

THIS TO CERTIFY THAT THE WORK OF  
**THE IMPLEMENTATION OF A STRATEGY FOR THE  
EFFECTIVE MANAGEMENT OF HIV/AIDS IN THE  
WORKPLACE:**

**A STUDY IN THE VAAL TRIANGLE REGION**

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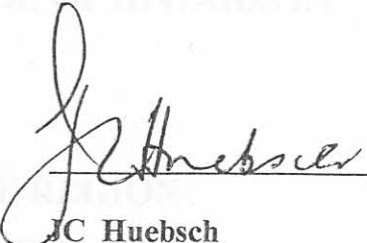


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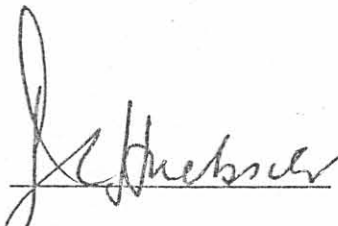
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**A STUDY IN THE VAAL TRIANGLE REGION**

Is my own work, that all the sources used or quoted have been indicated and acknowledged by means of complete references, and that this thesis was not previously submitted by me for a degree at another university.

.....

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**November 2001**

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## SUMMARY

It is an accepted practice in any business organization that the opportunities and threats

are identified and analyzed in order to determine the nature and extent of the

# **THE IMPLEMENTATION OF A STRATEGY FOR THE EFFECTIVE MANAGEMENT AND CONTROL OF HIV/AIDS IN THE WORKPLACE:**

The study is an exploratory research into the implementation of a strategy for the

## **A STUDY IN THE VAAL TRIANGLE REGION**

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by

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## **FREDDIE VENTER**

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The proposal part of the study consisted of a questionnaire to determine the

and more within the area of work. The objective was to determine the

The results of the study will be used to determine the nature and extent of the

implementation of a strategy for the effective management and control of HIV/AIDS

understanding of the epidemic and its range could be formulated with a view to

various aspects of the organization and its operations

## SUMMARY

It is an accepted practice in any business organisation that the opportunities and threats facing organisations must be examined and plans drawn up to take advantage of the opportunities and to deal effectively with the threats. Surely HIV/AIDS is one of the greatest threats and challenges that organisations in South Africa are facing.

The study is an exploratory research into an important issue facing many organisations today and is adequately supported by a proper and detailed literature study supported by an empirical study on the relevant research topic. A number of interviews were also conducted to determine what specific viewpoints, suggestions and limitations there were, or could be, toward the evaluation of existing structures and strategies and what alternative actions could be used and implemented, to effectively manage as well as control the disease and its various impacts within the workplace.

The literature review within the scope and limitations of the study, therefore, concentrated on the specific nature and various impacts of AIDS as a starting point, followed by a detailed investigation why organisations need to implement sufficient action programmes, policies and strategies. The reality is that AIDS know no gender, race or class boundaries but is actually influenced by socio-economical factors such as poverty, violence and rapid urbanisation, with the potential to disrupt economic stability and growth for the country.

The empirical part of the study consisted of a questionnaire that was completed by various respondents (organisations) which included a minimum number of 500 employees and more within the area of study. The objective was to establish if current structures within organisations, are effective and suitable enough or lacking.

The research finding clearly indicated the various impacts that organisations are currently facing and what specific action programmes, policies and strategies needs to be implemented. It was the intention of this study to cover a wide variety of aspects related to the impact of AIDS within the workplace, so that proper insight and clear understanding of the epidemic and its nature could be formulated with all its facets and various impacts on the organisation and its resources.

## OPSOMMING

Dit is aanvaarbare praktyk in enige besigheidsonderneming dat geleentheid en bedreigings wat ondernemings in die gesig staar, eers ontleed en planne geformuleer word om voordeel te trek uit geleentheid en om bedreigings effektief te bestuur. VIGS is sekerlik een van die grootste bedreigings en uitdagings wat ondernemings regoor Suid Afrika raak.

Die studie behels verkennende navorsing oor belangrike aspekte wat baie ondernemings vandag raak, en word ondersteun deur 'n deeglike intense literatuur studie en empiriese navorsing. 'n Aantal onderhoude is ook gevoer om te bepaal watter spesifieke oortuigings, voorstelle en beperkinge daar wel bestaan tot sover die evalueering van bestaande strukture en strategieë asook watter alternatiewe aksies geneem en geïdentifiseer kan word binne die werksomgewing.

Die literatuur oorsig binne die beperkings van die studie dui op die spesifieke aard en verskillende impakte van VIGS, gevolg deur 'n in-diepte ondersoek waarom ondernemings 'n behoefte het om deeglike aksie programme, beleide en strategieë te implementeer. Die werklikheid is dat VIGS geen geslag, ras of klas grense ken nie en dat dit beïnvloed word deur faktore soos armoede, geweld en snel groeiende verstedeliking met die potensiaal om ekonomiese groei en stabiliteit van die land te ontwig.

Die empiriese gedeelte van die studie bestaan uit 'n vraelys wat voltooi is deur verskeie respondente (organisasies) met 'n minimum getal van 500 of meer werknemers. Die doelwit was om vas te stel of bestaande strukture binne ondernemings, effektief is, al dan nie.

Die navorsingsbevindinge dui ook daarop watter impakte ondernemings tans in die gesig staar en watter spesifieke aksie programme, beleide en strategieë geïmplimenteer moet word. Dit was die doel van hierdie studie om 'n groot verskeidenheid van aspekte in te sluit tot sover die impak van VIGS binne die werksomgewing, sodat 'n goeie idee en begrip vir die epidemie asook die verskeie impakte geformuleer kan word, met direkte invloed op die onderneming en al sy hulpbronne.

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CHAPTER 1

BACKGROUND AND DEFINITION OF THE STUDY

1.1 INTRODUCTION

South Africa's HIV/AIDS epidemic is among the worst in the world, and large businesses recognise the need to manage its impact on productivity and competitiveness. No generation has to longer hide from the reality of HIV/AIDS. The time to think that our clients will not affect business has passed. Recent statistics that more than one million South Africans are now living with HIV/AIDS are a stark reality for the year 2005 (Kingsley, 2006:72).

*Though you are Poor [in spirit or wisdom], do not say:*

*“I am penniless, so I cannot seek out Knowledge”.*

*Instead, bend your back to all discipline,*

*Purify your heart through all Wisdom,*

*And in the abundance of your intellectual potential,*

*Investigate the mystery of existence.*

*- The Dead Sea Scrolls*

## CHAPTER 1

### BACKGROUND AND DEFINITION OF THE STUDY

#### 1.1 INTRODUCTION

South Africa's HIV/AIDS epidemic is among the worst in the world, and many businesses recognise the need to manage its impact on productivity and competitiveness. Organisations can no longer hide from the reality of HIV/AIDS. The time to think that this illness will not affect business, is long past. Projections indicate, that more than four million South Africans will be HIV-infected by 2000 and almost six million by the year 2005 (Kinghorn, 2000:22).

Currently the levels of infection continue to grow in all nine provinces of South Africa. The epidemic will result in AIDS illness and deaths mainly among the 25 to 49 years olds, the core of the workforce population in South Africa. Another important fact is, that more than two-thirds of the world's total population living with HIV/AIDS, is living in sub-Saharan Africa, the region with the fastest spreading epidemic (Van Dyk, 2000:18).

The impact of the epidemic however, remains hidden, even in areas where it has reached an advanced stage. The reasons for this, is the interim delay of the HIV infection to full-blown AIDS and ultimately to death, averaging a period of about 8 to 10 years. In addition, the stigma and fear of discrimination of a person's HIV/AIDS status, ineffective control measures, policies and plain ignorance are also contributing factors. Over the next 10 years or so, many South African organisations and businesses will begin to lose approximately four per cent of their employees to AIDS each year. Virtually every manager and his/her co-workers will be affected by the epidemic in one form or another (Kinghorn, 2000:22).

Another important fact is, that HIV/AIDS will have a huge impact on the direct and indirect costs, in order to manage the epidemic successfully. It will also affect health

care and other employee benefits in organisations across the South African business spectrum. The socio-economic impact of HIV/AIDS will also have a significant impact on the economy as a whole. Costs of many medical schemes are likely to double within the next five years, while indirect costs are likely to have the most significant impact on many businesses. The vulnerability of many businesses, however, will vary, depending on various factors such as: the type of production process; risk profile of employees and employee benefit structures. As Deputy Minister of Mineral Affairs, Susan Shabanga, stated on the HIV/AIDS epidemic: “AIDS is not only a matter of concern for the industry, it is a matter of concern for the world. Some are of the opinion that since AIDS is not a notifiable disease, employers can therefore, conveniently distance themselves from any activity because of the possibility of violating the right of privacy and confidentiality” (Anon, 2000:4).

It is, therefore, imperative that organisations with well-developed Human Resources and Industrial Relations Management strategies and programmes, will be better equipped to manage HIV/AIDS costs, impact and overall vulnerability to the epidemic. The impact that HIV/AIDS will have on the workplace, will become more and more important to all levels of businesses in the South African economic environment. Organisations, therefore, must have a direct interest in ensuring that HIV/AIDS does not unnecessarily affect costs and production. HIV/AIDS will become a reality for South African organisations for decades to come and cannot be seen as the responsibility of the government and health services alone (Kinghorn, 2000:23).

It is behind this backdrop, that organisations and businesses over all spectrums must start realising that effective management is the only way forward. The scale of the epidemic requires that management on all levels must be strategic and analytical in their thinking processes in order to allow them to approach this epidemic in the right frame of mind. In doing so, businesses will still have a competitive edge in the economic environment. The word strategy, programmes and plans, must become synonymous with the words “prevention and precaution” in respect of the HIV/AIDS epidemic.

To consider the feasibility of this study, attention will be given to the implementation, management and maintenance of such structures and strategies that will have a positive outcome for organisations in dealing with the epidemic. Aspects like government and organisational policies on HIV/AIDS, different types of structures and action programmes to be implemented advantages, disadvantages and various other contributing factors will also be explored and discussed in this thesis.

## 1.2 LITERATURE REVIEW

Although the concepts HIV and AIDS are closely related, there is still a noticeable difference between the two terminologies. The word “HIV” is actually a letter group for the words “Human Immune Deficiency Virus”. The “HIV” is thus a virus that attacks and causes deterioration of the body’s immune system. The immune system is the body’s natural defence against infections and illnesses, for example the influenza virus or common cold. The HIV-virus is, therefore, the virus that is directly or indirectly responsible for the main cause of AIDS (<http://www.shcom.com/stopAIDS/htm>).

Although AIDS is also used as an acronym, its meaning becomes clear once one really understands its descriptive definition. Just like HIV, AIDS also have a role to play in a person’s immune system, actually a bigger role than HIV. AIDS stands for the words: “Acquired immune deficiency syndrome”. From the above description, we can make the following logistic assumptions: A person first has to acquire the HIV virus, before he/she can be infected by full-blown AIDS, which affects the body’s immune system in respect of common illnesses, such as colds or influenza. We can also conclude, that it must be acquired before it can be transmitted from one person to another from an outside source. It is a syndrome which implies, that a number of common symptoms will be present in the same way as would a person have who has contracted the common cold or influenza.

Descriptive definitions on HIV and AIDS can now be formulated relating as deduced from the information above. HIV is: “A virus that attacks and destroys the body’s immune (defence) system against infections and diseases” (<http://www.shcom.com/>

[stopAIDS/htm](#)). Another definition describes the virus as: a specific kind of germ called the HIV - human immune deficiency virus. The HIV invades the immune system and destroys it by killing the white blood cells that safeguard the body against illnesses (Visagie, 1999:1).

AIDS, however, can be defined as: “A syndrome (symptoms) that is transmitted from an outside source (person, needle or blood transplant) that affects the immune system, and causes a deficiency in the body’s natural defences against illnesses and diseases.” (<http://www.shcom.com/stopAIDS/htm>) or it could also be described as follows: “An immune deficiency meaning that the body’s immune system is incapable of functioning as a protective barrier against disease. A syndrome is comprised a group of symptoms or illnesses originating from one cause” (Visagie, 1999:1).

During the last two decades the spread of HIV/AIDS has become more intense and has exerted great strain on developing countries economies, such as that of South Africa. The simple truth is, that HIV/AIDS will become an issue that organisations and employees shall have to deal with on a daily basis as an integrated part of their daily management process. Therefore, organisations must adopt proper action programmes, action plans and implement sufficient structures and strategies that must be successful in managing and minimising the impact that the epidemic will have on the socio-economic development of the country. Attention must also be given to certain criteria that are necessary to analyse, evaluate and implement, such as action programmes, structures and strategies. Each organisation, however, will require a different strategy or action programme while the needs for globally competitive organisations will differ dramatically from a small to medium size business. Attention must thus be given to the term “strategy” or “plan of action”.

The word “strategy” implies the following. It is an action of choice in a changing environment, with the considerations of the organisation’s ability. The word “strategy” can also relate to a plan that links the available resources with the future possibilities of outcomes in a specific market or market environment. However, before a strategy can be implemented, a thought process or some sort of strategic thinking must first take place. This is primary the responsibility of managers in key

positions within organisations in order to identify and evaluate such plans for implementation. This action is the so-called “thinking process” or “strategic” thinking process. It involves the whole thought process to create a strategic plan or plan of action (Kroon, 1997:35).

Alternatively, an action plan or plan of action could be seen as: “The fundamental element of management that determines what an organisation proposes to achieve and how it should go about doing so” (Cronje, 1997:116). It is, therefore, necessary that an existing plan of action or proposed plan of action does not succeed in attaining the predetermined objectives, or should some new objectives be established.

It is absolutely imperative that organisations must be clear in their strategic way of thinking and doing so, that sufficient structures, strategies, action plans and programmes can be implemented efficiently and effectively in dealing with the HIV/AIDS epidemic. Certain criteria will be evaluated and analysed in order to determine if a particular strategy will be considered effective or not. These criteria are essential for the success and survival of the organisation in the long term. The important roles all stakeholders have to play in fighting the epidemic, will also form a crucial part of the study. Management is, therefore, confronted with various options in determining strategy or action programmes that will effectively manage and control the HIV/AIDS epidemic in the workplace.

The empirical part of the study will, therefore, focus on suitable and concrete strategies and plans of action available for the effective management of HIV/AIDS in the workplace. Government legislation and policies on the subject and all relevant role players input on the management and control of the epidemic will also be discussed. The attitudes and perceptions of employees and organisations will also be highlighted.

### **1.3 BACKGROUND AND IMPORTANCE OF THE STUDY**

HIV/AIDS is a stark reality. Organisations can no longer sit on the sideline and hope that “the problem” will go away. Intensive action plans and reactive management



philosophies are needed to combat and manage the devastating illness. A controlled scientific study carried out by government over a nine-year period, has shown that the general South African public has been affected to such an extent, that HIV/AIDS will have a significant impact on the entire business industry. The infection rate in the country is currently in the region of 18 to 20 per cent of the sexually active population.

The epidemic has already reached the level where it will seriously affect the production capacity of the country. The average life expectancy in South Africa is expected to fall from 60 years to around 40 years between 1998 and 2008. Towards the end of 1998, 50 per cent of all new infections in Southern Africa that occurred that year, was in South Africa, and were catching up with neighbouring countries such as Botswana, Namibia, Swaziland and Zimbabwe (Moore, 1999:3). It is estimated that, by 2005, nearly one in five workers in South Africa will be HIV positive. The way organisations and industries tackle the many issues AIDS raises in the workplace, will ultimately determine whether South African organisations will remain productive beyond the next decade. However, the disease is such, that the effects are still largely invisible. The extent of this impact is so vast, that is hard to comprehend even when communicated scientifically. For example, if the correct treatment approaches were used to treat those people who are currently HIV-positive and who in the next four years will be suffering from full-blown AIDS, the cost alone would exceed the current national health budget (Anon, 2000:1).

The effect that HIV/AIDS will have on the country's resources and economic development is enormous. It is not the fight of government and health sectors alone. Organisations and businesses in all sectors must unite and must have a common goal to square up the epidemic. This would mean that organisations would have to make an impact study or formulate a damage assessment contingency plan in order to ascertain the possible impact of the HIV/AIDS epidemic within the workplace. Organisations that are implementing a well-structured action programme and strategy by using standard practices, will show better results, even if they were to compare to global benchmarks or trends. The truth however, is that the impact of the epidemic is

not related to only organisational internal labour markets, but also to the external customer market, thus affecting profits on all sides.

The fact is, that HIV/AIDS will become an issue that management will have to deal with on a daily basis. Ignore the issue, and it will kill business (Anon, 2000:2). It is, therefore, absolutely imperative, that management play an active role in formulating suitable strategies for the implementation on the short, medium and long term. The importance of the study lies in the investigation and implementation of cost-effective ways and methods to reduce the HIV/AIDS impact on the economy and more importantly, in the workplaces of businesses. More effective management methods are needed to positively impact on employees and operation processes within the business environment. Comprehensive responses to the implementation of action programmes and cost-effective strategies, will benefit businesses directly and will have wider benefits in communities and society at large (Kinghorn, 2000:23).

The socio-economic impact that HIV/AIDS will have over the next decade, will surely test the management ability of many organisations. Management has an active role to play in the formulating, implementing and maintaining of HIV/AIDS policies, procedures and action plans. Organisations must be seen as part of a greater alliance between other role players like government and trade unions, in order to combat the epidemic on all fronts of the labour market. The central focus of the study can, therefore, be seen from the perspective of management to identify and formulate effective structures, strategies and action plans to combat the HIV/AIDS epidemic within the workplace of organisations, together with other important role players.

#### **1.4 DEFINITION OF THE RESEARCH PROBLEM**

From the above, it is clear that there is a need for organisations to become more actively involved in the management of HIV/AIDS in the workplace. It has become an issue that cannot be ignored any more. From this viewpoint, certain research problems can be identified.

- Why is it necessary for businesses to become more actively involved in the management of HIV/AIDS?
- Are there effective and sufficiently structured policies and action programmes in place currently to manage the HIV/AIDS epidemic successfully (if any)?
- Are organisations really aware of the impact that HIV/AIDS will have on their resources and the ability for future growth and development?
- What strategies and programmes are already in place and are these strategies and action programmes successful to combat the epidemic (if possible)?

### **1.5 PURPOSE OF THE STUDY**

The main purpose of the study is to investigate and determine an effective management strategy towards the management and control of HIV/AIDS in the workplace; more specifically, to investigate and explore the following aspects relating to the HIV/AIDS epidemic.

- The socio-economic impact of HIV/AIDS in South Africa.
- The investigation and analyses of effective structured policies, action programmes and strategies to manage HIV/AIDS more effectively.
- The positive and negative implications that HIV/AIDS will have on the business environment.
- The role that organisations and management have to play in order to allow these to manage the HIV/AIDS epidemic more effectively.
- The responsibility that the various role players have towards the implementation and maintaining of reactive management practices towards the management and control of the HIV/AIDS epidemic.

### **1.6 OBJECTIVES OF THE STUDY**

One primary, and five secondary objectives have been identified for this particular research study.

*Primary objective.*

- Investigating and analysing strategies, action programmes and policies for the effective management and control of HIV/AIDS in the workplace.

*Secondary objectives.*

- (1) Measuring the impact of HIV/AIDS in the workplace.
- (2) Measuring the effective management of the HIV/AIDS epidemic in the business environment.
- (3) Measuring the role of management in order to combat the disease.
- (4) Measuring existing action programmes and strategies for successful implementation within the workplace.
- (5) Measuring the success rate of these action programmes, policies and strategies for the organisation (if possible).

## **1.7 METHOD OF THE STUDY (RESEARCH METHODOLOGY)**

The study consists of a literature study, as well as an empirical study and personal interviews.

The three different approaches can be outlined as follows.

*Personal interviews*

Personal interviews have been conducted to determine general trends and impressions towards regarding HIV/AIDS action programmes, procedures and strategies. This, in turn, will be an aid in the process of compiling the relevant questionnaire.

*Literature study*

A literature study has also been compiled on the relevant subject of study so as to provide a better insight into the research problem and the necessary background to

guide the empirical part of the study. Apart from the information obtained from textbooks, other sources will be consulted in order to obtain the information needed for this particular study. Sources such as journal articles, magazines and Internet will be consulted. Statistics and other relevant information will also be used during the study.

The Harvard Method of source referencing and acknowledgement will be used. Footnotes will not appear on the bottom of each page; instead quotations and references are specified directly after the particular quotation of reference.

### *Empirical study*

The literature study is followed by an empirical study.

Interviews conducted, include:

- HR managers and officials responsible for the formulation and the maintenance of various HIV/AIDS structures, action programmes and statistical reports.
- Medical officers, Occupational Health nurses and EAP advisors responsible for the implementation of such HIV/AIDS action programmes and strategies.

A number of industrial organisations (with a minimum of 500 or more employees within the Vaal Triangle Region) will be targeted according to the random sampling method. A questionnaire will also be compiled. The questionnaire will be compiled in order to allow the researcher to achieve the primary and secondary aims of the study. The questionnaire will consist of three sections.

*Section A:* General and demographic information.

*Section B:* Information concerning the evaluation of existing HIV/AIDS policies and structures by the relevant organisation in question.

*Section C:* Information regarding the evaluation of specific statements/factors that have an influence on policy and structure formulation/implementation within the workplace.

Respondents will remain anonymous, ensuring greater objectivity.

## **1.8 DEMARCATION AND LIMITATIONS OF THE STUDY**

The area of study includes the major industrial organisations that operate within the Vaal Triangle. Emphasis is thus placed on the major industrial organisations with 500 employees and more within the area of study. The Vaal Triangle, as far as the scope of this study is concerned, consists of the following towns: Vereeniging, Vanderbijlpark, Sasolburg, Meyerton and Carletonville. The study will include Sasolburg as its being functionally and economically inter-linked with this particular region's economic activities, and should be interpreted as such.

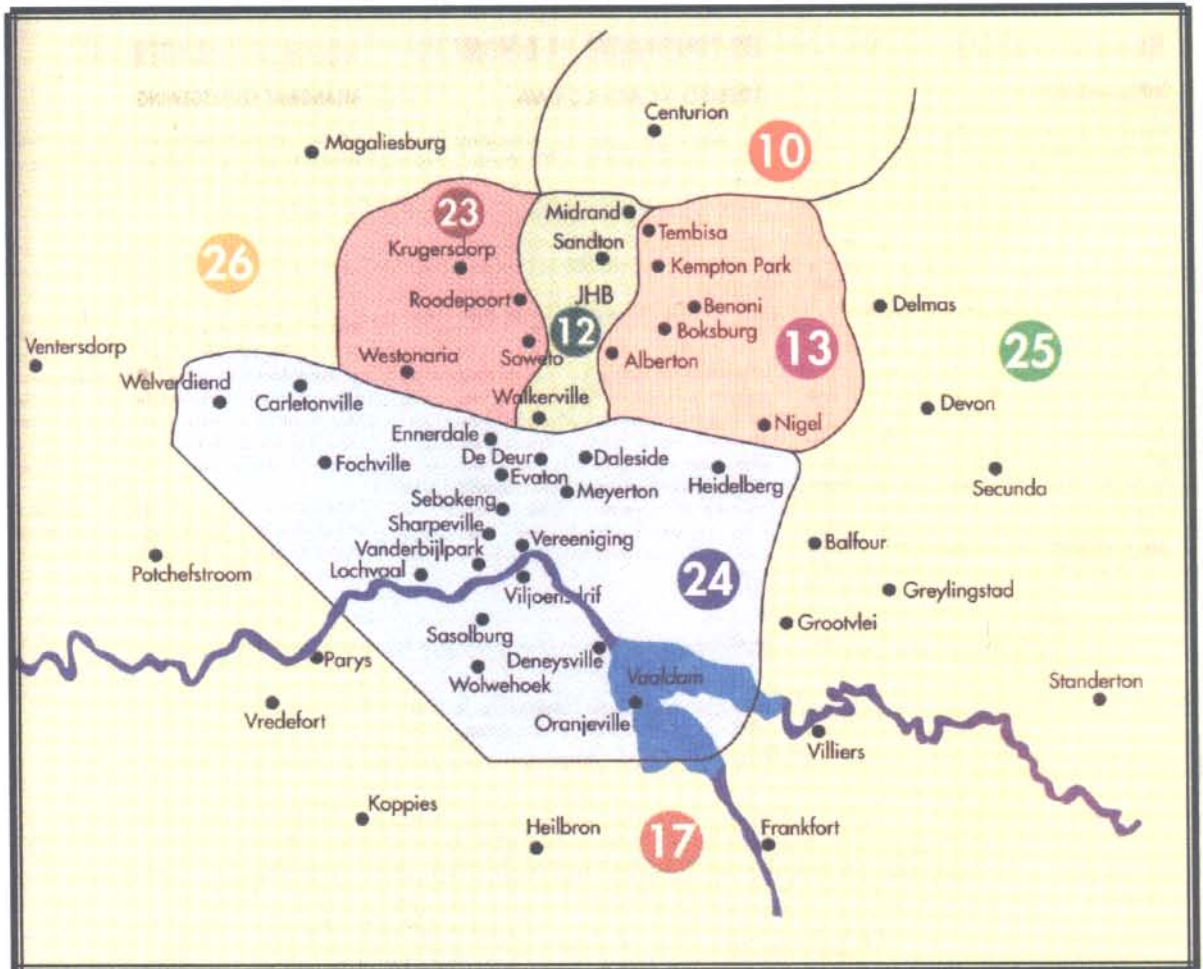
The following can be regarded as major limitations to the study.

- HIV/AIDS figures and statistics available, are representative of South Africa and do not reflect the Vaal Triangle trend.
- This area of study does not represent the entire workforce of the South African economy, but only a certain percentage of the economic active population within the particular region of study.

Figure 1.1 to follows on p.12.

Figure 1.1: Map of study area

VAAL TRIANGLE AREA – 24



<b>Legend:</b>	10	Pretoria	17	Free State	25	Mpumalanga
	12	Johannesburg	23	West Rand	26	North West Province
	13	East Rand	24	Vaal Triangle		

## 1.9 STRUCTURE OF THE STUDY

The research study consists of eight chapters, the content, which could be summarised as follows.

### ***Chapter 1: Background and Definition of the Study***

This chapter comprises the introductory section of the study. Background is provided, while the importance and the purpose of the study are clearly stated. The scope of the study is discussed, as well as the importance for such a study and the need thereof. Reference is also made to certain major limitations that may have an influence on the outcome of this particular study.

### ***Chapter 2: Theoretical Perspective and Impact of HIV/AIDS in South Africa***

This particular chapter will focus on the need for action to be taken against the impact of HIV/AIDS in South Africa. It will also focus on the history and spread of the HIV/AIDS epidemic over the last decade, together with the socio-economic impact it will have in South Africa, as well as on some Southern African countries globally. The need to control and manage the spread of the disease within the micro-environment, will also be discussed.

### ***Chapter 3: South African Businesses and the HIV/AIDS Threat***

Chapter 3 will focus on the need for organisations, especially the private sector organisations, to get actively involved in the management and prevention of the spreading of the disease within the workplace. The different role players and their responsibilities will also be discussed. Attention will be given to the direct and indirect costs of managing the disease within the working environment, as well as the legal implications in managing the illness. The chapter will end with a short discussion on different structures to combat and manage the impact of HIV/AIDS in South Africa more effectively.



**Chapter 4:**                    *Analysing Structures/Strategies and Action Programmes for the Effective Management of HIV/AIDS in the Workplace*

In this chapter various structures, strategies and action programmes will be identified and analysed according to certain criteria and guidelines. Certain strategic models, their significant and functions for businesses, will be identified and discussed by means of practical case studies. The role that management has to play in the management and implementation of well-structured strategies and action programmes, will also receive attention.

**Chapter 5:**                    *Implementing a Strategy for the Effective Management and Control of HIV/AIDS*

After the evaluation and analysis of a number of alternative action programmes and strategic plans in Chapter 4, this particular chapter will focus on the importance, function and necessity of and for a suitable and sustainable broad national strategy and action plan for the implementation by management of organisations across the business spectrum. Again attention will be given to certain criteria and principles necessary for the effective implementation and management of these so-called success strategies and action plans to manage HIV/AIDS more effectively.

**Chapter 6:**                    *The Empirical Perspectives towards the Implementation of Suitable Strategies and Action Programmes on HIV/AIDS*

This chapter will focus on the empirical part of the study. Various statistical methods and techniques used and applied during the scope of the study will be identified and discussed in detail. The chapter will also aim at the reliability and validity of the study in question and the importance thereof.

**Chapter 7:                    *Research Findings***

Chapter 7 will explain all the research findings by means of descriptive research; reliability tests and cross tabulations and other graphical explanations relevant to the study.

**Chapter 8:                    *Conclusion and Final Recommendations***

In this chapter conclusions and recommendations regarding the implementation of suitable strategies and action programmes on HIV/AIDS will be discussed and highlighted.

**1.10    TERMINOLOGY**

Terminology used within the scope of the study includes the following.

*Affected employee:* An employee who is affected in any way by HIV/AIDS e.g. if he/she has a partner or a family member who is HIV-positive.

*AIDS:* AIDS is the acronym for “acquired immune deficiency syndrome”. AIDS is the clinical definition given to the onset of certain life-threatening infections in persons whose immune system have ceased to function properly as a result of infection with HIV.

*CD4 counts:* The CD4 lymphocyte cell count is a measure of the cumulative damage caused to the immune system by infection with HIV.

*Epidemiology:* Relating to the study of disease patterns, causes, distribution and mechanisms of control in society.

*HIV:* HIV is the letter group representing “human immune deficiency virus”. HIV is a virus, which attacks and may ultimately destroys the body’s natural immune system.

*HIV testing:* Taking a medical test to determine a person's HIV status. This may include written or verbal questions, inquiring about previous HIV tests; questions related to the assessment of 'risk behaviour' (for example questions regarding sexual practices, the number of sexual partners or sexual orientation); and any other indirect methods designed to ascertain an employee's or job applicant's HIV status.

*HIV positive:* Having been tested positive for HIV-infection.

*Infected employee:* An employee who has tested positive for HIV or who has been diagnosed as having HIV/AIDS.

*Informed consent:* A process of obtaining consent from a patient, which ensures that the person fully understands the nature and implications of the test before giving his or her agreement to it.

*Pandemic:* A global or very widespread epidemic such as that of AIDS

*Policy:* A document setting out an organisation's position on a particular issue.

*Pre- and post- test counselling:* A process of counselling which facilitates an understanding of the nature and purpose of the HIV test. It examines what advantages and disadvantages the test holds for the person and the influence the result, positive or negative, will have on them.

*Reasonable Accommodation:* Any modification or adjustment to a job or to the workplace, that is reasonably practicable and that would enable a person living with HIV or AIDS, to have access to or participate in or advance in employment.

*STD's:* Letter group representing "sexually transmitted diseases". These are infections passed from one person to another during sexual intercourse, including syphilis, gonorrhoea and HIV.

*Surveillance Testing*: This is anonymous, unlinked testing done in order to determine the incidence and prevalence of disease within a particular community or group so as to provide information on the control, prevention and management of the disease.

## 1.11 ABBREVIATIONS

(Ordinary contractions, letter groups and acronyms)

Abbreviations used within the study, are presented in alphabetical order and include the following.

AIDS	Acquired Immune Deficiency Syndrome
ARP	Anti-Retroviral Therapy
ATICC	AIDS Training Information and Counselling Centre
ATT	AIDS Task Team
BHF	Board of Health Funders
CBO's	Community-based Organisations
CDC	Community Development Council
CEO	Chief Executive Officer
CGE	Commission on Gender Equality
CONTRALESA	Congress of Traditional Leaders of South Africa
DG's	Director-General Forums
DOE	Department of Education
DOH	Department of National Health
DOJ	Department of Justice
DOL	Department of Labour
DOW	Department of Welfare
EAP	Employment Assistance Programme
EC	Eastern Cape
EU	European Union
FS	Free State
GCIS	Government Communication and Information Systems
GDP	Gross Domestic Product
GP	Gauteng

HCW	Health Care Worker
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HR	Human Resources
HRC	Human Rights Commission
HSRC	Human Sciences Research Council
IDC	Interdepartmental Committee
IDU	Transmission through Drug Use
IEC	Information, Education and Communications
ILO	International Labour Organisation
IMC	Inter-Ministerial Committee
KAP	Knowledge, Attitudes and Practices
KR-20	Kuder Richardson 20 formula
KZN	Kwa-Zulu Natal
MEC's	Member of Executive Committee
MET	Multi-Employer Trust
MINMEC	Ministry for Members of Executive Council
MOH	Ministry of Health
MP	Mpumalanga
MRC	Medical Research Council
MSM	Men who have Sex with Men
MTCT	Mother-to-child Transmission
NAC	National AIDS Council
NACOSA	National AIDS Co-ordinating Committee of South Africa
NAPWA	National Association of People Living with HIV/AIDS
NATOP	National AIDS Training and Outreach Programme
NC	Northern Cape
NGOs	Non-Governmental Organisations
NP	Northern Province
NPPHON	National Progressive Primary Health and Organisation Network
NW	North West
PHRC	Provincial Health Restructuring Committee
PPE	Personal Protective Equipment

PWA	People living with HIV infection or AIDS
RSA	Republic of South Africa
SA	South Africa
SABS	South Africa Bureau of Standards
SADC	Southern African Development Counsel
SAIMR	South African Institute of Medical Research
SALC	South African Law Commission
SAMA	South African Medical Association
SANAC	South African National AIDS Council
SANC	State Antenatal Clinics
SANDF	South African Defence Force
SAPS	South Africa Police Service
SAS	Statistical Analysis System
SHE	Safety Health and Environmental
SPSS	Statistical Programme for Social Sciences
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
UN	United Nations
UN-AIDS	Joint United Nations Programme on HIV/AIDS
US	United States
US-AID	United States Aid International Distribution
VCT	Voluntary HIV Counselling and Testing
WC	Western Cape
WHO	World Health Organisation

## 1.12 SYMBOLS

Symbols used within the scope of study include the following.

$\Sigma$	(summation) take the sum of
$\chi^2$	chi-square statistic
$\alpha$	(alpha) level of significance or probability of a Type I error
<i>F</i>	F-statistic

$F(x)$	cumulative distribution function of a random variable $X$
$K-1$	Number of degree of freedom
$N$	sample size
$P$	sample proportion
$r$	sample Pearson correlation coefficient
$S$	sample standard deviation
$S^2$	sample variance (inferential statistics)
$\mu$	( <b>mu</b> ) population mean
$V$	variance of a random variable
$W$	population or universe
$X$	random variable
$\bar{x}$	sample mean

### 1.13 GENERAL

- Annexures are proved at the back of this thesis.
- The Harvard method for source references will be used.
- Tables and figures are placed on relevant pages in this thesis.
- Questionnaires will be provided as an annexure at the back of this thesis.
- Where no sources are mentioned, it refers to own research.
- If reference is made only to the year, emphasis is placed on the general impression of the author.

## CHAPTER 2

# THEORETICAL PERSPECTIVE AND IMPACT OF HIV/AIDS IN SOUTH AFRICA

### 2.1 INTRODUCTION

HIV/AIDS is the greatest challenge facing South Africa today. There is evidence to suggest, that political leadership is now becoming aware of the enormity of the problem. Like president Mbeki wrote in a letter dated 3 April 2000 to president Clinton: “In 1998, our government decided radically to step up its own efforts to combat AIDS, this fight having, up to this point, been left largely to our Ministry and the Department of Health” (Whiteside & Sunter, 2000:134). Predictions indicate, that there are several South Africans who know, of or who are living with someone who is HIV-positive. In many townships parties and weddings have given way to people attending funerals on a grand scale. The AIDS challenge for South Africa has only just begun.

Businesses across the South African economic spectrum, can no longer see the HIV/AIDS epidemic as only a government or health care problem. Undoubtedly HIV/AIDS is rapidly becoming a workplace issue. AIDS have become everyone’s problem, regardless of where he/she lives. At the recent 13<sup>th</sup> International AIDS Conference held in Durban in July 2000, the theme was “Breaking the Silence”. It was not only an acknowledgement of many silences which surrounded and imprisoned HIV/AIDS, but also an invitation to local organisations and the global community to have open debates and discussions on new facts and to share past and present experiences on the epidemic (Adler, 2000:62).

The impact of HIV/AIDS on the South African workplace, has compelled organisations to start thinking of strategic ways to deal with the disease. The business sector, together with government and other important role players such as trade unions and health care, needs to unite in an effort to effectively manage and control



the impact that the disease will have on the active economic workforce of the country. It will become increasingly important for any Human Resources or employees assistant managers to put HIV/AIDS at the top of their personal agenda (Meeson & Van Meelis, 2000:44).

A culture of openness and acceptance regarding HIV/AIDS in an environment with silence and denial still lurking in the background, is one of the biggest challenges in managing the epidemic successfully in any environment. Collective response of the South African business sector is needed in order to change the situation around. However, organisations in general have responded passively up till now and in some cases not at all, in dealing with the HIV/AIDS epidemic. These attitudes and perceptions need to be changed before business in general can make any contributions towards fighting the disease. Like Mr. Vosloo, an HIV-positive employee rightfully remarks: “There is a real contradiction when management supports policy verbally, but not in practice” (Meeson & Van Meelis, 2000:47).

The HIV/AIDS epidemic cannot be contained unless the South African business sector in particular, together with other important role players make an exceptional effort and focus in addressing the problem. The South African milieu consists of is government, business, labour, AIDS service organisations and society in general. The impact of HIV/AIDS will force organisations and government to take strategic decisions and to examine the direct and indirect labour costs on staff and other related aspects (Gresak, 2000:13).

This chapter will focus on and investigate the following important aspects.

- A background study on HIV/AIDS in South Africa.
- The global trend on HIV/AIDS.
- The socio-economic impact of the disease on South Africa.

## 2.2 BACKGROUND ON HIV/AIDS IN SOUTH AFRICA

In 1982 the first cases of HIV were identified in South Africa. For the first eight years, the epidemic was located primarily among the white homosexual population of South Africa. However, as the number of infections rose, so the disease began to spread to other groups within the general population. In July 1991, the numbers of heterosexually transmitted cases were equal to the number of homosexual cases. Since then, the homosexual epidemic was completely overshadowed by the heterosexual epidemic within the general South African population (Whiteside & Sunter, 2000:47).

From being first regarded as a “minority group” disease, HIV/AIDS has gradually been shown to be essentially a heterosexually transmitted infection. In some industrialised countries, such as South Africa, AIDS is regarded as a disease restricted only to under-developed countries in the world. Such complacency is one more reason why HIV/AIDS will persist for a very long time to come, for the history of the disease has shown, that when complacency occurs and vigilance weakens, infection agents take full advantage of the situation (Anon, 2000:13).

### 2.2.1 Epidemiology and data collection

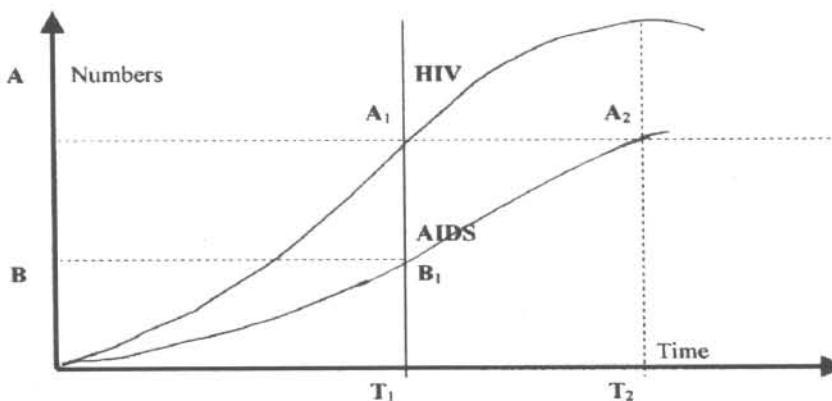
Before a full assessment of the HIV/AIDS situation in South Africa can be made, it is important to understand the basic epidemiology of both the HIV/AIDS epidemics. Epidemiology refers to the study of the distribution and the determinants of states of health in populations, its objective being the prevention and control of ill health. Epidemics usually follow an “S” curve, as shown in Figure 2.1. At first, the epidemic starts slowly and gradually, but when a certain point is reached, a critical mass of infected people is reached and the growth of new infections thereafter accelerates. The epidemic then spreads through the general population until many of those people who are susceptible to the infection, are infected. In the final phase of an epidemic, where the “S” curve flattens off at the top, people are either getting better or deaths starts to overtake the number of new cases, so that the total number alive and infected

passes its peak and begins to decline. For most diseases, the curve will decline rapidly, but for the HIV/Aids epidemic it is totally different.

What sets HIV/Aids apart from other epidemics is that there are two curves present, as indicated in Figure 2.1. These two curves represent the HIV/Aids epidemics separately in the general population. The HIV epidemic precedes the Aids epidemic by about six to eight years, reflecting the incubation period between first being infected and the full onset of the illness. This is why HIV is such a lethal epidemic compared to other forms of epidemics. HIV is a silent killer. The epidemic is a silent and fast spreading disease, creeping it's way through the population and it's only later when the HIV pool has risen to a considerable level that the true impact of the epidemic is felt in terms of full blown Aids deaths.

Figure 2.1 shows this point clearly. The vertical axis represents numbers and the horizontal axis time. At  $T_1$ , when the level of HIV is at  $A_1$ , the number of Aids cases will be very much lower at  $B_1$ . The Aids cases will only reach  $A_2$  at  $T_2$ . A considerable amount of time will have elapsed and the HIV will have risen higher, though it seems to be levelling off. Another important point that can be drawn from the chart is that, while prevention efforts may be aimed at lowering the number of infections without affordable and effective treatment, Aids will still be increasing long after the HIV epidemic has turned (Whiteside & Sunter, 2000:27).

**Figure 2.1: The two epidemic curves**



**Source:** Whiteside & Sunter, 2000:27

Epidemiological data are usually drawn from official sources, such as statistics and cases based on the incidence and prevalence rates.

These rates don't always measure the impact of prevention efforts accurately, with the consequence that statistics are not always representative of the general population and mathematical models that generate projections, produce different results, depending on the limitations of data addressed. Another important fact, is that AIDS case data can also be misinterpreted (Allen, Simelela & Makubalo, 2000:10).

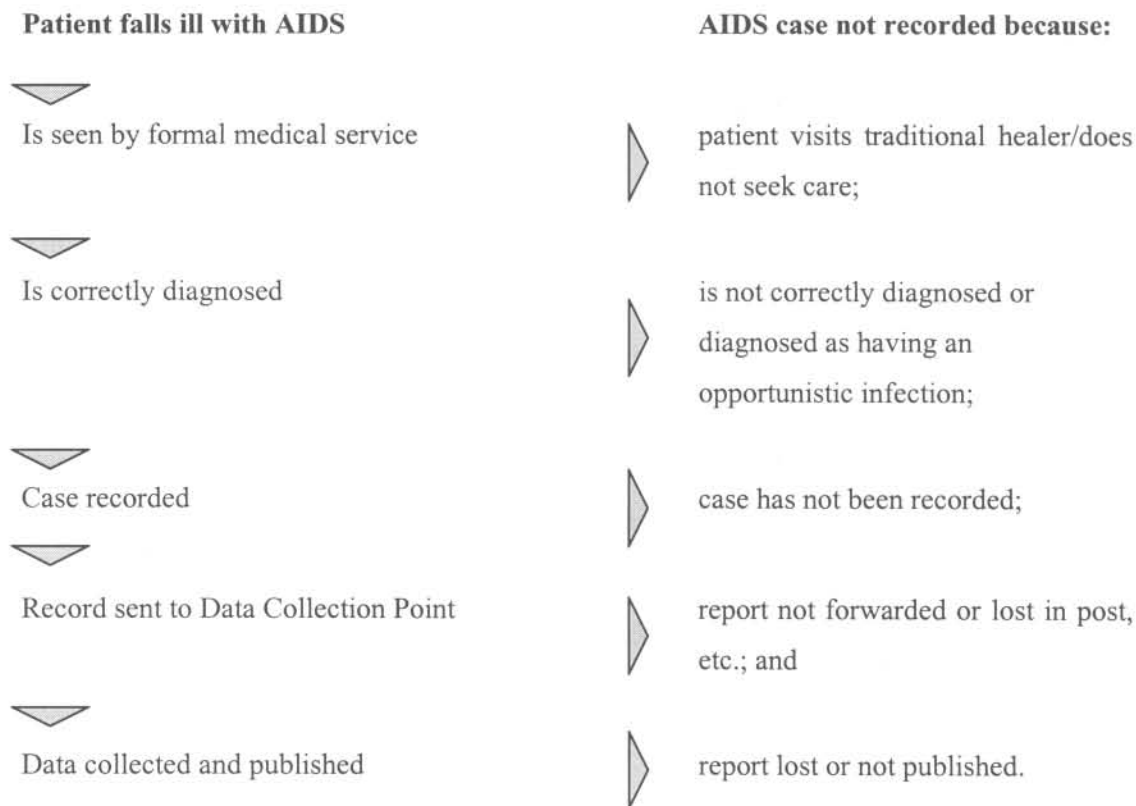
There are a number of reasons for this.

- Reporting of the actual case may be very slow. It takes time for data to flow into a central point to be collected.
- Data may be inaccurate, because of the unwillingness of medical staff to report cases. This may be due to the stigma associated with AIDS or medical aid societies and insurance companies paying out more for other diseases.
- AIDS may not be the condition diagnosed. Instead, the patient may be recorded as having TB or meningitis.
- Doctors may feel that it is pointless to report cases, as there are always problems with the collection of data.

In many developing countries such as South Africa, one of the major stumbling blocks to cases being reported, is that most people are not seen by formal medical practitioners but that they prefer to visit traditional healers. The process through which a person with AIDS has to go, in order for him/her to be officially recorded as having the disease, can be illustrated by the following figure, as well as the wrong way in going about reporting the disease.

Figure 2.2 to follows on p. 26.

**Figure 2.2: The problem of AIDS case reporting**



**Source:** Whiteside & Sunter, 2000:31

The question now arises: What can be done to ensure that the value of these AIDS case data will be correct and representative of the general population? HIV data in South Africa are drawn from surveys of specific groups. In the early years of the epidemic, these surveys included blood donors, sexually transmitted disease clinic attendees, people with TB and women attending State antenatal clinics. Surveys were also conducted among sex workers and truck drivers. At present the only fairly reliable, consistent data come from women attending State antenatal clinics countrywide (Allen, Simelela & Makubalo, 2000:10).

In trying to establish the trend of the disease, as well as the impact thereof, scientists needed a sample, which would be broadly representative of the general population. They required a sample that could be drawn on at regular intervals, usually every year or two. Antenatal clinic attendees provided a good sample, because they were

sexually active and were adults. Another advantage is, that blood samples are routinely taken from these women for tests. In South Africa the annual survey is carried out in October/November each year and each sample is labelled, with the location and age of the woman, therefore, a small amount of other information, such as marital status or income, can also be obtained without compromising confidentiality.

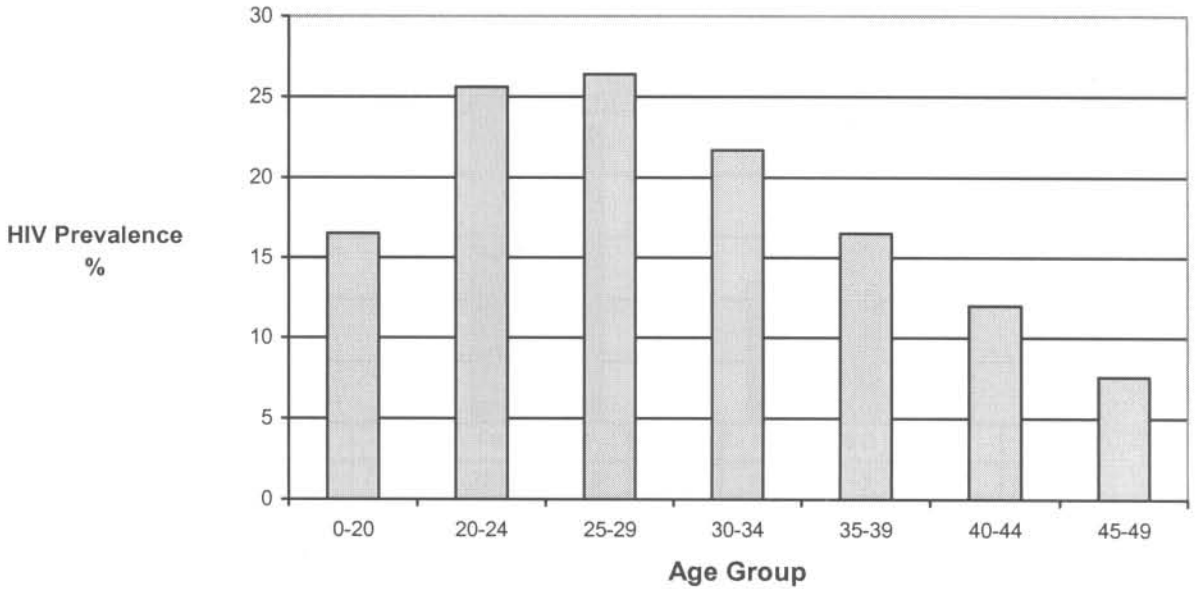
Once the raw data have been collected, it is taken into more representative numbers, using various computer and mathematical models. Recent population-based studies, have shown that antenatal clinic data do provide a relative good estimate of HIV prevalence among adults aged 15 to 59. However, when the epidemic is model, the data are then manipulated in order to provide estimates of prevalence for all adults and for the population at large. One advantage of antenatal clinics, is that the HIV/AIDS data provided, are appropriate when the epidemic is largely heterosexually driven, as in the case of Sub-Saharan Africa. Because most samples are very limited, there is a level of uncertainty about HIV/AIDS figures. One of the priorities, is to collect better and more reliable data in the field (Whiteside & Sunter, 2000:34).

It is clear that South Africa needs a far better method of assessing the HIV/AIDS status of the general population. Sampling the general population on a direct basis, could be effective. This will mean, that people have to give blood for survey purposes and such surveys would also be expensive.

The following figures show data collected, and indicate the HIV prevalence rate in women attending State antenatal clinics in South Africa, by province and age group, as expressed in percentages.

Figure 2.3 to follows on p.28.

**Figure 2.3:** HIV-prevalence rate in women attending State antenatal clinics, by age group in South Africa

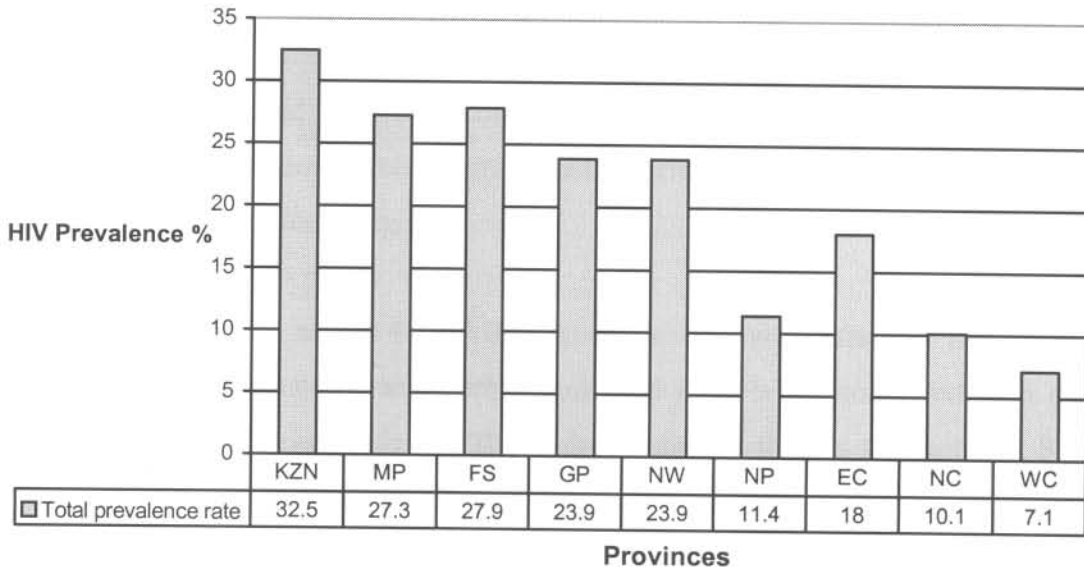


**Source:** Allen, Simelela & Makubalo, 1999:10

Figure 2.3 presents HIV prevalence data by age group for women attending State antenatal clinics. Data indicate, that the highest HIV zero prevalence is in women aged 20 to 30 years, although the average prevalence rates are high in all age groups. It is also further estimated, that more than half of the new HIV-infections in women occur in the age less than 20 year.

