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AN HIV/AIDS INTERVENTION PROGRAMME IN THE WORKPLACE:
A CASE STUDY OF A MEDIUM-SIZED CONSTRUCTION COMPANY IN
THE WESTERN CAPE

**Presented to the University of Cape Town in partial fulfilment of the
requirements for the degree of Master of Philosophy in HIV/AIDS and Society**

by Roger Griffiths

[GRFROG001]

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This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this

dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signed by candidate

Roger S Griffiths

ABSTRACT

In South Africa, the economic system is capitalistic in nature, and the free market system encourages the pursuit of profits in a competitive environment.

Government and other NGOs want private sector companies to assist in countering the effects of HIV/AIDS by introducing interventions which follow generic outlines developed by the State and other institutions. The programmes are mainly aimed at the Human Rights of those who are HIV+, and do not have a commercial element. The assumption is that these programmes provide a cost benefit which outweighs the costs of a programme.

There is no legal requirement to introduce an intervention, nor does Government offer any incentives to companies to provide a programme for their employees, although the local Construction Education and Training Authority did provide funds for awareness and testing initiative within the industry.

Managers in private sector companies have pressures put on them from a number of stakeholders who require a return on their investment. In a highly competitive environment, profits depend to a large extent on maintenance of cost leadership. An HIV/AIDS programme adds to the cost base. Unless a cost benefit can be shown, companies have no incentive to introduce a programme.

An examination of a company in the road construction industry identifies the problems with implementing an HIV/AIDS programme in a highly competitive environment. The company has an intervention which closely follows the generic programmes, but it has not completed a cost benefit analysis. In addition, the programme has not been made part of the operational processes of the company, nor is there any evidence of a concerted effort to provide the leadership necessary for the success of the programme. Although HIV+ employees are assisted with obtaining treatment, less than 10% of those who tested positive have presented for disease management because of fear of stigma, discrimination and possible loss of employment.

There may therefore be good commercial reasons for not having an HIV/AIDS programme in the current economic environment, given that the projected downturn in the economy arising from the disease has not yet occurred.

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ABBREVIATIONS

ACT	Awareness, Counselling and Testing
AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ARV	Antiretroviral
BER	Bureau for Economic Research
CETA	Construction Education and Training Authority
COSATU	Congress of South African Trade Unions
GRI	Global Reporting Initiative
H&I	Haw and Inglis
HIV	Human Immunodeficiency Virus
HIV+	Human Immunodeficiency Virus Positive
HST	Health Systems Trust
MRC	Medical Research Council of South Africa
MTCT	Mother to Child Transmission of HIV
NEDLAC	National Economic and Labour Commission
NGO	Non-Governmental Organisation
NUM	National Union of Mineworkers
PTMTC	Prevention of Mother to Child Transmission of HIV
SABCOHA	South African Business Coalition on HIV and AIDS
SACOB	South African Chamber of Business
SACP	South African Communist Party
SAFCEC	South African Federation of Civil Engineering Contractors
SANAC	South African National AIDS Council
STD	Sexually Transmitted Disease
TAC	Treatment Action Campaign
UNAIDS	Joint United Nations Programme on HIV/AIDS
VAC	Viral Assistance Centre
VCT	Voluntary Counselling and Testing

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CHAPTER 1

INTRODUCTION

HIV/AIDS IN SOUTH AFRICA

South Africa has economic policies which encourage competition and profit-taking. Commercial entities are therefore required to adopt strategies which have profitability as a major objective, and any issue which affects this objective has to be dealt with in a manner which reduces the impact on profits. In highly competitive, undifferentiated sectors of the economy, cost leadership is the generally accepted strategy, requiring companies to adopt cost reduction activities to maintain their position.

The HIV/AIDS epidemic has become well established in Southern Africa over the past two decades, with predictions of a severe curtailment of economic activity. Whiteside and Sunter cite a number of studies undertaken in the 1990's, which stated that the economies of those countries with high HIV/AIDS Prevalence Rates would be severely curtailed. Because of the impact it has on the economically active part of the population, the disease is forecast to devastate the economy through high death rates amongst workers, the drop in demand for products and services in many sectors, and the increased costs of doing business because of the need to provide programmes for those infected and affected by AIDS, including education and treatment programmes. [Whiteside and Sunter, 2000].

They also provide examples of a number of reports which predict a similar decline in economic growth in South Africa because of HIV/AIDS. They forecast that there would be an impact on the economy from several points of view. Annual Gross Domestic Product growth will be between 0.3 and 0.4 percentage points lower than the no-AIDS baseline over the next 15 years. AIDS will exacerbate the skills shortage; there will be a smaller labour force, with lower productivity and income, at the same time as a growth in demand for services such as health and welfare. Lower tax revenues arising from lower profits will put pressure on the Government's budget deficit. Rising inflation rates, combined with a smaller savings pool, will put upward pressure on interest rates. Domestic savings will be squeezed to a point where foreign

investment is essential to fill the gap, and AIDS will deter such investment.

[Whiteside and Sunter, 2000].

Apart from the macro-economic impact of the epidemic, problems are predicted at the individual company level. HIV/AIDS is thought to impact on costs in a number of ways. These include a reduced labour pool, a shortage of skills in the labour force, and increased worker absenteeism. Demand in the environment within which the organisation is active will change as disposable income at the individual level shifts from consumer goods to food and medicines. The epidemic, by affecting the workforce, increases costs through reductions in productivity, increased recruitment and training, increased benefit costs, and a potential impact on the quality of work produced.

The HIV/AIDS epidemic could therefore threaten the existence of companies, many of whom do not have any type of HIV/AIDS intervention in place, if the predicted rising costs, low economic growth and the loss of key staff materialise. Employers will be at risk through loss of profits; employees will be at risk of losing their jobs due to the organisation failing because of economic problems associated with the disease. Any intervention by a company must therefore be examined against the cost benefits of undertaking such an intervention. If the cost of an intervention is greater than the costs incurred by the disease, there is no economic incentive to introduce an HIV/AIDS programme.

At the same time as having to deal with the impact of the epidemic on the operations of the company, management has to deal with the demands of stakeholders, such as shareholders who require a return on their investment; the Government, which is looking to the private sector to assist in countering the epidemic; the competition in the industry, which could require the company to maintain a low cost base; the community, which requires some sort of social investment; and their clients, who require low costs and high service standards.

This thesis tests the assumption that companies need to have an HIV/AIDS intervention to protect the investment and profit-taking that is an inherent part of the

capitalist structure, through a case study of Haw and Inglis [H&I], a medium-sized construction company in the Western Cape.

The assumption is that the macro- and micro-economic effects require special attention from both

Government and Business to counteract the impact of the disease. The Government and Non-Governmental organisations such as the South African Business Coalition on HIV and AIDS [SABCOHA], reacting to the predictions of researchers at the time, have established generic intervention programmes which businesses are urged to adopt. These programmes are regarded as being critical to counteract the effect of HIV/AIDS on both the country as a whole, and on individual organisations.

Interventions at the workplace are regarded as essential to an organisation's survival. They are based on the premise that they are needed to protect the rights of workers infected and affected by the disease, and that a programme which assists in protecting an organisation's viability makes good business sense.

As the programmes coming from Government and NGOs involved in HIV/AIDS issues are basically concerned with the human rights aspects of the disease, the assumption that programmes make good business sense remains to be examined. A study of a company that has already introduced a programme enables an analysis of the need for such a programme. It also examines whether the programme is effective in view of the various priorities which management and employees have at various levels within an organisation.

During the research, it became questionable whether the assumption that companies require a programme to ensure survival was valid from a commercial perspective. In a highly competitive environment, where cost containment is a major factor in an organisation's viability, protection of the investment and profit-making may well take precedence over social issues. A business has a number of stakeholders who have an economic relationship with the organisation, and this group requires a return on their investment. This promotes specific actions on the part of managers which may conflict with the desire to introduce an HIV/AIDS intervention. With the Government taking responsibility for treatment of those infected by HIV through the Antiretroviral [ARV] roll-out, there may be no commercial need for an intervention at the individual

company level, especially for those private organisations with limited financial and manpower resources. This could result in the organisation regarding an HIV/AIDS intervention as a low priority. While large public companies may have the resources and a need to undertake a programme as part of their social responsibility functions, this may not be an option for smaller enterprises.

In addition, the predicted economic decline has not yet occurred. The forecast declines did not take place in countries such as Uganda and Botswana, despite the high infection rates. [Whiteside and Sunter, 2000]. In South Africa, according to the South African Government, the country has been experiencing moderate but sustained growth for the past decade. In the last decade of apartheid, the economy grew at an average of 1.1%. Between 1994 and 2003, economic growth averaged 2.9%. There was no decline in growth between 1993 and 2003, and the economy grew at 3.7% in 2004. [SA Government, 2005]. The lack of an adverse effect on the macro-economy does not mean that the epidemic will not have a major impact on economic growth in the future; Whiteside and Sunter point out that a combined projection of the AIDS epidemic and economic trends, both difficult to model on their own, produces uncertain results. [Whiteside and Sunter, 2000]. The effects of the epidemic as described by the models may be delayed; the timings of the models' predictions may be inaccurate rather than the size and nature of the ultimate effect. Thus, although the forecasts of low economic growth and the adverse effects of the AIDS scenario have not yet materialised in South Africa, there are still concerns about the future effect of the epidemic. The number of people infected with HIV in South Africa had reached 5 million by 2004. [UNAIDS, 2004; Dorrington et al 2004].

The annual HIV/AIDS Survey undertaken by the Department of Health, covering pregnant women presenting at government antenatal clinics, shows the trends in infection rates amongst that group over the last three years for which figures are available.

Table 1.1:

**SOUTH AFRICAN HIV PREVALENCE RATES BY PROVINCE AMONGST
WOMEN ATTENDING GOVERNMENT ANTENATAL CLINICS: 2002 – 2004**

PROVINCE	2002 [%]	2003 [%]	2004 [%]
KwaZulu Natal	36.5	37.5	40.7
Gauteng	31.6	29.6	33.1
Mpumalanga	28.6	32.6	30.8
Free State	28.8	30.1	29.5
Eastern Cape	21.7	23.6	28.0
North West	26.2	29.9	26.7
Limpopo	15.6	17.5	19.3
Northern Cape	15.1	16.7	17.6
Western Cape	12.4	13.1	15.4
South Africa	26.5	27.9	29.5

Source: Department of Health, 2004.

In all provinces, there has been a growth in Prevalence Rates between 2002 and 2004. The highest infection rates are in the more northern and eastern provinces, indicating that the disease is spreading from north to south and east to west. The rate of increase in the disease is greater in the south, illustrating that the disease will probably reach the scales of the more northern provinces in the future.

Dorrington et al forecast the gender and age breakdown of HIV infections in South Africa as:

Table 1.2: SOUTH AFRICAN HIV INFECTIONS BY GENDER: JUNE 2004

DESCRIPTION	MILLIONS	% infected by age group
Total Infected	5.0	
Adult Men [18 – 64]	2.2	17.6
Adult Women [18 – 64]	2.5	18.6
Total Adults [18 – 64]	4.7	18.1
Adult Men [15 – 49]	2.0	16.6
Adult Women [15 – 49]	2.6	20.2
Total Adults [15 – 49]	2.5	18.5

Source: Dorrington et al, 2004

Table 1.3: SOUTH AFRICAN HIV INFECTIONS BY AGE: JUNE 2004

AGE	MALES [%]	FEMALES [%]
20 – 24	9.5	24.7
25 – 29	23.3	29.7
30 – 34	26.4	26.8
35 – 39	24.9	22.7
40 – 44	22.2	16.8
45 – 49	19.0	9.6
50 – 54	15.3	3.8
55 - 59	11.1	1.0

Source: Dorrington et al, 2004

The above two tables indicate that Prevalence Rates are high in both sexes, with infection rates amongst females peaking in the 25 – 29 age group, and males in the 30 – 34 age group. In both sexes, the infection rates are highest in the under 35 year olds, indicating a skew towards the younger, economically active age groups.

Infection rates differ depending on the employment status and skills levels of economically active people; HIV/AIDS is generally higher amongst the unskilled and low-skilled workforce. [Versteeg, 2004]. In general, the prevalence of HIV amongst the employed population is lower than that measured among antenatal clinic attendees in the same area. [HST, 2004]. A survey of six companies revealed that unskilled and skilled workers are two to three times more likely to be HIV positive than supervisors and executives. [Rosen et al, 2003]. These findings place pressures on semi-skilled and unskilled workers. Not only are they faced with uncertainty over continued employment, they are also threatened with termination of their employment because of their inability to perform according to their job requirements because of health problems. The current high unemployment makes low-skilled people easy to replace, which from a company point of view could reduce the risk of HIV/AIDS to the company. [Versteeg, 2004].

Deaths from AIDS-related infections in South Africa are difficult to estimate. Bradshaw et al determined that there had been an increase in deaths over a six-year period from 1998 – 2003. Their research revealed continuing shifts in the age distribution of deaths over the period, with large increases in deaths amongst younger people, especially women. Deaths amongst women in the age group 20 - 49 years old have shown an increase of 190% over the period, with around 150% attributable to AIDS-related infections after taking account population growth and improved registration of deaths. Deaths amongst males showed similar patterns, but at lower absolute numbers. [Bradshaw et al, 2003].

UNAIDS and WHO calculate that 10% - 14% of those needing ARV treatment in South Africa are receiving it. South Africa's target was 450 000 patients, but is only treating between 97 000 and 138 000 at present. The Joint Civil Society Monitoring Forum reported in 2005 that 42 000 patients were on ARV treatment at government sites as at March 2005, out of a total requirement of approximately 500 000 to 650

000. [HST, 2005]. The latest Government figures indicate that 50 000 people are getting Antiretroviral [ARV] treatment at state hospitals and clinics as at June 2005. [Kahn, 2005].

Although the Government has a duty to take steps to put a programme in place to try and improve the right of access to health care services, as far as HIV/AIDS is concerned, its ability to provide the necessary services to those infected is questionable. Butler points out that, post-1994, there has been little improvement in the public services in rural areas, especially in health care and educational opportunities. [Butler, 2004a]. The Joint Civil Society Monitoring Forum [2005] concluded that the failure of the Government to provide the necessary access to treatment was the result of a number of factors. These included the lack of formally accredited sites, the lack of human resources to provide the treatment services, long waiting lists at sites and the lack of an adequate infrastructure such as water, electricity and sanitation at clinics. It also stated that there was a lack of essential services such as accessible Voluntary Counselling and Testing [VCT], and Prevention of Mother To Child Treatment [PTMCT], particularly in the rural areas, and a lack of capacity to monitor and evaluate the ARV programme. [JCSM, 2005]. Persons needing treatment in an area where it is not offered are therefore reliant on the private sector for the necessary treatment, or must forego treatment if they cannot afford it.

The growing awareness of the nature and impact of the epidemic on South Africa led to a number of initiatives aimed at providing organisations with programmes to counter the epidemic's effect on the economy and society. In 2000, the Department of Health published its HIV/AIDS Strategic Plan for the five-year period 2000 to 2005. It stated that the major determinants of the epidemic were unprotected sex, multiple sex partners, and a high prevalence of Sexually Transmitted Diseases [STD]. The underlying causes were believed to be poverty, migrant labour, commercial sex, the low status of women, illiteracy, the lack of formal education, stigma, and discrimination against those infected and affected by the disease. The Plan had two main objectives: a) reducing new infections and b) reducing the impact of HIV/AIDS on individuals, families and the community. It proposed four methods of tackling the disease.

Firstly, the plan dealt with the Prevention of infection. Planned activities involved the promotion of safe and healthy sexual behaviours, improved control of Sexually Transmitted Diseases, and reducing the Mother to Child infections. Voluntary HIV testing and counselling was to be stepped up, as well as post-exposure testing, for example after rape or needle-stick injuries. Improved controls were to be introduced to cover blood transfusion issues.

Secondly, the plan covered Treatment, Care and Support for those infected and affected by the disease. This section of the plan covered the provision of treatment, care and support services in health facilities and communities, with special reference to providing care for children and orphans.

Thirdly, the issues of Research, Monitoring and Surveillance were addressed. Activities in these areas included the development of an AIDS vaccine, investigating treatment and care options and conducting policy research. Regular surveillance of the spread of the epidemic and the demographics of those most infected and affected formed part of this activity.

Finally, the issues of Human Rights as part of all activities were specified, covering the development of appropriate social and legal environments.

While these are essentially national public policies, Government is looking for partnerships with a number of organisations, including Business, in implementing the plan. Business is represented on the South African National Aids Council [SANAC], and has been allocated specific activities. Businesses are to have partial responsibility for prevention, for promoting on-site access to voluntary counselling and testing services, ensuring that the employment rights of those living with HIV and AIDS are not transgressed, and assisting in the prevention of the spread of the disease by providing condoms at work-sites. Amongst each economic sector's requirements for assisting Government in dealing with the epidemic are specific sectoral requirements, including identification of determinants in the spread of the disease, the formulation of sectoral responses, and the documentation of best practices within the sector. [Department of Health, 2000]. However, none of these responsibilities are enforceable by legislation. Business organisations can either comply with the requests, or ignore

them. In addition, the Government does not offer any incentives for companies to implement HIV/AIDS programmes.

A number of governments and NGOs have produced guidelines, including generic programmes and policies, for dealing with the epidemic in the private sector. Some major private companies have also placed their action plans for HIV/AIDS in the public domain, allowing other organisations to draw from these programmes those elements which are pertinent to their specific circumstances.

In South Africa, organisations such as the Department of Labour, the Confederation of South African Trade Unions [COSATU], the National Economic and Labour Commission [NEDLAC], and the South African Federation of Civil Engineering Contractors [SAFCEC] have all provided outlines of programmes. These best practices and programmes are based, to a large extent, on ideas developed in First World economies where the HIV Prevalence Rates amongst the workforce are very low compared to South Africa, and where the impact can be dealt with under existing programmes and policies without much effort on the part of individual organisations. These programmes appear to have been developed mainly to protect employees who are HIV+.

Programmes proposed for the private sector by these institutions are similar in scope and outline. They are complex and multi-faceted, covering mainly the rights of employees, rather than the disease's impact on the organisation's viability. Individual businesses are expected to introduce a programme which covers aspects such as a review of benefits available to employees, the establishment of a counselling and testing procedure, treatment protocols and a risk analysis covering the impact on the markets serviced, the human resources risks, a cost impact analysis, and a monitoring system covering the issues relevant to the organisation.

The Policy Statement of a company is regarded as the core strategic document for the management of AIDS in the workplace. Good policy should be developed by consultation between the major stakeholders in an organisation and cover issues such as a cost/benefit analysis, value added by the policy, and social and corporate responsibility. The policy should be followed by a detailed document outlining the

instructions and principles for dealing with the disease in terms of management and supervisory practices, procedures, and issues for daily operational activities within the company.

Each company can develop its own programme, depending on its own objectives and priorities. Such a programme will depend on many factors, such as the size of the company, the ideological stance of its managers and shareholders, the economic sector it belongs to, and its financial resources. These programmes require organisations to establish new and amended processes, allocate financial and human resources to new activities dealing with the epidemic, and integrate HIV/AIDS into their daily operational activities.

As the various codes and programmes are not enforceable under law, any pressures for an intervention and the elements contained in a programme would have to come from other sources, such as shareholders, the employees themselves or the unions. Until there is legislation to enforce the codes, or to lay down reporting mechanisms for the application of programmes, companies are able to regard the introduction of a programme as a low priority, as long as it has complied with any legal requirements.

Public companies in South Africa are required to place many of their activities in the public domain. They are likely to opt for HIV/AIDS programmes which include a social dimension, thereby appealing to the shareholders and allowing the company to make public relations capital out of their intervention, while at the same time protecting their share price. In particular, the multinationals with Head Offices overseas would be inclined to emphasise the social content of their interventions to enhance their standings with their shareholders. Private companies do not come under such pressures and can tailor their programmes to suit their own particular needs. The social conscience of the managers and other stakeholders could then become a major driving force in developing a programme, but it would generally be subservient to the main priority of the organisation.

HIV/AIDS AND BUSINESS PRESSURES

Managers of companies in South Africa have to deal with much larger HIV Prevalence Rates in very different economic and social structures than their First World counterparts, in a geographic area where the disease has been active for around twenty years. They also have to face a plethora of advice from Government, institutions which have developed their versions of an appropriate intervention, and pressures from other interested parties. This will have an effect on the way in which Management approaches the problem, and the very high prevalence of HIV/AIDS will have a much larger impact on decision-making than in the First World countries.

Versteeg [2004] outlines the issues facing managers when determining a response to the HIV/AIDS epidemic; there are legal, strategic and moral issues that have to be taken into account. When companies decide on their strategies to address HIV/AIDS, they are subject to different forces. They will have to balance what is profitable to do; what is required by legislation, regulation and public expectations; and what they should do in reflecting the values of the company's decision-makers, its moral convictions, and the social and religious issues surrounding the epidemic. In the early days of the epidemic, HIV/AIDS was not perceived as a threat and there was little pressure from the Government, trade unions and other NGOs to respond in a proactive manner. Companies that had conducted extensive research had concluded that a comprehensive approach to the disease made economic sense, but these were a few, mainly large international companies, and their motives may not have been entirely altruistic. Companies had a lot of freedom to decide how to respond to HIV/AIDS in the context of low stakeholder involvement and an abundance of low skilled labour. [Versteeg, 2004].

SABCOHA [2004] notes that companies have to deal with a range of problems associated with HIV/AIDS; limited understanding of the long term impact on the organisation, problems of getting policies and programmes implemented within the work environment, stigma, treatment options and the contributory role played by companies such as the use of migrant labour. At the same time, companies have shareholders, are required to comply with governance rules, and sustain profits. [SABCOHA, 2004].

The link between poverty and disease has been well-established, with most communicable diseases affecting the poor to a greater extent than the rich. [Walt and Vaughan 1981; Sanders and Carver 1985; Baum and Sanders, 1995; Head 1996; Head 2000; Head 2003]. It is therefore reasonable to assume that any epidemic is likely to spread more easily amongst the poor and, by extension, the unemployed. Any organisation drawing its labour force, in particular the temporary or short-term workers, either completely or in part from the ranks of the more poverty-stricken population groups, has a greater risk of diseases affecting their daily operations than those organisations with a more settled, permanent labour force.

The policies of the apartheid government controlled where people could live and where they could take up employment. A direct result of these policies was the institutionalisation of migrant labour, with rural males travelling to urban areas to find work, and returning to the rural areas after a period of employment, usually about a year. After a brief period at home, the worker would again obtain a contract for a specific period of work in the urban areas. This migrancy resulted in many families facing poverty in the rural areas, with large unemployment and the consequent health problems. Head points out that the use of migrant labour allows companies to deny responsibility for temporary employees after their contracts have ended, thereby reducing costs by eliminating the majority of benefits offered to permanent employees such as retirement funding. [Head, 1980]. Post-1994, the situation has not improved significantly. There is still mass unemployment in the rural areas, and migrant workers of both sexes are commonplace. An abundance of labour means that companies have an inbuilt tendency to reduce employee costs by means such as low wages, temporary employment and reduced benefits. Organisations have the ability to structure themselves in ways which improve their competitiveness, which in a highly competitive sector will include cost-minimization strategies to take advantage of such opportunities.

Companies also have to respond to a number of pressure groups which can influence Management's decisions, including the decisions required to deal with the potential AIDS threat. Each will have their own views on how an organisation should act in dealing with the epidemic. Their views on an appropriate intervention will be

influenced by their own particular priorities. Management has to balance these priorities.

Shareholders require the company to generate returns on investment, providing them with dividends and capital for further investment. Profits are therefore a critical objective for Management. The drive for profitability is increased when Management enjoys profit-sharing benefits, either through part ownership of the organisation or through other mechanisms such as performance bonuses or improved benefits. Anything which increases costs and reduces profits is a major factor in the way in which the shareholder views Management as performing in a satisfactory manner. An HIV/AIDS intervention does not necessarily translate into visible results, while affecting profits through increased costs.

Clients put pressure on the organisation to maintain quality of services and products. This demands employees who are fully trained and experienced in dealing with the operational issues that arise. Within a highly competitive industry, companies are required to maintain service levels to ensure survival and growth. The prices charged by an organisation are a major part of service levels. Should costs increase because of HIV/AIDS, an organisation may find itself becoming uncompetitive in the marketplace. Companies may regard a minimal AIDS intervention, with its lower costs, as a strategic competitive advantage.

Employees are anxious about job security and benefits they receive from their employment. Depending on their position within the organisation, they will have different views on the need and nature of an intervention. Any AIDS intervention will inevitably generate costs to the organisation and may impact on both charges to clients and a reduction in profitability, thereby putting employee benefits and continued employment at risk in a competitive environment. The organisation also has responsibilities to staff in terms of a safe environment in which to work, and to assist employees who develop non-work-related health problems during employment. These obligations are both legal and moral/ethical, and includes those employees who are HIV+.

Suppliers are a factor from two points of view. Firstly, the company needs reassurance that suppliers of critical goods and services are able to maintain their levels of service, such as servicing and the provision of spares for any high investment machinery used. Secondly, suppliers will be under cost pressures arising from their own HIV/AIDS impacts. Increased charges for goods and services will impact on profits and the organisation's pricing strategies.

The **Community** within which the company operates for labour and marketing purposes will expect a degree of corporate investment by the company as part of its licence to operate within a particular area. These corporate social investments are currently part of the cost base of an organisation. The Community may be looking at whether the organisation has included HIV/AIDS as part of its corporate social responsibility programmes, as well as the way in which the organisation treats its employees.

Government can influence the way in which a company operates, using laws controlling areas such as the workplace environment, pay and benefit levels, and hiring and firing processes. The Government's strategic plan for HIV/AIDS places some responsibilities and commitment on businesses to assist in countering the effects of the disease through moral rather than legal pressure.

In addition to the stakeholders described above, there are other organisations affecting the way in which Management reacts to the need for an intervention. Various **national and international** institutions will put pressure on Management to provide an intervention. These institutions emphasise a Human Rights approach to the epidemic and do not necessarily consider the business issues involved. Such an approach may place a priority on an HIV/AIDS intervention which conflicts with the organisation's main priorities.

There will also be peer pressure on the organisation from successful interventions within and outside the organisation's economic sector.

Taking into account the economic and social environments prevailing in South Africa and the pressures on managers of companies, managers have to determine whether

there are commercial reasons for introducing an HIV/AIDS programme. Government and NGOs active in the AIDS field indicate that there is a need for companies to have an intervention. If this assumption is false, then firms may be wasting both financial resources and time. The question therefore is:

- **What business pressures are caused by HIV/AIDS?**
- **What incentives does an organisation have to introduce an HIV/AIDS intervention?**
- **How does a company, when considering the introduction of an HIV/AIDS programme in the workplace, reconcile the different objectives of the stakeholders within the organisation in developing and maintaining the intervention?**

Guided by these questions, this thesis presents a case study of a company that has introduced an HIV/AIDS intervention programme. It will illustrate how management of the company deals with the practical issues of HIV/AIDS, including the potential impact on its operations. It examines the problems faced in dealing with the disease as a part of normal management processes and pressures. In particular, the study examines those processes used for establishing the nature, scope and range of an intervention within the parameters of the organisation's goals and general ethos. The study also examines the effectiveness of any intervention and how it meets the criteria of the various stakeholders. Finally, the thesis returns to the question of whether there is a need for HIV/AIDS interventions in smaller South African construction companies. The predicted economic downturn has not materialised, the Government has introduced treatment for those who are HIV+, and most of those affected by the infection are unskilled or lower skilled workers. This may indicate that companies can avoid the introduction of an intervention.

