

THE EFFECTS OF HIV/AIDS ON MEDICAL PRIVATE PRACTICE  
BUSINESSES IN KWAZULU NATAL: THE CASE STUDY OF UMLAZI  
TOWNSHIP

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## **ABSTRACT**

The HIV/AIDS pandemic has had a seriously negative impact on the South African workplace, with industries experiencing the many adverse effects of the disease such as the problem of absenteeism. Other effects of HIV/AIDS at the workplace include loss of productivity and profitability, especially if the disease is not managed properly. The aim of this study was to investigate the effects of HIV/AIDS within the private medical practice industry in Umlazi Township, in the Province of KwaZulu Natal. The research methodology used was quantitative. There are only 40 private medical practices in Umlazi Township. The entire population of private medical practices is included in the sample because of the manageable population size. No sampling method was therefore used. Close-ended questionnaires were hand delivered to all the doctors in all the private medical practices in Umlazi. The questionnaires were collected once the doctor indicated that s/he completed it.

The salient finding of this study were that HIV/AIDS induced absenteeism is a major challenge for private medical practitioners. A good HIV/AIDS policy is necessary for the medical doctors to effectively manage HIV/AIDS at their private medical practices. While the respondents acknowledged the effectiveness of an HIV/AIDS policy if implemented, they understood that it would be difficult to implement it. Because of its effect on business sustainability, HIV/AIDS can result in serious problems for private medical practices, including bankruptcy. The recommendations of the study are for private medical practices to implement their own HIV/AIDS policy – which must encompass education, training and treatment of those that are infected and/or affected by HIV/AIDS. The study highly recommends and encourages staff to undergo VCT (Voluntary Counselling and Testing) so that the disease can be identified early – which makes management of it timely, and more effective.

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## **CHAPTER 1 INTRODUCTION AND BACKGROUND OF THE STUDY**

### **1.1 INTRODUCTION**

HIV/AIDS is a pandemic that has affected the world beyond all original expectations. It has had adverse effects both on society and in the workplace – both socially and economically (Clark, 2008, p.1). The aim of this research is to uncover the effects of HIV/AIDS in medical private practices in KwaZulu Natal, particularly in Umlazi Township. The impact of HIV/AIDS at the workplace has been felt for more than 3 decades, with the negative effects growing exponentially over the past 10 years (Moustapha, 2000, p.1). The aim of this research is to find out what the effects of HIV/AIDS within the private medical industry. According to Fasset (2005), the prevalence of HIV/AIDS is quite high, even within the individuals that operate within the medical industry. According to Deghaye, Pawinski and Desmond (2006), HIV seroprevalence amongst healthcare workers is estimated at 16%. This relates to both the public and private health sector. Doctors in private practices within the townships are affected by negative factors like poor performance, absenteeism and low productivity as their employees become both infected, and affected by HIV/AIDS.

### **1.2 BACKGROUND TO THE RESEARCH**

The study focussed on the impact of HIV/AIDS from the doctor's perspective particularly those who that operate in Umlazi Township and who have supporting staff members in their businesses. In essence, this study is about the effects of HIV/AIDS specifically from the employer's point of view. The study shows that HIV/AIDS has indeed had an adverse impact on the workplace because: if not properly managed HIV/AIDS will lead to increased absenteeism, decreasing of productivity at work and a decline in domestic income. All these factors adversely affect the Gross Domestic Products (GDP) of the country, place a strain on various forms of education and lead to demotivation of workers that are infected or affected by HIV/AIDS.

As has been mentioned above, this study concentrates primarily on a specific type of workplace in the Umlazi Township in KwaZulu Natal. According to the statistics that have been provided by Ethekewini Municipality Business Unit, there are 40 medical



practices that operate within Umlazi Township. Employers, more especially those in management positions, are tasked with the formulation of policies set out as frameworks for managing HIV/AIDS in the workplace. Although in most cases, employers exceed the requirements for formulating HIV policies; the implementation and application of such policies remain a challenge. It has been recognised that most global businesses are aware of the impact of HIV on their bottom line, yet only 6% have instituted written HIV policies. This is a serious indictment on the part of management, considering that HIV/AIDS is a disease that carries one of the highest rates of both morbidity and mortality, especially in sub-Saharan countries. The unique potential contribution for this study is based on the fact that no similar study that has been done in the medical industry, in Umlazi Township. Umlazi is a growing and developing township, and many young doctors aspire to open their practices in this location. To do this, they need to apply for finance, and they incur high loan repayments that have to be made during the course of the business. It would be of great benefit for these aspiring, and current practitioners, to understand to what extent HIV/AIDS has the potential to negatively affect the sustainability and survival of their businesses.

### **1.3 MOTIVATION FOR THE STUDY**

There is a drive in South Africa, as it is the case in many economies around the world, to promote Small Micro and Medium Entrepreneurs (SMME's). In the medical, in every other sphere of business, HIV/AIDS continues to have negative effects. According to Fasset (2005), on the other hand, there is no evidence to suggest that HIV/AIDS will be "arrested" anytime soon. Businesses, irrespective of their sizes, must develop methods and policies to deal with HIV/AIDS. This is the main motivation behind this study.

This study will greatly benefit employers (in this case the medical doctors that run their own practices), the employees, healthcare organisations and government. The employers and the employees will be in a better position to understand how productivity is affected by the disease, and such information could be used for preventative interventions. The healthcare workers would also benefit from the

research as their understanding of co-workers would be enhanced by a better understanding of the effects of the disease. “Government funds a greater portion of its fiscal undertaking through taxes, and if HIV/AIDS negatively affects revenue, such funding will also be negatively affected” (Akande, 2009, p.2). Both employers and employees have an equally important role to play in the management of HIV/AIDS in the workplace.

Twenty-two (22) million of the thirty-three (33) million HIV-infected people worldwide reside in sub-Saharan countries and South Africa itself has approximately 5.7 million of those (UNAIDS Global Report, 2008). “Employers are mostly aware of the role they are supposed to play in the education of their employees about the prevention and management sexually transmitted infections (STIs), which contribute to the escalation of HIV infections” (Clark, 2008, p.4). Employers who accept HIV/AIDS management as a critical part of their corporate social responsibility will be in a better position to benefit from policies and interventions. HIV/AIDS has a negative effect on productivity and for that reason there is the need for aggressive intervention activities to deal with its challenges. According to Fasset (2005), the expenditure on such programmes might seem wasteful and excessive in the short-run, but in medium to long-term, the benefits will far outweigh the costs. Committed employers should set up HIV/AIDS awareness committees which are specifically tasked with ensuring the full participation of employees.

This study is also important for the employees, who must be made aware of the spread of HIV/AIDS, if the disease is not properly managed. Employees have an important role to play in the prevention and management of HIV/AIDS. One of the objectives of this study is to uncover the specific strategies that are currently being implemented by both employers and employees in the prevention and management of HIV/AIDS at workplace. Furthermore, special preventative measures could be effectively put in place to deal with this challenge once the situation is well understood. The results of this research, and maybe others in the future will give a

fuller understanding of the situation and offer recommendations to mitigate against potential ruin.

### **1.3 FOCUS OF THE STUDY**

As it has been mentioned during the introduction, this study focuses on the private medical industry in Umlazi Township. The majority (98%) of the respondents are black males and female doctors who are entrepreneurs. They set up their practices after they had spent the required time within the public sector, as per government requirements. The study will focus on all the practices within the township, irrespective of their size, structure or in existence. The surrounding areas like Isipingo, Clairwood and others adjacent to Umlazi will not form part of this study.

Absenteeism as a result of the ill-health of a worker is unproductive to any business. Often a worker's chronic illness is neglected or ignored by management because of a lack of resources to deal with it; or even more seriously because of the absence of will to intervene in the management of that health hazard. According to Taylor, De Young and Boultrini (2004), many employers are aware of the impact of the HIV/AIDS on their workplace but only 6% were found to have instituted written HIV policies. This demonstrates a regrettable lack of enthusiasm on the part of employers to deal with this pandemic. It has been found that the lack of any HIV intervention programme will be costly to the business. Another element that will be covered by the study involves around the stigma and discrimination against HIV/AIDS that prevents people from disclosing their status. When this happens, they obviously do not get assistance and support from their employers who, in this study are medical doctors. Furthermore, some supporting staff members are even reluctant to test their status for the fear of victimisation, should they test positive.

Despite these interesting factors, the study will not involve the supporting staff members, because of the following factors:-

- Since the research is undertaken for an MBA qualification, the study wanted to look at HIV/AIDS from an entrepreneur's point of view (the doctor in the private practice) rather than from a medical point of view;
- The researcher is a qualified medical doctor, and wanted to be in a position to consult with and assist other doctors based on the results of this study, and
- The aim is to keep the study simple, yet comprehensive and "deep" instead of widening the pool of respondents.

It is however possible that the results of this study could be applied in other townships in and around South Africa, as dynamics in such locations are usually similar (Clark, 2008, p 6). This study investigates the level at which HIV/AIDS affects the normal running of businesses in the medical private practice. Ultimately, the researcher (being a medical doctor himself) will make recommendation for the establishment and implementation of HIV/AIDS intervention programmes in the workplace. Companies are always interested in the bottom line, i.e. profits. This study will demonstrate the benefit of having HIV/AIDS programmes in place that can be implemented and monitored to contribute to attaining the financial goals. It will demonstrate the cost-effectiveness to the company of having HIV intervention programmes.

#### **1.4 PROBLEM STATEMENT**

One of the main challenges that have been identified around the issue of HIV/AIDS within the medical related practitioners entail (but are not limited) to the following:-

- Medical practitioners are sometimes complacent on the issues relating to their own safety when it comes to HIV/AIDS (Clark, 2008);
- There is an even greater stigma that is associated with being an HIV/AIDS sufferer when one is employed in the medical field (Clark, 2008);
- Doctors that run their own practices ultimately risk bankruptcy, as the absenteeism from their affected and/or effected supporting staff members escalates (Akande, 2009) and
- Overall, the infection rate of HIV/AIDS remains very high in the townships, including in Umlazi Township (Akande, 2009).

The study is going to assist with many, possibly all, of the above mentioned challenges. This could be achieved in the following ways:-

- The medical practitioners will be aware from the results of the study that the effects of HIV/AIDS are rife within their industry. This is critical for the development and implementation of relevant interventions.
- The entrepreneurs (doctors) who run their practices will be able to access the current situation (the effects of HIV/AIDS) in businesses similar to theirs, and be realistic about the potential success or failure of such businesses, and more importantly be able to learn how to mitigate such challenges;
- Lastly, this study will act as a warning, specifically to the supporting staff members in the medical field about their vulnerability to the scourge of HIV/AIDS despite the fact that they work in the medical field.

Ultimately, this study has the potential to act as an “eye opener” about the realities of HIV/AIDS in the medical field as a whole.

When not well-managed, the HIV/AIDS epidemic has been linked to a high rate of absenteeism in the workplace. HIV/AIDS, when incorrectly managed, has a negative impact not only on absenteeism, but also on education and on the families of those who are HIV- infected or affected. Businesses experience escalating costs owing to a high rate of absenteeism. Employees are often stigmatised and discriminated against. According to Akande (2009), households may experience difficulties should the breadwinner, be unable to earn a salary owing to his/her illness.

This study identifies the seriously adverse effects HIV/AIDS has in the workplace if not properly managed. Proper management of HIV/AIDS will only be achieved if the practice has realistic and achievable HIV/AIDS policies in place, and also has the willingness to implement them. This study highlights the importance of HIV intervention programmes and the potential benefits to medical businesses that have managed to come up with HIV/AIDS policies which are implementable and well

monitored. This study enables both the employees (supporting staff) and employers (doctors) to have a complete understanding of the effects of the HIV/AIDS epidemic and more importantly of the recommended HIV policies to deal with HIV/AIDS challenges within the private medical practice industry.

## **1.5 OBJECTIVES**

The objective of this study is to investigate the effects of HIV/AIDS within the private medical practice industry within Umlazi Township, in the Province of KwaZulu Natal. The following specific objectives have been identified for the study:-

- To investigate the effects of absenteeism within the private medical practices as a result of HIV/AIDS;
- To investigate the current policies aimed at dealing with the challenges of HIV/AIDS within the private medical practices;
- To investigate the effectiveness of current policies aimed at dealing with the challenges of HIV/AIDS; and
- To evaluate the extent of the effect of HIV/AIDS on the businesses sustainability.

The study is mindful of the fact that the issues surrounding HIV/AIDS are sensitive, and in most cases are kept secretive by those that are affected by and/or infected with the disease. This might have a negative bearing on the results of this study.

## **1.6 RESEARCH METHODOLOGY**

A comprehensive literature search has been conducted to identify as many factors as possible that are a result of HIV/AIDS within the private medical practices. International and national data searches through the University of KwaZulu-Natal Libraries have also been conducted. According to Clarke (2008), since HIV/AIDS is such a pertinent and current social and economic challenge, much information has been retrieved from newspapers, magazines and from the Internet. As the title of the study suggests, the focus of the study is “localised” (i.e. within Umlazi Township) and

as such local newspapers have been comprehensively used as a secondary source of information. Furthermore, specifically selected journals have also been utilised as a way to gain further access to advanced secondary information.

Primary data has been collected through closed-ended questionnaires, as this is a quantitative study. As mentioned earlier, no sampling technique has been used, as the population was very limited. The questionnaires were hand delivered, and either wait for the practitioner to fill the questionnaire, or collected as per the request of the practitioner him/herself. The questionnaire was designed to include a seven Point Likert Scale format, and was divided into 5 sections. Section One covered the personal details of the practitioner (the name of the practitioner and that of the practice, together with its location within the township, were deliberately left out). Sections Two to Four covered each objective in the same order as they have been enumerated in section 1.5 above. In line with the views of Moustapha (2000), the researcher decided against posting the questionnaire via internet or the post system, as the responses to these methods are slow, and often of very poor quality. The design of the questionnaire, including the structuring of statements has been simplified to avoid undue confusion. Since this was a study of an altogether new subject matter there were severe time limitations, and therefore there was no pilot study activity. That is why the researcher spent large amount of time on the questionnaire design, to ensure the simplicity and “straight-forwardness” of the questionnaire.

A pilot study should have been done where another set of similar respondents could have been used to ascertain whether the research instruments are functioning well, whether there is any confusion about certain questions and to help detect any problems about the future research. The pilot study would have laid the foundation for bigger study and clarify any problems and unwanted confusion. However, due to time constraints a pilot study was impossible.

## **1.7 LIMITATIONS OF THE STUDY**

As it has been mentioned above, one of the major limitations of this study is that the issue of HIV/AIDS remains sensitive, despite the calls from different stakeholders that it needs to be accepted like any other disease. This sensitivity motivates and intensifies the levels of secrecy surrounding the manner in which matters about HIV/AIDS are handled. Furthermore, for this study, the effects of HIV/AIDS are analysed from the doctor's point of view as he/she deals with his/her staff members that might be affected and/or infected.

The study was conducted only at Umlazi. This created a limit on its own because it could have covered a wider area, including areas like Isipingo, Lamontville and Clairwood. The researcher would have preferred to conduct his research in a larger number of townships around KwaZulu Natal. The researcher, however, is mindful that there are many similarities between townships, and as such the results of the study could be generalised, of course with some measure of caution.

Lastly, the fact that the study is quantitative in nature is indeed a limitation. The respondent is not afforded an opportunity to express him/herself, to reflect and to engage. For a complex issue like HIV/AIDS, an unstructured interview would have been more appropriate but this was not possible because of the time limitations mentioned earlier.

## **1.8 CONCLUSION**

The objective of this chapter was to cover the issue of HIV/AIDS from a historical point of view, whilst placing special emphasis on this issue in the context of the private medical practices that are located within the Umlazi Township. Absenteeism in the workplace has a great impact on productivity and profitability. Therefore, employees absent at work due to poor health will affect this dynamics. It is imperative that the employers understand the impact of HIV/AIDS at the workplace. The special focus of



the study has been mentioned, together with the objectives and methodology of the study. Lastly, the limitations of the study were covered.

The next chapter will cover the literature review. It is important to note that the researcher will not be restating what other sources contribute to the topic, but will try and identify gaps (or voids) in the current research and how these will be “filled” by his research.

## **CHAPTER 2 LITERATURE REVIEW**

### **2.1 INTRODUCTION**

HIV/AIDS has had a severe impact on the world and on society at large. It has spread at a much faster rate than expected since when it was identified more than 20 years ago. According to UNAIDS Global Report (2008), the epidemic had infected 33 million people worldwide. Of these, 22 million will be from sub-Saharan Africa, 5.7 million of whom were from South Africa. A shocking 5.4 million of the infected were in the 15+year age-group (UNAIDS Global Report, 2008).

“HIV and AIDS has had an impact on social capital, population structure and economic growth” (Piot, Bartos, Ghys, Walker and Schwartinder 2009, p.1). Most HIV-related deaths have occurred in Africa. According to McIntosh (2007), Africa’s share of the total estimated deaths from HIV/AIDS since the beginning of the epidemic is over 85%. He also states that, “new infections (3.4 million) occurred in 2001, 2.3 million Africans dying of AIDS in that year alone”. The UNAIDS Global Report (2008) stated that, the Actuarial Society of South Africa put the average workforce HIV infection rate at 18.8% (ranging from 10% to 59% across different industries) with the cost to the economy around R2 billion. According to Akande (2009), UNAIDS/WHO 2008 reported that ‘a third of all new infections in 2007, and AIDS-related deaths globally occur in South Africa and its southern African neighbours’ and the numbers will continue growing if the disease is not contained soon.

### **2.2 HIV/AIDS GLOBALLY**

The global business sector has not escaped the scourge of the HIV/AIDS pandemic. It has been affected by one of the deadliest pandemics of the century. “The pandemic has caught people globally, pants down, factually, literally and scientifically” (Akande 2009, p.1). The business sector employs the most active people in society between the ages of 15 and 49 years: and unfortunately these are the ones who were most often either infected with or affected by the HIV/AIDS epidemic. According to Rosen, Simon, Vincent, MacLeod, Fox and Thea (2004), HIV prevalence in the workforce studied in Southern Africa ranged from 7.9% to 25%. They state that, HIV/AIDS

among employees added 0.4 - 5.9% to the companies' annual salary and wage bills. HIV and AIDS have a profound effect on absenteeism and other aspects of the workplace. According to Kumaranayake, Churchyard and Charalambous (2007), HIV positive individuals are likely to have a 30% higher rate of absenteeism as compared to healthy employees within the labour force. The outlook becomes more serious when those HIV-positive employees are not on any HIV/AIDS intervention programme. According to Habyarimana, Mbakile and Pop-Eleches (2007), the introduction of ARV treatment into the workplace is followed by significant reduction in absenteeism in the 6-12 months following treatment.

The effect of HIV and AIDS is also potentially palpable in other areas of the workplace, including:-

- Strategic supply of labour
- Demand for labour
- Poverty reduction strategies

The devastating effects of HIV and AIDS on the workplace often includes stigmatisation and discrimination, decreased production, human rights violations, a decrease in quality of life in affected households and a negative effect on the education of the relatives or dependants of HIV-infected workers. HIV and AIDS also affect the profitability of companies and the entire business sector, be it private or public.