Figure 2.4 represents HIV prevalence data by province for women attending State antenatal clinics at the end of 1999 in South Africa. These data also indicate, that there are geographical disparities in the overall distribution of the HIV/AIDS epidemic in South Africa. These geographical differences have persisted since the introduction of the surveys.

**Figure 2.4: HIV-Prevalence in pregnant women attending State antenatal clinics, by province in South Africa**



[KZN – KwaZulu Natal; MP – Mpumalanga; FS – Free State; GP – Gauteng; NW – North West; NP – Northern Province; EC – Eastern Cape; NC – Northern Cape; WC – Western Cape]

**Source:** Allen, Simelela & Makubalo, 1990:10

The conclusions that can be reached from assessing the above data, are the following.

- The HIV epidemic in South Africa is one of the fastest growing epidemics in the world.
- Young women aged 20 to 30 years, show the highest prevalence rates.
- The HIV prevalence varies by province, from 7,1 per cent to 32,5 per cent.
- The HIV epidemic is affecting young blacks and economically poor sub-populations in South Africa more severely than any other groups in the country.



### **2.2.2 Analysing the past, present and future impact of HIV/AIDS in South Africa**

By 1991, the total HIV/AIDS cases in South Africa's general population, began to mirror that of all Southern African countries infected by the HIV/AIDS virus. This was further confirmed with data collected by the Department of National Health (DOH) and Population Development. South Africa was indeed on its way to be rapidly infected with the virus.

An important aspect of the HIV/AIDS epidemic in South Africa is that there is absolutely no difference between urban and rural areas when compared with other countries North of South Africa. The main reason for this, is the fact that South Africa's population is fairly mobile and that the country has a good infrastructure as compared to other African countries on the Continent (Whiteside & Sunter, 2000:53).

In September 1998, the Department of Health organised a meeting of experts to develop a consensus on the future spread and impact of HIV/AIDS in South Africa (refer Chapter 5). This included epidemiologists, actuaries, economists, health specialists and others with an interest in dealing with the issue. The meeting resulted in an agreement, to set projections concerning the spreading of the disease over present and future periods of time in South Africa and was based on a spectrum of scientific models. It is important to note, that these models are only tools to guide or estimate decisions regarding HIV/AIDS data. The definition regarding models, is that it is only a representation of an aspect of reality and cannot replace the complexity that a real situation presents (Allen, Simelela & Makubalo, 2000:10).

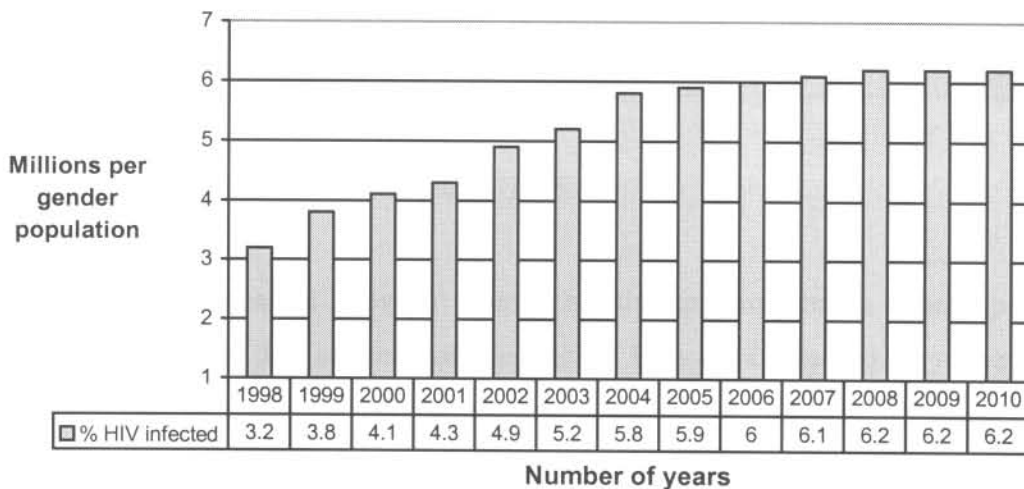
These projection models can be used for determining information such as:

- projecting the HIV prevalence rates and numbers,
- projecting future numbers of AIDS cases,
- examining the demographic impact of AIDS and addressing questions relating to the impact of HIV/AIDS on population growth rates, and

- the formulation of different intervention strategies concerning their strengths and weaknesses.

Using these more or less reliable statistical techniques, epidemiologists and other parties interested, are confident that they can use State antenatal clinic data and estimated HIV prevalence levels for each of the important groups in the South African general population aged 15 to 59. These groups include adult females, adult males and children. Based on the previous information and methods mentioned in this chapter, the current calculations of the total number of HIV infected South Africans in the past, present and future can be calculated and illustrated by means of the following figure.

**Figure 2.5: Total number of HIV infected South Africans aged 15 to 59 (past, present and future estimates)**



**Source:** World Health Organisation, 1998:168

It is also important to study the impact effects other countries in the region. UNAIDS made estimates aimed at adult prevalence rates, number of people infected by the HIV/AIDS virus and the number of orphans resulting from AIDS mortalities. A comparison of South Africa's neighbours on the information supplied above, is shown

in the table below. This table reflects only estimates based on the information obtained from the UN-AIDS Report of 1998.

**Table 2.1: UN-AIDS estimates for South and Southern Africa 1998 estimates**

Country	Adult prevalence rate (per cent)	Number of adults & children living with HIV/AIDS	Estimated number of orphans
Botswana	25,1	190 000	25 000
Lesotho	8,4	85 000	8 500
Mozambique	14,2	1 200 000	150 000
Namibia	19,9	150 000	7 300
South Africa	12,9	2 900 000	180 000
Swaziland	18,5	84 000	7 200
Zambia	19,1	770 000	360 000
Zimbabwe	25,8	1 500 000	360 000
<b>Total/Average</b>	<b>Av. 12</b>	<b>10 805 000</b>	<b>2 214 000</b>

**Source:** World Health Organisation, 1998:48

Interpreting the information above, it seems that the epidemic has a natural peak, should one consider the information regarding Botswana, the country that is experiencing one of the worst HIV epidemics in the world. In order to assess the impact on social and economic growth, an idea of the future course of the epidemic needs to be predicted. Using various mathematical models, with various computer programmes to make prognoses this could be done and projections made possible, as already mentioned previously (Adler, 2000:67).

South Africa as a nation is highly susceptible to the spread of the HIV/AIDS epidemic and also highly vulnerable to the impact the epidemic will have on the country and its resources. There are also particular segments in general society, which are particularly susceptible and vulnerable to the epidemic.

Mann and Tarantola (1996:25) suggest that individuals who experience not only individual vulnerability, but also programmatic vulnerability to the extent that programme-based responses can either increase or decrease an individual's vulnerability to the risk of infection. This is a very sobering thought. However, societal influences can also be important factors influencing an individual's behaviour (Adler, 2000:69).

In South Africa, the highest rates of infection are amongst people between 20 and 44 years of age - the group that is economically economic active. Because of this, HIV/AIDS has the potential to create havoc on social, economic and above all, human development in the country. Despite a late start, HIV has taken off in South Africa, with devastating consequences for the country. As a direct result, South Africa now faces the daunting task to combat and prevent a major HIV/AIDS crisis. In terms of the actual impact that the epidemic will have, there is still a great deal of uncertainty. As the epidemic will continue to spread, the sheer number of illnesses, deaths and the number of orphans, will surely be greater in South Africa than in the other countries in the region.

The reason for this, is that South Africa has a highly and more advanced economy than have other Southern African economies within the region. The South African economy is, therefore, dependent on skilled labour. Losses of skilled and also professional staff, can seriously hamper economic growth in future. The illness also has the potential to result in major social and political instability, which will have far-reaching fiscal and monetary implications for South Africa. In order to understand and plan for the HIV/AIDS impact on South Africa, it is absolutely imperative that the South African general population understand what effect the HIV/AIDS epidemics will have on aspects related to income, education, skills, employment and location. Many people will be infected; they will fall ill and they will die as a result of the epidemic. The end-result will mean, that many children will be orphans and left behind uncared for (Kinghorn, 2000:23).

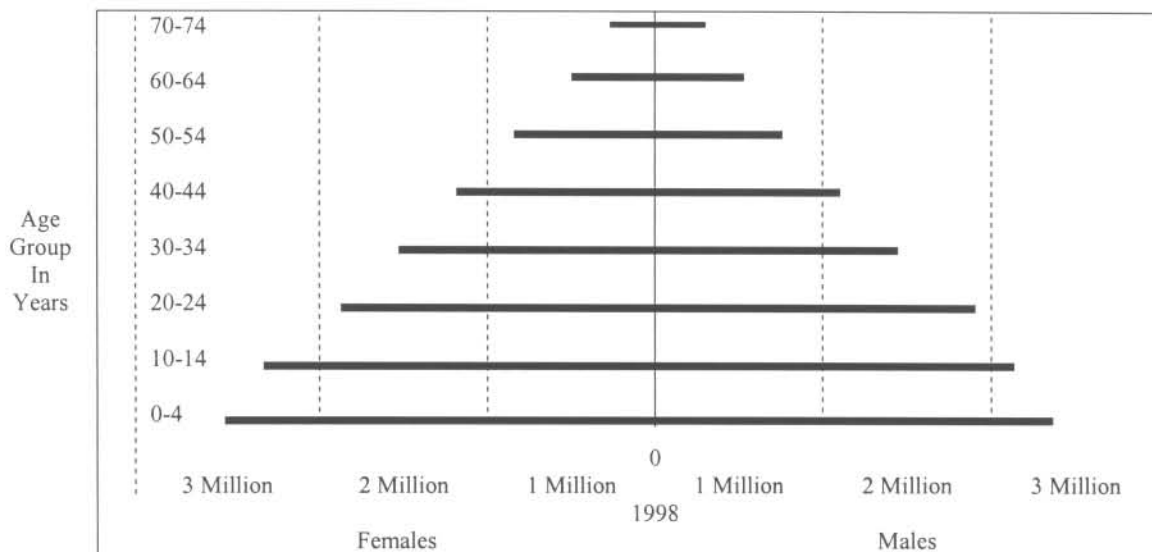
In 2000 it was found that South Africa was already well ahead of schedule concerning the current HIV-infection rate. It was estimated that South Africa was expected to reach 4,2 million infections only by the end of 2002. However, the latest estimates

for the year 2000 is already on 4,2 million HIV-positive adults and children. This figure poses a real challenge for South Africa in dealing with the spread and infection rate of its people. It's also generally believed, that the HIV/AIDS epidemic is likely to lead to a negative population growth and decrease in population figures. However, there are some expectations that this might be a combination of very high cases of HIV prevalence and the rapidly declining of fertility, such as is in the case of KwaZulu Natal (refer Figure 2.4).

In 1998 the US Bureau of Census projected, that the annual population growth rate for South Africa (including HIV/AIDS) would be approximately 1,4 per cent and without HIV/AIDS, 1,9 per cent of the general population. For 2010 the respective figures are estimated at 0,4 per cent with HIV/AIDS and 1,4 per cent without HIV/AIDS. The reality is, however, that the overall population growth rate will become sharply negative with an estimated slower growth rate in the general population. In South Africa the estimates are, that without HIV/AIDS, the population would have risen to 51,3 million by 2010 but with the impact of HIV/AIDS it is expected to reach only 47 million by 2010 (Whiteside & Sunter, 2000:71).

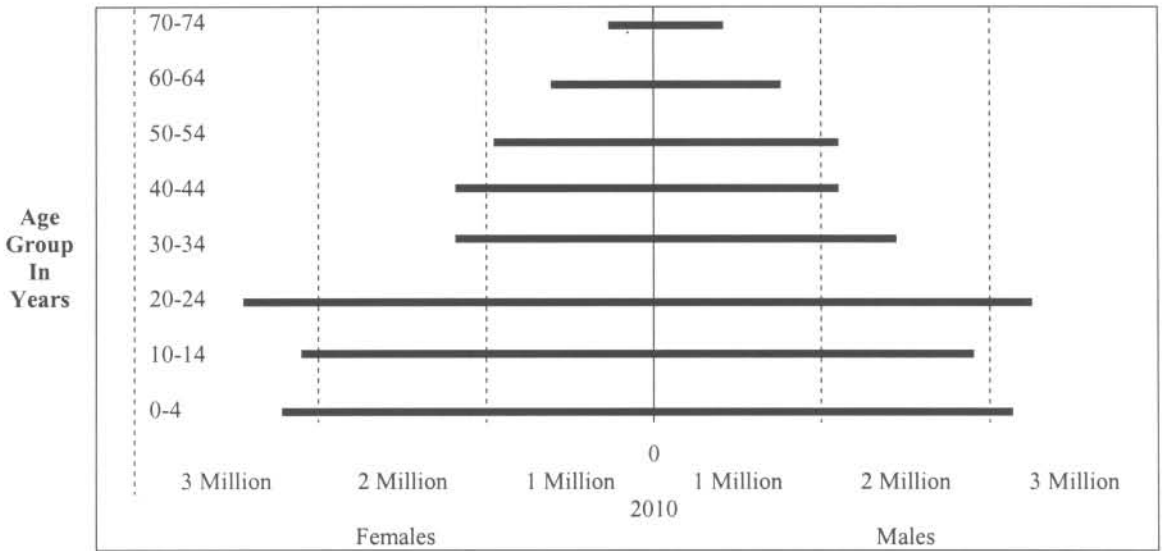
The following figures reveal just how much AIDS will change the shape of the general South African population from 1998 to 2010.

**Figure 2.6: Estimated population structure for South Africa in 1998**



Source: Kinghorn, 2000:23

**Figure 2.7: Estimated population structure for South Africa in 2010**



**Source:** Kinghorn, 2000:23

In order for the HIV/AIDS epidemic to be considered in the country’s population policy, there are two pre-conceptions.

- Firstly, those in charge with developing a populating policy, must be aware of the importance of the epidemic and be able to incorporate the implications into their policy and projections.
- Secondly, there must be enough data available on HIV-prevalence rates in order for the epidemic to be scientifically modelled and predicted.

The reasons why scientists and other people are concerned about the spreading of the diseases, are that it causes people to fall ill and die. An increase in illness and death in the population will inevitably have economic and social implications and consequences for the country. What is not yet clear at present is the degree of the impact HIV/AIDS will have on South Africa, especially at macro level (Thomas & Khupiso, 2000:1).

The following table provides a hierarchy of organisations and the various environments that will be affected in both direct and or indirect manner, because of the impact of the HIV/AIDS epidemic.

**Table 2.2: Hierarchy of organisations affected by HIV/AIDS**

<b>Social</b>	<b>Economic</b>	<b>Spatial</b>
<b>Individual</b>	Consumer/producer	Living space
<b>Family</b>	Household	Home
<b>Community</b>	Unit of production	Village/neighbourhood
<b>Tribe</b>	Sub-sector	Province/regions
<b>Ethnic group</b>	Sector	Province/region
<b>Nation</b>	National economy	Country
<b>Mankind</b>	Global economy	Earth

**Source:** Whiteside & Sunter, 2000:82

Note: This is indicative – there will be variations in countries and societies.

In Sub-Saharan Africa and South Africa in particular, the epidemic is of different magnitude and the impact of the epidemic will be much more severe. At present the effects are only just beginning to be felt.

Reasons for this, are the following.

- South Africa is at the moment experiencing an HIV-epidemic, while the AIDS epidemic is still developing. However, the HIV epidemic is projected to peak in 2010, while the number of AIDS cases will still grow for another 5 to 10 years to come (refer Table 2.3).
- At micro-level, households will feel the full impact and effects of the HIV/AIDS epidemic. The economic impact will slowly manifest itself as the number of individual illnesses and deaths accumulate over a period of time.

- Another important factor is, that the economic impact will depend on how many people are infected and in which way they are affected. Everyone is seen as a potential consumer, even if they are not producers.
- Finally, as shown in Figure 2.8 social impacts will also arise, because people will interact in ways other than economically (Anon, 1999:25).

**Table 2.3: Time scale of HIV/AIDS epidemic**

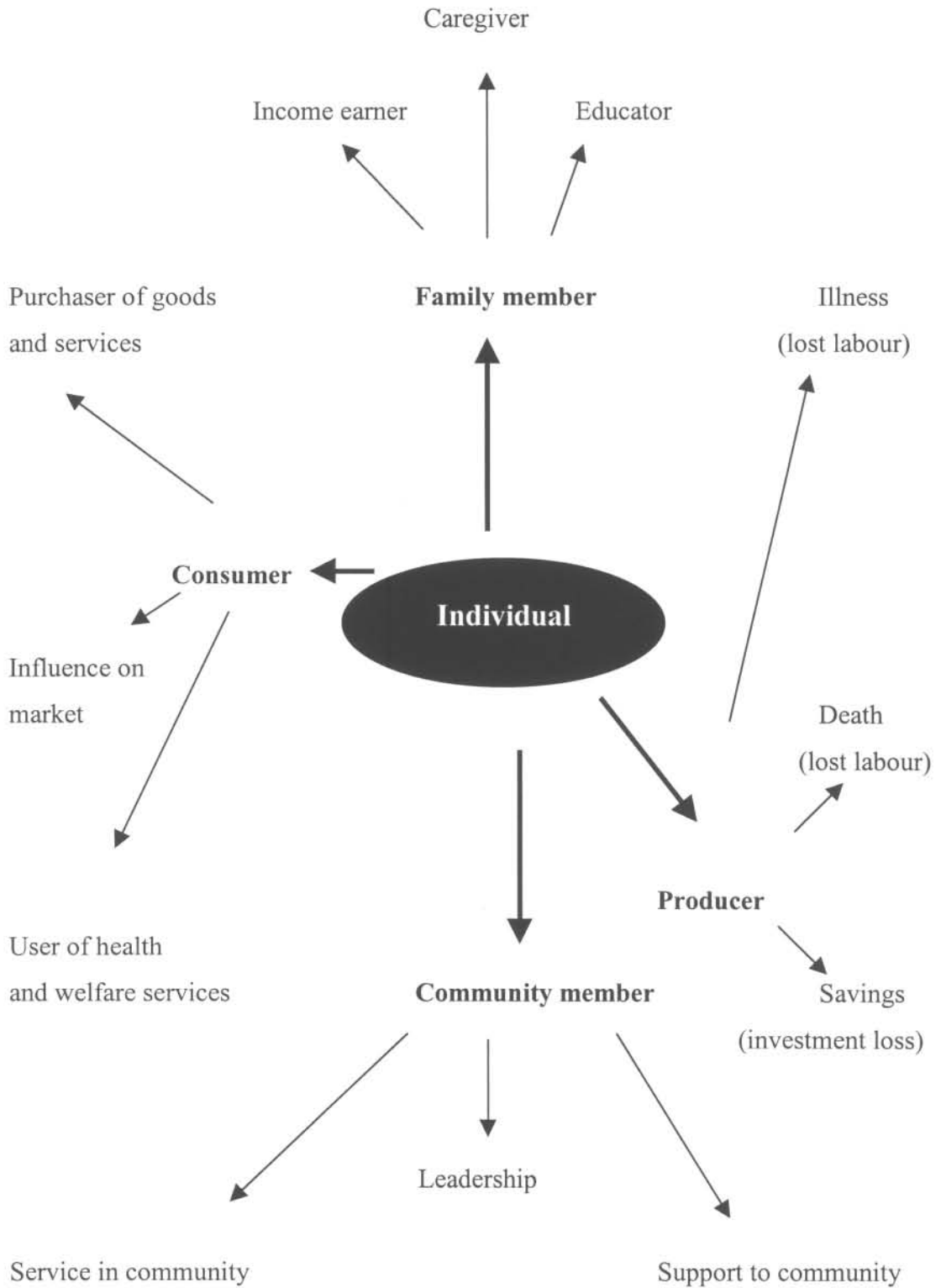
<b>From – to (in years)</b>	<b>Minimum</b>	<b>Maximum</b>
First AIDS case to peak of HIV in urban areas	12	25
Urban HIV peak to national HIV peak	8	10
National HIV peak to peak in AIDS cases	5	10
Impact on next generation	10	85
Total	35	85

**Source:** Anon, 1999:27

Figure 2.8 to follows on p.38.



**Figure 2.8: Inter-actor: the individual as an economic and social actor**



**Source:** Whiteside & Sunter: 2000:84

South Africa has wasted too much time on an incomprehensible approach to the HIV/AIDS epidemic. While the window of opportunity has passed to prevent a generalised epidemic, positive steps could be taken to prevent the further spreading of the epidemic. The fact remains, that the direction that HIV/AIDS must take in the country, rests primarily with government (refer Chapter 4). It is government that has the power to create an environment in which positive steps can be taken to combat, prevent and manage the epidemic successfully (Adler, 2000:69).

### **2.3 THE GLOBAL IMPACT OF THE HIV/AIDS EPIDEMICS**

The Joint United Nations Programme on HIV/AIDS (UN-AIDS) and the World Health Organisation (WHO) have estimated, that at the end of 1999, 33,4 million people (32,4 million adults and 1,2 million children) were infected with HIV. Approximately 96 per cent of people with HIV/AIDS live in the developing world and recent estimates suggest, that of all people infected with HIV world-wide, 70 per cent (6 out of every 10 men, 8 of every 10 women, and 9 of every 10 children) live in sub-Saharan Africa (refer Appendix C). More than 40 million people globally will be HIV-positive by the end of this year, and still no cure has been found. The impact of the epidemic is already being felt in most developing countries, including South Africa. Life expectancy has been significantly reduced, as many people in the 15 to 59 year age group are now dying of AIDS. It is further predicted, that the infection rates could continue to rise in countries where poverty, poor health systems, lack of education, inequality and limited resources for the prevention and treatment of the epidemic are evident (Allen, Simelela & Makubalo, 2000:9).

The following table shows the spread of the HIV/AIDS epidemic on a world-wide scale, as well as regionally, and these figures were released in December 1999 by the World Health Organisation (WHO).

**Table 2.4: Global summary of the HIV/AIDS epidemic, December 1999**

<b>People newly infected with HIV in 1999</b>	Total	5,6 million
	Adults	5 million
	Women	2,3 million
	Children <15 years	570 000
<b>Number of people living with HIV/AIDS</b>	Total	33,6 million
	Adults	32,4 million
	Women	14,8 million
	Children <15 years	1,2 million
<b>AIDS deaths in 1999</b>	Total	2,6 million
	Adults	2,1 million
	Women	1,1 million
	Children <15 years	470 000
<b>Total number of AIDS deaths since the beginning of the epidemic</b>	Total	16,3 million
	Adults	12,7 million
	Women	6,2 million
	Children <15 years	3,6 million

**Source:** Helfand, Lazarus & Theerman, 2000:1028

Table 2.5 to follows on p.41.

**Table 2.5: Regional HIV/AIDS statistics and features, December 1999**

Region	Epidemic started	Adults & children living with HIV/AIDS (prevalence)	Adults & children newly infected with HIV in 1999 (incidence)	Adult prevalence rate (per cent)	Proportion of HIV-positive adults who are women (per cent)	Main mode(s) of transmission for adults living with HIV/AIDS
Sub-Saharan Africa	Late '70s – early '80s	23 300 000	3 800 000	8,0	55	Hetero
North Africa & Middle East	Late '80s	220 000	19 000	0,13	20	IDU, Hetero
Southern & South-East Asia	Late '80s	530 000	120 000	0,07	15	IDU, Hetero, MSM
Latin America	Late '70s – early '80s	1 300 000	150 000	0,57	20	MSM, IDU, Hetero
Caribbean	Late '70s – early '80s	360 000	57 000	1,96	35	Hetero, MSM
Eastern Europe & Central Asia	Early '90s	360 000	95 000	0,14	20	IDU, MSM
Western Europe	Late '70s – early '80s	520 000	30 000	0,25	20	MSM, IDU
North America	Late '70's – early '80's	920 000	44 000	0,56	20	MSM, IDU, Hetero
Australia & New Zealand	Late '70s – early '80s	12 000	500	0,1	10	MSD, IDU
<b>TOTAL</b>	Late '70s – early '80s	33 600 000	5 600 000	1,1	46	

**Source:** Whiteside & Sunter, 2000:38

Note the following:

- The adult prevalence rate in the fourth column, is the proportion of adults (15 to 59 years of age) living with HIV/AIDS in 1999, using 1998 population numbers as the denominator.
- In the last column, “MSM” stands for sexual transmission among men who have sex with men; “IDU” stands for transmission through drug use by injection; “Hetero” stands for heterosexual transmission.

### **2.3.1 The nature and diversity of the HIV/AIDS epidemic around the world**

In many industrialised countries, the epidemic is largely under control, due to effective treatment and adequate health care systems. The total number of new cases of HIV/AIDS and AIDS deaths has fallen significantly, because of the availability of anti-retroviral therapy for most of those who are infected. In America the total AIDS deaths has decreased by almost 42 per cent between 1996 to 1997 and another half of that percentage by the end of 1998. In Europe, the number of deaths has fallen some 20 per cent by the end of 1989. However, this does not mean, that the epidemic is under control on a world wide scale. In fact, a new development reported by UN-AIDS researcher, is that the so-called “Life-prolonging therapies” may lead to the risk in risky behaviour by those who are already infected. There is also evidence to suggest that the HIV infections among those who are at particular risk in contracting the disease, are actually increasing. These include drug users and other marginalised groups. What makes it more serious, is the fact that in a population with a history of high risk behaviour, the absolute number of HIV-positive people are actually growing, because they are surviving longer with the so-called anti-retroviral treatment (Whiteside & Sunter, 2000:39).

#### **2.3.1.1 General**

UN-AIDS together with the WHO, also estimated that some 15 million people were living with the HIV virus in the West at the end of 1999. These regions include North America, Western Europe, Australia and New Zealand. However, the world’s steepest HIV epidemic curve in 1999, was recorded in the newly independent states of the former Soviet Union, where population figures doubled for those who are infected with the HIV-virus. In the Middle East the level of reported infections remains relatively low. In Tunisia the use of drugs is one of the main contributors responsible for more than one-third of AIDS cases reported. In Egypt, one HIV/AIDS case in 10 is among drug users, while in Pakistan 5,4 per cent of 703 drug injectors tested HIV-positive. It is not only drug abusers, but also a combination of both drugs and high risks behaviour, that make out the main culprits in the spreading of the epidemic.

**2.3.1.2**      *Latin America, the Caribbean and Haiti*

In Latin America, the HIV-epidemic is still low, while even among people with sexual transmitted diseases that are usually considered as a high-risk group, the HIV-infection rates are relatively low. In Uruguay similar low rates of infections were recorded. The HIV-epidemic is not the same everywhere. In Central America and the Caribbean, HIV-infections are on the increase. In Guatemala two to four per cent of pregnant woman tested HIV-positive at antenatal clinics in major urban areas in 1999. It is predicted, that the Caribbean basin has some of the worst HIV epidemics outside of sub-Saharan Africa. In Guyana the HIV prevalence rate was 3,2 per cent in blood donors who were thought to represent a population at low risk. Research in respect of urban sex workers in 1998, showed that approximately 46 per cent were already infected. In Haiti, HIV surveillance among pregnant woman carried out in 1996, showed that 6 per cent tested positive for the virus (Whiteside & Sunter, 2000:41).

**2.3.1.3**      *Asia*

In Asia the results are mixed. In some countries the epidemic appears to be under control. These include the Philippines, Malaysia and Sri Lanka. In Bangladesh, Indonesia, Vietnam and Pakistan, the prevalence rates are relatively normal, but could rise as the HIV-virus spreads out from mainly drug users the general population. Elsewhere on the Asian Continent, it appears that HIV-infected incidences are becoming a serious and fast-growing epidemic. Asia's highest levels of infection continuous to be recorded in Cambodia, where surveillance indicates, that the HIV epidemic is well established in the general population. Nationally some 3,7 per cent of married women of reproductive age were tested HIV-positive at the end of 1998. At present the prevalence rate in men is somewhat higher at 4,5 per cent of male blood donors compared to 2,5 per cent of female donors. The result is that the HIV epidemic is a fast growing one among the heterosexual population.

#### **2.3.1.4        *India***

Because of India's high population figure this means that they will dominate assessments of HIV prevalence in Asia. However, in India the situation is extremely variable. In the Southern regions of the country, HIV has a significant grip on the urban populations, with one pregnant women testing HIV-positive out of every 50 women attending state antenatal clinics. In the North East the HIV-infection has been spread through drug injections and has spread the virus already to the general population. India however, still remains as one of the worst hit areas on the Asian continent and indeed in the world.

#### **2.3.1.5        *China***

China, another huge and vast country on the continent, represents a relatively low HIV infection rate compared to India. It is important to take note that China is not regarded as a developing country but for the sake of explaining and to understand the HIV-trend on the Asian continent reference will be made to China's situation. The bulk of new infections remain to be concentrated in the drug using population but the trend is started to change dramatically. In the densely populated coastal region of Gwangdong, in China, the percentage of drug injectors has rose from almost zero in 1998 to almost 11 per cent by the end of 1999. The potential for HIV to spread from drug injectors to the general population is a threat that are becoming more and more a reality. It is also estimated that there are as many as four million sex workers throughout the country with devastating consequences (Whiteside & Sunter, 2000:43).

#### **2.3.1.6        *Thailand***

Thailand however, shows opposite trends concerning the spreading of the HIV infections. Also regarded as a developed country, the government in 1991 already started with its prevention efforts, well ahead of the rest of the world. One of their success stories was, to make it compulsory for condoms to be used in brothels. As the condom use rose, so did the number of Sexual Transmitted Diseases (STD) fall. This in-turn, had a positive influence on the spreading of the HIV virus in the general

population. It is a well-known fact by now, that in order to prevent the HIV epidemic from spreading, prevention methods must first be introduced to prevent or successfully treat STD infections. The result will have a positive outcome for the spread of both HIV/AIDS. In the badly affected Northern region of Thailand, the percentage of HIV-positive people infected, fell dramatically from 6,4 per cent to 4,6 per cent in 1997, with this new precautionary action introduced by government (Adler, 2000:69).

### *2.3.1.7 Africa*

The picture in Africa is similar to that of Asia – a mixed one. While North Africa is relatively HIV-free, Sub-Saharan Africa is one of the worst affected areas in the world at present (refer Appendix C). At the beginning of 2000, it was estimated by the World Health Organisation, that the HIV virus already had infected 23,3 million people in sub-Saharan Africa. This means, that 70 per cent of the world's infections are found in an area with 10 per cent of the global population. Another important statistic is, that almost 90 per cent of all infants and child infections are also found in this part of the world, which means that it will have serious socio-economic implications for the region in future (World Health Organisation, 1998:166).

The following table presents the number of populations worst infected with HIV/AIDS at the end of 2000.

Table 2.6 to follows on p.46.



**Table 2.6: Global estimates of total populations infected with HIV/AIDS at the end of 2000**

Region	Total number of people infected with HIV/AIDS
North America	920 000
Caribbean	390 000
Latin America	1 400 000
Western Europe	540 000
North Africa & Middle East	400 000
Sub-Saharan Africa	25 300 000
Eastern Europe & Central Asia	700 000
Southern & Southern East Asia	5 800 000
Eastern Asia & Pacific	640 000
Australia & New Zealand	15 000 000
<b>TOTAL</b>	<b>36 100 000</b>

**Source:** McGeary, 2001:48

It is globally agreed, that HIV/AIDS is the worst infectious disease to hit the African continent recorded in history. According to the World Bank, deaths due to the HIV/AIDS epidemic in Africa, will soon surpass the 20 million Europeans killed by the plague epidemic of 1347 to 1351. Population-based surveys, indicate that infection rates in men are significantly lower than in women in the same region. UN-AIDS in conjunction with WHO, estimated that at the end of 1999, 12,2 million women and 10,1 million men aged 15 to 59 were already infected with HIV. The data implies, that in many Sub-Saharan countries, men will start to outnumber women very soon. The epidemic is, however, not uniform in all parts of the African continent. In many West-African countries for example, the spread of the HIV virus is still slow and in some cases even contained, as in the case of Uganda. In Nigeria the epidemic is fast emerging and spreading, while the Eastern and Southern regions of Africa are the worst affected areas in the world. The reason for the fast spread of the epidemic in these regions, is that Africa is a relatively poor and underdeveloped continent. Most African countries are still underdeveloped or are still developing nations with

fragile economies and infrastructures with health care and education systems still in a poor state. In Africa the HIV/AIDS epidemics have reached enormous proportions, with devastating consequences for the continent (McGeary, 2001:48).

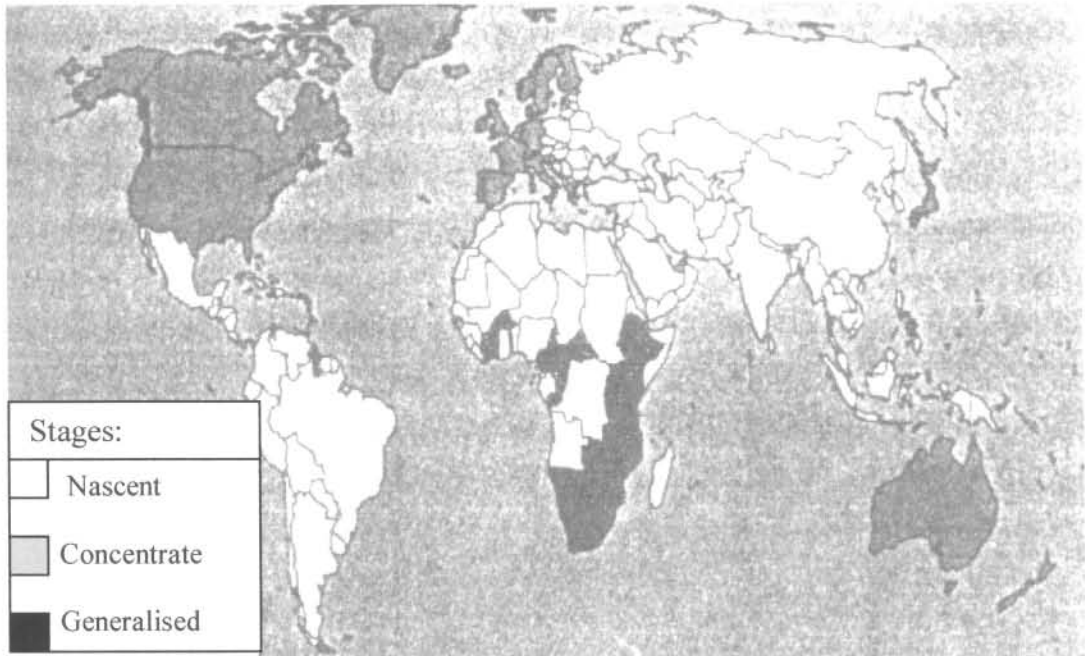
The following facts speak for themselves.

- In the past decade, 12 million people in Sub-Saharan Africa have died as a result of AIDS.
- Each day AIDS claims another 5 500 men, women and children.
- In 1998, AIDS was the largest killer on the African continent, accounting for 1,8 million deaths in Sub-Saharan Africa alone. It is nearly double the one million deaths for Malaria and eight times that of TB.
- A 15-year-old living in Zambia today, has a 60 per cent chance of dying from AIDS before his/her 35<sup>th</sup> birthday.
- Where at least 10 per cent of the adult population is HIV positive, AIDS will soon be reducing life expectancy by as much as 17 years.
- Due to children acquiring the infection before or during birth, in Namibia, infant mortality is expected to reach 72 per 1 000 live births as opposed to 45 per 1 000 without AIDS.
- In Zimbabwe some organisations have reported that AIDS costs are absorbing as much as one fifth of the gross national earnings.
- In Zambia some organisations report that AIDS illness and death already cost them more than their total annual profits (McGeary, 2001:49).

Another way of viewing the epidemics around the world, can be explained by identifying three major stages, as shown in the following figure.

Figure 2.9 to follows on p.48.

**Figure 2.9:** Stages of the HIV epidemic in developing countries around the world



**Source:** Whiteside & Sunter, 2000:38

**Note:** This figure is only representative of under or still developing countries such as South Africa for example.

These stages can also be briefly explained as follow.

- **Nascent:** HIV is less than 5 per cent in all known sub populations presumed to practice high-risk behaviour.
- **Concentrated:** HIV prevalence is above 5 per cent in one or more sub populations presumed to practice high-risk behaviour but only among women attending State antenatal clinics that are still below 5 per cent.

- Generalised: HIV has spread far beyond the original sub-populations with high-risk behaviour, which is now severely infected. The prevalence rate among women attending state antenatal clinics, is 5 per cent higher.

The reality is, that South Africa in particular has an epidemic much larger than experienced by the worst-hit industrialised country in the world (refer Table 2.6). It is, however, important to take notice that different countries have different epidemic patterns, which implies, that different precautionary programmes and strategies will apply for those countries infected.

In his address to symposiums around the world, Dr. Piot, an executive director of UN-AIDS, expressed the belief, that meeting the challenge imposed by the HIV/AIDS epidemic, is a complex but feasible one. He identified five crucial elements that will be needed to turn the tide of the epidemic. By this statement, he implied not only prevention of new infections, but also the acceleration of suffering resulting from the epidemic (Adler, 2000:58).

These elements include the following.

- Tools (which are already available) to curb the epidemic.
- A shift in thinking about how to confront the epidemic.
- A need to think big – from pilot to countrywide and regional interventions.
- Ongoing learning through basic and applied research.
- Investment in global public goods, such as knowledge, vaccines and pharmaceutical products.

## **2.4 THE SOCIO-ECONOMIC IMPACT OF HIV/AIDS IN SOUTH AFRICA**

The World Health Organisation (WHO), predicted that HIV/AIDS will soon cost the world economy \$5 000 billion a year, or four times South Africa's \$122 billion economy. Even if only 10 per cent of South Africa's estimated 3.6 million HIV-

positive inhabitants should be treated next year, the cost could amount to ± R5 billion. Apart from the spending on health care alone, a similar amount will be lost through productivity losses, reduction of the buying power, retraining of new employees and absenteeism. This will have a devastating affect on the already fragile South African economy (Van Zyl, 1999:10).

The irony of the situation is, that the HIV/AIDS epidemic is still far from peaking. According to the South African Health Department (DOH), the infection in South Africa has risen by 33,8 per cent during last year. It is an increase that will result in illness and deaths among the economically active people of South Africa, with tremendous social consequences for the country. It will also put strain on limited resources and infrastructure. So why are South Africans still turning a blind eye to the impact of HIV/AIDS?

In a recent survey carried out among South African businesses, Old Mutual found, that 86 per cent of employees were aware of the effect HIV and AIDS could have on health benefits, but only 3 per cent saw it as an important strategic issue in their own context. “For the majority of South Africans HIV and AIDS are still too broadly regarded as someone else’s problem,” says political analyst Mr. Willie Esterhuysen. “It has long been more than just a bedroom problem” (Van Zyl, 1999:11).

The threat of AIDS claiming 1 500 lives a day within the past two years and the severe consequences it has for the South African economy, at least seem to be spurring government and business into action. Is it too late or could government and business still make a difference?

#### **2.4.1 HIV/AIDS and the economic implications for South Africa**

The UN has ranked South Africa twelve positions lower in its Human Development Index (HDI), because of the shortened average life expectancy of its economically active population. It is further estimated that the life expectancy will reach 48 years on average by the year 2008 as a result of expected AIDS-related deaths. This means, that other countries world-wide will think twice before investing in South Africa. It is

also predicted, that every economically active South African will pay for the consequences of the country's large incidence of HIV infections tax-wise, or through higher medical and life assurance premiums. As Professor Ruben Sher, Director of the National AIDS Training and Outreach Programme, explains: "We can't even visualise what it will cost South Africa's economy in future, notably from 2005, when millions of HIV-positive cases develop into full-blown AIDS". He also stressed the fact, that organisations should be filled with trepidation, knowing that this will have a huge effect on South Africa's Gross Domestic Product (GDP). South Africa's economically active workforce is fast becoming HIV-positive. "We're talking about a loss of unskilled and skilled workers, as well as training costs, much lower productivity and higher costs of health care and pension pay-outs in the event of death". Productivity will be affected through disease and funeral attendance, together with a higher incident of accidents and even discrimination and tension within the workplace (Van Zyl, 1999:11).

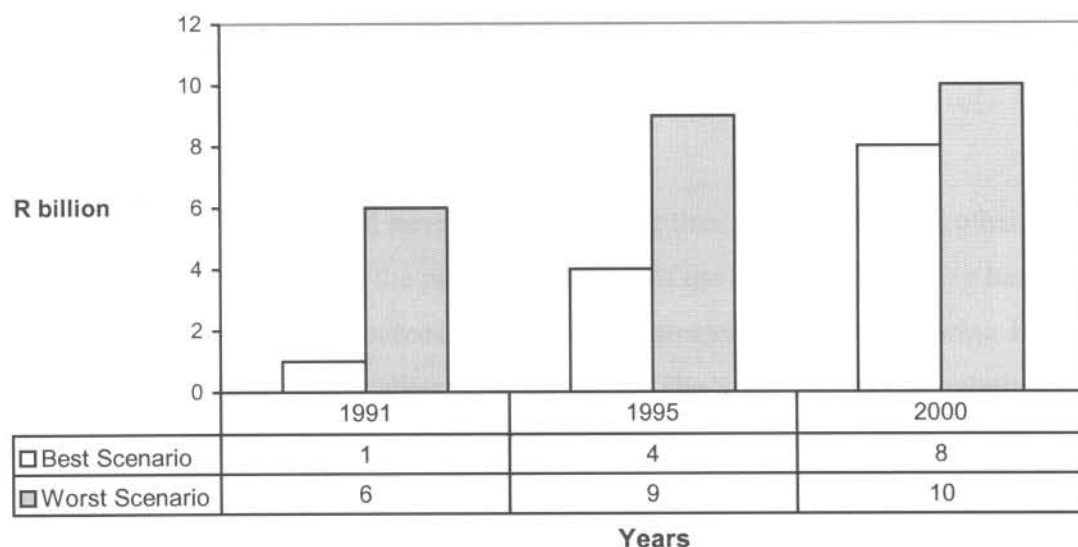
Another important factor that will have a negative impact on the economy, is the ever-diminishing buying power of consumers. When people have less money to spend, or when six million people are suddenly no longer there, it will seriously affect the economic growth of South Africa. Metropolitan Actuary Deane Moore believes that HIV will affect the production capacity to such an extent by 2005, that organisations will battle to survive. He further estimates, that employers already pay R500 to R1 000 more on average per person in terms of medical fund contributions each year. This amount to R200 to R400 a month more for an average family and these figures can be expected to escalate in years to come. The assumption can, therefore, be made that HIV/AIDS will affect the average family's disposable income by 10 to 15 per cent and that this figure will drastically rise as the impact of the HIV/AIDS epidemic is felt everywhere (Anon, 2000:11).

Another fact is, that treatment for HIV/AIDS patients will cost between R24 000 and R34 000 a year. This is still well below the WHO estimates of \$15 000 (±R91 500) a year. Dr. G. Haggis Guild, an AIDS consultant to Billiton and Angus Vaal, explains, that South Africa's economy could not afford to give each of the estimated 3,6 million HIV-positive people triple therapy. At a conservative R200 a month, the cost

would be in the region of R129, 6 billion, which contributes about 17 per cent South Africa’s National Gross Domestic Product (Van Zyl, 1999:10).

Figure 2.10 predicts the effect HIV/AIDS will have on direct health costs for the country.

**Figure 2.10: HIV/AIDS in South Africa: surge in indirect health costs**



**Source:** Van Zyl, 1999:10

#### 2.4.2 The impact of HIV/AIDS at micro-level

Besides the effect on the economy, HIV/AIDS will also seriously affect the micro- or household level of the country. The economic and social impact of HIV/AIDS remains a complex issue and is hard to predict. Household structure and behaviour will change dramatically as the size, composition and productivity of the labour market are affected. Infected individuals will require medical treatment and special foods, increasing demands on households with limited resources. At the same time, if the person is an adult, illness and death will reduce household production capacity and result in a decline of the total income earned by households. There are no studies at present in South Africa on the effect of HIV/AIDS on households. The only broadly-

based study of household responses to the impact of HIV/AIDS is the Kagera study conducted in Tanzania (Whiteside & Sunter, 2000:90).

The overall economic impact of an adult is demise on surviving household members, varies according to certain characteristics and determinants.

- The deceased individuals age, gender, income and actual cause of death.
- The household itself, such as composition and assets.
- The community, such as attitudes towards helping and supporting needy households as well as the general vulnerability of resources.
- Living standards within the community.

It seems that HIV/AIDS will have a greater impact than will deaths from other causes. The main reason for this, is the protracted nature of the illness. There may be lengthy depletion of household resources, giving rise to greater and more enduring hardship than might be the case with other types of death. The South African population is, by African standards, highly urbanised, with over 50 per cent of the population living in urban or pre-urban areas. The reasons for this, are that there are no developed community support mechanisms and that people are more seriously impoverished and that many do not have access to sufficient food crops (Thomas & Khupiso, 2000:1).

Another possible problem facing people in South Africa, is the type of scheme whereby basic homes are provided to poor people. The concept is that basic housing should be provided, with occupants paying towards the cost of their homes and for utilities. If households are facing the loss of income and increased demand on their resources on account of HIV/AIDS, this may no longer be feasible. The links between poverty and health are increasingly recognised. It is not 100 per cent clear, that AIDS is actually a disease of poverty, although poverty undoubtedly helps to drive and nourish the epidemic. In South Africa the poorest 40 per cent of households receive only 11 per cent of the total income, while the richest 10 per cent receive 40 per cent of the total income. About 50 per cent of the total population ( $\pm$ 21 million) live in the poorest 40 per cent of households and are, therefore, classified as being poor. For these households an AIDS case will certainly deplete income and increase



the demands on existing limited resources available. Thus, in effect HIV/AIDS, has the potential to push households deeper into poverty. An important scenario will be, that richer households will purchase assets from AIDS-stricken poorer households as part of the survival strategy, therefore resulting in the spreading of inequalities in the distribution of incomes and assets (Whiteside & Sunter, 2000:92).

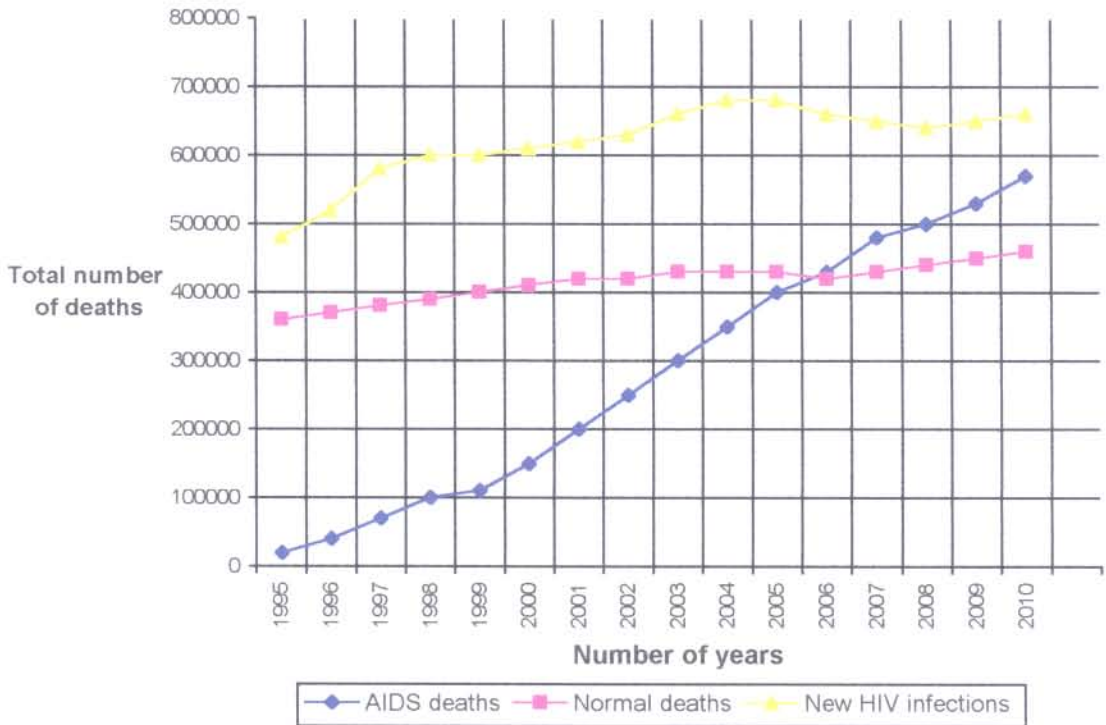
The cost of the disease will also affect households in one of the following ways.

- Where workers are too ill to work, they will be medically boarded, resulting in the loss of benefits. Ultimately they will be forced to rely on state funds in order to allow them to care for their families, putting a greater burden on government and State resources.
- State hospitals are more and more recognising that they can no longer provide sufficient and adequate care for people living with AIDS. Their patients are therefore, discharged to be cared for at home, which places extra financial burden on households.
- People living in urban areas, may return to their rural houses when they fall ill, but can no longer get access to sufficient health resources.

### **2.4.3 HIV/AIDS, the mortality rate and orphans**

Besides the economic and household implications of HIV/AIDS for South Africa, another important factor to be taken into account, is the mortality rate. The most direct consequence of HIV/AIDS, is an increase in mortality. Without effective treatment of the HIV infection, people will develop full-blown AIDS and die. Another aspect, is that the age at which the majority of people are infected, means that AIDS will increase the rate of mortality among those who have the lowest mortality rates. The impact of HIV-mortality is clearly illustrated by the following figure (Adler, 2000:57).

**Figure 2.11: Number of normal deaths, AIDS deaths and new HIV-infections**



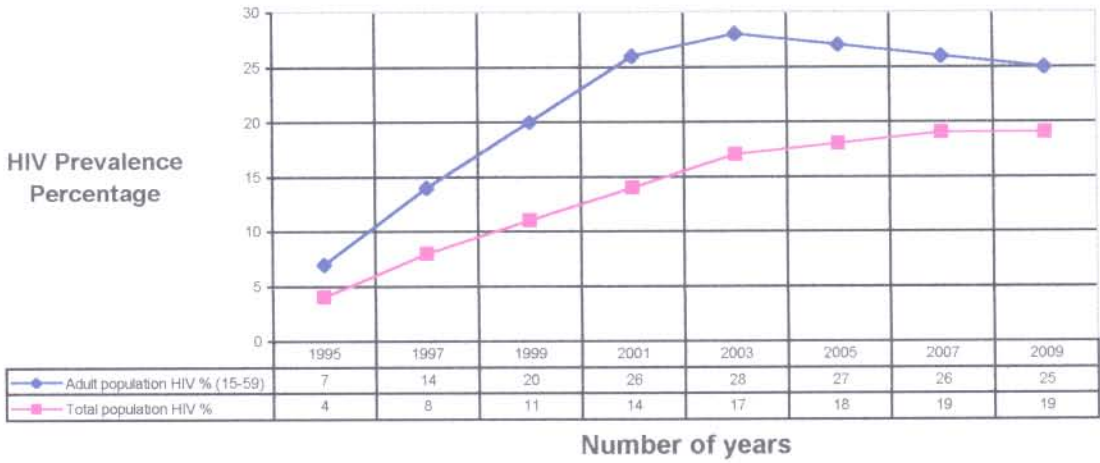
**Source:** Whiteside & Sunter, 2000:70

The figure clearly indicates that by about 2006, there will be many deaths resulting from AIDS as opposed to all other forms of death causes. The important fact to remember is that AIDS will kill mainly young adults in the economically active age group.

It is further estimated, that the AIDS mortality would probably peak at around 2004 to 2005 in South Africa, which will result in approximately 130 000 deaths per year. By 2016, the total number of cumulative deaths as a result from full-blown AIDS in KwaZulu Natal (the worst affected area in South Africa) alone will exceed two million people (Adler, 2000:59).

This particular province will have to face the legacy of 350 000 orphans in two years and 800 000 by the year 2010 as a direct result of the AIDS epidemic. The following figures support this view.

