

**Corporate Policy on HIV/AIDS Intervention: a policy analysis**

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## ABSTRACT

This study is concerned with corporate policy on HIV/AIDS. This was investigated by speaking to key-informants from fifteen enterprises in KwaZulu Natal. They were asked about their policies and programmes and what they had put in place to combat this epidemic. The rational choice model was used as a framework for analysis of the policies. This model is discussed in the first part of the study and was chosen as it seems to reflect the dominant policy outlook in South Africa and may shape the way that organisations respond.

The second part of the project is the report and discussion of the findings. It is a presentation of the responses given by the key informants regarding their perceptions and understanding of the problem of HIV/AIDS as well as the policies of their companies regarding the same. Most of the companies in the study did not have policies specific to HIV/AIDS. Some had general guidelines and treated HIV/AIDS as any major illness. There seemed to be denial, especially among the management, of the seriousness of the disease despite evidence of its significant impact within the various organisations. There were few to no resources set aside for HIV/AIDS programmes and interventions and this seems important in defining the HIV/AIDS problem as one of the future rather than the present.

In the third part of this project, the theoretical framework and the findings were linked. There was an attempt to answer the question of how rational the policy process is within the companies in the study and whether the responses of these organisations can be understood in the context of the rational choice model. It seems that this model does aid in understanding of the policy process when there is a realisation that it interacts with other human factors to create what we observe.

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## INTRODUCTION

This study uses the rational choice model as the framework for analysis of corporate policy on HIV/AIDS. This particular model is used to try and understand the approach taken by fifteen enterprises in KwaZulu Natal in response to the HIV/AIDS epidemic.

The HIV/AIDS issue is becoming an increasingly important one as it continues to have an impact on, among other aspects of life, the economy and the labour market. It is predicted that labour supply will be affected by an anticipated decline in productivity due to absenteeism- time taken off as sick leave or to attend funeral services. This means that companies will face higher costs associated with factors such as lower productivity, replacement of workers, benefit payments and ensuring occupational health and safety standards. These are some of the effects that the disease will have. "At the end of 1998... in the most hit province, Kwazulu Natal, prevalence rates were as high as 33%. Already, by 1991, locally developed and reliable modelling work had established the potential for a serious HIV epidemic in South Africa." (Schneider and Stein, 2000: 3).

It is clear then that this is an important issue and that it is worthwhile to investigate corporate policy on HIV/AIDS intervention in order to have an idea of what some companies are doing. Also, whether or not the interventions and programmes that are in place are effective and enough is being done to combat this disease or at least to limit its negative effects. It is for this purpose that this study is carried out. Moreover, to place the actions taken by these companies within the context of the rational choice model.

Face to face semi- structured questionnaires were administered to key informants from fifteen purposefully chosen business organisations in and around Pietermaritzburg. The

questionnaire dealt with the understanding of HIV/AIDS as a problem as well as with the policies and guidelines that were in place to deal with the disease. Another question dealt with resources. The key informants were asked whether their companies had set aside any resources for the realisation of their HIV/AIDS policies or interventions. They were also asked whether they thought that their policies were up to the task of keeping their organisations in business in face of the projections of the effects of the disease.

The problem of HIV/AIDS is serious one. The infection rate among the economically active population in South Africa is predicted to peak at 22% in 2006 compared to an estimated peak of around 16% for the total population. (Quattek, Ing Barings, 2000: 13). In light of these projections it is important for business to formulate strategies to cope with this scenario. This study tries to answer the question of what some organisations are doing in this regard. This project is an effort to use the rational choice model to analyse the response of business to the HIV/AIDS epidemic. It tries to point out some of the limits to rationality that these organisations face in their attempts to respond. The model is also taken in conjunction with other human factors such as perception and definition of the problem- cognitive capacity, in trying to understand these responses.



## PART ONE

### 1.0 THEORETICAL FRAMEWORK

“Employers of today find there are an ever increasing number of social burdens placed on them. Although the law does not require an employer to develop a workplace AIDS policy and programme, to do so makes good business sense and makes for good labour relations. It gives a clear message to the workforce that the employer is committed to social issues, enables employees to protect themselves against possible infection, provides the employer with an opportunity to plan for the impact of HIV/AIDS and allows for the minimising of the impact of the epidemic.” (Smart, *AIDS Analysis Africa*, Jun/Jul 1999 pg. 6). “The moralistic overtones of prevention messages and AIDS workers’ rhetoric have an alienating effect, allowing people to deflect the disease onto the Other. Consequently, we see a population that is manifestly *aware* of AIDS - to the point of being bored, dismissive and fatalistic - but that lacks the conceptual tools for effective behavioural and attitudinal changes. (Marais, 2000: 10). It has unfortunately not been the case that availability of and exposure to the information regarding HIV and AIDS has led to rational behaviour on the part of the population. Fredland writes in *AIDS Analysis Africa*. “Cultural values such as fatalism, family responsibility, economic responsibilities, the cultural role of intimacy and traditions, play at least as large a role in AIDS education as do epidemiological considerations. Consequently, policy must be developed and coordinated among donors, whether they be United Nations organs, the Red Cross, or church agencies. And almost never can the message be effectively delivered by a non native to the culture.” (Fredland, 1994: 7).

Policy- making and implementation are complex processes that do not automatically follow a rational model. It makes sense to focus on the rational model because this model of policy making has been sometimes used to illuminate national policy and it may also shape the way that organizations respond to various issues. “ The study of policy indicates the complexity of the policy process. Its elements may be described as an

environmental system from which demands and needs arise and upon which policy seeks to have an effect; a political system in which policy decisions are made; an organizational system through which policy is mediated and executed.” (Barrett and Fudge, 1981: 2). A key question is whether or not the rational model assists in making effective policy or aids us in our understanding of national policy.

The rational model of policy analysis includes as some of its key techniques; cost benefit analysis, economic forecasting and social indicators. “ Although there are quite a few variants on what has been termed *the* model of rational choice....most models of decision making under comprehensive rationality are based on three fundamental assumptions. First, all possible states of the world facing decision - makers can be ranked in regard to desirability. Second, decision- makers know the connection between the strategies they may choose from the desired goals, or evaluated states of the world. Third, decision-makers optimise. That is, they choose the strategy that brings about the largest total amount of satisfaction to them (which is the best state of the world discounted by the cost of the strategies that can be used to bring it about.)” (Jones, 1994: 37, 38). Two other assumptions, according to Jones, seem necessary in most situations. One is that the search for alternatives should be exhaustive. However, this is irrational because such a search would presumably cost more in terms of time and money than the benefits it would yield. A final common assumption is that complex decisions may be broken down into parts without damaging the basic model. In effect, this means maximizing the solutions to the part is the same as maximizing the whole. However, this is not necessarily the case. The relationship between the means of achieving an objective and the desired end are not always that simple in the real world. This is because there is not always *certainty* - the assurance that every means will lead to a specific outcome. There is *risk* and *uncertainty*. Risk is the situation where each strategy leads to one of the number of ends each with a known possibility. Uncertainty is the case where outcomes are known but the probabilities associated with them are not. These factors contribute to the complexity of the means end relationship and maximizing as well.

James G. March, in Rational Choice, says that, "Rational choice involved two kinds of guesses: guesses about future consequences of current actions and guesses about future preferences for those consequences. We try to imagine what will happen in the future as a result of our actions and we try to imagine how we shall evaluate what will happen." (Elster, 1986: 144). "The idea of rationality," Parsons writes, "has been central to the practice of decision making in the post war era. Models of decision making which focus on rationality argue that if we wish to understand the real world of decision, we must consider the extent to which a decision has been the outcome of rational processes." (Parsons, 1995: 273.)

Green and Shapiro in, Pathologies of Rational Choice Theory, in their discussion of the generally accepted assumptions about the nature of rational choice theory state that, "Rational behaviour is typically identified with, 'maximisation of some sort.' They assert that "...rational choice involves *utility maximization*. To say that a person maximises utility is to say that when confronted with an array of options, she picks the one she believes best serves her objectives." They go on to say this, "Rational Choice theorists agree, second, that certain *consistency* requirements must be part of the definition of rationality. These requirements are seen as essential to the science of social action...." (Green and Shapiro, 1994: 14, 15). Another assumption that is made is that, "...each individual maximizes the *expected value* of his own payoff measured on some utility scale." (Luce and Raiffa, 1957: 50). There is a focus on expected rather than actual utility and this is because decision making often takes place under conditions of uncertainty. Green and Shapiro further discuss a fourth assumption that is common among rational choice theorists. This is that, "relative maximising agents are *individuals*." (Green and Shapiro, 1994: 14, 15). The final assumption that is made is that, "...their models apply equally to all persons under study - that decisions, rules and tastes are "stable over time and similar among people." (Stigler and Becker 1977: 76). However, as Goetze and Galderisi note, "If utility functions and perceptions differ widely, and if people have very different combinations of altruistic and self interested motives, then the construction of adequately explanatory models might be frustrated. Patterns of universal behaviour may not [in that case] be discoverable." (Goetze and Galderisi, 1983: 38). This is because

people have different perception, motives and goals and there are always different contexts within which people operate. There is no guarantee of uniformity or predictability.

“In sum,” Green and Shapiro conclude, “rational choice theorists generally agree on an instrumental conception of individual rationality, by reference to which people are thought to maximise their expected utilities in formally predictable ways. In empirical applications, the further assumption is generally shared that rationality is homogenous across the individuals under study.” (Green and Shapiro, 1994: 17).

In Chapter Three of Rational Choice, entitled ‘Advances in Understanding Rational Behaviour,’ John C. Harsanyi writes that, “In everyday life, when we speak of rational behaviour, in most cases, we are thinking of behaviour involving a choice of the best *means* available for achieving a given *end*. This implies that already, at a common sense level, rationality is a normative concept: it points to what we *should* do in order to attain a given end or objective. But even at a common sense level, this concept of rationality does have important positive (non- normative) applications: it is used for *explanation*, for prediction and even for mere *description* of human behaviour. Indeed, the assumption that a given person has acted or will act rationally, often has very considerable explanatory and predictive power because it may imply that we can explain or predict a large number of possibly very complicated facts about his behaviour in terms of a small number of rather simple hypotheses about his goals or objectives.” (Elster, 1986: 83).

As we have seen, cost benefit analysis is a key technique of the rational model. “The problem with the cost benefit analysis model is the same as J.S. Mills had identified in Utilitarianism: not all pains and pleasures are equal. Putting a price on various components of a scheme is not as straight forward as the model suggests...Cost benefit analysis has its problems and limitations, the first of which is that assumptions and values of welfare economics may not be applied to some policy decisions: the prices and costs and utility of ‘good health’ or ‘noise’ or ‘deaths’ may be considered to be matters which are not of the kind which may be easily calculated and measured.” (Parsons, 1995: 400 -

402). Cost benefit analysis, economic analysis and social indicators are all ridden with problems associated with value judgments.

James G. March, in Chapter Six of "Rational Choice" writes, "At first blush pure models of rational choice seem obviously appropriate as guides to intelligent action, but more problematic for predicting behaviour....So long as we use individual choice models to predict the behaviour of relatively large numbers of individuals or organisations, some potential problems are avoided by the familiar advantages of aggregation...On the other hand, if we choose to predict small numbers of individuals or organisations, the saving graces of aggregation are mostly lost." He continues, "Rational choice involves two kinds of guesses....we try to imagine what will happen in the future as a result of our actions and we try to imagine how we shall evaluate what will happen. Neither guess is necessarily easy. Anticipating future consequences of present decisions is often subject to substantial error. Anticipating future preference is always confusing." (Elster, 1996: 143-144). Rational choice theories are concerned with these guesses and the way in which we deal with their complications. Those that focus on choice under uncertainty emphasise the difficulties of determining the consequences of actions taken now. Theories of choice under conflict and ambiguity focus on the difficulties of guessing what will be desired in the future. Some of our ideas about choice behaviour have changed due to idea of bounded rationality.

Bounded rationality is a concept that was developed by Herbert Simon to explain a rationality which is limited but is not 'irrational.' In Chapter Five of "Administrative Behaviour," Herbert Simon clearly lays out a formulation of his position that human rationality is limited or bounded: "It is impossible for the behaviour of a single isolated individual to reach any high degree of rationality. The number of alternatives he must explore is so great. The information he would need to evaluate them so vast that even an approximation to objective reality is hard to conceive. Individual choice takes place in a series of 'givens' - premises that are expected by the subject as bases for his choice; and behaviour is adaptive only within the limits set by these 'givens.'" (Simon, 1957: 79). Simon goes on to say that decision-making by human rationality is also bounded by an



organisational environment which frames the processes of choice and that human beings are limited by their psychological environment.

Parsons, in Public Policy, An Introduction to the theory and practice of policy analysis, says of rational techniques, "...it is important to note that there are no 'facts' out there. Data is not neutral, but it is the result of an exercise of values, beliefs and assumptions. In studying any decision making episode, it is well to remember that the first questions to ask are those that focus on the issues of how, why, when and for whom the data was collected. Rational techniques are only as good as the data which is used." (Parsons, 1995: 399).

As we have seen, rational choice involves two guesses - a guess about uncertain future consequences and a guess about uncertain future preference. Human rationality is limited by the incomplete and fragmented nature of knowledge. "What unites both areas of analysis in and of the policy process is the way in which both have stressed the role of information and knowledge. As a subject, policy analysis has for the most part been shaped by a neo-pluralistic view of the decision making process. Within this model, the role of information is central. Theorists of the policy process focus on the mediation and filtering of ideas and information whilst those in policy analysis for the policy process itself focus on the relationship between information, knowledge and 'better decision making.'" (Parsons, 1995: 428). Parsons goes on to write that, "The use of models and techniques to improve decision making has had mixed fortunes. The inherent messiness of politics militates against the naive belief that decision-making can somehow be made more 'rational.' There are severe limitations on the use of analytical work in real decision making." (Parsons, 1995: 433).

"The model of policy making," Deborah Stone argues in Policy Paradox: The Art of Political Decision Making, "is a production model where policy is created in a fairly orderly sequence of stages, almost as if in an assembly line...The production model fails to capture...the essence of policy making in political communities: the struggle over ideas." (Stone, 1997: 10,11). According to Parsons, it also ignores the idea that there may

be the "...use of analysis to reinforce and legitimate decisions which have already been made rather than to enable decision makers to choose 'rationally' between options. In other words, decision makers make a choice and then find a plausible analytical story which will back it up." (Parsons, 1995:433). Another limitation of rational analysis that has been identified by several analysts is that, "...analysis may be strong on the diagnosis of problems and formulation of policy but weak in terms of how a policy should be implemented." (Parsons, 1995: 433).

