HIV/AIDS

A Risk Management Perspective

By

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CONFIDENTIALITY CLAUSE

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DECLARATION

This research has not been previously accepted for any degree and is not being currently submitted in candidature for any degree.

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ABSTRACT

The emergence of renewed emphasis on risk and risk management has opened a huge portal in attempting to deal with the negative impacts of HIV/AIDS in the workplace. The study recognises the importance of risk management in achieving optimal benefits within any organisation. Furthermore it examines the devastating effect of HIV/AIDS on the social and economic structure of South Africa and provides a benchmark programme in addressing this issue.

A case study is presented (*Care for the Caregivers Programme,* at McCord Hospital), which provides the framework of a programme in operation. The dissertation dissects the programme and evaluates the outcomes against a set of developed criteria. In maximising the benefits of such programmes, emphasis on proper implementation and monitoring is essential. The study proceeds to provide suggestions to harness the full potential of the programme.

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CHAPTER ONE

INTRODUCTION

1.1. INTRODUCTION

The threat posed by HIV/AIDS on the workforce of corporate South Africa, demands effective risk management. The implementation of comprehensive HIV/AIDS programs is presented as a mechanism to limit company exposure to this risk.

The proposal presented attempts to explore the potential pitfalls in implementing a comprehensive in house HIV/AIDS program at a small organization (McCord Hospital). It details the method by which such challenges will be identified. An analysis of the current HIV/AIDS policy will be carried out to determine the success of the policy in comparison to a benchmark. The HIV demographics of the company will be analysed and compared to the national statistics. The costs involved in implementing the program will be obtained from the relevant source. Moreover the programme will be set against a benchmark and evaluated on the proposed criteria of the benchmark. The dissertation then embarks on a chapter involving mechanisms to overcome the identified shortcomings.

1.2. BACKGROUND

The reality of the HIV/AIDS national pandemic is:

- South Africa has more HIV positive people than any other country in the world- about 4,74 million of a population of 44 million.
- By 2005, 15-20% of South Africa's workforce will be infected with HIV.
- Unless intervention occurs, AIDS will account for half the national death rate in South Africa in less than 10 years.
- The cost of re-training the workforce will increase 10 times by 2005 (Internet 18).

Businesses with interests in South Africa are at the centre of the HIV/AIDS epidemic, and cannot ignore the effect this public health crisis is having on the overall economic security and individual commercial performance. The ramifications for corporate South Africa are massive and demand that this threat be addressed from a corporate governance perspective. Good corporate governance is synonymous with good business practice, which demands effective risk management. For companies, the HIV/AIDS environment is one of increasing risk and increasing costs. By understanding and limiting its exposure to this risk, a company is able to meet its obligations to shareholders of maximizing value. Management of the HIV/AIDS risk assists a company to observe its legal, social and environmental responsibilities, thereby enhancing its corporate reputation as a good citizen.

The basic elements of risk management are risk identification, analysis, reduction and monitoring. These elements are implemented by understanding the risk; identifying what can be done; and formulating a response to minimize the exposure.

As explained above HIV/AIDS will have major consequences on profitability and productivity; furthermore, AIDS discourages investment, tourism and consumption in heavily affected countries undermining shareholder and consumer confidence. The long-term consequence will be felt throughout the global economy. The most pressing challenge for corporate South Africa is to protect their own workforce through comprehensive HIV workplace packages that cover both prevention

and care. Implementing such procedures would allow businesses to understand and limit their exposure to the HIV/AIDS risk.

Companies may provide all or some of the elements of a comprehensive program, in house, or contract part of it to an external service provider. Heineken and the mining industry of South Africa are examples of companies that provide medical treatment through the company's own workplace clinics staffed by internal and external medical personnel, with the support of trade unions. Many companies including Standard Chartered Bank, Eskom and Daimler Chrysler have contracted to Medscheme's "Aid for AIDS" programme to finance and administer private health care, with additional financial supplementation to cover partners and dependants of employees. This concept of subsidizing medical insurance for employees is not always the best option. Medical Aids are frequently exclusionary in their approach (either on membership or on claims). Those schemes that do offer annual Aids benefits are expensive and are in reality only available to upper income brackets. This leaves the neediest, lower income brackets uncovered. Furthermore a massive percentage of blue collar workers are not on medical aid (due to cost) and therefore are not able to access HIV benefits that their white collar colleagues can. In addition insurance companies bearing the costs of increasing number of claims will inevitably increase market rates to factor in HIV implications.

Therefore the most feasible option to companies operating in resource poor settings is to provide the necessary health services through in house medical facilities. Formulating a programme that conforms to legal, ethical, business and social requirements is challenging. The study intends to evaluate the current in-house HIV/AIDS programme at McCord Hospital, and intends to identify shortcomings within the programme. Furthermore an attempt is made at rectifying these weaknesses through a recommendations chapter.

1.3. MOTIVATION OF THE STUDY

Recent times have seen the movement of risk management into the spotlight at business arenas. The catastrophic effects of HIV/AIDS on both social and economic aspects of South Africa have also been well documented. A merger of these two concepts has led to an increasing demand for guidance in this area. The aim of the study is to provide a holistic view of the concepts of risk management and present a solution to this identified need.

1. 4. BENEFITS OF THE STUDY

- Provides a comprehensive review of the concepts of risk and risk management.
- Provides a framework for tackling the devastating effects of HIV/AIDS in the workplace.

Evaluates an existing programme in light of the challenges of reality and negative perceptions surrounding the virus and provides a positive way forward. The study presents a value added mechanisms in dealing with this risk and provides a basis for an exceptional risk management process.

1.5. PROBLEM STATEMENT:

How should McCord Hospital, adapt its current HIV/AIDS programme (*Care for the Caregivers Programme*) to ensure maximum success?

1.6. RESEARCH OBJECTIVES:

The objectives of this exercise are to determine the exact economic effects of HIV/AIDS on business in South Africa. Furthermore the establishment of guidelines in addressing this issue, is presented as coping mechanism. Lastly, the dissertation examines the *Care for the Caregivers Programme* at McCord Hospital, and evaluates the success of McCord Hospital in implementing a comprehensive in house HIV/AIDS care and prevention policy.

1.7. LITERATURE REVIEW

The literature review focuses on two subject areas, both of which are equally important in attempting to respond to the problem statement:

- Risk and Risk Management
- Economic effects of HIV/AIDS on business in South Africa.

1.7.1. RISK AND RISK MANAGEMENT

The understanding of risk forms the basis of any risk management process. Risk types involves various categories ranging from business risk through to reputational risk. In monitoring the total performance of a firm, the collective effects of these various risks is important. The definition of risk adopted throughout this dissertation is that risk is the uncertainty of future outcomes. This suggests that risk is something that happens in the future and cannot be predicted exactly today. Corporate activity is saturated with risks (Olsson, 2002).

Risk management involves the process of dealing with these uncertainties. An effective risk management model should facilitate the identification of the major risks that could undermine business objectives (Waite, 2001). Managing risks makes sense because it reduces a firms' chance of experiencing financial distress and shields it against events that might distort its' agenda of activities.

In attempting to deal with risk and unceratinty, the manager might follow an analytical approach for practical problem solving, which typically involves a logical sequence of steps for handling the risks. This sequential process has formed the basis in attempting to resolve the problem statement. The process begins with risk identification, moves over into risk measurement and proceeds to decision making, all of which is set within an appropriate framework that ensures monitoring and feedback (Doherty, 1985).

1.7.2. ECONOMIC IMPACT OF HIV/AIDS ON BUSINESS IN SOUTH AFRICA

An undisputed fact is that HIV/AIDS is a major risk of doing business in South Africa. It is comparative to other major risks such as: personal and asset security, exchange rate volatility and political and infrastructure risks. While it is true that all of these particular risk factors exist across the globe, nowhere else do they seem to combine with such severe implications to deter investment and raise the cost of doing business, as in South Africa (Internet 1).

Statistics compiled by The Bureau for Economic Research, on the economic impact of HIV/AIDS on business in South Africa, in February 2004 prove detrimental. The survey results reveal they many businesses are already facing the consequences of the epidemic. All in all, 9% of the companies

surveyed indicated that HIV/AIDS has already had a significant adverse impact and another 43% envisage a significant negative impact in five years' time.

AIDS related illnesses and death of managers, employees and their family members, will have a significant impact on business. It is expected that companies will need to increase their contribution to pension, life, disability and medical benefits on accounts of the AIDS epidemic. In addition to these direct cost increases, indirect costs to companies may also rise. These costs include: recruitment and traning costs, costs of increased labour turnover, lost skills, worker absenteeism due to illness or compassionate leave to attend funerals and care for sick family members. Further to that is the lower labour productivity due to physical disability, stress and reduced morale caused by the illness or death of friends, fellow employees and relatives. This also includes legal fees and time spent on negotiations between labour and management, and well as costs involved in ensuring occupational health and safety standards (The Economic Impact of HIV/AIDS on Buisiness in South Africa, condcuted by the BER for the SABCOHA, 2004).

The astounding results only fortify the need for appropriate risk management models to combat the risk HIV/AIDS poses on business in South Africa and will be utilised as a valuable tool in dissecting the programme under review.

1.8. RESEARCH METHODOLOGY:

The objectives of this study will be attained by employing a qualitative research design.

Phases of the project

Phase 1 - to gather all relevant secondary data including:

- data involving risk and risk management
- recent studies on the subject of HIV/AIDS as a business risk.
- National HIV demographics in order to extrapolate infection rates at the hospital.
- To gather data relating to the standard assumptions employed by the Actuarial Society in its HIV/AIDS modeling.

- To gather statistics relating to HIV infection rates from the staff doctors and social workers. These results will be compared to the above 2 sources.
- The demographics of the hospital will be elicited from its human resource department.
- The costing data will be gathered through the finance department.

Phase 2 – formulating the case presentation and the evaluation criteria

Phase 3 – evaluating the programme under review based on identified benchmark.

1.9. LIMITATIONS:

- Sensitivity surrounding HIV status of employees. Although the proposal does not demand specifics over the HIV status of patients there may be some reluctance in disclosing HIV statistics at the organization.
- McCord Hospital is not a public organization and therefore disclosure of its financial records is not obligatory. There may be some resistance to utilizing such records as the costing data contain confidential salary details.

1.10. STRUCTURE OF THE DISSERTATION

The dissertation is presented as a series of chapters aimed at addressing the problem statement. The chapters are arranged in a sequential manner and provide a logical step-wise process that aids in the development of the issues that surround this study.

Chapter two provides a theoretical presentation of the concepts surrounding risk and risk management. The development of a risk management process is essential in addressing such a problem. The chapter concludes with a model aimed at addressing the issue of HIV/AIDS as a risk management issue.

Chapter three reviews the devastating economic effects of HIV/AIDS on business in South Africa. With the aid of recent survey results and a recommended solution to tackling HIV/AIDS in the workplace, the chapter serves as a benchmark to this dissertation.

Chapter four brings to the fore a programme in operation. The *Care for the Caregiver Programme,* at McCord Hospital is presented against a backdrop of the company's organisational structure, culture and operations. This case presentation, demonstrates a programme in operation and highlights the motivations as well as the provisions of the programme.

Chapter five assesses the programme under review. The effectiveness of the programme is assessed utilising the concepts offered in chapter three. Th e key concepts and the proposed model are reviewed and compared to the in-house HIV/AIDS programme under review. This qualitative assessment provides a foundation for the development of the *Care for the Caregivers Programme* into a recognised industry standard. The establishment of compliance/non-compliance forms the basis for chapter six.

Chapter six serves as recommendations and conclusion chapter. Herein lies the answer to the identified shortcomings of the programme. The chapter provides recommendations aimed at harnessing the full potential of the *Care for the Caregivers Programme*, and developing it into an industry standard.

1.11. SUMMARY

The emergence of risk management into the spotlight, has highlighted the need for appropriate risk management processes. The high national prevalence rates of HIV/AIDS and an incresingly negative impact on business, has made the development of HIV/AIDS programmes, at work, imperative. The need for business to step-up to this challenge of this epidemic and design appropriate coping mechanisms, cannot be stresses enough. It is to this end that McCord Hospital has developed an in-house HIV/AIDS programme.

The purpose of this study is to evaluate the activities surrounding this programme, and provide solutions to ensure that such efforts are maximally effective and efficient. The relevant theory is employed to facilitate this process.

CHAPTER TWO

RISK MANAGEMENT THEORY

2.1 INTRODUCTION:

Effective risk management is developing into a competitive edge for those companies that adopt a proactive stance in this area.
Through understanding risks and potential costs to their business, organisations can better determine the need to mitigate against particular risks. Risks could well become a key success factor in attracting stakeholders.

Organisations have always assessed and managed risk, but until recently this function has been isolated and little understood. Now risk management is moving into a broader spotlight, taking its rightful place aside strategic and operations management.

This chapter explains the fundamentals and highlights the changing role of risk management in managing financial and technological risks, minimising catastrophic risks, limiting corporate exposure to legal liability, funding disability, retirement and other human resource issues.

2.2 DEFINITION OF RISK AND RISK MANAGEMENT:

Risk refers to a lack of predictability about structure, outcomes or consequences in a decision or planning situation. Risk is therefore related to concepts of chance as the probability of loss or the probability of ruin (Hertz & Thomas, 1983).This perception of risk is quite common, where it is defined from a negative aspect and by reference to adverse consequences only.

Carl Olsson claims that this is too narrow a viewpoint to take because it focuses attention on potential losses and draws it away from the probability that there can be benefits obtained from taking risks. He proposes that businesses are essentially based on the premise that they need to take risks in order to earn a return, it is important to avoid this narrow viewpoint. Therefore, the definition adopted in Olsson's book *Risk management in emerging markets* (2002) is simply:

Risk is the uncertainty of future outcomes.

This is a short and simple statement, which suggest that risk is something that happens in the future but cannot be predicted exactly today because there is uncertainty. Risk and uncertainty do not have to be negative factors (*Olsson, 2002*).

Given this definition, it is obvious that corporate activity is saturated with risk, and the definition of the various risk categories is set out in table 2.1.

Risk type	Description
Business risk	The risk of failing to achieve business targets due to inappropriate strategies, inadequate resources or changes in the economic or competitive environment.
Credit risk	The risk that a counterparty may not pay amounts owed when they fall due.
Sovereign risk	The credit risk associated with lending to the government itself or a party guaranteed by the government (not to be confused with country risk).
Market risk	The risk of loss due to changes in market prices. This includes - interest rate risk - foreign exchange risk - commodity price risk - share price risk (it does not mean risk of falling demand in economic markets which is part of business risk).
Liquidity risk	The risk that amounts due for payment cannot be paid due to lack of available funds.
Operational risk	The risk of loss due to actions on or by people, processes, infrastructure or technology or similar which have an operational impact including fraudulent activity.
Accounting risk	The risk that financial records do not accurately reflect the financial position of an organisation.
Country risk	The risk that a foreign currency will not be available to allow payments due to be paid due to a lack of foreign currency or the government rationing what is available.
Political risk	The risk that there will be a change in the political framework of the country.
Industry risk	The risk associated with operating in a particular industry.

Risk types	Description
Environmental risk	The risk that an organisation may suffer loss as a result of environmental damage caused by themselves or others, which impacts on their business.
Legal/regulatory risk	The risk of non-compliance with legal or regulatory requirements.
Reputational risk	The risk that the reputation of an organisation will be adversely affected.
Systematic risk	The risk that a small event will produce unexpected consequences in local, regional or global systems not obviously connected with the source of the disturbance.

Table 2.1. Risk types *(Carl Ollson, 2002, Risk Management in emerging markets, Pearson Educational Ltd. Great Britain, pg.34)*

In monitoring the total performance of a firm, the collective effects of these various risks is important. Each single risk will usually have an effect on total corporate risk.

Risk can be further divided into two categories of risk ie. 'pure risks' and 'speculative risks'.

Speculative risks involve the possibility of both gain and loss for a business. The rewards for taking such speculative risks are the profits, which eventually accrue. This comprises marketing, production and financial risks faced by firms in the market environment, and consequent potential political and technological risk and changes in the wider economic environment.

Pure risks exists for businesses when the chance of loss or no loss (ie. no potential gain) exists. Examples of such risks include physical damage to assets and losses through fraud or criminal acts.

RISK MANAGEMENT is concerned with the outcomes of future events (whose exact outcome is unknown), and how to deal with these uncertainties (eg. a range of possible outcomes). Generally, outcomes are classified as favourable or unfavourable, and risk management is the art and science of planning, assessing (identifying and analysing), handling and monitoring future events to ensure favourable outcomes. Thus, a good risk management process is proactive in nature, and is fundamentally different than crisis management (or problem solving) which is reactive *(Internet 1)*.

The risk management procedure starts with setting the right strategy and involving risk professionals in the debate. It carries through to the development of a risk framework appropriate to the company's strategy. This framework must be adequately resourced so that it can operate effectively with a degree of flexibility, which will allow it to respond to an ever-changing environment. The entire procedure is set out in the following risk management model (figure 2.1).

2.3 THE RISK MANAGEMENT MODEL

This effort involves the creation of an intergrated and flexible process, which formalises the manner in which key risks affecting an organisation are identified, managed and monitored while at the same time allowing for clarity in accountability and responsibility. The whole process in turn is set within a suitable infrastructure that supports this mechanism

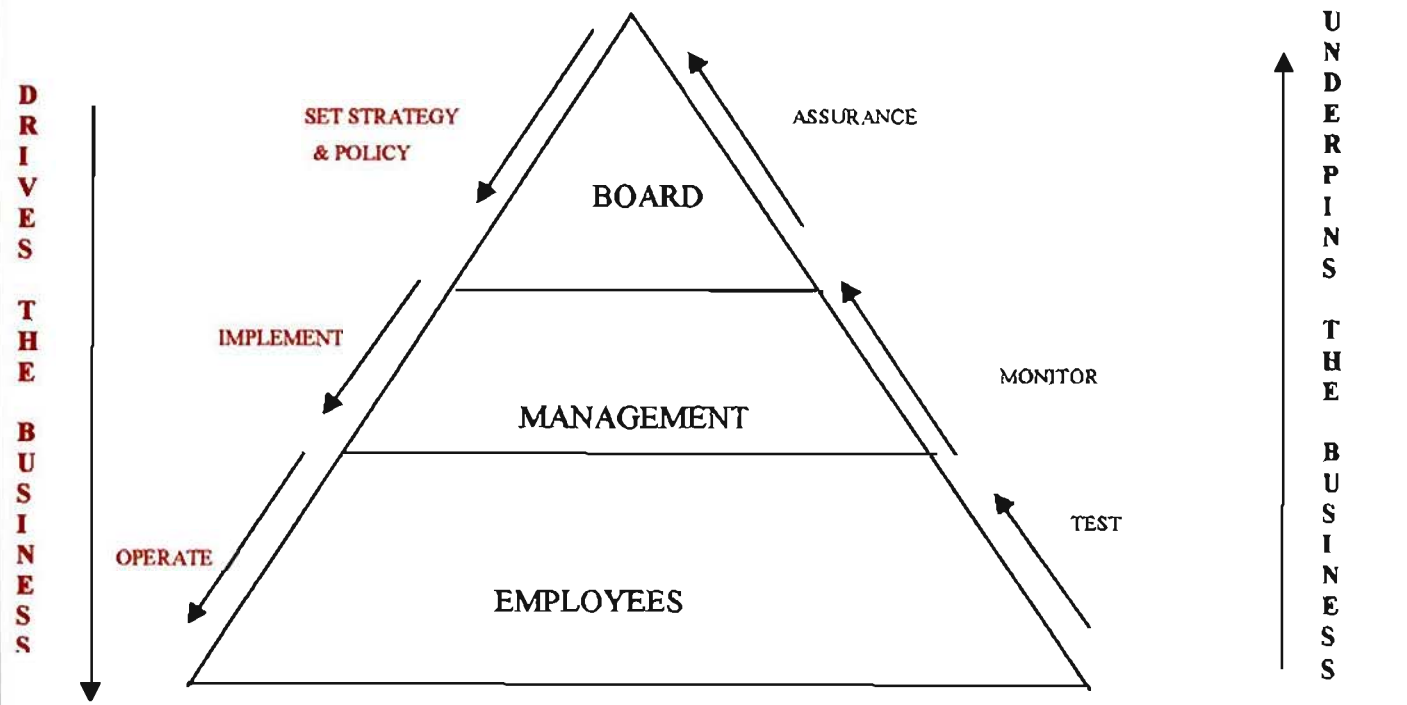

Figure. 2.1 The infrastructure of risk modeling *(Bill Waite, 2001, Managing Risk and Resolving Crisis, Pearson Education Ltd, Great Britain, pg.12).*

An effective risk management model should facilitate the identification of the major risks that could undermine business objectives, as illustrated in Fig. 2.2. The architecture should allocate responsibility for managing those risks, including the board's responsibility to its shareholders.

