

SHIVAJI: So it is a Catch-22 situation?

LORENZO: Ja, ja, well for that matter, most organisational staff including us, are contractual staff. If anyone of us is on ARV it stops being available to us when we finish our contract and I do not think it is available for us out there. It could generate a resistant-type of epidemic with HIV.

> SHIVAJI: Which links back to your point that they have not thought ... (intervenes)
>
> LORENZO: Ja, I think it has not been thought through really.

Seamus and Lorenzo (quoted above), are project staff member working in the area of HIV and AIDS. Their assignment requires them to be intimately aware of the HIV and AIDS policy. Their inconsistent understanding of the HIV policy begs the question, "How does the organisation propose to successfully disseminate a policy when even the insiders to the policy do not know about it or feel compelled to know about it?" Lorenzo's commentary also leads us to the understanding that it is important for managers and the organisation to think through the policy and its implementation at different levels in order to address the complexities articulated by Lorenzo.

Patricia (quoted below) was, on the other hand, an administrative staff member who worked closely with the implementation of organisational policies and staff contracts. As is evident in the conversation below, Patricia too had a similar, but more strident, perspective from her vantage point of being an administrative staff member who interacts with various categories of staff members.

> SHIVAJI: Tell me are you aware that your organisation has an HIV and AIDS policy?
>
> PATRICIA: I am aware that it does yes. Do you want me to elaborate?
> SHIVAJI: Yes absolutely.
>
> PATRICIA: I am aware that it does have an HIV AIDS policy. I do not particularly see its effects; I do not see its relevance in a lot of instances and quite frankly rarely see its implementation.
>
> SHIVAJI: As a person who is involved closely with the administration and the management of the organisation you are seeing its implementation or the lack of it at close quarters. Now is the policy uniformly applicable to all people who work under this roof from security to cleaning to all the staff, different levels contracts?
>
> PATRICIA: Well NO!!! Most certainly NOT!!! I do not see that. I do not find that it does encompass everybody that (not to go into such legal speak) but people that do contracts or sub-contracts, it does not all cover that. It covers, most

certainly, a very select few people. The organisation, well I have issues, a lot of issues with the organisation. But the organisation differentiates. It categorises its people and it will cover a certain category of its people. Whether it does that for business reasons, to cut down on costs, to be more cost effective, I do not know. But you know I do fail to see the relevance between its being a humanitarian organisation and the fact that it does not treat its own contracted staff or sub-contracted staff in a humane fashion.

To cover a wider cross section of staff, I broached the question of knowledge and information regarding the policies to Nancy who performs a largely secretarial function supporting programmes managed by advisors. She had this to say in corroboration of Seamus and Patricia's view:

> SHIVAJI: Are you aware of an HIV and AIDS policy within the workplace?
>
> NANCY: Yes, I am.
>
> SHIVAJI: Okay, would you know what has been implemented and how much? What are some of the things that are important, but are not implemented? What are some of the things that are important, but are not even in the policy?
>
> NANCY: I know about the policy, but probably not in the detail … it should be. But I know that in UN organisations there are the right documents with enough of the policy talk, but it is not really effective in how it is implemented. If you look at the different grades that people are put in, the type of contract determines what kind of coverage you get. So if you look at it like that it [the HIV Policy] does not take on the oneness of a disease that knows no grade, no rank … If I have the disease and I am on an SSA [a short term agreement, usually under a year, though it can and is sometimes extended after a break] for example, I do not get anything in terms of coverage. I have to pay my own bills. I have to go to the doctor myself. I sign a contract that tells me that I am not an employee. I am a consultant, things like that. So the policy works insofar as addressing [issues]. Obviously it has been studied, you know, and it addresses all the right issues, but the organisational structure does not match it. I do not know how to explain it, but it does not match. You have a policy that address[es] all these wonderful things, but when you bring it here, like in our office, you bring it, it (indistinct). Those that are in better jobs, if I can say that, they have a better deal, so [they] can get ill, [and they] are covered, [and their] families are covered [too].

The United Nations office focussed on in this study outsources select functions such as building security and cleaning services to independent private organisations. However, it appears that the contracted organisation's health and personnel policies on health and

HIV do not form a part of the United Nation's selection criteria, nor indeed is it regarded as its concern. As a result, significant sections of the staff serving at the United Nations agencies do not have health care that is as comprehensive as the health care services available to their colleagues directly employed by the UN, underscoring the vulnerability of contract workers.

> SHIVAJI: Thank you very much … Now tell me are you aware that the United Nations has an HIV and AIDS policy in the workplace?
>
> GREG: Ja, ja, I am.
>
> SHIVAJI: Now does your organisation, [name of a security organisation contracted by the organisation], for which you serve the United Nations, do they have a policy on HIV and AIDS?
>
> GREG: To be honest with you, I have never heard of one.
>
> SHIVAJI: You have never heard of one?
>
> GREG: No, never.
>
> SHIVAJI: Okay. Does it have a medical policy like does it cover its staff for illness, sickness?
>
> GREG: No, it does not, it does not.
>
> SHIVAJI: So, what happens when one of the [Name of the outsourced security agency] security staff would fall sick? What would happen?
>
> GREG: I have gone through that experience. Because my auntie was working there and then she passed away, she was buried on [date].
>
> SHIVAJI: Oh this year, I am so sorry.
>
> GREG: This year. She was sick, but to be honest with you, when she was sick we never received anything from the company.
>
> SHIVAJI: Did they give any of her family members a job to compensate like ... (intervenes)
>
> GREG: Until now, no, even her husband is unemployed.

SHIVAJI: And when she was sick, was she given any kind of compensation during the sickness period? Did she get a salary?

GREG: No, she got a salary until the time she stopped working where she was registered. I think it was for a month then it was us who were carrying over from there.

SHIVAJI: Now, are you aware that the UN medical policy covers its entire staff for medical treatment in the case of HIV for HIV treatment and things. Are you aware of that?

GREG: Ja, ja, ja.

SHIVAJI: How does it make you feel that you are working in the same work space where some staff are getting medical coverage and you are working just as hard as everybody else but you do not get the medical? How does it make you feel?

GREG: It is bad, it is bad, simply bad. It is simply bad. It is really bad. It is like we do not know what will happen tomorrow but now you are not even covered, then, sometimes it is just a matter of there is nothing you can do about it.

SHIVAJI: Tell me, why do you think the organisation does not cover for medical for its staff, [the name of the security organisation]? What advantage do they get out of it?

GREG: That one I am not sure because, I cannot tell.

SHIVAJI: What do you think are the advantages an organisation can get when they do not look after their people with medical cover?

GREG: That one I cannot, I do not know. We have been thinking about this too. But we could not come to a conclusion why they do not do that, you see. That one I really cannot.

SHIVAJI: Do they have other programmes, like, do they train their staff about HIV issues, tell them about it, how they can be safe and where they can get medical coverage even if the organisation does not give it? Do they have any kind of advisory function for their staff?

GREG: Ja, maybe to those ones in the offices but not to us.

SHIVAJI: Not people in the field?

GREG: No.

SHIVAJI: But the largest number of people is in the field.

GREG: Are in the field, ja. Because now I am telling you what is happening with the ones in the field, and we never even saw one coming. We read it only in the newspapers, we see it on the TV, and now while I am conducting with you now, that is [we hear about these things]. But with our organisation, NO!!!

Sandra, who is part of another organisation contracted by the UN, has similar experiences of lack of health coverage.

SHIVAJI: You are employed by [name of organisation contracted by the UN]?

SANDRA: Yes.

SHIVAJI: To do the cleaning?

SANDRA: Yes.

SHIVAJI: What do they give you? They give you a salary and do they give you any benefits?

SANDRA: No they just give me a salary.

SHIVAJI: Do they give you UIF [Unemployment Insurance Fund] and Provident Fund and all that?

SANDRA: No, I only have UIF, some they have Provident Fund but me and other staff who are working here, we don't have Provident Fund.

SHIVAJI: But UIF you have?

SANDRA: Yes.

SHIVAJI: Why do some of you have Provident Fund some don't have Provident Fund?

SANDRA: Yes.

SHIVAJI: Why is that?

SANDRA: They ask our Area Manager. He says that he will register the time elapsed to do that, so you are free to ask him, okay.

SHIVAJI: What would happen if you did ask him?

SANDRA: He is not somebody who you can ask if you have got a problem, you won't ask him anything you are afraid to ask him.

SHIVAJI: How does he treat the staff, how does he interact with them?

SANDRA: He is our Area Manager, he is treating us very bad because he won't even.... for example I was sick on one of the days and I ask him [for permission] to go to hospital. [But] he doesn't want to hear my story. He said, "To be sick is your own lookout it is not my fault, don't tell me … don't go there". Or you can choose another day. I say no, the doctor I have, [has] already give me the day to go to hospital. So then I go to hospital then he take that from my money... more than. So I didn't know how to go to him. I was afraid. I just keep quiet.

SHIVAJI: What is the rule of your organisation if you are sick, or if any staff is sick do they pay the salary or do they deduct the salary of the staff who is sick for [name of organisation contracted by UN]?

SANDRA: For example on September this year I was sick for two weeks then I came with letters from the different doctors, my Area Manager again he deducted my money for two weeks. Then I give to … my supervisor these letters and they didn't pay me anything back, they deduct all my money. So which means they didn't pay us. If you are sick they deduct all your money. So you are forced to [attend work]. Whether you are sick [or not], you are forced to come to work [when you are] not feeling well, because [if not you are] not getting that money. Then if it is deducted you won't get it.

SHIVAJI: And does the UN, the United Nations help you when situations like this happen?

SANDRA: Yes.

SHIVAJI: Do the people separately help you or does the organisation help you? Like do one or two people from the United Nations who know your story help you?

SANDRA: Yes.

SHIVAJI: Or is it the organisation, that the office sanctions a cheque for you, the United Nations?

SANDRA: No.

SHIVAJI: The office does not? Who helps you, the office or the people?

SANDRA: The people.

SHIVAJI: The people.

SANDRA: Not the office. Some people are working in the UN and they help me.

SHIVAJI: They help you?

SANDRA: But not all of them, just one or two.

SHIVAJI: Okay.

SANDRA: Because I told them the story what is happening and they help me.

The conversation with Sandra reveals an interesting development. We are initially exposed to various testimonials pertaining to staff members managing the system who have interpreted policy and rules to the disadvantage of people who are ill (Lydia's example of the haemophiliac colleague) or people living with the virus, such as in Maud's case outlined earlier. Now we hear from Sandra in her above testimony about some staff members who help others from their personal resources, deepening the tacit acknowledgement that staff members living with an illness ought to be supported and that the UN system didn't fulfil this aspect of its mandate. This enigma draws attention to the critical issue of human agency. People bring their personal beliefs to the office and both interpret and act on and around policy. Where the formal policy does not enjoy implementation, a more informal code of ethics operates among staff members. It is however noteworthy that the managers themselves (in these cases) did not refer to (in their testimonies) or from my observations react to the situations, by either implementing the formal policy or joining any informal network of support created by the staff members.

Judy has an allegation of double standards as far as the UN is concerned. She feels that,

> JUDY: It is a very strange situation with the UN because I have seen that we are ready to support Treatment Action Campaign. We are ready to support the GIPA movement as long as it is talking to somebody else. In our own internal issues, even those we have called as GIPA [workers], we keep on fighting to get them to sign it and we actually for me, I would say it is black mail … (interruption)

The implication of Judy's statement is enormous. According to her the organisation advocates for specific rights based policies with its clients in government and civil society without the ethical consistency of either practicing these rights based policies uniformly in its own workplace or by mandating it for its contractors.

Greg's allegations of racism (as evident in his opinions below) have not been directly verified with his organisation (contracted by this UN organisation) as it does not form a part of the focus of the study. It has been quoted essentially to flag the fact that differential privileges among personnel working under one roof creates dissonances among those who feel that the organisational policies short-change select employees in terms of benefits.

> SHIVAJI: So then why do you think that your organisation does not follow that policy, since there are so many advantages?
>
> GREG: [From] my point of view you can find that in some instances they can be doing it to other people, you understand. The way I know my company but I am sore to discuss it with you because they are seeing like racists. You can find that some of the people they are covered.
>
> SHIVAJI: Even in the field staff?
>
> GREG: No, mostly within the organisation. But this thing is within the umbrella organisation.
>
> SHIVAJI: Some are covered, some are not.
>
> GREG: Ja, some are covered.
>
> SHIVAJI: On what basis?
>
> GREG: Colour, colour details a lot.
>
> SHIVAJI: But then in a country where the government talks about complete equality and insists on complete equality, how are they able to get away with something like that?
>
> GREG: No, not to our company and sometimes it is many things, we just keep it under [the] carpet and keep quiet. But some of the things are not done straight. That is why I am not even quite sure. Sometimes even this covering, you find that

> they are covering. For instance like this study thing, you know, we have a, we are supposed to have an advantage of taking your financed to go and study, but it is only to the Whites who are getting that opportunity. I have to pop up money from my pocket. But when you check it, you find that it is there, and there is some money, we are supposed to go to school but they are not giving us [the opportunity].
> So sometimes we happen not to ask if you are losing the job, you understand, those kind of things.

Gewirth's view that "persons refrain from coercing or harming one another but also that they help one another" brings the spotlight clearly on the organisation and managers in my study. Another view that does so is Rawls's 'Difference Principle' (Kelly 2003: 61-66). Rawls unpacks the difference principle as a "principle of distributive justice" where the "least advantaged… share with other citizens the basic equal liberties and fair opportunities but have the least income and wealth" (Kelly 2003: 64). As such, according to Rawls (*ibid.*), any inequality is acceptable only if it effectively contributes to the welfare of those least advantaged. He articulates some key criteria and preconditions. Rawls clearly believes that the principle is,

> subordinate to both the first principle of justice (guaranteeing the equal basic liberties) and the principle of fair equality of opportunity. It works in tandem with these two prior principles and it is always to be applied within background institutions in which those principles are satisfied (Rawls as cited in Kelly 2003: 61).

Both Gewirth and Rawls's views (outlined above) are relevant to my study on two counts:

First, because they underline the mandate of the managers in international development organisations such as the United Nations with the responsibility of providing staff with the basic rights of equality of liberty and opportunity. As such a person living with the virus in the organisation should receive equal treatment with those living either sero-positive or living un-detected (either to themselves or to the work community at large). Greg and Sandra both serve within the United Nations compound, much as any other United Nations staff employee but don't receive the same sort of coverage as the staff. This creates potential dissonance as different colleagues in the same workplace are

managed by different terms of employment. It can be argued that since Greg and Sandra are not directly employed as United Nations' Staff the manager's hands are tied on the matter of their salary construct and perquisites. However, since the manager is responsible for hiring the organisations that provide out-sourced services and for assessing their deliverables, the manager can both directly and indirectly influence the contractor's staffing policy if he or she believes it is does not conform to the ethical beliefs of the United Nations system. The difference between the policies of the UN and those of its contractors highlights both limitations and possibilities for the organisation in its workplace HIV policy implementation.

Second, if there is to be a differential treatment, (since Rawls's principle works in tandem with the principle of equality) it needs to be affirmative in nature, instituted to correct unfair imbalances and restore equity. As Rawls (2003: 65) illustrates, if men in society are historically advantaged and have greater rights and opportunities than women, any inequalities can be only be justified if they are to the advantage of women and viewed by them as an advantage. This holds true in the case of potential affirmative action in the context of those living with the virus in the workspace. Rawls and Gewirth's principles serve effectively to analyse the performance of the organisation and the actions of managers who are authorised to represent the organisation's best interest.

The findings in this sub-section, entitled, 'Manifestation of policy: Emerging dichotomies' suggests a subtle and usually indirect discrimination of staff members living with the virus. This discrimination undermines the mandated implementation of HIV and AIDS policy in the organisation. Thus, far from being mechanical tools of policy implementation, the sociological perspective as expounded by Ness and Brechin (1988), emphasises that organisations are live collectives that often reflect dichotomies, contradictions and discrimination in practice. Subsequent sub-sections go deeper into the manifestations of this discrimination and attempt to explore some of the reasons for it.

4.3 Perceptions and expressions of power

This sub-section of the findings deliberates on two aspects of power; the perceptions that smudge the efficacy of policy, and the expressions of power that determine policy implementation or the lack of it.

In order to assess the merits of the argument in this section, it is important to outline the Weberian power hierarchies of a bureaucracy. First, the “decision-making authority” directly relates to the “task responsibility” assigned to individuals in the organisation. Secondly, “each lower office in the hierarchy is under the control and supervision of a higher office” (Jones 1995: 113-119). This organisation of reporting structures and authority clearly exists at the United Nations, the international development organisation under observation. However, Weber’s description of the rule book as an absolute truth (what Weber [1978: 975] calls, “calculable rules”) and that generates one clear interpretation that guides decisions and actions in a particular direction, does not apply in this case study. On the surface of things the rule book does appear to rule. The rule in the context of this study is the stated HIV/AIDS policy which comes with the endorsement of the organisation’s senior-most executive authority, the Secretary General. However, the implementation of the policy often fails to conform to principles enshrined in the HIV Policy. From testimonies gathered, the dichotomy in implementation seems to be related to the judgments, decisions and interpretations of managers and senior staff and not to inefficiency. In fact, it is my observation that the subversion of the policy, as evidenced in the interviews, requires knowledge of a broad range of organisational rules and a degree of efficiency in its execution. Some rules appear to clash with the manager or decision-maker’s beliefs, views or self-interest, resulting in them rationalising their actions and decisions of non-compliance through an interpretation of the rules. Some of the decisions and actions taken by the managers and on their behalf may be determined by what Weber (1978: 975) extrapolates to be “purely personal … elements”.

As Max Weber states in *Economy and Society* (Weber 1968; 1978: 926), “The structure of every legal order directly influences the distribution of power, economic or otherwise,

within its respective community". In the "legal order" of a bureaucracy, power and authority are divided across different entities such as operations managers, heads of office, human resources and headquarters as also into specialist functions like medical officers and medical boards. It is sometimes difficult to locate the source and reason for the manipulation of a situation, particularly if the person or persons do not wish to be visible in their actions. This works well in the manager's favour, if the manager is circumventing a prescribed policy and does not wish to draw attention to his or her actions.

I have already outlined Maud's case in some detail in the previous sub-section. It is however necessary to invoke Maud's case once again to illustrate the observations made in the two earlier paragraphs. First, that decision maker's circumvent stated policy using multiple interpretations. Second, the specific point and level of management at which the decision is being made is not always evident to the staff member. In Maud's case, the medical body that carried out the tests indicated unfitness without taking a clear position on the action that needed to be taken. Doctor A, who was in touch with the selected employee reassured her but did not take a clear position and moved the decision to the organisation's HQ and medical board. The HQ board stated that Maud was unfit to work, but did not inform Maud of the "standards that they used" (to use Maud's words) to make the decision. The holders of power within the international development organisation further manipulated the situation when they kept Maud working for six months without giving her any indication that she would not be allowed to complete her contracted one year tenure. During these six months (a safe window for the management, when they employed incumbent without making any long term commitments to her), Maud filled in for three unoccupied portfolios. She was also asked to train the person who eventually replaced her, without being informed that she was doing so. After all this, it seemed reasonable for the organisation to tell Maud that her medical examinations deemed her unfit to work and that she would not be allowed to complete the term of the contract she was selected for. A section of the conversation with Maud is quoted below:

> SHIVAJI: But did they explain what the medical problem was and how that medical problem, if it was not related to HIV… would affect your work?

MAUD: No, they did not really explain.