In the second edition of Administrative Behaviour, Simon argues that in order to clarify what he means by rationality in organizational decision making, we have to use two models: "economic man and administrative man." (Parsons, 1995: 278). Simon writes, "While economic man maximises - selects the best alternative from all those available to him; his cousin whom we shall call administrative man, satisfices - looks for the course of action that is satisfactory or 'good enough.' Examples of satisficing criteria that are familiar enough to businessmen, if unfamiliar to most economists are 'share of market,' 'adequate profit,' 'fair price.' Economic man deals with the 'real world,' in all its complexity. Administrative man recognises that the world he perceives is a drastically simplified model of...the real world. He is content with this gross simplification because he believes that the real world is mostly empty - that most of the facts of the real world have no real relevance to any particular situation he is facing..." (Simon, 1957: xxv). This means that in making decisions, he takes into account only a few of the factors that he considers crucial and relevant. He simplifies the complex reality so as to make the process easier and more practical.

Parsons writes therefore, "Thus, Simon characterizes decision making by 'administrative man' as operating in a world of bounded rationality and as motivated by satisficing rather than maximising: this means that he makes decisions which are not derived from an examination of all the alternatives. And furthermore, because he sees the world as 'empty' and ignores the inter relatedness of things - complexity - he can make decisions which do not exceed his limited cognitive capacities." (Parsons, 1995: 278, 279). According to Simon, this is a more accurate and realistic picture of reality. We do,

indeed have to recognise the limitations that are faced by individuals and organisations when it comes to rationality. It is difficult or impossible to consider all the options and all the information when making a decision and this is due to limited cognition and constraints of time and money. There is also the distinct possibility that there may be bias in the attitudes of individuals and this means that not only is there an organisational context, but there is a psychological one as well. This is the framework, or background in which decisions are taken.

A possible limitation of rational analysis is exemplified when people have different perceptions of the same problem and when they have motives that may appear to be conflicting. This can be seen, for example when formulating policies regarding HIV/AIDS: policies that will determine the response of organisations, thus affecting their employees. Decisions relating to benefits, training, hiring practice and so on may affect companies which may find themselves torn between humanitarian aspects and business, profit making considerations. Employers may often be caught between their obligation to be or at least to appear to be committed to social issues that affect the larger community and the requirements of the job which ultimately may be profit making. Perhaps the rational model can be understood as the attempt to strike this balance.

Differing perspectives and perceptions may also pose difficulty in the approach to problem solving. Individuals may perceive various issues as being key and warranting immediate attention whereas others may perceive of the same issue as probably warranting attention, not at the present moment but in the future. Human perception may be clouded by numerous factors, some of which may be purely personal, for example when they are influenced by deep seated opinions, values, or when individuals have a personal stake in the eventual outcomes of the decisions that they make. Parsons writes, "Is it really possible for decision makers to make a calculation with regard to the outcomes of policies? In the real world of decision making, actors do not confront organisations devoid of values, prejudices, history, culture and experiences." (Parsons, 1995: 279).



Kingdon, in Agendas, Alternatives and Public Policies, writes, "The values one brings to an observation play a substantial role in problem definition. A mismatch between the observed conditions and one's conception of an ideal state becomes a problem." (Kingdon, 1995: 110). Thus, perception is important, as well as problem definition. An individual, who is in a position to influence policy relating to health, pollution, transport and so on, may be affected by his personal experiences. Kingdon writes, "Sometimes, subjects become prominent agenda items partly because important policy makers have personal experiences that bring the subject to their attention." This is an important factor in understanding problem definition - the psychological context that may cloud rational decision-making.

Predicting future consequences is another problem of rationality that we have discussed. This problem is related to the fact that available knowledge is limited or fragmented and that often it is necessary to rely on valuations and projected estimates because future estimates cannot really be known. An example is that it is perhaps more difficult to estimate the number of people that may be affected by an epidemic or a particular health crisis because unlike in some other policy area, health disasters often occur gradually and often over a prolonged period of time. Perhaps also, there is the question of visibility where the people are affected patient by patient rather than simultaneously in large numbers. Kingdon writes, "The basic unit in health is the patient provider exchange. When something goes wrong, it does not show up in a major crisis. If there is to be a crisis scale impact, it must occur in a series of minute changes, patient by patient and eventually build to a problem of major proportions, or the individual cases must be aggregated into a study or statistic that proves to be compelling." (Kingdon, 1995: 95, 96).

We see therefore that this is an area where rational analysis may be difficult to carry out due to insufficient information. Prediction may not be as accurate as desired. This is the case where we find different 'experts' coming up with a wide range of predictions and estimates; statistics that sometimes further confuse issues rather than illuminate them. Herbert Simon believes that some arrangements are 'better' than others for attaining a

more rational decision making process. "When an issue becomes highly controversial - when it is surrounded by uncertainty and conflicting values - then expertise is very hard to come by, and it is no longer easy to legitimate the experts. In these circumstances, we find that there are experts for the affirmative and experts for the negative. We cannot settle such issues by turning them over to particular groups of experts. At best, we may convert the controversy into an adversary proceeding in which we, the laymen, listen to the experts but have to judge between them." (Simon, 1983: 197). This ties in to the issue of information which is an important prerequisite if rational analysis is to be done.

The notion of rationality being limited by an individual's psychological, political, social environment is key to the understanding of decision making. It is important to ask where information comes from and what processes of legitimating information sources are in place to ensure credibility. Hein Marais, in AIDS Review 2000, says for example, of the South African government's response to HIV/AIDS, "The decisions, actions and omissions that shaped the....response...were also influenced by a mix of other factors, among them political concerns, the inevitable imprints of the society's history of racism (and on going racism) and the personal sensitivities of high ranking politicians. An inquiry....has to also venture into the thicket of intersections between the political, social and personal domains."(Marais, 2000: 44). Therefore, opinions or policies that may appear to be inconsistent and incompatible with existing, accepted and established facts may have to be analysed bearing the mentioned factors in mind.

As we have already mentioned, in some cases decision- makers seek out information or use analysis as a tool to reinforce decisions already made, rather than as a guide for choosing rationally between alternative courses of action. Thus, it is worth bearing in mind that rational techniques are reliant on sufficient, accurate and unbiased data and this is problematic considering that human beings operate within an environment where there is so much conflicting information which clouds or biases perceptions. Simon, in his discussion of administrative man, paints quite a useful picture of the way that he 'satisfices' and takes account of only the facts he considers relevant to him at the moment in a necessary simplification of reality, thus preventing or minimising conflict during

analysis. This would seem useful in decision making and appears to be a more realistic approach to both the analysis and understanding of decision making.

As we have seen above, individual perception and understanding has an influence on problem definition. In addition, there may be more than one motive and this may create a conflict as it frames decision-making. An example is with environmental policy - there may be a conflict between economic development and pollution. Where industries are taxed for the pollution emitted into the environment, or where they have to dispose of their waste safely but expensively, policy makers may have to perform a difficult juggling act to strike a balance between industrial or business interests and the concerns of environmentalists. We can take this illustration a step further as it emerges that there is often a clash between different policy areas which at the end of the day may have similar motives or goals. Because it is difficult or impossible to please everyone, policy making may draw from the rational model but perhaps may have to bear other considerations in mind and perhaps compromise will be necessary. As we have seen, there is always politics at play in the policy cycle and individuals, as well as organizations often have to consider the opinions of interest groups, environmental lobbyists, AIDS activists and so on. Different pressures come to bear on the policy process.

Taking all these factors into consideration, it is clear that the policy process is complex and numerous factors come into play. The rational model which has been described as an 'individual choice model,' may be advantageous in cases where there is no attempt to find a uniform explanation through aggregation. Prediction becomes a problem where various individuals and organisations behave in ways that seem inconsistent and unrelated. This means that whereas the rational model may be a useful guide for action, other factors that influence the policy process may make prediction and generalization difficult as each case is unique.

The different problems and difficulties encountered in an attempt to make decision making rational have led to certain changes in the model that allow for other influences. As we have discussed, Simon's model of bounded rationality is one such model and it

seems to paint a more realistic picture of the policy process. In this regard, therefore, it enables a greater understanding. In the face of overwhelming information, options, causes and consequences, individuals make their choices based on simplified versions of reality. This seems plausible when we compare it with our own patterns of decision and action on a daily basis. It simplifies by leaving out what is defined as irrelevant and includes only what is considered crucial and relevant - and this may vary from case to case. A universal explanation may be difficult to provide. It is important then, if we are to understand the policy process, to consider the particular context and to try and uncover the hidden dynamics that may be at work and are likely to influence the process. Although it seems that pure rationality is a very ambitious model that may be somewhat impossible to achieve, it is no doubt useful in understanding various aspects of the policy process. This is especially so when we consider its limitations and the fact that 'bounded' rationality is a more realistic model if we are to enlighten ourselves about various issues and processes.

"To understand actions and responses, we need to look at the group of actions involved, the agencies within which they operate and the factors which influence their behaviour. We need to consider actors and agencies not just in single roles as the makers of policy for others to implement or the implementers of someone else's policy ...but in a combination of roles including a third, that of interested parties affected by the outcomes of policy made and implemented by themselves or others." (Barrett and Fudge, 1981: 26).

The top down rational system of implementation was the first model on the scene and brought to an end the neglect of the politics of implementation. The original study by Pressman and Wildavsky set out an essentially 'top - down' view of implementation. Effective implementation, they argued, required a good chain of command and a capacity to coordinate and control. Pressman and Wildavsky describe implementation as, "a process of interaction between the setting of goals and actions geared to achieve them...The rational model is imbued with ideas that implementation is about getting people to do what they are told and keeping control over a sequence of stages in a system

and about the development of a programme of control which minimises conflict and deviation from the initial 'policy hypothesis.' (Pressman and Wildavsky, 1973:xiii, xv). They further argue that "...implementation will become less and less effective as the links between all the various agencies involved in carrying out a policy form an 'implementation deficit.' Goals have to be clearly defined and understood, resources made available, the chain of command be capable of assembling and controlling resources and the system able to communicate effectively and control those organisations or individuals involved in the performance of tasks." (Parsons, 1995: 464).

A limitation of rational analysis that has been identified by several analysts is that it is strong on the diagnosis of problems but weak in terms of how a policy should be implemented. Perhaps this is due to the fact that as Lindblom and Cohen, in Usable Knowledge, have argued, "Information and analysis provide only one route among several to social problem solving because...problem solving is and ought to be accomplished through various forms of social interaction that substitute action for thought, understanding or analysis....ordinary knowledge and causal analysis are often sufficient or better for social problem solving." (Lindblom and Cohen, 1979: 10). "Policy analysis since the 1950's has however, as Parsons writes, "...been dominated by the rational 'information' model. Our age has been one which has seen quite a phenomenal increase in information and in our capacity to store and process this information. Policy analysis with its variety of 'qualitative' and 'quantitative' approaches has been one response to the knowledge revolution. The use of computers has also been seen as a powerful technological answer to the quest for more rational decision making." (Parsons 1995: 428). This idea has been the inspiration behind the development of policy analysis in the post war era.

We must note however that in the final analysis, it is policy makers who must carry out the finer details of policy analysis and implementation. Computers cannot solve the problems of ineffective management and government. There are many factors which have to work in conjunction with technological advancements. "Among these factors must be included political will and judgement and the relationship between the structures of

decision making and the behaviour of politicians, bureaucrats and professionals involved in a policy or programme.” (Reinermann, 1987: 186). Implementation is more likely to be successful when a programme enjoys a high degree of political support. One of the most commonly voiced criticisms of the South African government’s AIDS programme is that it was not buttressed by sufficient political commitment. Hein Marais writes in AIDS Review 2000, To The Edge, “Assuming that sufficient political commitment indeed was lacking (at least until 1998), one can ask whether adequate commitment would have translated into an effective AIDS programme. The query resists a definitive answer. It has been argued that...political will was not the single factor shaping the efficacy of the...response. Indeed, excessive emphasis on political commitment leads one to the idea that anything becomes possible as long as it is impelled by sufficient will. A more troubling question should be posed: Would a constant stream of pronouncements and exhortations have pierced the shroud of invisibility surrounding HIV and AIDS? Perhaps the answer is revealed by posing an inverse but rhetorical question: Has the disease been combated anywhere effectively without steadfast and persistently expressed political commitment? The response has to be ‘no.’ Political commitment seems to be an essential, but in itself insufficient factor in an effective bid to manage the disease.” (Marais, 2000: 27, 28).

Schneider and Stein, in Implementing AIDS policy in post apartheid South Africa, argue that, “Lack of political will or commitment is a common reason given, by both internal actors and external observers for the difficulty of implementing AIDS policy in South Africa. Political commitment is taken to mean a number of things including personal identification with AIDS cause by influential politicians...and willingness on their part to mobilise adequate resources and to ‘fast track’ implementation.” (Schneider and Stein, 2000: 9). It does not mean, however, that political commitment will remove implementation difficulties experienced by the government. There is an assumption that for major policy change to occur there has to be action taken by political leaders. This takes it for granted that there are resources such as capital and that there is institutional capacity as well as stability. This is a rational model which is not always easy to find in reality.



The rational model is to a certain extent useful for understanding the policy process. It does have its merits but there are certainly various factors that could be considered in an attempt to improve the rationality of the process as a whole. It is important to base decisions not on a single case, but on numerous ones. This is useful as it reduces the chances of bias and inaccuracy and improves the chances that prediction will be more accurate and reliable, based on averages. It is also worth making sure that decisions are thought through before implementing them because each case, while possibly modelled on another, is unique. It is also important to ensure that in a group context, individuals feel free to express opinions that run counter to accepted wisdom. Evidence that may be 'controversial' or unconventional, and may challenge existing data may also be worth looking into. As we have seen, it is also important to have experts especially when carrying out cost benefit analysis and impact assessment tests. It is crucial to have a grasp of elementary statistics.

With all these factors in mind, the question arises of whether or not the rational model as we know it aids in understanding the policy process. We have mentioned already ways in which this model can give an insight into the policy process especially so the model of bounded rationality. Therefore, it seems that the rational model must be studied or applied within a certain context, based on each unique case. It is important to realize that rationality is indeed bounded by difference in perceptions and problem definition, differences in opinion regarding what is and is not relevant, difference in priority, conflicting interests, and other factors that interact and impact on the process.

