

# Managing HIV in the workplace

## Learning from SMEs

Jocelyn Vass and Sizwe Phakathi

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# ACRONYMS

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AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
AIDC	Automotive Industrial Development Corporation
Cosatu	Congress of South African Trade Unions
DMP	Disease management programme
ECI	Ebony Consulting International
GDP	Gross domestic product
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
HR	Human resources
IR	Industrial relations
IT	Information technology
MDWT	Mission directed work teams
Merseta	Manufacturing, Engineering and Related Services Sector Education and Training Authority
NUMSA	National Union of Metalworkers of South Africa
OH	Occupational health
PLWHA	Persons living with HIV and AIDS
RDP	Reconstruction and Development Programme
SME	Small and medium-sized enterprise
VCT	Voluntary counselling and testing
UAWSA	United and Allied Workers of South Africa
SACWU	South African Chemical Workers' Union



## Background to the study

Jocelyn Vass

### Introduction

The effective management of HIV/AIDS in the workplace is critical in reducing the negative consequences of the epidemic to the economy. The Employment and Economic Policy Research unit at the Human Sciences Research Council has been conducting a research programme on the impact of HIV/AIDS on the labour market and critical economic sectors. Part of this programme involves case studies on the impact and management of HIV/AIDS in the workplace of six small and medium-sized enterprises (SMEs). The study explores the extent to which HIV-risk factors related to social capital and restructuring play a role in the HIV/AIDS burden of each SME. This provides useful baseline information for developing sero-prevalence survey indicators for future survey studies. Further, the study sought to document the experiences of SMEs in managing the HIV/AIDS burden and to draw out possible lessons and best practices from within the SME sector. This, we hope, will complement and add to the current set of best practices that have been based mainly on the experiences of larger companies with more extensive resources to manage the risk of HIV/AIDS.

To gain an understanding of possible HIV/AIDS risk factors for SMEs, the case studies provided a profile of each SME and their vulnerability to the consequences of the disease. These factors and/or characteristics were then examined in the light of the company's current management of HIV/AIDS. It is hoped that a more detailed study of SMEs will provide government policy makers with more effective tools to assist SMEs in managing HIV/AIDS. Moreover, it will provide those in the SME sector with a greater understanding of their specific risk factors, and possible best practices in the mitigation of the HIV/AIDS impact.

This report provides an overview of the research methodology, a literature review of the impact of HIV/AIDS on SMEs, a presentation of the findings in each company case study as well as a discussion of the research findings and key lessons learned.

### Methodology

The study conducted in-depth case studies of six randomly recruited small and medium sized businesses. The main criteria for selection were:

- companies that employed fewer than 500 employees;
- companies that had an existing HIV/AIDS programme;
- companies with some records or statistics that indicate the impact of HIV/AIDS in terms of HIV-prevalence rates;
- companies that were prepared to allow the research team to interact with employees other than management representatives.

The case studies were developed through the use of different qualitative research techniques. The choice of specific techniques depended on features of the targeted respondents. Table 1.1 summarises the overall approach.

Table 1.1: Overview of case study methodology

Research method	Research instrument	Target respondents
Individual face-to-face interviews	Structured questionnaire/ interview guide	Senior management Operations/ line management HR/personnel management Occupational health practitioner
Individual/group face-to-face interviews	Structured questionnaire/ interview guide	Trade union representatives
Group interviews	Structured questionnaire/ interview guide	HIV/AIDS committee/forum
Focus groups (two each per company)	Focus group discussion guide	Volunteers or sample selection of two to ten employees from production staff (paid hourly/weekly) and administrative staff (paid monthly)
Documentary analysis		Reports on HIV/AIDS prevalence HIV/AIDS policies or guidelines, company information guides Presentations on HIV/AIDS Employee equity reports (extracts)

Qualitative interviews and focus groups were conducted with key individuals and groupings within the company during periods agreed upon by the Human Sciences Research Council (HSRC) and the company contact person. Interviews were carried out with key representatives from senior and line management, the human resources (HR) or industrial relations (IR) manager or related occupations, the occupational health (OH) practitioner, the trade union representatives, and the HIV/AIDS committee/forum. In companies where peer educators operated, peer educators were interviewed as part of the HIV/AIDS committee or forum.

In each company, separate focus group discussions were conducted with production (hourly/weekly paid) employees and administrative/support (monthly paid) employees. The motivation for this differentiated approach was that these two groups of employees tend, historically, to be differentiated by population group, skill level and occupational category in South African companies. As a result this differentiation may have an effect on their perceptions of HIV/AIDS and its impact.

Half of the companies provided employee lists of those who were employed at the time of the research, from which a few people were randomly selected. Individuals or groups involved in other research interviews were excluded from these lists before sample selection. In the remainder of the companies, the company contact person invited volunteers to participate after providing an explanation of the purpose of the research. Employee members of company HIV/AIDS committees generally attended the group interviews without senior management representatives.

All the interviews and focus groups were based on an interview and/or discussion guideline. Where information was required from company records (for example, staff

profiles), the relevant sections of the interview guidelines were faxed or emailed to the company representative for completion. Most (90 per cent) of the companies returned such information.

The interviews and focus groups were facilitated and supervised by an HSRC research fieldworker. All interviews were conducted during working hours and generally lasted an hour to an hour and a half. The focus groups lasted an hour, because most workers could not take more than an hour off work. Prior to each interview or focus group discussion the participants were provided with a short briefing on the nature of the research, and asked if they would participate. Participants were given a consent form after they had agreed to take part in the research. Details of the form were discussed before they were signed.

In addition to the structured interviews and focus groups, a survey of existing research and literature was conducted to provide a contextual background to the company case studies and to inform the development of the research instruments. This literature review consolidated existing data and information on the impact of HIV/AIDS on small and medium-sized enterprises. It also provided useful research indicators to be employed in the qualitative research. Finally, while this research may not be generalisable to the SME sector, given the small number of companies studied, the experiences and perceptions of the employers and employees may provide greater depth and insight to findings generated in quantitative studies on SMEs and the management of HIV/AIDS.

### **Ethics and confidentiality**

The HSRC submitted the project proposal, research instruments and a written consent form to the HSRC ethics committee. The project was approved subsequent to a few suggested changes. All companies were guaranteed anonymity; however, all chose to attach their company names to the individual case studies. It was particularly important to ensure anonymity given the sensitivity of some of the comments and opinions in the focus groups. All the interviews were recorded in written form, with some voice recordings to ensure accuracy.

### **Recruitment and fieldwork process**

The process of recruiting companies and the ensuing consultation process to arrange site visits took longer than expected. Referrals to particular companies were solicited from management consultants working in the HIV/AIDS and disease management fields using the snowball technique. These contacts were followed up with an initial telephone call. The reason for the request was explained, followed by a check on whether the companies fulfilled the criteria for selection. Fifteen companies were contacted and six agreed to participate in the research. The primary reason for company participation was that the research provided an opportunity to conduct an initial evaluation of their workplace interventions. Thus, the research findings would be particularly pertinent to problems regarding poor uptake of their HIV/AIDS programmes among employees. The HSRC agreed to provide a separate report or the relevant case study to three of the companies and possibly also a presentation to their HIV/AIDS committee.

A letter of request was faxed or emailed to companies after identifying the appropriate contact person. In most cases, formal agreement was reached after one or more face-to-face meetings with a senior management representative and/or the contact person. This was then followed by internal company consultation, after which the

decision to participate was communicated to the HSRC. The arrangements for interviews were conducted by phone and email, and schedules of interviews were agreed upon in advance. Focus groups were fitted around production schedules, including shift work, so that production employees could participate with the least disruption of work schedules.

# Literature review

**Sizwe Phakathi**

### Introduction

Available literature on the response of SMEs to HIV/AIDS highlights the risk to which SMEs are exposed to HIV/AIDS as well as those factors that contribute to their susceptibility and vulnerability. This literature review also unpacks the HIV risk posed to SMEs in comparison to large employers, as this may be of particular interest to key stakeholders, including SME employers, large companies, organised labour, HIV/AIDS service providers, policy-makers and government.

There is a dearth of research in South Africa on SMEs' risk of and vulnerability to HIV/AIDS. Research has focused on large companies, most of which are well resourced and have the capacity to design and implement comprehensive HIV/AIDS intervention programmes in the workplace. The resulting lack of sufficient and generic data has made understanding the nature and extent of the impact of HIV/AIDS on SMEs extremely difficult.

SMEs play an important role in the South African economy, both in terms of the gross domestic product (GDP) and employment creation (Ntsika 2002). Yet the analysis of the economic impact of HIV/AIDS has hitherto been restricted to studies involving large companies. Large companies have been able to respond effectively to the challenge of HIV/AIDS, given their greater access to significant capital and human resources. Fraser et al. (2003) as well as Connelly and Rosen (2004a, 2004b) have argued that SMEs face particular structural constraints in designing and implementing effective HIV/AIDS workplace programmes. Deloitte and Touche (2002) showed that SMEs have not yet begun to implement significant firm-level HIV/AIDS workplace interventions. On the other hand, Connelly and Rosen (2004b) argue that SMEs' difficulty with responding effectively is because there are currently no HIV/AIDS workplace programmes specifically designed to suit their needs.

This literature review is divided into four sections: section one locates the role of SMEs within the South African economy; section two focuses on HIV/AIDS risk and vulnerability in SMEs, including the impact on SMEs and their responses to HIV/AIDS; and section three presents the challenges that SMEs face in accessing, designing and implementing comprehensive HIV/AIDS workplace programmes. The fourth section discusses opportunities for SMEs to effectively deal with HIV/AIDS in the workplace. Ways in which research on SMEs could be expanded to complement the current ungeneralisable data, and to enhance our understanding of their vulnerability to HIV/AIDS, are also discussed. This provides an opportunity to enhance our understanding of their HIV/AIDS risk and vulnerability within the context of industrial restructuring, working conditions, the changing nature of work and employee welfare.

## SMEs and the South African economy

In order to understand the contribution of SMEs to the national economy, it is necessary to first define and locate them within the South African economy. Rogerson (2000: 13) identifies three sets of enterprises that characterise the South African SME economy.

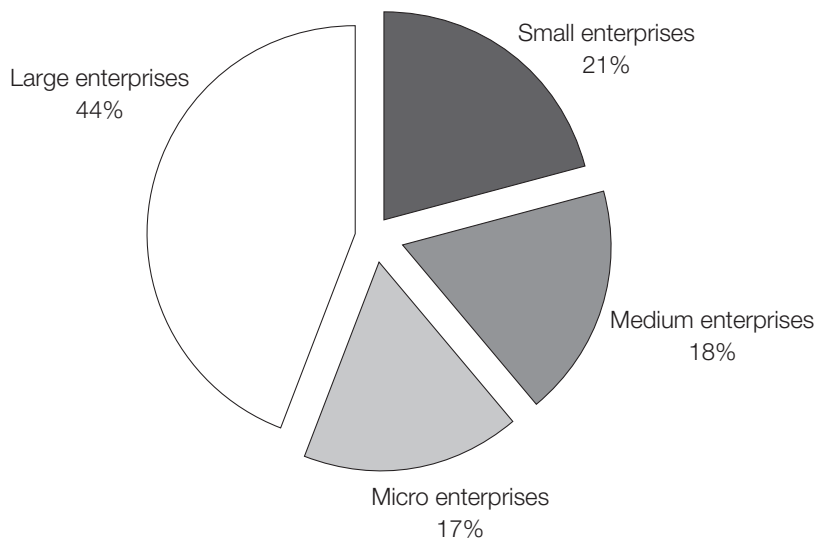
Survivalist enterprises operate in the informal economy. These are defined as a set of activities undertaken primarily by unemployed people unable to find regular employment. In this group, incomes usually fall short of minimum standards, little capital is invested, skills training is minimal and scant prospects exist for growth into viable small business enterprises.

Micro-enterprises involve the owner, possibly some family members and, at most, four employees. Such businesses frequently escape the trappings of formality, such as licenses or formal premises and the entrepreneurs sometimes have only rudimentary business skills or training. Many micro enterprises can change into viable formal small businesses.

Small and medium sized enterprises constitute the basis for the formal SME economy. SMEs are usually owner-managed, operate from fixed premises and generally bear all the trappings associated with formality.

The National Small Business Act of 1996 (RSA 1996) defines small companies as those employing between five and 50 permanent employees and medium-sized companies as those that employ between 51 and 200 permanent employees. The Ntsika (2002) review of the state of small business development in South Africa indicates that small enterprises constitute the most significant SME employer (accounting for 21 per cent of total SME employment), followed by medium-sized enterprises (accounting for 18 per cent of total SME employment) and micro-enterprises (accounting for 17 per cent of total SME employment). Figure 2.1 shows the contribution of the SME sector to national employment.

Figure 2.1: Distribution of employment by enterprise size



Source: Ntsika (2002)

In South Africa, about 11 million people work in the formal and informal sectors; most work in SMEs. The number of SMEs has been increasing since 1994 and entrepreneurial activity in general has increased significantly. This reflects the key role of the SME sector in the South African economy – a role that is set to escalate in future with the continued removal of constraints and provision of incentives (Ntsika 2002). High rates of unemployment (over 50 per cent) among people younger than 30 means that the small business sector is set to expand as young adults resort to self-employment. Sadly, the prospects of SME growth are being undermined by the HIV/AIDS pandemic (Khanye 2003). HIV/AIDS is largely affecting economically active groups, especially youth. This is the challenge the small business sector is facing and which it will have to deal with if small business is to effectively and significantly sustain South Africa's economic growth.

The significant role of small businesses is also evident in the economies of Western European countries and in the USA. In the UK, Germany, Italy and Spain, SMEs are responsible for an average of 70 per cent of job creation. In the USA, the world's largest national economy, 50 per cent of the GDP is being created by businesses that were not in existence a mere decade ago (Bulletonline 2000).

In 2000, SMEs' contribution to overall employment was well above 60 per cent, with 75 per cent and more achieved in trade, agriculture and business services. Recently, the SME sector, both formal and informal, has been the key creator of employment in the South African economy. The importance of SMEs is not confined to employment creation. It extends to economic growth and transformation of the post-apartheid economy. By 2000, SMEs accounted for 36 per cent of South Africa's GDP (Ntsika 2002: 35).

The Ntsika 2002 SME review indicates further that SMEs' contribution to employment has been faster than its contribution to the GDP. The review reveals that, 'in 1995, the contribution of the SME sector to employment in the private sector was 1.35 times greater than the contribution of the SME sector to the GDP. In 2001, this factor was 1.5. This implies a very high labour absorption capacity of SMEs, and again highlights the job creation potential of the sector.' (Ntsika 2002: 36). Table 2.1 illustrates the distribution of private sector employment by company size.

*Table 2.1: Private sector employment by company size (% of total private sector employment)*

Size of enterprise	Percentage of total private sector employment	Cumulative percentage
Survivalist	10.9	10.9
Micro (0)	9.1	20.0
Micro (1–4)	11.7	31.7
Very small	9.9	41.6
Small	14.3	55.9
Medium	12.3	68.2
Large	31.8	100.0

*Source: Extracted from Ntsika (2002)*

Seventy per cent of all SMEs are concentrated in three provinces: Gauteng, KwaZulu-Natal and the Western Cape (Ntsika 2002: 43). These provinces also account for 69.4 per cent of national employment (Ntsika 2002: 42). It is notable that the prevalence rates of HIV/AIDS differ between provinces. These provincial differences in prevalence are important in understanding the impact of HIV/AIDS on SMEs across the country.

### **HIV/AIDS risk: susceptibility and vulnerability in SMEs**

The terms 'susceptibility' and 'vulnerability' need to be understood within the context of HIV/AIDS. 'Susceptibility' refers to the individual, group and general predisposition to infection; 'vulnerability', to the features of a social or economic entity that make it more or less likely to cope with the adverse impacts of the disease (Barnet and Whiteside 2002: 166).

HIV/AIDS statistics reveal that South Africa has the largest proportion of its total population confirmed as living with HIV/AIDS in the world. In 2002, about 5.3 million South Africans were HIV-positive (DoH 2003). This has serious implications for South Africa's business sector. The results of the Bureau for Economic Research/South African Business Coalition on HIV/AIDS (BER/SABCOHA) (2004) HIV/AIDS survey indicate that many businesses are already facing the consequences of the epidemic:

All in all, nine per cent of the 1006 companies surveyed during October and November 2003 indicated that HIV/AIDS has already had a significant impact on their business. More than 40 per cent envisage a significant negative impact on their business in five years time. (BER/SABCOHA 2004: i)

The business environment in South Africa has become riskier as a result of the HIV/AIDS epidemic (Khanye 2003: 14—19). Research in South African companies reveals that the small business sector is not effectively dealing with and mitigating the impact of HIV/AIDS. Most SMEs operating in the Southern African Development Community (SADC) are not well equipped to deal with the impact of the epidemic in the workplace. The impact of HIV/AIDS on business is threefold: direct, indirect and systematic costs (Muwanga 2001; Barnett and Whiteside 2002; ECI 2001; Fraser et al. 2003; Vass 2003; Brink 2003; Connelly and Rosen 2003; Lehutso-Phooko 2003).

Direct costs involve increased financial outlays by the company. Indirect costs include reduced workforce productivity, less output for a given level of expenditure on labour, including reduced productivity both by the infected employee and by other employees diverted from their normal responsibilities, as well as systematic costs resulting from the cumulative impact of multiple HIV/AIDS cases.

The BER/SABCOHA (2004) HIV/AIDS survey of 1006 companies is the most comprehensive to date. Although the survey focused on companies that were larger than small SMEs, the results do shed light on the extent to which SMEs are responding to the HIV/AIDS epidemic.

The survey shows that, overall, only a quarter of South African companies have an HIV/AIDS policy in place. However, among companies with fewer than 100 employees, only 13 per cent have implemented a policy. More than 90 per cent of large companies (with more than 500 employees) have implemented an HIV/AIDS policy. Overall, 41 per cent of respondents indicated that they have an HIV/AIDS awareness programme, 18 per cent a voluntary counselling and testing programme, 13 per cent a care, support and treatment programme; only 6 per cent provide antiretroviral therapy in the workplace.

The survey shows that the main impact is being felt in production costs, labour demand and fixed investment, sales, prices and profitability. However, the extent and nature of the impact is more visible in large companies than in SMEs because of their comprehensive response to the epidemic. SME employers do not believe that HIV/AIDS is a major cause of employee attrition. The impact of HIV/AIDS at the point of production at the shop floor is small or unnoticeable. In their study of a random sample of 80 SMEs in Gauteng and KwaZulu-Natal, Connelly and Rosen (2004b) found that employee attrition among surveyed SMEs averaged 13 per cent per year while AIDS-related labour turnover averaged 1.4 per cent. There was no AIDS-related employee attrition reported in Gauteng.

SME employers are reluctant to design and implement comprehensive HIV/AIDS workplace programmes. This complacency and lack of sufficient response to HIV/AIDS can be attributed to low costs of labour demand. According to Connelly and Rosen:

The direct and indirect costs of recruiting and training replacement employees, especially unskilled workers are modest. For unskilled workers, 85 per cent of the surveyed companies incur no direct costs in recruiting and training. Vacancies are filled in less than a day and workers are considered fully productive within five days. For skilled workers, 50 per cent of the surveyed companies incur no costs to recruit and 66 per cent no direct costs to train. Vacancies are filled within 10 days, and managers believe that skilled workers become fully productive within 20 days' (2004c: 4).

The susceptibility and vulnerability of companies between provinces and across sectors is not identical. The BER/SABCOHA (2004) survey results show that companies in KwaZulu-Natal and Gauteng have been worst affected. More than 40 per cent of companies operating in KwaZulu-Natal and Gauteng indicated that HIV/AIDS has led to lower labour productivity or increased absenteeism. Companies based in the Western Cape have experienced a much smaller impact, with less than 20 per cent of these companies noting an AIDS-induced, adverse impact on their production. These results are consistent with estimates of HIV prevalence among pregnant women visiting antenatal clinics, which show that HIV prevalence is highest in KwaZulu-Natal, followed by Gauteng, and lowest in the Western Cape. The question that must be asked is to what extent location and the type of sector in which SMEs operate influence responses to HIV/AIDS. Connelly and Rosen (2004b) argue that SMEs operating in KwaZulu-Natal are more willing to respond to HIV/AIDS because of the high HIV/AIDS prevalence rate in the province.

More than half of the manufacturers surveyed indicated that HIV/AIDS has led to lower labour productivity or increased absenteeism, and some 40 per cent of manufacturers reported that HIV/AIDS has already reduced profits. Retailers appear to be the least affected, with less than 20 per cent of respondents indicating that HIV/AIDS has had a negative impact on their profits. The impact of HIV/AIDS on the building and construction, motor trade and wholesale sectors is rated somewhere between that of the high-risk manufacturing and lower-risk retail sectors.

These provincial and sectoral perspectives have serious implications for the SME sector. The nature and extent of susceptibility and vulnerability of SMEs to HIV/AIDS is dynamic and determined by the type of sector and the province in which they operate. Mining, general government, transport and storage, agriculture, construction and accommodation and catering are regarded as high-risk sectors. Metals, retail and chemicals are medium-risk sectors, while financial, business services and communication are regarded as low-risk sectors (Vass 2002; 2003).

SMEs are dominant in the agriculture and construction sectors (Ntsika 2002). SMEs operating in the agriculture sector in KwaZulu-Natal have already been affected by HIV/AIDS. Connelly and Rosen (2004b) note that SMEs operating within the agriculture and construction sectors have, respectively, recorded 7.5 per cent and 5 per cent AIDS-related labour turnover in the last two years. Table 2.2 shows the distribution of private sector enterprise by sector and company size.

Table 2.2: Distribution of private sector enterprise by industry and company size (%)

Sector	Survivalist	Micro (0)	Micro (1-4)	Very small	Small	Medium	Large	Average total
Agriculture, forestry and fishing	0.4	3.4	11.1	14.9	21.1	23.8	25.3	100
Mining and quarrying	0.4	0.7	3.3	4.6	6.8	4.9	79.3	100
Manufacturing	0.8	0.7	4.9	6.8	11.3	18.2	57.3	100
Construction	0.4	3.7	14.3	13.4	21.1	20.4	26.7	100
Wholesale trade	1.1	2.8	15.0	19.9	19.0	17.2	25.3	100
Retail trade (including motor trade)	32.0	36.1	15.9	11.6	3.9	0.3	0.2	100
Catering and accommodation	12.2	29.2	21.3	18.2	16.4	2.1	0.6	100
Transport, storage and communication	0.7	7.6	12.5	7.0	10.2	15.6	46.4	100
Finance and business services	1.1	2.4	8.6	11.2	16.7	19.8	40.2	100
Community, social and other personal services	1.2	1.9	7.8	10.2	19.1	23.6	36.2	100
Total	5.0	8.8	11.5	11.7	14.6	14.6	33.8	100

Source: Extracted from Ntsika (2002: 39)

Furthermore, unlike large formal companies, the susceptibility and vulnerability of SMEs to HIV/AIDS is exacerbated by the nature and form of employment conditions. SME employees tend to have insecure jobs, are poorly paid and are largely unskilled. Large firms often outsource or subcontract some of their business activities to private contractors. Employees of the subcontracting company are usually employed in a particular way. Apart from working irregular hours in poor working conditions, earning low wages and lacking trade union representation, subcontracted workers are usually

denied employment benefits such as pension, medical aid and life insurance (Muwanga 2001, Barnett and Whiteside 2002; Brink 2003, Vass 2002; 2003; Lehutso-Phooko 2003, Fraser et al. 2003).

Fraser et al. (2003), in a study on the impact of HIV/AIDS on 120 selected SMEs in South Africa, note that despite the fact that employers do not rank HIV/AIDS a priority in their businesses, HIV/AIDS is critically affecting SMEs. SMEs are suffering from decreasing levels of productivity, increasing direct and indirect costs, increasing HIV/AIDS-related illness, absenteeism and death in the workplace.

The same study found that SMEs broadly perceive the effect of HIV/AIDS in terms of reduced productivity, production losses and failure to meet deadlines. HIV/AIDS is also reported to affect staff morale as a result of the psychological impact on non-affected staff and by creating tension in the workplace. Many firms (about 18 per cent of the sample), cited loss of skilled staff and skills within their operations as a concern. Another 13 per cent brought up the issue of the costs associated with finding replacement employees. This study found that, 'overall, the common concern that SME owners and managers expressed related to maintaining production levels. This was either via the direct ability of their operations, or through indirect factors such as staff cohesion, skill maintenance and the "replaceability" of staff' (Fraser et al. 2003: 72). Table 2.3 details reported perceptions of small and medium firms on the effects of HIV/AIDS on a business.

*Table 2.3: Reported perceptions of the impact of HIV/AIDS in SMEs*

Response	Number of firms	Percentage of total
Decreased productivity / production loss / failure to meet deadlines	51	43
Decrease in staff morale / psychological effect on other staff / tension in work environment	22	19
Loss of skilled staff / skills	21	18
Increase in replacement costs and time for finding and training permanent replacements	15	13
Other	9	7

*Source: Extracted from Fraser et al. (2003: 72)*

Furthermore, the study found that most SMEs reported workforce-related costs as indirect rather than direct costs. In the study by Fraser et al. (2003), direct costs are described as including benefits payments, recruitment and training expenditure, overtime and casual wages. Simply put, direct costs equal increased expenditure and indirect costs equal decreased revenue. Table 2.4 illustrates factors leading to increased and decreased expenditure.

Table 2.4: Factors leading to changes in expenditure by SMEs

Factors leading to increased expenditure	Factors leading to decreased revenue
Health care costs, benefit claims	Absenteeism due to illness
Pension	Time off to attend funerals
Burial fees	Time spent on training
Training and recruitment	Labour turnover

Source: Extracted from Fraser et al. (2003: 72)

Absenteeism and sick leave are particular problems for SMEs because of their small size. According to Fraser et al. (2003: 73), 'this could include attending funerals, but might not be directly related to HIV/AIDS. So, clearly health is an important consideration for employers. This implies that from the standpoint of risk, every firm should factor HIV/AIDS mitigation into their particular experiences with absenteeism and sick leave'. Absenteeism could also result from poor health of the employee or his or her family and friends. Over 23 per cent of firms surveyed said absenteeism had increased in the previous year. The most common reason (45 per cent) for absenteeism was poor health or illness. The other reasons for absenteeism included family responsibilities (10 per cent), attending funerals (7 per cent) and attending to sick children and family members (7 per cent). The latter two might also be attributed to health and illness issues. This increase in absenteeism cannot be entirely attributed to HIV/AIDS. However, it shows that absenteeism is an indicator that SMEs should begin to monitor closely.