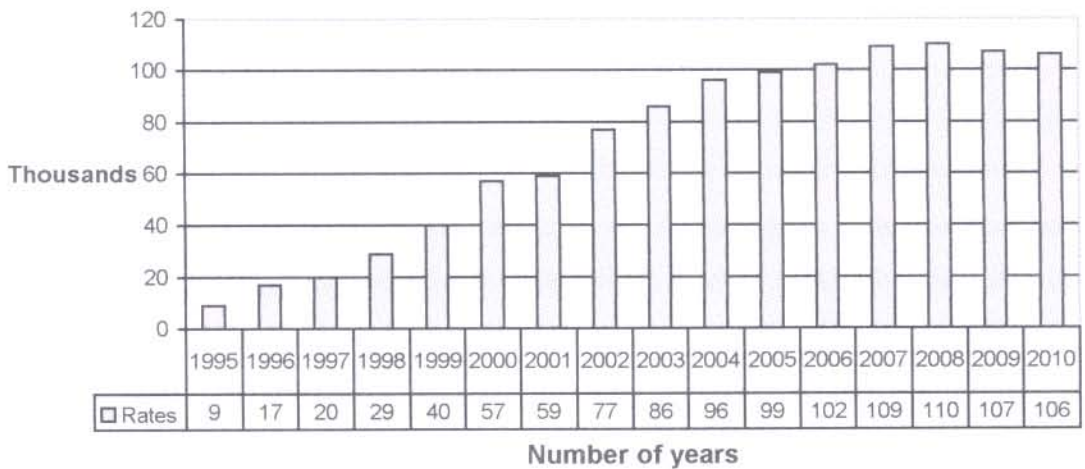
**Figure 2.12: Projected total and adult HIV prevalence rates in KwaZulu-Natal**



**Source:** Whiteside & Sunter, 2000:71

If the above percentage is translated into figures, then an estimated 1 115 000 adults are already infected in KZN. The projected deaths for this province, are illustrated in the next figure.

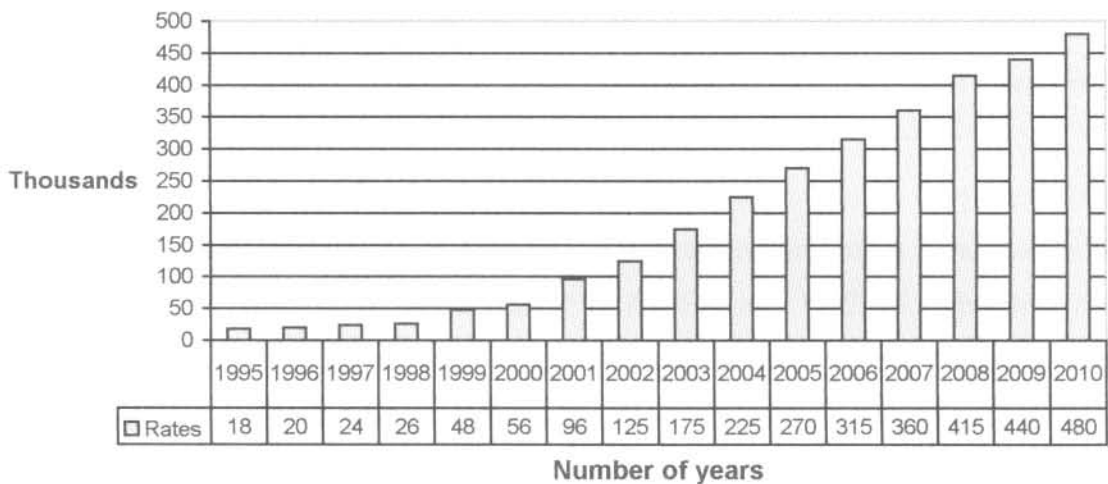
**Figure 2.13: Projected AIDS deaths in KwaZulu Natal**



**Source:** World Health Organisation, 1998:72

One of the conclusions that can be drawn from the data, indicate that the total population of KwaZulu Natal will continue to grow until 2008, after which it is expected to decrease sharply. This will in turn result in a sharp increase, in the total number of orphans as a result of the AIDS impact on the general population in KwaZulu Natal. These predicted trends are summarised in the next figure.

**Figure 2.14: Projected AIDS orphans in KwaZulu Natal**



**Source:** World Health Organisation, 1998:72

The above data clearly indicate, that the population structure will change very rapidly and that a population growth will be seriously affected.

Before engaging into further discussion, it is absolutely imperative to understand what is meant by the terminology “AIDS orphan”. An AIDS orphan is defined as a person of 15 years or younger whose mother or father has died of an AIDS-related illness. It is further estimated that one third of all children born to HIV-positive mothers will be infected, while all children born to HIV-positive parents are doomed to be orphaned. For a child living with a parent who has AIDS, it will have serious social and psychological implications. As HIV is sexually transmitted, the consequences will be, that the other parent will also be infected. Children who lose one parent to AIDS are thus at a considerable risk of losing their remaining parent as well (Anon, 1999:7).

Manton Schönsteich of the Institute for Secondary Studies in Pretoria predicts a bleak and frightful future. He warns, that AIDS and age will be significant contributors to an increase in the crime rate of South Africa over the next 10 to 20 years. There will be a boom in South Africa's orphan population during the next decade, as the AIDS epidemic takes its toll among the population of South Africa. Every fourth South African will be between the age of 15 and 24 years. Within this age group people's propensity to commit crime, are at its highest (Van Zyl, 1999:11).

Research conducted by UN-AIDS has shown that adult relatives look after only 12 per cent of the world's orphans. So, in effect, 88 per cent are cared for by the state or have turned to begging and crime in order to survive, which in turn will have great implications for South Africa.

Gauteng Health Department (AIDS Programme Director, Liz Floyd) says that South Africa will already have orphans as a result of AIDS deaths by 2005. This province alone, will have to care for 100 000 AIDS orphans in 2003 and 500 000 in 2015. The result will be massive social problems and costs, which will be the tragic consequences of AIDS, and which will ultimately also affect population and tourism growth, as well as South Africa's support structure (Van Zyl, 1999:12).

The question now arises: Who will care for these children? The best environment to raise any child is within a family, but this may not always be feasible. Other alternatives may include community- or neighbourhood-based structures or enterprise-centred "Kibbutz" type collectives for women and children. Institutional care should be considered only as a last resort. South Africa will also experience a rapid increase in the number of children growing up with no parents at all, or only one parent because of the effects of AIDS. Most orphans will grow up without adequate parental supervision, guidance and discipline under these impoverished conditions. Without a home, mass work-seeking migrations into urban centres, will be the only option for many orphans. Without a family support structures, these children are vulnerable to many types of exploitations such as the following.

- being hired for sweatshop labour,
- forced into commercial sex work,
- co-opted into gangs,
- girls existing at great risk, as they are preferred for domestic work.

As Mann and Tarantola (1996) rightfully suggests, there is one golden rule when it comes to HIV/AIDS: no matter how or where the epidemic enters a country, it will always move to those communities which are marginalised, stigmatised and discriminated against, prior to the onset of the epidemic. South Africa is a good example of this maxim. The country has emerged from an intensively repressive past. Yet it is precisely these types of environments that lie in the heart of the behaviour that spreads HIV/AIDS. It also explains to a certain extent, why South Africa has one of the fastest growing epidemics in the world. Finally, current procedures for adoption needs to be re-evaluated for the future placement of huge numbers of orphans in the next 5 to 10 years. These procedures need to be implemented now (Adler, 2000:69).

## 2.5 CONCLUSION

The way, in which management addresses HIV/AIDS in the workplace, will determine whether companies survive the first decade of the 21<sup>st</sup> century. Already a negative growth rate had been identified in KwaZulu Natal by the end of 1999, due to the effects of the HIV virus. Based on the most recent statistics, it is projected that 11 per cent of the total South African workforce is HIV-positive and an estimated 0,6 per cent have full-blown AIDS. By 2020, 21 per cent of the South African workforce is projected to be HIV-positive with 2,9 per cent AIDS sick (Vincent, 2000:1).

These predictions can have far-reaching implications for South Africa's economic growth and stability. HIV/AIDS are the greatest challenge facing the country. Business, together with government and all parties interested, must unite and find a solution for the effective management of AIDS in Africa. An African solution must be found for an African problem. Prevention of the epidemic needs to be the first priority. The lack of prevention will mean that South Africa has to deal with the

impact flowing from the illness and death of many of people. As already, indicated AIDS will initially be felt by the health sector, followed by the private sector who already care for a sizeable percentage of South Africans, most of whom are covered through medical aid schemes. One of the most important principles challenging the private sector is to understand the benefits in providing care for workers as well as the effective management of HIV/AIDS in the workplace. This could be achieved only by setting clear and reliable objectives and goals, as well as the implementation of cost-effective methods and strategies that will actually be successful in limiting the spread of the disease.

Although many of the impacts have been briefly discussed, many of them are already in full progress. Much will depend on how the epidemic is handled and managed over the next few years to come. It's a crucial time now; there is still adequate time to take precautionary measures and to make a difference.

In the next chapter (Chapter 3), the focus will be on the threat HIV/AIDS poses to the South African business sector and how organisations could respond to the legal challenge and implications that HIV/AIDS have on the working environment, as well as current structures available on national and provincial level to fight the disease head-on.

## CHAPTER 3

### SOUTH AFRICAN BUSINESSES AND THE HIV/AIDS THREAT

#### 3.1 INTRODUCTION

In 1996, epidemiologists agreed, that the overall national prevalence (worst scenario) would probably plateau at about 27 per cent. In 1999, with the worst case scenario now a reality, estimates have shifted to 30 per cent. In other words, 30 per cent of economically active South Africans in 2001 are expected to be infected with HIV, resulting in so much illness, deprivation, and death and of course, costs. As if this is not enough, the Metropolitan Doyle Model on AIDS projects, that by 2010, 18 per cent of South Africa's workforce will be HIV-positive. These statistics mean that the country's national policy and resources must be managed adequately so as to limit the impact of the epidemic, wherever possible (Gresak, 2000:13).

In a growing emergent economy, such as that of South Africa, which is destined to remain labour-intensive for many years to come, the consequences of AIDS are staggering, allowing also for the fact that all governments tend to underestimate the full extent of the disease and impact AIDS is going to have on businesses and the economy. Many organisations still seem to hope that the problem will vanish, or that it will not affect them. Consequently, few organisations have faced up to the excruciating dilemmas of their counterparts in countries North of South Africa (Robinson, 1999:15).

Further estimates have indicated that the majority of HIV patients in 17 sub-Saharan countries hardest hit by the epidemic were from the most productive sector of society. A sick workforce places enormous pressure on sales and marketing professionals. Organisational targets still have to be met, even though fewer people are spending. Medical and Aid tariffs will rise dramatically over the years to come, further reducing expendable income of households; and the average life expectancy is expected to drop from 60 years to 40 years in the next decade. All these factors will have a devastating



effect on organisations to survive. The result is clear: AIDS is going to impact heavily on bottom line profits.

### 3.2 THE PRIVATE SECTOR AND THE HIV/AIDS EPIDEMIC

The private sector has a special role to play in achieving sufficient economic growth and to raise the general standard of living in South Africa. This can be achieved only if organisations and businesses are functioning properly, with a healthy work force. There are, however, two realities facing managers at present.

- There will be a steady increase in HIV-illness and AIDS deaths in South Africa and much of it will be among the working age population.
- Only limited information is available on the actual impact of HIV/AIDS on businesses.

The vulnerability of the business sector will depend on factors such as the type of production process, risk profiles of employees, the skill factor of employees infected, as well as employee benefit structures, such as medical aid and pension schemes. Representative data on the magnitude of costs to South African organisations are almost non-existent. Available data indicates that, for most organisations, irrelevant of size, the costs of HIV/AIDS among employees are unlikely to be devastating for any one particular year. Time over however, costs will be substantial, and in some businesses, illness or the death of entrepreneurs or even key employees, may prove disastrous (Kinghorn, 2000:22).

The following table indicates the different types of HIV/AIDS costs to organisations as a percentage of the total HIV/AIDS costs.

Table 3.1 to follows on p.63.

**Table 3.1: Types of HIV/AIDS costs as a percentage of the total HIV/AIDS costs**

Type of costs	Organisation A	Organisation B	Organisation C	Organisation D
Absenteeism	54	32	54	25
Training and recruitment	23	20	24	-
Funerals and travel	1	18	10	5
Medical costs	14	15	12	38
<b>TOTAL</b>	100	100	100	100

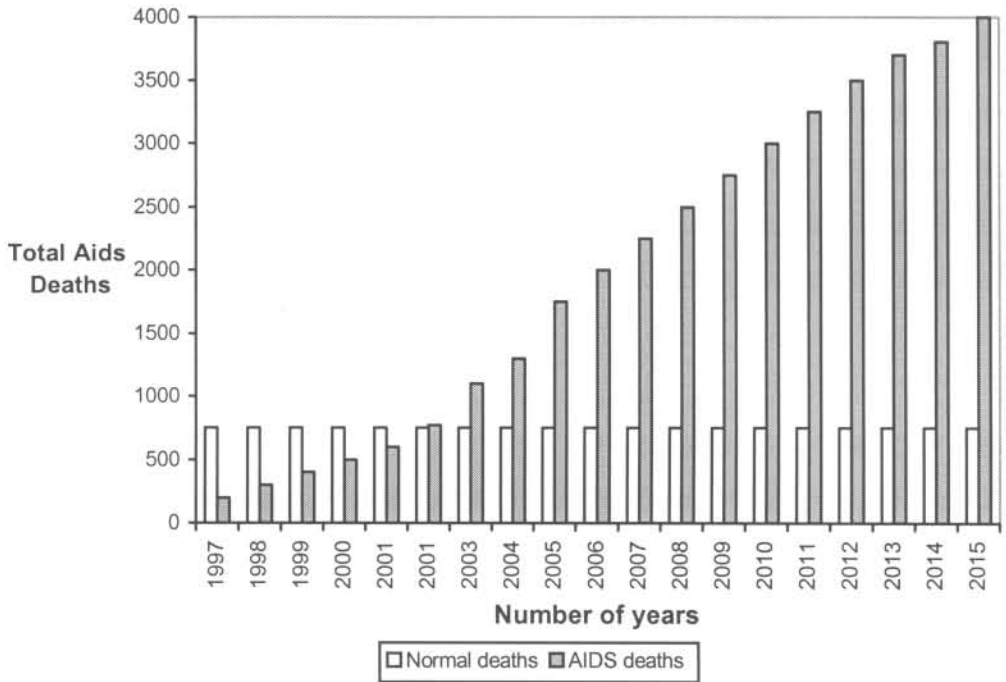
**Source:** World Health Organisation, 1998:68

Many organisations will be affected if suppliers of key inputs fail to manage the HIV/AIDS impacts adequately. As a result, organisations have a direct role to play in ensuring that HIV/AIDS does not unnecessarily affect costs and the business environment. Over the next 10 years, many South African organisations will begin to lose approximately 4 per cent of their employees to AIDS each year. The HIV/AIDS impact will affect every manager and employee (Robinson, 1999:22).

The following figures indicate the projected AIDS death rates, as well as the total HIV prevalence rate among South African employees, age 15 to 59, for the following decade to come, as compared to normal deaths.

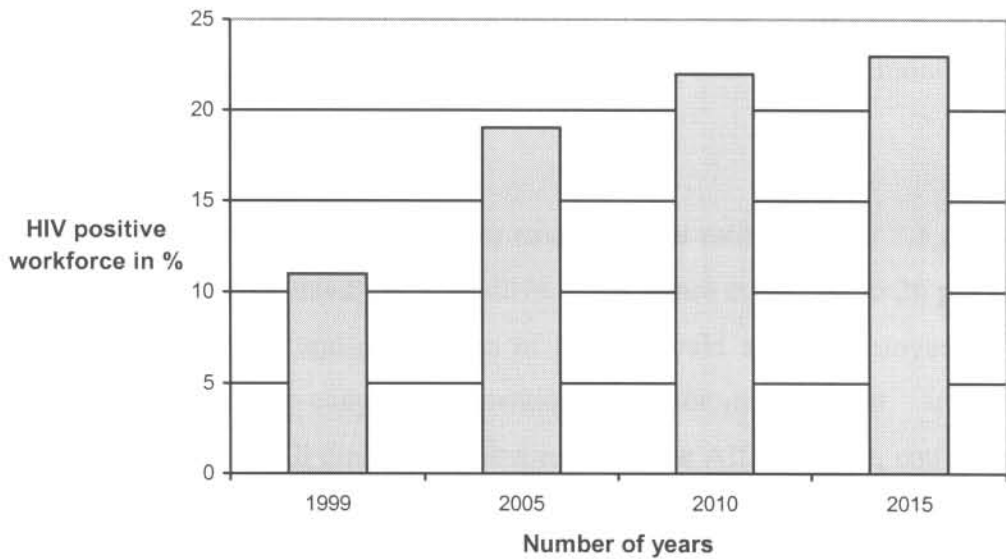
Figures 3.1 and Figure 3.2 to follow on p.64.

**Figure 3.1: Total projected AIDS deaths among South African employees compared to normal deaths**



**Source:** Kinghorn, 2000:22

**Figure 3.2: HIV-prevalence among workforce 15 to 59 Years (total RSA population estimates)**



**Source:** World Health Organisation, 1998:163

Another important fact is that about 45 per cent of South Africa's mineworkers are HIV-positive, according to Janina Slawski, senior director at Alexander Forbes and head of the actuarial society's AIDS committee. A very frightening fact. This has already reduced production figures by 15 per cent and is also widely regarded as the highest infection rate of any industry in the country. Slawski states that about 70 per cent (almost half) of all mine workers already have full-blown AIDS, which means they can only provide one tenth of the production of healthy workers. This will in effect increase production costs and other indirect costs relating to HIV/AIDS impacts.

The result will be, that mine management will have to employ 20 per cent more workers to maintain production levels, thus increasing labour cost by almost a third. Dr. Hagys Guion, an AIDS consultant attached to various Mining Houses in South Africa, confirms the need for extra workers to do the same amount of work: "It is also difficult to decide exactly when to appoint these people – doing it too soon could place an additional burden on the organisation" (Van Zyl, 1999:12).

The mining industry is the only sector that has a relatively good idea of how AIDS will affect it, while the agriculture sector has also started to feel the effects of the high incidence of HIV-positive cases. At a recent Agriculture Union economics symposium held in Gauteng, it was mentioned, that a sugar producer in KwaZulu Natal lost 57 per cent of his total work force of about 150 in recent months through AIDS-related cases (Van Zyl, 1999:2).

In large organisations such as Escom for example, it is estimated that 2,5 per cent of its total work force are already HIV-positive. This figure could rise to 26 per cent by 2005. These estimates and predictions of how it could affect employee levels of production have already caught the attention of senior management. It is further estimated, that the overall direct costs as a result of the AIDS impact, could reach as much as 15 per cent of the organisation's payroll by the end of 2005 onwards. Ill health retirements would amount to almost 10 per cent of the total salary bill (Meeson & Van Meelis, 2000:45).

In the case of government sectors, it is not so clear, yet it is estimated that approximately a quarter of the South African police force and about 15 per cent of all civil servants, are HIV-positive. This could prove vital to the social and political stability of the country. The risk of HIV infection in South Africa tends to be greater among employees who are less skilled and hailed from disadvantaged communities (Robinson, 1999:15).

The effects of HIV/AIDS on organisations, are reduced productivity, increased costs and loss of customers and consumer spending, with the result, that profits will be depressed by a number of factors.

These factors can be summarised as follows.

- Absenteeism is increasing, not only because of ill health experienced by employees, but also because workers take time off to care for their families (these demands are felt especially by women), and for funerals.
- The morale of the work force is sagging.
- Sick workers are less productive at work and cannot carry out the more demanding physical jobs.
- Accidents occur more frequently because of fatigue in the workplace.
- Employees, who die or retire on medical grounds, have to be replaced; their replacements may be less skilled and experienced and, therefore, may require training.
- The average age and experience of workers fall as the proportion of new and younger recruits (novices in the mining industry) rises.
- Employers are increasing the size of their workforce to provide for deaths during apprenticeship and because of absenteeism generally.
- As skilled workers become scarcer, wages have to be increased for the limited pool available.
- The communities in the neighbourhood of a business need more support to weather the crisis.
- The costs of health care, medical aid, and hospitalisation are rising steeply.

- When organisations have granted credit to customers for purchases, and those customers should die of AIDS, the balance of the loans has to be written off.
- Growth in the volume of sales, and in some cases, the actual volume of sales itself, are declining as the market shrinks through sickness and death.

South Africa's private sector thus needs to seek and develop a cost-effective way of combating HIV/AIDS. This can be done both on the short and the long term, by implementing and developing a response programme on the immediate short-term, while dealing with the social determinates on the longer term, as will be discussed in the following chapters. This however, poses a dilemma. It is known that in many Third World countries, a programme-based response is problematic and in many contexts, will only have limited or even no effects, due to social determinants that stem in the way of behavioural change (Adler, 2000:70).

On the other hand, changing the social context is a very long and arduous process, with no guarantees for success. This raises the difficult question of what can realistically be achieved by the business sector in order to address the epidemic head-on. Because an answer is critical for full understanding, the extent to which business can engage directly with the epidemic and what strategy should be pursued to effectively utilise resources on the short- and long term, should be investigated.

### **3.3 THE DIRECT AND INDIRECT COSTS OF MANAGING HIV/AIDS IN THE WORKPLACE**

HIV/AIDS could have a devastating affect on organisations in South Africa and ultimately have a huge impact on economic growth and stability. This would mean, that the absolute number of potential customers, making markets that are relatively saturated and which depend critically on population growth, the most vulnerable. The impact of the epidemic on specific markets will depend on factors such as the demographic profile of consumers. Where the demand of goods is far from saturated and is growing strongly, many consumers who will die or have their disposable income reduced by HIV/AIDS, will be replaced by new earners and consumers. Yet

the strongest markets will feel the impact on their overall GDP and consumption expenditure will be badly affected (Whiteside & Sunter, 2000:109).

It is predicted, that the South African consumer base is likely to grow slowly until 2010. Thereafter, the demographic impact of AIDS will “kick in”, resulting in an 18 per cent decline in consumer-based figures by 2015 in all provinces across South Africa. The effects of the epidemic, will mean that consumption patterns will change as disposable income is reallocated, reducing profits considerably; while in turn, this will have a “knock-on” effect on the granting of credit, because customers’ credit-worthiness may well be impaired. What does this actually mean for business in the private sector?

The bottom line is, that HIV/AIDS will make it more expensive for any organisation to produce a given quantity of its products, unless it can reduce its costs in other ways. Should the increase in HIV/AIDS-related costs be large enough, the organisation may face the result of going out of business. Obviously, top management will try to avert such a prospect by formulating and implementing strategic plans and other methods (refer Chapter 4).

First an analysis of the different types of costs that have an impact on business, has to be done. This includes especially three types of costs.

- Direct costs, which reflect the impacts of increased financial outlays by the organisation.
- Indirect costs, which reflect reduced workforce productivity in terms of both infected employees and employers who are diverted from their normal responsibilities.
- A systemic cost, that refers to costs that is the result of the cumulative impact of total HIV/AIDS cases.

The following figure explains these costs in more detail.

**Figure 3.3:** The different types of costs as a result of the economic impact of HIV/AIDS on business University of Pretoria etd – Venter, F. (2006)



**Source:** Whiteside & Sunter, 2000:112



Most direct costs can be easily measured by using relevant human resources and financial data that large organisations annually collect. Indirect costs are more difficult to measure. Such costs will include the costs as a direct result of absenteeism and morbidity factors. For on-the-job morbidity, estimates are needed of the percentage of productivity loss in terms of man-hours loss experienced by sick workers and duration of productivity loss. Determining the opportunity cost of management time devoted to HIV/AIDS-related issues, is more difficult. System costs are the most difficult to measure, especially in the short-term and for individual organisations. These type of costs include the toll that the illness has as well as total mortality among co-workers on overall employee morale and motivation, as well as the occurrence of slacking and theft and the overall loss of experience and skill in the workforce. To estimate the total costs on the business, requires three other important facts of information. These include the actual HIV/AIDS prevalence rate, morbidity and mortality rates. These must be either measured or modelled through processes such as testing (voluntary or anonymous). Once all potential influences that HIV/AIDS could have on the organisation's internal and external environments have been ascertained, suitable responses to the challenge can be formulated (Anon, 1999:2).

These responses can be divided into the following sectors.

- The impact on production and employees.
- The impact on total costs.
- The impact on markets.
- Business society.

AIDS will make it increasingly difficult for organisations based in South Africa to sustain any competitive advantage they enjoy at the moment: as stated by Moore (1997:28). The direct costs associated with the disease, are likely to continue escalating, especially in ongoing provisions of employee benefits such as life, disability and medical cover. It has been predicted, that for many retirement funds, the cost of an average set of benefits is likely to double by 2005 and triple by 2010, putting more strain on the organisations to maintain a competitive edge (Anon, 1999:3).

AIDS has already cost businesses a great deal of money in respect of direct and indirect costs in managing the illness. Therefore, in order to manage the impacts of HIV/AIDS on employees, operations and competitiveness, effective comprehensive responses must be implemented to the benefit of organisations and will result in the following positive outcomes.

- Visible commitment of businesses to the HIV/AIDS epidemic.
- Well-designed programmes to reduce infection, increase awareness among employees and renew overall total costs as a result of the HIV/AIDS epidemic, if possible.
- Create continued openness and acceptance among workers.
- The implementation of programmes that are guided by sound input assessments, policies and strategies (Kinghorn, 2000:23).

Aside from cost organisations also have to consider the input of HIV/AIDS in terms of organisational downtime to AIDS-related absence. This could have a significant impact on labour costs resulting in lower profits to be made by organisations. It is, therefore, important that organisations have to take an active role in minimising South Africa's economic exposure to the impact of HIV/AIDS (Robinson, 1999:15)

### **3.4 HIV/AIDS AND THE LEGAL FRAMEWORK**

The way, in which employees with HIV or AIDS are treated in the workplace, has various legal implications for both the worker, as well as for the employee. The Employment Equity Act (Act 55 of 1998) is the only act which expressly refers to HIV/AIDS. Management, and especially labour unions, needs to find a balance between the right of workers in the workplace and that of employees. Unfair discrimination against the employee on the grounds of HIV-status that includes medical testing under certain circumstances, can only be intervened with by the authorisation of the Labour Court.

There are, however, many other laws in the field of labour, health and safety, which will impinge on organisations and where they will have to check for compliance. The South African Constitution (Act 108 of 1996) is the supreme law of the country and all other laws must comply with its provisions. The Bill of Rights within the Constitution, sets out a number of rights which protects employees. As a result, there are seven laws of labour in South Africa. These include the following.

- The Employment Equity Act, No. 55 of 1998.
- The Promotion of Equality and Prevention of Unfair Discrimination Act, No. 4 of 2000.
- The Labour Relations Act, No. 66 of 1995.
- The Occupational Health and Safety Act, No. 85 of 1993.
- The Miners' Health and Safety Act, No. 29 of 1996.
- The Compensation for Occupational Injuries and Diseases Act, No. 130 of 1993.
- The Basic Conditions of Employment Act, No. 25 of 1997.

Other pieces of legislation, policies and protection also exist within the common law; although not directly employment-related, they have an impact on the management of HIV/AIDS in the workplace.

Among others, there are the following.

- The Medical Schemes Act, No. 131 of 1998.
- The proposed notification of AIDS disease and death.
- The Department of Health's draft national policy on testing for HIV.
- Common Law protection of the right of privacy and dignity.

South Africa has also become a member of many international agreements and codes such as the International Labour Organisation (ILO) Convention III on discrimination (employment and occupation) 1958. However, the only one which relates specifically to HIV/AIDS in the workplace, is the SADC coding on AIDS and employment which was approved in September 1997 (Whiteside & Sunter, 2000:158).

### 3.4.1 HIV testing, confidentiality and disclosure

To provide an overview of the legal framework for employment relationships, with a focus on aspects that have HIV/AIDS implications, it is necessary to concentrate on certain elements in the broad framework of legislation (RSA, 2000:5).

#### 3.4.1.1 *HIV Testing*

- i) **No employer may require** an employee, or an applicant for employment, to undertake an HIV test in order to ascertain that employee's HIV-status. As provided for in the Employment Equity Act, employers may approach the Labour Court to obtain authorisation for testing.
- ii) Whether section 7 volume 2 of the Employment Equity Act prevents an employer-provided health service supplying a test to an employee who requests a test, depends on whether the Labour Courts would accept that an employee can knowingly agree to waive the protection in the section. The courts have not yet decided this issue.
- iii) In implementing the sections below, it is recommended that parties take note of the position set out in item ii) above.
- iv) Authorised testing.

Employers must approach the Labour Court for authorisation in, among others, the following circumstances.

- During an application for employment.
- As a condition of employment.
- During procedures related to termination of employment.
- As an eligibility requirement for training or staff development programmes.
- As an access requirement to obtain employee benefits.

- v) Permissible testing.
- (a) An employer may provide testing to an employee who has requested a test in the following circumstances.
- As part of a health care service provided in the workplaces.
  - In the event of an occupational accident carrying a risk of exposure to blood or other body fluids.
  - For the purposes of applying for compensation following an occupational accident involving a risk of exposure to blood or other body fluids.
- (b) Furthermore, such testing may take place only within the following defined conditions.
- At the initiative of an employee.
  - Within a health care worker and employee-patient relationship.
  - With informed consent and pre- and post-test counselling, as defined by the Department of Health's National Policy on Testing for HIV.
  - With strict procedures relating to confidentiality of an employee's HIV-status, as described in clause 7.2 of this Code.
- vi) All testing, including both authorised and permissible testing, should be conducted in accordance with the Department of Health's National Policy on Testing for HIV issues in terms of the National Policy for Health Act, No. 116 of 1990.
- vii) Informed consent, means that the individual has been provided with information, understands it and based on this, has agreed to undertake the HIV-test. It implies, that the individual understands what the test is, why it is necessary, the benefits, risks, alternatives and any possible social implications of the outcome.
- viii) Anonymous, unlinked surveillance or epidemiological HIV-testing in the workplace, may occur, provided it is undertaken in accordance with ethical

and legal principles regarding such research. Where such research is done, the information obtained, may not be used to unfairly discriminate against individuals or groups of persons. Testing will not be considered anonymous if there is a reasonable possibility that a person's HIV-status can be deduced from the results. (RSA, 2000:6).

#### **3.4.1.2 Confidentiality and disclosure**

- i) All persons with HIV or AIDS have the legal right to privacy. An employee is, therefore, not legally required to disclose his or her HIV-status to their employer or to other employees.
- ii) Where an employee chooses to voluntarily disclose his or her HIV-status to the employer or to other employees, this information may not be disclosed to others without the employee's express written consent. Where written consent is not possible, steps must be taken to confirm that the employee wishes to disclose his or her status.
- iii) Mechanisms should be created to encourage openness, acceptance and support of those employers and employees who voluntarily disclose their HIV-status within the workplace, including:
  - encouraging persons openly living with HIV/AIDS to conduct or participate in education, prevention and awareness programmes;
  - encouraging the development of support groups for employees living with HIV or AIDS; and
  - ensuring that persons who are open about their HIV- or AIDS-status are not unfairly discriminated against or stigmatised (RSA, 2000:8).

#### **3.4.2 Promoting a safe workplace**

**3.4.2.1** An employer is obliged to provide and maintain, as far as is reasonably practicable, a workplace that is safe and without risk to the health of its employees.

3.4.2.2 The risk of HIV-transmission in the workplace is minimal. However, occupational accidents involving bodily fluids may occur, particularly in the health-care professions. Every workplace should ensure that it complies with the provisions of the Occupational Health and Safety Act, including the Regulations on Hazardous Biological Agents, and the Mine Health and Safety Act, and that its policy deals with, amongst others, the following.

- The risk, if any, of occupational transmission within the particular workplace.
- Appropriate training, awareness, education on the use of universal infection control measures so as to identify, deal with and reduce the risk of HIV-transmission in the workplace.
- Providing appropriate equipment and materials to protect employees from the risk of exposure to HIV.
- The steps that be taken following an occupational accident, including the appropriate management of occupational exposure to HIV and other blood-borne pathogens, including access to post-exposure prophylactics.
- The procedures to be followed in applying for compensation for occupational infection.
- The reporting of all occupational accidents.
- Adequate monitoring of occupational exposure to HIV in order to ensure that the requirements of possible compensation claims being met.

### 3.4.3 Compensation for occupationally acquired HIV

3.4.3.1 An employee may be compensated if he *or* she becomes infected with HIV as a result of an occupational accident, in terms of the Compensation for Occupational Injuries and Diseases Act.

3.4.3.2 Employers should take reasonable steps to assist employees with the application for benefits including:

- providing information to affected employees on the procedures that will need to be followed in order to qualify them for a compensation claim, and
- assisting with the collection of information, which will assist with proving that the employees had been exposed occupationally to HIV-infected blood.

**3.4.3.3** Occupational exposure should be dealt with in terms of the Compensation for Occupational Injuries and Diseases Act. Employers should ensure that they comply with the provisions of this Act and any procedure or guideline issued in terms thereof (RSA, 2000:10).

#### **3.4.4 Management of HIV in the workplace**

**3.4.4.1** The effective management of HIV/AIDS in the workplace, requires an integrated strategy that includes, amongst other, the following elements.

- An understanding and assessment of the impact of HIV/AIDS on the workplace.
- Long- and short-term measures to deal with and reduce this impact, including:

(a) an HIV/AIDS Policy for the workplace, and

(b) HIV/AIDS Programmes, which would incorporate:

- on-going sustained prevention of the spread of HIV among employees and their communities;
- management of employees with HIV, so that they are able to work productively for as long as possible; and



- strategies to deal with the direct and indirect costs of HIV/AIDS in the workplace (RSA, 2000:12).

The above legislation aspects pertaining to HIV/AIDS are only a few that make up the total legislative framework in South Africa.

It is important that the Employment Equity Act stays in touch with the constitutional prohibition that HIV/AIDS should be treated in all relevant respects likewise to other comparable life-threatening conditions. Employees and prospective employees with AIDS should be treated in a just, humane and life-affirming way. Employees, employers and their respective organisations, should acknowledge continued employment of an employee with AIDS. This may constitute a rational policy towards training new employees. HIV-status should, therefore, not be a basis for refusing, continuing or renewing an employment contract, nor refusing to train, develop or promote an employee (Vincent, 2000:6).

### **3.5 CURRENT STRUCTURES IN SOUTH AFRICA TO ADDRESS THE IMPACT OF HIV/AIDS**

The following structures form part of an expanded national response to the impact of HIV/AIDS within the South African business sectors, inclusive of the public and private sectors. It is also important to take note, that all other sectors, including parastatals, NGO's and other related organisations, include persons as co-ordinators dedicated to effectively managing the impact of HIV/AIDS on their organisations. These initiatives and structures are important in ensuring that South Africa has a more co-ordinated response to the impact of the HIV/AIDS epidemic. These structures are by no means exclusive and provide information on only some of the current structures available to minimise the impact of HIV/AIDS and the prevention of STD's.

These structures can be briefly explained and include the following.

### **3.5.1 Cabinet**

The Cabinet is the highest political authority in the country. The Cabinet meets weekly, but HIV/AIDS issues are not regularly discussed at this level, as this has been deferred to the South African National AIDS Council.

### **3.5.2 Interdepartmental committee on AIDS (IDC)**

This committee consists of representatives from all government Departments who co-ordinate HIV/AIDS activities. The IDC meets monthly to review government programmes and to fulfil requests from SANAC. Goals of the IDC include facilitating the development of HIV/AIDS workplace policies in all Government Departments, ensuring that all Government Departments allocates financial resources to HIV/AIDS; and developing minimum HIV/AIDS programmes for all Government Departments.

### **3.5.3 MINMEC**

The MINMEC consists of all Provincial Health MEC's and the national Minister of Health. The MINMEC meets every six weeks, and is the body that approves national policies and guidelines. HIV/AIDS is a standing item, where reports on national and provincial programmes are discussed.

### **3.5.4 South African National AIDS Council**

The South African National AIDS Council is the highest body that advises government on all matters relating to HIV/AIDS. Its major functions are to: (a) advise government on HIV/AIDS/STD policy, (b) advocate for the effective involvement of sectors and organisations in implementing programmes and strategies, (c) monitor the implementation of the Strategic Plan in all sectors of society, (d) create and strengthen partnerships for an expanded national response among all sectors, (e) mobilise resources for the implementation of the AIDS programmes, and (f) recommend appropriate research.

### **3.5.5 Government**

Ministers of Health; Education; Welfare and Population Development; Agriculture; Arts, Culture, Science and Technology; Transport; Labour; Finance; Provincial and Local Government; Defence; Minerals and Energy; Correctional Services; Public Service and Administration; The Deputy CEO of the Government Communication and Information Systems; the Chairperson of the Portfolio committee on Health; and the Chairperson of the Select Committee on Social Services (Anon, 2000:12).

### **3.5.6 Sectors represented**

One representative each from Business; people living with HIV/AIDS; non-government organisations; faith-based organisations; Trade Unions; women; youth; traditional healers; traditional leaders; Legal and Human Rights; disabled people; Celebrities; Sport; Media; Hospitality Industry; NAPWA, and Local government.

### **3.5.7 Technical task teams**

The SANAC is assisted in its deliberations and decisions by technical task teams comprising experts in the following five areas: a) Prevention; b) Care and Support, c) IEC and Social Mobilisation, d) Research, Monitoring, Surveillance and Evaluation; and e) Legal Issues and Human Rights.

### **3.5.8 Provincial Health Restructuring Committee (PHRC)**

This committee consists of all Provincial Heads of Health and meets on a monthly basis in order to discuss the strategic issues of national and provincial importance. HIV/AIDS is a standing agenda item, where reports from the National HIV/AIDS/STD Directorate and Provincial HIV/AIDS Co-ordinators are discussed. Once the PHRC has discussed and approved documentation, it is referred to the MINMEC for political approval.

### **3.5.9 Director-General Forum**

This forum consists of Directors-General from all National Government Departments and meets regularly. HIV/AIDS is a standing agenda item, where reports from the IMC are discussed.

### **3.5.10 HIV/AIDS and STD Directorate, Department of Health**

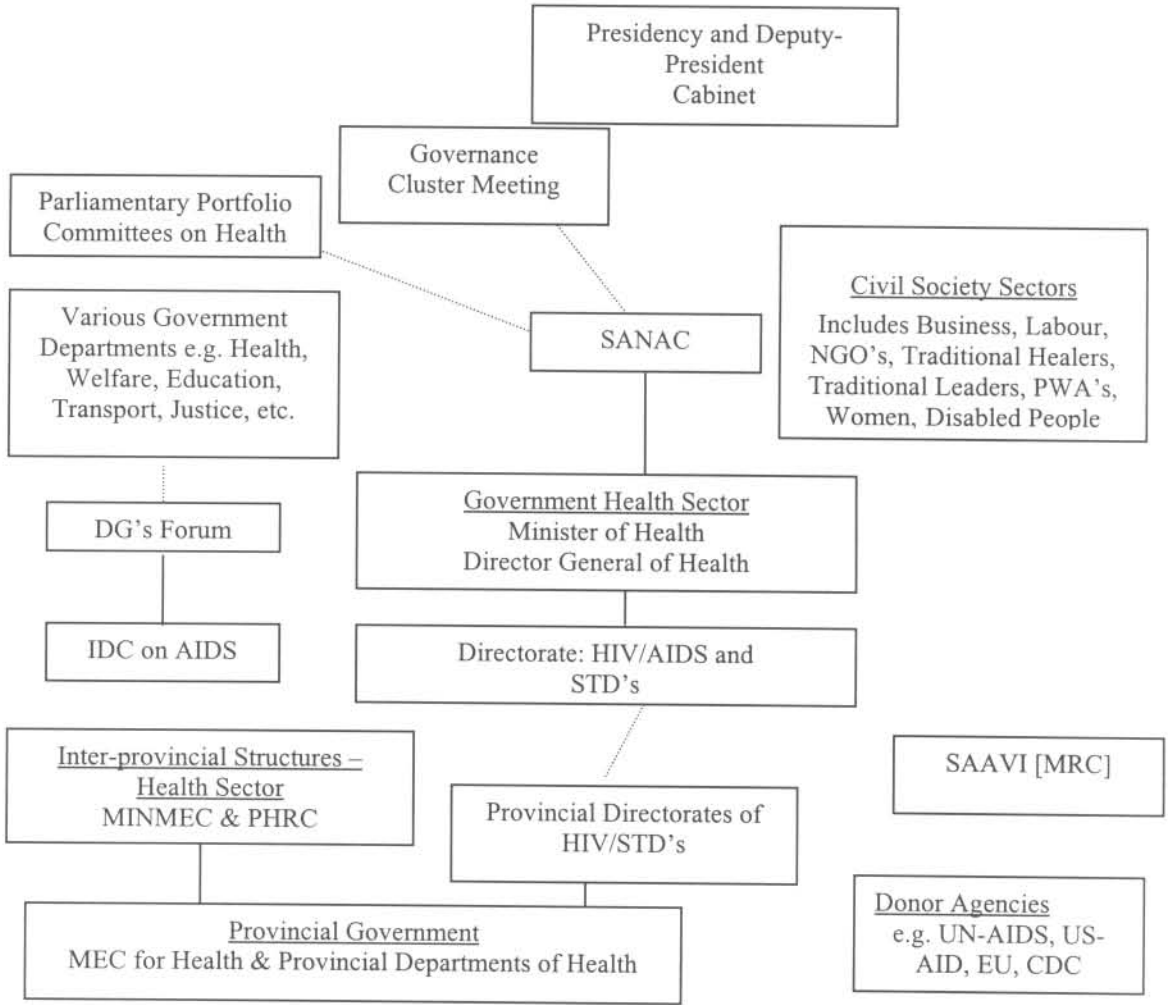
HIV/AIDS issues are brought to the attention of the above national bodies by the Department of Health's Directorate of HIV/AIDS and STDs. This Directorate prepares briefing documents for these national forums, and attends meetings to provide further information to assist in decision-making in these national committees and bodies (Anon, 2000:13).

These structures are needed to establish mechanisms of constant and consistent feedback by means of provincial and national structures and vice versa. Information obtained from regular review, should be used to serve as an information tool in communicating between provinces, as well as used for other stakeholders to provide sustainable guidelines on activities to be involved in relation to the effective management of HIV/AIDS infections and the prevention of increased STD levels across South Africa.

Each sector is also encouraged to establish an AIDS technical committee, which will be responsible for the managing and co-ordination of the implementation of HIV/AIDS activities within the sector. The effective monitoring and co-ordination of these structures, will also identify strengths and weaknesses within various sectors and will also identify areas that need redirection of resources, in order for them to cope with the impact of HIV/AIDS in the working environment. The cost effectiveness of selected interventions will also be determined by way of special operational research policies and programmes (Anon, 2000:29).

These structures available to the government and to other stakeholders in managing the impact of HIV/AIDS, are also diagrammatically represented in the following figure.

**Figure 3.4: National and provincial structures to combat the impact of HIV/AIDS**



**Source:** Anon, 2000:14

South Africa as a whole needs to include all parties and stakeholders in order to successfully formulate and implement well-designed and soundly constructed structures, policies, action programmes and strategies towards minimising the impact of the disease successfully. In order to do so attention must be given to the following factors.

- The reduction of the number of new HIV-infections, especially among the youth.
- Reducing the impact of HIV/AIDS on individuals, families and communities.

### 3.6 CONCLUSION

In the next chapters, attention will be given to just how businesses can be rendered cost-effective in managing the epidemic, by identifying analysing and implementing cost-effective action programmes and strategies. By applying the right strategy for the right work scenario, the impact of both the HIV/AIDS epidemics could be successfully managed.

As Deane Moore, an actuary of Metropolitan Life, rightfully states: a holistic solution to the AIDS problem, should include the following.

- Projection of the impact on staff, employee benefits and consumer markets.
- Customisation of employee benefits to meet specific needs.
- On-going presentation of AIDS evaluation programmes.
- Counselling for HIV-positive employees.
- In-depth Human Resource planning to manage the impact of HIV/AIDS on recruitment, training and productivity.
- Effective management of STD's (Anon, 1999:5).

It is thus important that management and labour collaborate in order to find proactive and holistic solutions. The starting point, is to determine the stage of the epidemic within the organisation. Organisations in general, need to know where they are lying on the AIDS curve (refer Chapter 2). Prevention programmes are best for those organisations having a low level of infection, while those with high prevalence rates, will need to take actions to extend the life expectancy of their HIV-positive employees and plan for the total impact on productivity (Vincent, 2000:1).

This chapter also focuses on various structures within the broad framework of national and provincial government that already exist to deal with the impact and

prevention of HIV/AIDS. In the following chapter (Chapter 4), attention will be focused on identifying alternative sufficient, reliable and cost-effective ways to minimise the impact of HIV/AIDS in the workplace. Attention will be given to various action programmes and strategies available to management, in order for them to manage and control the epidemic more sufficiently.

## CHAPTER 4

# ANALYSING STRUCTURES/STRATEGIES AND ACTION PROGRAMMES FOR THE EFFECTIVE MANAGEMENT OF HIV/AIDS IN THE WORKPLACE

### 4.1 INTRODUCTION

Education and training around HIV/AIDS in the workplace, are fast becoming buzz concepts in major corporate boardrooms around South Africa. Many human resource and employee assistance managers, are also becoming more aware of the necessity to put HIV/AIDS on the top of their priority lists. It is estimated, that by the year 2005, one in every five workers in South Africa will be HIV-positive. With this in mind, it is suggested, that it will become increasingly more difficult for South African organisations to maintain a competitive advantage (Meeson & Van Meelis, 2000:44).

HIV/AIDS significantly impact on everyone in the modern workplace. It is not just the individual, who has to deal with the disease on a personal level, but also co-workers who will be affected in both a direct and an indirect way. They may have exaggerated fears that they may “catch” the disease at work. Managers therefore should be trained on how to handle the different diverse issues related to HIV/AIDS. Both managers and workers need to understand HIV/AIDS transmission and treatments, as well as the psychosocial implications and they must thus be able to anticipate irrational fears and negative reactions from co-workers (Smith, 2000:1).

Besides personal fears and negative reactions by workers, management must also face the impact of HIV/AIDS on organisations’ resources and profits. The effects of HIV/AIDS on organisations, are reduced productivity, increased costs and the loss of customers. As organisations begin to feel the effects of HIV/AIDS within the workforces, concern is growing about the economic impact the disease will have on formal-sector organisations, and the best way to manage rising costs associated with the ever-increasing levels of HIV/AIDS within the workplace (Miller, 2001:2).



The direct and indirect costs associated with the disease, are likely to escalate, especially with the on-going provision of employee benefits such as life, disability and medical cover (refer Chapter 3). AIDS prevention and cure has been sold to organisations for a long time by health experts, on the basis that dealing “... with HIV/AIDS in the workplace, is good for workers”. However, experience has already shown, that both management and workers have important parts to play in the battle against HIV/AIDS in the workplace (Anon, 1999:3).

It is with this frame of mind, that effective structures, action plans, policies and strategies need to be investigated, formulated, evaluated and implemented in order for those concerned to manage the impact of HIV/AIDS more successfully. Different organisations will have different and varying strategies for HIV/AIDS intervention and management within the particular business environments. The bottom line is, however, that the epidemic will have a significant impact on productivity, costs, markets and ultimately, profitability. HIV/AIDS is already costing businesses a great deal of money in terms of the loss of resources and organisational downtime. Organisations who take the initiative to take a leadership role by lending their name and resources in order to fight the epidemic in the workplace, as well as in local communities, will bear the fruit of success in managing and controlling the epidemic more successfully (Meeson & Van Meelis, 2000:44).

Comprehensive action programmes, structures and HIV/AIDS strategies, therefore, need to be evaluated and established within the workplace for a small portion of the total cost, that would otherwise be incurred as a result of HIV/AIDS-related illnesses and deaths.

## **4.2 CORPORATE RESPONSE TO HIV/AIDS**

Undoubtedly HIV/AIDS is rapidly becoming a top workplace priority. Many organisations have begun to invest in HIV/AIDS programmes for their employees, and some have also started providing education programmes for employees’ families, their suppliers and other members of community. It is no illusion any more, that most

organisations, most valuable resource is its workforce, whether they be blue- or white-collar workers. An employee's capacity to perform his/her daily task is, therefore, a serious management concern (Jacobs, 1995:1).

In order to sustain a competitive advantage, businesses have to keep their workforce healthy, skilled and adequately compensated. In failing to do, so organisations will have to face the consequences that could generate the following results.

- The loss of experienced personnel – particularly at middle management and skilled worker levels.
- The need for increased resources to hire and retain replacements.
- An increase in absenteeism and labour turnover.
- A decrease in productivity levels.
- An increase in healthcare costs (Anon, 1999:2).

How can organisations then reduce the impact of HIV/AIDS in the business environment? Organisations' experiences have indicated, that pro-active and transparent management action, will be important key factors in the implementation of suitable and sustainable structures, strategies and action programmes, in order to minimise the impact of the epidemic in the workplace (refer Appendix E). Most organisations have found that long-term strategic planning is useful to them, as well as managing employee welfare in order to allow them to reduce overall costs (Smith, 2000:3).

In South Africa, labour market adjustments to HIV/AIDS, such as increasing capital intensity of the use of less skilled labour that is cheaper to replace, may exacerbate economic and political polarisation. Market growth for goods and services may also be severely affected, resulting in lower profits and increasing costs for organisations (Whiteside & Sunter, 2000:105).

As the HIV/AIDS epidemic becomes worse, so will the employee-related issues that organisations must face. To deal effectively with these issues, organisations need recruitment and employment policies that are both fair and based upon sound medical

facts (refer Chapter 3). These policies need to be communicated clearly and applied constantly across the organisation's labour force (Miller, 2001:3).

A number of key policy areas that employers must deal with, include:

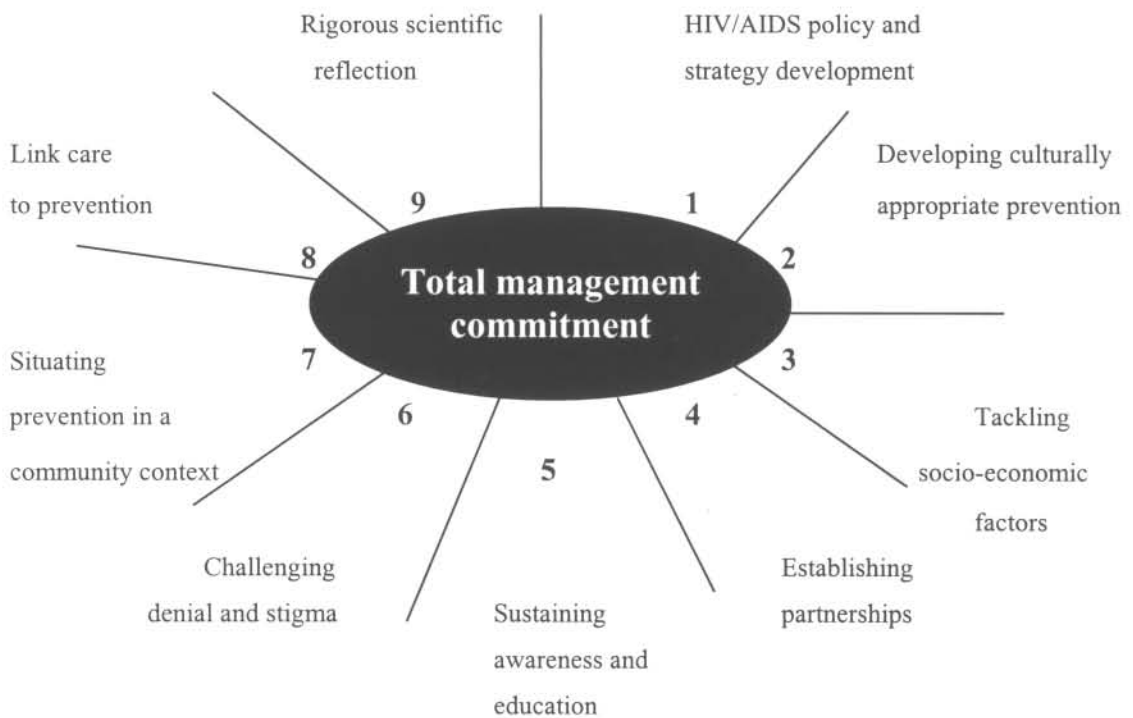
- health care
- employee benefits (pensions and disability)
- training
- work duties and performance
- recruitment, and
- costs.