According to Taylor, De Young and Boldrini (2004), globally, nearly half of business executives surveyed recognise some current or future impact of HIV/AIDS on their business, notwithstanding only 6% of them have instituted written policies. According to Taylor *et al* (2004), you must secure top management's emotional and rational engagement and allocate resources and assign responsibility.

“This pandemic needs multi-sector mobilisation, particularly for business engagement to successfully control the HIV pandemic that has been widely touted” (Taylor *et al*

2004 p.3). It should be noted that although the research specifically examines the effects of HIV/AIDS in the private medical sector in Umlazi Township, it is also important to look at other sectors or businesses in general. A broader study will lead to a fuller understanding of the effects of HIV and AIDS in our workforce in general.

### **2.3 WORKPLACE DYNAMICS AND THE EFFECTS OF HIV/AIDS**

HIV/AIDS has a direct bearing on the performance of enterprises and the employees involved. According to McIntosh (2007), the HIV/AIDS epidemic comprises at least two aspects: financial consequences and the basic rights of the infected and affected worker.

“Given the variables and incomplete reporting on AIDS pandemic in Africa, it is difficult to assess its economic impact with exact precision” (Clark, 2008 p.7). According to McIntosh (2007), the most obvious impact of HIV/AIDS on the workplace is a direct reduction in earnings. Enterprises are obliged to incur significant costs caused by declining productivity, increasing labour replacement and training interventions”. The infected and affected workers face the daunting challenge of stigmatisation and discrimination. Erosion of basic human rights is rife, which impinges on the prevalence and perpetuation of the disease amongst workers. A decline in production and profitability is then felt. Any appropriate intervention in the workplace must be well planned and implemented and responsibly monitored.

#### **2.3.1 Strategic Supply of Labour Force**

It should be stressed that the impact of HIV and AIDS on the workplace has resulted in adverse effects in terms of the strategic supply of employees. This has in turn led to a change in the composition of the working population, leaving workers vulnerable within their place of employment. The working environment is often a true reflection of the demographics of society at large.

According to Taylor *et al* (2004), there is a direct linkage between the consequences of the resulting demographic shifts in respective countries, and what happens at the

workplace. The rampant spread of HIV and AIDS has led to a negative population growth in some countries, if not worldwide. According to Taylor *et al* (2004), it is taken for granted that countries with a high prevalence of HIV/AIDS are likely to experience a reduction in the working population, concomitantly with the reduction of the general population.

According to McIntosh (2007), the US Bureau of Census has predicted 8 to 31 years of life will have been lost in those countries most affected by HIV/AIDS in sub-Saharan Africa by the year 2010. Using population data from Botswana, Cameroon, Ethiopia, Cote d'Ivoire, Kenya, Malawi, Mozambique, Namibia, Nigeria, South Africa, Tanzania, Uganda and Zimbabwe the International Labour Organisation made an observation in 2000 including:-

- In the wake of the AIDS pandemic, there would be about 24 million fewer workers in hard-hit countries alone by the year 2020.
- The labour force will inevitably be 10 to 22% smaller in those countries where the infection rate is higher than 10% of population than would have been case had there been no HIV/AIDS by the year 2020.

(Adapted from ILO 2000)

The type of work an employee does has an effect on the risk of HIV/AIDS infection at the workplace. This will be influenced by the worker's behaviour there. According to McIntosh (2007), certain work situations are more conducive to the spread of infection than others. For example those involving mines, oilfields and road-and-dam building projects are at higher risk. According to Brink and Pienaar (2007), Anglo American Mining Company calculated that by the end of 2006, some 24 000 of its employees in eastern and southern Africa (this represents approximately 21% of its total workforce) were infected with the virus. This puts workers in the Anglo American Mining Company in the highest percentage category of all workers generally affected or infected by this virus. Certain elements or factors do play a role in the behaviour of these workers. They are perforce separated from their families for extensive periods

of time and have little opportunity for social interaction. Their health facilities are also often tenuous.

The behaviour of employees continues to drive the probability curve upwards and increase the probability that a worker and/or employer may acquire the infection. This includes unprotected sexual intercourse with partners whose HIV status is not known. "Men and women experience different vulnerability to HIV/AIDS; it impacts differently on the different gender groups" (Ghana AIDS Commission 2004). According to Ghana AIDS Commission (2004), there are biological factors which make women more vulnerable to infection than men and structural inequalities in the status of women in certain societies that make it harder for them to take measures to prevent infection. These factors intensify the impact of HIV/AIDS. Another reality is that women are often left vulnerable to the abuse they experience at the hands of dominant males. A climate of discrimination and lack of respect for human rights also plays an important role in the behaviour of workers. Workers may not adhere to infection-control warnings and coupled with this, certain cultural norms and values may also lead to the further spread of the disease. Workers affected and/or infected may have difficulty in dealing with the disease because of the discrimination and/or abuse directed at them by HIV-negative workers and/or their employers.

According to McIntosh (2007), a further disastrous effect has been on the quality of the existing labour force as a result of the spread of HIV/AIDS in the labour force working in high HIV prevalence countries. The HIV/AIDS epidemic affects the quality, education, training and work experience of the labour force. Skilled and experienced employees are lost to the epidemic, leaving behind inexperienced workers who must fill the gaps. The productivity and profitability of the company is negatively affected, which in turn may lead to a large staff turnover. The knock-on effect could easily be derailing for the company which might be forced to employ the unemployed and inexperienced to replace the staff lost to HIV/AIDS. Labour quantity may be preserved but labour quality may not be. According to McIntosh (2007), an HIV-

infected employee is unlikely to find worthwhile employment, leaving the burden of earning a living to other family members including the children.

The quality of a future labour force will be compromised by the impact HIV/AIDS has on the education system. The epidemic affects both students and teachers. Students will suffer the ill-effects of the epidemic, either having to care for an HIV/AIDS-infected relative, or they may become an orphan who has to be the bread-winner for the rest of the family. In some cases, in addition to these burdens, the child may himself have been born with the virus, making his health unreliable. The almost intolerable level of stress felt by the student does not enhance his prospects of success. Failure to perform at school results in early 'dropping out'. Unfortunately these students have acquired too few skills to perform proficiently in the workplace, meaning that both quantity and quality of the labour force decreases.

Teachers, on the other hand, are not exempt from this epidemic. Deaths among educators are occurring in large numbers in countries seriously affected by the disease. According to McIntosh (2007), teacher mortality from HIV/AIDS in Botswana increased by 60% between 1994 and 1999. McIntosh (2007), also found that in Zambia, 40% of teachers are infected with HIV and are dying at a faster rate than the number of teacher-graduates being trained. The morbidity and/or mortality rate of teachers naturally affects the quality of instruction in the classroom. The stress of sickness and the knowledge of impending death reduce the quality of lecture preparation and delivery. This in turn will affect the quality of information and tuition received by students. Those students therefore have a slim chance of reaching the highest level of education. According to Coombe and Kelly (2001), the evidence is clear that education helps individuals to protect themselves against HIV infection. "HIV infection rates appear to be declining more rapidly among young educated women than among those less educated" (Coombe and Kelly 2001, p.8). Students will enter the workforce with greater skills if they are educated and if their educators are well protected against the HIV/AIDS epidemic. The quality of the future labour force

will be protected and maintained to the highest standard if well-planned measures are put in place to curb the HIV/AIDS epidemic throughout the workforce.

### **2.3.2 Demand for Labour**

In as much as the general population has felt the force of the HIV/AIDS epidemic, both the quality and quantity of labour in the workplace has been negatively affected. This has been demonstrated by the parallel demographic shifts seen in both the general public and the labour force. The demographic shifts mirror both sections of society. According to Rosen (2004) *et al*, up to 25% of the labour force in Southern Africa is HIV-infected. HIV/AIDS-infected employees are often unwell, with many having to take early retirement, and others dying while still employed.

According to McIntosh (2007), the business sector may be able to replace a worker, but that could mean replacing an experienced and skilled worker with an inexperienced and unskilled worker. The employer requires a skilled worker, not one needing costly training. Cost to company must be calculated in both monetary and non-monetary terms. A demand for recruitment and training arises as a result of staff turnover and loss of skills. According to McIntosh (2007), for example, 36 out of 1600 Barclays Bank of Zambia employees died of AIDS-related deaths. A situation like this calls for the employment of extra labour intensified training in multiple skills, succession strategies and extensive human resources monitoring to cope with staff fluctuations and losses.

According to Rosen (2004) *et al*, the South Africa unemployment figure currently stands at 28% of the total workforce. In the current global recession unemployment may rise as high as 35% in our country. At present South Africa has the strongest economy in Africa:- so one can only speculate on the rate of unemployment in other sub-Saharan countries. Africa, the poorest continent, is the hardest hit of all continents affected by HIV/AIDS, leaving it desperate for more labour, especially of the skilled variety.



HIV/AIDS is rife in poverty-stricken countries which has a deleterious effect on the entire populace. Those affected or infected by HIV and AIDS have to be cared for by relatives. In some instances this task is taken on by children who should be attending school. It is stressful to a child to assume adult responsibilities. If the child is compelled to leave school early he will then suffer the effects of being under-skilled for any sufficiently remunerated employment. According to Coombe and Kelly (2001), mitigating the impact of the pandemic on education implies ensuring that those affected and infected by the disease can work and learn in a caring environment which respects the safety and human rights of all.

This is also true for the employees in the medical sector in Umlazi because HIV and AIDS will give rise to a shortage in the labour force of suitable skilled and qualified workers if this pandemic is not addressed.

### **2.3.3 Stigma and Discrimination**

Stigma and discrimination are the most blatant barriers to the efficient management of HIV and AIDS in the workplace. According to Mawar, Sahay, Pandit and Mahajan (2005), in the absence of an effective medical intervention, social factors such as stigma and discrimination attached to HIV/AIDS are a major obstacle to the curtailment of the disease. These factors require urgent attention. According to UNAIDS (2002), HIV/AIDS is increasingly being recognised not merely as a medical problem, but also as a social problem. According to Rule and John (2008), at a sociological level, it was initially associated with “other people” namely homosexual men and drug users. HIV and AIDS have also been associated with marginalised groups such as migrant workers, sex workers and the poor. “It should be recalled that HIV and AIDS used to be called Gay-related Immune Deficiency (GRID)” (Rule and John, 2008, p.84). The ‘othering’ is seen in the communities here in South Africa used to discriminate those individuals with HIV and AIDS. It is a strategy used for identifying, differentiating, subordinating and discriminating against HIV infected or affected. Before dawn of democracy (that is before 1994) this ‘othering’ strategy was

used to discriminate against the black majority of this country which also happened to be the poor and marginalised. In 1994 those who had been marginalised expected their lives to improve for the better. However, HIV/ AIDS still affect mainly the former marginalised (poor, black and women) in South Africa. According to Rule and John (2008), women, homosexuals, foreigners and blacks are blamed for spreading the disease in South Africa. This has led to stigma and discrimination. The consequences of this stigma result in two different, but equally tragic situations. Firstly, there is lack of support and care for the HIV-infected both at the level of community and in a health-care setting. Secondly, the fear of stigma may dissuade many individuals from being tested. According to Mawar *et al* (2005), people living with HIV are stigmatised, leading to severe social consequences related to other rights, health care services, freedom, self-identity and social interactions. It hampers the treatment and diagnosis of HIV, contributing to the further spread of the disease. There is an assumption by the public or society that all HIV-infected individuals have been involved in risky behaviour of one kind or another. The persons suffering from stigmatised disease are assumed to have violated certain social norms and taboos and are thus solely responsible for their predicament. According to Skinner and Mfecane (2004), stigma drives HIV out of sight, reducing the pressure for behaviour change. "Stigma undermines the person's identity and capacity to cope with the disease" (Akande, 2009 p.2). Fear of discrimination limits the possibility of disclosure even to potentially important sources of support such as family and friends.

According to Akande (2009), the AIDS epidemic has often been associated with severe negative public reactions ranging from banning the entry of HIV-infected individuals, to isolating an individual in the family, deserting a pregnant wife on discovering her HIV status in the hospital, firing a person from his job, or even denying a child admission to school. These negative reactions have shaped the behaviour of infected individuals and have reduced the effect of prevention efforts. "AIDS-related stigma and its attendant prejudice and discrimination, have triggered an anxiety-related stress response to the perceived threat of catching the disease" (Akande, 2009, p.3). "Behaviour characterising the stress response includes avoidance,

extreme precautions and verbal expression of fear concerning HIV/AIDS” (Akande, 2009, p.4).

According to Akande (2009), stigma is seen through the eyes of certain people as spoiled identity and there is something about the victim that seems to discredit him; resulting in him/her being accorded less respect than a non-sufferer. Discrimination, on the other hand, implies the discriminate meting out of treatment to people who should be treated alike. There is a close relationship between stigma and discrimination. According to Dickinson (2005), if we stigmatise somebody, then this provides a justification to discriminate against them. People in the workplace are often ill-informed about the disease, many myths and old wives’ tales prevail in the community. According to Akande (2009), misinformation and wrong conceptualisation about HIV/AIDS and its association with marginalised and morally bankrupt people of the society has led to negativity and stigmatising attitudes, thoughts and behaviour towards people living with HIV/AIDS”. People in a company who are known to be HIV-positive face stigma and discrimination from fellow workers, supervisors and managers. Stigma extends beyond those few people who have been brave enough to be open about their HIV status in the South African workplace to those who are merely suspected of being HIV-positive. People look for signs of HIV/AIDS, such as weight loss or skin rashes, they make assumptions and then treat the fellow-worker as though he were HIV-positive. According to Dickson (2005), this creates an environment in which rumours flourish and where people fear even to look ill. Stigma can extend to all groups of people who share some common features, such as race, where this is assumed to be connected in some way to HIV/AIDS.

According to Akande (2009), in some sections of South Africa, community-level stigma, fear and discrimination have gone too far, to the extent that people living with HIV/AIDS (PLWHAs) are ostracised, rejected, physically, verbally and emotionally abused and maltreated. “The hostile community’s reaction to PLWHAs has made them to self-stigmatise” (Akande, 2009, p.4). According to UNAIDS (2006), these people disappear from public life after having been forced to leave their home, or they

change their daily activities such as shopping, socialising or networking. The perpetrators of stigma and discrimination may also be a danger to themselves in that their attitudes hide the true nature of the risk of HIV/AIDS. HIV-positive workers have not challenged the discrimination against the disease. This is not surprising because, by adopting a challenging stance, they would be making a clear statement of their own status. It is important to have proper HIV/AIDS education in place to alleviate the problem of HIV/AIDS at the workplace.

According to Dickson (2005), stigma and discrimination *vis-à-vis* HIV/AIDS impacts on the workplace in a number of ways including:-

- Lowering workforce morale: HIV-infected workers fear disclosing their status. Workers shun the testing process, and avoiding associating with HIV-infected workers.
- The effectiveness of the workplace HIV/AIDS programme is undermined. An ineffective workplace programme wastes resources and raises the costs to the company of HIV/AIDS in terms of absenteeism and the loss of employees and their skills.
- Certain groups have been associated with a high risk of HIV/AIDS in South Africa. This influences racial attitudes that lead to a decline of support for those attempting to organise workplace responses to the epidemic.

(Adapted from Dickson 2005).

A zero-tolerance approach should be used against discrimination of HIV-infected workers. The HIV/AIDS epidemic in the workplace has seen women more prone to discrimination. The social hierarchy and the different power relations that exist in certain sectors, blame women for bringing infection into the family. According to Mawar *et al* (2005), women are blamed for spreading both sexually transmitted disease (STIs) and HIV. This is because of the patriarchal nature of certain societies. "In some instances those discriminated against may receive a double dose of stigma, an example seen with homosexuals and women" (Akande, 2009, p.4). According to Mawar *et al* (2005), the definition of the HIV/AIDS syndrome results in dual stigma,

first from the identification of AIDS as a seriously incurable illness, secondly from the identification of AIDS with persons and groups already stigmatised owing to their behaviour prior to the epidemic. The stigma attached to AIDS as an illness is layered upon pre-layered stigma. “The problem of stigma is inextricably linked to the issues of human rights, health and law” (Akande, 2009, p.4).

It is important for management to comprehend the issues pertaining to stigma and discrimination in the work place, in respect of maintaining relevant programmes, rather than allowing them to stagnate. According to Akande (2009), Health Education models such as the Health Belief Model (Janz and Becker 1984); the Attitudes of Social Influence Model (De Vries and Backbier 1994); the theory of reasoned action (Fishbein and Ajzen 1997); and the social learning theory (Bandura 1986), all emphasise the importance of attitudes and beliefs in health promotion and the prevention of disease”. “Some models acquire that, in the interest of effective risk reduction, individuals must see the disease as being serious, avoidable; themselves as being at risk also; and the benefits of prevention as outweighing the costs” (Akande, 2009, p.6). According to Mawar *et al* (2005), certain steps can be taken to minimise stigma. These include :-

- Statements can be specifically included in the company HIV/AIDS policy promoting an environment in which HIV/AIDS is not stigmatised. Every employee should be supplied with a policy document stressing that stigma is not tolerated.
- Ensuring that senior management and trade unions publicly back the company’s HIV/AIDS programme. This will demonstrate that HIV/AIDS is everybody’s concern.
- The education of everyone in the company about HIV/AIDS. This should be an inclusive programme, automatically including supervisors.
- Alleviation of fear amongst the workers: by providing accurate knowledge of the disease, the mode of transmission and how it can be prevented must be taught. Employees should be made aware that having HIV/AIDS is not

necessarily a death-sentence; and that by adopting a healthy lifestyle and treatment an infected individual can live longer and be productive in life.

- Openly discussing HIV/AIDS: attitudes towards HIV-infected individuals must be addressed.

(Adapted from Mawar *et al* 2005).

Stigma and discrimination clearly instils fear in vulnerable employees. This can be detrimental to the effective running of HIV/AIDS intervention programmes in the workplace, whether their focus is on prevention or treatment. According to Fasset (2005), employees will be reluctant to go for voluntary counselling or testing (VCT) for fear of stigmatisation and discrimination. “Behaviour such as wanting to use condoms could be seen as a marker of HIV, leading to rejection and stigma” (Skinner and Mfecane, 2004, p.3). This may cause an escalation of the HIV/AIDS epidemic.

Stigma and discrimination are very serious negative elements at the workplace. Employees are unwilling to have voluntary counselling and testing (VCT) at the medical practices in Umlazi in case they are seen to be doing so by members of their family or workforce. The most dramatic outcome of this fear is the unnecessary death of a person because of a lack of testing and treatment.

#### **2.3.4 Cost to Business**

There are direct and indirect opportunity costs associated with each intervention taken in response to the HIV/AIDS epidemic. “As the rate of infection increases, so do the costs associated with the epidemic” (McIntosh 2007, p.9).

The first question that should be asked is “Does HIV/AIDS increase costs to the business?” and the second question must be “Do HIV/AIDS intervention programmes have any cost benefit to the business?” There are many studies which have been undertaken which view or address these two questions.

