An organisational change model for successful HIV/AIDS workplace interventions

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Abstract

It is essential that the business community responds to the threat presented to both economic and societal sustainability by HIV/AIDS. The National Strategic Plan for HIV & AIDS has called for the private sector's involvement in a multi-sectoral response. No empirical studies exist on the process of change management used in successful HIV/AIDS change initiatives in organisations. This fine-grained qualitative research set out to meet that need. Ten experts were asked to identify the sample of ten companies with HIV/AIDS workplace interventions widely acknowledged to be successful. In-depth interviews were conducted with the manager responsible for HIV/AIDS interventions at each of these companies. The change efforts were found to be large scale and motivated by a combination of a moral obligation and a persuasive business case and to depend on nine crucial elements, along with commitment from the most senior leadership in the organisation. Legitimate and expert power bases were most commonly leveraged. A detailed model for the change management process is offered which could assist organisations that wish to successfully implement HIV/AIDS workplace interventions.

1 Introduction

"The estimated 5.7 million [4.9million–6.6 million] South Africans living with HIV in 2007 make this the largest HIV epidemic in the world" (UNAIDS 2008:40). By 2010, 5.5 million people will have died from Aids in South Africa (Bureau for Economic Research (BER) 2006). The national prevalence is estimated to be 18.8%, (UNAIDS 2008:173). The macroeconomic impact of HIV/AIDS on South Africa needs to be urgently addressed (BER 2006). "Using standard economic models, the best available evidence suggests that HIV is likely to reduce economic growth in high-prevalence countries by 0.5% to 1.5% over ten to twenty years" (Piot in UNAIDS 2008:23). The World Economic Forum (Porter & Schwab 2007) found that the South African impact of HIV on business is one of the worst in the world, at 129th out of 131 economies. Ineffectual leadership and the lack of coordination in the response to the pandemic from both the public and the private sector have been cited as the primary causes for South Africa's dire epidemic (AIDS Foundation of South Africa 2008).

The International Labour Organisation (International Labour Conference 2008) points out that the epidemic disproportionately affects people during their most productive years. The sustainability of the market is also at stake, as when people get sick they cease to be economically productive and the little disposable income they have is spent

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on health care, with very little left to be spent on products and services. Consequently the private sector suffers the dual effects of an underskilled workforce as well as a dwindling market. Njobe and Smith (2004) clearly articulate that business vulnerability and increased costs as a result of the disease are unquestionable. The National Strategic Plan for HIV & AIDS and STIs (NSP) (2007) has called for a multisectoral response that requires business to play a major role in combating the disease. Business is clearly an important role player, but to date the interventions undertaken by the South African business community to reduce the epidemic have on the whole been inadequate (Bloom, Bloom, Steven & Weston 2005*)* but some businesses have intervened successfully. What has been absent is an empirical, behavioural study into determinants of successful HIV/AIDS organisational change interventions.

Bloom in Taback (2006) indicates that business involvement in HIV/AIDS could take the epidemic out of the shadows, which is where it thrives, and present it out in the open so that it can be dealt with. This is supported by Roedy (in Taback 2006:1), who feels that "HIV and AIDS is the defining moral issue of our time and businesses must play a critical role in the fight against the global spread of the epidemic. The business community is uniquely positioned to use its influence, resources and leadership to challenge stigma, promote prevention and facilitate treatment. Business has to respond, and a response will demand effective leadership of planned, comprehensive, organisational change initiatives that address HIV/AIDS in the workplace. Many studies have been carried out from the perspectives of medicine and economics.

The business sector urgently requires information and tools in order to be equipped for an effective response, which includes best practice components and policies for HIV/AIDS interventions. These would affect elements of workplace programmes such as testing and the provision of antiretrovirals (Whelan, Dickinson & Murray 2008) as well as consolidated knowledge of how the change processes should be managed. It is the latter aspect that this research addresses, namely best practice regarding the management of organisational change, the reasons for embarking on the change interventions and the power bases used in getting the organisation to respond effectively to the pandemic. There is no literature available on these aspects of HIV/AIDS interventions. "True leaders …will pursue evidence informed policies and programmes to reduce the epidemic's long-term toll" (UNAIDS 2008:193). "There are companies with world class programmes, which contribute to the national effort in the fight" (Ngozwana in Mzolo 2006:3).

This research had as its objective the documentation of best practice (Whelan et al 2008) in the business sector's change management processes with regard to the HIV/AIDS epidemic. This was done to give other companies access to an empirically based model on which to base their HIV/AIDS change interventions. This research was limited to HIV/AIDS workplace change interventions in the broader context of the multisectoral strategic plan to address the crisis. Only successful workplace interventions within the organisation were considered and the perspective adopted was that of the senior management. The study was limited to large profit-oriented businesses in the South African economy.

2 Literature review

2.1 *HIV/AIDS*

Nattrass (2004) states that the AIDS pandemic in Southern Africa is not only a major public health crisis, but also a threat to economic development and social solidarity.

Retarded economic development will perpetuate the crisis of unemployment and poverty in South Africa. The productivity of the workforce is rapidly declining while commerce and industry are in desperate need of skills. The private sector faces mounting direct and indirect costs as a consequence of the unchecked pandemic. Whiteside and Sunter (2000) have stated that this is both a management and a strategic issue.