SHIVAJI: Like there are other staff members who have had TB, they do not necessarily lose their job for TB.

MAUD: No, no.

SHIVAJI: With medication you are treated, you are okay.

MAUD: Yes, you are okay.

SHIVAJI: The people with cholesterol problems, they have their medication, their cholesterol comes down and they continue their work.

MAUD: Yes.

SHIVAJI: So did they explain the medical reasons to you?

MAUD: No, they did not, no.

SHIVAJI: Did they give you any compensation?

MAUD: No …. and they even told me that I should not worry about coming back to work because they felt that I was not too strong to come to work. Maybe that is when they were preparing to get someone for the post I was on, because they were able to fill up those three posts and they already got someone, because there was a lady who I was training at the HR, but I thought they were training her for [an]other [job], [in] an[other] agency. Because, when I was training her they did not exactly tell me that she was going to work in my office …

SHIVAJI: She is now holding your post?

MAUD: Yes, she is.

The lack of transparency in the decision-making of senior managers and the manipulative exercise of power evidenced in Maud's case is anecdotally corroborated by another interviewee, Phillip. A senior manager in the same organisation, Phillip said with reference to another incident known to him,

> I have seen one case … where … somebody fell sick and then there was this desperate attempt to come up with a reason … to come up with a performance issue that never was documented before.

This instance is a clear indication of management's efforts at manipulation. Wrong (2002: 28) notes that,

> "If … the power holder fails to make explicit certain actions he [or she] induces … he [or she] has manipulated the power subject in addition to exercising other forms of power over him [or her]".

In both Phillip's testimony and Maud's this manipulation is in clear evidence.

The above testimonies suggest that decision-makers within large international development organisations manage situations not only by the letter of the policy, but also by their own individual perceptions. It also suggests that policy making requires interpretations which are in turn open to conflicting commitments and competing demands. Managers interpret HIV policies to resolve emerging situations in consonance with their own judgment. In the case of Maud this interpretation would be that persons living with the virus are ill-equipped to effectively take on a post in the organisation. When there is a mismatch between the statement of policy and their own views, managers find other policies and approaches to resolve the situation as they see fit. This finding is corroborated by both Phillip and Maud's testimony. Phillip talks of managers potentially trying, post facto, to construct performance criteria to remove staff from their posts. Maud talks of separation on grounds of an unexplained lack of fitness. This, at a time when she had covered up for three vacant posts and unknown to herself trained the person who was being groomed to replace her.

As can be seen in Maud's case, a person living with the virus cannot be dismissed specifically on those grounds. Yet their appointments, inexplicably, fail to materialise. So successful have been the managers in Maud's case that there are other colleagues in the system who are not even aware of such a development. Jack (a policy specialist and senior to Maud, though not a part of senior-management) and Gordon (at a comparable level to Maud with the responsibilities of a support-staff function), were colleagues of Maud in the same organisation, and have no knowledge of her case. Some of the time it gets across to staff members through the network of rumours, such as in Caitlin's testimony where she heard about a case from a source that violated the basic code of

confidentiality. As Caitlin (quoted earlier in greater detail) stated it, "the reason that we know that is that the tests were sent to someone else's desk who then … told".
Maud and Phillip's testimonies suggest that discrimination does exist, though there is no evidence (as Jack and Gordon's testimonies below suggest) of discrimination being universal in the system. This indicates that the rule book (in this case the HIV workplace policy) is not absolute, but open to the interpretation of select managers.

> SHIVAJI: Have you known of any case in your organisation where a person who is living with the virus has been denied a job or has been discovered as living with the virus and has been asked to leave?
>
> JACK: No, not really. No. In my working experience with the organisation, I did not hear about anybody who has been fired because of being ill, no this thing is not existing.
>
> SHIVAJI: Do you know of any cases within the system where, and you do not have to take names, you can just tell me about the basic situation. Do you know of any cases where a person who is living with virus and is known to be living with the virus, who has been dismissed from his or her job?
>
> GORDON: No, no.
>
> SHIVAJI: No?
>
> GORDON: Not, at all

Yet others, such as Patricia, Caitlin and Lydia, are aware of this and other cases. Patricia believes that HIV related discrimination exists in the organisation and this discrimination is covered-up with rationalisations and a lack of transparency. In the quote below, Patricia provides an explanation for what she sees as a clear case of discrimination and lack of transparency:

> PATRICIA: … Okay I am not too in-depth with what happens at recruitment. But I have a feeling; I mean I have seen some cases and I have a feeling, that the organisation does [discriminate]. You know that there is a compulsory medical examination for anybody who is on an SSA of nine months or longer even, which means everybody. Unless you are an SSA of less than that, I am not sure about the actual SSA period of time but here for example even service contract holders have to go through this compulsory medical examination.

> I also know that they test you for HIV/AIDS even though they claim not to, I know that for a fact also, and I say that on record, I know that for a fact. They test you for HIV.
>
> SHIVAJI: What do they do with that information because they are not supposed to?
>
> PATRICIA: Well I have yet to see… like I said, I have yet to know of somebody who is infected with HIV who is a fixed terms contract. I know there are several people in the organisation who have HIV, who I know are on SSA [contracts] or at the most service contracts. I have yet to see one, on a fixed terms contract. In fact point someone out to me who is HIV infected with a fixed term contract and quite frankly, I will FALL DOWN DEAD. So you can read between the lines there.

Another emerging feature that drives this manipulation by managers is self-interest and personal ego. This feature appears to supersede the mandates of development in the actions of some managers. The conversation (below) with Mona highlights this point.

> MONA: My experience so far has been that the organisation that I am working for focuses on things for as long as the person who had the passion for a programme is still there and most programmes go on for three, four years, five years. Once it is done and another person comes everything changes and there is no continuity in the development that would have been started. Of course I could be biased because I personally like some of the people that I have worked with. But … *when the people that have the passion for it [a program] go, it [the program] also goes*. Then it ceases to be development because development must continue. So if every year a new focus starts why not continue with the same one, improve it if it needs to.
>
> SHIVAJI: Why do you think it is like this?
>
> MONA: I think again it is power, I think it is the struggle for power.
>
> SHIVAJI: So in a bureaucracy how does it work? Are you saying that one comes into an organisation or department and then establishes one's power by changing the programmes?
>
> MONA: Yes.
>
> SHIVAJI: Elaborate on that?
>
> MONA: Also maybe the person comes in with new brooms which are supposed to [be] sweeping much cleaner. So the person thinks I am coming with something new. Whereas, something new starts people from the beginning all the time,

> instead of continuing. We mentioned also about donors, some donors prescribe what they want. We can only support you if you are doing this and that. Then it limits the way people think, the way people want to develop because they have to develop [grow in their careers] in a certain way.

Mona's opinion that managers are driven more by self interest and ego than by the need for programmatic continuity appears to have manifested itself in the organisation on a much larger and more significant canvas. While the example I am about to quote is not directly linked to the implementation of HIV Policy in the workplace, it is related to one entity's global HIV programmatic strategy. Moreover, it sheds light on both the mindset of managers who lead programs and the level of emphasis the organisation places on programmatic continuity. Across a five-year period (2001-2006) one entity of the organisation completely changed its strategic focus on HIV following the departure of one global head of HIV and the recruitment of another.
To illustrate, the three focus areas of this particular entity changed from:

> Focus 1: Leadership and capacity development. Promoting leadership at all levels, and developing the capacity of governments, civil society, development partners, communities and individuals to effectively respond to the epidemic.
>
> Focus 2: Development planning, implementation and HIV/AIDS response. Strengthening development planning and systems to comprehensively address HIV/AIDS at national, district and community levels.
>
> Focus 3: Advocacy and Communication. Generating a society-wide response that is gender-sensitive and respectful of the rights of people living with HIV/AIDS through advocacy and communication.

…to three new focus areas, namely:

> Focus 1: HIV/AIDS and Human Development: In order to support countries to mitigate the impact of HIV/AIDS on human development, [promote] multi-sector responses that mainstream HIV/AIDS into national development plans, sector programmes and decentralized plans.
>
> Focus 2: Governance of HIV/AIDS Responses: [Support] harmonization and alignment of [the] system and donor assistance to national AIDS authorities, and provides implementation support for the three ones principles for coordination of national AIDS responses.

> Focus 3: Human Rights, Gender dimensions of HIV/AIDS: [Support] countries in creating an enabling human rights environment to protect the rights of people living with HIV/AIDS, women and vulnerable populations.

An analysis of focus areas of the two consecutive global HIV strategies (led by consecutive incumbents) signals the following changes. The first focus area of the old strategy was eliminated in the later strategy. The second focus area was modified and incorporated as the first focus area of the later strategy. The third focus area was essentially only re-phrased in the new strategy. A whole new focus area was included in the form of the second focus area in the new strategy.
The analysis begs the questions: Would the strategies have changed if the earlier incumbent to the job continued to manage the portfolio? Was five years enough for a global strategy on HIV and AIDS to unfold completely and successfully before a change was necessary? Why was it necessary for some focus areas to be merely rephrased in the later strategy? Was the old strategy researched and found lacking before it was changed? Was it a case of self-interest and personal legacy?

The above questions are important as they stimulate introspection and lead staff members like Mona to observe that when senior management move from their assignments the programmes they are passionately committed to also leave with them. The ignominy of it is that development programmes are enriched through commitment and continuity. This appears to be missing in the system. This leads the researcher to conclude that the implementation of HIV Policy in large IDOs depends and progresses to the extent of the manager's individual knowledge, capacities, personal opinions and committed presence.

It is crucial at this point to highlight the fact that as a staff member within the system, the researcher reports to higher officials and also has staff members reporting to him. He has had both positive and negative experiences in the exercise of power, in the course of his duty. As a result, he would have personal views on the perceptions and expressions of power within the organisation. It is therefore possible that his position within the organisation would influence his analysis and acceptance of Mona's view that when senior management move from their assignments the programmes they support often

leave with them. Within the context of that cognition the researcher has attempted to be as circumspect as possible in his analysis and presentation.

Both Lydia and Judy further corroborate the observation that the level of implementation of HIV policy is also a factor of the manager's inclination and capacity.

> SHIVAJI: But in a development organisation where …the principle of human rights…is an important aspect. Surely…the managers…should, if anything, err on the side of care regarding their staff?
>
> LYDIA: It is about efficiency and …resource management. So, as I have said before, if you were to ask people you know in plain terms about their support of HIV positive people in the workplace, they will, almost to the last person, answer in the positive that they do support this principle. However, when it comes to understanding what that support implies in terms of delivering their work programmes…that understanding is not well developed….. Also, because this policy is new…the understanding of it is patchy. People who work on HIV have a better understanding of it than say people who work on areas which are quite removed from it. For example people who are working in food security.

Judy echoed a sentiment similar to Lydia's in her testimony below.

> SHIVAJI: Tell me about the policy itself. How much of it is simply exact or do you think it is open to interpretation by different managers? … So how much is the implementation about the rule itself and how much is it the interpretation of the manager who decides which way to go on it?
>
> JUDY: Normally, if you check all writers on organisational behaviour, they tell you that rules and laws are there to suit the people so that you can get the best out of them. But in the UN depending again, on the openness of the manager or the friendliness, or whatever the case is. You find that they are either open to discussion and looking at how to use that rule to favour the people or some use it as punitive and something to lock people up with.
> Again, there is no consistency. There is no consistency at all and I am sure you have seen it as well in your career with the UN. Sometimes you, depending on how you are, you can use a rule to help develop your staff or help them access or help so that the organisation gets more, or you can use it as a tool for exclusion. It depends on the openness of the manager.
> And yet the common practice normally is that the law or the rule should be used in the best way possible, to avoid anarchy and all these things that are counter-productive. But also to suit the staff so that the staff can give the best he [or she] can to the organisation.

SHIVAJI: Can you give me some example without using names, general examples to elaborate on your observation because it is a very interesting and important point you make?

JUDY: Yes. Let us say for example, what I can give. Let say leave. I am taking something that is very politically acceptable. Leave normally you know, we have different types of leave and some people will tell you family leave is how many days again, two ... (intervenes)

SHIVAJI: … and half days per month.

JUDY: Per month. That is sick leave. I think family leave is a maximum of two days per month not exceeding seven days per year, okay. So we have a case of a lady whose husband is sick regularly. So she had to go [home often], you know he sometimes gets into a serious state and sometimes even [requires medical] evacuation [to a location that provides the necessary facilities] and things like that. So they exhaust their leave okay.
If you are a very closed person, you then say that is it. You have finished your leave, your annual leave is finished, your sick leave, your family leave is finished. That is it. There is nothing we can do for you so next time he is sick get a relative or somebody to take care of him.
Another person would say okay, since you have yourself sick leave or 2.5 days per month for all the 12 months, let us look at how we could use that sick leave to accommodate that position. Which is not exactly what the law says or the rule says but because you have seen that it is for the betterment of the staff member and to appease the insecurity that may raise around this whole sick leave thing, you can adopt that.
And in any case, whether you do that or not, if [as a supervisor] you say, 'That is it. We are finished with you". What is the person going to say? She is going to say, 'Okay' and start lying to you. Two days and a half a month I tell you I am sick and you start losing on the trust, on the faithfulness and eventually you will even start guessing that she is not actually sick and you lose trust as well. So that can end in a breach of trust between staff member and manager which could have been easily avoided by just working around the rule to make it suitable for [the staff member]...
But I do not know if that is a good example.

SHIVAJI: And tell me, this actually leads us to another issue of power. What is the power structure in the thing? Is it hierarchical or is it flat?

JUDY: In the bureaucratic ... (intervenes)

SHIVAJI: Because all these things are exercised through interventions of power...

JUDY: Yes.

> SHIVAJI: Power decisions at different levels. Is it hierarchical or is it a flat structure?
>
> JUDY: Normally it is hierarchical in a true bureaucratic organisation but then in the UN, the other thing is, it is not that. Across the ranks you can be P4 programme officer and yet the Admin P4 or P3 officer gives you a hard time and yet he is not your immediate [supervisor]. It is because of the type of authority that has been given to him. What he thinks or she thinks is the type of authority that she has or he has upon your life, can give you a hard time.
> So it is not 100% vertical which normally it should be in a bureaucratic organisation.
>
> SHIVAJI: It is interesting. And what do they use? How do they exercise the power there? [I understand that the] power comes from the portfolio that they have but how do they exercise it?
>
> JUDY: ...that is mainly for the whole Admin- HR thing. Because of the rules they think that it is just theirs. Yes, they use that [the rules] as a power, as an authority tool.

I dwell on Judy's testimonial on general issues such as sick leave and the hierarchical nature of the bureaucracy as they are linked to HIV and the management of illness.

Mabel adds an additional dimension to Lydia and Judy's observation that a lack of inclination and capacity among managers inhibits policy implementation. She observes (debatably) that a lack of local managers at the highest level of the organisation in the country results in the management's disconnection with the deeper needs of a country.

> SHIVAJI: In your organisation the number one and two heads of the organisation are all foreigners, they are not South Africans. Is there an advantage in that or is that a problem?
>
> MABEL: There is a problem. Because they are foreigners they might not know exactly what is happening in our country. So I think that if the Number 1 can be the foreigner and the Number 2 be a local manager that would be fine, he will understand what is happening in the country.

Regarding Mabel's testimony above, it is important to point out that while there is logic to her implication that local managers may understand a country better than managers

foreign to the local environment, there is no validation that such an observation is true and absolute.

Foucault (1979) depicted power as "pervading all social relations" in the form of a micro-political system which exercises itself "from innumerable points… Power is everywhere, not because it embraces everything but because it comes from everywhere". This assertion, of Foucault's, that power is not centralized, occasionally deepens the challenge of locating the source and origin of a particular action. In Judy's testimony, below, a colleague seems to react to this amorphous all pervading pressure which seems to originate from no specific quarter but is generically labelled as organisational. Judy feels the exercise of power without specifically being able to locate or identify the source of origin. Yet it is restricting enough to silence the bold, the outspoken and even important globally influential personalities.

> JUDY: You find that people who … had very strong positions about things, after a few years in the UN actually we see it even on each one of us. After a few years in the UN you feel this stuff is going down. So that active ingredient, we are losing it. Maybe because if he talks too much, who knows, maybe he wants to renew his contract. Maybe they do not even realise it themselves.
> I discussed with one of the GIPA persons who is with the [name of organisation] office somewhere, and he is someone who impressed me you know. He had really strong positions and was people-orientated. But now, you know, he can barely express what he thinks. So I … think we want them to advocate and make noise when they talk to governments and all the other stakeholders but when they come back home, they must keep quiet….
> I heard with great shock, I do not know if you know, maybe you will take the name off [from the interview]... (Intervenes)
>
> SHIVAJI: Yes of course.
>
> JUDY: Do you know she has resigned.
>
> SHIVAJI: She has actually resigned?
>
> JUDY: She has resigned, because she cannot cope anymore. Somebody that is a global world figure, the [organisation] somehow manages to shut them up …

Judy suggests in her testimony above that there is a powerful tension between conscience and self preservation, often resulting in either silence or an exit from the organisation. She alludes to the hegemony of management.

As Featherstone *et al*. (1991: 66) point out, the capability of predominant entities to "reproduce themselves, and to legitimise this reproduction", depends on their capacity to determine what a community, society or group of people hold as legitimate. The finding of the present thesis is a more complex one. Dominant groups exercise a subtle hegemony. But, while the management appears to circumvent the mandates of the policy it does so without redefining it. It merely finds an alternate arrangement to work around it. The distinction that the microcosm of this society (the organisation) holds continues to be defined by the framework of the HIV policy. The manipulation protects the manager from having to come into direct conflict with the policy. A transparent process and direct confrontation of the policy would have resulted in, either the re-enforcement of the organisations policy or a re-definition of it. But by manipulating the outcome and obfuscating the process, the management of the unit has defied its principles without attempting to re-define it. Phillip, a senior manager in the organisation acknowledges a similar experience of managers controlling though manipulation and obfuscation:

> SHIVAJI: But it is interesting because at one level one's cholesterol levels or uric acid levels do not really bother the organisation. As long as you are competent for the job you get some kind of medical category and you continue your job and it [the organisation] goes back on nothing. Yet when it comes to HIV and AIDS, I am aware of situations where people's contracts have not been extended after they have been detected living with the virus. And, because the rules of the organisation do not permit discrimination on that ground, the whole case just hung, it was being thrown around various departments, in head office and country office, bouncing around the place without actually taking a decision. So nobody can be caught for not having done anything, yet nothing happened and that was not about the job.
>
> PHILLIP: No I think there are definitely cases where, not just for HIV and AIDS but also for other issues. The way the organisation, or the way certain managers choose to handle a situation is by letting it drag on. I do believe from what I have seen that there are two scenarios like that. Where there is a person who for one reason or another has a performance issue. Then on top of that there is one of these other elements and that then almost becomes, it becomes maybe the drop

that makes the barrel run over. Which is obviously not acceptable but there are other issues as well and this is almost used as the final straw.
However nobody dares to openly say it, so either it is being left hanging or suddenly all kinds of other issues are being pulled out of the drawer. If for example medical condition or HIV AIDS would not have entered the picture, nobody would have bothered to look at it. Because everybody would have seen that at least standard or acceptable behaviour or performance was practiced.
Then there is the other case where there is no previous history, so it is not really that there is a performance issue that you could pinpoint, either in the abstract or going in comparison to others. Then the only thing that comes in is medical condition, HIV AIDS, something like that. Then there is an attempt to construct a performance issue, which is objectively known there. I have seen one case of the latter where there was really a case where somebody fell sick, then there was this desperate attempt to come up with a reason to come up with a performance issue that never was documented before.
Is the organisation equipped to detect this? Unfortunately, I am afraid, in nine out of ten cases not, if the person is not willing to really pursue it. Particularly in cases with medical conditions. Most of these people have bigger problems and are feeling not necessarily either safe or physically ready to actually pursue this through the regular channels of justice which as in most [a particular group of] organisations are long and arduous and success often depends more on your stamina than on the merits of your case.
So yes I think in terms of internal justice [name of organisation] and a lot of [a particular group of] organisations have a long way to go. My personal working thesis would be that [a particular group of] organisations are not all equally effective, particularly about issues like HIV AIDS. The reason being that there are quite a number of international organisations who are headquartered in central Europe, who have no field presence. So by definition their exposure and the chances of their staff being affected is probably much lower than for example an organisation like [the name of the organisation] which has very, very vast field representation and very, very vast representation from various nationalities. So it would be interesting to see whether or not an organisation that technically speaking is much more at risk to its staff being in some way [or the other] affected by HIV and AIDS has more advanced policies, less advanced policies, than an organisation like the international telecommunication union which is stationed in Geneva, largely staffed by people from industrialised countries.
So it would be interesting to compare that. Who is more aware of these issues? I would not be surprised if organisations where quote, unquote, less danger in being exposed to risks of staff who in having been exposed in some way or [other] to HIV AIDS issues, have actually better policies. Even if there is a case it is going to be less risk to them so they can afford more inclusive policies. They can afford to be more aware and so on and so forth. While in an organisation like ours where there are estimates that 10% of our staff could be HIV positive [or] could be HIV AIDS affected in some way or [other].
So that is a huge number for us. This is not peanuts, so just from the view of the corporate organisation could we actually afford it if all these people would

> suddenly step up and say, *I am affected, what is the organisation going to do for me and my family?* So it is just out of these sheer demographic differences almost and staffing that I would be very interested in seeing how other [a particular group of] organisations respond to this because their staff make up is very different and their situation is very, very different.