Another important fact is that organisations have become more globally linked: politically, economically and technologically, affecting the character and culture of many organisations' workforce, their customers and their products and services, as well as the communities in which they are operating. These socio-economic changes have been found to have direct links with the risk and spread of the HIV/AIDS disease. This may create or aggravate circumstances that will have a significant impact on the general spread of the epidemic or the prevention thereof (Anon, 1999:8).

The following figure identifies certain key elements that are necessary in order to compile a comprehensive HIV-prevention programme and policy.

Figure 4.1 to follow on p.89.

**Figure 4.1:** Key elements that are essential to a comprehensive HIV-prevention programme



**Source:** Whiteside & Sunter, 2000:104

Many businesses also need to utilise a number of tactical plans in their aim to deal with the various issues relating to the effective management and control of HIV/AIDS: these will be discussed in detail.

These include the following.

- Establishing AIDS action programmes and policies for employees and other stakeholders.
- Creating links between organisations and the local community.
- Undertaking cause-related marketing.
- Implementing and evaluating suitable cost-effective structures and strategies (Anon, 1999:9).

It is, therefore, absolutely necessary for organisations to find cost-effective ways in order to reduce, minimise and manage the impact of the HIV/AIDS epidemic as effectively as possible. In failing to do so, many organisations will have to face the consequences.

#### **4.2.1 Establishing AIDS action programmes and policies for employees and other stakeholders**

Organisations across South Africa have already invested a lot of money and resources in various HIV/AIDS campaigns and programmes for their employees.

A peer-led and education programme that was introduced across 40 factories in Zimbabwe, showed that new HIV-infections among employees were 34 per cent lower in participating business than in factories that were not part of the programme. This particular programme cost Zimbabwe only ± \$6 per worker which, as one individual stated, is less than the cost of a set of protective overalls. It shows that organisations do not have to spend millions of Rands to fight the epidemic, but that they need to invest only a fraction of their total costs in the effective management of HIV/AIDS awareness programmes, that will save them actually millions of Rands in the long term (Smith, 2000:4).

The following case study illustrates the lessons that can be learned from the experience of organisations that have already established HIV/AIDS programmes and policy structures in their businesses.

#### ***CASE STUDY: VILLARES***

#### **Villares is a speciality steel and elevator manufacturer with 8 000 employees and 18 000 employee dependants**

Villares is an excellent example of a organisation that has established a comprehensive programme at a modest cost, and are already reaping the benefits. Their programme was established in 1995 and includes the following.

AIDS/STD education via:

- presentations,
- teamwork,
- training sessions,
- distribution of information materials (refer Appendix C),
- condoms sold to employees and dependants at below-market prices, and
- offering counselling and encouragement to HIV-positive employees to act responsibly.

These, and other efforts by Villares, have resulted in a **31 per cent reduction in the incidence of new HIV-infections** after one year of the programme (Anon, 1999:10).

From the above case study, it is evident that a dedicated business response to the management of HIV/AIDS has the potential to make a substantial impact on the spreading rate of the disease, as well as a positive difference and impact in areas such as -

- overall business operations,
- markets, and
- different stakeholders.

Another tactic that organisations are currently employing, is to train some of their employees to act as “peer-educators”. These so-called “peer-educators” are responsible for talking to colleagues about the risks of the disease and also to discuss signs and symptoms of the illness that might occur. The focus is, however, on the implementation of preventive methods that are discussed and encouraged, with the emphasis on condom use and safer sex practices by employees (Haskins & Kleiner, 2001:1).

#### 4.2.2 Creating links between businesses and local communities

It is absolutely imperative, that organisations in all sectors of all shapes and sizes understand the implication and total impact of HIV/AIDS on organisational resources and economic growth. Small organisations with a lack of organisational, financial and even human resources may, collaborate with the public health care facilities in order to provide adequate services and care for their employees and families. Many non-governmental organisations (NGO's) have well-established educational, condom-distribution and counselling programmes in order to help employees. A partnership between businesses and these organisations, could help a lot in order to prevent, educate and save costs associated with the management of the illness (Smith, 2000:5).

In the case of bigger and more financially secure organisations, the picture is more colourful. Many organisations have already embarked upon "Social Investment" programmes where the focus is on AIDS-related initiatives within the external environment. These action programmes and policies already yielded benefits such as:

- the improvement of the overall corporate image,
- reduced costs, and
- a healthier workforce.

Escom's 1999 annual report on dealing with HIV/AIDS activities and action programmes, indicates that the results of the report provided a good base line against which future progress can be measured. According to Mrs. Biothoko Makhooane, AIDS co-ordinator within the Employee Assistance Programme (EAP) at Escom, believes that the report will act in favour of the organisation's AIDS awareness policies and is a clear indication that the variety of fears associated with the HIV/AIDS epidemic, are decreasing and that more employees are now committed to acknowledging and understanding the various issues related to the epidemic (Meeson & Van Meelis, 2000:44).

By working together, large co-operations, organisations and local communities can use a variety of AIDS-prevention programmes and strategies based on suitable and

sustainable corporate structures. These various AIDS-prevention action programmes include:

- video tapes,
- exhibitions,
- group workshops,
- comic books, and
- peer -educators.

A combination of rapid assessment techniques and health communication skills, is needed and can also be combined with financial and human resources of other interested partners so as to produce an effective, continuous on-going AIDS initiative programme in the workplace. Once again, Escom's strategic initiatives towards the effective management of HIV/AIDS in the workplace, is a good example of partnerships formed between various stakeholders including -

- the Department of Health,
- the Department of International Development (Southern-Africa),
- non-governmental organisations (NGO's), and
- various other role players across the corporate sector.

The result of Escom's successful HIV/AIDS programme has received international attention, with the result that the International Labour Organisation (ILO) has commissioned a report on Escom's HIV/AIDS action programmes, in order to assist other organisations around the world to get workplace initiatives, structures and policies on HIV/AIDS up and running (Meeson & Van Meelis, 2000:45).

#### **4.2.3 Cause-related marketing**

It has also become a popular practice in many organisations to promote the HIV/AIDS message as part of the total "product offering" made to consumers. The tactic employed in the strategy, is to include an AIDS-related message and the highly recognised AIDS ribbon on products, while various organisations have also donated proceeds to support AIDS activities, national programmes and NGO's. These methods and strategies used by organisations can both help the organisations and their



AIDS programmes through public awareness of AIDS-related issues that affects worker and their families (Anon, 1999:12).

Various organisations have already extended their AIDS programmes and policies into wider society. Examples of this include the following activities.

- Organisations have donated equipment and technical support to assist AIDS organisations at local, national and international levels.
- Many organisations have already engaged in local philanthropic programmes, giving free use of their facilities and equipment in order to manage the epidemic more effectively.

These actions undertaken by most organisations cost only a small portion, but are invaluable to the HIV/AIDS efforts. However, contributions made by organisations, offer minimal or even no financial returns to businesses, but do provide benefits in terms of strengthening the organisations' standing and their corporate image in the community (Anon, 1999:13).

#### **4.2.4 Implementing and evaluating suitable cost-effective structures and strategies for organisations**

Two significant factors about HIV/AIDS make it a strategic issue to business. The first lies in the degree of social stigma and injustice that surrounds the illness, the second reason is, that of its epidemic scale and magnitude – so exceptional, that no other disease could begin to parallel it. Besides the impact of the illness on socio-economic development, attention must also be given to what impact the epidemic will have on organisations' costs and resources on the long term. Representative data on the magnitude of costs to South African organisations are very scarce. Without restructuring and the implementation of effective action programmes and strategies, the cost of an average set of risk benefits is expected to double over the next five to ten years (Gresak, 2000:13).

The following table provides a good explanation and analysis of the progression of HIV/AIDS cases and the costs associated with the illness within the workforces of organisations, as well as the impact of these costs on organisational resources, profitability and productivity levels.

**Table 4.1: Progression of cases and costs of workforce HIV/AIDS**

Progression of HIV/AIDS in the workplace	Economic impact of individual case	Economic impact of all cases
1. Employees become infected with HIV virus	<ul style="list-style-type: none"> <li>▪ No cost to organisation at this stage</li> </ul>	<ul style="list-style-type: none"> <li>▪ No cost to organisation at this stage</li> </ul>
2. HIV/AIDS-related morbidity begins	<ul style="list-style-type: none"> <li>▪ Sick leave and other absenteeism increase</li> <li>▪ Work performance declines due to employee illness</li> <li>▪ Overtime and contractors' wages increase to compensate for absenteeism</li> <li>▪ Use of organisations' on-site health clinics increases</li> <li>▪ Employee requires attention of human resource and employee assistance personnel</li> </ul>	<ul style="list-style-type: none"> <li>▪ Overall productivity of workforce declines</li> <li>▪ Overall labour costs increase</li> <li>▪ Additional use of medical aid benefits causes premiums to increase</li> <li>▪ Additional medical staff must be hired at the organisation's health clinics</li> <li>▪ Managers begin to spend time and resources on HIV-related issues.</li> <li>▪ HIV/AIDS interventions are designed and implemented</li> </ul>
3. Employee leaves workforce due to death, medical boarding, or voluntary resignation	<ul style="list-style-type: none"> <li>▪ Payout from death benefits or life insurance scheme is claimed</li> <li>▪ Pension benefits are claimed by employee or dependants</li> <li>▪ Other employees are absent to attend funeral</li> <li>▪ Funeral expenses are incurred</li> <li>▪ Organisation loans to employee are not repaid</li> <li>▪ Co-workers are demoralised by loss of colleague</li> </ul>	<ul style="list-style-type: none"> <li>▪ Payouts from pension fund cause employer and/or employee contributions to increase</li> <li>▪ Returns on investment in training are reduced</li> <li>▪ Morale, discipline, and concentration of other employees are disrupted by frequent deaths of colleagues</li> </ul>
4. Organisation recruits a replacement employee	<ul style="list-style-type: none"> <li>▪ Organisation incurs costs of recruitment</li> <li>▪ Position is vacant until new employee is hired</li> <li>▪ Cost of overtime wages increases to compensate for vacant positions</li> </ul>	<ul style="list-style-type: none"> <li>▪ Additional recruiting staff and resources must be brought in</li> <li>▪ Wages for skilled (and possibly unskilled) employees increase as labour markets respond to the loss of workers</li> </ul>
5. Organisation trains new employee	<ul style="list-style-type: none"> <li>▪ Organisation incurs costs of pre-employment training (tuition, etc.)</li> <li>▪ Organisation incurs costs of in-service training to bring new employee up to level of old one</li> <li>▪ Salary is paid to employee during training</li> </ul>	<ul style="list-style-type: none"> <li>▪ Additional training staff and resources must be brought in</li> </ul>
6. New employee joins the workforce	<ul style="list-style-type: none"> <li>▪ Performance is low while new employee comes "up to speed"</li> <li>▪ Other employees spend time providing on-the-job training</li> </ul>	<ul style="list-style-type: none"> <li>▪ There is an overall reduction in the experience, skill, institutional memory and performance of the workforce</li> <li>▪ Work unit productivity is disrupted as labour turnover rates increase</li> </ul>

Source: Whiteside & Sunter, 2000:111

The result of increased cost on restrictive employee benefits can also have a profound impact on workers' morale and discourage early disclosure, making responses such as succession planning very difficult for organisations in general. It is, therefore, important that action programmes policies and strategies will include and address key issues that will have a definite impact on productivity, profitability and the availability of resources within the organisation (Kinghorn, 2000:23).

These key issues will include and address the following aspects.

- Identify and reduce vulnerability of key aspects of production processes.
- Health care and support for infected and affected employees, to sustain their productivity, combat problems such as TB, and create supportive conditions for employees to disclose their HIV status early.
- Strengthen human resource management, planning and development.
- Develop appropriate employee benefit structures, which balance sustainability and effectiveness in keeping workers motivated and productive.
- Invest in training and education, and the prevention of infection in learners, to ensure sustained growth of skills in organisations and the economy.
- Improve information on HIV/AIDS impact and effective responses. At both organisational and sectional level, more information is needed for better planning.
- Co-ordination between businesses, labour, government and communities at all levels, is needed to facilitate feasible, cost-effective responses. Many organisations have found that they cannot manage HIV/AIDS impacts on employees without looking "beyond the fence". Inadequate or inappropriate responses by individual sectors or businesses can also have knock-on effects on other organisations (Kinghorn, 2000:23).

Besides the above key issues and aspects that form part of an integrated action programme and strategy, certain responses are also likely to reduce and minimise the impact of HIV/AIDS on organisations.

These include:

- visible commitment of business leadership to address HIV/AIDS issues,
- HIV-prevention. Well-designed action programmes and policies that target all employees, including management,
- reducing the stigma of HIV/AIDS,
- workplace impact management.

With these key issues, aspects and responses already mentioned, attention can now be given to the identification, evaluation and implementation of various key alternative structures and strategies available to management for the successful management and control of HIV/AIDS-related issues in the workplace. These various structures and management strategies are based on actual case studies and background information, which include certain criteria and situations on how to deal with the effective management and control of the epidemic and its consequences on the worker level.

It is important to note, that these case studies are only a broad guideline and act as mere indicators on how to manage certain and specific situations within business environments and do not provide any immediate solution to various complex issues and situations that might be experienced elsewhere. It must be seen as a complex problem that could result in various positive outcomes for organisations if they should implement and follow the right action programmes, structures and strategies applicable to their specific needs and circumstances.

#### **4.2.4.1 Case Study: Organisation A**

The interviewed individual at **Organisation A** states, that HIV/AIDS is a problem among their workforce, particularly in those areas where the known incidence is high (areas such as Northern KwaZulu Natal). The individual believes that the problem is growing. **Organisation A** does not have any exact figures for the incidence of HIV/AIDS among employees. This is because he/she feels they are unable to measure these figures, due to the confidentiality surrounding the HIV/AIDS status of infected employees.

**Organisation A** has not calculated the cost of the impact of HIV/Aids on the bottom line. However, the interviewed individual states that as workplace costs are felt, it may soon be necessary to develop management guidelines in this area. The individual at **Organisation A** feels, that the impact of HIV/Aids is likely to be most strongly felt by the organisations' healthcare and retirement funds. The individual states, that the medical aid society has provided for a maximum benefit for the treatment of HIV/Aids. The insurance premiums which are payable for death and disability benefits in the retirement funds, have been capped.

**Organisation A** has formal organisation policies and guidelines in place to deal with the problems of HIV/Aids. These policies and guidelines have been distributed to all managers. In some instances, operational managers have developed joint local policies with their trade unions. Educational programmes that are supported by local health authorities have been provided to employees at operations. Occupational Health Nurses working at **Organisation A** have also received ethical training (Corporate Leadership Council, 1999:14).

**Organisation A's** policies and strategies are communicated by utilising the following two main methods.

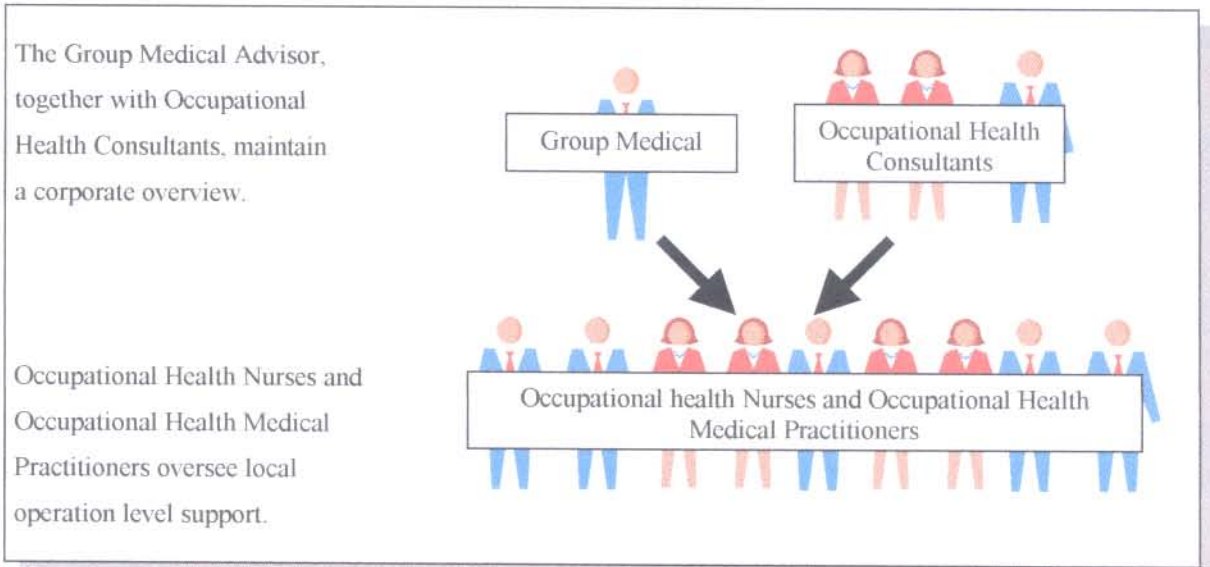
- Operation Level Workers' Forums.
- Educational programmes.

Corporate level policy at **Organisation A** is communicated to managers by using human resources Intranet.

**Organisation A** has supported and implemented all local and national regulations regarding HIV/Aids.

The figure below presents the structure of **Organisation A's** approach to the problems of HIV/AIDS. The interviewed individual at **Organisation A** states, that they do not have a formal project team in place at present.

**Figure 4.2: Organisation A's approach in dealing with the HIV/AIDS situation**



**Source:** Corporate Leadership Council, 1999:15

**Organisation A** also maintains a mutual relationship with their local community health organisations. **Organisation A's** corporate AIDS policy reflects the guidelines that have been provided by the Department of Health.

#### 4.2.4.2 Case Study: Organisation B

The interviewed individual at **Organisation B** states, that the organisation sees HIV/AIDS as a real problem, although they are unable to provide figures as to the number of employees affected. The individual maintains, however, that their workforce is well-educated and generally follow lifestyles that caution against those risk factors connected to HIV/AIDS (Corporate Leadership Council, 1999:15).

The interviewed individual at **Organisation B** states, that the organisation has undertaken a number of calculations, looking at the financial impact of HIV/AIDS.

**Organisation B** does have policies and programmes in place to deal with the problems of calculations, looking at the financial impact of HIV/AIDS. The

interviewed individual states, that they generally pursue a strategy of using education in the workplace as a preventative intervention, including –

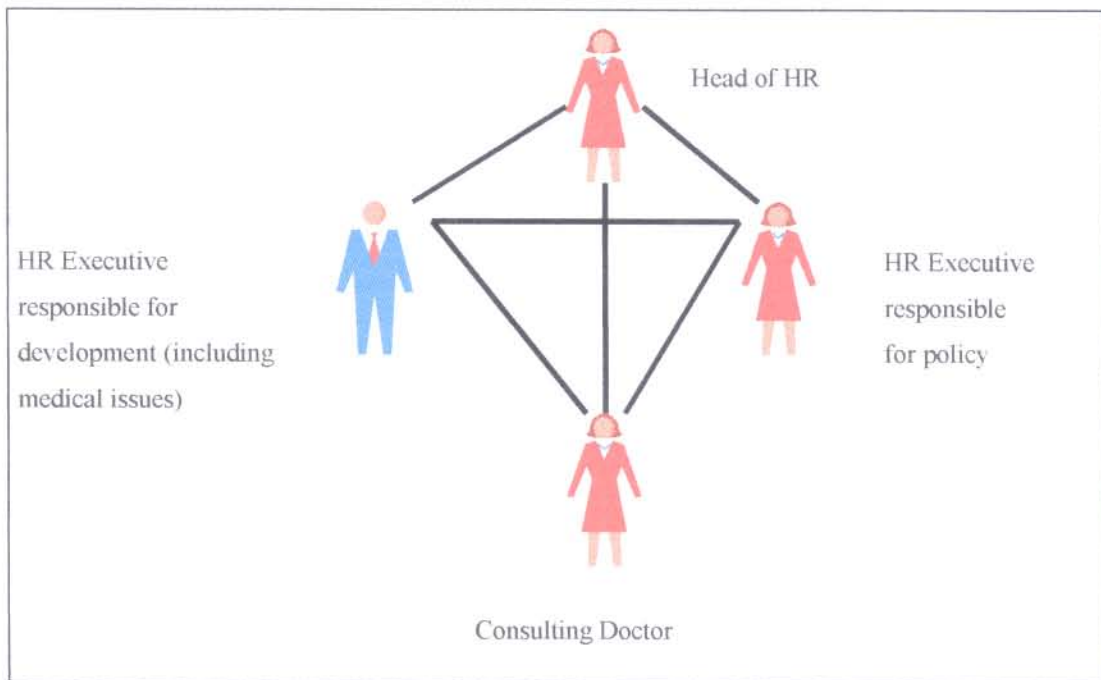
- awareness talks,
- information brochures,
- AIDS days.

**Organisation B** also reactively has policies in place, which are managed by senior HR managers, and are dealt with in a confidential manner, and on a ‘need-to-know’ basis.

**Organisation B** has supported and implemented all local and national regulations regarding HIV/AIDS.

**Organisation B** has a standing team in place to guide the organisation on the issue of HIV/AIDS. The structure of this team is presented in the following figure.

**Figure 4.3: Organisation B HIV/AIDS standing team**



**Source:** Corporate Leadership Council, 1999:16

The interviewed individual at **Organisation B** states that the organisation does not communicate their policies on HIV/AIDS. They feel it is best for the organisation to keep policies in the background and to only apply them only as and when necessary.

#### 4.2.4.3 *Case study: Organisation C*

The interviewed individual at **Organisation C** states, that AIDS is a problem among their employees, although they do not have any exact figures regarding the number of employees who have been affected by HIV/AIDS. The individual at **Organisation C** states, that this was due to the fact that the employee's confidentiality must be protected.

**Organisation C** is examining the costs to the organisation caused by HIV/AIDS, but they have not as yet come up with any figures to support their concerns regarding the effect HIV/AIDS is having on the organisation. The interviewed individual feels, that the rises in healthcare and pension costs will be the most keenly felt (Corporate Leadership Council, 1999:17).

**Organisation C** has formal organisation policies and guidelines in place to deal with the problems of HIV/AIDS. These policies and guidelines have been distributed to all managers. Educational programmes are provided to employees at operations.

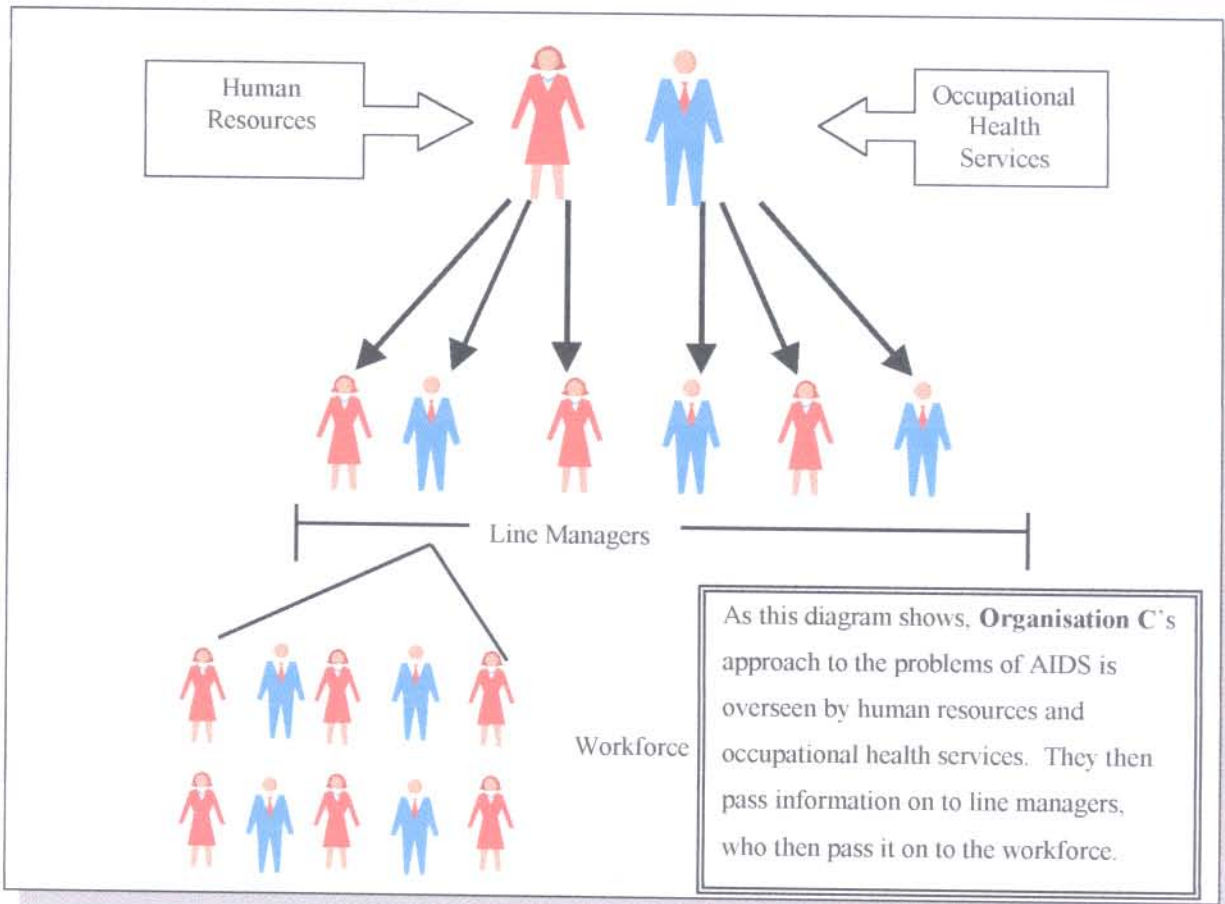
**Organisation C** has supported and implemented all local and national regulations regarding HIV/AIDS.

**Organisation C's** approach to the problems of AIDS is explained in the next figure.

Figure 4.4 to follows on p.102.



**Figure 4.4:** Approach to problems of HIV/AIDS



**Source:** Corporate Leadership Council, 1999:17

HIV/AIDS policies and strategies at **Organisation C** are communicated through the line managers to the employees, or they are posted onto the organisation’s Intranet.

**Organisation C** has had contact with a number of NGO’s, while developing organisation HIV/AIDS policies, and are also in contact with UN-AIDS.

**4.2.4.4 Case Study: Organisation D**

The interviewed individual at **Organisation D** works in human resources in a business unit of the organisation, and their views, therefore, only reflect the policies of that business unit.

The interviewed individual at **Organisation D** does not feel that HIV/AIDS is a major problem for their business unit. This is because the majority employees are educated up to degree level, and are thus better informed in respect of HIV/AIDS. It is also felt that it would unlikely for them to be engaging in high-risk activity. They stated that if the workforce changes, they might have to look more closely at the problem. Due to this, it is thought that there is not 'more than a handful' of employees having HIV/AIDS. **Organisation D** does not see itself as having a major problem with HIV/AIDS; however, they have not produced any figures as to the cost and impact of HIV/AIDS on the organisation or business unit.

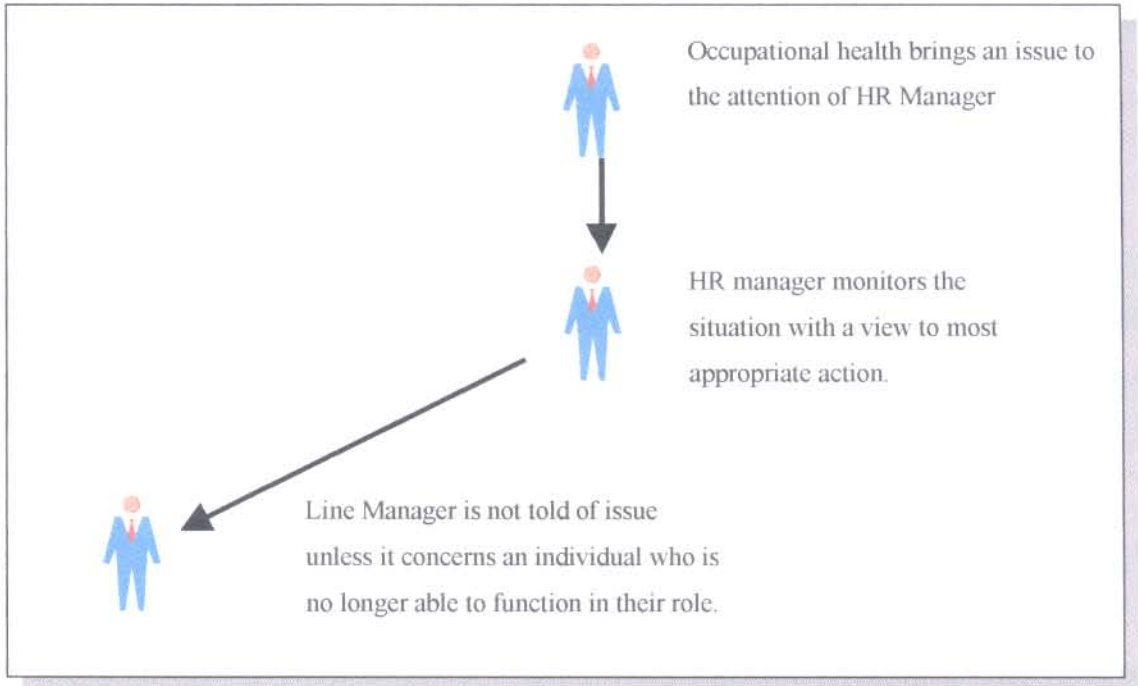
**Organisation D's** policies relating to HIV/AIDS, are decided by corporate headquarters, and passed down to the business unit. These policies cover both preventative and reactive policies providing education for employees and raising awareness. The business unit decides when these policies need to be put into practice, depending upon the need within the workforce (Anon, 1999:17).

**Organisation D** has supported and implemented all local and national regulations regarding HIV/AIDS, and they feel that they have usually pre-empted and exceeded these directives.

The structure, through which **Organisation D's** approach to HIV/AIDS is overseen, is presented in the following figure.

Figure 4.5 to follows on p.104.

Figure 4.5: Organisation D's HIV/AIDS policy structure



Source: Corporate Leadership Council, 1999:18

#### 4.2.4.5 Case Study: Organisation E

The interviewed individual at **Organisation E**, does not see HIV/AIDS as the most important issue facing the organisation at this time, although it is recognised that it constitutes a real problem for other organisations, that it could also be for them. **Organisation E** does not have figures in respect of the number of their employees affected by HIV/AIDS, as testing is not compulsory and due to the confidential nature of the information, no record is kept.

**Organisation E** has not made any calculations regarding the costs of HIV/AIDS or the impact of HIV/AIDS on the bottom line.

The interviewed individual at **Organisation E** stated, that the organisation had formulated policies to deal with the problems of HIV/AIDS, and that these policies are in line with local and national regulations regarding HIV/AIDS. The only problem **Organisation E** sees in dealing with employees working with food is that these people may not have been tested.

**Organisation E** communicates policies and strategies relating to HIV/AIDS by using three main methods.

- During employees orientation period with the organisation.
- During the induction period at the organisation.
- Over the organisation's Intranet system.

**Organisation E** brings external trained counsellors to assist in dealing with HIV/AIDS-related problems on a discretionary basis (Corporate leadership Council, 1999:18).

#### 4.2.4.6 *Case Study: Organisation F*

The interviewed individual at **Organisation F** states, that HIV/AIDS is not yet a major problem at the organisation. They are aware of only two known cases of HIV-positive individuals at the organisation. However, the individual states, that because it is not obligatory to disclose one's HIV/AIDS status, it is not known what the full extent of infection within the organisation is.

The interviewed individual at **Organisation F** states that no calculations have yet been made regarding the impact and costs for the organisation resulting from HIV/AIDS.

**Organisation F** has no formal policy to deal with HIV/AIDS within the organisation. Intensive awareness programmes took place in 1997. Although this has not taken place on an organisation-wide level since 1997, the material is still available to line managers who wish to run the programme for their subordinates. **Organisation F** does, however, fund various HIV/AIDS awareness and education projects that take place outside of the organisation (Corporate Leadership Council, 1999:19).

The interviewed individual at **Organisation F** states, that apart from the forbidding of discrimination on the basis of HIV/AIDS, the organisation's chief medical officer is responsible for any matters relating to HIV/AIDS.

The interviewed individual at **Organisation F** states, that at present there are no policies or strategies relating to HIV/AIDS. They do not, therefore, have any methods to communicate these to employees.

#### 4.2.4.7 *Case Study: Organisation G*

The interviewed individual at **Organisation G** states, that HIV/AIDS is a problem at their organisation. Up until 1998, the cumulative number of HIV-positive diagnoses was 89, and the total number of AIDS cases was 35.

The interviewed individual at **Organisation G** states that a number of financial analyses have been carried out around the impact of HIV/AIDS on the organisation:

- **Organisation G** has undertaken projections in respect of the likely impact on benefits by the year 2005. **Organisation G** estimates, that by 2005 the costs to benefits will be R15 million, which is 15 per cent of **Organisation G**'s annual payroll. Of this 15 per cent of the annual payroll, the interviewed individual believes, that 10 per cent will be on the pension fund, 4,1 per cent on medical aid, and the remainder on benefits such as motor insurance, funeral benefits and mortgage bonds (Corporate Leadership Council, 1999:19).
- The interviewed individual also states, that **Organisation G** has analysed the actual costs of HIV/AIDS.

This includes the following.

- HIV/AIDS education cares and support.
- HIV/AIDS surveillance study.
- Employee benefits.
- Health personnel salaries.

**Organisation G**'s calculated costs for the past two years are:

- 1998: R108 multiplied by 38,000 employees = R4.2 million
- 1999: R125 multiplies by 37,700 employees = R4.7125 million.

The interviewed individual at **Organisation G** states, that the organisation has had a formal HIV/AIDS policy in place since January 1993, which is made up of the following key components.

- Provisions of HIV/AIDS education and information.
- Preservation of confidentiality of those infected and their families.
- Provision of health services. The organisation has developed a protocol for care of those with sexually transmitted diseases that supports and cares for infected employees. This is paid for by the organisation, but does not include anti-retroviral therapy, which is available through the employees' organisation-subsidised medical aid.
- HIV/AIDS testing – voluntary, at employee's request.
- Non-discrimination against individuals who are living with HIV/AIDS.
- Health retirement – granted on the basis of the employee's health status.
- Provision of prophylactic devices – including gloves and condoms (Corporate Leadership Council, 1999:19).

The interviewed individual at **Organisation G** also states, that they have a number of informal HIV/AIDS programmes, which include the following.

- Awareness campaigns – such as industrial theatre.
- Radio Talk Shows – Programmes on local and national radio.
- World AIDS Day – Involving every business unit within **Organisation G**.

**Organisation G** also has formal training and support programmes in place regarding HIV/AIDS, including the following.

- Training of HIV/AIDS peer educators – a training programme consisting of seven days' training.
- Training of mentors – a one-day programme.
- Training of management and trade unions – a one-day programme.
- Counselling and therapy – using an internal and external network of professional officers, social workers and psychologists.

- Medical support – treatment of STD's, HIV-testing and HIV/AIDS monitoring, including CD4 counts.

The interviewed individual at **Organisation G** states, that their organisation policy regarding HIV/AIDS preceded national regulations. An example of this, is that the Equity Bill prohibiting pre-employment HIV-testing, is due to be published later this year, whereas this has been **Organisation G's** policy since 1993. **Organisation G** has also agreed to form a partnership with the government and other organisations as a forerunner in AIDS programmes. **Organisation G** has worked with some government departments to establish their programmes (Corporate Leadership Council, 1999:20).

**Organisation G** has worked with a number of external organisations regarding their HIV/AIDS policy, which includes activities of the following departments and organisations.

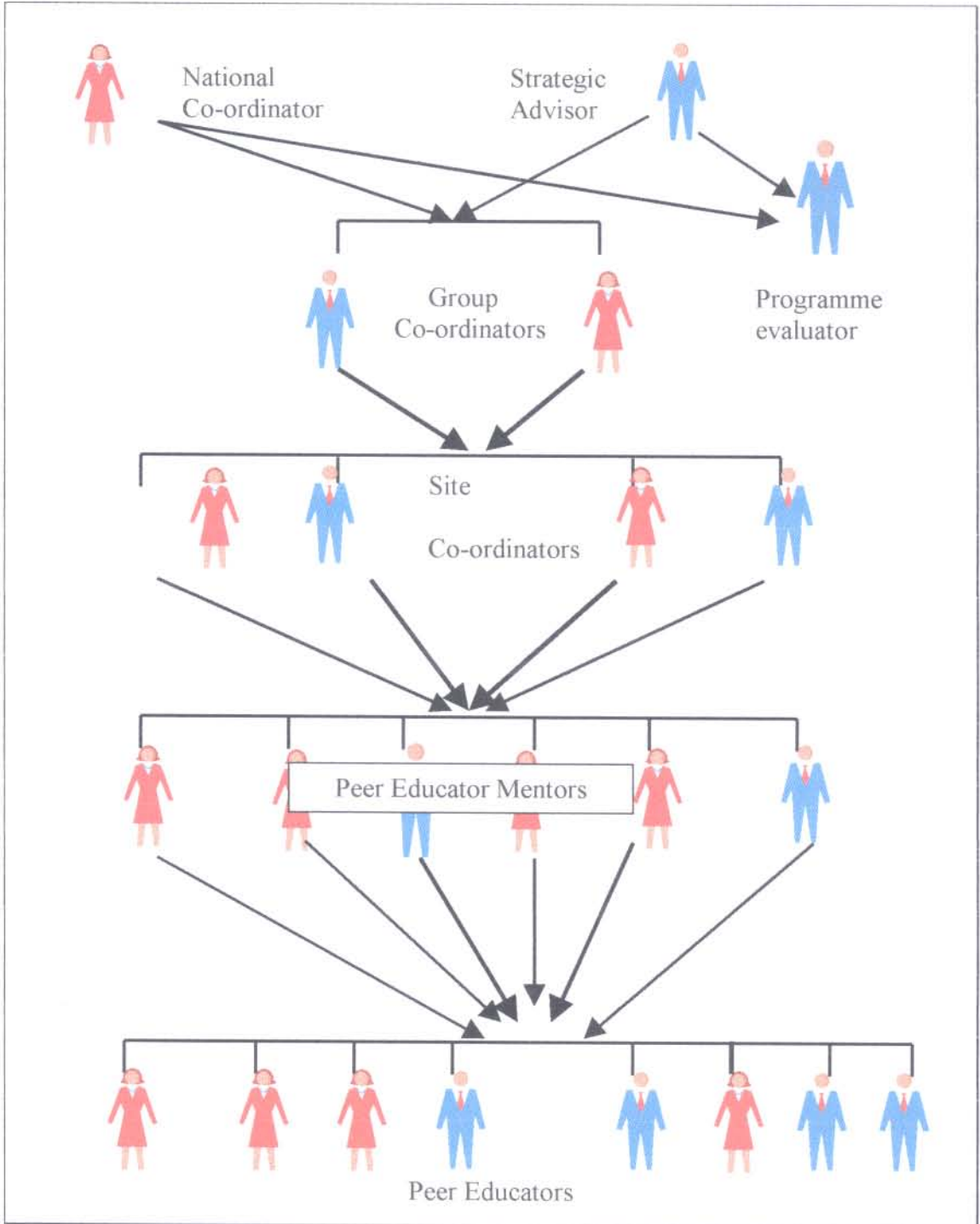
- **Organisation G** has established joint ventures with NGO's working on such areas as training curricula.
- **Organisation G** has established joint ventures with local government and other organisations for community-based educational programmes.
- **Organisation G's** peer educators have also trained community members such as teachers, students and priests in peer education.

The interviewed individual at **Organisation G** states, that HIV/AIDS policies or strategies are communicated in the following ways.

- Manager and peer-education training.
- Education Road shows.
- Newsletters and organisation television.
- Educational items such as T-shirts and mugs (in 1998 **Organisation G** distributed 18 000 T-shirts and 2 000 mugs to employees).

The interviewed individual at **Organisation G** is the overall co-ordinator of the organisation's approach to HIV/AIDS. The structure of those working with HIV/AIDS at **Organisation G** is presented in the following figure.

**Figure 4.6: Organisation G's HIV/AIDS policy structure**



**Source:** Corporate leadership Council, 1999:21



Based on the various structures above, management can formulate suitable and cost-effective strategies for the implementation and management of HIV/AIDS in the workplace. Beside these structures, action programmes and policies management also needs to pay attention to the effective management of EAP's as well.

#### 4.2.4.8 *Implementing cost-effective employees assistance programmes*

EAP's have long been noted to provide adequate counselling for a broad range of issues that affect the workers' ability to work, thus indirectly effecting productivity and profits. EAP's are responding positively to the increased impact that HIV/AIDS have on the workplace and are increasingly becoming an important tool for management to provide adequate counselling for a broad variety of issues (refer Appendix D). Many more EAP's need to become more pro-active in promoting and managing HIV/AIDS in the workplace, as well as introducing more cost-effective policies and action programmes (Haskins & Kleiner, 2001:2).

It's important for EAP's to make staff more sensitive to HIV/AIDS-related issues. They must understand the relationships that could exist between someone who has the disease and his or her co-workers, as well as be able to deal with conflicts that may arise as a result. Other issues include physical and emotional pain, dying processes and fear of losing the ability to take care of oneself. EAP's also need to keep in touch with management objectives, so that they can accomplish goals and work together with HR and Union representatives to establish a steering committee task force that will ensure a safe, fair, legally consistent and humane work environment for workers at all levels in the business environment. Through teamwork, the appropriate roles of all affected departments and groups within the working environment can address and properly reduce the impact of HIV/AIDS (Haskins & Kleiner, 2001:3).

In order for EAP's to function effectively and be able to assist workers within the broad framework of business that includes various departments, business units and functions, it is absolutely necessary to have well-established and well-formulated guidelines for the effective management of HIV/AIDS in the work environment.

### **4.3 GUIDELINES FOR THE EFFECTIVE MANAGEMENT OF HIV/AIDS IN THE WORKPLACE**

Predictions indicate, that over two-thirds of large corporations and one out of ten small businesses will employ a number of infected persons. With the majority HIV-positive people aged 20 to 45, the primary workforce will be the hardest hit by the impact of the disease (Smith, 2000:1).

It is, therefore, important that employees must be able to remain on the job while learning how to manage the impact of the disease effectively. This can only be achieved only by focusing on the following criteria that will serve as general guidelines in reducing the impact of HIV/AIDS in the workplace.

#### **4.3.1 Educate management**

Managers and supervisors set the standards for workplace behaviour. Stress confidentiality, non-discrimination and compliance with state and laws and regulations. Encouraging managers to pursue corporate AIDS goals, regardless of employee resistance or apathy.

#### **4.3.2 Communicate with employees**

Never assuming that employees understand HIV risks or how to avoid infection. Generally, employees are most concerned about *AIDS* facts and myths; contagion and transmission; legal, discrimination and accommodation issues; employment and termination concerns; insurance and health benefits; and human resources and confidentiality issues.

#### **4.3.3 Conduct AIDS training**

Taking the AIDS prevention message into the community. After all, HIV/AIDS can impact the lives of customers, vendors, employees' friends and families, as well as the employees themselves.

#### **4.3.4 Establish an AIDS policy**

A written workplace AIDS policy should be developed and implemented before problems arise (refer Appendix E). A work force that understands how the disease is transmitted, are less likely to panic when an infected employee announces his or her status.

#### **4.3.5 Confidentiality statement**

Legally, the confidentiality of employee medical records and insurance documentation must be protected and cannot be shared without the employee's written consent. Any breach of confidentiality, including water-cooler gossip, shall not be tolerated.

#### **4.3.6 Non-discrimination policy**

Strict adherence to all state and local laws covering HIV/AIDS discrimination is necessary. Treat HIV/AIDS-infected employees with the same dignity, respect and compassion shown to sufferers of other long-term, chronic illnesses.

#### **4.3.7 Personal protective equipment**

If employees operate within a workplace in which latex gloves or other personal protective equipment (PPE) can be used to reduce risk of injury or disease transmission to co-workers, it should be provided.

#### **4.3.8 Mandatory education**

A degree of AIDS training is required, for example, mandates blood-borne-pathogens training for those whose job place them at higher risk in respect of HIV, Hepatitis B and other blood-born infections.

#### 4.3.9 Employee exposure plan

Organisations that provide first aid or other medical treatment, should include an action plan covering workplace exposure to HIV or Hepatitis B, including protocols for testing employees in the event of workplace exposure (Smith, 2000:2)

From the above information, the following conclusions can be made regarding the perceptions of management towards the management of HIV/AIDS.

- Managers must understand HIV/AIDS transmission and treatments, as well as psychosocial issues. Unfortunately, many people still believe that HIV/AIDS is transmitted easily. Managers must be able to anticipate the irrational fears and negative reactions from co-workers, including their disclosure of the worker's HIV-status to others.
- Managers must learn about the corporate culture regarding HIV/AIDS. Before managers can counsel employees, they must know how their corporate culture views the disease, whether the organisation has a specific policy that addresses HIV/AIDS and whether the policy is associated with training. For example, if a corporation has a specific policy, it should prohibit workplace discrimination. The HIV-positive employee may be unaware of such a policy. Consequently, managers who can describe the policy should be ready to ease the employee's mind with regard to the tenor of the corporate culture.
- Managers must learn the legal issues related to HIV/AIDS. A common concern among HIV-positive individuals include the need for advice about advanced directives for healthcare, financial matters, guardianship concerns to ensure for the care of children in the event of incapacity or death, application for Social Security disability benefits (sometimes available while the person is still working), insurance coverage disputes or related problems and the ability to obtain or maintain access to healthcare (Miller, 2001:3).

Despite the involvement of private organisations across the business sector to cope with the impact of HIV/AIDS as well as the management thereof, the infection rate has increased significantly over the last five years. This calls for a renewed commitment from all South Africans to face the challenge and impact of the epidemic head-on.

#### 4.4 CONCLUSION

During the last two decades, the HIV/AIDS epidemic has taken a terrible human toll, laying claim to millions of lives, inflicting pain, causing fear and threatening economic devastation. According to the joint United Nations Programme on HIV/AIDS (UN-AIDS) and the World Health Organisation (WHO), the number of people living with HIV/AIDS at the end of 1998 was estimated to be 33,4 million, a 100 per cent increase as compared to that of 1997. Assuming that no cure is found, it is estimated, that more than 40 million people globally will be infected with HIV by 2000. As already mentioned, the impact of the epidemic on economic growth is already being felt in many countries, especially in South Africa, with life expectancy estimated to drop considerably (Anon, 2000:5).

With these factors in mind, organisations across the South African Business sector are becoming increasingly aware of the need to formulate and implement cost-effective structures, action programmes, policies and strategies for the effective management of HIV/AIDS within the workplace. This chapter briefly focuses on the necessity for cost-effective ways in order to reduce the spread and impact of the HIV/AIDS epidemic on business organisations.

Attention is also given to suitable and sustainable strategies and action programmes for the education of workers, managers and community. Together the private and public sectors can play a significant role in managing and reducing infection rates by implementing cost-effective and sustainable structures, action programmes and policies that will form the basis for the implementation of suitable strategies in coping with the effects of the disease head-on.

The aim of this chapter lies in the fact that structures first needs to be identified, formulated and implemented before actual cost-effective strategic alternative can be introduced successfully. The following chapter will investigate and identify such a possible strategy that can be introduced into the corporate structure for the effective management and control of HIV/AIDS within the workplace.

## CHAPTER 5

### IMPLEMENTING A STRATEGY FOR THE EFFECTIVE MANAGEMENT AND CONTROL OF HIV/AIDS

#### 5.1 INTRODUCTION

South Africa is facing an HIV/AIDS epidemic of tremendous magnitude and severity, which will present new and enormous challenges and threats as has already been mentioned in Chapter 2. The dynamics of the epidemic and the peculiar nature of the HIV virus present a unique set of problems, which will need extraordinary approaches to manage within the working environment. Unlike many other diseases, HIV/AIDS targets the reproductive age group and hence the economically active and those in their working age group. The workplace, therefore, becomes a major target area of the epidemic (Bennett, 2000:8).

Managing the epidemic appropriately and effectively in the workplace, is in itself a critical factor for the future viability of organisations and for the health and welfare of its employees over a wide economic spectrum. The HIV/AIDS epidemic is still evolving and expanding at a rapid rate and the ultimate size and impact is not fully comprehended or certain. With this in mind organisations, together with their employees, need to understand the complexities of the epidemic and find joint solutions in a participatory process. Consistent new approaches and especially strategies for dealing with the problem and its complexities must be formulated and implemented in time.

HIV/AIDS policy guidelines need to be evaluated reviewed and altered on a continuous basis. This will keep organisations abreast, updated with new developments within the working environment, and will also inform their constituencies accordingly. It is with this frame of mind, that effective solutions need to be found or created in order to reduce the impact of the disease. This can be achieved only through the cost-effective implementation and management of clearly

set goals and objectives based on a simple and sound strategy for the control and effective management of HIV/AIDS in the working environment (Bennett, 2000:9).

There is, however, still much ignorance and disbelief about the epidemic and many myths and misconceptions about AIDS. Employee participation is a key element for an effective strategy, as well as other creative methods for informing and educating workers in the workplace. The main aim of this chapter thus is to identify and discuss such a strategy to combat, prevent and minimise the impact of this disease as effectively as possible within the workplace in organisations.

## **5.2 THE PURPOSE AND NEED FOR A BROAD STRATEGIC PLAN**

Most corporate organisations in South Africa have not yet undertaken an AIDS impact assessment and do not have any policies or action programmes in place to deal with the problem. Many organisations still seem to hope that the HIV/AIDS epidemic will not affect them. Aside from the costs of such a stop-gap approach, many organisations also have to consider the impact of AIDS-related absence in terms of organisational down-time that will have a significant impact on productivity levels within the organisation (Robinson, 1999:15).

It is recognised that no single sector, ministry, department or organisation is by itself responsible for addressing the HIV/AIDS epidemic. It is envisaged, that all government departments, business organisations and various stakeholders will develop and implement a suitable and practical strategy that will be based on their own strategic operational plans to maximise efficiency and effective control.

In July 1999 a meeting was initiated by the Minister of Health, Dr. Monto Tshabalala-Msimang in response to President Mbeki's challenge to all sectors of society, to become actively involved in initiatives designed to address the HIV/AIDS epidemic. The meeting was attended by representatives of various faith-based organisations, people living with HIV-infection and AIDS, Human Rights Organisations, academic institutions, the civil military alliance, the media, organised labour unions, organised businesses, insurance organisations, women's organisations, health professionals,



political parties and relevant government departments. All sectors of society were present in an effort to find a practical and manageable strategy to combat the impact of HIV/AIDS more effectively (Anon, 2000:5).

The result was a well drafted and clearly understandable document that included a broad national strategic plan designed to guide the country's response as a whole to the impact of the epidemic. It is not a strategic plan for the health sector alone, but a statement of intent for the country, which include various sectors within and outside of the scope of government.

The need for such a strategic plan was echoed throughout the public and private sectors of the economy, because a well-formulated and structured strategic plan was needed from government to form the basis whereupon business organisations within the public and private sectors could formulate and implement their own strategic plans, based on their own priority areas for prevention, treatment, care, support, legal rights, research, evaluation and management of the disease (Anon, 2000:6).

In September 1999 the Minister of Health, together with the nine provincial MEC's for health, confirmed the priority areas that needed attention. This was followed in October by a two-day National AIDS meeting where provincial AIDS co-ordinators, the national DOH, HIV/AIDS and STD Directorate, and various representatives of several private organisations discussed progress within a five-year HIV/AIDS and STD strategic plan. In November 1999 this task team met again in order to further develop goals and objectives to streamline the implementation of such a strategic plan for all sectors of business and society. The final document was completed in January 2000 and included a well-structured and well-formulated strategic plan to be implemented by all sectors of business and civil society (Anon, 2000:6).

The following primary goals, objectives and actions were identified and incorporated within this strategic plan.

- Reducing the number of new HIV infections.
- Reducing the impact of HIV/AIDS on individuals, families and communities.