According to Clark (2008), given the variables and incomplete reporting on the AIDS pandemic in Africa, it is difficult to assess its economic impact with any precision. An

increase in costs to the company will come about for a variety of reasons. Of these there are worth mentioning:-

- “Increased staff turnover owing to HIV/AIDS infection gives rise to the demand for recruitment and training. More staff are needed to replace the sick and the early-retired. Increased staff turnover leads to falling rates of human capital formation” (McIntosh 2007).
- Companies should provide health care to the sick or infected employees. “A study of a commercial agro-estates in Kenya estimated that medical expenditure rose to over 400% above that of projected expenditure which did not include the cost of AIDS” (Rugalema, 1999, p.1).
- “Company life insurance premiums and pension fund commitments will rise as a result of early retirement” (McIntosh 2007). The costs will burgeon with the increase in mortality rates in those companies providing funeral costs cover to employees. Additional costs are incurred from frequent absenteeism owing to illness or attendance of funerals.

According to McIntosh (2007), in sub-Saharan countries the rate of infection is high and up to 25% of the workforce is already affected by the HIV/AIDS epidemic. That has both direct and indirect opportunity costs associated with it. Business will bear the brunt of increased staff turnover as a consequence of morbidity and/or mortality. It will require further recruitment and training, provision of medical care to sick employees and lastly but not least the funeral costs of a deceased employee which may be covered by the company. According to Fasset (2005), in replacing lost workers, there are direct and indirect costs involved. The direct costs include:-

- Advertising or soliciting applicants for a position.
- Reimbursement for travel payments during interviews.
- A portion of the salary of recruiters and interviewers.
- A bonus or related payments to hire select staff (this may apply primarily to the hiring of expatriate staff).
- Travel and relocation expenses for new staff.

Indirect costs include:-

- Lost production while a position is vacant (this may partially be offset through savings by not paying the salary and benefits for a staff member until a replacement is found).
- Loss of production while new staff becomes acquainted with the position and organisation.
- Time for supervisors to train new staff, acquainting them with the functions of the position.
- Additional training of new staff if required.
- Effect on morale and efficiency (including absenteeism) of other staff who must fill-in to cover vacant positions.

(Adapted from Fasset 2005).

According to Rosen *et al* 2004, providing employees and their dependents with lists of services and resources is not inexpensive, but is a major form of assistance. According to Fasset (2005), the HIV/AIDS intervention programmes should not be seen as an expense to the business but rather as an investment by the company in the long term or in the future. According to Rosen, Feeley, Connelly and Simon (2007), treatment of HIV-positive employees is a good investment for many large companies. "The opposite cannot be said about small companies because of the small workforce". The authors also state that while these returns on the investment made by the companies in HIV/AIDS prevention programmes were not always large, the fact that they were positive suggested that companies should invest more in HIV-intervention programmes. According to Rosen *et al* (2004), the benefits of treatment programmes in the private sector have been studied widely. "One of the most extensive studies, from companies in South Africa, found that providing free ARV's at every level of workforce, rather than absorbing the direct and indirect costs of HIV/AIDS, made financial sense" (Rosen *et al*, 2004, p.5).



According to Rosen *et al* (2004), HIV/AIDS among employees added between 0.4 and 5.9% to the companies' annual salary and wage bills, and the present value of an incident HIV infection ranged from 0.5 – 3.6 times the annual salary of the affected worker. The costs vary widely across firms and among job levels within firms. According to Rosen *et al* (2004), the key reasons for the differences included HIV prevalence, levels and stability of employee benefits, and the contractual status of unskilled workers. In Kampala, Uganda, a study was conducted amongst HIV-infected workers. “A hybrid intervention (beginning with cotrimoxazole antibiotic (CTX) prophylaxis, followed by HAART – (highly active antiretrovirals) proved to be cost-effective” (Marseille, Saba, Muyingo and Kahn, 2006, p.1). This generated a savings to a Ugandan company.

The costs of HIV/AIDS to business are huge because of the expense of mounting and sustaining HIV/AIDS programmes. These intervention programmes come in the form of preventive and/or treatment programmes. Many managers take fright at these costs without considering the money that can potentially be saved by effective prevention, care and treatment of their employees. Savings are both monetary and non-monetary. The monetary savings achieved include reduced sick leave expenses; pension and death benefits not being immediately required to be paid; reduced need for recruitment and training and reduced medical and drug costs. According to Rosen *et al* (2004), the non-monetary savings are improved efficiency, fewer disruptions in delivery of services and in daily work, and less stress on remaining employees. In addition treatment of opportunistic infections will contribute to non-monetary benefits.

The costs of running a private medical practice can escalate if the human capital or staff is not healthy. An employer needs to be sure that the staff is physically and emotionally healthy in order to have a productive working environment and as a result, be in a position to save on costs to the business.

### **2.3.5 Effect on Production and Profitability**

HIV/AIDS causes a major threat to any business enterprise. Its effect on productivity impacts negatively on the profits of the company.

HIV/AIDS is a threat to enterprise delivery capacity and performance. According to McIntosh (2007), HIV/AIDS will result in a high staff turnover which will then impact negatively on the production, delivery and capacity of the firm. All of that will cause a decline in profits for the business; and the competitiveness of the enterprises in the production of quality goods and services will be affected. This can directly affect the quality control of products and services, leading to reputation losses and ultimately a reduction in customers. "Maize output for small farmers in Zambia fell by 45% owing to the death rate" UNAIDS (2000). According to UNAIDS (2000), when AIDS was factored out as the cause of death, maize production figures fell by 61%, cotton 47%, vegetables 49% and groundnuts 37% respectively.

HIV/AIDS causes a disruption in the production of goods and services as a result of absenteeism in businesses with HIV/AIDS related illness amongst employees. A worse case scenario arises when skills are lost following workers' suffering untimely deaths or being obliged to take early retirement. According to McIntosh (2007), such disruption is severe if it impacts on the 'intellectual capital' of the company, which has become increasingly important relative to 'financial capital' and with the progressive changes in the way companies are now valued. Skills losses could lead to lower value or lower quality products and decrease the value of goods produced. It should be noted that the impact of HIV/AIDS could then roll down to other sectors. According to McIntosh (2007), for example, skills losses and interruption of production in telecommunication and electricity sectors may lead to production losses in all other sectors using these services.

According to Maphosa (2005), a direct link exists between HIV/AIDS and declining productivity and profits. The impact of HIV/AIDS on productivity includes increasing absenteeism, increasing staff turnover and lower morale. "The impact of HIV/AIDS on

profitability includes increased costs, a decline in investment and a threat to the consumer base” (Maphosa, 2005, p.3). According to UNDP (2000), the declining levels of productivity lead to declining profits especially when production costs are not declining at an equal rate, as is usually the case when the prevalence rate of HIV/AIDS is high among the productive segment of population. “For example, a transport company in Zimbabwe incurred a total cost equal to 20 percent of profits to deal with HIV/AIDS related issues in the company” (UNDP 2000).

In reality, the company will face the daunting task of operating under severe strain. Its capacity to operate will be severely affected resulting in a decline in profits. “Additionally, when productivity is on the decline or unpredictable, the ability for business to meet supply demands for consumers decreases” (McIntosh 2007, pg.8). This situation in turn has an impact on the present and future reputation of firms, which translates into depressed profitability.

“HIV/AIDS affects an organisation in the sense that it can cause organisational disruption within the workforce when there is a high rate of morbidity and mortality” (Maphosa, 2005, p.4). Morale can also be severely affected by the loss of colleagues, discrimination against people living with HIV/AIDS, and the disruption of work activities in order to attend to infected and affected workers.

### **2.3.6 Human Rights**

HIV/AIDS has brought the issue of human rights under the spotlight because of its link to stigma and discrimination in the workplace.

The human rights of the HIV positive employees have been violated in South Africa. These employees have been denied access to the workplace; have been isolated, derogatively labelled on the basis of association and/or on the assumption that a certain group is more prone to HIV/AIDS infection; and have faced unfair dismissal in the workplace. Misinformation is the root cause of this situation.

In South Africa, various labour related laws provide protection for the employee. South Africa boasts the Employment Equity Act no. 55 of 1998; the Compensation for Occupational Injuries and Disease Act no. 130 of 1993;- the Basic Conditions of Employment Act and Labour Relations Act no. 66 of 1995. All these Acts are enshrined in South African constitution, providing guidance for the protection of workers' rights in the workplace.

The Employment Equity Act no. 55 of 1998 has an appended Code of Good Practice on Key Aspects of HIV/AIDS and employment. This guide acknowledges that "the HIV/AIDS epidemic will affect every workplace, with prolonged staff illness, absenteeism, and death impacting on productivity, employee benefits, occupational health and safety, production costs and work morale". Furthermore, HIV/AIDS is still a disease surrounded by ignorance, prejudice, discrimination and stigma. According to Akande (2009), in the workplace unfair discrimination against people living with HIV and AIDS has been perpetuated through practices such as pre-employment HIV testing, dismissal for being HIV positive and the denial of employee benefits. The Employment Equity Act no. 55 of 1998 gives a clear guidance on the policy framework which will serve to erase the marginalisation faced by HIV positive individuals. One cannot be discriminated against solely on the basis of one's HIV status.

Other Acts like the Compensation for Occupational Injuries and Disease Act no. 130 of 1993 make provision for compensation should a worker become infected with HIV as a result of work-related activities. The Basic Conditions of Employment Act prescribes the number of days' paid sick leave that an individual or employee is entitled to per leave cycle. The Labour Relations Act no. 66 of 1995 enshrines an individual's right of freedom from unfair labour practices.

The International Labour Organisation (ILO) has also published guidelines which highlight the following:-

- Recognition of HIV/AIDS as a workplace issue.
- Non-discrimination against HIV positive workers.

- Gender equality – relating to gender dimensions of HIV/AIDS that should be recognised. Women face more discrimination in the workplace: and this has far-reaching consequences for any attempts to control HIV/AIDS in the workplace.
- Social dialogue - implementation of an HIV/AIDS policy and programme requires cooperation and trust between employers, workers and their representatives.
- HIV/AIDS screening should not be required of job applicants or persons in employment.
- Confidentiality - there exists no justification for asking job applicants or workers to disclose personal HIV-related information.
- HIV infection is not a cause for termination of employment.
- Prevention - HIV is preventable: Changes in behaviour; knowledge of the disease; seeking treatment for the disease and the creation of a non-discriminatory environment should all be feature in an HIV/AIDS programme.
- Care and support must be provided to workers infected and affected by HIV/AIDS.

(Adapted from ILO)

According to UNAIDS (2006), the human rights issue has caused people living with HIV/AIDS to disappear from public life, be forced to leave their homes, or change their daily activities such as shopping, socialising, or networking (UNAIDS 2006).

### **2.3.7 Education**

HIV/AIDS impact on education is very evident in sub-Saharan countries where the epidemic rages.

According to McIntosh (2007), the effect on the school system is manifested in its impact on students' learning curves and classroom performance. Many children suffer from grief, trauma and/or negative experiences from seeing close relatives,

friends and teachers fall sick, suffer and die of AIDS. It is even worse for the student who knows that he is infected with the virus and may die early. According to Coombe and Kelly (2001), in Southern Africa, there may be as many as 8 million AIDS orphans by the end of this decade.

Teachers are not immune from the epidemic or pandemic. This disease affects both student and teacher. Deaths among teachers are occurring in large numbers in highly affected countries. According to McIntosh (2007), for example, the number increased by 60% between 1994 and 1999 in Botswana including 84 primary school teachers who died in 1999 compared to only 8 in 1994.

The HIV/AIDS epidemic has caused a lot of disruption in the family clusters. This is evident when the breadwinner of the family is bedridden or becomes unemployed because of illness resulting from HIV/AIDS. According to McIntosh (2007), the epidemic's impact on the education system could affect the quality of future labour inputs in the workplace mainly resulting from poor outflow of new entrants. The HIV/AIDS epidemic will then contribute to an increase in the unskilled labour force in the workplace. New entrants are not experienced: so enterprises will have to spend valuable resources training of new staff. In turn this will affect business profit.

There is another dimension to HIV/AIDS and education. Education can be used as a tool to alleviate the problem of the HIV/AIDS pandemic. According to UNESCO (2000), the World Education Forum, held in Dakar in April 2000, noted that 'a key objective of an international strategy' must be to realise the enormous potential that the education system offers as a vehicle to help to reduce the incidence of HIV/AIDS and to alleviate its impact on society. According to Coombe and Kelly (2001), what HIV/AIDS does to the human body, it also does to institutions. AIDS constitutes one of the greatest threats to the global education agenda.

"The education systems must first secure themselves against the onslaught of HIV/AIDS before coming to the assistance of their clientele" (Coombe and Kelly, 2001,

p.1). According to Coombe and Kelly (2001), it is important to stabilise the education system even while it is under attack, to ensure that teachers are teaching, children are enrolling and staying in school, older learners are learning, managers are managing, and personnel, finance and professional development systems are performing adequately. “It is equally important to mitigate the impact of the disease to ensure that those infected with and affected by the disease can work and learn in a caring environment which respects the safety and human rights of all” (Coombe and Kelly, 2001, p.2).

Evidence is accumulating that education helps individuals protect themselves against HIV infection. According to Coombe and Kelly (2001), although the evidence is still patchy, HIV infection rates appear to be declining more rapidly among young educated women than among those with less education. “In Zambia, for instance, surveillance data for Lusaka show that the prevalence rate for women 15 – 19 years of age dropped from 27.6% in 1993 to 14.6% in 1998” (Coombe and Kelly, 2001, p.8).

HIV/AIDS has a significant impact on the education system. There seems, however, to be a positive correlation between level of education and the probability of engaging in high-risk sexual behaviour. That correlation is also evident between level of education and actual infection. “It should also be stressed that community participation must be central to every innovation aimed at adjusting the education delivery system in response to the challenges of HIV/AIDS” (Coombe and Kelly, 2001, p.8). The education system must make certain that children have access to primary education and that education-for-all goals are designed to combat the HIV/AIDS epidemic. “This will have the effect of an ‘education vaccine’ since learners might be staying at school for longer hours” (Coombe and Kelly, 2001, p.12). The educational institutions should be well managed while linking school closely to the community.

## **2.4 HIV/AIDS AND ABSENTEEISM**

HIV/AIDS has been identified as one of the leading causes of absenteeism in the workplace. According to Kumaranayake *et al* (2007), HIV positive individuals

remaining within the labour force are likely to have a 30% higher rate of absenteeism. It is even worse when those HIV positive employees are not on any HIV/AIDS intervention programme. According to Habyarimana *et al* (2007), the introduction of antiretroviral (ARV) treatment in the workplace is followed by a significant reduction in absenteeism in the 6 – 12 months following treatment.

HIV/AIDS and absenteeism are closely linked in that if the former is not well managed, the latter will surge and that will affect the profitability of the enterprise. According to Shisana, Hall, Maluleke, Chauveau and Scwabe (2009), healthcare workers will not be able to carry out their responsibilities effectively because of frequent absenteeism, owing to HIV/AIDS in their workplace. An absence of one day can cost a company three days' worth of salary. According to Shisana *et al* (2009), the cost of absenteeism is not only limited to the employee's salary for the day that he/she is not working: it is actually three times the day's salary, taking into account related costs involved including sourcing a temporary replacement and the loss of productivity. Anglo American Mining Company calculated at the end of 2006, "some 24 000 of its employees in Eastern and Southern Africa (this represents approximately 21% of its workforce) were infected with the virus". According to Brink and Pienaar (2007), as individuals begin to fall sick, so productivity declines, absenteeism increases, and healthcare costs mushroom. According to these authors, without a treatment programme, it has been estimated that HIV/AIDS can cost the company 5% of its payroll.

According to Kumaranayake *et al* (2007), individual-specific HIV status measures allow for joint consideration of absenteeism and separation behaviour in the labour force. In other words, firms are likely to encourage early retirement or retrenchment of sick employees. "A differential absenteeism impact between HIV-positive and negative individuals was found" (Kumaranayake *et al* 2007, p.6).

Habyarimana *et al* (2007), undertook a study at Debswana Diamond Company in Botswana. According to their results, compared with workers who had never enrolled



in the treatment programme, there was no statistically significant difference in the absenteeism rate of enrolled workers in the period 1 – 5 years prior to the starting of treatment. Enrolled workers in the Debswana mine were found to be absent for about 20 days in the year leading up to the treatment initiation, with a peak of 5 days in the final month and this was about 5 times the annual days absent owing to illness among non-enrolled workers. According to Habyarimana *et al* (2007), “The introduction of ARV treatment was followed by a large reduction in absenteeism 6 – 12 months following the treatment inception”. “Absenteeism 1 – 4 years after the treatment started was low and was similar to non-enrolled workers at the firm” (Habyarimana *et al*, 2007, p.7).

According to Habyarimana *et al* (2007), found that ‘the health benefits of ARVs are by now well established in the developed world’ (Hammer *et al* 1997; Duggan and Evans 2005; Florida *et al* 2002). A number of research papers have also shown a large reduction in morbidity and mortality in the first years after treatment starts in poor country settings. “A link was also found between the health status of a worker (measured by his/her CD4 count) and worker absenteeism in a given month where it was found that as the CD4 count improves, causes of illness related to absenteeism decreases by roughly 3.5 days per month (Habyarimana *et al* 2007, p.15).

According to Habyarimana *et al* (2007), it is important for firms to provide ARV treatment to their workers within a certain framework which will maximize their profits or productivity while ensuring that workers are staying healthy, or at least not ill as a result of HIV/AIDS.

According to Habyarimana *et al* (2007), “this indicates that when the productivity difference between healthy, experienced workers and new recruits is small, firms prefer to hire new workers rather than provide treatment to infected workers and conversely when the productivity gains associated with treatment (keeping experienced workers) are large, firms are now likely to provide treatment”.

It has been proven that the benefits to the firm make up for 10 – 33% of the cost of ARV treatment: which can go some way towards encouraging the firm to provide ARVs. At the same time, there will be a dramatic decrease in absenteeism from work once employees have started the ARV treatment. HIV workplace programmes cost less than it costs not to have them. Direct costs to the business relate mainly to absenteeism. Employees are often absent because of ill-health or the need to care for family members or to attend funerals.

## **2.5 IMPACT OF HIV/AIDS ON POVERTY REDUCTION STRATEGIES**

HIV/AIDS impacts on poverty reduction strategy in various ways. The increasing prevalence of HIV/AIDS is concomitant with the increasing numbers of households left destitute, especially in Africa.

Africa already ranks as the poorest continent and the one most affected by the HIV/AIDS pandemic. In December 2007, it was estimated that there would be thirty-three million people infected with HIV worldwide; and of these twenty-two million would be living in the sub-Saharan region (UNAIDS Global Report 2008). According to McIntosh (2007), as profits to business decrease, so do the income-earning opportunities for those entering the labour market; and those workers who are laid off will swell the ranks of the unemployed and impecunious.

McIntosh (2007) also stated that, it must be remembered that at the centre of any poverty reduction strategy is the need for people to gain a livelihood through formal wage employment and/or self-employment. Declining growth and employment opportunities will increase poverty, thus increasing the risk of contracting HIV/AIDS.