Caitlin's testimony outlines how the power equations play out in the context of the bureaucracy and how managers and supervisors use bureaucratic inertia to their advantage:

> *SHIVAJI: And so you are saying the people are not testing or engaging with workplace programmes?*
>
> *CAITLIN: Ja. And a lot of it is based on how people think they are going to be treated by their colleagues, possibly senior colleagues but my sense is more the person that you share your desk or your office with, the person in the open plan office environment who you engage with, how they are going to be perceiving and responding to you.*
>
> SHIVAJI: And how does the bureaucratic structure in which you are housed interact with this, either precipitating the problem or facilitating a solution? What are the characteristics of the bureaucracy and how does it interface with the policy implementation aspect?
>
> CAITLIN: I do not know if I am maybe able to say, but my sense is that there is quite a lot of concern around confidentiality. The way we apply for anything in the system that is linked to medical insurance schemes is not necessarily confidential and so people are worried that because of HIV, someone will say something to somebody else and then it will get around the office. But I do not know if that is specific to the organisation, I think that is just specific to the human [being living with] HIV.
>
> SHIVAJI: And as far as specifically this organisation is concerned, the bureaucratic structure, how does the bureaucratic structure itself pan out as an inhibitor and / or a facilitator?
>
> CAITLIN: I have to say I do not know because I have not experienced it.
>
> SHIVAJI: Okay, what are the characteristics of the bureaucracy that you are housed in for the last three years?
>
> CAITLIN: Well I try and avoid the bureaucracy as much as possible so I do not see myself as getting tangled in the web too much but ...(intervenes)

SHIVAJI: But you have to work through contracts …

CAITLIN: Ja, it is a very slow process that is also based on whether someone feels like doing something for you or not. So I think it actually is an inhibitor in making people believe that they can be comfortable with the systems that are in place. So I know that if I am not, if I do not speak the right kind of language or say the right words at a particular time, it might have a negative result on me getting my payments in time. So, if someone is very desperate for something and they are not sucking up to the right extent then they could effectively be blocked from getting whatever kind of support the system is offering. Whether it be payments back from medical, medical costs spent that they owed or, I mean and that would have obviously quite a significant effect on someone who is either ill or taking care of a family.

I have *italicised* a section of Caitlin's testimonial above to draw attention to a similar mindset that I developed when I was diagnosed with cancer. I started responding to what I perceived to be the opinion of colleagues who engaged with a person living with a life threatening illness. It was my fear that colleagues might be inclined to write me off as a person who would soon prove unproductive and drop out of the system all together and therefore unworthy of additional responsibilities. As a result of this I was inclined to tailor my actions and responses to demonstrate heightened mental and physical health and energy. If for example in the past I developed a fever I would report sick from work until I recovered. After being diagnosed with cancer, I would push myself to attend office despite fevers and other ailments which I would dismiss as minor and inconsequential. It must be said that I had no evidence to validate my perception of my colleague's opinions in the matter of people living with a life threatening ailment, but they, nevertheless, appeared real to me and caused me to act on my assumptions.

Mona (who is openly living with the virus) has a more positive opinion of the organisation's implementation of HIV Policy. Mona's testimony yields the following insight:

SHIVAJI: When you say rights based and you used the words protection of employees and employers what specifically are the elements of an employee and specifically the elements of an employer that need to be protected in this situation, in an HIV policy?

> MONA: I will start with the employee. The employee would be protected from being fired…after being tested. So the recruitment would be based on what skills and capabilities the employee has, not on the status, on the negative or positive status. The recruitment would then not be biased towards those that are living with HIV.
>
> SHIVAJI: Do you think as far as an employee is concerned in your organisation this particular right is protected?
>
> MONA: I think it is protected. It is largely protected though there could be some loopholes in terms of people cynically not doing things, not coming out to really say it is about HIV. That might not mention that the problem could be HIV. But by and large this is kept.

According to Mona, while "loopholes" were present in the policy and some managers did exploit these "loopholes", the system "by and large" worked in favour of those living with the virus.

These contrasting opinions on the level of policy implementation in one unified organisational system underline my point that the demarcation between policy and implementation are smudged by the actions of managers and staff. The findings of this section contradict the allegations of critics of bureaucracy, such as Merton (Thompson & McHugh 1990: 176), who states that "standardization and predictability could easily degenerate into rigidity and defensive behavior, a kind of 'trained incapacity' resistant to innovation". Contrary to Merton's view, it is my observation that denying Maud her right of employment after her technical selection to the job took a great deal of flexibility and ingenuity of interpretation, which was far from rigid or resistant to innovation. As such, my findings disagree with Weberian typification of the rule book exercising absolute power in bureaucracies (see Weber, 1968). In the context of this study the policy on HIV (the rule book) is not the final authority that decides the outcome of a situation.

It is important to state, that the reasons for the lack of implementation of the HIV policy are not germane to the study. The effort is not to find precise management motive for the dichotomy between policy and practice. In the final analysis it is immaterial whether the reasons are related to priorities or prejudices, to capacity or resource constraints. The fact

is that policies are not being implemented fully in bureaucratic systems which ideally (according to Weberian logic) have been driven by the letter of the law or policy. Bureaucracies appear to be changing with the times and the principles outlined by Weber seem to be evolving with changes in the environment.

In the literature review I suggest viewing Geras's (1998: 28) insight from an action-oriented position, where we as human beings in a society, as colleagues in a workplace commit to a contract of mutual empathy, in which we have the responsibility to empathize and support those around us in need, to the best of our ability. I have suggested that this empathy would create a momentum for positive social change, as articulated in the United Nations Charter and (in the context of this study) address some of the drawbacks of the gap between policy and practice emerging in the presentation of the research findings. In conversation, Mona, who works in the area of HIV, senses a level of indifference and calls for mutual empathy as, what she believes, is an effective way forward.

> SHIVAJI: What makes people in bureaucracies and international development organisations like yours feel that in the face of such an epidemic it is okay to go slow. You used the word 'cultural' earlier, what is this culture manifested in? Why is it manifested in this fashion?
>
> MONA: I do not know how I could explain it but all I know that things are very slow and decisions take time and actions take even more time. I do not know how. Do you want an example?
>
> SHIVAJI: Yes.
>
> MONA: Well the example that I have given is happening in my organisation at the moment where there is a process that must be taken before … we can have anonymous testing. The other slow things are not so much the organisation for example when people fill in their forms to the medical service provider, it is supposed to be paid in three days. But it depends in which country you are in, if there is no DHL and it goes by a slow post, then by the time it goes to France and comes back it can even take three weeks instead of the three days that the service provider promised. So sometimes it is not also the organisation but the country that the organisation is functioning in.
>
> SHIVAJI: To go back to the people, now in the organisation, to go back to the organisation. Do the managers and the people, do they themselves go slow on the

process, do they feel that this is something that I can deal with tomorrow or next week. Or do they clear it quickly?

MONA: I think people go slow and the reason being that it is again about how touched you have been and how serious[ly] one looks at the epidemic.

SHIVAJI: Do you find them taking it seriously?

MONA: Some yes, others not.

SHIVAJI: If you were to divide it what is the majority?

MONA: In my organisation I think it is 40 and 60. Forty for quick response and 60 for slower response.

SHIVAJI: This 40% that respond quickly; how do they respond, how much do they try to push, what they try to do? Are they able to beat the system, are they able to speed this up? Like what if the difference between a manager who would push things fast and a manager who would push things slow how much time does it take for the whole process to turn around in each case. If you have examples could you share it?

MONA: If only managers who push things would be the kind of people that are one with the employees [and] who would feel exactly the same punch that the employees are going through in terms of HIV. If there is anything that is happening, or say for example a workshop, if managers that are quick and would want to see things move, they together with their employees with the people that they are working with. Things move faster then when they dedicate themselves on paper and they encourage on paper and they themselves are not there. Because then it shows that oh okay it is really for you it is not for me and there are a lot of managers that I have seen in the organisation that are good on paper. [But] they themselves do not make that effort to be part and parcel. Because, for me, in the end they are also employees.

Jack is a senior advisor in the organisation. His work requires him to think and analyze processes and strategic situations related to HIV. He was somewhat uncomfortable with exploring some of the power hierarchy issues that govern the organisation, yet he was clear that it was a top down unilateral structure which could benefit from some decentralization and flatness in the structure:

SHIVAJI: What is the power distribution in the organisation, is it a flat structure with a horizontal distribution of power or is it hierarchically distributed?

JACK: Oh you know, you know this whole power…. I did not see any power - any flat power - it does not exist. I think that the people are hierarchical and… (intervenes)

SHIVAJI: And what is the basis of that hierarchy, is it rank and position? What drives the power structure?

JACK: First it is the structure and then the personality… and the people fit in the structure and then the individuality, depending on their way of managing their leadership to influence, but first it is your structure that is important.

SHIVAJI: And how does this particular vertical structure of hierarchy, how does that either inhibit or facilitate the implementation of policy within the organisation?

JACK: Really I did not think about that …. I have no response to that… I do not have any response to that. I need to go slow, I cannot respond to that.

SHIVAJI: Okay, if you want to see one particular change in the organisation that would help implement the policies faster and better and more efficiently? What would that change that you want to see be. What is the advice you will give the organisation to make that change?

JACK: To make the change to speed-up … (intervenes)

SHIVAJI: Policy implementation. What can the organisation do that will facilitate better policy implementation?

JACK: No I think one of the steps should be a wider decentralisation, because we have to match the structure with the working environment. Secondly, there should be a kind of decentralisation to [bring] the management … closer to the people and to improve and influence the climate of exchanging ideas, of planning, of doing things together and taking decisions. This kind of management is more democratic in the decision-making. I think decentralisation and the democratic decision-making should be very, very good move for change of policies.

As evidenced in the above testimonial from Jack there is, in the organisation, a clear and distinct hierarchy which exercises power. Even an experienced and senior person such as Jack feels too intimidated to respond to a query on the facilitative and inhibitive use of power within the organisation. His response is to request the interviewer to "go slow". This enables one to understand why staff members such as Maud did not attempt to exercise a more aggressive line of intervention on her hiring process and merely gave up after trying for a while. Caitlin too refers to system inhibitors that, as suggested in the

literature survey, serve in the final analysis to constrain both exchanges between the different categories of staff and policy implementation in the internal workplace.

Leon, Caitlin and Maud's testimonials seem to indicate that in some cases managers self-interest drives their actions to the point to which they may appear insensitive and uncaring about the consequences of their decisions and actions. Their testimonials invoke Geras's (1998) theory of the *contract of mutual indifference* which Geras propounded as a consequence of personally experiencing the actions of people in Nazi Germany as they watched injustice unfold in their presence without either taking any preventive or even palliative action. What horrified Geras was the peoples' ability to go back to their homes and lead normal lives. Similarly in Maud's, Caitlin's and Leon's cases one cannot escape the conclusion that the personal agenda's of managers may render them insensitive to the plight of people over whom they hold dominion. In the final chapter of the study, the researcher will attempt to suggest recommendations that shift the mindsets of managers and personnel from a state of mutual indifference to one of mutual empathy.

4.4 Trust in the policy: A leap of faith

It is my submission, that being a normative body and an unbiased arbiter demands of the United Nations system a consistency of values and positions in areas of policy development and implementation, not just externally (with its clients, the nation states) but internally (within its own system) too. My findings focus on internal consistencies and contradictions by bringing the HIV and AIDS policy and its implementation under the microscope. It further seeks to understand the consensuses and conflicts, the disagreements and negotiations, the breakdowns and breakthroughs that fuel the dynamic social exchanges that in turn drive the implementation of HIV and AIDS policy. In my opinion the effective implementation of an HIV policy in the United Nations workplace, requires two characteristics. First, an efficient, empathetic and committed management and organisational implementation capacity and second, the trust and faith of the employees for whom the policies are made. In this section, the study explores the mindset

of the employee vis-à-vis the HIV and AIDS Policy as it affects the lives and conditions of employment of staff members. It is apparent from some of the testimonies that lack of transparency and in some cases the lack of capacity has resulted in a certain tentativeness and insecurity among staff members. In the case of Leon, despite the fact that he is medically covered by the organisation during his working life, he is unclear of the extent and implication of the terms of his coverage and unhappy with what he understands of it. The conversation that ensued was as follows:

> SHIVAJI: And after retirement, will you continue to get your medical?
>
> LEON: Well!!... I have not discussed with the organisation yet. I did not reach that point if I go away on retirement, what will happen. I have not discussed that. It is that situation whereby I have to get another job. At the moment I do not have a guarantee that [the name of the organisation] will continue, supplying me medication or if I had to [leave or], if it comes to a situation whereby I feel I cannot go to work normally, (inaudible) allow me. But at the moment, I am doing fine, I am coming to work like any other person, you know and the office always promises that as long as I am within the organisation, I will be covered. That is the promise that they will always keep.
>
> SHIVAJI: But are you saying that they do not cover you after you retire?
>
> LEON: I am not saying that they said they do not cover me. I do not have the information. I do not know what will happen at the moment. I do not have the information at what will happen if I go, or if I decide that, look guys, I feel I am unable to come to work anymore, no I (inaudible) cover and if I had to stay home.
>
> SHIVAJI: What is your salary level now?
>
> LEON: In terms of?
>
> SHIVAJI: The amount that you get, take home.
>
> LEON: I am taking home R5 000.
>
> SHIVAJI: And that is not enough to cover for medical and food and rent and everything?
>
> LEON: Well you know, with money we always want more. I can say it is not enough to cover for all that because as an HIV positive person you know, you always have to eat healthy food, fresh vegetables every day you know, fresh fruit and vegetables, fruit juices, they come at a cost, transport, accommodation and everything else.

SHIVAJI: But if you buy vitamins and things, they will take 80% of your [expenses]?

LEON: Well it is not the vitamin; the vitamin medication is not part of the prescription.

SHIVAJI: Is that so?

LEON: Yes, they are not part of the prescription. I have to go and buy them with my own money and I cannot claim anything back.

SHIVAJI: You cannot claim on vitamin though for HIV vitamin is a minimum requirement.

LEON: Well, you know with my medical aid, the office is only covering the antiretroviral only.

SHIVAJI: And when you had pneumonia and TB they covered that.

LEON: They covered that. You know, the policy says that when you are hospitalised in whatever condition that you are, you are covered 100% but if you are an outpatient and you go for treatment, then they cover this 80% and you have to deliver 20% out of your pocket. So this is the situation, it is a condition and it has been there ... (intervenes).

SHIVAJI: Do you have an SSA contract?

LEON: No, it is a temporary fixed contract.

SHIVAJI: Temporary fixed contract for eleven months.

LEON: Yes

SHIVAJI: Then two weeks break and then again eleven months.

LEON: Eleven months.

SHIVAJI: And those two weeks, you do not get paid for.

LEON: I do not get paid for and like I was told by my [supervisor], in those two weeks I am not covered because I do not have a contract, so in that two weeks break, I am not covered. I have to make sure that I have the medication that can take me during the two weeks until I come back to the office you know, and there is never that I can see that my contract is renewable, you know, there is no way I

> am seeing that it is going to be renewed. It is a temporary fixed term. It is called a temporary fixed term contract.

Similarly, in the case of Gordon there is a partial and unclear comprehension of his medical coverage:

> SHIVAJI: Does your contract provide full medical coverage?
>
> GORDON: No.
>
> SHIVAJI: What does it provide?
>
> GORDON: My medical aid, I do not think I have one because they told me I have to pay a certain amount of money and then I have to pay the whole medical…and then they will refund me, pay me something like 80%. So I have never used my medical aid.
>
> SHIVAJI: So when you do have a medical [expense], what do you do?
>
> GORDON: When I do have?
>
> SHIVAJI: Say if you have a medical expense where you have to spend R500, you have to pay R500 anyway…
>
> GORDON: Ja.
>
> SHIVAJI: …but you do not put the bill in and recover the money?
>
> GORDON: No.
>
> SHIVAJI: Why not?
>
> GORDON: I do not know, you know ... (Shivaji intervenes)
>
> SHIVAJI: There must be something about the system which is not comfortable, which is why you are not putting in [medical] bills [for recovery]?
>
> GORDON: Because it seems it is a wrong process and then I am not sure if ever I am covered.
>
> SHIVAJI: Ja, but the others whom I have spoken to, were on medical cover, they are also on Service Contract. So, is there something in the system which makes you feel uncomfortable or difficult to actually [approach with medical issues], because, see even if you are healthy there are children who are falling sick and you know, sickness is something that we all face.

> GORDON: No there is nothing that makes me [uncomfortable], it is just because of my contract, the type of contract that I have is the one that makes me ...(Shivaji intervenes)
>
> SHIVAJI: Not claiming.
>
> GORDON: Ja".

It is pertinent to observe (from the above testimony) the degree to which Gordon has accepted the "type of contract" he is on, as absolute and unquestionable. So much so that he is not uncomfortable at being denied medical support for himself and his family.

In the case of another employee, the experience was different. Maud lost her job when her status was detected by decision makers in the organisation. Maud's experience in her words:

> MAUD: So I worked for more than six months, they would not give me the salary, so I could not continue for the seventh month. Even though they gave me a year contract, I could not continue, that is what they told me. And that is when they gave me a copy of that policy, just showing me that I could not work for more than six months. But, before [the situation came to a head] I did not know about it. They only gave it when the six months was over and I could not contest it.

Leon and Maud's cases ended very differently, one retained his job and received coverage while the other lost her job and medical coverage at a time when she needed it most. Common, however, in both Leon's and Maud's experience was the circumstance of non-transparency. In neither case was there any clarity to the staff member of either operational process or managerial motive.