Cowlin in Dickinson (2006:38) states that "Today HIV and AIDS should really be regarded as a manageable chronic disease that can be treated cost effectively." The sooner companies can get their workforce educated on HIV/AIDS fundamentals, tested and onto treatment where necessary, the sooner they will benefit from lower absenteeism, higher workplace morale, and improved and sustained skills transfer. The statistics show that anti-retroviral treatment works. This is no longer open to question. Dickinson (2006) says that a company's intervention can be considered successful if it has positive outcomes with regard to a complete situation analysis, HIV/AIDS policy and procedures, a high proportion of staff undergoing voluntary counselling and testing (VCT), an HIV disease management programme, psychosocial support and ongoing monitoring and evaluation. Smith (2008) gives details of the components needed in the assessment, planning, implementation, monitoring and evaluation phases. Whelan et al (2008) assessed the implementation of the components of the programmes. However, there is no evidence-based research on how the change process involved in implementing the components is best managed.

2.2 *Organisational change*

"The brutal fact is that about 70% of all change initiatives fail" (Beer & Nohria 2000:133). It is quite possible that HIV/AIDS workplace interventions have failed not because the objectives or components of the programmes were in any way deficient but because the approach to the change was wrong. Knowing the outcomes required from an intervention is only part of finding a solution (Cummings & Worley 2005; Kanter, Stein & Jick 1992; Kotter 1996; Covin & Kilmann 1990). Managing the changes that result in those outcomes is crucial. Burke (2002) asserts that the change that occurs in organisations is mainly unplanned and most of it is gradual and evolutionary and thus it is often only in retrospect that one can identify the success factors of change. Three theory bases have been used as the basis for this research, namely change strategies as described by Beer and Nohria (2000), Kotter's (1996) designated eight stages of successful organisational change and finally French and Raven's (1959) seminal power bases.

Beer and Nohria (2000) state that there are three major change strategies. Theory E change is understood to be motivated by pure economics, the bottom line profit impact of undertaking the change. Theory O change is the converse – it is change that is aimed at improving and enhancing organisational capabilities by focusing on people, their attitudes and behaviours and organisational learning. Theory E's focus is on the "hardware" – the systems and structures, whereas Theory O is focused on building the "software" – culture, behaviour, attitudes and the empowerment of employee teams. Progress is characterised by the achievement of specific targets and dates in Theory E, as opposed to the evolutionary and emergent process of Theory O. Beer and Nohria (2000) compare these approaches along several dimensions: goals, leadership, focus, process, reward system and use of consultants. Beer and Nohria (2000:138) found that "Paradoxical as those goals may appear our research shows that it is possible to apply theories E and O together. The simultaneous use of E and O strategies is more likely to

which approach, or combination of approaches, is consistently more effective in bringing about change in the successful HIV/AIDS workplace interventions.

Achieving successful change in an area where the complexity of human behaviour plays a big part requires a systematic approach. In his seminal work, Kotter (1996) lists eight stages that are required, in sequence, for change to succeed. His eight stages, together with the common reasons for failure, are shown in table1 below. Adjacent are insights from the literature into how each step is relevant to HIV/AIDS workplace interventions.

Table 1
Kotter's steps (1996) and their relevance to change around HIV/AIDS

Required Stage (Kotter 1996)	Common cause of failure (Kotter 1996)	Relevance to research
1 Establishing a sense of urgency	Allowing too much complacency	"The workplace has become a silent battle ground as employers fail to realise the importance of adopting HIV/AIDS prevention and treatment programmes" (Mzolo 2006:4).
2 Creating the guiding coalition	Failing to create a sufficiently powerful guiding coalition	Piot (2007) illustrates this point: "The sobering reality is that we will need to sustain an effective AIDS response over many decades. This will require sustained and exceptional leadership of all of us." This leadership will need the support of senior management.
3 Developing a vision and strategy	Underestimating the power of vision	The BER study (2006) reveals that GDP growth could be 0.5 percentage points lower than it would have been in the absence of HIV/AIDS. Leaders need to present a vision of what the economy would look like with a coordinated intervention, the vision of an economy without the burden of AIDS.
4 Communicating the change vision	Undercommuni-cating the vision by a factor of 10 (or 100 or even 1,000)	The lead from government, in particular President Mbeki's interventions, resulted in widespread confusion, especially given that he took the dissidents' theory seriously, and virtually undercommunicated the vision (Nattrass 2004). Mixed messages, inconsistent communication and conflicting messages, as well as outdated information (especially around cost and effectiveness of treatment) and statistics also equate to undercommunicating the vision.
5 Empowering broad-based action	Permitting obstacles to block the new vision	Dissidents like Mbeki present an obstacle by denying that HIV causes AIDS, as do suggestions from other quarters that it is not worth spending the money to treat AIDS (Nattrass 2004).
6 Generating short-term wins	Failing to create short-term wins	Reddy and Swanepoel (2006) were able to demonstrate that over a two-year period treatment costs fell by 30% to 40%. These and other similar statistics should be considered short-term wins, supporting the cause for interventions.
7 Consolidating gains and producing more change	Declaring victory too soon	With each change the impetus needs to be maintained to create even more change. "Instead of declaring victory, leaders of successful efforts use the credibility afforded by short term wins to tackle even bigger problems" (Kotter 1995:66).
8 Anchoring new approaches in the culture	Neglecting to anchor changes firmly in the corporate culture	Organisation change on HIV/AIDS has to be entrenched in culture in order for behaviour around prevention and the eradication of stigma to be effective.