The following general strategies are to be stressed.

- An effective and culturally appropriate information, education and communications (IEC) strategy.
- Increased access and acceptability to Voluntary HIV Counselling and Testing.
- Improving STD management and the treatment of opportunistic infections and promoting increased condom use in order to reduce STD and HIV transmission.
- Improving the care and treatment of HIV-positive persons and persons living with AIDS so as to promote a better quality of life and limit the need for hospital care (Anon, 2000:16).

Implementing a successful HIV/AIDS and STD strategic plan is essential and vital to success and survival of all organisations that operate within the private and public sectors of society. The implementation of a well-formulated strategic plan based on government national goals and objectives will mean that those activities, actions and practices are appropriate and cost-effective for South Africa. In order for those concerned to achieve this, certain critical key areas for effective delivery within the private and public sectors must first be identified and implemented.

These key areas are explained in the following table.

Table 5.1 follows on p.120.

**Table 5.1: Critical key areas for effective delivery**

KEY FACTOR	KEY AREA FOR EFFECTIVE DELIVERY
<b>AUTHORITY (GOVERNMENT/MANAGEMENT) AND POLITICAL WILL AT ALL LEVELS</b>	
STRUCTURES	Delivery and implementation co-ordination
RESOURCES	Financial Resources Human Resources Technical Resources
CAPACITY	HIV/AIDS and STD understanding Management Monitoring and evaluation
COMMUNICATION	National ↔ Provincial Provincial ↔ National Provincial ↔ Provincial Provincial ↔ District ↔ Community Government ↔ Civil Society Government ↔ Public sector ↔ Private sector Government ↔ Private sector Private sector ↔ Community

**Source:** Anon, 2000:25

The HIV/AIDS and STD strategic plan provides a good framework for government, NGO's, Business, Labour, women and all sectors of society to develop and implement more specific action plans and policies based on their individual role that they have to play in society. These plans and policies should form the foundation of each sector's comparative advantage in implementing and maintaining these planned activities and goals. Sectors', especially the private sector are, encouraged to establish technical AIDS committees and other prevalent bodies within the working environment, which will be responsible for advocating, managing and the co-ordinating of HIV/AIDS

activities, programmes and action plans within that particular organisation. It is also important, that management oversees all bodies and committees progress and that the implementation and management of an overall strategic plan based on the broad framework of government policies, procedures and goals is maintained (Bennett, 2000:9).

The sectoral HIV/AIDS committees will also be responsible for liaison with other sectors, public and private and also to the directorate: HIV/AIDS and STD's. The recommended role of the sectors, both private and public, will be as follows.

- Identify determinants of the spread of HIV/AIDS/STD's specific to the sector.
- Identify strengths and weaknesses with respect to HIV/AIDS/STD's.
- Identify obstacles to the response within the sector.
- Integrate HIV/AIDS/STD's activities in their yearly plans.
- Formulate specific HIV/AIDS sectoral plans and budget for their implementation.
- Mobilise resources for the interventions.
- Document best practice within the sectors and share information.
- Prepare and submit quarterly reports to the SANAC (Anon, 2000:28).

### **5.3 IMPLEMENTING A NATIONAL STRATEGIC PLAN**

The effective implementation and successful management of a national strategic plan will depend largely on the availability of human, financial and institutional resources available to businesses. The sustainability of responses will depend on an efficient monitoring process in the areas of policy development, institutional strengthening and service delivery.

Certain areas are identified as priority areas that need to be addressed and managed by both the private and public sector businesses. These so-called priority areas form the basis of a broad strategic plan, initiated by government to help businesses in formulating and drawing up their own unique action programmes, policies and strategies to be implemented and managed over the next 5 years, with the aim to

bringing about meaningful changes in the spread of the HIV/AIDS epidemic in South Africa (Bennett, 2000:10).

The strategic plan is structured according to the following priority areas of responsibility and will be discussed in more detail.

- Prevention.
- Treatment and care.
- Human and legal rights.
- Monitoring research and surveillance.

### 5.3.1 Priority Area 1: Prevention

This is the first priority area in the overall broad strategy to be initiated by government and implemented by both public and private sectors. This area includes the following important goals to be achieved and also indicates what selected strategies are needed in order for it to be successful.

- Goal 1: Promote safe and healthy sexual behaviour.
- Goal 2: Improve the management and control of STD's.
- Goal 3: Reduce mother-to-child transmission (MTCT).
- Goal 4: Address issues relating to blood transfusion and HIV.
- Goal 5: Provide appropriate post-exposure services.
- Goal 6: Improve access to Voluntary HIV Counselling and Testing (VCT).

#### **GOAL 1: PROMOTE SAFE AND HEALTHY SEXUAL BEHAVIOUR**

Objective	Selected Strategies	Lead Agencies
<b>Promote improved health-seeking behaviour and adoption of safe sex practices</b>	<ul style="list-style-type: none"> <li>a) Produce and disseminate IEC material and messages to different stakeholders.</li> <li>b) Implement life skill education in all primary and secondary schools.</li> <li>c) Increase the number of trade unions who have implemented HIV/AIDS &amp; STD policies and programmes.</li> <li>d) Facilitate and support the trucking industry's AIDS High Transmission project.</li> </ul>	DOE, DOH, NGO's, Trade Unions, DOL, DOH Youth Sector.

Objective	Selected Strategies	Lead Agencies
<b>Broaden responsibility for the prevention of HIV to all sectors of government and civil society</b>	a) Develop sector-specific policies and plans for the prevention of HIV/AIDS/STD's, focussing specially on the following sectors: Government sectors; Health; Education; Welfare; Local Government; Transport; Justice; Police; Correctional Services; Home Affairs; Civil society sectors; Traditional leaders; Youth; Faith-Based Organisations; Business; Entertainment and media.	DOH, SANAC, All Sectors
<b>Implement HIV/AIDS prevention for migrants</b>	a) Develop a health programme with an HIV focus. b) Facilitate cross-border interventions. c) Work in partnership with other SADC countries.	DOH, SADC, UN-AIDS
<b>Develop and implement counselling and care programmes for all national government departments, public and private sectors</b>	a) Create public awareness of HIV/AIDS & STD's in all government departments. b) Identify, train and support peer educators. c) Distribute condoms in all government departments and businesses.	DOH, Government Departments, Private and Public Businesses.
<b>Improve access to and use of male and female condoms, especially amongst 15 to 25 year olds</b>	a) Expand condom distribution through non-traditional outlets. b) Improve access to condoms in high transmission areas (e.g. truck stops, borders, mines and brothels). c) Increase acceptance, attitudes, perceptions, efficacy and use of condoms as a form of contraception among the youth.	DOH, All sectors (private/public) and civil society

**Source:** Anon, 2000:17

**GOAL 2: IMPROVE THE MANAGEMENT AND CONTROL OF STD's**

Objective	Selected Strategies	Lead Agencies
<b>Ensure effective syndromic management of STD's in the private sector</b>	a) Investigate granting dispensing licences to nurses for STD treatment. b) Monitor and regulate the quality of care in the private sector. c) Training on syndromic management within the private sector. d) Review Medical Schemes regulations to ensure minimum reimbursement for treatment of STD's.	DOH <sup>2</sup> , SAMA, Board for Health Funders, Health Professions Council of SA, Technical AIDS committees.

Objective	Selected Strategies	Lead Agencies
<b>Ensure effective Syndromic Management (SM) of STD's in the private sector</b>	a) Training in Syndromic Management undergraduate/basic curricula of all nurses, doctors and pharmacists. b) Regular in-service training of HCW's.	DOH, SANC, Nurse training institutions, Medical Schools.
<b>Collaborate with traditional healers to improve health care-seeking behaviour for STD treatment.</b>	a) Development, print and distribution of training manuals in various languages. b) Conduct capacity building workshops with TH's. c) Sensitise the health sector regarding traditional medicine. d) Consider referral systems between traditional and western medicines.	DOH, Traditional Healer Organisations, CONTRALESA.
<b>Increase access to youth-friendly reproductive health services – including STD management, VCT and rapid HIV testing facilities (special focus on youth, women and migrant workers)</b>	a) Make clinics and HCW's "youth friendly". b) Make schools places where youth can access friendly and supportive counselling services.	DOH, DOE, Youth Sector.

**Source:** Anon, 2000:18

**GOAL 3: REDUCE MOTHER-TO-CHILD HIV TRANSMISSION (MTCT)**

Objective	Selected Strategies	Lead Agencies
<b>Improve access to HIV testing and counselling instate clinics</b>	a) Develop counselling guidelines. b) Train counsellors (private/public).	DOH, Women's Sector, NGO's
<b>Improve family planning services to known HIV positive women</b>	a) Train reproductive health providers on HIV/AIDS counselling. b) Improve access to comprehensive reproductive health services for HIV positive women.	DOH, Women's Sector, NGO's NPPHON.
<b>Implement clinical guidelines to reduce the transmission of HIV during childbirth and labour</b>	a) Train all relevant midwives and medical practitioners.	DOH, Nursing Training Institutions, Medical Schools.

**GOAL 4: ADDRESS ISSUES RELATING TO BLOOD TRANSFUSION AND HIV**

Objective	Selected Strategies	Lead Agencies
Maintain a safe blood transfusion service	a) Monitor implementation of current guidelines on blood transfusion. b) Develop national guidelines on HIV and blood transfusion. c) Improve the recruitment of low-risk blood donors.	DOH, DOL, Technical AIDS committees.

**GOAL 5: PROVIDE APPROPRIATE POST-EXPOSURE SERVICE**

Objective	Selected Strategies	Lead Agencies
Provide services for needle-stick injuries and occupational exposure	a) Ensure appropriate policies for needle-stick exposure in the private sector. b) Ensure the supply of anti-retroviral drugs to treat occupational exposure. c) Reduce exposure to occupational exposure through the appropriate disposal of medical waste and sharps.	DOH, DOL, Technical AIDS committees.
Investigate options to reduce HIV/STD transmission and pregnancies resulting from sexual assault	a) Review research on use of ARV to prevent HIV transmission following sexual assault. b) Assess services for women and men following sexual assault.	DOH, Research Institutions.

**GOAL 6: IMPROVE ACCESS TO VOLUNTARY HIV COUNSELLING AND TESTING**

Objective	Selected Strategies	Lead Agencies
Increase the number of Voluntary HIV Counselling and Testing sites	a) Introduce counselling service in all new testing sites. b) Expand use of rapid testing methods. c) Increase the proportion of workplaces that have on-site counselling and testing services.	DOH
Increase the number of persons seeking voluntary testing and counselling services	a) Promote access to VCT services, especially for the youth.	DOH, All Sectors

Source: Anon, 2000:19



### 5.3.2 Priority Area 2: Treatment, care and support

This area includes the following important goals and selected strategies to be implemented.

#### ***GOAL 7: PROVIDE TREATMENT, CARE AND SUPPORT SERVICES IN HEALTH FACILITIES, INCLUDING GOVERNMENTAL, PUBLIC AND PRIVATE ORGANISATIONS***

<b>Objective</b>	<b>Selected Strategies</b>	<b>Lead Agencies</b>
<b>Improve treatment, care and support for people living with and affected by HIV/AIDS</b>	<ul style="list-style-type: none"> <li>a) Develop guidelines for the treatment and care of HIV/AIDS patients in health facilities and the community.</li> <li>b) Ensure uninterrupted supply of appropriate drugs for the treatment of opportunistic infections and other related conditions.</li> <li>c) Build capacity of health professionals to provide comprehensive HIV/AIDS/STD/TB treatment, care and support.</li> <li>d) Establish strong links between health facilities and community-based support programmes.</li> <li>e) Improve prevention and treatment of TB and other opportunistic infections.</li> </ul>	DOH, Training Institutions, PWA's.
<b>Objective</b>	<b>Selected Strategies</b>	<b>Lead Agencies</b>
<b>Establish poverty alleviation projects to address the root causes of HIV/AIDS/STD's and TB</b>	<ul style="list-style-type: none"> <li>a) Incorporate HIV/AIDS/STD's and TB as indicators of poverty.</li> <li>b) Involve relevant government departments and the private sector in poverty alleviation projects.</li> </ul>	Agricultural sector, Government departments, NGO's, Business
<b>Ensure appropriate practices in the private sector and medical insurance industry for the care and treatment of HIV-positive clients</b>	<ul style="list-style-type: none"> <li>a) Review international and regional practices relating to HIV and medical insurance.</li> <li>b) Lobby the medical schemes industry to review benefits and coverage for HIV positive clients.</li> <li>c) Standardise a minimum package of treatment and care for people living with HIV/AIDS in the public and private sectors.</li> </ul>	DOH, BHF.

**Source:** Anon, 2000:20

Goal 8: Provide adequate treatment, care and support services in communities.

Goal 9: Develop and expand the provision of care to children and orphans.

**GOAL 8: PROVIDE ADEQUATE TREATMENT, CARE AND SUPPORT SERVICES IN COMMUNITIES**

Objective	Selected Strategies	Lead Agencies
Develop and implement models of community/home-based care in all provinces	<ul style="list-style-type: none"> <li>a) Develop appropriate home-based care implementation guidelines.</li> <li>b) Promote the establishment of inter-sectoral task teams at community level to develop community/home –based care.</li> <li>c) Reduce stigma of HIV/AIDS in communities and develop IEC materials targeted at communities.</li> </ul>	DOH, DOW, NGO's
Increase acceptability to community/home-based care	<ul style="list-style-type: none"> <li>a) Use media for more exposure to the issues of home-based care in communities</li> </ul>	DOH, DOW, NGO's, Media, all sectors.

**GOAL 9: DEVELOP AND EXPAND THE PROVISION OF CARE TO CHILDREN AND ORPHANS**

Objective	Selected Strategies	Lead Agencies
Develop and implement programmes to support the health and social needs of children affected by HIV/AIDS	<ul style="list-style-type: none"> <li>a) Promote advocacy of all relevant issues that affect children.</li> <li>b) Mobilise financial and material resources for orphans and child-headed households.</li> <li>c) Investigate the legal protection of child-headed households.</li> <li>d) Provide social welfare, legal and human rights support to protect educational and constitutional rights.</li> </ul>	DOH, DOW, DOJ, NGO's, Business
Implement measures to facilitate adoption of AIDS orphans	<ul style="list-style-type: none"> <li>a) Investigate the use of welfare benefits to assist children and families living with HIV/AIDS.</li> <li>b) Subsidise adoption of AIDS orphans.</li> </ul>	DOW, DOE.

Source: Anon, 2000:21

**5.3.3 Priority Area 3: Research, monitoring and surveillance**

Goals to be achieved and realised include the following.

- Goal 10: Ensure AIDS vaccine development.  
 Goal 11: Investigate treatment and care options.  
 Goal 12: Conduct policy research.  
 Goal 13: Conduct regular surveillance.

**GOAL 10: ENSURE AIDS VACCINE DEVELOPMENT**

Objective	Selected Strategies	Lead Agencies
Support efforts to develop a Clade C HIV vaccine	a) Conduct biological and behavioural research to support the development of an AIDS vaccine. b) Support the South African AIDS Vaccine Initiative. c) Develop South African ethical guidelines for vaccine research.	DOH, MRC, Research Institutions.

**GOAL 11: INVESTIGATE TREATMENT AND CARE OPTIONS**

Objective	Selected Strategies	Lead Agencies
Review and revise policy on anti-retroviral use for reducing mother-to-child HIV transmission	a) Review, monitor and evaluate current research on the use of anti-retroviral therapy to reduce mother to child HIV transmission. b) Identify and implement additional areas of research for example the private sector. c) Review and update national policies to reduce MTCT.	DOH, Academic institutions, Research Institutions, Women's Sector, Technical AIDS committees.
Conduct research on the cost-effectiveness of other forms of non-retroviral treatment and prophylaxis.	a) Review international research. b) Facilitate local research.	MRC, DOH, Research Institutions.
Conduct research on the effectiveness of traditional medicines	a) Conduct clinical trials. b) Review international research. c) Collaborate with traditional healers.	Traditional Healers, MRC, DOH

**GOAL 12: CONDUCT POLICY RESEARCH**

Objective	Selected Strategies	Lead Agencies
Conduct HIV/AIDS studies in selected departments and businesses	a) Commission research.	DOH, DOF, Government Departments, Private and Public sectors.
Conduct research to determine HIV incidence	a) Conduct HIV incidence surveys in narrow age groups to approximate incidence.	MRC, DOH

**GOAL 13: CONDUCT REGULAR SURVEILLANCE**

Objective	Selected Strategies	Lead Agencies
Develop mechanisms for long- and short-term training to improve the capacities of provincial and district staff to conduct HIV/AIDS/STD-related operations research, surveillance, and research	a) Training for provincial and district staff on research and surveillance in collaboration with research and training institutions. b) Training for private technical committees.	DOH, Academic Institution, Private sector organisations.
Conduct National Surveillance on HIV and STD risk behaviours, especially among youth	a) Conduct behavioural sentinel surveys, with a focus on youth. b) Conduct routine STD surveillance. c) Conduct surveillance of AIDS morbidity and mortality. d) Conduct national HIV-infections surveillance in selected populations and groups, including STD and TB clients, hospitalised patients, men and youth.	DOH, HSRC, GCIS, MRC, Youth Sector

Source: Anon, 2000:22

**5.3.4 Priority Area 4: Human and legal rights**

This is the last priority area of the nationally-based strategic plan for the effective management and control of HIV/AIDS in various governmental, public and private

sector organisations and includes the following important goals and strategies that need to be implemented.

Goal 14: Create an appropriate social environment.

Goal 15: Develop appropriate legal and policy environment.

**GOAL 14: CREATE AND APPROPRIATE SOCIAL ENVIRONMENT**

Objective	Selected Strategies	Lead Agencies
<b>Develop a National Inter-Sectoral Campaign on Openness and Acceptance of People Living with HIV/AIDS</b>	<ul style="list-style-type: none"> <li>a) Promote open discussion of sexual practices in various sectors of society (private and public).</li> <li>b) Promote voluntary testing and counselling services.</li> <li>c) Target awareness regarding rights and responsibilities of people living with HIV/AIDS in 4 key areas: employment rights, education, health care and social service rights.</li> </ul>	SANAC, government Departments, NGO's, all Sectors, SABS
<b>Create a legal and policy environment which protects the rights of all persons infected and affected by HIV/AIDS by 2005</b>	<ul style="list-style-type: none"> <li>a) Review existing legislation and ensure the protection of rights of people living with HIV/AIDS.</li> <li>b) Develop policy on the management of mentally challenged HIV-positive persons.</li> <li>c) Review and enact new Children's Law to take into account the needs of children infected and affected by HIV/AIDS.</li> </ul>	DOJ, DOH, SALC, Private and Public sector.
<b>Monitor human rights abuses and develop enforcement mechanisms for redress</b>	<ul style="list-style-type: none"> <li>a) Statutory commissions (HRC and CGE) to set up a discrimination database to collect information on the nature and extent of discrimination against people affected by HIV/AIDS.</li> <li>b) Improve access to justice for people infected/ affected by HIV/AIDS.</li> </ul>	DOJ, HRC, CGE

**GOAL 15: DEVELOP AN APPROPRIATE LEGAL AND POLICY ENVIRONMENT**

Objective	Selected Strategies	Lead Agencies
<b>Develop policy and legislation relating to HIV/AIDS and employment</b>	<ul style="list-style-type: none"> <li>a) Finalise the Code of Good Practice on HIV/AIDS in the Workplace, and organisation regulations, to enforce workplace HIV/AIDS policies.</li> <li>b) Support the development of workplace HIV/AIDS policies.</li> </ul>	DOL, DOH, Technical AIDS Committee

Objective	Selected Strategies	Lead Agencies
<b>Develop policy and legislation relating to HIV/AIDS, commercial sex workers and sexual assault</b>	a) Develop criminal law mechanisms, which protect the rights of victims of sexual violence. b) The provision of counselling to victims of sexual violence. c) Investigate decriminalising commercial sex work.	DOJ, DOH, SALC, Public sector.

**Source:** Anon, 2000:23

Implementing the HIV/AIDS and STD strategic plan is essential in order not only to ensure the achievements of national goals, but also to act as a basis for further strategic and goal formulation by the various public and private sector organisations, in order to combat and manage the impact of the disease effectively. South Africa as a whole, which includes government and all stakeholders, needs not only to track the course of the epidemic over the next five years, but should also take note of changes in attitude, social values, health practices, socio-economic conditions and behaviours that act as predisposing factors of the epidemic. It is, therefore, vital that a broad strategic plan is needed that include both private and public sector businesses so as to evaluate, address and manage the impact of HIV/AIDS as effectively as possible (Anon, 2000:6).

This can be achieved only through comprehensive goal formulation and implementation of specific strategies, action programmes and policies in order to reduce, manage and control the epidemic on all fronts of business and society. The implementation of a broad strategic plan must be seen as an umbrella that embraces all individual organisational strategies and action programmes in order to co-ordinate and address the impact of the disease as effectively as possible. It is the basis for strategy and goal formulation and must be seen as a mechanism for organisations to formulate their own action programmes, policies and strategies according to their own individual needs and situations within the business environment.

### **5.3.5 Principles for the effective implementation of the HIV/AIDS strategic plan**

Broad principles for the implementation of such a strategy include the requirement that activities and practices are appropriate and cost-effective for South Africa. These activities should be based on known evidence-based practices. The effective implementation of the HIV/AIDS and STD strategic plan for South Africa can be achieved if only the following issues are addressed properly.

#### ***5.3.5.1 Approval of the HIV/AIDS and STD Strategic Plan by national bodies such as SANAC and the National HIV/AIDS and STD's Directorate, followed by provincial and local structures***

The HIV/AIDS and STD Strategic Plan should be used in developing national, provincial and district operational plans. Annual operational plans should be based on realistic objectives. These should be developed, taking into consideration existing financial and human resources, the capacity thereof, the process of recruitment, as well as the political commitment in each of the provinces. The setting of national goals will allow for inter-provincial comparisons and ensure a measure of unity, regardless of the relative autonomy of the province. The provinces should then take these national goals and objectives and present them to key role players within the province in order to ensure that all buy into what would be a Provincial Strategic AIDS Plan (Anon, 2000:26).

#### ***5.3.5.2 Improve Structures for Delivery***

This involves reviewing and developing where necessary structures at all levels, from the national to the community level. The concept of appropriate national structures such as the IDC and SANAC should be considered for duplication within provinces, keeping in mind the importance of delivery within business communities. The most important structures to create to guide the implementation of a Strategic Plan, are the following.

- A National AIDS Council, with duplicate bodies in each province,
- Interdepartmental Committees on HIV/AIDS in every province. One of the functions of the Interdepartmental Committees within the provinces, would be to define each government department's unique and generic responsibility within the HIV/AIDS and STD Strategic Plan.

Equally important, is the establishment of appropriate structures at local level in order to ensure the implementation of the HIV/AIDS and STD Strategic Plan. It is thus recommended that local government and business HIV/AIDS Committees be established. These local government and business structures should include the communities that represent major role-players within the relevant community in the field of HIV/AIDS. These committees should also include local government to ensure the integration of HIV/AIDS/STD's and TB issues and the development of plans. It is vital that these plans include non-health issues as part of HIV/AIDS/STD planning, such as transport and poverty alleviation (Anon, 2000:27).

#### **5.3.5.3 *Establish Acceptable Standards for Provinces and Local Structures with Respect to Resources***

- a) **Financial Resources:** It is important to ensure that adequate funding is available at national and provincial levels within the healthcare environment in order for it to ensure delivery. One method is to establish an agreed resource standard for all provinces to directly place financial resource into HIV/AIDS. This is currently (in 1999/2000 prices) set at R10 per person per year, or a total of ± R400 million per year for the whole country.

Related activities include the following.

- Auditing financial resources for HIV/AIDS activities within Provinces over the preceding three years.
- Comparing resources between provinces on a per capita and per HIV infected population.



- Agreeing on standards or conditions by National bodies such as MinMEC, PHRC for allocating dedicated HIV/AIDS funding from National bodies.
- Costing the HIV/AIDS and STD Strategic Plan and Programmes.
- Agreeing on the continued funding by the National DOH of activities and products [such as condoms] that have a major alleviation impact (Anon, 2000:28).

**Funds for HIV/AIDS should be devolved to provinces from the national government, only on the condition that certain standards are met.**

These include the following.

- Presence of an Inter-departmental Committee on HIV/AIDS.
- Commitment to “ringfence” funds for direct HIV/AIDS activities within provinces.
- Commitment to distribute funds according to the HIV/AIDS and STD Strategic Plan.
- Commitment to spend over 80 per cent of the funds in one financial year.
- Commitment to roll funds over funds into the new financial year without risk of penalty.
- Commitment to prioritise the process of HIV/AIDS spending within the provinces.
- Commitment to ongoing national and provincial communication.
- Regular review of the implementation of HIV/AIDS Plans.
- Establishing realistic goals and objectives than can be implemented within provinces, districts and local businesses.

**b) Human Resources:** It is vital to the success of this Strategic Plan that adequate human resources are available to ensure delivery. The constraint on action is arguably capacity rather than funding. The current standard suggested is one dedicated employee per 100 000 population. To evaluate the

availability of human resources, it will be necessary to audit the existing human resources at national, provincial, regional and local levels. This audit should inform the process of establishing standards of personnel at district, regional and provincial levels of management alleviation (Anon, 2000:28).

#### **5.3.5.4 Regularly Review the Implementation of the Strategic Plan**

The HIV/AIDS Strategic Plan must be reviewed every 12 months at national and provincial and local levels, with quarterly reports to be submitted to local, provincial and national levels.

The National DOH has overall responsibility for the implementation of the Strategic Plan within provincial structures. Specific measurable targets and indicators will be developed for each objective and reported in an annual operational plan. The Strategic Plan will be monitored by these behavioural surveys. These surveys will measure changes in HIV-related risk behaviours including condom use, delay of sexual initiation among youth, HIV incidence, and the number of sexual partners.

Another important point is to establish a mechanism of constant and consistent feedback and reporting by provinces to local and national structures and vice versa. Information from the regular review should be used to serve as an information tool in communication between all parties of successes, as well as to other stakeholders to provide guidelines on activities to be involved in (Anon, 2000:28).

#### **5.3.6 Effective management and control of the HIV/AIDS and STD strategy**

The HIV/AIDS and STD strategic plan is a broad framework initiated by government but also by NGO's, business, labour and all sectors of society. Like already mentioned each sector is responsible to develop more specific plans based on their own specific role and responsibilities in managing the input of HIV/AIDS more effectively. Sectors and in particular the private sectors, are envisaged to establish technical AIDS committees, as already mentioned, but they also are responsible for the implementation, maintaining and management of a cost effective HIV/AIDS

programme and action plans within their specific working environments. To achieve this, management must first become aware of the situation within their working environments and must therefore realise the following.

- Management must realise the rapid spread of HIV/AIDS in South Africa and the potentially devastating effects. HIV/AIDS will have on the country, its employees and their families.
- Management must be committed in making every effort to reduce the spread of HIV amongst its workforce.
- Management, but also labour, must try to minimise the impact of HIV/AIDS on employees and their departments, colleagues and on business in general.
- In all matters, management must aim to balance the need and interests of the employees with HIV/AIDS, his/her colleagues and also the organisation.
- A written policy is needed which is in line with current international and South African business practices.
- Employee HIV/AIDS Education (Ellen, 2000:85).

The effective management and control of a suitable HIV/AIDS strategic plan will largely depend on the availability of various resources within and to the disposal of businesses. There is, however, much ignorance and disbelief about the epidemic and there are also many myths and misconceptions about AIDS. It is thus critical, that management needs to take the initiative and formulate, implement and manage the epidemic as successfully as possible. This can be achieved only through a well-drafted and formulated action programme. The main aim of such a programme, will include the following.

- To make employees aware of the risk of HIV/AIDS to themselves and their families.
- To make them aware of preventive measures.
- To inform them about their rights and responsibilities with regard to legal, ethical and policy issues relating to HIV/AIDS.
- To encourage supportive attitudes toward people with HIV/AIDS.

- Provision and distribution of condoms and protective equipment at the workplace and in other strategic places.
- Periodic evaluation and assessment of the knowledge, attitudes and practices (KAP) of employees as they relate to HIV/AIDS education programmes (refer Chapter 8).
- The prevention and treatment of sexually transmitted diseases (STD's).
- The provision of social services which facilitate the strengthening of family life of employees, including those employees working far away from their homes (Gottlieb, 2000:3).

Employee participation is a key element of this programme, as already mentioned. To achieve this, these employees will be selected and invited to be trained as peer-educators. These peer educators will be supported to provide education to the workforce both formally – through organised sessions – and informally (refer Chapter 4). The educators will be trained during work-time and at the business's expense. They will also be encouraged to use their knowledge and skills to educate their families and communities in their private time (Kass, 2000:1026).

People living with HIV/AIDS (both within and outside of the business, for example, guest speakers) will also be involved in this programme so as to ensure maximum impact and effectiveness of the programme.

Other creative methods of informing and educating the workplace will be explored. These include, for example, the use of print media (posters, leaflets, etc.), educational/industrial theatre, puppetry programmes, electronic media, video, periodic seminars and workshops.

Beside action programmes that need to be formulated and implemented, it also needs to be controlled for effective management by the organisation and its employees. This can be achieved only through the appointment of various programme co-ordinates, task teams and representatives within the working environment and will include the following important functions.

- The HIV/AIDS programme will be initiated, managed and monitored centrally through Head Office and fall under the responsibility of an appointed programme co-ordinator.
- A task team will be established and the programme co-ordinator will manage the team.
- The team will be made up of appropriate representatives from both the employer and employees and may vary from region to region.
- Regional task teams will be established, with voluntary representation from the employee body. These task teams will plan, implement and monitor the programme at a regional and local level (Smith, 2000:9).

Task teams will also ensure that the necessary steps are taken to disseminate the policy to all employees through the education programme.

An annual policy review will also be undertaken: this will include the following important tasks.

- Due to the dynamic nature of the HIV/AIDS epidemic, management will review this policy on an annual basis, or more frequently, if necessary.
- Every effort will be made to balance the needs of the employee and the employer.
- Policy review will take into account international and national trends at all times (Smith, 2000:10).

The effective control and therefore, the effective monitoring of such action programmes and policies, must be implemented according to the national HIV/AIDS strategic plan initiated by government as discussed and that each implementing sector, either public or private, needs to contribute to the accomplishments of various aims and broad national objectives.

This strategy must also be seen as mutually beneficial to all implementing agencies, sectors and organisations to assess their individual performance, seek collective measures and formulate appropriate policy, action programmes and ultimately

strategies. Effective monitoring and evaluation tools must therefore, be developed and customised for each individual intervention. These tools will ultimately identify strengths and weaknesses within response programmes and activities and also identify areas that need the redirection of resources. The cost effectiveness of these selected interventions, will be determined through special organisational and operational research (Smith, 1996:15).

The effective management and control of a specific strategy, which aim it is to manage and limit the impact of HIV/AIDS in the working environment, will ultimately depend on managerial ability to manage, formulate, implement and control action programmes and policies to reduce the risk that HIV/AIDS will have on organisational resources and ultimately, on its workforce. Employees are vulnerable to HIV infections for many different reasons. Some of these reasons are relatively simple, with simple ways to reduce vulnerability while others are very complex and woven into the socio-economic circumstances in which employees find themselves. Managing the epidemic appropriately and effectively by means of a strategy that can be implemented in the workplace, is in itself a critical factor for the future viability of businesses and also for the health and welfare of its employees.

#### **5.4 CONCLUSION**

The dynamics of the epidemic and the peculiar nature of HIV, the resultant disease and mortality, present a unique set of problems, which will need extraordinary approaches to managing it in the workplace. The HIV/AIDS epidemic is still evolving and expanding and the ultimate size and impact is not fully certain. New approaches and strategies for dealing with the problem, will also evolve and develop over time. HIV/AIDS policy guidelines must be dynamic and keep up with trends and developments in order to keep abreast and updated with new developments in order for those concerned to manage and control the disease more effectively, especially within the workplace (Anon, 2000:29).

There are no known cures for HIV/AIDS. Therefore, prevention is a critical factor in fighting the disease head-on. For this reason, organisations must commit themselves

to the education and informing of employees about HIV/AIDS at all levels, by way of a continuous education and awareness programme, based on a sound business strategy with the aim to reduce and control the impact of HIV/AIDS. Mr. Whiteside, a health economics researcher, propounds as follows: “The full impact will unfold over the next few years and there is no doubt that it will be devastating in all sectors, starting with health and education” (Ngubane, 2000:5).

AIDS deaths are expected to impact heavily on all South Africans. An estimated R7,2 billion has already been spent on educating those of productive age, who died in the 1999-2000 period alone. By 2003, 12 per cent of highly skilled workers and 27,2 per cent of low-skilled workers will be infected, according to a study by ING Barings. It will cost an estimated R250 000 to replace each skilled labourer lost to AIDS. Medical aid claims are expected to rise rapidly and some medical schemes could face bankruptcy. It will cost the public health system ± R16 900 a year to treat each AIDS patient. Escom estimates that it will spend R400 million a year on pensions, medical aid, lost productivity and the recruitment of new workers from 2005 onwards.

Presenting data from its own research, the Medical Research Council, in the words of Dr. Salim Abdool Karim, states that South Africa was being hit by many strains of the virus, unlike in other countries, which have to cope with only one strain. “We have multiple small epidemics which are coalescing” (Pretorius and Jacobson, 2000:2). It is behind this backdrop, that South Africa as a whole need to implement, maintain and manage the impact that HIV/AIDS will have on the economic growth and social development of the country. A broad national strategy thus is inevitable, together with suitable and sustainable policies, action programmes and related business strategies to cope with the spread and devastating impact of HIV/AIDS on all fronts and sectors of business and society.

In the next chapter the emphasis falls on the empirical perspectives of the study and will include descriptive research, reliability tests, cross-tabulations, as well as other relevant graphical explanations, and representative data.

## CHAPTER 6

### RESEARCH METHODOLOGY RELATED TO THE STUDY UNDER INVESTIGATION

#### 6.1 INTRODUCTION

The aim of this chapter, is to provide a better and adequate insight and understanding of the basic methodological techniques and methods used during the study, how it was applied and what purpose it played, in order to obtain the relevant data. Various aspects relating to the particular research methods and techniques will be investigated so as to determine whether it would be adequate and sufficient enough within the broad framework of this research study. The chapter will also provide a better understanding of what the empirical part of the study entails.

Aspects and concepts such as population size, sample frame, sample size, methods of data collection, as well as the validity and reliability of the research study, will be investigated. Attention will also be given to questionnaire design, data processing, analysis and the evaluation of results.

First, the term “methodology” needs clarification. Wellman and Kruger state as follows: “The application of various methods, techniques and principles in order to create scientifically obtained knowledge by means of objective methods and procedures within a particular discipline” (Wellman & Kruger, 2000:2). Research methodology can also be evaluated and interpreted according to the nature, scope and volume of particular research methods applied, which in turn form part of the logic behind the methods that are applied within the research methodological field of study.

The study of methodology is concerned with the acquisition of knowledge and is also very practical in nature and, therefore, is focused on specific ways and methods that can be applied to better understand the field and scope of study, which in the case of this particular study, refers to the various methods and principles used within the



general research process. Another aspect closely related to methodology is research itself: “Research gives the history of a particular study, including what the researcher wanted to find out, why that seemed worth discovering, how the information was gathered and what he or she thought it all meant” (Locke, Silverman & Spirduso, 1998:23).

## **6.2 DEFINITION OF THE RESEARCH PROBLEM AND OBJECTIVES**

### **6.2.1 Problem definition**

According to Wellman & Kruger (2000:11), a research problem refers to some difficulty which the researcher experiences in the context of either a theoretical or a practical situation and to which he or she wants to obtain a solution. The definition on the research problem is, however, one of the most important steps and is the first stage in any research process.

The nature and problem of this particular study, are clearly stated and defined in Chapter 1. It is clear that there is an ever-increasing need for organisations to become more actively involved in the management of HIV/AIDS in the workplace. Especially from management’s perspective, the issue can not be ignored any longer. It has become a priority for organisations to implement sufficiently structured policies, action programmes and strategies to effectively manage and minimise the impact of HIV/AIDS in the workplace. There is an ever-present need to actually investigate this aspect by means of applied research in the industry, in order to determine if management is committed or simply reluctant in respect of the whole issue of HIV/AIDS within the workplace (Wellman & Kruger, 2000:22). The purpose of the study is, therefore, to evaluate and investigate whether suitable and effective policies, action programmes and strategies are in place to manage and minimise the impacts of the HIV/AIDS epidemic within the working environment of organisations, and also to determine what the actual needs are of organisations with respect to the management and control of the disease.

As already mentioned, the method of applied research within the industry is a suitable method of research for this particular study, in that it has the following outcomes for the organisations under investigation.

- Firstly, the need for research in industry develops because of organisational problems. Problems arise, for example, with excessive absenteeism, staff turnover and job dissatisfaction, and this could be the beginning of a research study that is designed specifically to reduce the seriousness of the problems.
- Secondly, the goal of research in industry, is to improve the effectiveness of an organisation.
- Thirdly, the participants in research within industry, are typically employees or job applicants.
- Fourthly, if the results of research in industry are positive and usable, the research unit of the organisation where the research is done, will attempt to have the conclusions of the study accepted and implemented by the rest of the organisation (Wellman & Kruger, 2000:22).

## 6.2.2 Objectives of the research study

### *Primary objective*

To investigate and analyse structures (strategies), action programmes and policies for the effective management and control of HIV/AIDS within the workplace.

### *Secondary objectives*

The following secondary objectives support the primary objective.

- (1) To measure the impact of HIV/AIDS in the workplace.
- (2) To measure the effective management of the HIV/AIDS epidemic in the business environment.
- (3) To measure the role of management in combating the disease.

- (4) To measure existing action programmes, policies and strategies for the successful implementation of measures within the workplace.
- (5) To measure the success rate of these action programmes, policies and strategies for the organisation (if possible).

## 6.3 UNIVERSUM AND SAMPLING TYPES

### 6.3.1 Universum

The first step in the sampling process is to define the universum or population. According to Blakenship & Breen (1993:36) population refers to the total group under investigation, while Wellman and Kruger (2000:18) define it as the study object, which may be individuals, groups, organisations, human products and events or the conditions to which they are exposed. The size of a particular population or universum is indicated by N and IF, for example, the size of the universum is 256; it will be indicated as N=256 (Wellman & Kruger, 2000:47).

Another important aspect to be taken into account when defining the universum is to define the universum (population) units. Bennett (1997:31) also states, that an important point of departure is to define the unit analysis, which refers to the major entity that one is analysing within a particular study. According to this viewpoint, the analysis being done, is to determine what the unit is and not the sample that is being drawn.

Units of analysis typically refer to:

- humans;
- groups (for example, couples married in a particular year; households in a particular geographic region; homosexual clubs; gangs; criminal syndicates; etc.);
- organisations or institutions (for example, schools; classes; congregations; hospitals; political parties; companies; etc.);

- human products or outputs (for example, houses; paintings; articles published in a particular journal in a particular period; dramas; etc.); or
- events, for example, elections; riots; court cases; etc. (Wellman & Kruger, 2000:50).

In the case of this particular study, the universum is comprised individuals (HR Officials, Medical Officers, Occupational Health Nurses and EAP Advisors), while the unit analyse is the specific organisations that are being investigated within the area of study (Sudman & Blair, 1998:334). The next stage, is to determine the universum boundaries of units, which in the case of this research study, will be medium to large industrial organisations with a minimum of 500 or more employees (according to the American definition on organisational size).

### 6.3.2 The sample frame

Cooper and Schindler (1995:204) identify a sample frame as the listing of elements or units from which the actual sample will be drawn. Another descriptive definition of a sampling frame, is a complete list on which each unit of analysis is listed only once. The sample, however, should be representative of the sample frame, which ideally is the same as the universum, but which often differs, due to practical problems relating to the availability of information (Wellman & Kruger, 2000:49).

The availability of a sampling frame is one of the most important aspects in determining a suitable sampling design. The sample frame that was used in this particular study was organisations operating within the Vaal Triangle area; especially in the main industrial areas within the Greater Lekoa Vaal Metropolitan area.

Sudman & Blair (1998:338) identify the following ways in which the sample frame may differ from that of the universum.

- The frame may contain duplicate listings.
- The frame may contain ineligibles that are not part of the universum (population).

- People daily relocate from one population group to the other, or die.
- A frame may contain lists, which do not contain all relevant units of analysis, and if the missing units differ in a systematic manner from those on the list, incorrect conclusions will be the result.
- The frame may omit specific units of the universum.

It is also possible that biases could exist between the various viewpoints and opinions of the members within the universum under investigation. However, it is assumed that the viewpoints and information obtained from the sample frame, represents informed viewpoints of the universum units within the boundaries of this specific research study. The sample frame that was used in the study consists of all major industrial orientated organisations within the Greater Lekoa Vaal Metropolitan area.

### **6.3.3 Sample size, methods and response rate**

#### **6.3.3.1 *Sample size***

According to Lockhart & Russo (1994:144), a sample size refers to the number ( $n$ ) of items to be selected from the universum of the population to make up a specific sample. Principles and considerations to be taken into consideration when determining the desirable sample size are identified by Cooper & Schindler (1998:25) and will hence be briefly discussed.

- Firstly when we determine the size of the sample ( $n$ ), we should bear in mind the size of the population ( $N$ ). In general, it holds that the smaller the total population, the relatively larger the sample should be in order to ensure satisfactory results.
- Secondly, the desired sample size does not depend on the size of the population only, but also on the variable. As a general rule, the larger the variance of the variable, the larger the sample required.
- Thirdly, if each stratum of a highly heterogeneous population is relatively homogeneous, a relatively smaller stratified sample than that required for a random sample may be sufficient. If the strata differ in size and heterogeneity,

the next step will be to adjust the size if the respective samples are taken from them accordingly. The smaller the stratum and/or the more heterogeneous it is, the relatively larger the sample should be, that is drawn from it.

- Fourthly, in determining sample size, it is important to bear in mind that the number of units of analysis from which usable data might be obtained must be smaller than the number, which have originally been drawn. It may not be possible to trace some individuals, others may refuse to participate in the research, while still more may not provide all the necessary information or may not complete their questionnaires, so that their information has to be discarded. Therefore, it is usually advisable to draw a larger sample than the one for which complete data are eventually desired.

As a general rule, no sample with fewer than 15 units of analysis should be used, but preferably one with more than 25 units of analysis (Huysamen, 1991:56). If the population size is 500, then the sample size should be 200. It is not necessary to use a sample size bigger than 500 units of analysis, no matter what the size of the population may be.

### **6.3.3.2        *Sampling Methods***

Due to the nature and scope of this particular study, it was decided that a questionnaire be sent out to various respondents and that personal interviews be conducted on a random scale. In this case, conceptually random sampling was the most attractive type of probability sampling used (Wellman & Kruger, 2000:52). However, it is also believed that personal interviews can be a very effective sampling tool for the purpose of gathering information, although it could be very costly. The greatest value, however, lies in terms of the depth of information and detail that can come from it (Cooper & Schindler, 1998:291).

Research questionnaires were sent out to all industrialised organisations having a minimum of 500 employees and more (refer Appendix F). Over a period of two months, 80 organisations were targeted, with a response rate of 53 completed questionnaires, which accounts for a 66,25 per cent overall success rate. With regard

to personal interviews, a total of 21 interviews out of a possible 35 were conducted, which related to an overall 60 per cent response.

Mail surveys were not conducted because of the typical low response rates that are synonymous with the application of this type of survey method. Another important factor is that the so-called non-respondents to mail surveys could feel that they do not know enough about the topic of survey being conducted. (Leedy, 1997:32)

The most suitable alternative, was to design a research questionnaire that was aimed at a specific group of respondents that have significant information and know-how on the topic being investigated, supported by the interviews conducted.

### 6.3.3.3 *Response Rate*

The response rate for this study was 66,25 per cent (53 responses from a total of 80 were received).

The response rate refers to the number who is measured, observed or who respond to a survey (numerator), divided by the number of eligible respondents (denominator). All studies aim at a high response rate; however, no standard exists to assist the literature reviewer in deciding whether the aim has been achieved and, if not, the effect on the particular study's outcomes (Fink, 1998:87).

The response rate can be calculated by applying the following formula:

$$\text{Response rate} = \frac{\text{Number who respond}}{\text{Number eligible to respond}}$$

## 6.4 DATA COLLECTING METHODS

For the purpose of this study, it was decided to develop a well-structured questionnaire as an instrument for collecting data, which the respondents in question would complete. According to Blankenship & Breen (1993:122), there are certain

fixed guidelines, as to which methods a researcher should use for collecting primary data, but that the researcher must collect data as accurately and as ambiguously as possible.

#### 6.4.1 Questionnaire design

The first step in the design of the questionnaire was to draw up a preliminary questionnaire where all the questions asked were open-ended and unstructured. The purpose for this was to assure that the research problem really existed and the study was going to be of value to the subject discipline of business management. The preliminary questionnaires were distributed to eight respondents and randomly selected. The main purpose for this was to evaluate it against the objectives that were set out for this particular study.

The next step involved the listing of aspects of the relevant data obtained from the preliminary questionnaire, as well as from the actual problem definition and objectives. This was done in order to develop and finalise the final research questionnaire.

Parasuraman (1991:363) defines a questionnaire as a set of questions designed to generate the data necessary for accomplishing a research project's objectives. Equally important, is to evaluate the questions being asked. This can be achieved by asking the following questions, as described by Orna & Stevens (1995:21).

- Are the questions really necessary in view of the objectives for the particular research study?
- Will the respondents be willing and able to provide adequate information on the subject?
- Do the questions cover the content area for which it was designed?
- What does the research questionnaire seek to find out?
- What limits must be set to the breadth and depth of the particular questions asked?



- What are the potentially useful ways in applying the research questionnaire (methodological options)?

Once these questions have been addressed, the researcher must try and ascertain the type of questions he or she will be using within the limits of the actual research questionnaire. To achieve this aim the following type of questions could be useful, according to Bennett (1997:42).

- Open-ended questions, which require the respondents to provide their own personal opinions and answers to the questions.
- Multiple choice questions, which require the respondent to choose an answer or alternative answer from a list provided within the questionnaire.
- Dichotomous questions which are the opposite from multiple choice questions and which allows the respondent only one or two responses such as “Yes” or “No”.
- A standard five-point Likert-scale, which are used in most questions in order to ensure consistency and which is also easy to complete by the relevant respondent.
- A nominal scale, which is used for questions relating to demographics that, can be completed by the respondent by means of a multiple-choice form.

#### **6.4.2 Measuring instruments**

In measurement, a clear distinction is made between different levels of measurement on the basis of the following four features of the numbers assigned within the research process.

- Distinguishability (the number 2 is different from the number 1).
- Order of rank (2 has a higher rank than 1).
- Equal intervals between successively higher numbers.
- Absolute size.

According to Wellman & Kruger (2000:133) a different level of measuring may be assigned corresponding to each of these four characteristics. Zikmund (2000:276) clearly describes these four categories of measurement scales.

- **Nominal scale**

A scale in which the numbers or letters assigned to objects, serve as labels for identification or classification; a measurement scale of the simplest type.

- **Ordinal scale**

A scale that arranges objects or alternatives according to their magnitudes.

- **Interval scale**

A scale that not only arranges objects according to their magnitudes but also distinguishes this ordered arrangement in units of equal intervals.

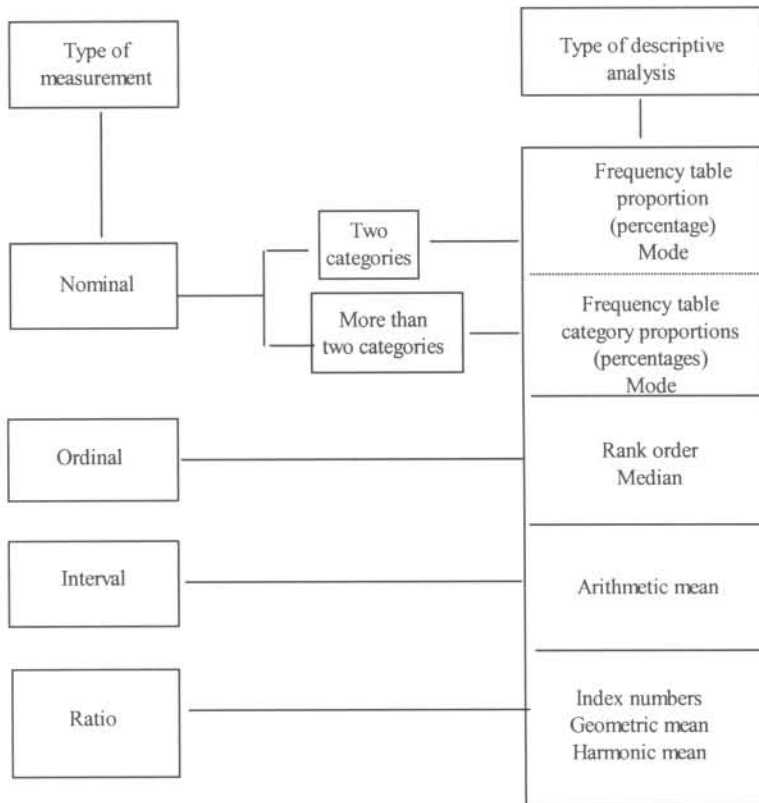
- **Ratio scale**

A scale having absolute rather than relative quantities and possessing absolute zero, where there is an absence of a given attribute.

The following tables clearly illustrate the various scale types used during the application of descriptive statistics.

Tables 6.1 and 6.2 to follow on p.152.

**Table 6.1: Descriptive statistics permissible with different types of measurements**



Source: Zikmund, 2000:437

**Table 6.2: Scale types**

Type of Scale	Numerical Operation	Descriptive Statistics
Nominal	Counting	Frequency in each category Percentage in each category Mode
Ordinal	Rank ordering	Median Range Percentile ranking
Interval	Arithmetic operations on intervals between numbers	Mean Standard deviation Variance
Ratio	Arithmetic operations on actual quantities	Geometric mean Coefficient of variation

Note: All statistics that are appropriate for lower-order scales (nominal is the lowest), are appropriate for higher-order scales (ratio is the highest).

Source: Zikmund, 2000:278

### 6.4.3 Questionnaire testing

The questionnaire was tested by distributing a copy to respondents in different fields in various organisations during a pilot study. Interviews were conducted and respondents were asked to comment on the clarity of the particular questions asked. The result was that the questionnaire was adapted and vague or unclear questions were being excluded from the final questionnaire.

It is, however, important to notice that there is always a chance that some questions could cause problems and as such, questionnaires need to be tested in order to identify and eliminate problems that might occur (Sudman & Blair, 1998:300).

### 6.4.4 Data processing and analysis

The Department of Statistics directly captured the various responses from the relevant research questionnaire at the University of Pretoria. Calculations were made in order for the researcher to check the reliability of data analysed.

After the researcher is sure that the relevant data has been correctly coded and entered, as described by Bennett (1997:44) he/she must then decide on an appropriate computer programme in order to analyse the data obtained. The following programmes can be considered.

- Quattro or Lotus that is particularly useful for specific data analysis programmes such as SAS and BMDP.
- The statistical program for the social sciences or SPSS package.

Finally the primary data were assimilated by means of a statistical software package where the final analysis and cross-tabulations were done.

#### 6.4.5 Editing of data and code frame

The final responsibility of the researcher is to edit his/her own work and check for completeness and accuracy (Orna & Stevens, 1995:177). Although it is legitimate for an editor to complete a missing answer, the researcher must be aware of the fact that such an action could bias the responses of a particular research study.

In the case of this particular study, the editor did not complete incomplete answers, as it could bias the responses of the study. In some cases questionnaires were discarded as unreliable, due to a less than 70 per cent completeness, and were consequently totally ignored.

A code frame was drawn up, where every answer was given a code, in order to simplify the relevant data obtained. Coding refers to the assignment of numbers to answers, so that responses can be grouped into a limited number of classes or categories. In order to simplify the capturing of data every answer was coded (Cooper & Schindler, 1998:381). According to Bennett (1997:43), the following four aspects are important at this stage.

- The editing and encoding process has to be planned properly.
- A preliminary check should be run before data are subjected to final editing and encoding.
- Incorrect answers should be detected, especially if the answers to two or more questions are inconsistent.
- Where possible incomplete answers should be completed.