It is clear that HIV/AIDS and poverty have a synergistic relationship. McIntosh (2007) found that, HIV/AIDS often leads to poverty, while poverty increases the risks of contracting HIV/AIDS and HIV/AIDS affects people during their most productive years of life. For such people earnings are reduced as a result of illness and higher

expenditure on health care and premature death. On the aggregate, it is the household and communities that are the direct victims of the epidemic. According to McIntosh (2007), national and local resources and efforts which could have been used for community development projects are increasingly being used to deal with the impact and consequences of HIV/AIDS.

McIntosh (2007), states that at the level of the individual and the household the impact will be felt in three ways:-

- Total and disposable individual and household income will fall in real terms.
- The psychological impact of the epidemic on the individual worker's family members is grave. For example, an HIV infected worker may be unable to bath himself. This causes stress to those who sympathise with him, as well as to those who have to perform the daily task for him.
- There will be orphans and people left destitute after the death of a family member affected with the virus.

(Adapted from McIntosh 2007).

According to McIntosh (2007), this may lead to some workers' being forced or encouraged into lower paying jobs particularly in the informal sector, exacerbating the vicious poverty cycle and re-enforcing the relationship between poverty and HIV/AIDS.

## **2.6 MACRO-ECONOMIC IMPACT OF HIV/AIDS**

"HIV/AIDS has an inestimable impact on the macro-economic growth of a business. Strong economies reflect the underlying positive performance of individual firms" (Taylor *et al* 2004, p.3).

According to Taylor *et al* (2004), the economies of countries where people live longer and healthier lives are more likely to grow more rapidly than the economies of countries where citizens suffer greater illnesses and die sooner. For example, an additional year of life expectancy is estimated to raise a country's per capita GDP by

about 4 percent. Taylor *et al* (2004) state that, given that the number of AIDS deaths in Africa has risen from 218 000 in 1990 (2.7% of all deaths) to 2.2 million in 2002 (21% of all deaths), one should look carefully at the link between HIV/AIDS and economic growth.

In Africa, HIV/AIDS poses a threat to the growth of the economy. “Of 33 million HIV-infected individuals globally, 22 million are in the sub-Saharan region” (UNAIDS Global Report 2008). HIV/AIDS is set to slow economic growth in this region more than ever before. According to McIntosh (2007), one study using data from Tanzania, Cameroon, Zambia, Swaziland, Kenya, KwaZulu Natal and a few other sub-Saharan African countries, found that the rate of economic growth may be reduced by as much as 25% over a 20 year period as a result of the pandemic. According to Taylor *et al* (2004), ‘Bloom argues that studies suggest high prevalence areas are currently experiencing reductions in economic growth’. ‘In 2002, UNAIDS estimated a 2.6% drop in annual GDP growth when prevalence passes 20%’ (UNAIDS 2002). According to Mawar *et al* (2005), who examined the destruction of human capital in Africa, asserted that “the economic costs of HIV/AIDS will be higher than previously predicted”. “In Thailand, calculations suggested that the average annual growth rate per capita GDP between 1990 and 2015 will be reduced by about 0.7% points” (Taylor *et al* 2004).

It is obvious that the impact of HIV/AIDS on macro-economic growth needs to be monitored and controlled through various HIV/AIDS intervention programmes. A stunted or negative macro-economic growth of any country will further escalate the HIV/AIDS epidemic.

## **2.7 HIV/AIDS POLICIES AND PROGRAMMES**

According to Taylor *et al* (2004), globally, nearly half of business executives surveyed recognise some current or future impact of HIV/AIDS on their business, nevertheless only 6% have instituted written policies.

According to George & Quinlan (2008), health management of employees is becoming imperative for companies that do business in regions where there is an HIV epidemic. The ILO Code of Practice on HIV/AIDS recommends that companies develop policies to promote non-discrimination, to maintain confidentiality, and not to link HIV testing or status to employment. While a policy is not an end in and of itself, the process of developing a written HIV-specific policy can stimulate dialogue with key stakeholders outside of management. According to Taylor *et al* (2004), policy implementation is not a good substitute for actions but some companies may choose to focus on policy development in lieu of workplace activities.

The HIV/AIDS intervention programmes come in two forms; prevention and treatment. According to Fasset (2005), programmes focus initially on awareness and prevention activities which aim to address high-risk behaviours, reduce discrimination, increase the company's ability to manage the disease, and increase the enrolment of HIV-positive employees in the company's treatment programme. Effort, time and, where necessary, money must be invested in HIV/AIDS education and training. Fasset (2005) also states that, HIV/AIDS training and education must include both the employee and the management. HIV/AIDS education and training will be a tool for formulating the HIV/AIDS policy framework as a plan of action in implementing the HIV/AIDS programmes. Fasset (2005) also states that, programmes must be aimed at sustained prevention of the spread of HIV amongst employees and their communities and employees with HIV must be managed so that they are able to work productively for as long as possible. The author continues to state that, a workplace policy on HIV/AIDS and STIs is central to developing and implementing an effective workplace programme. The policy provides the framework for action. It is important to understand that STIs predispose an individual to HIV infection, meaning that these diseases and their prevention must be included in any HIV/AIDS policy.

The HIV/AIDS programmes should be designed to accommodate the disease dichotomy in the workplace (Fasset, 2005, p.15). According to Fasset (2005),

management training should focus on strategic, risk management and performance management issues such as the development and/or implementation of an HIV/AIDS policy, handling of the problem in the workplace, including loss of productivity, absenteeism, etc; and legal issues including recruitment, succession, planning, and handling of HIV/AIDS cases, discrimination and dismissal. According to Taylor *et al* (2004), on the other hand the employee-training is aimed at promoting general awareness and disseminating information about HIV/AIDS to employees and training at this level is aimed at preventing transmission of the virus by tackling the attitudes and beliefs that cause people to take risks.

It must be stressed that HIV workplace programmes cost less than the costs incurred by ignoring the problem. According to Fasset (2005), efforts must be made to prevent transmission of the virus from infected persons to others. HIV/AIDS education and training must deal with how the disease is spread and how to prevent transmission. The responsibility lies with both the employer and the employee to assist in combating the HIV/AIDS pandemic. Fasset (2005) states that, it is important to note that HIV/AIDS policies and programmes are part of the corporate governance function, in the sense that corporations are operating within a legal framework, which deals extensively with HIV/AIDS. This raises matters of legal compliance (generally an imperative for good corporate governance) and legal risk.

## **2.8 CONCLUSION**

It is clear that the HIV/AIDS pandemic, if not correctly managed in the workplace, is a serious threat to all sectors of business and enterprise.

This chapter has looked at the impact of HIV/AIDS pandemic on absenteeism, cost to the company, the household, the workforce, education and the economy. It has provided a detailed look at the holistic effects of HIV/AIDS and how it has affected all aspects of industry, with emphasis on the critical role of intervention through HIV/AIDS programmes in alleviating this pandemic. HIV/AIDS programmes have been shown to be beneficial and cost-effective for businesses, dealing with the

negative consequences of HIV/AIDS, viz. absenteeism, low productivity, profit loss, etc. When HIV/AIDS programmes are well-managed by the employer, he automatically becomes the beneficiary of higher profits. All of the above factors are directly related to the environment at the private medical practices in Umlazi. Stigma, discrimination, cost to business, staff turnover and HIV/AIDS policies are important and relevant in managing HIV and AIDS at the private medical practice.

In the next chapter this study will focus on data-collection strategy, research design and method, and the analysis of the data.

## **CHAPTER 3 RESEARCH METHODOLOGY**

### **3.1 INTRODUCTION**

In this research quantitative research methodology has been used to collect the data where a self-administered (or assisted) questionnaire completion activity was facilitated. The research strategy is unpacked in detail. The research design and method which helps in the formulation of a questionnaire based on the objectives of this study is also discussed. It will also help in identifying relevant or appropriate respondents through sampling method. If the researcher arrived at the practice, and the doctor (respondent) had time, and allowed the researcher to help him/her complete the questionnaire, that activity was executed immediately. However, as respondents are normally very busy, some of them would request that the questionnaires are left with them so that they could fill them when they are "less busy". The questionnaires had been designed in a simple and straightforward manner so that this arrangement would not compromise the results.

### **3.2 AIM AND OBJECTIVES**

The aim of the study is to uncover the effects of HIV and AIDS in private medical practices in Umlazi Township. The surrounding townships or areas are not included in the study. According to UNAIDS (2006), there are 5.7 million HIV-infected individuals in South Africa; 5.4 million of them in the 15yr= age group. According to Rosen *et al* (2004), The labour force in South Africa falls into the category 15 – 65 years of age; the most active employees are in the age group 15 – 29 years.

The objectives of this study or research are as follows:-

- To investigate the effects of absenteeism within the private medical practices as a result of HIV/AIDS;
- To investigate the current policies that are in place to deal with the challenges of HIV/AIDS within the private medical practices;



- To investigate the effectiveness of current policies that are aimed at dealing with the challenges of HIV/AIDS; and
- To evaluate the extent of the effect of HIV/AIDS on the businesses sustainability.

The above objectives will make it easier to design a research instrument. They will also ensure that the data collection instrument is designed to collect the desired information.

### **3.3 PARTICIPANTS AND LOCATION OF THE STUDY**

The research was conducted in the private medical practices in Umlazi Township. According to EThekweni municipality there are only 40 private medical practices in Umlazi which serves approximately 400 000 people.

The interview will be in a form of closed-ended questionnaire, which will either be self-administered or assisted by the researcher. The study was conducted in the medical practices during doctor's spare or free time. A questionnaire was issued to all the doctors, irrespective of whether they were in partnership or not. All 40 medical practices were included in the study because it is a small population.

### **3.4 DATA COLLECTION STRATEGIES**

It has been mentioned above that the population size of the sample is 40; and all the medical private practices will be included in the sample because it is small. There are no sampling methods used in this research because the entire population is used.

There are different strategies can be used to collect research data. "The choice of strategy depends on identifying the one that works best for the particular research project in mind" (Denscombe, 2010, p.4). A researcher needs to consider three key questions before adopting a certain strategy, namely:-

- Is it suitable – will it produce appropriate kinds of data?
- Is it feasible – can it be done?

- Is it ethical – will it allow me to be ethical in my dealings with participants?

In this study a survey strategy is used in a form of questionnaires as a method for data collection.

### **3.5 RESEARCH DESIGN AND METHODS**

#### **3.5.1 Description and Purpose**

According to Bryman and Bell (2007), a research design provides a framework for the collection and analysis of data. They state that a choice of research design reflects decisions about the priority being given to a range of dimensions of research process. A research method is simply a technique for collecting data. A cross-sectional research design was used based on the fact that this study is a quantitative research and best suited for this study. A questionnaire was designed as a tool for data collection. This research covers the impact of HIV/AIDS from the doctor's view point at the medical practice. Therefore, the study needs to measure some aspect of a social phenomenon or trend.

##### **3.5.1.1 Construction of the Instruments**

A research instrument is constructed based on the objectives of the study. The objectives are mentioned above; and they include investigating the effect of absenteeism, current HIV/AIDS policies, effects of HIV/AIDS policies and effects of HIV and AIDS on business.

Primary data was collected through close-ended questionnaires, as this is a quantitative study. As has been mentioned, no sampling technique was used, as the population was very limited (i.e. 40 practices). The questionnaires were hand delivered, and either filled in with the practitioner, or collected as per the requirements of the practitioner him/herself. The questionnaire was designed in a seven Point Likert Scale format, and was divided into 5 sections. Section One covered the personal details of the practitioner (the name of the practitioner and that of the practice, together with it's location within the township were deliberately

left out). Sections Two to Four covered each objective in the same order as they have been enumerated in Section 3.2 above.

The design of the questionnaire, including the structuring of statements was simplified to avoid undue confusion.

### **3.5.1.2 Recruitment of Study Participants**

The population size of the sample is only 40 private medical practices and the entire population was used in this study. The questionnaires were hand delivered to the medical practice. The questionnaire design was simple and straight forward with closed-ended questions. In most cases it was self-administered service but where assistance was required, help was available. No questionnaires were emailed, faxed or posted to avoid undue delays.

### **3.5.2 Pre-Testing and Validation**

It is important that quantitative data which is recorded or collected is accurate and precise. Only appropriate data should be collected which should give an assurance that the data collected is measuring what is meant to. Errors should be eliminated in the data collected.

Because of time constraints a pilot study was not carried out to check the validity of the data. However, it should be noted that a face validity of the data is also allowed as one of the tools of validating quantitative data. According to Bryman and Bell (2007), validity affects the integrity of the conclusion that is generated from a piece of research. There are different types of validity:-

- Face validity – this is essentially an intuitive process. “A researcher should be able to establish at face value whether the measure reflects the content of the concept in question” (Bryman and Bell, 2007, p.165). A third person may assist in addressing the face validity.
- Concurrent validity – here a researcher is using a concurrent measure. An example could be, for instance, a measure of job satisfaction and a

criterion for absenteeism. In this case a researcher will be establishing whether those who are not satisfied with their jobs have an increased rate of absenteeism at work than those who are satisfied.

- Predictive validity – is the same as congruent validity; however a future rather than simultaneous criterion measure is employed.

It is important that the data collected will be the same whenever the same research is used in future. The results are reliable in terms of the respondents giving the same answers to similar questions. The data will allow any other researcher to arrive at the same conclusion when using the same research instrument. The findings will apply to other people and the analysis is correct.

### **3.5.3 Administration of Questionnaire**

The questionnaires were hand delivered to all 40 medical practices. It was a self-administered exercise but help was available if required. The questionnaires were collected once the doctor had completed them.

## **3.6 ANALYSIS OF THE DATA**

In quantitative research you collect the data and analyse it with the assistance of statistical test.

The statistical test used is in this study descriptive statistics. This test helps in the analysis of the data collected and it gives a description and interpretation of the data. The data is presented in the form of figures (pie and bars graphs) and tables using numerical or numbers. This numerical data is independent of the bias of a researcher. There are limitations to this study which restricts the data collected. The limitations are HIV/AIDS which carry stigma and discrimination, limited area covered when doing the study and that the study is quantitative thus limiting the respondent in expressing himself or herself.

### **3.7 CONCLUSION**

In this chapter it has been demonstrated how the data collection strategy was used. A research design and research method chosen for this study (including pre-testing and validation of the questionnaire) has been discussed.

In the next chapter it is a presentation of the data in figure and table form.

## CHAPTER 4 PRESENTATION OF RESULTS

### 4.1 INTRODUCTION

The data in this chapter is presented in descriptive statistics. Figures (graphs – bars and pie) and tables are used to present the data collected from the respondents. Section A of the questionnaire is presented in pie graphs and tables and Section B (Lickert Style Data) is presented in bar graphs only. In this chapter a researcher does not interfere with the data collected. The data is entered as is and the results are presented in graphs and tables. A descriptive statistic test is used in analysing the data. It is noted that this test makes it simple to analyse and interpret the results of the data collected.

### 4.2 HEADINGS

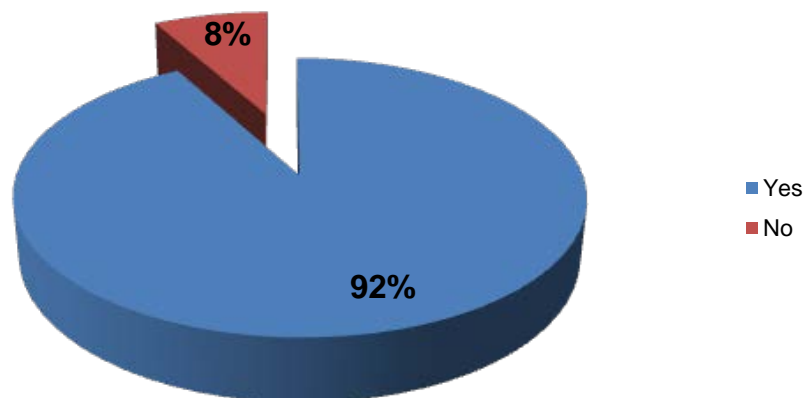
The following is the presentation of data in descriptive form.

#### SECTION A:

QUESTION 1: Are you the only medical doctor in your practice?

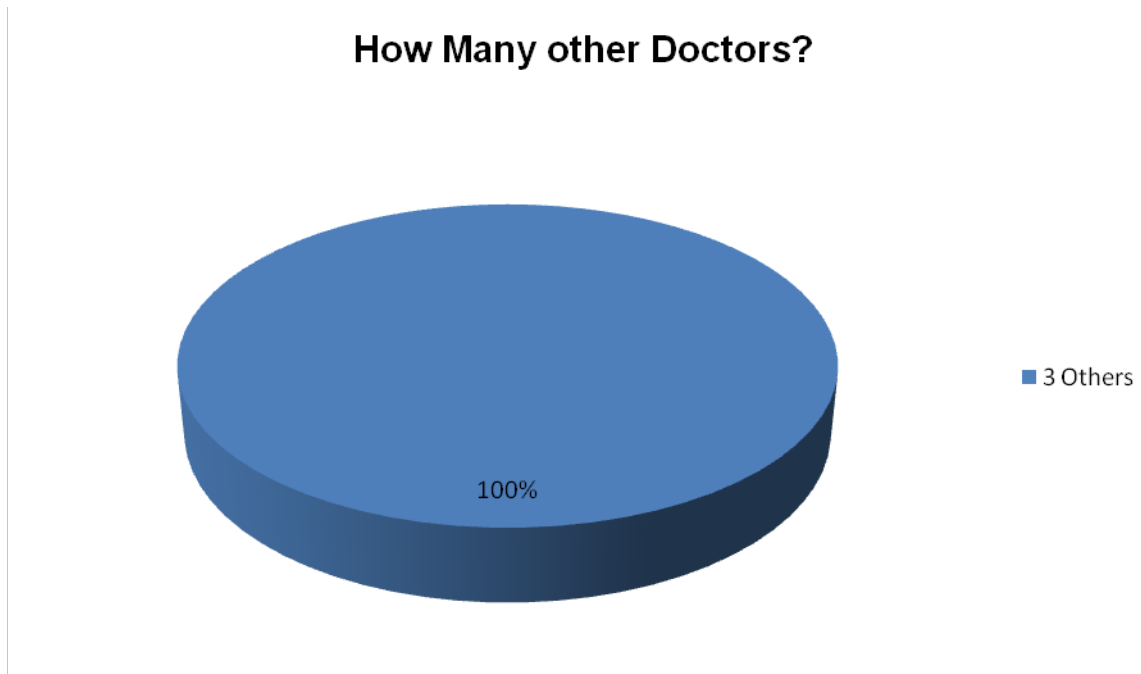
Figure 4.1

#### Only Medical Doctors in the Practice?



QUESTION 2: If your answer in Q1 is yes, how many other doctors do you practice with?