As we have seen, another important factor is capacity - institutional, political - in the policy process. This seems to be an assumption of the model. In the concluding remarks of, Pathologies of Rational Choice Theory, by Green and Shapiro, we read, "If social science were viewed less as a prizefight between competing theoretical perspectives, only one of which may prevail, and more of a joint venture in which explanations condition and augment one another, the partisan impulses that give rise to methodologically deficient research may be held in check. The question will change from 'Whether or not

rational theory?' to something more fruitful: 'How does rationality interact with other facets of human nature and organization to produce the politics that we seek to understand?'" (Green and Shapiro, 1994: 204). This is indeed an important question. It seems clear that there are numerous factors that should be taken into consideration when analysing the processes of policy making and implementation. Human beings are dynamic social and political creatures and there is an organizational context too that may impact on these processes in their attempt to achieve rationality. Perhaps the rational model is more useful when it is seen as an ideal upon which other factors come into play, thus modifying it. Green and Shapiro, in their response to one of the counter arguments that may be advanced in response to their critique of the rational choice theory, write that, "In practice, few rational choice theorists who tangle with empirical questions in a serious way are pure universalists." (Green and Shapiro, 1994: 192). There is instead, a commitment to other types of rationality - segmented universalism, partial universalism or the family-of-theories view. Proponents of segmented universalism contend that rational choice theory is only successful in certain areas of politics. Partial universalists are of the opinion that rational choice explains some and not all behaviour in all situations. Thus, they leave open just how much is explained by the maximisation of interests. Those who defend the family-of-theories, as the name suggests, feel that there is not one rational choice theory and that different ones generate quite different predictions. This is because each model relies on competing assumptions.

The point that rationality interacts with other factors is important and it does seem to create a better understanding of the policy process. An example is at the implementation stage. We have already noted that the rational top down approach of implementation assumes a number of factors about the context. In his book, Limits to Administration, Christopher Hood (1976) set out five conditions for perfect implementation. One is that ideal implementation is a product of unitary 'army' like organization, with clear lines of authority. Thus, there is a clear hierarchy with a clear and a good chain of command. Secondly, that norms would be enforced and objectives given. People should know what they are doing and what they are required to achieve. Their activities should also conform to certain standards and expectations. The third condition is that people would do what



they are told and asked. This means that people will follow orders and there will be no dissent. This is to ensure objectives are met and that things run smoothly. Fourthly, that there should be perfect communication in and between units of organization. This is related to the clear lines of command and the clear understanding of objectives. People should know exactly what is expected of them and they should understand what it is that are supposed to achieve. This is only possible where there is effective communication. The final condition is that there would be no pressure of time. This means that there is sufficient time available to do what is to be done. This will ensure there is effective and systematic implementation of policy. Thus, according to this model of implementation, "where implementation has failed - that is, a policy objective has not been met - it may be said to be due to factors such as the selection of the wrong 'machinery' or 'instruments;' the programming of the bureaucracy was incorrect; operationalization was poor; something went wrong at the 'shop floor level' or there was a poor response to problems." (Dunshire 1990: 15).

However, policy makers should realize that policy is best implemented by what Elmore (1985) termed as backward mapping of problems and policy which involves defining success in human or behavioural terms rather than as a completion of a 'hypothesis.'

Forward mapping - or the top down approach is difficult to maintain and may not be effective where the context is not right. It does not take a sufficient or realistic account of the role of actors in the process of implementation. Human beings are not simply machines in a line of command and they often bring to the policy process their own interpretations and perception. Thus, the relationship between policy makers and deliverers is more complex than this approach suggests.

Therefore, implementation takes place, or is carried out within a certain context and conditions may not necessarily be as perfect and ideal as stipulated in the rational model. Thus, implementation difficulties in particular instances may not be fully understood using this framework, for example where the institutional context does not facilitate action or encourage problem solving. Here, we may possibly return to the example of priorities, or indeed capacity. There is a need for functional organisations and

management systems as well as an enabling social, political and economic context with skilled and committed personnel. In the absence of this type of enabling environment, it becomes difficult to adapt the rational model in formulating effective policy as well as implementing it. However, perhaps it could aid in the understanding of national policy when the context is taken into consideration and reality is compared with what would be ideal: that is, if rationality is used as a frame of reference, a kind of point of departure.

Perhaps it is true to say that perfect rationality may be an ideal that is impossible to put into practice. There needs to be creativity and a mixture of various strategies depending on the context. Even if perfect rationality may be unachievable, perhaps if a committed effort were made to really understand the problem and explore alternatives the policy process would be a more efficient one.

Whatever the case, perfect rationality seems to be an ideal that could be useful in the policy process if taken as such and if there is a realisation that human actors interact with rationality to create what we observe in politics.

## **PART TWO**

### **2.0 STUDY FINDINGS AND DISCUSSION**

This study was carried out in the province of Kwazulu- Natal. A semi- structured questionnaire was administered face to face to respondents from fifteen companies. The questionnaire dealt with HIV/AIDS policy. Respondents were asked about their understanding of the issues surrounding HIV/AIDS and what they were doing about them- their policies, programmes and interventions.

Purposive sampling was used because it was feasible. The companies that participated in this study were purposefully chosen to reflect enterprises that differ both in scale of employment and type of activity. Where there was unwillingness by a certain company to participate, it was easy to choose another one as long as there was some variation in the sample.

According to the Department of Trade and Industry's White Paper on National Strategy for the Development and Promotion of Small Businesses in South Africa, 1995, small enterprises constitute the bulk of established business with employment ranging from 5 to about 50. These businesses are likely to operate from business or industrial premises, be tax registered and meet other formal registration requirements. The classification in terms of assets and turnover is difficult, given the wide differences in various business sectors like retailing, manufacturing, professional services and construction. Medium enterprises constitute a category difficult to demarcate vis-à-vis the 'small' and 'big' categories. The employment of 200 and capital assets (excluding property) of about R 5 million are often seen as the upper limit. Table 1 below is ordered in terms of scale of employment.

**Table 1: Company Activities, Number of Employees and Average Age**

COMPANY	TYPE OF ACTIVITY	TOTAL OF EMPLOYEES	TOTAL OF MALES	TOTAL OF FEMALES	AVERAGE AGES
A	Shipping Company	1542	1141 (74%)	401 (26%)	35-40
E	Aluminium Plant	1400	1384 (98.9%)	16 (1.1%)	36
J	Water Management	1200	850 (70.8%)	350 (29.2%)	45
D	Newspaper Company	983-1080	735 (74.8%)	248 (25.2%)	32-36
K	Wax and Oil Byproducts	500	125 (25%)	375 (75%)	25-30
B	Manufacture Brake Pads	477	459 (96.2%)	18 (3.8%)	36
H	Chemical Plant	300-320	287 (95.7%)	13 (4.3%)	30-35
G	Packaging Plant	309	299 (96.8%)	10 (3.2%)	30
F	Manufacture Chip Board	212	202 (95.3%)	10 (4.7%)	28-32
N	Supermarket	145-205	93 (64.1%)	52 (35.9%)	30-35
I	Retailers	70-150	23 (32.9%)	47 (67.1%)	32
L	Manufacture Animal Feed	90	77 (85.6%)	13 (14.4%)	46
M	Maize Mill	78	67 (85.9%)	11 (14.1%)	35-40
O	Retailers	48	25 (52.1%)	23 (47.9%)	32
C	Social Issues	24	13 (54.2%)	11 (45.8%)	40

Note: Where there are two values for number of employees, this represents occasional casual labourers.

The table shows that eight companies employ over 300, four of which have over 1000 employees and can be considered to be large enterprises. Three companies employ between 100 and 212 people and can be described as middle size companies. The

remaining four companies are small enterprises employing between 24 and 90 people each.

Kinds of activities and age vary as well. Different business sectors are represented and these include food manufacturing and retailing to chemical and metal processing. Other enterprises range from the packaging and water management to the shipping industry. The gender composition of the workforce is influenced by the company's activity. The shipping company and the processing plants overwhelmingly employ males whereas retailers had a higher proportion of females. "In the developing world, slightly more women than men are infected." (Quattek, 1999: 2). The average ages of the employees, ranged from 25-46 years of age. This is an interesting demographic as "the disease is found mainly in two specific age groups, infants and adults between 20 and 40 years of age." (Quattek, 1999: 2).

### ***2.1 Company Policy on HIV/AIDS***

The Key Informants were initially intended to include Chief Executive Officers and Senior Management. The basis of the selection was that the Key Informant was required to have a knowledge and grasp of company policy regarding HIV/AIDS as well as matters relating to resource allocation. However, these individuals invariably referred the matter to the Human Resources Manager. There was only a basic knowledge by senior management of what HIV/AIDS policy and/or practice entailed. For the companies that had clinics on site, the nurse was mentioned as a person who was intimately involved with the company's HIV/AIDS strategy. However, for a wider view of the issues, it was important to speak to someone in management who may be in a better position to answer questions relating to policies including hiring, training and benefits. Thus, the Key Informants were usually the Human Resources Managers of the companies. In addition, a few other opinions were sought from some clinic staff.

The respondents recognized that HIV/AIDS was a problem. There was also the feeling from the Key Informants that HIV/AIDS had had an impact on their companies. The impact had been felt differently in the various companies when, for example there had

been HIV/AIDS related deaths. There was also a financial impact reported by some of the respondents. This came from training people who passed away due to the illness. Also, from having to retrain people to replace them without the guarantee that the same thing would not happen.

In light of the impact of HIV/AIDS on companies, the respondents were asked if the companies that they represented had any policy on HIV/AIDS. Of the fifteen respondents only four stated that the companies they represented had any such policy. One additional company had a draft policy. KI-F reported that the policy had been in existence for about two months. KI-H said that the company he represented had formulated a policy just over a year ago. KI-L's company had had a policy for two years and the company which had had a policy in effect for the longest time- nine years – was represented by KI-J. The respondents were asked about whom helped them to develop their policies. Key Informants D and F reported that their policies had come down from their head offices. The latter said that it had come from the Group Risk Manager. Key Informants J and L mentioned that they had had assistance from people from the medical profession. Medical consultants and Occupational Health Nurses had been involved. KI-H said that the policy was developed within the company and ideas were borrowed from what other companies were doing. Some organisations that were mentioned that were also consulted were ACTS (Association of Catholic Tertiary Students) and ATICC (AIDS Training Information and Counselling Centre).

### **2.1.1 How Extensive is the Policy?**

All the policies but one- from company J- were not very extensive. They were rather brief and basic covering issues that were discussed in general guidelines for employment practice. They basically assured that an HIV positive employee will be treated as any other and that pre employment testing will not be required. All employees would have access to agreed company benefits. There would also be a confidentiality guarantee regarding the HIV status of employees.



One of the documents seemed vague when it came to the question of pre employment testing. It stated that, "Discrimination against persons applying for advertised positions on the basis of HIV status is illegal. Pre employment medical examinations will take place to ensure that the person is fit for the job in question." It is simply one statement followed by another and there does not seem to be a clear stand on the issue. The policies also did not specify important measures such as ongoing education and reeducation campaigns. Also, there is no mention of the resources that will be allocated towards realising the policies. Moreover, they make no mention, for example of recognition of and sensitivity to the employees' different religious, political and cultural beliefs. These are important aspects because they may influence perception and understanding of HIV/AIDS and related issues.

### **2.1.2 The Companies without Policy specific to HIV/AIDS**

The other eleven informants reported that their companies did not have policies specific to HIV/AIDS. A common response was that the policies they had were wide reaching and not specific. There were a few general sweeping remarks made about the importance of policy even among those who did not have any, thus,

"Policies are important...implementation is important...there will be future consequences." (KI-A)

Despite this statement, little was being done by way of trying to develop a policy or putting any meaningful interventions in place. The Key Informant (A) who made this statement is an individual who worked in a shipping company and had stated that the disease is going to escalate especially because of the nature of the work - people were at sea for months on end. He stated too that testing was compulsory according to the law for 'transport people.' When he was asked about what he would expect if employees became too sick to work, he replied,

"We would help them... We can only aim for those that are negative and care for those that are positive." (KI-A)

This is a rather vague response and it characterised many of the responses of the key informants so much so that it seemed as though there was a lot of tokenism and no clear explanation of what plan there was for a meaningful response to HIV/AIDS. The fact that this key informant stated that policy and implementation were important did not translate into a practical approach to the problem, even if he thought that his company would be particularly affected by the epidemic.

Others said that there were general guidelines and that AIDS was treated like any other major illness. Some used the Code of Good Practice or the Employment Equity Act as guidelines. KI-K reported that the company that he worked for used the Code of Good Practice. This came from an initiative at an October 1995 Durban conference organized by AIDS Legal Network. This document was intended to be a guideline and a quote from it reads, "Employers, employees and organisations are encouraged to develop and refine the principles in the code into detailed HIV/AIDS policies and programmes that are suited to the character of each particular workplace." This had clearly not been done by the company that KI-K represented. Another respondent reported that all practice was consistent with what was laid down in the Employment Equity Act.

The definition of HIV/AIDS as any other disease was evident. Many of the respondents reported that although there was no policy specific to dealing with this particular disease, it fell under the framework of general health policy and it was treated as any other major illness. However, it is clear that HIV/AIDS is not like any other illness. Besides the fact that it is a disease to which a lot of social stigma is attached, it is a disease that could and is having potentially devastating effects not only in small communities but to entire economies as well. Therefore, it may not be enough to place the response to this disease within general health policy. Although many of the respondents said HIV/AIDS was treated as any other major illness, there was some inconsistency as some stated that HIV/AIDS should be treated differently. An informant, who represented a company that had no policy, felt that an important issue that had to be addressed was that of equity of benefits. She felt that it was expensive to manage a person from the sick stage, to



sheltering them. She felt that it was not fair for people with HIV/AIDS to get the same benefits as other employees. She said,

“All the people who are dying are young people who have given a relatively short service. We need to work out their benefits in a different way because it does not seem fair that they will be treated the same as people who have been here for a longer time. There does not seem to be equity of benefits. This will also affect profit margins and affordability in the long run.” (KI-B)

There was a common response that was given that summed up the guidelines that were used. These included a no testing policy, no discrimination in hiring or training, accessibility to counselling and provision of education. Sick and other benefits were dealt with as with other major illness. However, these guidelines were often vague and they often did not address issues of importance. One informant felt strongly that there was a need for policy that the management was ignoring. She felt that there was a need to have a systematic way to deal with an employee who fell ill and could not continue to work,

“There should be something official to inform us of how to deal with financial needs and provisions, pension... death benefits and whether they would cover HIV/AIDS. Also, how would it be handled if someone needed more time after they have exhausted their sick leave... if someone's spouse or child was sick... do you consider this in the policy as well? What about the question of taking time off to attend funerals. Is there a limit?” (KI-C)

These were some of the issues that she felt should be addressed by her company which did not even have a policy. She also felt that basic information was required and so was the access to condoms and information leaflets.