CONCLUSION

The main thrust of the Government's expressed desire for the private sector to become involved in HIV/AIDS programmes is that these programmes are needed to ensure the

continued viability of companies. This appears to be based on the predicted downturn in the economy and the reduction of labour pool. This decline has not happened.

There is also an assumption that programmes are required for all organisations, including private sector companies, for them to remain viable. Apart from the legal requirements, however, the State does not provide any major incentives for companies to comply. These programmes ignore the cost benefit side, favouring the human rights elements of interventions. Companies are therefore placed in a position where they are requested to undertake an initiative which affects their profitability and has an impact on those stakeholders who are expecting a return on their investments. Managers are under pressure to implement cost-saving activities to enhance profitability, rather than cost-increasing activities. While protection of the labour force from infection and through treatment of those who are infected can be regarded as protecting the investment, this has to be weighed against the effect on financial returns. With the undersupply of treatment for those infected by HIV, managers wishing to introduce a treatment programme face difficult choices. Treatment in the Western Cape is more accessible to those infected with HIV than in the Eastern Cape because of the different rates of national roll-out of the treatment systems. [HST, 2005]. Companies in the Western Cape should have the ability and confidence to recommend infected employees to the public sector.

As interventions are not enforceable, companies may place themselves at a competitive disadvantage should interventions not become the norm within their economic sector.

The statistics on HIV infections indicate that the younger, less skilled workers may be at higher risk than older, more skilled workers. Should the epidemic take hold, there will be a threat to the organisation through the loss of future key employees.

Construction companies would appear to have a relatively low risk profile because of the average age of the workforce, but this may be offset by the nomadic lifestyle within the industry. Within the construction industry, there are doubts as to whether the epidemic will affect profits to the extent that it is necessary to have an intervention.

As the predictions of the forecasters have not occurred, the assumption that there is a commercial reason for companies to introduce an intervention may be flawed. There is therefore a need to examine an HIV/AIDS intervention in a company by putting the intervention into context as a part of the activities of the organisation and not as a stand-alone initiative.

Before discussing the case study, it is necessary to look at the economic, legal and business environment within which companies act in South Africa, as these policies dictate, to a large degree, the way in which a company operates. This will form the basis for Chapter 2. The competitive pressures on managers and the pressure groups involved in promoting action on HIV/AIDS in the workplace will also be described. The impact of the epidemic on benefits and costs will be discussed, as will those factors influencing decisions made around the nature of an intervention. The nature of the construction industry in South Africa will be outlined, with a brief description of HIV/AIDS within the industry.

Chapter 3 describes the operations of Haw and Inglis, the incidence of the disease in the company, and the HIV/AIDS programme it introduced. It also explains the methodology used in obtaining the source data used in the study. It covers the perceptions of employees regarding work pressures and priorities they face, and their perceptions of the intervention.

Chapter 4 contains an analysis of the intervention. It looks at a comparison between the company's HIV/AIDS intervention and the generic programmes available, and discusses the strengths and weaknesses of H&I's programme. A number of conclusions about the intervention are made, and the applicability of these conclusions to similar-sized firms is discussed.

Chapter 5 presents the conclusions drawn from the study.

CHAPTER 2

THE ENVIRONMENT WITHIN WHICH BUSINESS ACTS

ECONOMIC ENVIRONMENT

The economic environment shapes the nature of decisions taken by managers, including the decisions regarding HIV/AIDS.

Historically, South Africa had a capitalist economy which was based on the exploitation of low-paid labour drawn from the peasantry. Migrant labour, as institutionalised by the mining industry and supported by the State, drew men into wage labour for regular periods. Over time, the agricultural productivity in the rural areas declined, with the result that the requirement for wage work became an economic necessity for the peasantry. By the end of the apartheid era, there were effectively two economies in the country. The First Economy was a developed private sector, with a number of State Owned Enterprises. This economy was capitalist in nature, sophisticated and, in general, closed to the majority of the population through legislation and social inequalities in areas such as education, and ownership of assets such as land. The Second Economy developed as a result of the exclusion of the majority of South Africans from the First Economy. This economy was basically informal and consisted of unskilled labour and the unemployed. Social welfare benefits were not generally available and the ability of people to move into the First Economy was limited, although the labour from people in the Second Economy was required to support the First Economy, mainly through migrant labour.

The South African Government post-1994 has maintained a macro-economic policy which is capitalistic and tends towards being part of global markets, despite the stated intentions of the three members of the Tripartite Alliance who make policy: the African National Congress [ANC], the South African Communist Party [SACP] and the Confederation of South African Trade Unions [COSATU].

In its 1997 Strategy and Tactics Paper, the ANC looked to steer an economic course which followed neither socialism nor capitalism, stating that there are many positive

elements of the market system. The party was trying to find a middle path between what it called 'rampant market forces' and 'mechanical social parity'. It saw a mixed economy, with market forces playing an important role and the state ensuring economic growth and development. However, in the same paper, the party perceived major dangers in the capitalist system, stating that capitalism was responsible for inequalities in wages and the insidious influence of the trans-national companies, with their undue influence on both the political and economic policies of the emerging and developing countries. [ANC, 1997].

The South African Communist Party regards capitalism as a basic infringement of human rights, with around a million workers being retrenched, and as the cause of increasing poverty in South Africa. [SACP, 2003]. COSATU has similar, though not as vehement, views. In its Constitution, it states that the economy should be structured in the interests of the working class, with the creation of wealth being democratically controlled and shared amongst the working class. [COSATU, 2004]. It regards the free market element of the current economic policy as a failure, resulting in massive job losses, slow growth and low investment. [COSATU, 2001].

In contrast, the South African Chamber of Business [SACOB], claiming to represent some 35,000 businesses in South Africa, has a market-driven approach to the economy. The Chamber is also on record as promoting labour market flexibility; market forces are required to match supply and demand for labour and the deployment of labour within an organisation. [SACOB, Undated]. The protection of current and future investments is guaranteed through profit-making and, where necessary, profit repatriation, thereby ensuring that, to some degree, the economic policies follow free-market principles as in the past. In an environment where unemployment is high, this will allow companies to depress wages based on supply and demand principles.

The ANC Government post-1994 was therefore under pressure from a number of sides. The other members of the Tripartite Alliance wished to introduce a socialist economy. The previously disadvantaged members of the electorate wanted to enjoy the fruits of democracy in terms of employment, welfare benefits and a general improvement in living standards, while the local business community wanted to maintain their profitability. The transnational companies required conditions such as

freedom to repatriate profits and a friendly economic policy for investment; the Government's decision to be part of the global community in order to expand exports required policies that promoted freedom of trade with other countries and organisations.

Current economic policy therefore emphasizes economic stability, market-friendly policies and fiscal discipline to enable a stable environment for private investment and to attract foreign investment. Partial privatisation of public assets is included as part of the economic strategy. In terms of the Second Economy, the Government has instituted micro-management policies and extended the welfare system. [Butler, 2004b].

The Government's Programme of Action, updated in October 2004, illustrates the different approaches to the First and Second Economies. In the case of the First Economy, there is no stated intent to change the macro-economic management process, with continued use of the inflation rate target as the anchor to stabilise the economy. Amongst the objectives are a focus on exports within global competition and the growth of the small and medium business sectors within a market-driven approach.

The Second Economy plans deal mainly with public works programmes and social issues such as education, development of opportunities for those actively seeking work and an emphasis on agricultural development. [SA Government, 2004].

However, the ANC's National Council paper on Economic Issues sees the advances made in the First Economy as being of little benefit to the Second Economy; the bulk of resources flowing into the Second Economy are inevitably returned to the First Economy, leaving those in the Second Economy permanently on the periphery. [ANC, 2005].

The economic course followed by Government has a major impact on Business and the way in which it organises itself. Capitalism and the free market system it engenders allows companies to introduce systems and work structures that reflect the need to make profits while remaining both competitive and viable.

GENERIC BUSINESS STRATEGIES

Company structures and work programmes develop to enhance the drive towards profitability, which can be improved in three ways. **Reducing overall costs** allows a company to make greater profits while maintaining sales and margins at current levels. **Increasing margins** allows for greater profits while maintaining current costs and sales, while **increasing sales volumes** generates greater profits while maintaining current costs and margins.

Which of these strategies is used depends to a large extent on the degree of competitiveness within an industry. In a highly competitive environment, margins are squeezed and sales volumes tend to be restricted. The only way to improve competitiveness is therefore to contain or reduce costs. Construction, including road construction, is a highly competitive industry, with large sums spent by both the public and private sectors in South Africa. Managers of construction companies are therefore subject to pressures within the sector and within their company to maintain a constant flow of projects to remunerate their investment in the expensive machinery required for undertaking these projects.

There are a number of external pressures acting on a company in a competitive industry. Porter [1980] defines these pressures as coming from a number of sources.

Firstly, **competitors** within the same industry will put pressure on margins and sales volumes. In a highly competitive environment, prices charged for goods and services are likely to decline as companies attempt to obtain a competitive price advantage. Any reduction in prices means the cutting of margins and hence profits. At the same time, available sales will have to be shared amongst competing companies looking for an increase in market share.

Secondly, where there are relatively few **buyers**, as in the construction industry for public sector projects, these buyers can force prices down and demand additional services from companies. Low prices in themselves may not be sufficient to obtain tenders; there may be additional factors which will enhance a company's proposal, but at a cost. These factors include after-sales services, tight completion deadlines,

penalty clauses and training support; all of these additional factors increase the overall costs, but at the expense of margins.

Thirdly, where there is a need for a company to meet specific standards of quality and performance, **suppliers** of goods and services could have an impact on the performance of the company. In this respect, issues such as the cost of machinery, and costs of services and spare parts, play a role. Labour is generally regarded as a supplier in this instance; in the South African context, scarcity of skills in an industry could play a role in determining the success or otherwise of a company.

Fourthly, there is the possibility of the introduction of **substitute products and services** as technical advances are made. In the road construction industry at present, substitutes are not as significant as the other factors, as there have not been major changes in the general methodology of construction.

Finally, there is the influence of **potential entrants to the industry**. Local companies can create barriers to entry to potential newcomers by reducing their margins, thereby protecting their positions by discouraging them from making the large investments required to establish themselves.

Porter also suggests three generic strategies which a company can adopt in a competitive environment.

In the **Overall cost leadership** strategy, companies attempt to become the low-cost leaders. Such a strategy can be used when there is little differentiation in the products and services offered. The main criteria for selection of the company's services will therefore be based on prices charged, which reflect the costs included in the price build-up.

The **Differentiation** strategy aims to offer a product which is substantially different from those of the competition. It is used where such differentiation can be demonstrated easily, and a premium price can be charged for the unique difference. The strategy is commonly used for goods and services which appeal to a broad market.

In the **Focus, or Niche Marketing**, strategy, companies concentrate on those smaller areas and markets which are not attractive to other companies, but where delivery of products and services can command a premium price. [Porter, 1980]

Competition within an industry drives down the rate of return on investment by reducing profits. In a relatively undifferentiated sector such as construction, cost leadership appears to be the most acceptable strategy. This will cause companies within the industry to promote strategies which reduce the overall costs of the organisation, including manpower costs. Where economies of scale require large investment in plant and machinery, this can lead to the substitution of machinery for labour in an attempt to reduce costs and thereby improve profitability.

ORGANISATION OF THE WORKFORCE

The key feature of capitalism is that ownership and control of wealth is in private hands, within a relatively free market. It involves the pursuit of profit, with other considerations being generally subordinate to the overall profit objective. It should therefore be expected that this pursuit of profits has a major effect on the way in which a company organises its labour force and work patterns.

In Industrial Capitalism, a form of society evolves in which large-scale or complex machinery and associated techniques are applied to the pursuit of economic efficiency. [Watson, 2003].

Braverman, quoted in Watson, postulates that the pursuit of capitalist interests has led to deskilling, routinising and mechanising of jobs, aided and abetted by modern electronic techniques which reduce the need for capitalist employees to depend on human skills. [Watson, 2003]. There is no need to keep large permanent workforces available when the use of temporary labour can assist in cost reduction initiatives. While the introduction of casual or temporary labour is a cost impact, companies can save some costs by offering lower wages and reduced benefits such as retirement funding and medical insurance.

Watson discusses the concept of Dualism, where there is an effective division of the economy into those who are part of a prosperous and core sector of enterprises and those who on the periphery and are relatively and systematically disadvantaged. He also puts forward the concept of the 'Flexible Firm', where the workforce is divided into core elements who have security and rewards in exchange for a willingness to adapt, innovate and take on new skills, and peripheral elements who are given more specific tasks and less commitment of continuing employment and skills enhancement. [Watson, 2003].

The concept of a split workforce is expanded on by Webster et al. The development of capitalism has resulted in two labour markets in South Africa. The primary labour market is characterised by jobs with high wages, good working conditions, stable employment, job security, trade union protection and mobility within the firm; the secondary market has low pay, no job security, poor conditions and a lack of unionisation. [Webster, 1994]. Firms are encouraged by the capitalist system to exploit the mass of unemployed by offering work at low wages to maintain the system. [Wright, 1995]. The most exploited members of society are the unskilled workers who are often part of the 'reserve army of labour'. [Haralambos and Holborn 1995]. This reserve army of workers provides a reservoir for replacement of staff, as well as acting as a control on labour costs.

Within the free market system, there are implications for workers. Firms are increasingly reconfiguring contracts of employment, with the aim of reducing costs and exposure to the risks that accompany employment. In particular, **casualisation**, where workers are engaged on temporary or part-time terms, has become a norm in those sectors where flexibility in terms of seasonal or contractual projects can be utilised. Casualisation ranges from strategies to increase the daily and seasonal flexibility of labour in response to changing production requirements, to the use of part-time workers to meet demands at peak times. These arrangements are designed to meet a range of different requirements on the part of employers. They reduce costs and risks through making use of cheaper labour, directly reducing wage and benefit costs and making it easier to hire and fire. They enable employers to respond rapidly to fluctuating demand or production conditions without incurring long-term labour costs such as retirement funding and medical insurance. [Von Holdt and Webster, 2005].

The unemployed workers, however, bring some problems with them to the labour market when employed as casual or temporary staff. Haralambos and Holborn [1995] identify, in particular, **social effects**, such as feelings of inadequacy and no sense of purpose. This will affect the way in which employees in this group approach their work, and can affect productivity. They also identify **health issues**, stating that there is a higher mortality, and greater problems with mental health and suicides in the group. Stress levels are higher and community support declines. [Haralambos and Holborn, 1995]. Health problems in particular are of concern to those companies using temporary employees, as anticipated savings in labour costs may not be realised to the extent predicted if there is a high incidence of disease amongst the group.

LEGAL REQUIREMENTS:HIV/AIDS

From a purely legal point of view, an organisation is required to ensure that employees who are infected with HIV are not discriminated against in any way. This includes recruitment, training, development, promotion, job security, benefits, and protection against discrimination by other employees. Managers must consider two questions with respect to the legal issues surrounding HIV/AIDS: What are the legal requirements regarding HIV/AIDS as they affect the organisation, and what must be done to ensure that these legal requirements are reflected within the policies and practices of the organisation.

The legal framework concerning HIV/AIDS in South Africa is summarised below:

Table 2.1: SOUTH AFRICAN LAWS COVERING HIV/AIDS

ACT	COMMENTS
Constitution [108, 1996]	Right to fair labour practices Right to privacy
Labour Relations Act [66, 1995]	Right to fair labour practices, including job application. No unfair dismissal for HIV+ employees.
Employment Equity Act [55, 1998]	No unfair dismissal for HIV+ employees. Right to privacy.
Occupational Health and Safety Act [85, 1993]	Safe working environment.
Mine Health and Safety Act [29, 1996]	Safe working environment
Compensation for Occupational Injuries and Diseases [130, 1993]	Compensation if infected with HIV while at work.
Basic Conditions of Employment Act [75, 1997]	30 days sick leave per 3-year cycle.
Medical Schemes Act [131, 1998]	Non-discrimination by medical aid schemes.
Promotion of Equality and Prevention of Unfair Discrimination Act [2, 2000]	Specific mention of HIV/AIDS regarding discrimination

According to the above pieces of legislation, an organisation does not have a legal obligation to provide an HIV/AIDS intervention; it is merely required to ensure that HIV+ employees are treated in the same way as HIV negative employees.

Apart from the legislation, there are a number of voluntary codes of practice regarding the disease which have been mooted by Government, through the Department of Labour, and some NGOs. They are not legally enforceable, and there is no obligation on a company to introduce any intervention as long as it complies with the various laws as outlined above. Generally, voluntary codes of conduct are not monitored for

progress and implementation; implementation relies upon self-regulation and the goodwill of the target audience, with no sanctions or incentives to comply. [Vass, 2004].¹

There are therefore no legal requirements on a company apart from those outlined in table 2.1 above, and it is not onerous for a company to comply with them. Until the Government makes the introduction of codes of conduct and policies legally enforceable, organisations are free to develop whatever interventions they choose, and can determine for themselves how an intervention can assist in meeting their priorities and objectives. Social and commercial issues would therefore appear to have more influence on a company's HIV/AIDS activities than the law.

HIV/AIDS PRESSURE GROUPS

Pressure Groups have developed to coerce organisations to take action as the epidemic has spread, but these groups have not necessarily taken a business approach to the issue. Companies doing something about the epidemic appear to have done so under pressure from 'risk-averse' international head offices, or to reduce the negative perceptions of foreign investors. This approach seems to have evolved into a competitive environment, especially among large corporates, which attempted to outdo each other to obtain awards. While moving the action forward, it is not regarded as a main reason for establishing an intervention. [Vass, 2004]. Dorrington states that companies do not perceive HIV/AIDS as a top priority. Most do not see an economic or business impact, nor do they see much pressure from governments, trade unions or NGOs, who each have higher priorities. [Dorrington, 2004]

The investment community, at least, want to know where particular companies stand with respect to HIV/AIDS. Reporting on HIV/AIDS by individual businesses is the

¹ Some commentators believe that there is therefore a need to review the legal enforceability of the codes. They believe that HIV/AIDS policies would gain significance if the Government puts more pressure on companies through monitoring and penalties for non-compliance. COSATU in particular regards the enforceability of codes as necessary to ensure the effectiveness of programmes, and has expressed concern about the absence of reporting and inspection requirements. [COSATU 2000b; Vass, 2004; Versteeg, 2004].

subject of both international and South African reporting guidelines. It has become part of the 'triple bottom line' of sustainability reporting. On the international front is the Global Reporting Initiative [GRI].

'The Global Reporting Initiative is a long-term, multi-stakeholder organisation whose mission is to develop and disseminate globally applicable Sustainability Reporting Guidelines ("*Guidelines*"). These *Guidelines* are for voluntary use by organisations for reporting on the economic, environmental and social dimensions of their activities, products, and services. The aim of the *Guidelines* is to assist reporting organisations and their stakeholders in articulating and understanding contributions of the reporting organisations to sustainable development.'

[Global Reporting Initiative, 2002]

GRI performance indicators for sustainability includes, as one of the four points under Health and Safety: 'Description of policies or programmes (for the workplace and beyond) on HIV/AIDS', indicating the expectations that companies will report voluntarily.

Locally, groups such as SABCOHA have attempted to influence the private sector to introduce comprehensive programmes. Both the Johannesburg Stock Exchange and the South African Institute of Chartered Accountants have indicated a desire to see more reporting on the matter, thereby pressurising companies who put their reports in the public domain to disclose their initiatives. The Second King Commission on Corporate Governance, published in 2002, contains a recommendation that companies should report on HIV/AIDS activities as part of sound corporate governance. The report outlines principles such as management of the risks to the company attached to the disease as part of the fiduciary duties of the directors. [SABCOHA, 2004]. King recommends only and does not prescribe. It has recognised the challenges presented by HIV/AIDS, and recommends that the board of directors should ensure it understands the social and economic impact that HIV/AIDS will have on business activities, adopt an appropriate strategy, plan and policies to address and manage the potential impact of HIV/AIDS on business activities, and report on all of the above to stakeholders on a regular basis. [SAICA, Dec 2004]. While this may be a public relations requirement for listed companies, private companies may choose to ignore the recommendation.

Pressure groups as a whole seem to have had little impact on the majority of organisations in South Africa. The number of companies which have developed HIV/AIDS intervention programmes is very low, according to the SABCOHA survey in 2004. High unemployment does not allow for great worker pressure, and the unions have other short-term priorities such as job security, influenced by the global market initiatives of the Government, and wages. [SABCOHA, 2004].

There is no significantly dominant social movement in the country to force treatment issues to be prioritised. While the high-profile Treatment Action Campaign [TAC] has undertaken a number of initiatives, its main activities are aimed at forcing Government to introduce large-scale treatment, rather than the private sector introducing HIV/AIDS programmes. [Butler, 2005; TAC, 2005].

IMPACT OF HIV/AIDS ON COMPANY BENEFITS

Capitalism does not have to fulfil the functions of social security [Head, 1980]. While organisations do not have to take the place of the State in offering social benefits to employees, there may be good business reasons for instituting a range of benefits for employees, especially in terms of attracting and retaining staff. There may also be moral and social reasons for organisations implementing benefits for employees as part of their social responsibility activities. Management will have to examine the benefits offered to employees as part of a cost impact analysis, especially where the benefit is outsourced to service providers such as retirement funds and medical insurance organisations.

Dickinson and Stevens [2004] state that, where there is relative certainty regarding the impact of HIV/AIDS on a benefit such as pension, health insurance and life insurance, which are often outsourced and companies are charged directly by the service provider, there has been decisive action. They also postulate that action on employee benefits is related to the degree to which employees enjoy such benefits. A range of benefits exists, which depend on the income level of the employee, with the lower paid employees enjoying fewer social benefits. [Dickinson and Stevens, 2004]

The main benefits offered by organisations are Retirement Funding, Life and Disability Insurance, Leave, and Medical Insurance. Each benefit is affected by the epidemic. Where the company is involved in partial payment of subscriptions and premiums, there is an obvious impact on the profitability of the organisation; where the organisation is responsible for all or part of the payments, any increases in costs would put that particular benefit at risk. Where employees are responsible for all or partial payment of subscriptions and premiums, they may feel that short-term increased cash requirements outweigh the long-term benefit and they may elect not to participate.

Pension and Provident funds, which includes disability insurance, will be required to pay out increasing lump sums to employees who are medically boarded, but have not paid a full working life's contributions. Increased deaths amongst younger employees will shift the balance of contribution towards 'risk cover', leaving a smaller fund to provide retirement benefits to those who survive to full retirement. [Dickinson and Stevens, 2004]. A possible solution is to increase the contributions to the retirement fund, but this is a cost which companies will try and avoid. The employee, on the other hand, has an immediate financial requirement for daily living expenses and may not be able to increase payments to a fund which will only benefit him or her in the future.

Leave is also likely to become a more contentious issue as the epidemic spreads and more employees move from being HIV+ to AIDS. COSATU wants to extend sick leave for those who are HIV+, including leave required for opportunistic infections, thereby allowing those infected to work after recovery. COSATU claims that this is cheaper than additional recruitment and training, and allows for continued contribution to retirement funds, hence preventing their depletion. SACOB states that this would undermine confidentiality, is unfair to non-HIV+ employees in terms of other ailments, will increase stigmatisation and has a potential risk to profitability. [Fafu, 2003]. Managers therefore have to balance work requirements with the establishment of precedents for other illnesses.

The most important benefit decision is that regarding **medical treatment** of infected employees. A treatment regimen is considered a good fundamental business decision

from a cost point of view. One report states that the savings from treating all employees who are HIV+ will be a proper cost-savings exercise as long as there is a reasonable uptake amongst employees after proper testing amongst staff. Outsourcing to deliver the programme of treatment is also recommended to maintain the necessary confidentiality. [Business Report, 2003]. According to the Health Systems Trust [HST], the key challenge to treatment is the ability to expand treatment in ways that do not reinforce existing public health inequalities across race, gender, age, geographical area, the public/private sector areas, primary/tertiary care and rural/urban health sectors. COSATU argues that, if the distribution of drugs is to be effective, the health service infrastructure must be improved to ensure that there are accessible medical centres staffed by appropriately trained staff. [COSATU, 2000a]. HST [2004] agrees that treatment can only occur if people have access to adequate and functioning health systems; the demand for ARVs should be accompanied by demands for a better health service. [HST, 2004] A SABCOHA survey in 2004 found that the uptake of employees on ARV treatment was low in the private sector, ascribing this to both the stigma of being HIV+ and the infancy of some of the programmes. The survey found that employers believed that stigma was the main problem for low uptakes on treatment, rather than costs. Treatment programmes were generally believed to be cost-effective. [SABCOHA, 2004]. The costs to a company of health care, lost productivity, replacement and death and disability benefits could be as high as five to seven times the employee's annual salary, making treatment a viable option. [Lundin, 2002]. However, there could be problems: a study by FutureForesight and the Wits Health Consortium suggested that a poorly managed treatment programme could double the costs of treatment for a company. Problems in this area include starting treatment when employees are already at an advanced stage in the disease, poor clinical management and follow-up, and a high proportion of patients failing therapy and developing resistance. [HST, 2004]. When health and life insurance costs rise, some companies will be forced to reduce benefits and people will seek care from the public sector. Because of these costs, some researchers have examined the impact of companies looking to shifting the burden of ARV provision to the family or state. There are indications that some South African companies have attempted to do this by cutting benefits whilst raising eligibility standards, or using 'screening' of some kind. The more a company can shift health care onto the state, the higher the profits it can earn. Management would therefore prefer a more efficient

public health system, which would bear the costs of health without affecting a company's operations. [Brookings, 2001; Rosen, et al, 2003; Dickinson and Stevens, 2004; Dorrington, 2004b; Lewis, 2004]. The Health Systems Trust also speculate that companies are protecting themselves from the impact of the epidemic. In particular, the trend to outsource lower skilled jobs to labour brokers who frequently do not provide benefits, is of concern because the burden of caring for HIV infected individuals will now fall on the state and the family. [HST, 2004]

Assuming that the provision of treatment is a good business decision, at least for the more highly skilled sections of the workforce, managers face the problem of how to deliver and fund the treatment.

Medical aid schemes offer one avenue, but have limitations. Benefits are varied from time to time by medical aid schemes depending on contributions and plan options. Limits are often used to manage claims. Low limits often cannot cover treatment and care of patients, while even higher income plans may offer sufficient cover for drugs, but not hospitalisation. Certain medical aids limit their cover to wellness programmes and drug management programmes without covering the cost of care or medication. Many of the plan options for low-income earners do not provide adequate benefits and certain categories of employees are not on medical aid. There is also the issue of medical aid cover for family members. [SABCOHA, 2004]. Stevens [2004] states that there is a clear growth in the medical aid scheme industry which facilitates access by companies to the schemes. The benefits are uneven and fewer employees are able to access this benefit. [Stevens, 2004]. The main factor driving medical scheme contribution increases is the escalating health care costs, which are higher than inflation. [HST, 2004]. The use of medical schemes by lower paid workers to pay for expensive chronic conditions rather than as health insurance suggests that the health insurance strategies employed by companies may be nullified should the stigma associated with HIV/AIDS break down and the lower paid employees join the medical aids. Medical aid benefits are generally too high for lower paid staff to afford the premiums. [Dickinson and Stevens, 2004].