Moreover, the study also found that SMEs are experiencing AIDS-related deaths among their employees. Fraser et al. state that during their study:

...an alarming number of 32 former employees had died of AIDS-related illnesses between phase one and two interviews. This is a significantly high number of deaths given the small sample (120 firms) and represents about one per cent of the total of full-time employees of the firms sampled. (2003: 74)

### Challenges in implementing comprehensive HIV/AIDS workplace programmes

This section focuses on the manner in which SMEs are implementing HIV/AIDS workplace programmes to mitigate the effects of HIV/AIDS and the challenges and obstacles they encounter.

A number of studies indicate that, as a result of constraints and lack the skills required, only a small number of SMEs are carrying out activities to mitigate the effects of HIV/AIDS on the company and staff. Most of those who do have an HIV/AIDS programme distribute educational material, such as literature and posters. Programmes involving condom distribution are also common among this group, as are workshops by external consultants. However, most programmes do not address both prevention (including education) and mitigation (counselling and testing as well as treatment) (Fraser et al. 2003; Connelly and Rosen 2004b), and lack a holistic approach. A few, well-designed proactive measures could substantially reduce a company's liability to HIV/AIDS. Few SMEs invest in employee benefits. Only 64 per cent of SME employees receive retirement benefits and less than one third belong to company-sponsored medical

schemes (Connelly and Rosen, 2004: 3). Ten per cent of companies offered on- or off-site medical facilities. By keeping employee benefits at a modest level, SMEs are effectively reducing the cost of losing an employee.

Connelly and Rosen (2004a; 2004b; 2004c) identify a number of constraints to the supply and demand of HIV/AIDS services in SMEs. There are three main barriers to effective supply of HIV/AIDS services in SMEs: costs, communication and capacity.

### **Cost**

Providing HIV/AIDS services tend to cost more for SMEs than large companies because the supplier's fixed costs are not easily covered by the delivery of services to an SME. Marketing to SMEs also tends to be disproportionately expensive. These costs combine to make it difficult for service providers to target SMEs. They often charge an SME up to four times more than a large company for the same service.

### **Communication**

HIV/AIDS service providers generally target large companies, and their primary contacts are HR managers, who generally have the capacity to design, implement and manage HIV/AIDS workplace programmes. SMEs lack capacity in personnel issues. As a result, providers are generally not interested in supplying and marketing their HIV/AIDS services to SMEs. Furthermore, lack of access to services is compounded by the SMEs' unwillingness to pay for and invest in HIV/AIDS workplace programmes for the various reasons cited elsewhere in this review.

### **Capacity**

SMEs are generally perceived by HIV/AIDS service providers to be uncertain markets. Most lack capacity in HR and personnel issues. As a result, less informed business owners or managers usually make the necessary decisions around human resources and personnel. In addition, SMEs lack information on HIV/AIDS issues. Connelly and Rosen (2004a; 2004b; 2004c) found that most SMEs had little knowledge of the available HIV/AIDS services, the benefits and costs of providing them and where they could be obtained. The study also found that most SMEs do not have anyone designated to handle HIV/AIDS issues. This is not surprising given the reluctance to pay for, and lack of interest in, HIV/AIDS services among SMEs.

Connelly and Rosen (2004a; 2004b; 2004c) identify four key constraints on the demand for HIV/AIDS services by SMEs: low willingness to pay, stigma, lack of information, and lack of pressure to act.

#### *Low willingness to pay*

This point has been briefly mentioned above. The low willingness of SMEs to pay for HIV/AIDS care is attributed to the following:

- SMEs invest little in employee benefits;
- AIDS is not a major cause for worker attrition;
- Employees can be readily and quickly replaced;
- Even though most companies have lost employees to AIDS and expect a moderate to large impact from HIV/AIDS, the virus is not a major business concern for SMEs. When asked to rank ten major business concerns, HIV/AIDS was ranked ninth by SME managers.

*Stigma*

Stigma, rather than cost, has been a greater stumbling block than cost for SMEs in preventing the effective design and implementation of HIV/AIDS intervention programmes. Connelly and Rosen (2004c) found that of the 15 SMEs that had considered implementing HIV/AIDS services, 7 did not, citing refusal by, or lack of interest from, their workers.

*Lack of information*

Lack of information or the inability of SMEs to access information is caused by a number of factors ranging from lack of capacity in human resources to lack of interest in HIV/AIDS issues by SME employers and employees. Connelly and Rosen (2004b) point out that SMEs seem largely to rely on the public sector for health-related information and services. Unlike large companies, HIV/AIDS service providers seldom provide the information SMEs need. Even SME managers who are interested in taking action indicated that they lack the time to find, consider, negotiate and implement programmes.

*Lack of pressure to act*

Demand for HIV/AIDS services in SMEs is also constrained by a lack of both internal and external pressure to implement HIV/AIDS workplace programmes. SMEs are not motivated to invest in employee welfare, unlike large companies (Connelly and Rosen 2004b), where there is both internal pressure (exerted by organised labour, activists and shareholders) and external pressure to adhere to international standards, a business culture with corporate social responsibility programmes and a realisation of the benefits of investing in human capital.

**Delivery and financing**

Some of the constraints and challenges that prevent SMEs from responding effectively to HIV/AIDS are beyond their control. There is not yet an SME-friendly HIV/AIDS workplace programme in place. The focus has been on supplying HIV/AIDS services to large companies to the disadvantage of SMEs. Connelly and Rosen (2004: 3) identify four models of delivery and financing of HIV/AIDS services generally used by suppliers, none of which are suitable for SMEs.

*Individual service providers*

Individual service providers offer one particular service to employers directly or through larger providers. Fees for SMEs work out greater per employee given the minimum fees set for such services.

*Medical scheme disease management programmes (DMPs)*

Medical scheme DMPs act as financial administrators for treatment-based HIV/AIDS services and receive a small fee per eligible beneficiary from the medical scheme administrator. They offer case management of HIV/AIDS treatment for HIV-positive individuals in order to improve outcomes and manage costs for the administrator. Since medical schemes cover the individual beneficiary in open medical schemes, or employees in large companies eligible for closed medical schemes, this model is not appropriate for SMEs. A small proportion of SME employees are eligible on an individual basis for DMP services through their medical aid.

*Employer DMPs*

Employer DMPs are marketed to companies directly and offer a comprehensive response to HIV/AIDS including managed treatment of HIV/AIDS for employees not eligible for

medical scheme coverage. Employer DMPs charge a small fee for each HIV-positive person enrolled in their programme and other HIV/AIDS services are usually charged on a fee-for-service basis. This model encourages employees to enrol in their programme by offering HIV/AIDS education and awareness to employees and voluntary counselling and testing. For SMEs, this model is expensive and provides limited cover.

### *Clinic providers*

Clinic providers, including OH, primary care and networked healthcare providers, offer HIV/AIDS services as additions to existing healthcare services. They act as the central coordinators for different providers in order to offer a broad array of HIV/AIDS services. This allows some of the logistical difficulties associated with delivering various HIV/AIDS services to be overcome. Clinic providers charge a set fee per employee per month for a set package of services. Additional services are available on a fee-for-service basis. Since many of these providers have existing relationships with SMEs, they are better positioned to expand services to SMEs. However, at the moment there is limited coverage.

### **Encouraging SME intervention programmes**

Connelly and Rosen (2004a; 2004b) identify the following five opportunities in which government, donors and large companies could encourage and facilitate SME participation in the design and implementation of comprehensive HIV/AIDS intervention programmes:

1. Extensive campaigning that provides information on HIV/AIDS services and benefits to managers (this can be an effective and inexpensive way to enhance demand for services offered by private or non-profit providers);
2. Adapting current provider models to increase affordable and accessible coverage for all sectors of the business community;
3. Subsidising the costs of services for certain sectors, such as agriculture and construction, to make services more affordable;
4. Linking up with business associations, which represent a means of increasing service provision to SMEs through existing aggregations of companies, effective communication channels, experience in organizing services and trust from employers (this should be aimed at particular industries and geographical areas);
5. Securing donor assistance towards existing union programmes on education and awareness; working through the unions may be regarded as more credible by employees and contribute towards changes in attitudes and behaviours.

### **Conclusion**

SMEs play a vital role in the South African economy, particularly in creating employment. However, the development and expansion of this important and emerging sector could be seriously hampered by the HIV/AIDS epidemic. Research on the impact of HIV/AIDS reveals that SMEs are finding it difficult to design and implement comprehensive and effective HIV/AIDS workplace programmes. The supply and demand for HIV/AIDS services has focused on large business to the detriment of SMEs. HIV/AIDS service providers do not market their services to SMEs, which are not considered lucrative clients. Lack of resources and capacity to respond effectively to the HIV/AIDS epidemic is the major constraint. Research also shows that the epidemic has started to have a negative impact on SMEs. This is important in the light of the reluctance of SME employers to pay for HIV/AIDS services and the fact that HIV/AIDS is not perceived as a priority. There is a lack of internal and external pressure for SMEs to invest in employee welfare, particularly in the area of HIV/AIDS. The literature surveyed also revealed that SMEs' HIV/AIDS risk is dynamic and is influenced by particular structural constraints.

However, further research is necessary to determine the specific nature of, and extent of the constraints on SMEs preventing them from mitigating HIV/AIDS in the workplace. Current research on SMEs and HIV/AIDS indicate that there is still a lack of detailed, holistic and representative data. Research conducted to date relies heavily on interviews that record managers' subjective perceptions. There is a lack of data on SME employees' points of view. This data is critical to understanding the factors that shape SMEs' responses to HIV/AIDS in the workplace, particularly given that stigma seems to be a greater barrier to implementing or expanding services than cost (Connelly and Rosen 2004c). Research has hitherto been top-down rather than bottom-up. Manager's perceptions need to be complemented by case studies and focus group research tools.

# Case study 1:

## Autoliv Southern Africa (Pty) Ltd

Jocelyn Vass

### Introduction

Autoliv Southern Africa (Pty) Ltd is a medium-sized company in the automotive component-manufacturing sector with a labour force of approximately 150 employees. It is based in an industrial area, Chamdor, in Gauteng province, South Africa. Autoliv is the Southern African subsidiary of the Swedish multinational, Autoliv Inc., the world's largest supplier of automotive safety goods, which is listed on the New York Stock exchange.

### History of the company

Table 3.1 provides a timeline of the key events defining the history and development of Autoliv Southern Africa (Pty) Ltd and changes in ownership. Autoliv SA was established in 1965 as a private entity. In 1980, it was incorporated as Autoflug SA (Pty) Ltd, when Autoflug GmbH acquired a 13 per cent share in the company, and the company started to manufacture motor vehicle seatbelts. In 1992, Autoflug GmbH increased this share to 26 per cent. Table 3.1 tracks the lines of acquisition of various parts of the business by the Swedish-based Autoliv Inc, through 1998, when Autoliv SA (Pty) Ltd came under wholly foreign ownership, and subsequent developments.

*Table 3.1: Timeline of developments in Autoliv SA (1980–2003)*

Year	Milestone(s)
1980	Incorporated as Autoflug SA
1992	Autoflug GmbH increased equity to 26%
1994	Autoliv Inc. acquired Automotive Division of Autoflug
1995	Autoflug increased equity to 49%
1998	Autoliv Inc. acquired 100% of Autoflug SA
2001	Obtained VW business
2002	First airbags in South Africa manufactured
2003	Obtained Delta business

The company product range includes seatbelts (75 per cent), airbags (10 per cent) and automotive components (15 per cent). It was the first in South Africa to produce airbags for motor vehicles. Its main market is the motor vehicle safety equipment sector, specifically motor vehicle manufacturers and those in the automotive component replacement market. Volkswagen, Toyota and BMW are among its main customers (as reflected in Table 3.2).

Table 3.2 provides trends in economic performance. It shows that in the past five years the company gross turnover has increased by 68 per cent. This has been accompanied by a shift in its customer base, predominantly towards VW SA, as well as a major reduction in its main export markets in the United States.

*Table 3.2: Major trends in economic performance by Autoliv SA between 1999 and 2003*

	1999	End of 2003
Employees	210	150
Gross turnover (Rand)	R56.3 Million	R94.7 Million
Major product markets/ customers	Toyota – 34% BMW – 25% Atwood – 17% Ford – 16% Nissan – 8%	Volkswagen – 51% Toyota – 22% BMW – 10% Atwood 7% General Motors – 5% Ford – 4% Nissan – 1%
Trends in export markets	USA 17%	USA 7%

Senior management indicates that foreign ownership has had advantages in terms of transfers of skills and knowledge, management, technology and business networks. Thus, while the company itself only engages in limited product development, its business networks through Autoliv Inc. subsidiaries facilitate the importation of products and components on a global level (Graaff et al. 2004). Senior management cites the Motor Industry Development Plan (MIDP) – an incentive programme established by the Department of Trade and Industry to facilitate exports in the automotive industry – as well as the African Growth Opportunities Act (AGOA) as key policy interventions from which it has gained.

## **HIV/AIDS risk profile**

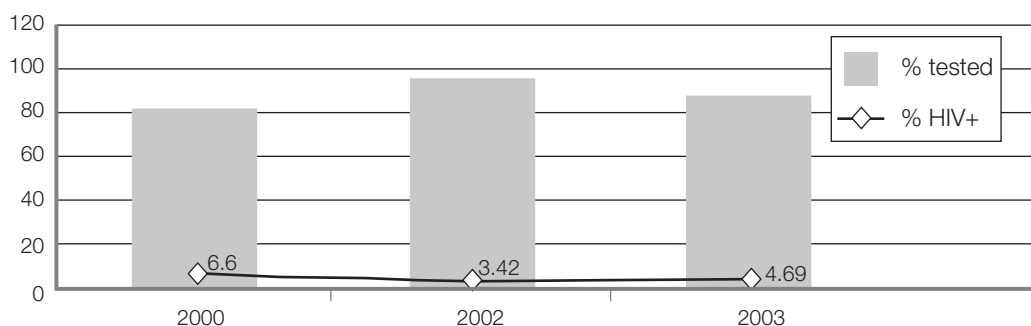
This section provides an analysis of the relative exposure to the HIV/AIDS risk and vulnerability faced by Autoliv. An overview of available HIV-prevalence statistics, demographic and skills profiles is provided. This is followed by an overview of related factors such social capital or community-related factors and organisational risk factors as revealed in interviews with employees and management. It also highlights perceived and observed risks and vulnerability to HIV/AIDS.

### **HIV/AIDS statistics**

The company conducted three voluntary and anonymous, linked HIV-prevalence surveys in 2000, 2002 and 2003. These show that the HIV-prevalence rate has remained consistently lower than 7 per cent, while varying over the period. [Figure 3.1] illustrates some of the more pertinent results flowing from these surveys. It shows that the survey participation has remained consistently high, ranging from 82 to 96 per cent of the available workforce. However, given the decline in the size of the workforce, these participation rates are not necessarily comparable, especially in the earlier period. The variability in the prevalence rate may be due to a number of factors. Between 2000 and 2002, the prevalence rate declined to 3.42 from a high of 6.6 per cent. There was

a gap year, during which a survey was not conducted. During this period the HIV/AIDS education and awareness programme was launched. Also, in this period company restructuring occurred, resulting in a number of retrenchments. This restructuring was quite significant and resulted in a decline in the workforce from between 500 and 600 employees to 150 employees. Thus, with nearly half the workforce retrenched, the possibility exists that some of the retrenched may have included HIV-positive employees.

Figure 3.1: HIV-prevalence rate and survey participation rate at Autoliv SA (2000, 2002, 2003) (%)



The reason for the 8 per cent decline in participation rate in 2003 compared to 2002 is not clear. The company believes that it could be caused by a change from blood testing in 2002 to saliva testing in 2003, along with the impact of restructuring the company, which resulted in a staff reduction from 210 to 150 employees. However, despite this variability the average HIV-prevalence rate is considerably lower than the national adult prevalence of 15.6 per cent as well the national rate for all people older than 2 years (11 per cent).

### Workforce profile

Autoliv employs approximately 150 permanent employees, most of whom are in semi-skilled occupations. As shown in Table 3.3, the workforce is predominantly female, coloured and African. Most employees have many years of experience, and the average length of continuous service is 13 years. Thus, the workforce remains stable.

Table 3.3: Workforce by age groups, population group and sex (2003)

	African		Coloured		Indian/Asian		White	
	Men	Women	Men	Women	Men	Women	Men	Women
20–29 years	3	0	0	1	0	0	6	0
30–39 years	6	11	0	18	1	0	9	2
40–49 years	10	20	1	19	0	0	4	5
50–65 years	3	12	0	7	0	0	6	3
Total	22	43	1	45	1	0	25	10

The staff turnover on the production side is generally regarded as fairly low. This is despite the retrenchments experienced in 2001. The company described the production

process as being equally distributed between the use of labour and capital. The workforce is predominantly semi-skilled, mainly Coloured and African, workers with the highly skilled and skilled positions mostly occupied by white men (see Table 3.4).

Table 3.4: Workforce by age groups, skill category and sex (2003)

	Highly Skilled		Skilled		Semi-skilled		Unskilled	
	Men	Women	Men	Women	Men	Women	Men	Women
20–29 years	6	0	3	0	0	1	0	0
30–39 years	5	2	8	0	4	32	0	0
40–49 years	1	0	5	0	7	41	0	0
50–65 years	3	0	3	1	4	20	0	0
Total	15	2	19	1	15	94	0	0

*Occupational category code list*

*Highly skilled: managers, professionals, directors, engineers, nurses etc.*

*Skilled: technicians and associated professionals, crafts- and trades-people*

*Semi-skilled workers: service, administrative and clerical employees, operators*

*Unskilled workers: labourers, cleaners, elementary occupations*

The age distribution shown in both Table 3.3 and Table 3.4 suggests a larger proportion of female employees in the older age cohorts, upwards of 40 years. At the same time, there were fewer in the age cohort 30–39 years, and hardly any aged 20–29 years, a highly susceptible category. This may be one of the reasons underlying the relatively low HIV-positive rate reported in Autoliv prevalence surveys.

Table 3.5: Employment status by skill of Autoliv SA workforce

Skill level	Permanent/fulltime workers
Highly skilled	17
Skilled	21
Semi-skilled	109

*Employment status code list*

*Permanent: working at least 40 hours per week on a full-time basis on an indefinite contract*

*Temporary/fixed contract: contract with a definite ending date, and specific hours per week/month*

Table 3.5 shows that the workforce is permanent, with a concentration of employees in the semi-skilled occupations. National projections on the skill distribution of HIV/AIDS prevalence indicate that the highest rates will be found in unskilled and semi-skilled positions (Bureau for Economic Research 2001; Abt Associates 2000), as well as among young women. However, contrary to these projections, a relatively low HIV-prevalence rate is found in a mainly semi-skilled, female, Coloured and African workforce at Autoliv SA. It appears that the particular age profile may, in this instance, outweigh the risks posed by sex, population group profile and skill category.

### **Social capital issues contributing to HIV risk**

This section provides an overview of the social and community characteristics of the workforce and how these may have an impact on HIV risk.

Workforce stability and length of service were raised as some of the contributory factors to the low HIV-prevalence rate. Internal advertising is the main recruiting technique at Autoliv, especially among the production staff. This results, to some extent, in a recycling of existing employees among different jobs. The low employee turnover rate (with the exception of the retrenchments) also implies that the workforce is very stable, resulting in a consolidation of skills and experience as well as of organisational culture. The length of service is 13 years on average, and at its highest, is approximately 24 years. Reasons for this stability may vary. One reason relates to the variable marketability of a predominantly semi-skilled workforce given the high levels of unemployment. Further, a predominantly female workforce in older age cohorts implies established and more stable families and a greater awareness of security in terms of jobs and incomes.

Autoliv draws its workforce largely from two Gauteng townships, Toekomsrus and Kagiso, areas that have been the main recruiting pool. Given the low employee turnover, the workforce is steadily growing older, and younger potential recruits from surrounding townships are not joining the company in significant numbers. This is evident from the fact that the workforce includes hardly any workers younger than 30 years old.

As in similar communities, social problems are also evident within the workforce. There have been reported incidents of domestic violence against female employees by their partners. Levels of unemployment are high in the surrounding areas, and many of the employed women are supporting unemployed partners. However, these factors do not appear to have played a major role in determining HIV risk.

### **The HIV/AIDS policy and programme**

This section provides an overview of the history and development of the HIV/AIDS policy and programmes at Autoliv. It then outlines the institutional and support structure established to facilitate, implement and evaluate both policy and programme. Finally, it provides an evaluation by key individuals and stakeholders at the company of the policy and programmes.

#### **History of the HIV/AIDS policy**

An HIV/AIDS policy sets the overall framework, within which programmes are developed. A cumulative range of personal experiences, both internal and external to the company, informed the development of an HIV/AIDS policy and AIDS programme, the AZA Forum, at Autoliv. The experience of a key member of the forum, whose 23-year-old son contracted the virus and subsequently died of AIDS, partly contributed to an awareness of the possible impact of the disease inside the company. The employee's openness about her personal experience of the impact of the disease and the external support she received from a community care AIDS hospice, was one of the key factors most often raised by participants. The previous Managing Director (MD) heard her story and sent two employees to a seminar on HIV/AIDS. In 2000, an employee (now chairperson of the AZA AIDS Forum) also attended the 13<sup>th</sup> International Conference on HIV/AIDS in Durban. During this period, an employee who was diagnosed HIV-positive outside the company disclosed their status to the OH sister. Most respondents indicated that the positive response and enthusiasm of the MD contributed to the development of the AZA Forum.

*The AZA HIV/AIDS Forum*

The AZA AIDS Forum was established in March 2000; membership was voluntary. The forum consists of the current MD, the OH sister and volunteers from the workforce, including two union shop stewards. There is no formal representation of the trade union on the committee, as both shop stewards joined as individuals. The forum chair is the training officer.

While there is extensive participation by production employees, and support from senior management, no members of line management currently serve on the committee. Much of the voluntary participation of production members is driven by personal exposure to AIDS-related illnesses and deaths among relatives and in their communities. There is also awareness that, given the sensitive and stigmatised nature of the disease, there is a need for the workforce to feel free and open to talk about HIV among themselves.

The initial aim of the forum was to facilitate awareness in the workforce through education and information on HIV/AIDS. The aims and objectives of the forum are:

- Decreasing the number of new HIV infections;
- Empowering the workforce, through education;
- Providing a non-discriminatory environment for employees infected with HIV/AIDS;
- Assisting employees who are terminally ill, and cannot afford necessities and medication;
- Extending into the community and its supplier base. (Kretschmer 2004)

An HIV/AIDS handbook – a reprint of a publication developed by Ford and the National Union of Metal Workers of South Africa (NUMSA) – was published in September 2001, and the contents are geared towards increasing knowledge and information on how the disease is contracted, preventive measures, and the basic rights of those infected with and affected by the disease. This handbook also includes a condensed one-page version of the Autoliv Southern Africa (Pty) Ltd HIV/AIDS policy as at 2001. The committee says that all employees were handed a copy at the time of publication.

The HIV/AIDS policy was established in 2001 (under the auspices of the former MD, and a revised version was produced in 2003 (under the auspices of the current MD). It contains the following components:

- A commitment to acknowledging the seriousness of the disease and committing resources to an intervention programme;
- A commitment to a non-discriminatory work environment, including employee rights, employee benefits, the application of ill-health retirement for those medically unfit;
- A commitment to job security for those medically fit to work with the proviso that different work standards will not be applied, irrespective of health status;
- An assurance of confidentiality of HIV/AIDS status;
- On-site provision of voluntary counselling and testing;
- The provision of an adequate budget (unspecified);
- A commitment to regular updates and review of policy in light of emerging information.

**Overview of the HIV/AIDS programme**

Since 2000, the company has conducted three annual HIV-prevalence surveys, which were voluntary and linked, and facilitated through an external consultant. The participation rates in all the surveys were very high. The programme over the last two years consisted of the following:

- Internal information and education programmes;
- Information on HIV/AIDS available at the onsite OH clinic;
- In-house training during working hours;

- Presentations by persons living with HIV and AIDS (PLWHA);
- AIDS awareness as part of induction training;
- Videos and training manuals;
- Two Open Days per year (including World Aids Day);
- Provision of male condoms;
- External training;
- Counselling skills for forum members/peer educators;
- Self-awareness training for the forum members;
- Supplier base support and information sessions;
- Treatment of opportunistic infections, where appropriate;
- Absenteeism management;
- Support for both infected and affected staff;
- An annual HIV/AIDS prevalence survey (by an external disease management company);
- Finger-prick blood test (November 2002);
- Saliva test (December 2003).

The initial objective of the programme was the extension of information and education to all staff members. Thus, the first Open Day included a presentation by a person living with HIV/AIDS.

There is a common view expressed by all respondents that the programme started off very enthusiastically, but that it has somehow lost ground. Members of the AZA Forum felt that the programme was becoming 'monotonous' and 'not alive, it's dying'. Management have recognised that interest may be waning. In 2003 the forum strategy was revised. The following table outlines a SWOT analysis, as reported by the MD, and reflects the views of the AZA Forum at the time.

*Table 3.6: Strengths, weaknesses, opportunities and threats for the AZA HIV/AIDS Programme*

Strengths	Weakness
A policy has been established	Networking capacity is limited
A certain level of awareness exists among the workforce	Participation is not as high as anticipated 'People don't see reality'
A track record has been established	The programme is not seen as exciting anymore
Opportunities	Threats
The scope of education	New infections
Networking	A lack of confidence in the forum
Reducing to zero infections	Discrimination of those infected Rejection of those infected A disabling environment Programme and interventions becoming stale and stagnant

*Source: Kretschmer (2004)*

However, at the time of the interviews in mid-2004, no HIV/AIDS-related programme activities had reportedly taken place since December 2003. There is a plan however, for another Open Day on a Saturday, which would be aimed at families, focusing on both production and HIV/AIDS issues.