**Figure 4.2**

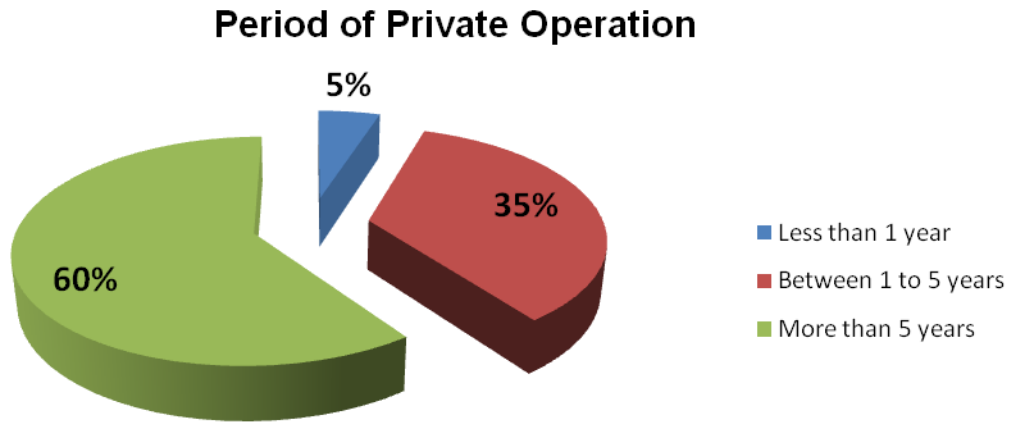


QUESTION 3: For how many years have you been operating privately?

**Table 4.1**

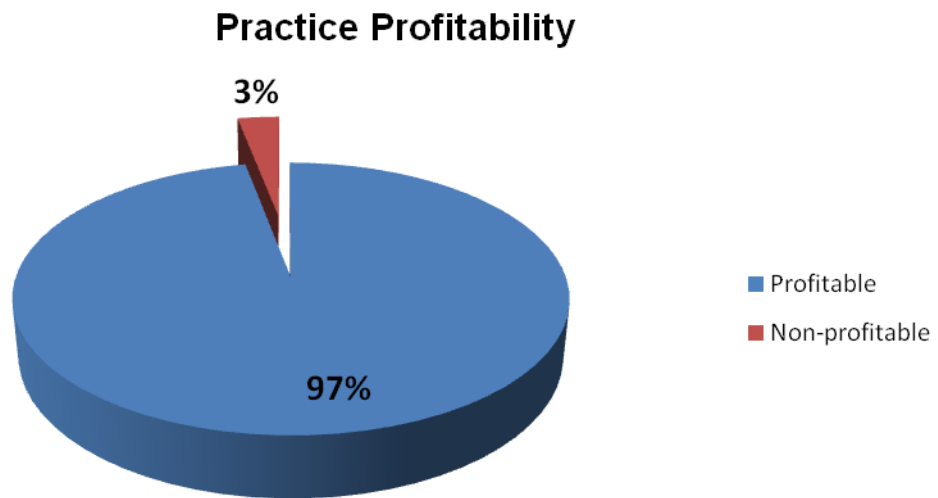
Period Range	Selected Period (in numbers)	Selected Period (in percentages)
Less than 1 year	2	5%
Between 1 – 5 years	14	35%
More than 5 years	24	60%

**Figure 4.3**



QUESTION 4: Would you categorise your practice as presently profitable?

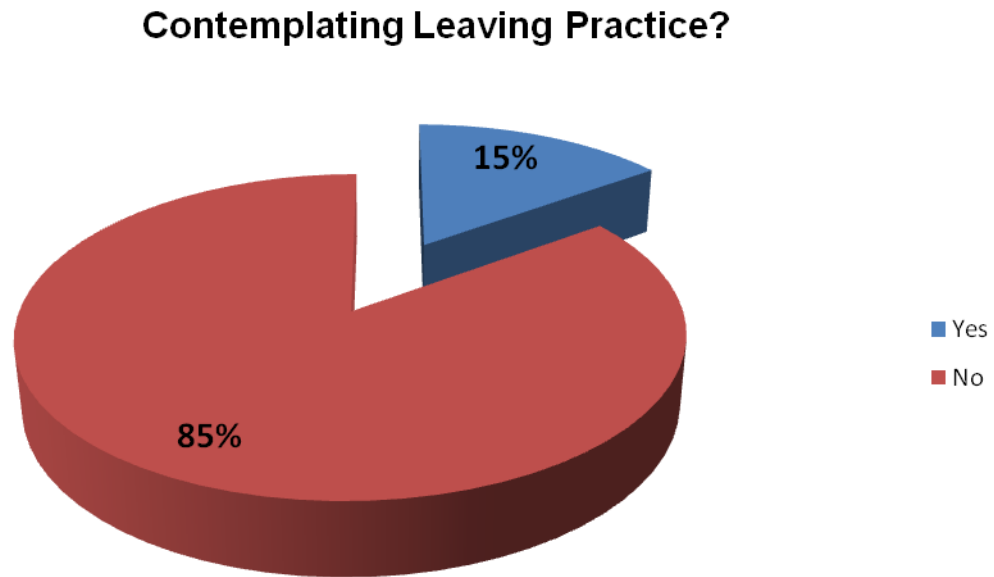
**Figure 4.4**





QUESTION 5: Are you contemplating leaving private practice?

Figure 4.5



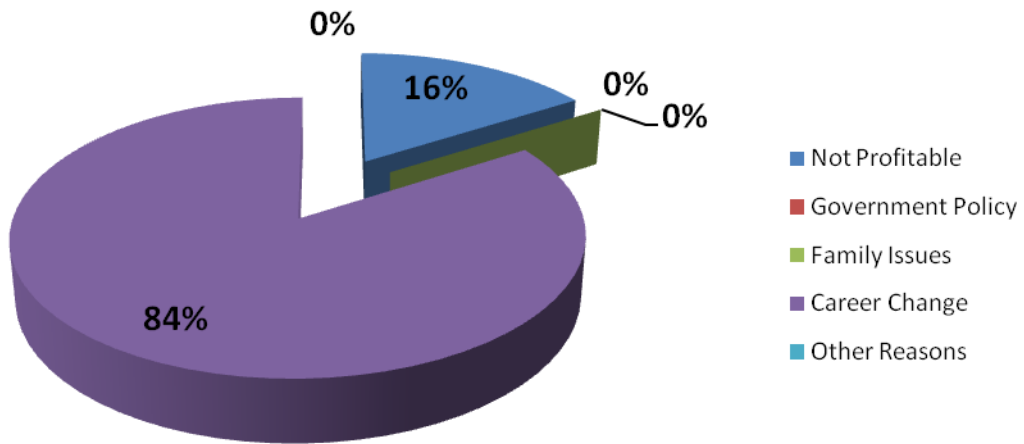
QUESTION 6: Why are you contemplating leaving the practice?

Table 4.2

Reason to Contemplate Leaving Practice	Percentage from the Total of SIX
It is not Profitable	16%
Government Policy	0%
Family Issues	0%
Change of Career	84%
Other Reason	0%

Figure 4.6

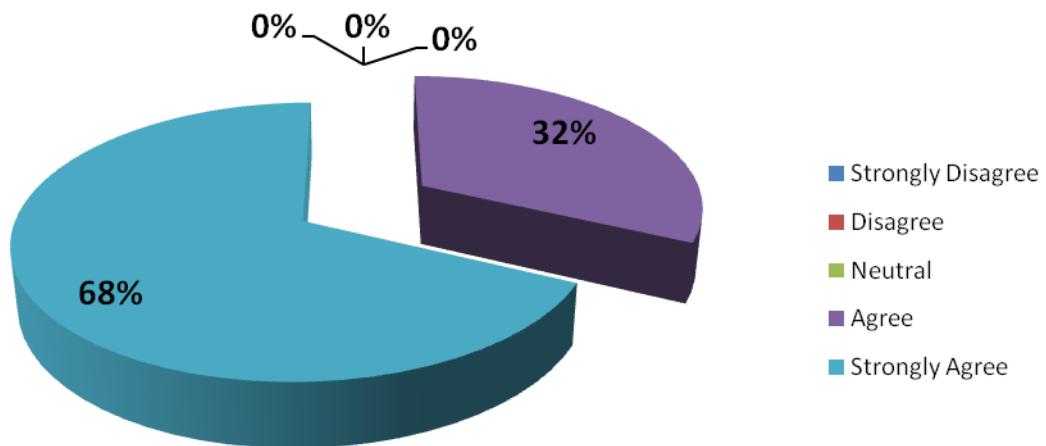
### Reasons to Contemplate Leaving Private Practice



QUESTION 7: The respondents were asked whether they agree with the statement that “Employees in the medical service industry are equally vulnerable to HIV/AIDS”

Figure 4.7

### Are Medical Service Industry Employees Valnurable to HIV/AIDS?

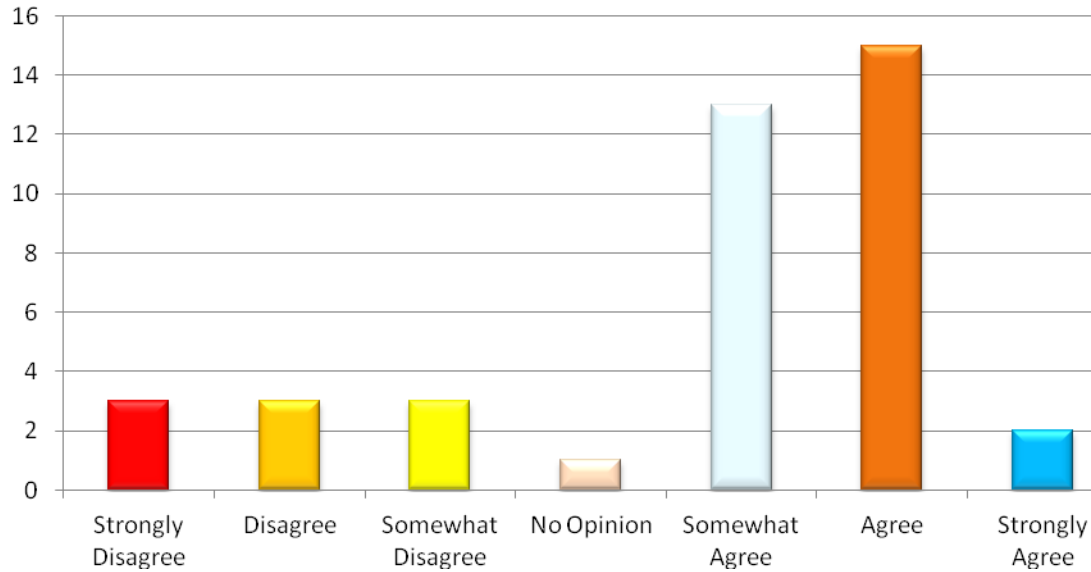


**SECTION B: Questions Relating to Absenteeism**

STATEMENT 1.1: HIV/AIDS related absenteeism is a major challenge in my practice.

**Figure 4.8**

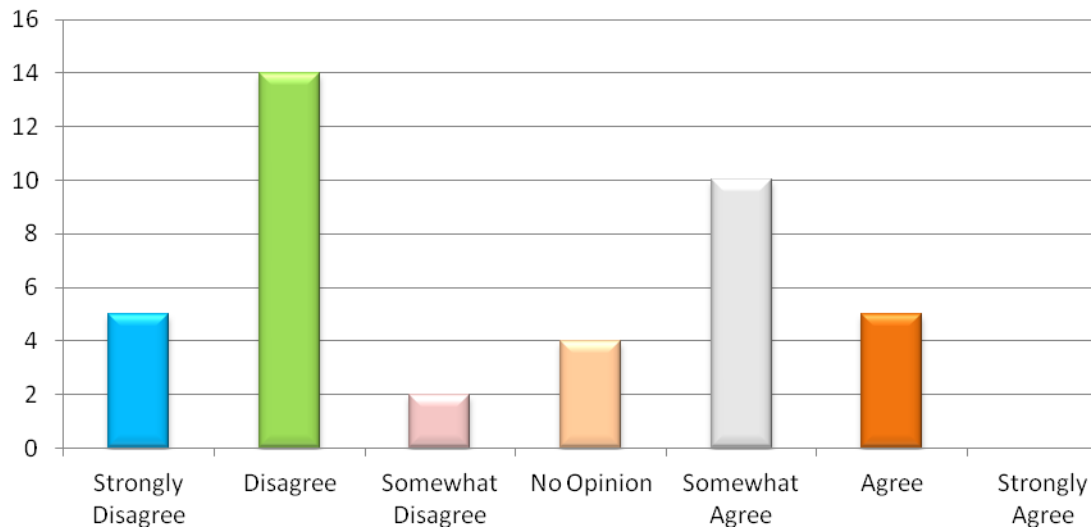
**HIV/AIDS Related Absenteeism a major Challenge**



STATEMENT 1.2 : My practice loses business because of HIV/AIDS related absenteeism.

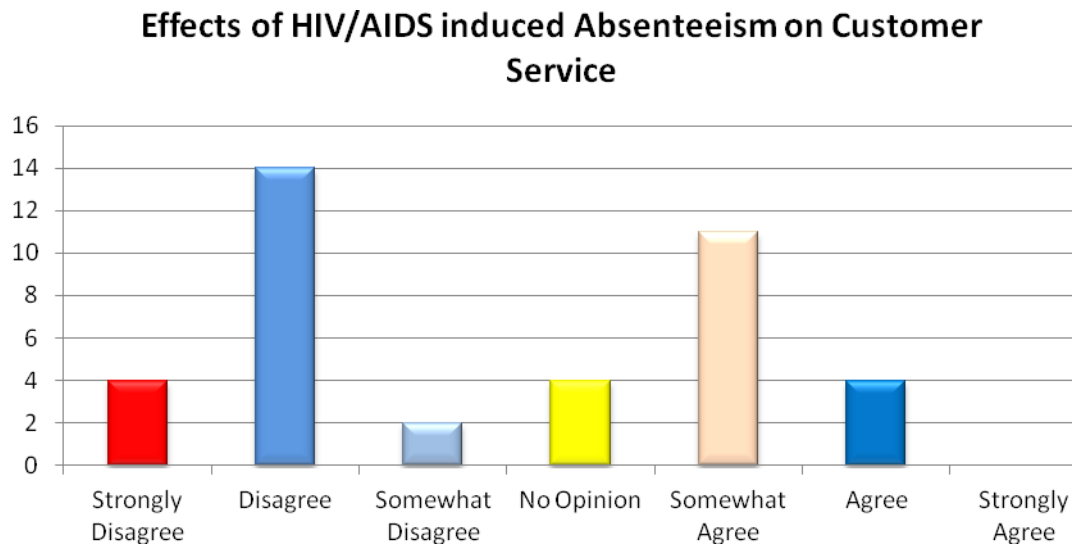
**Figure 4.9**

**Loss of Business because of HIV/AIDS induced Absenteeism**



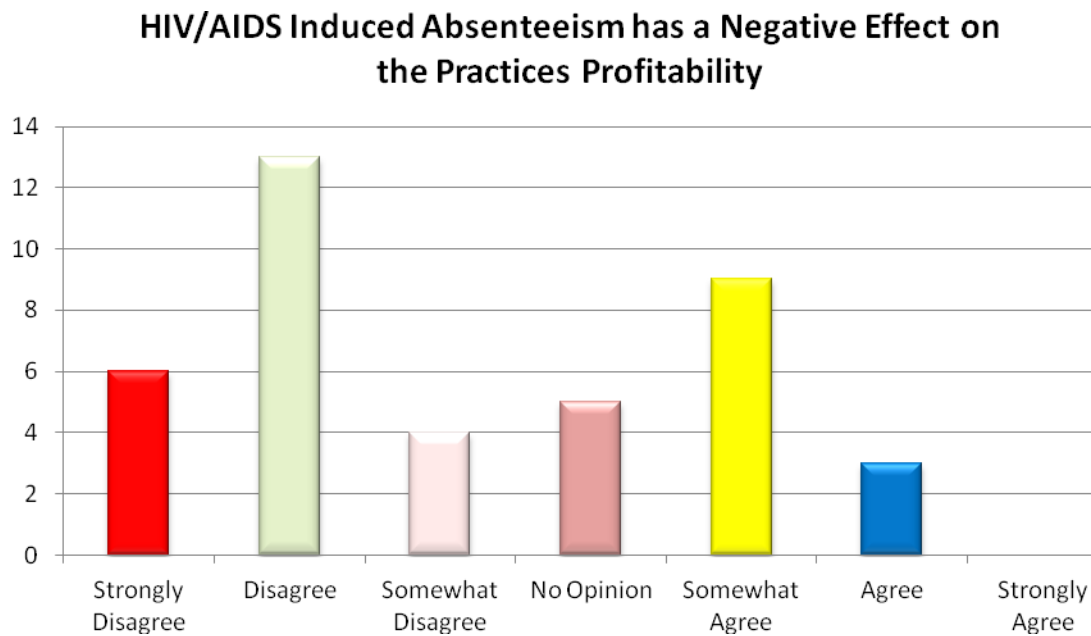
STATEMENT 1.3: The customer service in my practice is negatively affected by HIV/AIDS related absenteeism.

**Figure 4.10**



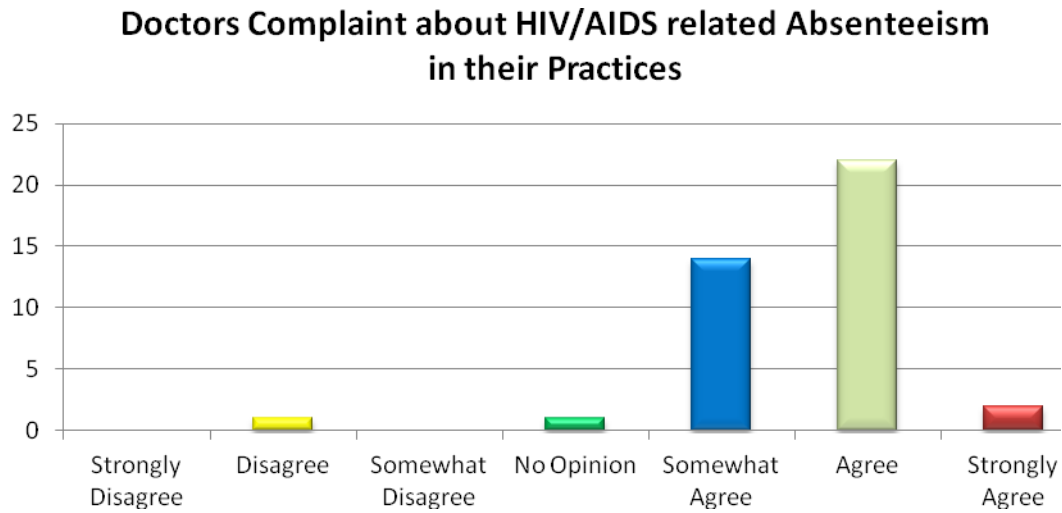
STATEMENT 1.4: The profitability of my practice suffers because of HIV/AIDS related absenteeism.

**Figure 4.11**



STATEMENT 1.5: Other doctors in the private practice complain about HIV/AIDS related absenteeism in their business.