Other authors suggest different necessary stages for successful organisational change. Both Cummings and Worley (2005) and Kanter et al (1992) suggested 10 stages. Covin and Kilmann (1990) name seven critical elements. The research findings of all these authors are reviewed and compared in table 2. In many cases there are common

stages identified by all the authors, but some stages are only suggested by one or two of the authors. The research set out to determine which of these stages are required for a successful HIV/AIDS workplace intervention and whether additional stages are required that are peculiar to HIV/AIDS interventions.

Table 2
Comparison of change management models

Cummings and Worley (2005)	Kanter, Stein and Jick (1992)	Covin and Kilmann (1990)
Creating readiness for change and overcoming resistance to change	Separate from the past	
Vision - describing the core ideology	Create a shared vision and common direction	Creating a shared vision
Constructing the envisioned future activity and commitment planning	Craft an implementation plan	The preparations and diagnosis are critical to success; thoughtful planning is required
Political - assessing change agent power, identifying key stakeholders and influencing stakeholders	Line up political sponsorship	Encouraging employee participation. Involving employees from every part of the organisation. Soliciting commitment and visible support
		Reward for change – rewards need to be linked to the desired change and they need to be consistent and occur in a timely manner
Providing resources for change and developing new competencies and skills		Make sure adequate resources are available for implementation and that there is adequate time for implementation
Building a support system for change agents	Develop enabling structures	
Communicate to overcome resistance to change. Staying the course	Communicate, involve people, and be honest	Communication must be constant and broad based Communication of the programme goals and activities Communication of success stories from the change Frequent meetings for evaluation of the programme
Reinforcing new behaviours	Reinforce and institutionalise the change	

Other findings on change management that may provide useful insights into HIV/AIDS change management processes include those of Yukl (2006), who says that one of the most important and difficult leadership responsibilities is leading change and this requires certain skills and leadership styles. The leadership of change is a shared process involving different leaders at different levels (Shrock 2004). Successful managers want to be winners (Maccoby 2001) and this can be used to the

organisation's advantage in change interventions, by leveraging the fact that people are naturally competitive and that competition focuses people on goals.

2.3 *Power bases*

One of the major aspects of organisational change, which is underrepresented in the literature, is the power that leaders apply to bring about the required change. Understanding how power works enables one to be a more effective manager (Robbins & Judge 2007). Power refers to a capacity that A has to influence the behaviour of B so that B acts in accordance with A's wishes (Bass 1990). In order to get the organisation to comply with the change initiatives, certain power bases or a combination of power bases must be employed. French and Raven (1959), in their seminal work on social power bases, identify a five-fold typology for the various power bases that leaders have at their disposal and Robbins and Judge (2007) divide these five into formal power (reward power, coercive power and legitimate power) and personal power (expert and referent power). Each power base has different consequences and hence leaders need to select the one or the combination that is most appropriate for change interventions.

In reward power people comply because doing so produces positive benefits such as pay raises, promotion or better work assignments. With coercive power there is an expectation on the part of the employee that they will be punished by the leader if they fail to conform to the influence attempt. Punishment could take the form of ridicule, exclusion or an inferior pay rise. In legitimate power, the power is by virtue of one's structural position and one's authority within the hierarchy of the firm. Expert power is largely as a result of the leader's special skill, expertise or knowledge. Expertise has become one of the most powerful sources of influence in the modern world of work (Robbins & Judge 2007). Referent power has to do with admiration and respect (Robbins & Judge 2007). The research aims to reveal which power bases are more effective in eliciting the support of the organisations' employees in the successful HIV/AIDS change processes.

2.4 *Conclusion and research aims*

HIV/AIDS presents an undeniable threat to our economy and society. With South Africa the hardest hit country, our response to the epidemic needs to be rigorous. Business has a vested interest in succeeding in the fight against HIV/AIDS. The premise of this research is that business's responses must transcend policy and programmes and embody large-scale organisational change. The research aims to develop a change model based on best practice. In order to do this, three research questions were used to structure the collection of empirical data.

1 What underlying approaches to change were used in the successful interventions?

2 What steps in the change processes were found to be necessary?

3 What power bases were found to be the most effective?

3 Research methodology

The research design was qualitative, fine-tuned and of an exploratory nature (Zikmund 2003). Qualitative research attempts "to answer questions about the complex nature of phenomena, often with the purpose of describing and understanding the phenomena from the participants' point of view" (Leedy & Ormrod 2001:101). The research was

undertaken in two phases, with the first phase enabling identification of ten companies that are proven leaders in HIV/AIDS interventions. In the second phase, in-depth interviews were conducted with the leaders responsible for these workplace interventions.

3.1 *Phase 1*

The population of relevance for this phase consisted of experts in the field of HIV/AIDS from government, NGOs, business, academia and the media, all people whose opinions carry some weight. Judgement sampling (Zikmund 2003) was used to select the sample. A sample of ten people was drawn and nine of the ten experts were interviewed in person. They were asked which leaders and companies, in their opinion, had successful HIV/AIDS workplace interventions. In these discussions, fewer than 30 companies were identified. This confirms the view that to date the response by business at large to the HIV/AIDS epidemic has been poor (Bloom et al 2006). The responses from the experts were ranked according to the number of mentions. Ten of the eleven top companies identified made themselves available for interviews.