The respondents were aware that involuntary HIV/AIDS testing was prohibited by the law. Also, that confidentiality of status was supposed to be, if desired by an individual, guaranteed by the company. The absence of policy not only makes it difficult to act when confronted with related issues in the workplace. There is clearly a need for policy to guide and inform action. Besides this, lack of policy increases the chances that there will

be discrimination and inconsistency when dealing with issues. In the absence of policies that are specific and suited for the particular company's needs, individuals can make their own rules and implement them as they see fit. Thus, although all of the Key Informants stated that there was no discrimination on the basis of HIV/AIDS status, in practice, this was not always the case. According to National Policy, there are supposed to be no marks on an employee's medical report that indicate HIV status. However, an informant from a company with no policy pointed to a possible loophole in the system especially where there was a company clinic or doctor. She said,

“If a person goes to the company clinic and it is suspected that he/she is infected, he/she is referred to the company doctor. When the medical report comes back, even if it does not specify HIV/AIDS, we know because of the way it is phrased, whether the person is HIV positive.”(KI-D)

The fact that there was a mechanism in place to find out secretly, whether or not an employee was HIV positive, begs the question of for what purpose this information was used. This is a company that had little by way of interventions and it was clear that there were no structures in place to deal with employees who were HIV positive.

Other informants felt that the absence of a policy seemed to propagate a certain amount of complacency. Various reasons were given for this and they were expressed explicitly as well as with some speculation. One respondent clearly stated that there was discrimination that stemmed from a perception about those affected by the disease. The deaths were occurring only among unskilled workers. A comment made by one black respondent was thus,

“It is mostly black workers who are affected by the disease... they are seen to be easily replaceable... I think that if it was white people who were infected, something more would be done.” (KI-E)

Some respondents, including KI's G and K, did not have clear responses when they were asked about what measures they would take if an employer became too sick to work. They answered that they dealt with individuals on a case by case basis. In the absence of

a policy framework to inform decisions of this nature, there may be room for subjectivity and an inconsistent response.

There is room to deal with the workers on a case by case basis which means that if someone is known to be a steady and consistent worker and generally has a good reputation, this is considered before any action is taken. (KI-K)

This hardly seems like an impartial way to deal with an individual who has become too ill to work. Thus, it seems that in the absence of policy, there are situations that may arise that may not be dealt with efficiently and fairly.

## ***2.2 Company Understanding of HIV/AIDS and the challenges posed to their organization***

Although most of those interviewed reported that there was no HIV/AIDS policy in their companies, key informants said that they were 'concerned' or 'very concerned' about issues related to HIV/AIDS in the workplace. Commonly AIDS was regarded to be an important issue nationally and by projection, something that would affect companies although this impact was seen to be largely in the long term. The attitudes of the key informants seemed coloured more by their race than their gender. In general terms, black respondents felt that not enough was being done while white and Indian respondents felt that the HIV/AIDS problem was a personal health issue and more importantly a cultural one.

### **2.2.1 The Problem of HIV/AIDS (Is HIV/AIDS recognised as a problem?)**

Despite the fact that most of the companies in the study did not have policies regarding HIV/AIDS, the disease was seen as a serious issue. Some companies had already begun to feel the impact of the disease and had been made more aware of its immediacy by several recent deaths.

"The problem is bigger than we think. I am not aware of the status of each and every individual on site but there have been quite a number of deaths." (KI-F)

"It is a problem but it is hard to paint a realistic picture. We cannot be sure of the exact statistics but we know that since 1994, we have had 29 AIDS related deaths. (KI - E)

" People ignore it but it is going to have a definite effect... for people at sea especially, it is going to escalate." (KI - A)

For some, the company's physical location aggravated and contributed to the scale of the problem.

"I believe that we have a higher than average occurrence of AIDS as there was a trucking company next door to us. The employees from here and those from next door frequently interacted at a social level." (KI-B)

Management denial of the problem is manifest in several ways. Sometimes it is explicit. Attempts over three years to get the company to develop and implement a policy, in one instance, has met with consistent management denial about the possible impact of HIV/AIDS on the workforce. As she put it,

"There is denial that AIDS could affect the organization. I have been trying for the last three years to get management to consider formulating and effecting an HIV/AIDS policy... but nothing." (KI - C)

At other times, the denial is more concealed as company management tries to place the problem in a broader occupational health context. Thus,

"It is difficult for us to tell who is infected because this area was formally marshy and so the workers are exposed to damp conditions especially when they work the night shift. We do not know whether some of the symptoms we see relate to this or to HIV/AIDS. The doctor has sent alarm bells ringing to management but we just do not know." (KI - E)

Ignorance also emerged in the course of the interviews:

'It is a problem because the window period is about ten years. We just do not know enough. (KI-G)

Ignorance about the disease was also revealed when one informant externalised the issue,

"We should not discriminate because we should know better but that is not always how it is. This is not a race or a gay issue. Everyone who is promiscuous is vulnerable. Unfortunately, there is a stigma and we really do need acceptance. I think that this would go some way in dealing with the problem" (KI-N)

Whereas there is a plea for acceptance and an attempt to move from the stereotype of the infected individual, this informant showed that she was not sufficiently aware of the facts herself. HIV/AIDS does not only affect people who are promiscuous and this is an attitude that projects the disease onto the 'other.' The situation will not be effectively dealt with if this is the attitude.

Many of the respondents reported that they were aware of the impact of the disease because of the problems of weight loss, absenteeism and death of the employees. KI-H felt that it was a problem for the company because there was increased absenteeism and people were falling ill. The workforce was affected. Another respondent felt that the company would have felt the impact of the illness but for a mistake by the personnel department. He said,

"It would have been a bigger problem than it is at present but because personnel made a mistake and hired too many people who all signed contracts, the impact of AIDS related deaths is not being felt." (KI-K)

If the problem is defined in these terms, perhaps there will be a justification for non-response. In this case, the company does not feel the impact of the disease because of a mistake by the personnel department. This begs the question of whether or not the company has a social responsibility to act even when the impact has not yet been felt. There was awareness in this company that the employees were affected but the complacency stemmed from the fact that the labour was still available.



Most of the respondents reported at least one death a year for the past three years. Key Informant M reported five deaths in the last three years from a company with a total of 78 employees. KI-E who stated that the company had been 'hit hard' said that there had been 29 AIDS related deaths since 1994. Key Informant K reported five deaths in the year 2000 and said that there was a 30% infection rate. KI-G, from a company employing 309 employees reported two deaths in the past two years. She also stated that six more were positive and that twenty- eight others were suspected to be the same.

This understanding of HIV/AIDS as simply a problem of deaths among employees seems to be a very limited understanding. If HIV/AIDS related deaths are not recorded by the company, then it is possible for HIV/AIDS not to be defined as a problem. However, this is dangerous because the disease may be invisible, depending on the stage of infection. This means that companies may be feeling a false sense of security and they may not be acting to protect themselves from future consequences. There seemed to be a feeling that the problem was not immediate, even where there were deaths. Perhaps this is linked to the question of who was affected most and how valuable they were considered to be by the company.

There was also some misunderstanding in this area. One of the respondents who did not feel that HIV/AIDS was not an immediate problem for the employees in her company felt that age profile of employees was seen to act against any negative impact. She reported that the average age of the employees in her company was about 46 years, which she felt meant that they were not particularly vulnerable to the disease as she associated it with younger people. This was despite the fact that most employees worked in the factory in shifts often working irregular and unsociable hours. She said, for example, that they worked from two o'clock in the afternoon to ten o'clock at night, and were unable to return home at the end of their day. Ironically, she noted that the fact that they were forced to stay away from home meant that STIs were common among staff. This seems to indicate confusion between HIV and AIDS. The fact that STIs were common among the employees means that they had definitely exposed themselves to a risk of contracting

HIV/AIDS and so they were, contrary to the perceptions of the respondent, vulnerable to the disease.

The question of who is infected is an important question because it may help to clarify the attitudes of some of the respondents that the disease is not an immediate problem, even in the face of multiple deaths. There were reports that management was not always in tune with the Key Informants. This is a very important aspect as one of the Key Informants (KI-L) pointed out that the branch manager of the company that she represented was a great believer that the employees were the company's greatest asset and their welfare was of paramount importance. There was concern expressed about his impending departure. Thus, it is important to note that even where there is understanding and recognition of the issues, this does not always filter down to all the employees in the company.

Key Informant C stated that there was an attitude of 'us' and 'them,' where the former referred to the organisation and the latter the larger community. The company employed a small number of people and was concerned with issues of social action. Thus, there was the feeling that it was people in the greater community who were affected and not the employees themselves. This again is an externalization of the problem and it does reveal ignorance about the nature of the disease.

There was also a feeling by a number of the interviewees that where there was no sense of urgency, it was due to the fact that the disease was seen as a 'black versus white' issue. KI-E felt, for example that,

"There have been about 5 deaths each year since 1994 and these have all been AIDS related. This should be enough to set alarm bells ringing. I think that the reason that nothing major has been done so far is because most of the people who are infected are black... there is an anti black attitude even from the company clinic." (KI-E)

There was a feeling from this African Key Informant that the issue would be addressed with a greater sense of urgency if the demographics were different. About 50% of the workforce of 1400 employees in this chemical plant comprised Africans.

Although another respondent was rather less committed in her response she seemed to feel that there were some sections of management that felt that the HIV/AIDS issue was a race issue. She mentioned that this attitude was there among some people in top positions. She herself was white.

“There are some mumblings from management that this disease affects black people but we ignore these attitudes... they feel that HIV/AIDS affects this group because of the cultural attitudes of black men. I do not know if more would be done if it was felt that white people were as affected.....I couldn't say.” (KI-M)

The fact that the HIV/AIDS issue was compounded by the race factor was also apparent in another response. One respondent, an Indian, felt that there was a lot of silence surrounding the disease, especially from certain sections of the workforce. He said,

“The black staff especially are reluctant to speak about the AIDS issue because most believe it is a black issue.”(KI-I)

It is interesting to note that of the 70 employees in company I, 70% were Indians and only 10% were blacks. Despite this, the Indian respondent singled out the black workers when the issue of HIV/AIDS was brought up. He did not have a clear answer as to why he came to this conclusion. This perhaps indicates that it is his personal perception that the issue is a race issue. The fact that race is such a factor where HIV/AIDS is concerned serves to complicate the issue even further. It colors peoples' attitudes and acts as a bias so there is a stereotype that is created and there is further externalisation of the problem by people who feel safe by virtue of the fact that they are not black.

The issue of HIV/AIDS being a race issue was intimately linked to the skill factor. This is to say that besides the attribution of the disease to black cultural attitudes, the majority of black people occupied the unskilled and semi- skilled positions. There was the feeling



among some of the respondents that because the disease was seen to affect those who were less skilled, it was not such a major issue. The fact that the semi- and unskilled sectors of the workforce comprised black people thus seems to further polarise the issue into a black and white one.

“It is the workers who are seen to be easily replaceable who are affected. I feel that if this was not the case, more would be done.” (KI-E)

Thus, the question of who is affected is important, as it seems to determine whether or not the disease is defined as an immediate problem or not. If the black semi and unskilled workers are the ones who are infected it may not be such a problem, more so when it not the direct responsibility of the company to hire people. Outsourcing was becoming a common practice,

“It is a pity because before the outsourcing, we used to pay the workers more. The labour companies pay them less... we may go back to how it was before. Right now, when we need workers, we just inform the labour company. I suppose that is why we are not feeling the impact of the recent deaths.”(KI-G)

“It is not our direct responsibility to find employees. Perhaps the impact will be felt elsewhere. The fact that there is outsourcing makes our task more manageable and ensures that we stay in business.” (KI-M)

“The thing is that the problem is not being felt as such because of contracting by x company. The responsibility of finding workers has been shifted to them.” (KI-K)

Thus, in some instances the full impact is not felt because there is a reliance on this seeming endless supply of labour. This solution seems to be short term and may create a false sense of security for the company. It may be the case that this scenario discourages a proactive approach by business and removes some of the pressure for employers to act. There is the shifting of responsibility in some cases to the labour companies with the assumption that there is an endless supply of labour. However, it is not ideal for companies to have a high staff turnover and even where the labour is unskilled, there is often a period of time where productivity falls as the new employee tries to settle into the

job. Besides this, this solution is not feasible where there is a need for skilled workers. It is only a matter of time before there is a shortage of skills due to HIV/AIDS and it is important for companies to develop responses now that will cushion them in the future instead of shifting the responsibility to someone else.

It seems clear that as long as HIV/AIDS is being defined mainly as a problem of death and loss of workers to the company, then perhaps the ultimate solution will be sought in outsourcing. This may not go to the route of the problem and if the issue is not addressed, it is companies that are going to suffer in the long run.

HIV/AIDS is also defined as a disease to which a lot of stigma is attached. Because of this there is secrecy surrounding the disease and there are unexpected effects.

“People are really reacting to the disease. The effects are tremendous. Fat people are becoming the envy of the factory. People are so afraid to be associated with his illness that they are overeating and going to the gym so that they can gain weight.” (KI-G)

“The workers associate HIV/AIDS with loss of weight. Even slight weight loss is to be avoided by all means. People are getting overweight and although this brings other complications of health, they are not concerned about that. They are only concerned about people thinking that they have AIDS.” (KI-K)

Here again we see what is a somewhat dangerous confusion of HIV and AIDS. It may be that people are not as educated as they should be about this illness. In fact, emaciation does not occur immediately with this disease and it is at this seemingly healthy stage that infected people can really spread the virus. The false sense of security that is obtained by people and their partners who gain weight is dangerous as well as ill informed. Where this type of reasoning is manifest and people in key positions are aware of it, there is the question of whether enough is being done to educate employees about this disease and to get rid of their misconceptions. There is no sufficient awareness of how the disease manifests itself at its different stages. Thus, the misconceptions about HIV/AIDS still

prevail in the workplace and there are the predominant stereotypes associated with the disease.

“When a worker is suffering from tuberculosis, he has to go to the company clinic to get the medication. People do not like to collect this medication because it is in full view of the other workers in the waiting room and everyone associates TB with AIDS.” (KI-E)

HIV/AIDS is often still associated with gay men and because sex and related issues are seen as taboo, this reinforces the stigma. There is sometimes a feeling of hopelessness and resignation- feelings which may go a long way in explaining the ineffectiveness or non- existence of educational campaigns aimed at changing the attitudes of workers and making them better informed.