The second avenue is for a company to fund the provision of treatment, including drugs. This is expensive and such an action sets a precedent for dealing with other health issues and illnesses. There may be extra costs to a company of introducing

ARV therapy, without necessarily improving productivity or reducing other costs to any significant degree.

Where employees are unwilling or unable to pay the increased premiums for medical aid benefits, or the company does not have its own treatment policy, they become subject to the public sector for health services. The public health system has introduced treatment of HIV+ people as part of its plan. However, this has not been successful to date in terms of providing treatment to all who need it. Dickinson and Stevens [2004] identify practical problems for employers whose workers use the state health systems. Employees' use of the public health system is costly to the company because their workers are required to take time off for queuing to receive medication at clinics and hospitals, especially when they are required to go to several clinics to obtain medication. When statutory leave is used up, employees who rely on the state sector become a problem for employers who start to lose income; the system contributes to absenteeism and loss of production. [Dickinson and Stevens, 2004]. Also, as seen in Chapter 1, the public health system appears unable to provide treatment to all those who need it at present.

IMPACT OF HIV/AIDS ON COMPANY COSTS

Increased costs of benefits are only part of the additional HIV/AIDS costs which may be incurred by a company. In the writer's experience, there is no single formula which can calculate these additional costs. Companies have different policies and benefit structures, different employee demographics and will have different HIV infection rates. The nature of an organisation's commercial ventures and therefore job requirements will create differing worker profiles from company to company; for example, the employee profile of a bank will be different to that of a mining company. Companies are familiar with historic costs and can develop budgets and plans which cater for these costs. The emphasis of an HIV/AIDS cost impact analysis is on the **additional** costs incurred as a result of the disease, as organisations are concerned about cost increases over and above those costs currently incurred. In determining the impact, a base case using current data is developed, with the impact of various intervention activities modelled as alternative scenarios. This enables a company to

evaluate the impact of activities, as well as determining the key cost components. It is therefore only possible to describe the general areas where costs are incurred.

Anything which increases costs is a target for a cost reduction plan. As HIV/AIDS is regarded as a cost, companies using the overall cost leadership strategy will develop plans to reduce costs associated with the disease. Firms are often structured to require individual business units to be profitable, looking first at the immediate bottom line of their investments. Many of the more serious costs of the epidemic, such as reduced productivity, cannot be measured by traditional cost methods, and hence are not included in the profitability matrix. [Nattrass et al, 2004]. Despite the dearth of data, there is some evidence that AIDS is already increasing the cost of doing business; it is, in effect, a payroll tax, as companies pay direct costs for the treatment of employees and more expensive health and insurance benefits, as well as the indirect costs of lower productivity, absenteeism and increased costs of replacement of staff. [Brookings, 2001]. A study where data was collected between 1999 and 2001 to estimate the financial impact of the epidemic as a percentage of salaries and wages in six southern African firms employing over 500 people reports a range between 1.8% and 5.9% of the payroll costs. [Rosen, et al, 2003]

The total impact of direct costs on firms will vary depending on factors such as worker benefits, increased absenteeism and decreased reliability of supply chains and distribution channels, HIV prevalence across grade bands and the loss of skills levels over time, and the public relations risk of inaction. [Nattrass et al, 2004].

Given the importance of profit-making within an organisation, Management has to consider the cost-effectiveness of any HIV/AIDS intervention. While basic direct costs, such as the costs of training and recruitment, and any cost increases which may be made by service providers for retirement funds, medical insurance and life insurance are generally freely available, there are hidden costs, for example the decline in productivity and absenteeism, which are difficult to determine as they depend, to a large extent, on a knowledge of the exact HIV status of each employee within the organisation and the stage of infection they have reached. Costs will differ from employee to employee, depending on the level of the employee within the organisation.

Increased costs will be experienced in a number of areas. Recruitment and Training costs will increase with additional staff requirements arising from increased employee turn-over. Absenteeism will be increased by additional health problems amongst those employees who are HIV+ or have progressed to AIDS. Overtime costs will be incurred as healthy employees are required to perform tasks normally done by those who are ill. There is also a danger that injuries on duty will increase as staff are required, on an emergency short-term basis, to perform tasks for which they have not been trained. Any increase in funeral attendances, sick leave and compassionate leave will affect productivity, as will family leave for employees to attend to family issues caused by the epidemic. Death in service costs, such as funeral costs and repatriation of the bodies of employees who have died, will increase as death rates rise.

Premiums for benefits such as life insurance, medical aid and retirement funding may increase due to increases imposed by service providers. Suppliers of goods and services may increase charges to cover their own HIV/AIDS programmes and interventions. According to Stevens et al [2004], the general thinking regarding HIV/AIDS in the workplace is that it will hamper production by increasing rates of absenteeism and decrease productivity, which in turn impacts on profits. Possibly due to the invisibility of the disease, companies have failed to make allowance for the impact, believing that there is a pool of unaffected workers from which to hire and rehire. [Stevens et al, 2004]. As lower income earners tend to have few benefits, the impact of HIV/AIDS on direct costs may not be as high as expected. [HST, 2004]. There is a suggestion that the lack of data from companies, and therefore lack of action, is because of the highly politicised nature of HIV/AIDS, leading to a battle between Government and Business over who pays in dealing with HIV/AIDS. [Fafu, 2003].

While the determination of the additional costs to a company of HIV/AIDS is currently an inexact science, there are models which can provide Management with level of magnitude estimates on the impact of the disease on the organisation's costs, as well as the areas where the costs are likely to be incurred. As part of his consultancy practice, the writer developed a cost impact model. In the recent past, he completed cost impact assessments for different companies.

The table below illustrates the breakdown of additional costs incurred by four South African medium to large companies because of the epidemic. As companies are looking to reduce or contain costs in a competitive environment, Management needs to identify the cost areas, their magnitude and the relative proportions to each other to develop an intervention which will concentrate on the key areas. The table also compares the result of the model runs to the cost areas identified by Whiteside and Sunter [2000].

Table 2.2: COST AREAS AS A PERCENTAGE OF TOTAL HIV/AIDS COSTS

COST AREA	W & S	Co A	Co B	Co C	Co D
Training	7	6	8	4	2
Recruitment	6	13	10	2	6
Labour Turnover	5	9	5		
Funeral Attendance	6	7	9		
HIV/AIDS Absenteeism	52	65	67	60	29
Burial Costs	16				6
Health Care	5				30
Ex Gratia				5	21
Work Cover				20	6
Other	3		1	9	
Total	100	100	100	100	100

Sources: Whiteside and Sunter [W & S]

Griffiths [Companies A - D]

A description of the Griffiths model is contained in Appendix 1.

Variations in the percentages are due to the different nature of the various companies. As an example, financial institutions will have different cost profiles compared to mining houses because of the different skills required, leading to different employee

profiles. The absolute cost numbers derived from modelling the cost impact will also depend on factors such as the prevalence rate in the workforce, who is infected and what stage of infection they have reached, and the costs of benefits. The models appear consistent in highlighting absenteeism as the major cost area. This confirms Dickinson's assertion that AIDS-related absenteeism and skills loss were seen as the most likely areas where AIDS might impact on company operations. [Dickinson and Stevens, 2004]. Organisations seeking to reduce the cost impact of HIV/AIDS should be aiming to minimise the absenteeism element of their costs.

Companies should also be completing cost analyses at regular intervals, as the environment changes. The increased availability of drugs through the State system could remove some costs which a company is currently incurring. On the other hand, a treatment regime introduced by a company, although perhaps increasing costs in the short term, will change the long-term costs implications by allowing infected employees to work longer and thereby reducing the impact on productivity. If the structure of a work-force changes, such as an increase in temporary labour through casualisation, the costs impact will change.

BUSINESS RESPONSE TO HIV/AIDS

However, costs are not the only determinant of a company's response to the epidemic. Dickinson and Stevens [2004] identify six drivers of the business response to HIV/AIDS in South Africa, including costs.

- There are **legal requirements**, but these are fragmented as illustrated earlier, with no single act covering the issue of HIV/AIDS at work. Companies interpret the law within the context of business imperatives. Where the law and profits are not complementary, actions taken by businesses are sometimes aimed at loopholes within the law to maintain business activities. The law has done little to encourage businesses to take a pro-active stance regarding HIV/AIDS.

- **Voluntary regulation**, including best practice codes, exists but is not enforceable. Companies can agree to abide voluntarily by principles that take into account concerns beyond short-term profit maximisation, and subscribe to one of the codes of good practice that have been developed by governments and other interested parties.
- **Business costs** are often used as a driver of a response to HIV/AIDS. However, despite strong theoretical arguments and conventional wisdom regarding the cost of the epidemic to companies, Dickinson and Stevens state that there is little evidence to suggest that companies have been involved in a cost-benefit analysis to any great degree. He also claims that there is still a strong element of 'racial capitalism' evident within the business sector, which maintains that there is a sufficiently large labour pool amongst black workers to enable replacements to be hired easily. Cost-benefit analyses depend on determination of the prevalence rates within a company and the financial implications of the infection rate on employee benefits and productivity. Despite the existence of the disease for a lengthy period in South Africa, neither is easy to determine. Companies have ignored the epidemic and its consequences for a long time, and the general lack of knowledge of prevalence rates within the workforces of individual companies means that any cost impact analysis is based on estimates rather than a concrete evaluation. Obtaining prevalence rates within a company has ethical problems because of the legal requirement for confidentiality.
- **Social pressures**, including peer pressure from other companies within the same economic sector, are regarded as a possible reason to introduce an intervention. The national prevalence rates should require a response from all parties concerned, but the state, as the only actor with a mandate to co-ordinate a response, has not responded strongly enough, leaving others to respond without any proper guidance. Businesses, with their aims of profit maximisation, appear unwilling to act with regard to the social issues of the epidemic. In some cases, companies in the same economic sector take their cues from each other as to deciding an appropriate response.

- The **visibility** of the disease is an issue. HIV/AIDS is invisible for a number of reasons; not only does the disease have a long incubation period, issues such as stigma and the slow response from social institutions has caused a lack of openness among those who are infected. In the context of companies downsizing, a common occurrence in South Africa in the recent past, fear of being earmarked for redundancy because of being HIV+ may have caused a number of employees to remain silent about their status.
- A response also depends on which **individuals within the company** take responsibility for dealing with the disease. These individuals tend to be either those who have a personal interest in the disease or belong to staff functions, especially Human Resources, where the responsibility for an intervention has been placed. Staff functions are generally subordinate to other departments within a company and hence there is a lower importance given to the intervention.

[Dickinson and Stevens, 2004].

This last point has been emphasised by others. Versteeg [2004] states that, in the majority of companies, people without decision-making authority and often in low positions had been appointed by management to formulate an HIV/AIDS policy or low-budget prevention and awareness programmes. [Versteeg, 2004]. Stevens [2004] maintains that, in many companies, Human Resources is the domain for responsibility for HIV/AIDS, at a relatively low level and within a staff function rather than within line functions. [Stevens, 2004]. Where a relatively low level person is perceived to be in charge of the intervention, employees may find it difficult to believe that Management is serious about the problems posed by the epidemic.

Once Management has conformed to the legal requirements regarding HIV/AIDS, it will have to decide whether there is a need to have an HIV/AIDS intervention, given the socio-economic environment and the current and forecast impact of the epidemic on business. Management's priorities will determine the nature and extent of any intervention. Each company in the private sector can review the proposals of the institutions recommending formal processes for an intervention, and the ways in which major companies have dealt with the disease, and develop its own programme

depending on the nature of its activities, its objectives and priorities. The programme will depend on the size of the company, the ideological stance of its managers and shareholders, the economic sector it belongs to, and its financial resources.

Any intervention's scope and nature will depend on a number of factors.

The **Prevalence Rate** of HIV within the organisation is a major factor. A relatively low level of HIV+ employees may mean that the organisation can handle the impact of the epidemic within existing benefits, policies and practices. A high prevalence rate, as generally experienced in South Africa, will require a more extensive overall programme. Faull poses the question: 'Imagine you are a South African employer. How many of your South African employees are HIV positive? If you cannot answer that question, you cannot assess the cost and this element of risk to your business. But you are not allowed, by law, to require your employees to submit to testing. There is only one legal way out of this: you have to encourage voluntary testing in a way that gives you access to the data.' [Faull 2005].

Also of importance is **who** is HIV+ within the organisation, and what impact it will have on the current and future operations of the organisation. Within each organisation there are key employees who are critical to the provision of services to clients and customers; should the disease be widespread amongst these employees, it poses a threat to the viability of the organisation and increases the requirement for a formal intervention. The makeup of the workforce is also important. Should a company employ a majority of those at high risk, such as in the younger age group, or a preponderance of females, there is a likelihood of the Prevalence Rate being higher than if its employee breakdown reflected the demographics of the country.

The **priorities** set by the organisation is a further factor. If there is a drive towards profits at any cost, the organisation could introduce a minimal intervention to satisfy the major pressure groups, but without having a comprehensive programme. On the other hand, an organisation may see itself as a major player in tackling the epidemic from a corporate social investment viewpoint. The most obvious method of reducing HIV-related costs is the treatment of those employees, especially key employees, who are HIV+. This is not without penalties, however; ARVs can keep HIV positive

employees alive for up to 19 years, but can put an employer out of business because of the costs. [Lundin 2002]. However, this is changing, with the availability of drugs through the public health system. Treatment also delays the costs of termination rather than removing them. [Rosen et al, 2003]. Delaying these costs via treatment assists an organisation to retain short-term profitability and competitiveness. This option requires an analysis of the labour force in terms of age, skills level and likelihood of being infected; this can only be examined through a cost benefit analysis.

The **resources** – personnel, materials and finances – available to an organisation will have an influence on the extent of any programme. A small organisation may wish to have a very comprehensive and far-reaching programme, but may not be able to afford it.

The **personal values** of the implementers play a part. The decisions made regarding the scope and range of an intervention will depend on the priorities determined by management, which in turn are influenced by factors such as their personal objectives and ideological convictions. Some managers may regard it as their moral duty to have a programme, while others will regard it as a business decision, requiring business criteria to measure the need.

The **broader expectations of Society** are of importance. Management's decisions are made within the context of how people outside the organisation are expecting the organisation to act. In the case of HIV/AIDS, there are general expectations, including from Government, that the private sector will take a leading role in going beyond the legal requirements and providing a comprehensive intervention, meeting the demands of each stakeholder to some extent.

These factors, combined with the pressures from the stakeholders, dictate the manner in which an organisation reacts to the epidemic. Any intervention will reflect the organisation's choices as regards the objectives important to that particular organisation, and will need to be integrated within the overall policies, practices and goals of the organisation.

The impact of the disease on the organisation's overall **Strategy** must be evaluated. This will encompass areas such as the economic development of the country and the decisions made by the government regarding expenditure on infrastructure, and hence growth in the areas of activity of the organisation. It will include the competitive nature of the business sector that the organisation belongs to, as well as the financial, labour and material resources required to maintain viability.

Secondly, there will be an impact on the **Operational** activities of the organisation. This will include areas such as recruitment and training, costs of an intervention, safety, benefits policies and application, and daily client service requirements.

Thirdly, there is a potential impact on the **Reputation** of the organisation. An intervention becomes part of the public domain after implementation, and is comparable with the actual interventions of other organisations and those desired interventions promoted by pressure groups. There is also the possibility of an employee failing to apply the policies correctly by acting contrary to policy, such as dismissing an employee for being HIV+, and thereby generating a public relations controversy.

The decision-makers within the organisation have to be convinced that a programme is necessary.

This generally requires some benefit to be recognised and advanced as a compelling reason for Management to make any decision regarding the scope and nature of an intervention. In most cases, this would be a cost benefit. Where such benefits can be illustrated, Management will probably be amenable to supporting the programme and can provide the necessary leadership and promotion.

The programme has to be explained to all staff in a manner which enables them to support the intervention at all levels. There has to be some incentive for employees, who need to know how they will benefit before the programme is introduced.

Any HIV/AIDS initiative will require management time and effort. Management should therefore be aware of the probable overall costs in financial and management

time resources, and be prepared to provide the necessary support and leadership for the intervention.

While the nature of an organisation, its structure and objectives play an important part in determining the extent and depth of a programme, there are some basic criteria against which the need for a programme can be measured and debated. Management is required to weigh up the various arguments and evaluate them as they pertain to their own organisation before making the decision. There is no universal solution to the problem, but rather a matter of judgement on the part of decision-makers as to the appropriateness of introducing an intervention.

THE CONSTRUCTION INDUSTRY IN SOUTH AFRICA

During the period 1998 – 2003, the construction sector was responsible for around 3% of the total GDP in South Africa, and grew by about 6% in 2004. [SA Government, 2005: SA Reserve Bank, 2005]. According to HEARD [undated], the industry is one of the top five employers in any country and is characterised by a salaried core of skilled graduates and technical staff, and a team of unskilled, mainly temporary, workers. The ratio of skilled to unskilled workers varies according to the types of construction being undertaken at any one time, as well as the ratio of labour to capital costs, which can also vary considerably. The economic activity in the country or region where the work is undertaken affects employment. Fluctuations in activity will impact on employment levels and capital expenditure, depending on the amount of work available at any one time. Construction is characterised by relatively short-term work on any site, which often requires a nomadic life-style for permanent employees who may spend lengthy periods away from home, as well as the recruitment of local workers on a limited duration basis. [HEARD, undated]. In road construction, there is often a need for workers to travel to remote parts of the country for periods of up to two years.²

² It should be noted here that, because of the connotations associated with the term 'migrant labour' during the apartheid era in South Africa, when capital, supported by the State, drew male labour from the peasantry for short-term contracts in industry. When the contract ended, workers returned to the rural areas. This thesis will use the term 'nomadic labour' to describe those employees who travel to remote sites for lengthy periods.

According to the Cape Times [2005], the South African Federation of Civil Engineering Contractors [SAFCEC] says that the construction industry in South Africa is entering a period of sustained growth, but there are still problems regarding the ability of the industry to meet the renewed demands. Growth of 25% in residential and 10% in non-residential projects is forecast, with real term turnover expected to increase by 8% in 2005, and 10% in 2006. There will be increased spending in state-owned enterprises and a focus on service delivery by the provincial and local governments. This growth will accentuate supply side constraints. Over the past years, skills have been lost to other sectors; the local industry may have to rely on expatriates, and implement strategies to develop the existing skills base amongst the younger workers. Anything which removes skilled employees from the work-force must be regarded as a threat to performance and viability of companies.

The construction industry is key to the growth of 6% that the Government has targeted, and needs to grow at around 7% to achieve its part in the growth. Loss of foremen and supervisors, who take a long time to train, is a major concern of the industry. Attrition rate amongst foremen trainees is high, with around 80% of those trained as foremen being lost to the industry over 5 years. [Lake, 2005]

According to the Bureau for Economic Research [BER] survey in 2004, undertaken with the South African Business Coalition on HIV and AIDS [SABCOHA], the construction industry has a labour breakdown as follows:

Table 2.3:

SOUTH AFRICAN CONSTRUCTION INDUSTRY DEMOGRAPHICS: 2004

DEMOGRAPHIC DATA	%
SKILLS:	
Semi-Skilled	37
Skilled	31
Highly Skilled	32
AGE [Years]:	
Under 30	20
30 – 45	39
45+	40

Source: SABCOHA, 2004

The age profile shows a skew towards the older age groups, with a fairly even split in skills levels.

HIV/AIDS IN THE CONSTRUCTION INDUSTRY

The SABCOHA 2004 survey on selected business sectors reveals a number of particular issues facing the construction industry and HIV/AIDS.

The industry has a relatively high percentage of highly skilled workers, but also employs a large number of workers on a contract basis, especially semi- and unskilled workers. The SABCOHA survey also reveals that the prevalence of HIV is higher in semi- and unskilled workers than amongst highly skilled and white-collar workers. The survey indicates that this is likely to cause particular vulnerability to the disease in the industry.

The construction industry seems divided on the issue of the effects of HIV/AIDS. The SABCOHA survey revealed the following perceptions of construction companies

regarding the effects of the epidemic. Percentages given relate to the number of companies who mentioned the particular effect.

Table 2.4:

PERCEIVED EFFECTS OF HIV/AIDS EPIDEMIC ON CONSTRUCTION COMPANIES IN SOUTH AFRICA

EFFECT	%
Absenteeism up, Productivity down	35
Greater Labour Turnover	28
Loss of Experience	30
Increased Recruitment and Training Costs	21
Increased Employee Benefit Costs	28
Have a Policy	21
AIDS costs cannot be passed on to clients	82
Invest in labour-saving equipment	10
Profits affected currently	28
Profits affected in 5 years time	41
AIDS has significant effect on business now	7
AIDS will have significant effect in 5 years time	33

Source: SABCOHA

The predominant view appeared to be that the epidemic would not have a major effect on construction.

Less than half of the respondents believed that HIV/AIDS would adversely affect the industry and its profitability, even in the future. Less than a third of the industry had implemented an AIDS policy, while the general feeling in the sector was that the impact of the disease was currently 'small'. In South Africa, only 9% of construction sector companies surveyed in 2003 indicated that HIV/AIDS had already had a significant adverse impact on their business and less than half anticipated a significant negative impact on their business in five years time. [SABCOHA, 2004].

A relatively small percentage of construction companies had experienced lower labour productivity, increased absenteeism or higher turnover rates because of HIV/AIDS. However, many construction companies have downscaled their permanent workforce in recent years, with the retention of skilled employees and the use of local labour on limited duration contracts. [SABCOHA, 2004]. This is a result of cost containment exercises rather than a result of deliberate action arising from the HIV/AIDS epidemic. There are indications from SAFCEC that the industry is set for growth, but that skills are in short supply; the impact of HIV/AIDS will exacerbate this shortage. [SAFCEC, undated].

A significant proportion of organisations polled in the survey believed that there is sufficient labour available to ensure that companies can continue operating, and that the epidemic will not be significant in terms of disrupting normal business practices. A small number of companies would invest in labour-reducing equipment. Less than half believed that profits would be affected in the future. [SABCOHA, 2004].

Although the majority of respondents were of the opinion that the epidemic would not have a severe impact on the industry, over 75% of large companies indicated that HIV/AIDS had led to lower labour productivity or increased absenteeism, higher employee benefit costs, and higher labour turnover rates. [SABCOHA, 2004]. Less than 20% of the sector's companies believed that they would be able to pass on the costs of the disease to customers by increasing prices. One third of respondents felt that AIDS would have a significant effect on business in 5 years time, compared to 7% now. [SABCOHA, 2004].

While the majority of companies surveyed perceive that the disease has had a relatively small effect on both operations and profits to date, a significant number of companies, in particular the larger companies, believe that the epidemic will have a serious impact on the industry in the future. The conclusion is that it should encourage managers to make strategic decisions on HIV/AIDS to prepare for the future.

Road construction, as with other production activities, requires the units of production – personnel and machinery – to be available at the place of utilisation to reduce

inefficiencies and costs. In the case of road construction, it is the rural areas between cities and towns. Road construction companies have a work structure which is believed to promote the spread of the disease. Placement of employees within the road construction industry is different from the normal understanding of migrant labour in that it is the permanent employees who are subject to the system, and they include skilled workers as well as key workers within the organisation. Workers from a central base are sent into the field without their families for periods of two years or longer during construction of roads, and are introduced into rural communities as people with money to spend. Temporary workers are recruited from the local community for the duration of the construction period. This situation is the opposite of the classic migrant labour pattern. Here the skilled men migrate, while the unskilled are recruited locally. The construction process uses machinery, controlled by trained, skilled operators, to perform the heavy tasks such as scraping, smoothing and application of materials, while the temporary, unskilled labour is used for tasks such as clearing verges, final landscaping and for duties such as flagmen. Each site has a Site Agent, engineers and skilled administrative staff, all of whom are nomadic.

The epidemic seems likely to impact on the road construction industry in two ways. Firstly, permanent employees are at risk of being infected because of their nomadic life-style, with a concomitant effect on the costs to the company of benefits and productivity. Secondly, the unskilled labour drawn from the local workforce will be affected by their periods of unemployment and the need to look after their family members who are already infected. Replacement of employees in both these categories will increase training and recruitment costs as well as any applicable retirement or medical benefit costs. [HEARD, undated]. According to Lake, around 70% of operators in KwaZulu Natal are HIV positive. The age of employees and managers is at the older end, in an industry where HIV infections are running at around 20%. [Lake, 2005].

A company within the road construction sector would therefore be a useful case study of the necessity for active involvement in preventing and treating HIV/AIDS. The work requires a nomadic lifestyle, which managers have to take into account when developing an intervention. It has both permanent and temporary employees, enabling a review of the different benefits available to these two groups. It is in an economic

sector where there is high competition, with the consequent emphasis on cost containment.

Some research has already been done in the Western Cape on HIV/AIDS in the construction industry. In 2003, the Viral Assistance Centre [VAC], a South African based private company that provides HIV/AIDS related management services in the construction and civil engineering sector, motivated a project through SAFCEC for Construction Education and Training Authority [CETA] funding to investigate the HIV Prevalence Rate in the construction industry in the Western Cape. Companies would be put through a programme of voluntary, anonymous testing and employees were able to know their status. Participating companies obtained statistics on their individual infection rates and were able to determine their own strategies to deal with the epidemic. The goal was not testing *per se*, but personal knowledge for participants, allowing individuals to pursue treatment if positive, and implement behaviour changes. VAC did the testing and provided the results to each participating company, with suggested responses. The idea was for each company to develop and control its own programme depending on its priorities and needs. Ten companies agreed to participate in the exercise.

VAC used a system of Awareness, Counselling and Training [ACT] rather than the traditional Voluntary Counselling and Treatment [VCT]. ACT is regarded as a more proactive approach which emphasises concentrated awareness training of participants prior to offering VCT, using narrative counselling techniques, emphasising respect for differences in culture, language, and religious beliefs, and using the home language of participants. [VAC,2004].

The programme yielded the following results [Table 2.5]:

Table 2.5: WESTERN CAPE CONSTRUCTION 10-COMPANY HIV TESTING: 2003:

ACTION	NUMBER	COMMENTS
Attended Training Sessions	2357	
HIV and Life-Skills Counselling	2324	98.6% of those attended
Tested for HIV	2110	90.8% of those counselled
HIV+	232	11.0% of those tested
Obtained Results of Test	2099	99.5% of those tested

Source: VAC [2004]

The very high numbers of those who attended the training sessions continuing to the testing phase indicates that the VAC methodology has a good success rate in convincing employees to be tested, a critical element in the development of a programme. The Prevalence Rate of 11.0% in those companies that went through the testing procedures reflects both the low infection rate in the Western Cape [15.4%] at the time and the dominance of older, male employees in the industry who are less likely to be infected [40% over 45 years old]. This would appear to indicate that the incidence of HIV+ employees in the construction industry in the Western Cape is relatively low, and may not be a significant problem.