3.2 *Phase 2*

In-depth interviews (McCracken 1988) were conducted with the leaders who championed the HIV/AIDS workplace interventions at the ten companies. The objective of the interviews was to explore the reasons for the success of the HIV/AIDS workplace interventions in the light of the steps taken in the organisational change efforts, the underlying change approaches and the power bases used. The companies in the sample represented large enterprises in the following industry sectors: Mining, Telecoms, Automotive Manufacturers, Public Utilities, Food and Beverage, Pulp and Paper and Financial Services. Each interview lasted for approximately one hour and provided depth and richness in the responses.

A 12 question interview guide was utilised in order to give structure to the interview and to ensure that all the relevant data had been obtained for coding, content analysis and comparison. The guide was compiled with the aid of the three major frameworks that form the basis of the research questions discussed above. In order to establish any critical success factors or obstacles to change not alluded to in the literature that may be specific to the case of HIV/AIDS workplace interventions, open-ended questions were interspersed throughout the guide. This was done to avoid confining data to the theoretical frameworks. Beer and Nohria's (2000) Theory E and Theory O were distilled into tabular form that presented three options for the respondents to choose from for each of the six broad categories proposed by Beer and Nohria. The constructs of the theory were re-worded in précis form in terms of HIV/AIDS workplace interventions. Each choice was elaborated on during the interview. Similarly, Kotter's (1996) theory was reworded to make it relevant to the subject of HIV/AIDS workplace interventions. Kotter's constructs that could best be captured on a continuum were presented as Likert scales and those constructs that were better suited to qualitative discussion on the topic were phrased as open-ended questions. French and Raven's (1959) power bases were investigated using the constant sum scale technique (Churchill 1986). The five power bases were briefly summarised by the researcher and displayed in a table with a column to record the results. It was expected that a combination of power bases would be used and this allowed the respondent to assign a weighting to each power base. The exact format of the interview schedule can be discerned from the results section below.

Data analyses. All interviews were audio recorded and these data were combined with data from the interview guide to produce a table with 34 fields for coding the data. These fields included the elements of the three theoretical frameworks as well as additional themes that emerged. The table was split into quantitative items, such as Likert scale scores and the constant sum answers and into qualitative responses where the richness and depth of the responses were recorded. It took roughly three hours per interview to capture, code and analyse the data. The development of the spreadsheet was an iterative process and modifications to the fields were made as themes emerged. Content analysis was used to analyse the data. Patterns, themes or biases were identified during this analysis (Leedy & Ormrod 2001).

Research limitations. External validity is not an objective of exploratory research of this nature as there was no extrapolation to the total population. Only one person at each company was interviewed. They undoubtedly viewed their own programmes and successes differently from the way an impartial observer would view them, which could result in response bias (Zikmund 2003). The research was only examined from the perspective of Beer and Nohria (2000), Kotter (1996) and French and Raven (1959), which limits the findings to these fields. For instance no light can be shed on the efficacy of the interventions from a medical point of view.

4 Results and discussion

The findings from the interviews are presented and discussed below.

4.1 *Research question 1*

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

Beer and Nohria (2000) categorised the key elements of change into six broad topics: Goals, Leadership, Focus, Process, Rewards, and Use of Consultants. For each of these the interviewees were asked to select an option that reflected one of the approaches to change, namely Theory E or Theory O or a combination of the two. The table below gives the options presented to the interviewees and their responses in the bolded numbers.

Table 3
Responses to the Theory E and Theory O change options

Theory E	Theory O	Combination of E and O
Goals		
Were your goals purely financial – not addressing HIV/AIDS would mean that in the long term the company would lose money?	Was your goal to develop a culture that embraces HIV/AIDS and the people affected by it?	A combination of responding to HIV/AIDS while acknowledging that a failure to do so would ultimately impact shareholder value negatively?
0	**0**	**10**
Leadership		
Manage change from top down – little or no input from managers, employees or the unions?	Encourage participation from the bottom up, including emotional commitment to solving the problem at all levels?	Set direction from the top and engage the people from below?

continued

Theory E	Theory O	Combination of E and O
Goals		
3	**1**	**6**
Focus		
Emphasis on the physical systems and processes that would achieve the change. Outsourcing where necessary?	Build up corporate culture through a focus on employees' behaviour and attitudes, getting managers' buy-in?	Focus simultaneously on the hard (structures and systems) and the soft stuff like the culture and attitudes.
2	**1**	**7**
Process		
Did you implement a compelling and rigid plan and establish programmes with stringent dates and targets to achieve your objectives?	Did you experiment and allow the plan to evolve with input from employees, encouraging their ideas and subjecting the plan to a number of iterative evaluations?	Did the plan have measurable targets but allow for spontaneity, innovation and change where necessary?
0	**2**	**8**
Reward System		
Did you motivate managers through financial incentives?	Did you motivate through commitment and convincing managers of the reality of the need?	Did you use a combination of getting buy-in but with financial incentives linked to success?
1	**5**	**4**
Use of Consultants		
Did consultants play a significant role, analysing the problems and shaping the solution?	Were consultants not used or only used to support management in shaping their own solutions?	Would you say that consultants provided expert resources to empower employees?
0	**4**	**6**
Total over the six categories		
6	**13**	**41**

These results support the premise by Beer and Nohria (2000) that, in most successful change processes the drivers are a combination of the business case and the need to enhance the organisational capabilities.