#### 6.4.6 Data cleaning and transformation

The first step was to calculate out-of-range values for every variable, followed by wild-code checks in order to calculate the minimum and maximum values for each of the research questions. Any particular wild codes were then changed, according to the original response on the questionnaire. Averages for all the questions within the

research questionnaire, were calculated with the aim of highlighting out-of-range values attached to each specific variable (Sudman & Blair, 1998:429).

Once the data have been captured the next step is to transform the raw data into usable variables in the process of analysing information. The process whereby data is transformed into a “List of required information”, forms the essence of the searching and transformation that occur within the research process (Orna & Stevens, 1995:17).

The following transformations were part of this study.

- In order to get all scores for scale items to be in the same direction, particular ratings were reversed for those specific items.
- All scale totals were then transformed to a standardised 100-index (per cent).

## **6.5 DATA: ANALYSIS AND INTERPRETATION**

Once the appropriate research design and suitable means of measuring the relevant variables have been done, the next step was to choose an appropriate statistical procedure to analyse and interpret the data that have been captured. The relevant data must be interpreted, so that results can be obtained against the formulated research problem (hypothesis). The analysis of data is done mainly by means of reliable statistical techniques and methods aimed at investigating variables and their effect, relationships and patterns of intent, within the particular area of study (Wellman & Kruger, 2000:201). For this particular study, data analysis was done through the SAS and SPSS software programmes to produce outputs respectively.

### **6.5.1 Tabulated data**

Data tabulation is the process whereby data are converted into the “List of required information” required by a prior step in the research process. At this stage, the researcher has ample data, but very little information. (Information is “Meaningless” data that have been converted into useful units). The researcher may have many completed questionnaires, but until they are tabulated and analysed it will remain useless (Bennett, 1997:43).

The particular data for this research study was first analysed by means of tabular format. A standard set of tables were produced which included an average response rate for each of the items expressed in terms of a standardised 100-index (per cent). The average response, however, refer to the particular score of each item as expressed in terms of the standardised index.

According to Boyd (1981:407-415), a tabulation plan specifying the precise counts must be obtained and prepared so as to eliminate errors in the raw data. This means, that the researcher must choose between uni-variate and multi-variate tabulations in counting the particular data. The former is a tabulation of a set of responses to one question at a time, and the latter to the tabulation of responses of two or more questions simultaneously (Drew & Hardman, 1998:236-245). In some instances the deviation in the scores of items must be calculated in order to measure certain variations in responses.

Before discussing a few of the statistical methods, it is necessary to distinguish between categorical and continuous variables. Categorical variables are ones that cannot be quantified, or that can be measured only in terms of classes or categories, or that are more conveniently measured in categories than on a continuum (Bennett, 1997:46).

A second form of categorical data can be obtained by employing an ordinal scale. The data obtained are referred to as ordinal-scale responses. Although responses are categorised, the numbers possess the power of rank order. Two summary statistics, the mode and the median, can be used to good effect in interpreting ordinal scale responses (Zikmund, 2000:284).

Continuous variables, on the other hand, are ones that can be quantified or measured on a continuum rather than in a class or category. A respondent's age, height and number of children are examples here. Two types of response categories fall into this group, namely interval-scaled responses and ratio-scaled responses. All summary statistics, namely the mode, median and mean and the standard deviation, can be used to good effect in the case of interval-scaled responses.

The difference between interval-scaled responses and ratio responses, lie in the fact that, despite the fact that the values or units of measurement in the interval scale remain constant throughout, its starting point or zero point, is arbitrary. An interval scale, therefore, may start with zero (0) or one (1), with the result that different interval-scale responses cannot be meaningfully compared or interpreted. The ratio-scaled response, however, has an inherent, unambiguous starting point. The starting point of such scales will always be equal to absolute zero.

The above-mentioned classification should be kept in mind when selecting statistical procedures to analyse data, since some methods can be used only when the data is categorical, whilst in other cases the data has to be of a continuous nature (Parasuraman, 1991:407-447).

## **6.5.2 Chi-square analysis and analysis of variance**

Data that are tabulated in column or row forms and that are representative of different categories, can significantly differ from one another. Differences attributed to sampling variations can make use of the following two techniques.

### **6.5.2.1 Chi-square analysis**

The object of Chi-square analysis is to determine whether the differences observed between two sets of data are attributable to sampling variation or not. In order to employ this method, the following four conditions must be met.

- There must be two observed (collected) sets of sample data or one set of observed sample data and one hypothetical set of data. Typically, these data are arranged in columns and rows, or in frequency distribution form.
- The two sets of data must be based on the same sample size.
- Each cell in the data must contain an observed or hypothetical count (not percentage) of five or larger (refer Chapter 7).



- The different cells in a row or column may represent either categorical variable or continuous variable data that have been put into classes or categories (Boyd, et al, 1981:432).

Applying this method, involves the following.

- Calculating a statistic (called the Chi-square statistic) that summarises the difference between the two sets of data.
- Determining the degrees of freedom associated with the data set.
- Using these two values and a table of the Chi-square distribution so as to determine whether the calculated Chi-square statistic falls within the range which may easily have occurred by chance, as a result of sampling variation (Boyd, Westfall & Stasch, 1981:432-438).

The logic inherent in the  $\chi^2$  test allows us to compare the observed frequencies ( $O_i$ ) with the expected frequencies ( $E_i$ ) based on the theoretical ideas about the population distribution or the presupposed proportions. In other words, the technique tests whether or not the data come from a certain probability distribution. It tests the “goodness of fit” of the observed distribution with the expected distribution.

Calculation of the chi-square statistic allows us to determine if the difference between the observed frequency distribution and the expected frequency distribution can be attributed to sampling variation. The steps in the process are the following

- Formulate the null hypothesis and determine the expected frequency of each answer.
- Determine the appropriate significance level.
- Calculate the  $\chi^2$  value, using the observed frequencies from the sample and expected frequencies.
- Make the statistical decision by comparing the calculated  $\chi^2$  value with the critical  $\chi^2$  value.

After the chi-square test has been determined appropriately at the .05 level of significance (or some other probability level), the chi-square statistic may be calculated (Zikmund, 2000:471).

To calculate the chi-square statistic, the following formula is used:

$$\chi^2 = \sum \frac{(O_i - E_i)^2}{E_i}$$

where

- $\chi^2$  = chi-square statistic
- $O_i$  = observed frequency in the  $i$ th cell
- $E_i$  = expected frequency in the  $i$ th cell

The sum-squared differences are, therefore:

$$\chi^2 = \frac{(O_1 - E_1)^2}{E_1} + \frac{(O_2 - E_2)^2}{E_2}$$

Like many other probability distributions, the  $\chi^2$  distribution is not a single probability curve but a family of curves. These curves, although similar, vary according to the number of degrees of freedom ( $k - 1$ ). Thus we must calculate the number of degrees of freedom.

### 6.5.2.2 *Analysis of Variance*

The major difference between Chi-square analysis and Analysis of Variance is that the latter is used to establish the significance of differences within a single set of data, rather than between two sets of data. This technique is most commonly employed with a set of categorical data collected in an experimental setting (Boyd, Westfall & Stasch, 1981:440-450).

### 6.5.3 **Cross-tabulation, correlation and regression**

The statistical procedures already discussed above, determine whether observed differences are significant, but they do not explain why these differences occur. To establish this cross-tabulation, correlation and regression were applied within the

boundaries of this study. The use methods assume three things, according to Bennett (1997:48).

- The data to be analysed, are obtained from descriptive studies.
- The data are from representative samples.
- The data include measures on a number of variables for each respondent.

#### **6.5.3.1      *Cross-tabulation***

Cross-tabulation is a method, which can be used when both the dependent and the independent variables are categorical. The following serves as an example.

Whenever a researcher wants to determine why respondents exhibit different behaviour from other, a number of independent variables could be selected that could influence the behaviour of respondents, and then these are cross-tabulated with the dependent variables (for example average consumption of a product). From this, the researcher would be able to establish whether the independent variable has an effect on the dependent variable (Parasuraman, 1991:407-447).

One of the major drawbacks of cross-tabulation, is that the results must be evaluated subjectively by the researcher. Some researchers employ correlation and regression analysis in order to overcome this problem, provided they have ordinal data at their disposal (Boyd, et al., 1981:456-462).

#### **6.5.3.2      *Correlation and regression***

Correlation and regression analyses were also used during this study and typically refers to:

- data recorded as continuous variables (ordinal data),
- more than one variable being measured for each respondent, and
- the number of respondents being greater than the number of variables.

### *Example*

When the researcher has two or more sets of variables and he or she wants to determine whether there is a relationship between, for example, income and wine consumption, he could use correlation analysis. It is accepted that there is a positive relationship between the variables of higher levels of wine consumption as associated with higher income. (In other words, the more money people earn, the more wine they drink).

When correlation analysis fails to describe the relationship between two variables, clearly the researcher may resort to regression analysis. Correlation analysis may point to a positive relationship between two sets of data, but it does not describe the effect changing the independent variable will have on the dependent variable (Boyd, et al., 1981:468-482).

#### **6.5.4 Interdependencies: cluster analysis, factor analysis and Alpha factor analysis**

One major difference between the methods discussed up to now and that of both cluster analysis and factor analysis is that the latter methods do not treat some of the variables as being independent and others as being dependent. Instead, they attempt to identify interdependencies among a number of variables without treating any of them as being dependent or independent.

In contrast with the previous mentioned methods, alpha factor analyses are used for both binary-type and large-scale data. Cronbach's Alpha coefficient is, therefore, a measure of correlation between observed scores and true scores to allow researchers to determine whether variables derived from test instruments, are reliable or not.

##### **6.5.4.1 Cluster analysis**

Cluster analysis is primarily used in market segmentation studies. This method identifies different groups (or clusters) of respondents. Respondents in any one

cluster would thus be similar, while those who fell in different clusters, would be different from that of another cluster. This analysis searches through all the data and identifies respondents who have given identical or very similar answers to a certain combination of questions (Bennett, 1997:52).

Cluster analysis is normally used on data, which have been recorded on scales, such as a 5-point or 7-point scale, although it could also be used on continuous variable data and categorical variable data.

As part of the most important research techniques applied within this particular study, extensive attention will now be given to factor analysis, as well as to Cronbach's Alpha coefficient as part of a diverse number of techniques used to discern the underlying dimensions of regularity in phenomena.

#### **6.5.4.2        *Factor analysis***

The general purpose of factor analysis, is to summarise the information contained in a large number of variables into a smaller number of factors.

If a researcher has a set of variables and suspects that these variables are interrelated in a complex fashion, then factor analysis may be used to untangle the linear relationships into separate patterns. The statistical purpose of factor analysis is to determine linear combinations of variables that aid in investigating the interrelationships. The researcher, however, may want to reduce the large number of variables to certain underlying constructs or dimensions that will summarise the important information contained in the variables. The purpose is thus, to discover the basic structure of a domain and to add substantive interpretation to the underlying dimensions. Factor analysis could accomplish this by combining these questions in order to create new, more abstract variables called factors. In general, the goal of factor analysis is to reduce a large number of variables to as few dimensions or constructs as possible (Zikmund, 2000:544).

Factor analysis, therefore, examines the relationship of exact or large series of variables with every other one so as to determine which are highly correlated with other ones. The process ends with a reduced number of alternative variables. Factor analysis thus calculates a series of factors that are a confirmation of the alternative variables being analysed. Factor analysis can also be used to reduce a large number of variables to a few interpretable dimensions (Blankenship & Breen, 1993:226).

The next step is to analyse the various factor loadings; a factor loading refers to the set of the correlation of the original variable with the factor. Each factor loading is, therefore, a measure of importance of a variable in measuring a particular factor, a means of interpreting and labelling each factor (Zikmund, 2000:545).

In addition to factor loading, the total variance of variables (factors) must be explained. Severe factor loading can be very helpful in this regard and indicate what percentage of the variance in an original variable is explained by a factor (Sudman & Blair, 1998:547).

The result is, therefore, that factor analysis procedures also apply factor scores that represent each observation's calculated value or score on each of the factors. The factor score will represent an individual's combined response to the several variables representing the factor. The factor scores may be used in subsequent analyses. When the factors are to represent a new set of variables that may predict or will be dependent on some phenomenon, the new input may be factor scores.

In addition to reducing a large number of variables to a manageable number of co-linearity dimensions, factor analysis may also reduce the problem of multi-co-linearity in multiple regression. If several independent variables are highly correlated, a factor analysis as a preliminary step prior to regression analysis and the use of factor scores, may reduce the problem of having several inter-correlated independent variables, as already mentioned. Thus factor analysis may be utilised to meet the statistical assumptions of various models (Zikmund, 2000:346).

By applying factor analysis, the researcher may also wish to know how much a variable has in common with all other factors. Communality is a measure of the percentage of variable's variation that is explained by the factors. A relatively high communality indicates, that a variable has much in common with the other variables taken as a group (Zikmund, 2000:547).

The question now arises, "How many factors will be in the problem's solution?" This question requires a complex answer. It is complex, because there can be more than one possible solution to any factor analysis problem, depending on factor rotation. The term rotation is important in factor analysis and it should receive some attention. Solutions to factor analysis problems may be portrayed by geometrically plotting the values of each variable for all respondents or observations made. Geometric axes may be drawn to represent each fact. New solutions are represented geometrically, by rotation of these axes. For example, in a scatter plot, the regression line is represented as the original X-axis rotated, so that it approximates the regression line. This type of rotation is known as variance (variability) of the new factor (variable). Therefore, a new solution with fewer or more factors is called a rotation (Cooley & Lohnes, 2001:3).

Other terminology closely inter-linked with factor analysis is a number of universal terms, such as the following.

- *Eigen values*

These equal the sum total of the squares loading for the variables on a factor, provided that a measure of the percentage of variance is contributing variables that are explained by the factor.

Eigen values can be found for square symmetric matrices. There are as many Eigen values as there are rows (or columns) in the matrix. A realistic description of an Eigen value demands a sound knowledge of linear algebra. However, conceptually they can be considered to measure the strength

(relative length) of an axis (derived from the square symmetric matrix). Eigen values are also known as Latent Variables (Zikmund, 2000:347).

**Rotated matrix**

This matrix represents the relationship between the original  $p$ -variables and the  $k$ -orthogonal linear combinations of these variables, the canonical variates or factors. The latter are only unique up to a rotation in the  $k$ -dimensional space they define. A rotation can then be found that simplifies the structure of the matrix of loadings, and hence the relationship between the original and the derived variables. That is, the elements,  $\lambda^*_{ij}$ , of the rotated matrix,  $\hat{\Lambda}^*$ , are either relatively large or small. The rotations may be found by minimising the criterion:

$$V = \sum_{j=1}^k \sum_{i=1}^p (\lambda^*_{ij})^{4-\gamma} - \sum_{j=1}^k [\sum_{i=1}^p (\lambda^*_{ij})^2]^\gamma$$

where the constant  $\gamma$  gives a family of rotations with  $\gamma = 1$  giving varimax rotations and  $\gamma = 0$  giving quartimax rotations.

It is generally advised that factor loadings should be standardised, so that the sum of squared elements for each row is one, before computing the rotations.

The matrix of rotations,  $R$ , such that  $\hat{\Lambda}^* = \hat{\Lambda}R$ , is computed by using first an algorithm, which involves the pairwise rotation of the factors. Then using a similar method makes a final refinement, but instead of the Eigen value decomposition, the algorithm has been adapted to incorporate singular value decomposition (Sudman & Blair, 1998:548).



- ***Orthogonal matrix***

A square matrix  $\mathbf{A}$  (of real elements) is said to be orthogonal if and only if

$$\mathbf{A}^{-1} = \mathbf{A}'.$$

From this definition, it follows that an orthogonal matrix has the property  $\mathbf{A}'\mathbf{A} = \mathbf{I}$  and that the determinant of an orthogonal matrix is plus or minus one. Also, the inverse (as well as the transpose) of an orthogonal matrix is itself an orthogonal matrix (Bennett, 1997:54).

The researcher, however, must be aware of blindly using statistical procedures before understanding the full implications of the various options and the assumptions they are based on. The desire is to attempt to fit the technique to the problem and not the other way around.

Factor analysis, therefore, calculates a series of factors that are a weighed combination of the variables being analysed. These combinations can be expressed by applying the following formula -

$$F = w_1x_1 + w_2x_2 \dots + w_kx_k$$

where  $F$  is the factor  $x_1$  through  $x_k$  are the variables being analysed, and  $w_1$  through  $w_k$  weights applied to those variables: the weights for each factor and the various contributing variables, subject to a constraint that each factor is uncorrelated to all preceding factors (Zikmund, 2000:538).

The purpose of factor analytic techniques is firstly to reduce the number of variables and secondly, to detect structure in the relationship between variables. Therefore, factor analysis is applied as a data reduction or structure detection method (Zikmund, 2000:544).

#### 6.5.4.3 *Alpha Factor Analysis (Cronbach's Alpha)*

The point of departure for the method of Alpha Factor analysis, as stated by its developers (Kaiser & Caffrey, 1965), (“... is that common factors (in a sample of tests) are to be determined which have maximum correlation with corresponding universe common factors”. A set of factors satisfies this principle if each of them has maximum generalisability. The concept of generaliability has been studied by many researchers and can be traced back to Kuder-Richardson or the KR-20 formula of reliability for sum scales. In either case, the purpose is to check for the internal consistency within a single test (Cooley & Lohnes, 2001:23).

What is Cronbach Alpha? The Cronbach Alpha coefficient is a measure of squared correlation between observed scores and true scores. Put another way, reliability is measured in terms of the ratio of true score variance to observed score variance. The theory behind it, is that the observed score is equal to the true score, plus the measurement error ( $Y = T + E$ ). For example, if I know 80 per cent of the materials but the score is 85 per cent because of lucky guessing, then the observed score is 85 while the true score is 80. The additional 5 points are due to the measurement error. A reliable test should minimise the measurement error so that the error is not highly correlated with the true score. On the other hand, the relationship between true score and observed score should be strong. Therefore, the reliability comes to the forefront when variables developed from summated scales are used as predictor components in objective models. Since summated scales are an assembly of interrelated items designed to measure underlying constructs, it is very important to know whether the same set of items would elicit the same responses if the same questions are recast and re-administered to the same respondents. Variables derived from test instruments are declared to be reliable only when they provide stable and reliable responses over a repeated administration of the test ([http://www.joe.org/joe\\_1999\\_April/tt3.html](http://www.joe.org/joe_1999_April/tt3.html)).

Computation of Alpha is based on the reliability of a test relative to other tests with the same number of items, and therefore measuring the same construct of interest (Cooley & Lohnes, 2001:3).

For the purpose of this research study, either SAS or SPSS can perform this analysis effectively. SAS is a better choice due to its better detail. The SAS syntax to run Cronbach Alpha is as follows.

Data one;

    Input post\_em1\_post\_em5;

Cards;

1 1 1 0 0 1

1 0 1 1 1 0

1 1 1 1 1 1

0 0 0 1 1 1

0 1 0 0 1 0

    proc corr alpha nocorr nomiss; var post\_em1\_post\_em5; run;

In this example, the “nocorr” option suppresses the item correlation information. Although the correlation matrix can be used to examine whether particular items are negatively correlated with others, a more efficient way, is to check the table entitled “if items are deleted;K”. This table tells you whether particular items are negatively correlated with the total and thus it is recommended to suppress the correlation matrix from the output (<http://www.ats.ulca.edu/stat/spss/faq/alpha.html>).

It is important to include the “nomiss” option in the procedure statement. If the tester has not answered several questions, Cronbach Alpha will not be computed. In surveys, it is not unusual for respondents to skip questions that they don’t want to answer. Also, if you use a scanning device to record responses, the scanner may not detect slight pencil marks. In both cases, you will have “holes” in your data set and the Cronbach Alpha procedure will be halted. To prevent this problem from happening, the “nomiss” option tells SAS to ignore cases that have missing values.

However, in the preceding approach, even if the tester skips one question, his entire test will be ignored by SAS. In a speeded test where testers may not be able to complete all items, the use of “nomiss” will lead to some loss of information. One way to overcome this problem, is to set a criterion for a valid test response. It is

assumed, that 80 per cent of test items must be answered in order to be included into the analysis. The following SAS code should be implemented:

```
Data one; infile "c:\data";
    Input x1-x5;
    If nomiss (of x1-x5) > 1 then delete;
    Array x {1} x1-x5;
        Do I=1 to 5;
            If X(I) =. Then X (I) = 0;
        Proc corr alpha nomiss; var x1-x5; run;
```

In this preceding SAS code, if a record has more than one unanswered question (80 per cent), the record will be deleted. In the remaining records, the missing values will be replaced by a zero and thus these records will be counted into the analysis (<http://www.joe.org/joe> 1999 April/tt3.html).

It is acceptable to count missing responses of a test as wrong answers and assign a value of “zero” to them. It is not appropriate to do so if the instrument is a survey such as an attitude scale. One of the popular approaches for dealing with missing data in surveys, is the Mean Replacement Method (Afifi \* mp; Elashoff, 1966), in which means are used to replace missing data. The SAS source code for the replacement is the same as the preceding one, except for the following line.

```
If X (I) =. Then X (I) = mean (of x1-x5);
```

Cronbach Alpha can also be used with both binary-type and large-scale data. On the other hand, KR can be applied to dichotomously scored data only. For example, if your test questions are multiple choices or true/false, the responses must be binary in nature (either right or wrong). If your test is composed of essay-type questions and each question is worth 10 points, then the scale is ranged from 0 to 10.

To interpret the SAS output, the mean output as shown, tells the tester how difficult the items are. In this case the answer is either right (1) or wrong (0). The mean

ranging from 0 to 1. 0.9, indicates that the question is fairly easy and thus 90 per cent of the testers have scored it. It is a common mistake that people look at each item individually and throw out the item that appears to be too difficult or too easy. Actually the entire test should be taken into consideration.

The Cronbach Alpha procedure involves two coefficients.

- *Raw*

It is based upon item correlation. The stronger the items are interrelated, the more likely it is the test is consistent.

- *Standardised*

It is based upon item co-variance. Variance is a measure of how a distribution of a single variable (item) spreads out. Co-variance is a measure of the distributions of two variables. The higher the correlation coefficient is the higher the co-variance.

Some researchers mistakenly believe that the standardised Alpha is superior to the raw Alpha because they assume that standardisation normalises skewed data. Actually standardisation is a linear transformation, and thus it never normalises data. Standardised Alpha is not superior to its raw counterpart. It is used when scales are comparable, because as mentioned before, variance and co-variance are taken into account for computation (<http://www.joe.org/joe> 1999 April/tt3.html).

In order to determine whether the entire test is consistent, Cronbach Alpha computation examines the co-variance matrix – all possible pairs, to draw a conclusion. Not all the information is usable. Users of Cronbach's Alpha have often wondered whether the liability that they obtained, is both good and representative.

However, the higher the Alpha is, the more reliable the test is. There isn't a generally agreed cut-off. Usually 0.7 and above is acceptable (Nunnally, 1978). It is a common

misconception that if the Alpha is low, it must be a bad test. The test may measure several attributes/dimensions rather than one and thus the Cronbach Alpha is deflated. For example, it is expected that the scores of GRE-Verbal, GRE-Quantitative, and GRE-Analytical may not be highly correlated because they evaluate different types of knowledge.

If the test is not internally consistent, the researcher may want to perform factor analysis to combine items into a few factors, as already discussed.

The formula for calculating Cronbach's Alpha ( $\alpha$ ) is,

$$\alpha = (k / k - 1) * [1 - \sum (S_i^2) / S_{sum}^2]$$

where:

$S_i^2$  = the variance for the k individual items; and

$S_{sum}^2$  = the variance for the sum of all items.

If there is no true score but only error in the items (which is esoteric and unique, and therefore, uncorrelated across subjects), then the variance of the sum will be the same as the sum of variance of the individual items (<http://www.statsoft.com/textbook/stathome.html>).

Therefore, coefficient Alpha will be equal to zero. If all items are perfectly reliable and measure the same thing (true score), then coefficient Alpha is equal to (1), as already mentioned. (Specifically,  $1 - \sum (S_i^2) / S_{sum}^2$  will be equal to  $(k-1)/k$ ; if multiplied this by  $k/(k-1)$  the answer = 1).

## 6.6 VALIDITY AND RELIABILITY

Researchers often neglect to refer to any possible shortcomings and negative aspects related to the research results in question. Reliability and validity are major contributing factors for any research data especially in the case of this study for it to be useful and is, therefore, a necessity to prove the reliability and validity of the

particular study in question. It is also important that any given measuring instrument must measure the following components.

- The construct intended.
- Irrelevant construct.
- Random measurement errors (Fink, 1998:110).

### 6.6.1 Validity of measures used

According to Cooper & Schindler (1998:148), validity addresses the problem of whether a measure (for example, an attitude measure) measures what it is supposed to measure. Validity therefore, refers to the measuring instruments applied, and that these measuring instruments are valid only to the extent that it measures what it is intended to measure.

The following types of validity can be identified, according to Locke, Silverman & Spirduso (1998:117):

#### - *Internal validity*

It is concerned with whether the research has been designed so that it truly deals with what is being examined. For example, can the data collected, actually be used to answer the questions being asked?

#### - *External validity*

This issue is concerned with the external question of whether or not the results will remain truthful when subsequently applied to people, situations or objects outside the scope of the original investigation.

For the purpose of this study, attention will now be given to the nature of both the important aspects relating to the concept validity.

### 6.6.2 Internal – versus external validity

The most common circumstance, in which external validity becomes an issue, occurs when one group of people is examined in a particular study, but the results and conclusions are applied to another group. What is true for the particular sample of people in the study, simply may not be valid for (may not tell the truth about) another group of people – particularly if that group differ in some substantial way.

Medical research commonly presents such problems of external validity. Because studies of this kind are so expensive and consume so much precious time, it can be tempting to extend hard-won knowledge about medicines or medical procedure to people not included in the samples of earlier investigations. It also can be unfair, misleading, wasteful, or dangerous (Locke, Silverman & Sipuro, 1998:117-121).

In contrast, internal validity is not concerned with generalisability as already mentioned, but with the integrity of the study itself. These issues range from simple and perfectly obvious to arcane and exceedingly obscure, but in the end, they all have to do with whether the study has been designed to yield truthful results.

According to Campbell and Stanley (1983) “instrumentation” of a study, presents some of the most common problems of internal validity. Data collection takes a variety of forms, including machines that use computer programmes to direct the monitoring of biological processes, survey forms filled out by door-to-door interviewers, psychological tests completed by subjects, field notes from investigators watching children on a playground, and systematic examination of cultural phenomena through the recording of words used in books, television, or movies: all very different methodologies, but all subject to the same question, “Do these data provide a truthful reflection of what the study is intended to examine?”

Nevertheless, the problems of internal and external validity are ubiquitous and must be confronted by researchers in study formats as disparate as questionnaire surveys and field ethnographies (Locke, Silverman & Spirduso, 1998:117-121).



6.6.2.1 *Other forms of validity applicable*

According to Zikmund (2000:282), validity can also include the following types of validity.

- *Construct validity*

Construct validity is established by the degree to which the measure confirms a network of related hypotheses generated from a theory based on the concepts. Establishing construct validity occurs during the statistical analysis of the data. In construct validity, the empirical evidence is consistent with the theoretical logic about the concepts. In its simplest form, if the measure behaves the way it is supposed to, in a pattern of inter-correlation with a variety of other variables, there is evidence for construct validity. To achieve construct validity, the researcher must have already determined the meaning of the measure by establishing what basic researchers call “convergent validity” and “discriminant validity”.

- *Criterion-related validity*

With criterion validity, the criterion may be a construct that one would logically expect to be associated with the new measure. Thus, to establish validity, the new measure should “converge” with other similar measures. A measure of a theoretical concept has convergent validity when it is highly correlated with different measures of similar constructs.

- *Discriminant validity*

A measure has discriminant validity when it has a low correlation with measures of dissimilar concepts. This is a complex method of establishing validity and of less concern to the applied researcher than to the basic researcher.

- ***Concurrent validity***

Concurrent validity refers to a classification of criterion validity, whereby a new measure correlates with a criterion measure taken at the same time.

- ***Predictive validity***

Predictive validity refers to a classification of criterion validity whereby a new measure predicts a future event or correlates with a criterion measure administered at a later time.

- ***Content validity***

Content validity refers to the subjective agreement among professionals that a scale logically appears to reflect accurately what it purports to measure. The content of the scale appears to be adequate. When it appears evident to experts that the measure provides adequate coverage of the concept, a measure has face validity.

- ***Face validity***

Face validity refers to professional agreement that a scale logically appears to be accurately reflecting what was intended to be measured.

### **6.6.3 Reliability of measures used**

Trochim (1997:2) defines reliability as the extent to which the measurement process is free from random error and that it is concerned with consistency, accuracy and predictability of the actual research findings. It is also important to distinguish between (at least) three irrelevant sources of systematic variations with the context of measurement, namely:

- measurement occasion
- measurement form, and
- measurement user.

Wellman & Kruger (2000:142:145), distinguish between the following types of reliability used within the research process.

- ***Test-retest reliability***

Test-retest reliability refers to the degree to which a measurement/test is immune to a particular measurement/test occasion on which it is administered, so that scores obtained on one occasion, may be generalised to those which could potentially have been obtained on other comparable occasions. It also refers to the consistency of repeated measures of the same theoretical concept over a period of time and the correlation between those measures.

- ***Internal consistency***

Internal consistency implies a high degree of generalisability across the item within the measurement/test. It also refers to two or more measures of the same theoretical concept obtained at the same point in time and the agreement between the measures ascertained.

- ***Parallel-form reliability***

Parallel-form reliability of a measurement/test is determined by the interchangeable versions of a particular measurement/test, which have been compiled to measure the same construct and quality well, but by means of different content. This could also be measured by administering both forms that are measured and getting the desired correlation between the two forms.

- *Interrater or inter-coder reliability*

Interrater or inter-coder reliability refers to the unreliability due to accidental, inconsistent behaviour on the part of the individual administering or scoring the measurement/test. In such cases, the frequency is found that a particular tester consistently marks either too strictly or too leniently. Interrater reliability is, however, appropriate when the measure is a continuous one in which case the correlation can be calculated between various ratings of the two concepts observed.

#### **6.6.4 The importance of validity and reliability for research**

It is clear, that the researcher must establish ways of collecting data that are both valid and reliable (Martins, Loubser & Van Wyk, 1996:104).

In many cases, instruments for collecting data can be checked for validity and reliability before they are actually put to use in a study. This is true, for example, of written tests, electronic and mechanical hardware, and rating scales. Often, reports contain descriptions of such verification, including figures that display precisely how close the research tools come to theoretically perfect validity and reliability.

However, validity and reliability remain elusive qualities, and few studies are designed in ways that resolve all possible threats to consistent truth. The reader of a research report has the right to expect that researchers have shown awareness of such issues, report what they have done to control the problems, and their success in doing so (Orna & Stevens, 1995:174).

The researcher must however, remember that standards for validity and reliability cannot be applied as simple absolutes. Given the complex nature of many research questions, reviewers often must ask, “How much lack of confidence in the consistent truthfulness of this study is tolerable?” The answer will be determined by many factors, but everyone – reviewers, editors, researchers, and readers – knows what is

ideal. The research should come as close to producing reliably valid results as human skill and effort can devise (Orna & Stevens, 1995:176).

## 6.7 CONCLUSION

In this chapter only a few methods and techniques have been discussed in order to create scientifically obtained knowledge by using objective methods and procedures. However, research involves different methods for different studies because they have different aims. In this particular study, relevant and applicable methods and research techniques were used in order to investigate and test the research problem and objectives by means of tough methodological investigation techniques.

The universum was identified, from which a suitable sample frame was derived. The next step was to draw up a preliminary questionnaire in order to finalise the research questionnaire. The relevant data were captured by means of statistical programmes, edited, coded and finally analysed. The various methods, techniques and steps used, were clearly discussed within the scope of this particular chapter. Various tests were also applied in order to determine the viability and reliability of the research questionnaire and final results of the study.

During the research study, both a preliminary and a final questionnaire were drawn up, tested and distributed to approximately 80 respondents, of which 53 respondents successfully replied. This means, that a 66,25 per cent success rate was achieved. The relevant data were then captured on computer, edited, coded and finally analysed and interpreted.

In the next chapter the empirical findings of this particular research study will be discussed in detail.

## CHAPTER 7

### RESEARCH FINDINGS

#### 7.1 INTRODUCTION

A theoretical perspective, the impact of HIV/AIDS, as well as the threat that HIV/AIDS have on the South African business sector, were clearly discussed within the scope of Chapter 2 and 3. The data for this particular study have been obtained from the research questionnaires that were distributed to various HR-managers and practitioners, as well as to medical officers, occupational health nurses and EAP advisors within the various organisations under investigation.

The first part of this particular chapter deals with the research findings in respect of all the general information, as well as specific issues related to HIV/AIDS within the work environment of organisations under investigation (Section A and B of the questionnaire). In the second part of this chapter, all relevant statements concerning the evaluation of action programmes, policies and strategies (Section C of the questionnaire) are being reported and results on the reliability presented. Some cross tabulations were also conveyed as part of the overall interpretation and presentation of the research results in question. All relevant results of the empirical findings towards this chapter are provided in tabular format as to make understanding and the interpreting of results easier and more understandable. Also important is the fact that all relevant abbreviations used within the descriptive literature and tables provide within the scope of Chapter 7, are explained within Chapter 1 under the heading acronyms.

## 7.2 GENERAL INFORMATION ON THE ORGANISATIONS THAT RESPONDED

Section A of the questionnaire relates to the general information and refers to the following.

- Respondent's position within the organisation.
- Primary end-product or service rendered.
- Number of permanent employees.
- Location of organisations within the area of study.

Each of these aspects will now receive some attention.

### 7.2.1 Respondents position

**Table 7.1: Respondent's position within the organisation**

Position	Frequency (n)	Percentage (%)
HR-Manager	16	30,19
HR-Officer	15	28,30
Medical Officer	7	13,21
Occupational Health Nurse	5	9,43
EAP Advisor	2	3,77
Other	8	15,10
<b>TOTAL</b>	<b>53</b>	<b>100,00</b>

According to Table 7.1, the majority of respondents were HR-managers and HR-officers responsible for policy formulation, representing 30,19 per cent and 28,30 per cent respectively. Implementation, however, is seen as the collective responsibility of both medical officers and occupational health nurses who are almost equally representatives of one another, representing 13,21 per cent and 9,43 per cent of the total response rate to this particular question. Others include SHE- and other officers who also play an important role in the effective management and control of

HIV/AIDS in the workplace, representing 15,10 per cent; while in the case of EAP advisors, who are not always representatives in all organisations, are therefore, marginally representative (3,77 per cent) in this case. It is clear that HR-officials, together with health care officials, play an important and vital role to ensure that HIV/AIDS are successfully and effectively managed and properly controlled within the working environment of organisations.

### 7.2.2 End product or service rendered

**Table 7.2: Primary end product or services rendered**

Product or Service	Frequency (n)	Percentage (%)
Chemical/Pharmaceutical	10	18,86
Manufacturing	23	43,39
Petroleum	4	7,55
Utilities	4	7,55
Mining	4	7,55
Construction	1	1,89
Other	7	13,21
<b>TOTAL</b>	<b>53</b>	<b>100,00</b>

The following table (Table 7.3) clearly indicates that more than 40,00 per cent (43,39 per cent) of the primary end-product or services are representative of the manufacturing sectors alone, followed by the chemical/pharmaceutical sector with a total response of 18,86 per cent, while the petroleum, utilities and mining sectors are more or less equally representative of one another, representing 7,55 per cent each of the total response rate. Others include various organisations that could not be clearly classified under the above categories but that were also representative of the economic sector within the particular area of study.

It is important to note that all the above sectors play an important role within the local economy of the area under study, although some sectors are only marginally representative.



### 7.2.3 Number of permanent employees

According to Table 7.3, the number of permanent employees that are the most prominent within the organisations under investigation, were between 500 and 1 000 employees that represented just more than 40 per cent (43,40 per cent) of the total respondents (organisations) employees. The second highest number of employees were between 1 000 – 1 500 respectively that represented 20,75 per cent of the total respondents, while the rest of the number of permanent employees are more or less evenly representative between the various levels of: 1 500 – 2 000 (9,43 per cent), 2 000-2 500 (7,55 per cent), 2 500 – 3 000 (11,32 per cent) and 3 000 or more (7,55 per cent). It is very interesting to note, that almost 8 per cent (7,55) of the total number of organisations that responded, had a permanent worker force of more than 3 000 employees per organisation. It is, however, a very important factor within the boundaries and nature of this particular research study. The intention was to identify organisations with a large number of employees, in order to allow the researcher to determine what the effect and implications will be of the HIV/AIDS epidemic on organisational resources, especially on human resources and the effective management and control thereof.

**Table 7.3: Number of permanent employees within the organisation**

Number of employees	Frequency (n)	Percentage (%)
500 – 1 000	23	43,40
1 000 – 1 500	11	20,75
1 500 – 2 000	5	9,43
2 000 – 2 500	4	7,55
2 500 – 3 000	6	11,32
More than 3 000	4	7,55
<b>TOTAL</b>	<b>53</b>	<b>100,00</b>

#### 7.2.4 Location of organisations

**Table 7.4: Location of organisations within the area of study**

Location of Organisations	Frequency (n)	Percentage (%)
Vereeniging	12	22,64
Vanderbijlpark	15	28,30
Sasolburg	16	30,19
Meyerton	9	16,98
Carltonville	1	1,89
<b>TOTAL</b>	<b>53</b>	<b>100,00</b>

Table 7.4 illustrates the various locations of the different organisations under investigation and clearly indicates that these organisations are almost evenly distributed within the area of study. Vereeniging (22,64 per cent), Vanderbijlpark (28,30 per cent) and Sasolburg (30,19 per cent), were representative of the entire major and majority of industrial organisations within the area of study, while the opposite is evident in respect of Meyerton (16,98 per cent) and Carltonville (1,89 per cent). There can be different reasons for this, but the most obvious reasons in the case of Meyerton is, that industries are largely scattered (decentralised) and are normally insignificant (number of employees) to the nature of this particular study, while Carltonville has a very low response rate, due to its location (West Rand) and scope of industry (mining). Another important factor is, that Carltonville is actually part of the Greater Johannesburg Metropolitan area and does not play a major and significant role within the direct economic activities of the Vaal Triangle region as such. It is, however, important to at least include Carltonville, due to the inputs of information than can be obtained.

### 7.3 SPECIFIC ISSUES RELATED TO HIV/AIDS WITHIN THE WORK-PLACE

The purpose of this particular section of the questionnaires (Section B), was to determine and identify the following important aspects.

- What type of policy, action programmes (plans) and strategies were currently in use (operation) within the working environment (if any): questions 5 and 6.
- To determine (if possible) how many employees are HIV-positive (infected or may be infected): question 7.
- Does AIDS actually form part of the overall business strategy or policies concerning life-threatening diseases (that includes benefits and other plans to accommodate workers with HIV/AIDS): questions 8 and 9.
- What is the actual impact (effect) of HIV/AIDS on the organisation: question 10.
- What kind of discriminating practises or human rights violations are evident within the working environment regarding workers who are HIV-positive (if any): question 11.
- What is the organisation doing right with regard to the effective management and control of HIV/AIDS: question 12.
- What is the organisation doing wrong with regard to effective management and control of HIV/AIDS: question 13.

These are all important issues for the organisation and need to be discussed clearly and as openly as possible, so that a good idea and clear understanding of the impact that organisations face with regard to HIV/AIDS could be made and addressed. The aim, of this research study, therefore, is to investigate the various impacts that HIV/AIDS have in the workplace of organisations and to investigate and analyse action plans and strategies currently in operation or that can be implemented by the organisation to effectively manage and control the disease properly (if any).

These aspects are -

## 7.3.1 Type of action programme, policy or strategy currently in use

**Table 7.5: Formal or informal action programmes, policy or strategy**

Category	Frequency (n)	Percentage (%)
Formal	33	62,26
Informal	16	30,19
Don't know	4	7,55
<b>TOTAL</b>	<b>53</b>	<b>100,00</b>

The above table clearly indicates that almost two-thirds of the total respondents (62,26 per cent) do have a formal HIV/AIDS action plan, policy or strategy, while almost a third (30,19 per cent) of the total respondents indicated that they have an informal action plan, policy or strategy of some sort in place. Equally important is, that almost 8 per cent (7,55) of the total respondents indicated that they do not have any (formal or informal) form of action programmes, plans or strategies currently in place. This raises a very important issue: Although most of the respondents have some sort of plan, policy, programmes or strategy in place, are these plans, policies or strategies effective enough to manage and control the impact of HIV/AIDS, as well as to prevent infections from spreading further, especially within the workplace of organisations under investigation. Once again, the aim of the study lies in to determining and investigating whether organisations (respondents) have the necessary resources to adequately cope, manage and control the impact of HIV/AIDS. The next table attempts to determine just that.

### 7.3.2 Distribution of action programmes, policies and structures currently in use within organisations to effectively manage and control HIV/AIDS in the workplace

**Table 7.6: Distribution of action programmes, policies and structures currently in use**

Action programmes, policies and structures	Frequency (n)	Frequency (n)	Frequency (n)	Total number of respondents	Percentage (%)	Percentage (%)	Percentage (%)
	Yes	No	Don't know		Yes	No	Don't know
Peer-led programme	16	21	4	(41)	39,02	51,22	9,76
Education programmes	36	8	1	(45)	80,00	17,78	2,22
Presentations	32	11	1	(34)	72,73	25,00	2,27
Teamwork	14	25	2	(41)	34,15	60,97	4,88
Training sessions	29	10	2	(41)	70,73	24,39	4,88
Distribution of info. materials	43	4	0	(47)	91,49	8,51	0
Condoms sold and distributed to employees and dependants	31	15	1	(47)	65,96	31,91	2,13
HIV-positive workers are offered counselling and encouraged to act in a responsible manner	33	11	4	(48)	68,75	22,92	8,33
Group workshops	14	28	1	(43)	32,56	65,11	2,33
Distribution of educational items such as T-shirts, etc.	17	22	1	(40)	42,50	55,00	2,50
Employee assistance programmes, EAP	33	11	0	(44)	75,00	25,00	0
<b>TOTAL</b>	<b>53</b>	<b>53</b>	<b>53</b>	<b>53</b>	<b>100,00</b>	<b>100,00</b>	<b>100,00</b>

According to Table 7.6, the emphasis is to establish and determine which type of action programmes, policies and structures (if any) are currently in operation within the workplace of the various organisations (respondents) and how these policies, programmes and structures are distributed (applied).

The following results clearly indicate, that respondents responded positively to the action programmes, policies and structures that were the most popular methods currently used in order to educate and inform employees.

- Distribution of information measures (91,49 per cent).
- Education programmes (80,00 per cent).
- EAP programmes (75,00 per cent).
- AIDS presentations (72,73 per cent).
- Training sessions (70,73 per cent).
- Counselling services (68,75 per cent).
- Condom distribution (65,96 per cent).

The above information indicates that these methods are very popular in the prevention, management and control of the disease. It is also important to notice, that all the above methods currently in operation, represent more than two-thirds of the total number of respondents (organisations) under investigation. Other methods also used presently include: the distribution of education items such as T-shirts, coffee mugs, etc. (42,50 per cent), peer-led programmes (39,02 per cent), team work (34,15 per cent) and group workshops (32,56 per cent), which represent more or less one-third of the total number of respondents (organisations) responding.

However, the following respondents responded negatively and stated that they do not have some or a combination of the above-mentioned methods to inform or evaluate their employees properly. These include: the lack of group workshops for employees (65,11 per cent), less teamwork among employees (60,97 per cent), ineffective distribution or educational items such as T-shirts, coffee mugs, etc (55,00 per cent) and no peer-led programmes (51,22 per cent). Other methods also not adequately addressed, include: the ineffective distribution of condoms (31,92 per cent), ineffective EAP programmes and AIDS presentations, both representing 25,00 per cent of the total response rate as well as insufficient training sessions (24,39 per cent), the lack of proper counselling services to employees (22,92 per cent), lack of education programmes (17,78 per cent) and no distribution of information materials (8,51 per cent) to employees.

Due to the nature and scope of these particular questions, some respondents (organisations) also indicated, that they do not know or are not aware of some or combinations of the above mentioned action programmes, policies or structures (methods) within their organisation at present and present the following response rates:

- Peer-led programmes for employees who are or may be infected (9,76 per cent).
- Counselling and support (8,33 per cent).
- Teamwork and training sessions (4,88 per cent).
- Distribution of educational items (2,50 per cent).
- Group workshops (2,33 per cent).
- AIDS presentations (2,27 per cent).
- Education programmes (2,22 per cent).

Although most of the respondents clearly indicated that they do have some of the action programmes, policies and structures in place to manage and control the disease effectively, others indicated, that there are some that are under-utilised and not effectively implemented or properly applied. The fact that respondents did not know if they were using some of the methods, clearly indicate, that management can do more and be more aware of which adequate methods can be applied properly in order to manage and control the disease more effectively.

The following table gives an indication of the number of respondents who did not answer (react) to the particular question.

Table 7.7 to follows on p.189.

**Table 7.7: Number of respondents that did not respond**

Action programmes and structures	Frequency (n)	Percentage (%)
Peer led programmes	12	22,64
Education programmes	8	17,78
Presentations	9	16,98
Teamwork	12	22,64
Training sessions	12	22,64
Distribution of information materials	6	11,32
Condoms sold and distributed to employees and dependants	6	11,32
HIV-positive workers are offered counselling and encouraged to act in a responsible manner	5	9,43
Group workshops	10	24,39
Distribution of educational items such as T-shirts, mugs, etc.	13	25,00
Employee assistance programmes – EAP's	9	16,98

### 7.3.3 Estimated known HIV-status of employees

**Table 7.8: HIV-status of employees**

Category	Frequency (n)	Percentage (%)
Yes	38	73,08
No	14	26,92
<b>TOTAL</b>	<b>52</b>	<b>100,00</b>

The above table clearly indicates that 73 per cent (73,08) of the total respondents are aware of employees in service that might be HIV-positive, while almost 27 per cent (26,92) indicated, that they did not know of any employees who are HIV-positive within the organisation. Although the response is favourable enough (73 per cent), there is, however, a clear indication that a large percentage of respondents do not know of any employee or employees who are HIV-positive (27 per cent) within the organisation. The reasons for this can be, that respondents do not want to get involved, do not know or do not want to respond, due to the nature and confidentiality



related to the issue of HIV/AIDS within the workplace, or the lack of policies and action programmes within the particular organisations under investigation. Only one of the total number of respondents did not respond to the above question.

#### 7.3.4 Percentage of possible infected employees within organisations under investigation

To support the above-mentioned information obtained, the following data were also collected and are clearly presented in the table to follow. The following table clearly indicates the estimated percentage of employees within the particular organisation who could have a positive HIV-status. It is important to note, that the information below presents only estimates by the respondents and must, therefore, be interpreted as such. Equally important, is that 24,49 per cent of the total number of respondents did not answer the particular question. The reasons for this can be due to the sensitive nature of the question, as well as the level of confidentiality attached. More than half (53,66) of the total number of respondents, however, indicated that they are aware or know of employees who are or might be HIV-positive, which amounts to 10 per cent or less of the total number of employees within the organisation, while only 2,44 per cent of the respondents indicated, that between 30-40 per cent of employees may or might have AIDS. Again, twelve respondents did not answer the particular question.

**Table 7.9: Percentage of possible infected employees**

Percentage of estimated HIV-positive employees	Frequency (n)	Percentage (%)
< 10%	22	53,66
Between 10-20%	10	24,39
Between 20-30%	8	19,51
Between 30-40%	1	2,44
Between 40-50%	-	-
>50%	-	-
<b>TOTAL</b>	<b>41</b>	<b>100,00</b>

### 7.3.5 HIV/AIDS as part of the overall business strategy or policies concerning life-threatening diseases and benefits that include workers who are HIV-positive

#### 7.3.5.1 *HIV/AIDS as part of the overall business strategy or policies concerning life-threatening diseases*

According to Table 7.10, a clear distinction can be made between various options available to the respondents (organisations) under investigation, to include and address HIV/AIDS as part of a larger policy concerning life-threatening diseases or to deal with it on a separate basis, or not at all. The information gathered, are clearly represented within the table to follow.

**Table 7.10: HIV/AIDS policies and strategies concerning life-threatening diseases**

Category	Frequency (n)	Percentage (%)
Part of a larger policy concerning life-threatening diseases	34	65,38
Dealing with it on a separate basis	16	30,77
Not dealing with it at all	0	0
Don't know	2	3,85
<b>TOTAL</b>	<b>52</b>	<b>100,00</b>

It is clear from the above information, that almost two-thirds of the total respondents (65,38 per cent) indicated that HIV/AIDS must be part of a larger policy concerning life-threatening diseases, while a third (30,77 per cent) indicated that HIV/AIDS must be dealt with on a separate basis. Another 3,85 per cent of the total respondents also indicated that they do not know whether or not the organisation is addressing the whole issue to include HIV/AIDS as part of their policies and strategies, while one of the respondents did not answer the question.

### 7.3.5.2 *Organisational benefits that make provision for employees who are HIV-positive*

The next table deals with the provisions made by the organisations under investigation to accommodate employees who are HIV-positive, as part of their organisational benefit structures.

**Table 7.11: Organisational benefits that include employees who are HIV-positive**

Organisation benefits	Frequency (n)	Frequency (n)	Frequency (n)	Total number of respondents	Percentage (%)	Percentage (%)	Percentage (%)
	Yes	No	Don't know		Yes	No	Don't know
Health Care	30	16	4	(50)	60,00	32,00	8,00
Pension and disability	19	24	3	(46)	41,30	52,17	6,53
Training	31	14	4	(49)	63,27	28,57	8,16
Work duties and performance	15	26	6	(47)	31,91	55,32	12,77
Recruitment	15	25	8	(48)	31,25	52,08	16,67
<b>TOTAL</b>	<b>53</b>	<b>53</b>	<b>53</b>	<b>53</b>	<b>100,00</b>	<b>100,00</b>	<b>100,00</b>

Table 7.11 clearly identifies the various organisational benefits. According to this question within the broad frame work of the research questionnaire, the emphasis was to determine and establish if organisations (respondents) do make actual provision within their specific benefit plans to accommodate employees who are HIV-positive. The following responses were achieved: Almost two-thirds (60,00 per cent) of the total respondents (organisations) have clearly indicated that they include health care and training on top of their priority list to include employees who are HIV-positive as part of their organisational benefit plans. In contrast to this, almost a third of the respondents clearly indicated that health care (32,00 per cent) and training (28,57) were not part of organisational benefits applied to accommodate HIV-positive employees. Other benefits also included within the organisation's benefits, to accommodate employees who are HIV-positive, were: the provision for pension and disability benefits (41,30 per cent), work duties and performance (31,91 per cent), as well as recruitment of HIV-positive employees (31,25 per cent). Equally important,

was the negative response rate to the above question, related to organisational benefits that included the following outcomes: the lack of provision for pension and disability to accommodate employees who are HIV-positive (52,17 per cent), work duties and performance (55,32 per cent), as well as the lack of recruitment of HIV-positive employees within the organisation (52,08 per cent).

It is very important to take note of the fact, that although health care and training sessions were addressed equally (more than 60,00 per cent) by organisations in respect of accommodating employees who are HIV-positive, the opposite applied to the pension and disability benefits, work policies and performance benefit structures, as well as the lack of effective recruitment of employees who are HIV-positive. In all the above-mentioned benefits, the negative response rate was higher than 50,00 percent, which is a good indication that more or less half of the respondents (organisations) do not effectively make provision for the accommodating of employees who are HIV-positive. Therefore, the conclusion can be made, that although health care and training are adequately addressed, many organisations still have to implement or better some organisational benefits and have to address employees who are or may be HIV-positive. By addressing all the above benefits, organisations will create a climate of openness, acceptance and most of all, security for those employees affected by the disease.

According to Table 7.11, some respondents (organisations) did not know whether or not they had any of the above-mentioned organisational benefits in place. It is important to state, that these so-called “non-responses” are very low and marginally representative of the overall response rate towards the specific question and do not have any impact as such.