Other concerns expressed by the committee members include the difficulty in getting forum members released during working time to attend forum meetings. The view was expressed that given the emphasis on 'work [production] first', it is difficult to get permission from line team leaders to release forum members. In turn, the operations director indicated that the activities of the forum had not had a discernible effect on production, as reported by his supervisors and team leaders, as 'very few people go there'. These differing interpretations suggest that clarity be sought regarding time off for forum members.

#### *Role of the occupational health (OH) facility*

Autoliv has an OH clinic on site, staffed by a part-time OH practitioner, who is also an OH consultant to a number of other companies. Before the retrenchments, the OH practitioner was employed full-time. The hours have since been reduced to Monday to Friday from 07h00 to 10h30. The main functions of the facility include the provision of occupational health (medical surveillance related to fumes [in the past], noise levels and glue, and the provision of primary healthcare. The OH clinic also facilitates the implementation of HIV/AIDS-related education and awareness programmes and provides counselling on a Monday for HIV/AIDS and other issues. Currently the main focus is on maintaining a wellness programme and providing annual medical examinations for all staff. Again, these two activities relate very well to the HIV/AIDS programme.

Information on HIV/AIDS is available in a reading room, which is available to all staff, and condoms are distributed as well. Symbolic rituals such as candle-lighting are also used as means to increase awareness of the importance of the disease.

#### *Costs of the HIV/AIDS programme and interventions*

The company has provided training to the forum members in order to facilitate their support of employees. Members have attended counselling skills training, as well as self-awareness training. The counselling training comprised of 14 sessions of on average 3 hours each. Half of the training was on company time, while the balance was in employees' own time. The self-awareness training took place in members' own time. It is clear that the issues of time off during production hours and the impact of HIV/AIDS interventions such as meetings are continuing to be sensitive.

The forum members indicated that in the past a budget was set aside. However, at the time of the interview, none of them had any idea of the size of the budget.

#### *Role of the trade union*

The National Union of Metalworkers of South Africa (NUMSA) is the recognised, representative union at AZA. Management reports that the union represents 41.5 per cent of the bargaining unit. The head shop steward, however, reports that the union represents 67 per cent of the bargaining unit. The difference may be due to the fact that the union only became the majority union in 2004. NUMSA reports that the union does not have separate meetings with management, but the Workers Representative Council (union and non-union representative and management) has monthly meetings. The union does not have any formal representation on the AIDS Forum, nor is it actively involved in the formulation of policy or implementation of the programme. However, the union representative expressed general satisfaction with the company's approach to the issue.

## Perceptions on the effectiveness of HIV/AIDS interventions

This section provides overviews of the responses derived from two focus group discussions among production (weekly or hourly paid) and administrative (monthly paid) employees.

### Focus group: Production employees

At this plant, employees were asked to volunteer for participation in the focus group discussion. On the day, eight production (hourly paid) employees attended. However, one of the supervisors came in, saying 'we are losing money' and requested that two of the employees return to the production line. Apparently stock deliveries were delayed due to an absenteeism problem on that day. The two employees were then replaced by one female employee. The focus group discussion lasted for approximately one hour. Discussions started off rather slowly, but later on responses improved and participation was lively and interesting. The length of years of service among participants ranged between nine months and 17 years at Autoliv.

#### *Knowledge and understanding of the impact of disease on the company*

Participants were not very open to sharing their perceptions of the impact of HIV/AIDS on the company. All were uncomfortable with answering questions. However, when asked to share their knowledge of the HIV/AIDS programmes, responses were more forthcoming.

#### *Knowledge and awareness of the policy/committee*

None of the group members indicated that they were aware of the company policy, and were generally vague about the policy. None of them appeared to know about the handbook published by the company when it was shown to them. However, all of the group members were aware of the existence of the HIV/AIDS committee and its representatives. People said that the reason they knew about the HIV/AIDS Committee was because representatives were usually called to meetings over the public intercom.

#### *Factors driving participation in HIV/AIDS programme*

Group members displayed some knowledge of some aspects of the HIV/AIDS programme. Some activities mentioned included the information and awareness sessions, especially the Open Days. Other activities include the request by the company for donations to support those living with HIV, candle lighting at the OH clinic for those infected and a talk by an HIV-positive person. All of those present indicated that they have participated in the company programmes.

The group was unanimous that the talk and visit by an HIV-positive person was most effective in influencing their perceptions and behaviours regarding HIV/AIDS. This confirmed to them that 'HIV/AIDS is real and not a myth'.

The scheduling of voluntary counselling and testing (VCT) services influenced participation. Employees felt that the VCT facility was targeted mainly at day-shift employees. Because the OH clinic only operates during the day, those on night shift had to wait until their shift changed before they could use it.

Condoms (male) are available at the OH clinic. Employees felt that distribution was not sufficiently widespread, as access to condoms depended on going to the clinic, which most employees did not do regularly. However, people raised the fact that they feel condoms are misused, for example, 'people steal condoms...they take the whole box... same problem with toilet rolls'. Employees felt that distribution was limited because of this misuse. A related issue is the limited opening hours of the clinic – 07h00 to 10h30.

Production employees indicated that they generally do not go to the clinic, and complained that the clinic sister was not licensed to dispense medicine (at the time of writing). However, some people said that they preferred to buy condoms themselves and others said that they were happily married and did not need condoms.

All participants said that they are aware that HIV/AIDS-related treatment is available or procured through the OH nurse. However, they also felt that stigma prevents infected people from asking for treatment. This stigma extends to non-HIV/AIDS-related treatments or supplements. The group said that if a person asks to buy E-Pap (a nutritional supplement with immune-boosting properties, used generically as well as for HIV/AIDS) or is seen with E-Pap, this is immediately regarded as a sign that that person is HIV-positive. The group also said that since there is still not sufficient openness 'it is difficult to be open about the disease in this company'. However, the group also felt that only by coming together and supporting one another could this be overcome, because anyone could be affected.

The entire group participated in the company HIV-prevalence survey in 2003, conducted by an external company that used anonymous, linked saliva testing. While all participated, only four of the seven participants went to fetch their results. Those who did not fetch their results cited a 'lack of privacy' and possible leakages of confidential information as the reason. Most indicated that they preferred to get their results from external/outside organisations.

It is clear that the group believe that HIV/AIDS is serious and 'AIDS can kill', as they have seen the effects on people who are HIV-positive in their communities. They see this experience as the driving force behind changes in their own attitudes and behaviour around HIV/AIDS.

#### *Confidentiality and openness about HIV/AIDS*

Members of the AIDS Forum raised the issue that some employees lack confidence in the OH nurse's ability to keep information about an individual's health status confidential. The forum took up an incident around an employee's TB status with line supervisors and employee representatives. However, the OH nurse denied that she had been responsible for any leakage of private information. There were reports that team leaders and co-employees refused to work with someone who was diagnosed with TB, and the person was shifted around. This only stopped when a memorandum preventing this was sent out. However, people felt that after exposure to an HIV-positive person this type of behaviour might have declined.

#### *Perceptions of the role of the trade union*

The group expressed mixed feelings on the role and involvement of the trade union in HIV/AIDS at the company. It was generally felt that, while the union does support the HIV/AIDS programme, the support was not enough. Comments included '[we] have the union, but they never organise meetings – we do not go to meetings'. It was also felt that HIV/AIDS was not an issue raised or discussed by the union. While a union official will focus on the outcomes of wage negotiations, they do not raise the issue of HIV/AIDS.

#### *Perceptions of the role of management*

Participants said that although management were obviously having meetings around HIV/AIDS issues, information from these meetings did not reach employees. Employees also felt that management were failing to invest money in the HIV/AIDS programme. These views appeared to relate to the period immediately before the interviews because there had been so few activities since December 2003.

*Suggestions for improvements in policy and programme*

Participants were concerned that since December 2003, the HIV/AIDS programmes had come to a standstill; there was no information and no organised events. Participants felt that while the programme started off well, activity had died down. The group felt that management and employees needed to make time to sit together and talk. The perception at that time was that there is a distance between management and employees in their approach to handling HIV/AIDS at work.

**Focus group: Administrative employees**

Three women and four men participated in this focus group. The length of work experience ranged from two months to 23 years, providing a wide range of company experience.

*Knowledge and understanding of the impact of the disease on the company*

The group reported that the company provided information on the impact of HIV/AIDS at its quarterly meetings.

*Knowledge and awareness of the policy/committee*

This group did not know about the HIV/AIDS handbook published by the company, nor were they aware of the contents of the company policy. One person knew that the company is in the process of formulating changes to the policy, but this also seemed to be speculative. However, employees did indicate that they know that they have particular rights, particularly non-discrimination against those with HIV. However, all claimed that they have not seen anything about HIV/AIDS on the workplace notice boards.

However, the group did say that the AIDS forum could serve as a model of best practice for other companies, because it had apparently received requests for advice from other companies: 'apparently other companies are learning from us...think we are good', one employee commented. Employees were aware that one function of the forum was to 'conscientise people about AIDS, and stigma'.

*Participation in HIV/AIDS programmes*

The group were generally aware of aspects of the HIV/AIDS programme. Some quoted the information sessions with PLWHA, information sessions including various suppliers, the Open Days, the collection of food, soap and other donations by the AIDS Forum for those living with the disease, and the two HIV-prevalence surveys. Most have participated in the Open Days, and one has participated in an induction session for new employees.

Condoms are known to be available at the OH clinic and at the clinic. However, the group expressed concerns about access and availability of condoms at these sites. Firstly, no female condoms were available. Then, while most workers said that they use the OH clinic, they felt that there was insufficient HIV/AIDS-related information available, and that the limited opening hours of the clinic limited access to condoms. Further, while condoms and more information were available at the training centre, most of the group could not say when they had last been to the training centre, nor did they have any reason to go there. It seems then that more use can be made of the training centre; 'people only go there when they want something or are attending training'. Access to the training centre is not casual, and may restrict how often employees have access to condoms. The group said that condoms should be made available in more places, including the canteen and the change rooms.

*Factors driving participation in specific programmes/interventions*

The group regarded participation in the HIV-prevalence survey as voluntary. However, while the entire group participated, only three out of the seven workers asked for, and received, their results. Some said that they received their results over the telephone, apparently through the external disease management company.

The group were also very affected by the presentation by an HIV-positive person. Some expressed shock at seeing this person at an advanced stage of the disease, while others commented that 'there are other people who look fine, but they have AIDS'.

*Perceptions on confidentiality*

It is widely perceived that a person's HIV/AIDS status is not confidential in the company. Rumours and gossip about a person's HIV status persist among employees. There is a culture of mistrust, mainly towards the OH nurse. The group could not clarify what the source of this mistrust was. Some said that they do not believe that there have been disclosures of individuals' status in the company.

**Summary of strengths and weaknesses****Strengths**

1. Recognition of the role of the supplier network in HIV/AIDS risk reduction and the need to involve them in AIDS awareness and networking programmes.
2. HIV/AIDS awareness and education is part of the induction programme of new employees.

**Weaknesses**

1. A lack of line management involvement.
2. Difficulties in keeping the momentum of the programme going. Between December 2003 and the holding of interviews (end of July 2004) no activities had taken place.
3. Workers have no clear knowledge of the company HIV/AIDS policy and their rights.

**Lessons learned**

There are a number of elements of the Autoliv case study that are instructive:

The company has conducted regular HIV-prevalence surveys (despite being a medium-sized company), which has allowed it to track the development of the disease. This allows the company to make conclusions about the effect of their HIV/AIDS interventions in reducing the level of infections.

The employee-driven HIV/AIDS committee, with senior management support, has been a driving force behind the programme. This is in spite of the fact that it is currently going through a difficult period and needs to become sustainable and find resources and information by itself.

The company is conscious of HIV-risk factors, including workforce stability, lifestyle, community-related factors and demographic profile. This allows them to better focus their intervention programme.

The company is unique (compared to other participating companies) in that its supplier networks are integrated through the distribution of information and increased awareness on HIV/AIDS.

This particular case study highlights the extent to which empirical data can confirm or reject results generated by a projection model. In this case, although the age, education and demographic profile of employees reflect a high-risk group, HIV prevalence (among those tested) was not high. This extends our understanding of how the various risk factors may interact with one another.

### **Main contributors**

Interviews were held with the following groups and individuals:

- Managing director
- Operations director
- OH nurse
- HIV/AIDS committee
- Trade union: chairperson of the NUMSA shop stewards' committee
- Focus groups (two): production employees; administration employees.



## Case study 2: Osborn Engineered Products SA (Pty) Ltd

Joceleyn Vass

### Introduction

Osborn Engineered Products (Pty) Ltd is the South African subsidiary of the US based Astec Industries Inc. group. Based in Gauteng, Osborn SA is a medium-sized company, employing about 220 employees. It manufactures heavy equipment for the mining and construction industries, with significant shares in the markets for crushers, feeders, screens and conveyors. The head office and manufacturing site is at Elandsfontein, Gauteng, and the distribution network has sales branches in Cape Town, Richards Bay, Durban, Witbank and Welkom.

### History of the company

Osborn was established in 1919, as Samuel Osborn. At that time, the company was a subsidiary of a steel company based in Sheffield, England, promoting steel products for South African industry and mining.

In the early 1980s, the company became Osborn Boart Longyear (Table 4.1), in the Anglo American stable. This, the company argues, integrated the financial and training expertise at an Anglo level. In 2000, Astec Inc., a US based multinational, bought a 90 per cent majority share in Osborn. The company argues that foreign ownership has facilitated the transfers of skills and knowledge, and management expertise as well as technology transfers. On the whole though, the company operates relatively independently from their foreign owners and this is reflected in their approach to HIV/AIDS.

*Table 4.1: Changes in ownership at Osborn Engineered Products (1919–2003)*

Year	Milestone/s
1919	Samuel Osborn subsidiary
1982	Osborn Boart Longyear
2000	Astec Inc. acquires 90 % share in Osborn

The product profile of the company is dominated by the manufacturing of crushing equipment (60 per cent), followed by feed and screening equipment (25 per cent) and conveying equipment (15 per cent). Table 4.2 provides an overview of trends in broad economic indicators. Top management indicates that annual gross sales have remained fairly flat over the past five years, a result in part of the strength of the local currency as well as imports from Europe.

Table 4.2: Major trends in economic performance by Osborn Engineered Products (1999–2003)

	1999	End of 2003
Employees	Not provided	220
Gross sales (Rand)	Approx. R180 million p.a.	R180 million p.a.
Major product markets/ customers	Not provided	Mining and quarrying (80%)
Trends in export markets	Not provided	Exports (20%)

While the export component has been averaging about 15 per cent per annum, some declines are likely. The company describes itself as both labour and capital intensive. However, equipment is relatively old, and replacement possibilities are limited, given the significant cost involved. In this sense, therefore, maintaining equipment is highly dependent on keeping a pool of skilled technicians and artisans, an area that will be explored later. Input industries, such as steel and the foundries, have a significant impact on the competitiveness of the company. The price dollar parity system in input materials is identified as a problem. The company relies upon the input of Steel and Engineering Industries Federation of South Africa (SEIFSA) for this issue, but does not see itself as having any say in the matter. Senior management cites government policy on skills development as an advantage, leading to improvement in productivity and quality and extending the productive use of employees, as well as meeting health and safety requirements.

### **The role of the trade union**

Osborn has two recognised trade unions, Solidarity and NUMSA, who respectively represent 8 per cent and 23 per cent of the relevant bargaining units. The period of recognition is over the last two years. The company is part of the Metal and Engineering Bargaining Council, which sets employment standards across the industry.

### **HIV/AIDS risk profile**

This section provides an analysis of the relative risk exposure to HIV/AIDS that Osborn faces. The section provides an overview of available HIV-prevalence statistics, and the demographic and skills profile. This is followed by an overview of related factors such as social capital or community-related factors, as well as organisational risk factors that emerged in interviews with employees and management. It also highlights perceived and observed risks and vulnerability to HIV/AIDS, as reported to the research team.

### **HIV/AIDS statistics**

In the 12-month period from September 2003 to August 2004, 75 employees underwent VCT, and another nine were tested for HIV through a disease management company. Of those tested, seven were found to be HIV-positive, suggesting an infection rate of eight per cent among those tested. This does not necessarily reflect the average rate within the workforce, as only a third of the workforce was tested. One of the main concerns expressed by AIDS Forum members is the very low take-up rate of VCT. Just over a third of all employees have taken up the offer of testing either on-site or off-site, with testing in both cases conducted by health practitioners from an external disease management company. Of the seven found to be positive, three are currently on antiretroviral therapy.

The company had not considered doing an HIV-prevalence survey. Some concerns were expressed – given that results from company-based HIV-prevalence surveys conducted in the East Rand industrial area indicated that HIV prevalence in surrounding companies stands at roughly 15 per cent – that the estimate at Osborn may be grossly underestimated. The following section provides an overview of the workforce profile as well as other factors that may contribute to the relative level of susceptibility and vulnerability of the company.

### *Workforce profile*

The workforce profile is presented in terms of its demographic characteristics (age, sex and race) as well as skills and other related factors. The section analyses the relationship between these characteristics and the general HIV-risk factors.

Osborn employs between 191 and 220 permanent employees. Sixty per cent of the workforce is white, followed by Africans at 36 per cent (see Table 4.3). Men constitute 84 per cent of the workforce and most of the few women that are employed are white.

*Table 4.3: Workforce by age groups, population group and sex (end of 2003)*

	African		Coloured		Indian/Asian		White	
	Men	Women	Men	Women	Men	Women	Men	Women
20–29 years	7	0	0	0	0	2	6	2
30–39 years	17	0	0	0	0	0	14	9
40–49 years	19	1	1	3	1	0	34	6
50–65 years	24	0	0	0	2	0	37	6
Total	67	1	1	3	3	2	91	23

The male workforce is ageing; 72.7 per cent of the male workforce are 40 years and above, with 39 percent of these aged 50 to 65 years. Less than a third of the male workforce is younger than 40 years. In summary, then, the workforce is chiefly made up of white men aged 40 years and older. This may explain the low take-up rate of VCT because white men do not usually see themselves as being at high risk of HIV. The perception still persists that HIV/AIDS is a predominantly black disease. At the same time, African men within the company have a similar age distribution to that of the white men, and so may also not see themselves as at risk. However, research indicates that the infection rates among men start to increase in older age categories, whereas women tend to be infected at a younger age. This is because of the importance of cross-generational sex between younger women and older men.

### *Skills profile*

Table 4.4 shows that Osborn is a relatively skill-intensive company, as slightly more than half (54.9 per cent) of employees are skilled, and 20.9 per cent are highly skilled. White men are assumed to be the majority of the highly skilled and skilled employees. Furthermore, as in most other companies, training and investment in craft and trade-

related skills would historically have been geared towards white men (prior to the advent of democracy in 1994).

However, shifts have taken place at Osborn, as African men constitute just less than 50 per cent of the skilled workforce. The company is attempting to engage black apprentices and provide training to upgrade the skills of African workers. It may be assumed that most of the semi-skilled employees are African, and that white women occupy most of the administrative positions. However, semi-skilled employees constitute a small proportion of the workforce. The racial and gender distribution of the workforce is reflected indirectly in the skills profile of the company.

*Table 4.4: Workforce by age group, skills category and sex (end of 2003)*

	Highly Skilled		Skilled		Semi-skilled		Unskilled	
	Men	Women	Men	Women	Men	Women	Men	Women
20–29 years	0	0	13	4	0	0	0	0
30–39 years	1	0	17	9	10	0	3	0
40–49 years	22	4	18	4	11	0	5	1
50–65 years	12	1	35	5	8	0	8	0
TOTAL	35	5	83	22	29	0	16	1

*Occupational category code list*

*Highly skilled: managers, professionals, directors, engineers, nurses etc.*

*Skilled: technicians and associated professionals, crafts- and trades-people*

*Semi-skilled workers: service, administrative and clerical employees, operators*

*Unskilled workers: labourers, cleaners, elementary occupations*

The average length of continuous service among the workforce is approximately 15 years. Staff turnover is not high, resulting in a relatively stable workforce. The company has a cumulative pool of skills and experience, and any significant losses will have an adverse impact. The age distribution of skills in Table 4.4 points towards potential vulnerability in skills replacement needs. Forty two per cent of the skilled men are in the 50-65 year age cohort and are likely to retire soon.

The company currently employs six apprentices. It anticipates that as the impact of HIV/AIDS starts to be felt, the replacement rate will increase. The company already, in certain instances, needs to employ more than one person to cover for absenteeism. Management respondents said that absenteeism remains high, but at the moment it is linked more to a culture where sections of the workforce tend to take their entire sick leave allotment. So, sickness-related absenteeism is apparently high, but the perception at the moment is that this is not necessarily related to HIV/AIDS.

#### *Changes in employment status*

One of the major factors driving changes in the workforce profile in the last five years has been the demand for skilled labour, in response to new competitive demands. This has

led to the use of subcontracted labour from labour brokers. These contractors tend to be skilled artisans and operators. Subcontracted labour constitutes about 20 per cent of the workforce. Most are employed through labour brokers on rollover contracts, renewable every 12 months. Some are employed on a limited duration contract, renewable every four months. Consequently, there is substantial reliance on fairly long-term contract labour. Some of these subcontractors have been with the company for lengthy periods – some up to 10 years – and are recalled regularly, depending upon the workload.

### **Social capital issues contributing to HIV risk/vulnerability**

Osborn employees come from the surrounding East Rand communities, and are regarded as coming from stable families. Most employees are married. No major social problems are reported, reflected in the fact that the average length of continuous service is 15 years and most workers are 40 years and older. Employees tend to work overtime, and this is regarded as a positive factor, in that they would not have ‘...time to do anything otherwise’.

The company stopped the housing assistance programme in 1997. Most of the African employees stay in informal settlements or in the old council township houses and are gradually moving into Reconstruction and Development Programme (RDP) housing.

#### *Perceptions of risk*

Responses from management indicate that contractors are regarded as low-risk because their presence is temporary, their involvement in the company depending on differing requirements. At times there are between 40 and 50 contractors, although generally the contractor population is small. Most stay for periods ranging from three to six months although some may stay for extended periods. The company is hesitant to put them on the VCT programme.

Management report difficulties in getting a larger proportion of the permanent workforce to participate in VCT. The unions, specifically NUMSA, have not participated. The perception is that most of those not taking up VCT are African employees.

In general, the workforce is regarded as healthy, going by the reports that emerge from their regular attendance at the OH clinic. Few cases of sexually transmitted infections have been reported, generally regarded as an indicator of HIV susceptibility. Nutritional levels are reportedly high, and annual medical examinations apparently indicate stable weight levels, also an indicator of overall good health levels and habits.

#### *Organisational risk factors*

The company reports the increased use of labour brokers who provide labour on a flexible basis. This reduces the company’s liability for costs of retrenchments. However, subcontracted employees tend to be employed for extensive periods (in one case, up to ten years). Because the bargaining council now regulates the conditions of employees of labour brokers, the company feels that levels of exploitation should be minimal.

### **The impact on production**

Thus far there has been no discernible impact of HIV/AIDS on production at Osborn. No AIDS-related deaths have been reported, although a few AIDS-related deaths of relatives have been reported. The company reports ‘fairly high absenteeism’, but this is clearly not monitored against the impact of HIV/AIDS.

There is a feeling that there is a 'great reluctance among black artisans and casuals' to know their status. The impact of HIV/AIDS on skilled employees is obviously an issue of concern. This is particularly so given the cost of skilled labour, the overwhelming bias in the skills profile towards skilled artisans, and the need to meet equity requirements in employing more black skilled workers. The company employs contractors (artisans and operators) from labour brokers. This practice seems to relate to a number of factors: levels of absenteeism, workload requirements and a buffer against future potential retrenchments in case of restructuring. This also potentially supplies a back-up pool of skilled employees to draw upon, in anticipation of the potential impact of HIV/AIDS.

It is clear that management believes that the HIV-infection rate is likely to be higher than that recorded in their prevalence survey, given the higher rate in surrounding areas and the low take-up rate of VCT among the workforce. Artisans are multi-skilled and able to work flexibly across vastly different machines and their skills are valued highly. It is this flexibility that worries management, as replacement would be expensive and require additional investments in training. Losses in organisational culture and work ethic could also be substantial. The unions believe that not enough artisans are being trained. Some describe the organisational culture as relaxed, to which the low labour turnover rate in the company is attributed, at least in part.

## **HIV/AIDS policy and programme**

This section provides an overview of the history and development of the HIV/AIDS policy and programme at Osborn.

### **Policy development process**

The HIV/AIDS policy sets the overall framework, within which programmes are developed. Osborn management developed this policy not specifically in response to HIV/AIDS issues within their own company, but after a director had read an article in *Time* magazine 18 months previously about the general impact of AIDS. Increased media cover, including that by prominent businessmen such as Clem Sunter, also played a role. In 2000, when Osborn was taken over by Astec Inc., HIV/AIDS was still not regarded as a strategic issue by either local or foreign management.

In May 2002, the HR director, the finance manager and the OH sister drew up a broad policy statement on HIV/AIDS. At this stage, neither of the two unions was involved in this process. The company was in a dispute with NUMSA and this is probably at least part of the reason for their non-participation. Union respondents interviewed indicated that neither union has seen a written copy of the current HIV/AIDS policy, although they are aware of the main provisions and objectives. However, both unions have representatives on the company AIDS Forum, a voluntary body of individuals given the task of implementing and promoting the HIV/AIDS programme. Management indicates that they solicited opinions on the policy from unions at the first AIDS Forum meeting.

The current policy has not been reviewed since 2002, although changes have occurred in the interim period. These include the provision of VCT, the launch of the medical management programme, including nutritional support, and provision of antiretroviral treatment (ART). A written brief to this effect has been issued. Minutes of the AIDS Forum meetings are distributed and issued on company notice boards.