Support for a combination of Theory E and Theory O change in the goals category was undisputed. One respondent pointed out that they were able to quantify benefits in an undisputed business case. However, not one organisation embarked on the change for purely economic reasons. Most felt that an HIV/AIDS workplace intervention was not just about the money but also about the employees and their skills. Hence businesses need to give due consideration to the cost/benefit decision while considering the moral imperative and the soft issue implications of their intervention.

Table 3 reflects a disparity around the dimension of leadership. Three companies indicated that urgency was driven from the top, with senior management acting first and fast, and that only later was there a groundswell from the bottom. This was indicative of a combination of the two theories. However, one company applied an almost exclusively bottom-up approach; there was a groundswell from the bottom and leadership just steered it. The interviewees found that the intricacies and sensitivities around HIV/AIDS workplace interventions require substantial and comprehensive consultation with all stakeholders.

In the responses to the focus dimension the data show that the respondents felt that, as important as the hard issues of structures and systems are, organisations must not ignore the soft issues around attitudinal and behavioural change. Ignoring either the hard aspects or the soft aspects could lead to adverse consequences. The two need to be addressed simultaneously. Creating awareness and changing behaviour were seen as the biggest challenge and a combination of Theory E and Theory O approaches was most successful.

Table 3 indicates what the process is not: a compelling and rigid plan with stringent targets and inflexible delivery dates. The process needs to be flexible, with room for innovation and creativity, subject to the discipline of targets, metrics and deadlines. One respondent described the process as iterative: as he learned, he was able to develop the process. The process dimension falls convincingly within the ambit of a combination of Theory E and Theory O change. The plans have to be flexible and responsive to adjust to the various phases of the implementation.

Table 3 shows that the reward system dimension inclines most strongly to pure Theory O. For the most part the companies interviewed were not in favour of substantial financial rewards. Compliance was secured by convincing managers and getting their commitment. The one company that did elect to use rewards did so aggressively, with managers getting a financial incentive to comply with the HIV/AIDS programme. A number of the companies used trivial rewards to ensure that the implementation of elements of the programme was successful; for example to get people to test or to go for training. However, in one form or another, targets for HIV/AIDS initiatives appeared in managers' metrics. Examples include the percentage of the workforce tested in the financial year, the percentage of HIV positive staff on a managed health care programme and the ratio of peer educators to employees. Some companies with HIV/AIDS related performance indicators said that where the measures introduced were not linked to incentives the change was not as pervasive or successful.

Table 3 shows that consultants were used primarily for their expertise and not as surrogates for an internal capability. An HIV/AIDS workplace intervention is a long-term and costly undertaking and the study showed that every successful company interviewed had developed capability within its own structures. Not one of the companies researched outsourced the entire intervention. Four of the ten companies represented typical Theory O behaviour in respect of their use of consultants. Their use was confined to areas around impact assessments, prevalence surveys and cost/benefit analyses. The companies that advocated a combination of Theory O and Theory E change used consultants for their expertise but a substantial part of the change intervention competence was always retained in-house.

Conclusion to research question 1

The last row in Table 3 represents an aggregate figure across the six dimensions. The aggregate score given is 41 out of a possible 60, indicating that 68% of the responses supported the use of a combination of the two approaches in the successful HIV/AIDS change interventions. Only 22% of the responses support pure Theory O change and a meagre 10% of the selections were in favour of pure Theory E change. This indicates that there needs to be both a profit motive and an awareness of the fact that the intervention is necessary for the sustainability of the organisation's capabilities and because of a moral obligation to employees. It shows that decisive leadership and effective structures and systems are required but that it is also necessary to support organisational capabilities through attention to attitudinal, behavioural and cultural

factors. The process requires discipline around deadlines and deliverables, evaluation and monitoring but not at the expense of flexibility, creativity and innovation. This compelling evidence should encourage managers to focus on both the hard and the soft issues when implementing HIV/AIDS interventions.

4.2 *Research question 2*

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

The responses to the questions for each of Kotter's (1996) stages are presented below, with the research questions replicated as well as the frequency of responses on the Likert scale (in the bold figures where relevant). The qualitative analyses are used to add depth to the descriptive statistics.

(i) Creating a Sense of Urgency. Score out of 5 for the degree of urgency you created in the HIV/AIDS intervention.

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

The scores were all high, with the consensus being that urgency must be created for an intervention to gain momentum. The interviewees said that as public knowledge grows and the epidemic approaches a mature stage, generating urgency has become increasingly possible. One of respondents said the prevalence statistics galvanised the company into responding. At some companies, leadership made HIV/AIDS their top priority. Understanding that the tools exist to stop the AIDS epidemic was found to be important at the outset. Five of the respondents said that the reputational risk if the organisation did not respond adequately to the epidemic acted as a catalyst in the change process. It would appear that Kotter (1996) is correct in suggesting that business must create a sense of urgency at the beginning of a change intervention for success to be realised within an acceptable timeframe.

(ii) Leadership and a guiding coalition

The open-ended question posed was: Can you describe what would be required from a leadership point of view to make this change happen? Who was involved? What roles did they play? In every case, bar one, the respondent mentioned the company chief executive by name and indicated that he or she had played an important role. In only one company did the groundswell come from middle management. This company was successful without the impetus of senior leadership involvement. Without exception every manager interviewed was passionate and optimistic about the impact his or her interventions would have on the trajectory of the epidemic. As Ramsingh and Van Aardt (2006) observe, one of the most notable complaints regarding unsuccessful policy implementation is that senior management do not provide commitment and support. As Goleman, Boyatzis and McKee (2002) state, passion breeds the courage to take on the tough tasks involved in change. "Leaders can't ignite the flame of passion in others if they don't express enthusiasm for the compelling vision of their group" (Kouzes & Posner 1995:11).