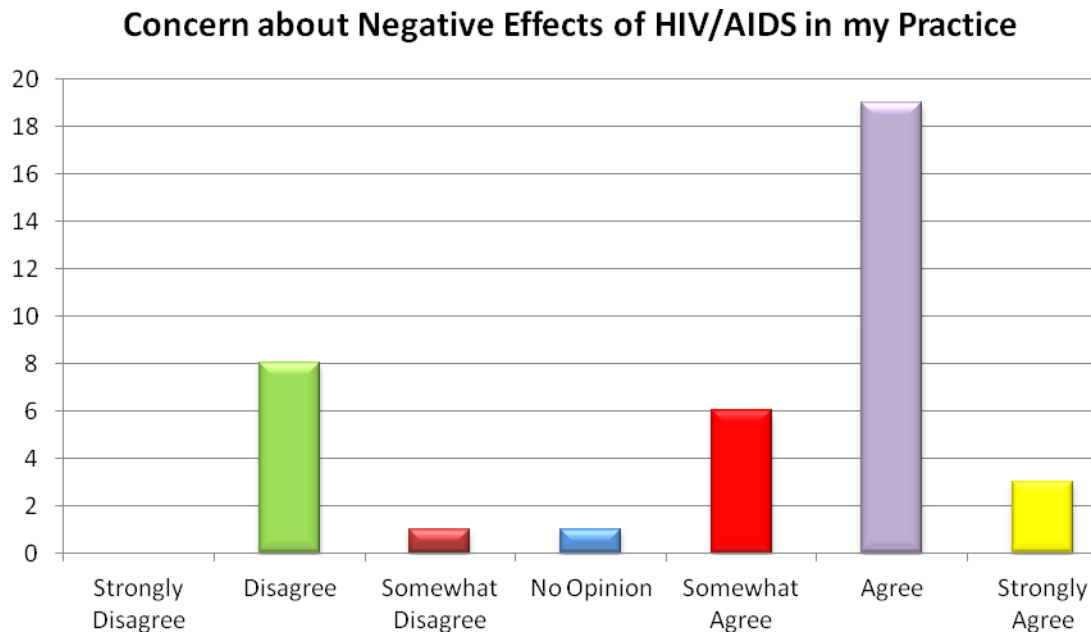
Figure 4.12



### SECTION C: Statements Relating to Current HIV/AIDS Policies

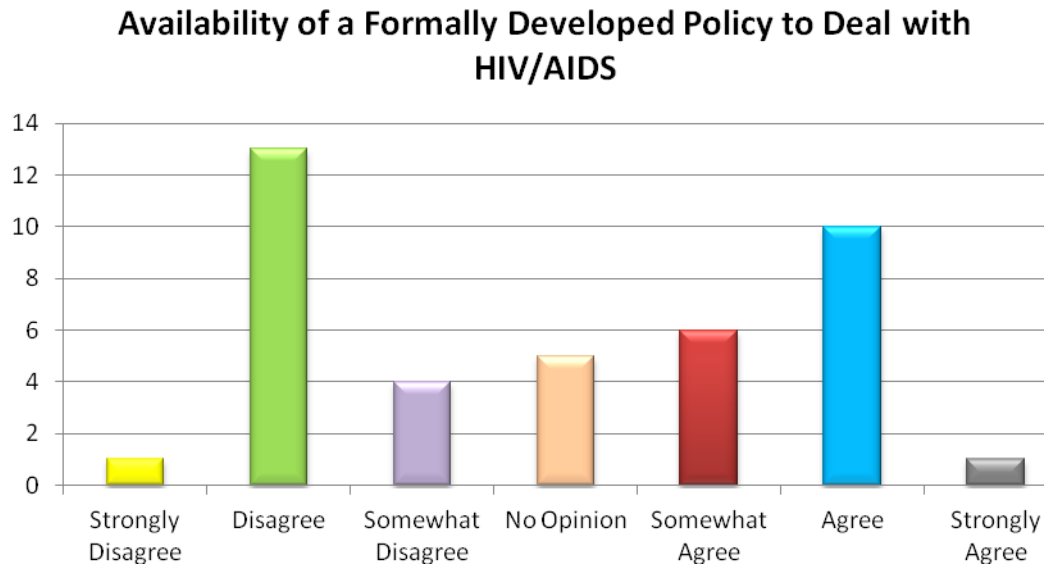
STATEMENT 2.1: I am concerned about the negative effects of HIV/AIDS related effects on my business.

Figure 4.13



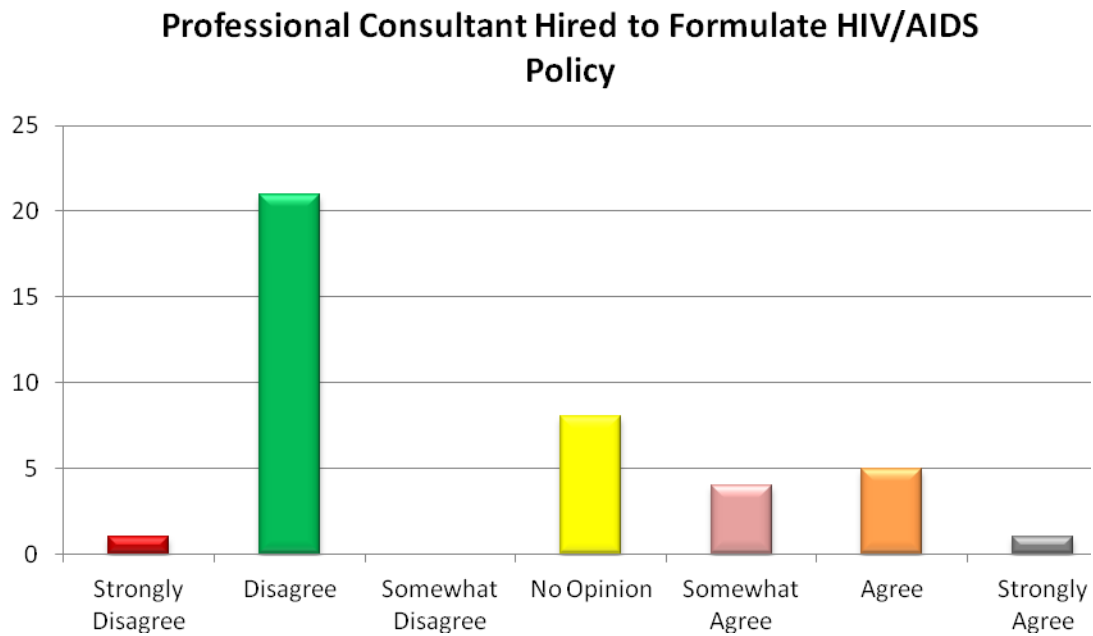
STATEMENT 2.2: There is a formally developed HIV/AIDS policy to deal with its effects in my practice.

**Figure 4.14**



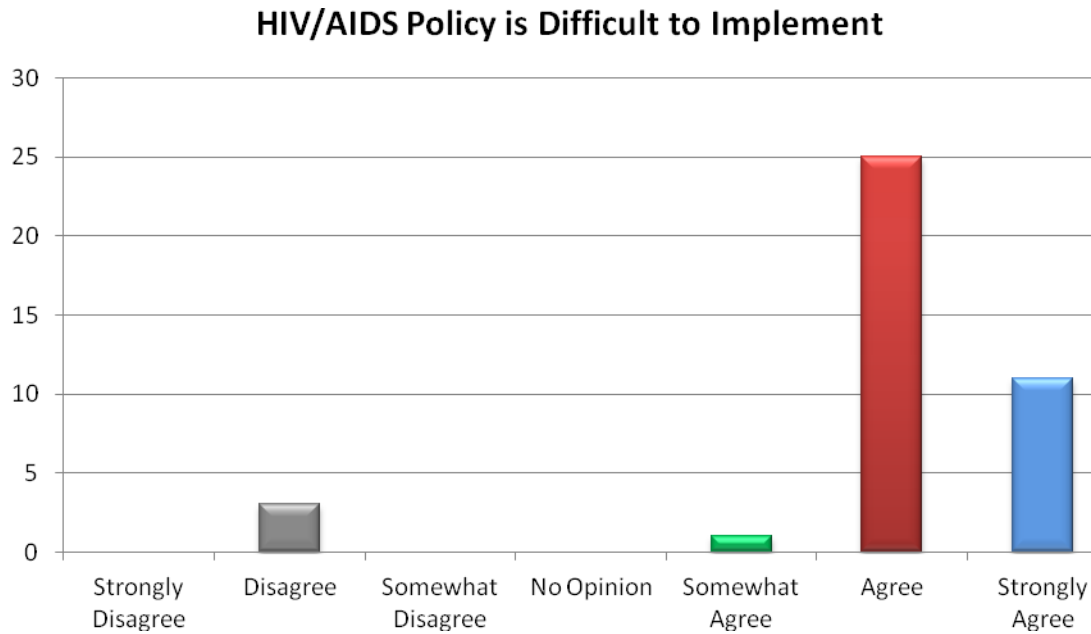
STATEMENT 2.3: I hired a professional consultant to formulate an HIV/AIDS policy in my practice.

**Figure 4.15**



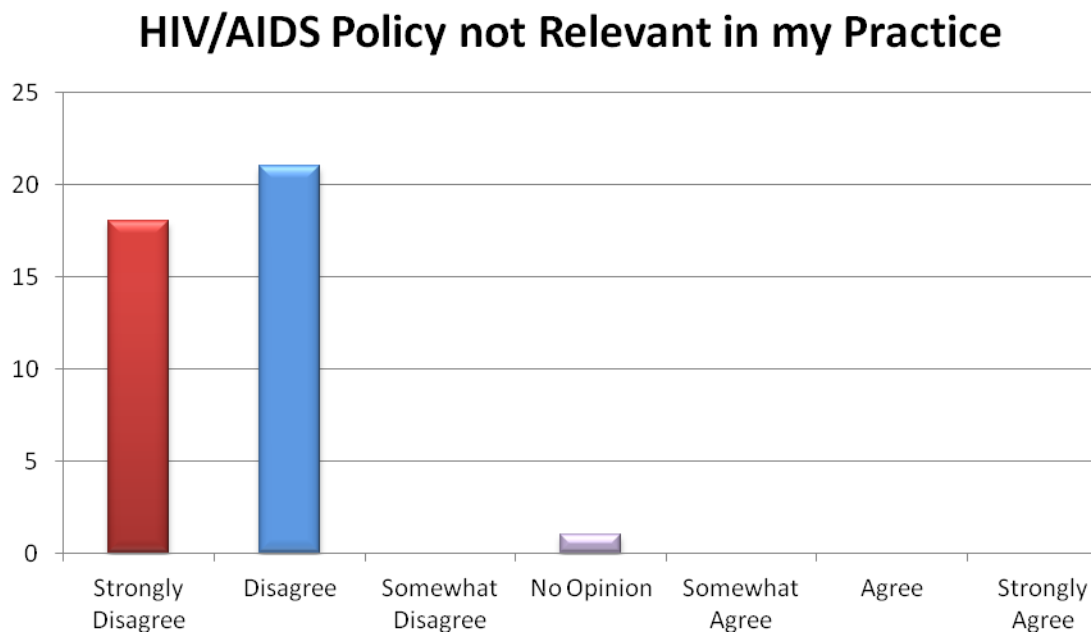
STATEMENT 2.4: An HIV/AIDS Policy is difficult to implement.

Figure 4.16



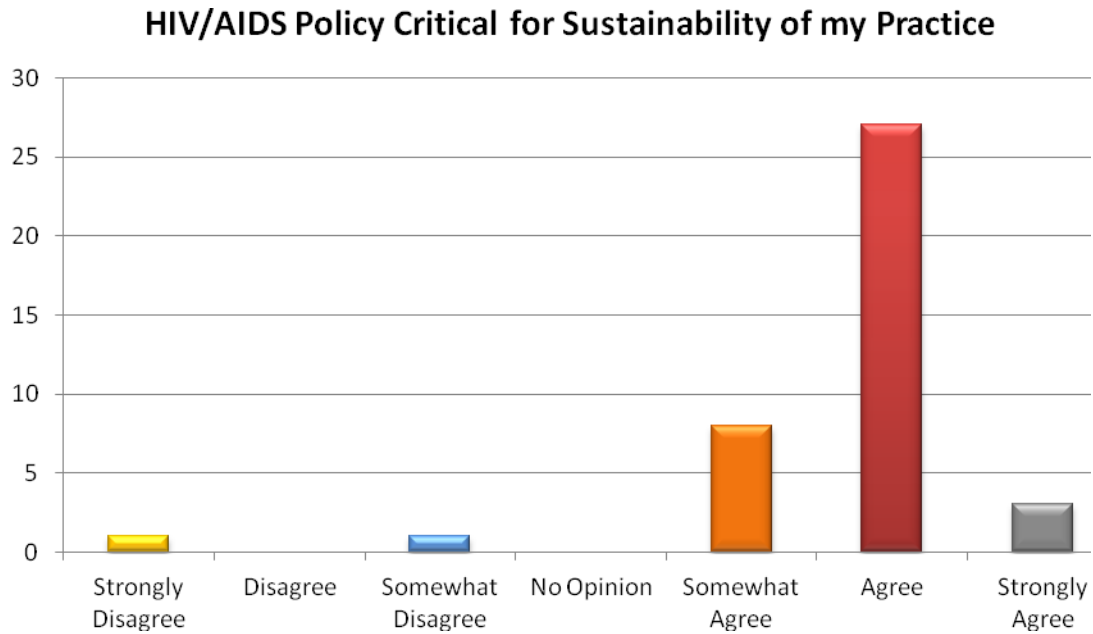
STATEMENT 2.5: An HIV/AIDS Policy is not relevant in my business.

Figure 4.17



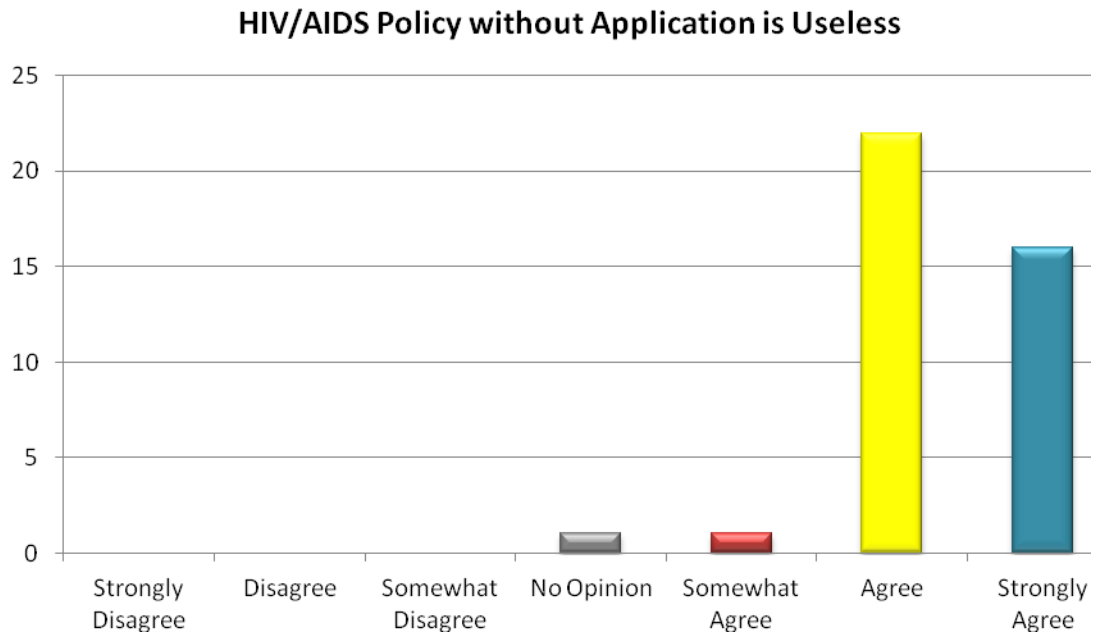
**SECTION D: Statements Relating to Effectiveness of HIV/AIDS Policies**  
**STATEMENT 3.1: An HIV/AIDS Policy is critical for the sustainability of my practice.**

**Figure 4.18**



**STATEMENT 3.2: An HIV/AIDS policy without an application is useless.**

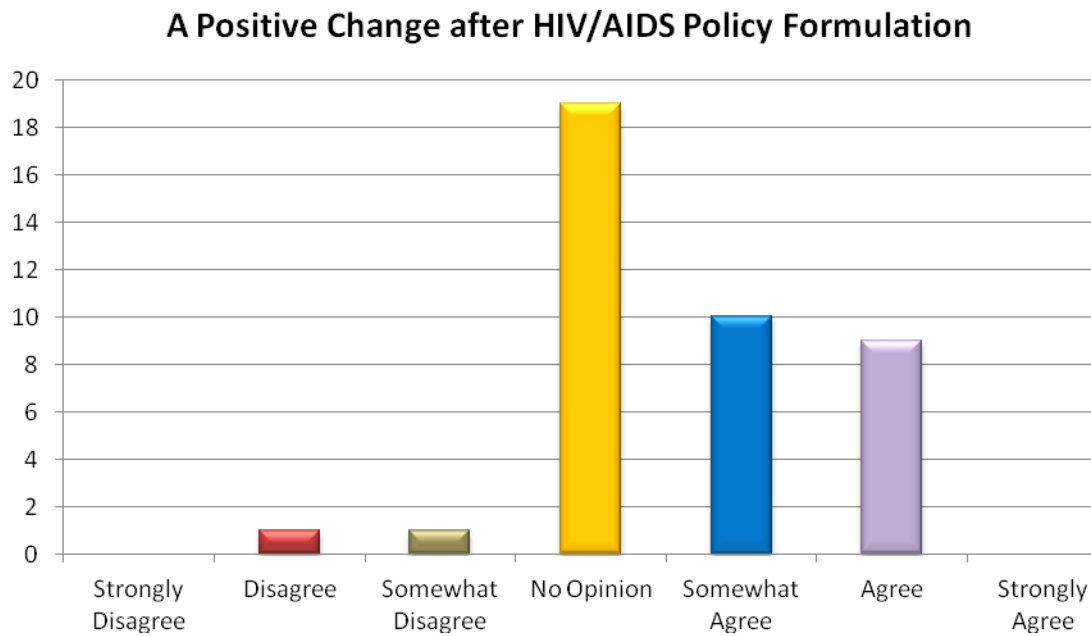
**Figure 4.19**





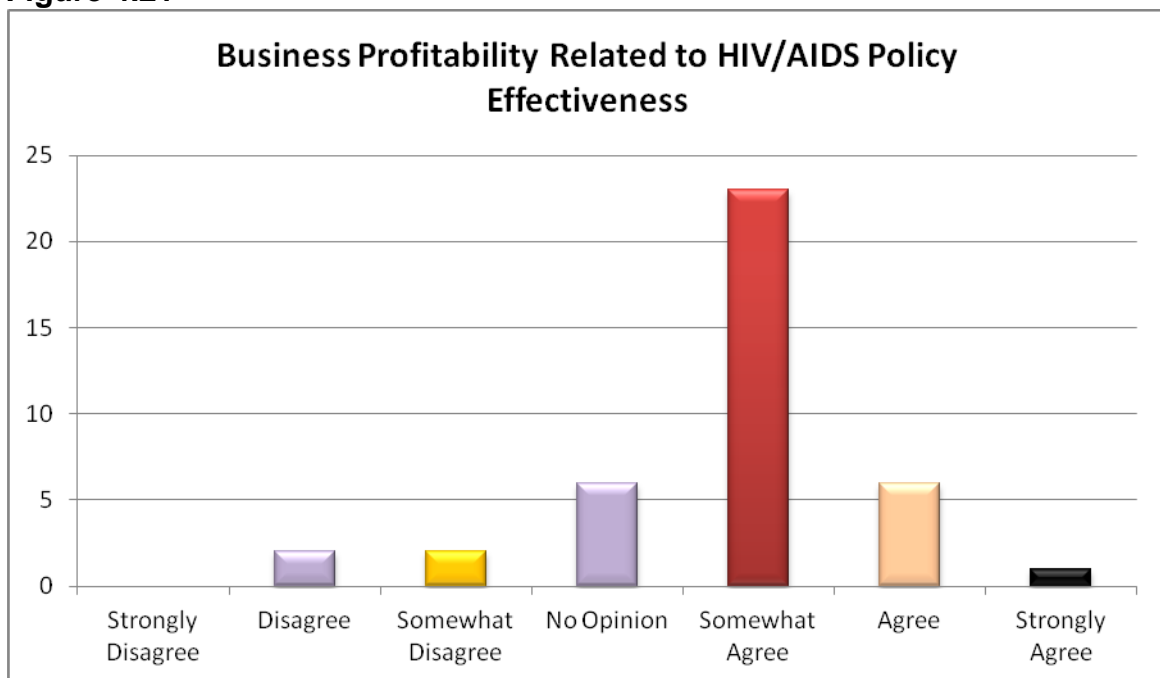
STATEMENT 3.3: After I formulated a HIV/AIDS related policy my business had a change for better.