Even where policies are in place, cases are sometimes managed by personnel who do not match up to the expectations of the policy. As a 'Confidential Report' (dated 17 December 2006) on the capacity of the IDO's Official Staff Physician and Sister stated,

> I felt that, generally most of the staff members were extremely [un]comfortable with the [organisation's] physician and sister but special reference was made to the [organisation's doctor] in terms of confidentiality around HIV and AIDS. I

actually had two HIV+ Staff Members who confided in me and they testified that confidentiality had been [breached] and they suffered a lot of stigma.
The Staff Members I am referring to are seemingly managing to keep their heads above water but they are concerned and would like what happened to them not to be repeated to any of the staff members in future.

Despite a stated policy on HIV, there is an acute and sometimes stridently articulated lack of faith in its implementation in the organisation. In her testimony below Patricia is unequivocal in her opinion that the organisation screens staff for HIV and uses the information to determine who they will hire and for how long. It is her impression that on the issue of contractual commitment, the most that the organisation would do for a staff member living with the virus is give him or her short term contracts.

SHIVAJI: So …how does a transparent organisation... (Patricia intervenes)

PATRICIA: …Transparent in quotation marks, underlined in bold.

SHIVAJI: How does an organisation like this actually get by with that, they are not supposed to check for HIV... (Patricia intervenes).

PATRICIA: You know when they do your blood check, obviously a full test, as well as showing what your platelet count and your white blood cell counts and blah, blah. From there they can easily see whether you are HIV positive or not.

SHIVAJI: That is true.

PATRICIA: So they have not got a line there which says HIV test, positive or negative you understand. There is nothing you can take them to court for if you had the jurisdiction, which you do not.

SHIVAJI: But do they flunk people for ... (Patricia intervenes)

PATRICIA: Please!!! We are not talking about a stupid organisation either. There will be other reasons for perhaps not hiring but like I said this is my experience. I do not know, do you know of anybody with HIV who is on a fixed terms contract?

SHIVAJI: Who did not contract it after?

PATRICIA: Well yes you know. I know of a few who are, but they are on SSA's. Most they are on SC's. SC is a renewable one [contract]…I mean anything can happen, funds can run out, you know what I mean. Funds may regenerate after a few months but yes funds can run out for the programme, then

> obviously it states on the contract that well it is renewable based on fund availability. That is what they always say, that is what is always said…there is no obligation for the organisation to provide any sort of assistance. You will read in the regulation of SSA's and SC's, people they put on short contracts, for any type of support whatsoever.

The fact that Patricia's statement, "I do not know, do you know of anybody with HIV who is on a fixed terms contract?" is not true is not as germane to the thesis as the fact that it is her impression. It suggests fears of stigma, discrimination and lack of confidentiality. The result of the emerging stigma and discrimination is a lack of confidence in the implementation of the HIV policy.

To addresses such fears as Patricia's, in May 2006, the organisation carried out a VCCT & HIV/AIDS Medical Management Programme which included Voluntary Confidential Counselling and Testing. Despite promotion of the event in the form of posters on doors and elevators, emails from senior managers, only 52.5% of staff attended. Further, while the initiative was also open to family and friends, only 2 spouses attended. Even if one were to take into account that a section of staff were either on leave or away from the office on work, the number of staff members choosing to stay away would have been significant. The cases quoted above illustrate the fears and concerns that motivated almost half the staff to stay away (Lifeworks: 2006: 2).

The HIV epidemic in the region is snowballing epidemiologically, manifesting itself across families, communities and corporations. Issues such as stigma and discrimination are not unique to any one society or corporation. Enhancing the delivery of the HIV policy and increasing the trust of the staff in it, will require a greater degree of democracy from a bureaucratic system intrinsically designed to be hierarchical. Viewed from the lens of Warren Bennis, this may not be an easy task. "[D]emocracy" according to Bennis (1993: 19)

> is a nice way of life for nice people, despite its manifold inconveniences — a kind of expensive and inefficient luxury, like owning a large medieval castle. Feelings about it are for the most part affectionate, even respectful, but a little impatient.

It is therefore critical for the bureaucracy to modify itself to address the epidemic and to bring staff and management closer together in response to the epidemic. This will require what Bennis (1993: 8) refers to as

> the secondary tasks of (1) maintaining the internal system and coordinating the 'human side of enterprise' – a process of mutual compliance [mediating the differing goals of management and staff] here called *reciprocity* and (2) adapting to and shaping the external environment [with a focus on a rapidly proliferating epidemic] – called *adaptability*.

Evident in the testimonies of staff members past and present and in the statement of policy is the concern for the effects of stigma and discrimination. It is not just a fear of stigmatization resulting in management discrimination but also self-discrimination and the discrimination of colleagues and peers. As stated in an earlier study undertaken by the researcher, "One important observation pertaining to this disqualification of PLWHA from "full social acceptance" is that human relationships are based on perceptions, not always on facts" (Bhattacharya 2003:40). In the words of Caitlin, one of the interviewees for the study:

> CAITLIN: I think that, depending on the contracts of an individual living with HIV, there is a level of insecurity so if someone is on a contract that is short term [and] that is up for review, they might be reluctant to reveal their status. I do not know that someone on a longer term contract or a more stable contract would have that same level of concern, but they might. I also think that there is a lot of fear around disclosing your status because of what peers are going to be saying and it seems to be that that is more of a fear than a fear of disclosing to a superior but again, that is just my perception. I think the thing that holds people back from testing and from disclosing their status is how their friends at work are going to treat them afterwards. I think that is more of an immediate concern [and] what your boss is going to say about it would come two steps behind.

Caitlin's testimony reflects an awareness that the stress of perceptions related to HIV and AIDS weigh heavy on the minds of staff members. As Goffman (1961) observes at a more theoretical level, the yard stick that the marginalised individuals measure themselves by is one they incorporate from the "wider society". This yard stick tends to render marginalised individuals "intimately alive" to what they perceive as others' views of their failing. This perception causes them to agree that they fall short of what really ought to be. Further, as a result of these perceptions, shame becomes a "central

possibility", arising from the individual's perception of their "attributes as being a defiling thing to possess", and one they could well do without. The bottom line of this whole process is "self-hate" and "self-derogation" engineered within the marginalised person.

Sarah in her testimony underlines the consequences of colleagues testing for their HIV status without the opportunities of receiving treatment. She felt that some colleagues might be "scared" to expose themselves to the possibility of testing positive if they were unsure of receiving treatment:

> SARAH: I think I will just speak about the medical things.
>
> SHIVAJI: Okay.
>
> SARAH: If they can involve those who don't have medical aid, I think it would be better. Because even after you get tested then you know that you are safe or otherwise. If you get tested and then at the end of the day you don't get the treatment it will be difficult. That is why maybe sometimes people get scared to go and get tested, rather dying without even knowing whether they are sick because of HIV or not. Because after you find out that you have got HIV you start thinking more.

Despite its mandate as a development organisation founded on the principles of the Human Rights Charter, Sarah's testimony suggests that sections of the management are no different from the 61% of respondents in a study on the manifestations of HIV and AIDS related stigma and discrimination in Ethiopia, Tanzania and Zambia, who said they would reject a trader or merchant with HIV (Nylablade et al 2003: 32).

Lydia (quoted below) however makes a countering point to Sarah's, she feels that people living with the virus are not necessarily "disempowered" and suggests that if the policies were adequately implemented employees living with the virus could do so openly, productively and with dignity.

> LYDIA: In terms of the fact that HIV positive people begin the process disempowered, I am not entirely in agreement with this statement. For one…the fact that the policy exists, legitimises…people who are positive. So in that sense they are not really beginning the process disempowered because the fact that the

> policy exists, empowers them. [The HIV policies] recognises them [people living with the virus] and it gives them dignity and it gives them the power to speak and to act…I do not believe that people by virtue of being positive are being discriminated. They are being discriminated because the policy is not being implemented efficiently and in its full spirit. And the policy is not being implemented efficiently and in its full spirit because the larger organisation is ignorant of all of the issues that need to be addressed for the policy to be implemented properly.

The HIV policy is a generic statement of intent with guidelines for management actions. It is left to the organisations and managers in the field to implement these policies, within the guidelines, to the fullest extent of their vision. The policy, as Lydia suggests above, is significant because it "legitimises" people living with the virus and is as such potentially empowering. Consistently, though, the hierarchical structure impedes performance and debilitates action and trust (Ness & Brechin, 1988). The social relevance of this is huge because not only is an organisation such as the United Nations measured by its visibility and intervention in the international arena but also through its moral integrity in upholding the values of the individual societies (and communities) that it seeks to serve (See Aldrich, 2001).

4.5 Organisational preparedness: Struggling to keep up with a galloping epidemic

An important subtext of the analysis is the fact that senior managers and decision makers within international development organisations are usually international staff members who are routinely transferred to other assignments in other countries. This transient status, of senior staff members at the United Nations who are posted on rotational assignments, would imply that, "top managers [could] lack much of the knowledge" (Donaldson 2001: 37) of local conditions, needs and sensitivities that need to advise their decisions. The findings are nuanced with regard to staff and management orientation and on structural efficiencies as they relate to the implementation of policy.

This sub-section of the findings is a lengthy one, since the research probes issues of management orientation and structural efficiencies to get to the basis of the decisions and actions of managers and staff, namely the beliefs and information they hold vis-à-vis the HIV and AIDS epidemic and the policies that they implement and experience within the reciprocally inter-reliant structure of a bureaucracy.

The manager's insight into management practices and strategies of engagement goes a long way towards determining organisational preparedness to deliver on the implementation of policy. Below is a part of the conversation with a very senior member of the organisation in the country.

> SHIVAJI: Let me try to get into the mind of the bureaucrat.
>
> SHAUN: Yes.
>
> SHIVAJI: When I come to you for a sanction that is urgent and I push you to push the system to give it to me, can you stick your neck out more than mine to give me that [sanction] so that I can do it [the project]?
>
> SHAUN: Yes.
>
> SHIVAJI: So for me then the ground is connected. Ten years later I am sitting on your head in New York and I am not giving you the same sanctions that I am advocating to you for today. Why? I am trying to get into the head of the bureaucrat.
>
> SHAUN: Yes. The bureaucrat is an individual - to start with. The bureaucrat is a mentality, the bureaucrat is a system and the bureaucrat is an accumulation of things done in a certain way that, so the bureaucrat is these various things in people. Sometimes it is difficult to pin him down, it down, them down and these things down and therefore make the changes I would need to make happen.
> Now when the bureaucrat is a person, the bureaucrat dances to what they perceive as the changing tunes. Sometimes the tunes are really changing and so they modify their dance step. Sometimes the tunes are not changing and they still think that it might and they modify their dance step… because they think they want to pre-empt … the tune change.
> And so you see the bureaucrat is a person who wants very much to dance to the external tunes and not dance sufficiently to the internal tunes that should come from them as people. These internal tunes establish consistencies that make one more principled. We are all a combination of principles because of what we believe in, but also try to obey what the system has for us. So the more one is

NOT listening (if one is not listening to enough of good internal tunes that guide the person) the person then basically shuffles a lot because they are trying to imagine … what … tune to dance to. Sometimes you can hear two or three different tunes and you lose your dance step because you really do not know which tune to dance to. , And so the bureaucrats you find [when] new, you then begin to think are complete different individuals. Year one and then year two, and you wonder: but isn't that the same guy who.... [laughing].
If people can learn to listen to internal tunes and voices that is the principle by which [people] do their work of leadership, their work of managing and their work of delivering results and so on. External tunes often have to be checked against the internal consistency…..

SHIVAJI: What are some of those distracting external tunes?

SHAUN: There are those that come from surprise (indistinct) quarters, so the persons begin to say, Oops!!! Maybe this is what X person would like to hear, like to see, like to have. And so … there are lots of people who have very sleepless nights guessing what kinds of tunes he is going to be singing. Is it a tango, is it the cha-cha, is it this? ….

SHIVAJI: Ready to change and make the cha-cha look like a tango?

SHAUN: Yes. So that is one from those who are supervising. The other tunes come from the peers, colleagues. Colleagues do have extraordinary influence on people who are in search of external tunes. These colleagues exert pressure on the system tunes by what they say, what they ask, and what they rumour around. So people again who do not have enough internal strong values and tunes to guide them, very quickly, will be out searching for people to hear, to ask and get questions: what do you think about this? What do you think is the best thing? So people placed in that situation start giving them the personal (indistinct) into this thing because they think, if X person said this and X person knows Y person who is related to the new Administrator [global head of the organisation] then maybe I'd better dance closer to that tune because this might be the defining tune in six months to come or three months to come.
And then the other external tunes, that is a more understandable situation. They come from the system itself. I have met good people so far somewhere along the line, and I [have] also [met people who] leave some scars. The rate at which people can deal with scars differs…. Some people can make scars disappear quickly and some people may not be able to make scars disappear easily and therefore, as the saying goes: when you have been bitten by a snake once, when you see a worm you will run. I mean you will run as fast as you can. [Laughter]. You do not want to stay by because it could have been a snake. You do not have the time to see whether it is really a snake or just a worm, you just remember and you want to disappear away as fast as you can.
So if the system has quite often sometimes wrongly handled good people in a bad way, that can leave scars and make the people then, for survival purposes want to

> dance or in search of what (indistinct) the external tune to dance to. So, not that people are bad themselves, but they are sort of suffering from what the system has put them through, has caused them. So these are some of the ... (intervenes)
>
> SHIVAJI: So that means in essence, therefore what I am seeing is that the politics of an action is more important than the product of the action itself, which is why people are looking for the tune long before someone starts playing it?
>
> SHAUN: Okay. Yes, depending on whom, yes, that can certainly be said and I would not disagree with that. But that is applicable depending on who is judging. There are people to whom the politics or the action definitely, the politics of the action, the politics of the approach weighs fairly heavily, it is rated very highly, it is very important and therefore the product of the action and the timeliness of the product of the action become probably not as important to some people. They would never say so, never going to be caught on record as implying so, but you can then picture (indistinct) everything … about their approaches.
> So they ask the questions in organisation where that (indistinct). There are also situations in the organisation where the value of action, of good action, of timely action which cardinally we will define as effective action leading to good results… had not been adopted as the driving force on a day to day basis by people.

In the section quoted above, Shaun (a senior manager in the organisation) candidly accepts that the politics of managers taking particular decisions “weighs fairly heavy” on the organisation. These decisions, often taken for reasons of political and programmatic expediency, in turn determine the course of action these managers direct for the organisation, corroborating the criticality of human agency. An important point to take note of is the view that managers would never accept that they are driven by the politics of an action over the spirit and letter of the policy they are charged to implement. Shaun is clear that the actions of managers depend on the managers themselves. In his opinion the actions of different managers in similar situations would differ from person to person.

In the subsequent testimonial Shaun dwells on the question of arousing the organisation and the managers, who are driven by the politics of their actions rather than the letter of the policy, into responding more constructively to the epidemic in the workplace, when he enquires:

> SHAUN: How do we prick the organisation’s soul so that it hurts and so that the organisation fears in the way … people who are infected fear and worry?

> And this is probably going to be the one challenge that we need to find an entry point of something, because the challenge that you would find in organisations, international ones, but given at a level of organisations at the country level, whether it be the ministry of Education, the Ministry of the private sector and so on and so forth. If one can find where to prick those organisations souls, and steer them with the fears that the normal person infected, or as a person infected fears. The normal worries, the normal agony.
> And on the pandemic we need to be able to do that. We have grown up in systems to be complacent because we keep looking as we are. We should start by helping other people move out of trouble. That trouble today could be poverty, yesterday was poverty, today is HIV/AIDS and so on. We need to be able to define the organisations and systems involved in the HIV/AIDS. You can prick and you find that the organisation does have a soul. Now, if one moves from that sort of philosophical visioning to say, in pragmatic terms, how does one do that, how does one prick an organisation's soul? How does one find if the organisation has a soul that can be made attentive to the pandemic? How does one then view an organisation with a soul so that its level of empathy with the pandemic and its effects can be much dreaded?
> Those are the things that probably shape the next horizon of work for all of us who are involved in promoting (indistinct) to combat the pandemic. How do you prick an organisation's soul, if one exists? The kind of sensitisation that we do with outside groups or country level groups, it is easier to handle because these groups are sort of willing buyers and consumer…. But there needs to be a ground level sensitisation upwards, towards the corporate levels of the organisation.

I have quoted the conversation with Shaun extensively, as he has an intimate knowledge of the bureaucracy and the nature of the bureaucrat. In the above quote he outlines the rigidities of the bureaucratic mind when he argues that "the bureaucrat is an accumulation of things done in a certain way".

Yet, in the same testimony Shaun goes on to highlight the flexibility and judgemental aspect of the bureaucrat's personality and scope of operation when he asserts the view that, "the bureaucrat[s] dance… to what they perceive as … changing tunes" with the clear ability and flexibility to "modify their dance steps" when the need arises. This brings to the management equation the aspect of human agency, which serves as a corrective to Weber's description of the bureaucratic machine and the impossibility of individual managerial initiative to circumvent official routines or reconstruct habitual activities (Weber, 1946; 1968)

In the above discussion with Shaun the role of human agency is quite clear and the course of action charted by managers in the implementation of policy differs from person to person. However, it begs the question, "What is the role of the organisation in this equation?" Clearly the inclination of select managers to play in synchronicity with the "politics" of a situation and to "modify their dance steps" to maintain stride with what they perceive as the "changing tunes" within the bureaucracy directs our attention to the environment within the organisation…an environment that may induce such views, decisions and actions from select managers.

> SHIVAJI: But are we putting progressive managers in place? Are we looking at it? Are we picking up the signals?
>
> SHAUN: Some of the signals have been picked up but probably not by enough people and not with enough speed. Sometimes the damage is done because of the slowness by which the system picks up the signals that things are not moving well. It is not an easy issue because the organisation has a whole range of different individuals and styles. There have been various attempts to have leadership and a managerial training programme in the [organisation]. The last corporate organised training that was run for quite a number of years came to an end in, I think 1996 or 1997. For about five to seven years there was training of managers at the middle to senior levels that was organised, and that did help.
> But for a big organisation like this, it … has to be a running programme because it allows people to come in and go through the kind of self examination in a corporate training environment, which forces them to understand the impact of their own actions. Some of which may be parochially [narrowly restricted in scope] defined, some of which may be good, but it allows for regular examination and benefiting from discussion and exchanging ideas in a training environment.
> A number of [managers] have been a facilitator on one of those [training sessions], participated in the first one and then facilitated one or two and I think we need to go more in that direction.
> The other thing which …. is also important is the pressure that the [organisation] is going to face more and more from the third world countries, from the developing countries, the partners. And so the [organisation] is going to be expected to shape up and deliver more and better than that expectation, when it begins to come as it is coming now from the development countries is going to be a powerful defining force and wholly show the relevance of the [organisation].

The conversation with Shaun demonstrates the veiled and metaphoric approach to answering questions. A question pertaining to the duplicity of perspective is acknowledged only through the metaphor of tunes, dancing, music and inner voices. But it seems clear that both the knowledge and the motivation to implement HIV policies are

low, despite their stated mandate. Shaun also gives the impression of management jobs being driven by fear and leaving scars that make professions less spontaneous. None of these features are good indications of preparedness to execute HIV policies in the organisation as it may inhibit bold actions.

On the subject of preparedness, Seamus and Dean take the view that conflicting commitments and constraints at the financial and human resources level have been partly responsible for the ineffective implementation of the HIV and AIDS Workplace Policy, leaving, what Seamus refers to as, “a huge void”.

> SHIVAJI: To what do you attribute this lack of engagement from the institution’s side, I am more interested in what the institution is doing or not doing towards making this particular policy visible?