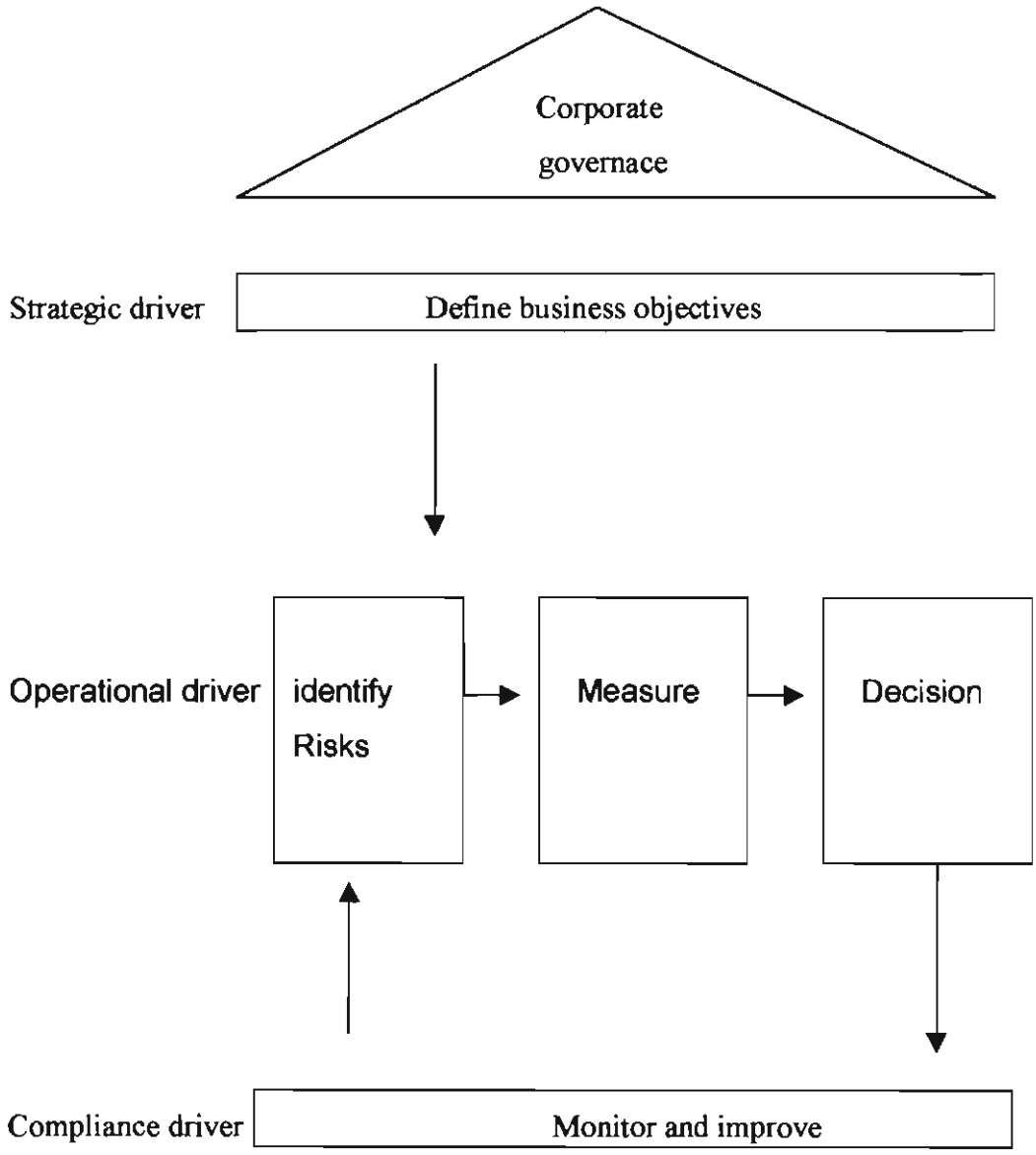

Figure.2.2.The architecture of a risk management model *(Bill Waite, 2001, Managing Risk and Resolving Crisis, Pearson Education Ltd, Great Britain, pg. 13)*

- Corporate Governance

It is vital for the board and executive management to fully support the concept of active risk management. Without commitment at the highest level it will be difficult to convince the rest of the workforce of its importance and ensure they treat it with the requisite enthuasiasm.

- Strategic Driver

Setting strategy is a key element in managing risk because it sets the direction for the business as a whole. A clear strategy, appropriate to current and future competitive position of a business, which is properly executed, should ensure that the risks assumed are manageable.

- Operational Driver

Consists of the risk management process, which involves risk identification, measurement, and decision making, set within a framework than incorporates monitoring and modification.

- Compliance Driver

It is critical that there is an adequate monitoring and reporting system in place. The prime function of this element of the model is to continually assess the effectiveness of the risk management process and to stimulate revision and improvements to take account of key changes in the company.

For an organisation to successfully develop and implement risk management processes it needs to make sure:

- It is driven from the board down.
- It is kept simple.
- It gets everyone involved.
- Everyone is aware of their roles and responsibilities in the process.
- There is accountability.

Managing risk makes sense because it reduces a firm's chance of experiencing financial distress and shields it against events that might distort its agenda of activities. Progressive, well-managed firms exhibit their quality of leadership in the way they handle risk. At most companies, many different employees are responsible for managing risk. Because they generally work in isolation from one another, with distinct priorities, goals, models and techniques, it would be surprising if some of their activities were not at cross-purposes. Therefore the diverse activities of line managers, the treasurer, the risk manager should be co-ordinated so that, through their joint efforts, the company achieves a maximum reduction of risk at a minimum cost (*Waite, 2001).*

2.4 THE PROCESS OF RISK MANAGEMENT:

In attempting to deal with risk and uncertainty the manager might follow an analytical approach for practical problem solving, which would typically involve a logical sequence of steps for handling risk (Figure 2.3).

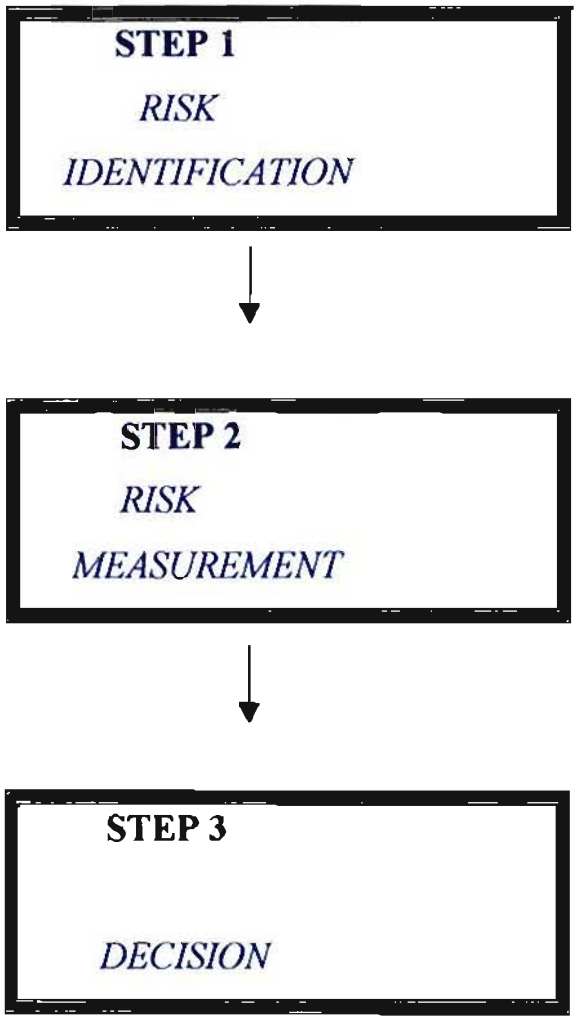

FIGURE 2.3. Flowchart of the Risk Management Process *(Neil A. Doherty, 1985, Corporate Risk Management- a financial exposition, McGraw-Hill Inc, New York, pg.24).*

STEP 1: RISK IDENTIFICATION

Developing an understanding of the nature and impact of risk on the current and potential future activities of the organisation.

STEP 2: RISK MEASUREMENT

This is the assessment and classification of risky situations.

STEP 3: DECISION

This involves the judgement about actions to risk and the possible need to re-evaluate risk options *(Doherty, 1985).*

2.4.1 RISK IDENTIFICATION

The first step calls for the identification of those risky events that impose contingent losses on the firm. As management evaluates each of its operations, it will identify the risk inherent in them. Many of the significant risks facing a company are obvious, and management is likely to have an instinctive feel for the nature of those risks. Others may be less obvious.

Risk identification is equivalent to risk diagnosis. During this stage, we seek to reduce the uncertainty about the identity and potential impact of the key variables that characterise risk in the problem situation under consideration. In essence, we need to diagnose the problem and develop an understanding of its structure, utilising it as a potential aid both in terms of risk reduction and in the sensible solution of the problem (*Doherty, 1985).*

This risk landscape has changed for many companies. The globalisation of many markets, coupled with technological advances, has led to the emergence of new industries and new risks. The biggest risks many companies face at present are not necessarily those that have been covered traditionally

by the insurance or capital markets. Some of the most important risks today are: negative publicity, warranty obligations; cash flow uncertainty; failed product launches and the departure of managers in key positions (*Shimpi, 2001).* The focus of this dissertation is strictly on pure risk. Pure risks may be subdivided into a finer classification entailing:

LOSSES TO PRODUCTIVE ASSETS			*CONTINGENT PECUNIARY CLAIMS*
PHYSICAL ASSETS	Destruction of or damage to productive assets	Denial of access to productive assets	Liabilities for injury to or damage of property of employees, customers, and/or public agents.
	Fire and related damage to assets, loss of human capital	Theft, strikes, disease.	
LIQUID ASSETS	Fire and related damage	Theft ,fraud, strikes	

TABLE 2.2: Finer classification of pure risk Process *(Neil A. Doherty, 1985, Corporate Risk Management- a financial exposition, McGraw-Hill Inc, New York, pg.25).*

- Risks that threaten the productive assets of a firm eg. fire, theft, disease/death of employees. Productive assets include financial assets that result in an investment yield and money that is used as working capital. Liquid assets can therefore be productive assets in the same sense as the physical assets of plant equipment and human capital. The loss of productive assets directly interferes with the business operations of the firm. If the loss is large enough, or if it hurts some strategic process, it will bring the firm to a halt, cutting off its ability to offer income to its stakeholders. Without some corrective action, the firm will fail to survive.

- Risks related to contingent pecuniary claims against the firm in the course of operations, a firm may incur liabilities from those actions of its officers or agents which result in damage or injury to third parties and or property. The third party may be contractually related to the firm, such as injured employees, or they may not, such as motorists involved in a collision with a firm's vehicle. Financial claims are in the form of litigation, or threatened litigation, after the injury or damage or after responsibility for the damage has been established. Contingent pecuniary claims do not directly impede a firms productive operation, but the firm must raise funds to meet the damages. If the firm uses existing assets for this purpose, selling off physical assets or depleting liquid assets, the effect is the same as if these assets were destroyed. However, the firm may seek new funding to pay damages but the burden of new funding may, in severe cases, be so onerous that survival is not feasible or desirable. Thus, ultimately, contingent financial claims have an effect that is similar to that of risks involving the physical destruction of property *(Holliwell, 1998)*.

2.4.2 MEASUREMENT

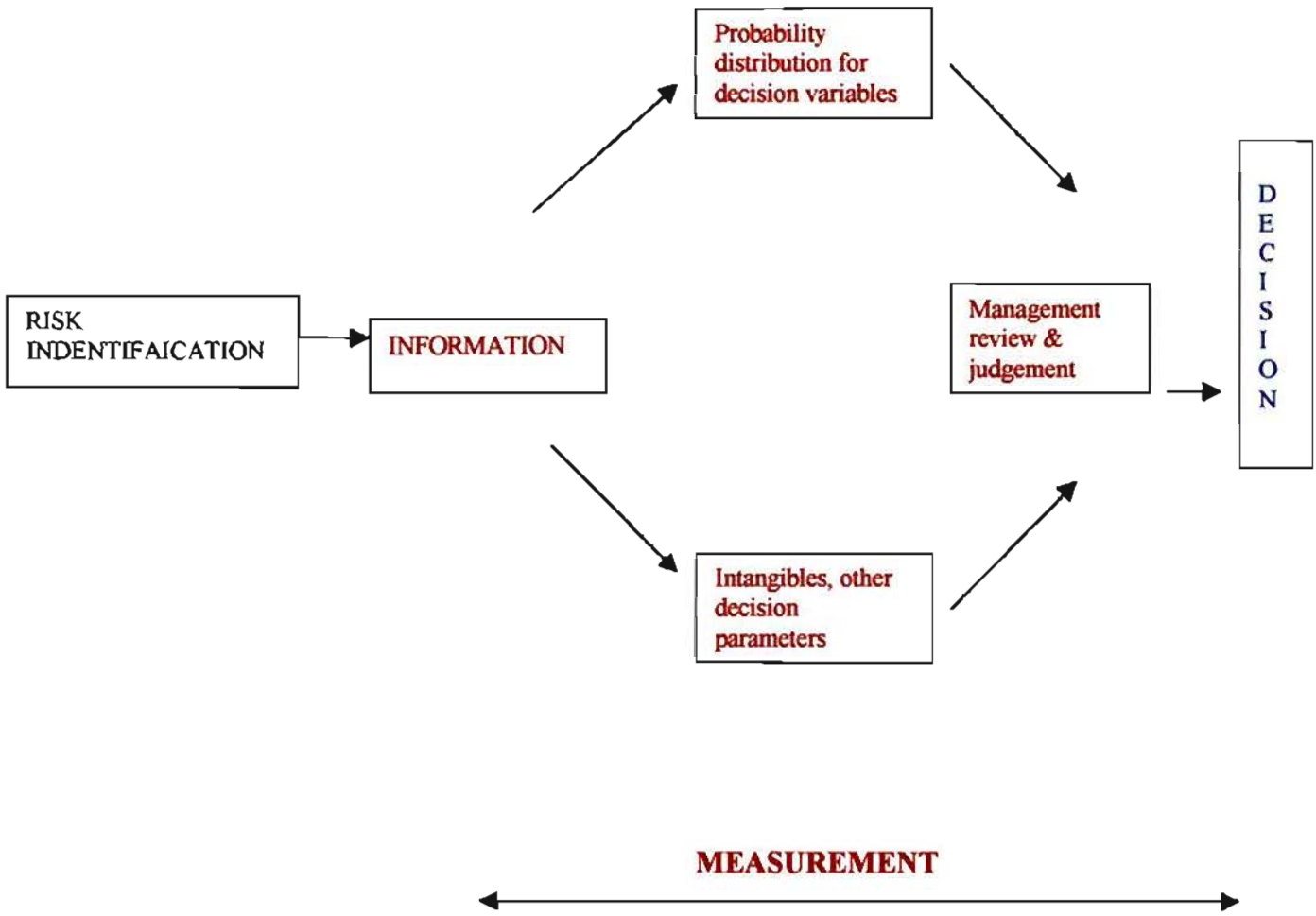

FIGURE 2.4. The risk analysis process(*Adapted from Y. Haimes, 1998, Risk Modeling, Assessment and Management, John Wiley & sons Inc, New York, pg.64)*

Once risk exposures are identified, their potential for destroying share value must be measured. This is a combination of both qualitative and quantitative analysis. A quantitative assessment describes a risk in a way that aids the understanding of how risk presents itself and how it impacts on the firm's operation. For a corporation, it is natural to think about measures of financial impact on the firm. There are a variety of measures that can be used. Some can reflect the impact on financial statements such as earnings or cash flow volatility. Others can focus on the impact on economic value such as value-at-risk or market capitalisation *(Olsson, 2002)*.This calls for measurement of the value of the resources affected and their productivity in generating earnings, together with appropriate loss probabilities. All of which involve intensive analytical calculations.

The ease of measurement is determined by the risk type, as there are some types of risk that are relatively easy to measure, such as credit risk, and others that are much more difficult, such as reputational and systematic risk. Other risk types fall between the two extremes eg. some aspects of operational risk can be measured relatively easily while others cannot. This is shown diagrammatically in Figure 2.6, which shows rough positions only.

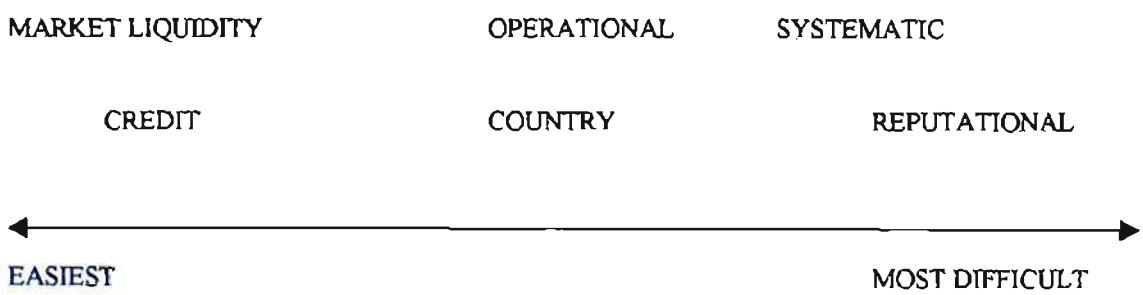

FIGURE 2.5. Ease of measuring risk *(C.Olsson, 2002, Risk Management in Emerging Markets, Pearson Education Ltd, Great Britain, pg.68)*

Table 2.3. covers the risk types and outlines the issues relevant to the measurement of risk for each one. There is a rough ordering, those on top are easier to measure than those at the bottom.

RISK TYPE	DESCRIPTION
Market risk	There are sophisticated models, which measure the extent of market risk but care is needed when dealing with outputs from complex models.
Liquidity risk	Schedules of payments in and out in the immediate future should be available for most businesses together with a list of sources of funds, which could be called upon at short notices. The longer the time period however, the less the reliability of this data.
Credit risk	It is easy to know how much credit you have plus any interest accrued but not paid. What is often not known is any additional cost incurred in recovery. Also rating the risk (probability of default) involves subjective as well as objective elements. Exposures in different currencies add an extra degree of uncertainty.
Sovereign risk	As a subset of credit risk, amounts due from governments will generally be known. However, determining the probability of default is even more fraught for government entities than for other counterparties.
Country risk	Information on exposures to various countries should be available but there are often definitional problems and time lags in data collection.
Industry risk	It is relatively easy to collect information about specific industries – size of market, growth rates, number of companies, etc – but less easy to put a number on potential developments such as innovation, regulatory change, etc which could fundamentally change prospects for the industry. Ranking is easier to do than defining an absolute measure of risk for each industry.
Operational risk	Operational trigger points in manufacturing plants can usually be measured as can several areas

Operational risk contd.	of staff matters - overtime levels, number of vacancies unfilled, etc. Other areas such as vulnerability to fraud are not so easy to measure.
Business risk	It is relatively easy to dissect the main areas of activity of a business's sales and the structure of its costs. This combined with macro economic data can give some idea of the vulnerability of the business to adverse change but there are many aspects to business risk where it is not easy to put a number on.
Accounting risk	Reliance on financial information from external parties can be determined. Dependency on the financial strength of one or a small number of counterparties (customers) will also be known. Quality of the financial information received is not that easy to determine however.
Environmental risk	It is possible to measure the level of certain types of emissions but some areas of environmental risk are problematic, especially where their impact is evident only some time later e.g. asbestos claims or acid rain fall out.
Political risk	It is relatively easy to identify those countries where political risk is higher but not easy to put objective numbers against it. Again, rankings rather than absolute measures are easier to define.
Legal/compliance risk	Impact of non-compliance is often readily evident, fines received for instance, but it is difficult to measure vulnerability to it.
Reputational risk	As with legal and compliance, measurement is difficult until after the event and even then not easy.
Systematic risk	Given its very nature it is more or less impossible to measure systematic risk.

TABLE 2.3 Risk types and the measurement of risk *(C.Olsson, 2002, Risk Management in Emerging Markets, Pearson Education Ltd, Great Britain, pg. 69)*

The need for measurement is that it is easier to talk more objectively about risk when there are numbers attached to it. There is a considerable amount of subjectivity surrounding risk issues, so the more that subjectivity can be removed, the easier it will be to make meaningful decisions about risk issues. Once those decisions are made, the more objective data we have the easier it will be for the impacts of those decisions, good or bad, to be tracked *(Olsson, 2002).*

To achieve this objectivity, we need to collect data, lots of it, but more importantly, we need to convert it into information and then ensure that it is delivered to the right people at the right time in a way that helps them make better decisions. The principal source of this data is likely to be historical observations. However, such data may be implemented by subjective judgement based on a technical and organisational understanding of the firm's operations. Historical data is usually more reliable than subjective data, also because the interpretation of historical data lends itself to analytical techniques. The form in which data is available is important. Data may be available in the form of annual records of the total cost of losses arising within, or paid within, each year. The distribution of such annual values can be used to estimate future loss probability. Availability of separate records for loss frequency and severity would enhance tbe value of the data *(Haimes, 1998).*

Some losses are either so remote or so routinely small that they are of minor concern eg. a hurricane destroying business premises. At the other extreme, we may encounter losses with a very high probability but with insignificant consequences. Between the ends of this spectrum lurk some risks with sufficient probability and severity to impose significant and conspicuous uncertainty. These are the losses that give rise to managerial concern. To set the stage for any decision, the extent of risk requires measurement.

The proper estimation of loss distribution precedes the efficient handling of risk. Each firm faces a set of loss exposure that may be thought of as contingent costs for the firm. Each of these exposures may be represented as a probability distribution; and collectively, these distributions determine the total contingent costs for the firm. This aggregate cost is itself represented as a probability distribution and is labeled the distribution of aggregate loss.

The combined effect of loss values and associated probabilities will determine the degree of riskiness of the risk management exposure. The severity of the exposure would determine the type of risk management decision to be taken *(More, 1983).*

2.4.3 DECISION MAKING

Once the nature of the risk management exposure is identified and its severity and extent are measured, the firm faces a decision. What, if anything, should be done?