At the time of the testing process, VAC identified some problems. VAC could only talk about benefits in general terms, such as counselling and the promise of government-sponsored Antiretroviral drugs [ARVs], as there was no indication of what companies would do after the testing phase. Employees perceived a high risk of both job loss and discrimination with testing. Employees were hesitant to discuss testing with their spouses, as it indicated a distrust of their partner. Some site managers did not participate in the testing process. Counsellors were mainly responsible for overcoming the fears of employees.

The survey indicated that there was a significant incidence of HIV infections within the construction industry. There appears to be differing opinions amongst companies within construction as to whether the epidemic will impact on their operations and profitability. The industry employs both skilled, permanent employees and temporary labour for relatively short periods. The skilled permanent employees are often nomadic, spending up to two years on site with very little home leave. These nomadic employees are susceptible to the disease because of their lifestyle. The low infection rates determined by the VAC sample of 10 companies compared to the national HIV Prevalence Rates indicates that there may be a much higher infection rate in the industry in the next decade, although many of the employees are temporary and will have finished their contracts.

It was therefore decided to examine a medium-sized company in the road construction industry in the Western and Eastern Cape. Geographically, the company is active in an area where the HIV Prevalence Rate has not yet reached the proportions of the rest of the country, and the decision to introduce an intervention would not be overly influenced by the overwhelming infection rates of, for example, KwaZulu Natal.

The company selected for the study was Haw and Inglis [H&I], road construction specialists based in the Western Cape and active in the southern parts of the country. It employs people who, because of their age, sex, socio-economic background and working environment are susceptible to infection. The company employs between 500 and 1000 workers, the majority of whom are semi-skilled or unskilled temporary workers. Terminations through death and illness are at a low level within the company, indicating that the disease has not yet made a significant impact on productivity. In the case of H&I, the areas where they are active are the Western Cape, with a prevalence rate of 15.4%, and the Eastern Cape, with a prevalence rate of 28.0%. [Dorrington et al, 2004].

The company introduced an HIV/AIDS intervention in 2004 after a successful education and testing programme, which revealed that around 16% of employees were HIV+. The programme closely followed the suggested programmes of institutions such as the South African Business Coalition on HIV and AIDS, and the South

African Federation of Civil Engineering Contractors, and was similar to the programmes introduced by a number of major South African companies. The company claims that the programme was introduced for commercial reasons, as it was felt that an intervention made good business sense in view of the forecasts of economic downturns and the shortages of skilled employees.

CONCLUSION

There are several arguments in favour of an HIV/AIDS programme. An intervention should assist in protecting staff through the awareness and education aspects of a programme. In particular, key staff will have the information to protect themselves against the disease; productivity and service levels are thereby protected. There is a Health, Safety and Environment element to a programme, in that the organisation is legally obliged to protect employees, and an HIV/AIDS programme can be regarded as part fulfilment of this obligation.

From a business perspective, a programme could reduce costs associated with the disease significantly and protect the profitability of the organisation. A cost impact analysis could determine the extent of such cost savings. From a public relations aspect, a programme will elicit favourable reactions from the unions, the government and the community at large.

Strategically, an intervention will provide a good base for future action should the epidemic begin to affect the company.

Finally, a programme will assist in promoting the organisation as a 'caring company', both internally and externally. Allied to this, an intervention can be regarded as meeting any moral obligation on the part of shareholders and Management that they should be doing something to assist in fighting the epidemic.

The main business argument against an intervention is costs. Managers generally require an indication of costs before making any major decisions. An HIV/AIDS programme is no different from any other environmental issue impacting on an

organisation, in that the decision-makers will have to have an indication of how the company will benefit and the impact on profits.

Cost benefits are difficult to determine in the case of HIV/AIDS because of the amount of indirect costs involved. While direct costs such as awareness, education, testing and provision of condoms and other safety equipment can be estimated with a reasonable amount of accuracy, the hidden costs are not easily calculated. They are generally the product of estimates, and can be challenged. The danger lies in management inertia while arguments take place around the accuracy of the cost exercise. Any programme, with its attendant costs, could make the organisation uncompetitive and result in loss of business. Time spent on the programme elements such as awareness and education could affect the service levels required to remain competitive.

Decisions must also be made regarding treatment options. While effective treatment reduces cost implications for companies, the question of who is to pay for the treatment remains: Government or the company. Companies would prefer the Government to be able to provide drugs for all those infected, thereby relieving firms of the costs of treatment. Apart from deciding how treatment will be handled, either through the public health system or directly by the company, decisions must also be made regarding who is to receive treatment. There is more than drug affordability to consider. There is also the danger of setting a precedent regarding the handling of HIV+ employees with respect to benefits such as leave. Should they be regarded as a special case, with management affording them special terms and conditions, employees with other life-threatening diseases could logically expect to be afforded similar treatment, increasing the overall cost implications for the organisation. The successful implementation of a treatment programme also relies on the willingness of employees to come forward for treatment; should this not happen, the organisation will not obtain the full benefits of an intervention.

Private industry is therefore caught in a dilemma. Should an organisation elect to treat its employees who are HIV+, it is setting a precedent and raising expectations amongst all its workers that they will always be treated for HIV. The company is making itself a hostage to fortune should infection levels increase and it could be

required to institute treatment at an unacceptable cost. If companies decide to provide treatment for their employees, the Government is relieved of that aspect of dealing with the epidemic and can abrogate its responsibilities to the private sector. It would therefore appear that the use of medical aid schemes for treatment is viable mainly for permanent employees who are earning good salaries. This effectively removes this option from the temporary and the lower paid staff. The limited benefits offered by a number of medical aid schemes will also reduce the benefits available to employees, especially if the company does not wish to supplement the subscriptions payable by the employee. Reliance on the public sector for treatment, as shown above, is a debatable option at present, as the availability of drugs to many of those infected, while improving, is limited. Managers may come to the conclusion that it cannot treat all employees. It will be forced into making a choice between treating all, some or none of its employees. While treatment appears to be cost-effective, the impact on a company's bottom-line profits may make a company opt for a less generalised treatment programme than it would prefer, and concentrate on its key and/or permanent employees.

The economic system promotes the implementation of strategies congruent with the lower cost alternative, whether it is the use of technology, the employment of large manual work forces, or a combination of the two. Companies can institute a workforce consisting of a core of highly skilled, permanent employees, and a peripheral manual labour cadre, often temporary in terms of employment and therefore able to be hired at a low cost, and easily laid off as circumstances dictate.

Organisations are being pressurised into treating HIV+ employees differently from other employees regarding leave arrangements. Where the company relies heavily on skilled labour, the resultant decline in productivity should they agree to prolonged leave for those infected will impact negatively on the profitability and perhaps the service levels offered by the organisation.

The increased costs of employee benefits where premiums are shared between the company and the employee are likely to cause employees in the lower paid grades to opt for short-term solutions which allow for greater current cash flows to meet existing needs, rather than seeking to maximise their long-term benefits. Temporary

and short-term workers in particular rarely have the choice of belonging to institutions such as medical aids, retirement funds and life insurers. As a result, the impact on the State social safety-nets is likely to increase, putting further pressure on an already strained infrastructure. In order to pay for these social grants, taxes on both companies and individuals are likely to increase. As these taxes will be evenly spread across all companies, the individual organisation will suffer a reduction in profits but not in competitiveness.

The overall consideration from a legal point of view is that all employees should be treated the same. Organisations will be reluctant to create any precedents arising from treating HIV+ employees any differently from other employees. Managers have to enforce policies equally to HIV+ employees as well as those who suffer from other life-threatening diseases. This could negatively affect employees who are HIV+, in that the organisation may not be able to accommodate them within existing company policies and practices.

It would appear that it is the resource-constrained small to medium-sized companies that will feel the greatest difficulty in providing an HIV/AIDS intervention.

In Chapter 3, the HIV/AIDS programme of a medium-sized enterprise in the highly competitive road construction industry, Haw and Inglis, is described to establish what the impact of the epidemic has been, how the company has responded, and how it fits with the pressures on managers and the profit motives of the company.

CHAPTER 3

THE CASE STUDY: HAW AND INGLIS

Thus far, the thesis has argued that there are no incentives for an organisation to introduce an HIV/AIDS intervention. It has identified the pressures on management in an economic environment to produce profits, the business pressures that it is also subject to, and has outlined the additional pressures that the epidemic has brought to bear. The aim of this chapter is to apply these hypotheses to a medium-sized company in the competitive road construction industry. Its margins are always under pressure from competition within the industry and it does not have the resources of a large enterprise to undertake social responsibility programmes. The company chosen, Haw and Inglis, is typical of others in the same industry in terms of its operations, such as the use of nomadic labour and skilled operators of heavy machinery. The study of a firm of this type will raise questions for others in the industry.

The aim of the case study is not to produce definitive conclusions, but rather to reveal issues which need to be investigated more generally. Its relevance will be limited to other enterprises of a similar size and structure in the road construction industry. Broader issues have emerged, such as casualisation and the structure of work, and the responsibilities of the State and capital in the reproduction of labour, which apply more generally.

METHODOLOGY

The methodology used was mixed, involving documentary investigation and interviews, both individual and in focus groups.

When considering the research requirements for the dissertation, the writer has drawn on his experience of 30 years in business, which culminated in the position of Managing Director for an international oil company in Zambia. It was this posting which brought him into direct contact with HIV/AIDS, as there were several HIV+ employees within the company, with a number of deaths from AIDS-related diseases

during his tenure. This posting was followed by the development of an HIV/AIDS action plan for the company and a period of consultancy to organisations on the business issues surrounding the disease.

It has become clear to him that a gap exists between the treatment of the disease as a stand-alone issue and the application of interventions in the work-place as an integral part of doing business. It is with this background that the data requirements were developed. Several differing approaches were required to establish the context of an intervention. Desk research covered a number of areas. There was a need to examine the pressures on company managers to meet the requirements of stakeholders in the organisation. This involved a review of business strategies to allow for any programme to be evaluated as part of an organisation's activities rather than as a separate issue. There was also the need to examine the legal requirements placed on enterprises with respect to the disease. The epidemiology of the disease was reviewed to establish the potential impact on employees from differing backgrounds and levels within an organisation. Businesses do not operate in isolation. Decision-making within companies has to take into account the pressures exerted on their operations by the economic system, hence the economic system of South Africa was reviewed.

The writer is aware of a number of organisations and companies who have developed generic HIV/AIDS programmes and placed them in the public domain. The opportunity was taken to review these programmes and develop a matrix of programme elements which could be used as a benchmark for evaluation of the case company's programme. The writer analysed the HIV/AIDS programmes of seventeen major South African companies against the generic programmes proposed by Government and NGOs active in the AIDS field. The majority of these are multinational companies, listed on either the South African or international stock exchanges. They will be subject to pressures from individual and institutional shareholders and agencies such as the Global Reporting Initiative and the King Commission to make their interventions public. As a result, it is likely that their programmes will follow the parameters of the most all-embracing programmes. These large companies are also financially sound and can afford to have comprehensive programmes.

The generic programmes of seven organisations were examined. They are:

- Department of Labour, Government of South Africa
- Confederation of South African Trade Unions
- The National Economic and Labour Commission
- The International Labour Organisation
- South African Federation of Civil Engineering Contractors
- The Southern African Development Council
- Workinfo

A table was developed to reflect the elements which these organisations considered important and requiring inclusion in a programme.

The actual programmes of seventeen companies were also analysed. These companies are:

- AngloGold Corporation
- Anglovaal Corporation
- Barloworld
- BMW
- BP
- Coca Cola
- Daimler Benz
- De Beers
- Goldfields
- IBM
- Metlife
- Nedcor
- Old Mutual
- Siemens
- SouthDeep
- Standard Bank
- Unilever

Finally, the elements of the H&I programme were identified and categorised through documentation and interviews. As H&I has an HIV/AIDS policy document but not a written HIV/AIDS programme, the elements are reflected as being incorporated within the H&I programme if they were part of the general company documentation or were mentioned in interviews.

Research into the company required a significant amount of primary research. It took the form of collection of company data from the administration functions in Head Office, and interviews with employees. The Human Resources function provided basic employee statistics in raw data form, as well as general information contained in company publications, policies and reports. Interviews with employees provided general data, impressions of the HIV/AIDS initiative and other information regarding work issues. Interviews took place at Head Office in Cape Town, at remote sites, and with the consultant employed for the HIV/AIDS intervention.

The interviews were designed to uncover motives, actions, expectations and suggestions for future programme elements and activities, from each level of the company.

Senior Management at Head Office, defined as the Chairman, Directors and Heads of Departments, were interviewed to discover why the programme was initiated, what benefits they expect to get from it and how they determined the nature of the intervention. There was also a need to focus on the importance of HIV/AIDS in the company's priorities and the intentions of the firm in the future.

Questions to this group related more to the strategic issues involved with the disease rather than the operational processes of the intervention. Interviews were done on an individual basis.

Site Agents, who are responsible for the daily operations of the company at remote sites, were interviewed to determine the practical difficulties in dealing with the disease and its impact, and how the implementation of the programme took place. Three site managers were interviewed on an individual basis.

A **union** shop steward was interviewed to ascertain the union's point of view and whether it is satisfied with the company's actions.

Finally, interviews were held with two groups of employees to discover where the disease has impacted them, both at work and in their private lives, and how they viewed the intervention. These two groups are Permanent Staff, who have specific benefits, including job security, and Limited Duration employees. Included in the permanent staff were Head Office employees below management level. Group interviews were held for those at remote sites; individual interviews were held at Head Office.

In order to obtain a reasonable cross-section of views, interviews took place in the Western Cape at Head Office in Durbanville and at a site in Paarl, and at sites in the Eastern Cape at Kei River Mouth and Adelaide. No Limited Duration employees were interviewed at Kei Mouth, as the project is a joint venture and H&I does not employ any Limited Duration employees at this particular site. At one site, a particular group was not comfortable in English: a translator was therefore used.

While questionnaires were specific to each group, there were some general information requirements which were standard. These information requirements covered areas such as what the respondent believes are the most important priorities for the company and for themselves either at work or in their private lives; where HIV/AIDS fits within these priorities; what they know about HIV/AIDS, and where they learned it; their perception of the success of the Haw & Inglis's intervention, especially the issue of benefits; and what they believe could be done to improve the programme.

The **Consultant**, Mr H Lake of Viral Assistance Centre [VAC], who assisted in setting up the programme and in its initial implementation, was interviewed to establish the brief that the company gave him at the start of the initiative, the elements that have been included in the programme, and the follow-up programme post-implementation. Copies of the questionnaires and a list of respondents are attached as Appendix 2.

As South Africa has an economy based on capitalism and cost issues play a major part in a competitive environment, the final area of research was the use of cost models to establish what the elements of any additional costs arising from HIV/AIDS are, and where the key areas of intervention should be aimed. The writer developed a cost model for use in his consultancy, and was able to use the results of some companies as illustrative material.

HAW & INGLIS

Haw & Inglis [H&I] is an unlisted company, created in its present format in 1984. The company is owned by the Haw & Inglis Family Trust [30%], with a share scheme for Management and staff for the balance of the shares. The current shareholders, descendants of the original founding families, decided on this company shareholding to ensure that permanent staff have a personal interest in the management and profitability of the company. [Inglis, 2005].

The company is based in Cape Town and classifies itself as a Civil Engineering Contractor. Its core business is the construction and maintenance of roads, although there is a secondary emphasis on associated businesses such as low cost housing. The company's main geographic area of activity is the Western and Eastern Cape. There has recently been an expansion into work in KwaZulu Natal and the Free State.

There are three types of employee. **Permanent Salaried Staff** are paid monthly, and consist of the mainly skilled and qualified employees, such as engineers and administrative staff. **Permanent Wages Staff** are paid fortnightly and are made up by the balance of the permanent employees, including skilled operators of machinery and foremen. **Limited Duration Staff** are generally recruited locally for the duration of a contract, and are temporary employees for periods of up to two years, paid fortnightly.

Management regards the development and training of employees as a core requisite for the company's success. All employees are eligible for equal treatment in training, career development, mentoring and employee benefits. Management is committed to a non-discriminatory policy of betterment and skills transfer. Management's stated

intentions are to maintain the company's position in their field, and to expand by means of 'structured organic growth' through a dedication to quality and through care, education and upliftment of all employees. [H & I, undated]. The company is part of SAFCEC and has a collective bargaining agreement with the National Union of Mineworkers [NUM] for unionised employee benefits and pay scales.

The company also has a concern with HIV/AIDS. The Chairman, Mr P Inglis, indicated that H&I had a good HIV/AIDS programme, which was used as a model for the construction industry in the Western Cape. The local chapter of SAFCEC had obtained permission from the company to make the programme available to its members in the Western Cape. [Inglis, 2005].

COMPANY ORGANISATION

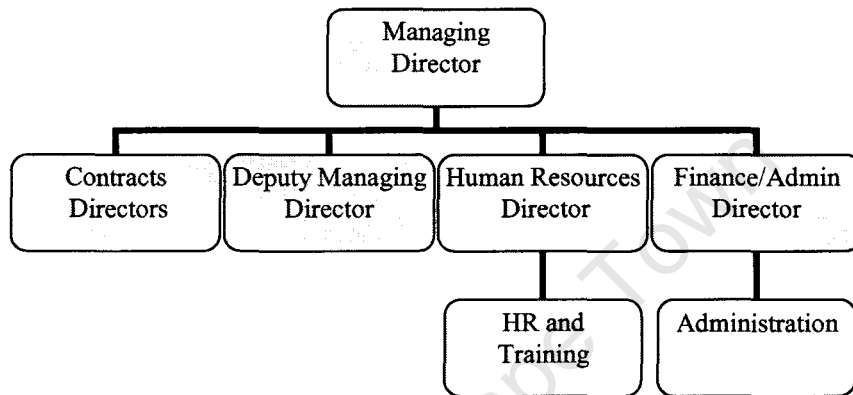
The company is structured around the need to have direct control of contracts on site. Teams are placed at each site where the company has been awarded a contract to provide service, either as sole providers or in a joint venture. Head Office staff act as back-up, thereby removing the requirement for regional offices. This arrangement requires some of the Permanent Employees to live away from home for several months at a time. Site Agents and other senior permanent staff are provided with accommodation for themselves and their families for the period of the contract. Lower level permanent employees are transferred without their families and are provided with accommodation, either in caravans or camps, a food allowance, and recreational facilities such as television.

An organogram illustrates the organisation of staff along contract lines, with the Head Office being kept to a minimum and the bulk of employees at remote locations.

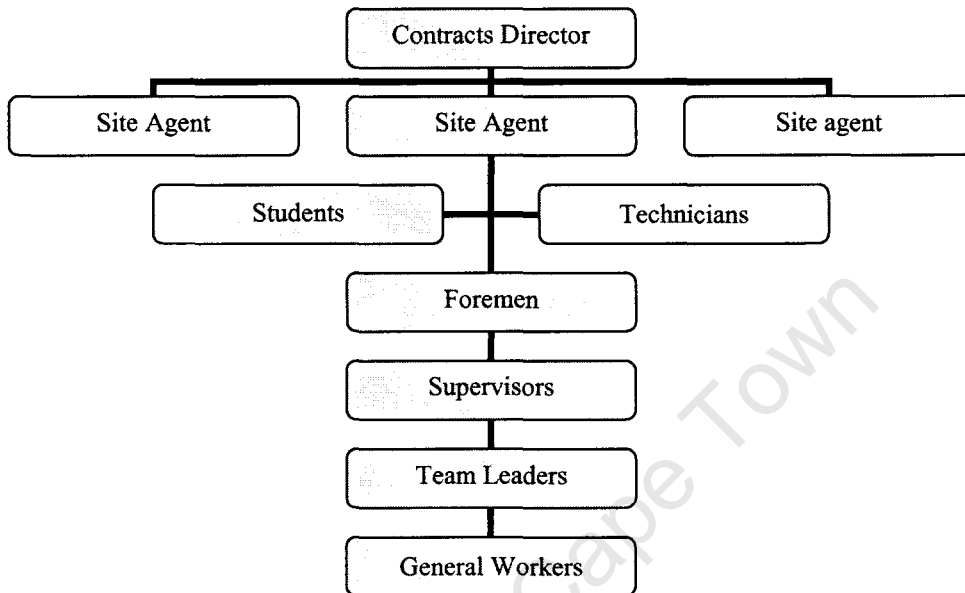
[Figure 3.1].

Figure 3.1: COMPANY ORGANOGRAM

HEAD OFFICE: 25 Employees



SITES: 500 – 900 Employees



Source: H&I

The company employs between 500 and 1000 staff, depending on the number of contracts being undertaken at any one time. Head Office is small, with around 25 employees, made up of the directors and other administrative and technical staff. The balance of employees are located on sites around the region. The largest single group is made up of labourers, who are employed to do unskilled and semi-skilled work. Each site has a Site Agent, who is a qualified engineer and is the senior employee on site, responsible for both operational and administrative activities. Site Agents are supported by an administration staff. Each site also has a number of skilled workers, the most important being Operators, who operate the heavy machinery, and Foremen, who head up teams of labourers responsible for the completion of daily tasks. Both Operators and Foremen are permanent employees, and are part of the nomadic employee group. Each site also has a number of technical staff, responsible for

ensuring that the materials used in the road construction are of an acceptable standard. In addition, there are employees in workshops around the sites to maintain and repair the machinery used in road construction.

An analysis of the workforce is difficult. The nature of the work, with a large number of temporary employees, as well as the lack of a comprehensive personnel database and computer system, requires the manipulation of raw data to obtain an idea of the workforce structure and demographics. In some cases, the data has had to be extrapolated from other sources.

As at November 2005, H&I employed 935 people, with a strong bias towards males [89%]. This bias is evident in all three employee groups. Limited Duration employees make up over 60% of the total workforce.

Table 3.1: H&I: EMPLOYEE NUMBERS [NOVEMBER 2005]

	PERMANENT SALARIED	PERMANENT WAGES	LIMITED DURATION	TOTAL
MALE	131	202	495	828
FEMALE	18	9	80	107
TOTAL	149	211	575	935
% OF TOTAL	16	23	61	100

Source: H&I

Using the Identity Numbers of Permanent Salaried employees to obtain their year of birth and hence their ages, the table below indicates that the age profile of this employee group is skewed towards the younger end.

Table 3.2:

H&I: AGE PROFILE: PERMANENT SALARIED STAFF [NOVEMBER 2005]

AGE [YEARS]	NUMBER	% OF TOTAL
Under 30	58	39
30 – 45	52	35
45+	39	26
TOTAL	149	100

Source: H&I

It was possible to obtain the Identity Numbers, and hence the ages, of those employees in all three groups who had left the company over the period 2002 – 2005. While this does not give an accurate picture of the current employees, it does make it possible to construct a table reflecting the age profile by combining the Permanent Salaried Employees with those who have terminated their contracts for one reason or another over the past three years. It was not possible to disaggregate Terminated Employees by type of worker, Permanent or Limited Duration. When comparing this with the Industry average, it can be seen that H&I has, by comparison with Industry, a much younger group of employees than the average.

Table 3.3:

H&I: AGE PROFILE: PERMANENT SALARIED STAFF AND TERMINATED EMPLOYEES [2002 – 2005]

AGE	PERM	TERMINATED	TOTAL	% TOTAL	INDUSTRY %
Under 30	58	333	391	36	20
30 – 45	52	445	497	46	39
45+	39	160	199	18	40
TOTAL	149	938	1087		

Source: H&I

The vast majority of Permanent Salaried Employees have been with the company for less than 10 years; this is consistent with the age profile shown above.

Table 3.4:

**H&I: LENGTH OF SERVICE, PERMANENT SALARIED STAFF
[NOVEMBER 2005]**

SERVICE [YEARS]	NUMBER	%
1 - 9	105	70
10 – 19	39	26
20+	5	3
TOTAL	149	

Source: H&I

The company offers a number of benefits to its employees, but differentiates between permanent and casual employees, as illustrated in table 3.5.

Table 3.5:**H&I: BENEFITS OFFERED BY EMPLOYEE GROUP [NOVEMBER 2005]**

BENEFIT	PERMANENT SALARIED EMPLOYEES	PERMANENT WAGES EMPLOYEES	LIMITED DURATION EMPLOYEES
Pay	YES	YES	YES
Medical Aid [compulsory]	YES		
Medical Aid [optional]		YES	
Pension Fund	YES	YES	
Funeral Benefits	YES	YES	
Life and Disability Insurance	YES	YES	
Sick Leave [Standard]	YES	YES	YES
Builders' Holidays	YES	YES	YES
13 th Cheque	YES	YES	
Profit Sharing	YES	YES	
Accommodation on site	YES	YES	
'Absenteeism' Bonus		YES	YES
Overtime		YES	YES
Pro-Rata Bonus			YES

Source: H&I

Permanent employees can belong to Discovery Health Medical Aid, which covers HIV+ treatment.

Premiums are shared between the employee and the company on an equal basis.

Membership is compulsory for salaried staff, but optional for wages employees. The company pays for ARV treatment for permanent employees, and refers casual employees to the nearest public health facility.

Retirement funding is available to permanent employees through a pension fund outsourced to Life Sense, with spouses eligible for a pension until death, and children until they turn 21. Funeral assistance is available for the employee, partner and children; assistance via loans is available for other dependants.

Standard sick leave and compassionate leave allowances are applied. Employees requiring additional sick leave are required to use annual leave, unpaid leave and, should it be necessary, are medically boarded for ill-health. Group life and disability insurance for death or disability in service is available for permanent employees, with the premiums being shared on an equal basis between the company and the employee. Pay for unionised employees is determined by the collective bargaining process. All permanent staff are entitled to a measure of profit-sharing.

Wages staff are provided with overtime. All permanent employees are eligible for bonus payments and a 13th cheque annually. Casual staff are eligible for bonuses on a pro-rata basis. In addition, wages staff, including Limited Duration employees, are given an attendance bonus.

All on-site permanent employees are provided with accommodation. The level of accommodation depends on the grade of the employee. Temporary staff recruited at the site are not provided with this benefit.

The most striking differences between the Permanent and Limited Duration employees is the lack of social benefits for the latter. Limited Duration employees are not eligible for medical insurance, retirement funding, or life and disability insurance. As a result, they are faced with decisions regarding these benefits: whether to utilise part of their pay for such benefits through a service provider, or to use their income to meet daily needs and rely on the State system for these benefits in the future.

An examination of the **leave** taken by employees can reveal how productivity being is affected, as well as being an indicator as to whether HIV/AIDS has started to impact on the company through the amount of sick leave taken. The company's leave policies allow for various types of leave.

Annual leave is set at 15 days per annum, taken during the annual shutdown in December/January each year. This is standard throughout the industry.

Unpaid leave may be given at the company's discretion and does not set a precedent for other employees.

Religious holidays which are not statutory public holidays are not given as leave. Employees may request occasional leave for these days.