> SEAMUS: Now the other area where I think there is a huge void is in terms of human resources. The workplace programme has not been a priority at all at the [name of the organisation]. And human resources insofar as getting contracts signed, insofar as administrative details - certainly, when it comes to publicising the HIV/AIDS in the workplace policy - I feel like that has been a void and continues to be one, actually.

Dean’s testimonial was as follows:

> SHIVAJI: Okay. To get back to HIV and AIDS and medical coverage issue, why is it that organisations which pay salaries like that, do not want to go into medical coverage? Why do you think organisations resist it?

> DEAN: I am not really sure but I think it is very costly. Because I know most of the companies are paying 50% of it [medical expenses] and I mean these days if you go private you can say R2 000 for a family of three. I mean if they had to pay out 50% of it, it is R1 000 from there. I think that is where the story comes from. They, I do not know if they do not want to or if they do not think there is enough money in the company to do something, I do not know. It is actually very strange because [name of organisation] is a very, very big company.

Rosa corroborates Dean’s and Seamus’s thought with the observation that it is always tougher to practice a principle than preach it and the organisation appears better at preaching.

> SHIVAJI: We are in the midst of an epidemic that has been around for over two decades and the [Name of the organisation] and other development organisations have been in forefront of trying to support its clients, other governments on HIV and AIDS.
> How is it in international development organisation whose prime mandate is Human Rights and Development, that we should, with all good intentions, still be lagging so far behind [in our implementation of workplace HIV programmes]?
>
> ROSA: I think internalising something is much more difficult than just preaching. So we are good at pointing fingers and starting new things and trying to facilitate the process with others, without feeling [or] looking into their own situation. This is not only for HIV; this is for any other too.

While it is important in this study not to brush the implications of duplicity and fear under the carpet, it is simultaneously critical to keep in mind the fact that the above quote is a single person's opinion, albeit a senior and globally experienced staff member. It is also vital to take into consideration the fact that the sample size of managers in one organisation is not large enough to table their views as global, universal and all encompassing in the system. However, various conversations among the interviewees do corroborate Shaun's opinion. Like for example Phillip, when he states, "…my confidence in the implementation of the policy is not too high" or Patricia, when she says, "In fact point someone out to me who is HIV infected with a fixed term contract and, quite frankly, I will fall down dead" or Mona who feels that once a person moves on from his or her assignment, "another person comes, everything changes and there is no continuity in the development that would have been started" by the previous incumbent of the job.

Phillip, quoted below, is (as already stated) a senior officer of the organisation. His experience while similar to Shaun's in some respects is nuanced in its differences. He feels that his experience at the headquarters in New York was positive. He also feels policies were well implemented there and any violation would have been unacceptable to senior managers. He however agrees with Shaun in the view that the policies are not fully implemented in the office in which the study is located and accepts the possibility that the implementation of HIV and AIDS policies may be weak in other offices out in the field.

> SHIVAJI: Are you aware of an HIV and AIDS policy in your workplace?

PHILLIP: Yes.

SHIVAJI: To what extent do you feel that the policy is fully implemented?

PHILLIP: I think the problem is that we have a lot of different locations in [the organisation] therefore the degree of implementation of any of the policies is it is going to be very much dependent on these localities. The two duty stations that I have been in, for a long period of time, I see very big differences. In New York I think there was a fairly high degree of awareness, there were a lot of communications that was sent out. My general impression there is that the policy is being communicated and that any violations of the policies would not be acceptable to senior managers. In my current duty station I am less convinced. While I think on the surface there is a lot of stuff happening that speaks to the spirit of the policy in terms of making it visible, making it understood, the people have certain rights. That they have access to drugs, to treatment and tests and so on, that all of that is in place. There is some underlying aspect that I feel is missing here.

It is kind of being put in place as an order, not as a live conviction. So I see these two differences just between these two duty stations, which leads me to believe that in other duty stations it has probably got to be even worse. That implementation of the policy like so many other policies that we have in [the organisation] might be even more spotty. So my confidence in the implementation of the policy is not too high.

SHIVAJI: What would you ascribe that to? So that means, from what you are saying, the policy is not a mandate that is complete in itself but it is left to the interpretation of managers as it flows out?

PHILLIP: I think there are two big differences, one is I think the policy very much tries to do two things. One is putting in place certain regulations and rules on how within the [organisation] workplace HIV and AIDS issues need to be addressed. In as much as they affect staff, in as much as they affect our office environment, in as much as they affect our work … and how we are expected to react as international civil servants, to discrimination issues, to issues of HIV AIDS.

So I think there is this one prong in the policy that very much tries to put very cut and dry rules and regulations in place that are standards for human resources in particular on non discrimination, on access to treatment and so on and so forth. There is a second element in the policy. Which to me looks much more like an awareness in trying to promote culture change. By definition that is not a mandatory element, it is almost an appeal to staff that as part of a larger family within the [organisation] that is separate from the culture and the environment that they might feel themselves in, in their everyday life.

There is a separate identity that needs to be adhered to as sub standards that although in your country certain issues might be acceptable in terms of behaviour, there might be certain laws in place when you step into the office environment there is a different code of conduct almost that has to apply. But this is an attempt at promoting culture change, it is therefore very much left to country offices to implement that because they will face various degrees and levels of complication *vis-à-vis* taboos in the offices in terms of sexual behaviour.
So there is one element that I feel is very much trying to do this establishment of rules and procedures, norms and those are enforceable. While the second part of the policies are not enforceable and therefore it is very much left up to individuals and individual country office environment to foster that kind of an environment.

SHIVAJI: How have you found managers and decision makers at these country offices interpreting these policies? They could go biased towards rights based perspectives; some could go by the rule of the books in some cases. Personal prejudices might come into play and decide how to interpret it. So how do you find the managers by and large interpreting the policies?

PHILLIP: There are three offices in particular that I have worked in for a long period of time. Two were in New York [and] one was obviously here in South Africa. The feeling I got in New York was that managers first and foremost were extremely supportive, not just as a letter of the law. Which was almost a no nonsense issue for them. The fact that you could not discriminate against a person based on the HIV status was not even worth a thought to them. This was something that was completely clear to them. But they actually I felt very much went the extra mile in trying to create an office environment where people would feel comfortable approaching a manager and saying look I have a problem.
I have a problem with my health, I have a problem with a family member and I believe that in those two cases the managers would have done anything within their power to accommodate such a person. In my current office environment I am sure that people would try to adhere to the letter of the law but I do not think they would go necessarily an extra step. It is a very different culture here from what I have seen in my other two offices. To a certain extent what it requires is a certain team spirit. You are able to free up a person because there is a common understanding that there will be others who are part of the team who will chip in, who will take over certain functions that otherwise would be that persons responsibilities. Here I do not think we have that.

For two reasons, one is in a lot of functions there is only one person. If that person is not here, is not able to perform the function is not going to get done. Second we do not have this kind of team spirit here yet. This might be partially due to the fact that we are a young entity and the people still have more allegiance and more in common with the original units or teams than they necessarily have as an office team [here]. So I am not convinced in how far it would work here if somebody who actually knows [his/her status] would go to a manager and say, look I have a

health problem and I need to take care of this and I can only work part time. I do not think this would fly.

Phillip's opinion that the organisation lacks "team spirit" both corroborates and explains Shaun's view that managers dance to their perceptions of changing tunes in the organisational environment. Boris (quoted below) corroborates Phillip and Shaun's sentiment by highlighting the thought that managers do not have the necessary incentive to step up to the plate and implement the HIV and AIDS policy.

SHIVAJI: What kind of incentive would managers need to, to put it up on the agenda priorities?

BORIS: For me again there are two things. One would be that managers would need to generate the kind of commitment that says that HIV/AIDS is a different kind of epidemic; it is a complex epidemic that should be explored in its entirety, including access to treatment. That has not been done. That is one. Two, I think that in this organisation, after talking to a few people, I have just realised that people do not want to put emphasis on HIV/AIDS because HIV/AIDS is, [an illness people stigmatise and avoid engaging].

Why do you not leave it for people to talk and deal with it just like any other [illness]? When somebody has a heart disease or diabetes or whatever, he [or she] is not singled out, so I have spoken to a few people where people are still grappling with why the need, the why of making HIV AIDS treatment high on the agenda. I do not think [the issues have] been firmly discussed and understood. Again the whole idea of the amount of impact of HIV/AIDS on the organisation, has not been well documented. It has not been well argued and it is not seen [as important], so why do we have to you know? I have always held the view that unless there is a very compelling evidence given to people who outline some of these policies [no progress on the policy implementation front can be envisaged]. Whatever has been advocated for outside [the organisation] in the work we do, needs also to be advocated for and unless that is done (intervenes)...

SHIVAJI: It is not done enough?

BORIS: I do not think so. I do not think it is done enough. I [do not] think that there has been compelling evidence, studies or some basic analysis within the organisation to compel us to do it. I have not seen it.

SHIVAJI: What will your clients, the governments that you advise, say if they knew that the same advice that has been given to them, is not fully implemented in the adviser's [own] organisation?

BORIS: Oh, that is exactly a part of the dilemma we face. What I usually do is that I give [our organisation] as an example. I let people know that it is not an easy task because in my own organisation I do not think if we had done enough. We have written out a policy very well, yet we would still have 30, 40, 50% of our people saying they would not want to work with people who are infected with HIV. If we had done enough we would not have our own staff who are not on any treatment, you know. We would not be seeing people at country level dying because of fear of the other people even knowing that they are positive.

Focusing purely on the organisational management in an attempt to assess organisational preparedness undermines the influences of emergent social groups within divisions of the organisation, in other words, the strength and potentialities of staff networks within the office. When the rhythm of organisational systems face new challenges, in rapidly transforming international environments, they should be encouraged to struggle through their dilemmas, to adapt, and to harmonise the demands of the external environment with that of the internal challenges (Keidel, 1994; Perrow, 1970). Gwen talks about the staff members mobilizing around a person living with HIV in the organisation, whom the organisation itself felt constrained to help:

SHIVAJI: And the system does not gear itself to help them?

GWEN: No. Because … we have even some people who will be sick, who want to go to the doctors every day for check up and they cannot afford to go to the doctors. So you know that is when people chip in and contribute so that the person can go to the doctor and get better treatment.

SHIVAJI: So, you are saying that, the staff members rally around and raise money for this but the organisation does not.

GWEN: Yes. No.

SHIVAJI: Could you give me an example?

GWEN: Any way, I am not going to ... (intervenes)

SHIVAJI: Take names...

GWEN: Ja, but anyway we have actually contributed for one person who was sick the other time. The person actually [could not] stand and she could not even afford [treatment]. And the situation was bad that you know she could not go for [treatment]. Of course she could go to the government hospitals, but at that stage

it was a bit late for her to go to the government hospital or stand in the cue because of the situation.

So we decided to contribute and raise some funds. In fact one person actually volunteered and took the person to the hospital and the next visit they wanted some money. She did not have money so we had to contribute and buy the drugs as well.

SHIVAJI: For an HIV related issue?

GWEN: Ja, and by then we did not even know so if the organisation had set itself right then, and we had all these visitors centre at our workplace, it was going to be of assistance.

And we had one situation where this person, the other person was even bitter, you know, really needed some counselling but you know it takes time for one to open up until they are confident with someone.

SHIVAJI: Can you tell me about any situation that you have been involved in directly where you had a similar problem and the organisation has not stepped out to help.

GWEN: Ja, like this particular case.

SHIVAJI: You were involved?

GWEN: Ja, I was involved in contributing and...

SHIVAJI: And how many people contributed, how many people was the offer made to and how many contributed?

GWEN: You know it was actually the people who are just close to each other. We did not want to do it because we did not know how the other people would feel, you know if you go and ask for a donation. So we just say to those who are just close by let us just assist each other.

Rather than a tendency viewed as oppositional to management apathy, some see the emergence of networks as a crucial systemic response, that is, as social action forging opportunities for self-organisation and co-operation, rather than competition or subordination (as might be the norm in most large scale organisations) (Stacey, 1996). The conversation below with Phillip on staff networks of support yields an intriguing contradiction between the generosity of personal intervention vis-à-vis and the detached distance of official action.

SHIVAJI: In some of my conversations with people I have interviewed, I have seen that there is a certain community support network that informally kicks in among individual staff members who may back people up and support them in situations of crisis. Where when they have come to the larger more formal organisation that kind of sensitivity and support does not exist. Are you aware of such a phenomenon? And if it exists then why would it be so? This is a development organisation with a development and rights based mandate, yet some of the sensitivities that you see in individual people, you do not see in them once they...(intervenes)

PHILLIP: Once they step into their official functions?

SHIVAJI: Yes. Yet their function is not selling soaps and tooth pastes, their function is human development?

PHILLIP: I have seen it not necessarily related to HIV AIDS issues. But definitely to other policy areas where people have formed in their minds a distinction between … how they would as an individual respond to a certain situation versus what they are going to do in their official capacity.
Why would that be so? The only thing that comes to my mind right off the top of my head is an old proverb, where you sit is where you stand. People tend to take on convictions based on the responsibilities that they are put into regardless of what their personal convictions are. They suddenly take on a lower rank *vis-a-vis* what they perceive to be the important considerations of their function or of their job.

I do not think it is a good explanation and I do not know why people would do it and to what extent people are doing it, but if they are doing it I think it is to a large extent it is also a question of insecurity. People do not necessarily feel that they can take a strong stand on an issue unless they feel that your organisation is backing them up. So for example [people avoid] reporting sexual harassment, unless they feel firmly secure that the organisation is going to back them up. To file a claim regardless of what the merits of the case are, but that you have rights to get this reviewed without any further judgment on you as a person filing this claim… then you are not going do it. I think it is very similar to reporting a case of HIV AIDS.

Unless people feel that their organisation would support them institutionally. Also recognise that it is important that staff support people living with the virus or who are affected in some way or shaped by HIV AIDS, then they would not do it. I think that is an area where we are very weak; this in general would be called social courage. *We are not an organisation with social courage*. It is not something that is very strong with our values and I think that is exactly what you need.

> This [*social courage*] creates more obligations for the organisation to actually recognise a problem; the organisation is not going to do it by itself. It is usually because there is a core group of people who push this issue and show that there is a moral obligation of the organisation through their individual actions. Again I think the only cases where we have gone that route was because others outside of the system have done it before us. It is not because we ourselves have done it.

Phillip's perspective on the importance of *social courage* within an organisation is a critical opinion to review. Phillip feels that the *social courage* to recognise problems and make changes is an important characteristic for a rights based organisation such as the United Nations. He is also clear in his opinion that the cast of characters who would drive this courage are individuals with commitment. To my mind this commitment or social courage is a factor of orientation and can be instilled in the system and among managers and staff through suitably focussed interventions.

One organisational inhibitor to the staff's ability to mobilize is the absence of staff morale and a belief that staff members matter to the organisation. Morale is particularly important in a development organisation like the UN, where staff members are its greatest asset. Judy, a staff member with 7-8 years experience in the organisation and the experience of having worked both in a Human Resources function and as an HIV and AIDS specialist had the following to say:

> SHIVAJI: how aware are you of the HIV and AIDS policy that the organisation has?
>
> JUDY: I have read it but not really owned it as such. I have read it out of curiosity because of my former background in HR and also because of my studies, but not owned it because I have seen it is exclusive. It does not include me that much because of the type of contract I have. So I did not really get time to familiarise myself with it because I know it is not very useful to me.
>
> SHIVAJI: So tell me, about this contract issue, since you bring up the issue of the contract, let us deal with that. There are different sets of people doing similar work but with different contracts. Okay.
> Now, why is it necessary for the organisation to have two different people doing similar work for the same duration of the day, same duration in the month and year to get a different contract? How does it help the organisation? What are [they] thinking?

JUDY: For me I think … it is not a very well informed decision and I see it as a flaw in the HR management and if one counts even the side effects of that, I think it will cost much more than having aligned and proper contracts and same rights amongst the staff.
So I do not think the organisation takes time to really look at itself and look at the rules that they have; how it is affecting delivery and how it is affecting the whole organisational behaviour of the staff. It is, in one part negligence, in another part I think is also lack of knowledge and lack of proper study of the impact of the difference in contracts.
I do not agree that it is maybe serving anything to the organisation. I think rather it takes something away from the organisation.

SHIVAJI: Okay fine. And tell me what, I mean why, what in the culture of the organisation, or the structure of the bureaucracy of the organisation that you are in? What is it that is leading to this perspective [that] you are calling a short sighted perspective? What is leading to that?

JUDY: It is two things. First of all because it is a *bureaucratic organisation* but it has *become too heavy*. Normally bureaucratic organisations are very well structured and most of the time rules and procedures are really entrenched in the culture of the organisation but in our organisation I think it has become heavy and there is something of a distance because the HR is not as decentralised as it should be. There are those who make policies and rules who are sitting in one place and those who are implementing them are sitting here. I assume the person seated somewhere in Denmark ... does not know what I am feeling [seated here] with my [short term] service contract. Yet the person who is, [on an] SSA [contract], and the person who is managing [that] SSA contract has no power [to] change the policy directing [them].
So, there is a problem of physical distance and a problem of lack of empowerment of the decentralised body ... to ... give informed decisions. So I think for me, that is what I think because it is unlike bureaucratic organisations. Because normally bureaucratic organisations are some of the best in terms of rules and policies and things like that but that we are not having that in [this organisation]. Yet we are a bureaucratic organisation in other, all other types of aspects of ... (intervenes)

SHIVAJI: And what do you think is the [reason] for the organisation's lack of evolution up the bureaucratic structure and what do you ascribe it to?

JUDY: You find that most of our HR managers at least at a decentralised level are still [the] very old school type of HR managers...
If I may give an example, actually when I started in the [organisation] I was very attracted by HR as a field so I entered that. And at the same time I was doing the work but studying as well. So I wanted to apply what I was studying as HR cutting edge technology into my [work and met with] terrible resistance. I had to quit on HR. That is how I left the HR because I did not agree with how...

> One of the last things that made me leave the field was that I was advocating for a staff development component of the HR that would go hand in hand with the appraisal component and I have done the needs assessment, I had checked, interviewed staff, done the profile of staff and looked at it and did the proposal that was rejected and the reason being that the HR manager at that time could not understand what I was talking about.
> So most of the time in the [organisation] people get to where they get just because of the many years they have spent in the field. Maybe this person does not even have the qualifications that are needed to be there. Today HR managers in other companies, especially like in [the] corporate [world], you find that there are people that are very well thought of and who are keeping updates of how the field is moving and because that they have known now that the asset of an organisation is people versus anything else, they invest in that field and [in this organisation it] is not the same.
> You find that actually people move into the administration and HR field for I do not know, maybe I do not want to be insulting but in the way it is the most secure and easier and more routine type of field, most of the time. *And so that you find that you have people who are not innovative enough to look at how to empower the [organisation].* That is why we miss, for me I am convinced that productivity we have could be much, much better just by the changing of the HR consideration of the [organisation].
>
> SHIVAJI: So you do not think that people are at the top of the agenda.
>
> JUDY: For me I do not think people are the top of the agenda. Actually, the people in the [organisation] are at the bottom of the agenda. I think everything else is at the top. *First of all there is pleasing the donor, second pleasing our stakeholders, third, pleasing all forces that are pulling left, right and centre but the people in the [organisation] are at the bottom.* That I think, I do not know if I am mistaken, but the few years that I have spent in this organisation, I have seen that it is not an organisation that takes care of its people.
>
> Yes, we have the best, some of the best salaries. That is not the issue. We have maybe some of the best, even work in terms of content and the agenda, but then the well being of the staff goes beyond that. I think the well being of the staff is about management showing its staff that it cares and that is not in the UN.