The following table clearly indicates the number of respondents who did not responded

**Table 7.12: Number of respondents not responding (organisational benefits)**

Organisational Benefits	Frequency (n)	Percentage (%)
Health care	3	6,52
Employee benefits (pensions and disability)	7	13,21
Training	4	8,16
Work duties and performance	6	12,77
Recruitment	5	9,43
<b>TOTAL</b>	<b>53</b>	<b>100,00</b>

### 7.3.6 The negative impact of HIV/AIDS on the organisation

The following table indicates the negative impacts or effects that HIV/AIDS already have on the various organisations under investigation.

**Table 7.13: Negative impact of HIV/AIDS in the workplace**

Negative impact effects	Frequency (n)	Frequency (n)	Frequency (n)	Total number of respondents	Percentage (%)	Percentage (%)	Percentage (%)
	Yes	No	Don't know		Yes	No	Don't know
Loss of experienced personnel – particularly at middle management and skilled workers levels	20	23	5	(48)	41,67	47,92	10,41
The need for increased resources to hire and retain replacements	20	24	1	(45)	44,44	53,33	2,23
An increase in absenteeism and labour turn-over	34	12	3	(49)	69,39	24,49	6,12
A decrease in productivity levels	22	22	6	(50)	44,00	44,00	12,00
An increase in healthcare costs	32	11	4	(47)	68,09	23,40	8,51
Loss of customer and consumer spending	8	29	9	(46)	17,39	63,04	19,57
<b>TOTAL</b>	<b>53</b>	<b>53</b>	<b>53</b>	<b>53</b>	<b>100,00</b>	<b>100,00</b>	<b>100,00</b>

It is a fact that HIV/AIDS will impact negatively on the organisation and its various resources. The way in which the organisation responds to these impacts, will have a contributing effect on how the epidemic is managed and controlled in future. The

following table needs to be explained and discussed in detail. Table 7.13 clearly identifies these negative impacts within the workplace.

The most important negative impacts identified, which will have some influence within the workplace and that represent more or less two-thirds (66,00 per cent) of the total number of respondents, were: an increase of absenteeism and labour turnover (69,39 per cent) and health care costs (68,09 per cent) followed by the following impacts that represents just more than 40,00 per cent of the total respondents: Loss of experienced and skilled personnel (41,67 per cent), a decrease in productivity levels (44,00 per cent) and the need for an increase in human resources (44,44 per cent). Only 17,39 per cent of the total number of respondents identified the loss of customers and consumer spending (buying power) as a negative impact. It is important to understand, that these above impacts could have a profound effect on the organisation and its resources, if not properly managed and controlled.

In total contrast to the above information obtained, over half (50,00 per cent) of the respondents (organisations) clearly indicated that there is no need for increased human resources (53,33 per cent) as well as for the loss of customer and consumer spending (63,04 per cent), while almost 50,00 per cent (47,62) of the respondents feel that the loss of experienced and skilled personnel will not impact negatively within the workplace. It is important to take note of this important trend. Either organisations (respondents) feel that there are adequate structures, policies or action programmes in place to deal with the epidemic, or it is a case of pure ignorance and reluctance by organisations to manage and control the disease. Other factors that organisations feel that may have very limited impact, are: the increase of absenteeism and labour turnover (24,49 per cent) and the increase in health care cost (23,40 per cent).

It is noteworthy, that the same number of respondents (organisations) (44,00 per cent) indicated that decreases in productivity levels would either have an impact or have no impact at all. The reason for this result, can either be that the number of respondents that have not yet been effected, did not make provision for such an impact, while those respondents that indicated a definite impact, may already have been experiencing the effects and are taking them seriously. According to Table 7.13,

some respondents did not know if these impacts were effecting their organisations negatively or not. Again, these responses represent a small margin and do not have any influence as such.

The next table once again indicates the total number of respondents not having responded to the particular question.

**Table 7.14: Number of respondents not responded (negative impacts)**

Negative impact/effects	Frequency (n)	Percentage (%)
Loss of experienced personnel – particularly at middle management and skilled workers levels	5	9,43
The need for increased resources to hire and retain replacements	8	17,78
An increase in absenteeism and labour turn-over	4	8,16
A decrease in productivity levels	3	6,52
An increase in healthcare costs	6	12,77
Loss of customer and consumer spending	7	13,21
<b>TOTAL</b>	<b>53</b>	<b>100,00</b>

### **7.3.7 Discriminating practices and human rights violations regarding employees who are HIV-positive (if any)**

According to this particular table the emphasis is to determine what the levels are within the organisations regarding discriminating practices or violation of human rights regarding to employees who are HIV-positive (if possible).

Table 7.15 to follows on p. 197.

**Table 7.15: Discriminating practices and human right violations within the organisations under investigation**

<b>Discriminating practices and human right violation</b>	<b>Frequency (n)</b>	<b>Percentage (%)</b>
None to our knowledge	31	58,50
Unwillingness to associate with person who is HIV-positive	6	11,32
Limited contact (interaction) with person who is HIV-positive	5	9,43
Disclosure of HIV-status will have a negative impact on person who is HIV-positive	7	13,20
Confidentiality will be impaired if person who is HIV- positive is known to their fellow colleagues	1	1,89
Limited medical support available	2	3,77
Affordable medical treatment not available	1	1,89
<b>TOTAL</b>	<b>53</b>	<b>100,00</b>

It is clear from the above table, that the majority 58,50 per cent of respondents to this particular question evaluating themselves as not being discriminatory towards employees who are HIV-positive, or that any other of human rights violations are taking place within the organisations under investigation. This high response could be due to the nature and sensitivity of this particular question and that respondents might feel to respond in a manner that is neutral and non-offensive. Another important factor to pay attention to, is that 13,20 per cent of the respondents saw the disclosure of an employee's HIV status as negative, rather than positive, which could have a possible influence on creating a climate of openness towards the disease within the workplace. Also contributing to this fact, is that many employees don't want to be associated (11,32 per cent) with, or did not want to have any contact (9,43 per cent) with employees who are HIV-positive, while 1,89 per cent felt that confidentiality will be impaired if a person's HIV-status will be made known by the organisation while 1,89 per cent of the total respondents indicated that affordable medical treatment was not available or almost non-existent.

### **7.3.8 The management and control of HIV/AIDS in the workplace (what is the organisation doing right?)**

Table 7.16 indicates what the positive results are with regard to the proper management and control of HIV/AIDS in the workplace.



**Table 7.16: Positive outcomes with regard to the effective management and control of HIV/AIDS**

Positive outcomes	Frequency (n)	Percentage (%)
AIDS training and awareness programmes	15	29,41
Proper medical support	4	7,84
Multi-training skills	2	3,92
Better counselling services	5	9,80
Aid for AIDS	2	3,92
Management involvement and commitment	3	5,88
Effective distribution of condoms	6	11,76
Prevention of discriminating practices within the working environment	3	5,88
Regular and frequent testing of employees	3	5,88
Community investment and support structures	2	3,92
Employee care and support programmes (EAP)	5	9,80
Allocation and provision of funds	1	1,99
<b>TOTAL</b>	<b>51</b>	<b>100,00</b>

Table 7.16 identifies all the positive aspects with regard to the management and control of HIV/AIDS in the workplace of the various organisations under investigation. According to the information obtained, most of the organisations responding, indicated that AIDS training and awareness programmes were on the top of their list of priorities (29,41 per cent), followed by the effective distribution of condoms (11,76 per cent), EAP support programmes and better counselling services for employees (9,80 per cent) as well as proper medical support (7,84 per cent), the prevention of discriminating practices from occurring, regular and frequent testing of employees, as well as better management involvement and commitment (all which represent 5,88 per cent of the total response rate respectively). Other positive outcomes include aid for AIDS programmes (3,92 per cent), community involvement and support (3,92 per cent), and the allocation and provision of adequate funds (1,99 per cent). Only two of the respondents did not answer the particular question.

### 7.3.9 The management and control of HIV/AIDS in the workplace (what is organisations doing wrong?)

The next table pays attention to the aspect that has a negative influence on the effective management and control of HIV/AIDS within the working environments of the particular organisations under investigation.

**Table 7.17: Negative outcomes with regard to the ineffective management and control of HIV/AIDS**

Negative outcomes	Frequency (n)	Percentage (%)
Limited funds available	4	7,54
Limited or no facilities available	3	5,66
No AIDS training and awareness programmes	8	15,10
Lack of overall strategy and policies	5	9,43
No peer educators or proper counsellors	2	3,77
Management reluctance towards the epidemic	4	7,54
Insufficient condom distribution	3	5,66
Lack of proper support structures	2	3,77
Discrimination on basis of HIV-status	1	1,90
Lack of commitment and ignorance towards HIV/AIDS	4	7,54
Inadequate testing	1	1,90
Respondent is doing nothing wrong at present	16	30,19
<b>TOTAL</b>	<b>53</b>	<b>100,00</b>

According to the above table 30,19 per cent of the respondents indicated that they were not doing anything wrong at present in respect of the proper management and control of the disease within the workplace. However, there were sufficient negative outcomes, that included the following: 15,10 per cent of the total respondents indicated, that no AIDS training and awareness programmes were currently in operation, while 9,43 per cent indicated, that their organisations experienced a lack of sufficient policies and active strategies to combat the disease effectively. Other important aspects include: management's reluctance towards the epidemic (7,54 per cent), as well as limited funding (7,54 per cent), the lack of commitment, and

ignorance towards HIV/AIDS within the work environment, which represents almost 8 per cent (7,54 per cent) of the total number of responses, while 5,66 per cent represented negative aspects such as: Limited or no facilities available, as well as insufficient or under-utilised condom distribution, non-existent peer-educators and the lack of proper support structures both at work and at home, representing (3,77 per cent). Aspects such as the discrimination on the basis of an employee's HIV-status (1,89 per cent) and the inadequate testing of employees (1,89 per cent), were also representative of the total number of responses received. The organisation must, therefore, take notice of these various negative factors and influences that can have some effect on the management and control of HIV/AIDS within the workplace.

It is, therefore, absolutely imperative to take notice of all the above tables and the various responses that they represent, so that adequate measures can be taken towards the effective management and control of HIV/AIDS within the workplace of organisations under investigation. It is also important from management's perspective that clear and sound solutions are found to address the various impacts that HIV/AIDS pose. Management must therefore, be reactive in the way it is dealing with the disease and must also try to understand what threats and implications the organisation faces with regard to the way in which the disease is managed and properly controlled. Organisations must thus be effective in the way they manage, control and respond to the impact, effects and challenges that HIV/AIDS will have on the organisation and its resources.

Further attention will once again be given by analysing the various responses towards the evaluation of current action programmes, policies and structures for the implementation/formulation within the workplace (Section C of the Research Questionnaire). Attention will also be given to what specific actions and recommendations can be used and implemented in order to ensure a proper and more successful strategy formulation/implementation by management and officials responsible.

#### 7.4 EVALUATING PROGRAMMES, POLICIES AND STRUCTURES

The aim of question 14 within the boundaries of this particular study, was to determine to what extent the listed statements/factors (items) have an effect or could have an effect or influence on current policies, action programmes and structures, as well as the important role that these statements/factors play within the formulation and implementation of such policies, action programmes or structures, to effectively manage and control the impact of HIV/AIDS within the workplace.

Respondents (organisations) were asked to indicate to what extent they agreed or disagreed in respect of the particular list of statements/factors. Thirty-one statements (factors/items) were presented and the respondents had to evaluate these factors (items) by means of the 5-point Likert-scale. The response to this question is set out in Table 7.18.

The total sum percentages (responses) of the two lower scales (scales 1 and 2) to each statement, are indicated first, followed by the two higher scales (scales 4 and 5). Scale 3 was not included within Table 7.18, due to its nature of uncertainty and the very low response rate it represents. These responses were thus automatically rejected, because they do not add any value to the nature and scope of this particular study.

The mean (average) of each factor (item), together with the variance and standard deviation of each item, is also clearly indicated within the specific columns within Table 7.18. In the last column, the item-scale correlation of each item is also indicated as to measure the statistical covariation or association between two variables.

Table 7.18 to follows on p. 202.

**Table 7.18: Statements/factors that influence or might have an influence on action programmes, policy and structure formulation or implementation**

Variable no.	Statement/ Factor/Item	Lower scales (scales 1 & 2) (%)	Higher scales (scales 4 & 5) (%)	Mean $\bar{x}$	Variance ( $S^2$ )	Standard deviation (S)	Item scale- correlation
V41	Increased vulnerability as more employees get infected with HIV/AIDS	<b>92,45</b>	0	<b>4,340</b>	0,375	0,612	<b>0,54</b>
V42	Production costs will not increase as more employees are infected	13,21	66,04	3,755	0,902	0,950	0,70
V43	Absenteeism will impact negatively	<b>96,23</b>	1,89	<b>4,358</b>	0,381	0,617	<b>0,46</b>
V44	Reduced performance due to HIV/AIDS; sickness on the job	<b>92,31</b>	1,92	<b>4,404</b>	0,472	0,687	<b>0,39</b>
V45	Training and recruitment of employees will be severely affected	<b>83,02</b>	7,55	<b>4,132</b>	0,756	0,869	<b>0,48</b>
V46	Illness and death of key employees may prove disastrous for the organisation	<b>79,25</b>	13,21	<b>4,000</b>	0,943	0,971	<b>0,75</b>
V47	Employee benefit structures will be affected, with an increase of HIV/ AIDS cases	<b>90,57</b>	3,77	<b>4,075</b>	0,409	0,640	<b>0,55</b>
V48	An increase in direct costs	<b>84,62</b>	1,92	<b>4,115</b>	0,487	0,698	<b>0,57</b>
V49	Morale of workforce will not be affected as more co-workers get infected and ultimately die of full-blown AIDS	16,98	73,59	3,811	1,436	1,198	0,64
V50	Average age and experience of employees will be affected	<b>79,25</b>	9,43	<b>3,868</b>	0,643	0,802	<b>0,70</b>
V51	Accidents within the work environment will not be affected	11,32	58,49	3,566	0,774	0,880	0,66
V52	Organisational resources will not be affected	11,54	<b>88,46</b>	<b>3,942</b>	0,477	0,691	<b>0,64</b>
V53	No disruption of schedules, work teams or units	11,32	<b>88,68</b>	<b>4,113</b>	0,478	0,691	<b>0,58</b>
V54	An increase of organisational down-time due, to AIDS-related absences	<b>79,25</b>	7,55	<b>3,849</b>	0,656	0,810	<b>0,61</b>
V55	Unfair discrimination or stigma against an employee on the grounds of HIV-status	48,08	28,85	3,231	1,062	1,031	0,56
V56	Reduction in the average level of skill, performance, institutional memory and experience of work-force	<b>81,13</b>	7,55	<b>3,906</b>	0,576	0,759	<b>0,65</b>
V57	Business will not be affected if suppliers of key inputs fail to manage the HIV/AIDS impacts adequately	20,75	73,59	3,717	0,995	0,997	0,55
V58	Employees who are HIV/AIDS infected and who die or retire on medical grounds, do have to be replaced	<b>75,47</b>	13,21	<b>3,717</b>	0,769	0,877	<b>0,30</b>
V59	Employers don't have to increase the size of their work force to provide for deaths during apprenticeship and because of absenteeism generally	13,46	61,75	3,558	0,670	0,819	0,50

Table 7.18 continues

Variable no.	Statement/ Factor/Item	Lower scales (scales 1 & 2) (%)	Higher scales (scales 4 & 5) (%)	Mean ( $\bar{x}$ )	Variance ( $S^2$ )	Standard deviation (S)	Item scale- correlation
V60	The costs of health care, medical aid and hospitalisation will not be affected	3,77	<b>90,57</b>	<b>4,226</b>	0,515	0,718	<b>0,68</b>
V61	Consumer-base and credit loans will not be affected by the HIV/AIDS epidemics	5,66	<b>84,90</b>	<b>4,019</b>	0,547	0,740	<b>0,32</b>
V62	Growth in the volume of sales will remain unaffected	9,43	56,66	3,528	0,551	0,742	0,57
V63	HIV/AIDS will make it more expensive for an organisation to produce a given quantity of its products unless it can reduce its cost in other ways	71,15	5,77	3,904	0,702	0,838	0,47
V64	Well-designed programmes to reduce infection that leads to an increased awareness among employees, will have a positive impact on the management of HIV/AIDS in the workplace	<b>90,38</b>	1,92	<b>4,192</b>	0,425	0,652	<b>0,47</b>
V65	All persons with HIV or AIDS have the legal right to privacy in the workplace	<b>76,92</b>	7,69	<b>3,981</b>	0,865	0,930	<b>0,66</b>
V66	Methods should be created to encourage openness	<b>88,24</b>	1,69	<b>4,216</b>	0,483	0,695	<b>0,31</b>
V67	The risk of HIV transmission in the workplace is minimal	58,82	27,45	2,510	1,387	1,178	0,36
V68	Providing appropriate equipment and materials to prevent employees from the risk of exposure to HIV in the workplace, will have a significant impact on the spreading of the disease	63,46	21,15	3,558	0,939	0,969	0,50
V69	An employee may not be compensated if he or she becomes infected with HIV as a result of an occupational accident within the workplace	5,88	70,58	3,961	1,018	1,009	0,57
V70	Legislation aspects pertaining to HIV/AIDS in the workplace is non-existent	15,69	68,63	3,627	0,979	0,989	0,26
V71	HIV/AIDS will not affect business	3,85	<b>92,30</b>	<b>4,385</b>	0,660	0,812	<b>0,44</b>

According to Table 7.18 and Table 7.19 more or less 75 per cent of all the respondents (organisations) agreed that the following statements/factors play an important role in the formulation and implementation of policies, action programmes and structures, as well as the evaluation thereof. (The respondents responded either to 1: “agree strongly” or to 2: “agree” on the 5-point scale)

Table 7.19 to follows on p.204.

**Table 7.19: Total number of respondents agreed**

Statements/Factors	% agreed
Absenteeism will impact negatively (statement 3)	(96,23 %)
Increased vulnerability as more employees are infected (statement 1)	(92,45 %)
Reduced performance due to HIV/AIDS sickness on the job (statement 4)	(92,31 %)
Employee benefit structures will be affected with an increase of HIV/AIDS cases (statement 7)	(90,52 %)
Well designed programmes to reduce infection that leads to an increase awareness among employees will have a positive impact on the management of HIV/AIDS in the workplace (statement 24)	(90,38 %)
Methods should be created to encourage openness (statement 26)	(88,24 %)
An increase in direct costs (statement 8)	(84,62 %)
Training and recruitment of employees will be severely affected (statement 5)	(83,02 %)
Reduction in the average skills level, performance, institutional memory and experience of workforce (statement 16)	(81,13 %)
Illness and death of key employees may prove disastrous for the organisation (statement 6)	(79,25 %)
Average age and experience of employees will be affected (statement 10)	(79,25 %)
An increase of organisational down-time due to AIDS-related absences (statement 14)	(79,25 %)
All persons with HIV/AIDS have the legal right to privacy in the workplace, (statement 25) and	(76,92 %)
Employees who are HIV/AIDS infected and who dies or retire on medical grounds do have to be replaced (statement 18)	(75,47 %)

The mean average of all fourteen statements/factors obtained from Table 7.19 represents 3,7 out of a possible 5. Also important to note, is that the two factors (illness and death of key employees and the average age and experience of employees) are relatively high item scale correlation, which means that these factors are more or less strong and positive.

The following five factors received 80 per cent of the total statement (item) response rate and clearly indicate, that respondents disagree with these statements. (The respondents either responded to 4: “disagree” or to 5: “disagree totally” on the 5-point scale).

These statements (items) are clearly presented with the next table to follow.

**Table 7.20: Total number of respondents that disagree**

Statements/Factors	% disagreed
HIV/AIDS will not affect business (statement 31)	(92,30 %)
The costs of health care, medical aid and hospitalisation will not be affected (statement 20)	(90,57 %)
No distribution of schedules, work teams or units (statement 13)	(88,68 %)
Organisational resources will not be affected (statement 12)	(88,46 %)
Consumer base and credit loans will not be affected by the HIV/AIDS epidemics (statement 21)	(84,90 %)

The above results clearly indicate, that respondents believe that HIV/AIDS will have a negative impact on their business.

## 7.5 SPECIFIC ACTIONS AND RECOMMENDATIONS

The last question of the research questionnaire (question 15), was open-ended, asking respondents (organisations) to clearly indicate their own specific actions and to identify the most important recommendations towards effectively managing and controlling HIV/AIDS within the workplace.

The aim of this question was, to gather as much information as possible and also on the most important aspects to effectively manage and control the HIV/AIDS epidemics. Through these recommendations, suggestions and actions, managers and officials responsible for policy and strategic formulation or implementation, can gain important insight and valuable information on how to predict certain trends, as well as to assist them in the formulation and implementation of “new” action programmes, policies or strategies to “better” manage and control the impact of HIV/AIDS within the workplace. Other parties that can gain from these particular recommendations and suggestions, are counsellors, peer-educators, NGO’s and academics and consultants concerned with the impact of the disease within the workplace of the organisation (respondents).



Table 7.21 clearly indicates these specific actions and recommendations identified by the various respondents under investigation.

**Table 7.21: Specific actions and recommendations made by respondents**

Specific Actions and Recommendations	Frequency (n)	Percentage (%)
Create a climate of "openness" towards HIV/AIDS	1	1,89
Greater management involvement and commitment	4	7,54
Better and more effective education and training programmes	3	5,66
Provision for family support structures	1	1,89
More "frequent" testing of employees	2	3,77
Better and more improved recruitment policy	3	5,66
More AIDS awareness campaigns	2	3,77
Better and more cost-effective prevention methods	1	1,89
Create an "open door" policy to accommodate employees who are or might be HIV-positive	1	1,89
More open and frequent group discussions on HIV/AIDS	2	3,77
More effective distribution of information materials	3	5,66
More freely distribution of condoms	2	3,77
EAP programmes for infected workers and their families	2	3,77
A more effective HIV/AIDS strategy needed	4	7,54
Peer-educator programmes driven by medical staff	1	1,89
Changed attitude and morals towards HIV/AIDS	1	1,89
Target youth and commercial sex workers	3	5,66
More effective leadership by management	1	1,89
Regular audit reports on costs and productivity regarding HIV/AIDS	1	1,89
Regular updates on absenteeism and medical registrations	1	1,89
More effective training of counsellors	2	3,77
Allocation of a separate HIV/AIDS budget (if possible)	1	1,89
The implementation of separate AIDS committees and forums	2	3,77
Better communication	3	5,66
Voluntary and anonymous surveillance with regard to HIV/AIDS within the workplace	1	1,89
Availability of resources to better manage and control the impact of HIV/AIDS	3	5,66
Better training methods and techniques to minimise the impact of HIV/AIDS	1	1,89
Involve trade unions and others in the fight against AIDS	1	1,89
<b>TOTAL</b>	<b>53</b>	<b>100,00</b>

According to Table 7.21, all the respondents (100,00 per cent) indicated some suggestions or recommendations. The reason for this can be, that all the respondents (organisations) felt that it was important and essential to contribute to the specific question and thus to the objective of this particular study. The two recommendations that represent the highest response rate (7,54 per cent), were clearly: greater management involvement and commitment and, that a more effective HIV/AIDS strategy is needed to accommodate and address the impact of HIV/AIDS more clearly and effectively. It is now very clear and evident that the primary objective of this research study, is becoming important. The question once again is: Do organisations have effective policies, action programmes and proper structures in place to successfully manage and control the impact of HIV/AIDS within the workplace. According to the above responses, it clearly is not sufficient enough.

## 7.6 RELIABILITY TESTING OF RESPONSES RECEIVED

As discussed within the scope of Chapter 6, it is a common misconception that if the Alpha level is low, it must be a bad measuring instrument. Usually a reliability level of 0,70 will be sufficient enough on predictor tests or measures of a construct. In the case of this particular research study, 31 statements/factors within the scope of question 14 (refer Section C and Table 7.18), were grouped into five main critical constructs, in order to make reliability testing more effective, followed by an item analysis. The five critical constructs identified include the following.

- *Construct 1: Vulnerability and absenteeism*

Statement no. 1	Increased vulnerability of employees.
Statement no. 3	Absenteeism will impact negatively.
Statement no. 7	Benefits structures affected.
Statement no. 14	Increase in organisational down-time.
Statement no. 18	Replacement of infected employees.
Statement no. 19	No replacements for infected employees.

- *Construct 2: Management and control*

Statement no. 5	Training and recruitment.
Statement no. 9	Morale of workforce unaffected.
Statement no. 11	Accidents not affected.
Statement no. 13	Minimum disruptions.
Statement no. 17	Business unaffected.
Statement no. 20	Costs unaffected.
Statement no. 26	Encourage openness.
Statement no. 30	Legislation non-existent.

- *Construct 3: Discriminating practices*

Statement no. 15	Unfair discrimination and stigma.
Statement no. 25	Legal rights to privacy.
Statement no. 29	No compensation for infected employees.

- *Construct 4: Structures*

Statement no. 21	Consumer-based and credit loans unaffected.
Statement no. 24	Programmes to increase awareness.
Statement no. 27	Risk of transmission is minimal.
Statement no. 28	Provide appropriate prevention materials.
Statement no. 31	Legislation is non-existent.

- *Construct 5: Production and organisational resources*

Statement no. 2	Production costs not affected.
Statement no. 4	Reduced performance due to AIDS.
Statement no. 6	Death of key-employees may prove disastrous.
Statement no. 8	Increase in direct cost.
Statement no. 10	Experience and age affected.
Statement no. 12	Organisational resources unaffected.

Statement no. 16	Reduction in the skill level and performance of employees
Statement no. 22	Sale figures unaffected.
Statement no. 23	Production costs affected.

Since correlation coefficients reveal the magnitude and direction of relationships (comparisons) it is important to analyse the correlation coefficients of the above critical constructs identified. The Pearson (simple) correlation coefficient is a statistical measure of the covariation or association between two variables. The correlation coefficient ( $r$ ) ranges from  $+1,0$  to  $-1,0$ . If the value of  $r$  is  $1,0$  there is a perfect linear (straight line) relationship. If the value of  $r$  is  $-1,0$  a perfect negative linear relationship or a perfect inverse relationship is indicated. No correlation, however, is indicated if  $r = 0$ . The correlation coefficient, therefore, indicates both the magnitude of the linear relationship and the direction of the relationship (Zikmund, 2000:511).

**Table 7.22: Pearson correlation coefficients**

Construct	Vulnerability and absenteeism	Management and control	Discriminating practice	Structures	Production and organisational resources
Vulnerability and absenteeism	1,000				
Management and control	0,592	1,000			
Discriminating practice	0,371	0,338	1,000		
Structures	0,151	0,440	0,500	1,000	
Production and organisational resources	<b>0,675</b>	<b>0,713</b>	0,334	0,321	1,000

The correlation coefficient of 0,713 within Table 7.22 is a good indication of the significant relationship between production and organisational resources affected or unaffected and that of management and control of the disease. There are also a significant relationship between production and organisational resources affect or unaffected and vulnerability and absenteeism. All the above correlation coefficients are relative large and significant at a 5 per cent level. This is an indication of how

important a production and organisational resources are with regard to the proper management and control of the disease within the workplace, as well as the aspects of vulnerability and absenteeism within the workplace. Production and organisational resources are thus positively related to the proper management and control, vulnerability and absenteeism towards the disease within the workplace.

The reliability of the above critical constructs were further tested by applying the Cronbach's Alpha reliability coefficient. The following table gives the Alpha coefficients.

**Table 7.23: Cronbach's Alpha reliability coefficients**

Group	Number of items	Range	Mean	Medean	Cronbach's Alpha
Vulnerability and absenteeism	6	6-30	2,168	2,142	0,567
Management and control	8	8-40	3,347	3,375	<b>0,710</b>
Discriminating practice	3	3-15	2,905	3,000	0,618
Structures	5	5-25	3,054	3,000	0,620
Production and organisational resources	9	9-45	2,630	2,625	<b>0,846</b>

The above information clearly indicate that although only two constructs are above 0,70 the remaining three is still high enough to represent fairly reliable information (evidence). An average Alpha coefficient of 0,672 was achieved for the above constructs.

## 7.7 CROSS-TABULATIONS

For the purpose of this study, cross-tabulations were included as a method of descriptive statistics within the scope of this particular chapter, and to identify and explain some important comparisons, and what effect they have within the scope and nature of this particular research study.

According to (Zikmund, 2000:439) cross-tabulations refer to “... a technique organising data by groups, categories or classes, thus facilitating comparisons; a joint frequency distribution of observations on two or more tests of variables”. The purpose of categorisation and cross-tabulation, is to allow for the inspection (analysis) of differences among groups and to make comparisons.

The following cross-tabulations were done and will receive some attention.

- To establish if there is a direct comparison between the appearance (distribution) of HIV/AIDS and the type of industry (sector) which the organisation (respondents) is representing: questions 2 and 7.
- To establish, if there is any comparison between existing (action programmes, policies and structures and the appearance (distribution) of HIV/AIDS: questions 5 and 7.
- To establish if there is any comparison between the location of industries and existing (formal and informal) action programmes, policies and structures: questions 4 and 5.

#### **7.7.1 Estimated distribution of HIV/AIDS within the particular type of industry (sector)**

The following table clearly indicates the two variables: distribution of HIV/AIDS and the type of industry by means of cross-tabulation with relevant percentages.

Table 7.24 to follows on p.212.

**Table 7.24: Distribution of HIV/AIDS by type of industry**

Distribution of HIV/AIDS						
Type of Industry	Frequency (N) Total Percentage (%)	<10%	Between 10%-20%	Between 20%-30%	Between 30%-40%	Row total
	Chemical and/or pharmaceutical	6 14,63	1 2,44	2 4,88	0 0	9 21,95
	Manufacturing	<b>9</b> <b>21,95</b>	<b>5</b> <b>12,20</b>	<b>4</b> <b>9,76</b>	0 0	<b>18</b> <b>43,90</b>
	Petroleum	2 4,88	1 2,44	0 0	0 0	3 7,32
	Utilities	2 4,88	1 2,44	0 0	0 0	3 7,32
	Mining	1 2,44	1 2,44	1 2,44	<b>1</b> <b>2,44</b>	4 9,76
	Construction	0 0	0 0	0 0	0 0	0 0
	Other	2 4,88	1 2,44	1 2,44	0 0	4 9,76
	Column Total	22 53,66	10 24,39	8 19,51	1 2,44	41 100,00

Number of missing observations = 12

According to the above cross-tabulation, the highest distribution of HIV/AIDS (21,95 per cent) was in the category of 10 per cent or less within the manufacturing sector, which also represents the highest number of respondents (9) while almost no responses were received within the category 30 – 40 per cent except for one respondent within the mining industry, which represented 2,44 per cent of the total response rate. Equally important is, that in the category 10 – 20 per cent, the highest distribution (appearance) of HIV/AIDS is from within the manufacturing industry (sector) in the area under study.

According to the above information the assumption that can be made that although quite a number of respondents indicated the level of infection within their particular organisations, many respondents responded actually do not know the exact number of infections within their particular organisation.

Also important, is that no organisation (respondents) within the construction sector responded positively, as well as the total number of missing observation (12) which also made it difficult to run any significant chi-square tests. Another important aspect was, that a total response rate of 43,90 per cent to this particular question was achieved within the manufacturing sector alone which is a good indication that this particular sector is representative of all main manufacturing industries under investigation.

### 7.7.2 Estimated distribution level of HIV/AIDS and the existence of any formal and informal action programmes, policies or structures.

Table 7.25 tries to determine, if there is any direct comparison between existing, current policies, action programmes or structures (formal or informal) and the distribution (appearance) of HIV/AIDS

**Table 7.25: Distribution of HIV/AIDS by existing action programmes, policies or structures (formal or informal)**

Distribution of HIV/AIDS						
Existing actions programmes, policies pr structures	Frequency (N) Total Percentage (%)	<10%	Between 10%-20%	Between 20%-30%	Between 30%-40%	Row Total
	Formal	15 36,59	8 19,51	5 12,20	0 0	28 68,29
	Informal	6 14,63	2 4,88	3 7,32	1 2,44	12 29,27
	Do not know	1 2,44	0 0	0 0	0 0	1 2,44
	Column total	22 53,66	10 24,39	8 19,51	1 2,44	41 100,00

Number of missing observations = 12

Table 7.25 clearly indicates, that the lowest distribution level of HIV/AIDS (<10 per cent) was evident within organisations who implementing and using formal action



programmes, policies and sufficient structures (36,59 per cent) in order to minimise the effect and the impact of HIV/AIDS within the workplace, while the opposite applies to those organisations who used only informal action programmes and policies (14,63 per cent). The above information, therefore, can be interpreted as a skew distribution of data towards the interpretation of the final results within the context of this specific research method applied.

Only one respondent (organisation) indicated, that it is not aware of any formal or informal action programmes, policies or sufficient structures currently in operation, representing 2,44 per cent of the total response rate. From the above information, it is also evident, that the more formal the action programmes, policies and structures are, the lesser the level of distribution will be of HIV/AIDS. A total of 12 respondents did not answer or respond in any way to the above questions, which made it very difficult to run any significant tests. The aim therefore, was to focus only on important aspects and to highlight these to make some fairly reliable comparisons.

### **7.7.3 Distribution of any formal and informal action programmes, policies or plans related to the specific location area of respondents**

Table 7.26 is reflecting the relationships (comparisons) between the appearance of informal and formal action programmes, policies and plans within the specific location areas of respondents (organisations).

Table 7.26 to follows on p.215.

**Table 7.26: Comparison between the appearance (distribution) of formal or informal action programmes, policies and plans by location area of respondents (organisations) under study**

Distribution of formal or informal action programmes, policies and plans

Location area of respondents under study	Frequency (N) Total Percentage (%)	Formal	Informal	Do not know	Row
	Vereeniging	8 15,09	3 5,66	1 1,89	12 22,64
	Vanderbijlpark	8 15,09	6 11,32	1 1,89	15 28,30
	Sasolburg	12 22,64	3 5,66	1 1,89	16 30,19
	Meyerton	5 9,43	3 5,66	1 1,89	9 16,98
	Carltonville	0 0	1 1,89	0 0	1 1,89
	Column total	33 62,26	16 30,19	4 7,55	53 100,00

Number of missing observations = 12

According to the above information it is evident that the distribution of most formal action programmes, policies and plans are found more or less evenly distributed within organisation (respondents) located in the more industrialised town within the area under study. These towns include Vereeniging (15,09 per cent), Vanderbijlpark (15,09 per cent) and Sasolburg (22,64 per cent), while the appearance of formal action programmes, policies and plans are very marginal or non-existent within the towns of Meyerton and Carltonville. The reason for this is already mentioned in that Meyerton is not part of the heavy industrialised towns within the area under study and also due to its location from these heavy industrialised regions while Carltonville is almost non-representative due to the low responses received as well as to its location on the far Western boundaries within the area under study. Another contributing factor that could have an indirect influence on the response rate of organisations under investigation are the population density within the relevant area under study. The

above reasons can be regarded as the most important reasons why Meyerton and especially Carltonville have such low response rates.

In the case of the distribution (appearance) of informal action programmes, policies and plans, Vanderbijlpark is representative as the town with the highest response rate (11,32 per cent) followed by the towns Vereeniging, Sasolburg and Meyerton that are similarly representative of one another (5,66 per cent), while Carltonville again was marginally representative (1,89 per cent). A total of 4 respondents (7,55 per cent) indicated that they do not know if their specific organisations both have formal or informal action programmes, policies or plans currently in operation. A total of 12 respondents did not answer the particular question.

## 7.8 CONCLUSION

From the above research findings and the information obtained and explained within the scope and boundaries of Chapter 7, the final results will be concluded as well as recommendations made regarding the evaluation and analysis of current action programmes, policies, plans and structures within organisations in order to efficiently manage and control the impact of HIV/AIDS in the workplace within Chapter 8. During the course of this particular chapter relevant information was obtained and explained by means of descriptive statistics. As already mentioned, all relevant data that were captured, were provided in tabular format so as to make understanding and the interpreting of results easier and more understandable. The various research techniques and methods as discussed within the scope of Chapter 6, have been practically applied (if possible) within Chapter 7.

The following were identified as limitations within the scope of Chapter 7 but do not restrict the importance of this particular study in any way. The only interdependency method that could not be used, was factor analysis, although it is explained in detail within Chapter 6. The main reason for this, was that the total response rate (n=53) was inadequate for the construction of an efficient test. This can also be attributed to the nature and scope of this specific study. An important criteria was to only identify respondents (organisations), with a number of 500 or more employees which made it

extremely difficult to obtain a relative high response rate. Where possible tests were conducted, analysed and interpreted.

For the purpose of this study, cross-tabulations were included as a method to determine if the relevant scores are reliable and therefore, valid. However, a significant Chi-square test could not be performed due to the low response rate and also to the total number of missing observations received which made it extremely difficult to calculate any significant Chi-square scores of 0,05 and less. However, some cross-tabulations were included to calculate and determine some comparisons.

Attention will now be given to the conclusion and most important recommendations as well as possible future research that could be done. This will be done by applying the information obtained within the boundaries and limitations of this particular research study.

## CHAPTER 8

### CONCLUSION AND FINAL RECOMMENDATIONS

#### 8.1 INTRODUCTION

Within the scope of Chapter 7, the research findings of this particular study were identified and clearly discussed by means of various statistical methods and techniques. This chapter therefore, focuses on the conclusions and recommendations, as well as on some limitations and future research that could be undertaken.

During the literature review relevant subject literature were investigated and explored in order to establish and identify what the nature, scope and impact of HIV/AIDS are in South Africa and in particular the threat it poses to the business sectors, especially also to the private sector. The next step was to identify and discuss one of the most important long-term aspects related to the subject under investigation, namely: to investigate and analyse various structures, action programmes, policies and strategies (if any), as well as some relevant case studies to establish whether organisations are doing enough or not, to effectively manage and control the impact of HIV/AIDS within the workplace of organisations. With this primary objective in mind, it left the researcher at the point where further empirical research was needed in order to establish and determine what the actual impact of HIV/AIDS are within the workplace.

#### 8.2 LITERATURE REVIEW OF THE STUDY UNDERTAKEN

Currently HIV/AIDS are prevalent occurrences amongst the young, targeting people at the peak in life. This method of attack will have a serious effect on the country's economy, robbing it of its most precious asset – its people. The future may see the demise of working generations, leaving behind AIDS orphans and the aged. The South African workforce, from labourers to professionals, is under threat and action

is, therefore, needed to curb and minimise the spread and impact of HIV/AIDS, especially within the workplace.

AIDS is already costing businesses a great deal of money. These costs will continue to rise if organisations do not respond rapidly. AIDS increases health, pension and welfare costs. Pension funds are being hollowed out by premature death, since payments into the fund are cut off early just as payments-out increase. Insurance premiums are also increasing as well as secondary costs that include the following.

- Absenteeism, including funeral leave and leave to care for dependants with AIDS.
- Reduced productivity due to sickness and loss of motivation and concentration.
- Management resources such as time to develop response strategies and policy development and problem solving.

Therefore, it is absolutely imperative that comprehensive programmes and appropriate HIV/AIDS policies must be established within the workplace for a small portion of the total cost that would otherwise be incurred because of AIDS-related illness and death.

#### **There are four major ways in which HIV/AIDS could affect organisations**

- There will be a limited selection of employees – many talented people will succumb to the disease, some may be uneducated, as salaries are spent on medical fees, rather than on schools and tertiary institutions, and others will be left to care for the sick.
- There will be an increase in the cost of risk benefits, absenteeism, and costs related to the recruitment and training of new staff.
- There will be a reduction in overall productivity.
- The cumulative effect will cripple the country's economy.

The aim and importance of this particular study is, therefore, to determine and investigate whether or not the organisations under investigation have suitable and

sustainable structures, action programmes or policies in place in order to address the above issues (impacts) effectively.

In Chapter 1, research problems were defined and the purpose and objectives for the study were stated. A distinction was also made between various concepts such as: HIV/AIDS, strategy and action planning so as to make understanding of these concepts more understandable within the scope and nature of the described literature.

In Chapter 2, the theoretical aspect and impact of HIV/AIDS in Southern and South Africa, as well as globally, was investigated and analysed. Attention is also given to the background, epidemiological nature, socio-economic implications, as well as the impact on South Africa's population structure and future impacts of the disease. This was done in order to clearly comprehend how the disease is functioning and affecting the country's economy and its resources, especially with reference to South Africa's unique situation.

The following Chapter narrowed the focus of the study to the specific impact of HIV/AIDS on the South African business sectors, especially the private sector. The literature study is again supported by various statistical data as in the case of Chapter 2. Emphasis is placed on the direct and indirect costs of managing HIV/AIDS within the workplace and the legal implications (framework) on how to deal with the disease legally and legitimately within the workplace. Attention is once again given to various current structures in operation within South Africa in respect to addressing and reducing the impact of HIV/AIDS.

The corporate responses to HIV/AIDS have been identified and discussed in Chapter 4 especially with reference to various case studies. This was done to get a clear understanding of what type of strategy, action programme or policy could be applied or introduced with reference to specific conditions, needs and circumstances evident within specific organisations. Another important issue also addressed, included guidelines for the effective management and proper control of HIV/AIDS in the workplace.

In the last chapter on literature, (Chapter 5) the aim was to identify a specific strategy for the implementation by both the public and private sectors. The need and purpose for such a broad strategic plan, were then identified and discussed and included various important priority areas that needed to be addressed properly and effectively. One of the major issues within the scope of this particular research study, was to identify the possibility and to consider the evaluation and analysis of a broad national strategic plan based on the availability of human, financial and institutional resources within organisations in order to effectively manage and control the impacts of both HIV/AIDS especially in the workplace. As mentioned already, these priority areas needs to be effectively addressed and properly managed in order to reduce the impacts of HIV/AIDS. Various principles for the effective implementation of such a HIV/AIDS and STD plan, were also identified and clearly discussed.

### **8.3 ACHIEVEMENT OF THE STUDY'S OBJECTIVES**

Within the scope of Chapter 1 specific objectives were identified. Having examined various aspects related to the research topic under investigation, it is now possible to determine whether these objectives were met or not.

#### **8.3.1 Primary objective**

For organisations to effectively manage and control HIV/AIDS within the workplace, a sound and reactive approach is needed by means of well-formulated action programmes, policies, plans and a cost effective strategy or strategic plans of action. It was the intention of the study to determine if organisations do have measures (structures) in place to effectively manage and control HIV/AIDS within the workplace.

Although organisations clearly indicated that there are measures in place to manage and control the disease, other organisations clearly indicated that these co-called measures (action plans and programmes) are insufficient and do not properly address the situation adequately. Also important was the viewpoint held by organisations, which responded that there are a lack of support and ignorance towards management's



involvement towards the proper management and control of the disease within the workplace.

From the empirical findings it is however clear and evident that although organisations indicated that there are some structures in place to manage and control the disease, many organisations indicated that these structures are not sufficient and clear enough and that alternative measures (action plans and programmes) are needed to curb the spreading of the disease within the workplace of organisation.

### **8.3.2 Secondary objective**

The various secondary objectives of the study that were identified as supportive towards the primary objectives were also met.

- The literature study has provided a fair amount of information concerning the impacts of HIV/AIDS within the workplace.
- Various structures and action plans were clearly identified and discussed towards the effective management and control of the HIV/AIDS epidemic within the business environment.
- The role of management and other stakeholders were clearly identified and discussed in order to combat the disease.
- Various existing action programmes and policies were identified and discussed. Attention was also given to the implementation of a sound national strategic plan to be implemented by both the public and private sector businesses as well as the need, purpose and advantage of such a strategy for the organisation.
- The empirical part of the study was clearly aimed at measuring the success rate of these action programmes, policies, plans and strategies for the organisation (if possible).

From the above, it is clear that the secondary objectives of the study as outlined within the scope of Chapter 1, were met, where possible.

## 8.4 CONCLUSION AND RESEARCH FINDINGS

The following were identified as the most important conclusions and research findings within the specific scope and nature of this research study and were also derived and supported by the empirical research conducted within Chapters 6 and 7.

### 8.4.1 General information

It is important to take note of the fact, that although the information within this particular section does not directly contribute to the above objectives, it was still necessary to include this type of information within the broad scope and limitations of the particular study so as to make some important comparisons and interpretations.

It is interesting to note, that the majority of respondents responding include HR-managers (30,19 per cent) and HR-officers (28,30 per cent). This means, that HR-managers and HR-officers are still evaluated as important instruments for the formulation, implementation and maintenance of sufficient action programmes, policies and structures/strategies within the organisations under investigation, while the highest number of respondents (organisations) were representative of the manufacturing sector (43,39 per cent). It is, therefore, a very good indication that this particular sector is adequately represented within the area of study. It also proves the trend of the majority of economic activities conducted within the manufacturing sector, although the other sectors are also representative within the area under investigation.

Another important aspect, was the total number of permanent employees represented by the various organisations under investigation. As expected, the majority of respondents (43,40 per cent) represented a permanent number of employees between 500 and 1 000, which were more or less in line with the minimum requirement for the study, as already mentioned in Chapter 6. Interestingly enough, almost eight per cent (7,55 per cent) of the total number of respondents, indicated that they represent 3 000 employees or more, which indicates that some large organisations are representative and thus included within the scope of this study. The purpose of the study was to

include as large as possible organisations, in order to include as many as possible employees, so that these organisations (respondents) represent the majority of workers within the area under investigation. This was done in order to determine what the effects and implications of HIV/AIDS will be within the workplace, and especially on organisational resources.

The location of the various organisations was also an important factor within the scope and nature of this particular study. According to the information received, most organisations (respondents) under investigation, were more or less equally representative within the area of study, which included the majority of heavily industrialised (centralised) towns. These towns include Vereeniging (22,64 per cent), Vanderbijlpark (28,30 per cent) and Sasolburg (30,19 per cent). As already mentioned, the above information is also a good indication that industries (organisations) are relatively equally distributed within the area of study, which makes responses relatively representative and reliable.

#### **8.4.2 Specific issues**

As mentioned in Chapter 7, various specific issues related to the impact of HIV/AIDS within the workplace, need to be addressed and discussed in-depth. The following research findings and conclusions were identified as contributing towards the objectives identified within the scope of Chapter 1.

##### **8.4.2.1 Objective 1: To measure the impact of HIV/AIDS in the workplace**

According to the HIV-status of employees within the total number of respondents (organisations) responding more than two-thirds (73,08 per cent) indicated, that they do know of or may know someone (employees) who are infected with AIDS. This is quite a significant response and clearly indicated the proportion (impact) of the disease within the workplace of the various organisations under investigation. To cast further light on the matter these objective respondents were asked to indicate by means of percentages how many employees were infected or may be infected with AIDS. The response was that just over 78,00 per cent of the total number of

respondents responding, indicated that the infection rate of employees within the various organisations represented 20,00 per cent or less, which is again an important response to the particular question. From the above information, the conclusion can be made that most employees infected within the various organisations under investigation also represent 20,00 per cent of the total number of respondents (organisations) employees respectively. This is an important fact and once again poses the questions: “Are organisations fully aware of the impact that HIV/AIDS have on the organisation?” and, “are both the organisation and especially management reluctant towards the impact that HIV/AIDS have on the organisation and its resources?”

Other negative impacts related to HIV/AIDS within the workplace, include -

- an increase in absenteeism and labour turnover, as well as
- an increase in direct health care costs.

It is important to understand that the various aspects mentioned above could have a profound effect and impact on the organisation and its resources, if not properly managed and controlled. Equally important to the impact of HIV/AIDS, are discriminating practices and human rights violations evident within organisations. Almost 60,00 per cent (58,80 per cent) clearly stated that they were not aware themselves of having done anything wrong in this respect. Once again, the conclusion can be made, that almost 60,00 per cent of the total respondents responding do not see themselves as being discriminatory towards employees who are HIV-positive and therefore, do not impinge on the human rights of infected employees. However, there is some evidence to suggest that organisations can do more to prevent more negative influences within the workplace. Some discriminating practices still evident, include the following.

- The disclosure of a person’s (employee) HIV-status within the workplace.
- Unwillingness to associate with a person (employee) who is HIV-positive.
- Limited contact (interaction) with a person (employee) who is HIV-positive.

**8.4.2.2      *Objective 2: To measure the effective management of the HIV/AIDS epidemic in the business environment***

To support the above objective respondents were asked to indicate if they did have any adequate measures (formal or informal action programmes, policies or strategies) in place to effectively manage the AIDS epidemic within the workplace. As expected almost two-thirds of the total number of respondents indicated, that they did have some formal measure in place in order for them to manage and control HIV/AIDS. Although the response rate is in favour (62,26 per cent) of formal measures being used, it is still worrying that the rest of the total number of respondents indicated, that they did not have some form of informal or no measure in place in order to manage and control HIV/AIDS (37,74 per cent) at present. The conclusion that can be drawn from the above information is that although more than 60,00 per cent of respondents (organisations) may feel that they are adequately prepared, almost 40,00 per cent indicated that it might not be the case. Once again, the primary aim of this study is being addressed. Do organisations have sufficient and adequate action programmes, policies and structures in place to manage and control HIV/AIDS within the workplace?

**8.4.2.3      *Objective 3: To measure the role of management in order to combat the disease***

In order to achieve the above objective, it was important to determine what active role management is playing to effectively manage and control HIV/AIDS within the workplace.

These included aspects such as the following.

- HIV/AIDS as part of the overall business strategy or policies concerning life-threatening diseases.
- Organisational benefits that make provision for employees who are HIV-positive.

The following conclusions were drawn from research on the various aspects mentioned above. With reference to the first aspect, most of the respondents (organisations) responding, felt that HIV/AIDS must be included as part of a larger policy concerning life threatening diseases (65,38 per cent) as opposed to merely dealing with it on a separate basis (30,77 per cent). This point of view by the total number of respondents (organisations) responding, provide an important insight into what ways management is dealing with the disease and what management feels how HIV/AIDS should be addressed and managed within the workplace. With regard to the second issue, most respondents indicated, that training (63,22 per cent) must form an integrated part and must be included within organisational benefits that make provision for employees who are infected, as well as provision for primary health care (60,00 per cent). The opposite, however was evident as pension and disability (52,17 per cent) were not included as part of organisational benefits that made provision for employees who are HIV-positive.

**8.4.2.4      *Objective 4: To measure existing action programmes, policies and strategies for the successful implementation within the workplace***

According to the distribution of action programmes, policies and structures currently in operation within the workplace of organisations, the following important conclusions were drawn. A relatively large number of respondents indicated, that they are distributing information materials on the subject by means of pamphlets, newsletters, brochures and billboards (91,49 per cent), while 80,00 per cent indicated, that they (organisations) are making use of various educational programmes in order to educate and inform employees, followed by well-structured EAP programmes (75,00 per cent). It seems that these methods are currently the most popular and effective ways used by the various organisations under investigation to effectively manage and control the disease within the workplace.

Equally important, was that the majority of respondents (organisations) clearly indicated, that there is a greater need for improved teamwork (60,97 per cent) among all parties involved, as well as effective group workshops (65,11 per cent) for employees on all levels of management.

Once again, the emphasis is on everybody (management and employees) to see to it that effective and sufficient programmes, policies and structures are in place, so that adequate steps could be taken to minimise the threat and impact of AIDS within the workplace.

**8.4.2.5      *Objective 5: To measure the success rate of these action programmes, policies and strategies for business (if possible)***

As mentioned, if specific action programmes, policies and strategies are correctly used and implemented, certain specific positive outcomes will be realised. The aim of this particular objective is to determine just that. The following positive outcomes were achieved by the various organisations responding.

- Effective education programmes.
- Effective distribution of condoms.
- EAP programmes and proper support.
- Better counselling services.

The above outcomes must not be seen as the only viable methods to effectively manage and minimise the impact of HIV/AIDS, but must be seen as part of the total options available to all parties (management and employees) involved in the fight against AIDS. However, some outcomes also represented negative aspects that clearly need to be addressed by management.

These include -

- no or limited AIDS training and awareness programmes,
- the lack of overall strategy and policies,
- management reluctance towards the epidemic, and
- lack of commitment and adequate funding.

## 8.5 STATEMENTS/FACTORS THAT INFLUENCE OR MIGHT HAVE AN INFLUENCE ON ACTION PROGRAMMES, POLICY AND STRUCTURE FORMULATION OR IMPLEMENTATION

One of the main focuses of the study relating to Objective 2, namely to measure the effective management of the HIV/AIDS epidemics within the workplace, will now receive attention. The following statements/factors were identified as the most important according to the viewpoint of the total number of respondents (organisations) responding within the scope of this particular research study. These particular viewpoints were clearly identified after the mean (average) for each item, together with the variance, standard deviation and item scale correlation had been calculated and include the following.