Sick leave is not regarded as a right by the company; the company will not be sympathetic in granting additional leave privileges for periods of prolonged illness if the employee has 'abused' their basic sick leave privileges. Thirty-six days sick leave per 3-year cycle is allowed. No paid sick leave is granted if the illness is a result of the employee's own 'misconduct'. No definition of 'misconduct' is contained in the Leave Policy. Additional sick leave may be granted at the discretion of the company depending on a medical report, length of service and previous sick leave record.

Maternity leave of 4 months is allowed for women in permanent employment.

Family responsibility leave of 3 days per annum is allowed for compassionate leave, paternity leave and childcare. [H&I, 2003]

The amount of leave taken outside of the industry's normal annual closure in December – January each year is tabulated below. Leave taken is expressed both in total number of days, and leave per employee in the Salaried and Wages groups to allow for comparison between the groups to establish whether there are differences in the type and amount of leave taken by the average employee in each group.

**Table 3.6: H&I: LEAVE TAKEN [EXCLUDING BUILDERS' HOLIDAYS]:
2005**

TYPE	SALARIED STAFF: TOTAL DAYS	DAYS/EMP n = 149	WAGES EMPLOYEES: TOTAL DAYS	DAYS/EMP n =786
Family Leave	13	0.09		
Leave Taken	20	0.13		
Management Leave	14	0.09		
Sick	121	0.81	1235	1.57
Absent			1834	2.33
Absent with Permission			555	0.71
Compassionate			6	0.01
Injured on Duty			286	0.36
Total	168	1.13	3957	5.03

Source: H&I

Over 4000 days are lost due to leave other than annual leave. There are distinct differences between the leave taken by the Salaried Staff and the Wages Staff, including the Limited Duration employees, outside the normal annual leave. The most common explanation given for leave taken is 'Absent', or 'Absent with permission', which does not allow for analysis of why the employee was not at work, and precludes any attempt to track trends over time. There could be compassionate reasons, illness, or funeral attendance, aggregated within the catch-all 'Absent' reason. It is possible, though, to compare the leave taken in total by group. On average, Wages Staff are likely to take 5 times more leave per annum than Salaried Staff. Wages Staff are also twice as likely to take sick leave.

The fact that employees in either group have used, on average, less than two days of their sick leave for the year, as well as the very low level of compassionate leave taken, indicates that there has been little requirement for such leave. This might lead to the conclusion that HIV/AIDS has not had an effect on the work-force as yet. However, an examination of the individual leave records reveals that a small number of employees in both the Salaried and Wages groups are responsible for over 40% of sick leave taken. Three employees [2.0% of staff complement] have taken 51 out of 121 [42.1%] days sick leave in the Salaried group, while 18 employees [2.3% of employee group] are responsible for 509 out of 1235 [41.2%] days sick leave amongst the Wages employees.

Table 3.7: H&I: SICK LEAVE FOR SELECTED EMPLOYEES: 2005

SICK LEAVE DAYS	SALARIED STAFF	WAGES STAFF
10 – 19	2	7
20 – 29	1	3
30 – 49		5
50+		3
TOTAL	3	18

Source: H&I

Six employees have exceeded the standard policy of 36 days in a three-year cycle during 2005, with three being close to double the three year standard in the one year. Unfortunately, the data does not specify the particular illnesses that have caused the leave requirement.

The vast majority of **terminations** are due to contracts coming to an end, and staff being laid off until new contracts are obtained. An examination of the termination data over the period 2002 – 2005 revealed that there had been 15 deaths [including 2 Permanent Employees], 6 terminations due to Disability and 5 due to ill health. Breakdowns by Age, Age Year and Reason, and by Year and Reason, are shown below for Wages employees; there have been two deaths of Permanent Employees during the three year period, one from a road accident and one from natural causes.

Table 3.8: H&I: DEATHS AND ILLNESS: WAGES EMPLOYEES [2002 – 2005]

REASON	Under 30	31 - 45	45+	Total
Died	1	5	6	12
Road Accident	1			1
Disability		2	4	6
Poor Health	1	3	1	5
Total	3	10	11	24

Source: H&I

Note: During the same period, 2 Permanent Salaried Employees died:

1 = Heart Attack [2005]

1 = Road Accident [2004]

University of Cape Town

Table 3.9:

H&I: DEATHS AND ILLNESS: WAGES EMPLOYEES: BY AGE, YEAR AND REASON [2002 – 2005]

AGE	REASON	2002	2003	2004	2005	TOTAL
UNDER 30	Died		1			1
	Disability					
	Ill Health	1				1
	Accident			1		1
	Total	1	1	1		3
31 - 45	Died		2	2	1	5
	Disability			1	1	2
	Ill Health		3			3
	Total		5	3	2	10
45+	Died	2		1	3	6
	Disability		2		2	4
	Ill Health		1			1
	Total	2	3	1	5	11
TOTAL		3	9	5	7	24

Source: H&I

Table 3.10:

H&I: TERMINATIONS: WAGES EMPLOYEES BY YEAR AND REASON [2002 – 2005]

REASON	2002	2003	2004	2005	TOTAL
Died	2	3	3	4	12
Ill Health	1	4			5
Road Accident			1		1
Disability		2	1	3	6
TOTAL	3	9	5	7	24

Source: H&I

An analysis of the above three tables shows that, while there has been a slight increase in the numbers of deaths in service during the period, it is from a low base. The deaths are mainly amongst the Wages Staff, both Permanent and Limited Duration. In the case of the under 30 years old employees, there have been two deaths, of which one was a road accident, and one termination due to ill-health. If HIV/AIDS had taken hold in the company, higher figures of both deaths and ill-health retirements would be expected. Deaths amongst the two other age groups are similar, and the retirements due to disability and ill-health are also similar. This is to be expected, as the older age groups should be showing a greater propensity towards disease than the younger age groups except in the case of HIV/AIDS-related illnesses.³

Management and Site Agents regard the Plant Operators and the Foremen, who were mainly responsible for the completion of the work to a high standard [‘they run the whole show’] as the **key employees**. Both groups require training and experience to develop the required skills, and any absence from work causes problems in the quality of work and completion of tasks. Current figures were extracted from the basic employee data provided by the company. Employees designated as Foremen, including Junior Foremen and Trainee Foremen, and all employees with ‘Operator’ in their title are included. Of the 360 Permanent Employees, 40% [143] are in the key positions of Foreman [38] or Operator [105]. This indicates that there is a heavy reliance on these two categories of employee, with a need to ensure that the company has sufficient numbers of trained employees for these two positions. These skilled workers are also those who are most likely to be nomadic, as the company is reluctant to incur costs associated with training local employees to the required standard, losing the training benefits at the completion of the contract, and having to repeat the training with new local employees at the next contract.

³ However, if the epidemic spreads as forecast, there should be a greater number of deaths amongst the younger employees over the next 10 years.

PRIORITIES AND PRESSURES WITHIN H&I

Employees are subject to pressures within the workplace, and have to consider different priorities during the daily operations of the company.

Senior managers interviewed were definite on the main priority of the company: to make a profit, and to grow the company. A major priority was the creation of wealth; permanent employees at all levels will share in this profitability through a scheme which is in the process of being finalised. Other priorities mentioned were safety, providing opportunities for people to grow, quality of work, and the creation of a company ethos which drives people to work for job satisfaction as much as for pay.

At the same time, there was a social component to the priorities of the company. HIV/AIDS was seen as one of the issues that required company attention and some sort of action, but within the confines of the major objective of profitability. The Chairman saw the introduction of an HIV/AIDS programme as being beneficial to the overall performance of the company by improving morale and therefore productivity, through the concept of a caring company.

Pressures on management came from competitiveness within the industry, although the degree to which this impacts on H&I differed from manager to manager. The majority believed that competition was high. Managers were also concerned with continuity of the firm and aimed to hand over a successful and going concern to the next generation of employees, who would, to a greater or lesser extent, be shareholders. The need to have a better Employment Equity spread was also an objective of Management; the company was perceived to be mainly white and male at senior management and site agent levels, although some changes were starting to take place. Some concern was expressed about the increased legal requirements being imposed by the Government.

Site Agents regarded their main priority as getting the job done, on time and within budget. The financial aspect was important to them, as was the need for a high quality of work. Safety, as would be expected, was also a priority. Pressures for them were the lack of trained personnel, occasional lack of plant, and safety issues.

Permanent employees at Head Office regarded the well-being of their families as important; this included health. Permanent employees at the sites were also concerned with health and happiness of their families, but also regarded being employed as important. Work pressures in these groups were mainly around meeting deadlines.

Amongst **Limited Duration** staff, safety, health, and employment were priorities. Some members of one group expressed the desire to better themselves through education and being trained in areas such as nursing and Human Resource management, and saw their current employment at H&I as a source of finance for further education.

The **union's** aim was to improve the life of its members through negotiation of benefits and working conditions. A new aspect of the union's activities was to improve the life of its members outside the workplace, in areas such as providing bursaries for education of members' children.

In summary, the company has the following characteristics: It is a private company, active in the construction industry with an emphasis on road construction. The company is dominated by men. The age profile tends towards the younger end, contrary to the industry profile. Management is mainly white and male. There are two key employee groups, both in the Permanent Employee category: Operators and Foremen. Many of the Permanent Employees are nomadic for the duration of contracts. The company employs a large number of Limited Duration [temporary] employees. Permanent employees are, or soon will be, shareholders in the company, and are therefore directly affected by the profits made by H&I. There have been relatively few deaths in service, or medical boarding due to ill health, over the past four years. The more senior staff see their priorities as being work-related with the emphasis on profitability, while the lower level workers are more concerned with family, health and continued employment.

The age profile of the workforce, and the nomadic nature of many of the skilled workers, means that employees will be at risk from HIV infection as the epidemic spreads in the areas where the company is active. At present, the low levels of sick

leave taken and the relatively low death rate, particularly amongst the younger employees, indicates that the disease has yet to take hold within H&I. Additional costs associated with the disease should therefore be low at present, although there is a possibility that they will increase in the future should the HIV Prevalence Rate be high.

HIV/AIDS IN H&I

The Prevalence Rates in the two provinces where H&I is active sets the base for comparison with the Prevalence Rate within H&I, and any action by the company. While the breakdowns by province are derived from antenatal clinics and therefore relate to pregnant women, they are thought to be indicative of the prevalence rates in the general population and the way in which the disease has spread over the past three years. The 2002 – 2004 period has been selected as it covers the period when H&I became aware of the potential impact of the disease on the company.

Table 3.11:

SOUTH AFRICAN HIV PREVALENCE RATE BY PROVINCE IN ANTENATAL CLINICS: 2002 - 2005

PREVALENCE RATE	2002 [%]	2003 [%]	2004 [%]
Eastern Cape	21.7	23.6	28.0
Western Cape	12.4	13.1	15.4
South Africa	26.5	27.9	29.5

Source: Department of Health, 2004

While the Eastern Cape shows a Prevalence Rate slightly lower than that of South Africa overall, the Western Cape has a significantly lower infection rate. This is to be expected, as the geographic spread of the disease from the north to the south means that the disease has impacted on the Western Cape later than the other provinces. However, this also means that the epidemic is in an early stage in the province, and

that it should be expected that, if unchecked, the infection rate will continue growing until it reaches similar proportions to the rest of South Africa.

At the time that H&I became concerned about the possible impact of the disease, the Medical Research Council of South Africa [MRC] released the data below, illustrating the differences between the two provinces under review.

Table 3.12:

**SOUTH AFRICAN HIV PREVALENCE RATE BY SELECTED PROVINCE:
2002**

AGE	EASTERN CAPE [%]	WESTERN CAPE [%]	S AFRICA [%]
Adults [18 – 64]	20.5	6.7	23.4
Adult Men [18 – 64]	19.0	5.8	23.3
Adult Women [18 – 64]	21.9	7.6	23.5
Male Youth [15 – 24]	4.9	1.1	5.8
Female Youth [15 – 24]	20.1	5.5	21.6
Antenatal Clinics	26.5	11.4	29.0

Source: Medical Research Council, 2002

The MRC had calculated the impact on the general population by extrapolating figures obtained from the antenatal clinics. These figures are comparable with the 2002 figures released by the Department of Health.

H&I's decision to introduce an HIV/AIDS intervention was based on business criteria. The thinking at the time was that the epidemic would cause a deterioration in economic growth. Within the company, H&I perceived an increase in the death rate amongst employees in 2003. As a construction company, there was a likelihood that

the use of nomadic labour and casualisation would have led to high Prevalence Rates. The directors made a strategic decision that an HIV/AIDS programme was required. One manager provided a number of reasons for the intervention. As with any external threat to the company's viability, there was a need to understand how AIDS could threaten the business, and protection of the company's profits was essential. It would be an advantage to managers to know the prevalence rate within the company to counteract any potential damage to the operation. Each employee could ascertain their own status and obtain treatment as and when required, either through the company or through the public health system.

H&I decided to introduce a programme consisting primarily of education, counselling, testing, treatment and ongoing training. The aim was to get people to know their status, and then agree to treatment if necessary. However, there was also a secondary objective: to get all employees to change their behaviour through knowledge, leading to benefits at the individual level. Keeping HIV+ employees productive is congruent with the principle of treating infected employees to maintain productivity.

The intervention was therefore based on four objectives.

From a **prevention** perspective, the company wanted to keep employees who were HIV negative at the same status. This would be achieved through Education and Awareness. In addition, condoms would be distributed throughout the company's operations. H&I also wanted to enable employees to know their **status** through company-sponsored counselling and testing, and either come forward for treatment if HIV+, or use their knowledge to maintain their negative status. The company also decided to sponsor **treatment** for HIV+ employees. For Permanent Employees, this is through a confidential system set up by VAC. In the case of Limited Duration employees, VAC would assist them to enter the public health system for treatment. Finally, H&I would ensure that the company met all the **legal** requirements. These four elements of H&I's intervention are comparable to the Department of Health's four-point plan as outlined in its strategy. [Department of Health, 2000].

In 2003, after the Western Cape research in which H&I participated, the company contracted VAC to undertake an education and voluntary testing programme. H&I

provided VAC with the mandate to do the awareness and counselling road-shows, and to facilitate access to treatment programmes.

Benefits explained to employees by VAC for undergoing testing were based on getting employees to manage their own lives within the confines of the disease, including behaviour changes if necessary. A key decision was the early provision of treatment to manage the disease if the employee was positive, either through a treatment regime paid for by the company if the employee was on permanent staff, or by assisting Limited Duration employee to be treated at public health facilities.

VAC managed to obtain full turnouts by employees at awareness sessions by getting the company to make attendance at awareness training compulsory, making it a disciplinary offence to refuse to attend as the company would be paying. Employees could then decide for themselves whether or not to be tested on an anonymous basis, with the results for the individual available to them alone through VAC. In excess of 90% of employees were tested. All managers went through the testing process in a very visible manner; pictures of the Managing Director being tested were published in the company's in-house publication. It could not be established what the high testing rate amongst employees could be attributed to, whether the employees were convinced of the need for testing, peer pressure or fear of discrimination if they refused to be tested.

Given the high level of unemployment and poverty in South Africa, especially in the rural areas where H&I have a number of projects, it is likely that H&I will employ a number of workers who have already been exposed to infectious diseases of all kinds, including HIV/AIDS. This means that the company may be importing a high proportion of employees infected by the disease through the use of temporary workers, as well as compounding the problem of possible HIV infection amongst its permanent employees through the nomadic system. The employee infection rates for H&I would therefore have been expected to be above the Western Cape, but below the Eastern Cape, infection rates.

Of the 585 people employed by H&I and their joint venture partners at the time [2003], 550 were counselled, 527 tested and 519 obtained the results of their tests; 75 [14.2%] were HIV Positive. [Table 3.13].

Table 3.13: H&I: EMPLOYEE HIV TESTING: 2004

ACTION	NUMBER
Attended Training Sessions	585
HIV and Life-Skills Counselling	550
Tested for HIV	527
Obtained Results of Test	519 [98.5%]
HIV+	75 [14.2%]

Source: H & I

There are differences in infection rates between the various levels within the organisation. [Table 3.14]

Table 3.14: H&I: INFECTION RATES BY EMPLOYEE GRADE: 2004

EMPLOYEE GRADE	NUMBER	HIV+	% GRADE	% TOTAL
Head Office	25	0	0	0
Labour	171	26	15.8	4.9
Operatives	92	17	18.5	3.2
Foremen	35	5	14.3	0.9
Workshop	31	3	9.7	0.6
Other/Unknown	173	24	13.9	4.6
Total	527	75	14.2	14.2

Source: H & I

The company reflects, to a large degree, the underlying causes of infection as described by the Department of Health. [Department of Health, 2000]. The better educated and residentially stable Head Office employees have a zero infection rate,

while the infection rates amongst the nomadic employees and the unskilled labourers show significant prevalence rates.

Further, as the company provided testing for both permanent and non-permanent staff, differences between the permanent and other staff can be determined. [Table 3.15]. Joint venture partners at the various sites were included in the testing programme; government and sub-contractor employees were also able to have their status tested, although H&I did not include them in their treatment options.

Table 3.15: H&I: HIV INFECTION RATE BY EMPLOYEE TYPE: 2004

EMPLOYEE TYPE	TOTAL	HIV+	% OF TYPE	% OF TOTAL
Permanent	254	42	16.5	8.0
Limited Duration	133	19	14.3	3.6
Provincial Government	71	3	4.2	0.6
Sub-contractors ⁴	69	11	15.9	2.1

Source: H & I

The number of HIV+ employees is similar to the Western Cape regional prevalence rates. HIV+ incidence is higher in the lower job levels, with very little difference between permanent, casual and sub-contractor staff. HIV+ employees at all levels, apart from Head Office, are high enough to cause concern regarding the possible attrition rate due to AIDS and its effect on company operations, especially amongst key employees.

The 14.2% Prevalence Rate amongst all those tested should, however, be qualified. There were 387 H&I employees at the time of testing, of whom 61 [15.8%] were HIV+. The infection rates amongst the Provincial Government and Subcontractors will only be of concern to H&I if they affect the performance of their partners' workforce. The company's main concern will be for its own employees and the effect the disease may have on their performance. The high infection rates amongst the key,

⁴ Subcontractors provide specialist services to the company. They are therefore not employees of H&I, but are also subject to the same risks and, in some cases, are also nomadic.

nomadic employees should be a cause of concern for H&I, because they operate costly machinery, have a high Prevalence Rate and are eligible for treatment by the company, thereby increasing the company's costs.

H&I HIV/AIDS PROGRAMME

The high incidence of HIV infections amongst its employees, pointing to a need to protect the investment by protecting their workers and keeping them productive, coupled with a sense of social responsibility towards all employees, including Limited Duration, caused H&I to take action. With the assistance of VAC, H&I introduced a written HIV/AIDS Policy, which was made available to all employees [Appendix 3]. Within the policy, the company adhered closely to the best practices as outlined by the institutions mentioned in Chapter 1. As H&I is in the construction industry, the civil engineering association's guidelines for dealing with HIV/AIDS were also utilised. SAFCEC's guidelines follow standard procedures for dealing with the epidemic: prevention of new infections, care and support for those with the disease, and management of employees, both HIV+ and those not infected. [SAFCEC, undated]. However, H&I did not produce a written plan of action outlining the full programme.

H&I's policy document covered the main elements of testing, benefits, medical assistance, the company's responsibilities to employees, operational issues and awareness and education sessions. The policy also covered the sensitive areas of confidentiality and protection against discrimination, implementation and monitoring. As there is no written programme document, programme elements were derived from the interviews and other documents such as the leave policy.

H&I, with the assistance of VAC, set up a patient management programme for all HIV+ permanent staff, which includes counselling sessions, monitoring the disease [Viral Load and CD4 Count] and access to drugs; Limited Duration employees are assisted to register at identified local State clinics which provide ARVs. The company provides condoms on site. They are targeting communities through their awareness campaigns to get employees to spread the message and knowledge as far as possible. H&I claims that there is buy-in from all employees, including the board.

As part of the communications strategy, H&I started the programme with a series of employee meetings explaining the issue, providing the required awareness and education and acting as a stimulus to employees to be tested. Since the initial phase, the company has reinforced the messages by written communications in the form of newsletters and posters in English, Afrikaans and Xhosa. The issue has also been placed on the agendas for mass meetings, held every month on site.

H&I has reviewed leave benefits, and has made some attempt to cover those who are HIV+ and need special treatment, but has not committed itself in any way to guaranteeing unlimited leave for those who are ill. Other standard benefits have not been upgraded. The one new benefit which has been introduced is the treatment option for Permanent Employees who are HIV+, which is paid for by the company. Surveillance monitoring has not taken place since the first awareness and testing sessions.

Reports are made on the programme to the Board at H&I at every Board meeting, but this would appear to be information-giving only. H&I claims to have met all the legal requirements.

The company has identified the key and high-risk employees, but without introducing training for emergency replacements. Operators and Foremen, who have relatively high infection rates, are both key personnel and part of the nomadic group of employees and therefore high risk. Loss of significant numbers of these employees could seriously affect the operations and hence the profitability of the company.

The Board of Directors has defined the main criteria for success as the number of people who discover their status, and the number of HIV positive people who enrol on the VAC disease management programme; the objective is an 80% uptake of those who are HIV+ and have their CD4 count measured 6 monthly or annually. Although 89% of employees have discovered their status, numbers on the disease management programme are small, with around 10% of those identified as being HIV positive having come forward for treatment. This indicates that there is a problem with the most important part of the intervention, the treatment of employees to maintain their productivity.

A further testing initiative was planned for 2005, but this was not done despite the fact that there has been a growth in employee numbers to over 900. Other management issues appear to have taken precedence. Control of the programme is based within Human Resources rather than being a line responsibility, with the result that there is no line responsibility for the ongoing operations of the programme. The initial programme related to education, testing and treatment of employees only; there have been no initiatives regarding the families of employees or the community.

Financial results for the company were not available. It is therefore not possible to derive statistics such as the proportion of costs of the programme to the overall profitability of H&I.

The only costs available for the programme are those relating to the direct costs of the education, counselling and testing elements undertaken by VAC, and the costs of the treatment programme.

Table 3.16: H&I HIV/AIDS COSTS 2003 - 2004

2003	RANDS
Facilitator training	28500.00
Awareness training and testing - Facilitators	3853.20
Awareness training and testing – Head office	14227.20
Total	46580.40
2004	
Awareness training and testing: sites	142864.80
Expenses	17467.30
Awareness training and testing – sites	14706.00
Total	175038.10
Overall total	221618.50

Source: H&I

Because of an agreement with the Construction Education and Training Authority [CETA], H&I has been able to recoup the initial awareness and testing costs from the CETA. The treatment costs were set at a base minimum of R10, 000.00 per month: the minimum charge has never been exceeded because of the low number of HIV+ employees who have come forward for treatment, and has therefore been R120, 000.00 per annum.

VAC recommended a programme for the next five years. Regular report-back sessions to each site would form part of the communication process. Preventative measures, such as the introduction of condom dispensers and post-exposure prophylaxis kits at all sites, including Head Office, were to be introduced. Facilitators were to receive two-day refresher courses, while all employees were to be subject to a de-stigmatisation course. As part of the monitoring process, all employees would be put through Awareness, Counselling and Testing every two years. H&I have provided condoms at all sites, including Head Office. Managers reported good offtake of the supply, indicating that some employees may have started to use the knowledge they have been given. While the preventative measures were introduced, the balance of the programme was not put in place. Since the initial phase, the company has reinforced the messages by written communications in the form of newsletters and posters in English, Afrikaans and Xhosa. The issue has also been placed on the agendas for mass meetings, held every month on site under the direction of the Site Manager.

In the writer's experience, HIV/AIDS programmes have been characterised by policy statements and action plans at a high level within organisations, but have not been transformed into practical action to all levels of staff, nor have they been incorporated into daily operational activities. As a result, nobody has effective management of the implementation and review of these programmes.

It was therefore anticipated that H&I's management would believe that the company has a strong intervention, but that lower levels of employees would either be ignorant of the programme, or would believe that it did not meet their needs. Further, the action plans would not be implemented, as the initial enthusiasm for a programme would be overtaken by the need to meet daily business priorities. The programme,

instead of being a part of the organisation's routines, would become a short-term initiative. It was also anticipated that the responsibility for the programme would devolve upon the Human Resources department, in the belief that it is a personnel issue. Leadership of the programme would therefore become diluted.

EMPLOYEE PERCEPTIONS OF THE PROGRAMME

There were differences in the perceptions of the various employee levels regarding the impact of the disease on the company and the programme. **Senior managers** appreciated the business implications of the disease. They were in agreement that the decision to introduce the HIV/AIDS programme was driven by business requirements – potential loss of profits, reduced productivity, and increased costs. The loss of key staff was the base cause, although there was mention of the social responsibility of the company. All knew the objectives of keeping the HIV+ employees healthy and productive, and ensuring that those who tested negative maintain their status. All Senior Managers had been through the programme in a very public way to promote the testing initiative. They all stated that they would advise the company should they discover that they are HIV positive, and knew the process to obtain treatment. They felt that work methods in the industry dictated the need for the placement of senior staff at remote locations, even though it meant that a number of key personnel were at risk. The movement of lower level staff with their families was regarded as being too expensive and would make the company uncompetitive at tenders, as well as causing complications with domestic issues such as the schooling of children.

The main problem with the programme for senior managers was the lack of people acknowledging their positive status and coming forward for treatment. This was regarded as a problem of the employees, as H&I had put the necessary processes in place. One reason offered is that the company has yet to experience a significant number of deaths in service, and employees did not appreciate the seriousness of the problem. The lack of uptake was closely related to the stigma being attached to being HIV positive. According to senior managers, Site Agents and supervisors had not fully bought in to the programme, and a lack of role models was causing the programme to suffer. Peer facilitators were not getting sufficient support. This was

caused by the absence of performance objectives for managers and supervisors, reflecting the lack of real control, monitoring and drive relating to the programme.

However, they felt that there was a need to persevere with the programme. There were a number of suggestions for improving the programme: encouraging those who are HIV+ to present themselves for treatment, doing more for the Limited Duration employees, reducing stigma and discrimination, and including families in the education process. There was some difference of opinion between Senior Managers as to whether the programme is a success or not. While they regarded the programme as having some success in terms of the testing and the introduction of the treatment options, their main criteria for success was the number of people who discovered their status and who enrolled on the VAC disease management programme. A senior manager described the initiative as dying off, and needing reviving.

Site Agents believed that the main effect of the disease on the company was the impact on skills; the intervention was designed to ensure that the profitability of the firm was not compromised. They agreed that the disease could affect productivity and profitability in the longer term if the epidemic continued to grow, but this was not based on any specific analysis or cost impact assessment. They also agreed that behaviour change was not the main objective of the programme. They had all been through the programme and were aware of the testing and treatment procedures. There was no common response regarding the issue of disclosure of status. One agent would be very hesitant to disclose his status if he were HIV positive, one was a bit hesitant, while the third would disclose immediately. They felt that the nomadic labour system would remain part of the work process. Site Agents had a number of suggestions regarding the programme. They believed it was necessary to have one-on-one discussions with employees to remove peer pressures, a need to encourage people to report for treatment, a comprehensive and ongoing testing programme, constant communication with employees, and to involve employees' families. However, time spent on the disease at site level seemed minimal, restricted to mentions at mass meetings and at safety committee meetings. One agent estimated it to be around an hour every two months. This reflected the fact that dealing with the disease was not part of their annual performance objectives. Site Agents also had some doubts regarding the effectiveness of the programme. There was uncertainty whether there

had been changes in behaviour amongst the employees, and they had no suggestions on how to measure success.