Judy implies that both inertia and vested interest drive management actions when she refers to a “heavy” bureaucracy where senior personnel are un-innovative and overtly focussed on “pleasing the donor” rather than empowering their own staff. Mona concurs, but also finds the organisation ill-equipped to fully implement the policy, despite the presence of select committed individuals. Thus, Donaldson’s (2001) argument that the mechanics of (centralised, bureaucratically dense) organisations are overwhelming, is

relevant here – at particular historical moments such a structure and its concomitant culture becomes psychologically debilitating for subordinates, creating dependence and distress.

> SHIVAJI: So you work across [Name of Organisation] offices implementing the programme. Now what do you see or find by way of organisational coping mechanism to deal with an epidemic of this sort, because it has now reached a level where [it has] start[ed]… affecting our workplace and environment around us? How do you find the organisation coping with it? What shocks do they appear to feel and how do they cope with it?
>
> MONA: The first shock that I see is that they are losing manpower, human resources, people are dying and people are getting sick. People are not able to cope with what they need to do and some are stressed. I see that in some countries even the supervisors themselves get too stressed and there is nothing in place so far to deal with stress related to HIV and AIDS bereavement. If you lose three employees in your offices in one year it is already too much for one supervisor. I think there are also, I have experienced country offices which have become bankrupt and would have to ask for extra money from the head office, because they have been giving money to temporary services, temporary employees because their own employees are sick. There is a need to start multi-skilling people. To also start helping the employees to understand why it should be that they should multi-skill. I know that there are also companies that have come to a stage where people are working a few days a week so that they cover for the other. So, and in a bureaucratic set up, maybe that would take ages to happen.
>
> SHIVAJI: What skills do they need?
>
> MONA: Multi-skilled person.
>
> SHIVAJI: Oh multi-skilled person.
>
> MONA: One who can do this and the other.
>
> SHIVAJI: Just quickly give me an idea of the various levels of hierarchy that a particular approval has to go through before a contract is finalised or a bill is paid. Just to get a sense of the hierarchies and on an average what kind of time it takes?
>
> MONA: Well I can talk of a renewal of an SSA contract. My contract almost took three months to be renewed and personally as a person living with HIV I felt like I am being let down by [the] organisation. If they still needed my services, I felt like then they should have been quick. I did get supervisors, who had empathy to the whole situation, but again I did not feel then that it was one man’s problem to have to make me be there.

> *I just felt that this is a bureaucracy that is taking a lot of time. If I were to die, I could have died because then I was in hospital, there was no money and all those things*. Contracts should not take too much time to be renewed. That is another process that I know has been experienced not only by me but by other people also and not only by people living with HIV but by people that are just employees who are also negative.
> But, especially in my case, *I feel sometimes I am not walking the talk, because I work for an organisation which preaches access to treatment [yet] the organisation is not even giving me access to treatment.*

Mona's predicament in this testimonial was that, as a professional working to help implement the policy in the workplace she had to represent and explain the organisation's policy and position on HIV issues such as access to treatment. Her quandary lay in the fact that she herself was a short term contract holder for about three years with no access to medical aid and has had to rely on the personal financial support of select colleagues.

> MONA (continues): Again this is where again the individual supervisor comes in, because I have had supervisors who have come in on their own personal basis. One [supervisor] actually said, 'Okay we [shall] add so much to your salary so that we cover medical expenses'. This is not policy, it was somebody who just thought, if the situation is like this then the best thing to do is [attempt to respond to it in whatever way possible]. I have had supervisors who would say how are you feeling? What do you need? And would be there for me in terms of saying financially I can be there.
> I have had supervisors who would give me time to heal so and again this was NOT organisation [al policy]. It was individuals and my experience has been even with the individual employees who are not supervisors, whatever came from as a response to my situation was more individual than it was organisational.
> *I think there is need for an organisational approach to HIV*. For me if it was linked to this programme then there would be a data base, so and so is not well. As an organisation this is what we do. That did not seem to be there except again from individual people that would say, "What can I do for you?" And for me for any organisation to have productive people, I did find one supervisor who treated HIV as a business issue. For me I thought like the supervisor knows that if this person has got to be productive then this person must have 1, 2, 3 done. I was conscious of what was going on and the aim was not only for the person to be healed but for the person to be able to continue working and be productive for the organisation.
>
> SHIVAJI: So tell me these individuals who have taken these positive steps have they had to bend the system and tweak the rules a little and reinterpret it or stretch them or even break them to increase their support to the healing, to increase their support to the productivity?

MONA: Yes ... they did because what I found was that again it was mostly from a personal point of view so they had at times to bend the rules.

SHIVAJI: So that means the implication would be that the rules themselves are not enlightened or broad enough to be able to support his kind of a process... That means the rules sound like they have been rigid and cast too tight?

MONA: Yes… it is not good enough because there was need to bend rules and to hide some things and to say them in a certain way in order to make an impression on the others [who would] also concede to the decision.

SHIVAJI: What are some of these rules?

MONA: I think some of the rules were for example that, depending on the type of contract one has, one has to wait for four months before the contract is renewed. So one of the supervisors felt like if a person has to wait for that long how does the person live in terms of other responsibilities that the person has. Rent, just the upkeep of life, *so in such a case the supervisor had to use my [HIV] status to say this is where we are and from a humanitarian point of please just make sure this happens.*
I also think that the organisation employs people that are living with HIV and in my case they know my status and I think because they know my status in terms of skills the organisation should not feel like they are taking me because I do not have a skill but I have HIV. But that if they want me, [they] must make sure [that they] train me so that I get the necessary skills to make an impact in the organisation.

Mona sees the organisation going through stresses due to HIV at close quarters, from staff and colleagues who approach her and confide in her. Much of her own stress is heightened by her exposure to the confidential revelations of staff members and colleagues. Further, she seems to second guess the organisation on the issue of her own job. She is conflicted about whether the organisation has her on board because it truly needs her or whether her presence in the organisation is a token one (because she is only given short term assignments with no permanence or contractual stability). Mona is alive to the possibility that she is on board to establish respect and openness towards people living with the virus and to give the impression of a comprehensive implementation of the HIV and AIDS policy in the workplace. Nonetheless, she also refers to the humaneness and caring demonstrated by select supervisors, who have attempted to make allowances within the system to accommodate her needs as a person living with the virus.

If one reviews Mona's testimony (above) alongside Maud's testimony (earlier) one views two different types of managers in the same organisation. One interpreted the rule book to support Mona while the other's interpretation of the rule book cost Maud her job. These contrasting testimonies underscore my fundamental finding, that the extent to which the HIV policy is implemented in the workplace relates more to the interpretations and decisions of managers than to the dictates of policy.

> MONA: That is one example I can give. The other examples I can give of also people that are living with HIV in terms again of contracts. While one feels that I have not been discriminated and I have an input, I have something to add to the workplace. A lot of people that are living with HIV have felt used and a lot have never felt open enough to disclose their status in the workplace because of not being sure about the confidentiality.
> Of not being sure about stigma and of not been sure about how they would be treated. Hence it sounds like confidentiality is there when in fact it is more about people being afraid to air their views around HIV. I have, in my work I have counselled very high profile people that would talk freely to me about their status or about what is going on in terms of HIV in their homes. [And others who] would not be free, [who] would … stigmatise me because they do not want to be seen talking to me in the open because everybody they know would suspect that perhaps it is about their status that we are talking about. That type of stigma I have felt in this organisation and in the other organisations I have worked in where people stigmatise themselves more than they are stigmatised... So I think that the environment in the organisation has a lot to be improved in terms of simply living and let live.

Caitlin believes that the system is not equipped to deliver due to a regressive spiral triggered by a monolithic system, lack of accountability and employee apathy:

> SHIVAJI: And to what do you attribute this slow system? Is it the system or is it the people?
>
> CAITLIN: I think it is just such a huge system. It is just so big. I do think the new systems they have got in place have the ability to move things very quickly but *I think it is still the people who operate the system who can make things quite sluggish no matter how efficient your system is*, no matter what ... (intervenes)
>
> SHIVAJI: So what do you think ... (intervenes)
>
> CAITLIN: I think that you can still have people who think, I have got twenty things to do and *this really is not a priority …*

SHIVAJI: So is that the structure that is inhibiting or is it the people that are inhibiting or is it the structure that makes people [act] a certain way that is inhibiting? What is it?

CAITLIN: I think it could be all three of those at varying degrees but I know that it is possible to have a travel authorisation from New York in under 24 hours. I also know that I have had colleagues who struggled for three weeks to get the same kind of authorisation. And I actually did not say anything special to anybody to get that authorisation. So if it is the same system that we are working with and the same people, then what is, the variable must be just what that person decided to do or not do on a particular day.

SHIVAJI: So would you say that the people in the system are not really held accountable which is why they can be ... (intervenes)?

CAITLIN: Absolutely. No, there is no accountability in the system. I know that for myself.

SHIVAJI: Elaborate on that please.

CAITLIN: I mean I just think there is a general lethargy around being precise. We are not precise. So even if we say it is a deadline, we do not really treat it as a deadline. It can slide and no one really loses out or we do not perceive anybody as losing out because I did not meet my deadline… but actually the organisation does lose because we have got such a really bad name amongst caterers and other function people that we are basically black-listed. No one really wants to offer us any of their services anymore because we are so late with payments. I think no one really wades through the documents that we produce because they are not friendly to a normal person, not that we are not normal.
I do not think that there is enough rigour and we do not maybe draw the dots for ourselves about how my work is really going to impact on bringing down the rates of infection. And there is a reluctance to actually hold ourselves accountable for that. We do not really want to be responsible for that. I mean I have had discussions with colleagues where there is a reluctance to say that this programmatic input is going to lead to this kind of output which will have this result in bringing down HIV/AIDS or in helping a country with its response to HIV/AIDS which ultimately will lead to a decreasing in infections.
So there is that level of responsibility and then I think in terms of the bureaucracy, just the functioning of bureaucracy as well there is no [accountability]. I do not think people, the same person who got me my travel authorisation in 24 hours; I do not think anyone has said anything to that person for taking three weeks to get another colleague's travel authorisation. I do not think that there is that level of [accountability]. I mean you do not want it to be like a school system either, but I just feel that there is no [accountability]. *I think caring is such a vicious cycle when you care about something and then know that no one else is supporting you in that caring whether it be in the HIV team or in gender or the environment.* I

> am sure they all experience exactly the same kind of thing of low levels of input and then not seeing that you are supported by the bureaucracy.
> And the programme staffs are also not drawing those dots. We should be feeding back to that finance person and say, 'Hey man, do you realise that what you did was so valuable because it resulted in X, Y and Z?'
> Ja, it is really a pity because I think that if we were functioning more as a coherent system and not as request and demand and then erratic supply, it might actually be quite different. Maybe we see our supply and demand too internally like I am demanding this from you and you supply me with this. Whereas it actually is not what it is…

Judy on the other hand, quoted below, believes that the organisation, while ill-equipped to deliver, can actually deliver "if they are forced to…"

> SHIVAJI: And could we go to another area? How is the organisation geared to deal with uncertainties and change because HIV and AIDS is a pandemic that is rapidly flowing through the thing? So is the organisation's own bureaucracy and structure trying to deal with this, or is it just business-as-usual?
>
> JUDY: I think there is a lot of goodwill at the high level to see things change. A lot is spoken about even changing the contracts so that people can access especially along these areas of HIV AIDS, so that people can access you know their entitlements that is provided for in the policy. But the thing is the structure is not very flexible to allow that. With all the goodwill I have seen, I have seen managers come and go but to get to real change it is not happening.
> I have heard of change ever since I joined in 2001, and ever since [then] we have been talking about contracts. Since 2001 up to this very moment. Nothing really substantial has changed. The entitlements and the lack of entitlement I had in 2001 I think they are the very same in 2005. And it is not that people do not want to help. I have seen that at the highest level ... they are really well intentioned but the structure is just not flexible enough.

At one level Judy is comforted and encouraged by a perceived "goodwill" among senior management staff. At another level she appears disconcerted by what she views as a systemic inflexibility that pervades the organization resulting in a lack of any "real" or lasting change.

> SHIVAJI: Why is that?
>
> JUDY: ... I think I guess it is because of the rules and the regulations that are just too old.

> SHIVAJI: So how do you think an organisation like this will deal with the whole epidemic flowing over it where people are dying, getting sick, not coming to work? How will they deal with that?
>
> JUDY: For me what I think if we are all really concerned about this. We love the organisation... we are concerned about ourselves and about our people as well. I think it has to come from bottom up... I think there has to be a consciousness [among] staff about their own entitlements and it has to be demanded... (intervenes)
>
> SHIVAJI: And do you think the organisation has ears to listen to a bottom up request?
>
> JUDY: If they are forced to. Because *they cannot live without [their staff], the [organisation] is about people, more than any other organisation*. You know, so *if they are forced to they will.*

Judy's testimony underlines the importance of human agency. Given her perception of the transience of management personnel, she believes it is important for a proactive drive to "come from bottom up" with staff demanding their "rights and entitlements".

4.6 Conclusion

While the situation vis-à-vis the implementation of the HIV and AIDS policy in the workplace at the UN cannot be labelled as, to use Kant's descriptor, a complete "euthanasia of reason" (as quoted by Zizek 2008: 89), one must admit there is a "strange [if somewhat inconsistent] logic at work" (Zizek 2008: 93) guiding some of the decisions of managers. But before I unpack the logic I would like to set it up as Zizek did using Freud. "The joke evoked by Freud in order to render the strange logic of dreams gives us a useful gloss on the strange logic at work here: (1) I never borrowed a kettle from you; (2) I returned it to you unbroken; (3) the kettle was already broken when I got it from you. Such an enumeration of inconsistent arguments, of course, confirms by negation what it endeavours to deny – that I returned your kettle broken" (Zizek 2008: 93). Getting back to the decisions and actions of a manager at the United Nations; (1) The UN HIV Policy states that people living with the virus are entitled to the job they are fit to carry

out and will not be discriminated on account of their sero-status; (2) Maud lost her job at a United Nations agency (which she successfully held) when she was detected to be living with the virus; (3) Maud didn't really lose her job, her contract (for no explicable reason) was never renewed and one day another person (whom Maud trained) was recruited for the job. So, the very principles the manager at the UN stood committed to uphold was contradicted by the action the manager took, leaving this study with the understanding that, a gap between the stated commitments to rights based HIV and AIDS policy and its implementation in a large international development organisation that is the United Nations system, clearly exists. The acknowledgement of this gap highlights the contradictory and ineffective management responses to HIV and AIDS policy implementations, and the heightened discontent and counter-organisation of staff on the one hand. On the other hand it underlines the possibilities of building *social courage,* trust and sensitivity within a historically monolithic bureaucracy.

The literature survey (of this thesis) drew attention to understandings of the workings of bureaucracies – they can be defined in terms of how they address predefined goals, administrative agendas and formal generalised rules (amongst other attributes). Furthermore, as Weber (1946, 1968) alluded, the intra-organisational roles that define authority and purpose are established on the basis of "technical competence" rather than other less scientific factors. Implicit in the classical and contemporary analysis of organisational management are tensions between representations of the conforming and agentic behaviours of bureaucratic managers. A greater part of the literature places emphasis on the structural and objective constraints that leave managers, as Weber (1946; 1968) argues, 'chained to routines'. He suggests further, and in a positive spirit, that the fate of people who rely on the organisation depend upon the "correct functioning" of its systems in capitalist society. The literature review reveals that whilst excellent Human rights based policy has come into being, the volatile global climate in which the UN operates tends to make "correct functioning" or socialisation of social justice mandates (Rawls; Gewirth) extremely difficult. The voices in this chapter point to the circumventing of managerial obligations and thus the necessity for some realignment of organisational goals with effective management response. Organisations, as Thompson

and McHugh (1990) indicate have grown in complexity, yet their need to survive and transcend fragmentation remains impervious. The HIV and AIDS epidemic ought to drive greater structural and agentic revision, as the managers in this case themselves suggest.

Maud provides a first person account of her experience of working at the organisation. Nevertheless, it is an account from her perspective and is not fully verified by seeking accounts from other actors involved in the incidents, whose understandings and rationalisations do not constitute a part of the investigation. This is of course also the case with all the other testimonies such as Lydia's and Caitlin's. This it is a particularly important acknowledgement to make since my position that bureaucracies are not run purely by the rule book strongly hinges around Maud's testimonial. In defence of its use in the thesis, I would state that I was as staff member exposed to some elements of the case, even if peripherally. My knowledge of the case would not stand up to the cast iron needs of legal scrutiny. However, I do believe there are enough facts on the ground to merit its use as a testimonial. Similarly, Greg's allegation of racism has not been independently verified and I have qualified it as such at the juncture of its use. Besides, the purpose of using the quote was to flag the differential privileges among personnel working within one office, not to make a point on racism which does not form a part of the scope of the study. It is my submission, therefore, that while the facts themselves are important, people's impressions and opinions strongly influence their actions and need to be explored.

5 – Substantive findings and thoughts on implementation: Dichotomy between policy and practice

5.1 Introduction

The findings, take a position on whether the perspectives of Human Rights to which the caretakers of the organisation are contractually committed actually influence their belief systems and actions. Examining this proposition is a complex task. An attempt at justifying such concepts as 'reasons' and 'beliefs' are likely to be, at best, "plausible and useful" (Raz 2002: 15) but difficult to prove empirically. Nevertheless, an attempt is made to address them through the use of distinctions and by inference from the findings of the research.

Further, the findings attempt to understand managers as predominantly 'rational' decision makers (motivated by their role as productive agents); as opposed to being predominantly 'reasonable' decision makers, driven by the motivations of equality and "fair cooperation" (Rawls 1993: 52). It is important to be aware that in the practical world, the two concepts are not mutually exclusive.

5.2 Reflections on the rule book: Synergies and departures evidenced in the study

The study investigates the key questions in the context of Arendt's view that bureaucracy is a "rule of Nobody". She rationalises her point with the observation that,

> "in a fully developed bureaucracy there is nobody left with whom to argue, to whom one can present grievances, on whom the pressures of power can be exerted" (Arendt as cited in Wrong 1997: 251).

While it is true that some of the voices in my research did not have a person to "argue" with, or one to "present grievances" to, it was not for the same reason that Arendt implies. According to her the rule-book takes precedence and control rather than individuals. The findings of this study, however, demonstrate that human agency uses its resources and ingenuity (to varying degrees of success), to interpret and manage the rules and policies of bureaucratic structure.

The above argument is consistent with the finding that the rule book that guides and determines policy implementation is only as exact as the managers and staff members who interpret and implement them make them out to be. Thus, based on the assumption that individuals differ in background and perspectives, it is my syllogistic conclusion that similar rules would be implemented differently in different organisations based on the person who is in charge or the persons who are at the receiving end of policy decisions. As Karl Marx (Gubrium & Holstein cited in Denzin & Lincoln 2003: 215) would have it, people (in this case both the managers and staff) are inclined to construct their own world as they see it, though not entirely on or in their own terms and, I add, with differing results. While this study is designed to explore the dichotomy between stated HIV policies and its implementation in the workplace of a specific United Nations organisation, the findings cannot be validly extrapolated across all UN and Bretton Woods Institutions globally. While one study (ILO/AIDS 2004) quoted in this thesis suggests that (in Africa at least) the situation may be similar, the findings cannot be universalized on the strength of this one study alone. That would need to be the task of a larger global initiative undertaken in the future.