- Absenteeism will impact negatively (statement no. 3).
- Increased vulnerability as more employees are infected (statement no. 1).
- Reduced performance due to HIV/AIDS sickness on the job (statement no. 4).
- Employee benefit structures will be affected with an increase of HIV/AIDS cases (statement no. 7).
- Well-designed programmes to reduce infection that leads to an increased awareness among employees, will have a positive impact on the management of HIV/AIDS in the workplace (statement no. 24).
- Methods should be created to encourage openness (statement no. 26).
- An increase in direct costs (statement no. 8).
- Training and recruitment of employees will be severely affected (statement no. 5).
- Reduction in the average skills level, performance, institutional memory and experience of workforce (statement no. 16).
- Illness and death of key employees may prove disastrous for the organisation (statement no. 6).
- Average age and experience of employees will be affected (statement no. 10).
- An increase of organisational downtime due to AIDS-related absences (statement no. 14).



- All persons with HIV/AIDS have the legal right to privacy in the workplace (statement no. 25).
- Employees who are HIV/AIDS infected and who die or retire on medical ground do have to be replaced (statement no. 18).

All the factors/statements were seen from the viewpoint as their being equally important and very significant within the formulation and implementation of policies, action programmes and structures, as well as the evaluation thereof. After all the factors/statements were compressed into a smaller number of significant categories the following important factors/statements were identified as being important towards investigating and analysing specific structures (strategies), action programmes and policies in order to effectively manage and control AIDS within the workplace.

- Construct 1: Vulnerability and absenteeism towards HIV/AIDS within the workplace: statement no. 1, 3, 7, 14, 18 and 19.
- Construct 2: Management and control of HIV/AIDS within the workplace: statement no. 5, 9, 11, 13, 17, 20, 26 and 30.
- Construct 3: Discriminating practices and human rights violations on the ground of HIV-status: statement no. 15, 25 and 29.
- Construct 4: Specific programmes and structures to reduce the impact of HIV/AIDS within the workplace: statement no. 21, 24, 27, 28, 31.
- Construct 5: Production and organisational resources effected or not effected: statement no. 2, 4, 8, 10, 12, 16, 22 and 23.

## 8.6 RECOMMENDATIONS

It is important to include specific actions and recommendations as part of this particular chapter so as to make a contribution towards the specific literature study on the relevant subject under investigation. Recommendations and more clearly, specific actions, are needed in order to establish and determine in what way future action programmes, policies and strategies could be utilised and implemented in order to reduce the impact of AIDS within the workplace and effectively manage and control.

The following actions and recommendations were identified as the most important within the scope and nature of this research study.

### **8.6.1 Greater management involvement and commitment**

For any HIV- or AIDS-policy, action programmes or strategies leading to effective management involvement and commitment are essential. The way, in which management respond to and manage the HIV/AIDS threat within the workplace, will have a profound and significant effect on how the rest of the organisation will respond to such challenges. Management can achieve this goal only by implementing the following guidelines.

- By conducting an actuarial impact analysis.
- Designing a specific strategic response based on the above analysis.
- Developing policies for implementation and training purposes.

The way in which management respond and react to the impact of AIDS within the workplace, will ultimately determine success or failure.

### **8.6.2 A more effective HIV/AIDS strategy**

The following recommendation is seen as constituting a very important and vital aspect within the scope of this particular study. Without an effective strategy, many organisations will ultimately fail and lose the fight against AIDS within the workplace. Any effective strategy, however, requires a holistic approach on how to properly manage the impact of AIDS on organisational resources. This holistic approach includes the redesigning of risk benefits in order to ensure long-term viability and survival. In the end, it is in the best interest of employers (organisations) to keep employees healthy and productive for as long as possible. By investing in the health of employees, management could ensure positive outcomes for all employees, namely -

- reducing absenteeism,
- increasing productivity levels,
- reducing employee benefit costs,
- ensuring a competitive advantage over other organisations that do not manage and control the AIDS epidemic effectively.

Once again, the emphasis is placed on the need for a well-formulated and structured AIDS strategy that can be implemented to the benefit of the organisation and its employees (Chapter 4) as a whole.

### **8.6.3 More effective education and training programmes**

It is absolutely imperative that organisations should seek new and innovative ways to effectively educate and train employees on various issues related to HIV/AIDS. The key still is education with a capital “E”. Some of the programmes that could be implemented to educate employees, include the following.

- The vital consequences if the disease continues to spread at its current rate.
- Social responsibility projects (programmes) within communities in which employees live.
- Reaching as many people as possible for purposes of personal care and family support.

There is an ever-increasing need and demand, that education programmes and training methods used, must become more effective, especially in the way messages are conveyed and communicated across to various target audiences. Implementing the so-called KAP survey, can enhance the design of training programmes. The (KAP) survey assesses the following in respect of both employees and management respectively.

- Knowledge: Insight into HIV/AIDS, how it is transmitted and how it can be prevented.
- Attitudes: Perceptions of personnel risks towards the disease.

- Practices: Sexual behaviour in the community, as well as discriminatory behaviour (<http://www.accountancysa.org.za>).

The KAP programme, therefore, plays an important role and is also seen as the most important stage towards the development of an effective AIDS-training strategy.

#### **8.6.4 A better and more improved recruitment policy**

The recruitment of employees already infected with HIV/AIDS, will become an ever-increasingly possibility for organisations. In order to keep abreast, organisations must apply recruitment policies that make provision and address the issue fairly. This means, that a recruitment policy must be in place to cover the situation adequately from the moment a person applies for a job, till the day he or she leaves the organisation. This means, that the following specific actions must be implemented by the organisation.

##### **8.6.4.1 *Pre-employment medical examination***

Many factors are taken into account in the selection of suitable applicants. The medical criterion for employment, is fitness to fulfil the job requirements. The selection process may include a medical examination designed to screen applicants. Applicants with signs of advanced HIV disease or AIDS, will be submitted for a full medical assessment and their fitness for work should be assessed by the medical practitioners involved.

Pre-employment HIV-screening will not succeed in keeping the workforce free of HIV infections, as many employees will become infected whilst they are employed. For this and other reasons, HIV-screening will not be sufficient enough (refer Chapter 3).

There are no rational grounds for testing employees for HIV-infection as the infection does not normally pose any threat to co-workers and it is recognised that HIV is not spread only casually. For this reason, mandatory HIV-testing

will not be conducted and fitness for work must, therefore, be the criterion for continued employment.

#### **8.6.4.2      *Retention in employment***

An employee with HIV/AIDS is entitled to continue working as long as he/she is able to adequately fulfil his/her job requirements and as long as his/her work does not pose a threat to himself/herself or his/her colleagues. Termination of employment as a result of HIV/AIDS will be considered only if and when an employee is unable to carry out his/her normal work function, or should the employee be unable to attend the required number of working days, provided all sick leave and other appropriate leave have been fully utilised. Incapacity to do the job will be the major criterion for boarding employees or for dismissal. An independent medical assessment may also be called for, to assist in the assessment of the employee and may be utilised to determine:

- the employee's ability to perform his/her work, and
- the possible threat posed to himself/herself or his/her colleagues.

#### **8.6.5    *The effective distribution of information materials***

The success rate in how the impact of HIV/AIDS will be controlled and reduced (if possible) within the workplace, will ultimately determine if organisations are capable to cope with the disease in the long-term or not. For this very reason, it is important that various resources be identified to ensure that sufficient studies and monitoring systems provide improved and up-to-date information on the impact of AIDS within the workplace of organisations.

As respondents (organisations) already indicated within the scope of this particular study, more effective distribution of information materials are needed to curb the spreading of the disease among employees (Appendix D). The following recommendations could be implemented for the effective distribution of information materials.

- Information about the nature of the illness and programmes available to combat AIDS and to support infected employees must, be disseminated effectively, in user-friendly communication format, such as:
  - posters,
  - pamphlets,
  - newsletters,
  - billboards,
  - T-shirts, coffee mugs, and
  - Fact cards.
  
- Information about AIDS fluctuates almost daily, therefore, the organisation must stay abreast of new developments and disseminate up-to-date information, as and when it becomes available.
  
- Continuous education is the best weapon for combating employee fears related to AIDS.

#### **8.6.6 Better and more effective communication**

The evaluating process for any policy, action programme or strategy, lies in the question as to whether management, especially task force members, have sufficient knowledge about all aspects of the disease within the workplace and very importantly, the ability of those concerned, to effectively communicate the knowledge to employees and their families. The following recommendations could be regarded as vital aspects within a well-formulated and structured communication programme.

- Managers and supervisors should be made aware of employees' concerns and the importance of confidentiality should be carefully addressed.
- The evaluation of a well-formulated and structured communication programme should be examined thoroughly in order to determine whether the general workforce understand the important facts and issues regarding AIDS and related company policies.
- Do employees know how AIDS is (is not) transmitted.

- Do employees understand the so-called “in-house” AIDS-related communication programme and channels available?

Many organisations may believe that in order to develop an effective AIDS communication programme, would be costly and difficult to implement. However, dealing with this issue responsibly, effectively and pro-actively will in the long run, benefit both the organisation and its employees when also assisted by well-formulated AIDS policies and comprehensive action programmes and structures in order for the organisation to cope effectively with AIDS in the workplace.

#### **8.6.7 The availability of adequate resources to better manage and control the impact of HIV/AIDS**

The availability of sufficient and adequate resources to manage and control AIDS within the workplace, is one of the major issues that could hamper the successful control of the disease. The organisation, therefore, needs to conduct a meaningful and intense impact assessment study in order to effectively determine what could be done and what the actual impact of HIV/AIDS comprises on organisational resources. The following areas were identified as being vital, if organisations are to succeed in improving their available resources to fight and control the disease effectively.

- Improved medical aid schemes and disability funds that make provision for infected employees as well as pension funds.
- Improving recruitment policies that make provision for infected applicants.
- Increasing awareness and improving training and education programmes.
- Allocating financial resources towards countering the impact of HIV/AIDS – the cost of managing the disease more effectively.
- Measures to calculate the supply and cost of labour affected by the impact of AIDS.
- Provision for socio-economic prosperity and workers’ morale.
- The integration of workplace policy and programmes that are fully inter-sectoral by nature.

- Adequate provision made by the organisation with regard to positively steer the impact on the individual (worker), family, community and society.

### **8.6.8 Targeting youth and commercial sex workers**

All recommendations discussed until this point, was more or less workplace-orientated. The following recommendations are not the responsibility of only and exclusively business, but that of local government as well. In order to be effective, a partnership is, therefore, needed between the private and public sectors of business, especially in educating the youth and commercial sex workers.

Health education for young people has the potential to reduce the unwanted outcomes of coital activity. Given the complex and multi-determined nature of sexual behaviour, it is realistic for health educators to expect young people to modify their practices after formal education. The answer once again lies in the effective communication of a number of successful programmes aimed at delaying the initiation of intercourse, reductions in unwanted pregnancies, birth and abortion rates, as well as increased use of contraception and condoms. These success programmes are more vital when it comes to changing attitudes and increasing levels of factual knowledge than in merely modifying actual sexual practices.

With regard to commercial sex workers, different types of education programmes are needed in order to curb and further prevent infections from spreading (if possible). One of the methods identified as being effective, is to hire specialists to train “peer-educators” – prostitutes who teach other prostitutes about safe sex and the risks associated with these practices.

However, the concern about the limited success of interventions in changing sexual behaviour in the direction of greater contraceptive and/or common use and reduced coital activity, has led to the use and identification of those features of programmes which have been associated with change. The following criteria have been identified as contributing towards the achievement of the increased use of contraceptives and condoms, as well as the reduction in coital activity.



- Basing the programmes on behaviour-change theories.
- Time aspect and implications attached to programmes.
- The involvement of various interactive activities, such as:
  - role play,
  - skills rehearsal,
  - discussions, and,
  - strategy development.

Furthermore, education programmes appear to have a greater success should it be part of behaviour that is pro-active, rather than modifying pre-existing practices.

#### **8.6.9 Specific actions required**

The following actions were also identified as important to the nature and scope of this particular research study although these actions and recommendations are only marginally representative of the overall response rate. It is believed that the following actions get a clear view and understanding of the various needs and expectations within the various organisations under investigation. Due to the scope and nature of this chapter, these specific actions and recommendations will only be identified and not discussed.

These include the following.

- More frequent testing of employees (if possible).
- More AIDS-awareness campaigns.
- More openly and frequent group discussions on HIV/AIDS.
- More freely and open distribution of condoms.
- Adequate EAP programmes for infected employees.
- More effective training of counsellors
- The implementation of separate AIDS committees and forums.
- Creating a climate of openness towards HIV/AIDS.

- Provision for family support structures.
- Better and more cost-effective prevention programmes.
- Creating an “open door” policy in order to accommodate employees who are or might be infected.
- Peer-educator programmes driven by medical staff.
- Change in attitudes and morals towards HIV/AIDS.
- More effective leadership by management.
- Regular audit reports on costs and productivity regarding HIV/AIDS.
- Regular updates on absenteeism and medical registrations.
- Allocation of a separate HIV/AIDS budget (if possible).
- Voluntary and anonymous surveillance towards HIV/AIDS within the workplace.
- Better training methods and techniques to minimise the impact of HIV/AIDS.
- Involving trade unions and others in the fight against AIDS.
- Multi-skilled training of employees, in order to ensure that replacements are on hand should trained workers die.

#### **8.6.10 Other actions identified**

The following additional recommendations were identified as being supportive towards the objectives within this research study and those will be briefly discussed.

##### **8.6.10.1 *Accelerate socio-economic development***

Poverty, inequality and structural factors, which disrupt a stable family and community life, will continue to make people susceptible to HIV-infection. Poverty and inequality also increase the possible impact of HIV/AIDS. Adequate income, housing, water supply and sanitation, are critical to households' abilities to cope with HIV-related illness, and to maintain the dignity of people with a late-stage illness. Reducing unemployment and improving living standards in general, are thus critically important towards combating the cycle of poverty, which will sustain the epidemic and worsen its impact.

#### **8.6.10.2      *Improve prevention programmes within the workplace***

Prevention programmes are a particularly urgent priority in organisations where HIV prevalence is still not as high as in other cases, but that remains prevalent even in organisations with a high prevalence rate, as a large number of new infections continue to occur daily. Particular attention should be paid to reaching those employees who are most susceptible to infection and who are most likely to spread it further. Legislation, regulations and attitudes which hinder prevention among employees with STD's most at risk, must be challenged.

Programme messages should aim at reducing the stigma of HIV/AIDS and provide information, which helps organisations to manage the impact of HIV/AIDS. All prevention programmes must actively strive to help employees to address the personal, social and economic circumstances, causing them to resort to less safe sexual practices.

#### **8.6.10.3      *Establish inter-sectoral co-ordination***

An effective response to HIV/AIDS, requires an inter-sectoral approach. All sectors have an interest in reducing the impact of the epidemic and incorporating it into their planning. The issue cannot simply be seen as only being the responsibility of the public or health sectors alone. The following demand close attention.

- Sectors need to collaborate in order to build capacity for appropriate responses to HIV among their employees.
- Many of the priority needs of people with HIV/AIDS will be, to develop capacity for care, which meets HIV/AIDS needs in an affordable and cost-effective way. Health workers at all levels must be given the skills and knowledge to care effectively for people with HIV/AIDS.

**8.6.10.4      *Reduce the HIV/AIDS stigma within the workplace***

The key to effective medical intervention, is the early diagnosis of HIV-infection. In addition, early knowledge of infection is central to the ability of infected people, their families and employers, to plan and to reduce the impact of the disease. It also makes possible the control of the further spread of HIV. In the light of these factors, it is essential that the current stigma surrounding HIV/AIDS be reduced. People (employees) with the disease, need to be confident in the sense that knowing and revealing their status, will not expose them to prejudice, or financial and other penalties, especially within the workplace.

**8.6.10.5      *Support affected people and orphans***

Efficient, affordable ways to provide financial and other support to people infected and affected by HIV/AIDS, must be identified as a matter of urgency. Experience in other countries indicates that interventions, which reinforce existing community and family support systems, will invariably be the most cost-effective. Institutional care for orphans, the elderly, or people with HIV/AIDS, is often more expensive than grants or other mechanisms to support community-based care, and has only limited ability to meet their priority needs. Organisations must, therefore, be prepared what implications the above impact will have on workers' morale and especially on family life.

AIDS orphans represent one of the most enduring and damaging effects of the epidemic. Focused research and planning are urgently needed in order to ensure that the effect on children and society at large, is adequately managed.

**8.6.10.6      *Improve information on the epidemic and its impact within the workplace***

Resources must be identified so as to ensure that proper studies and monitoring systems provide improved information on the impact of HIV/AIDS, especially within the workplace.

**8.6.10.7      *Recommendations towards the adoption of an AIDS strategy for organisations***

A strategy to cope with AIDS in the workplace, should ideally be developed before the first case has been diagnosed and should include the following six basic recommendations for the management of organisations (if possible):

- Stay well-informed.
- Formulate and practise organisational policies.
- Enter into discussions and negotiations with the organisation's health insurance carrier.
- Provide employees with opportunities to attend organisational-sponsored AIDS education seminars.
- Explore the option of joining a Multi-employer trust for insurance coverage.
- Stay abreast of current, as well as new legislation.

**8.7      FINAL COMMENTS**

Although the AIDS epidemic is increasing in intensity across South Africa, it seems unlikely that government had any or little impact in managing the disease effectively. This fact can be due to present governmental legislation that prevent employees from disclosing their HIV-status within the workplace, as well as the prevention of employers to make use of any methods to test employees (Act 108, 1996 – refer Chapter 3). However, many organisations have already learned, that through aggressive strategic actions, several specific issues related to the impacts of HIV/AIDS within the workplace, can be effectively addressed and properly managed.

These issues include the following.

- HIV-prevalence rate across different sectors of the business.
- Corporate strategic issues.
- Cost implications for retirement benefits.

- Cost implications for group insurance benefits.
- Cost implications for medical benefits.
- Impact on manpower and productivity.
- Evaluation of Human Resource and Industrial Relations policies and procedures.

Based on the above issues, a tailored strategic response designed to save the organisation money and time, can be developed.

An effective response to HIV/AIDS in the workplace, must include the development of a formal organisational policy on AIDS. The policy must address the organisation's legal obligations and must provide a framework in respect of how management and employees will be expected to deal with AIDS-related issues within the workplace.

Following any policy development, a thorough response would include the development and implementation of a cost-effective training programme.

Effective AIDS training programmes are two-fold. All employees, including management, should take part in a programme designed to prevent infection, teach people living with HIV or caring for someone with HIV how to stay healthy, and teaching them about the issues that arise when co-workers are living with HIV. The second part of the training programme, shall be designed to educate management on the business impacts of AIDS and to ensure that they are prepared to deal with these issues in accordance with company policy and legislation.

Without effective and proper AIDS programmes, policies and strategies, organisations will be doomed because of the way they are managing and controlling the disease. Therefore, it is of the utmost importance, that organisations will react in a way that will minimise the impact and risk on organisational resources, so that organisations can still be effective in the way they are conducting business.

## 8.8 LIMITATIONS OF STUDY AND FURTHER RESEARCH

The study has certain limitations namely –

- The sample frame that were used within the scope and nature of this study, included only the greater Lekoa Vaal Metropolitan area, and it is, therefore, important that any reference made to this study, should be interpreted as such and not as representative of the total South African population.
- The sample consisted of 53 respondents, which is relatively low. This could be due to the specific criteria related to the particular study, namely that only heavily industrialised organisations that represented 500 employees and more were included, which exclusive of all other forms of industries within the area of study.

The following opportunities for future research were identified in the course of this study.

- A comparative study in other metropolitan industrialised areas within South Africa to investigate any similarities and trends.
- A comparative study, with the emphasis on small –sized or medium-sized organisations within the relative area of study.
- A comparative study between the major industrialised regions within the country in order to investigate any similarities or trends.
- Investigating the probability for an “AIDS strategy for business” as a long-term result and outcome of this particular study.

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**HIV/AIDS IN THE WORKPLACE:  
PRELIMINARY RESEARCH QUESTIONNAIRE**



**HIV/AIDS IN THE WORKPLACE  
PRELIMINARY RESEARCH QUESTIONNAIRE**

Dear Respondent,

The following questionnaire is a preliminary questionnaire to finalise the final research questionnaire on HIV/Aids in the workplace. It will be appreciated if the questionnaire would be completed as thoroughly and accurately as possible. All information will be treated on a strict confidential manner and will only be used for academic and research purposes. Your co-operation in this regard will be highly appreciated.

Thank you,

Freddie Venter  
University of Pretoria

.....

**Instructions for completion:**

Please answer all the questions.

**Question 1:**

Briefly explain your organisation’s formal policy to address HIV/Aids in the workplace.

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.....  
.....

**Question 2:**

What structures do your organisation have in place to manage the HI/Aids epidemic effectively (e.g. policies, employee care programmes, etc).

.....  
.....  
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**Question 3:**

Does your organisation address HIV/Aids as part of a larger policy concerning life-threatening illnesses, or separately? Please give your reasons why.

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

**Question 4:**

Briefly explain your employee care programme, if any.

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

**Question 5:**

What is your organisation's policy with regard to medical testing?

.....  
.....  
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**Question 6:**

Does your organisation's Medical Aid Plan make special provision for people with HIV/Aids? If yes, please explain.

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

**Question 7:**

What methods do your organisation use to educate employees on the HIV/Aids?

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

**Question 8:**

What measures do your organisation take to ensure the safety of employees – not to contract the virus from co-workers.

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.....  
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.....

**Question 9:**

How have aids influenced your company over the last five years?

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.....  
.....  
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**Question 10:**

What health and social support services (such as counselling, testing and condom distribution) does your company offer?

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

***THANK YOU VERY MUCH FOR YOUR CO-OPERATION IN COMPLETING THIS SURVEY***

**HIV/AIDS: RESEARCH QUESTIONNAIRE**

UNIVERSITY OF PRETORIA

For office use only  
v1 

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 1-3

DEPARTMENT OF BUSINESS MANAGEMENT

HIV/AIDS: RESEARCH QUESTIONNAIRE

Dear Respondent,

The following questionnaire is part of an extensive doctorate research study undertaken to investigate and determine if there are suitable and sustainable structures, action programmes, policies or strategies in place to combat and effectively manage and control HIV/Aids in the workplace. It will be highly appreciated if you (the respondent of this research) would complete and answer the questions as thoroughly as possible. All information will be treated in a confidential manner and will only be used for academic purposes.

Thank you for your co-operation,

Freddie Venter  
Department of Business Management  
University of Pretoria  
Cell: 082 801 2658

***Instructions for Completion:***

1. Please answer all relevant questions regarding to the impact of HIV/Aids as objective and honest as possible.
2. Where asked for comments or to express own opinion etc., keep answers as short and to the point, but yet thoroughly and honest as possible.
3. Mark a tick or cross in the spaces provided, which reflects your answer the most accurately and correctly after each question.
4. Answer all questions, if possible, this will provide more information to the researcher so that an accurate analysis and interpretation of data can be made.

## SECTION A

### GENERAL INFORMATION

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1. Your position within the organisation?

v2  4

1.	HR-Manager	
2.	HR-Officer	
3.	Medical Officer	
4.	Other (please specify) .....	
	.....	

2. Primary end product or service rendered in your organisation

v3  5

1.	Chemical and/or pharmaceutical	
2.	Manufacturing	
3.	Petroleum	
4.	Utilities	
5.	Mining	
6.	Construction	
7.	Other (please specify).....	
	.....	

3. Number of permanent employees in your organisation  
(please indicate only the number of your Vaal Triangle-based employees)

v4  6

1.	More than >500	
2.	Between 1 000 – 1 500	
3.	Between 1 500 – 2 000	
4.	Between 2 000 – 2 500	
5.	Between 2 5 00 – 3 000	
6.	More than >3 000	

4. In which town in the Vaal Triangle region is your organisation  
Located

v5  7

1.	Vereeniging	
2.	Vanderbijlpark	
3.	Sasolburg	
4.	Meyerton	
5.	Carltonville	

**SECTION B**

**HIV/AIDS: SPECIFIC QUESTIONS**

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v6   8-9

5. Does your organisation have a formal or informal HIV/Aids action plan, policy or programme?

1.	Formal	
2.	Informal	
3.	Don't know	

6. What programmes, policies or structures are currently used in your organisation to manage the impact of HIV/Aids more effectively in the workplace?

	Yes	No	Don't know		
1. Peer led-programme				v7	<input type="checkbox"/> 10
2. Education programmes				v8	<input type="checkbox"/> 11
3. Presentations				v9	<input type="checkbox"/> 12
4. Teamwork				v10	<input type="checkbox"/> 13
5. Training sessions				v11	<input type="checkbox"/> 14
6. Distribution of information materials				v12	<input type="checkbox"/> 15
7. Condoms sold and distributed to employees and dependants				v13	<input type="checkbox"/> 16
8. HIV-positive workers are offered counselling and encourage to act in a responsible manner				v14	<input type="checkbox"/> 17
9. Group workshops				v15	<input type="checkbox"/> 18
10. Distribution of educational items such as T-shirts, mugs, etc.				v16	<input type="checkbox"/> 19
11. Employee assistance programmes – EAP's				v17	<input type="checkbox"/> 20
12. Other (please specify) ..... .....				v18	<input type="checkbox"/> 21

7. Are you aware of any employees in your organisation who are HIV-positive or who had been diagnosed with full-blown Aids?

v19  22

1.	Yes	
2.	No	

If yes, please indicate by means of percentage (if possible).

v20  23

1.	< 10%	
2.	Between 10-20%	
3.	Between 20-30%	
4.	Between 30-40%	
5.	Between 40-50%	
6.	Between 50-60%	

8. Do you believe that Aids should be addressed as:

v21  24

1.	Part of a larger policy concerning life-threatening illnesses?	
2.	Dealing with it on a separate basis?	
3.	Not dealing it at all?	
4.	Don't know?	

9. Has your organisation adjusted its benefits and other plans to accommodate workers with HIV/Aids by addressing the following:

	Yes	No	Don't know			
1.	Health care			v22	<input type="text"/>	25
2.	Employee benefits (pensions and disability)			v23	<input type="text"/>	26
3.	Training			v24	<input type="text"/>	27
4.	Work duties and performance			v25	<input type="text"/>	28
5.	Recruitment			v26	<input type="text"/>	29
6.	Other (please specify)			v27	<input type="text"/>	30
	.....					
	.....					



10. What negative impact does HIV/Aids already have on your organisation?

	Yes	No	Don't know		
1. Loss of experienced personnel – particularly at middle management and skilled workers levels				v28	31
2. The need for increased resources to hire and retain replacements				v29	32
3. An increase in absenteeism and labour turn-over				v30	33
4. A decrease in productivity levels				v31	34
5. An increase in healthcare costs				v32	35
6. Loss of customer and consumer spending				v33	36
7. Other (please specify) ..... .....				v34	37

11. Describe what kind of discriminating practices or human rights violations if any, do you still see or experience related to HIV/Aids infected workers? v35 


 38-39  
v36 


 40-41

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

12. What is your organisation doing well with regard to the management and control of HIV/Aids in the work place (if applicable)? v37 


 42-43  
v38 


 44-45

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

13. What is your organisation doing wrong with regard to the management and control of HIV/Aids in the work place? v39 


 46-47  
v40 


 48-49

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

## SECTION C

## EVALUATING ACTION PROGRAMMES, POLICIES AND STRATEGIES

14. This section of the questionnaire indicate to what extent the following statements below, will have an influence on policy and structure formulation/implementation within the working environment of your specific organisation and to what extend you agree with each particular statement below (please mark every statement whether it applies or not).

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STATEMENT	1	2	3	4	5			
	Agree strongly	Agree	Uncertain	Do not agree	Disagree totally			
1. Increased vulnerability as more employees get infected with HIV/Aids						v41		50
2. Production costs will not increase as more employees are infected						v42		51
3. Absenteeism will impact negativity						v43		52
4. Reduced performance due to HIV/Aids sickness on the job						v44		53
5. Training and recruitment of employees will be severely affected						v45		54
6. Illness and death of key employees may prove disastrous for the organisation						v46		55
7. Employee benefit structures will be affected with an increase of HIV/Aids cases						v47		56
8. An increase in direct costs						v48		57
9. Morale of workforce will not be affected as more co-workers get infected and ultimately dies of full-blown Aids						v49		58
10. Average age and experience of employees will be affected						v50		59
11. Accidents within the work environment will not be effected						v51		60
12. Organisational resources will not be affected						v52		61

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STATEMENT	1	2	3	4	5			
	Agree strongly	Agree	Uncertain	Do not agree	Disagree totally			
13. No disruption of schedules, work teams or units						v53		62
14. An increase of organisational down-time due to Aids-related absences						v54		63
15. Unfair discrimination or stigma against an employee on the grounds of HIV-status.						v55		64
16. Reduction in the average level of skill, performance, institutional memory and experience of workforce						v56		65
17. Business will not be affected if suppliers of key inputs fail to manage the HIV/Aids impacts adequately						v57		66
18. Employees who are HIV/Aids infected and who die or retire on medical grounds do have to be replaced						v58		67
19. Employers don't have to increase the size of their work force to provide for deaths during apprenticeship and because of absenteeism generally						v59		68
20. The costs of health care, medical aid and hospitalisation will not be affected						v60		69
21. Consumer-base and credit loans will not be affected by the HIV/Aids epidemics						v61		70
22. Growth in the volume of sales will remain unaffected						v62		71
23. HIV/Aids will make it more expensive for an organisation to produce a given quantity of it's products unless it can reduce it's cost in other ways						v63		72

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STATEMENT	1	2	3	4	5			
	Agree strongly	Agree	Uncertain	Do not agree	Disagree totally			
24. Well designed programmes to reduce infection that leads to an increase awareness among employees will have a positive impact on the management of HIV/Aids in the workplace						v64		73
25. All persons with HIV or Aids have the legal right to privacy in the workplace						v65		74
26. Methods should be created to encourage openness						v66		75
27. The risk of HIV transmission in the workplace is minimal						v67		76
28. Providing appropriate equipment and materials to prevent employees from the risk of exposure to HIV in the workplace will have a significant impact on the spreading of the disease						v68		77
29. An employee may not be compensated if he or she becomes infected with HIV as a result of an occupational accident within the workplace						v69		78
30. Legislation aspects pertaining to HIV/Aids in the workplace is non-existent						v70		79
31. HIV/Aids will not affect business						v71		80

15. Respondent number

v72 

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 1-3

16. Card number

v73 

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 4-5

17. Repeat number

v74 

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 6

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15. What specific actions and recommendations can you suggest to ensure a proper and successful HIV/Aids strategy to be implemented or managed by management on all organisational levels?

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v75			7-8
v76			9-10
v77			11-12
v78			13-14
v79			15-16

Please describe:

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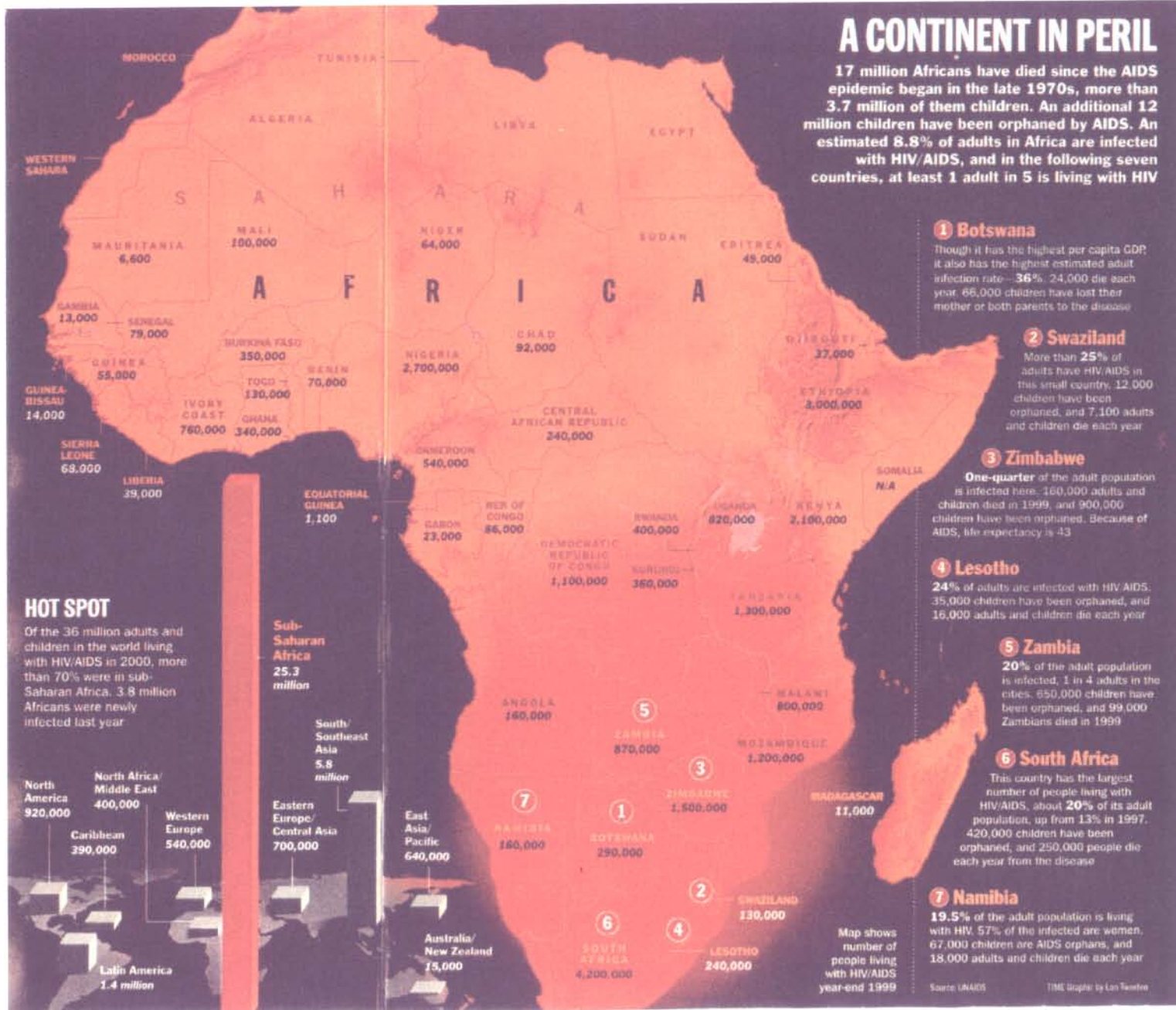
*Thank you very much for your co-operation and participation*

**APPENDIX C**

**THE GLOBAL IMPACTS OF HIV/AIDS WITH SPECIFIC  
REFERENCE TO SUB-SAHARAN AFRICA**

# A CONTINENT IN PERIL

17 million Africans have died since the AIDS epidemic began in the late 1970s, more than 3.7 million of them children. An additional 12 million children have been orphaned by AIDS. An estimated 8.8% of adults in Africa are infected with HIV/AIDS, and in the following seven countries, at least 1 adult in 5 is living with HIV



**APPENDIX D**

**EXAMPLES OF USER-FRIENDLY COMMUNICATION  
MEDIUMS AVAILABLE TO ASSIST EMPLOYEES WITHIN  
THE WORKPLACE**



# Put the bounce back in your step



BOUNCE

## Employee Assistance Programme (EAP)

FOR A CONFIDENTIAL APPOINTMENT OR FOR MORE  
INFORMATION ABOUT THE PROGRAMME CONTACT  
THE NATIONAL TOLL FREE NUMBER  
0800 00 4770



Centre for Human Development

Helping **organisations** and  
**people** to perform better.



**L**iving in today's complex world is challenging. As we strive to balance the demands of work, family and our own personal needs, there may be times when we feel our ability to cope is being stretched. When a personal problem makes life difficult, it affects all aspects of our lives – at home and at work.

Personal problems are a normal part of living. For this reason our company offers an Employee Assistance Programme (EAP) to help deal with life's tough spots – whether they occur on or off the job. When you are helped with a personal problem, your home life improves, work improves and everyone benefits.

### **What is your EAP?**

Your EAP is a confidential programme designed to help resolve personal problems. Information, consultation and brief solution-orientated therapy are provided by professionals at the Centre for Human Development/PPCI, an independent firm. The programme encourages early use – when you become aware of a problem and your own efforts to resolve it have not been satisfactory.

- ▶ Fees for employees and eligible family members are usually paid by your employer.
- ▶ Services are confidential.
- ▶ Use of your EAP is voluntary.

### **Your EAP can help with:**

Your EAP can assist you with a variety of personal problems such as:

- ▶ Emotional and personal difficulties
- ▶ Family and relationship concerns
- ▶ Drug and alcohol abuse
- ▶ HIV/AIDS
- ▶ Managing stress and change
- ▶ Budgeting
- ▶ Work-related issues
- ▶ Trauma

### **Is it really confidential?**

Information shared in your EAP is always treated as confidential. Information about individual employees who use the programme is not shared with your employer.

Most individuals make their own appointments. When an employee is referred to the EAP as a result of employment concerns, information related to employee participation may be required by the workplace. There is no discussion of what occurred in the sessions; personal information remains confidential.

Employees who wish to disclose information about their consultation with the EAP must sign a release of information form. This permits specific information to be shared with designated individuals. These exceptions will be discussed with you before your first session begins, by receiving a CHD/PPCI Statement of Understanding. This document describes your EAP and the confidentiality of the programme.

### **What happens in therapy?**

- ▶ Clarifying the problem: discussing the problem to help you determine what steps to take.
- ▶ Identifying options: exploring alternatives for resolving the problem.
- ▶ Developing a plan of action: deciding on a course of action and implementing your plan.
- ▶ Working together: achieving your goals.



## THE AIDS VIRUS IS A KILLER

**“I CARE... DO YOU?”**

It is now almost two decades ago that the virus that kills millions of people worldwide had been identified as the Human Immuno deficiency Virus (HIV). **This is the virus that causes AIDS.** To date there is still no cure for this deadly infection.

HIV lives in the body fluids like vaginal fluids, semen, blood, breast milk, tears, urine and saliva. Some of the body fluids like sweat and tears have so few of the virus that you have to drink more than a cup of infected saliva to become infected yourself.

Skin is a natural barrier to the virus – it cannot go through the skin. That is why it is perfectly safe to hug someone with AIDS or shake their hand. Remember that the infected fluid has to actually get into your bloodstream to infect you. A break in your skin can increase your risk of becoming infected. It is therefore important to cover any open wound.

Most people get the virus from having sex. During sex there is an exchange of body fluids. The semen of the man and the vaginal fluids from women end up inside the bodies of their sexual partners. This is called **unprotected sex**. You can protect yourself by using a condom during sex. A lot of other sexually transmitted infections cause sores on private parts and sometimes even discharges. These sores and discharges make it easier for you to get HIV. It is always a good idea to be treated for any sexually transmitted infections as soon as possible.

Other ways of transmitting the virus is by sharing needles and syringes to inject drugs into your body. HIV can also be transmitted to babies of pregnant women or through breastfeeding.

Other than **being infected** by HIV, we are all affected by this devastating disease through our involvement with our families, friends and the community we live in.

*As South Africans we should not get stuck in denial about AIDS.*

The latest estimates are that around 5 million South Africans are infected with HIV (This is more than 10% of the population) with 1500 additional new infections per day. With more people dying of AIDS related diseases we will have to care for the sick and the orphaned babies. In the workplace, we will be confronted with a whole lot of other work related issues such as absenteeism, sick leave and the loss of a skilled workforce, that will lead to increased costs of doing business for the company.

### COMPASSION

People infected with the HIV need more emotional support than anything else. We need to help them to learn as much as possible about HIV/AIDS. They need to know how the disease is passed on and how to stay healthy. During the early stages of illness the people who are HIV positive need to continue to live a normal life for as long as possible. They need to carry on working and carry on with their hobbies or sports. Even at this early stage of the illness HIV positive people need to go to their clinics or doctors for regular check-ups. Eating the right food, practicing safer sex, abstaining from alcohol and smoking are some of the ways that can help to keep you healthy for longer.

As friends and family of an HIV positive person that starts to get sick, it is important for them to know that we will be there for them all the time, spend time with them, read to them, listen to music together.

### WHAT CAN YOU DO!

- **Be informed** – to prevent the spread of the Human Immuno deficiency Virus (HIV)
- **Be aware** – of the support that is available for people living with AIDS
- **Show compassion** for people living with HIV/AIDS

For more information or a confidential appointment contact your EAP provider, the Centre for Human Development at the toll free number:



# PHARMACEUTICAL BENEFIT MANAGEMENT

## Aid for AIDS - Doctor's Information

Dear Doctor,

- Please **examine** your patient, **complete and sign the Aid for AIDS (AfA) application form**. Only **one application per person, for life**, is necessary. You do not need to submit another application for your patient: annually or for future HIV-related events or changes. Applications submitted for these reasons will not be paid under the 0199 tariff code.
- This consultation and completion of the application form as well as a possible telephonic consultation will be paid **under the tariff code 0199 (R150 VAT included)**. Please submit your account to PBM, Private Bag X1003, Claremont, 7735 for authorisation. *Payment is on the proviso that patients belong to one of the medical scheme options listed below, that they are HIV positive, and that their AfA application form is fully completed.*
- Please note that **only one practitioner** should complete the application form. Ideally this should be the practitioner who is most regularly responsible for your patient's HIV/AIDS medical care.
- Please **either fax** the completed form, **to our toll-free fax line: 0800 600 773, or post** it to the AfA programme in the **business reply envelope** provided.
- Please feel free to contact us on **0800 227 700**, for any **programme queries** or e-mail us at [afa@pbm.co.za](mailto:afa@pbm.co.za).
- **Please always deal directly with the Aid for AIDS programme, including submission of claims, in order to ensure confidentiality for your patient.**

### Schemes contracted to the AfA programme:

- |  |   |
|--|---|
| • AACMED (305)                               | • Medshield                                 |
| • ABI  | • Midmed (027)                              |
| • Barlow                                     | • Oilmed                                    |
| • BMW  | • Phila (062)                               |
| • Bonitas (238 - 240; 020; 277; 278)         | • Rennies (316; 317)                        |
| • Esmed                                      | • SABC                                      |
| • Finmed (004; 074; 094; 255; 256)           | • SA Breweries Medical Aid Society (290)    |
| • G5Med                                      | • SAB Castellion Medical Scheme (034)       |
| • Haggie                                     | • Sasolmed (053, 054)                       |
| • Independent Newspapers Medical Aid Society | • Sizwe                                     |
| • Meddent Medical Scheme                     | • Southern (309)                            |
| • Medical Services Plan                      | • Stocksmmed (059)                          |
| • MEDS (310; 311)                            | • Wits (060)                                |
|  | • Wooltru Healthcare Fund (Medisure option) |

Please contact us on **(021) 658-6464** if your Medical Scheme is missing from this list.



Only one in 10 people who are HIV-positive are aware of their condition. Please allow us to help you identify the illness at an early stage and let us jointly manage your health and well-being so that you can remain an active and healthy member of your family, community and workplace.

## Join the Aid for AIDS programme today

Contact us at:  
Tel: 086 0100 646  
Fax: 0800 600 773  
Private Bag X1003  
Claremont 7735



## How to apply to the Aid for AIDS programme

### Step One

If you are worried that you might have HIV, ask your doctor or clinic to test you. This test will be paid for by your medical scheme and only you and your doctor will be informed of the results.



### Step Two

If the results show that you are HIV-positive, call **Aid for AIDS** on 086 0100 646 and ask for an application form.

### Step Three

Your doctor will examine you and help complete the form. This examination will be paid for by your medical scheme.



### Step Four

Fax your completed form to **Aid for AIDS** on their toll-free number: **0800 600 773**, or post it in the pre-paid envelope provided.



### Step Five

The **Aid for AIDS** medical team is specially trained to review your medical details. They will contact your doctor if necessary, and agree on the most appropriate treatment for your HIV/AIDS condition, which will be paid for by your medical scheme.



### Step Six

You will need to visit your doctor for regular examinations and tests. These will be paid for from your usual scheme benefits.

### Step Seven

Your doctor will contact **Aid for AIDS** to keep them informed about your condition. If necessary, your treatment plan will be updated.



### Step Eight

Send all HIV claims to **Aid for AIDS** at:

Private Bag X1003  
Claremont  
7735.

# Has your company quantified its HIV/AIDS liability?

**Question 1:** Have you done a comprehensive HIV/AIDS business impact assessment?

YES	NO
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**Question 2:** Do you know if you can afford and sustain current employee benefits in the face of HIV/AIDS?

YES	NO
-----	----

**Question 3:** Have you quantified the cost of an HIV infected employee to your organisation?

YES	NO
-----	----

**Question 4:** Have you established appropriate HIV/AIDS management interventions to reduce your HIV/AIDS liability?

YES	NO
-----	----

**Question 5:** If you have implemented HIV/AIDS interventions, have you measured the effectiveness and are you able to justify the costs of such interventions?

YES	NO
-----	----

**If you answered no to any of the above questions, contact us immediately!**

(011) 481 5500 Office Number

Dr Duncan McAulay (MBChB, DOH) 082 455 2344 or

Michelle Pirie (MA, MBA) 082 940 8888



■ Risk Management Consultants ■

**APPENDIX E**

**A TEN-POINT PLAN FOR THE EFFECTIVE  
MANAGEMENT AND CONTROL OF HIV/AIDS WITHIN THE  
WORKPLACE**

## APPENDIX E

### A TEN-POINT ACTION PLAN FOR ORGANISATIONS TO MANAGE AND CONTROL AIDS

The following 10-point plan, developed by Rutsohn and Law (1991), include many recommendations, additional and pragmatic details on how to implement a suitable plan of action within the workplace and include:

*Point 1: Form a task force of key personnel*

The task force will develop the organisation's Aids policy and guide the Aids education program. The group should include managers and representatives from the human resource, medical, safety, and labour relations arenas, if possible. The task force can include employees who are interested in the issue and willing to participate. Members of the task force should be knowledgeable about and have good access to up-to-date medical, social, and legal information about Aids. To obtain this knowledge, consultation with local health officials and lawyers is recommended.

*Point 2: Review the organisations benefit package.*

The organisations employee health insurance should be reviewed to ensure that it provides broad-spectrum coverage for all catastrophic illnesses, including Aids. While some insurance is treating Aids as they would any other major catastrophic disease, other insurance companies are limiting coverage due to the tremendous treatment costs involved. Since courts have ruled both ways concerning the rights of insurance companies to limit coverage for Aids victims, it is imperative to stay abreast of the legal issues.

Rutsohn and Law (1991) make several worthwhile suggestions about benefits options. First, they suggest that organisations obtain in writing insurance companies' policies on covering treatment and disability costs incurred by Aids-afflicted employees.



Thereafter, organisations should shop around for more effective coverage. They also suggest that employers explore the possibility of joining a multi-employer trust (MET) for insurance coverage.

*Point 3: Understand the legal responsibilities of the business and of employees*

The courts have determined that Aids is a workplace issue and that employers' responsibilities extend to both infected and non-infected employees. Thus, infected employees are protected against discrimination, and non-infected employees have the right to a safe workplace. In addition, Aids victims have a right to medical coverage and long-term disability benefits. Therefore, adverse employment decisions about an Aids-afflicted employee should only be made if the employee has become incapable of acceptable job performance.

*Point 4: Develop a written Aids policy*

The written Aids policy should present factual information on the disease and indicate that those afflicted will be treated the same as employees with any life-threatening, catastrophic disease. It also should state that employees with Aids-related conditions will be viewed as having a disability, that discrimination will not be tolerated, and that provision will be made to reasonably accommodate Aids-afflicted employees. The policy should also indicate that medical information will remain confidential and that all policies, including sick leave and other benefits will be applied uniformly.

*Point 5: Train personnel as Aids resource specialist or enlist outside specialists to provide education programs*

Local health officials, representatives of hospice and other resource providers are often available to provide education programmes or train in-house specialists (peer educators) to serve as the primary presenters. The latter is preferable because employees tend to trust people they know and can relate to.

*Point 6: Formal introduction of the topic*

A regular employee's communication vehicle, such as the organisation's newsletter or a bulleting board, can be used to familiarise employees with the Aids issue. Employers may consider sending each employee a letter about the upcoming employee's seminar on aids.

*Point 7: Educate managerial and supervisory employees*

Managerial and supervisory employees play an important role in every organisation; therefore, they should be educated first. Employees can then rely on managers and supervisors for guidance and information. A "For Managers/Supervisors Only Aids Education Seminar" should focus on the medical, social, and legal issues involved with the disease. In addition, managerial/supervisory employees must be properly prepared to handle confidential information related to Aids cases within the workplace.

*Point 8: Educate the general workforce*

An easy-to-follow program is recommended for educating the general workforce. If peer-educators have been properly trained, outside experts need not serve as the primary presenters.

After welcoming the employees and thanking them for taking the time to learn the facts about this deadly disease, organisational policies regarding Aids and/or catastrophic illnesses should be discussed. It should be stressed that Aids is not transmitted by casual contact, particularly the type of contact that occurs in the workplace. The seminar should inform employees about disease and answer their questions, but care should be taken not to pass judgement on anyone or intrude into personal matters.

Showing of a videotape on the basic fact about Aids is recommended, and the viewing should be followed by group discussion period. Employees should be encouraged to

ask questions, as well as to write questions down. These written questions are then collected and raised by the discussion leader. The procedure ensures that no employee will be directly linked to a specific question and creates a more open environment.

Although the primary presenter should, if possible, be an in-house specialist, local medical and legal experts should also be present to answer frequently asked questions about Aids. If their presence is not possible, the peer educator specialists should be completely prepared to answer such questions.

At the conclusion of the program, general information brochures and a seminar evaluation form should be distributed to all employees; in-house resource specialists should be introduced; employees should be informed that the organisation will provide them with updated information as it becomes available; and local community resources should be discussed. Finally, employees should be asked to share what they have learned with family and friend.

*Point 9: Keep employees informed about the disease*

Information about Aids changes almost daily; therefore, the organisation must stay abreast of new developments and disseminate up-to-date information, as it becomes available. Continual education is the best weapon for combating employee fears about Aids.

*Point 10: Evaluate the program for overall effectiveness*

The evaluation process should begin by asking whether the task force members have sufficient knowledge about all aspects of the disease and its ramifications and the ability to effectively communicate the knowledge. Managers and supervisors understanding of employees' concerns, as well as the importance of confidentiality, should be carefully assessed. In addition, the evaluation should examine whether the general workforce understands the important facts about Aids and related organisational policies.

**APPENDIX F**

**LIST OF INDUSTRIAL ORIENTATED ORGANISATIONS  
WITHIN THE AREA OF STUDY**

## SASOLBURG

Eskom (Lethabo Power Station)  
Karbochem  
Natref  
Omnia  
Polymer  
DOW Chemicals  
Sasol Chemical Industries (SCN)  
Sigma

## VANDERBIJLPARK

Acrow Engineering  
Afrox Ltd  
Air Products (Pty) Ltd  
Baldwin Steel  
Cape Gate  
Isacor Ltd  
Metal Box S.A. Ltd  
Rand Air (Pty) Ltd  
Rheem S.A. (Pty) Ltd  
Roxound Engineering (Pty) Ltd  
Sargo  
Slagment (Pty) Ltd  
Steinmuller (Pty) Ltd  
Suprachim (Pty) Ltd  
Universal Metals  
Van Leer S.A. (Pty) Ltd  
Vantin (Pty) Ltd  
Zimmerman & Jansen S.A. (Pty) Ltd  
Vaal Colliery

## **VEREENIGING AND MEYERTON**

African Cables

Afrigro

Apex Implements

Danmot Industries

Dorbyl Heavy Engineering

Driehoek Concrete Works

Engineering Fabricators

Heckitt Multi Service

Ilca Trading (Pty) Ltd

Prinsco Engineering (Pty) Ltd

Roto Engineering Works (Pty) Ltd

Samancor

Starcor Industries

Stewarts & Lloyds

Vereeniging Refractories

Acrow Engineering

## **CARLTONVILLE**

Elandsrand Goldmine

Anglo American