### Components of the HIV/AIDS programme

The company contracted an external disease management company to conduct the programme, in order to ensure confidentiality and buy-in. Programme elements include:

- an education and awareness programme;
- a drive to 'know your status' that includes a VCT service, with on- or off-site testing paid for by the company.

Reportedly, the VCT programme was well supported at the start, but support has been declining. Between September 2003 and August 2004, 75 tested on-site and 9 off-site at the disease management company. Others report that they have had tests through their life insurance companies. The lack of support for the VCT programme is regarded as so serious that the company has even considered providing a self-test programme using which employees would be able to test themselves. However, this idea has been shelved for practical and ethical reasons. Given that the company has not been receiving bills for off-site testing, clearly employees are not taking up the opportunity to have off-site tests paid for by the company. Other efforts to improve the participation in VCT included:

- An incentives programme to encourage employees to be tested, involving a voucher system and chocolates;
- Male nurses conducting VCT sessions after complaints that female nurses may be inhibiting a predominantly male workforce (the response rate remained poor, however);
- An industrial theatre production was considered, but no budget had yet been allocated;
- A peer educator programme (there are currently 17 trained peer educators);
- An HIV/AIDS Forum consisting of volunteers from all sections of the workforce;
- The provision of a nutritional support and antiretroviral programme, facilitated by the external disease management company, paid for by the company, including those employees not belonging to a medical aid. The antiretroviral programme also includes the spouse, who can access their medicine at the company or have it delivered elsewhere. Those who are on antiretroviral treatment (three out of seven infected employees) have the option of having the medication delivered in an unmarked box.

The extension of the disease management programme to include providing antiretroviral treatment to the spouses of infected employees is in response to what was described as 'havoc in the community', referring to the problems in the implementation of the government roll-out programme.

The HIV/AIDS programme extends to the contractors, but not beyond the provision of VCT. Reportedly, a small proportion of these workers have been tested. Extension of full services to contractors would be costly, as they represent at least 20 per cent of the workforce. Contractors are not covered through the company medical aid, and the company argues that it checks that contractors' conditions of employment and these are in line with the bargaining council agreement with the labour brokers.

The company has not considered conducting a cost impact analysis yet, either in terms of the overall risk posed or in terms of increased direct and indirect costs. This may largely be because, so far, costs have not been prohibitive. However, as the disease becomes entrenched, costs related to treatment may become an issue.

### **The role of the occupational health (OH) clinic**

The company employs a full-time OH sister from 07h30 to 15h45 seven days a week. She has been with the company 16 years, and so has a very good understanding of the health dynamics of the workforce. The clinic services include primary healthcare, OH services, health education and awareness and processing injury-related claims for the compensation commissioner. A doctor attends once a week for an hour.

The clinic is reportedly well attended with several repeat attendees. The sister has a dispensing license and has moreover received training on HIV/AIDS through the external disease management company. The VCT programme is run through the OH clinic in conjunction with the external disease management company. The latter provides the test kit, which is administered by the sister. Information recorded includes age and sex. When a person tests positive for HIV, this information is sent to the external company, which then follows up options with the infected person. Of the seven people who have tested positive, six went through the on-site process, and one went to the external company.

### **Perceptions of the trade unions**

Solidarity and NUMSA are the main organising trade unions. When asked to provide their members' perspectives on HIV testing the responses were very different and suggested divergent perspectives. Solidarity (mainly white artisans) felt that their members would wish to know their status in order to plan ahead for both themselves and the company. Most would not have difficulties going to the on-site OH clinic to have the sister conduct the test. Further, there is a clear concurrence with the view of management (and therefore the company) that knowledge of status can allow the company to plan ahead. NUMSA shop stewards felt that their members' perceptions were 'what's the point?', the 'sister can't give you treatment'.

### **Perceptions of the effectiveness of the workplace policy and programme**

This section provides overviews of the responses derived from focus group discussions among production (weekly or hourly paid) and administrative (monthly paid) employees.

#### **Focus group: Production employees**

This focus group consisted of eight manufacturing staff members. They were randomly selected from a list of staff members who are currently part of the full-time staff.

#### *Awareness of company policy*

Participants were aware of the existence of the company policy on HIV/AIDS and knew about peer educators, information and communication through weekly briefings, and pamphlet distribution. They also knew of the AIDS Forum, which meets once a month, and provides feedback to workers through worker representatives and noticeboards. There is condom distribution in the clinic; participants thought that condoms should also be available in the toilets and shower room because the clinic opens between 7am and 1pm and this is the only time they can collect condoms. Participants also knew that they could go to the clinic for testing. All except one participant knew their status. One person felt that the company is forcing them to test by continuously reminding them, especially those who have not gone for VCT.

*Understanding confidentiality*

Even though there was an assurance of confidentiality of HIV status, participants were concerned that testing at the on-site clinic would result in a lack of confidentiality. Thus, they referred to the fact that the sister would be aware of the results and the antiretroviral account would reflect an employee's name. For the participants, this meant that the company would eventually know about an individuals' status. Participants were suspicious that confidentiality would not be 100 per cent. There were also concerns about the procedures followed by the external disease management company, namely, that the medication would be sent by post, that it would contain the individual's name and that the clinic sister would know the contents. Others felt that people trusted that the company would help them if they were positive. Other participants felt that HIV/AIDS is a sickness like any other and that there was no reason not to seek help from the sister. One of the participants said that he was not ready to be tested at all given his background and lifestyle. Those who did not go for testing at the company sponsored on-site clinic or at the off-site disease management company went for outside private testing. Some of those who did not go for testing felt that they would not be able to handle a positive result.

**Focus group: Administrative employees**

Participants in the focus group had 7 to 22 years of service with the company. They were randomly selected from a list of staff members who were currently part of the full-time staff. The group covered support functions such as finance, administration and information technology (IT).

*Awareness of the HIV/AIDS policy and programme*

Most participants said that they know that the company has an HIV/AIDS policy, but no one had actually seen it.

The company started its HIV/AIDS activities when they approached the external disease management company, which trained peer councillors, organised seminars and VCT. The company has a weekly brief around HIV/AIDS and an OH clinic. Internal safety meetings also look at HIV/AIDS. There is condom distribution at the clinic. There was an impression that although information was readily available on HIV/AIDS, people did not necessarily understand it well. Only some employees have been tested. Half the people have had testing internally because they said they felt much more comfortable with the sister and the clinic was easily accessible. Two people went outside for testing for life insurance, for which testing was compulsory, but said that they would use the clinic next time around. One of the people who were tested outside did so because he wanted 100 per cent confidentiality. Another said that he did not feel the need to be tested at all because he trusted his wife. The company had invited a person living with HIV/AIDS to talk to employees. One person said that even after this he still would have to see a person ill with AIDS to be convinced about going for testing.

Participants said that some employees generally felt there was no need to be tested because of their lifestyle, which they regard as 'good'. Further, some associate testing for HIV status with a 'loose lifestyle', showing ignorance of the range of risk factors for HIV infection. Also, testing has been stigmatised, because it is assumed that those who go for testing have a 'bad lifestyle'. The company had used various incentives to encourage testing, including chocolates, and more recently, chickens. Participants felt that, paradoxically, it was the 'secrecy around testing that scared them from testing'. So, while they regard confidentiality as important to protect people from stigma and discrimination,

the secrecy also makes people concerned. Participants thought that the company was urging them to test, in order to protect its 'HR investment', to 'cut future costs' and as part of its social responsibility.

### *Education and awareness*

Information about HIV/AIDS is communicated to employees through seminars, notice-boards and photographs on notice-boards. Participants felt that information seminars did not reach everyone because they do not take place often enough. For example, there were only two information sessions in 2003. The seminars do reach participants, but people are still not going for testing. One person said that he attended the briefing because the company had insisted. The company has 12 counsellors or peer educators, but it seemed that participants did not understand their role, or who they were, and no one had used them.

### *The role of government in HIV/AIDS*

Participants expressed concerns about the role of the government, which they regarded 'as part of the problem' because of 'confusing messages' about HIV/AIDS. They also acknowledged that there are leaders or politicians who have been straightforward about HIV/AIDS. However, special mention was made of the Minister of Health's message about the side effects of antiretroviral treatment and the impression that such treatment is '...not good'. Some feel that this has contributed to some employees regarding testing as unimportant. Participants felt that the company's message to test to establish their HIV status, in order to take the appropriate treatment and prolong their lives, is not convincing, as it contradicts messages sent by government. The stigma around HIV/AIDS was identified as another impediment to people being tested.

## **Lessons learned**

There are a number of factors that are instructive from this case study. Employee participation is highly valued, as illustrated by the HIV/AIDS Forum and the peer counsellor system. However, implementation of the peer education system has not been monitored, and the extent to which this has had an impact on employee attitudes is not clear. Although the trade unions are formally involved in the HIV/AIDS Forum, it appears that the participation in policy development by trade unions (especially NUMSA) was obstructed by an unresolved dispute. Employee participation in HIV/AIDS awareness activities does not seem to be sufficient to ensure that they will find out their HIV status. This may partly be ascribed to the fact there is a difference between the company's reasons for wanting employees to know their status and the employees' individual reasons for being tested. Business and personal reasons for knowing HIV status do not coincide. Employees feel that the company's efforts are an imposition and do not motivate employees to be tested. This may partly explain the low take-up of the VCT service.

The demographic profile may also play a role in the disparities in attitudes to being tested. HIV/AIDS prevalence statistics suggest that the white population is low-risk relative to Africans. White employees may regard themselves as at low risk of HIV infection, and there is a predominance of white employees in the company. On the other hand, African workers may be reacting to the public perception that AIDS is a black disease and therefore resist being tested. The company may be inadvertently undermining their own efforts to improve testing rates by believing that there should be a higher infection rate among employees (as in the surrounding East Rand companies) without any other evidence to the contrary. They have not conducted a risk analysis to establish the

impact on the labour force, the potential costs and the broader impact on their business. They have also not conducted a general sero-prevalence survey, which would provide baseline information on the company HIV status. However, the company has taken all the formal steps to implement an extensive programme, yet this has not necessarily been successful. The programme is also unique (compared to other companies in the study) in that it extends antiretroviral treatment to spouses of infected employees, and covers the costs of all those requiring the treatment.

### **Main contributors**

Interviews were held with the following groups and individuals:

- Managing director
- HR director
- IR and training manager
- Operations director
- OH nurse
- HIV/AIDS Forum and peer counsellors
- Trade unions: NUMSA and Solidarity
- Focus groups (two): production employees; administration employees.



# Case study 3: BIC South Africa (Pty) Ltd

Jocelyn Vass

### Introduction

BIC South Africa is a medium-sized company, in the stationery and office equipment sector, with a labour force of approximately 250 employees. The head office is in Gauteng. Until recently, BIC France had a majority shareholding, with the minority share held by the current Managing Director (at the time of the research). Subsequent to the research BIC France acquired majority shareholding. Before then, BIC SA was run largely as a South African initiative. The MD (at the time of the research) who had been with the company for 40 years, described BIC SA as a 'paternalistic' business where the employees were regarded as 'extended family'. It was anticipated that this organisational culture might experience some changes with the takeover by BIC France. Already, an increased involvement in the company, including visits to the plant, has become evident.

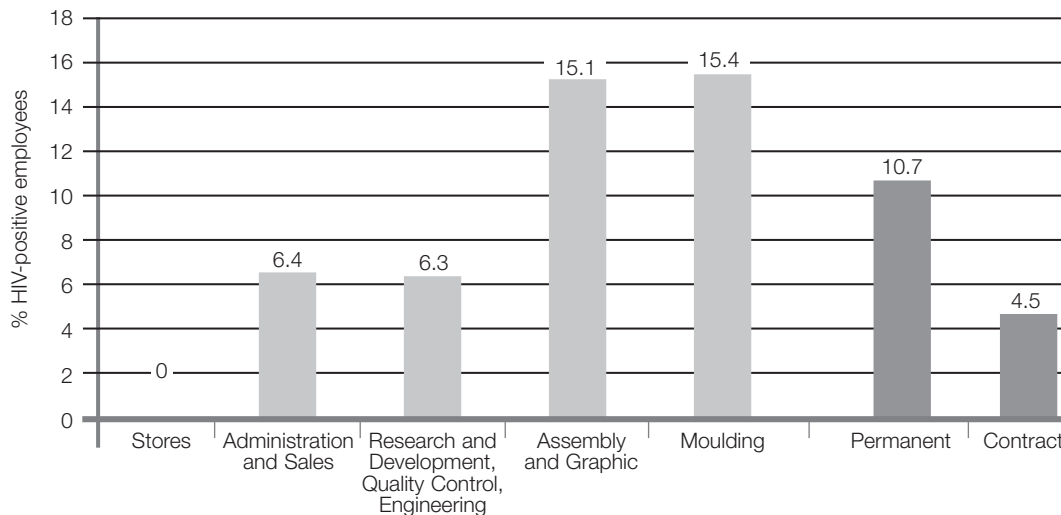
### HIV/AIDS risk profile

This section provides an analysis of the relative exposure to HIV/AIDS risk and vulnerability faced by BIC. An overview of available HIV prevalence statistics as well as the demographic and skills profile are provided. This is followed by an overview of related social capital or community-related factors, organisational risk factors, and the impact on production revealed by interviews with employees and management. Finally, the study highlights perceived and observed risks and vulnerability of the company to HIV/AIDS.

### HIV/AIDS statistics

BIC conducted a voluntary, anonymous and unlinked HIV-prevalence survey in February 2002 among both permanent and contract employees. The objectives of the survey were to determine HIV prevalence within departments as well as age- and gender-specific HIV prevalence across the company. The survey participation rate was very high: 84 per cent of total permanent employees. The participation rate among contract employees was not known, as the number of contract employees present on the day was not known. The findings indicated that the average HIV-prevalence rate at BIC was 10.1 per cent, made up of 10.7 per cent among permanent employees and 4.5 per cent among contract employees (Figure 5.1). This shows that BIC SA has a significant epidemic among permanent employees. However, these results are still lower than the average HIV-prevalence rate of 15.6 per cent for people aged 15 to 49 years, found in the Nelson Mandela Foundation/HSRC national household sero-prevalence study conducted in 2002.

Figure 5.1: HIV prevalence at BIC SA by department and employment status (February 2002) (n=227)



Source: Evian (2002)

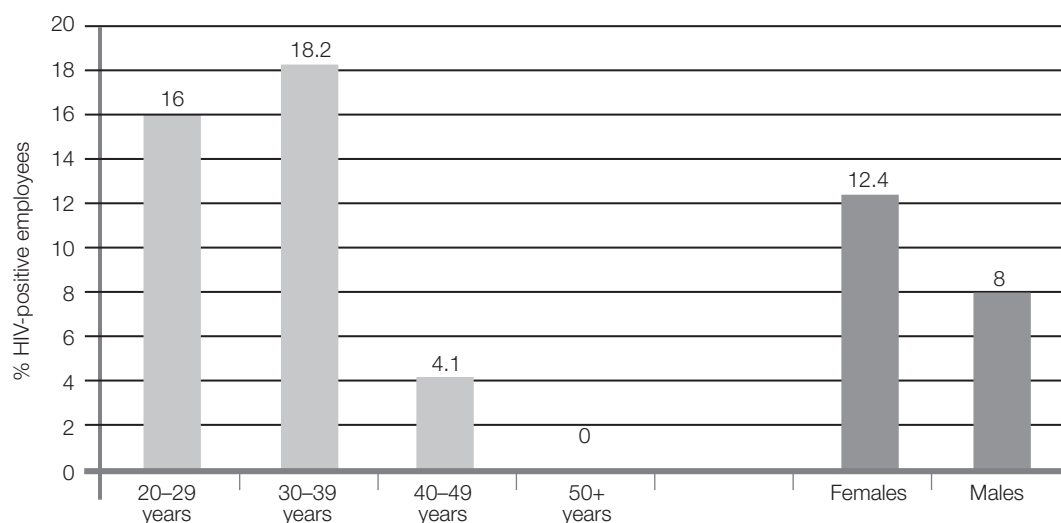
The results for departmental HIV prevalence were treated with caution, as there were indications that some participants might have recorded their departments incorrectly. However, it appears that the Moulding section had the highest HIV-prevalence rate (15.4 per cent), followed by Assembly and Graphics at 15.1 per cent. Research and Development, Quality Control, and Engineering recorded 6.3 per cent prevalence and Administration and Sales 6.4 per cent, whereas Stores recorded 0 per cent. The latter had a very low participation rate and it was felt that this might be a department that was recorded incorrectly.

The highest percentage of HIV-positive employees were in the age category 30-39 years (Figure 2), followed closely by those aged 20-29 years. The most susceptible age category is younger employees in the age range 20-39 years. This is in line with the age distribution of HIV prevalence among economically active adults in the national population. More worrying is the finding by the Medical Research Council that in the period between 1985 and 2000, the mortality rate doubled among those aged 30 to 39 years (Dorrington et al. 2001: 5-6), which is ascribed to the effects of HIV/AIDS. Given that these are probably also the categories of employees with significant skills and experience, the implications are that there may be potential skills losses to the company, in the absence of an effective HIV/AIDS intervention programme to prolong productive lives and to prevent future infections.

Female employees had a higher percentage of infection (12.4 per cent) compared to male employees (8 per cent) (Figure 5.2). The fact that women constitute 60 per cent of the workforce may account for the higher HIV-prevalence rate amongst women.

In summary, those most severely affected by the HIV/AIDS epidemic are permanent women employees, aged 20 to 39 years and working in the assembly, graphics or moulding departments at BIC. In 2004, there were three AIDS-related deaths in the company. These HIV-prevalence results need to be interpreted in relation to the broader workforce profile, in order to provide an idea of the overall significance of the impact of HIV/AIDS.

Figure 5.2: HIV prevalence at BIC SA by age category and sex (February 2002) (n=227)



Source: Evian (2002)

### Workforce profile

BIC SA employs 250 permanent staff and a number of temporary and contract employees. The demographic and skills profile (Table 5.1 and Table 5.2) show that the workforce predominantly comprises African women in the age group 20 to 39 years, employed in semi-skilled and to lesser extent in unskilled occupations.

Table 5.1: Workforce profile at BIC SA by race, sex and skills (2003/4)

	African		Coloured		Indian		White	
	Men	Women	Men	Women	Men	Women	Men	Women
Highly skilled	0	0	0	0	1	0	19	8
Skilled	8	0	2	0	1	0	16	1
Semi-skilled	39	74	1	2	4	2	5	32
Unskilled	20	76	0	2	0	0	0	0
Total	67	150	3	4	6	2	40	41

Occupational category code list

Highly skilled: managers, professionals, directors, engineers, nurses etc.

Skilled: technicians and associated professionals, crafts- and trades-people

Semi-skilled workers: service, administrative and clerical employees, operators

Unskilled workers: labourers, cleaners, elementary occupations

Source: BIC SA Workplace Skills Plan 2003/4

Most HIV-positive staff at BIC are likely to be unskilled or semi-skilled African women (Bureau for Economic Research 2001). This is in line with national trends, as African women (age range 15 to 49 years) are disproportionately affected by the epidemic. While at much lower rates, the departmental HIV-prevalence rates among those in

administration and sales (6.4 per cent) should be monitored as these generally include some semi-skilled positions. There are reasonable numbers of white women in semi-skilled positions in the company and their HIV status should probably also be monitored. Thus, when considering HIV-risk categories, all the possibilities should be considered.

*Table 5.2: Age and skills profile of BIC SA employees (2003/4)*

Age	Highly Skilled	Skilled	Semi-skilled	Unskilled	Total
<20 years			1	1	2
20–29 years		2	44	36	82
30–39 years	7	9	53	34	103
40–49 years	10	15	42	21	88
50–59 years	5	5	19	6	35
60+	5	–	3	–	8
Total	27	31	162	98	318

*Source: BIC SA Workplace Skills Plan 2003/4*

Finally, the workforce is concentrated in the age range 20 to 49 years, and semi-skilled and unskilled occupations (Table 5.2). This is in line with the pattern of the HIV-prevalence rate within the company. As indicated before, this has serious implications for future planning in terms of the retention and replacement of skills, given anticipated AIDS-related losses in these areas.

### **Social capital issues contributing to HIV risk**

Available literature shows that social capital or community-related factors may play a key role in the susceptibility of individuals or groups. There is limited evidence that religious and/or sport affiliation has some protective effect, while those living in urban informal areas (squatter camps) appear to have higher HIV-prevalence rates. The BIC workforce is predominantly African women in their mid-thirties who are single mothers and who tend to be the sole breadwinners in their households. Most live in Soweto in types of housing ranging from ex-council houses and RDP houses to shacks in areas such as Orange Farm.

Socio-economic status and its relationship with unsafe sexual practices was raised as a concern. Alcohol abuse was also raised as contributing to unstable lifestyles, resulting in aggressive and irrational behaviour in both men and women. Employees said that this mindset needs to be dealt with and that people needed to do 'better things with their spare time'. Lack of leisure activities or access to such facilities after work may lead to alcohol abuse and exacerbate risky behaviours.

Transactional sex was also raised as an issue, with some feeling that some women employees tend to rely on their boyfriends for additional income to pay for groceries and rent. Women feel that men should provide, and in turn the boyfriends do not expect to wear a condom when having sexual intercourse. The literature describes this as 'sex for support', which is generally related to women's economic dependence on men and the exchange of financial support for sex. Thus, women of a low socio-economic status are more likely to engage in such survivalist activities. Women employees at BIC said they feel that these are their circumstances. They feel powerless and they cannot say 'no';

they cannot negotiate with their partners on the use of condoms. It was felt that younger women in particular do not have life skills and do not know how to be independent. Clearly this is regarded as a very serious issue, to the extent that the development of life skills has been considered as part of a possible intervention programme.

Another group of employees felt that the lack of proper housing or affordable housing (some live in shacks, backyard rooms, and very few in RDP houses or with parents) lead to some having their 'boyfriends pay for the room'. Few female employees are married, and so do not have access to another income. The lack of affordable housing may therefore exacerbate their financial dependence and powerlessness.

Employees feel it acceptable that men have multiple partners, seeing this as part of their culture and as a sign of manhood. However, women were also seen to have multiple relationships. It is not clear whether this was to the same extent as men, but clearly it does occur. Many of the employees are also in informal partnerships, involving living together, possibly because lobola has not yet been paid. It is also clear that discussion of risk factors generally referred to the African section of the workforce, and that white employees were perceived not to have risky living circumstances.

### **Impact on production**

The BIC MD at the time of the research described the company as profitable. This was partly illustrated in terms of the increase in the workforce from 220 to 250 employees over the period 1995 to 2004 and a resultant increase in outputs. This had been driven mainly by increased automation since 1998, shifting the production process from a low skills base to one that needed more semi-skilled operators. This is evident from the relatively small proportion of unskilled employees compared to semi-skilled operators (see Table 5.2).

Increased automation has also resulted in the production workforce becoming multi-skilled, taking on increased responsibilities by working on a cell or row of machines, instead of on individual machines. This required additional training, through the Plastics Federation and Merseta. In-house training has focused largely on adult basic education and training and establishing the ISO 9000 quality system.

The company has experienced AIDS-related deaths and 21 employees are HIV-positive. This has not resulted in significant changes to production output – in part as a result of two responses made by production management: relocation of ill employees; and general training in more than one skill, which enabled existing staff to fulfil all tasks needed to assure continuing production.

Management indicated that infected employees could be relocated to lighter jobs where possible (when required and depending upon health status). This relocation was subject to a formal process of written disclosure to appropriate managers. Thus, all employees who wished to be relocated had to sign a consent form, administered by the company's nursing sister, disclosing current HIV status and the request for relocation. The production manager and operations director would consider such requests. Since this procedure also applied to relocation requests for reasons other than HIV/AIDS, it was hoped that stigma related to relocation might be reduced. Supervisors may also not necessarily know why the relocation took place. In practice, however, stigma remained a problem, and relocations were regarded with suspicion and accompanied by speculation on HIV/AIDS status. On the whole, such relocations had been successful, although some

problems and concerns had been raised. While senior management believed that such relocations were still manageable in general, production management voiced concerns. However, management also felt that the rate at which very sick employees had recovered subsequent to starting antiretroviral treatment facilitated their relocation to lighter jobs.

The company has not conducted an HIV/AIDS impact analysis and cannot predict what its replacement needs will be in future. However, the introduction of increased automation, accompanied by multi-skilling, had facilitated both direct replacement and relocation. In an indirect manner, this restructuring has become a response to the impact of HIV/AIDS. Thus, the fact that employees 'know how to do everything' and no one person is solely responsible for a particular job or machine has addressed absenteeism and possible AIDS-related replacement needs.

As for the impact of HIV/AIDS programmes on production, management reports that the education and awareness sessions are regarded as an obligation and not a production cost. The extent to which such views are shared by line management was not clear.

### **The role of the trade unions**

There are two representative trade unions. The United and Allied Workers of South Africa (UASA) has been represented at BIC SA in the 1980s. UASA represents 34 per cent of the workforce. The South African Chemical Workers' Union (SACWU) has been with the company since 1986, and represents 33 per cent of the workforce. The presence of the two unions is a result of dissatisfaction by some UASA members with its union's inability to conduct local plant-based negotiations and this has led to the establishment of SACWU at the plant.

The company had no history of strikes, mainly because, according to shop stewards, in the past most of the strikes were called by the Congress of South African Trade Unions (Cosatu), while they belonged to other federations, including the National Council of Trade Unions (NACTU) and Federation of Democratic Unions of South Africa (FEDUSA). However, the first march at BIC took place in August 2004 in support of calls made on all union members from the various federations represented at the Metal and Engineering Bargaining Council. This was the first time that non-Cosatu union members also felt that their unions were involved in the action.

The shop stewards said that they have two representatives on the AIDS steering committee. They also said that the HIV/AIDS policy has been discussed, criticised and then taken to union officials. This however, seems to have happened in the BIC workplace forum. The latter structure was formed as a result of problems in the company. At first, only departmental representatives were present, excluding the unions. Now the unions have a representative and discuss what they describe as 'family stuff'. Other structures include the Equity Committee, which has representatives from HR, the workplace forum, trade unions, and management. The aim of this committee is to discuss skills development and equity.