“There is stigma, not only in the company but in the greater community as well and this has a negative impact on those who are infected. It also impacts on others and sometimes there is a feeling, almost of fatalism or resignation. Like everyone is going to get ‘this thing’ and die.” (KI-L)

“Some people seem to have a very casual attitude toward the issue... they do not seem to care about the possibility that they may be infected. It is as though they are saying ‘too bad... if I am positive, I am positive.’ This is a very dangerous attitude.”(KI-F)

The realisation that this is a very dangerous attitude does little to help the fact that the workers do not seem to have a sufficient grasp of the issues concerning HIV/AIDS. Education and awareness is supposed to enlighten workers about the issues and it is worrying that there were such feelings of despair and hopelessness. This frame of mind may not be fruitful for educational campaigns and awareness. The employees seem to be a far way off from internalising the messages of prevention as well as positive living.

The employees did not seem to have sufficient motivation to go for testing for HIV/AIDS. Perhaps this is also testament to the fact that not enough had been done to quell their fears and show them the attributes of testing,

“The majority of the workers feel that they are better of not knowing their status.”  
(KI-G)

“Testing does not help because the attitude from some people is, ‘personally I don’t want to know.’” (KI-H)

This is a problem as testing is potentially a very important intervention. It is crucial that employees understand the value of testing so that it is not seen merely as an ordeal to be encountered. The responses show that the companies seem incapacitated by ignorance of how to deal with HIV/AIDS. Perhaps the problem seems too overwhelming. However, it is clear that without testing other interventions may not have the intended impact and there is no use having ad hoc interventions with no systematic response to the problem. If it is a known fact that employees are not well informed enough to let go of their misconceptions and that they are too afraid to go for an HIV/AIDS test perhaps we can draw some conclusions about the approach of the company. There has to be some response to problems such as these.

Another attitude that was uncovered was that it was not fair for companies to spend a lot of money on HIV/AIDS interventions because the disease was a personal health issue and perhaps it was not the responsibility of the company to deal with it. Also, it was not fair for companies to spend so much on people who were not going to change their cultural attitudes no matter what was done. Many of the respondents felt that one of the major problems faced was that of finance. HIV/AIDS was seen to be costing the companies especially in terms of training and retraining. It was particularly difficult for companies to cope when people who were dying were younger persons whose service had been relatively short,

“... one individual who passed away a month ago was a trainee... this is very expensive and the company has no assurance that the employee will be healthy enough to complete the training and be productive. A big challenge is the conflict between benevolence and humanitarianism and the company’s productivity.” (KI-B)

“It is very expensive for the company to train apprentices. It costs about R60, 000 over a period of three years. All the apprentices are Africans. We have no guarantee that an individual will not fall ill during the training period or after it... you just don't know.” (KI-F)

Both respondents felt that because HIV/AIDS testing was prohibited by law, it was impossible to estimate how long the productive life of the employee would be. Another respondent said that although there was no discrimination, it was true to say that the company would not hire someone who did not appear healthy enough for the job. This statement was contradictory. The company she represented was a maize mill and she explained that there was a lot of lifting and people were required to carry heavy things. She said,

“Physical strength is a job requirement and we cannot employ someone who does not appear strong enough for the job... training would generally not be offered to a person who is too sick.” (KI-M)

Whereas all the respondents were quick to point out that there would be no discrimination, these are the attitudes that were uncovered. This raises the question of what would happen if, there was pre-employment testing done by these companies. Also, the question arises here of who determines whether or not an individual is too ill- what criteria are used to conclude that an individual is not strong enough for the job. There is the possibility that policy is being made here and implemented outside the agreed upon guidelines. The criteria are subjective and open to prejudice and this is a very unsystematic response to the problem of HIV/AIDS. The fact that pre-employment HIV/AIDS testing is prohibited by law is not a guarantee that there will be no discrimination on hiring and training. It seems to leave room for guessing as employers try to determine whether or not individuals are ill. It is also important to determine what the purpose of testing is.

Again we see the point that sometimes individuals feel that it is not up to the employer to intervene when an individual is HIV positive. However, this reasoning fails to recognise the fact that HIV/AIDS is a problem for everyone and that business will have a stake in it as well. It does no good to project the disease onto the other and reduce it to a matter of finance and saving costs. In fact, it is ironical that all the respondents who brought the question of cost had made no attempt to investigate all the alternatives when trying to deal with the disease. Perhaps in the long run it would be cheaper to have interventions that focussed on prolonging the life of HIV positive employees rather than doing nothing until they succumbed to the illness. These options had not been meaningfully explored and perhaps it was because there was a fear of cost and HIV/AIDS was not an issue that was defined as a high priority.

### ***2.3 Intervention Programmes***

Although the companies discussed above did not have policies specific to HIV/AIDS, they were asked about any interventions or programmes that they had. The following table is a record of their responses.



**Table 2: Intervention Programmes**

COMPANY	CONDOM PROVISION	EDUCATIONAL			VOLUNTARY TESTING	COUNSELLING
		TALKS	PLAYS	PAMPHLETS		
A	x			x	Compulsory	
B	x			x	x	x
C						
D	x			x		x
E	x	x	x	x	x	x
F	x	x		x	x	x
G	x	x		x	x	x
H	x	x		x	x	x
I		x				x
J	x	x		x	x	x
K	x					x
L	x		x	x	x	x
M	x	x			x	x
N				x		
O						

Above is a table reflecting the most common responses that were given. The table shows that eleven of the fifteen companies made condoms available to employees. There were interventions that were educational and these mainly included organising group or individual talks, providing pamphlets and information leaflets and staging plays. Only two companies had had a play performed on site and seven companies had organised some type of talks for employees. The table also reflects the fact that nine companies provided access to voluntary testing. The counselling column reflects the companies that offered counselling on site at the occupational health clinic. There was no big difference in the intervention of the companies according to the size of their workforce besides the fact that all the companies that did not provide condoms in the workplace were relatively small. Also, these are the companies that did not have medical personnel on their staff.

### 2.3.1 Condoms

This was the most common and consistent response that was given by the Key Informants. However, Key Informants C, I, N and O had not made condoms available to the workers at the workplace.

“I personally suggested having condoms in the toilet but this was rejected because it would be offensive to some of the people that we work closely with. However, I feel that it is important that we ensure that there is access to condoms in the workplace.” (KI-C)

Another of the respondents who worked in a retail store said that although there was little that was being done in this particular store.

“The factories are doing a lot more. There, they provide condoms to the workers.” (KI-I)

Perhaps here again we see the attitude that HIV/AIDS belongs in a certain category of race and class. This is inferred from the fact that the retail store comprised 70% Indians and only 10% Africans and here there was no condom provision. On the other hand the factory which comprised of a majority of black workers was provided with condoms. This was the respondent who felt that the black workers did not want to discuss HIV/AIDS because they felt that it was a black issue.

The informants who stated that they provided condoms were not very optimistic about the effectiveness of this intervention,

“We do provide condoms but people will not necessarily change their sex lives. Condom use is up but it is intermittent. Take birth control....there is birth control on site but out of fifteen women of child bearing age, three were pregnant within four months of their employment.” (KI-B)

“Although we provide condoms, there are so many issues surrounding that. People do not know that they are supposed to use condoms even if they are HIV positive... there is also a resistance to condom use by some people. Some of the workers have said to me that they do not like to use condoms because when they

suggest it, their wives think that they are cheating on them. It is like a vicious circle. There is only so much you can do with condom use. You cannot force people....you cannot be sure that they are doing what they should.” (KI-G)

“The women in this factory are not receptive to the condom. I try to tell them that they are even more at risk of contracting the virus but they do not seem to hear. At the end of the day, it is difficult to change peoples’ attitudes.” (KI-K)

Another said that there were condom dispensers for the truck drivers and there were also condoms provided for the rest of the employees. There was the collection of up to 1, 000 condoms a week from 90 employees. However, she too expressed concern,

“I have talked to some people who felt that they would rather not use them. It is difficult to tell whether they are practicing safe sex and whether they are doing it correctly.” (KI-O)

This respondent had reported earlier that STI’s were common among the workers. These are some of the opinions that were expressed by the interviewees about the problems that were associated with the use of condoms. The general feeling was more or less one of helplessness. Condom use could not be enforced or monitored. This they felt was challenging perhaps especially so because condom use was presented as one of the major interventions. The high number of condoms taken from the workplace could mean that the employees were also distributing them to their friends and possibly not making use of them. There was a feeling that was really no way of knowing the extent to which condoms were effective.

There was a general perception among respondents that in the final analysis, people had to take responsibility for their own sexual behaviour and that little could be done to change this fact. Whereas it is evident that individuals must take personal responsibility for their actions, the attitude that HIV/AIDS is a purely personal health issue is a misleading one. This is a disease that has had and will have far- reaching social and economic consequences. Business would do well to realise that it has a stake in this issue especially if nothing is done now. Perhaps there is feeling that businesses are

incapacitated by the overpowering nature of the problem and there is a lack of knowledge of how to proceed and what to do. At any rate, it is worrying to have heard these types of sentiments expressed by the informants who seemed to feel that their most popular intervention was less than effective despite the fact that it was the most sustained intervention that was mentioned. Thus, there were definitely weaknesses in the focus of interventions on condom provision and these were evident in the statements of the key informants.

This focus on condom provision did not take too much account of the stage of the disease. Thus, there had been no attempts to investigate or pursue other interventions that might be more fruitful and relevant. All the companies that were doing something were mainly providing condoms and there had been little or no consideration for example of interventions that managed opportunistic infections and improved the quality of life. These are the interventions that could prolong the productive life of an individual.

There were other activities and programmes that were mentioned but they were erratic, irregular and not very effective.

### **2.3.2 Talks**

Not all the companies had organised presentations to be made for their employees. Below is a table showing the companies that organized educational talks. It also reflects the regularity of these talks.

Table 3: Regularity of Educational Group Talks

REGULARITY OF GROUP TALKS	COMPANIES
Never	A, B, C, D, E, K, L, N, O
Once in the Past Two Years	G, H, M
Twice in the past Two Years	F, I

Company J is not in the above table because the company had an AIDS awareness month and there were also trained peer-educators who were accessible to workers at all times. The state of affairs regarding education of employees was not a very good one. The company that was represented by Key Informant J is the only one that had a sustained programme of education. Ongoing education and re-education campaigns are essential to reinforce and promote safe sexual behaviour as well as to inform workers in a meaningful and effective way. This was not done, according to the responses of the interviewees.

“We have had educational talks twice this year... an educator from ‘Info AIDS’ came to talk to the workers... We also had a workshop where the families of the employees were invited. There were talks, competitions and prizes and we even provided transportation to the site where this is necessary.” (KI-F)

The other Key Informant (I), whose company had had talks twice during the year reported that someone from ATICC (AIDS Training, Information and Counselling Centre) had come to speak to the staff twice. Key Informants G, H, and M all reported that once in the past two years there was a guest speaker who had been invited to speak to the workers.

Some of the Key Informants said that although they had not organised group talks, they had one on one talks and employees could talk to the occupational health nurses where they were available.

"The doctor takes it upon himself to take about five minutes of his time to talk to the employees who go and see him." (KI-E)

"We cannot organise group talks as this will disrupt production so it is up to the nurse to make factory rounds and talk to the people then one by one. Each employee is called aside. This is done frequently. We see it as an advantage as people are freer to ask questions when they are being spoken to in private." (KI-K)

Key Informant L said that this year talks were not on the list of activities but that it would be there next year.

As we can see, where they existed, the talks were irregular and there was no continuity. This begs the question of whether these presentations had any meaningful impact on the understanding of the employees. Moreover, one reported that even when there was a talk, only the black employees attended. This was about half of the entire workforce. She said,

"There is still a need for education but... only the black workers attended... perhaps the rest feel that they know enough about the disease." (KI-M)

When attendance was not made compulsory it may defeat the whole purpose of organising such an activity with the purpose of educating people. Perhaps, too, the fact that people in management positions and those of other races did not attend the talk will have a damaging impact. It sends a clear message about peoples' perceptions and this may not be good for the morale of the workers or their understanding of the disease. It may also give workers a signal that the issue is not an important one.

Besides the problems of irregularity and inconsistency in organising educational talks, and the fact that attendance was not always compulsory, there were only five companies that had organised any educational talks at all for their employees. It is clear that, in this case, the companies were not taking the initiative of educating the workers and this was seen as a problem especially so because as we saw in the table above, they were not doing much else.



### 2.3.3 Plays

Only two companies reported that they had had an educational play on site during the year. One stated that R40, 000 had been spent on this. He seemed confused about whether or not he felt that the play had been a success,

“The play was successful but how do you measure success?” (KI-E)

This statement is contradictory and it indicates a level of uncertainty from a lack of standards that measure success. Thus there may have been money spent on a play but there did not seem to be a target that was set or criteria that were pre determined to evaluate the success of this intervention. The other respondent felt that,

“The play was powerful....we closed the factory and we included the community....it was adopted to fit the older generation and it was in languages. I feel that it was a success as people were talking about it for months after the event.” (KI-L)

There had been no standards set to determine the level of success of this intervention. The plays were staged but there were no pre- determined criteria for measuring their success. Both respondents unfortunately reported that few or no individuals went for testing after the play. In addition, there was still the report that STP's were common among workers- this from KI-L. Attitudes of fear of testing did not seem to change among the employees as we shall see below. It is important to evaluate the success of interventions in order to figure out what more can be done or what can be done differently. It is thus important to develop criteria to make these judgments in order to evaluate the impact of interventions and where this is not done there are likely to be gaps in information and this is problematic. There need to be guides for action so that responses can be systematic.

### **2.3.4 Testing**

Only eight of the respondents stated that their companies provided for voluntary testing. Key Informant A stated that testing for HIV/AIDS was a requirement of law for persons who worked in the transport industry. He worked for a shipping company. The respondents were asked about the purpose of testing but they could only say what it was *not* for. That is, that it was not for any discriminatory purposes. However, some responses indicated somewhat different attitudes and opinions. Although the majority of the respondents were quick to agree that testing was not necessary, as it might allow discrimination to take place as far as training, employment and benefits were concerned, there were some inconsistent responses.

#### **2.3.4.1 Testing and Discrimination**

Two respondents stated that it was expensive for the company to train an individual who would not have a long productive life, or who would not even last for the duration of the training programme. They felt that the government policy of no testing was a problem for the company.