(iii) Vision and strategy

On a five-point scale, how important was the development of a vision and strategy for the organisation's HIV/AIDS workplace intervention?

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

The broad spread of the scores above indicates that vision and strategy are important, but are not the most important aspect of the change agenda. Those who recorded scores of fewer than five felt that developing the vision and the strategy were not highly important on their own, but that the communication of vision and strategy was critical. Cummings and Worley (2005), Kanter et al (1992) and Covin and Kilmann (1990) all refer to a shared vision. It is only Kotter (1996) who incorporates the strategic dimension. The vision most commonly articulated in the companies was one of an AIDS-free future with the four zeros: zero new infections, zero deaths, zero positive babies and zero discrimination.

(iv) Communication of the vision

Did the leaders communicate the change vision and to what degree?

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

As strongly indicated in the previous section, communication of the vision and strategy emerged as critical for the success of an HIV/AIDS workplace intervention. However eight out of ten respondents felt that their target audiences were experiencing HIV fatigue, described by Buchanan, Claydon, and Doyle (1997) as initiative fatigue. The interviewees said that the message had to be reinvigorated and reenergised as complacency sets in. Seven out of the ten respondents mentioned the need to keep the message simple and contextually relevant. "The main issues influencing the effective communication of the policies and programs are clarity and the ability to be understood, conciseness and interaction and participation" (Ramsingh & Van Aardt 2006:192). It was also important that the companies communicate that the organisation is winning against AIDS. This endorses the view of Covin and Kilmann (1990).

(v) Empowerment and participation

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

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

When questioned regarding participation, a number of the respondents said they were not satisfied with less than 100% involvement of all staff and consequently felt they could not score participation too highly. Overall the value of participation to the success of the intervention was undisputed; it was just that some had set the bar extremely

high. Eight out of ten respondents said that involving the unions, as part of a broad-based strategy, was important. Another form of involvement centred around "champions" and peer educators who engaged the workforce at the grassroots level. This supports Kanter, Stein and Jick (1992), who refer to this as developing enabling structures. In one respondent's view, there has to be a transition from "What is being done about it?" to "What can I do about it?" It was found that broad-based participation by all stakeholders is a prerequisite to success.

(vi) Quick wins

The open-ended question asked: "Did you identify and go for any 'low hanging fruit' or 'quick wins'? Did you focus on small successes along the way? What impact did this have?" Seven out of ten respondents went for quick wins in their interventions, with treatment, testing and achievable targets being the most popular. VCT was found to be a fairly mechanical process but one that required lots of planning and creative communication. Getting it established and reaching measurable targets was viewed by many respondents as a quick win. As uptake improves, this helps to give the programme momentum. As one respondent said, (and this is supported by Holland [1995] and Kotter [1998]), "celebrate the low figures and then raise the bar." The value of quick wins is undisputed, but as Katzenbach (1996) points out, there is a risk that celebrating the quick wins can detract from the ongoing and long-term focus of the intervention.

(vii) Consolidate and produce more change

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

All the respondents said that consolidating gains, learning from the various elements of the intervention and applying those learnings to the way forward were essential to the success of the interventions. It was evident that success breeds success, and the celebration of the success stories maintained the impetus. They found that the positive learnings must be implemented while the negative learnings are discarded. Each success was seen as the progenitor of the next component of change. This reflects the dynamism of interventions in the rapidly changing field of HIV/AIDS. Replicating successes has been a hallmark of HIV/AIDS workplace interventions (Whelan et al 2008).

(viii) Anchor change in the culture

The open-ended question was: "Can you describe what this change has meant to your company? Has the initiative remained in management hands or is it more pervasive than that? Are the initiatives now anchored in the culture"? Seven out of ten respondents expressed confidence that the response to HIV/AIDS is now embedded in the organisational culture, with the remaining three feeling they are almost there. The ownership of intervention should be the "way we do things around here" (Kotter 1995; Kanter et al 1992). It must be added that all of the companies interviewed considered themselves to be in the early stages of the intervention, although they are acknowledged leaders in this field. This is a reflection of the expected timeframe of an HIV/AIDS workplace intervention. Most of the respondents mentioned that if stigma and discrimination and the resultant secrecy, which is an obstacle to progress in combating HIV/AIDS, are ever to be eradicated, the response to the epidemic will have to be pervasive in companies and embedded in the cultural fabric of the organisation.

Additional theme and conclusion. After the questions posed around Kotter's (1996) eight steps, the interviewees were asked: "Is there anything else that happened in your intervention that you consider a critical factor in its success?" All ten respondents felt that measurement, metrics, monitoring and evaluation were important in the success of their interventions as measurements drive behaviour. Kanter et al (1992) list as their first step the need to analyse the organisation's need for change. Covin and Kilmann (1990) speak of diagnosis, which amounts to a baseline measurement. The need for both initial prevalence and ongoing measurement of a number of metrics is convincingly supported by the research findings. The data show that all of Kotter's (1996) eight stages are required for change to be realised in an HIV/AIDS workplace intervention and that an additional element, measurement and metrics, is vital to augment Kotter's eight stages.