The testimony of staff members, at all levels of the organisation, ingeminate the view that the realisation of the HIV and AIDS policy within UN agencies is incomplete. Lydia, one of the participants in the research, sums it up in her statement, "The implementation of the [HIV and AIDS] policy … does not reflect fully the spirit in which the policy was intended when it was introduced". Lydia's observation is a significant one, in the light of a few factors:

First, according to the UNAIDS publication, 'Living in a world with HIV and AIDS' (UNAIDS/04.27E 2004: 46) a significant 5% of UN employees are estimated to be living with the virus, yet the organisational commitment to allocating budgets for implementation for the implementation of the HIV and AIDS policy is still low. In this study, participants Maud, Patricia, Caitlin, Lydia and Leon all testify to either being discriminated or witnessing the experience of the discrimination of others firsthand, validating the finding presented in the ILO Progress Report 2004 that 32% of staff are not confident that their status will be kept confidential. Also, the United Nations agencies are rights based organisations, purportedly subscribing to Gewirth's (1982: 65) fundamental assertion that equity is a

> "matter of everyone's having, as a matter of principle, the right to be treated in the appropriate way when he [or she] has the need, and the duty to act in accord with the right when the circumstances arise… and he [or she] has the ability to do so…".

Further, the rule book which, according to Weber (1946; 1968; 1978) and various sociologists and political scientists since, is thought to play a key role in determining the path of a bureaucracy is not the sole determining factor when it comes to the implementation of HIV and AIDS Policy in the workplace at the United Nations Agency where the study was located. The rule, in this case the HIV/AIDS policy, carries the endorsement of the organisation's senior most executive authority, the Secretary General. However, the implementation of the policy often fails to conform to principles enshrined in the HIV Policy, signalling that there is often a disjuncture between rhetoric and practice, between policy position and administrative action. From testimonies gathered, the dichotomy in implementation seems to be related to the judgments, decisions and interpretations of managers and senior staff and not to inefficiency. For example, in Maud's case the management kept her in the dark about the impending outcome of her contract extension case and ensured that she had trained a person before they removed her from the workplace. It is my observation that the subversion of the policy, as evidenced in the interviews, required knowledge of a broad range of organisational rules and a degree of efficiency in its execution. Some rules appear to clash with the manager or decision maker's beliefs, views or self interest, resulting in them rationalising their

actions and decisions through an interpretation of the rules. Some of these actions are driven by "purely personal… elements" (Weber 1978: 975).

Maud, Leon and Mona's personal experiences of feeling stigmatised and discriminated along with Caitlin, Phillip and Lydia's second hand narrations of observed discrimination indicates (to different degrees) what Norman Geras refers to as "the contract of mutual indifference" (Geras 1998: 28). As suggested in the literature review, we, (and in this statement I also wear the hat of a United Nations staff member) should view Geras's insight from an action-oriented position, where we as human beings in a society, as colleagues in a workplace commit to a contract of mutual empathy, in which we have the responsibility to empathise and support those around us in need, to the best of our ability. I have suggested that this empathy would create a momentum for positive social change, as articulated in the United Nations Charter and (in the context of this study) address some of the drawbacks of the gap between policy and practice emerging in the presentation of the research findings.

It would be pertinent at this juncture to introduce my personal experience to the analysis of the study, as an insider to both the content and context of the study. On the 13th of March 2008, about two weeks after the submission of the 1st composite draft of my thesis, doctors discovered a carcinogenic tumour in my appendix. I went through a series of surgeries all of which were successful in removing the cancer from the body. As I write this section, I am undergoing a six-month intervention of chemo-therapy, prescribed as a treatment for cancer and a prophylactic against recurrence. Yet, despite the prognosis being good this medical episode in my life has influenced my perspective vis-à-vis living with a potentially life threatening illness in the workplace. For instance, I now fear that I may be viewed as a person with a potentially life threatening illness who would, in the medium or long term, be ineffective as a staff member. I further fear that this may prejudice the organisation and decision makers into subtly denying me a fast track career in the organisation leading to my concern that this mindset may affect my career ambitions at the UN. It would be fair to state that I have had no evidence that these fears and concerns of mine are real or founded in fact. My colleagues and supervisors

have been nothing short of considerate and supportive. I had colleagues from South Africa and senior colleagues from my head quarters in New York visiting me through my convalescence and recovery from surgery. I have been told that despite work considerations my health was a priority and that I should take whatever time I needed to nurture myself to good health. Yet, despite the positive prognosis of my recovery and the overt generosity of colleagues, I fear that a covert and subtle prejudice from colleagues, may affect my career in the organisation. This fear of mine is in no uncertain terms linked to the experiences of some of my participants in this research. Maud lost her job and was never told why, Leon's medical coverage is limited, and Mona has felt the effects of stigma. My head was reeling with questions, "Were Leon, Mona and Maud's experience evidence of prejudice against people living with a life-threatening illness? Was I to be another victim of this? Should I be concerned? Did I need to mount an extraordinary effort within the workplace to protect my career and inoculate myself against what I feared may be a prejudiced view of people living with a potentially life-threatening ailment?"[32] I came to the conclusion (invalid as it may seem in hindsight) that I had to act on my fears as real concerns. This is what I did. I returned to work as soon as I possibly could and took every opportunity both verbally and in writing to reassure colleagues and superiors that I was well, recovered and back at work 100%. I pushed myself hard to take on more work and deliver on and ahead of deadlines. I made every effort to establish that the cancer was in the past and irrelevant to my performance in the present.

The situation described above reminded me of a conversation I once had with a colleague living with the virus. She had mentioned that, as a person living with HIV, she felt that some colleagues while overtly supportive tended to write her off as a terminal health case and therefore not likely to be a long term investment in the organisation. As a reaction to this she tended to over-correct by pushing herself to the limit and taking on more work than she would normally have done, with the sole purpose of establishing her presence

[32] The point of these reflections is not to imply that the stigma endured by AIDS-affected people in organisations is similar in nature to organisational attitudes towards cancer affliction. Fears of prejudice and exclusion do coincide however and this realisation allowed me to empathetically connect with affected staff and better understand their responses in the aftermath of being diagnosed as living with a life threatening ailment.

and proving her competence. In the same way, I was, as a result of my medical situation, attempting to establish competence in a manner I would not have done six months back.

My personal experience of living through a potentially life-threatening health condition, corroborates and underlines my view, in this study, that HIV and AIDS policies and indeed other health policies for life-threatening aliments (within large international development organisations mandated by the Charter of Human Rights and equity), are only as effective as the men and women who implement and live by them determine them to be. In order for the implementation to be effective, it is necessary for staff members at all levels to be engaged collectively in the response. Given the understanding that there is an epidemic in our society and citizens are living and dying with the virus, it is crucial for Human Rights based bureaucracies to reconstruct themselves and espouse change, rather than baulk from it, in order to effectively “identify and solve problems almost before they have names” (Bennis 1993: xii).

Even the compelling rigidity of the bureaucracy’s commitment to being governed by the rulebook cannot render HIV policies fully implemented unless those that live by their codes take concerted action to make them so. The concerted action to fully implement HIV policies in the workplace is rendered more complex in the light of the fact that perception leading to stigmatisation and marginalisation in the workplace is not just a factor of stigmatising another living with HIV, but also a factor of self-stigmatisation by those living with a life-threatening medical condition.

Organisations are neither static in their characteristics nor stationary in time and the United Nations too will evolve as time goes by. As the administrative machinery contends with and responds to new and urgent demands, conflicting agendas and contradictions, the actions of some key decision-makers will be questioned and the organisation as a whole might be compelled to embrace change and embed a stronger Human Rights consciousness within its internal context. In these moments of change, articulations of managerial agency, and whether actions are structured to drive or subvert HIV policies, would be significant (Bennis, 1993; Thompson & McHugh, 1990). This

study is a snapshot of a United Nations agency as I see it struggle to reconcile its stated mandate to implement a Human Rights based HIV and AIDS policy with the contradictory actions of some of its managers and the consequent stresses undergone by some of its staff dealing with real, potential and perceived stigmatisation and discrimination. A more caring institutional environment in which managers actively implement policies and remain consistently accountable to staff would require some disruption of the routinisation of organisational life (Giddens, 1984) – in which managers are sometimes indifferent and subordinates deferent. *It is also important to understand that the limitation of the 'rule book' lies in the fact that, while it can articulate organisational principles and define courses of action, it cannot legislate the good judgement of managers. It is this understanding that has not been captured in Weber's analysis of bureaucracies and their modus operandi.*

The findings of this study offer a myriad experiences; each experience comes with its own set of organisational implications and learning. I have attempted to lay them out within the structure of the findings. Being a qualitative study I sought to combine analysis with empathy for both the subject matter and the participants of the interview process. As a direct and in some cases indirect colleague to many of the participants I am also cognisant of the potential seepage of my own preconceptions. As such I have attempted to quote many of the participants in detail to enable the reader to hear the multiple layers of voices and discern the contrasting meanings emanating from the commentaries.

The findings are diverse and eclectic in nature and the pieces stand out individually even as they hang together in one rich tapestry. As a researcher and active presence in the milieu of the study I hope that the thesis will have use for, not just academics but also, managers in the workplace. The United Nations is an organisation whose mandates and principles I respect and subscribe to wholeheartedly. It is also an organisation that I have been a part of for many years prior to the study and hope to continue being so for many years into the future. I hope that the study and its findings will in the future empower managers and staff alike to demonstrate the "social courage" Phillip refers to and to turn

the lens towards themselves and their workplace, and create an environment conducive to a just and principled implementation of the HIV and AIDS policy.

5.3 Key sociological insights

This sub-section attempts to consolidate the key sociological insights in the context of the central questions underlying this study. Since the responses to the two questions are closely entwined, the following paragraphs (though separated) attempt to bring the insights together in one integrated and composite response.

1. How do personnel in a local office of a large Human Rights based bureaucracy perceive and experience the implementation of HIV and AIDS policy in the workplace?

> There is a strong sense among a number of staff members that the implementation of the workplace HIV and AIDS policy is both ineffective and inequitable. The general narrative seems to be that HIV positive staff members are discriminated against, stigmatised and involuntarily dismissed. Within the accumulating subjective accounts merging into organisational discourse one discerns the fundamental contradiction of policy and practice in the Human Rights based case study. In an era when South Africa's defence of social justice is celebrated throughout the world, the 'organisational citizens' talked about themselves as having no rights in the micro-domain of the workplace - of experiencing discomfort about revealing their statuses, particularly if their contracts were under consideration for renewal, and of not being treated impartially. The ignominy of the matter lies in the fact that the international development organisation (despite being a humanitarian concern) has not demonstrated its ability to comprehensively practice its own rights based policies. For instance, there is inadequate information-dissemination on HIV-related rights of staff members and those employed in the workplace, staff members have experienced job-losses

having contracted the virus and others are struggling to gain access and reimbursement for medical treatment.

While staff perspective of the Human Rights based organisation's internal practices conjure up a largely negative collective-discourse, an informal and positive 'code of ethics' appears to have emerged among staff members themselves. Testimonies reveal that staff support one another and those among them who are living with the virus. At the workplace-level staff have formed an informal community of sustenance and commitment which rallies to sustain those afflicted and affected, assisting them with personally mobilised resources and information.

The responsibility for implementation and the burden of incomplete implementation is separately located in the power-hierarchy of international development organisations. Managers have the responsibility for implementation but do not seem to face the potential consequences of non-action or insufficient action. Staff members, however, seem to carry the burden of ineffectively implemented policies, making the price of inadequacy unequal and skewed. On the one hand, the price the manager pays, at worst, is a transfer to another post or a golden handshake (which, in its ignominy, serves as an exit-dowry). On the other hand, staff members at lower levels of the organisation, and with temporary contractual arrangements, can expect termination papers or annulment of time-bound contracts. This makes it convenient for managers to act rationally in their own interest without carrying the burden of being reasonable in the larger interest of the organisation.

The managers function within the system as **operational chameleons**. Managers (in the study) seem to overtly espouse and advocate for principles governing the HIV and AIDS policy. Yet, they are occasionally known to act on a separate and concealed set of views, values and decisions; thereby *dancing to the tune* they perceive to hear even when it contradicts the organisation's stated views, values

and policy mandates. One can therefore conclude that contrary to Weber and Bennis's understanding, bureaucratic structures and procedures though rigid and mandatory are only *de jure* drivers of policy implementation. The *de facto* drivers are the managers. It appears that the higher one travels up the ladder of authority the more one exhibits demonstrable evidence of mutual apathy. However, at lower levels of staff hierarchy there is mutual empathy and sharing, such as the fund-raising efforts of staff members to support those living with the virus and financially constrained by the consequence by it. It is interesting to note that while staff members are determined and active in their empathy; they are simultaneously in passive acceptance of the inefficiencies of policy-implementation, viewing it as a *fait accompli.* This finding underlines my fundamental premise that human agency and ingenuity supersedes organisational structure and the rigour of organisational policies and rules.

I further posit that the discretionary power of managers is not only the key driver of policy implementation, but it also affects the organisational and management credibility of institutions. To bridge this disengagement between the perspectives of managers and staff, a more empowering and participatory process may be called for to facilitate efficient implementation. In the South African tradition, the collective mobilisation of people around causes has always ignited larger changes. This may yet be a key vehicle for creating the impetus for shifting managerial indifference. "Change", as one participant suggested, must "come from the bottom up".

The following section, entitled *The road ahead* seeks to address this issue by suggesting ways in which the capacity and perspective gap can be bridged.

2. How does the Human Rights based bureaucracy, as exemplified by this South Africa case study implement the HIV and AIDS policy in its workplace?

An important finding of the study is that implementation of internal policy is sometimes thwarted by the interfacing of 'officialdom' and 'personal dynamics', such as: personal mandate driven managers in charge of implementing HIV and AIDS policy; systems of mandate setting, monitoring and implementation made inefficient by a "heavy" bureaucracy and over-centralisation, a lack of transparency and rigidity in management approach recurrently destabilised by a high top-management turnover.

The bureaucratic structure of the present-day international development organisation is an evolved version of Weber's bureaucracy (1946). It does not replicate the characteristics of the model in its entirety; these organisations exist within their own unique environment and are subject to variations over time. These variations, in turn, drive exogenous changes and impact on internal organisational systems, policy making and implementation, and individual ethics. In Weber's classical formulation experts function at 'full capacity', and are committed and loyal to the organisation which serves as moral and legitimate authority. In the contemporary competitive, rapidly paced international development arena managers might display loyalty but do not operate at full capacity in meeting their obligations (Scott, 2003). Temporal rhythms, subversive management practices and the vibrancy and imperfections (Powell & DiMaggio, 1991) of the international arena imply that a Human Rights based bureaucracy could find itself facing immense difficulty when attempting to implement policy consistently and credibly. This study finds, however, that lapses of policy implementation are more closely aligned with managerial manipulation and ingenuity rather than organic processes associated with increasing organisational specialisation and complexity. Thus, the gap between policy and implementation necessitates a more careful scrutiny of managerial agency and commitments, than Weber envisaged, as well as the socialisation of a non-instrumental adherence to Human Rights and respect for people's dignities within the international development organisation (Risse, Ropp & Sikkink, 1999).

5.4 The road ahead: Thoughts on better implementing the mandate and principle of the United Nations HIV and AIDS policy

One of the participants, Lydia, provided me with the insight that underpins my recommendations for the way forward. She was clear that managers were not necessarily setting out with the objective of being maliciously and wilfully discriminatory towards those living with the virus. None of my conversations with managers or even staff members in this study conclusively yielded such an observation. As Lydia pointed out in her interview,

> … the [HIV] policy is not being implemented efficiently and in its full spirit because the larger organisation is ignorant of all of the issues that need to be addressed for the policy to be implemented properly.

Lydia's observation begs the question, "What would remove the managers' and staff's ignorance of "the issues that need to be addressed"? What would enlighten them, not just to the rule of law or the text of the policy, but to the reality and principle that the policy is founded on? What would alert them to the reality that living with the virus is not necessarily a death sentence and that those living with the virus are capable of the same level of productivity as those living free of it…. the reality that stigma and discrimination can induce those living with the virus into self-stigmatisation and push them into concealing or ignoring their status to their own and the organisation's detriment?
What would inculcate in them the values and principles on which, not just the AIDS policies but the *raison d'être* of the United Nations is founded…the principle that Human Rights are universal, inalienable and indivisible? Most significantly, what role does the organisation play in bringing parity to the dichotomy between the HIV and AIDS policy and the actions of managers? Clearly the organisation has both the mandate and the responsibility to manage the environment within the organisation and to induce reality based and principles driven views, decisions and actions from managers, in the larger interest of ensuring an efficient and equitable implementation of policy.

In my observations on Phillip's testimonial on social courage, I mentioned that "social courage is a factor of orientation and can be instilled in the system and among managers and staff through suitably focussed interventions". As such, the United Nations would benefit immensely from assigning all managers and staff to an *orientation exercise* that includes such elements as an HIV competency test, information exchange process, counselling exercise, policy orientation and implementation session and more innovatively a period of consciously experiencing the reality of living with the virus. This I believe would help address an issue raised by Shaun, a senior manager in the organisation, when he claimed that the "politics of the approach weighs fairly heavy" on select managers rendering the "product of the action and the timeliness of the product" less significant. It is my opinion that the competency testing, information exchange and counselling would help bring all managers up to speed with the policies of the organisation and most significantly, appreciate the rationale behind the HIV and AIDS policy.

Below, is a brief elaboration of the initiatives[33] suggested in the paragraph above:

The *competency test* would enable the organisation to determine the gaps in knowledge and the emotional and psychological needs of managers and staff as they deal with HIV in the workplace.

The *information exchange* process would provide a learning process for managers and staff on the facts of the virus in both its bio-medical context as also its socio-economic and cultural context in society and the workplace.

A *counselling* session could be a crucial part of the orientation exercise as mere information exchange may be inadequate for staff members and managers who have strong pre-conceived notions and misconception about the virus and those living with it.

[33] While some of these initiatives (such as the competency test, information exchange and counselling sessions) have been sporadically practiced elsewhere in the organisation, they have not been brought together as one consistent and institutionalised intervention mandated for staff and managers.

Counselling could open their mind to the new information they receive and set them up better for the next session on policy and implementation.

Policy orientation and implementation sessions could enable the staff and managers to understand the policy and how they could best implement it. They would get a sense of what the United Nations HIV and AIDS policy is, what it mandates for the staff and managers and how a full and comprehensive implementation of the policy is not just a Human Rights necessity but could increase productivity in the workplace. This, I believe, could go a long way towards addressing Caitlin's concern that, "if we [the United Nations] were functioning more as a coherent system and not as request and demand and then erratic supply, it might actually be quite different".

Experiencing the reality of living with the virus may require more innovation. It could begin with a motivational speech followed by an open conversation and question and answer session with a counsellor living with the virus. If feasible it may also help to select certain staff members and managers to work in close proximity with a staff member known to be living with the virus. This is a more feasible option in countries like South Africa, Lesotho, Botswana and Swaziland among many others, where the epidemic is more generalised and larger numbers of staff members may be openly living with the virus.

It may also be feasible for an organisation, like the United Nations, which works across geographical borders and linguistic categories to establish a growing *roster of roving AIDS Ambassadors.* Such a roster would comprise United Nations staff members with requisite organisation-relevant-skills (such as management, finance, secretarial or any of a host of others) and the additional qualification of living openly with the virus. These roving ambassadors could be empowered further with counselling skills and sent out to United Nations offices across the globe to work with other staff and management teams. Over and above their contribution as professional accountants, contract specialists or secretaries, they could take on the additional task of mainstreaming HIV in the workplace. The initiative would provide a process of *experiential learning,* empowering

fellow staff members with knowledge about the virus and living with it. It could serve the purpose of normalising staff perceptions of the virus and make them comfortable with the idea of working alongside a person living competently and productively with the virus, through the sheer experience of doing so.