“One of the big challenges is that we are not able to tell who is infected because of the no testing policy of the government.” (KI-B)

“You just do not know... it is so expensive to train and apprentice... you cannot be sure whether the individual is ill or not and whether they will be productive at all.” (KI-F)

Another respondent who said that there would be no discrimination of HIV positive persons seemed to be inconsistent in her responses. She felt that, generally speaking, an individual would not be employed if he/she looked like he/she was ‘too weak for the job.’ This, she felt would save the company some money in the long run. She said,

"We act in accordance with the Skills Development Act and the Employment Equity Act but generally, if we felt that an individual was too ill to undergo training, we would not take him on." (KI-M)

All these respondents seem to be saying in one way or another that people who are HIV positive may not always be given a fair chance to compete with the rest of the workforce if their status was known. This calls into question the real purpose of HIV/AIDS testing. The first two respondents reported the difficulties that they encountered when they had to train individuals who they were not sure would be healthy enough to complete the training and become productive members of the workforce. One may ask oneself whether a company would consider training an individual who was known to be HIV positive- this, in spite of the fact that there was supposedly no discrimination of any kind of such individuals in both training or hiring practice.

The third respondent felt that in the absence of the knowledge of the HIV/AIDS status of an individual when hiring, it was the practice that some kind of standard would be used to determine whether or not the person was fit enough for the job. These standards seemed vague, unspecific and subjective. We may again consider the repercussions for an individual of the knowledge by the company of his/her HIV status before the hiring process. Thus, the whole purpose of testing is an important aspect of HIV/AIDS interventions.

#### **2.3.4.2 Purpose of Testing**

Understanding the purpose of testing was important. One informant felt that testing was of little use as,

“There is no immunity against this disease... someone could test negative today and then test positive tomorrow.” (KI-H)

Whereas this is a statement of fact, this attitude seems to be a little narrow and pessimistic as it does not acknowledge the purposes of testing other than as a punitive measure. Testing could be made to be a useful and positive response. Some respondents were not specific about what they thought testing was for. The respondents above expressed concern about hiring and training individuals who were HIV positive without the knowledge of this fact. This indicates that the understanding of the purpose of testing was that those found to be HIV positive would be denied access to training programmes and possibly to employment. Thus, testing would be for punitive purposes rather than for help and support.

People experience anxiety at the prospect of going for an HIV/AIDS test. Perhaps if testing was used as a means of equipping individuals with information that could improve their lifestyle or cause them to change their behaviour, people would be less apprehensive about getting tested. It is important for companies to have support structures to make testing a meaningful intervention. Testing is of little value when there is no positive planned response after testing has been done. People must be made to feel that there are support systems to assist them if they infected with HIV/AIDS. This may make the prospect of going for the test a little easier to deal with.

Testing as a preventive measure is important and this can be inferred from the fact that the respondents often stated that the employees were afraid to be tested. They were so afraid to be found HIV positive that many said they would rather not know their status. Perhaps, even despite the guarantee of confidentiality, they were afraid that their status

would be revealed and they would be penalised for it. Respondent D explained that even though there was no testing allowed and even after testing, confidentiality was guaranteed, there were some loop-holes in the system so that the status of an employee could be discovered. If an individual went to the company clinic with symptoms thought to be relating to HIV/AIDS, they would be referred to the company doctor. Even if the medical report did not specify HIV status, the diagnosis and prognosis would be phrased in such a way as to indicate this fact.

Testing can also be used as a preventive measure through education. It is important to educate people who are infected once there is knowledge of this fact. This could help to prevent them from passing the infection to others who are not infected. HIV positive individuals could be trained as peer educators and they may be more effective in informing the workers who work closely with them.

#### **2.3.4.3 Are Employees Getting Tested?**

Besides all the issues that surrounded testing and the fact that not all the companies in this study provided for it, there were some respondents who said that employees were not taking advantage of the facility. One informant said,

“A majority of the employees feel that they would rather not know their HIV status.” (KI-G)

Key Informant H was also of the opinion that there were many in the company who did not want to know their status. Others felt the same.

“Some feel that... everyone is going to get ‘that thing’ and die... there is a lot of stigma still attached... some would rather not know.” (KI-L)

This fear perhaps was preventing more people from getting tested. Thus, it seems that workers were not made more aware of the potential benefits of testing and perhaps they

were not made to feel confident that testing was not purely for punitive purposes. In addition it seems that education, whether it was on a one on one basis or at group level, did not impact enough on the workers to encourage them to go for an HIV/AIDS test. There were other respondents who reported that no worker had gone for voluntary testing for the whole year. One of the respondents whose company had had a play on the factory site said,

“I do not know... no one on site came for testing after the play. We invited the community and perhaps we covered more outside.” (KI-E)

Another reported that no one had come for testing this year.

“Within the next three years after 1994, of those who came for voluntary testing, 18% of the workforce tested positive for this disease. No one has come for testing this year.” (KI-H)

Without testing, it may be the case that the other interventions- a good example being counselling, are not as effective as they would be. Perhaps this is a measure of the success of what the companies have been doing until now.

### **2.3.5 Counselling**

This was mentioned by eleven of the respondents as another intervention. Although counselling is very important aspect of dealing with HIV/AIDS, the question arises of how effective it is when few or no people are going for HIV/AIDS testing. There was the mention of pre and post- test counselling and the counselling of individuals who are infected, as well as their family members if possible. All the respondents who referred to counselling talked about it in terms of helping the HIV positive individual to live a full life and giving him/her hope for the future. There was also talk of giving dietary information and information to improve the quality of life. Thus, this intervention seems to be effective or largely applicable where there is knowledge of the status of an individual. In this case then, testing is important.



## 2.4 Resources

The respondents were asked whether they had allocated specific financial and personnel resources to realise their policies and programmes. Perhaps it can be inferred from the data above that the answers to this question were largely negative. In the absence of policy, money from the budget could not be allocated. In addition, the activities that were carried out in all of the companies appeared to be irregular and unsystematic. There was no real effort at consistency and there were no systematic attempts to follow up on what little had been done –for example, the lack of criteria for measuring the success of these programmes. This seeming lack of structure and long term strategy is not an ideal situation when resources are being allocated. The table below reflects the responses that were given when the Key Informants were asked whether they had set aside resources for HIV/AIDS interventions.

The table shows that *none* of the companies had allocated financial resources specifically to HIV/AIDS interventions. On the issue of personnel resources, ten of the companies stated that the company clinic dealt with HIV/AIDS and pertinent issues. The response to HIV/AIDS was thus the responsibility of the clinic staff. In general, this comprised very few individuals whose responsibilities were wide ranging. None of the companies had allocated specific financial resources to realising their policies or programmes.

All the ones who reported that they had personnel charged with the responsibility of coordinating the programmes and planning the interventions said that this was a responsibility for the company clinic. The company clinic was in most cases staffed by only one nurse. At least the nurse was the only one who was there during working hours on a daily basis.

Table 4: Company's Resource Allocation

COMPANY	RESOURCES	
	FINANCIAL	PERSONNEL
A	-	-
B	-	Company Clinic
C	-	-
D	-	Company Clinic
E	-	Company Clinic
F	-	Company Clinic
G	-	Company Clinic
H	-	Company Clinic
I	-	-
J	-	Company Clinic
K	-	Company Clinic
L	-	Company Clinic
M	-	Company Clinic
N	-	-
O	-	-

Many of the respondents said that the financial resources for matters connected with HIV/AIDS programmes fell under the Human Resources Department.

“There is a massive training programme in the Human Resources Department...about R4, 500 was spent on Health and Safety Training. We also spent R350 an hour for a training programme from Edu/AIDS.” (KI-B)

When asked what percentage was dedicated to health issues, the respondent only said that there was R195, 000 and this was from a total budget that was going to be trimmed by R750, 000 in the coming year. She seemed to feel that the allocation was a rather small percentage of the whole company budget. The programmes fell under the Human Resources Department. Another company had clinic personnel totalling seven. There was one doctor who runs the clinic and there were two occupational health nurses and four

nursing assistants. This was the largest number of personnel who could deal at some level with the issue of HIV/AIDS. Another informant responded as follows,

“We spend 2% a year on community development, social responsibility and job creation. HIV/AIDS falls within this... we do not intend to increase this percentage but if need be, perhaps HIV/AIDS will take a bigger portion of the overall.” (KI-H)

In this company, the nurse was responsible for issues relating to HIV/AIDS. Other key informants reported that,

“The money comes from the Human Resources Department... there was not enough money for one of the programmes so it had to be borrowed from Public Relations.” (KI-J)

“The resources that go towards HIV/AIDS interventions are part of the normal clinic costs... we do not skimp on spending money on employees if they are ill.” (KI-M)

Thus, again we can see a trend towards defining HIV/AIDS as a personal health issue. The response to the disease is the responsibility of the company clinic. It is also defined in terms of a problem of labour, under human resources and perhaps it is telling that in one case, it draws from the public relations department. There is a feeling that this issue is relegated to a level of less importance than it should be. It does not demand a budget of its own and in almost all the cases, one or two people- one doctor and one nurse- constitute the total personnel allocated to tackling the company's response. Perhaps there is a certain degree of tokenism involved in this kind of attitude which seems to indicate some lack of commitment to an issue of potential threat to the companies involved.

“The clinic is seen as a liability but the law requires that it be there... there is more or less an ‘open’ arrangement as regards the financing of interventions. The nurse draws up a budget of the clinic expenses and the money is provided by the management.” (KI-K)

This seems a rather casual attitude and it reflects the lack of strategy and long term planning that should characterise a serious response. It must be noted that the budgets submitted by many of the nurses charged with the responsibility constitute the total clinic costs and a large part of these consist of the costs of medication. Medication provided, when it comes to HIV/AIDS simply means the provision of vitamin tablets or pain-killers. Other than vitamins, medicine is expensive and was not provided by the company.

“We do not supply AZT or cocktails. That is an expensive issue.” (KI-M)

Others felt that antibiotics were effective but that AZT was a complex issue that had the government involved and was too expensive for companies to get into.

“It is too expensive. It costs about R1, 500 or something like that.” (KI-K)

“All that the nurse can do is counsel about the diet...the government should sanction drugs...” (KI-G)

In this attitude we see that there is a transfer of responsibility to the government when it comes to medication and a feeling that the company is helpless because of government policy on the provision of this medication. However, this seems like a scapegoat in light of the fact that so little was given to HIV/AIDS intervention in the first place. Also, no real effort had been made to put interventions in place that dealt with opportunistic infections. Instead, some companies had gone as far as hinting that it was too expensive for the company to deal with HIV/AIDS and that it would be helpful for the company to know the status of employees. Thus, the attempts to shift the responsibility onto the government and the opinions that medication would be provided if it was not expensive do not sound genuine.

Another respondent (KI-L) stated that it was up to the nurse to draw up a budget for the clinic and to decide how much would go to HIV/AIDS. Another simply had this to say,

"We do not have a special budget for HIV/AIDS but hopefully we will in the near future." (KI-F)

The company clinic bore the responsibility of dealing with the HIV/AIDS issue and it was up to the nurse to provide counselling, dietary support and advice on how to live with HIV/AIDS. Some of the respondents admitted that this was stressful to the nurses but that nothing could be done about this fact because of lack of resources. The nurse from company J felt that,

"I am not doing justice to the job. During our AIDS awareness month, we offered free testing and I had to counsel all the employees who took advantage of the service. I feel that there is a need for more staff and I have been saying this for years but each time I bring it up I am told that due to money matters they cannot employ anyone else." (Nurse from Company J)

The nurse from company L stated that she did the personnel work as well and although this was good as it gave her a bigger picture of the profile of the worker, it was emotionally draining and time consuming. She said,

"It is very emotionally taxing especially because of the issue of confidentiality. I feel that I have quite a bit to deal with...I do not foresee a remedy in the near future. I deal with it on a personal level through stress management and physical exercise." (Nurse from Company L)

These are two of the nurses from the companies that were included in the study. They felt that management was not addressing the issue of capacity to implement the programmes that were in place. They mentioned the counselling which they were responsible for and which was very taxing. This was just one of the aspects that they were responsible for.

It seems that besides the fact the interventions that were in place were not very effective as regards the level of success there was also the issue of the commitment of management to allocate resources to these interventions. This perhaps tells the loudest tale regarding priority. It was the case more often than not that HIV/AIDS related expenses were defined in terms of liability for the company. This seems like a short - term view of the problem.

Thus, the company clinic was charged with dealing with all issues relating to HIV/AIDS. This was done in conjunction with the Human Resources Department only as far as monetary issues were concerned. Where there was no clinic, the issue was seen as a personnel person problem regardless of whether this individual had sufficient expertise to deal with it. One respondent said,

“One issue that I feel has to be addressed is the job definition of a Human Resources Manager... is he a Human Resources Manager or a Health Hygienist?”  
(KI-H)

HIV/AIDS was not an issue that was made part and parcel of the planning strategy of the company. There is definitely a need for companies to get into grips with the situation so that they can see that there is a real stake in it and that it requires more attention that it is being given at least in the companies in this study.

## **2.5 Success or Failure**

We have seen that most of the companies did not have policies specific to HIV/AIDS. There were mixed feelings that were expressed by the informants about the success of any activities that geared toward dealing with the disease. Some felt that they were doing all they could. They projected the rest of the responsibility onto the labour companies or the politicians and the government,

“There is still a need for education... the comments that Mbeki has made have left many people confused about this disease.” (KI-M)

“...our policies seem to be effective...the thing is that the responsibility has shifted to the labour contractors...on the issue of medication, AZT is expensive and this is more of a government thing.” (KI-K)

These statements were made even though the companies were not doing much to begin with. Furthermore, the fact that contracting companies were responsible for providing



labour does not mean that the company is not responsible for the welfare of the workers. Others, who were doing little or nothing, surprisingly felt that they were successful. Most of the time, success was defined in terms of what was perceived as an increased level of awareness among workers;

“Yes, our policies are effective. There is a lot of awareness.” (KI-G)

“I think that the workers are a hundred percent aware of AIDS.” (KI-E)

“The policy has been in place for just over a year and we are thinking of revisiting it now. However, we seem to have been successful in creating awareness.” (KI-H)

“The factories do a lot more than we do... they provide condoms. In the sense of creating awareness, I think we have been successful.” (KI-I)

“Yes. Our programmes and policies are effective. People are responding freely and openly and are moving from the stigma of talking about AIDS.” (KI-L)

KI-L was from a company where the workers had not gone for HIV/AIDS testing in a while. This raises the question of what criteria are used for determining that awareness had increased. This is especially so in light of the fact that KI-L reported that STT's were still common among the workers and that many of the other informants felt that condoms were used only intermittently. Some did not want to use condoms at all. It is not useful for people to be aware of something but to fail to change their behaviour as a result. Also, it is important to use certain criteria in order to determine whether or not there is indeed awareness. Awareness does not always translate to a proper understanding.