**Figure 4.20**



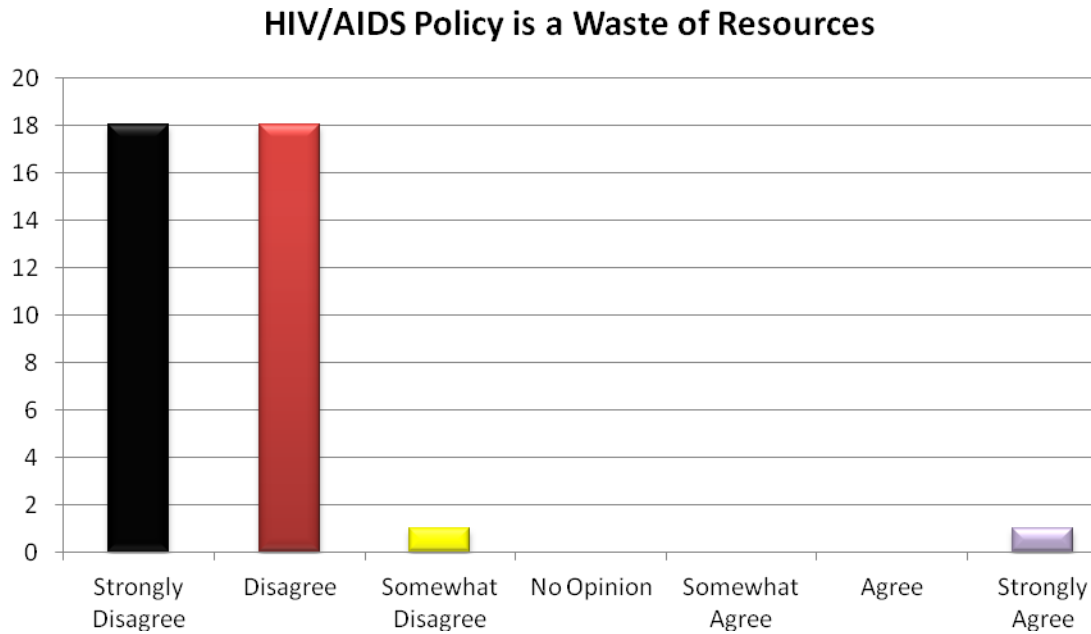
STATEMENT 3.4: The profitability of my business is positively related to the effectiveness of the HIV/AIDS policy in my practice.

**Figure 4.21**



STATEMENT 3.5: An HIV/AIDS policy is a waste of my practices resources.

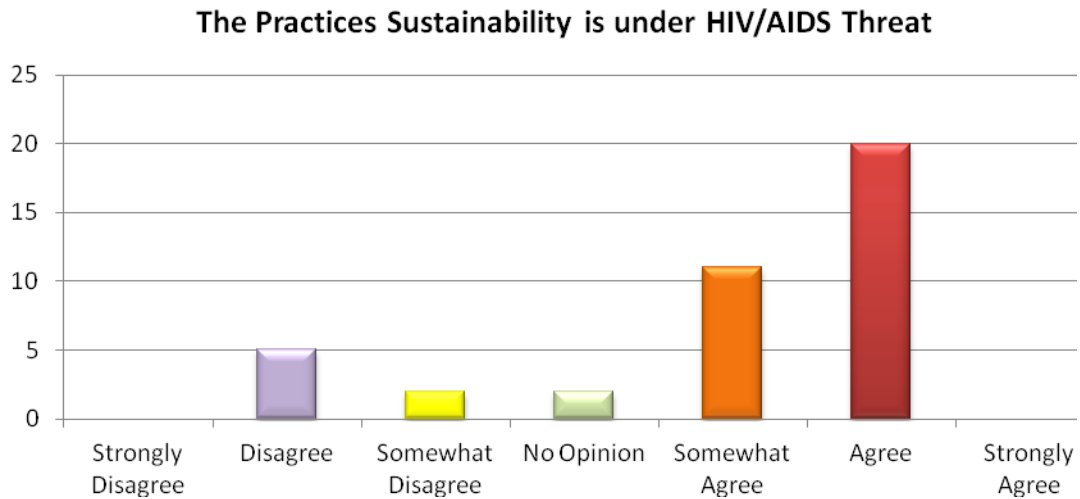
Figure 4.22



**SECTION E: Statements relating to Business Sustainability**

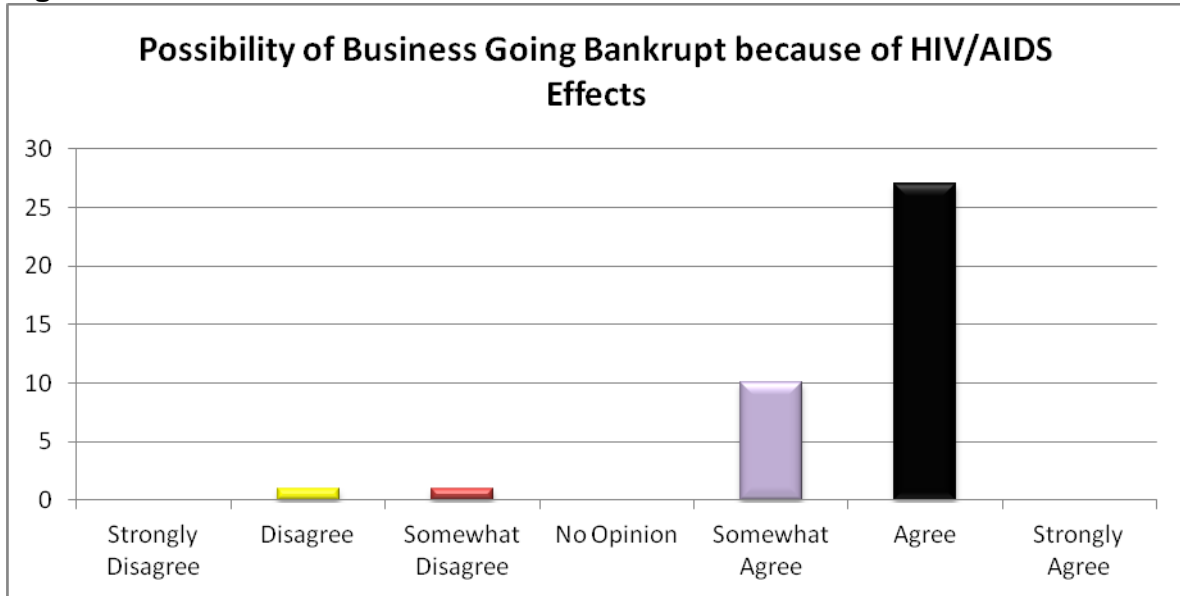
STATEMENT 4.1: I believe that my practice’s sustainability is under a serious threat from the effects of HIV/AIDS.

Figure 4.23



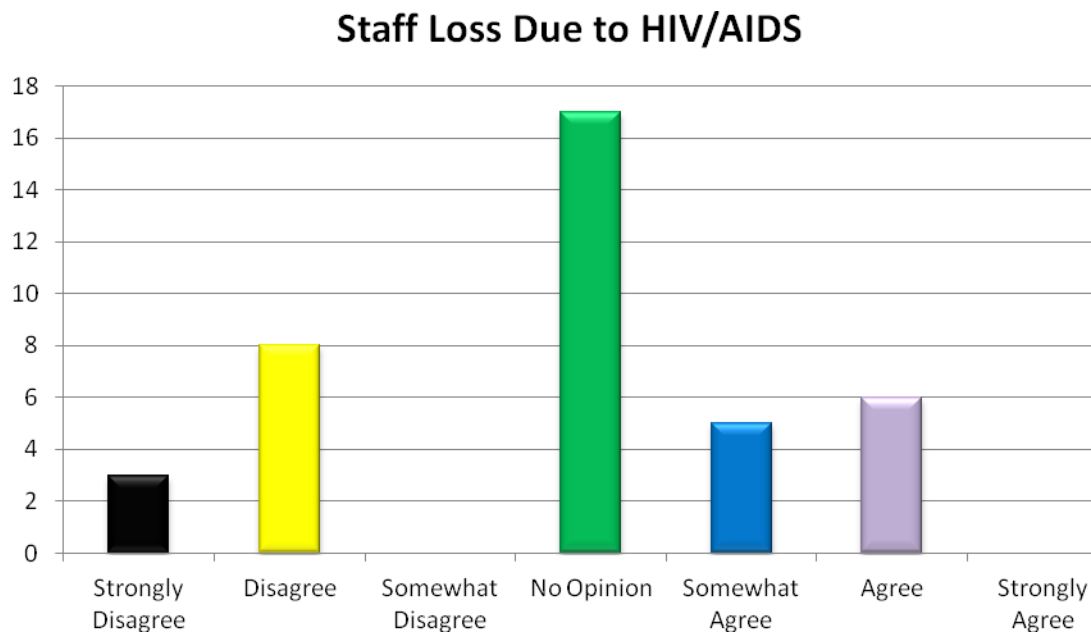
STATEMENT 4.2 It is possible to have ones practice going bankrupt because of the negative consequences of HIV/AIDS.

Figure 4.24



STATEMENT 4.3 I have lost some staff members because of the effects of HIV/AIDS.

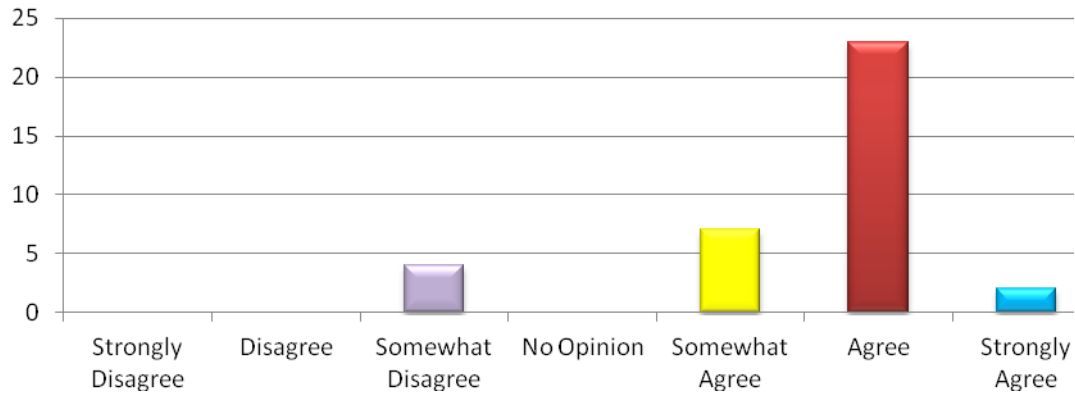
Figure 4.25



STATEMENT 4.4 My staff members are comfortable discussing their personal HIV/AIDS related issues with me.

Figure 4.26

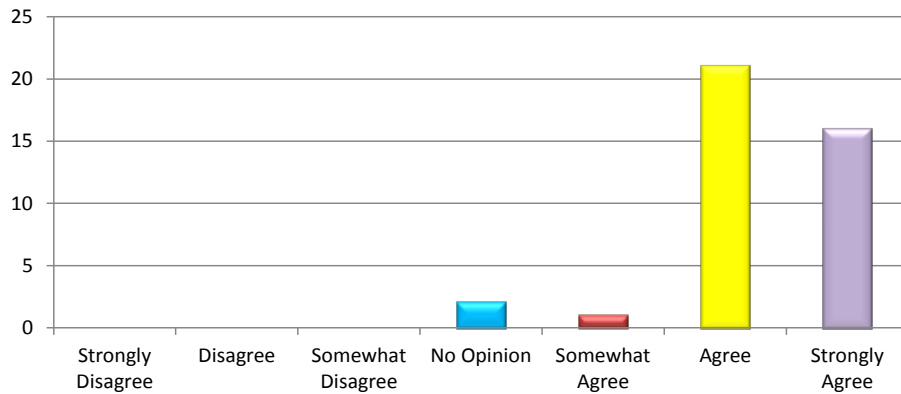
### Staff Comfortable Discussing HIV/AIDS Related Issues



STATEMENT 4.5 My staff members are frightened of contracting HIV.

Figure 4.27

### Staff Members are Frightened of Contracting HIV



### **4.3 CONCLUSION**

In this chapter the data collected has been presented in descriptive statistics using graphs and tables. All the data collected in a questionnaire has been entered without any alteration or interference. That has made it easier for a researcher to do the interpretation.

In the next chapter a discussion of the research findings is done. That's where an interpretation of the results will be explicitly done.

## **CHAPTER 5 DISCUSSION**

### **5.1 INTRODUCTION**

In Chapter 4 the results were presented in descriptive and inferential statistics. The results obtained in Chapter 4 needs to be discussed in detail to establish if there is any relationship between HIV/AIDS and absenteeism from the workplace. In other words, results must be viewed, deciding whether there is any correlation between the two variables, namely HIV/AIDS and absenteeism. That is not intended to exclude the relationship between other variables and HIV/AIDS.

The questionnaire addressed the different effects and outcomes of HIV/AIDS in the workplace. The questionnaire, therefore, investigated different aspects of the effects and outcomes of HIV/AIDS with regard to absenteeism from the workplace as well as HIV/AIDS policies and their effects. The descriptive and inferential statistics help to explain and interpret the results obtained from the data collected. The data collected is presented in a numerical form which makes it easier to explain the data collected.

### **5.2 AIMS AND OBJECTIVES**

In this chapter, the evidence of a relationship between HIV/AIDS, absenteeism and other variables as demonstrated in Chapter 4 is unpacked. The evidence is based on the answers obtained from the questionnaires returned by the respondents (medical doctors)

The aim of this research is to investigate the effects of HIV/AIDS on private medical practices in Umlazi. The objectives of the research are:

- To investigate the effects of absenteeism within the private medical practices as a result of HIV/AIDS;
- To investigate the current policies that are in place to deal with the challenges of HIV/AIDS within the private medical practices;
- To investigate the effectiveness of current policies in dealing with the challenges of HIV/AIDS; and
- To evaluate the extent of the effect of HIV/AIDS on the businesses

sustainability.

This chapter will examine the results and test the objectives outlined for this research. These results will confirm or refute a hypothesis that HIV/AIDS has a serious impact on absenteeism at workplace. It will also discuss the HIV/AIDS policies and the effects of HIV/AIDS on business sustainability.

### **5.3 DISCUSSION**

The questionnaire is divided into 2 sections – Section A (1 part) and Section B (4 parts). That means there are 5 sections in total. In Section B, the 4 parts have questions linked to the 4 objectives. In other words questions are formulated around the 4 main objectives mentioned above; namely absenteeism, policies, effects of policies, and effects of HIV/AIDS on business. The questionnaire is designed with seven Point Likert Scale with five questions addressing each objective. The aim is for the questionnaire to address the objectives of this study. In this discussion every question will be explained and an interpretation of the results will be made and compared to similar studies or cases.

#### **5.3.1 Section A**

This section deals with the personal details of the medical doctor while the other four parts deal with the objectives of the study. Results are presented in graphs and tables. In Section A, figure 4.1 shows that most doctors are the sole partners in their practices (92%) which is a significant number for the purpose of this study. In table 4.1 and figure 4.3, the majority (60%) has been in practice for more than five years and that indicates a lot of experience in the majority of the doctors interviewed. In figure 4.4, the majority of doctors viewed medical practices as profitable and thus very few (15%) are prepared to leave private medical practices as shown in figure 4.5. In figure 4.5, of the few (15%) who are prepared to leave their practices the majority (84%), figure 4.6, would do so because of a change in career. In figure 4.7, a significant 68% of the respondents strongly agree that medical service industry employees are

vulnerable to HIV/AIDS and 32% agree with the statement. That means 100% of the respondents agree with the statement although there was a difference in the degree of agreement.

### **5.3.2 Section B**

This section was made up of four parts which are divided according to the four objectives outlined above. There were 40 medical practices which mean there were 40 respondents. The results below will be reported in numerical form based on the results from the graphs in chapter 4.

#### **5.3.2.1 Absenteeism**

In figure 4.8, 15 respondents or doctors agree, 2 respondents strongly agree and 13 somewhat agree that HIV/AIDS related absenteeism is a challenge to their medical practices. However, in figure 4.9 21 of respondents (majority) have not experienced the negative effects of induced HIV/AIDS absenteeism and in figure 4.11 the majority (23) haven't experience adverse effects on profitability of the medical practice due to HIV/AIDS induced absenteeism. This is probably because the employees are not being open to with the employer about their HIV status. It should be remembered that HIV and AIDS is a very sensitive health issue. It normally gives rise to stigma and discrimination once people know that you are HIV infected or affected. It should be recalled that in the literature review, stigma and discrimination associated with HIV/AIDS are an obstacle to an effective medical intervention. According to Mawar *et al* (2005), stigma and discrimination attached to HIV/AIDS are major obstacles to treating the disease. It has been learnt from other literature that HIV positive employees are more likely to be absent repeatedly than HIV negative employees if their health and treatment are not effectively managed. According to Kumaranayake *et al* (2007), HIV positive individuals within the labour force are likely to have a 30 percent higher rate of absenteeism. This concurs with the results supporting a statement that HIV/AIDS induced absenteeism is a challenge at workplace. A slight majority of the respondent did not see the bearing of HIV/AIDS induced absenteeism on



profitability. This was an unexpected result but it can also be linked to the fact that employees do not freely disclose their status and thus whenever they are sick it is not linked to HIV/AIDS. However in the literature review HIV/AIDS has been largely attributed to an increase in costs and decrease in productivity at workplace because of absenteeism and/or early retirement of a worker due to HIV/AIDS. According to Shisana *et al* (2009), the cost is not only limited to the employee's salary, but also to sourcing a temporary replacement and a loss of production. When HIV positive employee is repeatedly absent, the bottom line of a company might be affected. However, it can be seen that, in general the majority of doctors interviewed, have heard complaints from their colleagues about HIV/AIDS induced absenteeism at their practices as shown in figure 4.12. That means that absenteeism in the workplace is probably more common than acknowledged in this study.