4.3 *Research question 3*

French and Raven (1959) and Robbins and Judge (2007) refer to reward power, coercive/punishment power, legitimate power, expert power and referent power. Which power bases were employed in the successful HIV/AIDS workplace interventions?

A constant sum scale technique in the interview guide was used to determine the spread of the power bases used. Respondents were asked to divide 100 points between the five power bases that the researcher described to them. Table 4 shows the aggregated relative importance of the power bases.

Table 4
Relative usage of the power bases in the change processes

	Legitimate power	Expert power	Referent power	Reward power	Coercive power
Mean	34%	27%	21%	13%	6%
Median	29%	30%	15%	5%	5%
Min	0%	10%	0%	0%	0%
Max	80%	43%	60%	50%	20%

The power bases that were successfully leveraged were: legitimate power, expert power and to a lesser degree, referent power. This supports the thesis of Robbins and Judge (2007). A powerful lesson lies in this finding, as compliance with the intervention's initiatives was found to be largely due to the fact that the boss used his authority and position to simply request that employees comply. When people in positions of authority became involved in the intervention this engendered more success. The use of reward power proved insignificant and the use of coercive power was seen to have negative consequences. The interviewees found that expert power combined with legitimate power had the greatest impact. HIV/AIDS is an information-intensive field and it is important that leaders are knowledgeable about AIDS.

4.4 *Other themes which emerged*

In-depth interviews result in rich qualitative data, much of which may enhance the constructs formulated in the research questions. These "emergent" themes are a vital part of exploratory and fine-tuned research. Some of the dominant themes which emerged in this way are:

Watersheds, defining moments and personal experience that catalysed the need for an intervention were mentioned as being important in eight of the ten responses. Seven out of ten of the managers stated that the response to HIV/AIDS was a business imperative critical for sustainability and that it needs to be understood as such and be part of day-to-day risk management. They said it is more than a "nice to have"; HIV should form part of every business continuity discussion. Six out of ten respondents said that one cannot focus on just one aspect of policy or stage in the change processes. All the processes have to take place simultaneously as nothing operates in isolation. All aspects are interdependent and hence there is no specific order that can be prescribed for the various stages in the change process.

Six out of ten respondents mentioned the fundamental importance of human rights, confidentiality and trust. They found that stigma and discrimination promote the secrecy which is the paramount obstacle to fighting the epidemic. This can be addressed through vigilant observance of the confidentiality of employees' HIV status, building and maintaining relationships of trust and a broad-based paradigm shift with regard to the disease and its implications. It is often not in the nature of a business to be mindful of these soft, human issues, but they cannot be ignored if interventions are to be successful. Six out of ten of the companies house the HIV/AIDS workplace interventions within a broader wellness programme. HIV testing is now done during routine check-ups. Health in general is focused on, with programmes concentrating on physical and financial wellness, stress management, divorce counselling and information on depression and substance abuse. The companies found that this leads to the important normalisation of the HIV syndrome.

5 Recommendations: a change model for HIV/AIDS workplace interventions

This research culminates in recommendations that have been consolidated into a best-practice, results-based model that illustrates the elements required for a successful HIV/AIDS intervention. The model shown in figure 1 comprises nine stages of change, four dimensions of the necessary strategy for change and four leadership factors that influence HIV/AIDS change processes. It is an integration of all the results discussed above.

The nine stages critical to successful HIV/AIDS workplace interventions are presented in the centre of the diagram. Research question 2 explored the required stages of change and the findings in section 4.2 above show that while all Kotter's (1996) stages are critical, an additional stage, namely measurement, has emerged. The sequence in which they are presented is not prescriptive. All the elements should be considered and exploited throughout the intervention, with different emphases at different times. The nine stages begin with establishing, through situation analysis and statistics, the risk that the organisation faces and using this to create urgency around the response. Leaders at three levels – on the board (preferably championed by the CEO or Chairman), at the HIV/AIDS manager level and then at the operational line manager level, must be involved. A simple, well-communicated vision must be created. Measurement of, and toward, targets as well as including the HIV/AIDS related elements in management indicators is essential. There should be broad-based engagement with employees, the unions, the community, the government through public/private partnerships, health providers, peer educators and coalitions with other companies. This must be an inclusive process in every respect. Short-term wins at the outset come from delivering on the elements of the programme that can be procured,

such as VCT and treatment. Successes should be celebrated and the learnings used as a foundation on which to build more change. Finally, it should be the ultimate aim of every organisation to have this intervention entrenched in the organisation's culture.

Four broad dimensions of the strategy for change (shown on the right of the model) significantly impact on the success of the nine stages. This begins with employing a combination of Theory E and Theory O change, that is a combination of the business case and the organisational capability case. Beer and Nohria's (2000) six dimensions have been adapted to include only those dimensions relevant to an HIV/AIDS workplace intervention as shown in the discussion on table 3. The salient points include the requirement that goals should be both economic and motivated by the moral obligation. Leadership must be both decisive and consultative. Focus and process have considerable commonality and are combined into one dimension. The process must be vigilant about outcomes but flexible and responsive on how these are achieved. Finally, the organisation must develop capabilities within its ranks and only draw on the expertise of consultants to augment their knowledge and capacity. The findings in table 4 and in section 4.1 show that the use of rewards does not play a significant role in the success of an intervention.