I am aware that the United Nations often has to rush staff members with specific skills to country offices to temporarily fill in skill shortage situations while they are selecting a suitable staff member for the job. These situations could naturally and seamlessly provide an opportunity to mobilise the skilled roving ambassadors to country offices temporarily, if a skill match can be established.

I am also aware of such staff members in the system, already equipped to perform such functions. One of them is a colleague, who of her own volition has been a friend and mentor to me, not just as an adviser on work related issues pertaining to HIV, but more recently from the psychological and lifestyle perspectives to deal with the personal reality of being faced with a life threatening ailment. This person, from my experience, is already equipped to take on such an assignment.

I believe the *significance* of the study is substantiated by the fact that the implementation of HIV and AIDS policies within the United Nations workplace has been reviewed and studied by an insider to the system. At one level it dispels the notion that "Outsiders, rarely experience the UN firsthand" (Weiss *et al.* 2005:1) and need to be content with second hand material cobbled together from news pieces and editorial articles, the internet and textbooks. At another level the study also dispels the view that the United Nations appears be "more a collection of boring bureaucrats than a creative centre of gravity for international problem-solving" (*ibid.*). As a staff member, I argue, that I have taken a step towards dispelling the view that the United Nations are staffed by "boring bureaucrats" by taking the trouble, late in life, to re-engage with academia to freshen up my perspectives as also my research and analytical skills. The study demonstrates that staff members of the United Nations are able to objectively review their policy implementation and have the support of senior management and the organisation to do so.

The significance of the study also lies in the fact that the research and analysis in the thesis is designed to induce organisational introspection at the United Nations vis-à-vis the HIV and AIDS workplace policy implementation. It is envisaged that this study will stimulate a broader and more in-depth study based on larger and more geographically dispersed samples, spread across countries with varied HIV prevalence and incidences. It is also envisaged that such a study will be carried out by an independent body and funded by the United Nations. This I believe will enable validation and enhancement of my argument from a larger evidence base across countries and continents, providing more recommendations for the way forward for the United Nations.

It would be pertinent to conclude the thesis by revisiting aspects of the United Nations Charter that may inspire the organisation that I work for, love and respect, as it takes considered steps towards universally and comprehensively implementing the HIV and AIDS policy in its own workplace. The effective implementation of the HIV and AIDS policy is, to a great extent, a matter of concern and respect for the equality, dignity and worth of the human person.

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Annexure

Interview Guide: Information and data needs

The information needs have been clustered into categories and sub-categories to ease management of a nonlinear line of inquiry. The categories are flexible and designed to accommodate new findings as generative questioning techniques are used.

General issues:

Policy:

What is the HIV and AIDS policy in the organisation?

What is it based on and attempting to achieve?

Have you conducted any studies on the HIV and AIDS in the workplace?

Policy Implementation:

What aspects of it have been implemented fully and well?

What aspect of the policy implementation needs more attention, commitment and focus?

Is there a Work Welfare Program in the organisation?

What is it designed to achieve and how much has it achieved?

What is on the anvil as Work In Progress?

What is the perceived level of commitment behind the implementation?

What are the factors that have facilitated the policy implementation that has been completed and is in place as a practice?

What are the factors that are inhibiting its implementation? Why are these factors inhibiting it?

What is preventing people from accessing policy provisions? Policy? Structural? Human?

Are there financial reasons for non-implementation? What are they?

Mapping a timeline on policy implementation:

Is there a change in the pace and completion of policy implementation over time? What is the change? When did it start changing? To what can we attribute the change? Where do we see it going from here? Why?

Coping with uncertainties:

It will be important for my study to understand the structure and coping mechanism of international development organisations and to recognize its influence on decisions of policy implementation. What are the uncertainties and what are the changes that International Development Organisations have to deal with from within the organisations and externally? How do they do so? It will also be necessary to understand the structure of the organisations and what the hierarchical elements and participatory processes are. This will help me compare them with Weberian characteristics expected of bureaucracies and to see if they are making the journey of change and how.

External influences and pressures:

Probe the stands and pressures of organisations and movements outside the organisation under study. What do GIPA and TAC stand for in terms of principles and the changes they want to see in society? Then probe what influence it has had on the organisation's stands.

GIPA involvement: What do GIPA and TAC as movements stand for in terms of principles and the changes they want to see in society? Does it influence the program in your organisation?

What is the nature of the GIPA program in your organisation? How does it work? What are the strengths and drawbacks of the process as it is implemented today?

Has there been any impact of the larger advocacy influences of the movements like the Treatment Action Campaign in your organisation? What have these been and how have they influenced the HIV and AIDS policy and implementation?

Policy implementation & interpretation:

Is the policy absolute or is it open to interpretation? If it is open to interpretation what are the differences between staff and managers?

How much of policy implementation is based on 'standardized' rules and how much is based on consultative or centralized decision making (i.e. Is the implementation a clear execution of policy based on the letter of the rule book or is there an aspect of interpreting the meaning and feasibility of the policy along with the level and time frame of implementation? Get examples based on these decisions.

If implementation of HIV and AIDS policies are partly or wholly decision driven, who decides on the nature and implementation of HIV and AIDS policy? What qualifies them to do so? Is there a chain of command in the decision making and implementation process? Who does what in that chain (i.e. how are responsibilities divided?)? How does that work? Are there any suggested modifications that might help improve the process and make it more effective?

Role of finance and resources in decision making:

What if any is the role of finance in the implementation of policy? How is it pushing the policy forward and how is it pulling it back? It is illegal in SA to discriminate on the basis of a person's health (including HIV) and this may not entirely be in tune with the conventional wisdom of financially oriented managers with immediate performance criteria to fulfill. Get responses on grounds of humanness, economic and management practicability.

Get a sense of the argument in the context of the mandate, choices, decisions, actions vis-à-vis beliefs of the stakeholders (both managers and staff) and the information available to them. Is there a 'belief trap' where the cost of maintaining the belief is too high? How do managers and staff decide and act in these situations? Eg. Value/HumanRights vs. Financial imperatives? Peer group pressures?

Power and policy implementation:

What is power based on in the organisation? Analyze each:

- Rank and position.
- Personality: Dominant and dependant.
- Resources: Resource or politically based power.
- Moral authority:

How do staff and management negotiate power or decisions? Egs?

Manager related issues:

Policy understanding:

What are the policies on HIV and AIDS in the organisation? What is the feasibility of it? Are there specific examples of feasibility or lack of it? What are they? Should it be modified to cover any aspect it may have missed out on?

How much of the policy has been implemented? Why? What are future plans for it?

How empowered are you to manage, change and implement the policies? If you are not who is?

Can you describe any phenomenon, distinct or highlight-able facts/ occurrences/ perceptions that came about through the HIV and AIDS Policy and program in your organisation that may have caught your attention? It may be a complex situation arising from well-meaning action, a problem or even a solution that is working.

Personal beliefs, interpretation & HIV Policy:

What are your personal beliefs vis-à-vis the HIV situation in society?

What are your personal beliefs vis-à-vis the HIV situation in the organisation?

What are your personal beliefs regarding the nature, relevance and effectiveness of the organisation’s HIV and AIDS policy? Track how personal beliefs influence their decisions and actions as managers implementing policy. What are the other factors affecting the decisions?

We have been living with the virus (in our lives, our families and our workplaces for many years now). Is there subtle or overt stigmatization in the workplace? What form does it take? What are the direct and/or indirect effects of Stigmatization on the implementation of HIV and AIDS policies in the organisation? Does it lead to discrimination among colleagues? What are its manifestations?

In a variant for managers specifically, probe if they feel pressure to implement HIV policy. If yes, what kind? If no what is the propulsion or inducement to do so?
Then what is the reason for implementation bottlenecks?

What in the system (vis-à-vis HIV and AIDS policies and their implementation) is driven by standardized rules and what is driven by your authority and discretion? How much of your action is driven by your personal judgment, interpretation and inner analysis of the feasibility of a policy implementation and how much on the letter of the law or rule book? Are some of the rules open to interpretation or are they uniform and implying only one action? Give examples. Are there any policies that you feel disinclined to implement either at all or for now? What? Why?

Uncertainties & external influences on policy implementation:
Are there uncertainties that the organisations have to deal with at this point in time (uncertainties or situations of change) that may threaten the survival of the organisation at one level or that may prevent the implementation of HIV and AIDS policies at another? Are there external movements or pressures that organisations are facing or need to look out for or respond to? They could be positive or negative. What are they? How do they impact on the organisation? Is the organisation responding to it already? How? If not why not? (Probe GIPA / TAC and find out others unprompted 1st)
If staff were to push you on a decisions, how would you react? How would you act on the situations? E.g.?

Pressures & policy implementation:

Do the needs and pressures of the staff sometimes differ from the rules and needs of the organisations? E.g. Anti Retro-Virals for consultants on Short term Special Assignments (called SSAs in some organisations). How do you balance between the organisation's rules and the staff's needs? Do you think the organisation's rules on the issue of SSA and family's access to full medical coverage will change? Should it? Is it viable? What are the issues and decision making parameters? How would you resolve them if they are pulling in different directions?

What is the cost effectiveness of the HIV and AIDS Workplace program in relation to organisational productivity. There were earlier fears that the costs would be unmanageable, yet organisations these days are talking about surprising benefits that accrue from a strong care and treatment program. We would like illustrated views on it from both sides of the argument. Do you have calculations or reports that reflect the issues of cost effectiveness and cost burdens? Could we have copies and analyses of these reports?

Are staff members psychologically dependent on superiors and managers? What form does it take? What are the implications?

How does the program influence the wider family and community of the staff member? Are the families involved in the programs directly or indirectly? Is there are trickle down effect? What is the nature of it? Does it need to be improved? How?

International managers in local jobs:

Do senior managers who are international staff lack a knowledge and understanding of local conditions? How important do they believe it is? If important how do they make up for it? What are the implications and consequences of this mobility? Does it affect the relationship with national staff? How? How does all this link to HIV policy implementation HIV?

Staff related issues:

Policy understanding:

What are the policies on HIV and AIDS in the organisation? What is the feasibility of it? Are there specific examples of feasibility or lack of it? What are they? Should it be modified to cover any aspect it may have missed out on? How much of it has been implemented? Why? What are future plans for it? How empowered are you to manage, change and implement the policies? If you are not who is?

Personal beliefs, interpretation & HIV Policy:

What are your personal beliefs vis-à-vis the HIV situation in society?
What are your personal beliefs vis-à-vis the HIV situation in the organisation?
What are your personal beliefs regarding the nature, relevance and effectiveness of the organisation's HIV and AIDS policy? Track how personal beliefs influence their decisions and actions as managers implementing policy? What are the other factors affecting the decisions? How does it determine the staff's decisions and actions? How does it (in their perception affect the manager's decisions and actions?

What in the system (vis-à-vis HIV and AIDS policies and their implementation) is driven by standardized rules and what is driven by the manager's authority and discretion? Get a commentary on it.

Entitlements in implementation:

Are all those working in the organisation entitled to medical coverage? Are all staff member's who are entitled to medical coverage fully accessing this coverage? If no, why not? Find out if that is ok or if it is perceived to need rectification? If it needs rectification, what can the organisation do to rectify the situation? What can they as staff members do to rectify it?

Interpretation and policy implementation & power issues:

What actions of implementation or non-implementation are based on the letter of the policy and how many are based on the manager's decisions? Examples? What power does the staff have to influence this process? For example to provide ARVs?

Give examples of a manager using power to enable an implementation of policy in the interest of the staff? Where has a manager used power over staff to pressure or leverage a situation? Examples?

Are there any policies that managers seem to feel disinclined to implement either at all or for now? What? Why is it so?

Policy and external influences:

Are there external movements or pressures that organisations are facing or need to look out for or respond to? They could be positive or negative. What are they? How do they impact on the organisation? Is the organisation responding to it already? How? If not, why not? (Probe GIPA / TAC and find out others unprompted 1st)

Are staff members psychologically dependent on superiors and managers? What form does it take? What are the implications?

How does the program influence the wider family and community of the staff member? Are the families involved in the programs directly or indirectly? Is there are trickle down effect? What is the nature of it? Does it need to be improved? How?

Relevance of international managers in local jobs:

Do senior managers who are international staff lack a knowledge and understanding of local conditions? How important do they believe it is? If important how do they make up for it? What are the implications and consequences of this mobility? Does it affect the relationship with national staff? How? How does all this link to policy implementation especially HIV?

Personal actions & acceptances vis-à-vis policy:

How much of your action or acceptance of the situation is driven by your personal judgment, interpretation and inner analysis of the feasibility of a policy implementation and how much on the letter of the law or rule book? Are some of the rules open to interpretation or are they uniform and implying only one action? Give examples.

How empowered or powerless do staff members perceive themselves to be vis-à-vis the rule book and the manager's interpretation of the rule book?

Key-concept clusters

Staff:

- Discrimination; fairness; performance issues; sickness among staff and from management/ people living with the virus leaving jobs: I explored in my probes and questions if staff living with the virus in the work space felt (in any way) stigmatised and discriminated against. This concept was explored both among those known to be living with the virus and those either not living with the virus or unaware of it.
- Disillusionment / Caste system: This point inquired if staff felt disillusioned by the organisation and the speed and efficiency of the AIDS policy implementations. It also aimed to test whether there was an unstated class structure within the organisation that distanced management from staff or those living with the virus from others.
- Women as managers and staff: gender issues and status of women; privileges and discrimination of women in the system
- Psychological dependence of staff on managers: This point set out to explore if (as a factor of the hierarchical construct of the organisation) staff members had lost their own initiatives and tended to depend on senior managers and supervisors for perspectives and actions.
- Local and foreign managers in international development organisations: This point of inquiry was driven by the assumption that local managers may be better aware of the local culture and understand local staff better. It also held in perspective the possibility that foreign staff may be open and unprejudiced in their interactions.
- Organisational connectedness and isolation vis-à-vis staff: I attempted to find out if the staff felt connected or isolated from the organisation they worked for.
- Managers: management style; feudal; dictatorial; hierarchical. This point explored manager's style of management and its implications on connectedness with staff, motivation and disillusionment and also its effects on HIV policy implementation.
- Stamina and focus: What gives a person the strength to negotiate the situation of living with the virus? How do staff members negotiate their condition in the workplace? I explored this not just from the perspective of the participants but also from my own view of experiences within the organisation and from my own

experiences of living with a potentially life-threatening illness that may be construed as an impediment to a staff member's ability to perform at work.

Contracts:

This set of explorations enabled me to understand the nature of contracts, the degrees of permanence and transience and their effects on staff members living with the virus. It also enabled me to understanding how managers could potentially use these contracts as tools of management:

- SSA or short-term contracts / Differentiation between the different types of contracts/ Cutting Costs and Re-profiling as a management tool/ Procedures (how fair they appear to be to staff members)/
- Access to treatment, testing and medical coverage for staff members with different types of contracts and related levels of stress and comfort with the benefits available to them.

Culture of the UN/International Development Organisations:

This cluster of queries enabled me to understand the culture of the organisation vis-à-vis staff support and management:

- Relevance of the UN (as an organisation/ staff / policies of the organisation)
- UN Reforms; efficiency; harmonization
- Culture of UN; competitiveness among succeeding managers attempting to establish their own mark within the system
- Team Spirit and the staff members' ability to rally around colleagues experiencing problems
- Values & Principles that managers and staff members use as a basis for decision-making and action; Fostering an environment conducive to the roll out of policy
- Confidentiality and trust, a critical aspect of managing HIV and AIDS
- Sensitivity of staff members and sensitisation programmes undertaken by staff members

Policy issues:

In this cluster, I structured a set of probes to determine the policies themselves and the manner in which they were being interpreted and implemented:

- Policy interpretation
- Policy implementation
- Approachability of managers to determine how comfortable staff members feel with not just the policy but also the sensitivity and thoroughness with which managers implement the policies
- Confidence in policy implementation; how complete is a policy… flexibility, fixed or cast in stone; internal policy; connectedness of internal and external policy; practicing what we preach;
- Wellness programme; a broadened and all-encompassing programme to provide confidence and greater support to staff members; follow-up and couple testing;

Bureaucracy:

Within this set of probes, I inquired about the organisational structure itself and the level of preparedness to implement and manage the epidemic within the organisation

- Hierarchical organisation; bureaucracy; transparency with which managers implement policies.
- Responses to change: How equipped is the organisation to manage change?
- Commitment/ challenges / bottlenecks/ obstacles/ pressures

Influence of the External Environment on implementation of policy and *modus operandi* of international development organisations:

- Connectedness to environment; GIPA, TAC; Comparisons to private sector organisations / Obligations of international development organisations to respond to the needs and demands of communities negotiating the epidemic at the ground level

UN HIV workplace initiatives

Caring for Us is a UNICEF-initiated programme that now includes UNFPA. *Caring for Us* promotes a caring environment for people living with, or affected by, HIV, as well as for staff members affected by other health and personal issues. Measures to help staff members and their families cope with illness or death are complemented by learning opportunities on related topics, such as access to ART.

With its initiative *HIV/AIDS in the Workplace*, WFP is strongly committed to accepting and supporting colleagues living with HIV and AIDS in a tolerant, just and compassionate work environment. The initiative is designed to ensure that WFP's personnel policies on HIV and AIDS meet and exceed the international standards set within the UN, extend to all WFP staff training on effective AIDS awareness in the workplace, and support the development of AIDS workplace programmes in all regions. WFP works 22 of the 25 countries most affected by AIDS, and building awareness of the epidemic is high on its agenda.

UNDP's *We Care* initiative supports the implementation of the UN system's workplace policy on HIV/AIDS, ensures protection of the rights of those living with HIV, and promotes a supportive work environment. *We Care* enhances AIDS awareness among UNDP and other UN-system staff members and facilitates a workplace environment free of discrimination and stigma.

Launched in 2002, ACTION (Access, Care, Treatment and Inter-Organisational Needs) is a project of the UN system medical services. In 10 pilot countries (Cambodia, Ethiopia, India, Nigeria, Rwanda, Senegal, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe), ACTION is mapping locally available resources for care and support, enhancing local capacity to address HIV prevention and AIDS care, and improving interagency coordination on workplace issues. Benefiting from the technical expertise of WHO, ACTION facilitates treatment initiatives that are appropriate to individual countries. For example, ACTION has established a revolving fund to purchase a constant

and reliable supply of high-quality ART drugs to ensure a continuous supply for UN employees and dependants who need them. In addition, ACTION undertakes workplace initiatives to foster a compassionate and supportive work environment for people living with HIV. It is hoped that ACTION will eventually extend beyond the initial 10 target countries.

To intensify the fight against HIV and AIDS in the workplace, the World Bank has appointed internal focal points (Task Team Leaders) in all its offices world-wide. These individuals are responsible for increasing awareness among staff and their dependants, promoting access to the free voluntary counselling and testing services provided by the World Bank, and ensuring access to PEP kits for those who need them. The World Bank guarantees confidentiality in the processing of medical claims through its Health Services Department in Washington and facilitates the supply of antiretroviral drugs to its HIV-positive staff and dependants.

In several countries, the UN system has moved beyond agency-specific initiatives to promote a fair and non-discriminatory workplace. The consolidation of all of its HIV and AIDS-related workplace efforts has enabled the UN system to target all staff members working in these countries.