Various responses are available. The term "response" is used to signify the firm's approach to managing risk. In considering these responses, there are some important conceptual distinctions to be made. For example, responses may be proactive and planned-deliberate actions taken to minimise the risks of absenteeism. Alternatively, responses may be reactive, essentially coping strategies after the event and in the absence of prior planning. The detail and adequacy of these approaches is an empirical matter. But it will be likely that there will be both mixed responses and less than adequate responses, not least because the distribution of economic resources will preclude some who are proactive from making adequate provision (*Risk, Trust & Welfare, pg. 105).*

The following flowchart is summarised representation of the various choices available:

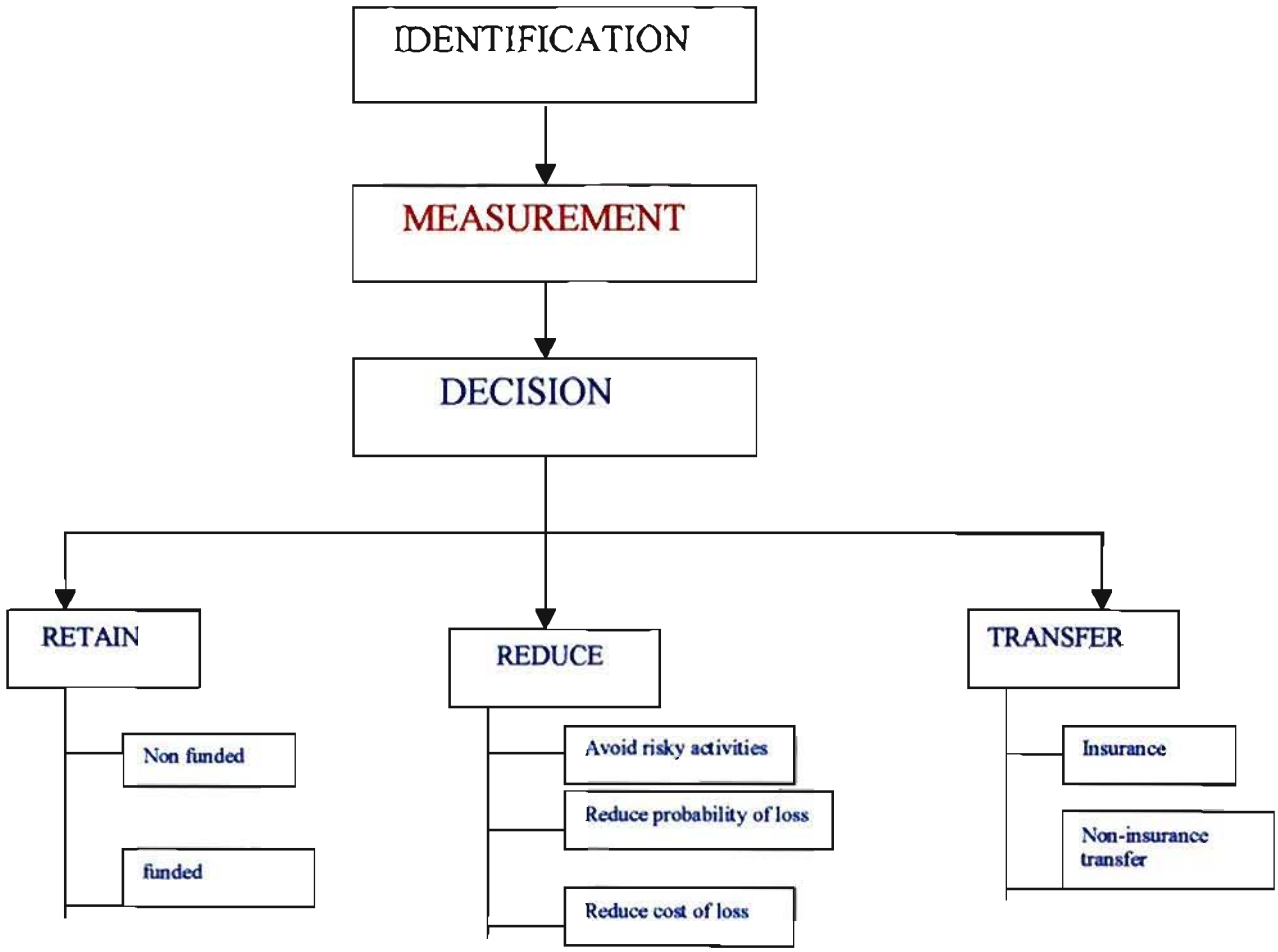

FIGURE 2.6: Available choices in decision making *(Y. Haimes, 1998, Risk Modeling, Assessment and Management, John Wiley & sons Inc, New York, pg. 89).*

The set of decision devises grafted into the original structure, Figure 2.1, comprises of the following:

- RETAIN ie. the retention of risk. The financial burden of loss is left as a deadweight loss to the firm. The firm may or may not choose to manage such retention by establishment of a reserve fund from which future losses are to be paid.
- REDUCE ie. the reduction in the cost of contingent losses. This may be achieved by reducing the size, or probability, of such losses or by avoiding those activities that result in exposure to loss.
- TRANSFER ie. Risk transfer. The costs of contingent losses are transferred to another party. The most conspicuous devise for achieving transfer is insurance, although other possibilities also exist, such as the incorporation of liability clauses into business contracts (*Doherty, 1985).*

Decision analysis is required to enable decision-makers to carry out a thorough and logical evaluation of the alternative strategies open to them, so that the best available strategy is selected from the alternative choices using some stated preference criteria. Once the decision is made, it is essential to continue to monitor and go through the process repeatedly.

2.5 THE SIGNIFICANCE OF RISK MANAGEMENT

The failure to actively and effectively manage risks, could result in *(Waite, 2001)*:

- Reduction in shareholder value;
- Missed opportunities;
- Failure to capture and exploit intellectual capital;
- Lack of innovation for future growth;
- Loss of shareholder confidence and public trust;
- Inability to raise future funding;
- Increase in the cost of capital;
- Collapse of the company.

In publicly traded companies, risk is important to shareholders, not because the risk per se is a problems to the firm's owners, but because risk can have indirect effects that will reduce expected shareholder income. Moreover it is important to understand these disruptive effects of risk because appropriate risk management strategies can be formed effectively only if we understand the precise effects of risk.

Historical evidence shows that unhedged risks can increase expected taxes; cause agency conflicts between various classes of corporate stakeholders that result in dysfunctional investment decisions; deprive the firm of funding of new investments; and interfere with the design of effective compensation plans for managers.

Risk increases transaction costs, and hedging or insurance reduces these costs and adds value to a firm. But hedging is only one of several risk management strategies. For each transaction cost, value can be created either by reducing or by redesign of the firm's financial, organisational, or contract structure, so that it can tolerate the risk without imposing higher costs.

Insurance represents only one of a number of ways of handling pure risk, and the costs of insurance, represents only part of total risk management costs. Adding in the costs of loss reduction, retained loss etc. will no doubt inflate the relative importance of risk management.

The importance of risk management cannot be gleaned solely from an examination of the size of its cash flows. Destruction of corporate assets can impose a serious, if not fatal, financial burden on a firm, even if the assets are insured.

Similarly liability settlements can wipe out a firm's assets. The rapid escalation in awards for injury claims, the spread of class action suits, and legal developments that impose liability for hazardous exposure over long periods of time (eg. Asbestos); have all contributed to the mammoth contingent liabilities for defective products, industrial injuries or disease, that firms typically face today *(Management for the 21st Century, 1982).*

Notwithstanding this, the operation of proper risk management strategies should be considered for the benefits it can deliver rather than just the problems it can avoid, some of the advantages and rewards from creating and implementing suitable risk management models are*(Waite, 2001)*:

- The company's business objectives are accomplished;
- Shareholder value and market confidence are increased;
- It becomes easier and cheaper to secure capital;
- It serves as an early warning indicator of potential problems;
- It can provide a competitive advantage;
- Resources can be used more efficiently;
- It mitigates against corporate crisis.

2.6 HIV/AIDS AND BUSINESS RISK MANAGEMENT

Businesses with interests in South Africa at the center of the HIV/AIDS epidemic, and cannot ignore the effect this public health crisis is having on the overall economic security and individual commercial performance.

Most people infected with HIV/AIDS are between the ages of 20 and 45, and are currently employed. This could mean that someone you know, or employ, or an employee's family member or close friend has HIV/AIDS. As an owner or manager of a business, it is imperative to be alert to conditions that effect the business, the employees and their family, the customers and the community.

As with any catastrophic epidemic, HIV/AIDS can effect business in many crucial ways. Dealing expeditiously with workplace disruptions from co-workers of an HIV-infected person (or an employee perceived as being HIV infected), can help prevent major problems.

It is vital for companies to bear in mind that sick employees cost the employer money and treatment costs less. If an employee carries on working throughout most of the disease cycle and only initiates treatment toward the latter part of the disease, then the company will have carried the cost of the illness (e.g. lower labour productivity and increased absenteeism), as well as the price of treatment. Furthermore, premature death results in group life, pension and medical benefits being paid out much earlier than planned, adding to the costs of the disease. For each new infection a firm's prevention efforts successfully avoid, the company saves the cost of that infection. Studies have shown that the financial benefits of investment in prevention and treatment programmes will almost certainly exceed the costs (Internet 22).

While many businesses seem to have underestimated the future impact of HIV/AIDS on their own organisations, they are becoming increasingly aware of the costs associated with HIV/AIDS in the form of increased absenteeism, staff turnover and recruitment and training costs. Not to mention the direct medical care, insurance, retirement funds and funeral funds.

HIV infection and AIDS affect business in the following ways (*Internet 4*).

- Higher insurance and health care costs
- Loss of productivity
- Customer concerns
- Employee morale
- Confidentiality and privacy
- Potential legal costs from discrimination or privacy suits
- Loss of highly trained, experienced and qualified personnel who represent years of training and institutional memory
- Recruiting, screening, hiring and training costs for new employees
- Disability requirements
- Job accommodation
- Disruption of workplace when co-workers do not know the facts about transmission and prevention.

HOW CAN BUSINESS RESPOND?

When making decisions we must start with a clear view of where we are today. What we need to do is determine, where we want to be, over various time horizons, and then consider the consequences of undertaking the various options open to us (i.e. retain, reduce or transfer the risk).

An ideal tool to illuminate this process is the gap analysis:

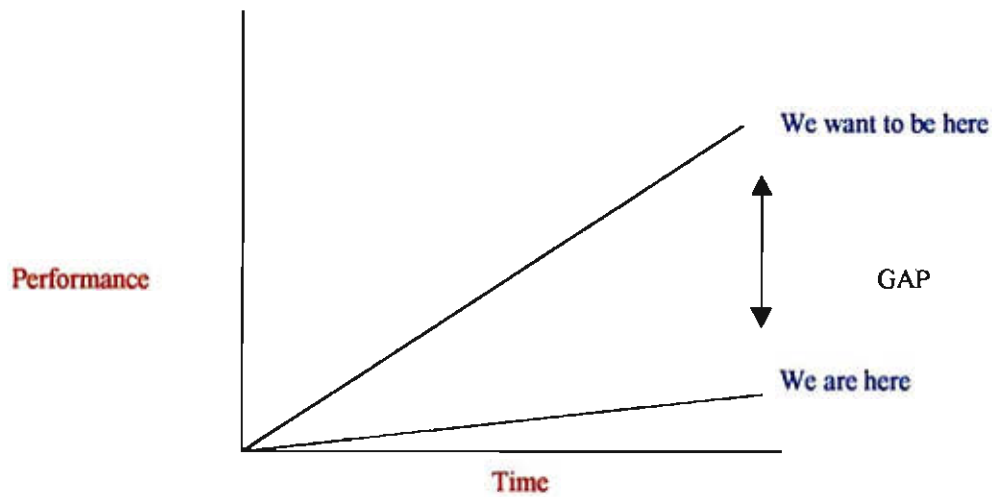

FIGURE 2.7 Gap analysis

We are here- describes the position we are in currently where HIV is having a serious negative impact on productivity, employee morale and recruitment and training costs amongst various others.
We want to be here – describes the position we want to be in where the impact of HIV is contained and limited in terms of operational losses and social implications.

Having recognised that there is a gap the manager needs to develop strategies that will close/ reduce the discrepency of positions.

In order to reduce this gap the organisation may utilise the following approach:

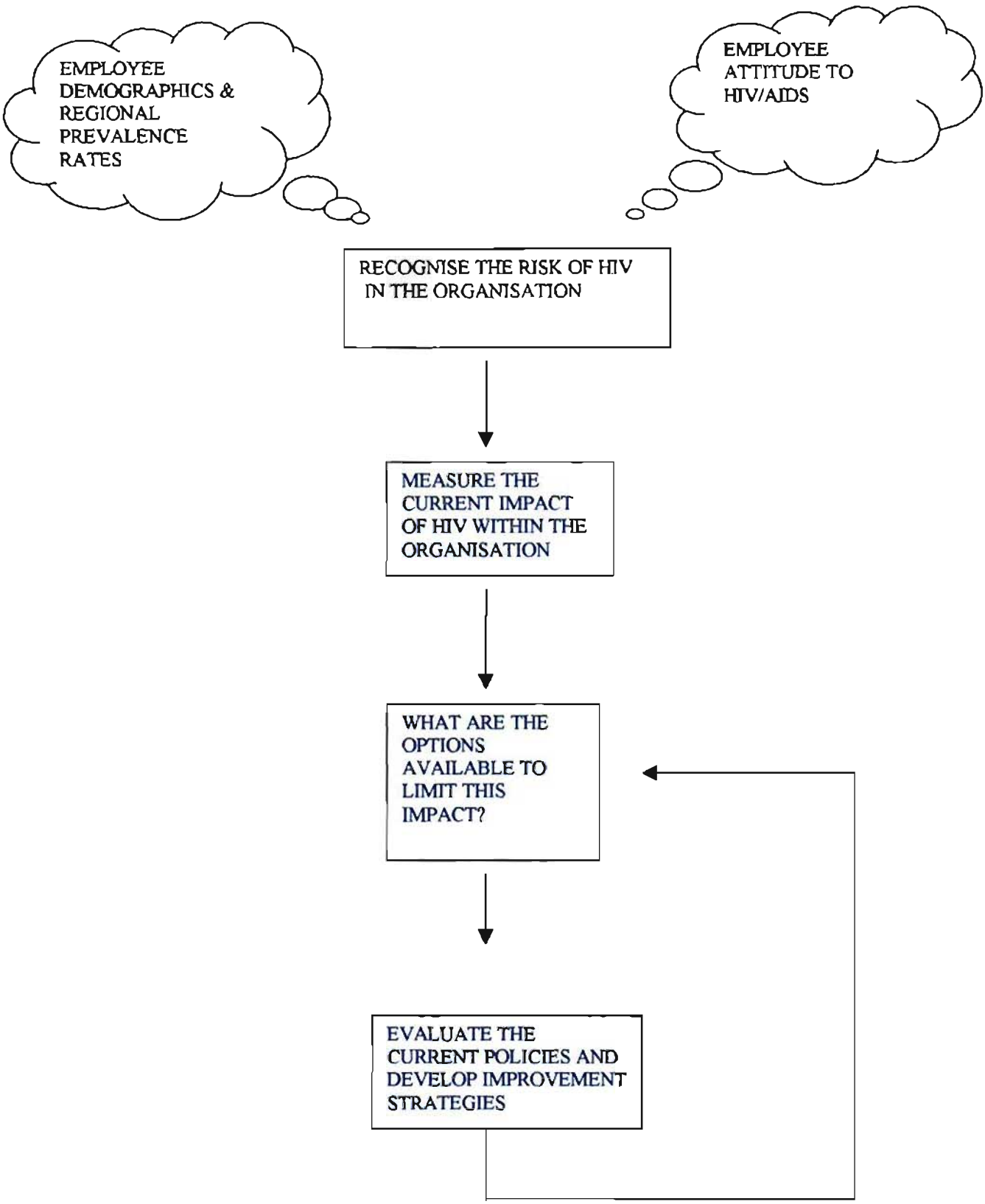

Figure 2.8. Proposed model to combating HIV/AIDS in the workplace

Business can respond in a variety of ways:

- Implementing workplace prevention and care programs and policies. In many countries workplace programs will be the only source of accurate information employees will have about HIV/AIDS
- Bringing business' core strengths of creativity and flexibility to improve reach and effectiveness of AIDS programs. Business can do this faster and more effectively than anyone else.
- Leadership and advocacy by business leaders. Business has an unparalleled opportunity to tackle head on the stigma and discrimination that has enabled this virus to spread.

As our former President, Nelson Mandela stated HIV/AIDS is no longer just a disease, it is a human rights issue. It is only with transparent and comprehensive involvement by all, that this epidemic can be contained so that the repercussions to business and its environment are minimised

2.7 CONCLUSION

It is obvious that it is necessary to manage risk in order to protect ourselves from the adverse consequences of a risk event occurring and ensuring that the benefits from taking risks are achieved. This is true, however, only if the risks are identified and recognised and conscious decisions taken to manage them – even if the decision is to do nothing.

If we fail to manage risk we may suffer a significant impact which might be physical, financial or reputational. Even if there is only minimal impact we are likely to be distracted from our normal activities. The more this happens, the more likely we are to spend time fire-fighting rather than running the business.

To address this in the business world, we need to ensure we have in place a robust risk management framework. This will not only include processes for identifying, measuring and managing risks, but also provide mechanisms to enable feedback on changes in risk and crisis management procedures or contingency plans, for those events which will inevitably occur from time to time, which are not forseen.

CHAPTER THREE

BENCHMARKING

3.1 INTRODUCTION

HIV/AIDS is the risk of doing business in South Africa. The result of more than 120 independent surveys conducted throughout the region show that well over 18% of employees are already living with HIV/AIDS. It is right up there with the other major identified risks in the region: personal and asset security; exchange rate volatility; and political and infrastructural risk.
While it is true that all of these particular risk factors exist across the globe, and some may even be greater in other parts of the world. However, nowhere else do they seem to combine with such severe implications to deter investment and raise the cost of doing business, as in South Africa.

Like all of the risks identified above, HIV/AIDS must be measured and proactively managed. One of the problems, and there are many, with HIV/AIDS as a business risk is that it is perceived by employers to be more a social or community problem than a company-specific risk. Employers, largely through ignorance, tend to shy away from direct risk management- often applying the argument that is the governments' responsibility to provide education and healthcare.

But in the real world, managers are highly proactive in managing their assets and invest billions of rands annually to protect them, regardless of the state infrastructure. So, should be the case with HIV/AIDS. By managers sitting back and abdicating responsibility leads to dire consequences. The results of inaction are detrimental. The good news is that HIV/AIDS is manageable. It requires specialised skills, investment and crucially, management focus. As with other business risk the response must be multi-dimensional.

3.2 THE KEY CHARACTERISTICS OF HIV/AIDS.

Much has been said about the devastating effects of HIV/AIDS on operational parameters including reduced productivity, increased absenteeism, decreased morale etc. all of which negatively affect profitability and success. The mechanism of the disease has been deliberately ignored, simply because it features biological and physiological factors that are not relevant to the organisation, however the understanding of the disease progression is valuable. Therefore this section explaining the key characteristics of HIV/AIDS has been included.

The AIDS (Acquired Immune Deficiency Syndrome) epidemic is a fairly new epidemic, with the first AIDS deaths only registered within the mid-1980s. AIDS is caused by a virus that attacks the human body's CD4 and lymphocytes- a key part of the body's immune system. This virus is commonly known as HIV (Human Immunodeficiency Virus). In order to attack a person's immune system the virus must enter the bloodstream. Transmission can occur through sexual intercourse, from an infected mother to her child (through the placenta, during birth or via breast milk), through the use of contaminated blood or blood products or by sharing intravenous drug-injecting equipment. Given the modes of transmission, it is not surprising that HIV/AIDS is concentrated among infants and adults between the ages of 20 and 40. People with other sexually transmitted diseases are more susceptible to HIV/AIDS infection via sexual intercourse than those without sexually transmitted diseases. Furthermore, females appear to be at higher risk of becoming infected via heterosexual intercourse than males *(BER, 2003)*.

The manner in which the disease progresses and the time frames provide an indication as to why the effects of this epidemic have only become apparent in recent years. The time frame from HIV infection to illness (and ill-health absenteeism) is five to eight years. There is an extended time period during which the infected individual looks and feels healthy (often unaware of the infection) and is able to infect others.

Most HIV tests detect the presence, in the blood, of an antibody to the virus. Since the immune system takes some time to produce the antibody there is a time where the individual has HIV, is

infectious but if tested may return an HIV-negative test. This is termed the *window period*, which lasts about six weeks. Only once antibodies are detected is the individual termed HIV positive.

HIV affects the immune system and, if untreated, causes a gradual deterioration in the body's ability to fight off infections. While this is occurring the individual may not be aware of their HIV status and appears to be healthy. Despite this, there is still an ability to infect others, but only through body fluids. This period last five to eight years.

Once the immune system is significantly weakened the body loses its ability to fight off infection, illness ensues and the patient is termed as having AIDS. Left untreated, the immune system continues to weaken and death occurs after one or two years, usually due to opportunistic infections such as: common pneumonia, meningitis or tuberculosis *(Internet 7)*.

Interestingly, the key to treating HIV lies not so much in the provision of antiretroviral therapy (ART), but in early diagnosis and the provision of proactive medical care to all employees who are HIV-positive. While the use of ART is an essential component in the treatment of patients living with AIDS, for a programme to be both medically and economically successful, the proactive treatment of healthy HIV-positive patients should never be ignored.