Permanent employees below management level did not understand or appreciate the potential effect of the disease on the company, but rather viewed the disease in terms of personal issues. Some of the more senior staff at Head Office mentioned the possible impact of the loss of skills and the additional costs incurred by the company, but this was not a common view. Permanent employees at Head Office saw the intervention as having two aspects: a business aspect, where the company had introduced the programme to protect profits, and a corporate responsibility aspect, where the company was looking after its employees for altruistic reasons: 'It is the right thing to do'. Site staff were more vague about the reason for the programme. Some saw it as a business issue, to protect profits, while others saw it as protection for the workers. There was an element of uncertainty amongst this group regarding the physiology of infection, although most could quote the methods of infection, which had been mainly learned at the H&I seminars. Most members of this group were clearly uncomfortable talking about sex as a means of infection, and would rather talk about cross-infection arising from injuries. Most claimed not to know anybody within their immediate or extended families who were HIV+ or who had died of AIDS-related diseases.

The majority of Head Office permanent employees would advise the company if they are HIV positive. One, however, expressed a concern that they may be rejected by other employees and was also concerned about the possibility of losing his/her job. A similar position existed at the sites: some permanent employees said that they would tell the company, while others would not for fear of losing their jobs and being subject to discrimination.

Some Head Office permanent employees had been nomadic labourers in the past before being transferred to Head Office. There was mixed reaction in this group towards the problems associated with the nomadic lifestyle. Some employees liked it, while others admitted to missing their families and being subject to the boredom of compound living. Employees in this group, when asked about their leisure activities at remote sites, mentioned that they spent their weekends doing laundry, watching

television and going to church. Although the majority also mentioned visiting local bars and clubs as an option, very few admitted to taking part in that specific activity.

When asked what the programme consisted of, most permanent employees were able to identify the Awareness, Education, Prevention, Testing and Treatment elements, as they had been through the course. The general problem of employees not coming forward for treatment was mentioned in some instances; reasons given related to stigma and fear of discrimination. Head Office employees were generally more positive towards the programme than those on site, where the fear of stigma and discrimination was higher. Most permanent employees regarded the programme as being successful; the criteria for success appear to be based on the provision of knowledge, employees knowing their status, and the treatment opportunities.

The feeling amongst the lower level employees was that H&I is a 'caring company', and introduced the programme to assist employees, in addition to the business reasons. One site in a Joint Venture was concerned that the programme only covered H&I employees, and felt themselves at risk because the Joint Venture partners were not subject to the same education and awareness seminars. It was described as 'When you have a kraal full of sheep, you do not inject only some sheep against foot and mouth disease, you inject them all'.

Limited Duration employees claimed to have been treated differently regarding the awareness and education process. At one site, the group had attended the education seminar, had been tested, but had heard nothing since. This group knew to go to the local public health clinic if they suspected they were HIV positive. The group had also received reinforcement of the messages through mass meetings. At the other site, there had been no seminar, nor had there been testing. This group stated that nobody from H&I had been to talk to them. There was no discussion of the disease at mass meetings. This group regarded H&I as having an obligation to assist them. Groups at both sites had an awareness of the effect the epidemic has on people at work and in the community, rather than any business implications. Mention was made of deaths in the family and in the community. They had a basic knowledge of the causes and effects of HIV/AIDS, but showed a certain amount of confusion as to exactly how the

disease was transmitted. One group had received their knowledge at H&I, the other group had relied on the radio, television and church for their information.

The majority of Limited Duration employees at both sites would not advise the company if they were HIV positive. This is based on the fear of losing their job, loss of confidentiality, and fear of discrimination at the site. One site saw the programme as being introduced for the safety of the employees, while the other group had received the message that it was important to know their status so that they could obtain assistance such as counselling and treatment. At one site, the Limited Duration employees regarded the programme as a success, especially for the younger employees. Those who were suspected of being HIV positive were experiencing discrimination in the communities and this reinforced their fears of discrimination at the workplace. The other site claimed no knowledge of a programme, and could not therefore comment on its success. However, all members of both groups had cards with the VAC contact telephone number, indicating that they have been exposed to some aspect of the programme.

The **Shop Steward** had not personally been involved in the development of the programme, although he had negotiated with management about the introduction of such a programme after attending a union congress. The epidemic was important to the union because it was losing members. The union aimed to teach workers the seriousness of the disease and to encourage workers to look after themselves. The issue is on all union meeting agendas.

The Shop Steward would advise the company if he became infected, as it would be able to provide him with the necessary assistance. He felt that there was no solution to the nomadic labour issue. Previously, strict rules prevented visitors to the compounds; these rules had been relaxed and each worker is now required to look after himself. He regarded the programme at H&I as a success because it did not stop at testing, but also provided for treatment for those who tested positive. It also catered for the Limited Duration employees, by testing them and encouraging them to be treated at government clinics. The union regarded the H&I programme as good, with H&I the best in the construction industry.

The **Consultant** expressed concern that prevention of infection amongst the employees was not part of the performance contracts of the managers and supervisors. HIV/AIDS-related activities were not included in the performance objectives for any employee. He did not believe that the programme has been a success; while it achieved the early objectives of awareness, education and testing, it was regarded as a failure because of the low uptake of employees for treatment. The fact that employees in the field were carrying VAC cards with contact telephone numbers indicated that they have a good working knowledge of HIV/AIDS. He believed that a high-profile manager is required to take responsibility for the programme to ensure that it is treated with a degree of urgency.

There was confusion around who has the responsibility for driving the programme at site level. Answers ranged from the Site Agent, to Head Office, to the Site Facilitator under the direction of Human Resources. This again illustrates that the lack of specific HIV/AIDS objectives for employees can impact negatively on the success of the intervention. Human Resources personnel were responsible for the programme's introduction, but there is now an element of confusion as to who is responsible for ongoing activities in the HIV/AIDS plan.

THE PROGRAMME IN THE FUTURE

Management's realisation that the programme had failed in its major objective of enabling HIV+ employees to register for disease management has led to the establishment of a steering committee, consisting of the Personnel Director, Personnel Assistant, the Consultant and employee representatives. The group is to meet monthly and ensure that the programme receives the necessary attention. The intention is to demonstrate that being infected is not a death sentence, but that by going for treatment, those who are HIV+ can be assisted in living useful and productive lives. The company plans to use an HIV+ employee who has received treatment as an example of the effectiveness of the programme and the treatment. The message to be conveyed would be more direct than at present, along the lines of: 'You will die, and condemn others to die, unless you know your status and have treatment. The company will assist. It is not a crime to be HIV positive'. Management has also stated that it

would be 'far less sympathetic' to employees who tested positive after the awareness sessions. This is to place some onus on employees to remain uninfected by behaving responsibly. While this harder approach may be regarded as an attempt to influence the behaviour of employees, it may open up debates on the ethical and legal aspects of the changed attitude towards the disease.

The choice of facilitators will be reviewed, as there is some concern over the effectiveness of the current facilitators. More assertive employees will be trained as facilitators. External facilitators are not seen as a success, and Management believes it is preferable and more impactful to use those employees who have 'come back from the dead' i.e. those employees who have been for treatment and returned to work.

The next round of testing is needed, but, as H&I would be responsible for all costs for this testing initiative, there is a debate as to whether the company should concentrate on the Permanent Employees only, leaving the Limited Duration employees to their own devices. In the initial round of testing, the CETA paid. The company is lobbying to get the Government, via CETA, to pay for the testing of Limited Duration workers.

The aims of the plans for 2006 and beyond confirm that Management at H&I is concerned that the current low level of impact of HIV/AIDS on the company may change. The need therefore is to institute plans which limit the effect of the disease on profits as much as possible. This approach is consistent with the company's concern about the cost issue.

CONCLUSION

H&I should anticipate a high infection rate amongst its employees for a number of reasons. The nature of the work, with its nomadic lifestyle for a significant part of the permanent employee group, may well spread the disease. The company's workforce has a much younger age profile than the industry average, and infection rates are highest in the younger age groups. The company also employs labourers from the local community, who have a greater propensity for contracting infectious diseases than the more stable, permanent workers, as described in Chapter 1.

These factors are reflected in an HIV infection rate higher than the provincial rate. The low death rate in a company which has been in the road construction industry for many years can be interpreted as a reflection of the low rates in the Western Cape. It may also be that employees who are HIV+ are still at the early stages of infection, and the worst is yet to come. This is further supported by the low level of sick leave being taken on average, and the relatively few employees who are taking the major proportion of such leave.

The profit motive is very high and drives a number of HIV-related decisions made by managers. A prime example of this is the different treatment benefits offered to permanent and limited duration employees. The decision to lobby the CETA for funds for testing of the Limited Duration employees is a further indication of the cost curtailment strategy followed by H&I.

Protection of the workers can be equated with protection of the investment. Key workers therefore need protection and treatment when necessary, but they are also the ones most likely to be infected because of being part of the nomadic work group.

Given the low death rates, the pattern of sick leave, which has not yet reached critical levels, and the profit motive, there must be a question mark over the need to have an extensive programme as desired by the Government. Despite the company's statements that it has a social aspect to the introduction of the programme, managers and senior staff have been adamant in their view that the programme is a business decision rather than one based on altruism and a social conscience. The lack of response to the treatment option and the lack of a company ethos which promotes openness about employee status tends to confirm the conclusion that the profit motive is paramount. This stance is in line with the commercial needs of the company rather than the needs of the employees. Further support for this conclusion comes from the Site Managers' statements that HIV/AIDS is not discussed at any length during staff meetings. In addition, Human Resources rather than a senior manager is the custodian of the programme. This may be seen by employees as a downgrading of the importance of the programme.

In the writer's experience, HIV/AIDS programmes have been characterised by policy statements and action plans at a high level within organisations, but have not been transformed into practical action to all levels of staff, nor have they been incorporated into daily operational activities. As a result, nobody has effective management of the implementation and review of these programmes.

The examination of the H&I intervention continues in the next chapter, where the intervention is analysed, and detailed conclusions drawn.

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CHAPTER 4

ANALYSIS OF THE INTERVENTION

BENCHMARKING THE INTERVENTION

In analysing H&I's intervention, the starting point is an examination of the programme against the generic programmes developed by institutions and established companies. At the time of the intervention, there was agreement amongst H&I's managers on the basic objectives of the company's intervention: to enable employees to be tested and know and understand their status; to keep HIV positive employees happy, healthy and productive; and to keep HIV negative employees uninfected.

However, this was subservient to the profit objective.

As the SABCOHA programme has been established specifically for the private sector in South Africa, it can be used as a benchmark to analyse H&I's programme.

Table 4.1:**H&I HIV/AIDS PROGRAMME COMPARISON WITH THE SABCOHA RECOMMENDATIONS**

SABCOHA RECOMMENDATION	H&I ACTIVITY
Representative HIV/AIDS Committee	Not done. An informal group of 3 from Human Resources, including the HR Director, were charged with development of the programme.
Senior Staff member as Champion	Not done as an identified person.
Involve the Union at an early stage	According to the union representative, done.
Establish an HIV/AIDS budget	Not done.
Review employee benefits	Partially completed.
Establish surveillance and monitoring processes	Partially done via VAC – people presenting for treatment
Establish Prevalence Rates	Done once.
Measure the business impact	Partially done.
Establish the costs to the company	Not done.
Establish the impact on Markets and Customers	Not done.
Establish internal human resources risks	Done.
Undertake a Knowledge, Attitudes and Practices survey	Not done.
Determine Key Performance Indicators to measure success	Done. One indicator – the number of people presenting for treatment – used.
Monitor sick and compassionate leave trends	Not done.
Establish a communication strategy	Done.

Source: SABCOHA

The South African Civil Engineering and Contractors Association [SAFCEC] has also produced guidelines for its members regarding HIV/AIDS. In the guidelines, the dangers inherent in the nomadic nature of the industry are stressed, with particular emphasis on the arrival within rural communities of relatively wealthy people, and the injection of wealth into the local community through the employment of temporary labour. Along with this wealth goes the dangers of these employees being targets for local people who are able to offer sex in exchange for remuneration of some kind.

SAFCEC's main objectives are along standard processes for dealing with the epidemic: prevention of new infections, care and support for those with the disease, and management of employees with HIV/AIDS as well as those not infected. [SAFCEC, undated]. As the industry's association, its members regard it as the source of advice for industry-wide issues.

Table 4.2:

H&I HIV/AIDS PROGRAMME COMPARISON WITH SAFCEC PROGRAMME RECOMMENDATIONS

SAFCEC RECOMMENDATION	H&I ACTION
Elect an AIDS Committee	Not done.
Perform a needs analysis	Not done.
Draft a policy	Done.
Prevent new infections	Done via education and condom provision.
Care and support those already infected	Done.
Train managers and supervisors in performance assessment	Not done.
Assess internal and external impacts	Not done.
Assess impact on employee benefits	Partially completed.

Source: SAFCEC

Generic programme elements can be divided into three main areas.

The first area is the establishment of a **policy and programme**. This covers issues such as a written policy and programme, drawn up in consultation with staff; counselling and testing protocols; a review of all benefits; the responsibilities of both the organisation and employees; HIV/AIDS education processes; and a cost impact assessment.

The second area deals with the **operational processes** which may be affected by the disease. These are recruitment, training and development, promotion within the organisation, and adherence to local HIV/AIDS legislation for all policies and activities. The impact of the disease on client service processes, health and safety procedures, and financial and operational controls also fall in this section.

The third area deals with the issues surrounding the **implementation** of the programme. This area includes issues such as leadership, confidentiality, protection against discrimination, monitoring of the programme, and a budget.

Appendix 4 contains details of the generic programmes and measures H&I's programme against them.

REVIEW OF THE H&I PROGRAMME

There are a number of areas where the H&I programme is shown as deficient according to the SABCOHA and SAFCEC recommendations and the generic programmes. There is no HIV/AIDS Committee. This inhibits the monitoring and review process, which can result in the company either undertaking actions which are not relevant, or failing to provide activities where required.

Nearly all programmes stress the need for leadership to come from the top of the organisation when introducing programmes. This is to ensure that employees understand the intent of the company in introducing the intervention and that the activities are part of the way of doing business. H&I has no easily identifiable person who has been nominated as the Champion and the figurehead for the programme.

Without a senior manager as the Champion, employees may feel that the programme is not receiving the right amount of management attention. The omission of any mention of leadership can also result in the programme becoming the responsibility of employees who do not have the visible support of senior management, and it becomes an initiative rather than part of daily operations. In the case of H&I, the senior managers were prominent in attending the initial sessions and being tested. After that, however, the programme became the responsibility of Human Resources, and the drivers are now lower level staff. The perceived importance of the programme has been diluted and employees are probably under the impression that other priorities exist which supersede the HIV/AIDS initiative.

No budget has been established. The lack of an HIV/AIDS-specific budget means that the overall costs of the intervention, both direct and indirect, cannot be measured and its cost-effectiveness is unknown. A budget also assists in promoting action; what gets measured, gets done. While the costs of the awareness and testing by VAC are known, and the company has made money available for treatment, there are other costs which require budgeting, as illustrated in Chapter 2. A budget also acts as an indicator that the company is serious about the intervention.

From a business perspective, the prime motivator for an intervention must be the control of costs to reduce the impact on profits. Cost analyses are able to identify those areas where the organisation needs to concentrate its efforts, allows an organisation to establish benchmarks for the success of an intervention, and acts as a base for the measurement of any impact on profits. However, cost analyses, including 'hidden' costs such as loss of productivity, extra recruitment and training costs, and downtime for awareness and education purposes, are seldom attempted in the industry, especially as any programme will only be shown to be viable in seven to ten years time, when those who would have died are still working. [Lake, 2005]. The payback period for investment is thus very long, and has to be weighed up against current and short-term demands for capital. However, a broad calculation of the costs involved will assist in guiding a company when debating the nature and extent of an intervention.

H&I has not completed a full cost assessment for the impact of the disease, and therefore cannot determine with any accuracy where the cost-benefit is most marked. The only costs available for the programme are those relating to the direct costs of the education, counselling and testing elements undertaken by VAC, and the costs of the treatment programme set up. H&I's management have become aware of some of the potential costs with the plan to undertake another testing initiative, for which the company will have to bear the full costs. The company may, for cost reasons, have to limit the testing to permanent employees.

Without a cost impact assessment, the company is unable to determine the effectiveness of the programme against the main priority of the company, maximising profitability. Annual HIV/AIDS costs to the company are estimated at R250 000, which management regards as low, as an inefficient grader operator can cost the company a similar amount in a month.

The lack of a cost analysis is therefore a major omission. H&I do not know whether their programme is producing a cost benefit. In the light of their profit priority, this does not allow them to evaluate the effectiveness of the initiative. While the current programme does not appear to have severe direct cost implications for H&I, the high prevalence rate amongst its permanent employees could result in major expenditure in the future in areas such as recruitment, training, loss of productivity and treatment for the permanent employees, which is now an established benefit at the firm.

The lack of a cost analysis is compounded by the lack of a forecast of the future of the industry should the epidemic reduce the economic growth within South Africa. This could affect H&I's long term plans in areas such as the purchase of expensive heavy-duty machinery, which requires a large investment and which could, in an economic downturn, be a heavy debt burden for the company. The disease could create a shortage of labour, especially skilled labour in those key positions that H&I have identified, so the lack of a long-term plan is a serious oversight on the part of the company. The extra costs of either increased recruitment and training of new staff, or the costs of multi-skilling existing employees, will have a negative effect on profitability in the future.

None of the senior managers has access to statistics which can be helpful in measuring and monitoring the possible impact of the disease on operations, and hence profitability and productivity. Managing the programme requires data which measures trends and provides information on Key Performance Indicators.

There is no monitoring of leave trends, which can act as warning signals of the progress of the disease, especially amongst the skilled, key staff. Reasons for employees being absent are not captured; sick leave statistics which identify the specific illness causing absence are not available, nor are reasons for other absenteeism recorded. Both these sets of data can offer valuable information regarding trends and provide pointers to the impact of the disease on the workforce. Identification of specific illnesses is an important trend indicator; for example, where Tuberculosis is increasing, this can be used as an indicator that HIV infection rates are increasing. Time taken for funeral attendance would further assist in estimating the spread of the disease in the community, and hence the likelihood of temporary employees being infected.

VAC provided the initial Awareness and Education sessions for employees at H&I, but spouses, partners and children of employees were not included in these sessions. The generic programmes all advocate the involvement of families in the programme so that the messages the company wishes to send are received directly by them. As the infection is also located in the community and is not a specific work-related problem, exposing employees' families and, where possible, the community, to the programme will assist in preventing infection in the community at large. The lack of comprehension of the causes and effects of the disease amongst some employees interviewed indicates that any information being transferred to non-employees might be suspect. Without changing the environment within which the company operates, there is a constant danger of infection between the nomadic workers and the local community in both directions.

The benefits section of the policy is silent regarding the effect the disease may have on Life Insurance, Early Retirement and Redundancy. These areas are of concern to employees, who are anxious to protect their benefits.

In order for all employees to understand and, where necessary, implement the strategy and action plan for HIV/AIDS within a company, a comprehensive communication strategy is required. This strategy should take into account the subject matter content, the media to be used, the messages which need to be conveyed, and the language to be used. H&I started the programme with a series of employee meetings facilitated by VAC and using local languages where necessary, explaining the issue, providing the required awareness and education, and acting as a stimulus to employees to be tested. As no comprehension testing has been done, it is difficult to know whether employees have retained any information after the initial meetings. Communication post-testing is limited to posters, articles in the company newsletter, and discussions at monthly mass meetings. The reinforcement of the educational aspects of the programme therefore depends, to a large extent, on the literacy of employees. Site Agents confirmed that many of their workers are illiterate, thereby negating an important aspect of the communication process. In addition, there has been a significant increase in the number of employees since the original awareness and education sessions, and the new employees may not have had the benefit of face-to-face meetings on HIV/AIDS. This emphasises the need for an ongoing programme rather than a short-term initiative.

Counselling and testing are regarded as a critical component of any programme. Legally, testing must be voluntary and anonymous, with pre-and post-testing counselling available to employees; best practices also indicate that testing should be free. Faull identifies three possible reasons for a poor uptake of testing and treatment: employees may remain unconvinced of the need to undergo testing; they may be confused by the process; or they may be uncertain as to the ability of the company to maintain confidentiality. [Faull, 2005]. H&I used VAC to introduce employees to the concept of being tested at the education sessions, with a great deal of success; although attendance at the sessions was compulsory, being tested was voluntary. Peer pressure and expectations may have contributed to the number of employees undergoing testing, but the outcome was a success in that around 90% of employees were tested in 2003 and knew their status. However, there has been no follow-up since the initial testing. The number of employees has grown considerably, and there is a need to repeat the testing to see if there have been any changes over the past two years, especially amongst the key and Permanent Employees. H&I are planning the

next round of testing for 2006, as the initial plans for retesting in 2005 were not carried out. Senior Managers expressed doubts as to whether the company will test the Limited Duration employees because of the costs involved.

The cost-benefits of keeping employees productive points to some sort of treatment regime. Best practice is to make ARVs available to employees through the best route available to the company, either through the private sector in terms of medical aid-funded treatment, through the company paying directly for the drugs, or through the public health system. H&I made the decision to differentiate between the ways in which their employees are treated. Permanent Employees are able to obtain treatment through a third party during employment, ensuring confidentiality. The company provides the funds, and HIV+ employees can contact the service provider for disease management. The company has made a pragmatic decision in providing avenues for treatment of the Limited Duration employees without becoming directly responsible for their treatment. As it cannot provide treatment after termination of employees' contracts, the company assists Limited Duration employees in making contact with the closest public health clinic that provides treatment. The lack of clinics where the roll-out of ARVs has taken place is also an area of concern, especially in the Eastern Cape, where the availability of drugs is uncertain at present. Limited Duration employees who wish to be treated may not have the opportunity to obtain such treatment, as they are not catered for within the H&I policy. A particular problem with all treatment programmes is the need to track people and their treatment history over a long period. There are no such systems in place in South Africa, and the company will not be able to ensure that those requiring treatment will continue to receive it after termination of their contracts. [Lake, 2005].

Company ethos should encourage those who are HIV+ to feel comfortable in coming forward for treatment, including monitoring of CD4 counts to ensure comprehensive treatment at the appropriate time. The desired ethos has not been achieved at H&I. Only 10% of those who tested positive at the initial testing phase have agreed to disease management, despite the guarantee of anonymity. The stigma attached to being HIV+ has not been reduced within the company as far as the lower level

employees are concerned, nor has the fear of discrimination or the fear of losing their jobs.

A review of employee benefits is considered part of any programme. H&I has reviewed its leave policies, and made some attempt to cover those who are HIV+ and need some sort of special treatment, but has not committed itself in any way to guaranteeing leave outside of policy for those who are ill.

Other standard benefits have not been upgraded. The one benefit which has been introduced is the treatment option for HIV+ Permanent Employees, which is paid for by the company.

Once a programme has been introduced, there should be constant monitoring and reporting on the effectiveness of the action plan. The most important part is the repeat testing to ascertain whether the Prevalence Rate within the company is increasing, which employee groups are most affected, and the numbers of employees on managed treatment. While a service provider covers the latter activity and can advise on the treatment aspect for those who were HIV+ from the initial testing, retesting has not taken place and the company is not able to measure the effectiveness of containing or reducing the infection rate.

There is no clear solution to the problem of the nomadic nature of the work at present. The potential loss of Operators and Foremen, who have relatively high infection rates, to AIDS could seriously affect the operations and hence the profitability of the company. This has been recognised as a requirement and H&I will be creating a trained cadre of employees in these two groups as replacements.

There are three other major failings with the H&I programme.

Firstly, there is no written programme, although there is a written policy. This results in an uneven application of the programme elements, as employees are not aware of the specific requirements and activities required to meet the objectives of the plan.

Secondly, there are no Key Performance Indicators which would enable the company to measure the success or otherwise of elements of the programme, or the success of

the overall programme. The only indicator used measures the number of employees reporting for disease management. While this is an important indicator, there are other indicators which could be used, such as the number of employees tested, the number of mentions at mass meetings, the number of follow-up training sessions and the Prevalence Rate of employees measured over time.

Thirdly, there are no individual HIV/AIDS performance objectives for employees at any level. These objectives are important as they assist in measuring the implementation and ongoing activity of the programme, and force managers and supervisors to maintain the impetus of the intervention.

CONCLUSION

To all intents, H&I have introduced an initiative which conforms to the generally accepted requirements of interested parties' generic programmes. While there are gaps in the H&I programme, the existing programme and the proposed changes outlined for 2006 would give the company a programme which would score well on an audit.

Its policy on HIV/AIDS follows the parameters of the SABCOHA and SAFCEC outlines to a large extent. It feels a certain moral obligation to meeting the needs of its employees, but its main priority is to make a profit.

In particular, H&I made a major step forward by introducing a programme where testing and the opportunity for treatment have become an acceptable norm. The employees have been provided with the necessary knowledge of the disease, and the processes whereby they can safely and in confidence determine their own HIV status and obtain treatment should they be infected. The success of the initial testing programme has put the company in a position where they could build employee confidence in the process. H&I have also benefited by being able to identify the infection rates amongst broad bands of employees and can set up processes to cater for the impact on those key and at risk employees.

Importantly, the company does know the Prevalence Rate amongst its staff and the breakdown in fairly broad categories of workers. The company therefore knows the possible effects of the disease should all its HIV+ employees progress to AIDS. As it is not yet seeing any impact in terms of deaths and increased absenteeism, though, there is no pressing need for action.

H&I have also provided some resources to support their programme. Facilitators are available at each site to provide assistance to employees and preventative measures have been introduced in the awareness and education sessions, as well as making condoms available to those who want them. The provision of a financial reserve for treatment of the permanent employees indicates that the company is prepared to provide resources to keep those employees, especially the key employees, happy, healthy and productive. Their pragmatic approach to the treatment issue for Limited Duration employees, who are put in touch with the nearest public health system clinic that deals with HIV/AIDS, is a realistic attempt to cater for the different types of employee and establish a system for assisting temporary employees who are infected.

On the surface, H&I's programme would therefore satisfy the desires of a number of those stakeholders putting pressure on the company to act.

However, there are also a number of negative conclusions to be drawn which indicate that the programme has failed in some critical areas.

The lack of a cost-benefit analysis is a major weakness in the programme. Without it, there can be no measure of the commercial effectiveness of the programme, which should underpin any intervention.

Against the company's stated objectives at the implementation of the programme, there has been limited success. The first objective of the plan was met, with around 90% of employees knowing their status. The company does not know if it has succeeded in the second objective, which was to keep those who tested negative in 2004 uninfected because there has been no follow-up testing process.

The third objective was to have those who tested positive come forward for disease management. This objective has not been met, as only seven out of 61 HIV+ H&I

employees had registered. Of these, 42 were Permanent Employees; it is not known if the 19 HIV+ Limited Duration employees have reported to their local clinic.