However, the HIV/AIDS steering committee felt that, although individual shop stewards were involved, there had been no involvement from the trade unions. A shop steward confirmed this opinion in a separate interview. It is also clear that in this case, the specific union offices have played no role in advising individual shop stewards on how to approach the HIV/AIDS issue (policy or programme) at the workplace.

Finally, in their assessment of the HIV/AIDS programme, shop stewards raised concerns regarding confidentiality. They feel that calls to individuals on the shop floor on a Friday by the 'HIV/AIDS doctor' result in speculation among the workforce that the person suffers from the disease. However, others disagree and feel that this particular doctor checks everyone. The workforce gave the impression that they do not want to be tested or be exposed as suffering from the disease. None of the shop stewards have gone for a test to determine their HIV status at the company clinic.

## **HIV/AIDS policy and programme**

The HIV/AIDS programme at BIC was started in 2000, with limited education and awareness sessions that included video sessions for all employees. In 2000, the fact that the disease affected the company was brought home to employees when a fellow employee who is HIV-positive disclosed her status and spoke openly about her experiences.

### **Policy development process**

The HIV/AIDS policy sets the overall framework within which specific programmes are then developed. The BIC HIV/AIDS policy was started at the end of 2001, after taking policy examples from various other companies and a guide called 'Guidelines for developing a workplace policy and programme on HIV/AIDS and STDs', which was developed in 1997 by the Department of Health and the European Union. The BIC policy was largely developed by the OH sister, ratified by the HR section and approved at the workplace forum.

At the time, the policy specifically excluded antiretroviral provision, which was thought to be too expensive. However, by November 2002, this was changed when it emerged that two employees needed antiretroviral treatment and could not afford it. At that time, the treatment cost R1 500 per person per month. By early 2003, this figure had gone down to R900, excluding blood tests. At the time of this research (September 2004), the cost had come down even further to between R600 and R800 per person per month. Those receiving treatment make a contribution of R25 per week as a way of showing their commitment to the treatment regime. The policy was revised in mid-2003. Currently there is some discussion as to the coverage of spouses for nutritional support and antiretroviral treatment. Where employees have multiple spouses, this presents a problem. Spousal coverage and the manner in which other companies approach it is currently being investigated.

### **HIV/AIDS committee**

In 2001, the AIDS steering committee (Ascom) was formed, with its primary objective to assist those infected and affected by HIV/AIDS with financial support towards nutrition and necessary medicines. All employees made a voluntary contribution of R2.50 per person per week. This voluntary fund was then taken to the workplace forum, and it was agreed that the company would match employees' contributions on a Rand-for-Rand basis.

In late 2002, after the HIV/AIDS policy had been formulated, another steering committee was formed. This committee's objectives were policy and financial issues related to HIV/AIDS. In 2003, it met monthly, and in 2004, was meeting every six weeks.

The peer educators have received training for bereavement counselling and peer education. The AIDS steering committee relies mainly on the OH sister for information.

### Components of the HIV/AIDS programme

The OH nurse largely spearheaded the implementation of the HIV/AIDS programme, with assistance from the AIDS steering committee. The company's approach to managing the HIV/AIDS programme is unusual in that it has very limited assistance from external consultancies, with the exception of the HIV-prevalence survey in February 2002.

Components of the HIV/AIDS programme include:

- An education and awareness programme that uses videos, discussion groups, presentations by PLWHA;
- HIV-prevalence surveys (February 2002, to be repeated in 2004);
- The formation by employee and company contributions of the Aids Steering Committee (Ascom) Voluntary Fund, which pays towards preventative antibiotics and antiretroviral treatment;
- A blood donation fund (for every unit of blood donated, the company makes a contribution to the Ascom Voluntary Fund).

Awareness activities in 2000 also included a talk by an employee living with HIV, a Family Day at Kloofendal Resort that included a braai and a puppet show, as well as a drama in 2002.

In 2003, the peer educator programme started with five volunteers who had undergone five days' training the previous year. The programme uses a system in which groups of employees provide education sessions using posters and videos. There are no peer educators from the administrative section, and some argue that it confirms the poor participation rate of administrative employees compared to those in production. In one of the discussions, a peer educator admitted never having gone for an HIV test, yet advising other employees to do so. It was not apparent how widespread this behaviour was among peer educators. It did point towards fundamental problems relating to the selection criteria for peer educators, their education and training, and monitoring and evaluating their progress, both in terms of their public and private roles as well as their behaviours more generally. In March and September 2003 there were video sessions for employees. A Family Day was held, to which most employees sent their teenage children separately because they felt that it is easier to speak to teenagers about safe sex without their parents.

Condoms from the Department of Health are available in the main ablution blocks and in the waiting room outside the OH clinic. Take-up is good and has improved since the condoms began to be distributed in packs of ten instead of in single units.

VCT services are provided. In the first year (2003) about 40 employees were tested, and by mid-2004 this number had increased to 75. This was a very low take-up rate, and while many had come for repeat tests, the majority of the workforce had not established their HIV status. Workers may be going for off-site testing but this is not thought to be the case. Reluctance to be tested seems to be related to fear of the disease, and fear that knowing their status might 'kill them'. Some were under social pressure and were fearful that their status would be revealed to others. If someone's status became known, the clinic sister was blamed. This issue was also be raised in the focus group discussions.

It was felt that the programme was taking off slowly in 2004. Video sessions had been held over the period July to August and employees were well aware of basic information. An industrial theatre session was held, which was well received: 'It had all of us

laughing', said one employee. However, some of the problems identified include the role of peer educators who find it difficult to 'find a way to people'. Further, many employees still find it difficult to go for testing to establish their HIV status. The AIDS committee was considering conducting a needs analysis to deal with these issues.

Antiretroviral treatment is well used. Out of 20 HIV-positive employees, 7 are on antiretroviral treatment and doing well. Two more should be on antiretroviral treatment because of the extent of progression of their disease, but they have refused. The company found the cost of providing antiretroviral treatment is less than expected. However, although there was a commitment to providing antiretroviral treatment for life, this was dependent upon employees' employment status. The policy states that if the person leaves the company's employment the provision of antiretroviral treatment stops. The issue of extending coverage to infected family members has been raised. This was being looked at particularly because it is known that infected people will share their medication with an infected spouse or children.

There is an informal support group formed by one of the employees who is HIV-positive. This was a recent development as only two sessions had occurred at the time of this research. Four employees attended the sessions, but various problems, such as transport and accessibility, were raised. So far, only women had attended and it was felt that men would have greater difficulty disclosing their status. The main focus of the support group was sharing tips on how to stay healthy, and to draw support from work, as this may be the only support some employees receive. Some infected employees had apparently not told their parents or relatives of their status.

The AIDS steering committee felt that line management and the foremen were very supportive, particularly where people have disclosed. Support was really only possible where disclosure had been made to a specific manager. This disclosure tended to happen only if necessary, for example, when someone needed to be off sick more often than usual. However, there was still speculation about a person's HIV status if someone displayed obvious symptoms of the disease or was off sick often.

It was felt that the trade unions had not been involved at all, although individual shop stewards had been involved.

### **The role of the occupational health (OH) facility**

The OH clinic is central to the HIV/AIDS programme and policy implementation. The OH nurse facilitated drawing up the policy, was involved in committee development, information gathering, and the education and awareness programme and is now in charge of the implementation of VCT and the administration of the antiretroviral programme. The only exception was the HIV-prevalence survey that was conducted by an external company.

Prior to the HIV/AIDS programme, the OH sister worked until 13h30. Now, however, the facility is open for seven and a half hours every day of the week. The company made a conscious decision to maintain the programme in-house and to develop internal capacity instead of outsourcing it to an external company. The company thought it had the internal capacity to do this 'better and more cheaply'. It does have assistance from two doctors, one of whom attends monthly to assist with AIDS-related issues, and another who looks at broader OH issues for an hour per week.

The main problem with the clinic, as stated by the sister herself, is persistent rumours of a lack of confidentiality on HIV status. Despite this, all of those on antiretroviral treatment disclosed to the sister and signed a disclosure form in order to access the antiretroviral programme. At the time of this research, the company was committed to continuing to supply antiretroviral treatment until financial constraints become a problem. Only then will the government roll-out programme be considered. Also, at this time, the company 'feels safer about internal treatment'.

The information and support system for the programme relied heavily on information and workshops from the Department of Health, the two doctors at the company, and seminars organised by doctors. In future the company would consider peer educator training offered by the SEIFSA.

### **Perceptions of the effectiveness of the workplace policy and programme**

This section provides overviews of the responses derived from focus group discussions around the company's HIV/AIDS policy for production employees (weekly or hourly paid) and administrative (monthly paid) employees.

#### **Focus group: Production employees**

The production focus group was attended by 11 employees, with lengths of service at BIC ranging from 1 to 23 years. Participants were randomly selected from an employee list.

#### *Knowledge and understanding of the impact of the disease on the company*

All employees were given the HIV-prevalence results from the survey conducted in 2000. Focus group participants discussed ways in which HIV prevalence differed according to department and age group. They felt that these disaggregated results resulted in speculation about who was infected. One participant said her white co-workers tended to avoid her because the results showed that the virus affected her age group. Participants thought that releasing the results by age group and department created stigma because people then thought of these groups as high prevalence. Employees then started to wonder if they themselves were infected.

A media release on the HIV/AIDS programme at BIC caused anger among employees. At the time, production employees were upset at senior management's failure to consult with them before releasing HIV/AIDS statistics at BIC. Employees were 'furious' and embarrassed at having such information released publicly. One participant asked, 'why expose us?' – particularly when given assurances that such information would remain private and confidential. Participants said that the company indicated that they disclosed this information to encourage other companies to develop HIV/AIDS programmes.

However, employees felt that 'it is in BIC's interest to look after us, in that way they are helping themselves by helping us'. It was clear that workers and management had completely different attitudes to publicly releasing information about the impact of the disease on the company. The company regarded this as a way of encouraging other companies to develop HIV/AIDS programmes and to promote its own activities. Among sections of the workforce, on the other hand, there were definite fears of being stigmatised by members of their communities and the public.

*Knowledge and awareness of the policy*

None of the participants could remember receiving or seeing a copy of the HIV/AIDS policy document, whether in an abbreviated form or otherwise. However, most indicated that they are aware of their rights, based on feedback they receive from their supervisors. These include the right to job security for those infected. All knew of the payment of R2.50 towards helping with nutritional assistance for those infected because it was deducted from their pay. Some felt that this contribution was necessary, given the slow progress of the government rollout of antiretroviral treatment. Further, most had seen the positive results of their contributions, 'people who are positive are OK now', they are 'everyday at work'. Only some participants knew that there was a contribution made by people receiving antiretroviral treatment.

Contract workers said that their contracts they did not require them to pay the voluntary contribution of R2.50. They argued that the HIV/AIDS policy grants the same rights to contract workers as it did to permanent employees, but said they are afraid that, irrespective of this policy, the company would not adhere to this in practice.

*Participation in HIV/AIDS programmes*

Contract workers said that they did not participate in VCT as there was a general perception that should they test positive they would be dismissed. This was reinforced by the general levels of job insecurity, given the short-term nature of their employment.

Employees participated in the HIV-prevalence survey, despite expressing some fears. However, of the 11 participants in the focus group, only four had gone for VCT at the clinic. When asked the underlying reasons for non-attendance, their responses fell into a few areas. Most indicated that testing at the clinic was 'where the problem started'. Those who were tested clearly indicated that they wanted to know their status. For those who did not have tests internally or outside, one of the strongest concerns expressed was that testing was not really about them as individuals, but to 'satisfy other people', 'to please others' or that the employee was 'doing the company a favour'.

A fear was evident that infected individuals would not be able to handle the knowledge of being HIV-positive or what that would mean for their futures – in the words of one, 'what is going to happen to me?' Some said they need to be emotionally ready and are not. Others adopted a fatalistic attitude, saying they 'will go [die] when its time, when I am sick'. Some people know that their partner or child is not positive and so assume that they are not. Others feel that their lifestyles do not put them at risk of infection. Others fear the gossiping that tends to follow when people disclose their HIV status. Some people feel that disclosure was a personal choice, that they were prepared to live with the consequences, gossip or not, and regard this as a positive thing to do.

The absence of a cure, and the fact that antiretroviral treatment will probably only prolong life for a certain time, also made participants hesitant to establish HIV status because the medication 'will only help me for a short time'. Some women were worried that they did not know what their partners or husbands were 'doing outside'. The issue of control over their life circumstances was clearly a concern for some women. These participants also discussed the assumption that single women sleep around, particularly black women. However, others felt that it was 'outsiders', and not the workforce, who were the cause of the problem of HIV. Some women told of the difficulties they had in persuading partners to use condoms, indicating that their partners were 'illiterate' in the sense that they did not have similar levels of knowledge and information about AIDS. Thus, while '...work is

fine' in terms of information about HIV/AIDS, 'back in the township' it is a different issue. While participants indicated that the unions were involved at the time of the survey, in general they had no idea of the unions' involvement in the HIV/AIDS programme.

### **Focus group: Administrative employees**

The focus group consisted of six administrative staff members, who were randomly selected from a list of staff members. Their years of work experience ranged from 2 to 20 years in the company.

#### *Knowledge and awareness of the HIV/AIDS policy and programme*

These participants had a fair level of awareness of their rights and other aspects of the HIV/AIDS policy and programme. They mentioned the pamphlets and literature on HIV/AIDS as well as shows and drama aimed at raising awareness. All were aware of the fundraising, where all employees made a voluntary monthly contribution of R10 every month, as well as the contribution the company made for blood donations. Special mention was also made of World AIDS Day. The OH sister was also mentioned as vital in the company for support for HIV-infected employees, general health and information and HIV testing. This group of employees was also aware that the company provided antiretroviral treatment for HIV infected employees. They also mentioned the news brief, particularly the fact that the managing director provided an update on the progress on HIV/AIDS to date in the company.

#### *Voluntary counselling and testing*

When asked why they participated in the prevalence survey, participants said that they did not have to, but were encouraged to go for the test. Some did it 'for the spirit of teamwork' and to support management initiatives. The participants had no concerns related to the release of prevalence results by department and age groups. They felt that these results allowed the company to understand which departments and age groups were most affected by HIV. Further, some felt that this manner of release would prompt employees to consider how they were affected and encourage them to go for HIV testing, inside or outside the company.

When asked how they felt about the survey results, the workers said it was very sad to know the state of the epidemic in the company. One of the workers said, 'I was not happy because there were lot of people infected in my age group.' Another worker added, 'I think it does worry people...to think about their lifestyle and behaviour.' Those workers who had gone outside for HIV testing said that this was for insurance purposes. Those who have gone for HIV testing inside the company have done so for work. Those who did not go for HIV testing assumed that they were negative because 'they live responsibly'. However, they said that going for an HIV test is a good thing to do. One worker said 'If it was not for the insurance, I would not have gone.' Employees remarked on the fact that there was high uptake for the anonymous survey and saliva testing, but very low intake for VCT. Participants suggested the following reasons why employees may not want to know their HIV status:

- Being scared;
- Believing that you are fine;
- Taking things for granted – in the words of one employee, 'we turn away from the problem and assume that we are fine. We should go [for HIV testing], but do not go.'

Participants generally felt that employees did not think 'AIDS is black people's disease'.

However, one disagreed, saying 'There is still a general perception that HIV/AIDS is a black people's disease, but [I] have seen a white person dying from AIDS'.

### *Stigma*

The participants referred to some of their experiences of stigma in the workplace. One said 'People are not open because they are discriminated against by their communities and families'. They referred to one particular BIC SA employee who did not disclose his status until it was too late to offer any care. Another worker died from HIV/AIDS, but people were told he had died of methylated spirit poisoning while working in the factory. Workers said that there was still denial of HIV/AIDS.

### *Confidentiality*

Participants generally felt assured that HIV status remained confidential at the company. However, they cited rumours about some people's HIV status and that there may on occasion have been information leakages. The OH sister was perceived as a credible and reliable person, who kept an individual's HIV status confidential. This group also referred to an incident where production workers at BIC SA were not happy when management unilaterally decided to publish the company's HIV-prevalence rate in the newspaper. Participants believed that this matter was resolved when management accounted for its actions by explaining the reasons for the newspaper publication to the workers, namely, that BIC SA wanted to be a model to other companies and also to learn from other companies.

### *Success stories*

The Kloofendal AIDS Show was felt to have been the most successful HIV/AIDS awareness event to date at BIC SA. The workers made mention of the fact that BIC SA was fully supportive of HIV/AIDS sufferers and that there was good participation from the workers and their families. Overall, these participants felt that BIC SA was doing well as far as the HIV/AIDS workplace programme was concerned.

## **Lessons learned**

There are a number of factors that are instructive in the case of BIC SA. The company's predominant demographic profile, namely African women employees younger than 40 years and occupying semi-skilled and unskilled positions, is a perfect match of highly susceptible groupings in the national population, identified in major studies (Shisana and Simbayi 2002; Bureau for Economic Research 2001). Accordingly, continuous tracking and monitoring of HIV-prevalence trends are needed to assess the extent to which the HIV/AIDS intervention is reducing new infections.

The risk environment is greatly influenced by the interaction between low economic status and social and community-related factors. Thus, the emergence of 'sex for support' or 'sex for favours' relationships, and the expression of a sense of 'powerlessness', especially among women, were identified in the discussions. These and other factors affecting the personal stability of employees emerged as key factors to be considered in the HIV/AIDS intervention programme and are moreover linked to alcohol abuse, the economic dependence of women and multiple partners.

The low participation rate in VCT compared to the prevalence survey may be attributed to the fact that employees still do not identify with managements' reasons for wanting to know the impact of HIV on the company. However, individual and collective motivations

for knowing and acting on HIV status have been identified in the course of this study and need to be taken into account when developing education and awareness programmes.

The role of peer educators, their selection criteria as well as education and training, need to be re-assessed and continuously monitored.

The role of the OH clinic in facilitating the entire HIV/AIDS programme is a useful example of using and extending local resources rather than outsourcing and relying solely on external resources. Within the broader study, BIC SA was the only company that relied solely on internal capacity and facilitation and limited external involvement. While this had been successful in the short-term, long-term operational sustainability should be monitored and assessed continually, particularly accounting for potential turnover among staff members central to the HIV/AIDS intervention.

Unlike most other participating companies, the role of the HR division was very limited, perhaps largely because HR activities were outsourced. However, the impact of HIV/AIDS interventions on the nature and scope of HR policies will become evident over time, and as such the role of the HR division may well also become more central. However, historically the prominent role of HR in company HIV/AIDS interventions suggests a marginalization of HIV/AIDS to a mere 'personnel issue'. Similarly, the close association of HIV/AIDS and occupational health may also have the effect of separating HR from the issue.

The long-term implications of HIV/AIDS on production have not been considered in any formal way. In the short-term, multi-skilling has been the indirect response. The sustainability of such an approach needs to be considered and monitored, as well as the effectiveness of relocation.

The co-funding model with equal contributions by management and the workforce is unique among the participating companies. It represents an innovative approach, and draws in employees in an active responsive manner. The related model of co-payment by those receiving antiretroviral treatment is also innovative, but compliance with treatment needs to be assessed.

## Conclusion

The HIV/AIDS policy and programme at BIC SA has a strong participative element, both in support by senior management, and involvement by staff members on the AIDS committee and the OH sister. While this is a key strength of the company's programme, this has not necessarily translated into active employee participation in VCT, a key determinant of HIV status. It does point towards a fundamental assessment of the effectiveness of education and training, and the extent to which this translates into behaviour change.

## Main contributors

Interviews were held with the following groups and individuals:

- Managing director
- Operations director
- OH nurse
- Personnel assistant
- Trade unions: SACWU and UASA shop stewards
- Focus groups (two): production employees; administration employees.

## Case study 4: Secoroc (Pty) Ltd

Jocelyn Vass

### Introduction

Atlas-Copco Secoroc (Pty) Ltd is a medium-sized company, based in Springs, Gauteng. It produces drilling equipment for the mining industry and currently employs 150 staff members. It is part of the Swedish-based multinational Atlas Copco. In South Africa, it falls under Atlas-Copco South Africa (ACSA). At an operational level it reports to the Swedish subsidiary, Atlas Copco Secoroc AB.

### History of the company

The company has been in existence since 1948, always under Swedish ownership, with local management. In the late 1980s, the multinational restructured its manufacturing base, reducing the number of companies world-wide from fourteen to four. South Africa was one of those that survived this restructuring. In 1999, the company developed an export market. Secoroc (Pty) Ltd does not have any direct South African rivals, as the Swedish subsidiary allocates production directly to it. Senior management indicated that the advantage of foreign ownership lies in its capacity to cushion local fluctuations in the SA market, provide access to new markets and supply design and development support.

Table 6.1 shows trends in economic performance over the past five years. There has been a significant turn-around in profits and export trends. This has been achieved through restructuring in 1999, involving the adoption of lean manufacturing techniques. One such approach included the reduction of employees by outsourcing the logistics chain (truck distribution fleet) to an external company. Most workers affected chose to take voluntary retrenchment packages.

*Table 6.1: Major trends in economic performance by Secoroc (1998–2002)*

	1998 (5 years ago)	Now (end of 2002)
Employees	200	153
Net profit (% of net income sales)	1%	12%
Trends in exports as a % of sales	15%	33%

### HIV/AIDS risk profile

This section provides an analysis of the relative exposure to HIV/AIDS risk and vulnerability faced by Secoroc. It provides an overview of available HIV prevalence statistics and the demographic and skills profile. This is followed by an overview of related factors, such as social capital and community-related factors, as well as organisational risk factors, and the impact on production, as seen through interviews with

employees and management. Finally, it highlights perceived and observed risks as well as the vulnerability of the company to HIV/AIDS.

### **HIV/AIDS statistics**

The company has conducted two HIV-prevalence surveys, facilitated by an external disease management company. The participation rates in the second survey (2004) were reportedly lower than in the first one (2003), but information on the size of the decline was not available. In 2003, 125 of the 150 employees were tested. Of these, 90 per cent were counselled. Eighteen tested positive, giving a prevalence rate of 14.4 per cent among those who tested. This rate is slightly lower than the national adult prevalence rate of 15.6 per cent for adults aged between 15 and 49 years in 2002. The results for the subsequent survey in 2004 were not available at the time of the research.

### **Workforce profile**

This section provides an overview of perceived and observed risks and vulnerability to HIV/AIDS. In this case information on the workforce profile was not available. As a result, the researchers' on-site observations as well as verbal feedback received during the interviews provide the basis of a broad and superficial overview of the workforce profile.

There are 90 to 101 shop floor employees (10 are temporary) and 50 support staff. In 2004, nine new staff members were employed. The workforce in production and distribution (shop floor) is predominantly male. All new employees are required to have at least matriculated successfully. Products are generally easy to make, and training is easy. As a result, employees are easily replaceable and 60 per cent can be trained within one year. The workforce, especially on the production side, is mainly African men. The company has undergone significant changes in its sex profile. It has introduced an increasing number of women in operations and as lift operators. At the time of the research, women constituted 37 (24.6 per cent) of the total workforce of 150. Most employees are between 35 and 45 years, although more recently there has been increased employment of younger people.

National statistics suggest that men contract the HI virus at an older age (upwards of 30 years) compared to women. Thus, given the age and sex profile at the company, the workforce may be at risk. Given the decline in the survey participation rate in 2004, changes in the HIV-prevalence rate may not reflect the full impact of the disease.

### **The impact of restructuring**

For the last eight years, the company has been using the principles of lean production in order to restructure and meet the requirements of a world class manufacturing facility. This included a range of training interventions to reduce production lead-times. In principle, every employee is supposed to receive five days training a year to improve production. About 20 employees require higher-level skills. Employees were trained in multiple skills so that 'they know everything'.

Elements of lean manufacturing including green areas, flow simulation games and company briefings were used as a means to change the nature of jobs. The same workers are responsible for everything from setting up machines to quality control. Active incentive schemes for teams are used to increase motivation for determining and reaching production targets. The fundamental organising factor, according to management, is the team principle. Senior management emphasised the principle of developing a sense of

ownership of the production process among employees who determine, set and reach targets themselves. The South African operation remained open as a result not only of its mining markets, but also because it had been able to develop these improvements, including a reduction of lead-time from 2 or 3 weeks to 48 hours, as well as management and union alignment.

While the company is vulnerable to the loss of multi-skilled employees, there is an acknowledgement that multi-skilling also acts as a security cushion against AIDS-related losses. Workstations have been combined, and management felt that 'it is still better to do with [to use] labour'. The relative labour intensity of production derives largely from the ease and low cost of training.

### **Social capital issues contributing to HIV risk/vulnerability**

Most employees are from the surrounding township, KwaThema. Some are affected at community level by HIV/AIDS. The company reports that there has been an increase in family responsibility leave, although this may not necessarily be attributable to HIV/AIDS. In general, employees are regarded as having stable family environments and households, and thus as less prone to unsafe sexual behaviour. The company provides up to R14 000 per employee for housing assistance. The take-up of home loans is used as a proxy for relative stability. However, although employees generally seem to have stable families and lack mobility, apparently not all are stable.

### **Impact of HIV/AIDS on production**

The company says that it has a 4 per cent absenteeism rate, half of which it attributes to HIV/AIDS. Absenteeism has always been monitored for organisational issues, but is now monitored for AIDS-related absenteeism as well. The management team (including line management) meets daily and considers levels of absenteeism, the deployment of the temporary pool of employees and any other related issues. The impact on production is not significant because the jobs do not require high skill levels and lost skills are easily replaceable, as most jobs have 'at least five other people' able to do it. There is also a temporary pool of employees, mainly for illness-related absenteeism. With the company policy of re-engineering and multi-skilling the perceived risk is low.

However, the company does foresee a potential cost problem. The company has few staff, and if several employees are off at the same time, this will have an impact on production. At the time of this research the company felt that this risk was manageable. Overall, the company still regards the general production risk as low. At the same time, the current labour laws are regarded as an obstacle in that '...it is difficult to get rid of people'. The company has retrenched employees for operational reasons. Three employees were retrenched as a result of medical incapacity. It was not clear whether the latter retrenchments were as a result of AIDS-related medical incapacity. However, the company also cited employment growth as an explanatory factor in the period 2001 to 2002. During this period, the workforce increased from 140 to 153, including 10 temporary workers.