The reality is that most HIV positive individuals learn of their status only at or after the onset of the final AIDS stages of the disease (between five and eight years after infection). This fact is probably the greatest hurdle to effective medical management. Currently, educating employees why it is in their best interest to go for confidential individual couselling and testing, is the right place to start. Through early diagnosis, a patient may proactively manage his or her health with the objective of retarding the progression of the disease. Nutrition, lifestyle education and general medical care for unrelated infections (or intercurrent diseases) have all been shown to have major benefits, most often without the use of ART. In fact, leading medical thinking is that doctors delay the use of ART as long as possible, particularly in resource poor settings.

The positive effects of early diagnosis and the provision of proactive medical care both prior to and during AIDS stages of the disease are obvious. As more patients receive early medical care, the economic benefits of HIV/AIDS risk management programmes will surge. Not only are the patients, by definition healthy and productive, but the costs of care are significantly lower than the intensive drug treatment required by patients living with AIDS.

It is estimated that around 90% of all employees with HIV are still healthy in the asymptomatic, pre-AIDS stages. They must not be ignored if we are to effectively manage the risk of HIV/AIDS- both medically and economically. Employers need to recognise this fact now and respond expeditiously *(Internet 6)*.

3.3 STATISTICS ON THE EFFECT OF HIV/AIDS ON BUSINESS IN SOUTH AFRICA.

An in-depth survey on the impact of HIV/AIDS in South Africa, by the South African Business Coalition on HIV/AIDS (SABCOHA), was conducted by the Bureau for Economic Research (BER), during October and November 2003. Respondents were from the manufacturing, retail, wholesale, motor trade and building and construction sectors. With 1006 companies participating in the survey, it is considered the largest survey on the impact of HIV/AIDS on business in South Africa to date. Some of the findings of the report (released on 3 February 2004), were as follows.

Dr Leighton McDonald, spokesperson for SABCOHA said " with 34% of the companies surveyed reporting that HIV/AIDS has already had a negative impact on their profits, the survey shows that HIV/AIDS is undoubtedly a bottom line issue for business".

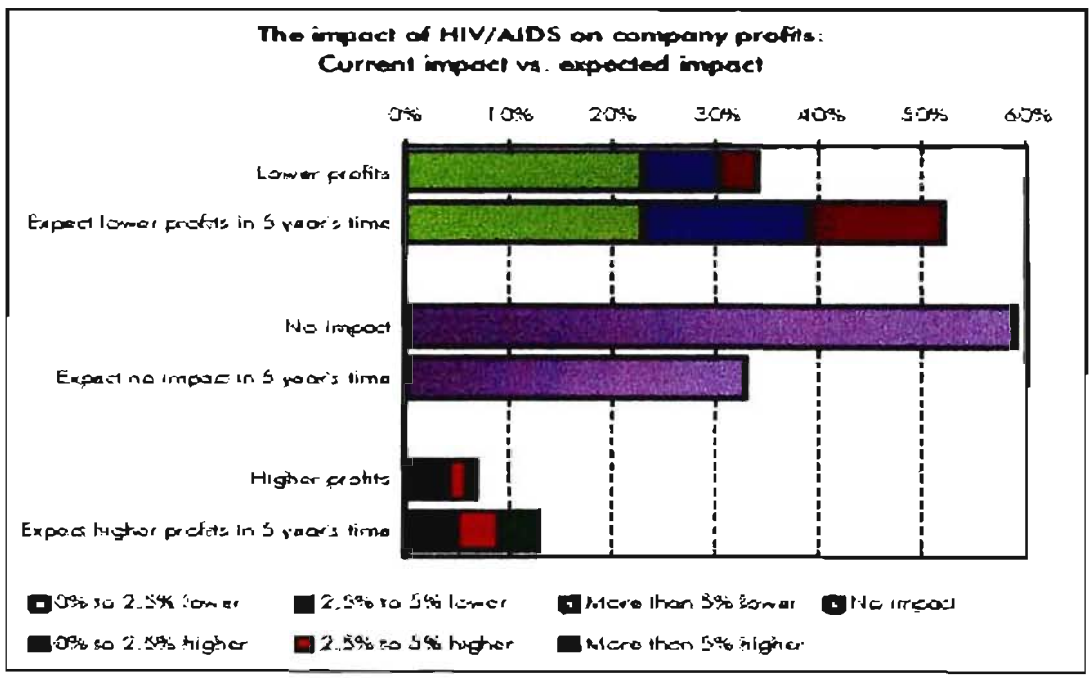

FIGURE 3.1. The impact of HIV/AIDS on company profits *(Survey on: The economic impact of HIV/AIDS on business in South Africa, 2003, conducted by BER for SABCOHA, p.g.50)*

HIV/AIDS will put profitability under pressure, not only due to HIV/AIDS induced cost increases, but also because it will reduce the size of a company's target market and hence shrink sales compared to a no-AIDS scenario. When asked how HIV/AIDS has affected company profits, the majority of respondents indicated that the epidemic has had no impact on profits. Approximately a third of the companies surveyed reported that profitability has been adversely affected by HIV/AIDS, while only 7% indicated that profits were higher (e.g. pharmaceutical companies and funeral parlours). However respondents were a lot more pessimistic when they were asked what they expected the impact on profits to be in five years time. More than half of the companies surveyed expected that HIV/AIDS will adversely affect their profits: 23% expected profits to be down by 0% to 2.5%. 16% expected profits to be between 2.5% and 5.0% lower and 13% foresee that profits will be more than 5% lower than what would have been possible in the absence of HIV/AIDS.

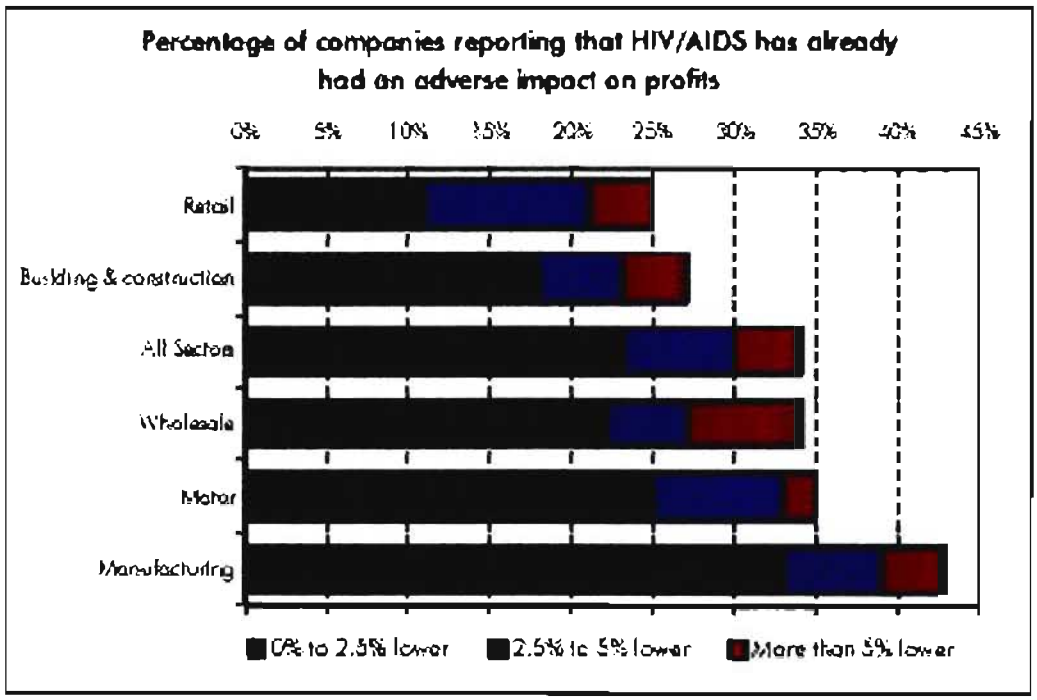

FIGURE 3.2. % of Companies reporting that HIV/AIDS has already had a negative impact on profits *(Manufacturing sector hard hit by HIV/AIDS, 2004 Available at www.redribbon.co.za)*

Companies located in KwaZulu-Natal and Gauteng appear to be worst affected. More than 40 % of companies operating in these two provinces indicated that HIV/AIDS has led to lower labour productivity or increased absenteeism. Companies based in Western Cape have experienced a much smaller impact, with less than 20% of these companies noting an AIDS induced adverse impact on

the production side of their business. These results are consistent with estimates of HIV prevalence among pregnant women visiting antenatal clinics, which suggests that HIV prevalence is highest in KwaZulu-Natal, followed by Gauteng, and lowest in the Western Cape.

When asked if HIV/AIDS affected the production side on their companies, respondents indicated the following:

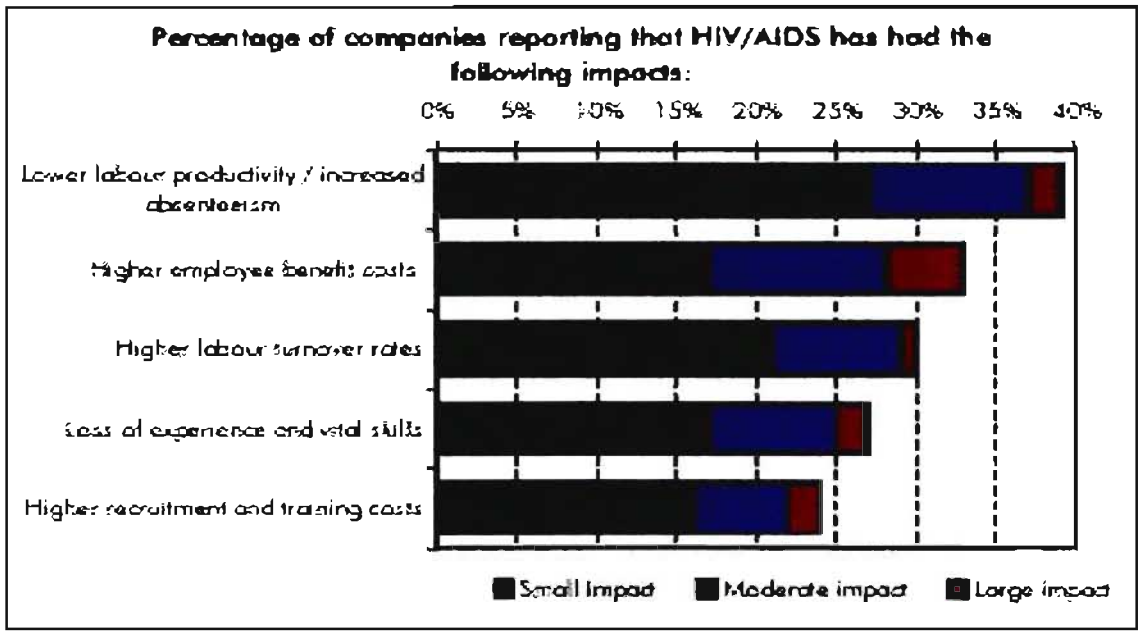

FIGURE 3.3. Companies reporting the impact of HIV/AIDS (Survey on *The Economic impact of HIV/AIDS on business in South Africa, 2003, conducted by BER for SABCOHA, pg. 34)*

Fig 3.3 shows that 39% of respondents indicated that HIV/AIDS has already reduced labour productivity or increased absenteeism among employees. Close to one in three companies surveyed indicated that HIV/AIDS has increased the cost of employee benefits and has led to higher labour turnover rates. Some 27% of respondents reported that they have lost experience and skills due to HIV/AIDS, while 24% feel that they have incurred recruitment and training costs due to the epidemic. Most of the companies that have had to face these cost implications of the epidemic indicated that the impact had been "small". However, a significant percentage of companies are already experiencing moderate or large impacts, especially on employee benefit costs.

In order to achieve significant and sustainable results, business has to put comprehensive programmes in place. The motivation for a business to respond to HIV/AIDS varies and is often

dependent upon factors such as HIV prevalence within the company and the area of operation, the employee benefits available to the workforce, as well as the level of knowledge and awareness of its leadership of the existing and potential impact of the epidemic on the company.

Any workplace HIV/AIDS programme should consist of two basic elements, namely programmes that aim to prevent or reduce new HIV infections (e.g. voluntary counselling and testing and HIV/AIDS awareness programmes) and programmes that provide treatment, care and support to employees and their families who are infected or affected by HIV/AIDS. For any of the above to be successful, there must be a good communication strategy to ensure that all staff is aware of the the policy and the programmes. The objectives of workplace HIV/AIDS programmes should include the prevention of new infection, care and support for infected employees and minimising the impact on the company. Comprehensive workplace programmes can be put into place at a fraction of the amount that would otherwise be incurred due to AIDS-related illness and death. Companies should therefore view money spent on HIV/AIDS as an investment rather than a cost.

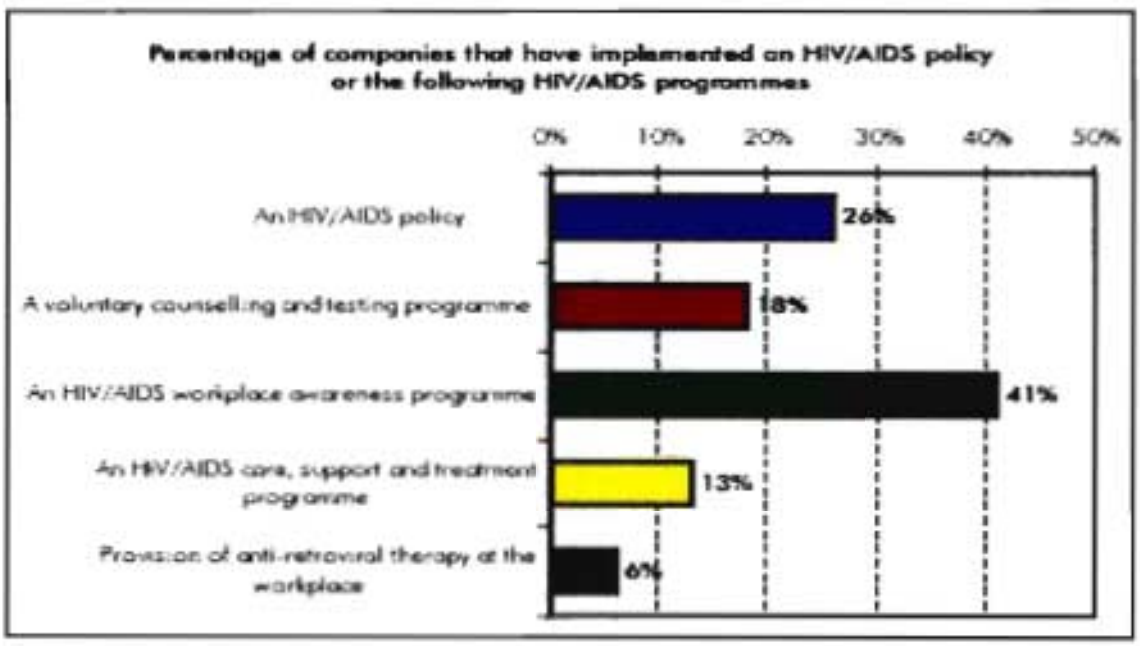

FIGURE 3.4. % of Companies that have implemented and HIV/AIDS programmes (Survey on *The Economic impact of HIV/AIDS on business in South Africa, conducted by BER for SABCOHA 2003, pg. 25).*

The number of companies with workplace programmes in place is somewhat low. Overall, 18% of respondents to the survey indicated that they have implemented a voluntary counselling and testing programme, 41% an HIV/AIDS awareness programme, 13% a care support and treatment programme, while only 6% provided anti-retroviral therapy at the workplace. A breakdown is provided per size, sector and region. It is very clear that smaller companies lack a strategic response to HIV/AIDS and for the most part have a great deal of work to do in rolling out workplace prevention and awareness programmes.

The survey results reveal that many businesses are already facing the consequences of the epidemic. All in all, 9% of the companies surveyed indicated that HIV/AIDS has already had an adverse impact on their business and another 43% envisage a significant negative impact in five years' time. HIV/AIDS is undoubtedly a bottom line issue for business, as it impacts on production costs and consumer markets. Approximately a third of the companies surveyed reported that HIV/AIDS has already had a negative impact on profitability, while more than half expect an adverse impact on profitability in five year's time. The global spread of the epidemic and increasing evidence of the associated impacts on business has highlighted the need for business to step up to the challenge and take action against the epidemic.

3.4 PRIVATE SECTOR INVOLVEMENT

The private sector is in a unique position to respond to the epidemic. Their role is critical if efforts to fight HIV/AIDS are to be effective and sustainable. Businesses have valuable resources that can be easily and cost effectively utilised, including financial resources, management and marketing skills and access to workers, communities and consumers. It provides the ideal forum for the dissemination of information. No business in South Africa is immune to AIDS. Many South African companies have HIV/AIDS policies, but these are often inadequate because business leaders fail to react strategically to the epidemic.

The private sector needs to recognise that the boundaries that they once thought existed as far as where HIV/AIDS ended and began as far as their involvement is concerned, are no longer there. All key stakeholders, NGO's and all vested parties in the fight against HIV need to start giving up their

territory and stop being defensive and hanging on to their own agenda and make sure that we confront this epidemic as true partners.

Some business people have become adept at playing avoidance tactics when it comes to dealing with HIV. There is going to be a reversal of decades of development gain, associated with the increased burden of the disease. The recent World Health Organisation report said that if we don't confront this epidemic at a much higher level than what we have been doing until now, we are likely to face a 50% drop in GDP by 2050.

With regards to solutions, there needs to be a genuine partnership between government, businesses and various sectors aimed at mobilising resources, developing intense campaigns, programmes and policies to fight the scourge. The private sector has either avoided dealing with healthcare within its workplace or simply out-sourced it by engaging the services of medical aids.

An HIV/AIDS programme, and in fact more broadly, a broader health and wellness programme should be a natural inclusion in the strategic management of the organisation, and if you do not have it you are considered not to be managing your company properly (Ref: *Office of the Premier,* March 2004,Brad Mears of the Durban Chamber of Commerce and Industry).

3.5. A SEVEN STEP PRESCRIPTIVE APPROAH IN ADRESSING HIV/AIDS IN THE WORKPLACE

The relentless progression of HIV/AIDS epidemic has made it imperative that measures are put in place at all levels to minimise the impact. A series of articles published by Real Business, describes what steps should be taken in implementing an HIV/AIDS management programme in the workplace. Written by Dr Leighton McDonald, executive manager of health risk management consultancy Qualsa, a division of New Africa Capital. McDonald is on the board of governors of the SABCOHA and on the executive committee of the South African HIV Clinicians Society. These articles will form the bases of the advocated approach of this dissertation.

While much is said about the detrimental effects that HIV/AIDS will have on business, it is heartening to know that much can be done by businesses to address the risks posed by the virus.

There are seven steps to effectively address HIV/AIDS in the workplace:

- Assessment of risk liability;
- Situational analysis;
- Strategic planning;
- Policy and procedures;
- Prevention strategies;
- Care and support;
- And outcomes measurement.

3.5.1. Assessment of risk liability

The variability that exists among businesses (size, industry, markets) means that the HIV profile of these organisations will also vary. In order to plan and budget for and HIV/AIDS programme, organisations need to have at least a rough idea of what their level of exposure is. Every aspect of the business should be examined to assess the likely effect that a maturing HIV epidemic is likely to have. Initial risk assessments to evaluate the scale of the HIV problem in workforces, societies and markets are crucial in helping companies devise target programs.

In particular, risks have been assessed in terms of:

- Existing levels of HIV/AIDS within the workforce and within surrounding communities
- Costs to the company of HIV/AIDS related employee absence and death (absenteeism, recruitment, training, reduced productivity etc.)
- Costs to the company resulting from hospitalisation, home care and any existing prevention activities.

The first step of any impact assessment should be the quantification of the HIV prevalence in the workplace – this is the percentage of the workforce that is HIV infected. HIV prevalence can be quantified in a number of ways.

One way would be application of an actuarial model to the company specific circumstances. This is easily carried out, but results are based on a number of assumptions, making confirmation difficult. If not entirely accurate, an approximate prevalence is given. The only way to get a truly accurate

answer to the number of infected employees would be to test all employees for HIV. This is often not possible, for a number of reasons, including legislation, logistics and labour relations issues.

The most commonly used method is that of 'anonymous, unlinked' seroprevalence testing, where samples of blood or saliva from the workforce are tested for HIV. Only basic demographic details are attached to the sample, not sufficient to identify individuals. Even though this is anonymous the testing has to be thoroughly discussed with the workforce and/or their representatives to get sufficient buy-in for high voluntary participation. The results of the initiative are then used to identify the company's projected prevalence. Mandatory HIV testing is illegal unless the permission of the Labour Court is granted following a substantive motivation.

Irrespective of the method used, it is useful to get an idea of, not only total prevalence, but breakdown into categories specific to the organisation (income levels job grading; geographic areas) as this assists with planning. Once this level of detail is available, it is used to assess the projected impact of absenteeism, disability, deaths, staff turnover, productivity, recruitment costs, training and employee benefits. The information, along with others, is then used in the process of planning a relevant, targeted workplace programme to minimise the identified risks *(Internet 9)*.

3.5.2. Situational Analysis

To maximise the benefits obtained by an HIV/AIDS programme in the workplace it is essential that all interventions are planned based on all available information. Previously the impact analysis was outlined and the level of liability faced by an organisation was assessed. Step two is a situation analysis of all HIV/AIDS-related issues in the company. The results not only provide the information to enable targeted intervention, but also provide the basis for measurement of the results of the interventions. The situation analysis assesses the level of 'AIDS competence' within the organisation and comprises three main aspects: a workplace overview; an HIV/AIDS initiative audit; and a survey of knowledge, attitudes and practices (KAP).