The issue of most concern is the lack of action post-testing on the part of HIV+ employees. The Board's objective is to have 80% of those who are HIV positive to have their CD4 count measured either 6 monthly or annually, leading to ARV treatment for those who need it. This removes the main rationale for introducing the programme, namely the desire to keep HIV+ employees productive for as long as possible. There was a suggestion that those who have come forward for treatment are those who go home every night i.e. not those who are part of the nomadic labour system. The main reason for the lack of employees revealing their HIV status would appear to be the fear of losing one's job, especially amongst the Limited Duration employees. This fear was not restricted to the Limited Duration employees, though; there were a number of Permanent Employees who expressed fear for their jobs should they become infected. There was also an expressed fear of discrimination against those who were HIV+, the inference being that the company lacks credibility in this area. Management has to adopt a higher profile in supporting the programme, with the Site Agent acting as an important link-man for the programme. While there may be some Limited Duration employees who have contacted their nearest clinic directly without informing the company, the lack of Permanent Employees presenting for disease management is well below the company's objectives. There may be a requirement for incentivisation, or perhaps a specific objective as part of the performance contract for each manager and supervisor. . Ideally, there should be monthly reporting of testing and treatment to ensure the control and monitoring necessary for the success of the programme.

H&I has not tackled the issue of costs with any vigour. There are some direct costs which it knows, but there have been no attempts to examine the effects of the disease on the economic sector to which it belongs, nor the overall costs to the company of the disease. The basic Prevalence Rate is known, and indicative costs could be calculated if the company considered it important to the success of the business. Costs are therefore not considered to be a driver of a programme for H&I, apart from management's belief that some costs are involved. This is at odds with Management statements that the intervention is a business issue.

The lack of an ongoing programme, with constant follow-up sessions to engage those employees who may have missed the original awareness and testing sessions, or have recently become employed, means that the programme appears to have declined in importance. In addition, there could be new employees who have not received the basic awareness and education sessions. Uncertainty over the company's position regarding the disease could increase the fear of discrimination and job loss amongst this group.

A major problem with the current programme is that it seems to have become an initiative rather than being integrated into the normal operating procedures of the company. After a high-profile start to the programme, with the awareness and education sessions, the public testing of all the senior managers and the availability of treatment, the programme has become the property of Human Resources, and has not been driven by the senior executives. This has seriously detracted from the initial impact that the programme had on employees, and may now be seen as 'yet another initiative'.

The Limited Duration employees, who make up the majority of the work-force at present, were included in the initial testing process. However, they are likely to be excluded in the future as their numbers increase and the costs of dealing with these workers will probably not be borne by the Government through CETA, creating the impression that they carry a lower priority in terms of the programme.

The company can enhance its programme in several ways, but at a cost penalty. The Awareness, Education, Testing and Treatment aspects should always remain a part of any intervention, but with added activities.

The company could consider subsidised travel home at more frequent intervals for employees who operate at remote sites. This will reduce the risk of these employees being subject to the problems, associated with migrant labour, especially sexual interaction with the local population, which promotes the spread of the disease in both directions between the workers and the community. The company could also arrange for frequent family visits to the remote sites. This would create an environment where

the employee can maintain contact with the family without the temptation of becoming involved with local people for recreation.

H&I could also provide all nomadic employees with family accommodation at remote sites to maintain the family unit. This would require a major change to the current operational structure. Many of those interviewed at remote sites were not in favour of this suggestion, as they claim to prefer the nomadic lifestyle afforded to them by the system.

H&I could extend the awareness and education aspects of their programme to the community at large, to provide the local population with the knowledge required to prevent the spread of the disease.

These suggestions are probably more expensive than the existing programme. Any increases in costs, as seen previously, are a drain on the profits and Management's aim is to contain costs as much as possible. If the alternatives are more expensive than the current option, there is no incentive for H&I to adopt them.

The plan to restrict the testing and treatment to Permanent Employees only, indicates that H&I intend protecting their investment as the overwhelming priority, relegating the HIV/AIDS programme to an initiative which is aimed at reducing costs rather than providing social benefits for their employees.

Management's intentions for 2006 are to set up a Committee which will be responsible for review and ongoing management of the programme. However, this committee will not be successful if it does not learn from the omissions of the existing programme. The failure of the programme to fully meet company objectives so far indicates that there has to be a written action plan, with roles defined for those employees directly involved in promoting the intervention, specific objectives for each employee involved in the activities, and meaningful Key Performance Indicators to measure the effectiveness of the programme. The company should also investigate the development of an industry-wide, enforceable programme within the construction industry through SAFCEC. However, without the critical cost-benefit review, H&I have no commercial basis for the programme.

CHAPTER 5

CONCLUSION

This case study has examined the pressures on managers in a company, both internal and external. It has also looked at whether a company has commercial incentives for introducing an HIV/AIDS intervention, and how the various stakeholders are catered for in a programme. While the conclusions reached are specific to the company and the its economic sector, there are general conclusions which could assist other companies considering an HIV/AIDS intervention in developing their programme. Large public national and international companies have sufficient resources to implement a far-reaching programme without major concerns about the costs, although it would be in their interests to go through the processes as outlined in the generic programmes. It is the smaller companies in highly competitive sectors of the economy that would probably have difficulty in justifying an intervention. Smaller companies do not have pressures put upon them by public shareholders, nor are there any requirements for them to conform to any code formulated by any organisation or NGO.

The use of a medium-sized company such as Haw and Inglis as a case study illustrates the problems associated with the practicalities of an HIV/AIDS intervention. The main objective for a commercial enterprise is maintaining profits. Any intervention has to be subject to the profit imperative. Where the objectives and priorities of the organisation are in conflict with desired activities, the major objectives will dominate. Commercial entities are not extensions of the State, and are not required to be involved in solving the social problems of the State, unless the company is able and willing to adopt a social responsibility stance towards the epidemic.

There are few commercial incentives for a company to introduce an HIV/AIDS programme. From an internal perspective, there is a need to keep employees productive. This can be achieved with prevention and treatment activities, but there have to be clear indications that these actions are justifiable from a financial perspective. Where there is no discernible impact of the disease on operations or profits, management has no incentive to introduce an intervention. This requires a cost

impact analysis, using HIV prevalence rates found within the organisation. If there has been very little impact, there is no incentive to take action no matter what the infection rate is.

External influences on a company to have a programme come from the Government and NGOs. The State has not provided any financial incentive; although the CETA did provide funds for the initial testing at H&I, there are indications that further funding is not going to materialise. Once a company has met the legal requirements, it has no further obligations as far as the Government is concerned. NGOs can provide moral pressure, but this is not a major persuasive argument in a commercial environment.

The Government nevertheless does expect the private sector to be part of the processes counteracting the effects of the epidemic. Government's emphasis is on the human rights aspects of the disease, which clashes in part with its free market economic policies. This conflict in policies provides the private sector with a dichotomy; whether to be part of an HIV/AIDS process which directly affects their profitability, or to ignore the requests and allow the epidemic to run its course, dealing with any problems on an *ad hoc* basis. The commercial imperatives will take precedence in a highly competitive environment. By bringing a social problem into the business environment, the Government has highlighted its need for private sector assistance in dealing with the problem. At the same time, the Government has not indicated its intentions of providing support to those companies which may fail or incur costs which render them uncompetitive if they follow Government requests and introduce plans which have no cost benefits. The reliance of the Government on the good will of companies places those companies willing to act in a difficult position. While they may wish to take action, they are handicapped by the possibility of placing themselves at a competitive disadvantage.

Without the Government introducing regulations forcing organisations to have a programme, there is no incentive for organisations to become involved in a programme which has social implications, such as education of families and the community. A rebate allowing companies to claim the full costs of an HIV/AIDS programme would encourage more companies to become involved in such

programmes, as they would not lose any cost competitive advantage they may have. Government should therefore consider introducing regulations requiring organisations over a certain size to have interventions, but with incentives for those organisations with an agreed HIV/AIDS programme. These Public-Private sector partnerships would be beneficial to both sides, as the epidemic could be fought on a more united front than at present. In particular, organisations opting to stay out of initiatives would not gain a competitive advantage if all organisations in an economic sector are required to become involved, or if there are no cost penalties for those investing in a programme.

Generic programmes proposed by the Government and institutions such as SABCOHA and SAFCEC mirror Government's human rights approach to the epidemic. These programmes are complex and may not fit with a company's commercial requirements; they are not specifically business-friendly. The objectives of these programmes seem to be aimed at ensuring that HIV+ employees enjoy special treatment. They are only effective if they lead to action on the part of the organisation. Where they clash with commercial requirements, they are ineffective. Where there is an uneven approach to the problem amongst companies in the same industry, with only a few organisations becoming involved, there are issues of competitiveness and company survival to consider when making decisions, as the organisation has stakeholders other than Government to consider.

The case study illustrates that, from a business perspective, the cost impact analysis is critical to decision-making. For businesses, the crucial question is whether the cost of doing nothing is less than the cost of an intervention. If the cost of an intervention programme is higher than the costs of additional recruitment and training of replacements, there is no incentive to have a programme. It is therefore imperative that companies base their commercial decisions regarding the possible intervention on cost benefit data. Even if the decision to introduce a programme is based on altruistic reasons, enterprises should have a grasp on the financial obligations that a programme will entail.

In an environment where there are no sanctions for not providing a programme, where there is a surplus of labour and a reservoir of unskilled labour for employment, a low

death rate and therefore no major reduction in productivity, and ARVs are being provided by the State, there is a strong argument for not implementing an HIV/AIDS action plan. Other commercial pressures require HIV/AIDS to have a low priority if it is not affecting the company at present. A company therefore needs to have knowledge about the effects of the disease rather than merely following the generic programmes without an appreciation of how it is going to affect the viability of the organisation. If a company does have a plan, it has to be congruent with the company's objectives and operations, and at a level where the cost-benefit achieved does not affect profitability.

Companies also have a number of options from a business perspective when considering a programme. However, each of these options requires a company to understand what is meant by the intervention, including management and cost implications, what the various objectives are, and how they fit with the organisation's objectives.

They can opt at the start not to introduce a programme. If they elect to pursue this option, it does not necessarily place the organisation in a more disadvantageous position compared to those companies who do implement a programme. Management time saved and the lack of expenditure on the programme allows managers and employees at all levels to concentrate on the main priority of profit-making. The absence of Government incentives to take action against the disease promotes such a stance

A company can introduce those elements which it believes are necessary for its particular circumstances. This partial intervention will include only those elements which provide the best cost benefits.

A company can also introduce an intervention based on all the elements as proposed by the institutions, with the attendant costs.

Once a company decides to introduce an intervention, there are management and employee expectations which have to be met if the programme is to be successful. Commentators such as Versteeg, Dickinson and others point out that there are several

problems with an intervention, as shown in Chapter 2. However, the real business implications are those closely related to profits and costs, and relate to the commercial benefits a company obtains from an intervention. As an example, the H&I intervention scores well on a scorecard of best practices and is regarded as a success by employees and the union, but it has not achieved its main objective of getting HIV+ employees on an AIDS management programme.

This would indicate that the mechanics of an intervention are relatively easy to introduce. The key is to have a company ethos which allows those who are infected and who wish to be treated to come forward without fear. Without this ethos, the initiative will fail to meet its objectives. A company can have a good pragmatic intervention according to its own criteria which satisfies stakeholders, but if employees are not capable of using the system for their own benefit, the programme cannot be regarded as a success.

The study also illustrates how programme activities require support at all levels within an organisation. In the writer's experience, HIV/AIDS programmes are characterised by policy statements and action plans at a high level within organisations, but are not transformed into practical action for all levels of staff, nor are they incorporated into daily operational activities. As a result, nobody has effective management of the implementation and review of these programmes. The H&I programme started in a very public way, with managers undergoing public testing and report-backs to all sites. The responsibility for the programme was placed in a staff function, and Site Managers, who were supposed to maintain the momentum of the programme, appear to have neglected their role. As the responsibility was not made clear through performance objectives, the programme has become a remote initiative and managers are concentrating on business issues to the exclusion of the programme. The lack of any action on the 2005 plan confirms that the programme has been allowed to become a lower priority than other issues. Long-term plans have a tendency to become short-term initiatives unless they are integrated into the operational processes of a company.

The position of temporary employees with respect to HIV/AIDS before, during and after employment requires a more in-depth study. The study has highlighted the problem with the way in which temporary employees are catered for in any

programme. Temporary workers, who are drawn mainly from the unemployed in the rural areas, may be more prone to infectious disease. They are employed for limited periods, and enjoy relief from the daily struggle to survive, after which they are again thrown back on their own devices. During their employment, they are subject to pressures to retain their jobs, especially if they are the breadwinners for an extended family. They are therefore unlikely to do anything which could jeopardise their employment, including admitting that they are HIV+, and are therefore reluctant to report for treatment in case they are dismissed. Interviews with the Limited Duration employees of H&I revealed that there is a widely held belief that there is no possibility of the status of HIV+ employees remaining confidential. This mistrust of the system, despite their legal rights, is indicative of a climate in the company and the country where those who are infected perceive that they will be discriminated against.

The study also illustrates the difficulties faced by managers in trying to reconcile business and social issues in the daily operations of the company. Managers have to decide how far their company will go in dealing with a problem which is caused by factors outside their sphere of activity and influence. Managers and staff may perceive their organisation to be a caring company with a social conscience, but the realities of meeting the prime objective of profits means that the social aspects of the HIV/AIDS programme must be regarded as subservient to the profitability requirements. While there are businesses such as mining, transport and construction which, because of their use of the nomadic labour system, can be said to have contributed to the spread of the disease, the causes of the epidemic relate to social problems which the State should be addressing. Where the introduction of a programme will not make a significant difference to the profitability of an organisation and there are pressures from shareholder groups to provide a programme as part of the social responsibility of the organisation, management can afford to implement a programme.

There is also a need to review whether the company is wasting its time with an extensive programme. In H&I, the current low death rates, the low uptake of disease management activities and the lack of any noticeable impact on the business indicate that there may well be an argument for the company to allow the disease to run its course, and only re-introduce the intervention should there be a noticeable impact on daily operations and profits. From a moral and social responsibility perspective, the

company needs to decide whether they want to have a role to play, but from a commercial aspect there appears to be no need to have an intervention. The company may wish to monitor the Prevalence Rates amongst its employees and indicators such as sick leave statistics, and only introduce an enhanced intervention when there are indications that the epidemic is starting to impact on profits.

In the final analysis, the study of H&I suggests that there are three major inhibitors of a successful implementation of an HIV/AIDS programme for a commercial organisation.

Firstly, a programme which follows the generic programmes suggested by those organisations which have established criteria and parameters for HIV/AIDS programmes is not necessarily the best commercial option for a company if it fails to include an examination of costs. The business imperative requires a cost-benefit analysis to be the basis of any intervention to establish the impact on profitability before any decision is made on the nature of an intervention. Any intervention must, of necessity, be subservient to the practical needs and priorities of an organisation, which should dictate the specific elements of an intervention.

Secondly, the reduction of the impact of absenteeism caused by the disease is a fundamental part of any programme and must be a major objective in order to reduce the effect on productivity. Elements of the programme should be geared towards this objective.

Thirdly, no matter what the nature and extent of a company's programme, the overwhelming need is to create an ethos within the company which allows for employees to feel comfortable with disclosing their status. The company can then take the appropriate steps to both counter the effects of the epidemic and monitor progress of the intervention; this will only come about through good leadership from the most senior parts of the organisation. Any programme which fails to meet this requirement will be wasting time and money.

Without any legal requirement or incentives from the State, businesses are unlikely to gain any commercial benefit from implementing an intervention based solely on

generic programmes; there are doubts as to whether such interventions are justified. What businesses need is a more business-friendly, joint approach to the epidemic which allows them to co-operate with other interested parties without affecting their profit imperative.

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REFERENCES

- ANC. 1997. African National Congress. *ANC Strategy and Tactics*. As amended at the 50th National Conference 1997. [Online]. Available: <http://www.anc.org.za/ancdocs/history/conf/conference50/strategyamend.html> [2005 May 5]
- ANC. 2005. African National Congress. ANC National General Council 2005. Discussion Document: *Development and Underdevelopment. Learning from Experience to overcome the Two-Economy Divide*. [Online]. Available: <http://www.anc.org.za/ancdocs/ngcouncil/2005/2economydivide.html> [2005 May 5]
- Baum, F and Sanders, D. 1995. Can Health Promotion and Primary Health Care achieve Health for All without a return to this more radical agenda? *Health Promotion International* Volume 10 No 2, pp 149 – 160. Oxford University Press.
- Blaauw, D et al. 2004. Governmental Relations and HIV/AIDS Service Delivery. In *South African Health Review 2004*, published by Health Systems Trust, Durban. Chapter 9.
- Bradshaw, D. et al. 2003. *Unabated Rise in number of Adult Deaths in South Africa*. [Online]. Available: <http://www.mrc.ac.za/bod/AIDSdeathsSAMJ.pdf> [2005, September 12]
- Brookings. 2001. *The Economic Impact of HIV/AIDS in Southern Africa*. Brookings Institute. [Online]. Available: <http://www.kitera.org/atf/cf}{Brookings%20Institute%20Economic%20Impact%20in%20SA.pdf> [2005, July 11]
- Business Report. 2003. *The More You Treat, the More You Save*. [Online]. Available: <http://www.busrep.co.za/index.php?fArticleID=158079> [2005, July 25]
- Butler, A. 2004a. *Contemporary South Africa*. Basingstoke: Palgrave Macmillan. Pp 65 – 85.
- Butler, A. 2004b. *Contemporary South Africa*. Basingstoke: Palgrave Macmillan. Pp 51 - 53.
- Butler, A. 2005. Lecture: *Interest and Pressure Groups in South Africa*. Department of Political Studies, University of Cape Town. POL406X: Public Policy. April 22, 2005.
- Cape Times. 2005. *Construction Sector in Buoyant Mood*. Cape Times Business Report, 19 October, 2005.
- COSATU. 2000a. Congress of the South African Trade Unions. *Submission on HIV/AIDS Treatment and Support*. Memorandum to Health Portfolio Committee of the South African Government. [Online]. Available: <http://www.cosatu.org.za/docs/2000/hiv-aids.htm> [2005, July 1]
- COSATU. 2000b. Congress of the South African Trade Unions. *Submission to NEDLAC on Code of Good Practice: June 2000*. [Online]. Available: <http://www.cosatu.org.za/docs/2000/hiv-ned.htm> [2005, July 1]
- COSATU. 2001. Congress of the South African Trade Unions. *COSATU: The Peoples' Budget 2001*. 21 February, 2001. [Online]. Available: <http://www.cosatu.org.za/docs/2001/peob2001.htm> [2005, May 12]
- COSATU. 2004. Congress of the South African Trade Unions. *Constitution of the Congress of South African Trade Unions, as amended at the 8th National Congress in 2003*. [Online]. Available: <http://www.cosatu.org.za/docs/2004/03-2006constitution1.pdf> [2005, May 12]
- Department of Health. 2000. South African Government Department of Health. *HIV/AIDS/STD Strategic plan for South Africa 2000 – 2005*. [Online]. Available: <http://www.doh.gov.za/2000/index.html> [2005, July 1]

- Department of Health. 2004. South African Government Department of Health. *National HIV and Syphilis Ante Natal Sero-Prevalence Survey 2004*. [Online]. Available: <http://www.doh.gov.za/aids/index.html> [2005, September 12]
- Dickinson, D. and Stevens, M. 2004. Understanding the response of large South African companies to HIV/AIDS. *HIV/AIDS in the Workplace Research Symposium, University of the Witwatersrand*. June 2004. [Online]. Available: http://www.redribbon.co.za/documents_vz/business/00_Complete_symposium_Proceedings1.pdf [2005, June 30]
- Dorrington, R. et al 2004. *The Demographic Impact of HIV/AIDS in South Africa. National Indicators for 2004*. Centre for Actuarial Research, University of Cape Town and South African Medical Research Council. [Online]. Available: http://www.redribbon.co.za/home/default.adsp?access_page=5825 [2005, October 10]
- Dorrington, R. 2004. Round Table Discussion: Corporate Response (II). *HIV/AIDS in the Workplace Research Symposium, University of the Witwatersrand*. June 2004. [Online]. Available: http://www.redribbon.co.za/documents_vz/business/00_Complete_symposium_Proceedings1.pdf [2005, June 30]
- Fafo. 2003. *Crossing Borders to Fight HIV/AIDS*. Fafo Institute for Applied Social Science. Cape Town.
- Faull, N. 2005. *HIV/AIDS Employer programmes: A Study in Risk Management*. Graduate School of Business, University of Cape Town. Unpublished.
- Global Reporting Initiative. 2002. *Guidelines*. [Online]. Available: <http://www.globalreporting.org/guidelines/2002/gri-companionlite.pdf> [2005, July 14]
- Griffiths, R. Undated. HIV/AIDS cost impact model developed for own use in consultancy. Unpublished.
- H&I. Undated. *The Road Makers*. Business brochure of Haw and Inglis. Designed and Produced by Peter Bacon Photography cc, Cape Town.
- H&I. 2003. Haw and Inglis. Annual and Occasional Leave Policy. 12 August, 2003.
- Haralambos, M. and Holborn, M. 1995. *Sociology: Themes and Perspectives*. 4th edition. London: Collins Educational.
- Head, J. 1980. State, Capital and Migrant Labour in Zambezia, Mozambique: A Study of the Labour Force of Sena Sugar Estates Limited. Doctoral Thesis, University of Durham.
- Head, J. 1996. Health and Development: Some Concerns about South Africa's Health Policy. *Urbanisation and Health Newsletter*. No. 30. September 1996. Pp 33 – 48.
- Head, J. 2000. Health and Development in Southern Africa: What Role Does Unemployment Play? *Medical Research Council: Urban Health and Development Bulletin*. Vol 3, No 1. March, 2000.
- Head, J. 2003. Reconceptualising Migration in Southern Africa: Some Aspects of the Health Impact. *Migration and Health in Southern Africa*. Conference, Graduate School of Business, University of Cape Town, 26 – 29 January, 2003.
- HEARD. Undated. Health Economics and Research Division, University of KwaZulu Natal. *AIDS Brief Construction Sector*. [Online]. Available: <http://www.ukzn.ac.za/heard/publications/AIDSBrief/sec/Construction.pdf> [2005, July 18]
- HST. 2004. Health Systems Trust. *SA Health Review Annual Report 2004*. Published by Health Systems Trust, Durban. [Online]. Available: <http://www.hst.org.za/generic/29> [2005, April 7]

- HST. 2005. Health Systems Trust. *Difficulty in Getting ARVs*. Report dated 17 June, 2005. [Online]. Available: <http://www.hst.org.za/news/20040851> [2005, July 14]
- Inglis. 2005. Interview with Mr P Inglis, Chairman Haw and Inglis. Cape Town, 5 September, 2005.
- JCSM. 2005. Joint Civil Society Monitoring Forum. *Report on ARV Roll-out*. [Online]. Available: http://dedi20a.your_server.co.za/alp/images/upload/JCSMF%204th%20meeting%20resolutions%20FINAL%20AS%20IS.doc [2005, August 22]
- Kahn, T. 2005. *SA falling behind in AIDS treatment*. Report in Business Day, 30 June 2005. [Online]. Available: <http://www.businessday.co.za/articles/article.aspx?ID=BD4A62571> [2005, July 14]
- King. 2002. King Report on Corporate Governance for South Africa (2002). Institute of Directors of South Africa.
- Lake, H. 2005. Interview with Mr H Lake, Consultant, Viral Assistance Centre. Consultant to Haw and Inglis. 29 November, 2005.
- Lewis, D. 2004. Assessing the demographic and economic impact of HIV/AIDS. In *AIDS and South Africa: the social expression of a Pandemic*. Kauffman, K.D. and Lindauer, D.L. [eds]. Palgrave MacMillan Ltd. Pp 97 – 119.
- Lundin, J. 2002. *Companies need dedicated approach to AIDS issues*. Financial Mail Special Report: Corporate AIDS Awareness. [Online]. Available: <http://free.financialmail.co.za/report/aids2002/aidssb.htm> [2005, July 25]
- Medical Research Council. 2002. Dorrington, R., Bradshaw, D., Budlender, D. *HIV/AIDS Profile in the Provinces of South Africa*. [Online]. Available: <http://www.mrc.ac.za/bod/AIDSindicators2002.pdf> [2005, July 14]
- Metlife. Undated. *What is the State's duty to fulfil Socio-Economic Rights?* [Online]. Available: <http://www.redribbon.co.za/legal/default> [2005, July 5]
- Natrass, N. et al. 2004. *Opportunities for Business in the fight against HIV/AIDS*. Global Business Coalition on HIV/AIDS. [Online]. Available: <http://www.businessfightsaids.org/site/apps/nl/content.asp.c=nmKOLaP6E&6=238517&ct=BOCDD2195872}Executive%20Summary.pdf> [2005, July 11]
- Porter, M. 1980. *Competitive Strategy*. New York: The Free Press. Chapters 1 and 2.
- Rosen, S. et al. 2003. AIDS is your Business. *Harvard Business Review*, February 2003. Pp 80 – 87.
- SABCOHA. 2004. South African Business Coalition on HIV and AIDS. *SABCOHA/BER Survey 2004: The Impact of HIV/AIDS on Selected Business sectors in South Africa, 2004*. [Online]. Available: http://www.ber.sun.ac.za/downloads/2004/aids/HIVAIDS_Report2004.pdf [2005, June 30]
- SACOB. Undated. South African Chamber of Business. *Labour Market Flexibility – What does it mean?* [Online]. Available: http://www.sacob.co.za/Labour/Labour_Market_Flexibility.doc [2005, May 14]
- SACP. 2003. South African Communist Party. *SACP Statement for Human Rights Day – Capitalism violates Human Rights*. [Online]. Available: <http://www.sacp.org.za/pr/2003/pr03196.html> [2005, May 12]
- SAFCEC. Undated. South African Federation of Civil Engineering Contractors. *Civil Engineering and Contracting Industry HIV/AIDS Programme Objectives*. [Online]. Available: http://www.safcec.org.za/CIVIL_ENG_CONTRACTING_INDUS.PDF [2005, July 14]

- SA Government. 2004. Government's Programme of Action – 2004. Economic Cluster. [Online]. Available: <http://www.info.gov.za/aboutgov/poa/report/economic.htm> [2005, May 10]
- SA Government. 2005. South African Government. *South Africa: An Assessment of the Investment Climate*. [Online]. Available: http://www.info.gov.za/otherdocs/2005/dti_ica.pdf [2006, January 28]
- SAICA. 2004. South African Institute of Chartered Accountants. *Corporate Governance and AIDS*. [Online]. Available: http://www.saica.co.za/documents/Corporate_Governance_HIV_AIDS.pdf [2005, July 25]
- Sanders, D. and Carver, D 1985. *The Struggle for Health*. London: Macmillan. Chapters 1 and 2.
- SA Reserve Bank. 2005. South African Reserve Bank Quarterly Bulletin March 2005. [Online]. Available: <http://www.thedti.gov.za/econdb/sddsdata.html> [2006, January 28]
- Stevens, M., et al. 2004. Comparisons over time: managing HIV/AIDS in the Workplace. *HIV/AIDS in the Workplace Research Symposium, University of the Witwatersrand*. June 2004. [Online]. Available: http://www.redribbon.co.za/documents_vz/business/00_Complete_symposium_Proceedings1.pdf [2005, June 30]
- TAC. 2005. Treatment Action Campaign. *Annual Report 1 March 2004 to 28 February 2005*. [Online]. Available: <http://www.tac.org.za> [2006, January 8]
- UNAIDS. 2004. *Country HIV/AIDS Estimates, 2005*. [Online]. Available: <http://www.unaids.org/en/geographical+area/by+country/south+afrika.asp> [2005, June 30]
- VAC. 2004. Viral Assistance Centre. *Achieving a successful HIV/AIDS workplace programme. An ongoing case study of the Viral Assistance Centre HIV/AIDS Intervention programme: as implemented at Haw and Inglis (Pty) Ltd during 2003/2004*. Document made available by H&I.
- Vass, M. 2004. Policy versus reality: a preliminary assessment of the South African Code of Good Practice on HIV/AIDS and Key Aspects of Employment. *HIV/AIDS in the Workplace Research Symposium, University of the Witwatersrand*. June 2004. [Online]. Available: http://www.redribbon.co.za/documents_vz/business/00_Complete_symposium_Proceedings1.pdf [2005, June 30]
- Versteeg, M. 2004. A Licence to Choose? HIV/AIDS workplace responses from South African profit-making companies in context. *HIV/AIDS in the Workplace Research Symposium, University of the Witwatersrand*. June 2004. [Online]. Available: http://www.redribbon.co.za/documents_vz/business/00_Complete_symposium_Proceedings1.pdf [2005, June 30]
- Von Holdt, K. and Webster, E. 2005. *Work Restructuring and the Crisis of Social Reproduction: A Southern Perspective*. [Online]. Available: <http://www.cosatu.org.za/docs/2005/workpla.pdf> [2005, August 8]
- Walt, G. and Vaughan, P. 1981. An Introduction to the Primary Health Care Approach in Developing Countries. *London School of Hygiene and Tropical Medicine. Ross Institute of Tropical Hygiene*. No. 13.
- Watson, A.J. 2003. *Sociology, Work and Industry*. 4th edition. London: Routledge.
- Webster, E. 1994. New Winners, New Losers. In *Work and Industrialisation in South Africa*. Webster, E., Alfred, L., Bethlehem, L., Joffe, A., Selikov, T.[Eds]. Randburg: Raven Press. Pp 316 – 328.
- Whiteside, A. and Sunter, C. 2000. *AIDS: The Challenge for South Africa*. Cape Town: Human and Rousseau (Pty) Ltd. Chapter 8.
- Wright, E.O. 1995. The Class Analysis of Poverty. *International Journal of Health Services*, Vol 25 No. 1. Pp 85 – 100.