### **Perceptions of the trade unions**

NUMSA has been the representative trade union at the Springs site since the 1970s. A new shop stewards' committee was elected in 2003. At the time of the interviews, the union was in dispute with the company or as quoted 'in dispute with the HR manager'. The union places a clear divide between the time when senior management was made

up of Swedish expatriates and the time since South African management has been in place. At the time of the research, the local general manager had been relocated to the USA. The nature of the current dispute centred upon a review of all major HR policies, which coincided with the appointment of a new HR manager. The specific issues included negotiation of the recognition agreement pertaining to releases and leave for shop stewards, as well as access of union officials to workers; the implementation of company-based wage increases in addition to the bargaining council rates; and a review of the occupational grading structure. The Commission for Conciliation, Mediation and Arbitration (CCMA) has been approached and a certificate has been issued.

The union agrees that teamwork is one of the ways in which employees set production targets themselves and determine the rate of production in order to meet these targets. The main incentive is a production bonus, and so 'people measure themselves on their own targets'. As a result, employees take responsibility and monitor themselves, because they set targets in consultation with management and have to adjust their output accordingly. The union did not have any problems with production targeting itself. However, it did indicate that in 2000, the previous GM promised to give a profit share to employees. Instead, a production bonus was provided. The union argues that the formula for this calculation is not transparent, nor is it communicated to employees.

Another area of dissatisfaction expressed by the union is that the company is 'not doing anything' about skills training. This relates particularly to the fact that, according to the union, '...only a few employees attended college'. In keeping with the Skills Development Act (SDA), a committee has been set up to facilitate the process of training. There is also an employment equity committee, which according to HR is 'not working' as the 'union destroyed it'. The break-up of this committee seems to have arisen from the current dispute. It seems that much of the union's unhappiness with the committee was that after four years in existence, it had not achieved much, as there was 'no one with a certificate in training'. The union interprets the process of multi-skilling adopted by the company as 'people get[ting] trained from one machine to another'. It appears therefore that the union does not necessarily regard the process of multi-skilling as contributing to skills enhancement.

The employment equity committee provides an essential forum for discussing the AIDS policy as well. Given its apparent collapse, the research team enquired about the AIDS policy development process.

The shop stewards acknowledged that they discussed the guidelines for the policy after a presentation by an external management consultant. Although they agree that the current guidelines are good, they believe that it 'is not a policy', because a policy would require more detail. According to the shop stewards, they have asked for further information from the external consultant because they believe that the current 'two pager' is not sufficient. On the other hand, the union shop stewards did not appear to have drawn upon resources (information or officials) from NUMSA itself. It was indicated that NUMSA would provide training on HIV/AIDS before December 2004. It does appear that the shop stewards had no specific demands or provisions that they would wish to include in the current policy.

The union confirmed that the workforce was reluctant to go for VCT or prevalence survey testing, and that this is regarded as a 'sensitive' issue. A range of reasons for refusals to test was suggested. Some people would undergo testing only when a vaccination against HIV becomes available, while others would go only once they become sick.

The union also said that employees do not go for testing unless they are forced to do so for insurance.

There was also confusion about the reliability of saliva testing, with some thinking that only a blood test can show HIV antibodies. This would explain the decline in the survey participation rate in the 2004 survey as opposed to the 2003 survey, when different testing methods were used. Thus, in the 2003 anonymous survey, when saliva testing was used, many people were not comfortable with the test as they did not trust it.

It appears that the information provided during awareness sessions was seen as contradictory. Thus questions were raised, such as, 'if kissing cannot transmit HIV how could a saliva test establish HIV status?' The union indicates that this confusion was the main reason why employees did not go to fetch their results. They felt that the test was not reliable. The shop stewards also did not fetch their own results. The shop stewards themselves felt that they would only go for HIV testing when they became sick. They would moreover insist on a blood test. More counselling is needed to encourage employees to go for testing. Finally, they reported that despite the fact that the cost of E-pap, a well-known immune booster, is subsidised by the company, the product is stigmatised because it is now associated with HIV-positive status.

### **HIV/AIDS policy and programme**

As a subsidiary of AtlasCopco South Africa, the existing policy and programme at Secoroc is developed and coordinated by the group. All the sites have uniform policies and programme elements, and use the same consultants in the implementation of the programme. However, the cost of programme implementation is borne by individual subsidiaries. The role of the Swedish owner appears to be marginal, other than receiving board presentations on the levels of risk experienced at the relevant sites.

#### **Policy development process**

An HIV/AIDS policy sets the overall framework, within which programmes are then developed. The current HIV/AIDS policy falls under the umbrella of AtlasCopco SA, and was developed by a management consultant under the supervision of the coordination team, which adopted a broad group policy in November 2003. Management indicated that there was no employee consultation in this process.

It is reported that the Secoroc site has had its own HIV/AIDS policy since 1992, although this was not updated until the broad group policy was adopted in 2003. In 1992, the interventions focused upon condom distribution and information about HIV/AIDS. By 2000/1, HIV/AIDS messages and an audit on general cleanliness were conducted. The policy in 2003 attempts to be more comprehensive and includes education and awareness, HIV prevalence testing and VCT.

It appears that the current dispute with NUMSA at Secoroc (including recent industrial action) has had an impact on the extent to which the HIV/AIDS policy and programme have been absorbed into organisational culture. For example, the centre of the dispute revolves around the review of all HR policies, including those on HIV/AIDS. In the absence of an agreement with the union on how to proceed, the re-induction of employees (including the provision of HIV/AIDS education and awareness) has not proceeded as planned (see overleaf).

### **HIV/AIDS programme**

The company said that the HIV-prevalence rate is still low compared to the rest of the industry. Employees disclosed their status when they were absent more often than usual or where sick leave and sick pay had been exhausted.

Education and awareness programmes started in 2003, under the new policy. They were conducted by an external management consultancy and supported by a disease management company. The company intends to repeat this process, under its proposed re-induction programme for all employees. There are no peer educators and the company acknowledges that the HIV/Aids policy needs to be discussed and specific individuals trained. This is one area to be resolved with the trade union.

The company does not have an HIV/AIDS committee. In the absence of an agreement with the trade unions, the shop stewards are not involved in policy formulation or programme implementation. Elements of the programme include:

- Education and awareness sessions;
- HIV-prevalence survey (2003);
- VCT (external testing);
- Disease management programme.

Management reported that the take-up rate of the disease management programme is apparently good. Most of those who need intervention are currently on the programme.

Medical aid coverage is widespread and 98 per cent of the workforce is on a medical aid. According to the HIV/AIDS policy, the company will cover the AIDS-related costs, once medical aid cover is exhausted. So far, the company is only expecting one such case. This information was relayed to employees through the information and education sessions conducted by the disease management company.

### **Perceptions of the effectiveness of the workplace policy and programme**

Focus group discussions were held among production (weekly or hourly paid) and administrative (monthly paid) employees, in order to derive their perceptions of the effectiveness of the company HIV/AIDS policy and programmes.

#### **Responses of production employees**

This focus group consisted of 12 volunteers from production. The group included two women (white and black), a white man and nine black men.

#### *Knowledge and awareness of HIV/AIDS policy*

All of the participants claimed that they had no idea of who had HIV/AIDS, nor what assistance the company may be providing to them. They further claimed that they first heard about the company's HIV/AIDS policy and its provisions from a disease management company that conducted HIV/AIDS awareness and testing. None of them participated in the drafting of the policy or have even seen a copy of it. They are, however, aware that the company will make certain provisions in terms of assistance for HIV-positive employees and that HIV-positive employees' jobs would be secure. The most common source of information is the health and safety committee that regularly places minutes of their meetings on the notice boards. Participants said that there was no HIV/

AIDS committee or representatives 'because this issue is a sensitive one'. The first point of contact in case of HIV/AIDS is the on-site OH clinic in the company. The group displayed knowledge about the various aspects of the company HIV/AIDS programmes. Those cited include:

- Education and awareness programmes conducted by two companies, including Lifeworks;
- HIV-prevalence surveys conducted in 2003 (saliva test) and 2004 (blood test);
- Introduction of nutritional supplements, including E-pap and soya foods;
- Group and individual counselling (linked to the HIV-prevalence surveys);
- Provision of antiretroviral treatment.

Participants indicated that they prefer not to go for testing in 'outside' government clinics because there they are told bluntly of their positive status, and that they 'are going to die'. This reflected a perception by participants that government clinic services do not provide counselling, a caring attitude and confidentiality about people's status.

#### *Factors driving participation in HIV/AIDS programmes*

Participants referred to three education and awareness interventions, one in 2001 and another in 2003 (which both included the saliva prevalence test as well as group and individual counselling), and the prevalence survey (using blood samples) in 2004. There was a range of responses to this last intervention, conducted by Lifeworks. Perceptions were that many people went for testing in order to know their own HIV status; others simply went in response to the general manager's expressed need to make future plans in anticipation of the impact of the disease of the company; others were motivated by the general manager's promise that those affected would be moved to 'lighter' jobs, as needed. Some of those who were tested did not fetch their results. The information provided by Lifeworks at the last prevalence test made people take HIV/AIDS seriously, and persuaded some to go for testing. Despite this, others were not sufficiently convinced of the process and are still afraid of being tested.

It was felt that beyond these interventions, 'workers in their plant hear, see and know nothing' about HIV/AIDS in the workplace and that more interventions are needed to deal with employees' fear about being tested. There is a lack of trust in management promises because workers have not seen the written policy in 'black and white' or in their files. This raises doubts as to the reliability of management promises around HIV/AIDS. Participants said that they have not seen anyone moved to lighter jobs, and so doubt that this will happen. The company has not disclosed the size of its antiretroviral budget, or its expenditure on antiretroviral treatment, nor are they aware of the company's commitment to providing antiretroviral treatment for an HIV-positive employee. This means that people doubt whether the company will provide antiretroviral treatment for infected employees. In fact, the participants felt that in spite of the 14 per cent prevalence rate among employees, the company does not pay for antiretroviral treatment.

Participants had clear opinions on the difference between the saliva and blood samples used in the two HIV-prevalence surveys. They expressed doubts about the voluntary blood testing conducted in 2004 because fewer people were tested using the blood test than had been tested using saliva. This appeared to be partly because of poor communication about the testing, despite the efforts of some team leaders. Because it only took 20 to 30 minutes to get the results, workers wondered about the reliability of these results. Some speculated that Lifeworks probably takes such a short time to do the testing because they are 'in business' and want to make quick money.

The reliability of the saliva tests was questioned. This seemed to result from an incident where an employee received different results from the two types of tests. Participants did not understand that there could be good reasons, such as the window period, for this difference. The information session seems to have given the impression that saliva test is less reliable, because participants were told that HIV could not easily be transmitted through saliva. This misconception is an important indicator of the technical difficulties in HIV/AIDS education.

After the prevalence survey carried out in 2003, the company introduced E-pap and soya-based foods for their nutritional value and immune boosting effects. While most participants indicated that they continue to buy these products for general use, these foods are still stigmatised because they are linked to HIV status. The way in which the two foods were advertised continued to make people associate it with HIV status.

The OH facility does not play a direct role in the HIV/AIDS intervention other than referring employees to Lifeworks for testing and condom distribution. None expressed a need for more HIV/AIDS related interventions beyond the general health and safety services currently provided by this facility.

In terms of confidentiality of HIV status, most participants agreed that individual disclosure was a personal decision. Some thought that such disclosure might be necessary to receive assistance and access to services. They had confidence that HIV status will remain confidential if the person was tested by Lifeworks. Participants also seemed to believe that confidentiality would be maintained if HIV/AIDS services were provided from within the company.

## **Lessons learned**

There are a number of factors that are instructive in this case:

The centralised approach to HIV/AIDS under the auspices of the AtlasCopco group reduces some of the burden on local management. Although there is a uniform policy and programme, there is also an opportunity for autonomy. However, in practice, both subsidiaries have followed very similar programmes.

Multi-skilling and re-engineering have emerged as a possible cushion against AIDS-related losses of skills and experience. While the company may have engaged in this process for operational reasons, it is becoming evident that this will help with AIDS-related losses.

Similarly, the pool of temporary employees for sickness-related absenteeism may very well also be in place for AIDS-related illnesses as well. The poor labour relations history within the company has definitely had a negative impact on how the trade union relates to the company on HIV/AIDS issues, as well as the policy and programme implementation process. This has hindered both parties' attempts to advance the HIV/AIDS issue. The marginal contribution of the trade unions is also noted.

Finally, the confusion on the reliability of saliva versus blood testing in establishing HIV status is a key problem underpinning the decline in survey participation rates. Clearer communication strategies on the motivation behind the change in the testing techniques would assist in more effective programme implementation.

## **Main contributors**

Interviews were held with the following groups and individuals:

- General manager
- HR manager
- Senior shop steward
- Focus group: production employees.



# Case study 5: Rand-Air

**Jocelyn Vass**

### **Introduction**

Rand-Air is a subsidiary within the Atlas Copco SA group, which forms part of the Swedish multinational, Atlas Copco. It is in the generator and compressor hire business and its head office is in Wadeville, Gauteng, with depots all over South Africa. It is a medium-sized business, employing 160 permanent employees.

### **History of the company**

Rand-Air has been part of the Atlas Copco group since 1998. The current general manager has been with the company since 1986, assuming his current position when the previous owner left in 2001. The main clients include construction (of civil roads) (55 per cent), mining, petrochemical and special events. The company hires out compressors (80 per cent) and generators (20 per cent), providing air and power. The generator business is a growth area especially since 1999, and there is an increasing need for long term hiring.

### **HIV/AIDS risk profile**

This section provides an overview of the HIV/AIDS statistics and the workforce profile, in order to construct a general HIV-risk profile.

#### **HIV/AIDS statistics**

The company conducted an HIV-prevalence survey in 2003, and was awaiting the results of a 2004 survey at the time of the research. In 2003, the participation rate was 96 per cent, and the HIV-prevalence rate was between 17 and 20 per cent, which translates to between 27 and 32 HIV-positive employees. The age, race and sex distribution of those who are positive was not available. However, with approximately one-fifth of the workforce HIV-positive, Rand-Air has a serious epidemic, at a rate higher than that in the national adult population (15–49 years) of 15.6 per cent in 2002.

#### **Workforce profile**

This section provides an overview of perceived and observed risks and vulnerability to HIV/AIDS. The average length of service is eight years. This suggests that the workforce is relatively stable and that there is a consolidation of skills and work experience.

The workforce is relatively evenly distributed between whites and Africans (Table 7.1). White women (31.6 per cent) and African men (37.3 per cent) constitute the largest proportion of the workforce. There is a relatively even spread over the age cohorts, but with larger concentrations of employees less than 40 years old. Almost two-thirds (61 per cent) are between 20 and 39 years old.

Table 7.1: Workforce by age groups, population group and sex (end of 2003)

	African		Coloured		Indian/Asian		White	
	Men	Women	Men	Women	Men	Women	Men	Women
20–29 years	8	3	1	4	1	0	6	18
30–39 years	23	3	5	4	0	0	7	16
40–49 years	19	1	3	2	0	2	7	14
50–65 years	9	0	0	0	1	0	1	3
Total	59	7	9	10	2	2	21	51

The workforce is predominantly skilled (51.5 per cent), with semi-skilled employees making up 37.8 per cent (see Table 7.2). This reflects the fact that the company provides a high-end service.

National HIV prevalence statistics show that men tend to be infected at an older age than women. Rand-Air has a concentration of men in the age groups 30 to 49 years (40 per cent), one of the most susceptible categories for HIV infection. Infection among women generally occurs at a younger age, which again reflects the age distribution at Rand-Air, as the company employs more women in the age range 20 to 29 years and 30 to 39 years (together totalling 30 per cent of the workforce). However, the majority of women in the company are white and little is known about overall HIV prevalence among white women. However, African men who are in the above age category are known to be at high risk of HIV infection.

Table 7.2: Workforce by age groups, skills category and sex (end of 2003)

	Highly skilled		Skilled		Semi-skilled		Unskilled	
	Men	Women	Men	Women	Men	Women	Men	Women
20–29 years	0	0	9	18	7	7	0	0
30–39 years	2	4	12	14	19	5	2	0
40–49 years	2	4	14	12	13	3	0	0
50–65 years	1	1	2	2	7	0	1	0
Total	5	9	37	46	46	15	3	0

*Occupational category code list*

*Highly skilled: managers, professionals, directors, engineers, nurses etc.*

*Skilled: technicians and associated professionals, crafts- and trades-people*

*Semi-skilled workers: service, administrative and clerical employees, operators*

*Unskilled workers: labourers, cleaners, elementary occupations*

There is a concentration of skilled and semi-skilled employees in the age range 30 to 49 years. Given the susceptibility of this age range, particularly among men, AIDS-related losses may have a negative impact on the company. However, information on the distribution of HIV prevalence by skill category was not available to the research team. This made it difficult to anticipate the scope and nature of the HIV/AIDS impact.

### **Social capital issues contributing to HIV risk/vulnerability**

The average length of continuous service is eight years. Most of the black staff comes from townships such as Katlehong, Daveyton and Soweto. The company does not provide a housing benefit. There was very little information forthcoming on the lifestyle stability factors among the workforce, and it is therefore not possible to reach any conclusions as to its contribution to the current HIV-prevalence rate.

### **Impact on production**

Interviews with senior management indicated that the company has undergone a number of changes in its requirement for skills and technology. New technology has been adopted, resulting in a new demand for auto electricians. Most of these workers are subcontracted as the current workforce cannot provide this particular skill. The general workforce is difficult to replace, because it takes a minimum of six months to train people. Matric is the minimum requirement for new employees who need some technical or mechanical knowledge. Training employees in several skills has made it easier to replace people. Management says that the practice of multi-skilling is in line with the new management practice of mission directed work teams (MDWT). These teams operate as business units so that they feel part of the business process. The provision of skills training modules such as business skills (incorporating company vision), quality assurance and sales, is key to the MDWT process. A multi-skilled workforce is also seen as more cost effective, given the cost of labour and also, according to management, improves quality and safety. Thus, there is a substantial investment in employees that may be at risk, given the rate of HIV prevalence.

Management put forward the following reasons for instituting an HIV/AIDS policy and programme:

- Extending the productive lives of those infected;
- Providing disease management, through the medical aid.

However, it is clear that even if multi-skilling had not been adopted in response to the negative impact of HIV/AIDS, it has generally improved the capacity of the company to replace labour losses, for whatever reason. Further, HIV/AIDS has not had a demonstrated impact on illness-related absenteeism. A year-on-year evaluation of sick leave showed that for the period June 2003 to June 2004, average sick leave had declined by 25 per cent. This is against a background of a steady workforce with little turnover or deaths.

On the other hand, the management of extended sick leave has started to worry the trade union. Management had no opinion on this issue.

### **Perceptions of the trade union**

The Black Allied Mining and Construction Workers' Union (BAMCWU) has been the recognised labour representative at Rand-Air since 1992. It has a recognition agreement, and represents 60, mainly black, employees. Most white employees do not belong to a trade union. The shop stewards describe the relationship with local management

as 'very good'. Negotiations take place at plant-level, with the annual wage round in September/October.

The shop stewards indicated that they had not raised the issue of HIV/AIDS with their members in any formal way. The union office has also not given any special attention to the issue, although in 2003 a union official did raise the issue of HIV/AIDS among many other issues. In general the shop stewards felt that there was insufficient communication between them in the depots of the different regions.

The main concern around HIV/AIDS was exhaustion of sick leave. Shop stewards had bad experiences of this in the past and needed clarity from management on this issue.

### **HIV/AIDS policy and programme**

As a subsidiary of Atlas Copco South Africa, the existing policy and programme at Rand-Air is developed and coordinated by the group. All the sites have uniform policies and programme elements and use the same consultants in the implementation of the programme. However, the cost of programme implementation is borne by individual subsidiaries. The role of the Swedish owner also appears to be relatively marginal, except insofar as it receives board presentations as to the levels of risk experienced at the relevant sites. This section looks at the policy development and programme implementation processes, its history and progress.

#### **Policy development process**

The HIV/AIDS policy sets the overall framework within which programmes are developed. Management said that they became aware of HIV/AIDS in 1998 as a result of speeches made by Clem Sunter of the Anglo American Corporation. At the time the costs of treatment came to R30 000 per person, which was considered prohibitive, and not all staff belonged to a medical aid. By 2000, some initial training was provided, and in 2002 Rand-Air worked with Atlas Copco SA group to address HIV/AIDS by developing a group policy.

The HIV/AIDS policy was instituted in 2003 as part of the group policy. This was done in consultation between management and shop stewards and the policy was tabled for consideration at the plant Employment Equity committee. Some changes were proposed which were then referred back to Atlas Copco SA. Atlas Copco Sweden has not had any input in this process, but would have reports to the board.

Management reported that the policy was communicated to employees. Each employee received a copy of the policy and it was also covered in HIV/AIDS training and at the South African depots. The policy was communicated and promoted by an external HIV/AIDS training consultancy. Management argue that on a formal level most employees should be informed. The shop stewards, on the other hand, argued that most of their members had probably not read the policy. However, the union itself has not taken up the issue of HIV/AIDS with their members.

#### **HIV/AIDS programme**

An external HIV/AIDS management consultant facilitates the HIV/AIDS programme and more recently a disease management consultant has also been retained. This is in line with group policy. The following elements are part of the programme:

- education and awareness, including information posters and information sessions in September 2003 and early 2004;
- HIV-prevalence surveys in 2003 and 2004.

The disease management provider conducts the information sessions in conjunction with the HIV-prevalence surveys.

The company claims back a discretionary grant for the provision of HIV/AIDS education and awareness from the Services Sector Education and Training Authority. The process is outsourced because it is very complex.

## **Perceptions of the effectiveness of HIV/AIDS policy and programme**

This section provides overviews of the responses derived from the focus group discussion on their perceptions of the company's HIV/AIDS intervention.

### **Focus group**

The focus group consisted of 13 participants, who were attending a monthly management feedback meeting at the time. The group was not randomly selected; they represented a cross-section of the staff including administration, line management and service staff. However, researchers were told afterwards that some staff members might have been inhibited by the presence of team leaders. Although participation was slow to start with, most participants gave their opinions when asked to do so. The length of service of the participants ranged from four months to 16 years. This meant that the group could reflect adequately on the dynamics of the company. However, due to the mixed nature of the group, many of the social dynamics specific to groups of employees could not be dealt with sufficiently.

### *Knowledge and awareness of the HIV/AIDS policy/programme*

There was a mixed response from the participants when asked if they were aware of the company's HIV/AIDS policy. Those who had some knowledge about the policy acquired this during training sessions in September 2003 and early 2004, in preparation for the HIV-prevalence surveys. Participants said that, ideally, HIV/AIDS should be among the issues discussed in the MDWT team meetings. When asked about the rights contained in this HIV/AIDS policy, the most commonly cited provisions included confidentiality of HIV status, non-discrimination, job security if HIV-positive and the role of the external disease management company that conducted the HIV-prevalence surveys. A link was made between non-discrimination towards those who are positive and the fact that an external company was secured to manage the company's HIV/AIDS programme. There was a difference of opinion as to what happens once the medical aid coverage for HIV/AIDS is exhausted. Some participants said the 'company will intervene' to cover further costs as long as those affected became part of the disease management programme. Others were uncertain as to whether this provision 'was in writing' and so not simply speculative. Participants also said that the company pays for drivers (who are subcontracted) and cleaners even if they are not on medical aid.

All the participants were aware of the process carried on through the Employment Equity committee. However, they said that they needed more feedback and reports of the activities of these committees, including HIV/AIDS. The general feeling was that although employees would like to have more information made available to them, they did not know what to know details of the company's prevalence rate.

*Factors driving participation in HIV/AIDS programmes*

The external disease management company provides the HIV testing (prevalence survey and VCT) service. Participants were satisfied with the training provided and felt that it was effective. Workers participated in the prevalence surveys because it was convenient (on company premises) and free. Only one person had gone for further VCT as a requirement for a life insurance policy. Others indicated that they would go for re-testing even if it is not provided in the company. However, none indicated if any had gone for VCT subsequent to the prevalence survey. There was some debate as to whether the prevalence survey participation was compulsory or voluntary.

The most controversial differences of opinion arose from differing interpretations of the practical implications of confidentiality of HIV status and the dynamics of HIV status disclosure. Some felt that there was no clarity on what happens to a person who has been continually ill and, with long absences from work, has now exhausted their sick leave.

One idea was that if the person is HIV-positive, they should approach someone they trust in management to disclose their status as the reason for absenteeism. People felt that the company would be flexible. Another idea was that an infected person could approach the external disease management company. The view was that if a person was to have access to treatment, the company had to be aware of their status. Without this, the 'positive employee would be fighting a losing battle'. The opposing view was that such an approach amounted to 'forced' disclosure because it should remain an individual's choice to keep their status confidential because of possible discrimination and stigma. Those with this view felt that there was no real confidentiality, because exhausting sick leave forced people to approach management and possibly open themselves up to mistreatment. There were concerns that an external disease management company does not necessarily ensure confidentiality. 'When the company pays [the HIV/AIDS] bill, it [the company] would want to know who they were paying for.' Others felt that such transactions were anonymous, and maintained the confidentiality of the people affected.

Overall, although there seems to be a healthy level of awareness and knowledge about the policy and programme, there are still high levels of distrust among sections of this group on the practical implications of HIV status disclosure and how management will deal with those who are HIV-positive in practice. In the group, this distrust was largely among the black participants. However, some black shop stewards displayed more confidence than other black participants. Those in line management positions were generally white and expressed more confidence in the approach of management, which may reflect their positions and work history.

Finally, participants were concerned that government prevention campaigns apparently did not include white teenagers, whom some regarded as a vulnerable category as well. Most people felt that the government rollout of antiretroviral treatment should not affect the company's role in antiretroviral provision because of the delays in getting treatment from government hospitals.