The workplace overview involves the study of the nature, structure and processes of the workplace environment. In order to plan an HIV/AIDS programme than can be integrated seamlessly rather the 'added to', it is useful to have details on all aspects of the organisation including:

- Workplace structure (physical as well as hierarchical);
- Who and where the people are;
- Operational processes and requirements; and
- Communication forums (meeting/newsletters).

The initiative audit is comprehensive and structured, carried out on all HIV/AIDS initiatives. The aim is to provide a holistic view of the programme status. This involves interviews with key role players, a review of all available documentation and an analysis of statistics and key indicators. Information gleaned in this process should include:

- The nature of past and present interventions as well as their levels of success or failure;
- The level of management awareness and extent of the commitment and budget; and
- The availability and content of organisational HIV/AIDS policy and procedures.

This audit is especially relevant in those organisations where a number of fragmented HIV/AIDS initiatives have taken place over a period of time.

The KAP survey assesses levels of awareness of HIV/AIDS and personal responses to the epidemic, both of which vary greatly between individuals or groups. If such education programmes are to be effective they need to be relevant to the specific circumstances of the organisation. A KAP survey is a structured survey conducted among all levels of employees to provide an indication of:

- Knowledge: The level of knowledge about HIV/AIDS including the condition, methods of transmission, treatment and prevention;
- Attitudes : Individual attitudes about the disease, level of personal risk, infected colleagues, family and friends; and
- Practices: The assessment of risk-taking behaviour with regard to HIV transmission.

To ensure maximum employee participation, the process should be carried out only after thorough consultation with employees and should be conducted on an anonymous basis to encourage honest feedback. The results of this exercise assist in the planning of a targeted education programme. For example, if the level of knowledge about all aspects of HIV/AIDS is found to be very high among

employees but they appear to be embarking on risky behaviour, it would be appropriate to focus on education that fosters an awareness of personal risk and provides skills for risk prevention. Starting off without the provision of basic information on the condition would be inappropriate and likely to reduce the effectiveness of the programme.

Once the above mentioned processes have been carried out and there is a clear view of the status of all HIV/AIDS-related issues within the organisation it is time to move on to the next step, which is the planning of the HIV/AIDS programme *(Internet 10)*.

3.5.3. Strategic Planning

The successful implementation of any intervention in the workplace is based on an extensive planning process- this is especially relevant in the case of HIV/AIDS programmes where there is little room for error. Given the scale of the epidemic along with issues of social, psychological, emotional and legal sensitivities associated with the virus, any mistakes could not only be costly but could jeopardise future interventions.

The objectives of a workplace HIV/AIDS programme include:

- Prvention of new infections;
- Care and support of infected employees; and
- Minimising the impact on the organisation.

To get buy-in from all stakeholders, it is essential that the planning process, where applicable, involves management, human resources and employee representatives. Information available from the liability assessment (step one) as well as situational analysis should be used to guide the process - this will have indicated the size and nature of the problem within the organisation as well as its specific requirements.

Sufficient time should be set aside for programme planning – this usually requires a one or two-day workshop depending on the complexity of the organisation. All documentation should be distributed to the participants along with the expected outcome of the workshop well in advance to allow the participants to formulate ideas.

The following are guidelines that may be used to structure the process:

The workshop should begin with a description of the key objectives and deliverables of the project, thereby ensuring that all participants have a clear understanding of the expectations. Thereafter, the key findings of the liability assessment and the situation analysis could be presented to the group. Participants could then be asked to identify three to five key focus areas that may include items such as policy and procedures; education and awareness; communication; care and support; and employee benefits. Key actions within each focus area then need to be identified to ensure focused and meaningful activity aimed towards the achievement of the pre-determined goals. Key actions may include activities such as setting up an HIV committee or reviewing the organisation's HIV/AIDS policy. Once the participants are clear on the strategy and activities, a clear action plan can be developed for the roll out. They action plan will assign resources to each task with agreed deadlines and milestones, and will outline a budget for the project.

The success of any project needs to be measured, and the best method of doing this is to appoint a champion to review the project in its entirety for the purposes of measuring its effectiveness and achievement of goals. Since the issues are likely to be complex, small task teams may be required to plan specific focus areas. This needs to be co-ordinated by one person who has the capacity and authority, as all elements of the programme are linked and the outcome depends on a seamless implementation. The final result of the planning process is a document that gives detail on what needs to be carried out and by when, as well as who is responsible for each action. A monitoring process is an integral part of the plan.

For each of the interventions, a measurable outcome must be identified and quantified on a regular basis to allow for ongoing planning by identifying successes and failures. The rapidly changing nature of the epidemic make it likely that some objectives may not be met – it is critical for this to be identified early and corrective action taken.

Common pitfalls include:

- Not including all stakeholders in the planning process – this makes getting their subsequent buy-in difficult;
- Trying to finalise all the elements of the plan in one session. Some areas maybe best tackled by smaller groups.
- Compiling a plan that cannot be supported by the available budget. Partial implementation can sometimes be worse than no implementation as it discredits the process and those involved, and jeopardises future interventions. Rather structure the plan for a realistic phased implementation with structured outcomes measurement and give feedback on successes achieved; and
- Not including a monitoring and replanning process in the programme to ensure that the stated objectives are achieved.

The planning and implementation of HIV/AIDS workplace programmes can be successfully carried out by all organisations, including small businesses, by following a structured approach and ensuring the plan fits in with the organisation rather than having to change the organisation to suit the programme. Make use of existing structures, forums and meetings for education wherever possible rather than creating additional infrastructures. Where there are a number of small businesses in the area, it may be wise to get together and pool resources and purchase services together. Implementing a comprehensive HIV/AIDS programme can be a rewarding process for all stakeholders – ensure this by planning properly *(Internet 11)*.

3.5.4. Policies and Procedures

An organisational policy on HIV/AIDS in the workplace is an essential component of any employer-based response to the epidemic and should be viewed as a crucial requirement for good corporate governance.

The policy is necessary as it *(BER, Feb 2004):*

- Provides a structured framework for all stakeholders to base decisions on matters relating to HIV/AIDS in the workplace;
- Protects both employer and employees with regard to the employment issues; and
- Facilitates the necessary scrutiny of all relevant aspects of the workplace where there is a potential HIV/AIDS impact.

The function of an HIV/AIDS policy is to:

- Define an organisation's position on HIV/AIDS and to set out clear guidelines on how HIV/AIDS will be managed within the workplace;
- Align the workplace response to the legal framework;
- Ensure fairness;
- Identify and protect the rights and responsibilities of employers and employees in the context of HIV/AIDS;
- Set standards of behaviour expected of all employers and employees;
- Establish consistency within the company;
- Set the standard for communication about HIV/AIDS;
- Provide a good foundation upon which to build an HIV/AAIDS workplace programme;
- Inform employees what assistance is available for HIV and AIDS;
- Send a strong message that HIV/AIDS is a serious issue in the workplacce;
- Indicate commitment to dealing with HIV and AIDS; and
- Ensure consistency with national and international practices.

While policy provides a framework, it should be emphasised that it should always be accompanied by a set of procedures that support policy principles. For example, if the policy indicates that the employer will arrange and fund post-exposure prophylaxis (after an employee has been exposed to potentially HIV-infected body fluids), the procedure should state clearly how this will be done and who is responsible for each step.

Some argue that HIV/AIDS does not need a specific policy as it should be viewed in the same way as any other chronic illness and fall in line with policies on these. While this argument is partially valid, the gravity of the impact as well as the potential for discrimination warrants a dedicated policy.

The policy and procedures should always be specific to the circumstances of the organisation. There are, however standard principles on which the policy should be based: scope and legislative compliance. The policy should cover all employees (and prospective employees) and should be applicable to all workplaces. All aspects of employment relationships should be included (from pre-employment through to finalisation of the employment exit).

Legislative compliance is non-negotiable. In SA the following labour legislation is applicable: the constitution; Labour Relations Act; Basic Conditions of Employment Act; Compensation of Occupational Injuries and Disease Act; Employment Equity Act; Occupational Health and Safety Act; National Policy on Testing; and the Code of Good Practice. Compliance with legislation informs the content of the policy and ensures an environment of fairness and non-discrimination.

The HIV/AIDS policy should be compiled by all relevant role players (employer and employee representatives) and should include the following facets:

- Prevention of new infections. Detail on the nature as well as the scope (to include families, surrounding communities) should be documented. This will include issues such as information, education, skills building, and condom distribution;
- Pre-employment process. Direct or indirect HIV testing of prospective employees is forbidden – exceptions can be granted only upon successful application to the Labour Court with substantive motivation;
- HIV testing – compulsory testing for HIV is not permissible (unless with permission from the Labour Court). Voluntary testing is permissible subject to a range of conditions including access to counselling, informed consent and guaranteed confidentiality;
- Confidentiality – the stigma that is still associated with this condition makes the issue of protection of confidentiality an important element of the policy;
- Employment status and benefits. HIV infection alone should not affect the employment status of the employee or any of the benefits available;

- Disability management. HIV-infected employees who are no longer able to work are to be handled in accordance with standard disability procedures – as for any employee with ill health;
- Risk management. Should there be a risk of occupational HIV exposure, infection prevention should be covered in the policy. This should include access to compensation if necessary; and
- Human resource procedure. Infected employees should be subject to standard HR disciplinary and grievance policies.

Once the HIV/AIDS policy and procedures have been signed off, these should be communicated to all employees in an understandable manner and should be readily available to all employees. Labour relations as well as HIV/AIDS are dynamic fields where frequent changes are commonplace, necessitating at least annual review of policy and procedures by all stakeholders *(Internet 12)*.

3.5.5. Prevention Strategies

Considerable emphasis is placed on the levels of HIV infection in SA and in organisations and much is said about management of infected employees – but it must always be remembered that the majority of the workforce is not infected and every attempt must be made to maintain this situation.

The advent of widespread antiretroviral therapy has often resulted in a reduction on the prevention focus. Studies carried out in these circumstances have shown rising HIV infection rates as a consequence of 'treatment optimism'. The message is clear – prevention of new infections is an essential component of any workplace HIV/AIDS programme. The nature of the epidemic and the necessity to change human behaviour effectively makes HIV-prevention a complex field, with intervention strategies needed to be tailor-made for each target population.

To design optimal prevention programmes for an organisation the following is necessary:

- Analysis of target population: This is done by examination of the structure of the workplace and the demographics of employees. A knowledge, attitudes and practices survey is an essential part of this process as it provides information on the level of 'HIV competence' of the workforce;
- Integration into HIV/AIDS programme and company operational structure: Prevention programmes have been shown to achieve best results when they are easily accessible to

employees and are relevant to their specific circumstances. Information provided should address the specific gaps identified.

- Skills building is essential: While provision of information is non-negotiable, employees can use this information only if they are able to personalise their own risk of infection and take effective steps to protect themselves. This will vary, depending on the target population – for example negotiation skills for safe sexual practices would be more relevant to female workforce than male-dominated workforces where there may be more focus on the benefits of the condom use;
- A non-discriminatory environment: All aspects of the HIV/AIDS programme will function effectively only within an environment of non-discrimination and where the stigma often associated with this condition is minimised. No further interventions of initiatives should take place unless this issue has been comprehensively addressed. This is best done by frequent mention of HIV in workplace forums, a non-discriminatory policy as well as by showing visible support for the process at all levels; and
- Ongoing intervention: Prevention programmes should be seen as an ongoing process rather than one-off projects. The nature of these interventions should be informed by monitoring the effectiveness of interventions. The needs of the workforce will change as they move up the 'HIV competence ladder'.

Methods for changing behaviour will vary depending on the target population and may include:

- Peer group education: Training of selected employees within the workforce to provide information to their collegues;
- Individual theatre: Relevant information portrayed by means of well designed (and entertaining) plays;
- Literature: Ongoing provision of HIV-related information by means of newsletters, meetings, bulletin boards, e-mails and workshops; and
- Provision of protective devices: This includes the seamless availability of male and female condoms as well as access to post-exposure prophylaxis in the event of exposure to potentially infected bodily fluids.

Interventions should be based on requirements of the workforce and their effectiveness monitored on an ongoing basis to ensure appropriateness. Finally, it should be emphasised that prevention programmes are best positioned for success when integrated into a total risk management

programme. Ideally this should be integrated with voluntary counselling and testing and treatment programmes *(Internet 13)*.

3.5.6. Care, support and treatment

Businesses can help their employees living with HIV/AIDS continue to contribute to the business for as long as possible, by providing a range of care and support services through company clinics or in partnership with other healthcare providers. For some this is an extension or an expansion of existing provision, whether in-house or through health insurance, to employees and their immediate families.

Some of the most common and fatal opportunistic infections like Pneumocystis carinii pneumonia (PCP) and TB can be treated and prevented by inexpensive drugs. By providing basic treatment like these, companies can improve the health of their HIV employees and immediate families for significant periods. Many companies collaborate with local AIDS service organisations to provide home based care, to help alleviate the onset of serious illness and to provide palliative care, medical advice, and support to families and caregivers.

More companies are now offering antiretroviral therapy for infected employees and families. The companies are providing the classic 'cocktail' of triple therapy, which has been so successful in improving the lives of people with HIV/AIDS in the industrialised world *(Internet 14)*.

3.5.7 Outcomes measurement

Implementing an HIV/AIDS risk management programme is a complex exercise, influenced by a number of financial, social, political and emotional factors. Best-practice strategies have evolved over time as a result of increasing access to better information and there is no doubt that this evolution will continue as the epidemic matures. In order to focus the evolution it is essential that the results of these programmes be closely monitored so that, should changes be necessary, they are timeously made.

There is an argument to suggest that outcomes measurement may be an unnecessary expense for companies if they have implemented tried-and-tested HIV/AIDS risk management interventions. There are, however good reasons why companies should track the results of their initiatives. These include:

- Ensuring objectives are achieved. The complexity of the epidemic as well as an infinite variety of company-specific circumstances make it essential that companies measure the results in their own organisations is order to identify success and failures. Successes need to be built on and failures need to be addressed.
- Circumstances change.
- The epidemic is dynamic, changing its nature as it matures. For this reason interventions that were appropriate yesterday are not necessarily appropriate today. Regular monitoring should pick up these changing needs to allow for strategy revision.
- Resources are scarce. While that can be done, fairly inexpensively to mitigate the risks posed to companies, all interventions have a financial and human resource requirement. With so many competing priorities in the workplace, it is useful to prove the value of the HIV/AIDS programme to secure ongoing support and funding. This will become increasingly important as smaller companies start to get access to donor funding, for which proof of sustainability will be a prerequisite.
- Maintain programme impetus. The HIV/AIDS programmes often make use of volunteers and people with a special interest in the epidemic. Due to the sometimes difficult nature of this involvement (resistance from others, dealing with emotional issues, making do with minimal support) it is essential that all role players receive regular feedback on the outcomes of their efforts. Successes will provide positive reinforcement, early detection of problems prevents failures.
- Sharing information. There is still not enough reporting of outcomes and sharing of this information. Immense value can be gained by publishing success stories but in order for these to be credible, tangible programme outcomes need to be demonstrated. This can act as a catalyst for the implementation of programmes and provide a benchmark for the business.

The first step is to decide what outcomes should be measured. The principle to be followed is that no initiative should be started unless tangible outcomes (and the means to measure them) have been identified. The actual nature of these parameters depends on the specific circumstances of the company and the programme implemented.

Despite this there are a number of ways that programme results can be monitored. These can be looked at on three levels: operational, HIV/AIDS competence and programme outcomes.

The operational level would focus on monitoring programme implementation, making sure that timelines are met and awareness campaigns carried out, and that patients are enrolled on treatment programmes. For each intervention, timelines and responsibilities should be identified and progress measured against these.

For level two, since the majority of programmes are focused on empowering individuals and companies with information to minimise the effects of HIV/AIDS, it is important to measure (proxy) outcomes for this objective. One example is to measure employee knowledge and behaviour changes to assess the impact of awareness campaigns. Condom distribution statistics assist with this, as do knowledge, attitudes, perceptions and behaviour surveys. Enrolment rates on treatment programmes can also be measured to assess the accessibility of the programme.

On level three, the programme outcomes focus on overall objectives of the programme and are an indicator of its success (or otherwise). These outcomes are measured in the longer term and include: HIV infection incidence (new infections over a specified period), HIV seroprevalence rates (total number of employees infected with HIV) , and HIV/AIDS absenteeism, disability and mortality.

These examples do not represent an exhaustive list of outcomes measures these should be identified at the time of programme planning. HIV/AIDS costs should also be closely tracked, including costs of absenteeism, costs of employee benefits increases and costs of intervention programmes.

To structure an 'outcomes measurement timetable' one needs to consider the comprehensive programme and all its elements. Each separate element should be analysed to identify the type of outcome required and what the minimum monitoring interval is. This information can then be collated to structure a practical measurement and reporting system. This will include weekly, monthly, quaterly and annual measurements.

As a rule of thumb, operational parameters need to be measured more frequently; behaviour changes should show meaningful results if they are measured annually; and feedback from the target population can be carried out every six months to assess the appropriateness of the interventions.

Once the measurement system has been structured it needs to be fed into a formal review and planning cycle so that information gained can be acted upon. In conclusion, all robust HIV/AIDS

risk management programmes have comprehensive outcomes measurement components that allow for assessment of success and informs future direction. No intervention should take place unless an outcomes measure has been predetermined and the mechanism for quantifying the outcome is in place *(Internet 15)*.

3.6. CONCLUSION

The global spread of the epidemic and the evidence of the associated impacts on business has highlighted the need for business to step up to the challenge and take action against the epidemic. Management of the disease requires specialised skills, investment and critically, management focus.

The 7 step prescriptive approach is recommended as a crucial tool in the successfully managing this business risk. It should be a natural inclusion in the strategic management of an organisation. The implementation, constant monitoring and modification of such programmes are critical if efforts to fight HIV/AIDS are to be effective, and sustainable. To ensure success the response must be immediate and multi-dimensional.

CHAPTER FOUR

CASE STUDY: McCord Hospital

4.1 INTRODUCTION

The mother McCord Mission is a Christian foundation that provides training and community services, acts as a role model, embodies a family culture and harnesses the power of its committed workforce. With 3 key focus areas, each one attached by an umbilical to the mother, the McCord Mission provides care and support in order to nuture each focus area.

The 3 key focus areas are:

- The McCord Hospital;
- The Education and Training center;
- HIV/AIDS Management Center.

The focus of this dissertation is restricted to the hospital and therefore the other aspects of the McCord Mission are deliberately ignored.

McCord Hospital is registered with the KZN Provincial Administration as a "Private" (State Aided Mission) Hospital. The hospital receives a subsidy from the KZN Provincial Administration, annually. At present the hospital has 240 beds and provides the following services to the community: Medical, surgical, obstetrics & paediatric care, a 24 hour outpatient facility, specialist clinics (dermatology, gynaecology) and essential paramedical services.

In addition to the subsidy receive from the provincial administration, income required to operate the hospital is derived from the fees collected from cash paying hospital patients, Medical Aid Associations, Workmen's Compensation for injury on duty patients and the health department (for the provision of services i.e. the treatment of TB and other infectious diseases).

The major functions are training and the provision of health care in a Christian environment. The hospital plays a significant role in KZN in the training of nurses, midwives, advanced midwives, interns and doctors. The approach adopted is to act together as part of a healing team, concerned with the treatment of the patient as a whole, viz. mind, body and spirit. In order to achieve this they have adopted an attitude that has the patient's best interest at heart, reviewing aspects of their present illness, their family, friends and home circumstances, employment factors and their spiritual needs. The hospital serves as an employer to approximately 400 people, through whom it endeavours to create a pool of skills and competencies to meet business objectives and challenges of the future.

4.2. MISSION STATEMENT

The mission of McCord Hospital is to share the love of Jesus Christ in providing a comprehensive and holistic health service, relevant to prevailing needs and in partnership with our communities.

4.3. OBJECTIVES

1. To encourage Christian principles in action in health care provision, in training and administration.
2. To facilitate and provide, effective, efficient primary health care that includes preventative, promotive, curative, rehabilitative and palliative services at primary, secondary and selected tertiary levels.
3. To train medical and nursing personnel, and the other health workers, particularly in those training fields where there are unmet needs, and to encourage professional excellence and dedication.
4. To actively promote and market the services of McCord Hospital.
5. To develop health services in partnership with selective communities.
6. To develop and maintain optimal financial management at all levels.
7. To establish and implement organisational and management policies which are just, fair, equitable and efficient.
8. To nuture prayerfully and humbly, the spirit and teaching of Jesus Christ within the community of McCord Hospital, so that all its members will live and work together in harmony and love, caring for one another and for all who come to the hospital so that all things will be done with thanksgiving.

4.4. VALUES

1. Christian ethos
2. Patient centered care (Batho Pele)
3. Justice and respect for patients and colleagues dignity, worth and uniqueness.
4. Integrity (combination of honesty and responsibility).
5. Caring communication.
6. Self respect and self discipline.
7. Accountability.

These values impact on the care offered to patients and to the reputation of the institution. These values are encouraged as a way of life at the hospital.

4.5. BACKGROUND

Officially established on 1 May 1909, at 28 McCord Road, the starting point of McCord Hospital dates back to 1836, when Dr & Mrs. Newton Adams arrived in Cape Town by ship from the USA. They were sent by the American Board Mission to do medical work in Natal.