#### **5.3.2.2 HIV/AIDS policy at workplace**

In figure 4.13, the data collected clearly showed that the majority (28) of medical doctors interviewed agree that HIV/AIDS has negative effect on their medical practices. There is a general feeling that HIV/AIDS policy is a necessity for the medical practices. However, in figure 4.14 most doctors (18) compare to 17 doctors, do not have formal HIV/AIDS policy in their medical practices. In figure 4.16 the majority of doctors (37) agree with the statement that HIV/AIDS policy is difficult to implement. This concurs with the literature review done in Chapter 2. According to Taylor *et al* (2004), globally, the majority of business executives interviewed globally recognise the future impact of HIV/AIDS in their business but only 6 percent have implemented an HIV policy. In figure 4.17 almost all doctors or respondents (39) acknowledge the importance or relevance of HIV/AIDS policy in their practices.

#### **5.3.2.3 The effectiveness of an HIV policy**

In figure 4.18, the results obtained in this question show that the majority (37) of the respondents agreed that an HIV/AIDS policy is very important and is critical

for the sustainability of the practice. In figure 4.19, the majority (39) of respondents agreed with the statement that an HIV/AIDS policy without application is useless. It also emerges that a distinct majority in figure 4.20, 18 compare to 2, agree with the statement that an HIV/AIDS policy results in positive changes. In figure 4.21, 32 doctors agree with the statement that business profitability related to HIV/AIDS policy effectiveness. In figure 4.22 almost all the respondents (39) agreed that an HIV/AIDS policy is not a waste of resources. This is in line with the literature review done in Chapter 2 that an HIV/AIDS policy will bring positive changes at the workplace if implemented. An HIV/AIDS policy that deals with prevention and treatment will help forge non-discrimination, promote confidentiality and not link HIV status with employment. According to Fasset (2005), programmes focus initially on awareness and prevention activities which aim to address high-risk behaviours, reduce discrimination, increase the company's ability to manage the disease, and increase the enrolment of HIV-positive employees in the company's treatment programme. An HIV/AIDS prevention programme, which is developed as a policy, should play a role in educating workers in term of prevention and the importance of testing. Employees should be educated about voluntary testing and counselling (VCT). This will bring about education on concomitant diseases like sexually transmitted infections and the importance of safe or protected intercourse. The employees will also be educated on confidentiality which will encourage more workers to be tested. Eventually workers will be made aware of the importance of antiretrovirals (ARVs) and its advantage once you have been diagnosed with HIV. According to Habyarimana *et al* (2007), infected workers display an increased number of days absent from work prior to starting the treatment, however, once the HIV-infected worker is put on HIV/AIDS treatment (ARVs) there is a marked improvement in the medium to long term (usually after 6 months on treatment) where absenteeism of HIV -infected workers is similar to non-infected workers". Kenyan tea-estate workers who were put on ARVs showed a great improvement, working twice as many days 12 months after the initiation of ARVs. According to Larson *et al* (2008), treatment had a positive

impact on the ability of workers to undertake their primary work activities in the first year on ARVs. That concurs with the fact that an HIV intervention programme is essential at work. If HIV/AIDS policy is formulated and implemented, production level and absenteeism will greatly improve.

#### **5.3.2.4 The sustainability of business during HIV/AIDS pandemic**

In figure 4.23, the majority (31) of respondents agree with the fact that private medical practices in Umlazi are under threat because of HIV/AIDS. That means that the sustainability of the business is in doubt if the HIV/AIDS health issue is not addressed urgently and effectively. The majority of respondents (37) in figure 4.24 also agreed that HIV/AIDS can cause medical practices to go bankrupt. This concurs with the findings in the literature review that HIV/AIDS has a negative effect on business if not managed properly. In the long run there might be a reduction in population because of increased mortality rate per annum for that particular country. In turn there will be a reduction in GDP or economic growth. According to Taylor *et al* (2004), given that the number of AIDS deaths in Africa has risen from 218 000 in 1990 (2.7% of all deaths) to 2.2 million in 2002 (21% of all deaths), we should look carefully at the link between HIV/AIDS and economic growth.

It can be seen that the respondents are equally divided on the issue of staff loss due to HIV at work in figure 4.25. Initially the number of deaths due to HIV was on the increase. That might be due to the fact that private medical doctors in Umlazi were not getting the feedback of the real reason why an employee had died. This can be linked to high levels of secrecy about the disease due to the stigma and discrimination attached to HIV/AIDS. However, the mortality rate due to HIV/AIDS has stabilized because of intervention programs currently present in South Africa. In figure 4.26, the majority (32) of the staff at these medical practices were found to be comfortable discussing their HIV status with their employers. This is contrary to an earlier thought about staff being secretive about their HIV status thus leading to the data not linking HIV/AIDS induced absenteeism to negative effects at workplace as well as profits.

## **5.4 CONCLUSION**

In this chapter it has been demonstrated that the objectives of this research were thoroughly interrogated in the questionnaire and the data gave results, the majority of which concurred with the literature review. Thus it can be seen that the data collected give a generally expected view about HIV/AIDS at the workplace.

The issue of HIV/AIDS induced absenteeism, HIV/AIDS policy, effects of HIV/AIDS policy, and the effects of HIV/AIDS on business sustainability are all interconnected. A well formulated and implemented HIV/AIDS policy and intervention program will give an employer an effective tool to manage HIV infected and affected workers. That will reduce HIV/AIDS induced absenteeism, save costs and increase productivity.

The next chapter, discuss whether the study addressed the objectives. In other words whether the problem was solved. The implication of the study will be analyzed, recommendations for research problem be made and recommendations for future studies.

## **CHAPTER 6 RECOMMENDATIONS AND CONCLUSIONS**

### **6.1 INTRODUCTION**

HIV/AIDS has presented a very serious threat to the world for the past three decades or more, particularly in Southern Africa. In the previous chapters several indicators of the magnitude of the disease have been discussed including the case studies. Comparison of the data collected for this research has been either refuted or concurred with several case studies mentioned in Chapter 2. That has lead to an impact of HIV/AIDS at workplace being unpacked in Chapter 5.

In this chapter, it will be demonstrated whether the study has solved what it set out to solve. This should then tie in with the objectives set out for this study. If the objectives are reached then it means that the problem is solved. The implication of this study will have to be highlighted to see if it has contributed to the scholarship of this topic. This is important in that it is helping other stakeholders to have a better understanding of the research problem. This study needs to demonstrate whether the stakeholders will benefit from the study. In this research recommendations will have to be made concerning the research problem. Recommendations should be relevant, realistic and practical. The costs to the company implementing those recommendations will have to be taken into consideration. In this chapter, recommendations for future studies have to be made and any problem encountered during this study should be highlighted.

It is important that this study highlights the research problem and make recommendations which are realistic for any company to implement. It is important to do this because HIV/AIDS is a very serious and costly disease in the entire world and, especially at the workplace, if not properly managed.

### **6.2 RESEARCH PROBLEM**

The aim of this study is to investigate the effects of HIV/AIDS in private medical practices in Umlazi township. If not properly managed the effects of HIV/AIDS in

business can be catastrophic. HIV/AIDS give rise to stigma and discrimination at the workplace. Amongst the objectives of the study was to investigating the effects of HIV/AIDS on absenteeism; to investigate HIV/AIDS policy implementation and its effectiveness, and lastly to examine the effects of HIV/AIDS on business sustainability. In Chapter 5, it has been reported that the results show that HIV/AIDS induced absenteeism is a challenge at those private medical practices. However, not much evidence was seen or reported about the negative effects of HIV/AIDS induced absenteeism. HIV/AIDS policy is a necessity and very relevant to the medical practices in Umlazi. If implemented, the effects of HIV/AIDS policy can have a spin-off or positive rewards for the medical practice. It has been shown that it is important to manage HIV at workplace because the effects of HIV/AIDS can cause bankruptcy if not properly managed. Looking at the objectives and the outcome of the data collected, it proves that the problem is solved because the effects of HIV/AIDS have been highlighted.

### **6.3 IMPLICATION OF THIS RESEARCH**

This research highlights the problems arising from the impacts of HIV/AIDS in the workplace; and the implication of this study as it provides in-depth information about the effects of the HIV/AIDS at workplace.

This study has contributed another dimension of HIV/AIDS at the workplace. That has happened because the study was conducted in the private medical sector in Umlazi. Some of the results, if not all, have been reported about impact of HIV/AIDS in the other industries. This study will contribute to many other studies that have been done about the effects of HIV/AIDS at workplace. The stakeholders, including medical doctors interviewed and their staff will benefit by having a better understanding of the disease. This study not only highlighted the disease itself, but also unravelled the best methods or tools to use in fighting this disease. In other words it has highlighted the advantages of using HIV intervention programmes. Recommendations will be made in the following section.

#### **6.4 Recommendations to Solve the Research Problem**

According to Taylor *et al* (2004), the majority of business executives interviewed worldwide recognizes the future impact of HIV/AIDS in their business but only 6 percent have implemented an HIV policy. That is worrying because HIV is a devastating disease across the world if not managed properly. An HIV/AIDS policy is a must at the workplace and it should be implemented. It has been established that it is difficult to implement an HIV policy but the companies see it as part of their social responsibility. At the private medical practices the following should be done;

- The doctors need to be trained about HIV intervention programs. They should be made aware of their importance.
- They need to train their staff. They can either do that themselves or hire a professional HIV/AIDS counselor to come to the practice. A counsellor can assist a medical practitioner in formally formulating HIV policy and the same counsellor can train the staff about HIV intervention program. Using a counsellor or outsourcing this function might be expensive for a small business like a medical practice.
- A well formulated HIV/AIDS policy will be needed to implement an HIV intervention program. That program will be a tool for HIV/AIDS education thus alleviating negative outcomes of HIV like stigma and discrimination. The staff will understand the importance of VCT (voluntary counseling and testing). An HIV/AIDS policy will also communicate an element of confidentiality whenever a staff member goes for testing. This will be practical and relevant for the medical practice.

## 6.5 RECOMMENDATIONS FOR FUTURE STUDIES

The study was conducted amongst the medical doctors running medical practices in Umlazi. It is homogenous population because of their similar background, levels of education and income.

There are various areas of improvement which can be undertaken by future studies of similar topics, the better to understand the impact of HIV/AIDS on the workplace. These areas are as follows:

- The study only covered private medical practices in Umlazi township. For a wider understanding of the situation, the study should have included the surrounding areas like Isipingo, Lamontville township, Umbumbulu and Amanzimtoti. In other words more townships in KwaZulu Natal need to be included. That would have been a larger sample and most likely would have been more representative of medical practices. Unfortunately, time constraints prevented this.
- A quantitative research is limiting in that it is a structured interview where a respondent is not free to express him/herself. This can be avoided in future studies by providing a better research design and method which will allow an unstructured interview. For the purpose of this research it is understandable because of time constraints.
- In future studies of this nature and research problem it would be advisable to cover issues of treatment and homecare intervention. This can give some insight into the whole perspective of HIV intervention programs.

The above points need to be dealt with in future studies of a more inclusive nature to widen the understanding of this pandemic, and to provide better insights into methods which can be used to contain the disease.



## **6.6 CONCLUSION**

This study shed light on the problems encountered as a result of the HIV/AIDS pandemic and looks at the effects of HIV/AIDS at the workplace including absenteeism. It also examined other variables by HIV/AIDS reflected in the data collected.

This study is a salient reminder to business of the severe nature of the pandemic, stressing the importance of early and effective intervention if one hopes to contain the problem. Business and industry must ensure that their HIV/AIDS policies form part of their corporate governance initiative, with proper management being imperative. The study discusses how medical practices can become more vigilant about HIV/AIDS; because a business can only have a competitive edge over its rivals if its workforce is healthy. Taking the recommended steps will be found to be a cost-effective measure.

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## APPENDIX 1

<b>INSTRUCTIONS:</b>
----------------------

**For Section A:** Please answer the relative question by placing a tick (✓) in the provided space that is in line with your choice(s).

**For Section B – E:** please place a Cross (X) in the relevant box, 1 representing **Strongly Disagree** and 7 representing **Strongly Agree**.

### SECTION A

1. Are you the only medical doctor in your practice?  Y  N
2. If your answer in (1) above is NO, how many other doctors do you practice with?.....
3. For how many years have you been operating privately?
 

Less than 1 year	0 – 5 years	More than 5 years
------------------	-------------	-------------------
4. Would you categorise your practice as profitable?  Y  N
5. Are you contemplating leaving private practice?  Y  N

6. If your answer in (5) above is YES, please select the reason.

It is not Profitable	
Government Policy	
Family Issues	
Change of Career	
Other (please state.....)	

7. Employees in the medical service industry are equally vulnerable to the effects of HIV/AIDS like anybody else.

Strongly Disagree	
Disagree	
Neutral	
Agree	
Strongly Agree	

	EXTENT OF AGREEMENT
--	---------------------

B. Statements relating to Absenteeism:		STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	NEUTRAL OR NO OPINION	SOMEWHAT AGREE	AGREE	STRONGLY AGREE
1.1	HIV/AIDS related absenteeism is major challenge in my practice.	1	2	3	4	5	6	7
1.2	My practice loses business because of HIV/AIDS related absenteeism of my staff.	1	2	3	4	5	6	7
1.3	The customer service in my practice is negatively affected by HIV/AIDS related absenteeism.	1	2	3	4	5	6	7
1.4	The profitability of my practice suffers because of HIV/AIDS related absenteeism.	1	2	3	4	5	6	7
1.5	Other doctors in the private practice complain about HIV/AIDS related absenteeism in their businesses.	1	2	3	4	5	6	7

C. Statements relating to Current HIV/AIDS Policies:		EXTENT OF AGREEMENT						
		STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	NEUTRAL OR NO OPINION	SOMEWHAT AGREE	AGREE	STRONGLY AGREE
2.1	I am concerned about the negative effects of HIV/AIDS related effects on my business.	1	2	3	4	5	6	7
2.2	There is a formally developed HIV/AIDS policy to deal with its effect in my practice.	1	2	3	4	5	6	7
2.3	I hired a professional consultant to formulate an HIV/AIDS policy in my practice.	1	2	3	4	5	6	7
2.4	An HIV/AIDS policy is difficult to implement.	1	2	3	4	5	6	7
2.5	An HIV/AIDS policy is not relevant in my business.	1	2	3	4	5	6	7

EXTENT OF AGREEMENT	
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D. Statements relating to Effectiveness of HIV/AIDS Policies:		STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	NEUTRAL OR NO OPINION	SOMEWHAT AGREE	AGREE	STRONGLY AGREE
		1	2	3	4	5	6	7
3.1	An HIV/AIDS policy is critical for the sustainability of my practice.	1	2	3	4	5	6	7
3.2	An HIV/AIDS policy without an application is useless.	1	2	3	4	5	6	7
3.3	After I formulated an HIV/AIDS related policy my business had a change for better.	1	2	3	4	5	6	7
3.4	The profitability of my business is positively related to the effectiveness of the HIV/AIDS policy in my practice.	1	2	3	4	5	6	7
3.5	An HIV/AIDS policy is a waste of my practices resources.	1	2	3	4	5	6	7
E. Statements relating to Business Sustainability:		EXTENT OF AGREEMENT						
		STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	NEUTRAL OR NO OPINION	SOMEWHAT AGREE	AGREE	STRONGLY AGREE
4.1	I believe that my practice's sustainability is under a serious threat from the effects of HIV/AIDS.	1	2	3	4	5	6	7
4.2	It is possible to have one's practice going bankrupt because of the negative consequences of HIV/AIDS.	1	2	3	4	5	6	7
4.3	I have lost a very some staff members because of the effects of HIV/AIDS.	1	2	3	4	5	6	7
4.4	My staff members are comfortable discussing their personal HIV/AIDS related issues with me .	1	2	3	4	5	6	7
4.5	My staff members are frightened of contracting HIV.	1	2	3	4	5	6	7

## APPENDIX 2

Informed Consent Letter 3C
----------------------------

UNIVERSITY OF KWAZULU-NATAL  
SCHOOL

Dear Respondent,

**MBA Research Project**

**Researcher:** Name (Telephone number)

**Supervisor:** Name (Office Telephone number)

**Research Office:** Ms P Ximba 031-2603587

I, Roy Thulasizwe Msomi is an MBA student at the Graduate School of Business & Leadership, of the University of Kwazulu Natal. You are invited to participate in a research project entitled *The Effects of HIV/AIDS on Medical Private Practice Businesses in KwaZulu Natal: The Case Study of Umlazi Township*. The aim of this study is to evaluate the effects of HIV/AIDS on the medical private practitioners businesses who are operating within Umlazi Township.

Through your participation I hope to understand what effect does the scourge of HIV/AIDS has in businesses categorized as private practices at Umlazi Township. The results of the focus group are intended to contribute to understanding how much HIV/AIDS affects medical entrepreneurs in the form of doctors that run their private practices.

Your participation in this project is voluntary. You may refuse to participate or withdraw from the project at any time with no negative consequence. There will be no monetary gain from participating in this survey/focus group. Confidentiality and anonymity of records identifying you as a participant will be maintained by the GSB&L, UKZN.

If you have any questions or concerns about completing the questionnaire or about participating in this study, you may contact me or my supervisor at the numbers listed above.

The survey should take you about 15 minutes to complete. I hope you will take the time to complete this survey.

Sincerely

Investigator's signature \_\_\_\_\_ Date \_\_\_\_\_



**UNIVERSITY OF KWAZULU-NATAL  
SCHOOL**

**MBA Research Project**

**Researcher:** Name (Telephone number)  
**Supervisor:** Name (Office Telephone number)  
**Research Office:** Ms P Ximba 031-2603587

**CONSENT**

I.....(full names of participant)  
hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT

DATE

.....

## APPENDIX 3



Research Office, Govan Mbeki Centre  
Westville Campus  
Private Bag x54001  
DURBAN, 4000  
Tel No: +27 31 260 3587  
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[Ximban@ukzn.ac.za](mailto:Ximban@ukzn.ac.za)

3 April 2012

Dr Roy Thulasizwe Msomi (863865586)  
Graduate School of Business and Leadership

Dear Dr Msomi

PROTOCOL REFERENCE NUMBER: HSS/0335/09M  
NEW PROJECT TITLE: The Effects of HIV/AIDS on Medical Practice Business in KwaZulu Natal: The Case study of Umlazi Township

**APPROVAL AND CHANGE OF DISSERTATION TITLE**

I wish to confirm that ethical clearance has been granted full approval for the above mentioned project:

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach/Methods must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Best wishes for the successful completion of your research protocol.

Yours faithfully



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Professor Steven Collings (Chair)  
Humanities & Social Sciences Research Ethics Committee

cc Supervisor Mr S Msomi  
cc Mrs Wendy Clarke