APPENDIX 1

COST MODEL

The author has been a consultant on HIV/AIDS to a number of companies. As part of his consultancy practice, he has developed a cost impact model.

Recently, he completed cost impact assessments for four different companies as part of the consultancy.

The four companies are all South African and are:

Company A: A major distributor and retailer

Company B: A major manufacturer

Company C: A major manufacturer

Company D: A Department within a large Parastatal organisation

Data for the models was obtained from each of the companies and reflect the base cost. Various scenarios were run to develop a range of results.

COST AREAS AS A PERCENTAGE OF TOTAL HIV/AIDS COSTS

COST AREA	W & S	Co A	Co B	Co C	Co D
Training	7	6	8	4	2
Recruitment	6	13	10	2	6
Labour Turnover	5	9	5		
Funeral Attendance	6	7	9		
HIV/AIDS Absenteeism	52	65	67	60	29
Burial Costs	16				6
Health Care	5				30
Ex Gratia				5	21
Work Cover				20	7

**Sources: Whiteside and Sunter [W & S]
Griffiths [Companies A through D]**

The table shows the degree to which various cost areas will be affected by the disease in the four companies, and also uses the results of the Whiteside and Sunter model from their book 'AIDS: The Challenge For South Africa' [Whiteside, 2000].

The Griffiths model uses data obtained from a company to calculate a range of additional costs associated with the disease. Several categories of staff can be modelled to examine the impact on various levels of employee.

INPUT DATA REQUIREMENTS

For each Category of staff [up to 10 categories]:

1. Number of staff
2. Average monthly remuneration
3. Number of weeks to acquire a new employee
4. Number of weeks that a new employee requires a dedicated trainer

5. Fees paid to trainer per week
6. Average number of new employees being trained simultaneously
7. Number of weeks for new employees to be fully trained
8. Monthly salaries paid to new employees while undergoing training
9. Amount of money spent on recruiting a new employee
10. Number of weeks after training it takes a new employee to become fully effective
11. Average number of days an employee who suffers from symptoms of AIDS is absent from work per year [it is assumed that other employees are absent for an average of 5 - 10 days per year for other reasons. This also excludes annual leave]
12. Average number of days an employee who is HIV + [but does not yet have AIDS] is absent from work per year.
13. Average number of days leave taken for funerals by an employee.
14. Number of employees who attend any particular funeral
15. Cost of a coffin and other direct funeral benefits
16. Other burial costs not paid to family [excluding lost labour]
17. Average number of medical benefits claims made per employee per year
18. Average cost to company per claim
19. Average number of medical benefit claims per employee per annum suffering from AIDS
20. Average number of medical claims per employee per annum suffering from HIV infection
21. Prevalence of AIDS as a percentage of the total employees in the category
22. Prevalence of HIV infection as a percentage of the total employees in the category

Companies offer different additional benefits, which are not common to all. These benefits also form part of the cost impact and are calculated outside of the direct modelling process.

Also required for Cost Impact:

1. Housing loans and repayment criteria.
2. Other staff loans
3. Ex gratia payments [eg. Relocation expenses]
4. Life insurance premiums
5. Medical Aid subscriptions
6. Education loans
7. Any other benefits or costs peculiar to the company which may require calculation

To enable the model to reflect reality as closely as possible, it is desirable to have some indicators of current absenteeism etc. These will be used to interpret the data.

1. Absenteeism data over the past few years [with reasons if possible].
2. Sick leave trends over the past few years [with reasons]
3. Deaths in service over the past few years [with reasons]
4. Age and sex profile of current staff

Detailed results by employee group are produced by the model. The printout below illustrates the Summary for all employees. Managers can determine where the costs are greatest, and introduce specific action plans for those areas.

Company: COMPANY X

RESULTS

YEAR: 2004

SUMMARY

ALL EMPLOYEES

	<u>(R000s)</u>	<u>TOTAL</u>	<u>%</u>
Staff HIV+		161.3	16.0
Staff with AIDS		25.2	2.5
Recruitment		81,355	2.2
Training		133,685	3.6
Productivity		352,173	9.5
Funeral Attendance		0	0.0
Compassionate Leave		0	0.0
Absenteeism		2,212,747	59.8
Work Cover		730,206	19.7
Medical Costs: HIV		0	0.0
Medical Costs: AIDS		0	0.0
Group Life		0	0.0
Education		0	0.0
Loans		0	0.0
Ex Gratia		189,000	5.1
Total		3,699,166	100.0

APPENDIX 2

LIST OF INTERVIEWEES

INDIVIDUAL INTERVIEWS

HAW AND INGLIS EMPLOYEES: HEAD OFFICE

Mr P Inglis. Chairman [18 November, 2005]
Mr L Menegaldo. Managing Director [30 November, 2005]
Mr A Armstrong. Human Resources Director [14 December, 2005]
Mrs R Messenger. Finance Director [8 November, 2005]
Mrs C Poole. Human Resources Assistant [27 October, 2005]
Mrs M Coetzee. Wages Clerk [16 November, 2005]
Mr Y Benjamin. Accounts Clerk [11 November, 2005]
Mr M Nyumbeka. Accounts Clerk [8 November, 2005]
Mr I Human. Assistant Accountant [11 November, 2005]
Mr I Roxiso. Human Resources Assistant [8 November, 2005]
Mr A Majoli. Union Shop Steward [1 December, 2005]

HAW AND INGLIS EMPLOYEES: SITE AGENTS

Mr S Tanner. Site Agent, Paarl. [15 November, 2005]
Mr E Fourie. Site Agent, Kei River Mouth [22 November, 2005]
Mr K Myburg. Site Agent, Adelaide [23 November, 2005]

CONSULTANT

Mr H Lake. Viral Assistance Centre [29 November, 2005]

GROUP INTERVIEWS

HAW AND INGLIS SITE EMPLOYEES: PERMANENT STAFF

Paarl: 4 employees [15 November, 2005]
Kei River Mouth: 5 employees [22 November, 2005]
Adelaide: 5 employees [23 November, 2005]

HAW AND INGLIS SITE EMPLOYEES: LIMITED DURATION STAFF

Paarl: 5 employees [15 November, 2005]
Adelaide: 5 employees [23 November, 2005]

HAW AND INGLIS

QUESTIONNAIRE: MANAGEMENT

Theme 1: Business Priorities

What are the company's business priorities and why?
What are the strategic goals and criteria for success for each goal?
What pressures are you getting from stakeholders regarding priorities?
What are these pressures?

Prompt: Shareholders

Employees

Suppliers

Competitors

Community

General interested parties [SAFCEC, ILO, Union, SABCOHA etc] Government

Theme 2: HIV/AIDS in the company

Have you examined the effect of HIV/AIDS on the firm's overall goals
[lack of staff, economic development etc]

Where does HIV/AIDS fit as a priority within the other priorities?

What are the likely effects of the disease on your department

What do you think will happen as the epidemic increases in the areas where you are active

How has the disease impacted on your department [14% within firm]

What do you know about the legal requirements for HIV/AIDS

How has AIDS impacted on policies, especially leave [sick, compassionate]

What is the effect of the epidemic on availability of staff

Do you have statistics such as sick leave, deaths in service etc which will allow you to monitor the possible impact of the disease

What are the costs to the company of the epidemic

What are the key [positions within the firm? Your department?

What are the high risk positions within the firm? Your department?

Are replacements readily available?

How much time is spent on HIV/AIDS at Board, Departmental level

Theme 3: Intervention

What was the rationale for introduction of the intervention

What is to be achieved by an intervention [what are the objectives]

[Give information? Change behaviours? Protect Productivity?]

Is the current intervention successful? How do you measure success?

What do you think the employees want from an intervention

Who is responsible for implementation and monitoring of the intervention

Is there a budget for the disease

Is the firm doing enough for those who are HIV+

Is the firm doing enough for the Community

If you discovered that you were HIV+, do you know where to go for assistance?

Would you tell the firm? Who?

Migrant labour

The firm's working patterns require an element of migrant labour. With respect to AIDS, this is seen as helping to spread the disease. Comments? Is there a better way of working? How does your programme cater for this?

For Finance:

What has been the effect of HIV/AIDS on the profitability of the firm?

Rate of Return? How much is saved/costs to firm

What are the shareholding benefits [who owns the firm]
What do they get from the profit-sharing

For P Inglis:

Shareholding? Profit-sharing policies

For HR:

Is the AIDS programme part of the performance appraisal/objectives of managers?

How are pay scales determined for a] permanent employees

b] non-unionised wage scales

c] Limited Duration employees

Is literacy a problem with the programme? How is this overcome?

University of Cape Town

HAW AND INGLIS

PERMANENT AND LIMITED DURATION WORKERS QUESTIONNAIRE

Theme 1: Basic priorities

What are the most important things in your life
Tell me about yourself, what your family life etc is like
What are the most important things regarding your job
How long have you been working
What do you do
What training have you had

Theme 2: HIV/AIDS

How much do you know about HIV/AIDS
How important is HIV/AIDS in your life
How has AIDS affected you and your family
What do you think is the effect on the company
What do you know about what the firm is doing about HIV/AIDS
Where did you learn this
Why do you think that H&I introduced this programme
Has it changed the way that you act
Is the programme sufficient for you
Is it good
If you were HIV+, do you know where to go for assistance
Would you tell the company if you were HIV+
Who – Boss/Personnel/someone else
Are you part of the migrant labour system used here
How often do you go home
What do you do in your spare time

FOR UNION REPRESENTATIVE

Who do you represent
What are the most important issues between the union and the firm
Where does HIV/AIDS fit in
Were you involved in the development of the intervention
What does the union want employers to do regarding the disease
Does the H&I intervention meet your union's criteria
What more can be done by the firm regarding HIV/AIDS
Migrant labour is part of the firm's work patterns. What is your opinion on this
What could be done better by the company

HAW AND INGLIS

SITE MANAGERS QUESTIONNAIRE

Theme 1: General Priorities

How long have you been with the firm
What about your personal life? Married? Children?
What are your priorities at this site in general
What is most important to you as a manager
What pressures are you under and from whom
Where does HIV/AIDS fit within these priorities
Is it part of your performance objectives

Theme 2: AIDS and the workplace

What do you know about HIV/AIDS and its effects on business
What are your key positions here
What are your high-risk positions
Do you know the prevalence rate of HIV at this site? Can you estimate it
Does HIV/AIDS affect the operations of the site
How do you think the disease will affect the operations in future
What has been the trend in Absenteeism and sick leave at this site
How much time is spent on HIV/AIDS at the site
How does this affect productivity
Is replacement of staff easy here

Theme 3: Intervention issues

Why do you think the intervention was introduced
[Behaviour change/Education/PR]
Has it changed you and the way you act
Has it changed the way your staff act
Who is responsible for the intervention at this site
Is the intervention a success
What criteria do you use for success
What more could be done
How have employees accepted the intervention
Is the firm doing enough about HIV/AIDS
Is it good
What more can be done

HAW AND INGLIS

CONSULTANT QUESTIONNAIRE

Theme 1: General Background

What do you do regarding an HIV/AIDS intervention
Can you describe your role in the treatment process for a firm

Theme 2: Intervention

How did you get involved with Haw and Inglis
What was the brief from H&I regarding the intervention
What was the objective of the intervention as you understood it
[PROMPT: Behaviour change/knowledge/PR]
Is the intervention successful
What criteria are you using for this monitoring
What is the rate of take-up of treatment [how many do you know are in the programme]
What did you advise re the literacy problem regarding their intervention
Are H&I doing enough
What more could the firm do
Do you have an ongoing relationship with the firm
What will you be doing this year/2006

Migrant Labour

The firm's work methods demand an element of migrant labour, with its attendant problems relating to the spread of the disease. What did you recommend re that?

APPENDIX 3

HAW AND INGLIS

HIV/AIDS POLICY

DEFINITIONS

"HIV" Human Immune deficiency Virus

"AIDS" Acquired Immune Deficiency Syndrome

INTRODUCTION

HIV and AIDS are serious public health problems which have socio economic, employment and human rights implications which will affect the workplace, with prolonged staff illness, absenteeism and death, impacting on productivity, employee benefits, occupational health and safety, production costs and workplace morale and pension portfolio.

HIV/AIDS is a disease surrounded by ignorance, prejudice, discrimination and stigma.

POLICY

The policy of this Company shall be to create an informed non-discriminatory work environment for those employees suffering from HIV/AIDS disease such that confidentiality and equality shall be maintained at all times during the employment cycle within a safe, healthy and motivated work environment.

Further, no applicant for employment shall be unfairly discriminated against based on their HIV status.

The Company shall also subscribe to the principles of the provisions of the Code of Good Practice on HIV/AIDS and Employment, issued under terms of Section 54(1)(a) of the Employment Equity Act with reference made to the Technical Assistance Guidelines on managing HIV/AIDS in the workplace.

The Company shall ensure that every workplace works towards developing and implementing a workplace HIV/AIDS programme aimed at preventing new infections, providing care and support for employees who are infected or affected, and managing the impact of the epidemic on the organisation.

1 PROMOTING A NON-DISCRIMINATORY WORK ENVIRONMENT

- 1.1 No person may unfairly discriminate against an employee, or an applicant for employment, on the basis of their HIV status. This means that no person with HIV or AIDS shall be treated unfairly within the employment relationship or within any employment policies or practices, including with regard to:
 - 1.1.1 recruitment procedures, advertising and selection criteria;
 - 1.1.2 appointments and the appointment process;
 - 1.1.3 job classification or grading;
 - 1.1.4 remuneration, employment benefits (medical aid and pension) and terms and conditions of employment;
 - 1.1.5 job assignments;
 - 1.1.6 the working environment and facilities;
 - 1.1.7 training and development;
 - 1.1.8 performance evaluation systems;

- 1.1.9 promotion, transfer and demotion;
 - 1.1.10 disciplinary measures short of dismissal; and
 - 1.1.11 termination of services.
- 1.2 The Company and employees shall adopt appropriate measures to ensure that employees with HIV and AIDS are not unfairly discriminated against and are protected from victimisation through positive measures such as:
- 1.2.1 the communication of the HIV/AIDS policies and programmes for the workplace;
 - 1.2.2 conducting awareness, education and training on the rights of all persons with regard to HIV and AIDS; and
 - 1.2.3 informing employees of the grievance procedures and disciplinary measures that will be implemented to deal with HIV related complaints in the workplace

2 HIV TESTING, CONFIDENTIALITY AND DISCLOSURE

2.1 HIV Testing

- 2.1.1 An employee, or an applicant for employment, shall not be required to undertake an HIV test in order to ascertain that employee's HIV status, unless authorisation has been obtained from the Labour Court.
- 2.1.2 Where HIV testing has been authorised by the Labour Court it should be carried out in terms of the conditions prescribed by the Court with regard to:
 - 2.1.2.1 the provision of counselling;
 - 2.1.2.2 the maintenance of confidentiality;
 - 2.1.2.3 the period during which the authorisation for HIV testing applies;
 - 2.1.2.4 the category or categories of jobs or employees in respect of which the authorisation for HIV testing applies.
- 2.1.3 HIV testing, where permissible and where a court order has not specifically prescribed the conditions under which such testing may take place, should be carried out after obtaining voluntary, informed consent. It should further be accompanied by pre- and post-test counselling.

2.2 Confidentiality and Disclosure

- 2.2.1 All persons with HIV or AIDS have the legal right to privacy. An employee is therefore not legally required to disclose their HIV status to the Company or other employees.
- 2.2.2 Where an employee chooses to voluntarily disclose their HIV status to the company, this information may not be disclosed to others without that employee's express consent.
Any breach hereof will result in disciplinary action.

3 EDUCATION AND TRAINING

- 3.1 Workshops shall be conducted throughout the Company to inform all employees about HIV/AIDS and shall include:-
 - 3.1.1 Education on HIV/AIDS, including how it can and cannot be transmitted;

- 3.1.2 Company and employee rights;
- 3.1.3 Encouragement for openness, acceptance and support for those who voluntarily disclose their HIV status within the workplace
- 3.1.4 Every workplace should ensure that its management and first aiders are educated, trained and aware to deal with:
 - 3.1.4.1 the risk, if any, of the occupational transmission of HIV within that particular workplace;
 - 3.1.4.2 appropriate training, awareness, education and on the use of universal infection control procedures so as to identify, deal with and reduce the risk of HIV transmission at work;
 - 3.1.4.3 providing appropriate equipment and materials to protect employees from the risk of exposure to HIV;
 - 3.1.4.4 the steps that must be taken following an occupational accident including the appropriate management of occupational exposure to HIV and other blood, pathogens, including access to post exposure prophylaxis;
 - 3.1.4.5 the procedures to be followed in applying for compensation for occupational infection;
 - 3.1.4.6 the reporting of all occupational accidents; and
 - 3.1.4.7 adequate monitoring of occupational exposure to HIV to ensure that the requirements of possible compensation claims are being met.
- 3.1.5 Where possible:-
 - 3.1.5.1 use of persons openly living with HIV or AIDS in education, prevention and awareness programmes;
 - 3.1.5.2 encourage the use of support groups for employees living with HIV or AIDS;
 - 3.1.5.3 the promotion of the use of condoms; and
 - 3.1.5.4 ensure that persons who are open about their HIV or AIDS status are not unfairly discriminated against or stigmatised.

4 PROMOTING A SAFE WORKING ENVIRONMENT

- 4.1 The Company shall provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of its employees.
- 4.2 The risk of HIV transmission within most workplaces is minimal. However occupational accidents involving bodily fluids may occur, particularly within first aid.
- 4.3 Every workplace should ensure that its management and first aiders are educated, trained and aware of how to deal with accidents involving bodily fluids (refer clause 3.1.4).

5 COMPENSATION FOR OCCUPATIONALLY ACQUIRED HIV

- 5.1 An employee may be compensated if he or she becomes infected with HIV as a result of an occupational accident. For example if an employee became infected with HIV through a needle stick injury.
- 5.2 The Company shall take reasonable steps to assist employees with the application for benefits including
 - 5.2.1 providing information to affected employees on the procedures that will need to be followed in order to qualify for a compensation claim;
 - 5.2.2 assisting with the collection of information which will assist with proving that the employees were occupationally exposed to HIV infected blood; and
 - 5.2.3 ensuring that all compensation testing is carried out in accordance with Section 7(2) of the Employment Equity Act.

6 EMPLOYEE BENEFITS

- 6.1 Employees with HIV or AIDS may not be unfairly discriminated against in the allocation of employee benefits.
- 6.2 Employees who become ill with AIDS should be treated like any other employee with a comparable life threatening illness with regard to access to employee benefits.
- 6.3 Information from benefit schemes on the medical status of an employee should be kept confidential and should not be used by the company or any other party.
- 6.4 The Company shall ensure, that as far as reasonably practicable, where an employee is a member of the Company's medical scheme as part of the employee benefit package that this scheme does not unfairly discriminate, directly or indirectly, against any person on the basis of his or her HIV status.

7 DISMISSAL

- 7.1 Being HIV positive or having AIDS is not a sufficient reason to dismiss a person. Employees with HIV/AIDS may not be dismissed solely on the basis of their HIV status.
- 7.2 Where an employee has become too ill to work, the Company is obliged to follow accepted guidelines regarding dismissals for incapacity before terminating an employee's services. These include attempts to adapt the employee's duties, to accommodate the employee's disability and to find alternative employment for the employee
- 7.3 The Company shall ensure that as far as possible, the employee's right to confidentiality regarding his or her HIV status is maintained during any incapacity proceedings. An employee cannot be compelled to undergo an HIV test or to disclose his or her HIV status as part of such proceedings unless the Labour Court authorised such a test.

8 GRIEVANCE PROCEDURES

- 8.1 The Company shall ensure that the rights of employees with HIV/AIDS, and the remedies available to them in the event of a breach of such rights, become integrated into existing grievance procedures.
- 8.2 The Company shall create an awareness and understanding of the grievance procedures and how employees can utilise them.

- 8.3 The Company shall develop special measures to ensure the confidentiality of the complainant during such proceedings, including ensuring that such proceedings are held in private.

9 MANAGING HIV/AIDS EMPLOYEE

- 9.1 HIV infected employees should continue to work under normal conditions in their current employment for as long as they are medically fit to do so.
- 9.2 The Company shall maximise the performance of all employees. This includes reasonable accommodation for employees who develop conditions associated with HIV/AIDS to help ensure that they maintain their employment for as long as possible.
- 9.3 Employees with HIV/AIDS have the same rights to sick leave as other employees, and a joint investigation by the company and the employee should be undertaken to consider alternative sick leave allocations, in accordance with the Basic Conditions of Employment Act, No 75 of 1997
- 9.4 The Company shall take all reasonable steps to assist employees with referrals to appropriate health, welfare and psycho-social facilities within the community, if such services are not provided at the workplace.

10 WORKPLACE HIV/AIDS PROGRAMME

- 10.1 The nature and extent of a workplace programme shall be guided by the needs and capacity of each individual workplace. However, it is recommended that every workplace programme shall attempt to address the following:
- 10.1.1 Include in the Company's induction programme, education, training and awareness of HIV/AIDS
 - 10.1.2 conduct education and training on HIV/AIDS for existing employees;
 - 10.1.3 hold regular HIV/AIDS awareness programmes;
 - 10.1.4 promote condom distribution and use;
 - 10.1.5 encourage health seeking behaviour for sexually transmitted diseases;
 - 10.1.6 establish a wellness programme for employees affected by HIV/AIDS;
 - 10.1.7 enforce the use of universal infection control measures;
 - 10.1.8 create an environment that is conducive to openness, disclosure and acceptance amongst all staff;
 - 10.1.9 provide access to counselling and other forms of social support for people affected by HIV/AIDS; and
 - 10.1.10 regularly monitor, evaluate and review the programme.
- 10.2 Regular programme evaluation and reviews should be carried out and, where necessary, changes to the workplace programme should be agreed upon and implemented by all parties.

APPENDIX 4

HAW & INGLIS HIV/AIDS PROGRAMME: COMPARISON WITH GENERIC AND PUBLIC COMPANIES' PROGRAMMES

A number of organisations have produced generic programmes for HIV/AIDS, including generic policies. These programmes have been designed to reflect 'best practices', and have been developed mainly to protect those who are HIV+.

A number of major South African companies have introduced HIV/AIDS programmes, and made them public.

This table lists the elements of the 'best practices' programmes, examines the programmes of the major companies, and indicates where H&I's programme is congruent with the best practices and other companies' elements.

HAW & INGLIS HIV/AIDS PROGRAMME: COMPARISON WITH GENERIC AND PUBLIC COMPANIES' PROGRAMMES

	INSTITS n = 7	CO'S n = 17	H&I
Policy:			
Does it exist		17	YES
Is it in writing		17	YES
Available to all?			YES
Communicated to all?	4		YES
Consulted with staff?	5	7	YES
Consulted with Union?	5	7	YES
Testing of Staff:	7	17	YES
Voluntary	5	16	YES
Paid by Company	1		YES
Counselling	2	16	YES
Benefits:	6	12	YES
Medical Aid	4	15	YES
Retirement Funding	2	6	YES
Life Insurance	1	5	
Early Retirement	1	10	
Redundancy	2	3	
Funeral Assistance			YES
Job Accommodation	2	9	YES
Extra Leave	1		
Medical assistance:	6		YES
Same as any other illness	5	12	YES

Responsibilities of Company:	4	5	YES
Work Environment	4	16	YES
Committee		9	YES
Responsibilities of Staff:	2	9	YES
Take reasonable steps re their health		4	
Honesty re ability to perform job		3	
Recruitment:	4	14	YES
Training and Development:	3	8	YES
Continued employment		15	YES
Promotion:	4	12	YES
Based on merit and ability	1	10	YES
Counselling:			YES
Available to all	1	13	YES
Education:	6	15	YES
Staff	3	15	YES
Families	2	4	
Local Legislation:	2	5	YES
Community Support:		5	YES
HIV/AIDS Programme:	2		YES
Does it exist		1	YES
Does it have a champion			YES
Was it developed in consultation with staff			YES
Developed in consultation with Union?			YES
Partnerships		10	YES
Is there specific mention of:			
Leadership		1	
Confidentiality	6	16	YES
Protection against Discrimination	6	17	YES
Communication Programme	2	6	YES
Implementation and Co-Ordination	3	5	YES
Monitoring	5	10	YES
Budget	1	1	