It took 3 long months to travel by ox-wagon to Amazimtoti. Dr Adams came into an atmosphere of fear and suspicion. He was the very first medical doctor in Natal and he arrived without a clinical thermometer nor any aspirin, there were no antiseptics or anaesthetics and yet, history states that he was a bold and successful surgeon. He had very limited funds, so he turned his hand to many things. His Zulu name was "Udokotela unamjazi amatathu" which meant "the doctor with 3 coats". A name derived from the way he conducted his day- in the morning he worked as a farmer wearing an old greenish-black coat, at noon he put on a white coat to attend to his patients and on Sundays, he preached wearing his best black coat. Dedicated and fearless he died at an early age of 41 years, burned out by the relentless expenditure of energy during the sixteen years he served in Natal. As a tribute to this pioneer of medicine in Natal, a foundation stone at the out-patient department in McCord Hospital is a memorial honouring Dr Newton Adams.

It was 40 years later that Dr Bridgeman was sent, by the American Board of Missions, to re-start medical work at Amazimtoti, where the Adams College had been founded. Behind his hill-top home, overlooking the college campus, Dr Bridgeman built, in 1893, a 3-roomed cottage with dirt floors and wattle and mud walls. It was primitive indeed, but much good work was done out of the cottage. On account of his wife's ill-health, he was forced to resign and once again there was no doctor available to the community.

In 1903, Dr James Bennet McCord reopened Dr Bridgeman's hospital at Adams Mission. He was the son of a congregational minister and from early boyhood he had dreamt of venturing into Africa. Having met his wife at a university in America, he ventured into the study of medicine and she included some medical subjects into her course. So determined were they to work at Adams mission that they went to Britain to obtain a medical qualification recognised in Natal, and further to that he studied Zulu for a year at Esidumbeni prior to reopening the hospital.

With the help of Umquibelo, who became a fine male nursing assistant, and Mrs. Katie Makanya, interpreter and helper, a great many patients were attended to at the hospital. They came as far as Maphumulo by train and walked five miles from the Isipingo railway station over the hills to Adams Mission. It was when one patient, with amoebic dysentery, died on his long walk, that Dr McCord decided to move to Durban. So it was in 1904, he arrived in an ox-wagon, at a cottage in Beatrice Street, Greyville, and there he, Mrs. McCord, Katie Makanya and Umquibelo, set up hospital. His first operation was the removal of a large fibromyoma. The theatre was the back porch, and the table was brought out from the kitchen. Mrs. McCord was the anaesthetist and she nursed the patient.
Recognising a need for expansion and after a fierce battle against prejudiced Durban people, the doors of McCord Hospital were opened. 12 patients were transferred from Beatrice Street on 1 May 1909, to 28 McCord Road, to the McCord Zulu Hospital. Established 27 years before King Edward viii Hospital was built.

In 1917, Dr McCord closed the hospital and went back to America to fight for his country in the first world war. On a troop train he met a young doctor who was committed to going out to China as a medical missionary, and so Dr Alan Taylor was persuaded to work at the McCord Zulu Hospital and help establish a medical school. In June 1921, Alan and Mary Taylor arrived by ship in Durban. They too came dedicated to a lifetime of service. Dr Taylor took over the hospital and Dr McCord ran a large out-patient practice at 86 Beatrice Street. Dissapointingly all efforts get McCord Medical School recognised failed and so emphasis shifted to the training of nurses. Dr McCord's dream did

come true, and before his death in America, he knew that Dr Alan Taylor had been appointed the first dean of the Durban Medical School.

McCord's 18th birthday was celebrated with a great victory in the battle for registration of african nurses. Beatrice Msimang was sent to write the same exam as the white nurses, and against much prejudice she passed both the general and midwifery examinations. She was the first african nurses in the Natal to be registered R.N.R.M. In 1946 Dr K.N.Pillay and DR J.L.Njongwe became the first non-whites in South Africa to do a resident internship at McCord Hospital. In 1948 Dr Mary Malahlele graduated at Wits and came to do her internship at McCord Hospital. She was the first African woman doctor to qualify in South Africa. Doctors of all races and nationalities came to work at McCords. Some came to prepare for work under tough conditions in mission hospitals. They came to learn and in-turn enriched the McCord family with their goodwill and understanding. Exciting new things happened and the hospital grew leaps and bounds, fulfilling the needs that arouse within the community. Expansions to ensure patients needs were met, rebuilding, renovating, keeping up to date and even reaching out, McCord Hospital is constantly pioneering.

4.6. McCORD HOSPITAL BOARD OF DIRECTORS

The McCord's board consists of 16 positions. All positions are autonomous and voluntary. The executive committee consists of:

CHAIR PERSON	-Professor Zulu
DEPUTY CHAIR PERSON	-Dr Joe Ndlovu
TREASURER	-Mr. Charles Wells
SECRETARY	-Mr. Brian Baylis
HOSPITAL MANAGER	-Dr H. Holst

The board consists of members from within the community, who come from diverse backgrounds. Bringing their vast expertise to the hospital allows for informed and educated decision-making

4.7. MANAGEMENT STYLE

As the health care manager and thus organisational leader at McCord Hospital, Dr. H. Holst views her management style as situational, allowing for flexibility to presiding circumstances. She encourages a participative management, and may be autocratic when necessary. Her leadership style allows for elasticity and encourages involvement from all departmental managers. Her goal is to create an environment in which employees can reach their full potential, sometimes leading, sometimes allowing others to lead and learn, to make their own errors and grow more confident and hence allowing for the conception of good managers. In today's highly competitive workplace, outstanding talent management has become a crucial factor in differentiating company performance. Recognition of this fact is central to management attitude in giving control and responsibility back to the employees. If managed successfully, it is one of the crucial factors in allowing an organisation to get and stay ahead of the competition, and to achieve their goals. These factors encourage a management style that creates and maintains an environment in which the health care worker can provide optimal patient care.

4.8. CRITICAL SUCCESS FACTORS

- Service excellence (Individual care)
- Information technology-upgrade of all services
- Independent sources of funding (including McCord Medical Aid)
- International partnership (including exchange programmes)
- Local partnerships (including University of Natal medical school)
- Strengthening of the McCord ethos/culture (through the development of staff)
- Focus on the market of employed people
- Location/Infrastructure development

4.9. RECENT MILESTONES

- ~ 1998 Renovated the out-patient department
- ~1990 Built doctors quarters
- ~1991 DEPAM (Decentralised Programme for Advanced Midwifery)
- ~1994 VTP started (Vocational Training Programme)
- ~1994 Free Health Service introduced for pregnant women and children under 6, hospital inundated with patients
- ~1995 Renovated A5 children's ward
- ~1996 Rebuilt the theatres
- ~1996 Sinikithemba HIV/AIDS care started
- ~1997 36% reduction in subsidy, stopped "free" services
- ~1997 Strategy work: Vision 2001 and beyond
- ~1998 Built A1 and A2 wards into semi-private wards
- ~1998 Dine-a-cord staff cafeteria opened
- ~1999 Cycle the world tour
- ~1999 Built the medical center
- ~2000 Achieved hospital accreditation
- ~2002 Purchases and started renovating Ridge House
- ~2002 Links with Dream Center established
- ~2002 Long term lease for renovating Davida signed

4.10. EMPLOYEE DEMOGRAPHICS AT McCORD HOSPITAL:

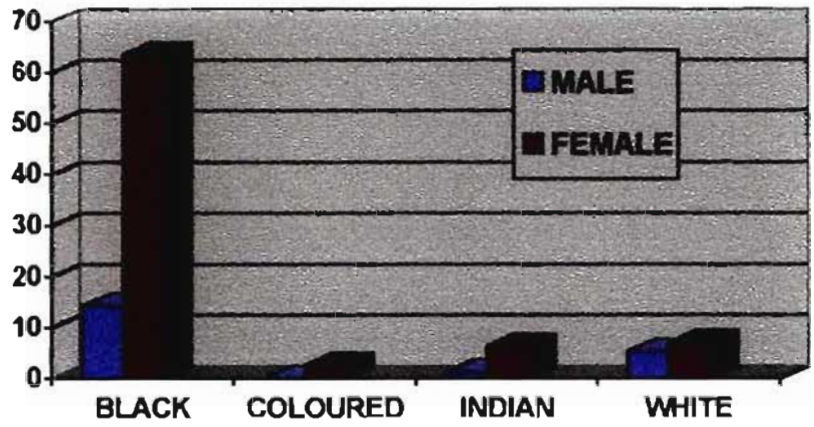

FIGURE 4.1. Racial profile of McCord Hospital *(Ref: McCord Hospital Employment Equity Plan-2002)*

The figure below provides the numerical data to the above graph

ASIAN		BLACK		COLOURED		WHITE		TOTAL		GRAND TOTAL
F	M	F	M	F	M	F	M	F	M	
25	5	254	57	10	0	28	21	317	83	400
6.25%	1.25%	63.5%	14.25%	2.5%	0%	7%	5.25%	79.25%	20.75%	

Table 4.1. Numerical data to support figure 4.10.1.

DEPARTMENT	TOTAL	PERCENTAGE
Medical Full time	50	13.6
Medical Sessional	1	0.3
Nursing Part time	7	1.9
Nursing Full time	188	51.2
Paramedical	30	8
Administration	62	16.9
Domestic	18	4.9
Maintenance	8	2.2
Transport	3	0.8
Total	367	100

TABLE 4.2. Table exhibiting the different departmental totals.

Table 4.2 clearly demonstrates that the majority of staff are highly skilled professionals, 75% being from the medical and profession.

4.11. HIV/AIDS AT McCORD HOSPITAL

McCord is at the forefront in managing HIV/AIDS within the province. Establishment of Sinikithemba HIV clinic in 1996 was the fledgling of HIV care at McCord Hospital. Today the HIV/AIDS clinic is an HIV /AIDS care center that adopts a comprehensive, proactive approach to the epidemic. Incorporating social, psychological, spiritual and medical treatment into a holistic solution to HIV/AIDS. The HIV/AIDS care center is a McCord offering that provides a social support group, together with caring empathetic medical and non-medical staff to guide and care for patients so that the spread of HIV/AIDS is contained.

Being in possession of these scarce resources, skills and capabilities, made the loss of four staff members to the disease, unacceptable. In an interview with Dr H. Holst she said ' the decision to implement the programme was an emotional one, I presented my ideas to the board, who were in agreement'. HIV/AIDS and deaths relating to HIV was a huge emotional burden to the staff. The nursing of young adults dying of AIDS introduced fear, hopelessness and denial. Disillusioned by the lack of cost-efficient treatment options, few staff members were willing to be tested. Between June and September 2001, 4 staff members died of AIDS in the hospital. One knew her status but didn't tell the physician looking after her. The others were not willing to be tested until very late in their illness-were little could be done.

4.12. THE CARE FOR THE CAREGIVERS PROGRAMME

The hospital does not offer formal medical aid subscriptions to its employees, therefore free treatment is offered to all employees via the staff clinic. This includes both in-patient and out-patient treatment which covers most acute and chronic conditions. In 2001, certain items were not included due to high costs, and staff members were asked to pay for these medicines, Antiretroviral therapy was one of them. Staff members could be initiated on treatment at the staff clinic but had to bare the costs of the medication, amounting to approximately R1200/month in 2001. The 4 staff members that

passed-on in 2001, costs the hospital R105 950 in medical expenses. The staff clinic noticed an increase in hospital admissions and sick leave.

It was decided to devise an action plan to counteract these expanding financial and human costs. The staff-doctor (Dr. Uebell), in consultation with management and the board, union representatives and HIV counsellors developed the in-house HIV/AIDS programme dubbed the *Care for the Caregivers Programme.*

Assumptions of the programme

- staff complement of 500
- 20% HIV prevalence rate
- 100 employees HIV positive
- 25% of these need ART
- ART cost ~R12000 per annum
- Max costs R200 000 per annum

HIV/AIDS management programme consists of:

- VCT (Voluntary counselling and testing)
- Screening and prophylaxis
- Indications for ART
- Monitoring of ART

VCT (Voluntary counselling and testing)

Due to confidentiality issues, voluntary couselling and testing is carried out by the staff doctor and at the staff clinic. The hospital is a very close knit community therefore employees are reluctant to in coming forward to be tested, for fear of word getting around. The opportunity to be tested is offered to all staff members presenting with opportunistic infections. Blood sent to the in-house laboratory have coded identifiers that only the staff-doctor can decipher.

Screening and Prophylaxis

Not all HIV positive patients can or should receive Anti-retroviral therapy (ART). Screening test include

- annual CD4 counts
- Chest X-Ray
- Mantoux test (TB testing)
- Pap smears

All patients are initiated on TB prophylaxis (Isoniazid) with a positive Mantoux (>5mm).

Co-trimoxazole prophylaxis is initiated on patients with a CD4<200.

Fluconazole prophylaxis is initiated for those who have had Cryptococcal Meningitis.

Indications for ART

- CD4<200
- Significant symptoms e.g. atypical TB, severe weight loss.

Monitoring ART

- Baseline FBC, U&E, LFT, Amylase, CD4 and Viral load
- Monthly FBC, U&E, LFT, Amylase for the first 3 months
- Thereafter quarterly CD4 and viral load.

Drugs

First line	3TC, Zerit, Stocrin/Viramune
Second line	Retrovir, Videx, Kaletra

The initial first line drugs were Videx, Zerit and Stocrin/Viramune, however due side effects these drugs fell out of favour. Over the last three years the first line agents utilized have been adjusted, partially due to decreasing costs of the medication and partially due to the presentation of severe side

effects. The regimens adopted varied from Videx, Zerit and Stocrin/Viramune to Combivir and Stocrin/Viramune, to the present regimen of 3TC, Zerit and Stocrin/Viramune.

Costs of treatment between Jan-Dec 2002

ART	R28 800
Monitoring and Bloods	R11 410
Total	R40 210

Since 2002 drug prices have dropped drastically, and HIV testing protocols have changed to the utilisation of two rapid tests which is a quicker and far cheaper method.

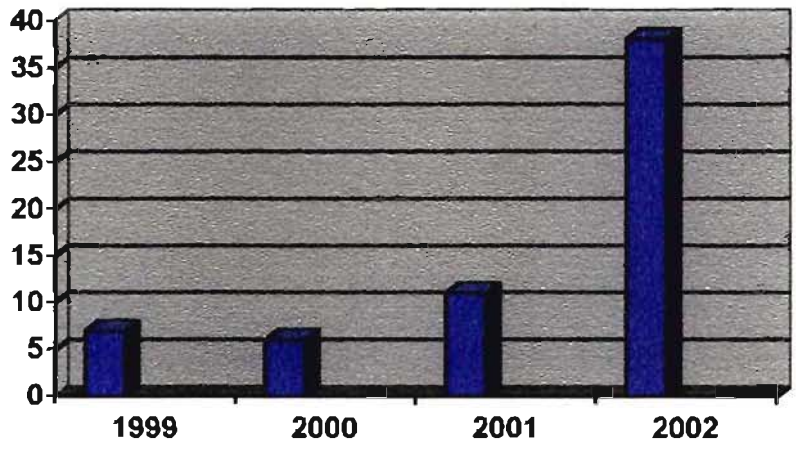

FIGURE 4.2. Staff utilising the VCT programme.

The gradual increase in numbers proves the increasing confidence and awareness of the programme. Staff members are gradually acknowledging the benefits of treatment, the programme is however in its teenage years with several adolescent problems plaguing it but growth is inevitable.

Results obtained as of September 2003 were as follows:

- 38 have had CD4 counts done
- 10 have had Isoniazid TB prophylaxis
- 13 are on ART, 3 of which are in conjunction with TB medication
- 1 stopped ART upon leaving the hospital
- 1 stopped ART with treatment failure

At the introduction of the programme no formal assessment of the knowledge levels was conducted, however in early 2004, this need was identified and task team set out formulating a questionnaire to assess exactly what the knowledge level was. The questionnaire consisted of 18 closed ended questions (true/false/don't know). It was witten in English and administered as a random convenient sample, in person, to 100 staff members of 11 designations. These included doctors, trained and untrained nurses, paramedics (pharmacists, laboratory technicians, radiographers and Sinikithemba HIV counsellors) and administrative staff. Porters, drivers and maintenance (PDM) staff were also included.

The results obtained were as follows:

The mean age of the 103 participants in the study was 35.35.

Of the total participants 20.4% were male and 79.6% were female.

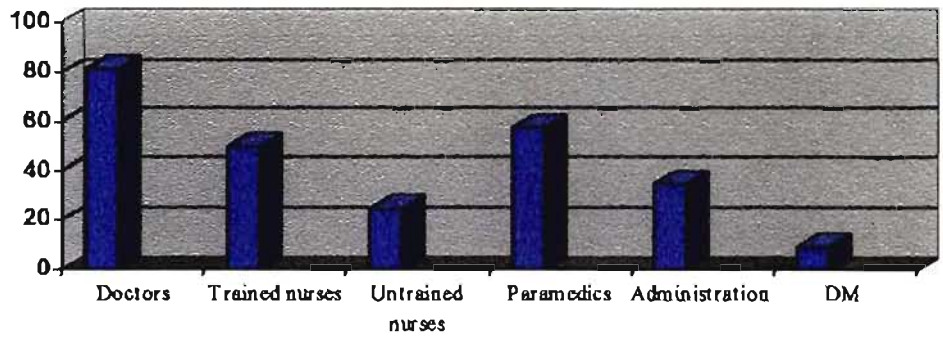

Figure 4.3. Represents the Total Score Percentage of each designation.

Doctors achieved the highest score at 81.3% and the PDM participants scored the lowest at 9.2%

The mean total score was 45.04%.

Problems identified

- Confidentiality
- Access to ART
- Adherence

- **Confidentiality**

The staff clinic is not solely an HIV/AIDS clinic and therefore there are several limitations in terms of confidentiality. Patients of varied illnesses are seen here. This is would not be a problem in a private consulting room, however here, everyone knows each other and usually work closely together, therefore extra precautions need to be taken to ensure results, prescriptions and patient files are secure.

- **Access to therapy**

All permanent staff members are granted access to the free programme. Pupil nurses doing the 2 year course at the McCord Hospital Nursing School are also welcome. Family members would have to pay hospital rates but can be seen by the staff doctor.

- **Adherence**

Although counselling is conducted over 2-3 visits, adherence is a problem, because of the large pill load and drug side effects, patients may be reluctant to take their medication. Each patient initiated on ART is issued 7 daily pill bottles for ART, TB therapy and opportunistic infection prophylaxis. Due to confidentiality issues adherence counselling is usually only performed by the staff-doctor. Pharmacists and HIV counsellors are not involved. Adherence is still a problem even after counselling and therefore a treatment buddy to motivate and monitor treatment is warranted.
The high pill load is exacerbated when concurrent medication to ART has to be added e.g. Co-trimoxazole, TB treatment and Fluconazole) all of which is very daunting for the patient. South Africa is limited in terms of combination therapy, the new triple combination medications are not as yet available to South African patients.

The programme was initiated due to a personal commitment by the staff-doctor and the health care manager to prevent orphans, the unnecessary loss of life and contain the spread of the disease, but

they soon realised that it makes social, economic and business sense as well. Although optimistic, it is feared that the programme is not being fully utilised by staff members. There is a silent denial due to the stigma attached to the disease and this needs to be combated.

FUTURE OUTLOOK

Management anticipates a higher utilisation of the programme as it sheds its teenage problems and moves in to the mature adult phase.

Drug resistance may be a problem further down the line. In America there's an emergence of resistance amongst IV drug abusers, these resistant strains of the disease can spread through societies easily. Although the South African profile of the infected is different to that of first world countries, we can be certain that the virus is smart and easily adaptable, with increased usage of Antiretroviral drugs adherence problems are bound to emerge, resistant strains are therefore inevitable. Behavioural changes, adopting a healthy lifestyle and commitment to one partner are the best methods available to counteract the virus (*Dr H.Holst*).

4.13. CONCLUSION

McCord Hospital is a model of public-private partnership, with a sustained beneficial impact on its surrounding communities. The loose structure and open lines of communication has allowed for speedy reactions to deficiencies identified. A strategic impetus has resulted in the comprehensive approach adopted to the HIV/AIDS pandemic with resultant benefits.

This new and tangible example in action will pave the way to success against the virus. Furthermore this latest initiative can serve as a benchmark to other health care organisations and is great example of organisations making a difference in the fight against HIV/AIDS.

CHAPTER FIVE

CASE EVALUATION

5.1. INTRODUCTION

Presenting an informative results and evaluation chapter for qualitative research is likely more challenging than doing so for a quantitative research. However with good research having generated dependable data and the employment of practices that were conducted professionally, the outcome can be used confidently for managerial decision making.

The adoption of a well-organised strategy that involves a step by step evaluation of the *Care for the Caregivers programme,* allows for a clear and comprehensive presentation. This in- house HIV/AIDS programme at McCord Hospital is compared and contrasted against the backdrop of the benchmark programme offered by the South African Business Coalition on HIV/AIDS (SABCOHA) in Chapter 3. Though not formally structured into the flowchart of Chapter 2, the 7-step procedure is a natural evolution of the flow diagram presented. This benchmark contains all of the essential components of the diagram. The flowchart will be employed as a guideline, whilst the benchmark provides the specifications.

It was in Chapter 3 that a detailed 7-step approach to HIV/AIDS in the workplace was proposed. This concept will be briefly re-introduced and concurrently screen the *Care for the Caregivers Programme,* in order to establish compliance or non-compliance.