**Lessons learned**

A number of factors are instructive in this case study:

The company has a functioning policy and programme, which is centralised at head office level. The company has a relatively high HIV-prevalence rate, higher than the

average national prevalence rate for adults (15–49 years). The demographic profile indicates that there are high-risk groupings in the company. However, with no discernible increases in absenteeism it appears that the company has not yet felt the impact of HIV/AIDS. However, the generic nature of the HIV/AIDS programme (as decided at head office) may imply that risk factors specific to Rand-Air are not addressed. It is clear that even if multi-skilling may not have been adopted in response to the negative impact of HIV/AIDS, it has improved replacement capacity.

While the trade union has had a marginal role in policy development and promotion among the workforce, it is evident that they have identified the extension of sick leave (including AIDS-related sick leave) as a contentious issue in future.

Finally, the centralisation of governance (EE committee) of the HIV/AIDS policy and programme may have contributed to a certain level of distrust of the management's approach to HIV disclosure, as expressed among sections of the workforce. Increased sharing of information and communication at plant-level, including exact procedures for disclosure, may begin to address this issue more effectively.

### **Main contributors**

Interviews were held with the following groups and individuals:

- General manager and marketing manager
- Trade union shop stewards: four BAMCWU members
- Focus group: approximately 20 administration/service employees.



# Case study 6: Inergy Automotive Systems

Jocelyn Vass

### Introduction

Inergy is small company in the automotive component-manufacturing sector, with a labour force of 62 employees nationally. The head office is in Brits, North West Province, with a smaller plant in Uitenhage. The company produces blow-moulded plastic fuel tanks for the automotive industry. It was established in 2001 as a subsidiary of the French multinational, Inergy. The current director is French, while the general manager is South African. At start-up in 2001, Inergy incorporated a sister company and took over some of its employees.

### HIV/AIDS risk profile

This section provides an analysis of the relative exposure to HIV/AIDS risk and vulnerability faced by Inergy. An overview of available HIV prevalence statistics and the demographic and skills profile of the company is provided. This is followed by an overview of related factors such as social capital or community-related factors as well as organisational risk factors, and the impact on production as revealed in interviews with employees and management. Finally, it highlights perceived and observed risks and the vulnerability of the company to HIV/AIDS.

### HIV/AIDS statistics

In early 2004, Inergy conducted a VCT project over a week at the Brits factory. An external service provider, facilitated by the Automotive Industrial Development Corporation (AIDC), conducted HIV testing. Of the 48 employees at the Brits plant 33 volunteered for testing, a participation rate of 68.8 per cent. Six tested positive, giving an HIV-prevalence rate of 18.2 per cent among those who were tested. The bulk of those who were tested collected their results and are therefore aware of their HIV status. Subsequent to this round of testing, two more employees tested positive, bringing the HIV-prevalence rate up to 21.6 per cent for the 37 employees who were tested. This is considerably higher than the national prevalence rate of 15.6 per cent among adults 15 to 49 years in 2002.

### Workforce profile

Inergy employs 62 permanent employees, of whom 12 are based at the Uitenhage plant, and 50 in Brits. At the Brits plant, 20 are operators and 30 are employed as quality controllers in the stores and offices. The demographic and skills profile as illustrated in Table 8.1, shows that the workforce is made up mainly of African men, predominantly in semi-skilled positions. However, while whites generally occupy more skilled positions, Inergy employs three highly skilled African men in senior and middle management.

Table 8.1: Workforce profile by race, sex and skills (2004)

	African		Coloured		Indian		White	
	Men	Women	Men	Women	Men	Women	Men	Women
Highly Skilled	3	0	0	0	0	0	7	1
Skilled	9	0	0	0	0	0	1	1
Semi-skilled	31	0	5	0	0	0	1	3
Unskilled	0	2	0	0	0	0	0	0
Total	43	2	5	0	0	0	9	5
Non-permanent	4	3	0	0	0	0	0	1

*Occupational category code list*

*Highly skilled: managers, professionals, directors, engineers, nurses etc.*

*Skilled: technicians and associated professionals, crafts- and trades-people*

*Semi-skilled workers: service, administrative and clerical employees, operators*

*Unskilled workers: labourers, cleaners, elementary occupations*

*Source: Inergy employment equity report for small business, 2004*

The company employs eight temporary employees as cover for absenteeism.

Information on age distribution was not available, but the majority of employees are apparently in their early 30s. If the prevalence rate from the survey is generalised to the rest of the workforce, the average prevalence rate is closer to 16 per cent. This indicates a relatively serious epidemic among Brits employees, which is generally higher than the national population HIV-prevalence rates of 11 per cent across all ages.

The average length of continuous service at Inergy is short (around four years) because the company was only established in 2001. However, eight staff members who came over from a sister company have had their years of service acknowledged. The company has grown from 20 employees in 2001 to 60 nationally in 2004. The intention is to employ 20 more when a new Durban plant is opened. Given anticipated employment growth, the recruitment pool of young men may present a challenge as they fall within a high-risk group.

### **Social capital issues contributing to HIV risk**

The majority of the Inergy employees are African men who come from the surrounding townships in Letlabile in Brits, Motloung (in the old Garankuwa) and Mabuleke.

Differences emerged among employee representatives when asked about factors that influence lifestyle stability. On the one hand, it was argued that, as a result of the three-shift system, most employees are too tired for leisure activities over the weekend and using alcohol 'is the only thing they do'. One example cited was an attempt to organise a soccer competition, but this did not elicit much interest among the workforce. On the other hand, employees also felt that they live fairly stable lives in their communities. Management regards most of the employees as single men whereas employees regard

themselves as ‘traditionally married’ or living with someone. Most have dependants, including children. While it was not possible to make conclusions as to specific lifestyle factors, the incidence of alcohol abuse reported may be a key factor in explaining the relatively high HIV-prevalence rate at the company.

### **The role of the trade unions**

The current shop stewards’ committee was not available for an interview. However, one of the peer educators, an ex-chairperson of the shop stewards committee, shared his opinions and experiences on the HIV/AIDS process during his term.

NUMSA is the recognised trade union and has organised most of the production employees. The union argued that it was not involved in the policy development process and it was apparent that the union had different expectations of what that should have looked like. Thus, the policy was introduced to all workers, including the union shop stewards. However, at the time of the research, the establishment of an HIV/AIDS policy had not reached closure, according to all stakeholders. Although the HR consultant said that the general manager had signed off on it, employees apparently expected that both management and employees representatives would sign the policy.

### **HIV/AIDS policy and programme**

This section provides an overview of the history and development of the HIV/AIDS policy and the programme implementation process. Inergy has been a participant in an HIV/AIDS initiative conducted by the AIDC, a subsidiary of the Blue IQ project under the Gauteng provincial government. The AIDC initiative was aimed at developing HIV/AIDS policies and programmes in the automotive component sector in Gauteng province.

### **The policy development process**

An HIV/AIDS policy sets the overall framework, within which policy objectives are developed. The company policy is a one-page document that summarises the main policy principles and components of the workplace programme. As a small company, an external consultant responsible for HR also facilitated the development of the HIV/AIDS policy and programme manages the HR section. The main motivation for developing an HIV/AIDS intervention included an increased emphasis by the Manufacturing, Engineering and Related Services Sector Education and Training Authorities (Merseta) on HIV/AIDS and a general concern for employee assistance.

The Inergy intervention started in late 2002 and largely operated in terms of the AIDC initiative. This meant that it adopted a uniform programme facilitated by the AIDC and several selected service providers. Both the AIDC and the company had to make equal financial contributions and sign a contract. The programme was rolled out in March 2003, starting with consultations between the company and the AIDC representative. An employee volunteered to act as the company HIV/AIDS coordinator to facilitate buy-in on the floor. At the time of the research, a second coordinator had been appointed after the first coordinator was promoted to team leader. Apparently, the new position meant that this person would be involved in the discipline of fellow employees and it was felt that such authority might interfere with the role of the HIV/AIDS coordinator.

The Inergy policy is based on that of the AIDC. According to management, this policy was checked by both management and the shop stewards and then signed off by the

general manager in April 2003. There is no formal HIV/AIDS committee consisting of management and employee representatives. However, the peer educators and the HIV/AIDS coordinators (all employees) have formed a committee. Part of its role is to facilitate the extension of the company HIV/AIDS policy. Management does not appear to regard this committee as an element of the programme. It does appear though that the committee was formed informally to meet the specific needs of its members.

### **The HIV/AIDS programme**

Phase 1 of the HIV/AIDS programme consisted of policy and promotion awareness (see policy development) that included employee sessions, videos, a talk by an HIV-positive person, condom distribution and posters as well as training and prevention. Under the latter, twenty employees volunteered for a week of training as peer educators, of whom eight went for a further four days of training in 2002. It is not clear what the turnover rate among peer educators was or what progress they had made. The peer educator's task was to spread information to the employees in general meetings. The last meeting of peer educators was in 2003 and at this meeting the company's approach to HIV-positive people was discussed. Peer educators apparently approached the company after the VCT session in 2004 to change the menu in the canteen to healthier food. At the time of the research a response was still forthcoming, but in the meanwhile employees were offered the option of fruit juice or tea during breaks.

At the end of Phase 1, a further agreement was reached with AIDC that included co-funding. This next phase included a VCT intervention to establish HIV status. In early 2004, Inergy conducted a week-long VCT session in conjunction with external service providers (social workers and a pathologist). In that period, 33 employees volunteered for blood tests. A nursing sister provided pre- and post-test counselling. Subsequent to the testing campaign a few employees went to outside doctors for tests, with the assistance of the HIV/AIDS coordinator. Counselling has now come to an end, but at least one peer educator is available to employees on each shift. When asked about the effectiveness of the peer educators, the management representative responded, 'it is not my job to check [if they are fulfilling their requirements]'. It seems that there is very little monitoring of the effectiveness of the peer educators, or any discussion around the level of support they receive from line management. This approach comes from management's perception that they are not in the business of HIV/AIDS and therefore it is not a priority. This is not an unusual stance by most small businesses. Management said that they do not intend repeating the campaign unless there is high staff turnover. At the time of the research, the company had not experienced abnormal absenteeism, so the impact on production was not noticeable.

None of those who tested positive during the survey have disclosed their status to management, and the company reported that it had no idea who these individuals were. The company does not intend to provide antiretroviral treatment or 'unnecessary time off'. At least 50 per cent of the employees were on a medical aid. The company feels that affected employees would have to access their medical aid for HIV related treatment.

### **The impact on production**

Management said that HIV/AIDS has not had a discernible effect as the company had not experienced any abnormal absenteeism. However, at another level, some employee participants felt that the HIV/AIDS programme may be negatively affected by the current production schedule. According to participants, the programme proceeded smoothly before the survey as the production schedule allowed for it. However, the company has recently

changed its production schedule to accommodate a new contract. This leaves little time for HIV/AIDS activities. The AIDC service provider is apparently concerned about this.

## **Perceptions of the effectiveness of the workplace policy and programme**

This section provides overviews of the responses derived from the focus group discussion among production (weekly or hourly paid) employees. Only one focus group was conducted given that there are very few administrative employees at Inergy.

### **Production employees**

The focus group consisted of two machine operators who volunteered to participate.

One of the participants was a trained peer educator and therefore was quite knowledgeable about the HIV/AIDS programme. Both had participated in all of the activities, including education and awareness sessions (videos, drama), pre- and post-counselling sessions, and the prevalence survey.

When asked about the HIV/AIDS policy of the company, the participants said that they had not seen the document. According to them, the previous shop stewards committee had negotiated the policy with management, and they assumed that this was still continuing. One of their main concerns was how the company would behave towards those who were HIV positive. A meeting of the peer educators and the director had not provided clarity on this issue. They felt that now that the company knew the prevalence – and knew the potential impact – that it may assist those who are infected.

One of the reasons forwarded for non-disclosure by infected employees was that it was not clear if any assistance would be forthcoming from the company. On the other hand, it was felt that the company would respond positively, but felt that most employees ‘do not have this trust’.

They reported that, subsequent to receiving their results, those who were positive and had disclosed privately ‘felt bad’. The discussion also revealed that some of those affected need more counselling, while others can deal with the diagnosis and adopt safe sexual practices.

Participants felt that most employees have made life plans, which played a role in changing their behaviour subsequent to HIV testing. An additional motivator appeared to have been a very effective presentation by an HIV-positive person, which both shocked and impressed employees. Participants acknowledged that they were initially reluctant to have HIV testing. Most of the workforce was worried about getting their results and the impact this may have on their ‘life plans’.

### **Lessons learned**

The experiences of Inergy, as a small business, are instructive in several ways:

The involvement of an external facilitator (AIDC) was obviously a major reason for the company adopting and implementing the HIV/AIDS policy and programme. The partnership meant that the company has had to commit some of its own resources (financial, human resources and time), but in return has been provided with a range of

resources, including a range of service providers, examples of a policy format, and the components of an HIV/AIDS programme. On the other hand, this type of intervention may not be sustainable once the company has to continue with the process by itself. As the HR consultant indicated, HIV/AIDS is not their business and the demands of the business may have an impact on the time available to deal with HIV/AIDS issues.

Inergy has not conducted a risk assessment analysis and so has no idea of the possible impact of HIV/AIDS in spite of the fact that the prevalence rate is relatively high for such a small company and it is clearly growing.

The programme shows high levels of employee representation (peer educators, worker HIV/AIDS coordinator). However, there are questions around employee participation because the unions have not been involved in the policy development and obviously still expect to sign the policy.

In common with many other companies, Inergy has no plans to monitor the role and effectiveness of their peer educators. The company's demographic profile and some lifestyle factors may make it vulnerable to HIV. However, these factors have not shaped the company intervention. In such a small company, there are probably not sufficient resources, including time, staff and money, to explore how it may modify its programme to mitigate the negative impact of its HIV risk. On the whole it appears that in the absence of concrete impacts, such as significant increases in illness-related absenteeism, the programme will remain minimalist.

### **Main contributors**

Interviews were held with the following groups and individuals:

- HR consultant
- HIV/AIDS coordinator
- Ex-chairperson of the shop steward committee
- Focus group: two production employees.

# Discussion of research findings

Jocelyn Vass

## Introduction

The research adopted a case study methodology in order to provide in-depth and detailed information about dynamics that generally may not be evident in survey-orientated research. At the same time, this methodology has the disadvantage that the research findings are not strictly generalisable to the targeted research population. However, the findings may be indicative of broad trends in HIV-risk factors and the management of HIV/AIDS, including strengths and weaknesses of various approaches taken by companies. In this manner, the study seeks to complement the aggregate findings generated by studies of larger businesses, while adding local variations.

## HIV-risk factors

The study started from the premise that the research would confirm the general trends pertaining to risk factors identified in previous research, such as antenatal clinic surveys, national household surveys, and projections on the HIV prevalence levels on the basis of demographic profile and skill profile. It also looked at other risk factors such as restructuring and social capital that are less well explored in the research literature. This section reviews the findings on demographic and skills profile, length of service, the impact of restructuring and social capital and community-related factors.

## Demographic and skills profile

Much of the current research indicates that the distribution of HIV/AIDS prevalence depends on the age, sex, population group and skill or occupational category of the population being studied. Smaller empirical studies at a local level have to some extent confirmed these aggregate findings, while others have differed significantly. The latter variations are reflected in this study as well, based on the prevalence statistics provided by companies (derived from either formal prevalence surveys or VCT data). One of the more interesting findings was a case in which the low HIV-prevalence rate contradicted the predicted outcome based on the company demographic profile (African, Coloured and women) in semi- and unskilled occupations. While it was not immediately apparent why this was the case, the impact of the age profile (older women) as well as the apparent stability of the employees (length of service) were considered as contributory factors. Other companies illustrated the need to look at the dynamics and trends in HIV prevalence among men, especially in industries other than high-risk sectors such as mining, construction and transport. Thus, HIV prevalence results for African men in semi-skilled, unskilled and skilled occupations were variable and did not conform to national projections. On the other hand, where there was a concentration of high-risk individuals, such as young African females, HIV-prevalence rates were generally high, in line with national studies.

### **Length of service and lifestyle stability**

Lifestyle stability is often cited as a contributory factor to the adoption of safe sexual practices. It is an area that is not particularly well defined, and may include the impact that socio-economic factors – such as employment, income, housing, transport and marital status – can have on a stable lifestyle or on sexual and personal behaviour.

One of the factors related to lifestyle stability that emerged was the length of service of employees at a particular company. In this case, the study did not consider long-term and steady employment with several other companies. In most companies, long service (upwards of five years) was normally associated with older employees, who were less likely to have high prevalence rates. It is therefore not clear what role of length of service plays in this, as other factors such as age as well as demographic profile may play an equally important, and perhaps more direct, role in low prevalence rates. However, long service may be a key element in lifestyle stability as steady employment may contribute towards more stable families. Two contrasting examples of relatively long service histories ranging on average between 8 and 13 years showed widely varying HIV-prevalence rates. In these cases, it appears that the different demographic profiles may be one of the key factors explaining the variation. Thus, it would be important to explore the extent to which employment stability causes differences in HIV susceptibility. It seems plausible that those in relatively stable long-term employment, in which they have accumulated considerable skills and experience, may be more likely to engage in risk averse behaviour to protect their own accumulated personal capital (a family, a home, personal status in community and social aspirations).

### **The impact of restructuring and atypical employment**

One of the questions in this project was the extent to which restructuring, or more specifically the consequences of restructuring, may emerge clearly as a risk factor in HIV susceptibility. Where restructuring resulted in the increased employment of non-permanent employees (contract, casual or contract employment), did these employees display increased HIV prevalence?

The employment of temporary or contract employees was not prevalent in all companies. Where they were employed, either insufficient prevalence data or none at all were available so comparisons with permanent employees were not always possible. Other research has shown that non-permanent employees tend to have higher HIV prevalence compared to their permanent counterparts, indicating that there is still a need for further detailed research on the level of risk.

It did emerge in this study that the use of non-standard employees coincides with restructuring and multi-skilling. Further, in some cases non-standard employees are employed in skilled occupations (due to skill shortages among the permanent workforce) as well as in cases of illness-related absenteeism. In general, non-standard employees did not get a similar level of coverage in terms of the HIV/AIDS programmes; their coverage often excluded treatment and even VCT. This implies that such employees would still pose a risk in terms of HIV incidence and may not necessarily be a replacement workforce.

Further, the cost advantage of non-standard employment is gradually being reduced through the standardisation and formalisation of conditions of employment of temporary and contract employees through the Basic Conditions of Employment Act and bargaining council agreements. However, often this standardisation relates particularly to wages,

hours and leave conditions – not necessarily to other benefits such as medical aid and/or retirement benefits. Finally, the exclusion of such employees from HIV/AIDS programme shifts the burden of HIV/AIDS on to individual, community and state resources.

### **Social capital and community-related risk factors**

A study by Campbell et al. (2002: 41–54) has shown that there may be a relationship, albeit a complex one, between social capital (affiliation to community related organisations such as churches, sports' or youth clubs and residents' associations) and HIV status and HIV risk. Johnson and Budlender (2002: 53) found some evidence that certain religious affiliations may be associated with the adoption of safe sexual practices.

In this study, participants were asked what social and or community-related factors might play a role in HIV susceptibility of the workforce. In general, management tended to have very limited information about the social circumstances of their employees. So they were not able to identify risk factors related to their employees' living and social circumstances. This question usually led to a discussion on the circumstances of black employees rather than all categories of employees. This may indicate underlying assumptions about which groups of employees are at the greatest risk of HIV infection, while overlooking risk factors particular to other sections of the workforce. It was especially difficult to explore risk factors specifically related to administrative and white-collar employees across all population groups. Most maintained that they had steady and permanent relationships and trusted their partners. It may be necessary to employ different research methodologies in order to understand the dynamics of HIV risk among such employees.

Among production employees, a range of community-related factors was raised, confirming at least some of the common conclusions reached in other research. The factors that stood out as increasing HIV susceptibility included alcohol abuse (by both men and women) as well as sex for support, especially among younger women. The incidence of sex for support was related to survivalist behaviour where unmarried women engaged in unprotected sex with their boyfriends in exchange for rent, clothing and food. This is also associated with feelings of powerlessness to negotiate safer sexual practices. Alcohol abuse was associated largely with male-dominated companies (at all ages), and related to having nothing else to do after work. In this regard the absence of leisure facilities for adults in the townships was often raised as a factor in alcohol abuse.

In one of the female-dominated companies, instances of domestic violence against female employees by their male partners were reported. However, in this case it might not have been pertinent as HIV-prevalence rates were relatively low. Religious adherence or church affiliation was only cited as a protective factor at this particular company, but was not raised in any of the other. Multiple relationships generally – or a high turnover in sexual relationships among married employees – were cited in most instances as a factor in HIV susceptibility. This was thought to be specific to black men and interpreted as related to cultural practices and attitudes.

The uptake of housing loans was cited in one company as a proxy for lifestyle stability. Thus, the commitment to home ownership and accordingly to repaying a home loan may be interpreted as a commitment to a stable family and an investment in the family. It was not clear whether such home loans are used for the homes built in the township where employees live or in the rural areas where their extended families may live. This study was not able to establish such a relationship, but there is definitely value in exploring the extent to which home ownership contributes to greater lifestyle stability.

Finally, the apparent disjuncture between levels of knowledge and information about HIV/AIDS in the community and the workplace was raised as one of the key challenge facing workforces. Thus, women raised the relative ignorance of their partners as a key obstacle in convincing their partners to adopt preventative behaviours. Thus, the impact of public sector information campaigns is particularly important in ensuring that individuals in both the community and the workplace enjoy sufficient exposure and compatibility. Awareness of this issue was addressed in some companies through Family Days where both teenage children and spouses could be addressed. Further, one company also provided ARV treatment for spouses.

### **Factors that create a willingness to act on HIV/AIDS**

The willingness and capacity to act, or the lack thereof, may be regarded as a key risk factor in terms of reducing or increasing the susceptibility and vulnerability of a company to HIV/AIDS. Thus, the implementation of effective prevention programmes on HIV/AIDS is key to reducing incidence. Several senior management representatives referred to speeches and articles by Clem Sunter of the Anglo American Corporation as one of the factors that raised awareness on the importance of addressing HIV/AIDS in business. In most companies this provided the impetus to act, even though these messages came from the head of a large corporation. It appears that credible business leaders may be able to create sufficient motivation even among SMEs. Further, internal pressure from key employees who have had some exposure to the impact of HIV/AIDS in their personal lives and/or communities may be an important factor in galvanising action. However, it is not clear what the galvanising factors would be for trade union shop stewards and representatives. What is evident though is that there is a major gap between the public pronouncements from the head offices of some of the unions involved and the levels of knowledge and action by shop stewards on the shop floor.

### **Indicators of best practices in the management of HIV/AIDS**

This section provides an analysis of indicators of best or most common practices found among participating SMEs in the management of HIV/AIDS. The analysis highlights both strengths and weaknesses of these management practices as shaped by the particular circumstances of SMEs.

#### **Governance and structures**

The approach to governance and structure in the management of the impact of HIV/AIDS largely followed generic processes and procedures available in the general HIV/AIDS impact management literature. To a large extent, the interventions in these SMEs mimicked those of larger companies. In most of the companies, with one exception, a management consultant introduced, mediated and conducted the HIV/AIDS policy and programme and played a fundamental role in the implementation. The following table summarises the role of consultants and/or other service providers in the main elements of HIV/AIDS programmes.

Table 9.1: Summary of roles of management consultants in HIV/AIDS programmes at the workplace

Participating companies	Type of management consultant	Disease management provider
Autoliv	OH consultant Policy development and promotion Education and awareness	HIV-prevalence survey
Osborn Engineering		Policy promotion VCT Education and awareness
Inergy	Policy development, promotion, education and awareness	VCT (once-off)
Secoroc; Rand-Air	Policy development and promotion Education and awareness	VCT, education and awareness counselling
BIC SA	No consultants Internally managed education and awareness, VCT, peer educators Part-time doctors on-site for advice	Prevalence survey

### Organisational capacity to conduct HIV/AIDS programmes

The organisational capacity to develop and implement HIV/AIDS policy and programmes differs among companies. This is complicated by the fact that it has taken most companies a while to regard HIV/AIDS as a business issue. In general non-core issues are outsourced, in order to reduce costs and to focus on core production issues. Similarly, some aspects – if not all – of the HIV/AIDS interventions tend to be outsourced. In this research study, all except one of the participating companies interviewed contracted an external management consultancy and disease management providers to manage and conduct all or part of their workplace programmes. Specialised activities such as conducting HIV-prevalence surveys, the provision of VCT, or the provision of anti-retroviral treatment were outsourced to external disease management companies. Alternatively a management consultant facilitated access to such services. The next section discusses this area in more detail.

Most companies had one or two staff members in the HR management division or in the OH facility to oversee these interventions and to manage the consultants. The internal managers carried out activities pertinent to HIV/AIDS in addition to their usual function in the company. This allocation of responsibilities was largely influenced by the fact that the functions of HR policies and/or general occupational or primary health services would overlap with, or be influenced by, the impact of HIV/AIDS interventions.

### The role of external facilitators and partnerships

Where companies used external facilitators these tended to be management consultants who were contracted to deliver a range of services. In one case however, the company formed a partnership with an external service provider in the automotive industry (AIDC) in order to facilitate the development and implementation of its HIV/AIDS policy and programme. It is clear from the discussions that, given the resource constraints of small companies, the involvement of an external facilitator plays a fundamental role in the

capacity of the company. The partnership meant that the company had to commit some of its own resources (finance, human resources and time), but in return was provided with a number of resources, including a range of service providers, examples of a policy format, and the components of an HIV/AIDS programme. This type of intervention may not be sustainable once the company has to continue with the process by itself and once time for HIV/AIDS interventions may become secondary to other company issues.

### **The role of HIV/AIDS committees/forums**

The South African workplace is characterised by a proliferation of committees that have emerged as a result of a range of legislative imperatives. In the participating companies, the most common type of committee appeared to be in response to the Labour Relations Act (taking shape as a workplace forum), the Employment Equity Act (EE Committee or Affirmative Action Committee), Skills Development Act (training committee or absorbed in the EE committees). In addition there is now the HIV/AIDS committee/steering committee/forum dedicated to the management of the impact of HIV/AIDS.