On the left hand side certain power bases, leadership traits and behavioural constructs, which influence the effectiveness of the change, are shown. These are based on table 4 and the new themes which emerged. Expert power can be developed by improving leaders' knowledge of HIV/AIDS. Enlisting more senior members of the organisation into the leadership coalition can strengthen legitimate power. The traits that leaders must embody in order to drive the change are passion and optimism, which are difficult to create, but the magnitude of their presence will directly influence the success of the intervention. Finally it has been shown that the inherent tendency of human beings to compete via communicating success on a number of metrics, for example VCT uptake, can be used to leverage success, both within and between companies.

All of this must be achieved in an environment of confidentiality and trust, the value of which is exponential. Every effort must be made to ensure that trust is preserved and that confidentiality and human rights are sacrosanct. The ultimate outcome of a successful HIV/AIDS intervention will be the behavioural change required to prevent new infections, prevent mother to child transmission, eradicate stigma and discrimination, improve the uptake of VCT, enrol more people in treatment management programmes, prevent people from getting sick and dying and ultimately to win the battle against the scourge of HIV/AIDS.

6 Conclusion

As the threat of complacency looms large, business leadership must take stock of the long-term realities surrounding the impact of HIV/AIDS. Prevention and behavioural change are vital and require a long-term perspective. "Leaders on HIV recognise that the epidemic is a generations long challenge that requires persistence, vision, and flexibility; in short, HIV leadership means planning for the long-term" (UNAIDS 2008:193). There is a perception that workplace interventions are losing momentum as AIDS fatigue sets in. As the quick wins of testing and treatment are achieved, the hard work of long-term organisation-wide change processes must be addressed. The model built from the data elicited in this research should assist in the process.

Areas for future research are: Determinants of successful organisational change in the HIV/AIDS workplace interventions in small and medium enterprises, how organisations sustain successful HIV/AIDS workplace interventions, and the role of labour unions and other stakeholders in business HIV/AIDS interventions.

South Africa has been exposed to the worst burden of the global HIV/AIDS epidemic. By applying the findings of this empirical research, business leaders will be better positioned to lead successful HIV/AIDS workplace interventions. The research shows that large-scale organisational change, driven by a combination of the business case as well as a moral imperative, is required for the response to HIV/AIDS to be effective. This research will prove valuable to those business leaders who wish to initiate HIV/AIDS interventions as well as to those who perceive their endeavours in this area to be ineffective. Most importantly, the research demonstrates that, notwithstanding all the intricacies, complexities, trials and difficulties, it is most certainly possible to succeed in workplace responses to the HIV/AIDS epidemic.

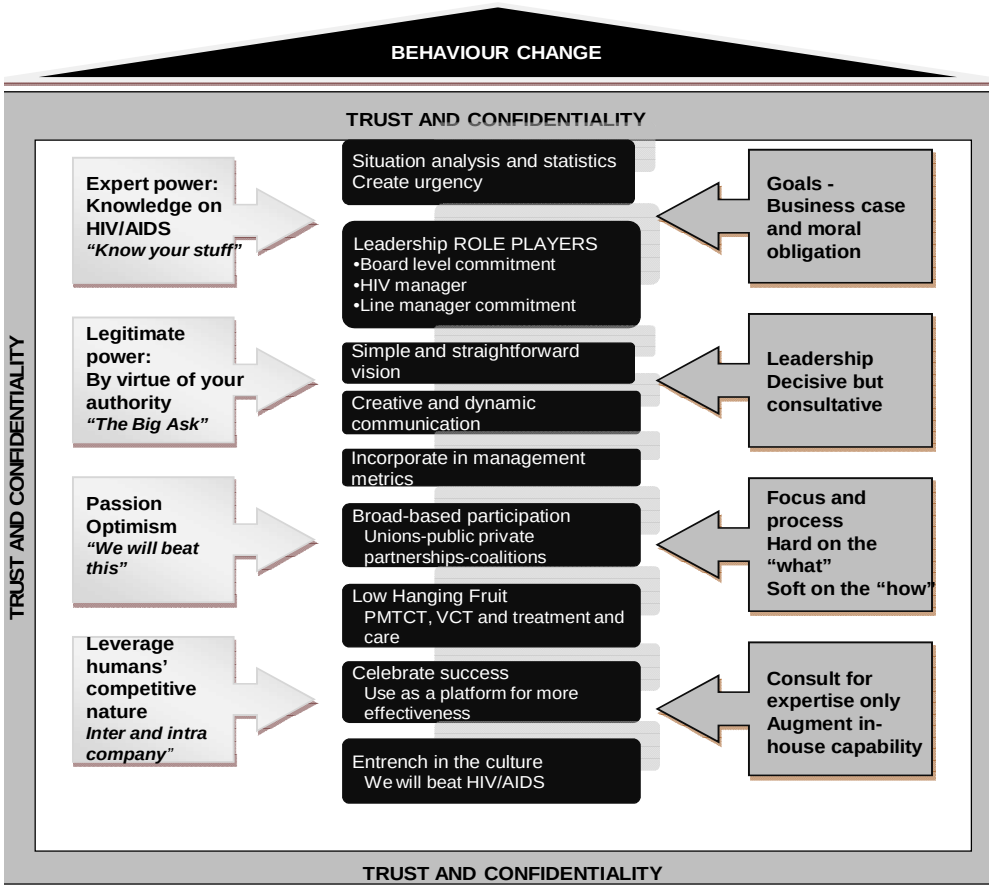

Figure 1
Essential organizational change elements for successful HIV/AIDS workplace interventions

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