5.2. MERGER OF THE PROPOSED MODEL AND THE BENCHMARK

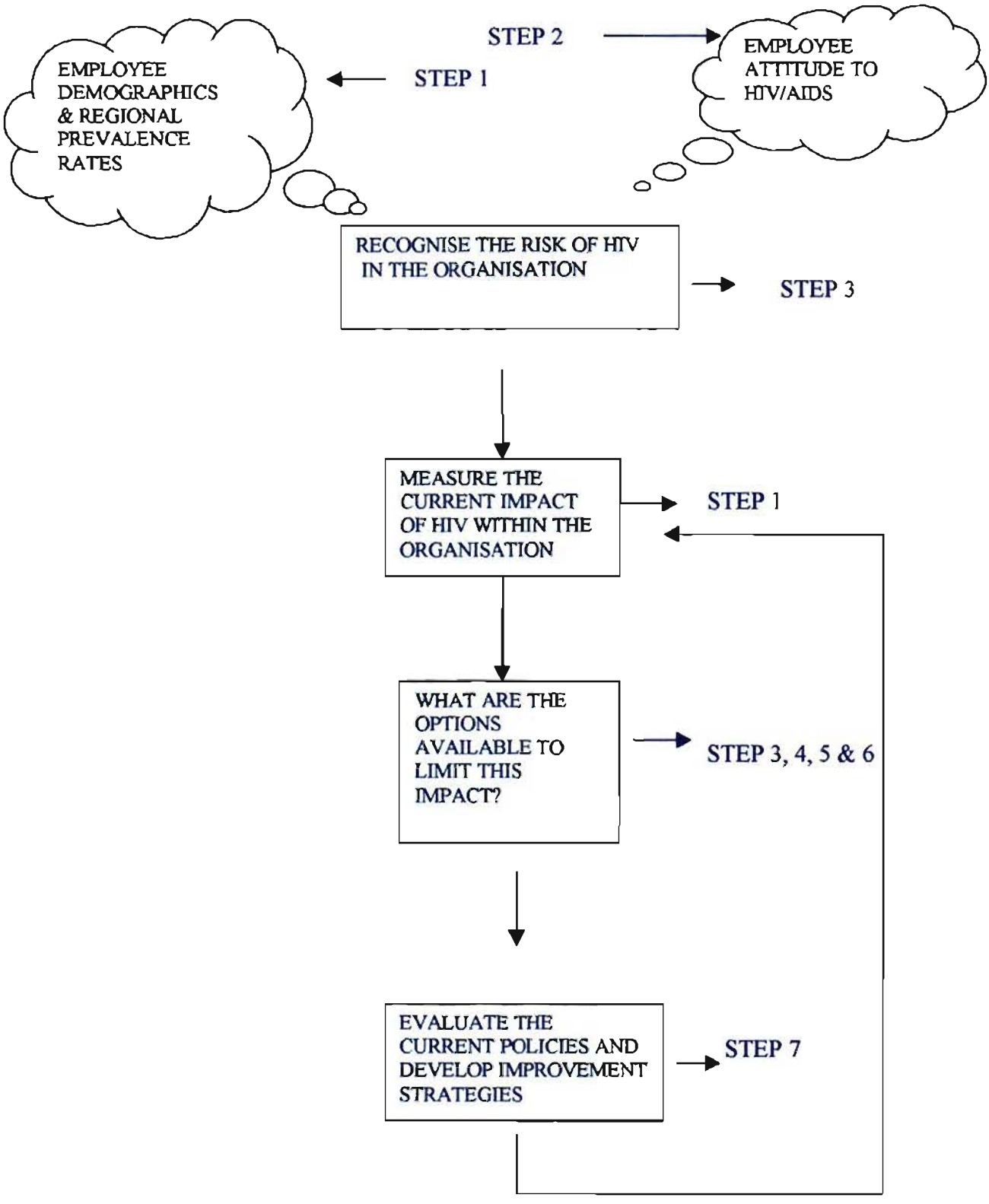

Figure 5.1 . Merged Flow diagram

5.2.1. The Benchmark revisited

STEP 1	Assessment of risk liability
STEP 2	Situational Analysis
STEP 3	Strategic Planning
STEP 4	Policy and Procedures
STEP 5	Prevention Strategies
STEP 6	Care and Support
STEP 7	Outcomes Measurement

A re-evaluation of the flow diagram (Figure 2.8) proposed in chapter two, clearly demonstrates that the elements of identification, measurement, decision and monitoring are contained within the 7-step benchmark. Therefore the stipulated benchmark will be utilised to evaluate the current in-house HIV/AIDS programme at McCord Hospital.

5.3 STEP 1- Assessment of Risk Liability

The establishment of the HIV profile of an organisation is the launch-pad of any initiative aimed at dissipating the horrendous effects of HIV/AIDS. The programme should therefore call for risks to be assessed in terms of:

- Existing levels of HIV/AIDS within the workplace and within surrounding communities.
- Costs to the company of HIV/AIDS related employee absence and death (absenteeism, recruitment, training, reduced productivity etc.)
- Costs to the company resulting from hospitalisation, home care and any existing prevention activities)

These 3 assessment criteria will be utilised in establishing the extent to which the *Care for the Caregivers Programme* conforms to this standard. The aim is to deduce whether the said programme is compliant, partially compliant or non-compliant.

5.3.1. Existing levels of HIV/AIDS within the organisation.

As explained previously the existing levels can not be accurately attained and approximations of prevalence rates are utilised, because it is not possible to test all employees, due to legislation, logistics and labour relations issues.

On examining the programme adopted at the hospital it is clear that the programme is wholly based on a prevalence rate of 20%. This figure is deliberately exaggerated when compared to the rate proposed by Shisanu, O. in the Symposia session of the South African AIDS conference, August 2003, to accommodate for shortfalls in calculations or to provide "extra padding". This figure was calculated cased on a survey of 200 healthcare institutes nationally. However on closer examination of data presented regarding prevalence rates within the province this figure appears deflated, offering an unrealistic estimation and with little flexibility.

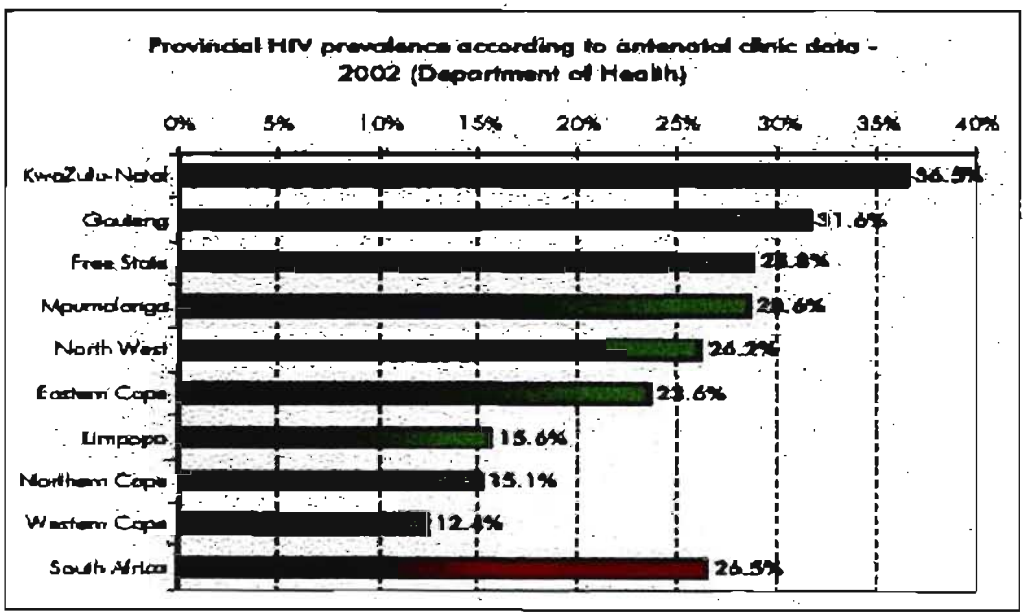

Figure 5.2. Provincial HIV prevalence, 2002 (Survey on *The Economic impact of HIV/AIDS on business in South Africa, 2003, conducted by BER for SABCOHA).*

It is clear from the above presentation that the HIV prevalence rate in KwaZulu-Natal is estimated at 36.5%, a far cry from the 20% proposed in the *Care for the Caregivers Programme*. Further evidence of this shortfall is the HIV prevalence rates per age group detailed in the following graph.

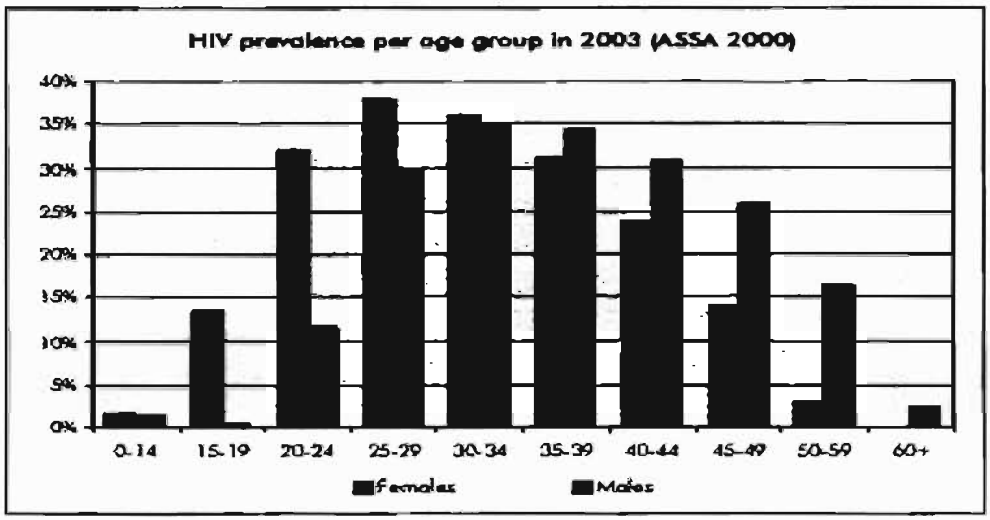

Figure 5.3. HIV prevalence per age group in 2003.*(Survey on The economic impact of HIV/AIDS on business in South Africa,2003, conducted by BER for SABCOHA).*

Figure 5.3. clearly points to a rate of >30% in young female aged 20-39, it further points to a rate of >30% in males aged 25-44. From previous demographics of McCord Hospital showed the female population at McCord at 79.25% as opposed to the males at 20.75%. It can be gleaned that the female prevalence rates are of greater significance.

DEPARTMENT	TOTAL	PERCENTAGE
Medical Full time	50	13.6
Medical Sessional	1	0.3
Nursing Part time	7	1.9
Nursing Full time	188	51.2
Paramedical	30	8
Administration	62	16.9
Domestic	18	4.9
Maintenance	8	2.2
Transport	3	0.8
Total	367	100

TABLE 5.1 Table exhibiting a staff breakdown of each department.

Table 5.1. demonstrates that the majority of staff are highly skilled professionals, and according to labour force details presented in The Economic impact of HIV/AIDS on business in South Africa pg. 21, 73% of the workforce in KwaZulu-Natal is <45years. Given the modes of transmission of the disease it is not surprising that HIV/AIDS is concentrated among infants and adults bet 20 and 40 (BER).

It can be argued that the prevalence rate used in the programme was appropriate for 2001, however the projections produced by Actuarial Society of South Afirica (ASSA) 2000 model, on the prevalence of HIV among young adults, prove otherwise.

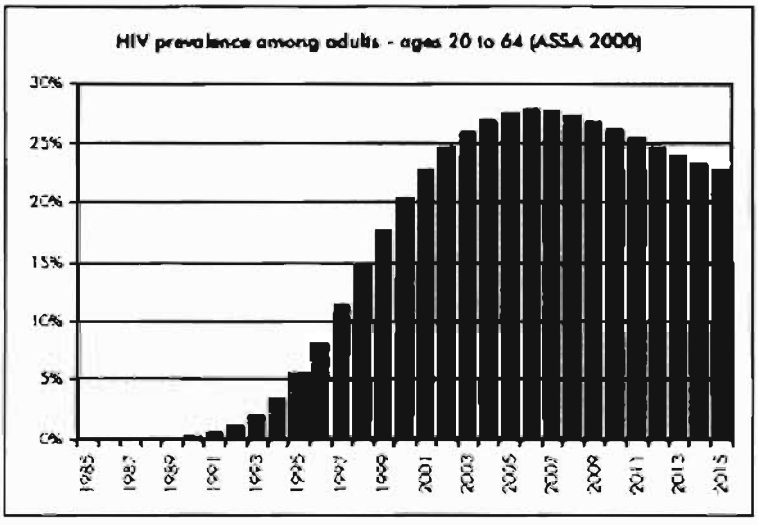

Figure 5.4. HIV prevalence among adults-age 20 to 64 (Survey on *The Economic impact of HIV/AIDS on business in South Africa, 2003, conducted by BER for SABCOHA*)

The above graph clearly leans toward a prevalence rate of >20% in 2001 with increasing rates over the following 10 years. All evidence presented lean toward a prevalence rate of between 25 and 35%. And therefore indicate that the prevalence rate adopted by the HIV/AIDS programme at McCord Hospital, is conservative at best and needs reevaluation. The repercussions of such a conservative rate will be examined in the next chapter.

5.3.2. Costs to the Company.

McCord Hospital's programme presents a figure of R105 950 in terms of costs to the hospital for the medical expenses of the first 4 staff members lost to the disease. These employee benefit costs are a small portion of the total costs to the company. As illustrated in Chapter 3, figure 3.3.3, the picture is far more gruesome. With 39% of companies reporting lower labour productivity or increased absenteeism, more than 30% reporting that HIV/AIDS has increased the cost of employee benefits and has led to higher labour turnover rates. The loss of experience and skills compounded by higher recruitment and training costs also feature high on the survey.

Furthermore the costs of prevention activities were omitted from the programme costing exercise.

PARTIALLY COMPLIANT

Assessment of risk liability by McCord Hospital complies with some of the requirements set out in the benchmark, it is therefore rated as partially compliant.

5.4. SITUATIONAL ANALYSIS

The situational analysis assesses the level of "AIDS competence" within the organisation., and comprises three main aspects:

- A workplace overview
- An HIV/AIDS initiative audit
- A survey of knowledge, attitudes and practices (KAP)

5.4.1. A workplace overview

This involves the study of the nature structure and processes of the workplace environment, incorporating the physical as well as the hierarchical structure. Who and where the people are, operational processes and requirements as well as communication forums (meetings/newsletters).

The case under study involves a well integrated organisation, with a single holistic purpose and all units functioning toward a single unified output i.e. Patient care and treatment. The common goals and purposes and the close-knit community environment that prevails within the organisation ensures that new programmmes and policies easily filter through to departments. Regular HOD meetings and monthly newsletters that accompany salary slips are easy methods of communicating new ideas and promoting new programmes.

The structure already in-place for the treatment of staff at the hospital was popular and well utilised by most employees. A single staff doctor functioning within the hospital, utilising all amenities available at the hospital, and dedicated to treating staff and their dependants was a successful alternative to providing formal medical aid cover. This central, reknowned clinic was an ideal launch-pad for the programme. Although not formally debated, it was accepted as a natural inclusion into the prevailing staff treatment pathway. The site of activity had to be accessible and non-discriminatory in its location and therefore the prevailing HIV/AIDS clinic was not considered as a treatment site for staff. This choice proved to be very successful in providing a private and confidential environment, free from victimisation and stigmatisation.

5.4.2. HIV/AIDS initiative audit

The initiative audit is a comprehensive and structured audit carried out on all previous HIV/AIDS initiatives at the organisation. This audit is especially relevant in those organisations where a number of fragmented HIV/AIDS initiatives have taken place over a period of time. It calls for analysis of all previous documentation, statistics and key indicators.

At McCord Hospital, the previous attempts of intervention are not documented, partially because it was not addressed in its entirety and partially because anti-retroviral medication was not a mainstream, due to both procurement and cost issues.

The formulated programme was conceived only after the identification of a prevailing need. Management awareness was triggered by the death of the initial four employees and commitment to combat the problem was established. Being in possession of the necessary resources in terms of medical and non-medical personnel, technology and equipment necessary for testing and diagnosis, had all contributed to tappering the financial costs of implementing the programme. This left the

large costs of anti-retroviral medication being the largest contributing cost and therefore the determining cost factor. Drug companies in keeping with the "not-to-profit" policy regarding ARV drugs have reduced their prices over the years and have extended their licenses for the generic manufacture and sale of ARV's to sub-Saharan Africa. This bold initiative has had a very local impact, with large social and welfare impetus, these companies have reduced the pricing of their anti-retroviral drugs to make it more affordable, and therefore facilitated the implementation of the *Care for the Caregivers Programme.*

5.4.3. KAP survey

The KAP survey assesses the level of awareness of HIV/AIDS and personal responses to the epidemic, both of which vary greatly between individuals and groups.

Employing a KAP survey provides an indication of:

- Knowledge: this includes the level of knowledge about HIV/AIDS including the condition, methods of transmission and treatment and prevention options.
- Attitudes: Individual attitudes about the disease, level of personal of risk, infected colleques, family and friends.
- Practices: the assessment of risk-taking behaviour with regards to HIV transmission.

An analysis of the employee profile within the hospital indicates that 75% of employees are medical personal, all of whom are likely to have a high level of knowledge about HIV/AIDS, however the high rates of infection among healthcare workers (16%), implies that perhaps they embark on risky behaviour. The programme employed largely ignores this fact and concentrates on treatment rather than prevention. The processes of prevention have been given minimal exposure.

The research conducted in may 2004 revealed a lack of knowledge on the part of nurses, both trained and untrained, in relation to HIV/AIDS. As the organisation demographics reveal, the nurses constitute the >50% of employees. This issue needs to be addressed.

PARTIALLY COMPLIANT

5.5. STRATEGIC PLANNING

Strategic planning is a key element in managing this risk, it sets direction for the business as a whole. A clear strategy, that is appropriate to current and future risk profiles, which is properly executed, should ensure success of the programme. As stated previously to get buy-in from all stakeholders, it is essential that the planning process, where applicable, involves management, human resources, and employee representatives. Information available from the liability assessment as well as situational analysis should be used to guide the process, this will have indicated the size and nature of the problem within the organisation as well as its specific requirements.

The formulation of a discussion group in September 2001 demonstrated this strategic impetus. Involving various staff and management groups as well as consulting with an expert in HIV treatment in the developing world (Dr Gerald Fruedland) helped in the formulation of the in-house HIV/AIDS programme adopted at McCord Hospital.

Although it is difficult to ascertain the exact cause or mechanism under which the workshop functioned, we can only view the outcome (Care for the Caregivers Programme) as an indicator of success or failure. Although flawed the programme does offer the vital essentials and the aim and motivation are most definetly on course for success. Minor modifications and on-going monitoring and replanning will ensure that the programme is on par with the rapidly changing nature of the epidemic.

Thus far the programme has been successfully co-ordinated by one person (Dr K Uebell), who has the capacity and authority to guide and monitor the programme, as all elements of the programme are linked and the outcome depends on this seamless implementation. The decision to implement the programme was an emotional one, therefore the deliverables were mainly saving lives, promoting well-being and ensuring health. However measureable outcomes were not properly identified or quantified, goals were not set, making outcomes successes or failures subjective. Agreed deadlines and milestones, as well as a budget for the project are not detailed in the policy and procedures adopted.

PARTIALLY COMPLIANT

5.6. POLICIES AND PROCEDURES

Here a checklist is established to determine whether the *Care for the Caregivers Programme* complies with the functions of an HIV/AIDS policy as described in Chapter 3.

√	Define an organisation's position on HIV/AIDS and to set out clear guidelines on how HIV/AIDS will be managed within the workplace;
√	Align the workplace response to the legal framework;
√	Ensure fairness;
√	Identify and protect the rights and responsibilities of employers and employees in the context of HIV/AIDS;
√	Set standards of behaviour expected of all employers and employees;
√	Establish coonsistency within the company;
√	Set the standard for communication about HIV/AIDS;
√	Provide a good foundation upon which to build an HIV/AAIDS workplace programme;
√	Inform employees what assistance is available for HIV and AIDS;
√	Send a strong message that HIV/aids is a serious issue in the workplace;
√	Indicate a commitment to dealing with HIV and AIDS; and
√	Ensure consistency with national and international practices;

A checklist demonstrating the programme's compliance with the different facet requirements of an HIV/AIDS policy is detailed below:

X	Prevention of new infections. Detail on the nature as well as the scope (to include families, surrounding communities) should be documented. This will include issues such as information, education, skills building, and condom distribution;
X	Pre-employment process. Direct or indirect HIV testing of prospective employees is forbidden – exceptions can be granted only upon successful application to the Labour Court with substantive motivation;
√	HIV testing – compulsory testing of HIV is not permissible (unless with permission from the Labour Court). Voluntary testing is permissible subject to a range of conditions including access to counselling, informed consent and guaranteed confidentiality;
√	Confidentiality – the stigma that is associated with this condition makes the issue of protection of confidentiality an important element of the policy;
√	Employment status and benefits. HIV infection alone should not affect the employment status of the employee or any of the benefits available;
√	Disability management. HIV- infected employees who are no longer able to work are to be handled in accordance with standard disability procedures – as for any employee with ill health;
√	Risk management. Should there be a risk of occupational HIV exposure, infection prevention should be covered in the policy. This should include access to compensation if necessary; and
√	Human resource procedure. Infected employees should be subject to standard HR disciplinary and grievance policies.