There were other key informants who felt that their programmes had not been fully successful,

“There is only so much we can do... condom use is intermittent and people will not necessarily change their sex lives.” (KI-B)

Here again it is evident that the major intervention was the provision of condoms and that HIV/AIDS was defined as a cultural or personal issue and that the company could do

little about this. Others had the same sense of hopelessness stemming from ignorance and lack of sureness about what to do.

“No...our policies and programmes may not be very effective. Maybe we are not prepared for the future. But how do we prepare? Employ ten percent more people to replace the ten percent who will die?” (KI-E)

This is a passive approach to the problem and it does not require any planning at all. Perhaps this attitude stems from lack of knowledge and the overwhelming nature of the problem. It is more or less a wait and see approach which was evident elsewhere.

“Our policies seem to be effective for the moment but if anything happens, it will be up to the management to figure out a way to react to the situation.” (KI-K)

There was more evidence that HIV/AIDS was treated as a personal health issue that the company could do little about.

“We can only encourage employees to belong to medical aid schemes and perhaps subsidize them a little. Senior management have this facility but it is expensive for the rank and file.” (KI-E)

Again, HIV/AIDS is defined as a personal health issue. From the respondents who felt that they had been successful, it seems that there was a sort of denial. This is because it is clear from their previous responses that little was being done and that even this had not borne too much fruit. There was also the fact that there were no established criteria for determining success. Denial is not only a psychological response where there is denial of the problem. It is a social response as well as it excuses inaction. Thus, it is also a failure to act or to recognise the futility of action taken.

### Possible Reasons why No One Seems to be Doing Enough

We have seen that a number of respondents felt that a challenge that was faced was what was seen as the cultural attitudes and practices that undermine attempts at education and awareness. We must note that in all the companies, Africans comprised 45% to 80% of the total workforce. Key Informant K reported that when an employee's death was AIDS related, some African workers would attribute it to witchcraft. This was a company which comprised 82% Africans out of 500 workers. Respondent M pointed out that there was a section of management that felt that HIV/AIDS was prevalent because of 'black men's cultural attitudes.' Thus, Africans were felt to be attributing the disease to other causes or behaving in ways that put them at higher risk. This was believed by some of the Key Informants to be a result of cultural influences and there was therefore a sense that little could be done to educate these individuals or persuade them away from their cultural beliefs.

Key Informants B and G (both white) felt that the bottom line was that condom use could not be enforced or monitored. Respondents B, K and L suggested that there was a certain resistance to condom use. Respondent K (Indian), from a company employing 82% Africans and 65% women, stated that 'women were not receptive to the condom.' This, they felt was challenging, perhaps especially so because the provision of condoms was presented as one of the more major interventions. This was also tied to cultural values and perceptions relating to condom use. There was also, here, a feeling of helplessness because many felt that it was really up to the individual to decide whether or not they would use a condom and little could be done about this. There was a general perception among most respondents that at the end of the day, people had to take responsibility for their own sexual behaviour. Thus, HIV/AIDS was more or less viewed as a personal health issue as though the company did not have a stake in the lives of its employees or a responsibility to take meaningful initiatives to combat this disease.

There also seemed to be a feeling among some of the respondents there was an inherent conflict between the goals of the organization - profit making, and the practices of the organization in connection with HIV/AIDS and employees. This perhaps stems from the opinions discussed above that cast HIV/AIDS as a personal health issue intimately connected to a cultural inclination. The company was there to make a profit and not to perform a social service. Thus, perhaps anything that was done by the company by way of intervention was seen as a sort of good will gesture.

These are some of the attitudes that were uncovered and they all seemed to remove any responsibility from the company and place it fully on the individual or the society. Where companies were doing something about HIV/AIDS there was an opinion commonly expressed that this was out of good will rather than a sense of responsibility or a realisation that the company had much at stake. The question of the understanding of HIV/AIDS and the challenges that it poses is important because it ultimately determines the responses and interventions that are put in place. If the understanding is not sufficient, the response will also be inadequate.

## **PART THREE**

### **FINAL REPORT**

The HIV/AIDS epidemic poses multiple challenges for a country like South Africa. There is a lot of debate about the accuracy of various projections but it is clear that HIV/AIDS is not only a personal health issue but a developmental issue as well. It may have major institutional impacts and this may have a bearing on the functioning of companies. We have seen that businesses may have to spend more money to retrain workers to replace those that die as a result of the disease. Also, productivity will fall due to missed workdays. This study has been concerned with corporate policy on HIV/AIDS interventions. It has investigated the understanding of the issue of HIV/AIDS among the key informants from fifteen companies. The study found that not all the companies in the sample had policies specific to HIV/AIDS but that most had general guidelines. There was a feeling from the key informants that the companies would react as the problems arose and that at the moment the problem was being effectively dealt with. Most of the companies dealt with HIV/AIDS positive employees on a case by case basis. Below is a discussion of the findings of the study within the context of the rational choice model.

#### ***3.1 The Rational Choice Model and HIV/AIDS Policy***

Policy-making and implementation are complex processes that do not automatically follow a rational model. However, the rational choice model could help us to understand the policy process, especially when studied in conjunction with other human factors. This is because, as we have seen, human rationality is limited due to numerous factors.

The companies in this study seemed to be doing little regarding HIV/AIDS in the workplace and this was surprising perhaps because of the projections that tell us that businesses will be affected. Despite the economic forecasting, however, there was a feeling that information is not always accurate and there was a feeling of confusion and uncertainty about this. Some of the key informants felt that they did not know which

estimates they should rely on. This may be a limit to rationality- the incomplete and fragmented nature of knowledge.

HIV/AIDS is a disease laden with a great deal of stigma. People hesitate to go for HIV/AIDS tests and those who do are often reluctant to disclose their status. Thus, it is not always easy for companies to make projections of the impact of the disease on their workforce. Many of the key informants expressed feelings of helplessness at this fact and felt that they could do little if people were not willing to come forward and be tested. Some felt that it was necessary for them to know the statistics regarding infection rates among their employees so that they could plan their responses appropriately according to the stage of the epidemic. Perhaps there would be differences in emphasis of the interventions in relation to the rates of infection.

Thus, there was a point that was made that the knowledge of the status of employees would be important for the companies to respond. This knowledge may be important in order for a planned and strategic response that is relevant. Perhaps an example of this would be that the companies could stress their efforts on preventive education in cases where infection rates are low. Where there is a high rate of infection, there could be education as well as a stress on interventions that deal with opportunistic infections. The response cannot be rational where there are gaps in knowledge and information.

However, it is the case that where there is information, it may be used in ways that do not necessarily conform to the original objectives of the policy. This was uncovered through some of the statements made by the key informants. Although many were quick to point out that their policies or guidelines were all in conformity with the law and with national policy on testing, there were certain facts that were uncovered that were not consistent with this assurance.

The national policy on testing is careful to protect HIV/AIDS positive individuals from discrimination at the workplace. Thus, testing should only be voluntary. Moreover, there should be a guarantee of confidentiality for those who do not desire to disclose their

status. However, it became apparent from some of the statements made by the key informants that there were some problems in connection with the implementation of this aspect of the policy. Firstly, although there was a general feeling that discrimination was unnecessary and that it was frowned upon in the policies and practices of the various companies, it was clear that the issues of testing and its purpose were surrounded by some confusion. Where on one hand there was an embracing of national policy and the declaration that an employee would not be discriminated against on the basis of HIV/AIDS status, the purpose of testing was not clearly defined. Where there was a voluntary testing policy there was no demonstration of a grasp of why testing was vital, especially in light of the fact that there were no structures that were in place to deal with the aftermath of testing. Thus there was the question of what sort of response there would be after an employee had gone for an HIV/AIDS test and then revealed his/her status to the employer.

It was discovered in the course of various interviews that testing would perhaps serve another purpose, quite contrary to that stipulated in policy regarding HIV/AIDS. Some key informants felt that it was unfair for the company to carry the costs of training HIV positive individuals who would not have a long productive life and may not even last for the course of the training. Thus, inadvertently they were saying that testing would be a means for discrimination- for selecting individuals who would be trained at a cheaper cost to the company. This was the logic of cost benefit analysis. It was seen to be a more cost- effective option to be aware of the status of employees- instead of taking a gamble that the company would benefit from long service in the long run. Thus, it is evident that in some cases, testing could potentially be used as a basis for some sort of discrimination, inconsistent with the aims of the national policy that so many companies seem to embrace. Perhaps this can be explained in a number of ways.

Firstly, social indicators are important in this situation. The issue on HIV/AIDS is a topical issue and there has been a lot of discussion and controversy surrounding it. This means that companies, especially big business, in the public eye are under some sort of pressure to respond to HIV/AIDS in the workplace. AIDS activists are also keen to



propagate the HIV/AIDS cause and these factors may all put pressure on companies to act. Thus there may be a hasty embracing of national policy without a real effort to analyse its content. This is because it may seem politically correct for companies to be seen to be supporting the politically correct policies of voluntary testing and no discrimination and embrace the general guidelines and policies regarding the issue. Perhaps the social cost of appearing callous or unconcerned with the issue of HIV/AIDS prompted companies to act fast. This seems like a quick fix mentality. There was, among the companies in this study, little effort to develop policies relevant to the needs of the particular company. Instead, there was a trend towards adopting guidelines that were general and were developed as a basic starting point for companies to build on.

It was clear that a number of those who responded were not fully aware of the spirit in which the policies were developed and the intentions of it. The voluntary testing policy entails quite a bit more than just providing counselling before and after. Also, it requires that companies develop interventions that are supportive of those who have opted to go for testing. If this does not happen, testing may indeed become nothing more than a tool for discrimination.

Thus, it is clear that rationality is limited by the organisational environment- for example, whether or not the company is proactive in terms of problem solving. These are the factors that frame the processes of choice. This means that individuals can only act within the constraints of the organisation and its policies. If these policies have not been developed in house, it may be more difficult at least in the sense of understanding the policy. If there is no understanding of the policy then implementation will be poor. If there is little or no attempt to decipher the guidelines and to tailor them to the specific needs of the company, perhaps policy will be less effective in achieving its ends. Companies should not be satisfied with tokenism- embracing national policy with neither sufficient input from themselves nor a sufficient grasp of what the policy entails.

In addition to the organisational context, rationality is also limited by the fact that HIV/AIDS cases were dealt with on a case by case basis. This is not only time consuming

but subject to human error and bias as well. This system of dealing with the problem results from the fact that the available guidelines were insufficient and lacked enough substance to react to the different situations that presented themselves. Thus, a common response that was given by the key informants when they were asked about what they would do if an employee became too sick to work was that each case was dealt with differently. This means that there were situations that required on the spot improvisation because few of the issues were dealt with in the policy. Some of the key informants mentioned the fact that numerous factors were considered when dealing with an employee who had become too ill to work. These were factors such as the previous conduct of the employee, for example, whether the individual was thought to be a good worker or to have a disruptive influence. Factors such as job performance and attendance were also taken into consideration. When there are no clear-cut rules and regulation to guide decision-making, there is room for subjectivity and this reduces the chances of rationality. The absence of official policy leaves room for improvisation and the creation of policy even as it is being implemented.

This is the same with the issue of testing. Although the official stance was one against discrimination on the basis of HIV/AIDS status, this was not always the case in practice. We have seen that rationality is limited especially when there are no clear policies to guide action. In the absence of policy, there is more room to adjust behaviour according to purposive goals. When goals are felt to conflict with each other, perhaps the goal that is defined as priority wins the day. In any case, in such a situation, implementation may become haphazard- a juggling act. An example of this is where there seems to be a conflict between the goals of the organisation and what may be seen as social or humanitarian goals. In the first case, the goals of the organisation may be profit making and in a cost-benefit analysis sense it may not be feasible to train or employ an individual who is HIV positive. However, business may have a social conscience and may want to support people who are HIV positive. Thus, implementation will depend on who decides which goals take precedence and whether or not there can be a compromise. This is the human element that could be a limit to rationality and it is where implementation may depart from official policy.

The fact that pre-employment testing is against the law does not necessarily prevent employers from discriminating. In some situations, the individual doing the recruiting may adopt a policy of simply observing the prospective employee in trying to determine whether he/she appears to be fit and healthy. This may seem naïve and may border on the ludicrous. However, one key informant felt that in the circumstances, it was within the rights of the company to do whatever it could to try and ensure that they would not suffer the financial consequences of employing someone who would not have a long productive life. This is a very dangerous and discriminatory practice. Besides the fact that it is by no means foolproof in achieving the desired ends, it is seen as a means of getting around what is prescribed by law. This is all in an attempt to limit the costs of trying to deal with HIV/AIDS in the workplace. However, it does not seem rational at all. Trying to avoid the problem is not a practical response.

In the same way, even though policy stipulates that general medical check ups are not supposed to indicate in any way the HIV/AIDS status of an employee, it was discovered that here again there were loopholes. One informant mentioned that there was at times an understanding between the company doctor and the management so that a diagnosis phrased in a particular way would mutually be understood to constitute a disclosure of the positive status of the employee. Therefore it is clear that policy is being made even as it is being implemented and official policy is not always consistent with what is actually happening. This is because people react to situations as they arise, depending on how they define the problem as well as the priorities- again the human element comes into play. Although it is perhaps true to say that in each situation action is taken after there is an attempt to weigh the costs and benefits it is clear that the processes of choice are framed within a particular context. Individuals realise how much freedom they have to act within the context of their organisations and they are aware of their agendas and priorities.

Individuals may have discretion in applying policy. This is especially so where a particular issue is not defined as high priority and there is no regular evaluation of the policy. Of course, where there are only general guidelines, as we have seen, there is even

more room for flexibility and personal interpretation and thus, the introduction of bias. The rational model of implementation does not give this due consideration. It further assumes that there is good communication between policy makers and those who implement or deliver the policy. This is not always the case.

Firstly, there are cases where the policy is not developed from within the company and so it may not be effective in the sense that the particular needs and problems of the company may not have been addressed in an informed manner. This happens for example when the policy comes from the regional office of a company and is supposed to filter down to the rest of the branches which may be different in the sense of demographics, budget and capacity. The policy may not be completely applicable in such instances. There is also room for misinterpretation of the content or aims of the policy. This may even be worse where the guide for action is taken to be a document that was developed at a national level. The question of how specific this policy is comes to mind and how applicable it is to a particular company. Even when the policy is developed within the company, there may be a difference in perception between the management and the rest of the staff so that there is a lack of consensus and understanding. "What if workers do not share the objectives of their superiors? Lower level participants in organisations often do not share the perspectives and preferences of their superiors and hence in some respects cannot be thought to be working toward state agency goals." (Lipsky, 1980:16).