Participating companies have adopted varying approaches. At one level, given resource constraints, some have included HIV/AIDS within the agenda of existing committees, notably the Employment Equity committee or the workplace forum. Generally these committees are representative of both labour and management. Companies do not always adhere to the relevant legislation on the make-up of such committees. However, some companies created separate committees dedicated to HIV/AIDS policy, programme development and implementation. Where such committees operated, participation and membership were generally voluntary. In this case, it was often found that important categories of employees and management, such as line management and/or trade unions were not represented in any formal manner.

Finally, it was clear that even where employee representatives were very committed, most relied upon the OH practitioner or the management representative for information and resource support. In all cases, the trade unions played no role in providing such support.

The case studies show that there is not necessarily a direct relationship between employee representation at committee level and participation of general employees in HIV testing (especially VCT interventions). However, where committees were functioning well, they generally managed to ensure that rights including confidentiality, VCT and ART (where applicable) are extended to employees. This study argues that given the relatively low impact of HIV/AIDS on the companies in the research, it has been possible for these committees to secure these rights in the absence of collective bargaining. However, the role of these committees may be reduced given increased morbidity and mortality and the costs that result, placing greater pressure on the formal collective bargaining process and trade unions.

### **The role of senior management representatives**

It is generally accepted that the involvement of a senior management representative in the HIV/AIDS policy and programme lends legitimacy and consolidating the strategic nature of HIV/AIDS as a business issue. The case studies suggest that support by the MD or senior management figures does play a key role in conferring legitimacy on the activities of the HIV/AIDS committee. In these SMEs, this is especially important as the hierarchy of functions may not be as extensive as in large corporates. Thus, in some of the participating companies the MD also served on the committees. In most cases,

though, senior representatives in the HR division or consultants (where HR is outsourced) remained the driving force behind policy and programme development.

### **Development of workplace policies and programmes**

The development of a workplace policy and programme on HIV/AIDS was accepted as the foundation of any intervention at the participating companies. Management consultants played a key role in the initial development process. Most policies and programmes were relatively generic, and a major challenge for companies lay in updating policies and programmes to fit their specific needs. Often it was found that changes to the policy and programme were implemented in practice but not necessarily reflected in updates to the policy itself.

Even HR managers struggle to access information and resource networks that are appropriate and relevant. Government departments, with the exception of the Department of Health, were generally regarded as poor sources of information. Alternatively, where departments do acquire relevant data, it is generally poorly marketed and disseminated to SMEs. On the whole, the participating companies relied on management consultants and, in some cases, non-governmental organisations.

### **The role of line management**

The case studies suggested that the role and/or involvement of line and production management in formulating and putting HIV/AIDS policies and programmes into operation have been very limited. Most companies had not conducted an analysis of the future impact of HIV/AIDS on their main business indicators, including output capacity and skills needs. While there generally seems to be support for programme implementation by senior management, it is the realisation of these programmes that has had a direct impact on production management.

However, line management does not seem to be involved in policy formulation and programme implementation. Their role is primarily interpreted as improving and increasing production, and spending time on HIV/AIDS interventions may, in the short term, have a negative impact on production. Some committees complain about difficulties in getting time off to attend meetings and training. On the whole though, as most companies have not yet been negatively affected, production managers have not yet absorbed the need for a preventative culture. There is evidence that absenteeism is monitored, but most production managers admit that it is difficult to separate out AIDS-related absenteeism from that for other reasons. The case studies suggest that even where senior management regards HIV/AIDS as a business issue in the long-term, this may not necessarily be reflected in the attitudes or approaches by line management, who may have very short-term goals in terms of meeting production targets.

### **The role of the trade unions**

One of the most interesting trends discernible among these studies is the low level of unionisation. In most cases, the unions represent less than 50 per cent of the bargaining units. Added to this has been the low level of involvement of the unions in the HIV/AIDS policy-making process and the establishment of related programmes. Thus, in most cases, the union representatives had neither a clearly defined approach nor any proposals on policy or programmatic changes. None had received any guidance from their respective trade union regional or head offices.

In most cases, the unions seem to have left policy development and programme implementation to the OH nurse, management and/or the HIV/AIDS committee. With the exception of one company, none of the shop stewards interviewed have ever received any training from their respective trade unions on how to approach management on the issue, nor have they promoted a pro forma agreement to be negotiated with the company. Union responses have largely been reactive, in response to management initiatives.

None of the unions seem to have played a clear and definite role in calling for and establishing HIV/AIDS policies in their workplace. None had received guidance from their respective trade union offices or head offices on a uniform policy approach. Further, where policies and programmes have been established, none of the unions seem to be actively involved in monitoring their implementation or dealing proactively with the problems that workers may be experiencing. A common union approach to lack of participation by their members or the workforce in VCT has been simply to acknowledge that this is the case. None of the unions have considered means and methods that may be useful in encouraging members to participate, nor do they address the fears that members may have around breaches of confidentiality. In some instances, shop stewards themselves seemed subject to the same fears and concerns as their members, which may in turn prevent them from acting proactively.

Overall, while employee representation on workplace HIV/AIDS committees was generally good, the role of the trade unions was marginal in most instances. One of the contributory factors considered was that most of the participating workplaces fell within the scope of the Bargaining Council, which perhaps explained the low levels of union involvement. Further, the bargaining council represents a forum where a standardised approach and policy regarding HIV/AIDS may be developed in the absence of local union involvement.

### **The role of workplace occupational health (OH) services**

At least seventy-five percent of the participating companies had an on-site OH facility. These generally consisted of an OH nurse, either part-time or full-time, a consulting doctor and a physical facility or clinic. Most of the case studies highlighted the vital importance of a functioning and relevant OH facility as a basic building block for the implementation of HIV/AIDS intervention systems. The service generally included primary healthcare as well as occupational health, and in most cases, HIV/AIDS intervention fell within its ambit as well.

Primary healthcare facilities provide opportunities to monitor, detect and treat sexually transmitted infections (STIs). This is essential to the HIV prevention programme as untreated STIs may increase HIV susceptibility. Further, annual medical examinations are an important means of tracking and monitoring major shifts in the health and nutritional status of the workforce. This included STIs and significant and unexplained fluctuations in body weight. Moreover, information and advice related to good nutrition and building the immune system can be made generally available at these examinations. OH practitioners are also essential to training and information on the HIV treatment regime, especially in administering medication and monitoring compliance.

However, a common thread in all participating companies with OH practitioners is concern around confidentiality or leakages of information on HIV status. This does not exclude the fact that there were as many employees who expressed complete trust and confidence in the OH practitioner.

### **Monitoring the role of peer educators**

The role of peer educators is regarded as fundamental to the implementation of effective workplace programmes and participation of the workforce. However, the case studies show that companies experienced difficulties in facilitating the role of peer educators over the longer term. Thus, whereas the initial introduction and training of peer educators were successful, maintaining their commitment, upgrading their skills and facilitating access to the workforce were fraught with problems. This related partly to the capacity of companies in an area of activity with which most are unfamiliar, the role of line management in facilitating access to employees, as well as the general understanding among the workforce of the role of peer educators. In the absence of effective monitoring, the provision of peer educators may represent a wasted opportunity for increasing employee participation.

### **Approaches to funding HIV/AIDS programme**

The ability to fund programmatic activities, especially in regard to disease management, poses a major challenge to SMEs. The literature identifies affordability of services as one of the key obstacles to SMEs accessing HIV/AIDS services. The case studies show that the SMEs adopted very creative means to providing services. In most cases, companies provide a menu of services, depending also on the extent to which medical aid coverage is available.

One such approach involved linking up with an external partner to initiate basic elements of a programme (education and VCT services) on the basis of co-funding. This approach in the automotive industry is particularly useful for small companies that cannot afford a wide range of services. Another approach included a co-funding arrangement between the company and the workforce to pay for disease management, such as nutritional support, antiretrovirals and treatment for opportunistic infections. This is only effective if the number of infected persons eligible for treatment is small; in the long-term it may not be viable. Another approach is to require co-payments by persons on antiretroviral treatment in the hope that this will improve adherence to treatment. It is not clear, however, that the two factors are positively related. Further, selected medical treatment, excluding antiretroviral treatment, but including treatment for opportunistic infections, was also encountered. In another example the company provided full funding. That is, all aspects of the programme are paid for, including awareness programmes, VCT, survey testing and additional coverage once the medical aid benefit is exhausted. The sustainability of the fully funded model is not clear, as the numbers of persons on the disease management programme may increase as levels of morbidity increase.

Companies generally felt that the government antiretroviral programme has as yet not been a key factor to consider in their own workplace programmes. Perceptions of chaos in the rollout imply that while many would like to access the programme, they do not believe that it may be feasible. In one case, these considerations led to the extension of antiretroviral treatment to spouses of infected employees.

Finally, in certain sectors, the relevant Sector Education and Training Authorities (SETAs) do provide discretionary grant for HIV/AIDS programmes. Where applicable, companies do access these grants, but the bureaucratic nature of such grants act as a disincentive, and outsourcing of this function is often a necessity.

### **External partnerships and intermediaries**

External partnerships where SMEs are linked to a resource and information network are possibly one of the more effective means to initiate the policy and programme development process. The example in this study was a partnership with an NGO that was linked to the industry and therefore provided a level of continuity and familiarity for the company concerned. This effectively reduces the time and money spent on securing service providers, as the intermediaries had already assessed these. An area of further exploration may be the role that bargaining councils and industry associations may play in acting as effective intermediaries to reduce some of the operational constraints within which SMEs operate.

### **Procedures for disclosure of HIV status**

One of the key obstacles to HIV disclosure was found to be a lack of knowledge on the actual process and procedures involved in doing so. Further, even where assurances are given in regard to policy provisions, such as antiretroviral treatment, employees expressed disbelief and distrust regarding the maintenance of confidentiality. In order to reduce this distrust, management and labour representatives need to reach agreement on the procedures and processes that accompany HIV disclosure. This needs to be communicated to employees in a manner that is visible and permanently available. This may reduce the high levels of speculation that appear to exist among the general workforce.

### **Factoring in multi-skilling practices**

None of the participating companies had conducted a long-term impact analysis of the effects of HIV/AIDS on their main business performance indicators. So, none had really considered the impact of the disease on skills retention or long-term productivity. However, what emerged is that one of the by-products of the common practice of multi-skilling is that it provides a cushioning effect against potential HIV/AIDS-related losses of skills and experience. Thus, the practice of multi-skilling is in effect becoming a default response to the potential HIV/AIDS impact. Thus, in certain instances, multi-skilling has become part of the solution to deal with employees on extended sick leave or who require relocation as a result of AIDS-related complications.

Management appears to argue that the pool of skills will remain relatively constant given the adaptability of the workforce. Further, most of the companies employ predominantly semi-skilled labour, which is easily replaceable and fairly cost-efficient given the short length of training. Where companies employ artisanal labour, the most common concern appeared to be relative shortage of skilled labour as well as being able to employ black employees to fulfil equity requirements. None had considered or factored into their programmes the extent to which HIV/AIDS may exacerbate their ability to meet skills and/or equity requirements.

In addition, none had intensified their training programmes in response to the anticipated impact of HIV/AIDS or the possible impact on their current investment in skills upgrading.

SMEs may be particularly vulnerable in terms of AIDS-related skills and labour losses given the small pool available of skilled people. However, the case studies suggest that this has not become an area of concern given the predominance of semi-skilled employees in the participating companies. This is a shortsighted view which may shift as the effects of increased AIDS-related morbidity and mortality accelerate as infected employees become ill, die or leave the workforce.

### **Handling supply chain implications**

It became apparent that there is little awareness (if any) and very little attempt to consider the level of the risk HIV/AIDS poses to the supply chain. Thus, the extent to which the AIDS-related vulnerability of suppliers of input products may increase – and possibly result in production disruptions, labour and skills losses and reduction in the quality of products – did not emerge as a factor within the HIV/AIDS programmes or policies of participating companies. In only one of the case studies participants actively considered the risk posed by their suppliers with regard to HIV/AIDS and accordingly invited suppliers to HIV/AIDS information sessions. Their awareness appeared to have been informed by the importance of export contracts that may be at risk if disruptions occur among suppliers. In another case, where the main market was the high-risk sector of mining, HIV/AIDS had not been factored in as a possible risk to the supply chain. However, this attitude may be an unfortunate spin-off of the active approach generally taken in the mining sector in the management of HIV/AIDS. None of the companies pursued their HIV/AIDS programmes with a clear sense that they themselves might pose a risk to their client companies. Yet participating SMEs are suppliers to large corporates in the mining, retail and automotive assembly sector, and therefore inter-dependency within the supply chain should be a key factor driving business practice. Much of the driving force for HIV/AIDS interventions was internal consideration in terms of labour losses and sustaining profitability.

On the whole therefore, most of the participating companies had not considered the extent to which HIV/AIDS-related disruptions in the supply chain and the management thereof maybe a key strategic dimension in the overall management of HIV/AIDS in the workplace. This will continue to the case as long as the management of HIV/AIDS remains an ‘own affairs’ issue and the long-term business implications, both internally and externally, are not sufficiently appreciated.

In conclusion, best practices as generally advocated cannot be taken at face value, especially given the limitations of SMEs. It is clear that most SMEs tend toward centralisation of policy as well as programme development and its implementation, whether facilitated by external or internal providers. One of the key problems identified is the failure of trade unions in playing an effective role in representing employees’ needs around HIV/AIDS governance.

### **Measures of the impact and effectiveness of the programme**

This section provides an analysis of those measures that may be indicative of the impact and effectiveness of the workplace HIV/AIDS programme. It also provides an overview of particular challenges that SMEs face in shaping appropriate business practices in regard to HIV/AIDS programme implementation and sustainability.

#### **Employee knowledge of the impact of HIV/AIDS on the company**

One interesting issue raised in the focus groups was that some employees seemed embarrassed to receive or give information on the number of people infected within the company. In fact, most expressed a clear lack of desire to have any personal knowledge in this regard – even if it only referred to aggregate data such as the average percentage of HIV infected employees. Interestingly, the union representatives displayed a similar attitude, in that none expressed a need to know the impact of the disease beyond discussion of budget allocations for prevention and treatment measures. This is in

contrast to the desire historically among South African employees, especially unionised employees, to have access to information on business issues – particularly those having implications for employees. Further, this occurs in a period in labour relations when there is a particular emphasis on access to information (for example, for purposes of restructuring, retrenchments and collective bargaining) and the existence of relevant legislation. The case studies suggested that both employees and union representatives interpret the release of HIV prevalence information to the workforce as a breach of the individual's right to confidentiality. This is despite the fact that HIV-prevalence rates are generally released on an aggregate basis and anonymously. This resistance becomes more understandable where rates of HIV prevalence are categorized by occupations or other sections of the work force, as in cases where the number of people involved in a category is low, the release of the information may increase speculation and even risk exposure of infected individuals.

It also became clear that most employees appreciate the importance of the size and nature of the HIV impact in terms of business planning. This partially explains their participation in HIV-prevalence surveys. However, it may also be argued that employees interpret HIV-prevalence rates in a more personal and private manner. There appears to be a particularly narrow interpretation of confidentiality as well as considerable stigma attached to how individual HIV status contributes to the size of the overall company HIV status. The next section seeks to explore the complex issue of confidentiality of HIV status further.

### **Confidentiality of HIV status**

Confidentiality and non-discrimination are the bedrock of all HIV/AIDS interventions. These principles are enshrined in a range of legislation in South African labour law, including the Employment Equity Act and the Code of Good Practice on Key Aspects of HIV/AIDS and Employment. They have the clear intention of protecting the rights of those infected and affected. However, this study raised concerns around the understanding generally prevalent among employees as well as the extent to which confidentiality affects the ability of those who are infected to access resources. The practical implications of confidentiality need to be considered more carefully.

At the one extreme, the interpretation at the shop floor is that no one is supposed to know about an individual's HIV status. In one instance, employees felt that the fact that the OH practitioner conducted VCT implied that at least one person known to them would know their status. Accordingly, many thought that there was insufficient secrecy around testing. In another instance, those who require disease management (nutritional support, treatment for opportunistic infections and antiretroviral treatment) needed to disclose their status in order to have access to these services at company level. In some cases, such disclosure is regarded as forced because those who are infected have no choice – disclosure determines access to treatment. Companies sometimes reported that the take-up rate for their disease management programme did not fully reflect the numbers of those who were eligible for treatment. As a result, a range of alternative interventions has been developed, including posting medicines to either the company or the individual's home. The role of external disease management service providers is essential in order to reduce the involvement of the company and its representatives to a minimum. One company even explored the possibility of self-administered tests in order to alleviate employees' fears around failures of confidentiality.

Thus, the interpretation and practical implementation of the principle of confidentiality present complex dilemmas to practitioners in the workplace. Conflicting interpretations and perceptions of confidentiality among the workforce may become a major obstacle in improving take-up of prevention and disease management programmes.

### **Employee participation in HIV testing**

HIV testing is one of the key measures to establish the impact of HIV/AIDS on the company. It also assists employees in establishing individual HIV status, a potentially important factor in behaviour change as well as accessing treatment. Thus, the participation rate of employees in HIV testing (whether on- or off-site) is a valuable indicator of success. All of the case studies displayed an enormous disjuncture between the participation rate in voluntary counselling and testing and that in anonymous unlinked prevalence surveys.

All the case studies showed that employee participation rates are significantly higher in anonymous, unlinked prevalence surveys than in VCT. This difference occurs irrespective of the provision of on-site or off-site VCT facilities. Neither access nor location appeared to play a significant role in the reduced success of VCT uptake.

Further, a frequently cited reason for not taking up VCT is the fear of being informed of individual HIV status. This is not the case in anonymous unlinked prevalence surveys because participants can choose whether or not to access their results. In these case studies, it was reported that in general some people would not fetch HIV results generated in prevalence surveys. However, accessing HIV test results is inherent to participation in the VCT process.

Contributory factors in the participation in prevalence surveys include a perception among employees (often unspoken) that participation is compulsory, even when it is clearly stated that such participation is voluntary and the survey takes place as a high-profile event at the workplace. Covert peer pressure (observation of colleagues participating) may also play a role, as employees, colleagues and management are all seen to be taking part. The motivation for taking part in a prevalence survey may have less to do with the individual's desire to know their status and more with their perception of the company's desire to know what impact the disease may have. A collective rather than an individual approach may contribute to low participation in prevalence surveys and VCT.

Low uptake of VCT appears to be related to a number of factors according to the case studies. VCT is entirely voluntary and employees have to make an appointment with the health practitioner (whether internal or external) and the decision rests entirely on an individual's motivation to establish their HIV status. This choice may be overridden by fears, causing the person to postpone making a difficult decision. There is little peer pressure to participate. As indicated previously, accessibility or location appears not to matter in VCT up-take, whereas fears around confidentiality seem to be more important when testing is on-site.

The literature does suggest that a range of obstacles including a fear of knowing one's HIV status bedevils VCT uptake. The apparent difference between uptake of prevalence surveys and VCT suggests that the form HIV testing takes in the workplace is complex, appearing to address to different needs at company and individual levels. Thus, while a prevalence survey may be appropriate to establish aggregate HIV status of a company,

it may not necessarily be sufficient to increase knowledge of HIV status at an individual level. This is further exacerbated by the poor uptake of VCT testing. Thus, companies and labour representatives need to develop common goals with regard to HIV testing. If the testing is solely to establish company HIV status, this may not necessarily translate into a reduction of HIV incidence. This is largely due to the fact that establishing individual HIV status is an important precursor to rethinking sexual behaviours and practices.

In general, all companies reported good participation of employees in awareness and education programmes, with some differences between administrative and production employees. The key obstacles related to the uptake of VCT as outlined before.

### **Linking risk factors and programme development**

The identification of risk factors specific to a workforce can be a powerful means to appropriately shape the nature and scope of HIV/AIDS programmes. The case studies show that there is a general awareness of demographic risk factors, including age and sex of the workforce. Among management there was often limited awareness of the social circumstances of employees or the role that these may play in terms of HIV risk, such as alcohol abuse, nutritional status and others. In one case, average HIV-prevalence rates in the surrounding industrial area was used as a proxy for the level of risk faced by the workforce. However, it appears that no linkage was made between the type of HIV/AIDS intervention and the potential risks specific to a workforce. In one case, the 'helplessness' of young African women as a result of economic dependency was identified as a future area of intervention that should include life-skills training.

An additional factor relates to the programmes offered by management consultants. Given resource constraints, it may be difficult for companies to develop customised programmes. Using 'one size fits all' programmes may produce an 'AIDS fatigue', reflected in declining interest resulting from programmes that are not geared to specific needs and priorities.

### **Appropriate communication strategies**

One of the consequences of generic information campaigns is that the information provided does not always address the real issues or concerns of the workforce. It was apparent from all of the employee focus groups that, at times, information overload creates confusion in an atmosphere that is already highly speculative given the sensitivity around HIV/AIDS. Thus, in one instance, confusion about the use of different types of biological testing to establish HIV status as well as the relative validity thereof contributed to distrust and a decline in employee participation. Another example relates to the stigmatisation of the use of nutritional supplements, which highlights the importance of introducing and marketing such products or services appropriately.

Further, employees often reported that they had not actually seen a written policy document. As a result, while some were able to describe some of the policy provisions, different interpretations abounded along with a lack of trust in the company's commitment to adhering to policy. It is clear that policy provisions and procedures should be displayed in a highly visible and accessible manner in order to reduce speculation about their content. In an atmosphere where there is such a high level of sensitivity and stigmatisation, more upfront communication is essential.

One of the key problems of the communication strategies is that sources of information are predominantly management-directed, although employee representatives on HIV/AIDS

committees do play a key role. The peer educator system has not been successful in most of the companies where it was introduced. Finally, the trade unions have not emerged as a credible communicator and appear to have handed this role to management.

### **Company size and HIV/AIDS management**

Although this study looked at only one small company, it would appear that size does matter and that medium-sized companies perform better than compared to small companies. Medium-sized companies have shown in this study that they can exercise more autonomy, although they generally struggle to maintain momentum and address many of the challenges faced in implementation.

### **Implications**

As shown in the literature review, there is an apparent failure by small- and to a lesser extent medium-sized companies to manage HIV/AIDS effectively, when compared to large companies. However, it is evident from these case studies that there are obstacles faced by SMEs that cannot simply be explained by a lack of will or resources. The case studies show that participating SMEs are prepared to devote resources – human, financial and time – to the management of HIV/AIDS. However, HIV/AIDS management requires an innovative set of business practices that go beyond the essential elements of a policy and programme to provide sufficient support, information networks, funding and consistent follow ups. Without these dimensions, many opportunities created may be wasted.

SMEs experience difficulties in reconciling current business practice with the demands and challenges of HIV/AIDS management. Thus, a common response may be, quoting a business consultant, ‘...we are in the business of making profits, not of HIV/AIDS’. Further, HIV/AIDS management occurs in a business context where so-called non-core business functions, such as HR, are often outsourced. Doing so with certain technical aspects of HIV/AIDS management – such as education and awareness programme, HIV prevalence testing, VCT and the administration of ART – makes sense, as these interventions require particular expertise not appropriate to normal business practice. However, this implies that HIV/AIDS intervention, as a non-core function, does not become internal to business practice. Further, companies do not necessarily receive customised programmes. On the other hand, given the resource constraints among SMEs it is not arguable that HIV/AIDS interventions should become an in-house operation function. Moreover, the case studies suggest that SMEs find it extremely difficult to deal with the challenges and problems arising from HIV/AIDS programmes and do not necessarily have the relevant skills or expertise given the nature of these challenges. As a result, given difficult choices in terms of resource allocation, HIV/AIDS interventions may suffer in the long-term.

The case studies suggest that while these SMEs are able and willing to initiate HIV/AIDS programmes (even if outsourced, as in most cases), the sustainability of such programmes poses a definite challenge to programmatic capacity. This challenge relates largely to dealing with unblocking obstacles to programme participation including stigma, fear of HIV status, the minor role so far assumed by trade unions and a lack of sustained external support from government departments and industry associations. ‘HIV/AIDS fatigue’ among employees poses a particular problem as workplace committees seek to find new and interesting ways to maintain interest and participation among employees. Given waning participation and support by employees, the continued strain on resources and the pressures of production, it becomes virtually inevitable that HIV/AIDS programmes decline.

As shown in these case studies, the innovative capacity of the small number of people responsible for HIV/AIDS programmes is severely challenged. Thus, access to information and resource networks is essential, as the lack of sufficient support, information and follow-ups mean that many opportunities created at workplace level are often wasted. Ongoing institutional support through bargaining councils, trade unions, industry associations and the relevant government departments will play a key role in this regard.

Some SETAs do provide a discretionary grant for HIV/AIDS interventions, but it is not necessarily a standing feature and, given changing priorities, may change from year to year. The complexity of claiming back grants, however, poses a serious challenge to SMEs, who tend to outsource this administrative function. SETAs need to consider targeted HIV/AIDS grant allocations for SMEs while reducing the administrative burden involved.

There is a need to develop synergies between workplace provision of antiretroviral treatment and how SMEs (where necessary) link up with the government antiretroviral roll-out programme. Further, the accessibility of government clinics, both during working hours and for shift employees, is crucial. Long queues at such public facilities result in increases in sick leave and losses in production time and wages.

A final comment relates to the dissemination and appropriate use of best practices in SMEs. In all but one of the companies, the approach to policy and programme development mirrored those in large companies. Of course, there were key adjustments made over time. It is clear that there is a need to promote the notion of increased flexibility in practices as well as more practices suited to the needs and circumstances of SME. Moreover, given their time and resource constraints, SMEs cannot afford to learn by trial and error in this regard – failures in the management of HIV/AIDS in the short-term mitigate further resource allocation.

## **Conclusion**

This study collates the experiences of a group of SMEs in managing the HIV/AIDS burden. Much of the current research on the drivers of HIV susceptibility and the management of HIV/AIDS in the workplace is derived from quantitative surveys. There is very little qualitative information available in the public domain on such dynamics. This study is an attempt to breach this gap by allowing both employers and employees to voice their opinions and reflect upon their own experiences of the challenges of HIV/AIDS and its management in the workplace.

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