The tables above distinctly indicate the extent to which the *Care for the Caregivers programme* complies with stipulated requirements. It is obvious that the area of frailty is the prevention programme or lack of it.

MOSTLY COMPLIANT

Taking into account the fact the policies and procedures adopted at McCord Hospital complies with most of the ideas set out in the benchamark, it is rated mostly compliant.

5.7. PREVENTION STRATEGIES

The obvious absence of any significant prevention activities is glaringly apparent. As stated previously the programme estimates an HIV prevalence of approximately 20% and does everyhting in its power to ensure the good health of this 20%. As sound as this principle is, there is still more that can be done. The majority of the staff (80%) is largely ignored in this issue, and here-in lies the problem. For not only are they also prone to infection, they maybe engaging in risky behaviour and may pass on that infection to others within the community undetected. The reality is that most HIV-positive individuals learn of their status only at or after the onset of the final AIDS stages of the disease (on average six to seven years after infection). This lack of emphasis on the non-infected employees is a potential catastrophy in the making. An examination of figure 5.4 reveals the ASSA prediction of rising infection rates over the next decade. Perhaps with correct prevention strategies in place, that promote abstinence and faithfulness, this can be averted, or rather curtailed.

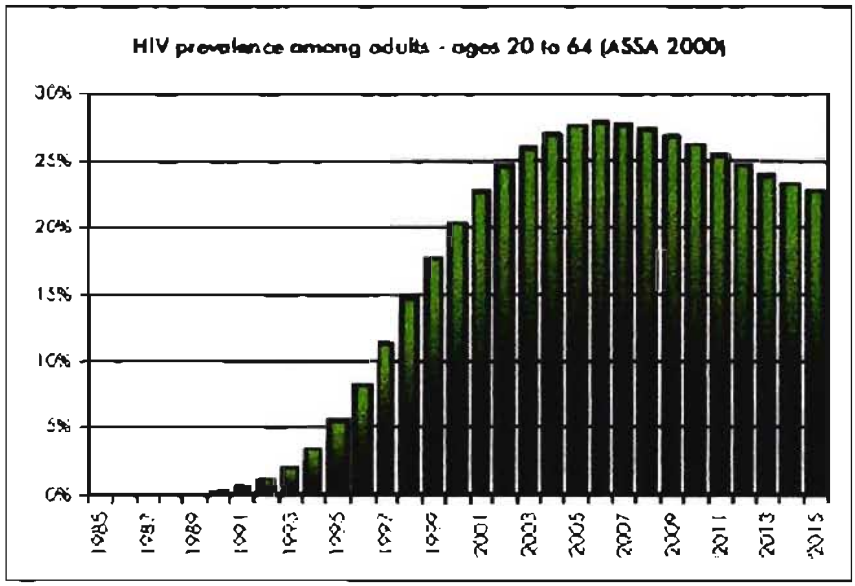

Figure 5.4. HIV prevalence among adults-age 20 to 64 (Survey on *The Economic impact of HIV/AIDS on business in South Africa, 2003, conducted by BER for SABCCOHA).*

NON-COMPLIANT

The lack of prevention activities at McCord Hospital is glaringly obvious and it is due to this that the programme under review is rated non-compliant in the implementation of prevention programmes.

5.8. CARE, SUPPORT AND TREATMENT

The support services available within the hospital are admirable. A highly visible pastor, provides spiritual advice, guides and encourages both patients and staff members, the in-house psychologists-ensures confidential emotional support, and a well-developed HIV/AIDS care center provides support strictures for home-based care, when necessary.

Although these adjunctive mechanisms are not formalised into the programme access to these avenues are not restricted. Unfortunately knowledge of the programme and the amenities are the first step to utilisation, and unless encouraged by the staff doctor, knowledge of these support mechanisms is contained within departments who have regular exposure to these role players. There is a lack of integration in this area.

PARTIALLY COMPLIANT The presence of a strong structure is nullified due to the lack of integration and therefore is not completely effective. The rating of partially compliant is attributed to this section of the programme.

5.9. OUTCOMES MEASUREMENT

The outcomes measurement of the *Care for the Caregivers Programme* has been formalised into a few parameters incorporating:

- The number of staff undergoing VCT;
- The number of HIV positive staff and;
- The number of staff on ARV's.

The model prescribed by the SABCOHA stipulates that monitoring has to be addressed on 3 different levels:

- Operational;
- HIV/AIDS competence and;
- Programme outcomes.

The operationl level would focus on monitoring programme implementation, making sure that time-lines are met and awareness campaigns carried out, and that, patients are enrolled on treatment programmes. Unfortunately, due to sensitivity surrounding confidentiality all of these aspects can only be monitored and controlled by the staff doctor, this adds to the increasing workload, for not only must the VCT, initiation of treatment, monitoring of disease progression and treatment success, be conducted, but also the monitoring of the overall programme. This is a mammoth task for a single person.

Level two involves HIV/AIDS competence testing. This area had been largely ignored until recently, when research in this domain was conducted, and the results attained were quite alarming. The acquired mean percentage of 45.04% was unacceptable for a medical environment. These statistics point to a need to increase awareness campaigns.

Although it is argued that the increasing numbers of staff coming forward implies that the programmes popularity is growing and is therefore successful, addressing only a segment of the disease is not as victorious as addressing the it in its entirety.

Outcomes measures of level three involve long term measures of programme outcomes, such as HIV infection incidence (new infections over specified period), HIV seroprevalence rates (total number of employees infected with HIV), and HIV/AIDS related absenteeism, disability and mortality.
All of these measures though logical, are quite unrealistic. They require a baseline measure, which can only be attained in an ideal world, where confidentiality, stigmatisation and superstition do not rule the day. The best way forward is the encouragement of VCT, promotion of positive life choices, education and support structures.

PARTIALLY COMPLIANT

With only some of the outcomes measures established, the programme demonstrates a gap in the outcomes measurement, that needs to be addressed, for this reason it is rated partially compliant.

5.10. CONCLUSION

Benchmarking the 7-principles (advocated by SABCOHA), has resulted in a successful evaluations chapter. Although not formally structured into the flowchart of chapter two, these principles correlate with the different elements under discussion in the flowchart.

The results obtained through this process have highlighted several areas of contention within the current *Care for the Caregivers Programme*. The area of frailty has been identified as the lack of prevention activity at the hospital. These areas of weakness will be elaborated of in the recommendations and conclusions chapter.

There evaluation revealed that not only are there areas that can be improved upon, there are activities that fall well within the scope of the benchmark and need to be commended.

CHAPTER SIX

RECOMMENDATIONS

&

CONCLUSIONS

6.1. INTRODUCTION

The problem statement posed at the onset of this study has formed the basis for this dissertation, and has highlighted the need for McCord Hospital, to assess their in-house HIV/AIDS programme, to ensure optimal results. The need for proactive management of HIV/AIDS in the workplace, has resulted in the development of a solid framework to aid and guide organisations through this sensitive issue. This chapter reviews the theory explored, the benchmark established and the results obtained through the qualitative evaluation process.

6.2. REVIEW OF RISK MANAGEMENT THEORY

The theory presentation has highlighted the importance of risk management in developing a competitive edge. The fundamental principles underlying risk management together with its changing role in the corporate environment has moved the subject into the spotlight in recent years.

Defining the risk, and understanding the concept of risk management is key to formalising any policy on the subject. Recognition of its influence on all stakeholders and potential for averting losses or ceasing possible gains, assists in a greater appreciation of the subject. Corporate activity is saturated with risk and the collective effects of the various risk catergories are essential in monitoring the total performance of a firm. A good risk management process is proactive in nature.

The ideology governing risk management procedures are standardized into a sequential procedure commencing with setting the right strategy and involving the various risk professionals in the debate. It carries through to the development of a risk framework appropriate to the company's strategy. This framework must be adequately resourced so that it can operate effectively with a degree of flexibility, which allows it to respond to the ever-changing environment.

The risk landscape has changed for many companies. With the globalization of many markets, coupled with technological advances has led to the emergence of new industries and new risks. The biggest risks many companies face at present are not necessarily those that have been covered traditionally by the insurance or capital markets. The emergence of HIV/AIDS in the 1980's and the

rapid spread of the disease through the African continent has resulted in HIV/AIDS being one of the major risk companies face in these countries. HIV/AIDS has been identified as a major risk of doing business in South Africa. It right up there with other major identified risks in the region, including, personal and asset security, exchange rate volatility, as well as political and infrastructure risk. As with all of these risks, HIV/AIDS must be measured and proactively managed. It requires specialized skills, investment and crucially management focus. As with other business risk the response must be multi-dimensional.

To this end a strategic model was developed to guide the process. This model incorporates the fundamental principles of risk identification, measurement, decision-making and monitoring. Furthermore the model presents a framework to managing the risk of HIV/AIDS in the workplace and incorporates a logical sequence of actions.

6.3. REVIEW OF THE BENCHMARK

A presentation of the statistics obtained by the South African Business Coalition on HIV/AIDS (SABCOHA), details the economic impact of HIV/AIDS in South Africa. The statistics validates the negative impacts of the disease identified initially. These impacts include a loss of company profits, decreasing labour productivity, increasing absenteeism, higher employee benefit costs, higher labour turnover rates, loss of experience and vital skills, as well as higher recruitment and training costs.

KwaZulu-Natal and Gauteng prove to be the worse affected with more than 40% of the companies operating in these two provinces indicated that HIV/AIDS has led to lower productivity or increased absenteeism. Furthermore, the results reveal that many businesses are already facing the consequences of the epidemic. All in all, 9% of the companies surveyed indicated that HIV/AIDS has already had an adverse impact on their business and another 43% envisage a significant impact in five year's time. The global spread of the disease and the increasing evidence of the associated impacts on business, has highlighted the need for business to step up to the challenge and take action against the epidemic. The need for private sector involvement in combating HIV/AIDS is critical if efforts to fight the disease are to be effective and sustainable.

In view of the vast gap in the risk management policies of organisations in combating HIV/AIDS in the workplace, SABCOHA have presented a 7-step plan which involves:-

- Assessment of risk liability
- Situational analysis
- Strategic planning
- Policy and procedures
- Prevention strategies
- Care and support, and
- Outcomes measurement.

6.4. REVIEW OF THE CASE STUDY

McCord Hospital was officially established in 1909, however its history dates back to 1836. The missionary origin of McCord Hospital validates the values and culture adopted at the hospital. As a 240-bed state aided mission hospital, it aims to provide services to both surrounding communities and in-house personal. Major functions include training and a provision of healthcare in a Christian environment. The milestones achieved from its humble beginnings are outstanding, identifying prevailing needs within it's communities, McCord Hospital has successfully adapted to fill the gaps in healthcare. The most recent challenge of HIV/AIDS in the workplace, has seen McCord Hospital extending the care, support and treatment they offer to their patients, to incorporate its valued employees.

The demographics presented, describe a workplace dominated by females (79.25%), and an environment consisting of mainly medically educated persons (75%). The in-house HIV/AIDS programme, dubbed the *Care for the Caregivers Programme,* provides treatment and support to HIV positive staff members. This benefit includes VCT, screening and prophylaxis, ART and monitoring ART. In the three years of implementation the programme has demonstrated an increasing confidence and accelerated utilisation. This has been concluded from the greater numbers opting for VCT and rising number of employees accessing care.

6.5. REVIEW OF THE EVALUATION

Employing an evaluation technique that involves an assessment set against the benchmark has resulted in an enlightened view of the *Care for the Caregivers Programme.* The 7 principles advocated by the SABCOHA revealed many pitfalls in the current programme. It also highlighted the many accomplishments of the programme. With most categories fairing quite well under scrutiny, attaining a partial compliant listing, it was only the analysis of the current prevention activities at McCord Hospital, which revealed a non-compliant ranking.

The assessment of risk liability proved useful. With an analysis based on three levels, the assessment aimed at analysing the HIV profile of the hospital. The existing levels of HIV/AIDS within the hospital, is set at 20%. However, on closer examination of national statistics by the Department of Health 2002, and ASSA 2000, reveals a shortfall in the programme. Both organisations project rising infection rates, with higher rates of infection in the KwaZulu-Natal area. Furthermore the programme under review, limits the costs to the company to the employee benefit costs incurred by the first four HIV/AIDS victims. Costs incurred due to absenteeism, recruitment and training and reduced productivity, as well as the costs of prevention activities, are ignored.

The situational analysis exposed a vast area of unchartered territory. Not formalised within the programme, this operation had unconsciously been adhered to. A workplace overview unveiled a very well integrated, close-knit organisation. The launch site of the programme was the central and popular staff clinic that provided a private and confidential environment. An HIV/AIDS initiative audit was not necessary, because prior attempts at addressing the problem were never formalised. Recognising a need for a KAP survey, research was conducted in May 2004 and the results proved surprising. It showed a distinct lack of knowledge of HIV/AIDS, on the part of nurses, both trained and untrained. With nurses comprising more than 50% of staff compliment, this proved to be a very serious issue.

Strategic emphasis of the *Care for the Caregivers Programme* is unwavering. Management support and commitment to improving health of infected employee is incontestable. Formulation of discussion groups to bolster the programme is another example of this strategic impetus.

Co-ordination by single person, who has the authority and capacity to guide the efforts, ensures seamless integration.

The policies and procedures adopted are a reflection of a progressive and proactive organisation. Weaknesses identified within the policies and procedures were analogous to previously stated shortfalls.

Prevention strategies or lack of it, was the major area of weakness, with no visible efforts to promote prevention of HIV/AIDS, this proved to be an area in need of much development. Furthermore there was a lack of integration in terms of care and support. The availability of such services was not an obstacle, it was more a lack of efforts to formally unite these concepts with the *Care for the Caregiver Programme.*

A review of the proposed outcomes measures, likewise, highlighted a need for development. It is quite clear that the outcomes measures adopted by the *Care for the Caregivers Programme* is limited to programme outcomes and largely ignores operational and HIV/AIDS competence parameters. It was only recently (May 2004) that a step towards ascertaining HIV/AIDS competence levels, was taken. This delayed response to these essential measures, can prove detrimental to programme success.

6.6. RECOMMENDATIONS

Based on the results obtained through the evaluation process, it is recommended that McCord Hospital make the following amendements to its current in-house HIV/AIDS programme (*The Care for the Caregivers Programme*).

- The discrepancies arising from the assessment of risk liability necessitates a re-evaluation of the adopted prevalence rates. It is evident that the programme needs to accommodate for higher prevalence rates than originally predicted. Such adjustments would ensure flexibility and minimise budgetary constraints that may arise due to shortfalls in forecasting.

- Furthermore is it plain that the calculations of costs to the company due to HIV/AIDS, is conservative at best. The total effects of the epidemic on any organisation are considerably more than just employee-benefit costs and increased absenteeism as identified in the *Care for the Caregivers Programme.* Lack of the quantification of HIV/AIDS related absenteeism, and death and its resultant recruitment and training costs as well as the reduced productivity, can be limiting. It may be argued that such effects are widely understood and quantification is not necessary, but in order to get stakeholder buy-in, proof of these effects is highly credible. The need for measurement is that it is easier to talk more objectively about the risk when there are numbers attached to it. There is a considerable amount of subjectivity surrounding these risk issues, so the more that subjectivity can be removed, the easier it will be to make meaningful decisions about risk issues. Once those decisions are made, the more objective data we have, the easier it will be for the impacts of those decisions, good or bad, to be tracked *(Olsson, 2002).*

- The survey of knowledge among staff members about HIV/AIDS was astounding. It was assumed that healthcare professionals would be proficient on the topic of HIV/AIDS, but that proved to be incorrect. A mean total score of 45.04% was established, with the trained and untrained nurses attaining a score of 49.72% and 24.42% respectively. These appalling scores do not argue well for the programme. A lack of knowledge is usually the largest hindrance in such a programme. To alleviate this gap, it is suggested that the company facilitate an increased awareness of the disease by declaring an open day. This would increase the exposure the *Care for the Caregivers Programme* and help with increasing knowledge base health service delivery. In other words as infected staff members live longer and stay in the health care system longer, the risk of experiencing a bad outcome as a result of medical errors, and drug side-effects may increase (Internet 23). McCord Hospital should heed this warning and incorporate measures to protect both external and internal patients.

- The successful implementation of any intervention in the workplace is based on extensive planning process, and this is especially relevant in the case of HIV/AIDS programmes where there is little room for error. Given the scale of the epidemic along with issues of social, psychological, emotional and legal sensitivities associated with the virus, it is recommended that an HIV/AIDS committee be established. Such a committee would involve all stakeholders

including representatives from management, human resources and employee representatives. The leader of the current priogramme (Dr K. Uebell) could easily serve as the champion to review the project in its entirety for the purposes of measuring its effectiveness and achievement of goals.

- Encourage VCT among all staff members regardless of race, age, gender or health status. This can be achieved by efforts in promoting openness and decreasing stigmatisation and superstition that surrounds the disease. Furthermore, achieving a baseline measure can be establish prevalence rates, and can therefore assist in determine the programmes success or failure in terms of increasing or decreasing rates of new infection.

- For each intervention, a measurable outcome must be identified and quantified on a regular basis to allow for ongoing planning by identifying successes and failures. A monitoring process is an integral part of the plan and hence necessitates attention. As a rule of thumb, operational parameters need to be measured annually, and feedback from the target population can be carried out every six months to assess the appropriateness of the interventions. Once the measurement system has been structured it needs to be fed into a formal review and planning cycle so that information gained can be acted upon. To complete this process it is vital to involve the HIV committee(Internet 13).

- The widespread use of highly aggressive anti-retroviral treatment for HIV/AIDS has improved patient outcomes, resulting in decreasing mortality, inpatient utilisation and opportunistic infections across the board. As HIV infection continues to shift to a chronic illness, HIV programmes need to focus their attention on strenghthening systems to care to avoid fragmentation in delivery of service, to improve communication throughout the system, and to prevent errors in health service delivery. In other words as infected staff members live longer and stay in the health care system longer, the risk of experiencing a bad outcome as result of medical errors, and drug side-effects may increase (Internet 23). McCord Hospital should heed this warning and incorporate measures to protect both external and internal patients.

- Interestingly the key to treating HIV lies not so much in the provision of anti-retroviral therapy (ART), but in the early diagnosis and the provision of proactive medical care to all employees who are HIV positive. While the use of ART is an essential component in the treatment of patients living with HIV/AIDS. For the programme to be both medically and economically successful the proactive treatment of healthy HIV positive patients should never be ignored.

(Internet 6). 90% of employees with HIV are still healthy in the asymptomatic pre-aids stages- they must not be ignored if we are to effectively manage the risk of HIV/AIDS.

- The lack of prevention efforts is glaring obvious. The importance of such efforts should not be overlooked. With increasing focus on the prevention of treatment, attention has moved away from preventing new contacts. For each new infection a firm's prevention efforts successfully avoid the company saves the costs of that infection, which include lower labour productivity, increased absenteeism, as well as treatment costs. Furthermore premature death results in group life,pension and medical benefits being paid out much earlier than planned adding to the costs of the disease. Studies have shown that the financial benefits of investment in prevention and treatment programmes, will almost ceratinly exceed the costs of such programmes (Internet 22).

6.7. CONCLUSION

Implementing an HIV/AIDS risk management programme is a complex exercise, influenced by a number of financial, social, political and emotional factors. Best-practice strategies have evolved over time as a result of increasing access to better information and there is no doubt that this evolution will continue as the epidemic matures. In order to focus the evolution it is necessary to follow a structured approach and ensure that the adopted plan of action fits in with the organisation.

The common pitfalls to failure have been identified as:

- Not including all stakeholders in the planning process – this makes getting their subsequent buy-in difficult;
- Trying to finalise all the elements of the plan in one session. Some areas maybe best tackled in smaller groups.
- Compiling a plan that cannot be supported by the available budget. Partial implementation can sometimes be worse than no implementation as it discredits the process and those involved, and jeopardises future intervention. Rather structure the plan for a realistic phased implementation with structured outcomes measurement and give feedback on successes achieved; and
- Not including a monitoring and replanning process in the programme to ensure that the stated objectives are achieved.

To avoid this trap of potential pitfalls, it is necessary for McCord Hospital to ensure that it modifies the current programme to ensure lasting results. A review of the prevalence rates and an inclusion of a more realistic figure would ensure an accurate budget allocation. Although it may be viewed as overt pessimism and lack of confidence in employee health status, building in higher prevalence rates would focus management attention and increase awareness of the issues.

Costing activities in terms of decreasing productivity or increasing absenteeism may be difficult to quantify, however costs pertaining to recruitment and training are easier to assess. Attempt should be made to establish a comprehensive report, aimed at removing the subjectivity that surrounds this risk issue, to ensure the presentation of objective data, this allows for meaningful decision making.

Off primary importance is the need for the inclusion of prevention activities into the current programme. It must always be remembered that the majority of the workforce is not infected and every attempt must be made to maintain this situation. Prevention of new infections is an essential component of any workforce HIV/AIDS programme and are best positioned for success when integrated into a total risk management programme.

This bring to the fore the need to integrate support structures into *The Care for the Caregivers Programme.* The need for home based care, psychological and spiritual counselling to be formally integrated into the programme, is highly advantageous. As this encompasses a holistic approach to HIV/AIDS care. McCord Hospital has thus far been eager to adapt to prevailing needs, utilisation of this rare ability would ensure fruition.

It is concluded that the *care for the Caregivers Programme,* is indeed deserving of praise. Fulfilling legislative, social and ethical standards together with the provision of antiretroviral therapy is truly cutting edge. Modifications to counter the identified shortcomings would revive the programme and ensure optimal success rates.

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