Development of policy without consulting those who are to deliver it may be a limiting factor when it comes to implementation. Sometimes there is a feeling that management is going about tackling the problem in the wrong way and people at lower levels of the hierarchy may feel that higher-level officials are too far removed from the reality of the situation. This may cause resentment or frustration. The top down approach of policy making may not be very effective, "One can expect a certain degree of non compliance if lower level workers' interests differ from the interests of those at higher levels and the incentives and sanctions available to higher levels are not sufficient to prevail." (Lipsky, 1980:17). Non compliance may also result from racial tensions. This may be particularly relevant to this area of policy making. HIV/AIDS is defined in terms of race and class

and this undoubtedly compounds the complexity of the attempts to deal with it. Black people implementing policy may be resentful and may feel that too little is being done to deal with the disease. This may influence the way they deliver policy. On the other hand, white people may feel that the company's resources cannot be spent on trying to intervene in a personal health issue that is intimately tied to cultural practice. This difference in perception may cause discrepancies in how a policy is implemented. This is a situation that is rife for individuals to take matters into their own hands and implement the policies or general guidelines as they see fit. The bottom-up approach involves negotiation and consensus and recognises the fact that implementation may not always proceed as prescribed by the policy.

Another factor that may limit the rationality of the responses of companies to HIV/AIDS is the fact that human beings tend to resist change and try to maintain the status quo. Because human beings are creatures of habit and routine, companies may feel that it is simpler and more straight-forward to place HIV/AIDS within the context of a broader and previously existing health policy. This was a common occurrence among the companies in the sample. However, the point is that HIV/AIDS is a disease to which a lot of stigma is attached. Further, it is a multifaceted problem with serious consequences on a large scale. This in itself should guarantee its unique status. The reluctance to acknowledge this fact in the face of overwhelming evidence of the seriousness of the issue may prevent a rational response to it.

There is also a question of the psychological barriers to rationality. This was evident in the interviews that were conducted. As we have seen, there was a kind of denial from the management despite the fact that the disease was having such an impact on the workforce. This could be attributed to various issues, for example, a feeling of helplessness and not knowing how to deal with the situation. It is also possible that some were not so well informed about the nature of the disease and its likely consequences. Thus there was the factor of ignorance. The psychological environment may also refer to the perceptions regarding the disease- who it affects and why. This may really have an impact on the response. It was found that some of the key informants were of the opinion

that HIV/AIDS affects people from the African group and this was linked to the cultural practices of this race group. It was also found that this race group comprised workers who were mostly unskilled or semiskilled and therefore the problem was not defined as having reached crisis proportions because this type of labour is easily replaceable.

Perhaps in a cost- benefit sense certain companies felt that the cost of interventions is higher than that of replacing workers who succumb to the illness. However, this had not been officially evaluated. This also brings us to another point- that of the difficulty of putting a price on various components of a scheme to manage HIV/AIDS. There is a problem of measuring variables such as loss of life. There is also the complicating factor that not all pains and pleasures are equal. Can the quality of an employee's life be measured in terms of money, benefits and the costs of rehiring? Another fundamental question is whether or not companies do have an obligation to the employer and to what extent this obligation reaches. When social responsibility to the individual and to society is in opposition to the aims and profit making goals of the company, perhaps it is not difficult to guess which will take precedence. According to the economic forecasts however, business will be acting in its own interests as well if the problem is tackled now.

Ignoring the problem or having token interventions that have little impact is clearly not the solution. A short- term solution like trying to hire people who are not infected may seem rational but it is not practical. An individual's HIV/AIDS status can change at any time, even after employment. Planning for the long term is much better. The attitude that only unskilled workers are affected and that they are easily replaceable seems not only callous but dangerous as well. It may give a false sense of security to businesses. This is because according to economic forecasts skilled people will also be affected and this may have a great impact on business. A shortage of skills may be experienced and this will affect businesses that have not planned in advance.

Another limit of rationality is the fact that consequences are not always known. However, it is important that decision- makers take the time to get all the information that they can

and sometimes where necessary to make educated and informed guesses or estimates. It is recognised that unlike in other policy areas, health disasters may be more difficult to predict as they occur gradually and over longer periods of time. Therefore, because of this sort of invisibility, it is not always easy to identify a health crisis immediately. There is a reliance on projections and only when individual cases are aggregated into statistics can the problem seem compelling. Thus, rational analysis may be difficult to carry out due to insufficient information. We may note, for example that within the setting of a business enterprise, skilled personnel have access to private medical care which may be out of reach for the rank and file who may have to rely on occupational health care. People who are financially able are more likely to successfully withhold information regarding their status and also to afford medication that will increase their quality of life as well. Thus, the disease becomes a private and personal health issue. A combination of these factors may make it difficult to determine the rate of infection among the skilled category of the workforce.

Absence of this type of information may not paint an accurate picture of the situation. This in turn may mean that the urgency may not be felt. The key informants, for example, felt that HIV/AIDS would pose a bigger problem in the future rather than now. Those who were affected were easily replaceable workers and there was no sense of urgency to try and deal with the situation now. The costs to the company were limited or at least much less than they would be if the skilled employees were the ones who were falling ill. Thus, many felt that they would deal with the problem when it arose but there was some vagueness about how this would be done. The problem of HIV/AIDS was not seen to be a prominent one on the agenda of most of the companies in the sample.

Rationality ignores the fact that there are political or social considerations that may motivate action and these may not seem rational at all. However, all human behaviour is goal oriented even though the purpose may not be immediately clear. These considerations can justify decisions already made and decision-makers may not choose rationally between options. If a company decides to spend money on an intervention that may cost a lot and may not be very effective, this may not seem rational at all. It may be



due to factors such as the political or social environment. More may be spent on interventions that are visible such as plays and visual displays so that the company can be seen to be doing something. This does not necessarily depend on the rationality of the intervention- how effective it is as compared to its cost. It may simply be based on the fact that it is a grand event that is visible in the community and this will cast the organisation in a positive light. Rationality can also be used to justify decisions already made rather than to guide action. This may be due to a resistance to change and a preference for habit or routine. At times this reluctance to explore new options even if they are cost effective, causes companies to spend more while doing less by way of meaningful interventions.

Rationality could also be used as an excuse for inaction. This is tied to the issue that data is not neutral. As we have seen, rationality is bounded by the fact that individuals work in different environments and have different perception of things. This frames the processes of choice. The questions of how, why, when and for whom the data was collected are important ones. There may be a difference in the way that black and white people react to the data. The fact that current data shows a greater impact of the disease among members of the African community seems to factor into the reaction of management who are mostly white. There was vagueness when some key informants were asked if more would be done by way of programmes, if white people were affected as much as black people. There was feeling from some black informants that in the face of clear evidence that the disease was taking a great toll on the African workers there was complacency on the side of management. Perhaps if there were more black people in management positions the reaction would be a little different, presumably because black communities may be experiencing this disease at a deeper level especially within the context of poverty. The point is that personal experiences count and they may bring to bear on the policy process. They may serve to bring certain issues to the limelight.

Data is often collected for white people in management positions. We must realise that it is also collected at a certain stage in the epidemic. There is expected to be an increase in

deaths even if people change their sexual behaviour and this is because the rates of infection are already high. Thus, the worst is yet to come and the full brunt of the epidemic has not been borne. Failure to realise this will have a negative impact on companies that are not prepared. At present there seems to be the feeling that data is being exaggerated and that deaths from HIV/AIDS may serve the positive function of decreasing unemployment. Whatever the issues and perceptions that surround the disease and the interpretation of the available data, it is clear that data is very important for decision-making and it is not neutral.

Another way in which inaction may be justified through rationality is, for example, when HIV/AIDS is attributed to cultural practices or defined as a personal health issue. This is where companies may feel that meaningful interventions are costly and there is no point of spending money on these because HIV/AIDS is a problem tied to culture. Thus, the human element again comes in because it is a question of how data is interpreted. When interventions are not seen to make an impact, one could attribute this to a number of factors. Either the interventions are not effective in themselves because of their approach, or the people to whom the interventions are aimed are too steeped in culture to respond to the messages they are receiving. Thus, it is a matter of interpretation. This came up in several of the interviews. It was clear that the data was being interpreted by individuals who were of a different race to those that were most affected by HIV/AIDS. Thus, casting HIV/AIDS as a cultural issue could justify the futility of interventions and the poor attempts to combat the disease in the workplace. It could lend credence to the fact that companies were doing all that they could but that it was ultimately impossible to deal with this problem effectively as it was tied to the question of culture.

Thus, even when data is statistically accurate, it may not lead to rational analysis. Often, choices are made from available alternatives that are never really exhaustive. Instead, they are the options that are seen to be feasible or 'good enough.' That is, politically correct, within the bounds of legality or within the existing health budget. In an effort to choose what is simply good enough rather than what is the best option some important interventions may be left out. A good example is the fact that the key informants reported

that there were no significant efforts aimed at providing medication for opportunistic infections. The issue of medication was also one that had been politicized. The companies felt that these medications were too expensive to provide to employees. However, none of the companies had calculated and compared the costs of retraining or rehiring against prolonging life by providing medication. These are some of the factors that may be left out in the decision making process. Decisions are not made after all the alternatives are explored and the alternatives that are left out depend on the priorities of the particular organisation.

Another important factor to note is that the way the problem is defined is very important in determining the response to it. Issues gain or lose importance according to, in a company, for example, what department they fall under. The fact that HIV/AIDS was dealt with under the Personnel Department, which more often than not relegated it to the company clinic, shows that it was not such a big priority and that it did not play a significant part in the formulation of the company strategy. Few companies had policies specific to HIV/AIDS and there were no significant resources put aside for this particular issue. Other than falling within a department, and not commanding a specialised team or section of it's own, HIV/AIDS was more often than not defined as any other major illness. In light of the fact that this disease is unique and may have major institutional impacts, this definition of HIV/AIDS relegates it to a position of less significance than is required for a rational response to be planned.

## CONCLUSION

The issue of HIV/AIDS is a complex one. It is not merely a personal health issue. It is a developmental issue and could turn into a national calamity in South Africa with a bearing on the way that companies function. Thus, there may be a major institutional impact with real economic implications.

With this in mind, it is important for companies in South Africa to formulate workable strategies to deal with this problem. Most of the companies in this study did not have policies specific to HIV/AIDS. Neither did they have specific funds allocated to realising the programmes that were in place. The most sustained intervention was the provision of condoms, the success of which had not been evaluated, but was in doubt according to the responses of the key informants. All the other interventions were unsystematic and intermittent. Nevertheless, many of the key informants felt that they were successful, despite a lot of evidence to the contrary. This perhaps due to the fact that there were no predetermined criteria for determining the success of the interventions in addition to the fact that there was a contradictory and messy understanding of the issues surrounding HIV/AIDS. Also, there was denial and this translated into an insufficient social response. These are some of the factors that will prevent a rational response from companies.

The rational choice model does seem to aid in our understanding of the policy process but perhaps only when we realise that it works together with other human factors. Rational decision making is limited, as we have seen, in various ways. People may not share a similar definition of the HIV/AIDS problem. Perceptions may differ as a result of personal factors that influence opinions- race, gender, personal experience, values and prejudices. Therefore, the result is often a less pure form of cost-benefit analysis, coloured, or *bounded* by these factors.

Moreover, there is, as we have seen an organisational context and this too determines how the reaction will be and how the analysis of the problem will be carried out. It is



important to know the goals and objectives of the organisation as well as what issues are defined as of a high priority.

Implementation is hampered and may be impossible where resources are not sufficient to meet policy demands. This is another factor that will limit rationality. Human behaviour is goal oriented and will involve some weighing of cost and benefits of various courses of action. What is important to realise is that it is almost impossible to come up with the perfect solution. This is because of all the limits to rationality that we have encountered in the course of this study- psychological, political, social and economic. These limit rationality and affect decision- making. There is also the question of limited cognitive capacity as a barrier to rationality. This we have seen in the seemingly overwhelming nature of the HIV/AIDS problem so that many respondents were not aware of how to react.

Perhaps it is true to say that, "Strategies that aim at perfect rationality are plausible and appealing but they seem virtually impossible to execute. There is not one single strategy that can guarantee that it will lead to the discovery of the best available alternatives....discovery requires an imaginative search. There is then, in political analysis, an indispensable need for the informed imagination; for speculation guided by knowledge....for the willingness to think hard about unthinkable alternatives and the all too easily thinkable solutions. There is in short a need for a creative search inspired by the hunch that somewhere between the unattainable best and the kind of mediocrity so often attained in political matters there lies a universe of better alternatives- and worse ones too- all waiting to be explored. (Dahl, 1991: 143).

Whatever the case it is clear that the companies here have to better understand the issues at hand so that they are better placed to respond. Without this basic knowledge, any type of response may be inadequate.

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## APPENDIX ONE: QUESTIONNAIRE

### HIV and AIDS in Enterprises in KwaZulu Natal

1. Name of company

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2. Type of company

.....

3. Number of employees

.....

4. Skill composition of workforce

..... skilled ..... semi-skilled ..... unskilled

5. Gender composition of workforce

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6. Racial composition of workforce

..... White ..... Coloured ..... Indian ..... African .....

7. Do you have an age profile of employees? Please attach

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I am going to talk to you about HIV and AIDS as it affects your organisation.

8. How do you understand the problem of HIV and AIDS?

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9. What do you feel is the biggest challenge HIV and AIDS poses to your organisation?

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12. What, if any intervention programmes do you have? Please describe these in detail.  
(Where is it directed? -within the organisation; in employee communities; in the  
broader society, HIV testing and counseling (who provides the service?)).

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13. What about interventions to manage HIV, to deal with opportunistic infections, to prepare for death etc)

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14. How did you come to develop this policy and/or intervention programme? (Is it something you developed in an ad hoc way from experience; did you get outside help from whom, was capacity built within the organisation generally or was it division directed etc.).

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15. Have you allocated specific financial and personnel resources to realise your policy/programmes (department, level% within the department, level % of overall budget, amount).

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16. Do you think that your policies and programmes are effective? (why do you say this, in what way, what's missing)

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17. Given the scale of the HIV epidemic and its now recognised economic and social impacts, do you think your programmes and policies are up to the task to keep your organisation in business?

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